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FY 2023-24 Medi-Cal Specialty Behavioral Health External Quality Review

PARTNERSHIP HEALTH PLAN

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, "Partnership Health Plan" or "PHC" may be used to identify the Partnership Health Plan DMC-ODS program.

DMC-ODS INFORMATION

Review Type — Virtual

Date of Review — April 23-25, 2024

DMC-ODS Size — Medium

DMC-ODS Region — Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano Counties contracted with PHC.

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	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	5	1	0
Quality of Care	8	5	3	0
Information Systems (IS) [1]	5	3	1	1
TOTAL	**23**	**16**	**6**	**1**

[1] Please note that one Key Component in Information Systems is not applicable as the multi-county model does not lend itself to a Plan EHR. Therefore, the total items rated equals 23.

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Enhancing linkage between acute care and substance use disorder (SUD) providers with community health workers (CHW) assisting with transitions in care	Clinical	01/2024	Planning	Low Confidence
Administrative support tools for CHWs supporting acute care and SUD providers coordination for members	Non-Clinical	01/2024	Planning	Low Confidence

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐ Youth ☐ Residential ☐ Outpatient ☒ MAT/NTP* ☐ Perinatal ☐ Other	6
2	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	10

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

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

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

- PHC expanded care coordination with counties to enhance transitions to care and access for members, including positions to assist with outpatient and recovery residence access after completing residential treatment. PHC has 80 staff members in its care coordination unit.
- PHC expanded and coordinated MAT access, including NTPs, primary care clinics, and emergency department (ED) Bridge prescribers, supporting members in transition or with medical complexity. This effort includes incentives for coordinated transitions from the EDs and cross-program coordinated care for alcohol and opioid MAT providers.
- New performance improvement projects (PIPs) focused on systemwide funding and service capacity for specially trained community health workers (CHWs) in hospital EDs, documenting service engagement and coordinating care on step-downs into SUD treatments, with a $4 million investment in interventions.
- Youth wellness and prevention programs linked to behavioral health (BH) services and health equity services were expanded. These programs are both in schools and community-based locations. Solano has been a role model for this by joining programs with the County Office of Education and BH systems of care.

- Member participation in care is reflected in high penetration rates (PRs). PHC expanded the SUD Continuum to meet rising member requests for treatment. Five new providers were added in the last year, and seven are in negotiations to meet service needs. PHC coordinated efforts with county leadership to help with startup, facility identification, and infrastructure.

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

- Overdose rates continue to be high, particularly for Native American members in Mendocino and Lassen Counties, based on the 2022 DHCS opioid surveillance dashboard.[2] This is despite PHC having 37 providers providing MAT in tribal communities.
- Access Call Center services require many handoffs of members between three or more access staff before members are given an appointment for an assessment. This discourages members from getting treatment and increases dropped calls.
- The regional model has unmet service needs for youth, particularly residential treatment. County stakeholders and medical leadership explained how youth and family members need these intensive services within the region.
- The ASAM dataset has less than 11 follow-up assessments, indicating that more data tracking or staff training is needed to monitor ongoing members using services.
- Website information for members with urgent or crisis needs requires some updates to provide as much clarity as possible regarding emerging mobile crisis services and the focus on integrated care with MH.

Recommendations for improvement based upon this review include:

- Consider areas where enhanced MAT is needed for Native American populations and work with the Department of Healthcare Services (DHCS) and key local stakeholders to expand access sites and mobile services.
- With new services emerging, such as mobile crisis, coordinate with the regional model counties to streamline Access Call Center processes. This is particularly critical for both urgent and non-urgent members calling for care or information. These integrated access numbers and services should also be reflected on the PHC website and linked to the regional model counties' BH websites.
- Collaborate with regional model counties and other key stakeholders to identify opportunities to add these needed youth residential services and/or propose pilot programs to help fill critical gaps in care.

[2] www.skylab.cdph.ca.gov

- Work with the provider network and staff involved in ASAM data systems to evaluate why these numbers are so low and take corrective actions.
- Enhance the PHC website in coordination with regional model counties to clearly identify urgent and non-urgent BH treatment resources for members, including new mobile crisis resources.

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

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

This report presents the FY 2023-24 findings of the EQR for Partnership DMC-ODS by BHC, conducted as a virtual review on April 23-25, 2024.

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 personal lived experience 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 the prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from multiple source files: Monthly Medi-Cal Eligibility Data System Eligibility File; DMC-ODS approved claims; Treatment

Perception Survey (TPS); the California Outcomes Measurement System (CalOMS); and the ASAM LOC data.

CalEQRO reviews are retrospective; therefore, Plan documentation that is requested for this review covers the time frame since the prior review. 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 had 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) – summary of the validation tools are included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii).[3]
- 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.

[3] Due to the unique claiming process for the PHC regional plan, CalEQRO was unable to extract PHC PMs from the DHCS approved claims data set used for all other Plans. PHC provided FY 2022-23 claims data for inclusion in this report. This may limit the comparability to the CY 2022 statewide data.

- 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 the calculation of initially suppressed data or corresponding PR 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 did not experience any significant issues affecting its operations.

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.

- PHC implemented payment reform current procedure terminology (CPT) billing but did not have new payment reform rates proposed by DHCS for the regional model counties. These will be implemented in 2025 for the unique capitation model. They also worked with DHCS to establish a payment mechanism for counties to be reimbursed for tribal Indian Health Services within the DMC-ODS.
- Both the county system providers and other network providers changed or updated their EHRs, practice management, and claims system to implement CPT billing and other California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- PHC implemented a new financial model to retain and expand residential providers in the regional model counties. In addition, PHC added incentives for quality initiatives for hospital ED settings, which resulted in the addition and retention of substance use navigators.
- PHC implemented additional case management capacity with 80 regional care coordination staff.

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 not addressed may be presented as a recommendation again for this review. However, if the DMC-ODS has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 1: To continue to address these workforce challenges in rural areas, PHC should work with leadership from the California Behavioral Health Directors Association and key community leaders and support the rapid deployment of new peer supports and other BH workforce initiatives.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- PHC is actively working to implement peer support workers to enhance workforce capacity.
- PHC continued providing a development grant for DMC-ODS counties and providers in FY 2022-23 to hire new counselors and licensed practitioners of the healing arts (LPHAs). They receive a signing bonus of $5,000 per qualified individual.

Recommendation 2: PHC has opportunities to partner with local counties and providers and use funding and grants to develop and support recovery residence housing. This is essential for positive member outcomes and has been successful in prior years.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Recovery residence management resides outside the regional contract for PHC.
- PHC, however, expanded care coordination to support members with leveraging and coordinating key community resources linked to recovery residence access and other vital community resources for smooth transitions in care.
- This recommendation is not continued because the responsibility for this LOC is outside the scope of the PHC contract with the regional counties. However, PHC would benefit from collaboration with its counties on this issue, as recovery residences are critical for many members' success in outpatient treatment.

Recommendation 3: PHC with county and provider involvement should meet regularly with DHCS and have a coordinated communication lead from DHCS on the launch of CalAIM issues vital to comprehensive quality SUD care including payment reform within the regional model.

(This recommendation was a carry-over from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- PHC worked with DHCS to have two primary analysts working with them on quality, compliance, and new initiatives.
- Counties, DHCS, and PHC have met monthly to improve communication. This provided more clarity across the region on new policy initiatives, program requirements, and areas needing clarification by DHCS.

Recommendation 4: PHC should maintain current levels of customer service and communication as it expands and launches health services in the ten new counties and provides mechanisms for feedback if problems arise.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Regional counties reported no reduction in customer services or support due to the managed care expansion of PHC with new counties.

Recommendation 5: PHC should work with DHCS and the counties to identify ways to support members utilizing new high-risk drugs that require supervised medical withdrawal management (WM) at the closest hospitals or intensive treatment setting such as a 3.7 ASAM LOC.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- PHC held roundtable meetings to share best practices within the network for addressing members using new high-risk drugs such as xylazine and other concerning drug trends. One site became a clinical champion for consults related to high-risk cases.
- The PHC medical director conducted and recorded extensive training on issues with fentanyl addiction, withdrawal, and treatment for all providers in PHC counties. Stakeholders reported that the availability of new drugs was being

addressed with new clinical training and monitoring, also available on the PHC website.

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 healthcare services from a healthcare system. It encompasses multiple factors, including insurance/plan coverage, a 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 to care, 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 30 percent of services were delivered by county-operated sites, and 70 percent were delivered by contractor-operated sites. Overall, approximately 99 percent of services provided were claimed to Medi-Cal.

The DMC-ODS has a toll-free Access Line available to Plan members 24-hours, 7-days per week, operated by contract provider Carelon Behavioral Health staff. Members may request services through the Access Line as well as directly through network providers. The DMC-ODS operates a centralized access team responsible for linking members to appropriate, medically necessary services. This is done via a contract with Carelon, a statewide call center supporting several county BH plans.

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 175 adults, <11 youth, and <11 older adults across 5 county-operated sites and 51 contractor-operated sites. Among those served, <11 members received telehealth services in a language other than English.

NETWORK ADEQUACY

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

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

For Partnership regional model counties there are two different time and distance standards due to requirements related to population density. For the six small rural counties (Modoc, Siskiyou, Mendocino, Lassen, Humboldt, and Shasta) the time and distance requirements are 60 miles and 90 minutes for outpatient SUD services, residential services, and Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP) services. For Solano County, a medium-sized county, the time or distance standards are 30 miles or 60 minutes. These services are further measured in relation to two age groups – youth (0-17) and adults (18 and over).

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

AAS				
The DMC-ODS Plan was required to submit an AAS request due to time and distance requirements	☒ Yes ☐ No			
AAS Details	**Opioid Treatment**		**Outpatient SUD Services**	
	Adults (age 18+)	Youth (age 12 -17)	Adults (age 18+)	Youth (age 12-17)
# of zip codes outside of the time and distance standards that required AAS request		153		117
# of allowable exceptions for the appointment time standard, if known (timeliness is addressed later in this report)		N/A		N/A
Distance and driving time between the nearest network provider and zip code of the member furthest from that provider for AAS requests		223		230
Approximate number of members impacted by AAS or allowable exceptions		45,000		35,100
The number of AAS requests approved and related zip code(s)		153		117
Reasons cited for approval		0		0
The number of AAS requests denied and related zip code(s)		N/A		N/A
Reasons cited for denial		300 days		300 days

- The DMC-ODS did not meet all time or distance standards and was required to submit an AAS request.
- The DMC-ODS Plan worked to enhance time and distance by adding five new providers throughout the region and expanding the capacity of existing providers, and seven more providers are in negotiations for expansion or new sites.

- PHC continued to expand non-methadone MAT at hospitals and primary care clinics.

Table 1B: PHC 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
OON Details	
Contracts with OON Providers	
Does the DMC-ODS have existing contracts with OON providers?	☒ Yes ☐ No
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: Click or tap here to enter text.

- PHC aims to continue expanding the network and provides incentives linked to the quality plan to attract and keep providers.
- PHC is working closely with regional counties to identify gaps and seek options to address them. For example, Mendocino County and PHC are interested in exploring the development of a youth residential program for the region with its existing providers.

