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DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

CONTRA COSTA DMC-ODS REPORT

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CONTRA COSTA DMC-ODS REPORT

Beneficiaries Served in Fiscal Year (FY) 2018-19: 1,891
Contra Costa Threshold Language(s): Spanish
Contra Costa Size: Large
Contra Costa Region: Bay Area
Contra Costa Location: East of San Pablo Bay, south of Solano, west of Sacramento and San Joaquin, and north of Alameda
Contra Costa Seat: Martinez
Contra Costa Onsite Review Process Barriers: COVID-19 challenges with CFM groups and normal process of site visits.

Site Review Special Characteristics

This review took place during the COVID-19 pandemic when the Governor's Executive Order established restrictions on in-person gatherings and other public safety precautions. In response, CalEQRO worked with Contra Costa to design an alternative to the usual in-person onsite review format. Sessions including client focus groups were conducted using Zoom. Contra Costa also was dealing with serious fires and needed to relocate a 25-bed residential program to a hotel for safety but continued to provide services and supports. They had to remain in the hotel for two weeks due to evacuation orders.

Introduction

Contra Costa officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in June 2017 for Medi-Cal recipients as part of California's 1115 DMC Waiver. Contra Costa was the fifth county to launch DMC-ODS services statewide.

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

How Beneficiaries Access Care

There are some best practices important to DMC-ODS programs in how they organize their access to care. To understand whether a county is doing these, it is important to know how they have organized their access systems. In addition, the special terms and conditions (STCs) of the 1115 Waiver have specific requirements for the 24-hour Access (ACCESS CALL CENTER) or as many describe it their "Access Call Center". They play different roles in different counties in the linkage of clients to treatment depending on the size of the county and the design of the access points. To evaluate the access system

quality and timeliness, it is important first to understand how each DMC-ODS has chosen to organize its access system with intake locations and use of screenings, assessment, and engagement.

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

Primary entry points into treatment:

1. Contra Costa's Access Call Center has and continues to play a pivotal role in facilitating client access to treatment when first entering the DMC-ODS, as well as in helping with transitions in levels of care over time. A very large percentage of services were and continue to be linked to the Access Call Center as it is operated. The STCs require Access Call Center with 24-hour capacity. Contra Costa is adding Optum Health services to assist in afterhours and weekend services which were not covered before except by an answering machine. This new contract is scheduled to begin October 2020. While clients can still approach clinics and contract providers directly, with COVID-19 there was a major shift from direct contacts to using the Access Call Center.

2. With reductions in direct requests for services with community providers, the Access Call Center needed to expand to cover a higher volume of requests and link them to treatment with screenings. A system reorganization was done to add 11 case management (CM)/clinician positions linked to the Access Call Center. These staff were to assist with the client engagement and linkage particularly for those with co-occurring mental health needs or physical health needs. These positions were licensed and certified and could provide counseling assistance also to clients until they completed their full ASAM assessment and were linked to the appropriate level of care. This new Transition Team is part of one of the Contra Costa PIPs for quality improvement.

   The Contra Costa Access Call Center does not itself do authorizations for residential but assists with linkage to those who do the full assessment and placement. CM supports as discuss above are available for urgent requests and those with complex conditions. CM navigation for referrals from ED and Jail and Homeless is also available to help with linkage into treatment. Contra Costa also has a real time resource for placement options and system capacity.

   Initially after COVID-19 orders were in place there were challenges with access and engagement. The addition of the transition team made a significant difference in retention and successful linkage to care and after several months the systems were in place to make placements into care in an expedited manner.

Continuum of Care Overview

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

Contra Costa has a complete system of care services with the exception of recovery services which is just beginning to be provided. This year there was new service capacity added to residential treatment, CM, and MAT support. Contra Costa is still working on the addition of an NTP in the central county area. There were legal challenges to opening this program from the city of Concord, but they were successful in court and hoping to open a facility in the next year.

Case Management/Care Coordination Model

CM and coordination of care in a managed care model based on the ASAM continuum of care is a critical service. DMC-ODS programs have approached this element of the care system in vastly different ways. Because it has such a major impact on the clients and their outcomes, it is important to understand how the DMC-ODS has chosen to organize this service as part of the continuum of care. In many ways, it is the glue that makes the system work as a whole for the client versus siloed program elements. CM services include advocacy, linkage, support, monitoring, and practical assistance based on a foundation of a therapeutic alliance with the client with SUD. Given the levels of impairment and stages of change experienced, many clients need these CM supports especially in early stages of treatment to be successful in initiation and engagement, and ultimately in progress and positive outcomes.

As discussed, Contra Costa has CM in the new Transition Team with 11 staff linked to the Access Call Center. They also assist with new client requests from youth serving agencies, criminal justice agencies and hospital emergency departments. In addition, CM services are part of most contract agencies scope of work and is limited to intake/benefit functions and discharge planning. The contractors did not add staff in most programs to provide this function, and so it is provided on a limited basis. As soon as the client is discharged from the residential or outpatient program, all CM is stopped by the contract provider.

The best practice model for CM includes case managers who see the client on an ongoing basis across all the levels of care. System-wide CM programs has been very effective where clients can keep relationships with case managers over multiple phases of their treatment process.

EXTERNAL QUALITY REVIEW COMPONENTS

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

The State of California Department of Health Care Services (DHCS) has contracted with 30 separate counties and seven Partnership counties to provide Medi-Cal covered specialty DMC-ODS services to DMC beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the FY 2020-21 EQR findings of Contra Costa's FY 2019-20 implementation of their DMC-ODS by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

Both a statewide annual report and this DMC-ODS-specific report present the results of CalEQRO's validation of 16 performance measures (PMs) for ongoing implementation of the DMC-ODS Waiver as defined by DHCS. The 16 PMs are listed at the beginning of the PM chapter, followed by tables that highlight the results.

[1] Department of Health and Human Services for Medicare and Medicaid Services (2017). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR). Protocol , Version 2.0, September 2017. Washington, DC: Author.

Performance Improvement Projects[2]

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

The CalEQRO staff provide trainings and technical assistance to the County DMC-ODS staff for PIP development. Materials and videos are available on the web site in a PIP library at http://www.caleqro.com/pip-library. PIPs usually focus on access to care, timeliness, client satisfaction/experience of care, and expansion of evidence-based practices and programs known to benefit certain conditions.

DMC-ODS Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which Contra Costa meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of Contra Costa reporting systems and methodologies for calculating PMs. It also includes utilization of data for improvements in quality, coordination of care, billing systems, and effective planning for data systems to support optimal outcomes of care and efficient utilization of resources.

Validation of State and County Client Satisfaction Surveys

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

[2] Department of Health and Human Services, Centers for Medicare, and Medicaid Services (2017). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services, Centers for Medicare, and Medicaid Services (2017). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol, Version 2.0, September 1, 2017. Washington, DC: Author.

UCLA analysis and outliers in the results to discuss with the DMC-ODS leadership any need for additional quality improvement efforts.

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

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

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

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

Discussed in the following sections are changes from FY 2018-19 and since the launch of the DMC-ODS Program in February 2017 that were identified as having a significant effect on service provision or management of those services. This section emphasizes systemic changes that affect access, timeliness, quality, and outcomes, including any changes that provide context to areas discussed later in this report. This information comes from a special session with senior management and leadership from each of the key SUD and administrative programs.

PRIOR YEAR REVIEW FINDINGS

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

Status of Prior Year Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

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

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

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

Prior Year Key Recommendations

Recommendation 1: Secure a vendor or staff coverage plan for night and weekend Access Call Center services to provide DMC-ODS beneficiaries 24-hour access line services as Contra Costa does during the week.

Status: Met

- Since 2016, Contra Costa has been part of an inter-regional agreement which includes San Mateo, Marin, Sonoma counties for mental health. Following the EQRO last year, Behavioral Health conducted a feasibility assessment to consider various options to address after hours calls requirement for both the MPH and the DMC-ODS plans. The process for reestablishing the agreement was initiated back in October 2019 and has continued through implementation in October 2020. With the new agreement with San Mateo, the new night and weekend services with Optum linked to the DMC-ODS access program will be covered as required.

Recommendation 2: Continue efforts to expand and stabilize the provider network to meet network adequacy standards and DMC billable services as detailed in the state contract.

Status: Met

The following new providers were added to the DMC-ODS Provider Network to enhance capacity and timeliness of access:

- Health Right 360 - Level 3.5 residential treatment

  Contra Costa developed a protocol for a seamless transition of DMC beneficiaries from Contra Costa to San Francisco for 3.5 residential treatment with HR360. An array of support including medications has resulted in successful treatment completions at HR360.

- Richmond Health and Wellness through WestCare NTP and Residential

  As reported last year, with a new provider in the network recently received the provisional license to operate residential treatment levels 3.1, 3.2 and 3.5 in the Western part of Contra Costa. This addition addressed much needed 3.2 and 3.5 bed capacity for men. This program began operations on August 15, 2020 with 25 beds. WestCare provides a variety of services in the State, and they are based in Fresno county. COVID-19 restrictions on social distancing has made it impossible to fill all the beds, and this is an issue of concern to the contractor and the county.

- Bright Heart Health

  A leading expert in telemedicine, BHH has initiated outpatient services through a Virtual clinic. Preparations for implementation of this innovative program include the installation of tablets at two Oxford House recovery homes whereby clients can participate in treatment while at a Recovery Residence. As part of the coordinated approach, a Tuesday Lunch Call included an introductory presentation by Bright Heart Health to all substance use residential providers and Access Line staff. BHH, is also a DMC-ODS Medi-Cal certified MAT provider.

- Methadone (MAT) Provider in Central Contra Costa

  Following multiple unsuccessful attempts for over two years to site a location on various cities in central areas of the county, and three years of contentious negotiations with City Planning which culminated with a lawsuit to the City of Concord, MedMark was able to receive support for the opening of a MAT clinic with several contingencies. Plans to operate a clinic on Solano Way in Concord continue. A leased was signed for a site conveniently located at a shopping center with easy access to the freeway and public transportation. Plans to submit license application have been slowed down as a result of COVID-19 but is still the goal of the County.
  https://www.eastbaytimes.com/2019/03/01/methadone-clinic-can-open-in-concord-after-city-settles-lawsuit/

Recommendation 3: Enhance efforts as discussed in Cultural Competence and other sessions to expand bilingual Spanish-speaking staff, both County and contract, considering new incentives, training opportunities, loan forgiveness, and other potential solutions to increase access.

Status: Partially Met

- AODS has applied and received approval for the hiring of two Spanish-speaking substance abuse counselors. Both of which will be a part of *The Transition Team* and one will be dedicated to support perinatal and pregnant women. In addition, Contra Costa continues to encourage providers to hire bilingual counselors and provide bilingual pay. Recruitment for both positions will start in early September. Contra Costa maintains a contract with The Latino Commission and Pueblos del Sol fully represented by Spanish speaking staff. In addition, there is a Spanish-speaking Latino Outreach Worker as part of county staff. Outreach efforts over the last year resulted in increased calls to Access requesting services who were Spanish-speaking and there is a desire to continue this plus add more bilingual staff across the continuum. One of the goals in the Cultural Competence Plan is to increase the diversity of our workforce both county and contract providers.

Recommendation 4: To support the good work this year with contract providers in enhancing partnerships and communication, create a Contra Costa provider manual similar to other counties. This would allow for enhanced understanding of expectations and requirements and procedures as well as coordination of care goals and other expectations.

Status: Partially Met

- Contra Costa AODS completed a draft of the Clinical Documentation Section of the Provider Manual along with a timeline for completion, AOD staff had started weekly meetings to ensure completion. Unfortunately, and in response to the corona virus national public health order all county services followed shelter in place guidance. Contra Costa had anticipated convening several collaborative workgroups to include county and provider staff to finish this section and discuss the needs of other sections of the Manual.

Recommendation 5: As recommended last year, Contra Costa should develop a solid plan and timeline for an EHR for the DMC-ODS program including the contract agencies or at least inter-operability with the contract agencies to improve care coordination, quality, and billing efficiency.

Status: Partially Met

- EPIC (ccLink) is the integrated electronic health record (EHR) system for the Contra Costa Health System hospitals, ambulatory care, clinics, mental health, and detention. AODS only has partial access to ccLink due to 42 CFR Part 2 segmentation requirements.
- Since February 2020, Contra Costa has started rolling out a Behavioral Health Services (BHS) Provider Portal to contract providers with view access to ccLink data. Through this portal, SUD providers are able to view relevant medical and mental health treatment-related client data in support of continuity and coordination of care.
- In addition, AODS is developing a Face Sheet from ShareCare that highlights all the clinical services received by the client in SUD services. It is envisaged that this Face Sheet will allow SUD providers to view the client's complete substance use treatment history.
- In March 2020, planning discussions on the development of an EHR were derailed by the COVID-19 public health emergency.
- Given the billing challenges and extra coordination needed to insure standards are met with Medi-Cal claiming, treatment plans, and documentation, the automation the IS system for SUD is needed including the EHR with contract provider participation. The portal was one step forward, but addition efforts are needed to successfully operate the DMC-ODS as a managed care plan.

