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

LOS ANGELES FINAL REPORT

☐ MHP

☒ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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EXECUTIVE SUMMARY

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

DMC-ODS INFORMATION

Review Type: Onsite

Date of Review: November 13-16, 2023

DMC-ODS Size: Very Large

DMC-ODS Region: Southern California

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	5	0	1
Quality of Care	8	6	2	0
Information Systems (IS)	6	4	2	0
TOTAL	**24**	**18**	**5**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Expanding Patients treated for Opioid Use Disorder (OUD) for 180 days or more	Clinical	11/2022	Planning	Moderate confidence
Enhancing Follow-up Service Rates after Emergency Department Visits with Alcohol and other SUD Disorders among HealthNet Medi-Cal members (FUA)	Non-Clinical	04/2023	Planning	Low confidence

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐ Youth ☐ Residential ☐ Outpatient ☒ MAT/NTP* ☐ Perinatal ☐ Other	[redacted]
2	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP* ☒ Perinatal ☐ Other	
3	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	
4	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	

*Medication-assisted treatment (MAT), Narcotic Treatment Program (NTP/OTP)

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

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

- The DMC-ODS developed a 2023-2028 Strategic Plan with goals built on California Advancing & Improving Medi-Cal (CalAIM) principles as well as local access and treatment needs.
- The DMC-ODS developed and implemented a three-tier rate system for the provider network which included payment incentives linked to quality and system improvements.
- The DMC-ODS developed and expanded a range of services for high-need youth as part of criminal justice reform efforts.
- The DMC-ODS expanded access and engagement efforts with a range of public media tools and websites available on a range of SUD topics and needs in multiple languages.
- The DMC-ODS expanded services in prevention and American Society of Addiction Medicine (ASAM) levels of care for at-risk SUD conditions (Level 0.5)

as well as adding treatment sites and new providers to address Network Adequacy (NA) requirements and enhance treatment access.

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

- Most non-OTP outpatient and residential programs are not currently billing the DMC-ODS for medication services for MAT as a direct part of their services at those levels of care (LOC). Integration of MAT provides easier access for the members to this evidence-based practice and would require adding a prescriber integrated into the program with associated policies and procedures.
- There is currently no DMC-ODS data capacity for monitoring no-shows for assessment services after referral from the Access Call Center or for those directly requesting services from the provider network.
- The DMC-ODS requires additional staffing resources to fully meet the needs for provider network monitoring and to support for the new reimbursement system, as well as the CalAIM requirements for additional reporting.
- There continues to be a higher level of overdose events in the central downtown area with homeless encampments.
- There were some providers using drug testing to evaluate admission needs for specific programs. This was creating a barrier to admission and did not appear to be clinically needed.

FY 2023-24 CalEQRO recommendations for improvement include:

- The DMC-ODS should continue efforts to engage providers in adding MAT prescribers to their treatment programs with incentives.
- The DMC-ODS should continue working with the provider network to implement the capability of documenting and tracking no-shows for admission assessments and visits as part of the Electronic Health Record (EHR) or other methods in 2024.
- The DMC-ODS requires additional staffing resources to fully meet the needs for provider network monitoring and support for the new reimbursement system, and CalAIM requirements for developing new quality-related data and clinical documentation requirements.
- There is a concentration of overdose events in specific areas of the county. Outreach and engagement efforts as well as addition of potential new sites should prioritize areas of the county that have a higher concentration of overdoses.
- As part of the “95 Percent Campaign” to bring persons with SUD into the care system, the DMC-ODS should help providers review admission processes to eliminate potential barriers to admission into care including drug testing.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2023-24 findings of the EQR for LA DMC-ODS by BHC, conducted as an onsite review on November 13-16, 2023.

REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2022 and FY 2022-23, unless otherwise indicated. As part of the pre-review process, each DMC-ODS is provided a description of the source of data and a summary report of Medi-Cal approved claims data. These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

DMC-ODS CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING DMC-ODS OPERATIONS

There was no environmental impact on the operations of the DMC-ODS.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The DMC-ODS made major changes to the EHR and billing systems to address the changes in service delivery and claiming for CalAIM and other DHCS requirements.
- The DMC-ODS added many programs at multiple LOC to address the requirements associated with NA and Criminal Justice Reform for youth resulting in increased access for youth and members in rural areas.
- The DMC-ODS expanded and implemented new models of integrated care at the Martin Luther King (MLK) campus for SUD including withdrawal management (WM), a sobering center, residential treatment, and outpatient care. These were coordinated with similar LOC needs with mental health (MH), primary care, inpatient, and criminal justice also located at the MLK campus.
- The DMC-ODS developed a new set of tiered rates with payment incentives linked to many quality practices and improvements in workforce, including adding additional SUD counselors, licensed practitioners of the healing arts, prescribers, and SUD capacity by adding additional LOC and sites.
- The DMC-ODS enhanced access to services for youth at-risk with the addition of ASAM level 0.5 services which are linked to robust prevention services in the schools and community centers.
- The DMC-ODS is working to add MAT services at new NTP/OTP sites in high-risk areas of the downtown in coordination with homeless services activities.
- The DMC-ODS reduced the call abandonment rate from 15 percent to 8 percent since taking the service over in 2022 and has added four SUD counselors and one clinician, with plans to hire three to five more as needed.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the county has either:

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

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

Recommendations from FY 2022-23

Recommendation 1: Clarify expectations for providers that a basic screening using the program Co-Triage is done to identify any urgent clients presenting on the day they request SUD care at provider sites by phone or in person. The goal is to determine if they meet the urgent definition for WM to ensure they are screened and referred within the required 48 or 72 hours to WM services if needed.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The DMC-ODS added focused training for the network providers to enhance screening and referrals for persons presenting at their sites who might have urgent conditions and need admission or referrals to urgent WM sites.
- The DMC-ODS enhanced tracking and documentation of these conditions when they occurred at the network provider sites to track the timeliness of urgent conditions and ensure these members were accurately screened for possible urgent needs and referral more accurately.

Recommendation 2: Work with Forensic Services and Health Services to get support for expansion of capacity for the DMC-ODS services accepting referrals from Detention for aftercare treatments This group has a substantial risk of overdose upon release if not identified and offered services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The DMC-ODS in partnership with Forensic Services and Health Services expanded MAT in the criminal justice detention system with all new and existing approved medications, including the latest long-lasting medication for OUDs,

Brixadi. This medication, per clinical staff interviewed, has fewer side effects than Sublocade and comes in one-week and one-month formulations.

- In addition, SUD treatment and care coordination services were expanded inside and outside of detention for smooth transitions in care from inmate services to community treatment programs, and where appropriate, to recovery housing for those with SUD.

Recommendation 3: Continue efforts to expand housing resources for both those in the SUD and housing systems that are not stable in their housing but need treatment linked to housing, including necessary coordination between the housing system and SUD treatment, when applicable including families.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Recovery housing was approved for expansion in 2024 utilizing State Behavioral Health Bridge Funding and opioid settlement funds to 550 new beds to the existing bed capacity for persons with SUD. This will increase bed capacity to approximately 1,700.
- In all member focus groups with CalEQRO, housing access with support was reported by members to be an important element for them in achieving successful SUD recovery and stability over time.

Recommendation 4: Implement strategies in coordination with centralized Department of Public Health Human Resources staff to identify and address gaps and challenges to recruiting for and filling key positions in a timely manner to ensure that staff vacancies do not impact the ability to deliver SUD services and manage and develop the DMC-ODS provider network.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Additional personnel resources were added to fill vacancies more rapidly in the DMC-ODS and enhance coordination with the county's central Human Resources department. A detailed report related to position improvements was shared including availability of position lists and length of time to fill positions.
- There remain challenges with specific classifications at the DMC-ODS and countywide. LA County Personnel is now reviewing hiring and recruitment practices. The goal is to make changes to enhance recruitment and hiring countywide in hard to fill classifications.

Recommendation 5: Besides membership in the Health Information Exchange (HIE), continue to partner with key hospitals with high SUD presence to share/exchange information for client care to demonstrate best practices between systems of referrals into and out of acute care and into the DMC-ODS continuum of care.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The DMC-ODS has obtained all HealthNet Medi-Cal member information needed to coordinate care at all LA hospitals which is the focus of two of their PIPs. Currently, systems are being established to coordinate care and exchange data across the LOCs with both hospitals and acute care.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE DMC-ODS

SUD services are delivered solely by contractor-operated providers in the DMC-ODS. Regardless of payment source, no services were delivered by county-operated/staffed clinics and sites, and 100 percent were delivered by contractor-operated/staffed clinics and sites. Overall programs, 85 percent of services provided were claimed to Medi-Cal.

The DMC-ODS has a toll-free Access Line available to plan members 24-hours, 7-days per week that is operated by county staff under the supervision of the DMC-ODS; members may request services through the Access Line as well as through the following system entry points: all LOCs including NTP/OTPs, outpatient, residential, WM, and recovery support services. The DMC-ODS operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. This center known as Substance Abuse Service Helpline (SASH) has utilizes a robust public-facing service database which provides information on all LOCs and languages, special needs, locations, and current capacity on the Substance Abuse Availability Tool website (SBAT). Members and families are also able to directly call and present to provider network services for screening and possible admission. Approximately 68 percent of members obtain care coordination services linked to access to care or transitions in care based on 2022 data. There are 18 staff, with 12 bilingual individuals. Based upon focus group feedback and an 8 percent dropped call rate, there was some concern that it was taking too long to do screenings and linkage to care resulting in dropped calls. Staffing was increased by an additional four counselors which should address this need and there are plans to add three to five more staff in the next year.

In addition to clinic-based SUD services, the DMC-ODS provides telehealth services to youth and adults. In FY 2022-23, the DMC-ODS reports having provided telehealth services to 9,342 adults, 723 youth, and 76 older adults across the 377

contractor-operated sites. Among those served, 710 members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for Plan members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of WIC Section 14197, including the information contained in Table 1A and Table 1B.

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

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

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

AAS	
The DMC-ODS was required to submit an AAS request due to time and distance requirements	☐ Yes ☒ No

Table 1B: Los Angeles DMC-ODS Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The DMC-ODS was required to provide OON access due to time and distance requirements	☐ Yes ☒ No

- Because the DMC-ODS can provide necessary services to a member within time and distance standards using their network providers, the DMC-ODS was not required to allow members to access services via OON providers. However, the DMC-ODS has an approved signal use agreement if needed for special needs and circumstances.

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The DMC-ODS expanded services substantially to youth members who are in the Criminal Justice system as well as to youth who meet the 0.5 ASAM LOC which occurs in coordination with prevention and school programs.
- The DMC-ODS is working with the County mental health plan (MHP) to address the goals for coordinated service delivery required as part of CalAIM. This is a focus because the MHP and the DMC-ODS reside in two different county departments. This effort includes new joint programs beginning this year.

ACCESS PERFORMANCE MEASURES

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

The Penetration Rate (PR) is a measure of the total Plan members served based upon the total Medi-Cal eligible population which is unduplicated. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount

of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The current PR has limitations because the numerator is unduplicated members, but the denominator does not consider the monthly average eligible county of services with SUD in the county resulting in a possible underestimation of the PR.

The statewide PR is 0.95 percent, with a statewide average approved claim amount of $5,998. Using PR as an indicator of access for the DMC-ODS, the PR is somewhat lower than statewide at 0.72 percent and the challenge is reaching the population that could benefit from SUD treatment over such a large region with culturally diverse populations. This challenge has led to several public information campaigns with professional media in the threshold languages.

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

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

Age Groups	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
Ages 12-17	453,235	777	0.17%	0.29%	0.25%
Ages 18-64	2,326,304	21,330	0.92%	1.29%	1.19%
Ages 65+	510,867	1,607	0.31%	0.56%	0.49%
Total	**3,290,406**	**23,714**	**0.72%**	**1.04%**	**0.95%**

Note: Total eligibles may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The DMC-ODS PRs for all age groups are lower than PRs for other large counties and statewide.
- Though the PR increased, the numbers of members served decreased from 24,882 in CY 2021 to 23,714 in CY 2022, a 5 percent decrease.

