



Behavioral Health Concepts, Inc.
info@bhcegro.com
www.calegro.com
855-385-3776

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

ORANGE 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, “Orange” may be used to identify the Orange County DMC-ODS program.

DMC-ODS INFORMATION

Review Type — Virtual

Date of Review — September 19-21, 2023

DMC-ODS Size — Large

DMC-ODS Region — Southern

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	8	8	0	0
Information Systems (IS)	6	4	2	0
TOTAL	24	22	2	0

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Increase services and individual counseling for Outpatient Members to Improve Satisfactory Progress	Clinical	09/2023	Submitted for approval	Moderate
Increasing Linkage to Lower Residential lower level of care following Withdrawal Management Residential Detox Discharge	Non-Clinical	09/2023	Submitted for approval	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐ Youth ☐ Residential ☐ Outpatient ☐ MAT/NTP ☒ Perinatal ☐ Other	2*
2	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP ☐ Perinatal ☐ Other	9
3	☒ Youth ☐ Residential ☐ Outpatient ☐ MAT/NTP ☐ Perinatal ☐ Other	6
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

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

- The DMC-ODS completed a reorganization of its administration and resources resulting in the implementation of a new Substance Use Disorder (SUD) Division dedicating leadership and subject matter expertise to SUD treatment.
- The DMC-ODS continues to provide multiple entryways into treatment. The “No Wrong Door” initiative is well established with all assessment staff trained in both Mental Health (MH) and SUD assessments. All treatment programs are capable of treating some co-occurring disorders.
- Medication Assisted Treatment (MAT) services are easily accessible through the DMC-ODS. All SUD treatment programs accept members utilizing MAT, all recovery residences are required to accept members utilizing MAT, four NTP sites provide MAT to adolescents, and the jails provide MAT and will allow inmates that come in on methadone to continue.

- The development of data dashboards and the examples of CalOMS data review is at a useful development stage as the DMC-ODS moves towards interoperability opportunities.
- The Behavioral Health Equity Committee (BHEC) is an excellent example of the DMC-ODS' community collaboration efforts. The BHEC public meetings are designed for brainstorming and discussion of current cultural issues related to behavioral health. Attendees break out into tables of small groups enabling meaningful bi-directional communication.

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

- The no-show rate for the DMC-ODS members' first appointment is 51.95 percent. Although this is a slight improvement from the previous year (54.48 percent), over fifty percent of members do not attend their initial appointment.
- Although a new quarterly meeting with contract provider QI coordinators has been launched, providers continue to express frustration with the DMC-ODS in relation to their partnership and communication. Contract providers stated, and review of meeting agendas and minutes confirm the meetings are driven by the needs of the DMC-ODS and they do not experience meaningful bi-directional communication.
- Despite the successful MAT expansion activities, non-methadone MAT utilization is extremely low. In CY 2022, the percentage of members receiving three or more MAT services was 0.63 percent while the statewide average was 3.66 percent indicating a disconnect between access and utilization.
- The DMC-ODS, along with many other counties, revised their existing MHP cultural competence plan to meet the requirements for the DMC-ODS Waiver. The current version the DMC-ODS continues to use is outdated and does not support cultural competence information and activities for SUD as effectually as the MHP.
- IS teams within the Orange Health Care Agency (HCA) are under-staffed due to increased workloads of ongoing development and support, combined with the changes required by CalAIM and SmartCare. The vacant staff positions are critical for effective and timely assessment of system capacity, timeliness, and performance measures used in making data-informed decisions.

FY 2023-24 CalEQRO recommendations for improvement include:

- The DMC-ODS should take active steps to address the no-show rates. A comprehensive analysis should be conducted which should include feedback from contracted program staff as well as the DMC-ODS operated programs. The new SUD Division could benefit by prioritizing effective information gathering on no-show rates from all program line staff and supervisors.

(This is a continuation of a similar Recommendation from the previous two EQRs.)

- The DMC-ODS should consider creating a meeting for contract provider clinicians and line staff inviting them to propose ideas for improvement, provide insight into what staff are experiencing, and share success stories.
- The DMC-ODS should take steps to address the extremely low MAT utilization in the County. The DMC-ODS could benefit from enhancing relationships with NTPs to allow for meaningful discussions and problem solving regarding non-methadone MAT utilization.
- DMC-ODS should utilize the new SUD division to work in partnership with QI and the BHEC to develop a revised cultural competence plan specific to SUD.

(This is a continuation of a similar recommendation since FY 2021-22.)

- Additional IS staff positions for the Orange County HCA are needed for ongoing support and development within the DMC-ODS system of care. The DMC-ODS HCA would benefit from enhanced support from County HR for the successful recruitment of vacant data analytics positions.

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 substance use disorder (SUD) treatment services to Medi-Cal Plan members under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal DMC-ODS. DHCS contracts with Behavioral Health Concepts, Inc., (BHC) the CalEQRO to review and evaluate the care provided to the Medi-Cal Plan members.

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

This report presents the FY 2023-24 findings of the EQR for Orange DMC-ODS by BHC, conducted as a virtual review on September 19-21, 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 American Society of Addiction Medicine (ASAM) level of care (LOC) data.

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (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) – a summary of the validation tool is included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii).
- Validation and analysis of each DMC-ODS' NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the DMC-ODS and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county DMC-ODS' reporting systems and methodologies for calculating PMs, and whether the DMC-ODS and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of Plan members' perception of the DMC-ODS' service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and family members.
- Summary of DMC-ODS strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

The DMC-ODS continues to experience high staff vacancy rates which have yet to return to pre-pandemic levels. The lack of sufficient staff impacts general operations from administration to treatment programs. Focus group attendees reported their counselors were so busy sometimes they were not available to meet with them.

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 department's administrative reorganization is fully implemented which includes the creation of a new SUD division positioned to oversee the SUD continuum of care.
- The DMC-ODS is contracting with a community-based organization (CBO), Mind OC, for the reopening of the Be Well Campus and operation of SUD services, including residential treatment. The DMC-ODS is also working on a new Be Well campus to be located in Irvine.
- CalAIM expectations are beginning to have a positive impact on programs. Although there is still confusion and more training to be conducted, the providers indicated the changes in documentation are helpful.
- The DMC-ODS has entered into an agreement with a community partner, Mind OC, for the operation of Mental Health and SUD programs at the Be Well campus in Orange County which will include residential SUD treatment.

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: The DMC-ODS should continue to conduct analyses of no-shows to first sessions, determine commonalities and root causes, and adjust existing interventions to lower the rate by increasing prospective members' initial connection to treatment. (This is a continuation of a similar Recommendation from the previous EQR)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The DMC-ODS noted that data analysis was conducted, and some interventions have been implemented; however, there is no indication of a comprehensive evaluation of root causes, limiting the additional interventions that could enhance success.
- The DMC-ODS has yet to dedicate resources to conduct an in-depth analysis of the causes of no-shows and develop a comprehensive improvement process to fully address the continuing high no-show rates.

Recommendation 2: The DMC-ODS should take active steps to rebuild residential treatment bed capacity, prioritize making efficient and welcoming assessment and admission processes into residential treatment, and ensure that discharges from residential WM are followed by rapid connection to appropriate treatment. (Access, Timeliness, Quality, IS). (This is a continuation and expansion of a similar Recommendation from the previous EQR)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The DMC-ODS continues to work toward increasing residential beds through reaching out to potential providers individually and through a process of continuous Requests for Applications (RFAs).
- The Access to Residential Treatment (ART) team procedures have been revised and streamlined which has significantly reduced wait times for assessments. The DMC-ODS has added recovery residence beds that are available for members discharging from withdrawal management (WM) and requesting residential treatment when no beds are available. Members are admitted to outpatient treatment in addition to a recovery residence so they can continue treatment until a residential treatment bed becomes available which is monitored by the ART team.

Recommendation 3: The DMC-ODS should prioritize its planned reorganization that includes a dedicated SUD division and use this administrative change to improve its collaborative partnership with SUD providers. The new SUD Division Director should take meaningful steps to improve partnerships with providers by clarifying the rationale for new policies and procedures, actively soliciting provider input on their implementation, and ensuring feedback and follow through on that input with a bi-directional emphasis. The SUD Director should also initiate dialogues with providers regarding changing provider costs, implications for rate setting, and support regarding staff recruitment efforts. (This is a continuation of a similar Recommendation from the previous EQR, with an added emphasis on the potential contribution of high-level leadership.)

☒ Addressed

☐ Partially Addressed

☐ Not Addressed

- An Interim Deputy Director for SUD has been appointed and a new SUD Division has been created to oversee the SUD continuum of care including prevention.
- The new SUD Division participated in a retreat to kick-start team building, identify processes that are effective or need revision, and create opportunities for growth.
- The new SUD team is beginning site visits and in-person meetings with contracted providers to build effective working relationships.
- The DMC-ODS has implemented a quarterly meeting with contracted providers with the goal of bi-directional communication.

Recommendation 4: The DMC-ODS should review CalAIM for opportunities to streamline some of their QI/QA policies and procedures, especially those pertaining to documentation and Medi Cal claiming. They should engage providers in a collaborative effort to identify opportunities for streamlining QI/QA procedures and implement them.

☒ Addressed

☐ Partially Addressed

☐ Not Addressed

- The Quality Management Services (QMS) SUD Support Team (SST) focus has shifted from a compliance-oriented approach to a more technical assistance process based on the new CalAIM requirements.

- County and provider QA staff attend monthly QI/QA meetings to discuss documentation requirements and facilitate bi-directional communication and collaboration. The new SUD division has created more opportunities for strengthening contracted provider partnerships with the DMC-ODS.
- The EHR rules have been updated to align claiming for the new CalAIM documentation requirements. Progress notes were streamlined to be less structured and include only the required items. A new DMC-ODS documentation manual and CPT guide reflecting CalAIM changes has been distributed to all providers. Several trainings on the changes have been provided.

Recommendation 5: The DMC-ODS should refine and expand its provider training focused upon CalOMS discharge ratings within a member-centered care framework, expand and broadcast their reporting of member outcomes to include using CalOMS pre-post data, and analyze outcome ratings at the provider level to identify opportunities for treatment quality improvement. (Quality, IS). (This is a continuation of a similar Recommendation from the previous EQR).

☒ Addressed

☐ Partially Addressed

☐ Not Addressed

- Trainings on CalOMS have been developed and provided to program staff. The training includes a focus on how to determine the most appropriate CalOMS discharge status. As an example of a more member-centered approach, harm reduction was put forward as a methodology to consider when making a discharge determination. An online training was also developed to provide more thorough guidance on the new CalOMS requirements.
- The DMC-ODS conducted an in-depth analysis on member discharge outcomes. Length of stay in treatment, drug of choice on admission, and level of care were factors included in the analysis. Dashboards were and continue to be developed allowing for interaction by the user to query the data for a specific data point.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE DMC-ODS

SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS. Regardless of payment source, approximately 34 percent of services were delivered by county-operated/staffed clinics and sites, and 66 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 41.6 percent of services provided were claimed to Medi-Cal although the DMC-ODS notes their practice of disallowing services based on the current claiming process requirements to prevent recoupment from State audits.

The DMC-ODS has a toll-free Access Line (AL) available to plan members 24-hours, 7-days per week that is operated by contract provider staff; members may request services through the AL as well as through all SUD treatment sites and county-operated MH clinics. The DMC-ODS operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. When a member contacts the AL, a brief assessment is conducted to determine the appropriate type of service and level of care. The AL staff will schedule an appointment with a provider for a full ASAM assessment and determination on level of care admission.

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 406 adults, 29 youth members, and 18 older adults across five county operated sites and nine contractor-operated sites. Among those served, 11 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 December 2022, DHCS issued its FY 2022-23 NA Findings Report for all DMC-ODS' 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 Orange County, the time and distance requirements are 15 miles and 30 minutes for outpatient SUD services, and 15 miles and 30 minutes for NTP and Opioid Treatment Program (OTP) services. These services are further measured in relation to two age groups – youth (12-17) and adults (18 and over).

