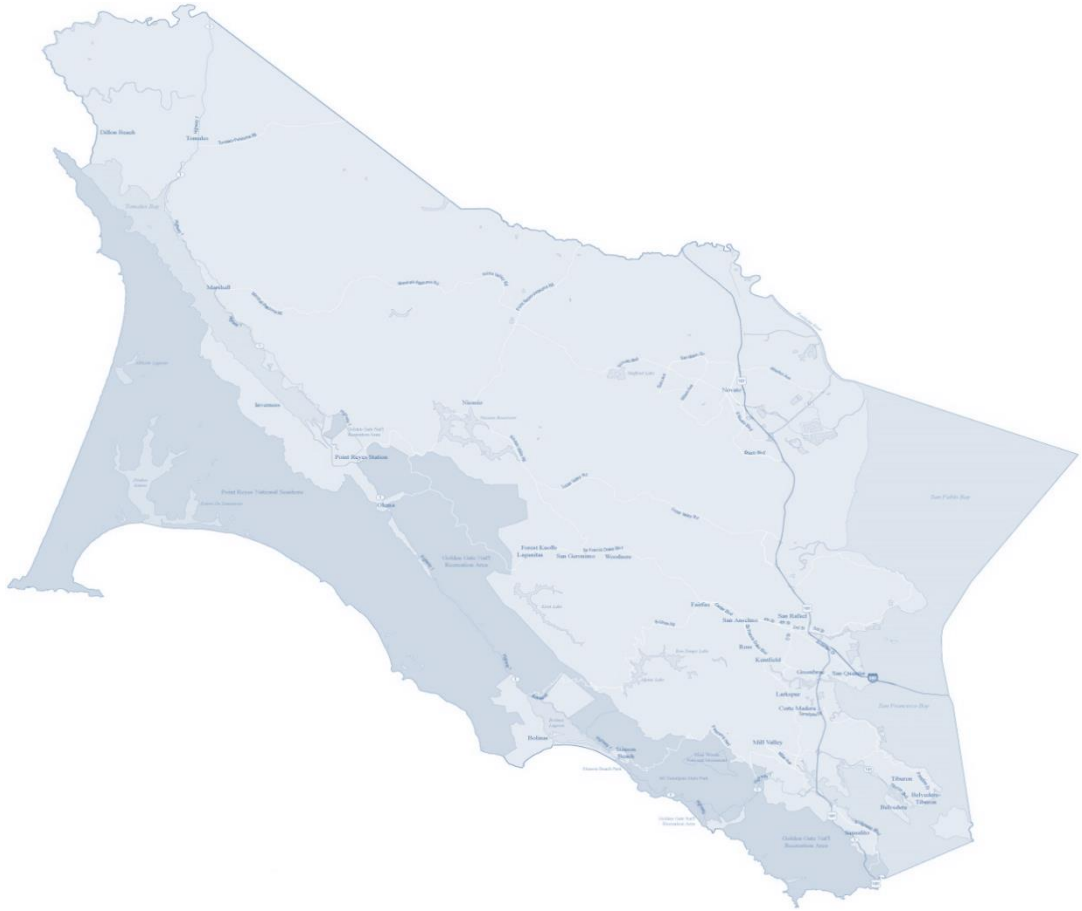
# Marin County
# Drug/Medi-Cal Organized Delivery System (DMC-ODS)
# Quality Improvement Work Plan
# July 1, 2023 – June 30, 2024





COUNTY OF MARIN

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

**Quality Management Program Description**

The Marin Drug/Medi-Cal Organized Delivery System (DMC-ODS) Quality Management (QM) program is responsible for monitoring the DMC-ODS' effectiveness and for providing support to all areas of DMC-ODS operations by conducting performance monitoring activities which include, but are not limited to: utilization management, utilization review, provider appeals, credentialing and monitoring, resolution of beneficiary grievances, and analysis of beneficiary and system outcomes.

The QM program's activities are guided by the relevant sections of Federal and California State regulations, including the Code of Federal Regulations Title 42, Title 9, and the DMC-ODS' Intergovernmental Agreement with the State Department of Health Care Services (DHCS).

Activities in the QM program are performed by the DMC-ODS Administrative team, which consists of the County Alcohol and Drug Administrator, Program Manager, two Department Analysts, two Senior Program Coordinators and one Administrative Services Technician, as well as partners—and integrates many functions with—the Behavioral Health and Recovery Services Quality Management team, which includes licensed clinicians dedicated to performing Utilization Reviews for the DMC-ODS. QM staff carries out their job responsibilities as defined by their individual professional disciplines and scopes of practice.

The Utilization Management (UM) program is a component of the QM program. The UM program assures that beneficiaries have appropriate access to DMC-ODS services. Program activities include: the evaluation of medical necessity determinations, the appropriateness and efficiency of services, as well as the access to capacity and geographical distribution of services provided to Marin County Medi-Cal beneficiaries. The different programs and committees within the QM Department provide structure for the quality improvement and oversight responsibilities of the organization.

The **Operations Committee** is led by QM, Fiscal, Administrative and IT representatives. During these meeting, stakeholders identify and discuss issues across the BHRS system that relate to the Electronic Health Record (EHR) system, the practice management system, policies and procedures, documentation processing, and other administrative tasks that are essential to providing quality services to consumers and family members.

**Quality Improvement Program**: The Quality Improvement program monitors the overall service delivery system with the aim of improving processes of care provision and increasing consumer and family member satisfaction and outcomes.

**The Quality Improvement Committee (QIC)** is a combined MH and SU services committee, and is comprised of a diverse group of stakeholders, including representatives from DMC-ODS and MHP administration and clinical programs, peers/family members, the patient rights advocate, and contractors/community partners. QM staff is responsible for facilitating a quarterly QIC meeting to review findings from a range of compliance and quality improvement activities, including specified DMC-ODS data elements, and to obtain input into these and other areas for improvement.