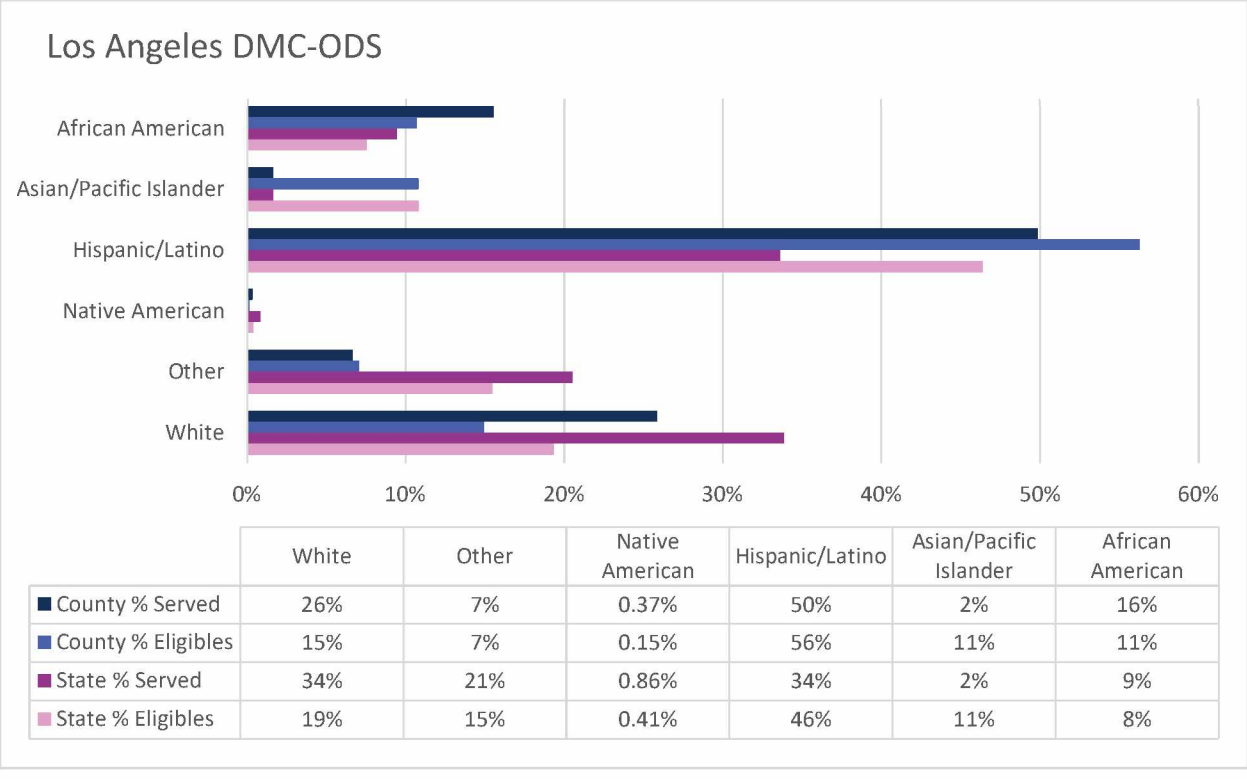
Table 4: Los Angeles DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Racial/Ethnic Group, CY 2022

Racial/Ethnic Groups	# Members Eligible	# Members Served	County PR	Same Size Counties PR	Statewide PR
African American	352,770	3,692	1.05%	1.29%	1.19%
Asian/Pacific Islander	355,740	390	0.11%	0.15%	0.15%
Hispanic/Latino	1,852,592	11,827	0.64%	0.74%	0.69%
Native American	5,080	87	1.71%	2.34%	2.01%
Other	232,538	1,582	0.68%	1.34%	1.26%
White	491,687	6,136	1.25%	1.89%	1.67%
Total	**3,290,404**	**23,714**	**0.72%**	**1.04%**	**0.95%**

Note: Total eligibles may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- PRs for all racial/ethnic groups are lower than PRs for large counties as a group and statewide.
- The PR for Hispanic/Latino members increased from 0.55 percent to 0.64 percent since the last review. During the same period, the PR for Native American members decreased from 1.95 percent to 1.71 percent.

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



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
County % Served	26%	7%	0.37%	50%	2%	16%
County % Eligibles	15%	7%	0.15%	56%	11%	11%
State % Served	34%	21%	0.86%	34%	2%	9%
State % Eligibles	19%	15%	0.41%	46%	11%	8%

- The distributions of members served and members eligible by race/ethnicity are similar to CY 2021.
- Hispanic/Latino members are proportionally underrepresented in the DMC-ODS, though the gap between eligibles and members served is smaller than the statewide gap for the same group and has improved since the previous EQR.
- The most proportionally underrepresented racial/ethnic group is Asians/Pacific Islanders.

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

Eligibility Categories	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
Affordable Care Act (ACA)	1,511,460	16,659	1.10%	1.53%	1.42%
Disabled	281,901	2,963	1.05%	1.51%	1.37%
Family Adult	596,397	3,753	0.63%	1.03%	0.94%
Foster Care	11,121	190	1.71%	2.08%	1.84%
Medicaid Children's Health Insurance Program (MCHIP)	161,658	199	0.12%	0.20%	0.18%
Other Adult	433,517	261	0.06%	0.10%	0.09%
Other Child	305,704	521	0.17%	0.32%	0.27%
Total	**3,290,404**	**23,714**	**0.72%**	**1.04%**	**0.95%**

- The DMC-ODS PRs for all eligibility categories are lower than those of similar size counties and statewide.
- Approximately 98 percent of DMC-ODS members are eligible for services through either the ACA, Family Adult, or Disabled eligibility categories.

Table 6: Los Angeles DMC-ODS Average Approved Claims by Eligibility Category, CY 2022

Eligibility Categories	County AACM	County Size Group AACM	Statewide AACM
ACA	$8,009	$5,742	$6,216
Disabled	$6,678	$5,393	$5,707
Family Adult	$6,050	$5,180	$5,296
Foster Care	$2,993	$2,578	$2,716
MCHIP	$3,623	$3,692	$3,594
Other Adult	$4,305	$3,880	$4,075
Other Child	$3,121	$3,427	$3,194
Total	**$7,588**	**$5,607**	**$5,998**

- AACMs in the DMC-ODS are higher than in similar size counties and statewide for all eligibility categories, with the exception of Other Child and MCHIP.
- The total AACM is also higher than comparable counties and statewide, continuing a pattern from CY 2020 forward. The AACM increased about 7 percent from CY 2021 to CY 2022.

Table 7: Los Angeles DMC-ODS Services Used by Plan Members, CY 2022

County			Statewide	
Service Categories	**#**	**%**	**#**	**%**
Ambulatory Withdrawal Mgmt	17	0.05%	56	0.04%
Intensive Outpatient	5,584	16.68%	14,422	9.58%
Narcotic Treatment Programs	5,404	16.14%	37,134	24.67%
Non-Methadone MAT	482	1.44%	7,782	5.17%
Outpatient Treatment	8,165	24.39%	46,441	30.85%
Partial Hospitalization	0	0.00%	13	0.01%
Recovery Support Services	2,223	6.64%	6,400	4.25%
Res. Withdrawal Mgmt	2,399	7.17%	10,429	6.93%
Residential Treatment	9,198	27.48%	27,841	18.50%
Total	**33,472**	**100.00%**	**150,518**	**100.00%**

- The most used DMC-ODS services are residential treatment, outpatient treatment, intensive outpatient, and NTP/OTP.

- The use of recovery support services increased by more than 30 percent from CY 2021 to CY 2022.

Table 8: Los Angeles DMC-ODS Approved Claims by Service Categories, CY 2022

Service Categories	County AACM	County Size Group AACM	Statewide AACM
Ambulatory Withdrawal Mgmt	$897	$234	$484
Intensive Outpatient	$1,999	$1,207	$1,729
Narcotic Treatment Program	$4,206	$4,279	$4,526
Non-Methadone MAT	$1,368	$1,601	$1,660
Outpatient Treatment	$3,413	$2,304	$2,547
Partial Hospitalization	$0	$2,802	$2,802
Recovery Support Services	$1,601	$1,660	$1,669
Res. Withdrawal Mgmt	$3,114	$2,278	$2,392
Residential Treatment	$11,577	$10,379	$10,178
Total	**$7,588**	**$5,607**	**$5,998**

- The DMC-ODS AACMs for all service categories exceed those of comparable counties and statewide, with the exceptions of NTP/OTP, non-methadone MAT, and recovery support services.
- The AACM increased since the previous CY for each individual service category.
- The DMC-ODS provides its members with a full range of services, as evidenced by utilization and claiming across the continuum of care.
- The DMC-ODS reported continued growth in services to members in volume and diversity in 2023 as programs rebound from COVID-19 impacts on staffing vacancies and fears of direct contact have reduced somewhat for members as reported in member focus groups.

IMPACT OF ACCESS FINDINGS

- Continued engagement efforts have been ongoing to expand access and initiatives for those with SUD not in treatment such as the population health initiative in Los Angeles. The “95 Percent Campaign” is a positive use of media to improve engagement and access. Expanded harm reduction services are also part of this effort, as are community specific engagement efforts with new staff in the community.

- Expansion of NTP/OTP sites and services especially in areas of homeless encampments with high overdose rates is an important goal for 2024 and two buildings were recently identified for this service need.
- While claims data indicates that utilization of non-methadone MAT is lower within the DMC-ODS than found statewide, the DMC-ODS has multiple, robust relationships that foster access for members within the larger healthcare system whose diagnoses are OUD or alcohol use disorders (AUD). This includes additional coordinated MAT websites for education and access. Also, the opioid coalition crosses multiple departments and the private sector for more complete community impacts.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 9: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered MAT Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Residential Treatment	Met
2E	WM Readmission Rates	Met
2F	No-Shows/Cancellations	Not Met

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

- The DMC-ODS has extensive data tracking linked to their Access Center and the EHR documents which t members contacted through outreach and engagement

staff and the provider network. All services require authorization though some of the approvals are after the initial assessment phase based on the new definition of medical necessity.

- Offered appointments and new procedures for tracking urgent appointments presenting directly to the provider network are in place.
- There is no mechanism in place to track no-shows for initial assessments and scheduled visits following an Access Center encounter with a referral or direct requests to the provider network.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the DMC-ODS reported in its submission of the ATA, representing access to care during the 12-month period of FY 2022-23. Table 10 and Figures 2-4 display data submitted by the DMC-ODS; an analysis follows. These data represent the entire system of care for the DMC-ODS. The DMC-ODS submitted timeliness data for urgent services in days rather than hours, which the EQRO has converted to hours. No-shows were not tracked by the DMC-ODS.

