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DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

EL DORADO DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
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EL DORADO DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Fiscal Year (FY) 2019-20: 356.
El Dorado Threshold Language(s): Spanish
El Dorado Size: Small
El Dorado Region: Superior
El Dorado Location: North-East of Sacramento in Gold Country
El Dorado Seat: Placerville
El Dorado Review Process Barriers: None noted

Review Special Characteristics

This review took place during the COVID-19 pandemic when the Governor's Executive Order established restrictions on in-person gatherings and other public safety precautions. In response, California External Quality Review Organization (CalEQRO) worked with El Dorado to design an alternative to the usual in-person review format. El Dorado requested a virtual review with just county staff since they are in their first year of implementation. This included numerous video sessions with technical assistance as reflected in the agenda.

Introduction

El Dorado officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in June 2019 for Medi-Cal recipients as part of California's 1115 DMC Waiver. El Dorado was the 27th county to launch statewide. In this report, "El Dorado" shall be used to identify the EL Dorado DMC-ODS program unless otherwise indicated.

El Dorado is a small, rural, mountain community that lies in the Sierra Nevada Mountains. It is located northeast of Sacramento with Placer County to the north and Amador to the south. The northeast corner of the county is the Lake Tahoe Basin. It encompasses 1,786 square miles with a population is 192,843 according to the US Census (2019). The largest city in the county is South Lake Tahoe. The other main city in the county is the county seat in Placerville.

According to the county profile, Latino/Hispanic population represents 9.3 percent of the population with Spanish being the only threshold language. The median household income is $80,582 and the county has a poverty rate of 8.94 per cent. The percentage of the population that has achieved a high school diploma is 93.4 per cent.

El Dorado ranks as 17th on the overall health according to the County Health Rankings and has had this ranking since 2018. This report also found that El Dorado had poor to fair health for 12 percent of the county residents compared to 17 percent statewide.

Excessive drinking was 22 percent which is slightly higher than statewide average of 19 percent.

El Dorado's Behavioral Health Division is part of the larger County Health and Human Services Agency.

Access

There are some best practices important to DMC-ODS programs in how they organize their access to care. To understand whether a county is doing these, it is important to know how they have organized their access systems. In addition, the special terms and conditions (STCs) of the 1115 Waiver have specific requirements for the 24-hour beneficiary access line or as many describe it their "Access Call Center". The Access Call Centers play different roles in different counties in the linkage of beneficiaries to treatment depending on the size of the county and the design of the access points. To evaluate this element of quality, it is important first to know how this DMC-ODS has chosen to organize its access system to bring beneficiaries into the treatment system via screenings, assessment, and engagement.

El Dorado individuals seeking services enter the Substance Use Disorder (SUD) system through the El Dorado SUD county-run Access Call Center. El Dorado moved the SUD Call Center, from the integrated Mental Health (MH) system to the primary SUD at the Spring Street location in Placerville. The call number is assigned to dedicated SUD staff which rolls over to eight other SUD staff who are available to answer calls as needed. If an access line is not answered within the specified rings, the call rolls over to another staff who is available to answer the call. El Dorado is a small county with SUD staff stationed at one primary location, within easy access to each other, and are all considered the primary access group.

A "pre-admit form" is opened by the access clinician and staff obtain client information and enter the information into the Electronic Health Record (EHR) system. El Dorado tracks the request for service and pre-admit information that is funneled into the Avatar system. El Dorado identified delays in scheduling the screening appointments, telephone tag is not uncommon, and in response developed their Performance Improvement Project (PIP) to address this access barrier. After screening, the access clinician facilitates a triage session with the beneficiary and the treatment provider to determine the level of care. The assessment appointment is scheduled within 10 days. When someone needs to be triaged to residential treatment or withdrawal management (WM) or both, an assessment appointment with a county assessor staff is scheduled. The assessors and case managers are typically the same person and are assigned to follow the beneficiary throughout the treatment episode. The assessors/case managers are closely linked to the treatment programs. Case managers are stationed at the main clinic in Placerville, South Lake Tahoe, AB109-Community Corrections Program (CCP) Day Reporting Center, and at the El Dorado Behavioral Health building. Assessment appointments are based on the beneficiary's availability.

The beneficiary is assigned an assessor/case manager to conduct the assessment, who can be a SUD counselor or clinician. This is followed by a Licensed Professional of the Healing Arts (LPHA) who reviews the assessment(s), determines medical necessity, and submits the treatment authorization report (TAR). The TAR includes the following documentation: full assessment, medical necessity determination and American Society of Addiction Medicine (ASAM) level of care and consent, which is then sent to the contract provider.

The case manager facilitates the placement and working with the beneficiary, creates a case management plan that is completed during the assessment. The intent is to adapt a case management plan that indicates the services and needs of the beneficiary. Parallel needs of case management and the level of care treatment services are considered when developing the plan.

El Dorado case managers can coordinate care for the beneficiary throughout the lifecycle of treatment. The case management commitment helps the beneficiary meet their treatment plan goals and objectives and stabilizes the beneficiary throughout treatment. Contracted providers provide case management services for beneficiaries who directly contact the SUD providers for Narcotic Treatment Provider (NTP), outpatient, and intensive outpatient services.

El Dorado provides each beneficiary, at a minimum, three hours of case management services per treatment episode. When the beneficiary needs more than the initial three hours, the contract provider submits a request for additional hours. This process allows the providers some leeway in utilizing case management and sets a benchmark for ensuring El Dorado is notified of higher utilizers of case management.

When the beneficiary enters services through the treatment program and not the access call line, the contract providers submit a monthly Excel tracking document. El Dorado conducts monthly and quarterly utilization reviews to monitor and manage the few instances when this occurs. When El Dorado learns of delays into treatment, they follow-up immediately to resolve the issue within a timely manner and ensure the beneficiary has access to treatment services.

The ASAM based brief screening is conducted by the Access Call Center staff and reviewed by a LPHA. Once the level of care is determined, the contract provider conducts a more in-depth ASAM assessment. El Dorado has a close relationship with their surrounding counties and was able to implement a brief screening tool that other counties utilize.

El Dorado contracts with a call center for afterhours and weekends. This call center is the same one that is used by the El Dorado County Child Protective Services (CPS) and by the mental health department. El Dorado has a rotation schedule for staff to be on-call afterhours and weekends. When there is an immediate need for treatment

services, the on-call SUD practitioner is contacted by the afterhours call center contractor.

El Dorado has certified bi-lingual staff working for SUD and preparing to fill one vacant position. The Access Call Center staff responds to information requests and the afterhours on-call contractor is provided with a script on how to respond to these types of requests. El Dorado plans to update the script and training to include real life SUD situations. The scripts include directions on what needs to be completed for Spanish callers and how to connect beneficiaries to a certified speaker.

Non-methadone Medication Assisted Treatment (MAT) services are provided by the Federally Qualified Health Centers **(**FQHCs) and the Emergency Department at Community Health's complex care unit, and the counselor has a direct line to El Dorado to help facilitate people that do not want to go through the NTP. Barton Health and El Dorado are working with the primary care providers to improve communications and access to health services for non-methadone MAT services. Safe prescribing guidelines discussions is slated for El Dorado's next provider workgroups. One of the stated goals is to move toward county wide adoption of the policies set forth by the Centers for Disease Control and Prevention (CDC). All of El Dorado's MAT programs follow CDC best practices.

El Dorado has a robust Opioid Coalition and stakeholders include, public health managers, Community Health Centers, Marshal Medical Center, Shingle Springs Health and Wellness, AmeriCorps, El Dorado Health and Human Services, Barton Health, Sierra Harm Reduction Coalition, Law enforcement Agencies, Community Based Organizations, and High School Districts. Community discussions are held on stigma and the acceptance of MAT within the El Dorado community. Representatives from the Opioid Coalition plan to begin attending the El Dorado SUD provider meetings.

El Dorado is currently in discussions with the Opioid Coalition to obtain more up-to-date and "real time" data. A report of a data analyzation process to determine the top three priority areas to focus next intervention strategies was completed. That report will be released soon and made available to share. Opioid Coalition members meet quarterly to share strategies, discuss interventions, and adopt best practices toward the shared goal of reducing opioid addiction. As a result of collective efforts, the county has seen a steady decline in opioid prescriptions, an increase in the availability of MAT and a decrease in opioid overdose-related deaths.

Timeliness

El Dorado collects timeliness data from Excel spreadsheets that the contract providers completed and submit on a monthly basis. The QM staff are responsible for the data collection and data analysis in addition to their other job responsibilities. El Dorado reported that they review the requests for pre-admit and requests for services reports on a daily basis. If any issues are identified, the issue is discussed at the weekly leadership meetings.

EL Dorado defined urgent care as a condition perceived by the beneficiary as serious, but not life threatening. Further the condition disrupts normal activities of daily living and requires an assessment by a health care provider and if necessary, treatment services within 24 to 72 hours. El Dorado reported that they consider other factors such as if the beneficiary is pregnant or if the beneficiary is putting themselves or others in danger as being an urgent condition. The average length of time from request to actual visit was 2.37 days. El Dorado met the three-day standard 82 percent of the time. El Dorado also reported that their goal is to have the beneficiary seen within 48 hours and placed, if required, immediately. If the beneficiary is not able to be admitted immediately to a residential treatment facility, El Dorado will provide case management services in the interim.

El Dorado tracks the time from initial request to first offered appointment using the state standard of ten-days as the benchmark. El Dorado met that standard 86 percent of the time with the average length of time from request to offered appointment being 5.88 days.

