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2019-20
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

CONTRA COSTA DMC-ODS REPORT

Prepared for:
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CONTRA COSTA DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Calendar Year 2018 — 1,917
Contra Costa Threshold Language(s) — Spanish
Contra Costa Size — 1,155,879 population (CA Department of Finance Population Estimates for Cities, Counties and the State – January 1, 2018 and 2019)
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 — none

Introduction and Site Characteristics:

Contra Costa County officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in June 2017 for Medi-Cal recipients as part of California's 1115 Drug Medi-Cal Waiver. Contra Costa County was the fourth County to launch in California's Bay Area Region and fifth statewide. This report is for its second year of delivering DMC-ODS Services. In this report, "Contra Costa" shall be used to identify the Contra Costa County DMC-ODS program unless otherwise indicated.

Contra Costa is a large County located in the eastern Bay Area region with a large land mass of 429,000 square miles and a water mass of 723 square miles. It is located on the eastern San Francisco Bay between Solano, Sacramento, San Joaquin and Alameda Counties. The population estimated for 2019 by Contra Costa is 1,149,363 (source: 2010 Decennial Census). The County is primarily suburban with the Medi-Cal beneficiaries residing primarily in the eastern, northern and western areas. Healthcare is the largest industry employer in Contra Costa followed by retail and professional services, (including scientific and technical services) according to DataUSA (https://datausa.io/). Because the County is primarily suburban, Contra Costa has experienced difficulty in establishing new substance use treatment programs in several areas due to the negative response of the neighbors.

The population in Contra Costa is 46 percent Caucasian and 24 percent Hispanic. Other significant populations include Asians (15 percent) and African Americans (nine percent). Females comprise 51 percent of the population. County Health Rankings and Road Maps (http://www.Countyhealthrankings.org/app/california/2018/overview) ranks Contra Costa in the top 20th percentile of healthiest counties in California. This includes indicators for mortality, health behaviors, and social and economic factors. The most significant environmental concern for Contra Costa is the long commute for almost 50 percent of their population.

Medi-Cal insures 17 percent of the overall population including 56 percent who are female and 31 percent who are Hispanic. Spanish is the only threshold language in Contra Costa County.

Contra Costa County, like many other California counties, has experienced a significant increase in opioid overdose deaths in the last decade. To their credit, they have several coalitions working together to address this issue and have made some headway in reducing the number of local deaths and opioid prescribing based on the California Opioid Overdose Dashboard of the California Department of Public Health.

This Executive Summary provides highlights of the review. The full body of the report includes further details on access, timeless, quality and outcomes linked to required federal protocols and the CMS-approved Special Terms and Conditions of the DMC-ODS Waiver.

Access

During the first year of services, Contra Costa had established and begun billing for all required services in their DMC-ODS approved plan. During the second year of services they continued to expand services, but also experienced instability with three of their non-profit contract agencies which were important programs in their network of SUD providers. In the area of challenges to the network, one of their largest organizations experienced the unexpected death of its long-time director, leading to a period of significant instability and loss of certification of its outpatient program in Pittsburg due to not turning in its re-certification paperwork. An experienced interim director was found who worked with the Board and staff to stabilize the program and complete needed paperwork for programs to be re-certified. After a period of nine months, a permanent director was hired to continue keeping the core programs operational and serving the community.

In addition, two other contract programs discontinued services with Contra Costa. ANKA Corporation, a provider of outpatient services, filed for bankruptcy. In March 2019, Bay Area Community Resources decided to discontinue its outpatient services. They reported financial issues linked to their ability to work in successful ways within the Medi-Cal program. Fortunately, with leadership from Director Suzanne Tavanno and other key leadership of the SUD staff, a new contractor, CenterPoint, was identified to come into Contra Costa County to minimize disruption to these outpatient treatment services in the western and central areas of the County.

There were also some important activities related to relocation and expansion of services. BAART Narcotic Treatment Program (NTP) in West County asked to relocate and a new location was identified close to a homeless shelter. The program continues to operate while the new facility is under construction. In addition, a centrally located NTP site has been identified in Concord to meet Network Adequacy and community needs. This relocation underwent a significant legal challenge that was resolved, and

the program will now proceed to work on establishing a new facility with all the required construction, licensing, and certifications steps to open.

Most of the treatment services provided through Contra Costa are contracted to community-based organizations, and only 15 percent are delivered by County staff in County-run clinics. Contra Costa is in the process of expanding several of its treatment services. They are in the process of increasing both residential and withdrawal management beds in the western part of the County. Also, during the last year County SUD counselors began working side by side with mental health counselors in the County-run clinics that had become DMC-ODS certified to provide more integrated care for clients with co-occurring substance use and mental health disorders.

The County has an Access Call Center with nine English- and Spanish-speaking County staff. The Center operates Monday through Friday from 8 a.m. to 5:30 p.m., has sophisticated call software with three-way calling capacity to link to providers for ASAM assessment appointments, and has a number of staff with specialized skills to work with varied populations. Monthly call volume averages 1,973 calls and wait times and dropped calls are low. Call dispositions are tracked and approximately 110 persons per month are referred to residential treatment settings. The County had been negotiating with Optum for weekend and after-hours coverage without success and thus calls during these hours are currently routed to an answering machine for follow-up the next morning. This is not a quality service and will be the subject of a recommendation in this report. The referral patterns of the staff during their operational hours showed skill and efforts at linking clients to care including MAT. Reports showed 350 referrals from the prior year to buprenorphine clinics for treatment in the “Choosing Change” program, which will be described in more detail later in the report in association with ASAM training.

One of the performance improvement projects (PIPs) for Contra Costa County is focused on access to assessment in a timely manner to thereby improve timely access to treatment services as well as timely transitions to follow-up services after residential treatment discharge. Contra Costa is monitoring and tracking its system throughput and access issues carefully across the system and is very aware of additional areas of need. Several requests for proposals for additional services are in process for both youth and adult services, as well as modification of existing contracts to enhance access and timeliness.

Timeliness

Contra Costa used a variety of systems to track timeliness. They are able to track call requests and external referrals through the call center and County clinics. However, tracking through contractor data was more uneven, especially at the NTP sites. Overall, the timeliness of first offered appointments for both youth and adult was within the state requirement of ten business days – 71.6 percent of adult appointments met this standard and 83.3 percent of youth appointments met this standard. For timeliness of first actual face-to-face appointment, the mean for adult appointments was 9.5 days and

for youth 8.3 days, both of which are quite good. Also, the percentage of appointments which met this standard were 67.6 percent for adults and 75 percent for youth. Contra Costa provided significant back-up documentation to support these figures and while the contract data was less complete than County programs there was improvement from the first year of services.

For timeliness to first methadone dosing, the CalEQRO data showed a rapid response with dosing within one day of entry into the program. For timeliness to first buprenorphine dose provided by the County primary care clinics which did not bill DMC-ODS (they bill FQHC Medi-Cal), there was no timeliness data. However, the clinics engaged with and accepted significant referrals for persons requesting non-methadone MAT services for SUDs from the DMC-ODS programs. Contra Costa reported that over 700 clients were currently on buprenorphine at the County primary care clinics, the numbers were continuing to grow in the County “Choosing Change” program, and the number of referrals from the DMC-ODS access line to the program had doubled from year one of DMC-ODS services to year two. Reports from Access Line data showed approximately 350 referrals to those clinics in the past year in the disposition data specially for non-methadone MAT requests.

The County staff reported having a definition of urgent appointments they were using to track timeliness of urgent appointments, but the data system was not able to accurately capture and report all of those encounters. CalEQRO included a recommendation that for the upcoming year Contra Costa should further clarify its definitions of urgent appointments and implement a tracking mechanism to be sure that clients are accessing care within the required 48 hours.

Contra Costa tracks transitions from residential to outpatient and other levels of care. Their transition rate of eight percent is low, and they consequently focused one of their PIPs on raising that rate. They noted that along with this low engagement rate in stepdown care after residential treatment, the readmission rate to residential treatment was high and they would be working to reduce it as well.

They were also tracking and monitoring re-admissions within 30 days to withdrawal management (WM). The readmission rate of 7.3 percent was relatively low, as most clients were transitioning successfully to residential or other treatments following discharge from WM.

Contra Costa-generated reports indicate they are tracking no show rates for clients’ first scheduled appointments, which ranged from 22.5 percent to 48 percent depending on how many days out they were scheduled. The longer time until the appointment, the more likely the no-show. They also had been making many efforts to engage clients with calls including using motivational interviewing with new clients, but rates of no-shows remain high. Because Contra Costa frequently finds there are insufficient assessment appointment times to meet the need, the substantial number of no-shows are causing great concern. Contra Costa may focus a new PIP on trying some blocks of

open walk-in appointment times, learning from what some other DMC-ODS programs do.

Quality

Contra Costa has continued to work proactively on quality of care in their ASAM continuum with training, tracking, and identifying areas needing resources and seeking new provider partners especially in remote areas. They are building strong and effective partnerships with mental health clinics by co-locating SUD staff in County clinics to serve individuals with co-occurring disorders, and by providing training and consultation for those clinics in concurrent treatment of co-occurring disorders. Contra Costa works well with both of their physical health plans, and particularly with their County-operated plan in which most of their clients are enrolled. They also work well with their many primary care clinics. The DMC-ODS leadership and services also coordinate many unique joint programs and models with their criminal justice system partners focused on treatment access, rehabilitation, restorative justice, education, jobs, and housing supports.

Contra Costa evaluates treatment impacts through the use of several measures. They use client ratings of treatment on the Treatment Perception Survey (TPS) and its results reported to them by UCLA. They work to improve care at the sites that received lower client ratings, and they work to inspire best practices by highlighting the sites that received the best client ratings. They also use provider ratings from ASAM criteria level of care (LOC) referral data and the reports from UCLA on the congruence between what the criteria suggested as the appropriate LOC referral and what referral was actually made. Contra Costa showed a congruence in 68.2 percent of their client assessments and treatment referrals.

Coordination of care particularly after residential treatment is a key issue and is the focus of their active PIP for this year because of the low engagement rate after discharge. Special training has started with residential staff on case management--what it means, how to do it, and how to support smooth transitions in care that include fostering a positive therapeutic alliance with counselors at the new treatment site for someone being discharged. Contra Costa is also considering different models of case management similar to Riverside County where a case manager can follow individuals across multiple levels of care and have an ongoing support relationship to help with both quality and continuity of services for high-need, complex individuals.

The other PIP, which Contra Costa recently completed, focused on two residential treatment programs (one serving women and one serving men). All clients had higher levels of anxiety and depression. They participated in a customized cognitive behavioral treatment (CBT) curriculum for six weeks that addressed symptoms of anxiety and depression and focused upon improvement of coping skills with homework. Treatment sessions were held twice per week in a small group format. Measurement results indicated significant client improvement based on pre/post testing using the Patient

Health Questionnaire-9 (PHQ-9). Contra Costa reported that other clients clamored to get into the group based on word of mouth in the client community. The actual participants often wanted to stay after the six weeks and continue. The program model now will continue and be spread to other residential programs. Contra Costa was encouraged to document the program to share with other County DMC-ODS programs.

A key quality improvement opportunity for Contra Costa is to fill in the coverage gap for beneficiary access line services during nights and weekends. Contra Cost tried unsuccessfully to address this through a contract with Optum. Counties in the Bay Area have found a variety of models that work for them which Contra Costa should consider, and CalEQRO included this suggestion in the Recommendations section of this report.

Finally, one of the most positive efforts of Contra Costa is its commitment to the ASAM continuum of care and principles of individualized treatment as evidenced by continued efforts to expand and refine their Continuum of Care. Their expansion efforts include recovery housing with the Oxford House contractor and “Support 4 Recovery” non-profit efforts to address homelessness particularly for those with SUD.

Outcomes

Both CalOMS and TPS data were being used to measure client outcomes. The County was working on improving the accuracy of the CalOMS data at intake and discharge so they could use that data more extensively and effectively for outcome measurements and quality improvements. Contra Costa’s administrative discharge rate of 27.4 percent is significantly lower than the statewide average of 37 percent and signifies a likelihood of higher reliability for CalOMS discharge data. Also, 57.8 percent of the clients served showed improvement at the end of their SUD treatment, which is high than the statewide average for all DMC-ODS counties of 51.9 percent. Homelessness was a big concern for the County as real estate prices continued to increase over the last five years and urban and rural homeless have become more visible. This high rate of homelessness is also reflected in data in the CalOMS services profile.

In the TPS data for adult clients, nearly 90 percent of all respondents rated most aspects of their services positively. The lowest ratings were regarding coordination of care, and those were still high with approximately 85 percent of clients rating that function positively. Contra Costa decided to select care transitions for quality improvement in part because of the slightly lower rating that function received from clients, and partly because of the low level of Medi-Cal billings for case management and recovery support services.

While Contra Costa does use data to help make decisions and improve services, it has no fully functioning EHR for the DMC-ODS system. There are multiple reasons for this, including some of the challenges of the federal 42CFR Part 2 confidentiality rules. The County would like to develop an integrated system with health data using EpicCare (used by the hospital and clinic systems) and Sharecare (a behavioral health billing program used by mental health and DMC for billing). However, this proposed data

software programming merger is highly complex and may take many years to succeed. In the meantime, the DMC-ODS network and system works with limited software functionality for many of its complex needs. There is a “can do” attitude among the staff and data analytics resources are expanding, but the tools for running a fully functioning managed care organization are not in place. Many operational “work arounds” which are labor intensive and prone to potential problems abound in trying to accomplish many requirements.

Client/Family Impressions and Feedback

CalEQRO conducted two client focus groups in Contra Costa, one in Spanish and one in English. The Spanish group were participants at a residential treatment center. They spoke positively about the important improvements with access they experienced in the last two years, the honoring they experienced of their culture, the feeling of being supported and valued in their recovery, and their wish for some of those they know to come into treatment programs similar to the one in which they were participating. The participants recommended adding more counselors to the program and more help with transitions as clients are discharged with such supports as housing, education, family reconciliation, sponsors, and groups.