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

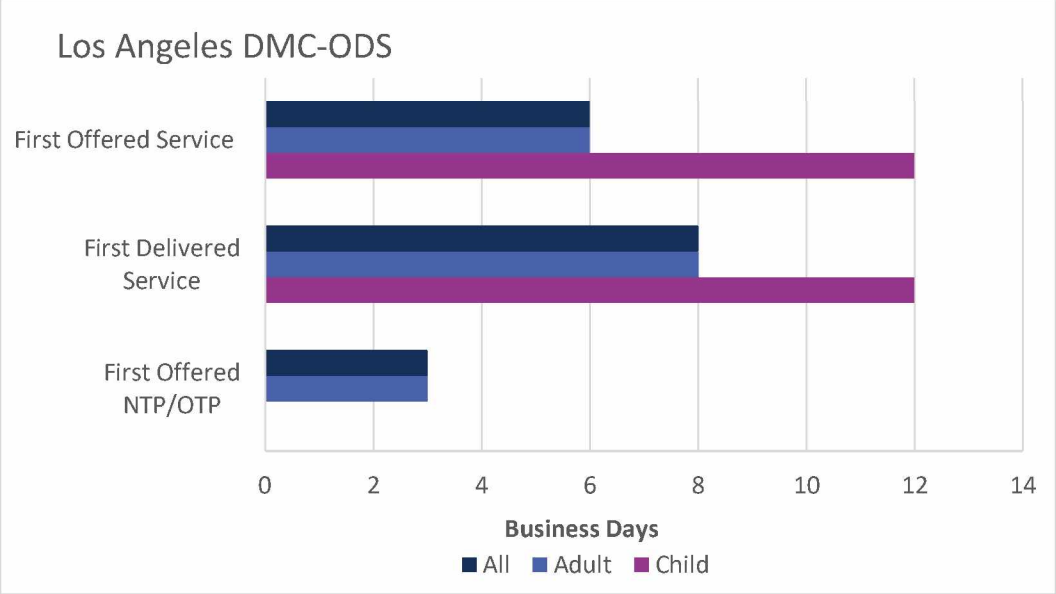
DMC-ODS-Reported Data

Table 10: FY 2023-24 Los Angeles DMC-ODS Assessment of Timely Access

Timeliness Measure	Average/Rate	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6 Business Days	10 Business Days*	82%
First Non-Urgent Service Rendered	8 Business Days	10 Business Days**	74%
Non-Urgent MAT Request to First Offered NTP/OTP Appointment	3 Business Days	3 Business Days*	80%
Urgent Services Offered	24 Hours	48 Hours**	92%
Follow-up Services Post-Residential Treatment	7 Calendar Days	7 Calendar Days**	24%
WM Readmission Rates Within 30 Days	8%	n/a	n/a
No-Shows	***	n/a	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** DMC-ODS-defined timeliness standards *** The DMC-ODS did not report data for this measure			
For the FY 2023-24 EQR, the DMC-ODS reported its performance for the following time period: FY 2022-23			

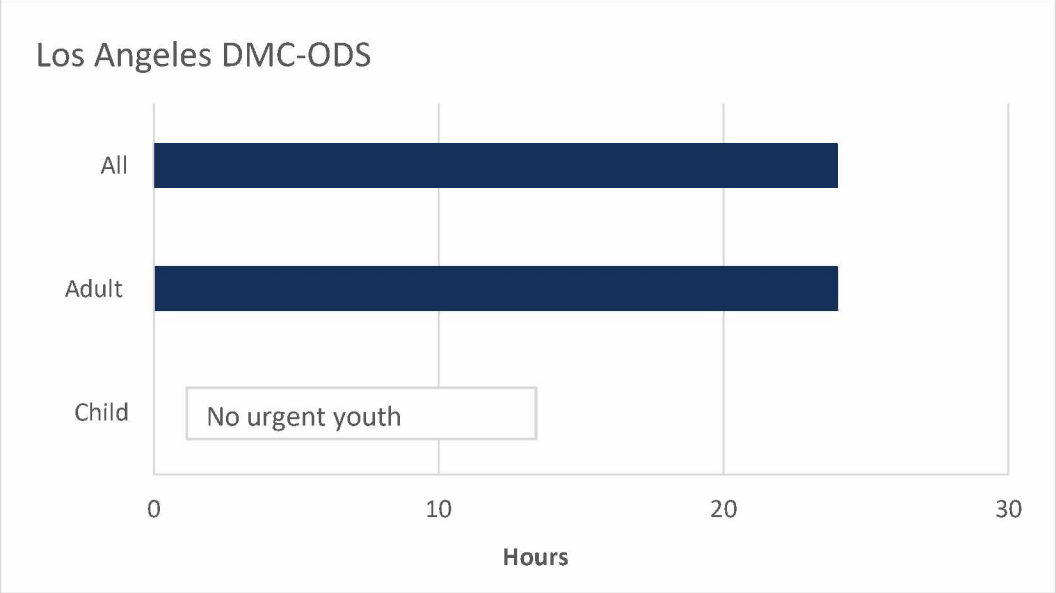
- The largest change in the ATA results as compared to the previous year is for urgent services offered. In CY 2021, the proportion of members offered timely urgent services (i.e., that met the 48-hour standard) was 86 percent. In CY 2022, the percent that met the standard was 92 percent. The remaining timeliness measures results were static during the same period.

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



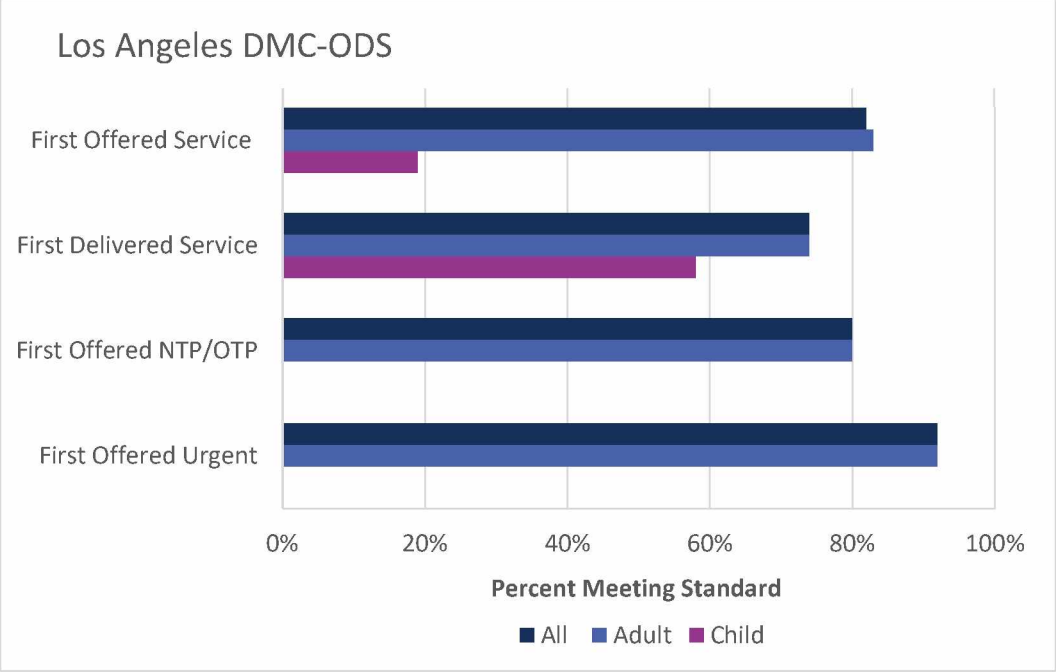
- The DMC-ODs met their 10-day standard for the first offered service 80 percent of the time. The percentage is consistent with the CY 2021 percentage of 81 percent.

Figure 3: Wait Times for Urgent Services



- The DMC-ODS standard for timeliness to urgent services is 48 hours. According to the data provided, they met that standard 92 percent of the time.

Figure 4: Percent of Services that Met Timeliness Standards



- The percentage of services that met the first non-urgent delivered service standard increased from 72 percent in CY 2021 to 74 percent in CY 2022.The percentage of services that met the first offered urgent service standard increased from 86 percent in CY 2021 to 92 percent in CY 2022.

Timeliness from Medi-Cal Claims Data

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

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

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

County				Statewide		
Age Groups	# of Members	%	Avg. Days	# of Members	%	Avg. Days
12 to 17	<11	-	-	15	0.04%	12.60
18 to 64	4,398	82.10%	4.67	31,839	87.46%	3.59
65+	-	-	-	4,551	12.50%	0.56
Total	**5,357**	**100.00%**	**3.88**	**36,405**	**100%**	**3.19**

- The average time to first dose of methadone in the DMC-ODS (3.88 days) is about 16.5 hours longer than the average wait statewide (3.19 days).

- The average time to first dose of methadone increased slightly (about eight hours) for both the DMC-ODS and statewide from CY 2021. Transitions in Care

Transitions in Care

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

	N = 9,110		Statewide N = 27,232	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	1,211	13.29%	3,243	11.91%
Within 14 Days	1,498	16.44%	4,515	16.58%
Within 30 Days	1,778	19.52%	5,706	20.95%

- The proportions of members receiving transitions in care following residential treatment within 7, 14, and 30 days the DMC-ODS results are similar to statewide. However, over 80 percent of members who discharge from residential services are not receiving a transition in care within 30 days of discharge.
- The proportions of members transitioning in care within all three points in time decreased from CY 2021 in the DMC-ODS, while statewide timely transitions increased from the prior year.

Residential Withdrawal Management Readmissions

Table 13: Los Angeles DMC-ODS Residential Withdrawal Management Readmissions, CY 2022

County			Statewide	
Total DMC-ODS admissions into WM	2,930		13,062	
	#	#	#	%
WM readmissions within 30 days of discharge	227	7.75%	1,148	8.79%

- Members who had residential WM were readmitted within 30 days of discharge at a slightly lower rate than statewide. The DMC-ODS is providing incentives to enhance LOCs by providers to facilitate easier linkage and supports for the lower LOCs.

IMPACT OF FINDINGS

- Overall, the timeliness results are similar to statewide and meet DHCS requirements.

- Timeliness data indicates that methadone dosing occurs with some lag and enhanced monitoring, or workflow adjustments may be needed to reduce from an average of 3.88 to 3.0 days to first dose from initial contact.
- Lacking a systemwide ability to track provider no-shows and data for initial contact and assessment appointments made by the Access Call Centers, limits the DMC-ODS ability to utilize a key performance indicator for initial member engagement.
- Network providers scheduling modules, especially for those not on Sage (the adopted DMC-ODS version name for Avatar EHR), limits tracking follow-up care. However, the effectiveness of referral and engagement services cannot be fully evaluated without this data.
- The DMC-ODS states that changes from CalAIM, the focus on the workforce, and new definitions removing some restrictive mandates for medical necessity have assisted in linking members to care in an easier and more rapid manner.

QUALITY OF CARE

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

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

QUALITY IN THE DMC-ODS

In the DMC-ODS, the responsibility for QI is part of an overall quality management department which includes both quality-focused activities, compliance, and safety activities. There is a data support division that is critical in these areas and provides monthly or weekly reports depending on the measure being evaluated. The QI program includes a focus on member grievances and data related to evidence-based programs and encouraging promising clinical practices across the provider network.

Quality is seen as an essential priority for the successful treatment of SUD from initial contact to successful recovery in the community across the ASAM continuum. Services design and capacity are carefully monitored in partnership with the contract compliance program and the data analytics program. There are a range of workgroups focused on different services, initiatives, and challenges such as overdose prevention, the use of payment incentives for foster improvements, and enhanced member and provider communication. CalAIM payment reform incentives are being included to address key capacity and clinical challenges such as workforce needs, expansion in LOCs, and integration of those LOCs for positive member outcomes.

The DMC-ODS monitors its quality processes through the quality improvement committee (QIC), the QAPI work plan, and the annual evaluation of the QAPI work plan. The QIC is comprised of 12 individuals including a Medical Director, an Assistant QI director, a range of clinical SUD staff, persons with lived experience, providers, and is supported by the data analytics program. The QIC meets every other month and completed six meetings in the past year. The QI branch of the QIC meets every other week. Specific workgroups related to authorizations and grievances meeting more frequently if needed. Of the 11 QI goals identified for the CY 2023 QAPI work plan, the DMC-ODS met or exceeded 10 of the 11 goals. There were several data challenges with processing all authorizations, denials, and appeals for services within timeliness standards. These problems were corrected and the goal of 95 percent success with

timeliness standards for approvals, denials, and appeals processing is the goal for 2024. This may require additional staffing to achieve.

QUALITY KEY COMPONENTS

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

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

Table 14: Quality Key Components

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

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

- The DMC-ODS utilizes data and research extensively in clinical program expansions, problem solving, and planning as evidenced by a range of accessible reports and data enhancements to ASAM screenings and assessments, CalOMS, and the TPS, and operations in general.
- Coordinated efforts have been very constructive and continue with LA County's Criminal Justice Detention Center improving access to MAT and enhanced discharge planning and coordination with the DMC-ODS.

- New models for integrated care were demonstrated at the new MLK site with parallel LOCs for MH and DMC-ODS services working closely together. This also includes primary and acute care coordination for member access as well.
- The DMC-ODS providers particularly residential and outpatient report challenges adding medical providers to enhance their capacity to integrate MAT into their services and sites. DMC-ODS efforts for addressing this need with incentives for the residential and outpatient programs are a positive first step to enhanced ease of access for members for more integrated care if opioid and alcohol disorder MAT could also be included in program sites.

