California's Drug Medi-Cal Organized Delivery System
2018 Evaluation Report

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

2018

UCLA Integrated Substance Abuse Programs

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

Submitted on July 30, 2018, in fulfillment of Deliverables #4, #7, and #8 for Year 3 of the California Organized Delivery System Evaluation and Technical Assistance contract (DHCS Contract # 15-92178). Revised October 19, 2018.

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. Therefore, for consistency, we use the term "patients" throughout this report, except where "client" is used in a direct quote.

Live-Waiver, Pre-Implementation, and Non-Waiver Counties

In this report, unless otherwise specified "Live-Waiver counties" refers to the group of seven counties that were approved by the California Department of Health Care Services (DHCS) and the federal Centers for Medicare and Medicaid Services (CMS) to provide Drug Medi-Cal Organized Delivery System (DMC-ODS) services and began providing them as of July 1, 2017. Some counties started all services on that date, while other counties implemented services gradually. The Live-Waiver counties are Contra Costa, Los Angeles, Marin, Riverside, San Francisco, San Mateo, and Santa Clara. "Pre-Implementation Counties" refers to the group of 33 counties that submitted DMC-ODS implementation plans but did not "go live" as of July 1, 2017. "Non-Waiver counties" refers to the group of 18 counties that did not submit a DMC-ODS implementation plan before the deadline to do so.

Acronyms

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

Executive Summary

In 2015, the Centers for Medicare and Medicaid Services (CMS) approved a request from the California Department of Health Care Services (DHCS) to initiate an innovative demonstration pilot program called the Drug Medi-Cal Organized Delivery System (DMC-ODS). The pilot was designed to reorganize specialty substance use disorder (SUD) treatment in the state based on the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment. This includes treatment placement and planning based on a multidimensional assessment of the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structure. The DMC-ODS pilot also adds or expands DMC coverage of residential treatment services, case management, and recovery support services, it enables selective provider contracting, it supports coordination with managed care health plans, it facilitates quality improvement, utilization management, evidence based practices, and it promotes use of a licensed workforce.

DMC-ODS implementation is occurring on a county-by county basis, and the first counties began delivering services in 2017. In this report, UCLA examined implementation in counties that had begun delivering DMC-ODS services in the first half of 2017 ("Live-Waiver counties") and compared them to counties that were still preparing for DMC-ODS participation ("Pre-Implementation counties"), and to "Non-Waiver counties" that had no plans to participate in the DMC-ODS pilot. The following is a summary of findings from this year's report.

Access

> *"The state did, I think, a really good job in expanding what's accessible through the waiver."*
>
> *County Administrator*

- Increased access. Across funding sources, in Live-Waiver counties the number of people accessing treatment increased by about 7%. In particular, access to residential treatment increased.
- Beneficiary access lines (BALs). The DMC-ODS is facilitating establishment of BALs to enable easier access to treatment information and referrals. Secret shopper calls confirmed that all Live-Waiver counties had functioning lines, and feedback is being provided to these counties on BAL functioning and potential improvements. Among Pre-Implementation counties, 80% reported the waiver had facilitated their BAL efforts. Surprisingly, 44% of non-waiver counties also reported that the waiver facilitated their BAL efforts, suggesting the DMC-ODS is having an effect beyond the counties formally participating in it.
- Penetration rates. The initial treatment penetration rate for people who need treatment in Live-Waiver counties is estimated to be 4.3%. This penetration rate is expected to increase as treatment access continues to expand. However, survey results from the Substance Abuse and Mental Health Services Administration suggest the most common reason people with SUD do not seek specialty treatment is that they do not feel they need it. This suggests a need to reach out to and engage people in conversations about their substance use through other

systems like primary care, since they are otherwise unlikely to seek out the specialty treatment system on their own.

- <u>Capacity expansion challenges.</u> Counties report that capacity expansion is challenging, especially for medical detoxification/withdrawal management. Where these services are delivered in medical settings, this generally falls outside of the county behavioral health/SUD administrator's oversight, and resolving billing issues for these services has been very challenging as a result. Counties also report that the process of adding withdrawal management beds to existing facilities within the DMC-ODS system is administratively challenging.
- <u>Technical assistance opportunities</u>. There is a need for technical assistance among counties and providers regarding recovery support services, and youth services.
- *Recommendations*
  - o *Continue working with counties to resolve voluntary inpatient detoxification billing issues provided through fee-for-service Medi-Cal.*
  - o *Explore with CMS the possibility of streamlining the process of adding withdrawal management services to existing providers.*
  - o *Examine options to help counties and providers with startup costs to increase capacity.*
  - o *Consider additional technical assistance on recovery support services and youth services.*

Quality

- <u>Levels of care.</u> Preliminary analysis of level of care data suggest that about 90% of referrals were made to the level of care indicated on American Society of Addiction Medicine (ASAM) screenings or assessments, which indicates that the tools are being used as intended. This also suggests that the expanding use of residential treatment in Live-Waiver counties represents better matching of patients to their appropriate level of care.

> *"There's still a lot of work on our system to actually be using the ASAM really in the spirit that it was meant. . . . it takes a while to learn how to do something new and different, and to do that well."*
>
> *County Administrator*

- <u>Successful treatment engagement.</u> DMC claims data suggest that treatment engagement in Live-Waiver counties ranged from 54% in outpatient and 96% in residential, which is consistent with or above engagement rates found in studies from other states.
- <u>Patient transitions along the continuum of SUD care.</u> DMC Claims indicate that patients in Live-Waiver counties did not typically move along the continuum of care to receive subsequent treatment (e.g., outpatient) or case management within 14 days of discharge from withdrawal management or residential services. Improving transitions following these levels of care should be a priority to provide better care consistent with the ASAM Criteria and to guard against "revolving door" use of these services.

- Developing practices. Survey results suggest counties are encountering a challenging learning curve as they begin to implement utilization management, DMC billing, and evidence-based practices.
- Quality-related requirements. Every Live-Waiver county reported having implemented a quality improvement committee, a written SUD quality improvement plan, ASAM Criteria-based assessment and placement, evidence-based practices, use of licensed practitioners of the healing arts, and physician consultation services. Live-Waiver counties unanimously

> *"Without the waiver we would not be working on developing SU quality improvement activities."*
>
> *County Administrator*

reported that the DMC-ODS waiver had a positive impact on their quality improvement activities, as did 92% of Pre-Implementation counties.

> *"Since coming here I got my family back, a job, a place to live. Staff here is very kind and supportive."*
>
> *Patient*

- Patient perceptions of treatment. Patients participating in the Treatment Perceptions Survey anonymously rated their treatment in Live-Waiver counties on five domains: access, quality, care coordination, outcomes, and general satisfaction. Patients overwhelmingly expressed positive ratings of their treatment (93% positive).

- *Recommendations*
  - *Provide training and technical assistance (e.g., collaborative learning opportunities, frequently asked questions and the answers, information notices) in the following areas: ASAM Criteria assessment and placement; DMC billing; utilization management; patient flow along the continuum of SUD treatment, especially provision of additional services after discharge from residential treatment and withdrawal management; and evidence-based practices, particularly trauma-informed treatment and motivational interviewing.*
  - *Develop and/or make available youth-specific ASAM Criteria assessments to counties that wish to use them.*

Integration/Coordination

- Comprehensive substance use, physical health, and mental health screening. Survey responses confirmed that ASAM assessment and placement was fully or partially available in 2017 in all (100%) of the Live-Waiver counties, in the majority (63%) of Pre-Implementation Waiver counties, and in half (50%) of the Non-Waiver counties, suggesting the DMC-ODS has had a positive effect on the implementation of comprehensive substance use, physical health, and mental health screening.

- <u>Cross-system care coordination and effective communication among providers.</u> Cross-system coordination and communication have been enhanced by the DMC-ODS. In particular, DMC-ODS has improved linkages with physical health care systems through coordination with managed care plans. County administrators report that although channels of communication have expanded, there is still a need for even greater communication and collaboration.

> *"The waiver has allowed for a more open line of communication and has increased the already integrated approach to client services."*
>
> *County Administrator*

- <u>Navigation support for patients and caregivers through case management.</u> Significant challenges continue to impede case management service delivery, including provider confusion over exactly which services are appropriately billable as case management. Counties also reported that it was financially challenging to hire and develop case management staff to deliver robust case management services even with the new case management benefit.

- <u>Facilitation and tracking of referrals between systems.</u> The DMC-ODS has not yet had a significant impact on the facilitation and tracking of referrals between SUD systems, mental health, and health care according to available data. Challenges include SUD providers' beliefs about and/or unfamiliarity with referral and care coordination services, and barriers in other systems (e.g., difficulty getting a timely appointment). Data also do not yet indicate that the DMC-ODS has facilitated an increase in referrals from healthcare or mental health sources to SUD care. The extent to which this is due to actual weakness in referrals or alternatively to undercounting issues in the available data source (California Outcomes Measurement System, Treatment, CalOMS-Tx) is unclear.

- *Recommendations*
  - *Consider additional technical assistance on the case management benefit with a focus on: 1) defining case management and care coordination; 2) billing for allowable services; and 3) sharing successful practices and lessons learned among counties.*
  - *Facilitate collaborative learning on a variety of implementation topics related to care coordination. In many cases, counties were struggling with very complex issues (e.g., best ways to approach case management, care coordination across systems, transitioning patients between levels of care). These may be best addressed via collaborative learning efforts that enable counties to learn from the experiences of their peers.*

Conclusions

Analyses suggest that the DMC-ODS is making progress and having a positive impact in a number of areas. Patients are accessing treatment in increasing numbers and are reporting high satisfaction with their care. Counties are engaging in processes intended to improve quality and coordination of care, and they are reporting that the waiver has had a positive impact on these efforts. At the same time, stakeholders are also navigating

a number of challenges, particularly in capacity expansion, patient movement between systems and levels of care, and fully understanding new benefits and processes.

Limitations
Analyses in this report focus on the seven counties that had begun delivering services under the DMC-ODS waiver through by July 1, 2017. Due to lag times in data reporting, timeframes vary by dataset and not all counties are included in each analysis. There were also statistical limits to which analyses could be performed with the relatively small number of Live-Waiver counties. These limitations will be mitigated after more counties begin services.

I. Introduction

A.   Overview of Waiver Implementation in FY 2017-2018

In the third year of the Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration project under California's Section 1115 waiver, the Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), and California counties have continued to work together to implement changes specified in the DMC-ODS special terms and conditions (STCs) with the aim of improving substance use disorder (SUD) care for DMC beneficiaries. Fiscal Year (FY) 2017-2018 was a landmark year in which the first counties began billing services under the new DMC-ODS benefits for the first time.

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 earlier years of implementation, please refer to the previous reports submitted by UCLA for FYs 2015-2016 and 2016-2017.[1]

Since the DMC-ODS was launched in 2015, a large number of counties have submitted implementation plans (IPs) and received approvals from DHCS and CMS. The final deadline for IP submission for counties was September 1, 2017. California's tribal partners will have a later deadline. A total of 40 counties submitted DMC-ODS implementation plans to DHCS. Table 1.1 below shows past and projected "go live" dates, meaning the dates on which counties were approved by DHCS and CMS to begin providing services under the DMC-ODS.

---

[1] These reports can be found at http://uclaisap.org/html/past-updates-reports.html

Table 1.1: County implementation status as of June 30, 2018

Counties with Submitted Applications	"Go Live" Date*
Alameda	7/1/2018
Contra Costa	6/30/2017
El Dorado	pending
Fresno	pending
Humboldt (PHP**)	pending
Imperial	7/1/2018
Kern	pending
Kings	pending
Lassen (PHP)	pending
Los Angeles	7/1/2017
Marin	4/1/2017
Mendocino (PHP)	pending
Merced	pending
Modoc (PHP)	pending
Monterey	7/1/2018
Napa	12/15/2017
Nevada	7/1/2018
Orange	7/1/2018
Placer	pending
Riverside	2/1/2017
Sacramento	pending
San Benito	pending
San Bernardino	3/1/2018
San Diego	7/1/2018
San Francisco	7/1/2017
San Joaquin	7/1/2018
San Luis Obispo	1/1/2018
San Mateo	2/1/2017
Santa Barbara	pending
Santa Clara	6/15/2017
Santa Cruz	1/1/2018
Shasta (PHP)	pending
Siskiyou (PHP)	pending
Solano (PHP)	pending
Sonoma	pending
Stanislaus	pending
Trinity (PHP)	pending
Tulare	pending
Ventura	pending
Yolo	7/1/2018

* "Go Live" date, in this report, is referring to the date in which a county was approved by the Department of Health Care Services and Centers for Medicare and Medicaid Services to provide Drug Medi-Cal Organized Delivery System (DMC-ODS) services.
Source: http://www.dhcs.ca.gov/provgovpart/Pages/County-Implementation-Plans-.aspx ** PHP refers to Partnership Health Plan.

## B.   Population Reach of the DMC-ODS

The vast majority of California's population resides in counties that will participate in the DMC-ODS. According to data from the 2010 Census, the seven Live-Waiver counties are among the state's most populous, with approximately 16.6 million people, representing 44.6% of the state's population. The 33 Pre-Implementation Waiver Counties have a population of approximately 19.5 million, which comprises 52.4% of the state's population. If all of these counties succeed in going live, 97.0% of Californians (96.9% of Medi-Cal eligibles) will live in counties that are participating in the DMC-ODS.[2]

C.   Status of UCLA Evaluation

Evaluation goals

This report documents the third year of the DMC-ODS evaluation, focusing on findings for the period of July 1, 2017 through June 30, 2018.

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.
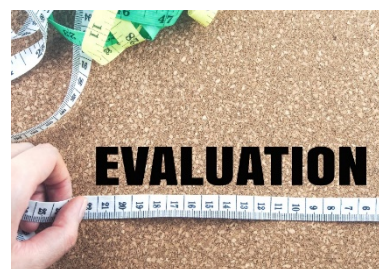
Evaluation hypotheses include:

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.

---

[2] State of California, Department of Finance, E-4 Population Estimates for Cities, Counties, and the State, 2011-2017, with 2010 Census Benchmark. Sacramento, California, May 2017

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 reports for the prior two years.

D. Data Sources

Administrative data

For the purposes of this report, available administrative data included the California Outcomes Measurement System, Treatment (CalOMS-Tx), and Drug Medi-Cal Claims. The dates on which these files were updated were May 31, 2018 for CalOMS-Tx and April 25, 2018 for Claims.

Level of Care Placement data

This is a large new data collection effort. Given that the ASAM Criteria are a defining feature of the DMC-ODS, this effort was created to collect data on the use of ASAM level of care screenings, assessments, reassessments, and services delivered. UCLA is working with DHCS and counties to collect these data. DHCS Information Notice 17-035 describing the requirements and procedures to collect Level of Care (LOC) data was released September 2017. These data include the date of screening or assessment, type (brief screen, initial assessment, follow-up assessment, indicated level(s) of care, actual placement decision(s), the reason for the difference between indicated and actual levels of care (if any), and the reason for delays in placement (if any). Marin, San Francisco, San Luis Obispo (not a Live-Waiver county for this report), San Mateo, and Santa Clara counties submitted LOC data to DHCS by July 2018. The reasons for other counties not submitting data as of this date varied, but often included issues integrating it with electronic health records. UCLA will continue to follow up with these counties.

Treatment Perceptions Survey (TPS)

The TPS was developed by UCLA based on San Francisco County's Treatment Satisfaction Survey and with input from DHCS, the Substance Abuse Prevention Treatment+ Committee (SAPT+) of the County Behavioral Health Director's Association (CBHDA) of California, the DMC-ODS External Quality Review Organization (EQRO) Clinical Committee, Behavioral Health Concepts (BHC), and other stakeholders. The TPS is designed to serve multiple purposes. The first is to fulfill the county's EQRO requirement related to conducting a patient satisfaction survey at least annually using a validated tool. The TPS also addresses the data collection needs for the CMS required evaluation of the DMC-ODS demonstration. Lastly, the TPS supports DMC-ODS Quality

---

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

Improvement efforts and provide key information on the impacts of the new continuum of care.

The survey includes 14 statements addressing patient perceptions of access to SUD treatment, quality of care, outcomes, coordination/integration of care, and general satisfaction. Patients indicate the extent to which they disagree or agree with the statements using a 5-point Likert scale (1=strongly disagree and 5= strongly agree). The survey also collects demographic information (e.g., gender, age, race/ethnicity, length of time receiving services at the treatment program). TPS survey forms are available in 13 languages (English, Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern Armenian, Western Armenian, Vietnamese, Cambodian) and in one-page and two-page (larger font) versions. The relevant MHSUD Information Notice (17-026), survey instructions, forms in multiple threshold languages, and other materials (e.g., Frequently Asked Questions, TPS Codebook, sample county and program summary reports) are available online at: http://www.uclaisap.org/ca-policy/html/client-treatment-perceptions-survey.html.

County administrators coordinated the survey administration and data collection within their provider network and submitted it to UCLA. UCLA analyzed the data and prepared county- and provider-level summary reports, and gave each county access to its raw data, as requested.

Seven counties that had executed DMC-ODS contracts with DHCS as of September 2017 administered the TPS among adult patients who presented in person for SUD treatment services within their provider network during the November 6-10, 2017 (or January 22-26, 2018 for Los Angeles county) survey period. The counties included San Mateo, Marin, Riverside, San Francisco, Contra Costa, Santa Clara, and Los Angeles. Data were analyzed and a summary of the results are included in this report within the Quality of Care domain. TPS results are also referenced in other relevant domains (e.g., access, care coordination) in this report. The second survey period occurred October 1-5, 2018. The analysis of these surveys will be included in the 2019 UCLA evaluation report. See Appendix B for the statewide summary report for the seven counties.

Key Informant Interviews.

These interviews have been and will continue to be conducted with SUD treatment administrators from counties that are participating in the DMC-ODS waiver. DMC-ODS waiver implementation interviews were conducted in July 2017 with administrators from the first three counties to have DMC-ODS contracts executed between January and April 2017 (San Mateo, Riverside, and Marin) to collect their experiences with and perspectives on the implementation of the waiver. Another set of interviews was conducted in March and April 2018 with administrators from counties that had DMC-ODS contracts executed in June and July 2018. The purpose of these key informant interviews is to continue to compile in-depth information on selected waiver topics, implementation lessons learned, promising strategies, and recommendations for improvement. The findings help to inform other counties' and the State's implementation efforts and to aid in the interpretation of

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

Secret shopper calls

Calls are being conducted on an ongoing basis by UCLA secret shoppers 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 completed "secret shopper" calls to the county BALs of all seven Live-Waiver counties (Contra Costa, Marin, Los Angeles, Riverside, San Francisco, San Mateo, and Santa Clara). Each county was called at least once during each of three time periods; daytime (between 9am – 4pm), evening (between 5pm – 7am) and the weekend (at any time). After each call, UCLA did not call the same county again for a period of at least three weeks.

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

To date, UCLA has conducted 34 "secret shopper" calls in 14 counties. Nineteen have been conducted in Spanish. Analysis and discussion of these data are included 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 2017-2018, UCLA conducted a follow-up County Administrator Survey to track annual changes, collecting data from November 2017 through February 2018. Responses from 49 counties were received and compared with baseline data collected in 2015-2016. Throughout the report, these surveys are referred to as the 2017 and 2015 surveys, respectively. Items from the survey relevant to access, quality, and coordination will be described in the pertinent report sections.

Treatment Provider Survey

UCLA initiated data collection processes among the Live-Waiver counties following their "go live" date and submission of contact information for providers participating in the demonstration project. At the time of this report, only a portion of the Live-Waiver counties completed the data collection process, therefore analysis and discussion of these data will be included in future reports.

E. Analysis Plan and Framework for Report

For this report, UCLA used an analysis plan that split counties between Live-Waiver counties, Pre-Implementation Waiver counties, and Non-Waiver counties in order to determine whether the waiver was associated with changing practices.

Unless otherwise specified "Live-Waiver counties" refers to the seven counties that "went live" or were approved by DHCS and CMS to provide DMC-ODS services as of July 1, 2017 (Contra Costa, Los Angeles, Marin, Riverside, San Francisco, San Mateo, and Santa Clara). "Pre-Implementation Waiver Counties" had submitted DMC-ODS implementation plans but had not yet "gone live" as of July 1, 2017. Non-Waiver counties had not submitted a DMC-ODS implementation plan.

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 are 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.
.

II. Access to Care

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

Lack of appropriate access to care can affect the health and well-being of individuals with a substance use disorders (SUD). The University of California, Los Angeles (UCLA) is therefore tracking changes in access to care using multiple data sources and measures.

A.   Data Sources

This chapter focuses on data from six data sources: The California Outcome Measurement System - Treatment (CalOMS-Tx), Drug Medi-Cal (DMC) Claims, Level of Care (LOC) placement data, County Administrator Surveys, County Administrator Interviews, and Beneficiary Access Line (BAL) Secret Shopper Calls. Medi-Cal Managed Care and Fee-For-Service (FFS) data were not available for the waiver period (2017-2018), but analysis of these data will be included in future reports. Analysis of these data, where appropriate, focused on measurable change between Drug Medi-Cal Organized Delivery System (DMC-ODS) Live-Waiver counties, Pre-Implementation Waiver counties, and Non-Waiver counties in order to determine whether the waiver was associated with changing practices.

B. Measures

Existence of BALs

County administrators who responded to UCLA's Administrator Survey reported whether their county had a toll-free BAL for SUD services, as required by DMC-ODS special terms and conditions. All Live-Waiver counties reported having BALs and provided the phone number. Pre-Implementation counties were the next most likely to have BALs, and Non-Waiver counties were the least likely to have them (see Figure 2.1).

Figure 2.1: Percentage of counties with a toll-free BAL for SUD services
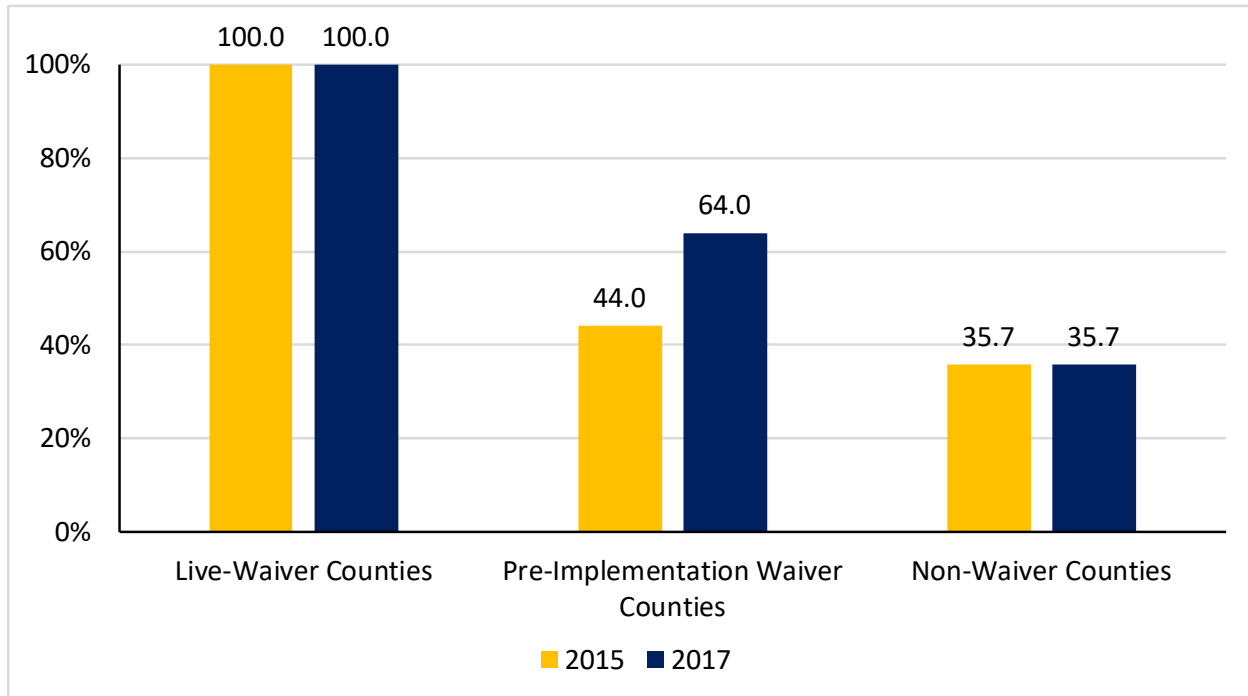
Counties were also asked whether their preparation for the DMC-ODS facilitated establishment of a BAL. In Live-Waiver counties, a little over half reported that the DMC-ODS waiver had facilitated their BAL efforts. According to 2015 surveys, these counties all had some form of functioning BAL prior to the waiver, so there was less room for the waiver to have an impact on BAL practices in these counties. In contrast, most Pre-Implementation counties did not have BALs in 2015, and in 2017 80% of them reported that the waiver had facilitated their efforts as they established new lines to meet DMC-ODS requirements. Surprisingly, even among Non-Waiver counties, 44.4% reported that the waiver had facilitated their BAL efforts. Some of these counties have not previously provided DMC services but are being required to do so.[4] These counties may therefore be preparing to follow DMC-ODS requirements even if they are not formally participating in the current waiver.

---

[4] For example DHCS Information Notice 18-009 reminds counties that "If a county fails to arrange, provide or subcontract for any DMC covered services within their county, in accordance with Government Code Section 30027.10, the State may elect to divert the amount needed of that county's BHS allocation to pay for DMC services provided to those residents . . . "

Figure 2.2: Percentage of counties in which preparation for the DMC-ODS waiver has facilitated either the establishment of a BAL or the addition of SUD services to an existing number
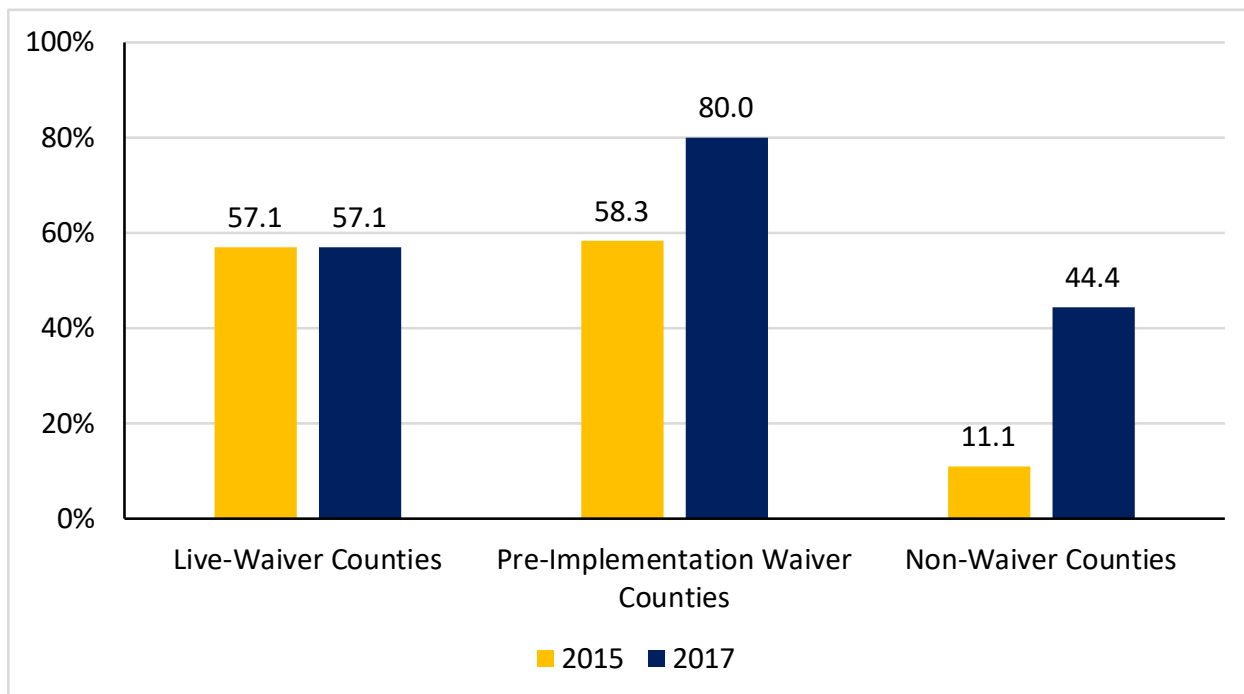
For more information on the successes and lessons learned from Riverside County's experiences with establishing a BAL (particularly in the areas of call volume, call duration, staffing, and advertising), see UCLA's 2016-2017 DMC-ODS evaluation report.[5]

In interviews conducted during the past year, an additional issue arose in one county that could provide useful information for counties that are still establishing BALs. The county administrator explained:

> *"Then we had a number of clients stuck in jail that couldn't make phone calls (because) we centralized the point of access or entry into the system through the behavioral health access line. In jail, clients . . . cannot call 800 numbers. That was a barrier for them."*

The county was able to implement a creative solution, however:

> *"While not an easy fix at the time because we did not have any leverage with the sheriff, they created a speed dial number that comes straight into the same call center number."*

---

[5] http://www.uclaisap.org/html/past-updates-reports.html

Beneficiary Access Line Secret Shopper Calls

To date, UCLA has conducted 34 "secret shopper" calls in 14 counties. Calls are continuing to be made as new counties reach their "go live" dates.

Across the 34 calls, it took callers an average of 47 seconds to find the county access line number. On average, callers rated the ease of finding the county access line a seven out of ten.

In some cases, multiple attempts were needed to complete the secret shopper call. In five instances across three counties, the phone was not answered during first attempts to call. In 12 instances across six counties, the call was answered but the caller was instructed to call a different number. In five instances across three counties, the caller was asked to call back at another time due to high call volume. Overall, each county was called between three and seven times to successfully complete the three contacts.

The average number of phone rings before a person answered was two. The average time the caller waited before they were able to speak to a real person was 104 seconds. This average was skewed by three calls to three different counties that had exceptionally long hold times (152, 167, and 1,565 seconds). Without these calls, the average time was 36 seconds. The average length of the call was 362 seconds. Access line staff were rated as friendly, with an average score of eight out of ten.

Not surprisingly, as new access lines and procedures were established and call volumes spiked, there were some initial challenges. Importantly, in all cases, the callers eventually reached someone who could help them, but in some instances, it required multiple calls, particularly when the caller spoke Spanish. UCLA is in the process of reaching out to individual counties to provide feedback and will continue to monitor BAL functioning.

Availability and Use of the Required Continuum of Care

Live-Waiver counties generally did provide the required continuum of care according to DMC-ODS claims (see Figure 2.3). This includes outpatient, intensive outpatient, narcotic treatment program (NTP), and at least one level of residential treatment and withdrawal management (WM). One county, San Francisco, reported that it was initially not submitting DMC Claims for some LOCs.[6] San Francisco has therefore been excluded from DMC Claims analyses in this report, since the claims do not yet provide an accurate depiction of the county's actual treatment activities. (The county is included in analyses of all other data sources, including CalOMS-Tx.) In two of the remaining counties, claims for WM were not found, but qualitative interviews suggested these services actually were being delivered. UCLA will continue to investigate the reasons for this disparity.

---

[6] The county has historically provided services using county general funds and decided to initially continue to do so due to concerns about programs' ability to immediately meet standards and submit approvable claims. There was concern that a large amount of denied claims might lead some to close and lead to a reduction in system capacity. The county therefore reported taking a cautious approach to DMC Claims even though they reported providing DMC-ODS services.