The second group had more individuals new to treatment services. They reported feeling lucky to be in those services and were just beginning to understand how to cope with their cravings. They said they wanted to know more about MAT, wanted more time with their counselors, and wanted more help with clean and sober housing to stay successful.

Further details of each of these areas are included in the chapters of the report.

Recommendations are summarized at the end of the full report as well.

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 received 40 implementation and fiscal plans for California 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. DHCS has approved and contracted thus far with 31 of those counties, and EQRO has scheduled each of them for review.

This report presents the FY 2019-20 EQR findings of Contra Costa's CY 2018 data and 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 twelve performance measures (PMs) for year one 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. As a County in its second year of services, Contra Costa will have 16 PMs evaluated.

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

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.

This is the second year for this DMC-ODS program to develop and implement PIPs so the CalEQRO staff have provided extra trainings and technical assistance to the County DMC-ODS staff. Materials and videos are available on the web site in a PIP library at http://www.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

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

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

to the specific SUD program that administered the survey so that quality activities can follow the survey results for services at that site. CalEQRO reviews the UCLA analysis and outliers in the results to discuss with the DMC-ODS leadership any need for additional quality improvement efforts.

CalEQRO also conducts 90-minute client focus groups with 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 and different ethnic groups and languages. Focus group forms which guide the process of the reviews include both structured questions and open questions linked to access, timeliness, quality and outcomes.

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

CalEQRO onsite reviews also include 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.

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

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

PRIOR YEAR REVIEW FINDINGS

In this section, the status of last year's (FY 2018-19) 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 2018-19 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 2019-20 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: The DMC-ODS needs an electronic health record system to support enhanced documentation, care coordination, data tracking and service system improvements. The DMC-ODS EHR system needs to be available to their contracted providers who provide 87 percent of services.

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

Status: Not Met

- The Contra Costa Health Agency's leadership maintains their plan for an integrated system, using EpicCare and Sharecare software, will be the best long term investment for client needs. It is their intent to maintain their plan for integration with EpicCare and Sharecare software. They will continue to fund adjunct staff and different software to complete specific tasks in the meantime. Many of these cannot link data together across the DMC-ODS or contract agencies.

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

Status: Met

- Two analytics staff were added to DMC-ODS to support with some other limited software products for DMC-ODS assessment functions as well as other needed special reports for compliance functions.

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

Status: Met

- CalOMS reports and other reports increased significantly as part of work with contract providers which included development of a shared web portal for exchange of information, community-based organizations (CBO) rapid improvement projects, monthly meetings, SUD data group, forms development group with CBOs, recovery support services group with CBOs.

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

Status: Partially Met

- Process was improved for providers but is still not integrated into Sharecare or Epic Clinical Desktop.

Recommendation #5: Meet monthly with contract providers to address their

concerns about the DMC-ODS implementation. Also invite their input on enhancements to the DMC-ODS and on improvements to provider/County collaboration.

Status: Met

- As part of the extensive re-design of the relationship with the contract providers and their daily working systems, monthly meetings and many other improvements were implemented with leadership from Director Suzanne Tavano. She hired Homebase, a non-profit organization, to help facilitate the process and support the activities of this major undertaking which is still ongoing.

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

Status: Partially Met

- Contra Costa made enhancements to these needed services in the last year and has additional services planned for the Richmond and Concord area and in contracts with neighboring counties with facilities near the County lines. It is anticipated adjustments to network capacity to meet beneficiary needs will be an ongoing process.
- Reviewing network adequacy and capacity is an ongoing review task and an important focus of the CalEQRO review. It is a key goal for meeting the needs of the beneficiaries and is the responsibility of the DMC-ODS plan. This recommendation is continued in FY 2019-20 report

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

Status: Partially Met

- Contra Costa has been meeting with providers on case management and recovery support services as requested. Training has begun, but the level of knowledge and skill on case management services, as well as recovery support is much more limited than anticipated. Very few contractors or SUD counselors had ever done this type of service before and had no understanding of billing, documentation, or the role of case management as a

core service. The DMC-ODS staff plan to continue these training efforts and expand them over this coming year.

- Recovery support plan as required is submitted to DHCS, but no services delivered were delivered though programs that are certified yet. Once the recovery training plan is approved, it can be implemented. Contra Costa hopes to partner with a local community college and then some recovery oriented training and recovery services could begin. Training on charting billing would also be needed.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

Contra Costa appointed Suzanne Tavano as the new Behavioral Health Director and Dr. Matthew White as the new Behavioral Health Medical Director. A new youth Program Manager was hired for the Alcohol and Other Drugs Services (AODS) program. Two data analysts were added to AODS for support of County and contractors and an additional person for Quality Management.

As stated in the executive summary there were significant changes in the network providers in the last fiscal year with one having a major leadership crisis due to an unexpected death, another having a bankruptcy, and another withdrawing from the DMC-ODS program. New contract provider CenterPoint was added to Contra Costa services and regional efforts are underway to expand options for youth residential treatment and WM 3.7 and 4.0.

Past Year's Initiatives and Accomplishments

Contra Costa was in its second year of service delivery and was continuing to refine the service delivery system as discussed below.

- Applied and got certification for high school clinic in Antioch and new contractor sites in coordination with contract providers.
- Applied for DMC certification for all County clinics (both east County clinics are waiting for DHCS PED certification).
- Worked on legal actions to add NTP site in Concord to meet Network Adequacy and successfully settle with city of Concord.
- Contracting for expanded access to residential and WM in Richmond.

- Exploring new youth residential treatment options in partnership with Bay Area counties.
- Conducted major initiative to improve the partnership with non-profit provider network and include them in decision-making and enhance communication.
- Worked with County and contract providers to use TPS, ASAM LOC data, and CalOMS to improve quality and outcomes.
- Began training and support activities to expand case management and recovery support services.
- Partnered with County primary care clinics on the Choosing Change MAT program to enhance access to buprenorphine.
- Partnered with Criminal Justice on re-entry programs for persons with SUD to access treatment and other support services.

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

Contra Costa Goals for the Coming Year

- Continue efforts to enhance communication and partnership with contractors on data systems, clinical services, planning, and quality of care.
- Finish getting all programs DMC-ODS certified and billing systems started and working smoothly including WM, County clinics, case management, and recovery support services.
- Open NTP program in Concord to meet Network Adequacy requirements.
- Expand residential and withdrawal management services in Richmond.
- Secure residential services for youth in partnership with Bay Area counties.
- Consider contracts with Alameda, Solano, and San Francisco contract providers to meet needs of SUD close to the County border or with unusual treatment needs.
- Continue training and development of case management and recovery support services with staff and contract providers.

- Provide input into the DMC 1115 Waiver Renewal based on experience with DMC-ODS program.
- Continue efforts to improve computer systems with Sharecare and EpicCare integration to have a functioning electronic health record.

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, CalEQRO identified twelve performance measures to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, CalOMS, and the ASAM level of care data for these measures.

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

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 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 LOCs, 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 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 complementary 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 2 of Waiver Services

This is the second 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 (CY 2018), and from UCLA for TPS, ASAM, and CalOMS data from CY 2018. 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.

DMC–ODS Clients Served in CY 2018

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

CY 2018 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 has higher penetration rates across all age groups than like size counties and statewide averages, particularly in adults 18-64 (Contra Costa at 1.08 percent versus the statewide average of 0.77 percent).

Table 1: Penetration Rates by Age, CY 2018

Table 1: Penetration Rates by Age CY 2018					
Contra Costa				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	30,941	55	0.18%	0.14%	0.16%
Ages 18-64	147,706	1,597	1.08%	0.78%	0.77%
Ages 65+	27,230	265	0.97%	0.55%	0.52%
TOTAL	**205,876**	**1,917**	**0.93%**	**0.65%**	**0.64%**

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).

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. Contra Costa's average approved claims are more costly than statewide averages across all age groups, with an average total cost of $4,993 compared to $3,863 statewide.

Table 2: Average Approved Claims by Age, CY 2018

Table 2: Average Approved Claims by Age CY 2018			
Contra Costa			Statewide
Age Groups	Total Approved Claims	Average Approved Claims	Average Approved Claims
Ages 12-17	$105,427	$1,917	$1,430
Ages 18-64	$8,130,744	$5,091	$4,054
Ages 65+	$1,335,948	$5,041	$3,168
TOTAL	**$9,572,119**	**$4,993**	**$3,863**

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS. If they all had similar patterns, one would expect the proportions they constitute of the total population of DMC-ODS enrollees to match the proportions they constitute of the total beneficiaries served as clients. In Contra Costa, clients who are White, African-American and Other access services more readily than Hispanic/Latino and Asian/Pacific Islanders. Twenty percent of eligible beneficiaries are White, but they make up 43 percent of clients served. However, 33 percent of eligible beneficiaries are Hispanic/Latino, but they only make up 13 percent of clients served. This was discussed with Contra Costa and they expressed a goal of expanding services to the Hispanic/Latino population. Barriers they identified were challenges hiring trained, qualified bilingual staff for clinical positions. They also shared that the local Latino population had increasing concerns related to use of any government services because of threats to permanent citizenship. Recent decisions on “public charge” issues for the administration have led to fears for themselves or members of their family who are seeking legal status. These fears were expressed as reasons for refusing services.

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, CY 2018

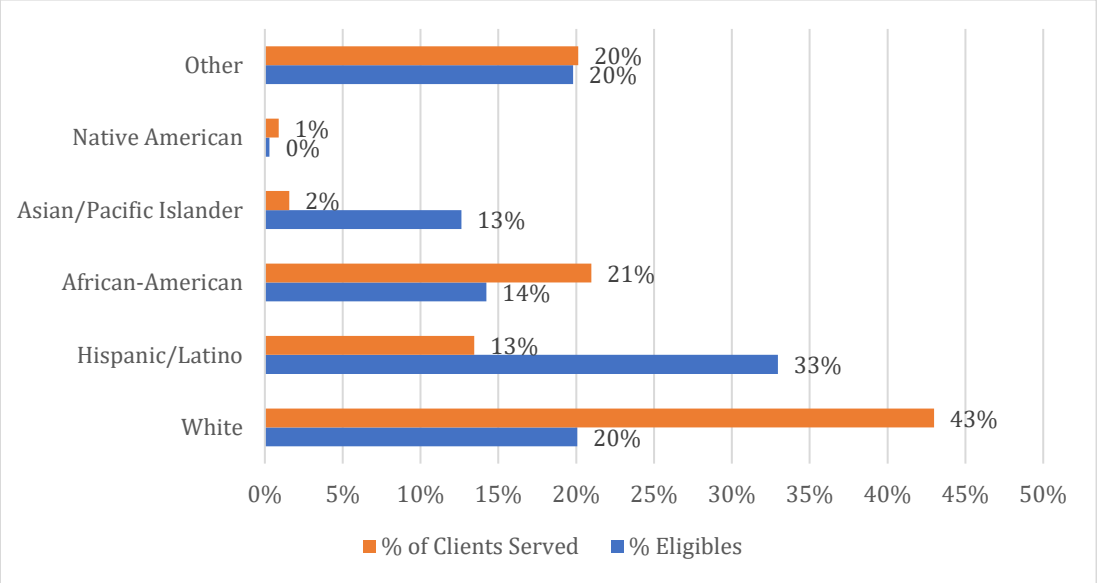


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. Only the Latino/Hispanic group has a lower penetration rate while all other ethnic/race groups have similar or higher rates.

Table 3: Penetration Rates by Race/Ethnicity, CY 2018

Table 3: Penetration Rates by Race/Ethnicity CY 2018					
Contra Costa				Large Counties	Statewide
Ethnic Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	41,317	824	1.99%	1.36%	1.20%
Latino/Hispanic	67,852	258	0.38%	0.44%	0.46%
African-American	29,310	402	1.37%	0.95%	0.95%
Asian/Pacific Islander	25,994	30	0.12%	0.10%	0.11%
Native American	625	17	2.72%	1.44%	1.01%
Other	40,779	386	0.95%	0.65%	0.69%
TOTAL	**205,877**	**1,917**	**0.93%**	**0.65%**	**0.64%**

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 majority of clients served are in the ACA, Disabled and Family Adult eligibility categories. This is similar to other counties.

Table 4: Clients Served and Penetration Rates by Eligibility Category, CY 2018

Table 4: Clients Served and Penetration Rates by Eligibility Category, CY 2018				
Contra Costa				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	26,094	537	2.06%	1.19%
Foster Care	659	*	n/a	1.38%
Other Child	18,228	32	0.18%	0.17%
Family Adult	40,155	444	1.11%	0.63%
Other Adult	31,172	40	0.13%	0.07%
MCHIP	13,435	15	0.11%	0.11%
ACA	75,970	908	1.20%	1.01%

Table 5 below shows Contra Costa's approved claims per penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. With Foster Care being an exception, Contra Costa's average approved claims cost more than statewide averages in all other eligibility categories.

Table 5: Average Approved Claims by Eligibility Category, CY 2018

Table 5: Average Approved Claims by Eligibility Category, CY 2018				
Contra Costa				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	26,094	537	$4,975	$3,112
Foster Care	659	*	n/a	$1,083
Other Child	18,228	32	$2,195	$1,337
Family Adult	40,155	444	$5,371	$3,281
Other Adult	31,172	40	$5,310	$2,928
MCHIP	13,435	15	$1,700	$1,710
ACA	75,970	908	$4,626	$4,274

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

Children 12 and under rarely need treatment for SUD. Foster Care, Other Child, and

Maternal and Child Health Integrated Program (MCHIP) include children of all ages contributing to a low penetration rate.