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

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

- The DHCS required a corrective action plan (CAP) for the 2021 DMC-ODS NACT. Due to an error on the original NACT submission, the time and distance standards for youth outpatient and youth OTP did not meet requirements. The mistakes were corrected, and a letter of explanation was submitted to DHCS. The DMC-ODS received a CAP resolution letter dated June 24, 2022. The FY 2022-23 NACT submission date has been extended to November 2023.

Table 1B: Orange 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
Contracting status:	☒ The DMC-ODS is in the process of establishing contracts with OON providers ☐ The DMC-ODS does not have plans to establish contracts with OON providers
Contracting efforts and barriers cited by DMC-ODS	The DMC-ODS established single-case agreements with a provider in Los Angeles for treatment for monolingual Spanish speakers. Further requests to the provider have been made with the goal to establish a future contract.
OON Access for Plan Members	
The DMC-ODS ensures OON access for Members in the following manner:	☒ The DMC-ODS has existing contracts with OON providers ☒ Other: Use of single-case agreements to ensure residential treatment is available to monolingual Spanish speaker members.

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The Language Line is embedded in all access points to services and SUD information in several languages is located on the DMC-ODS website. All staff are trained on use of the Language Line, and bilingual staff are employed on treatment sites, however, not currently in all programs. The DMC-ODS continues recruiting efforts to increase bilingual staffing.
- Despite these options, focus group participants indicated several concerns with the Language Line including dropped calls and lack of staff expertise when attempting to utilize the service. Input provided to CalEQRO from focus groups also indicated staff are committed to helping those with language barriers by calling staff from other programs to assist when possible, and using smart phone translation apps.
- The penetration rate for the Asian/Pacific Islander population is 0.10 percent, which is lower than all other racial/ethnic groups and the state average indicating minimal participation in SUD services from this population.
- The Cultural Competence Plan is an older MHP version with SUD added to the document and is not designed to capture all SUD specific cultural concerns.

ACCESS PERFORMANCE MEASURES

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

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

The Statewide PR is 0.95 percent, with an average approved claim amount of \$5,998. Using PR as an indicator of access for the PR for the DMC-ODS increased from the prior year to 0.75 percent, remaining below the large county and statewide PRs, indicating some challenges to accessing services as compared to statewide.

The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SUD 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: Orange 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	116,155	205	0.18%	0.29%	0.25%
Ages 18-64	539,492	5,195	0.96%	1.29%	1.19%
Ages 65+	114,794	342	0.30%	0.56%	0.49%
Total	770,441	5,742	0.75%	1.04%	0.95%

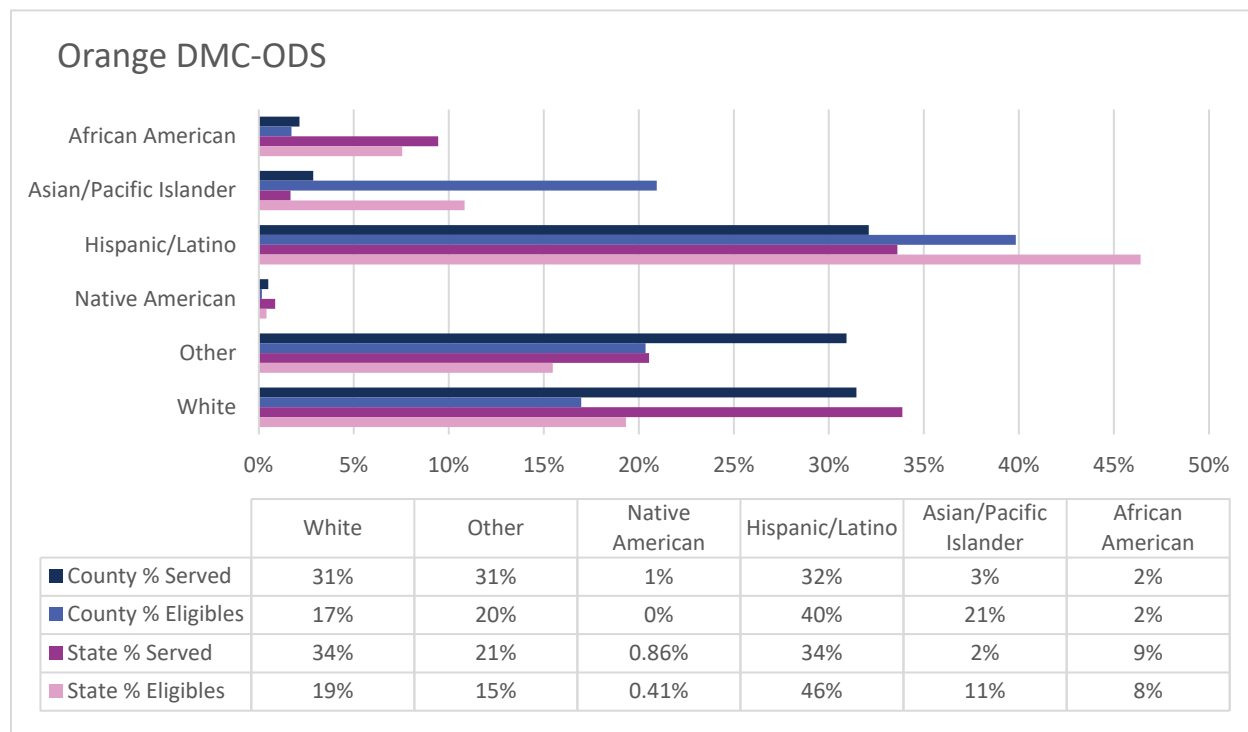
- The DMC-ODS primarily served adults between the ages of 18-64, with a PR of 0.96 percent within that age group. PRs for all age groups are below the corresponding PRs of large counties and statewide.

Table 4: Orange 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	13,264	123	0.93%	1.29%	1.19%
Asian/Pacific Islander	161,379	165	0.10%	0.15%	0.15%
Hispanic/Latino	306,901	1,843	0.60%	0.74%	0.69%
Native American	1,307	29	2.22%	2.34%	2.01%
Other	156,809	1,776	1.13%	1.34%	1.26%
White	130,781	1,806	1.38%	1.89%	1.67%
Total	770,441	5,742	0.75%	1.04%	0.95%

- The PRs for all racial/ethnic groups increased across the state since the FY 2022-23 review. The DMC-ODS PRs remain below statewide averages for all racial/ethnic groups except the Native American group.
- The Asian/Pacific Islander population has the lowest penetration rate at 0.10 percent.

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



Eligibles and Members Served by Race/Ethnicity, CY 2022

- The largest gaps between percentages of eligibles and members accessing services are seen in the Hispanic/Latino and Asian/Pacific Islander racial/ethnic groups, both of which are proportionally underrepresented in the system, and represent 40 and 21 percent respectively in the eligible population. Conversely, the White and the Other categories are proportionally overrepresented.

Table 5: Orange 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
ACA	355,641	4,105	1.15%	1.53%	1.42%
Disabled	49,547	451	0.91%	1.51%	1.37%
Family Adult	141,163	1,044	0.74%	1.03%	0.94%
Foster Care	1,030	25	2.43%	2.08%	1.84%
MCHIP	55,827	85	0.15%	0.20%	0.18%
Other Adult	100,213	61	0.06%	0.10%	0.09%
Other Child	68,387	138	0.20%	0.32%	0.27%

Note: Eligibles may be in more than one aid code category during a year.

- The primary eligibility categories for members served in the DMC-ODS are Foster Care, ACA, and Disabled.
- The youth eligibility categories have notably smaller numbers of members served compared to adult categories, and all categories are below statewide PRs except Foster Care which exceeds the statewide rate.

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

Eligibility Categories	County AACM	County Size Group AACM	Statewide AACM
ACA	\$3,992	\$5,742	\$6,216
Disabled	\$3,771	\$5,393	\$5,707
Family Adult	\$3,604	\$5,180	\$5,296
Foster Care	\$2,739	\$2,578	\$2,716
MCHIP	\$1,443	\$3,692	\$3,594
Other Adult	\$1,411	\$3,880	\$4,075
Other Child	\$1,708	\$3,427	\$3,194
Total	\$3,894	\$5,607	\$5,998

- The average approved claims are lower than the large county and statewide averages in all eligibility categories.

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

County			Statewide	
Service Categories	#	%	#	%
Ambulatory Withdrawal Mgmt	0	0.00%	56	0.04%
Intensive Outpatient	1,072	13.43%	14,422	9.58%
Narcotic Treatment Program	2,032	25.45%	37,134	24.67%
Non-Methadone MAT	58	0.73%	7,782	5.17%
Outpatient Treatment	2,501	31.32%	46,441	30.85%
Partial Hospitalization	0	0.00%	13	0.01%
Recovery Support Services	344	4.31%	6,400	4.25%
Res. Withdrawal Mgmt	1,050	13.15%	10,429	6.93%
Residential Treatment	928	11.62%	27,841	18.50%
Total	7,985	100.00%	150,518	100.00%

- The majority of members receiving services were enrolled in outpatient services (31.32 percent). This reflects a higher outpatient service utilization rate than the statewide rate (30.85 percent).
- While WM exceeds the statewide service utilization rates (13.5 percent compared to 6.93 percent) residential treatment is well below statewide at 11.62 percent compared to 18.50 percent.
- NTP service levels remained consistent with the prior EQR and were the next most accessed modality at 25.45 percent (compared to 24.67 percent statewide), followed by Intensive Outpatient at 13.43 percent (compared to 9.58 percent statewide).

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

Service Categories	County AACM	County Size Group AACM	Statewide AACM
Ambulatory Withdrawal Mgmt	\$0	\$234	\$484
Intensive Outpatient	\$522	\$1,207	\$1,729
Narcotic Treatment Program	\$3,917	\$4,279	\$4,526
Non-Methadone MAT	\$975	\$1,601	\$1,660
Outpatient Treatment	\$886	\$2,304	\$2,547
Partial Hospitalization	\$0	\$2,802	\$2,802
Recovery Support Services	\$1,120	\$1,660	\$1,669
Res. Withdrawal Mgmt	\$1,714	\$2,278	\$2,392
Residential Treatment	\$10,114	\$10,379	\$10,178
Total	\$3,894	\$5,607	\$5,998

- The AACMs by service category for the DMC-ODS are all lower than the large county and statewide averages.
- The AACMs increased for residential treatment, non-methadone MAT, and NTP compared to the previous year.

IMPACT OF ACCESS FINDINGS

- Other than the foster care PR, which is higher than the statewide average, the PRs continue to be low in all service categories, indicating most populations are underserved.
- There appears to be lack of understanding or sufficient training of providers on the use of the Language Line and translation services which leaves them with an inability to triage options, should alternative communication paths for member access be needed. A more current analysis of demographic needs and demand for service will benefit the DMC-ODS when the cultural competence plan is revised.
- Residential treatment utilization is significantly lower than Statewide and WM is significantly higher than Statewide. With limited access to residential treatment, the high WM utilization rate could indicate the wait times for residential services is impacting members in need of those services resulting in overutilization of WM and/or member relapse leading to readmission.

TIMELINESS OF CARE

The amount of time it takes for Plan members to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful in 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	Withdrawal Management Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- According to input from system providers, the continued residential treatment bed shortage in the DMC-ODS left members discharging from WM being placed on a

waiting list for residential admission, resulting in relapses while they waited for an open bed.

- The DMC-ODS has expanded the number of recovery residence beds in an effort to decrease the WM readmission rates. Members can access the recovery residence services upon discharge from WM and will also be enrolled in outpatient treatment until a residential treatment bed is available.
- The DMC-ODS is limiting the definition of urgent services to members requesting ASAM level 3.2, resulting in many circumstances that could be considered clinically urgent that are not defined as such for access staff. Expanding the definition could provide quicker access to services for members in need of urgent services. Revising the urgent services definition was identified in the FY 2022-23 EQR report.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, DMC-ODS' complete and submit the Assessment of Timely Access 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 Assessment of Timely Access (ATA), representing access to care during the 9-month period of July 2022 through March 2023 (the first three quarters 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.

