California's Drug Medi-Cal Organized Delivery System

FY 2016–2017 Evaluation Report

Prepared for the Department of Health Care Services
California Health and Human Services Agency

Year 2

UCLA Integrated Substance Abuse Programs

Darren Urada, Ph.D., Valerie P. Antonini, M.P.H., Cheryl Teruya, Ph.D., Elise Tran, David Huang, Ph.D., Howard Padwa, Ph.D., Kevin Castro-Moino, Anne B. Lee, M.A., L.C.S.W. & Jason Grossman

Table of Contents

Note on Terminology

Individuals Receiving Services

Individuals who are eligible for, or are receiving, substance use or behavioral health services have been referred to as "clients," "consumers," "beneficiaries," and "patients." While "client" is still the dominant term in the substance use field, the increasing integration of behavioral health with physical health care means that clinicians will need to unify around standard terms. For consistency, we use the term "patients" throughout this report.

Modalities/Levels of Care

The state's California Outcomes Measurement System - Treatment (CalOMS-Tx) does not record ASAM levels of care, but the modalities included in this data system have been used as an approximation in this report. The modalities in CalOMS-Tx include detoxification, outpatient, intensive outpatient/day care rehabilitative, residential, and narcotic treatment programs (NTPs). These provided approximations for the ASAM-defined services of withdrawal management, outpatient, intensive outpatient, residential, and opioid treatment programs, respectively. Future analyses using data from Drug Medi-Cal claims will use ASAM levels of care.

Due to the movement of the field toward standard use of the ASAM Criteria, we use the term "withdrawal management" throughout the report to refer to services that are referred to in CalOMS-Tx as "detoxification." Withdrawal management, as defined by ASAM, can also occur as a standalone service or within other settings. Similarly, we use the ASAM term "intensive outpatient" treatment to refer to services referred to in CalOMS-Tx as "Outpatient Day Program intensive / Day Care Rehabilitative" services.

Early Adopters, Rest of State

In this report, Early Adopters are 15 counties that had submitted Drug Medi-Cal Organized Delivery System implementation plans as of March 2017 and had returned two waves of administrator surveys to UCLA during surveys conducted in 2015-16 and 2016-17. "Rest of State" were 29 counties that had not submitted implementation plans as of March 2017 but had returned two waves of surveys. For more information on these groups, please see Section I: Introduction.

Acronyms

A reference for all acronyms used in this report can be found in Appendix A.

Executive Summary

A. Summary and Recommendations

California counties are only just beginning to deliver Drug Medi-Cal Organized Delivery System (DMC-ODS) services. Early successes and challenges encountered during this transitional time are summarized below, along with recommendations to address these challenges.

Access

- *Improvement in DMC certification.* California has had some success in addressing early challenges. For example, one year ago the process of facility certification was one of most frequently reported challenges to capacity expansion, but following collaborative efforts between the counties and state over the past year, the number of counties reporting certification as a significant challenge has receded.
- *Emerging challenges.* As progress has been made on some challenges, others have risen to the forefront. In particular, concerns over barriers to the expansion of medical detoxification/withdrawal management and residential treatment have risen. Counties rated this as the most challenging service to expand, citing an array of issues including upfront costs and claims being rejected for reasons that are unclear.
- *UCLA recommends* an analysis of the reasons for non-approved treatment authorization requests for medical detoxification/withdrawal management, followed by a collaboration with counties and providers to address the reasons found.
- *UCLA also recommends* stakeholder discussion of financial hurdles as they relate to opening new facilities. For example, in some cases, it appears a provider may find it cannot become DMC certified until it is open, and has no funding to open until it becomes certified. There may be potential work-arounds using SAPT block grant funding or loans from a community development finance institution. A collaborative effort between DHCS, counties, and providers to clarify rules and identify methods that work best would be ideal.

Quality

- *Use of ASAM Criteria-based tools for placement and assessment.* As expected, Counties who submitted their implementation plans relatively early (Early Adopter counties) tended to make greater use of ASAM assessment. The tools being used vary widely from county to county, however, and few counties are using adolescent ASAM-based tools. Overall, counties continue to find the use of the ASAM Criteria somewhat challenging.
- *Patient transitions along the continuum of SUD care.* As in previous years, patients receiving non-NTP withdrawal management or residential services in 2016 did not typically move along the continuum of care to receive additional treatment.
- *Use of evidence-based practices.* The majority of counties reported using at least two of the five EBPs listed in the STCs, but in the most recent survey, this was

also rated as the most challenging issue out of a list of 14 potential challenges. Additional training or technical assistance on this issue appear to be needed, particularly on trauma-informed treatment.

- *Establishment of quality improvement committees and plans.* All Early Adopter counties reported that the waiver had a positive influence on quality improvement activities. Consistent with this, Early Adopter counties were more likely to have developed QI plans than the rest of the state.
- *Utilization management, Drug Medi-Cal Billing, and LPHAs* were all in greater use in Early Adopter counties compared to the rest of the state, and generally increased over time. Notably, while Drug Medi-Cal Billing became less challenging for the Early Adopter counties, it became more challenging for the rest of the state.
- *UCLA recommends* continued or expanded training and technical assistance on ASAM criteria, Evidence-based practices (particularly trauma-informed care), transitioning patients along the continuum of care, and Drug Medi-Cal billing.
- *UCLA recommends* expanding the physician consultation benefit, if possible. Counties felt the benefit would be more useful if it were applicable to consultation to physicians that are serving DMC beneficiaries at other sites that are not DMC clinics (e.g. Federally Qualified Health Centers).

Integration/coordination

- *Cross-system care coordination and effective communication*: All Early Adopter counties reported that the waiver had positively influenced SUD/MH communication, and nearly all reported that it had improved communication between SUD and health services. Remaining barriers to effective communication across systems generally consist of "bandwidth" issues, lack of trickle down to line staff, and various other needs, including more meetings with additional entities, more time, more collaboration, and stronger stands from county leadership.
- *Department/Division Integration*: Integration of services is greater between SUD and Mental Health services than between SUD and physical health services. However, integration ratings were *lower* among the Early Adopter counties compared to the rest of the state. Based on interviews this seemed to reflect greater realism on the part of the Early Adopter counties as challenges became more apparent and county administrators gained a fuller understanding of their systems.
- *Case Management: The implementation of case management as a billable* service under the ODS remains somewhat challenging across the state, but case management planning is more detailed for the Early Adopters compared to the Rest of the State. Overall, methods of care coordination implementation varies considerably, but from all accounts case management is occurring, it has expanded, and the counties are working to build a service delivery culture that works together.
- *Coordination of Services with Medi-Cal Managed Care plans:* Coordination of services with Medi-Cal managed care plans was better in Early Adopter counties and became less challenging over time.

- *Facilitation and tracking of referrals between systems*:   Health care referrals to SUD services were higher in Early Adopter counties than in the Rest of the State. Overall rates remain low, however.

UCLA recommends collaborative learning efforts. Across Access, Quality, and Integration/Coordination, counties are struggling with complex issues that do not have a single solution (e.g. implementing case management and care coordination, transitioning patients from one level of care to another, overcoming financial barriers to expansion). These issues may be best addressed via an ongoing collaborative learning effort that facilitates sharing of information between stakeholders. Possible avenues include:

- o The existing CIBHS DMC-ODS Forum, currently funded by Blue Shield through December 2017. Another collaborative learning effort to take its place after funding ends would be valuable.
- o A new learning collaborative modeled after the Care Integration Collaborative and the Care Coordination Collaborative, both of which were conducted previously by CIMH with funding from DHCS (UCLA assisted with SUD content). Counties and providers participated and were able to fulfill the mental health Performance Improvement Project (PIP) requirement by participating. The same could be true for the new DMC-ODS PIP requirements.

B. Limitations

Analyses in this report focus on the period July 1, 2016-June 30, 2017, but only three counties had begun delivering services under the DMC-ODS waiver through June 30. Qualitative data from interviews with these three counties focusing on their implementation experiences is included in this report, but quantitatively this is primarily a baseline report on early issues and progress in the lead-up to waiver implementation. Data sources for this report were limited to CalOMS-Tx, stakeholder surveys, and stakeholder interviews. As additional datasets become available and time passes, future reports will expand to include analyses of Medi-Cal and Drug Medi-Cal claims, level of care data, secret shopper data, provider surveys, patient surveys, and other data sources.

I. Introduction

A.   Overview of Waiver Implementation in Year 2

In the second year of implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration project under California's Section 1115 waiver, the California Department of Health Care Services (DHCS), the federal Centers for Medicare & Medicaid Services (CMS), and California counties have continued to work together to bring about changes specified in the DMC-ODS standard terms and conditions (STCs) with the aim of improving substance use disorder (SUD) care for Drug Medi-Cal beneficiaries.

The primary goals of the DMC-ODS are to improve access to SUD services, improve the quality of SUD care, control costs, and facilitate greater service coordination and integration, both among SUD providers and between SUD providers and other parts of the health care system. To meet these goals, Medi-Cal SUD services in participating counties are being restructured to operate as an organized delivery system that:

- provides a continuum of SUD care modeled after the American Society of Addiction Medicine's Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (ASAM Criteria);
- increases local control and accountability;
- creates mechanisms for greater administrative oversight;
- establishes utilization controls to improve care and promote efficient use of resources;
- facilitates the utilization of evidence-based practices (EBPs) in SUD treatment; and
- increases the coordination of SUD treatment with other systems of care (e.g., medical and mental health).

For a more detailed description of the DMC-ODS and an overview of its first year of implementation, please refer to the previous report submitted by UCLA for the fiscal year 2015-2016.[1]

Since the DMC-ODS was launched in 2015, several counties have submitted implementation plans (IPs) in a staggered rollout by regional phases and have received approvals from DHCS and CMS. Appendix B contains more information on this phased rollout. DHCS has developed an implementation matrix[2] to guide counties through the process of submitting an IP and all the steps required before contract execution and the start of DMC-ODS services for each county. The final deadline for IP submission for Phases 1-4 is September 1, 2017. Implementation of Phase 5, which will consist of California's tribal partners, will have a later deadline.

As of June 30, 2017, 34 counties wishing to opt in to the DMC-ODS had submitted IPs to DHCS. Three counties had executed contracts allowing services under the DMC-ODS to

---

[1] The report can be found at http://uclaisap.org/html/past-updates-reports.html
[2] Available at http://www.dhcs.ca.gov/provgovpart/Documents/DMC_ODS_IP_Matrix_Sep_2016.pdf

formally begin as of June 30: Marin, San Mateo, and Riverside. Additional counties were scheduled to begin in July, but could not be included in the analyses in this report. The eight Phase 4 counties submitted their implementation plan together as a regional model with Partnership HealthPlan. Table 1.1 contains a listing of participating counties and their status as of June 30.

Table 1.1: County implementation status as of June 30, 2017.

County	DHCS approval	Contracted executed
PHASE 1		
Alameda	January 2017	---
Contra Costa	August 2016	---
Marin	August 2016	March 2017
Monterey	October 2016	---
Napa	April 2017	---
San Francisco	June 2016	---
San Mateo	April 2016	October 2016
Santa Clara	June 2016	---
Santa Cruz	June 2016	---
Sonoma	February 2017	---
San Benito	---	---
PHASE 2		
Imperial	March 2017	---
Kern	---	---
Los Angeles	July 2016	---
Orange	December 2016	---
Riverside	July 2016	January 2017
San Bernardino	May 2017	---
San Luis Obispo	March 2017	---
Santa Barbara	June 2017	---
Ventura	November 2016	---
San Diego	---	---

| PHASE 3		
Yolo	December 2016	---
Fresno	---	---
Placer	---	---
Merced	---	---
Sacramento	---	---
PARTNERSHIP (MOSTLY PHASE 4)		
Humboldt	---	---
Lassen	---	---
Mendocino	---	---
Modoc	---	---
Shasta	---	---
Siskiyou	---	---
Solano	---	---
Trinity	---	---

Entries marked with --- are in the review process

This listing of counties is by no means final, as counties may choose to opt in any time prior to the September 2017 IP submission deadline.

B. Status of UCLA Evaluation

Evaluation goals

This report documents the second year of the DMC-ODS evaluation, focusing on findings for the period of July 1, 2016 through June 30, 2017.

The University of California, Los Angeles, Integrated Substance Abuse Programs, under contract with DHCS, is evaluating the DMC-ODS demonstration project. The design of the DMC-ODS evaluation employs a multiple baseline approach to accommodate the multiple-phase

rollout. It focuses on four key areas: access, quality, cost, and coordination/integration of care.
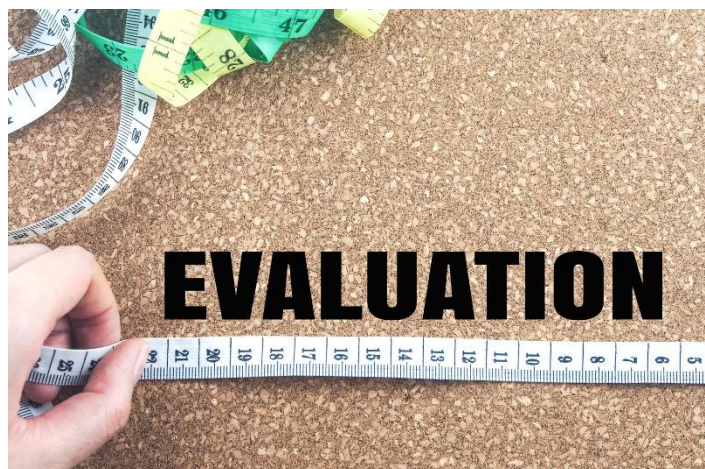
Evaluation hypotheses include:

Hypothesis 1:   Beneficiary access to treatment will increase in counties that opt in to the waiver compared to access in the same counties prior to waiver implementation and access in comparison counties that have not opted in.

Hypothesis 2:   Quality of care will improve in counties that have opted in to the waiver compared to quality in the same counties prior to waiver implementation and quality in comparison counties that have not opted in.

Hypothesis 3:   Health care costs will be more appropriate post-waiver implementation than pre-waiver among comparable patients; e.g., SUD treatment costs will be offset by reduced inpatient and emergency department use.

Hypothesis 4:   SUD treatment coordination with primary care, mental health, and recovery support services will improve.

UCLA is utilizing a mixed-methods approach to measure the impact of the waiver using state-, county-, provider-, and patient-level data to test these hypotheses. The evaluation will use both quantitative and qualitative measures to mitigate the weaknesses of each. Quantitative methods are used to analyze trends over time and compare groups, whereas qualitative methods are used to help interpret and supplement the quantitative data within the broader context of stakeholder perceptions.

Additional evaluation details can be found in the evaluation plan for the DMC-ODS[3] and in UCLA's report for the prior year.

Data collection and analysis status

Existing data sources

For the purposes of this report, available administrative data was limited to the California Outcomes Measurement System, Treatment (CalOMS-Tx).

In the future, UCLA anticipates acquiring and analyzing Medi-Cal and Drug Medi-Cal data. UCLA did receive an initial Drug Medi-Cal dataset from DHCS on June 27, 2017. Analyses of this data will be included in next year's report.

New data collection dependent on the stage of waiver implementation

UCLA evaluators were able to collect some baseline and early implementation data, and anticipate continuing to do so in Year 3.

---

[3] The evaluation plan is available online at: www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

Level of Care Assessment data: UCLA is working with DHCS and counties to collect this data. An information notice is anticipated in Summer 2017, and initial data has been submitted to DHCS by Marin and Riverside counties.

UCLA Treatment Provider Surveys are being initiated after approved counties submit contact information for providers that will participate in the demonstration project. UCLA has begun survey collection in Los Angeles County and plans to accelerate collection in the rest of the state shortly. Analysis and discussion of this data will be included in future reports.

UCLA Patient Survey, the Treatment Perceptions Survey (TPS), was developed by UCLA based on San Francisco County's survey and through consultation with DHCS, individual counties, the Substance Abuse Prevention Treatment+ Committee of the County Behavioral Health Director's Association of California, the DMC-ODS EQRO Clinical Committee, Behavioral Health Concepts (BHC), and other stakeholder input. It measures patient perceptions of access to SUD treatment, quality of care, and coordination/ integration of care. Use of the TPS is required to fulfill the county's EQRO requirement to have a valid client survey administered at least annually. Surveys will begin in November 2017 for counties beginning waiver services between January and September 2017, and in October 2018 for the remaining DMC-ODS counties. To date, one county, Marin, has administered the survey. The relevant MHSUD Information Notice (17-026), survey instructions, forms in multiple threshold languages, and other materials are available online at: http://www.uclaisap.org/ca-policy/html/client-treatment-perceptions-survey.html [See Appendix C for the Treatment Perceptions Survey form and a sample report for Marin County.]

Stakeholder Interviews have been and will continue to be conducted with SUD treatment administrators from counties that are participating in the DMC-ODS waiver. Pre-implementation interviews were conducted with administrators from San Francisco, San Mateo, Santa Clara and Santa Cruz counties (the first four Phase 1 counties to submit their implementation plans to DHCS) to gain a better understanding of county administrators' experiences as they prepared for implementation. These interviews covered challenges and successes as well as lessons learned and recommendations to help inform other counties that are in the process of planning or preparing for the waiver, DHCS in its efforts to provide technical assistance, and UCLA for purposes of evaluating the waiver (see Appendix D for a copy of the pre-implementation interview report).

Another set of key informant interviews were conducted with administrators from the first three counties with executed DMC-ODS contracts (San Mateo, Riverside, and Marin) approximately three to five months after they began providing ODS services to beneficiaries. The purpose of these waiver implementation interviews is to continue to compile lessons learned and promising strategies to help inform other counties' implementation of the waiver and to aid in the interpretation of the quantitative survey results. In addition, administrators from five counties (Riverside, San Mateo, Santa Clara, Riverside, and Los Angeles) were interviewed to explore the current status of adolescent-specific screening and assessment tools and practices being used for determining

placement into treatment settings/ASAM levels of care, as well as related challenges and recommendations for technical assistance.

Qualitative findings and illustrative examples (e.g., quotations) drawn from key informant interviews with stakeholders are presented throughout the report to supplement the quantitative results.

Secret shopper calls are being conducted by UCLA to evaluate access to counties' beneficiary access lines (BALs). The purpose of these calls is to verify that the requirement of having a phone number available to beneficiaries is being met by counties that have started providing DMC-ODS services. Initiation of these "secret shopper calls" occurs soon after the county's contract with DHCS is executed. UCLA will continue conducting calls to beneficiary access line during three different time periods: (1) During normal business hours, Monday – Friday, 8am – 5pm, (2) Outside normal business hours, Monday – Friday, 8pm – 2am, and (3) On weekends, Saturday – Sunday, 8am – 5pm.

Several case scenarios of patients or relatives of patients seeking information about treatment were developed for these calls. Measures for each call included:

- time to find the phone number
- number of times the phone rang before someone picked up
- whether someone answered
- time it took for someone to pick up
- the total length of the call

UCLA will also assess language capacity to the extent possible. To date, UCLA has conducted eight "secret shopper" calls in four counties (San Mateo, Riverside, Marin, and Los Angeles). Four have been conducted in Spanish. Analysis and discussion of this data will be included in future reports.

<u>New data collection not dependent on the stage of waiver implementation</u>

Since only three counties had begun delivering services under the waiver at the end of the period covered by this report, the data collection activities that are not dependent on the stage of waiver implementation will supply most of the findings in this report.

County Administrator Survey. UCLA developed an online county administrator survey to obtain information and insights from all SUD/BH administrators (regardless of opt-in status or intent). The survey addressed the following topics: access to care; screening and placement practices; services and training; quality of care; collaboration, coordination, and integration of services; and waiver implementation preparation/status. In Year 2, UCLA conducted a follow-up administrator survey to track annual changes, collecting data from December 2016 through April 2017. Responses from 46 counties were received and compared with baseline data collected in Year 1. Throughout the report, items from the survey relevant to access, quality, and coordination will be described in the pertinent report sections.

C. Analysis Plan and Framework for Report

It is not yet possible to compare counties that are participating in the DMC-ODS waiver with those who are not because counties are continuing to submit implementation plans. Therefore, for this report UCLA used an analysis plan that split counties between "Early Adopter" and "Rest of State" groups in order to determine how the waiver was beginning to change practices in counties in the later stages of their waiver preparations compared with the rest of the state. The groups were defined as follows:

Early Adopters are 15 counties that had submitted Drug Medi-Cal Organized Delivery System implementation plans as of March 2017 and had participated in both waves of administrator surveys conducted by UCLA during 2015-16 and 2016-17. Twenty counties had submitted plans by March 2017, and 15 of those had returned both surveys: Alameda, Kern, Los Angeles, Marin, Monterey, Napa, Orange, Riverside, San Bernardino, San Francisco, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, and Yolo.

Rest of State were the 29 counties that had not submitted implementation plans as of March 2017 but had returned two waves of surveys. A total of 38 counties had not submitted plans, and 29 of these had returned both surveys: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Kings, Madera, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Diego, San Joaquin, Shasta, Sierra, Siskiyou, Solano, Tehama, Trinity, Tulare, and Tuolumne.

Note that this is not a "non-waiver" comparison group. These are counties that had not "opted in" yet. Some did submit plans later, and others may continue to do so. The evaluators cannot yet classify counties by "opt in" versus "opt out" status until the deadline for new implementation plan submissions passes.

The framework for this report addresses three of the key areas in UCLA's Evaluation Plan: (1) access to care, (2) quality of care, and (3) the integration and coordination of SUD care. Cost will be addressed in future reports after sufficient Drug Medi-Cal and Medi-Cal data is available for cost analysis. Each key area will be discussed by defining the data sources, presenting results, and describing evaluation plans for future years of the evaluation. A general discussion with recommendations closes the report.

An index of tables and figures used in the report can be found in Appendix E, and further resources on the evaluation can be found in Appendix F.

II. Access to Care

Darren Urada, Ph.D., Cheryl Teruya, Ph.D., David Huang, Ph.D., Valerie Antonini, M.P.H., Elise Tran, and Kevin Moino

Lack of appropriate access to care can impact the health and well-being of individuals with SUDs. Over the course of the evaluation, UCLA will track changes in access to care using multiple measures and data sources.

A. Data Sources

The baseline measures below reflect analysis of three data sources. The first, the California Outcome Measurement System - Treatment (CalOMS-Tx), was the only administrative dataset available to UCLA evaluators for this report; future analyses will be conducted using Drug Medi-Cal claims, Medi-Cal Managed Care encounter data, and level of care data. The second and third sources are data that UCLA collected via the County Administrator Survey and county administrator interviews.

B. Measures

Availability and use of full required continuum of care: number of admissions

The purpose of this measure is to determine the extent to which all required levels of care are being used in county systems. In the future, Drug Medi-Cal claims data will provide a more accurate accounting of admissions to specific ASAM levels of care, but for this report, the treatment modalities in CalOMS-Tx will be used as a reasonable approximation. The modalities that can be identified within CalOMS-Tx include detoxification, outpatient, intensive outpatient/day care rehabilitative, residential, and narcotic treatment programs (NTPs). These provide approximations for the ASAM-defined services of withdrawal management, outpatient, intensive outpatient, residential, and opioid treatment programs, respectively.

Through January 2017, the number of patients in specialty care who were also Medi-Cal beneficiaries (regardless of whether that payment source was used for the current treatment) was generally stable. This relative stability will make it easier for the evaluation to detect changes associated with waiver implementation in the future.[4] Statewide, outpatient treatment remained the dominant form of treatment, but all modalities were present (see Figure 2.1). In the future, admissions will be analyzed in greater depth for DMC-ODS counties by the ASAM level of care indicated in Drug Medi-Cal claims.

---

[4] Large increases had occurred in earlier years, particularly in January 2014 after the Medi-Cal expansion associated with the Affordable Care Act was implemented. These changes may have been due to a mix of data reporting issues and true new admissions. For further discussion of these changes, see Urada, Lovinger, Lim, & Ramirez (2015).