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 CY 2018. The majority of Contra Costa clients served are in NTPs (61 percent), followed by outpatient drug free programs (20 percent) and residential treatment programs (12 percent).

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

Table 6: % of Clients Serviced and Average Approved Claims by Service Categories, CY 2018			
Service Categories	**# of Clients Served**	**% Served**	**Average Approved Claims**
Narcotic Tx. Program	1,256	61%	$4,164
Residential Treatment	238	12%	$6,123
Res. Withdrawal Mgmt.	*	n/a	$0
Ambulatory Withdrawal Mgmt.	*	n/a	$0
Non-Methadone MAT	*	n/a	$889
Recovery Support Services	*	n/a	$0
Partial Hospitalization	*	n/a	$0
Intensive Outpatient Tx.	159	8%	$9,210
Outpatient Drug Free	413	20%	$3,434
TOTAL	**2,069**	**100.0%**	**$2,647**

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 often anxious about giving up their use of 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.

Most Contra Costa clients are able to receive their first dose of methadone within one day after assessment and diagnosis.

Table 7: Days to First Dose of Methadone by Age, CY 2018

Table 7: Days to First Dose of Methadone by Age CY 2018						
Contra Costa				Statewide		
Age Groups	# Clients	%	Median Days	Clients	%	Median Days
Ages 12-17	*	n/a	n/a	*	n/a	n/a
Ages 18-64	981	81%	<1	21,338	79.4%	<1
Ages 65+	*	n/a	n/a	*	n/a	n/a
Total Count	**1,213**	**100%**	**<1**	**26,886**	**100%**	**<1**

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

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 many feel the need for further clinical consultation once they begin prescribing. Consequently, physician uptake throughout most counties throughout the state tends to be slow.

Contra Costa has County operated primary care clinics which operate MAT programs for SUD called “Choosing Change” and were serving as estimated 750 clients on buprenorphine at the time of the review. The Access Call Center reported they had referred over 300 clients to these primary care clinics for MAT who requested buprenorphine. They also reported this number had doubled from the first year of the DMC-ODS, and the community awareness of the program and its benefits appeared to be responsible for this expansion of requests for services. Thus, performance measurement data for non-methadone MAT delivered and billed through non-DMC-ODS Contra Costa providers via the FFS Medi-Cal system is estimated as follows

based on County reports: Clinics served 750 in CY 2018 clients: Buprenorphine (n=750), Naltrexone (n=825), Disulfiram (n=unknown) and other (n=unknown).

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

Tables 8 display the number and percent of clients receiving three or more MAT visits per year provided through Contra Costa DMC-ODS providers and statewide for all active 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.

There is insufficient CY 2018 claims data on Contra Costa clients' use of non-methadone MAT services in their NTPs to support any analysis. This data was linked to NTP prescribing of non-methadone which is very low. Contra Costa staff reported that their NTP provider was continuing to have billing problems with non-methadone services which they were attempting to address with DHCS.

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

Table 8: DMC-ODS Non-Methadone MAT Services by Age, CY 2018								
	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	*	n/a	*	n/a
Ages 18-64	*	n/a	*	n/a	1,734	3.16%	723	1.32%
Ages 65+	*	n/a	*	n/a	*	n/a	*	n/a
TOTAL	*	n/a	*	n/a	**1,871**	**2.88%**	**767**	**1.18%**

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

Transitions in Care Post-Residential Treatment – CY 2018

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

Table 9 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.

Table 9 shows the percent of clients who began a new level of care within 7 days, 14 days and 30 days after discharge from residential treatment. Also shown in each table are the percent of clients who had follow-up treatment from 31-365 days, and clients who had no follow-up within the DMC-ODS system.

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

In Contra Costa, 356 clients were discharged from residential treatment in CY 2018 and 67 (18 percent) transitioned to a lower level of care. This is higher than the statewide average of 14.4 percent. Nonetheless, this is the focus of a PIP for improvement for Contra Costa as they see this as being in part due to inadequacy of case management skills and services.

Table 9: Timely Transitions in Care Following Residential Treatment Contra Costa, CY 2018

Table 9: Timely Transitions in Care Following Residential Treatment CY 2018				
	Contra Costa (n= 356)		Statewide (n= 20,141)	
Number of Days	**Transition Admits**	**Cumulative %**	**Transition Admits**	**Cumulative %**
Within 7 Days	20	6%	1140	5.7%
Within 14 Days	32	9%	1,579	7.8%
Within 30 Days	42	12%	1,987	9.9%
Any days (TOTAL)	**67**	**18%**	**2,895**	**14.4%**

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

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 1, 2018 through June 30, 2019. The most significant finding in review of the Access Call Center is that there is no coverage at night or on the weekends at this time. All calls roll to an answering machine. Contra Costa County reported it is negotiating with Optum to provide coverage similar to their Mental Health Plan, and if this fails it will explore other options with bay area counties.

Table 10: Access Line Critical Indicators, FY 2018-19

Table 10: Contra Costa Access Line Critical Indicators 7/1/2018 through 6/30/2019	
Average Volume	1,973 calls per month
% Dropped Calls	6%
Time to answer calls	90 seconds
Monthly authorizations for residential treatment	100
% of calls referred to a treatment program for care, including residential authorizations	10% of callers are linked to treatment through the Access Line
Non-English capacity	1 FTE Access Line staff are bilingual (English/Spanish) and Contra Costa has contract with a language line

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 $11,172 approved claims per year. The table lists the average approved claims costs for the year for Contra Costa HCBs compared with the statewide average. The table also lists the demographics of this group by race/ethnicity and by age group. Some of these clients use high-cost high-intensity SUD services, such as residential WM without appropriate follow-up services, and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment, including care coordination through case management, to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a but reflects the averages for all DMC-ODS counties statewide.

Contra Costa has 616 high cost beneficiaries in CY 2018, with an average approved claim of $19,243. Compared to the statewide average of 6.4 percent, Contra Costa's 32 percent is significantly higher.

Table 11a: High Cost Beneficiaries by Age, Contra Costa, CY 2018

Table 11a: Contra Costa High Cost Beneficiaries by Age, CY 2018						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	55	*	n/a	n/a	n/a	n/a
Ages 18-64	1,597	543	34%	$19,337	$1,837,011	23%
Ages 65+	265	*	n/a	$17,747	$106,484	8%
TOTAL	**1,917**	**616**	**32%**	**$19,243**	**$1,943,495**	**20%**

Table 11b: High Cost Beneficiaries by Age, Statewide, CY 2018

Table 11b: Statewide High Cost Beneficiaries CY 2018					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	2,498	25	1.0%	$17,005	$425,116
Ages 18-64	54,833	3,939	7.2%	$29,974	$86,556,047
Ages 65+	6,511	173	2.7%	$20,893	$3,614,507
TOTAL	**64,870**	**4,137**	**6.4%**	**$21,899**	**$90,595,670**

Withdrawal Management with No Other Treatment

This PM intends to measure engagement after WM for beneficiaries with no other DMC-ODS treatment services for their SUDs. The goal is to track levels of engagement for a high-risk group of clients who are using only WM.
There is insufficient CY 2018 claims data to support an analysis of Contra Costa's withdrawal management services. They have not started billing for WM.

Table 12: Withdrawal Management with No Other Treatment, CY 2018

Table 12: Withdrawal Management with No Other Treatment CY 2018				
	Contra Costa		**Statewide**	
	# WM Clients	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
TOTAL	*	n/a	3,794	1.95%

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.

Contra Costa's ASAM screening congruence is 68.2 percent when matched against client level of care placement. Where the level of care determination is different from referral, the primary reasons are clinical judgement (14.8 percent) or patient preference (9.9 percent). These are appropriate considerations for change in recommendations.

Table 13: Congruence of Level of Care Referrals with ASAM Findings, CY 2018

Table 13: Congruence of Level of Care Referrals with ASAM Findings, CY 2018						
ASAM LOC Referrals Nov 2018 to May 2019	**Initial Screening**		**Initial Assessment**		**Follow-up Assessment**	
If assessment-indicated LOC differed from referral, then reason for difference	**#**	**%**	**#**	**%**	**#**	**%**
Not Applicable - No Difference	708	68.2%	0	0.0%	0	0.0%
Patient Preference	103	9.9%	0	0.0%	0	0.0%
Level of Care Not Available	69	6.6%	0	0.0%	0	0.0%
Clinical Judgement	154	14.8%	0	0.0%	0	0.0%
Geographic Accessibility	0	0.0%	0	0.0%	0	0.0%
Family Responsibility	0	0.0%	0	0.0%	0	0.0%
Legal Issues	0	0.0%	0	0.0%	0	0.0%
Lack of Insurance/Payment Source	2	0.2%	0	0.0%	0	0.0%
Other	2	0.2%	0	0.0%	0	0.0%
Actual Referral Missing	0	0.0%	0	0.0%	0	0.0%
TOTAL	**1,038**	**100.0**	**0**	**0.0%**	**0**	**0.0%**

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 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.

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and between the 15th and 45th day following initial DMC-ODS service. Contra Costa's adult clients have higher treatment initiation and engagement rates when compared to rates of like size counties and statewide. This is also true for youth initiation into treatment.

Table 14: Initiating and Engaging in DMC-ODS Services, Contra Costa and Statewide, CY 2018

Table 14: Initiating and Engaging in DMC-ODS Services CY 2018								
	Contra Costa				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	1,978		59		56,612		2,095	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	1,880	95.0%	47	80.0%	50,174	88.6%	1,634	78.0%
Clients who then engaged in DMC-ODS services	1,659	88.2%	29	61.7%	38,411	67.8%	1,046	64.0%

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. Most Contra Costa clients began their treatment by accessing NTP services (64.2 percent), followed by outpatient treatment (21 percent) and residential treatment (10.5 percent). These services were the first "touch" into the system of care.

Table 15: Initial DMC-ODS Service Used by Clients, Contra Costa and Statewide, CY 2018

Table 15: Initial DMC-ODS Service Used by Clients, CY 2018				
	Contra Costa		Statewide	
DMC-ODS Service Modality	#	%	#	%
Outpatient treatment	422	21%	20,623	30.1%
Intensive outpatient treatment	95	4.7%	4,337	6.3%
NTP/OTP	1,307	64.2%	28,012	40.9%
Non-methadone MAT	*	n/a	179	0.3%
Ambulatory Withdrawal	*	n/a	*	n/a
Partial hospitalization	*	n/a	*	n/a
Residential treatment	213	10.5%	11,749	17.2%
Withdrawal management	*	n/a	3,281	4.8%
TOTAL	**2,037**	**100.0%**	**68,436**	**100.0%**

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 CY 2018), 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 beginning date goes back to the prior year as far back as the beginning of the DMC-ODS for that County. 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 139 days (median 88 days), compared to the statewide mean of 132 (median 78 days). 49.5 percent of clients had at least a 90-day length of stay; 28.7 percent had at least a 180-day stay, and; 17.3 percent had at least a 270-day length of stay. Contra Costa's LOS percentages for 90-day, 180-day and 270-day are similar to statewide experiences.

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, Contra Costa and Statewide CY 2018

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services CY 2018				
	Contra Costa		Statewide	
Clients with a discharge anchor event	1,433		63,490	
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)
	139	88	132	78
	#	%	#	%
Clients with at least a 90-day LOS	709	49.5%	29,455	46.40%
Clients with at least a 180-day LOS	411	28.7%	15,193	23.90%
Clients with at least a 270-day LOS	254	17.3%	10,149	16.00%

Withdrawal Management Readmissions

Table 17 measures the number and percentage of withdrawal management readmissions within 30 days of discharge. Contra Costa is not yet billing for WM. Thus, there were no clients admitted into residential WM in Contra Costa, hence none were readmitted within 30 days of discharge. For all DMC-ODDS counties, 6.2 percent readmitted within 30 days. Getting WM certification and billing into the DMC-ODS system is a goal for this year.

Table 17: Residential Withdrawal Management (WM) Readmissions, Contra Costa and Statewide CY 2018

Table 17: Residential Withdrawal Management (WM) Readmissions, CY 2018				
	Contra Costa		Statewide	
Unduplicated clients of the DMC-ODS*	1,917		63,490	
	#	%	#	%
Total DMC-ODS clients who were admitted into residential withdrawal management (WM)	*	n/a	4,560	7.2%
Clients admitted into WM who were readmitted within 30 days of discharge	*	n/a	284	6.2%

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 CY 2018. Opioids (68.4 percent), other stimulants (13.4 percent) and alcohol (9.7 percent) are the most common substances leading clients to treatment in Contra Costa.

Table 18: Percentage Served and Average Cost by Diagnosis Code, CY 2018

Table 18: Percentage Served and Average Cost by Diagnosis Code, CY 2018				
Diagnosis Codes	Contra Costa		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	9.7%	$7,000	16.0%	$5,870
Cannabis Use	5.6%	$4,690	8.0%	$1,116
Cocaine Abuse or Dependence	2.2%	$5,716	2.4%	$5,342
Hallucinogen Dependence	0.1%	$250	0.3%	$4,353
Inhalant Abuse	0.2%	$3,953	0.0%	$4,785
Opioid	68.4%	$4,381	45.4%	$3,372
Other Stimulant Abuse	13.4%	$6,641	25.1%	$4,865
Other Psychoactive Substance	0.1%	$8,012	0.8%	$4,035
Sedative, Hypnotic Abuse	0.2%	$10,504	0.6%	$6,565
Other	0.2%	$1,420	1.4%	$3,730
Total	**100%**	**$4,991**	**100%**	**$4,010**

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

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.

Contra Costa scores well across all domains in the adult survey. Two areas with lower client satisfaction scores are Access and Care Coordination (Work with Mental Health Providers). In the youth survey, Contra Costa scores well in the Therapeutic Alliance domain but not as well in the Quality questions.