BHRS has an active **Equity and Community Partnerships Committee** (ECPC), formerly Cultural Competency Advisory Board (CCAB**),** which is comprised of BHRS management, BHRS line staff, contract agency providers, consumer advocates, consumers, community leaders from ethnic communities and an administrative aide to one of the county's Supervisors. There are three existing working committees within the Board: Training, Policy, and Access. The board is tasked to analyze data, review existing improvement plans, examine practice approaches and make recommendations related to policy, service delivery, staffing and training needs, and system improvements. QM staff provides data for the CCAB, and there is shared participation in both the QIC and ECPC on the management, staff and consumer level.

BHRS convenes a monthly **DMC-ODS Contractors** meeting which is comprised of management staff from the contracted provider network, County DMC-ODS staff, BHRS QM staff and Recovery Coach/Care Managers. BHRS also convenes periodic joint DMC/MHP Provider meetings.

**Quality Improvement Work Plan**: The intent of the Quality Improvement (QI) Work Plan is to create systems whereby data relevant to the performance of the DMC-ODS is available in an easily interpretable and actionable form. The elements of this QI Work Plan are informed by the quality improvement requirements of the DMC-ODS performance contract, and feedback from the EQRO and QIC. This year's plan continues the work of the previous plan's work of improving the capture, analysis and use of data to support contractual compliance, performance management and decision making. Performance improvement activities focus on improving provider network adequacy, accessibility, timeliness and outcomes of services and serve to enhance the DMC-ODS's daily work of supporting the recovery and resiliency of the consumers and family members in our community. Efforts have also focused on embedding an equity lens into our service design, delivery and continuous quality improvement efforts.

## DMC-ODS QI Work Plan (July 1, 2023 – June 30, 2024)

| Category | Goal | Planned Activities |
|---|---|---|
| Timeliness – Access to Services | In FY 2023-24, at least 95% of beneficiaries will be served within the Final Rule timely access standards. At a minimum, timely access measures will include number of days to first DMC-ODS service at an appropriate level of care following initial request or referral and timeliness of services of the first dose of NTP services. | 1. Review reporting capability in data collection systems to identify any needed revisions and update accordingly [e.g. Access Contact Log, SmartCare]<br>2. Review data collection methodology for calculating out-of-county residential admissions and implement recommendations<br>3. Provide training, as needed, to DMC-ODS Providers on updated SmartCare regarding timely access<br>4. Create an automated report from SmartCare to monitor timely access metrics.<br>5. Monitor and analyze timely access data at a minimum quarterly, including stratifying by race/ethnicity and preferred language<br>6. Present timely access data to stakeholders, including DMC-ODS Providers and the Quality Improvement Committee<br>7. In instances of exceeding timely access standards, provide assistance to Providers to identify and address. |

<table>
<tr><th>Evaluation</th><th>FY 2023-24 Performance Targets and Baseline Metrics</th></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td>
<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2023-24)</th></tr>
<tr><td>Days from Initial Request to First DMC-ODS Service</td><td>95% within 10 business days</td><td>• Outpatient/IOS: 97.3% [Mean: 2.8 days] 396/407<br>• Residential: 97.8% [Mean 3.6 days] 181/185<br>• Residential WM: 100% [Mean 0.1 days] 545/545</td></tr>
<tr><td>Days from Initial Request to First DMC-ODS Service disaggregated by race/ethnicity</td><td>95% within 10 business days for all races/ethnicities</td><td>
<table>
<tr><th></th><th>OS/IOS</th><th>Residential</th><th>Residential WM</th></tr>
<tr><td>Overall Average</td><td>95.1%</td><td>95.7%</td><td>100.0%</td></tr>
<tr><td>Alaskan Native or American Indian</td><td>100%**</td><td>100%**</td><td>100%**</td></tr>
<tr><td>Asian</td><td>84.6%</td><td>100%**</td><td>100%*</td></tr>
<tr><td>Black / African American</td><td>91.4%</td><td>94.7%</td><td>100%</td></tr>
<tr><td>Hispanic/Latino</td><td>96.6%</td><td>96.6%</td><td>100%</td></tr>
<tr><td>Other Race</td><td>100%*</td><td>87.5%</td><td>100%</td></tr>
<tr><td>Two or More Races</td><td>50%**</td><td>100%**</td><td>100%*</td></tr>
<tr><td>White</td><td>95.5%</td><td>95.7%</td><td>100.0%</td></tr>
</table>
*Sample size of 9 or fewer,**sample size of 5 or fewer
</td></tr>
<tr><td>Days from Initial Request to First Dose of NTP</td><td>95% within 3 business days</td><td>100% [Mean: 0.06 days, Min: 0 days, Max: 3 days] 93/93</td></tr>
<tr><td>Days from Initial Request to First Dose of NTP disaggregated by race/ethnicity</td><td>95% within 3 business days for all races/ethnicities</td><td>
<table>
<tr><th></th><th>NTP (Target w/i 3 days)</th></tr>
<tr><td>Overall Average</td><td>94.6%</td></tr>
<tr><td>Alaskan Native or American Indian</td><td>N/A</td></tr>
<tr><td>Asian**</td><td>100%</td></tr>
<tr><td>Black / African American</td><td>100%</td></tr>
<tr><td>Hispanic/Latino</td><td>100%</td></tr>
<tr><td>Other Race**</td><td>100%</td></tr>
<tr><td>Two or More Races**</td><td>75.0%</td></tr>
<tr><td>White</td><td>93.4%</td></tr>
</table>
*Sample size of 9 or fewer,**sample size of 5 or fewer
</td></tr>
<tr><td>Days from Assessment** to Admission [First Treatment Visit]</td><td>95% within 10 business days</td><td>• Residential WM: 545/545, 100% [Mean 0.10 days]<br>• Outpatient (OS/IOS): 396/407, 97.3% [Mean 0.98 days]<br>• Residential: 181/185, 97.8% [Mean 2.2 days]</td></tr>
<tr><td>Days/hours from Initial Request to Urgent Appointment</td><td>95% within 48 hours</td><td>• 98.5% [Avg. of 0.1 days] 521/530</td></tr>
</table>
*Baseline for Urgent Appointments is based on the determination of a need for withdrawal management and a withdrawal management encounter within two days (rather than 48 hours) of the identification.<br>**Used intake as metric for start date.
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<table>
<tr><td>Timeliness – Authorization for Services</td><td>In FY 2023-24, 100% of responses to Residential Treatment Authorization Requests (TAR) will occur within 24 hours of the request.</td><td>1. Analyze Residential Authorization data at least quarterly and present it to stakeholders, including DMC-ODS Providers and Quality Improvement Committee<br>2. Monitor timely submission of sending and documenting NOABDs</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2"><table><tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr><tr><td>Percent of Access Line responses within 24 hours of receiving Residential Treatment Authorization Requests (TAR)</td><td>100%</td><td>97.7%<br>(337 of 345)</td></tr><tr><td>Percent of Notices of Adverse Benefit Determination (NOABD) issued for responses to TARs that are greater than 24 hours</td><td>100%</td><td>100%</td></tr></table><br>Data Source: BHRS Access (TAR) Log; BHRS NOABD Log.</td></tr>
<tr><td>Timeliness – Residential Authorization Quality</td><td>In FY 2023-24, there will be a 20% reduction in TARs put in Pending status.</td><td>1. Analyze Residential Authorization data at least quarterly and present it to stakeholders, including DMC-ODS Providers and Quality Improvement Committee<br>2. Review Pending TARs to identify trends and any technical assistance needed to improve the quality of and appropriateness of TARs<br>3. Provide technical assistance and ASAM Training, as needed, to Residential Providers and Access Line staff to ensure TARs are submitted for beneficiaries appropriate for Residential treatment</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2"><table><tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr><tr><td>Percent of TARs with a Pending disposition</td><td>6.8%</td><td>8.4%<br>(29 of 345)</td></tr></table><br>Data Source: BHRS Contact (TAR) Log</td></tr>
</table>