Figure 2.3: Patients served by level of care and county in Live-Waiver counties following DMC-ODS Live Date, 2017 (Source: DMC Claims)
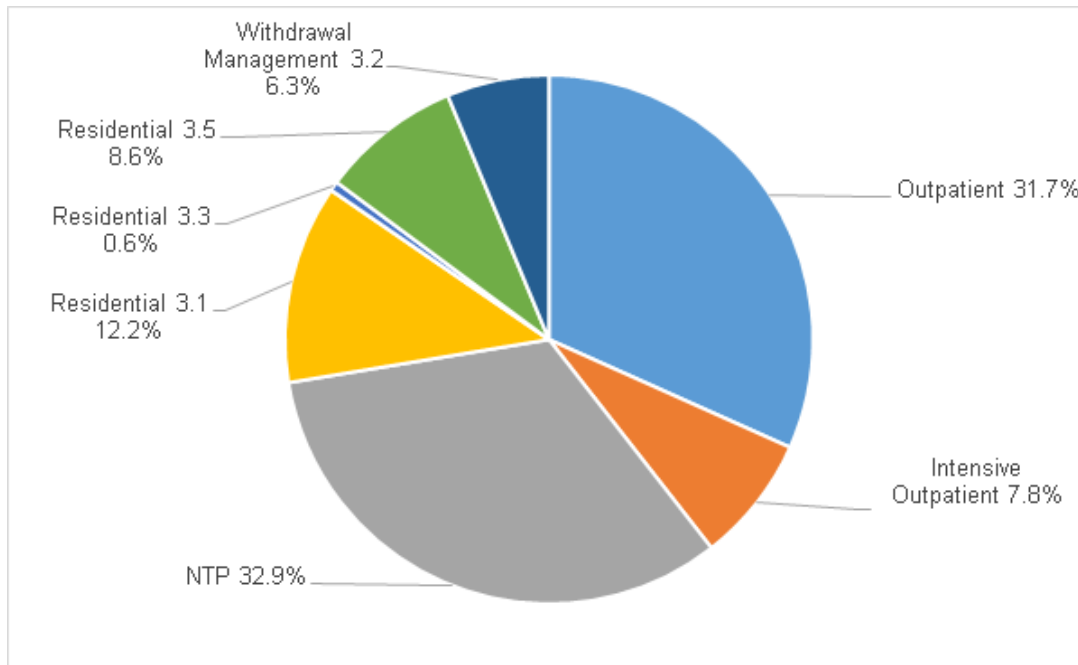
Change in the Number of Patients Served

Between February 1 and July 1, 2017, counties started to "go live" with their DMC-ODS services, and in each case there was a measurable, and in some cases profound, effect on the number of unique individuals receiving DMC-ODS services. Compared to December 2016, by the end of 2017 the Live-Waiver counties had increased the total number of patients being served by DMC by 28.4%. There was great variation between counties, with increases ranging from 5.1% to 52.2%. In some cases, DMC-ODS participation appeared to have an immediate impact, while in others their "go live" date signaled the start of a more gradual rollout (see Figure 2.4).

Increasing the number of individuals served by the DMC-ODS means these patients can potentially receive improved care, and they are able to access SUD treatment through Medi-Cal consistent with the goals of parity. It does not, however, necessarily mean that more individuals are receiving treatment overall than prior to the DMC-ODS. At least a portion of the new patients served under the DMC-ODS would have been treated under other funding sources like the Substance Abuse Prevention and Treatment (SAPT) block grant in the absence of the DMC-ODS. To measure the impact of DMC-ODS on overall access to treatment, the total number of patients being treated under all funding sources is needed.

For a broader view, CalOMS-Tx data for Medi-Cal eligible patients was analyzed for December 2016 through October 2017.[7] The analysis was based on unique patients within each month residing in each county based on the patient's zip code of residence (or the county of service, if the person was homeless). See Figure 2.5. Overall, the average total number of unique patients admitted per month increased 7.4% between the pre-DMC-ODS and post-DMC-ODS periods, or 10.9% after excluding San Mateo, which appeared to have anomalous data.[8] By comparison, Non-Waiver counties had a 4.1% reduction in patients over the same timeframe. UCLA also conducted an analysis using average monthly CalOMS-Tx admissions for a full year prior to each county's "go live" date and found an increase of 7.1% while excluding San Mateo. Los Angeles naturally has a large impact on these results due to its size, but even if Los Angeles is excluded an increase of 4.9% persisted among the remaining five counties.

Preliminary analyses suggest the increase is driven in large part by increasing admissions to residential treatment. In Live Waiver counties, 815 patients received residential treatment in the month prior to their "go live" dates and 1,044 received it the month after their "go live" date.

Although there was variation between counties it does appear there was an overall expansion in the number of patients served that is robust to different calculation methods. UCLA will continue to monitor these numbers as time passes and additional counties join the ranks of the Live-Waiver counties. UCLA plans to also conduct analyses of the components of change (e.g., by levels of care), and additional services (e.g., case management, recovery support services). More advanced statistical analyses using a multiple baseline approach as described in UCLA's evaluation will also be conducted after more counties "go live", but there was inadequate statistical power to conduct these analyses with only seven Live-Waiver counties.

The increases in patients served appears to be occurring despite several factors that counties stated may be causing headwinds, including:
- DMC-ODS maximum of two residential admissions, as opposed to unlimited residential admissions under other funding sources.
- Electronic Health Record (EHR) implementation and other new DMC-ODS-related requirements and procedures may have decreased productivity of staff initially.
- Reductions in criminal justice referrals. DMC-funded criminal justice treatment cannot be mandated by the criminal justice system without established medical necessity of treatment services. With residential care now covered by DMC for non-perinatal beneficiaries, the criminal justice system can no longer order residential treatment or specify a number of treatment days without establishing medical necessity as they had previously under other funding sources.

---

[7] At the time of the data download for these analyses CalOMS-Tx data was incomplete beyond October 2017. For San Francisco, October admission data also appeared to be incomplete (45% lower than the month prior), so data for that month was omitted.

[8] Admissions varied by more than 3,000% between months during this period, suggesting possible data reporting issues. UCLA is following up with this county to better understand the issue.

Figure 2.4: Preliminary* change in unique patients receiving DMC services by month. <u>DMC Claims data</u>, December 2016-December 2017
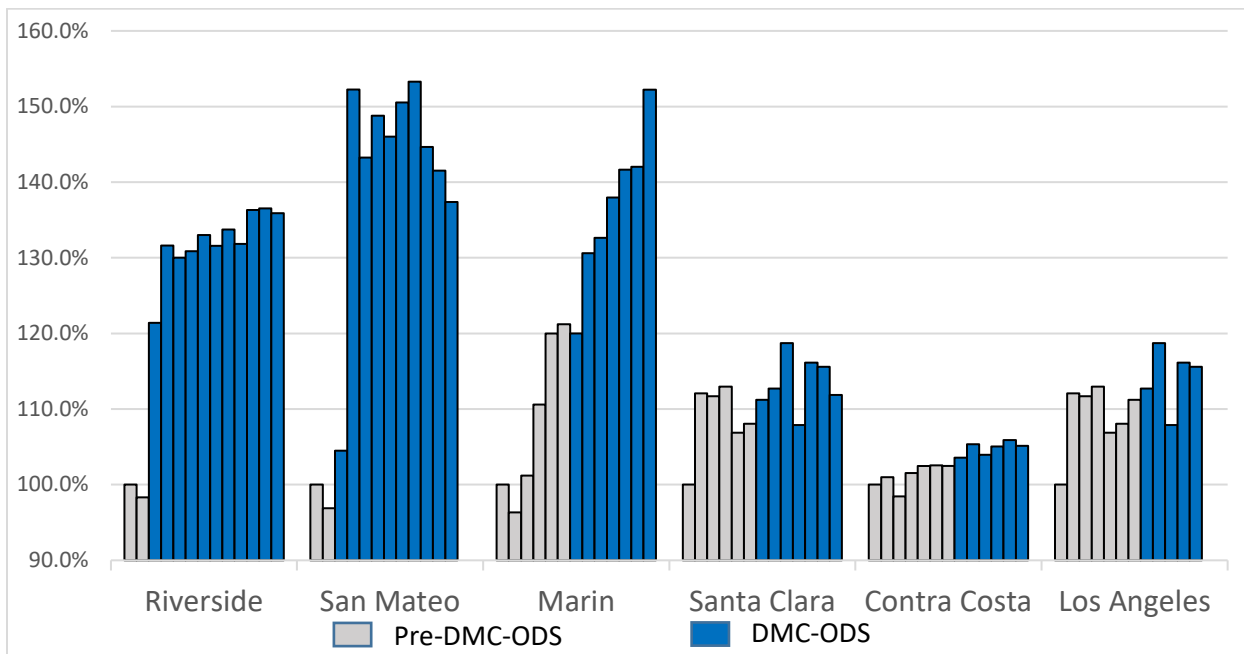
* Claims data are from April 25, 2018, four months after December 2017. Providers have up to six months to submit claims from the time of service, however, so counts in later months may change somewhat.

Figure 2.5: Preliminary Change in Admissions among Medi-Cal Clients Residing in each County by month. <u>CalOMS-Tx data</u>. (December 2016-October 2017)
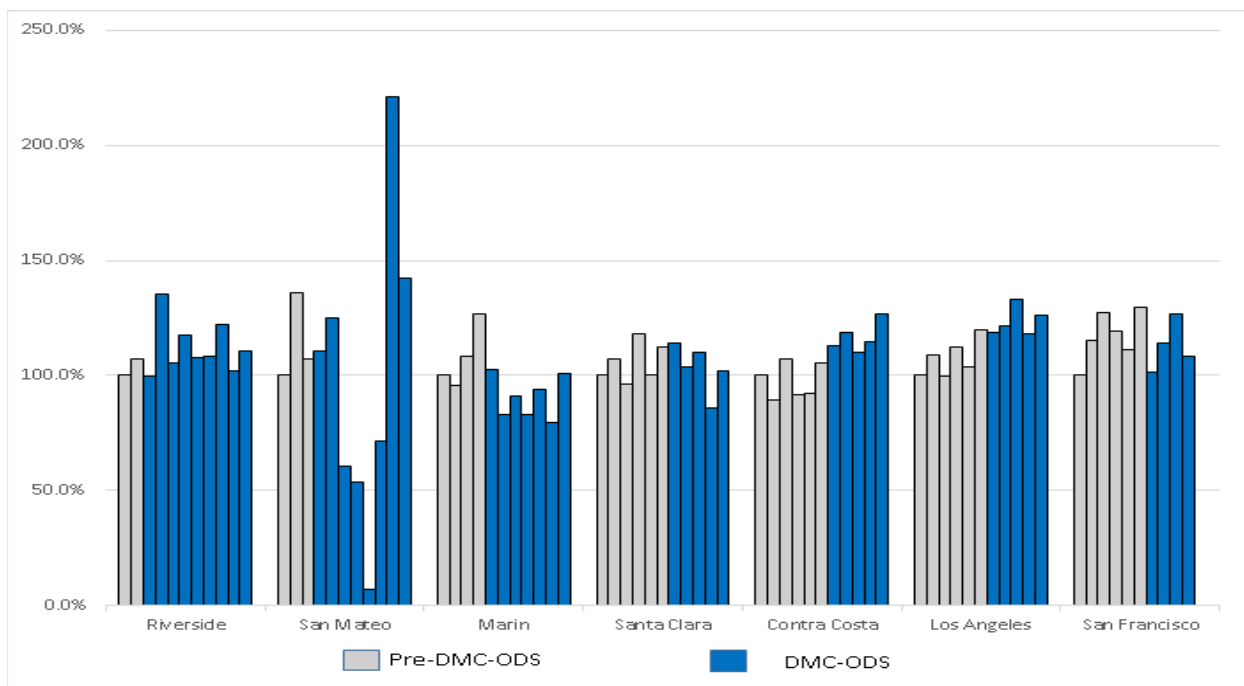
Capacity Expansion

Challenges

When counties were asked via the County Administrator Survey which modality is the *most* challenging to expand, *every* Live-Waiver county selected some form of detoxification/WM. Six out of the seven Live-Waiver counties (86%) indicated that medical detoxification/WM specifically is the most challenging. These services are generally delivered in medical settings outside of the BH/SUD administrator's oversight. The seventh county selected Non-medical WM. Among Pre-Implementation counties, residential treatment was selected most frequently as the most challenging to expand followed closely by medical detoxification/WM (see Figure 2.6).

In key informant interviews, counties expanded upon several barriers to enhancing access to WM services under the DMC-ODS, noting, as one administrator explained, *"bed availability is definitely an issue."* Another administrator expressed a similar sentiment, saying that *"detox is still our hardest accessible point…we need more."*

Figure 2.6: 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)
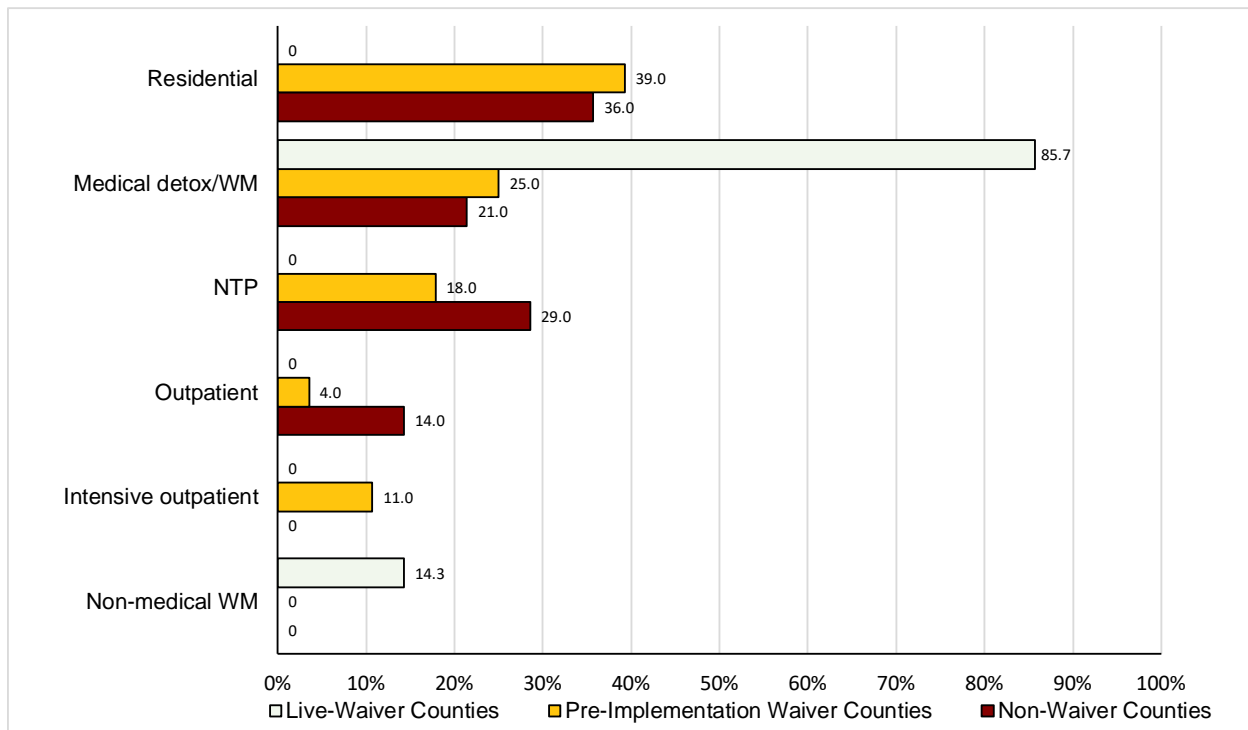
In some counties, while potential WM resources exist, interviewees suggested that administrative barriers make it challenging to integrate these services into counties' continuums of SUD care. Only one level of WM is required, and additional levels are optional, but *"It would take a provider, an existing provider with a facility,"* explained one administrator, *"to update their licensure and to be licensed through DHCS to be able to allow them to have withdrawal management beds in their facility."* As another administrator elaborated, even when programs get the appropriate licensure, the task of "*(establishing) the rate (of reimbursement) and amending the (county) implementation plan"* to incorporate new WM services into county DMC-ODS systems may be time-consuming. These steps are required under the current waiver's special terms and conditions. If DHCS and CMS are able to identify and agree upon more streamlined processes for adding WM services to existing providers under the current or future waiver efforts, this could facilitate capacity expansion in this critical area.

To address the barriers to WM under the DMC-ODS, counties reported using several different solutions. One county reported that they are trying to designate some of their residential beds to be able to provide WM services. Another reported working with programs geographically located outside of their county to provide WM services to their residents, while others reported providing the service within their county, but not using providers who are certified to provide DMC services. *"You won't see it in our (DMC-ODS) bills,"* explained one administrator, *"but it (withdrawal management) is available to our beneficiaries."* Some administrators reported having claims for medical Voluntary Inpatient Detoxification (VID) WM initially rejected, thus delaying its availability. This is a benefit that is available to managed care plan members through the separate Medi-Cal FFS program, meaning it operates outside of the DMC "silo" that DMC-ODS providers and administrators are more accustomed to working within. Administrators expressed frustration with billing rejections and an inability to resolve why they occur. For additional discussion of these VID medical WM expansion challenges and recommendations, see UCLA's 2016-2017 DMC-ODS evaluation report (p. 17-18, 21).[9]

One county reported that to streamline the process of expanding WM capacity, it is working to develop directly (county) operated WM services instead of seeking out contract providers to provide the service and meet certification requirements. While confident this would eventually lead to an expansion of WM services, this administrator anticipated that it would "*probably take a couple of years,"* before new county-operated WM services could begin operation.

It should be noted that DHCS released All Plan Letter 18-001 clarifying VID benefits, and Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 18-031 providing additional guidance on incidental medical services, which can include WM in residential settings, but it is too early to evaluate the effect of these efforts with the data available.

---

[9] http://www.uclaisap.org/assets/documents/California-DMC-ODS-Evals/DMC%20ODS%20Evaluation%20Report%20FY%202016-2017%20final.pdf

Although detoxification/WM was reported to be the most challenging service to expand on the County Administrator Survey, especially in Live-Waiver counties, challenges do exist in other modalities as well. Some survey participants expressed frustration at only being able to select one as most challenging, and suggested that they would have selected most of the other modalities if it were possible.

When Live-Waiver and Pre-Implementation Waiver counties were asked to indicate on the County Administrator Survey which specific challenges significantly impeded their ability to expand treatment capacity, they selected a wide array of issues (see Figure 2.7). More challenges were selected by more respondents for residential treatment than any other modality. The most common challenges by modality were:

- Outpatient: Staff certification/licensing
- Residential and Non-Medical detox/WM: High upfront investment/financial risk
- NTP: Community opposition (Not In My Back Yard, NIMBY)
- Medical detox/WM: Regulatory issues

Figure 2.7 provides additional information on the challenges reported.

Figure 2.7: Significant challenges faced in expanding capacity, by modality, among Live-Waiver and Pre-Implementation Waiver counties
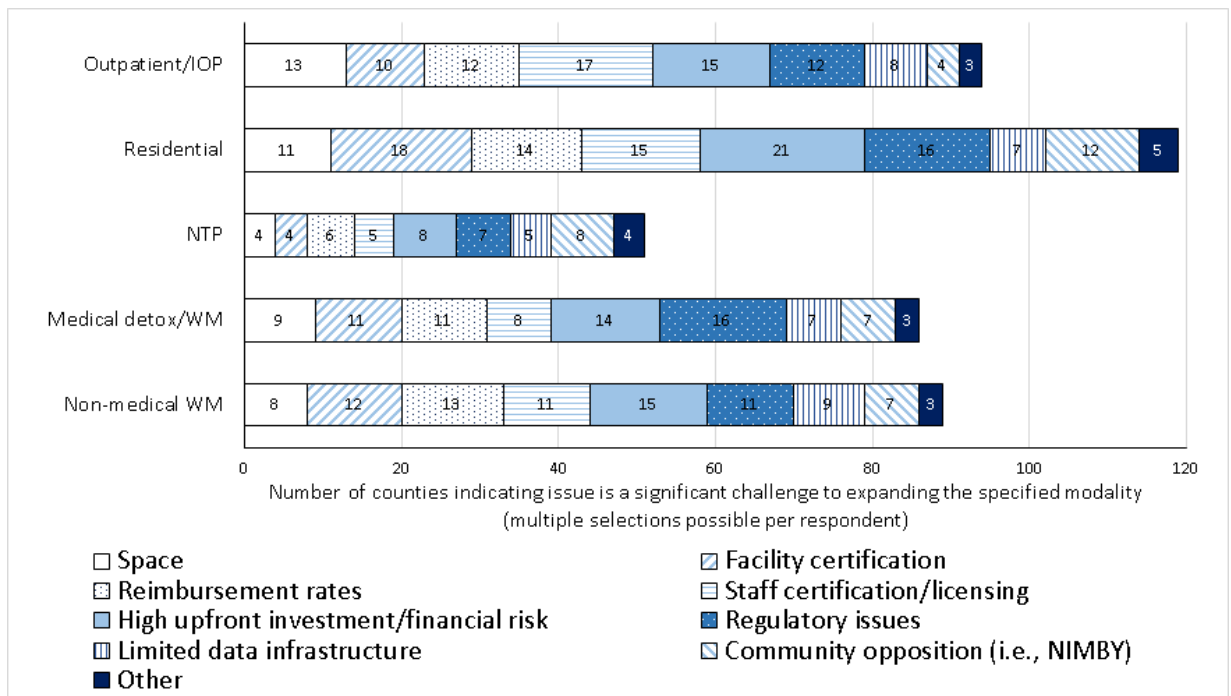
Among open-ended responses, some participants (including two Live-Waiver and one Pre-Implementation county) reported challenges in filling and retaining certified and licensed staff positions, citing a tight job market and competition within the county and

with other health providers (e.g. Kaiser) for limited staff in the area. The cost of living in the Bay Area in particular was cited as a barrier to recruiting and retaining staff there.

This was consistent with statements from Administrator Interviews.

> *"A lot of people (providers) are saying 'we just cannot hire enough people, even though they're billable staff and these are billable activities, to do these things.' That's a pervasive sentiment."*

Three respondents from small counties (including two Pre-Implementation counties) noted that their capacity, aside from outpatient, is primarily located out of county. This suggests capacity expansion for these counties may be less under their direct control and more reliant upon partnerships.

In addition, expanding SUD programs in some communities has been a challenge in some counties. One county, in particular, reported encountering significant community NIMBYism against the development of new programs. As one administrator summed up, *"everyone wants drug treatment, just not in my neighborhood."*

Medication-assisted treatment (MAT)

DMC-ODS facilitates use of any US Food and Drug Administration (FDA)-approved medication for the treatment of SUD. MAT is required in an NTP setting, and additional MAT delivered in other settings is optional. MAT is a particularly important issue for opioid use disorders (OUD), for which effective medications including methadone, buprenorphine, and extended release naltrexone are available. According to CalOMS-Tx records, patients with opioids as their primary drug problem were somewhat more likely to receive medications in Live-Waiver counties than other counties (see Table 2.1). However, this difference might not be directly attributable to the DMC-ODS waiver because pre-waiver trends in 2015 were in generally the same direction. This suggests the Live-Waiver counties *were already more advanced* in terms of MAT use prior to the waiver. "Other" medication was highest in Live-Waiver counties, which may in part reflect use of extended release naltrexone. The rate of buprenorphine use was actually highest in the Non-Waiver counties (5.9%), but this was based on a small number of individuals (21). It is unclear whether this is a temporary aberration or perhaps the result of Non-Waiver efforts like California's Hub and Spoke System.[10] UCLA will continue to monitor these trends.

---

[10] Hub and Spoke System is part of California's MAT expansion project. For more information see: https://www.dhcs.ca.gov/individuals/Pages/CA-Hub-and-Spoke-System.aspx

Table 2.1. Use of medications among patients with a primary drug of heroin or other opiates from January 1, 2017, to December 31, 2017. CalOMS-Tx data

Medication used in OUD treatment	Live-Waiver Counties	Pre-Implementation Waiver Counties	Non-Waiver Counties
Any Medication	**65.3%**	**61.5%**	**59.6%**
Methadone	58.2%	59.6%	53.2%
Buprenorphine (Subutex+Suboxone)	2.7%	1.5%	5.9%
Other	4.4%	0.4%	0.5%

In interviews, one county administrator commented on this use of MAT in NTPs.

> *"I would say by far, most of the MAT we're providing now is in the NTPs, and I think two or three of the clinics are offering buprenorphine, and the rest of them are gearing up, getting the new service codes, getting their NDC numbers straight . . . changing their DEA number, and all this stuff that's new."*

That said, other counties are preparing to provide more MAT in residential settings.

> *"We have also hired a full time physician to do MAT, just that. So she is actually starting to provide MAT in residential settings. I think over the next six months to nine months you'll see a pretty significant improvement in how much of that is going on."*

Consistent with this, some counties reported that while they are providing MAT services to their Medi-Cal beneficiaries, they are doing so outside of the DMC-ODS. As one administrator explained, it is *"by design"* that MAT services are being provided outside of DMC-ODS since the county is "*pushing providers to use the fee-for-service Medi-Cal benefit. If this (MAT) is something that is reimbursed somewhere else in Medi-Cal (other than DMC-ODS), that's where they're seeking payment for that medication."* Presumably, the goal of this strategy is to preserve funding in the county's behavioral health (BH) subaccount to fund other DMC-ODS services.

San Mateo County in particular is providing MAT in medical settings as part of an innovative Integrated Medication Assisted Treatment (IMAT) Model. To the extent MAT is being billed to managed care/FFS Medi-Cal rather than DMC, these MAT efforts cannot be tracked by UCLA at this time. Additional analyses are planned, however, when managed care/FFS Medi-Cal data become available for the waiver period

Telehealth

Counties are working on telehealth, but aside from use of the telephone, progress is occurring incrementally. Counties commented on their progress in interviews:

"Yeah. We haven't yet operationalized it, but we're preparing to do so . . . our largest provider . . . has the ability to do telehealth. We're hoping to use them first to expand service to (outlying areas)."

"Mental health is ahead of us in a number of ways. . . They were told, 'Go ahead and start. Stop testing things. It's doable. It's possible. It's being done in the whole state.' The idea is that they are going to start. They're going to fold us in, probably in the next year or so."

"We've been encouraging the programs to look at how they could use telehealth. . . . in our monthly meetings with our providers, we definitely discuss that as an option . . . Definitely they use the telephone. What I'm working with county council is actually looking at the more elaborate telehealth where they can do Skype and some other mediums."

Although there are place of service codes as part of the facility identification code in DMC Claims that can be used to track telehealth, no claims to date have used this code. As telehealth expands, in order to track its use and outcomes accurately, providers will need to be aware of and actively use these telehealth codes. UCLA will continue to monitor track telehealth developments through surveys and interviews, and look for corresponding activity in DMC Claims.

Youth

Incremental progress and challenges were also being reported on youth treatment.

"We finally got a provider for Youth Residential, which was a really big (deal) for us. . . Our whole youth system of care has been pretty darn anemic over the years. The funding has been just so limited. . . It's taken a really long time to find an appropriate site and to get that site up and running, or to get the site ready, and to hire the staff, and to get that drug Medi-Cal certification paperwork all set up. 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."

"We have one robust adolescent treatment . . . and mostly, they use motivational interviewing, a little bit of CBT (Cognitive Behavioral Therapy), and they also have mental health contracts. We have another one . . . that has decided not to offer Drug Medi-Cal. They're not gonna be in the waiver. In fact, what they do is kind of more like targeted prevention, like screening and brief intervention rather than actual treatment."

Treatment Standards from the National Institute of Drug Abuse (NIDA)[11] suggest that SUDs are adolescent onset disorders, which in turn requires the system to include different services than the adult system as well as pay attention to the clinical qualifications of the workforce.

<u>Recovery support services</u>

For recovery services, administrators described how poor understanding of what the services entail or what they are designed to do are the main barriers to operationalization under the DMC-ODS. *"I don't think they (providers) really know what to do….even our more sophisticated providers. I think it's a new animal,"* explained one administrator. *"We've tried to provide a good deal of guidance to them regarding the benefit, but (there's a) lack of understanding of really how to do it and what expectations we have."* Another administrator reported that misconceptions of what recovery support services entail—particularly the belief that they need to be *"medication-free"*—keep providers from developing these programs. In addition, one administrator reported that patients themselves also have not fully grasped the concept of recovery support services or what they can offer. "*It's a new model,*" this administrator summed up, "*it's getting beneficiaries to understand that here is continuing support that we can give you and engaging them in that."* Administrators reported optimism that as both providers and patients become more familiar with the idea of recovery support services within the next year, they will be accessed and utilized more regularly. Administrators also suggested that because they have well-established alumni programs that keep patients engaged after their conditions have been stabilized, NTPs might be the programs that are most likely to have initial success in implementing recovery support services.

Penetration Rates

UCLA calculated penetration rates in Live-Waiver DMC-ODS counties based on the Substance Abuse and Mental Health Services Administration (SAMHSA) 2016 National Survey on Drug Use and Health (NSDUH), California population estimates from the California Department of Finance, and 2017 eligibility and claims data from DMC.

The existing need for treatment is based on the 2016 NSDUH estimates for California.[12] These estimates suggest 2,088,000 Californians had alcohol use disorder (AUD) and 1,068,000 Californians had an "illicit" SUD. These numbers cannot be added together, however, because many individuals suffer from both disorders. Although SAMHSA does not report state-by-state numbers for individuals with alcohol or SUDs, it does report it nationally.[13] Specifically SAMHSA reported that, "In 2016, approximately 20.1 million people aged 12 or older had an SUD related to their use of alcohol or illicit drugs in the

---

[11] https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/principles-adolescent-substance-use-disorder-treatment

[12] https://www.samhsa.gov/data/report/2015-2016-nsduh-state-specific-tables

[13] https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#summary

past year, including 15.1 million people who had an alcohol use disorder." This suggests the number of people who have either an illicit SUD or AUD was approximately 20.1 million / 15.1 million = 133% of the number of people with an AUD alone. We therefore applied this to the number of Californians estimated to have an AUD to estimate a total of 2,088,000 x 133% = 2,777,040 with either an AUD or illicit SUD. We then divided this by the estimate of the California population 12 or over from the California Department of Finance[14] (33,192,763) to obtain an estimated rate of need of 2,777,040 / 33,192,763 = 8.4%. This rate was then applied to the average monthly number of Medi-Cal eligibles in the Live-Waiver counties (4,317,807) to obtain a need estimate 4,317,817 x 8.4% = 362,896. We then applied a correction to apply a need estimate of 38% for the homeless populations of these counties[15] based on a SAMHSA estimate[16] of alcohol dependence multiplied by 133% to produce a need estimate for both alcohol and SUD. This suggested a total Medi-Cal eligible population needing SUD treatment (AUD or illicit SUD) of 394,859. In these counties, an average of 16,896 patients per month received DMC-ODS services. This suggests a penetration rate of 16,896 / 394,859 = 4.3% based on the total Medi-Cal eligible population across the Live-Waiver counties. When the counties are weighted equally, however, the average Live-Waiver county had a penetration rate of 6.3%. Note this does not take into account people receiving treatment outside of the DMC system, e.g., MAT occurring in primary care. Some counties have made a major effort in these areas to complement their DMC-ODS system, so this penetration rate may somewhat understate treatment penetration.