Figure 2.1: Number of Medi-Cal beneficiaries by treatment modality.
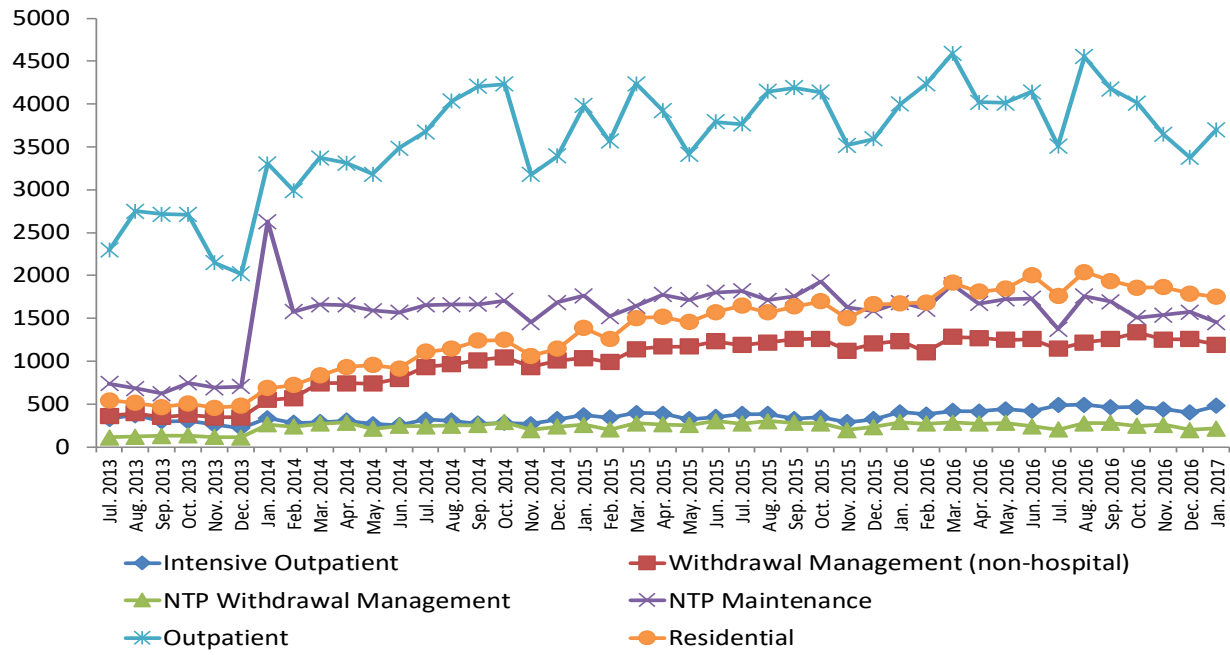
Figure 2.2. Percentage of counties with a toll-free beneficiary access line for SUD services.
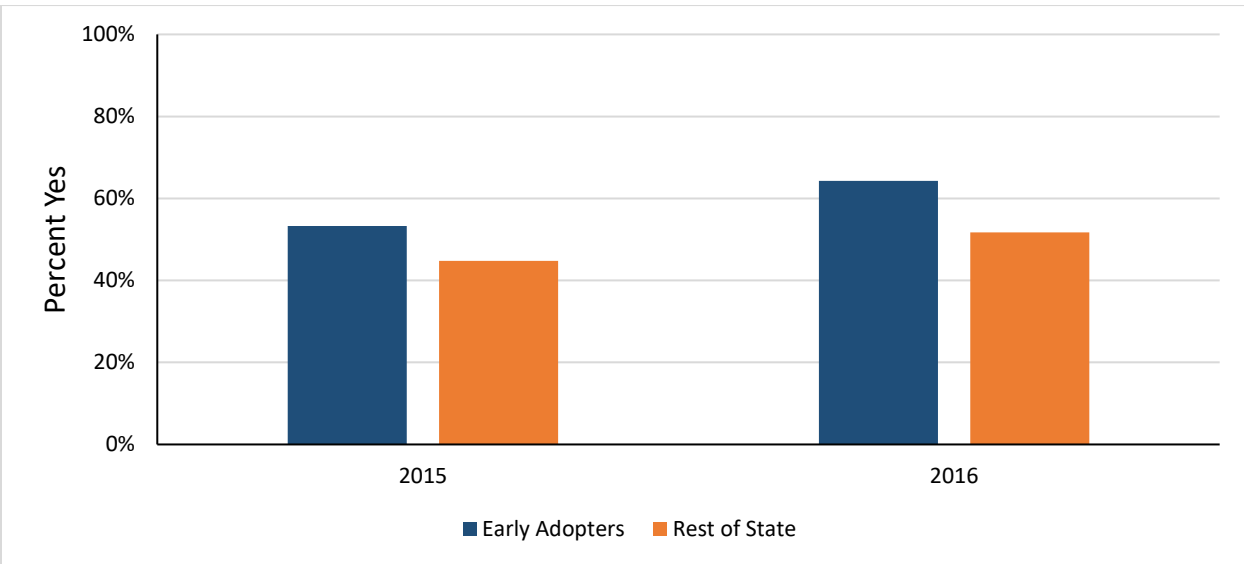
Beneficiary Access Line

According to administrator survey responses, a higher percentage of Early Adopter counties had beneficiary access lines (BALs) than in the rest of the state, though the difference was not statistically significant due to the small sample sizes (see Figure 2.2). There was also a trend toward more beneficiary access lines being established over time in both groups.

Survey respondents who indicated that their county had a BAL or were planning to establish one in the next 12 months were asked whether preparation for DMC-ODS facilitated establishment of this BAL. In 2015 Early Adopters (who began submitting implementation plans in 2015) were more likely to report that the DMC-ODS waiver facilitated their BAL efforts (see Figure 2.3). In 2016, this gap narrowed as counties in the rest of the state began reporting that preparation for the DMC-ODS waiver also facilitated their BAL efforts. The DMC-ODS waiver therefore appears to be directly contributing to the availability of BALs for SUD services.

Figure 2.3. Percentage of counties in which preparation for the DMC-ODS waiver has facilitated either the establishment of a beneficiary access line (BAL) or the addition of SUD services to an existing number.
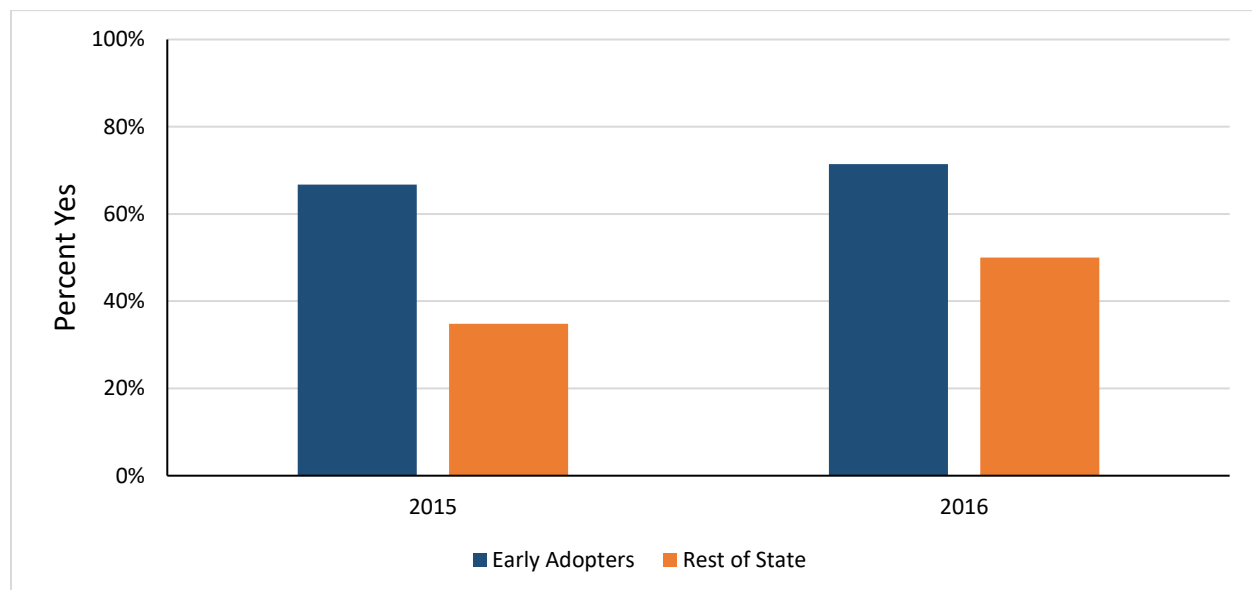
Administrator interviews suggested there were sometimes challenges beyond just establishing the line.

Riverside County experienced a much higher volume of calls than had originally been anticipated. Prior to the waiver, they had received about 140 calls per month from residents seeking service, but within the first six weeks of implementation, the call center received 6,488 calls, and other counties have requested consultations from Riverside as

a result, according to a publicly available report (Ono, 2017). In an interview with UCLA, the county explained:

> *. . . just a learning lesson for other people, and that would be the call-in center . . . the number of staff and the number of calls we could have really never planned for, and so the staffing wasn't in place. We're still hiring staff.*

Part of the challenge was that calls tended to take longer than anticipated:

> *Some of the other lessons that come with that is the amount of time that we're spending on the phone screening and placing consumers in residential or detox facilities can be exorbitant sometimes. In our mind where we set up to really have a 15 to 30-minute call, and we're moving on in that perfect world where everybody—all our contract providers are doing what we've asked and what we've designed, it's not always true, and so consumers not being prepared, meaning physicals, medical clearances, psychiatric clearances, 30-day supply of medications.*

> *Looking at the interaction between ourselves, psychiatric hospitals, physical healthcare providers, and our contracted residential and detox providers, just those duties and things that our staff are trying to do to get the consumer ready to go into treatment is now taking up sometimes an hour or two. We have all these other calls coming in, and we can't get to them. We're having to do callbacks at the end of the day . . . we're still trying to get the workflow nailed down to where it will be smooth.*

It is important to note that these issues are the result of an exceptionally successful advertising campaign in this county, which is something that itself may provide lessons for other counties.

> *Any place that we could advertise we did, and I think it just went overboard. We did a social media campaign. We did some press releases . . . We talked to everyone from CPS DPSS to WIC to anybody that would let us be an audience, we went there, and we gave them fliers. We made cards for consumers and families that just had the access center information on it. We did new trifolds and sent those out to the county hospitals and any—we gave them to IEHP and our managed care people. They put them in their lobbies. We did all that consecutively for 18 months before (the waiver started).*

Use of Medication-Assisted Treatment (MAT)

According to CalOMS-Tx records, 35.3% of patients with heroin or other opiates as their primary drug problem statewide were not treated with medications. Another 61.5% received methadone, and a small percentage received buprenorphine (Subutex or Suboxone) or "other" medication.

Patients with opiates as their primary drug problem were no more likely to receive medications in early adopter counties. Medication use by Early Adopter counties and the rest of the state are shown in Table 2.1.

Table 2.1. Use of medications among patients with a primary drug of heroin or other opiates from January 1, 2016, to December 31, 2016.

	Early Adopter County Patients (N=26,756)	Rest of State Patients (N=16,438)
Medication used in drug treatment		
None	35.6%	33.1%
Methadone	59.6%	65.5%
Buprenorphine (Subutex+Suboxone)	1.0%	0.9%
Other	3.7%	0.4%

Current use of buprenorphine within SUD treatment programs[5] was also low across the state according to CalOMS-Tx records. Previously, the medication was not a covered benefit under DMC; however, under the DMC-ODS, it will be.

Figure 2.4. Percentage of counties selecting each modality as most challenging to expand (such as by creating new programs, increasing capacity at existing programs, or having existing programs become DMC certified).

---
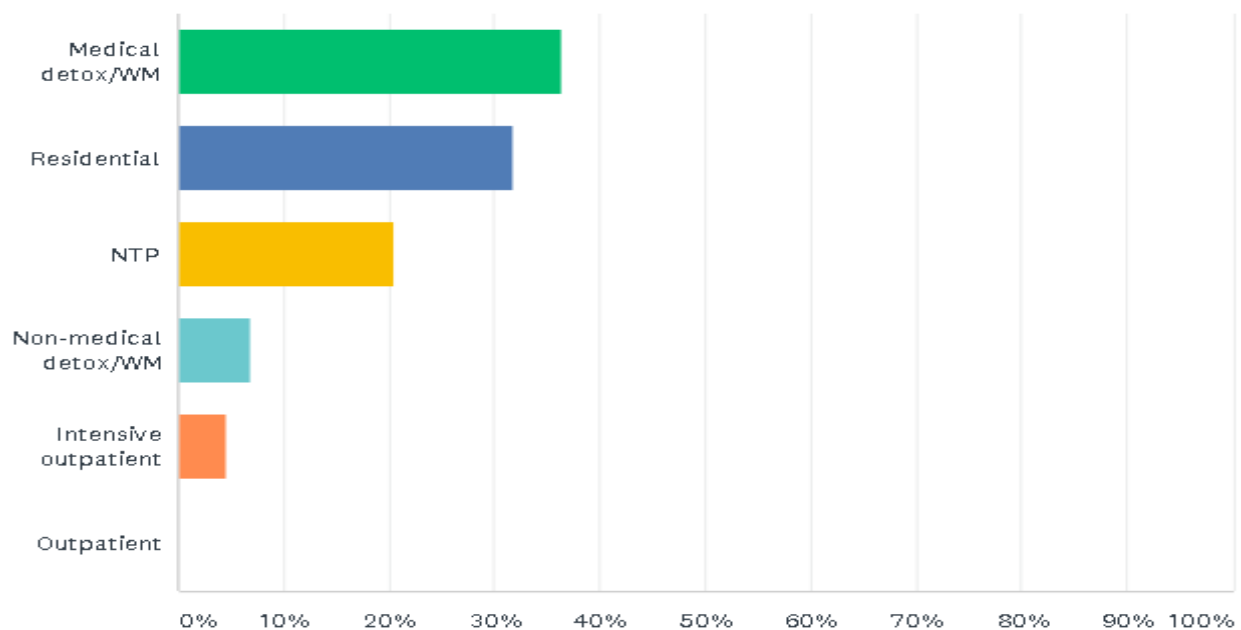
[5] Buprenorphine is also prescribed outside of specialty care (e.g., by physicians in primary care settings), but this is not captured in CalOMS-Tx.

Capacity Expansion

When asked which modality will be the most challenging to expand, medical detoxification and residential treatment were selected substantially more often than the other modalities (see Figure 2.4).

When asked what challenges they faced in terms of capacity expansion, a wide array of issues was selected by administrators. Again, the modalities with the most challenges were medical detoxification/withdrawal management and residential treatment. For both of these modalities, the high up-front investment/financial risk was the issue most frequently identified as a significant challenge (identified by 23 counties for both modalities); see Figure 2.5.

Figure 2.5: Significant challenges faced in expanding capacity, by modality.

Number of respondents indicating issue is a significant challenge to expanding the specified modality. (n=43, multiple selections possible per respondent)

- Space
- Reimbursement Rates
- High upfront investment/financial risk
- Limited data infrastructure
- Other
- Facility certification
- Staff certification/licensing
- Regulatory issues
- Community Opposition (i.e., NIMBY)

Residential Capacity Expansion

For residential treatment, resources were the greatest barrier, with reimbursement rates and high upfront investment/financial risk cited as the most common significant barriers.

> *We don't have funds to maintain staff and pay for residential treatment. We work with clients to find housing and employment.*

> *". . . how to pay for extremely high costs, and long delays with establishing a new site. Secure lease and pay rent, make building modifications, obtains SUDS certification/licensing, and DMC Cert . . . with no possibility to provide services and bill while waiting for certification. This makes cost of starting new programs tremendously expensive and time-consuming."*

Two counties singled out youth residential treatment in particular as being the most challenging, due to limited lengths of stay and a limited number of youth participating, resulting in high costs per youth participant.

Medical Detoxification/Withdrawal Management Capacity Expansion

For medical detoxification/withdrawal management, a variety of challenges was endorsed (space, staff and facility certification, regulatory issues, high upfront investment/financial risk). Respondents provided additional comments on the difficulty of getting hospitals to take on detoxification:

> *Because we have no county run hospital, getting our hospitals to take on medical detox is challenging*

> *Withdrawal Management services are affected by the non-existence of Voluntary Inpatient Detox (VID).*

> *Medical detox is a non-starter in our County due to lack of adequate reimbursement/lack of interest by the hospitals.*

Interviews provided further insight into these challenges. The challenges of working with hospitals that are not county run were mentioned by some interviewees.

> *I think what is true for the hospitals is they're afraid that if we get our clients in to an inpatient, then what do they do with them. Will there be a place to refer. That's going to take a big culture shift.*

The most serious and immediate challenge, however, had to do with billing.

> *Our hospital system . . . would provide the service, and then . . . the billing would get rejected. . . Then, we found the hospital was less inclined to take individuals, because they were concerned about it.*

The county reported working with DHCS on this issue, but expressed frustration at so being unable to resolve the issue so far.

> *I think that's probably been our biggest frustration, is we're so fortunate we have this resource in our county, and we know that we have clients who want to use it. We would love to be able to more confidently refer people in and out of that system of care, but we haven't been able to figure out what the issue is. . . We've been working very hard over two years to make sure it's available and have had very little headway.*

As a next step, the county further suggested looking at how many treatment authorization requests for medical detoxification had been submitted, how many had been paid, and what the aid codes were.

High Upfront Investment/Financial Risk

The high upfront investment and financial risk of starting up programs was the most frequently cited significant challenge to expanding residential treatment, NTP, medical detoxification, and non-medical detoxification. Interviews on the topic further illuminated these challenges.

> *The primary funding for this clinic is Drug Medi-Cal, so the clinic actually has not opened that because they were waiting for their certification, because that's how they're going to pay for the staff, and pay for the services. Yet, because they weren't open, they had their certification application denied.*

> *How do we launch new clinics when the funding source to support the new clinic is Drug Medi-Cal?. . . How do you have it up and running for six months while they're waiting for the paperwork to work its way through the PED certification process? It's a little bit of a conundrum to us. It requires deep pockets to be able to load an organization for months, staffed, and up and running, if it doesn't have more of a dedicated funding stream.*

While providers are paid upon DMC certification for services retroactive to their application date, new providers are not typically awarded a county contract until they are certified. As a result, between state and county requirements a new provider may find it cannot become certified until it is open, and has no funding to open until it is certified.

Improvement: Facility Certification
Notwithstanding certification's role in the aforementioned upfront investment issue, facility certification is an issue that is notable in its absence from the list of top challenges this year. In the 2015 survey, facility certification was singled out as one of the greatest challenges to expansion (Urada et al., 2016). DHCS initiated a number of changes to streamline the process in the time since then, and the number of survey respondents

reporting that facility certification as a challenge was reduced in the Early Adopter group for both residential and outpatient treatment (*p*=.06, p=*.10,* respectively*).* There was also a trend toward improvement in the rest of the state (see Figures 2.6 and 2.7).

Figure 2.6. Percentage of counties indicating facility certification is a significant challenge in expanding <u>outpatient treatment</u>.
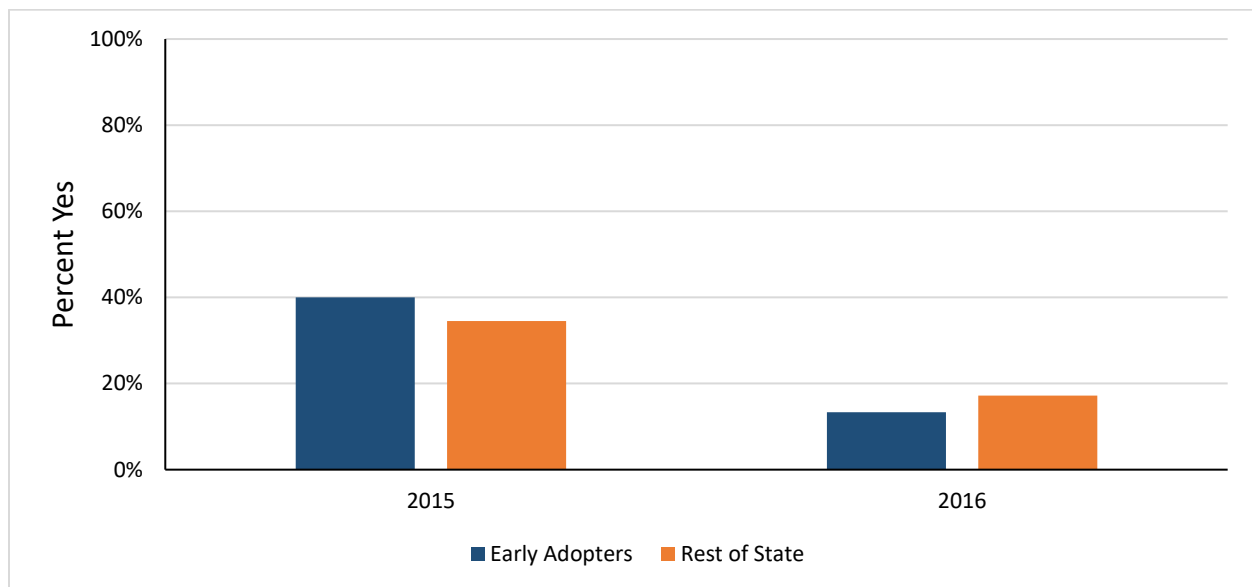
Figure 2.7: Percentage of counties indicating facility certification is a significant challenge in expanding <u>residential treatment</u>.
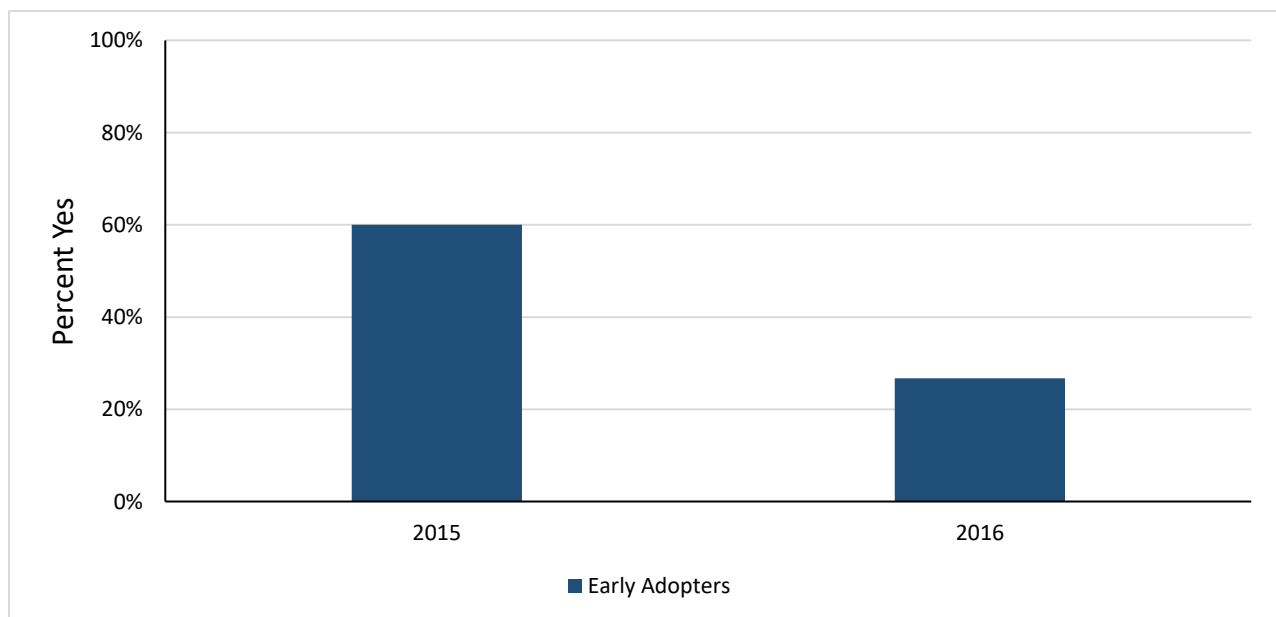
Other Emerging Challenges

Co-Occurring capable vs Co-Occurring enhanced
One county discussed provider challenges with respect to residential level of care 3.5.

> *(The ASAM Criteria) talks about co-occurring capable and then co-occurring enhanced level of service under 3.5. We are definitely finding that we have providers that will say: Well I'm co-current capable, but I'm not co-occurring enhanced, and I can't accept that client who is more symptomatic in terms of their mental health symptoms . . . we're struggling with that within our system. . . it's been a really big deal for us, who have a number of clients who we're denied from services and are like: Okay, now what? You're our 3.5 provider, you know?*

County of Residence:
County of residence came up as a challenge in the context of mobility and providing services in a timely manner.

> *This issue about county of residency, and how if somebody has already moved to your county and they haven't changed their residency, it can take 60 or 90 days for it to change. That could essentially be a denial of care, but we can't bill for it, and how do we address that?*

> *Our population is super mobile. They're on the move all the time. They're not that stable. This issue on residency comes in a lot. It's just one of those things where I think a coordinated regional approach is really needed to prevent having individuals just getting stuck in this: "Well, you don't live in this county, so I can't serve you. Go back over there." I think it's a challenge. It's a real challenge.*

Youth
In terms of preparing the county SUD system to provide treatment for youth patients, almost all administrators who wrote comments on the survey regarding youth noted that it is extremely challenging to provide options for withdrawal management and residential treatment for this population.

Geography
Smaller counties in particular face significant challenges to expanding capacity, in that they lack the facilities, funds, qualified and willing providers, and economies of scale that make this model more feasible for larger counties. However, larger counties cited their own issues as well, including the high cost of land in the Bay Area, and even competition for land with marijuana growers in one county.

Penetration Rates

UCLA plans to examine trends in statewide penetration rates before and after waiver implementation based on the number of people entering treatment divided by estimates of the prevalence of dependence from SAMHSA's National Survey on Drug Use and Health (NSDUH). However, in the 2015 survey, SAMHSA changed their questionnaire and data collection procedures, resulting in the establishment of a new baseline for a number of measures, including need for treatment (SAMHSA, 2017). Therefore, no California data has become available since the 2013-2014 data discussed in UCLA's previous DMC-ODS evaluation previous report (Urada et al., 2016). UCLA will provide updates when data from SAMHSA again becomes available, presumably in 2018.

C. Discussion and Next Steps

During 2015, the calendar year prior to waiver implementation, the number of patients in specialty care who were Medi-Cal beneficiaries was relatively stable, which will make it easier for the evaluation to detect changes associated with waiver implementation in the future.