El Dorado tracks the time from initial request to first appointment using the state standard of ten-days as the benchmark. El Dorado met that standard 73 percent of the time with the average length of time from request to offered appointment being 7.99 days. El Dorado reported that they think some of the delays are due to the telephone tag that occurs at the Access Call Center, and this is the focus of their non-clinical PIP. The other issue identified that affects this data was when the beneficiary does not show up for their appointment.

El Dorado reported that the average length of time from initial request to appointment for methadone was 2.37 days and that the standard of three days was met 77 percent of the time.

El Dorado has a seven-day standard for follow up after discharge from residential treatment but only met that standard 20.5 percent of the time. El Dorado reported that this will be a focus of training this next year and to monitor the documentation by the case managers to ensure the standard is met.

El Dorado did not have any beneficiaries that re-entered residential treatment within 30 days of discharge. The QM staff reviewed the data from WM and compared the cases and names to verify re-admission to residential treatment, but none were found.

El Dorado tracks the no-show rate for initial appointment. El Dorado tracks the appointment no-shows for any beneficiary who did not keep their first scheduled appointment, cancelled their appointment, or did not follow through to make an appointment. El Dorado plans to monitor the no-show rate on a monthly basis.

Quality

El Dorado developed a Quality Management (QM) Work Plan just for substance use disorders. The plan outlines the quality standard, quality benchmark, quality monitoring tools and measurement process and the benchmark assessment timeframe. The quality standards are accessibility of services and quality of services and member satisfaction. The accessibility of services includes the following activities: timeliness from request to services, time and distance standards, responsiveness of the access line, number of prior authorizations, cultural and linguistic services, reasonable accommodations for those with a physical or mental disability, and selection and retention of providers. The quality of services and member satisfaction quality standard includes the following activities: transitions between levels of care are timely and coordinated, safety and effectiveness of medication practices, frequency of follow-up appointments, review of complaints, grievances and appeals, member satisfaction, staff training, and use of evidence-based practices. The QM plan also outlines the steps for conducting deficiency investigation and remediation steps. The plan does not include any baseline data but needs more specific measurable goals, nor does it identify who is responsible for the quality activity. Some of the items in the work plan do not have measurable goals and objectives linked to quality improvement. El Dorado reported that their Health Educator is responsible for completing the quality activities.

El Dorado does have a Quality Improvement Committee (QIC) that is integrated for both specialty mental health and substance use disorders. The committee meets on a quarterly basis. The committee stopped meeting when there was a leadership change, but the committee resumed meetings when the new Behavioral Health Director began working for El Dorado County. El Dorado reported that a member of the Behavioral Health Commission is now a member of the QIC.

The QM staff are able to run requests for services reports from their EHR to monitor caseloads of the assessor/case manager staff. El Dorado reported that they are collecting data, but it collected from the contractor providers completing an Excel spreadsheet on a monthly basis. The data then needs to be tabulated and analyzed. The QM staff are responsible for completing the data analysis along with their other job duties. Even though, El Dorado was able to increase the number of quality management staff from 2 full time equivalents (FTEs) to 4.5 FTEs, but they do not have a dedicated staff to conduct data analysis activities. Since these functions are claimable at 75% it may be possible with some assistance from fiscal staff to evaluate the cost structure of the unit.

Outcomes

El Dorado provided ASAM trainings to staff through the University of California, Los Angeles Integrated Substance Abuse Programs (UCLA ISAP) and California Institute of Behavioral Health Solutions (CIBHS) prior to implementation of the DMC-ODS. Their documentation manual contains information on the ASAM levels of care and when to review the ASAM criteria. For FY 2019- 20, El Dorado recorded high congruence

between referrals and level of care placements in both initial screening (81.2 percent) and follow-up assessment (90 percent). The congruence was lower in initial assessment (56.4 percent) mostly due to clinical judgement.

El Dorado administered the Treatment Perception Survey (TPS) for adults for the first time in October 2020. Results were reviewed from the TPS and a discussion of findings was conducted during the virtual review. El Dorado scored high ratings in most TPS domains, but the best scores were noted in Quality and General Satisfaction measures. The highest rating was in recommending the agency with a score of 89.4. The lowest score was noted in a General Satisfaction measure when beneficiaries were asked if they got the help, they needed with a score of 73.1. Quality of services and member satisfaction is also a core component of their Quality Management Plan.

El Dorado provided California Outcomes Measurement System (CalOMS) reports from Department of Health Care Services (DHCS) as evidence of meeting this standard of outcome data. It is important to note that 56.8 percent of El Dorado beneficiaries had a positive CalOMS discharge status which was on par with the statewide average of 45.8 percent, either completing treatment or leaving before treatment completion but with satisfactory progress.

El Dorado has a full continuum of care with the exception of 3.7 and 4.0 WM which is not a required level of care for DMC-ODS. Medication Assisted Treatment (MAT) is provided by the FQHC and primary care providers and are not contracted with the county to provide these services. Aegis provides methadone and non-methadone services at their Roseville clinic. El Dorado contracts with Aegis Treatment Centers for NTP and non-methadone services in Roseville and they have a medication only clinic located in Placerville. There have been discussions between the Aegis and the county on converting this medication only clinic to a full NTP clinic once there are enough beneficiaries to support it.

El Dorado works with three primary care providers for beneficiaries needing Level 1.0 WM services. There is an established, open, two-way referral channel with the following primary care providers: Barton Hospital in South Lake Tahoe, Marshall Cares in Placerville, and El Dorado Community Health Center (FQHC) in Placerville and Cameron Park. Coordinators from the Community Health Center and Marshall Cares program attend the El Dorado SUD contract provider meetings.

Residential treatment levels 3.1 and 3.5 are provided through a contract with three different providers. El Dorado also contracts with two providers for recovery residences. El Dorado reported that contract providers are uncertain about recovery support services and when and how to bill for them. El Dorado plans to address this gap and their SUD Practice Guidelines outline treatment services, procedures, and service protocols that include information on recovery services.

Client/Family Impressions and Feedback

Due to the COVID-19 public health emergency, this was a virtual review and the county elected not to have any consumer/family focus group sessions.

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 review of each DMC-ODS Plan.

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

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

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

Each DMC-ODS county is required to conduct two PIPs, one is a clinical and the other is a 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

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

data showing opportunities for improvement. The PIPs are discussed in detail later in this report. The CMS requirements for the PIPs are technical and were based originally on hospital quality improvement models and can be challenging to apply to behavioral health.

The CalEQRO staff provide trainings and technical assistance to the County DMC-ODS staff for PIP development. Materials and videos are available on the website 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 El Dorado meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of El Dorado 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 beneficiaries, and how they are being utilized as well as any local client satisfaction surveys. DHCS Information Notice 17-026 (describes the TPS process in detail) and can be found on the DHCS website for DMC-ODS. The results each year include analysis by UCLA for the key questions organized by domain. The survey is administered at least annually after a DMC-ODS has begun services and can be administered more frequently at the discretion of the county DMC-ODS. Domains include questions linked to ease of access, timeliness of services, cultural competence of services, therapeutic alliance with treatment staff, satisfaction with services, and outcome of services. Surveys are confidential and linked to the specific Substance Use Disorder (SUD) program 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 whenever possible. With COVID-19 this has not been possible in all counties and when it has occurred it is

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

done by video or phone. The client experiences reported on the TPS are also compared to the results of the in-person client focus groups conducted on all reviews. Groups include adults, youth, parent/guardians from various ethnic groups and languages. Focus group forms which guide the process of the reviews include both structured questions and open questions linked to access, timeliness, quality, and outcomes.

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

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

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

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

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

- El Dorado had challenges due to the COVID-19 public health emergency. Their contract providers stopped conducting intakes at the beginning of the pandemic. The contract providers also experienced staff shortages due to COVID-19 and they did not have enough staff to cover all of the shifts. El Dorado was able to convert to telehealth within a couple of weeks from the start of the pandemic.

- Public Safety Power Shutoffs (PSPS) impacted several contract providers and the delivery of treatment services. The impact in 2020 was not as impactful as it was in 2019. Nonetheless, there were minor delays in conducting intakes and delays in coordination of care due to the lack of electricity.

- Progress House, a contract provider, had to close one of their residential treatment facilities which resulted in the loss of 18 beds. El Dorado now contracts with Granite Wellness located in both Placer and Grass Valley for this level of care.

- There has been a change in leadership with a new Behavioral Health Director who started in April 2020, a new Deputy Director started two months ago, and a new Chief Financial Officer started in December 2020.

Past Year's Initiatives and Accomplishments

- El Dorado had a youth treatment provider that required extensive technical assistance in order to be able to provide and bill for outpatient treatment services. El Dorado had to issue a corrective action plan, but this has been cleared and the contract provider is now providing and billing for the services.

- El Dorado stabilized the local youth services provider and helped them to being providing DMC-ODS services to youth beneficiaries.

- El Dorado was able to expand from two Quality Management staff to four and a half-staff. The new staff are now all trained in conducting quality management activities.

- El Dorado spent time training and monitoring all of their contract providers in order to successfully implement the full continuum of care.

El Dorado Goals for the Coming Year

- Begin the collection of performance measures data for all of their contract providers.
- Increase the county provided treatment services for beneficiaries throughout the county.
- Increase the productivity of staff through structured supervision and support.
- Implement both performance improvement projects.