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- Access services include care coordination back-up for all members who do not get appointments from the Access Line when they call to request services.
- PHC has case managers assigned to all counties to assist with difficult and complex cases with unique needs and combined services. They also assist with access for members with transitions in care whose providers identify as having special needs. These sometimes require OON or single-case agreements.
- Members and counties reported challenging experiences with the Access Line and its processes and facilitation of access. As a workaround, one county encouraged members to visit their walk-in BH access center instead of using the PHC Access Line.

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 a statewide average approved claim amount of $5,998. Using PR as an indicator of access for the DMC-ODS, the PHC PR exceeded statewide PR, indicating fewer barriers to accessing services than seen statewide.

The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SUD treatment services through the DMC-ODS. If they all had similar patterns, one would expect the proportions they

constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total Plan members served.

Please note that this year's PHC report include data provided by PHC for FY 2022-23. This differs from comparisons which represent CY 2022. The unique billing structure between PHC and DHCS did not allow for compilation of the approved claims data from the SDMC data set CalEQRO obtained from DHCS.

Table 3: PHC DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, FY 2022-23

Age Groups	# Members Eligible	# Members Served	PHC PR	Medium Size Group PR	Statewide PR
Ages 12-17	37,822	105	0.28%	0.26%	0.25%
Ages 18-64	204,890	5,159	2.52%	1.37%	1.19%
Ages 65+	32,326	114	0.35%	0.72%	0.49%
Total	**275,038**	**5,378**	**1.95%**	**1.11%**	**0.95%**

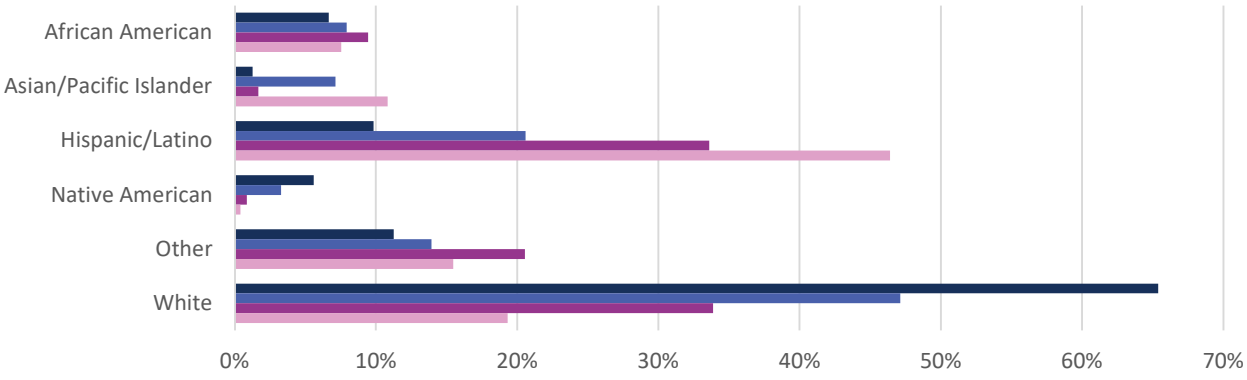
- The number of eligibles increased by 5 percent from CY 2021 to FY 2022-23.
- The total PHC PR is higher than in comparable medium-sized counties and statewide. The PHC PR is 76 percent higher than that of other medium-sized counties and more than twice the statewide PR.

Table 4: PHC DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Racial/Ethnic Group, FY 2022-23

Racial/Ethnic Groups	# Members Eligible	# Members Served	PHC PR	Medium Size Counties PR	Statewide PR
African American	21,834	358	1.64%	1.35%	1.19%
Asian/Pacific Islander	19,619	68	0.35%	0.23%	0.15%
Hispanic/Latino	56,644	529	0.93%	0.69%	0.69%
Native American	9,008	301	3.34%	2.07%	2.01%
Other	38,318	605	1.58%	1.51%	1.26%
White	129,625	3,517	2.71%	1.85%	1.67%

- The PHC PRs exceed those of medium-sized counties and statewide in all racial/ethnic categories.
- The PHC PRs for FY 2022-23 for each racial/ethnic group exceed the PHC PRs for CY 2021.

Figure 1: Percentage of Eligibles and Members Served by Race/Ethnicity, FY 2022-23



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
County % Served	65%	11%	6%	10%	1%	7%
County % Eligibles	47%	14%	3%	21%	7%	8%
State % Served	34%	21%	0.86%	34%	2%	9%
State % Eligibles	19%	15%	0.41%	46%	11%	8%

- The majority of eligibles were White (47 percent), and this group was also the largest group of members served (65 percent). Having the proportion of members served exceed the proportion of eligibles indicates a group was proportionally overrepresented in the DMC-ODS.
- Native Americans were the only other racial/ethnic group whose proportion of members served (6 percent) exceeded the percentage of eligibles (3 percent).
- All other racial/ethnic groups experienced the opposite trend with the proportion of eligibles greater than the percent served. This means that all other racial/ethnic groups experienced some degree of being proportionally underrepresented.
- The largest gap between the percent served and percent of eligibles for minority racial/ethnic groups was for Hispanic/Latino members, who represented 21 percent of eligibles but only 10 percent of members served.

Table 5: PHC DMC-ODS Plan Members Served and PR by Eligibility Category, FY 2022-23

Eligibility Categories	# Members Eligible	# Members Served	PHC PR	Medium Size Group PR	Statewide PR
ACA	112,125	3,083	2.75%	1.68%	1.42%
Disabled	37,104	779	2.10%	1.65%	1.37%
Family Adult	62,640	1,107	1.77%	1.11%	0.94%
Foster Care	983	24	2.44%	1.62%	1.84%
MCHIP	13,637	13	0.09%	0.18%	0.18%
Other Adult	24,061	50	0.21%	0.13%	0.09%
Other Child	25,151	69	0.27%	0.29%	0.27%

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

- Most PHC members served are DMC-ODS Medi-Cal eligible through the Affordable Care Act (ACA), Family Adult, and Disabled eligibility categories. The PRs for these categories exceed the statewide and medium size counties' PRs as well.
- At the time of the prior EQR, the number of foster care (FC) members was too low to report. In FY 2022-23, PHC had 24 FC members served.

Table 6: PHC DMC-ODS Average Approved Claims by Eligibility Category, FY 2022-23

Eligibility Categories	PHC AACM	Medium Size Group AACM	Statewide AACM
ACA	$8,037	$5,669	$6,216
Disabled	$8,507	$5,769	$5,707
Family Adult	$6,052	$5,322	$5,296
Foster Care	$2,083	$1,917	$2,716
MCHIP	$2,317	$2,663	$3,594
Other Adult	$7,074	$4,740	$4,075
Other Child	$1,872	$1,933	$3,194
Total	**$7,389**	**$5,621**	**$5,998**

- The total PHC AACM is higher than that of medium-sized counties and statewide.
- Maternal and Child Health Integrated Program (MCHIP), FC, and Other Child show AACMs lower than statewide.

Table 7: PHC DMC-ODS Services Used by Plan Members, FY 2022-23

PHC			Statewide	
Service Categories	**#**	**%**	**#**	**%**
Ambulatory Withdrawal Mgmt	0	0.00%	56	0.04%
Intensive Outpatient	792	10.45%	14,422	9.58%
Narcotic Treatment Program	2,076	27.38%	37,134	24.67%
Non-Methadone MAT	61	0.80%	7,782	5.17%
Outpatient Treatment	2,078	27.41%	46,441	30.85%
Partial Hospitalization	0	0.00%	13	0.01%
Recovery Support Services	104	1.37%	6,400	4.25%
Res. Withdrawal Mgmt	956	12.61%	10,429	6.93%
Residential Treatment	1,514	19.97%	27,841	18.50%
Total	**7,581**	**100.00%**	**150,518**	**100.00%**

- The most-utilized service in PHC was outpatient treatment (27.41 percent) followed closely by NTP (27.38 percent). Residential treatment was the third-highest used service (19.97 percent).
- The percentage of PHC members using residential WM services is more than 80 percent higher than statewide utilization.
- Service utilization patterns look very similar to CY 2021.
- PHC had fewer non-methadone MAT services than statewide because most of these services are delivered outside of the DMC-ODS in medical clinics.

Table 8: PHC DMC-ODS Approved Claims by Service Categories, FY 2022-23

Service Categories	PHC AACM	Medium Size Group AACM	Statewide AACM
Ambulatory Withdrawal Mgmt	$0	$693	$484
Intensive Outpatient	$3,295	$2,311	$1,729
Narcotic Treatment Program	$9,644	$5,257	$4,526
Non-Methadone MAT	$3,529	$1,842	$1,660
Outpatient Treatment	$1,360	$2,270	$2,547
Partial Hospitalization	$0	$0	$2,802
Recovery Support Services	$345	$1,419	$1,669
Res. Withdrawal Mgmt	$1,790	$2,254	$2,392
Residential Treatment	$8,136	$8,691	$10,178
Total	**$5,242**	**$5,621**	**$5,998**

- The service category with the highest AACM for FY 2022-23 is NTP. This service category also had the highest AACM in CY 2021.
- The next-highest PHC AACMs are residential treatment, non-methadone MAT, and intensive outpatient.
- The PHC AACM is slightly lower than in both medium-sized counties and statewide.

IMPACT OF ACCESS FINDINGS

- PHC provides various options for member access to screenings and care, including direct access to the provider network, the Access Line, and follow-up services provided by the PHC case management program, which links hundreds of members to appointments and assists with the placement of complex cases.
- The PR is higher for all age groups except youth than statewide PR rates.
- There has been a significant increase in the number of members who accessed care between CY 2021 and FY 2022-23.

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 greater the 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 with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors DMC-ODS' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate DMC-ODS timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

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

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

Table 9: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered MAT Appointment	Partially 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:

- PHC provided FY data for timeliness, which showed the improvements linked to the new transportation and case management systems.

- While PHC does not have the capacity to track offered appointments, given that they reported providing the requested service in 2.7 days on average, the average offered non-urgent appointment also meets the ten-business day standard. Additionally, 93 percent of members received their first service within ten business days. This implies success with the initial offered appointment. Should performance decrease on the delivered service, it may become important to track the offered appointment.
- There was a discrepancy in CalEQRO data on the non-urgent request for MAT based on different measurement tools. CalEQRO measures the first billed contact to the first dose, while PHC measures the request date for services to the first dose. PHC's data showed compliance with the three-business day requirement, but CalEQRO's measure was slightly longer.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the DMC-ODS reported in its submission of the ATA, representing access to care during the 12-month period of FY 2022-23. Table 10 and Figures 2-4 display data submitted by the DMC-ODS; an analysis follows. These data represent the entire system of care.

