FY 2019-20

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)
November 16, 2020

BHC Behavioral Health Concepts, Inc

Acknowledgements

Behavioral Health Concepts, Inc. (BHC) would like to acknowledge the people of California who persevered through unprecedented challenges this year. Most notable among these challenges has been COVID-19 (still ongoing at the time this report was submitted), fires statewide, and other pressures both within and beyond our control. Yet people have continued to strive not only for their own health and behavioral health, but for those of others.

The COVID-19 pressures and other stresses 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 26 DMC-ODS plans that participated in the California External Quality Review Organization (CalEQRO) reviews, including staff, volunteers, contract providers, key stakeholders, and many others. In particular, we acknowledge all of the clients and family members who shared their experiences with us.

In addition, BHC would like to acknowledge the support and collaborative evaluation staff from UCLA Integrated Substance Abuse Programs and its leadership, and the support and collaborative efforts at sharing training and quality information statewide with California's Behavioral Health Directors Association (CBHDA). Both of these organizations worked to support efforts to foster quality of care and best practices for SUD services, discovering 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 responsible for quality and evaluation of the 1115 Waiver, Network Adequacy, and Substance Use Disorder (SUD) licensing and services have 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 Used in This Report

AAS	Alternate Access Standard
AB	Assembly Bill
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.
BQUIP	Brief Questionnaire for Initial Placement
CalAIM	California Advancing and Innovating Medi-Cal
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
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
EBP	Evidence-based Program or Practice
ED	Emergency Department
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 Master Eligibility File
MOU	Memorandum of Understanding
NACT	Network Adequacy Certification Tool
NCQA	National Committee for Quality Assurance
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
QIP	Quality Improvement Plan
RPT	Relapse Prevention Therapy/Treatment
SAPC	Substance Abuse Prevention and Control
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT BG	Substance Abuse Prevention and Treatment Block Grant
SASH	Substance Abuse Services Helpline
SBAT	Service and Bed Availability Tool
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 Report
2019-20

Executive Summary

Executive Summary

Steady progress and ongoing challenges in California's third year of 1115 Waiver implementation

Introduction

After this third year of reviewing the Drug Medi-Cal / Organized Delivery System (DMC-ODS) counties and their implementation of the 1115 Waiver, it is clear that the Waiver is improving clients' access to treatment, enhancing timeliness to get into treatment, and building key elements of quality that are benefiting the clients and system of care as a whole. California's substance use disorder (SUD) Waiver was the first in the nation, responding to a dual national and statewide crisis. Many notable examples of these clinical and program improvements were observed and documented across the first 26 counties reviewed.

To see these system changes in more depth, data from the initial pioneer counties were separated from the counties that newly launched their DMC-ODS services in the last 12 months. 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 remain. As counties demonstrate innovative approaches to addressing the challenges they face, they are able to 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.

DMC-ODS Statewide Annual Report Contents

Data sources, findings, and recommendations are detailed in nine chapters, highlighted in this summary:

- Introduction
- Methods
- Access
- Network Adequacy
- Timeliness
- Quality
- Outcomes
- Structure & Operations
- Conclusion & Recommendations

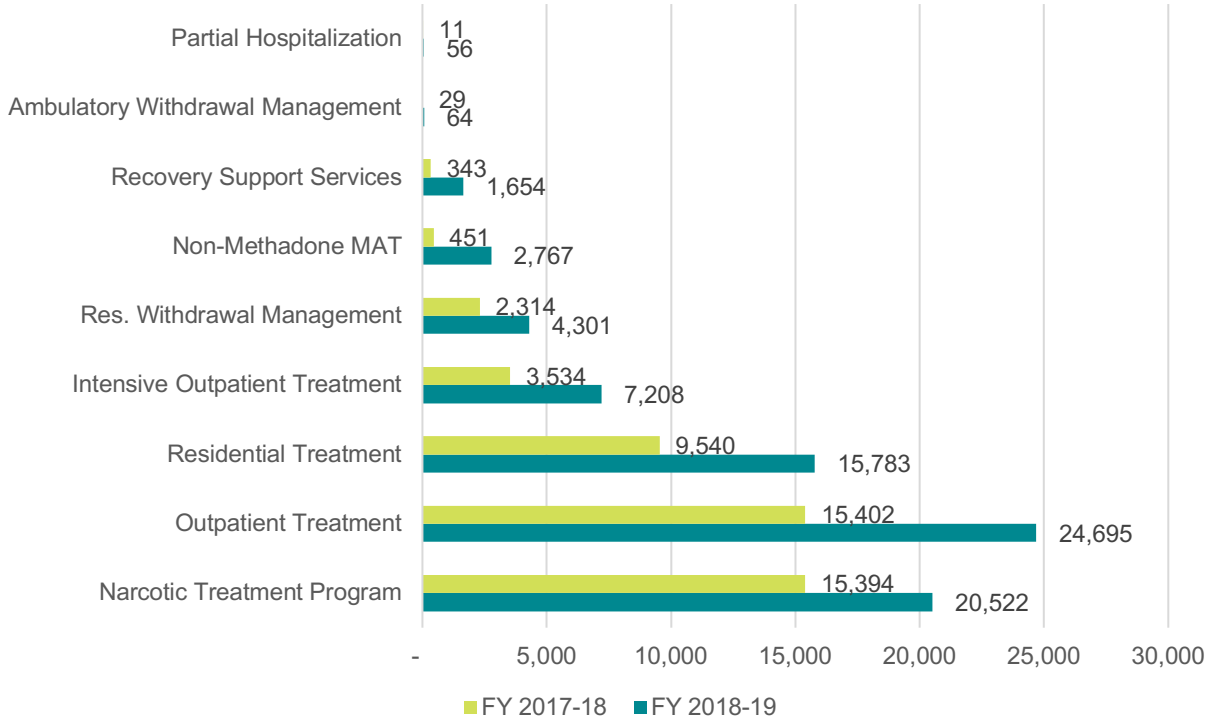
Timely Access to Appropriate Care

The Fiscal Year (FY) 2019-20 findings from review of the 26 counties showed expanded service delivery across the American Society of Addiction Medicine (ASAM) levels of care, for both historical and new Medi-Cal treatment services. The pioneer counties showed the most significant growth across

the continuum of services. First-review year counties also expanded services, although to a more modest degree. In addition to serving 77,050 unduplicated clients with DMC-ODS Medi-Cal services, the penetration rates of clients served exceeded statewide averages as well. These penetration rates, based on all Medi-Cal eligibles in a county, also showed improvement across all ethnic/racial groups when comparing the data from the reviewed counties to statewide data. (See Figure 3-3 in this report's chapter on Access.) This trend has continued for each of the three years.

Besides serving more people, it is also important to consider what SUD services these clients are getting. While all levels of care expanded during the review period, some did so more rapidly than others. Some specific services were still underdeveloped in terms of access and quality of the care system as a whole. Some of the strongest growth in specific services provided in the Waiver continuum was in residential treatment, intensive outpatient and outpatient, Narcotic Treatment Programs (NTPs)/Opioid Treatment Programs (OTPs) with new expanded medication options, and case management. Levels of care where growth has been much slower included recovery residence housing, recovery support services, non-methadone Medication Assisted Treatment (MAT) both inside and outside the NTP/OTPs, ASAM levels 3.7 and 4.0 Withdrawal Management (WM) and inpatient care, and residential services for youth. These levels of care require more investment in order to meet client needs.

Clients Served in FY 2017-18 and FY 2018-19 in DMC-ODS Pioneer Counties (Units of Service Across Levels of Care)



DMC-ODS counties organized their systems in ways that made them much more accessible to clients, at every point from the initial request to delivering treatment at the right level of care. These best practices and evidence-based practices (EBPs) included:

- Offering a 24/7 access center or beneficiary access line (BAL) with call-center software, three-way calling capacity, and real-time SUD resource directories
- Linkages to historic records to streamline assessments/screenings and referrals
- Well-distributed program sites for full ASAM assessments
- Walk-in appointment hours
- Warm handoffs between providers
- Up-to-date appointment and vacancy information
- Access to navigators or case managers to help get clients to their first face-to-face appointment
- Data tracking alerts when system services were full or over capacity.

True access requires much more than offering an empty appointment or residential bed. In addition to time and space, it means an adequate workforce is in place at all levels of care, with the skills and licenses required for specific services. All counties and contractors that participated in this review needed assistance and support to expand their trained SUD workforce; they felt this was an area where state leadership was critical to expand college and program capacity to bring more people into this important field of work.

To make the Waiver services work for clients, timely access is especially important because so many clients are ambivalent or fearful about treatment. Giving up an addiction and facing the withdrawal that follows is challenging and, in many cases, painful work. To make this tolerable and to encourage clients to seek and sustain care, it is essential to match clients to the right level of care with welcoming, skilled counselors and providers. Best practices in this area include robust screening and prompt linkages to the right level of care, along with engagement with someone who can help clients with their specific needs, supporting them as they move forward through withdrawal to an appropriate 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 sites and staff and expanding their use of telehealth.

Quality of Care and Outcomes

The assessment and review tools used by CalEQRO suggest steadily improving quality of SUD services being provided to the Waiver counties' Medi-Cal clients. Design elements incorporated into the 1115 Waiver for DMC-ODS enhanced the quality of SUD services across California, as shown in the reviews for these first three years. A variety of data sources—ASAM level of care referral data, Treatment Perception Survey (TPS) data, California Outcomes Measurement System (CalOMS) results, PMs, and stakeholder and client feedback—document changes related to these elements of quality. They include:

1115 Waiver Design Elements Supporting Quality of Care and Outcomes

- **Client-centered services** in a continuum of care
- **Care coordination** and **recovery support** services
- **Infrastructure** and supports for quality of care

(1) Client-centered services in a continuum of care provided a solid foundation and model with varied intensity and a strong focus on science and EBPs.

(2) Care coordination and recovery support services connecting and communicating needs from request through the continuum of care, and then back into the community with assistance.

(3) Infrastructure and supports for quality of care based on best practices, scientific evidence, and investments in continuous quality improvement, linked to electronic health records (EHRs), efficient billing, and data and oversight systems.

Many examples of successful models and activities in all three domains surfaced during this year's reviews, along with areas warranting additional investment and potential system changes that can be addressed in CalAIM with collaborative care delivery systems. Challenges in this area are exacerbated by the number of providers within county DMC-ODS who are still unable to communicate client needs electronically, coordinate their care, and use resources efficiently. Behavioral health continues to have significant unmet information system infrastructure needs; this hinders communication across networks and between behavioral health and health care in general.

Recommendations and Next Steps

CalEQRO recommends that the DMC-ODS counties continue to develop new models that can be adapted by small counties that are not currently part of the Waiver. These models could include regional approaches, such as the Partnership Health Plan DMC-ODS, or other structures that provide access to a full range of DMC-ODS services in a coordinated manner, integrating mental health and physical healthcare.

CalEQRO also recommends that the Waiver renewal process consider best practices in access, timeliness, and quality learned from the CalEQRO reviews and UCLA evaluation, to ensure these are integrated into SUD care models for the future.

State and local investments in information system and infrastructure components such as electronic health records (EHRs), workforce capacity, and quality management systems should continue. These structural supports not only enhance the capacity of DMC-ODS plans to leverage their clinical and community potential to alter and save individual clients' lives, but also have significant impacts on community and family health and decrease SUD's impact on the criminal justice and child welfare systems.

Like other investments in improving SUD systems of care, investments in SUD stigma reduction and affordable housing have tremendous potential to improve outcomes for those in SUD treatment. Just as crucial is their potential to support those at risk for SUD, who may avoid seeking care earlier in the progression of their addiction due to stigma. The DMC-ODS plans are embedded in societies whose attitudes affect the programs'—and clients'—success.

Recommendations for Building on DMC-ODS Progress

- Continue to develop new models for **adaptation by smaller counties** (e.g., regional approaches)
- Incorporate **best practices in access, timeliness, and quality** into the Waiver renewal process
- Continue state and local **infrastructure investments**
- Support **stigma reduction** and **affordable housing** initiatives to support clients and communities

Chapter 1

Introduction

Introduction

Year Three: The Evolution of DMC-ODS 1115 Waiver Services

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

Introduction

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, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid managed care programs. These rules require an onsite review or a desk review of each Medicaid (Medi-Cal in California) Drug Medi-Cal Organized Delivery System (DMC-ODS) and each Medi-Cal Mental Health Plan (MHP).

As of August 2020, the State of California Department of Health Care Services (DHCS) contracted with 30 DMC-ODS counties and one regional 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. DHCS also contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. Each MHP also requires an annual EQR.

This report presents the fiscal year (FY) 2019-20 findings for the 26 California DMC-ODS counties that have been operational in providing clinical services for one year or more. Findings are the result of data collection, analyses, and reporting by the California External Quality Review Organization (CalEQRO),

Behavioral Health Concepts (BHC). Additional information, including CalEQRO resources, DMC-ODS reports, and presentations can be found on the website at www.caleqro.com.

Structure of the 2019-20 BHC-CalEQRO DMC-ODS Statewide Annual Report

1. **Introduction**
   Year Three: The Evolution of DMC-ODS 1115 Waiver Services
2. **Methods**
   Methods Used in the EQRO Evaluation of California's DMC-ODS 1115 Waiver
3. **Access**
   How California 1115 Waiver Counties are Improving Access to Substance Use Disorder Treatment
4. **Network Adequacy**
   How DMC-ODS Counties are Meeting New Standards for Timely Access to Care
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   How DMC-ODS Counties are Improving Outcomes for People with Substance Use Disorders
8. **Structure and Operations**
   How Structure, Operations, and Informations Systems Affect Quality in DMC-ODS Plans
9. **Conclusion and Recommendations**
   Implications of CalEQRO's FY 2019-20 Review

This is the third year that the quality of services has been evaluated since the Waiver's launch. California's Waiver implementation was the first in the nation to respond to a major opioid crisis through the Medicaid Waiver process and restructure the entire substance use disorder (SUD) system to encompass new quality requirements and services based on the American Society of Addiction Medicine (ASAM) continuum of care for persons with addiction disorders.

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 (CFR 42, Part 438). BHC was awarded the contract to be the EQRO for California. As the EQRO, BHC is required to conduct a review of the county on an annual basis to review access, timeliness, quality, and outcomes. The review criteria are based on CMS 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; and
- Client satisfaction with the services received, measured through a survey and other mechanisms.

This EQR report represents the FY 2019-20 Annual Report of the DMC-ODS programs by CalEQRO. There were 26 reviews this past FY for counties that had been operational for 12 months or more as a DMC-ODS. For 12 of the 26 counties, FY 2019-20 was their first year of DMC-ODS clinical services. These will be referred to as Year One counties in the report. Eleven counties were completing their second year. These counties have additional PMs and were in a different stage of developing in their networks and in many of their quality initiatives. Three original counties—Marin, San Mateo, and Riverside—began in February and April of 2017 and were in their third year of direct services under DMC-ODS. The second and third-year counties are referred to in the report as the "pioneer" counties, due to their earlier starts and more mature stage of network development.

This report evaluates the quality and impact of services in the 1115 Demonstration Waiver on clients being treated, as well as associated changes in the counties' care systems and their operations. It also identifies strengths and challenges the programs have faced, barriers to improvement, and recommendations to overcome these barriers. The review and report include DMC-ODS counties as large as Los Angeles and as small as Nevada County. The goal of this report is to evaluate the success of the Waiver in reaching some of the goals set forth in the Special Terms and Conditions (STCs); the expansion of science-based care models such as Medication Assisted Treatment (MAT) services; expansion of telehealth services due to COVID-19; and the model's strengths and challenges at the county service delivery level.

Goals of California's Waiver

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

The Waiver also required appropriate standards of care based on ASAM criteria. ASAM assessment criteria were chosen mainly because they reflect a national set of guidelines for appropriate placement of care for clients who suffer from a SUD. The criteria provide a common language for the levels of care within the continuum of services. ASAM criteria also were recommended by stakeholders and were already in use by providers in several counties.

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

DMC-ODS Network Landscape

Electronic Health Records

Most of the DMC-ODS counties reported that they continue to use paper client charts. Since the majority of the SUD treatment services are delivered through contracts with community-based provider organizations (CBOs), providers frequently must enter their data twice into two different computer systems, which is prone to error. In addition, many interoperability issues arise when entities are using two different computer systems.

DMC-ODS counties also have reported a lack of electronic health record (EHR) vendors that specialize in SUD. Often, fiscal considerations drive the selection process, instead of clinical ones.

DMC-ODS counties also struggle with the lack of technology for their 24/7 access call centers. This lack of infrastructure is also complicated by meeting the confidentiality requirements in 42 CFR.