Figure 2: Percentage of Participants with Positive Perceptions of Care, Contra Costa, TPS Results from UCLA, Adults

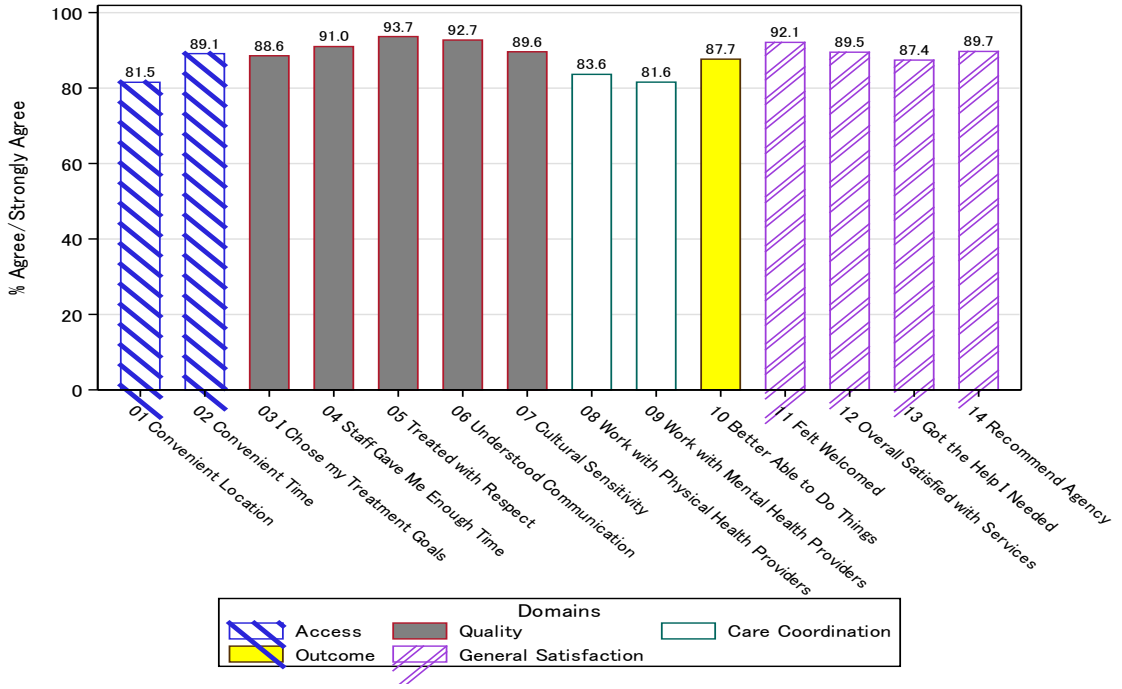
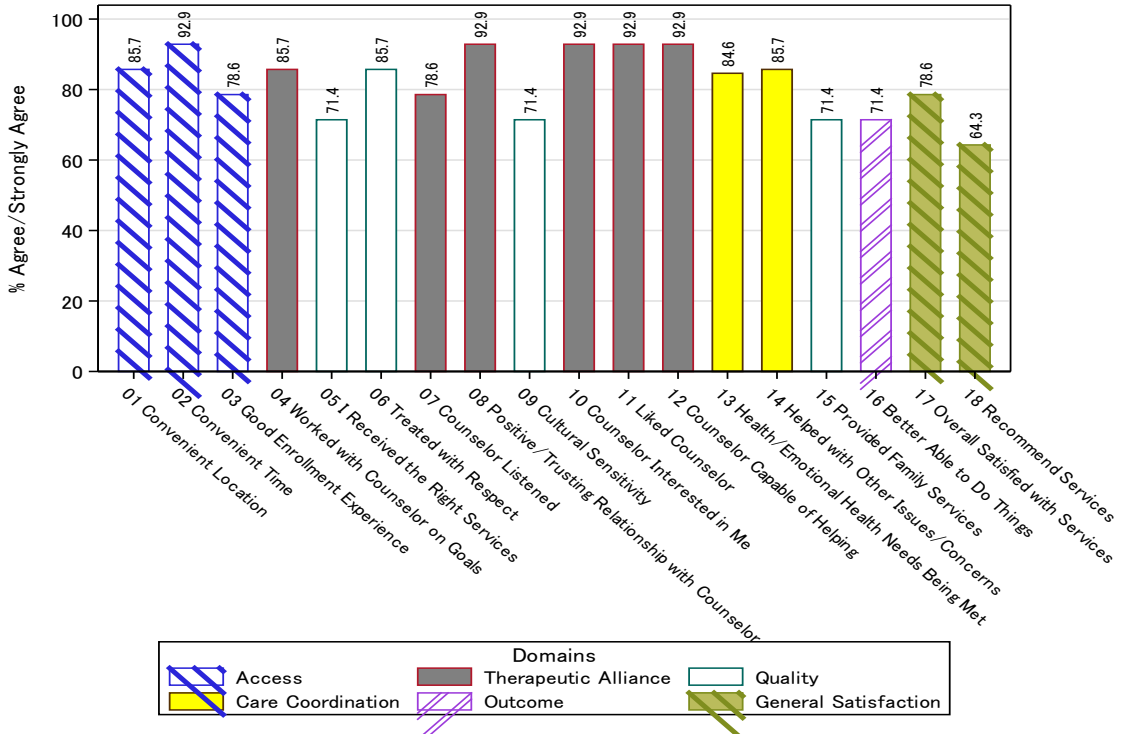


Figure 3: Percentage of Participants with Positive Perceptions of Care, Contra Costa, TPS Results from UCLA, Youth



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 and evaluate 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. As reflected below, 25.5 percent of Contra Costa's clients are homeless, which is on par with the statewide 26.2 percent. 74.8 percent of Contra Costa's clients have no criminal justice involvement, which is higher than the statewide percentage of 59.8. Also, 78.7 percent of Contra Costa's clients are unemployed, almost identical to the statewide average of 78.9 percent.

Table 19: CalOMS Living Status at Admission, Contra Costa and Statewide, CY 2018

Table 19: CalOMS Living Status at Admission CY 2018				
Admission Living Status	**Contra Costa**		**Statewide**	
	#	**%**	**#**	**%**
Homeless	317	25.5%	24,020	26.2%
Dependent Living	654	52.7%	26,296	28.6%
Independent Living	271	21.8%	41,472	45.2%
TOTAL	**1,242**	**100.0%**	**91,788**	**100.0%**

Table 20: CalOMS Legal Status at Admission, Contra Costa and Statewide, CY 2018

Table 20: CalOMS Legal Status at Admission CY 2018				
Admission Legal Status	**Contra Costa**		**Statewide**	
	#	**%**	**#**	**%**
No Criminal Justice Involvement	928	74.8%	54,930	59.8%
Under Parole Supervision by CDCR	*	n/a	2,288	2.5%
On Parole from any other jurisdiction	*	n/a	890	1.0%
Post release supervision - AB 109	247	19.9%	28,801	31.4%
Court Diversion CA Penal Code 1000	*	n/a	1,259	1.4%
Incarcerated	*	n/a	389	0.4%
Awaiting Trial	38	3.1%	3,221	3.5%
TOTAL	**1,240**	**100.0%**	**91,788**	**100.0%**

Table 21: CalOMS Employment Status at Admission, Contra Costa and Statewide, CY 2018

Table 21: CalOMS Employment Status at Admission, CY 2018				
Current Employment Status	Contra Costa		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	156	12.6%	12,134	13.2%
Employed Part Time - Less than 35 hours	108	8.7%	7,259	7.9%
Unemployed - Looking for work	436	35.1%	25,522	27.8%
Unemployed - not in the labor force and not seeking	542	43.6%	46,873	51.1%
TOTAL	**1,240**	**100.0%**	**91,788**	**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, attempt to persuade the client to complete treatment. Contra Costa has fewer administrative adult discharges at 27.4 percent when compared to the statewide average of 37.9 percent. This increases reliability of data findings.

Table 22: CalOMS Types of Discharges, Contra Costa and Statewide, CY 2018

Table 22: CalOMS Types of Discharges, CY 2018				
Discharge Types	Contra Costa		Statewide	
	#	%	#	%
Standard Adult Discharges	470	51.4%	43,654	42.1%
Administrative Adult Discharges	251	27.4%	33,344	37.9%
Detox Discharges	*	n/a	8,470	9.6%
Youth Discharges	*	n/a	2,609	3.0%
TOTAL	**915**	**100.0%**	**88,077**	**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.

Contra Costa clients have overall better improvement on discharge (57.8 percent) than the statewide average (51.9 percent).

Table 23: CalOMS Discharge Status Ratings, Contra Costa and Statewide, CY 2018

Table 23: CalOMS Discharge Status Ratings, CY 2018				
Discharge Status	Contra Costa		Statewide	
	#	%	#	%
Completed Treatment - Referred	292	31.9%	20,054	22.9%
Completed Treatment - Not Referred	15	1.64%	6,015	6.9%
Left Before Completion with Satisfactory Progress - Standard Questions	159	17.4%	12,155	13.9%
Left Before Completion with Satisfactory Progress – Administrative Questions	63	6.9%	7,227	8.3%
Sub-total	529	57.8%	45,451	51.9%
Left Before Completion with Unsatisfactory Progress - Standard Questions	198	21.6%	16,187	18.5%
Left Before Completion with Unsatisfactory Progress - Administrative	184	20.1%	24,666	28.2%
Death	*	n/a	96	0.1%
Incarceration	*	n/a	1,195	1.4%
Sub-total	386	42.2%	42,144	48.1%
TOTAL	**915**	**100.0%**	**87,595**	**100.0%**

Performance Measures Findings—Impact and Implications

Overview

Access to Care PM Issues

- Latino/Hispanic clients are underserved in Contra Costa. Latino/Hispanics make up 33 percent of eligible beneficiaries, but only 13 percent of clients

served. Hiring more Spanish-speaking providers and conducting more outreach will improve this group's access to services.

- Non-methadone MAT services provided through Choosing Change clinics are billed through Medi-Cal FFS and not accounted for in DMC-ODS claims, but by self-report appear to be a robust source of buprenorphine and naloxone/Narcan for the population with opioid issues in treatment as well as those at risk of overdose.
- Additional effort is needed with the NTP providers to provide required non-methadone MAT medications and learn how to resolve their billing concerns.
- Contra Costa has identified some excellent areas for additional case management and recovery support efforts such as transitions from residential.
- Certification and billing for WM, case management, recovery support, and physician consultation are required services under the DMC-ODS waiver and are still not being billed. Contra Costa is aware of this and it needs to be a focus for resolution in their third year of services, both in terms of resolving issues of certification as well as training and billing challenges. Without billing it is difficult to assess PMs and other quality measures.

Timeliness of Services PM Issues

- Contra Costa clients have timely access to NTP treatment, with time to first dose of methadone less than one day after assessment/diagnosis.
- The Timely Transition to a Lower Level of Care following Residential Treatment measure shows Contra Costa's performance to be slightly better than the statewide average (18 percent versus 14 percent).

Quality of Care PM Issues

- Treatment initiation and engagement are high in Contra Costa for adults, and treatment initiation is high for youth.
- No withdrawal management readmissions data is available for performance analysis and certification and billing delays for this service need resolution.
- The congruence between ASAM screening and level of care determination is in high 60s with clinical judgement playing a major role at 14 percent.

Client Outcomes PM Issues

- Treatment perception surveys indicate Contra Costa adult clients are satisfied with services provided and rated Quality higher than Care Coordination.

- CalOMS discharge data showed higher than average improvement on discharge compared to state averages.
- Youth therapeutic alliance scores are high, and this domain is one of the best indicators of positive outcomes in treatment on the TPS satisfaction survey

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment 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: Distribution of Services, by Type of Provider

ISCA Table 1: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	14.21%
Contract providers	85.79%
Total	**100%**

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 7.65 percent.

The budget determination process for information system operations is:

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

DMC-ODS currently provides services to clients using a telehealth application:

☐ Yes ☒ No ☐ In Pilot phase

Summary of Technology and Data Analytical Staffing

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

ISCA Table 2: Summary of Technology Staff Changes

ISCA Table 2: Summary of Technology Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
8	0	1	1

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

ISCA Table 3: Summary of Data and Analytical Staff Changes

ISCA Table 3: Summary of Data and Analytical Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
6.5	2	0	0

The following should be noted regarding the above information:

- Sharecare support is provided by Contra Costa Health Services (CCHS) IT staff.
- Data analytics support consists of:
    - Two AODS data analysts who support Sharecare data integrity and accuracy.
    - Two Behavioral Health Services Planning and Evaluation FTEs who support NACT and timeliness reporting.
    - 2.5 Health Services Business Intelligence FTEs who support single client ID maintenance and data interface between ccLink and Sharecare.

Current Operations

- AODS does not have an electronic health record (EHR). Sharecare is used for billing, DMC claim submission, and state-mandated reporting including CalOMS. ASAM is submitted electronically as required in the DHCS info notice, but not via Sharecare.
- End-users need to use up to four stand-alone systems and paper charts to support clients. See ISCA Table 4 to identify systems and functionality.

- Jail SUD services are entered by detention health staff including doctors and nurses who also have access to historical SUD episodes and services.
- Sharecare training is provided to new users and those who need refreshers. A newsletter is used to communicate system updates to users.
- AODS data analysts provide phone/on-site Sharecare support to contract providers when needed.
- A secured website has been established to exchange data between the County and contractors and it is an ongoing effort with a large workgroup.
- Given recovery support, case management, WM, physician consultation, and non-methadone MAT via NTPs are supposed to be billed via DMC-ODS more technical support and training on claiming and billing systems with contractors is needed. Some of this cannot be completed until PED approval is secured, however.