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

Orange DMC-ODS-Reported Data

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

Timeliness Measure	Average/Rate	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	3.4 Business Days	10 Business Days*	97.23%
First Non-Urgent Service Rendered	4.0 Business Days	10 Business Days**	85.71%
Non-Urgent MAT Request to First Offered NTP/OTP Appointment	0.1 Business Days	3 Business Days*	99.91%
Urgent Services Offered	7.2 Hours	2 Calendar Days**	99.06%
Follow-up Services Post-Residential Treatment	14.9 Days	7 Days	22.33%
WM Readmission Rates Within 30 Days	5.58%	n/a	n/a
No-Shows	51.95%	n/a	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033			
** DMC-ODS-defined timeliness standards			
For the FY 2023-24 EQR, the DMC-ODS reported its performance for the following time period: July 2022 through March 2023			

- No-show rates decreased slightly from 54.48 percent noted in the FY 2022-23 review to 51.95 percent.
- The DMC-ODS reported a 22.33 percent rate of meeting the follow-up to residential services timeliness standard of an outpatient service within seven days of discharge.

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

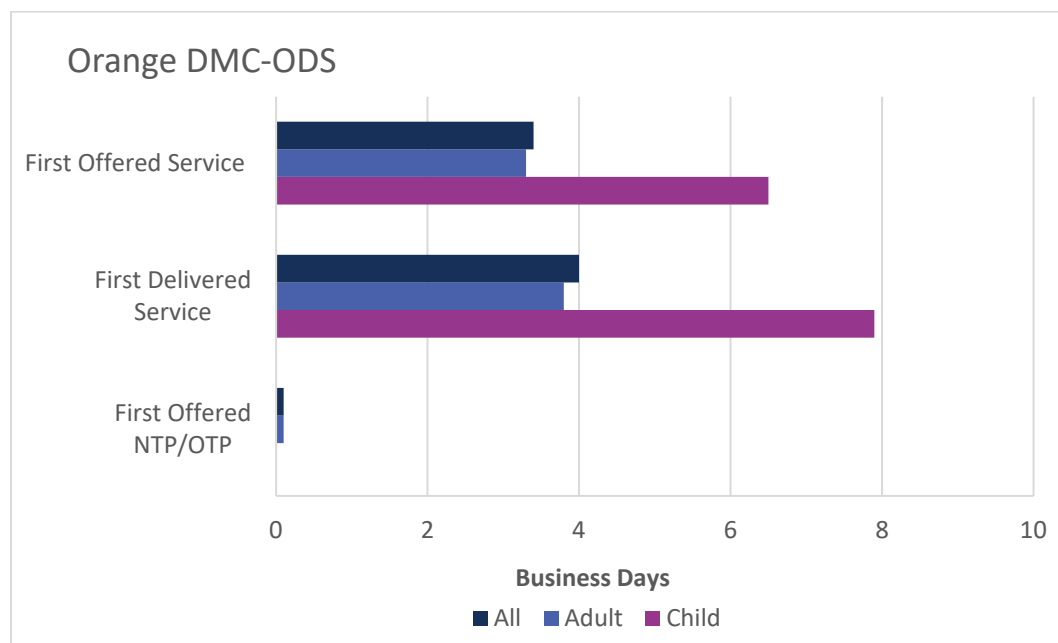


Figure 3: Wait Times for Urgent Services

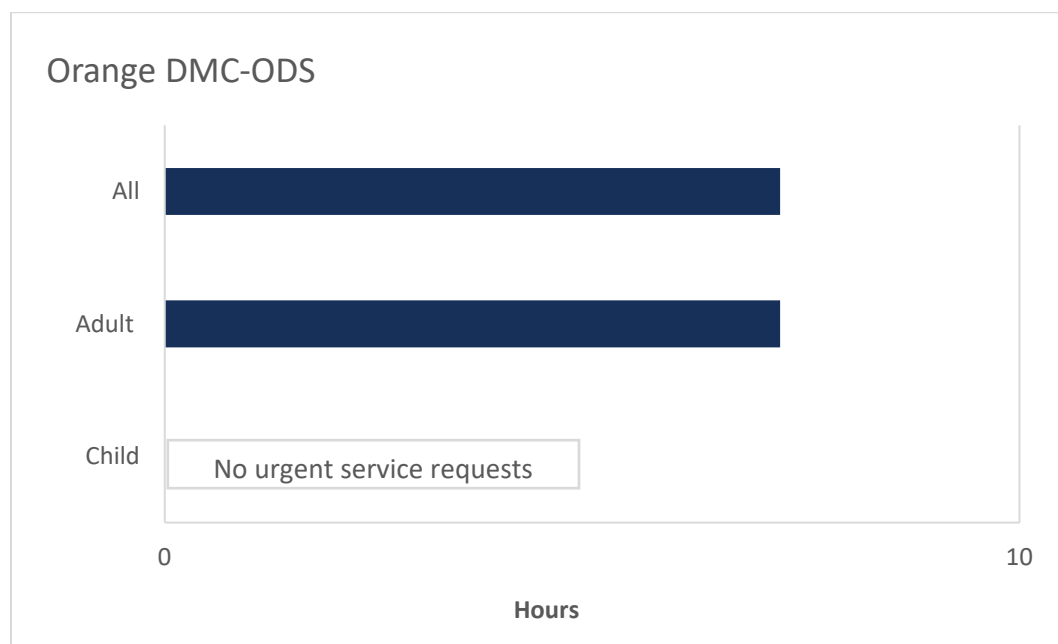
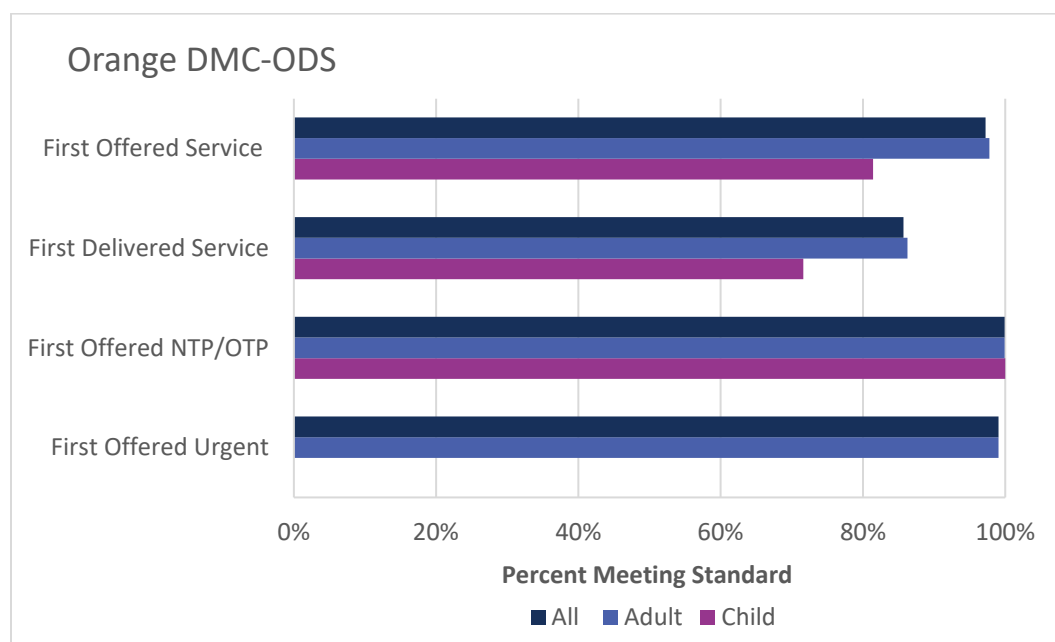


Figure 4: Percent of Services that Met Timeliness Standards



- Timeliness standards for the first offered and first delivered services for children were not met as efficiently as the services for adults, indicating possible access issues for this population.

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: Orange DMC-ODS Days to First Dose of Methadone by Age, CY 2022

County				Statewide		
Age Groups	Members	%	Avg. Days	Members	%	Avg. Days
12 to 17	0	0.00%	N/A	15	0.04%	12.60
18 to 64	1,783	89.06%	3.28	31,839	87.46%	3.59
65+	219	10.94%	1.31	4,551	12.50%	0.56
Total	2,002	100.00%	3.07	36,405	100%	3.19

- On average, members in the DMC-ODS receive their first dose of methadone in 3.07 days, now lower than the statewide average of 3.19 days. The DMC-ODS average improved substantially from the prior year's average of 5.82 days.

Transitions in Care

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

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

	N = 865		Statewide N = 27,232	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	108	12.49%	3,243	11.91%
Within 14 Days	182	21.04%	4,515	16.58%
Within 30 Days	235	27.17%	5,706	20.95%

- The DMC-ODS discharged 865 members from residential treatment. Of those, 27.17 percent had a follow-up service within 30 days, which was higher than the statewide rate of 20.95 percent.
- Timely transitions to follow-up service within seven days improved from 5.74 percent in CY 2021 to 12.49 percent in CY 2022, and now exceeds the statewide average.

Residential Withdrawal Management Readmissions

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

County			Statewide	
Total DMC-ODS admissions into WM	1,371		13,062	
	#	%	#	%
WM readmissions within 30 days of discharge	163	11.89%	1,148	8.79%

- The DMC-ODS had 1,371 admissions into residential WM in CY 2022. The readmission rate in the DMC-ODS was higher (11.89 percent) than the statewide readmission rate (8.79 percent).

IMPACT OF FINDINGS

- The DMC-ODS met the timeliness standard for first offered urgent service almost 100 percent (99.06 percent) of the time, indicating resources are in place to effectively meet the needs of members meeting the existing, though narrow, definition of urgent services. However, expanding the definition could provide

quicker access to services for members in need of urgent services they currently cannot access in a timely manner. The suggestion of revising the urgent services definition was noted in the FY 2022-23 EQR report.

- The timeliness standard for first delivered service was met at a noticeably lower rate for children than adults which may indicate access difficulties for that population.

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-ODS' 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 Orange County Behavioral Health Services Department, the responsibility for QI and QA is shared within the same QMS service area. The SUD support team within QMS has the primary role for QI and QA for the DMC-ODS and works conjointly with the SUD Division and program staff who are responsible for monitoring the contract providers' performances. Multiple other QMS teams contribute to the QI activities of the DMC-ODS, including the Data Analytics Team (DAT), Integrated Records Information System (IRIS) team which supports the EHR, the Managed Care Support Team, and Office Coordination/Billing. There is also a core QI Coordinators group with representation from every DMC-ODS program in the network. The QI Coordinators are responsible for implementing QI activities and QA requirements within their own programs.

The DMC-ODS monitors its quality processes through a behavioral health Community Quality Improvement Committee (CQIC) and a SUD Quality Improvement Coordinators (SUD QIC) Group, the QAPI workplan, and the annual evaluation of the QAPI workplan. The CQIC oversees both MHP and SUD quality management issues, meets quarterly, and met three times since the last EQR. Its membership includes plan members and family members, providers, and county staff and management. In addition to the CQIC, the SUD QIC meets monthly except for December and met eight times since the last EQR. The SUD QIC is comprised of 158 members, most of whom are Quality Improvement Coordinators from each of the DMC-ODS programs. Over 50 members attend each meeting.

The QAPI program results included both MHP and DMC-ODS goals divided into six domains: accessibility, beneficiary satisfaction, pips, safety of services/clinical care, utilization management, and quality assurance. In total there were 37 goals pertaining to SUD for FY 2022-23 of which eight focused on Accessibility, two focused on Beneficiary Satisfaction, two focused on PIPs, five focused on safety of services/clinical care, seven focused on utilization management, and 13 focused on quality assurance. At the time of

this review, the DMC-ODS had not finalized the evaluation of results of its FY 2022-23 workplan.

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	Met
3D	Evidence of an ASAM Continuum of Care	Met
3E	MAT Services (both NTP and non-NTP) Exist to Enhance Wellness and Recovery	Met
3F	ASAM Training and Fidelity to Core Principles is Evident in Programs within the Continuum of Care	Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Met
3H	Utilizes Information from the Treatment Perception Survey to Improve Care	Met

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

- The DMC-ODS has many access points for MAT and all SUD providers support the use of MAT by members participating in their treatment programs.

QUALITY PERFORMANCE MEASURES

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

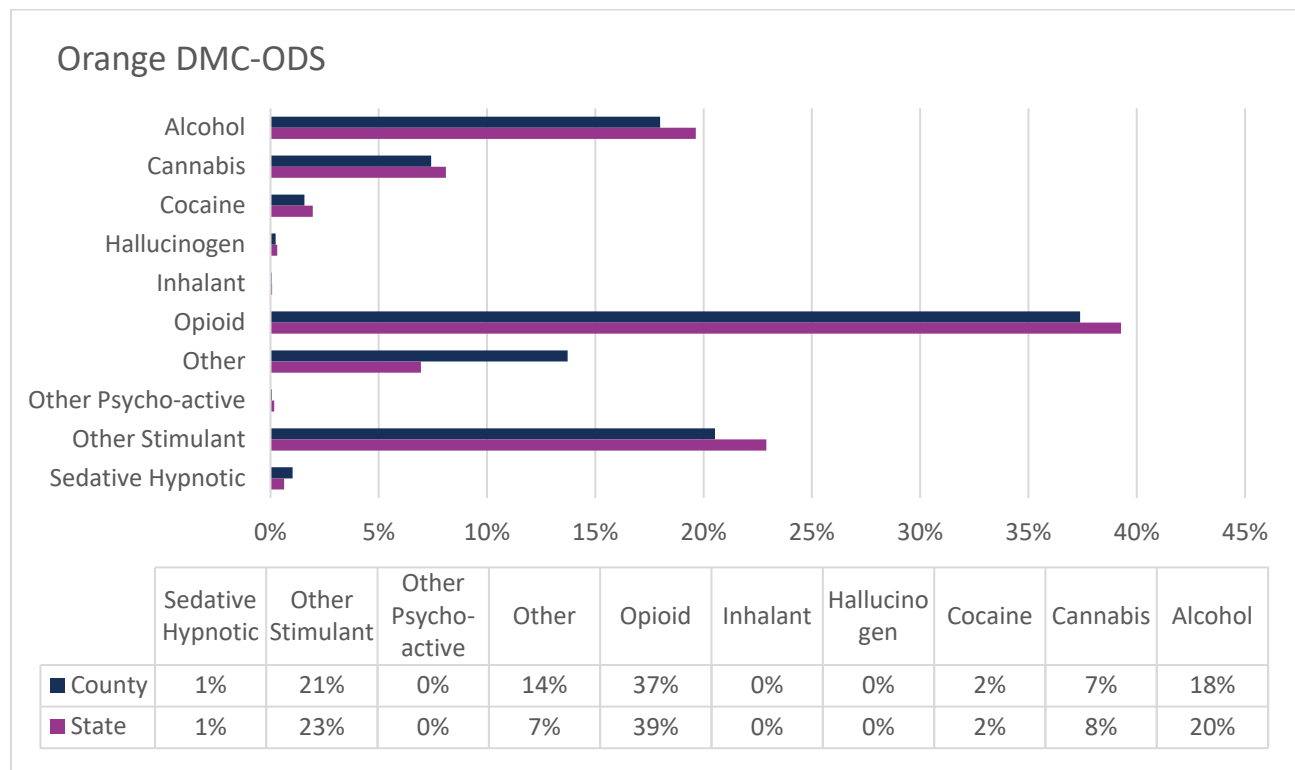
- Members served by Diagnostic Category
- Non-methadone MAT services

- 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

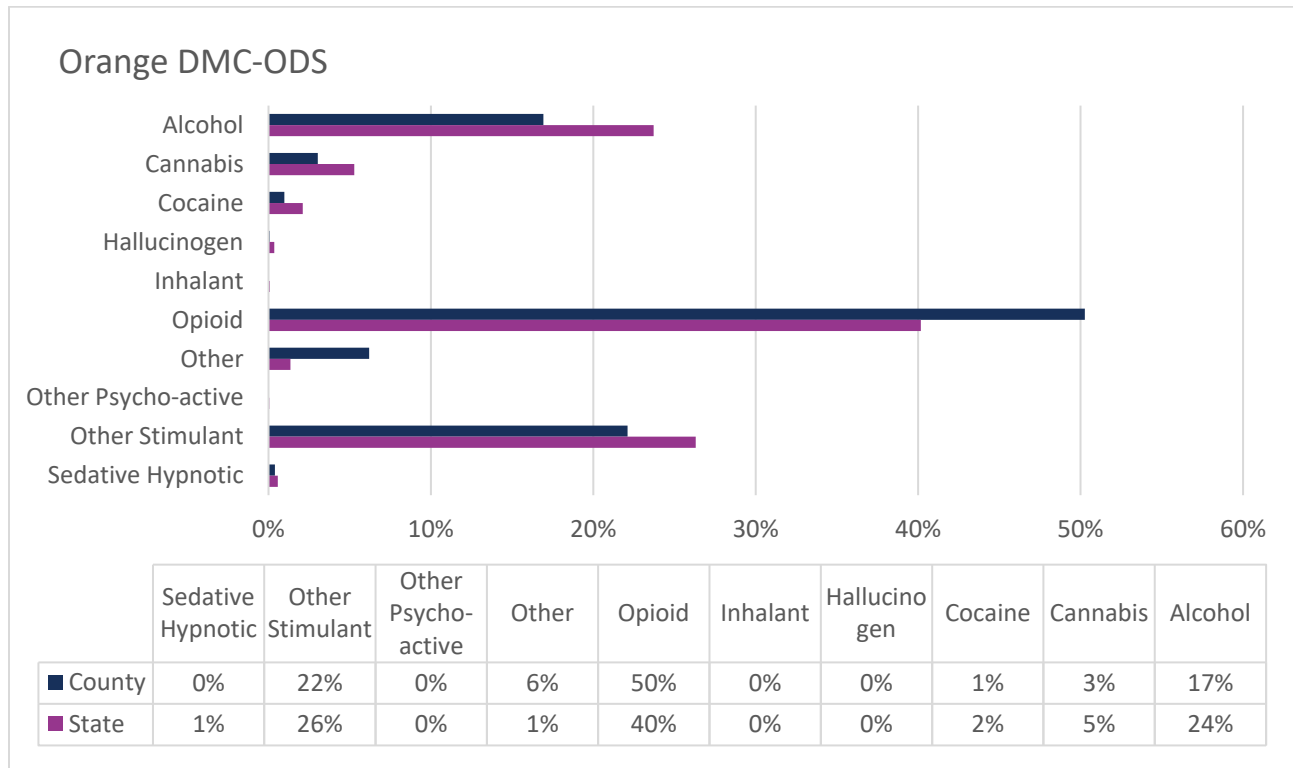
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SUD, is a foundational aspect of delivering appropriate treatment. Figures 5 and 6 represent the primary diagnosis as submitted with the DMC-ODS' claims for treatment. The first figure 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. The second figure shows the percentage of approved claims by diagnostic category compared to statewide.

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



- For the DMC-ODS, 37 percent of members receiving services were diagnosed with an Opioid Use Disorder (OUD), followed by Other Stimulant as the next most common diagnosis of 21 percent.
- The primary diagnostic pattern in the DMC-ODS is comparable to the statewide diagnostic pattern, except for higher rates of “Other” than statewide.

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



- OUD is the dominant diagnostic category, accounting for 50 percent of claims.

Non-Methadone MAT Services

Table 15: Orange 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	0	0.00%	0	0.00%	24	0.56%	13	0.30%
Ages 18-64	-	-	-	-	7,473	7.96%	3,881	4.13%
Ages 65+	<11	-	<11	-	428	5.78%	173	2.34%
Total	58	1.01%	36	0.63%	7,925	7.13%	4,051	3.66%

- The DMC-ODS had substantially lower initiation and engagement in non-methadone MAT compared to the statewide rates. Older adult data is suppressed due to the small number, and the adult category is suppressed so that the older adult number cannot be calculated. Nonetheless, this represents only 58 members, of whom 62 percent (n=36) are retained for at least three services.

Residential Withdrawal Management with No Other Treatment

Table 16: Orange 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	27	2.66%
Statewide	205	2.00%

- The DMC-ODS had 27 members receiving three or more WM services with no other treatment. While the percentage of members does exceed the statewide rate, the vast majority of members receiving WM accessed services within other treatment modalities.

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 withdrawal management. HCMs may be receiving services at a level of care 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: Orange DMC-ODS High-Cost Members by Age, CY 2022

Age Groups	Total Member Count	HCM Count	HCM % by Member Count	Average Approved Claims per HCM	HCM Total Claims	HCM % by Total Claims
Ages 12-17	205	<11	-	\$23,970	\$191,763	0.86%
Ages 18-64	5,196	290	5.58%	\$21,936	\$6,361,462	28.45%
Ages 65+	342	-	-	\$24,295	\$291,543	1.30%
Total	5,743	310	5.40%	\$22,080	\$6,844,768	30.61%

Table 18: Statewide High-Cost Members by Age, CY 2022

Age Groups	Total Member Count	HCM Count	HCM % by Member Count	Average Approved Claims per HCM	HCM Total Claims	HCM % by Total Claims
Ages 12-17	4,337	57	1.31%	\$26,397	\$1,504,639	0.23%
Ages 18-64	93,916	5,405	5.76%	\$24,539	\$132,634,739	20.62%
Ages 65+	7,404	262	3.54%	\$24,400	\$6,392,826	0.99%
Total	105,657	5,724	5.42%	\$24,551	\$140,532,204	21.84%

- As seen in table 17, 310 HCMs served by the DMC-ODS accounted for 30.61 percent of the total claims for CY 2022.
- The rate of HCMs (2.26 percent) is lower than the statewide rate (5.42 percent).

ASAM Level of Care Congruence

Table 19: Orange DMC-ODS Congruence of Level of Care Referrals with ASAM Findings, CY 2022 – Reason for Lack of Congruence

ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
Not Applicable /No Difference	538	93.70%	6,480	90.50%	2,375	89.70%
Patient Preference	27	4.70%	574	8.00%	198	7.50%
Level of Care Not Available	<11	-	12	0.20%	-	-
Clinical Judgement	<11	-	22	0.30%	18	0.70%
Geographic Accessibility	<11	-	0	0.00%	0	0.00%
Family Responsibility	<11	-	<11	-	0	0.00%
Legal Issues	<11	-	<11	-	<11	-
Lack of Insurance/Payment	0	0.00%	0	0.01%	0	0.00%
Other	<11	-	64	0.92%	41	1.60%
Actual Level of Care Missing	0	0.00%	0	0.00%	0	0.00%
Total	574	100.00%	7,155	100.00%	2,648	100.00%

- The DMC-ODS had a high congruence of LOC referrals with ASAM findings at initial screening, initial assessment, and follow-up assessment.
- The patient preference category was the primary reason the LOC upon initial assessment differed from the referral LOC.

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 20: Initiating and Engaging in Orange DMC-ODS Services, CY 2022

	County				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Members with an initial DMC-ODS service	5,114		95		99,855		4,026	
	#	%	#	%	#	%	#	%
Members who then initiated DMC-ODS services	3,883	76%	76	80%	83,830	84%	3,286	82%
Members who then engaged in DMC-ODS services	2,574	66%	46	61%	63,753	76%	2,202	67%

- Adult and youth members had lower rates of initiation and engagement in services compared to statewide rates.

Length of Stay

Examining DMC-ODS 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 21: Cumulative LOS in Orange DMC-ODS Services, CY 2022

	County		Statewide	
Members discharged from care (no treatment for 30+ days)	8,006		139,688	
LOS for members across the sequence of all their DMC-ODS services	Average	Median	Average	Median
	158	79	158	90
	#	%	#	%
Members with at least a 90-day LOS	3,817	48%	69,919	50%
Members with at least a 180-day LOS	2,316	29%	43,096	31%
Members with at least a 270-day LOS	1,550	19%	27,677	20%

- The average (mean) LOS for the DMC-ODS members was 158 days (median 79 days), which was the same as the statewide average of 158 (though the statewide median was 90 days).
- 48 percent of members had at least a 90-day LOS, 29 percent had at least a 180-day LOC, and 19 percent had at least a 270-day LOS. The proportions of members retained for each measured period were marginally lower than statewide.