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 12 performance measures to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, the, CalOMS, Treatment Perception Survey (TPS) and the ASAM level of care data for these measures.

1. CalOMS Treatment Data Collection Guide:

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

2. TPS:
   http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf

3. ASAM Level of Care Data Collection System:

   https://www.dhcs.ca.gov/individuals/Documents/MHSUDS_Information_Notice_18-046.pdf

The first six PMs are used in each year of the Waiver for all DMC-ODS counties and statewide. The additional PMs are based on research linked to positive health outcomes for beneficiaries 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, beneficiary interviews, staff and contractor interviews, observations as part of site visits or video sessions/calls with specific programs or staff, and documentation of key deliverables in the DMC-ODS Waiver Plan. The measures are as follows:

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries.
- Number of days to first DMC-ODS service after client assessment and referral.
- Total costs per beneficiary served by each county DMC-ODS by ethnic group.
- Cultural competency of DMC-ODS services to beneficiaries.

- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes).
- Coordination of care with physical health and mental health (MH).
- Timely access to medication for Narcotics Treatment Program (NTP) services.
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured.
- Timely coordinated transitions of beneficiaries between levels of care, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics).
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs).
- Percentage of beneficiaries 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 beneficiaries (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 WM within 30 days.

HIPAA Guidelines for Suppression Disclosure

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

Year One of Waiver Services

This is the first year that El Dorado has been providing DMC-ODS treatment services. Performance Measure (PM) data was obtained by CalEQRO from DHCS for claims, Medi-Cal eligibility, the provider file FY 2019-20, and from UCLA for TPS, ASAM, and CalOMS data from FY 2019-20. 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 providers have obtained all appropriate licenses and certifications. Thus, there may be a claims lag in billing for services and in the data available at the time of the review. CalEQRO used the time period of FY 2019-20 to maximize data completeness for the ensuing analyses. This data is from an October 2020 download of claims provided by DHCS. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. CalEQRO included in the analyses all claims for the specified time period that had been either approved or pended by DHCS.

DMC–ODS Clients Served in FY 2019-20

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

Table 1 shows El Dorado's number of beneficiaries 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.

El Dorado served 356 beneficiaries in FY 2019-20. In the ages 18-64 and 65+ groups, El Dorado's penetration rates were higher than small-sized counties and statewide averages. The overall penetration rate of 1.23 percent was higher than small-sized counties (0.58 percent) and on par with the State (1.10 percent).

Table 1: Penetration Rates by Age, FY 2019-20

El Dorado				Small Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	4,392	*	n/a	0.25%	0.32%
Ages 18-64	21,444	328	1.53%	0.69%	1.33%
Ages 65+	2,991	*	n/a	0.35%	0.81%
TOTAL	**28,827**	**356**	**1.23%**	**0.58%**	**1.10%**

The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it. The averages are calculated independently. Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Table 2 below shows El Dorado'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. El Dorado's average approved claim amount ($3,068) was lower than the Statewide average ($4,515) by $1,500.

Table 2: Average Approved Claims by Age, FY 2019-20

El Dorado			Statewide
Age Groups	Average Approved Claims	Total Approved Claims	Average Approved Claims
Ages 12-17	$760	$2,281	2,046
Ages 18-64	$3,047	$999,428	4,613
Ages 65+	$3,617	$90,415	4,837
TOTAL	**$3,068**	**$1,092,124**	**4,515**

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 beneficiaries.

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2019-20

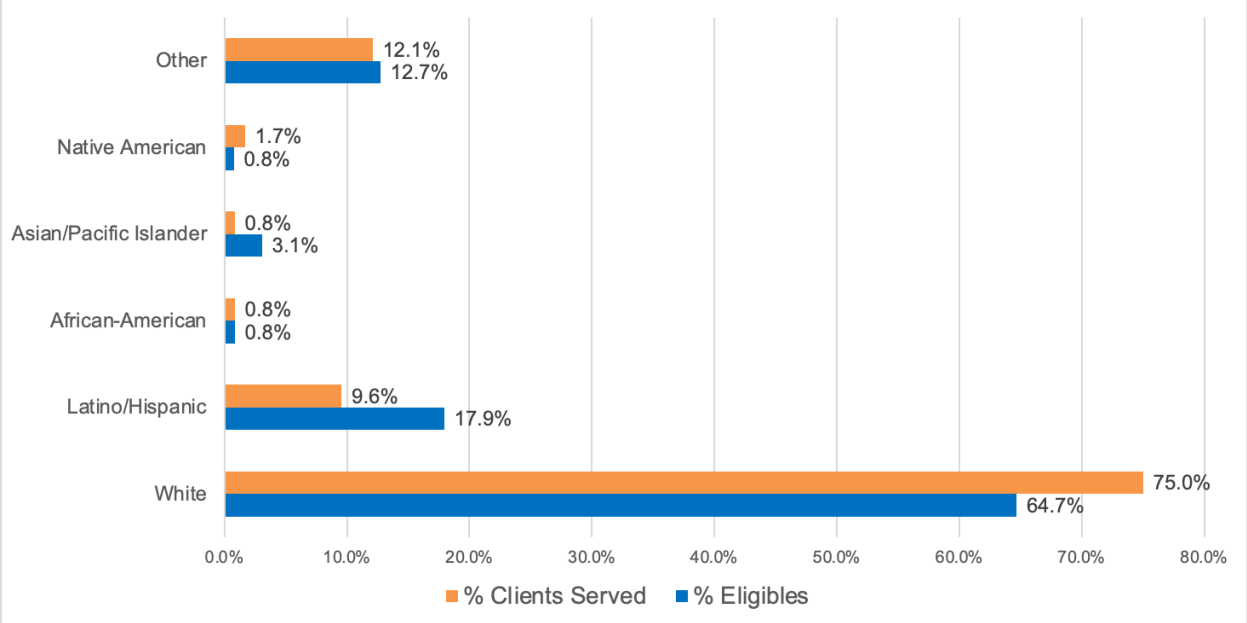


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. Based on FY 2019-20 data, 64.7 percent of El Dorado's eligible beneficiaries were White, but this group made up 75 percent of beneficiaries served so their use of services was not proportional to population size. Hispanic/Latino beneficiaries constituted 17.9 percent of the eligible population but only accounted for 9.6 percent of beneficiaries served. As such, their use of services was under-represented. Looking at penetration rates, El Dorado's Native Americans had the highest penetration rate at 2.75 percent, followed by Whites at 1.43 percent. The Hispanic/Latino population's penetration rate was low (0.66 percent) relative to the other race/ethnicity groups but on par with small-sized counties and Statewide averages.

Table 3: Penetration Rates by Race/Ethnicity, FY 2019-20

El Dorado				Small Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	18,641	267	1.43%	0.66%	2.08%
Latino/Hispanic	5,168	34	0.66%	0.56%	0.76%
African-American	243	*	n/a	0.54%	1.44%
Asian/Pacific Islander	886	*	n/a	0.10%	0.19%
Native American	218	*	n/a	0.29%	1.91%
Other	3,671	43	1.17%	0.54%	1.38%
TOTAL	**28,827**	**356**	**1.23%**	**0.58%**	**1.10%**

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

Table 4 below shows El Dorado's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. The ACA group was the leading eligibility category with 218 beneficiaries served, followed by the Family Adult group (94 beneficiaries).

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2019-20

El Dorado				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	3,985	54	1.36%	1.88%
Foster Care	180	*	n/a	2.46%
Other Child	2,608	*	n/a	0.34%
Family Adult	5,488	94	1.71%	1.15%
Other Adult	3,030	*	n/a	0.13%
MCHIP	1,821	*	n/a	0.24%
ACA	11,653	218	1.87%	1.74%

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

Table 5 below shows El Dorado's approved claims per penetration rates by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. Beneficiaries in the Family Adult group had the highest average approved claim at $3,423, followed by ACA beneficiaries at $2,772 and Disabled beneficiaries at $2,737. El Dorado's average approved claims were lower across all eligibility categories than Statewide averages except for Foster Care group.

Table 5: Average Approved Claims by Eligibility Category, FY 2019-20

El Dorado				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	3,985	54	$2,737	$4,513
Foster Care	180	*	n/a	$1,578
Other Child	2,608	*	n/a	$1,943
Family Adult	5,488	94	$3,423	$3,792
Other Adult	3,030	*	n/a	$4,042
MCHIP	1,821	*	n/a	$2,039
ACA	11,653	218	$2,772	$4,667

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

Table 6 shows the percentage of beneficiaries served and the average approved claims by service categories. This table provides a summary of service usage by in FY 2019-20. This table provides a summary of service usage by beneficiaries in FY 2019-20. Outpatient Services recorded the highest number of beneficiaries served at 177, followed by Residential Treatment at 127 and Narcotic Treatment Program at 92. The average approved claim was highest in Residential Treatment ($4,602).

Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2019-20

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	92	19.9%	$2,757
Residential Treatment	127	27.4%	$4,602
Res. Withdrawal Mgmt.	*	n/a	$609
Ambulatory Withdrawal Mgmt.	-	-	-
Non-Methadone MAT	*	n/a	$657
Recovery Support Services	*	n/a	$45
Partial Hospitalization	-	-	-
Intensive Outpatient Tx.	54	11.7%	$1,454
Outpatient Services	177	38.2%	$949
TOTAL	**463**	**100.0%**	**$3,068**

The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it. The averages are calculated independently. Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

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

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

Persons seeking methadone maintenance medication must first show a history of at least one year of opiate addiction and at least two unsuccessful attempts to quit using opioids through non-MAT approaches. They are likely to be conflicted about giving up their use of addictive opiates. Consequently, if they do not begin methadone medication

soon after requesting it, they may soon resume opiate use and an addiction lifestyle that can be life-threatening. For these reasons, NTPs regard the request to begin treatment with methadone as time sensitive.