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

DMC-ODS-REPORTED DATA

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

Timeliness Measure	Average/Rate	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	n/a***	10 Business Days*	n/a***
First Non-Urgent Service Rendered	2.7 Business Days	10 Business Days**	93%
Non-Urgent MAT Request to First Offered NTP/OTP Appointment	1.9 Business Days	3 Business Days*	93%
Urgent Services Offered ****	60 Hours	48 Hours**	86%
Follow-up Services Post-Residential Treatment	8.81 Calendar Days	7 Calendar Days	59%
WM Readmission Rates Within 30 Days	5.8%	n/a	n/a
No-Shows	16.1%	n/a	n/a

* DHCS-defined timeliness standards as per BHIN 22-033
** DMC-ODS-defined timeliness standards
*** DMC-ODS did not report data for this measure
**** Converted to hours from days by EQRO

For the FY 2023-24 EQR, the DMC-ODS reported its performance for the following time period: FY 2022-23

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

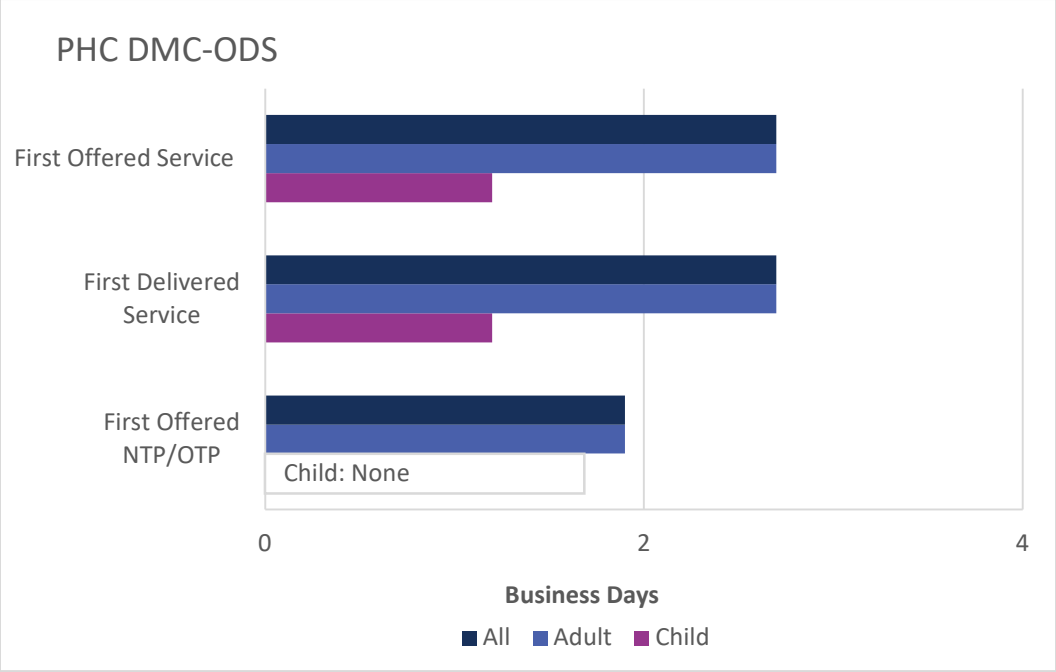


Figure 3: Wait Times for Urgent Services

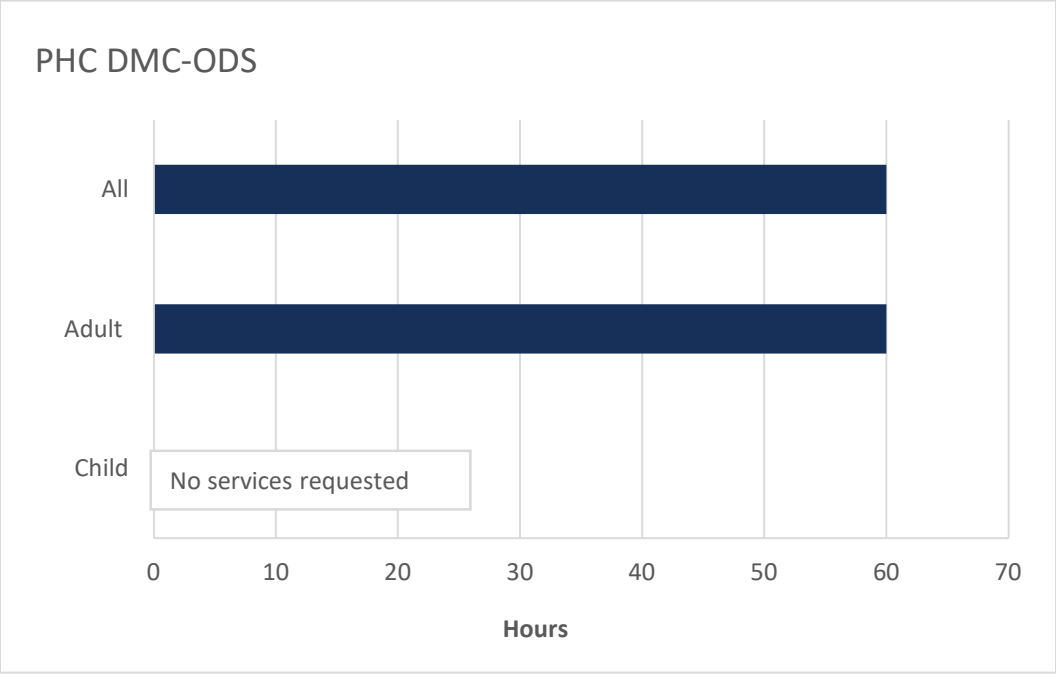
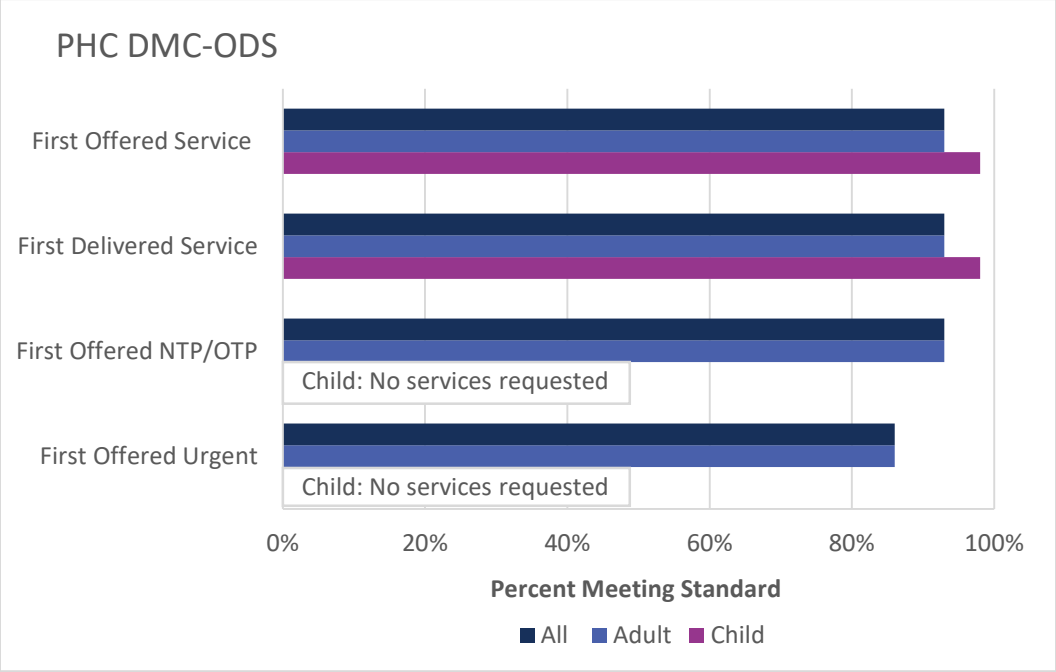


Figure 4: Percent of Services that Met Timeliness Standards



- PHC timeliness for the first offered service is not tracked, but the first rendered service averaged 2.7 days and 93 percent of rendered services met the ten business-day standard.

- For the first offered NTP/OTP appointments, the average days to first offered appointment was 1.9 days, and 93 percent of first offered appointments met the standard of three business days.
- The average hours from urgent requests to first-offered appointments was 60 hours, which exceeds the PHC standard of 48 hours. PHC reported that 86 percent of offered urgent appointments met the standard of 48 hours, and so it appears that outliers result in a longer average wait time.

TIMELINESS FROM MEDI-CAL CLAIMS DATA

The following data represents DMC-ODS performance related to methadone access and follow-up post-residential discharge, as reflected in the FY 2022-23 claims data set provided by PHC.

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

Table 11: PHC DMC-ODS Days to First Dose of Methadone by Age, FY 2022-23

PHC				Statewide		
Age Groups	# of Members	%	Avg. Days	# of Members	%	Avg. Days
12 to 17	0	0.00%	N/A	15	0.04%	12.60
18 to 64	1,868	96.09%	4.52	31,839	87.46%	3.59
65+	76	3.91%	3.96	4,551	12.50%	0.56
Total	**1,944**	**100.00%**	**4.34**	**36,405**	**100%**	**3.19**

- The PHC average days to first dose of methadone is slower than the statewide average days by 36 percent.

Transitions in Care

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

Table 12: PHC DMC-ODS Timely Transitions in Care Following Residential Treatment, FY 2022-23

	PHC N = 1,476		Statewide N = 27,232	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	199	13.48%	3,243	11.91%
Within 14 Days	266	18.02%	4,515	16.58%
Within 30 Days	321	21.75%	5,706	20.95%

- PHC's percentages of timely admissions following residential treatment compare favorably to the statewide percentages. For 7-, 14- and 30-day transition percentages, PHC exceeds the statewide percentages.

Residential Withdrawal Management Readmissions

Table 13: PHC DMC-ODS Residential Withdrawal Management Readmissions, FY 2022-23

PHC			Statewide	
Total DMC-ODS admissions into WM	956		13,062	
	#	#	#	%
WM readmissions within 30 days of discharge	64	5.48%	1,148	8.79%

- WM readmissions within 30 days of discharge were lower for PHC members than statewide by more than 3 percentage points, representing a readmission rate that is 38 percent below statewide. It is also slightly lower than the rate in CY 2021.

IMPACT OF TIMELINESS FINDINGS

- With transportation and case coordination enhancements, PHC reported excellent response times in accessing network LOCs.
- New expanded care coordination capacity appears to assist with timely access to residential treatment and transitions from acute care to treatment settings.
- PHC should improve timeliness related to urgent visits and help do more training with providers related to identification and documentation for tracking purposes.

QUALITY OF CARE

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

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

QUALITY IN THE DMC-ODS

In the DMC-ODS, the responsibility for QI is overseen by PHC and coordinated with the seven county plans. The QI structure includes and oversight committee which meets quarterly and a number of subcommittees including a specific Wellness and Recovery Committee which also holds meetings quarterly, focused on DMC-ODS quality issues and incentive programs. The committees include county leadership and providers of services as well as a large number of PHC analytics and quality staff. The entire QI staff includes 36 individuals.

The DMC-ODS monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI work plan, and the annual evaluation of the QAPI work plan. The QIC is scheduled to meet quarterly, and the DMC-ODS QIC has met four times as well since the last EQR, with additional quarterly QI meetings linking providers and cross-county coordination. The QIC is comprised of clinicians, analytics staff, care coordinators, medical leadership, and key stakeholders. Of the four key areas identified in the FY 2022-23 QAPI work plan goals, PHC improved all four areas, which were met or partially met over the prior fiscal year. The QI focus areas included transitions in care between LOCs, expansion of the network providers in specific areas and for specific LOCs and age groups, reducing readmissions to WM, and expansion of bilingual staff and the provider workforce overall.

QUALITY KEY COMPONENTS

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

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

Table 14: Quality Key Components

KC #	Key Components – Quality	Rating
3A	QAPI are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from DMC-ODS Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of an ASAM Continuum of Care	Partially 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	Partially 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:

- PHC's QI staff and leadership reviewed and addressed each goal and noted that the TPS target is 90 percent satisfaction.
- PHC is accredited for BH by the National Commission on Quality Assurance which includes BH quality questions in its Consumer Assessment of Healthcare Providers and Systems annual survey of the care experience for all members.
- PHC prepares special reports to evaluate the physical health needs of the DMC-ODS members and their access to care in all areas of need. These reports are shared with both health and BH staff and providers.
- PHC has identified that, with rising demand, more capacity is needed in a range of LOCs and regions. Five new providers were added, and seven are in contract negotiations, obtaining the needed licenses and certifications from the state.
- Areas of need identified include a youth residential treatment program in the central area of the region, mobile capacity for NTP and MAT services in general, programs for those with co-occurring disorders, and a program similar to a 3.7 ASAM LOC.
- ASAM training or systems need to be reviewed to evaluate the low reported levels of annual ASAM evaluations.

QUALITY PERFORMANCE MEASURES

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

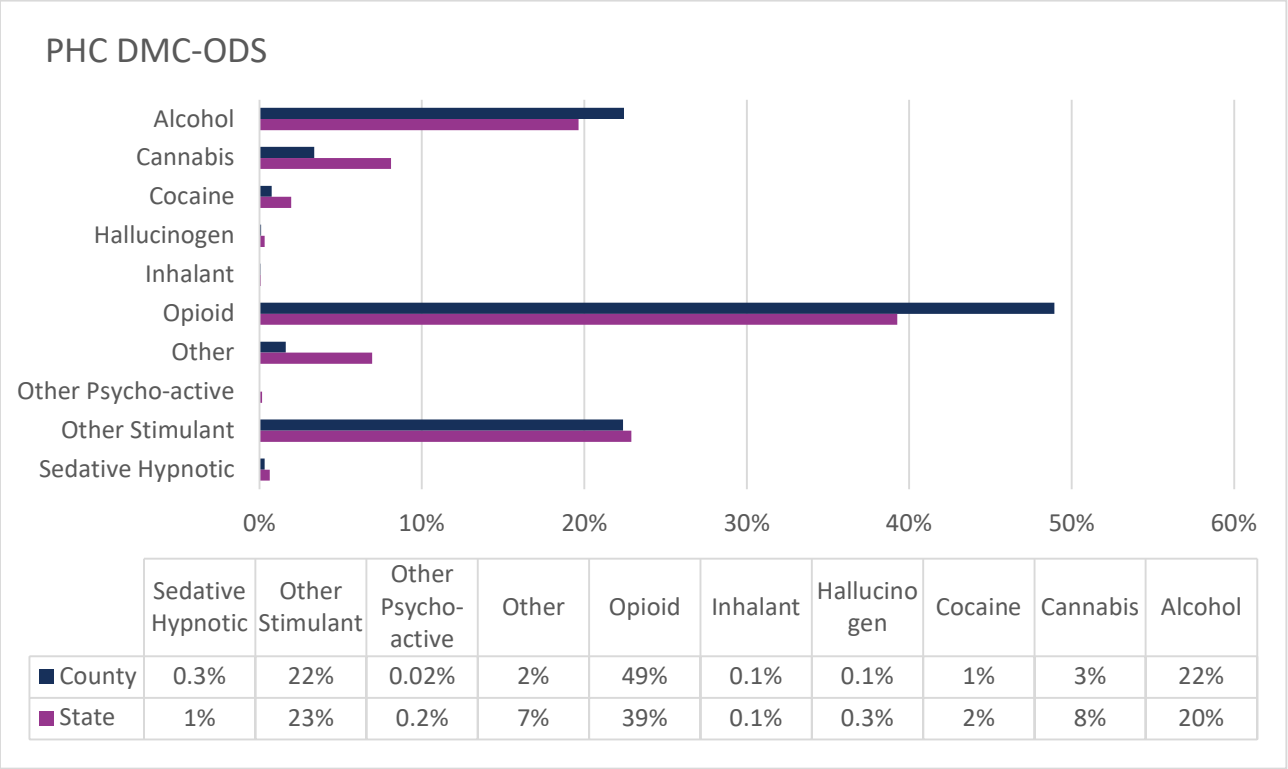
- Members served by Diagnostic Category
- Non-methadone MAT services
- Residential WM with no other treatment
- High-Cost Members (HCM)
- ASAM congruence
- Initiation and Engagement
- Length of Stay (LOS)
- CalOMS admission versus discharge for employment and housing status
- CalOMS Legal Status at Admission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

DIAGNOSIS DATA

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

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

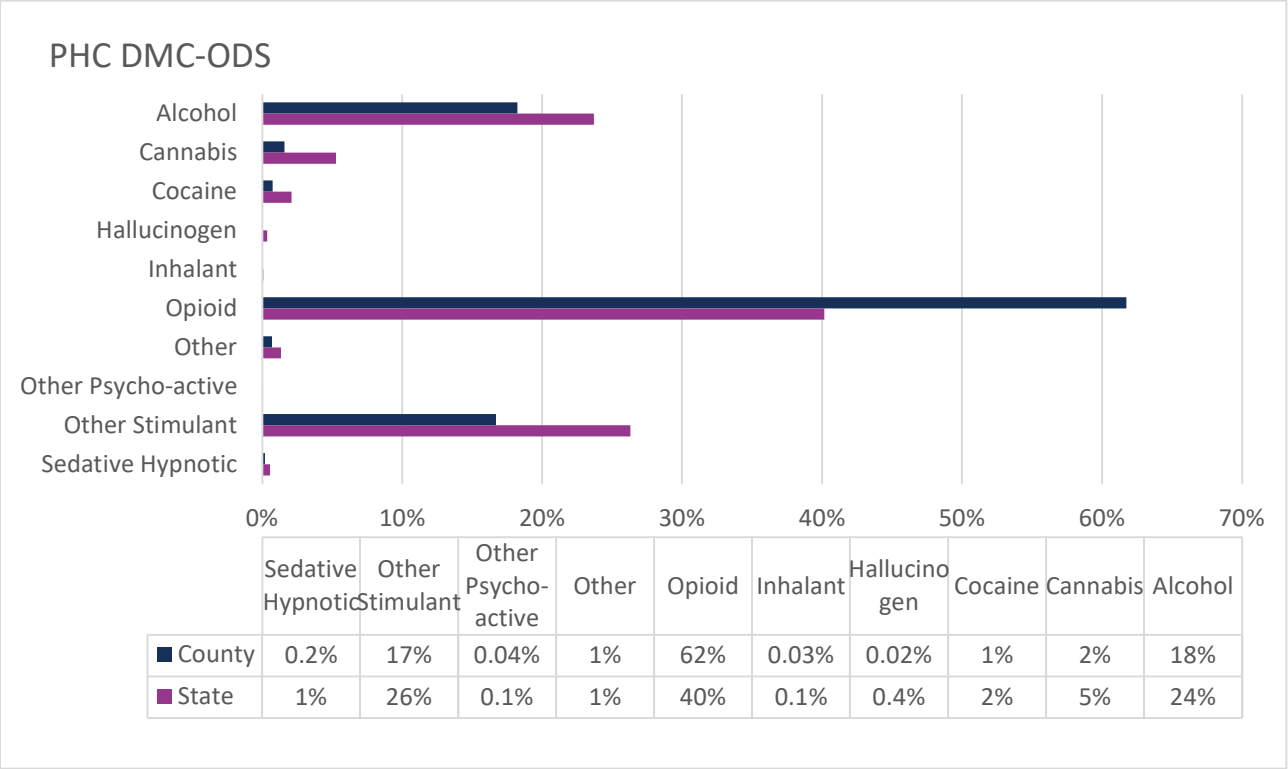
Figure 5: Percentage of Plan Members by Diagnosis Code, FY 2022-23



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	0.3%	22%	0.02%	2%	49%	0.1%	0.1%	1%	3%	22%
State	1%	23%	0.2%	7%	39%	0.1%	0.3%	2%	8%	20%

- PHC's leading substance use diagnoses in FY 2022-23 were opioid use disorder (OUD) (49 percent), other stimulant use (22 percent), and alcohol use disorders (AUD) (22 percent).

Figure 6: Percentage of Approved Claims by Diagnosis Code, FY 2022-23



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	0.2%	17%	0.04%	1%	62%	0.03%	0.02%	1%	2%	18%
State	1%	26%	0.1%	1%	40%	0.1%	0.4%	2%	5%	24%

- PHC showed lower AUD claims and increased OUD claims in FY 2022-23, when compared to CY 2021.
- OUD claims represent 62 percent of total claims, while claims for members with OUD diagnosis comprise 49 percent.
- While the percentage of cocaine abuse claims matches the percentage of members with a cocaine abuse diagnosis, and OUD claims are more than the percentage of members with OUD diagnoses, the claims for remaining diagnoses are less than the percentage of members with comparable diagnoses.

NON-METHADONE MAT SERVICES

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

PHC					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	0.0%	0	0.0%	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	**45**	**0.98%**	**20**	**0.43%**	**7,925**	**7.13%**	**4,051**	**3.66%**

- Forty-five members received at least one non-methadone MAT service from the DMC-ODS's NTP/OTPs.
- As previously stated, most non-methadone MAT is delivered through the primary care MAT substance use programs, which also can include counseling. Many of the primary care MAT programs also partner with outpatient programs for the counseling support component. This has benefited the members with more primary care health access and care coordination.

RESIDENTIAL WITHDRAWAL MANAGEMENT WITH NO OTHER TREATMENT

Table 16: PHC 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
PHC	14	1.53%
Statewide	205	2.00%

- The PHC percentage of members receiving three or more WM episodes and no other treatment is lower than the statewide percentage.
- During the prior EQR, PHC's percentage was more than four times higher than statewide. PHC attributed the high percentage to a group of members in one region who consistently did not engage in treatment following WM services. PHC worked with providers on the engagement issues in that county, and the results appear successful. This interpretation is consistent with CalEQRO's data.

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 LOC not appropriate to their needs. HCMs, for the purposes of this report, are defined as those who incur SUD treatment costs higher than two standard deviations above the mean, which for CY 2022 equates to claims of $17,188 or more.

Table 17: PHC DMC-ODS and Statewide High-Cost Members, CY 2022

	Total Members Served	HCM Count	HCM % by Count	Average Approved Claims per HCM	HCM Total Claims	HCM % by Total Claims
PHC	5,378	246	4.6%	$20,525	$5,049,150	13.60%
Statewide	105,657	5,724	5.42%	$24,551	$140,532,204	21.84%

- PHC has a low proportion of members considered to be HCMs compared to statewide.
- Most of the HCMs are associated with Mendocino County claims due to the higher rate associated with tribal NTP claims.

ASAM LEVEL OF CARE CONGRUENCE

Table 18: PHC DMC-ODS Congruence of LOC Referrals with ASAM Findings, FY 2022-23 – Reason for Lack of Congruence

ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
Not Applicable /No Difference	2,440	94.43%	1,389	70.87%	16	66.67%
Patient Preference	33	1.28%	37	1.89%	<11	-
LOC Not Available	57	2.21%	-	-	<11	-
Clinical Judgment	<11	-	357	18.21%	<11	-
Geographic Accessibility	<11	-	0	0.00%	0	0.00%
Family Responsibility	<11	-	<11	-	0	0.00%
Legal Issues	<11	-	0	0.00%	0	0.00%
Lack of Insurance/Payment	0	0.00%	0	0.00%	0	0.00%
Other	25	0.97%	164	8.37%	0	0.00%
Actual LOC Missing	0	0.00%	<11	-	0	0.00%
Total	**2,584**	**100.00%**	**1,960**	**100.00%**	**24**	**100.00%**

- PHC showed a high level of congruence for ASAM LOC for initial screenings, with a 94.43 percent rating for No Difference.
- The percentage of congruent referrals is lower (70.87 percent) for the initial assessment. The primary reasons for the difference between the ASAM findings and LOC referrals were Clinical Judgment followed by Other and then Patient Preference.
- At the time of last year's EQR, PHC said that they do not collect ASAM data routinely from providers, especially for follow-up assessments. To address this issue, since the last review, PHC incorporated the ASAM follow-up assessment into their software application to collect CalOMS data. Changes made since the last review are unlikely to be reflected in the data until the next EQR cycle.