QUALITY PERFORMANCE MEASURES

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

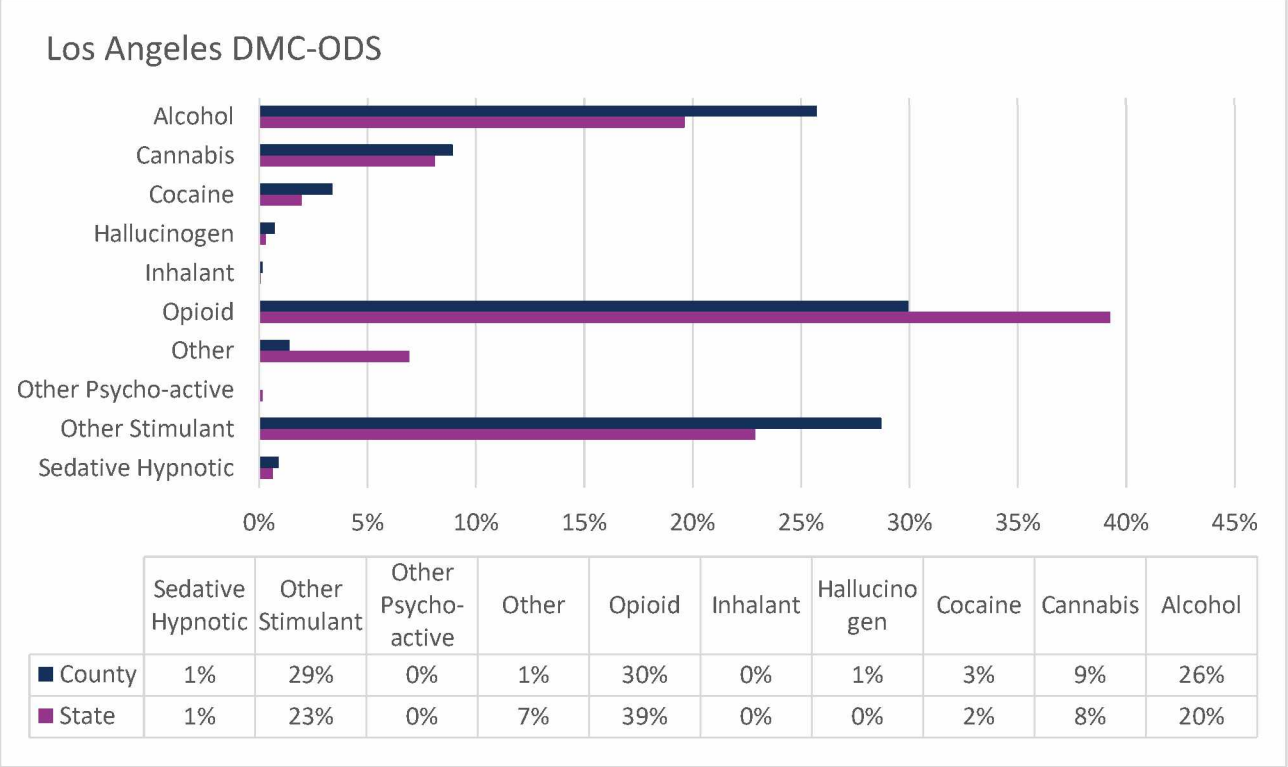
- Members served by Diagnostic Category
- Non-methadone MAT services
- Residential WM with no other treatment
- High-Cost Members (HCM)
- ASAM congruence
- Initiation and Engagement
- Length of Stay (LOS)
- CalOMS admission versus discharge for employment and housing status
- CalOMS Legal Status at Admission
- CalOMS Discharge Status Ratings

Diagnosis Data

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

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

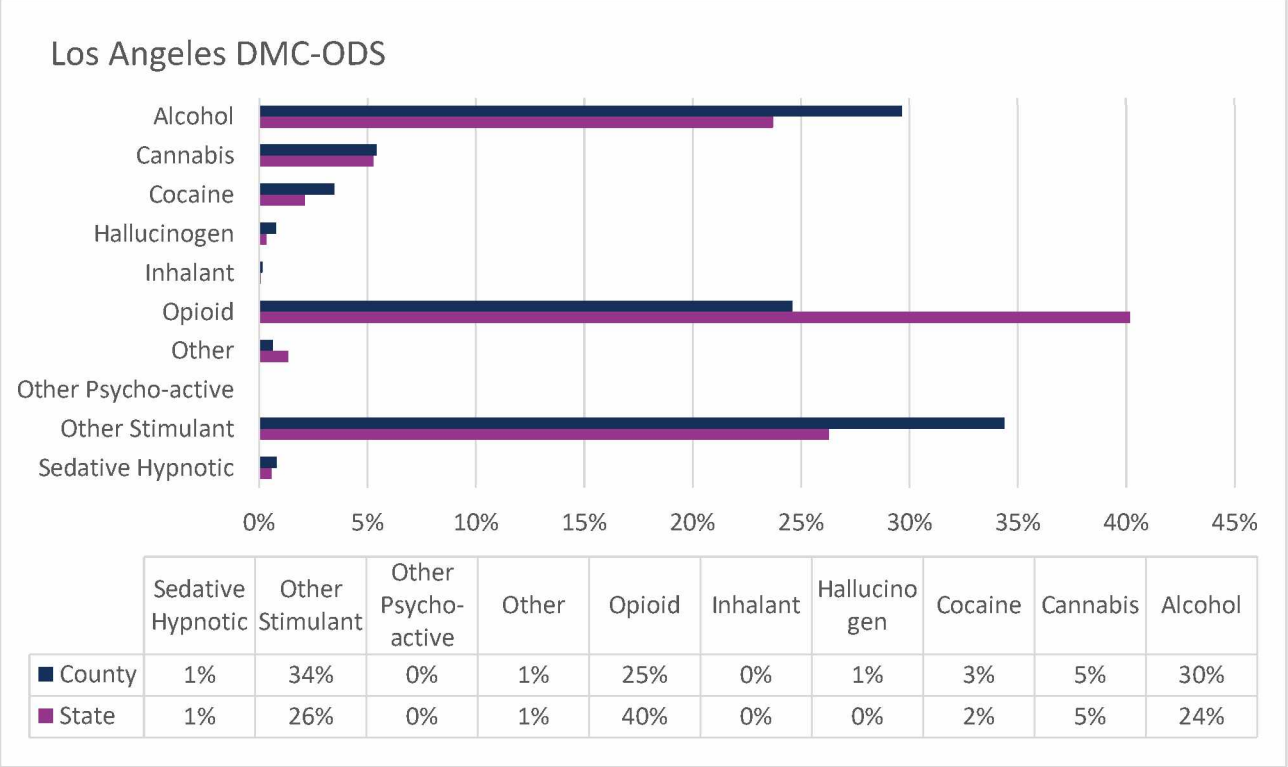
Figure 5: Percentage of Plan Members by Diagnosis Code, CY 2022



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	1%	29%	0%	1%	30%	0%	1%	3%	9%	26%
State	1%	23%	0%	7%	39%	0%	0%	2%	8%	20%

- Los Angeles's leading substance use diagnoses are OUD (30 percent), other stimulant abuse (29 percent), and AUD (26 percent).
- Other stimulant and alcohol-related diagnostic categories are much more prevalent in LA than statewide, whereas opioids were less prevalent than statewide. The DMC-ODS staff report that there have been challenges adding new NTP/OTP providers and sites. Also, there are many DMC-ODS members accessing non-methadone MAT through county and federally funded primary care clinics.

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



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	1%	34%	0%	1%	25%	0%	1%	3%	5%	30%
State	1%	26%	0%	1%	40%	0%	0%	2%	5%	24%

- The percentages of approved claims by diagnosis codes are congruent with diagnostic patterns seen in Figure 5.
- The proportions of claims associated with alcohol and other stimulant abuse in the DMC-ODS exceeded those seen statewide, while claims relating to opioids are proportionally lower than statewide. These numbers do not reflect the large number of fee-for-service claims that the county primary care clinics report to DHCS for non-methadone MAT services.

Non-Methadone MAT Services

Table 15: Los Angeles DMC-ODS Non-Methadone MAT Services by Age, CY 2022

County					Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 0-17	<11	-	<11	-	24	0.56%	13	0.30%
Ages 18-64	487	2.28%	[redacted]		7,473	7.96%	3,881	4.13%
Ages 65+	-	-	<11	-	428	5.78%	173	2.34%
Total	**507**	**2.14%**	**315**	**1.33%**	**7,925**	**7.13%**	**4,051**	**3.66%**

- Only 2.14 percent of members served by the DMC-ODS received non-methadone MAT services, compared to 7.13 percent of members statewide. Only 1.33 percent of members received three or more of these services, which is also lower than the statewide rate of 3.66 percent and reflects a 38 percent attrition rate from one to three services. The DMC-ODS system has implemented the updated CalAIM CPT coding to better capture medication services billed to the DMC-ODS outside of NTP/OTPs beginning in FY 2024-25.

Residential Withdrawal Management with No Other Treatment

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

	# Members with 3+ Episodes WM & No Other Services	% Members with 3+ Episodes WM & No Other Services
County	59	2.49%
Statewide	205	2.00%

- The proportion of members with three or more episodes of residential WM and no other services in the DMC-ODS declined very slightly from the previous year (2.82 percent in CY 2021 vs 2.49 percent in CY 2022) and is just above the statewide rate. This indicates that members with multiple residential WM episodes are being connected with other types of treatment as well.

High-Cost Members

Tracking the HCMs provides another indicator of quality of care. In SUD treatment, this may reflect multiple admissions to residential treatment or residential WM. HCMs may be receiving services at a LOC not appropriate to their needs. HCMs for the purposes of this

report are defined as those who incur SUD treatment costs higher than two standard deviations above the mean, which for CY 2022 equates to claims of $17,188 or more.

Table 17: Los Angeles DMC-ODS and Statewide High-Cost Members by Age, CY 2022

	Total Members Served	HCM Count	HCM % by Count	Average Approved Claims per HCM	HCM Total Claims	HCM % by Total Claims
County	23,716	2,316	9.77%	$24,308	$56,298,005	31.28%
Statewide	105,657	5,724	5.42%	$24,551	$140,532,204	21.84%

- 9.77 percent of DMC-ODS members served are considered to be high-cost, and claims made on behalf of those members account for 31.28 percent of all claims. Both the proportion of HCMs and the proportion of claims attributable to HCMs are much higher in Los Angeles than statewide.
- The DMC-ODS tracks HCMs regularly to ensure that they receive appropriate care.

ASAM Level of Care Congruence

Table 18: Los Angeles DMC-ODS Congruence of LOC Referrals with ASAM Findings, CY 2022 – Reason for Lack of Congruence

	Initial Screening		Initial Assessment		Follow-up Assessment	
ASAM LOC Referrals	#	%	#	%	#	%
Not Applicable /No Difference	10,492	68.76%	10,098	52.74%	3,783	45.89%
Patient Preference	1,714	11.23%	2,107	11.00%	886	10.75%
LOC Not Available	<11	-	0	0.00%	0	0.00%
Clinical Judgment	370	2.42%	3,631	18.96%	2,057	24.95%
Geographic Accessibility	<11	-	-	-	-	-
Family Responsibility	32	0.21%	83	0.43%	21	0.25%
Legal Issues	410	2.69%	126	0.66%	36	0.44%
Lack of Insurance/Payment	<11	-	<11	-	<11	-
Other	2,227	14.59%	3,049	15.92%	1,441	17.48%
Actual LOC Missing	0	0.00%	0	0.00%	0	0.00%
Total	15,259	100.00%	19,146	100.00%	8,243	100.00%

- The Los Angeles ASAM data had a noteworthy change from CY 2021 to CY 2022. The proportions of referrals that were congruent with ASAM findings decreased for all screening/assessment types (20 percent decrease for initial

screenings, 6 percent decrease for initial assessments, and 28 percent decrease for follow-up assessments), which also indicates an increase in referrals that lacked congruence with ASAM findings.