Recommendation 6: As discussed last year, Contra Costa should continue efforts to refine and implement CM and recovery services as they are a vital part of the 1115 Waiver and an entitlement for clients who need them.

Status: Partially Met

- Since 2018, Contra Costa *has provided very limited* with the provision CM and recovery services. These are particularly important during transitions in care. Contra Costa documented and provided an abundance of training and promotional material to support these service functions, particularly CM. In early 2019, Contra Costa received one-time only SABG funding which was earmarked for providers as start-up funds to hire dedicated case managers. Although there was a slight increase in CM, services are insufficient to meet client needs. Notably, all of the providers relied on Whole Person Care (WPC) case managers which had many CM services available rather than providing them directly.

  After the last EQRO, Contra Costa began to reconceptualize the CM model. Following EQRO advice, the AOD chief contacted Riverside and Marin county, which are both effectively supporting clients during transitions with centralized CM models. Several other counties, like Contra Costa, are also having billing challenges when they have a centralized CM unit working across the entire DMC-ODS continuum.

In early March 2020 and as a result of COVID-19, DMC services were re-organized. These staff formed the new Transition Team as a response to support the critical needs of clients. Many of these clients could not enter treatment due to shelter in place orders. The team resolved the challenges associated with obtaining COVID-19 and TB tests or physicals required for admissions, particularly to residential treatment. The success of the services was documented in a new PIP. Transition team members support the client to obtain needed treatment from the moment they call the Access Call Center. While the client is in treatment, they rely on the case manager of the treatment program, to prevent duplication. During the month of July, for example, Contra Costa's Transition Team received 82 client referrals and scheduled 74 intake appointments for treatment. Fifty-four clients completed their intakes and began treatment. Contra Costa met an important improvement goal of reducing 10 percent of their no shows.

- Treatment providers now rely on The Transition Team for support, and Contra Costa is delivering these CM services during transitions between levels of care, but the services are not entered into Drug Medi-Cal billing. Technical assistance is needed with these billing challenges. Contra Costa has incorporated this model of CM into a PIP. They are working to show that this is indeed an effective way to engage and support clients for both CM and eventually also recovery support services.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

Medical Director left the Behavioral Health division and with the exception of regular position turnover, there were no other major personnel changes.

The major changes to the environment were COVID-19 impacts and the fires of August and September impacting programs and evacuations.

Past Year's Initiatives and Accomplishments

Addition of residential services and MAT services.

- Addition of transition team in response to needs triggered by COVID-19
- Advocacy for financial support for provider organizations because of COVID-19 and in partnership with other counties.
- Addition of telehealth equipment and technology within 60 days of stay at home orders and shifting delivery of services in response to COVID-19 including adding PPE, COVID-19 testing priority, special quarantine housing options for

those testing positive, and up to minute new flash systems for quick and timely communication with the community and providers.

Contra Costa List of Current Initiatives

- Continued expansion of telehealth equipment and options for clients, staff, and contractors.
- Maintaining service capacity within legal limited of Public Health orders including residential programs and those serving the homeless SUD individuals in a safe and supportive manner.
- Access to PPE in all programs and for all client groups.
- Addressing funding reductions as a result of COVID-19 with as minimal an impact as possible on direct services and clients.
- Continue Collaboration in Action activities with CBOs and planning for the future including addressing NA issues and emerging needs.
- Continue behavioral health integration efforts including having all outpatient sites DMC-ODS certified for outpatient. These are integrated sites with mental health and SUD staff. Also adding a clinician’s luncheon for cross training and collaboration on optimal service delivery.
- Enhancing and supporting ED Bridge pilot with an SUD counselor on site at peak times and working with psych emergency clients as well with co-occurring needs.
- Adding two more recovery residence sites with Oxford House in the county which have proven so successful for residents.
- Continued efforts at improving computer systems such as Sharecare and access to Epic. This includes formation of a SUD data group, expansion, and refinement of the CBO ccLink portal to coordinate care, and improvement of revenue claiming and management.
- Service provider stabilization and collaboration to avoid loss of key providers and expansion of capacity where needed such as the efforts with Bright Heart Health.
- Improving productivity across Behavioral health and particularly outpatient DMC services with new data utilization and coordination.
- Continued partnerships with four primary care clinics on Buprenorphine access and SUD counseling (the Choosing Change program).
- Continued collaboration and support for MAT Expansion project in the local jails with Health management Associates including a new position for CM. This

includes a pilot project using Sublocade injectable in the detention centers to reduce diversion and improve outcomes and transitions to the community.

- Expansion of youth services for outpatient and intensive outpatient via RFPs and collaboration with bay area counties on residential needs. This included addition Antioch Children's Behavioral Health as a drug Medi-Cal site, submission of a Proposition 64 grant to focus on youth development and prevention, and expanded SUD youth services in schools such as Bay Point, Mt Diablo, and some junior high schools as well.

PERFORMANCE MEASURES

The purpose of PMs is to foster access to treatment and quality of care by measuring indicators with solid scientific links to health and wellness. CalEQRO conducted an extensive search of potential measures focused on SUD treatment, and then proceeded to vet them through a clinical committee of over 60 experts including medical directors and clinicians from local behavioral health programs. Through this thorough process, 12 performance measures were identified to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, the Treatment Perception Survey (TPS), CalOMS, and the ASAM level of care data for these measures.

1. CalOMS Treatment Data Collection Guide: http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf
2. TPS: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf
3. ASAM Level of Care Data Collection System: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

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

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

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries.
- Number of days to first DMC-ODS service after client assessment and referral.
- Total costs per beneficiary served by each county DMC-ODS by ethnic group.
- Cultural competency of DMC-ODS services to beneficiaries.
- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes).
- Coordination of care with physical health and mental health (MH).
- Timely access to medication for Narcotics Treatment Program (NTP) services.

- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured.
- Timely coordinated transitions of clients between levels of care, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics).
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs).
- Percentage of clients with three or more Withdrawal Management (WM) episodes and no other treatment to improve engagement.

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

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

HIPAA Guidelines for Suppression Disclosure

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

Year Three of Waiver Services

This is the third year that Contra Costa has been implementing DMC-ODS services. Performance Measure data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file (FY 2018-19), and from UCLA for TPS, ASAM, and CalOMS data from FY 2018-19. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there may be a claims lag for services in the data available at the time of the review. CalEQRO used the time period of FY 2018-19 to maximize data completeness for the ensuing analyses. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same

time period. CalEQRO included in the analyses all claims for the specified time period that had been either approved or pended by DHCS and excluded claims that had been denied.

DMC–ODS Clients Served in FY 2018-19

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

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

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

Contra Costa's FY 2018-19 claims data appeared incomplete when compared to what was reported for CY 2018. The FY 2018-19 data showed 1,891 unique clients received DMC-ODS services, yielding a total penetration rate of 0.94 percent which was on par with the statewide average but slightly lower than the average for large size counties.

Table 1: Penetration Rates by Age, FY 2018-19

Contra Costa				Large Counties	Statewide
Age Groups	**Average # of Eligibles per Month**	**# of Clients Served**	**Penetration Rate**	**Penetration Rate**	**Penetration Rate**
Ages12-17	30,458	67	0.22%	0.29%	0.27%
Ages 18-64	143,989	1,566	1.09%	1.24%	1.12%
Ages 65+	27,206	258	0.95%	0.78%	0.69%
TOTAL	**201,653**	**1,891**	**0.94%**	**1.03%**	**0.93%**

The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it. The averages are calculated independently.

Table 2 below shows Contra Costa's average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties. Average approved claims were less than statewide averages across all age groups.

Table 2: Average Approved Claims by Age, FY 2018-19

Contra Costa			**Statewide**
Age Groups	**Total Approved Claims**	**Average Approved Claims**	**Average Approved Claims**
Ages 12-17	$79,420	$1,185	$1,834
Ages 18-64	$5,752,244	$3,673	$3,951
Ages 65+	$1,024,160	$3,970	$4,643
TOTAL	**$6,855,824**	**$3,626**	**$3,921**

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

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2018-19

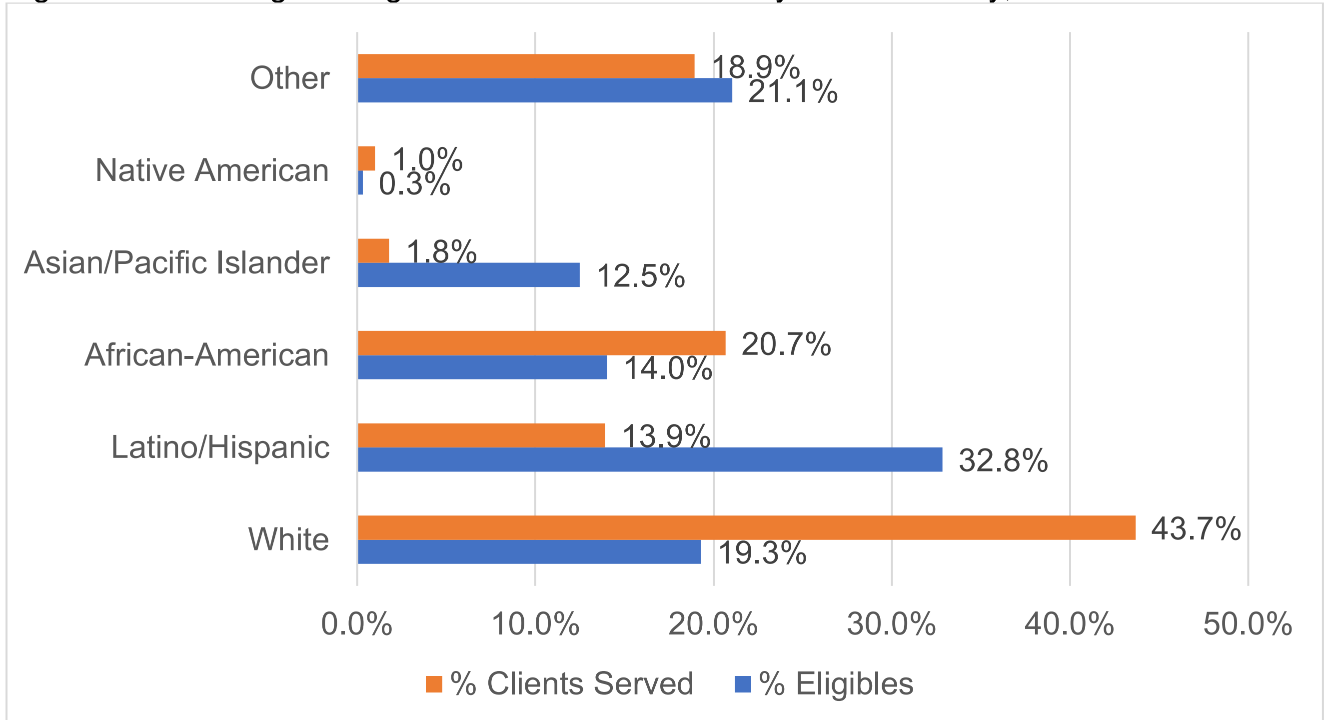


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. Clients who are White had a higher penetration rate than clients who are Latino/Hispanic, African American or Asian/Pacific Islander. Nineteen clients who received services are Native Americans and this group had the highest penetration rate.

Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19

Contra Costa				Large Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	38,913	826	2.12%	2.14%	1.77%
Latino/Hispanic	66,239	263	0.40%	0.73%	0.66%
African American	28,255	391	1.38%	1.36%	1.27%
Asian/Pacific Islander	25,168	34	0.14%	0.17%	0.16%
Native American	628	19	3.03%	2.53%	1.62%
Other	42,450	358	0.84%	1.08%	1.05%
TOTAL	**201,653**	**1,891**	**0.94%**	**1.03%**	**0.93%**

The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it.

Table 4 below shows Contra Costa's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. The largest eligibility group was ACA, followed by clients who are Disabled or in the Family Adult group. Even with incomplete claims data, Contra Costa showed a higher penetration rate for Disabled clients than the statewide average.

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2018-19

Contra Costa				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	25,574	524	2.05%	1.63%
Foster Care	633	*	n/a	1.77%
Other Child	17,909	41	0.23%	0.29%
Family Adult	38,805	440	1.13%	0.95%
Other Adult	31,002	42	0.14%	0.10%
MCHIP	13,115	*	n/a	0.20%
ACA	74,319	884	1.19%	1.46%

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

Table 5 below shows Contra Costa's approved claims per penetration rates by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. For average approved claims, Other Adults had the highest rate, followed by Family Adult and Disabled clients.