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

ISCA Table 4: Primary EHR Systems/Applications

ISCA Table 4: Primary EHR Systems/Applications				
System/ Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Sharecare	Billing and Claims	Echo	1	CCHS IT
ccLink	County EHR	Epic	7	CCHS IT
Accucare	Addiction Severity Index (Online Clinical Assessments)	Orion	>10	CCHS IT
Bed App	Bed/Service Slot Availability	CC IT	1	CC IT
OnBase	Enterprise Scanning, Document Archiving and Management	Hyland	2	CCHS IT
InSyst/PSP	Legacy Billing and Claims Payment	Echo	16	CCHS IT

Priorities for the Coming Year

- Create a secured web-based portal for contract providers to access treatment-related consumer data in ccLink.
- Complete a service upload interface to receive electronic data files from NTP/MAT providers.
- Implement Accucare ASI in electronic form to all AODS providers. This software has embedded all the clinical forms used by counselors during the intake process.

Major Changes since Prior Year

- Contra Costa County IT built a phone app for AODS called the Bed App. The application shows real-time residential beds and outpatient slots available in the County. Bed App went live during October 2018.
- Configured Sharecare to process NTP/MAT services.
- Started work on a service upload interface for NTP/MAT providers to submit services including National Drug Codes, drug units, and drug quantities.

Other Significant Issues

In the absence of an electronic health record system, many of AODS' processes are done manually:

- Client clinical documentation such as progress notes, treatment plans, labs and medications are kept in paper chart.
- Paper authorizations are entered by Utilization Review staff into Sharecare.
- Care coordination only happens for residential clients and involves printing an active census to verify they are in treatment.
- DMC state mandated ASAM level of care documents, TPS surveys, ASAM assessments and screenings, are all separately stored and transmitted to DHCS.
- Referral management happens in a number of ways. AODS counselors receive referrals from the Access Center via warm hand-offs from Mental Health providers in co-located regional clinics, and in the form of ccLink in-basket messages from Physical Health.
- Reports are used to identify open clients who need annual CalOMS updates and providers whose credentials are up for renewal.

Plans for Information Systems Change

- Sharecare was implemented in 2018 to replace AODS' legacy billing system InSyst. AODS has no plans to change its information system at this time.
- Contra Costa Behavioral Health including AODS providers are preparing to pilot test access to a ccLink web portal to view charts of clients shared between AODS and the contract providers. When implemented, contract providers will be able to see information such as client demographics, medications, care team, referrals and to exchange electronic messages.

Current Electronic Health Record Status

ISCA Table 5: EHR Functionality

ISCA Table 5: EHR Functionality					
		Rating			
Function	**System/ Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts				X	
Assessments				X	
Care Coordination				X	
Document imaging/storage				X	
Electronic signature—client				X	
Laboratory results (eLab)				X	
Level of Care/Level of Service				X	
Outcomes				X	
Prescriptions (eRx)				X	
Progress notes				X	
Referral Management				X	
Treatment plans				X	
Summary Totals for EHR Functionality:		**0**	**0**	**12**	**0**

Progress and issues associated with implementing an EHR over the past year are discussed below:

- Contra Costa does not have an EHR and Sharecare is used for billing and reporting. Configuring Sharecare to support DMC-ODS implementation had its challenges:

- There was an initial problem with facility-program codes which control the level of care and the funding source used for each placement. When the initial list of facility-program codes was released for use, the actual contracted facilities did not match what had been entered into the system. Providers began using the new codes found that many either had not been assigned to the correct staff members or had been duplicated. This led to multiple services being entered under the wrong codes and having to be re-entered, causing delays in billing and needs to restructure and re-bill which is costly.
- In November 2018, it was discovered that a function intended to split billable time among beneficiaries who participated in groups failed to work properly during implementation, so every person and every service had to be entered separately. By entering every service individually into the system, Sharecare was unable to properly divide the billable time as expected. Instead, all group billable time was billed to each beneficiary in the group. Due to the system's limited ability to notify the user of discrepancies, omissions and errors, providers were unaware of the generated errors produced by data entry staff and corrections were not made on time. The IT team had to submit hundreds of void and replacement claims and data correction is still ongoing.
- There is a problematic workflow to handle out of County Medi-Cal beneficiaries when they transfer their coverage to Contra Costa. This was estimated to impact services for at least 400-500 persons per year. During the transition when a person is not eligible to receive services, a provider has to create a placeholder in Sharecare associated with an alternate funding source until the client's Medi-Cal is reassigned to Contra Costa. Once Medi-Cal eligibility is transferred, the system is not capable of automatically assigning the services to DMC Medi-Cal. The only way to resolve this issue is to delete all services that have been entered, remove the admissions from Sharecare, and create a new admission under DMC in the system, as all the services are re-entered once again. Then they can be billed.

Clients' Chart of Record for County-operated programs (self-reported by DMC-ODS):

☒ Paper ☐ Electronic ☐ Combination

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

ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings

ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings			
	Yes	**No**	**%**
ASAM Criteria is being used for assessment for clients in all DMC Programs.	X		
ASAM Criteria is being used to improve care.	X		
CalOMS being administered on admission, discharge and annual updates.	X		
CalOMS being used to improve care. Track discharge status. Outcomes.	X		
Percent of treatment discharges that are administrative discharges.			27.4
TPS being administered in all Medi-Cal Programs.	X		

Highlights of use of outcome tools above or challenges:

- When clients contact the Access Call Center Line, they are checked for medical necessity and given an ASAM screening.
- CalOMS data was flagged as an issue by State audits and AODS hired two data analysts to improve reporting accuracy and data integrity including annual updates and administrative discharges which are lower than the state average but need monitoring and regular training.

Drug Medi-Cal Claims Processing

- AODS indicated 51.5 percent of DMC-ODS services provided by County-operated/staffed clinics are claimed to Drug Medi-Cal. 69.9 percent of DMC-ODS services provided by contract providers are claimed to Drug Medi-Cal.
- MAT services provided in FY 2018-19 by AODS' NTP provider, BAART, were submitted late due to time taken to configure Sharecare to handle National Drug Codes, drug dosages, and quantities.

Special Issues Related to Contract Agencies

- 85.8 percent of Contra Costa's DMC-ODS services are provided by contract providers.
- Since June 2019, Sharecare reports such as 835 denials, unauthorized services, Medi-Cal eligibility, and Service Activity Reports are delivered to contract providers via secured folders that they could access on a County

server. County staff assist in corrections, but more training was needed per the contractors.

- BAART sends electronic service data to AODS and enters client admissions data in Sharecare directly.
- Data exchange between AODS and other contract providers are in the form of documents/files attached to emails or via faxes.

Overview and Key Findings

Access to Care

- The Access Call Center does not have night and weekend coverage, and clients must leave a message for their service requests. Contra Costa stated they were working on a contract with Optum which provides call center services after hours and on weekends to the MHP.

Timeliness of Services

- AODS defines urgent appointments as withdrawal management and NTP services. Clients are allowed to walk-in for these services without appointments and tracking is minimal in these cases.
- Referrals for MAT are done on a walk-in basis and data is not collected regarding no-shows.

Quality of Care

- AODS has added staffing to improve CalOMS data integrity in the last year.
- A Daily Service Work queue was created in Sharecare to facilitate data error correction before releasing services for claim processing.

Client Outcomes

- Treatment perception surveys are done annually to gauge client satisfaction of services.
- CalOMS is regarded as an outcome tool and PHQ-9 was successfully piloted at Discovery House, a County-operated residential facility, as an outcome measure.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Contra Costa PIPs Identified for Validation

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

The following lists the number and titles of the PIPs submitted by Contra Costa, as required by the PIP Protocols: Validation of PIPs.[4]

PIPs Submitted by Contra Costa		
PIPs for Validation	**# of PIPs**	**PIP Titles**
Clinical PIP	1	PHQ9/GAD7 Improvement in SUD Trt using CBT group interventions for anxiety/depression
Non-clinical PIP	1	Increasing coordination/continuity of care for clients leaving residential trt to reduce re-admission rates (relapse) to residential & WM

PIP Table 1, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Applicable (NA), and Unable to Determine (UTD), or Not Rated (NR).

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

PIP Table 1: PIP Validation Review

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

PIP Table 2 provides a summary of the PIP validation review.

PIP Table 2: PIP Validation Review Summary

PIP Table 2: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	25	14
Number Partially Met	1	3
Number Not Met	1	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	19
Overall PIP Rating Clinical: ((25*2)+(1))/(25*2) Non-clinical: ((14*2)+(4)/(19*2)	**99%**	**85%**

Clinical PIP—PHQ-9/GAD-7 Improvement in SUD Treatment using CBT group interventions for anxiety/depression

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

Will providing a specialized CBT intervention of 6 intensive groups with skills for anxiety and depression reduce anxiety and depression symptoms on tests among SUD clients who scored high on the PHQ-9 and GAD-7 on admission for anxiety and depression in two SUD residential treatment centers thus improving functioning and wellness?

Date PIP Began: 7/27/18

Status of PIP: Completed

Brief Description: Many clients in the SUD residential treatment programs had high scores in domains of depression and anxiety on the PHQ-9 and GAD-7. Clinical staff identified specialized CBT skills which could benefit the clients and consolidated these anxiety and depression related treatment interventions and skills development into six weeks of structured groups. The groups had experiential homework and were to be provided twice per week in residential treatment. This intervention was to be tested over a year period of time in two residential settings. The staff who consolidated the curriculum were highly skilled in CBT and worked to provide the clinical staff conducting the groups with extensive supervision and tools for consistency. Only clients with high scores on anxiety and depression were included in these groups. The design was a “pre” and “post” testing model and looked for improvement which was statistically significant. As important as the statistical significance was client feedback. The clients

themselves reported a very strong benefit from the skills-based groups, a desire to stay in the groups, even after the completion of the program. They reported this program was one of the most “practical” real life therapies they had experienced to address some of their most chronic, ongoing life issues.

Parallel to this feedback, other clients in the residential program also began asking to be included in these CBT groups as well, hearing from the members of the group how helpful it was to work on “real life issues”. Based on the ongoing from the CBT treatment curriculum with the anxiety and depression skills modules, this will be offered in other residential programs, and testing will continue using primarily the PHQ-9 as it was complete and consistent in its results with the GAD-7.

Intervention: CBT groups with structured curriculum targeting anxiety and depression skills development with homework twice per week at two residential treatment facilities with SUD clients screened for high levels of depression and anxiety.

Indicators:

- Successful residential program completion for those in CBT group
- Average LOS for those who do not complete treatment
- Average LOS for those with severe depression at intake
- Improvement of PHQ-9 severity
- Improvement of GAD-7 score severity

Results:

- There was a significant improvement on PHQ-9 scores for those in CBT Depression group
- There was a significant improvement in GAD-7 score for those in the CBT Depression group.

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

Technical Assistance Provided: Lead reviewer consulted with the team on several occasions prior to the review and also the prior lead reviewer consulted as well. The TA include discussion of the interventions and documentation of the programming for other counties to use if it was successful. The CBT modules for depression and anxiety needed to be condensed to be able to fit within the 6 week residential length of stay so the most important and practical life skills needed to be identified and condensed with materials for the curriculum. TA also included how to handle some of the data for clients who did not complete the program due to factors out of their control etc.

Non-Clinical PIP—Enhancing Coordination/Continuity of Care for clients transitioning out of residential treatment.

Contra Costa's goal was to reduce readmissions to residential treatment and WM residential, and enhance engagement with outpatient and other treatment supports post residential.

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

Will a bi-weekly care coordination meeting for clients in residential treatment increase the post-discharge follow-up treatment rate in lower levels of care by 10 percent?

Date PIP Began: 4/1/2019

Status of PIP: Active and ongoing

Brief Description: The focus is enhanced care coordination and "wrap-around" services for the clients preparing to leave residential treatment via twice weekly meetings with residential counselors. The meetings include case conferences and planning linked to transitions with staff at the Access call center and other resources.

Intervention:

New care coordination meetings were established twice per week with residential treatment providers to help prepare clients for changes in levels of care. These meetings included review of treatment goals and options for support, and staff follow through with client and access team to find options for next level of care. Appointments are provided in the coordination call, and if needed supported housing is facilitated with SLE housing. County can subsidize this as well for the first few months at 100% and it is gradually lowered as client is stabilized with support. Training for residential providers is another intervention parallel to the new care coordination meetings.

Indicators:

Success is tracked with a variety of indicators compared to current baseline data including (1) percent of clients with follow-up care within seven days; (2) the number and percent of clients with follow-up within 30 days of discharge;(3) the number and percent of clients readmitted to residential within 30 days; and (4) the number and percent of clients admitted to WM within 30 days of discharge from residential treatment; and (5) the average length of stay in residential will be tracked.

Relevant details of the PIP data and design are included within the comments found in the PIP validation tool.

Results:

At the time of the review, Contra Costa had five months of data. As of the first five-month period of measurement, the results are not encouraging as the care coordination meetings are not improving the linkage indicators over the baselines, and many are worse. For example, more clients were relapsing and being re-admitted to residential treatment and WM, and there was no increase in outpatient admissions after residential discharge. Many felt that housing and desire for jobs were more important, than just going to more treatment and the approach needed to include meeting the client's needs in a more wholistic way to keep them engaged in treatment. There were many other ideas as well on possible improvements.

Reasons were discussed and other options for interventions were debated by the county staff and contractors. The PIP steering committee was going to review options for enhancing or changing their interventions as the impact of these relapses is very serious for the clients themselves and is indicative that there is need for systemic improvements. They will submit an enhanced PIP to BHC when the new interventions are decided.

Technical Assistance Provided: Several conference calls and drafts of this PIP went back and forth with the lead reviewer over the prior year, and there was a discussion of other potential interventions used in several other counties (as this is a common PIP topics) if this intervention is not working to improve transitions in care. Many clinical programs do have an overlap in residential and outpatient treatment (even though this is not billable to allow for transfer of therapeutic alliance and support) to a new counselor/clinician team. Contra Costa was discussing barriers to transitions based on lack on assessment appointments at appropriate programs and other issues. This was an important and necessary step to understanding the issues with their continuity of care challenges.