According to County Administrator Survey respondents, the most challenging modalities to expand were residential and medical detoxification/withdrawal management. As new challenges arose and old challengers were in some cases addressed, new issues emerged. Issues that were challenges last year (e.g. facility certification, NTP expansion, NIMBY-ism) were not ranked as highly in the most recent surveys or interviews. In the most recent year, challenges to the expansion of medical detoxification/withdrawal management and residential treatment rose the forefront, with concerns about billing and upfront costs becoming prominent issues. Facility certification receded as an issue as the state and counties worked out many of the issues that had elevated this issue in the past. It will be critical to apply the same collaborative problem solving approach to the newer issues.

Medical detoxification/withdrawal management is at this point the most common point of entry for referrals from the broader health care system, and along with non-medical detoxification it is likely to serve as the first stop for a large number of patients who will then either step down into various treatment levels of care, or receive withdrawal management concurrently with treatment. Given the pivotal nature of this service for the continuum of care, UCLA recommends DHCS assign a high priority to working with counties to resolve the medical detoxification billing issues discussed by counties. One county suggested analysis of submitted treatment authorization requests as a next step, which may be reasonable. UCLA is willing to assist if needed.

In future reports, UCLA will provide analyses of additional datasets (e.g. Drug Medi-Cal claims) and report on additional data collected via surveys and qualitative interviews in to examine in greater detail how the DMC-ODS waiver is influencing access to SUD treatment.

References

SAMHSA (2017). 2014-2015 National Survey on Drug Use and Health: Guide to State
    Tables and Summary of Small Area Estimation Methodology. Available at:
    https://www.samhsa.gov/data/sites/default/files/NSDUHsaeMethodology2015/NS
    DUHsaeMethodology2015.pdf

Ono, N. (2017). Expanded substance abuse treatment finds success in Riverside
    County. Available at: http://cafwd.org/reporting/entry/expanded-substance-abuse-
    treatment-finds-success-in-riverside-county#

Urada, D., Teruya, C., Antonini, V.P., Tran, E., Huang, D., Padwa, H., & Lim, J. (2016).
    Organized Delivery System, FY 2015–2016 Report, Evaluation of California's
    Section 1115 Demonstration Waiver. Available at:
    http://www.uclaisap.org/assets/documents/California-DMC-ODS-Evals/DMC-
    ODS-Evaluation-Report-FY-2015-2016-final.pdf

Urada, D., Lovinger, K., Lim, J., & Ramirez, D. (2015). Data Analysis: Understanding
    the Changing Field. In: *Evaluation, Treatment, and Technical Assistance for
    Substance Use Disorder Services Integration 2015 Report, 9-38*. Prepared for
    the Department of Health Care Services, California Health and Human Services
    Agency. Los Angeles: UCLA Integrated Substance Abuse Programs. Available
    at:
    http://www.uclaisap.org/Integration/assets/documents/2015%20ETTA%20report
    %20final%202015-10-19.pdf

III. Quality of Care

Cheryl Teruya, Ph.D., Valerie Antonini, M.P.H., Darren Urada, Ph.D., David Huang, Ph.D., Elise Tran, and Kevin Moino

> "Counties need to understand…that they're looking for a fully articulated managed care system, and it means that the county becomes the insurer for beneficiaries, as it were, and needs to take more of that view of, 'How do I deliver the best beneficiary services?' It means a somewhat different relationship with providers. In my mind, it puts the beneficiary between our county operations and the provider, and we have to be sure we're getting information in terms of what's working, and what we need to improve on to ensure the best level of care for the patients."
> *County Administrator (pre-implementation interview)*

The Institute of Medicine defines quality of care as "[t]he degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[6] UCLA analyzed data available during the first two years of the waiver to evaluate the quality of SUD care using multiple measures, including:

- use of an ASAM Criteria-based tool for patient placement and assessment;
- successful treatment engagement based on length of stay;
- successful transitions along the continuum of SUD care;
- use of evidence-based practices;
- patient quality-of-care perceptions;
- establishment of quality improvement committees and plans; and
- availability of selected quality-related components under the DMC-ODS waiver (utilization management, use of licensed practitioners of the healing arts, physician consultation services, DMC billing).

These and other measures for which data was not yet available will be analyzed and tracked over time to identify changes in the quality of SUD care provided under the waiver.

A. Data Sources

The data sources available for conducting the analyses included the California Outcome Measurement System - Treatment (CalOMS-Tx), the County Administrator Surveys, key

---

[6] For more, see: http://www.nationalacademies.org/hmd/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx

informant interviews with stakeholders (e.g., county administrators) regarding their experiences with and perspectives on the implementation of the waiver as well as adolescent-specific tools for screening/assessment for placement into level of care/treatment settings. UCLA expects the following additional data sources to become available in the future for evaluating the quality of SUD care: county ASAM data; DHCS ASAM audits; treatment provider surveys; Medi-Cal claims; patient satisfaction/perception of care survey; and grievance reports.

B. Measures

Use of ASAM Criteria-based tool(s) for Patient Placement and Assessment

The ASAM Criteria provides a common standard for assessing patient needs, improving placement decisions, determining medical necessity, and documenting the appropriateness of reimbursement. It facilitates the appropriate matching of a patient's severity of SUD illness along six dimensions with levels along a continuum of SUD treatment. While use of an ASAM-based assessment is a requirement under the waiver, counties have discretion over decisions about which ASAM-based assessment tools best meet their needs.

Analysis of Administrator Survey data from both 2015 and 2016 show that ASAM assessment and placement was more available in the Early Adopter counties than in the rest of the state (see Figure 3.1). This difference became statistically significant in 2016. Further, in the 2015 survey, a little more than half of the Early Adopters and only about one-third of the rest of the state reported that ASAM assessment and placement was fully or partially available in their counties.

The data in Figure 3.2 show a trend suggesting that the implementation of ASAM assessment and placement is on average, becoming less challenging for the Early Adopters, whereas it has remained somewhat challenging across the two years for the rest of the state. The comments of a key informant provide some insight into the challenges of implementing the ASAM Criteria:

> *There's still a lot of work on our system to actually be using the ASAM really in the spirit that it was meant. I think we've improved. I think we're doing a good job of it, and yet we still have a long ways to go. I think it takes a while to learn how to do something new and different, and to do that well.*

Figure 3.1: Percentage of counties with ASAM assessment and placement available for adult clients
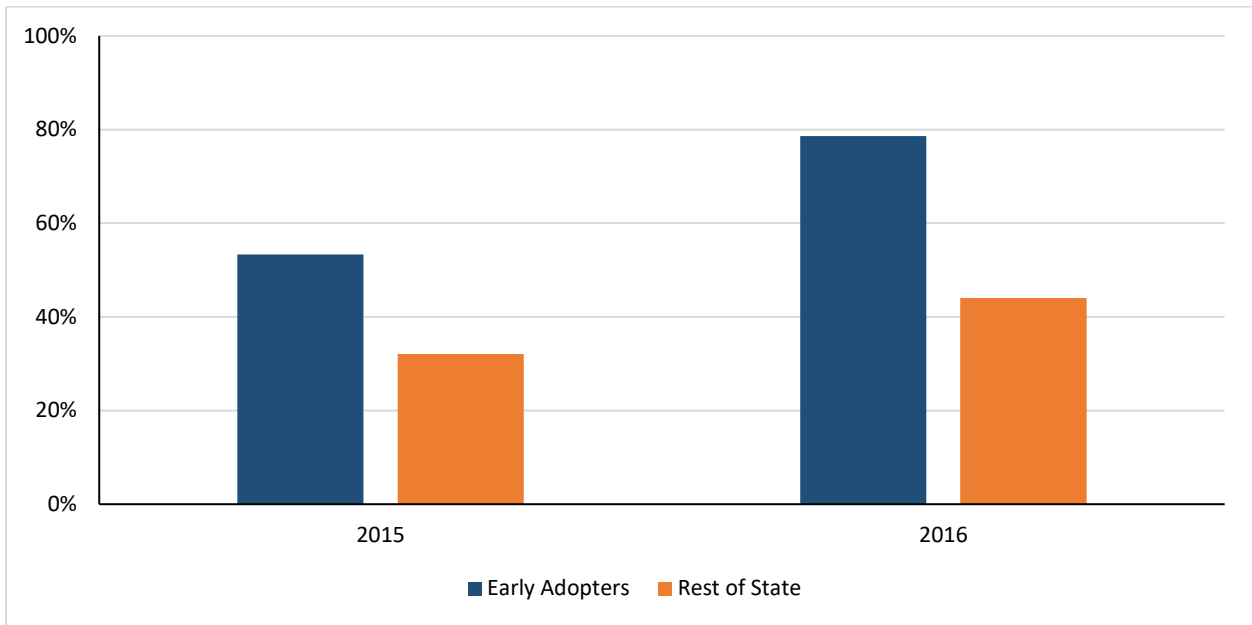
Figure 3.2: Mean rating of challenge level for implementing ASAM assessment and placement
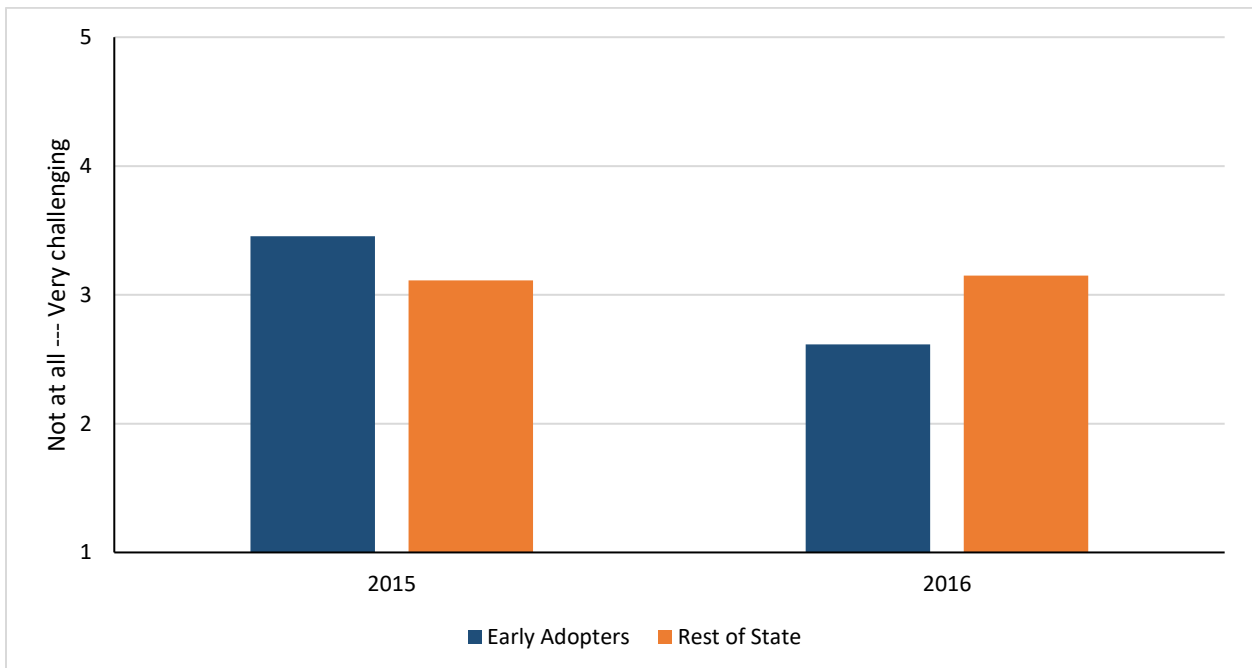
While some counties have developed their own screening tools for determining provisional placement into treatment and ASAM Criteria-based full assessment tools, UCLA continues to receive expressions of interest from counties about the free web-based tool that it is developing under contract with DHCS. Many counties, including those that participated in stakeholder interviews are also "very open to exploring", as one key informant put it, ASAM Criteria-based assessment tools that are validated, affordable, and that can be integrated with counties' existing electronic health record systems.

In addition, in 2016 the majority (73.3%) of Early Adopters, but less than half (48.3%) of the rest of the state reported that their counties are currently collecting ASAM Criteria data from assessment centers and/or treatment providers, which is an increase for both groups from the prior year (non-significant difference; data not shown).

As more counties begin implementation of the DMC-ODS waiver, the expectation is that the use of the ASAM Criteria for assessment and placement and collection of county ASAM data will increase.

<u>Youth-specific ASAM criteria-based tools</u>
In the 2016 survey, respondents were asked if a youth-specific ASAM criteria-based tool is currently being used in assessment centers and/or treatment providers in their counties. Among the Early Adopters, 28.6% reported that such a tool is currently being used compared to 13.8% of counties in the rest of the state (data not shown). The majority of counties in both groups (71.4% and 65.5%, respectively) indicated that they are planning to use youth-specific tools.

Qualitative interviews with stakeholders in five selected counties (all Early Adopters) exploring the current status of youth-specific screening and assessment tools/practices for placement suggest that there is a need for such tools. Some counties have developed their own tools because such validated tools for screening to determine initial placement into treatment and/or for fully assessing for placement and treatment planning do not currently exist. Others continue to search for tools that can be used or adapted to meet county needs (e.g., electronic health record systems). Below are comments from stakeholders that illustrate this need:

> *We know that we're gonna need an ASAM complete assessment. Not a placement tool, but an actual assessment that's still based on the six dimensions… We would then like to…change our treatment planning to then align with these six dimensions as well, instead of the ASI…We can't use the Continuum software. There would be no point, because we can't integrate it into our electronic health record. We're looking to model that next.*

Another stakeholder explained:

> *I would like to see some kind of an assessment tool that our whole system uses. I don't want to say the whole state, although that would be kind of nice too...It would be good to see what assessment tools are being used, and if*

there's a way to all agree on one particular assessment tool that our system was going to be using. At least here in [our] county, I think we would be in real good shape if we could come up with that.

Similarly, yet another stakeholder mentioned:

So when we talk about assessment, know that there is a lack of a consistent assessment process for youth, and for assessments overall, and that is going to be some work that the YAG [Youth Advisory Group for Substance Use Disorder Services] is going to take on as an identified priority.

Efforts are currently underway at the state level to address standardized assessment as well as other adolescent-specific issues and best practices (e.g., YAG). UCLA will continue to track the use of youth-specific screening and ASAM criteria-based assessment tools over the course of the waiver.

Successful Treatment Engagement

Patient engagement is vital for treatment success. The Washington Circle defines treatment engagement as the patient having two additional SUD treatments within 30 days after initiating treatment. In the absence of Drug Medi-Cal claims data, UCLA used CalOMS-Tx data to track lengths of stay of at least 30 days as a proxy for engagement once a patient enters treatment. During calendar year 2016, the majority of treatment admissions (excluding withdrawal management) for all programs resulted in lengths of stay 30 days or longer, including NTP maintenance (70.96%), outpatient (72.72%), intensive outpatient (68.29%), and residential (56.20%). These percentages were similar to the prior year. Lengths of stay 30 days or longer for the Early Adopters and the rest of the state in 2016 were as follows: NTP maintenance – 68.46% and 72.52%, respectively; outpatient – 72.37% and 72.42%, respectively; intensive outpatient – 69.78% and 64.14%, respectively; and residential – 56.69% and 57.22%, respectively.

The percentage of treatments with lengths of stay that were 30 days or longer was comparable among the Early Adopters and the rest of the state.

Successful Care Transitions

Patients are expected to move along the continuum of SUD care in an organized delivery system for SUD services. The Washington Circle defines continuity of care as when a patient receives additional services within a 14-day period after discharge from either withdrawal management or residential treatment. CalOMS-Tx data during calendar year 2016 was analyzed to measure, whether patients were moving along the continuum of care in a timely manner following Non-NTP Withdrawal Management and Residential services.

Service Delivery Following Non-NTP Withdrawal Management
Of all admissions in 2016 that initially were to non-NTP withdrawal management, 24.8% moved along the continuum of care in a timely manner (i.e., a transfer within 14 days). By destination, 15.1%% and 2.8% of patients in non-NTP withdrawal management continued

receiving services in residential treatment and outpatient/Day Care Rehabilitation, respectively. Another 6.6% of the patients stayed with the same treatment modality (i.e., non-NTP withdrawal management). The percentage of admissions moving along the continuum was very similar to prior years.

Analysis of admissions among the Early Adopters and the rest of the state that initially were to non-NTP withdrawal management showed that 24.4% and 25.9%, respectively, were moving along the continuum of care in a timely manner (i.e., a transfer within 14 days); see Figures 3.3 and 3.4. The percentages of patients that transitioned within 14 days to either NTP maintenance, NTP withdrawal management, or outpatient/intensive outpatient services were similar among the Early Adopters and the rest of the state.

Figure 3.3: Early Adopters - service delivery following non-NTP withdrawal management (transition within 14 days).
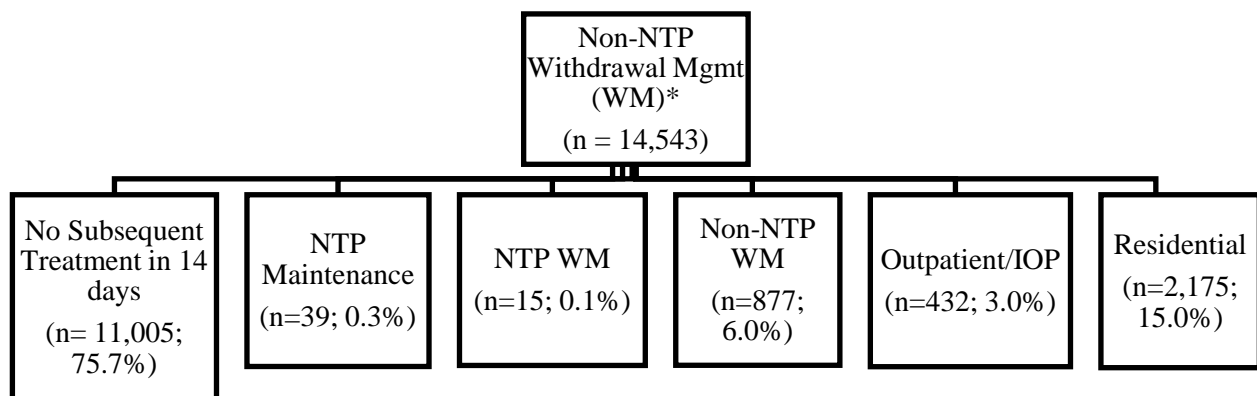
* Admissions during Jan. 1 – Dec. 31, 2016, for which non-NTP withdrawal management was the first admission in a treatment episode.

Figure 3.4: Rest of State - service delivery following non-NTP withdrawal management (transition within 14 days)
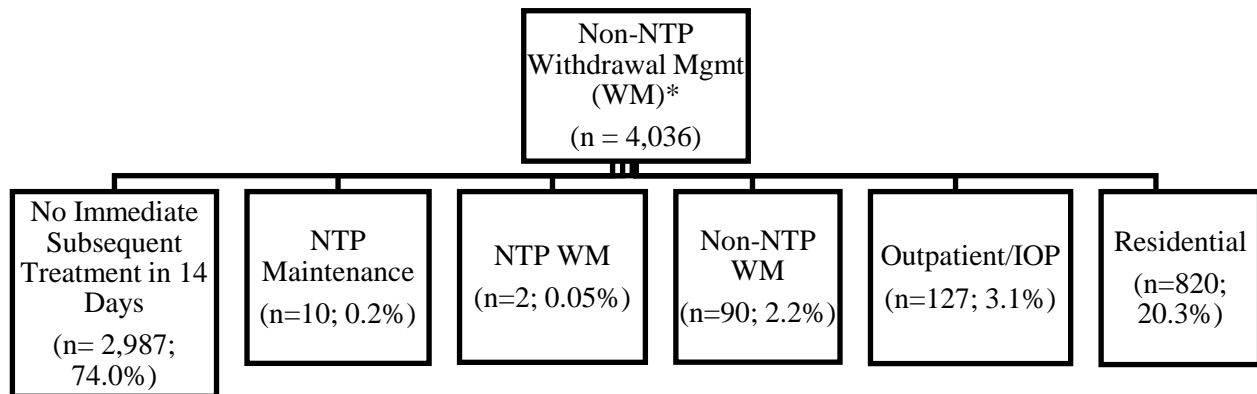
* Admissions during Jan. 1 – Dec. 31, 2016, for which non-NTP withdrawal management was the first admission in a treatment episode.

These findings suggest that patients receiving non-NTP withdrawal management services did not typically move along the continuum of care to receive additional treatment. Therefore, there is substantial room for growth in terms of continuity of care within the DMC-ODS. With the implementation of the waiver, it is anticipated that more patients will receive timely and appropriate treatment as they transition to different levels of treatment along the continuum of SUD treatment.

Service Delivery Following Residential Services
Of all admissions in 2016 that initially were to residential treatment in 2016, 13.4% were moving along the continuum of care in a timely manner (i.e., a transfer within 14 days). (Data not shown.) Analyzed by destination, 7.0% of these patients subsequently received services in outpatient/day care rehabilitation and 5.3% of them continued receiving additional episodes of residential treatment. The percentage of all admissions initially into residential treatment was similar to prior years, when almost ninety percent (88% in 2015 and 87% in 2016) did not receive immediate subsequent treatment.

The Early Adopter counties and the rest of the state showed similar patterns (12.9% and 13.0%, respectively) in terms of patients who were initially admitted to residential treatment and then moved along the continuum of care in a timely manner (i.e., a transfer within 14 days). See Figures 3.5 and 3.6.

Figure 3.5: Early Adopters - service delivery following a residential service (transition within 14 days).

Residential Treatment* (n = 20,431)

| No Subsequent Treatment in 14 Days (n= 17,787; 87.1%) | NTP Maintenance (n=11; 0.05%) | NTP Withdrawal Mgmt (WM) (n=2; 0.01%) | Non-NTP WM (n=220; 1.1%) | Outpatient/ IOP (n=1,483; 7.2%) | Residential (n=928; 4.5%) |
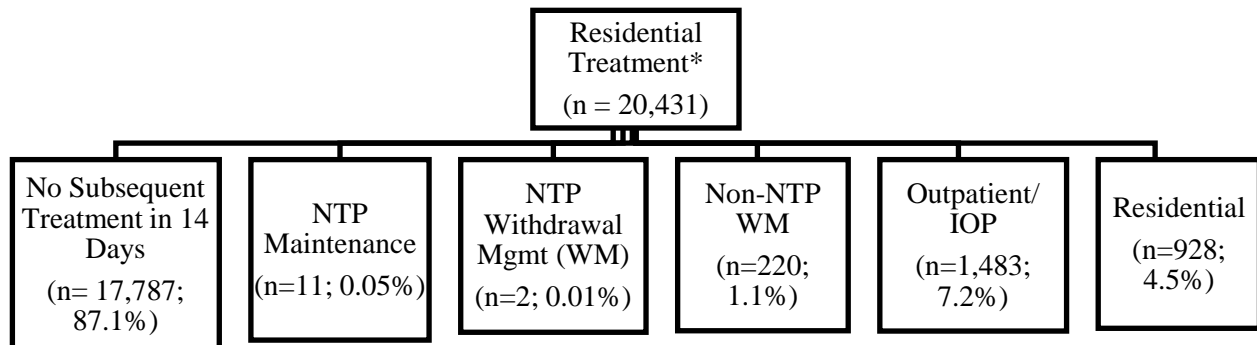
*Admissions Jan. 1 – Dec. 31, 2016, in which residential was the first admission in a treatment episode.

Figure 3.6: Rest of State - service delivery following a residential service (transition within 14 days).

Residential Treatment* (n = 11,004)

| No Subsequent Treatment in 14 Days (n= 9,572; 87.0%) | NTP Maintenance (n=20; 0.2%) | NTP Withdrawal Mgmt (WM) (n=1; 0.01%) | Non-NTP WM (n=87; 0.8%) | Outpatient/ IOP (n=693; 6.3%) | Residential (n=631; 5.7%) |
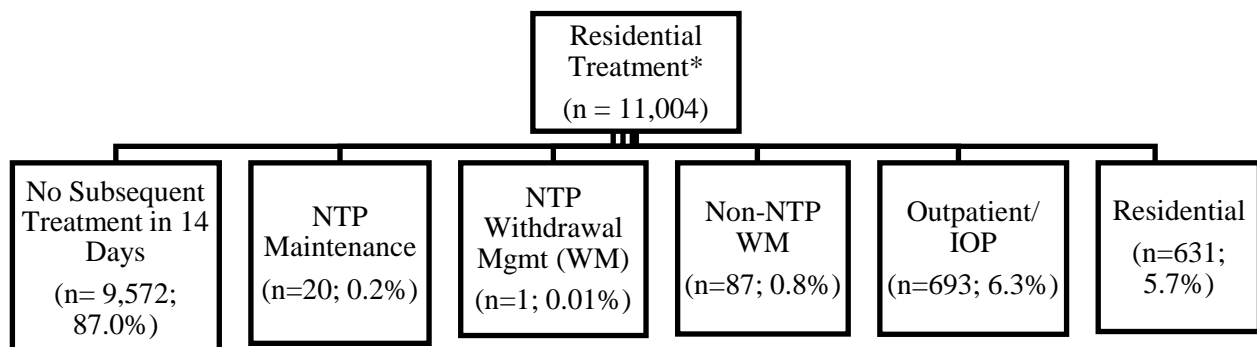
*Admissions Jan. 1 – Dec. 31, 2016, in which residential was the first admission in a treatment episode.