- The "Other" category was cited as the reason for non-congruence more in CY 2022 than CY 2021 (increase from 2.7 percent in CY 2021 to 14.59 percent in CY 2022 for initial screening, 10.4 percent to 15.92 percent for initial assessment, and 6.6 percent to 17.48 percent at follow-up assessment). Los Angeles identified that the majority of ASAMs classified as "Other" are missing a reason.

Initiation and Engagement

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

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 15th and 45th day following initial DMC-ODS service.

Table 19: Initiating and Engaging in Los Angeles DMC-ODS Services, CY 2022

	County				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Members with an initial DMC-ODS service	22,614		748		99,855		4,026	
	#	%	#	%	#	%	#	%
Members who then initiated DMC-ODS services	20,010	88%	605	81%	83,830	84%	3,286	82%
Members who then engaged in DMC-ODS services	15,099	75%	427	71%	63,753	76%	2,202	67%

- Initiation of adult members in the DMC-ODS (88 percent) exceeds the statewide rate (84 percent) and is only 1 percentage point below the statewide rate for engagement.
- The initiation rate for youth members in the DMC-ODS is 1 percentage point lower than statewide, as is the engagement rate of 71 percent, again below the statewide rate (67 percent).
- The Los Angeles adult and youth initiation and engagement rates in CY 2022 are similar to those in CY 2021.

Length of Stay

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

Table 20: Cumulative LOS in Los Angeles DMC-ODS – DMC-ODS Services, CY 2022

	County		Statewide	
Members discharged from care. (no treatment for 30+ days)	32,535		139,688	
LOS for members across the sequence of all their DMC-ODS services	Average	Median	Average	Median
	155	94	158	90
	#	%	#	%
Members with at least a 90-day LOS	17,010	52%	69,919	50%
Members with at least a 180-day LOS	10,444	32%	43,096	31%
Members with at least a 270-day LOS	6,262	19%	27,677	20%

- The average and median LOS in the DMC-ODS are similar to statewide LOS.
- From CY 2021 to CY 2022, the DMC-ODS average LOS increased by 25 percent and the median LOS increased by 4 percent.

CalOMS Data

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

Table 21: Los Angeles DMC-ODS CalOMS Legal Status at Admission, CY 2022

Admission Legal Status	County		Statewide	
	#	%	#	%
No Criminal Justice Involvement	13,395	65.05%	77,372	66.03%
Under Parole Supervision by California Department of Corrections	218	1.06%	2,152	1.84%
On Parole from any other jurisdiction	510	2.48%	1,874	1.60%
Post-release supervision - AB 109	3,940	19.13%	27,009	23.05%
Court Diversion CA Penal Code 1000	698	3.39%	1,645	1.40%
Incarcerated	91	0.44%	542	0.46%
Awaiting Trial	1,739	8.45%	6,590	5.62%
Total	**20,591**	**100.00%**	**117,184**	**100.00%**

- Similar to statewide, the majority of DMC-ODS members do not have criminal justice involvement.
- Most members with criminal justice involvement are on post-release supervision under AB 109.

Table 22: Los Angeles DMC-ODS CalOMS Discharge Status Ratings, CY 2022

Discharge Status	County		Statewide	
	#	%	#	%
Completed Treatment – Referred	4,977	26.74%	22,790	22.03%
Completed Treatment - Not Referred	2,313	12.42%	7,636	7.38%
Left Before Completion with Satisfactory Progress - Standard Questions	1,389	7.46%	13,465	13.02%
Left Before Completion with Satisfactory Progress – Administrative Questions	724	3.89%	8,322	8.05%
Subtotal	*9,403*	*50.51%*	*52,213*	*50.48%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	3,963	21.29%	17,832	17.24%
Left Before Completion with Unsatisfactory Progress - Administrative	5,183	27.84%	32,329	31.26%
Death	20	0.11%	200	0.19%
Incarceration	47	0.25%	856	0.83%
Subtotal	*9,213*	*49.49%*	*51,217*	*49.52%*
Total	**18,616**	**100.00%**	**103,430**	**100.00%**

- 50.51 percent of DMC-ODS members either completed treatment or left before completion with satisfactory progress.
- The first two discharge statuses combined indicate members who completed treatment (39.16 percent in the DMC-ODS as compared to 29.41 percent statewide). The proportion of members completing treatment was comparable to the previous year (39.2 percent).
- In sum, Los Angeles has a higher proportion of members completing treatment, and lower proportion of administrative discharges that fall into both the satisfactory and unsatisfactory category, than found statewide – generally indicating more positive clinical outcomes, a higher rate of member retention, and fewer summary exits due to client elopement.

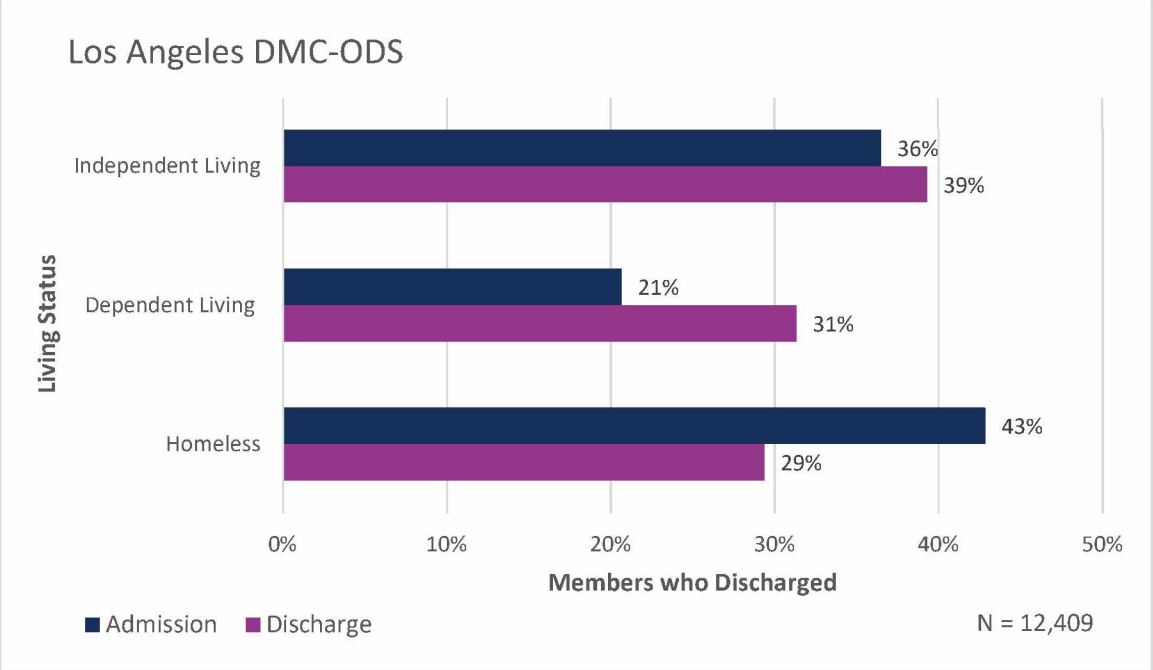
Table 23: Los Angeles DMC-ODS CalOMS Types of Discharges, CY 2022

Discharge Types	County		Statewide	
	#	%	#	%
Standard Adult Discharges	11,935	64.11%	52,677	50.93%
Administrative Adult Discharges	5,974	32.09%	41,707	40.32%
Detox Discharges	474	2.55%	7,233	6.99%
Youth Discharges	233	1.25%	1,813	1.75%
Total	**18,616**	**100.00%**	**103,430**	**100.00%**

- The proportion of discharges in Los Angeles that were standard adult discharges (64.11 percent) is 13.18 percentage points higher than the statewide proportion of standard adult discharges (50.93 percent).

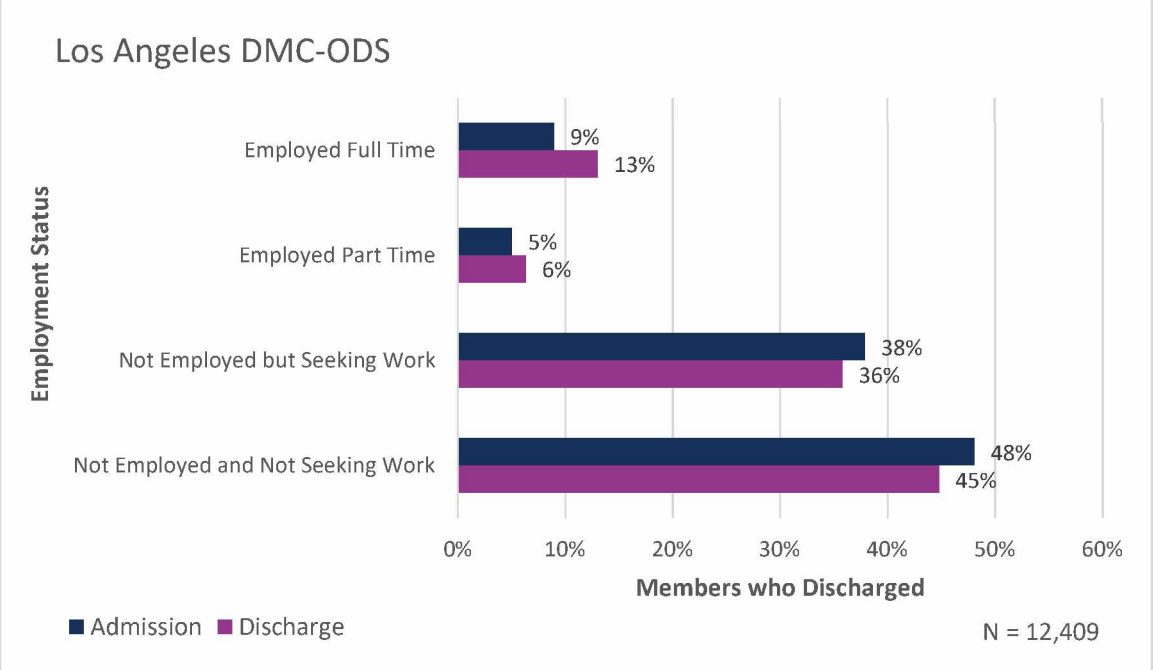
The data presented in Figures 7 and 8 reflect percent change at discharge from admission for both living status and employment status. Both questions are asked in relation to the prior 30 days.

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



- The DMC-ODs has prioritized its focus on helping members address issues they may be experiencing pertaining to housing.
- The proportion of members reporting dependent living situations increased by 10 percentage points from admission to discharge, which indicates enrollment in recovery residences. The percentage of members who reported being homeless decreased by 33 percent from admission to discharge.

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



- At discharge, more members were employed and/or seeking work (55 percent) compared to admission (52 percent).

IMPACT OF QUALITY FINDINGS

- In Los Angeles, Federally Qualified Health Centers provide most non-methadone MAT services according to DMC-ODS staff who reference a DHCS managed care plan (MCP) website and LA County Health Services information from their clinics.
- Los Angeles is working proactively to increase MAT prescribing providers within the DMC-ODS provider network using a variety of payment incentives. They also are coordinating with the Los Angeles Community Clinic Association and LA Care for those members who receive MAT through primary care providers.
- The DMC-ODS is working with LA County Medi-Cal health plans, the LA County Department of Health Services community health centers, and harm reduction syringe programs to increase identification of members with OUD and link them to treatment.
- Service improvements since the last review cycle include examples of coordinated prevention, Level 0.5 “at-risk” treatment, school-based models, and joint MH/SUD programs for youth. There was also an expansion of program sites and providers documented in all LOCs other than NTP/OTP.