PIP Findings—Impact and Implications

Overview

Both PIPs were active and working on important issues related to DMC-ODS services. The topic of transitions in care is a common challenge many counties are trying to improve. The CBT intervention and strategy was unique and particularly well done. Contra Costa has documented the CBT program in a thorough manner, and it has potential for the SUD field, and in particular for residential programs with shorter lengths of stay. The County staff were encouraged to write it up in detail to share with other counties as the depression/anxiety profile in SUD clients if very common, and many programs could benefit from this skills-based curriculum.

Access to Care Issues related to PIPs

Neither PIP specifically addressed access issues.

Timeliness of Services Related to PIPs

The non-clinical PIP specially addresses timeliness -the need to have timely access to outpatient and other supports after residential treatment to avoid risk of relapse. Because of the high risk of relapse after residential structure to a community unstructured setting, research often tracks linkage to aftercare within seven and thirty day increments to the next level of care. This is considered a best practice, and often there is resistance to continuing in treatment. Understanding that SUD is a chronic disease with high risk of relapse is very important.

Quality of Care Related to PIPs

Optimal quality is linked to continuity of care across the ASAM continuum of care and total length of stay in some type of SUD treatment and supports, thus the non-clinical PIP addresses many of these issues.

Also, the clinical PIP uses an evidence-based treatment intervention to assist SUD clients with common symptom profiles which hamper success in treatment and functioning. The fact that so many clients were eager to continue in this treatment or get into the groups themselves shows how beneficial good treatment can be. Sharing this PIP model would be very positive for other programs.

Client Outcomes Related to PIPs

Both PIPs track client outcomes and improvements in different ways. The clinical PIP tracks it related to relief from symptoms of depression and anxiety. The non-clinical PIP is tracking the ability of the system to support clients staying in treatment over time and over different levels of care which is linked to better outcomes in the research literature.

Recommendations for PIPs

Develop a new clinical PIP for this coming year and consider expanding the successful CBT PIP to other programs.

Study the non-clinical PIP intervention and barriers to success through client interviews and other data analysis to consider new interventions to improve success rates of transitions in care and continuity of care.

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 these two focus groups with eight to ten participants each, the details of which can be found in each section below.

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 specific to the DMC-ODS program 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 Outpatient 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.

Adult outpatient clients in services at CenterPoint, 1470 Civic Ct, Concord, CA.

Number of participants: Eight clients all new to outpatient within the last year. Four different ethnic groups represented (Caucasian, Latino, Asian, African-American), ages 25-59, a variety of preferred languages, and all male.

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	3-5
2. I got my assessment appointment at a time and date I wanted.	3.7	2-5
3. It did not take long to begin treatment soon after my first appointment.	3.9	3-5
4. I feel comfortable calling my program for help with an urgent problem.	3.5	2-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	2.5	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.8	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	3.5	2-5
8. Because of the services I am receiving, I am better able to do things that I want.	3.8	3-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.0	3-5

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

- Access was through Access line or through courts or friends. Need clean housing with outpatient to get a chance to stop using. Some clients need residential and can ask for more support. Recovery is about connections and community and it can start here in these programs. Women have more challenges at getting into residential programs and housing especially with kids.

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

- Being taught tools such as deleting phone numbers of people trying to sell you drugs is important. Practical skills and support help with cravings, family.
- More counselor support in the mornings would be helpful and longer time to be in groups and more “check ins” and reading materials about triggers and stressors and how to handle them.
- Many people with SUD avoid talking about drugs and alcohol, but it is important to really acknowledge what is behind the feelings and behaviors.
- Wish we had more one on one meetings with the counselors some are very skillful and can help with PTSD and therapies.
- Hard to do everything in groups especially really personal stuff.

- More long-term affordable housing and access to detox to begin recovery when ready to quit is needed.
- Employment helps with recovery too and support to integrate back is helpful and managing stress and triggers.

Recommendations for improving care included the following:

- More help with transportation for groups and activities in recovery community buses do not run after 8pm
- Stigma is real and it is hard to get jobs, help is needed to get started in community and have some support with resumes and computers and skills, and confidence with self esteem
- More access to treatments like CBT and DBT and wellness centers for meditations and difficult emotions and crisis supports.

Interpreter used for focus group 1: no

Focus Group Two: Spanish speaking Adult Group

CalEQRO requested a Spanish speaking adult group at a Culturally oriented treatment program including a mix of existing and new clients who have initiated/utilized services within the past 12 months.

This was a Spanish speaking group of eight men at Bi-Bett Pueblos del Sol, 2020 Commerce Ave, Concord, Ca. with translator. Most were encouraged to come by family and friends and felt staff had great respect for Latino culture.

Number of participants: 8

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	4-5
2. I got my assessment appointment at a time and date I wanted.	3.4	3-5
3. It did not take long to begin treatment soon after my first appointment.	4.2	3-5
4. I feel comfortable calling my program for help with an urgent problem.	3.1	3-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	2.5	2-4
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.1	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	3.0	2-5
8. Because of the services I am receiving, I am better able to do things that I want.	3.8	3-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	3.7	3-5

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

- Many had access to care after an episode of arrest or incarceration, support came from family friends and referrals often came from Access Line or court system. Some had used Spanish 12-step programs in the past without success. Several expressed fear at coming to the treatment program at first. Staff were very welcoming supportive and had respect for Latino community and culture including faith. Staff often encouraged persons who were alumni to stay in touch and call for support and social activities linked to the program. Felt the program was really strong and helpful for really working on staying clean and sober and reunifying to family and community.

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

- This program saves lives.
- I feel safe and supported here.
- I learned a lot of information and have new tools
- I love the food and it is like a home.
- I used to have trouble with my family and now we can talk and enjoy each other.
- Finally, I feel well enough to work and have a better sense of myself and life.
- The counselors are good are helping you understand yourself and SUD better.

- Staff is responsible and helps with therapy and medical and court issues.
- When I feel like I have urges I can talk with them.
- Wish everyone could see how treatment could make a difference.

Recommendations for improving care included the following:

- More information for our families to understand addiction
- More groups with skills and recovery movies and stories
- More programs for Spanish speakers especially in Concord area
- More therapists and counselors who speak Spanish including at recovery housing
- More transportation nights and weekends to participate in healthy activities linked to recovery and wellness.
- More case managers and mobile support staff who speak Spanish

Interpreter used for focus group two: yes

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
The Cultural Competence plan was complete but needed more goals and evaluation specific to the SUD programs and client populations, particularly the Latino/Hispanic population, which appears to be underserved based on penetration rate data.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
The Director and AOD Administrator used the Access Call data and other sources related to admissions and wait times to track needs for services at various levels of care for both youth and adults. There were many discussions over the three-day review of plans to enhance or relocate services to meet needs of client populations and different areas of the County. This was a major focus of effort for the County as part of the DMC-ODS program with special attention at the leadership level.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
This year, as part of a response to a prior year recommendation, Contra Costa began extensive engagement of their provider network related to treatment access and continuity of care. This was part of an overall effort to improve communication and shared decision making related to enhancing the ASAM continuum of care and quality of care. An outside consultant group was hired to help support this process,		

KC Table 1: Access to Care Components	
Component	**Quality Rating**
record results and recommendations, and assist with workgroups and problem solving processes. Contractors and county staff felt it had improved understanding of challenges and communication.	

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 of Services Components

KC Table 2: Timeliness of Services Components		
	Component	**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
This data is tracked and mean is 9.4 days and is tracked for all levels of care.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	M
This data is tracked and means after assessment is one day.		
2C	Tracks and Trends Access Data from Initial Contact to First Non-Methadone MAT Appointment:	NM
This was not tracked by NTP and other services are done in primary care and not tracked by DMC-ODS.		
2D	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	NM
Contra Costa reports being able to track this but the timeliness reporting form is blank for urgent appointment data		
2E	Tracks and Trends Timely Access to Follow-Up Appointments after Residential	M
This is tracked by the county. County goal/standard is seven days and eight percent meet this standard. Improvement in linked to care is the focus of the non-clinical PIP.		
2F	Tracks and Trends Timely Access to Follow-Up Appointments after WM	M
This is tracked and County readmission rate is 7.3 percent, which is lower than other DMC counties statewide, and is also a focus of their non-clinical 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	M
The BHC Director, Suzanne Tavanno and staff leadership show commitment to quality in a range of important efforts with health and mental health partners, criminal justice, and in support of client outcomes. Their current efforts are limited by their current information systems particularly for DMC-ODS because of 42 CFR Part 2, but they are making significant efforts meet to requirements despite these challenges.		
3B	Data is used to inform management and guide decisions	PM
To the extent that that the SUD leadership has data, they use it to guide and make decisions. They did add analytics staff to assist in this regard. The lack of an EHR for the County DMC-ODS and contract system does hamper many of the potential areas they could use data to help with chart monitoring, billing, timeliness tracking, and many other quality functions. This limitation will make success in managed care more challenging over time in both fiscal and clinical arenas.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
There was strong evidence that this past year Contra Costa was committed to engagement of stakeholders particularly contractors to enhance communications and shared decision-making. Using a special consulting firm for support they conducted many focus groups with contractors and stakeholders, got feedback on current communication and decision making, as well as barriers to effective and efficient care, challenges with Waiver implementation, and more. This has led to a number of system and organizational changes, information system changes, process changes, and the engagement is continuing in a positive direction.		
3D	Evidence of an ASAM continuum of care	PM
Based on the programs reviewed, CalOMS data, the Continuum of Care form, and client focus groups, all required services are operational, but many are not yet able to		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
bill DMC-ODS. Specifically, WM, recovery support, case management, and physician consultation need to have certification and billing changes completed in order to bill DMC-ODS. This will allow for full PM measurement and release funds for other unmet needs in the continuum of care.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M
NTP methadone and outpatient non-methadone MAT exists through primary care county clinics in Contra Costa. An NTP is being located in Concord to enhance Network Adequacy for clients utilizing methadone and other medications provided by the NTP. The primary care sites operated by the County developed the special buprenorphine program called “Choosing Change” and current have approximately 750 individuals receiving medication services integrated with primary care and DMC outpatient counseling. ASAM assessment finding link them to other treatment in the DMC continuum such as outpatient counseling, recovery residences, and residential treatment.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
The program staff and site visits as well as focus groups demonstrated knowledge of core principles of ASAM, particularly the need for individualized treatment, evidence based treatment practices, use of the six dimensions in assessment of needs, and matching individuals to appropriate levels of care. Training was documented and ongoing.		
3G	Measures clinical and/or functional outcomes of clients served	M
Contra Costa used the TPS scores by program site as well as CalOMS data to evaluate client outcomes and program performance. They were also using the PHQ9 and the GAD-7 for assessment in residential SUD treatment for co-occurring anxiety and depressions and adding specific CBT modules for those clients to enhance outcomes. This was the subject of their recently completed PIP with positive results		
3H	Utilizes information from client perception of care surveys to improve care	M
Contra Costa uses and values the TPS survey results shared from UCLA. It is used in review of contract provider performance and County program performance.		

DMC-ODS REVIEW CONCLUSIONS

Contra Costa County was in its second year of DMC-ODS service for this review. There were notable challenges and strengths in the provider network this year with additions and financial instability and closures of some non-profit SUD providers. The new director Suzanne Tavanno and her senior staff took steps to stabilize and expand the provider network and develop key plans for addressing network adequacy and other issues as detailed below.

Access to Care

Strengths:

- After stabilizing several very challenging changes in the SUD provider network for outpatient and residential treatment, Contra Costa recruited additional providers to their SUD network and continued to work on expanding certification to all County clinics.
- Contra Costa developed sound plans for addressing alternative access standards (AAS) in remote zip codes which did not meet time or distance standards under network adequacy rule for DMC-ODS for youth outpatient and adult NTP services. These alternate access standards were approved by DHCS with these plans to improve access.
- Contra Costa added SUD clinical staff to all County-operated clinics throughout the County to expand access and work side by side with mental health staff to serve persons with co-occurring disorders, help identify persons with SUD needs, consult on treatment for SUD disorders, and education and support.
- Contra Costa collaborates with County-managed care clinics to insure access to outpatient MAT services particularly buprenorphine through the “Choosing Change” program, and coordinates access to other services such as outpatient counseling, recovery residences, and residential treatment as appropriate based upon ASAM assessment findings.
- Contra Costa coordinates extensively with the criminal justice re-entry program to facilitate access to a range of treatment and support services for persons with SUD needs and dedicates staff to support the specialty courts and detention health services treatment efforts linked to access.

Opportunities:

- The Access Call Center has a strong and highly skilled program during daytime hours Monday through Friday but needs to have coverage in the evenings and on weekends. A contract provider or County-operated access call service is needed to fulfill the 24-hour responsibility to provide coverage to serve the DMC-ODS program in the evening and on weekends for service

requests, information and referrals, screenings, and general education on services, similar to the MHP.

- Many services are still in development phase with certification, training, and billing systems not yet operational including WM, recovery support, physician consultation and case management. These are core benefits in the 1115 waiver and need to be fully implemented.
- Fulfillment of the plans for addressing network adequacy with location of the NTP in Concord and addition of youth services to an outpatient contractor as described in the plan linked to the submitted alternate access standards should be implemented as quickly as possible.

Timeliness of DMC-ODS Services

Strengths:

- Contra Costa has met the standards for routine appointments from request to first face-to-face appointment and is regularly tracking timeliness data at County and contractor sites.
- Contra Costa is tracking timeliness of access to outpatient or recovery support after residential treatment and it is the subject of their non-clinical PIP.
- Contra Costa is tracking access to care after WM and this is also the subject of their non-clinical PIP in a timely manner.