Similar to patients receiving non-NTP withdrawal management services, the majority of the time, patients initially receiving residential treatment did not step down to additional lower-level treatment (e.g., outpatient treatment); thus, the DMC-ODS waiver provides a tremendous opportunity for improving patient transitions from residential to other treatment services along the continuum of care.

Care Coordination and Information Exchange between SUD Treatment Providers

As patients move to different levels of care within an organized delivery system, it is important that treatment be coordinated and essential that SUD treatment providers communicate effectively with each other to facilitate the transition. At the time of this

report, care coordination and effective communication among providers have been examined only at the county level through the County Administrator Survey.

Provider partnerships can play a significant role in the delivery of integrated care and improve care coordination between systems. UCLA inquired about county requirements of their SUD providers to establish formal procedures with other SUD providers to facilitate patient transfers and information exchange (two critical elements for care coordination and effective communication). Unexpectedly, the 2016 data revealed that 28.6% of Early Adopter counties, compared to 35.7% of the rest of the state, require SUD providers to establish formal transfer procedures with other SUD providers (e.g., MOUs between residential and outpatient providers).

UCLA asked administrators in the post-implementation qualitative interviews to elaborate on these processes in their counties, particularly since transfer facilitation along the continuum under the ODS waiver is a priority. Among the three counties, it was evident that care coordination across the continuum is a high priority and is occurring, but that the procedures are still a work in progress and vary depending on the county's delivery system structure, provider network, and phase of implementation. Most commonly, however, procedures are defined for those entering residential.

> *Because of the need to authorize and because my team overseas the bed capacity, it's more residential to residential, or outpatient to residential that we have those procedures for.*

> *Our contractors...are supposed to let us know within 24 hours that the consumer showed up and is there. Then, my staff, the care coordination staff, have 24 hours after that to engage and make contact with the consumer either in person or over the phone to ensure they have whatever they need, let them know they'll be coming out to see them weekly while they're in residential care, and to let them know if they need anything, to call…There are some definite challenges there that we're trying to work through.*

With regard to other levels of care along the continuum, the practices are less standardized and can occur in various ways, ranging from county or contracted care coordination staff, to provider-based case managers, recovery coaches. County notification and tracking of patient movement along the continuum was reported as an area for improvement that administrators are continuing to work through system-wide. Contractual language within provider agreements is not yet consistently present at this time. Through the qualitative interviews, administrators commented as follows:

> *Language is in the provider contracts around the timeliness of transfers and agencies working together, but it would be either us just kind of looking in the electronic health record at this point.*

We don't have formal reporting yet that allows us to see how clients are being transferred and moving their way through the system. I can't just look at a report that shows how that's happening. We have been working actually really hard to facilitate the transition of clients through our system of care.

Between our county-run clinics and county teams, whether it's the call-in center or the case managers or actual outpatient clinics, the information—it's, obviously, covered under our umbrella of contractor business agreements…and the provider can communicate back and forth to us.

The recovery coaches and case managers help with some of that linkage too but again, they don't necessarily notify us when they do that. They just work with the providers.

Information exchange was also reported as typically managed at the provider level, with "*the understanding that that they'd be operating under the QSOA [Qualified Service Organization (QSO) Agreement] to share just very basic information*". The way in which information is exchanged also varies depending on capabilities among the providers. Figure 3.7 shows the distribution in methods by which referral information is being tracked, comparing Early Adopter counties and the rest of the state. There are trends, although non-significant, that suggest Early Adopter counties have higher use of electronic mechanisms followed by paper and phone practices, while the rest of the state reported highest use of paper, then phone, then electronic mechanisms to facilitate and track information exchange.

Figure 3.7: Methods used by counties for tracking of referrals/communication.
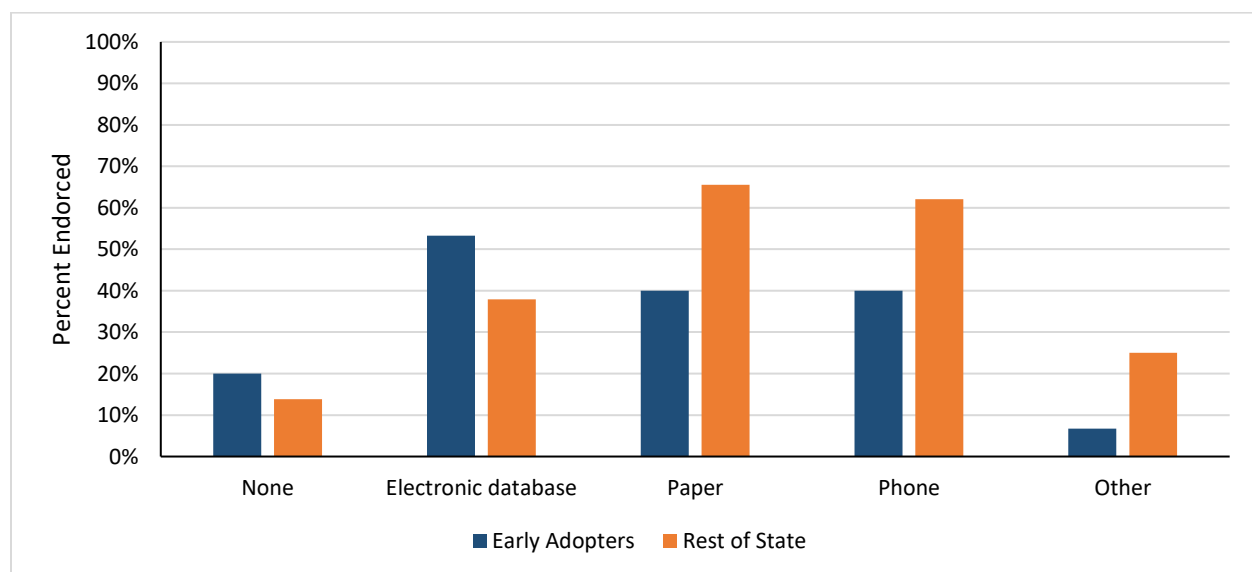
Further insights from the qualitative interviews with the three Early Adopter counties highlighted the issue that information exchange continues to pose as a barrier for counties regardless of phase of implementation.

> *Some of our providers have encrypted emails already set up—some of our larger providers—and some don't. The larger providers, I know, encrypt things back and forth, but some providers would have to fax or send it with the consumers themselves, and so the consumer's actually the one giving it to them.*
>
> *We're using a fax. That is not okay. It's taking too much time. Things are getting lost. In fact, I have a meeting in about two hours to go over an encrypted email system to give to my care coordination teams so that they have the ability to send data back and forth that's CFR 42 compliant, so [we have] a challenge there.*

Each indicated that they anticipate the tracking and information exchange processes will benefit from the progression of utilizing more standardized practices of ASAM criteria for placement and treatment planning, as well as the forthcoming ASAM tracking tool.

Overall, it appears that effective communication is a priority, and based on county responses, there are efforts in place to improve these practices. Comments from post-implementation county administrator interviews illustrate this.

> *We see a real difference in both the culture and capacity, and willingness, and program design of our providers, and how familiar they are with various other community services, and how proactive they are at partnering and working with those other providers to ensure the client has access to this whole continuum of care. That's actually something—and we just had a meeting this morning talking about how are we going to build the capacity of our system to better address these needs. We have policies in place, but how do we hold our providers accountable to really do this, how do we ensure they have the capability, and how do we really set up so that they can be successful?*
>
> *In our experiences, it's more in that situation driven by the county care coordinator or the county case manager helping that client move their way through the system, and not always how well the provider themselves are working with other providers to do that, is hard to know. I think a lot of it has to do at this point more with the provider's culture around partnering and that kind of coordination.*

Use of Evidence-Based Practices

Counties opting in to the DMC-ODS waiver are required to use two of the five evidence-based practice listed in the Special Terms and Conditions, which lists trauma-informed treatment, motivational interviewing, cognitive-behavioral therapy, relapse prevention, and psycho-education.

As Figure 3.8 illustrates, the majority of counties (more than three-quarters of both Early Adopter counties and the rest of the state) reported in both the 2015 and 2016 Administrator Surveys that they were using at least two of the five EBPs listed. There is evidence of a trend of more Early Adopters using the EBPs than the rest of the state. However, although administrators reported using EBPs, when they were asked to rate how challenging implementation various aspects of the waiver were "Use of at least two of the five EBPs listed in the DMC-ODS waiver" topped the list. See Figure 3.9.

Administrators were also asked to select the topics that are the highest priority for the county to receive training and technical assistance. Among the five evidence-based practices listed in the STCs, trauma-informed treatment was selected by the most counties. (See Figure 3.10.)

It is anticipated that even more counties will report using at least two EBPs as they submit their implementation plans and prepare for implementation of the waiver.

Figure 3.8: Percentage of counties with at least two of the five listed EBPs listed in the DMC-ODS waiver available for adult clients.
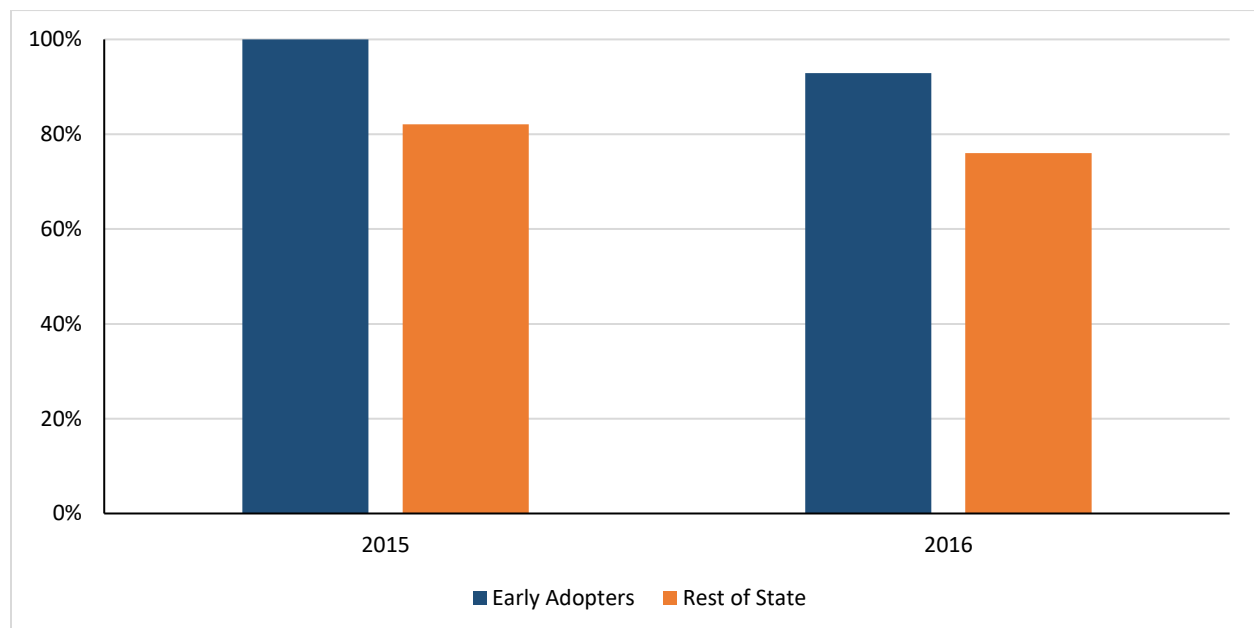
Figure 3.9: Mean rating of challenge level for implementing various aspects of the DMC-ODS waiver.
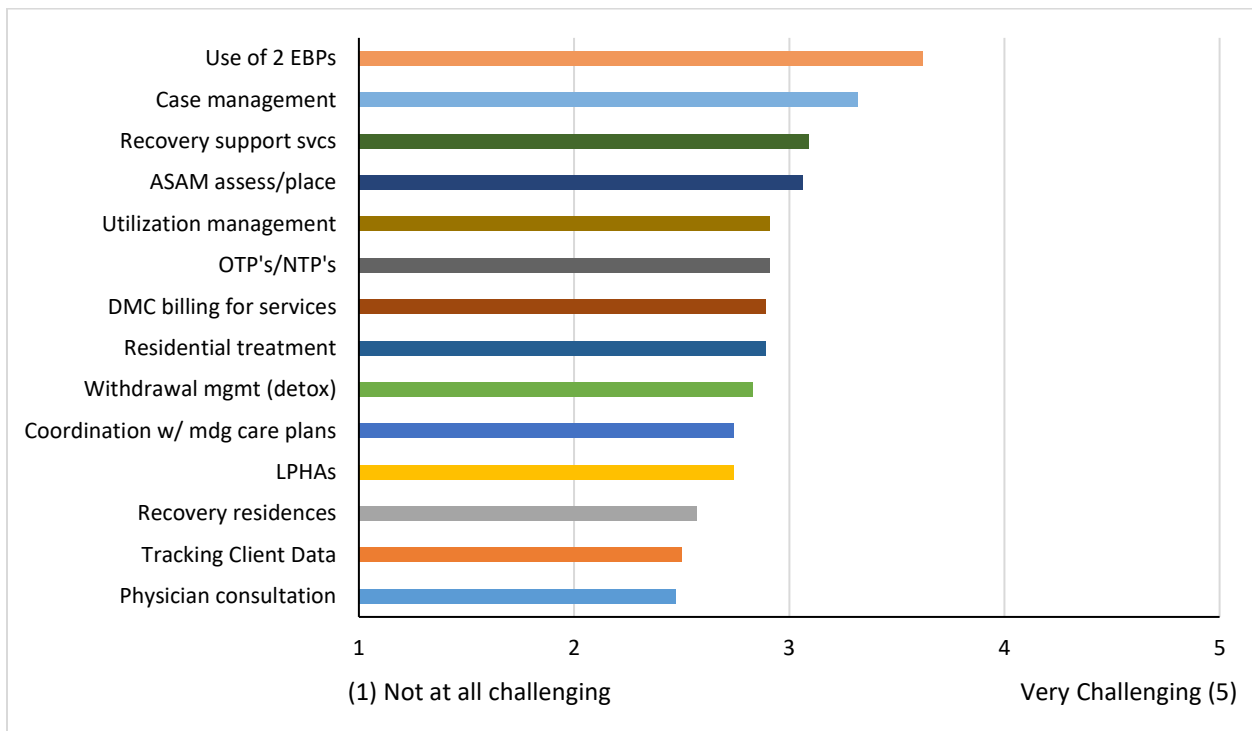
Figure 3.10: Percentage of counties selecting evidence-based practices as a high priority for training and technical assistance.
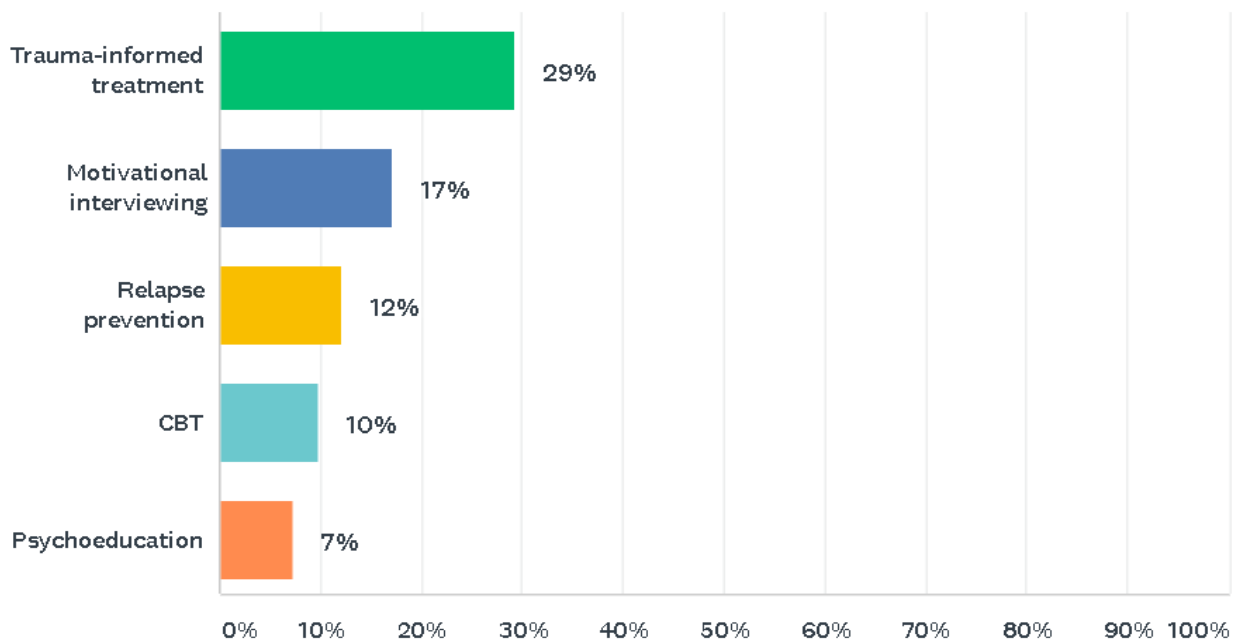
Patient Quality-of-Care Perceptions

Collection and use of patients' perceptions data are essential for gauging the quality of care patients are receiving and informing improvements to such care.

Results of the Administrator Surveys showed that in both 2015 and 2016, a higher percentage of the Early Adopters relative to the rest of the state reported requiring SUD treatment providers to collect client satisfaction/perceptions of care data; see Figure 3.11. In the 2016 survey this difference became statistically significant ($p=0.04$).

Figure 3.11: Percentage of counties currently requiring SUD treatment providers to collect client satisfaction/perceptions of care data.
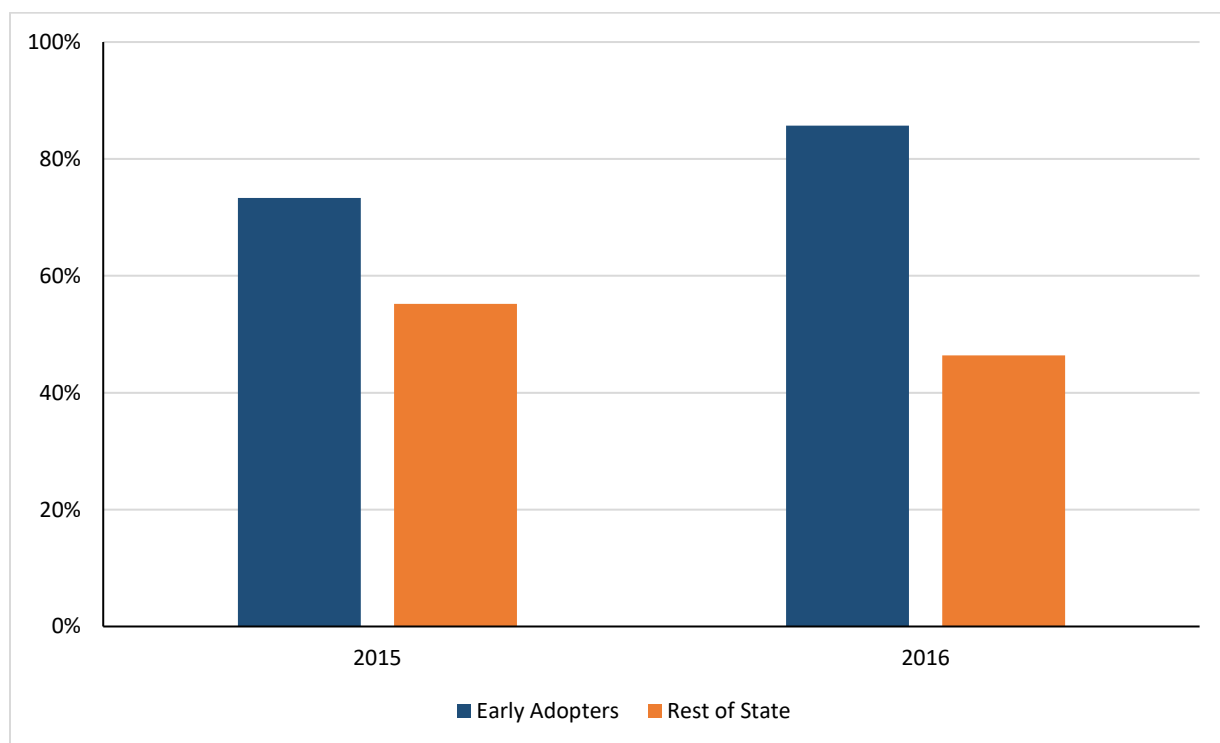
While the majority of Early Adopter counties are already collecting client satisfaction/perceptions of care data, on June 9, 2017, the DHCS released MHSUD Information Notice No. 17-026 providing guidance to counties participating in the DMC-ODS waiver for submission of client satisfaction survey data. These counties will be required to administer the Treatment Perceptions Survey (TPS) at least annually to fulfill their External Quality Review Organization (EQRO) requirements related to having a valid client survey.[7] [8] (See Appendix C for the Treatment Perceptions Survey form in English

---

[7] The EQRO selected, Behavioral Health Concepts, is the same organization that serves as the EQRO for mental health in California.

[8] The TPS was developed by UCLA based on San Francisco County's validated survey and through consultation with DHCS, individual counties, the Substance Abuse Prevention Treatment Committee of

and a sample Treatment Perceptions Survey report that was prepared by UCLA for Marin County.)

Administrator survey results and stakeholder input on the TPS suggest that in general, Early Adopter counties are already familiar with collecting client satisfaction/perceptions of care data and will be able to comply with the EQRO requirement based on current practices or future plans. UCLA will track this measure over the course of the implementation of the DMC-ODS.

Establishment of Quality Improvement Committees and Plans

Counties that opt in to the DMC-ODS waiver are required to have a Quality Improvement Committee (QIC). The majority of both Early Adopters and the rest of the state reported in the 2015 and 2016 Administrator Surveys that they already have a QIC that includes SUD participation (data not shown). However, in 2016 the Early Adopters were more likely than the rest of the state to report that they have written SUD treatment system quality improvement plans. (See Figure 3.12.) It is anticipated that as counties develop their implementation plans or prepare for actual implementation of the waiver, the percentage of counties with written quality improvement plans will likely increase.

Figure 3.12: Percentage of counties with a written substance use disorder treatment system quality improvement plan.
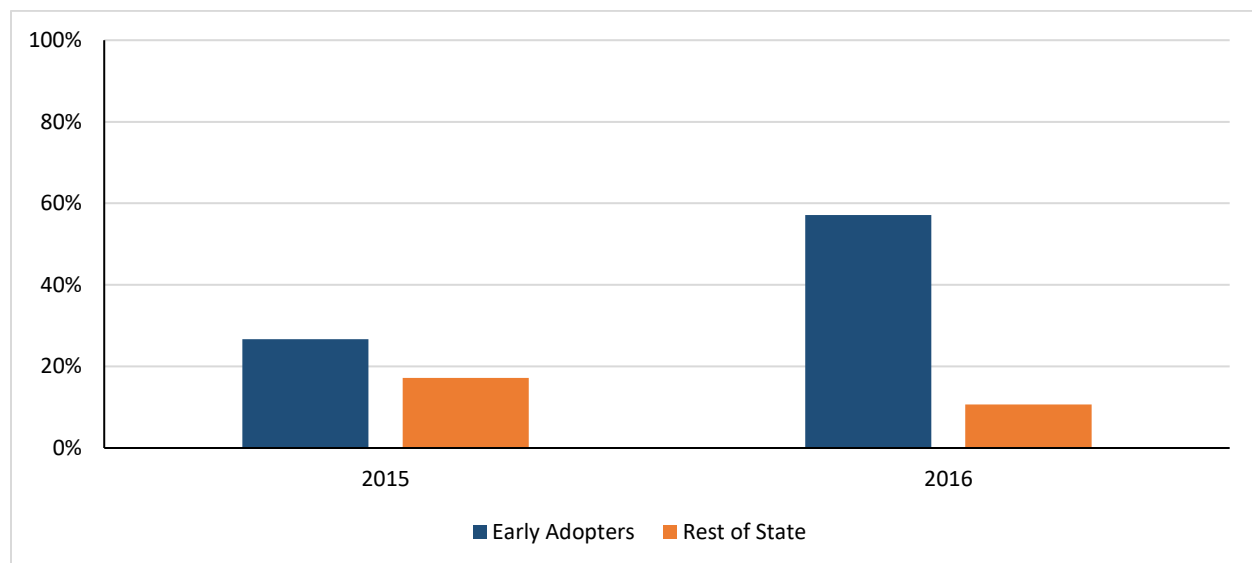
Data in Figure 3.13 suggests that the DMC-ODS waiver is already having an impact on counties' QI efforts according to Administrator Survey respondents. The majority of counties in both groups and both years of the survey reported that the waiver has positively influenced QI activities for SUD. In addition, a significantly higher percentage

---

the County Behavioral Health Directors' Association of California, the DMC-ODS EQRO Clinical Committee, and other stakeholder input.

of Early Adopters compared to the rest of the state reported that the waiver positively influenced such activities (p=0.01).