CalOMS Data

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

Table 22: Orange DMC-ODS CalOMS Legal Status at Admission, CY 2022

Admission Legal Status	County		Statewide	
	#	%	#	%
No Criminal Justice Involvement	3,401	68.60%	56,511	65.47%
Under Parole Supervision by CDCR	91	1.80%	1,649	1.91%
On Parole from any other jurisdiction	55	1.10%	1,427	1.65%
Post release supervision - AB 109	1,108	22.30%	19,933	23.09%
Court Diversion CA Penal Code 1000	28	0.60%	1,312	1.52%
Incarcerated	19	0.40%	446	0.52%
Awaiting Trial	255	5.10%	5,038	5.84%
Total	4,957	100.00%	86,316	100.00%

- A fairly high rate of members in treatment, 68.60 percent, self-reported having no criminal justice involvement, which is higher than the statewide proportion of 65.47 percent; this is not consistent with experience of providers and the DMC-ODS who perceive a much higher rate within their treatment population.

Table 23: Orange DMC-ODS CalOMS Discharge Status Ratings, CY 2022

Discharge Status	County		Statewide	
	#	%	#	%
Completed Treatment – Referred	791	14.20%	19,232	21.62%
Completed Treatment - Not Referred	316	5.70%	5,687	6.39%
Left Before Completion with Satisfactory Progress - Standard Questions	838	15.00%	12,302	13.83%
Left Before Completion with Satisfactory Progress – Administrative Questions	597	10.70%	7,046	7.92%
<i>Subtotal</i>	<i>2,542</i>	<i>45.60%</i>	<i>44,267</i>	<i>49.76%</i>
Left Before Completion with Unsatisfactory Progress - Standard Questions	845	15.10%	15,497	17.42%
Left Before Completion with Unsatisfactory Progress - Administrative	2,161	38.80%	28,288	31.80%
Death	<11	-	166	0.19%
Incarceration	-	-	740	0.83%
<i>Subtotal</i>	<i>3,034</i>	<i>54.40%</i>	<i>44,691</i>	<i>50.24%</i>
Total	5,576	100.00%	88,958	100.00%

- CalOMS data for CY 2022 indicates that while nearly half of the discharges in the DMC-ODS are considered satisfactory discharges (45.6 percent), the single highest discharge category at exit is “Left Before Completion with Unsatisfactory Progress, Administrative” at 38.80 percent. The DMC-ODS members also discharge with a somewhat higher rate of Unsatisfactory Progress with Standard Questions than seen statewide (15.0 percent vs. 13.8 percent).
- Just 14.2 percent of members discharged Completing Treatment with referral to follow-up treatment compared to the statewide rate of 21.6 percent.
- The overall satisfactory discharge rate increased from 42.1 percent in CY 2021 to 45.6 percent in CY 2022, still remaining somewhat lower than the statewide rate of 49.76 percent.

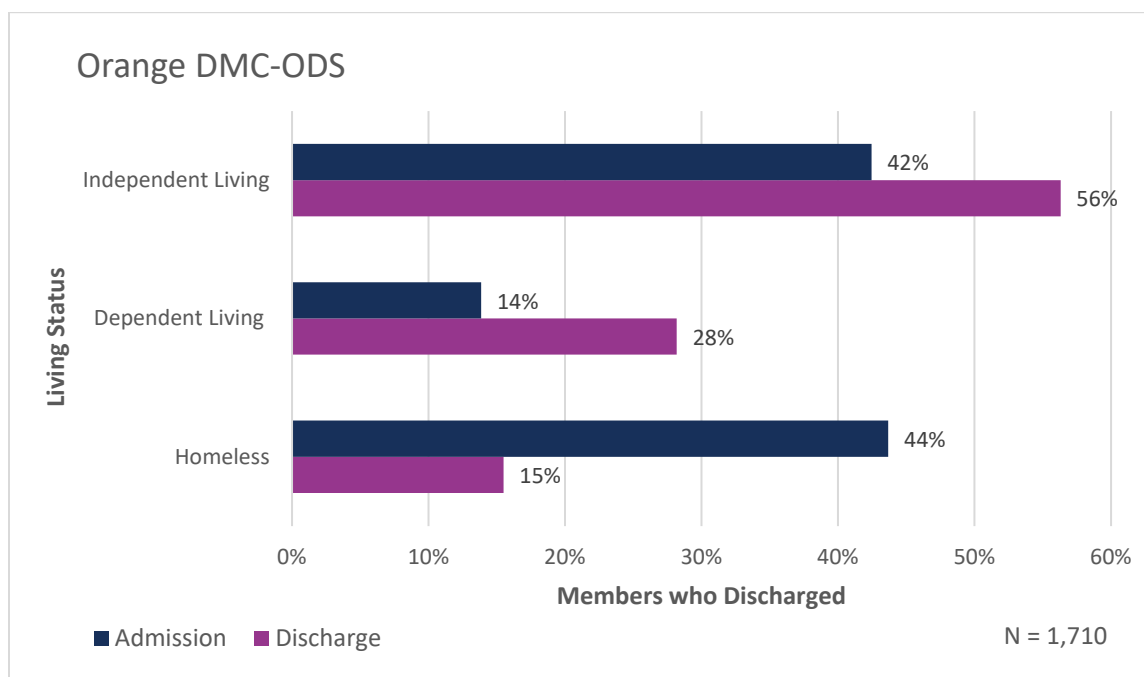
Table 24: Orange DMC-ODS CalOMS Types of Discharges, CY 2022

Discharge Types	County		Statewide	
	#	%	#	%
Standard Adult Discharges	1,829	32.80%	44,306	49.81%
Administrative Adult Discharges	2,786	50.00%	36,240	40.74%
Detox Discharges	920	16.50%	7,075	7.95%
Youth Discharges	41	0.70%	1,337	1.50%
Total	5,576	100.00%	88,958	100.00%

- Administrative adult discharges were the primary discharge type at 50 percent, and increased from the prior year when the administrative discharge rate was 45 percent, still exceeding the statewide rate of 40.7 percent.

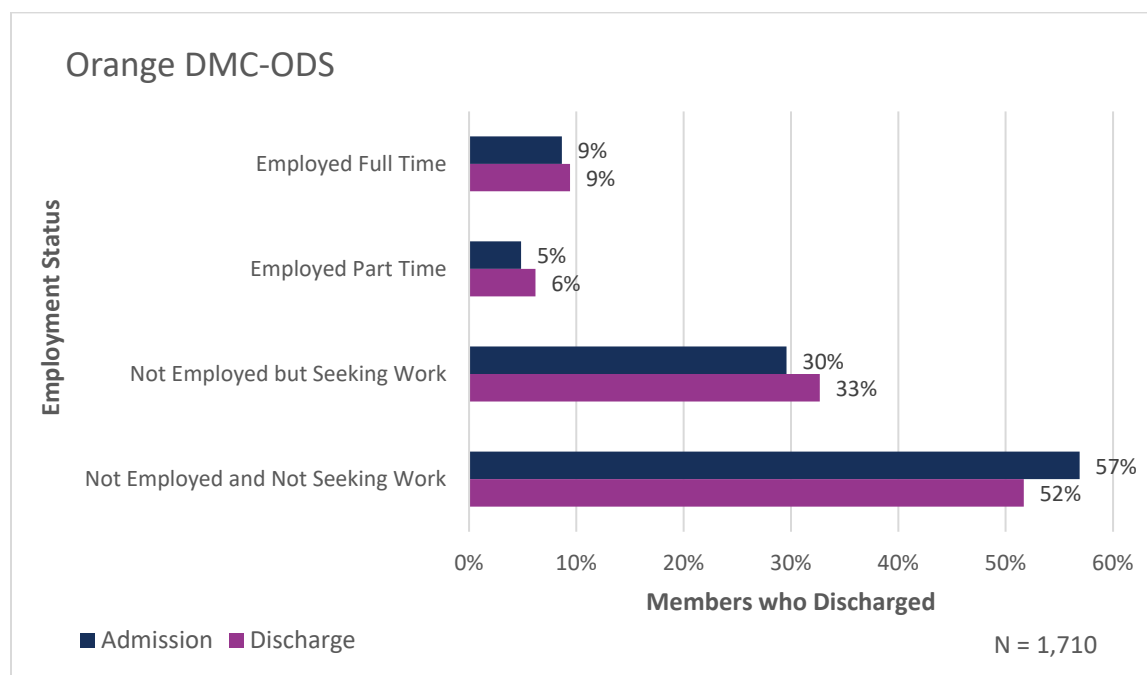
The data presented in Figures 7 and 8 reflect percent change at discharge from admission for both living status and employment status. Both questions are asked in relation to the prior 30 days.

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



- Almost half the members (44 percent) were homeless at admission which was a substantial increase from the CY 2021 CalOMS data which was 24 percent. On discharge the homeless rate decreased to 15 percent, and independent living improved from 42 percent at admission to 56 percent at discharge, indicating significant improvement in housing stability at the time of discharge. The increase in dependent living likely reflects the increased number of recovery residences.

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



- In CY 2022, there was a decreased rate of members unemployed and not seeking work at admission, compared to CY 2021. However, this number increased from 30 percent to 33 percent at discharge.

IMPACT OF QUALITY FINDINGS

- For CY 2022, CalOMS data indicates that members saw improved functioning in employment and housing at discharge, with a significant decrease in homelessness compared to admission going from 44 percent unhoused at time of intake to just 15 percent at time of discharge which will substantially increase members' likelihood of successful recovery.
- Staffing shortages are most likely contributing to the high number of unsatisfactory discharges. With current staff taking on larger caseloads, the necessary time needed with a counselor to develop a therapeutic alliance is often not available, which could result in members leaving treatment against staff advice because they do not feel connected to the treatment process.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION

All DMC-ODSs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330¹ 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.calegro.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: Increase Individual Counseling to Outpatient Members to Improve Satisfactory Progress

Date Started: 09/2023

Aim Statement: "Will increasing the number of face-to-face individual counseling sessions to 4 sessions within a member's first 60 days of an episode of care for ODF outpatient (non-court) members result in better member outcomes at discharge, as evidenced by a 10-percentage point increase from the baseline of satisfactory discharges (as measured on the CalOMS) for new members enrolled and discharged between September 2023 – August 2024?"

Target Population: Members who are in outpatient ODF non-court programs will be the focus of this project.

Validation Information: The PIP is in the approval stage.

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 has a high percentage of members discharged from outpatient treatment with unsatisfactory process as measured by CalOMS. The overall goal of the clinical PIP is to increase the percentage of satisfactory discharges for adult members participating in SUD outpatient treatment. The PIP was developed based on CalOMS data, local data analysis, and DMC-ODS management and staff input. Performance measures were informed through research on barriers to successful member engagement and PIP committee discussions. The interventions are designed to improve member engagement by sending automated reminders for scheduled appointments, offering group orientation and intake to shorten the length of time between first appointment and admission, and increasing the number of face-to-face services within the first 60 days of admission to treatment. Performance measures will capture data on no-shows, the length of time to complete assessments and intakes, and the number of sessions conducted for each member within the first 60 days of treatment.

The PIP will be piloted at one outpatient program site for year one and expand to other sites in years two and three. All adult members participating in outpatient treatment will be included in the Project.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because while increasing the number of face-to-face sessions for members in treatment should improve engagement and longer stays in treatment, members and contract providers were not included in the development process, and a comprehensive root cause analysis was not conducted, limiting the interventions to a few select possible causes. However, while several interventions are staff and member-driven, the strength of the design and capacity for the DMC-ODS to review program level outcome data enhances the project design. The DMC-ODS has a high staff vacancy rate that it will need to monitor to ensure capacity to implement the interventions.

