FY 2017-2021

EXTERNAL QUALITY REVIEW REPORT

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

Prepared for the California Department of Health Care Services (DHCS)

By Behavioral Health Concepts, Inc. (BHC)

BHC | Behavioral Health Concepts, Inc

Acknowledgments

Behavioral Health Concepts, Inc. (BHC) would like to acknowledge the people of California who persevered through unprecedented challenges during the time period of the launch of the Drug Medi-Cal Organized Delivery System (DMC-ODS), including the opioid crisis, state wildfires, and the COVID-19 pandemic, which is still being managed. Although there have been many challenges, people have continued to strive not only for their own health and behavioral health but also for others in program services and in their communities.

The COVID-19 pressures and other stressors have sadly contributed to a rise in overdose deaths and increased use of drugs and alcohol. To that end, it is even more important that the access, quality, and timeliness of the DMC-ODS services be available and continue to thrive. BHC would thus like to acknowledge the work of the 37 counties, which comprise 31 DMC-ODS plans, including 1 Regional Model with seven counties, that participated in the California External Quality Review Organization (CalEQRO) reviews. This acknowledgment includes staff, volunteers, contract providers, key stakeholders, and many others. We acknowledge the many clients and family members who shared their experiences with BHC.

In addition, BHC would like to acknowledge the support and collaborative staff from the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs and its leadership, and the support and collaborative efforts with California's Behavioral Health Directors Association (CBHDA). Both organizations worked to foster quality of care and best practices for substance use disorder (SUD) services, leading to the promotion of models that optimize success for different client groups and families.

Also, the guidance of and collaboration with the Department of Health Care Services (DHCS) divisions and programs responsible for quality and evaluation of the 1115 Waiver, Network Adequacy (NA), Policy, Quality, Compliance, Information Services, and SUD licensing and certification services have all been instrumental in the successful completion of the reviews and reports this year.

It is our goal that the findings, best practices, and opportunities for enhancement of SUD treatment outcomes from this report may be used to improve the care of people with SUD. It is also important to foster a statewide system of treatment that changes lives in creating positive health and community success for the Medi-Cal members who depend on these services.

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Acronyms List

AB	Assembly Bill
AAS	Alternate Access Standard
ACA	Affordable Care Act
ALOC	Assessment and Authorization for Level of Care
ASAM	American Society of Addiction Medicine
ASP	Application Service Provider
ATTC	Addiction Technology Transfer Center
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts, Inc.
CalAIM	California Advancing and Innovating Medi-Cal
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CAPHS	Consumer Assessment of Providers & Health Systems
CARF	Commission on Accreditation of Rehabilitation Facilities
CBT	Cognitive Behavioral Therapy
CCP	Cultural Competency Plan
CENS	Client Engagement and Navigation Services
CFM	Client and Family Member
CFR	Code of Federal Regulations
CHCF	California Health Care Foundation
CHIP	Children’s Health Insurance Program

CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
ED	Emergency Department
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIS	Health Information System
HRSA	Health Resources and Services Administration
IMAT	Intensive Medication Assisted Treatment
IMD	Institutions for Mental Diseases
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capacity Assessment

IT	Information Technology
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Professional in the Healing Arts
MAT	Medication Assisted Treatment
MCP	Managed Care Plan
MHP	Mental Health Plan
MI	Motivational Interviewing
MMEF	Medi-Cal Eligibility File
MOU	Memorandum of Understanding
NA	Network Adequacy
NACT	Network Adequacy Certification Tool
NIATx	Network for Improvement of Addiction Treatment
NIDA	National Institute on Drug Abuse
NSDUH	National Survey of Drug Use and Health
NTP	Narcotic Treatment Program
OTP	Opioid Treatment Program
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RPT	Relapse Prevention Therapy/Treatment

SAPC	Substance Abuse Prevention and Control
SAPT BG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SASH	Substance Abuse Services Helpline
SDMC	Short-Doyle Medi-Cal
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
SUD	Substance Use Disorders
TAR	Treatment Authorization Request
TPS	Treatment Perception Survey
TSA	Timeliness Self-Assessment
WM	Withdrawal Management

Drug Medi-Cal Organized Delivery System External Quality Review

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Executive Summary

Executive Summary

There was steady progress from 2017 to 2021 in California's 1115 Waiver implementation of DMC-ODS services; however, opportunities for improvement remain.

Overview of Progress

In August 2015, the State of California Department of Health Care Services (DHCS) received approval from the Centers for Medicare and Medicaid Services to launch the nation's first substance use disorder (SUD) demonstration project utilizing an organized service delivery model. The five-year project aimed to reorganize SUD services in a way that would improve access and health outcomes for the state's Medi-Cal beneficiaries. CalEQRO has been in the unique position to contract with DHCS to provide external quality reviews of all counties who have opted into this new model of service delivery allowed under Medicaid Section 1115 waiver, or what has become known as the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The DMC-ODS Waiver provided a necessary response to dual national and statewide health emergencies related to the opioid crisis. In CalEQRO's review of the DMC-ODS counties, including the recently launched multi-county regional DMC-ODS model, there is evidence that the Waiver is improving clients' access to treatment, enhancing timeliness to enter into treatment, and building key elements of quality that benefit the clients and system of care as a whole. Many notable examples of these clinical and program improvements were seen and documented across the counties reviewed. These findings are highlighted in this report and are designated by the level of care (LOC) provided, size of the to the extent they were found relevant. Finally, types of technical assistance (TA) need and supports for the programs are also highlighted

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Data trends, findings, and recommendations are detailed in nine chapters, highlighted in this summary, based on the 1115 Waiver goals, CMS quality protocols, and report requirements.

- Overview
- Methods
- Access
- Network Adequacy (NA)
- Timeliness
- Quality
- Outcomes
- Information Systems (IS)
- Recommendations for Continued Success
- Appendix Information Final Report

To see these system changes in more depth, data from the initial 14 counties who launched new treatment services under the DMC-ODS Waiver in 2017 and 2018, hereafter referred to as "Pioneer Counties," were separated from the counties that implemented their DMC-ODS services in the past two years. This distinction highlights the evolution of SUD system changes, pinpointing areas where key investments affected systems of care and clients' lives. Yet as with any major system change, many challenges and areas needing improvements

remain. As counties demonstrate innovative approaches to addressing the implementation challenges they face, they can learn from each other's best practices. Other system-wide challenges will need to be addressed by policy or programmatic, structural changes and requirements, or in more global ways as part of broader California Advancing and Innovating Medi-Cal (CalAIM) considerations.

Timely Access to Appropriate Care

The review findings and data from the five years of the Waiver experience showed expanded service delivery across the American Society Association of Medicine (ASAM) LOCs, for both historical and new Medi-Cal treatment services. However, there were service delivery impacts from COVID-19, such as decreased enrollments and utilization, though the impacts were short-term. The Pioneer Counties have shown the most significant growth across the continuum of new services though first and second-year counties also expanded services, although to a more modest degree. Although there has been an increase in unduplicated clients served under the DMC-ODS Waiver each year since 2017, the Pioneer Counties' penetration rates for Medi-Cal clients served exceeded statewide averages in each year reviewed. These penetration rates, based on all Medi-Cal eligibles in a county, also showed improvement across all ethnic/racial groups when compared to statewide data (see Figure 3-3 in this report's Access chapter). This trend has continued for each of the three years that CALEQRO has completed Medi-Cal claims data and the data suggests ongoing increases in these trends for FY 2020-21.

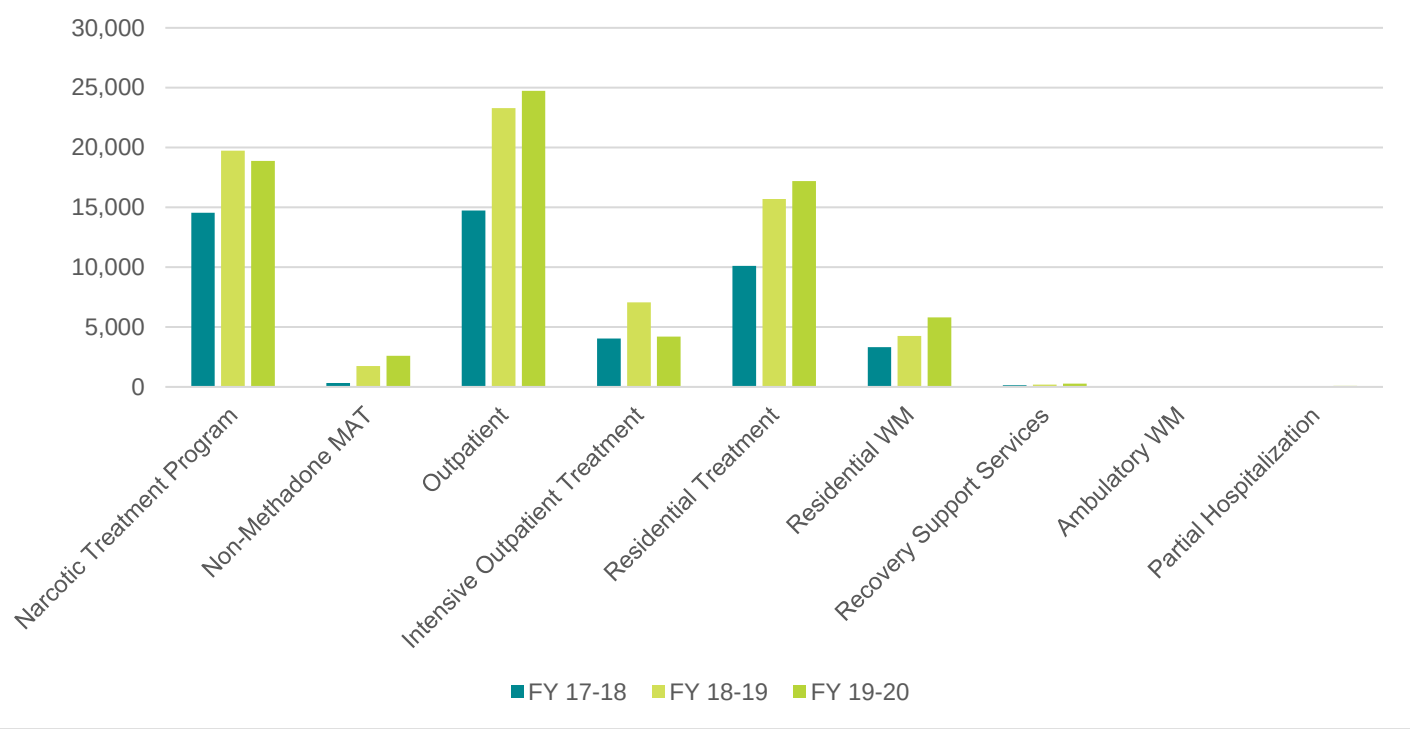
In addition to increasing the number of individuals served, it is also important to consider what form of SUD service these clients receive. The Waiver expanded the services within the DMC-ODS framework to meet the individualized treatment needs of SUD clients based on the ASAM model of comprehensive SUD care. While all LOCs expanded during the review period in total, some did so more rapidly than others. Required LOCs such as residential, narcotic treatment programs/opioid treatment programs (NTP/OTP), and outpatient LOCs expanded more rapidly than other programs. Optional services increased more slowly or not at all in some counties.

Required LOCs with strong expansion included residential treatment, outpatient and intensive outpatient, NTP/OTP treatments with their new expanded medication requirements, and case management. LOCs that grew more slowly were recovery residence housing, recovery support services (RSS), non-methadone MAT, additional NTP/OTP sites, ASAM levels 3.7 and 4.0 withdrawal management (WM), hospital-based emergency department (ED) voluntary WM, outpatient WM, and services for youth other than outpatient. These LOCs require more investment and expanded access to meet client needs in many areas of the state.

Figure ES-1 Clients serviced in the Pioneer Counties 2017 to 2020

Data indicates that for clients at all LOC there has been steady growth in all of the required services except for intensive outpatient treatment. Ambulatory WM and partial hospitalization are not required LOCs, and even though there are small efforts to add some of these services, they are minimal statewide.

Figure ES-1: Clients Served Across Levels of Care in DMC-ODS Pioneer Counties FY 2017-18 to FY 2019-20



Many DMC-ODS counties organized their systems to make them much more accessible to clients at every point of care, from the initial client request to delivering treatment at the right LOC and critical transitions in care to lower LOC. These best access practices and evidence-based practices (EBPs) include:

- Offering a 24/7 access center or beneficiary access line (BAL) services that conducts ASAM screenings with call-center software support, three-way calling capacity allowing for linkage to service with client on the line, and SUD resource directories with real-time capacity data to effectively link clients to the appropriate LOCs for services.
- Linkages to historic records to streamline assessments and referrals.
- Well-distributed program sites for that allow for convenient client access to ASAM in-person assessments and/or a robust telehealth infrastructure allowing for remote access to assessments.
- Walk-in appointment hours for screenings, assessments, information, and referrals.
- Warm handoff practices between providers help clients to build therapeutic alliances at new LOCs.

- Health information systems (HIS) with up-to-date appointment and vacancy information for convenience and coordination for the BAL staff and clinic/provider staff.

- Access to recovery navigators or case managers to help incoming clients access their first face-to-face appointment after making requests for services, particularly urgent requests. This "navigation" function is critical at several phases of care.

- Data tracking alerts when LOC services were over or close to capacity.

True access requires much more than offering an available appointment or a residential bed. In addition to time and space, an adequate workforce is needed at all LOCs, with the skills and licenses required for specific SUD services. Staff support is critical to helping and engaging clients who are often anxious or ambivalent about coming in for initial services. All counties and contractors that took part in CalEQRO review sessions voiced a need for more trained and experienced SUD staff at many levels. They shared the view that state leadership is critical to expanding college opportunities, training, and program capacity to bring more people into this important field of clinical work. Locally, they were working to raise salaries, hire interns, offer training, and even participate in matching programs for loan forgiveness. In spite of all these efforts, workforce adequacy remains an issue.

1115 Waiver Design Elements Supporting Quality & Outcomes

- Client-centered services in a Continuum of Care
- SUD workforce with diverse clinical and bilingual/bicultural skills
- Care coordination and recovery support services
- Infrastructure for Quality Improvement (QI) Systems

Research indicates that when an individual move beyond contemplating the need for treatment to taking active steps in seeking care, this can be an extremely stressful time, often fraught with fear and periods of lingering hesitancy. This makes timely access a critical element of assisting a new client in facing challenges in giving up an addiction, and possibly facing physical withdrawals. In order to make this tolerable and to encourage clients to seek and sustain care, it is essential to match clients to the right LOC with welcoming, skilled counselors and providers. Best practices in this area include skilled ASAM screenings, a full continuum of treatment options, and prompt linkages to the right LOC. It is also important to engage with someone who can help clients with their specific needs and treatment goals, supporting them as they move forward through withdrawal to a suitable treatment environment.

DMC-ODS counties have made progress in reducing the time to access care. They continue to work on more options for prompt access by adding additional treatment sites as well as expanding their use of telehealth, mobile services, and treatment kiosk sites. The data in this report will show the slow but consistent progress over the Waiver evolution.

Quality of Care & Better Outcomes

The assessment and review tools used by the CalEQRO over the past four years suggest that the quality of SUD services being provided to Medi-Cal beneficiaries in the DMC-ODS Waiver counties is steadily improving. Design elements that were incorporated within the DMC-ODS framework have enhanced the quality of SUD services across California. In addition to a review of direct services, CalEQRO considers a variety of data sources: ASAM LOC referral data, the Treatment Perception Survey (TPS) data, the California Outcomes Measurement System (CalOMS) results, the Performance Measures (PM) results, and stakeholder and client feedback and surveys. Some positive quality findings include:

(1) Counties have made significant progress in designing a client-centered service model that is provided across a continuum of SUD levels of care utilizing an ASAM structure of continuous assessment allowing for a provision of treatment with varied intensity and a strong focus on science and evidenced-based practices (EBPs).

(2) Counties have taken significant steps to overcome what historically was a fragmented and silo system by utilizing care coordination often through RS service activities that include connecting and communicating needs and addressing barriers throughout the treatment episode from service initiation to discharge planning and community placement.

(3) Counties that have committed infrastructure and support for quality of care have a system based on best practices, scientific evidence, and investments in continuous quality improvement which are linked to electronic health records, efficient billing, and data and oversight systems.

(4) An expanded workforce capacity with additional licensed staff at most LOCs and programs supports quality of care and improved outcomes.

The design of the 1115 Waiver included many elements that led to its success in quality, efficiency, and clinical effectiveness. Challenges remain as evidenced by the number of contract providers who are still unable to communicate client needs electronically with an EHR, coordinate their care using electronic tools and treatment plans, compounding an inability to use resources efficiently for administrative functions such as billing, cost-reports, and outcomes data. These challenges exist for some county-run programs as well, but contract providers constitute over 80 percent of the statewide DMC-ODS delivery system. Behavioral health, and particularly the SUD provider network, continues to have significant unmet IS infrastructure needs which hinders communication across networks and between behavioral health and health care providers.

Recommendations for Continued Success

- Continue to expand Regional Models such as Partnership Heath Plan (PHC) to enable the participation of small counties that are not currently part of the Waiver. These models could include regional approaches or other joint power structures that provide access to a full range of DMC-ODS and specialty mental health services in a coordinated manner. Regional partnerships could help to integrate mental health, DMC-ODS, and physical healthcare together to better serve the Medi-Cal population in rural and frontier communities. County Organized Health Systems (COHS) can provide a possible vehicle to facilitate the multi-county approach.
- Consider best practices in access, timeliness, and quality learning from the CalEQRO reviews and UCLA evaluation to ensure these are integrated into SUD care models for the future. CalEQRO will continue to document and update them in detail each year as part of annual reports.

Recommendations for Building on DMC-ODS Progress

- Continue to develop new models for adaptation by smaller counties (e.g., regional approaches)
- Invest in SUD workforce expansion options, including peers.
- Incorporate best practices in access, timeliness, and quality into the Waiver and regulatory processes
- Expand local infrastructure investments, especially for DMC-ODS contractor systems linked to quality
- Support stigma reduction and affordable housing initiatives to help clients and communities

- Bring SUD contract providers and behavioral health programs on par with primary care regarding the interoperability of EHRs and practice management systems. State and local investments in IS and infrastructure components, such as EHRs and quality management systems, are critical and will become even more important with CalAIM.
- State and local efforts to expand the behavioral health workforce are needed, with each level of government playing its role to support a successful outcome. More certified substance use counselors and mental health graduates along with trained staff with bilingual capacity are needed for an expanded level of clients' demand for service. Coordination with federal agencies is also encouraged, including plans to foster loan forgiveness as part of a California plan for success.
- DHCS investments linked to DMC-ODS programs have positive impacts on the criminal justice, child welfare systems and the vulnerable clients they serve. Special MAT programs such as the ED Bridge program and Criminal Justice

Collaboratives have positively influenced community access to treatment and attitudes toward stigma.

- Special incentives are needed to close the gaps in the SUD service continuum of care in many communities, some of which have recently launched their DMC-ODS plan or are not yet in the Waiver. Treatment service gaps that would benefit from added capacity and locations include: non-methadone MAT, residential WM, RSS, case management, residential programs including those that provide for perinatal services, and ED voluntary WM.

- Like other investments in improving SUD systems of care, investments in affordable housing that support recovery have tremendous potential to improve outcomes for those in SUD treatment. Every DMC-ODS county and the Regional Model said that they needed more stable recovery housing capacity for those coming out of residential treatment. According to UCLA data from the UCLA July 2021 Administrative Survey, only about 50 percent of those who need this supported housing option can access it. Joint state and local governments need to make affordable housing expansion a priority for all their citizens' quality of life. For those coming out of treatment, the investment in housing is critical for their ongoing wellness and stability.

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Overview

Overview

DMC-ODS Implementation Process & Environment: 2017- 2021

The United States Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of state Medicaid managed care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of state Medicaid managed care services. CMS rules (42 Code of Federal Regulations [CFR] §438; Medicaid Program, EQR of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid managed care programs.

Figure 1-1: Map of California DMC-ODS Counties

These rules require a review of Medicaid (Medi-Cal in California) DMC-ODSs and each Medi-Cal Mental Health Plan (MHP). The 1115 Waiver began in 2015 but actual DMC-ODS treatment services did not begin until early 2017 with the launch of three counties and with a staged approach, DHCS-approved planned launches of DMC-ODS services through the end of 2021 when the demonstration Waiver is set to expire.

As of August 2020, the State of California DHCS contracted with 30 DMC-ODS counties and one Regional Model group of seven counties to provide Drug Medi-Cal (DMC) treatment services, requiring an annual review for quality of care for each active DMC-ODS plan. This report presents a final summary quality review of SUD services from 2017 through May 2021 provided by 30 county DMC-ODS plans, and one seven-county Regional Model with Partnership Heath Plan (PHC).

Structure of the DMC-ODS 2017-2021 BHC Quality Report

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9. **Summary of Recommendations**
   Actions for Continued Success of SUD Services
10. **APPENDICES- Per Final Report Requirements**

Findings are the result of data collection, analyses, and reporting by the CalEQRO. Additional information, including CalEQRO resources, DMC-ODS county and annual reports, and presentations can be found on the website at www.caleqro.com. Also, resources used for reviews and training materials will be found in the appendix link as required by the contract for this final report of the Waiver cycle.

Meeting Federal EQRO Requirements

Since the opt-in counties now function as PIHPs, the federal requirement for an EQRO review apply. CMS requires that external reviews be conducted by an independent, external contractor (42 CFR, Part 438). EQRO is required to conduct a review of each county on an annual basis to review access, timeliness, quality, and outcomes. CALEQRO has reviewed the DMC-ODS Plans since they began services in February 2017 and concluded reviews under the current contract in June 2021. Reviews are retrospective for the prior year of services and thus the data being reviewed is from 2017 through May 2021. The review criteria are based on 42 CFR Part 438, subpart E, which outlines four major requirements:

- Performance Measures (PMs) to evaluate clinical effectiveness and service activity.
- Performance Improvement Projects (PIPs) that focus on clinical and administrative processes.
- Information System Capacity Assessments (ISCAs) to focus on billing integrity, care management, and delivery systems.
- Client satisfaction with the services received, measured through a survey and other mechanisms.

This final report represents the 2017-2021 DMC-ODS Report of the DMC-ODS programs by CalEQRO for this contract cycle for the 1115 Demonstration Waiver. There were 31 reviews this past fiscal year (FY) for counties and the PHC which included 7 counties in the northern area of California. There are eleven new counties who began services in the last year that were reviewed; these include the PHC Regional Model representing Modoc, Mendocino, Siskiyou, Lassen, Solano, Humboldt, and Shasta Counties and the independent counties of San Benito, Tulare, El Dorado, and Sacramento. These counties are in Year-One of the DMC-ODS service launch implementation process. There are fourteen counties in the initial “Pioneer County Group” which began services from early FY 2017-18 through early FY 2018-19. There are twelve counties that were reviewed and launched in the later years including FY 2018-19 and early FY 2019-20. These are referred to as Year Two, non-pioneer counties in the report as they have more years of developing their systems than Year One, but still are in a beginning phase of development.

The Developmental Process for DMC-ODS

After reviewing and providing early technical assistance (TA) to these counties between 2016 and 2021, there are clear phases to the start-up and implementation process which CalEQRO has observed.

Phase I Start-Up Activities and Challenges

In the first year, the typical DMC-ODS plan faces many varied challenges. Even if the DMC-ODS readiness requirements are met, there are still many complex challenges to meeting all of the access, timeliness, and quality of care requirements to implement the special terms and conditions (STCs) in the Waiver. Building an adequate provider network and getting them Medi-Cal certified and licensed for DMC-ODS are the major priorities for this first year in order to provide the required clinical services. There is Given the breadth and complexity of the DMC-ODS system of care, there is a core infrastructure to be established with the substance use treatment provider network. That network often with hundreds of staff to be hired and trained, also require a managed care level of administrative components to be established, and new set of training (from use of the ASAM to documentation and billing standards) to be delivered. Setting up and utilizing an SUD care model based on ASAM requires training to new workflow processes to begin care.

The design of the DMC-ODS system requires a major re-orientation of the existing SUD delivery system both clinically and administratively. Another major hurdle for the county providers was learning Medi-Cal requirements for clinical documentation and billing. Most SUD providers, other than methadone service providers, had little or no prior history with this type of reimbursement, no electronic health record (EHR), outdated basic billing software, and were staffed with primarily a paraprofessional workforce trained in older models of SUD service delivery. In most counties, the criminal justice system was and continues to be a primary referral source, often based on a court order. Educating criminal justice partners on use of the ASAM and medical necessity has been required to reset expectations with a system that was used to determining levels of care and the length of treatment from the bench, not based on clinical indications. This was a major change and loss of control that would take time to adjust to and cause political conflict if not managed skillfully.

The later counties benefited greatly from the work and experience of the earlier counties. As administrative processes and solutions to initial problems were found and solved by the early DMC-ODS counties with DHCS, key issues were resolved – particularly in certification, billing, and documentation requirements. CalEQRO found that getting these essential, core delivery systems in place and working with and training the newly hired workforce was a top priority in the start-up years for new programs.

Under the DMC-ODS, the Medi-Cal payor source is a complex third-party billing system and new to providers who had little billing experience. Many new LOCs and treatment modalities were being introduced to clinicians and into programs that had never delivered them before. Thus, billing and documentation systems were universally challenging in the first year of service delivery; for the 75 percent of the providers without EHRs, the challenges were even more difficult.

Given the complexity and scale of change it was difficult to go beyond meeting of basic Waiver requirements in the first year, and this was dominant theme in all but a few advanced SUD counties.

Phase II Moving from Requirements & Basics to a Quality Focus

As the DMC-ODS counties moved into the second phase of their implementation, CalEQRO observed a transition from the core Waiver requirements being met (including billing systems) to the refinement of the system of care (SOC) and an increased focus on issues linked to quality of care. Serious tracking of timeliness and capacity issues have become a primary focus. Adding capacity of programs and levels of care (LOCs) within the provider network and across different regions and age groups are emerging goals seen in Quality Improvement Plans (QIP) and local initiatives. There are shifts to more refined training of staff skills and more focus on individualized treatment program models and curriculums. Counties also enhance monitoring changes in access for different ethnic groups and ages or groups such as perinatal and those needing MAT, etc. Rethinking initial implementations of access and documentation systems is common. An often-stated goal has been to streamline these systems now that there is time available to work on them with providers and address specific concerns at the different LOCs. Concerns about documentation requirements and their burden were universal in the first year of implementation which CALEQRO heard from line staff, supervisors, and managers on reviews. This phase also includes moving from manual workflows to automation of certain processes resulting in efficiencies that can save staff time and improve the client experience. Some plans also began to think about new or expanded EHRs that have included utilization by their contract provider networks and makes data exchange more efficient and service coordination better. Part of this phase is also enhanced focus and priority on the expansion of new services under the Waiver, including those services that target underserved populations in need. Depending on the county, the most common groups of this focus included youth, older adults, pregnant women, women with children, and specific race/ethnicity groups. The new services where the most expansion and attention is directed included MAT, case management and care coordination systems in general, RSS, WM residential, youth services at all LOCs, and recovery residences or sober living environments linked to outpatient. In this phase, the quality efforts often begin by assessing for service needs, including data and experience drawn from relevant PIPs, TA with CalEQRO, along with provider discussions and conferring with other counties experiencing similar issues all with the goal to identify challenge areas and solutions. This movement towards quality and an expanded refined system of care (SOC) is reflected in the QIPs submitted each year to CalEQRO. Foremost examples of these are shared by CalEQRO with other counties to help them develop their QIPs, systems and share ideas and best practices.

Given the unique nature of each of the DMC-ODS counties, priorities are often based on local needs found within their environment, resources, and “hot spots” of what the local leadership considers the most urgent clinical or program issues. For example, in Orange County’s second year of review, there was a major increase in persons who were homeless, and the County leadership had converted the underground parking area in their building to a shelter for hundreds of people, many of whom had mental health and SUD needs, as well as other health and social service needs. This shifted their SUD treatment priorities to this at-risk group in terms of special teams to focus on access for this group into treatment, as well as supported housing linked to treatment.

Phase III Focus on Quality, Integration, & Expanded ASAM Continuum

CalEQRO has documented several counties which are in the third phase of implementation, having continued to expand their system integration efforts and evaluation skills often in an innovative fashion looking at outcomes and transitions in care. However, it was also observed that the impact of COVID-19 set back many of these efforts impacting project timelines due to impacts on the workforce, resources needed to address public health measures, changes in the way services were delivered all of which decreased overall access as much as 20 percent in some counties, although most have stabilized in recent months. The overall impacts related to the COVID-19 pandemic shall be addressed in another section of the report.

Despite the impacts noted above, several phase III counties expanded and refined capacity and quality efforts during the recent year. These DMC-ODS plans identified a need for continued expansion of non-methadone MAT access points, worked to improve case management services with refined and focused models, more activities to better integrate with both physical and mental health, as well as adding 3.7 and 4.0 ASAM LOC if possible. In some counties, there has also been more staff resources devoted to an evaluation of improved functioning and clinical outcomes based on hospital ED visits, hospital days and admissions, length of stay (LOS) in the system of care (SOC) and other measures including engagement over time, client satisfaction and therapeutic alliance.

Other new areas that some DMC-ODS counties are evaluating include use of care coordination facilitated by case management activities which appear favorably linked with better outcomes and overall improvements reflected in rates of positive CalOMS discharge type. Some are evaluating case management along with ASAM service level matching or congruence, which again appear to be linked with better outcomes on CalOMS. Another new avenue of evaluation beyond CalOMS data is measured in a client's progressive improvement on the first three dimensions of ASAM assessments over time. These are in the preliminary stages of exploration, as are expanded care models using peers. Additional measures represented to CalEQRO look at the utilization of MAT on balance with the percentage of clients with either an opioid use or alcohol use disorder, (OUD) and use of other evidenced-based practices (EBPs) associated with better outcomes.

This new level of expanding quality efforts and refinement of the ASAM continuum is only evident as the DMC-ODS systems of care mature. The systems must have stability and more sophisticated EHR and data resources available. Data analytics capacity is in very short supply in many counties and particularly at the contract provider level. By contrast, health plans such as Partnership and larger counties with greater resources were in a much better position to do this work being able to assist with smaller contract providers and having experience in assessing system-level quality issues related to effectiveness in client care. This was reflected not just in their PIPs but in the level of development pertaining to annual goals, re-organization

initiatives with integration elements, QI plans, and well-developed levels of care coordination with Federally Qualified Health Plan (FQHC), primary care services, probation, hospitals, criminal justice, and others.

While noting the various stages of DMC-ODS implementation within these three development phases, it does appear that many of the goals of the Waiver have been successful. In this report CalEQRO will review these in more detail through qualitative and quantitative data to see if there was success in reaching some of the goals set forth in the STCs; the expansion of science-based care models such as MAT services; and expansion of a client-centered system of SUD care.

Goals of California's Waiver

The Waiver's overall goal was to improve SUD services and outcomes of care for California's Medi-Cal beneficiaries. The services were to be client-focused, implement EBPs to improve treatment outcomes, and support integration and coordination of care across health and social service systems. Other goals included reducing ED and hospital inpatient stays and placing clients in the least restrictive LOC that was clinically appropriate. The Waiver model would require program and fiscal oversight, quality assurance activities, managed care model administrative systems, enhanced clinical workforce requirements and EQRs from an outside organization.

The elements built into the Waiver's STCs and benefit design were determined to offer many positive changes to clients in the first three years of evaluations by UCLA and by CalEQRO. (Prior reports are available from www.calegro.com and www.uclaisap.org.)

Trends Affecting the Quality EQRO Environment

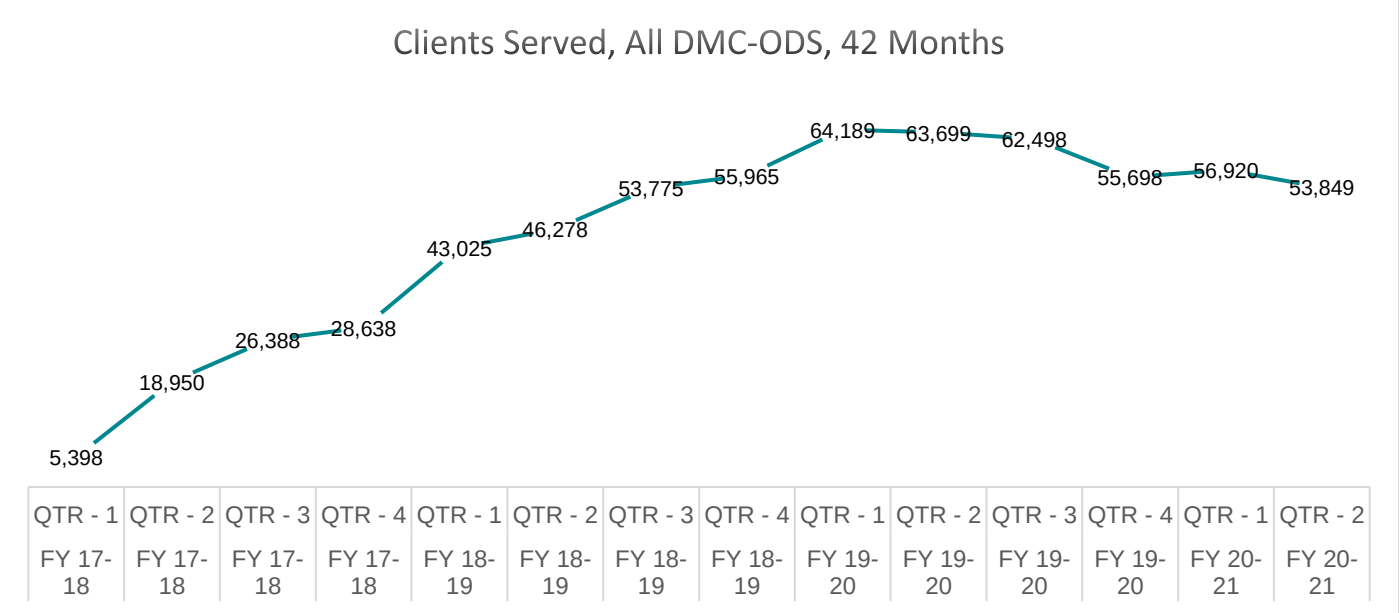
COVID-19

On March 19, 2020, California's Governor issued Executive Order N-33-20 which directed all Californians to stay home in order to protect health and well-being throughout the state and to establish consistency across the state to slow the spread of COVID-19. For CalEQRO, this led to an immediate shift from onsite reviews to desk reviews. This continued for all reviews scheduled in winter and spring of 2021. There were many impacts of COVID-19 on services as reflected in the 42 months of data analysis that will be shared in this report. It is hoped that some in-person review options, particularly client and family focus groups most impacted by the remote review requirement, can resume in 2022, though new variants and other factors related to the pandemic create uncertainty.

As reflected below quarterly data on unduplicated clients served from July 2017 through December 2020, DMC-ODS counties showed a steady increase in enrollment under the ODS

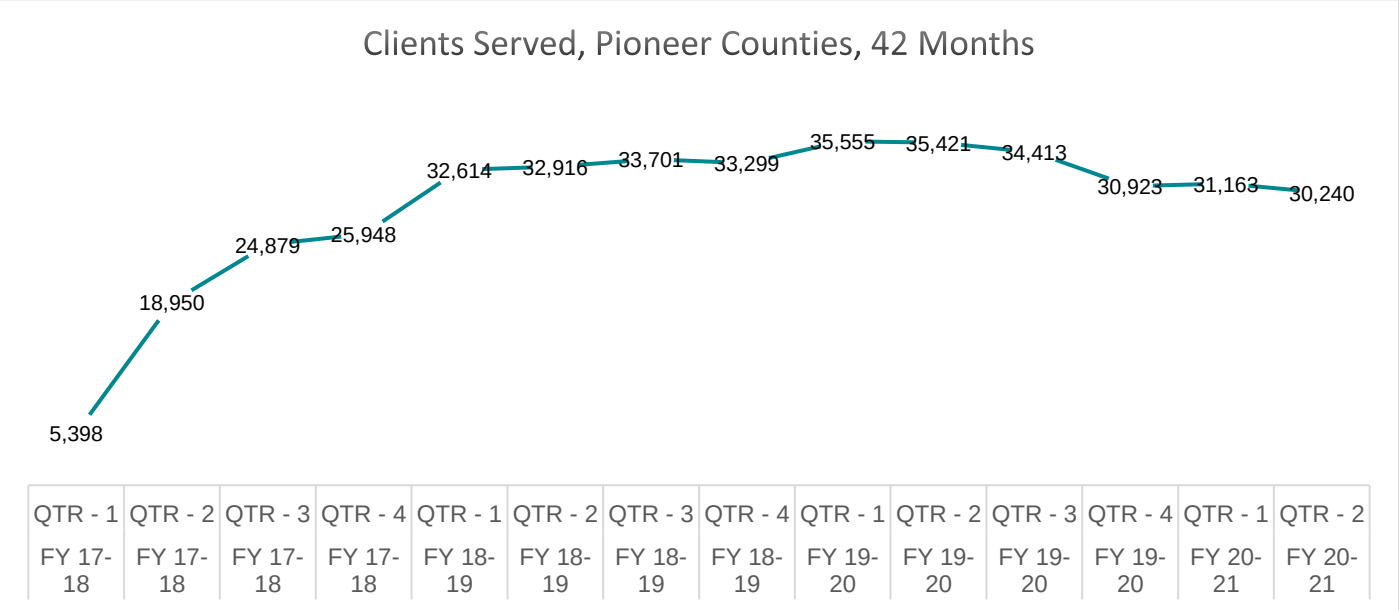
plans as they launched. In 2017, only four counties had launched services until mid-year when Los Angeles launched. Phase 2 counties launched in January 2018 and July 2019. FY 2020-21 concluded with 30 counties and a PHC with seven counties. COVID-19 and the accompanying health impacts that began in March 2020 reduced services statewide and slowed growth even with new starts that occurred after the beginning of the pandemic. Those impacts from COVID-19 continue today, though they have lessened. In the third quarter of FY 2019-20 when the Executive Order N-33-20 was issued, there is a clear drop in clients served from 63,699 to 53,656 as Californians were directed to stay home. That service level was still low but stabilized at the end of 2020. Unfortunately, claims data was not complete for January to June 2021 which would have shown the predicted improvements that were reported in the spring reviews of 2021. It is hoped that this report can be updated to show the improvements from vaccinations and other efforts to improve services in FY 2020-21.

Figure 1-2: All Clients Served, DMC-ODS, 42 Months



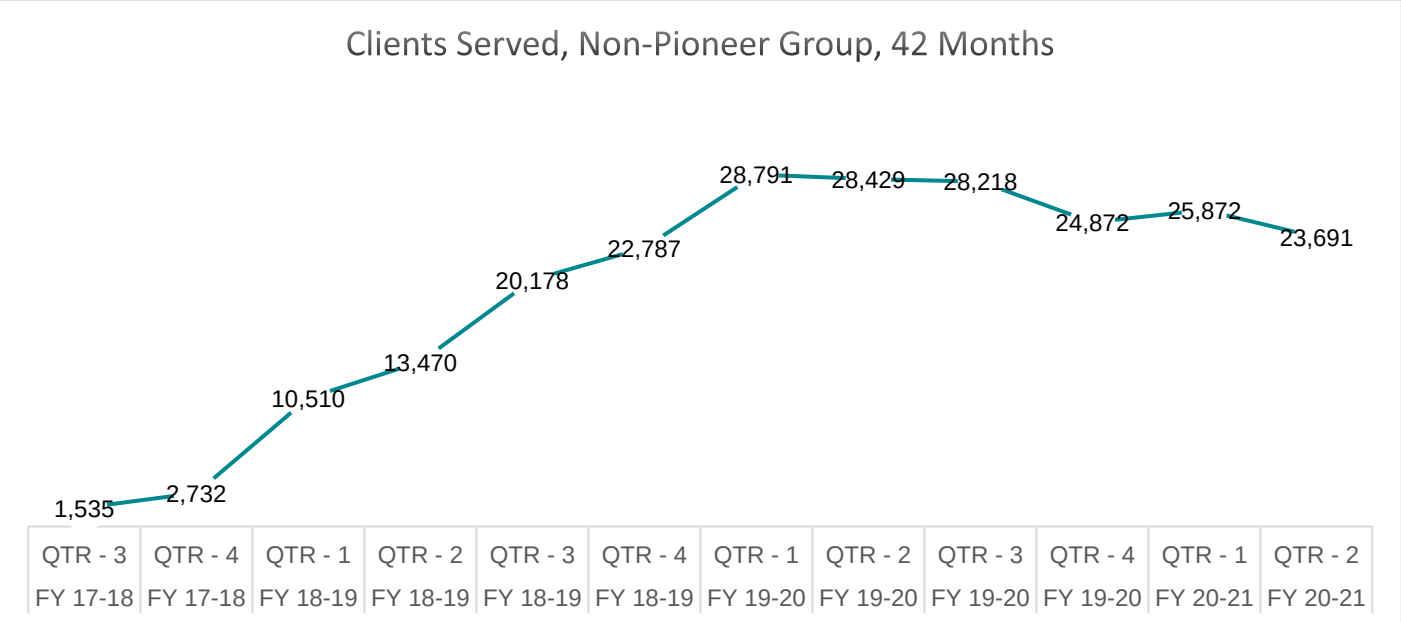
This trend was also seen for the Pioneer Counties who launched early in FY 2017-18 and were more stable when the COVID-19 order was issued, as reflected below in Figure 1-3. The drop in clients served was still significant, going from 34,413 to 30,923 but appeared to begin stabilizing quickly, moving to 31,162 in the next quarter.

Figure 1-3: Clients Served, Pioneer Counties, 42 Months



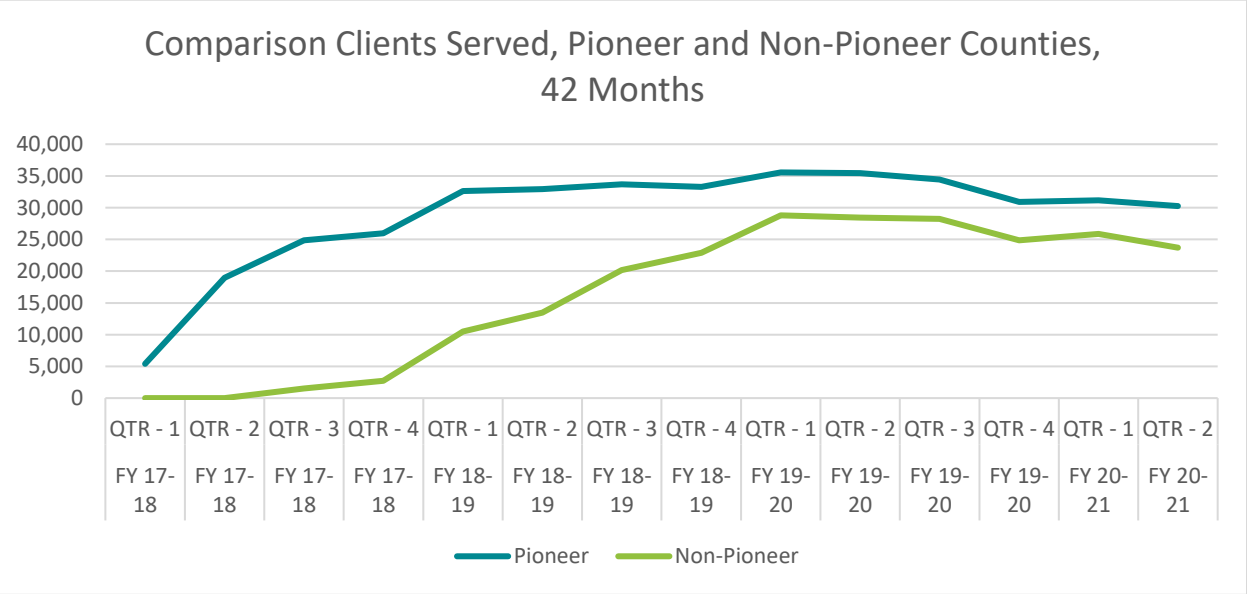
As anticipated, there was a slow and steady increase in clients served for the non-pioneer counties and the PHC that launched later. As shown in Figure 1-4, there was a drop in clients served after the COVID-19 order was issued, from 28,218 to 24,872 and a modest recovery to 25,872 for the next quarter. There was another decrease as winter approached in the second quarter of FY 2020-21 to 23,691.

Figure 1-4: Clients Served, Non-Pioneer Counties, 42 Months



While an increase in clients covered under Waiver services is seen, the It is important to note that DMC-ODS counties launched in a staggered fashion, at the start of a fiscal or calendar and a few launched in the middle of these dates. Additionally, levelling off of clients served can be accounted for by programs experiencing difficulty with licensing and certification resulting in major billing delays creating an impression of low client service data. While CalEQRO notes that this was often the case in the first and second years of Waiver services there were times when these issues persisted into the third year of implementation as well. With data refreshes, many of these problems were corrected but it is important to note that the systems of care did not launch uniformly in any of the counties in the start-up years. It was not uncommon for 40 percent or more of the contract providers to be unfamiliar with Medi-Cal billing and documentation requirements which required significant training and data to implement properly and lags in claims data.

Figure 1-5: Clients Served, Pioneer Compared to Non-Pioneer, 42 Months



COVID-19 Impacts on SUD Services and Levels of Care

DMC-ODS systems saw significant impacts on the following face-to-face services due to COVID-19:

- Residential treatment.
- Methadone NTP services which required a face-to-face physician visit to do an initial assessment and intake as well as daily dosing.

- Intensive outpatient which requires three hours per day, three days per week of services which is difficult to tolerate by telephone or video.
- Services for clients who do not have cell phones, internet, or enough minutes on their cell phone plans for long sessions and for clients who are homeless or otherwise have difficulty with access to the internet.

In addition, many programs wanted individuals tested for COVID-19 before they presented for assessments, particularly in residential or NTP services. If they were positive, isolation options needed to be found even if they were homeless. To compound these challenges, both county and provider programs had staff with health issues and COVID-19 exposures.

Rapid Expansion of Telehealth

With the onset of the COVID-19 public health emergency in March 2020, DMC-ODS counties had to pivot quickly to providing SUD treatment services via telehealth tools such as video and smart phones. CMS issued guidance to make it easier for clients to receive treatment through telehealth services. DHCS also issued numerous Information Notices (INs) to provide guidance on implementing telehealth services. These documents had enhanced billing codes which allowed increases in the claiming systems.

California Trends

California Advancing and Innovating Medi-Cal (CalAIM) & Integration

DHCS formally proposed the version of the 1115 Waiver known as California Advancing and Innovating Medi-Cal (CalAIM) in October 2019. DHCS identified the following three primary goals:

(1) Identify and manage member risk and need through Whole Person Care approaches and addressing Social Determinants of Health.

(2) Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

(3) Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.[1]

In the CalAIM proposal, DHCS outlines a plan for integrating SMHS and SUD into one behavioral health managed care program. The stated goal is to improve beneficiary outcomes

[1] DHCS Comprehensive Quality Strategy. Available from: https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx

and to reduce administrative burdens on the counties. In addition, the proposal outlines the desire to combine the EQR process and have one EQRO report for each county.

The CalAIM Section 1115 demonstration application seeks to amend and renew the existing Medi-Cal 2020 Section 1115 demonstration, approved through December 31, 2021. DHCS is requesting approval by December 2021 to enable implementation in July 2022.

Stakeholders were invited to comment on the CalAIM Section 1115 demonstration during the 30-day federal public comment period which began in July 2021. More information about the federal public comment period is available on the CMS website.

CalAIM Section 1915(b) Waiver Application

The CalAIM Section 1915(b) Waiver application seeks to amend and renew the existing Specialty Mental Health Services (SMHS) Section 1915(b) waiver and consolidate Medi-Cal managed care, dental managed care, SMHS, and the DMC-ODS under a single 1915(b) waiver.

With the onset of the COVID-19 public health emergency, DHCS has postponed the implementation of the CalAIM proposal. DHCS had requested a 12-month extension from CMS to extend the 1115 Waiver until December 31, 2021, which was approved. DHCS has submitted its proposed renewal of the 1115 Waiver, as well as the renewal of the NA.

Assurances of adequate capacity for services in Part 438.207 requires the counties to submit the Network Adequacy Certification Tool (NACT) to DHCS by April first of each year.

During 2021, NA data were reviewed for the second time during the annual EQRO review for DMC-ODS counties utilizing the NA data provided, alternate access standard (AAS) requests of the DMC-ODS plans, related data, contract and document review, and focus group and stakeholder interview information.

National Context for the 1115 Waiver

The Waiver's development represents a partnership between the State of California, local county behavioral health leadership, and the federal government through CMS. Years of work were devoted to examining best practices and clinical models, identifying strengths and barriers within federal and state requirements, and crafting a framework to encompass financing and service delivery as well as workforce development. Strong collaboration and teamwork by each of the key partners led to CMS's approval of the current 1115 Waiver for DMC-ODS.

A National Opioid Crisis

The national impetus to develop an effective SUD treatment delivery system was a response to a serious health challenge in the United States. This was clearly articulated with a positive and hopeful paradigm change in 2016 by the Surgeon General in *Facing Addiction in America*,

the first national report on SUD and treatment.[2] The report recommended a major shift to a clinical, scientifically based treatment approach similar to previous, successful efforts to address the toll of smoking and tobacco on the nation's health. The report discussed tobacco addiction and the impact of nicotine addiction on the brain and behavior which make this addiction go beyond individual choices and behaviors. Similarly, the report detailed the brain chemistry associated with SUD treatment, recommending it shift from a blame-oriented, criminally-focused system that ascribes SUD problems to a lack of moral character, and instead towards a brain science treatment model that draws on research approaches that have been shown to work.

The Surgeon General's report was timely and critical for challenges ahead. The rising tide of opioid-related deaths had reached a point of acute national crisis. Fueled by prescribing patterns that dispensed new, powerfully addictive medications for pain and framed pain as "the fifth vital sign" (thus warranting aggressive treatment), many Americans became addicted to opiates. As of 2017, there were approximately 1.7 million Americans suffering from an opioid use disorder[3] and more than 50,000 people died from an opioid overdose in 2019—a 4.6 percent increase from 2018.[4]

When physician prescriptions were no longer available to them, many of these patients alternatively turned to heroin and other illegal opiate drugs. Recent studies in prescribing patterns indicate that 80 percent of all prescribed opiates are being used in the United States which has just five percent of the world's population.[5] The dangerous strengths of these new medications led to many overdoses annually, surpassing annual deaths from motor vehicle crashes.[6]

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[2] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Spotlight on Opioids.* Washington, DC: HHS, September 2018. (Located on page 2 of 40): https://addiction.surgeongeneral.gov/

[3] Center for Behavioral Health Statistics and Quality (CBHSQ). *2017 National Survey on Drug Use and Health: Detailed Tables.* Rockville, MD: Substance Abuse and Mental Health Services Administration; 2018. Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.pdf

[4] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021. Retrieved from https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

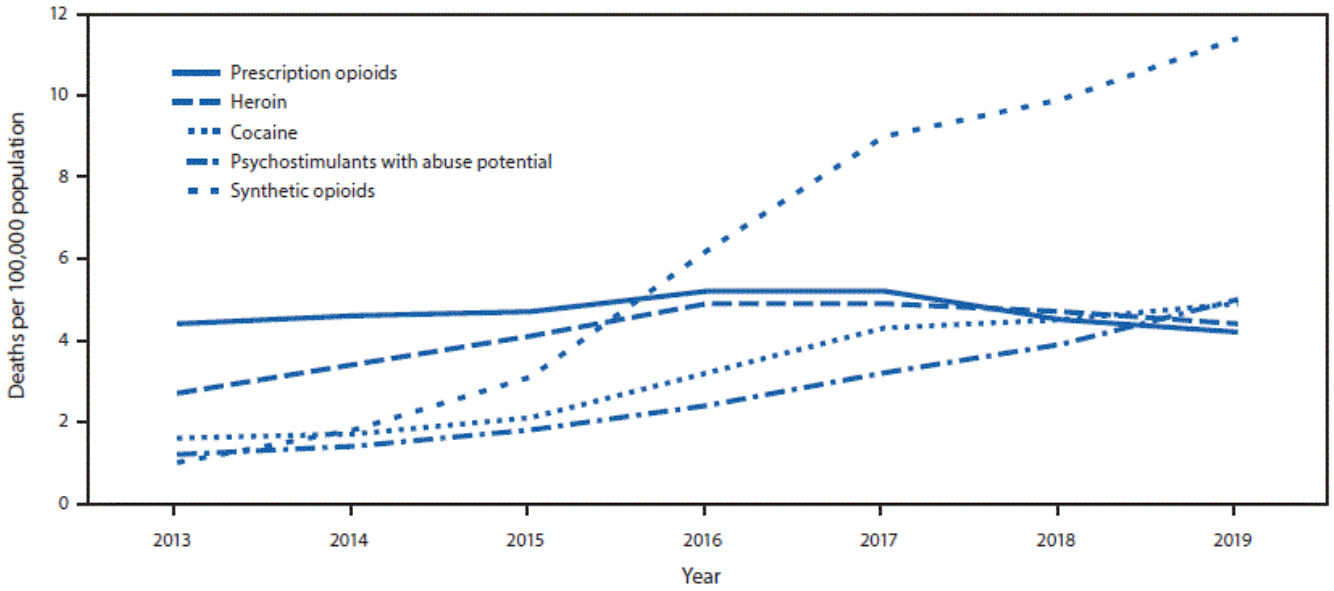
[5] Dunham J and Kearney S. *Data and Analytics to Combat the Opioid Epidemic.* International Institute for Analytics White Paper. June 2016. Available from https://www.sas.com/content/dam/SAS/ja_jp/doc/whitepaper1/wp-iia-data-analytics-combat-opioid-epidemic-108369.pdf

[6] National Safety Council. Injury Facts. Available from: https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/data-details/

The alarming and overlapping trends of opioid use and overdose deaths are illustrated by National Institute on Drug Abuse (NIDA) research,[7] as shown in Figures 1-6 and 1-7.

The CDC chart below from 2020 linked to preliminary data on national overdose deaths of 93,331 nationwide (also cited in 7/14/21 NY Times over those deaths from 2019. https://www.nytimes.com/interactive/2021/07/14/upshot/drug-overdose-deaths.html). This is particularly alarming because of the impact of synthetic opioids known as fentanyl on the overdose rates and them being mixed into so many street drugs.

Figure 1-6: Age-Adjusted Rates of Drug Overdose Deaths Involving Opioids, by Type of Opioid: United States, 2013–2019



Source: CDC 2019 Overdose Data Vital Statistics Reports

Figure 1-7: 12 Month-ending Counts of Drug Overdose Deaths, California-Specific

This figure shows the state-wide rates of overdose deaths provided by the California Opioid Overdose Dashboard hosted by the California Department of Public Health (CDPH). Fatalities appeared to stabilize in 2017 corresponding with additional MAT and treatment however the major increase of fentanyl availability in California as well as the pandemic has had a very negative impact on overdose deaths. Local data provided by county at the CDPH site indicates that in addition to synthetic opioids such as fentanyl, stimulants, and other drugs, are contributing to overdose death with some individuals not even aware that they are being exposed to fentanyl when buying street drugs. Given the potency and lethal nature of even small amounts of fentanyl, many counties have issued warnings to communities of this serious and real danger.

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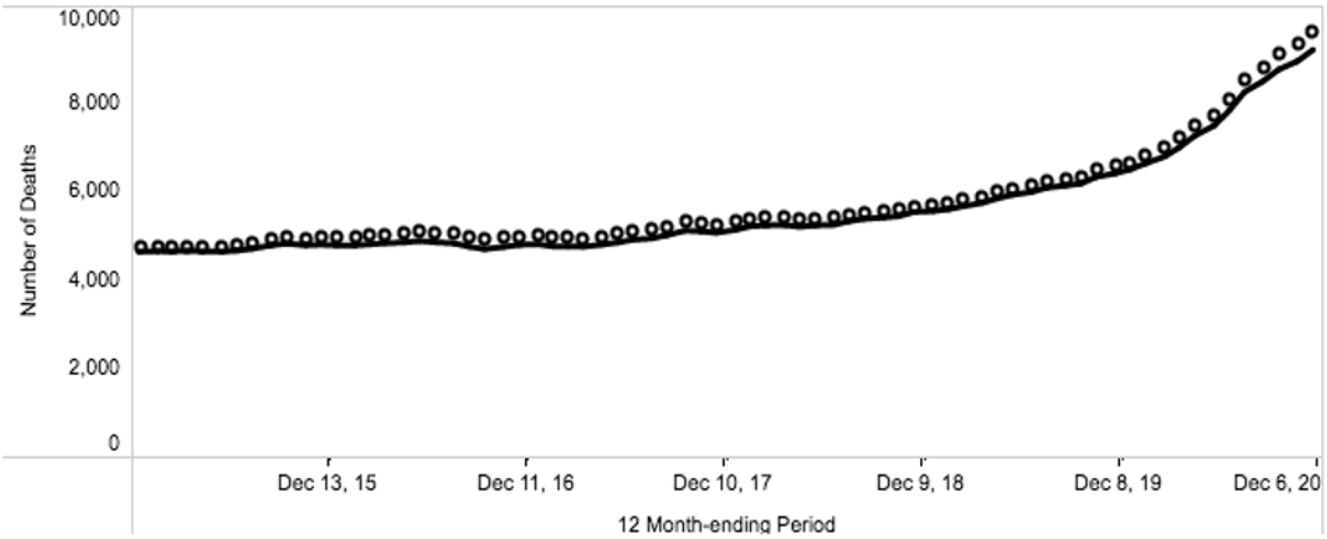
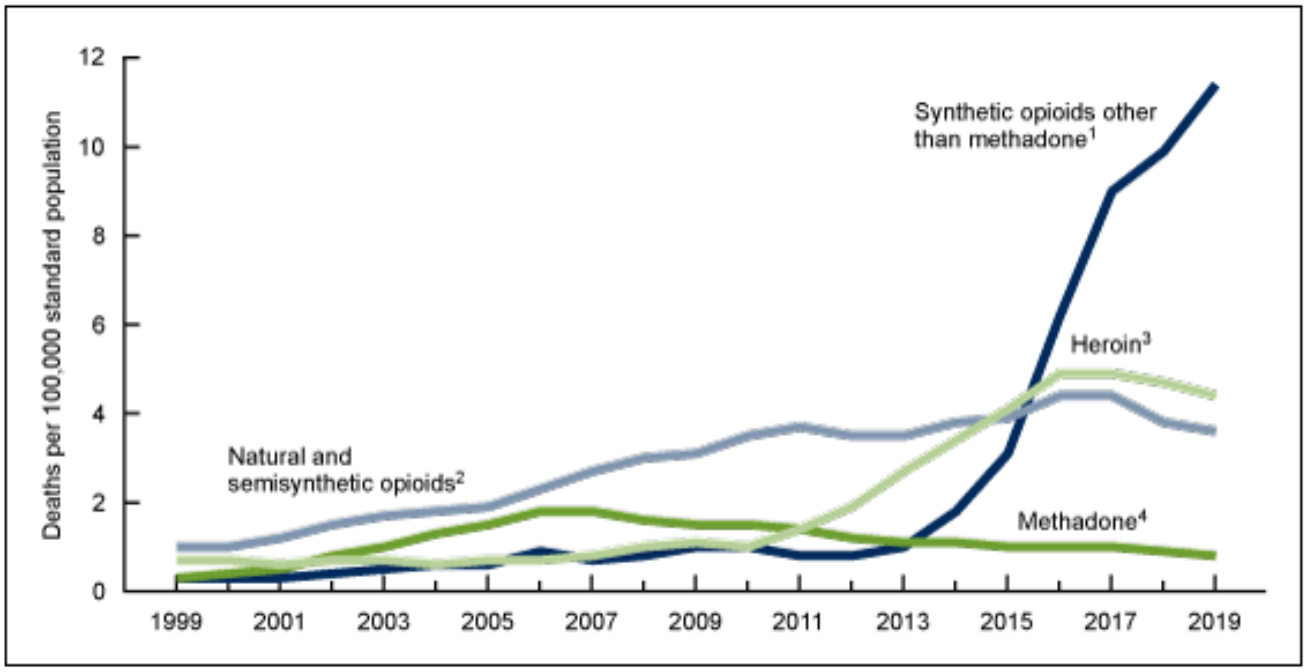
[7] National Institute on Drug Abuse. *Overdose Death Rates*. Compilation based on National Center for Health Statistics and Centers for Disease Control and Prevention data. Revised August 2018. Available from https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

Figure 1-7: 12 Month-ending Counts of Drug Overdose Deaths, California-Specific



Source: NCHS, National Vital Statistics System. Estimates for 2020 are based on provisional data. Estimates for 2015-2019 are based on final data (available from: https://www.cdc.gov/nchs/nvss/mortality_public_use_data.htm).

Figure 1-8: Age-adjusted rates of drug overdose deaths involving opioids, by type of opioid: United States, 1999–2019



Source: National Center for Health Statistics, National Vital Statistics System, Mortality

From the first Surgeon General's Report on substance abuse in America to the New York Times report on National and state interest in addressing the overdose epidemic peaked in

2020 with overdose fatalities exceeding 93,000 up 30 percent from the prior year according to the Centers for Disease Control (CDC). Americans risk for opiate addiction, overdose and death has been in the news cycle as well from high profile celebrity deaths to investigative articles in the Los Angeles and New York Times. And in 2016 the office of the Surgeon General issued a landmark publication entitled *Facing Addiction in America* highlighting the critical need to address substance abuse and provide drug treatment. Since 2017 the DMC-ODS service model continues to treat more and more people who need care at this critical time.

As the nation continues to grapple with the ongoing epidemic of drug addiction and mortality from overdoses, the medical community and policy makers continue to seek answers and potential solutions. National commissions and organizations have proposed priorities to address the opioid crisis, including enhanced access to treatment, expanded access to medications that reduce craving to support positive treatment outcomes, and reduced prescribing of these highly addictive medications. Criminal justice initiatives also have been proposed through increased use of drug treatment courts and efforts to stop the flow of illegal drugs—particularly fentanyl, a new and highly lethal synthetic opiate. County level opioid safety coalitions work across agency lines to provide a framework for data informed local solutions including drug take back days, youth and community education on the risks and realities of prescribed and illicit opioids, safe prescribing guidelines and increased collaboration for substance use systems and allied care entities.

While each state has explored separate ways to address the opioid crisis and add priority treatment access, California worked to develop a system of SUD treatment built on the ASAM principles with LOCs based on individualized treatment needs. Its key features include a six-dimension comprehensive assessment, individualized treatment based on risk factors and readiness to change, emphasis on science-based research approaches, and a full continuum of care that optimizes positive outcomes for clients.

Unfortunately, impacts from the COVID-19 pandemic, the related stress of unemployment, homelessness, and social isolation as well as an unprecedented proximity of illness and death have only increased the use and abuse of alcohol and other drugs. Overdose fatalities since the onset of COVID-19 have now surpassed the worst years of the opioid crisis. Part of this trend has been attributed to widespread access to the powerful opiate fentanyl. However, COVID-19 stay-at-home orders and other restrictions have made access to treatment and MAT more difficult, as well as adding stress and anxiety to the population overall. Thus, the latest data show a significant rise in overdose deaths.

Treatment access is more important than ever, but because of COVID-19, new tools are needed to ensure treatment can occur safely, without spreading the virus through in-person contact. DMC-ODS counties reviewed by CalEQRO between March 2020 to May 2021 showed significant efforts to expand telehealth, phone, and distanced visits so that treatments and medications could continue to be accessible. For the reasons noted above, continued development of the DMC-ODS treatment expansion is even more important to pursue both in California and nationwide than ever before.

Drug Medi-Cal Organized Delivery System External Quality Review

2017-2021 Statewide Report

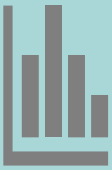
Methods

Methods for Analysis

Methods

Methods Used in the EQRO Evaluation of California's DMC-ODS 1115 Waiver

Data Sources



- Medi-Cal Eligibility File
- Medi-Cal Approved Claims
- CalOMS
- ASAM Referral Data
- Treatment Perception Survey
- Medi-Cal Provider files
- NA files
- County documents and plans
- Focus groups and stakeholder interviews

Introduction

As described in the previous chapter, the core EQRO evaluations are mandated by federal law and associated regulations; CMS rules (42 CFR, 438 of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid managed care programs. These rules require an annual video, on-site, or desk review of each Medicaid (Medi-Cal in California) DMC-ODS and MHP managed care program. Recently federal updated protocols focused on the core themes of the annual report: access, timeliness, quality, outcomes, and data system integrity. These protocols for evaluation are applied to all managed Medicaid MHP and DMC-ODS plans to ensure the value of these health care services funded by state and federal governments.

From 2017 to 2021, CalEQRO carefully reviewed and analyzed both quantitative and qualitative data based on these protocols to support and shape the themes and findings for the following chapters: Access, Network Adequacy, Timeliness, Quality, Outcomes, Infrastructure and Operations, and Recommendations. Each chapter includes tables and figures that capture the most relevant and important aggregate findings. Additional tables and figures can be found in the report's appendices: Medi-Cal Approved Claims Code Definitions and Data Sources, templates, scripts and tools developed for the DMC review processes, County DMC Toolkit and video link, PIP video links, Clinical Committee PM research and final PMs selected, training materials and presentation lists and links, materials for trainings will be identified based on counties and providers.

Counties and Populations

CalEQRO analyzes a specific subset of California's population linked to the counties that have completed one or more years of services under the 1115 Demonstration Waiver for DMC-ODS. The first CalEQRO review was possible in FY 2017-18 with three counties Riverside, San Mateo, and Marin. FY 2018-19 there were 11 new plus the original 3 counties

reviewed, and these 14 constitute the “Pioneer County” group which is compared to the FY 2019-20 counties which added 12 additional counties to be reviewed, and finally FY 2020-21 which included four independent counties and PHC which includes seven northern counties. FY 2021-22 is the fifth year since the launch of treatment services under the Waiver, though CMS approval of the actual Waiver was in 2015. At this time, 37 counties were evaluated with 7 being part of the PHC. These counties which are primarily large and medium sized make up 97 percent of the state’s population.

Pioneer Counties

The initial 14 counties that implemented the Waiver include Riverside, San Mateo, Marin, Contra Costa, Santa Clara, San Francisco, Los Angeles, Napa, San Luis Obispo, Santa Cruz, San Diego, Monterey, Nevada, and Imperial. This initial launch of the “Pioneer Counties” is compared to the “Non-Pioneer” group which launched services in late FY 2018-19, FY 2019-20 or FY 2020-21.

Pioneer counties had more time to implement the vision of the Waiver and resolve issues related to implementation challenges and infrastructure. Many also had completed core systems prior to COVID-19 which was a distinct advantage in terms of service delivery and coordination.

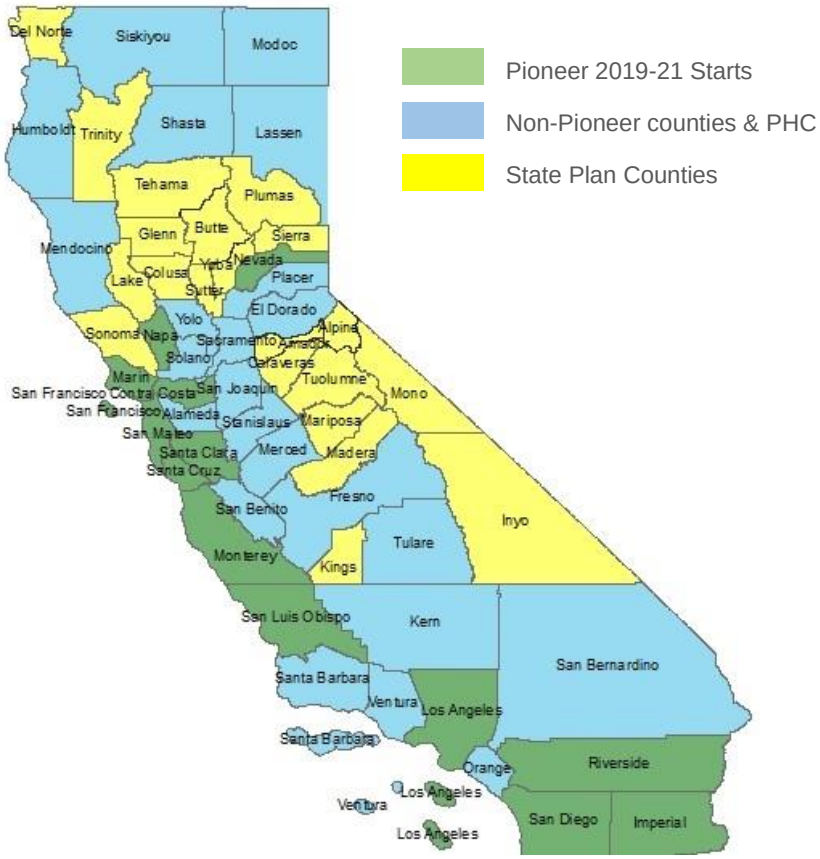
Other Counties Launch

An additional 12 counties implemented the DMC-ODS and were reviewed in FY 2019-20 and include Alameda, Kern, Merced, Fresno, Stanislaus, Santa Barbara, San Joaquin, Orange, Yolo, Placer, and San Bernardino.

Finally, there is the last non-Pioneer DMC group of four individual counties (Sacramento, San Benito, El Dorado, and Tulare) and the PHC regional group (Solano, Siskiyou, Humboldt, Shasta, Modoc, Lassen, Mendocino) which implemented during FY 2019-20 and FY 2020-21. This group was very challenged as they implemented during the peak of the COVID-19 pandemic, and also a serious wildfire period which impacted them all.

There are also state plan counties not in the 1115 Waiver which are primarily small rural counties in the northern and central valley areas.

Figure 2-1: Map of California DMC-ODS Counties



Pioneer and Newly Implementing Counties

Medi-Cal Population

Eligible: a person who is eligible to receive services funded through Medi-Cal. Eligibles are counted even if they have not received DMC-ODS services.

Client: a person who is Medi-Cal eligible *and* has received one or more DMC-ODS services.

California counties serve many populations in need of SUD services. The focus of the EQRO evaluation is the Medi-Cal population, which includes California residents who are elderly, disabled, adults, and youth who fall below the federal poverty level (FPL) and need SUD services. To be included in this population, a person must meet the criteria for Medi-Cal benefits. The term “eligible” is used to describe a person who is eligible to receive services funded through Medi-Cal. Eligibles are counted even if they have not received DMC-ODS services. The term “client” is used to describe a person who is Medi-Cal eligible *and* has received one or more DMC-ODS services. DHCS has assigned specific aid codes to identify the types of recipients eligible under Medi-Cal. These aid codes provide guidance on the types of services for which beneficiaries are eligible. Benefits may be full or restricted, depending on the aid code.

Data Sources and Measures

CalEQRO uses a variety of data sources for the evaluation analyses, including Medi-Cal Eligibility File (MMEF), Medi-Cal Approved and Pending Claims, CalOMS, ASAM screening and assessment referral data, TPS annual survey files, Medi-Cal provider data, NA files, and county submission documents which are included in the appendix related to quality, timeliness, access, data quality, cultural competence, and grievances. MMEF downloaded files are requested during the same time frame as claims and cover 15 months of eligibility. Claims and MMEF data are refreshed at least twice per year and aligned with state changes and information notices for the DMC-ODS program.

Medi-Cal Approved Claims files from DHCS include claims for the service period indicated, processed through the preceding month. Detailed definitions of claims fields used are included in the Appendix as a reference and shared with the counties annually and updated so they can generate their own PMs.

Performance Measures (PMs)

The purpose of PMs is to foster access to treatment and quality of care by measuring indicators with solid scientific links to health and wellness. CalEQRO conducted an extensive search of potential measures focused on SUD treatment and then vetted them through a clinical committee of over 60 subject matter experts, including medical directors and clinicians from local behavioral health programs. Through this thorough process, CalEQRO identified 12 PMs to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, TPS, CalOMS, and the ASAM LOC data for these measures.

The first six PMs are used in each year of the Waiver for all DMC-ODS counties and statewide. The additional PMs are utilized after the first year of implementation based on research linked to positive health outcomes for clients with SUD and related to access, timeliness, engagement, retention in services, placement at optimal LOC based on ASAM assessments, and outcomes.

As noted above, CalEQRO is required to validate the following PMs using data from DHCS, client interviews, staff and community-based provider interviews, observations as part of the annual review to specific programs, and documentation of key deliverables in the DMC-ODS Waiver Plan. The measures are as follows:

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries.
- Number of days to first DMC-ODS service after client assessment and referral.
- Average costs per beneficiary served by each county DMC-ODS by ethnic group.
- Cultural competency of DMC-ODS services provided to beneficiaries.

- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes).
- Coordination of care with physical health and mental health.
- Timely access to medication provided by NTP/OTP services.
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured.
- Timely coordinated transitions of clients between LOCs, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center screenings to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics).
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs).
- Percent of client with of mor WM episodes and no other treatment to improve engagement.

For counties beyond their first year of implementation, four additional PMs have been added. They are:

- Use of ASAM criteria in screening and referral of clients (also required by DHCS for counties in their first year of implementation).[8]
- Initiation and engagement measurement in DMC-ODS services.
- Retention in DMC-ODS treatment services.
- Readmission into residential WM within 30 days.

California Outcomes Measurement System

Another important data element is the CalOMS. All service providers who receive public funds for SUD treatment services are mandated to report CalOMS data to DHCS. Providers collect client information at admission and discharge as well as annually from the treatment program

[8] Counties are required to administer an ASAM-based assessment to determine the recommended LOC for clients. This assessment takes into consideration client risks and needs, strengths, skills, and resources to determine what intensity of treatment best matches identified client needs. The ASAM criteria for screening/assessment and referral of clients examines the congruence rate of assessed LOC to referred LOC, and also tracks the reason(s) for noncongruent. ASAM LOC Data Collection System details available from: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

https://www.dhcs.ca.gov/individuals/Documents/MHSUDS_Information_Notice_18-046.pdf https://www.dhcs.ca.gov/individuals/

to determine living, employment, and legal status. At discharge, providers must indicate whether clients successfully completed treatment or had an administrative discharge, meaning the client self-terminated services, and they must indicate whether they made progress on their SUD condition.[9]

Treatment Perception Survey

The TPS is an annual satisfaction survey that is administered to adult and youth clients receiving SUD services at all treatment sites. The information collected from the TPS is used to measure clients' perceptions of access to services, the quality of care, care coordination, general satisfaction with services, and includes one outcome question, and youth surveys also include a set of questions on therapeutic alliance.[10]

County Data Documents for Submission

As part of the pre-review preparation, counties submit documents and materials for the review team to analyze. These include:

- Response to prior-year recommendations.
- Key changes in the environment in the last year, and new initiatives.
- Timeliness Assessment of Services (TSA).
- PIPs (one clinical and one non-clinical).
- Completed ISCA form on IS.
- DMC-ODS Implementation plan, DHCS approved.
- QIP.
- QI plan evaluation results.
- Cultural Competency Plan (CCP).
- Organizational chart.
- Highlights of Innovative Programs.
- Programs applying for Certification through the Provider Enrollment Division.

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[9] CalOMS Treatment Data Collection Guide available from: http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

[10] TPS: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf

- Continuum of Care Form
- Access Call Center Key Indicators
- NA Data Form
- Quarterly Grievance Forms
- Minutes for QI Meetings
- Managed Care Health Plan MOUs

CalEQRO Review Activities

Review activities include client focus groups; stakeholder interviews; reviews of plans such as QIPs, cultural competence plans (CCPs), and PIPs; NA related interview sessions; ISCAs data review sessions and billing sessions; and relationships with managed care health plans, review of MOUs, and sessions with key partners, such as the criminal justice system, child welfare system, housing systems and hospital ED.

The pre-review documents, focus groups, and stakeholder interviews are then compiled and integrated for Key Component ratings related to access, timeliness, quality, and outcomes. CalEQRO emphasizes the DMC-ODS counties' use of data to promote quality and improve performance.

The CalEQRO review draws upon data from the DMC-ODS reviews to identify strengths, opportunities for improvement, and actions in response to recommendations.

Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.calegro.com.

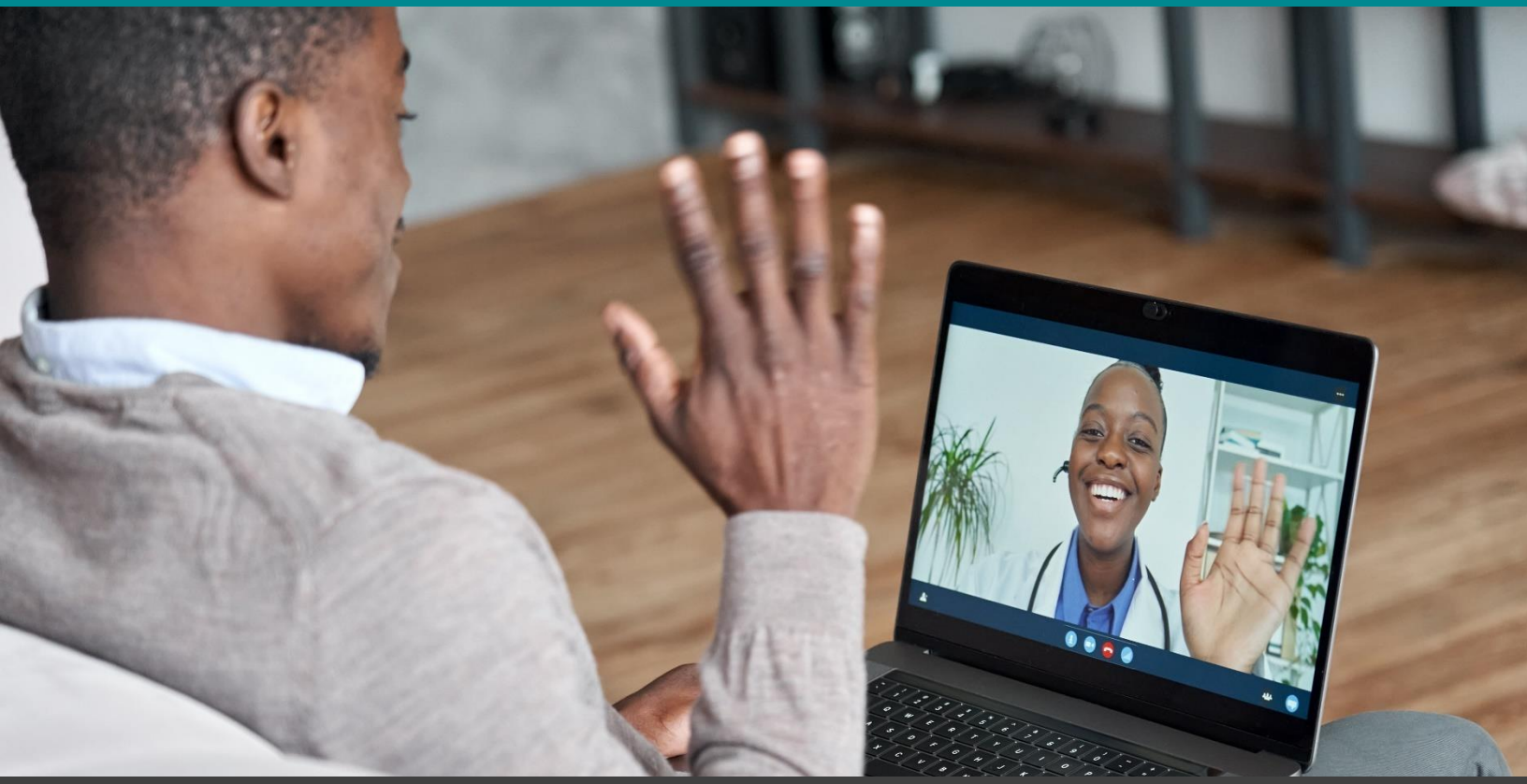
Analysis Tools

For this Five-Year Report, quantitative data are compiled and analyzed in Excel and SAS, with graphs and figures generated to highlight key findings. Quantitative data from key sources were combined to the extent it was complete from 2017 through December 2020. SAS was used for analysis and programming, and then data was converted to Excel. NVivo is used to manage and extract key themes from the vast amounts of qualitative data also from 2017 to 2021. CALEQRO did have focus group data and clinical data from the spring of 2021, but not claims data linked to MMEF so it was possible to do some qualitative analysis with NVIVO into 2021, but no claims and quantitative analysis into 2021. This mixed-methods approach is employed to generate highlights, key findings, best practices, and areas for improvement. CALEQRO used the "secret shopper" information from UCLA to help with evaluation of the BAL and access call center activities in each county.

Coordination with UCLA is ongoing with evaluation efforts related to validation of findings, and analysis in general, since each organization gets data from some additional complimentary sources.

Drug Medi-Cal Organized Delivery System External Quality Review

2017-2021 Statewide Report



Access

Access Findings, Trends, Challenges

Access

How Counties, Providers, & the Regional Model are Improving Access to SUD Treatment

Access requires:

- Outreach
- Engagement
- No Wrong Door
- Service Capacity

Introduction

The DMC-ODS Waiver placed a high priority on 24-hour access to information, ASAM-based screenings and referrals and supports into treatment—which are all critical ingredients for successful engagement of persons with SUD. All DMC-ODS programs must have a 24-hour beneficiary access line (BAL) available and staffed to provide information and screening to link individuals to SUD treatment. This requirement applies to those who have urgent conditions and those who seek help in languages other than English. This access requirement is included in the Waiver STCs. However, just having a BAL is not enough to guarantee easy access, so all DMC-ODS plans have a variety of "entries" or "gates" into care designed to make it as easy as possible for individuals to approach treatment programs for help. Often referred to as a "No Wrong Door" model, it isgood in principle, but complex to administereffectively assuring clients get linked to the care they need in a timely manner.

In order to provide timely access, counties must provide the 24-hour BAL, but also take into account the fact that many individuals will go directly to l either county-run clinics and provider sites asking for treatment directly. In fact, many counties consider networks of service providers a better option for convenient community access if they have an adequate number and distribution of treatment programs across a county's geographic areas. These programs must be able to provide a comprehensive assessment using ASAM dimensions if they are to function as gateways into the system of care. Use of the comprehensive ASAM assessment to match client need and appropriate LOC is another core requirement of the STCs in the 1115 Waiver. This matching of client needs to their optimal treatment is a PM and an important requirement.

Both the 24-hour BAL and the no-wrong-door access portal to treatment approach are used in the vast majority of counties to engage new clients and link them to care. Access portals utilize the ASAM-linked tools and principles to evaluate beneficiaries' needs. After completing this process, the next key issue is arranging access to the appropriate LOC--Is it available? Is there enough capacity? Is the service close to where the client lives, or would it require travel out of the county or for an extended distance? Whenever possible, screenings and rapid linkage to treatment are desired; without these, many individuals do not follow up with appointments into treatment. Many clients need assistance to even make it to their first

appointments due to ambivalence, fears, and anxiety. Some plans assign case managers either from or in coordination with the BAL to support clients into their first appointments.

The provider network, integrated across a continuum based on levels of treatment structure and intensity, is intended to match the spectrum of clinical need presented by individuals with SUD including those who have co-occurring mental health and physical health disorders. The

Overview of Major Access Findings

Finding 1 Total clients served in the DMC-ODS counties increased year over year even during FY 2019-20 with COVID-19 though at a decreased rate. And with half of FY 2020-21 data, it appears to show a trend for that year to exceed FY 2019-20 as well despite COVID-19 even with 11 new counties in their first year of services. Many counties in the first year normally showed a decrease in services.

Finding 2 While each type of service along the ASAM continuum increased over time residential programs, MAT, outpatient, and newer treatments slowly grew to have a more complete and more balanced continuum of care options for clients to meet their needs.

Finding 3 Across the four FYs, both the number and percent of clients served in the 14 DMC-ODS Pioneer Counties increased each year though lower in trend in FY 2019-20 and early FY 2020 due to COVID-19. And the trend for the non-Pioneer Counties was also positive though less robust.

Finding 4 In Pioneer Counties, expanded access was reflected in increased penetration rates for Medi-Cal clients across all three primary age groups from FY 2017-18, FY 2018-19, FY 2019-20, and FY 2020-21 (six months), and also expanded the numbers of clients served in each age group across the FYs as well.

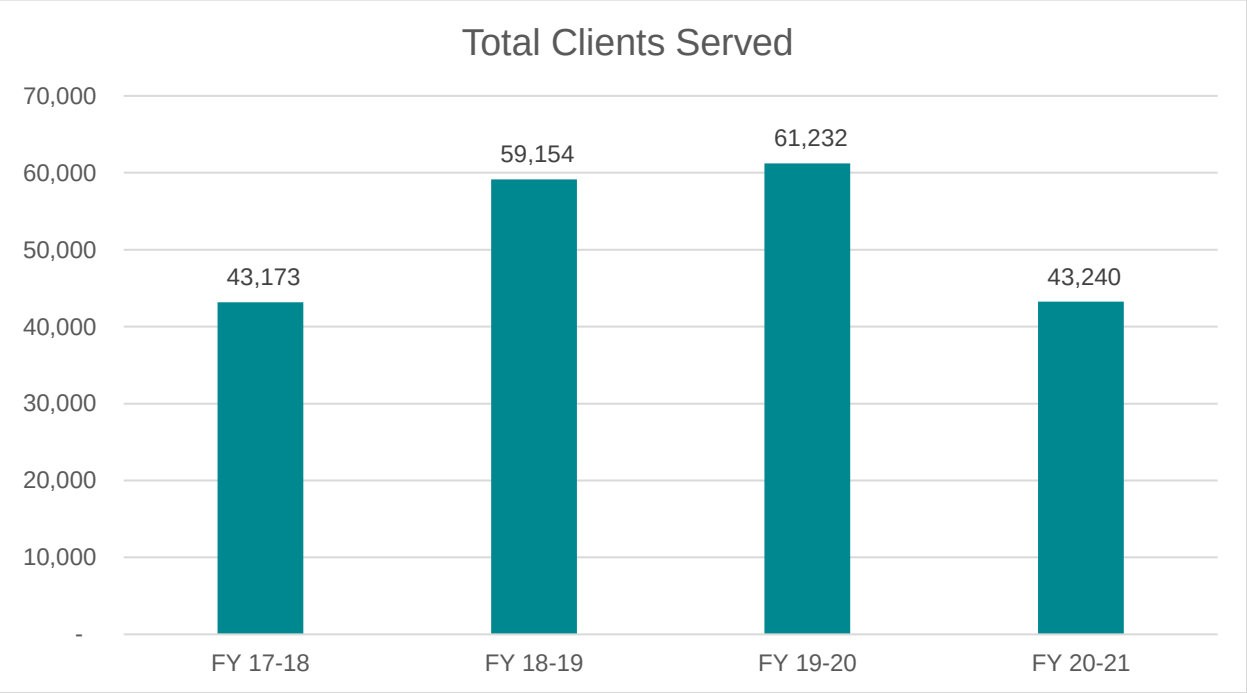
Finding 5 The increase in services for Medi-Cal clients in Pioneer Counties was also reflected across all race/ethnicity groups from FY 2017-18, FY 2018-19, FY 2019-20 and 2020-21 (six months of data). Similar trends to a less dramatic degree were reflected in the Year-Two DMC County group.

network of services established by the DMC-ODS plan is the foundation for timely and appropriate access to care. This is not only a key issue with access and timeliness, but also with quality, satisfaction, and retention in care.

2017-2021 Data Trends Related to Access

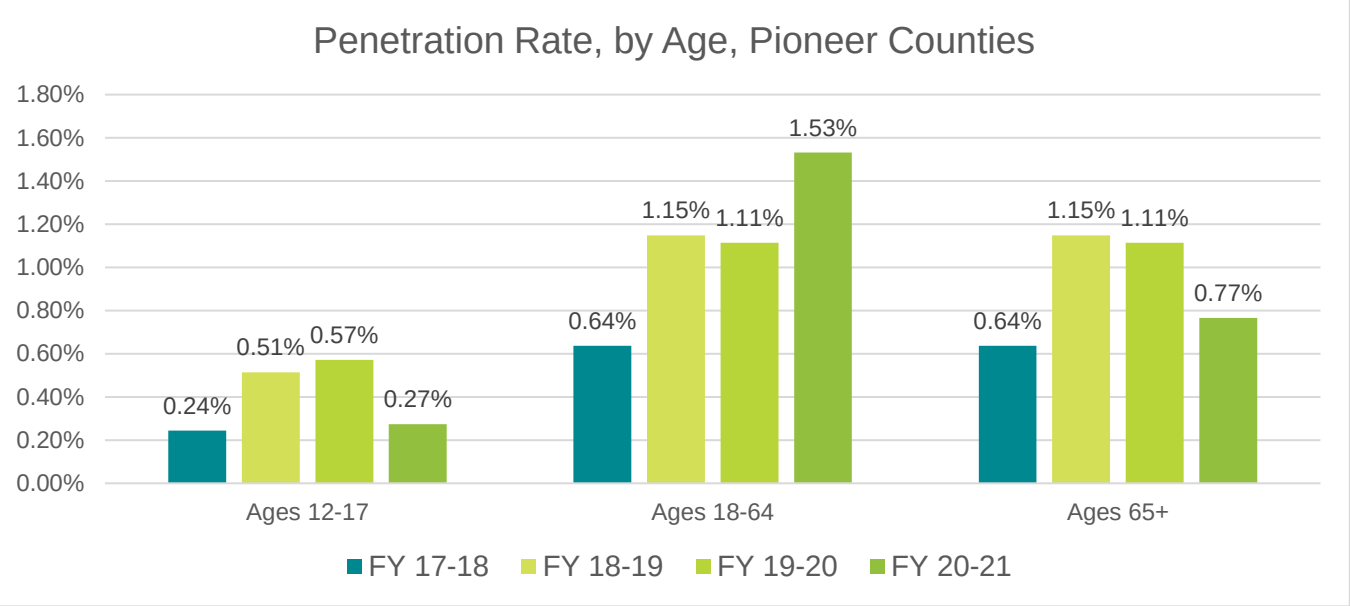
Below are key tables with data from each year of reviews showing the important trends for access by FY for all clients served. Table 3-1 includes all counties and the Regional Model. Table 3-2 shows the penetration rates over time of the Pioneer Counties to underserved ethnic groups. Table 3-3 shows the growth of groups by age within the Pioneer Counties and while they are all increasing, every Pioneer County expressed a desire to expand services to youth further and note the need to improve with early engagement through schools, social media and coordination with prevention programs. Table 3-4 shows the penetration rates for Year-Two, non-pioneer Counties. As noted earlier in this report, while they are less mature in terms of their service continuum still have done well in expanding access and range of services to the Medi-Cal population year over year.

Figure 3-1: Total Clients Served DMC-ODS, by Fiscal Year, All Counties



Note: FY 2020-21 includes only six months of data

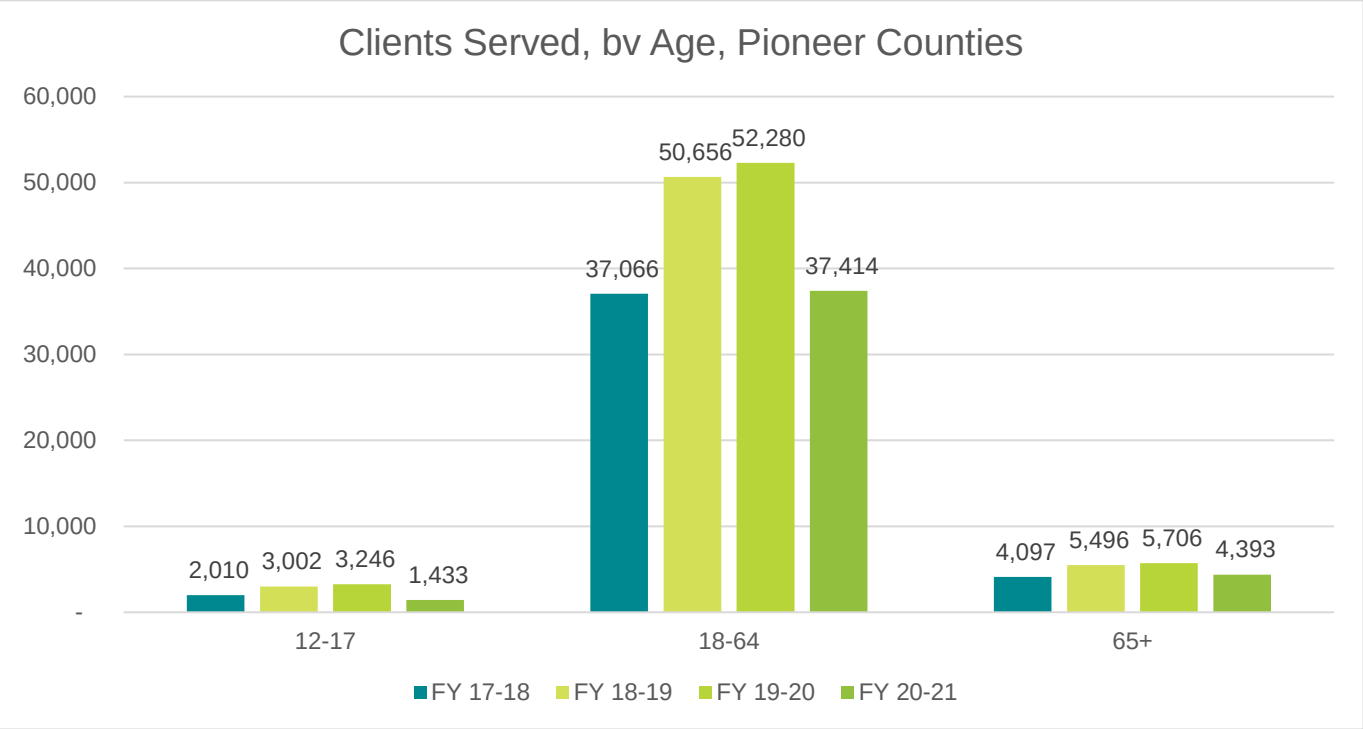
Figure 3-2: Penetration Rate by Age, by Fiscal Year, Pioneer Counties



Note: FY 2020-21 includes only six months of data

The Pioneer Counties have the most mature and stable continuums of care for their SUD clients due to the number of years they have had to work on expansion and refinement of their systems. Even with COVID-19 impacts there was some growth in clients served in each age group, though slower than prior years.

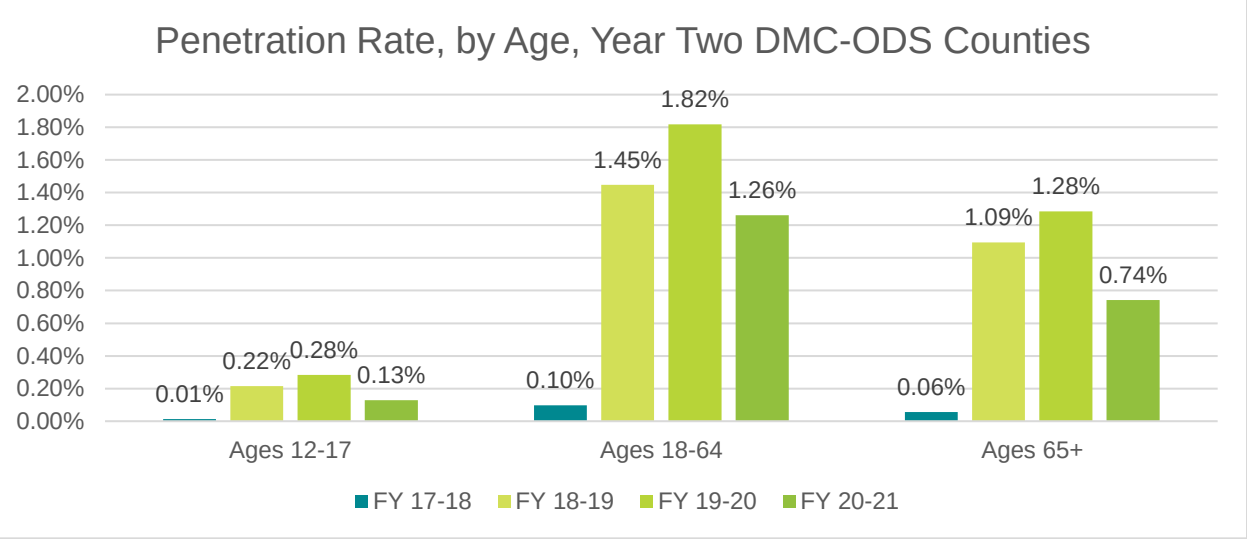
Figure 3-3: Unduplicated Clients Served by Age, by Fiscal Year, Pioneer Counties



Note: FY 2020-21 includes only six months of data

The trend of increasing unduplicated clients served designated by age group continued for the non-pioneer group as well as reflected in Figure 3-4.

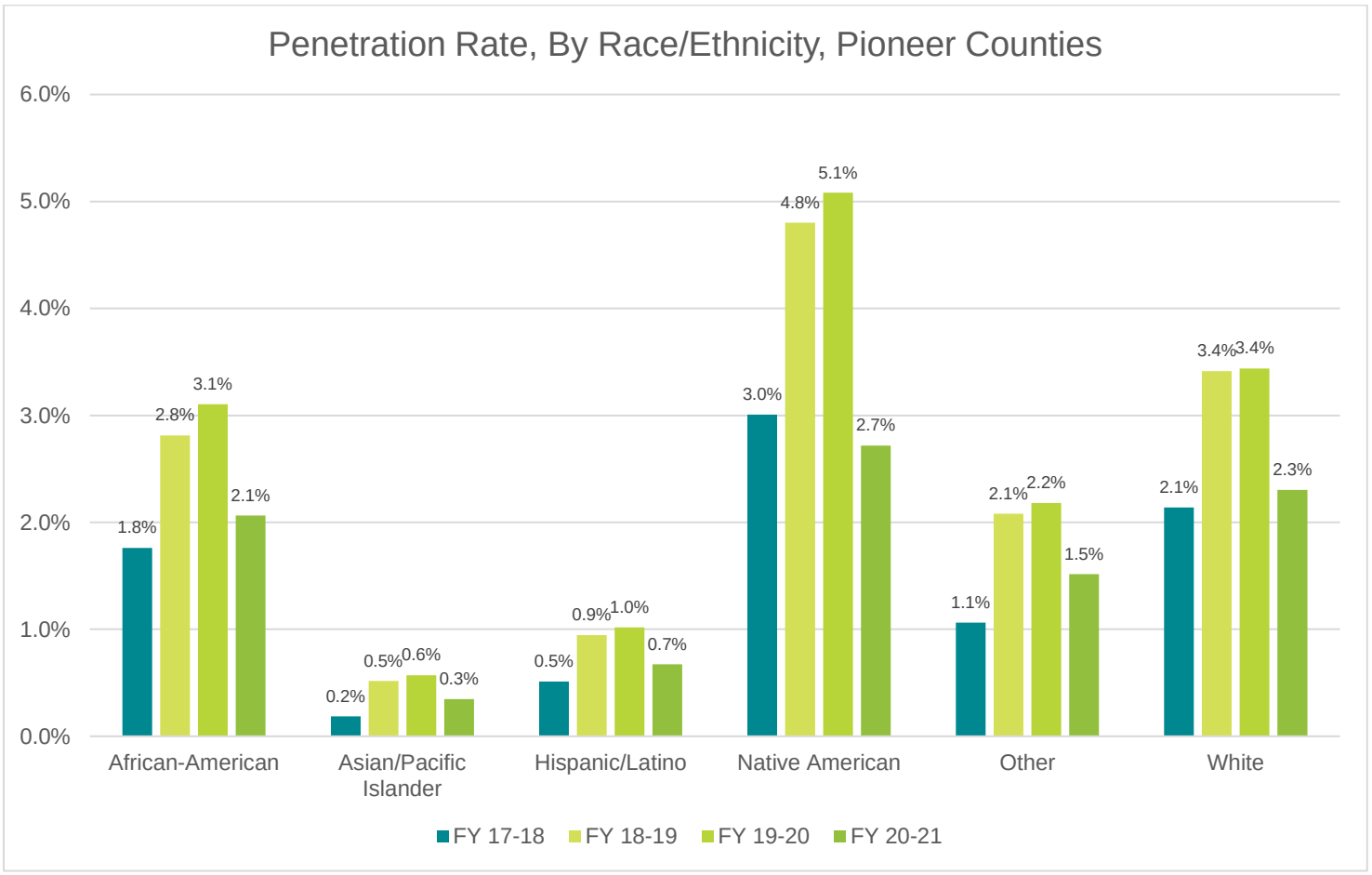
Figure 3-4: Penetration Rate by Age, by Fiscal Year, Year Two Counties



Note: FY 2020-21 includes only six months of data

Pioneer Counties saw a trend of increasing penetration rates by ethnic group by FY. Several of these DMC-ODS counties had PIPs targeting this issue and the project design often involved local community faith communities and schools, bilingual staff from diverse communities, along with special outreach efforts to community events, and other strategies.

Figure 3-5: Penetration Rate by Race/Ethnicity, by Fiscal Year, Pioneer Counties

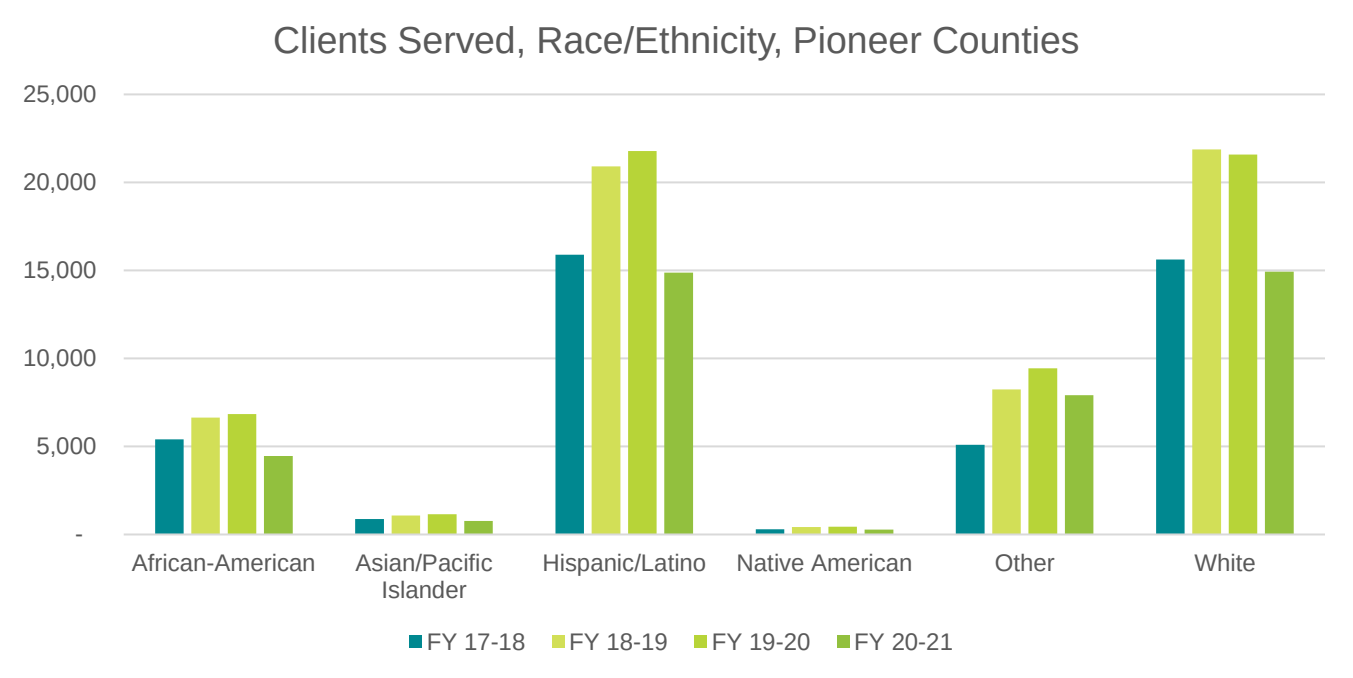


Note: FY 2020-21 includes only six months of data

With the exception of the White population, all ethnic groups served saw a trend on increased clients served by the Pioneer counties as well.

All ethnic groups served saw a trend of increased clients served by the Pioneer counties though because of COVID-19 and partial data a drop which reportedly has rebounded in FY 2021/22.

Figure 3-6: Clients Served by Race/Ethnicity, by Fiscal Year, Pioneer Counties



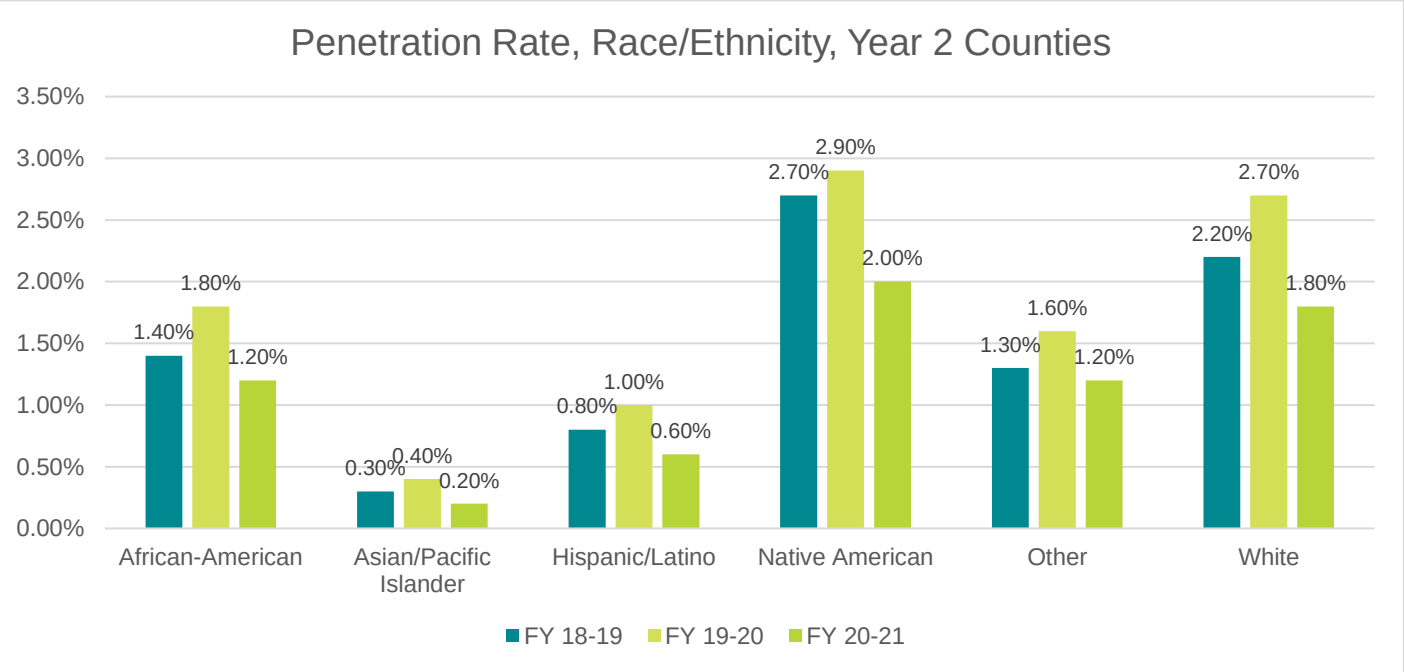
Note: FY 2020-21 includes only six months of data

Data for penetration rates by race-ethnicity for non-pioneer counties moved in a positive direction year over year correlating with a focus on this area for all the DMC-ODS counties.

Table 3-8:

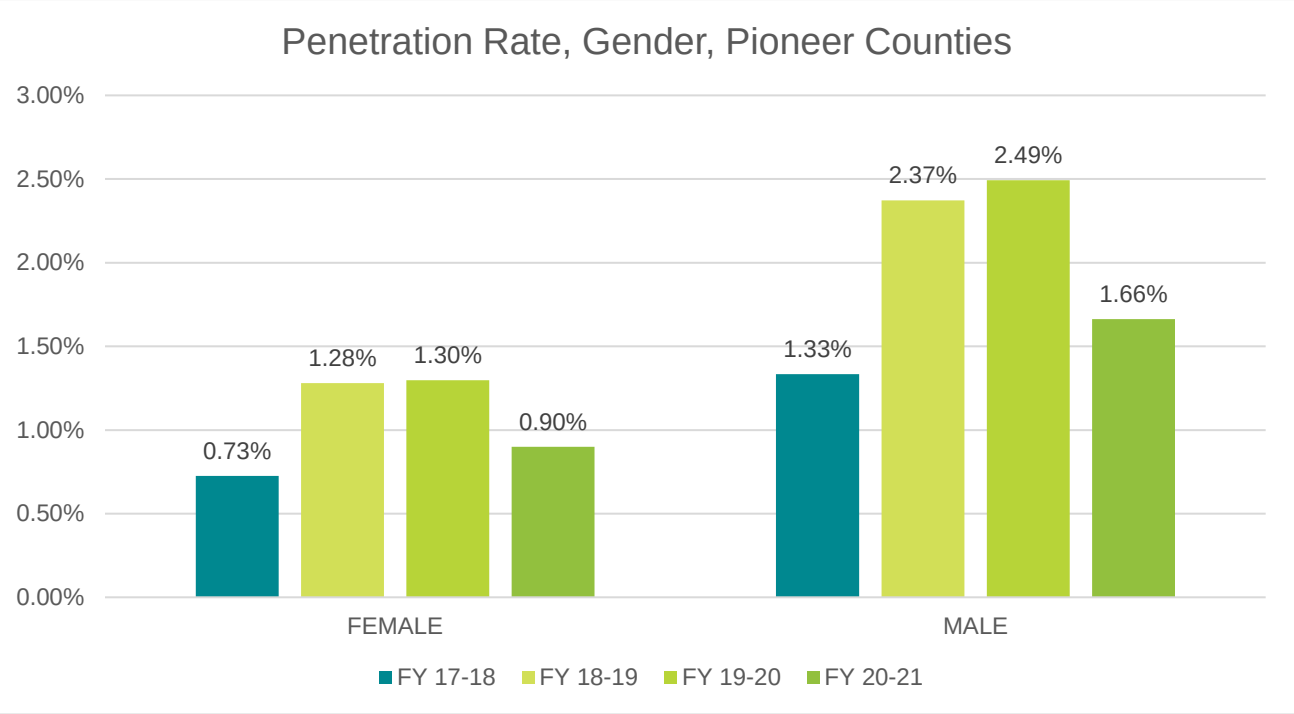
Penetration rate by gender for Pioneer Counties indicates that men were served somewhat more than women. This is likely accounted for given the number clients accessing from the criminal justice system, where a higher male rate of referral is expected. It is also important to ensure access, to females who have SUD, whereby DMC-ODS counties should assure outreach, identification, referral, and adequate capacity within their systems.

Figure 3-7: Penetration Rate by Race/Ethnicity, by Fiscal Year, Year Two Counties



Note: FY 2020-21 includes only six months of data

Figure 3-8: Penetration Rate by Gender, Pioneer Counties, FY 2017-21



Note: FY 2020-21 includes only six months of data

In summary, access has been improved with data indication that the number of clients served, as well as the type of clients served continued to grow. Compared to CalOMS data in year preceding the Waiver, it appears that this is not just a shift in payer source but true growth represented by those served in treatment. While significant challenges such as the beginning of COVID-19 with stay-at-home orders which caused setbacks, DMC-ODS counties quickly adapted. Alternate service delivery models by counties, the Regional Model, and providers shifted care to video and phone visits, while some programs were able to do some home and in-person contacts with precautions as necessary for urgent cases. In addition, the special Waivers for ongoing methadone clients with take-home doses for stable clients appears to have had a positive impact and retained clients in treatment. Also, evidence gathered to date from this group has not shown these clients to be involved in any increased overdose deaths as was the fear with to the relaxed regulation. While UCLA is doing more analysis, CalEQRO focus groups with clients or methadone providers corroborate these early impressions.

Tracking Access and Network Needs & Capacity

Expanded access is linked to DMC-ODS systems facilitating timely entry to appropriate care, as well as having a complete network of clinical providers at the LOCs that match individual and local needs. The 1115 Waiver expanded the Medi-Cal provider networks for SUD to include three levels of residential treatment plus residential WM, MAT, NTPs with an expanded range of medication options, partial hospitalization, case management, physician consultation, RSS, medical WM 3.7 and 4.0, and inpatient SUD WM 3.7 and 4.0 services. The counties were required to phase in an expansion of their networks across several years with an approved implementation plan. To meet Waiver requirements, they needed to operate like managed care plans in overseeing the quality of their networks, selective contracting, service authorizations, billing, and cost reports. In addition, NA requirements were added in recent years to enhance access in remote areas, with time and distance standard requirements.

DMC-ODS programs have continued to enhance and modify their networks to meet local needs. This has included **changing providers** and **expanding partnerships with neighboring counties** to facilitate more access with out-of-network providers.

Table 3-1: Standard State Plan and Pilot DMC-ODS Benefits

Standard State Plan Benefits (available to beneficiaries in all counties)	Pilot DMC- ODS Benefits (only available to beneficiaries in pilot counties)
Outpatient Drug-Free Treatment	Outpatient Services
Intensive Outpatient Treatment	Intensive Outpatient Services
Naltrexone Treatment (oral for opioid dependence or with Treatment Authorization Request [TAR] for other)	Naltrexone Treatment (oral for opioid dependence or with TAR for other)
Narcotic Treatment Program (methadone)	Narcotic Treatment Program (methadone, buprenorphine, disulfiram, naloxone is required + additional FDA medications optional)
Perinatal Residential SUD Services (limited by Institutions for Mental Disease [IMD] 16-bed exclusion)	Residential Services (not restricted by IMD exclusion or limited to perinatal) 3.1,3.3,3.5
Detoxification in a Hospital (with a TAR) via Managed Care Plan	WM (at least one level)
	Recovery Services

Standard State Plan Benefits (available to beneficiaries in all counties)	Pilot DMC- ODS Benefits (only available to beneficiaries in pilot counties)
	Case Management
	Physician Consultation
	Partial Hospitalization (optional)
	Additional Medication Assisted Treatment (optional)
	3.7 & 4.0 Medical Withdrawal & Inpatient (optional)

As observed over the four years of EQR reviews, the DMC-ODS programs have continued to enhance and modify their networks to meet local needs. This has included changing or adding providers and expanding partnerships with neighboring counties to facilitate more access with out-of-network providers, as needed.

Expanding "Access Gates" & Care

An expanded ability to reach more clients in need of SUD treatment with appropriate care remains one of the key goals of the 1115 Waiver. This is one of the mandated PMs reviewed by CalEQRO each year. While counties had solicited new providers, many struggled during their initial year to get these programs licensed and certified. In the second year, efforts shifted to achieving the full continuum of clinical services. CalEQRO noted evidence of that expanded continuum as counties made progress reaching more clients throughout previously underserved or remote regions of the state. Each year, counties make adjustments to their continuums of care. These changes include types and locations of residential treatment beds and evaluation of the needs for recovery housing to complement intensive outpatient and outpatient services (to address housing insecurity at this LOC). They also adjust capacity and locations of WM which, according to feedback from stakeholders, is often inadequate or too far away to be practical. Acting expansion of MAT in partnership with the ED Bridge programs and criminal justice collaboratives is also noted to be prevalent in many communities. With COVID-19 school closures and the resulting stress on youth, many counties are working across departments to coordinate reopening or establishing "new gates" to access care. Such initiatives are also present to expand access for those in the criminal justice and social services systems and/or those with complex health needs.

Some county BALs have added primary care clinics with MAT and SUD counseling to their database systems as an option for referrals. Others are focusing on CM teams that are poised at the front of the system which provides more active benefit to the incoming client by addressing barriers, transportation, and giving them support to get to their first appointment. CalEQRO has used data from these activities in reports to show levels of increased integration. This has been necessary as links to fee for service (FFS) Medi-Cal claims data is not directly available. The DMC-ODS counties have seen an expanded level of communication and collaboration with both the ED Bridge and inmate facility health providers in the last two years. This has been accelerated by the increased deployments of MAT expansion grants,

whose efforts focus not only on starting individuals on MAT within the healthcare system but coordinating linkage to the SUD continuum of care as well. This project has played a very positive role in changing attitudes of practice in many communities.

Detailed examples of this expansion including data by LOC are provided in the quality chapter under the ASAM continuum section.

Successful Access Practices & Strategies

County and even regional efforts have provided examples of best practices. Starting with the BAL centers, counties such as Riverside, Los Angeles, Santa Clara, San Diego, and Orange invested in call center software that gave them enhanced capacity to manage their access processes. Some of the many best practices include:

County best practices to increase access include offering case management or navigator supports to new clients to assist with urgent appointments or links to higher levels of care.

(1) Call Center software offering complete access to caller information, wait times, dropped calls, peak times of day, language, and disposition information on request calls in many standard timely reports.

(2) Call Center software with an ability to record interviews for training/supervision.

(3) BAL staffing with skills to triage, do ASAM screenings, and link clients, via three-way conference calling, to service providers at the appropriate LOC, thereby facilitating quick access. These BALs also have systems for handling after-hours access requests with all activities supported and tracked in the Call Center software.

(4) An ability to address urgent service requests, which is often beneficial not just to the client but partner agencies making referrals such as probation, human services, family members assisting the client through a BALs three-way calling capacity with SUD providers to better facilitate needed assistance.

(5) Use of Call Center software that can link to historical records from the county SUD system (if appropriate) resulting in a better assessment and disposition.

(6) BAL staff and Clinical staff can link to system wide real-time capacity database to more efficiently identify and refer clients to SUD providers who have intake openings. A well-designed database can sort by type of treatment resource, location, language, cultural orientation, and current vacancies to empower the BAL and other staff to make good choices for client referrals and support.

(7) Call Center Software that is capable to do an automated client satisfaction survey measuring their experience with the BAL and referral process.

(8) Assign case management or navigators to assist new, high-risk clients including to those individuals who have made urgent service requests, to assure timely access to initial appointments and treatment.

Other best access practices focus on coordination of transitions in care. This often included facilitating client access to either higher or lower LOCs, such as movement from residential treatment to an outpatient program, moving clients to specialized care such as perinatal programs, or getting them WM with transportation assistance. Riverside DMC-ODS offers supportive case management, that functions to assure system navigation for clients. This program assists both those who are moving to higher LOCs and incoming clients from the BAL whose urgent conditions need hands-on follow-up after requesting services. Los Angeles has specific contract providers in each region who are tasked with case management support and coordination activities so that no clients "fall through the cracks" in between levels of care. In both cases, these programs are vital to the system functioning as a continuum of care. In addition, the LA DMC-ODS has one of the best developed and organized resource databases for a BAL. The database was designed for Los Angeles Substance Abuse Prevention and Control (SAPC) system which has made it available to all providers, the BAL, and the public. It has a user-friendly interface, daily updates, and multiple levels of important program, service, location, and language information. It is also available for the public to use on the internet https://sapccis.ph.lacounty.gov/sbat/.

The attitude of some counties was "whatever it takes to get clients access to SUD care;" their BAL center staff or BAL contractors were empowered to provide clients with strong support activities to get them connected with care. Orange and San Diego had particularly strong partnerships with their long-term contract partners organizing their BAL centers to function in this way.

When clients went directly to clinics or programs in the provider network and did not use the BAL to request services, use or development of other best practices was indicated. Direct client access through these network providers necessitated workflows to register individuals requesting services in a central database allowing the county DMC-ODS to track timely access to service. This contractor database partnership and infrastructure was well-established in many counties that utilize EHRs, such as myAvatar or Cerner, although some counties use other applications. For many DMC-ODS systems, these database connections provide timeliness tracking capability, allows them to effectively identify and manage problem areas, and improves capacity management.

San Luis Obispo County operates a distributed clinic site model especially well. In addition to its call center, clients can utilize well-publicized regular walk-in hours for assessments and screenings at a variety of dispersed county clinic sites positioned along the two major freeway corridors and city bus lines. As a result of ads and word of mouth these services and locations are well known by the community, clients, and other agencies. The county clinics have the capacity to conduct full assessments and link clients to appropriate care, including MAT from those clinics. They have their own outpatient MAT clinic, which is very robust and serves a significant percentage of county SUD patients who need buprenorphine and other non-methadone medication. They are completing construction of their own residential treatment site for WM and 3.1 and 3.5 services as well in the county to enhance their continuum of care.

This will address the one LOC where there were some timeliness and capacity challenges remain.

Nevada County and Napa Counties have also re-organized access to have drop-in access for intakes and added large banks of appointments and flexible hours for doing the paperwork to make it easier to get key tasks done to facilitate access and admission. These refinements of workflows in both counties made major improvements in timeliness and no-shows. Adding features like text message reminders and some mobile capacity to get key documents for those who are home-bound helped as well.

Finally, ongoing steps to refine the SUD continuum of care to better meet the needs of underserved race/ethnicity groups requires enhancing engagement strategies, as well as creating new avenues for access an area known to need improvements. CalEQRO findings show DMC-ODS systems have been moving in the right direction regarding these needs designing relevant PIPs, improving recruitment of bilingual staff, and setting outreach goals in quality plans. Meeting the core requirements for 24-hour BALs with bilingual access linked to a robust provider network that meets NA standards is essential for the next phase of growth in this area.

Summary

Access systems for the DMC-ODS Waiver have progressed in a positive direction serving more clients and expanding the overall continuum of care. Some new services have proven more challenging to expand than others such as non-methadone MAT, residential WM, youth services residential, hospital WM, ASAM levels 3.7 and 4.0 WM, and RSS, but they are all slowly increasing. Leadership and staff shared with CalEQRO that workforce issues were a barrier to some of the expansion along with some of the regulatory burdens leading to complicated application process, heavy levels of required documentation of the state's provider enrollment division (PED), slowing expansion timelines. .

Client input provided in both focus groups and survey responses, were extremely positive regarding the changes made in access to care over the last four years. While this feedback noted some delays had still occurred in residential access, clients did note it had improved compared to prior experiences and getting better over time. There were continuing requests for more access particularly in MAT and case management Clients added that housing with support for recovery remains a need, and requested more flexibility on LOS in residential treatment, and more family therapy. Clients felt all of these were important and better now than prior to the Waiver.

Drug Medi-Cal Organized Delivery System External Quality Review

2017-2021 Statewide Report

Network Adequacy

Network Adequacy Findings, Trends & Challenges

Network Adequacy

How DMC-ODS Counties & the Regional Model are Meeting NA Standards

Overview of Network Adequacy Findings

Finding 1 Los Angeles, Orange, San Mateo, Contra Costa and Monterey FY 2019-20 counties with AAS **added providers within their counties as well as in neighboring counties** to reduce time and distances for their Medi-Cal beneficiaries. Most reduced the number of problematic zip codes and beneficiaries impacted by NA issues with Orange County no longer required to request AAS due to these efforts.

Finding 2 **In both FY 2019-20 and FY 2020-21, primary care partners** were willing to enhance access to non-methadone MAT for Medi-Cal beneficiaries by working with DMC-ODS plans to become part of their networks when financial feasibility of other MAT (such as NTP/OTP options) were not possible in remote, low-population areas.

Finding 3 **Frontier areas** not covered by Medi-Cal Health Plans posed extra challenges for DMC-ODS programs to find providers with DMC-ODS current licensing and certification requirements or the potential to meet these requirements. While challenging, these areas also pose opportunities for new MAT or outpatient partnerships with primary care clinics or rural health clinics.

Finding 4 All DMC-ODS Counties and the Regional Model were measuring timeliness to services, transitions between services, as well as other quality measures. SUD contractors without practice management systems and EHRs had difficulty tracking timeliness, leading to fragmented or incomplete reporting from the DMC-ODS counties. Infrastructure improvements are needed to make these systems reliable and stable to meet this requirement.

Finding 5 **Limited internet access** for client services in remote and frontier areas is a serious barrier to quality care, affecting both telephone and video telehealth options, and coordination of care for client care and client engagement strategies.

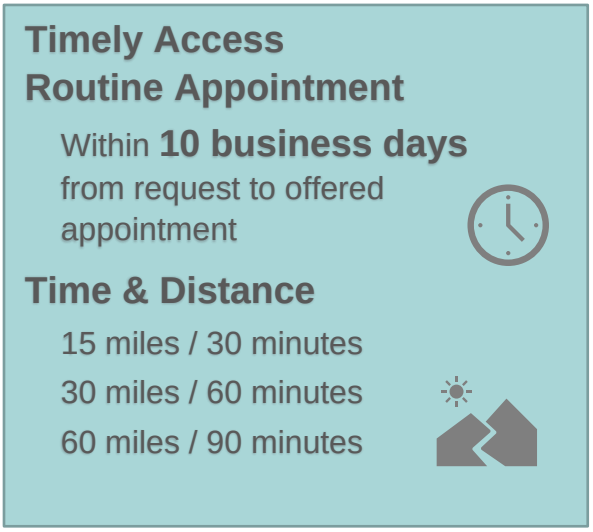
Finding 6 **NTP access** for adults and youth accounted for most of the NA time and distance issues in the CY 2020 counties with ten counties and the Regional Plan needing AAS. Only three counties and the Regional Plan had zip codes requiring AAS for additional providers for outpatient services for youth and adults to meet NA

Introduction

This is the second year for DMC-ODS counties to be reviewed for NA. This CMS requirement was added to assess DMC-ODS plans in 2018 regulations. It requires adequate access to care in a timely manner, even for those who live in remote rural and frontier areas. The California legislature also passed legislation, which clarifies how the new NA requirements would be applied in California with its diverse geographic areas and varying population density across California counties.

All DMC-ODS Counties and the Regional Model were measuring timeliness to services, transitions between services, as well as other quality measures. SUD contractors without practice management systems and EHRs had difficulty tracking timeliness

NA requirements apply to all Medi-Cal managed care plans, but this report only addresses the DMC-ODS plans reviewed in FY 2019-20 and FY 2020-21 by CalEQRO, and the expectations for access to care within time and distance standards published by DHCS.



To determine NA, each county submitted a detailed description of its network of providers—including their languages, locations, and capacity—in a document called the NACT. The NACTs were thoroughly reviewed by DHCS to identify which counties met time or distance standards in 2019 and also in 2020. They needed to meet standards as reflected in BHIN 20-12 related to time and distance. The county needed to submit an AAS request for a different standard and identify the closest providers and how many individuals would be impacted.

Based on DHCS, counties had to meet varied standards due to their populations and density, as reflected in Table 4-1 for outpatient services other than opioid treatment.

Table 4-1: NA Timely Access Standards for DMC-ODS Counties

Timely Access	Within 10 business days from request to appointment
Time and Distance Standard: **15 miles/30 minutes**	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara

Timely Access	Within 10 business days from request to appointment
Time and Distance Standard: **30 miles/60 minutes**	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura
Time and Distance Standard: **60 miles/90 minutes**	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

(Source of 4-1 NA information is AB 205, Chapter 738, Welf. & Inst Code, 14197)

Also required related to timeliness of services, NTP/OTP services must be provided within 3 business days of request and outpatient SUD services offered within 10 business days for routine appointments, and 48 hours for urgent appointments without authorization and 36 hours for services requiring authorization.

Best Practices to Expand Access in Remote ZIP Codes

Over the last two fiscal years, DMC-ODS counties have proposed many strategies and mitigations to improve access for Medi-Cal residents in those remote ZIP codes. These approaches are discussed in some depth in individual county reports, but several are highlighted here as examples of best practices for other counties and regional models to consider.

The best practices demonstrated by the counties overall are as follows:

(1) Negotiated with existing outpatient or NTP providers within their network to expand and add new sites or add adult or youth populations to existing sites to meet NA and community needs.

(2) Partnered with providers to identify property and locations to meet NA needs and worked with methadone providers on the land use permitting processes, including neighborhood meetings, court challenges, and assistance with rents and start-up costs.

(3) Sought out Behavioral Health and provider directors in surrounding counties to partner with on adding new or expanding programs near the borders of both counties, to enhance capacity and expand populations served in ways that benefit both counties' Medi-Cal members.

(4) Where populations needing MAT were limited and a full NTP/OTP was not feasible, sought medical partnerships with primary care and hospital providers to establish access to MAT clinics that could offer co-located SUD counseling and telehealth capacity and consultation, and also offer prescribing via X-Waivered prescribers for MAT.

(5) Explored new service location options with focus groups with the local community members in remote areas, finding that many preferred to drive to neighboring counties due to traffic or other factors, so worked with local health providers to increase access and then began to develop distinct types of innovative SUD partnership plans to expand services. Focus groups also led to new sites in community centers, churches, and schools with unused space for limited days per week and some mobile capacity.

(6) Expanded knowledge through focus groups with potential out-of-network providers, and explored the desire for telehealth, phone consultation, counseling options, and internet options for remote areas through schools and library supports, along with other opportunities to enhance services.

County Best Practice Examples for Improvement Efforts

Expanded telehealth options have made **reliable wireless internet access** in remote areas essential to services for all populations, but bandwidth still remains challenging in many frontier areas of California.

Los Angeles SAPC DMC-ODS exhibited many of the best practices noted above, but also added remote telehealth kiosks for residents to assure internet access and added more services in the remote areas of Antelope Valley and in partnerships with providers on Catalina Island.

PHC is working with two NTP providers to add new sites and has created an extensive network of primary care providers doing non-methadone MAT and behavioral health outpatient counseling in the region to assist with some of the remote access needs for those with OUD while these other projects are in development. Also, PCH is actively soliciting for new providers as part of their plan utilizing the combined resources of seven counties to expand their network across the ASAM continuum, beyond the outpatient and NTP/OTP service levels.

Contra Costa DMC-ODS worked with local providers to add needed outpatient services for youth and adults in some remote areas to address NA needs. They also worked with an NTP/OTP provider who faced a difficult land use issue trying to open a facility in Concord. The case went to court and the provider eventually won and are now in the process of becoming licensed and certified. When open it the new site will address their NTP needs. Contra Costa also has worked extensively with surrounding counties to add more providers and contracts providing proximity for residents who live near the county line thereby making access more convenient for their clients. While the number of ZIP codes from the prior year's AAS have been reduced, the county is still working on those remaining to meet time and distance standards for NTP.

San Mateo DMC-ODS is another county that has implemented many of these best practices to enhance access to care for its Medi-Cal members. For example, they added multiple outpatient and NTP contracts with other counties to meet their "members" needs in San Francisco, Santa Clara, Alameda, and will also add a contract in Santa Cruz. These contracts with adjacent counties will be more convenient for residents many of whom work or live on border areas.

Next Steps for Network Adequacy Expansion

CalEQRO expects DMC-ODS systems facing NA issues will continue to be innovative and additional best practices for outreach and engagement will be identified. While capacity building in the next year is planned, timelines and resources may be impacted relative to the status of COVID-19 related issues. Flexibility provided by telehealth and phone services along with alternate access portals for MAT via primary care and pharmacies provide helpful entry points for service, critical for isolated areas with little transportation, the elderly and disabled, and those who find local traffic or work realities a barrier. Expanded telehealth options have worked to obtain more reliable wireless internet access within remote areas an essential element to secure virtual services though sufficient bandwidth remains a challenge in many frontier areas of the state. For some of these areas with internet gaps, counties are working with schools, libraries and setting up either public kiosks to allow for access or coordinating similar efforts with other public services or health providers.

Key Timeliness Measures for Initial Appts & First Dose of Methadone

CalEQRO reviews timeliness of appointments using defined PMs for all counties regarding routine appointments, urgent appointments, and for NTP/OTP methadone dosing appointments following initial appointments. Standards for outpatient and NTP/OTP visits are defined in the STCs, as well as in the NA requirements for youth and adult populations.

Table 4-2 below shows routine appointment timeliness averages based on visits in all ZIP codes for all DMC-ODS plans reviewed in FY 2019-20 and FY 2020-21. Routine visits and the days to first dose of methadone for those requesting NTP/OTP services across all county ZIP codes are based on claims and initial request data from call centers and service request/screening tracking systems in the DMC-ODS counties. CalEQRO has direct access to all claims data, but the service request data logs are locally generated by the DMC-ODS and its provider network. These are used to calculate timeliness. It is important to note that several counties (El Dorado, Sacramento, San Benito, and Tulare) of the 30 counties reviewed and the Regional Model were in their first years of launching DMC-ODS treatment systems and associated infrastructure. First year counties often experience timeliness tracking problems and interoperability challenges between county and contract provider networks. DMC-ODS counties in their first years of implementation have found that tracking timeliness and all of the new managed care data is very difficult as many counties have a variety of systems and

providers even lack EHRs making for enormous complexity in sharing data. It is worth noting that some of the major behavioral health software programs cannot track offered appointments or delineate hours to adequately track urgent requests as defined.

Table 4-3 below includes three primary measures: offered routine appointments, actual appointment times from request to actual first billable appointment, and methadone dose after evaluation measured in FY 2019-20 and again in FY 2020-21. As stated not all software can measure offered appointments and some counties have dispersed access systems with many points of entry.This decentralized access system makes tracking requests very challenging, even more so when points of entry include partner agencies such as Child Welfare Given this complexity some DMC-ODS systems do not have the offered appointment data. Nonetheless, 13 DMC-ODS programs improved their offered appointment times in FY 2020-21 and 15 improved in actual timeliness of first billable appointments. This was particularly notable given the time frame of July 2020 through June 2021 was dominated by COVID-19 pandemic management. SUD service delivery changes during this time involved extra challenges which delayed access, limited contacts for testing, and in cases such as in residential, required social isolation prior to program access. Other related factors that likely impacted time to service included set up and use of telehealth or telephonic access points, establishing public health procedures such as use of personal protective equipment (PPE), resource impacts including staff being ill or reassigned to emergency centers, and vaccine distribution campaigns.

In addition to the data on timeliness, CalEQRO obtained participant feedback from client focus groups sessions which ask about timely access to care and reviewed the TPS results which also has questions related to this issue. Finally, CALEQRO also reviews Quarterly Grievance Log Complaints which DMC-ODS programs are required to send to DHCS related to access. Combining these sources of information, it is often possible to find patterns of access or timeliness and identify problem areas in specific programs. Such findings may generate recommendations for improvement and further inquiry.

Table 4-2: Average Timeliness for Routine Appointments, Methadone Doses, FY 2019-20 and FY 2020-21

County	FY 19-20 Time Offered	FY 20-21 Time Offered	FY 19-20 Time Face to Face	FY 20-21 Time Face to Face	FY 19-20 Methadone Dose	FY 20-21 Methadone Dose
Alameda	5	2.6	5	3.6	1	1
Contra Costa	8.3	5.6	9.4	6.4	1	1
Fresno	6.19	1.5	15.64	23	1	1
El Dorado	-	5.88	n/a	7.99		1
Imperial	15	10	18	8	1	1
Kern	n/a	n/a	8.72	5.2	1	1
Los Angeles	5	5	10.8	11	1	1
Marin	2.3	1.78	3.8	1.8	1	1
Merced	8	6.8	8	9.5	2	1
Monterey	4	3	6	4	1	1
Napa	5.4	n/a	14.7	8	1	1
Nevada	4	3	5	10	1	1
Orange	4.7	2.24	4.17	4.26	1	1
Partnership	n/a	n/a	n/a	5.15	n/a	1
Placer	n/a	n/a	39	20	1	1
Riverside	5.1	3.7	5.1	4.2	1	1
San Bernardino	n/a	n/a	39	28	1	1
San Diego	2.9	3.1	3.8	3.9	1	1
San Francisco	1.3	3	3.9	9	1	1
San Joaquin	n/a	1	2.9	1.9	1	1
San Luis Obispo	2.63	1.87	3.75	7	1	1
Sacramento	n/a	29	n/a	45	n/a	1
San Benito	n/a	5.18	n/a	5.6	n/a	1
San Mateo	n/a	1	31	30	1	1
Santa Barbara	5	5.2	6	5.3	1	1
Santa Clara	12	6	17	9	1	1
Santa Cruz	7.25	n/a	7.81	11.2	1	1
Stanislaus	7	4	8	5	1	1
Tulare	n/a	8	n/a	13	n/a	1
Ventura	n/a	n/a	13.6	21	1	1
Yolo	n/a	n/a	28	34	1	1
Average	**5.4 days offered**	**5.1**	**11.9 days**	**11.2**	**1 day**	**1**

Times to Access Initial Appointments

Cal EQRO has found that all of the DMC-ODS counties have been able to meet requirements that pertain to methadone sites, which requires initial dosing of clients to occur within three days of their assessment. Similarly, over 95 percent achieved average times that met time to service standards for routine face-to-face outpatient appointments, which must occur within ten business days. As noted earlier in this report most did not yet have software and infrastructure in place to track timeliness for offered appointments. In fact, in a review of the FY 2020-21 ISCA data provided by DMC-ODS counties, more than 50 percent of contract providers still lack EHRs. Lacking a unified EHR is a situation that remains quite common in DMC-ODS counties. Some counties, however, have been able to commit resources towards implementing a county-wide EHR system such as Los Angeles, Sacramento, and Santa Cruz which funded Avatar for the contract agencies that did not have EHRs. Most DMC-ODS programs have this as a goal, but few have the resources to develop this capacity. PHC also aided 50 percent of its providers to get EHRs to more efficiently support managed care billing and quality metrics and hopes to provide more help in the future. As said in previous CalEQRO annual reports, this lack of infrastructure for EHRs and core data analytics remains a handicap for the DMC-ODS system at both the county and contract agency level, compared to what exists in primary health care and hospital systems which benefited significantly from federal meaningful use funding.

The most common NA issues of unmet needs involved NTP/OTPs in rural/frontier areas for adults and youth. While outpatient services still had gaps, these were reported much less frequently, and more provider options for solving these remote zip code area issues exist than was the case with the NTP/OTP gaps. Out-of-network providers are easier to find or develop for outpatient services than with NTP/OTP because there are different and complicated requirements for licensing.

Strategies used to address some of these time and distance challenges were described above. These are discussed in depth in individual county reports posted on the CalEQRO.com website. The Partnership Regional Plan has the largest number of zip codes that do not meet time and distance standards related to NTP/OTP. This because for many years there were almost no such programs the part of the state north of Sacramento. It was reported by many who attempted to open programs that much of this was due to stigma and a belief that if there were no methadone clinics, there would be no one using heroin in the area or attracted to this area of the state. This was obviously a false belief, and the area has a genuine problem with opioid abuse and the need for NTP/OTP programs and non-methadone MAT along with a full continuum of ASAM treatments in this region is reflected in current treatment levels. Indeed, PHC have added several NTP/OTP programs and hope to add several more. They obtained several Hub and Spoke grants and many clinics providing non-methadone MAT with case management services noting that there is a robust caseload being served.

The region expanded treatment access with many Hub and Spoke grants from DHCS and has a robust set of primary care clinics providing MAT and counseling linking to three NTP/OTPs and plans to expand in the future. However, given the vast regions in northern California with low population density, a federal Waiver similar to San Francisco for pharmacy-based

methadone and mobile methadone van-based services, may be more practical to reach some of these really remote areas. These federal Waivers for pharmacy and mobile methadone licenses are not easy to obtain or operate, but the current federal administration may be open to exploring it. The site-based NTP/OTP program requirements are expensive and burdensome with potential providers noting that economy of scale limit their ability to service small numbers of people in these remote frontier areas without full cost reimbursement. Others have recommended an expanded primary care-based MAT program the primary source of opioid treatment in this part of the state, and adjust the NA regulations which currently require methadone maintenance for OUD treatment.

Summary

During first and second years of implementing NA, the DMC-ODS counties and Regional Model worked with their provider networks, other counties, out-of-network providers, primary care partners, and community leaders to improve their provider network sites and add LOCs through a variety of strategies. Through these efforts they were able in many cases to reduce the number of zip codes requiring AAS request approvals for youth and adult services particularly for outpatient and intensive outpatient. For NTP/OTP programs, improvements were made as well by some additional local sites, but mostly by formalizing contracts in neighboring counties. Where it was not possible to add new NTP/OTPs, they were frequently able to add access to telehealth MAT and/or primary care MAT or both. These opioid treatment options often included traditional SUD counseling for local beneficiaries in remote and frontier areas which is a best practice.

DHCS completed the review of the NACT and AAS request forms in a timely manner and coordinated changes of standards with the counties as required including working on capacity issues which is not the scope of CalEQRO. DHCS published documents on their website that were helpful and clear related to requirements. Regular trainings were also provided related to NA requirements and documentation, and these were required and posted by DHCS.

The DMC-ODS counties and PHC were making efforts to track timeliness with their software and access systems with capability still being refined worked complicated by new providers coming into the network. NACT forms included all the required details of each county's provider networks in terms of capacity and language. The AAS request forms and details included needed data on Medi-Cal beneficiaries affected by zip code, age, service type, and distance and driving time, as required with detailed mitigation efforts. Plans for improvement for zip codes by county included a range of strategies such as adding new out-of-network providers, developing new in-county providers, offering telehealth services, and developing new partnerships with primary care for outpatient SUD counseling and MAT services. All of these strategies represent positive efforts to support enhanced access to Medi-Cal SUD services for both youth and adult beneficiaries. In each review cycle these NACT plans, related NA documents are reviewed again relative to the AAS requirements to see what has been accomplished over the past year. CalEQRO confirms the validity of county reports and efforts in the review cycle and to detail progress, clients served, grievances, and other issues related to NA such as timeliness. Each of these areas reviewed link to the overall DHCS quality strategy NA report and analysis.

CalEQRO believes that improvements to cell phone coverage, inexpensive cell phone access for low-income and homeless individuals, and along with enhanced internet access in remote and rural areas would represent positive steps in addressing access barriers that exist in rural and frontier areas. If options become available in the infrastructure legislation for these it would be positive for SUD and general health access.

Consideration should be given to strategies to address OUD via mobile methadone vans or pharmacy-based methadone with direct observed therapy for beneficiaries living in remote areas of the state. Similarly, these additions could assist with more acute WM needs that often require a sub-acute level care should considered for future benefit options. DHCS under CalAIM may want to consider some benefit changes to support solutions in these areas or some pilot programs similar to other states.

Drug Medi-Cal Organized Delivery System External Quality Review

2017-2021 Statewide Report

Timeliness

Timeliness Findings, Trends & Challenges

Timeliness

How Counties, the Regional Model & Providers are Improving Timeliness to SUD Treatment

Introduction

Timeliness requires:

- Infrastructure
- Regular data review
- Actions for Improvement

Timely access to treatment is a critical ingredient for successful engagement of persons with SUD. A review of the literature indicates a main concern in substance use treatment programs is that many individuals who are admitted do not return to begin the treatment program.[11] "Typically, the longer substance users have to wait to be admitted to treatment, the more likely they are to not follow through with treatment."[12] Further, studies by Festinger et al. suggest that "the longer the delay between the initial phone contact and the scheduled appointment, the less likely a client is to attend an appointment."[13]

In order to successfully provide timely access to SUD treatment, counties must build two types of infrastructure: (1) the infrastructure to track timeliness and (2) the infrastructure to incorporate regular review of timely metrics so action can be taken when data reports indicate that timely access has not been achieved. This process begins in the first year of implementation, but usually takes several years to achieve a data-driven process able to increase timeliness throughout the continuum of care.

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[12] Redko C, Rapp Rc., Carlson RG. 2006. Waiting time as a barrier to treatment entry: perceptions of substance users. *Journal of Drug Issues.* 36(4). Available from: https://journals.sagepub.com/doi/abs/10.1177/002204260603600404

[13] Festinger D, Lamb R, Kountz M., Kirby K, Marlowe D. 1995. Pretreatment dropout as a function of treatment delay and client variables. *PCOM Scholarly Papers 1701*. Available from https://journals.sagepub.com/doi/abs/10.1177/002204260603600404

Timeliness to treatment can only occur if counties have developed the data infrastructure to track timeliness and are making system improvements in order to correct areas where timeliness is not meeting standards. Timeliness tracking is critical at various access points in the system including requests for initial, routine, and urgent services as well as in transitions points of care.

Overview of Major Timeliness Findings

Finding 1 From 2017 to 2021, **all counties report tracking timeliness of critical metrics** including initial requests, first face-to-face visit, first dose of methadone, and urgent appointments, ranging from 80 percent to 100 percent of their entire continuum of SUD services.

Finding 2- Pioneer Counties show fully developed efforts on timeliness tracking and linkage to care, with all but urgent appointments showing consistent excellent results.

Finding 3 On average, counties continue to work towards achieving statewide timeliness standards**. Tracking timeliness for urgent requests** is the one area most in need of statewide development and definitional clarity.

Finding 4 The **developmental process** for most DMC counties to improve timeliness to treatment, across the continuum evolves over several years with incremental improvements in timeliness year-over-year.

Tracking Timeliness

The chart below shows the summary changes for all counties in the last two years. This rate is well within the 10-day offered standard on average, but as shown in the individual county reports access is not the same for all LOCs. The counties who have more developed systems track and have dashboards for timeliness for each specific program and site. Often residential treatment, residential WM, and specific programs for perinatal, youth, bilingual, or disabled (such as hearing impaired) groups can be more challenged with access issues. This is frequently shared with CalEQRO during review sessions of provider stakeholders and supervisor groups related to access challenges.

Table 5-1: Timeliness Metrics for Time from First Request to First Offered Appointment in days, All DMC-ODS Counties, FY 2019-20 and 2020-21

Average Time from First Request to First Offered Appointment in days	FY 2019-20	FY 2020-21	Difference
Average length of time from first requested to first offered appointment	5.6	5.1	0.5
Timeliness Metrics and Percent Meeting the State Standard in FY 2020-21 in days	**% Meeting the Standard**	**Minimum**	**Maximum**
First requested to first offered appointment (10 business day standard)	85.3%	22.0%	98%

Days from Request to First Face-to-Face Appointment

The table below shows the actual timeliness to first face-to -face visit which is usually the ASAM full assessment and a very important engagement step into treatment. It reflects the average time from request to first face-to-face visit for all services. This is for all DMC-ODS billableEQRO programs and services for all counties and the data was provided by the county on the timeliness assessment form from FY 2019-20 and FY 2020-21 reviews. The average rate of timeliness by in days did reduce somewhat and came close to the state standard, yet COVID-19 was occurring and there were 11 new counties. PHC and the four new DMC-ODS counties in their first year of implementation are included in this data and those are usually the years where matching timeliness to the state standard is a challenge. Considering these factors, it is surprising it went down at all. Also, the percent of clients statewide obtaining services within the 10 day standard increased by 8.3 percent. This is likely because the Pioneer group including Los Angeles is a larger percent of the group and represents many of the lower timeliness rates. Thus, this important metric is moving in a positive direction, though as noted earlier in this report, there are still challenges in specific services that have capacity or distance issues.

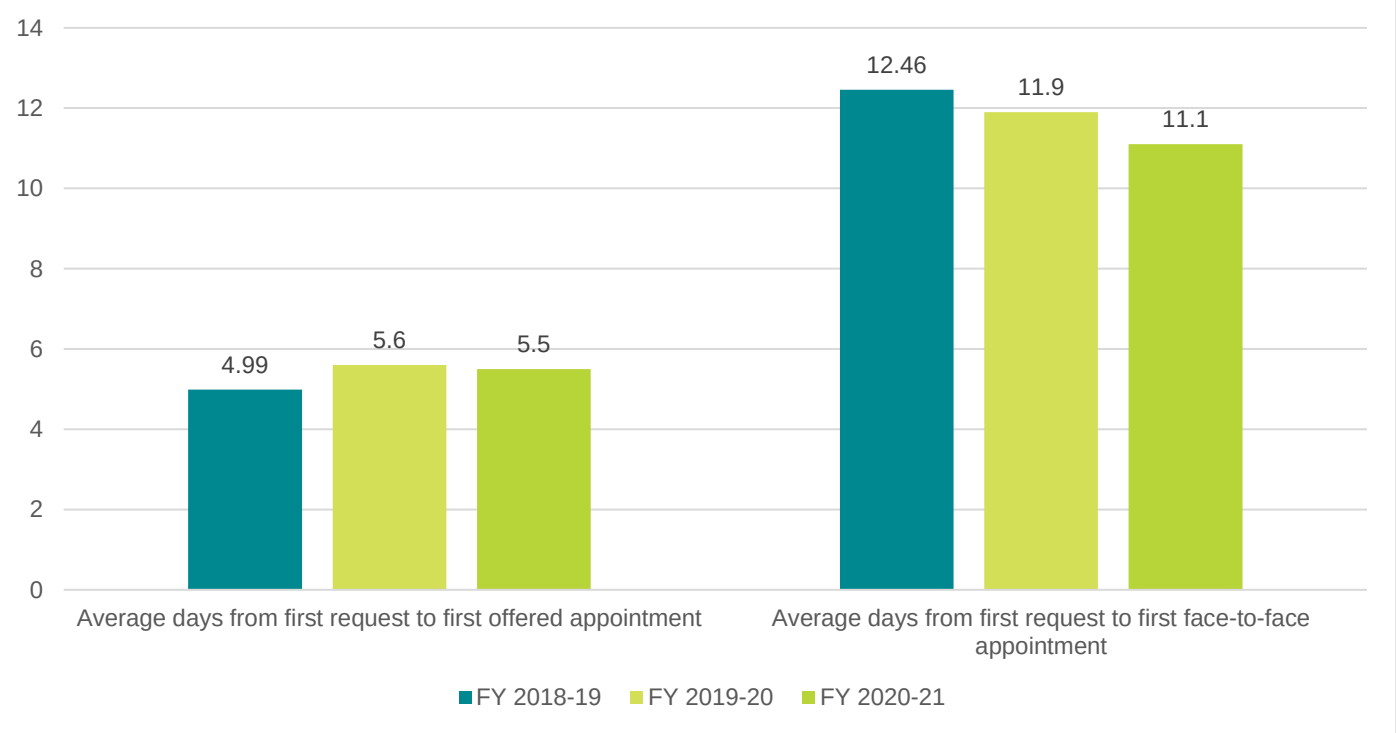
Table 5-2: Timeliness Metrics for Time by Day from First Request to First Face-to-Face Appointment in Days, FY 2019-20 and FY 2020-21

Average Time from First Request to First Face-to-Face Appointment in Days	FY 2019-20	FY 2020-21	Difference
Average length of time from first requested to first face-to-face appointment (in days)	11.9	11.2	0.7
Timeliness Metrics and Percent Meeting the State Standard for FY 2020-21	**% Meeting the Standard**	**Minimum**	**Maximum**

First requested to first face-to-face appointment (10 business day standard)	73.6%	26.0%	98.7%

Once a county has its infrastructure in place, staff can work to improve timeliness to treatment by adjusting their capacity for services and addressing location issues of needed services. Although counties reported different time periods in their timeliness self-assessment, for simplicity, the figure below uses the EQRO years of review, FY 2018-19, FY 2019-20, and FY 2020-21, as the time periods compared. This can be seen in Figure 5-1, comparing the timeliness rates over a two-year period, and showing that overall, time to the first appointment saw a positive decrease from 12.46 days to 11.1 days. This progress in year over year comparisons also shows the developmental process necessary to put metrics in place, measure them, and make course corrections as part of the implementation and management of the DMC-ODS continuum of care. It takes time to identify and change the specific programs or LOCs in counties seeking to improve timely access. This is typical of the improvement process.

Figure 5-1: Average Days from First Request to First Offered and First Face-to-Face Appointment, FY 2018-2019 and FY 2020-21



Timeliness to Urgent Appointments

As part of the DMC-ODS Waiver, definitions of urgent appointments were required of all counties. Counties have some latitude and variation in how they operationalize the definition of urgent appointments. Definitions range from narrow definitions such as only those who are

pregnant opioid users to expansive definitions letting the client determine the urgency. Also, some definitions use high scores on ASAM dimensions one through three, others use scales related to withdrawal symptoms that are more acute symptom definitions. These local variations and range what is defined as non-routine service request is problematic in terms of making comparisons across the individual DMC-ODS plans. In addition, how these service requests are measured, and the business rules of completion varies as well, and this has been discussed with counties in terms of which services constitute completion of addressing the urgent concern. For example, would bringing a client to a hospital ED for withdrawal constitute an acceptable response if the hospital refused to admit the client? Does case management support while waiting for a residential bed to become available constitute an acceptable response? The Waiver requires a clear, local definition to track requests coming from multiple sites. While this measure requires the development of a clear definition which can be operationalized in terms of identification, data collection and tracking, it would be helpful to have state guidelines for a set of defined follow-up actions for specific types of "urgent SUD conditions" to increase and measure timely access to appropriate care. In addition, the metric needs to be measured by counties and the Regional Plan in hours rather than days. Most EHR vendors are still not accommodating this change leaving most DMC-ODS systems without a capacity to track this time to service measure in hours.

The data shown below in Table 5-3 represent 19 of the 26 counties that were reviewed in FY 2019-20. Clearly this data indicates a continued area of growth for counties. Of the 26 counties reviewed this year, CalEQRO found that only ten of the DMC-ODS counties met this requirement to track urgent appointments, along with six that partially met this requirement, and ten that did not yet have this measure operationalized.

Data in the table shows the average length of time from request of an urgent appointment to the appointment was 7.3 days, with a range of 1.1 days to 22 days. The average length of time does not meet the standard for this metric of 48 hours. Further review shows that only 58 percent of clients requesting an urgent appointment were seen within 48 hours.

CalEQRO notes that counties need to continue to refine and clarify their definitions of urgent requests and complete the following key tasks to assure successful tracking of urgent requests:

- Finalize a clear operationalized definition of urgent requests.
- Train staff on the process of identifying and documenting urgent conditions and needed treatments.
- Develop data systems to capture urgent requests and urgent appointments or contacts, for example when mobile case management or counselors are deployed.
- Develop reporting systems for staff to enter data and capture these services.
- Add quality review systems with regular data reviews.

- Evaluate what changes are necessary so clients with urgent conditions can be identified and seen within 48 hours.

Eleven of the counties which counted their urgent responses by days averaged 6.14 days. Fourteen of the counties and the Regional Plan do count by hours and averaged 53.63 hours which is only slightly above the 48 hour standard and the median was much lower than the average indicating that there were individual outlier cases that skewed the averages much higher.

The goal for urgent requests is to have connected the client requesting services to a program within 48 hours if it is a program that does not require an authorization, or 96 hours if it does require an authorization such as residential treatment or inpatient psychiatric care. There were eight counties whose average response time for urgent requests was under 48 hours. PHC reported an average for urgent at 53.63 hours which was excellent for a first year DMC-ODS. However, given the wide variability in definitions and interpretations of successful completion, it was difficult to compare counties in this measure. In the aggregate, the DMC-ODS counties averaged a 5.74 day response time to urgent requests which, while above the state standard, showed improvement from the 7.66 days seen in the prior year. Clearly more work is required on this measure.

Many DMC-ODS counties include WM or related symptoms to their definition of urgent requests. Often and particularly for persons with alcohol dependence, IV drug users, late-stage alcoholism, teens that are using benzodiazepines, and pregnant women in withdrawal many of whom do not present simple withdrawal cases. This often leaves paraprofessional staff limited in their ability to safely support them in the current 3.2 WM license. Several counties have asked the state for a uniform definition which distinguishes urgent, acute or emergent needs. This can be a very subjective area requiring advanced clinical assessment skills. Regardless of the definition used for WM that most counties report, they almost universally do report not having enough bed and outpatient capacity in these LOCs. It has been difficult to expand residential WM due to intense community opposition to new sites in their neighborhoods. Also, there has continued to be confusion on the Medi-Cal benefit related to billing and medical protocols in the hospital ED WM voluntary service which has added to problems with access for this type of important WM treatment. While development of a clinical definition for the field to apply, triaging the complex and unique factors presented by clients demonstrates a need for a statewide clinical panel should be considered to make recommendations.

Table 5-3: Average Length of Response Time for Urgent Appointment, FY 2019-20 and FY 2020-21 DMC-ODS in Hours & Days

Average Length of Time for Urgent Appointment	FY 2019-20	FY 2020-21	Difference
Average length of time for urgent appointment (48-hour standard)	13.4 days	5.74 days	7.66 days
Timeliness Metrics and Percent Meeting the State Standard for FY 2020-21	**% Meeting the Standard**	**Minimum**	**Maximum**
Urgent appointment (48-hour standard)	51%	6%	82%

Infrastructure Development

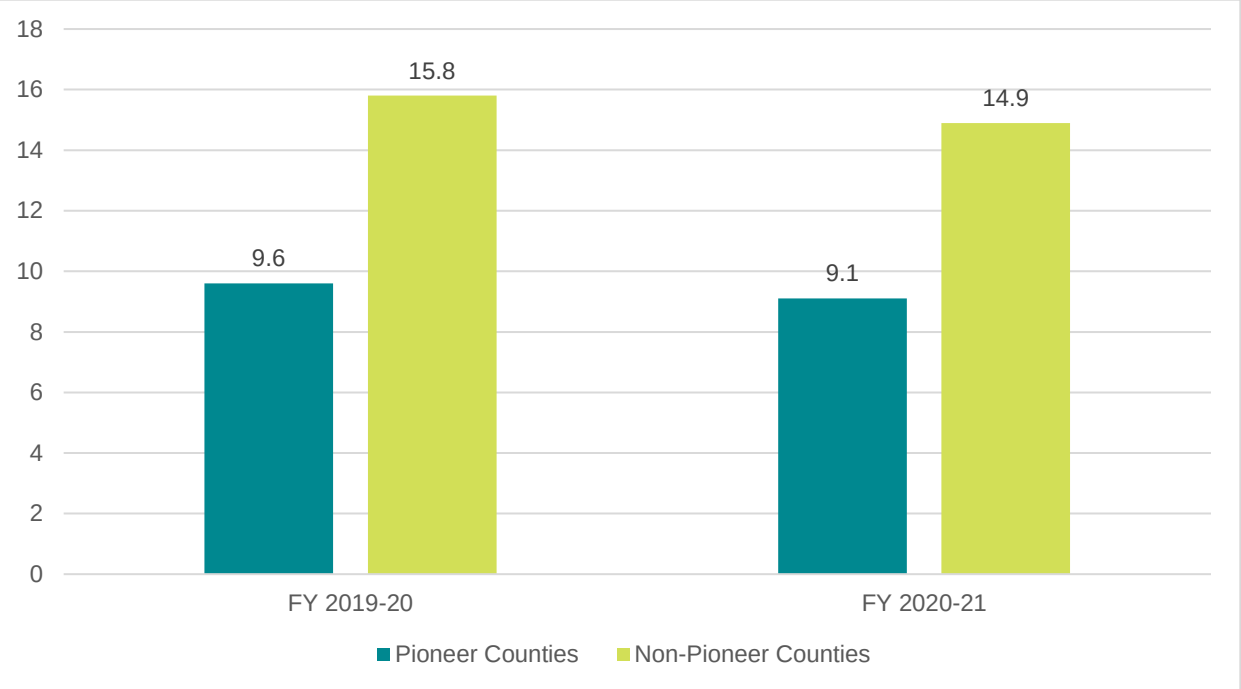
Most counties developed metrics prior to their first year of implementation, but many counties additionally took the first year or more to further develop their infrastructure to track all the newly required timeliness measures to treatment. Infrastructure is critical to collect available data to improve timely access to appropriate care and manage clinical service capacity across the provider network.

Infrastructure building continues to improve the quality of timeliness data.

A good example of this developmental process is to compare the Pioneer Counties to the first-year counties using the metric of the average number of days from request to the first face-to-face appointment. This metric is an initial focus of all counties. Once infrastructure is in place, if initial timeliness is an issue, a variety of changes are necessary including:

- Review of data for accuracy and make changes for increased consistency in reporting.
- Increasing tracking mechanisms for all providers across the system.
- Administrative changes to reduce the time of specific functions.
- Clinical and workflow changes to positively impact the timing of screenings and assessments include the addition of walk-in hours and home visits, and now the use of telehealth and phone assessments in the wake of COVID-19.

Figure 5-2: Average Days from First Request to First Face-to-Face Appointment, Pioneer Compared to Non-Pioneer Counties, FY 2019-20 and FY 2020-21



All but two Pioneer Counties were within DHCS standards on average for FY 2020-21 and nine out of seventeen non-Pioneer counties were within state standards. It is clear time is needed to develop the systems and infrastructure to track these complex metrics across the system of DMC-ODS services.

In the individual county reviews, many counties showed an increased number and quality of timeliness metrics year-over-year. The metric can be in place and still need refinement, so tracking occurs across the system. Even if the measurement is in place in the first year, it may take that entire year or the next to assure certain processes such as having reports distributed regularly so that staff and management can review the timeliness data and put in place system changes necessary to increase adherence with timeliness standards

Key ingredients for achieving timeliness to treatment throughout the continuum includes:

- Development of an infrastructure with regular dashboards/reports, regular review of metrics, and data-driven actions to address timeliness as needed.
- Brief screening, generally involving (outpatient or residential) so the client is referred to the appropriate treatment LOC.
- Expedited processes to the appropriate LOC for assessment and treatment.

Without a brief screening, consistent delays occur in access to treatment, resulting in an increased number of dropouts. Counties with centralized assessment programs often experience client delays in obtaining appointments. Clients must then wait to access the

appropriate treatment service and complain, returning for continued intake activity results in them having to tell their story again These policy, workflow, and capacity management issues often lead to multiple delays, which in turn results in higher levels of client drop out.

Best Practices to Ensure Timely Access to Treatment

Infrastructure best practices include the development of ongoing reports and dashboards that are regularly available and reviewed by county and contract provider staff, allowing data to be used for clinical and administrative process improvements. Examples of county infrastructure development include:

Monterey created an SUD dashboard tracking multiple metrics in a single document. It includes length of time from initial request to first offered appointment and first assessment; length of time from assessment to first MAT service; timeliness to follow-up treatment post-residential; SUD no-show rates; and WM readmissions. The dashboard functions as a quick reference tool that shows trouble spots needing attention from management and supervisors

Timeliness to service starts with first contact, which is not billable and thus requires specific data collection for tracking. A brief screening is critical to determine the general LOC. Clients have historically gone directly to community providers for service; counties have developed systems that assure this practice, sometimes called “no wrong door.” This requires developing systems that track clients who call the BAL as well as enter services through multiple provider sites or drop-in clinics across the whole continuum of care. Developing an electronic database standard for all these service requests that can track across the entire continuum of care is critical. This key task has taken counties time to develop, particularly because most of the continuum in DMC-ODS is operated by small nonprofit providers with more limited IS infrastructure and limited connectivity to county systems.

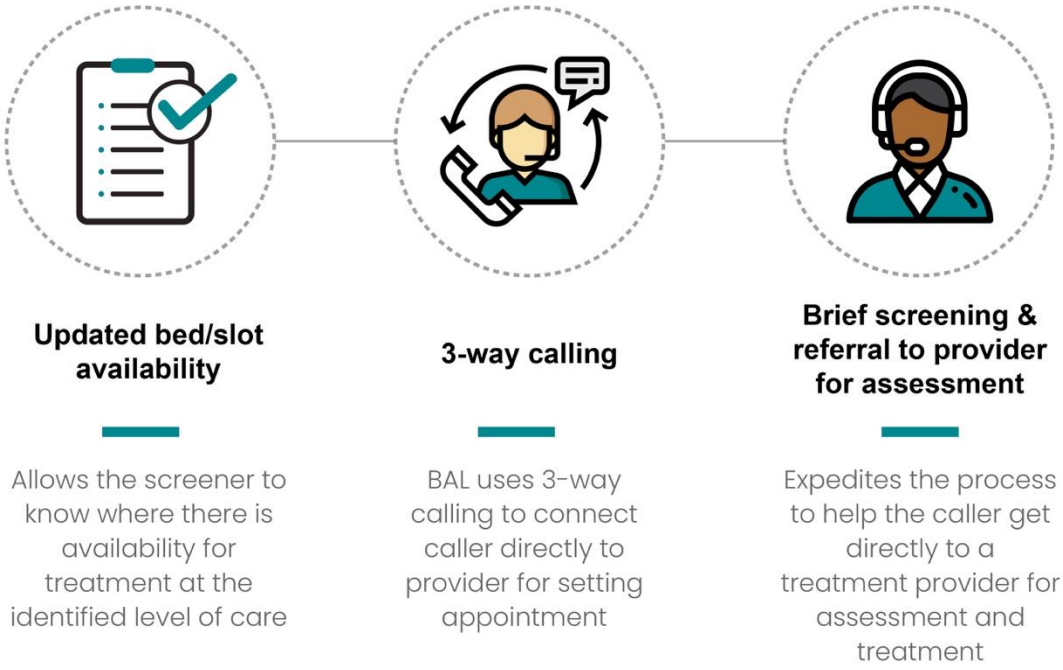
Examples of excellent cross-network databases for capturing service requests include the Service and Bed Availability Tool in Los Angeles County and the Contra Costa SUD resource database application for tracking daily capacity at all LOCs and contacts by clients at different providers. Both of these systems are managed at the county BAL and have providers entering data on capacity regularly to keep available service information up to date.

The brief screening process used by many counties expedites the client to the appropriate LOC, where a full assessment can take place. The use of brief screening tools has been increasing within counties that have sometimes completed a registration process and then a full assessment. When the county completes the full assessment, this assures there will be no provider bias in the choice of treatment modality, but it also can slow down timeliness to treatment, resulting in the potential loss of clients who cannot tolerate waiting.

The brief screenings generally have high accuracy rates but will never be 100 percent. Brief screens still result in a small percentage of clients needing assistance, after the assessment,

to reach the correct LOC, sometimes with a different provider. Counties need to build in a clear process for this to occur within their systems.

Figure 5-3: Best Practices for Ensuring Timely Access to Treatment



First contact best practices involve initial engagement, screenings, and timely response. Best practices include:

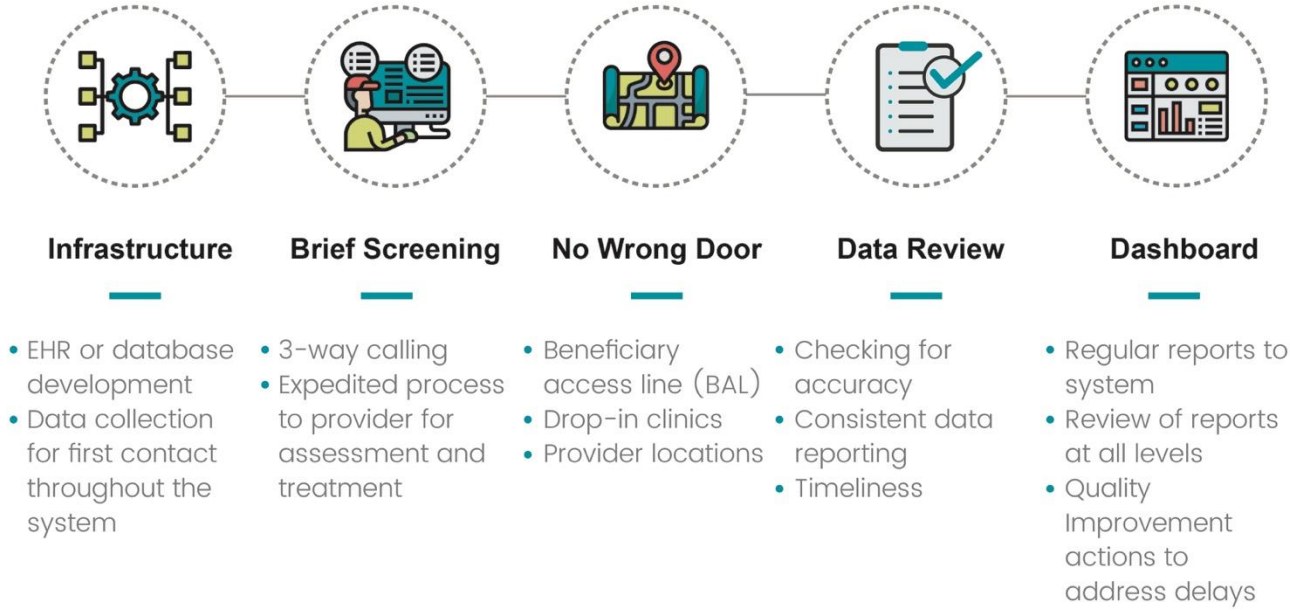
- Brief screening to determine initial LOC. Santa Clara has an excellent tool in place and UCLA's Brief Questionnaire for Initial Placement is also available for free. These brief screening tools usually sort between outpatient LOCs and residential LOCs. They have also been tested for accuracy against the full ASAM and over 80 percent matched.

If initiation into treatment is a call is to the beneficiary access line, then three-way calling to the provider can link the client directly to the service provider for an appointment and allow them an opportunity to gather critical screening data. This is especially important for clients who do not show for their assessment, as providers cannot reach out to the client unless they have their name and contact information. By contrast, when brief screening starts at the treatment provider site, the client is registered in the centralized system seamlessly as treatment begins.

Based on CALEQRO experience with the County reviews, multiple access models work, in both centralized and decentralized systems, to achieve timely services. However, they require coordinated infrastructure and communication systems. Centralized systems can sometimes over-manage the flow of clients, resulting in bottlenecks and decreased timeliness. With such slowdowns, client dropouts increase. Decentralized systems must develop strong first contact reporting systems at the provider site or links to timeliness and services cannot be tracked.

Both systems must have strong two-way communication processes in place between the county staff and service providers.

Figure 5-4: DMC-ODS Workflow Model for Timely Access System



Timeliness Lessons Learned

One barrier to infrastructure is the different EHR systems that are used by both counties and the network of contract providers. These systems vary in sophistication and some still use paper charts. Infrastructure development is expensive and time-consuming and takes dedicated leadership to both establish and maintain. As budgets are reduced, priorities of EHR system upgrades are sometimes the first to be delayed.

Counties lacking a software infrastructure and dedicated staffing to support the structure are not as successful at tracking timeliness. At times, the tracking system is in place with data for tracking access and timeliness, but refinement and stabilization are needed to confirm accuracy and consistency. If contract providers are not comfortable and need assistance, the data will be lacking until they are trained and given consistent support. Partnerships related to data and support with the contract network are critical.

Urgent conditions require a clearer definition that is understood across the system as the first step in tracking “urgent SUD” timeliness. Counties that do not have a clear definition are missing people who have urgent needs for treatment. Infrastructure for urgent conditions must be established, tracked in hours rather than days (as distinct from the other timeliness measures), and must be flagged in such a way as to distinguish this first urgent contact from non-urgent first contacts. This complex change has caused delays for many counties to achieve tracking and timely responses to urgent conditions in their first year of implementation.

The DMC-ODS establishes a continuum of care that links the county and all the contract providers together as one SUD system. This has been a cultural change for counties and providers in tracking the entire treatment episode for a client, rather than one treatment LOC at a time in a siloed fashion. It requires coordination among multiple treatment providers and the county to assure clients can continue to receive the appropriate LOC. This usually requires enhanced care coordination to assure timely treatment for clients during any transition between LOCs. This is one of the reasons case management systems are so important in the Waiver. Many providers still do not grasp this change and still do not see themselves as part of a system of care with the client having an entitlement to coordinated care.

Care coordination is also a best practice for enhancing timeliness, especially in the preliminary stages of treatment engagement and during transitions in care. This is often not the first element counties develop as they launch their DMC-ODS programs. It is most often seen in second- and third-year counties as a key to system improvement and development but does have a very real impact on timely access and no-shows for complex clients.

Summary

Timeliness has continued to improve incrementally over the four years of reviews though urgent conditions are problematic for reasons discussed. There were setbacks due to COVID-19. More use of peer navigators for engagement and support is encouraged for improving timeliness. Also, use of integrated software is needed for tracking and linking the contract providers, county providers together with Access centers. Some BALs are still without software to track their own metrics, timeliness, and outcomes, and oversee their county access systems as a whole. Recommendations by CalEQRO will continue to be made in these areas and DMC-ODS counties are aware that timeliness and access are critical issues where improvements are possible and necessary.

The DMC-ODS STCs have set clear expectations for all DMC-ODS plans in this area relative to the different times and types of service requests; for offered appointments; routine, urgent, and medication services; and for residential authorizations for access to treatment. CalEQRO has seen the DMC-ODS counties work with their networks to build the infrastructure and capacity over time to improve on meeting the DHCS standards. While challenges remain, clear and steady progress since the onset of the Waiver is evident and along with positive initiative and enthusiasm to move toward improving the SUD and behavioral health care overall.

Drug Medi-Cal Organized Delivery System External Quality Review

2017-2021 Statewide Report

Quality

Quality Findings, Trends & Challenges

Quality

Key Findings,Trends and Challenges by Counties, the Regional Model & Providers

Introduction

The DMC-ODS 1115 Waiver STCs defined and promoted care based on the ASAM continuum of services that are accountable for the quality of the treatment and recovery supports they provide. The STCs include many elements linked to the quality and require treatment services to be based on the latest SUD science and research. This concept was used to change historical services and create a new vision of SUD care. This chapter highlights data showing the progress of the continuum of SUD care related to ASAM quality concepts of individualized treatment based on a comprehensive assessment, a range of science-based treatments, and care coordination built on a new QI system.

Overview of Major Quality Findings

Finding 1	Client-centered treatment within a continuum of care based on ASAM models expanded from 2017 to 2021 in its capacity and types of services to meet individual & local needs in the challenging time of the COVID-19 pandemic.
Finding 2	Care coordination and recovery support services, both new treatment services added to the Medi-Cal benefit, enhanced continuity, and ongoing support, and were beginning to show their potential benefits to clients during the latter part of this Waiver period with flexible and effective services for clients.
Finding 3	Counties continued to enhance their new QI Programs specific to SUDs (QIPs) with plans, studies and monitoring systems linked to measurable goals. These systems were not in place in most counties prior to the Waiver. In many cases they are also integrated with mental health/behavioral health and in many also linked to physical health programs.
Finding 4	Flexible services such as phone and telehealth case management, RSS, mobile outpatient services, non-methadone MAT and ED Bridge services were expanded with DMC-ODS during the COVID-19 pandemic based on clients' needs and service demands. These services filled a needed gap in challenging times for clients in distress.

Progress in Developing the Clinical Continuum of SUD Care

As indicated in Table 3-1 of this report's Access chapter, the predominant types of DMC-covered LOC treatment services prior to the Waiver were NTPs and outpatient treatment. All the DMC-ODS counties are also establishing DMC-certified residential treatment at one or more levels as well as residential WM programs, expanded outpatient services and intensive outpatient LOCs, physician consultation, case management, expanded MAT medications at the NTPs, and RSS.

Established DMC-ODS counties not in their start-up years have also been adding Waiver-optional programs including partial hospitalization, MAT outpatient focusing on non-methadone medications, more levels of residential treatment and expanded capacity, youth services across the continuum, and inpatient medically monitored and medically managed WM programs for adults, youth, and perinatal populations. This expansion has given clients and families more choices, more local options, and improved timeliness of access. Table 6-1, below, compares traditional DMC with DMC-ODS Waiver services to show the range of potential expansion options. Also, many counties began to co-locate services with mental health and primary care partners to facilitate coordinated care and provide clients the option of getting multiple services in one clinic visit. They also began to customize programs for specific ethnic groups and populations such as pregnant women, immigrant groups, populations exiting prisons, and disabled groups with mental health or physical health needs. Others focused on more remote areas of their counties that needed services to meet NA.

Table 6-1: Traditional DMC vs. DMC-ODS Medi-Cal Services

DMC	DMC-ODS
Outpatient Drug-Free Treatment	Outpatient Services
Perinatal Intensive Outpatient Treatment	Intensive Outpatient Services
Perinatal Residential Treatment (16 beds only)	Residential Treatment Services (no bed limit)
Inpatient Hospital Detoxification	WM (residential 3.2)
Narcotic Treatment Program Services (methadone)	NTP Services with Methadone, Buprenorphine, Disulfiram, and Naloxone
	Recovery Services
	Case Management
	Physical Consultation

DMC	DMC-ODS
	Additional MAT (optional)
	3.7 & 4.0 WM

California also obtained approval from Substance Abuse Mental Health Services Administration (SAMHSA) to use some of its Substance Abuse Treatment (SAPT) grant funds for recovery residences in combination with treatment. Many DMC-ODS counties have established or expanded these residences to help stabilize clients in their recovery process.

Recovery residence housing is an especially important part of the continuum of care for SUD success to be paired with outpatient and intensive outpatient care for those without stable housing and needing a sober living environment.

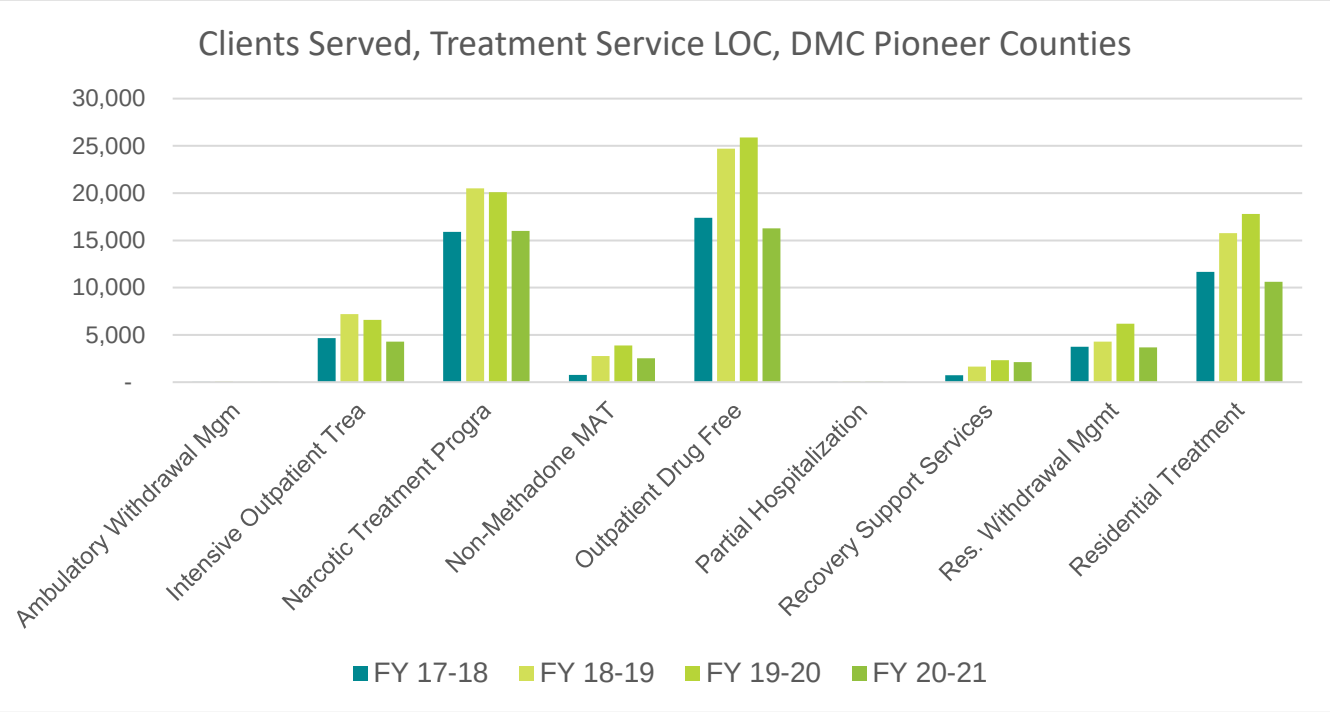
Figure 6-1 below shows the growth over four years in the Pioneer Counties of clients served in each of the LOCs. Growth was clearly slowest in optional services such as Partial Hospital and ambulatory WM and fastest in MAT with NTPs and non-methadone MAT, outpatient, and residential particularly 3.1 and 3.5 levels. Usually last to launch are case management and RSS. Also, non-methadone MAT increased significantly in the last two fiscal years compared to the prior two. More clients were seeking it and it became easier to find X-Waivered physicians and prescribers. As shown in earlier slides, youth services overall are growing but still extremely low, as are services to some ethnic groups.

There were some regional differences based on when program providers began services, but that was expected due to the phased launches of the Waiver by state region. Most counties launched services with their DHCS designed regional launch group such as “central valley” or “southern California”. Finally, it should be noted that CALEQRO has no complete billing codes yet for levels 3.7 and 4.0, and thus there are some counties providing this service in southern California, but it is not yet reflected in the data charts shown. It is hoped this can be corrected in FY 2021-22.

Per the requirements of this report, each 1115 Wavier LOC is reviewed, and the challenges and strategic successes documented. Counties, the Regional Model staff, and providers all shared their views of challenges and successes with each LOC in the continuum of the Waiver. There were no significant differences by region of the state, other than the availability of providers being more prevalent in urban areas, and there were a few differences in implementation by the size of the county, other than the overall depth of resources to apply to the implementation effort in terms of total funding, and administration and technology capacity, as well as clinical staffing depth. Bay Area counties have, in general, more county general funds, than central valley, southern and northern California counties, though there are individual variations depending on the counties. For details on this, the cost reports are one of the best sources of information.

Suggested changes and improvements in DMC Waiver services by the counties, providers, and the Regional Model staff going forward shall also be documented, including areas of questions and CalEQRO technical help per the Final Report requirements. The Pioneer Counties have the most mature systems due to time since the implementation of services and initially got the most technical assistance, including “practice” utilization review sessions with new DMC-ODS tools. The approach to treatment continuum design, which is an important design process, however, still has many individual characteristics defined by specific county needs, linked to geography, populations, and other key county-specific characteristics. Figure 6-1 below shows the growth of key services over the four initial years of the Waiver with MAT (NTP and non-methadone MAT), outpatient services, and residential services are showing the largest growth. This is a good representation of the overall picture of the range of services of the 14 Pioneer counties, except they have had ASAM WM and inpatient 3.7 and 4.0 services for several years. CalEQRO still does not have complete bill codes to program this billing from DHCS to process claims and add these LOCs to the PM reports. Los Angeles SAPC has 200 beds of services at these levels of care. Orange and Riverside have also added these levels of care, and there may be other counties that have added contracts as well. We are only aware of four providers offering these services and only two who have had PED certification. This is an important LOC not yet reflected in the costs of units of service or clients served. As reflected on the Chart, most LOC have services increasing, and some appear unused, but actually, there has been some new billing in ambulatory WM and also partial hospitalization but very small amounts. With the challenges of adding 3.2 level residential WM, there may be more interest in developing ambulatory WM to assist with WM access.

Figure 6-1: Clients Served in Treatment by Levels of Care for Pioneer Counties, FY 2017-2021



Note: FY 2020-21 has six months of data only.

Implementing Outpatient SUD Treatments from 2017 to 2021

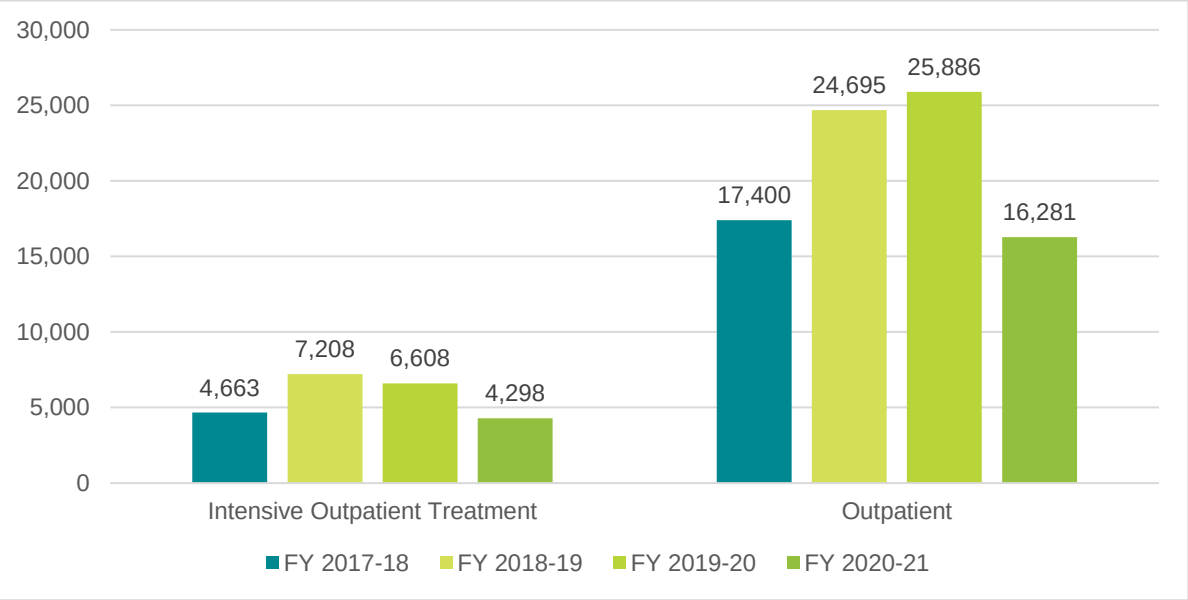
Challenges and Strategic Successes

Two levels of outpatient services shall be reviewed from the data available: outpatient drug free and IOT. The issues associated with these two types of outpatient treatment are quite different. Outpatient services, previously called Outpatient Drug Free, is a very flexible service which can be highly individualized for clients being served. For example, if the individual needed more group, case management and individual counseling visits on Tuesdays and Thursday mornings, it would be possible to do a treatment plan based on these needs. IOT requires three hours, three times per week, and usually at least 6 of the 9 hours is group time, and the other hours are primarily individual therapy and possibly one of these sessions includes a significant other for family therapy.

Therefore, IOT is much more structured and tends to be at fixed 3-hour time blocks per week. A therapist cannot move group times around to meet individual needs for IOT, and this often creates conflicts with jobs, school, childcare, etc. The flexibility of outpatient services has resulted in regular expansion in most counties and was particularly in demand during

COVID-19 pandemic quarantine periods. The data shows some vastly different use patterns for IOT, and clients served. Also, staff (provider and county) shared many challenges on client retention and successful completion in the IOT model, both adult and youth, as it is currently structured and implemented. Some shared that it was rarely completed unless there was a court order, and it was not ideal to not be able to individualize the treatment more to the unique needs and circumstances of the clients.

Figure 6-2: Clients Served in Outpatient and Intensive Outpatient, Pioneer Counties, FY 2017-2021



Note: FY 2020-21 has only six months of data

Figure 6-3 below also shows more clearly the steady growth in outpatient clients served in the DMC counties over the 42-month period of data. New counties were being added during this time, but there is a predictable drop at the outset of the Governor's confinement order.

Figure 6-3: Outpatient clients served, All DMC-ODS, FY 2017-20

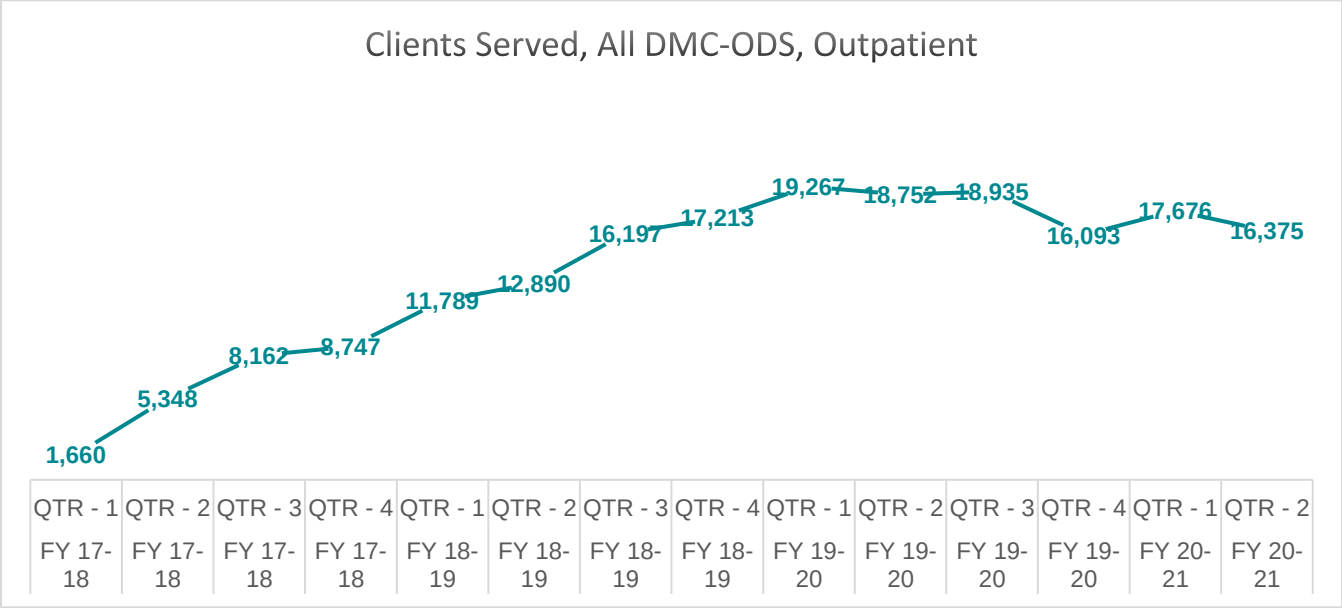
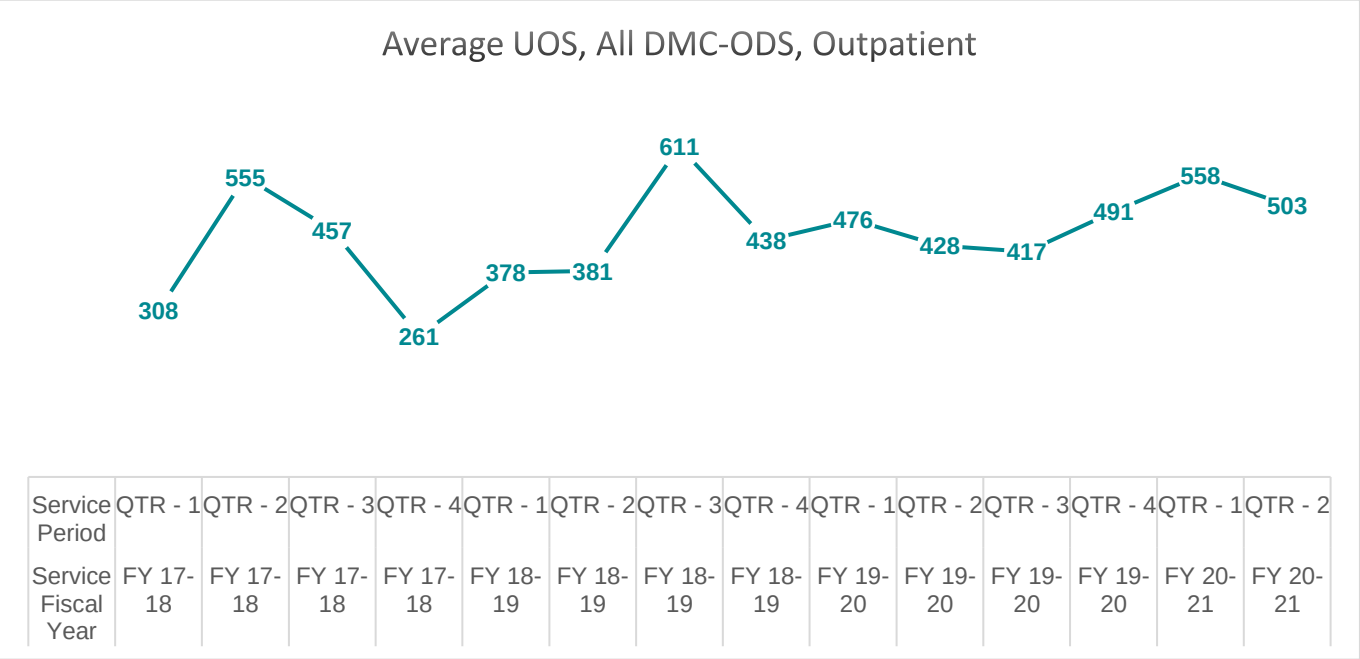


Figure 6-4 more clearly illustrates the average amount of outpatient minutes provided to Medi-Cal beneficiaries/clients per quarter which was not always the same but generally was slowly increasing. This table is average minutes of care per quarter per client. A unit of service is 15-minutes, and these are converted to minutes. For most adult clients 8 hours of treatment per quarter was a typical number of services based on 500 minutes. Based on youth counselor statements this was somewhat less for youth as they had more challenges once school access ended and did not have enough privacy in many home environments.

Figure 6-4: Average Units of Service (UOS) Outpatient Services, All DMC-ODS, FY 2017-2020



IOT clients served were not on a steady upward trend even with new counties joining and the Regional Model being added over the 42 months. As shared above, in Intensive outpatient services, staff reported a prominent level of client drop-outs from the programs. This was due to resistance due to the rigid structure and schedule conflicts with jobs, school, childcare, and other activities, as well as the added challenge of being on video sessions three hours, three days per week. This started when COVID-19 quarantine occurred. Also, many clients did not have phones or computers with internet access or enough phone minutes for these long sessions every week. All of these factors together impacted intensive outpatient participation.

In Figure 6-5, the data shows the erratic patterns of IOT clients served statewide.

Figure 6-5: Intensive Outpatient Treatment Clients Served, All DMC-ODS, FY 2017-2021

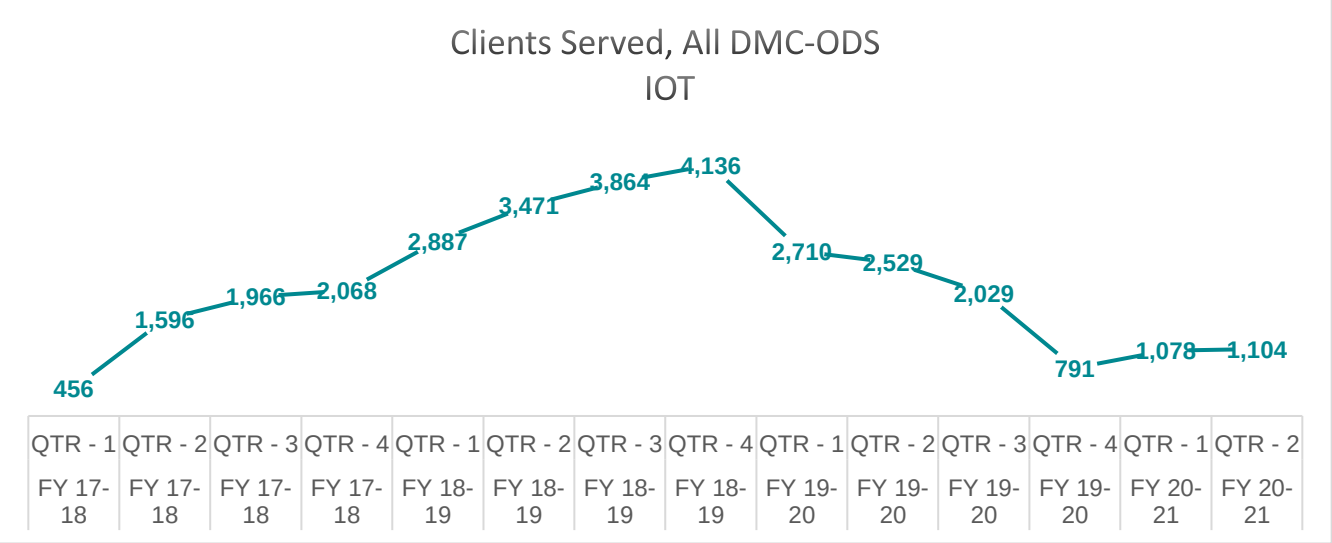
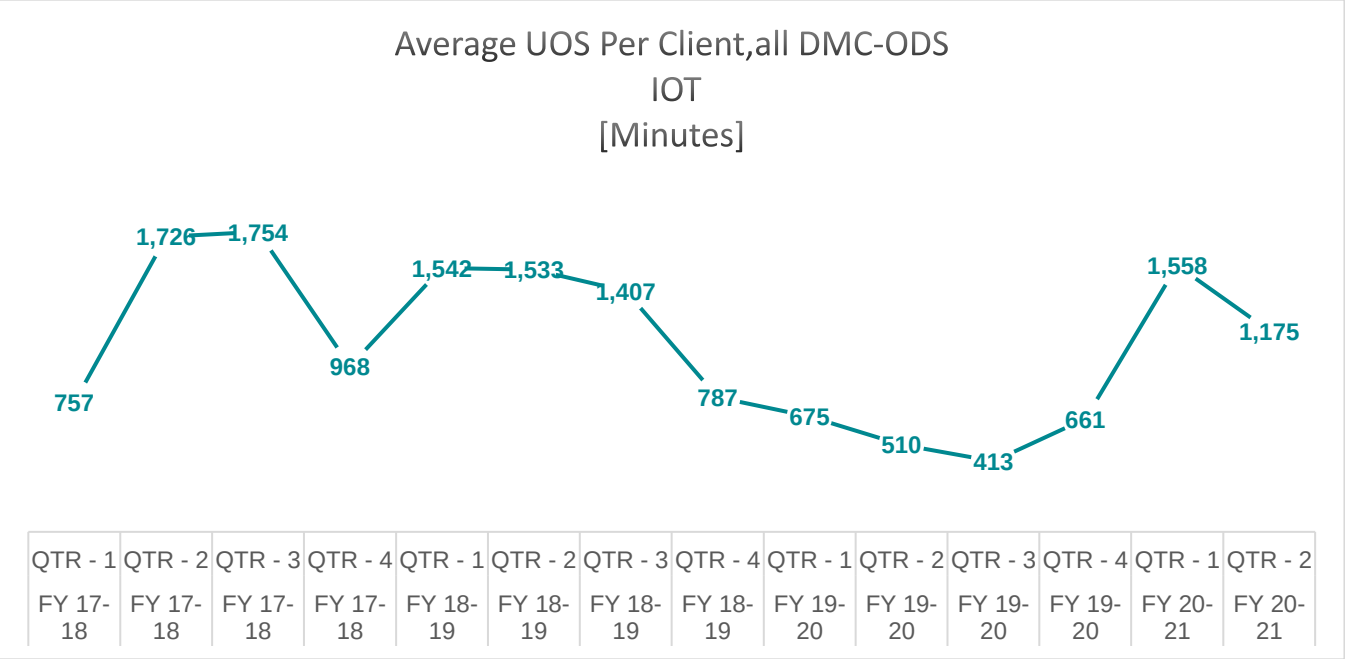


Figure 6-6 also shows below shows average minutes per quarter of services provided across all DMC counties over the 42 months of data. The pattern is erratic given the requirement for the program is nine hours per week and six hours per week for adolescent. Also, only specific services can be billed within those hours, primarily group, individual, and medication visits. Case management services and recovery services are not allowed to be billed in this program's nine and six core hours.

Figure 6-6: IOT Average Units of Service per Client Served, All DMC-ODS, FY 2017-2021



Strategic Successes and Challenges for the Outpatient and IOT LOC

Based on leadership and staff feedback from the counties, PHC, and providers there were a number of challenges impacting both outpatient services and IOT LOCs. The primary challenges were (1) learning Medi-Cal documentation from assessments, treatment planning, documentation of medical necessity, and particularly doing it based on the 24-hour clock. Group charting was particularly time intensive where both therapists do notes on each client for the sessions, and there can be groups of 12 people and multiple groups per day. Most programs continue to not have EHRs to assist with tracking times when updates to treatment plans and re-authorizations were needed if that was required by the county.

Case management and physician consultation were added new Medi-Cal services that most staff also were not familiar with in DMC-ODS. Many staff reported they did not understand what could or should be provided and documented. Many of the early counties now have Medi-Cal Documentation Manuals and regular trainings including online recorded options, such as Los Angeles, Orange County, and Marin, to aid providers in this ever changing and complex area. Also, requirements differ from mental health. Ideally these documentation and utilization review requirements will be aligned in CalAIM, if possible, to facilitate integration of their systems and to make co-occurring services easier to manage.

Many providers were particularly challenged with having enough staff for all of the activities requiring a Licensed Professional in the Healing Arts (LPHA) to complete in documentation.

Also, clinical oversight of programming and help with co-occurring clients is important and this was not adequately planned for in budgets and staffing. Competition for clinicians with licenses was high, and most reported they had little success at their salary levels getting these employees, especially with SUD experience. This was also a challenge for the counties in PHC. However, PHC provided enhanced rates for bilingual licensed staff to their provider network which was appreciated. Partnering with colleges to obtain student interns was a frequent practice with some local success. However, there were complaints that there were too few students graduating from these programs and program expansions were needed. Other counties did not have colleges in their regions to partner with and had fewer options for recruitment other than pay enhancements. Workforce, both licensed and unlicensed, for behavioral health was a constant theme in reviews, challenging most providers of SUD.

Many counties and providers were interested in having physicians be able to bill for any Medi-Cal person who needed a consultation for an SUD disorder even if they were not in their program at that moment. They felt this would encourage people to enter their programs. They expressed that the rules for billing physician consultation were too restrictive, and these rules are not used in physical healthcare consultation. DMC-ODS leadership requested flexibility similar to primary care for their physicians working with the SUD population. This could possibly be considered as part of CalAIM related to the physician consultation service.

The largest number of reported challenges were related to the adult and youth IOT service which many program directors felt needed to be more flexible to effectively engage and retain SUD clients in ongoing care. They recommended the nine or six hours of treatment be a mix of individual, group, collateral, case management visits, and include field-based activities with the client linking them to critical aftercare services, ancillary supports such as vocational and school assistance, housing, faith community, and recovery services, as well as in clinic treatment services. There should be an intensive focus on stability needs in the community and creating key supports for that. So, it was recommended by counties and providers that the nine or six hours might be spread over four to five days and be very individualized depending on the stage of change and recovery the individual is in and their individual housing and family situation. The program could really be individualized treatment, not just program driven care.

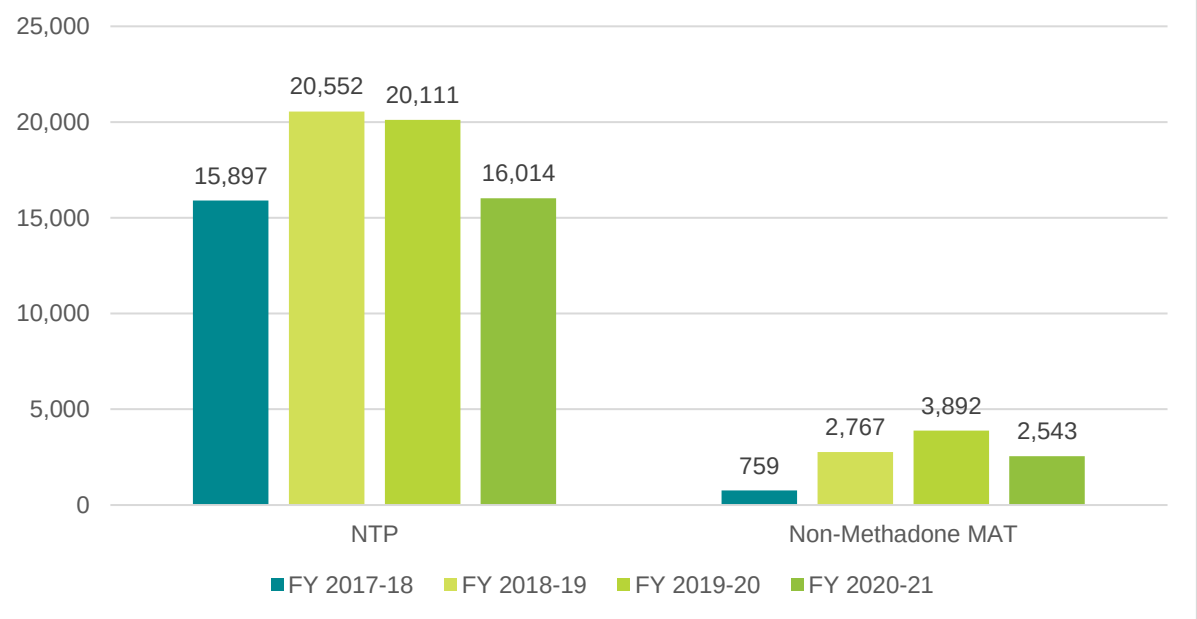
Also, ideally, anyone in unstable housing would also be in a recovery residence while in IOT and outpatient services after IOT. Linkage to recovery support should be planned for all persons leaving these LOCs especially if they are not on MAT. Peer group support with individuals also working on similar issues can make all the difference and be highly beneficial for both youth and adults. Thus, the IOT service is valued and important, but the model is considered too program driven and rigid, and this often results in large numbers of dropouts.

Promoting & Implementing Medication Assisted Treatment (MAT) from 2017 to 2021

Challenges and Strategic Successes

Access to MAT was one of the top federal priorities when the 1115 Waiver was approved and continues to be a critical element of the strategy for reducing opioid deaths in California and providing treatment for OUDs. This is a mandated service for each DMC-ODS and is a core requirement also with the federal NA requirements for the DMC-ODS plans. It is positive to see, therefore, the trend of services since the launch of the Waiver for the Pioneer counties in Figure 6-7.

Figure 6-7: Clients Served in NTP and Non-Methadone MAT, Pioneer Counties, FY 2017-2021



Note: FY 2020-21 has only six months of data

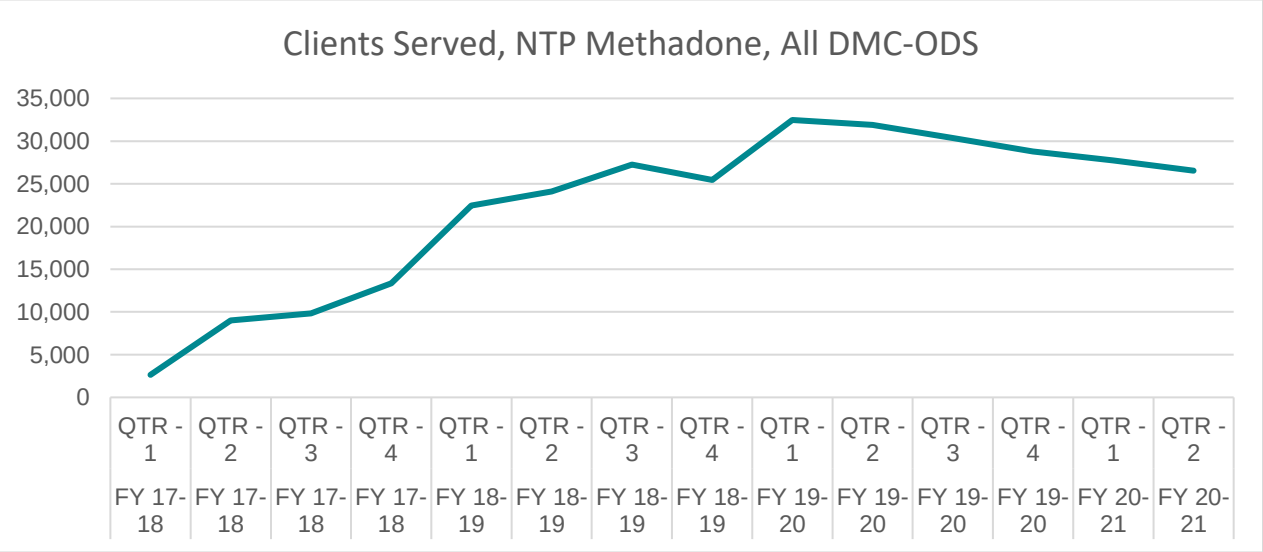
There was a clear impact starting April 2020 from COVID-19 with the Governor's stay at home order which would dramatically impact those on methadone and the staff who provide it for several months until adjustments were made to requirements. It also affected new patients seeking methadone since a face-to-face visit with a physician is required for the evaluation. Specific rules needed to be changed or waived for COVID-19 and these changes were implemented. Programs did rapidly make modifications with plastic shields and made other modifications to increase safety but still see clients. There were positive modifications made for

stable clients with take home doses which worked very well and hopefully can be maintained as they allowed less clinic visits for clients who are doing well and are stable.

Many new clients seeking relief and treatment are getting access to MAT for OUD through the non-methadone MAT programs as their data shows patient increases which appear to be continuing. Buprenorphine and other non-methadone medications are still increasing in prescribing especially in clinic DMC sites and as more ED bridge sites make referrals per the County SUD administrators.

Figure 6-8 shows clients served in NTP programs using claims data from July 2017 to December 2020 per quarter and the steady growth of these services. There are two impacts that lowered the numbers in Medi-Cal claiming. First, the introduction of coverage by Medicare as a primary payer of NTP services reduced those in the Medi-Cal data by 18 percent statewide because they did have Medicare due to disability or age. While this varied by county it did change the numbers of persons showing up in the Medi-Cal NTP/OTP reports starting in 2019 and 2020 as providers obtained Medicare certification and billing capacity. Then the COVID-19 period starting in the first quarter of FY 2010-21 with the mandatory quarantine also lowered NTP/OTP persons served. State claims programming changes in the future will allow the Medicare primary group to be tracked in the future by adding new fields so the total number of clients with both Medi-Cal and Medicare can be monitored. This dually benefitted group is important to track for many reasons.

Figure 6-8 Clients Served, NTP Methadone, All DMC-ODS, FY 2017-20



In Figure 6-9 the clients served with non-methadone MAT served shows a slow and steady rise in services provided over the Waiver. It is important to note however that the numbers of clients served are much lower on non-methadone MAT (under 2500) than those on methadone MAT(over 25,000) at the NTP/OTP programs. It is important to note that many counties have extensive partnerships with FQHC primary care clinics providing non-methadone MAT and their data billed through the fee-for-service (FFS) Medi-Cal is not available to CalEQRO at this

time. Thus, it is important to remember this is only a portion of the non-methadone MAT provided.

Figure 6-9: Clients Served MAT, Non-Methadone, All DMC-ODS, FY 2017-2020

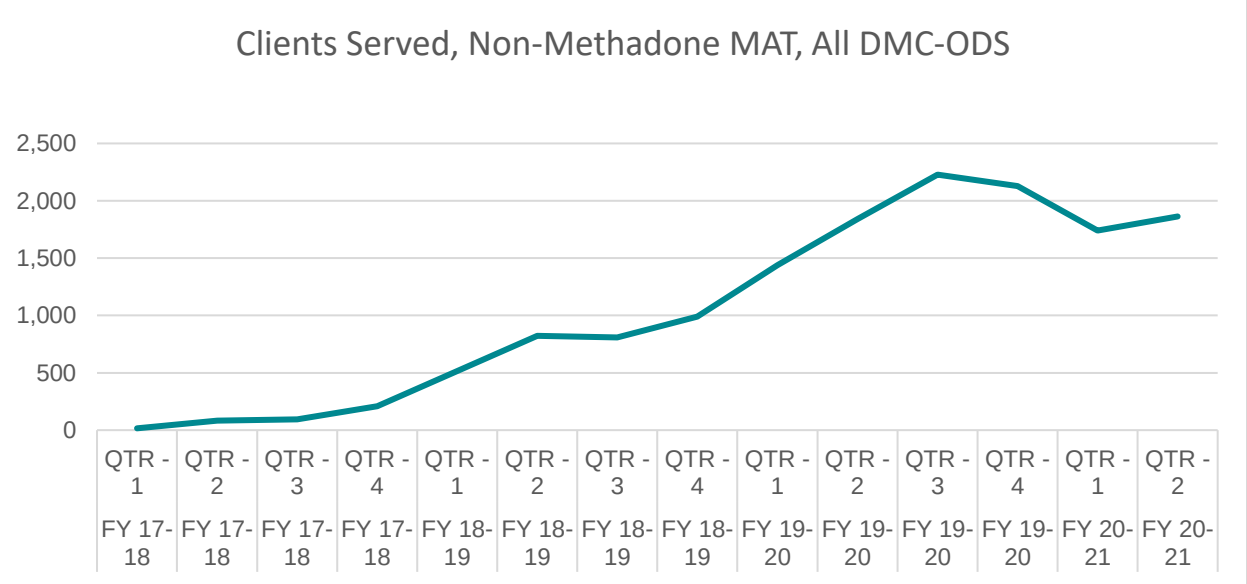


Figure 6-10 shows the average units of service for non-methadone medications per quarter, and this includes prevention medications such are Narcan which are being broadly distributed to prevent overdose deaths.

Figure 6-10: Average UOS for Clients, Non-methadone MAT, All DMC-ODS, FY 2017-2021

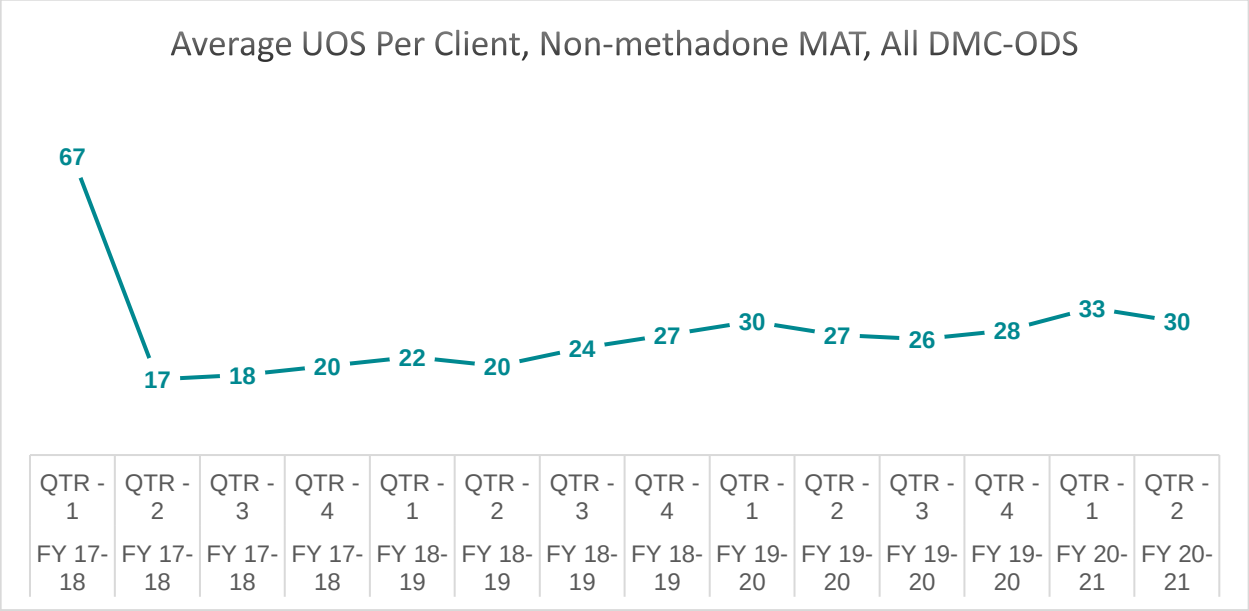
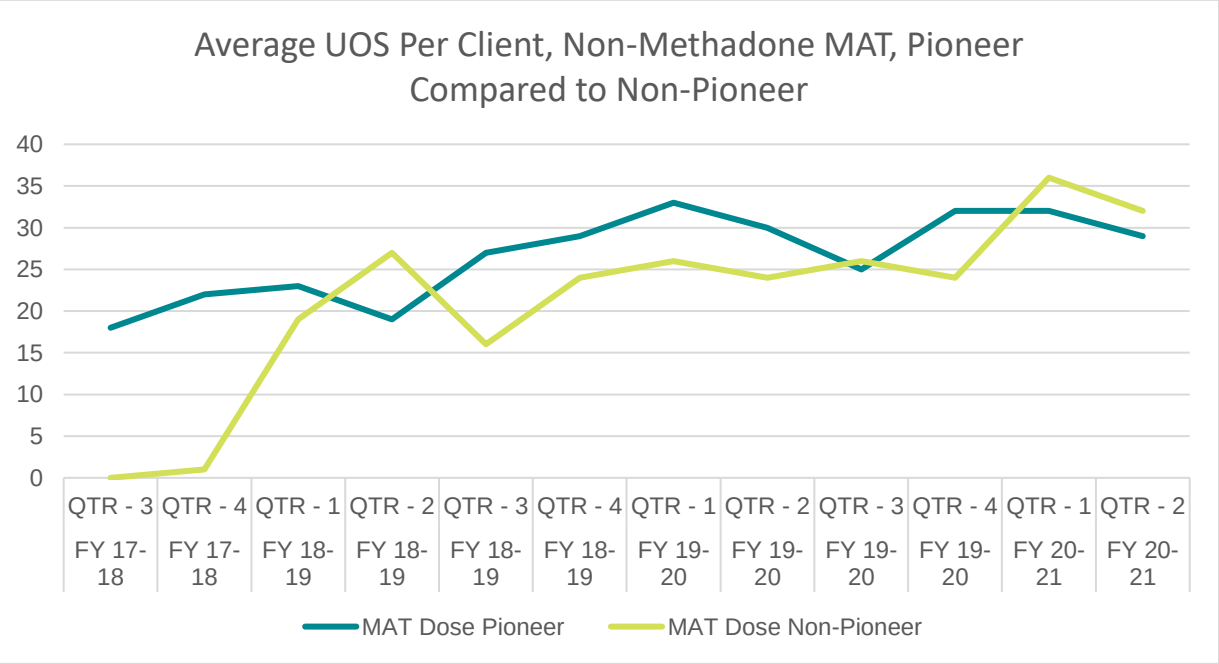


Figure 6-11 shows a steady growth in methadone services in both Pioneer and non-Pioneer Counties over their implementation years from 2017 to December 2020 with an expected dip due to the COVID-19 initial quarantine period impacts.

Figure 6-11: Average UOS Medi-Cal Clients, Non-methadone MAT, Pioneer versus Non-Pioneer, FY 2017-2020



In summary, despite many challenges, the California DMC-ODS counties have made steady progress through a variety of different programs and approaches to increase access to MAT. The move to increase and expand MAT services has been slower for some counties, especially those with limited providers. It is worth noting that Nevada County, which has no in-county NTP, has been able to set up MAT services and meet EQRO Key Concepts standards for MAT by proactively and creatively forming relationships with its contractor, Aegis. They have established a medication outpatient unit in Grass Valley and have various MAT "spokes" located in medical centers throughout the county. System navigators and peer supports are also provided for SUD clients placed on MAT by the Nevada County healthcare clinics or hospital. This is an excellent example of a small county model to meet this need.

Every DMC-ODS county surveyed demonstrated overall access improvement and improved adoption of MAT, including non-methadone forms. Access was enhanced by partnerships with FQHCs, county health plans, grant-funded projects in EDs and jail collaborative programs, and with an increased number of X-Waivered physicians and midlevel providers (nurse practitioners and physicians assistants) who prescribe in the community. Overall, timeliness was stable with counties able to provide dosing in one day or less in NTPs. Penetration was difficult to accurately evaluate because many MAT services are provided through fee-for-service clinics or programs that do not bill DMC-ODS and thus there are no claims data available for those sites. Many DMC-ODS counties tried to gather basic numbers as they are frequently coordinating care and providing counseling. Contra Costa County estimated they had between 500 and 650 clients who received MAT services from FQHC clinic providers. Most of these were referred from the Access Call Center, which has provided the clinic information to local Medi-Cal clients who request MAT, particularly buprenorphine or similar MATs through their access team. In the most recent year, they have further expanded both methadone and non-methadone MAT with Bright Heart Health, a DMC-ODS provider who can provide assessments and prescribe via telehealth.

As a best practice, all of these examples were explored and used in the different DMC-ODS counties and the Regional Model:

- FQHC primary care clinic partnerships and co-locations.
- FFS/Health Plan Medi-Cal funding and joint efforts including training, enhanced rates, and clinic partnerships.
- NTP Medication unit's coordination and expansion using Hub and Spoke grants, and new site development.
- ED Bridge Projects linked to DMC-ODS providers for follow-up care and coordination.
- Jails/Detention centers for assessment using ASAM and referral to treatment, including MAT initiation and transfer to community DMC-ODS programs. These collaboratives are part of MAT expansion initiatives and include linkage to community prescribing options.

- Integrated criminal justice probation and court services and referral into SUD community clinics through drug court programs, AB 109 programs, special diversion programs, and other shared initiatives.

- BAL Call Centers, including FQHC primary care clinics providing MAT and SUD services in the resource directory for referrals.

A powerful resource is physician leadership for positive change in the SUD culture and elimination of stigma in the community. More than ten counties used physician leadership to reach out to community physicians and mid-level providers (nurse practitioners and physician assistants to successfully provide trainings to add X-Waivered prescribers to their communities. This includes organizing peer-to-peer provider support to encourage dispensing and to provide case consultation on difficult cases, with both Medi-Cal and other insurance and coordinating and consulting on referrals from the ED. Marin, for example, includes a PIP that identifies non-fatal overdose cases in the ED and with Emergency Medical Service and coordinates outreach and follow up for MAT and other services with an SUD navigator linked to the DMC-ODS and also the ED.

San Luis Obispo also actively distributes the naloxone “red bag” to all who are receiving opioid treatment. This is a standard part of operations when clients are screened for services at one of the drop-in clinic sites. A psychiatric technician is responsible for the ongoing MAT education, nurse practitioner coordination, and “red bag” distribution. The red color signifies rescue and helps law enforcement and other first responders readily identify the bag. Standard access to naloxone to avoid overdose is important. Most counties have an overdose prevention coalition and work on prescribing practices and education, and also distribution of Narcan and naloxone.

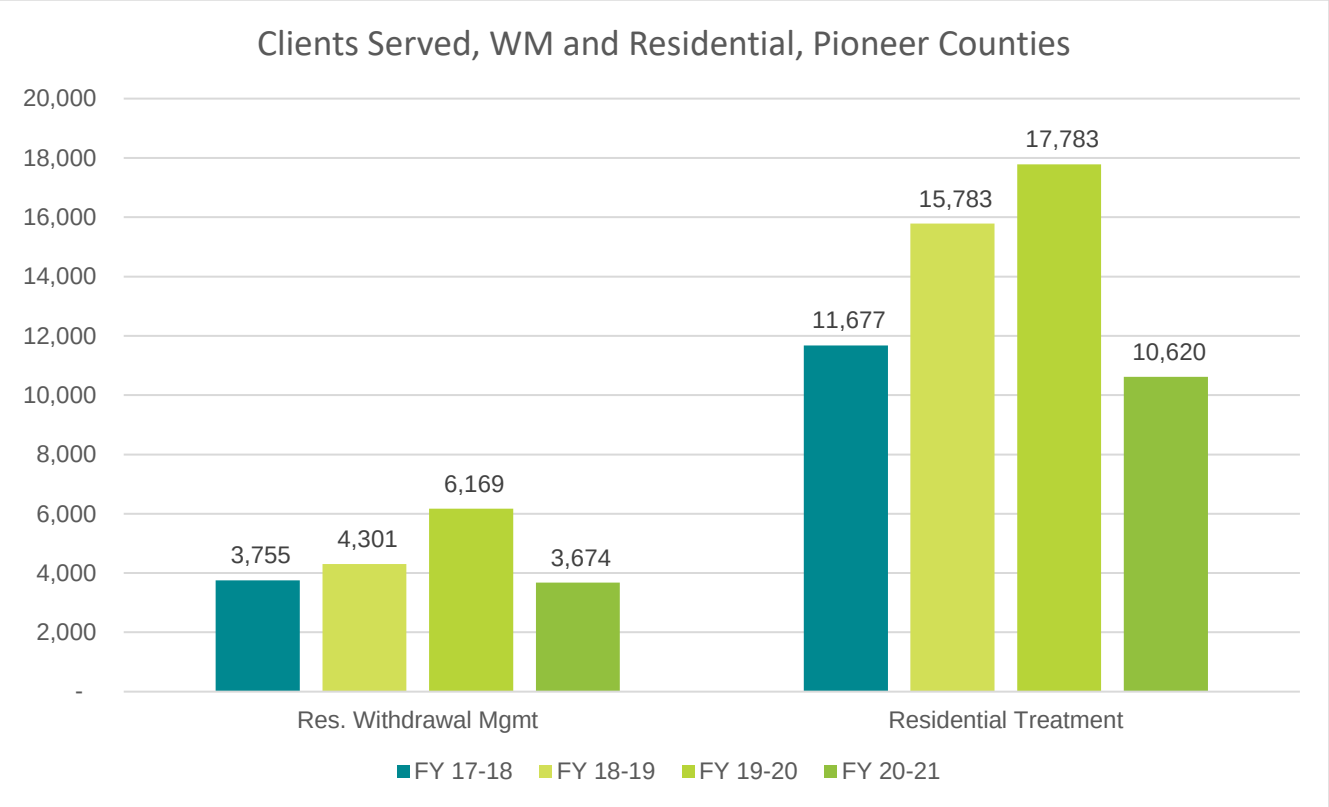
MAT is frequently cited in focus groups as a key element of success in recovery and helping with cravings and generally staying engaged in the system with a key provider. Beneficiaries say it best: “MAT gave me enough time to find recovery.”

Promoting and Implementing Residential Treatment from 2017 to 2021

Challenges and Strategic Successes

As shared in the introduction to the continuum of care data overview, residential was one of the fastest growing services. This growth was not as rapid with residential WM, however, even though it was a required service, and often an urgent service. Many counties did not have this LOC or could not find a provider within easy driving distance of their county to provide this LOC. Figure 6-12 displays data for clients served in Pioneer Counties from 2017 through December 2020 for the residential treatment which includes levels 3.1, 3.3, and 3.5 and 3.2 residential WM. The data shows more clients over time in the counties were able to access residential treatment and residential WM, and FY 2002-21 appears to project a similar pattern even with partial year data.

Figure 6-12: Clients Served in WM 3.2 and Residential Treatment, Pioneer Counties, FY 2017-20



Note: FY 2020-21 only six months of data

Figure 6-13 below shows the steady growth of the core residential beds over time for all counties as they initiate the Waiver services and also get their existing and new programs certified to participate in the DMC-ODS for Medi-Cal billing. One residential treatment program is required to be operational in the first year of the County's implementation and an additional level in the subsequent year. Many counties added more than one residential program in the first year once certification and preparation for billing was complete. They were adding more sites to address unique needs of perinatal clients, youth, different regions within large counties, and minority populations with different language needs. Many counties had programs that were predominately Spanish-speaking, and many had links to different cultural groups in surrounding areas that existed in large numbers in that region. There were also needs for specialty programs for co-occurring clients and those with more organic impairments (ASAM level 3.3 facilities) but only a small number had these programs. In 2021 many counties are identifying this as an important gap and trying to add this capacity through a contract or a new provider in their county or region which could be shared among counties. Significant research and literature are devoted to the co-occurring competence 3.3 LOC by ASAM publications including the different staffing levels and skills needed. These are outlined as well in the new residential accreditation guidelines and process recently published by ASAM in coordination with Commission on Accreditation of Rehabilitation Facilities (CARF). This is a new process which will be primarily for levels 3.3 and 3.5 services is just beginning nationwide. Information can be found on both the ASAM (www.ASAM.org) and CARF (www.CARF.org) websites.

Some challenges the residential providers and counties shared are similar to outpatient programs were:

(1) Workforce issues and challenges.

(2) Documentation confusion and burden of the Medi-Cal system and its impact of staffing needs and requirements.

(3) Billing challenges with case management, physician consultation, and use of modifiers in general, related to historical past use of staff both peer counselors and physician consultants. These billing codes are attached to residential treatment LOC but rarely used.

Challenges that are unique to residential providers and counties were:

(1) Lack of start-up funds for new site development since residential sites usually require major capital investments and modifications even if you are renting instead or purchasing to be in compliance with licensing and certification requirements.

(2) Neighborhood opposition being very difficult for residential programs in general but particularly WM, taking time and money to overcome and often ending potential projects where investments have been made.

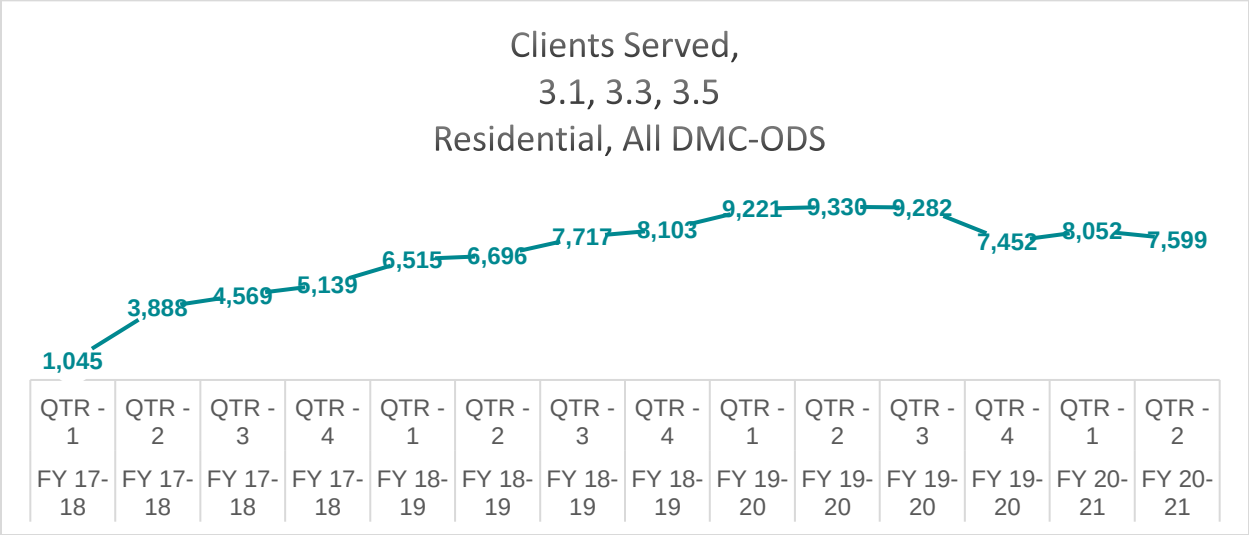
(3) Confusion and extra difficulties with PED and delays which cost money and programs must be active and running to be certified or even expanded, 12 to 18 months were some of the early delays, especially for example with new youth residential programs in Riverside which took two years with Social Services Community Care Licensing and DHCS.

(4) For youth residential there is often not enough capacity to sustain a full facility in county with just county youth so regional approaches are needed; and other residential options were too far away for clients to be willing to go and participate.

(5) Confusion and challenges with obtaining Incidental Medical Services Accreditation for the facility which many residential programs wanted to get for additional safety reasons especially for WM or if they had clients utilizing MAT at the program, and mixed messages on what you were allowed to do with this credential.

Despite the challenges as reflected in Figure 6-13, the clients served in the three levels of residential care alone has had a pretty steady rise until the COVID-19 period which drops clients served from a high of 9,282 to 7,599 per quarter.

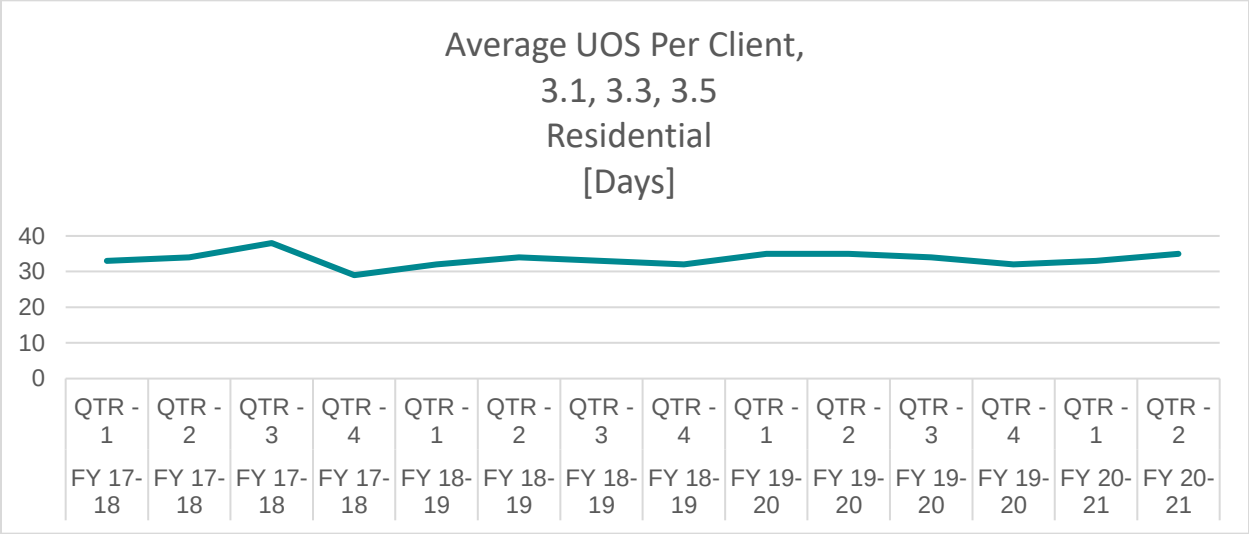
Figure 6-13: Clients Served Residential 3.1, 3.3, 3.5, All DMC-ODS, FY 2017-2020



FY 2020-21 is limited to six months of data.

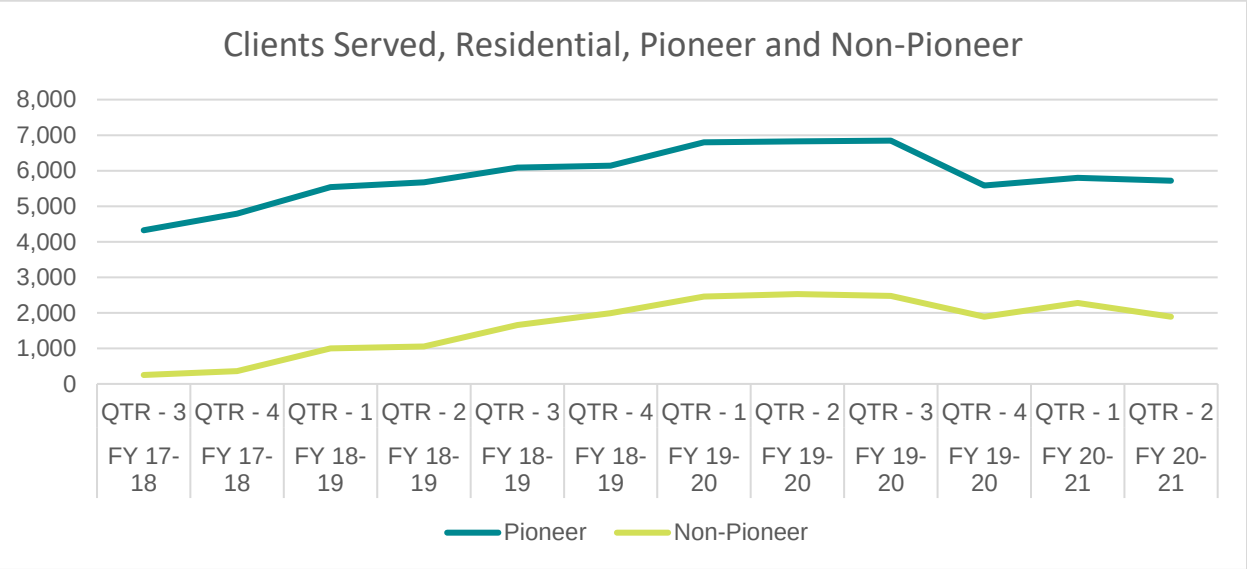
In general, however, the average units of service per quarter, which is a patient days of residential remains slightly above 30 throughout the period of Waiver services from FY 2017-18 to 2020-21. Also as previously mentioned the ASAM level 3.7 and 4.0 WM units are not included yet in this average which is a higher level of residential and more acute with generally shorter LOS.

Figure 6-14: Residential Average Days Per Client All DMC-ODS



In Figure 6-15, the pattern remains the same for both Pioneer and non-Pioneer Counties during the 42 months though the non-Pioneer Counties had less time to increase their numbers of clients served.

Figure 6-15: Clients Served, Residential Services, Pioneer versus Non-Pioneer, FY 2017-2020

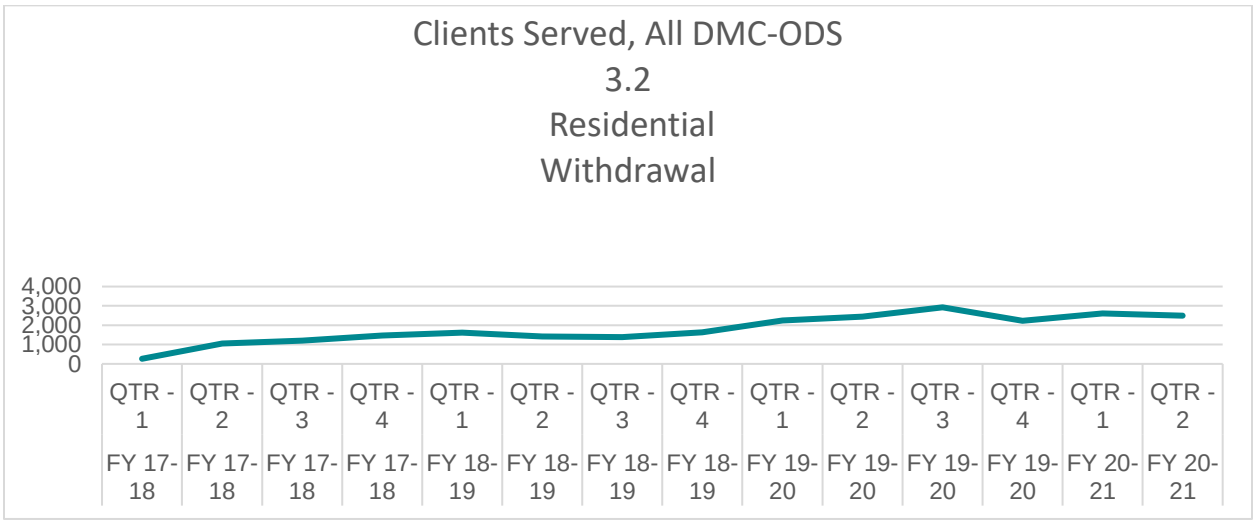


There was a slow increase in the number of clients served in residential WM as counties added new capacity to their systems. Most counties report this is still an area with capacity and location challenges because access to treatment needs to occur quickly to engage clients in the service and in aftercare for ongoing treatment. Distant locations are difficult for clients with active withdrawal symptoms that are often uncomfortable and difficult to cope with physically and psychologically. The desire to use their drug of choice is very strong and avoid the pain of withdrawal as well. Depending upon the drug or drugs they are withdrawing from and other factors, there can also be medical or physical dangers especially if the individual is pregnant. Because of these factors, proximity for assessment is immensely helpful if not essential. Individuals may, at times, need a higher LOC or even go to an ED.

In terms of location, these residential WM program providers have had difficult adding new locations due to neighborhood resistance as the concept of a “drunk tank” is not one that neighbors welcome, even though it is not the same as a sobering facility or a Sheriff’s facility for those who are just detained for being “drunk in public.” These programs for individuals to have social model WM and support to enter treatment. This is a difficult distinction to make to the public.

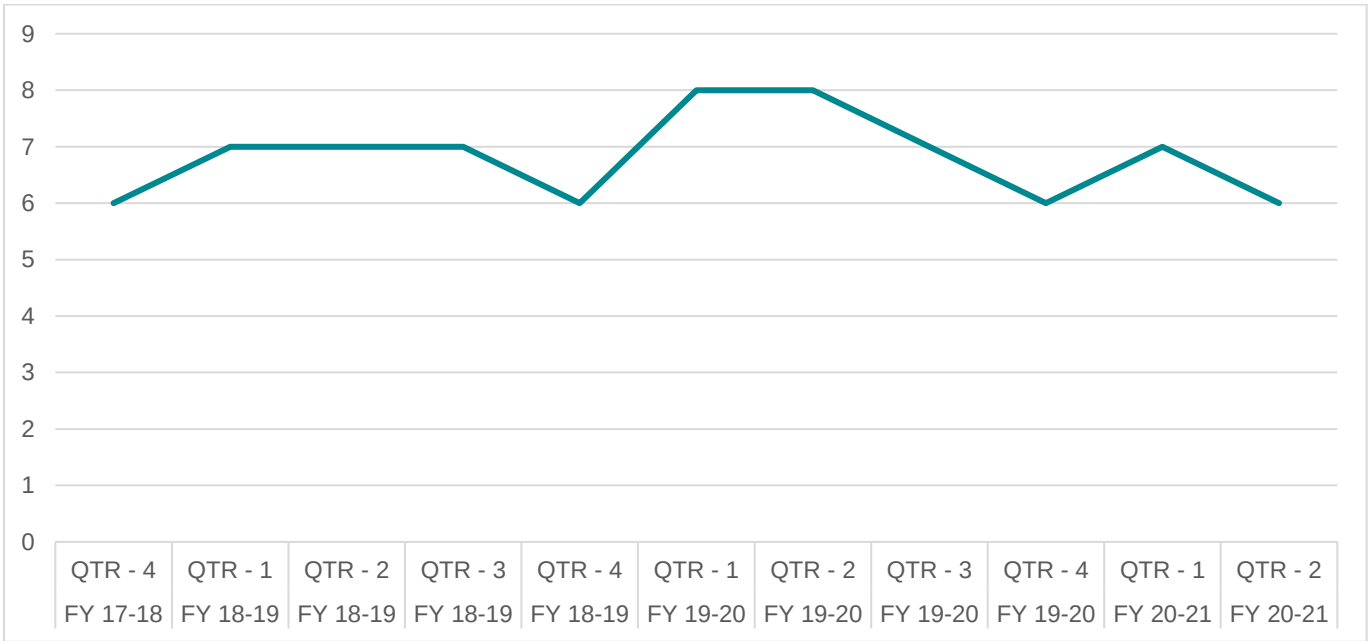
Counties and providers have used the legal system and community advocacy to try to overcome these barriers but often they are not successful. Some neighborhood groups have filed paperwork for re-call elections of the members of the Board of Supervisors or city council members who support treatment programs. It has therefore been a difficult challenge. Whenever possible the sites are in locations far from neighborhoods, but these are also often harder to get to for clients needing services and there are many transportations challenges. Many programs have asked about land use laws for protection, or zones where they are clearly allowed.

Figure 6-16: Clients Served, Residential WM 3.2, All DMC-ODS, FY 2017-2020



The average days per client for residential WM tend to be short ranging from 6 to 8 for most counties. This can vary and most try to keep clients long enough to ensure smooth transitions to treatment at the appropriate LOC whenever possible based on their ASAM assessment.

Figure 6-17: Average Days Per Client, Residential 3.2 WM, All DMC-ODS, FY 2017 to FY 2020



Implementing Case Management from 2017 to 2021

Challenges and Strategic Successes

Counties, the Regional Model programs, and providers of SUD care have long recognized the high need among their clients for case management services. Their clients need assistance with linkages to other types of services including physical and mental health care, social services and child welfare, justice system, and supported housing and employment. Prior to the Waiver treatment providers had provided some of these case management support. Always with stretched resources and without reimbursement, and therefore in an inconsistent manner. The new Medi-Cal case management services can make all the difference in preventing clients from slipping through the cracks and supporting them on their road to recovery.

One of the many positive elements in the 1115 Waiver design was recognizing the importance of these case management services and building into every LOC capacity to bill for case management services. There are specific billing codes for case management associated with any DMC-ODS certified treatment program, either contracted or county-operated. Some counties bundle case management services into their residential day rates when the services are delivered within residential treatment programs, while others bill for it separately. Several counties have county-operated SUD and Mental Health outpatient clinics across their regions which provide centralized case management services to their members as they enter care and across the continuum of care over time. These long-term case management relationships can be highly effective by building strong therapeutic alliances to support the client through the various stages of recovery. Other case management models are linked to individual providers and rely on them linking clients to services as part of discharge planning. These models have been less successful in linkage between care and making sure the initial access is achieved, but there have been systems working on providing additional support created by the County DMC-ODS plans through specialty case management contractors who job is to oversee services across specific regions.

Changes in Case Management Services

Growth of case management services is shown on Table 6-18-in terms of clients served. This does not include those counties who chose to include case management in bundled rates for residential treatment as it does not show up separately in billing. It does show that more clients, year over year, were getting case management. The two LOCs providing the most case management are outpatient and residential treatment. The residential programs with the most case management clients served, and units of service are focusing this effort on persons with multiple diagnoses and more complex problem areas such as homelessness and physical health challenges with their SUD. This was evident in claims volume and diagnoses, as well as

in staff sessions describing services to their populations getting case management services. Each county has a slightly different pattern of delivering case management by LOC. It is an impactful service which does appear to positively impact progress on CalOMS discharge ratings to some degree, and UCLA's last annual report also found a positive association for persons with multiple co-occurring disorders. Given this association, it is important to provide case management to as many clients as possible with multiple disorders meeting medical necessity. UCLA is continuing to track this linkage in their research. As expected with other services there was also a dip in case management services at the onset of COVID-19 quarantine time, but case management as a flexible and mobile service was quick to return to full and expanded utilization.

Figure 6-18: Clients Served, Case Management, All DMC-ODS, FY 2017-20

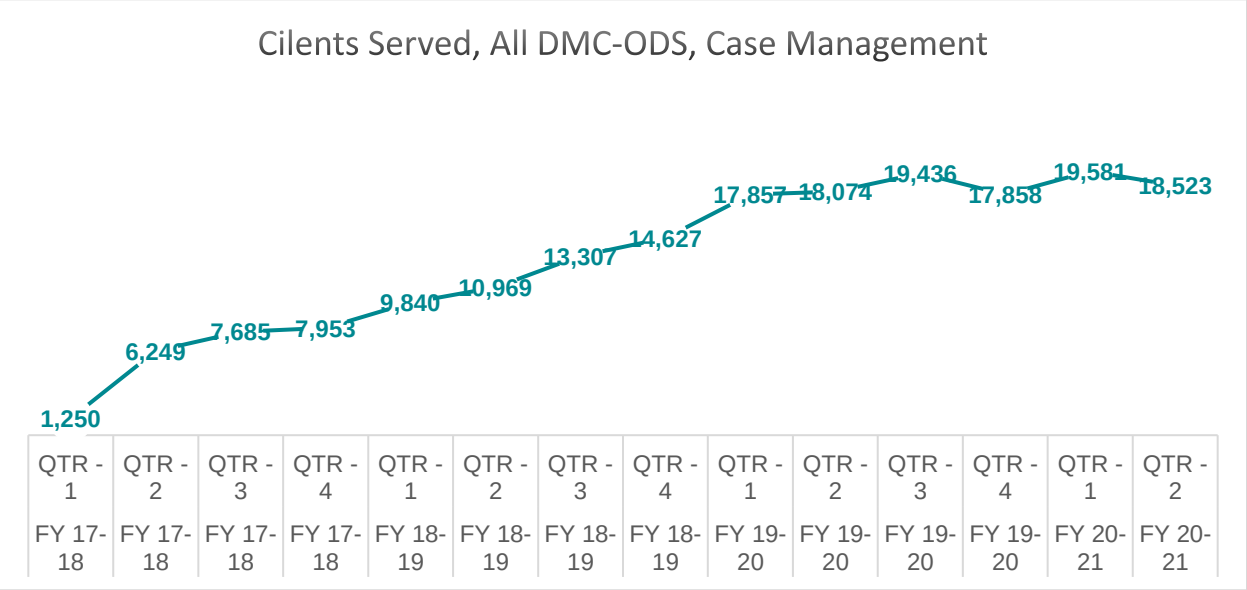
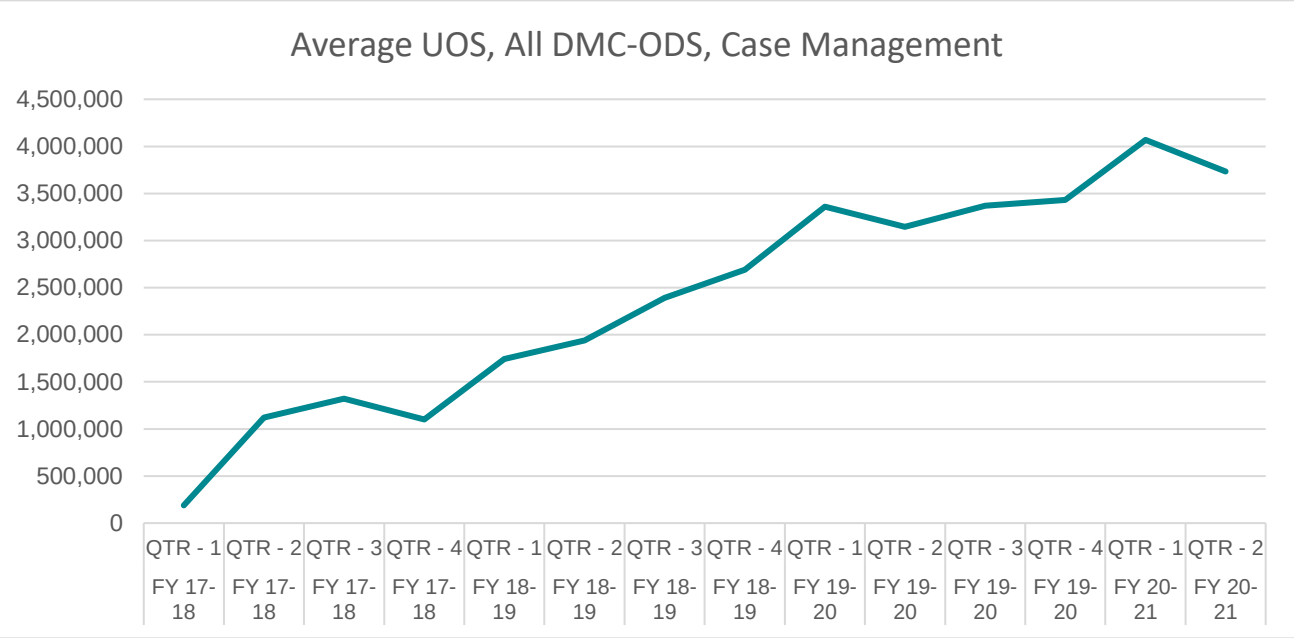


Figure 6-19 reflected the average amount of case management units that individual clients were getting across all counties over the 42 months of care tracked in the service data. There is clearly a steep climb in service intensity from a low of few minutes of services per quarter to over 3.5 million. These services are measured in 15-minute unit increments.

Figure 6-19: Average Units of Service, Case Management, All DMC-ODS, FY 2017-20



Units of Service, quarterly, statewide, 15-minute increments

The models demonstrating the most consistent success with linkage and program progress have ongoing long-term relationships between the case manager and client over time. Whether they work for the county (as in Riverside's model) or are developed via a regional support model by a specific contract agency (as in Los Angeles County's model), case managers serve as navigators and advocates for those clients in the SUD system and in their engagement of the community at large. Based on review of best practices to do this well, the case managers need to have case management as their primary job responsibility and a caseload low enough to allow them to be effective with SUD clients and their specific needs. Homeless clients have more complex needs as do the elderly and medically complex individuals, for example, and these issues were taken into account by providers and counties in setting caseload standards and productivity. The core of their effectiveness lies in developing trust, effective communication, and a strong therapeutic alliance with the SUD client.

Case management staff can be the eyes and ears of the system in its operations, highlighting both positive and negative trends in client impacts, system flow and access.

Another county best practice is to have special case management skill training and dedicated positions, case management supervisors and a communication channel to senior SUD managers for system problems and breakdowns. This allows case managers who cross multiple LOCs with their caseloads to see directly where access to critical services is breaking down, when admissions that should occur smoothly are not occurring due to barriers, and other systemic problems requiring higher level interventions, etc. These system best practices and the links to higher management were identified by lead managers in several counties as important for system improvement. Reasons for direct connections with the centralized case management team and

their problems and concerns. Several counties have set up “Fix it” committees to link case management problems with management to share major problems with management for more programmatic and system challenges, with superior results.

Case management navigation from first request to first face-to-face appointment has been valuable to increase successful initiation and engagement for many ambivalent and high-risk clients, as well as in all transitions in care levels. Many counties with better timeliness and engagement patterns have leveraged case management as a key strategy and part of their continuity of care philosophy. Many PIPs have also included this intervention for improving engagement and transitions. Often this includes empowering the case managers with flexible resources for transportation, joint community visits, childcare help, and night and weekend hours support, if necessary, mobile capacity to reach out to clients in their homes and flex funds.

Case Management Challenges

There were a host of challenges which impacted the adoption of case management services early in the Waiver process. Confusion related to the duties of case management for staff who had never done this service was a barrier, and confusion related to who could perform case management and do billing. Many programs assumed it was the same as Mental Health or that peers without certification or licenses could do this service, neither of which were accurate. Counties and providers were concerned about charting and claims denials, and many had problems accurately billing for services using the correct codes because they were complex and different than Mental Health which was their frame of reference.

In the initial year of DMC-ODS services, it was not uncommon to have large numbers of billing denials on case management as well as other claims in DMC-ODS programs. This was especially true for programs new to Medi-Cal certification and billing systems. Many smaller providers had not billed Medi-Cal or healthcare reimbursement systems of this type and complexity. The contract provider computer systems were particularly challenged with some of the new billing and charting. They also struggled with compliance with managed care processes such as tracking timeliness, authorizations, and most were and still are on paper charts for clinical documentation.

Many first-and second year counties implementing DMC-ODS counties were slow to start the delivery, documentation, and billing of case management services. In counties that had bundled case management into day rates for residential services, some staff reported case management was added to their counseling and assessment responsibilities, and they did not really have enough time to do many services other than some general discharge planning. This problem was particularly acute when no new clinical staff were added to the residential program with specific case management responsibilities.

Improving Transitions in Levels of Care

The DMC-ODS Waiver emphasizes client-centered care, one element of which is the expectation that treatment intensity and focus should change over time to match the client’s

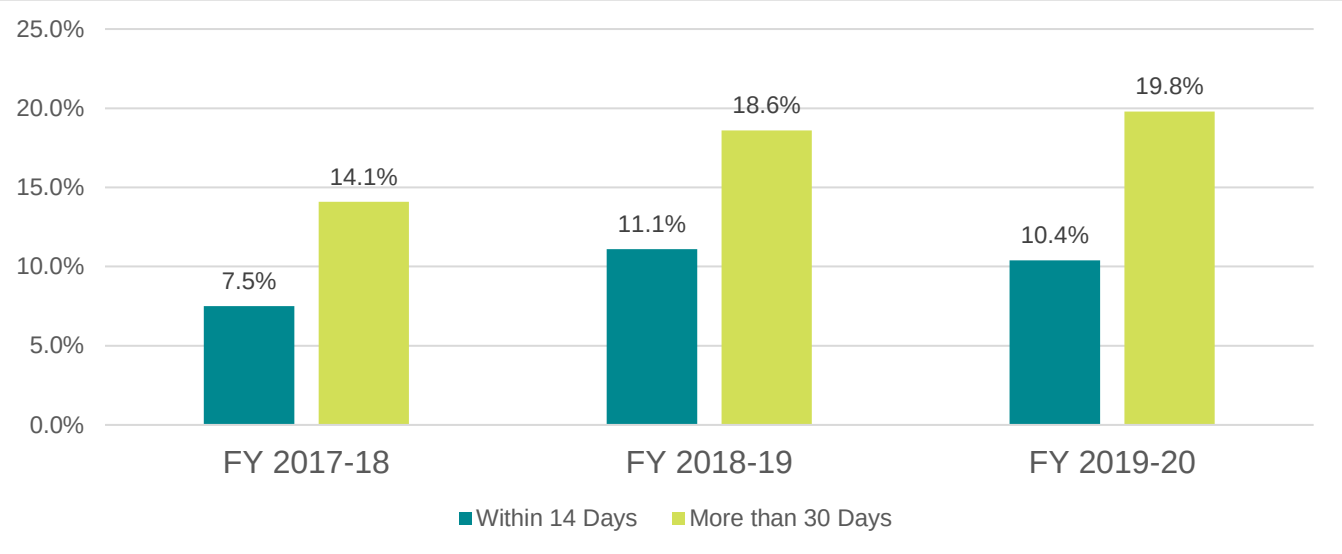
changing condition and unique treatment needs and circumstances. This treatment philosophy is in marked contrast to a program-driven approach in which treatment would be standardized for clients according to their time in treatment (e.g., week one, week two) in a structured treatment program at one LOC.

Figure 6-20 shows (1) the percentage of clients discharged from residential treatment who then received a follow-up treatment session at a step-down, non-residential LOC, and (2) the timeliness with which that was accomplished for those who were transitioned. The figure shows the percentage of clients who began a new LOC within 7 days and 30 days after discharge from residential treatment

Follow-up services that are counted in this measure are based on DMC-ODS claims data and include outpatient, IOT, partial hospitalization, MAT, NTP, outpatient WM, case management, RSS, and physician consultation. CalEQRO does not count re-admission to residential treatment or a transfer to residential WM in this measure. Additionally, CalEQRO was not able to obtain and calculate FFS Medi-Cal claims data at this time to track those whose treatment transitions to MAT in a primary care setting.

The transitions in care improved overall in the first two years of reviews but less so in the third year when there were 26 counties including 12 new counties who launched their DMC services. Case management is a critical intervention used in transitions in care. Data for FY 2020-21 is not yet complete and from individual reviews it appears mixed. Some counties were able to improve based on their prior year experience of transitions and some were not because discharges from residential were difficult with COVID-19 especially with limited housing resources for discharge. No clients in any programs were being discharged to homelessness in any county reviewed. LOS in residential may have increased in FY 2020-21 due to waiting for viable discharge plans to avoid homeless conditions as many shelters were closed and all counties have limited recovery residence housing.

Figure 6-20: Timely Transitions in Step-down Care Following Residential Treatment, FY 2017-18 to FY 2019-20



Although DMC-ODS counties are demonstrating improvements in their rate of successful client transitions upon discharge to less-intensive LOCs, the rates are still low, with ample room for improvements. What factors contribute to the low rates? Several counties have developed PIPs to improve their rates, and as part of PIP methodology have met with providers and clients to identify barriers. They include: (1) clients feeling ready to return to community life and still believing old models that they have "graduated" and do not need more treatment and can just go to an AA group if needed; or (2) client reluctance to go to lower LOC after bonding with the residential treatment staff to begin establishing trust with new program and counseling staff.

Best Practices Learned on Transitions in Care

Some DMC-ODS counties and their treatment programs have strategies to address these barriers. Santa Cruz contracts with a small number of provider organizations, each of which operates by design multiple LOCs, so clients can transition more seamlessly from one level to another within the same provider organization and often keep the same counselor. San Joaquin developed new transition protocols that include training staff in motivational interviewing, principles of client-centered care, and how to let go of their clients in a supportive manner during the warm handoff period. At the same time, outpatient staff are being trained in how to engage the referred clients, so they feel welcomed and are inclined to continue with outpatient treatment.

Many counties are conducting several planned overlapped outpatient and residential sessions to allow for bonding to the new counselor and setting up new goals the client and the new counselor agree to. Both programs cannot bill on the same day, but chances of a smooth transition are enhanced with this overlap strategy.

Napa used a unique strategy of having clients agree to have regular outreach support contacts after discharge to offer recovery support activities and social/job/food/health events linked to the Napa recovery program. Many Napa clients, if they do not transition immediately to RSS and case management, many do join later into these supportive activities and services as some of the stressors of community life are experienced.

Flexibility and individual activities with a social support component and linking individual to other with similar challenges would be a helpful and provide a support system in the community.

Recovery Support Services

During the past two decades, the paradigm for substance use treatment underwent a gradual shift from an acute, episodic care model to a recovery, self-management model similar to the approach for managing other chronic conditions.[14] [15] In this paradigm, clients have intermittent periods during recovery when they experience setbacks. Clients benefit from ongoing support to prevent these setbacks and to mitigate their frequency, duration, and intensity when they occur. This more recent paradigm is recognized and supported in California's Medi-Cal 1115 Waiver, which promotes a recovery-oriented system of care that includes RSS for clients whose SUD is in remission following treatment. Clients transitioning from the treatment phase with their SUD in remission can benefit greatly from longer-term intermittent RSS and case management in individual or group formats, delivered either in person or through telehealth.

Prior to Waiver implementation, the most common post-treatment service was the unbillable aftercare/alumni group. The Waiver expanded and formalized the types of clinical services beyond the aftercare group model to include as RSS: recovery monitoring, coaching, and support through outreach and linkage activities; peer-to-peer support services; case management assistance and empowerment linked to community resources and needs such as housing, education, jobs, and limited outpatient counseling as aspects of RSS. To qualify for billing, these services must be provided within the context of an individualized client plan that is documented according to DMC guidelines. The Waiver validated RSS as an important component of the system of care by permitting this billing under a separate code for RSS. Currently this is the only Medi-Cal service a peer counselor can bill for as part of the support service.

Napa and Santa Barbara have been particularly successful with RSS and are documenting many new best practices to share with other counties. The county conducts quarterly outreach and wellness checks to see how clients are doing and offer RSS if they did not initially enter

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[14] Institute of Medicine (US) Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington (DC): National Academies Press (US); 2001. 3, Formulating New Rules to Redesign and Improve Care. Available from: https://www.ncbi.nlm.nih.gov/books/NBK222277

[15] McLellan AT. Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*. 2002;97(3):249-252. doi:10.1046/j.1360-0443.2002. 00127.

RSS but now are struggling with SUD issues of SUD in community settings and needed support. In addition, Napa County co-located the RSS center on a campus where it is easy to get benefits, job help, food assistance, medical care, and other community supports to make the transitions into community living more successful. Incentives for participation and very flexible individualized plans for support also have been important for successful engagement. The flexibility was also very appreciated during COVID-19 and included video and phone support and some mobile visits as expressed by clients in focus groups.

Some counties reported challenges to implementation because of lack of interest among clients in longer-term services, and others because of unclear understanding by the county or providers of documentation and billing requirements. Most DMC-ODS counties have been slow to bill for these services, so the statistics based on claims data likely do not reflect fully the services provided. FY 2018-19 claims data showed that 66 percent (20 of 30) counties had billed for RSS. This was an increase over FY 2017-18, when only 8 percent claimed. Yet even with this increase, the total number of beneficiaries receiving services in 2018-19 was only 1,970. While it may be correct to assume that more RSS services were provided and more beneficiaries served, the lack of claims data prevents a full evaluation of their quality and impact on outcomes. The best example of use of RSS is in Napa County, which has provided it for three years and continues to expand these offerings. Napa has a robust program for a county its size and has reported positive outcomes for Napa's client population participating in RSS and more than 50 percent of outpatient clients transition to RSS after completion which is much higher than any other county.

As one of the clients shared in our focus groups, "This program has helped me with new friends, job options, a place to talk, share, and get advice when things get difficult. Napa staff really care about me, and it makes a difference. I feel like I am important to staff here."

CalEQRO discovered in its 2019-20 reviews that many DMC-ODS counties had prioritized other elements of their DMC-ODS for initial development and were expecting to focus on RSS services in the coming year. Some had begun developing their RSS services by recruiting and training their peer support workforce, improving their capability to document and claim for these services, and creating PIPs to analyze and improve these efforts. For example, as part of a clinical PIP, Santa Barbara is exploring how motivational interviewing strategies may be used to encourage more clients to use RSS services.

Based on data displayed in Figure 6-21, there is slow growth in clients served over the period displayed though as the number of counties with multiple years of implementation grew, the numbers of counties implementing RSS grew as well. The pandemic did impact growth as well though did appear to show a rapid stabilization after the brief dip during the COVID-19 period.

Figure 6-21: Clients Served, Recovery Support Services, All DMC-ODS, FY 2017-2021

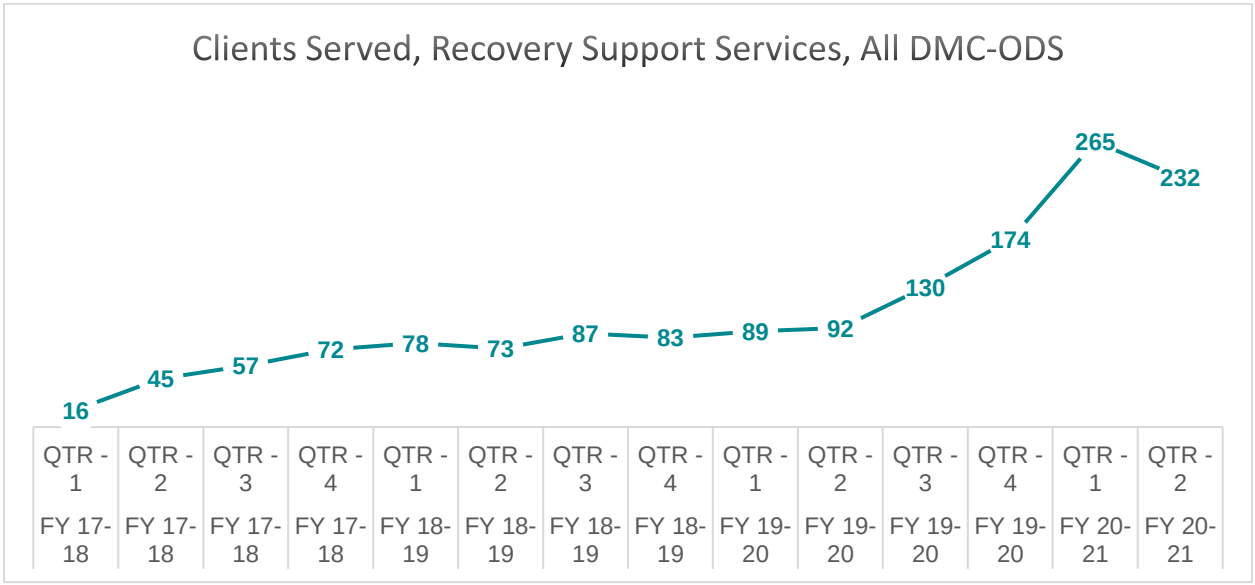
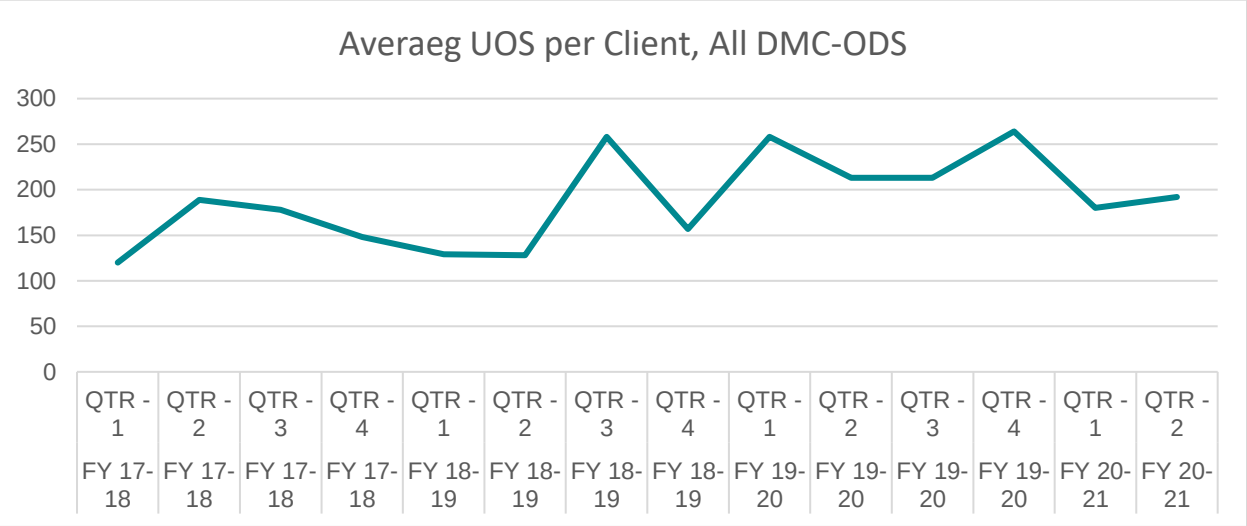


Figure 6-22 shows the average number of services per quarter that clients received over the time from 2017 to December 2020 and while erratic it was generally trending upward. Many counties had begun PIPs focused on expansion and linkage with outpatient services, and there was a general interest in expanding this service especially for clients who were not in MAT and did not have a structured way to maintain contact with the system of care time. There was a significant amount of confusion related to appropriate services to bill within RSS and how to assist existing peer programs to convert to offering this type of program. With the limits on who could bill it was decided that many of them could not offer this service at this time because a licensed practitioner of the healing arts (LPHA) or SUD counselor needed to do the case management and counseling services and the peer counselor was only able to do the support service.

Figure 6-22: Average Units of Service, Recovery Support Services, All DMC-ODS, FY 2017-20



Implementing ASAM Assessment Dimensions to Enhance Quality

The DMC-ODS pilot establishes a continuum of care modeled after the ASAM principles and care criteria for treating SUD disorders, based on the field's latest clinical science. The ASAM criteria and assessment dimensions create objective standards for SUD treatment, giving clinicians guidelines for individualized treatment planning and for identifying the least restrictive treatment services to provide safe, supportive recovery environment to improve symptoms and enhance functioning and wellness. Pioneer Counties understood the importance initiating DMC-ODS services with an ASAM-capable workforce and began training early, and some had used ASAM for doing assessments for several years before the Waiver began. This extensive training and use of the six ASAM dimensions to assess clients and develop individual treatment plans has helped to address outdated, program-driven models and beliefs, including more punitive blame-oriented models. Using ASAM training to educate criminal justice and child welfare workers has helped to bring them into the DMC-ODS system of care as partners in community wellness. Judges who received ASAM training report that it has influenced their bench practices, championing treatment over incarceration and leading recovery-promoting specialty courts. This alliance in system of care change has required more than training. Equally important is including the criminal justice sector in planning and QI efforts, and, in some cases, assigning specific court liaisons as points of contact to help solve problems. A number of counties (e.g., Riverside, Orange, San Diego, Los Angeles, Contra Costa, and San Francisco) have excelled in building these new criminal justice-SUD behavioral health relationships with the ASAM principles serving as a common language and common evaluation tool for SUD recommendations. These positive partnerships have helped clients and moved SUD services away from a punishment incarceration model and into a treatment model for addressing illness and promoting health.

ASAM is a fundamental philosophical shift in the SUD treatment approach and includes important science-based treatments such as MAT, which have shown ongoing benefit for those who participate in these treatments. For many staff, extensive retraining is needed because so much of this was never covered in educational environments.

On average, all screenings, assessments, and follow ups are matching at a 76 percent or higher rate, based on the ASAM dimensions to client needs.

Assessment accuracy and proper use of LOC recommendations are measured by congruence between ASAM findings and subsequent referral at the times of initial screening and assessment. These measures are displayed below in Table 6-2. The high congruence ratings seen across counties support the finding that there is efficacy in the application of the ASAM criteria. Where there is variance from the ASAM-recommended placement, it is most frequently due to patient preference. This supports the adherence to the principles of client-centered care. In addition, the ASAM principles address individually tailoring treatment to address the changing needs of each client over time through periodic reassessment.

Pioneer Counties have had the most experience matching initial client screening with their program continuums and have, in general, a complete range of treatment options. However, all three groups of counties and the regional plan are based on the ASAM-based tools used have matched to recommended LOCs from 76 to 90.6 percent. While there were no LOCs noted as missing in the new counties and Regional Model group, it is known that in fact, there are LOCs that are not available in close proximity to specific areas within or near several counties, which make access very difficult, specifically residential and residential WM for youth and in some areas for adults as well, also in other regions NTPs are also far away as well. Nonetheless, the efforts at matching clients to expressed and assessed needs are high.

Table 6-2: Congruence of Level of Care Referrals with ASAM-based Screening Findings, Pioneer, Year 2, and Year 3 County Comparison

ASAM Level of Care (LOC) Referrals	Pioneer Counties		Year 2 Counties		Year 3 Counties	
Dates of Screenings: July 2020- May 2021 **If assessment-indicated LOC differed from a referral, then the reason for the difference**	#	%	#	%	#	%
Not Applicable - No Difference	81,579	76.0%	37,595	78.2%	17,227	90.6%
Patient Preference	7,361	6.8%	3,292	6.8%	886	4.7%
Level of Care Not Available	161	0.1%	1,432	3.0%	114	0.6%
Clinical Judgement	9,718	9.0%	2,632	5.5%	473	2.5%
Geographic Accessibility	364	0.3%	22	.04%	48	0.2%
Family Responsibility	191	0.2%	25	.05%	19	0.1%
Legal Issues	1,229	1.1%	260	.54%	34	0.2%
Lack of Insurance/Payment Source	107	0.1%	67	.14%	38	0.2%
Other	6,609	6.1%	1,431	3.0%	172	0.9%
Referred Level of Care Missing	0	0.0%	1,287	2.7%	0	0.0%
Total	**107,319**	**0.0%**	**48,043**	**100.0%**	**19,011**	**0.0%**

Evidence-based Practices from 2017 to 2021

> **"I've learned to handle my angry feelings and impulses to use drugs to get away from them. … The work with my counselor is helping me feel good about myself again."**

The DMC-ODS Waiver promotes client-centered care, using researched, evidence-based, culturally competent approaches to SUD treatment including the application of the ASAM criteria, increasing professional Whole Person Care involvement, and supporting the use of MAT interventions. Following SAMHSA's lead toward transforming SUD treatment into a recovery-oriented system of care, the Waiver required that providers implement at least two of the following EBPs: Motivational Interviewing (MI); Cognitive Behavioral Therapy (CBT); Relapse Prevention Therapy/Treatment (RPT); trauma-informed treatment; and/or psychoeducation.

Counties have developed training programs that are knowledge rich in EBPs for SUDs. Even before DMC-ODS implementation, virtually every county was scheduling trainings on MI, CBT, Seeking Safety (trauma-informed care), or RPT. Reviews of each county's training calendar shows that EBP-related training continues in a repeating cycle, ensuring inexperienced staff are trained and experienced staff have their skills reinforced. Interest and excitement in learning new and better treatment methods and ideas are evident from staff comments during virtually every line staff focus group.

Each year CALEQRO has found counties are enhancing the EBPs used in their programs by adding more training and working more on the fidelity of their EBP programs with certifications, train the trainer programs, and keeping up with new EBPs. COVID-19 set back some of these efforts as it took much of the staff time and energy and re-directed it to safety and program issues and maintaining core services and then vaccine distribution. Now with new variants there are efforts to get all staff and clients vaccinated and also consider those who may also need boosters as well.

Initiation and Engagement in Treatment

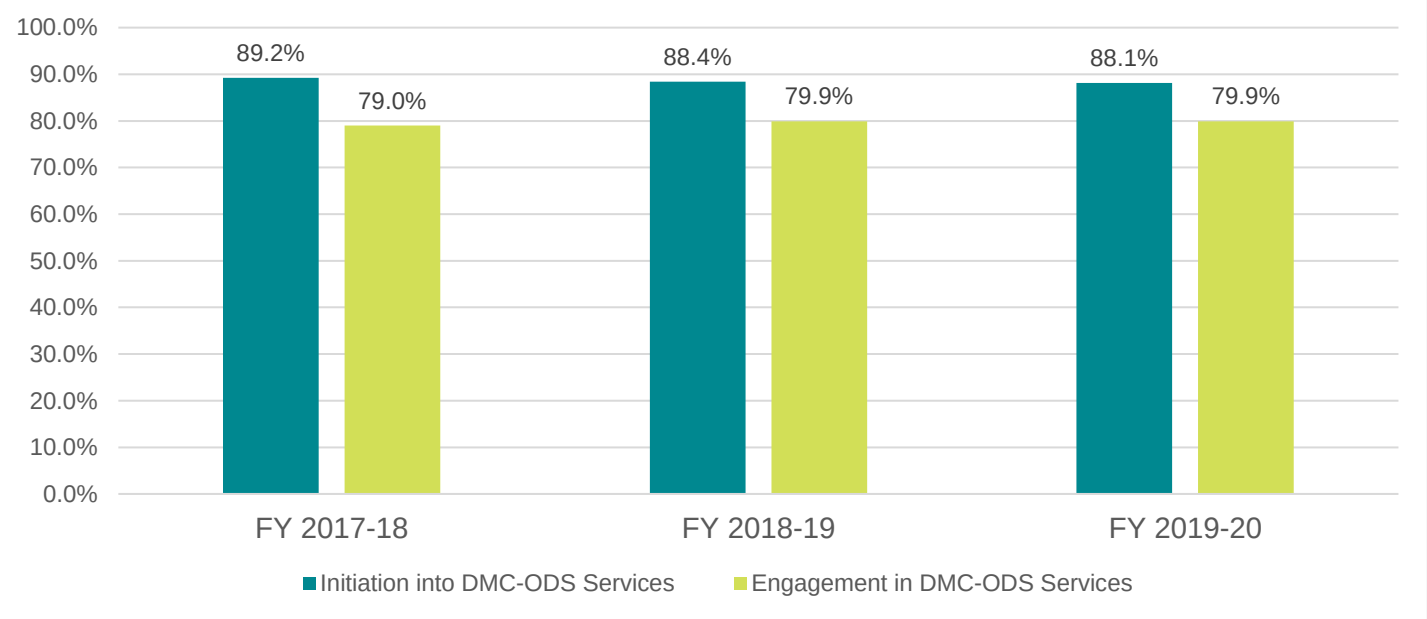
A vital component of quality care for treating clients with SUD is the ability to engage and retain them in treatment. Research indicates that building a strong therapeutic alliance with clients during the early stages of treatment is an important quality indicator that is predictive of longer treatment retention and positive outcomes.

CalEQRO developed two PMs to evaluate the extent to which clients stay involved during the early stages of treatment. The measures were adapted from similar ones used nationally in the National Committee for Quality Assurance's Health Evaluation Data Information Set (HEDIS) and from the National Quality Foundation. The measures are known as initiation into treatment

(percent of clients who have at least one visit or day in treatment within 14 days of their initial assessment) and engagement in treatment (percent of clients who have at least two more visits or days in treatment within 30 days after their initiation into treatment).

Figure 6-23 displays 3 years of initiation and engagement data from DMC-ODS counties, and all 3 years show high rates of initiation into treatment within 14 days after assessment. This PM indicates that clients had 1 or more visits within the first 14-day period after their first visit and retention within the later 30 days. Meeting the retention PM criteria means that the clients had an average of 2 or more visits or treatment days within the subsequent 30 days of treatment, thus they were retained in treatment. These include services across the DMC-ODS continuum of care, MAT, outpatient, residential, case management, RSS, physician consultation and partial hospitalization. The goal is to track continued engagement in the treatment system of care.

Figure 6-23: Initiation and Engagement in DMC-ODS Services, FY 2017-18 to FY 2019-20



These rates of initiation and engagement are all quite high, suggesting that once counties form accountable SOC, they perform accordingly and act to prevent clients from slipping through the cracks by dropping out of treatment. DMC-ODS counties were active in measuring their own effectiveness by using their client data to measure initiation and engagement. Some of the counties that did this regularly included Santa Clara, San Diego, Santa Barbara, Napa, and Riverside. Several counties went further to then review their results with providers and consider opportunities for QI to improve retention. Riverside was particularly proactive in providing case management for clients who they thought might be at high-risk of dropping out or not making transitions in care.

Quality Improvement Activities

Participating DMC-ODS counties are required to create a Quality Improvement Committee (QIC) with a structured QI plan, including an annual evaluation of measurable goals.

QI activities are a Waiver requirement and a key component for supporting system improvement to benefit clients' health. In 2017 most QIC created plans looking similar to the mental health plans, then they changed to focus on meeting SUD compliance requirements. But now many of the more mature plans and Cultural Competence Plans are now setting SUD specific quality goals. These include improving access to specific populations, timeliness for specific groups or programs, quality measures for areas needing improvement, and reducing adverse outcomes such as overdose rates, low transitions in care, low MAT or RSS levels, etc.

Cultural competence plans have also improved to target more SUD specific populations such as persons of color coming out of prisons, minority populations in the Asian or Native American communities, physically disabled, and co-occurring disorders populations. Also contract providers were initially not involved at all in these activities or PIPs and are not becoming increasingly evident in committee and projects and in QI plans.

Erecting a QI program can be daunting. Most counties have taken a reasonable route, integrating the mental health and SUD QI programs. They share staff and administration, operating from one integrated Mental Health-SUD QI plan. Integrated plans make good sense in that they fit well with the integrated, collaborative focus of behavioral health systems and offer potential economies of scale when resources are limited, as is almost always the case. This works when there is a balance between the two specialty areas with measurable clinical goals that are linked to the best science for each. Also needed are annual evaluations of these goals and data systems to support the measurement and tracking of the goals and staff resources to support quality as a priority. The plans have improved substantially since the first year and now are much more specific to SUD needs and quality issues.

Best Practices

Successful counties, providers, and the Regional Model shared several essential elements:

(1) SUD initiatives are using science-based research to drive treatment designs and methods.

(2) The QI plan's goals and aims are clearly written, measurable, with assigned responsibility and general monitoring.

(3) The QI plan supplies clear examples of how the county's QI efforts are intended to improve decision making and affect the quality, effectiveness, efficiency, and the cost of care.

(4) QI efforts are supported by adequate staff and data support systems.

(5) Evaluation and analytic resources are deployed effectively and create effective tools for communication of key quality learnings with line staff and stakeholders.

(6) Commitment to QI is a high and ongoing priority, with both mental health and SUD included in plan activities along with follow up, analytics, and community, client, and network provider involvement

Many of the DMC-ODS counties are collecting data to report on client outcomes but remain hampered by the software for generating reports and/or analysis capacity. Persistent challenges include staff skills in using the CalOMS dataset, TPS, and mechanisms for extracting data from their own data systems. Analytics staffing enhancements are needed in the majority of counties to optimize the data systems they currently have to make quality-related decisions; when staff capacity is present, the true value of QI can be realized. Recommendations for added analytics staff were quite common in review reports.

This last 18-months of quality reviews was dominated by challenges linked to COVID-19 and keeping core programs growing to meet needs but also meet client and staff safety concerns. Overall, the DMC-ODS counties managed this successfully and shifted quickly to offer services in new ways though the stress and difficulties did take a toll on the SUD population with higher rates of overdose and more use of drugs and alcohol to cope with confinement and the impacts on the economy and health. Despite this there were still expansions in care and more efforts to reach individuals in new ways and keep quality high even with the limitations placed on the delivery systems.

Perceptions of Care

Client feedback included information about unmet needs:

- Longer length of stay in residential treatment
- More bilingual counselors
- More assistance with housing and employment
- More family supports
- More information on MAT

CalEQRO regards the client perspective as an essential part of the EQR, especially for information regarding the quality of how treatment services are delivered. Quantitative data are derived from the TPS, and qualitative data are obtained from client focus groups. Each DMC-ODS county administers the TPS to its clients on an annual basis in October as part of a statewide evaluation of the DMC-ODS Waiver conducted by UCLA. DMC-ODS counties mail or upload the data to the UCLA Health Sciences box and the UCLA team analyzes the data and produces reports they send to each DMC-ODS county. In this chapter, the graphs include only the domain results pertaining directly to quality of care, which are Quality, Coordination of Care, and General Satisfaction.

Figure 6-24 shows the average TPS ratings by item and by domain on a five-point scale, aggregated across all 30 counties and the Regional Plan reviewed during the previous year. The results are uniformly high when aggregated across all counties and types of treatment, which masks differences when comparing the results of specific treatment programs.

Figure 6-24: Mean Score on Perception of Care Domains, Pioneer Compared to Non-Pioneer, CY 2020

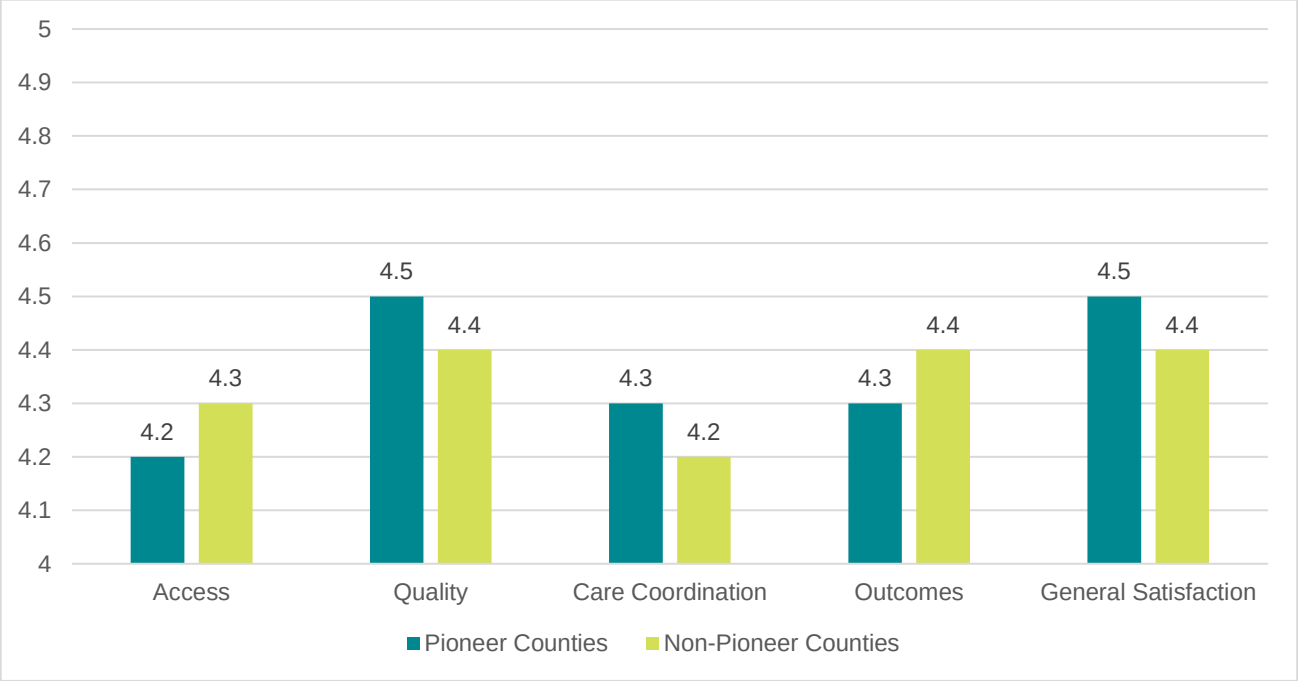
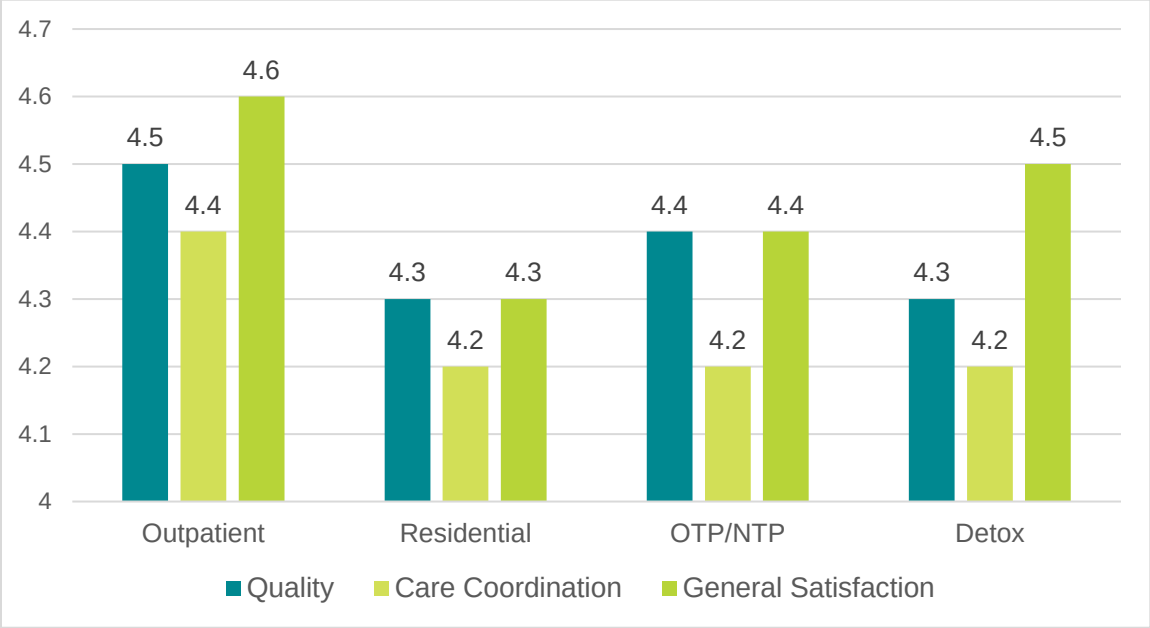


Figure 6-25 shows the average TPS ratings by domain on the same five-point scale, differentiated by type of treatment program. While still uniformly high, the ratings show more differentiation; ratings by clients in residential treatment are slightly lower than those by clients in the other types of treatment programs. Client participants in residential treatment focus groups voiced a recurring sentiment that they did not have a sufficient length of time in that treatment program to complete their goals. The Waiver STCs introduced tighter limits on residential treatment LOS, which was a major historical change. Residential treatment has the shortest LOS and outpatient and MAT in NTP/OTP programs have the longest lengths of stay overall. These scores also vary by county and by individual program site, so it is difficult to generalize.

Figure 6-25: Mean Score on Perception of Care by Domain and Treatment Setting, Pioneer Counties, CY 2020



In the CY 2020 TPS reports both for adults and youth there are overall positive scores by various dimensions. Adults scored higher than youth, but it is important to note that the coordination of care scores and access scores were higher for adults in the most recent year. For youth, the therapeutic alliance scores were higher, and they improved as well in general ways from the prior year. The outpatient and NTP positions had the higher scores for quality and satisfaction. Whereas residential and detox have the lower residential have lower scores, but they improve for the Pioneer counties over the years.

Figure 6-26: Percentage of Adult Clients in Agreement with Perception of Care Domains, All DMC-ODS, CY 2020

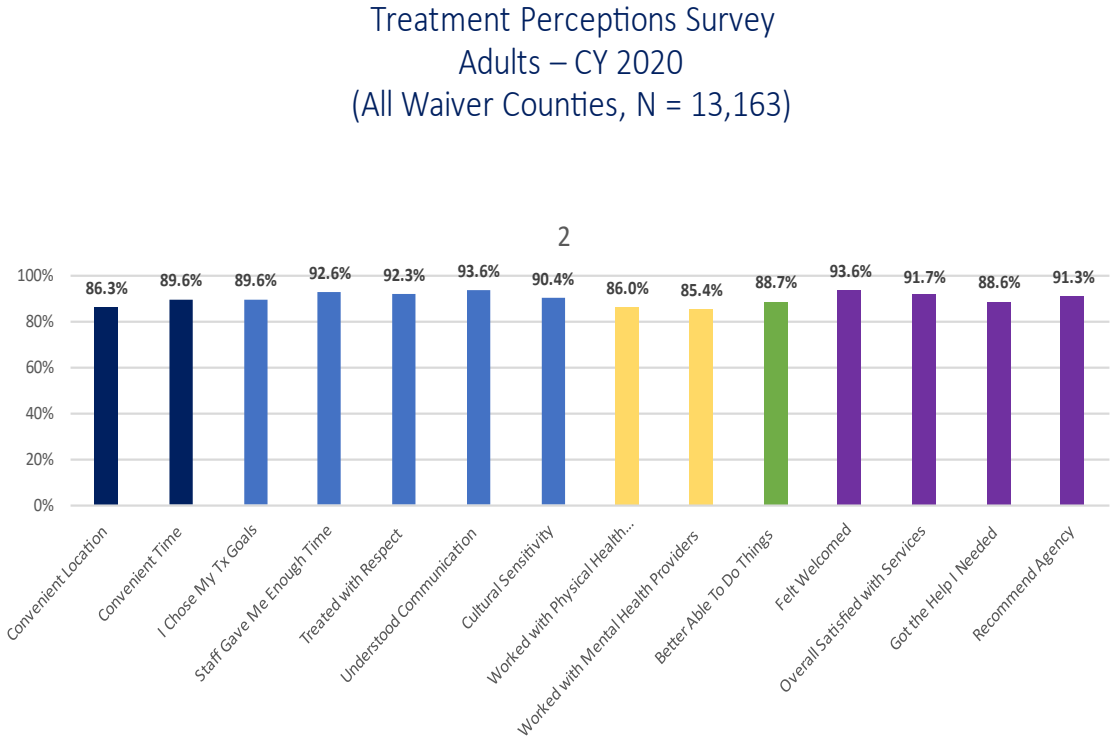
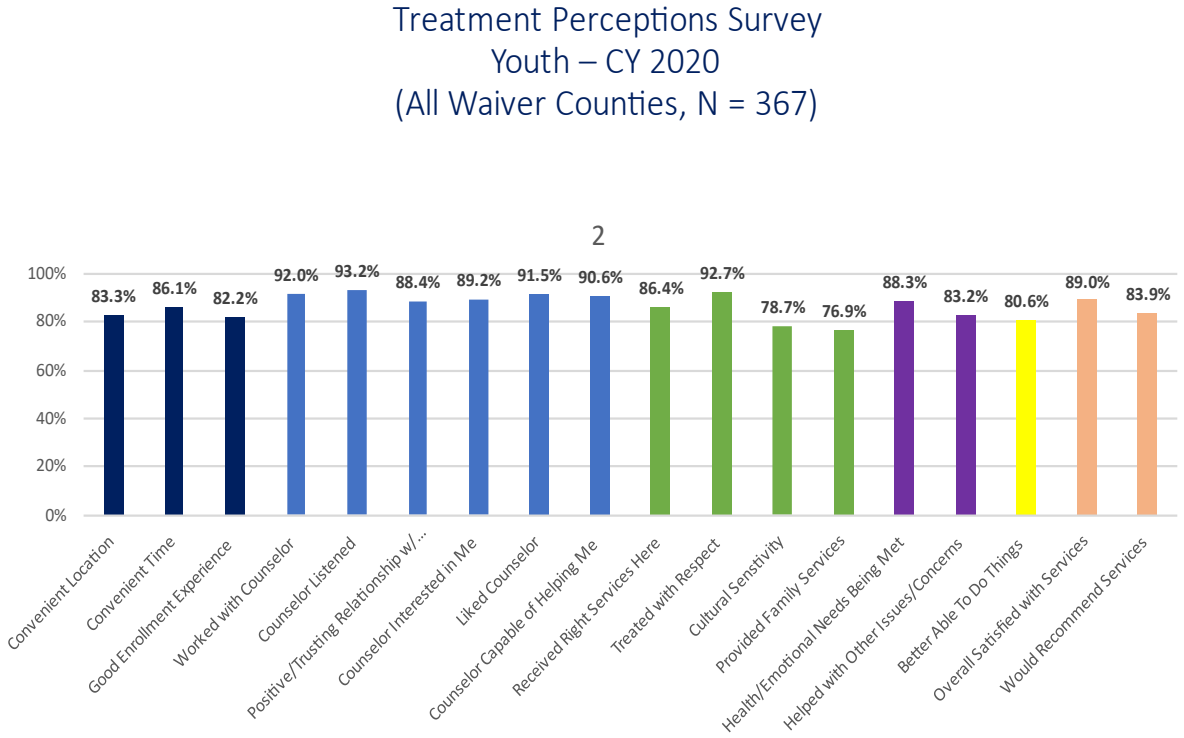


Figure 6-27: Percentage of Youth Clients in Agreement with Perception of Care Domains, All DMC-ODS, CY 2020



In the report sent by UCLA to each DMC-ODS county, results also are displayed for each specific treatment program and each specific site, with highs and lows to identify outliers. While most ratings per item per program were positive, a few programs tend to have markedly lower ratings. During the EQR, CalEQRO explores how each DMC-ODS county communicated and used the results for specific treatment programs as opportunities for QI. CalEQRO learned that, as a result of TPS feedback, some counties worked directly with specific providers on specific performance issues.

In FY 2020-21 CalEQRO conducted over 29 focus groups during the 30 DMC-ODS county reviews and Regional Model and would have done more were it not for the Governor's Executive Order requiring COVID-19-related sheltering in place restrictions beginning in mid-March. Each group was 75-90 minutes in duration and included up to eight clients. Most included a mix of male and female clients, although some were for females only, such as groups for single parenting women. Depending upon the feedback sought, a focus group's participants might include clients from outpatient treatment, residential treatment, or MAT. The focus group questions were designed to elicit feedback from client participants regarding their experiences in and perceptions of treatment. An electronic survey was also given to clients using survey Monkey.

Client feedback comments in the focus groups were wide-ranging and included many moving comments about the quality of care they received and the positive impact it had upon them. Clients also made varied suggestions for improvements, with a few issues emerging as recurrent themes. Many clients across all LOCs commented they had not received enough or any information and guidance about MATs. More interest in family therapy. The most recurring theme in feedback was suggestions for more guidance and support in finding suitable housing and employment, particularly for those in residential treatment and adults with families. Clients across all treatment modalities expressed the need for more aid with their relationships and family supports. Many clients also expressed appreciation for case managers and wanted more time and help from them with community issues and re-entry into community living.

Concluding Quality Themes and Recommendations

From 2017 to 2021 the Counties, the Regional Model, and providers have developed a framework for an SUD continuum of care which is developing and thriving the more time it has to mature. DMC-ODS counties have made substantial progress in expanding their continuum of care in breadth of services and in service capacity. They have worked well with their provider networks, most of whom are contracted, to adopt a more client-centered approach to delivery of treatment, ancillary services, and care coordination largely with case management systems and enhancing communication. They have made strides with their networks to incorporate a more science-based set of practices as prescribed by the Waiver STCs, including the use of a wider range of addiction medicines for MAT, though the client community requests more.

Drug Medi-Cal Organized Delivery System External Quality Review

2017-2021 Statewide Report

Outcomes

Outcomes: Findings, Trends, Challenges

Outcomes

Challenges and Strategic Successes of County, Regional Model Programs and Providers

Introduction

Outcomes data provide essential information for analyzing and determining program performance and clinical benefits for those in treatment. From 2017 to 2021, the DMC-ODS counties, providers, and the Regional Model program worked with a standard set of tools to evaluate the outcomes.

These included TPS, CalOMS discharge ratings, and PMs. The focus of the TPS questions relates to whether programs are making a difference in life experience and functioning, CalOMS discharge ratings related to progress in treatment and reduced drug use, and PMs related to retention and improvement in SUD care over time. Besides these metric tools, concrete client accomplishments and goals being met in treatment are also especially important. These include getting a job and returning to work, family re-unification and reconciliation, educational goals, resolution of criminal justice requirements and restitution, and finding and keeping housing.

For the clients who were able to participate in treatment progress of care from 2017 to 2021, the trends in satisfaction and improvements generally appear positive. However, there is no doubt of the seriousness of the setback that COVID-19 and the introduction of fentanyl have played in increasing overdose deaths based on the information provided by the CDC of the chemical components contributing to these increases in overdose deaths.

Overview of Major Outcomes Findings

Finding 1: TPS Findings

All 30 DMC-ODS counties and the Regional Model reviewed fulfilled the requirements related to administration of the TPS through the county and contracted SUD programs, with solid participation and a positive mean rate within the Outcomes domain overall "due to the program services I participated in I am able to do things better."

The TPS results also showed that clients were consistently positive about the outcome of care, variance was noted within the LOC experience. Residential findings scored lower and outpatient program and NTPs scored higher in outcome satisfaction findings related to helping the clients feel they are able to function and do things better in their lives. This was similar to prior years given short LOS in residential this is not unexpected.

Finding 2: Retention in Care PM Findings

The percentage of clients retained in treatment beyond 90 days has increased on average in the DMC-ODS counties as measured by 180 days and 270 days indicators. Increased retention and length of stay in the SUD care systems is associated with improved outcomes in functioning and reduced relapse events (such as loss of employment, arrests and rehospitalizations and readmissions). Reduction in relapse events is due to individual improvement in functioning.

Finding 3: MAT impacts per TPS findings had the highest impact on outcomes

The client ratings on the TPS MAT services (both NTP and non-methadone MAT) had the highest impact related to the statement "As a direct result of the services I am receiving, I am better able to do things that I want to do."

Finding 4: ASAM Ratings for Matching Placements to Client Assessment Needs ranged from 76 to 96 Percent across all the Counties and Regional Model programs.

The newer counties had a less robust range of services to match clients to, but still were able to keep rates of matching referrals high. The Pioneer counties had the widest range of developed LOCs and matches clients to them at over 74 percent with full assessments.

Data Sources for Outcomes

Treatment Perception Survey (TPS)

The DMC-ODS Waiver places a strong emphasis on client-centered care and requires counties to administer the TPS to determine the effectiveness of services by gaining insights from clients. In addition to satisfaction and quality of services, the TPS includes a specific domain pertaining to outcomes. Once submitted to UCLA for analysis, TPS results can be used by DMC-ODS counties to identify best practices, opportunities for improvement, and to set systemwide QI goals.

CalEQRO also regards the client perspective as an essential component of the EQR. Qualitative information from client focus groups during the onsite review is combined with quantitative information from TPS, which is administered at least annually to clients in treatment. Ratings from the 14 items yield information about five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction. The TPS Outcome domain measure asks each client to rate their perception since in treatment of being "better able to do things because of the treatment they are receiving." This rating is linked to the specific program and site where clients receive treatment in the DMC-ODS, so client beliefs can be used to gain insights and information at the program and system levels. TPS data can be used to guide and inform management about the client experience and evaluate barriers to improving outcomes related to service delivery.

Retention in Care Performance Measure

The CalEQRO definition of retention in treatment is a measure of how long the system of DMC-ODS care can maintain a client within its network of treatment and RSS. Retention data includes a count of the cumulative time that clients were involved in sequential SUD treatment and received care without an interruption of more than 30 days. Defined sequentially and cumulatively in this way, LOS in treatment has been found to be a significant predictor of positive post-treatment outcomes, such as decreases in unemployment and crime and SUD relapse.

Importantly and contrary to general thinking, the goal of measuring client retention is not to reduce utilization or save on costs, but rather to meet the needs of the client in the best possible way over time as they progress in self-management of their chronic condition. In the end, providing the right level and combinations of care at the right time is the goal. Persistence in care is of high value for SUD treatment and so is information gathered to monitor the client's progression of care. Sustained engagement at the appropriate LOC and moving clients toward improved outcomes and self-management adds value to programs clinically and ultimately reduces costs and risks of serious relapse.

California Outcomes Measurement System (CalOMS)

Federal and state regulations require that all SUD treatment providers receiving public funds collect standard client data at both admission and discharge. In California, these data are collected through the CalOMS. Client characteristics, drug use factors, health factors, and sociodemographic characteristics are collected with a series of defined questions and responses, along with clinical outcomes and program performance indicators.

With the institution of a standardized assessment and tool for matching the placement of individuals into the right LOC, the implementation of the DMC-ODS Waiver should show favorable improvements in clinical outcomes. Proper matching of treatment settings and types of individualized services provided has been shown to be of benefit in both client retention and desirable outcomes.

CalOMS provides both admission and discharge data along with clinical, functioning, and program performance information, which should provide insight on efficacy and how programs are performing. While complete, accurate, and consistently generated information can be useful in measuring efficacy and guiding resource and program adjustments, data can be subject to errors with administration and data extraction or other administrative management issues. As a mandated outcome measure for all clients served, CalOMS is an essential management aide in guiding effectiveness discussions and presents an opportunity to strengthen consistency.

There were many concerns expressed related to CalOMS. It is one of the data requirements most frequently cited as an administratively burdensome, too long, administered too frequently and not providing back valuable information in a timely way. Staff and clients consider it as repetitive as well. Parts of it are federal data requirements which must be completed for the federal block grant funding. Also, numerous standard reports used to be generated by the DHCS from this database for the counties and providers which are no longer. Most counties cannot produce these themselves. To create value for the CalOMS at the staff effort, these reports ideally will be made available again to Counties and providers again and the LOCs in CalOMS should be aligned with ASAM and the Waiver which they currently are not.

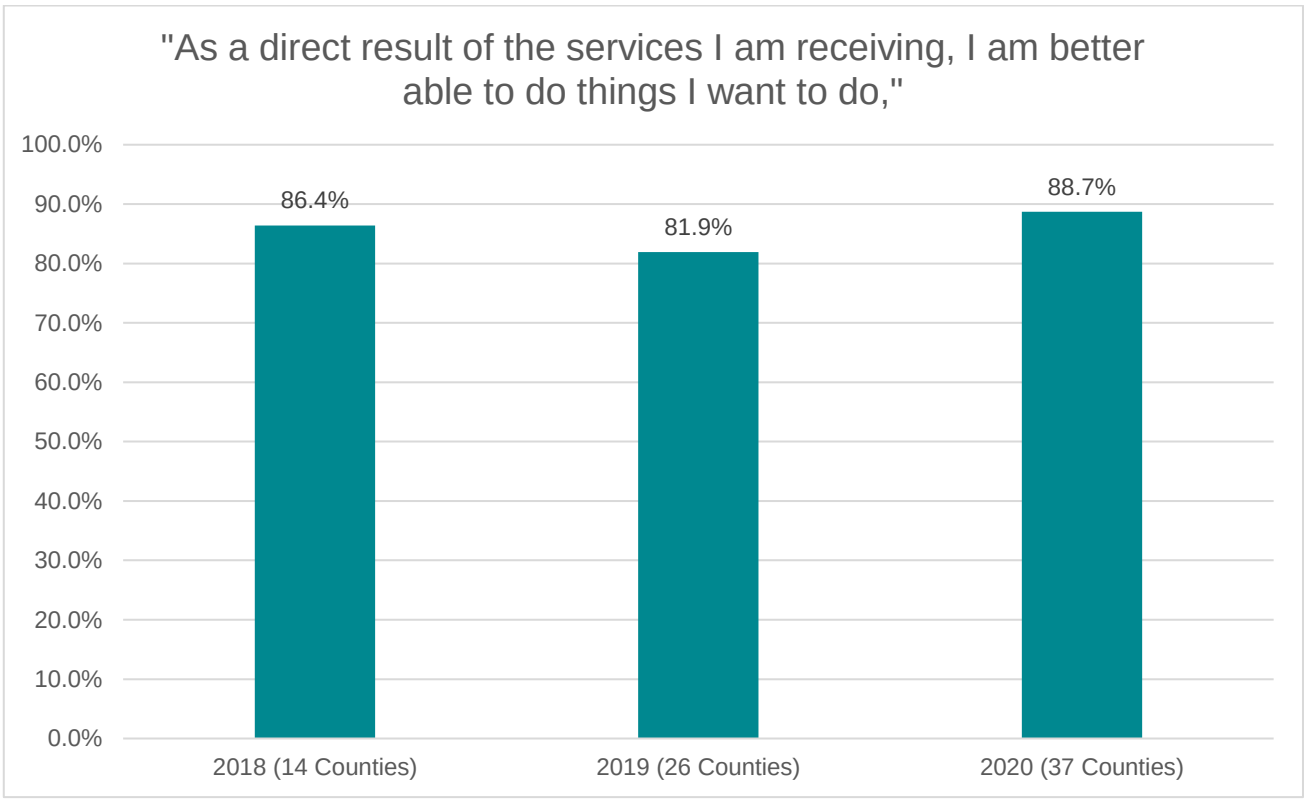
Outcomes from 2017 to 2021

TPS Findings and Themes

All 30 Counties and PHC (7 counties) participated in the TPS in 2020 and as noted there is one specific question linked to outcomes improvements. Results are reflected on Figure 7-1 below. There was a slight improvement within the Outcomes domain measure overall from 86.1 percent in 2018 to 87.1 percent in 2019. From 2019 to 2020 the percent increased to 88.7 percent with 37 counties participating. This measured whether the program was helping the individual to focus on improved functioning and coping skills.

Survey completion was generally robust, supported by the persistence of county staff.

Figure 7-1: Percentage of Clients in Agreement with the Outcome Domain of the TPS, CY 2020



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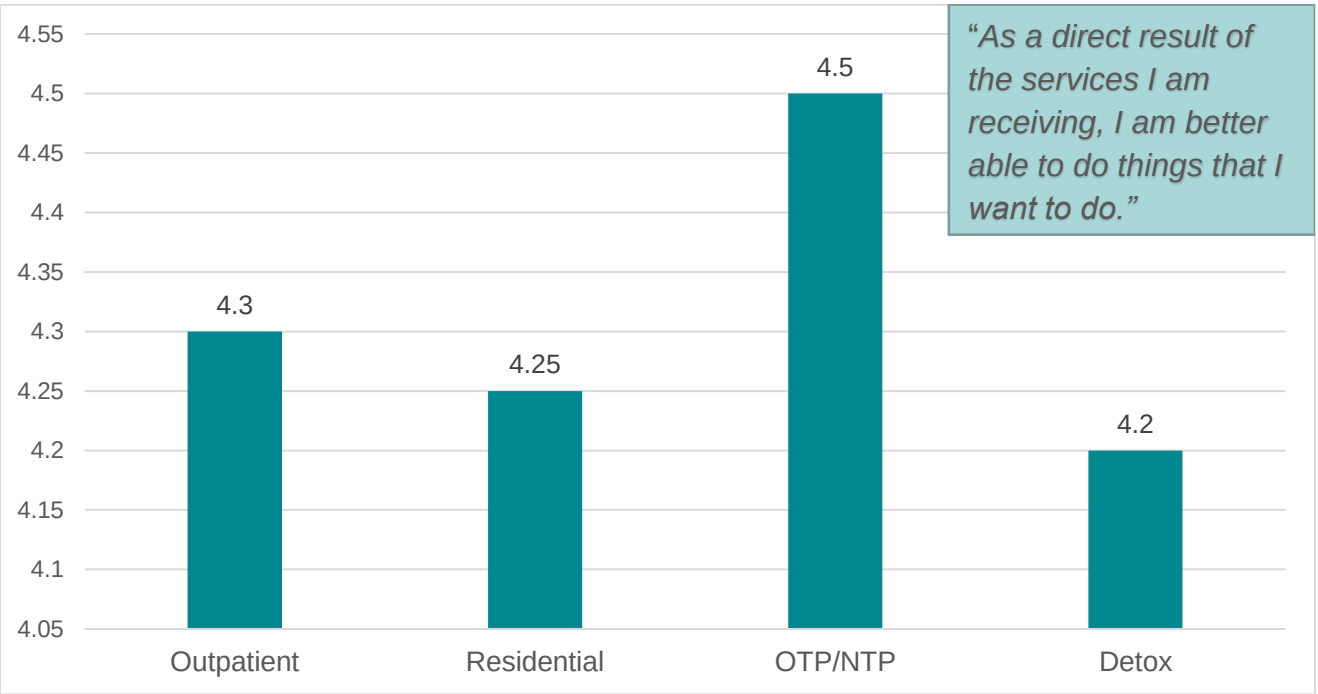
In 2020, 30 counties and the Regional Model participated in the TPS.

TPS Outcome Finding by Level of Care/Treatment Setting

The TPS results show that clients were consistently positive about the outcome of care, with some variance noted within the LOC with longer treatment programs doing better, as shown in Figure 7-2.

Figure 7-2: Mean Scores from TPS of the 0-5 Scale Regarding Favorable Client Responses on the Outcome Domain, Segregated by Treatment Setting



MAT services received the highest outcome marks from clients.

It is important to note that during this review cycle, CalEQRO found that while TPS results on perception of care showed some variations in the mean score for satisfaction regarding the Outcomes domain, such variance by treatment setting may be accounted for by individual factors by site or county.

The outpatient and NTP programs often had longer LOS in treatment and more time to engage and make substantial changes in lifestyle and health. This trend of longer LOS influencing better outcomes has been regularly sited in research studies compiles in the "The ASAM Principles of Addiction Medicine" (fifth edition, Ries, Fiellin, Miller, Saitz, 2014, Wolterwer Pub.).

Retention in Care Findings and Implications

Total time a person stays engaged in treatment, or the retention in care PM, is a measure applied only for counties in their second to fifth years of the DMC-ODS Waiver. This measure tracks participation in services across the entire continuum of care; clients must have at least one billable visit per 30 days to have their retention continue for that month.

The percentage of clients who are retained in treatment beyond 90 days has increased for the Pioneer Counties reviewed, which would likely be a positive factor in improved discharge status with treatment progress, transitions to other LOCs, and reduction in client elopement. This is a minor increase on average; as a new measure for DMC-ODS plans, but it is promising. As systems mature and the longer-term DMC-ODS clinical services expand to serve more clients (RSS, recovery residence housing, and ongoing MAT), it is the goal of many counties to see these long-term systems of support extended for clients after they are stable, but also to continue to be available for setbacks and to assist with stabilization treatments whenever clients need them.

Improving retention requires motivational engagement at three stages:

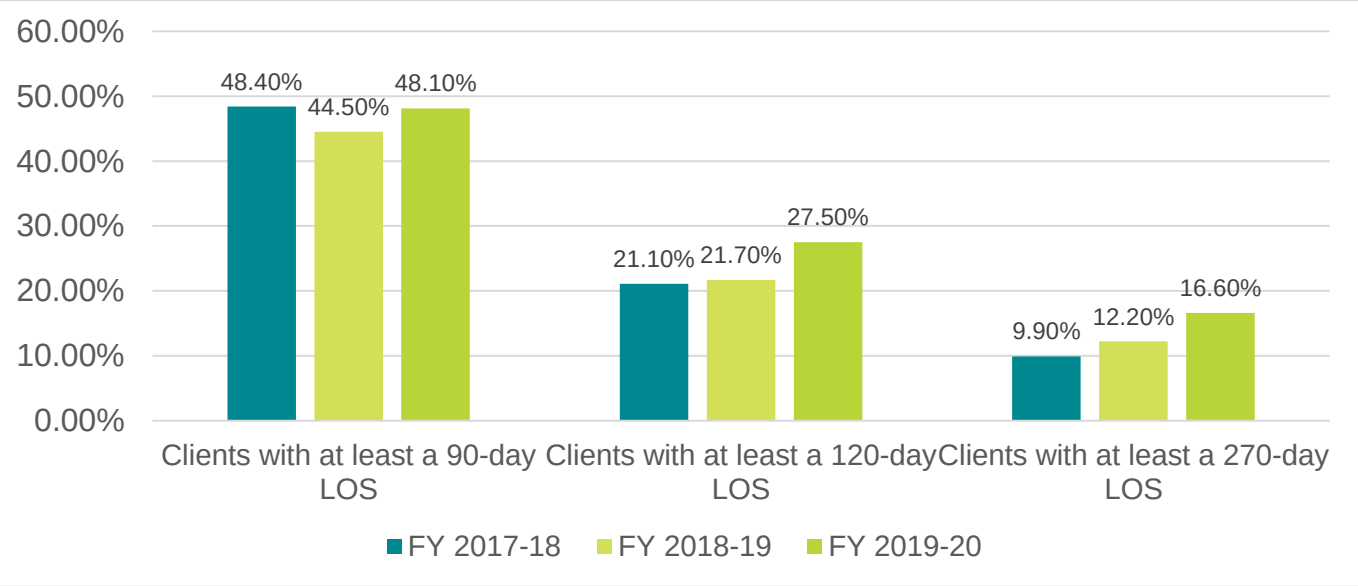
- Engage in initial level of care
- Engage for transitions in the system of care
- Engage in recovery support

Care coordination is the "glue."

MAT assists with retention and is associated with better outcomes.

Figure 7-3 illustrates Client Average LOS in Treatment. The LOS indicates engagement in treatment at any DMC-ODS LOC.

Figure 7-3: Client Length of Stay, Pioneer Counties FY 2017-18, FY 2018-19, and FY 2019-20



The CMS-mandated average LOS limits on residential treatment, which were included in all state Waivers for SUD services, are managed by most counties authorizing residential admission in no more than 30-day increments, each requiring an ASAM assessment and utilization management clinical review. The average residential LOS for most counties is in the

32-40-day range, but many are not yet billing for their residential WM services and others are adding these services because they do not have enough capacity.

Transitions in care, an important PM, reviewed in the Quality chapter of this report, are still low, generally affecting fewer than 25 percent of residential care clients. These two factors—decrease in authorized residential treatment days and low transition in care rates—contribute to the decrease realized in clients with the 90-day LOS. There was a slight increase in clients LOS at the 180- and 270-day lengths of stay. When MAT and NTP/OTP clients engage in treatment, they generally remain for 150 days or longer.[16]

Research indicates longer lengths of stay in treatment produce positive treatment outcomes including sustained abstinence and improved functioning in health and self-sustainability domains.

Research indicates these longer lengths of stay produce more positive treatment outcomes, including sustained abstinence and improved functioning in health and self-sustainability domains.[17]

CalOMS Findings and Themes

There were improvements overall from FY 2017-18 to FY 2018-19 in Standard discharge ratings indicating positive progress for clients in treatment for DMC-ODS. The results by county were not as clear or consistent from FY 2018-2019 to FY 2019-20 and into 2020 depending on when counties were reviewed. With the pandemic, required program changes to telehealth and other limitations, and external stressors for clients, this is not entirely surprising. County results varied quite a bit in terms of positive discharges and administrative discharges during the last 18-month period.

In the past review year, some of the counties that are not achieving the outcomes they desire have designed and implemented PIPs to increase client engagement and retention, anticipating measured improvement in the CalOMS discharge ratings. In some counties, PIPs were narrowly focused on a treatment subpopulation, such as only those who enter outpatient programs (San Luis Obispo), SUD clients who are physically disabled (Los Angeles), or individuals with co-occurring mental health disorders (Orange County). Additionally, several counties have begun to expand their QI initiatives beyond the mechanics and compliance areas of the DMC-ODS Waiver and into those with a more clinical and outcomes measures, including CalOMS.

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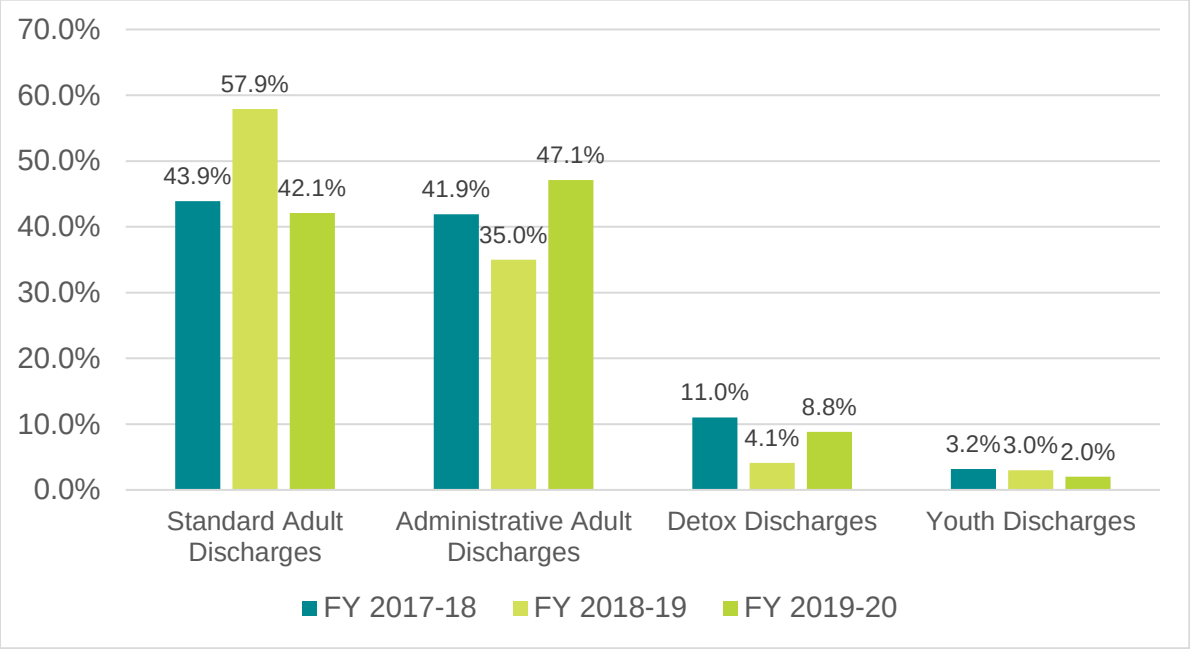
[16]Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS): 2012. Discharges from Substance Abuse Treatment Services. BHSIS Series S-81, HHS Publication No. (SMA) 16-4976. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[17]Thomas McClellan, et.al., Can Substance Use Disorders be Managed Using the Chronic Care Model? Review and Recommendations from a NIDA Consensus Group A., Public Health Rev. 2014 January; 35(2).

Figure 7-4: CalOMS Standard Discharge Progress in Treatment from FY 2017-18 to FY 2019-20 in all DMC-ODS Counties



CalOMS Outcomes Findings

Administrative discharge ratings indicate a positive reduction in client elopement and likely correlate with both an improved level of retention and planned exits for clients from treatment in FY 2018-19 compared to FY 2017-18. However, in FY 2019-20 the numbers of administrative discharges increased overall which shows more elopements and less completions. Since many services were done virtually this may have not been as engaging a form of services especially with the stress of the pandemic and more individuals did not find it meeting their needs. Standard discharges which show progress and completions were down and so this also indicates it was a difficult year and it was the beginning of the pandemic.

While data collected from the CalOMS discharge summary form show that DMC-ODS counties use the administrative rating option just over one-third of the time (limiting the value of the outcome data for episodes so rated), the reduced usage and percentage from 41.9 percent to 35.0 percent shown in Figure 7-4 does indicate that DMC-ODS counties focused more attention on planned discharges in FY 2018-19 over FY 2017-18. With the increase in standard discharges from 43.9 percent to 57.9 percent noted above, programs and the DMC-ODS counties now have a more complete understanding of the clients' progress in treatment. Summary exits by clients without notice and registered as an administrative discharge are of great concern in SUD treatment, indicating poor performance in engagement and suggesting more effort is needed to address vacillating client motivation. The research literature notes that

those clients who persist in treatment transition have better long-term outcomes than those who leave prematurely.[18]

Without prior notification of a client's intent to exit, no discharge interview is possible, limiting the value of the data that are registered under the administrative discharge summary and all but eliminating the opportunity to maintain the beneficiary's engagement at some level in the system of care. An ability to secure more immediate impressions of current state data from the reports once available from CalOMS through ITWS would reduce the burden on individual DMC-ODS counties. Contemporaneous visibility would create both a systemwide and site-specific baseline from which to effect local changes.

The DMC-ODS system must, have the analytic and EHR resources to capture and analyze CalOMS and similar data to use it for quality improvement for SUD outcomes.

CalOMS Outcomes Findings: Satisfactory Discharges from Care

While the discharge status ratings found in Table 7-5 varied widely both for specific counties and individual programs, overall program effectiveness has improved year over year in terms of the reduction of unsatisfactory and administrative discharge until this last eighteen-month period. A noteworthy distinction between the two FYs represented in Table 7-5 is that FY 2018-19 includes the addition of 12 first-year DMC-ODS counties. First-year counties have near-universal program and data challenges that are consistent with implementation for declines in standard discharges. Table 7-6 and Table7-7 both show negative trends in this last year with progress ratings in terms of discharge ratings with progress. Administrative ratings which relate to early elopement from programs and not completing treatment or letting staff know you plan to leave. Given the last 18 months were dominated with COVID-19 and the increase in synthetic opioids and methamphetamines in California, it is not surprising to see such mixed results and the results have been more difficult to ensure reliability and consistency of application and use by staff.

[18] University of California at Los Angeles (UCLA), Integrated Substance Abuse Programs (ISAP). Final Report of the 2001-2006 SACPA Evaluation, prepared for the Department of Alcohol and Drug Programs, California Health and Human Services Agency. UCLA, ISAP April 2007. Available from: http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf

Table 7-5: DMC CalOMS Discharge Status Ratings, Year-to-Year Comparison

Discharge Status	FY 2017-18	FY 2018-19	FY 2019-20
Completed Treatment - Referred	22.7%	19.3%	17.6%
Completed Treatment - Not Referred	7.8%	6.3%	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	11.1%	13.1%	14.8%
Left Before Completion with Satisfactory Progress - Administrative Questions	8.1%	7.1%	7.6%
Subtotal	*49.7%*	*45.8%*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	16.5%	14.6%	14.4%
Left Before Completion with Unsatisfactory Progress - Administrative	32.1%	38.2%	38.6%
Death	0.2%	0.2%	0.2%
Incarceration	1.5%	1.2%	0.9%
Subtotal	*50.3%*	*54.2%*	*54.2%*
TOTAL	**100.0%**	**100.0%**	**100.0%**

Figure 7-6: Positive and Negative Discharge Rates, All DMC Counties, FY 2017-18 to FY 2019-20

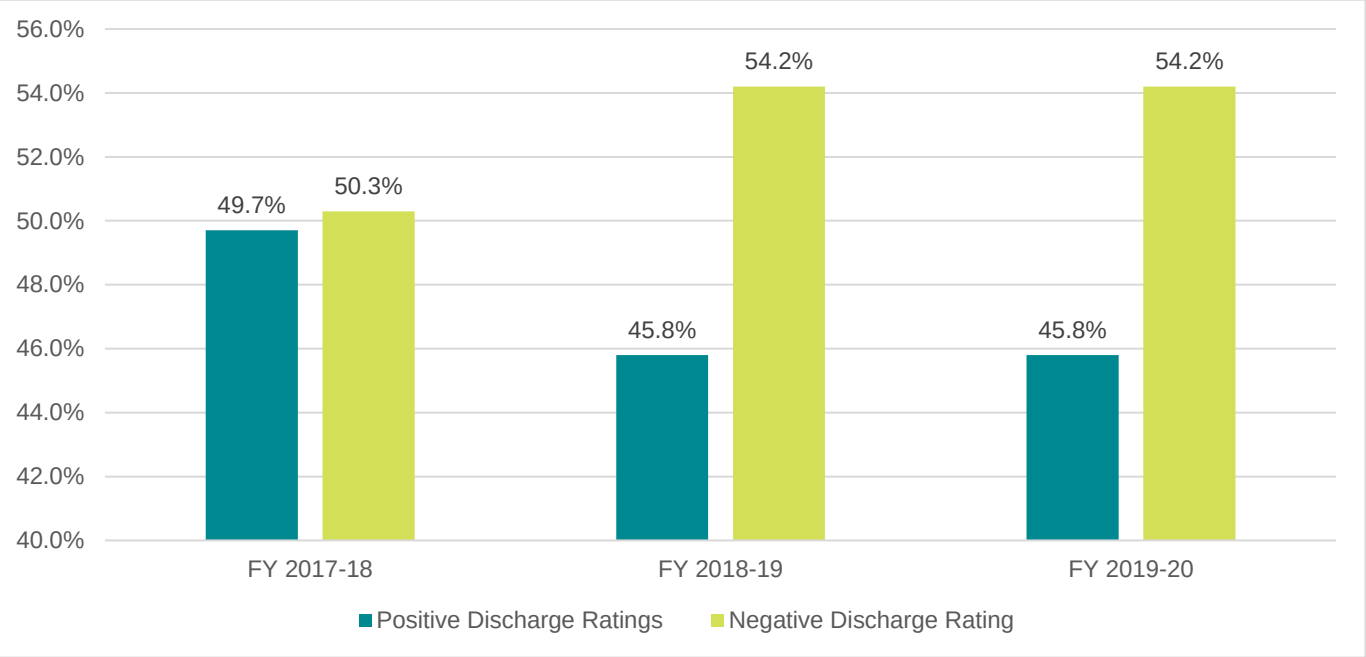
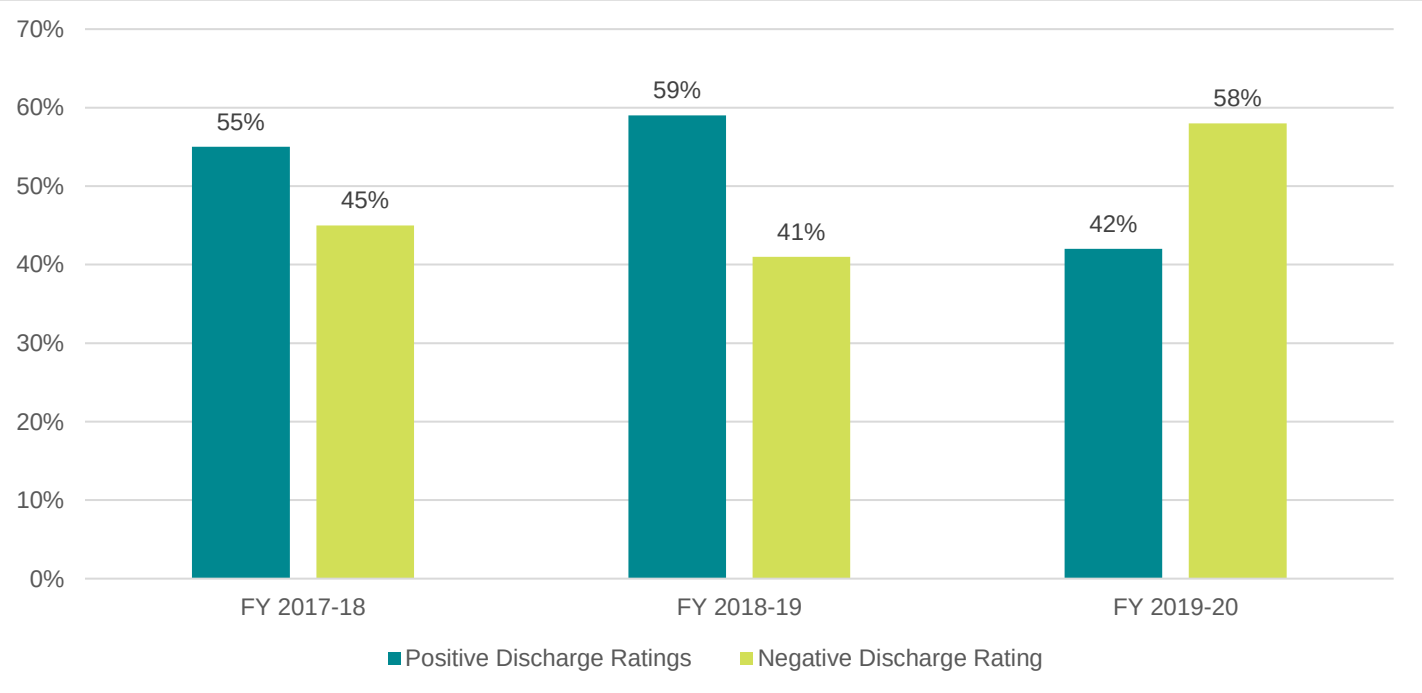


Figure 7-7: Positive and Negative Discharge Rates, Pioneer Counties, FY 2017-18 to FY 2019-20



Pioneer County CalOMS Experience with Discharge Outcomes Findings

In year-over-year comparison data from CalOMS, 12 of the original 14 DMC-ODS counties saw improvement in standard discharges during FY 2019-20 year of the Waiver as well as a reduction in unsatisfactory and administrative discharges. Only two counties did not see either stability or improvement and all 14 were over the statewide average. However, they were exceptionally large counties, and the numbers shifted the totals in a negative direction overall compared to the prior year.

In the aggregate, it is apparent that DMC-ODS counties in their third or fourth year of Waiver implementation benefitted from moving out of the implementation phase. This allowed them to focus more intensively on clinical efficacy. As noted above, while CalOMS outcomes data for FY 2018-19 indicate a decline in standard client discharges for the entire cohort of 26 DMC-ODS counties reviewed in that year, clearly some overall improvement is apparent when looking at counties that have become more experienced in the Waiver's managed care environment. In addition to the areas of engagement, retention, system navigation, case management, and discharge or LOC transition planning, it is likely these second-more experienced counties also have taken steps to improve data collection, submissions, service capacity, client-centered ASAM skills, and overall integrity.

Based on CalEQRO review data, results from these efforts do vary widely between the different DMC-ODS counties. Riverside works with counseling staff on continuous updates so that discharge summaries are based on current clinical information and can assist them in avoiding administrative designation. Overall, the challenges of the significant level of change required under the Waiver cannot be minimized. As the entire cohort moves past the very consuming aspects of systemwide implementation, improved outcomes should be anticipated.

Experience counts. Counties with 3 to 4 years DMC-ODS experience showed the most improvement in increasing satisfactory outcomes.

In summary, best practices to yield impacts in CalOMS include working to support clients through the treatment process with engagement and relevant goals to their individual treatment needs and desires, planning early on transitions and next steps, education on the nature of the chronic disease of addiction, offering assistance of MAT where possible for cravings, using science to become a true partner in wellness and empowerment of the client in their journey of recovery, and documenting this in the discharge status in CalOMS with regular training and feedback to programs.

Outcome Strengths: What is Working?

In the few DMC-ODS counties that have functional data and IS, visibility of CalOMS data enhances their capacity to make adjustments to procedures or programs. In most cases, there are positive indicators that retention and standard discharge rates are improving, as is confidence in data reliability. Likewise, an intentional local plan to manage data and reduce errors, omissions, rejected files, or large numbers of unreconciled CalOMS rejections have made targeted improvement strategies possible and effective.

TPS

The universal, statewide application of the TPS in DMC-ODS counties, much like CalOMS, allows comparisons of results across counties and among providers within counties. Even though the survey questions are broad in scope, variance in response results is a useful indicator for which programs are doing well, in which domains, and which programs need assistance.

UCLA also provides the counties in the analysis with a high-low comparison by domain, with outliers identified by program site. This makes it easy to identify areas needing improvement by program site, themes, and types of programs. The prompt analysis and return of data to the counties allow for actions to be taken to improve services in a meaningful way and to engage providers while issues and feedback are fresh.

Retention

Over the time from 2017 to present, improvement strategies that focus on providing system engagement, navigation, and linkage are consistently being reviewed and are the focus of improvement efforts. The analysis of data provided to CalEQRO indicates that the percentage of clients with LOSs longer than 90 days has increased over the four years of clinical service delivery. This shows efforts to retain clients so that they are more likely to stay, which increases the likelihood that they remain in treatment over a greater period of time and transition or complete treatment with satisfactory status.

Counties that have incorporated self-feedback loops, conducted outcome analyses for program staff, and continue to make case management and recovery supports available to clients have done better with enhancing continuity of care. Expanded MAT use also seems to correlate with those clients who are having longer lengths of stay and engagement across multiple LOCs. As an EBP, MAT both methadone and non-methadone are playing a bigger role in treatment and seem to be adding more ongoing stability, structure, and focus to the recovery process. It appears based on the data that the clients with case management services are doing better with completion rates, especially those with co-occurring diagnoses. Also, satisfaction rates with case management services based on client focus groups feedback and surveys given in groups is high.

County Provider Feedback for Improving Outcomes

Prioritize and standardize CalOMS staff training at County levels.

Adherent CalOMS data collection that is both timely and accurate varies greatly by county, which affects data quality. At present, training, and oversight in CalOMS administration varies between or within county programs, though some DMC-ODS counties have prioritized providing training and providing technical assistance to providers. Where and when DHCS makes changes, those trainings should be standardized as well.

Detailed analyses of county and program-level data are needed to guide system improvements.

DMC-ODS counties are interested in improving the awareness and utility of this data set to improve it and link it more closely to ASAM LOCs. The CalOMS data can be of use to counties whose QI plans currently lack measurable goals and whose are clinical in nature. Restoration of the state reports for CalOMS is recommended, alignment of the CalOMS structure with the ASAM LOC, and funds for HIS infrastructure in general for SUD health information development are needed.

Data reporting capability by DHCS to counties for CalOMS should be prioritized for restoration to enhance quality.

When DHCS moved CalOMS to the new system repository, the menu of existing reports was made unavailable. While the new system has recently allowed for some local access to CalOMS, data extraction has been problematic since the shift to the new reporting system in 2019. Improved access and reporting flexibility would provide more utility to the data counties have collected and provide them with an essential tool in a managed care environment. Counties and individual providers have consistently expressed that lacking access to CalOMS reports impedes their ability to fully understand QI needs at both the system and provider levels. Local IS resources are universally low and supports would be needed should reports become more available to the DMC-ODS.

Also, counties and providers have asked for a simplified version of CalOMS linked to ASAM LOCs and without as much paperwork burden for repeated admissions and re-admissions which can happen quite rapidly between LOCs to simplify this process and support it being more accurate.

It was noted by counties and providers that many DHCS collected reports and requests are duplicative and become burdensome. A recommendation for alignment and possibly integration of these data set requests and data sets into a data warehouse to make them more efficient and streamlined might allow DHCS and the Counties to achieve the goal of quality and accountability but reduce data duplication burden.

Challenges in Outcomes Data Access

Many counties would like to measure more concrete events linked to positive outcomes such as achievement of stable housing, jobs, arrests, and educational success as well as drug behavior to measure treatment success. Finding ways to access more indirect data to see these meaningful social data markers was of interest to many providers and counties. Perhaps a joint taskforce on the goal could be considered as they are clearly meaningful social events which communities' value as well.

Other tools such as HEDIS and CAPHS having more focus on behavioral health measures and questions were important as well and allow for comparison. The challenge with these was the current HIS infrastructure particularly at the provider level and smaller county level. In the work linked to quality the weak infrastructure of the HIS and workforce keep coming up repeatedly, but they are both real and major challenges to be addressed.

TPS

Boost TPS response rates among subpopulations at all program levels to fully represent beneficiaries to enhance benefit of findings.

While the TPS surveys are administered annually and completed and analyzed as required, wide variability in the patterns of response rates continues. Not enough minority groups are represented or youth or non-English speakers. Some DMC-ODS counties show a significant percentage of TPS response in specific LOCs and not others. Programs with a prominent level of daily client volume, such as NTPs, are often over-represented, while some out-of-county programs are not surveyed at all. Similarly, obtaining samples that reflect the linguistic diversity of a county appears to be a nearly universal challenge, as Spanish-language TPS often represent just a small percentage of the total annual surveys returned within a given DMC-ODS data set—even if a large number of the physical surveys were provided to SUD program sites.

Retention

Prioritize and standardize retention and engagement strategies.

Process improvement strategies that track and address indicators of a looming retention problem (such as no-shows and cancellations) would likely lead to better understanding of client retention. DMC-ODS counties should consider setting local standards to establish baselines by which to measure improvements in their strategies for engagement and retention.

Seek client feedback to identify barriers on an ongoing basis by location, age, and ethnic group.

Individual DMC-ODS counties have taken significant steps to identify and address barriers to improve persistence in treatment. This has included drilling down on specific program issues, such as hours of operations, easy access, and transportation. Some counties have worked to secure client feedback and used it to guide either program or system adjustments. In tandem with the clinical tools that are provided to staff, such as motivational interview training and workflow strategies that allow them to have easy access to performance data, client feedback can have a real impact on engagement, retention, and related outcomes. Research clearly shows a 90-day LOS for clients correlates with positive clinical outcomes, reduced costs to healthcare systems, reduced criminal justice involvement, and improved housing security. Active use of client feedback to measure program performance and therapeutic engagement can be effective in reducing premature drops out of treatment and provides mechanisms to re-engage clients who have left or have different needs.

Lack of focus on individual treatment needs

Most clients receiving care continue to stay for the traditional 90 days, not reflecting individualized treatment. While the levels of those 90-day stays are somewhat lower in the most recent review cycle, it is important to note that despite adoption of the ASAM placement criteria and improved movement of clients across the treatment continuum, many programs continue with a fixed 90-day program driven models and benchmarks. This holdover to the 90-day model may be due to individual hesitancy of staff, programs, or even primary referral sources such as criminal justice. Nonetheless, for treatment to be individualized and truly meet individual needs, letting go of fixed LOS and program models is needed. If paperwork requirements and fiscal rules and incentives were creating barriers for individualized care, these disincentives should be examined. Also, transitions to recovery housing for those who have no stable housing has been viewed as a reason to keep many in residential treatment, but this is not productive, and the core issue would be better addressed in other ways.

As more tools are in place to track outcomes in a science-based, measurable way, showing reduced symptoms, enhanced functioning, and goals being met to allow a return to life, the clearer the benefit of SUD treatments will be.

In summary, outcomes are an evolving area for SUD treatment and additional research tools are needed to look at outcomes in a more comprehensive way. The recommendations above will enhance the tools that are available now, but the long-term goal is a set of interventions and treatments linked to improvements in physical health, employment, educational achievements, reductions in criminal activities or recidivism, and positive family/social outcomes. These are more complex, but worth continuing to strive for to achieve the full benefits of treatment impacts on the lives of those with SUD conditions.

If all or most clients have the same LOS and similar treatment plans, that should be a warning sign that the program is not doing true ASAM assessments and individual treatment or treatment planning and needs re-examination.

Drug Medi-Cal Organized Delivery System External Quality Review

2017-2021 Statewide Report

Information Systems

Information Systems and Quality Findings, Themes, & Challenges

Information Systems

Challenges & Successful Strategies in Organizational Capacity and Infrastructure by County, Regional Models

Introduction

IS played a significant role in the effectiveness and efficiency of public substance use service systems. CMS regulations require EQRO organizations to examine the role of the HIS in DMC-ODS systems, particularly in operations, and the ability to manage the quality of care and efficient operations. These systems have three primary functions: (1) collection and storage of data, (2) analysis of data to support decision making, and (3) assistance with operational business processes. The latter includes quality of care and core operations as a managed care plan and for service delivery if that is also part of the core mission. This is one of the core CMS protocols for EQR, and from 2017 to the present, DMC-ODS programs have worked hard to improve in this area, but many challenges remain.

CalEQRO provides a yearly assessment of each DMC-ODS HIS. For each DMC-ODS annual report, the following major areas are highlighted:

- HIS infrastructure
- EHRs
- Telehealth services
- Use of data for QI

CalEQRO developed the ISCA tool, which can be found on the CalEQRO website (www.CalEQRO.com). The ISCA is an evolving document, normally updated yearly to reflect the evolution of DMC-ODS with respect to changes and enhancements, data collection, and regulation changes. The ISCA also examines financial, business, and clinical areas as they relate to IS. This is based on one of the CMS federal protocols for EQR. For this 5-Year Report on DMC-ODS, it is important to start with the fact the SUD system was funded primarily with federal block grant funding and a modest amount of Medi-Cal directed primary at a limited set of benefits which was shown before in the Access Chapter, outpatient and methadone services, and some perinatal residential. All of the Medi-Cal services had many restrictions,

and they were not organized into any type of cohesive system. They were silos of care mostly contracted out to a variety of providers statewide either through the state or counties.

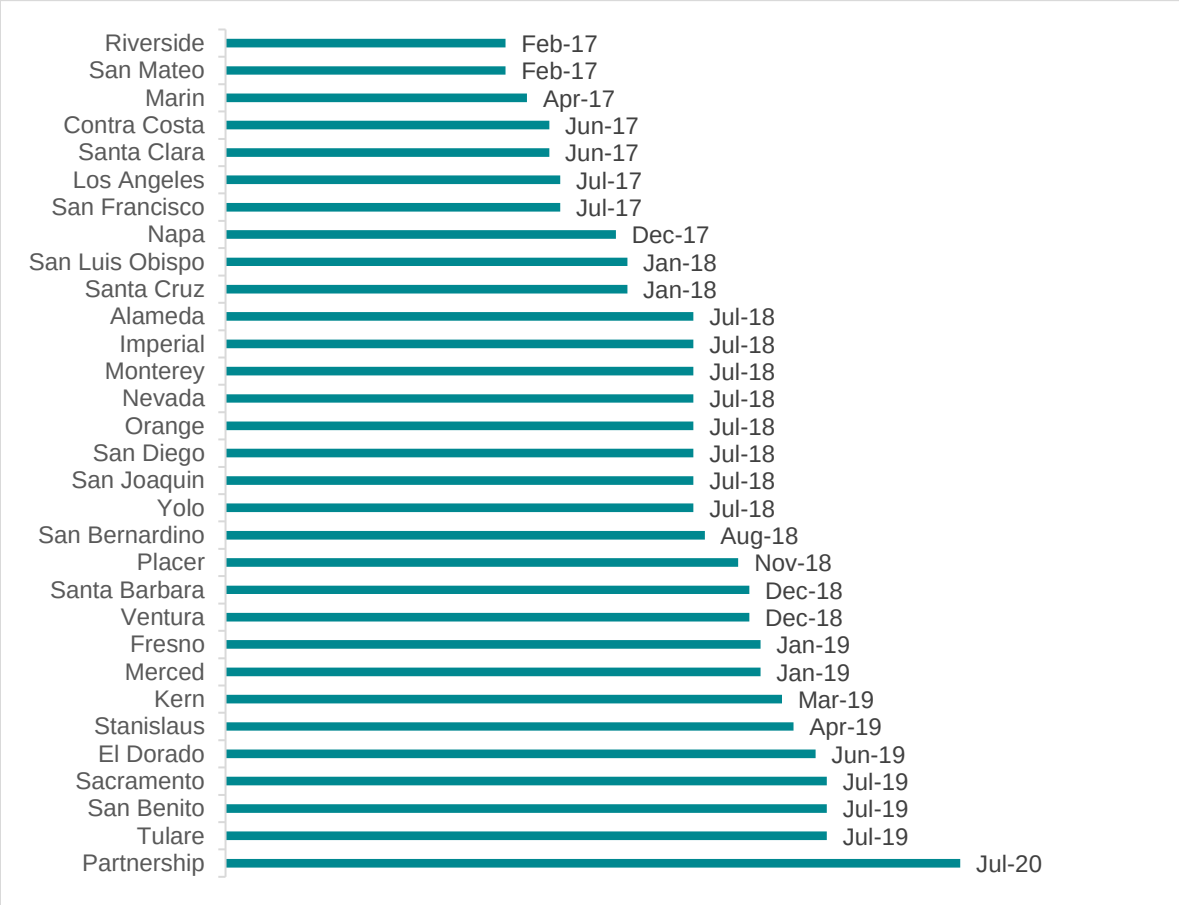
How Structure and Operations Affect Quality

The structure and operations of an organization includes many key elements of support linked to quality. These are described below for each area of the results.

The ISCA commonly requires input from multiple areas of the organization, such as IT/IS, Finance, Operations, and QI subject matter expert staff. Responses are returned to CalEQRO before the DMC-ODS review. DHCS data sources are used to assess and include Short-Doyle Medi-Cal (SDMC) for DMC-ODS, the MMEF, ASAM LOC referral data, TPS data, CalOMS, and the Master Provider File (MPF).

This Five-Year Report focuses on ISCA results for the 30 counties and the Regional Model that implemented DMC-ODS between 2017 and June 2021. Their go-live dates were when counties began to deliver client services, as shown in Figure 8-1 below. The report also illustrates trends from the beginning of the DMC-ODS with the original 14 “pioneer” counties that began in early calendar year 2017 and phased in FY 2017-18 and early 2018-19. Below is the chart indicating their start of service delivery for all 30 counties and the Regional Model with seven counties.

Figure 8-1: DMC-ODS Services Go-Live Dates, February 2017 – July 2020



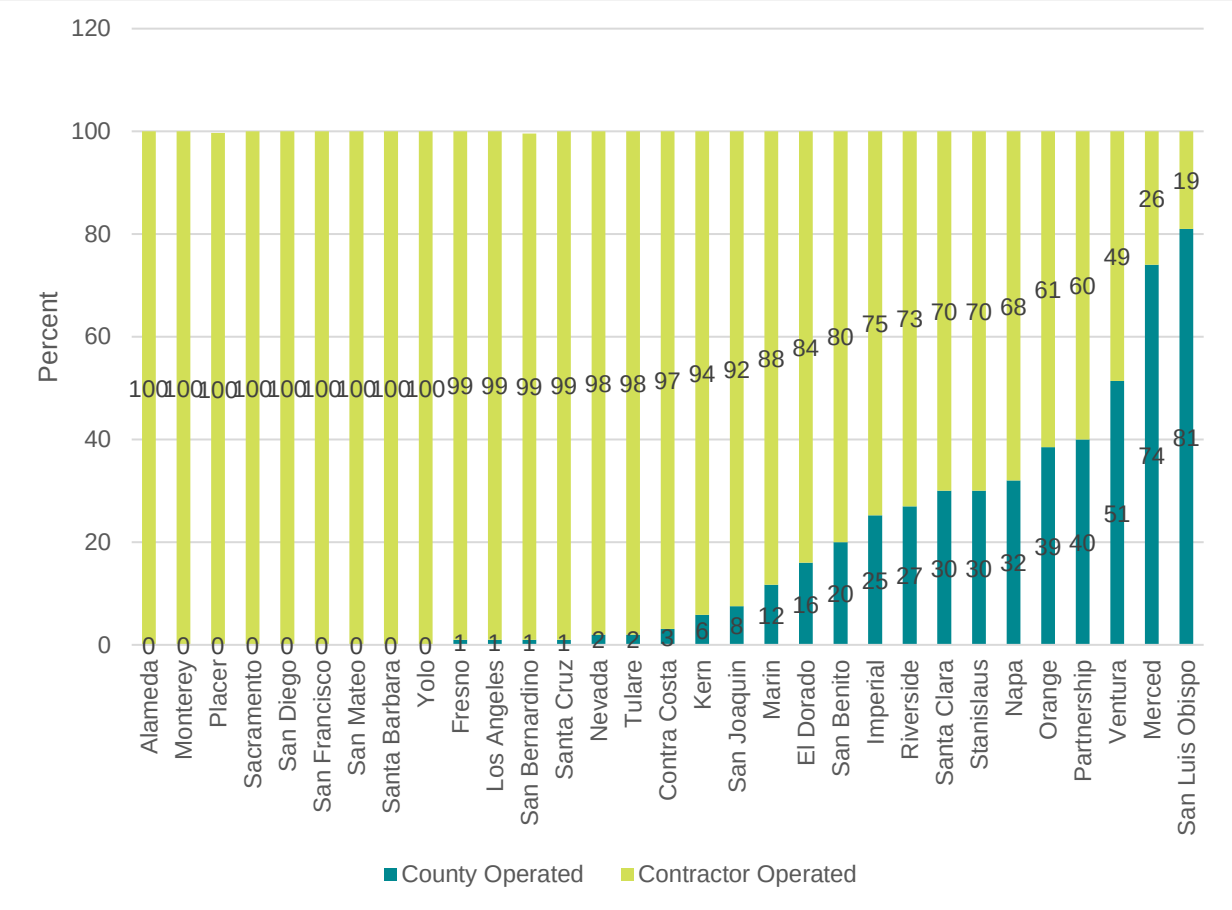
There is a large variance in how SUD services are delivered in DMC-ODS counties, ranging from the 100 percent contractor-operated systems in the counties of Alameda, Monterey, Placer, Sacramento, San Diego, San Francisco, San Mateo, Santa Barbara, and Yolo to 81 percent county-operated in San Luis Obispo. The results were based on a single point-in-time estimate prior to the most recent CalEQRO review and may have changed since then.

Mixed systems have additional flexibility to meet community needs, but also face challenges in terms of needing more integration of systems, information sharing, and communication.

Mixed systems seem to have additional flexibility to meet different community needs in a more rapid fashion, but also face challenges in terms of needing more extensive integration of data systems, information sharing, and communication between county and contractor data systems, though all need this to some extent. These challenges can be overcome with strong positive leadership, teamwork, and interoperability HIS. Figure 8-2 summarizes county-operated versus contractor-operated DMC-ODS services. This structure also has

implications for how you design and set up clinical care systems as well and maintain clinical oversight and care management.

Figure 8-2: County DMC-ODS-operated versus Contractor-operated DMC-ODS Clinical Services



Many factors play a role in how counties deliver DMC-ODS services: providers availability, geography, system of care infrastructure, workforce availability, resources, and implementation approach.

The number and size of the organizations in the provider network can also play a key role in the needs of each county's IS and the level of complexity needed for smooth coordination and communication systems. Core areas where communication is critical for quality and business functions include clinical care, claims, intake and assessment functions, case management, and transitions in care. It is also not unusual for contract providers to use multiple different computer systems to provide both practice management and EHR functions that can be different from each other and different from the County DMC-ODS as well as the local health plan and hospital systems.

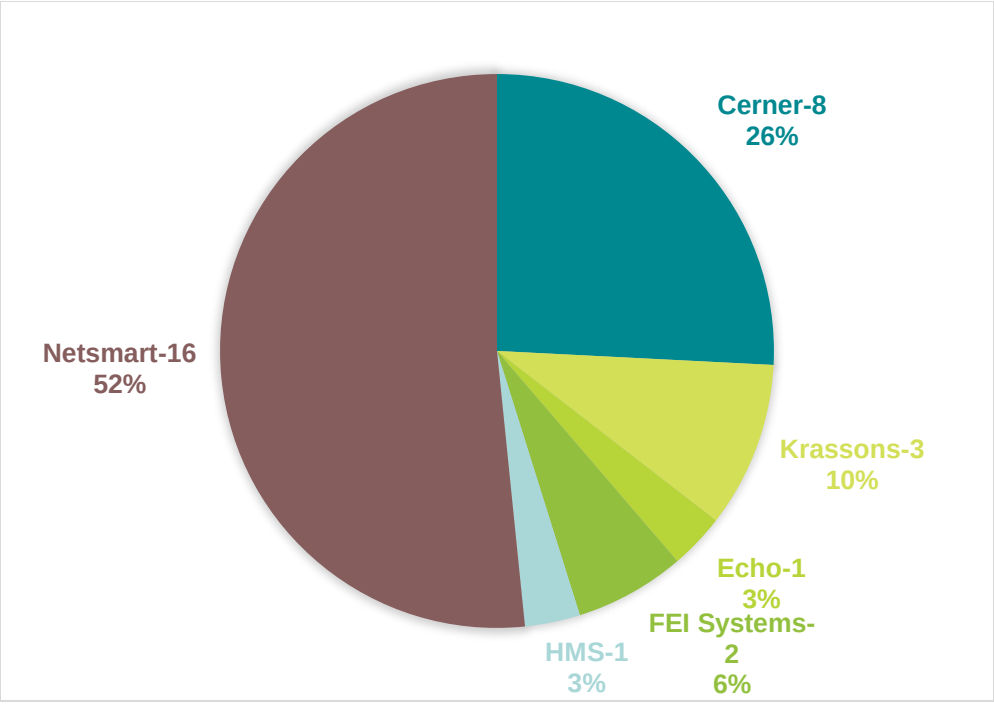
SUD Information Systems by Vendor

California counties have primarily relied on six technology vendors to support health technology in behavioral health: Cerner Corporation, Krassons Incorporated, HMS Healthcare, The Echo Group, Netsmart Technologies, and FEI Systems. This narrow range of vendors is a consequence of California's unique Medicaid claims processing business rules and state-mandated data reporting.

While these vendors continue to modify legacy systems to conform to state and federal data collection and reporting standards, there are few incentives to develop the next generation of EHR systems to improve healthcare professionals' workflow processes and efficiencies for substance use services, or behavioral health in general.

Sixteen counties use Netsmart myAvatar: El Dorado, Fresno, Imperial, Los Angeles, Monterey, Placer, Riverside, Sacramento, San Bernardino, San Francisco, San Mateo, Santa Clara, Santa Cruz, Tulare, Ventura, and Yolo. Eight counties use Cerner Community Behavioral Health: Kern, Merced, Napa, Nevada, San Benito, San Luis Obispo, and Stanislaus; Orange County uses Cerner's Millennium system. Three counties use Krassons Clinician's Gateway: Alameda, San Joaquin, and Santa Barbara. Contra Costa uses Echo ShareCare for practice management. Two counties—Marin and San Diego—use the FEI Systems/WITS. The Partnership uses HMS Healthcare's Essette system for case management/utilization management. With the 1115 Waiver the systems were not prepared for major changes thus the codes were based on existing structures and modifiers used to differentiate new services. Figure 8-3 summarizes DMC-ODS county system vendors.

Figure 8-3: DMC-ODS County System Vendors



Electronic Health Record Hosting

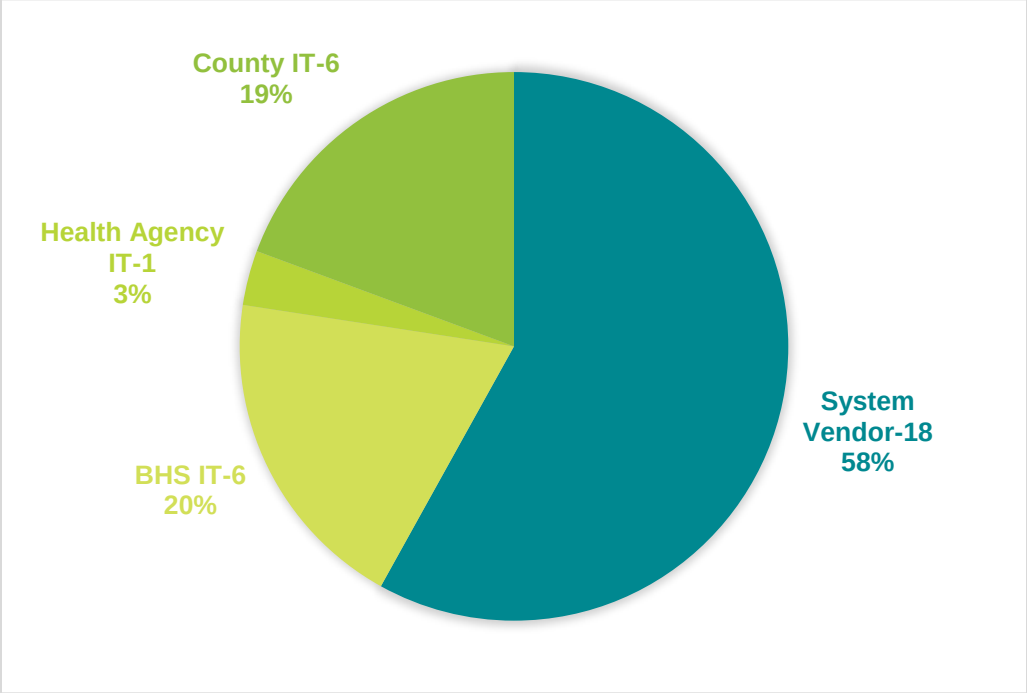
Hosting systems at vendors' sites reduces the need for local information technology (IT) staff to provide 24/7 operational support. System hosting usually includes benefits such as heightened system security, business continuity assurances, and 24-hour staffing by qualified technicians. The changing IT services market also plays a role in counties' system hosting and operation decisions. When the challenges of hiring, training, and retaining qualified technical staff are added to the equation along with the known benefits of vendor hosting, the cost-benefit ratio generally makes for a compelling case.

Eighteen DMC-ODS counties have core systems hosted by vendors, one county has its system hosted by health agency IT, 6 counties have hosting from county IT and 6 counties have hosting from behavioral health IT. Vendor-hosting counties vary in size and include El Dorado, Fresno, Imperial, Los Angeles, Marin, Monterey, Napa, Nevada, Orange, Sacramento, San Benito, San Diego, San Mateo, Santa Clara, Santa Cruz, Tulare, Ventura, and Yolo counties.

Most counties have implemented, or are in the process of implementing, a system that has core components that support EHR functionalities for DMC-ODS (and often mental health services as well). But few counties directly provide DMC clinical care, most have contractors provide this care.

Figure 8-4 summarizes current county EHR hosting status.

Figure 8-4: DMC-ODS County EHR Hosting



Electronic Health Record Replacement or Creation Efforts for DMC-ODS

Orange is implementing Cerner Millennium; The Partnership is shifting its core system to HealthRules Payor System and San Bernardino is implementing Netsmart myAvatar.

Contra Costa, Imperial, Kern, Napa, San Benito, Stanislaus, and Tulare are considering a new system for their behavioral health services.

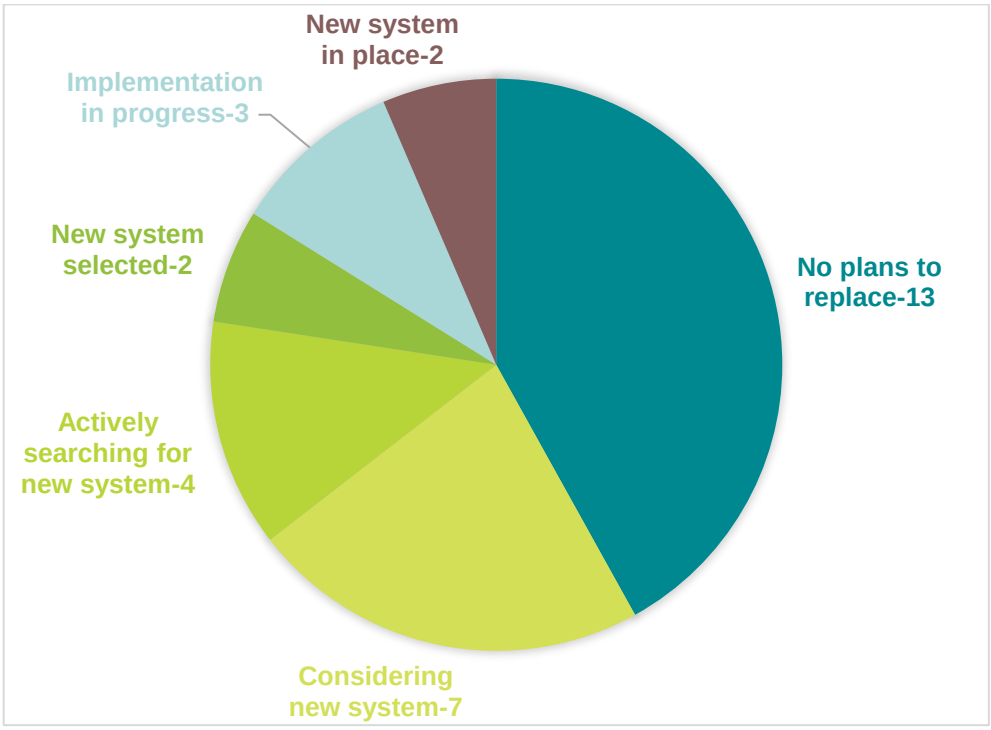
El Dorado, Los Angeles, Marin, Monterey, Placer, Riverside, Sacramento, San Diego, San Luis Obispo, San Mateo, Santa Cruz, Ventura, and Yolo have no plans to change their IS.

Counties that have selected new systems but have not yet implemented them include Alameda and San Francisco. San Joaquin has integrated ShareCare with Clinician's Gateway and Santa Clara has switched from Cocentrix Pro-Filer to Netsmart myAvatar.

Fresno, Merced, Nevada, and Santa Barbara are actively searching for new IS. With the COVID-19 crisis declaration and DHCS delaying the CalAIM initiative until pandemic conditions are resolved, counties need to proceed with caution when searching for new systems.

Figure 8-5 summarizes current EHR upgrade/replacement efforts.

Figure 8-5: DMC-ODS County EHR Replacement Status



Electronic Health Record Functionality

Collectively, only 69 percent of EHR core functions are present or partially present in county behavioral health systems, which significantly affects staff workflow. It is critical to note that this does not imply that their provider network of contractors have this level of EHR functionality; quite the contrary, as many of the contractors continue to rely primarily on paper medical records. Many continue to struggle with new documentation standards and tracking requirements for timeliness and authorizations.

Only 69 percent of EHR core functions are present or partially present in **county behavioral health systems**, which significantly affects staff workflow.

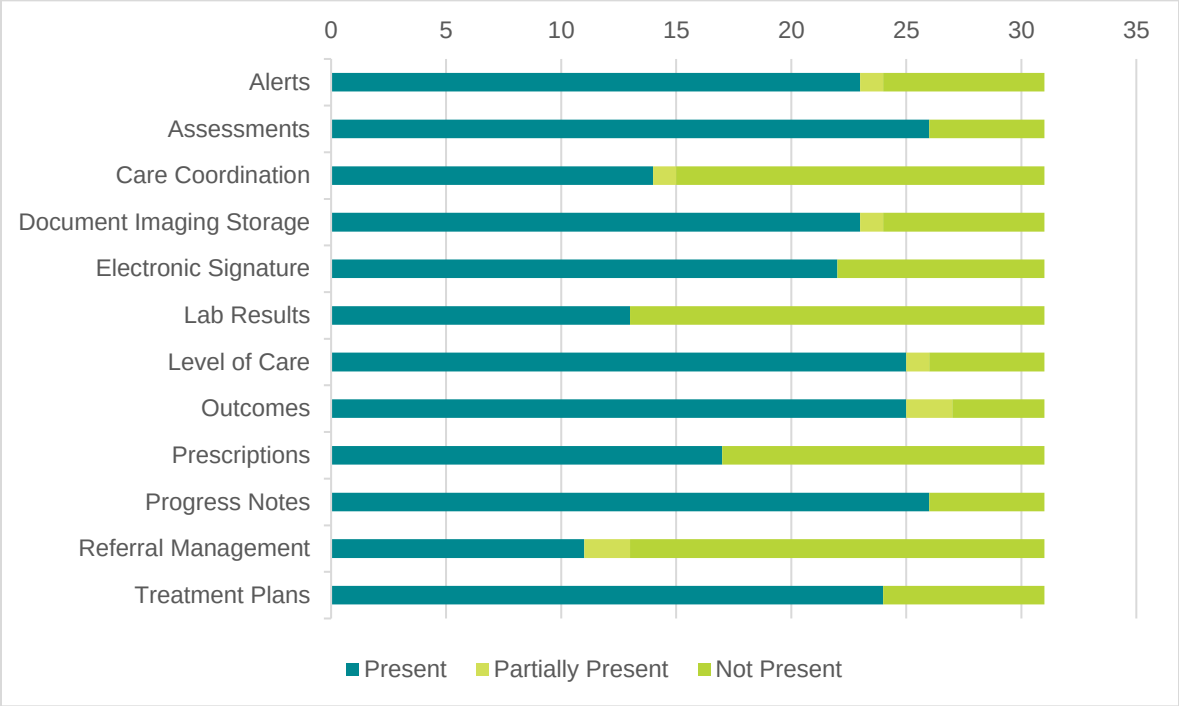
For those contract providers with local EHRs, the ability to electronically exchange client-level clinical transactions with county EHRs is generally lacking or is limited to service transactions for claims. Most contract providers with local EHRs also need to enter practice management data—demographic, clinical, and service information—directly into county behavioral health systems. Double data entry is quite common at this point of the ODS Waiver implementation phase.

Communication on cases, medication refills needed, and authorizations for residential treatment and many other clinical functions often require prompt action for urgent cases. IS are critical to assist in this regard. Current EHR systems generally lack capability to push out alerts to providers electronically; providers do have the ability to produce batch reports.

The majority of contractors continue to rely on **paper medical records.**

As Figure 8-6 indicates, referral management, care coordination and laboratory result functions are generally underused or unavailable in DMC-ODS county EHRs. However, assessments, LOC and outcome tools, progress notes, and treatment plans are present in support of services billing in most systems.

Figure 8-6: DMC-ODS County EHR Functions



Interoperability

Currently, none of the 30 DMC-ODS counties reviewed uses a **Health Information Exchange (HIE).**

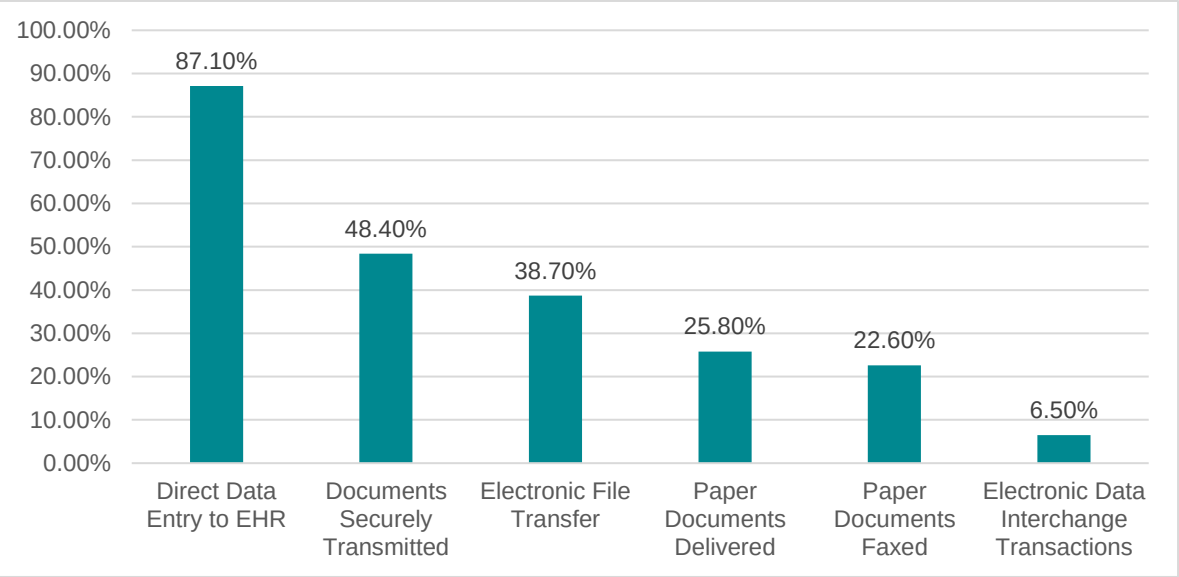
An overarching issue associated with implementing an EHR has been the integration of DMC-ODS services provided by contract providers into county systems. Generally, counties provide contract providers with two or more submittal methods to exchange client information.

Currently, none of the 30 DMC-ODS counties and the Regional Model reviewed uses a Health Information Exchange (HIE) as a primary tool for the exchange of SUD records, which is a more efficient method for a two-way exchange of client data between EHR systems. Special confidentiality requirements for SUD records make this protocol exceedingly difficult. At this point in development, vendors are prioritizing work with the counties to implement core systems for billing and state data reporting requirements. Many expressed a desire to do so but felt the federal confidentiality laws with SUD were a barrier and still in flux.

Figure 8-7 shows current data exchange options available to DMC-ODS contract providers, from EDI transactions to sending documents attached to secured e-mails. Where “Direct data entry to EHR” is noted, it almost always means that contract provider employees are entering the client data into their own EHRs, then logging into the county EHR to enter the same data there. Double data entry is inefficient, generally slows down the availability of data, is an ongoing drain on contract provider resources, and is a frequent source of data entry errors.

Notably, 27 counties (87.1 percent) indicated contract providers enter data directly into county or Regional Model systems.

Figure 8-7: DMC-ODS Data Exchange with Contract Providers



Interoperability continues to pose challenges for most DMC-ODS counties because it requires a level of resources, infrastructure, and skill sets not uniformly available to them. For the time being, for most DMC-ODS counties, some level of double data entry will continue to be required. Some counties still receive paper documents sent by contract providers for input and processing, which continues to be the most inefficient and error-prone option available.

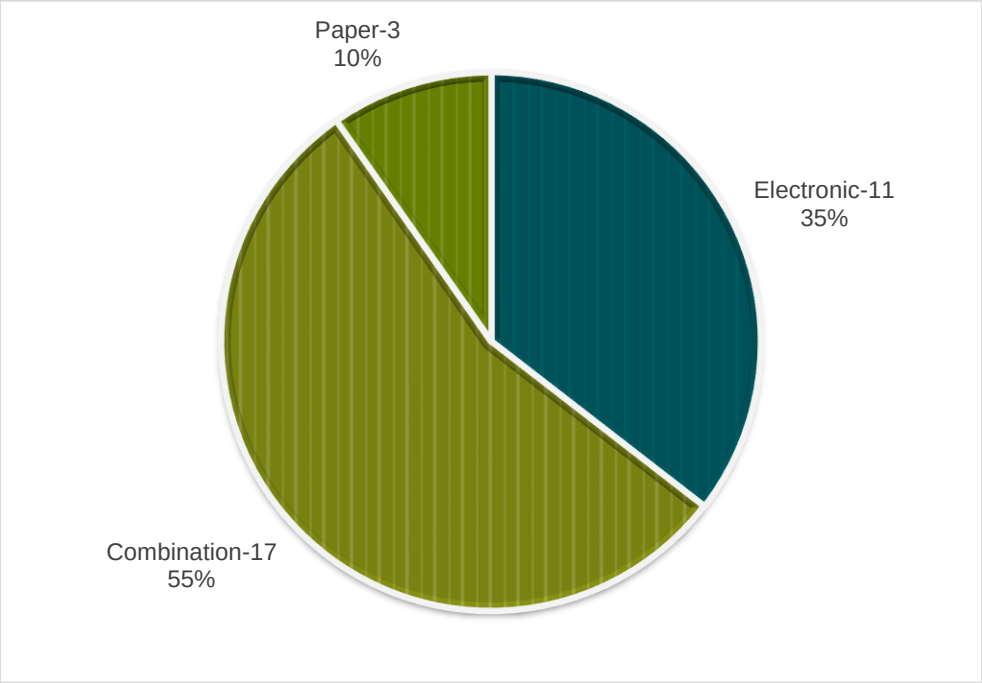
Clinical Health Records

Expanding access to clinical EHRs has slowly been evolving since the beginning of the Waiver as DMC-ODS programs have sought to expand and improve communication with their contract agencies and coordinate care as well as administrative processes. Several counties and the Regional Model have paid to allow contractors to have access to a universal EHR and practice management with the county to create a single coordinated system. Los Angeles and Santa Cruz began this, and others are expanding their systems to include their contractors increasingly. PHC is also helping contractors obtain EHRs to enhance quality and coordination as well. However, as long as providers are using paper records, there are many lost opportunities for improving timeliness, coordination, and communication. These represent real ways to improve care to clients and become more efficient.

Health records are rated functionally as electronic, paper, or a combination of electronic and paper that supports clinical operations. The most efficient method for clinic operations is a fully EHR model. The other two models require providers to initiate requests for a client's health record from a chartroom and review paper record documents along with viewing EHR screens for an overview of the client's treatment history.

Figure 8-8 shows eleven counties that reported having an electronic chart of record: El Dorado, Los Angeles, Monterey, Napa, Nevada, Partnership, Riverside, Sacramento, San Benito, San Mateo, and Santa Clara. Counties reporting paper records are Contra Costa, Fresno, and San Bernardino. Counties reporting a combination of electronic and paper records are Alameda, Imperial, Kern, Marin, Merced, Orange, Placer, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, Ventura, and Yolo. This represents the majority of counties. Discussions with contract agencies showed that the preponderance of paper charts was much higher.

Figure 8-8: DMC-ODS County Chart Environment



It is expected that as ODS evolves, more counties and their networks of contract providers will shift towards electronic charting. An EHR environment supports better communication and coordination of care among providers, including physical health providers. It facilitates the establishment of client portals to help motivate clients to manage their health. It is challenging to support and manage essential quality functions and systems tracking using paper records and maintain ease of access for coordination, supervision, authorizations, timeliness, and more.

An EHR environment supports better communication and coordination of care among providers, including physical health providers, and facilitates the establishment of client portals to help motivate clients to manage their own health.

Budgets Resources for Information Systems

The percentage of the DMC-ODS budget devoted to IS is a simple indicator of the IT resources and capabilities available to support the administration and delivery of SUD services. Although there are no standards for the percentage of the budget devoted to IT, there are literature references of 3 to 5 percent being considered the minimum necessary in health care organizations with a full-featured EHR.

In Figures 8-9 and 8-10, counties are grouped by size into large, medium, and trim for data analysis and discussion, as follows:

- Large (n=13)—Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Ventura.
- Medium (n=13)—Marin, Merced, Monterey, Partnership, Placer, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Yolo.
- Small (n=5)—El Dorado, Imperial, Napa, Nevada, and San Benito.

However, there is more to consider than the percentage of the DMC-ODS budget devoted to the IS. For instance, in a county where the core system is used for more than SUD (such as mental health), it may not be possible to clearly identify the SUD component of the overall system cost. In reviewing the data received in FY 2020-21 ISCAs, situations like this may have affected some of the budget percentages.

Figure 8-9 shows the FY 2020-21 statewide average of DMC-ODS budgets devoted to IS as 2.8 percent, which is lower than the 3 to 5 percent minimum necessary to maintain and improve EHR functionality. Both the medium and small county groups are below 3 percent.

Figure 8-9: Percentage of DMC-ODS Budget Devoted to Information Systems

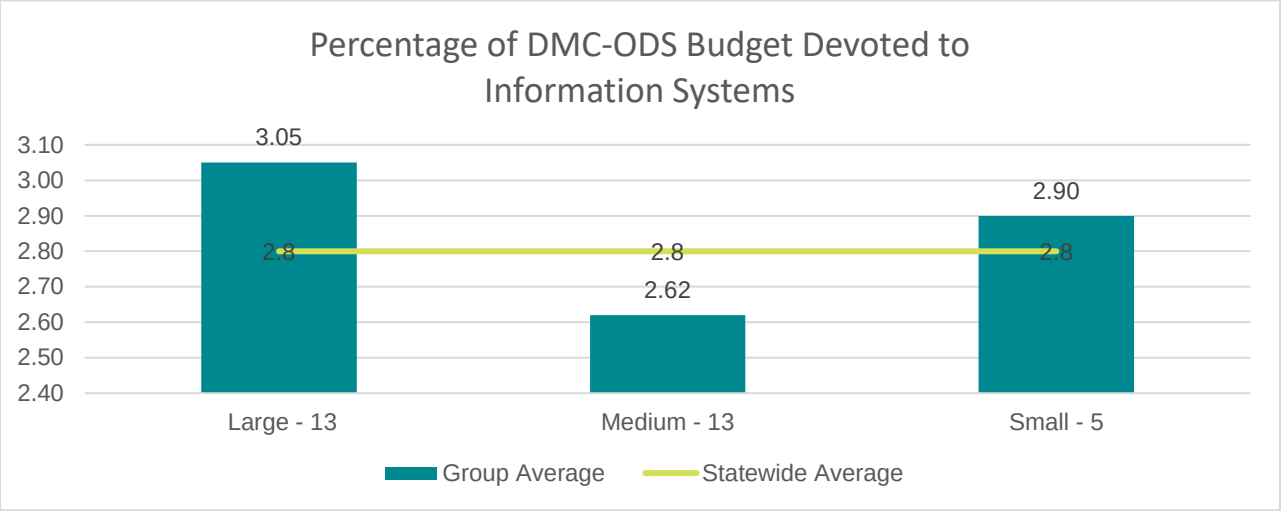
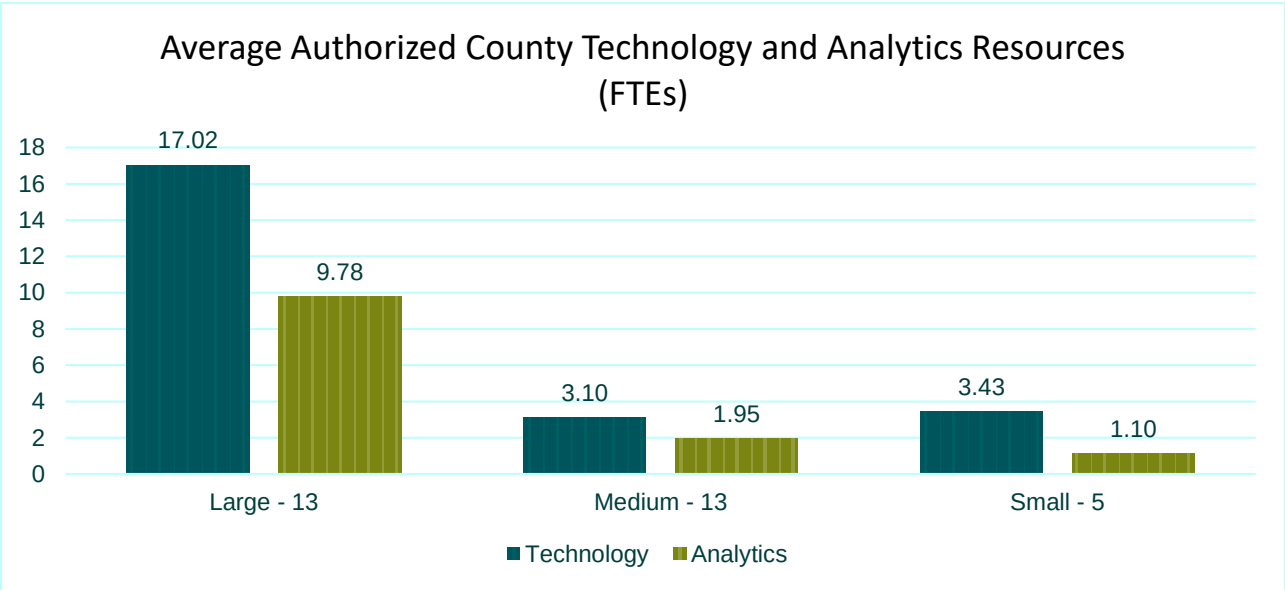


Figure 8-10 shows the FY 2020-21 average authorized technology and analytical resources in DMC-ODS counties, measured in FTEs. The medium-size counties group, on average, has only 3.10 technology FTEs and 1.95 analytics FTEs. These are small numbers in view of all the challenges involved with setting up an information system and meeting reporting requirements during DMC-ODS implementation.

Figure 8-10: Average Authorized County Technology and Analytics Resources (FTEs)



In addition to serving as an individual health record, EHRs offer aggregate data about the entire population served by the DMC-ODS. DMC-ODS staff can see outcomes at the population and target population levels; trends by race/ethnicity, gender, or age; provider-level performance; timeliness of services; and a great deal more. However, this is only possible if

the DMC-ODS employs sufficient numbers of people with the right data analysis knowledge and expertise.

Below a certain threshold of IT and data analytics staff capacity, DMC-ODS counties will not be able to realize the potential benefits of their EHRs or their practice management systems. Numbers matter, especially as the DMC-ODS county operations become more complex. However, the numbers alone do not tell the whole story. Below are some "beyond-the-numbers" scenarios to consider: Some counties included analytics staff in reported technology FTEs.

Telehealth and Mobile Technologies linked to Network Adequacy

Since the beginning of the Waiver in 2017 and the advent of NA in 2018, the expansion of telehealth and recent technologies has been important to access. Some counties embraced this early as they had vast areas where clients lived, and they needed to deliver services to. They also had poor transportation systems and shortages of providers such as Riverside and Kern counties. Other counties did not begin to use telehealth delivery until the pandemic and had little or no equipment or training. With the advent of COVID-19, it became critical to embrace this and rapidly, and many counties had to begin these services using phones and slowly add other equipment. They re-engineered their entire systems of service delivery to keep SUD service available for their clients. While initially there was as much as a 20 percent drop-in services in many counties within three months, most were back to close to pre-pandemic levels.

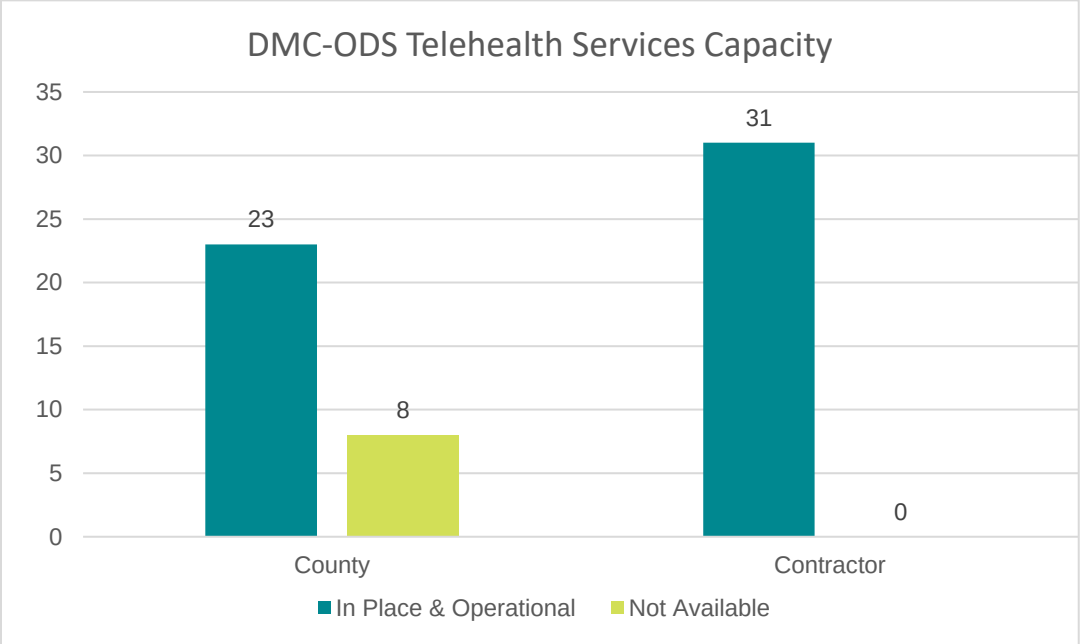
Delivering services via telehealth benefits both the client and healthcare practitioner,

especially during the COVID-19 public health emergency.

Delivering services via telehealth benefited both the client and healthcare practitioner during the COVID-19 public health emergency. For the client, telehealth expands access to care by overcoming the transportation challenges that are often a barrier to services. For providers, telehealth allows for the convenience of service delivery from existing locations and may allow them to serve clients more efficiently. It also helps to support NA requirements and offers more flexibility to both clients and providers who are in remote areas of California. Figure 8-11 shows that 23 counties (Contra Costa, El Dorado, Imperial, Kern, Los Angeles, Marin, Merced, Napa, Nevada, Orange, Partnership, Placer, Riverside, San Benito, San Bernardino, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Stanislaus, Tulare, and Ventura) currently have technology in place to support SUD services at a distance.

Contract providers in all 30 DMC-ODS counties and the PHC reported that they offer telehealth services to beneficiaries.

Figure 8-11: DMC-ODS Telehealth Services Capacity



Based on surveys conducted as part of UCLA's evaluation of the California Hub and Spoke MAT Expansion Project, only 23 percent of the providers offered telehealth service before COVID-19. Now, all of them are offering services using telehealth technology, both video, and phone. CalEQRO reviews also showed the rapid deployment of telehealth in counties reviewed from April to June 2020. Some reported major equipment challenges due to outdated computers with no cameras or microphones. In most counties, clients' access to the internet was not universal, with lower-income clients and those experiencing homelessness have the most limited access.

Counties such as Kern and Riverside that had been using telehealth for some time in service delivery had a distinct advantage in their equipment, infrastructure, and training skills. Still, all counties shared their best practices and learnings in this area with each other. In addition, National Committee for Quality Assurance just published a broad quality guide for telehealth services that should prove helpful in the future development of this crucial tool for behavioral health.

Barriers the NTPs reported in implementing telehealth services were that 11 percent of the programs had no telehealth systems in place; 9 percent had bandwidth internet issues; 62 percent reported clients had internet access challenges, and 47 percent reported clients had limited phone plans with limited minutes. Also, many reported billing challenges and needing space for social distancing for intakes and mandatory dosing and testing requirements. However, increases in take-home doses have helped considerably with compliance and access.

Consumer Outcome Measurement Tools

Initial as well as ongoing treatment can involve the use and tracking over time of outcome measurements to assist in the assessment of client progress. ASAM LOC assessments are a vital component of the DMC-ODS assessment and service delivery model.

All 30 counties and the Regional Plan reviewed in FY 2020-21 captured the ASAM-recommended LOC recommendations, referrals, and admissions for clients in their EHRs. 98.6 percent of clients who requested treatment were screened for LOC placement using the ASAM tool in all DMC-ODS counties.

TPS and CalOMS data are also used to assist with outcomes for clients, but staff members devoted to analytics of these tools are limited in many counties. Fortunately, UCLA helps with TPS analysis, and CalEQRO assists with CalOMS, but ideally, more internal resources would be devoted to these analyses on an ongoing basis.

The TPS, ASAM, and CalOMS have been valuable tools for evaluating quality and taking action for improvements, but the low level of analytics staff and the loss of CalOMS reports from DHCS have been barriers.

However, because of the limitations of the health technology systems of the DMC-ODS, the full potential is not realized with their tools such as CalOMS because of the data limitations at the provider level, mainly but the county level as well. The Regional Model has a large quality unit with adequate depth of analytic staff but has broad responsibilities besides just looking at the DMC-ODS issues. It has to evaluate hospital and specialty care for physical health and mild and moderate mental health.

Summary

In FY 2020-21, CalEQRO observed considerable progress in launching DMC-ODS continuums of new and expanded clinical services, associated billing, and quality systems, as well as challenges.

Integrating contractors into the county EHR as full partners has the potential to create a seamless and positive interface to serve the clients' needs in a highly effective and high-quality manner.

The 30 DMC-ODS counties reviewed are in various stages of implementing their EHRs; some are considering replacing or updating their IS systems entirely. These counties vary in size, deliver SUD services through different county/contractor program combinations, and have vastly dissimilar IS budgets and technology/analytics staffing resources. As noted above, the statewide average DMC-ODS budget devoted to IS was 2.8 percent—lower than the 3 to 5 percent industry benchmark for healthcare. PHC is in a better place but learning DMC-ODS and its billing requirements but has a strong quality unit.

A common but critical challenge shared by the counties is the interoperability between disparate EHR systems and Mental Health and the contract providers. It is paramount that

DMC-ODS IT can communicate securely across departments while respecting provisions in 42 CFR to coordinate care for clients especially given the substantial risk of overdose in the current SUD environment. This is also important for the network of contract providers, who render 84 percent of SUD services delivered across the counties, to communicate with county partners and others to coordinate care. This is also important to facilitate administrative functions, such as billing and authorizations. They, too, need to securely communicate with the DMC-ODS important clinical and fiscal information promptly. At this time, this capacity among contract providers is very limited.

In the absence of HIEs, contract providers are often users of the DMC-ODS counties' EHRs. Some county DMC-ODS programs are trying to ensure one information system will support uniform access to an EHR.

If the county is trying to integrate its contractor providers into an EHR, a full partnership is needed to allow for coordinated clinical care and management of the clinical database and communication systems. Los Angeles, Sacramento, Santa Cruz, and San Mateo are attempting to move in this direction with their systems. It will take time to develop this vision but integrating contractors into the county EHR as full partners has the potential to create a seamless and positive interface to serve the clients' needs in an incredibly positive and high-quality manner.

Telehealth has been an invaluable tool for providing SUD services during the pandemic. Counties report the relaxation of requirements related to telehealth has been helpful and there is support for extending some of these practices beyond the pandemic to expand access and treatment services overall. Relaxation of the NTP/OTP rules has been helpful for making access and dosing more available and also helping to increase non-methadone NTP. Telehealth can prevent new disparities in health access by making it easier for those who are homebound, disabled, homeless, and/or face transportation challenges in rural and frontier areas. It is important to facilitate data and phone plans that allow these services to continue for low-income clients, as well.

In conclusion, a plan to enhance the core IS infrastructure for the SUD EHRs and practice management systems is crucial. It should include community contract partners and address interoperability and effective communication systems. Also, IS plans need to be supported with adequate staffing to function as a quality managed care plan with spending levels similar to other health entities. Timing is important because California will soon be updating its Medicaid Waiver, which will likely change many requirements that affect county IS. Finally, telehealth and mobile service delivery enhancements in bandwidth, equipment, training, client supports, and systems cannot wait until added resources are available, since SUD overdoses as well as mental health crises are rising in the Medi-Cal and general populations. These behavioral health services are needed now.

Overview of Information Systems Findings linked to Quality of Care

Finding 1 In FY 2020-21, CalEQRO observed continued progress as counties expanded or refined their continuums of new or existing services to meet local needs, but also to continue to provide the vital DMC-ODS services with challenges from the COVID-19 pandemic. New counties launched their new DMC-ODS programs despite the pandemic, but with some challenges, particularly in **billing and infrastructure operations**, and changing impacts from COVID-19 and fire events.

Finding 2 The statewide average **DMC-ODS budget devoted to IS continues to be too low at 2.4 percent**—lower than the 3 to 6 percent industry benchmark for healthcare.

Finding 3 A critical challenge with IS needs for DMC-ODS plans is **interoperability**. Core systems cannot communicate across county departments, hospitals, primary care, and contract providers.

Finding 4 To serve the SUD needs of beneficiaries across the counties in an effective way, systems must have resources and capacity to function with strong **telehealth and mobile service capacity.**

Finding 5 **Double data entry to record contract provider services** will remain an operational challenge and barrier until the CalAIM initiative is approved by CMS. At that point, systems development can begin for the next generation of EHRs that supports integration with primary care services. Also, the current **complex billing and charting rules require** extensive and ongoing staff development and training. These could also be reconsidered with CalAIM redesign.

Drug Medi-Cal Organized Delivery System External Quality Review

2017-2021 Statewide Report

Summary of Recommendations

Recommendations for DMC-ODS Continued Treatment Progress

Summary of Recommendations

DMC-ODS Quality & Continued Treatment Progress

Even with the continued COVID-19 challenges, DMC-ODS counties, the Regional Model program, and providers, as well as the overwhelming number of clients CalEQRO interviewed and surveyed, reported that the 1115 Waiver changes made substantial positive changes to the SUD treatment system in California and their lives. Data in the report shows more access, richer services, and improvements in quality of treatment and outcomes from care and into community functions from those who can access care. From the provider's view, the Waiver is moving SUD treatment into the mainstream of the healthcare system as an essential partner with other specialty areas of treatment. And the progress continues to be made by DMC-ODS counties and the Regional Model with the providers with increasing access, timeliness, quality, and early indicators of outcomes over time. Many key best practices have been identified by counties that have demonstrated outstanding metrics in these areas. Training and education on these best practices are needed and more advanced use of ASAM in care and treatment planning, along with support for challenges identified below. The more detailed action steps to address some of these barriers and challenges are addressed in the chapters above but summarized briefly below:

Service Capacity and Proximity: Services in the ASAM continuum still need expansion and added capacity to meet needs in many counties. Specific services often named include RSS, recovery residence housing, non-methadone MAT, youth services at all levels but particularly youth residential access, and residential WM and hospital WM. Both are challenged in many counties.

(1) WM and MAT services need prompt access and proximity to locations where clients request those services as time and distance and ease of access is essential for effective treatment

(2) **Workforce** issues also need expansion at the college and junior college levels to meet statewide needs at multiple levels and disciplines: **physicians, midlevel providers, LPHAs, and SUD counselors**. Several counties also suggested examination of scopes of practice as well to expand workforce opportunities similar to other states, including:

- Allowing psychologists and more nurses to prescribe medications for behavioral health.
- Broader scopes for counseling options for licensed masters' social workers, and marriage family and school counselors with less than 3000 hours for a license.
- A formal license for SUD counselors, not just a certificate. Also suggested was the use of medical assistants to be able to assist in residential facilities and programs for medication support.

(3) Using trained **peers** as potential support within various DMC-ODS services is underdeveloped and an asset that could enhance services, particularly for navigator, support, and specific case management support functions.

(4) **Expanded Treatment and Engagement Services to Underserved Populations** including Ethnic Minorities, Mobility Challenged, Non-English speakers, and other groups is needed and can be accomplished through PIPs and special projects in partnership with DHCS and community partners. Several models are being tested in different counties already, which may require different approaches to treatment and funding.

(5) Continued and ongoing **telehealth** use and **flexible service models** from the COVID-19 related adaptations for services in NTPs as well as other DMC-ODS treatments have proven incredibly positive for clients. They have increased positive engagement and access for many, especially in rural and frontier areas.

(6) **NTP/OTP Waiver options** in other parts of the nation have been able to leverage additional flexibility with mobile services and pharmacy-based access to treatments and directly observed therapies. Waivers of this type could perhaps be explored to meet needs in rural and frontier areas of California.

(7) **Core IT infrastructure and interoperability** between county behavioral health or region model plans and their provider networks (as well as local health and hospital systems) require a concrete plan and major investment, and it is now identified and addressed in Cal-AIM.

(8) **Continued development and use of quality and outcome-tracking tools** to assist in enhancing the quality of care is needed. Examples include reports for CalOMS, broader distribution and use of TPS, and new opportunities for client input in feedback-informed care models.

(9) **Care coordination enhancements include systematic case management approaches** and overlapping care to support transitions from high to lower LOCs. These PMs have improved but still need more focus and effort. They are treating SUD as a chronic disease warrants additional education with clients as well as clinical staff, teaching principles of client activation and reward systems for building new lifestyle behaviors that can be permanent and positive.

(10) **Continued support for MAT expansion Partnerships** with criminal justice collaboratives enhancing MAT access in jails, health, and hospital ED Bridge systems DHCS has resulted in strategic and effective investments. These MAT expansion programs are having impacts on clients and community systems of care. Hospitals and Detention Centers are working directly with the DMC-ODS programs to send large numbers of clients into treatment and to make better use of Medi-Cal programs. This is better for the clients and their families, as well as the community as a whole.

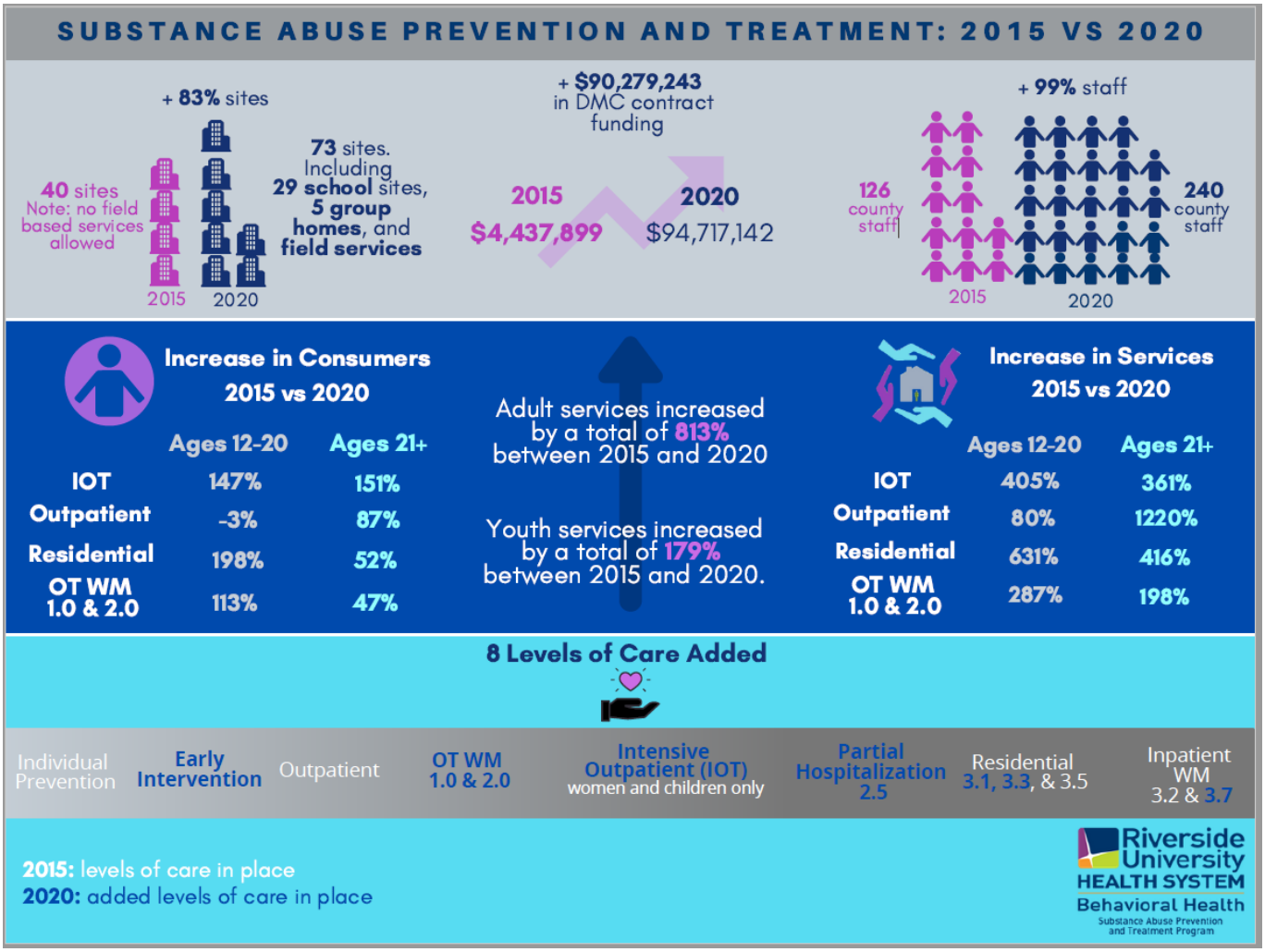
(11) **Integration** of licensing, financial, and documentation requirements, where possible, to make integration efforts easier within the behavioral health and primary care would be a positive goal for the future so that whole-person care is easier to achieve in community settings.

These recommendations are based on both the objective reviews of the 30 counties and one Regional DMC-ODS program, their providers throughout the state, their data, and the reports of the clients, stakeholders, and family members who participated in the reviews over the five years from 2017 to 2021.

CalEQRO appreciated the time, effort, and dedication of the County, PHC staff, and programs that assisted in these reviews. We would not have been able to do this work and identify these important findings. And to conclude and share in one visual example of how much was achieved from the time one county planned the efforts to support the Waiver in 2015 to their current system of SUD Care, below is a visual representation of changes from Riverside County in staff, program sites, clients served, and types of services provided to those with substance use needs in their county from 2015 to 2020.

There are comparable stories from other counties, but none quite so visual and clear, and it shows how a creative, committed staff working within the DMC-ODS have utilized the Waiver services to leverage and build and find other sources of revenues to meet clinical SUD needs for all ages across a broad, diverse region. A special thanks to Riverside for sharing this graph on the May 2021 review of their county.

Figure 9-1: Riverside Illustration of Waiver Implementation, 2015 to 2020



Appendix

All folders and documents referenced below can be viewed and downloaded at:
https://caleqro.app.box.com/folder/144052846482?s=snl5thcy20fa5jh1c74ub8z2k046eipv

1. County Only Trainings
2. County & Provider Trainings
3. County Data Submission Forms & Key References Used
4. Staff Training - Templates, scripts, materials
5. FAQ from Counties, Providers, Regional Model
6. Summary of Challenges by Counties, Regional Model, Providers
7. Summary of Successful Strategies & Recommendations