Figure 3.13: Percentage of counties indicating the waiver has had a positive influence on quality improvement activities for SUD.
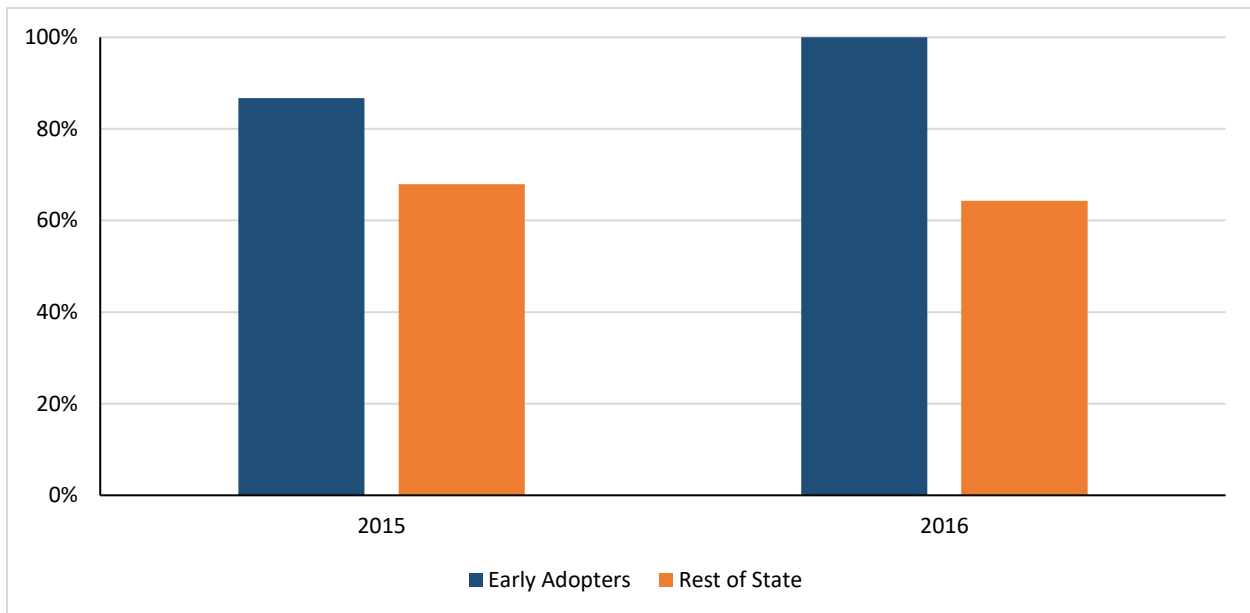
Below are examples of Administrator Survey respondents' written comments illustrating the impact the waiver already seems to have had on quality improvement activities for SUD in their respective counties.

"Caused use to do some strategic planning around SUD."

"It has helped to create a more standardized level of consistency in the SUD field as a whole."

"It has highlighted the need for these."

"New way of thinking and looking at issues."

"Prior to the waiver, there was no SUD participation in QI activities."

"We will be enhancing SUD related QI activities moving forward."

Similarly, an administrator of an Early Adopter county who participated in a stakeholder interview, commented on the "new landscape" and working with judges and probation around the changes:

We're really seeing the organized delivery system as our opportunity not just to authentically implement what the ODS wants us to implement, but to really, in a partnering way, draw the line and make these systems changes that we've really been wanting to make for a long time, and that we know we need to make, and this gives us some more leverage because we bring in all this federal money when we use the ASAM level of care to place people in treatment. It's important that we have a system of care…providers that aren't essentially just responding to what a judge is ordering, but is really looking at the client needs. These are huge and very important changes for quality.

Other Quality-related Components of the DMC-ODS Waiver

The Administrator Survey inquired about the availability of particular components of the DMC-ODS that are required and/or allowable for billing under the waiver, including having: a utilization management program; the ability to bill DMC; professional staff that are Licensed Practitioners of the Health Arts (LPHAs) or licensed-eligible practitioners working under the supervision of licensed clinicians; and physician consultation services.

<u>Utilization Management</u>
The intent of a utilization management (UM) program is to assure that beneficiaries have appropriate access to SUD services. According to the 2016 Administrator Survey data shown in Figure 3.14, a higher percentage of Early Adopters compared to the rest of the state reported that UM was fully or partially available (p=0.10). This pattern was also observed in the 2015 survey. In addition, the percentage of Early Adopters that reported the availability of UM increased significantly from 2015 to 2016 (p=0.05). As counties implement or prepare to implement the DMC-ODS, UM program availability is expected to continue to rise.

Figure 3.15 shows that most counties find implementation of a UM program as somewhat challenging. The trend suggests that both groups reported UM as being less challenging to implement in 2016 than in the previous year, and the decrease was marginally significant for the Early Adopters (p=.05). As counties gain more experience with implementing their UM programs, we would expect the ratings to decrease. Provision of training and/or technical assistance in this area many be indicated.

Figure 3.14: Percentage of counties with utilization management available for adult clients.
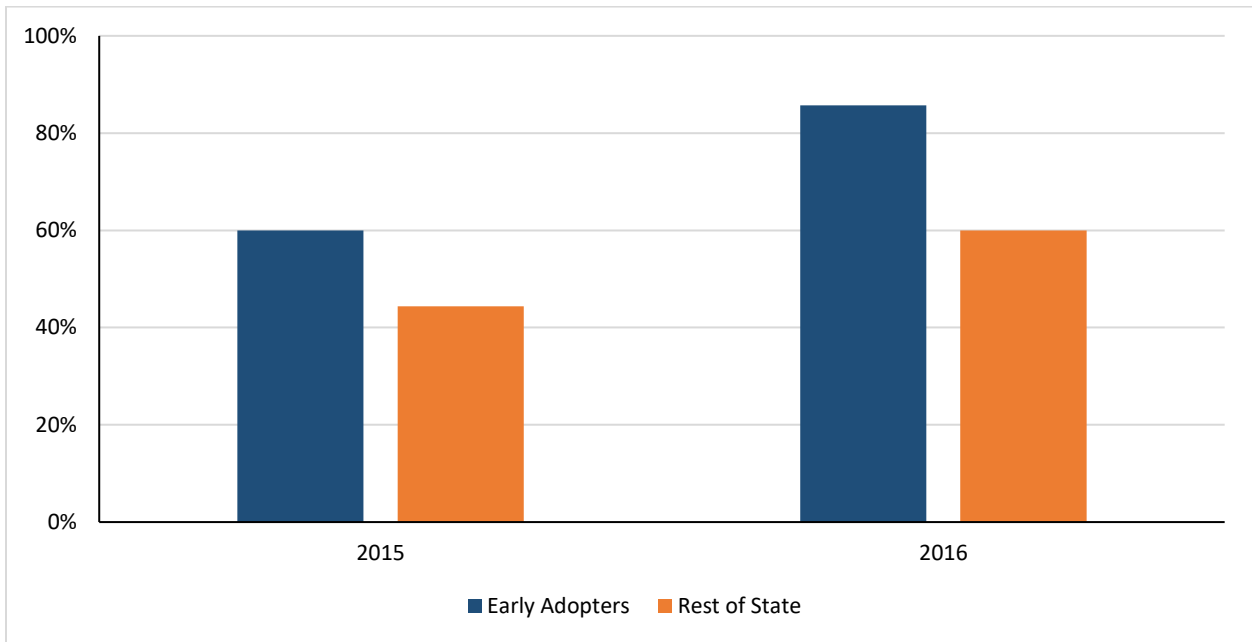
Figure 3.15: Mean rating of challenge level for implementing utilization management.
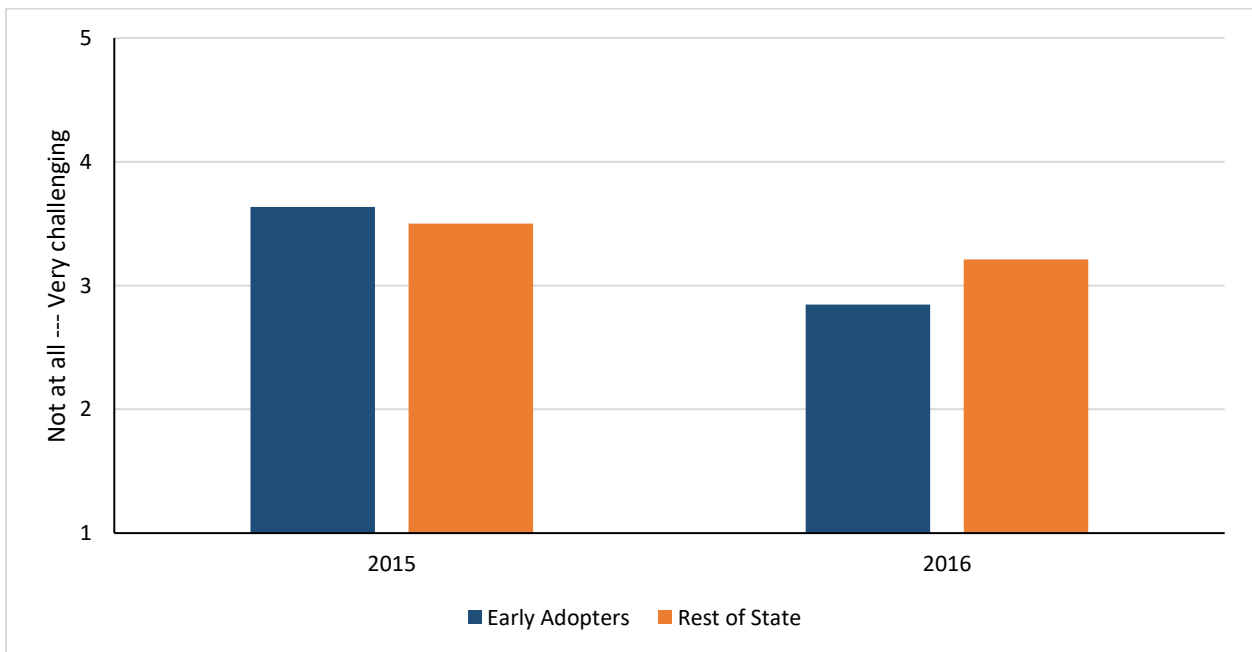
Drug Medi-Cal Billing
Under the waiver, counties are allowed to bill DMC for ODS services. However, some counties and providers were already billing DMC for some services prior to waiver preparations. As shown in Figure 3.16, the majority of both the Early Adopters and the rest of the state reported on the 2015 and 2016 Administrators Surveys that DMC billing for services was fully or partially available. Further, the Early Adopters were more likely than the rest of the state to report that DMC billing for services was fully or partially available in both 2015 (p=.01) and 2016, p=0.03).

Figure 3.16: Percentage of counties with DMC billing for services available for adult clients.
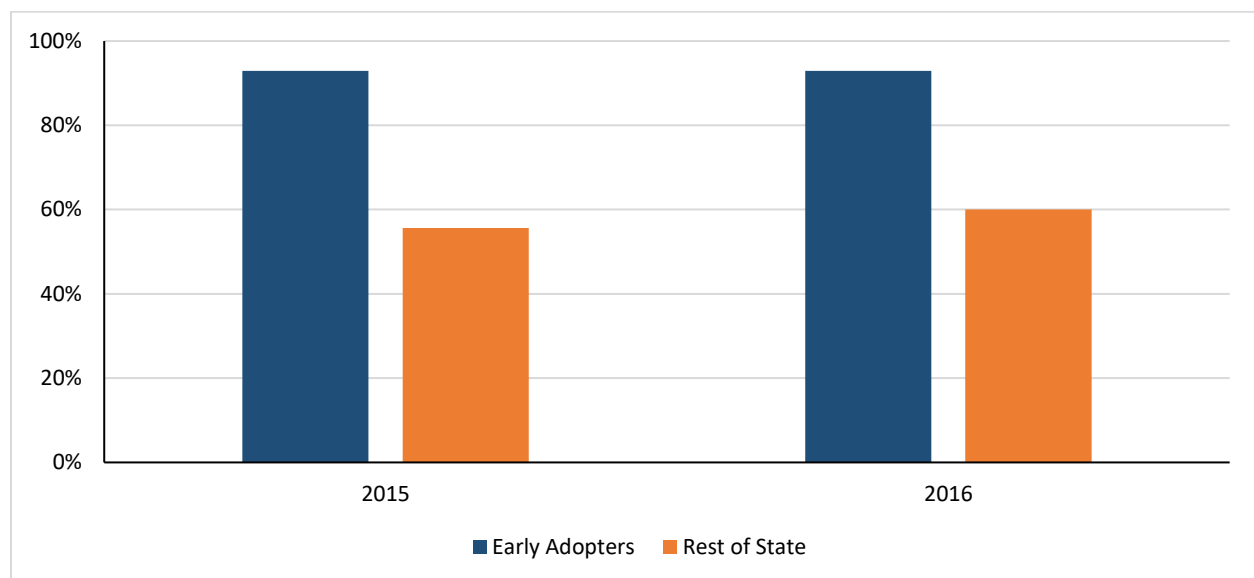
As shown in Figure 3.17, while the Early Adopters reported billing DMC as less challenging in 2016 than in the prior year (non-significant), the rest of the state indicated that it became significantly more challenging (p=.015).

Comments from an administrator from an Early Adopter county who was interviewed provide some insight into the results:

> *We have a phenomenal team that supports us on billing, and at least three of those employees have been in the system so long…they're phenomenal… I think another thing I've heard from other counties is…some of them have never even Drug Medi-Cal billing before. Well, we've been doing it for so long I think it was just a little bit easier for us.*

These results suggested that technical assistance and/or training may be helpful to some counties that are not as familiar with Drug Medi-Cal billing.

Figure 3.17: Mean rating of challenge level for implementing DMC billing for services.
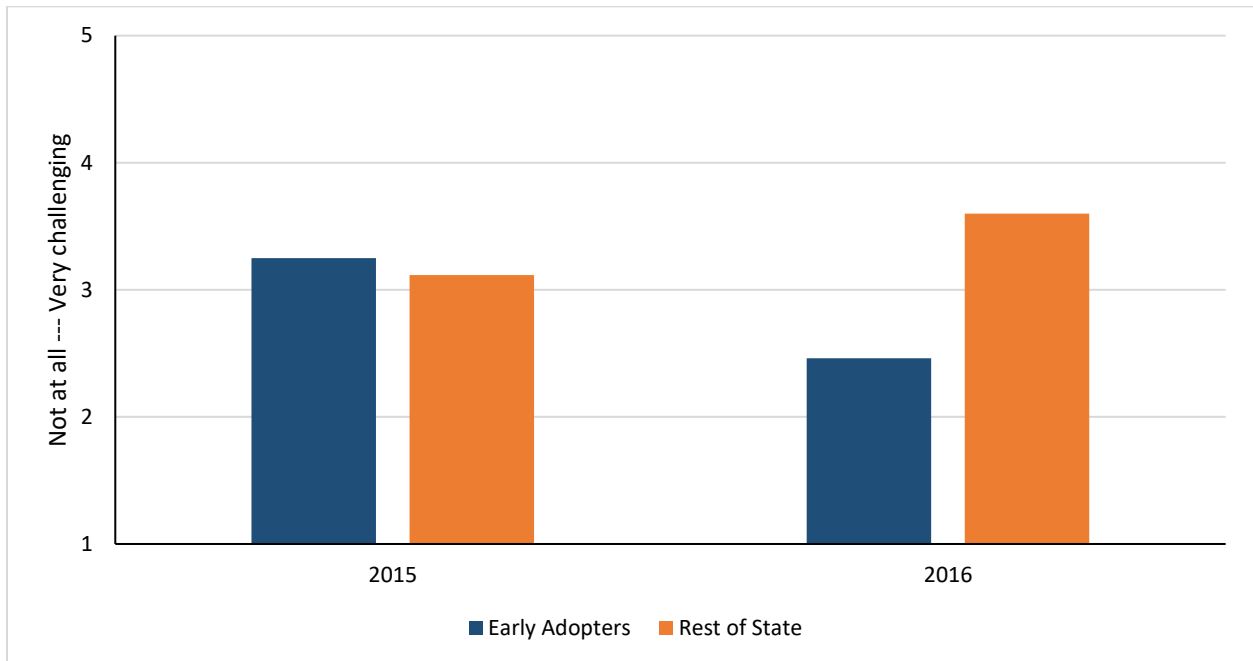
Figure 3.18: Percentage of counties with Licensed Practitioners of the Healing Arts (LPHA) available for adult clients.
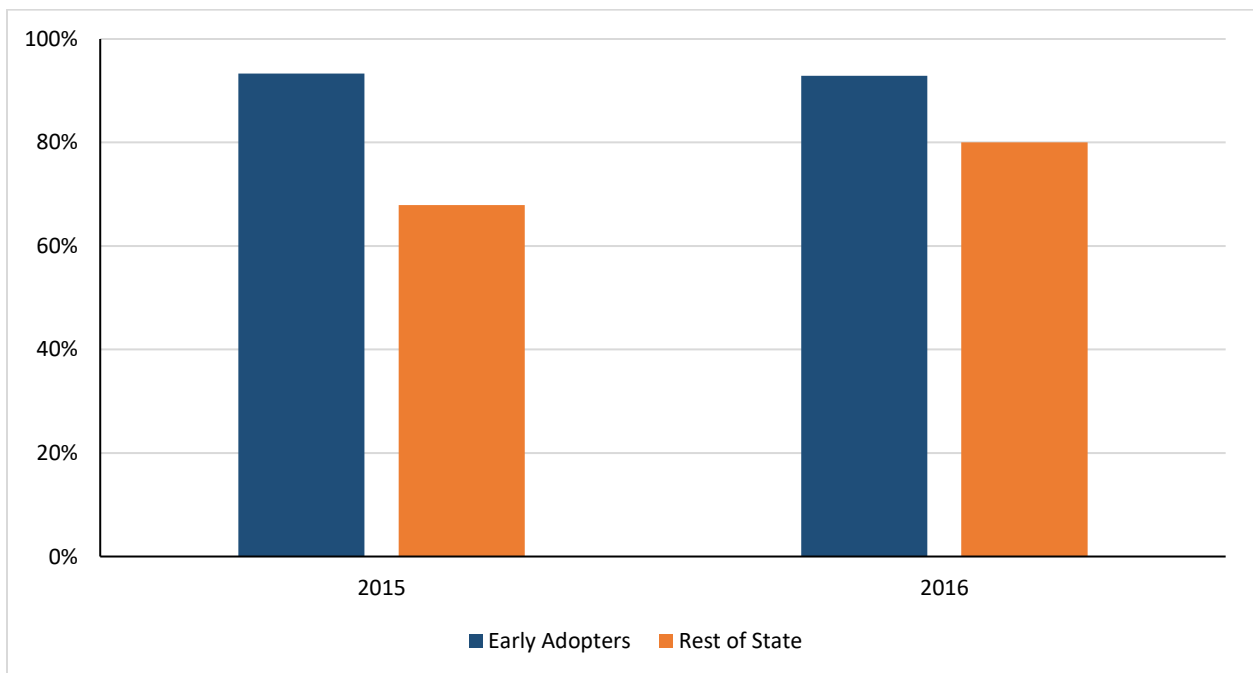
Licensed Practitioner of the Health Arts (LPHA)

Licensed Practitioners of the Health Arts include: Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians. Data from the 2015 and 2016 Administrator Surveys (see Figure 3.18) show that the majority of both the Early Adopters and the rest of the state reported that LPHAs were fully or partially available. In addition, in both years, a trend shows higher percentages of the Early Adopters compared to the rest of the state reported having LPHAs.

While the Early Adopters reported implementing the LPHA requirement under the waiver as less challenging in 2016 than in the prior year (non-significant), a slight increasing trend was observed for counties in the rest of the state. (See Figure 3.19.) It is not clear what factors may have contributed to making it more challenging for some counties to implement the LPHA requirement, but this might be an area for further investigation as it is possible that the finding could indicate a workforce issues in some counties.

Figure 3.19: Mean rating of challenge level for implementing Licensed Practitioners of the Healing Arts (LPHA)
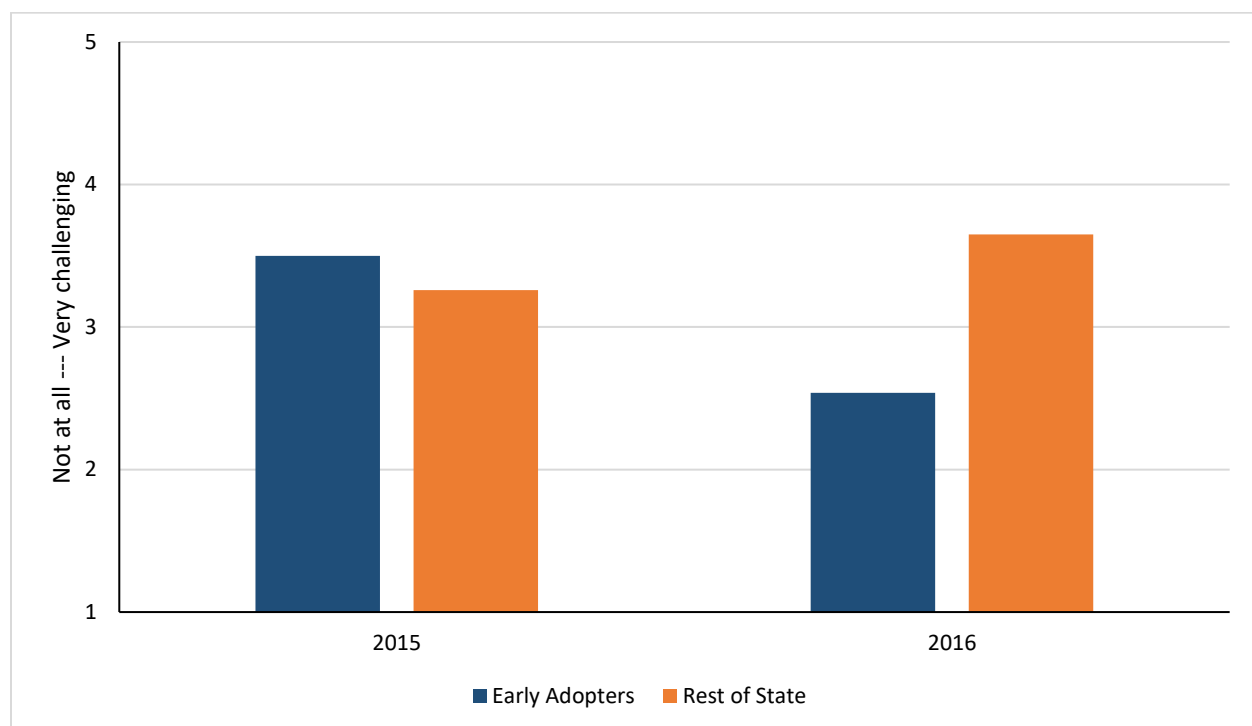
Physician Consultation

Physician consultation services include DMC physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. As shown in Figure 3.20, there is evidence of a decreasing trend from 2015 to 2016 among counties in the rest of state group reporting that physician consultation services are partially or fully available, whereas there was a slight increasing trend in availability of physician consultation among the Early Adopters. The results for the counties in the rest of the state group are somewhat surprising, as the overall trends observed in terms of implementing the other selected quality-related components of the waiver tend to show increases.

Figure 3.20: Percentage of counties with physician consultation available for adult clients
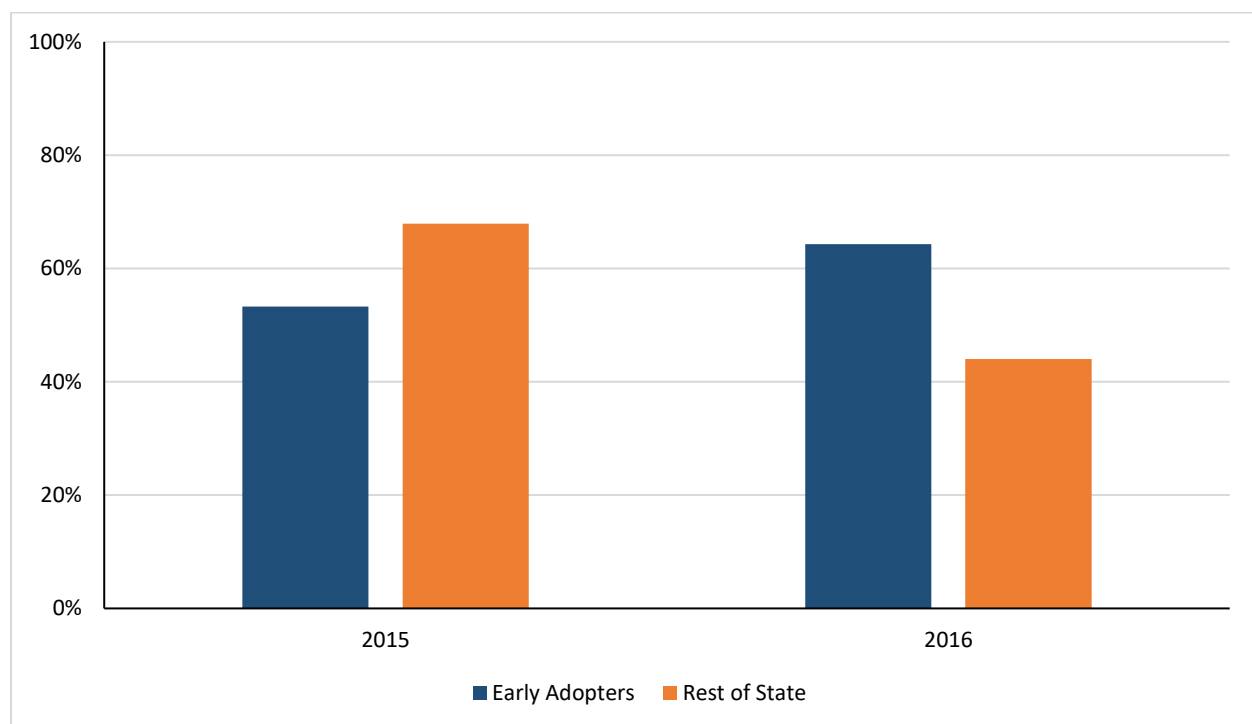
The results shown in Figure 3.21 shed further light on the findings. The trend shows that both groups indicated that the Physician Consultation benefit became more rather than less challenging to implement. During a discussion between UCLA and county administrators regarding the survey results at the June SAPT+ meeting, administrators indicated that they initially thought the benefit would be different from how it was actually written in the STCs. When administrators learned the details, they revised their responses (e.g., implementation status) and ratings (challenge) from the prior year. The comments below from two administrators from an Early Adopter county illustrate this.