The DMC-ODS requested TA for this PIP one month prior to the FY 2023-24 EQR.

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

- Involve current and former SUD treatment participants and contract providers, including line staff, in meaningful discussions around the possible causes and potential interventions that have not been identified.
- Consider piloting particular interventions for shorter periods of time to determine if the interventions need modification. Frequent analysis will be necessary given that the interventions are currently planned at one program site for a year.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Increasing Linkage to Lower Residential Level of Care Following Withdrawal Management Residential Detox Discharge

Date Started: 9/2023

Aim Statement: “For members who are discharging from WM services and who have requested linkage to residential services, but no residential beds are available, will the provision of interim outpatient services along with short term recovery residence housing, result in a 15-percentage point increase in linkage to lower level of care services within 30 days of WM discharge date? “

Target Population: The PIP targets all members with an SUD diagnosis discharging from WM and seeking residential treatment as the next phase of recovery.

Validation Information: The DMC-ODS’ non-clinical PIP is in the approval stage.

Summary

The goal of the non-clinical PIP is to increase linkage for members discharged from WM to a lower level of care within 30 days of discharge. The DMC-ODS is experiencing a shortage of residential treatment beds which results in members discharged from WM not having access to residential treatment in a timely manner. The DMC-ODS has expanded their residential recovery beds, given the number of residential treatment beds. The PIP will link members discharged from WM to a short-term recovery residence and admission to an outpatient program to support member engagement in treatment until a treatment bed becomes available.

The PIP focus was informed through the discussions during the DMC-ODS SUD QIC meetings and data indicating a high WM readmission rate. Performance measures will collect information on the number of days between member discharge from WM to admission to a short-term recovery residence and outpatient treatment

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because the interventions proposed may result in an increase of the percentage of successful linkages via members having access to a recovery residence and outpatient treatment services immediately upon discharge from WM. While the members will not be admitted to a residential treatment program, they will have access to a safe and sober environment that provides members with crucial support.

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

- Engage in collaboration with program staff to identify gaps in knowledge or skill related to member engagement in outpatient programs.
- For members receiving the intervention, consider adding more supportive services (e.g., IOP versus OP, case management, peer support) during the waiting period for a residential bed.
- Measure frequently in order to adjust course as needed.
- Increase residential treatment capacity, which as noted earlier in this report the DMC-ODS continues to work diligently on.

INFORMATION SYSTEMS

Using the Information Systems 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' Electronic Health Records (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 in 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 is Millenium Software Applications by Oracle, which has been in use for 22 years. Currently the DMC-ODS has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 1.04 percent of the DMC-ODS budget is dedicated to support all costs associated with the IS. The budget determination process for IS operations is a combined process involving the DMC-ODS control and another county department or agency.

The DMC-ODS has 696 named users with log-on authority to the EHR, including approximately 113 county staff and 583 contractor staff. Support for the users is provided by 3.9 full-time equivalent (FTE) IS technology positions. Additionally, there are 23.35 FTE IS technology positions supporting the mental health system of care. Currently there are 2.8 FTE positions vacant within the entire system of care.

As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the DMC-ODS EHR. Currently, all contract providers have the ability to enter service data but not clinical data, which is still maintained in contract providers' separate EHR systems. Contractor staff having 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 submit member practice management and service data to the DMC-ODS IS as reported in the following table:

Table 25: Orange DMC-ODS Contract Provider Transmission of Information to DMC-ODS EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between DMC-ODS IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into DMC-ODS IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	100%
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 have their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. In prior years, adults within the mental health system of care had access to PHR data. For the previous year, PHR data has been unavailable due to system limitations around confidential access to data. The DMC-ODS staff are working with the vendor to address issues and restore PHR functionality, but at the time of this review, no timeline had been established for resolving the issues.

Interoperability Support

While MH contract providers, DMC-ODS contract providers, and Orange County Public Health, and Correctional Health Services have access to the EHR, they do not currently engage in electronic exchange of information due to limitations regarding confidentiality. 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.

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 26: IS Infrastructure Key Components

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

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

- The DMC-ODS has continued to strategize and reorganize teams around data collection and reporting to more clearly define processes and support the department in future initiatives.
- In terms of investment in IT infrastructure and resources, the DMC-ODS appears to be understaffed in IS support positions, with 1 percent of the annualized budget supporting the DMC-ODS IS infrastructure. Data analytics approved positions are more substantial than IS at 11.5 FTEs; however, at the time of this review, county data analytics positions are at a 26 percent vacancy rate.
- The DMC-ODS continues with the business decision to have contract providers enter service data directly into the county EHR, while clinical data is maintained within the contract provider separate system. The DMC-ODS is not currently a member of an HIE; however, interoperability goals related to clinical data exchange and establishing a new integrated data warehouse are listed initiatives.
- The DMC-ODS is experiencing a current hold on Medi-Cal claims due to CalAIM payment reform updates impacting the EHR. Regular weekly meetings with the vendor are occurring with measures in place to capture services being provided and will be claimed once updates are complete.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

Table 27 shows the amount of denied claims by denial reason, and Table 28 shows approved claims by month, including whether the claims are either adjudicated or denied. This may also indicate if the DMC-ODS is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Tables 27 and 28 appear to reflect a substantially complete claims data set for the time frame represented.

Table 27: Summary of Orange DMC-ODS Denied Claims by Reason Code, CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Service location not eligible	2,416	\$328,101	28.26%
Beneficiary not eligible	2,491	\$297,293	25.61%
Other Healthcare coverage must be billed first	1,723	\$231,520	19.94%
Duplicate/same day service without modifier or other info needed for adjudication	1,818	\$196,665	16.94%
Missing valid diagnosis	357	\$73,485	6.33%
Late claim submission	172	\$19,738	1.70%
Other	72	\$14,006	1.21%
Total Denied Claims	9,049	\$1,160,808	100.00%
Denied Claims Rate	4.88%		
Statewide Denied Claims Rate	3.64%		

Table 28: Orange DMC-ODS Approved Claims by Month, CY 2022

Month	# Claim Lines	Total Approved Claims
Jan-22	13,824	\$1,679,035
Feb-22	13,111	\$1,559,179
Mar-22	16,203	\$2,015,454
Apr-22	15,459	\$1,969,715
May-22	15,759	\$1,992,965
Jun-22	15,716	\$1,996,498
Jul-22	13,896	\$1,831,788
Aug-22	15,919	\$1,969,204
Sep-22	15,921	\$1,928,731
Oct-22	16,086	\$1,971,896
Nov-22	15,273	\$1,842,671
Dec-22	15,547	\$1,881,475
Total	182,714	\$22,638,612

- This chart appears to reflect a stable number of claim lines and approved claim totals across CY 2022.
- The DMC-ODS's denied claims rate is higher than the statewide rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

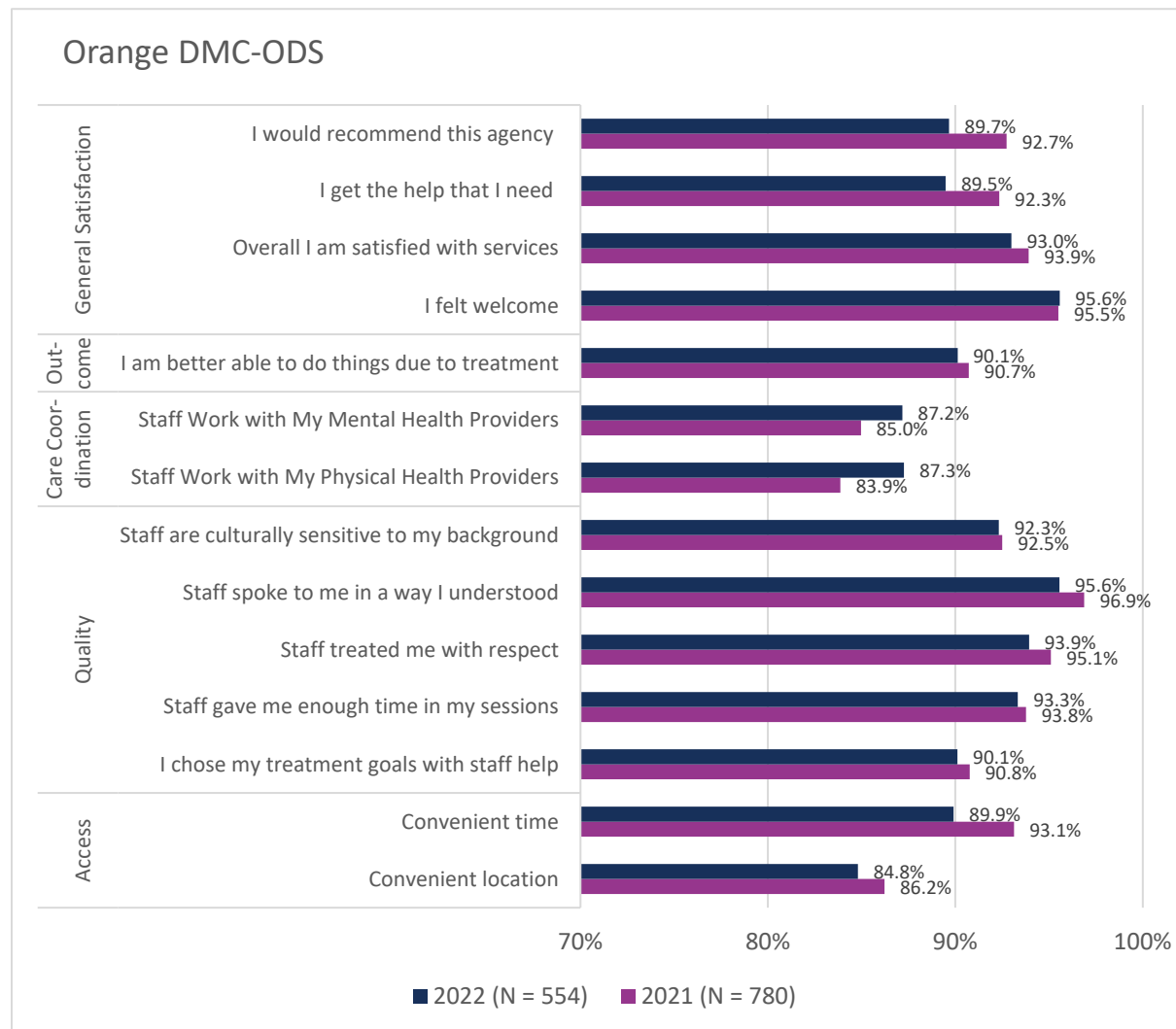
- The inability of contract providers to enter clinical data within the county EHR remains a barrier, though county data analytics staff have workaround processes in place to pull the data for assessment and reporting. While there are current initiatives to improve interoperability and access, more real-time data from contract providers, the current system limitations in timely reporting, and the manual processes involved, add substantial workload to the data analytics teams. Combined with the current 35 percent vacancy rate for county data staff, this requires added validation efforts which would be eased with further interoperability through an HIE and/or an integrated data warehouse.
- The understaffing of IS support positions and the current high vacancy rate for data analytics positions will continue to impact staff workload, as well as system development efforts related to clinical care and interoperability. With the expanded development of CalAIM, increased and focused investment and recruiting for these positions would expedite development.
- The system updates related to payment reform are negatively impacting cash flow for the DMC-ODS as well as contract providers due to the inability to claim under the new system, due to additional needed updates. While efforts are underway to implement these updates, continued delays will make it increasingly difficult for programs to absorb ongoing costs without reimbursement.

VALIDATION OF PLAN MEMBER PERCEPTIONS OF CARE

TREATMENT PERCEPTION SURVEYS

The Treatment Perception Survey (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.

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



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

- DMC-ODS members gave higher ratings in the Quality and General Satisfaction domains, and rated Access and Care Coordination questions lowest.
- In addition to the 29 percent decrease in those who responded to the TPS from the prior year, the DMC-ODS should address both the aggregate and individual program issues leading to scores falling below 90 percent.

PLAN MEMBER/FAMILY FOCUS GROUPS

DMC-ODS 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 three 90-minute focus groups with plan members and/or their family, containing 10 to 12 participants each.

Plan Member/Family Focus Group One

CalEQRO requested a diverse group of adult plan members who initiated perinatal services in the preceding 12 months. Only two members attended the session precluding the reporting of information gathered during the session due to confidentiality.

Plan Member/Family Focus Group Two

CalEQRO requested a diverse group of adult plan members who initiated services in the preceding 12 months. The time in residence ranged from three weeks to forty-seven days. The focus group was held via video conference and included nine participants. All members participating receive residential clinical services from the DMC-ODS.

Many of the participants indicated they heard about the program while they were in jail, although only one believed they were formally referred by criminal justice. One participant heard about the program from a friend while in a WM program.

All indicated their assessments were conducted the same day they were requested, and the intake process was thorough but fast. None of the participants expressed concerns about assessment date versus admission date indicating smooth transitions from assessment to admission. One participant explained a “big brother” is assigned upon admission to the treatment facility and assists with orientation and a tour of the facility.

One participant was on MAT and several indicated they were involved with local mental health services regularly. All participants voiced that staff are supportive and helpful regarding coordination with outside agencies, setting up telehealth appointments, and arranging transportation. Assisting with visitation with family was also mentioned.

All indicated they were strongly encouraged to partner with alumni, and/or find a sponsor and attend 12 Step meetings, which are available daily to weekly on-site and off-site depending on the program, and a Hospitals and Institutions (H&I) group conducts monthly twelve step meetings at one of the programs. Participants found sponsorship and the ability to create a sober network of friends with other participants to be very helpful. When discussing positive changes, participants stated they had increased self-esteem, had been able to connect more with their beliefs, and were able to forgive themselves.

Recommendations from focus group participants included:

- Visitation of family members (especially young children of participants)
- Extended workout times
- More assistance with job searches and employment (stating it should be a crucial component of discharge planning)
- Getting their phones back after being in treatment for a period of time.

Plan Member/Family Focus Group Three

CalEQRO requested a diverse group of youth (ages 12 to 17 years) members who initiated services in the preceding 12 months. The time in residence ranged from twenty days to one participant in treatment for over seven months. The focus group was held via video conference and included six participants. Five of the members participating receive clinical services in residential facilities from the DMC-ODS and one youth was receiving outpatient services.

Criminal justice, family, and mental health/other treatment programs were stated as the avenues leading to admission. Several participants confirmed having a co-occurring disorder and one was utilizing MAT. General consensus was the assessment was easy and fast; however actual admission took from two weeks to two months to be admitted into residential treatment.

All indicated staff encourage them to talk with their therapist or psychiatrist and coordinate with their primary physician. Telehealth is also available.

All attend groups daily ranging from 30 minutes to three hours, which include mindfulness, substance use, coping with emotions, life skills, healthy relationships, and handling conflict. All attend local 12 Step meetings off-site and sponsors come on-site as well. All indicated they felt their counselor was sensitive to their cultural needs.

Discharge planning was explained to include a home contract to assist with sobriety and safety. One participant stated, "It will be a smooth transition following graduation." However, one participant indicated there was no discharge planning.

Participants indicated they have learned more about coping skills, how to handle cravings, setting better boundaries with peers, and dealing with conflict. One participant

discussed learning how to manage post-trauma issues and work through relapse triggers. All would recommend their counselors and were impressed with the length of sobriety they have.

Recommendations from focus group participants included:

- Have guest speakers such as a person in successful recovery to share their experience.
- Introduce flexibility with the programs' schedules.
- Hire more understanding staff that truly listen.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall, participants indicated a positive experience and seemed engaged in the treatment process.

All indicated their counselors assisted with coordinating appointments, transportation, and whatever seemed to be needed. Specifically medical and mental health appointments were always encouraged and coordinated by counselors, improving the chances for success in recovery by addressing the “whole person.” All but one participant indicated their cultural needs were embraced and supported. One stated they had to change their prayer times due to group schedule conflicts; however, they did report the program adjusts the meals to match their religious practices.

Local sobriety-based support programs and sponsorship are available and encouraged by all programs. The general consensus was the meetings and sponsors were helpful, and in some instances were the most important part of the treatment process.

The youth residential participants all discussed the long wait times prior to admission. Residential youth beds are significantly less available in general throughout the State, and Orange County has done well to secure a contract providing this level of care. It appears however, more beds are needed for this population, which is not easy to accomplish. The adult focus group was not impacted by long wait times, which may be a result of the recent revision of the ART team processes. During the review, the DMC-ODS indicated participants were being admitted to residential treatment within two days of assessment.

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 completion of the BH administrative reorganization has enhanced the overall quality management of SUD services in Orange County. A new SUD Division was implemented providing leadership and subject matter expertise dedicated to SUD programs. The new division leadership conducted a retreat for staff to provide information on how the new division will operate and to jump start the collaborative team culture. The team has already begun site visits to programs to further develop effective communication and partnerships. (Quality)
2. As part of CalAIM, the DMC-ODS has established a comprehensive “No Wrong Door” policy. All assessment staff in SUD treatment programs and county-operated MH clinics are cross trained to provide SUD assessments and MH assessments, eliminating the possibility of an added assessment appointment before treatment referrals are made. Additionally, all SUD outpatient and residential programs are capable of providing treatment for members who have co-occurring disorders. (Access)
3. MAT services are easily accessible in Orange County. All SUD treatment programs accept members utilizing MAT, all recovery residences are required to accept members on MAT, four NTP sites provide MAT to adolescents, the jails provide MAT and allow inmates that come in on methadone to continue, and eleven of the twelve Federally Qualified Health Centers (FQHC) provide MAT. The DMC-ODS is partnering with MATConnect, a program working as a bridge between the FQHCs and hospitals to guide members to outpatient MAT treatment. The MATConnect Medical Director is an Addiction Medicine Physician who provides ongoing training to community medical providers bi-monthly. (Access, Quality)
4. The development of data dashboards (even at a time of manual data collection) and the examples of CalOMS data review is at an exciting development stage as the DMC-ODS moves towards interoperability opportunities. (Information Systems)
5. The Behavioral Health Equity Committee (BHEC) is an excellent example of the DMC-ODS community collaboration. The BHEC public meetings are designed for brainstorming and discussion of current cultural issues. Attendees break out into tables of small groups enabling meaningful communication. Prompts are offered

for the discussion such as: “What are the two most important issues facing your community regarding mental health and recovery (SUD).” Results are shared in the meeting by each small group and then reported to the entire group. Currently the BHEC has four sub committees: Deaf & Hard of Hearing, Spirituality, Threshold Language populations, and Outreach to the Black & African American Community. (Access, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Despite some improvement, the DMC-ODS still has a no-show rate of over 50 percent. The DMC-ODS indicated in their Response to Recommendations from the FY 2022-23 EQR they would be addressing this in their upcoming PIP. The current PIP presented for approval does provide one intervention related to no-show rates, but the focus of the PIP is to increase satisfactory discharges. (Access, Timeliness, Quality)
2. Although there is a quarterly meeting with SUD QI Coordinators (SUD QIC) in place, providers continue to express frustration with the DMC-ODS related to their partnership and communication. The DMC-ODS has an opportunity to utilize the new SUD Division to enhance efforts to develop effective relationships with contracted providers. (Quality)
3. Though the DMC-ODS has expanded its MAT capacity and partners with allied healthcare providers to ensure access to MAT for its members, DMC-ODS billing for non-methadone MAT remains well below statewide averages. (Access)
4. The DMC-ODS, along with many other counties, revised their existing MHP cultural competency plan to meet the requirements for the DMC-ODS waiver. However, the current plan is outdated and noticeably MHP focused, leaving facets unique to the SUD population unaddressed. (Quality)
5. IS teams within the Orange Health Care Agency (HCA) are under-staffed due to increased workloads of ongoing development and support, combined with the changes required by CalAIM. Additionally, the current county data analytics staff vacancies are at 35 percent. (Information Systems)

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 take meaningful steps to address the no-show rates. A comprehensive root cause analysis which includes meaningful interaction with all service providers and stakeholders should be conducted. Additionally, Orange should prioritize and take active steps to ensure all requests for services are being logged so the data is accurate. As the analysis identifies problems,

solutions should be formulated with the DMC-ODS implementing appropriate interventions to decrease no-show rates. (Access, Quality)

2. The DMC-ODS should consider creating a meeting for contract provider clinicians/line staff separate from the currently scheduled SUD QIC meetings. The meetings should be designed to invite staff to discuss challenges, propose ideas for improvement, share success stories, and provide insight into what staff are experiencing. The meeting would be effective with the small group format used in BHEC meetings depending on the number of participants. (Quality)
3. The DMC-ODS should take steps to address the extremely low MAT utilization in DMC-ODS SUD treatment programs. The DMC-ODS could benefit from enhancing relationships with NTPs to allow for meaningful discussions and problem solving around non-methadone MAT utilization. (Access, Quality)
4. DMC-ODS should utilize the new SUD Division to work in partnership with QI and the BHEC to revise the cultural competence plan by adding specific areas targeting SUD. The DMC-ODS could accomplish this task through the subject matter expertise of SUD division staff, BHEC activities, and the QI committee knowledge of cultural competency in general. (Quality)

(This is a continuation of a similar Recommendation since FY 2021-22)

5. Additional IS staff positions for the DMC-ODS HCA are needed for ongoing support and development within the DMC-ODS system of care. The DMC-ODS HCA would benefit from enhanced support from County HR for the successful recruitment of vacant data analytics positions that provide key support for the DMC-ODS in assessing system capacity, timeliness, and performance measures used in making data-informed decisions. (Information Systems)

EXTERNAL QUALITY REVIEW BARRIERS

The DMC-ODS did not identify any 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 - Orange 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
PIP Validation and analysis (conducted the week prior to the review)
Access Center/ART Staff Group Interview
Plan Member Focus Group #1 Perinatal
Clinical Supervisors Group Interview – contracted only
Coordination with Health Plan, Hospitals, FQHCs, and Mental Health – collaboration with DMC, MOUs, referral process to and from mental health services
Youth Treatment and Prevention – Overview of treatment programs, examples of outreach, education
Cultural Competence Plan – Significant changes, plan update, diversity, equity, and inclusion
Access to Services – No wrong door, network Adequacy, urgent and crisis, data reporting
Quality Management – Overview of SUD plan, program and provider monitoring, outreach to underserved populations
Plan Member Focus Group #2 Residential
ISCA – significant changes, user training, IS supports for data analytics and performance measures, interoperability, payment reform
Timeliness – First offered appointments, residential follow-up, no shows, cancellations
MAT – Overview of utilization, expansion, education, and prevention activities
Plan Member Focus Group #3 Youth
ASAM/Continuum of Care – Training and fidelity, use of ASAM by community agencies, review of continuum
Use of Data – Outcomes monitoring, aggregate data, dashboards, and other reports; use of reports (TPS, ASAM LOC Placement Data, CalOMS)
Questions and Clarifications
Closing session: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Cynthia Hudgins, Lead Quality Reviewer
Patrick Zarate, Assistant Director, Quality Reviewer
Joel Chain, Information Systems Reviewer
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.

DMC-ODS County Sites

All sessions were held via video conference.

DMC-ODS Contract Provider Sites

All sessions were held via video conference.