<table>
<tr><td>Access – Access Line Quality</td><td>By June 30, 2024, at least 75% of substance use treatment referrals from the Access Line will be to the indicated ASAM Level of Care.</td><td>1. At least quarterly, analyze and provide to staff Access Line referral and DMC-ODS Provider data.<br>2. Identify and address barriers to logging the recommended ASAM Level of Care field (Access Log)<br>3. Provide ASAM Criteria and other applicable training to BHRS Access staff.<br>4. Engage BHRS Access and DMC-ODS providers to identify strategies for improving accurate referrals, if needed, and to identify strategies to improve the percentage of beneficiaries referred that enroll in a DMC-ODS service. Continue to explore strategies through PIP implementation.</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
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<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Percent of beneficiaries referred from the Access Line to DMC-ODS services who are admitted to any DMC-ODS level of care within 14 days of referral.</td><td>25%</td><td>14.3%<br>(2/14)</td></tr>
<tr><td>Percent of beneficiaries referred from the Access Line to DMC-ODS services who are admitted to any DMC-ODS level of care within 30 days of referral.</td><td>35%</td><td>14.3%<br>(2/14)</td></tr>
<tr><td>Percent of referrals from the Access Line to the indicated ASAM Level of Care [screened LOC matched admitted LOC]</td><td>75%</td><td>100%<br>(2/2)</td></tr>
<tr><td>Percent of beneficiaries participating in a substance use screening with an ASAM level of care logged</td><td>85%</td><td>100%<br>(14/14 = ASAM LOC | 6/6 = N/A)</td></tr>
</table>
Data Sources: BHRS Contact Log; Marin WITS
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<table>
<tr><td>Access – Access Line Performance Metrics</td><td>In FY 2023-24, continue routine monitoring of the Access Line Performance metrics, including average time to answer a call and call abandonment.</td><td>1. At a minimum of monthly, analyze Access Line performance data<br>2. Continue to work with County IST to ensure all data is available<br>3. Perform test calls to the Access Line – include business and afterhours calls and in multiple languages<br>4. Distribute monthly Access Line dashboards and quarterly test call results to stakeholders.<br>5. If improvements are warranted, identify appropriate strategies to address the performance issues, including revisiting contract requirements for the afterhours provider.</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Average time to answer a call</td><td>20 seconds</td><td>12.5 seconds</td></tr>
<tr><td>Percent of abandoned calls</td><td>5%</td><td>Unavailable</td></tr>
<tr><td>Test calls placed</td><td>36</td><td>38</td></tr>
</table>
Data Source: Avaya/Cisco; BHRS Test Call Log submitted to DHCS. Average time to answer a call data (Access Dashboard – July 1, 2022 – June 30, 2023)
</td></tr>
</table>

<table>
<tr><td>Access – Afterhours Services</td><td>By June 30, 2024, 100% of County-operated and contracted DMC-ODS providers will have procedures in place to link beneficiaries with afterhours care.</td><td>1. Perform onsite reviews at DMC-ODS sites and assess compliance with posting afterhours information at sites and in admission agreements.<br>2. Perform test calls afterhours to assess linkage to care.</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2"><table><tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr><tr><td>Percent of DMC-ODS Providers with procedures in place to link beneficiaries with afterhours care</td><td>100%</td><td>100%</td></tr></table><br>Data Source: BHRS Site Visit; Provider Site Visit. Includes DMC-ODS sites and 24/7 facilities.</td></tr>
<tr><td>Access and Quality</td><td>By June 30, 2024, all DMC-ODS providers will be collecting Sexual Orientation and Gender Identity (SOGI) data in SmartCare.</td><td>1. Provide training and technical assistance to Providers on SOGI data, including the importance of its collection and how to complete the applicable fields in SmartCare.<br>2. Participate in CalMHSA Semi-Statewide EHR efforts to provide feedback regarding SOGI data elements being included and required fields.<br>3. Develop reporting templates to track data and provide feedback to Providers.<br>4. Provide ongoing technical assistance to improve data quality.</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #</td><td colspan="2">• Implementing in FY 2023-24, so no baseline data to report.</td></tr>
</table>