As discussed in the 2015-2016 DMC-ODS evaluation report, nationally 97.1% of people who needed treatment for an alcohol problem did not feel they needed specialty treatment (SAMHSA, 2015). This suggests that although efforts to increase penetration rates can and should include expansion of physical capacity, efforts to change perceptions about specialty treatment among prospective patients and to reach patients in non-specialty settings such as primary care will also be critically important to substantially increase penetration rates. The DMC-ODS waiver provides opportunities to pursue these through

---

[14] http://www.dof.ca.gov/Forecasting/Demographics/Projections/documents/P1_Age_1yr_interim.xlsx

[15]   Contra Costa: "2017 Point in Time Count a Snapshot of Homelessness in Contra Costa County", Contra Costa Council for Homelessness. https://cchealth.org/h3/coc/pdf/PIT-report-2017.pdf

           Los Angeles: "2017 Greater Los Angeles Homeless Count Results Los Angeles County and Continuum of Care" , Los Angeles Homeless Service Authority. http://www.vchcorp.org/wp-content/uploads/2017/06/2017-Homeless-Count-Results.pdf

           Marin: Marin County Homeless Census & Survey 2017 Comprehensive Report. Applied Survey Research. https://www.marinhhs.org/sites/default/files/files/servicepages/2017_07/marin_pit_executive_summary_2017.pdf

           Riverside: County of Riverside 2017 Point-In-Time Homeless Count Report: Riverside County DPSS. http://dpss.co.riverside.ca.us/files/pdf/homeless/agendas-and-minutes/2017-rivco-pit-report-1.pdf

           San Francisco: San Francisco Homeless Count and Survey 2017 Comprehensive Report. Applied Survey Research. http://hsh.sfgov.org/wp-content/uploads/2017/06/2017-SF-Point-in-Time-Count-General-FINAL-6.21.17.pdf

           San Mateo: 2017 San Mateo County One Day Homeless Count and Survey: Final Report August 2017. County of San Mateo. Human Services Agency. https://hsa.smcgov.org/sites/hsa.smcgov.org/files/2017%20One%20Day%20Homeless%20Count%20Final%20Report.pdf

           Santa Clara: Santa Clara County Homeless Census & Survey 2017 Comprehensive Report. Applied Survey Research.https://www.sccgov.org/sites/osh/ContinuumofCare/ReportsandPublications/Documents/2017%20Santa%20Clara%20County%20Homeless%20Census%20and%20Survey%20Report.pdf

[16] http://www.nationalhomeless.org/factsheets/addiction.pdf

improvements in quality and coordination of care, to be discussed in Chapters 3 and 4, respectively.

C.   Discussion and Next Steps

The DMC-ODS waiver is having a measurable effect on access. In any effort of this size and complexity there will be both successes and challenges, and DMC-ODS is no exception.

In Live-Waiver counties, there was an increase in the number of people accessing SUD treatment with preliminary estimates in the neighborhood of 7%. There is also an increase of about 28% in the number of people receiving treatment funded by DMC giving them access to potentially higher quality treatment (DMC-ODS Quality is discussed in Chapter 3). UCLA will continue to monitor this progress.

Counties report that capacity expansion is challenging, however, especially for withdrawal management. The number of beneficiaries that are able to access services, and therefore penetration rates, appear to be constrained by capacity expansion.

Recommendation: Continue working with counties to resolve voluntary inpatient detoxification billing issues provided through FFS Medi-Cal. To facilitate expanded withdrawal management within DMC, explore with CMS the possibility of streamlining the process for existing providers to add withdrawal management services.

Recommendation: Look into options to help with startup costs, possibly through non-DMC funding.

The need for better data was an overarching issue. Use of MAT may be expanding, but partly outside of DMC. Getting the full picture will require up-to-date Medi-Cal managed care/FFS data. UCLA is in discussions with DHCS and hopes to receive these data shortly.

DMC-ODS is facilitating establishment of BALs. This effect even seems to be extending to Non-Waiver counties as these counties plan to participate in DMC. Secret shopper calls suggest these lines are functioning but have experienced some growing pains. Counties are working to address these, for example by hiring additional staff. UCLA will continue to monitor BALs for improvement and provide feedback to the individual counties.

A few issues appear to be continuing to cause confusion among counties and providers, including what recovery support services are and what requirements exist, and how to overcome challenges to expand youth services under the waiver.

Recommendation: Consider additional technical assistance on these topics.

References

SAMHSA (2015). *Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health.* Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.htm

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/NSDUHsaeMethodology2015.pdf

III. Quality of Care

Cheryl Teruya, Ph.D., Howard Padwa, Ph.D., Valerie Antonini, M.P.H., Vandana Joshi, Ph.D., Darren Urada, Ph.D., David Huang, Ph.D., Kevin Castro-Moino, and Elise Tran

> **"Without the waiver we would not be working on developing SU quality improvement activities."** *Administrator – County Administrator Survey*
>
> **"Like the staff tells me, I was just ready. But I think it has a lot to [do] with the staff and curriculum."** *Patient – Treatment Perceptions Survey*
>
> **"Since coming here I got my family back, a job, a place to live. Staff here is very kind and supportive."** *Patient – Treatment Perceptions Survey*

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."[17] UCLA analyzed data available during the first three years of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver demonstration project to evaluate the quality of substance use disorder (SUD) care using multiple measures.

D.   Data Sources

The data sources available for conducting the analyses included the California Outcome Measurement System - Treatment (CalOMS-Tx), 2015 and 2017 County Administrator Surveys, County Administrator Interviews, Drug Medi-Cal (DMC) claims, and DMC-ODS

---

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

Level of Care (LOC), and patient perceptions of care surveys. Analysis of these data focused on measurable change between Live-Waiver counties, Pre-Implementation Waiver counties, and Non-Waiver counties in order to determine whether the DMC-ODS was associated with changing practices. UCLA expects treatment provider surveys and Medi-Cal claims to become available in the future for evaluating the quality of SUD care.

E.   Measures

Use of American Society of Addiction Medicine (ASAM) Criteria-based tool(s) for Patient Placement and Assessment

The ASAM Criteria provides a common standard for assessing patient needs, improving placement decisions, and documenting the appropriateness of placement. They facilitate 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 which ASAM Criteria-based assessment tools best meet their needs.

Use of ASAM Criteria-based assessments

Analysis of County Administrator 2017 Survey data show that ASAM Criteria assessment and placement was available in all (100%) of the Live-Waiver counties, in the majority (62.5%) of Pre-Implementation Waiver counties, and in half (50.0%) of the Non-Waiver counties. (See Figure 3.1.) The Live-Waiver counties show the largest increase from the 2015 survey (difference of 57% between 2015 and 2017), although the availability of ASAM-based assessment appears to have increased in all three groups. The difference among the three groups became statistically significant (p=.002) in 2017.

Figure 3.1: Percentage of counties with ASAM assessment and placement available for adult patients
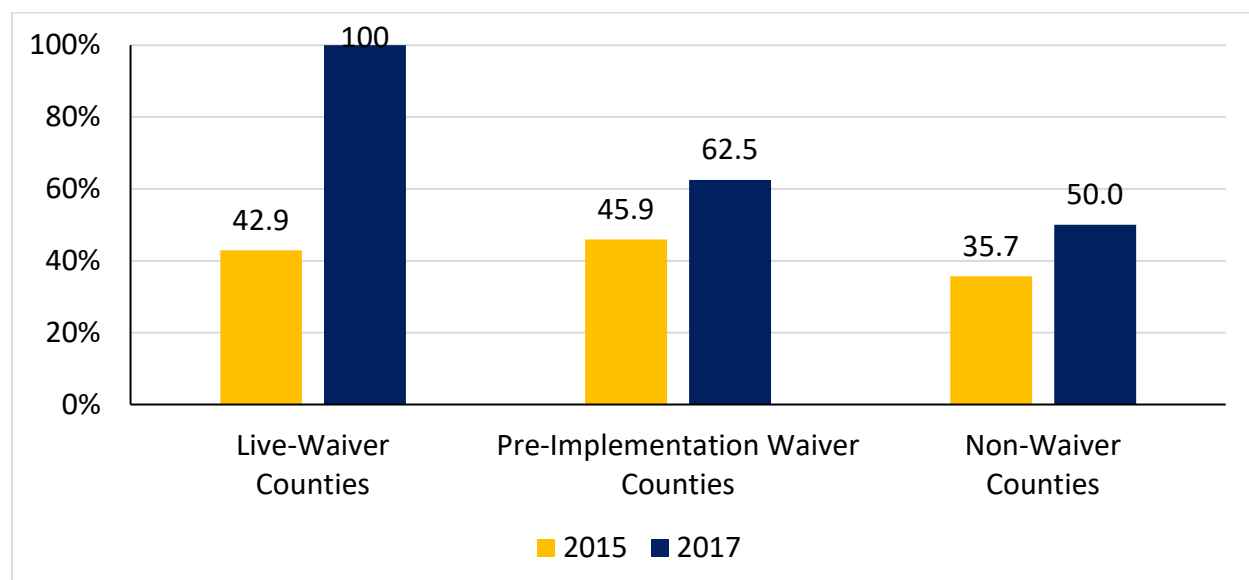
According to the County Administrator Survey, most counties are using tools that they developed internally for initial assessment (n=20), full assessment (n=16), and re-assessment (n=13). (See Figure 3.2 below.) The ASAM Criteria book and tools adapted from another county are also commonly used for conducting full assessments (n=16 and n=13, respectively) and initial assessments (n=10 and n=12, respectively). In addition, nine counties are planning to use the initial placement (screening) tool based on the ASAM Criteria that UCLA is developing and testing on behalf of the Department of Health Care Services (DHCS), known as the Brief Questionnaire for Initial Placement (BQuIP).

Figure 3.2: Number of counties using or planning to use different ASAM-based tools for initial, full assessment and re-assessment
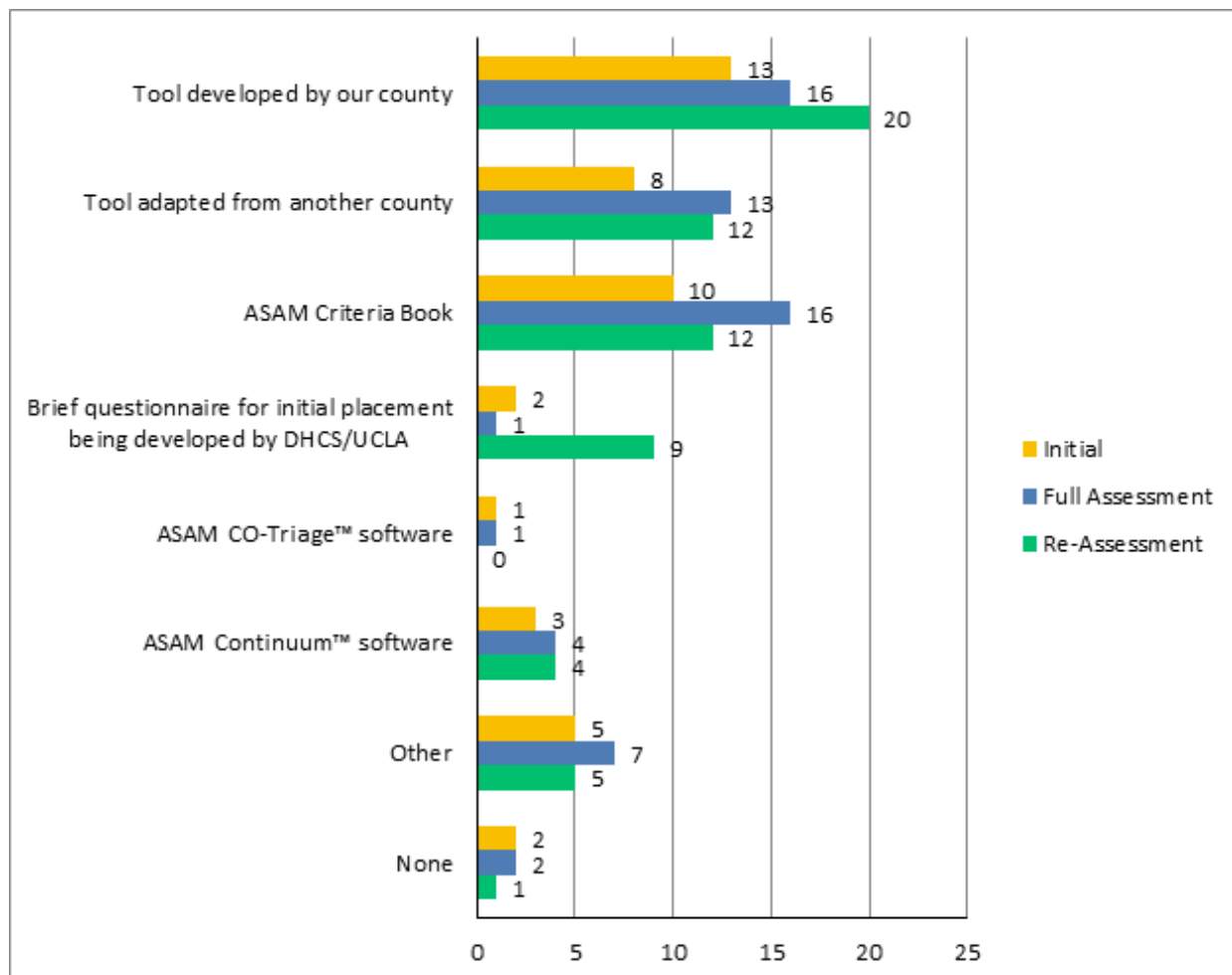
Survey respondents who indicated "Other" were asked to specify the tools they are using or planning to use. Below are selected respondent comments, which illustrate the diversity of initial assessment, full assessment, and/or re-assessment tools.

- *Will move toward CONTINUUM but for year 1 using a paper based [tool]*
- *Our EHR already has ASAM*
- *Our assessment tool has been put together using information from multiple tools/counties*
- *ASAM Framework developed by the Department*
- *ASI (Addiction Severity Index)*
- *We are currently using SU Assessment as per our Anasazi Software*
- *Texas Christian University Screening tools (SUD, MH, Criminal Thinking)*
- *Tools developed by SUD Providers*

While use of the ASAM Criteria for assessment and placement appears to have increased from 2015 to 2017 according to the County Administrator Surveys, implementation has nevertheless been somewhat challenging for some as shown by the increasing trend for the Live-Waiver and Pre-Implementation Waiver counties. (See Figure 3.3 below.)

Figure 3.3: Mean rating of challenge level for implementing ASAM assessment and placement

---
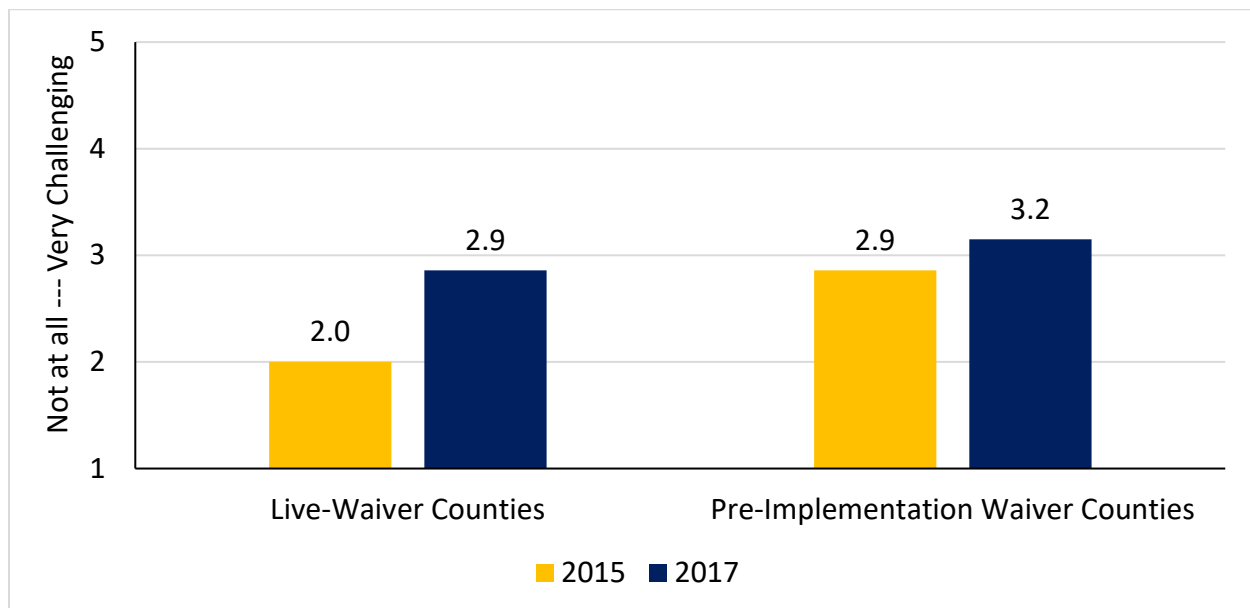
Interviews conducted with county administrators from Live-Waiver counties provide some insight into some of the challenges in implementing ASAM Criteria-based assessment and placement, which represents a cultural shift for many providers. Some administrators indicated that not surprisingly, many providers were more comfortable with the tools and clinical practices that they were already familiar with, and which they felt had been effective; thus, some providers resisted the implementation of ASAM assessments. Similarly, patients have had concerns about ASAM assessments, expressing that "*the ASAM kind of dictates their level of care.*" This concern is particularly prominent, one administrator reported, among patients for whom residential treatment was the only source of housing available. This administrator's comment highlights the need for housing

assistance (e.g., transitional housing, recovery residences): *"Some of them (patients)…were becoming fearful when the ASAM was coming along for them when they were scheduled to have their next ASAM to determine whether they were going to have a place to live or not, at that point."*

For some providers, adjusting to ASAM assessments has been particularly challenging since they are accustomed to different types of documentation. In particular, one administrator reported that the changes associated with ASAM implementation were very difficult for methadone providers. In this county, one methadone provider analyzed ASAM paperwork required by the county and found that in spite of its comprehensiveness, it did not include all of the paperwork required for methadone programs:

> *"The assessments that's required in Title 9 for methadone clinics, or Title 22 I guess it is, includes ten points that if they're not there, you'll be dinged and you'll be told you don't have the complete assessment. They're based on the ASI (Addiction Severity Index), not on the ASAM conventions. Some of the programs have added that to our tool at the bottom just to be sure that they hit all the points. Other programs have decided to do both the ASAM and the ASI."*

Among other providers, administrators reported that the length of ASAM assessments has slowed the rate at which programs can conduct assessments and begin admissions. *"It's constrained the rate of admission because the full ASAM takes longer than a lot of the…previous tools that some providers were using,"* explained one administrator. *"Also…reconfiguring of staff so that they could keep up the pace of admissions"* while conducting full assessments was a challenge for many providers.

Administrators suggested that in addition to the ASAM courses available online, further on-site hands-on training would be helpful in addressing many of the challenges providers are experiencing due to the cultural/system shift that the DMC-ODS is creating. In addition, they recommended that the ASAM Criteria be integrated into all future counselor training in California so that providers become fully proficient in conducting ASAM assessments.

<u>ASAM LOC placement data</u>

LOC data are being collected in Live-Waiver counties for the first time. Data for some counties have been delayed by technical issues, but data for three Live-Waiver counties were available for analysis from San Mateo, Santa Clara, and Marin. Data for the other counties are expected to be available for future reports.

Data are collected on three types of screenings or assessments:
- Brief Initial Screen - a short screening to determine a preliminary LOC placement;
- Initial Assessment - a longer, comprehensive assessment to determine the LOC recommendation and establish medical necessity; and

- Follow-up assessment - any re-assessment following an initial assessment that occurs during the same treatment episode.

Up to three indicated and two actual LOCs/Withdrawal Management (WM) can be recorded:

- Indicated LOC/WM - initial recommendations according to the screening/assessment instrument being used (prior to taking the patient's preference into account). For example, the indicated LOC/WM is listed under "Final Level of Care Recommendations" if using the CONTINUUM™ software.
- Actual LOC/ WM placement decision - actual LOC/WM decided upon after patient input.

The options for LOC are listed below. These include treatment settings that patients are referred to initially (e.g., outpatient/intensive outpatient) with the exact LOC (e.g., ASAM Level 2.1) "to be determined" after a full ASAM assessment has been conducted. The list also includes WM levels, which can be combined with ASAM LOCs.

None
Outpatient/Intensive Outpatient (OP/IOP), exact level TBD
Residential, exact level TBD
WM, exact level TBD
Ambulatory WM, exact level TBD
Residential/Inpatient WM, exact level TBD
Narcotic Treatment Program/Opiate Treatment Program (NTP/OTP)
0.5 Early Intervention
1.0 OP
2.1 IOP
2.5 Partial Hospitalization
3.1 Clinically Managed Low-Intensity Residential
3.3 Clinically Managed Population-Specific High-Intensity Residential
3.5 Clinically Managed High-Intensity Residential Services
3.7 Medically Monitored Intensive Inpatient Services
4.0 Medically Managed Intensive Inpatient Services
1-WM Ambulatory WM without Extended Onsite Monitoring
2-WM Ambulatory WM with Extended Onsite Monitoring
3.2-WM Clinically Managed Residential WM
3.7-WM Medically Monitored Inpatient WM
4-WM Medically Managed Intensive Inpatient WM

If at least one of the indicated and actual LOCs do not match, providers are asked to select the reason for the mismatch. The options are:

Not applicable - no difference
Clinical judgement
Lack of insurance / payment source
Legal issues

Level of care not available
Managed care refusal
Patient preference
Geographic accessibility
Family responsibility
Language
Used two residential stays in a year already.
Other

As shown in Figure 3.4, most treatment referrals were made to the same LOC indicated on the screening or assessment, including 92.9% of the time for brief screenings and 89.0% of the time for the in-depth initial assessments. When the actual placement decision could not be confirmed to match the indicated LOC, it was generally either because the actual placement decision was missing (i.e. a match may have actually occurred but the data are missing), or the patient was referred to a lower LOC than indicated. Patients were almost never referred to a higher LOC than indicated.

Figure 3.4: LOC placement decisions for three Live-Waiver counties
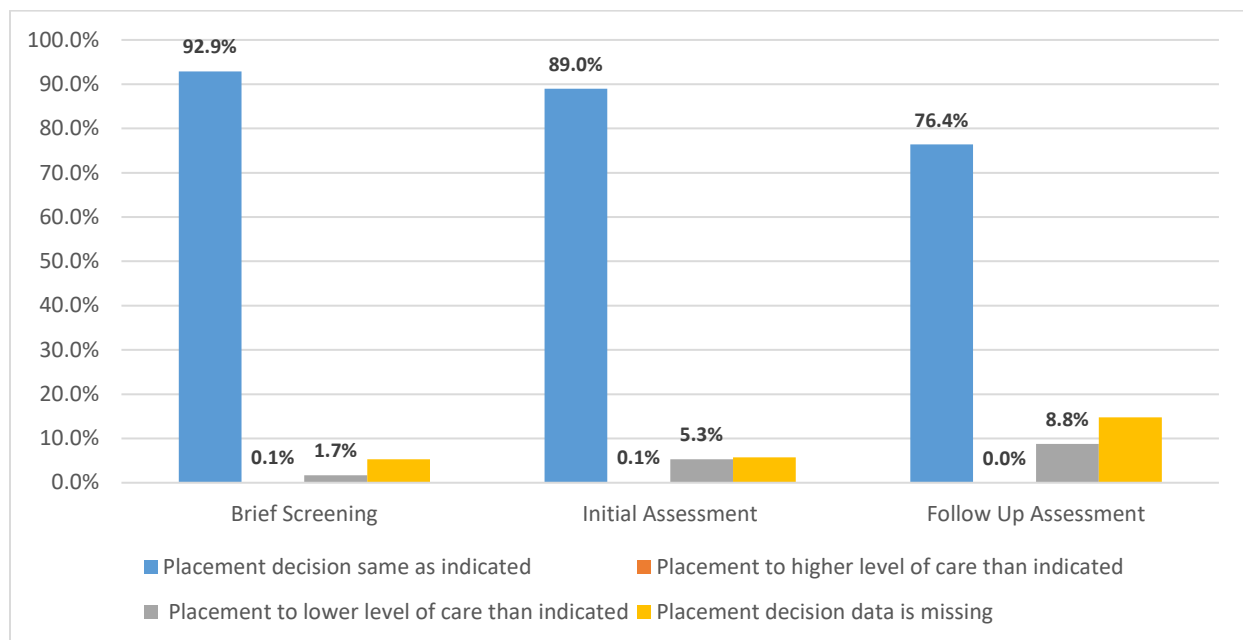
Among cases where indicated and actual levels of care did not match, the reasons differed depending on the type of screening or assessment. (See Figure 3.5 below.)

- For brief screens, the most frequent reason (30.9%) was missing data on the actual placement decision, making it impossible to confirm a match between indicated and actual levels of care (one may have actually occurred). Next most frequent was patient preference (29.9%). It was rare for the mismatch to occur due to clinical judgement (2.1%) or unavailability of the LOC (8.2%).

- For initial assessments, the most frequent reason was missing data on the actual placement and clinical judgement (both 27.5%), followed up by unavailability of the indicated LOC (21.1%).
- For follow-up assessments, the primary reason for differences between indicated and actual LOC was patient preference (45.7%).

In addition, patients whose indicated and placement decision levels of care were the same had a positive discharge status (completed treatment or left with satisfactory progress) 64.9% of the time, compared to patients whose levels of care did not match (63.0%).

Figure 3.5: Reasons for difference between indicated LOC and placement decision
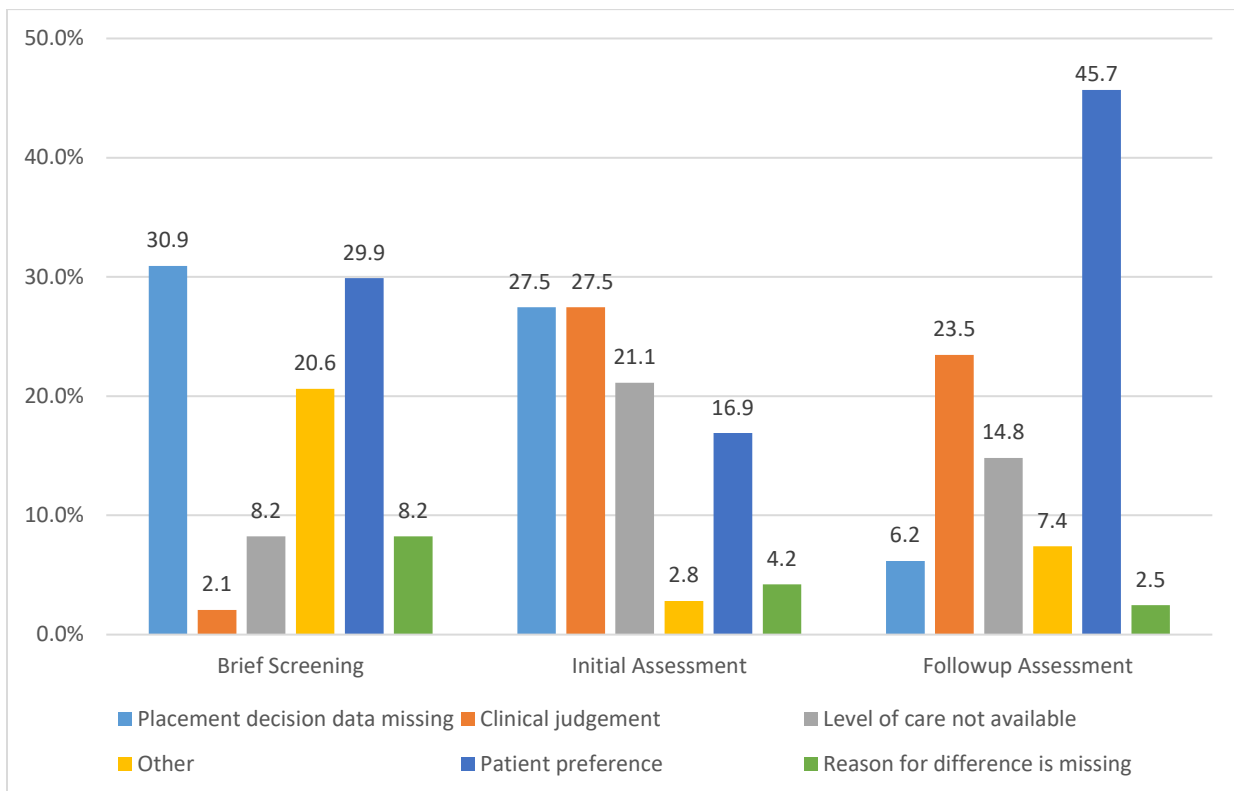
This is only a preliminary analysis of the first set of LOC placement data to arrive from three counties. UCLA will continue to collect and analyze this data and collect additional information to increase understanding of the reasons for the patterns found.

Youth-specific ASAM Criteria-based tools

In the 2017 County Administrator 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. Although only 16.3% of all counties reported that they are using such a tool, more than half (59.2%) indicated that they are planning to use an ASAM Criteria-based tool for youth (data not shown). Among the Live-Waiver counties, which are required to use an ASAM Criteria tool to assess all patients, three counties reported that the ASAM tool they are currently using was developed specifically for youth, while three other counties are planning to use such a tool, and one county is not using and does not plan to use such a tool. UCLA will continue to track the use of youth-specific screening and ASAM criteria-based assessment tools over the course of the DMC-ODS.

Utilization management (UM)

The intent of a UM program is to assure that patients have appropriate access to SUD services; medical necessity has been established; the patient is in the appropriate ASAM LOC; and that the interventions are appropriate for the diagnosis and LOC. According to County Administrator Survey data shown in Figure 3.6, among the Live-Waiver group there is a trend toward greater availability of UM. However, there was a statistically insignificant decrease from 54.2% in 2015 to 47.8% in 2017 for the Pre-Implementation counties, which created a larger gap between the Live-Waiver and Pre-Implementation groups. It is unclear what may have contributed to this trend, although it may be that, similar to the patterns seen for some of the other requirements under the DMC-ODS (e.g., Licensed Practitioners of the Healing Arts [LPHAs], physician consultation), once administrators learned the details, they revised their responses (e.g., implementation status) from the initial 2015 County Administrator Survey. UCLA will further investigate this area (e.g., upcoming administrator interviews and surveys).

In addition, there was an unexpected increasing trend from 30.8% in 2015 to 75.0% in 2017 for the Non-Waiver counties. A few Non-Waiver county administrators were contacted to try to better understand the trend. Administrators from two counties indicated that because they have integrated behavioral health departments, they are *"able to leverage resources"* from the mental health side as one administrator put it. The other administrator explained that the *"mental health side has a very structured UR [utilization review] system and I have my own system for doing UR for our SUD program (very simplified). As we become Medi-Cal certified I'm sure I will be learning a whole new way of doing things. It's my guess this could be true for other counties?"* Given that Non-Waiver counties are now required to provide all covered DMC services per Mental Health and Substance Use Disorders (MHSUDS) Information Notice Number 18-009, it is possible that more counties will obtain DMC certification and continue the trend toward providing UM. Similarly, as waiver counties implement, or prepare to implement, the DMC-ODS waiver, UM availability is expected to rise.