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

Last Name	First Name	Position	County or Contracted Agency
Aguilar	Glenda	Health Services Manager	Mental Health Recovery Services (MHRS) Substance Use Disorders
Alhawasli	Ashlee	Behavioral Health Clinician II	MHRS-Quality Management Services
Alma	Ken	Service Chief II	MHRS-Quality Management Services
Almodovar	Oksana	Customer Care Representative	Carelon
Amantine-Taylor	Liz	Administrative Manager I	MHRS-Quality Management Services
Anderson	Kyle	Research Analyst IV	MHRS-Data Analytics Team (DAT)
Ayala	Blanca Rosa	Behavioral Health Clinician II	MHRS-Quality Management Services
Balcom	Heather	Program Manager II	MHRS-Children and Youth Services
Banicki	Wendy	Service Chief I	MHRS-Substance Use
Bart	Ashley	Behavioral Health Clinician II	Disorders
Bautista	Paola	Administrative Manager II	MHRS-Quality Management Services
Bennett	Andrew	Research Analyst IV	MHRS-Children and Youth Services
Berardino	Stacey	Interim Assistant Deputy Director	MHRS-Data Analytics Team
Borucki	Ewa	Research Analyst IV	MHRS-Forensics and Justice Involved
Brack	Yvonne	Service Chief II	MHRS-Data Analytics Team
Button	Lisa	Outpatient Program Manager	The Teen Project
Calvario	Cynthia	Program Manager	Western Pacific Med Corp
Camarena	Oscar	Office Specialist	MHRS-Quality Management Services
Carroll	Esmeralda	Behavioral Health Clinician II	MHRS-Quality Management Services
Castaneda	Dolores	Service Chief II	MHRS-Quality Management Services
Castellanos	David	Information Security Officer	MHRS-Information Technology
Ceja	Eduardo	Behavioral Health Clinician II	MHRS-Quality Management Services

Last Name	First Name	Position	County or Contracted Agency
Chakravarthy	Bharath	Director MD-MPH Dual Degree Program	University of California Irvine (UCI) School of Medicine
Choi	Susie	Health Program Specialist	MHRS-Quality Management Services
Collins	Neil	Account Executive	Carelon
Crump	John	Health Services Manager	MHRS-Quality Management Services
Danioko	Sidy	Research Analyst IV	MHRS-Data Analytics Team
DeMarco	Patricia	Medical Doctor	Mental Health and Recovery Services
Dimitriadis	Kindra	Administrative Manager II	MHRS-Information Technology
Dinicola	Jennifer	Administrative Manager II	MHRS-Outreach and Engagement
Downey	Christian	Behavioral Health Clinician I	MHRS-Substance Use Disorders
Duplesse	Nichole	Health Program Specialist	MHRS-Substance Use Disorders
Elliot	Wendy	Service Chief II	MHRS-Substance Use Disorders
Ernt	Tracy	Health Services Manager	MHRS-Substance Use Disorder
Ewing	Tanji	Behavioral Health Clinician II	MHRS-Quality Management Services
Fernandez	Jennifer	Behavioral Health Clinician II	MHRS-Quality Management Services
Flores	Irma	Manager of Customer Care	Carelon
Garcia	Heather	Program Manager	Western Pacific Med Corp
Garcia	Joe	Mental Health Worker II	MHRS-Adult & Older Adult Mental Health
Gayfield	Jennie	Associate Manager BH Clinical Services	Carelon
Glinski	Michelle	Health Program Specialist	MHRS-Substance Use Disorders

Last Name	First Name	Position	County or Contracted Agency
Goff	Loren	Manager BH Clinical Services	Carelon
Gonzalez	Sophia	Senior Program Director	Phoenix House OC
Gonzalez de Griesse	Claudia	Behavioral Health Clinician II	MHRS-Quality Management Services
Greenberg	Kristina	BH Care Manager	Carelon
Hagos	Asmeret	Service Chief II	MHRS-Quality Management Services
Heilman	Rebecca	Research Analyst IV	MHRS-Data Analytics Team
Helmy	Deana	Acting Ethics Services Manager	Mental Health and Recovery Services
Henriquez	Jennifer	Administrative Manager I	MHRS-Quality Management Services
Hoang	Sharon	Office Specialist	MHRS-Quality Management Services
Howard	April	Senior Research Analyst	MHRS-Data Analytics Team
Huffman	Charles "Scott"	Associate Medical Director	Mental Health and Recovery Services
Ibarra	Marisela	Business Services Manager	MHRS-Quality Management Services
Inglis	Andrew	Associate Medical Director	Mental Health and Recovery Services
Ishikawa	Sharon	Interim Assistant Deputy Director	MHRS-Data Analytics Team
Jannise	April	Health Services Manager	MHRS-Quality Management Services
Johnson	Kimberly	Program Manager	Western Pacific Med Corp
Jones	Eric	LMFT, Clinical Manager	Phoenix House
Katsorov	Carmen	Executive Director, Behavioral Health Integration	Cal Optima
Kee	Matthew	Administrative Manager II	MHRS-Crisis and Acute Care Services

Last Name	First Name	Position	County or Contracted Agency
Keefe	Nicole	Administrative Manager II	MHRS-Crisis and Acute Care Services
Kelley	Veronica	Chief of Mental Health & Recovery Services	Mental Health and Recovery Services
Kemmer	Ian	Assistant Deputy Director	MHRS-Adult and Older Mental Health
Kettler	Marian	Service Chief II	MHRS-Adult & Older Adult Mental Health
Kim	Alice	Administrative Manager II	MHRS-Children and Youth Services
Ko	Grace	Behavioral Health Clinician II	MHRS-Quality Management Services
Kullar	Mandy	Director of Behavioral Health	Carelon
Lam	Chi	Health Services Manager	MHRS-Adult and Older Adult Mental Health
Lawrenz	Mark	Interim Assistant Deputy Director	MHRS-Substance Use Disorders
Le	Anthony	Administrative Manager II	MHRS-Administration and Finance
Lemire	Alicia	Division Manager	MHRS-Children and Youth Services
Linares	Maria	Behavioral Health Clinician II	MHRS-Adult & Older Adult Mental Health
Loff	Jewel	Consultant	Cal Optima Contractor
Lopez	Ashley	Office Assistant	MHRS-Quality Management Services
Lopez	Azahar	Interim Assistant Deputy Director	MHRS-Quality Management Services
Lopez	Nathan	Program Manager II	MHRS-Children and Youth Services
Lum	Mark	Clinical Psychologist II	MHRS-Quality Management Services
Matsubayashi	Chiyo	Health Services Manager	MHRS-Quality Management Services
Melear	Erika	Behavioral Health Clinician II	MHRS-Children and Youth Services

Last Name	First Name	Position	County or Contracted Agency
Meyers	Jeannie	Behavioral Health Clinician II	Mental Health and Recovery Services
Miltimore	Matthew	IT Applications Developer II	MHRS-Data Analytics Team
Moran	Berenice	Administrative Manager II	MHRS-Quality Management Services
Mugrditchian	Annette	MHRS Deputy Director	Mental Health and Recovery Services
Nguyen	Sarah	Behavioral Health Clinician II	MHRS-Substance Use Disorders
Nguyen	Thuy	Behavioral Health Clinician II	Mental Health and Recovery Services
Okubo	Sandra	Senior Research Analyst	MHRS-Data Analytic Team
Parsley	Laura	Behavioral Health Clinician II	MHRS-Quality Management Services
Peralta	Hilary	Service Chief II	MHRS-Quality Management Services
Phan	Nina	Administrative Manager I	MHRS-Administration and Finance
Phan	Sarah	Mental Health Worker II	Mental Health and Recovery Services
Pitts	Cheryl	Behavioral Health Clinician II	MHRS-Quality Management Services
Punchard	Erika	Administrative Manager II	MHRS-Crisis and Acute Care Services
Radomski	Rebekah	Service Chief II	MHRS-Quality Management Services
Read-Gomez	Christy	Service Chief II	MHRS-Substance Use Disorders
Renteria	Teresa	Health Services Manager	Mental Health Recovery Services
Rick	Tracy	Administrative Manager II	MHRS-Adult and Older Adult Mental Health
Roberts	Caroline	Behavioral Health Clinician II	MHRS-Quality Management Services
Robinson	Jill	Associate Manager BH Clinical Services	Carelon

Last Name	First Name	Position	County or Contracted Agency
Rogers	Michael	Administrative Manager II	MHRS-Administration and Finance
Row	Lisa	Health Services Manager	MHRS-Adult and Older Adult Mental Health
Ruelas	Maby	Staff Assistant	MHRS-Quality Management Services
Saavedra	Sherylove	Health Program Specialist	MHRS-Quality Management Services
Sabet	Kelley	Chief Compliance Officer/Civil Rights Coordinator	OC Health Care Agency, Office of Compliance
Sagubo	Erin	Behavioral Health Clinician I	MHRS-Quality Management Services
Sanchez	Omar	Utilization Management Representative	Carelon
Secrist	Carolyn	Administrative Manager II	MHRS-Substance Use Disorders
Serna	Renee	Office Specialist	MHRS-Quality Management Services (QMS)
Siddiqui	Adil	Chief Information Officer	MHRS-Information Technology
Siddiqui	Zara	Research Analyst I	MHRS-Data Analytics Team
Sigafoos	Timothy	Service Chief II	MHRS-Crisis and Acute Care Services
Smith	Dawn	Assistant Deputy Director	MHRS-Children and Youth Services
Stroem	Ida	Research Analyst IV	MHRS-Data Analytic Team
Tang	SangPatty	Behavioral Health Clinician I	MHRS-Quality Management Services
Taylor	Melody	Administrative Manager I	MHRS-Administration and Finance
Thomas	Vanessa	Senior Health Services Manager	MHRS-Crisis and Acute Care Services
Thornton	April	Health Services Manager	MHRS-Substance Use Disorders

Last Name	First Name	Position	County or Contracted Agency
Tran	Annette	Health Services Manager	MHRS-Quality Management Services
Trujeque	Desiree	Clinical Director	Twin Town
Turakhia	Atur	Associate Medical Director	Mental Health and Recovery Services
Weckerly	Christina	Senior Health Services Manager	MHRS-Outreach & Engagement
Weidhaas	Susan	Health Services Administrator	MHRS-Quality Management Services
Yu	Angela	Associate Medical Director	Mental Health and Recovery Services
Zavala	Natalie	Director, Behavioral Health Integration	Cal Optima

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	Increasing the number of face-to-face sessions for members in treatment should improve engagement and longer stays in treatment. However, members and contract providers were not included in the development process and a comprehensive root cause analysis was not conducted, limiting the interventions to a few select possible causes. Additionally, while several interventions are staff and member driven, the strength of the design and capacity for the DMC-ODS to review program level outcome data enhances the project design. The DMC-ODS has a high staff vacancy rate that it will need to monitor to ensure capacity to implement the interventions.
General PIP Information	
MHP/DMC-ODS Name: Orange County	
PIP Title: Increase Individual Counseling to Outpatient Members to Improve Satisfactory Progress	
PIP Aim Statement: “Will increasing the number of face-to-face individual counseling sessions to four sessions within a member’s first 60 days of an episode of care for ODF outpatient (non-court) members result better member outcomes at discharge, as evidenced by a 10-percentage point increase from the baseline of satisfactory discharges (as measured on the CalOMS) for new members enrolled and discharged between September 2023 – August 2024”	
Date Started: 09/2023	
Date Completed: N/A	
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:						
Target population description, such as specific diagnosis (please specify): The PIP targets all members with an SUD diagnosis participating in outpatient treatment.						
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): N/A						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A						
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): N/A						
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
Percent of members linked from residential or outpatient treatment to short term recovery residence	FY 2021-22	42.1%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ 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:

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 interventions proposed may result in an increase of the percentage of successful linkages via members having access to a recovery residence and outpatient treatment services immediately upon discharge from WM.
General PIP Information	
MHP/DMC-ODS Name: Orange County	
PIP Title: Increasing Linkage to Lower Residential Level of Care Following Withdrawal Management Residential Detox Discharge	
PIP Aim Statement: For members who are discharging from WM services and who have requested linkage to residential services, but no residential beds are available, will the provision of interim outpatient services along with short term recovery residence housing, result in a 15-percentage point increase in linkage to lower level of care services within 30 days of WM discharge date?	
Date Started: 09/2023	
Date Completed: N/A	
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:	

Target population description, such as specific diagnosis (please specify): The PIP targets all Plan members with an SUD diagnosis discharging from WM.						
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): N/A						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A						
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): N/A						
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
			☒ 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.						

PIP Validation Information

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:

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, 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.