> *The basic challenge is getting them to use it. The rule is the consumer has to be open to us….For example, at our county hospital, their physicians*

wanted to consult with my addiction physicians…We can't bill for that, because the consumer's not open to us. They're open to the hospital.

The spirit of the benefit is fantastic but the reality of how we can claim it is very, very limiting . . . We would love to see . . . it being applicable to consultation to physicians that are serving DMC beneficiaries even it's not at a DMC clinic."

Figure 3.21: Mean rating of challenge level for implementing physician consultation.
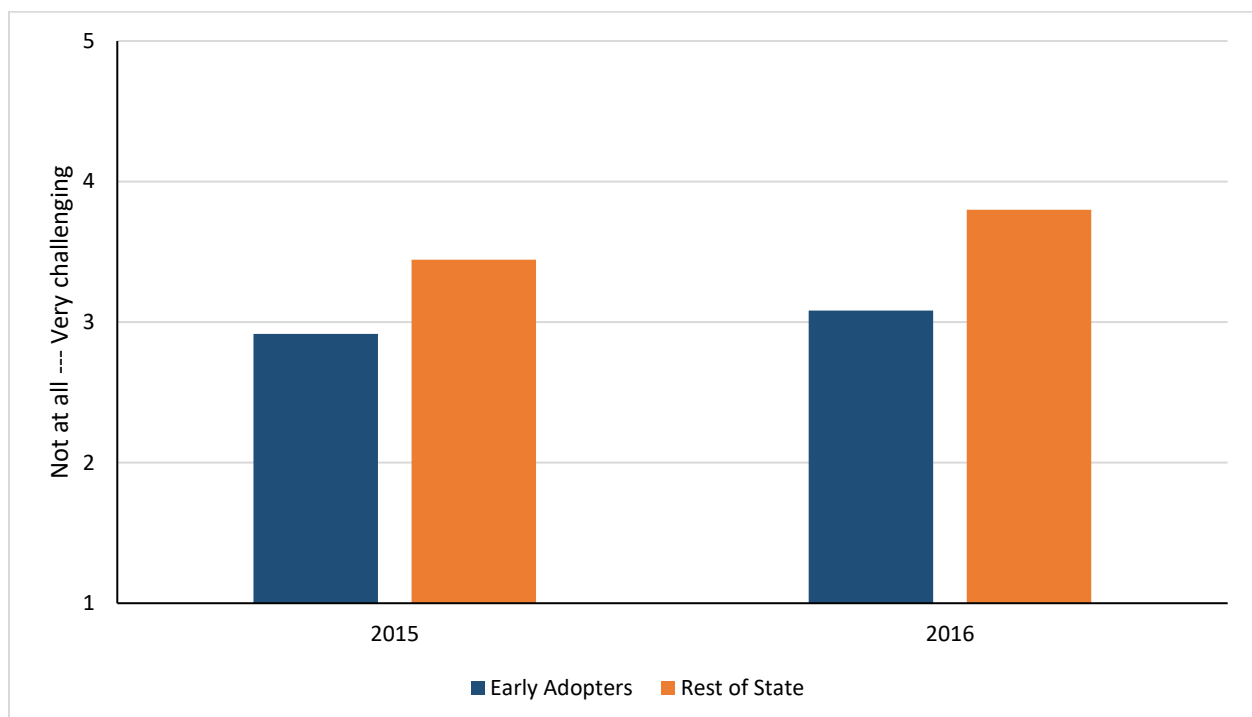
C. Discussion and Next Steps

The state demonstration of the waiver is still in the early stages, and to date, only a handful of counties have executed DMC-ODS contracts. This report therefore necessarily presents limited data on the quality of care using primarily CalOMS-Tx, County Administrator Survey (both quantitative and qualitative data), and key informant qualitative interview data. As data continue to be collected, they will be used to examine changes over time. The following highlights what is known about the status of quality measures at end of the second year of DMC-ODS waiver implementation:

- *Use of ASAM Criteria-based tools for placement and assessment.* As expected, Early Adopter counties tended to be further along in their use of ASAM assessment and placement and collection of data. The tools being used vary widely from county

to county, however, and few counties are using adolescent ASAM-based tools. Overall, counties continue to find the use of the ASAM Criteria somewhat challenging. Continued training and technical assistance on this topic are recommended. UCLA is also developing tools for brief screening that may help in the future.[9]

- *Successful treatment engagement.* During 2016, most treatment admissions (excluding withdrawal management) resulted in lengths of stay 30 days or longer. These percentages were similar to the prior year. Early Adopters and the rest of the state were similar on these measures.

- *Patient transitions along the continuum of SUD care.* As in previous years, patients receiving non-NTP withdrawal management or residential services in 2016 did not typically move along the continuum of care to receive additional treatment. The data continue to highlight care transitions as a priority area, which an organized delivery system that includes a full continuum of SUD care is expected to address.

- *Care coordination and information exchange between SUD treatment providers.* Provider partnerships were expected to play a significant role in the delivery of integrated care and improve care coordination between systems, but county administrator data indicate that requiring partnerships or establishing formalized procedures to facilitate patient transfers and information exchange is still relatively low. Qualitative interviews from county administrators form Early Adopter counties suggest care coordination across the continuum is a high priority, but the procedures are still a work in progress. Most common procedures are defined for those entering residential. Administrators reported that a culture shift is starting among some providers with regard to their willingness and capacity to partner and work together to ensure patients have access to the continuum. UCLA anticipates progress on this measure as county driven case management increases and ASAM criteria practices evolve.

- *Use of evidence-based practices.* In both 2015 and 2016, the majority of counties reported using at least two of the five EBPs listed in the STCs, but in 2016, this was also rated as the most challenging issue out of a list of 14 potential challenges. Additional training or technical assistance on this issue may be needed, particularly on trauma-informed treatment.

- *Establishment of quality improvement committees and plans.* The majority of counties already have a quality improvement committee with SUD participation. However, in 2016 the Early Adopters were more likely than the rest of the state to report that they have written SUD treatment system quality improvement plans. In addition, the DMC-ODS waiver appears to be already having an impact on counties' QI efforts, particularly among the Early Adopters.

- *Utilization management, Drug Medi-Cal Billing, and LPHAs* were all in greater use in Early Adopter counties compared to the rest of the state, and generally

---

[9] The report and tools will be made available online at: http://uclaisap.org/ca-policy/

increased over time. Notably, while Drug Medi-Cal billing became less challenging for the Early Adopter counties, it became more challenging for the rest of the state. These results suggest that technical assistance and/or training may be helpful to some counties with less experience billing Drug Medi-Cal.

UCLA plans to obtain access to and/or acquire additional data sources (e.g., county ASAM data, Medi-Cal claims, grievance reports), collect additional data via surveys (e.g., treatment provider, patient satisfaction/perception of care) and qualitative interviews (e.g., county administrators), and conduct further analyses (e.g., analyzing data from additional sources, tracking changes over time, comparing opt-in and non-opt-in counties) in the upcoming years to examine if and how the implementation of the waiver influences the quality of the SUD care provided to patients within an organized delivery system.

IV. Integration/Coordination of Care

Valerie Antonini, M.P.H., David Huang, Ph.D., Darren Urada, Ph.D., Cheryl Teruya, Ph.D., Elise Tran, and Kevin Moino

Greater coordination and integration of care for beneficiaries receiving SUD treatment is a key component of an organized delivery system of care. Advances in these areas can not only facilitate efficient transfers as patients step up/down across the various levels of care within the SUD continuum, but can also ensure effective treatment of individuals with co-occurring health concerns across systems.

To measure changes in coordination and integration, UCLA is examining over time the following coordination and integration goals: (1) comprehensive substance use, physical health, and mental health screening, (2) beneficiary engagement and participation in an integrated care program as needed, (3) shared development of care plans by the beneficiary, caregivers, and all providers, (4) care coordination and effective communication among providers, (5) navigation support for patients and caregivers, and (6) facilitation and tracking of referrals between systems. Where possible, UCLA will examine referrals to and from primary care and mental health, referrals to and from recovery services paid for by the DMC-ODS waiver, SUD identification in the health care system, and follow-up after discharge from the emergency department for alcohol or other drug use.

Given that only three counties have recently begun waiver implementation due to the phased roll out for participation, many of these listed measures cannot yet be evaluated fully. Therefore, for this Year 2 report, UCLA focused evaluation efforts on measures with accessible data in which there was potential for measureable change, comparing Early Adopter counties to the rest of the state. These measures and findings, discussed below, include:

- Comprehensive substance use, physical health, and mental health screening
- Cross-system care coordination and effective communication among providers, and
- Facilitation and tracking of referrals between systems.

For purposes of this report, we have incorporated discussions of such "within system coordination" into the quality-of-care section (see Section III), while the focus of this section is on the integration/coordination of SUD treatment with primary care and mental health.

A. Data Sources

The measures and findings below reflect analysis from three main data sources: the California Outcome Measurement System - Treatment (CalOMS-Tx), the County Administrator Survey, and data from qualitative responses and stakeholder interview activities. Medi-Cal claims data and MOUs will be analyzed in future reports. In the future, the evaluation will rely more heavily on provider/program-level data to determine how well counties and their providers are meeting their integration and coordination goals.

B. Measures

Comprehensive Substance use, Physical health, and Mental health screening

This measure will be more closely explored at the provider level in the future, but we are able to draw inferences now from county administrator survey and interview responses regarding ASAM criteria practices. ASAM Criteria assessments, required for DMC-ODS, includes assessment of biomedical conditions and complications (ASAM Criteria Dimension 2) and emotional, behavioral, or cognitive conditions and complications (Dimension 3). It is therefore anticipated that more comprehensive screening for physical and mental health problems will occur as counties join the DMC-ODS demonstration project.

Administrator Survey responses from the last two years support this expectation. Early Adopter counties report greater availability of ASAM assessment and placement services compared to the rest of the state (See Figure 3.1 in Section III). In addition, the data suggest a trend toward implementation of ASAM assessment and placement becoming less challenging for the Early Adopter counties, whereas it has remained somewhat challenging across the two years for the rest of the state. DHCS-sponsored training efforts on use of ASAM criteria may have contributed to increased availability of the assessment service and reduced challenges in implementation. See Section III for more information about measures for ASAM utilization.

Cross-system Care coordination and Effective Communication among Providers

Measures of coordination and communication were examined at the county level through the county administrator. The targeted areas of examination included their perspective of how well they think their health care departments/divisions are integrated, how effective their communication methods are to facilitate an organized delivery system, and whether they believe DMC-ODS waiver participation has positively impacted communication between systems. UCLA then inquired about county practices of care coordination and case management services.

Department/division integration
In the 2016 county administrator survey, UCLA asked administrators to rate the degree to which their SUD and mental health (MH) departments/divisions are integrated, as well the degree to which their SUD and physical health (PH) services departments/divisions are integrated. Using a 1–5 Likert scale from "*very poorly integrated*" to "*very well integrated*", counties on average rated MH-SUD integration higher than PH-SUD

integration, which is not surprising given that most counties have MH and SUD within a single behavioral health department. Interestingly, however, there was a non-significant trend toward integration with both MH and PH being rated lower among the Early Adopter counties (MH: 3.0 and PH: 2.6) compared to the rest of the state (MH: 3.8 and PH: 2.9). (See Figure 4.1.) This suggests that in Early Adopter counties, departments continue to struggle with integration even though they are further along into waiver implementation.

Figure 4.1: Mean ratings of the degree to which SUD and physical health divisions/departments, and SUD and mental health divisions/departments, are integrated within counties
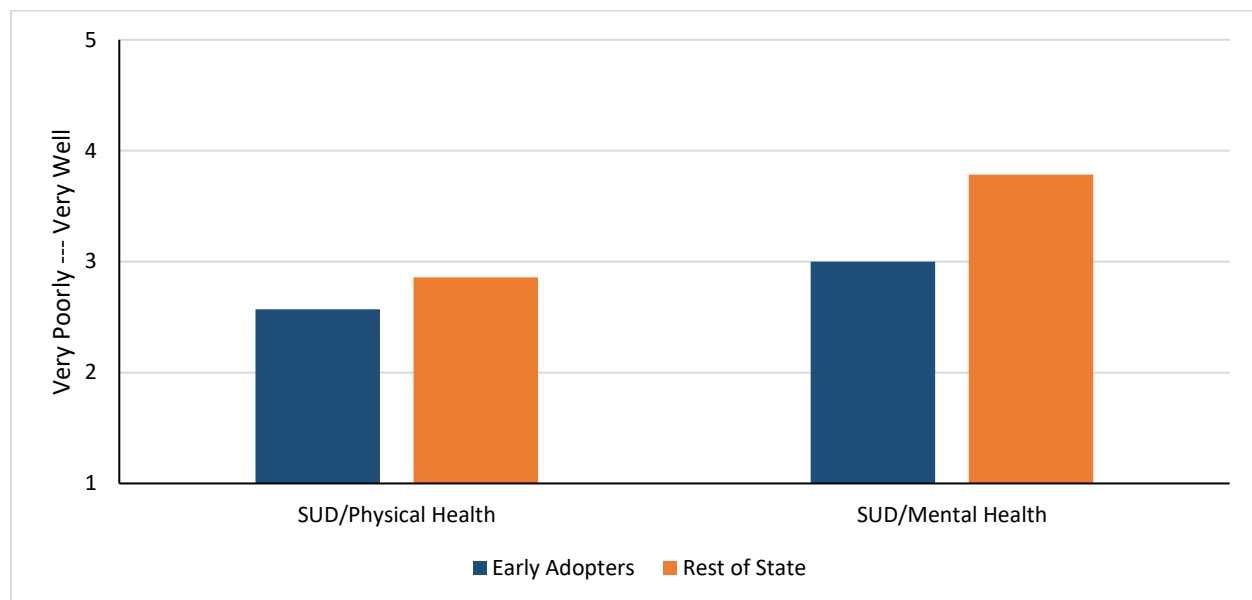
Qualitative interviews with county administrators provided some insight into how to interpret this finding. Early Adopter counties explained that despite preparations, surprising levels of challenges arose that were not apparent until implementation began. This was expressed during all three post-implementation qualitative interviews with Early Adopter counties.

> It's like a whirlwind" even with two years of planning and preparation, that it still feels like very significant changes that we're still trying to work with…with our providers and even our own county infrastructure.

> I think the lesson that I really think about is: We, I think, have been surprised by places in our system that…we thought our system worked better than it did before we started.

> This is really a pretty monumental change for our system, and I think there are some places within our county behavioral health where…maybe the assumption that because on the mental health side, a lot of kinds of

processes are in place…is that it would be an easy roll out to the SUD, but that's not necessarily the case…" and *"I think sometimes people don't realize what a significant change it's gonna be, until it goes into effect.*

Thus, although the data may at first appear to show less integration in Early Adopter counties, it appears the lower ratings may actually reflect greater realism on the part of these counties as the realities of all the challenges became more apparent. UCLA will continue to track this measure.

<u>Department/division communication</u>
UCLA asked county administrators whether they thought communications with Mental Health and Physical Health systems occurred frequently enough to support an organized delivery system. (See Figure 4.2). Agreement rates were higher regarding SUD-MH communication compared to SUD-PH communication, consistent with the integration findings discussed above. There was, however, an interesting trend toward Early Adopter counties rating communication with physical health higher the rest of the state, but rating SUD/Mental health department communication lower than the rest of the state. This interaction was marginally significant (p=0.09).

UCLA inquired further about this finding with county administrators; qualitative comments from the Early Adopter counties indicated the following as barriers:

MH and SUD staff need more time and bandwidth to facilitate integrated care...our system is resource confined and people are stretched which leads some to push back on integration and collaboration, even while most staff and the system is trying to "lean in" to this work.

To operationalize ODS in a manner that ensures integration with mental health services, our leadership will begin to meet more frequently in the coming months.

We are integrated fairly well at a Senior Management level but this has not filtered down to line staff as we have a MH system which primarily is county employees and a SUD system which is mainly contracted.

Figure 4.2: Percentage of counties indicating that SUD and physical health departments, and SUD and mental health departments, meet frequently enough to support an organized delivery system.
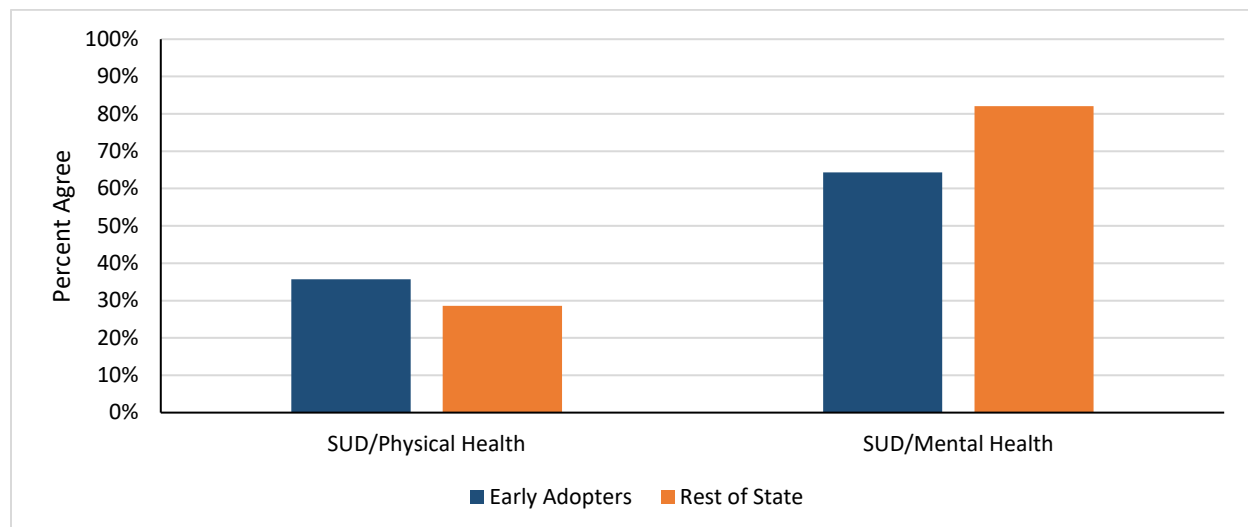
Qualitative comments about SUD/Physical health department level communication, suggested the barriers tended to be more about a broad array of needs, ranging from more meetings with additional entities, more time, more collaboration, and stronger stands from leadership. For example:

> *Leadership meets- some issues need more time, more collaboration, and a stronger stand from leadership, such as: PCPs prescribing Suboxone after induction and stabilization.*

> *Need more meetings with ER departments and with hospitals. Already have good meetings with FQHCs.*

> *We meet but sometimes it is hard to get all the players at the same time, to the same meeting to make progress.*

DMC-ODS Waiver Impact on Communication

In an effort to identify the impact of the DMC-ODS waiver on communication, UCLA asked specifically how much county administrators perceived the DMC-ODS waiver to have influenced department level communication. In 2016, 100% of the Early Adopter group reported that the waiver had positively influenced SUD/MH communication (see Figure 4.3). Compared to 2015 findings, there was a significant increase within this group of counties, 63.6% in 2015 to 100% in 2016, $p=.05$. In addition, there was a significant difference in 2016 between the Early Adopters and the rest of the state (57.1% and 100%, respectively), $p<.01$.

Figure 4.3: Percentage of counties indicating the waiver has had a positive influence on communication between SUD and MH.
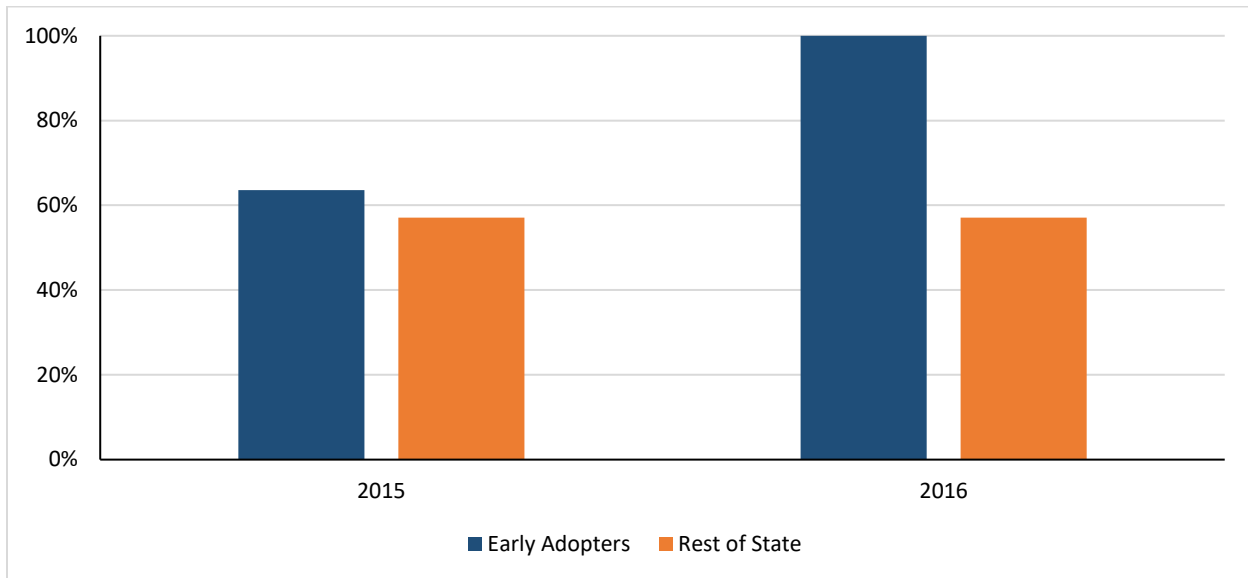
Likewise, Figure 4.4 shows findings about the waiver's impact on communication between SUD and Health departments. In 2016, a higher percentage of people (85.7%) in the Early Adopter group reported that the waiver positively influenced communication between SUD and physical health services compared to 2015 (46.7%, p=.06) or the rest of the state in 2016 (46.4%, p<.01).

Figure 4.4: Percentage of counties indicating the waiver has had a positive influence on communication between SUD and physical health services.
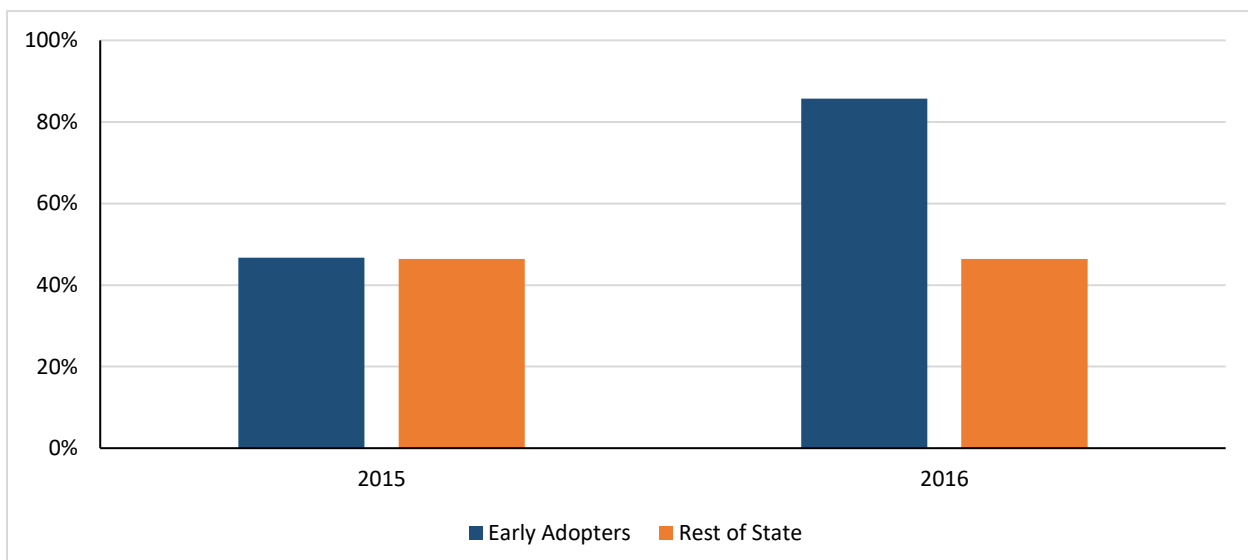
These findings suggest that the DMC-ODS waiver is having a growing impact on cross-system communication. This is an important finding, and UCLA will continue to monitor it in the future.