Budget Challenges

One of the consequences of the stay-at-home order due to the COVID-19 public health emergency was its impact on the economy. The Governor's May 2020 revised budget was dramatically different than the budget that was presented in January of this year. The majority of the SUD services being provided are funded through Medi-Cal, 2011 Realignment, and the Substance Abuse and Mental Health Service Administration (SAMHSA) Block Grant. The funding is driven by economic conditions rather than by the demand for services. The May 2020 revised Budget Act proposed to provide $1 billion to counties for

safety net services and to backfill the realignment funds. Approximately $750 million would be provided by the state and the remaining $250 million is dependent on the state receiving federal relief funds. DMC-ODS counties are struggling to meet their federal and state requirements with this budget shortfall in the middle of the ongoing public health emergency.

Trends Affecting 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 wellbeing 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.

CalEQRO quickly collaborated with the remaining DMC-ODS counties to conduct desk reviews for the remainder of the FY. For FY 2019-20, CalEQRO conducted 17 onsite reviews, 1 virtual review, and 8 desk reviews. The virtual review was conducted through video sessions with additional data and document reviews; while the desk reviews consisted primarily of reviews and analyses of data and documents from the county, augmented by phone consultations.

In addition, the consumer family member (CFM) focus group sessions were discontinued due to the Executive Order. CalEQRO notified DHCS that to protect consumers and family members, the onsite sessions were discontinued. DHCS approved of this change for the remainder of the FY reviews.

California Trends

California Advancing and Innovating Medi-Cal (CalAIM) and 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 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.

With the onset of the COVID-19 public health emergency, DHCS has postponed the implementation of the CalAIM proposal. The current 1115 Waiver is set to expire on December 31, 2020. DHCS has requested a 12-month extension from CMS to extend the 1115 Waiver until December 31, 2021, which has been approved.

Network Adequacy

In April 2016, CMS issued the Medicaid and CHIP Managed Care Final Rule, which aligned the Medicaid managed care program with other health insurance programs. Included in the Final Rule was the requirement for states to establish network adequacy standards that became effective in July 2018. These requirements are specific to timely access as well as time and distance standards. States must also annually certify networks to CMS, which demonstrates compliance with network adequacy. Assembly Bill (AB) 205 was signed into law on October 13, 2017 and codified California's network adequacy standards (Chapter 738, Statutes of 2017). The network adequacy standards are based on the population of each county.

The following are the three parts of the Managed Care Rule set forth in Title 42: network adequacy standards (438.68); availability of services (438.206); and assurance of adequate capacity and services (438.207).

- **Network adequacy standards** in Part 438.68 requires the states to develop time and distance standards for adult and pediatric behavioral health providers. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site.
- **Availability of services** in Part 438.206 requires the counties to meet timely access to care standards considering the urgency of the need for services.
- **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 1 each year.

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

This was the first year that network adequacy data were reviewed during the annual EQRO review for DMC-ODS counties.

Rapid Expansion of Telehealth

With the onset of the COVID-19 public health emergency, DMC-ODS counties had to pivot quickly to providing SUD treatment services via telehealth. CMS issued guidance to make it easier for beneficiaries to receive treatment through telehealth services. DHCS also issued numerous Information Notices in order to provide guidance on implementing telehealth services.

National Context for the 1115 Waiver

National Trends Affecting Quality and the EQRO Environment

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 responded 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 prior, successful efforts to address the toll of smoking and tobacco on the nation's health. Just as tobacco addiction was understood to be the product of forces beyond individual choices and behaviors, SUD treatment could shift from a blame-oriented, criminally focused system that ascribes SUD problems to a lack of moral character, and instead towards a brain science model that draws on researched population-based treatment and prevention approaches that have been shown to work.

The Surgeon General's report could not have come at a better time, because 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

[2] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.* Washington, DC: HHS, November 2016. Available from: https://addiction.surgeongeneral.gov/

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 turned instead to heroin and other illegal opiate drugs. Recent studies in prescribing patterns indicate that 80 percent of the world's prescribed opiates are being used in the United States.[5] The dangerous strengths of these new medications led to many overdoses annually, surpassing annual deaths from motor vehicle crashes.[6]

The alarming and overlapping trends of opioid use and overdose deaths are well illustrated by National Institute on Drug Abuse (NIDA) research,[7] as shown in Figures 1-1 and 1-2.

[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

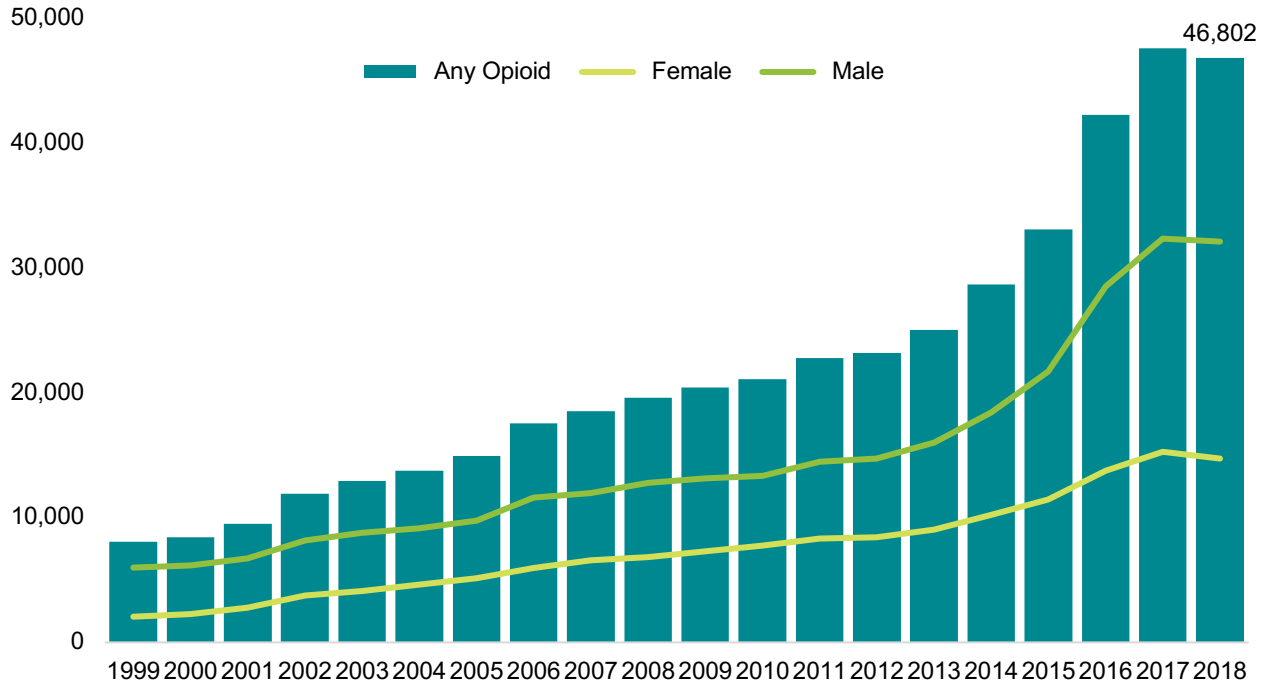
[4] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2020. Retrieved from https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[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://smartcitiescouncil.com/article/why-we-need-better-data-and-analytics-combat-opioid-epidemic

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

[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.

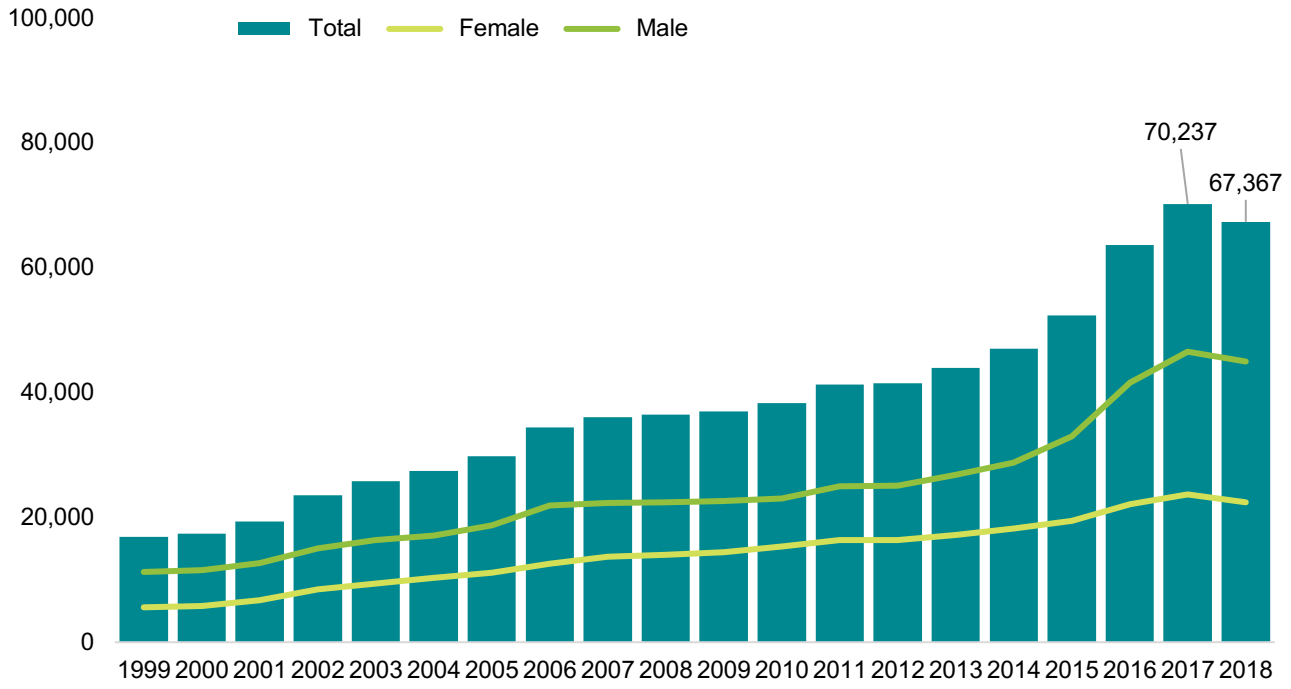
Figure 1-1: National Drug Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2018[8]



The emerging opioid crisis is clearly shown from 2014 to 2018, with the beginning of the Waiver and the launch of DMC-ODS services following in February 2017.

[8] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released January 2019.

Figure 1-2: National Drug Overdose Deaths in the United States, Number Among All Ages, by Gender, 1999-2017[9]



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.

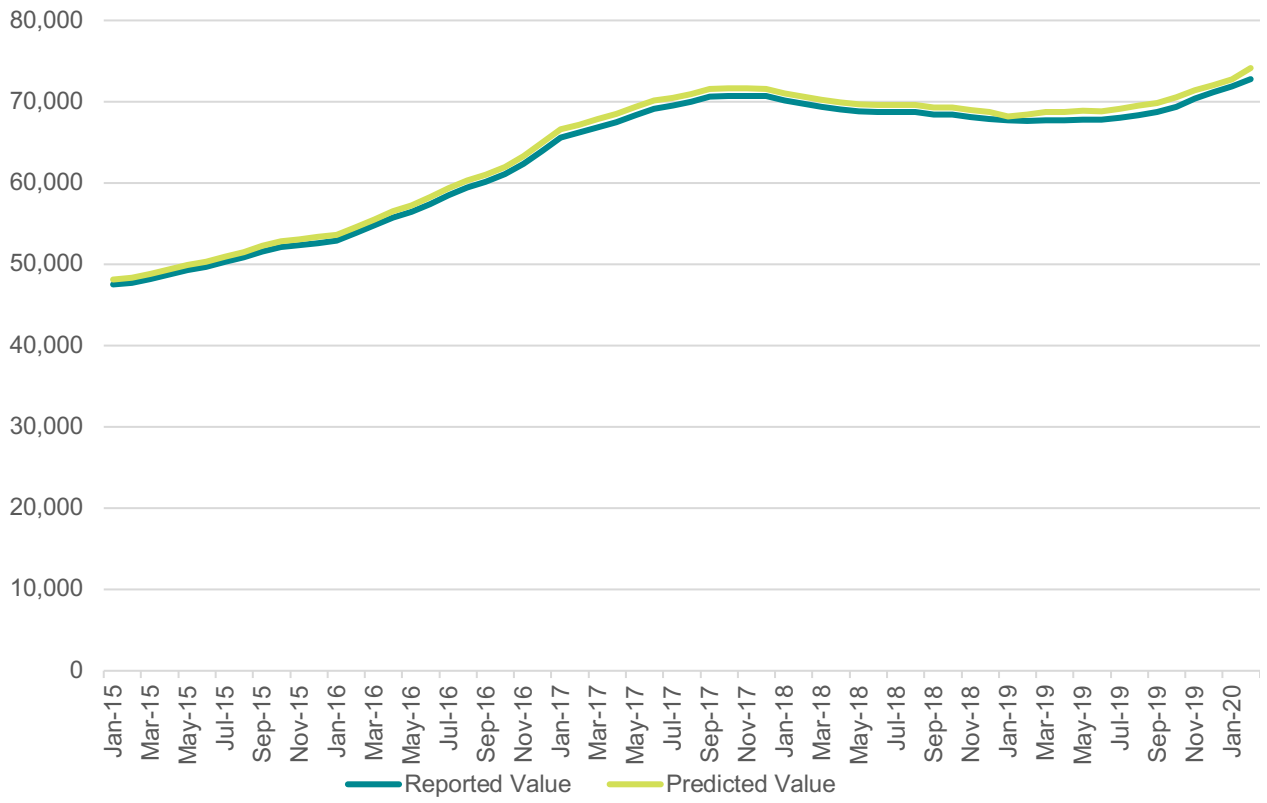
While each state has explored different ways to address the opioid crisis and add priority treatment access, California worked to develop a system of SUD treatment built on the ASAM principles with levels of care based on individualized treatment needs. Its key features include a six-dimension comprehensive 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.

[9] Ibid.

In 2018 in California, 2,428 people died from opioid overdoses and 786 people died from Fentanyl overdoses.[10] During this same time period, there were 19,808,224 prescriptions for opioids, which is a modest reduction from prior years. The overdose death rate continues to be above the state average in the following California counties: Modoc, Humboldt, Mendocino, Lake, Shasta, Lassen, Yuba, Del Norte, Siskiyou, and Ventura.[11]

Unfortunately, with COVID-19-related stress and job losses, we are again seeing a dramatic rise in overdose deaths nationally and in California, as shown in Figures 1-3 and 1-4. Part of this trend has been attributed to widespread access to the powerful opiate Fentanyl. However, COVID 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.

Figure 1-3: Drug Overdose Deaths, Month-ending Provisional Counts, United States[12]

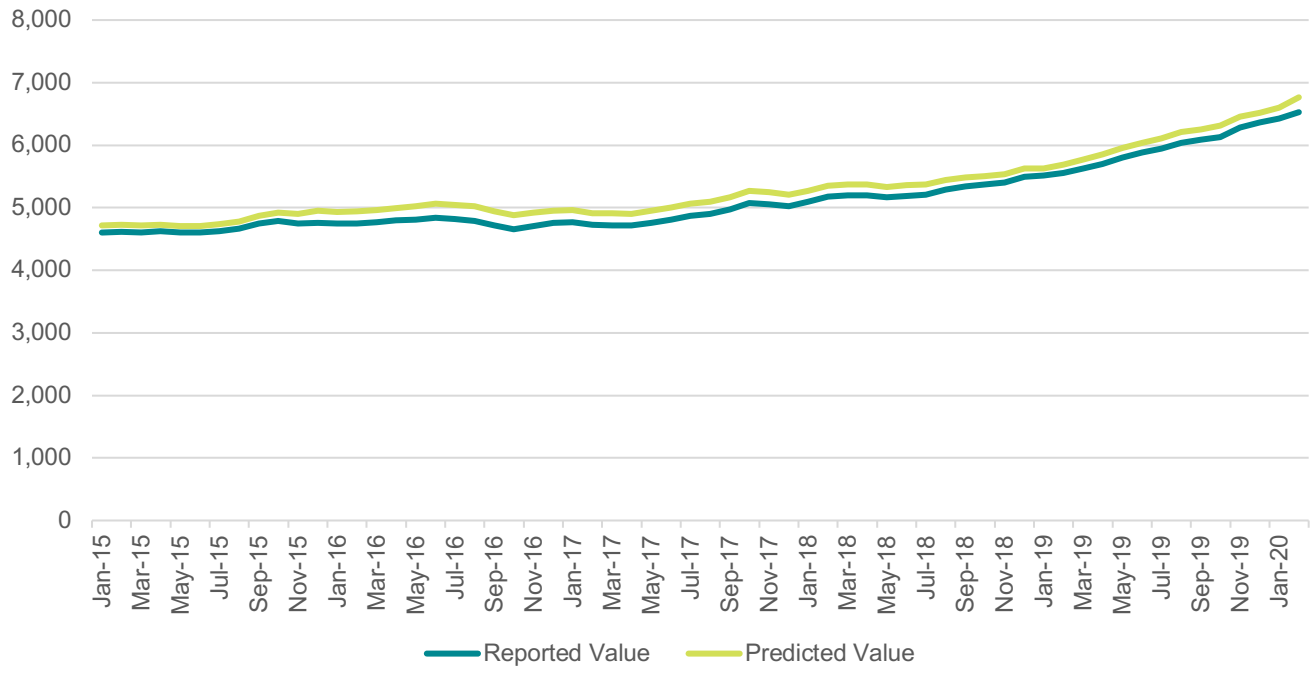


[10]California Department of Public Health. Opioid Overdose Surveillance Dashboard. Available from: https://discovery.cdph.ca.gov/CDIC/ODdash/.

[11]Ibid.

[12]Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Vital Statistics Rapid Release. Provisional Drug Overdose Death Counts. Accessed from: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Figure 1-4: Drug Overdose Deaths, Month-ending Provisional Counts, California[13]



Treatment access is more important than ever, but because of COVID-19, many new tools are needed to ensure treatment can occur safely, without spreading the virus through in-person contact. DMC-ODS counties reviewed from March to June 2020 showed significant efforts to expand telehealth, phone, and distanced visits so that treatment could continue, and medications could continue to be accessible. For that reason, the work on the DMC-ODS treatment expansion is even more important to pursue in California and nationwide.

[13] Ibid.

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Chapter 2

Methods

Methods

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

Introduction

As described in the previous chapter, the core EQRO evaluations are mandated by federal law and associated regulations; CMS rules (42 Code of Federal Regulations [CFR] §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid managed care programs. These rules require an onsite or desk review of each Medicaid (Medi-Cal in California) DMC-ODS and each Medi-Cal MHP. Recently updated protocols focus on the core themes of the annual report: access, timeliness, quality, and outcomes. These protocols for evaluation are applied to all managed Medicaid MHP and DMC-ODS plans to ensure the value of these services funded by state and federal governments.

Data Sources

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

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, PIPs, PMs, and Beneficiary Perspectives.

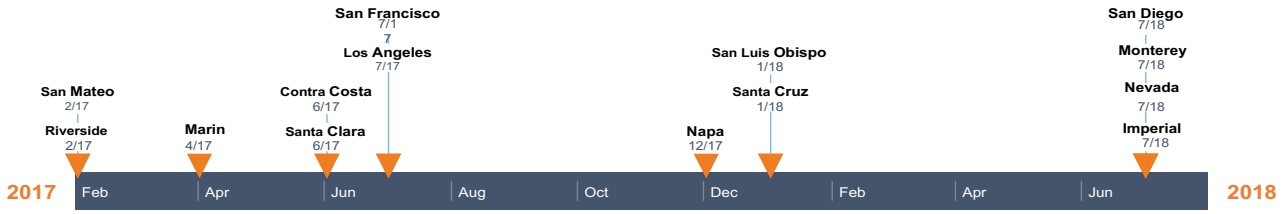
Counties and Populations

CalEQRO analyzes a specific subset of California's population linked to the counties that have completed a full year of services under the 1115 Demonstration Waiver for DMC-ODS. This is the third year of evaluation since the launch of treatment services under the Waiver and 26 counties were evaluated.

Pioneer Counties

The initial 14 counties that implemented the Waiver services 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.

Figure 2-1: Go-live Dates for DMC-ODS Pioneer Counties



First Review Year Counties

An additional 12 counties implemented services in the last year and include Alameda, Kern, Merced, Fresno, Stanislaus, Santa Barbara, San Joaquin, Orange, Yolo, Placer, and San Bernardino.

Figure 2-2: Go-live Dates for DMC-ODS For First Review Year Counties

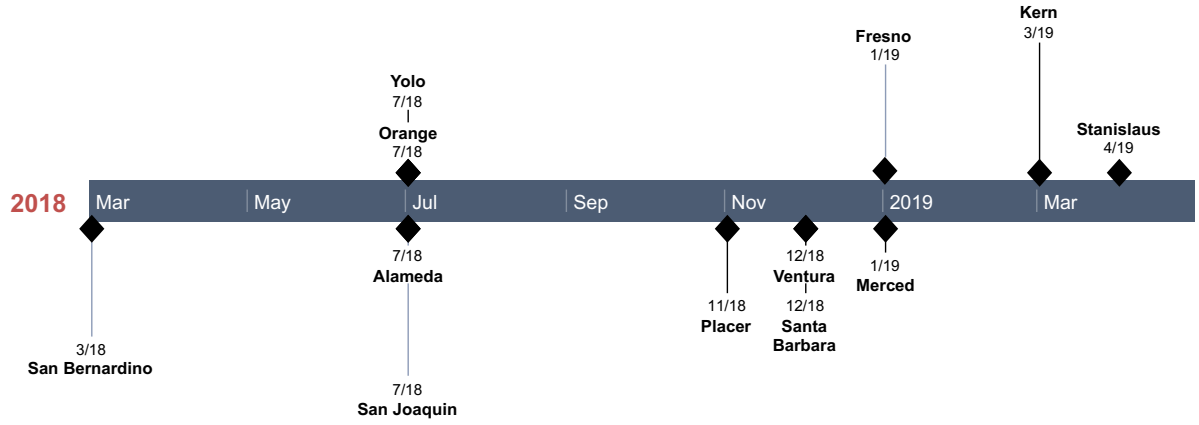


Figure 2-3: Map Showing Pioneer and First Review Year Counties

Medi-Cal Population

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.

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.**

Data Sources and Measures

CalEQRO uses a variety of data sources for the evaluation analyses, including Medi-Cal Master Eligibility File (MMEF), Medi-Cal Approved Claims, California Outcomes Measurement System (CalOMS), ASAM referral data, Treatment Perception Survey (TPS) annual survey files, Medi-Cal provider files, Network Adequacy files, and county submission documents. MMEF downloads are requested during the same time period as claims and cover 15 months of eligibility.

Medi-Cal Approved Claims files from DHCS include claims for the service period indicated, processed through the preceding month.

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 level of care 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 based on research linked to positive health outcomes for clients with SUD and related to access, timeliness, engagement, retention in services, placement at optimal levels of care 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 site visits 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 provided.
- Number of days to first DMC-ODS service after client assessment and referral.
- Total costs per beneficiary served by each county DMC-ODS by ethnic group.
- Cultural competency of DMC-ODS services 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 for Narcotics Treatment Program (NTP) services.
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measure.
- Timely coordinated transitions of clients between levels of care, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center line 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), and
- Percentage of clients with three or more Withdrawal Management (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);[14]
- Initiation and engagement in DMC-ODS services.
- Retention in DMC-ODS treatment services, and
- Readmission into residential WM within 30 days.

[14]Counties are required to administer an ASAM-based assessment to determine the recommended level of care 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 level of care to referred level of care, and also tracks the reason(s) for noncongruence. ASAM Level of Care Data Collection System details available from: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

California Outcomes Measurement System (CalOMS)

Another important data element is the CalOMS. Service providers who receive public funds for SUD treatment services and all NTPs are mandated to report CalOMS data to DHCS. Providers collect client information at admission and discharge from the treatment program 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.[15]

Treatment Perception Survey (TPS)

The TPS is an annual satisfaction survey that is administered to clients receiving SUD services. The information collected from the TPS is used to measure clients' perceptions of access to services, the quality of care, care coordination, and general satisfaction with services.[16]

County Documents

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

- Response to prior-year recommendations
- Key changes and new initiatives
- Timeliness Assessment
- PIPs (one clinical and one non-clinical)
- Completed ISCA
- DMC-ODS approved Implementation plan
- Quality Improvement Plan (QIP)
- Quality Improvement (QI) results
- Cultural Competency Plan (CCP)
- Organizational chart

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

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

CalEQRO Review Activities

Review activities onsite include client focus groups; stakeholder interviews; reviews of plans such as QIPs, CCPs, and PIPs; Network Adequacy issues; ISCAs; and relationships with managed care health plan and other partners, such as the criminal justice system.

The pre-review documents and onsite focus groups and stakeholder interviews are then compiled and integrated for Key Component ratings. CalEQRO emphasizes the DMC-ODS counties' use of data to promote quality and improve performance. The elements widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs.

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.caleqro.com.

Analysis Tools

For the Annual Report, quantitative data are compiled and analyzed in Excel and SAS, with graphs and figures generated to highlight key findings. NVIVO is used to manage and extract key themes from the vast amounts of qualitative data. This mixed-methods approach is employed to generate highlights, key findings, best practices, and areas for improvement.

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Chapter 3

Access

Access

How California 1115 Waiver Counties are Improving Access to SUD Treatment

Introduction

Access requires:

- Outreach Engagement
- No Wrong Door
- Service Capacity

The DMC-ODS 1115 Waiver has placed a high priority on 24-hour access to information and referral to treatment—a critical ingredient 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 substance use services. This requirement applies to those who have urgent conditions and those who seek help in languages other than English. These access requirements are among the Waiver STCs and constitute one of the many gateways counties have established to facilitate access to care.

In order to provide timely access to appropriate SUD treatment, counties must not only provide the 24-hour BAL, but also take into account the fact that many individuals in the community in need of care will go directly to local clinics and nonprofit providers of SUD treatment services and ask for treatment directly. In fact, many counties consider these networks of service providers a better option for community access if they have an adequate number and distribution of treatment programs across a county's geographic areas, easing access for local populations seeking care. These clinics must be able to provide a comprehensive assessment using ASAM dimensions to match individuals to programs that meet their needs if they are to function as gateways into the system of care. Use of the comprehensive ASAM assessment to match clients to their SUD needs and appropriate level of care is another core requirement of the STCs in the 1115 Waiver.

Both the 24-hour access call center and the no-wrong-door treatment approach (which uses both community treatment centers and clinics as gateways to access) are all used in the vast majority of counties to reach new clients and link them to care. As gateways into care, they use ASAM-linked tools and principles to evaluate beneficiaries' needs. After completing this process, the next key issue is arranging access to the *appropriate level of care*. 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.

The linkage to treatment cannot happen without an adequate provider network across the ASAM continuum of care. The provider network, integrated across a continuum based on levels of treatment structure and intensity, is intended to match the clinical needs of a full range of SUD including those with co-occurring mental health and physical health disorders. The network of services established by the DMC-ODS plan is the foundation for timely and appropriate access to care.

Overview of Major Access Findings

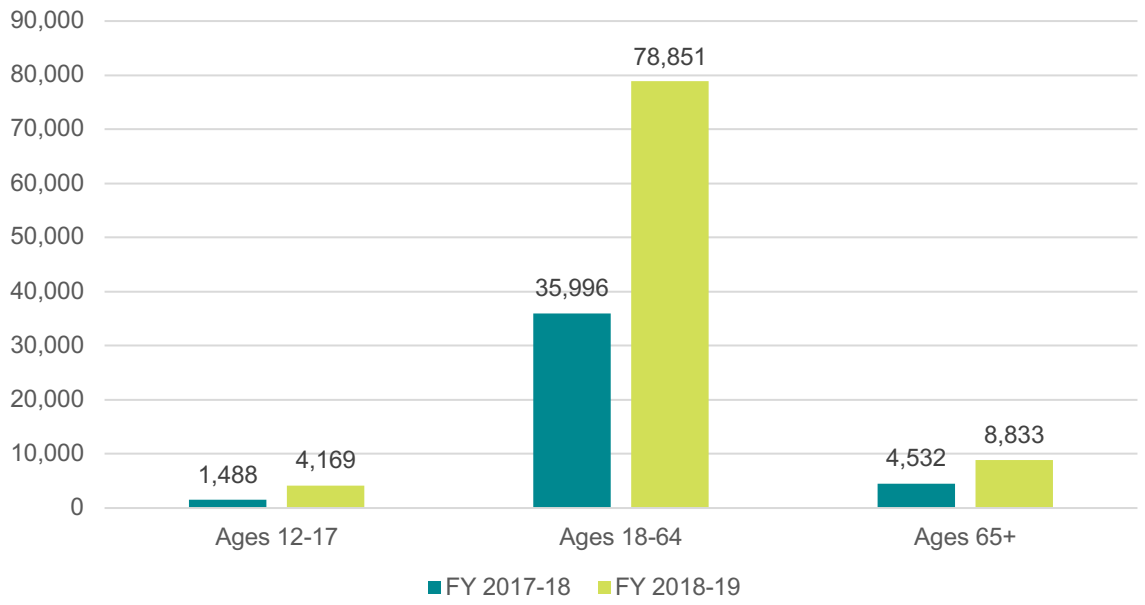
Finding 1 In FY 2018-19, both the number and percent of clients served in the 14 DMC-ODS pioneer counties increased substantially when compared with FY 2017-18, across all age groups.

Finding 2 In pioneer counties, expanded access was also reflected in increased penetration rates for Medi-Cal clients across all age groups from FY 2017-18 to FY 2018-19.

Finding 3 The increase in services for Medi-Cal clients in pioneer counties also was reflected across all race/ethnicity groups from FY 2017-18 to FY 2018-19.

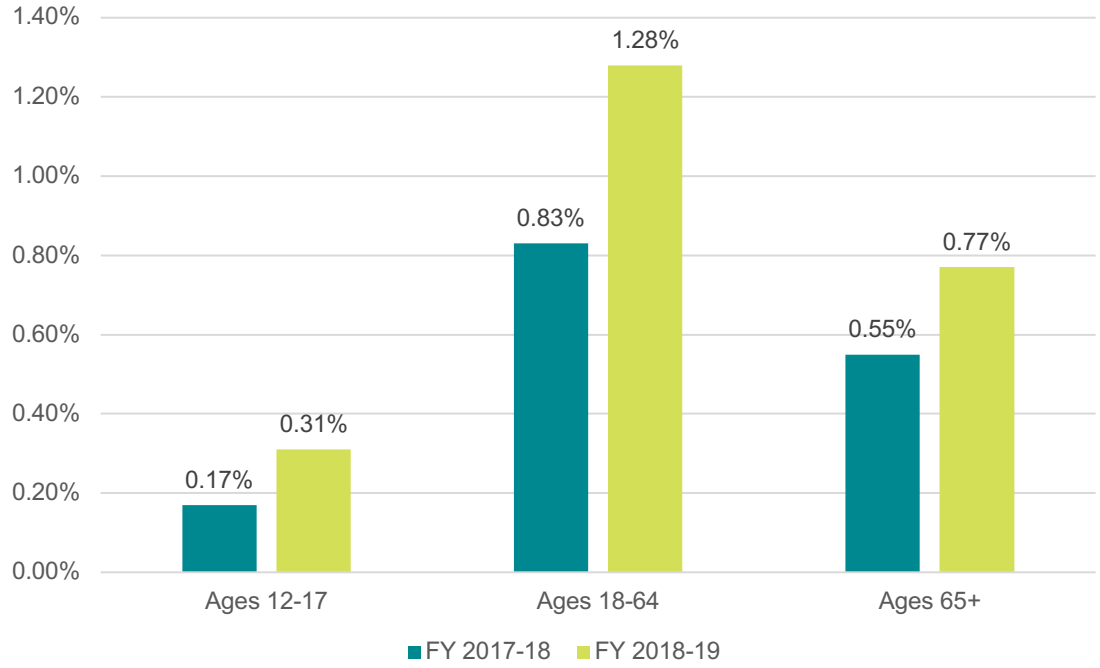
In FY 2018-19, both the number and percent of clients served in 14 DMC-ODS pioneer counties increased substantially when compared with FY 2017-18, across all age groups, as reflected in Figure 3-1. For youth and adults, the number of Medi-Cal clients served doubled, while for older adults it was slightly fewer. This pattern of year-over-year growth has continued to be observed as the programs launch their systems of care. The amount of services has expanded each year, from the first to second years of the Waiver, and then from the second to third years as well. This is typical of DMC-ODS programs as they add new services, capacity, and infrastructure to enhance access and engagement opportunities.

Figure 3-1: Medi-Cal Clients Served by Age Group in Pioneer Counties, FY 2017-18 and FY 2018-19



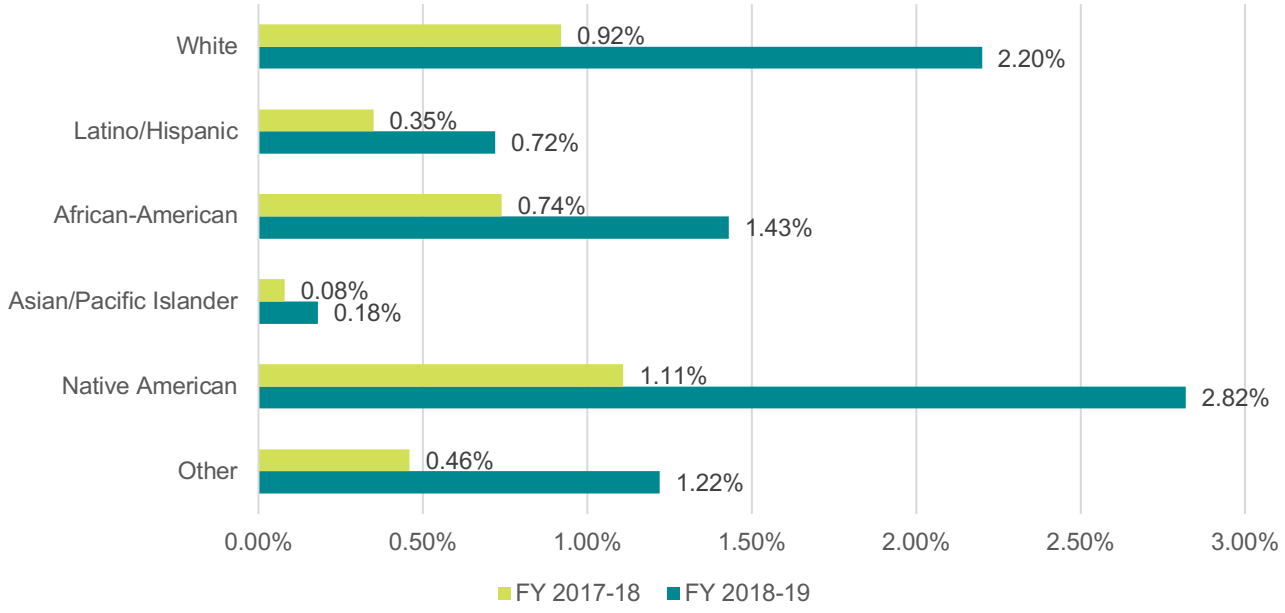
In pioneer counties, expanded access was also reflected in increased penetration rates for Medi-Cal clients across all ages from FY 2017-18 to FY 2018-19.

Figure 3-2: Penetration Rate by Age Group in Pioneer Counties, FY 2018-19 Compared to FY 2017-18



The increase in services for Medi-Cal clients in pioneer counties also was reflected across all race/ethnicity groups from FY 2017-18 to FY 2018-19, as reflected in Figure 3-3. This pattern is typical of the increases being seen as the DMC-ODS continuum of care expands and the access and timeliness systems continue to improve.

Figure 3-3: Penetration Rate by Race/Ethnicity in Pioneer Counties, FY 2017-18 and FY 2018-19



Tracking Access and Network Expansion

Expanded access is linked to systems facilitating timely entry to appropriate care, as well as a complete network of clinical providers at the levels of care that match 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, recovery support services, medical WM 3.7 and 4.0, and inpatient SUD WM 3.7 and 4.0 services. The counties were required to incrementally expand their networks over several years with an approved implementation plan. They had to operate like managed care plans in overseeing the quality of their networks, selective contracting, and service authorizations, billing, and cost reports. In addition, Network Adequacy requirements were added in recent years to enhance access in remote areas, with time and distance standards for the plans to meet.

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 DMC and Pilot ODS Benefits

Standard DMC Benefits (available to beneficiaries in all counties)	Pilot 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 are 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	Withdrawal Management (at least one level)
	Recovery Services
	Case Management
	Physician Consultation
	Partial Hospitalization (optional)
	Additional Medication Assisted Treatment (optional)
	3.7 & 4.0 Medical Withdrawal & Inpatient (optional)

As observed over the three years of reviews, the 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, as needed.

Expanded Services to SUD Clients in DMC-ODS Counties

An ability to reach more clients in need of SUD treatment with appropriate care remains one of the key goals of the 1115 Demonstration Waiver. This is one of the mandated PMs reviewed in each county for all groups each year. Many counties struggled during their initial year to get new services licensed and certified, staff ASAM-trained, and billing functioning for the full range of new required services. In the second year, efforts shifted to achieving the full continuum of clinical services, with evidence of progress reaching more clients throughout the regions of the state. Each year, counties are making adjustments to types and locations of beds, the needs for recovery housing to complement intensive outpatient and outpatient services (for those unstable in their housing but needing intensive outpatient SUD treatment), changing the amounts and locations of WM and MAT access, and working across departments to coordinate access to care for those in criminal justice and social services systems and/or with complex health needs as well as SUD.

County Examples of Best Access Practices

County examples of best practices were plentiful. Starting with the BAL centers, counties such as Riverside, Los Angeles, and Santa Clara invested in call center software that gave them enhanced capacity to manage their access processes. The upgrades include:

(1) IS software offering complete access to caller information, wait times, dropped calls, and disposition information in many standard reports.

(2) Ability to record interviews for training/supervision/quality.

(3) Ability to triage and link clients to existing service providers at the appropriate level of care and identify histories from prior clinical records.

(4) Providing three-way calling capacity for appointments and dialogue with providers, probation, others, and the client

(5) Setting up systems to include links to historical records, if appropriate

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.

(6) Linking to a real time SUD resource database for SUD bed and outpatient resources capacity by location, language, and current vacancies to empower the BAL staff to make good choices for client referrals.

Other county best practices to increase access include: (1) offering case management or navigator supports to new persons requesting services and (2) assisting with urgent appointments or links to higher levels of care, such as residential treatment or WM with transportation assistance. **Riverside** DMC-ODS, for example, had a very supportive case management system for assisting clients moving to higher levels of care or with urgent conditions needing hands-on follow up after they had requested services from an initial access point.

Warm handoffs and support also were evident in some BAL centers that coordinated placements with client support into treatment and informed child welfare and probation departments that referrals had been made at the request of the clients, using three-way calling. This function was less common and appeared to be more like social work support at the BAL centers, where the service encounter was documented in access charts. Two centers also made referrals for homeless clients to resources even if they did not need SUD treatment and coordinated with other resource banks to know a broad range of resources for the clients calling not just the SUD resources. The attitude of some counties was "whatever it takes to get clients access to SUD care;" their BAL center clinicians or BAL contractors were empowered to be very supportive of clients in these efforts. **Orange** and **San Diego** had particularly strong partnerships with their long-term contract partners organizing their BAL centers in this way.

When clients went directly to clinics or programs in the provider network and did not use the BAL to request services, other best practices were needed. The network providers, trained in ASAM, needed to register the client requesting services in a central database to allow the county DMC-ODS to track timeliness of services. This contractor database partnership and infrastructure were well established, leading to better tracking, effective management of problems, and improved timeliness of services.

It took time to set up these timeliness tracking systems, train the network staff to always capture these data, set up screening capacity using ASAM and assessment hours, or be able to offer warm handoffs to another site that could do this if the providers were not able to. For most counties, this was a multiyear process, as discussed in the timeliness chapter. The access goal is to remove as many barriers as possible to access when the client wants and needs it. Ideally, programs in the community need to be able to conduct ASAM screenings, assessments, and referrals if they themselves are not the right level of care for that particular client. The no-wrong-door approach is used in most county DMC-ODS programs, but takes time to work smoothly for the clients, the providers, and the DMC-ODS to ensure the client is still getting the appropriate SUD treatment they need in a timely manner.

San Luis Obispo County operates this distributed clinic site model especially well. In addition to its call center, clients can use regular walk-in hours for assessments and screenings at dispersed county clinic sites along key population centers along Highways 101 and 1 and bus lines. These services and locations are advertised and well known by the community, clients, and other agencies. The County

has the capacity to conduct full assessments and link clients to appropriate care, including MAT. They have their own outpatient MAT clinic, which is very robust and serves a large percentage of county SUD patients who need buprenorphine and other non-methadone medication. San Luis Obispo is one of the top three DMC-ODS counties in numbers of clients on non-methadone medication, based on FY 2018-19 data. They presented their outpatient services model for MAT, which they began approximately ten years ago prior to the Waiver, at the 2019 SUD conference.

Several key elements contributing to successful access have been well documented in the initial three years of quality reviews. Key is the adoption of a 24-hour BAL that is promoted so that everyone in the community knows there is a safety net for linking to services, including after hours and for urgent situations. In smaller counties, the BAL can be coordinated with county mental health and health units for efficiency. Skilled screenings with linkages to services using software are especially important in larger counties. Warm handoffs are very difficult without three-way calling capacity and an up-to-date, real-time program resource database for the system.

No-wrong-door services require these access components plus full ASAM assessment capacity and engagement with clients, to avoid making clients feel they are being "run around" to multiple sites and programs. This has been a frequent client complaint in systems where it takes two or more stops to get into treatment. This experience can become a barrier; many SUD clients become discouraged and lose an opportunity to engage in treatment. Many of the counties have articulated a goal of engaging clients in treatment rapidly and with enthusiasm in the first 30 days, giving clients hope and a positive experience of treatment and its impacts. These counties have set goals of at least four face-to-face treatment visits/encounters within 30 days. **Santa Clara, San Mateo, Orange**, and **Marin**, among others, have used this goal as one of their positive treatment quality benchmarks to track their progress in reaching new clients and engaging them in care. As a result, "four in thirty" is commonly heard as an important quality measure.

"4 in 30"

Counties have set goals of at least **four** face-to-face treatment visits/encounters within **30 days** urgent appointments or links to higher levels of care. As a result, "four in thirty" is commonly heard as an important quality measure.

Finally, the existence and ongoing refinement of a robust continuum of SUD care—one with enough capacity to service the local community—is critical in terms of reflecting the population, its ethnic/cultural needs, and geographic scope. The findings show the current DMC-ODS programs have been moving in the right direction. In the coming year, the process can continue with development and training of the SUD provider network workforce and the addition of four more counties, along with Partnership Health Plan coalition of seven additional counties. Maintaining and building on these lessons learned is an important access issue for the Waiver renewal. Keeping the core requirements for 24-hour BALs with language access linked to a robust provider network that meets Network Adequacy standards is essential for the next phase of growth of this benefit.

Summary

Significant progress in access expansion of SUD services has occurred in these initial three years of the 1115 Waiver for DMC-ODS. The structure of the ASAM continuum and STC requirements related to plan implementation both were positive influences; they provided a reasonable framework for expanding treatment capacity in a manageable way. With approved plans, counties hired staff, recruited providers to become DMC-ODS-licensed and certified, developed their billing and cost-reporting systems, added quality assurance and quality improvement infrastructure, opened 24-hour Access Call Centers, and trained all clinical staff in ASAM models of assessment and care.

Resulting systems and new models of care took time to stabilize but were often full. Excess demands for treatment within the first year led to expansions of provider networks and contracted services. The prior, limited information system (IS) capacity and new managed care requirements posed challenges for most counties, but efforts to address these systems continue. Counties that had adopted ASAM models of care with quality improvement frameworks prior to the Waiver were in a better position to implement and were frequently the first to launch DMC-ODS services.

Core learnings from Access Call Centers, use of ASAM assessment principles, matching to treatment services (including MAT), and individualized care requirements had positive impacts in shifting treatment to be more client-centered and evidence-based. Challenges remain in bringing all these systems and services to their full potential, with reviews continuing to show a multiyear progression as counties build these new clinical services and learn to manage them.

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

Chapter 4

Network Adequacy

Network Adequacy

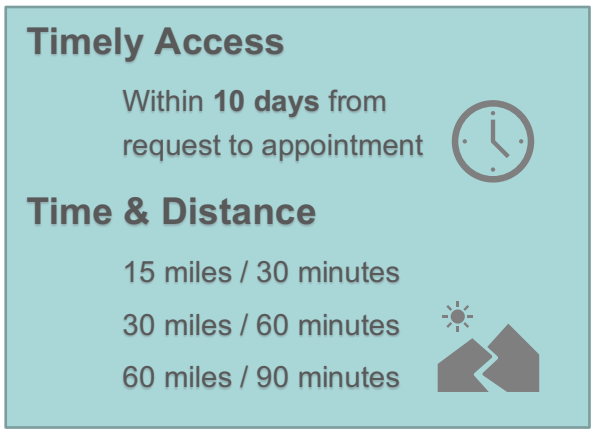
How DMC-ODS Counties are Meeting New Standards for Timely Access to Care

Introduction

This year, a new CMS requirement was added to assess DMC-ODS plans' Network Adequacy—adequate access to care in a timely manner, even for those who live in remote rural and frontier areas. The California legislature also passed AB 205, which clarifies how the new Network Adequacy requirements would be applied, given the diverse populations and population density across California counties.

Overview of Major Network Adequacy Findings

Finding 1	The ten counties with AAS made significant efforts to **identify additional providers within their counties as well as in neighboring counties** to reduce time and distances for their Medi-Cal beneficiaries.
Finding 2	**Primary care partners** often were willing to enhance access to MAT for Medi-Cal beneficiaries with SUD when financial feasibility of other MAT (such as OTP/NTP options) were not possible in remote, low-population areas.
Finding 3	**Frontier areas** not covered by health plans pose extra challenges for DMC-ODS programs to find providers with DMC-ODS current licensing and certification requirements.
Finding 4	All DMC-ODS programs were measuring timeliness to services and many transitions between services, as well as other quality measures. Because of the **lag in computer systems with many small SUD contractors,** infrastructure improvements are needed to make these systems reliable and stable.
Finding 5	**Limited internet access** for client services in remote and frontier areas is a barrier to quality care, affecting both telephone and video telehealth options.



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

To determine Network Adequacy, each county submitted a detailed description of its network of providers—including their languages, locations, and capacity—in a document called the Network Adequacy Certification Tool (NACT). The NACTs were thoroughly reviewed by DHCS to identify which counties met time or distance standards in 2019 and which will need to submit an Alternate Access Standard (AAS) or find new providers to meet the timeliness standard.

Based on AB 205 provisions, counties had to meet varied standards due to their populations and density, as reflected in Table 4-1.

Table 4-1: 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
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

Also related to timeliness of services, Opioid Treatment Program (OTP)/NTP services must be provided within 3 business days and outpatient SUD services within 10 business days for routine appointments.

Approved Alternate Access Standards (AAS) for ZIP Codes

Table 4-2 below includes the counties reviewed with AAS because one or more ZIP codes did not meet required time or distance standards in 2019 April submissions. Each county will be discussed separately, including what they have done to enhance access for residents of these areas.

Table 4-2: DMC-ODS Counties Reviewed with AAS for One or More ZIP Codes

DMC-ODS County	Service Type	Zip Code(s)	Approved Standard
Alameda	Adult-OTP	94550,94551	30 miles/60 minutes
	Adult-OTP	94505,94506,94523,94526,94597	30 miles/60 minutes
Contra Costa	Adult-OTP	94505,94506,94523,94526,94597	30 miles/60 minutes
		94553,94556,94582,94583,94596	30 miles/60 minutes
	Youth/ Adult OP	94582,94583	30 miles/60 minutes
Los Angeles	Adult-OTP	90265,91301,91361,93184,93532	30 miles/60 minutes
	Youth OTP	93536,93544,93591,93535	30 miles/60 minutes
	Ad/ Youth	90265, 90704, 93543, 93544	30 miles/60 minutes
	Outpt/IOT	93553,93591	30 miles/60 minutes
Monterey	Ad/Youth/OTP	93451	60 miles/90 minutes
Napa	Ad/Youth OTP	94567	60 miles/90 minutes
Orange	Adult OTP	92624,92629,92651,92672,92679 2675,92676,92677,92679,926889 2691,92692, 92694	30 miles/60 minutes
San Bernardino	Adult/YouthOTP	93562	60 miles/90 minutes
San Diego	Adult OTP	92059,92061,92065	60 miles/90 minutes
	Adult OTP	92028	30 miles/60 minutes
	Adult OTP	91963, 92036	45 miles/60 minutes
	Adult OTP	91906	60 miles/90 minutes
	Adult OTP	91905,91934,92086	30 miles/60 minutes
	Adult OP	91916,92028,92061,92065	30 miles/60 minutes
	Adult OP	92036	60 miles/90 minutes
	Ad/Youth OP	91906, 91963	45 miles/60 minutes
	Ad/Youth OP	91905	60 miles/90 minutes
San Mateo	Ad/Youth OP	94014,94015	33 miles/45 minutes
	Adult OTP	94019	30 miles/76 minutes
	Youth OTP	94019	22 miles/76 minutes
	Adult OTP	94037	32 miles/59 minutes
	Adult OTP	94038,94074	30 miles/60 minutes
	Adult OTP	94044	48 miles/60 minutes
	Adult OTP	94060	50 miles/76 minutes
	Adult OTP	94066	25 miles/45 minutes
	Adult OTP	94080	32 miles/55 minutes
	Adult OP	94080	40 miles/41 minutes
Santa Clara	Ad/Youth OP	95030,95033	30 miles/60 minutes

Best Practice Efforts to Expand Access in Remote ZIP Codes

The counties listed above (with AAS approved by DHCS) proposed many improvements and mitigations to improve access for Medi-Cal residents in those ZIP codes. These approaches are discussed in some depth in individual county reports, but several are highlighted here as examples of best practices.

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 Network Adequacy and community needs.

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

(3) Sought out directors in surrounding counties to partner on new or expanding county or contract 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 very 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 have co-located SUD counseling and telehealth capacity and consultation, but also offer prescribing via X-Waivered prescribers.

(5) Explored 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 different types of innovative SUD partnership plans to expand services.

County Best Practice Examples for Improvement Efforts

Los Angeles SAPC DMC-ODS exhibited many of the best practices above, establishing contracts with Ventura County to make it easier for residents with SUD living in areas north of Malibu or in other coastal areas to access services. Los Angeles negotiated with health providers and an existing provider to bring MAT and services to the island of Santa Catalina. The county also worked with an existing provider, Tarzana, to expand to meet needs in areas near Antelope Valley and coordinated some services with other counties, such as Kern and San Bernardino. The number of ZIP codes with access issues was greatly reduced from 2019 to 2020, even though the criteria went from time *or* distance to meeting the requirement based on time *and* distance. This reflected significant proactive efforts on the part of the Los Angeles leadership.

Orange County DMC-ODS also did an excellent job working on its NA issues in the southern region of the county, which needed an additional NTP/OTP to meet the needs of adults and youth. They helped the provider identify a property and supported them through the whole process, including the community relations, which were very difficult as the property was in a wealthy part of Orange County. However, many clients in the area needed services. It took two full years of work before certification was achieved; now they do not need an AAS. The coordination, commitment, and professional approach with the community were noteworthy.

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

Contra Costa DMC-ODS also worked with local providers to add needed outpatient services for youth or adults in some remote areas to address Network Adequacy needs. They also worked with an NTP/OTP provider who faced a very difficult land use issue trying to open a facility in Concord. The case went to court and the provider eventually won; they are now in the process of trying to open and become licensed and certified. Contra Costa also has worked extensively with surrounding counties to add more providers and contracts closer to some local residents, making access more convenient for their clients. Again, the number of ZIP codes from the prior year's AAS is reduced, even though this year the county is to meet time and distance standards.

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. They added many San Francisco contracts to their network to assist members living in the northern areas of their county to access NTP/OTP services and outpatient care. San Mateo also is building out strategic additions to services along the coastal areas of Highway 1 to expand access to MAT and outpatient services, even though the population in need of services becomes very low in the areas south of Half Moon Bay. There are efforts to link through the county's mountain area into Santa Clara services to meet the needs of the remote populations in this area. San Mateo also expanded early to add more telehealth services, along with added bilingual prescribing capacity. They have partnered in innovative ways with HealthRight360 on MAT to meet the needs in remote areas and conduct specific mobile outreach to people experiencing homelessness.

Next Steps for Network Adequacy Expansion

After this initial year of reviewing Network Adequacy, CalEQRO expects additional innovations and best practices for outreach and engagement will be identified. The flexibility of telehealth and phone services and medication access via primary care and pharmacies are also very helpful dimensions of access and are critical in these COVID-19 times, according to the clinical staff running services. 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.

Reviews of Timeliness Across the DMC-ODS Counties

Timeliness of Initial Appointments

CalEQRO reviews timeliness of appointments using PMs for all counties for 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 Network Adequacy and AB 205 requirements related specifically to Network Adequacy for youth and adult populations. NTP/OTP access is an important component in the DMC-ODS plans.

Table 4-3 shows routine appointment timeliness averages based on visits in all ZIP codes for all DMC-ODS plans reviewed in FY 2019-20. Routine outpatient 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 12 of the 26 counties reviewed were in their first year of launching their DMC-ODS treatment systems and infrastructure. DMC-ODS counties often experience interoperability challenges between county and contract provider networks to ensure tracking all of the new managed care data is complete.

In addition to the data on timeliness, CalEQRO conducts SUD services' clients (youth and adults) and family member focus groups at various levels of SUD care, as well as stakeholder interviews with line staff, supervisors, contractors, managers, and county leaders. These groups and interviews are critical to understanding whether there are access and timeliness barriers to care and/or problematic Network Adequacy needs in remote areas or for specific populations (e.g., individuals with disabilities and those who may be homebound due to mobility or other issues). Combining both sources of information makes it possible to identify patterns of access or timeliness problems in specific programs, levels of care, or regions of the county overall, or for specific groups. These, in turn, generate recommendations for improvement and further inquiry.

Table 4-3: Average Timeliness for Routine Appointments and Methadone Dose, FY 2019-20

County	Time Offered	Time Face to Face	Methadone Dose
Alameda	5	5	1
Contra Costa	8.3	9.4	1
Fresno	6.19	15.64	1
Imperial	15	18	1
Kern	n/a	8.72	1
Los Angeles	5	10.8	1
Marin	2.3	3.8	1
Merced	8	8	2
Monterey	4	6	1
Napa	5.4	14.7	1
Nevada	4	5	1
Orange	4.7	4.17	1
Placer	n/a	39	1
Riverside	5.1	5.1	1
San Bernardino	n/a	39	1
San Diego	2.9	3.8	1
San Francisco	1.3	3.9	1
San Joaquin	n/a	2.9	1
San Luis Obispo	2.63	3.75	1
San Mateo	n/a	31	1
Santa Barbara	5	6	1
Santa Clara	12	17	1
Santa Cruz	7.25	7.81	1
Stanislaus	7	8	1
Ventura	n/a	13.6	1
Yolo	n/a	28	1
Average	**6 days offered**	**11.8 days**	**1 day**

Average Times to Access Initial Appointments

All of the DMC-ODS counties were able to meet requirements related to overall times to methadone dosing within three days. Over 95 percent met times for routine face-to-face outpatient appointments, although some did not yet have software and infrastructure in place to track offered appointments in outlying contract agencies on different software systems. Problems with interoperability of software systems are common. A large percentage of the SUD delivery system involves contract agencies on different software than county health departments, and many also lack EHRs. This situation was very common in pioneer counties.

The most common issues regarding unmet needs for alternative access in remote areas involved NTP/OTPs in rural/frontier areas for adults and youth. Outpatient services still had gaps, but these were reported much less frequently and there were more options for solving these issues than was the case with the NTP/OTP gaps.

Four of the counties with AAS approvals, and their strategies and activities, were discussed above in the County Best Practice Examples for Improvement Efforts section. Below are brief descriptions of the other counties with AAS forms.

San Diego County has a large number of ZIP codes and areas needing NTP/OTP services as well as outpatient services, as noted in Table 4-2. They primarily recommended their county residents use services in Imperial and Riverside Counties. The closest sites that could meet these needs are in other counties. San Diego will contract with these programs on their AAS form to address their county residents' needs. The services are in Temecula, Murrieta, Lake Elsinore, El Centro, Calexico, El Cajon; these areas also are near Indian Health Centers. An area in the north of the county needs coverage and Orange County just opened a new OTP in the southern part of the county that might serve these residents. There may be more convenient opportunities with Indian Health Services, particularly for MAT. Review of opportunities for serving residents with Medi-Cal are discussed as part of the DMC-ODS review.

Santa Clara County has two ZIP codes in a remote area of the county in the Santa Cruz mountains. This AAS impacted five beneficiaries who would need more driving time to get to the San Jose clinic in Santa Clara, with one taking 17 minutes and another 24 minutes. The approach seems reasonable as it is not practical to add a clinic and it is not far in terms of distance, but in the mountains the driving time is greater than miles alone would suggest.

San Bernardino County has a number of ZIP codes in extremely remote areas near Kern County and the Arizona border. San Bernardino will need an AAS approval for these remote sites. To address the needs of the Medi-Cal residents nearest Kern County, San Bernardino contracted with two Aegis OTP/NTP providers in the northern areas across their border. One is in Kern County in the Ridgecrest area and another is in Hesperia, which will help with anticipated time and distance issues for 2020. There are Arizona providers in the Needles area that may be able to contract with San Bernardino county for their residents who need buprenorphine and other MATs. Meeting time and distance standards will be much more challenging for San Bernardino County, which is as geographically large as all of the New England states combined but with very low populations in most of the desert and mountain regions. San Bernardino County has submitted an AAS form to DHCS that was approved for time or distance for 2019 and had only a few zip codes. San Bernardino also used facilities in Riverside County for residents who live close to their shared border. Riverside has added facilities along the length of its county and does not need an AAS at this time. Based on the timeliness challenges in San Bernardino, additional technical assistance is needed in this area. There may be some Indian Health Service opportunities for partnership as well.

Napa has a ZIP code with approximately 188 Medi-Cal eligibles who need access to an NTP/OTP in the northern area of the county, in an area known as Pope Valley near some of the State Park lands and wilderness. There are no NTP/OTPs in Lake or Yolo Counties adjacent to this area. One rural Federally Qualified Health Center (FQHC) has expressed some interest in mobile services, which would provide some MAT. This would be a positive alternative and could be done via telehealth once cases are established, but the population is too small to try to open an NTP/OTP. The closest one is MedMark in Fairfield, 52 miles away. An AAS was approved by DHCS in 2019 and local ideas for more

rural health services in this region (even one day per week) are being explored by the local FQHC. A Tribal Health Center representative is active on the local advisory board and also expressed interest in supporting more MAT access. He attended the MAT session on the review with CalEQRO and shared his support of the DMC-ODS. Pope Valley is too far from the NTP in Solano to meet state standards at this time.

Monterey County has a number of ZIP codes in rural areas between the Big Sur area and inland valley where Highway 101 winds across the county. These areas are particularly related to the NTP/OTP gap in the southern region of the county. The county has proposed extending and expanding the current NTP/OTP provider to a new site in King City to address this issue. They intend to expand SUD services in King City by adding a residential program and more outpatient treatment services. This will also add new MAT, including methadone and non-methadone services. It takes time to add new NTP/OTP services and this is a major undertaking but will be good for the community. The commitment to a full continuum of care for south Monterey County will be very positive, as there are few services there or in north San Luis Obispo county. This plan was supported by the Board and DHCS.

Alameda County had one primary Network Adequacy challenge involving a lack of NTP/OTP services in remote areas. Alameda has developed plans to address outpatient issues with a number of contract agencies and staff were optimistic they would be able to address the issues. The area of the county with a distance issue related to an NTP/OTP, however, did not have a large enough population to support opening a new site or attracting a provider. Instead, Alameda was actively approaching FQHC clinics for possible partnerships and contracts to provide MAT for clients in the region and offer SUD counseling, outreach, and education to support the program as a local hub for youth and adult SUD services, including prevention and counseling services. This effort had not yet succeeded, but there were potential partners in the area and none of the existing methadone providers felt the site had potential to be sustainable. Based on several sessions and some follow-up technical assistance, it was evident the county was committed to doing all it could to meeting the standards and addressing local needs.

Summary

During this first year of implementing Network Adequacy, the DMC-ODS counties had ten counties with approved AAS standards and associated activities linked to improvement for local beneficiaries in remote and frontier areas. The other 16 counties reviewed met time *or* distance standards as defined in AB 205. In plans of correction, three counties had completed plans related to policies and procedures needing correction and one (Napa) had gaps in required services that were corrected in the subsequent year with new contracts. DHCS completed the review of the NACT and AAS forms in a timely manner and coordinated changes of standards with the counties as required. Published documents were on the internet site for DHCS and were helpful and clearly related to requirements.

The DMC-ODS counties are already tracking timeliness of services for their required services, and there is significant compliance among the 26 counties with these new Network Adequacy standards for times offered and face-to-face actual visits for routine outpatient services and NTP/OTP services. Client

focus groups and grievance logs did not identify patterns of access problems. NACT forms included all the required details of each county's provider networks in terms of capacity and language. The AAS forms and details included needed data on Medi-Cal beneficiaries affected by zip code, age, service type, and distance and driving time, as required. Plans for improvement for zip codes by county included a range of strategies including 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 represent positive efforts to support enhanced access to Medi-Cal services for persons with SUD, both youth and adults.

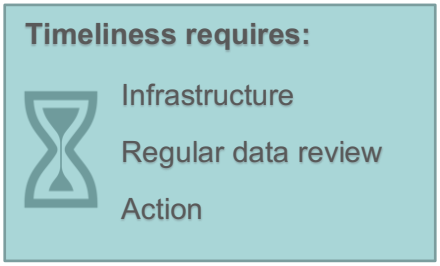
Chapter 5

Timeliness

Timeliness

How California 1115 Waiver Counties are Improving Timeliness to SUD Treatment

Introduction



The new DMC-ODS continuum of care and the 1115 Waiver have placed a priority on timely access to treatment—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.[17] "Typically, the longer substance users have to wait to be admitted to treatment, the more likely they are to not follow through with treatment."[18] 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."[19]

In order to be successful in providing timely access to SUD treatment, counties must build two types of infrastructure: the infrastructure to track timeliness and 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.

Timeliness to treatment can only occur if counties have developed the 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 points in the system including requests for initial, routine, and urgent services as well as in transitions of care.

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[17]Weisner C, Mertens J, Tam T, Moore C. 2001. Factors affecting the initiation of substance abuse treatment in managed care. *Addiction SSA Society for the Study of Addiction*. 96(5):677-797. Available from: https://doi.org/10.1046/j.1360-0443.2001.9657056.x

[18]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

[19]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

Overview of Major Timeliness Findings

Finding 1 In FY 2018-19, **all counties report tracking timeliness of critical metrics** including initial requests, first offered, 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 On average. counties continue to work towards achieving statewide timeliness standards**. Tracking timeliness for urgent requests** is one area most in need of statewide development and definitional clarity.

Finding 3 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

Time to First Offered Appointment

5.6

In FY 2019-20, average days from request to first offered appointment was 5.6 days.

Timeliness begins with the first contact, which is usually a request for service. These data must be collected consistently at the first point of entry, whether that is at the beneficiary access line or at some other point in the system, such as a contract provider location or a drop-in clinic. The data below reflect that the average time from first request to first offered appointment is 5.6 days, well below the standard of 10 business days, with a range of 0 days to 15 days. The data show 82.1 percent of clients are offered an appointment within 10 business days. The first offered appointment is important because it measures the system's responsiveness system to provide timely service. The following data represent 19 of the 26 counties that were reviewed in FY 2019-20; not all counties were able to track the time to first face-to-face appointment.

Table 5-1: Timeliness Metrics for Time from First Request to First Offered Appointment, FY 2019-20

Average Time from First Request to First Offered Appointment	Average	Minimum	Maximum
Average length of time from first requested to first offered appointment	5.6	0	15
Timeliness Metrics and Percent Meeting the State Standard	**% Meeting the Standard**	**Minimum**	**Maximum**
First requested to first offered appointment (10 business day standard)	82.1%	24.0%	100%

Time to First Face-to-Face Appointment

Timeliness tracking from first request to first face-to-face contact is an important measure and represents the system's capacity for providing timely access to treatment. As noted above, this is critical for treatment of SUD, as many people seeking treatment are ambivalent and the time of their first request represents a crucial period of opportunity for intervention. Extended wait times have been shown to reduce access to treatment as potential clients, due to their ambivalence, can give up quickly. Initiation and engagement begin with this first treatment contact but are best measured by whether or not the client returns for a second treatment contact and follow-up treatments. This performance measure is discussed in the quality of care section of this report.

11.9

In FY 2019-20, average days from request to first face-to-face appointment was 11.9 days.

The first face-to-face metric standard is measured as 10 business days or 14 calendar days from the first request for service to the first face-to-face encounter. The data below represent all 26 of the 26 counties that were reviewed in FY 2019-20.

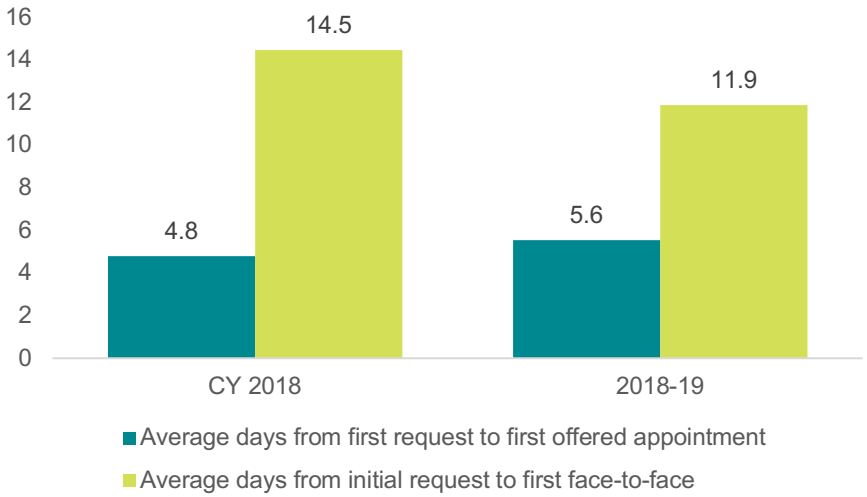
Table 5-2 below shows that the average of 11.9 days from the first request to first face-to-face appointment is timelier than the standard of 14 calendar days, with a range of 2.9 to 39 days. Of those served during the review year, 65.6 percent attended their first face-to-face appointment within the 10-business-day/14-calendar-day standard, while 34.4 percent did not. However, with new infrastructure in place to manage their service capacity, it is anticipated that counties will improve their timeliness to the first face-to-face appointment.

Table 5-2: Timeliness Metrics for Time from First Request to First Face-to-Face Appointment, FY 2018-19

Average Time from First Request to First Face-to-Face Appointment	Average	Minimum	Maximum
Average length of time from first requested to first face-to-face appointment (in days)	11.9	2.9	39
Timeliness Metrics and Percent Meeting the State Standard	**% Meeting the Standard**	**Minimum**	**Maximum**
First requested to first face-to-face appointment (10 business day standard)	65.6%	24.0%	98.5%

Once a county has its infrastructure in place, staff are able to work to improve timeliness to treatment and adjust their capacity for services and location of needed services. Although counties reported different time periods in their timeliness self-assessment, for simplicity, the graph below uses the EQRO years of review, FY 2017-18 and FY 2018-19, 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 decreased from 14.5 days to 11.9 days. This 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 levels of care in counties seeking to improve timely access.

Figure 5-1: Comparison of Review Years, 2018 and 2019



Time to First MAT Appointment

Timeliness tracking for MAT services is especially critical in substance use treatment. MAT is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUDs. Medication can ease a person's physical discomfort, increasing their ability to stay in treatment, reduce cravings, and support the learning of recovery skills. Persons in need of medication are especially sensitive to delays, and any delay has potential for treatment abandonment. This is why the metric for medication timeliness is shorter than that of routine appointments. The standard is measured as three days from first assessment to first appointment, which is often also when they receive their first dose of medication.

3.6

In FY 2019-20, average days from assessment to first MAT appointment was 3.6 days.

Medications offered in this metric include those available for opioid addiction through the DMC-ODS Waiver such as methadone (the most common medication), buprenorphine, naloxone, and disulfiram. Methadone has been a standard in the field for many years and a proven and effective way to treat opioid addiction, but the addition of buprenorphine, a new alternative to methadone, has advantages regarding ease of use, provider flexibility, and duration of treatment over methadone. However, specific medication options are very individualized, and each patient and their provider must evaluate which medication will work best for them. Methadone can be started immediately, even when the person is not fully withdrawn from opioids. However, other medications require time to taper off opioids before beginning treatment.

This metric is limited to those persons who are first identified as needing medication prior to other treatment options. It does not capture those who are in residential or outpatient treatment and for whom medication is determined to be needed during the course of their treatment. For persons already in treatment, the timeliness from first assessment is not relevant as their length of time in treatment would be extremely varied. The following data represent 20 of the 26 counties that were reviewed in FY 2019-20.

Table 5-3 below shows most clients receive their assessment and first MAT appointment in the same day, resulting in the minimum time being zero days. The average is 3.6 days, which is very close to the standard of 3 days. The range of days is 0 to 22 days. In addition, the great majority of persons, 85.2 percent, receive their first MAT appointment within the three-day standard. Methadone averaged close to one day for over 90 percent of the counties. Other medications took more time due to clinically appropriate tapering and other factors.

Table 5-3: Timeliness Metrics from First MAT Assessment for MAT to First Kept Appointment

Average Time from First MAT Assessment to First MAT Appointment	Average	Minimum	Maximum
Average length of time from first assessment for MAT to first MAT appointment (in days)	3.6	0	22
Timeliness Metrics and Percent Meeting the State Standard	**% Meeting the Standard**	**Minimum**	**Maximum**
First assessment for MAT to first MAT appointment	85.2%	22.2%	100%

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, ranging from narrow definitions such as only those who are pregnant opioid users to expansive definitions letting the client determine the urgency. **Counties have some latitude and variation in how they operationalize the definition of urgent appointments ranging from narrow definitions, such as only those who are pregnant opioid users, to expansive definitions letting the client determine the urgency.** The Waiver requires a clear, local definition to track requests coming from multiple sites. This metric requires the development of a clear definition, training of staff, development of a new tracking metric available across the system where new clients present for services and follow-up actions to increase timeliness. In addition, the metric is measured in hours rather than days, which requires a different tracking measure than other timeliness measures in the EHR or other established tracking mechanisms. The data below represent 19 of the 26 counties that were reviewed in FY 2019-20. This continues to be an area of growth for counties. Of the 26 counties reviewed this year, the EQRO scored 10 as meeting this requirement to track urgent appointments, 6 that partially met this requirement, and 10 that did not yet have this measure operational.

In Table 5-4, 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.

Counties continue to work to refine and clarify their definitions of urgent requests and complete the following key tasks for successful tracking or 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. (Sometimes 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.

Table 5-4: Timeliness Metrics and Average Time, FY 2018-19

Average Length of Time for Urgent Appointment	Average	Minimum	Maximum
Average length of time for urgent appointment (48-hour standard)	7.3 days	1.1 days	22 days
Timeliness Metrics and Percent Meeting the State Standard	**% Meeting the Standard**	**Minimum**	**Maximum**
Urgent appointment (48-hour standard)	58%	6%	100%

Infrastructure Development

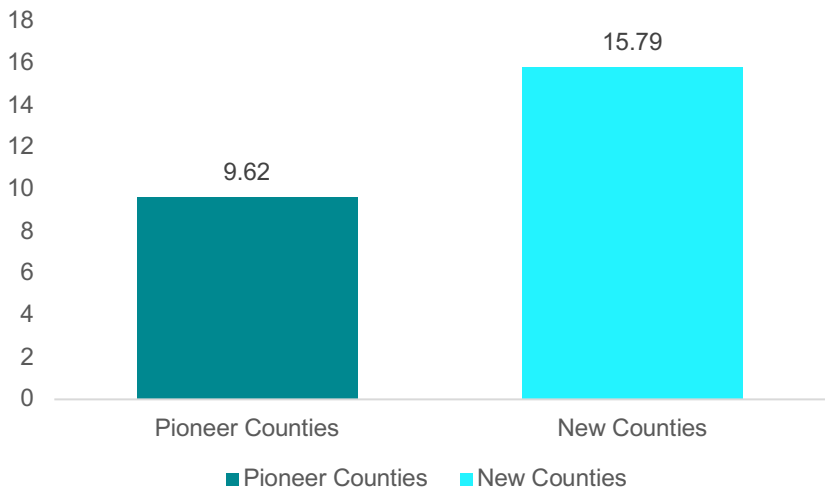
Most counties developed metrics prior to their first year of implementation, but many counties additionally took the first year or more to further develop their infrastructure in order to track all the newly required timeliness measures to treatment. Infrastructure is critical to collect available data 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 review 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 making changes for increase consistency in reporting.
- Increasing tracking mechanisms for all providers across the system.
- Administrative changes to reduce the time of specific functions.
- Clinical changes in the timing of screenings and assessments including walk-in hours and home visits, and now telehealth and phone assessments in the wake of COVID-19.

Figure 5-2: Average Days from First Face-to-Face Appointment, Pioneer Compared to Newly Reviewed Counties, FY 2018-19



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 but still need refinement so tracking must occur across the system. Even if the measurement is in place in the first year, it may take that entire year or the next year to assure that reports are distributed regularly so that staff and management can review the timeliness data and put in place system changes necessary to increase timeliness to services.

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 (usually sorted for outpatient or residential) to get to the correct treatment level of care.
- Expedited process to the appropriate level of care for assessment and treatment.

Without a brief screening, consistent delays occur in access to treatment at the appropriate level of care, resulting in an increased number of dropouts. Counties with centralized assessment programs often experience delays in getting appointments. Clients must then wait to access the appropriate treatment service and complain they must tell their story all over again, with these multiple delays leading to more and more clients dropping out of services.

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:

- **Santa Clara** established a variety of timeliness tracking mechanisms, analyzing the data that the mechanisms provided. This required a tremendous amount of set-up work, diligence in data entry, and staffing for data analysis. These efforts set the stage for producing timeliness data that enables Santa Clara to identify challenges and institute quality improvement activities.
- **Monterey** created a SUD dashboard tracking multiple metrics in a single document. It includes length of time from initial request to first offered 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.

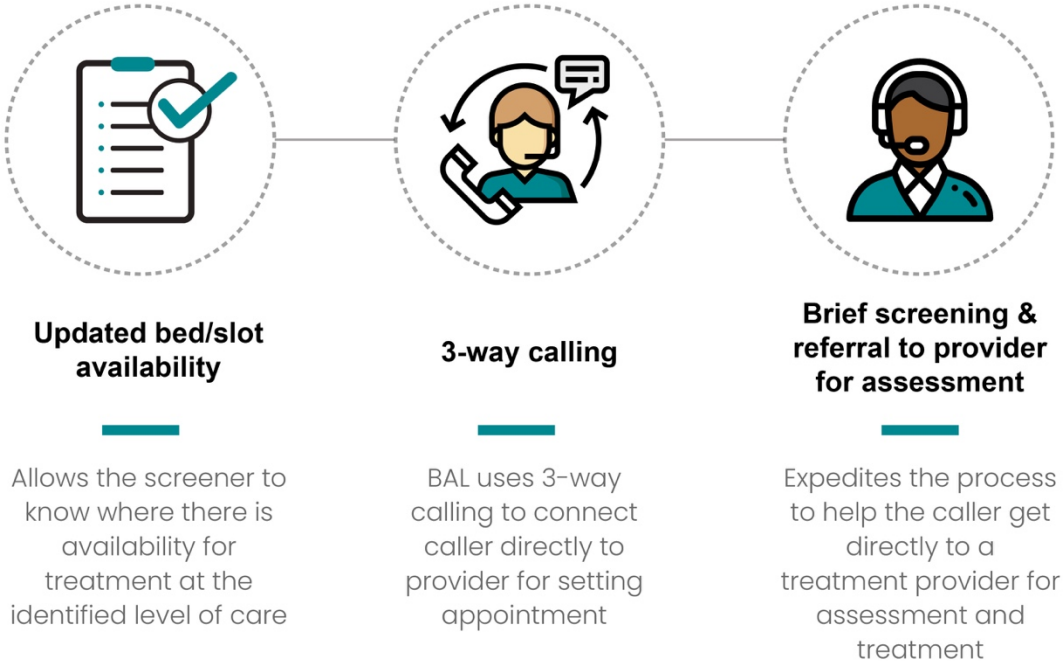
Timeliness to service starts with first contact, which is generally not billable and thus requires specific data collection for tracking. A brief screening is critical to determine the general level of care. Clients have historically gone directly to community providers for service; counties have developed systems that assure this practice, sometimes called “no wrong door.” This requires developing systems that track clients starting at the beneficiary access lines as well as multiple provider sites or drop-in clinics across the whole continuum of care. Developing an electronic database standard for all of these service requests that can track across the entire continuum of care is critical, but 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 (SBAT) in Los Angeles County and the Contra Costa SUD resource database application for tracking daily capacity at all levels of care 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 level of care, 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 can have high accuracy rates but will never be 100 percent. Brief screens result in a small percentage of clients needing assistance, after the assessment, to reach the correct level of care, sometimes with a different provider. Counties need to build in a clear process for this to occur within their systems. Counties need to determine whether they allow the providers to screen and complete the full assessment or whether they themselves take on this task. There are pros and cons to all models and each county has to consider its own dynamics and resources for the model that best fits their circumstances. All models require excellent communication between counties and providers.

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



First contact best practices motivational interviewing for initial engagement, screenings, and timely response to service access. Best practices examples include:

- Brief screening to determine initial level of care. Santa Clara has an excellent tool in place and UCLA's Brief Questionnaire for Initial Placement (BQUIP) is also available for free. These brief screening tools usually sort requests between outpatient levels of care and residential levels of care, as well as potential MAT needs.
- If the first call is to the BAL, then three-way calling to the provider can link the client directly to the service provider for an appointment and to gather critical screening data. This is especially critical for clients who do not show for their assessment, as providers cannot reach out to the client to re-engage unless they have their name and contact information.

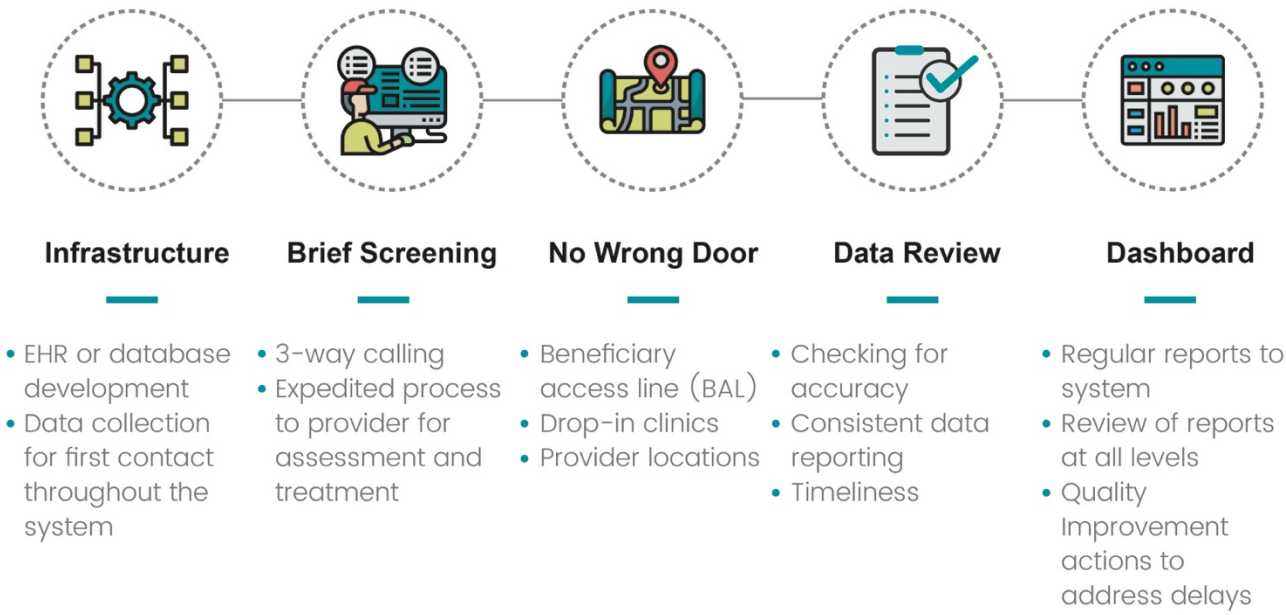
- When brief screening starts at the treatment provider site, then the client is registered in the centralized IS and medical record system seamlessly as treatment begins.

Multiple 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. Decentralized systems must develop strong first contact reporting systems at the provider site; if not, 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.

Examples of best practices include:

- **Ventura** developed a first-contact form to be used by all county staff and providers to assure the same data were captured and entered into their EHR. This assures a client can start at any point in the system, with the system able to seamlessly track timeliness from that point.
- Walk-in clinic models in **San Luis Obispo** for SUD, distributed throughout the county, allow easy access to brief assessment and referral to treatment, and work well in this medium-sized county. There seem to be an increasing number of counties augmenting their engagement services with this option. Some models also include providing a full assessment that is then sent to the provider of service. This can be problematic for the beneficiary, who must engage at the assessment and then re-engage at the treatment site. It is very important to form a positive therapeutic alliance with clients as soon as possible after they request services and show support and desire to assist them with their SUD issues.
- **Los Angeles** determined that paying contract providers for first-contact engagement, even when not a billable service, provided incentives and an expectation that the first contact data and a quality screening for clients are critical parts of treatment engagement. The payments were a constructive intervention to make these first contacts positive and enhance the effort to engage the client in SUD treatment. Feedback from clients and contractors suggested the experience from first contacts at program sites when requesting services was a good one.

Figure 5-4: DMC-ODS Models for Timely Access



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 clear definition that is understood across the system as the first step in tracking timeliness. Counties that do not have a clear definition are most likely missing people who have urgent needs for treatment. Infrastructure for urgent conditions must be established, tracked in minutes 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 level of care 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 level of care. This usually requires enhanced care coordination to assure their timely treatment for clients during any transition between levels of care.

Care coordination is also a best practice for enhancing timeliness, especially in the early stages of treatment engagement and during transitions in care. Care coordination is also essential to quality of care and is largely addressed in this chapter. 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 activity for service improvement but does have a very real impact on timely access and no-shows for complex clients.

County Examples: Working to Improve Timeliness

Fresno developed a PIP to test the Network for Improvement of Addiction Treatment (NIATx) model in an effort to increase engagement and retention in treatment, which will address timeliness as part of its engagement strategies.

Alameda and Nevada focused on expediting timely access to residential treatment. Alameda's plan includes modification of procedures for clients who have requested services while waiting for intake scheduling and linkage to care; addition of three-way calls to link clients to assessments at the residential treatment centers; mobile residential bed applications for tracking resources; and staff having immediate knowledge of available treatment resources for clients requesting care. No outcomes have been determined at this time.

Nevada plans to reduce no-shows for assessments by implementing a walk-in clinic to provide more convenient options for clients. Their goal is to provide any client who walks into the clinic an ASAM assessment and residential treatment authorization on that same day, if clinically appropriate. Outcomes included a significant reduction of no-shows from an average of 37 percent to a nine-month average of 7.2 percent, achieving their goal. Their timeliness of service, however, was increased from an average of 21 days to 33 days. This is most likely due to the drastic reduction in no-shows, which resulted in an influx of client intakes that needed to be completed.

Los Angeles, San Joaquin, Ventura, San Mateo, and Stanislaus are focused on improving timeliness from their access points. Los Angeles, a centralized system, focused on its Substance Abuse Services Helpline (SASH), especially lag times it was experiencing. Interventions addressed barriers of long provider "pre-intake" screening questions, quality customer service, excessive phone wait times at several large providers, lack of timely updates of intake availability from the SBAT, lack of WM capacity, and lack of established protocols for addressing dropouts from the SASH screening to admission

process. Los Angeles has seen significant progress regarding reduced time of screenings, improved satisfaction surveys, and improved updates to the database. Other areas still need work, resulting in a request and approval to continue for a third year.

San Joaquin provides screening and assessments at both the county-run outpatient clinics and a residential program, both on a first-come, first-served basis. Staff found that long waits discouraged many people, who were not willing to stay for an appointment. Their intervention was to offer clients both a walk-in and a scheduled appointment option, requiring a technological as well as a procedural change. In addition, San Joaquin was chosen as a beta tester for UCLA's BQUIP. This will provide the county with a brief screening tool prior to the full assessment. As this is a new study, no data are available yet.

Stanislaus similarly focused on increasing the percentage of clients enrolled in SUD treatment by offering assessments via alternative options (such as walk-in and in the field), in addition to the client's scheduled initial appointment. They are also increasing case management services following the initial assessment to assist clients to get to treatment. There are no data at this time. Stanislaus also is focused on improving timeliness to NTPs. In this project, they initially determined that the data entered in their first-year launch was not consistent or accurate. They had to correct the data prior to moving on with other interventions.

San Mateo focused on increasing the number of clients who attend a first appointment for SUD treatment after their initial request. They had discovered that only 47 percent of individuals requesting treatment attended their first outpatient program. San Mateo determined that transportation challenges were a significant factor contributing to client no-shows. By providing transportation for those in need, the county hopes to reduce the frequency of no-shows for first treatment sessions. Their strategy is to arrange for Lyft to pick up clients for their first appointment. There are no data at this time.

Summary

Timeliness is an important core aspect of quality of care, especially for those with SUD whose motivation to engage in treatment care fluctuates with circumstances. It is critical to make access to the appropriate care available in a prompt manner, with clinical staff who can form a meaningful therapeutic alliance to engage the individual in the treatment process. With this prompt initiation and engagement, clients benefit in understanding their SUD and have greater potential to make progress in managing their illness. The DMC-ODS STCs have set clear expectations for all county plans in this area relative to the different times of service requests; for offered appointments; routine, urgent, and medication face-to-face appointments; and for residential authorizations for access to treatment. CalEQRO has seen the DMC counties work with their networks to build the infrastructure and capacity over time to improve and meet or work towards state standards. While challenges remain, clear and steady progress over the last three years is evident.

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

Chapter 6

Quality

Quality

Quality of Care in California's DMC-ODS 1115 Waiver Counties

Introduction

The DMC-ODS 1115 Waiver STCs define and promote systems of care that are accountable for the quality of the treatment and recovery supports they provide. The STCs include many elements linked to quality and require SUD services to be based on the latest science and research. This chapter highlights the elements essential for successful treatment of SUD, challenges that DMC-ODS counties have faced in establishing and monitoring SUD quality care, best practices they demonstrated, and important opportunities for improvement.

Overview of Major Quality Findings

Finding 1 Client-centered treatment within a continuum of care based on ASAM models is **expanding its range and types of services to meet local needs**.

Finding 2 Care coordination and recovery support are **linking** services and clients.

Finding 3 Counties continue to enhance **Quality Improvement Committees (QICs)** with plans and monitoring systems linked to associated infrastructure and supports that was not required for SUD services prior to the 1115 Waiver.

Client-Centered Treatment in a Continuum of Care

Progress in Developing the Clinical Continuum of SUD Care

Prior to the DMC-ODS Waiver, counties were required to provide a comparatively limited set of DMC services, which often functioned in silos. Each of the 26 DMC-ODS counties reviewed by CalEQRO in FY 2019-20 experienced challenges in expanding its services to meet the Waiver's new requirements for a full continuum of care. This was needed so the DMC-ODS plan could offer services customized to clients' individualized SUD conditions and needs. Some larger counties had established several types of SUD treatment services not covered by previous DMC regulations, relying on non-Medi-Cal funding streams. Other counties, mostly medium- or smaller-sized ones, had to newly establish and manage several new types of treatment services with new requirements and providers. In either case, county and contract programs of these newly covered DMC services faced challenges in obtaining clinical staff, program locations acceptable to the community and local land use requirements, DHCS licenses, and, in some cases, certifications as DMC-ODS providers, while also learning new Medi-Cal clinical record documentation and a new complex billing system.

As indicated in Table 3-1 of this report's Access chapter, the predominant types of DMC-covered levels of care 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 and intensive outpatient, physician consultation, case management, expanded MAT medications at the NTPs, and recovery support services. Established DMC-ODS counties that are not in their start-up years are adding Waiver-optional programs including partial hospital, MAT outpatient, more levels of residential 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.

Table 6-1: Traditional DMC vs. DMC-ODS

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
	Additional MAT (optional)

Recovery housing is a very important part of the continuum of care for SUD success, due to shortened lengths of stay in residential treatment.

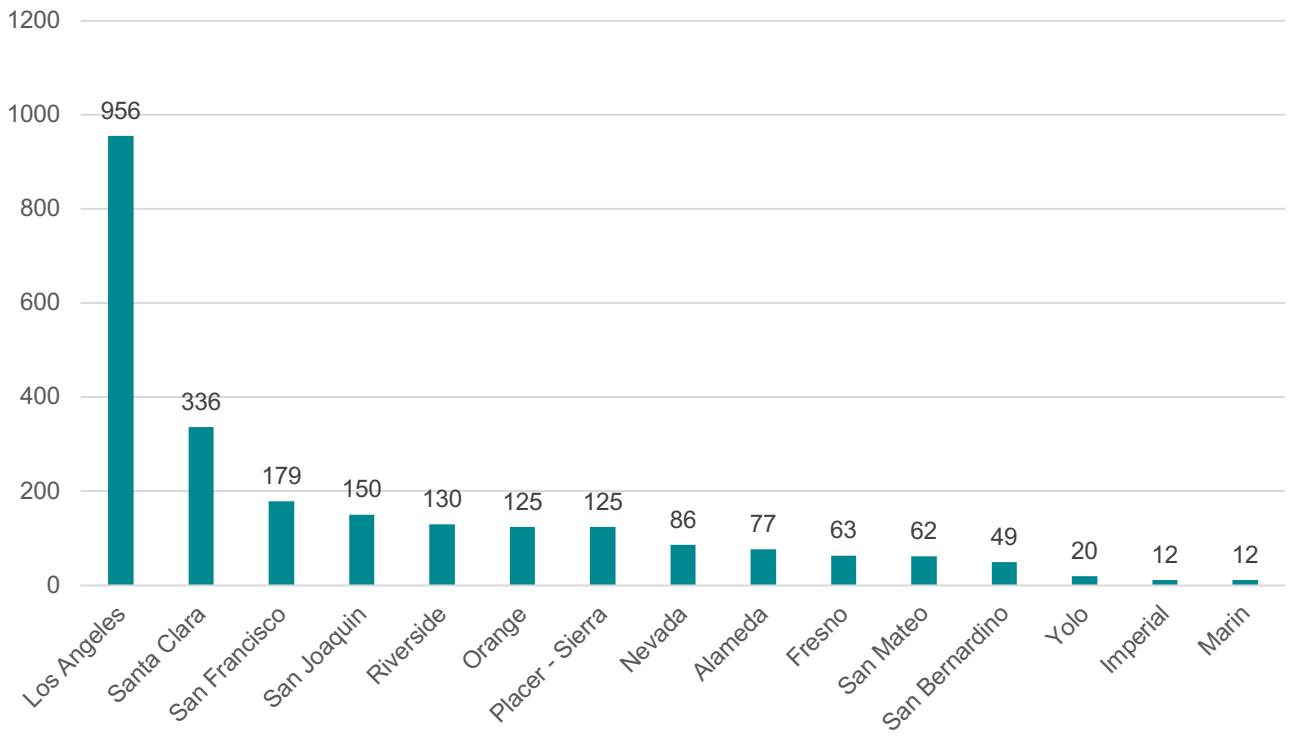
Some key areas needing further development include WM, recovery support services, recovery housing, youth services at all levels of care, and 3.7 and 4.0 intensive levels of care. All of these services appear to be under capacity in terms of prevalence of need, if National Survey on Drug Use and Health data are considered relative to county youth populations.[20] Client focus groups and stakeholder groups of providers also echo these themes in a majority of counties reviewed this year. County and contractor efforts to expand new SUD program sites are challenging due to neighborhood resistance and stigma. As discussed before, recovery housing is a very important part of the continuum of care for SUD success due to shortened lengths of stay in residential treatment, though it is not officially designated as a treatment level.

California obtained approval from SAMHSA to use some of its Substance Abuse Treatment Block 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. Santa Clara led the way, with approximately 400 beds, including seven facilities for single mothers with children and two facilities for single fathers with children. Kern is another county that made recovery residence beds an important part of its continuum with approximately 500 of these beds, although not all are formally under contract with the DMC-ODS. Los Angeles reported over 900 beds when they were reviewed this year and had a goal of many more to meet their needs. These recovery residence beds are a vital part of the continuum of SUD care, with a growing body of research to support their role in client recovery and successful ongoing transitions to outpatient and participation in outpatient care.

[20]Percent of those with dependence or abuse of alcohol or drugs derived from the National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), survey dates 2014,2015,2016,2017,2018 Substate reports CA 2014-2018.

Figure 6-1 below shows reported recovery residence beds by county.

Figure 6-1 Recovery Residence Beds FY 2019-20 Reported on Continuum of Care Form



Notes: Contra Costa, Kern, San Diego, and San Luis Obispo have an indeterminate number of beds. Merced, Monterey, Napa, Santa Barbara, Santa Cruz, Stanislaus, and Ventura have zero beds.

Riverside has one of the most comprehensive ASAM continuums of care in California, including two local youth residential treatment centers, many school-based treatment sites, regional clinics, a range of residential programs, partnerships with FQHC clinics for treatment, and 3.7 inpatient care (under contract but not yet billing services). The county also is negotiating for a local hospital to add 3.7 and 4.0 within Riverside County to have robust local access to these levels of care. Since beginning DMC-ODS services in February 2017, Riverside has continued to add capacity in many regions and levels of care to meet local needs as demands for treatment have increased. Riverside was the first county to launch DMC-ODS services and has continued to demonstrate many best practices benefitting other programs.

Implementing ASAM Assessment Criteria to Match Client Needs with Placement in Treatment Services

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 create objective standards for SUD treatment, giving clinicians guidelines for individualized treatment planning and for identifying the least restrictive treatment services to provide a safe, supportive recovery environment for individuals to improve symptoms and enhance functioning and wellness.

Early opt-in counties understood the importance initiating DMC-ODS services with an ASAM-capable workforce and began training early. At implementation, clinicians need to evaluate clients accurately and efficiently for medical necessity and establish SUD-specific service and level of care recommendations. A subtle but potent additional benefit was realizing that ASAM training involved more than learning to use an assessment tool; it helped participants understand the DMC-ODS continuum of care changes, as well as client-centered chronic care management. 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 those from large referral sources such as the court system. 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 quality improvement efforts, and, in some cases, assigning specific court liaisons as points of contact to help solve problems. A number of counties (e.g., Santa Clara, San Mateo, San Diego, and San Joaquin) 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 benefitted clients and moved SUD services away from a punishment incarceration model and into a treatment model for addressing illness and promoting health.

On average, all screenings, assessments, and follow ups are matching at an 80 percent or higher rate, based on the ASAM dimensions to client needs.

Because effective and efficient use of the ASAM principles is so important, training in virtually every county is frequent, made available with a reinforcing redundancy that includes web-based curricula, case consultations by supervisor or "ASAM champion" staff, as well as hands-on, in-person training by professional trainers and national experts. It 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.

Assessment accuracy and proper use of level of care 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. Many counties require reassessments only when there is a request for reauthorization for residential treatment. Other counties also require ASAM assessment and treatment plan updates when there is a change in any level of care and major change in functioning. It is important to note that on average, all screenings, assessments, and follow ups are matching at an 80 percent or higher rate based on the ASAM dimensions to client needs.

Table 6-2: Congruence of Level of Care Referrals with ASAM Findings, Statewide

ASAM Level of Care (LOC) Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
Dates of Screenings: FY 2018-19	#	%	#	%	#	%
Not Applicable / **No Difference**	37,269	**81.30%**	76,413	**81.2%**	33,355	**84.76%**
Patient Preference	2,507	5.47%	5,395	5.74%	1,854	4.71%
Level of Care Not Available	911	1.99%	878	0.93%	350	0.89%
Clinical Judgement	665	1.45%	3,598	3.82%	1,306	3.32%
Geographic Accessibility	139	0.30%	76	0.1%	42	0.11%
Family Responsibility	21	0.05%	129	0.14%	14	0.04%
Legal Issues	427	0.93%	511	0.54%	277	0.70%
Lack of Insurance / Payment Source	55	0.12%	78	0.1%	34	0.09%
Other	1,439	3.14%	3,960	4.2%	1,170	2.97%
Actual Referral Missing	2,410	5.26%	3,030	3.22%	950	2.41%
Total	45,843	100.0%	94,068	100.0%	39,352	100.0%

Best Practices Using ASAM

Santa Clara and Santa Cruz designed Assessment and Level of Care (ALOC) and ASAM reassessment tools in their EHRs to make it easy for staff to use and integrate ASAM into daily workflows. Many other counties also are following this model and working with software vendors to integrate all these tools into their EHRs. The DMC-ODS Treatment Plan tool is able to identify the linkages between the ASAM dimension and severity rating and the associated identified problem and goals/objectives. These counties' QI staff conduct monthly monitoring of sampled charts, focusing on

the use of ASAM criteria for level of care treatment planning, service delivery, and ASAM-indicated transitions of care.

Los Angeles uses ASAM Triage and Continuum software linked to its EHR. These are separate ASAM-developed products to conduct screening and assessments to match client needs to clinical services, and they assist in treatment planning. This product has provided tools and a rich database in terms of understanding the clients served. The level of data captured from these screenings and assessments is more detailed than the tools used in other counties. More analysis of the data will yield many helpful insights, including learning more about treatment effectiveness for different populations.

ASAM criteria encourage treating relapse as a learning experience as well as ensuring access to all beneficial and evidence-based treatments, including MAT. DMC-ODS counties have made policy changes to encourage treatment programs to accept clients who need MAT and to continue seeking ways to continue working with clients who have relapsed, or to temporarily transfer them to a more intensive, appropriate level of care (such as WM) rather than summarily terminating them from treatment. The positive attitude with no shame and more outreach and re-engagement has led to more prompt treatment after relapse and stabilization. This represents a major change from past practice and keeps clients in the treatment systems, instead of discharging them from treatment for their primary problem.