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 19 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 pending 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 14th and 34th day following initial DMC-ODS service.

Table 19: Initiating and Engaging in PHC DMC-ODS Services, FY 2022-23

	PHC				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Members with an initial DMC-ODS service	5,534		106		99,855		4,026	
	#	%	#	%	#	%	#	%
Members who then initiated DMC-ODS services	4,806	86.84%	66	62.26%	83,830	84%	3,286	82%
Members who then engaged in DMC-ODS services	3,627	75.46%	41	62.12%	63,753	76%	2,202	67%

- Adult members served by PHC had an 86.84 percent initiation rate and 75.46 percent engagement rate. The PHC initiation rate for adults is higher than the statewide initiation rate, and the PHC engagement percentage is just below the statewide percentage.
- PHC youth initiation (62.26 percent) and engagement (62.12 percent) rates are lower than statewide.

LENGTH OF STAY

Examining Plan members' LOS in services provides another look at engagement in services and completion of treatment. Table 20 presents the number of members who were discharged from treatment in CY 2022, defined as having zero claims for any DMC-ODS services for 30+ days, the average and median LOS for members, and results indicating what proportions of members had accessed services for at least 90, 180, and 270 days, as well as statewide comparisons for reference.

Table 20: Cumulative LOS in PHC DMC-ODS Services, CY 2022

	PHC		Statewide	
Members discharged from care (no treatment for 30+ days)	6,501		139,688	
LOS for members across the sequence of all their DMC-ODS services	Average	Median	Average	Median
	138	71	158	90
	#	%	#	%
Members with at least a 90-day LOS	3,043	47%	69,919	50%
Members with at least a 180-day LOS	2,026	31%	43,096	31%
Members with at least a 270-day LOS	1,432	22%	27,677	20%

- PHC's average LOS was 138 days, which was shorter than the statewide average of 158 days. Additionally, PHC's median LOS of 71 days was shorter than the statewide median of 90 days.
- Overall, 47 percent of PHC members had at least a 90-day LOS. Also, 31 percent had at least a 180-day LOS and 22 percent had at least a 270-day LOS.
- The PHC LOS was higher than the statewide LOS for the 270-day LOS. Retention in care is a positive trait related to outcomes.

CALOMS DATA

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

Table 21: PHC DMC-ODS CalOMS Legal Status at Admission, FY 2022-23

	PHC		Statewide	
Admission Legal Status	#	%	#	%
No Criminal Justice Involvement	2,514	60.86%	58,218	64.75%
Under Parole Supervision by CDCR	156	3.78%	1,545	1.72%
On Parole from any other jurisdiction	64	1.55%	1,476	1.64%
Post-release supervision - AB 109	956	23.14%	21,080	23.45%
Court Diversion CA Penal Code 1000	-	-	1,409	1.57%
Incarcerated	<11	-	523	0.58%
Awaiting Trial	391	9.47%	5,661	6.30%
Total	**4,131**	**100.00%**	**89,912**	**100.00%**

- The majority of PHC members, 60.86 percent, report having no criminal justice involvement. Slightly more PHC members report criminal justice involvement than statewide.
- Of those members with criminal justice involvement, most are on released status supervision (under AB 109).

Table 22: PHC DMC-ODS CalOMS Discharge Status Ratings, FY 2022-23

Discharge Status	PHC		Statewide	
	#	%	#	%
Completed Treatment – Referred	940	20.22%	20,269	21.94%
Completed Treatment - Not Referred	144	3.10%	6,389	6.92%
Left Before Completion with Satisfactory Progress - Standard Questions	903	19.42%	12,961	14.03%
Left Before Completion with Satisfactory Progress – Administrative Questions	182	3.91%	7,293	7.90%
Subtotal	*2,169*	*46.66%*	*46,912*	*50.79%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	1,134	24.39%	16,260	17.60%
Left Before Completion with Unsatisfactory Progress - Administrative	1,310	28.18%	28,344	30.68%
Death	<11	-	164	0.18%
Incarceration	-	-	692	0.75%
Subtotal	*2,480*	*53.34%*	*45,460*	*49.21%*
Total	**4,649**	**100.00%**	**92.372**	**100.00%**

- The first four discharge statuses listed are considered positive discharges while the last four statuses are considered less than satisfactory. PHC members had a satisfactory progress rating of 46.66 percent of discharges, and 53.34 percent reported unsatisfactory progress. PHC positive discharges were lower than statewide percentages.
- Overall, 23.32 percent of members completed treatment. That percentage is lower than the 28.86 percent of statewide members who completed treatment.
- The discharge status data for FY 2022-23 shows a downward trend from CY 2022, with a lower satisfactory discharge percentage.

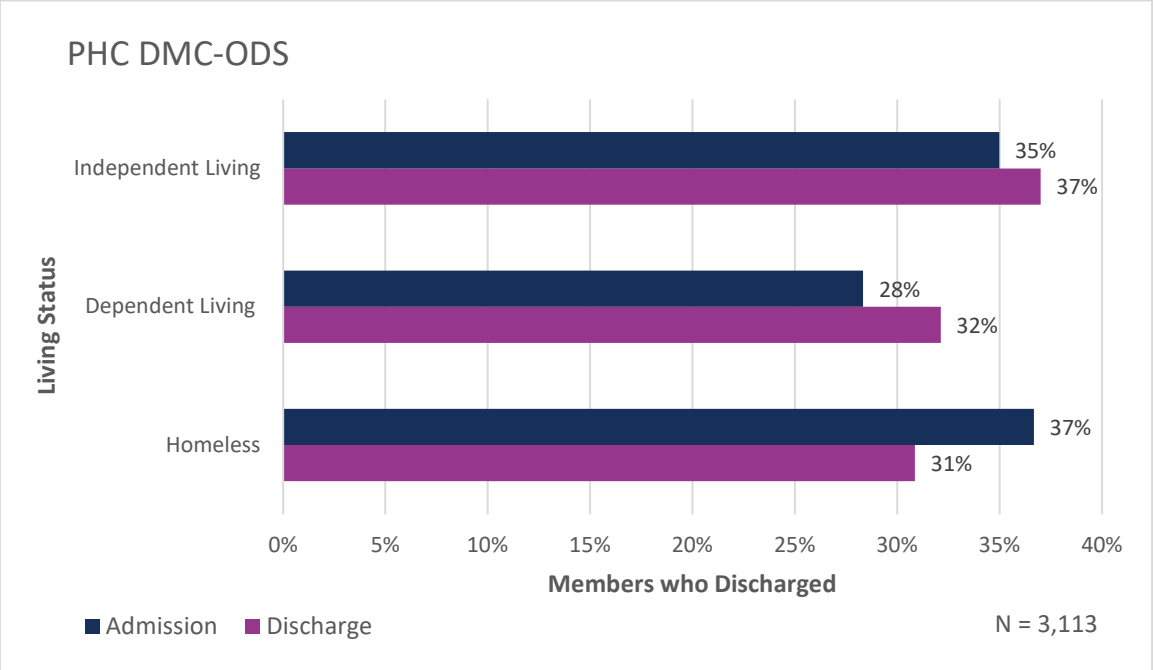
Table 23: PHC DMC-ODS CalOMS Types of Discharges, FY 2022-23

Discharge Types	PHC		Statewide	
	#	%	#	%
Standard Adult Discharges	2,102	45.21%	47,048	50.93%
Administrative Adult Discharges	1,528	32.87%	36,493	39.51%
Detox Discharges	-	-	7,409	8.02%
Youth Discharges	<11	-	1,422	1.54%
Total	**4,649**	**100.00%**	**92,372**	**100.00%**

- The percentage of PHC standard and administrative adult discharges, respectively, are less than the statewide percentages.

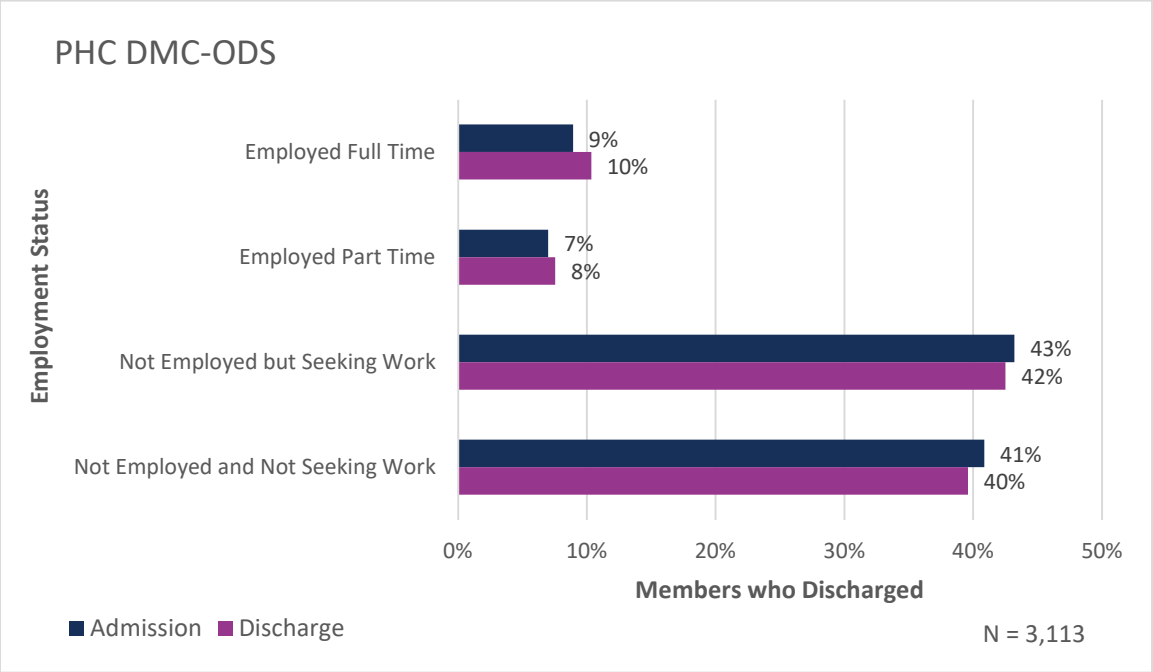
The data presented in Figures 7 and 8 reflect percent change at discharge from admission for both living status and employment status. Both questions are asked in relation to the prior 30 days.

Figure 7: CalOMS Living Status at Admission versus Discharge, FY 2022-23



- Data in Figure 7 compares CalOMS admission to discharge living status. The PHC data indicates that members' independent living improved, and homelessness decreased between admission and discharge.
- The PHC data shows that dependent living increased from admission to discharge. This difference is likely due to members living in recovery residences.