Opportunities:

- While Contra Costa has a definition for urgent appointments, there was no data provided related to tracking urgent appointments and how staff captured this data in the system, other than separate excel work sheets.
- The methadone provider stated they did not track phone call requests for service but had a walk-in policy and just encouraged clients to come over the same or next day.
- The system for capturing data at the contractor sites was reported to be labor-intensive by many contractors due to lack of EHRs and computer support. However, they stated the County was working closely with them on many computer interface issues and ways to improve communication.

Quality of Care in DMC-ODS

Strengths:

- The clinical PIP using CBT treatment for anxiety and depression in persons with SUD had very positive results for persons with this SUD profile and would be positive to share with other counties.
- Initiation and engagement PM results in Contra Costa were significantly better than the statewide averages, as were penetration rates which indicates solid clinical skills in early phases of treatment of SUD disorders.
- Feedback in client focus groups both conducted in Spanish and English at variety treatment programs was very positive in terms of life changes, counselor skills, and supportive, culturally sensitive environments.

Opportunities:

- More bilingual staff, field-based throughout the SUD system would help support expanded access for Latino/Hispanic populations needing treatment which appear to be lower based on penetration rate data compared with other groups.
- Case management models and training as planned by senior management are needed given low levels of transfers between levels of care and issued identified in the non-clinical PIP problem statement.

Client Outcomes for DMC-ODS

Strengths:

- CalOMS rates of improvement based on discharge ratings are higher than state averages for other DMC-ODS counties.
- Contra Costa uses both ASAM and TPS to look at whether client needs are being met in treatment placements (ASAM Level of Care Referral Data) and client satisfaction and outcomes (TPS) for both youth and adults linked to specific contract and County programs and sites.

Opportunities:

- Continue to monitor ASAM Level of Care data to ensure that clinical judgement is being used appropriately when overriding the recommendations of the ASAM assessment.

- Enhance the computer technology at the County and contractor level with an Electronic Health Record to improve coordination of care and support more effective treatment planning and tracking of outcomes

Recommendations for DMC-ODS for FY 2019-20

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

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.

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.

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.

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.

6. As discussed last year, Contra Costa should continue efforts to refine and implement case management and recovery support services in both County and contract programs so they can be both implemented and billed for as part of the DMC-ODS program.

As discussed, technical assistance on these recommendations is available, if needed, to support your success in implementing these quality related efforts.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

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

Attachment D: Continuum of Care Form

Attachment E: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A—On-site Review Agenda

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

Table A1—CalEQRO Review Sessions - Contra Costa DMC-ODS
Opening session – Changes in the past year, current initiatives, 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)
MHP coordination with DMC-ODS
Criminal justice coordination with DMC-ODS
Clinic managers group interview – County
Clinic managers group interview – contracted
Clinical supervisors group interview – County and contracted
Clinical line staff group interview – County and contracted
Recovery support services group interview including staff with lived experience – County and contracted
Client/family member focus groups such as adult, youth, special populations, and/or family
Site visits such as residential treatment (youth, perinatal, or general adult), WM, access center, MAT induction center, and/or innovative program
Key stakeholders and community-based service agencies group interview
Exit interview: questions and next steps

Attachment B—Review Participants

CalEQRO Reviewers

Rama Khalsa, Lead Reviewer
Jan Tice, Second Reviewer
Carolyn Yip, IS Reviewer
Diane Mintz, CFM Consultant

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

Sites for Contra Costa's DMC-ODS Review

DMC-ODS Sites

Contra Costa County Behavioral Health and Recovery Services
1220 Morello Ave
Martinez, CA

CenterPoint
1470 Civic Ct
Concord, CA

Access Call Center
30 Douglas Dr
Martinez, CA.

BAART NTP
3707 Sunset Lane
Antioch, CA.

BiBett Ozaman Center Youth
2931 Prospect Ave
Concord, CA

BiBett Pueblos Del Sol
2020 Commerce Ave
Concord, CA.

Table B1 - Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Abdullah	Nazneen	AODS Program Manager	Behavioral Health AODS
Aguirre	Priscilla	Quality Management Program Coordinator	Behavioral Health
Alexander	Scott	Mental Health Clinical Specialist	Behavioral Health Mental Health
Alexis	Carmen	Substance Abuse Counselor	Bi-Bett
Aswad	Tom	CFO	Support 4 Recovery
Beath	Lori	Client Advocate	Public Defenders Office
Bernstein	Marsha	Substance Abuse Counselor	Behavioral Health AODS
Blue	Donte	Deputy Director	Office of Reentry and Justice
Blunt	Sonya	Substance Abuse Counselor	Behavioral Health AODS
Boulden	Shanna	Program Coordinator	Bi-Bett
Brackett	Michelle	Clerical Staff- Discovery House	Behavioral Health AODS
Brown	Mitch	Substance Abuse Counselor	Behavioral Health AODS
Burton-Flores	Margie	LPHA	Behavioral Health Mental Health
Calloway	Vernon	Information Technology Manager	Health Services
Campos	Jaime	Executive Director	Bi-Bett
Cobaleda-Kegler	Jan	Adult Program Chief	Behavioral Health Mental Health
Coggburn	Jennifer	Director of Compliance, Quality Licensing & Training	Bi-Bett
Dedhia	Nirav	Data Support Analyst	Behavioral Health AODS
Dold	Amanda	Integration Services Manager	Behavioral Health Mental Health
Farrar	Jesse	Substance Abuse Counselor	Behavioral Health AODS

Table B1 - Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Fernandez	Antonia	Substance Abuse Counselor	Behavioral Health AODS
Fischer	Damon	Director of Residential Programs	Bi-Bett
Francisco	Nikki	Outreach Specialist	Support 4 Recovery
Fuhrman	Beverly	Program Manager	Behavioral Health Mental Health
Gallagher	Ken	Research and Evaluation Manager	Behavioral Health
Garofalo	Catherine	Substance Abuse Counselor	La Casa Ujima
Gargantiel	Paolo	Mental Health Program Supervisor	Behavioral Heath Mental Health
Garrett	James	Substance Abuse Counselor	Cole House
Gibson	Teresa	LPHA	Behavioral Health Mental Health
Greene	Lauren	LPHA Discovery House	Behavioral Health AODS
Hall	Keith	Substance Abuse Counselor	Behavioral Health AODS
Haverty	Denise	Substance Abuse Counselor	Behavioral Health AODS
Hill-Howard	Barbara	Substance Abuse Counselor	Behavioral Health AODS
Jacob	Jean	Planner Evaluator	Behavioral Health
Jarrar	Aous	Substance Abuse Counselor	Behavioral Health AODS
Johnson	Kennisha	Program Manager	Behavioral Health Mental Health
Kalaei	Dr. Susan	Behavioral Health Administrative Pharmacist Medication Monitoring Committee Coordinator	Health Services
Kekuewa	David	Data Performance Analyst	Behavioral Health AODS
Kersten	Melissa	Quality Improvement/ Quality Assurance-AODS	Behavioral Health

Table B1 - Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Kirske	Isabelle	Prevention Coordinator	Behavioral Health AODS
Lee	Pamela	Manager of Case Management	Contra Costa Health Plan
Loch	Oeum	Substance Abuse Counselor	Behavioral Health AODS
Loenicker	Gerold	Mental Health Program Manager	Behavioral Health Mental Health
Lopez	Lani	Program Coordinator	La Casa Ujima
Lovell	Michael	Substance Abuse Counselor	Bi-Bett
Luu	Matthew	Deputy Director of Mental Health	Behavioral Health Mental Health
Marchetti	Mickie	Executive Director	Bi-Bett
Matal Sol	Fatima	AODS Program Chief	Behavioral Health AODS
McCray	Dennis	Division Director	Center Point, INC
McVae	Gene	Program Specialist	Oxford House
Messerer	Mark	AODS Program Manager	Behavioral Health AODS
Moore	Greg	Program Director	REACH Project
Munoz	Dora	Substance Abuse Counselor	Bi-Bett
Nasrul	Kimberly	Mental Health Quality Improvement Coordinator	Behavioral Health Mental Health
Neilson	Jersey	Planner Evaluator	Behavioral Health
Noy	Mariana	Mental Health Program Chief	Hospital and Health Services
Nuval	Pepe	Finance	Health Services
Nybo	Erik	Business Intelligence	Health Services Information Technology
Pedraza	Christopher	AODS Program Manager	Behavioral Health AODS
Pena	Jorge	Lead Psp/Insyst Support Analyst	Behavioral Health Information Technology

Table B1 - Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Pierre	Natalie	Residential QA Director	Ujima
Pongrace	Kathie	LPHA	Center Point, INC
Pormento	Alicia	Finance	Health Services
Powell	Scott	Substance Abuse Counselor	Behavioral Health AODS
Rice	Megan	ccLink Behavioral Health Project Manager	Behavioral Health
Richardson	Michelle	AODS Program Manager	Behavioral Health AODS
Russell	Michelle	Outpatient QA Director	Ujima
Scaife	Lavern	DMC Case Manager	Bi-Bett
Schank	Rita	Executive Director	Ujima
Seastrom	Trisha	AODS Program Manager	Behavioral Health AODS
Sooter	Stephen	Treatment Center Director	BAART
Spikes	Chet	Assistant Director, Business Systems	Health Services IT
Stewart	Harrison	Program Coordinator-Discovery House	Behavioral Health AODS
Tavano	Dr. Suzanne	Behavioral Health Director	Behavioral Health
Todd	Zacariah	Access Line Lead Substance Abuse Counselor	Behavioral Health AODS
Vigil	Elizabeth	Substance Abuse Counselor	Bi-Bett
Washington	Tiffany	Program Manager	CA Medi-Cal Health Plan
Watters	Dr. Emily	Physician	Behavioral Health Mental Health
White	Dr. Matthew	Behavioral Health Medical Director	Behavioral Health
Wilder	Toni	Program Coordinator	Bi-Bett
Williams	Ulrika	Treatment Center Director	BAART

Table B1 - Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Wilson	Patrick	Chief Information Officer and Director of Information Technology	Health Services
Wong	Peter	Substance Abuse Counselor	Behavioral Health AODS

Attachment C—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET CLINICAL PIP	
GENERAL INFORMATION	
DMC-ODS: Contra Costa	
PIP Title: Improving PHQ9/GAD7 in SUD Treatment Center clients with depression and anxiety profiles	
Start Date 7/27/18: **Completion Date** 09/30/19: **Projected Study Period** 14: **Completed**: Yes ☒ No ☒ **Date(s) of On-Site Review10/03/19**: **Name of Reviewer**: Rama Khalsa	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): **This PIP measures the impact of a customized CBT curriculum focused on skills for depression and anxiety for SUD clients in residential SUD treatment with profiles of high scores of depression and anxiety on the PHQ-9 and GAD-7. The groups take place twice per week in the residential facilities with identified clients and measures the impact over a 6-week period of treatment on their scores as well as on their completion of the treatment program and self-report of improvements.**	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1 Was the PIP topic selected using stakeholder input? Did Contra Costa develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Adults with high scores of depression and anxiety on the PHQ9 and GAD7

☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other		
	Totals 3	**3** Met **0** Partially Met **1** Not Met **0** UTD
STEP 2: Review the Study Question(s)		
Will adding CBT depression skill groups improve client symptoms and treatment outcomes as reflected on the PHQ9 and GAD7 and increase the number of clients completing the treatment program?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals 1	**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Adults with high scores of depression	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Adults in SUD treatment with high depression anxiety scores on PHQ9 and GAD7
	Totals 2	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* (1) Percentage completing treatment	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

(2) Percentage with improved scores on tests pre and post		
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client-focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Improved skills and symptoms related to depression and anxiety based on test scores and self-report of clients
Totals 2		**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees?	☐ Met ☐ Partially Met ☐ Not Met	

_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☒ Not Applicable ☐ Unable to Determine	
	Totals 0	**0** Met **0** Partially Met **0** Not Met **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☐ Provider ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met	

Did the plan include contingencies for untoward results?	☐ Unable to Determine	
6.6 Were qualified staff and personnel used to collect the data? *Project leader: Mark Messer QA director* Name: Title: Role: *Other team members:* Names:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals 6		**6** Met **0** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions:* challenges with illness, backup	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals 1		**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly?	☒ Met ☐ Partially Met	

Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? *Indicate the time periods of measurements*: *Indicate the statistical analysis used*: *Indicate the statistical significance level or confidence level if available/known:*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals 4		**4** Met **0** Partially Met **0** Not Met **0** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

Did they utilize the same measurement tools?		
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☒ Yes ☐ No Clinical significance: ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Besides improvement on test scores clients reported improvements and wanted to stay in groups and other clients in the programs were asking to join the group who did not have high scores on depression and anxiety hearing how helpful the skills had been for members of the depression group
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☒ Strong	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals 5	**5** Met **0** Partially Met **0** Not Met **0** UTD
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**

Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☒ Yes ☐ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Excellent work on focused CBT curriculum for SUD clients with depression/anxiety profile with high levels of symptoms		
Recommendations: Expand to other residential programs and consider for outpatient as well with testing		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☒ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	

PIP item scoring

25 Met

0 Partially Met

3 Not Applicable

PIP overall scoring

((25x 2) + 1) / (25 x 2) **= 99%**

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET CY 2018
NON-CLINICAL PIP

GENERAL INFORMATION

DMC-ODS: Contra Costa **Improving Continuity of Care after Residential Treatment with linkage to Lower Levels of Care in a timely manner**

Start Date 4/1/2019:

Completion Date 3/31/2021:

Projected Study Period 24:

Completed: Yes ☐ No ☒

Date(s) of On-Site Review:

Name of Reviewer: 10/3/19

Rama Khalsa

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

Rated Active and ongoing

☒ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

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

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

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of this PIP is to improve coordination of care and transitions in care between residential treatment and lower levels of care after discharge. Many clients who leave residential treatment are not going to any other level of treatment and are being readmitted later to residential or withdrawal management or jail. These treatment relapses are not positive for clients and enhanced efforts to training and provide care coordination and continuity and support are needed. A twice weekly intensive case management meeting was established with the key counseling staff from residential programs to review client progress and assist with discharge planning and support services and linkage to aftercare supports early in the discharge planning process. These meetings are the core new intervention.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did Contra Costa develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	A multi-functional team was composed but it was not clear if there was any client specific input into the composition. Some of the staff have lived experience however with SUD.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data clearly demonstrated problem with continuity of care
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☒ Process of accessing or delivering care access to outpatient and recovery support services and as needed MAT as part of discharge planning
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The focus of the intervention was to prepare the client for transition from residential treatment to the next level of care.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met **1** Partially Met **0** Not Met **1** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Does biweekly care coordination meeting for clients in res treatment increase post discharge follow up rates in lower levels of care by 10%?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals 1		**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Includes all persons in residential treatment
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: ASAM Level of Care Results	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals 2		**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators: % of clients with follow up within 7 days;* *% of clients with follow up within 30 days;* *% of clients readmitted within 30 days;* *Average LOS*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All measures are clear

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client-focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Good outcomes with SUD are linked to longer LOS across a continuum of care based on SUD research. Indicators have strong associations with improved outcomes
Totals 2		**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable no sampling
	Totals 3	**0** Met **0** Partially Met **0** Not Met **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ASAM ☒ Claims ☐ Provider ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ASAM ☒ Other: claims	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	.
6.6 Were qualified staff and personnel used to collect the data? *Project co-leaders: Mark Messer QA Director* Name: Title: Role: *Other team members: See PIP* Names:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals 6	**6** Met **0** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions: Interventions were biweekly case reviews of clients who were preparing for discharge from residential treatment and developing support and transition plans for them with clinical staff.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The process improvement strategy was very reasonable but it is not clear why it is not working and more assessment or more aggressive interventions are needed as improvements are not happening with this intervention
	Totals 1	**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: Indicate the statistical analysis used: percentages Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Only 4 months since start of intervention so only one set of data was available to review, no repeats
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interventions:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals 3	**2** Met **1 Partially** Met **0** Not Met **1** NA **0** UTD

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Too early to determine only one measurement and not improving at this time

Totals 0	**0** Met **0** Partially Met **0** Not Met **0**NA **5** UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions: Consider other interventions and talk to clients who are not engaging in aftercare for more insights into options for improvement

Recommendations:

See above

Check one:

☐ High confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results

☐ Low confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible

☒ Confidence in PIP results cannot be determined at this time

PIP overall scoring

85%

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): August 25, 2019
Person completing form**:** Fatima Matal Sol, Pepe Nuval, David Kekueva
Please identify which programs are billing for DMC-ODS services on the form below.

Percent of all treatment services that are contracted: 85.79%

County role for access and coordination of care for persons with SUD requiring social work/linkage/peer supports to coordinate care and ancillary services.

Describe County role and functions linked to access processes and coordination of care:
Contra Costa operates an Integrated Behavioral Health Access Line,

The County operates an integrated Behavioral Health Access Line which includes Alcohol and Other Drugs certified counselors and Mental Health Clinicians. The unit operates 24/7 as a call center, 5FTE AOD counselors and 1FTE MH Clinician 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. In FY18-19, we added an additional 1FTE counselor position to support the volume of calls. AOD counselors provide intake appointments as needed and facilitate access to Medi-Cal enrollment with the BH Financial counselors. AOD counselors also provide brief support/encouragement to callers not ready for treatment along with information and referrals to significant others seeking information for their loved ones. When the counselors are on the phone serving another beneficiary, a clerical staff takes the call immediately and provides the caller with an approximate time in which the counselors will return the call.
AOD counselors also provide:

A) Referrals to recovery support oriented activities for individuals who have completed treatment
B) Facilitate transitions of level of care as needed by callers
C) Screenings for individuals who are incarcerated in all 3 County jails through a speed dial number *9098 established through a partnership with the Sheriff Services

While the County has centralized entry into the system through the Behavioral Health Access Line, there are other in the community **Portals of Entry**, which include:

1) 2FTE AOD Counselors who are part of the Access Line team conduct Face to Face screenings in all 3 Contra Costa courts, and coordinates transfers of levels of care as needed by clients who are referred by the Courts. The additional counselor has been placed in the Family Dependency Court to respond to the needs of women with children.

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

3) SAMHWorks assessment team- conducts SAMHworks screenings and referrals to Access Line for SUD treatment as needed. For the FY18-19, the assessment team transitioned operations from a Community Based Organization (CBO) to a County operated model.

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

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

Contra Costa initiated Care Coordination efforts in early January 2019, procedures were reviewed and developed with provider input through our Brown Bag call, our procedure or AODS IN 18-08 was approved by DHCS on January 25, 2019. Additional feedback from providers was received in February also during Brown Bag call. Implementation occurred in phases and in all residential programs. Initially, all programs were divided in two separate groups and the County manager (County Care Coordinator) and chief met individually with providers at each program for a period of two months. The County convenes and facilitates clinical reviews. We use the ASAM Clinical Case Conference format and stimulate feedback and promotes cross training and coordination. In addition, the County brokers and reminds staff of requirements, for example of accessing transportation benefits through managed care plans, coordinating with mental health, etc. The clinical review process facilitates movement and transition of levels of care.

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

Monthly estimated billed hours of case management: 199 billable hours.

Comments:

Case Management is billed through integrated contracted Drug Medi-Cal Certified providers and is not centralized. However, the County has adopted a centralized approach to coordination of care. There is some case management conducted through other funding sources such as AB109, SABG, etc. The counselor at Psychiatric Emergency Services (PES) provided 2,000 productive hours of case management services for high utilizers.

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

Pick 1 or more as applicable and explain below:

1) Included with Access 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

Total Legal entities offering recovery services: 7
Total number of legal entities billing DMC-ODS: 7
Choices: 1, 2, 3

Comments:

We envision that all programs in our system of care Outpatient and Residential will integrate recovery support services. To that end, Contra Costa expects that each program has a Recovery Support Specialist to provide recovery Support Services. Unfortunately, as new billable program, many of our providers did not submitted claims this year, even though the services were provided. Because this represents a shift in organizational practices in that many of the services that providers have given as part of the recovery process when clients step down, we engaged providers in a process of development of County procedures. As expected, many indicated having provided those services during the work group efforts. In addition to the procedures, a fact sheet and a brochure were developed with input from providers and clients. In FY18-19 the 2FTE AB109 County hired counselors provided 3,168 productive staff hours of additional recovery support services. Additionally, counselors at Access provide linkages and an abundance of recovery support services to callers while they await for treatment, after treatment completion or during transitions of levels of care.

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 hours 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

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

Number of sites: 8
Total number of legal entities billing DMC-ODS: 1
Number of beds: 80
Estimated billed hours per month: 6,166
Pick 1 or more as applicable and explain below:
1) Hospitals
2) Freestanding
3) Within residential treatment center

Choice(s): 3 (Freestanding within residential facility)

Comments: Total sites" BiBett East County Wollam House 2,4,12,14 Dave, BiBett Ozanam Center, BiBett PDS, BiBett Southern Solano Alcohol Council, Buckelew Programs-Helen Vine Recovery Center

BiBett is our only and largest provider for this level of care. The only detoxification programs that they have certified consist of a few number of beds integrated in 2 of our women level 3.1 DMC facilities. BiBett also operates our freestanding detoxification facility main program is Pueblos del Sol in the Concord area, and it has not yet become DMC certified; this time around the DMC applications have already been submitted to DHCS. In response to the limited WM bed capacity, Contra Costa contracted with Helen Vine Buckelew programs located in Marin County, this program directly addresses the needs of West Contra Costa residents, and it includes transportation back to the County. Helen Vine is a DMC facility, unfortunately, they relocated and as they did, the certification was not transferred in a timely manner by the State; thus, while they provided services those were not DMC claimable. To further alleviate the need, our clients can access Southern Solano Alcohol Council in Solano, the program is also under BiBett.
Additionally, we hope to begin operations for a new facility in West part of the County with the following capacity: 8 beds Level 3.2, 13 beds 3.1 and 5 Level 3.5 beds in late Fall 2019 due to the recent death of the BiBett executive director the opening of this facility has been significantly delay.

NTP 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 hours per month: 5292
Non-Perinatal – 5724 average billable hours per month
Perinatal- 18818 - average billable hours per month
Are all NTPs billing for non-methadone required medications? ____yes X no

Comments:

Legal entities: BAART Antioch and Richmond County.

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

Total legal entities: 1 Number of sites: 5
Total estimated billed hours per month: 0

Comments:

The County Health Services (CCHS) Department launched a major initiative prior to our DMC-ODS implementation. Through Choosing Change, CCHS is the largest provider of buprenorphine services. Behavioral health support and referrals for higher levels of care as well as other recovery support services in the community are provided by AODS this is a fully integrated County operated MAT program. West County Health Centers, Miller Wellness Center (Martinez), Martinez Health Center, Concord Health Center2, Antioch Health Center, and the Pittsburg Health Center. It is expected that in September, a 6th clinic will be added at the Brentwood Health Center. In FY 18-19, there were 465 inductions and there are 556 active patients. In addition, specialty clinics in our County operated hospital provide buprenorphine for SUD and is one of the Health Plan PIPs. As of June, there are 90 Waivered County physicians who are part of the Choosing Change network.

In 2016 there were 3 groups, in 2017 there were 6 groups, in 2018 there were a total of 7 groups, in 2019 there are 12 groups conducted each week. In 2018, we started Choosing Change services at the Martinez and Richmond jails, except they only include the medication, not the BH support and through the MAT Expansion in Jail Collaborative, we were able to hire 1FTE substance abuse counselor who has been designated to link the clients to services upon release, including coordination with the Hub & Spoke. Choosing Change is not a DMC billable service, since it occurs at an FQHC, the funding mechanism is separate; therefore, is not accounted in the NACT nor recognized as part of our Network and a major access point for buprenorphine. AODS involvement with the program, is perhaps one of the best models of integration with primary health care.

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: 17
Total number of legal entities billing DMC-ODS: 5
Average estimated billed hours per month: 873

Comments:

Legal entities: ANKA, BiBett, Center Point, Contra Costa County, REACH, Ujima

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: 613
Total legal entities: 4 Total sites for all legal entities: 9
Total number of legal entities billing DMC-ODS: 3
Average estimated billed hours per month: 613

Comments:

Legal Entities: ANKA, Center Point, REACH, Ujima

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

Comments:

NOT AVAILABLE IN CONTRA COSTA COUNTY

Level 3.1: Residential – Planned, and 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: 18
Total number of legal entities billing DMC-ODS: 5
Number of program sites: 18
Total bed capacity: 219
Average estimated billed bed days per month: 3756

Comments:

Legal Entities: BiBett, Contra Costa County, J Cole, Sunny Hills, Ujima

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

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
(Can be flexed and combined in some settings with 3.5)

Comments:

NOT AVAILABLE IN CONTRA COSTA COUNTY

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

Total sites for all legal entities: 2
Number of program sites: 4
Total number of legal entities billing DMC-ODS: 0
Total bed capacity: 2
(Can be flexed and combined in some settings with 3.5)

Comments:

Contra Costa established a contract with HR360 back in May 2019; most of time however has been invested in preparations for streamlined workflows that support smooth client transitions to and from San Francisco. The preparations have included training with Dr. Mee-Lee for County and SUD provider staff with respect to this level of care. During the process of preparing to coordinate placement with HR360, two of the BiBett locations received ASAM designations for 3.5 which includes the Ozanam Center and Diablo Valley Ranch.

Level 3.7: Medically Monitored, High-Intensity Inpatient Services – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??) __X__yes _ no

Number of program sites: 0
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed Capacity: N/A

Comments:

NOT AVAILABLE IN CONTRA COSTA COUNTY through DMC-ODS. Clients are seen through the emergency room.

Level 4: Medically Managed Intensive Inpatient Services – 24-hour services delivered in an acute care, inpatient setting. (billing Health Plan/FFS can you access services? _____yes ___no access)

Number of program sites: 0
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed capacity: 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: 19
Total bed capacity: Unknown

Comments:

Contra Costa launched Recovery Residences towards the end of 2018. We established contracts with Oxford House and have implemented 2 houses insofar. In addition, we contracted with Support 4 Recovery (S4R), a nonprofit grass root organization that serves as a broker to a wider network of sober living houses. S4R is comprised of people in recovery themselves, they have been actively involved in the development of the Recovery Residence Guidelines in Contra Costa, and have historically advocated for sober living housing in CC.

Yes, we have at least 4 CBO programs that have submitted DMC applications and we have submitted applications for the 2 Mental Health clinics to get DMC certified. In addition, the new location in West County is soon to apply for license and DMC certification.

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 Data Collection and Reporting 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
FC	Foster Care
FY	Fiscal Year
HCB	High-Cost Beneficiary
HHS	Health and Human Services
HIE	Health Information Exchange

HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IMAT	Term doing MAT outreach, engagement and treatment for clients with opioid or alcohol disorders
IN	State Information Notice
IOM	Institute of Medicine
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
MATRIX	Special Program for Methamphetamine Disorders
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MH	Mental Health
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NCF	National Quality Form
NCQF	National Commission of Quality Assurance
NP	Nurse Practitioner
NTP	Narcotic Treatment Program
NSDUH	National Household Survey of Drugs and Alcohol (funded by SAMHSA)
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
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
Seeking Safety	Clinical program for trauma victims
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
STC	Special Terms and Conditions of 1115 Waiver
SUD	Substance Use Disorder
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
TSA	Timeliness Self-Assessment
UCLA	University of California Los Angeles
UR	Utilization Review
VA	Veteran's Administration
WET	Workforce Education and Training
WITS	Software SUD Treatment developed by SAMHSA
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan
X Waiver	Special Medical Certificate to provide medication for opioid disorders
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version