- Los Angeles providers have more favorable outcomes with a higher level of members completing treatment, fewer eloping, and triggering a CalOMS administrative discharge; and discharge data indicates positive trends at discharge for housing and employment compared with status in those areas at admission.
- The DMC-ODS has expanded membership in the QI Committee with an Access Call Center representative, provider network representative, and outreach/engagement representative. They have introduced updated chart review protocols linked to new CalAIM and DHCS requirements along with reports linked to many of the quality and compliance items reviewed. Also, there were enhanced communications systems added cross-division to facilitate collaboration, information exchange, and support provider-level QI.
- A special grant was jointly developed by the MHP and DMC-ODS to serve members with co-occurring disorders. New joint services will be developed for this need and are expected to be operational in 2024.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Expanding patients treated for OUD for 180 days or more.

Date Started: 11/2022

Aim Statement: "The PIP Aim is to increase the percentage of LA DMC-ODS Medi-Cal beneficiaries getting Managed OUD (MOUD) treatment for an OUD for at least 180 days from 9.1 percent by 50 percent of the Quality Management (QM) benchmark by December 31, 2027, through education campaigns and MOUD capacity building at Medi-Cal funded sites."

Target Population: All Medi-Cal members with OUD in need of treatment in Los Angeles County 12 years and older.

Validation Information: The clinical PIP is in the planning phase.

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

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

Summary

The DMC-ODS worked with LA County Medi-Cal health plans, the LA County Department of Health Services community health centers, and harm reduction syringe services programs to increase the identification of the Medi-Cal members diagnosed with OUD and develop interventions to improve initiation and engagement to MOUD treatment. The PIP included expansion based on successful strategies to all members with OUD without access to MOUD.

The interventions include a broad training program for providers, care coordinators, and members. Also, other interventions included are expanded NTP/OTP sites and funding for prescribers with incentives at the DMC-ODS provider sites, particularly residential and outpatient. These data goals include linked measurable data goals for increased patients and visits as well as LOS in MOUD treatment.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence because of the structure of the design, use of measurable/available data, and detailed analysis of barriers to MOUD.

TA was provided during the review year in June and August related to phased design using HealthNet Medi-Cal members with intensive engagement at higher utilization sites.

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

- Because there are 76 hospital Emergency Departments (EDs) in Los Angeles County which members can access, it was recommended the DMC-ODS consider refining promising practices at high utilization sites for OUD ED events. This more intensive approach could provide more effective learning that could be generalized to other sites.
- There is a concentration of overdose events in specific areas of the county. Outreach and engagement efforts as well as addition of potential new sites should prioritize these areas.
- Consider interventions related to information exchange and placement of outreach/engagement staff at the ED sites with proportionately more SUD events for OUD. Information may be available through claims from the MCP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Enhancing Follow-up Service Rates after Emergency Department Visits with Alcohol and other SUD Disorders (FUA) among HealthNet Medi-Cal members.

Date Start: 04/2023

Aim Statement: "Within two years, enhance the follow-up rates among HealthNet Medi-Cal members by 50 percent within 7 days (from 4.1 to 8 percent) and by 50 percent within 30 days (8 percent to 12 percent) after ED visits for alcohol and other SUDs."

Target Population: All HealthNet Medi-Cal members with AUD or other SUDs.

Validation Information: The non-clinical PIP is in the planning phase.

Summary

The DMC-ODS developed a data exchange agreement with HealthNet related to those with AUD or other SUDs. Analysis of data showed a low follow-up rate for referrals after an ED event (4.1 percent).

Based on analysis and interviews with key staff at HealthNet and EDs, a number of root causes were identified related to knowledge of the system of care in LA County. Interventions were identified and PMs set to enhance the referral rate to 6.2 percent within two years. In addition, it was identified that African Americans had a lower rate of successful referrals and enhanced support was needed for their referrals to be successful.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence because of the number of EDs in LA that need the training and engagement for new approaches to referrals in order for the interventions to be successful.

TA was provided before and during the review. Numerous suggestions were made to continue to refine the PIP and enhance successful outcomes.

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

- Provide data exchange as a goal in real time as discussed so that ED and HealthNet staff can assist the members and their families while they are present in the ED.

- Consider having outreach/engagement staff available in high volume EDs to coordinate follow-up such as to support the SUD assessment and admission process.
- Field test the member education materials with relevant peers.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE DMC-ODS

The EHRs of California's DMC-ODSs are generally managed by county, DMC-ODS IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the DMC-ODS are Netsmart's Avatar and Provider ConnectNX, which have been in use for 5.7 and 0.2 years, respectively. Currently, the DMC-ODS has no plans to replace the current systems, which have been in place for more than five years and are functioning in a satisfactory manner. They are, however, aware of the behavioral health EHR landscape in California, and are open to considering a new system.

Approximately two percent of the DMC-ODS budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under DMC-ODS control. At the time of last year's review, the IS budget was 2.61 percent of the DMC-ODS budget. Staff did not report issues resulting from changes to their budget allocation, however payment reform has involved significant IT changes, training, and user engagement.

The DMC-ODS has 3,393 named users with log-on authority to the EHR, including approximately 286 county staff and 3,107 contractor staff. Support for the users is provided by 25 full-time equivalent (FTE) IS technology positions. Currently, the IS team has 11 vacancies. The team hired two staff positions and had three staff leave. The team contracted three temporary staff – two staff analysts and one assistant analyst – to help with the personnel shortage.

As of the FY 2022-23 EQR, all contract providers have the option to directly enter clinical data into the DMC-ODS' EHR. The DMC-ODS encourages use of their EHR by contract providers and pays all license and maintenance costs for all contracted staff. Some contracted providers have their own EHRs. Los Angeles works with providers who have their own EHRs to use electronic batch file transfer for required data submissions. Contractor staff that has direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 24: Los Angeles DMC-ODS Contract Provider Transmission of Information to DMC-ODS EHR

Submittal Method	Frequency	Submittal Method Percentage
HIE between DMC-ODS IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to DMC-ODS IS	☒ Daily ☒ Weekly ☒ Monthly	56%
Direct data entry into DMC-ODS IS by provider staff	☒ Daily ☒ Weekly ☒ Monthly	44%
Documents/files e-mailed or faxed to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Plan Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. Even though the DMC-ODS does not have a PHR for members, they plan to implement one for members in the next year.

Interoperability Support

The DMC-ODS is not a member or participant in an HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. Los Angeles plans to join the Los Angeles Network for Enhanced Services HIE once the DMC-ODS has developed robust consent management that protects SUD treatment and service information in compliance with federal and state regulation. The DMC-ODS engages in electronic exchange of information with its contract providers and the LA MCPs.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 25: IS Infrastructure Key Components

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

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

- The DMC-ODS contracts with their primary EHR vendor, Netsmart, to provide help desk ticket support and response 24 hours a day every day. They are satisfied with the service they receive from their vendor.
- The EHR support team is known as Sage EHR Management Division or Sage M.D. has experienced staff who actively propose technological solutions to enhance workflows. Additionally, they successfully implemented CalAIM payment reform, which required them to upgrade the Provider Connect software for both the DMC-ODS and contract provider staff. Their use of data solutions to update provider and claiming information saved the finance group many hours of data entry and validation.
- The denied claims rate exceeds the statewide denied rate.
- There are a number of EHR features that are not currently in use that could enhance care coordination and provision as well as the member experience. These features include prescribing, alerts, lab orders and results, referral management, and PHR.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

Table 27 shows the aggregated amount of denied claims by denial reason, and Table 28 shows approved claims by month, including whether the claims are either adjudicated or denied. It was requested to add the Denial Code Description with this breakdown so the reasons could be considered with the statewide comparisons. This may also indicate if the DMC-ODS has not yet submitted all its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

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

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible	20,958	$3,006,043	31.43%
Service location not eligible	18,880	$2,306,227	24.11%
Other Healthcare coverage must be billed first	92,631	$1,967,041	20.57%
Duplicate/same day service without modifier or other info needed for adjudication	15,195	$1,467,113	15.34%
Missing valid diagnosis	2,140	$442,466	4.63%
Other	288	$263,272	2.75%
Late claim submission	50	$100,399	1.05%
NPI issue	194	$11,410	0.12%
Total Denied Claims	**150,336**	**$9,563,971**	**100.00%**
Denied Claims Rate	**4.97%**		
Statewide Denied Claims Rate	**3.64%**		

- The DMC-ODS denied claims rate is higher than the statewide rate.

Table 27: Los Angeles DMC-ODS Claims by Month, CY 2022

Month	# Claim Lines	Total Approved Claims
Jan-22	172,402	$13,546,621
Feb-22	163,199	$13,402,705
Mar-22	186,737	$16,099,141
Apr-22	176,517	$15,161,372
May-22	180,325	$15,344,425
Jun-22	169,020	$14,368,508
Jul-22	172,900	$16,188,536
Aug-22	180,348	$17,074,768
Sep-22	173,946	$16,300,634
Oct-22	184,162	$16,869,949
Nov-22	174,237	$15,343,257
Dec-22	161,320	$13,233,327
Total	**2,095,113**	**$182,933,243**

- Table 27, reflecting monthly approved claims, shows consistent claims volume through the year.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The DMC-ODS has a Provider Advisory Panel with a number of workgroups that support the continued evolution of the SUD system. Two of the workgroups, Key Indicators and Business Technology, provide important input to the DMC-ODS technology initiatives and ongoing application maintenance. Along with advising the DMC-ODS about data measures, the workgroups provided critical input for the workflow development of the Provider Connect upgrade.
- Los Angeles has a robust data culture that permeates the organization. The organization uses many avenues to access information including data displays within applications, a key performance indicator module from their EHR vendor Netsmart, internally created dashboards, and a number of data marts available for internal business division reporting.
- The IS team created an application several years ago named SBAT to match members to available services and organizations with capacity for intakes. SBAT is available on the DMC-ODS website for use by members and the public. It is also available to care managers and contract providers to assist with placing members quickly and appropriately for their needs. To make sure the capacity is up to date, the IS team added a report of the last updated date for each organization and provides incentives to contract providers to keep the data current.
- The DMC-ODS cited two issues that make claiming more difficult. The first is an EHR issue. Avatar allows only one person at a time to create batches of claims. The second is the DHCS restriction of 837 claim files to 5,000 claim lines. Given the large volume of annual claims, these two issues have a large impact on workflow for the billing team.
- Sage Medical and the IS team still have a large number of staff vacancies. Their efforts to mitigate issues arising from the vacancies include contracting for technology staff and working with LA County Human Resources to overcome organizational barriers for hiring.

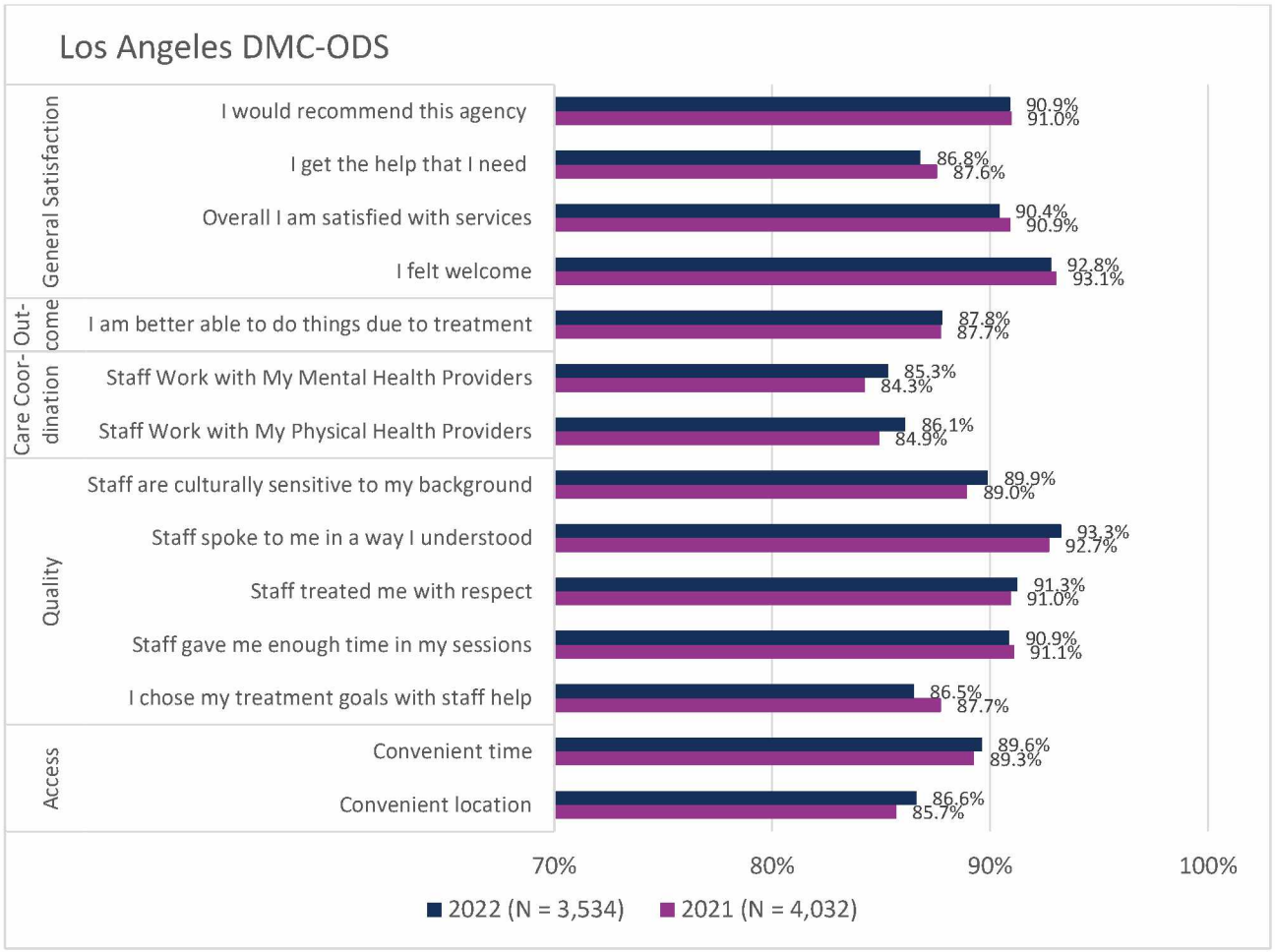
VALIDATION OF PLAN MEMBER PERCEPTIONS OF CARE

TREATMENT PERCEPTION SURVEYS

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

The DMC-ODS TPS response rate dropped 12 percent from CY 2021 to CY 2022. The Health Outcomes and Data Analytics team uses data from the TPS in a number of reports used by the Executive Team, Quality, and contract providers.

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



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

- The TPS responses are generally stable from CY 2021 to CY 2022. Several survey questions had an increase in positive responses including "Staff are culturally sensitive to my background," "Staff spoke to me in a way I understood," "Staff work with my MH providers," and "Staff work with my physical health providers."
- The remaining responses are within 1 percentage point of the response from the previous year.
- Los Angeles has a robust set of reports on TPS that include but not limited to year over year data comparison, ratings by LOC, and site-specific trends. The DMC-ODS actively utilizes TPS data to inform administration at a system level and has expanded the administration of an enhanced version of the TPS to multiple cycles a year.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested four 90-minute focus groups with DMC-ODS members and/or their family, each group containing 8 to 12 participants.

Plan Member/Family Focus Group One

CalEQRO requested a diverse group of male adult members who initiated services in the preceding 12 months. The focus group was held at an NTP/OTP with other LOCs, Behavioral Health Services, Inc. 15519 Crenshaw Blvd, Gardena, CA, and included [redacted] participants. All members participating receive clinical services from the DMC-ODS.

Members reported some difficulty with access to the program. Many had been in detention or other programs prior to entry and so were not currently using drugs, though it was reported that some members had been told they needed a drug test to come in to care by the interview staff. This purportedly resulted in these individuals leaving and using substances. Once in treatment they felt the counselors were incredibly good and supportive. There was a strong assertion from the group that family involvement and education were important. Other issues of concern related to more individual time with their counselors, access to MH services, and assistance in addressing their physical health needs.

Recommendations from focus group participants included:

- Including family education and visitation.
- Adding more time for individual sessions and fewer groups was recommended.
- Making clear the process for admission.

Plan Member/Family Focus Group Two

CalEQRO requested a diverse group of female adult members who initiated services in the preceding 12 months in a residential setting. The focus group was held at HealthRight 360, 845 E Arrow Hwy, Pomona, CA, and included [redacted] participants. All members participating receive clinical services from the DMC-ODS.

The group of [redacted] women had many concerns about the program. They reported they had extremely limited access to computers, phones, and any individual sessions to work on discharge needs including housing and requirements of Child Welfare services.

The DMC-ODS grievance form had been changed to send the form to HealthRight360 not the DMC-ODS administration. [The DMC-ODS reported they had received no grievances from this program. They were very concerned when they saw the modified grievance form and were going to immediately follow-up with the provider agency.]

Members indicated that the kitchen was running out of food for dinner. There was a group request for family education, visits, and counseling related to relationships. There were also timeliness issues with getting medications refilled and coordination with MH access. [redacted] not able to go to a Catholic church as there was only one option for worship activities.

Recommendations from focus group participants included:

- Family education and involvement is needed to have opportunities to reconcile and work with their families for support.
- Access to computers and phones as part of counseling related to discharge planning, housing, and Child Welfare requirements.
- Improved access to medical and MH needs including refills and appointments.
- Adequate food supplies and help with individual health needs.

Plan Member/Family Focus Group Three

CalEQRO requested a diverse group of male adult members who initiated services in the preceding 12 months in the new integrated programs at MLK. The focus group was held at MLK Center 1201 Wilmington Ave., Building 18, Los Angeles, CA, and included [redacted] participants. All members participating received clinical services from the DMC-ODS.

The group reported positive experiences with counselors and the facility was nice. They also requested family involvement, visits, and help with housing issues as they approached discharge. They reported some challenges with admissions, and many came from the criminal justice system. They wanted more activities and outside exercise and information in general regarding the services available at the new center. They also requested more access to MH counseling and transportation for needed outside visits such as the dentist.

Recommendations from focus group participants included:

- Provide more structured group or individual activities for members in the treatment program including opportunities for physical exercise.
- Add family education and involvement and a structured set of processes to facilitate discharge planning with access to needed technology and individual time with their counselor.
- Hire needed transportation support to ensure access to needed services in the community including dental and health.

Plan Member/Family Focus Group Four

CalEQRO requested a diverse group of adult members who initiated services in the preceding 12 months. The focus group was held at CRI-HELP, 4439, 4445, and 4455 Burns Ave., Los Angeles, CA, and included [redacted] participants. All members participating received clinical services from the DMC-ODS. The program site and group included residential WM and residential ASAM level 3.5.

The group reported relative ease of admission process, and helpful supportive counselors. Some member input related to the impacts of their care at this program include improvements such as “Better communication skills and I’m more social—I can express my emotions,” “I recognize I have an addiction and I also realize that I’ve hurt my loved ones,” “My decisions are better—I can now talk to people that before I wouldn’t have,” “I’ve always been very shy—here, the door opened because everybody has been very welcoming.”

Members reported additional efforts by the program to help them access MH and physical health needs. They also reported having more access to cell phones and computers to work on their discharge plans and get jobs. There was a concern that there was not enough access to recovery housing, and this was needed to stay in recovery. There was also a desire for more individual and family involvement. There was an interest in learning about recovery support services, which the group participants were not aware of. They were happy with MAT they were receiving.

Recommendations from focus group participants included:

- Provide more individual time with counselors.

- Add family education and especially visits and some reconciliation sessions as they get ready for discharge.
- Coordinate access for housing for those in need as part of discharge planning.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Members were generally reporting positive impacts from counseling in all the focus groups and gains for treatment. Areas of concern for members included family involvement and education, need for housing, access to MH and physical health needs. There were also requests for more access to computers and phones to do early planning for discharge for housing, jobs, and admissions to other services. Participants in two groups wanted more activities during the treatment day including exercise.

One program has some compliance and management issues that needed urgent attention and these issues were reported immediately to the program director, senior staff, and the DMC-ODS.

CONCLUSIONS

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

STRENGTHS

1. The DMC-ODS developed a 2023-2024 Strategic Plan with goals built on CalAIM principles as well as local access and treatment needs. (Quality)
2. The DMC-ODS developed and implemented a three-tier rate system for the provider network which included payment incentives linked to quality and system improvements. (Quality)
3. The DMC-ODS developed and expanded a range of services for high-need youth as part of criminal justice reform efforts. (Access)
4. The DMC-ODS expanded access and engagement efforts with a range of public media tools and websites available on a range of SUD topics and needs in multiple languages. (Access)
5. The DMC-ODS expanded services in prevention and 0.5 ASAM LOC for at-risk SUD conditions as well as adding treatment sites and new providers to address NA requirements and enhance treatment access. (Access, Timeliness)

OPPORTUNITIES FOR IMPROVEMENT

1. Most non-OTP outpatient and residential programs are not currently billing the DMC-ODS for medication services for MAT as a direct part of their services at those LOCs. (Quality, Access)
2. There is currently no DMC-ODS data capacity for monitoring no-shows for assessment services after referral from the Access Call Center or for those directly requesting services from the provider network. (Timeliness)
3. The DMC-ODS requires additional staffing resources to fully meet the needs for provider network monitoring and support for the new reimbursement system, and CalAIM requirements for developing new quality-related data and clinical documentation. (Quality)
4. There continues to be a higher level of overdose events in the central downtown area with homeless encampments. (Quality, Access)

5. There were some providers using drug testing to evaluate admission needs for specific programs. This was creating a barrier to admission and did not appear to be clinically needed. (Access)

RECOMMENDATIONS

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

1. The DMC-ODS should continue efforts to engage providers in adding MAT prescribers as a direct part of their services at those locations. (Access)
2. The DMC-ODS should work with the provider network to document and monitor no-shows for admission assessments and visits as part of the EHR or other methods. (Timeliness)
3. The DMC-ODS requires additional staffing resources to fully meet the needs for provider network monitoring and support for the new reimbursement system, and CalAIM requirements for developing new quality-related data and clinical documentation. (Quality)
4. The DMC-ODS should continue efforts to enhance MAT services in the central downtown area with high levels of homelessness and behavioral health challenges. (Quality, Access)
5. As part of the “95 Percent Campaign” to bring persons with SUD into the care system, the DMC-ODS should help providers review admission processes to eliminate potential barriers to initiation of services including drug testing. (Access)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from DMC-ODS Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions - Los Angeles DMC-ODS
Opening session – Significant changes in the past year, current initiatives, and status of previous year's recommendations, baseline data trends and comparisons, and dialogue on results of PMs
Access to Care, Timeliness of Services, and Quality of Care
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation and Analysis of the DMC-ODS Network Adequacy
Validation and Analysis of the DMC-ODS Health Information System
Validation and Analysis of Member Satisfaction
Fiscal/Billing
Quality Improvement Plan, implementation activities, and evaluation results
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
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments
MH coordination with DMC-ODS
Criminal justice coordination with DMC-ODS
Clinic managers group interview – contracted
Clinical line staff group interview – contracted
Recovery support services group interview including staff with lived experience – county and contracted
Site visits including residential treatment (perinatal and general adult), WM, access center, MAT induction center, and MLK innovative program
Key stakeholders and community-based service agencies group interview
Closing session: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rama Khalsa, PhD, Lead Reviewer
Cynthia Hudgins, Quality Reviewer
Eric McMullen, PhD, Quality Reviewer
Lorrie Sheets, IS Reviewer
Leah Hanzlicek, PhD, Data and IS Reviewer Manager
Laura Bemis, Consumer Family Member Coordinator
Katie Faires, Consumer/Family Member 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 both the pre-review and the post-review meetings and in preparing the recommendations within this report.

Los Angeles's DMC-ODS Review – Los Angeles Substance Use Prevention & Control (LASAPC) 1000 South Fremont Ave, Building A-9 East, 3rd Floor, Alhambra, CA. 91803

DMC-ODS County Sites

Los Angeles SAPC
Access Services
1000 South Fremont Ave, Building A-9 East, 3rd Floor
Alhambra, CA. 91803

DMC-ODS Contract Provider Sites

Behavioral Health Services, Inc.
15519 Crenshaw Blvd.
Gardena, CA. 90249

HealthRight 360
845 E Arrow Hwy
Pomona, CA. 91767

Martin Luther King, Jr. Behavioral Health Center
12021 Wilmington Ave, Bldg 18
Los Angeles, CA. 90059

CRI-HELP
4439, 4445, & 4455 Burns Ave
Los Angeles, CA 90029

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

Last Name	First Name	Position	County or Contracted Agency
Alesana	Fa'afouinea	Client Engagement Navigator Services (CENS) Supervisor	Los Angeles Center for Alcohol and Drug Programs
Amini	Nima	Assistant Medical Director	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Argo	Diane	Staff Analyst, Strategic Network Development Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Bane	Mandi	Senior Staff Analyst, JDTS Section Manager, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Bernstein	Karen	Director, Care Transitions	Los Angeles County (Department of Health Services)
Bui	Toa	Principal Application Developer, IT Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Centeno	Nicole	MFT, Prevention Coordinator	Pacific Clinics
Cexil	Cherene	Section Manager, Equitable Access and Promotion Section, Strategic Network Development Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Chen	Stephanie	Division Chief, Prevention Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Cherry	Dana	MH Program Manager II	Los Angeles County (Public Defender)
Corr	Casey	LMFT, Clinical Manager, Substance Use Treatment Services	Rancho San Antonio Boys Home
Cox	Jackie	MH Program Manager III, SA 6 Regional Chief	Los Angeles County (Department of MH)
Curnal III	Louis	Operations Supervisor	Tarzana Treatment Centers
Davalos	Jazmin	Youth CENS	Los Angeles Center for Alcohol and Drug Programs
Deniz	Daniel	Division Chief, Finance Services Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)

Last Name	First Name	Position	County or Contracted Agency
Fakhimi	Amita	Psy.D., OTP Clinical Supervisor	Tarzana Treatment Centers
Fernandez-Comer	Brandon	Chief Executive Officer	Cri-Help
Flaggs	Diana	Administrative Services Manager	Los Angeles County (Department of Children and Family Services)
Fowler	Keith	Division Director	Behavioral Health Services
Garg	Vinay	IT Supervisor, IT Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Gendreau	Andreea	Senior Clinical Supervisor	Tarzana Treatment Centers
Gibson	Michelle	Deputy Director	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Gonzalez	Christina	Executive Director	Principles, Inc. d.b.a. Impact Drug and Alcohol Treatment Center
Gonzalez	Baldomero “Junie”	Director of Operations	Cri-Help
Henderson Street	Marquisha	Health Program Analyst II, Strategic Network Development Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Higgins	Jonathan	Chief Compliance Officer	The Beacon House Association of San Pedro
Hindman	David	Division Chief, Sage Management Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Humphrey-Jones	Yvette	Manager, Contracts and Compliance Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Hurley	Brian	Medical Director	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Jones	Dane	Senior Supervisor of Long Beach	Tarzana Treatment Centers
Kennedy	Kyle	Section Manager, Policy and Strategic Initiatives Section, Strategic Network Development Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)

Last Name	First Name	Position	County or Contracted Agency
Kim	Tina	Division Chief, Health Outcomes and Data Analytics Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Lau	Bernie	Staff Analyst, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Lima	Yanira	Division Chief, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Manzella	Diane Catherine	Substance Abuse Counselor, Substance Abuse Service Helpline	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Medrano	Marika	Division Chief, Contracts and Compliance Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Monji	Julie	Senior Staff Analyst, Member Services Section, Strategic Network Development Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Monteilh	Gregory	Senior Probation Director	Los Angeles County (Probation)
Moore	Antonne	Division Chief, Strategic Network Development Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Morales-Sierra	Hayro	Substance Abuse Counselor, Substance Abuse Service Helpline	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Murillo	Claudia	Chief Operations and Compliance Officer	House of Hope
Negrete-Fernandez	David	Program Director	Behavioral Health Services
Palmer	Marissa	Clinical Social Work Supervisor I, SASH Supervisor	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Perez	Daisy	Fiscal Officer I, Finance Services Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Reyes	Francisco	Senior Staff Analyst, Finance Services Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)

Last Name	First Name	Position	County or Contracted Agency
Salazar	José C.	Dr.PH., Director Program Development and Contract Compliance	Tarzana Treatment Centers
Santellan	Rachel	Psychiatric Social Worker II, Clinical Services Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Schwarz	Greg	Supervising Psychologist, Sage Management Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Sharber	Monica	Program Director	Behavioral Health Services
Sifuentes	Valerie	Juvenile Justice Manager, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Singh	Jimmy	Assistant Staff Analyst, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Song	Sandy	Section Manager, Adult Services, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Sorg	Jim	Ph.D., Director of Care Integration	Tarzana Treatment Centers
Taetzsch	William	Lead Clinical Supervisor	Didi Hirsch Psychiatric Services
Ter-Barsegyan	Armen	Health Program Analyst I, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Thomas	Ronnie	Senior Staff Analyst, Health, Addiction Medicine Services – Integrated Correctional Health Services	Los Angeles County (Department of Health Services)
Todd	Cassidy	Ph.D., Clinical Supervisor of Outpatient SUD Services	Tarzana Treatment Centers
Tran	Duy	Staff Analyst, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Tsai	Gary	Bureau Director	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Tubadeza	Aris	Administrative Manager	Asian American Drug Abuse Program

Last Name	First Name	Position	County or Contracted Agency
Viana	Joseph	Staff Analyst, Systems of Care Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Villegas	Christina	Staff Analyst, Strategic Network Development Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Watt	Kathy	Executive Director	Van Ness Recovery House
Yeung	Janie	Senior Application Developer, IT Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Young	Ariel	Senior Staff Analyst, Finance Services Division	Los Angeles County (Substance Abuse Prevention and Control Bureau)
Zamani	Christy	Executive Director	Day One

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	LA DMC-ODS is systematically enhancing SUD and MOUD training, public resources for access including new MAT sites, adding a Consultation phone line for providers, providing resources for to the provider network to add MAT prescribers as well as incentives. The goal is to increase MAT servings to those with OUD.
General PIP Information	
MHP/DMC-ODS Name: Los Angeles DMC-ODS	
PIP Title: Expanding Patients treated for Opioid Use Disorder (OUD) for 180 days or more	
PIP Aim Statement: The PIP aim is to increase the percentage of LA DMC-ODS Medi-Cal beneficiaries for at least 180 days from 9.1 percent to 50 percent of the QM benchmark by December 31, 2027, through beneficiary education campaigns and MOUD capacity building at Medi-Cal funded sites.	
Date Started: 11/2022	
Date Completed: Projected date of completion - 12/2027	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ only youth (ages 12–17) * ☐ Adults only (age 18 and over) ☒ Both adults and youth *If PIP uses different age threshold for children, specify age range here: Youth 12-17	
Target population description, such as specific diagnosis (please specify): All persons of all ages with OUD in LA County with Medi-Cal.	

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training on MOUD and how to access treatment as well as benefits of that treatment.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training on MOUD and how to access treatment as well as benefits of that treatment including referral systems and other tools. Also, for prescribers' special resources for training and consultation to offer MAT. This will include primary care and hospital providers and health plan staff.
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): Set up formal exchanges of information electronically between DMC-ODS and the Medi-Cal Health Plans.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
SUD and MOUD trainings to health plan and provider sites.	2022	9.1 percent Of Healthnet data for Medi-Cal	☒ Not applicable—PIP is in planning or implementation phase, results not available	No remeasurement was available. Just starting interventions.	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 2-Expansion and monthly promotion of Prescriber and Clinician Consultation Telephone line. Measured by number of calls from provider network sites.	3rd Q 2022-23	Increase calls from DMC-ODS provider network	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 3- Increase number of NTP/OTP access points in system. Add one new access point per six months	3rd Q 2022-23	A. 18 non-NTP/OTO sites B. 39 NTP/OTP sites Target Goals One new site per six months	☒ Not applicable—PIP is in planning or implementation phase, results not available			
PM 4 Percent of patients with MOUD treated within DMC system of care. Intervention-1 Prescribing Clinician Cost-sharing program with Provider Network (Beginning 3rd quarter 22-23) for share start-up costs for MAT providers and supports. Intervention -: MOUD incentive program with awards based on the entire FY 22-23 baseline for increased MOUD visits for patients and adding prescribing into programs.	3rd Q 2022-23	More than 2 percent of patients with OUD have claim codes for services.	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 5. Enhanced member care coordination to support initiation and engagement in MOUD. Goal increase to more than 15% as needed to access MOUD.	Q 4 FY 21-22 15% of patients have care coordination with OUD	DMC clients with OUD also getting care coordination.	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year. ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: 1) Because there are 76 hospital EDs in Los Angeles County which members can access, it was recommended the DMC-ODS consider refining promising practices at high utilization sites for OUD ED events. This more intensive approach could provide more effective learning that could be generalized to other sites. 2) There is a concentration of overdose events in specific areas of the county. Outreach and engagement efforts as well as addition of potential new sites should prioritize these areas. 3) Consider interventions related to information exchange and placement of Outreach/Engagement staff at the ED sites with higher-than-average SUD events for OUD. Information may be available through claims from the MCP.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The DMC-ODS worked with HealthNet to establish a formal exchange of information for Medi-Cal members who had SUD diagnoses presenting in the EDs in Los Angeles County. They then established a PIP team with HealthNet to evaluate systems for referrals to the DMC-ODS treatment programs based on clinical needs. Training and other interventions were proposed to enhance referrals to treatment.
General PIP Information	
MHP/DMC-ODS Name: Los Angeles	
PIP Title: Enhancing Follow-up Service Rates after Emergency Department Visits with Alcohol and other SUD Disorders (FUA) among HealthNet Medi-Cal members	
PIP Aim Statement: Within two years, enhance the follow-up rates among HealthNet Medi-Cal members by 50 percent within 7 days (from 4.1 to 8 percent) and by 50 percent within 30 days (8 percent to 12 percent) after ED visits for alcohol and other SUDs.	
Date Started: 04/2023	
Date Completed: Projected date of completion - 04/2025	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17) * ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here: Youth over 12 years of age	
Target population description, such as specific diagnosis (please specify): All members with Medi-Cal starting with Healthnet members from LA County are the target population to be served. They will have visited an ED for needed treatments.	

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Members will have access to additional education, training, and assistance getting into treatment for their SUD both during and after their ED event.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providers, care coordinators, and MCP staff will have education and training on SUD treatments available and their benefits, be provided system tools to support the referral and engagement process. Data supports and exchanges will also be provided.
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): New data exchange systems and staff supports will be provided to key staff, patients, and families as part of increasing treatment access.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Completion rates of HealthNet staff in services training- goal80% of quality and care coordination staff	TBD	Sample size: 85/2059	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 2. Improvement in FUA rates for SUD services within 7 days of ED event	Q1-Q2 7/22-12/22	Sample size: 85/2059 4.1 %	☒ Not applicable—PIP is in planning or implementation phase, results not available	TBD	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM3 Improvement in FUA rates for SUD services within 30 days of ED event. Goal 12 %	Q 1-Q2 7/22-12/22	8% 165/2059	☒ Not applicable—PIP is in planning or implementation phase, results not available	TBD		

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM4 Improvement in FUA rates for SUD services within 7 days of ED event for African American members. Goal 5 %	Q 1-Q2 7/22-12/22	2.5% 12/481	☒ Not applicable—PIP is in planning or implementation phase, results not available	TBD		
PM 5 Improvement in FUA rates for SUD services within 30 days of ED event for African American members. Goal 8.5%.	Q 1-Q2 7/22-12/22	4.6% 22/481	☒ Not applicable—PIP is in planning or implementation phase, results not available	TBD		

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP: 1. Provide data exchange as a goal in real time as discussed so that ED and HealthNet staff can assist the member and family while they are present in the ED; 2. Consider Outreach/engagement staff to be available in high volume EDs to coordinate follow-up supports such as needed to support the SUD assessment and admission process. 3. Field test the Member education materials with relevant peers.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM DMC-ODS DIRECTOR

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