| | | |
|---|---|---|
| Access –Penetration Rates | By June 30, 2024, there will be a 15% increase from FY 2022-23 in penetration rates among the Latinx and Asian/Pacific Islander populations. | 1. Seek input from the DMC-ODS Provider network and community members on potential barriers to service for Latinx and Asian/Pacific Islander adults<br>2. Outreach to community leaders and organizations to seek input on strategies and/or services to more effectively serve the Latinx and Asian/Pacific Islander populations<br>3. Expand services as appropriate<br>4. Promote available resources<br>5. At least biannually, review penetration rate data to assess trends and identify opportunities to address disparities |
| **Evaluation** | **FY 2023-24 Performance Targets and Baseline Metrics** | |
| Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item # | | |

| Measure – Penetration Rates | Performance Target | FY 2022-23 DMC Claims | FY 2022-23 CalOMS Data |
|---|---|---|---|
| Overall | 1.81% | 1.73% (764) | 1.81% (799) |
| Race Ethnicity | | | |
| White | 3.45% | 3.30% (467) | 3.45% (490) |
| Hispanic/Latino | 1.15% | 0.83% (148) | 1.01% (174) |
| African-American | 4.00% | 3.48% (68) | 4.00% (78) |
| Asian/Pacific Islander | 0.95% | 0.70% (17) | 0.83% (20) |
| Native American | 5.13% | 3.85% (4) | 5.13% (4) |
| Other | 3.01% | 2.21% (22) | 3.01% (33) |
| Missing | N/A | 1.62% (39) | N/A (0) |

Data Source: Monthly average MMEF of beneficiaries ages 12+. DMC Claims (Dimensions) and CalOMS Data (Marin WITS)

<table>
<tr><td>Access – Network Adequacy</td><td>By June 30, 2024, Marin DMC-ODS will maintain and monitor a network of providers that is sufficient to provide adequate access to DMC-ODS services as evidenced by 100% of beneficiaries being able to access the appropriate level of care within the Final Rule time and distance standards.</td><td>1. Analyze and map beneficiary and service data to assess access to services within 30 miles or 60 minutes.<br>2. Prepare and post a monthly Provider Directory, which includes information on beneficiary capacity, linguistic capabilities, hours and physical accessibility of services, cultural competency and specialty.<br>3. Identify and seek additional network providers if gaps exist in terms of geography or level of care.<br>4. Submit Network Adequacy Certification data to DHCS annually</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Percent of beneficiaries able to access Outpatient services within 30 miles or 60 minutes</td><td>100%</td><td>100%</td></tr>
<tr><td>Percent of beneficiaries able to access OTP services within 30 miles or 60 minutes</td><td>100%</td><td>100%</td></tr>
<tr><td>Number of beneficiaries accessing community-based MAT services through the DMC-ODS</td><td>250</td><td>232</td></tr>
</table>
<ul><li>Data Sources: MMEF; Marin WITS. MAT beneficiaries include all unduplicated clients served at Marin Treatment Center receiving any MAT services, including Medicare.</li></ul>
</td></tr>
</table>

<table>
<tr><td>Access – Network Adequacy</td><td>In FY 2023-24, maintain all ASAM levels of care required in the DMC-ODS Waiver available to Marin Medi-Cal beneficiaries (18+).</td><td>1. Analyze MMEF and data for beneficiaries in substance use treatment to project the types and location of services needed<br>2. Review listing of Drug/Medi-Cal certified sites and identify gaps<br>3. Provide technical assistance to prospective providers to submit Drug/Medi-Cal applications<br>4. Outreach to out-of-county partners and programs to explore the feasibility of accessing additional services, if identified as a need. Consider regional contracting approaches, as applicable<br>5. Identify additional service gaps and strategies for ensuring all ASAM levels of care are available for beneficiaries (18+)</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
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<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Required: Percentage of DMC-ODS Required Services Available in FY 2023-24</td><td>100%</td><td>100%</td></tr>
</table></td></tr>
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| | | |
|---|---|---|
| Quality – Cultural Competency | By June 30, 2024, at least 80% of DMC-ODS beneficiaries will report services are culturally sensitive. | 1. Analyze SmartCare on preferred language, language in which service was provided, and whether an interpreter was used to deliver the service. Analyze data to assess percentage of beneficiaries receiving services in their preferred language<br>2. Analyze key metrics (e.g. access, timeliness, outcomes) by race/ethnicity, gender and other demographic characteristics to identify and address disparities<br>3. Prepare and post a monthly Provider Directory, which includes information on beneficiary capacity, linguistic capabilities accessibility of services, cultural competency and specialty.<br>4. Engage stakeholders to identify workforce development and training needs<br>5. Develop a training plan, including topics, trainers, timeframe and required/optional participants<br>6. Provide trainings and track attendance and outcomes<br>7. Work with providers to ensure cultural competence training. |

| Evaluation | FY 2023-24 Performance Targets and Baseline Metrics |
|---|---|
| **Annual Goal Met:**<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item # | |

| Measure | Performance Target | Baseline (FY 2022-23) |
|---|---|---|
| Percent of DMC-ODS staff participating in annual cultural competency training. | 90% | 86.4% (n=127/147) |
| Percentage of beneficiaries who have a positive response (4+ out of 5) on the Treatment Perceptions Survey when asked about cultural sensitivity of services | 90% | 89.8% (n=133/148) Average Score: 4.4 |
| Percentage of non-White beneficiaries who have a positive response (4+ out of 5) on the Treatment Perceptions Survey when asked about cultural sensitivity of services | 90% | 86.0% (n=37/43) Average Score 4.3 |
| Beneficiary informing materials available in all threshold languages [Spanish and English] and translation services available at no cost to the beneficiary | 100% | 100% |
| Percent of beneficiaries receiving services in their preferred language | 100% | 99% (1134/1148) |

Data Sources: Training Logs (NACT); Treatment Perceptions Survey (Fall 2022); Marin WITS (FY 2022-23)

<table>
<tr><td>Quality – Beneficiary Engagement</td><td>By June 30, 2024, at least 75% of beneficiaries will engage in DMC-ODS services.</td><td>1. Review existing data collection fields and systems to identify any needed revisions and update accordingly [e.g. Provider Logs, SmartCare]<br>2. Provide training to DMC-ODS Providers on fields regarding no shows in SmartCare<br>3. Monitor and analyze initiation, engagement and no-show data at a minimum quarterly.<br>4. Develop a new report to analyze no show by first scheduled service<br>5. Analyze initiation and engagement data by race/ethnicity<br>6. Consider additional methods to assess initiation and engagement<br>7. Present initiation, engagement and no-show data to stakeholders, including DMC-ODS Providers and the Quality Improvement Committee<br>8. Identify strategies for improvement in areas not meeting performance targets</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th>Measure</th><th>Performance Target</th><th>FY 2022-23 (Inc. Res WM)</th><th>FY 2022-23 (Excl. Res WM)</th></tr>
<tr><td>Percent of beneficiaries who receive a second service within 14 calendar days of admission to treatment</td><td>80%</td><td>91.5% (n=1099/1201)</td><td>98.7% (n=679/688)</td></tr>
<tr><td>Percent of beneficiaries who have at least four treatment days/sessions within the first 30 days from admission to treatment*</td><td>75%</td><td>83.6% (n=1004/1201)</td><td>97.4% (n=670/688)</td></tr>
<tr><td>Percent of No Shows to NTP-methadone appointments</td><td>3.5%</td><td colspan="2">0%</td></tr>
<tr><td>Percent of No Shows to non-methadone MAT appts.</td><td>3.5%</td><td colspan="2">0%</td></tr>
<tr><td>Percent of No Shows to counseling appointments</td><td>10%</td><td colspan="2">7.8%</td></tr>
<tr><td>Percent of No Shows to non-NTP/MAT appts. [OS/IOS]</td><td>10%</td><td colspan="2">2.3%</td></tr>
<tr><td>Percent of No Shows to first scheduled service</td><td>15%</td><td colspan="2">8.3%</td></tr>
</table>
Sources: MAT No Shows: MTC Tower and Marin WITS; Initiation and Engagement: Marin WITS. Note: For NTP/non-methadone MAT No Shows, WITS showed 0%. The OTP's EHR may have additional detail, but unable to provide.
</td></tr>
</table>

<table>
<tr><td>Quality – Clinical Documentation</td><td>By June 30, 2024, at least 90% of DMC-ODS beneficiary charts that are reviewed will be approved for upload to DHCS.</td><td>1. Update (as needed) and distribute procedures and resources related documentation to monitor BHIN, Title 9, DMC-ODS and 42 CFR 438 requirements and other pertinent information regarding documentation redesign<br>2. Provide relevant training/technical assistance to DMC-ODS providers on CalAIM policies, including documentation reform and the DMC-ODS requirements.<br>3. BHRS UR staff will be cross-trained to perform DMC-ODS and MHP documentation reviews.<br>4. A licensed UR specialist will perform documentation reviews that monitor DMC-ODS STCs, CalAIM requirements, Title 9 and applicable 42 CFR 438 requirements, including establishing medical necessity, ensuring the beneficiary is at the appropriate ASAM level of care, and the interventions are appropriate for the diagnosis and level of care.</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Percentage of beneficiaries that are in the assessed ASAM Level of Care</td><td>85%</td><td>• All ASAMs: 72.2% (n=1090/1509)<br>• Among Clients Served after (n=1089/1134) ASAM: 96.0%</td></tr>
<tr><td>Percentage of beneficiary files reviewed during the monthly URC that are approved for uploading to DHCS</td><td>90%</td><td>98%</td></tr>
</table>
Data Sources: ASAM Level of Care – Marin WITS/ASAM Log Submitted to DHCS. URC data reflects disallowed/recouped number of units.
</td></tr>
</table>

<table>
<tr><td>Quality – Primary Care Coordination</td><td>By June 30, 2024, at least 80% of beneficiaries participating in the annual TPS survey will report a positive response (4+ out of 5) when asked about coordination with primary care.</td><td>1. Engage DMC-ODS providers to identify current and proposed practices for identifying and linking a beneficiary to primary care<br>2. Review TPS data to identify areas of focus for improving coordination with primary care<br>3. Update SmartCare, as needed, to include a field(s) for recording whether a beneficiary has a primary care provider and efforts to link beneficiaries with care<br>4. Update documentation, as needed (e.g. Contractor Manual, Marin EHR training materials, Policies & Procedures, etc.)<br>5. Train DMC-ODS providers to in updated procedures and data collection requirements<br>6. Work with Partnership Health Plan to identify strategies for sharing data across primary care and substance use services</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Percentage of beneficiaries who have a positive response (4+ out of 5) on the Treatment Perceptions Survey when asked about coordination with primary care</td><td>80%</td><td>82.1% (N=119/145)</td></tr>
<tr><td>Average score on the Treatment Perceptions Survey regarding coordination with physical health providers</td><td>4 [Agree]</td><td>4.2 (Adult)</td></tr>
</table>
Data Source: Treatment Perceptions Survey, Fall 2022 administration
</td></tr>
</table>