Case Management

The service specifically designed to facilitate care coordination and linkage across systems is Case Management. In the 2016 administrator survey, UCLA inquired about the planning status of case management services planning and implementation. Using a Likert 1-7 scale ranging from 1="still figuring it out" to 7="we have detailed plans", overall the Early Adopter counties provided significantly higher ratings on the scale than the rest of the state. (5.6 compared to 3.5, $p<.01$); see Figure 4.5

Figure 4.5: County planning status regarding planning and implementation of case management.
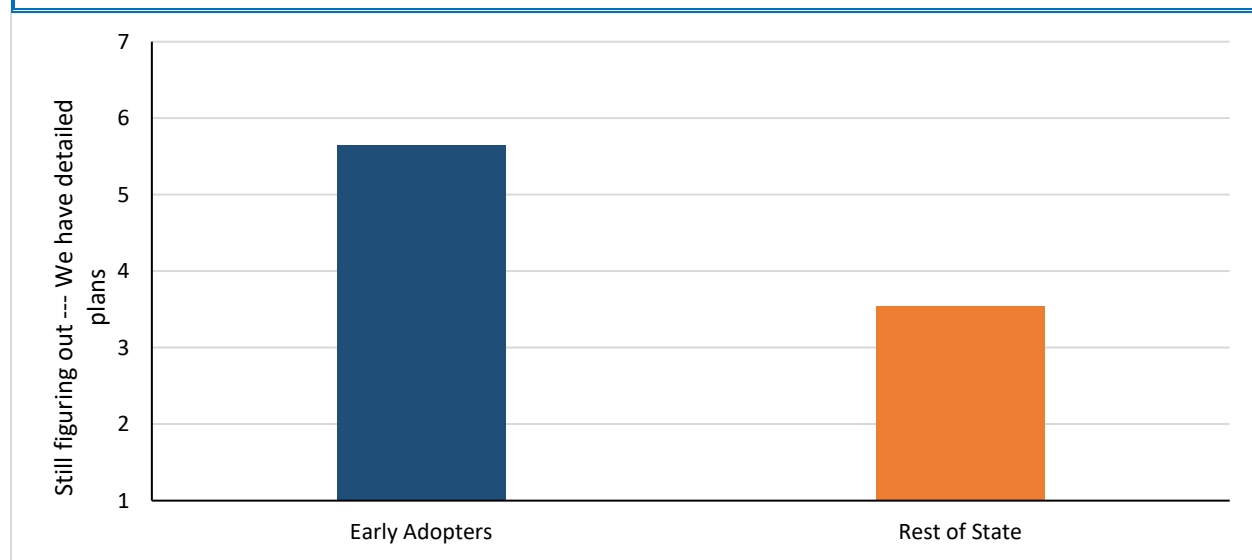
Along similar lines, UCLA further inquired about the current actual availability of Case Management services. In both 2015 and 2016 surveys, case management services were slightly more available in the Early Adopter counties than in the Rest of the State, although the differences were not statistically significant. In the 2016 survey, Early Adopter counties reporting 71.4% availability compared to Rest of the State with 60% availability. Availability was defined as either fully or partially available.

The data in Figure 4.6 show a non-significant trend suggesting that the implementation of Case Management may be becoming less challenging for the Early Adopters, whereas it has remained somewhat challenging across the two years for the rest of the state.

Figure 4.6: Mean rating of challenge level for implementing case management.
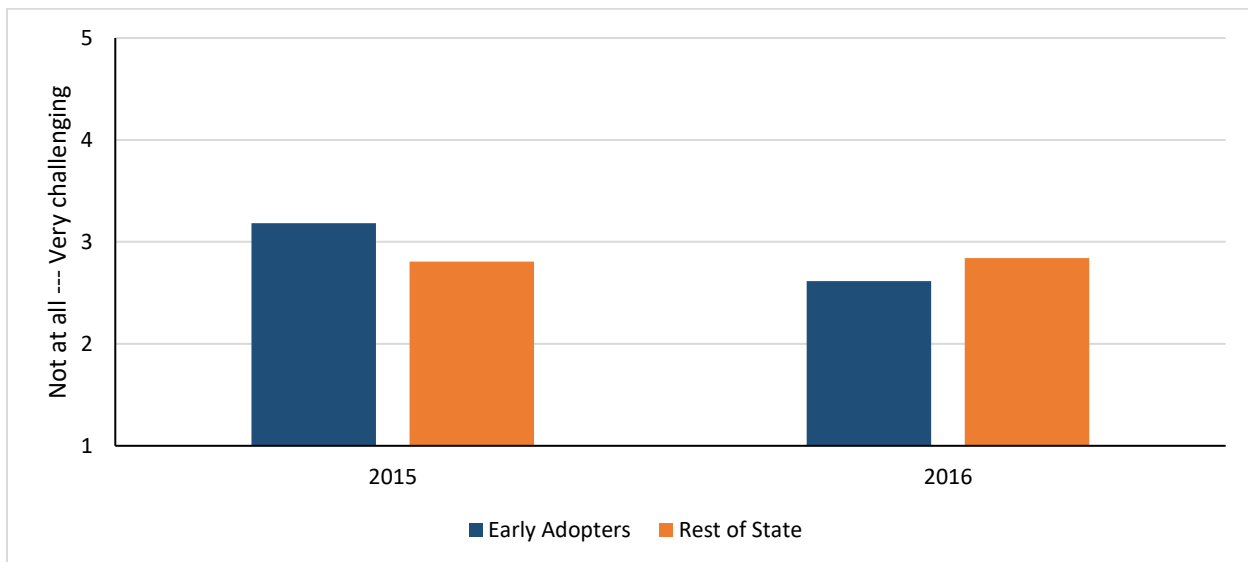
Qualitative interviews with the county administrators from Early Adopter counties illuminate these trends further. Care coordination implementation varies considerably. For example, some providers utilize their own staff for this service, and some will utilize county contracted case manager, for example. A common theme is that county administrators are seeking standardization or at least more clarity in the processes across their providers. From all accounts, however, case management is occurring, it has expanded, and the counties are working to build a service delivery culture that works together.

One county administrator reported: "*Coming from a place where there was always these silos, a great lesson is that those silos can be broken. It's possible. I think that's good.*"

Another county administrator indicated that they have been implementing care coordination and case management for some time before waiver implementation, but under small grant funds. The funding under the waiver expanded this service and the additional staffing were "*all created simply based on the waiver and the case management that we could do…that entire part of the system was built around the waiver.*"

Another administrator explained that "*because so much is varying by provider and folks are kind of at different stages so we're seeing more of a need to have more standardization and so we're working right now on putting together more of… manual that…[describes the] standard expectations.*"

Coordination of Services with Medi-Cal Managed Care *Plans*
Coordination of services with Medi-Cal Managed Care plans is a required component to participate in the DMC-ODS waiver demonstration, and developing MOUs with these

plans is expected. UCLA therefore asked county administrators survey questions about service coordination with Medi-Cal managed care plans.

Figure 4.7 shows the availability of Coordination of services with Medi-Cal managed care plans across the last two years. In both years, coordination of services with Medi-Cal managed care plans was more available in the Early Adopter counties than in the rest of the state. In 2015 Early Adopter counties reported 60% availability compared to the 32.1% in the rest of the state (p=.08). In 2016 Early Adopter counties reported 71.4% availability compared to 44% in the rest of the state (p=.10). Availability was defined as either fully or partially available.

Figure 4.7: Percentage of counties with coordination of services with Medi-Cal managed care plans available for adult clients.
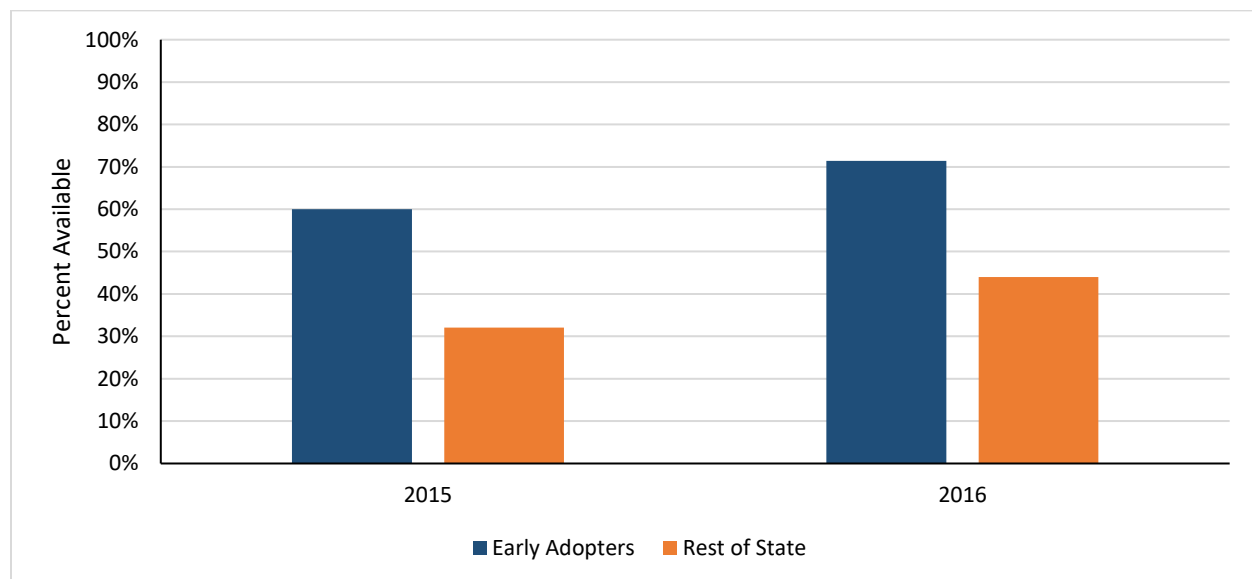
The data in Figure 4.8 show a trend toward coordination with Medi-Cal Managed care plans becoming less challenging for the Early Adopters, whereas it has remained somewhat challenging across the two years for the Rest of the State. In fact, the 2016 Early Adopter counties reported it to be significantly less challenging than the rest of the state (means of 2.7 compared to 3.8, respectively, p=<.05).

Facilitation and Tracking of Referrals between Systems

The degree of facilitation and tracking of referrals between systems is another measure by which cross-system integration and coordination can be gauged. This will be further explored though provider- and patient-level surveys in the future, as well as with claims data; however, UCLA began this investigation by examining available CalOMS-Tx data.

.

Figure 4.8: Mean rating of challenge level for implementing coordination of services with Medi-Cal managed care plans.
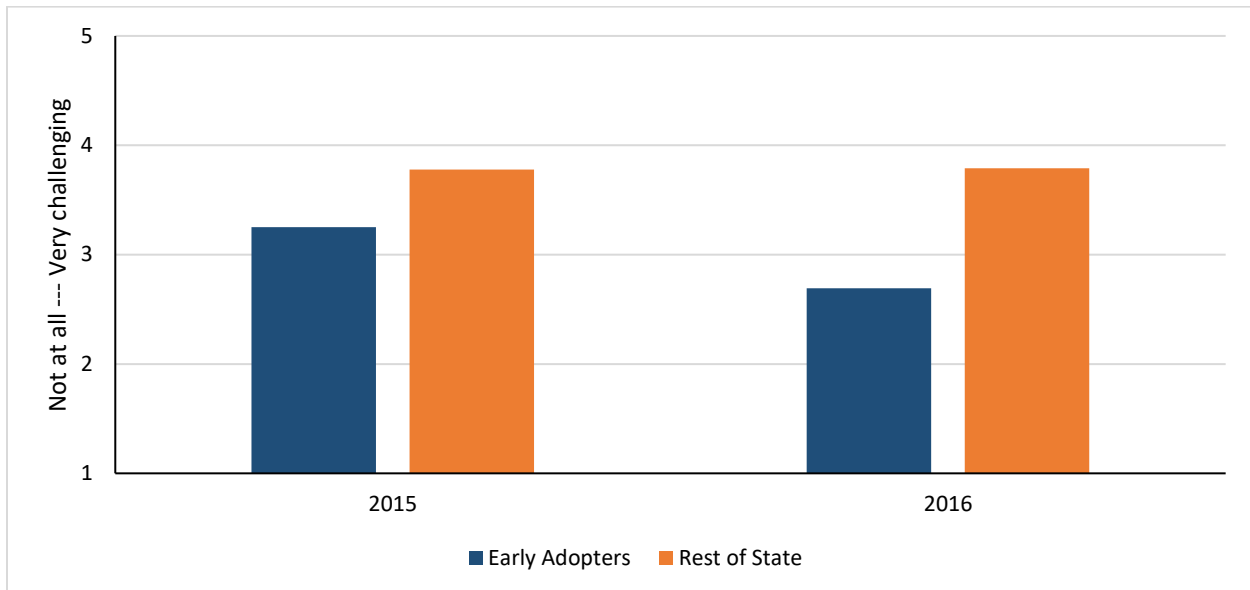
Referrals from primary care and mental health providers (combined) can be quantified using information from CalOMS-Tx on whether patients were referred from other health care providers. The Figures 4.9 and 4.10 show the percent of referrals from July 1, 2013 – January 31, 2017 comparing referral rates to program type between Early Adopter counties and the rest of the state.

The percentage of statewide admissions resulting from health care referrals in 2016 was 3.8% for the Early Adopter counties and 2.5% for the rest of the state. Although these rates are relatively low, they primarily reflect referral rates to outpatient treatment, since outpatient is by far the most common service modality. Within other modalities, particularly to withdrawal management, a larger percentage of referrals are from health care (e.g. 12.3% in January 2017 among Early Adopters) and the rates are steadily rising. Rates of referrals to this service have historically been higher in the Early Adopter counties, but rates in the rest of the state have increased recently as well.[10] If the DMC-ODS waiver is successful, patients who are initially referred to withdrawal management will increasingly be transferred to other levels of care upon discharge. UCLA will therefore continue to monitor these rates closely as waiver implementation proceeds.

---

[10] Similar patterns emerge when examining the absolute number of admissions, suggesting the increases are due to increasing health care referrals, not just to a change in the mix of referral sources.

Figure 4.9. Percent of referrals from health care providers from July 1, 2013 to January 31, 2017 (Early Adopter).
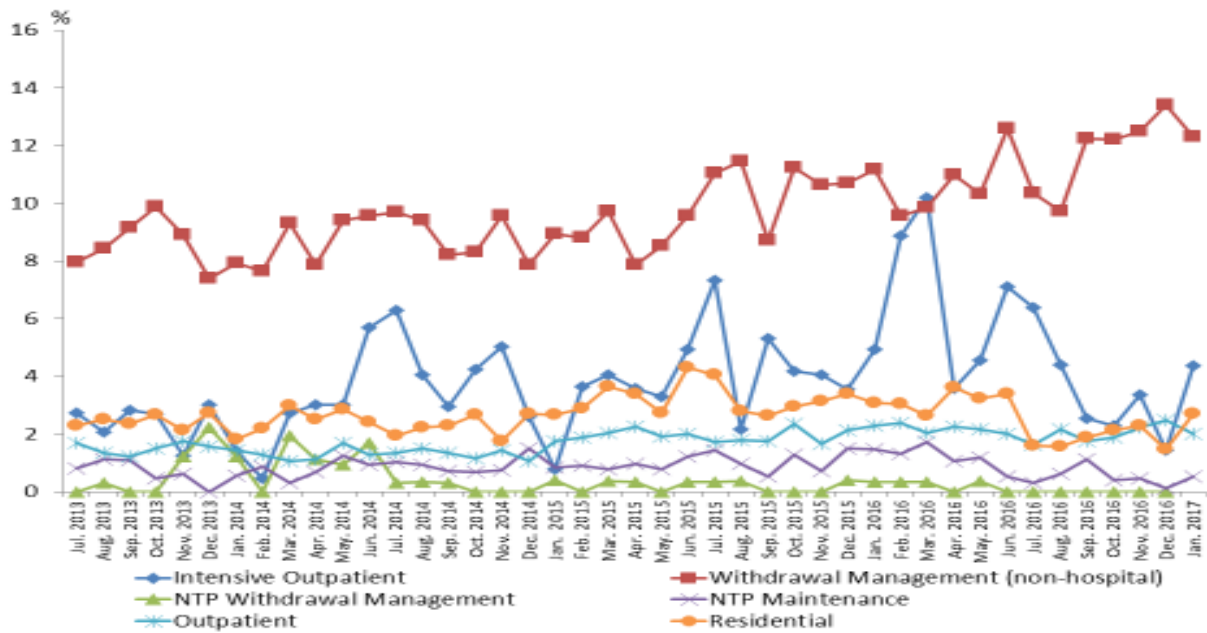
Figure 4.10. Percent of referrals from health care providers from July 1, 2013 to January 31, 2017 (Rest of State).
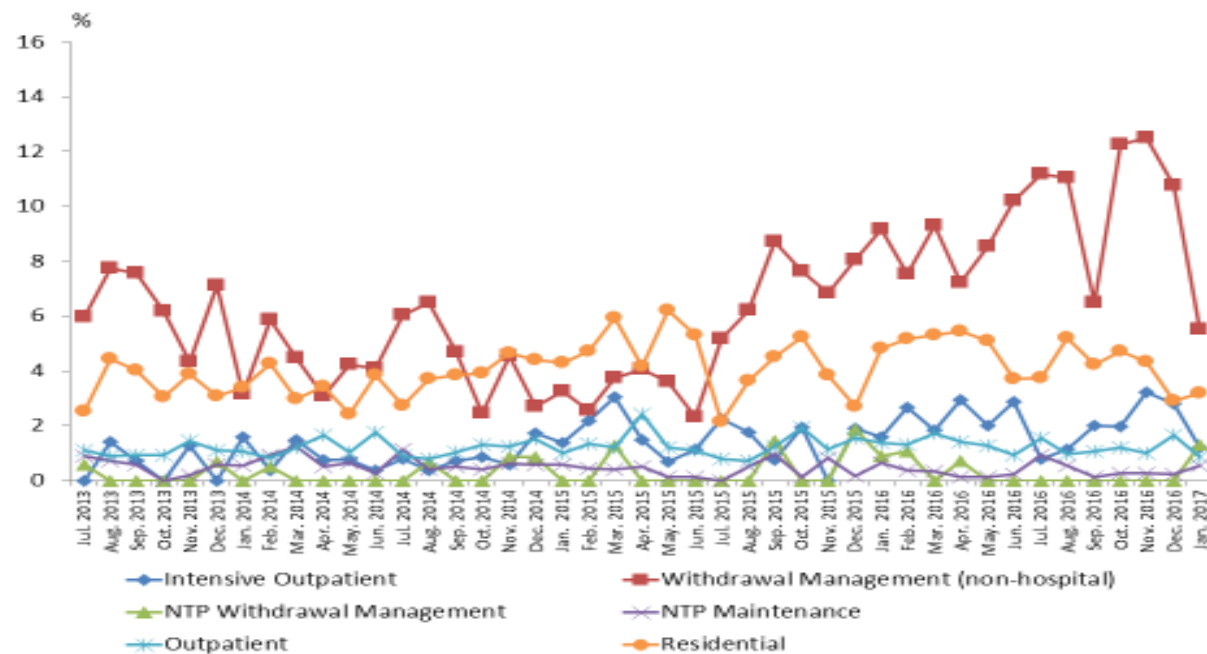
C. Discussion and Next Steps

Hypothesis 4 of the waiver evaluation states SUD treatment coordination with primary care, mental health, and recovery support services will improve as they prepare for and/or provide ODS services under the waiver. UCLA's effort to measure progress in this domain is still limited due to the phased roll out, as well as the time duration to meet preparation and contractual requirements. As the state demonstration of the waiver is still in the early stages, data collection (county, provider, and patient-level) was in the process of being collected. Key datasets including DMC claims data were not available in time for inclusion in this report, but this data will allow for more comprehensive analyses in future reports.

In this report, UCLA focused on targeted measures with accessible data in which there was potential for measureable change, comparing the identified Early Adopter counties to the Rest of the State. Using primarily county administrator surveys, interview data, and CalOMS-Tx data, the following is understood about the status of integration and care coordination upon the second year of DMC-ODS waiver implementation:

- *Cross-system care coordination and effective communication*: One of the most encouraging findings from our analysis in this measure was that 100% of the Early Adopter group reported that the waiver had positively influenced SUD/MH communication, and 85.7% between SUD and health services. Both were significantly higher compared to the rest of the state as well as to data from the previous year. These findings suggest that the impact of the DMC-ODS waiver on communication is strengthening as implementation begins. This is an important finding, since communication is a critical component to build change and cohesion across systems. Barriers to effective communication across systems generally consist of bandwidth issues, having lack of trickle down to line staff, having a broad array of needs, ranging from more meetings with additional entities, more time, more collaboration, and stronger stands from leadership.

- *Department/Division Integration*: Consistent with previous year's report, integration of services is greater between SUD and Mental Health services than between SUD and physical health services. However, a new trend emerged: integration ratings were *lower* among the Early Adopter counties compared to the rest of the state. Through qualitative methods, it was discovered that often the challenges of integrated or coordinated care do not all become apparent until implementation begins. This simply seems to reflect greater realism on the part of the Early Adopter counties as challenges became more apparent and county administrators gained a fuller understanding of their systems. Administrators reported that being part of the first group to implement comes with unforeseen barriers, and they continue to work hard to meet the needs at the system level to operationalize their plans.

- *Case Management:* The implementation of case management as a billable service under the ODS remains somewhat challenging across the state, but in the last year, the county level data suggested that Early Adopter counties have made some progress. Case management planning is more detailed for the Early Adopters compared to the Rest of the State. Overall, care coordination implementation

varies considerably. For example, some providers utilize their own staff for this service, and some will utilize county contracted case manager, for example. A common theme is that county administrators are seeking standardization or at least more clarity in the processes across their providers; But from all accounts case management is occurring, it has expanded, and the counties are working to build a service delivery culture that works together.

- *Coordination of Services with Medi-Cal Managed Care plans:* As a required component to participate in the DMC-ODS waiver demonstration, counties continue to negotiate and finalize MOUs with their county plans. Survey data show that coordination of services with Medi-Cal managed care plans was significantly more available in the Early Adopter counties than in the Rest of the State in 2015 and even more so in 2016. Additionally early adopter counties reported it to be significantly less challenging than the Rest of the State.

- *Facilitation and tracking of referrals between systems*: Consistent with reports of improving communication between SUD and PH and MH, health care referrals to SUD services were higher in Early Adopter counties than in the Rest of the State. Overall rates remain low, however, and referrals from health care are currently largely targeted at detoxification/withdrawal management. As counties implement ASAM-based treatment placement and withdrawal management becomes more available within other modalities (e.g. via MAT and incidental medical services), referrals from health care may begin to diversify in the future. Even if detoxification remains the primary gateway from health care into SUDs services, however, these patients should increasingly continue on to other parts of the continuum of care in DMC-ODS counties. UCLA's next report will provide the first look into whether this is happening in counties that have begun implementation of the waiver.

In many cases, counties were struggling with very complex issues (e.g. the best ways to approach case management, care coordination, transitioning patients from one level of care to another). These may be best addressed via collaborative learning effort such as the existing CIBHS DMC-ODS Forum, a new learning collaborative, or other collaborative learning efforts focusing on individual topics such as webinars.

Given that not all data are available or collected at this time, and counties have only begun implementing their waiver activities recently, we do not yet have a full picture of how all systems are integrating and coordinating care, but there are several early indications that waiver counties are improving and positioning themselves for potential further improvement in this area. Many elements of the waiver were purposefully designed to lift barriers and facilitate information exchange, care coordination, and multi-system case management. Upcoming activities (i.e.: county administrator interviews, provider- and patient-level surveys) will explore these areas further.

V. Conclusion

A. Summary and Recommendations

Although it is still too early to fully evaluate implementation under the DMC-ODS waiver, but a few themes did emerge:

- There were a number of early indications that the DMC-ODS waiver is having a positive effect, especially in coordination of care with mental and physical health.
    - All Early Adopter counties reported that the waiver had positively influenced SUD/MH communication, and nearly all reported that it had improved communication between SUD and health services.
    - All Early Adopter counties reported that the waiver had a positive influence on quality improvement activities. Consistent with this, Early Adopter counties were more likely to have developed QI plans than the rest of the state.
    - Coordination of services with Medi-Cal managed care plans was better in Early Adopter counties and became less challenging over time.
- California has had some success in addressing early challenges. For example, last year the process of facility certification was one of the top reported challenges, but after collaborative efforts between the counties and state over the past year, this challenge has mostly receded.
- As some challenges have been addressed, others have risen to the forefront:
    - Concerns over barriers to expansion of medical detoxification/withdrawal management and residential treatment were common. Billing issues and upfront costs were notable issues.
    - Patient transitions from detoxification/withdrawal management to other levels of care remain relatively rare. Administrators reported that a culture shift has begun among providers with regard to this, but substantial improvements have not yet appeared in the data.
    - Use of EBPs was rated as challenging. Among the EBPs identified in the STCs, training needs were highest for trauma informed treatment.
    - Drug Medi-Cal Billing became more challenging for counties that were not Early Adopters. Technical assistance may be helpful for these counties.
    - Counties reported that the physician consultation benefit was a good idea but has restrictions that limit its usefulness.