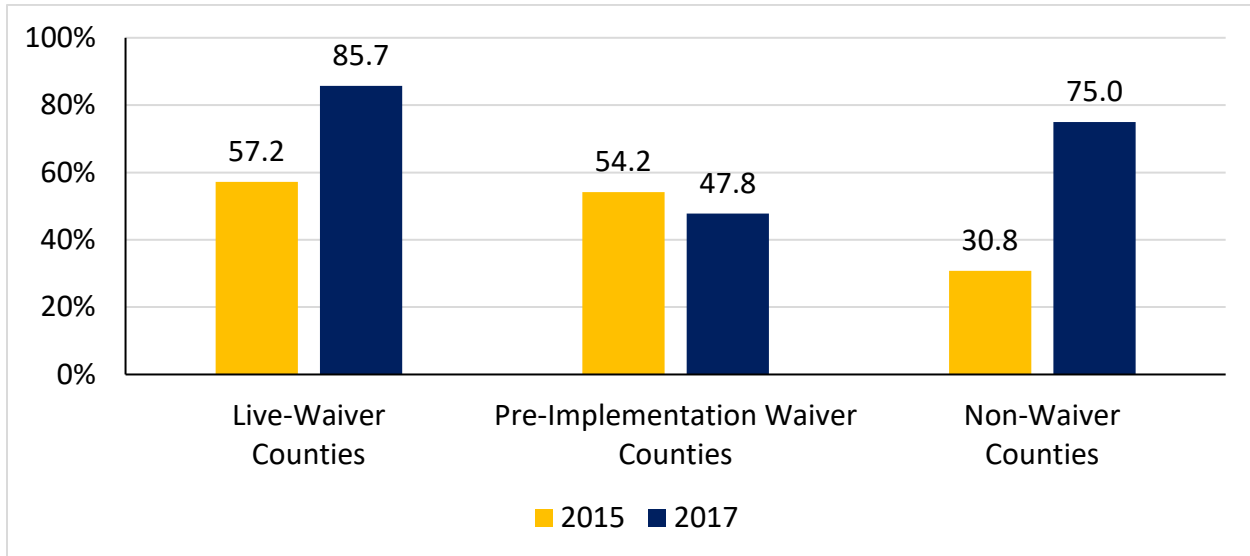**Figure 3.6: Percentage of counties with UM available for adult patients**

Figure 3.7 suggests UM challenges increased in Live-Waiver counties even as they availability of UM increased. In contrast, among the Pre-Implementation counties, both the availability and level of challenge of implementing a UM program decreased slightly. These results suggest that there is a challenging learning curve as counties begin implementing UM management programs. As counties gain more experience and refine their UM processes, these challenges may recede. To facilitate this, training or technical assistance in this area may be helpful.

Figure 3.7: Mean rating of challenge level for implementing UM
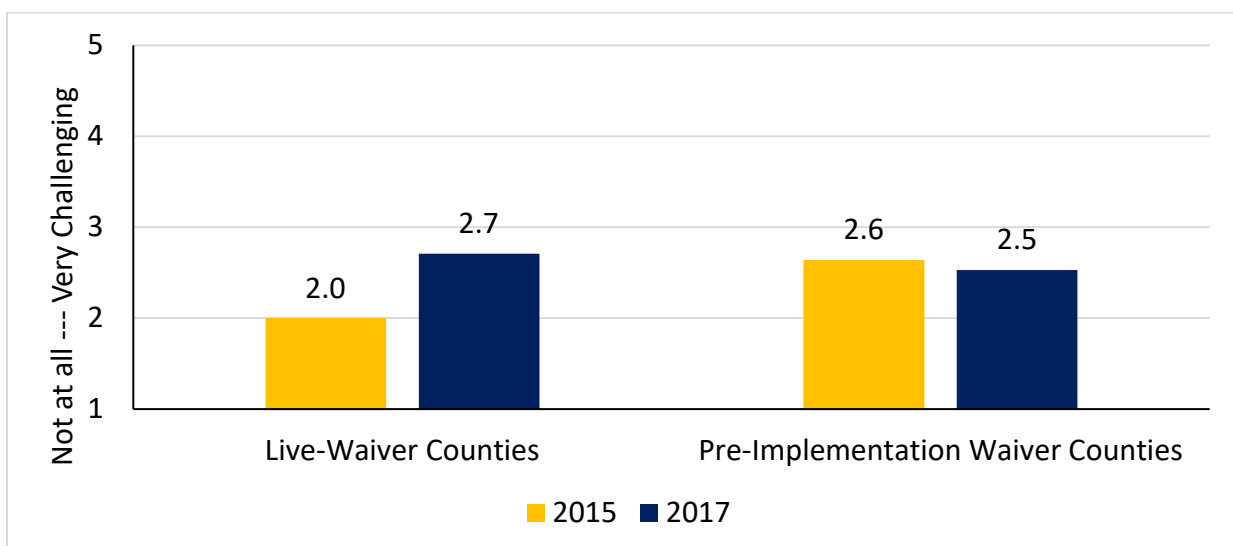
Interviews with county administrators, again, provide some insight in to the nature of the challenges that some counties and providers are experiencing as they implement use of the ASAM Criteria and UM, both of which typically represent major changes for treatment delivery systems. One administrator summarized the significant challenge the implementation of UM under the DMC-ODS has created for counties by saying, *"Any time you roll out a massive new workflow, there will be kinks."* Similarly, another commented, *"there's still a lot of work in our system…it takes a while to learn how to do something new and different, and to do it well."*

In particular, providers were unaccustomed to providing adequate clinical documentation to justify levels of care, particularly in cases when they believed that higher levels of care were necessary than those indicated by ASAM assessments. An administrator explained:

> *"If you feel strongly that you want to, as a clinician, override what ASAM is saying, you have to make a strong argument there for us to authorize a higher level of care …and teaching the workforce that was a real challenge."*

Treatment Engagement

Patient engagement is essential for treatment success. UCLA used DMC claims data through December 31, 2017 to track treatment engagement, as measured by three visits within the first 30 days. Engagement rates varied between treatment modalities, ranging from 53.6% in outpatient treatment to 96.0% in residential (sees Figure 3.8)... These figures are consistent with or above engagement rates in the literature. For example, Garnick et al. (2009) reported outpatient engagement rates of 47% averaged across five states, with states ranging from 24% to 67%. California's rate of 53.6% is in that same range and slightly above the average. The same study reported an average of 62% engagement in intensive outpatient across three states (range: 34%-75%). California's rate of 91.9% exceeds that at this point. UCLA will continue to monitor this measure as additional counties "go live".

Figure 3.8: Successful treatment engagement by modality of service
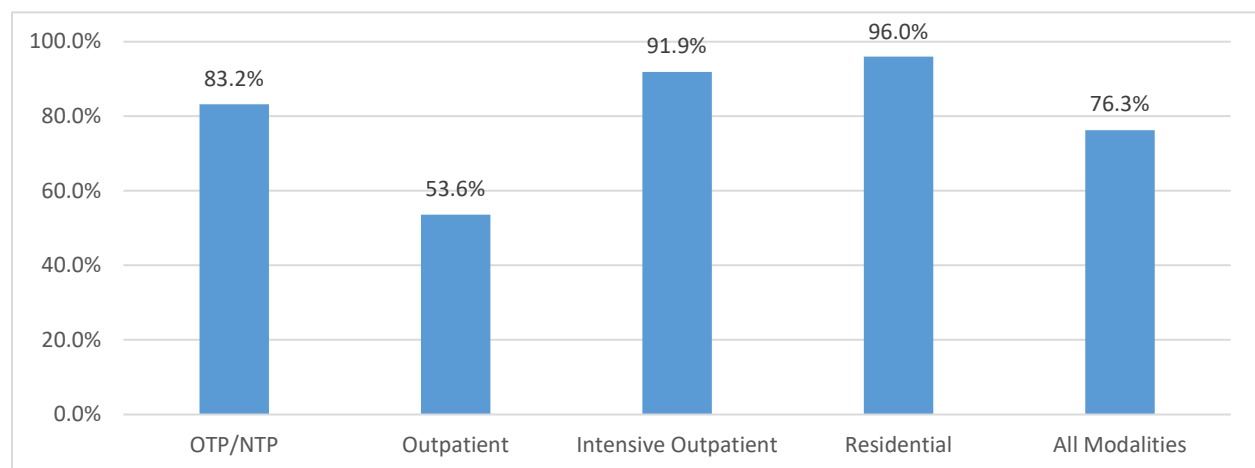
Care Transitions

Patients are expected to move along the continuum of care and receive additional services 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. Drug Medi-Cal claims data through December 31, 2017 were analyzed to measure whether patients received additional services in a timely manner following Residential services and Non-NTP WM. As shown in Figures 3.9 and 3.10, most patients who received residential treatment (86.4%) or withdrawal management (72.6%) in Live-Waiver counties (after they "went live") did not receive subsequent services within 14 days of discharge.

Figure 3.9: Live-Waiver counties - Service delivery following residential treatment (transition within 14 days)
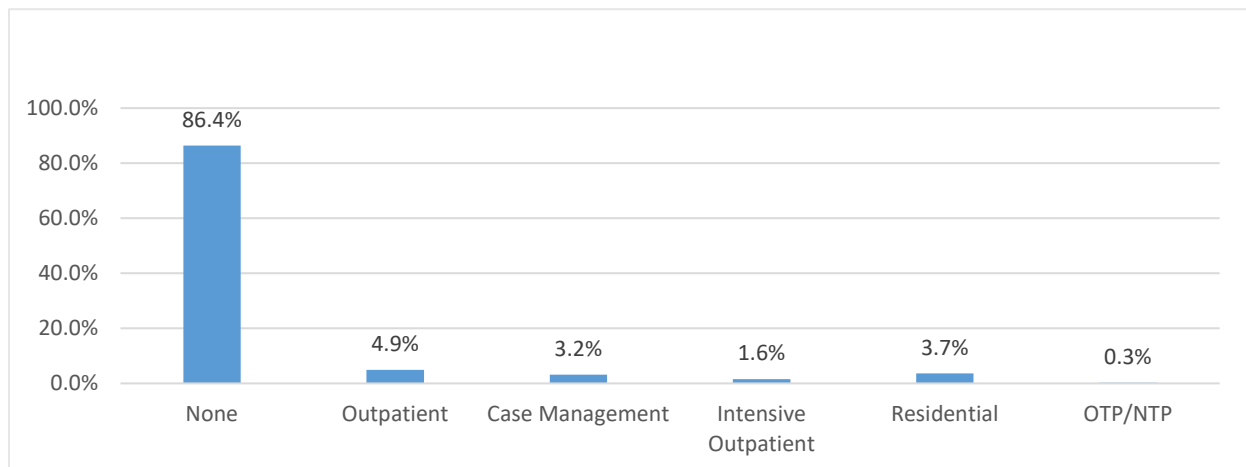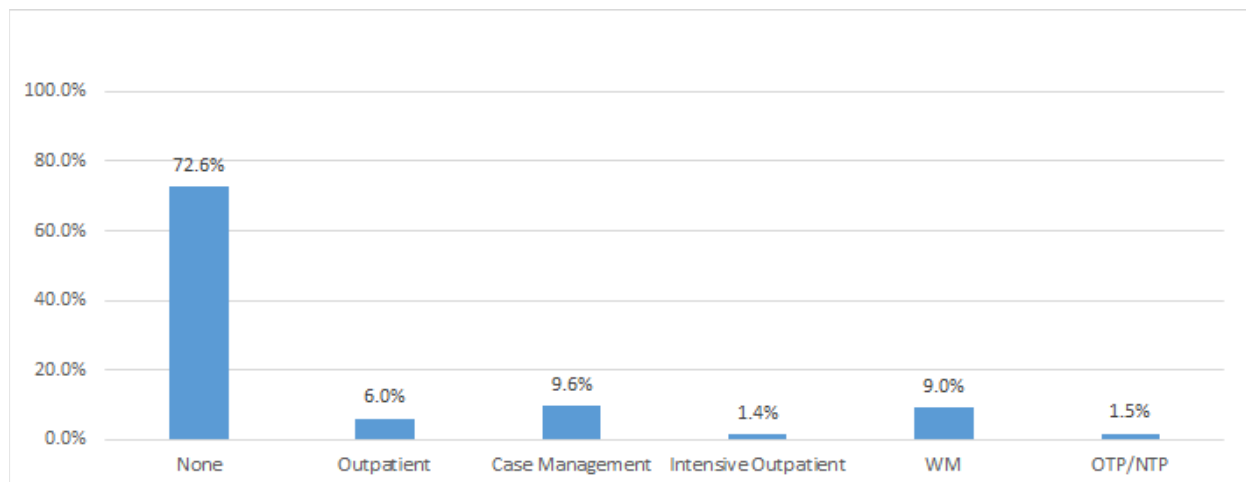

Figure 3.10: Live-Waiver counties – Service delivery following Non-NTP withdrawal management (transition within 14 days)

Interviews with Live-Waiver county administrators offer some insight into patient transitions to other levels of care. Some counties reported that even when they are able to collect data concerning the appropriateness of patient transfer or flow through the SUD continuum, they are not necessarily seeing patients switch levels of care. As one administrator elaborated:

> *"What we're not seeing is the actual transfer of the client. I'm seeing a lot of clients that are completing today in a residential facility with no plans of actually going to a lower level of care. I do see that in the ASAM, the client is no longer appropriate for (ASAM level) 3.1, more appropriate for level one…. (But) I haven't actually seen a client moving to another level of care. We should be discussing every week, 'Tomorrow or next week, Joe is gonna be ending 3.1, our plan is to connect him to level one. Here is the information on the client, let's be ready for the client.' We're not there yet, but I do think that the case management structure is gonna help us do that."*

Administrators also shared observations on the data they had concerning patient flow along the continuum of care in their counties. In one county, an administrator reported that the key to facilitating patient flow was to limit the use of residential services, reserving them only to stabilize patients before moving them on to more lengthy and rehabilitative treatment episodes in outpatient settings:

> *"We're only using residential as a stabilization component. We're looking that the majority of rehab is gonna happen in the outpatient program (so the) key is identifying residential as stabilization and then discharge to outpatient. With ASAM now, the definition of residential is placement of an individual in imminent danger. That's a much higher bar than traditionally what residential programs have used as the appropriate placement of individuals in their system…where they have residentials that have pretty much been on their own, 90-to-180 day stay, that's gonna be a struggle to either convince them or contract with them in a different manner and actually get them to focus on that stabilization component of recovery."*

In another county, an administrator observed that when LOC care transitions happen, they tend to be from residential services to outpatient, with little use of the intensive outpatient level. *"A lot of clients are being reassessed past the level 2.1 and going directly to 1.0"* the administrator observed. *"(We need to) work with our staff to get them to better realize when somebody is ready to step down to the intermediate level of care, the IOP, rather than going directly to outpatient."*

Similarly, administrators described the need for a "culture shift" so that both providers and patients could become accustomed to the idea of transitioning through the care continuum instead of having just one standalone treatment episode. As one administrator explained:

"I think that's where our biggest barrier with ASAM has been. Because it's really a different philosophy…not just providers and counselors but also the clients themselves have (believed that) when they're done with residential treatment, they're done. Not to another level of care or something. That doesn't compute for most."

Tracking Patient Movement along the SUD Continuum of Care

As patients move to different levels of care within an organized delivery system, it is important that treatment be coordinated, patient referrals and movement be routinely tracked and monitored, and pertinent patient information be shared to facilitate transitions and identify areas for improvement. Data from the 2015 and 2017 County Administrator Surveys and qualitative interviews with administrators from Live-Waiver counties were used to examine various aspects of patient movement within SUD treatment delivery systems.

According to the County Administrator Survey, Live-Waiver counties tended to increase sharing/tracking/monitoring of patient data along the SUD continuum of care (see Figure 3.11). It is notable, however, that among both the Pre-Implementation Waiver and Non-Waiver counties there was a decrease in sharing/tracking/monitoring this data. This trend for the Pre-Implementation Waiver counties is somewhat surprising, and merits further exploration. It is conceivable that as counties gain a better understanding of what is required under the DMC-ODS, and immerse themselves in waiver preparation, that they will re-evaluate their capacity to share, track and monitor patient data along the continuum of care.

Figure 3.11: Percent of counties indicating that the sharing/tracking/monitoring of patient data along the SUD continuum of care is fully or partially available
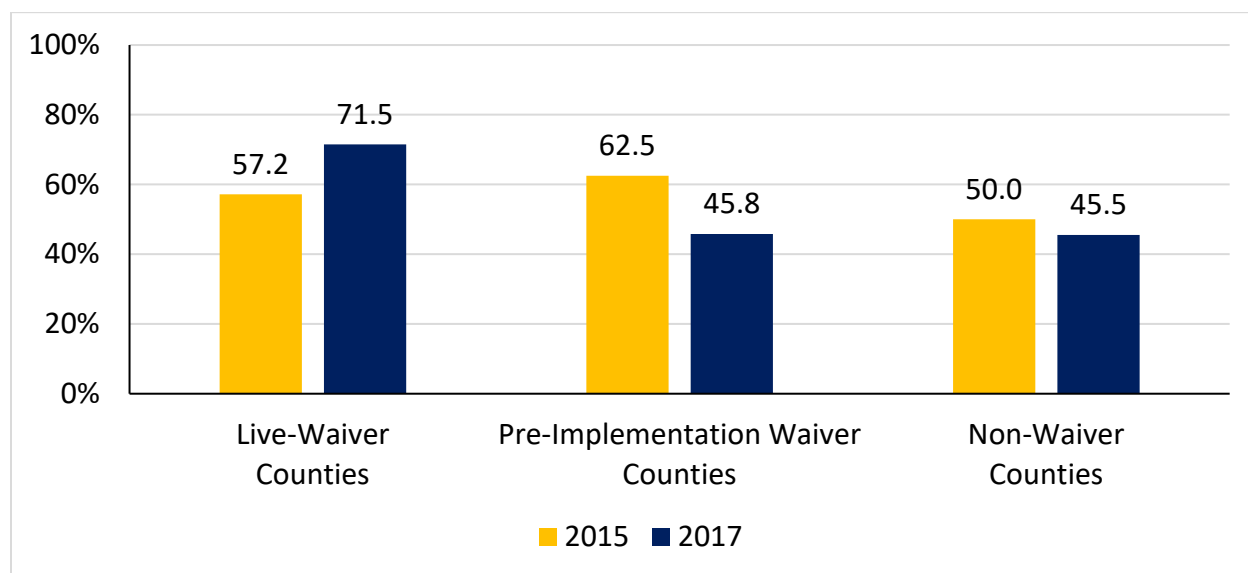
Interestingly, although the trends were in the opposite directions for the Live-Waiver (increasing) and Pre-Implementation Waiver (decreasing) counties as previously noted, the ability to share/track/monitor patient data did not appear to be especially challenging. (See Figure 3.12 below.) Further, only slight increases were observed between 2015 and 2017 for both groups.

Figure 3.12: Mean rating of challenge level for sharing/tracking/monitoring of patient data along the SUD continuum of care
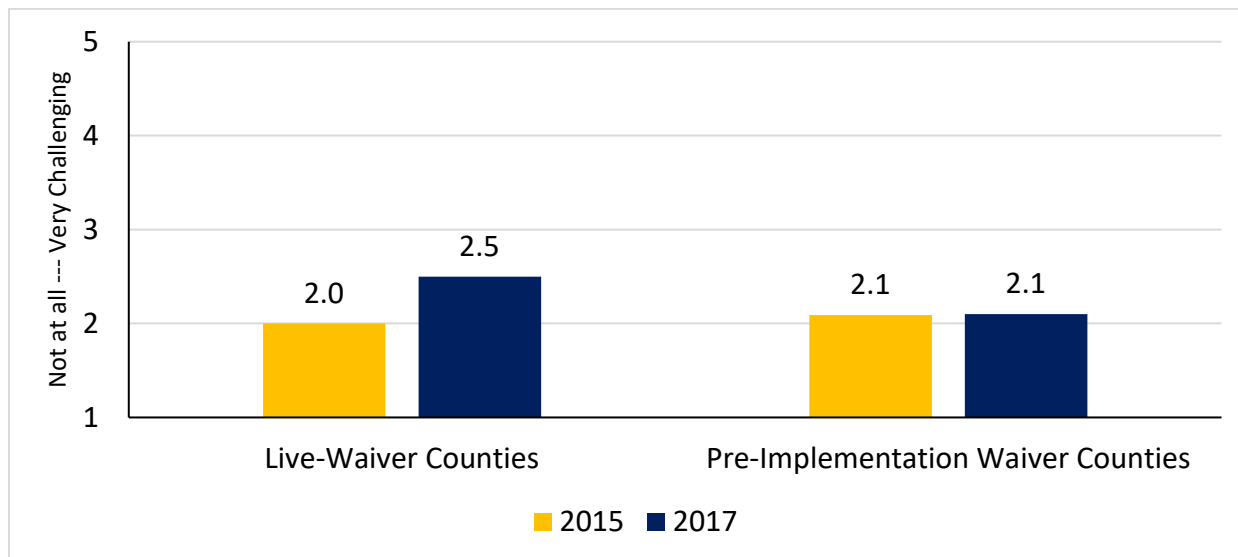
Administrators from Live-Waiver counties described successes and challenges in tracking patients from one ASAM LOC to another. One administrator reported, *"We're able to identify the…ability of moving people from one level of care to another, timely access, all of that."* The administrator added, *"That's data that we are capturing and actually feeding back to the system on a regular basis."*

However, other county administrators reported challenges collecting data that can be used to effectively track patient movement. As one administrator explained:

> *"We don't have a coordinated system of gathering data. We don't have a really good EHR (electronic health record) system that we're inputting…our providers are small providers, CBOs (community-based organizations) and they don't have EHRs, or if they do, it's something separate from what we are using. There's really no consolidated data collection system for us… (so) our biggest struggle is trying to get the data."*

As another county administrator described, the requirement for pre-authorization for residential care or county case management services can help provide insights into patient movement in the absence of comprehensive EHR systems capable of patient tracking:

> *"Right now we don't have all the systems in place in our electronic health record to be able to…actually really see how well that (client transfer) happens. The places where we actually can see how well it happens are either, one, when there's a residential authorization required, or two, if it's a place where one of our own county case managers who's working as a care coordinator is working with the client."*

In addition, administrators reported that they are able to use billing data to track patient movement through their systems of care, by using it to *"see what service was provided when, and what duration. Then you can see how the client moves…the billing information for us is probably going to be the most robust."*

County administrators were also asked on the 2017 survey to rate how well their counties track referrals and patient movement within the SUD system. As shown in Figure 3.13, the Non-Waiver group rated their counties as doing fairly well in this area, followed by the Live-Waiver, and then the Pre-Implementation Waiver group.

Figure 3.13: How well counties track referrals and patient movement within the SUD system
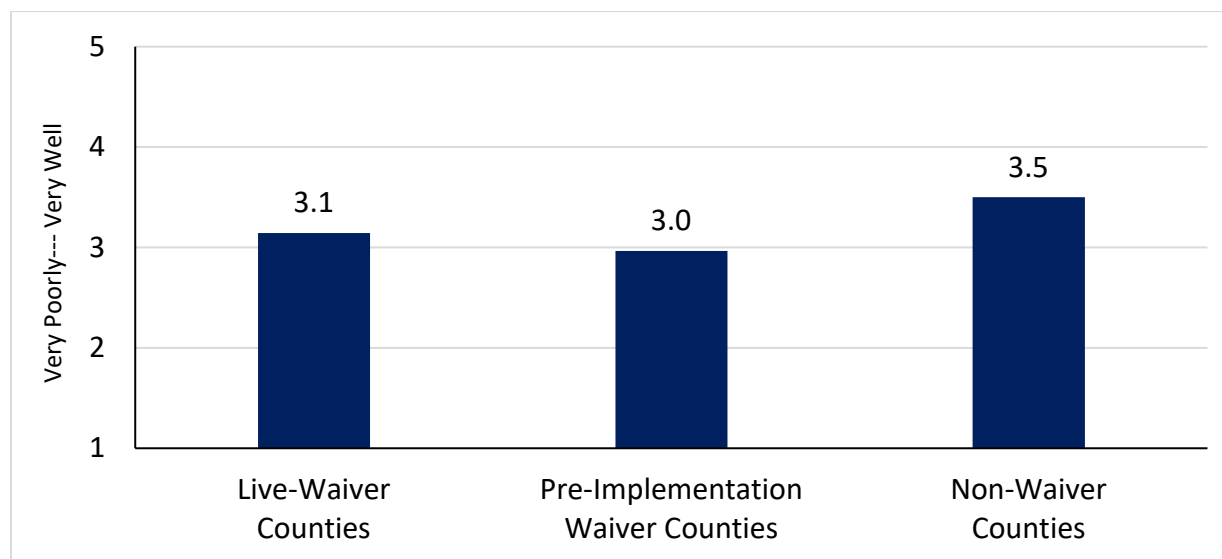
Comments from the County Administrator Survey respondents shed some light on the findings above. One of the Live-Waiver county administrators indicated that the county is *"just starting to develop the necessary structure to document client movement in the SUD system."* Another county administrator wrote that they *"need reporting (unit) to help us with the tracking,"* whereas another respondent identified 42 CFR, part 2 privacy rules as a "*major barrier*" in that tracking referrals and patient movement within the SUD system *"can be tracked only by central county QM (quality management), i.e. not in (the) normal course of care."*

Not surprisingly, comments from the Pre-Implementation Waiver group indicate that counties are at various stages, and have different systems/procedures for tracking patients. Several counties briefly described how their existing systems are working, including extensive monitoring of all clients in some counties to focusing on narrower populations including patients in residential treatment, collaborative courts, or wraparound programs.

Other comments from the Pre-Implementation Waiver group suggest that tracking systems do not currently exist in some counties, *and/*or are being developed.

In comparison to Live-Waiver and Pre-Implementation Waiver counties, several survey respondents from Non-Waiver counties commented that they *"have a system in place*" or can *"access and track referral info from our EHR."* Other respondents indicated that tracking referrals and patient movement is easier given the small size of their respective SUD treatment delivery systems.

Live-Waiver and Pre-Implementation Waiver counties appear to be in various stages of developing, implementing and refining their systems toward effectively and efficiently tracking referrals and patient movement within the SUD systems. Changes in the how well counties track patient movement will continue to be monitored across the waiver period.

Electronic Health Records (EHR) systems

While counties are not required to have EHR systems for SUD under the DMC-ODS, having such systems that are countywide and interoperable would likely facilitate improvements in the quality of care. EHR systems could, for example, potentially help counties efficiently track and monitor patient movement along the continuum of SUD care, share patient data as patients transition along the continuum, and help identify areas in the service delivery system that are problematic or working especially well. According to 2017 County Administrator Survey respondents, the group with the highest percentage of countywide EHR systems for SUD were the Live-Waiver counties, followed by the Non-Waiver counties, and then the Pre-Implementation Waiver counties as shown in Figure 3.14 below. According to administrators in a few Non-Waiver counties, a possible explanation for the relatively high percentage of Non-Waiver counties with countywide EHR systems may have to do with the size or the county and having integrated behavioral health departments that make it possible to leverage the resources of both the mental health and SUD sides. One of the administrators described the Non-Waiver counties as *"smaller counties"* that *"run the SUD program out of their Behavioral Health Dept. That is the case for us. Since we are integrated, we all had to use the Electronic Health Record as it was a requirement for the MH side."* It is anticipated that as Live-Waiver and Pre-Implementation Waiver counties continue to prepare for and implement the DMC-ODS, there will be increased implementation of EHR systems for SUD.

Figure 3.14: Percentage of counties with countywide EHR systems for SUD
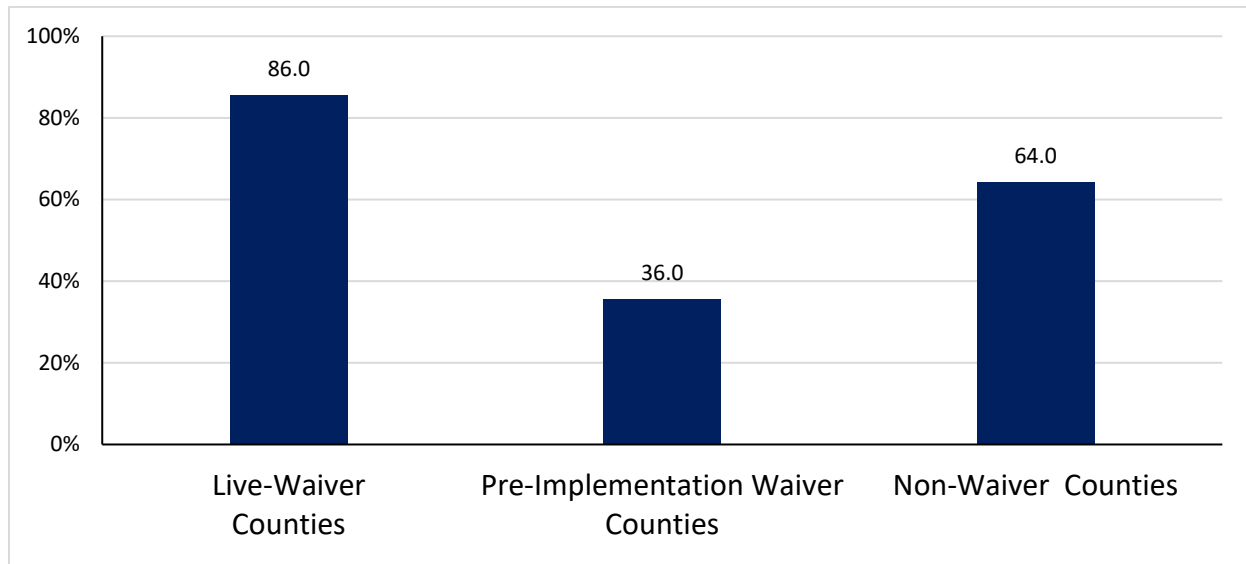
Staffing of Licensed Practitioners of the Healing Arts (LPHAs)

Licensed Practitioners of the Healing 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 2017 County Administrator Surveys (see Figure 3.15) show that by 2017, 100% of the Live-Waiver counties reported having LPHAs, followed by the Pre-Implementation Waiver and Non-Waiver counties, which is not surprising. The differences among the three groups became statistically significant (p=.002) in 2017

The perceived level of challenge in implementing the LPHA requirement among both the Live-Waiver and Pre-Implementation Waiver counties increased slightly, and remained somewhat challenging between 2015 and 2017 as shown in Figure 3.16. It is unclear what factors may have contributed to the increase, but could indicate a workforce issue.

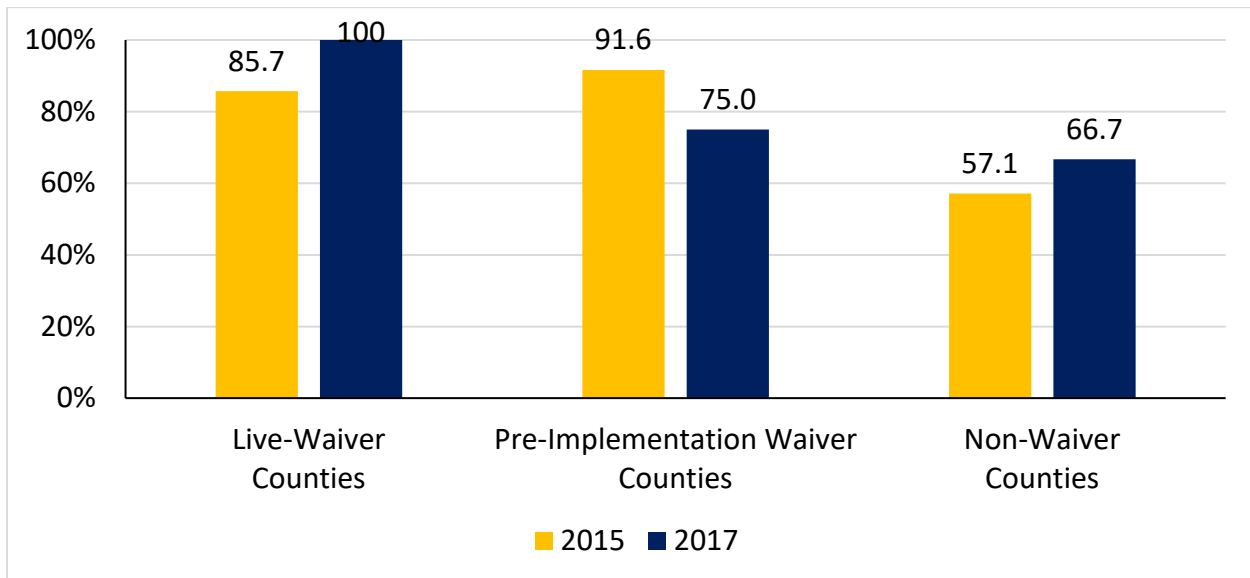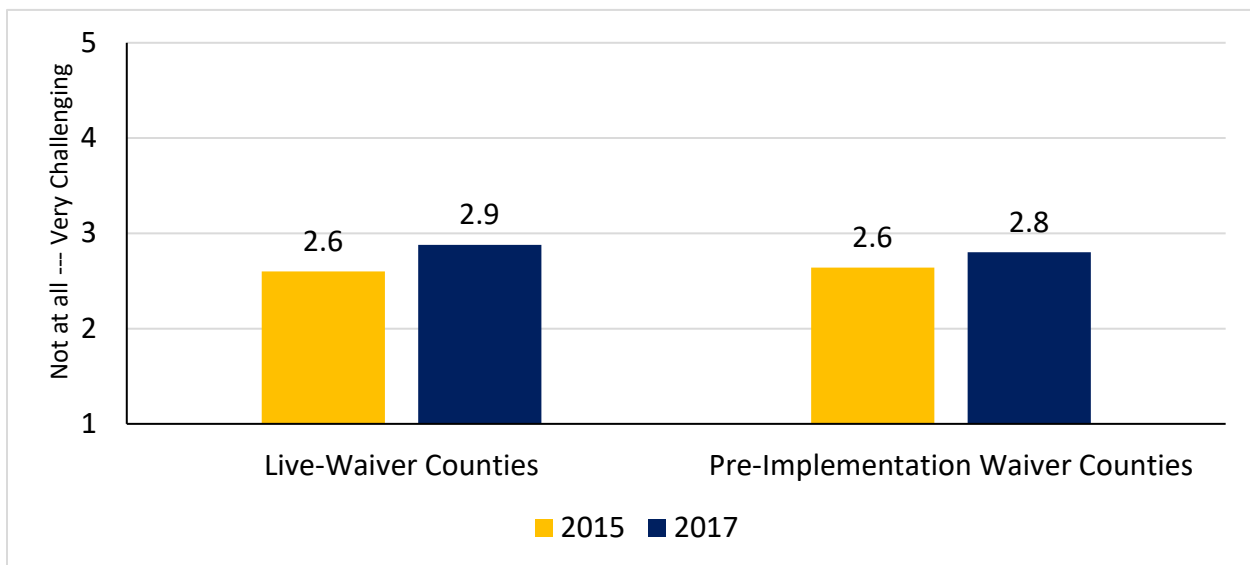**Figure 3.15: Percentage of counties with LPHAs available for adult patients**

**Figure 3.16: Mean rating of challenge level for implementing LPHAs**

Availability of Physician Consultation

Physician consultation services include DMC provider physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists employed by waiver counties. As shown in Figure 3.17, the availability of physician consultation increased among the Live-Waiver counties to 100% in 2017. However, availability in Pre-

Implementation Waiver counties decreased. This finding is unexpected as trends observed in other quality-related components of the DMC-ODS have increased over time for both Live-Waiver and Pre-Implementation counties. As Pre-Implementation Waiver counties begin services, the availability of physician consultant services may increase.

Figure 3.17: Percentage of counties with physician consultation available
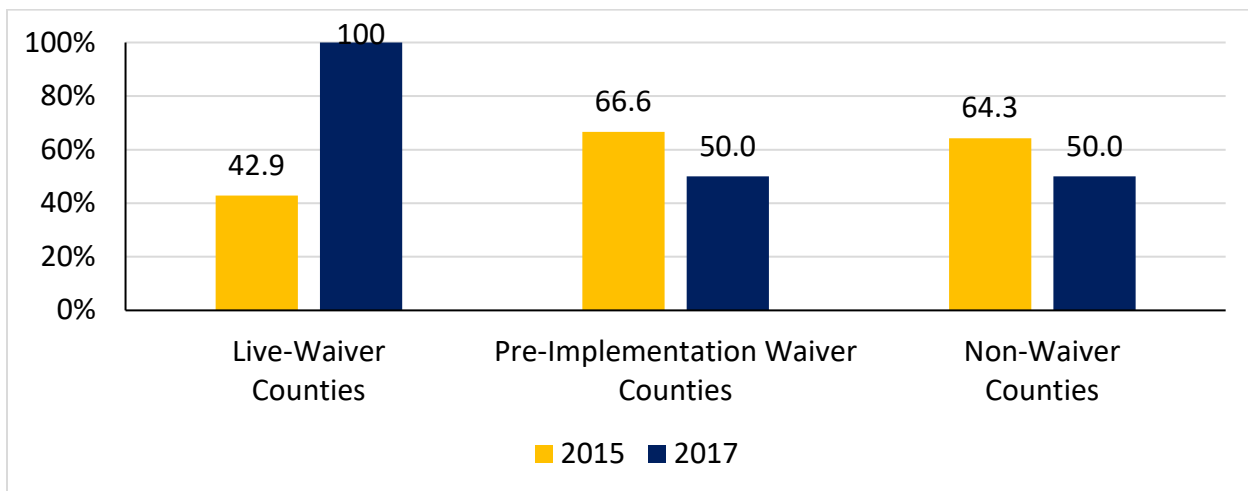
Although Live-Waiver counties have been able to make physician consultation available, such services continue to be somewhat challenging for both the Live and Pre-Implementation groups to implement. See Figure 3.18.

Figure 3.18: Mean challenge level for implementing physician consultation
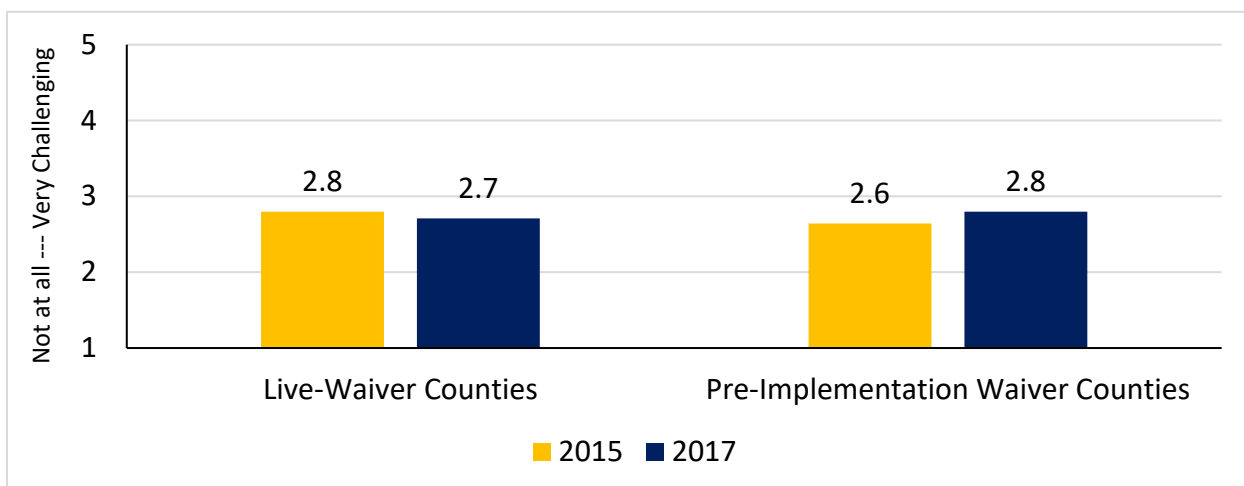

Use of Evidence-Based Practices (EBPs)

Counties opting in to the DMC-ODS are required to use two of the five evidence-based practice listed in the waiver's special terms and conditions (STCs), which lists trauma-
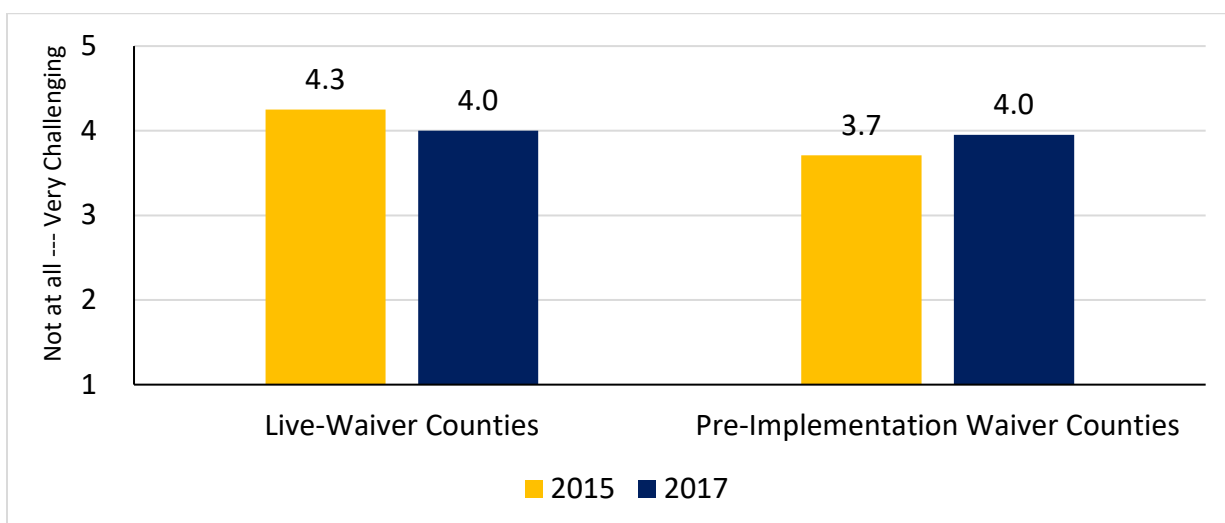
informed treatment, motivational interviewing, cognitive-behavioral therapy, relapse prevention, and psycho-education. As Figure 3.19 illustrates, all seven (100%) Live-Waiver counties and most Pre-Implementation and Non-Waiver counties reported that at least two of the five EBPs listed are fully or partially available in both 2015 and 2017.

Figure 3.19: Percentage of counties with at least two of the five listed EBPs listed in the DMC-ODS waiver available for adult patients
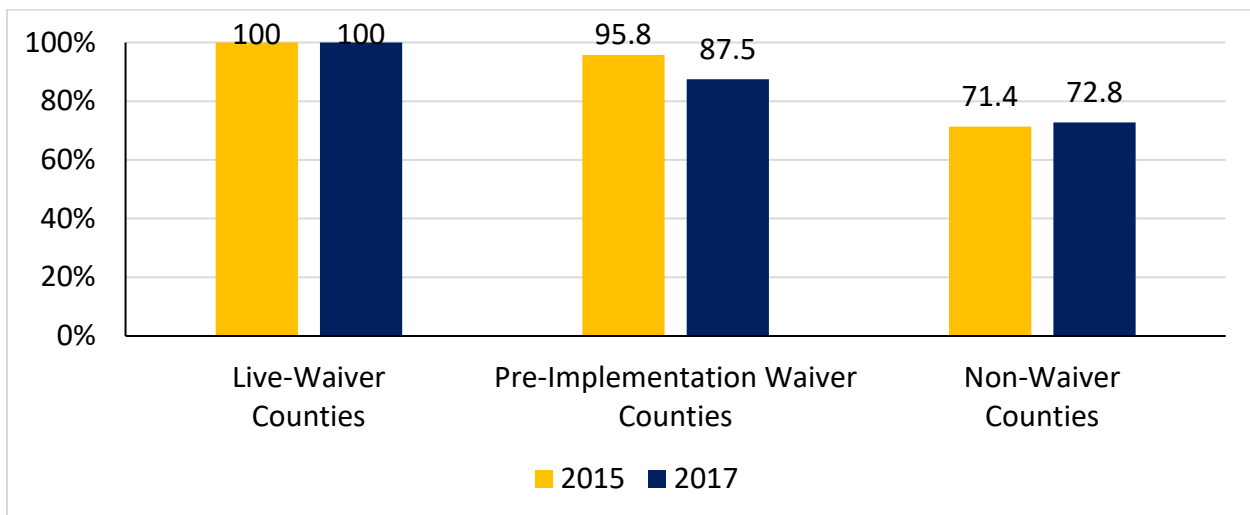
However, although administrators reported that EBPs are available, implementing at least two of the five EBPs listed in the DMC-ODS waiver continues to be challenging for both Live-Waiver and Pre-Implementation Waiver counties. (See Figure 3.20 below.)

Figure 3.20: Mean rating of challenge level for implementing at least two of the five EBPs listed in the DMC-ODS waiver

Administrators were also asked to select the topics that are the highest priority for training and technical assistance. Among the five evidence-based practices listed in the STCs, trauma-informed treatment and motivational interviewing were selected by the most counties (20% each), followed by cognitive behavioral therapy (CBT, 15.6%), relapse prevention (13.3%), and psycho-education (8.9%).

Establishment of Quality Improvement Committees and Plans

Counties that opt in to the DMC-ODS are required to have a Quality Improvement Committee (QIC). According to County Administrator Survey respondents, there was an increasing trend among all three groups as shown in Figure 3.21. Not surprisingly, all seven Live-Waiver counties reported on the 2017 survey that they have a QIC; it is expected that 100% of the Pre-Implementation Waiver counties will have QICs once their DMC-ODS contracts have been executed and as they begin to implement services under DMC-ODS.

With respect to having written SUD treatment system Quality Improvement (QI) plans, County Administrator Survey data in both 2015 and 2017 showed statistically significant differences (p=0.017 and p=0.034, respectively) among the three groups, with the Live-Waiver counties reporting the highest percentage, followed by the Pre-Implementation Waiver counties, and the Non-Waiver counties. (See Figure 3.22.) It is anticipated that the percentage of Live-Waiver and Pre-Implementation Waiver counties with written QI plans will likely increase similar to what has been observed with the QICs.

Figure 3.21: Percentage of counties with a quality improvement committee that includes SUD participation
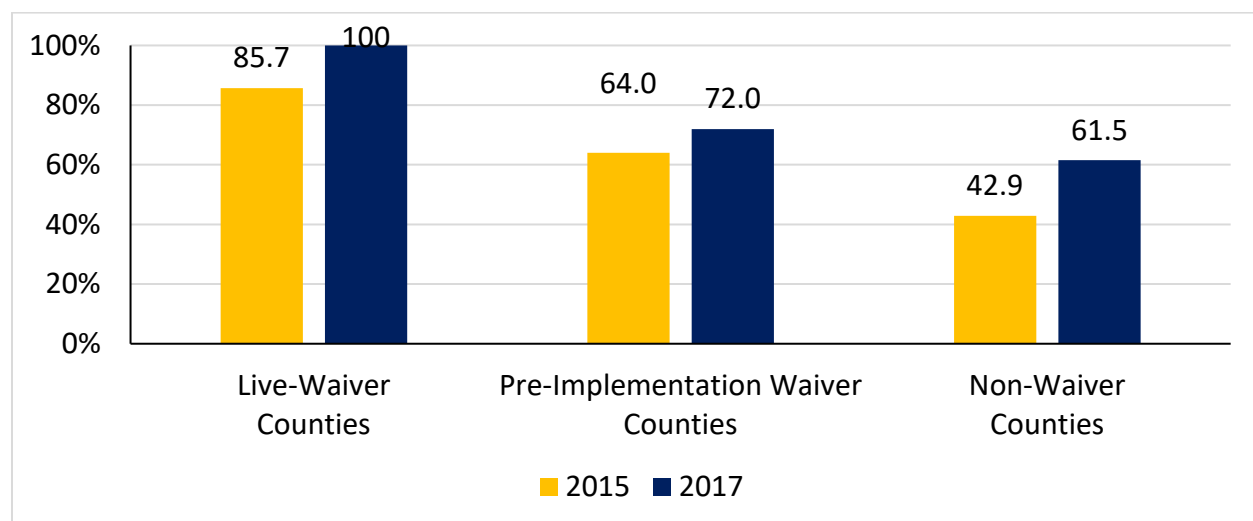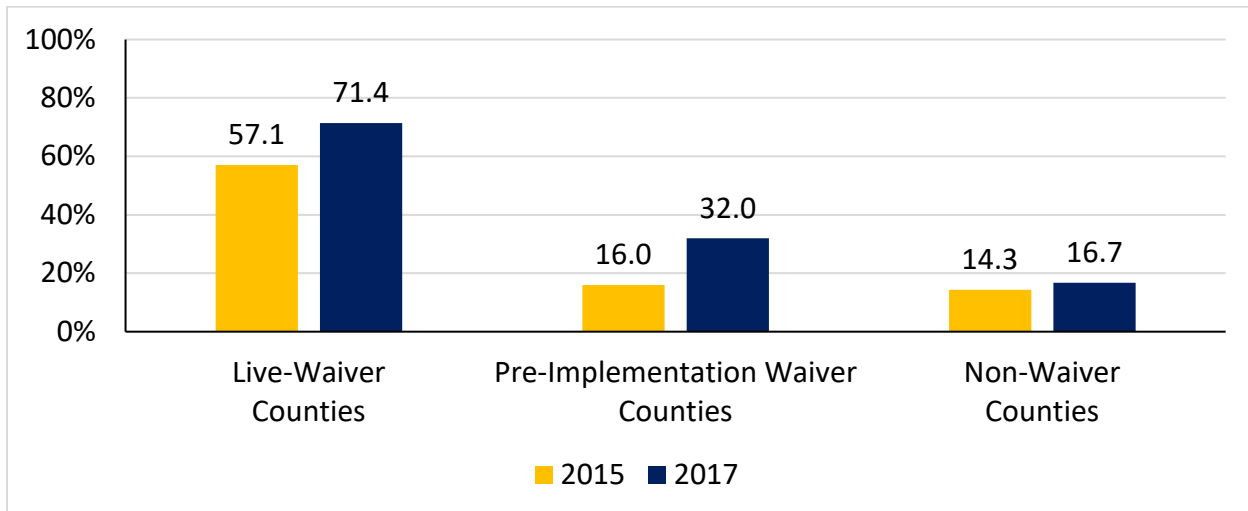
**Figure 3.22: Percentage of counties with a written substance use disorder treatment system QI plan**

Data in Figure 3.23 indicate that the DMC-ODS waiver has already been having an influence on Live-Waiver and Pre-Implementation Waiver counties' QI efforts according to County 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. By 2017, 100% of the Live-Waiver counties reported that the DMC-ODS had a positive impact on their quality improvement activities for SUD, followed by the majority of the Pre-Implementation Waiver group, and one-third of the Non-Waiver group. The differences among the three groups became statistically significant in 2017 (p=0.000).

Below are examples of County Administrator Survey respondents' written comments illustrating the impact the waiver seems to be serving as an impetus for quality improvement activities for SUD in their respective counties.

- *Without the waiver, we would not be working on developing SU quality improvement activities.*
- *We will be developing a QI plan because of the waiver.*
- *[Our] county has always had QI as a big part of the process. Until the last year, the QI program has not had time to look at QI for SUDS. That is now changing.*
- *The waiver has increased the need for consistent quality improvement.*
- *The waiver has increased our already stringent QI oversight.*
- *SUD didn't have a QI committee but developed one under the waiver.*
- *DMC-ODS has created a need to incorporate utilization review and authorization, which has enhanced treatment.*

Figure 3.23: Percentage of counties indicating the waiver has had a positive influence on QI activities for SUD
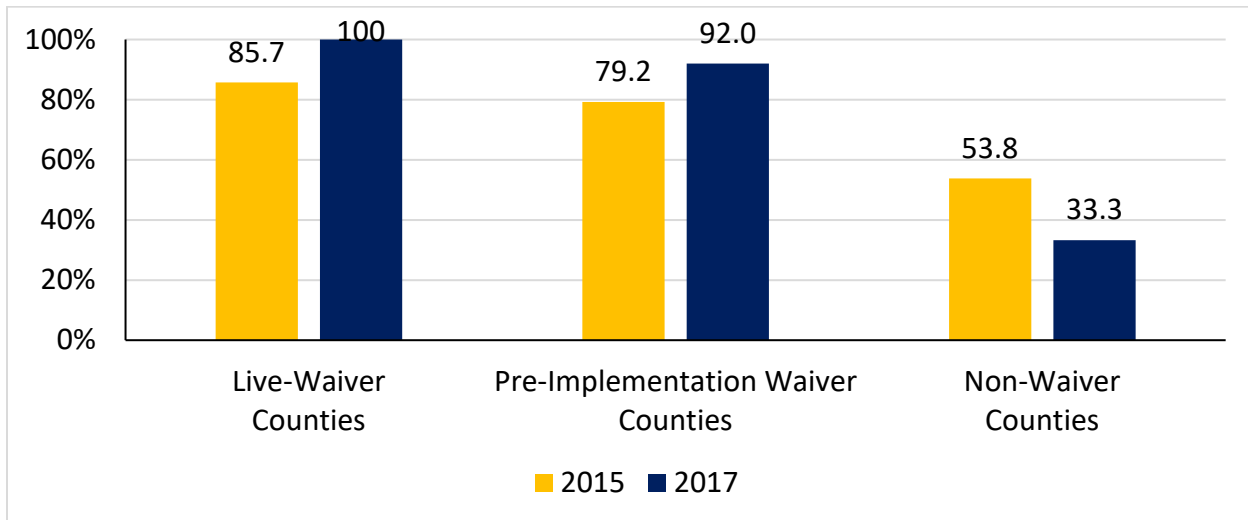

Billing DMC for Services

While prior to the waiver, counties were already billing DMC for some services, Live-Waiver counties are allowed to also bill DMC for DMC-ODS services. As shown in Figure 3.24, the trend among the Live-Waiver counties shows that from 2015 to 2017 DMC billing became more challenging. For example, according to a few of the administrators interviewed, Live-Waiver counties had to set up billing systems for new DMC-ODS services, and define what services/activities are and are not billable with respect to case management and recovery support services, and providers who were newly DMC certified had to learn about DMC billing.

Further, in 2017, the difference among the three groups became statistically significant (p=0.035), with the Live-Waiver counties showing the highest challenge rating, followed by the Pre-Implementation Waiver and Non-Waiver groups (data not shown). These results seem to indicate that as counties prepare for and begin to actually bill DMC for DMC-ODS services, they experience more challenges. They also suggest that technical assistance and/or training may be helpful to some counties as they implement the DMC-ODS. UCLA plans to collect more in-depth information about billing challenges from county administrators in upcoming interviews and surveys.

Figure 3.24: Mean rating of challenge level for implementing DMC billing for services
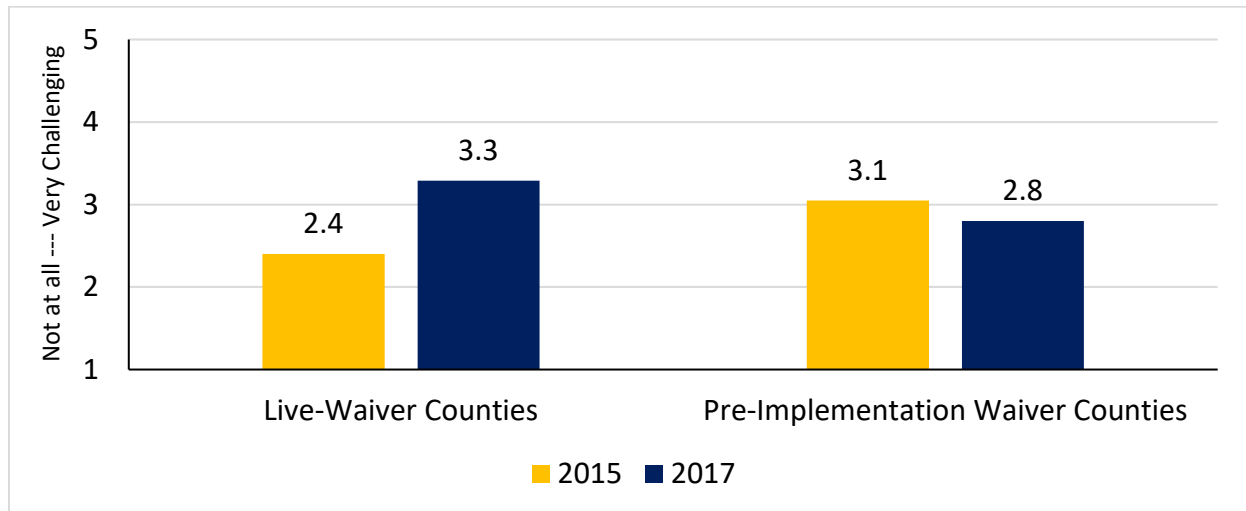
Treatment Perceptions Survey (TPS)

Patients' perceptions of and satisfaction with the SUD treatment services they are receiving are essential elements in assessing the quality of care and informing efforts to improve such care, as they may be associated with treatment outcomes (Carlson & Gabriel, 2001; Schafer & Rosemary, 2018; Zhang, Gerstein, & Friedmann, 2009).

For additional information on TPS methods see Chapter 1. The TPS survey included 14 statements addressing four domains (access, quality, care coordination, outcomes), as well as demographic items. The 14 items are listed below.

Access
1. The location was convenient (public transportation, distance, parking, etc.).
2. Services were available when I needed them.

Quality
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.).

Care Coordination
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.

Outcomes

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

General Satisfaction

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

Patients responded using a 5-point Likert scale where higher numbers indicate more satisfaction/positive perceptions. Descriptive analyses and statistical tests were conducted on the aggregated data from the seven counties. (See the Appendix for the TPS statewide report).

Characteristics of TPS survey respondents

Among the 379 programs[18] administering the patient survey, almost half (46.2%) were OP/IOP, about one-third (32.7%) were residential, 15.3% were OTP/NTP, and less than 4.7% were detox/WM (standalone); there were only two (2) partial hospitalization programs; and two (2) programs did not indicate a treatment setting. Of the convenience sample of 9,027 survey respondents, 39.4% were receiving services in OP/IOP, slightly over a third (36.3%) in OTP/NTP, almost a quarter (22.9%) in residential, 1.2% in Detox/WM; and less than 1% each in partial hospitalization and programs with missing treatment setting information. In addition, slightly more than half (53.1%) were from Los Angeles County, followed by 21.5% from San Francisco, 8.4% from Riverside, 7.0% from Santa Clara, 5.6% from Contra Costa, 2.9% from San Mateo, and 1.5% from Marin counties.

A little more than half (52.3%) of the survey respondents self-identified as male, with over a third (37.4%) as female; one percent of respondents declined to indicate their gender identity on the survey form; and less than one percent each indicated transgender or an additional identity. Respondents had the option to indicate multiple gender identities. Over half (54.0%) of the respondents reported being between 26 and 45 years old, 11.2% were between 18 and 25, 18.1% were between 46 and 55, and 16.7% reported being 56 years old or older. In terms of racial/ethnic groups, slightly more than one third (37.1%) identified as White/Caucasian, about one third (33.0%) as Latino, 16.1% as Back/African American, 9.5% as other race/ethnicity, and less than 5% as American Indian/Alaska Native (4.4%), Asian (2.9%), and Native Hawaiian/Pacific Islander (1.6%). (Multiple responses were allowed.) The vast majority (83.6%) of the respondents had received services at the treatment program for more than two weeks, although some (10.3%) had been enrolled for two weeks or less; for 6.1% of the respondents, it was their first visit day at the program. The majority (96.6%) of the survey forms completed were in English, with

---

[18] In this report, "program" is defined as a unit having a unique combination of CalOMS Provider ID and treatment setting and/or

3.3% in Spanish and only nine forms in Vietnamese, although forms were available in 11 additional threshold languages.

Patient Perceptions

As shown below in Table 3.1, the average patient ratings were high (at least 4.3 on a 5-point scale), indicating satisfaction among respondents in the OP/IOP, residential, OTP/NTP, and detox/WM treatment settings[19]. Statistical test results suggest significant differences among the four treatment settings (p<0.01), with respondents in residential treatment being less satisfied (p<0.05) than those in OP/IOP, detox/WM and OTP/NTP; and with respondents in OTP/NTP being less satisfied than those in OP/IOP.

Table 3.1: Average patient rating and percent of patients with a positive rating by treatment setting					
	Outpatient/ Intensive Outpatient	**Residential**	**Opioid/ Narcotic Treatment Program**	**Detoxification/ Withdrawal Management**	**Total**
Average patient rating[20] (SD)	4.5 (0.6)	4.3 (0.7)	4.5 (0.6)	4.5 (0.6)	4.4 (0.6)
Percent of patients with a positive rating[21]	94.7 %	89.1 %	93.8 %	91.1 %	93.0 %

Similarly, the percent of patients with an overall positive rating was high (at least 89%) in all four treatment settings. However, the differences among the treatment settings were statistically significant (p<0.01), with the percentage of patients with positive ratings in residential were significantly lower than those in OP/IOP and OTP/NTP (p<0.05).

As shown in Figure 3.25 below, the average score for each of the survey questions in the five survey domains was also high, as indicated by average scores of at least 4.2 on a five-point scale indicating greater satisfaction.

Figure 3.26 compares the average patient satisfaction scores in each survey domain (access, quality, care coordination, outcome, and general satisfaction) by the different treatment settings. While the average scores, again, are high (at least 4.2 on a 5-point scale), the differences within each domain are statistically significant, most likely due to the large sample sizes. As noted in Table 3.1, the average patient satisfaction scores

---

[19] Partial hospitalization and Other/missing treatment settings were not included due to small sample sizes (n=4 and n=21, respectively)

[20] Only patients who responded to all 14 questions were included in the analysis, N=7750.

[21] Overall positive rating was calculated using all 14 questions. Surveys with an average rating of 3.5 or higher were counted as having a POSITIVE rating. Only patients who responded to all 14 questions were included (N=7750).

observed in each of the five domains were lower for residential compared to the other treatment settings.

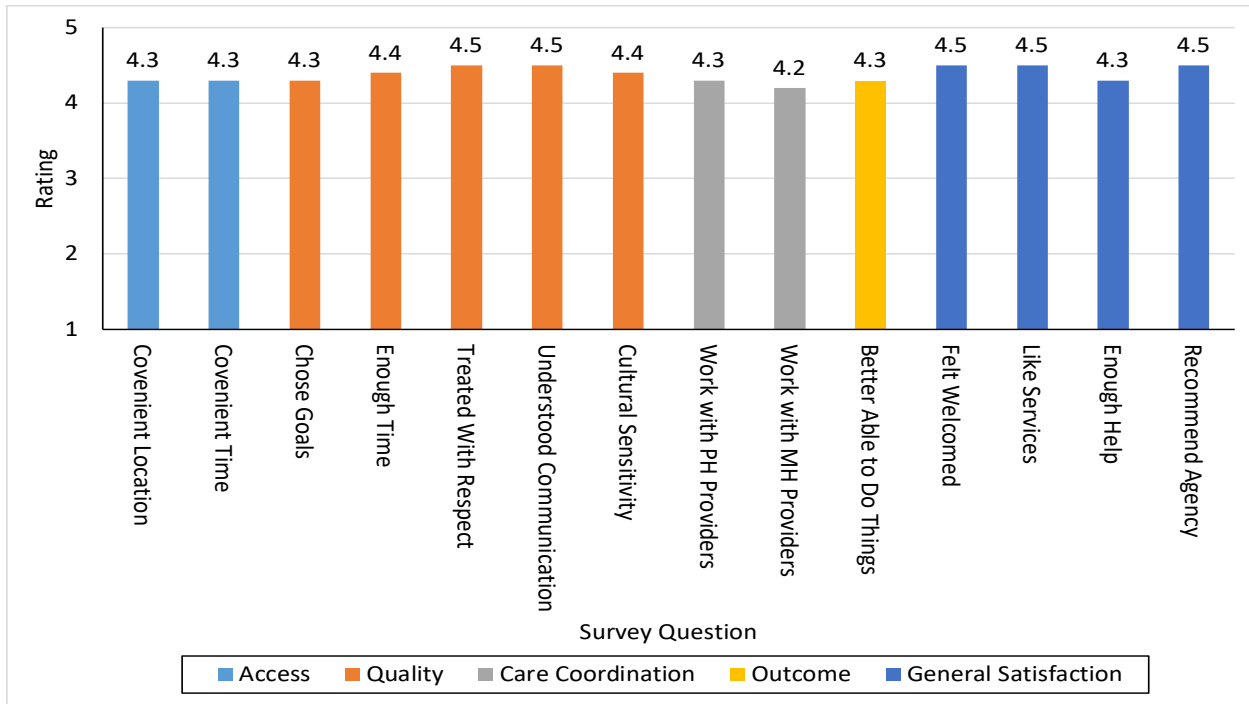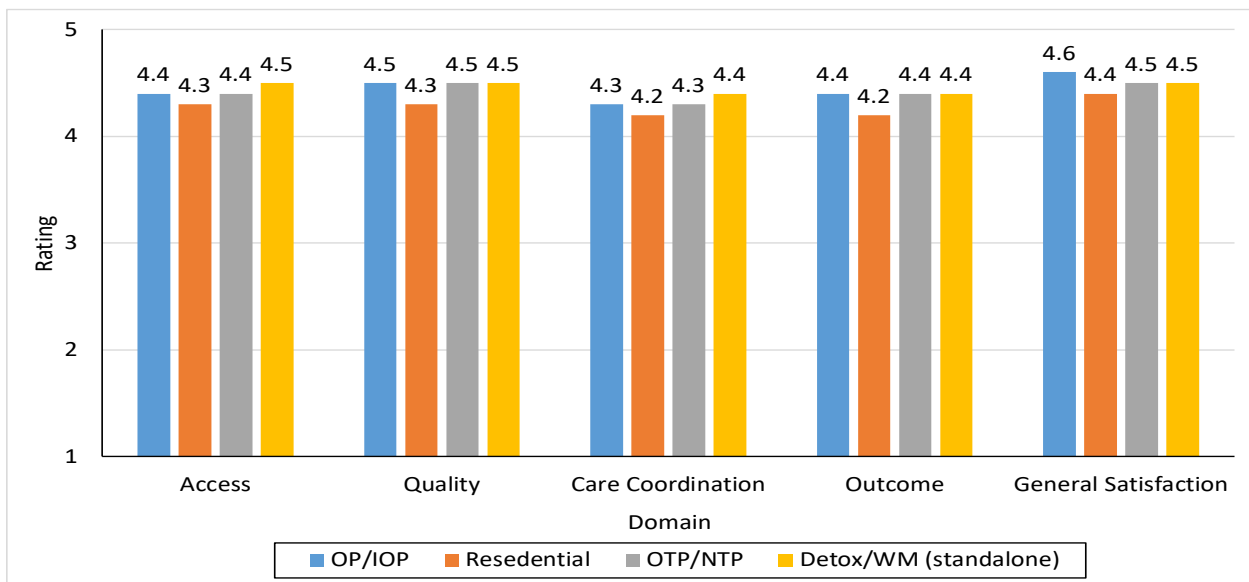**Figure 3.25: TPS - Average score of survey questions**

Figure 3.26: TPS - Average patient satisfaction score by domain and treatment setting

Patients responding to the TPS also had the opportunity to write comments on the form. Although UCLA did not review or analyze the comments, they are captured, compiled, and provided to the counties. Below are selected examples of patients' comments, including positive and negative sentiments, and recommendations for improving services.

- *"This program has not only given my life back but it gave my parents their son, my siblings their brother back and my son now has an active father. Very grateful for [this program]."*
- *"120+ days clean so the program does work."*
- *"Staff needs to be more flexible and understanding towards client backgrounds/experiences or trauma."*
- *"Physical activities are a huge component in wellness. More in this area is needed."*
- *"Please separate windows for take home patients and the regular detox/daily dosers. I feel that would decrease the wait time and satisfy clients."*
- *"I feel there should be more services for housing resources, and transitional housing. I don't have anywhere for me and my child to go after my treatment."*

Interviews with and feedback from county administrators and other stakeholders suggest that counties are using or planning to use the TPS data and/or reports, particularly the individual program reports, to inform quality improvement efforts. Below are a few examples of those efforts.

- Reviewed TPS reports with the QIC
- Reviewed and analyzed comments; if comments are negative, county personnel visits the program to discuss
- Shared report with DMC-ODS providers during onsite reviews
- Planning a deeper dive into the data (e.g., low cultural sensitivity scores at program with Spanish speakers)
- Considering including patient satisfaction as one metric in individual provider report cards relative to peers
- Planning regular administration (fourth visit and at discharge) to determine if meeting patients' needs/demands
- More in-depth analysis of TPS data used to offer guidance to counties during External Quality Review Organization (EQRO) site visits.

Overall from a statewide perspective, patients receiving treatment for SUD across the seven counties and treatment settings report being satisfied and having positive perceptions with respect to the survey domains of access, quality, care coordination, outcomes, and general satisfaction. In addition, average scores and percentage of positive ratings among patients in residential treatment appear to be lower than in the other treatment settings. As additional survey data are collected during subsequent annual TPS administrations, statewide trends and changes will be examined, and more in-depth analyses will be conducted (e.g., by demographics). A youth-specific TPS form will be available for use during the next survey period.

F. Discussion and Next Steps

Not surprisingly, the Live-Waiver counties are at the forefront in terms of implementing the various quality-related components needed for an organized delivery system, with the Pre-Implementation counties not far behind. Overall, most indications point toward improvement in the quality of care provided in the waiver counties, but additional patient outcomes and satisfaction/perceptions of data still need to be collected and examined to have a better understanding of whether and how the DMC-ODS is having a positive impact. The following highlights what is known about the status of quality measures at end of the third year of DMC-ODS waiver implementation:

- *Use of ASAM Criteria-based tools for placement and assessment.* As expected, all Live-Waiver counties use the ASAM Criteria for assessment and placement, while the Pre-Implementation counties show an increasing trend; implementation remains somewhat challenging. The assessment tools being used continue to vary from county to county, although overall, most counties are using tools that they have developed themselves. While Live-Waiver counties are using ASAM tools with all patients, including youth, the majority are either using or planning to use such tools that have been developed specifically for use with youth. In terms of patient placement, most treatment referrals were made to the same LOC as indicated on the brief screening or full ASAM assessment, which indicates that the tools are being used as intended. This is only a preliminary analysis of the first set of LOC placement data to arrive from three counties, and UCLA will continue to collect and analyze these data. The shift for many counties to use the ASAM Criteria is a major change that will take time and training to become a part of the culture of the treatment delivery systems and as providers become comfortable with the new tools and practices. Continued training and technical assistance on this topic are recommended.

- *Successful treatment engagement.* Drug Medi-Cal claims data suggest that treatment engagement in Live-Waiver counties varied between modalities, ranging from 54% in outpatient and 96% in residential, which is consistent with or above rates found in the literature. UCLA will continue to monitor this measure as additional counties "go live".

- *Patient transitions along the continuum of SUD care.* Drug Medi-Cal claims data indicate that patients in Live-Waiver counties did not typically move along the continuum of care to receive subsequent treatment or additional services (case management) within 14 days of discharge. This finding is consistent with prior reports using CalOMS-Treatment data, and highlights care transitions as a priority area for organized delivery systems that include a full continuum of SUD treatment and supportive services.

- *Tracking patient movement along the SUD continuum of care.* The sharing, tracking, and monitoring of patient movement within the SUD treatment system reportedly increased between 2015 and 2017 for Live-Waiver counties, but decreased for Pre-Implementation counties. The level of challenge appeared to

remain somewhat low for both groups, although it increased slightly for the Live-Waiver group. Both groups perceive that they are doing fairly well in tracking referrals and patient movement. UCLA anticipates that both Live-Waiver and Pre-Implementation Waiver counties will continue to make progress in this area as case management services, UM, DMC billing, and EHR systems evolve.

- *Utilization management* is available in the majority of Live-Waiver counties in spite of the trend toward it being slightly more challenging to implement in 2017 than in 2015, according to the County Administrator Surveys. However, among the counties preparing to implement the waiver, both the availability and level of challenge of implementing a UM program decreased slightly. The survey results indicate that as with many major changes, there is a learning curve as counties begin to roll out waiver services and implement their UM programs. As counties gain more experience with implementing their UM programs, we would expect the level of challenge to decrease. Provision of training and/or technical assistance in this area many be indicated.

- *Use of evidence-based practices.* In both 2015 and 2017, the majority of counties reported using at least two of the five EBPs listed in the STCs, yet waiver counties continue to rate this requirement as challenging to implement. Additional training or technical assistance may be needed, particularly on trauma-informed treatment and motivational interviewing.

- *Establishment of quality improvement committees and plans.* The majority of Live-Waiver and Pre-Implementation Waiver counties reported having quality improvement committees with SUD participation since at least 2015. However, the Live-Waiver group was more likely than the Pre-Implementation group to report that they have written SUD treatment system quality improvement plans, although an increasing trend was observed for both groups. In addition, the DMC-ODS appears already to have had a positive influence on both groups' (and even some Non-Waiver counties') quality improvement efforts according to county administrators.

- *Drug Medi-Cal Billing.* There was a reported increase in how challenging implementing billing for DMC-ODS services was among Live-Waiver Counties. This suggests technical assistance and training on DMC billing for DMC-ODS services may be helpful to some counties.

- *Live-Waiver counties* are already meeting many of the quality-related requirements under the DMC-ODS waiver. One hundred percent of Live-Waiver counties report having implemented: a quality improvement committee, a written SUD quality improvement plan, ASAM Criteria-based assessment and placement, at least two EBPs listed in the STCs, LPHAs, and physician consultation services. They are followed by the Pre-Implementation Waiver counties, as expected. However, it is notable that even Non-Waiver counties are showing increases in many of these areas, albeit to a lesser extent than the other two waiver groups, suggesting that

the DMC-ODS waiver (along with other State efforts to improve care) may be having a positive influence on the SUD treatment system as a whole.

- *Patient perceptions of treatment.* Overall, from a statewide perspective, patients participating in the TPS in Live-Waiver counties report being satisfied and having positive perceptions with respect to the five survey domains: access, quality, care coordination, outcomes, and general satisfaction. Average scores and percentage of positive ratings among patients in residential treatment appear to be lower than in the other treatment settings. As additional survey data are collected during subsequent annual TPS survey administrations, statewide trends and changes will be examined, and more in-depth analyses will be conducted.

- *Recommendation:* Continue to provide training and technical assistance (e.g., collaborative learning opportunities, Frequently Asked Questions [FAQs], waiver Information Notices) in the following areas in which counties find challenging to implement: ASAM Criteria assessment and placement; DMC billing; UM; facilitating patient flow along the continuum of SUD treatment, including the provision of additional services (e.g., case management) within 14 days after discharge from residential treatment and withdrawal management; and evidence based practices, particularly trauma-informed treatment and motivational interviewing.

- *Recommendation:* Develop and/or make available youth-specific ASAM Criteria assessments to counties that wish to use them.

UCLA plans to obtain access to and/or acquire additional data (e.g., ASAM LOC, Medi-Cal claims, patient satisfaction/perceptions of care survey), collect additional data via surveys (e.g., county administrator survey, treatment provider survey) and qualitative interviews (e.g., county administrators), and conduct further analyses in the upcoming years to examine how and the extent to which the implementation of the waiver influences the quality of the SUD care provided to patients within an organized delivery system.

References

Carlson, M. J., & Gabriel, R. M. (2001). Patient satisfaction, use of services, and one-year outcomes in publicly funded substance abuse treatment. *Psychiatric Services, 52*(9), 1230-6.

Garnick, D. W., Lee, M. T., Horgan, C. M., Acevedo, A., & the Washington Circle Public Sector Workgroup. (2009). Adapting Washington Circle Performance Measures for Public Sector Substance Abuse Treatment Systems. Journal of Substance Abuse Treatment, 36(3), 265–277. http://doi.org/10.1016/j.jsat.2008.06.008

Shafer, A., & Ang, R. (2018). The mental health statistics improvement program (MHSIP) adult consumer satisfaction survey factor structure and relation to external criteria. *Journal of Behavioral Health Services and Research.* 1-13. doi: 10.1007/s11414-018-9607-x.

Zhang, Z., Gerstein, D. R., & Friedmann, P.D. (2008). Patient satisfaction and sustained outcomes of drug abuse treatment. *Journal of Health Psychology, 13*(2), 388-400.

IV. Integration/Coordination of Care

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

Greater coordination and integration of services for beneficiaries receiving substance use disorder (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 transition through the SUD continuum of care, but they can also play a critical role in facilitating treatment for co-occurring medical and psychiatric conditions that often impact individuals with SUD. Thus, coordination and integration can play a critical role in both promoting recovery from SUD and in enhancing health and wellness. The Drug Medi-Cal Organized Delivery System (DMC-ODS) has significant potential to make the services available to beneficiaries with SUD more comprehensive and holistic because it allows for the reimbursement of services such as case management, which are particularly valuable in promoting care coordination and integration.

To measure how the DMC-ODS is impacting care coordination and integration, the University of California, Los Angeles (UCLA) is examining over time the following coordination and integration goals: (1) comprehensive substance use, physical health (PH), and mental health (MH) 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 is also examining referrals to and from primary care and MH, 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.

UCLA focused evaluation efforts on measures with accessible data in which there was potential for measurable change, comparing the Live-Waiver counties, Pre-Implementation Waiver counties, and the Non-Waiver counties. These measures include:

- Comprehensive substance use, PH, and MH screening
- Cross-system care coordination and effective communication among providers
- Navigation support for patients and caregivers through case management

- Facilitation and tracking of referrals between systems

For this report, we have incorporated discussions of "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 MH services.

A. Data Sources

For this report, the data sources available for analyses of coordination and integration included the California Outcome Measurement System - Treatment (CalOMS-Tx), County Administrator Surveys, and County Administrator Interviews. Managed Care/Fee-for-service (FFS) Medi-Cal data needed to draw conclusions concerning coordination and integration were not available for this time period.

B. Measures

Comprehensive Substance use, Physical Health, and Mental Health Screening

The available sources of data concerning substance use, PH, and MH screening were County Administrator Surveys and County Administrator Interviews. Addiction Medicine's Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (ASAM Criteria) assessments, which are required as part of the DMC-ODS, include assessments 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 PH and MH problems will occur as counties join the DMC-ODS demonstration project. In addition, it is anticipated that as counties centralize their initial assessment and patient placement activities under the DMC-ODS, they will implement standardized procedures designed to systematically identify beneficiaries' potential PH and MH service needs as they initiate treatment.

County Administrator Survey response comparisons between 2015 and 2017 across the three groups (Live-Waiver counties, Pre-Implementation Waiver counties, and Non-Waiver counties) support these expectations. ASAM assessment and placement was fully or partially available in 2017 in all (100%) of the Live-Waiver counties, in the majority (63%) of Pre-Implementation Waiver counties, and in half (50%) of the Non-Waiver counties. (See Figure 3.1. in Section III to find more information about measures for ASAM utilization.) In addition, all (100%) of the Live-Waiver counties reported having a centralized system for screening for all or some of their services (increased from 86% in 2015) which suggests a more uniform and standardized approach to identifying beneficiaries' potential PH and MH needs as treatment begins. Live-Waiver counties had the largest increase in centralized screening practices, compared to Pre-Implementation and Non-Waiver counties, which saw limited change or no change at all in centralized screening practices between 2015 and 2017 (see Figure 4.1)

Figure 4.1: Percent of counties with a centralized system for screening
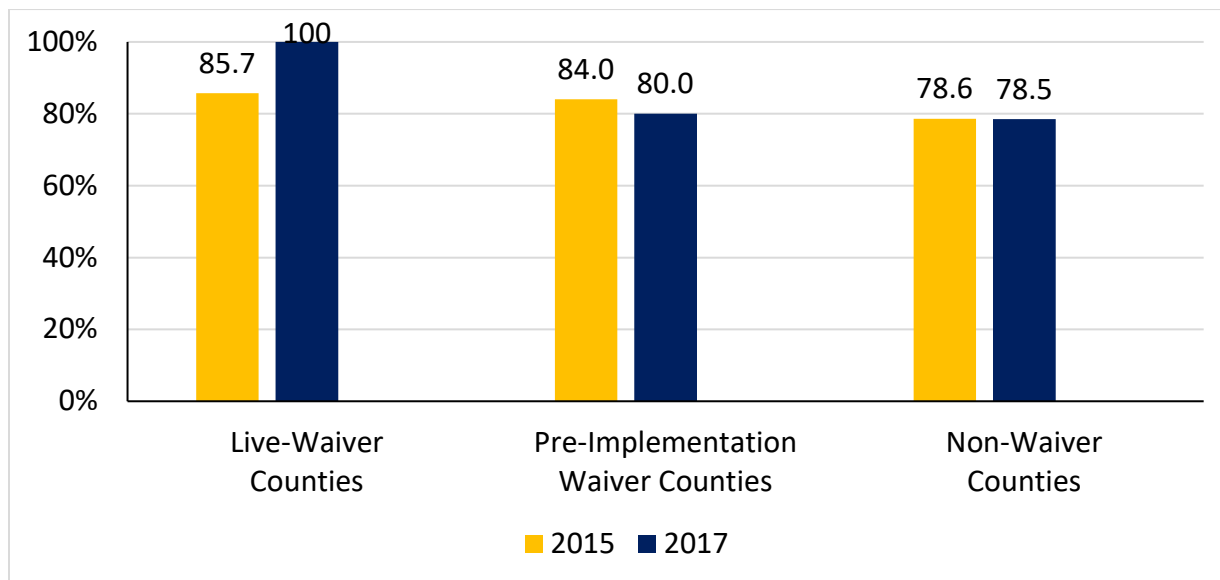
Cross-system Care Coordination and Effective Communication among Providers

Cross-system coordination and communication were examined at the county level through County Administrator Surveys and Interviews.

Department/division integration

In surveys, UCLA asked administrators to rate the degree to which their SUD and MH departments/divisions are integrated, as well the degree to which their SUD and PH services departments/divisions are integrated. Administrators rated levels of integration using a 1–5 Likert scale from "*very poorly integrated*" to "*very well integrated*", and counties' ratings were compared by group between the 2015 and 2017 responses. In both 2015 and 2017, administrators rated their counties' levels of MH-SUD integration higher than PH-SUD integration (MH: 3.5 in 2015 and 3.4 in 2017; PH: 2.6 in 2015 and 2.7 in 2017). These findings are not surprising given that most counties have MH and SUD within a unified behavioral health department. Though reported levels of MH-SUD integration decreased slightly and PH-SUD integration increased slightly between 2015 and 2017, neither change was statistically significant (data not shown).

Within each of the three groups (Live-Waiver, Pre-Implementation, and Non-Waiver), there were no statistically significant changes in ratings of MH-SUD or PH-SUD integration between the 2015 and 2017. Though the changes from 2015 to 2017 did not reach levels of statistical significance, it is nonetheless notable that compared to Pre-Implementation and Non-Waiver counties, Live-Waiver counties reported decreased levels of MH-SUD integration in 2017 compared to 2015, but increased levels of PH-SUD integration (see Figures 4.2 and 4.3).

Figure 4.2: Mean ratings of the degree to which SUD and MH divisions/departments are integrated within counties
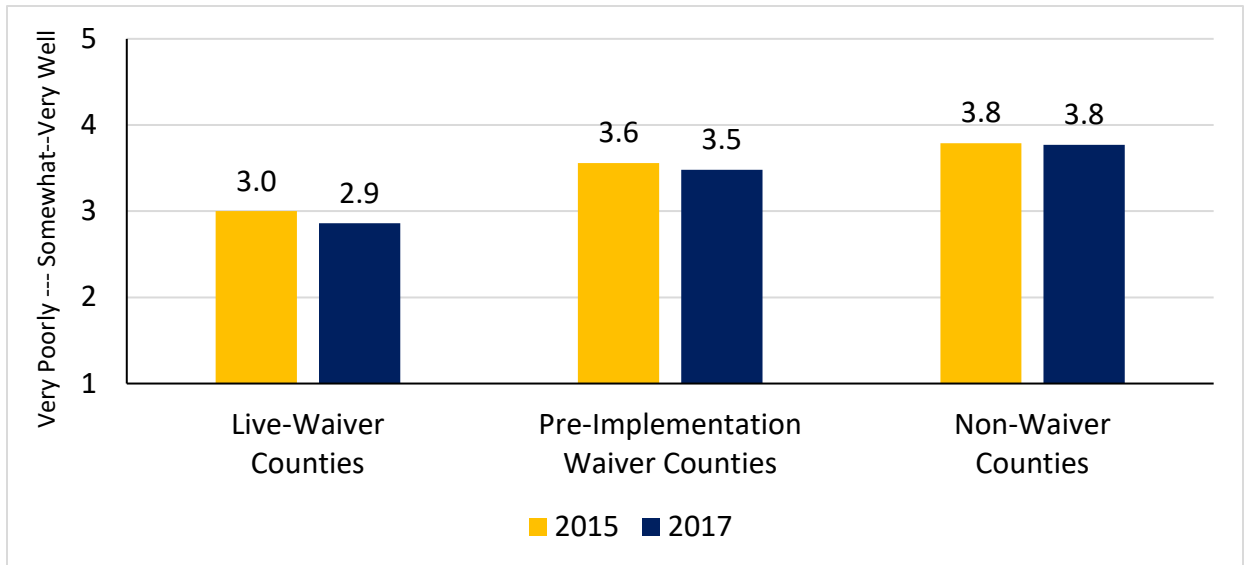

Figure 4.3: Mean ratings of the degree to which SUD and PH divisions/departments are integrated within counties
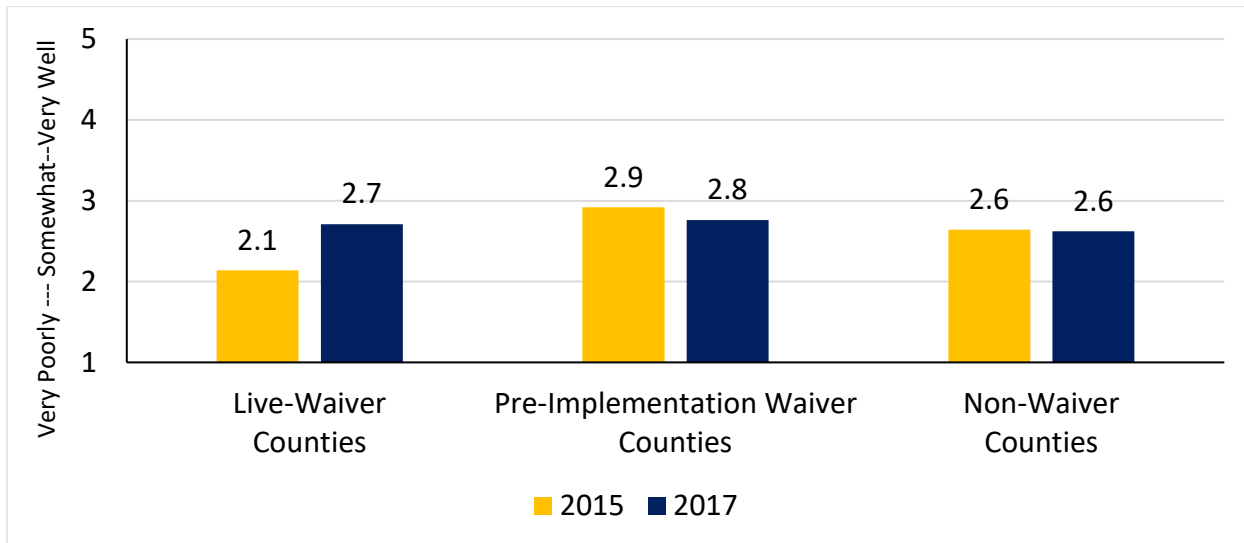
As noted above, MH divisions have historically been more integrated with SUD than PH divisions because they are usually housed within a unified behavioral health department. As one administrator explained, DMC-ODS planning and implementation has been *"a whirlwind"* that has required exclusive focus on SUD system transformation. As SUD county administrators focus more on DMC-ODS implementation, less attention to collaboration with MH may be an unintended consequence. *"Our system is resource-confined and people are stretched thin,"* one administrator explained, *"MH and SUD staff*

need more time and bandwidth to facilitate integrated care... (this) leads some to push back on integration and collaboration."

Conversely, SUD departments have historically been highly separated from departments that oversee PH services. Through specific requirements to coordinate SUD services with Medi-Cal managed care plans (discussed below), the DMC-ODS has facilitated the creation of new relationships between SUD administrators and their medical counterparts.

<u>Coordination of services with Medi-Cal managed care plans</u>

Coordination of services with Medi-Cal Managed Care plans is a required component to participate in the DMC-ODS waiver, and developing Memorandums of Understanding (MOUs) with these plans is expected. UCLA therefore asked county administrators survey questions about service coordination with Medi-Cal managed care plans. Figure 4.4 shows the capacity to coordinate with Medi-Cal managed care plans between 2015 and 2017 across the three groups. In both years, coordination of services with Medi-Cal managed care plans was greater in Live-Waiver counties than others, and greater in Pre-Implementation counties than in Non-Waiver counties. Coordination increased in counties that implemented the DMC-ODS, but not in Pre-Implementation counties. Since coordination with managed care plans is a DMC-ODS requirement, it is not surprising that it reached 100% in Live-Waiver counties.

Though the DMC-ODS has facilitated increased coordination with managed care plans, this process has been challenging. As Live-Waiver counties have reported increased coordination with Medi-Cal plans (Figure 4.4) they also reported that it was more challenging in 2017 when compared to 2015 (see Figure 4.5).

Figure 4.4: Percentage of counties with coordination of services with Medi-Cal managed care plans available for adult patients
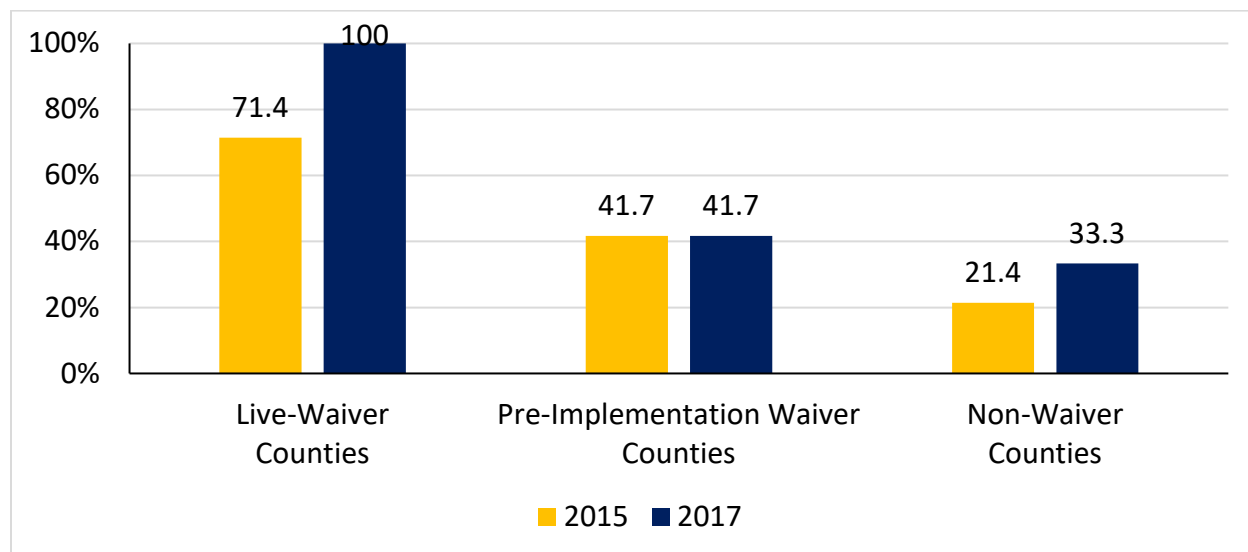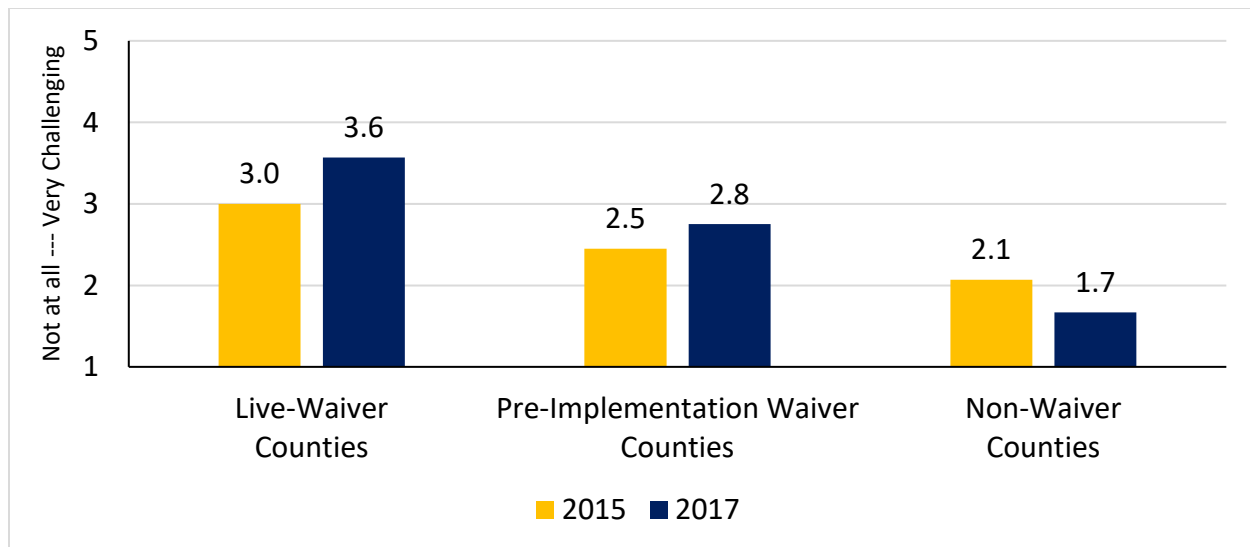
Figure 4.5: Mean rating of challenge level for coordination with Medi-Cal plans

Similarly, even though Pre-Implementation counties did not report greater coordination in 2017 when compared to 2015, they reported slightly greater challenges when they did coordinate with managed care plans. These data indicate that while the DMC-ODS is facilitating greater coordination between SUD departments and managed care plans, coordination is difficult. Notably, counties that reported the greatest increase in coordination (Live-Waiver counties) also reported the highest levels of difficulty with coordination. This speaks to the practical difficulties of coordination as it becomes more intensive and frequent, as it has in counties that have implemented the DMC-ODS.

Department/division communication

UCLA asked county administrators whether they thought communications with MH and PH systems occurred frequently enough to support an ODS. Consistent with the previous years' ratings, agreement rates were higher for SUD-MH communication compared to SUD-PH communication at both time points statewide (MH: 68.8% (2015), 65.9% (2017); PH: 41.3% (2015), 46.7% (2017); data not shown). Differences between 2015 and 2017 responses were not statistically significant for SUD-MH or SUD-PH communication.

Within each of the three groups (see Figures 4.6 and 4.7), the percentage of Live-Waiver counties and Non-Waiver counties reporting that they met frequently enough with other departments to support an ODS decreased between 2015 and 2017, while it increased in Pre-Implementation counties. These findings suggest that in the planning stages for DMC-ODS, administrators may have felt that they were meeting as much as needed with their counterparts in other departments to support the development of their systems of care, but that once the DMC-ODS began (in Live-Waiver counties) they were not meeting enough to accomplish what was needed to support implementation. These data

underscore the need for strong and frequent interagency communication not only as DMC-ODS systems of care are being designed, but also as they are implemented.

In both 2015 and 2017, and in all three groups (Live-Waiver, Pre-Implementation Waiver, Non-Waiver), administrators a greater need to meet more frequently with PH systems than with MH administrators. This is not surprising, given that most SUD county administrators work in behavioral health departments that also include MH.

Figure 4.6: Percentage of counties indicating that SUD and MH departments meet frequently enough to support an ODS
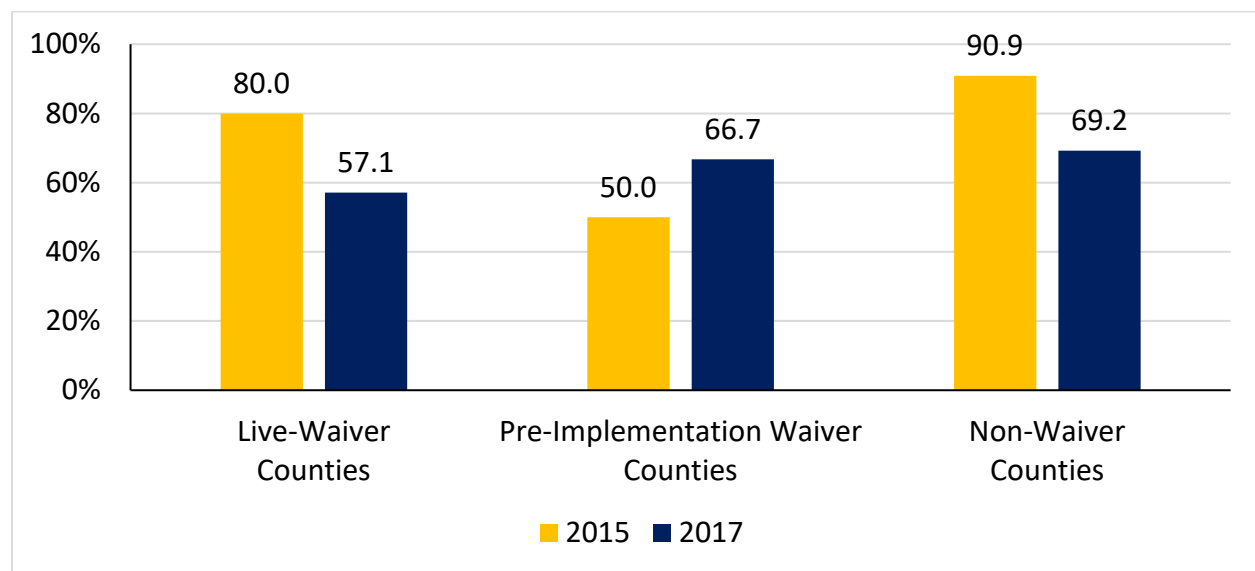
Figure 4.7: Percentage of counties indicating that SUD and PH departments meet frequently enough to support an ODS
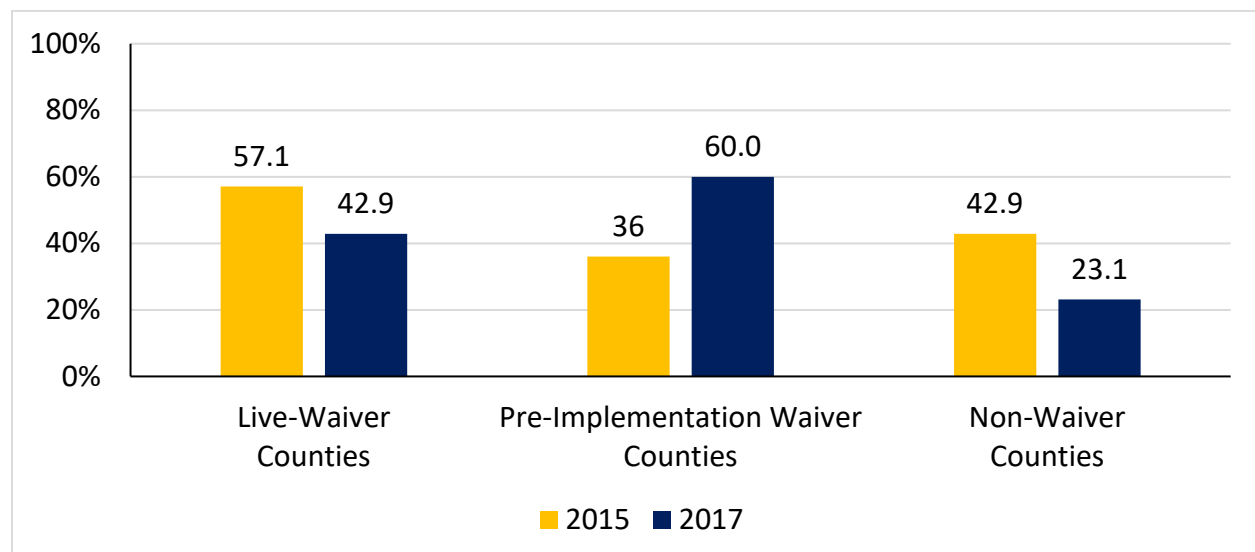
<u>DMC-ODS waiver impact on communication</u>

To quantify the impact of the DMC-ODS waiver on communication, county administrators were specifically asked (via survey) how much the DMC-ODS waiver influenced department-level communication. Among Live-Waiver and Pre-Implementation counties, the majority of administrators reported that the waiver has had a positive influence on communication with both MH and PH. The same did not occur in Non-Waiver counties. The differences among the three groups became statistically significant in 2017 (p<.01).

Figure 4.8: Percentage of counties indicating the waiver has had a positive influence on communication between SUD and MH.

Figure 4.9: Percentage of counties indicating the waiver has had a positive influence on communication between SUD and PH.

The increased percentage of counties reporting that DMC-ODS has positively influenced SUD-PH communication (from 28.6% to 71.4% in Live-Waiver counties, from 52.0% to 91.7% in Pre-Implementation counties) is particularly notable. This highlights the degree to which the DMC-ODS, while facilitating closer linkages wi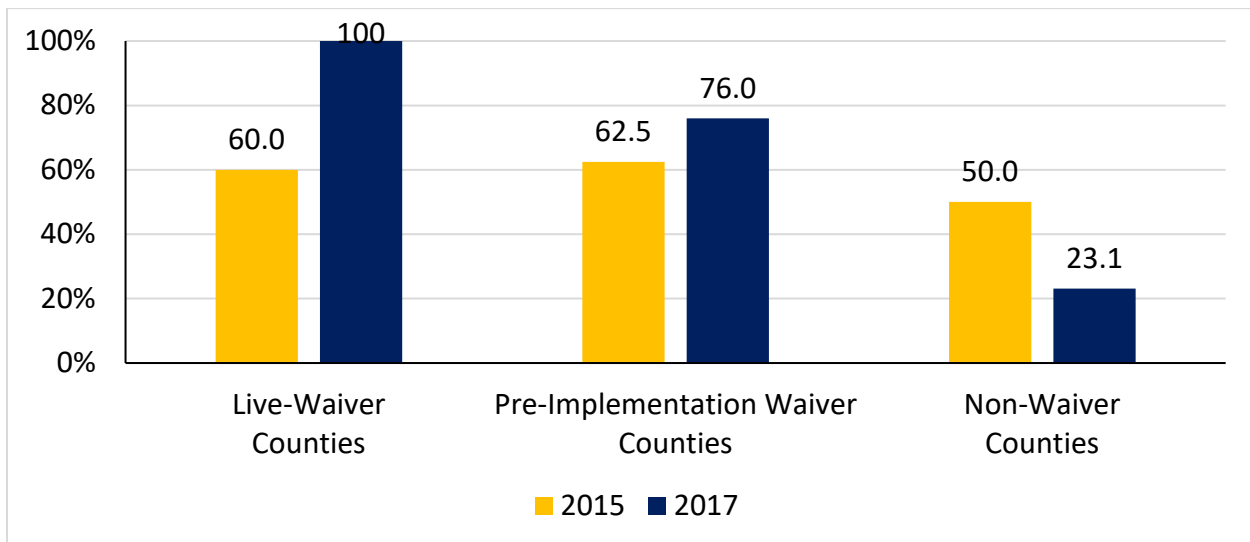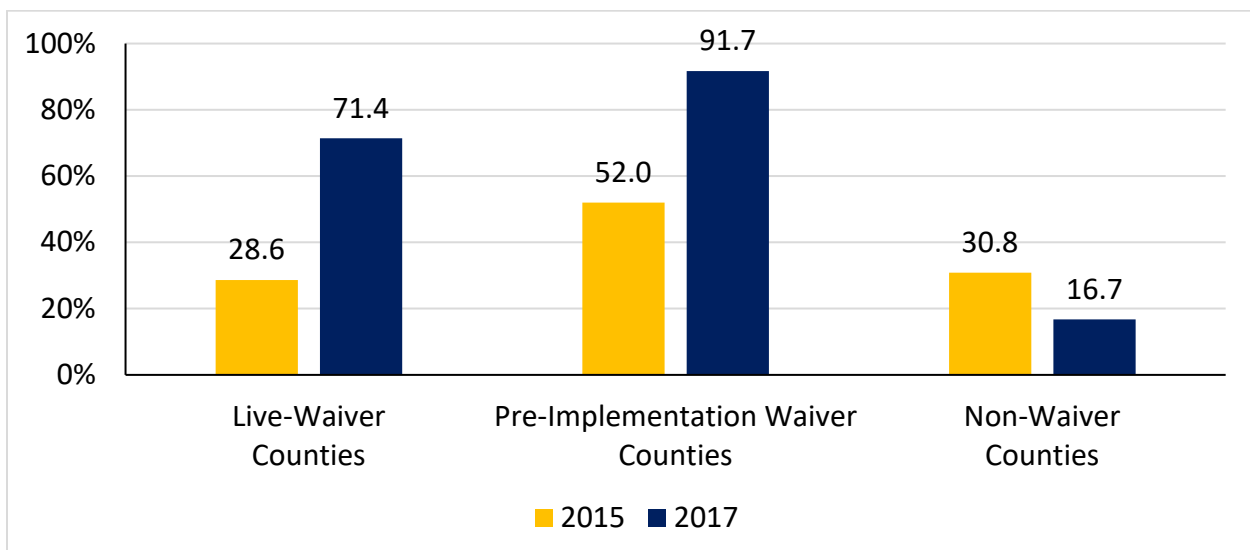th MH, is having a more profound impact on communication with PH systems. *"Prior to the waiver,"* summarized one administrator, *"we were not communicating with our Health Services Agencies."* With its requirements for coordination with managed care plans and services to improve integration with medical care, the DMC-ODS is facilitating integration with PH services in a way that never occurred before.

<u>Provider-level partnerships</u>

Another method to facilitate care coordination across systems is to establish partnerships between providers. County administrators were asked if they have guidelines or requirements for SUD providers to partner with MH and PH providers. Data from Figures 4.10 and 4.11 suggest that the practice of requiring or providing guidelines to establish partnerships changed only for relationships between SUD and PH providers, and only among the Live-Waiver counties (increasing from 42.8% to 85.7). However, in 2017, as shown in Figure 4.12, monitoring of the utilization of these partnerships across all groups remain low, including in Live-Waiver counties (14.3%).

Figure 4.10: Percentage of counties that have guidelines or requirements for SUD providers to partner with MH providers.
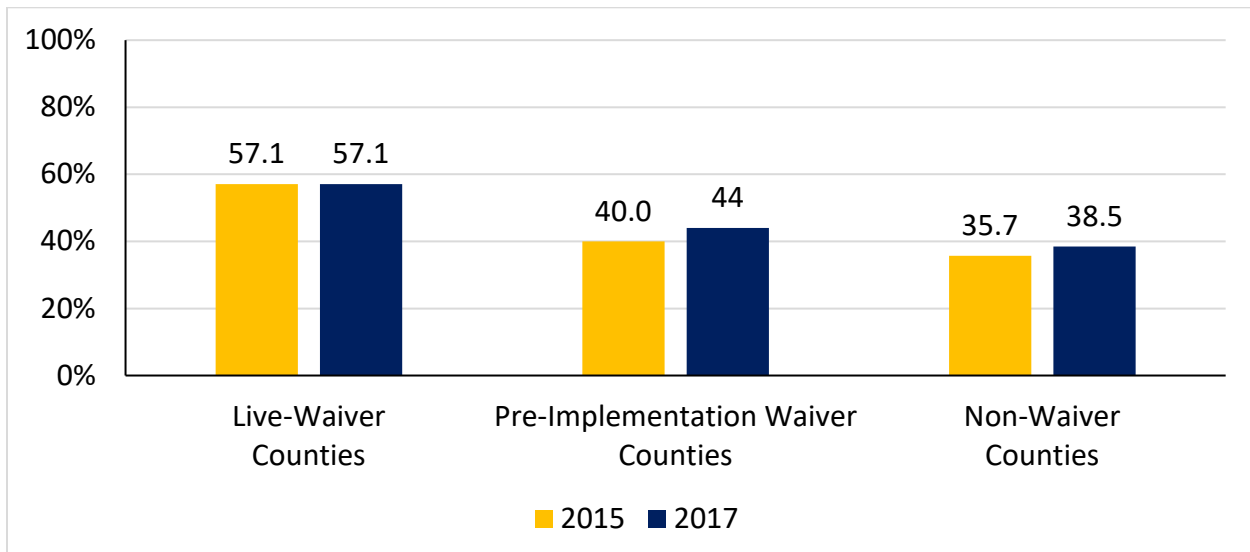
Figure 4.11: Percentage of counties that have guidelines or requirements for SUD providers to partner with PH providers.
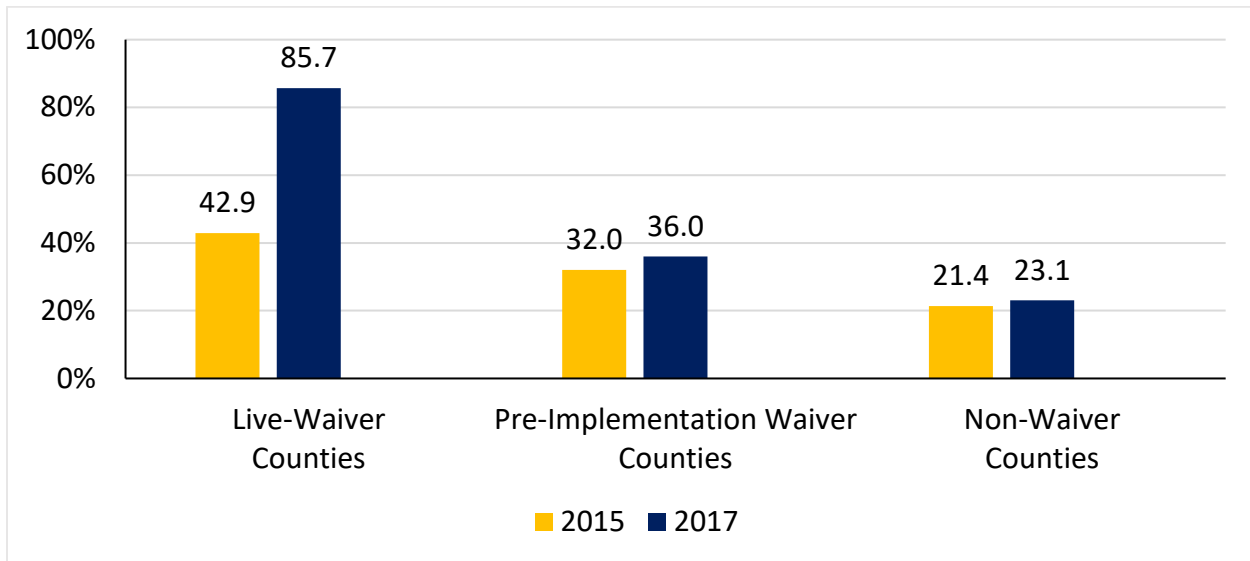
Figure 4.12: Percentage of counties that have procedures in place to monitor utilization of the above partnerships
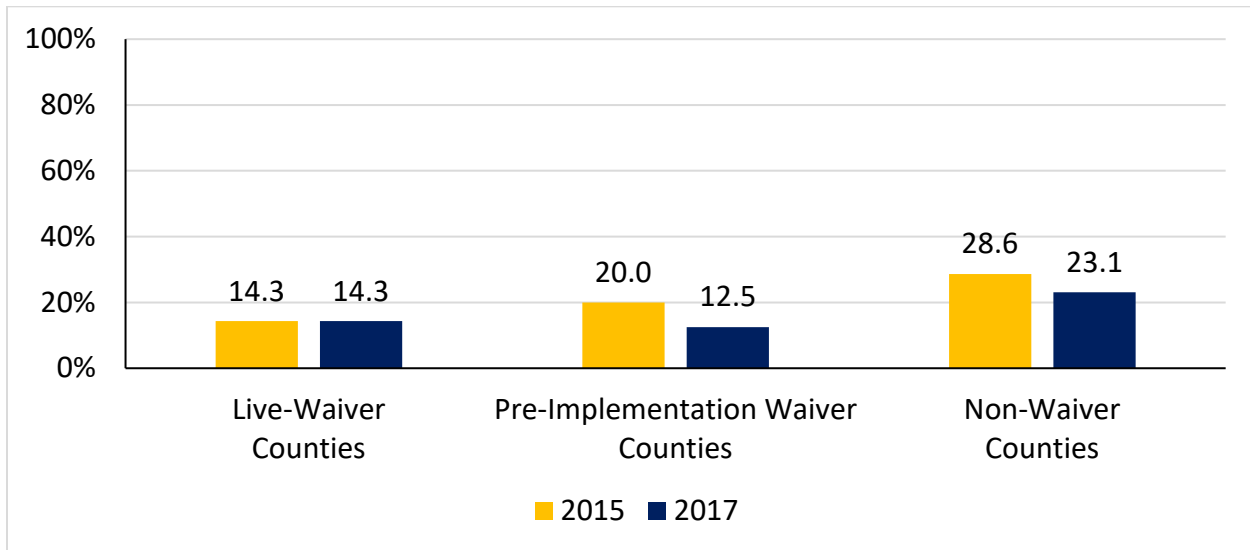
Navigation Support for Patients and Caregivers through Case Management

Case management

Case Management is specifically designed to facilitate care coordination and linkage across systems. In 2017, all (100%) of the Live-Waiver counties reported that the DMC-

ODS was positively impacting the delivery of case management services in their county, as did 69% of Pre-Implementation counties (see Figure 4.13).

Figure 4.13: Percentage of counties indicating the waiver has had a positive influence on case management services
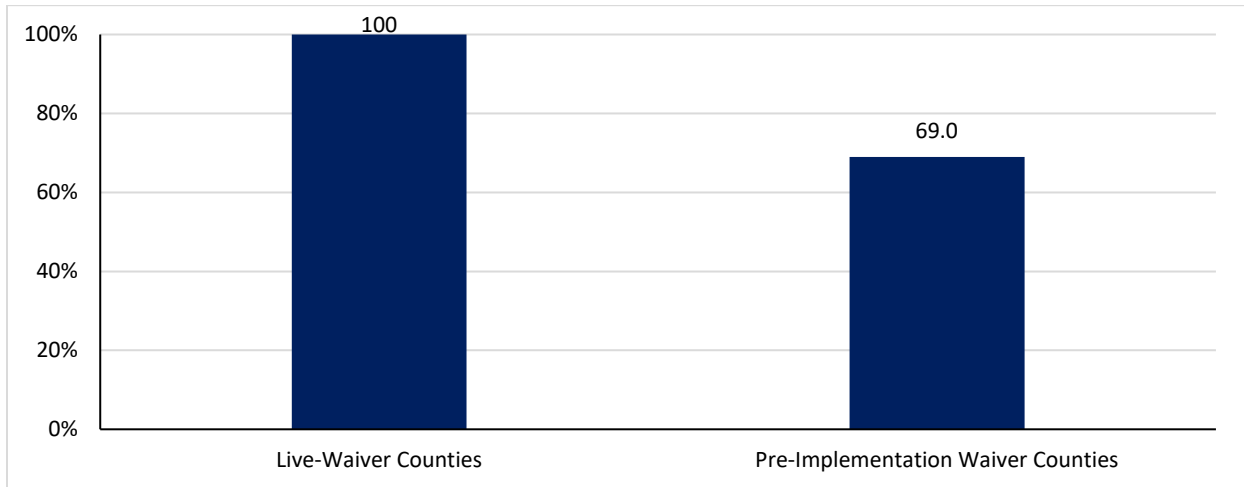
UCLA inquired about the planning status of case management services planning and implementation. Using a Likert 1-7 scale ranging from 1="still figuring it out" to 7="we have detailed plans", overall the Live-Waiver counties provided higher ratings on the scale than the Pre-Implementation counties. (Live-Waiver counties: 5.1 compared to Pre-Implementation counties: 4.4). (See Figure 4.14.)

Figure 4.14: County planning status: planning and implementation of case management
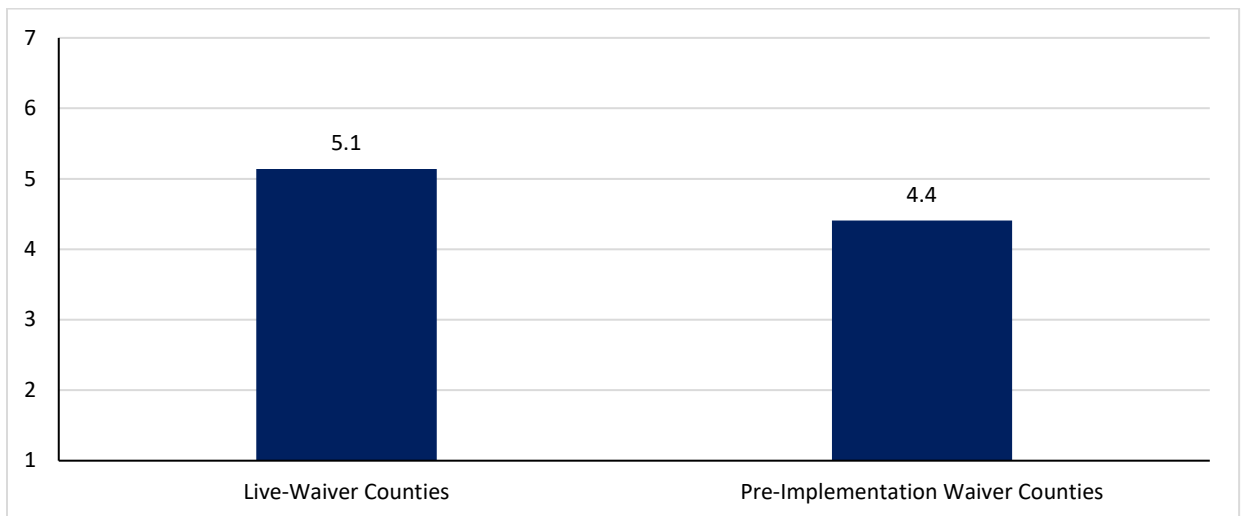
Data from Figure 4.15 reveal that Live-Waiver counties (86%) are much further along in the process of organizing access to and delivering case management services by providing guidelines for their providers, compared to Pre-Implementation (35%) and Non-Waiver counties (13%).

Figure 4.15: Percent of counties that have guidelines for providers to access or deliver case management services
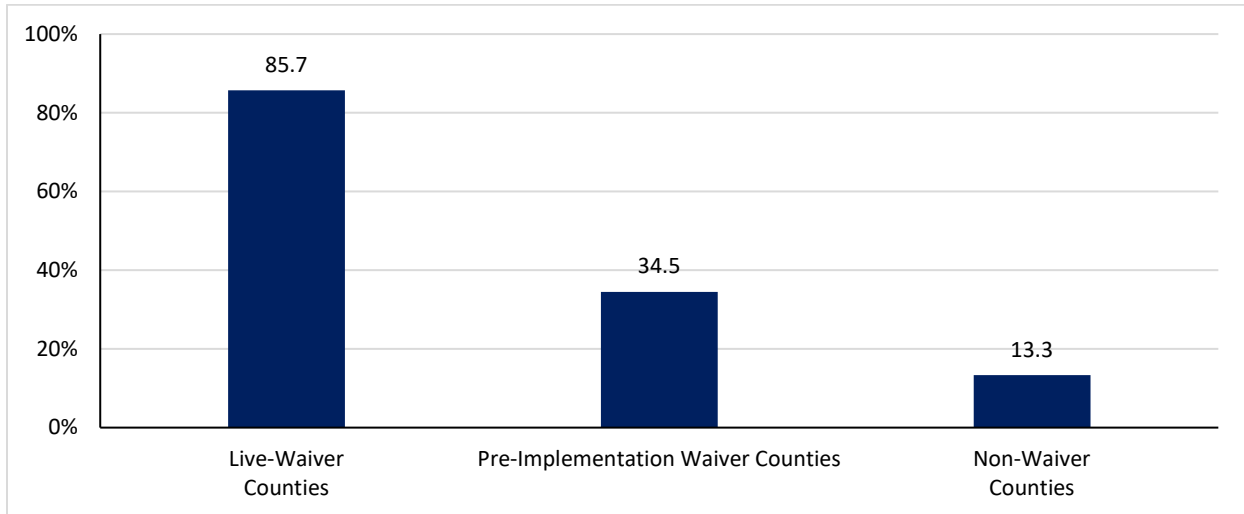
UCLA further inquired about the current actual availability of case management services, in which availability was defined as either fully or partially available (see Figure 4.16).

Figure 4.16: Percentage of counties with case management services available for adult patients
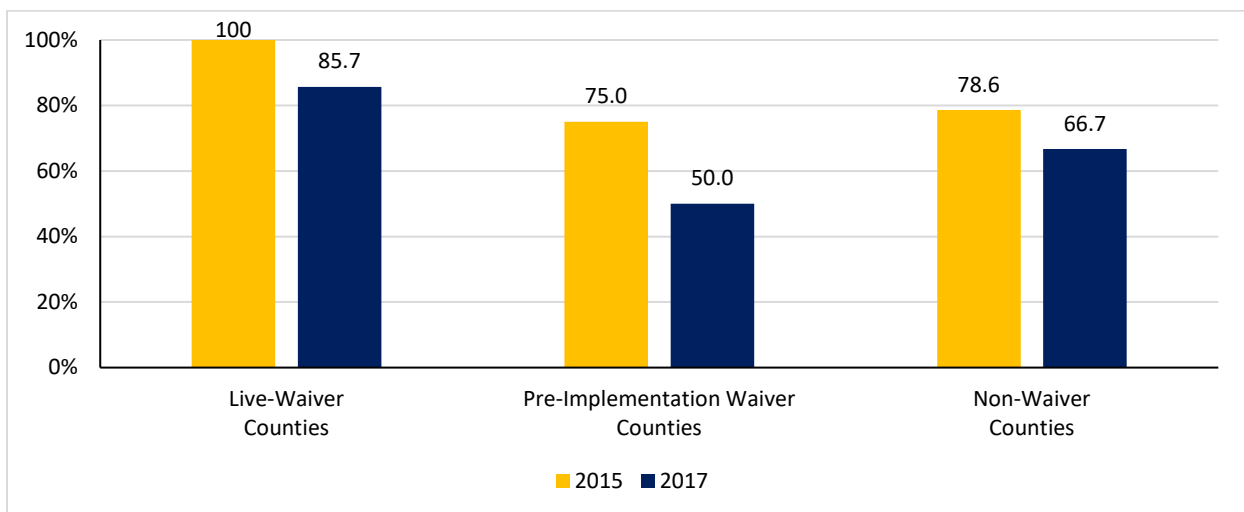
In both 2015 and 2017 surveys, case management services were more available in the Live-Waiver counties than the other groups; however, the overall availability of case management services decreased. As Figure 4.17 illustrates, this is at least in part because case management services remain challenging across the state, even in counties that have begun DMC-ODS implementation.

Figure 4.17: Mean rating of challenge level for implementing case management
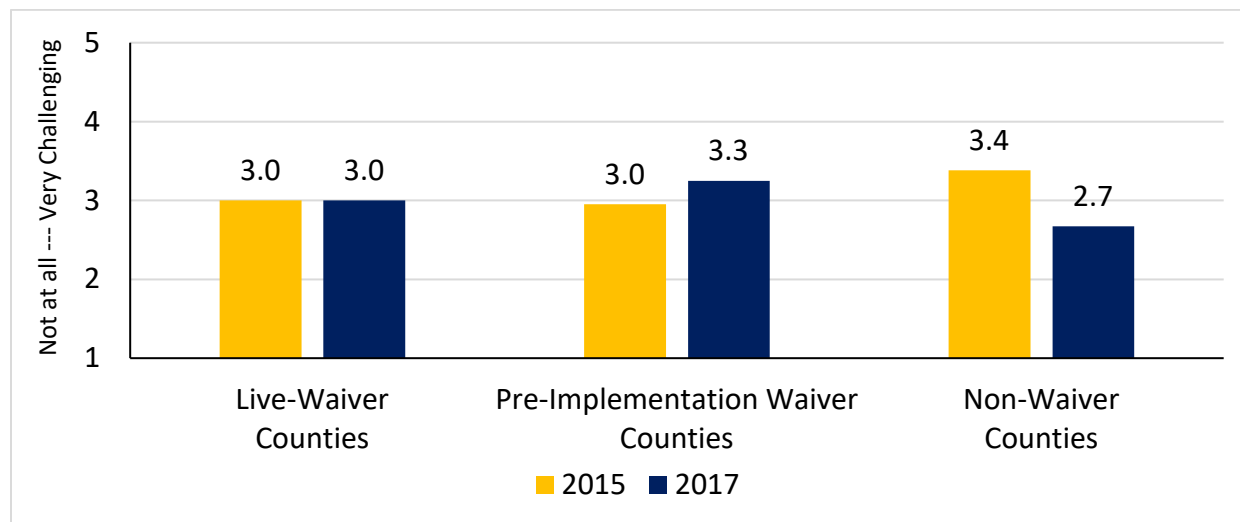
Qualitative interviews with the county administrators from Live-Waiver counties have highlighted many of the barriers to the delivery of case management services. In spite of its potential promise, administrators reported that significant barriers—both philosophical and financial—have prevented the optimal integration of case management services within DMC-ODS systems of care. *"It's just a new benefit to a lot of providers,"* explained one administrator. As another pointed out, "*the term case management has not completely been used to the full extent in substance use disorders—(it's been) more a function in mental health."* Consequently, it has been a *"foreign concept"* for many providers, and they have been unclear about what case management services should entail. As one administrator elaborated:

> *"Providers are trying to supplement payment in certain ways for activities that we don't really view as case management. One example: If staff from a provider were to go with somebody in court if they're going for some kind of hearing, that's not really case management. I mean, I could see sending a peer as a navigator or to provide peer support, but that's not really case management in our view. What we're thinking of is more active benefits acquisition, communicating information to other service providers, making sure that if somebody transitions from a residential only facility to an outpatient facility that information or a treatment plan is transferred…that sort of thing."*

Other administrators reported that many programs in their counties provide case management services, but do not call them by that name and do not bill for them accordingly. As one administrator said, *"some of the programs are having the counselors provide case management and bill it as counseling, which has happened forever. That's how it's been…half of what the counselors do is case management, but they usually bill it under the heading of 'counseling.'"*

Administrators also reported that even under the DMC-ODS, there were insufficient resources to support the development of robust case management services:

> *"We started with very minimal resources, and the same thing applies to our providers," reported one administrator. We did create a case management kind of manual, we created forms, we created a workflow for how we envisioned this to work. (But then) we saw that we didn't have the resources."*

The challenge, this administrator elaborated, was to *"generate enough revenue"* through the DMC-ODS to support the hiring of staff to provide case management services, as well as more experienced and higher-level providers to serve as case management supervisors.

Administrators also reported that for various reasons, they believed there might be insufficient motivation for providers to provide case management services under DMC-ODS. *"Based on our experience,"* one administrator explained, *"if we give providers an ability to keep that function within what they do, they really don't do any."* Another administrator voiced similar frustrations, noting that they had difficulty devising strategies to *"hold our providers accountable"* to provide care coordination and case management services.

Another administrator hypothesized that because more services are now covered under DMC-ODS, providers have less incentive to enroll patients in benefits programs to support their SUD care. *"Now that Medi-Cal is a primary payer,"* this administrator explained, "*these other county programs like CalWORKs or GR that they're historically motivated to enroll someone into because they get a payment attached with that, they're less motivated to enroll them in."* To increase provider motivation to provide case management services, this administrator suggested the creation of financial incentives to enroll patients in benefits programs for which they may qualify.

Based on these data, it is evident that Live-Waiver counties are further along in the process of developing and implementing case management services, but significant challenges to implementation remain.

Facilitation and Tracking of Referrals between Systems[22]

The degree of facilitation and tracking of referrals between systems is another measure by which cross-system integration and coordination can be gauged. Care coordination of SUD patients' additional needs such as MH problems and/or CODs have typically been hampered due to lack of SUD treatment resources. The DMC-ODS waiver provides a unique opportunity to improve levels of care coordination for patients who need both SUD and MH services. Baseline data for one year prior to DMC-ODS implementation in 2016 show that approximately 3% of patients receiving SUD services also received any type of MH services. These data indicate a substantial gap between patients who have COD diagnosis and those who are receiving services. Improving care coordination for these patients will depend on the effective collaboration of MH and SUD providers in coordinating the care of these patients.

The process of linking SUD patients to and from PH and MH services was explored through County Administrator Survey and Interviews among the Live-Waiver counties.

Linkage from SUD treatment to PH or MH care

Many counties reported using case management and care coordination services to help ensure that patients' co-occurring PH and MH service needs are addressed. In addition, the identification of unmet health-related needs during assessments helps providers learn of patients' conditions that they otherwise would have missed.

However, according to administrators, the implementation of PH and MH care linkage has been inconsistent, since some providers are unaccustomed to managing more than substance use-related needs. *"I don't know if our providers have become fully acculturated to (the idea that) 'We're taking care of this piece of your healthcare, but there's a bigger picture of your healthcare going on,"* explained one administrator. Thus, while *"it's getting better,"* summed up another, *"we have a ways to go. But we're on the right track."*

In particular, administrators reported that unless co-occurring PH or MH service needs are urgent, they are unlikely to be addressed. This is further complicated by the fact that it is difficult to get timely access to care. *"If somebody doesn't have a more urgent medical need,"* explained one county administrator, *"it can take three or four months just to get a routine appointment with their physical healthcare provider."*

Furthermore, many providers have little knowledge of the PH and MH services available in their communities, thus limiting their capacity to address patients' co-occurring health needs. As one administrator elaborated:

---

[22] Several findings in this section are also reported in Padwa, H., Huang, D., Castro-Moini, K., Teruya, C., Antonini, V., & Urada, D. (2018). *Linkages to SUD Systems of Care in the Early Implementation of California's Drug Medi-Cal Organized System Demonstration: Summary Report.* Report prepared for the California Department of Health Care Services.

"It's really important and some providers do it well—it's just second nature, it's how they work. (But) others are much more insular and just think about themselves as this little island, and don't often think about connecting people. We have a provider that's like three blocks away from a mental health provider, and somehow has a very difficult time, doesn't even know their intake folks. They're dealing with people who have SMI (serious mental illness) and they don't know the name of the mental health clinic down the street. There is a big variance. We are doing a lot of developmental work right now, and ongoing work around building our system's capacity to treat complex clients, building in that expectation that they know about other community services, that they help coordinate those services, that they know the providers."

Administrators in some counties reported that the development of strong working relationships at the health plan level has facilitated increased care collaboration. In particular, county partnerships with managed care plans have helped establish cross-system linkages that enhance access to medical care and has shown potential to improve MH service access. In one county, while the MH system could serve patients with serious mental illness, providers had challenges connecting patients with mild or moderate psychiatric conditions to care. Managed care plans in this county helped address this by creating strategies to link these patients to primary care providers who could provide MH medication services, or to community psychiatrists. Thus, engagement with managed care plans, one administrator explained, has contributed to *"silos breaking down,"* and shown promise as a strategy to facilitate coordination.

<u>Linkage from other health systems to the DMC-ODS waiver</u>

On the County Administrator Survey and in implementation plans, counties reported several different planned strategies to facilitate referrals from PH settings to DMC-ODS services.

In primary care settings, counties reported that they will:
- Co-locate behavioral health staff to facilitate referrals for full ASAM assessment and enrollment in DMC-ODS services
- Co-locate SUD treatment providers or behavioral health staff to conduct onsite screening and assessment
- Add SUD staff capable of providing SUD services within primary care settings

In emergency departments, counties reported that they will:
- Co-locate behavioral health staff to facilitate referrals for full ASAM assessment and enrollment in DMC-ODS services
- Co-locate SUD treatment providers or behavioral health staff to conduct onsite screening and assessment
- Have a care coordination teams dedicated to engaging patients identified in emergency settings

In MH settings, counties reported that they will:

- Co-locate SUD treatment providers or behavioral health staff to conduct onsite screening and assessment
- Create unified access points and assessments for MH and SUD services, so that individuals seeking MH care are automatically screened for SUD service needs at intakes, and referred for a full SUD assessment if needed
- Integrate SUD treatment staff into MH programs
- Promote DMC certification for MH programs, enabling them to directly provide DMC services

In sobering centers, MH urgent cares, and other short-term behavioral health service settings, counties reported that they will:

- Have care coordination teams work to engage patients identified in these settings and link them to access points where they can receive full ASAM assessments
- Co-locate staff to screen individuals for SUD and/or provide full ASAM assessments
- Co-locate SUD case managers onsite to help facilitate entry into treatment
- Directly transport individuals to residential or withdrawal management

Other general strategies counties will use to facilitate linkage from other services to DMC-ODS services include:

- Having all referral sources provide transportation for prospective DMC-ODS patients to screening and/or assessment
- Having SUD providers provide transportation from referral sources to locations where screening and/or assessment can be provided
- Establishing procedures to ensure referring organizations receive feedback on the status of referrals, with SUD providers notifying referral sources when referrals were received, and when patients initiate and complete treatment.

In spite of these innovations, CalOMS-Tx data suggest the implementation of DMC-ODS has yet to affect rates of referral from other systems of care to the DMC-ODS. The number of statewide admissions resulting from health care referrals across treatment modalities has remained relatively flat throughout DMC-ODS implementation and most of the referrals that have gone through have been to withdrawal management (See Figure 4.18).

Figure 4.18 Number of referrals from health care providers to SUD specialty treatment in Live-Waiver counties
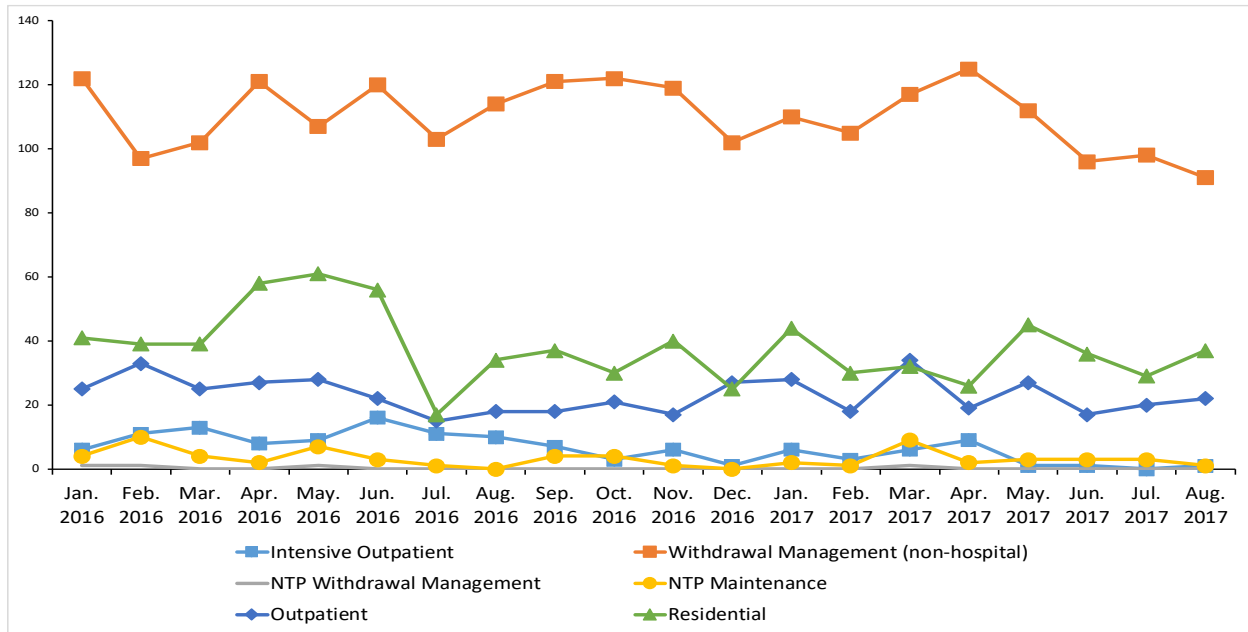
In interviews, county administrators from Live-Waiver counties provided two potential explanations for why DMC-ODS implementation has yet to impact healthcare referrals based on available administrative data: the shortcomings of CalOMS referral source measures, and the persistence of barriers to linkage from healthcare to SUD treatment.

County administrators reported that even though CalOMS-Tx collects information on referral sources from new service recipients, the information it captures does not necessarily reflect actual trends in referrals. Administrators reported that many individuals who are referred for assessment and intake may not report who referred them or for what reason, and would show up as "self-referred" in CalOMS-Tx. In addition, they pointed out that when asked about who referred them to care, patients are more likely to report that they were told to seek services by a judge or a probation officer than if they were encouraged to seek care from a healthcare provider. In addition, administrators reported that many individuals receive specialty SUD care in their systems but without formally entering treatment in programs that report to CalOMS-Tx. Patients who receive detoxification services in hospitals, medication assisted treatment in primary care settings, integrated MH and SUD services in behavioral homes, or SUD services that are integrated with other forms of health care through programs for special populations that have their own funding streams (e.g., Mental Health Services Act, Whole Person Care) do not have the services they receive entered into CalOMS-Tx. As one administrator summarized, with CalOMS-Tx data *"you're just actually seeing a portion of the pie, and not all of it."*

Administrator interviews also revealed the persistence of several barriers to successful linkage from healthcare to specialty SUD treatment early in DMC-ODS implementation. Whereas criminal justice programs have a long history of interfacing with SUD treatment systems through diversion and early-release programs, the infrastructure for referral from health care settings to SUD treatment remains relatively undeveloped in many counties. Consequently, in some counties, relationships between SUD and health systems are just beginning, and integration efforts have not yet reached the point of focusing on linkage to specialty care. "*We're really just at the point,*" summarized one county administrator, "*where we are trying to ensure that providers and beneficiaries…know that they're entitled to the (SUD) benefit and they know what number to call (to access services).*" In interviews and on surveys, some counties reported that hospitals, in particular, have been difficult to engage in meaningful relationships, and some administrators suggested that technical assistance on engaging hospital and emergency partners may help them establish fruitful relationships with medical systems.

In counties where relationships with health care partners are more established, most health care settings still have not developed effective protocols or procedures to link patients who need SUD treatment to specialty care. "*They're supposed to do SBIRT [Screening, Brief Intervention, and Referral to Treatment],*" elaborated one administrator, "*but they forget that beyond 'S' there is 'BIRT.'*" Many health care programs still do not proactively provide case management, linkage, or transportation supports needed to follow through on referrals to specialty care, though counties reported that under the DMC-ODS they are beginning to develop such services. In addition, administrators reported that some medical providers are disinclined to make referrals to SUD treatment because there are no mechanisms in place to find out if patients follow through and actually initiate services. In particular, several administrators cited 42 CFR Part 2 privacy rules as a barrier that makes it difficult for PH providers to find out if their patients followed through on SUD referrals.

C. Discussion and Next Steps

Hypothesis 4 of the waiver evaluation states SUD treatment coordination with primary care, MH, 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 in that only seven counties began implementation following approval from CMS/DHCS or "went live" in time for analysis, and provider level data, a key dataset for this domain, is still in the collection process among the Live-Waiver counties. Another key dataset, Medi-Cal managed care / FFS data, were not available in time for inclusion in this report, but these data will allow for additional analyses in future reports.

This report is focused on targeted measures with accessible data in which there was potential for measurable change from 2015 to 2017, comparing the identified Live-Waiver counties to the Pre-Implementation and to the Non-Waiver counties. Based on data drawn primarily from County Administrator Surveys, County Administrator Interviews, 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:

- *Comprehensive substance use, PH, and MH screening.* The DMC-ODS requirement to use ASAM criteria necessitates county implementation of comprehensive screening practices. County Administrator Surveys confirmed that ASAM assessment and placement was fully or partially available in 2017 in all (100%) of the Live-Waiver counties, in the majority (63%) of Pre-Implementation Waiver counties, and in half (50%) of the Non-Waiver counties. In addition, all (100%) of the Live-Waiver counties reported having a centralized system for screening for all or some of their services (increased from 86% in 2015). These data indicate that the DMC-ODS has positively impacted the implementation of comprehensive substance use, PH, and MH screening.

- *Cross-system care coordination and effective communication among providers.* Cross-system coordination and communication has been enhanced by the DMC-ODS. Though coordination and communication is stronger with MH systems, the DMC-ODS has had a greater impact on facilitating stronger linkages with PH care systems, particularly through coordination with managed care plans. However, as counties have implemented the DMC-ODS, they report that even though channels of communication have expanded, there is a significant need for greater communication and collaboration with MH and PH system administrators. In particular, administrators report a greater need to interface more with their counterparts who oversee PH services in their counties.

- *Navigation support for patients and caregivers through case management.* The implementation of the DMC-ODS has facilitated increased interest in, and implementation of, case management services. However, significant challenges continue to impede case management service delivery, including provider confusion over what case management is, a lack of interest/motivation among

providers to deliver the service, and insufficient resources to support counties and providers as they begin integrating it into their systems of care.

- *Facilitation and tracking of referrals between systems.* Available data do not yet indicate widespread facilitation and tracking of referrals between SUD systems, MH, and PH care. Challenges that impede referrals and care coordination for individuals receiving DMC-ODS services include SUD providers' beliefs about and/or unfamiliarity with referral and care coordination services, and barriers in other systems (e.g. difficulty getting a timely appointment) further impede referrals. Furthermore, data do not indicate that the DMC-ODS has facilitated an increase in referrals from healthcare or MH sources to SUD care. The extent to which this is due to actual weakness in referrals or rather to undercounting issues in the available data source (CalOMS-Tx) is unclear.

- *Recommendation:* Consider additional technical assistance on the implementation of the case management benefit with a focus on: 1) the overall understanding of the terms case management and care coordination, 2) billing and reimbursement strategies for allowable services, and 3) sharing successful practices and lessons learned among counties.

- *Recommendation:* Facilitate collaborative learning on a variety of implementation topics related to care coordination. In many cases, counties were struggling with very complex issues (e.g. the best ways to approach case management, care coordination across systems, transitioning patients from one level of care to another, linkage to and delivery of recovery support services, and/or overcoming financial barriers to expansion). These may be best addressed via collaborative learning effort.

V. Conclusion

A. Summary and Recommendations

In 2017, the first counties were approved by the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) to provide Drug Medi-Cal Organized Delivery System (DMC-ODS) services. Within this report, UCLA focused evaluation efforts on measures with accessible data in which there was potential for measurable change, comparing the "Live-Waiver counties", "Pre-Implementation Waiver counties", and the "Non-Waiver counties". Unless otherwise specified, Live-Waiver counties refers to the group of seven counties that were approved by DHCS and CMS to provide DMC-ODS services and began providing them as of July 1, 2017. These counties were Contra Costa, Los Angeles, Marin, Riverside, San Francisco, San Mateo, and Santa Clara. "Pre-Implementation Waiver Counties" refers to the group of 33 counties that submitted DMC-ODS implementation plans but did not "go live" as of July 1, 2017. "Non-Waiver counties" refers to the group of 18 counties that not submit a DMC-ODS implementation plan before the deadline to do so.

Overall, our findings indicate that the DMC-ODS waiver is having a measurable effect. In any effort of this size and complexity there will be both successes and challenges, and DMC-ODS is no exception.

Overall views and suggestions from county administrators

In interviews, county administrators reported overall being pleased with the DMC-ODS and its impact in their counties. *"I'm happy (with it), I'm happy with what we're doing with it,"* reported one administrator. Others concurred, saying that the improvements the DMC-ODS has brought to their county systems were welcome and *"long overdue"* and that *"the state did a really good job in expanding what's accessible through the waiver."* However, change can be difficult, and requires a shift in mindset for many providers and counties. *"People don't realize what a significant change it's gonna be until it goes into effect,"* one administrator said.

DMC-ODS implementation has not only improved services, but as one administrator explained, it has helped improve services in areas where counties were not even aware there were issues that needed to be addressed.

While county administrators were enthusiastic about the DMC-ODS and the changes it is bringing to their systems of care, they did share several thoughts on what they believed were shortcomings of the DMC-ODS as implemented, and suggestions on steps that could be made to further improve Substance Use Disorder (SUD) services in future.

County administrators suggested that more time and resources for counties would help counties and programs ramp up and pay for start-up costs associated with higher standards, hiring licensed staff, and delivering training, and opening new DMC clinics.

Another county administrator concurred, noting that *"having limited staff"* to allocate to the DMC-ODS hindered its early implementation. One complained that starting a new clinic "requires deep pockets" to run an organization for months, staffed, and up and running, if it doesn't have more of a dedicated funding stream while awaiting certification.

One suggestion that several administrators made in administrator interviews was shifting both administrative paperwork and data collection to better reflect a chronic care approach to SUD treatment. Currently under the DMC-ODS, administrators explained, the California Outcomes Measurement System – Treatment (CalOMS-Tx) system requires patients' treatment episodes to be "closed" when they complete one level of care (e.g. withdrawal management) and then "opened" again when they enter another (e.g. residential), even if they are transitioning between levels of care in the same program. One administrator questioned, *"Why should they close after detox and open in residential?...why should the treatment plan change…if they're just moving, say from residential to outpatient on the third floor versus the second floor?"* Another administrator suggested it would be beneficial to *"make (CalOMS-Tx) a chronic care program so you can open and close (cases)"* and collect data that facilitates *"chronic care management"* by tracking individuals throughout the care continuum instead of treating each individual treatment episode as its own discrete event. If DHCS' data systems could be re-engineered to collect outcomes as beneficiaries proceed through the continuum of care and through multiple treatment episodes, administrators suggested this would provide a more complete picture of chronic care management of SUD. DHCS is currently in the midst of a "CalOMS rewrite" that could incorporate this feedback.

Finally, administrators suggested that in the future, they hope DHCS can give counties additional opportunities to innovate their SUD systems of care. As one administrator said, *"I hope in the next iteration of this (DMC-ODS) that they do more about innovation or at least they allow the counties that are ready the space to do it….really let us get a little more creative in the next iteration."* In particular, this administrator suggested that allowing counties flexibility to structure payments and measure outcomes differently could help improve care and SUD treatment outcomes in the future. Other county administrators suggested that flexibility is also needed to address the needs of transient populations who frequently *"move county to county"* and could be better served if counties had more ways to collaborate without going through the onerous process of *"creating more contracts."*

Summary of Recommendations from this Report:

<u>Access</u>

- *Recommendation: Continue working with counties to resolve voluntary inpatient detoxification billing issues provided through fee-for-service Medi-Cal. To facilitate expanded withdrawal management within DMC, explore with CMS the possibility of streamlining the process for existing providers to add withdrawal management services.*

- *Recommendation: look into options to help with startup costs*

- *Recommendation: Consider additional technical assistance on these topics,*

<u>Quality</u>

- *Recommendation:* Provide training and technical assistance (e.g., collaborative learning opportunities, FAQs, Information Notices) in the following areas: ASAM Criteria assessment and placement; Drug Medi-Cal billing; utilization management; patient flow along the continuum of SUD treatment, especially provision of additional service after discharge from residential treatment and withdrawal management; and evidence-based practices, particularly trauma-informed treatment and motivational interviewing.

- *Recommendation:* Develop and/or make available youth-specific ASAM Criteria assessments to counties that wish to use them.

<u>Integration/Coordination</u>

- *Recommendation:* Consider additional technical assistance on the implementation of the case management benefit with a focus on: 1) the overall understanding of the service terms, case management and care coordination, in the context of the SUD continuum of care and whole person care under the DMC-ODS, and 2) billing and reimbursement strategies for allowable services.

- *Recommendation:* Facilitate collaborative learning on a variety of implementation topics related to care coordination. In many cases, counties were struggling with very complex issues (e.g. the best ways to approach case management, care coordination across systems, transitioning patients from one level of care to another, linkage to and delivery of recovery support services, and/or overcoming financial barriers to expansion). These may be best addressed via collaborative learning effort.

B. Limitations

While the results from the third 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.

Analyses in this report focus on the seven counties that had begun delivering services under the DMC-ODS waiver by July 1, 2017. Three out of the seven counties that implemented in CY 2017 went Live in February and April of 2017 while the remaining four counties went Live in July of 2017. Due to delays in data reporting, timeframes vary by dataset and not all counties are included in each analysis. Statistically, there were also limits to which analyses could be performed with a small number of counties. As more

counties begin services and new data becomes available, future reports will expand to include analyses that are more comprehensive.

Data sources for this report were limited to the data available. Managed Medi-Cal/ data were not available for the waiver period, and level of care data was only available from three of the Live-Waiver counties. UCLA is continuing to work with stakeholders to obtain additional data in the future.

Appendices

A. Acronyms

AOD	Alcohol and other drug
ASAM	American Society of Addiction Medicine
BH	Behavioral health
CalOMS-Tx	California Outcomes Measurement System - Treatment
CIBHS	California Institute for Behavioral Health Solutions
CMS	Centers for Medicare and Medicaid Services
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
EBP	Evidence-based practice
EHR	Electronic health record
EQRO	External Quality Review Organization
IOP	Intensive outpatient treatment; see DCH
ISAP	(UCLA) Integrated Substance Abuse Programs
LOC	Level of Care
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"
NSDUH	National Survey on Drug Use and Health
NTP	Narcotic Treatment Program
PIP	Performance improvement project
QA	Quality assurance
QI	Quality improvement
QIC	Quality Improvement Committee

QIP	Quality Improvement Plan
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
WM	Withdrawal Management

B. Treatment Perceptions Survey Report

Treatment Perceptions Survey (TPS) Report

Contra Costa, Marin, Los Angeles, Riverside,

San Francisco, San Mateo and Santa Clara Counties

N=9027

All Substance Use Treatment Programs Surveyed

November 2017/January 2018 Survey Period

Prepared by the University of California, Los Angeles

Integrated Substance Abuse Programs

Table 1. Number of programs** that returned survey forms

Outpatient/ Intensive Outpatient	Residential	Opioid/ Narcotic Treatment Program	Detoxification/ Withdrawal Management	Partial Hospitalization	Other/ Missing	Total
175	124	58	18	2	2	379

** In this report, "program is defined as a unit having a unique combination of CalOMS Provider ID and treatment setting and/or Program Reporting Unit ID (optional) as indicated on the survey forms or in the data file submitted to UCLA.

Table 2. Number of clients who returned survey forms by treatment setting

Outpatient/ Intensive Outpatient	Residential	Opioid/ Narcotic Treatment Program	Detoxification/ Withdrawal Management	Partial Hospitalization	Other/ Missing	Total
3556	2064	3275	107	4	21	9027

Table 3. Number of clients who returned survey forms by county

Contra Costa	Los Angeles	Marin	Riverside	San Francisco	San Mateo	Santa Clara	Total
507	4792	137	760	1939	258	634	9027

Table 4. Number of completed survey forms by language

Language of the Survey	Outpatient/ Intensive Outpatient	Residential	Opioid/ Narcotic Treatment Program	Detoxification/ Withdrawal Management	Partial Hospitalization	Other/ Missing	Total
ENGLISH	3314	2037	3242	101	4	21	8719
SPANISH	233	27	33	6	.	.	299
VIETNAMESE	9	.	.	.	.	.	9

Table 5. Demographics of clients

Demographics	N	%
Gender (Multiple response allowed)	.	.
Female	3369	37.4
Male	4702	52.3
Transgender	70	0.8
Additional Identity	26	0.3
Decline to answer	95	1.1
Age	.	.
18-25	885	11.2
26-35	2483	31.5
36-45	1779	22.5
46-55	1430	18.1
56+	1316	16.7
Race/ethnicity (Multiple response allowed)	.	.
American Indian/Alaska Native	379	4.4
Asian	252	2.9
Black/African American	1393	16.1
Latino	2896	33.0
Native Hawaiian/Pacific Islander	139	1.6
White/Caucasian	3236	37.1
Other	817	9.5
How long received services here	.	.
First visit/day	495	6.1
2 weeks or less	826	10.3
More than 2 weeks	6728	83.6

Table 6. Average client rating and percent of clients with a positive rating by treatment setting

'	Outpatient/ Intensive Outpatient	Residential	Opioid/ Narcotic Treatment Program	Detoxification/ Withdrawal Management	Total
Average client rating (SD)	4.5 (0.6)	4.3 (0.7)	4.5 (0.6)	4.5 (0.6)	4.4 (0.6)
Percent of clients with a positive rating	94.7 %	89.1 %	93.8 %	91.1 %	93.0 %

All 14 questions were used to calculate the average score (standard deviation, SD). Scores ranged from 1.0 to 5.0, with higher scores indicating greater satisfaction. Only clients who responded to all 14 questions were included (N=7750).

Overall positive rating was calculated using all 14 questions. Surveys with an average rating of 3.5 or higher were counted as having a POSITIVE rating. Only clients who responded to all 14 questions were included (N=7750).

Table 7. Number of responses (percent) for each survey question

item question	Strongly Disagree(1)	Disagree(2)	Neutral(3)	Agree(4)	Strongly Agree(5)
Domain: Access					
01 Convenient Location	143 (1.7%)	229 (2.7%)	749 (8.9%)	2545 (30.3%)	4581 (54.6%)
02 Convenient Time	97 (1.1%)	232 (2.7%)	618 (7.2%)	2968 (34.7%)	4618 (53.9%)
Domain: Quality					
03 Chose Goals	100 (1.2%)	192 (2.3%)	714 (8.4%)	2916 (34.2%)	4443 (52.2%)
04 Enough Time	73 (0.9%)	140 (1.6%)	563 (6.6%)	2811 (32.8%)	4893 (57.1%)
05 Treated with Respect	78 (0.9%)	132 (1.5%)	482 (5.6%)	2333 (27.2%)	5544 (64.5%)
06 Understood Communication	50 (0.6%)	87 (1.0%)	415 (4.8%)	2600 (30.2%)	5433 (63.1%)
07 Cultural Sensitivity	87 (1.0%)	150 (1.7%)	614 (7.1%)	2542 (29.6%)	5032 (58.6%)
Domain: Care Coordination					
08 Work with PH Providers	117 (1.4%)	225 (2.6%)	1004 (11.7%)	2557 (29.9%)	4277 (50.0%)
09 Work with MH Providers	97 (1.1%)	206 (2.4%)	1085 (12.8%)	2396 (28.2%)	3933 (46.3%)
Domain: Outcome					
10 Better Able to Do Things	110 (1.3%)	191 (2.2%)	801 (9.3%)	2633 (30.7%)	4763 (55.6%)
Domain: General Satisfaction					
11 Felt Welcomed	60 (0.7%)	91 (1.1%)	457 (5.3%)	2334 (27.1%)	5648 (65.6%)
12 Like Services	81 (0.9%)	123 (1.4%)	608 (7.1%)	2590 (30.1%)	5173 (60.2%)
13 Enough Help	131 (1.5%)	229 (2.7%)	815 (9.5%)	2659 (31.0%)	4706 (54.8%)
14 Recommend Agency	135 (1.6%)	131 (1.5%)	536 (6.2%)	2255 (26.2%)	5492 (63.8%)

Figure 1. Average score of survey questions (range 1-5)

Figure 2. Average scores of the five domains (range 1-5)

* Only clients who responded to each question in the domains were included.

Figure 3. Average client satisfaction score by domain and treatment setting

Treatment Setting

OP/IOP   Residential   OTP/NTP   Detox/WM (standalone)