Table 5: Average Approved Claims by Eligibility Category, FY 2018-19

Contra Costa				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	25,574	524	$3,754	$4,259
Foster Care	633	*	n/a	$1,157
Other Child	17,909	41	$1,391	$1,770
Family Adult	38,805	440	$3,853	$3,321
Other Adult	31,002	42	$4,106	$4,344
MCHIP	13,115	*	n/a	$1,884
ACA	74,319	884	$3,327	$3,911

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

Table 6 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of service usage by clients in FY 2018-19. In NTP/OTP services 57 percent of clients were served, followed by 20 percent in Outpatient Services and 13 percent in Residential Treatment. The service category with the highest average approved claims was Residential Treatment at $5,237.

Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2018-19

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	1,174	57.2%	$3,270
Residential Treatment	270	13.1%	$5,237
Res. Withdrawal Mgmt.	*	n/a	$1,868
Ambulatory Withdrawal Mgmt.	-	-	$0
Non-Methadone MAT	*	n/a	$1,515
Recovery Support Services	*	n/a	$40
Partial Hospitalization	-	-	$0
Intensive Outpatient Tx.	185	9.0%	$3,910
Outpatient Services	410	20.0%	$2,093
TOTAL	**2,054**	**100%**	**$3,338**

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

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

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

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

On average, Contra Costa clients received their first dose of methadone within 24 hours after being assessed/diagnosed, which reflects timely access to treatment.

Table 7: Days to First Dose of Methadone by Age, FY 2018-19

Contra Costa				Statewide		
Age Groups	**Clients**	**%**	**Median Days**	**Clients**	**%**	**Median Days**
Ages 12-17	-	-	-	*	n/a	n/a
Ages 18-64	922	80.10%	<1	29,072	80.27%	<1
Ages 65+	229	19.90%	<1	*	n/a	n/a
TOTAL	**1,151**	**100.00%**	**<1**	**36,219**	**100.0%**	<1

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

Services for Non-Methadone MATs Prescribed and Billed in Non-DMC-ODS Settings

Some people with opiate addictions have become interested in newer-generation addiction medicines that have increasing evidence of effectiveness. These include buprenorphine and long-acting injectable naltrexone that do not need to be taken in as rigorous a daily regimen as methadone. While these medications can be administered through NTPs, they can also be prescribed and administered by physicians through other settings such as primary care clinics, hospital-based clinics, and private physician practices. For those seeking an alternative to methadone for opiate addiction, or a MAT for another type of addiction such as alcoholism, some of the other MATs have the

advantages of being available in a variety of settings that require fewer appointments for regular dosing. The DMC-ODS Waiver encourages delivery of MATs in other settings additional to their delivery in NTPs. Medical providers are required to receive specialized training before they prescribe some of these medications, and the number of these providers is growing.

Contra Costa's Choosing Change program, which operates out of Primary Care FQHCs, provides non-methadone MAT (buprenorphine) to people who want to stop using opioids such as heroin, prescription painkillers like oxycodone, and similar drugs. These services are billed to the FFS Medi-Cal system and during the EQRO review, it was reported that Choosing Change currently serves over 600 clients at the time of the review.

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

Table 8 display the number and percentage of clients receiving three or more MAT visits per year provided through Contra Costa providers and statewide for all actively implemented DMC-ODS counties in aggregate. Three or more visits were selected to identify clients who received regular MAT treatment versus a single dose. The numbers for this set of performance measures are based upon DMC-ODS claims data analyzed by EQRO.

Only eight clients received three or more non-methadone MAT services in FY 2018-19, giving Contra Costa a lower rate than the statewide average.

Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2018-19

Contra Costa					Statewide			
Age Groups	**At Least 1 Service**	**% At Least 1 Service**	**3 or More Services**	**% 3 or More Services**	**At Least 1 Service**	**% At Least 1 Service**	**3 or More Services**	**% 3 or More Services**
Ages 12-17	-	-	-	-	*	n/a	*	n/a
Ages 18-64	*	n/a	*	n/a	3,251	4.20%	1,360	1.76%
Ages 65+	*	n/a	*	n/a	*	n/a	*	n/a
TOTAL	*	n/a	*	n/a	**3,545**	**3.86%**	**1,461**	**1.59%**

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

Transitions in Care Post-Residential Treatment: FY 2018-19

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

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

Table 9 shows two aspects of this expectation: 1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. The table shows the percentage of clients who began a new level of care within 7 days, 14 days, and 30 days after discharge from residential treatment. Also shown in the table are the percent of clients who had follow-up treatment from 31-365 days.

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

Only 5 percent of clients who left residential treatment was transitioned to a lower level of care within 7 days, which was a lower rate than the state average. However, if no date parameter is applied, Contra Costa had a higher rate of clients (21 percent) transitioning to another LOC than the state average (19 percent).

Table 9: Timely Transitions in Care Following Residential Treatment, FY 2018-19

Contra Costa (n= 326)			Statewide (n= 25,123)	
Number of Days	**Transition Admits**	**Cumulative %**	**Transition Admits**	**Cumulative %**
Within 7 Days	17	5.21%	2,067	8.2%
Within 14 Days	33	10.12%	2,787	11.1%
Within 30 Days	44	13.50%	3,447	13.7%
Any days (TOTAL)	**69**	**21.17%**	**4,677**	**18.6%**

Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUDs are understandably ambivalent about engaging in treatment and making fundamental changes in their lives. The moment of a person's reaching out for help to address a SUD represents a critical crossroad in that person's life, and the opportunity may pass quickly if barriers to accessing treatment are high. A county DMC-ODS is responsible to make initial access easy for prospective clients to the most appropriate treatment for their particular needs. For some people, an Access Line may be of great assistance in finding the best treatment match in a system that can otherwise be confusing to navigate. For others, an Access Line may be perceived as impersonal or otherwise off-putting because of long telephone wait times. For these reasons, it is critical that all DMC-ODS counties monitor their Access Lines for performance using critical indicators.

Table 10 shows Access Line critical indicators from July 2019 through June 2020. Contra Costa's percentage of dropped calls showed an increase from the previous year's 6 percent and the percentage of callers linked to treatment showed a decrease from 10 percent to 8 percent.

Table 10: Access Line Critical Indicators, FY 2019-20

Contra Costa	
Average Volume	1,784 calls per month
% Dropped Calls	9%
Time to answer calls	9 seconds
Monthly authorizations for residential treatment	85
% of calls referred to a treatment program for care, including residential authorizations	8% of callers are linked to treatment through the Access Line
Non-English capacity	1 FTE Access Line staff is bilingual (English/Spanish), and Contra Costa has a contract with language line interpreter services.

High-Cost Beneficiaries

Table 11a provides several types of information on the group of clients who use a substantial amount of DMC-ODS services in Contra Costa. These persons, labeled in this table as high-cost beneficiaries (HCBs), are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $10,589 in approved claims per year. The table lists the average approved claims costs for the year for Contra Costa HCBs compared with the statewide average. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through CM to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

Contra Costa's high-cost beneficiaries rate of 4.1 percent was less than the statewide average of 5.3 percent.

Table 11a: High Cost Beneficiaries by Age, Contra Costa, FY 2018-19

Contra Costa						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	67	-	-	-	-	-
Ages 18-64	1,566	*	n/a	n/a	n/a	n/a
Ages 65+	258	*	n/a	n/a	n/a	n/a
TOTAL	**1,891**	**78**	**4.1%**	**$13,303**	**$1,037,654**	**15.1%**

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

Table 11b: High Cost Beneficiaries by Age, Statewide, FY 2018-19

Statewide					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	4,161	34	0.8%	$14,208	$483,063
Ages 18-64	77,411	4,607	6.0%	$15,604	$71,888,322
Ages 65+	8,729	265	3.0%	$15,601	$4,134,267
TOTAL	**91,853**	**4,906**	**5.3%**	**$15,594**	**$76,505,653**

Residential Withdrawal Management with No Other Treatment

This PM is a measure of the extent to which the DMC-ODS is not engaging clients upon discharge from residential WM. If there are a substantial number or percent of clients who frequently use WM and no treatment, that is cause for concern and the DMC-ODS should consider exploring ways to improve discharge planning and follow-up CM.

Contra Costa did not have qualifying data for this performance measure in FY 2018-19.

Table 12: Residential Withdrawal Management with No Other Treatment, FY 2018-19

Contra Costa			Statewide	
	# WM Clients	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
TOTAL	*	n/a	5,170	2.38%

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

Use of ASAM Criteria for Level of Care Referrals

The clinical cornerstone of the DMC-ODS Waiver is use of ASAM Criteria for initial and ongoing level of care placements. Screeners and assessors are required to enter data for each referral, documenting the congruence between their findings from the screening or assessment and the referral they made. When the referral is not congruent with the LOC indicated by ASAM Criteria findings, the reason is documented.

Of clients who had ASAM screenings 78 percent showed the same indicated level of care as their referrals. 7 percent who had a different LOC between screening and referral was due to the level of care not available in the DMC-ODS. There appeared to be a problem with ASAM transition of assessment and follow-up assessment data thus there are zeros in assessment and follow-up assessment columns.

Table 13: Congruence of Level of Care Referrals with ASAM Findings, 07/01/18 to 02/14/20

Contra Costa ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
07/01/18 – 02/14/20	**#**	**%**	**#**	**%**	**#**	**%**
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	1,507	78.0%	-	-	-	-
Patient Preference	162	8.4%	-	-	-	-
Level of Care Not Available	139	7.2%	-	-	-	-
Clinical Judgement	113	5.9%	-	-	-	-
Geographic Accessibility	*	n/a	-	-	-	-
Family Responsibility	*	n/a	-	-	-	-
Legal Issues	-	-	-	-	-	-
Lack of Insurance/Payment Source	*	n/a	-	-	-	-
Other	*	n/a	-	-	-	-
Actual Referral Missing	-	-	-	-	-	-
TOTAL	**1,931**	**100.0%**	-	-	-	-

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

Initiating and Engaging in Treatment Services

Table 14 displays results of measures for two early and vital phases of treatment—initiating and then engaging in treatment services. They are part of a set of newly adopted measures by CalEQRO for counties in their second year of DMC-ODS implementation. An effective system of care helps people who request treatment for their addiction to both initiate treatment services and then continue further to become engaged in them.

Research suggests that those who are able to engage in treatment services are likely to continue their treatment and enter into a recovery process with positive outcomes. Several federal agencies and national organizations have encouraged and supported the widespread use of these measures for many years.

The method for measuring the number of clients who initiate treatment begins with identifying the initial visit in which the client's SUD is identified. Since CalEQRO does this through claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a client that is not preceded by one within the previous 30 days. This second day or visit is what in this measure is defined as "initiating" treatment. Adult clients had a similar treatment initiation rate (92 percent) than the statewide average (88 percent), but youth clients showed a slightly lower rate (76 percent).

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 15th and 45th day following initial DMC-ODS service. Adult clients had a similar treatment engagement rate (86 percent) than the state average (80 percent) while youth clients had a lower engagement rate (53 percent).

Table 14: Initiating and Engaging in DMC-ODS Services, FY 2018-19

	Contra Costa				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	1,907		70		90,926		4,303	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	1,756	92.08%	53	75.71%	80,346	88.4%	3,397	78.9%
Clients who then engaged in DMC-ODS services	1,502	85.54%	28	52.83%	64,232	79.9%	2,386	70.2%

Table 15 tracks the initial DMC-ODS service used by clients to determine how they first accessed DMC-ODS services and shows the diversity of the continuum of care. NTP/OTP treatment was the initial DMC-ODS service used by 62 percent of clients. 20 percent of clients had outpatient treatment and 11 percent had residential treatment as their initial services.

Table 15: Initial DMC-ODS Service Used by Clients, FY 2018-19

Contra Costa			Statewide	
DMC-ODS Service Modality	**#**	**%**	**#**	**%**
Outpatient treatment	388	19.63%	30,508	32.04%
Intensive outpatient treatment	142	7.18%	6,526	6.85%
NTP/OTP	1,224	61.91%	37,789	39.7%
Non-methadone MAT	-	-	191	0.20%
Ambulatory Withdrawal	-	-	43	0.05%
Partial hospitalization	-	-	16	0.02%
Residential treatment	223	11.28%	15,754	16.5%
Withdrawal management	-	-	4,057	4.3%
Recovery Support Services	-	-	345	0.36%
TOTAL	**1,977**	**100.00%**	**95,229**	**100.0%**

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

Retention in Treatment

Table 16 is a measure of how long the system of care is able to retain clients in its DMC-ODS services, and counts the cumulative time that clients were involved across however many types of service they received sequentially without an interruption of more than 30 days. Defined sequentially and cumulatively in this way, research suggests that retention in treatment and recovery services is predictive of positive outcomes. To analyze the data for this measure, CalEQRO first identified all the discharges during the measurement year (in this case FY 2018-19), defined as the last billed service after which no further service activity was billed for over 30 days. Then for these clients, CalEQRO identified the beginning date of the service episode by counting back in time to the date before which there was no treatment for at least 30 days. The claims data used for these calculations covers 18 months of utilization data, going back six months prior to the year in which discharges are counted. Clients in outpatient programs are counted as having seven days per week if they had at least one outpatient visit in a week.