Figure 8: CalOMS Employment Status at Admission versus Discharge, FY 2022-23



- PHC data for CalOMS employment status at admission and discharge shows a slight increase in members working full and part-time.
- Figure 8 shows that fewer members are not employed.

IMPACT OF QUALITY FINDINGS

- Methadone and non-methadone data and feedback show robust efforts to engage OUD-diagnosed members in treatment, including residential with MAT.
- Lack of follow-up assessment data should be reviewed to ensure that ASAM data is complete and accurate.
- Coordination with physical healthcare, not just for non-methadone MAT, is reflected in numerous goals and dashboards used across the region. Reports often highlight health risk factors and needs, BH status, and levels of engagement and retention.
- Youth engagement and retention need additional focus in the QI plan and goals across the region.
- QI goals for residential treatment and WM emphasized continuity of care and ongoing support from care coordination, including a focus on health equity issues impacting member outcomes.

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 §§ 438.330[4] and 457.1240(b)[5]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and Plan member satisfaction. They should have a direct Plan member impact and may be designed to create change at a member, provider, and/or DMC-ODS system level.

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

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

CLINICAL PIP

GENERAL INFORMATION

Clinical PIP Submitted for Validation: Enhancing linkage between acute care and substance use disorder (SUD) providers with community health workers (CHW) assisting with transitions in care

Date Started: 01/2024

Aim Statement: "By implementing the CHW program in acute care settings, will the Follow-Up after ED visits for Alcohol Disorders (FUA) rate increase by 5 percent over baseline by 12/30/2025?"

Target Population: All members with AUD seen in ED settings with a special focus on the top three diagnoses seen including alcohol dependency, opioid use disorder, and methamphetamine use.

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

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

Status of PIP: PIP is in the planning phase, which involves the identification of CHW services, documentation, and data collection to engage and assist members with access to appropriate SUD treatment and social support.

SUMMARY

With many substance use navigators in the EDs being eliminated due to the discontinuation of grant funding, the PHC PIP has the key goal of developing a CHW model to replace and enhance this vital service, which has improved engagement in treatment for members with SUD. This PIP includes new clinical tools, workflows, service definitions, billing codes, and documentation requirements. PHC is working with counties and the network to pilot this model. PHC approved 4 million dollars to define and test this model for regional needs. Regionally, 42 percent of members presenting to an ED resulted in a subsequent SUD encounter. The goals are to increase this rate by 5 percent and create a sustainable model for this important service.

TA AND RECOMMENDATIONS

As submitted, this clinical PIP was found to have low confidence because the definitions of the interventions and system supports are incomplete. Baseline data is available, and a pilot county with acute care needs and supportive providers has been identified.

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

- Continue to define the requirements and duties of the CHW positions using best practices related to engagement in the ED or community settings.
- Refine the intervention workflows and documentation as well as the key measures to be tracked relative to goals. Consider adding readmissions to ED within 30 days.
- Define baseline numbers for the pilot where possible and set goals for expected increases in identifying referrals, successful contacts with members, and the number of members admitted to treatment within a given timeframe.
- Identify social determinants impacting engagement in treatment, such as being unhoused, co-occurring diagnoses, and language issues.

NON-CLINICAL PIP

GENERAL INFORMATION

Non-Clinical PIP Submitted for Validation: Administrative support tools for community health workers (CHW) supporting acute care and substance use disorder (SUD) providers coordination for members

Date Started: 01/2024

Aim Statement: “Administrative Support Tools for CHWs supporting Acute Care and SUD provider coordination for members to document successful linkage to SUD care.”

Target Population: All members with AUD seen in ED settings, with a special focus on the top three diagnoses seen including AUD, OUD, and methamphetamine use.

Status of PIP: The PHC PIP is in the planning phase.

SUMMARY

The goal of the PHC PIP for CHWs is to stabilize and improve upon Substance Use Navigator (SUN) services, whose funding ended in July 2023. EDs and acute care staff have expressed the need for members to be given an SUD screening and support for transitions to SUD care. PHC works with workforce development staff to identify incentives to attract bilingual CHWs. PHC is also working on a billing model and curriculum for this program. In addition, they are developing a certification and reporting structure for the CHWs. These staff members would be certified by participating in a structured program curriculum and training. The goal is also to add billing codes for some of the services to assist with the tracking and documentation. A planning group is working on these elements. Regionally, 42 percent of members presenting to an ED resulted in a subsequent SUD encounter. The goals are to increase this rate by 5 percent and create a sustainable model for this important service.

TA AND RECOMMENDATIONS

As submitted, this non-clinical PIP was found to have low confidence because some of the essential elements of the PIP are still being planned. There needs to be more clarity on each administrative intervention and how its effectiveness will be measured. The goal of CHWs with experience and training in SUD treatments will take time to develop and involve other partners, such as DHCS if the model warrants consideration of new billing and documentation requirements. Measuring the impact on member transitions is possible once data elements are clearer from the ED through to admission into SUD with supports.

There was TA provided in one session outside of the review to explore the development of the PIP and key action steps to be successfully implemented.

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

- Clarify each administrative intervention and methods of measuring their success. Ensure that these interventions are tied to distinct goals that can be differentiated from the clinical PIP.
- Create specific goals for each intervention and outcome that can be measured.
- Send regular updates to EQR and key partners to identify barriers.

INFORMATION SYSTEMS

Using the IS Capabilities Assessment protocol, CalEQRO reviewed and analyzed the extent to which the DMC-ODS meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the DMC-ODS' 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 of California's DMC-ODSs are generally managed by county, DMC-ODS IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The DMC-ODS itself does not have an EHR, but instead utilizes a care management platform called Essette from Health Management Systems, which has been in use for eight years. Partnership member counties maintain their own various EHR systems. Currently, the DMC-ODS is actively implementing a new care management platform, Jiva by ZeoMaga, which requires heavy staff involvement to fully develop.

Approximately 6.7 percent of the DMC-ODS budget is dedicated to supporting the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is unique for the regional model. There are IS costs from the counties, but PHC determines the budget for IS for the DMC-ODS.

The DMC-ODS has 107 named users with log-on authority to the EHR. The PHC IT Support group provides support for the users. Currently, all positions are filled.

Provider access is available via an integrated, provider-facing platform: Online Services. This is how PHC collects all LOC and medical necessity data from providers.

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

Table 24: PHC 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	55%
Electronic batch file transfer to DMC-ODS IS	☐ Daily ☒ Weekly ☐ Monthly	40%
Direct data entry into DMC-ODS IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	0%
Documents/files e-mailed or faxed to DMC-ODS IS	☐ Daily ☐ Weekly ☒ Monthly	5%
Paper documents delivered to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

PLAN MEMBER PERSONAL HEALTH RECORD

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. A PHR is available to members with medical information including a list of all active medication prescriptions. Information about DMC-ODS treatment is not included yet.

INTEROPERABILITY SUPPORT

The DMC-ODS is a member or participant in an HIE. PHC is a member of SacValley MedShare regional HIE. PHC is not currently exchanging DMC-ODS data with SacValley MedShare. Currently, healthcare professional staff use secure information exchange directly with service partners through secure email, the care coordination application/module, and/or electronic consult. The following outside entities have access to the EHR or engage in electronic exchange of information with the EHR: Mental health contracted providers, Federally Qualified Health Centers, DMC-ODS contracted providers, community/rural health centers, hospitals, PCPs, Indian Health Center, and managed care plans.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 25: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	Partially Met
4D	EHR Functionality	n/a[6]
4E	Security and Controls	Met
4F	Interoperability	Not Met

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

- The PHC IT budget is over 6 percent of their total budget. Allocating a large amount of their budget to technology reflects the importance to PHC of data and up-to-date technology infrastructure.
- IT and data are integrated at all organizational levels. PHC staff champion the use of data from the executive team through the rest of the organization and with providers.
- PHC has data analytics teams dedicated to different parts of their business – *e.g.,* fiscal, population health, customer service, and utilization management. The PHC IS team is aware of and follows best practice guidelines in their work whether it is hardware, applications, or data.
- The PHC BH claiming process has been interrupted by the DMC-ODS member counties that are implementing new EHR software. Several of these counties have yet to submit claims for a full month since July 2023.
- PHC, as an MCO, does not use an EHR. PHC has claims processing, member support and management, clinical tools, and fiscal software applications.
- Following a security incident in CY 2022, PHC implemented and maintains excellent, comprehensive security measures.
- PHC is a member of the SacValley MedShare regional HIE and continues working with them to develop methods to share DMC-ODS data that conforms to the requirements of Federal regulations.

[6] Please note that the EHR Functionality Key Component is rated "not applicable," as the multi-county model does not lend itself to a Plan EHR.

INFORMATION SYSTEMS PERFORMANCE MEASURES

MEDI-CAL CLAIMING

Table 26 shows the amount of denied claims by denial reason, and Table 27 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, resulting in the claims data presented in this report being incomplete for CY 2022.

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

The DMC-ODS reports that their claiming is current through March 2024. Not all counties are up to date on submitting claims because of issues with their new EHR applications.

Table 26: Summary of PHC DMC-ODS Denied Claims by Reason Code, FY 2022-23

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
See note	n/a	n/a	n/a
Total Denied Claims	**n/a**	**n/a**	**n/a**
Denied Claims Rate	**n/a**		
Statewide Denied Claims Rate	**3.64%**		

Note: The PHC unique per member/per month billing structure results in few denied claims in our dataset.

- Due to PHC's per utilizer per month claiming to DHCS, denied claims analysis reveals no claims denials.

Table 27: PHC DMC-ODS Claims by Month, FY 2022-23

Month	# Claim Lines	Total Approved Claims
Jan-22	21,701	$2,814,545
Feb-22	27,221	$3,183,913
Mar-22	38,952	$3,161,570
Apr-22	40,565	$3,334,941
May-22	39,540	$3,356,366
Jun-22	34,552	$3,279,711
Jul-22	38,005	$3,352,157
Aug-22	37,531	$3,116,268
Sep-22	41,862	$3,473,321
Oct-22	41,857	$3,420,002
Nov-22	43,938	$3,586,131
Dec-22	42,414	$3,661,918
Total	**448,138**	**$39,740,843**

- The DMC-ODS shows a consistent level of claims throughout CY 2022 indicating little claims lag.
- All DMC-ODS contracted providers submit claims for DMC-ODS services to PHC, which then adjudicates and pays approved claims. PHC submits claims data to DHCS for per utilizer per month rates.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- PHC is implementing software named Jiva from ZeoMega to replace their highly customized Essette care management software, which has been in use for eight years. They have 25 contracted IT staff to assist with the software implementation and maintaining the ongoing standard business processes.
- PHC is very data-driven. Their data expertise extends to support of the DMC-ODS counties that contract with PHC. The key informants from counties agreed that PHC was supportive of their data requests and provided requested data to them in a timely manner.
- PHC contracts with Carelon Behavioral Health to provide Access Call Center services. Staff at Access cannot view PHC's information about past treatment history when contacted by members. Past treatment history is useful in the evaluation of members' treatment needs and building on therapeutic alliances that have been helpful to members.
- PHC has set up data triggers that notify key staff when changes to selected performance indicators reach critical levels. For example, if the responses to any

of the TPS questions drop below 90 percent approval, a notification is sent to the appropriate staff.

- The PHC DMC-ODS counties were not included in the payment reform implemented that occurred for other Plans in July 2023 as part of CalAIM. Their exclusion caused some confusion among contracted providers, especially those who deliver services in multiple counties, as they were concerned that they did not receive new, generally higher, rates.

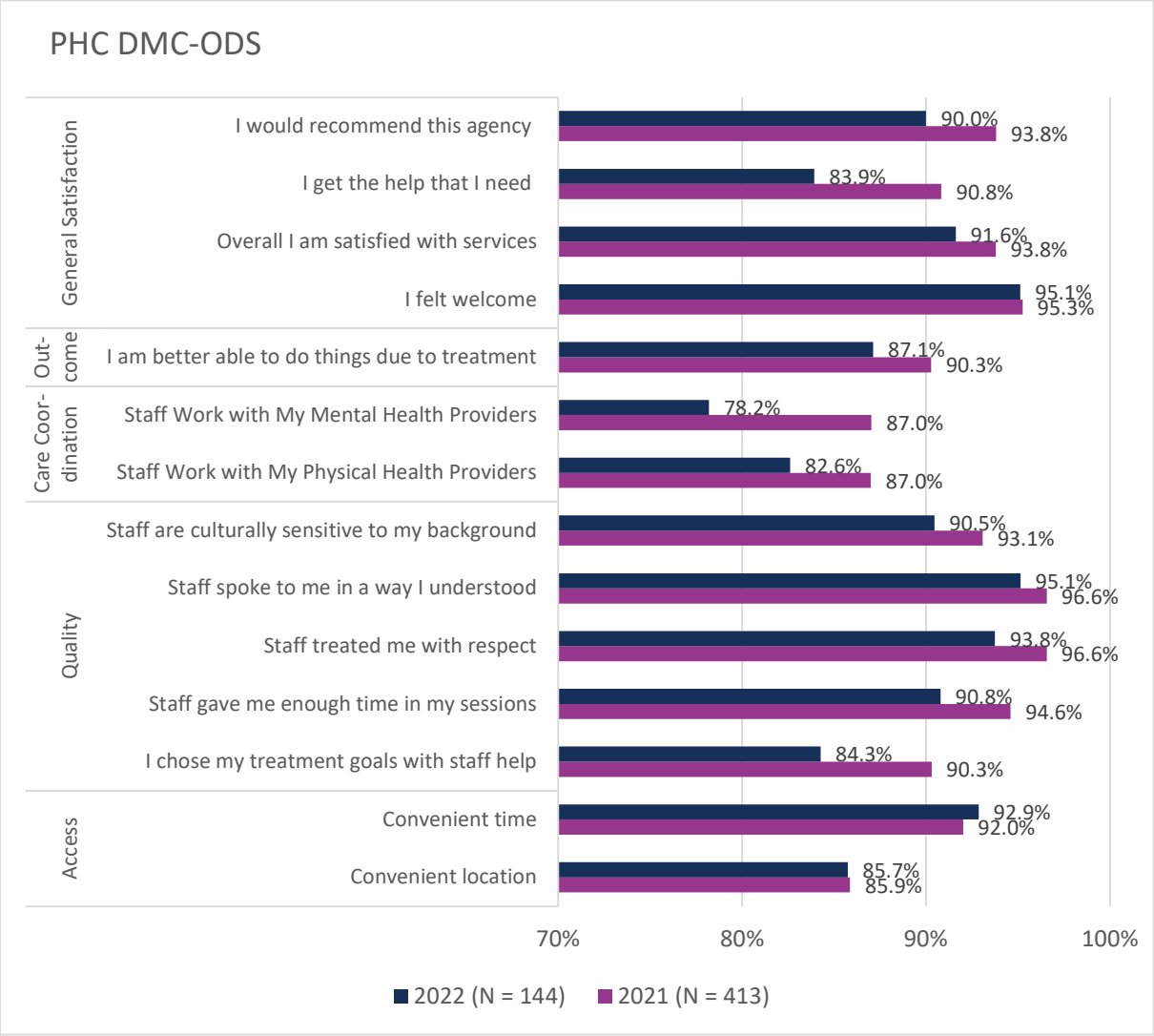
VALIDATION OF PLAN MEMBER PERCEPTIONS OF CARE

TREATMENT PERCEPTION SURVEYS

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

The DMC-ODS had a decrease in participation in the TPS compared to the prior year. The number of members who responded to the TPS in CY 2022 was only 36 percent of the number who responded in CY 2021.

Figure 9: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA, CY 2022



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

- The positive perception of care decreased for 13 of the 14 questions in the TPS from CY 2021 to CY 2022 – though two of the questions were minimally lower than in CY 2021.
- PHC reviews and responds to the TPS results. They address issues revealed in the TPS in the QAPI Work Plan.
- PHC completed a plan of correction for each result under 90 percent to investigate and improve ratings.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with Plan members and/or their families, each containing 10 to 12 participants.

PLAN MEMBER/FAMILY FOCUS GROUP ONE SUMMARY

CalEQRO requested 8 to 10 participants of diverse cultural backgrounds who had been in treatment during the last 12 months. The focus group, which included six participants, was conducted by video at a tribal NTP in Ukiah. All Plan members participating received clinical services from the PHC DMC-ODS network.

Participants reported smooth and timely access. The program site stays open until 2 p.m. and offers health and MH treatment as well, including family counseling. Several members reported not wanting take-home doses so they could come each day as staff and other members provided more social support. The counselors are excellent and go the extra mile to help with problems that could trigger a relapse. Also, staff will help them fill out grievances if they are unhappy with the care.

A participant shared an example of a counselor who assisted a member in the ED with pain. After being sent away from the ED as drug seeking, she was told she had a broken hip and was admitted.

Many of the members had been commuting to a Santa Rosa NTP before this clinic opened, and it was challenging. They were happy with this center and felt it was one of the best. “Staff are helping you with important challenges like housing and jobs as part of recovery. This is essential.”

Recommendations from focus group participants included:

- “In-person contact is valuable to maintain my recovery.” Three members mentioned that they were offered take-home doses but like showing up daily “to be accountable and get support.”
- More family and friend support are needed with events or special days “when we have achieved our goals.”

PLAN MEMBER/FAMILY FOCUS GROUP TWO SUMMARY

CalEQRO requested a diverse group of adult Plan members who initiated services in the preceding 12 months. The focus group, which included ten participants, was held at

a residential treatment program in Redding, CA. All Plan members participating received clinical services from the DMC-ODS.

Members reported a range of times getting into the program, from 1 day to 45 days. Some were waiting in jail where they could continue MAT. Referrals came from many sources, including criminal justice, family/friends, the agency website, Partnership Health staff, and Access. Most members had been in the program for two to four months. Six of the ten participants were on MAT. One representative comment was, “They treat us like we are worth something and give us hope.”

Recommendations from focus group participants included:

- “MAT is important, and so is transportation to make it work.”
- “Care coordinators are important and help us with getting critical services and things we need. More of these staff would be helpful.”
- “Animal therapy is helpful for healing.”
- “We need more programs where moms could bring children.”

SUMMARY OF MEMBER FEEDBACK FINDINGS

- Building out care navigation for support, especially with transitions in care, was valued. These staff were described as helpful, practical, and good advocates for access and key support services.
- Overall, both focus groups reported positive experiences with treatment programs and staff skills and dedication. Getting into residential treatment was more challenging than the MAT program. Both focus groups noted they had access to extra treatment and links to primary care and transportation.
- Both programs were built with more family-linked and social components, which were valued and motivating to members.

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. PHC expanded care coordination with counties to enhance transitions to care and access for members, including positions to assist with outpatient and recovery residence access after completing residential treatment. PHC has 80 staff members in its care coordination unit. (Quality)
2. PHC expanded and coordinated MAT access, including NTPs, primary care clinics, and ED Bridge prescribers, supporting members in transition or with medical complexity. This effort includes incentives for coordinated transitions from the EDs and cross-program coordinated care for alcohol and opioid MAT providers. (Access)
3. New PIPs focused on systemwide funding and service capacity for specially trained CHWs in hospital EDs, documenting service engagement and coordinating care on step-downs into SUD treatments, with a $4 million investment in the interventions. The end of funding for ED navigators was part of the motivation for this system-oriented PIP to design a sustainable, enhanced model. (Quality, Access)
4. Youth wellness and prevention programs linked to BH services and health equity services were expanded. These programs are both in schools and community-based locations. Solano has been a role model for this by integrating SUD and MH programs with the County Office of Education and BH systems of care. (Access)
5. Member participation in care is reflected in high PRs. PHC is expanding the SUD continuum to meet increasing member requests for treatment. Five new providers were added in the last year, and seven are in negotiations to meet additional service needs. PHC coordinated efforts with county leadership to help with startup and facility identification and infrastructure. (Quality, Access)

OPPORTUNITIES FOR IMPROVEMENT

1. Overdose rates continue to be high, particularly for Native American members in Mendocino and Lassen counties, based on the 2022 DHCS opioid overdose surveillance dashboard. This is despite PHC having 37 providers providing MAT in tribal communities. (Access)

2. Access Call Center services require many handoffs of members between three or more access staff before the members are given an appointment for an assessment. This discourages members from getting treatment and increases dropped calls. (Quality, Access)
3. The regional model has unmet service needs for youth, particularly youth residential treatment. County stakeholders and medical leadership explained how youth and family members need these intensive services within the region. (Access, Quality)
4. ASAM has less than 11 follow-up assessments, indicating that more data tracking or training is needed to monitor ongoing members using services and staff who are doing the assessments and recording the data. (IS)
5. Website information for members with urgent/crisis requests requires some updates to provide as much clarity as possible regarding emerging mobile crisis services and the focus on integrated care with MH. (Access)

RECOMMENDATIONS

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

1. Consider areas where enhanced MAT is needed for Native American populations and work with DHCS and key local stakeholders to expand access sites and mobile services. (Access)
2. With new services emerging, such as mobile crisis, PHC should coordinate with the regional model counties to streamline Access Call Center processes. This is particularly critical for urgent and non-urgent members calling for care or information. These integrated access numbers and services should also be reflected on the PHC website and linked to the regional model counties' websites. (Access)
3. Collaborate with regional model counties and other key stakeholders to identify opportunities to add these needed youth residential services and/or propose pilot programs to help fill critical gaps in care. (Access, Quality)
4. Work with the provider network and staff involved in ASAM data systems to evaluate why these numbers are so low and take corrective actions. (IS)
5. Enhance the PHC website in coordination with regional model counties to clearly identify urgent and non-urgent BH treatment resources for members, including new mobile crisis capacity. (Access, IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from DMC-ODS Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions - PHC DMC-ODS
Opening session – Significant changes in the past year, current initiatives, and status of previous year's recommendations, baseline data trends and comparisons, and dialogue on results of PMs
Access to Care, Timeliness of Services, and Quality of Care
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation and Analysis of the DMC-ODS Network Adequacy
Validation and Analysis of the DMC-ODS Health Information System
Validation and Analysis of Member Satisfaction
Plan Member/Family Focus Groups
QI Plan, implementation activities, and evaluation results
General data use: staffing, processes for requests and prioritization, dashboards, and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments and overdose prevention
Stakeholder Mental Health, Criminal Justice, School/Youth coordination with DMC-ODS
Clinic managers group interview – county Directors
Provider Network Managers Medical Directors
Clinical line staff group interview – county and contracted
Key stakeholders and community-based service agencies group interview
Closing session: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CALEQRO REVIEWERS

Rama K Khalsa, PhD, Lead Quality Reviewer
Anita Catapusan, RN, Quality Reviewer
Lorrie Sheets, IS Reviewer
Diane Mintz, Consumer/Family Member Reviewer

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

DMC-ODS COUNTY SITE

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
Agudelo	Vivian	BH Quality/Compliance Specialist	PHC
Ales	Jill	Clinical Manager	Mendocino
Armstrong	Tiffany	SUD Director	Lassen
Beltran	Erika	Access Manager	Carelon
Bennett	Gabriel	Program Manager	Humboldt
Bhandari	Navin	SUD Program Staff	Mendocino
Bontrager	Mark	Senior Director of Behavioral Health	PHC
Botzler-Rodgers	Emi	BH Director	Humboldt
Bradley	Josh	BH Program Staff	Lassen
Bray	Ashley	QA Manager	Siskiyou
Breazeal	Jack	Senior Manager	Humboldt
Bugnacki	Paul	Deputy Director	Humboldt
Bullock	Rose	Fiscal Manager	Siskiyou
Calderon	Fabiola	Access staff	Carelon
Caroll	Pauli	Program Manager	Humboldt
Catalan	Russ	BH Program Staff	Humboldt
Chilton	Melissa	BH Program Staff	Humboldt
Clevinger	Peggy	BH Program Staff	Modoc
Cogger	Bailey	Deputy Director	Shasta
Collard	Sarah	BH Director	Siskiyou
Cone	Amy	BH Program Staff	Humboldt

Last Name	First Name	Position	County or Contracted Agency
Cowan	Emery	BH Director	Solano
Da Silva	Robert	Access staff	Carelon
Dekruse	Jet	BH Program Staff	Humboldt
Delacruz Salas	Leticia	BH Administrator	Solano
Donovan	Breanna	Access staff	Carelon
Dosal	Alejandra	Access staff	Carelon
Dr. DeVido	Jeffrey	BH Clinical Director	PHC
Dr. Pottenger	Brent	Medical Director	Solano
Emry	Kayleigh	QI	Humboldt
Escobar (Talley)	Nicole	Senior BH Manager	PHC
Ezenwa	Yvonne	Program Manager	Solano
Flores	Irma	Access staff	Carelon
French	Alison	Account Manager	Carelon
Garcia	Anthony	Manager CSR	WellPoint
George	Rob	Senior QI Manager	Solano
Greco-Gregory	Judith	BH Supervisor	Solano
Green	Trevis	Senior Manager	Humboldt
Griffith	Lori	QI	Lassen
Halley	Katie	Account manager	Carelon
Halpin	Dani	Drug Courts	Solano
Hickey	Jeff	BH Program Staff	Shasta
Ibarra	Rachel	QM	Shasta

Last Name	First Name	Position	County or Contracted Agency
Irvin	Scott	Medical Records Manager	Humboldt
Kellum	Katherine	Drug Courts	Solano
Keppeler	Corina	BH Program Staff	Humboldt
Klinger	Ron	Manager of Care Coordination	PHC
Kullar	Mandy	BH Director	Carelon
Large	Arlette	Executive Director	Humboldt Recovery Center
Leonard	Ruth	Program Manager	Solano
Longo	Barbara	BH Director	Lassen
Mall	Anushua	BH Manager	Solano
McAllister	Debra	Director of Utilization Management Strategies	PHC
McKrola	Josette	BH Quality/Compliance Specialist	PHC
McLellan-Thompson	Lea	BH Program Staff	Humboldt
Miller	Kerra	Access staff	Carelon
Miller	Jenine	BH Director	Mendocino
Millis	Wendy	Program Manager	PHC
Mullane	Jen	Deputy BH Director	Solano
Munoz	Elizabeth	Access Staff	Carelon
Navarro-Turner	Dolores	BH Director	Humboldt
Nelson	Melissa	Manager	Aegis Eureka
O'Connell	Lisa	Associate Director of Housing and Incentive Programs	PHC
Olson	Chris	BH Supervisor	Humboldt
Phillips	Kevin	Executive Director	Archway

Last Name	First Name	Position	County or Contracted Agency
Reusze	Toby	SUD Administrator	Siskiyou
Reyes	Stacy	Senior Manager	Humboldt
Robinson	Jill	Access Staff	Carelon
Schwarz	Elvira	QI Manager	Humboldt
Smith	Zachary	Program Manager	Humboldt
Sphar	Stacy	HHS Director	Modoc
Starck	Nancy	Legislative & Policy Manager	Humboldt
Stephan	Martin	Fiscal Manager	Humboldt
Stimmann	Christina	BH Administrator	Solano
Thomas	Michelle	Director	Humboldt
Tiana	Ahimsa	BH Program Staff	Humboldt
Van Nocker	Tori	BH Program Staff	Siskiyou
Williams	Jacque	Executive Director	Ford Street
Wilson	Stephanie	Program Manager	PHC
Wisler	Loraine	BH Program Staff	Siskiyou
Zamora	Joel	Access Staff	Carelon
Zell	Aaron	BH Program staff	Humboldt

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	Partnership Health Plan with member counties is creating a new clinical model using community health workers to support successful transitions in care from hospitals and EDs to SUD treatment programs. Existing substance use navigators lost funding in July 2023 and are being repurposed or eliminated. This model using CHWs will build on the lessons learned from the ED Bridge program model and will be enhanced with new curriculum, certification, and documentation additions. It is in the Planning Phase.
General PIP Information	
MHP/DMC-ODS Name: Partnership Health Plan	
PIP Title: Enhancing linkage between acute care and substance use disorder (SUD) providers with community health workers (CHW) assisting with transitions in care	
PIP Aim Statement: "By implementing the CHW program in acute care settings, the FUA rates will increase by five percent over baseline by 12.30.2025."	
Date Started: 01/2024	
Date Completed: 12/2025	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one):	

☐ Children only (ages 0–17) * ☐ Adults only (age 18 and over) ☒ Both adults and children

*If PIP uses different age threshold for children, specify age range here: Youth over 12 years with FUA diagnoses

Target population description, such as specific diagnosis (please specify): members presenting in ED with alcohol and other drug diagnoses. In particular, the top three diagnoses are alcohol use disorder, opioid use disorder, or methamphetamine use disorder.

Improvement Strategies or Interventions (Changes in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):

Members will be engaged in the acute settings and offered treatment options by clinical staff with support and engagement assistance from a specially trained and certified CHW who will continue to contact the member to encourage and provide support for engagement in SUD treatment at an appropriate setting.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

Providers in the acute setting will identify the diagnoses of alcohol and other substance use disorders and make a referral to the CHW who will reach out to the member either in the acute setting or afterwards, in the community. The CHW will support and encourage members to consider SUD treatment, offering assistance in areas with barriers to care. They will work with members to contact treatment options and support their positive transition into treatment. Admissions and retention will be monitored for evaluation of PIP intervention success.

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 member registries or data tools):

PHC is developing the enhanced CHW provider group service to provide services similar to the substance use navigators previously funded by the DHCS ED Bridge project. The CHW model will include a structured curriculum, documentation, and billing. This initiative will be supported by a 4-million-dollar investment in creating this program to support members.

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
(1) Identification of members with FUA diagnoses in acute settings	CalMHSA baseline for diagnoses in ED		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
(2) Referrals to CHW to assist members in transitions to SUD treatment	No baseline available		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
(3) Admissions to SUD treatment by the members referred by CHWs	No baseline available		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
(4) CHW/LPHA staff who are certified with the new curriculum with incentives	No baseline available		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
EQRO recommendations for improvement of PIP: • Continue to define the requirements and duties of the CHW positions using best practices related to engagement in the ED or community settings in the curriculum. • Refine the intervention workflows and documentation as well as the key measures to be tracked relative to goals. Consider adding readmissions to ED within 30 days. • Define baseline numbers for the pilot where possible and set goals for expected increases in identifying referrals, successful contacts with members, and the number of members admitted to treatment within a given timeframe. • Also, identify social determinants impacting engagement in treatment, such as being unhoused, co-occurring diagnoses, and language issues.

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 PHC non-clinical PIP provides the data and administrative infrastructure for this new program including data collection and transfers, documentation requirements, billing codes for specific eligible activities, and providing a formal certification and training process for the new CHW navigator staff.
General PIP Information	
MHP/DMC-ODS Name: Partnership Health Plan	
PIP Title: Administrative support tools for community health workers (CHW) supporting acute care and substance use disorder (SUD) providers coordination for members	
PIP Aim Statement: "Administrative Tools for CHWs supporting Acute Care and SUD provider coordination for members to document successful linkage to SUD care."	
Date Started: 01/2024	
Date Completed: 12/2025	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17) * ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here: Youth 12 years and older.	

Target population description, such as specific diagnosis (please specify): All members with AUD seen in ED settings with a special focus on the top three diagnoses seen, including alcohol dependency, opioid use disorder, and methamphetamine use disorder.

Improvement Strategies or Interventions (Changes in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):

Members will be diagnosed by acute-care treatment staff and referred to a CHW navigator for assistance and support in considering options for SUD treatment and then supporting these options, taking into account barriers to treatment.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

Providers will document the diagnoses and send referrals to the CHW. These referrals will have rapid follow-up and, ideally, engagement while the member is still in the acute setting or soon thereafter. The CHW will be mobile and have a special training curriculum, certification for SUD, and knowledge of the DMC-ODS care system. They will also be trained in documentation, motivational interviewing, and care coordination skills.

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 member registries or data tools):

The PHC CHW project is a major system shift to support ongoing SUD navigators in acute settings and in the community. Data will be used to evaluate success; the goal is a 5 percent improvement over prior years in FUA linkage. New billing and documentation models for this pilot PIP will be developed as part of the implementation.

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
Electronic referrals to the CHW care navigators.	None available	CalMHSA available information	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Documentation from CHWs on support and contacts following the referral. % members contacted reflected in the documentation.	None Available		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of members admitted to SUD programs and services from ED referrals	2023 if available		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Numbers of members billed for and for which specific services.	None available		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
The concept of an enhanced FUA system with CHW-level navigators is positive if it provides continuity and support to the members from acute care into ongoing SUD treatment for their disorders. There are several administrative interventions to make the validation and tracking of referrals easier and to analyze barriers and challenges. The PIP is in an early planning stage, and definitions of measures and the refinement of all administrative actions need to be validated at a higher level. Most of the modeling is based on best practices and lessons learned from the ED Bridge program using the substance use navigators in acute settings, many of which have lived experiences relevant to enhanced engagement success. The investment in the model using CHW navigators with bilingual skills is building upon the ED Bridge navigator funding by DHCS as part of the MAT expansion program. The design is more complex because of the certification process of the new navigators and adding billing and documentation structures, but this will help with a more complete understanding of the benefits and challenges of the model. These administrative elements will help provide a more complete evaluation of the model's success.
EQRO recommendations for improvement of PIP: • Clarify each administrative intervention and methods of measuring their success. • Create specific goals for each intervention that can ideally be measured. • Clarify baseline data numerically where possible. • Send regular data and progress updates to EQR and key partners to identify barriers and get needed support.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the CalEQRO website: www.caleqro.com

ATTACHMENT E: LETTER FROM DMC-ODS DIRECTOR

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