El Dorado beneficiaries received their first dose of methadone within a day after completing assessment, which was similar to the Statewide experience in FY 2019-20.

Table 7: Days to First Dose of Methadone by Age, FY 2019-20

El Dorado				Statewide		
Age Groups	Clients	%	Median Days	Clients	%	Median Days
Ages 12-17	-	-	-	*	n/a	n/a
Ages 18-64	*	n/a	n/a	37,884	90.8%	<1
Ages 65+	*	n/a	n/a	*	n/a	n/a
TOTAL	**89**	**100.0%**	**<1**	**41,714**	**100.0%**	**<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). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

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.

El Dorado Community Health Center, Marshall Medical Center and Barton Health Hospital are parts of a Hub and Spoke system in the county and offer MAT services, although they are not contracted with DMC-ODS. In addition, Marshall Medical Center and Barton Health Hospital have a Bridge program.

Buprenorphine is also available from private practice physicians that accept Medi-Cal.

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

Table 8 display the number and percentage of beneficiaries receiving three or more MAT visits per year provided through El Dorado providers and statewide for all actively implemented DMC-ODS counties in aggregate. Three or more visits were selected to identify beneficiaries 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.

Based on claims data, only a few El Dorado beneficiaries received non-methadone MAT services in FY 2019-20 in the DMC-ODS system.

Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2019-20

El Dorado					Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 12-17	-	-	-	-	*	n/a	*	n/a
Ages 18-64	*	n/a	*	n/a	6,504	6.8%	3,036	3.2%
Ages 65+	-	-	-	-	*	n/a	*	n/a
TOTAL	*	n/a	*	n/a	**6,658**	**6.3%**	**3,095**	**2.9%**

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

Transitions in Care Post-Residential Treatment – FY 2019-20

The DMC-ODS Waiver emphasizes client-centered care, one element is the expectation that treatment intensity should change over time to match the client's changing condition and treatment needs. This treatment philosophy is in marked contrast to a program-driven approach in which treatment would be standardized for beneficiaries 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 beneficiaries discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. The table shows the percentage of beneficiaries who began a new level of care within seven days, 14 days, and 30 days after discharge from residential treatment. Also shown in the table are the percent of beneficiaries who had follow-up treatment from 31-365 days.

Follow-up services that are counted in this measure are based on DMC-ODS claims data and include outpatient, Intensive Outpatient Treatment (IOT), partial hospital, MAT,

NTP, WM, 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 Fee for Service (FFS)/Health Plan Medi-Cal claims data at this time.

7.32 percent of El Dorado Medi-Cal beneficiaries transitioned to another level of care following residential treatment within seven days, which was on par with the Statewide experience of 7.63 percent. Overall, 26.02 percent of El Dorado beneficiaries had a transition admission following residential treatment in FY 2019-20, which was higher than the Statewide average of 19.85 percent.

Table 9: Timely Transitions in Care Following Residential Treatment, FY 2019-20

El Dorado (n= 123)			Statewide (n= 30,303)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	*	n/a	2,312	7.63%
Within 14 Days	16	13.01%	3,161	10.43%
Within 30 Days	22	17.89%	3,987	13.16%
Any days (TOTAL)	**32**	**26.02%**	**6,016**	**19.85%**

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

Access Line Quality and Timeliness

Most prospective beneficiaries seeking treatment for substance use disorders 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 beneficiaries 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 12/14/2019 through 12/13/2020. Currently, El Dorado's call center system does not track some call metrics such as the percentage of dropped calls.

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

El Dorado	
Average Volume	99.4 calls per month
% Dropped Calls	Not tracked
Time to answer calls	Not tracked
Monthly authorizations for residential treatment	17.67 (7/1/2019 to 6/30/2020)
% of calls referred to a treatment program for care, including residential authorizations	21% of callers are linked to treatment through the Access Line
Non-English capacity	1 FTE Access Line staff is bilingual (English/Spanish), and El Dorado has a contract with a language vendor.

High-Cost Beneficiaries

Table 11a provides several types of information on the group of beneficiaries who use a substantial number of DMC-ODS services in El Dorado. 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 $12,973 in approved claims per year. The table lists the average approved claims costs for the year for El Dorado HCBs compared with the statewide average. Some of these beneficiaries 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 beneficiaries 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 for the averages for all DMC-ODS counties statewide.

Based on FY 2019-20 data, El Dorado's high-cost beneficiary count was negligible.

Table 11a: High-Cost Beneficiaries by Age, El Dorado, FY 2019-20

El Dorado						
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Ages12-17	*	-	-	-	-	-
Ages 18-64	328	*	n/a	n/a	n/a	n/a
Ages 65+	*	-	-	-	-	-
TOTAL	**356**	*****	**n/a**	**n/a**	**n/a**	**n/a**

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

Table 11b: High-Cost Beneficiaries by Age, Statewide, FY 2019-20

Statewide					
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims
Ages 12-17	5,018	22	0.4%	$18,095	$398,083
Ages 18-64	91,813	5,377	5.9%	$19,374	$104,171,358
Ages 65+	10,592	41	0.4%	$18,713	$767,217
TOTAL	**107,423**	**5,440**	**5.1%**	**$19,363**	**$105,336,659**

Residential Withdrawal Management with No Other Treatment

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

Only a few El Dorado beneficiaries received residential WM services in FY 2019-20, and none had three or more episodes to qualify as engaged beneficiaries.

Table 12: Residential Withdrawal Management with No Other Treatment, FY 2019-20

El Dorado			Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
TOTAL	*	n/a	7,836	3.4%

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).

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.

El Dorado recorded high congruence between referrals and level of care placements in both initial screening (81.2 percent) and follow-up assessment (90 percent) in the following FY 2019-20. The congruence was lower in initial assessment (56.4 percent) mostly due to clinical judgement.

Table 13: Congruence of Level of Care Referrals with ASAM Findings

El Dorado ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	26	81.2%	92	56.4%	*	n/a
Patient Preference	*	n/a	*	n/a	*	n/a
Level of Care Not Available	*	n/a	*	n/a	-	-
Clinical Judgement	-	-	61	37.4%	-	-
Geographic Accessibility	-	-	-	-	-	-
Family Responsibility	-	-	-	-	-	-
Legal Issues	-	-	*	n/a	-	-
Lack of Insurance/Payment Source	-	-	-	-	-	-
Other	*	n/a	*	n/a	-	-
Actual Referral Missing	-	-	-	-	-	-
TOTAL	**32**	**100.0%**	**163**	**100.0%**	*****	**100.0%**

Diagnostic Categories

Table 14 compares the breakdown by diagnostic category of the El Dorado and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2019-20.

Opioid was the leading diagnosis code, followed Alcohol Use Disorder and Other Stimulant Abuse. El Dorado's average cost across all diagnosis codes was lower than Statewide averages.

Table 14: Percentage Served and Average Cost by Diagnosis Code, FY 2019-20

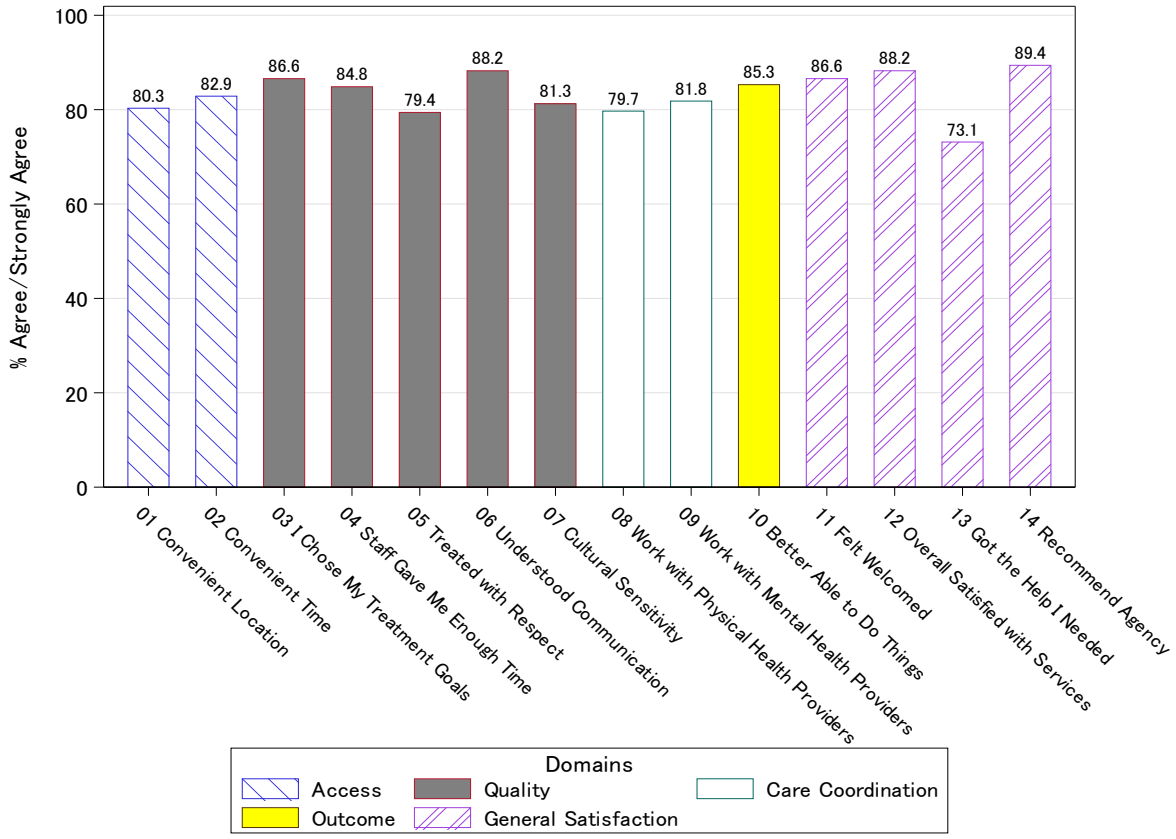
Diagnosis Codes	El Dorado		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	31.6%	$3,231	17.1%	$5,317
Cannabis Use	3.5%	$1,757	9.0%	$2,328
Cocaine Abuse or Dependence	0.8%	$4,011	1.9%	$5,273
Hallucinogen Dependence	0.0%	$0	0.23%	$5,151
Inhalant Abuse	0.0%	$0	0.03%	$6,809
Opioid	37.2%	$3,275	45.7%	$5,084
Other Stimulant Abuse	24.1%	$3,036	24.4%	$4,723
Other Psychoactive Substance	0.0%	$0	0.11%	$6,172
Sedative, Hypnotic Abuse	0.0%	$0	0.52%	$5,095
Other	2.9%	$1,406	0.90%	$3,259
Total	**100.0%**	**$3,068**	**100.0%**	**$4,776**