The mean (average) length of stay for Contra Costa clients was 232 days (median 151 days), compared to the statewide mean of 128 days (median 83 days). 61 percent of clients had at least a 90-day length of stay; 46 percent had at least a 180-day stay, and 39 percent had at least a 270-day length of stay.

Contra Costa clients had a considerably longer stay in DMC-ODS treatment than statewide averages.

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2018-19

Contra Costa			Statewide	
Clients with a discharge anchor event	2,269		86,896	
Length of stay (LOS) for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50th percentile)	Mean (Average)	Median (50th percentile)
	232	151	128	83
	#	%	#	%
Clients with at least a 90-day LOS	1,383	61.0%	40,481	46.6%
Clients with at least a 180-day LOS	1,038	45.7%	22,302	25.7%
Clients with at least a 270-day LOS	873	38.5%	13,194	15.2%

Residential Withdrawal Management Readmissions

Table 17 measures the number and percentage of residential withdrawal management readmissions within 30 days of discharge. Of 3 clients admitted into residential WM in Contra Costa, 0 percent were readmitted within 30 days of discharge as compared to the 7 percent statewide average for all DMC-ODS counties. Contra Costa had no client who were readmitted within 30 days of discharge from residential withdrawal management based on FY 2018-19 claims data.

Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2018-19

Contra Costa			Statewide	
Unduplicated clients of the DMC-ODS	1,891		91,853	
	#	%	#	%
Total DMC-ODS clients who were admitted into residential withdrawal management (WM)	*	n/a	6,392	7.0%
Clients admitted into WM who were readmitted within 30 days of discharge	-	-	446	7.0%

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

Diagnostic Categories

Table 18 compares the breakdown by diagnostic category of the Contra Costa and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2018-19. Opioid was the leading diagnosis code for clients who sought treatment, followed by Other Stimulant Abuse and Alcohol Use Disorder diagnoses. Statewide data showed the same diagnoses rankings but with very different percentages.

Table 18: Percentage Served and Average Cost by Diagnosis Code, FY 2018-19

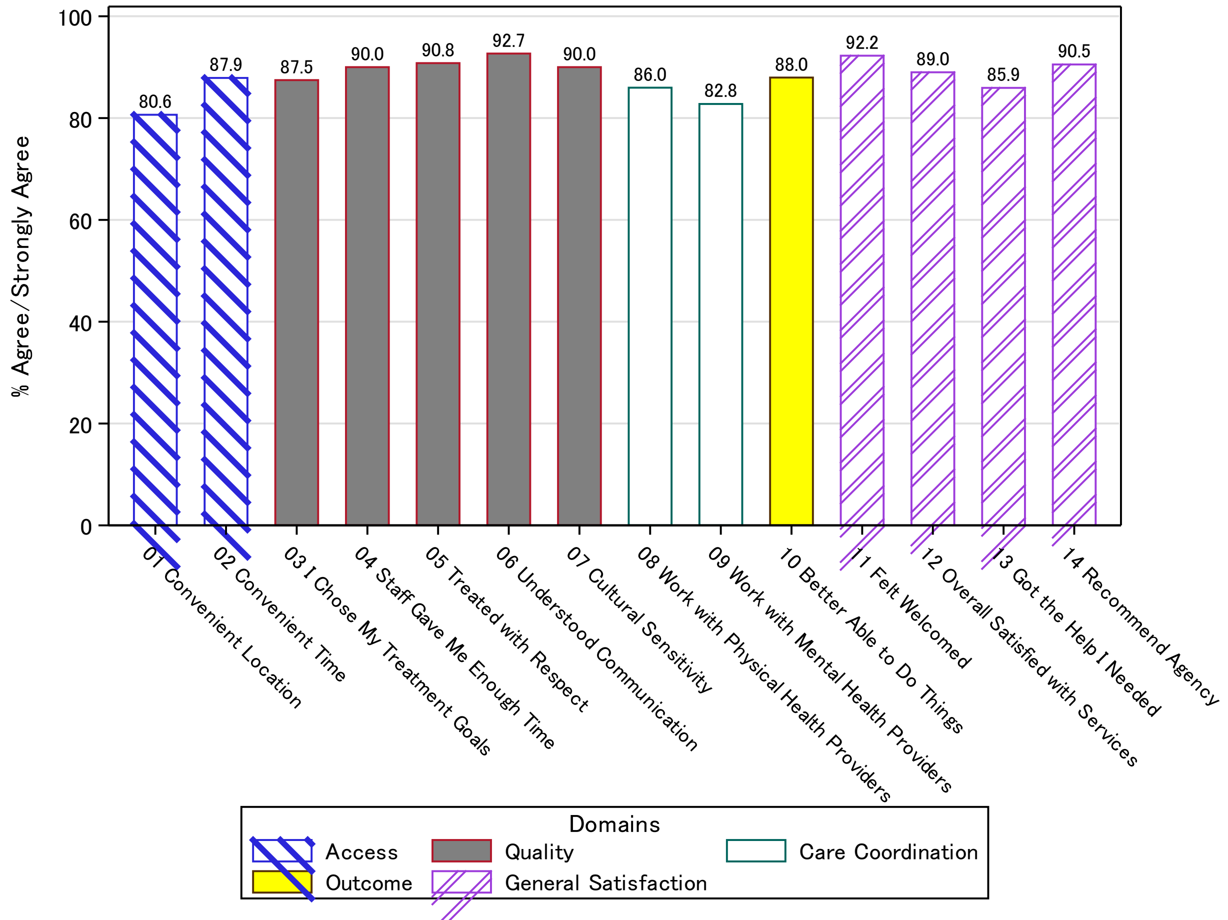
Diagnosis Codes	Contra Costa		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	10.2%	$3,477	15.7%	$4,370
Cannabis Use	7.0%	$1,250	8.7%	$2,029
Cocaine Abuse or Dependence	2.0%	$2,649	2.1%	$4,719
Hallucinogen Dependence	0.0%	$0	0.2%	$3,651
Inhalant Abuse	0.2%	$3,378	0.0%	$3,733
Opioid	65.2%	$3,603	47.0%	$4,307
Other Stimulant Abuse	15.1%	$4,219	24.4%	$3,868
Other Psychoactive Substance	0.0%	$0	0.4%	$3,757
Sedative, Hypnotic Abuse	0.2%	$449	0.5%	$4,291
Other	0.2%	$2,171	0.9%	$2,627
Total	**100.0%**	**$3,626**	**100.0%**	**$4,001**

Client Perceptions of Their Treatment Experience

CalEQRO regards the client perspective as an essential component of the EQR. In addition to obtaining qualitative information on that perspective from focus groups during the onsite review, CalEQRO uses quantitative information from the TPS administered to clients in treatment. DMC-ODS counties upload the data to DHCS, it is analyzed by the UCLA Team evaluating the statewide DMC-ODS Waiver, and UCLA produces reports they then send to each DMC-ODS County. Ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction.

Adult clients gave high scores to TPS questions in all five domains, particularly in the General Satisfaction and Quality areas.

Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA (N = 540)



CalOMS Data Results for Client Characteristics at Admission and Progress in Treatment at Discharge

CalOMS data is collected for all substance use treatment clients at admission and the same clients are rated on their treatment progress at discharge. The data provide rich information that DMC-ODS counties can use to plan services, prioritize resources, and evaluate client progress.

Tables 19-21 depict client status at admission compared to statewide regarding three important situations: living status, criminal justice involvement, and employment status. These data provide important indicators of what additional services Contra Costa will need to consider and with which agencies they will need to coordinate. CalOMS data showed Contra Costa clients have the same homeless rate as the state, but with less criminal justice involvement and a lower employment status.

Table 19: CalOMS Living Status at Admission, FY 2018-19

Admission Living Status	Contra Costa		Statewide	
	#	%	#	%
Homeless	649	28.9%	34,316	27.8%
Dependent Living	845	37.6%	32,097	26.0%
Independent Living	755	33.6%	57,048	46.2%
TOTAL	**2,249**	**100.0%**	**123,468**	**100.0%**

Table 20: CalOMS Legal Status at Admission, FY 2018-19

Admission Legal Status	Contra Costa		Statewide	
	#	%	#	%
No Criminal Justice Involvement	1,857	82.6%	77,761	62.4%
Under Parole Supervision by CDCR	*	n/a	2,232	1.8%
On Parole from any other jurisdiction	*	n/a	1,597	1.3%
Post release supervision - AB 109	114	5.1%	34,542	27.7%
Court Diversion CA Penal Code 1000	-	-	2,188	1.8%
Incarcerated	255	11.3%	720	0.6%
Awaiting Trial	20	0.9%	5,509	4.4%
TOTAL	**2,249**	**100.0%**	**124,549**	**100.0%**

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

Table 21: CalOMS Employment Status at Admission, FY 2018-19

Current Employment Status	Contra Costa		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	212	9.4%	15,683	12.6%
Employed Part Time - Less than 35 hours	176	7.8%	9,910	8.0%
Unemployed - Looking for work	714	31.7%	36,869	29.6%
Unemployed - not in the labor force and not seeking	1,147	51.0%	62,119	49.8%
TOTAL	**2,249**	**100.0%**	**124,581**	**100.0%**

The information displayed in Tables 22-23 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 22 indicates the percent of clients who left treatment before completion without notifying their counselors (Administrative Discharge) vs. those who notified their counselors and had an exit interview (Standard Discharge, Detox Discharge, or Youth Discharge). Without prior notification of a client's departure, counselors are unable to fully evaluate the client's progress or, for that matter, attempt to persuade the client to complete treatment. An administrative discharge rate of 51.9 percent means more Contra Costa clients left treatment before completion than those who completed their treatment. Contra Costa's rate of administrative adult discharges was similar than the state average of 46.6 percent.

Table 22: CalOMS Types of Discharges, FY 2018-19

Discharge Types	Contra Costa		Statewide	
	#	%	#	%
Standard Adult Discharges	987	30.7%	58,885	43.8%
Administrative Adult Discharges	1,667	51.9%	62,542	46.6%
Detox Discharges	481	15.0%	9,882	7.3%
Youth Discharges	78	2.4%	3,011	2.2%
TOTAL	**3,213**	**100.0%**	**134,320**	**100.0%**

Table 23 displays the rating options in the CalOMS discharge summary form counselors use to evaluate their clients' progress in treatment. This is the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for clients with SUDs. The first four rating options are positive. "Completed Treatment" means the client met all their treatment goals and/or the client learned what the program intended for clients to learn at that level of care. "Left Treatment with Satisfactory Progress" means the client was actively participating in treatment and making progress, but left before completion for a variety of possible reasons other than relapse that might include transfer to a different level of care closer to home, job demands, etc. The last four rating options indicate lack of satisfactory progress for different types of reasons.

In spite of having a high administrative discharge rate, Contra Costa clients had a more positive discharge status overall at 57 percent than the state average of 46 percent.

Table 23: CalOMS Discharge Status Ratings, FY 2018-19

Discharge Status	Contra Costa		Statewide	
	#	%	#	%
Completed Treatment - Referred	901	28.8%	25,720	19.3%
Completed Treatment - Not Referred	-	-	8,374	6.3%
Left Before Completion with Satisfactory Progress - Standard Questions	517	16.5%	17,486	13.1%
Left Before Completion with Satisfactory Progress – Administrative Questions	413	13.2%	9,419	7.1%
Subtotal	*1,831*	*57.0%*	*60,999*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	*	n/a	19,485	14.6%
Left Before Completion with Unsatisfactory Progress - Administrative	1,202	38.5%	50,941	38.2%
Death	*	n/a	207	0.2%
Incarceration	100	3.1%	1,633	1.2%
Subtotal	*1,382*	*43.0%*	*72,266*	*54.2%*
TOTAL	**3,213**	**100.0%**	**133,265**	**100.0%**

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

Performance Measures Findings: Impact and Implications

Access to Care

- Incomplete FY 2018-19 claims data has negatively impacted Contra Costa's penetration rates across all age- and race/ethnicity groups.
- Latino/Hispanic beneficiaries are under-represented in their use of DMC-ODS services.
- Choosing Change clinics located in FQHCs provide non-methadone MAT treatment to clients and referrals are processed through the Access Line.
- At the outset of the COVID-19 public health emergency, a Transition Team was created to provide telephonic CM support to clients awaiting treatment.
- Contra Costa added providers to the DMC-ODS continuum including Bright Heart Health, a leading expert in telemedicine and Richmond Health and Wellness, a provider of residential treatment and withdrawal management services.

- A NTP provider has provisioned 1-2 weeks take-home doses to some clients to ensure sheltering-in-place does not impede their access to medication.
- Contra Costa has contracted with Optum to provide after-hours phone coverage of the Access Line as a multi-county initiative.

Timeliness of Services

- Clients who need NTP treatment have timely access to their first dose of methadone, usually within a day after being assessed/diagnosed.
- Contra Costa has defined urgent condition as "a situation experienced by a beneficiary that, without timely intervention, is likely to result in an imminent substance use related emergency." Further, appointments for Urgent Conditions must occur within 48 hours of initial contact. However, this timeliness metric is not tracked currently in a way there is confidence. This area needs improvement.

Quality of Care

- Adult clients have higher treatment initiation and engagement rates than statewide averages. However, youth clients show lower rates in both treatment initiation and engagement.
- When date parameters are not applied, Contra Costa clients have a higher rate of transitioning to a lower level of care post residential treatment than statewide averages.
- Adult clients of the 2019 TPS gave high scores on Quality domain questions, ranging from 87.5 percent to 92.7 percent.
- The congruence between ASAM screening and referrals has improved from the last EQRO review period and was measured at 78 percent for data period July 2018 through February 2020.
- Contra Costa reported collecting ASAM initial and follow-up assessments data from contract providers and submitting the data monthly to the State. However, UCLA reported not having access to these two types of ASAM data.

Client Outcomes

- CalOMS data indicated Contra Costa clients have a more positive discharge status rate at 57 percent showing progress in treatment as compared to the statewide average of 46 percent.
- Adult clients in the TPS gave a high score (88 percent) on the outcome question Better Able to do Things.

INFORMATION SYSTEMS REVIEW

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

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

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

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

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

Entity	FY 2020-21	FY 2019-20	FY 2018-19
Contra Costa	5.00%	7.65%	5.00%
Large Counties	N/A	3.09%	3.94%
Statewide	N/A	2.40%	3.16%

The budget determination process for information system operations is:

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

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

ISCA Table 2: Business Operations

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

- Contra Costa Health Services IT is responsible for Information Security.
- Contra Costa Health Services IT manages information systems used by Behavioral Health Services and is responsible for system performance, upgrades, disaster recovery and cyber resiliency training.

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

ISCA Table 3: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	3.12%
Contract providers	96.88%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

ISCA Table 4: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	5	1	3	1
2019-20	8	0	1	1
2018-19	8	2	2	0

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

ISCA Table 5: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	8	0	1	1
2019-20	6.5	2	0	0
2018-19	31	10	10	6

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

- Technology and data analytical FTEs support Behavioral Health Services (Mental Health and Alcohol and Other Drug Services).
- Technology staffing was reduced when support on the InSyst/PSP legacy system ended in December 2019.
- Approximately 1.5 to 2 data analytical FTEs support Alcohol and Other Drug Services.

- Two AODS analyst positions dedicated to supporting contract providers in resolving ShareCare data errors were reduced to one FTE.

Summary of User Support and EHR Training

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

ISCA Table 6: Count of Individuals with EHR Access

Type of Staff	Count of DMC-ODS Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	54	133	187
Clinical Healthcare Professional	60	12	72
Clinical Peer Specialist	0	0	0
Quality Improvement	7	0	7
Total	121	145	266

- The information above shows access to ShareCare, the DMC-ODS billing system.

ISCA Table 7: EHR User Support

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

ISCA Table 8: New Users EHR Training

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

- Training is on ShareCare, the DMC-ODS billing system.

ISCA Table 9: Ongoing EHR Training and Support

Ongoing EHR Training and Support	Status	
DMC-ODS maintains a formal record of EHR training activities to evaluate quality of training material.	☐ Yes	No
DMC-ODS routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
DMC-ODS maintains a formal record of HIPAA and 42 CFR Part 2 Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Telehealth Services Delivered by County

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

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 10: Summary of DMC-ODS Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	N/A
Number of county-operated telehealth sites	N/A
Number of contract providers' telehealth sites	N/A

- Contra Costa started using telehealth services to comply with the county's Public Health Congregate Care Guidelines issued in response to the COVID-19-19 emergency.

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

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

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

- There has been a full conversion to telehealth in outpatient services. In residential settings, providers use virtual platforms to facilitate groups (e.g. Zoom, Webex) in order to observe social distancing requirements, prevent infection and ensure provider and client safety.
- Telehealth is used to support group therapy sessions, group education and support sessions, individual therapy sessions, CM, new client intake and assessment and recovery support services.
- In support of videoconferencing, laptops were deployed in recovery residences and a hotel used to hold prospective clients awaiting COVID-19 testing results.

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

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

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 11: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Bright Heart Health	N/A
Bi-Bett	N/A
REACH	N/A
Ujima	N/A

Current DMC-ODS Operations

- The lack of telehealth equipment posed barriers to treatment for many at the outset of the pandemic.
- Because the infrastructure for working remotely was not in place, a sudden disruption in services occurred for a few weeks in March/April but has since been improved substantially.
- AODS purchased laptops to support telehealth services and a Help Desk was set up to assist providers and staff on how to use Zoom.
- AODS does not have an EHR, ShareCare is used for claiming SUD services, billing, and State reporting. Clinical documentation such as progress notes, treatment plans, labs and medications are kept in paper chart.
- Separate databases are maintained for ASAM assessments and timeliness tracking.
- ShareCare is hosted and managed by Health Services IT.

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

ISCA Table 12: Primary EHR Systems/Applications

System/ Application	Function	Vendor/ Supplier	Years Used	Hosted By
ShareCare	Claims Billing and Payment Posting	Echo	2	Contra Costa Health Services IT
ccLink (Epic)	EHR (view only) Medical, clinical, and mental health information, care team members, results, referrals	EPIC	8	Contra Costa Health Services IT
AccuCare	Online Assessments (ASI)	Orion	11	Contra Costa Health Services IT
Bed App	Bed/Service slot availability	Contra Costa IT	2	Contra Costa IT

The DMC-ODS Priorities for the Coming Year

- A SUD Face Sheet that will highlight all clinical services a client has received in the DMC-ODS is in development.

- Contra Costa Health Services IT is planning to resume project work on initiatives to facilitate electronic data exchange between AODS and contract providers.

  First among these planned initiatives is a system interface to capture consumer data exported from contract providers' EHR system for import into ShareCare. This project completes the development and implementation of ShareCare database staging tables - which facilitate the import of Consumer Admissions, Diagnoses, and Services data extracted from the contract providers' EHR system for import directly into the ShareCare billing system. This data exchange will eliminate the need for dual manual entry of these three types of data into both the provider's EHR and into ShareCare.

  The next planned initiative is to implement the entry of AODS clinical notes data into the Epic EHR system. Now that revisions to 42 CFR Part 2 Final Rule include clearer and more feasible mandates for EHR security and SUD consumer consent compliance, CCHS IT plans to proceed with the AODS system build to

accommodate electronic data exchange between the Epic ccLink EHR and ShareCare.

Major Changes since Prior Year

- In November 2019, a new workflow was added in ccLink to track referrals made by Mental Health providers to SUD counselors co-located in regional clinics.
- Since February 2020, Contra Costa has started rolling out a BHS Provider Portal to contract providers. This Provider Portal gives contract providers a view of relevant medical and mental health treatment-related client data in ccLink. It is envisaged that this access will support the continuity and coordination of client care.
- All clients in SUD who are linked to Contra Costa Health Services have access to MyChart, an online patient portal in ccLink.
- ShareCare is set up to accept MAT service codes with National Drug Codes (NDC), drug units and drug quantity. The service upload record layout and routine have also been updated to include NDC, drug unit, and drug quantity. These enhancements will support MAT providers to either enter services directly into ShareCare or send service transactions via upload files.
- ASAM 3.5 was added as a level of care in ShareCare along with the creation of new service codes to support service delivery and billing. New service codes were also created for documention time for each level of care.

Plans for Information Systems Change

- Future plans involve the implementation of an automated data exchange interface between the BHS Clinical Documentation module in Epic (ccLink) and the ShareCare Billing System as part of a total BHS EHR implementation.
- This plan will support improved clinical documentation and data analysis, treatment and performance improvements, enhance timeliness of service, and better outcomes of DMC-ODS services.

DMC-ODS EHR Status

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

ISCA Table 13: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☐	☐	☒	☐
Assessments		☐	☐	☒	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/ Storage		☐	☐	☒	☐
Electronic Signature—DMC-ODS Beneficiary		☐	☐	☒	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service		☐	☐	☒	☐
Outcomes		☐	☐	☒	☐
Prescriptions (eRx)		☐	☐	☒	☐
Progress Notes		☐	☐	☒	☐
Referral Management		☐	☐	☒	☐
Treatment Plans		☐	☐	☒	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		0	0	12	0
FY 2019-20 Summary Totals for EHR Functionality:		0	0	12	0

Contract Provider EHR Functionality and Services

The DMC-ODS currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to DMC-ODS EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and DMC-ODS EHR system	0%	Not used
Electronic batch files submitted to DMC-ODS for further processing and uploaded into DMC-ODS EHR system	10%	Monthly
Direct data entry into DMC-ODS EHR system by contract provider staff	70%	Daily
Electronic files/documents securely emailed to DMC-ODS for processing or data entry input into EHR system	10%	Monthly
Paper documents submitted to DMC-ODS for data entry input by DMC-ODS staff into EHR system	10%	Daily

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

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

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

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

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

EHR Vendor	Product	Count of Providers Supported
Netalytics	Methasoft	1
Orion	AccuCare	1

Special Issues Related to Contract Agencies

- Contract agencies provide 96.88 percent of DMC-ODS services in Contra Costa County.
- A NTP provider enters client admission and demographics data in ShareCare but sends service transactions to ShareCare via batch files.
- Other contract providers enter service transactions directly in ShareCare. They also submit a number of paper documents to AODS such as residential treatment authorization requests and withdrawal management first contacts data.
- In additional to using ASAM for level of care assessment, providers also use ASI to determine clients' addiction severity once a year. ASI data is collected via an online application. ASAM assessments, however, are conducted on paper in the absence of an EHR system.
- Contract providers have access to many reports delivered to secured folders on a county server, which is an improvement over reports sent to their local printers.

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

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

Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey	Yes	No
ASAM Criteria is used for assessment for clients in all DMC Programs.	X	
ASAM Criteria is used to improve care.	X	
ASAM screening is entered directly into the EHR.		X
ASAM assessment is entered directly into the EHR.		X
TPS is administered in all Medi-Cal Programs.	X	

Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey	Yes	No
CalOMS is administered on admission, discharge, and annual updates.	X	
CalOMS is used to improve care by tracking discharge status and other outcomes.	X	

Highlights or challenges of use of outcome tools above:

- 51.9 percent of FY 2018-19 CalOMS discharges were administrative discharge cases. This means more clients left treatment before completion and did not meet with their counselors for an exit interview.
- CalOMS information is reviewed on a regular basis by both County and network provider staff through the Data Quality Workgroup.
- TPS results were shared with providers in June 2020. Results of the survey were also discussed in System of Care meetings and in smaller workgroups like the Data Management Workgroup.
- ASAM initial screening is done by Access Line staff via a smart form in ccLink.

Overview and Key Findings

Operations and Structure

- AODS provided great leadership and pivoted the DMC-ODS towards delivering telehealth services in response to the COVID-19-19 public health emergency.
- Mostly due to COVID-19 considerations, the percentage of DMC-ODS services provided by contract providers has increased from 86 percent in FY 2018-19 to 97 percent in FY 2019-20.
- Technology staffing has decreased by 3 FTEs due to discontinued support of a legacy InSyst system.
- ShareCare was enhanced to support billing for additional DMC-ODS services including MAT and high intensity residential treatment.
- Contract providers were given read access to a BHS Provider Portal to view their clients' primary care and mental health data including care team, physicals, and TB test.
- Clinical documentation, ASAM assessment, some timeliness capture, care coordination and referral management are done on paper through manual processes.
- The synthesis of different data sets to produce management reports and to satisfy State reporting requires extensive support from the Research and Evaluation Team.

Key Findings

- In the absence of an EHR system, the Contra Costa DMC-ODS relies on reports produced from data collected in a number of disparate systems/databases to monitor capacity, measure performance, and identify service needs.
- Clinical documentation is kept on paper so measuring client progress through treatment is very challenging.
- Into the third year of standing up an organized delivery system of DMC services, Contra Costa lacks the tools needed to measure many aspects of its operations, in particular the transition of clients through the continuum of care.
- Interoperability with contract providers warrants more attention as most providers are doing double data entry into their own systems and ShareCare. This inefficiency could be addressed through the development of interfaces with agencies that are ready to send service transactions batch files.

NETWORK ADEQUACY

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The time and distance to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Contra Costa services, and 30 minutes and 25 miles for NTP/OTP services. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient SUD services and NTP/OTP services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with DMC-ODS staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues. CalEQRO also reviewed the AAS form submitted for this year to DHCS. I had fewer zip codes with issues, and the majority related to NTP access in central Contra Costa and some services near the western and eastern borders of the county.

This AAS was substantially improved from the prior year where outpatient services including for youth were outside of time or distance requirements. With new clinics and contracts these have been resolved the plan of correction is to keep seeking access in the Concord area for NTP and outpatient services in Richmond and on the eastern border in small, isolated communities.

Review Sessions

CalEQRO conducted two client and family member focus groups, six stakeholder interviews, two staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas. The NTP issue with distance was the only one identified.

Findings

There were three zip codes with the submitted 2020 AAS in Contra Costa County. These zip codes (94505,94582,94583) were in the central areas of the county near Concord, Discovery Bay or San Ramon and were not meeting time and distance standards for (NTP/OTP) services for youth or adults. Legal efforts resulted in the county moving forward with a site with its contract provider BAART, but the license submission was slowed down due to COVID-19 but is expected to be completed soon. The other zip codes for the DMC-ODS for youth and adult (substance use disorder outpatient services) for (NTP/OTP services) met time and distance standards as required by DHCS. Approval of the AAS is still pending with DHCS.

The DMC-ODS identified the closest providers for youth, and adult NTP/OTP services for those with (AAS) as BAART Antioch for all of the zip codes. Driving times ranged from 22.78 minutes to 37.15 for residents in these zip codes. The AAS zip codes impacted 15 people based on the April data. Alternative standards proposed for minutes driving ranged from 22.78 to 37.15, and miles ranged from 16.17 to 23.25.

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

As stated above, Contra Costa continues to pursue the NTP opening near Concord to resolve these issues. There is a secured site and license application is being worked on for submission. There are more options for MAT access now with Bright Heart Health, and other NTPs such as the one in Antioch can provide more take home doses until the new center opens.

CalEQRO will follow up on this new site in the following review and insert it as one of the recommendations in this report.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each DMC-ODS that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Contra Costa DMC-ODS PIPs Identified for Validation

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

PIP Table 1: PIPs Submitted by Contra Costa County

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Transition Team CM
Non-Clinical	1	Coordination of Care

Clinical PIP

PIP Table 2: General PIP Information, Clinical PIP

DMC-ODS Name	Contra Costa County DMC-ODS
PIP Title	Transition Team CM
PIP Aim Statement	The aim of the Transition Team is to support and maintain clinical engagement with those who call the Access Line seeking SUD but are not able to schedule/engage in a timely intake. By providing daily telephonic CM and brief counseling, the Transition team seeks to increase successful client enrollment in SUD programs and decrease negative health and social outcomes such as arrests or emergency department utilization.

DMC-ODS Name	Contra Costa County DMC-ODS
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17) * ☐ Adults only (age 18 and above) ☒ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): There are a range of diagnoses with approximately 65 percent having opioid use disorders, 10.2 percent alcohol use disorder, 15.1 stimulants, 7 percent cannabis, and a small percentage of a variety of other drugs.	

PIP Table 3: Improvement Strategies or Interventions, Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Daily transition team phone contact providing CM and brief counseling.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): New team will provide phone and daily contacts with clients referred from Access.
DMC-ODS-focused interventions/System changes -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):

PIP Interventions (Changes tested in the PIP)
New CM team with specific focus (never attempted before) to facilitate early engagement and support transitioning clients into treatment following assessment visits.

PIP Table 4: Performance Measures and Results, Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
1. Intake appointments into care 2. Engagement in SUD treatment 3. Decrease percentage of arrests 6 months post screening 4. Decrease the percent of PES visits 6 months post screening 5. Decrease the percentage of ED visits 6 months post screening	2020	80	2020 ☐ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Was the PIP validated?	☒ Yes	☐ No

Validation phase: Just began interventions in late spring ☐ 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: Ensure charts include baseline, goal, and quarterly data on measures.
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: Two zoom sessions to review and provide feedback, consultation with national PIP expert.

*PIP is in planning and implementation phase if NA is checked.

Non-clinical PIP

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

DMC-ODS Name	Contra Costa
PIP Title	Coordination of Care and Transitions in Care
PIP Aim Statement	The aim of the PIP is to increase the percentage of client who enroll in lower levels of care within seven days of discharge from SUD treatment. Smooth transitions in care between ASAM levels is important to support best outcomes for clients and sustained abstinence and recovery. Average days are important for those in WM and residential treatment to keep engagement and therapeutic alliance in the transition in care.

Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Youth only (ages 12-17) * ☒ Adults only (age 18 and above) ☐ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:
Target population description, such as specific diagnosis (please specify): Adults in higher levels of SUD treatment needing support to transition to lower levels of care including all types of SUD addiction.

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

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Readmission rates to WM and Residential appear to be highest for those with no follow-up at lower levels of care after discharge. Goal is to change behavior to enter treatment at a lower level of care after discharge, ideally within 7 days.

PIP Interventions (Changes tested in the PIP)
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 will meet monthly to prioritize cases getting closer to discharge, educate clients of the chronic disease of SUD, and ongoing support is needed (not just one episode of residential or outpatient treatment), and coordinate linkage between the client and the access staff to help with new service access at the lower level of care (intake and admission to treatment).
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 will prioritize access to lower levels of care for clients being discharged through the Access team, educate staff that old models of “graduation” at not science based or effective and actually hurt client’s long term recovery,

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
1. Increase percent of clients getting trt at lower levels of care within 7 days of discharge.	2019	All discharges	2020 ☐ NA*		☒ Yes ☐ No	☒ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
2. Increase the percent of clients receiving care at lower level within 30 days.	2019		2020 ☐ NA*		☒ Yes ☐ No	☒ Yes ☐ No 57% for 3.1 94.1% for 2.1 Other (specify):
3. Decrease the percent of clients that readmit to 3.1 within 30 days	2019		2020 ☐ NA*		☒ Yes ☐ No	☒ Yes ☐ No 28.6% decrease ☐ <.01 ☐ <.05
4. Decrease the percent of clients that are re-admitted to 3.2 WM with 30 days of discharge.	2019		2020 ☐ NA*		☒ Yes ☐ No	☒ Yes ☐ No 41.3% Decrease (specify):

Was the PIP validated?	☒ Yes	☐ No

Validation phase: PIP began in prior year 2019 and initially showed little impact but this year the outcomes positive in reducing readmission and increase participation at lower levels of care. ☐ 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 There may be impacts from COVID-19 influencing bed and service access. "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: Continue efforts to retrain residential staff on elimination of "graduation" concept and reinforce concept of ongoing support and care.
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: Regular phone and video conference contacts analyzing and modifying PIP and activities and interventions to be as effective as possible include thorough review of system barriers to access lower levels of care and intakes.

*PIP is in planning and implementation phase if NA is checked.

CLIENT FOCUS GROUPS

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

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

Focus Group One: Adult Residential Treatment Group

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

The Adult Residential Stakeholder focus group was held at Cole House on September 22, 2020. Six men gathered to participate in a group interview using one laptop on zoom. The age range was 25 to 59 years, four were Caucasian and two were Latinx. Four of the six had initiated services during the past year.

Number of participants: 6

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected the participating group members’ own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients’ experiences and generate recommendations for system of care improvement.

Participants described their experience as the following:

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

The following comments were made by some of the 4 participants who entered services within the past year and who described their experiences as follows:
"Feel the counselors give us their time pretty freely. Get 1:1 if I ask."
"Primarily the sessions are group."

The Director is present and had assisted one resident's admission, due to 2 residential admits per calendar year. It was clear that Residential was the appropriate level of care as opposed to referral to OP.

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

"Program has really helped in getting reconnected to Mental Health and getting my meds adjusted."

Clients said they were given information about MAT services and all said they were encouraged to use MAT and psychiatric medications as needed and prescribed as a component for their recovery.

Recommendations for improving care included the following:

According to survey response, "because of COVID-19-19 the program is limited. More resources are needed for the Cole House."

More support for the Counselors so they do not get burned out or over stressed.

Interpreter used for focus group 1: No

Focus Group Two: Adult SUD Outpatient Group

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

On September 23, 2020, six participants from Chance for Freedom Outpatient Clinic, located in Pittsburg, CA, met using their cell phones for a zoom interview regarding their experiences of SUD services. Two women, four men, three of whom were Caucasian, two in the age group 25-59 and one 60+. The remainder of the demographic information was not gathered because only 50% of the participants completed the survey monkey questionnaire as requested. Three of the six had initiated services with the previous year.

Number of participants: 6

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

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.1	2-5
2. I got my assessment appointment at a time and date I wanted.	4.1	4-5
3. It did not take long to begin treatment soon after my first appointment.	4.6	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.1	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.1	4-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.6	4-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.6	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	3.9	2-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.6	4-5

The following comments were made by some of the 3 participants who entered services within the past year and who described their experiences as follows:

“Coming to these meetings is the only time I feel normal.”

“Access understood, called back to check on me, caring, supportive, fast.”

“This service provides anonymity and a safe environment.”

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

“I meet people like us, emotion of ‘I am not alone’”

“This has been a place that no matter what happens I want to come back.”

“Counselors and the group are open so I can say what I need to say.”

“This place has saved me.”

Recommendations for improving care included the following:

“Having the program 6 days a week.”

“I would support and allow for more services via zoom.”

“Identify more resources for necessities such as rent, financial aid, food, workforce development, just to name a few.”

“I would recommend some sort of client governance where counselors revisit client needs from time-to-time outside of groups sessions.”

Interpreter used for focus group two: No

Client Focus Group Findings and Experience of Care

Overview

Clients were very happy with services and quality of counselors. Many complimented staff who supported them until they began the program (Transition team case managers). Felt they cared and were super helpful with COVID-19 tests and other needs.

Access Feedback from Client Focus Groups

- Other than the new requirements for COVID-19 getting into care was not difficult.
- More zoom groups and individual sessions desired.

Timeliness of Services Feedback from Client Focus Groups

- Timeliness was not an issue for participants other than extra steps needed because of COVID-19.

Quality of Care Issues from Client Focus Groups

- More access to CM supports for housing, jobs, benefits, etc. would be helpful.
- Program services six days per week would be helpful.

Client Outcomes Feedback from Client Focus Groups

- Many expressed significant life improvements because of the program and a desire to stay connected.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
	Component	Quality Rating
1A	Service Access are Reflective of Cultural Competence Principles and Practices	PM
Services reflect cultural needs of clients including two specialty Spanish speaking programs. Outreach this year expanded into the community to encourage more access from Spanish speaking community. Access saw increase in calls and desire for services. However, more bilingual staff at the county and contract programs is needed to fully meet this need.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
Contra Costa leadership and Access monitor network capacity and service needs using an automated application on phones, plus regular adjustment to meet key areas where more capacity is needed. Both residential and MAT expanded this year with new providers.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
Contra Costa has leaders who work very collaboratively with the whole range of other community and county partners. There has been significant expansion of collaboration with Public Health to protect clients in residential facilities and ensure PPE is available at all recovery housing and residential locations. Testing of clients		

KC Table 1: Access to Care Components	
Component	Quality Rating
for COVID-19 has also been very aggressive to avoid spreading the virus in treatment programs.	

Timeliness of Services

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

KC Table 2: Timeliness to Care Components

KC Table 2: Timeliness to Care Components		
Component		Quality Rating
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
Despite the challenges without an EHR and integrated data tracking system Contra Costa has set up systems with the Access Call Center and programs to allow for monitoring requests at initial contact and first face to face appointments.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	M
Data tracking methadone access is available and indicates a rapid assessment and access to medication.		
2C	Tracks and Trends Access Data from Urgent appointments related to timely access.	PM
While data was provided for this measure it was acknowledged as unreliable and difficult to monitor given the definition, direct contacts with contract providers, and lack of an integrated data system with the providers in the network. This was an area where technical assistance was requested, and some solutions explored to improve timely access and better clarify between acute and urgent requests.		
2D	Tracks and Trends Access Data for follow-up appointments and re-admissions to residential treatment.	M
This was being monitored as part of a PIP and an area for ongoing improvements in case coordination and support.		
2E	Tracks and Trends Timely Access to Follow-Up Appointments and re-admissions to Residential WM Treatment	M
This was also being monitored as part of the same PIP and linked to positive results with new team coordination and Access team support for placements at a lower level of care.		
2F	Tracks Data and Trends No Shows for initial face to face (or video) intake assessment.	M

KC Table 2: Timeliness to Care Components	
Component	**Quality Rating**
This is also part of the PIP which includes the transition team and others linked to access to services after calling Access Call center. It is being tracked overall and as part of the PIP.	

Quality of Care

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

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	PM
The organization has quality as a goal and core focus of care. The plan was targeting key SUD issues and goals. It did need an updated evaluation for this year and that was due to COVID-19 and the fires. Several important quality initiatives were derailed due to COVID-19 and fires and it would be good to return to these important efforts related to quality, productivity, and outcomes.		
3B	Data is used to inform management and guide decisions	M
There are numerous reports and a new SUD data committee facilitating better focus on use of data to improve system performance.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	PM
Contra Costa had set up an excellent new monthly meeting process with contractors including the ccLink portal to facilitate coordination of care. These efforts and		

KC Table 3: Quality of Care Components

Component		Quality Rating
development of a clinical documentation manual would be good to complete. Line staff, supervisors, and clients all felt the system was in crisis model due to COVID-19, but felt staff were reaching out to communicate and solve critical problems.		
3D	Evidence of an ASAM continuum of care	PM
There is evidence of a complete ASAM continuum in terms of all required services. There is an effort to collaborate with the bay area counties to identify youth residential resources, and options for 3.7 and 4.0 when needed. There was solid and important expansion this year with a new residential provider and Bright Heart health.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M
Contra Costa has a particularly good set of resources for MAT. Besides the BAART NTP programs, they have four primary clinic partners serving over 600 clients with buprenorphine, and they added Bright Heart health for a virtual outpatient clinic for MAT and counseling.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
The county showed evidence of regular ASAM training being available and there is now a local database set up for intake evaluations. The core principles are being promoted in the treatment programs and shifts to working as a system of care instead of siloed care.		
3G	Measures clinical and/or functional outcomes of clients served	M
Contra Costa participates and monitors outcomes on the TPS survey, CalOMS, and on the congruence of ASAM assessments and placements. Several PIPs also include outcomes related to reducing arrests and ED visits for emergencies.		
3H	Utilizes information from client perception of care surveys to improve care	
TPS results are reviewed for each program and areas of improvement discussed. This is part of contract monitoring as well as looking a satisfaction with care in the various domains. It is being expanded to reach more clients and sites.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- New residential and MAT resources were added since the last review.
- A variety of initiatives are underway to expand youth access.
- MAT in the jail systems and linked to DMC-ODS provide smoother transitions into treatment.
- Two more Oxford house programs are being added to meet client needs.

Opportunities:

- Recovery Services need to be expanded and utilized to support clients after completing treatment.
- CM has expanded significantly with the Transition Team, but billing systems are not in place to capture the services as part of DMC-ODS or obtain reimbursement from Medi-Cal

Timeliness of DMC-ODS Services

Strengths:

- Routine and MAT timeliness of services are within state guidelines.
- Extra work was done with COVID-19 to insure access to testing, PPE, and placement into residential or outpatient care.

Opportunities:

- Urgent timeliness needs work to meet state guidelines and improve the computer infrastructure to allow for ongoing review and action steps.

Quality of Care in DMC-ODS

Strengths:

- Strong priority for public safety of residents and staff in residential settings and recovery housing with testing, monitoring, and PPE.
- Excellent client centered impacts from the new Transition Team.

- PIP on transitions and coordination of care also had positive results.
- Added to bilingual staff positions and did outreach into Latino and Spanish-speaking community to offer services.

Opportunities:

- Complete an evaluation this year of the goals in the Quality Improvement and Management plan.
- Expand Spanish speaking staff in contractor and county positions.
- Expand number of participates in the TPS to add more youth and Spanish speaking individuals and make the tool more useful.
- Add an EHR for SUD programs which can interface with mental health and physical health. Plan for a phase one this project.

Client Outcomes for DMC-ODS

Strengths:

- TPS and CalOMS show positive results in programs in a variety of domains.
- PIP on transitions in care showed positive outcomes for clients in engagement and access.

Opportunities:

- Track jail arrests and PES events for all ongoing SUD clients, not just those in PIPs.
- Expand and improve data systems to help track outcomes across the system.

Recommendations for DMC-ODS for FY 2019-20

1. To reduce paperwork burden, combine ASI and ASAM assessment elements into one document, and continue to look at other streamlining opportunities. CalEQRO will assist with ASI and ASAM if needed as this has been a common need across counties.
2. Start tracking urgent requests for services as it is a DHCS required timeliness metric and technical assistance is available from CalEQRO to assist.
3. Complete the development of a SUD Face Sheet that will highlight all clinical services a client has received in the DMC-ODS.

4. Follow through with plans to review electronic interface options with contract agencies to mitigate the latter's inefficiency of entering service transactions in their own systems and ShareCare.
5. Continue efforts to add Oxford housing and recovery housing in general.
6. Expand recovery services and CM and work with DHCS to optimize billing options particularly for CM. Technical assistance from DHCS may be required.
7. Develop a plan and timeline to develop an EHR for the DMC-ODS program inclusive of contract agencies.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: County Highlights none at this time.

Attachment D: Continuum of Care Form

Attachment E: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: CalEQRO On-site Review Agenda

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

Table A1: CalEQRO Review Sessions - Contra Costa DMC-ODS
Opening session – Changes in the past year, current initiatives, status of previous year's recommendations (if applicable), baseline data trends and comparisons, and dialogue on results of performance measures
Quality Improvement Plan, implementation activities, and evaluation results
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards, and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
PIPs
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments (MATs)
Network Adequacy
MHP coordination with DMC-ODS
Clinic managers group interview – county and contract
Clinical line staff group interview – county and contracted
Two client focus groups such as adult, youth, special populations, and/or family
Key stakeholders and community-based service agencies group interview
Exit interview: questions and next steps

Attachment B: On-site Review Participants

CalEQRO Reviewers

Rama Khalsa, Lead Reviewer
Jan Tice, Second Reviewer
Caroline Yip, IS reviewer
Marlene Gold, IS reviewer in training
Luann Baldwin, CFM Consultant
Valerie Garcia, CFM Consultant in training

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

Sites for Contra Costa's DMC-ODS Review

DMC-ODS Sites

All sessions were conducted virtually using secure Zoom platform.

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Abdullah	Nazneen	AODS Program Manager	Behavioral Health
Aguirre	Priscilla	Quality Management Program Coordinator	Behavioral Health
Battis	Claire	Planner Evaluator	Behavioral Health
Bernstein	Marsha	Substance Abuse Counselor	Behavioral Health
Bowman	Rob	Access Line Mental Health Counselor	Behavioral Health
Boulden	Shanna	Program Coordinator	BI-BETT
Brown	Mitch	Substance Abuse Counselor	Behavioral Health
Calloway	Vernon	Information Technology Manager	Health Services
Campos	Jaime	Executive Director	BI-BETT
Carofanello	Nick	Accountant	Health Services
Conry	Leonard	Substance Abuse Counselor	Cole House
Cristofani	Gary	Substance Abuse Counselor	Behavioral Health
Down	Adam	Mental Health Project Manager	Behavioral Health
Farrar	Jesse	Substance Abuse Counselor	Behavioral Health
Fernandez	Antonia	Substance Abuse Counselor	Behavioral Health
Fischer	Damon	Director of Residential and Detox Services	BI-BETT
Galamez	Fadua	Community Health Worker	Behavioral Health
Gallagher	Ken	Research and Evaluation Manager	Behavioral Health
Goode	LaShondra	Substance Abuse Counselor	Behavioral Health
Hall	Keith	Substance Abuse Counselor	Behavioral Health
Hamilton	Dr. Jessica	Medical Director	Public Health

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Hester	Darnell	Substance Abuse Counselor	REACH Project
Jacob	Jean	Planner Evaluator	Behavioral Health
Jarrar	Aous (AJ)	Substance Abuse Counselor	Behavioral Health
Johnson	Jeanine	Program Coordinator	Center Point
Jones	Lakeisha	Substance Abuse Counselor	Behavioral Health
Kalaei	Susan Dr.	Behavioral Health Administrative Pharmacist	Health Services
Kekuewa	David	AODS Data Support Analyst	Behavioral Health
Kendall	Vincent	Substance Abuse Counselor	BI-BETT
Lee	Pamela	Case Management Manager	Health Services
Luu	Matthew	Deputy Director of Behavioral Health	Behavioral Health
Mandell	Angelo	Treatment Center Director	BAART
Matal Sol	Fatima	AODS Program Chief	Behavioral Health
McCray	Dennis	Division Director	Center Point
Messerer	Mark	AODS Program Manager	Behavioral Health
Nielson	Jersey	Planner Evaluator	Behavioral Health
Oliveira	Phoebe	Public Health Nurse Program Manager	Public Health
Pedraza	Chris	AODS Program Manager	Behavioral Health
Pena	Jorge	BH IT Analyst/Consultant	Health Services
Peterson	Katherine	Clerk	Behavioral Health
Pormento	Alicia	Finance Manager	Health Services
Powell	Scott	Substance Abuse Counselor	Behavioral Health

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Razon	Danelyn	Accountant	Health Services
Reynolds	Suzanne	Substance Abuse Counselor	BI-BETT
Richardson	Michelle	AODS Program Manager	Behavioral Health
Rice	Megan	Behavioral Health Project Manager	Behavioral Health
Russell	Michelle	Outpatient QA Director	Ujima
Santiago - Nederveld	Catania	Substance Abuse Counselor	Behavioral Health
Seastrom	Trisha	AODS Program Manager	Behavioral Health
Serrano	Kristina	Mental Health Program Supervisor	Behavioral Health
Shelton	Cleadus	Interim Director of Criminal Justice & Director of Compliance	WestCare
Spikes	Chet	Assistant Director, Business Systems	Health Services IT
Stewart	Harrison	Program Supervisor	Behavioral Health
Tavano	Suzanne	Behavioral Health Director	Behavioral Health
Todd	Zachariah	AODS Lead Counselor	Behavioral Health
Washington	Tiffany	Program Manager	Blue Cross
Webb	Darren	Substance Abuse Counselor	Behavioral Health
White	Katy	Mental Health Program Manager	Behavioral Health
Wilson	Pat	Chief Information Officer and Director of Information Technology	Health Services IT
Woodard	Brandon	Substance Abuse Counselor	REACH Project
Wong	Peter	Substance Abuse Counselor	Behavioral Health

Attachment C: County Highlights

None at this time.

Attachment D: Continuum of Care Form

Continuum of Care: DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: CONTRA COSTA COUNTY Review date(s): September 22, 23,24, 2020
Person completing form: Fatima Matal Sol, Christopher Pedraza, Alicia Pormento, David Kekuewa, Nick Carofanello

Please identify which programs are billing for DMC-ODS services on the form below.

Percent of all treatment services that are contracted: 97%

County role for Access and coordination of care for persons with SUD requiring social work/linkage to coordinate care and ancillary services. Describe county role and functions linked to
access processes (Access Call Center) and coordination of care linked to access services

The county operates an integrated Behavioral Health Access Line which includes Alcohol and Other Drugs (AOD) certified counselors and Mental Health Clinicians. The unit operates 24/7 as a call center, 5FTE AOD counselors and 1FTE Clerk have been dedicated to Access; however, 1 counselor left in early February 2020, there are plans underway to fill this vacancy. Counselors conduct Level of Care placement screenings over the phone, facilitate warm hand offs via three-way calls between the prospective beneficiary and the SUD provider. AOD counselors provide intake appointments as needed and facilitate access to Medi-Cal enrollment by connecting beneficiaries to the BH Financial counselors. AOD counselors also provide brief support/encouragement to callers not ready for treatment along with information and referrals to significant others seeking information for their loved ones. Whenever counselors are on the phone serving other beneficiaries, a clerical staff takes the call immediately and provides the caller with an approximate time in which the counselors will return the call. AOD counselors also provide:

A) Referrals to recovery support-oriented activities for individuals who have completed treatment
B) Facilitate transitions of level of care as needed by callers
C) Screenings for individuals who are incarcerated in all 3 county jails through a speed dial number *9072# (West) and *9092# (Martinez) and established through a partnership with the county Sheriff.

In FY19-20, at the beginning of the COVID-19 pandemic in February 2020 and during Shelter in Place, we redirected all of the counselors who provide services at *Touchpoint* locations and repurposed the entire group for what we now call: *The Transition Team*.

Prior to COVID-19, besides the Access Line clients could enter treatment and receive face to face screenings through other community based portals of entry such as: Courts, detention facilities including the West County Reentry Center, probation Offices, Children and Family Services (CFS) offices, homeless shelters and the jails. The *Touchpoint* model is effective in that it meets the client where they are, and counselors can develop treatment readiness. Because of Shelter in Place, we regrouped the counselors back into the office and realized that this was an opportunity to support the clients after their call to the Access Line. Back in March, many of our programs were not admitting clients as there was an overwhelming amount of uncertainty as far as safety and only essential activities were allowed. Since then, we have changed to a variety of protocols, all intended to respond to new health orders but with the goal and determination of facilitating admission into treatment.

Additionally, there are other portals where clients enter treatment:

1) The SAMHWorks Assessment Team- conducts SAMHWorks screenings and referrals to SUD treatment as needed.
2) Beneficiaries may directly access Withdrawal Management and methadone treatment without contacting the Access Line.
3) Outpatient providers also facilitate the call to the Access Line with beneficiaries who present themselves into any program.

Contra Costa initiated Care Coordination efforts in early January 2019 for residential treatment providers. During 2019, we focused on formalizing the group by ensuring that members consistency, regularly scheduled meetings, and that protocols were clear. During the first year, there were opportunities for changes and adaptations as needed by the group. In 2019, we accomplished our goal of promoting client movement and coordination internally and externally. The county manager (County Care Coordinator) and chief continue to support Care Coordination. Providers are well prepared and participate in clinical reviews by utilizing the ASAM Clinical Case Conference format. In addition, the county brokers and reminds staff of requirements, for example of accessing transportation benefits through managed care plans, coordinating with mental health, referrals to MAT, etc. The effectiveness of Care Coordination in facilitating movement and transition of levels of care has been documented through our notes and reflected in the increase of admissions into Outpatient Treatment, which has also benefited from the addition of Recovery Residences. Furthermore, by adding the CBO Portal to the functions of Care Coordination, counselors started to identify other professionals or Care Team involved in the overall health care needs of the client.

As planned, In October 2019 we added Care Coordination for Outpatient services with a different criterion. We followed a similar process to obtain provider feedback, but none was received. While Care Coordination for Outpatient reviews a much smaller pool of clients, it supports similar goals: to facilitate upward movement, coordinate with mental health and physical health, increase CM and recovery support services. Unfortunately, due to COVID-19, we were unable to fully implement. To maintain the momentum, a modified version was implemented for at least a month; unfortunately, because of staff shortages resulting from COVID-19 infections and low service delivery the results did not

match expectations and defeated providers' efforts to stabilize. Although we were committed to both residential and outpatient Care Coordination, we were also cognizant of the primary needs of programs and clients.

Case Management- Describe if it is done by DMC-ODS via centralized teams or integrated into DMC certified contract or county programs or both:

Monthly estimated billed units of CM: 840

Comments: AODS has dedicated a team of 6FTEs County counselors whose positions are funded through various funding sources to support all client's transitions. The cost per month of the counselors is as follows:

Name	Emp #	Job Code	Salaries	Benefits	Total
1 (AB 109)	79857	VHVC	6,311.97	3,171.19	9,483.16
2 (AB 109)	87411	VHVC	6,011.40	2,980.84	8,992.24
3 (Amb Care)	79677	VHV3	7,086.40	3,319.03	10,405.43
4 (SABG perinatal)	88588	VHVC	5,725.14	2,866.15	8,591.29
5 (Court)	84077	VHVC	6,627.57	4,448.63	11,076.20
6 (MAT Jail Expansion)			5,536.00	2,766.13	8,302.13

Case Management is billed through integrated DMC certified providers. Despite our efforts to ramp up claims for this service; the number of claims in relationship to the need is disproportionate. There are a few factors that contribute to this situation: e.g. 1), The lack of staff dedicated to this function, -only the county's program has hired a case manager. Most programs have staff whose case management functions are considered ad-hoc. Even the county program utilizes the case manager to fill in for other functions during staff shortages. 2) Limited understanding to distinguish the difference between the functions of a counselor and a case manager. We have provided 2 trainings on case management for SUD, still the number of claims is limited. Conversely, we saw a high utilization and reliance on Whole Person Care case managers for all client needs and transition support. 3) In one of our Provider/County Collaborative meetings, Providers indicated that there is a shortage of workforce and that new counselors or student interns lack the skills to support the DMC-ODS requirements.

As advised by EQRO las year, the chief contacted both Riverside and Marin county to understand their case management structure. We have also elevated questions to SUD DHCS through multiple channels including email addresses and DHCS analyst, but no one has been able to provide guidance. Marin county indicated that they do not bill all services provided and not all billed services are approved. Riverside has an all-county-operated model throughout. We are, as to the preparation of this report, preparing to bill for 2 clients connected to the Transition Team and consider this a test. Like our Choosing Change program, Contra Costa is providing Case Management services focusing on Transition periods, but we are not billing DMC. We would like to emphasize that the benefit of providing services during transitions far exceeds expectations of engagement, admission into treatment and supporting gains made in treatment, but there is incongruency between the billing structure and the needs of the clients, which made the Whole Person Care case management model extremely successful. Moreover, the DMC billing mechanism does not encourage providers during "limbo" periods if the client is not linked to anyone. As part of the centralization under the Transition Team, we brought together AB 109, perinatal, court, jails, and PES counselor under the same umbrella. They all work as a coordinated team and have clinical meetings over zoom to ensure that clients referred to them by Access counselors receive the support they need prior to admission. Each counselor in this team has provided at least 640 hours per month of case management services, a total of 3,840 hours from March to the end of June. Our PES counselor alone, once again provided 2000 hours of case management services. We will be adding an additional counselor to support clients on General Assistance, this counselor will join the Transition Team and his Touchpoint site will be social services.

The combination of Care Coordination supported by the Transition Team and Access Line promote movement in the DMC system.

<u>Recovery Services</u> – Support services for clients in remission from SUD having completed treatment services but requiring ongoing stabilization and supports to remain in recovery including assistance with education, jobs, housing, relapse prevention, peer support.

Pick 1 or more as applicable and explain below:

1) Included with program sites for linkage to treatment
2) Included with outpatient sites as step-down
3) Included with residential levels of care as step down
4) Included with NTPs as stepdown for clients in remission

Choices: 1,2,3
Total Legal entities offering recovery services: 7
Total number of legal entities billing DMC-ODS recovery services: 6
The monthly estimated billed units of Recovery Support Services CM delivered by providers is: 12

Comments:

Again, just like Case Management both providers and county have had innumerable hours of discussions to identify opportunities to deliver Recovery Support Services. Discovery House, the county operated Level 3.1 men facility has attempted to begin rendering Recovery Support Services since the beginning of the COVID-19-19 pandemic with minimal success. The follow issues have arisen since start:

1. The limitations on the diagnoses that are acceptable for Recovery Support Services is too narrow and eliminates many people who are interested in the services. A diagnosis of "in remission" required at least 90 days of minimal need. Since Discovery House was following up with beneficiaries who had completed residential treatment in the last 180 days, this eliminated approximately 50% of the beneficiaries contacted immediately.
2. Many beneficiaries are interested in receiving Recovery Support Services from Discovery House. Because they are active in outpatient treatment, they are not eligible for Recovery Support, by default they join the Alumni Association. Moreover, instead of joining an Aftercare Recovery Group that can complement outpatient treatment, they attend a 12-step based group preventing programs to claim Medi-Cal for a service that would normally be covered under Recovery Services.
3. Many beneficiaries were interested in receiving services once or twice but were not interested in sitting through an entire ASAM assessment. The assessment, in some cases, would have taken more time than the actual services.
4. Many beneficiaries were interested in follow-up calls but not actual services. The calls were excellent for gathering post-treatment data and to offer basic assistance to beneficiaries but would not fall into the category of Recovery Services as currently defined.

Level 1 WM and 2 WM: Outpatient Withdrawal Management – Withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).

Number of Sites: 2
Total number of legal entities billing DMC-ODS: 1
Estimated billed units per month: 0

How are you structuring it? - *Pick 1 or more as applicable and explain below*

1) NTP
2) Hospital-based outpatient
3) Outpatient
4) Primary care sites

Choice(s): 1

Comments:

BAART Antioch and Richmond, CA

Level 3.2 WM: Withdrawal Management Residential Beds- withdrawal management in a residential setting which may include a variety of supports.

Number of sites: 5

Total number of legal entities billing DMC-ODS: 1

Total number of beds: 16

Estimated billed days/units per month: 225

Pick 1 or more as applicable and explain below:

1) Freestanding
2) Within residential treatment center

Choice(s): 1,2

Comments:

The number of sites is 5. Recently, DHCS consolidated licenses for Bi Bett's Wollam facilities which reduced the number facilities reported during the previous fiscal year, as the facilities had separated licenses at the time. Sites: Bi Bett E County Women's/Wollam, Pueblos del Sol, Southern Solano Alcohol Center (SSAC) the Ozanam, and West Care.

NTP/OTP Programs- Narcotic treatment programs for opioid addiction and stabilization including counseling, methadone, other FDA medications, and coordination of care.

Total legal entities in county: 1

In county NTP: Sites 2 Slots: 1500

Out of county NTP: Sites 6 Slots: 2255

Total estimated billed counseling units per month: 5546

Are all NTPs billing for non-methadone required medications? ☐ Yes ☒ No

Comments:

Sites: BAART Antioch and Richmond. Aegis: Stockton, Merced, Healthy Connections Lodi, HC Manteca, HC Stockton 1 +2

Non-NTP-based MAT programs - Outpatient MAT medical management including a range of FDA SUD medications other than methadone, usually accompanied by counseling and CM for optimal outcomes.

Total legal entities: Enter total number of entities. Number of sites: Enter total number of sites.
Total estimated billed units per month: Enter number of units.

Comments:

Level 1: Outpatient – Less than 9 hours of outpatient services per week (6 hrs./week for adolescents) providing evidence-based treatment.

Total legal entities: 6 Total sites: 18
Total number of legal entities billing DMC-ODS: 4
Average estimated billed units per month: 2678

Comments:

Billing DMC-ODS: REACH Project, Ujima Family Recovery Services, BiBett -A Chance for Freedom, Contra Costa County. Non-DMC Center Point. Bright Heart Health is a DMC certified program not yet billing DMC

Level 2.1: Outpatient/Intensive – 9 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient SUD treatment.

Estimated billed hours per month: 1023
Total legal entities: 5 Total sites for all legal entities: 7
Total number of legal entities billing DMC-ODS: 4
Average estimated billed units per month: 4090

Comments:

Billing DMC-ODS: REACH Project, Ujima Family Recovery Services, Bi Bett, and Contra Costa County. Non-DMC Center Point

Level 2.5: Partial Hospitalization – 20 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient treatment but not 24-hour care.

Total sites for all legal entities: N/A
Total number of legal entities billing DMC-ODS: N/A
Total number of programs: N/A
Average client capacity per day: N/A
Average estimated billed treatment units per month: N/A Enter treatment units.

Comments:

NOT AVAILABLE IN CONTRA COSTA COUNTY

<u>Level 3.1: Residential</u> Structured SUD treatment / recovery services that are provided in a 24-hour residential care setting with patients receiving at least 5 hours of clinical services per week.

Total sites for all legal entities: 15
Total number of legal entities billing DMC-ODS: 5
Number of program sites: 15
Total bed capacity: 138
Average estimated billed bed days/units per month: 3321

Comments:

Bi Bett (Wollam, Diablo Valley Ranch, Wollam House and Pueblos del Sol), Contra Costa County Discovery House, J Cole, The Latino Commission, Ujima Family Recovery Services and West Care.

<u>Level 3.3: Clinically Managed, High-Intensity Residential Services</u> – 24-hour structured living environments with high-intensity clinical services for individuals with significant cognitive impairments.

Total sites for all legal entities: N/A
Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Total bed capacity: N/A
Average estimated billed bed days/units per month: N/A
(Can be flexed and combined in some settings with 3.5)

Comments:

NOT AVAILABLE IN CONTRA COSTA COUNTY

<u>Level 3.5: Clinically Managed, High-Intensity Residential Services</u> – 24-hour structured living environments with high-intensity clinical services for individuals who have multiple challenges to recovery and require safe, stable recovery environment combined with a high level of treatment services.

Total sites for all legal entities: 1
Number of program sites: 1
Total number of legal entities billing DMC-ODS: 1
Total bed capacity: 9
Average estimated billed bed days/units per month: 6
(Can be flexed and combined in some settings with ASAM Level 3.5)

Comments:

Health Right 360 was the only 3.5 provider for FY19-20. The majority of the L3.1 residential Bi Bett facilities are now designated as ASAM Level 3.5 facilities for FY20-21.

<u>Level 3.7: Medically Monitored, High-Intensity Inpatient Services/ or WM</u> – 24-hour, professionally directed medical monitoring and addiction treatment in an

inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??) ☐ Yes ☐ No

Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed Capacity: N/A
Average estimated billed bed days/units per month: N/A

Comments:

NOT AVAILABLE IN CONTRA COSTA COUNTY

Level 4: Medically Managed Intensive Inpatient Services or WM – 24-hour services delivered in an acute care, inpatient setting. (Billing Health Plan/FFS can you access services? ☐ Yes ☒ No Access)

Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed capacity: N/A
Average estimated billed bed days/units per month: N/A

Comments:

NOT AVAILABLE IN CONTRA COSTA COUNTY

Recovery Residences – 24-hour residential drug free housing for individuals in outpatient or intensive outpatient treatment elsewhere who need drug-free housing to support their sobriety and recovery while in treatment.

Total sites for all legal entities: 2
Number of program sites: 35

Bed capacity for women with children: 71
Total bed capacity: 373

Comments:

Oxford House Inc has 3 sites and Support 4 Recovery has 32 sites.

Attachment E: Acronym List Drug Medi-Cal EQRO Reviews

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

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

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