<table>
<tr><td>Quality – Mental Health Care Coordination</td><td>By June 30, 2024, at least 80% of beneficiaries participating in the annual TPS survey will report a positive response (4+ out of 5) when asked about coordination with mental health.</td><td>1. Engage DMC-ODS providers to identify current and proposed practices for identifying and linking a beneficiary to mental health<br>2. Review TPS data to identify areas of focus for improving coordination with mental health<br>3. Update SmartCare, as needed, to include a field(s) for recording whether a beneficiary has a mental health provider and efforts to link beneficiaries with care, if appropriate<br>4. Update documentation, as needed (e.g. Contractor Manual, Marin EHR training materials, Policies & Procedures, etc.)<br>5. Train DMC-ODS providers to in updated procedures and data collection requirements<br>6. Work with Partnership Health Plan and BHRS to identify strategies for sharing data across mild/moderate and specialty mental health, respectively, and substance use services</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Percentage of beneficiaries who have a positive response (4+ out of 5) on the Treatment Perceptions Survey when asked about coordination with mental health</td><td>80%</td><td>84.9%<br>(n=118/139)</td></tr>
<tr><td>Average score on the Treatment Perceptions Survey regarding coordination with mental health providers</td><td>4 [Agree]</td><td>4.3 (Adult)</td></tr>
</table>
Data Source: Treatment Perceptions Survey, Fall 2022 administration
</td></tr>
</table>

<table>
<tr><td>Quality – Complaints, Grievances and Appeals</td><td>By June 30, 2024, respond to 100% of grievances, appeals and expedited appeals within the Final Rule timelines.</td><td>1. Review existing Policies and Procedures and update accordingly to incorporate requirements from the DMC-ODS STCs and 42 CFR 438<br>2. Review DMC-ODS provider policies, procedures and forms for complaints, grievances and appeals and provide technical assistance, as needed<br>3. Report grievance, appeal and other beneficiary protection information at least quarterly to DHCS and at QIC meetings</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th colspan="3">Baseline (FY 2022-23)</th></tr>
<tr><th>Number of Grievances</th><th>Received</th><th>Resolved within Final Rule Timelines</th></tr>
<tr><td>Access to Care</td><td>0</td><td>N/A</td></tr>
<tr><td>Quality of Care</td><td>1</td><td>100%</td></tr>
<tr><td>Program Requirements</td><td>1</td><td>100%</td></tr>
<tr><td>Service Denials</td><td>0</td><td>N/A</td></tr>
<tr><td>Failure to Respect Enrollee’s Rights</td><td>0</td><td>N/A</td></tr>
<tr><td>Interpersonal Relationship Issues</td><td>1</td><td>100%</td></tr>
<tr><td>Other</td><td>1</td><td>100%</td></tr>
<tr><td>Total</td><td>4</td><td>100%</td></tr>
</table>
*Data Source: Marin BHRS Grievance/Appeal Log
</td></tr>
</table>

| | | |
|---|---|---|
| Quality – Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) | By June 30, 2024, there will be a 15% increase in number of beneficiaries who are engaged in a substance use service within seven, 14 and 30 days following a non-fatal opioid overdose.<br><br>By June 31, 2024, there will be an equitable distribution of Marin Medi-Cal beneficiaries having a treatment encounter within 7 and 30 days following a non-fatal opioid overdose when disaggregated by race/ethnicity<br><br>By June 31, 2024, there will be an equitable distribution of Marin Medi-Cal beneficiaries having a treatment encounter within 7 and 30 days following a non-fatal opioid overdose when disaggregated primary language. | 1. Conduct a Performance Improvement Project to improve FUA.<br>2. Partner with HHS Epidemiology to develop procedures for routine sharing of EMS data<br>3. At least quarterly, analyze EMS and EHR data to identify service linkages and re-admission rates. Ensure analysis disaggregates data by race/ethnicity.<br>4. Partner with OD Free Marin, Substance Use Navigators, DMC-ODS providers and other stakeholders to review data and identify strategies for improving equitable service linkages between Emergency Departments and substance use services<br>5. Continue implementation of a bilingual Recovery Coach partnering with Marin EDs |

<table>
<tr><th>Evaluation</th><th colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</th></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Percent of beneficiaries with a substance use service treatment contact within seven days following a non-fatal opioid overdose.</td><td>22.1%</td><td>19.2%</td></tr>
<tr><td>Percent of beneficiaries with a substance use service treatment contact within 14 days following a non-fatal opioid overdose.</td><td>22.1%</td><td>19.2%</td></tr>
<tr><td>Percent of beneficiaries with a substance use service treatment contact within 30 days following a non-fatal opioid overdose.</td><td>22.1%</td><td>19.2%</td></tr>
<tr><td>Percent of white and non-white beneficiaries having a treatment encounter within 30 days of a non-fatal opioid overdose.</td><td>All: 22.1%</td><td>Overall: 19.2% (15/78)<br>White: 17.6%<br>Black/African American: 20.0%<br>Hispanic/Latinx: 20.0%<br>Asian or PI: 0%</td></tr>
</table>
Data Source: Baseline represents EMS and Marin WITS data for July 1, 2022 – May 31, 2023 (EMS Dashboard)
</td></tr>
<tr><td>Quality/Outcomes – Pharmacotherapy of Opioid Use Disorder - MAT Treatment Engagement (POD/OUD)</td><td>By June 30, 2024, of Marin Medi-Cal beneficiaries initiating MOUD services from the Plan, increase the percentage of continuous MOUD services over the first 30 days by 5%.</td><td>1. Conduct a Performance Improvement Project to enhance POD.<br>2. Establish data sharing agreements and workflows between MAT providers and other stakeholders.<br>3. Collect baseline data, including a disparity analysis.<br>4. Create a report in SmartCare to calculate retention<br>5. Engage beneficiaries and other stakeholders to identify interventions to address, with initial focus on engagement within the first 30 days of service.</td></tr>
</table>

<table>
<tr><th>Evaluation</th><th colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</th></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th>Measure</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Percent of beneficiaries initiating MOUD that have continuous services for the first 30 days.</td><td>83%</td><td>79%<br>(n=39 initiations / January – March 2023)</td></tr>
</table>
Data Source: Baseline represents EMS and Marin WITS data for July 1, 2022 – May 31, 2023 (EMS Dashboard)
</td></tr>
<tr><td>Quality – Frequency of Follow-Up Appointments</td><td>By June 30, 2024, there will be a 10% increase in number of beneficiaries who are engaged in a substance use service within seven, 14 and 30 days following discharge from a level of care.</td><td>1. Develop an automated report to track frequency of follow-up contacts post discharge from a level of care.<br>2. At least quarterly, analyze data to identify trends and opportunities for improvement/intervention. Disaggregate data by race/ethnicity.<br>3. Distribute data and engage applicable providers to improve frequency of follow-up, as needed</td></tr>
</table>

| Evaluation | FY 2023-24 Performance Targets and Baseline Metrics |
|---|---|

**Annual Goal Met:**
☐ Met: Item #
☐ Partially Met: Item #
☐ Not Met: Item #
☐ Continued: Item #

| Measure | Performance Target | Baseline (FY 2022-23) |
|---|---|---|
| Percent of beneficiaries with a contact in the next level of care within seven days following discharge from a level of care. | Residential: 31.9%<br>WM: 21.7%<br>Outpatient: 4.7%<br>IOS: 26.6%<br>OTP 9.1% | Residential [n=136]: 26.5%<br>WM [n=470]: 15.7%<br>Outpatient [n=117]: 6.0% (11.1%)*<br>IOS [n=112]: 33.0% |
| Percent of beneficiaries with contact in the next level of care within14 days following discharge from a level of care. | Residential: 38.3%<br>WM: 25.1%<br>Outpatient: 4.7%<br>IOS: 26.6%<br>OTP 18.4% | Residential [n=136]: 32.4%<br>WM [n=470]: 18.5%<br>Outpatient [n=117]: 6.0% (13.7%)*<br>IOS [n=112]: 33.9% |
| Percent of beneficiaries with a contact in the next level of care within 30 days following discharge from a level of care. | Residential: 47.9%<br>WM: 27.7%<br>Outpatient:4.7%<br>IOS: 26.6%<br>OTP 55% | Residential [n=136]: 42.6%<br>WM [n=470]: 20.0%<br>Outpatient [n=117]: 6.0% (14.5%)*<br>IOS [n=112]: 34.8% |
| Average days until first clinical appointment in next level of care after discharge from another level of care | Residential: 7.4<br>WM: 4.1<br>Outpatient: 1.8<br>IOS: 1.2<br>OTP: 17.3<br>All: 5.3 days | Residential: 9.1<br>WM: 3.9<br>Outpatient: 4.4<br>IOS: 2.2<br>All: 5.1 days |
| Average days until first clinical appointment in next level of care after discharge from another level of care by race/ethnicity | White: 5.3<br>Hispanic/Latinx: 5.3<br>Black/African American: 5.3<br>Asian/PI: 5.3<br>Native American: 5.3<br>Other: 5.3 | White: 5.7<br>Hispanic/Latinx: 4.8<br>Black/African American: 4.4<br>Asian/PI: 1.6<br>Other: 5 |

Source: Marin WITS. Average time between next level of care when diff days >0 and <=30. * Data in parentheses reflects Recovery Residence or Recovery Coach being included in the calculation for connection to next level of care.

<table>
<tr><td>Quality – Outcomes</td><td>By June 30, 2024, there will be improvements from admission to discharge in domains including reductions in substance use, improvements in mental and physical health, gainful employment/educational attainment, reductions in justice involvement, attaining stable housing, and improved family/social support.</td><td>1. Dedicate staff to perform analyses at least biannually. Analyses shall also include outcomes stratified by race/ethnicity, gender and other demographic categories<br>2. Outreach to DHCS to identify additional reporting features in BHIS<br>3. Engage stakeholders (e.g. QIC, DMC-ODS Providers) to review trends and identify strategies for improvements, if needed<br>4. Increase training for contractors on collecting data for administrative discharges.<br>5. Analyze the distribution of residential length of stay and whether there are external drivers influencing lengths of stay.<br>6. Work with providers to address preconceptions of length of stay rather than based on medical necessity.<br>7. See if there is any connection between outcomes (maybe discharge status) and length of stay.</td></tr>
<tr><td>Evaluation</td><td colspan="2">FY 2023-24 Performance Targets and Baseline Metrics</td></tr>
<tr><td>Annual Goal Met:<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item #</td><td colspan="2">
<table>
<tr><th colspan="3">Changes from Admission to Discharge – Adolescent [Outpatient and Intensive Outpatient]</th></tr>
<tr><th>Metric</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Percent Decrease in Juvenile Justice Involvement at Discharge</td><td>80%</td><td>100%<br>(From 1 to 0)</td></tr>
<tr><th colspan="3">Client Status at Discharge – Adolescent [Outpatient and Intensive Outpatient]</th></tr>
<tr><td>Percent Participating in Social Support Activities at Discharge</td><td>80%</td><td>10% (1 of 10)</td></tr>
<tr><td>Percent in School at Discharge</td><td>80%</td><td>10% (1 of 10)</td></tr>
</table>
Data Sources: Marin WITS CalOMS export
</td></tr>
</table>

| Client Status at Discharge – Adult [Outpatient, Intensive Outpatient and Residential] | | |
|---|---|---|
| Percent of Beneficiaries Employed at Discharge | 60% | **Overall: 53.1% (120 of 226)**<br>Outpatient: 57.7% (41/71)<br>Intensive OS: 68.6% (59/86)<br>Residential: 27.9% (19/68) |
| Percent Participating in Social Support Activities at Discharge | 75% | **Overall: 61.7% (235 of 381)**<br>Outpatient: 50.9% (57/112)<br>Intensive OS: 58.8% (77/131)<br>Residential: 73.2% (101/138) |
| Percent in Stable (Independent) Housing at Discharge | 40% | **Overall: 35.1% (120 of 342)**<br>Outpatient: 42.6% (40/94)<br>Intensive OS: 55.0% (61/111)<br>Residential: 13.9% (19/137) |
| Percent of Clients with a Positive Discharge (Codes 1-4) | 60% | **Overall: 52.0% (198 of 381)**<br>Outpatient: 44.6% (50/112)<br>Intensive OS: 48.1% (63/131)<br>Residential: 61.6% (85/138) |
| Percent of Clients with a Positive Discharge disaggregated by race/ethnicity (Codes 1-4) | All races/ ethnicities are within 5 percentage points of the average | FY2022-23 / OS / IOS / Res<br>White: 35% / 45% / 69%<br>Hispanic/Latinx: 67% / 55% / 50%<br>African American: 31% / 27% / 53%<br>Other Race: 36% / 60% / 64%<br>**Sample size 10 or fewer; ** Noted in red if more than 5 percentage points lower than the average* |
| Average Length of Stay by Episode | OS/IOS: 90 days | Overall: 70.7 days<br>Outpatient: 83.7 days<br>Intensive OS: 82.4 days<br>Residential: 49.1 days |

**Changes from Admission to Discharge – Adult [Outpatient, Intensive Outpatient and Residential]**

<table>
<tr><th>Metric</th><th>Performance Target</th><th>Baseline (FY 2022-23)</th></tr>
<tr><td>Average Length of Stay by Episode disaggregated by race/ethnicity</td><td>All races/ ethnicities are within 10% of the average</td><td>
<table>
<tr><th>FY 2022-23</th><th>OS</th><th>IOS</th><th>Res</th></tr>
<tr><td>White</td><td>78.7</td><td>75.6</td><td>53.4</td></tr>
<tr><td>Hispanic/Latinx</td><td>79.8</td><td>47.0</td><td>44.8</td></tr>
<tr><td>African American</td><td>113.8</td><td>86.5</td><td>42.9</td></tr>
<tr><td>Asian</td><td>51.0*</td><td>131.5*</td><td>25.0*</td></tr>
<tr><td>Two+ Races</td><td>63.6*</td><td>54.5*</td><td>25.0*</td></tr>
<tr><td>Other Race</td><td>122.3*</td><td>82.0*</td><td>41.7*</td></tr>
</table>
*Sample size 10 or fewer<br>**Noted in red if more than 10% lower than the average</td></tr>
<tr><td>Percent Decrease from Admission to Discharge in Criminal Justice Involvement at Discharge</td><td>75%</td><td>Overall decrease 66.7% (from 66 to 22)
<table>
<tr><th>FY2022-23</th><th>% Decrease</th></tr>
<tr><td>White</td><td>69.7%</td></tr>
<tr><td>Hispanic/Latinx</td><td>66.7%</td></tr>
<tr><td>African American*</td><td>62.5%</td></tr>
<tr><td>Other*</td><td>57.1%</td></tr>
</table>
*Sample size 6 or fewer<br>**Noted in red if more than 5% lower than the average</td></tr>
<tr><td>Percent Decrease from Admission to Discharge in Hospitalization/ ER- Physical Health</td><td>50%</td><td>65.9%<br>(From 85 to 29)</td></tr>
<tr><td>Percent Decrease from Admission to Discharge in Hospitalization/ER - Mental Health</td><td>25%</td><td>66.7%<br>(From 15 to 5)</td></tr>
</table>

| | | |
|---|---|---|
| Quality – Outcomes/ Effectiveness | By June 30, 2024, there will be a 10% decrease in beneficiaries accessing multiple episodes of withdrawal management services with no other DMC-ODS treatment. | 1. Develop a report(s) to track withdrawal management re-admission measures<br>2. At least quarterly, analyze data to identify trends and opportunities for improvement/intervention<br>3. Distribute data and engage withdrawal management providers and Recovery Coaches as applicable to improve linkage to DMC-ODS treatment following discharge. |

| Evaluation | FY 2023-24 Performance Targets and Baseline Metrics |
|---|---|
| **Annual Goal Met:**<br>☐ Met: Item #<br>☐ Partially Met: Item #<br>☐ Not Met: Item #<br>☐ Continued: Item # | |

| Measure | Performance Target | Baseline (FY 2022-23) |
|---|---|---|
| Percent of beneficiaries who received residential withdrawal management services and within 30 days of discharge were admitted into the same level of care | Episodes: 11.6%<br>Individuals: 12.3% | Episodes: 12.9%<br>(n=77 out of 599)<br>Individuals: 13.7%<br>(n=54 out of 395) |
| Percent of beneficiaries who received residential withdrawal management services and within 30 days of discharge were admitted into the same level of care by race/ethnicity | All Races/Ethnicities:<br>Episodes: 11.6%<br>Individuals: 12.3% | <u>Episodes</u><br>White: 13.5% (n=50/370)<br>Hispanic/Latinx: 14.7% (n=17/116)<br>Black/Afr. American: 11.3% (n=7/62)<br>Asian/PI: 0.0% (n=0/12)<br>Native American: 0.0% (0/2)<br>Other: 8.1% (n=3/37)<br><br><u>Individuals</u><br>White: 14.2% (n=34/240)<br>Hispanic/Latinx: 15.9% (n=13/82)<br>Black/Afr. American: 12.2% (n=5/41)<br>Asian/PI: 0.0% (n=0/9)<br>Native American: 0.0% (0/1)<br>Other: 9.1% (n=2/22) |
| Percent of beneficiaries with three or more withdrawal management episodes in a year and no other DMC-ODS treatment. | 7% | 7%<br>(n=25 out of 381) |
| Percent of beneficiaries with three or more withdrawal management episodes in a year and no other DMC-ODS treatment by race/ethnicity | All Races/Ethnicities:<br>7% | White: 7.1% (n=17/240)<br>Hispanic/Latinx: 6.5% (n=5/77)<br>Black/Afr. American: 5.1% (n=2/39)<br>Asian/PI: 0.0% (n=0/8)<br>Native American: 0.0% (n=0/1)<br>Other: 6.3% (n=1/16) |

Data Source: Marin WITS data