Recommendations
1. <u>Resolve Medical withdrawal management issues.</u> Counties rated these services as the most challenging to expand. In doing so, they cited an array of issues, some of which are difficult to resolve quickly (e.g. no county hospital available). One issue in particular, however, may be relatively straightforward to address: claims reportedly being rejected in a large proportion of cases for reasons that are unclear. UCLA recommends an analysis of the reasons for non-approved treatment authorization requests as a reasonable first step, potentially followed by a collaboration with counties and providers to address the reasons found. Resolving this should facilitate expansion efforts across the state, by enabling

these counties to assure local hospitals that they will be able to be paid if they offer this service, or at least enabling to clarify the conditions under which treatment authorization requests are and are not likely to be approved.

2. <u>Clarify ways to overcome financial hurdles when opening new facilities</u>. High up-front costs were cited as a barrier to expansion, including a requirement to be open and operating while awaiting DMC certification. While providers are paid upon certification for services retroactive to their DMC certification application date, new providers without existing county contracts are not typically awarded such a contract until they are certified. As a result, between state and county rules this means a new provider may find it cannot become certified until it is open, and has no funding to open until it is certified. Work-arounds using SAPT block grant funding as a temporary alternative source may be possible, but clarification on the process would be helpful for counties and providers. Third party organizations also exist that provide bridge loans to non-profit organizations that are awaiting payment.[11] The solution on this topic appears to be a collaboration between DHCS, counties, and providers to clarify rules and identify methods that have worked best

3. <u>Expand training and/or technical assistance on targeted topics</u>:
   a. Training on Evidence-based practices, particularly trauma-informed treatment
   b. Drug Medi-Cal billing, especially for counties that were not Early Adopters.

4. <u>Facilitate collaborative learning on implementation topics</u>. In many cases, counties were struggling with very complex issues (e.g. the best ways to approach case management, care coordination, transitioning patients from one level of care to another, or overcoming financial barriers to expansion). These may be best addressed via collaborative learning effort, for example:
   a. The existing CIBHS DMC-ODS Forum, funded by Blue Shield through December 2017. Another collaborative learning effort to take its place after funding ends would be very valuable.
   b. A new learning collaborative modeled after the Care Integration Collaborative and the Care Coordination Collaborative, collaboratives run previously by CIMH with funding from DHCS (UCLA assisted with SUD content). Counties and their providers were able to fulfill their county's mental health Performance Improvement Project (PIP) by participating. Similarly, participation could fulfill new PIP requirements for DMC-ODS.

5. <u>If possible, expand physician consultation</u>. Counties felt the benefit would be more useful if it were applicable to consultation to physicians that are serving DMC beneficiaries at FQHCs or other sites that are not DMC clinics.

B. Limitations

While the results from the second year of waiver implementation might be helpful to policymakers and those who are working to implement the waiver, there are important considerations to be kept in mind while interpreting these results.

---

[11] For example, the Nonprofit Finance Fund http://www.nonprofitfinancefund.org/ or other community development finance institutions (see Opportunity Finance Network https://ofn.org/financing)

The waiver is being implemented in phases and only three counties had fully approved state-county contracts at the end of June. This is, therefore, primarily a baseline report on early issues and progress, rather than a report on actual implementation outcomes. As implementation proceeds, the results presented here will be updated and expanded.

Data sources for this report were essentially limited to CalOMS-Tx, stakeholder surveys, and stakeholder interviews. UCLA anticipates future reports will include analyses of additional datasets including county level of care data, Medi-Cal and Drug Medi-Cal claims, patient surveys. These datasets will provide a great deal of additional quantification and insight into outcomes from the DMC-ODS waiver.

Appendices

A. Acronyms

AHRQ	Agency for Healthcare Research and Quality
AOD	Alcohol and other drug
ASAM	American Society of Addiction Medicine
BH	Behavioral health
CalMHSA	California Mental Health Services Authority
CalOMS-Tx	California Outcomes Measurement System - Treatment
CCI	(California) Coordinated Care Initiative
CIBHS	California Institute for Behavioral Health Solutions
CIHS	SAMHSA-HRSA Center for Integrated Health Solutions
CMS	Centers for Medicare and Medicaid Services
DATAR	Drug and Alcohol Treatment Access Report
DCH	Day care habilitative (treatment); see IOP
DHCS	(California) Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBP	Evidence-based practice
EHR	Electronic health record
EQRO	External Quality Review Organization
HCPCS	Healthcare Common Procedure Coding System
HRSA	Health Resources and Services Administration
IOP	Intensive outpatient treatment; see DCH
ISAP	(UCLA) Integrated Substance Abuse Programs
MCP	Managed care plan (non-SUD, non-MH)
MEDS	Medi-Cal Eligibility Data System
MH	Mental health
MHSIP	Mental Health Statistics Improvement Program
MOU	Memorandum of understanding

NIMBY	"Not In My Back Yard"
NQF	National Quality Forum
NSDUH	National Survey on Drug Use and Health
NTP	Narcotic Treatment Program
OSHPD	Office of Statewide Health Planning and Development
PIP	Performance improvement project
QA	Quality assurance
QI	Quality improvement
QIC	Quality Improvement Committee
QIP	Quality Improvement Plan
QSOA	Qualified Service Organization (QSO) Agreement
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening, brief intervention, and referral to treatment
STCs	Special Terms and Conditions
SU	Substance use
SUD	Substance use disorder

B. Map of Implementation Phases

County participation in the waiver is voluntary. Counties that opt in to participate in the DMC-ODS are required to submit an implementation plan that describes how they will meet the waiver requirements. The timing of these county submissions is staggered based on regional phases.

The phases include:

- Phase 1: Bay Area counties
- Phase 2: Southern California counties
- Phase 3: Central California counties
- Phase 4: Northern California counties
- Phase 5: Tribal Partners

The following page includes a map of all California counties by implementation phase.

This map is adapted from the California Behavioral Health Directors Association county regional map:
http://www.cbhda.org/wp-content/uploads/2014/12/County-Region-Map.pdf

C. Treatment Perceptions Survey Form and Sample Report

Treatment Perceptions Survey (Adult)

Print PDF as needed.
Do not photocopy!

County / Provider Use Only

CalOMS Provider ID

Program Reporting Unit (optional):

Treatment Setting: ○ OP/IOP   ○ Residential   ○ OTP/NTP   ○ Detox/WM (standalone)   ○ Partial hospitalization

Please answer these questions about your experience at this program. If the question is about something you have not experienced, fill in the circle for "Not Applicable". **DO NOT WRITE YOUR NAME ON THIS FORM.**

Your answers must be able to be read by a computer. Therefore, please use a pen, fill in the circle completely, and choose only one answer for each question.

Correct ●   Incorrect ◉ ⊗ ●

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. The location was convenient (public transportation, distance, parking, etc.).	○	○	○	○	○	○
2. Services were available when I needed them.	○	○	○	○	○	○
3. I chose the treatment goals with my provider's help.	○	○	○	○	○	○
4. Staff gave me enough time in my treatment sessions.	○	○	○	○	○	○
5. Staff treated me with respect.	○	○	○	○	○	○
6. Staff spoke to me in a way I understood.	○	○	○	○	○	○
7. Staff were sensitive to my cultural background (race, religion, language, etc.).	○	○	○	○	○	○
8. Staff here work with my physical health care providers to support my wellness.	○	○	○	○	○	○
9. Staff here work with my mental health care providers to support my wellness.	○	○	○	○	○	○
10. As a direct result of the services I am receiving, I am better able to do things that I want to do.	○	○	○	○	○	○
11. I felt welcomed here.	○	○	○	○	○	○
12. I like the services offered here.	○	○	○	○	○	○
13. I was able to get all the help/services that I needed.	○	○	○	○	○	○
14. I would recommend this agency to a friend or family member.	○	○	○	○	○	○

Comments
Please do not write any information that may identify you, including but not limited to your name and/or phone number.

Please answer the following questions

1. How long you have received services here: ○ First visit/day   ○ 2 weeks or less   ○ More than 2 weeks

2. Gender Identity (Please mark all that apply):
   ○ Female   ○ Male   ○ Transgender   ○ Additional identity ➤
   ○ Decline to answer

3. Ethnicity (Please mark all that apply):
   ○ American Indian/Alaskan Native   ○ Mexican/Latino   ○ Other
   ○ Asian   ○ Native Hawaiian/Pacific Islander   ○ Unknown
   ○ Black/African American   ○ White/Caucasian

4. Age Range: ○ 18-25   ○ 26-35   ○ 36-45   ○ 46-55   ○ 56+

64214

Thank you for taking the time to answer these questions!

Revised 06/26/17   10-328 Treatment Perception Survey - English

Treatment Perceptions Survey Report

Marin County

All Substance Use Treatment Programs Surveyed

Number of programs that returned survey forms:

8

Number of clients who returned survey forms: 91

Overall Average Satisfaction Score for All Programs: 4.0

All 14 questions were used to calculate the average score. Scores ranged from 1.0 to 5.0, with higher scores indicating greater satisfaction.

Percentage of clients who were Overall Satisfied: 75.8%

Overall Satisfied was calculated using all 14 questions. Surveys with an average score of 3.5 or higher were counted as SATISFIED.

Demographics	Overall Average Satisfaction Score (1.0-5.0)
Gender	.
Female	4.1
Male	3.9
Age	.
18-25	4.0
26-35	3.8
36-45	3.9
46-55	4.5
56+	4.2
Race	.
American Indian/Alaskan Native	4.2
Asian	4.0

Demographics	Overall Average Satisfaction Score (1.0-5.0)
Black/African American	3.9
Mexican/Latino	4.0
Native Hawaiian/Pacific Islander	3.2
Other	3.7
White/Caucasian	4.0
How long received services here	.
Firstvisit/day	4.0
2 weeks or less	3.9
More than 2 weeks	4.0

Survey

Questions

1. The location was convenient (public transportation, distance, parking,

etc.).

2. Services were available when I needed

them.

3. I chose the treatment goals with my provider's

help.

4. Staff gave me enough time in my treatment

sessions.

5. Staff treated me with

respect.

6. Staff spoke to me in a way I

understood.

7. Staff were sensitive to my cultural background (race, religion, language,

etc.).

8. Staff here work with my physical health care providers to support my

wellness.*

9. Staff here work with my mental health care providers to support my

wellness.*

10. As a direct result of the services I am receiving, I am better able to do things that I want to

do.

11. I felt welcomed

here.

12. I like the services offered

here.

13. I was able to get all the help/services that I

needed.

14. I would recommend this agency to a friend or family

member.

*The wording of the questions for items 8 and 9 were slightly different on 65 of the survey forms (Staff

here collaborate well with my physical health care providers to support my wellness. Staff here

collaborate well with my mental health care providers to support my wellness). Significant differences in

the data between the two wordings were not observed.

item_question	Strongly_Agree(5)	Agree(4)	Neutral(3)	Disagree(2)	Strongly_Disagree(1)	Not_Applicable
01 Convenient Location	42 (46.2%)	33 (36.3%)	13 (14.3%)	1 (1.1%)	1 (1.1%)	1 (1.1%)
02 Convenient Time	25 (27.5%)	38 (41.8%)	15 (16.5%)	8 (8.8%)	4 (4.4%)	1 (1.1%)
03 Chose Goals	24 (26.7%)	40 (44.4%)	17 (18.9%)	6 (6.7%)	2 (2.2%)	1 (1.1%)
04 Enough Time	32 (35.2%)	40 (44.0%)	13 (14.3%)	5 (5.5%)	. (. %)	1 (1.1%)
05 Treated with Respect	44 (48.4%)	28 (30.8%)	14 (15.4%)	4 (4.4%)	1 (1.1%)	. (. %)
06 Understood Communication	39 (42.9%)	37 (40.7%)	9 (9.9%)	3 (3.3%)	2 (2.2%)	1 (1.1%)
07 Cultural Sensitivity	36 (40.0%)	31 (34.4%)	14 (15.6%)	4 (4.4%)	1 (1.1%)	4 (4.4%)

item_question	Strongly_Agree(5)	Agree(4)	Neutral(3)	Disagree(2)	Strongly_Disagree(1)	Not_Applicable
08 Work with PH Providers	26 (28.6%)	33 (36.3%)	21 (23.1%)	5 (5.5%)	5 (5.5%)	1 (1.1%)
09 Work with MH Providers	25 (27.5%)	19 (20.9%)	20 (22.0%)	11 (12.1%)	4 (4.4%)	12 (13.2%)
10 Better Able to Do Things	36 (40.0%)	24 (26.7%)	15 (16.7%)	6 (6.7%)	6 (6.7%)	3 (3.3%)
11 Felt Welcomed	41 (45.1%)	36 (39.6%)	9 (9.9%)	4 (4.4%)	1 (1.1%)	. (. %)
12 Like Services	33 (37.1%)	24 (27.0%)	22 (24.7%)	5 (5.6%)	4 (4.5%)	1 (1.1%)
13 Enough Help	27 (29.7%)	29 (31.9%)	21 (23.1%)	10 (11.0%)	4 (4.4%)	. (. %)
14 Recommend Agency	32 (35.2%)	27 (29.7%)	23 (25.3%)	3 (3.3%)	6 (6.6%)	. (. %)

Responses of Each Survey Question

Survey Question Averages
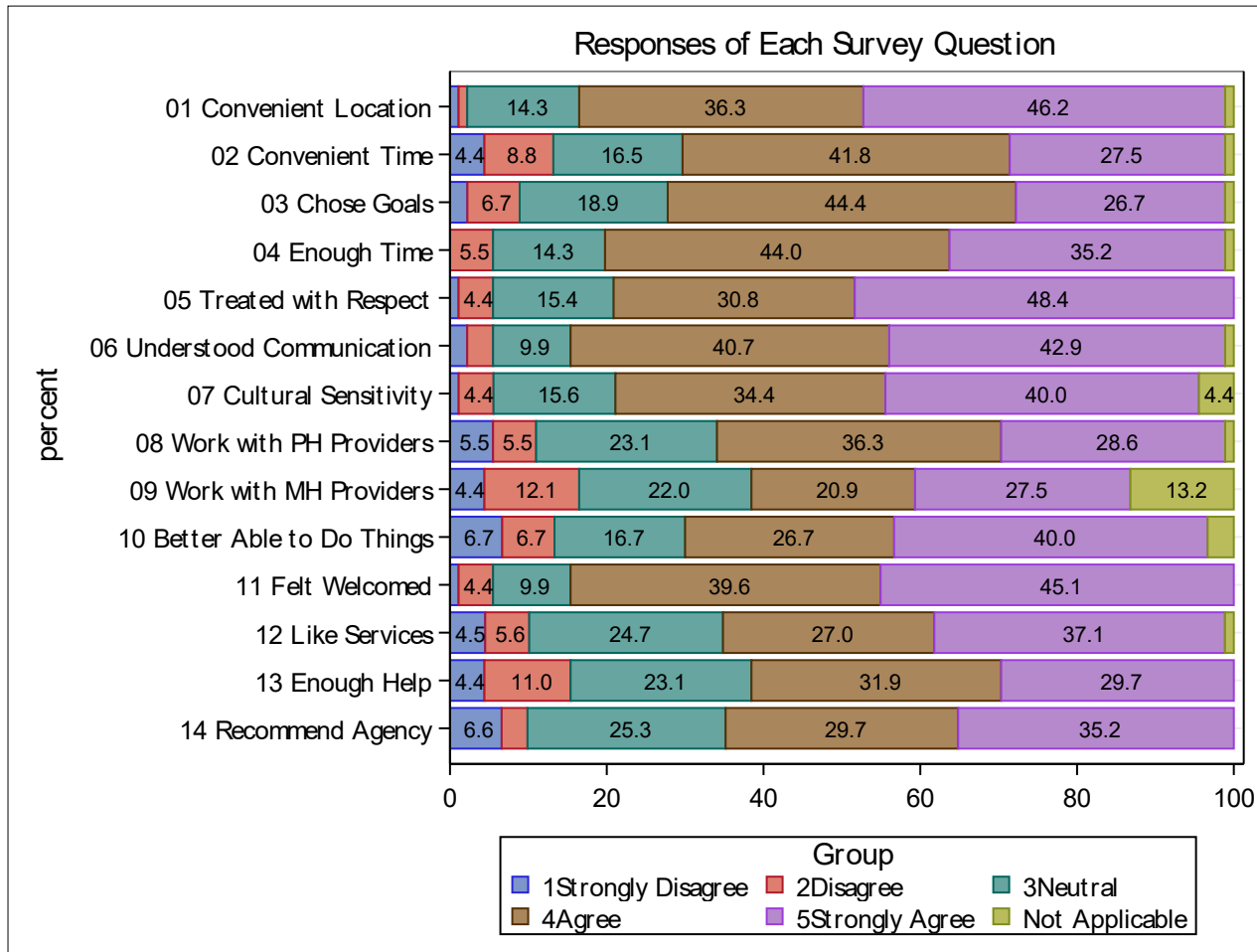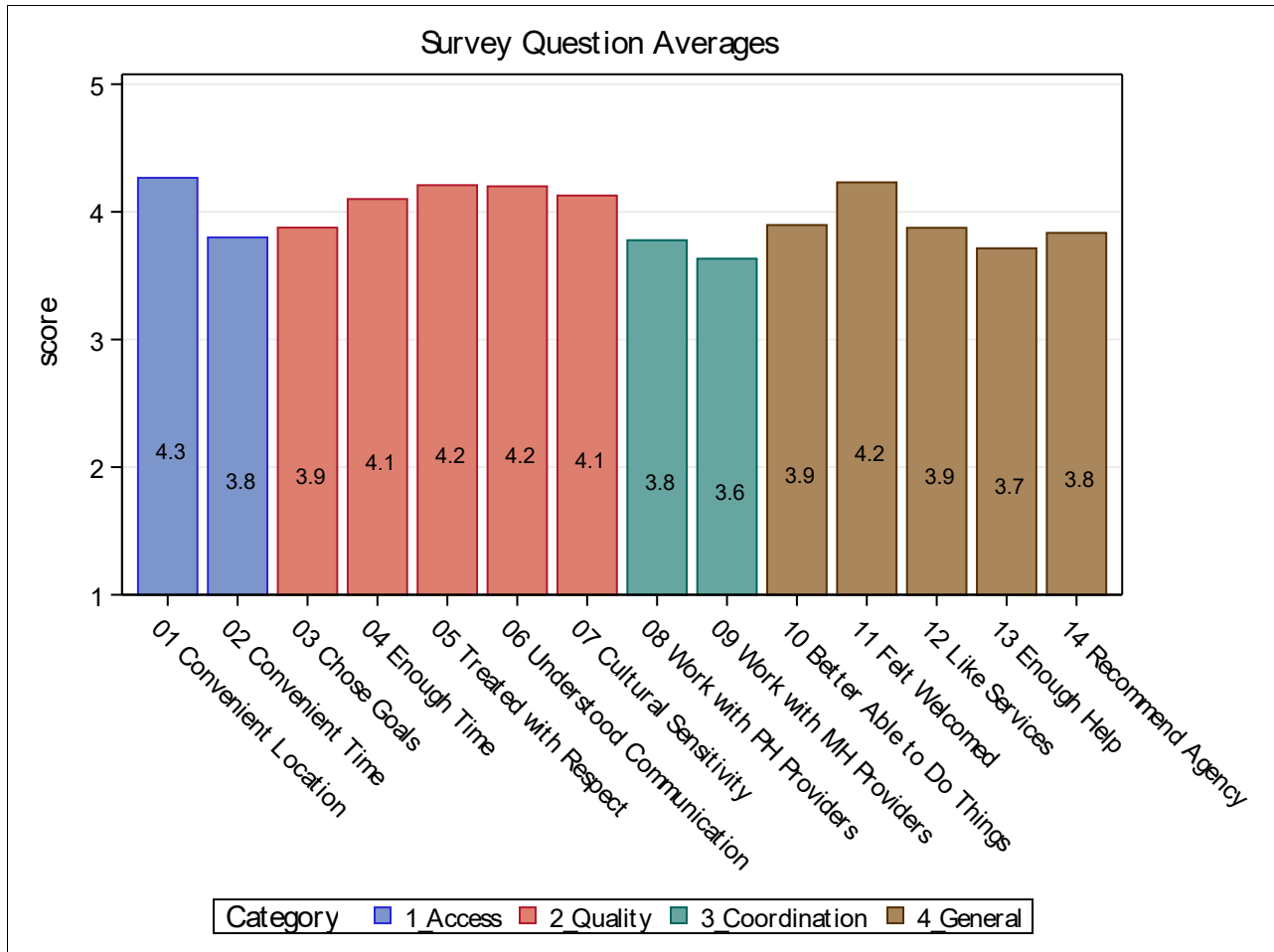
D. Pre-implementation Interview Report

The Drug Medi-Cal Organized Delivery System (DMC-ODS) Demonstration –
Perspectives of Behavioral Health Administrators in Four Phase 1 Counties
Brief Report – Recommendations for Other Counties

As part of the DMC-ODS evaluation, UCLA conducted pre-implementation interviews with the lead administrators from four counties at the forefront of the State's waiver implementation. This brief report focuses on recommendations for other counties that are participating in the DMC-ODS waiver.

Participating Counties
Administrators who completed the brief interviews during August 2016 were from San Francisco, San Mateo, Santa Clara, and Santa Cruz counties. All of the key informants were instrumental in the preparation of their respective county's implementation plan (IP).

Recommendations
The following recommendations for counties that are planning or preparing to opt in to the DMC-ODS demonstration were drawn from the interviews, and are wide ranging. Quotations from key informants are included as exemplars.

- Recognize that counties are becoming managed care systems.

    Counties need to understand…that they're looking for a fully articulated managed care system, and it means that the county becomes the insurer for beneficiaries, as it were, and needs to take more of that view of, "How do I deliver the best beneficiary services?" It means a somewhat different relationship with providers. In my mind, it puts the beneficiary between our county operations and the provider, and we have to be sure we're getting information in terms of what's working, and what we need to improve on to ensure the best level of care for the patients.

- Consider how much detail to include in counties' IPs.

    Be specific enough that you're answering the questions…sometimes if you go into more detail than that, you actually wind up generating more questions upon review... Be thoughtful about how specific you wanna be.

- Take an active role early on in helping providers become DMC certified.

    - *One of the first things we did about a year-and-a-half ago, was hire a program coordinator. She's become an expert of DMC certification, and I would say about two-thirds of the programs are now Drug Medi-Cal certified.*

▪ *When we submitted our plan…at the same time we coordinated having all our residential providers get DMC certified, so they're ready to go.*

- Read carefully and understand the county-specific contract.

   One thing I would say to other counties is, "Really read the contract"…Really read that contract and say, "Hmm, what am I gonna have to do to implement this contract?" There's a lot of new stuff in there for alcohol and drug programs that they haven't had to deal with in the past…That contract is kinda your bible if you're a county person.

- Prioritize tasks.

   Anything that you can say, "What do we…do now and what can we push off till later", is helpful.

- Use or modify counties' existing proven models (e.g., mental health MOUs with managed care plans, mental health plans) for the DMC-ODS – don't reinvent the wheel.

   We were figuring that it [health plan for the DMC-ODS] was gonna look a lot like mental health. It turns out that's true, and actually, that's made it much easier…For the most part, we can take mental health policies and procedures and client notices and stuff like that and modify them rather than having to start from scratch to create these…It's still a lot of work, but it's a lot easier than having to reinvent the wheel.

- Be realistic when developing unit rates.

   I want counties to be very realistic in terms of what their unit rates need to be, and not undershoot that. I would step back, and [ask], "What is the delivery system that you want? What is the average dose of service you want in each of the levels of care?" Then monetize that based on what it's gonna take to have that level of expertise and staff and the infrastructure to provide it.

- Gain a better understanding of how to work with primary care and what that means for SUD service delivery systems.

   In 2020 when the next waiver comes through, my feeling is that we'll either be fully carved back in, or they'll be a partial carving back into an integrated health care. Our providers need to understand what it means to work within that primary care side of the house, how we demonstrate success and value, and what it's gonna mean for quality improvement over the next three to four years.

<u>Limitations</u>

The interviews were conducted with selected administrators prior to implementation of their counties' IPs. Key informants' views may have changed since the interviews were conducted, and may not be representative of administrators who were not interviewed.

E. Figures and Tables

Figures

Tables

F. Further Resources

- UCLA's approved evaluation plan is available online at:
  www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

- UCLA's waiver website contains additional resources and will be updated periodically as new materials are developed:
  http://www.uclaisap.org/ca-policy/index.html

- UCLA's 2015 county administrator survey report and 2015 managed care plan medical director survey report, as well as additional evaluation materials, will be available at:
  http://www.uclaisap.org/ca-policy/html/evaluation.html

- The waiver STCs, approved county implementation plans, FAQs, and other helpful resources and documentation can be found on DHCS's waiver site:
  http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx