Drug Medi-Cal Organized Delivery System External Quality Review Report 2019-20

Appendix 1:

Medi-Cal Approved Claims Code Definitions and Data Sources

Drug Medi-Cal Claims Code Definitions and Data Sources

Last Modified by Rachel Phillips, Bill Ullom – March 2020 Source: Medi-Cal Aid Code Chart Master – May 1, 2019

Source: Data is derived from statewide source files.

1. Drug Medi-Cal approved and denied claims - Substance Use Disorder Services (SUDS) Department of Health Care Services (DHCS)
2. Monthly MEDS Extract File (MMEF): Statewide Medi-Cal Eligibility Data
3. Provider File – (MPF) Statewide master provider file. Includes providers CalOMS or Provider ID number.
4. CalOMS Treatment Data
5. American Society of Addiction Medicine (ASAM) assessment tool

Process Date: The date DHCS processes files for CALEQRO

The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2018 file with a DHCS process date of May 2019 includes claims with service dates between January 1 and December 31, 2018 processed by DHCS through April 2019.

MMEF file includes beneficiary Medi-Cal eligibility for April, plus 15 prior months and for October, plus 15 prior months.

Data Definitions: Selected elements displayed within this report are defined below.

Penetration rate	The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
Approved claims per beneficiary served per year	The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year.

Eligibility Selection Criteria:

Medi-Cal beneficiaries for whom the MHP is the “County of Fiscal Responsibility” are included, even when the beneficiary was served by another MHP. Reside in a county that opts into the Demonstration Waiver.

Medi-Cal age groups determined by beneficiary's age on January 1 of the reporting calendar year.
Children Group – age 0-11 **Youth Group** – age 12-17 **Adult Group** – age 18-64 **Older Adult Group** – age >64

Age Group - Beneficiary's age group is determined by beneficiary's age on January 1 of the reporting calendar year.

Eligibility Categories	Drug Medi-Cal aid codes used to report approved claims by eligibility category.
Disabled	2H, 36, 60, 63, 64, 66, 67, 68, 6C, 6E, 6G, 6H, 6N, 6P, 6R, 6V, 6W, 6X, 6Y.
Foster Care	40, 42, 43, 49, 4F, 4G, 4H, 4L, 4N, 4S, 4T, 4W, 5K.
MCHIP	Expanded eligibility for certain populations of children as defined in federal law as targeted low-income children who would not otherwise qualify for Medi-Cal. E1, H0, H1, H2, H3, H4, H5, H6, H9, M5, M6, T1, T2, T3, T4, T5, T6, T7, 5C, 5D, 7X, 8X, 8P, 8R, 8T.
Other Child	Beneficiary age is less than 18 AND has one of the following aid codes: 0A, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 07, 08, 2E, 20, 23, 24, 26, 27, 2P, 2R, 2S, 2T, 2U, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 44, 45, 47, 4A, 4E, 4M,

	54, 59, 5E, 6A, 6J, 72, 76, 7A, 7J, 7S, 7W, 86, 87, 8E, 8G, 8L, 8U, 8V, 8W, H7, H8, J1, J2, K1, M3, M7, M9, P1, P2, P3, P4, P5, P7, P9.
Family Adult	Beneficiary age is greater than or equal to 18 AND has one of the following aid codes: 0A, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 07, 08, 2E, 20, 23, 24, 26, 27, 2P, 2R, 2S, 2T, 2U, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 44, 45, 47, 4A, 4E, 4M, 54, 59, 5E, 6A, 6J, 72, 76, 7A, 7J, 7S, 7W, 86, 87, 8E, 8G, 8L, 8U, 8V, 8W, H7, H8, J1, J2, K1, M3, M7, M9, P1, P2, P3, P4, P5, P7, P9.
Eligibility	Drug Medi-Cal aid codes used to report approved claims by eligibility category.
Affordable Care Act (ACA)	ACA aid codes were effective January 1, 2014. The FFP is 100% from 2014 through 2016. In future years it will step down to 95% for 2017; 94% for 2018; 93% for 2019; 90% for 2020 and thereafter.
Other Adult	Beneficiary age is greater than 19 AND has one of the following aid codes: 1E, 1H, 1U, 1X, 1Y, 2E, 3T, 3V, 10, 13, 14, 16, 17, 48, 5F, 5T, 5W, 55, 58, 6U, 7C, 7M, 7N, 7P, 82, 83, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E4, G6, G8,
Excluded aid codes - not DMC funded or inactive in MEDS.	0, 00, OU, OV, 06, 2A, 3W, 46, 5J, 5R, 80, 8N, 9H, 9R, FX, IE, RR, E2, E4, E5, E6, E7, F3, F4, G4, G3, G5, G7, J5, J6, J7, N0, N7, N8, T0, T8, T9.
Eligibility Status	Three-byte code – Byte one reflects beneficiary's eligibility status; Byte two Medi-Cal ID card issuance; Byte three Pre/Post eligibility status information and eligibility established for retroactive months. Eligibility status must be LT 499 to be counted in "Average Number of Eligibles per Month" count for a month.
	1st Digit =Medi-Cal/CMSP/Other Eligible Status **0** Eligible with no conditions (includes zero SOC) **1** Share of Cost to be met by LTC claim **2** LTC/SOC plus other conditions (i.e.1+3) **3** Other conditions-Certified SOC, Restricted Service, Minor Consent or Partial Health Care Plan **4** Medi-Cal eligible with Full Service Medi-Cal Health Care Plan Coverage **5** Unmet Share of Cost Obligation (Uncertified SOC) **6** Health and Welfare Program other than Medi-Cal/MSP eligible (SLMB, QDWI, Out –of –State Foster Care, Unborn, Healthy Families, County MI, CHDP State Only, MCE State & County, HCCI, AIM Pregnant Mother)

	7 Hold **8** QMB pending Medicare part A & B confirmation **9** Ineligible **2nd Digit =Normal/Exception Eligibility** **0** Normal Eligible **1** Unconfirmed Immediate Need eligible reported more than 1 month prior **2** Unconfirmed Immediate Need Eligible reported 1 month prior **3** Unconfirmed Immediate Need Eligible reported in current month **4** Forced eligible due to late termination **5** Partial Month Eligibility (Healthy Families, etc.) **7** Exception eligible **8** Forced eligible from MEDS hold **9** Full Month Eligibility (Healthy Families, etc.) **3rd Digit=Timeliness /Misc. Information** **1** Regular eligible reported timely **2** Regular eligible reported retroactively **3** 3 months retroactive eligible **4** Continuing eligible reported timely **5** Continuing eligible reported retroactively **6** Ramos/Pickle/IHSS/Other Extended eligible **7** Aid Paid Pending Ramos/Myers **8** Hold from LTC/SOC status **9** Ineligible or Regular hold

Share of Cost	Share of cost the beneficiary is obligated to meet before Medi-Cal eligible and SDMC claims are approved for payment. Beneficiary with SOC are not included in “Average Number of Eligibles per Month” count for a month until SOC is zero dollars for that month.

Level of Care: Defined by Procedure Code and Modifiers; Revenue and Procedure Code System
Source: MHSUDS, Information Notice 2017-045 and Information Notice 2019-032

Service Categories	Procedure Code/ Revenue Code	Modifiers/ Procedure Code System	Service Unit
Narcotic Treatment Program (NTP) Methadone Dose	H0020	UA & HG	Dose
Narcotic Treatment Program (NTP) Individual and Group Counseling	H0004, H0005	UA & HG	10 Minute Unit
Narcotic Treatment Program (NTP) Case Management and Consultation	G9008, H0006	UA & HG	15 Minute Unit
Residential Hospital – 4.0, 3.7	0953 (Revenue)	PCS = HZ…. DPI = RH40 or RH37	TBD – check new IN for update/clarification.
Withdrawal Management – 4.0, 3.7	0953 (Revenue)	PCS = HZ2ZZZZ DPI = WM40 or WM37	TBD – check new IN for update/clarification.
Residential Day -3.5, 3.3, 3.1	H0019	U1, or U2, or U3	Day Unit
Residential - 3.5, 3.3, 3.1 - Case Management and Consultation	G9008, H0006	U1, or U2, or U3	15 Minute Unit
Residential Withdrawal Management -3.2	H0012	U9	Day Unit
Residential Withdrawal Management – 3.2 Case Management and Consultation	G9008, H0006	U9	15 Minute Unit
Ambulatory Withdrawal Management -	H0014	U4 & U7 or U5 & U7 or U4 & U8 or U5 & U8 or U4 & UB or U5 & UB	Day Unit
Ambulatory Withdrawal Management - Case Management and Consultation	G9008, H0006	U4 & U7 or U5 & U7 or U4 & U8 or U5 & U8 or U4 & UB or U5 & UB	15 Minute Unit
Medication Assisted Treatment (MAT) Non-Methadone MAT – NTP Service	S5000, S5001	UA & HG	Dose
Medication Assisted Treatment (MAT) Non-Methadone MAT – Non-NTP Service	H2010, S5000, S5001	U7 or U8 or U1 or U2 or U3 or U9	Dose
Partial Hospitalization	S0201	UB	Day Unit

Partial Hospitalization - Case Management and Consultation	H0006, G9008	UB	15 Minute Unit
Intensive Outpatient Treatment	H0015	U8	Day Unit
Intensive Outpatient Treatment - Case Management and Consultation	H0006, G9008	U8	15 Minute Unit
Outpatient Services – Individual and Group Counseling	H0004, H0005	U7	15 Minute Unit
Outpatient Services – Case Management and Consultation	H0006, G9008	U7	15 Minute Unit
Recovery Support Services - Individual and Group Counseling, Case Management	H0004, H0005, H0006	U6	15 Minute Unit
Recovery Support Services - Recovery Monitoring/Substance Abuse Assistance	T1012	U6	15 Minute Unit
Situational Modifiers: necessary to submit certain claims.			
HA - Adolescent/youth under age 21 at time of service. Will be validated with MEDS at time of claim adjudication.			
HD – Identifies pregnancy and perinatal services.			
59 – Identifies a distinct procedural service.			
76 – Identifies repeat procedure (service) by same person (clinician).			
77 – Identifies repeat procedure (service) by different person (clinician).			

Level of Care: Case Management
Defined by Procedure Code and Modifier
Source: MHSUDS, Information Notice 2017-045 and 2018-005

Program	Procedure Code	Modifiers	Service Unit
Narcotic Treatment Program (NTP)	H0006	UA	15 Minute Unit
Residential - 3.5, 3.3, 3.1	H0006	U1, U2, U3	15 Minute Unit
Residential Withdrawal Management – 3.2	H0006	U9	15 Minute Unit
Partial Hospitalization	H0006	UB	15 Minute Unit

Intensive Outpatient Treatment	H0006	U8	15 Minute Unit
Outpatient Services	H0006	U7	15 Minute Unit
Recovery Support Services	H0006	U6	15 Minute Unit

ASAM Levels of Care – Treatment
Source: MHSUDS, Information Notice 2015-035

Level	Service Criteria	Description
0.5	Early Intervention	Assessment and education for at-risk individuals
1	Outpatient services	Less than 9 hours service/week for Adults. Less than 6 hours service for Youth.
2.1	Intensive outpatient	More than 9 hours service/week for Adults. Six or more hours service/week for Youth.
2.5	Partial Hospitalization	20 or more hours service/week in a structured program for multidimensional instability.
3.1	Clinically Managed Low-intensity Residential	24-hour structure with trained personnel; at least 5 hours clinical service/week.
3.3	Clinically Managed High-intensity Residential	24-hour care with trained counselors; less-intense milieu and group treatment.
3.5	Clinically Managed High-intensity Residential	24-hour care with trained counselors; to prepare for outpatient treatment.
3.7	Medically Monitored Intensive Inpatient	24-hour nursing care with physician availability for significant problems.
4.0	Medically Monitored Intensive Inpatient	24-hour nursing care and daily physician care for severe, unstable problems.
OTP	Opioid Treatment	Daily or several times weekly opioid medication and counseling.

ASAM Levels of Care – Withdrawal Management
Source: MHSUDS, Information Notice 2015-048

Level	Service Criteria	Description
1 – WM	Ambulatory withdrawal management	Mild withdrawal with daily or less than daily outpatient supervision; without extended on-site monitoring.
2 – WM	Ambulatory withdrawal management	Moderate withdrawal with all-day withdrawal management support and supervision; with extended on-site monitoring.
3.2 – WM	Residential withdrawal management	Minimal to moderate withdrawal but needs 24-hour support to complete withdrawal management; unlikely to complete without medical and nursing monitoring.

3.7 – WM	Medically Managed Inpatient withdrawal management	Severe withdrawal and needs 24-hours nursing care and daily physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring.
4 – WM	Medically Managed Inpatient withdrawal management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and managed medical instability.

Beneficiary Race/Ethnicity Codes			
1 = White	2 = Hispanic	3 = Black	4 = Asian/Pacific Islander
5 = Alaska Native or American Indian	7 = Filipino	8 = No valid data reported	9 = Decline to state
A = Amerasian	C = Chinese	H = Cambodian	J = Japanese
K = Korean	M = Samoan	N = Asian Indian	P = Hawaiian
R = Guamanian	T = Laotian	V = Vietnamese	Z = Other

Beneficiary Race/Ethnicity Groups	**MEDS Code**
White	1
Hispanic	2
African-American	3
Asian/Pacific Islander	4, 7, A, C, H, J, K, M, N, P, R, T, V
Native American	5
Other	8, 9, Z

Beneficiary Languages	IN 13-09 **MEDS Code**		
0 = American Sign	1 = Spanish	2 = Cantonese	3 = Japanese
4 = Korean	5 = Tagalog	6 = Other Non-English	7 = English
8 = No Valid Data Reported	9 = No Response, Client Declined	A = Other Sign Language	B = Mandarin
C =Other Chinese Languages	D = Cambodian	E = Armenian	F = Ilocano
G = Mien	H = Hmong	I = Lao	J = Turkish
K = Hebrew	L = French	M = Polish	N = Russian
P = Portuguese	Q = Italian	R = Arabic	S = Samoan
T = Thai	U = Farsi	V = Vietnamese	

Beneficiary Primary Language Groups	**MEDS Codes**
English	7
Spanish	1
Threshold Languages–exclude Sp.	2, 4, 5, B, C, D, E, H, N, R, U, V

Non-Threshold Languages	3, 6, F, G, I, J, K, L, M, P, Q, S, T		
Sign Languages	0, A		
Decline to State/Missing Data	8, 9		
MEDS County Codes			
01 = Alameda	02 = Alpine	03 = Amador	04 = Butte
05 = Calaveras	06 = Colusa	07 = Contra Costa	08 = Del Norte
09 = El Dorado	10 = Fresno	11 = Glenn	12 = Humboldt
13 = Imperial	14 = Inyo	15 = Kern	16 = Kings
17 = Lake	18 = Lassen	19 = Los Angeles	20 = Madera
21 = Marin	22 = Mariposa	23 = Mendocino	24 = Merced
25 = Modoc	26 = Mono	27 = Monterey	28 = Napa
29 = Nevada	30 = Orange	31 = Placer/Sierra	32 = Plumas
33 = Riverside	34 = Sacramento	35 = San Benito	36 = San Bernardino
37 = San Diego	38 = San Francisco	39 = San Joaquin	40 = San Luis Obispo
41 = San Mateo	42 = Santa Barbara	43 = Santa Clara	44 = Santa Cruz
45 = Shasta	47 = Siskiyou	48 = Solano	49 = Sonoma
50 = Stanislaus	51 = Sutter/Yuba	52 = Tehama	53 = Trinity
54 = Tulare	55 = Tuolumne	56 = Ventura	57 = Yolo

Counties by DHCS Regions	County Code
Bay Area	01, 07, 21, 27, 28, 35, 38, 41, 43, 44, 48, 49
Central	02, 03, 05, 09, 10, 16, 20, 22, 24, 26, 31, 34, 39, 50, 51, 54, 55, 57
Los Angeles	19
Southern	13, 15, 30, 33, 36, 37, 40, 42, 56
Superior	04, 06, 08, 11, 12, 14, 17, 18, 23, 25, 29, 32, 45, 47, 52, 53
Counties by DHCS County Sizes	**County Code**
Large	01, 07, 10, 15, 19, 30, 33, 34, 36, 37, 38, 43, 56
Medium	04, 21, 24, 27, 31, 39, 40, 41, 42, 44, 48, 49, 50, 54, 57
Small	09, 12, 13, 16, 17, 20, 23, 28, 29, 35, 45, 51, 52, 55
Small-Rural	02, 03, 05, 06, 08, 11, 14, 18, 22, 25, 26, 32, 47, 53
Diagnosis Category Source: Information Notices: 17-034, 17-063, 19-013	**ICD-10 Diagnosis Codes**

Alcohol Use Disorder	F1010, F1011, F10120, F10129, F1020, F1021, F10220, F10229, F10230, F10239, F10920, F10929
Cannabis Use	F1210, F1211, F12120, F12129, F1220, F1221, F12220, F12229, F1223, F1290, F12920, F12929, F1293
Cocaine Abuse or Dependence	F1410, F1411, F14120, F14129, F1420, F1421, F14220, F14229, F1423, F1490, F14920, F14929
Hallucinogen Dependence or Unspecified	F1610, F1611, F16120, F16129, F1620, F1621, F16220, F16229, F1690, F16920, F16929
Inhalant Abuse/Dependence/Unspecified	F1821, F1810, F1811, F18120, F18129, F1820, F18220, F18229, F1890, F18920, F18929
Opioid	F1110, F1111, F11120, F11129, F1120, F1121, F11220, F11229, F1123, F1190, F11920, F11929, F1193
Other Stimulant Abuse/Dependence	F1510, F1511, F15120, F15129, F1520, F1521, F15220, F15229, F1523, F1590, F15920, F15929, F1593
Other Psychoactive Substance	F1910, F1911, F19120, F19129, F1920, F1921, F19220, F19229, F19230, F19239, F1990, F19920, F19929
Sedative, Hypnotic Abuse/Dependence	F1310, F1311, F13120, F13129, F1320, F1321, F13220, F13229, F13230, F13239, F1390, F13920, F13921, F13929, F13930, F13939
OTHER	Other ICD-10 codes not listed above which were submitted thru DMC claim transactions

Drug Medi-Cal Organized Delivery System External Quality Review Report 2019-20

Appendix 2: Performance Measures

<u>All 26 DMC-ODS counties are included in this summary of Performance Measures.</u>

Table 1: Clients Served and Penetration Rates by Age Groups, FY 2018-19

Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate
Ages12-17	1,336,550	4,130	0.31%
Ages 18-64	6,112,208	78,247	1.28%
Ages 65+	1,139,501	8,798	0.77%
TOTAL	1,336,550	91,175	0.31%

Figure 1: Penetration Rates by Age Groups, FY 2018-19

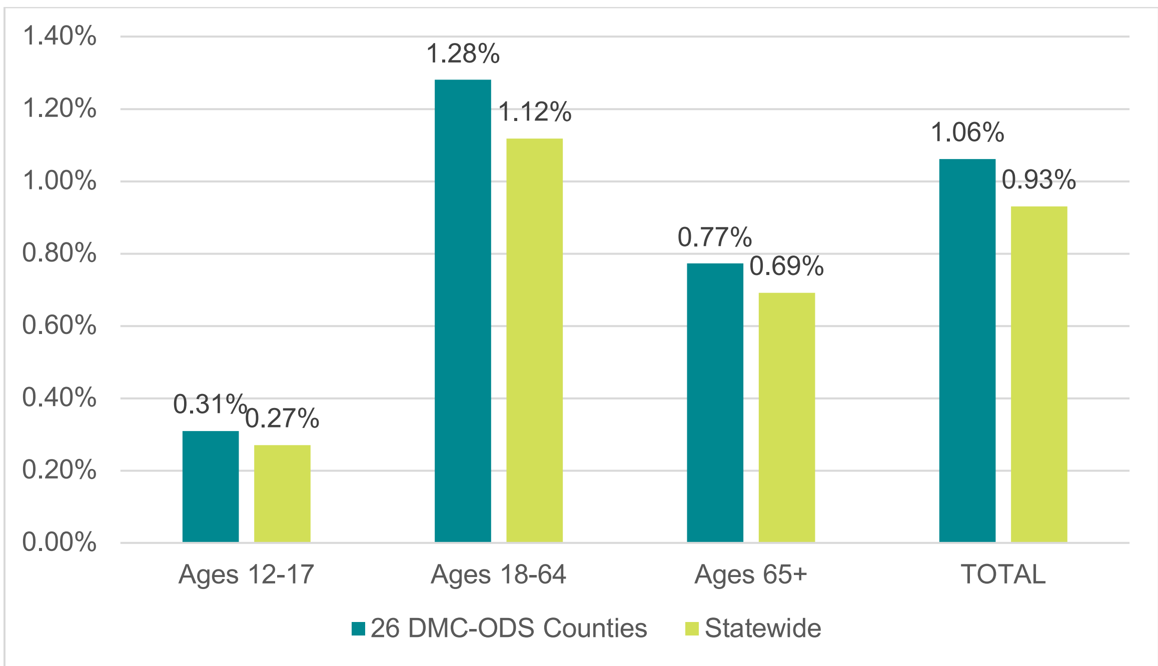


Figure 2: Average Approved Claims by Age Group, FY 2018-19

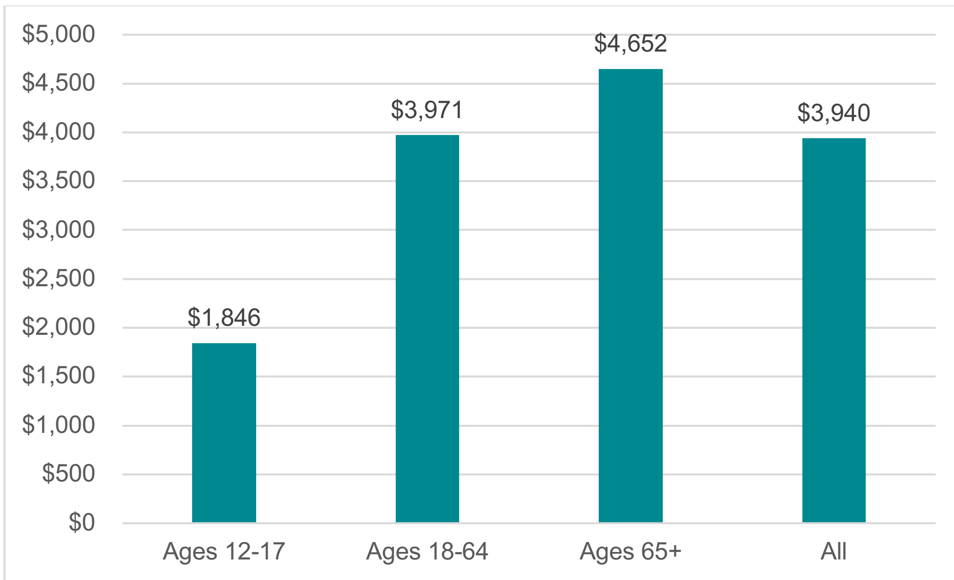


Figure 3: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2018-19

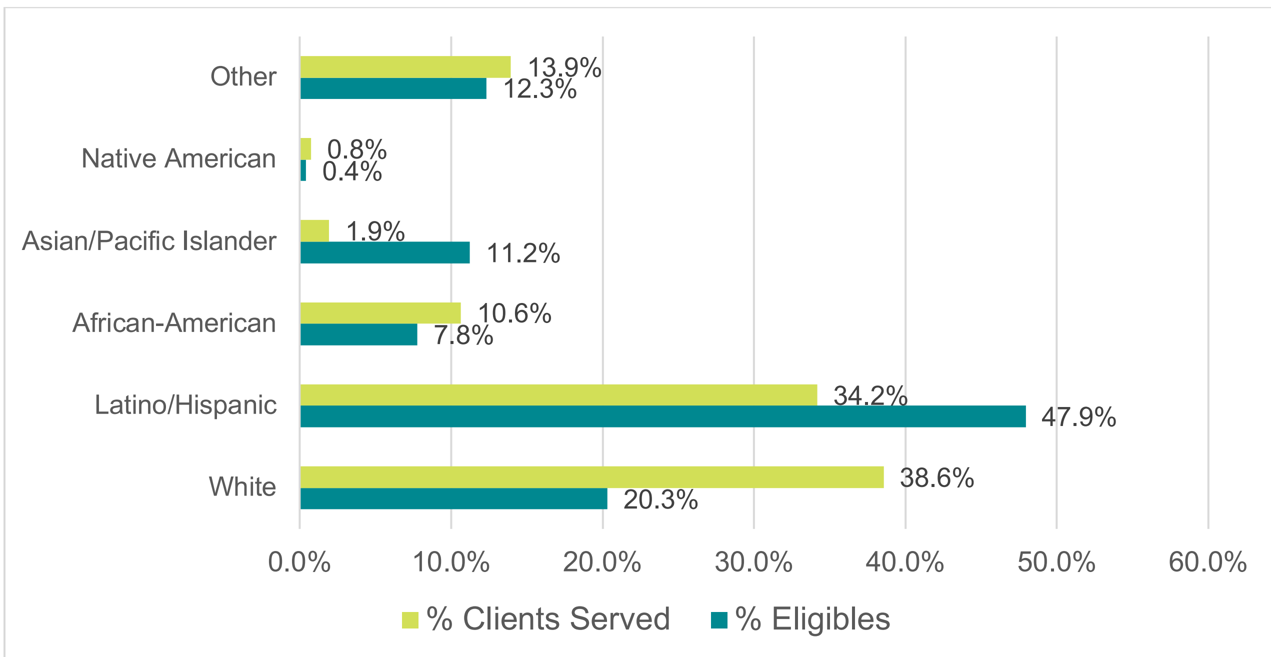


Table 2: Penetration Rates by Race/Ethnicity, FY 2018-19

Race/Ethnicity	Average # of Eligibles per Month	# of Clients Served	Penetration Rate
White	1,557,776	35,027	2.25%
Latino/Hispanic	4,303,410	31,262	0.73%
African-American	678,901	9,727	1.43%
Asian/Pacific Islander	1,004,222	1,775	0.18%
Native American	22,902	677	2.96%
Other	1,021,079	12,707	1.24%
Total	8,588,290	91,175	1.06%

Figure 4: Penetration Rate by Race/Ethnicity, FY 2018-19

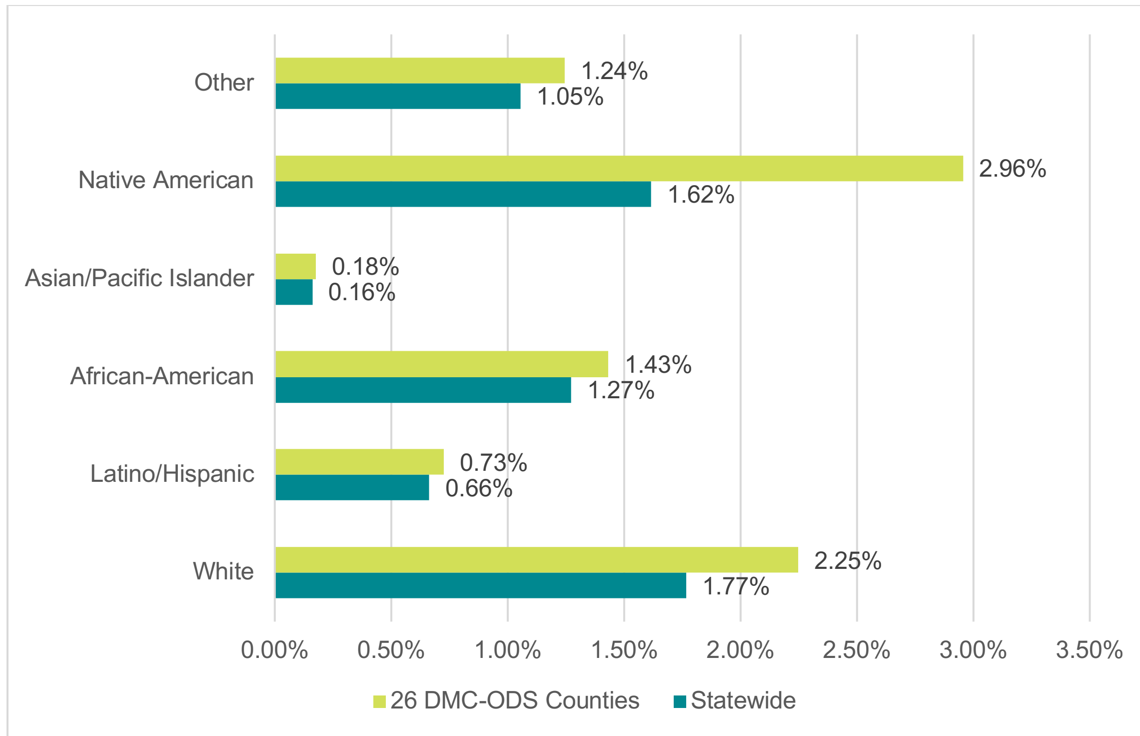


Table 3: Clients Served and Penetration Rates by Eligibility Category, FY 2018-19

Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate
Disabled	861,302	16,830	2.0%
Foster Care	27,164	547	2.0%
Other Child	835,159	2,741	0.3%
Family Adult	1,569,454	17,438	1.1%
Other Adult	1,456,200	1,636	0.1%
MCHIP	533,354	1,239	0.2%
ACA	3,292,884	54,492	1.7%

Figure 5: Penetration Rates by Eligibility Category, FY 2018-19

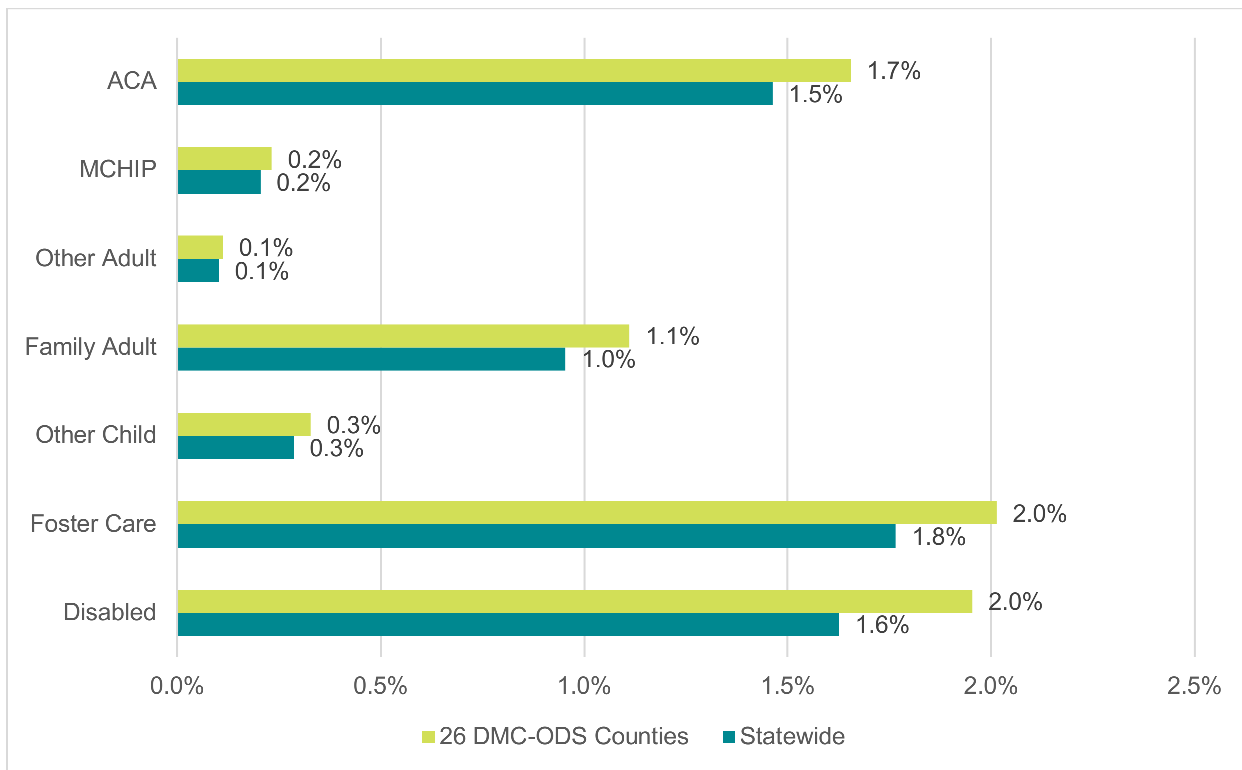


Figure 6: Percentage of Clients Served by Eligibility Category, FY 2018-19

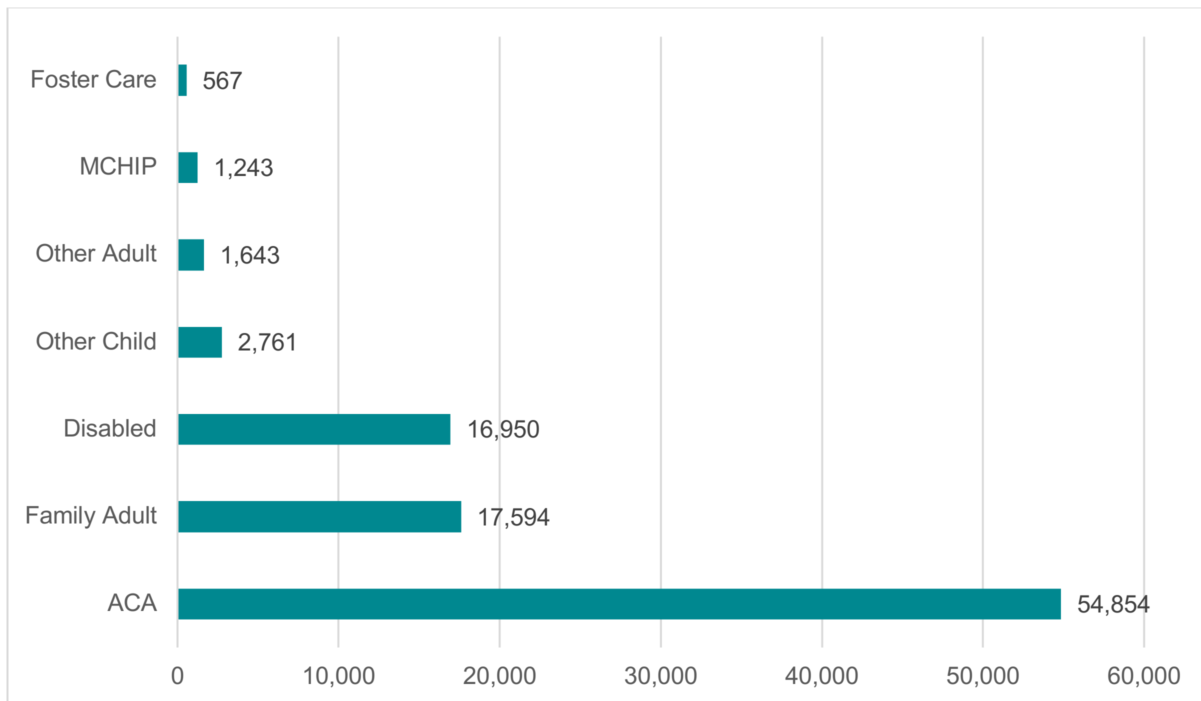


Figure 7: Average Approved Claims by Eligibility Category, FY 2018-19

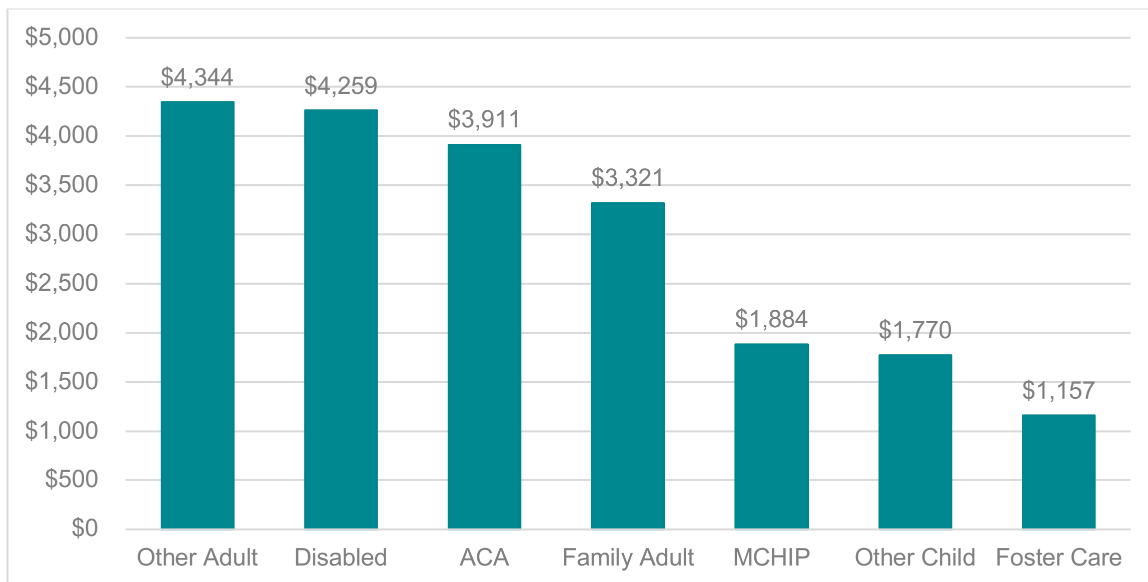


Table 4: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2018-19

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	36,623	32.2%	$4,011
Residential Treatment	20,129	17.7%	$6,490
Res. Withdrawal Mgmt.	5,331	4.7%	$1,855
Ambulatory Withdrawal Mgmt.	64	0.1%	$1,151
Non-Methadone MAT	3,411	3.0%	$620
Recovery Support Services	1,934	1.7%	$713
Partial Hospitalization	56	0.0%	$2,442
Intensive Outpatient Tx.	9,704	8.5%	$2,276
Outpatient Drug Free	36,529	32.1%	$1,260
TOTAL	113,781	100%	$3,157

Figure 8: Percentage of Clients Served by Service Categories, FY 2018-19

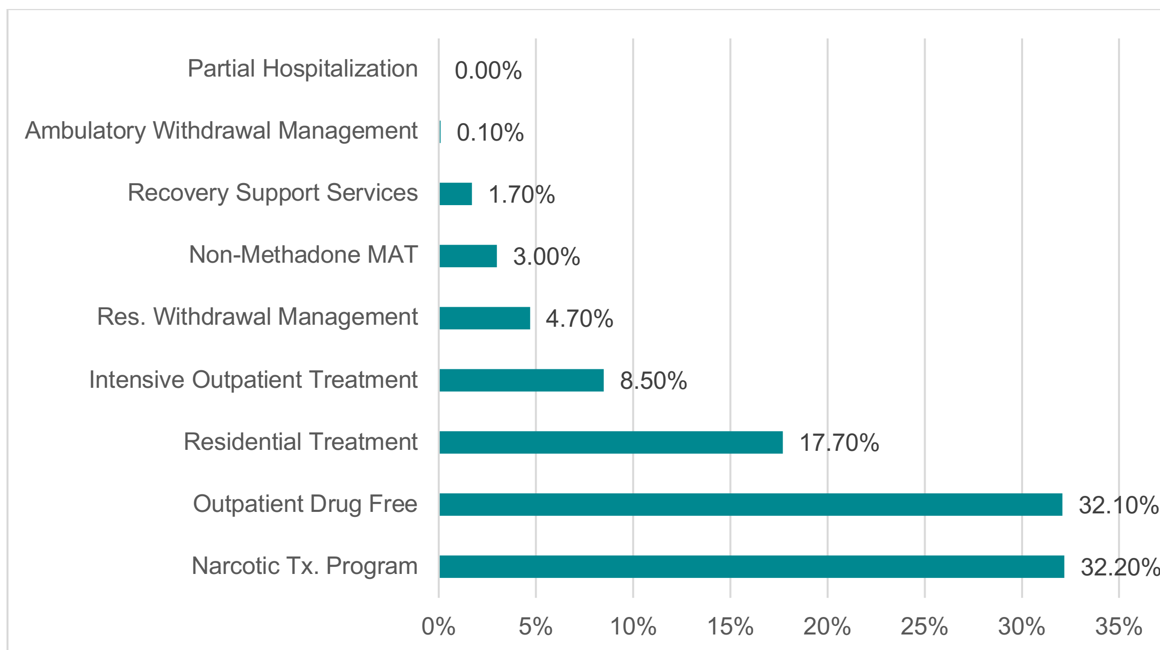


Table 5: Percentage Served and Average Cost by Diagnosis Code, FY 2018-19

Diagnosis Codes	Statewide	
	% Served	Average Cost
Alcohol Use Disorder	15.8%	$ 4,284
Cannabis Use	8.7%	$ 1,988
Cocaine Abuse or Dependence	2.1%	$ 4,610
Hallucinogen Dependence	0.2%	$ 3,648
Inhalant Abuse	0.0%	$ 3,442
Opioid	46.9%	$ 4,368
Other Stimulant Abuse	24.4%	$ 3,780
Other Psychoactive Substance	0.4%	$ 5,697
Sedative, Hypnotic Abuse	0.5%	$ 3,962
Other	1.0%	$ 2,729
Total	**100.0%**	**$ 3,994**

Figure 9: Percentage Served by Diagnosis Code for all DMC-ODS Counties, FY 2018-19

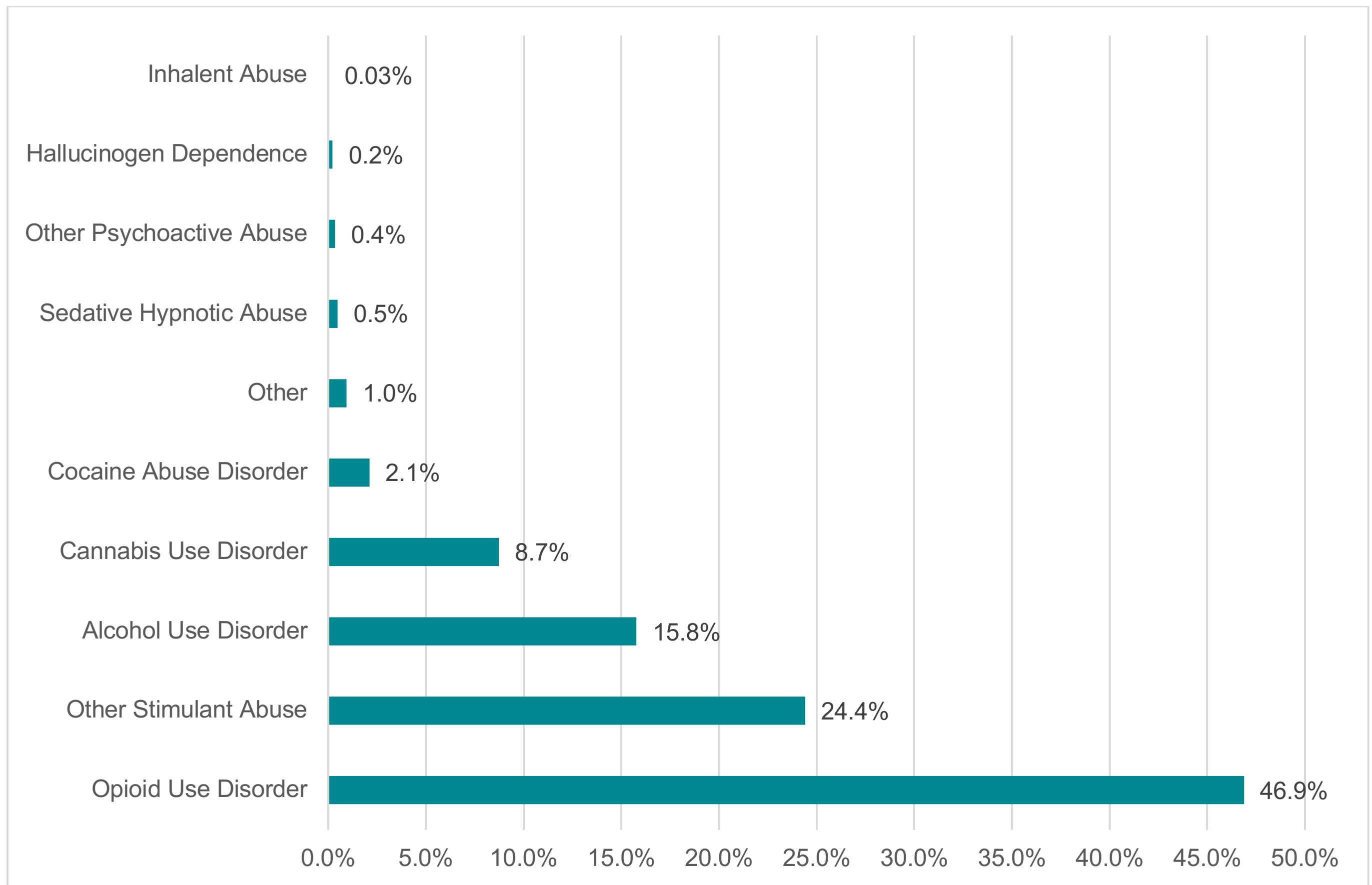


Table 6: Clients Served and Median Days to First Dose of Methadone, FY 2018-19

Age Groups	Clients	%	Median Days
Ages 12-17	0	0.0%	n/a
Ages 18-64	28,825	80.2%	<1
Ages 65+	7,114	19.8%	<1
TOTAL	35,947	100.0%	<1

Figure 10: Percentage of Clients with at Least One and with Three or More DMC-ODS Non-Methadone MAT Billed Visits for all DMC-ODS Counties, FY 2018-19

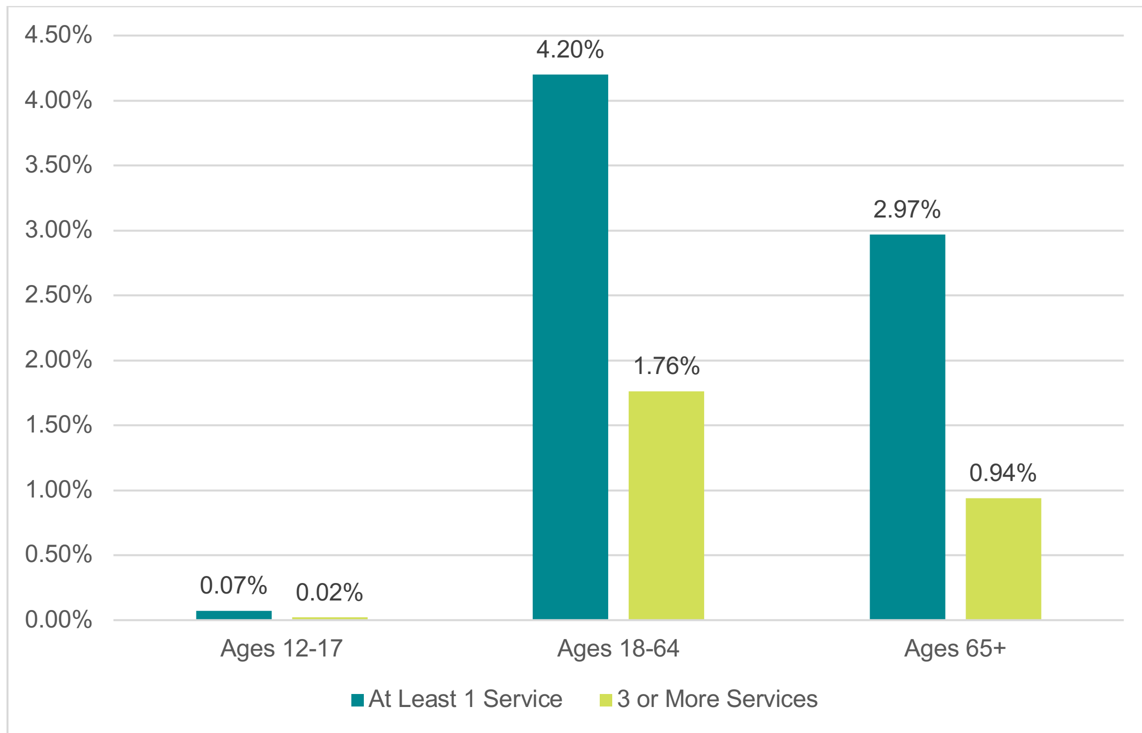


Figure 11: Percentage of Timely Transitions in Care Post-Residential Treatment for DMC-ODS Counties, FY 2018-19

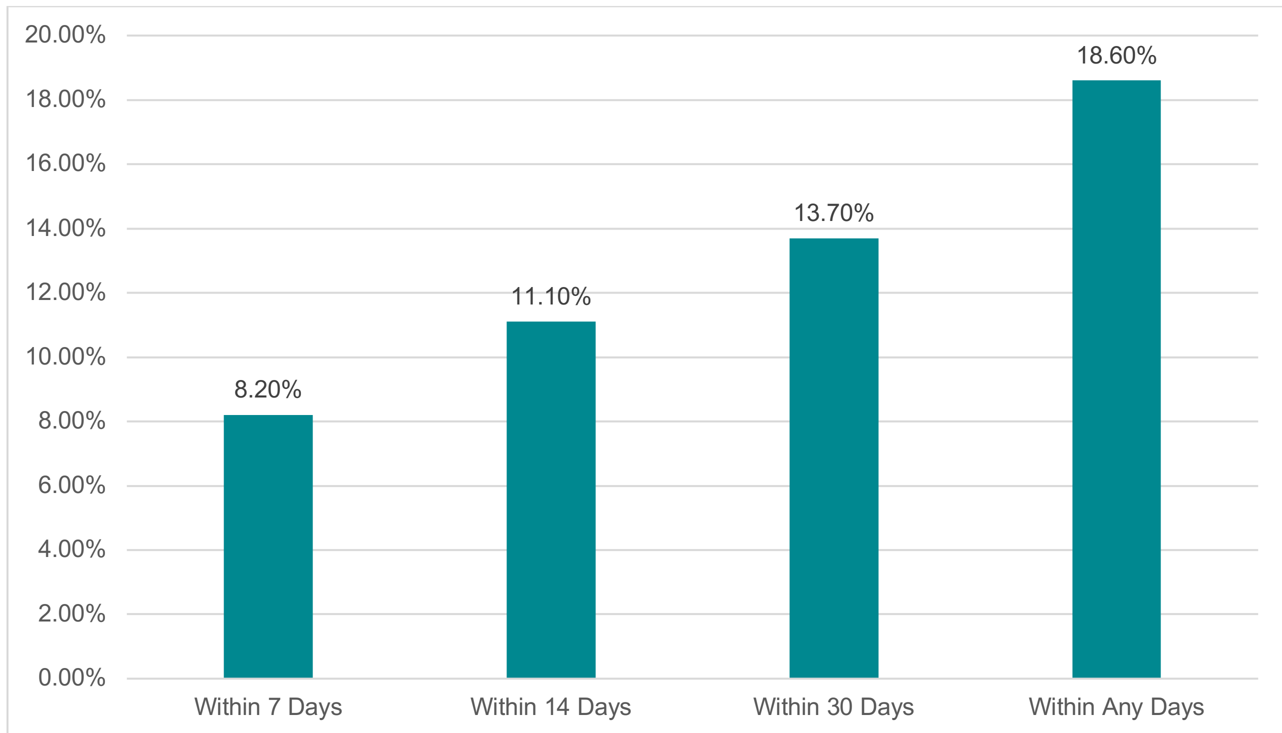


Table 7: High-Cost Beneficiaries by Age, FY 2018-19

Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims
Ages 12-17	4,161	34	0.8%	$14,208	$483,063
Ages 18-64	77,411	4,607	6.0%	$15,604	$71,888,322
Ages 65+	8,729	265	3.0%	$15,601	$4,134,267
TOTAL	91,853	4,906	5.3%	$15,594	$76,505,652

Table 8: Residential Withdrawal Management with No Other Treatment, FY 2018-19

DMC-ODS Counties	
# WM Clients	% 3+ Episodes & no other services
5,170	2.38%

Table 12: Congruence of Level of Care Referrals with ASAM Findings, 2/01/17 – 01/31/20

ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	3,828	93.3%	31,468	92.82%	2,097	91.81%
Patient Preference	147	3.58%	1,537	4.53%	66	2.89%
Level of Care Not Available	12	0.29%	147	0.52%	13	0.57%
Clinical Judgement	0	0.00%	3	0.01%	0	0.00%
Geographic Accessibility	1	0.66%	2	0.01%	0	0.00%
Family Responsibility	1	0.04%	67	0.20%	1	0.04%
Legal Issues	0	1.09%	4	0.01%	0	0.00%
Lack of Insurance/Payment Source	0	0.17%	30	0.09%	1	0.04%
Other	114	2.78%	644	1.90%	106	4.64%
Actual Referral Missing	0	00.00%	0	0.00%	0	0.00%
TOTAL	**4,103**	**100.0%**	**33,902**	**100.0%**	**2,284**	**100.0%**

Figure 13: Initiating and Engaging in DMC-ODS Services, 14 Pioneer Counties, FY 2018-19

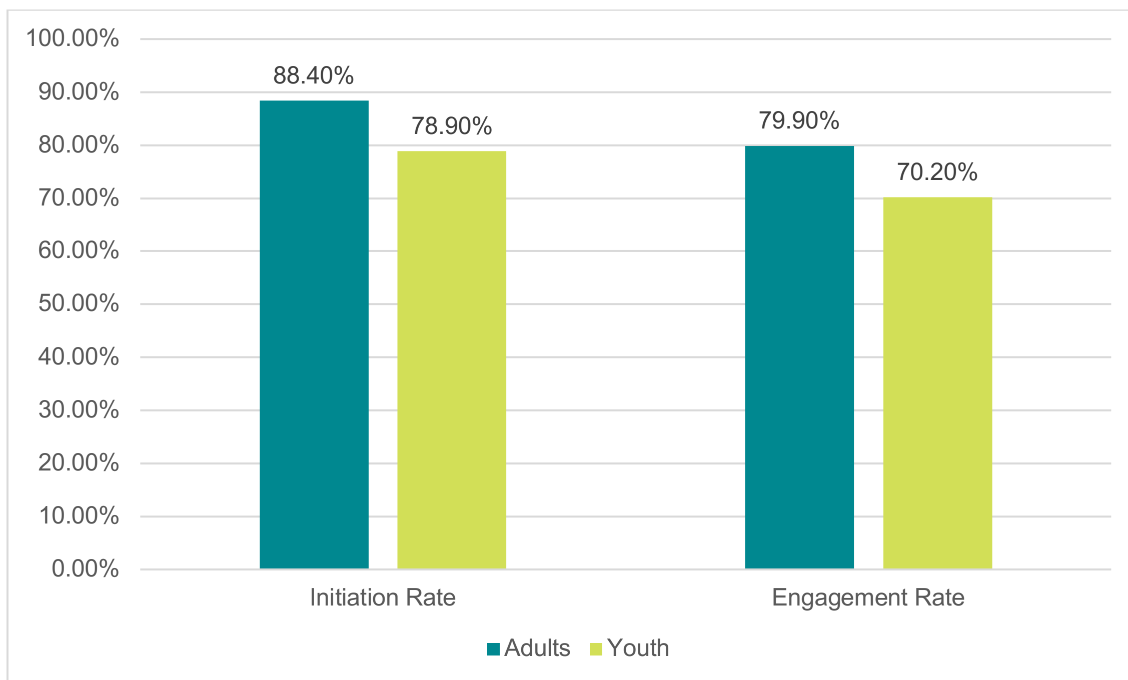


Figure 14: Initial DMC-ODS Service Used by Clients, 14 Pioneer Counties, FY 2018-19

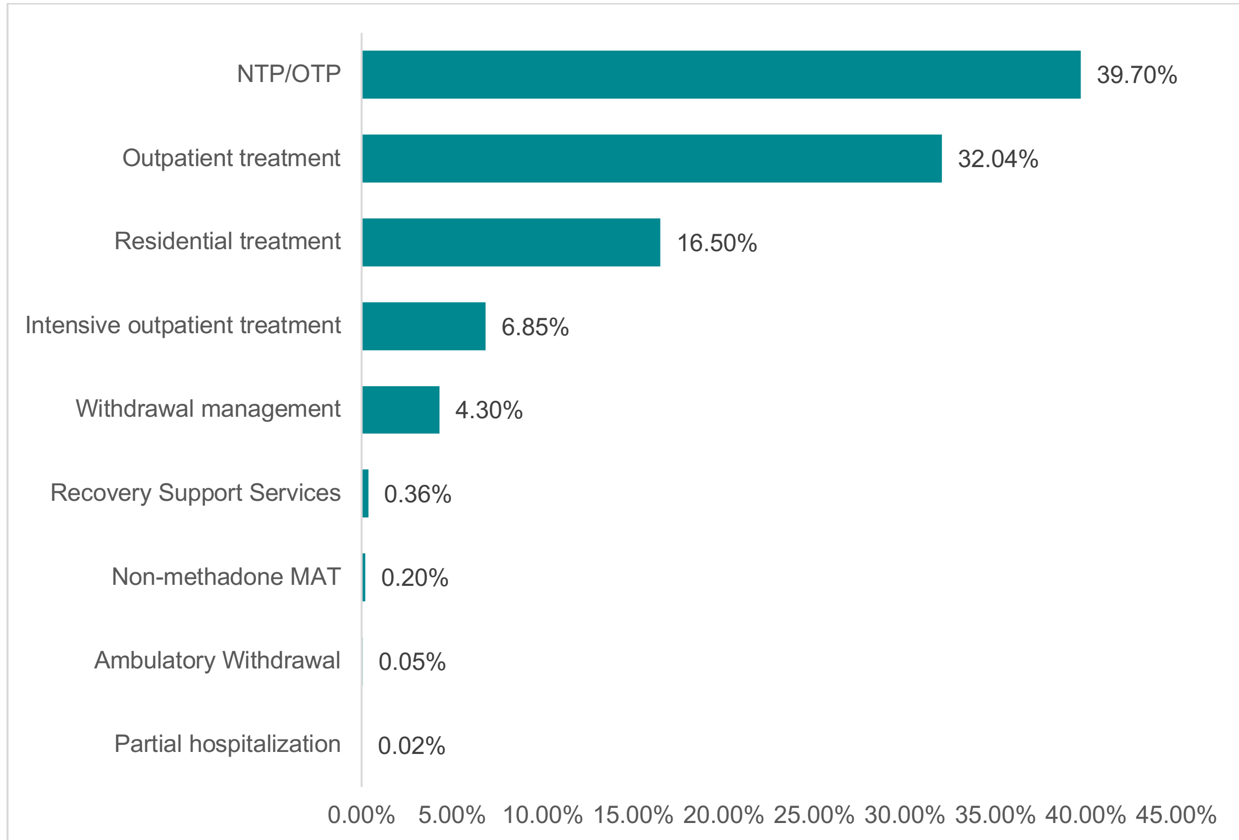


Figure 15: Cumulative Length of Stay (LOS) in DMC-ODS Services, 14 Pioneer Counties, FY 2018-19

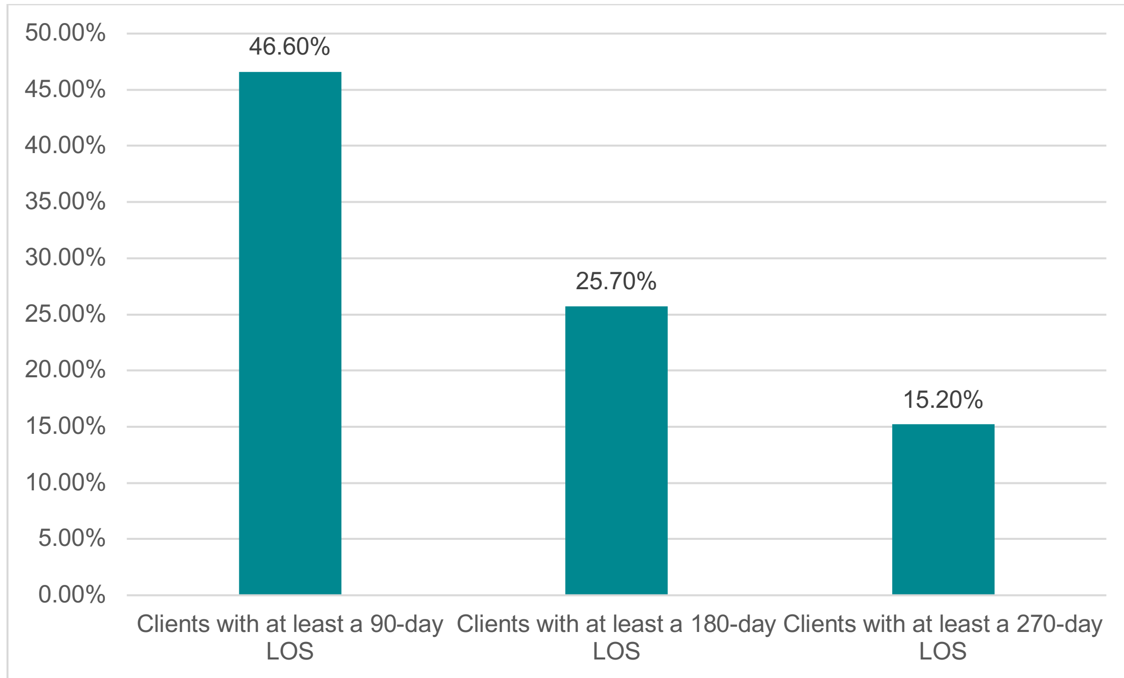


Table 10: Residential Withdrawal Management (WM) Readmissions, FY 2018-19

14 Pioneer Counties		
Unduplicated clients of the DMC-ODS		91,853
	#	%
Total DMC-ODS clients who were admitted into WM	6,392	7.0%
Clients admitted into WM who were readmitted within 30 days of discharge	446	7.0%

Table 11: CalOMS Living Status at Admission, FY 2018-19

Admission Living Status	Statewide	
	#	%
Homeless	34,316	27.5%
Dependent Living	32,097	26.0%
Independent Living	57,048	46.4%
TOTAL	124,581	100.0%

Table 12: CalOMS Legal Status at Admission, FY 2018-19

Admission Legal Status	Statewide	
	#	%
No Criminal Justice Involvement	77,761	62.4%
Under Parole Supervision by CDCR	2,232	1.8%
On Parole from any other jurisdiction	1,597	1.3%
Post release supervision - AB 109	34,542	27.7%
Court Diversion CA Penal Code 1000	2,188	1.8%
Incarcerated	720	0.6%
Awaiting Trial	5,509	4.4%
TOTAL	124,581	100.0%

Table 13: CalOMS Employment Status at Admission, FY 2018-19

Current Employment Status	Statewide	
	#	%
Employed Full Time - 35 hours or more	15,683	12.6%
Employed Part Time - Less than 35 hours	9,910	8.0%
Unemployed - Looking for work	36,869	29.6%
Unemployed - not in the labor force and not seeking	62,119	49.8%
TOTAL	124,581	100.0%

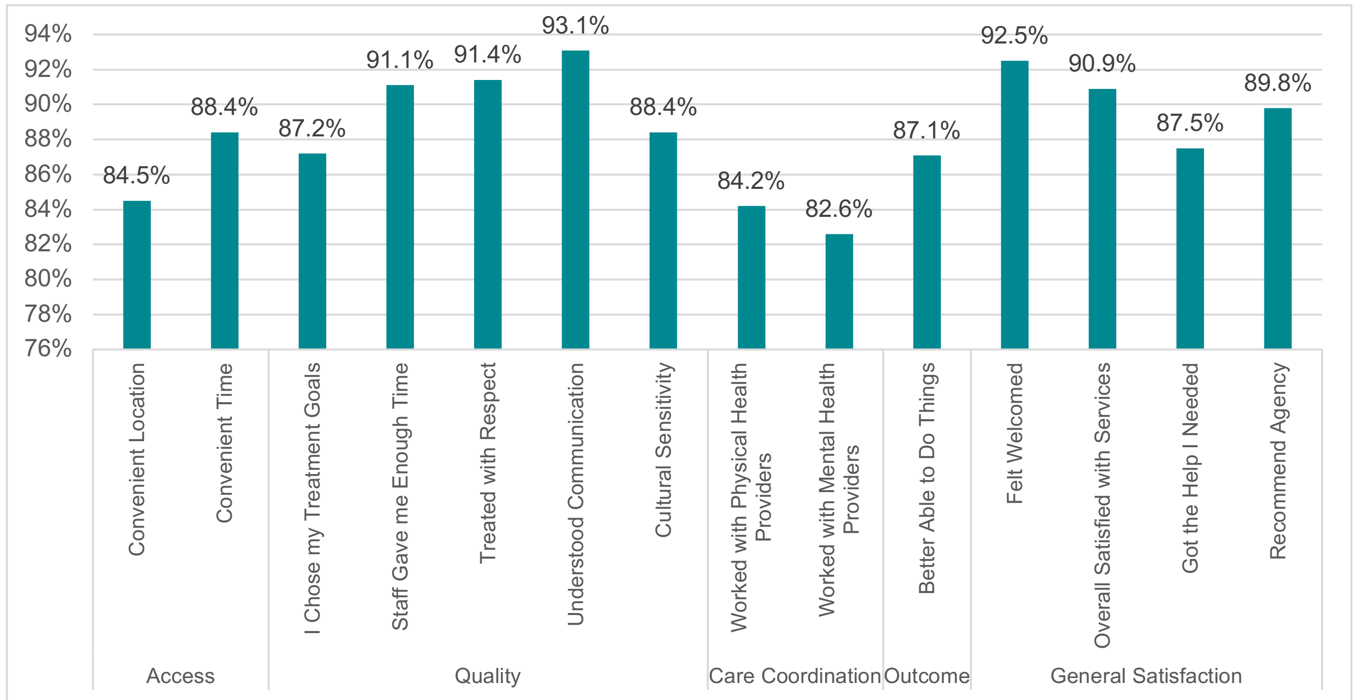
Table 14: CalOMS Types of Discharges, FY 2018-19

Discharge Types	Statewide	
	#	%
Standard Adult Discharges	58,885	57.9%
Administrative Adult Discharges	62,542	35.0%
Detox Discharges	9,882	4.1%
Youth Discharges	3,011	3.0%
TOTAL	134,320	100.0%

Table 15: CalOMS Discharge Status Ratings, FY 2018-19

Discharge Status	Statewide	
	#	%
Completed Treatment - Referred	25,720	19.3%
Completed Treatment - Not Referred	8,374	6.3%
Left Before Completion with Satisfactory Progress - Standard Questions	17,486	13.1%
Left Before Completion with Satisfactory Progress – Administrative Questions	9,419	7.1%
Subtotal	60,999	45.8%
Left Before Completion with Unsatisfactory Progress - Standard Questions	19,485	14.6%
Left Before Completion with Unsatisfactory Progress - Administrative	50,941	38.2%
Death	207	0.2%
Incarceration	1,633	1.2%
Subtotal	72,266	54.2%
TOTAL	133,265	100.0%

Figure 16: TPS Results for 26 Counties, 2019



Drug Medi-Cal Organized Delivery System External Quality Review Report 2019-20

Appendix 3: Performance Improvement Projects

Introduction

CalEQRO reviews a minimum of two PIPs in each DMC-ODS county as part of the annual review process. A PIP is defined by CMS as “a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner.” PIPs are opportunities for county systems of care to identify processes that could be improved if given careful attention, thus positively affecting client experiences and outcomes. The Validating Performance Improvement Projects Protocol specifies that CalEQRO validate two PIPs at each DMC-ODS county that have been initiated, are underway, were completed during the reporting year, or are in some combination of these three stages. Counties can submit more than two and one DMC-ODS county did this year.

Counties are expected to initiate and be at one or more of these stages with two PIPs, one clinical and one non-clinical. The clinical PIP is expected to focus on treatment interventions to improve outcomes and client experiences, while the non-clinical PIP is expected to focus on more administrative or systemic processes that improve care and the client experience. Both PIPs are expected to address processes that, if successful, will positively impact clients.

A clinical PIP might target some of the following:

- Prevention and treatment of a specific SUD condition
- High-volume services
- High-risk procedures and services, such as WM with pregnant women
- Transitions in care from 24-hour settings to community treatment settings
- Enhancing treatment access for special needs populations
- Access to MAT to enhance outcomes and symptom management

A non-clinical PIP might target some of the following:

- Coordination of care with pharmacy and ancillary care providers
- Timeliness and convenience of service improvements
- Improvements in customer service and initial engagement in care
- Addition of customized SUD services for home-bound disabled clients
- Improvement in access or authorization processes
- Improvements in network adequacy to reduce time and distance to services

Methods

The PIP Implementation and Submission Tool is a template provided by CalEQRO for counties to use when drafting their PIP narratives.[1] Prior to the onsite review, each DMC-ODS is to submit both PIPs to CalEQRO. The designated CalEQRO quality reviewer and the CalEQRO PIP consultant review all submitted PIPs for clarity, applicability, and relevance to the county's population, methodology used, and appropriateness of data and data collection tools. Counties can submit more than two PIPs and this year San Diego submitted three.

During the onsite review, the CalEQRO team conducts PIP sessions with the county to discuss the documentation provided on each PIP. During these onsite sessions, the team provides feedback and TA for strengthening the submitted PIPs. Following the onsite review, counties are allowed to resubmit their PIPs with any changes or additions discussed during the onsite review within five working days. The CalEQRO quality reviewer analyzes and validates any resubmitted PIPs in accordance with the requirements of CMS Protocol 3.[2] All PIPs are rated based on their completeness and compliance with the standards found in the CMS protocols.[3] Each of the nine PIP steps includes subsections with standards that are rated according to the PIP Validation Tool.[4]

Table 1: DMC-ODS PIP Status

General - PIP Type	Count of General - PIP Title
Clinical	26
Non-Clinical	27

The PIP rating steps and definitions are shown in Tables, below:

Table 2: PIP Rating Steps

Step	PIP Section
1	Selected Study Topics
2	Study Question
3	Study Population
4	Study Indicators
5	Sampling Methods

[1] To view the PIP Development Tool/Outline, visit CalEQRO's website: http://caleqro.com/#!california_eqro_resources/. The tool is found under Notification Materials/MHP Notification Materials Review Preparation Materials. There is a new tool for 2020-21.

[2] Ibid.

[3] Ibid.

[4] The PIP Validation Tool is available from CalEQRO's Website, www.CalEQRO.com. New Validation tools (EQRO Protocols) were introduced by CMS for use in the FY 2020-21 reviews, see PIPs tools on web site,

6	Data Collection Procedures
7	Assess Improvement Strategies
8	Analysis and Interpretation of Study Results
9	Validity of Improvement

Table 3: PIP Ratings Defined

PIP Rating	Definition
Met	Credible, reliable, and valid methods for the item were documented.
Partially Met	Credible, reliable, or valid methods were implied or able to be established for part of the item.
Not Met	Errors in logic were noted or contradictory information was presented or interpreted erroneously.
Not Applicable	Only to be used in Steps 7 - 9 when the study period was underway for the first year.
Unable to Determine	The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

A rating of met or partially met weighs positively into the overall average rating received by the PIP. Each met item receives two points, while each partially met item receives one point.

The overall average rating for each PIP is calculated using the following formula:

$$\frac{(Number\ Met\ \times\ 2) + (Number\ Partially\ Met)}{Number\ of\ Applicable\ Items\ \times 2}$$

Table 5-3 shows the categories and definitions of PIP status. Only active or completed PIPs are rated. PIP submissions that were rated as concept only, not yet active (and did not receive ratings for each PIP step) are not included in the tabulations in the figures and tables in this section.

Table 4: PIP Status—Categories and Definitions

PIP Status	Definition
Active and Ongoing	Baseline established on at least some of the indicators and at least some interventions have started. Any combination of these is acceptable.
Completed and to be scored	In the past 12 months or since the prior EQR, the work on the PIP has been completed.

PIP Status	Definition
Concept Only, Not Yet Active	Baseline may have been established, but interventions have not started. This is NOT an active PIP.
Inactive, Developed in a Prior Year	Rated last year and not rated this year. MHP has done work on it, but it has not yet started, or it has been suspended for some reason. This is NOT an active PIP.
Submission Determined Not to be a PIP	The write-up does not contain a plan, data, and/or has no indication where data will come from. This is NOT an active PIP.

Findings

Fifty-three Drug Medi-Cal PIPs were submitted for CalEQRO review. Of these, 43 PIPs (83 percent) were rated as active and ongoing including the ten completed in the last year, thereby meeting the submission standard, as shown in Table 5 below.

Table 5: PIP Status After Submission

General -DMC-ODS FY2019-20 PIP Status: 53 PIPS total	Count of General - PIP Status for 26 counties
Not Rated - Concept only, not yet active	9
Not Rated - Submission determined not to be a viable PIP	1
Rated - Active and ongoing	32
Rated - Completed since the prior External Quality Review (EQR)	10

Figure 1: DMC-ODS FY 2019-20 PIP Status of Counties, by Type

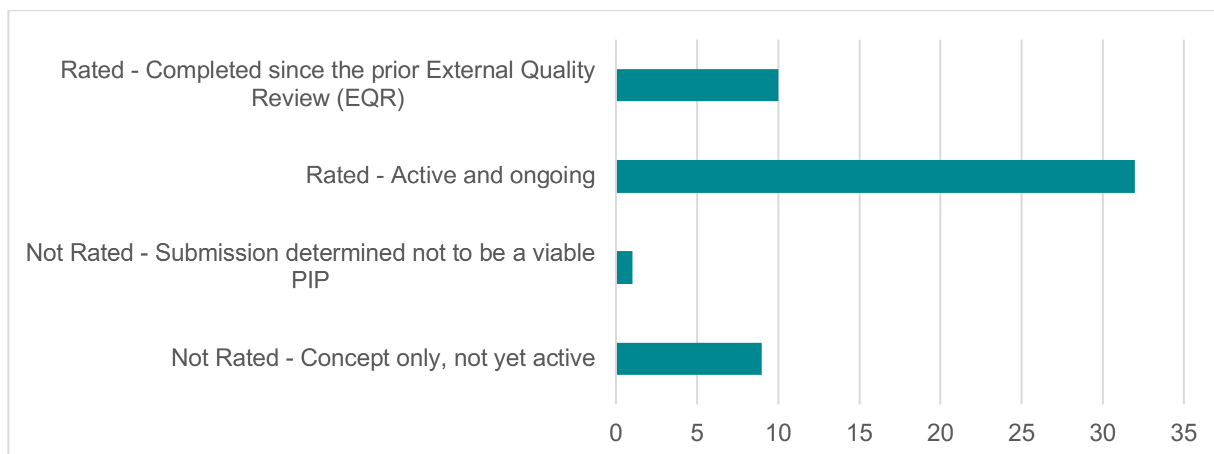


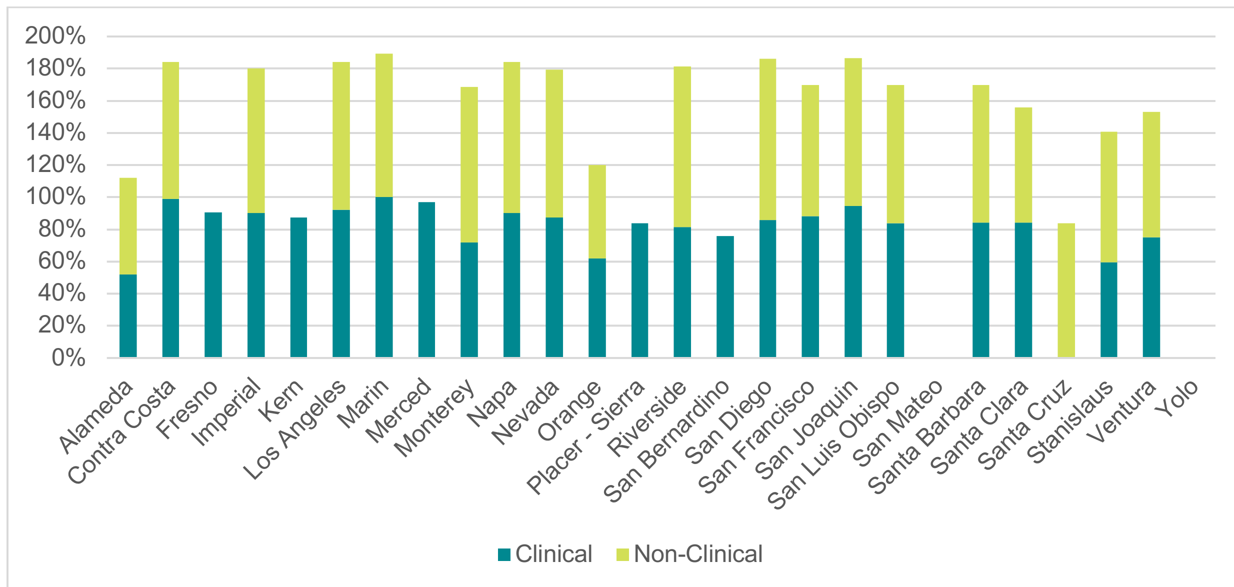
Table 6: PIP scores for Active and Completed PIPs

County	Clinical	Non-Clinical
Alameda	52%	60%
Contra Costa	99%	85%
Fresno	90.60%	Concept Only
Imperial	90%	90%
Kern	87.50%	Concept Only
Los Angeles	92%	92%
Marin	100%	89.50%
Merced	96.80%	Concept Only
Monterey	71.88%	96.88%
Napa	90%	94%
Nevada	87.50%	92%
Orange	62%	58%
Placer	84%	Concept Only
Riverside	81.25%	100%
San Bernardino	76%	Not Rated
San Diego	86%	100%
San Francisco	88%	82%
San Joaquin	94.70%	91.70%
San Luis Obispo	84%	86%
San Mateo	Concept Only	Concept Only
Santa Barbara	84.30%	85.40%
Santa Clara	84.30%	71.50%
Santa Cruz	Concept Only	84%
Stanislaus	59.38%	81.25%
Ventura	75%	78%
Yolo	Concept Only	Concept Only
Average	**82.87**	**85.11**

Clinical PIPs averaged 82.87 percent and non-clinical PIPs averaged 85.11 percent for FY 2019-20.

Notes the counties with active and recently completed PIPs in both clinical and non-clinical areas below.

Figure 2: PIP County Achievements for Active and Completed PIPs



Many of the pioneer counties were able to complete and provide active PIPs in both clinical and non-clinical areas.

Clinical and Non-Clinical Issues for DMC-ODS PIPs

The DMC-ODS counties reviewed developed PIPs on a variety of important issues impacting overall improvements in care. There were PIPs focusing on expanding access to underserved populations such as youth and disabled populations. Other access PIPs focused on improvements in Access Call Centers for beneficiaries and links to services. Many worked on expanding their levels of care to optimize their ASAM continuum of care choices to meet beneficiary needs.

In timeliness efforts the focus was often to establish data collection and infrastructure to track timeliness at all contract provider sites when clients request services as well as the newly required data element never required before, first offered appointment. Others focused on timeliness to first face to face visit which is usually the full ASAM assessment linking the client to treatment and a specific program or programs. And in this new year, many counties have met these goals and are working on timeliness for urgent conditions and no-shows for first assessment which is more complex and has varied definitions across the counties.

Linked to these issues were a number of PIPs focused on case management services and outreach, engagement, and retention in services. Case management is a new billable service for DMC-ODS counties and many programs were not staffed to provide this service other than some basic discharge planning and referral. The new models being tested were care navigators who linked with clients from

their request for care through to their first face to face appointment or beyond until they were fully engaged in treatment. Then case management would monitor progress and re-engage to support the transitions to other, usually lower, levels of care. There were centralized and de-centralized case management models. There were specialty population models with a target population and specific missions such as those linked to homeless clients, and others linked to seniors or physically disabled. The trials of case management models for different types of county organized structures is showing positive results impacting transitions in care in a positive way, client satisfaction with care and support, more success with benefits, housing, education and connections to community resources.

Another focus of the PIPs was recovery support services which is another new service and was tested with positive results in Napa and Santa Barbara counties with unique models of organizing these services and training with staff.

Outcomes were also used to track improvements using TPS and CalOMS. These tools have proven very helpful with measures related to program and client progress. Some counties have also used NSDUH and other federal metrics such as data from NIDA and SAMHSA. Many counties new to PIPs were just learning how to use and leverage data source for baselines, goals and key indicators for improvements. This was an area of regular technical assistance.

The descriptions of these topics are listed below but the full reports are on the web at www.Calegro.com and include substantially more detail on the logic of the designs, the data used to identify the problems, the analysis of these problems to identify key indicators as well as potential interventions for improvements. These reports also include literature reviews of the key topics and other science-based assessment of the issues at hand.

Table 7: PIP Description and Rating and Score Chart

County	PIP Type	PIP Title	PIP Score
Alameda	Non-Clinical	Improving Timely Access to Residential Treatment	60%
Alameda	Clinical	Recovery Coaches for Withdrawal Management	52%
Contra Costa	Non-Clinical	Enhancing Coordination/Continuity of Care for clients transitioning out of residential treatment.	85%
Contra Costa	Clinical	PHQ-9/GAD-7 Improvement in SUD Treatment using CBT group interventions for anxiety/depression in SUD res programs	99%
Fresno	Non-Clinical	Substance Use Disorder 24/7 Access Line	Concept Only

County	PIP Type	PIP Title	PIP Score
Fresno	Clinical	Client Engagement: Residential and Outpatient Continuation and transitions in care	90.60%
Imperial	Clinical	Post-Residential Treatment Care Coordination	90%
Imperial	Non-Clinical	Case Management enhancements to improve assessments	90%
Kern	Clinical	Kern BHRS Seeking Safety Implementation	87.50%
Kern	Non-Clinical	Enhancing Linkage to Assessment	Concept Only
Los Angeles	Clinical	Improving SUD Treatment and Satisfaction for Physically Disabled Populations	92%
Los Angeles	Non-Clinical	Improving Timely Access to SUD Treatment from Substance Abuse Services Helpline (SASH)	92%
Marin	Non-Clinical	Linkage to Continuing Treatment following Withdrawal Management (WM)	89.50%
Marin	Clinical	Road to Recovery for Co-occurring Clients	100%
Marin	Non-Clinical	Continuing Treatment Following WM	89.50%
Merced	Non-Clinical	Improving Teen Participation in the Recovery Assistance for Teens (RAFT) Program	Concept Only
Merced	Clinical	Client engagement after discharge from residential treatment	96.80%
Monterey	Non-Clinical	SUD Re-assessment Tool	96.88%
Monterey	Clinical	Reducing the Risk of Fatal Opioid Overdose for Youth and Adult Beneficiaries	71.88%
Napa	Non-Clinical	Increasing care transitions to recovery services and reducing SUD relapse experiences	94%
Napa	Clinical	Enhancing Engagement and Retention in Treatment	90%
Nevada	Non-Clinical	Removing Barriers to Accessing Residential Treatment	92%
Nevada	Clinical	Improve Transitions to Outpatient Treatment / Aftercare	87.50%

County	PIP Type	PIP Title	PIP Score
Orange	Non-Clinical	Increasing Engagement and Retention Through Motivational Interviewing	58%
Orange	Clinical	Addressing High Rates of PTSD Among Clients Enrolled in Substance Use Disorder Services	62%
Placer	Clinical	Care Coordination of Co-Occurring Needs	84%
Placer	Non-Clinical	Continuum of Treatment Services	Concept Only
Riverside	Clinical	Enhancing retention and completion of outpatient treatment by improving engagement of clients with a focus on treatment goals that are meaningful to them for success.	81.25%
Riverside	Non-Clinical	Increasing Access and Treatment Services to Adolescent Youth with SUD	100%
San Bernardino	Non-Clinical	Vivitrol Education and Outreach	Not Rated
San Bernardino	Clinical	Vivitrol Utilization & Outcomes	76%
San Diego	Non-Clinical	Grievances and Appeals Utilization	94%
San Diego	Non-Clinical	Non-Clinical PIP: Increasing Access and Treatment Services to Adolescent Youth with SUD	100%
San Diego	Clinical	Relapse Prevention Evidence-Based Practice	86%
San Francisco	Non-Clinical	San Francisco County Treatment with buprenorphine in the OTPs.	82%
San Francisco	Clinical	Medication Assisted Treatment for Serious Mental Illness Clients (SMI) with Alcohol Use Disorders (AUD)	88%
San Joaquin	Clinical	Linkage to Outpatient Following Residential Discharge	94.70%
San Joaquin	Non-Clinical	Providing Assessment Scheduling Options	91.70%
San Luis Obispo	Clinical	Individual Services to Improve Client Retention	84%

County	PIP Type	PIP Title	PIP Score
San Luis Obispo	Non-Clinical	Improving Retention in Medication Assisted Treatment	86%
San Mateo	Clinical	Increasing Residential Treatment and Admission Rates	Concept Only
San Mateo	Non-Clinical	Increasing OP/IOP Show Rates	Concept Only
Santa Barbara	Clinical	Recovery Services expansion and engagement	84.30%
Santa Barbara	Non-Clinical	Increasing Access to Screening and Referral	85.40%
Santa Clara	Clinical	Using Case Management to Increase Client Engagement	84.30%
Santa Clara	Non-Clinical	Increasing follow-up treatment admissions following WM3.2 services	71.50%
Santa Cruz	Non-Clinical	SUD Treatment participant access to MH Assessment	84%
Santa Cruz	Clinical	COVID-19 telehealth impacts and improvements	Concept Only
Stanislaus	Non-Clinical	OTP Access and timeliness	81.25%
Stanislaus	Clinical	SUD Clinical PIP-Care Coordination Team (CCT)	59.38%
Ventura	Clinical	Study of Care Coordination Post-Discharge from residential treatment	75%
Ventura	Non-Clinical	Study of Timeliness from First Contact to Assessment	78%
Yolo	Clinical	Co-Occurring Disorders tracking and access	Concept Only
Yolo	Non-Clinical	Access to Residential Treatment improvements	Concept Only

Technical Assistance

During the FY 2019-20 review year, CalEQRO provided PIP clinic webinars, shared YouTube training videos, and extensive individual consultation that focused on PIP development. Table 5-6 details the TA provided to all counties during the review year. The DMC-ODS EQR web site at www.CalEQRO.com includes a PIP library with videos specifically made for DMC-ODS counties and examples.

CalEQRO will use the findings from the review process to provide additional PIP clinic webinars and presentations focused on the areas identified in this report as well as new quality opportunities identified in the SUD field, working individually with all counties requiring assistance in the development of PIPs. Thirty counties and one Health Plan will be reviewed in FY 2020-21 and most have begun working with CalEQRO on their PIP designs and methodology. Many are focusing on access, timeliness, continuity of care, services to persons with co-occurring disorders, expanding MAT services and access to ASAM assessments, case management models, EBPs, treatment in criminal justice settings and in aftercare, reductions in overdose deaths, expansion of recovery services and other pertinent topics in the SUD field. Many counties are working with lead reviewers on new CMS forms and how to use them in the PIPs.

Table 5-6: Technical Assistance Provided by CalEQRO Outside of Onsite Reviews

Type of TA Provided	Location	Date
PIP & EQR presentation and later YouTube	In-Person and Online	February 2019
PIP Webinar	Online	October 29, 2019
PIP Webinar	Online	December 18, 2019
PIP Webinar	Online	March 27, 2020
PIP Webinar CMS Protocol 1	Online	June 29, 2020

In addition to the TA detailed in Table 4-6, CalEQRO provided one-on-one TA to counties before, during, and after their onsite reviews. This TA ranged from helping to develop measurable study questions, using available SUD data, to a comprehensive evaluation of all PIP validation steps. DMC-ODS counties are new to PIPs and needed extensive assistance with the development and evaluation of PIPs. Extra time was provided prior to the review of staff to outreach and do training and technical support because of this.

Outside of the onsite review process, CalEQRO provided individual TA to 24 counties for a total of 925 hours. One of the most common areas of assistance involved PIP study question formulation and assisting counties in the development of a new PIP concept. Many focused on challenges with capturing timeliness data (particularly at contract provider sites with outdated computer systems and limited IT interfaces with central county systems), expansion of recovery services, grievances, expansion of services to at-risk populations such as perinatal and youth, introduction of new MAT services, stigma and individualized treatment methods, continuity of care post-discharge from WM and residential treatment, and use of the full continuum of care to meet client needs.

Each of the 26 counties selected PIPs with implications core requirements of the DMC-ODS Waiver and the fundamental shift to an ASAM-driven system of care, with comprehensive assessments and individualized treatment models. There was also a shift to EBPs, access, transitions in care, expansion of care for rural and frontier areas, and engagement.

While not all of the PIP designs or studies were successful, each county with TA has reported a good learning experience related to the process of (1) identifying problems, (2) conducting data analysis of those problems or issues, (3)identification of indicators and establishing baseline data and measurable goals, and (4) identifying possible interventions to improve care and outcomes affecting the clients using services. Continued TA is available to assist in these efforts to refine and enhance quality in the DMC-ODS counties through the PIP process. In addition, it is anticipated the new CMS forms will be challenging for counties with less research-oriented staff and will need more support.

Areas for Improvement in PIP Design/Implementation

- DMC-ODS counties with ongoing active PIPs should continue to modify existing interventions that did not have desired impacts or add new interventions to refine their impacts/outcomes. Continuous efforts to improve quality are important, and technical assistance is available to help identify effective interventions.
- DMC-ODS counties should refine their knowledge and use of their key data sources, including the new data sources such as ASAM LOC referral data, NSDUH data, ASAM dimensions from the assessment, and TPS data to improve care for clients. These are powerful new tools for identifying both problems and strengths in the system of care. Current knowledge about them among both data and clinical staff is limited.
- Counties should consider implementing PIPs in stages to ensure that a larger population of clients can benefit from them. Bringing some interventions and program changes to scale takes time, and counties can use the PIP process to do this. These are new processes for DMC leadership and piloting models and then bringing them to scale is an effective approach.
- The PIP process should continue to be embedded in the counties' QI initiatives, whereby the county has a regular mechanism for:
    - Defining the problem
    - Asking stakeholders what should be done about the problem
    - Designing interventions to address the problem
    - Implementing those interventions
    - Measuring the effect those interventions have on the problem

- Counties invest time and resources in developing systems that not only collect data, but also generate helpful and user-friendly reports for clinicians and key managers that can be used to track improvements or problem issues in meaningful ways. This should continue with new counties joining the DMC-ODS program.
- It is recommended that the counties participate in TA provided by CalEQRO and other sources to improve their ability to collect, analyze, and use data as soon as their county is approved to participate in the DMC-ODS.

Summary

During this reporting year, CalEQRO found strengths in the DMC-ODS programs and practices related to PIPs and general efforts targeting improvements in care and operations. The PIP projects are having a positive impact on the overall delivery system and elements that are important to quality of care for clients and families. In these same areas, CalEQRO also noted opportunities for continuing to expand the QI focus and support of the system changes which could be improved with effective PIPs that identify problems, potential interventions, and track the impact via related indicators. These opportunities included expanding the basic data system analytics and knowledge to support PIPs and ongoing QI activities in general. More funding for training, IT systems, and staffing in these areas would be very helpful for long-term system improvements.

Drug Medi-Cal Organized Delivery System External Quality Review Report
2019-20

Appendix 4: Client Recommendations and Themes

This section presents findings from the CFM focus groups. CFM facilitators who lead the groups are people with lived experience in the substance use treatment public health sector as clients, caretakers, or family members of clients.

Introduction

CFM voices are an integral part of the CalEQRO review process. CFM feedback is built into the DMC-ODS systems through feedback at many levels of the county and provider organizations. The CalEQRO evaluation process solicits specific feedback through focus groups that include a variety of client groups in the DMC-ODS including youth, adults, and older adults. Many groups also target specific services for feedback such as residential and NTP services, or perinatal and WM.

Client focus groups may include any individual whose life is affected by substance use and addiction, including adults, youth, and families of adults and youth experiencing addiction. Client involvement in the review process elevates CalEQRO's findings and incorporates first-hand knowledge in a meaningful way into the success of the DMC-ODS counties.

Methods

During FY 2019-20, CalEQRO used CFM consultants to facilitate 37 client focus groups with 256 participants in 16 counties, with a focus on the client's experience of care in perinatal services, residential treatment, outpatient services, MAT in NTPs and community settings, youth-specific treatment programs, and WM. Once the Governor's order for shelter in place was implemented client focus groups could not be safely conducted and BHC obtained approval for the last ten counties to not have client focus groups. Instead, BHC relied on TBS and other results for impacts until new safe options could be developed.

Groups were conducted in Spanish and English and planned for additional languages in future reviews. The group participants were diverse in gender, age, race, and ethnicity. They were representative of client populations served within the county DMC-ODS where the groups were conducted. The composition of groups in total were 52 percent male and 48 percent females in the groups.

CalEQRO developed age-specific interview guides that are followed during each focus group session. The questions were printed and handed out to participants in appropriate languages, with a Likert Scale that includes visual faces from agreement to disagreement. This allowed people of all reading abilities and levels of comfort with public speaking to give feedback on their treatment experiences. The guided group discussion provided feedback in the areas of access to services, timeliness of care, quality/satisfaction with care, and impacts of care on their lives. Besides the structured questions, participants were encouraged to make suggestions on improvements and ideas for any service gaps. CFM facilitator/consultants used their own lived experience along with their training to effectively gather data reflective of beneficiaries' experiences within the DMC-ODS system. CalEQRO also collected

demographic information from CFM focus group participants. Findings were included in each county's DMC-ODS Review report.

The following tables summarize the CFM focus group findings by county size. Findings from the county focus groups were reviewed and analyzed to determine strengths, challenges, and recommendations in this year of DMC-ODS services.

Counties where it was possible to conduct groups this fiscal year are grouped by population size as follows:

- Small: Napa, Imperial, Yolo
- Medium: San Luis Obispo, Marin, Placer, Merced, San Joaquin
- Large: Alameda, Contra Costa, Santa Clara, San Francisco, Orange, San Bernardino, Fresno, Ventura
- Very Large: Los Angeles

Table 4-1 identifies the number and focus of client focus groups that were held in each county size group. Across the counties, there was a focus on feedback from people in the following groups receiving services: perinatal, youth, MAT, outpatient, and residential services.

Table 4-1: Number and Types of Client Focus Groups, by DMC County Size

Total Groups	# of Small County Groups	# of Medium County Groups	# of Large County Groups	# of Very Large County Groups
Adult Perinatal		3	2	1
Adult Residential	2	1	2	1
Adult Outpatient	1	4	3	
Youth		1	2	
NTP MAT Group			2	1
Adult Spanish Speaking Group	3	1		1
Adult SUD caretaker and family members of consumers		1		

Table 4-2 identifies the mean score of the answers to the client satisfaction focus group questions, by pioneer and Year One counties. Answers range from 1 to 5, with 5 being the best.

Table 4-2: Mean Responses to Focus Group Questions by Pioneer and Year One Status

	Pioneer Counties	Year One Counties	All DMC-ODS
Easily found treatment services as needed	4.50	4.34	4.43
I got my assessment appointment at a time and date I wanted	4.50	4.40	4.44
It did not take long to begin treatment soon after my first appointment	4.00	3.55	3.90
I feel comfortable calling my program for help with an urgent problem	4.00	3.27	3.66
Has anyone discussed with you (or your family) benefits of new medications for addiction and cravings?	4.10	3.12	3.71
My counselor(s) were sensitive to my cultural background (race, religion, language, etc.	4.30	4.24	4.27
I found it helpful to work with my counselor(s) on solving problems in my life	4.80	4.55	4.62
Because of the services I am receiving, I am better able to do things that I want	4.90	3.37	4.23
I feel like I can recommend my counselor(s) to friends and family if they need support and help	4.50	4.51	4.50

Pioneer counties scored higher on CFM quality-related survey questions overall.

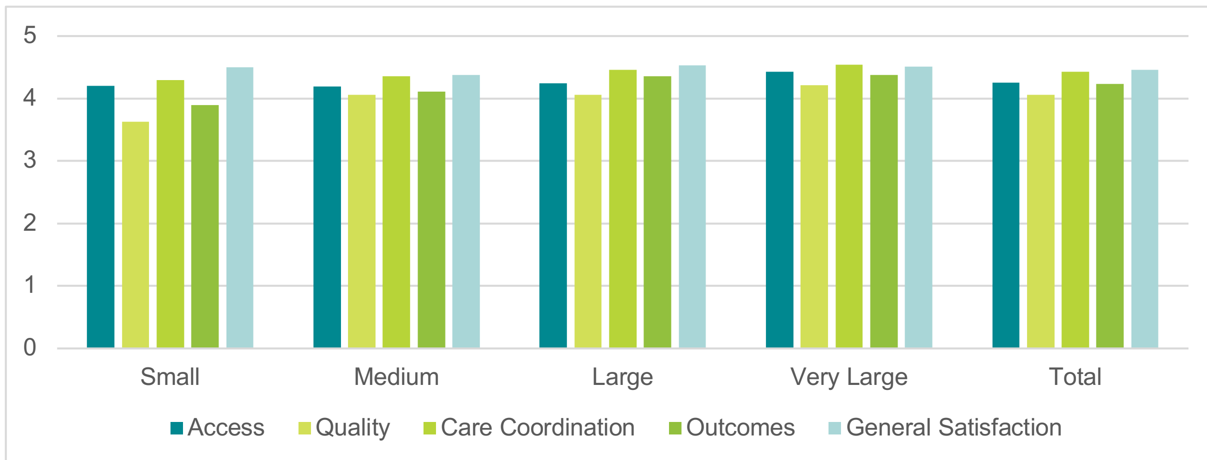
Feedback from Client Focus Groups

Comments from new clients who entered treatment in the last year were generally positive. Clients reported that:

- Services were more easily accessible.
- Services were lifesaving and helping with SUD recovery.
- Received help with problem solving.
- Counselors and therapists were caring, supportive and culturally sensitive.

- "If they don't have what you need [for recovery and wellness] they will try to get it and provide it."
- "I feel that I was given the tools I need to succeed."
- "I know I can talk to my counselor about my feelings."

Figure 4-1: Mean Responses to Client Focus Group Survey, by Domain and County Size



For clients completing surveys as part of the onsite focus groups, the general satisfaction, care coordination, and access were rated more highly for all sizes of counties than were quality and outcomes. The client groups saw an improvement in ease of access from experiences prior to implementation of the Waiver, and many remarked that case managers helped with access to residential, NTP services, and outpatient services, including MAT. Clearly the addition of case management supports, and community-based services affected vulnerable populations and improved their access to more types of support.

Treatment Perception Survey

In addition to the CFM feedback received by CalEQRO during the focus groups in onsite reviews, the DMC-ODS Waiver requires the submission of an annual client experience of care/satisfaction survey. The CalEQRO, in coordination with UCLA, is required to review client satisfaction surveys conducted by counties participating in the DMC-ODS Waiver. UCLA coordinates the survey with each DMC-ODS annually in October of each year after services are implemented, offering surveys customized for adults and youth in appropriate languages. Completed surveys are submitted to UCLA for scoring; an interpretive report is given to each county listing the results by provider site.

The information gathered from the surveys supports DMC-ODS QI efforts and provides key information on the effects of the new continuum of care. Counties must administer the TPS at least once annually. However, as a best practice, counties may conduct more frequent client satisfaction surveys and/or

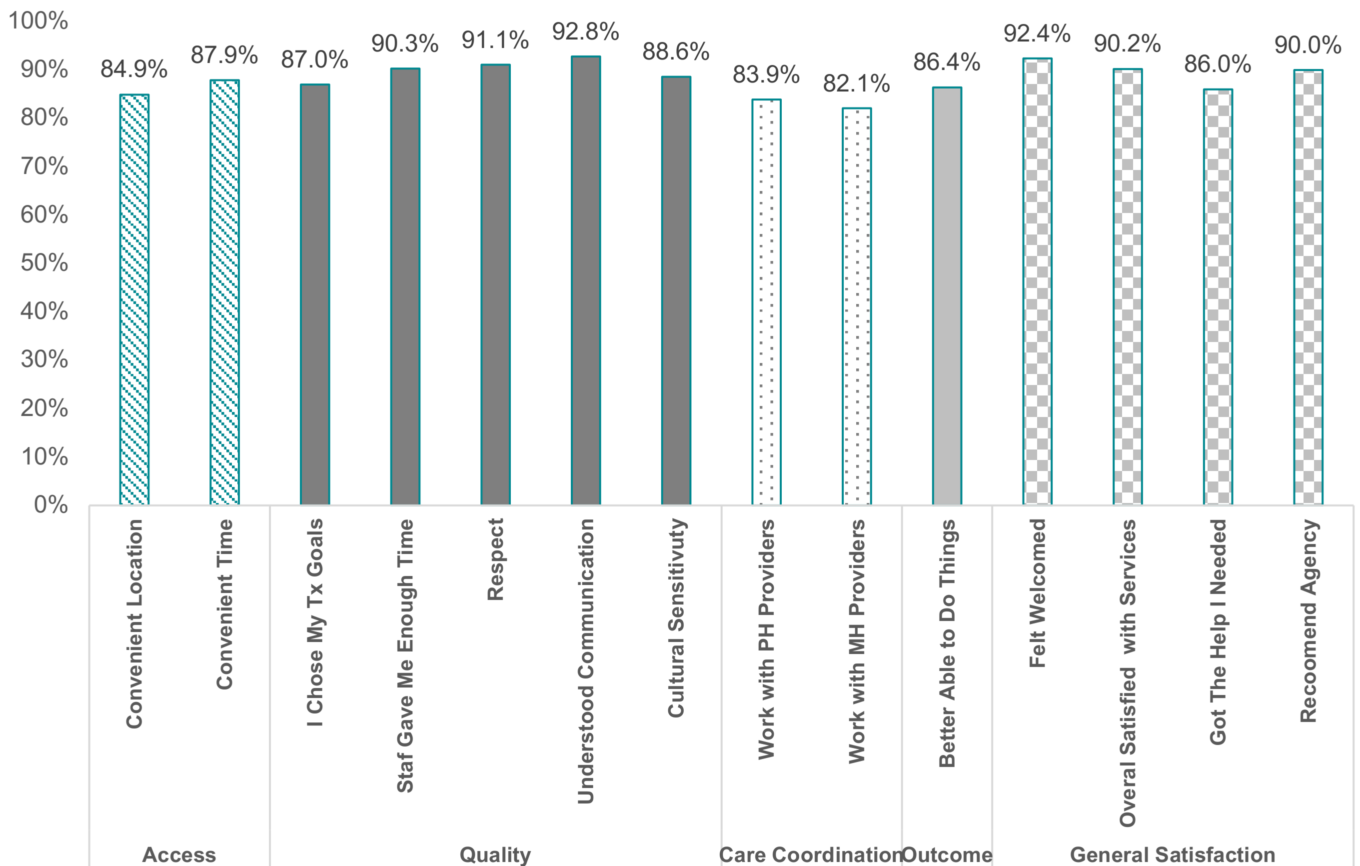
include additional survey questions if the standard TPS is used. Many counties have added questions and also have deployed their surveys more frequently than annually.

CalEQRO reviews the results given to each DMC-ODS as part of the onsite review to determine how they are using it for QI efforts and their high and low scores by specific site and program. Efforts to use these results are strongly encouraged as a key component of the annual QI plan and goals.

Results from the FY 2019-20 TPS results for the 26 counties reviewed show overall great satisfaction with services received during the second year of the DMC-ODS implementation. Scores are ranked on a satisfaction range from 1 to 5, with 5 being the most satisfied. Areas measured cover access, quality, care coordination, outcomes, and general satisfaction.

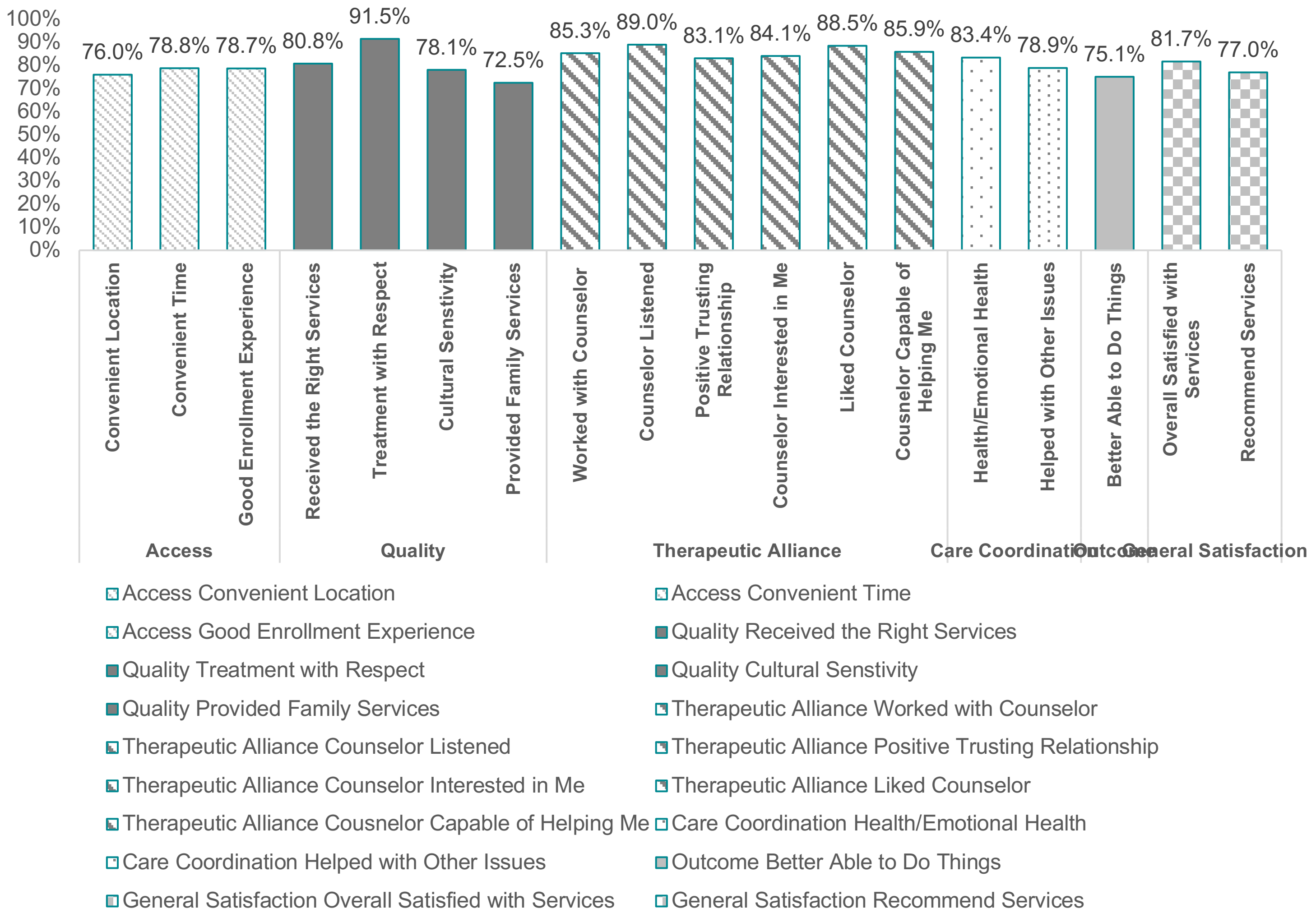
Data from the TPS are included in the quality and outcomes chapters as well as the full PM for TPS is in both the quality and outcomes chapters in more detail.

Figure 4-2: Percent in Agreement for Each Survey Question by Domain, TPS Adults



Overall, for adults, the statements about "feeling understood by staff" and "feeling welcomed into services" were rated the highest. Areas of lower scores related to care coordination with mental health and physical health, though all ratings were above 80 percent.

Figure 4-3: Youth Results for Treatment Perception Survey by Domain



The youth TPS survey had 18 questions linked to 6 domains. The highest rankings were linked to "treatment with respect" in the quality domain and "my counselor listened" in the therapeutic alliance domain. The lowest ratings overall linked to "provision of family services" in the quality domain and "better able to do things" in the outcome's domain. All DMC-ODS counties are provided their results by specific provider and site location so they can follow up and target QI activities to specific domains at specific sites. Part of the CalEQRO review involves discussing and formulating QI activities based on TPS results and suggesting design options of potential PIPs linked to the TPS results, or other appropriate actions related to improving the quality of care. The number of youths completing the surveys are still very low overall, and counties are encouraged to do more outreach in the next administration.

Strengths Based on Client/Family Feedback

More rapid access to treatment. The majority of clients in focus groups reported that finding treatment is now easier with DMC-ODS. Among those who had been in treatment before, many observed that services had changed. Some had used the Access Call Center lines for help with success. Some also had used the Access Call Center line to get information for family or friends about SUD issues and treatment. Wait times for most services were reduced in the DMC-ODS, with services usually available within two weeks and sometimes within 48 hours. Once a client's ASAM assessment was completed, it was generally reported that they could get into programs quickly. Some clients reported that the delays were from the request via the call center or walking into a treatment program to the assessment and admission. The exception often noted was for NTP services and depending on the county WM. Some clients reported that if they had a Probation Officer, they felt they got in faster than others. This was a common shared perception.

Quality of counselors and case managers were highly regarded and described as very helpful, knowledgeable, skillful, caring, and sensitive to cultural issues. Clients found the addition of case management, especially coordination of other services, very helpful. Clients generally rated the quality of the services they received as very high.

Quality of clinical programming was experienced as very positive and helpful. Clients appreciated the range of skills they were taught as part of their SUD treatment program, which included not only recovery-specific aids but also life skills that would support their recovery process and help them with family issues and vocational planning. The new addition of case management was seen as very positive and many clients wanted more case management time and support. It was described as "very practical and focused on what I needed to do to get back to my life and the community."

Many clients described MAT services as being available in many counties. In most cases, programs and clients were supported to maintain their involvement in this treatment. Many clients reported receiving information on the benefits of MAT services when they began treatment, and that they were supported to take advantage of this treatment. This had improved significantly from the client feedback from the prior year. There were still some counties and programs where this was not as integrated into treatment needed, but clear progress had been made.

Recovery services including peer mentor and support programs existed in a few counties, which showed particularly positive impact to both peer counselors and clients during and after recovery treatment programs.

Family and individual therapy had become a strong component in some counties' programs and was deeply appreciated by clients as a means to support them in their recovery. This could be a

practice to expand in other programs and services and counties. It was most prominent in perinatal programs and youth programs.

Opportunities for Improvements Based on Client/Family Feedback

The lack of recovery housing and affordable options was reported by clients and families to be a problem in the majority of counties, creating an added risk of relapse after discharge from residential treatment or residential WM. There was significant anxiety and concern by clients, family, and staff alike that without additional housing resources, many clients would become homeless and this would be a barrier to ongoing recovery, increasing the risk of relapse. This problem was particularly acute in expensive urban and coastal areas.

For some clients, access to MAT in all areas of the county and service settings was a concern. Counties continue to work with some providers, particularly residential programs, and intensive outpatient programs, to increase access and support for MAT services. Availability of prescribers with knowledge of SUD treatment and MAT is growing but increased this year over the first year of services. Also, telemedicine options have enhanced access in positive ways; an example of this expansion and integration is use of Brightheart Health telemedicine service which is 24-hour, seven-days-per-week and has rapid access to assessments and treatment providers as reflected in timeliness data in Marin and Contra Costa.

Many clients voiced requests for more family involvement in treatment particularly as they were planning for transitions into community settings other than residential. Some counties are working to expand services to include family-specific treatment education and family groups to support clients in recovery. This service could be expanded to more counties as a key support for successful recovery. Having family and community support is a key aspect of recovery services and as this expands, some of these needs may be addressed.

Burdensome paperwork taking time away from treatment was a common complaint. Many clients (and administrators) believe more staff are needed in treatment programs as a result of the increased focus on Medi-Cal-required documentation that is reducing the amount of time counselors and therapists can make available for client treatment services.

Many counties need to expand WM services, as evidenced by client and staff reports related to timely access and capacity issues. Many counties are in process of expanding these services through RFPs; some are converting a portion of available residential beds for residential WM to help to meet this gap in service. There have been regular problems with access to neighborhoods and also providers willing to provide 3.2 WM services.

There is a growing demand for more flexible programs (particularly residential and intensive outpatient) to allow persons who are trying to work, particularly when close to discharge while still attending treatment. In addition, flexible programming would also address the increased programming

of some residential programs that is not allowing clients to coordinate ancillary care and visitors while in residential treatment. This was part of the focus group discussions of need for more individualized approaches to treatment particularly in residential and intensive outpatient, not just hours in groups and sessions, but real-life, concrete tasks to begin community integration and testing of skills to support their recovery. These tasks were seen as critical to their success by clients.

Night and weekend outpatient and MAT hours for persons working (to continue their outpatient treatment) was also requested regularly, particularly for Spanish-speaking groups.

Clients reported that out of county Medi-Cal was a barrier and transfers to their new county where they were living, and new paperwork took too much time.

Many clients and families report that limits on residential treatment services were a problem, and some individuals need more time to get well and stable.

Key Themes from Clients and Families

In the DMC-ODS programs reviewed, clients continue to report high levels of satisfaction with the expanded treatment services as evidenced by the CFM focus surveys, groups, and the TPS results. Counties continued to implement program expansion elements during this time period and actively set up improved access systems for the community and key stakeholders. The ASAM continuums of care expanded in most counties in both their second and third years of services.

Based on the total sets of feedback received in groups prior to COVID 19 there were themes of key improvements desired from the SUD programs. Examples are quoted below:

- Help with housing, especially after residential treatment such as recovery residences and other step-down housing programs, especially for women with children.
- Increased family support and treatment programs as a core part of the continuum of care.
- Expanded access and support to WM and MAT treatment to meet the increasing demand for MAT services in all treatment programs and demands for WM access.
- Increase staff to meet counseling, case management, and support needs with new requirements; and show flexibility to support individual situations, goals, and challenges for SUD recovery success.
- More flexibility in structured programs such as residential and intensive outpatient to consider and focus on individual needs and avenues to improve functioning and community success.