Client Perceptions of Their Treatment Experience

CalEQRO regards the beneficiary perspective as an essential component of the EQR. In addition to obtaining qualitative information on that perspective from focus groups during the review, CalEQRO uses quantitative information from the TPS administered to beneficiaries 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.

El Dorado scored high ratings in most TPS domains, but the best scores were noted in Quality and General Satisfaction measures. The lowest score was noted in a General Satisfaction measure when beneficiaries were asked if they got the help they needed.

Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA (N = 70)



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

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

Tables 15-17 depict beneficiary 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 El Dorado will need to consider and with which agencies they will need to coordinate. FY 2019-20 data showed El Dorado beneficiaries having a higher homeless rate than the Statewide average and more criminal justice involvement, but similar employment rates.

Table 15: CalOMS Living Status at Admission, FY 2019-20

Admission Living Status	El Dorado		Statewide	
	#	%	#	%
Homeless	154	45.2%	32,027	28.7%
Dependent Living	111	32.5%	28,474	25.5%
Independent Living	76	22.3%	51,036	45.7%
TOTAL	**341**	**100.0%**	**111,537**	**100.0%**

Table 16: CalOMS Legal Status at Admission, FY 2019-20

Admission Legal Status	El Dorado		Statewide	
	#	%	#	%
No Criminal Justice Involvement	153	44.9%	68,737	61.7%
Under Parole Supervision by CDCR	*	n/a	2,255	2.0%
On Parole from any other jurisdiction	-	-	1,676	1.5%
Post release supervision - AB 109	160	46.9%	30,671	27.5%
Court Diversion CA Penal Code 1000	*	n/a	2,111	1.9%
Incarcerated	-	-	711	0.6%
Awaiting Trial	22	6.4%	5,324	4.8%
TOTAL	**341**	**100.0%**	**111,485**	**100.0%**

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

Table 17: CalOMS Employment Status at Admission, FY 2019-20

Current Employment Status	El Dorado		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	42	12.3%	13,156	11.8%
Employed Part Time - Less than 35 hours	29	8.5%	8,637	7.7%
Unemployed - Looking for work	67	19.6%	33,128	29.7%
Unemployed - not in the labor force and not seeking	203	59.5%	56.616	50.7%
TOTAL	**341**	**100.0%**	**111,537**	**100.0%**

The information displayed in Tables 22-23 focus on the status of beneficiaries at discharge, and how they might have changed through their treatment. Table 22 indicates the percent of beneficiaries 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 beneficiaries progress or, for that matter, attempt to persuade the beneficiary to complete treatment.

El Dorado had a higher standard adult discharge rate (71.1 percent) than the Statewide average (42.1 percent) in FY 2019-20, which is indicative of positive treatment outcome.

Table 18: CalOMS Types of Discharges, FY 2019-20

Discharge Types	El Dorado		Statewide	
	#	%	#	%
Standard Adult Discharges	280	71.1%	49,577	42.1%
Administrative Adult Discharges	114	28.9%	55,467	47.1%
Detox Discharges	-	-	10,420	8.8%
Youth Discharges	-	-	2,415	2.1%
TOTAL	**394**	**100.0%**	**117,879**	**100.0%**

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

Table 19 displays the rating options in the CalOMS discharge summary form counselors use to evaluate their beneficiaries' progress in treatment. This is the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for beneficiaries 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 beneficiaries 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.

It is important to note that 56.8 percent of El Dorado beneficiaries had a positive CalOMS discharge status which was on par with the Statewide average of 45.8 percent, either completing treatment or leaving before treatment completion but with satisfactory progress.

Table 19: CalOMS Discharge Status Ratings, FY 2019-20

Discharge Status	El Dorado		Statewide	
	#	%	#	%
Completed Treatment - Referred	126	32.1%	20,317	17.6%
Completed Treatment - Not Referred	62	15.8%	6,759	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	*	n/a	17,115	14.8%
Left Before Completion with Satisfactory Progress – Administrative Questions	*	n/a	8,734	7.6%
Subtotal	*223*	*56.8%*	*52,925*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	66	16.8%	16,693	14.4%
Left Before Completion with Unsatisfactory Progress - Administrative	99	25.3%	44,609	38.6%
Death	*	n/a	235	0.2%
Incarceration	*	n/a	1,058	0.9%
Subtotal	*169*	*43.1%*	*62595*	*54.1%*
TOTAL	**392**	**100.0%**	**115,520**	**100.0%**

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

Performance Measures Findings: Impact and Implications

Access to Care

- El Dorado shows higher penetration rates than Statewide averages in beneficiaries' use of DMC-ODS services in the 18-64 and 65+ age groups.
- Hispanic/Latino eligible beneficiaries, however, are under-represented in their use of services.
- El Dorado beneficiaries have access to non-methadone MAT services through primary care providers not contracted with DMC-ODS.
- In FY 2019-20, outpatient services and residential treatment were the most used DMC-ODS services.
- The NTP provider operates a clinic in Roseville where counseling services are provided and a medication unit outside of Placerville where methadone is dispensed. The agency is using telehealth to provide counseling to

beneficiaries, so they do not have to travel to Roseville before being dispensed take-home doses. Some of the NTP providers are part of the Hub and Spoke grant network to link with primary care.

- El Dorado's current call center system does not track some performance metrics such as the percentage of dropped calls and the average time a caller waits for his/her call to be answered.

Timeliness of Services

- El Dorado beneficiaries have timely access to methadone treatment, usually within a day after being assessed.
- In FY 2019-20, 7.32 percent of beneficiaries discharged from residential treatment transitioned to another level of care within seven days and 13.01 percent had a care transition within fourteen days. These rates were on par with statewide averages.

Quality of Care

- Beneficiaries who participated in the 2020 adult TPS responded positively in all survey domains, particularly in quality and general satisfaction measures.
- El Dorado recorded high congruence between referrals and level of care placements in both ASAM initial screening (81.2 percent) and follow-up assessment (90 percent). Congruence was lower in initial assessment due to clinical judgement.

Client Outcomes

- FY 2019-20 CalOMS data showed El Dorado beneficiaries having a higher standard adult discharge rate and more positive discharge status than the Statewide average. These are indications of good treatment outcomes.

INFORMATION SYSTEMS REVIEW

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

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

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

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

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

Entity	FY 2020-21	FY 2019-20	FY 2018-19
El Dorado	5.10%	n/a	n/a
DMC-ODS Small Group	n/a	2.80%	2.33%
Statewide	n/a	2.40%	3.16%

The budget determination process for information system operations is:

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

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

ISCA Table 2: Business Operations

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

- El Dorado County IT Department have the responsibility to perform, and monitor IS security duties and provide training on cyber security.

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

ISCA Table 3: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	16%
Contract providers	84%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

ISCA Table 4: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	2	0	1	1

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

ISCA Table 5: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	0	0	0	0

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

- One FTE technology staff is a dedicated DMC-ODS resource.
- Data analytics support is provided by SUDS administrative staff and Fiscal technicians.

Summary of User Support and EHR Training

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

ISCA Table 6: Count of Individuals with EHR Access

Type of Staff	Count of DMC-ODS Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	7	0	7
Clinical Healthcare Professional	9	0	9
Clinical Peer Specialist	0	0	0
Quality Improvement	4	4	8
Total	20	4	24

ISCA Table 7: EHR User Support

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

ISCA Table 8: New Users EHR Training

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

ISCA Table 9: Ongoing EHR Training and Support

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

- The Behavioral Health Department System Analyst provides myAvatar training to new users.

Telehealth Services Delivered by County

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

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 10: Summary of DMC-ODS Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	9
Number of county-operated telehealth sites	5
Number of contract providers' telehealth sites	4

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

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

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

- SUDS provide telehealth group services using Zoom as a video/audio platform.
- Telehealth is also used to facilitate assessments in the community.
- The NTP provider uses telehealth to provide counseling services to beneficiaries.

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

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

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 11: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Granite Wellness	3
Progress House	1

Current DMC-ODS Operations

- SUDS use myAvatar as its EHR system and contract with Netsmart for ASP support.
- Contract providers have limited access to the EHR to enter CalOMS data.

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

ISCA Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
myAvatar	Electronic Health Record	Netsmart	4	Netsmart

The DMC-ODS Priorities for the Coming Year

- Development of new brief screening and assessment forms based on ASAM criteria in myAvatar.
- Complete CalOMS program to include all contract providers to allow for submission through the EHR system.
- Build program and/or reports that will help QM better to respond to beneficiaries' timeliness and quality needs including identifying follow-ups to discharges.

Major Changes since Prior Year

Modifications made in myAvatar included:

- New forms – Individual and Group Progress Notes, Medical Necessity Form, Discharge Plan, Discharge Summary and Health Questionnaire.
- New widgets – SUDS Note Timeliness, Treatment Plans in Draft, ASAM Drafts Older than seven Days, SUDS Notes in Draft over two Days.
- New reports – Treatment Plan Report and Medical Necessity Report.
- Refined CalOMS program to support ODS data capture and reporting.

Plans for Information Systems Change

- No plans to replace current system (in place more than five years).

DMC-ODS EHR Status

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

ISCA Table 13: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	myAvatar	☒	☐	☐	☐
Assessments	myAvatar	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/ Storage	myAvatar	☒	☐	☐	☐
Electronic Signature—DMC-ODS Beneficiary	myAvatar	☒	☐	☐	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service	myAvatar	☒	☐	☐	☐
Outcomes	myAvatar	☒	☐	☐	☐
Prescriptions (eRx)		☐	☐	☒	☐
Progress Notes	myAvatar	☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans	myAvatar	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		8	0	4	0

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

- SUDS added new widgets, forms, and reports in myAvatar to support clinical workflows.

Contract Provider EHR Functionality and Services

The DMC-ODS currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to DMC-ODS EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and DMC-ODS EHR system	0%	Not used
Electronic batch files submitted to DMC-ODS for further processing and uploaded into DMC-ODS EHR system	0%	Not used
Direct data entry into DMC-ODS EHR system by contract provider staff	5%	Monthly
Electronic files/documents securely emailed to DMC-ODS for processing or data entry input into EHR system	95%	Monthly
Paper documents submitted to DMC-ODS for data entry input by DMC-ODS staff into EHR system	0%	Not used

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

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

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

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

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

EHR Vendor	Product	Count of Providers Supported
FYIdb Software	FYIdb	1
NextGen Healthcare	NextGen	1
Orion Healthcare	AccuCure	1
Athena Software	Penelope	1

Special Issues Related to Contract Agencies

- Contract providers deliver 84 percent of El Dorado's DMC-ODS services.
- Contract providers send service transactions including dosing data monthly to SUDS in the form of Excel files via secured email. Behavioral Health Fiscal technicians extract the data from Excel files and enter them into myAvatar for billing.

- Timeliness data is also sent monthly to SUDS in Excel files via secured email. The data is kept on a secured drive but not entered into the EHR.
- CalOMS data is entered directly into myAvatar monthly by contract provider staff.
- Contract providers send ASAM assessment data directly to the State.

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

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

Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey	Yes	No
ASAM Criteria is used for assessment for clients in all DMC Programs.	X	
ASAM Criteria is used to improve care.	X	
ASAM screening is entered directly into the EHR.	X	X*
ASAM assessment is entered directly into the EHR.	X	X*
TPS is administered in all Medi-Cal Programs.	X	
CalOMS is administered on admission, discharge, and annual updates.	X	
CalOMS is used to improve care by tracking discharge status and other outcomes.	X	

*Contract providers

Highlights or challenges of use of outcome tools above:

- El Dorado adopted the ASAM criteria as a SUD level of care tool prior to implementing DMC-ODS and provide ongoing ASAM training to county staff and contract providers.
- Prior to the 2020 TPS, SUDS staff met with contract providers to ensure instructions on how to complete the survey online/on paper were understood. El Dorado also shares TPS findings with all providers.
- El Dorado refined the CalOMS program in myAvatar to capture all data elements required for State reporting and to facilitate system-wide data collection.

Overview and Key Findings

Operations and Structure

- El Dorado pivoted to telephonic and telehealth services quickly at the outset of the COVID-19 pandemic.
- SUDS contract with Netsmart for ASP support on its EHR but have lean county technology and data analytics capacity to support DMC-ODS operations.
- Monthly, contract providers send service transactions and timeliness data to SUDS in Excel files via secured email. Fiscal technicians enter service transactions into the EHR for billing, but timeliness data is reviewed but stored separately. To report on timeliness metrics, SUDS staff have to manually combine data from myAvatar reports and multiple Excel files.

Key Findings

- El Dorado is building up its electronic health record system to support DMC-ODS implementation. After the first year, many building blocks are in place, but more work is required to optimize the EHR's capability to produce timely data to measure encounters and performance that support quality assessment and improvement projects.
- Consideration should be given for contract providers to have more access to the EHR to enter their own service transactions and timeliness data.
- Another option is to explore use of electronic file transfers. The current process to manually extract contract provider data from Excel files and entering the data into the EHR is both inefficient and error prone.
- El Dorado should also consider procuring a database management software to organize and manipulate varied data collected. Currently, El Dorado has to spend extensive efforts to monitor the DMC-ODS system as it develops or to quantify areas for improvement when performance falls short against previously established goals. Several counties have applied for and gotten excess SAPT funds to enhance their Avatar systems to improve in these ways.

NETWORK ADEQUACY

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For El Dorado, the time and distance requirements are 90 minutes and 60 miles for SUD outpatient services, and 75 minutes and 45 miles for NTP/OTP services. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient and NTP/OTP services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with DMC-ODS staff all relevant documents (NACT, AAS) and maps related to Network Adequacy (NA) issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted virtual review with the county staff due to the public health emergency and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

The county DMC-ODS met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

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

DHCS issued a conditionally pass for EL Dorado DMC-ODS but found that the county was out-of-compliance in terms of capacity using NSDUH data in the following areas:

- Outpatient Drug Free for 0 to 17
- Intensive Outpatient Treatment for 0 to 17
- Residential Treatment for 0 to 17
- Residential Treatment for 18 and older
- Opioid Treatment for 0 to 17 and
- Language Capacity.

To meet the required standards and enhance beneficiary access to care El Dorado DMC-ODS has a contract with a provider for outpatient treatment for 0 to 17 ages and a provider for Intensive Outpatient Treatment for the same age range. El Dorado currently has a request for quotation for residential treatment for the same age range. El Dorado now has a contract for language capacity, but that contract was not finalized when the stated issued the conditional pass. El Dorado DMC-ODS would be in full compliance with current NA standards assuming that no other providers discontinued their contracts or services.

Also discussed as part of NA were access issues for physically disabled beneficiaries. This was a special feature in the El Dorado DMC-ODS where they assess the physical compliance to Americans with Disability Act on an annual basis. El Dorado also utilizes the California Relay Services for those who are hearing or visually impaired.

In addition, El Dorado DMC-ODS monitors transportation needs of members to support access to care through the Managed Care Plan (MCP). No issues were reported, and the staff now contact the MCP several days in advance of the appointment.

El Dorado has one local tribe and attempted to collaborate with them, but the tribe declined to become part of the county’s network. The tribe provides services through a tribal health center.

DHCS provided a timely response to the El Dorado DMC-ODS network adequacy application in April 2020 as required within the 90-day timeline. El Dorado are awaiting the DHCS response to the April 2021 submission.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

CMS revised the protocols in October of 2019. On the first page of the new protocol a PIP is defined by: "A PIP is a project conducted by the MCP that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/of MCP/system level. "

El Dorado DMC-ODS PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. During the virtual review, CalEQRO reviewed two PIPs which have not been implemented, as shown below.

PIP Table 1: PIPs Submitted by El Dorado

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Client Linkage to primary and behavioral health care
Non-clinical	1	Direct intake scheduling

Clinical PIP

PIP Table 2: General PIP Information, Clinical PIP

DMC-ODS Name	El Dorado
PIP Title	Client Linkage to primary and behavioral health care
PIP Aim Statement	Will the implementation of regularly scheduled case management meetings, between El Dorado County Substance Uses Disorders Services (EDC SUDS) case managers and contracted providers, increase the proportion of treatment plans documenting D2 and D3 impairments identified in the assessment; thereby, increasing documented ASAM Dimension 2 (D2) goals from 46 percent to 56

DMC-ODS Name	El Dorado
	percent, or better, and ASAM Dimension 3 (D3) goals from 47 percent to 57 percent or better, over a one-year period?
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17)* ☒ Adults only (age 18 and above) in a residential treatment program ☐ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): All beneficiaries with an ASAM Dimension 2 and/or Dimension 3 impairment who are enrolled in one contract provider's ASAM level 3.1 and/or level 3.5 residential treatment program.	

PIP Table 3: Improvement Strategies or Interventions, Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Change member experience of access to needed care via their treatment plans including goals for linkage to mental health and physical goals as reflected in the assessment of ASAM assessment of those needs (via those two dimensions).
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)-Training alone is not an intervention need to link to clients. Yearly training on county case managers and residential treatment staff describing case management best practices and the linkage process. Weekly intensive case management consultations. To link the beneficiary with an ASAM Dimension 2 and/or Dimension 3 impairment to primary medical care and/or mental health care, utilizing the assessment data via agency provider formulated treatment plan. Utilization review

PIP Interventions (Changes tested in the PIP)
of all completed treatment plans and related technical assistance by the QM coordinator. Supervision of staff to help goals be met for clients.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Systemic approach to help see goals met in linkage to care systems and bringing to primary care with partners and if needed enhance MOUs for access, and same for MH.

PIP Table 4: Performance Measures and Results, Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
An increase in Progress House Residential Treatment Program beneficiaries with ASAM Dimension 2 identified impairments on treatment plan from 46 percent to 56 percent. Linkages of at least 20 percent of the 56 percent to primary health care.	n/a	n/a	☒ n/a*	n/a	☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
An increase in Progress House Residential Treatment Program beneficiaries with ASAM Dimension 3 identified impairments on treatment plan from 47 percent to 57 percent. Linkages of at least 20 percent of the 57 percent to mental health care.	n/a	n/a	☒ n/a*	n/a	☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Was the PIP validated?	☒ Yes	☐ No

Validation phase:

☐ PIP submitted for approval.
☒ Planning phase still formulating measures, action items.
☐ Implementation phase
☐ Baseline year
☐ First remeasurement
☐ Second remeasurement
☐ Other (specify):

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: It was recommended that the county conduct a focus group with beneficiaries to validate the issues that were identified. Other suggestions provided were quickly incorporated into the PIP. The focus of the PIP is to implement more coordination and communication with physical health care and mental health and not to just identify the issue on the treatment plan. Also, may need to enhance MOUs or action plans with primary care and MH to have access enhancements for clients in need especially if they do not have Medi-Cal
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: Technical assistance was provided during the virtual review on 2/23/2021. Several follow up reviews and another will be made available when draft is done.

*PIP is in planning and implementation phase if n/a is checked.

Non-clinical PIP

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

DMC-ODS Name	El Dorado
PIP Title	Direct intake scheduling
PIP Aim Statement	Will immediate direct scheduling of beneficiaries’ intake appointments with providers reduce the number of missed assessments due to “loss of contact” by 50 percent, as well as reduce the average amount of time it takes from initial client request for service to initial face-to-face assessment over a 12-month period?

DMC-ODS Name	El Dorado
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): All county residents of all ages who have requested substance use disorder services.	

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

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): The strategy of this intervention is to reduce the time from a request for services to a scheduled intake appointment. The goal is to eliminate “phone tag” from the elapsed time from an initial request for treatment services to intake screening and assessment.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Reduction in number, and by 50 percent, in the proportion of beneficiaries scheduled without having to receive a call back for assessments as compared to baseline of 100 percent or 398 clients.	2021	n/a	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Reduction and percent proportion of requests for services dispositioned as “loss of contact” as compared to baseline of 22 percent or 88 clients.	2021	n/a	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Reduction in the average amount of time between initial contact and face-to-face assessment by 25 percent.	2020	10.08 days	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Proportion and number of beneficiaries that receive assessment within 7.56 days, each quarter since intervention began.	n/a	n/a	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Proportion of ASAMs that indicate appropriate level of care.	n/a	n/a	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Was the PIP validated?	☒ Yes	☐ No

Validation phase:

☐ PIP submitted for approval.
☒ Planning phase gathering critical baseline and intervention system info.
☐ Implementation phase
☐ Baseline year
☐ First remeasurement
☐ Second remeasurement
☐ Other (specify):

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: It was recommended that the county conduct a focus group with beneficiaries to validate the issues that were identified. Other suggestions provided were quickly incorporated into the PIP. This is common if three way calling for immediate appointment not available, or drop-in hours, several recommendations made, based on similar issues in other start up counties.
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: Technical assistance was provided during the virtual review on 2/23/2021.

*PIP is in planning and implementation phase if n/a is checked.

CLIENT FOCUS GROUPS

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, DHCS direction for a pause in review guidance and hardship for the county, no beneficiary focus group sessions were conducted as part of CalEQRO's desk review of El Dorado DMC-ODS this year.

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 beneficiaries 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	M
El Dorado has a FY 2020-21 Cultural Competence Plan. In El Dorado's Treatment Staff Documentation Manual, the following were noted: The inclusion of cultural perspectives and practices are critical components of assessments and treatment planning, to ensure perceived problems or issues are identified, and placed in the appropriate clinical context. Within assessments, SUDS staff will document evidence of: • A discussion of the exploration of culturally significant topics with the client and/or significant support person(s). • An exploration and discussion of relevant cultural issues that may pertain to the presenting substance use disorder related impairments and which can be used in the development of a culturally- appropriate treatment plan. • How linguistic accommodations are made, either through a bilingual certified staff or interpreter service. Services are to be provided to beneficiaries in their preferred language. Language interpretation or translation services should be utilized, as necessary. Contracted service providers are required to maintain, at contractor's sole cost, access to bilingual interpreters, if needed.		

KC Table 1: Access to Care Components		
Component		**Quality Rating**
El Dorado contracts for language support services through Language People. They also have bilingual staff that must be certified in order to provide translation services. El Dorado provided staff training on “Native Values, Attitudes and Behaviors”, “Cultural Competency: National CLAS Standards” and “Latino Outreach”. Counselors participated in online certificate training on “Improving Cultural Competency for Behavioral Health Professionals”. El Dorado reviews CLAS standards on an annual basis.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
From the ISCA form, El Dorado reported that they identified that there were extended wait times for residential and WM in the Fall 2019, due to a couple compounding issues. They focused on getting a third residential and WM provider contracted that added 42 residential beds and 6 WM beds to the network. The waitlists for residential treatment were reduced once the contract was implemented. MAT services in county are a Medication Only unit but if they serve at least 125 beneficiaries, Aegis has reported that it could be convert it to a full NTP clinic.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
El Dorado reported positive, collaborative working relationships with other county departments, law enforcement, school districts, criminal justice system, managed care plans, FQHC’s, local hospitals and emergency departments. County staff are assigned to the Community Corrections Center to work with beneficiaries referred by the Probation Department. El Dorado spoke about the extensive stakeholder engagement prior to implementation of DMC-ODS services.		

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 beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

KC Table 2: Timeliness to Care Components

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
El Dorado reported an average of 73 percent of the time met the state standard of ten days from initial request to first appointment. El Dorado reported that the staff are		

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
required to document the amount of time it takes between a beneficiary's first request for services and their first appointment with the treatment provider.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	M
El Dorado reported that the average length of time from initial request to appointment was 2.37 days and that the standard of three days was met 77 percent of the time.		
2C	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	M
EL Dorado defined urgent care as a condition perceived by the beneficiary as serious, but not life threatening. Further the condition disrupts normal activities of daily living and requires an assessment by a health care provider and if necessary, treatment services within 24 to 72 hours. The average length of time from request to actual visit was 2.37 days. El Dorado met the three-day standard 77 percent of the time.		
2D	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	PM
El Dorado has a seven-day standard for follow up after discharge from residential treatment but only met that standard 20.5 percent of the time. El Dorado reported that this will be a focus of training this next year and to monitor the documentation by the case managers to ensure the standard is met.		
2E	Tracks and Trends Data on Follow-up and Re-Admission to Residential Withdrawal Management	M
El Dorado did not have any beneficiaries that re-entered residential treatment within 30 days of discharge. The QM staff reviewed the data from WM and compared the cases and names to verify re-admission to residential treatment, but none were found.		
2F	Tracks Data and Trends No Show Data for Initial Appointment	M
El Dorado tracks the no-show rate for initial appointment. El Dorado tracks the no-shows for any beneficiary who did not keep their first scheduled appointment, cancelled their appointment, or did not follow through to make an appointment. El Dorado plans to monitor the no-show rate on a monthly basis.		

Quality of Care

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

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	PM
El Dorado has a Quality Management Plan just for substance use disorder. The plan includes a quality standard, quality benchmarks, monitoring tools and measurement process and assessment timeframes. The plan does not include any baseline data or goals, nor does it identify who is responsible for the quality activity. Some of the items in the work plan do not have measurable goals and objectives linked to quality improvement.		
3B	Data is used to inform management and guide decisions	PM
El Dorado has a Network Provider Performance Standard and Measures document that reviews access, transitions between levels of care, care coordination, MAT, culturally competent services, delivery of individualized and quality care for each level of care. This document contains measurable goals for each level of care. El Dorado reported that they are collecting data, but it is via Excel spreadsheets received from each contract provider on a monthly basis. The data then needs to be tabulated and analyzed but the county does not have a dedicated staff to conduct these activities. Their QIC has started meeting again on a quarterly basis since they hired the new Behavioral Health Director.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
El Dorado provided a presentation on provider training and provided minutes from the providers meetings. El Dorado reported that a member of the Behavioral Health Commission is now a member of the QIC. They also want to add a substance use disorder consumer or family member to the Behavioral Health Commission. El Dorado reported that they meet with their contract providers on a monthly basis and that they have positive, collaborative relationship with all of their contract providers. El Dorado conducted an extensive stakeholder process prior to and during implementation of the DMC-ODS.		
3D	Evidence of an ASAM continuum of care	M
El Dorado has a full continuum of care with the exception of 3.7 and 4.0 WM which is not a required level of care for DMC-ODS. El Dorado provided an example of a CalOMS report from DHCS as evidence of the analysis of outcome data. El Dorado provided trainings to staff through UCLA and CIBHS. Their documentation manual contains information on the ASAM levels of care and when to review the ASAM criteria.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
El Dorado staff participates in the Opioid Coalition of El Dorado County. The Opioid Coalition monitors the overdose data on a regular basis. The County epidemiologist works with a Deputy from the Sherriff's/ Coroner's office. The Coalition also monitors prescribing guidelines and follows CDC policies. El Dorado does not have a committee that reviews client data on prescriptions, etc. Their MD does review records during their annual monitoring of NTP providers. Education of MAT is provided during the assessment and treatment planning per QM staff.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
El Dorado provided training to staff on ASAM. El Dorado utilized UCLA and CIBHS for training. They also utilized on-line training through the Change Companies. El Dorado provided certificates as evidence of the training for the staff.		
3G	Measures clinical and/or functional outcomes of clients served	M
El Dorado provided CalOLMs reports as evidence of meeting this standard. Quality of services and member satisfaction is also a core component of their Quality Management Plan.		
3H	Utilizes information from client perception of care surveys to improve care	M
El Dorado administered the TPS for the first time in October 2020. Results were reviewed from the TPS and a discussion of findings was conducted during the virtual review.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- El Dorado held extensive stakeholder engagement meetings prior to implementation of the DMC-ODS.
- El Dorado has established a full continuum of care for year one county and has expanded SUD treatment services. In FY 2019-20, outpatient services and residential treatment were the most used DMC-ODS services.
- El Dorado shows higher penetration rates than statewide averages in beneficiaries' use of DMC-ODS services in the 18-64 and 65+ age groups.
- El Dorado beneficiaries have access to non-methadone MAT services through primary care providers not contracted with DMC-ODS.
- The NTP provider operates a clinic in Roseville where counseling services are provided and a medication unit outside of Placerville where methadone is dispensed. The agency is using telehealth to provide counseling to beneficiaries, so they do not have to travel to Roseville before being dispensed take-home doses.
- El Dorado pivoted to telephonic and telehealth services quickly at the outset of the COVID-19 pandemic.

Opportunities:

- Hispanic/Latino eligible beneficiaries, however, are under-represented in their use of services.
- El Dorado's current call center system does not track some performance metrics such as the percentage of dropped calls and the average time a caller waits for his/her call to be answered. It does not have software to help track all the quality metrics or three-way calling of other centers which allows for immediate appointments with providers.
- El Dorado is redesigning their Access Call Center via their PIP in order to increase engagement into SUD treatment services and provider immediate appointments.
- There are no MAT services in the jail. The new Behavioral Health Director plans to continue to work with the Sheriff's Department to see if this policy could be updated.

- Recovery residence housing would benefit the continuum of care for those without stable housing with and without children.

Timeliness of DMC-ODS Services

Strengths:

- El Dorado reported an average of 73 percent of the time met the state standard of 10 days from initial request to first appointment.
- El Dorado beneficiaries have timely access to methadone treatment, usually within a day after being assessed.
- In FY 2019-20, 7.32 percent of beneficiaries discharged from residential treatment transitioned to another level of care within 7 days and 13.01 percent had a care transition within 14 days. These rates were on par with Statewide averages.
- El Dorado tracks the no-show rate for initial appointment. El Dorado tracks the no-shows for any beneficiary who did not keep their first scheduled appointment, cancelled their appointment, or did not follow through to make an appointment. El Dorado plans to monitor the no-show rate on a monthly basis.

Opportunities:

- EL Dorado defined urgent care as a condition perceived by the beneficiary as serious, but not life threatening. El Dorado would benefit from further defining urgent care such as including pregnancy as an urgent condition in order to accurately track utilization.
- Monthly, contract providers send service transactions and timeliness data to SUDS in Excel files via secured email. Fiscal technicians enter service transactions into the EHR for billing, but timeliness data is reviewed but stored separately. To report on timeliness metrics, SUDS staff have to manually combine data from myAvatar reports and multiple Excel files.

Quality of Care in DMC-ODS

Strengths:

- El Dorado has a Network Provider Performance Standard and Measures document that reviews access, transitions between levels of care, care coordination, MAT, culturally competent services, delivery of individualized and quality care for each level of care. This document contains measurable goals for each level of care.

- Their QIC has started meeting again on a quarterly basis since they hired the new Behavioral Health Director.

- El Dorado provided an example of a CalOMS report from DHCS as evidence of the analysis of outcome data.

- El Dorado staff participates in the Opioid Coalition of El Dorado County. The Opioid Coalition monitors the overdose data on a regular basis. The County epidemiologist works with a Deputy from the Sherriff's/ Coroner's office. The Coalition also monitors prescribing guidelines and follows CDC policies.

- El Dorado was able to expand from two Quality Management staff to four and half-staff. The new staff are now all trained in conducting quality management activities.

Opportunities:

- El Dorado reported that they are collecting data, but it is via Excel spreadsheets received from each contract provider on a monthly basis. The data then needs to be tabulated and analyzed but the county does not have a dedicated staff to conduct these activities.

- El Dorado does not have a committee that reviews client data on prescriptions or access to MAT for those with opioid use disorders or alcohol use disorders. Their Medical Director does review records during their annual monitoring of NTP providers.

- Consideration should be given for contract providers to have more access to the EHR to enter their service transactions and timeliness data.

- Another option is to explore use of electronic file transfers. The current process to manually extract contract providers data from Excel files and entering the data into the EHR is both inefficient and error prone.

- El Dorado should also consider procuring a database management software to organize and manipulate varied data collected. Currently, El Dorado has to spend extensive efforts to monitor the DMC-ODS system as it develops or to quantify areas for improvement when performance falls short against pre-established goals.

Client Outcomes for DMC-ODS

Strengths:

- El Dorado recorded high congruence between referrals and level of care placements in both initial screening (81.2 percent) and follow-up assessment (90 percent) in FY 2019-20. The congruence was lower in initial assessment (56.4 percent) mostly due to clinical judgement.

- Beneficiaries who participated in the 2020 adult TPS responded positively in all survey domains, particularly in Quality and General Satisfaction measures.

- El Dorado administered the TPS for the first time in October 2020. Results were reviewed from the TPS and a discussion of findings was conducted during the virtual review.

- FY 2019-20 CalOMS data showed El Dorado beneficiaries having a higher standard adult discharge rate and more positive discharge status than the Statewide average.

Opportunities:

- The lowest score was noted in a General Satisfaction measure when beneficiaries were asked if they got the help they needed.

Recommendations for DMC-ODS for FY 2019-20

1. El Dorado has developed both a Clinical and Non-clinical PIP and now just needs to implement both projects. TA remained available if needed.

2. El Dorado should examine alternative means of collecting data from their contract providers instead of using monthly Excel spreadsheets which are subject to human error as well as being labor intensive.

3. It is recommended El Dorado a add staff or contractor resource dedicated to data analysis in order to monitor data, performance measures and outcomes more effectively to enhance quality of care and enhance productivity and efficiency. This type of resource will have many benefits and is a gap in the system which can be reimbursed through quality funding.

4. El Dorado should also consider procuring a database management software to organize and manipulate varied data collected from claims and other key service and quality metrics.

5. The Quality Management Plan needs to include baseline data where applicable, measurable goals and objectives and identify who is responsible for monitoring and reporting back on each activity.

ATTACHMENTS

Attachment A: CalEQRO Review Agenda

Attachment B: Review Participants

Attachment C: County Highlights: none at this time

Attachment D: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: CalEQRO Review Agenda

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

Table A1: CalEQRO Review Sessions – El Dorado DMC-ODS
Opening session – Implementation, 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 multiple sessions
Medication-assisted treatments (MATs)
Criminal justice coordination with DMC-ODS
Access to care and Timeliness of services
Exit interview: questions and next steps

Attachment B: Review Participants

CalEQRO Reviewers

Karen Baylor, Lead Reviewer
Sharon Loveseth – Second Reviewer
Caroline Yip – Information Systems Reviewer

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

El Dorado's DMC-ODS Review

EQRO conducted a virtual review.

Table B1: Participants Representing El Dorado			
Last Name	**First Name**	**Position**	**Agency**
Baker	Christine	Program Assistant	El Dorado Behavioral Health Division
Diaz	Ramona	Program Manager, Fiscal/Budget/Billing	El Dorado Behavioral Health Division
Drennan	Salina	Alcohol & Drug Program Division Manager	El Dorado Behavioral Health Division
Ebraham-Nuyken	Nicole	Director, Behavioral Health Division	El Dorado Behavioral Health Division
Gula	Kristin	Billing Supervisor	El Dorado Behavioral Health Division
Hayes	Amy	Deputy Director, Behavioral Health Division	El Dorado Behavioral Health Division
LePore	Matthew	Senior Department Analyst	El Dorado Behavioral Health Division
Nevarez	Deborah	Mental Health Clinician/SUD QA Clinician	El Dorado Behavioral Health Division
O'Malley	Shaun	Supervising Health Education Coordinator	El Dorado Behavioral Health Division
Rodriguez	Lisa	Department System Analyst	El Dorado Behavioral Health Division
Schue	Lynn	Health Educator	El Dorado Behavioral Health Division
Wade	Dennis	Health Educator	El Dorado Behavioral Health Division
Wracker	Nita	Chief Financial Officer	El Dorado Behavioral Health Division

Attachment C: County Highlights

None at this time.

Attachment D: Acronym List Drug Medi-Cal EQRO Reviews

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

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

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