Promoting and Implementing Medication Assisted Treatment (MAT)

> **"MAT gave me enough time to find recovery."**

COVID aside, California counties remain in a public health crisis as a result of opioid addiction. Fatal overdoses are at their highest rates since the beginning of the opioid epidemic in 2017[21] and Hepatitis C virus is the norm among people who inject drugs. Thus, providing for the rapid availability of MAT to reduce cravings and avoid extreme drug use is more important than ever to avoid spiraling overdose rates. Methadone and buprenorphine are drugs used to treat opioid use disorders and have been established as the gold standard of treatment by the National Institutes of Health.

Despite many challenges (discussed below), 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

[21] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Vital Statistics Rapid Release. Provisional Drug Overdose Death Counts. Accessed from: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

navigators and peer supports are also provided for SUD clients placed on MAT by the Nevada County healthcare clinics or hospital.

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 physician's 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. 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 300 and 350 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.

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

- 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 Med units coordination and expansion
- 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 programs. These collaboratives are part of MAT expansion initiatives.
- Integrated criminal justice services and referral into SUD community clinics
- Access Call Centers, including FQHC clinics providing MAT in the resource directory for referrals.

A powerful resource is physician leadership in the community. Marin County is successfully providing physician trainings to become X-Waivered. This includes organizing peer-to-peer physician support to encourage dispensing and to provide case consultation on difficult cases, with both Medi-Cal and other insurance and coordinating referrals from the emergency department, including a new PIP that identifies non-fatal overdoses and coordinates outreach and follow up for MAT and other services with an SUD navigator linked to the DMC-ODS.

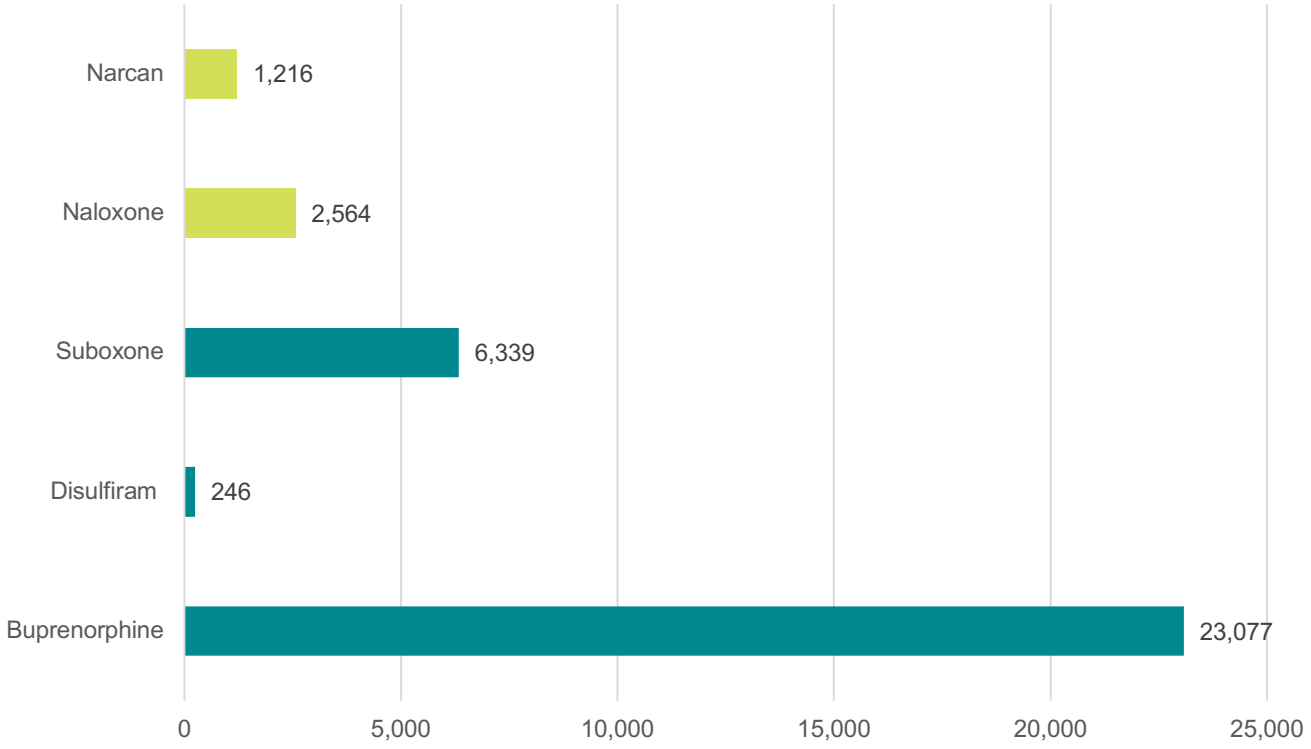
San Luis Obispo continues to provide a robust non-methadone MAT program that began over ten years ago, leading California in early access to non-methadone MAT. Many San Luis Obispo clients received MAT as their initial DMC-ODS service (compared to 0.2 percent statewide); at some stage of their overall treatment, 13 percent of San Luis Obispo clients received non-methadone MAT. 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 clinic sites with drop-in assessment hours. 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 very important; this service is used in all the of counties reviewed. San Luis Obispo and Santa Cruz County DMC-ODS programs lead the state in highest percent of clients in treatment who are also on MAT.

Beneficiaries say it best: “MAT gave me enough time to find recovery.”

Below are figures showing services of non-methadone and methadone MAT provided in FY 2018-19 by DMC-ODS counties reviewed. These services continue to grow and are linked frequently with counseling and other support services.

Figure 6-2: Unique Non-methadone MAT Claims for FY 2018-19 Provided by NTPs



Note: Narcan and Naloxone are medications for overdose prevention.

Figure 6-3: Unique Clients Receiving Non-Methadone MAT at NTPs, FY 2018-19

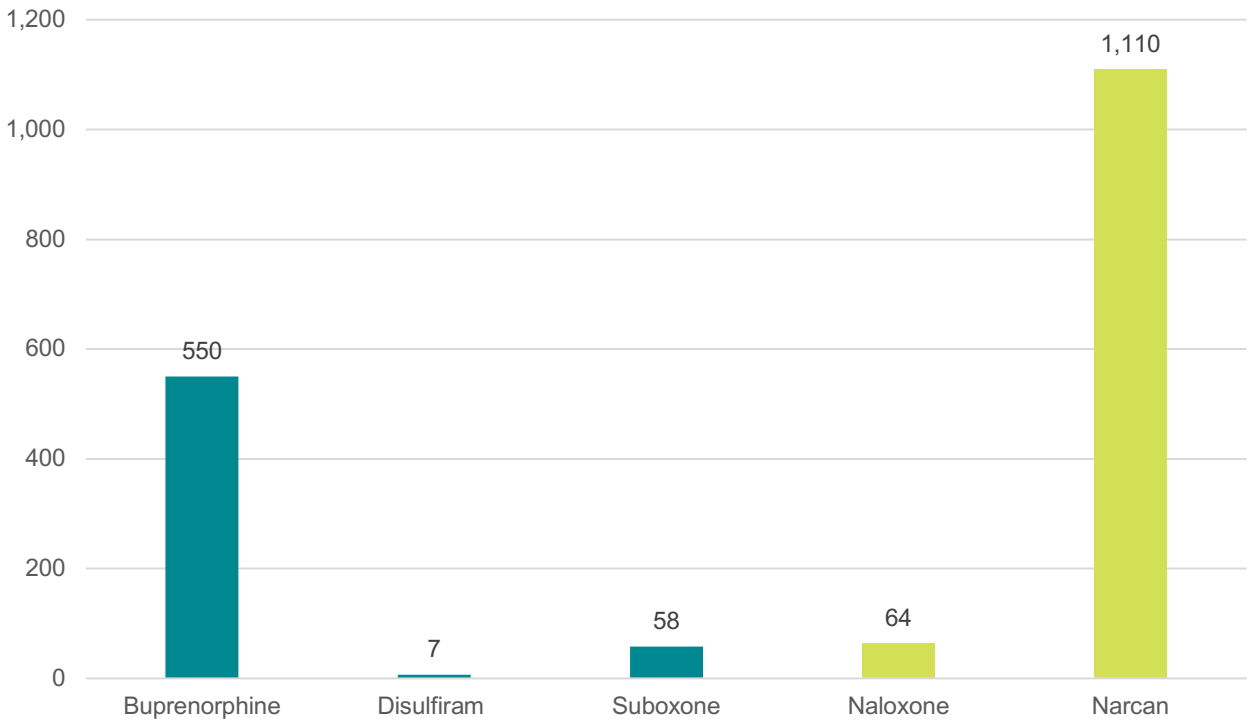


Figure 6-4: Percentage of Total Clients Served Who Receive Non-Methadone MAT as Outpatients, FY 2018-19

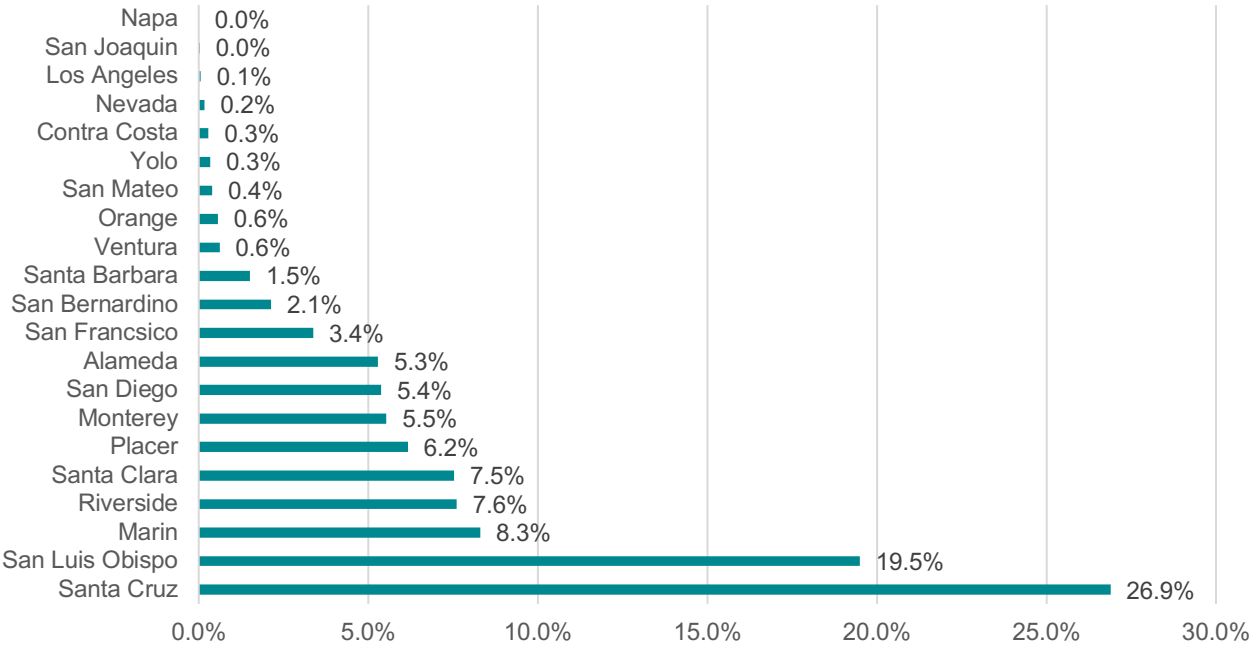
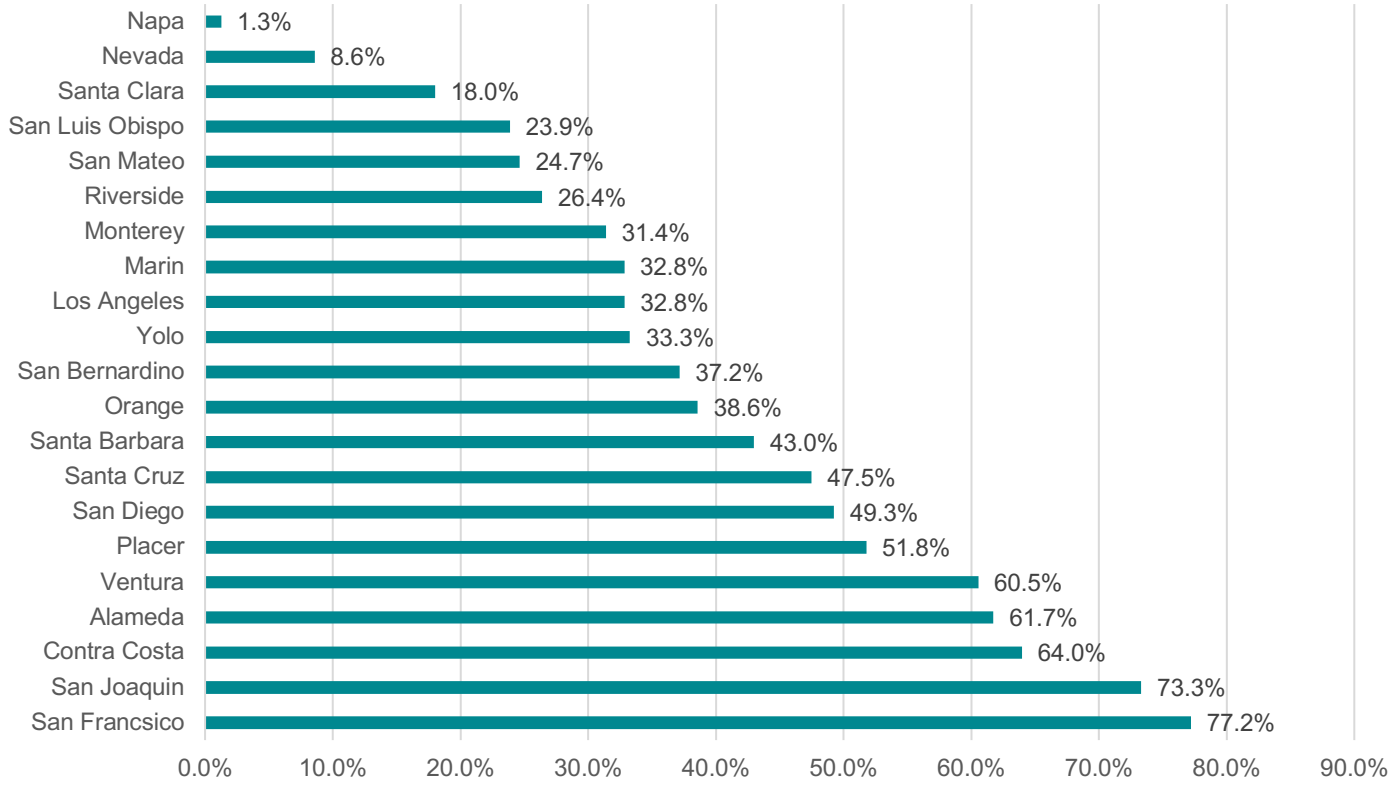


Figure 6-5: Percentage of Total Clients Served Who Received Methadone in NTPs, FY 2018-19



Implementing Evidence-based Practices (EBPs)

> **"I've learned about my relapse triggers and how to manage them … The Seeking Safety work with my counselor is helping me stay here."**

The DMC-ODS Waiver promotes client-centered care, utilizing 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. In 1993, SAMHSA acknowledged the gap between clinical evidence and clinical practice in SUD treatment and established a national network of Addictions Technology Transfer Centers (ATTCs) to unify science, education, and service to bring evidence-based recovery practices into the SUD recovery and treatment field. 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 psycho-education.

Ensuring that providers are providing EBPs with absolute fidelity would require studies beyond the scope and capability of many county QI programs and may provide limited value. Yet counties do take seriously the DMC-ODS mandate regarding best practices. More importantly counties, treatment providers, and SUD clinicians have embraced the growing professionalism and science-based approach to recovery. 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 new 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.

For example, San Joaquin gives priority to addressing the high incidence of co-occurring mental health disorders and SUD. They cross-train staff so that mental health staff are familiar with the DMC-ODS continuum of care and use of ASAM criteria, SUD staff are trained in co-occurring disorder treatment, and both staffs are trained in several EBPs: MI, CBT, and Seeking Safety. Some staff with mental health expertise are embedded in SUD treatment programs, and some with SUD expertise in mental health programs.

Other counties' QICs monitor treatment programs with site visits and program schedule reviews to validate the scheduling of EBP activities in provider programs. The strongest evidence is heard from beneficiaries who frequently comment about the quality of the treatment and satisfaction with the help they receive. Some mention programs like Seeking Safety and RPT specifically. As one client remarked in a CFM focus group, "I've learned about my relapse triggers and how to manage them," adding "The Seeking Safety work with my counselor is helping me stay here."

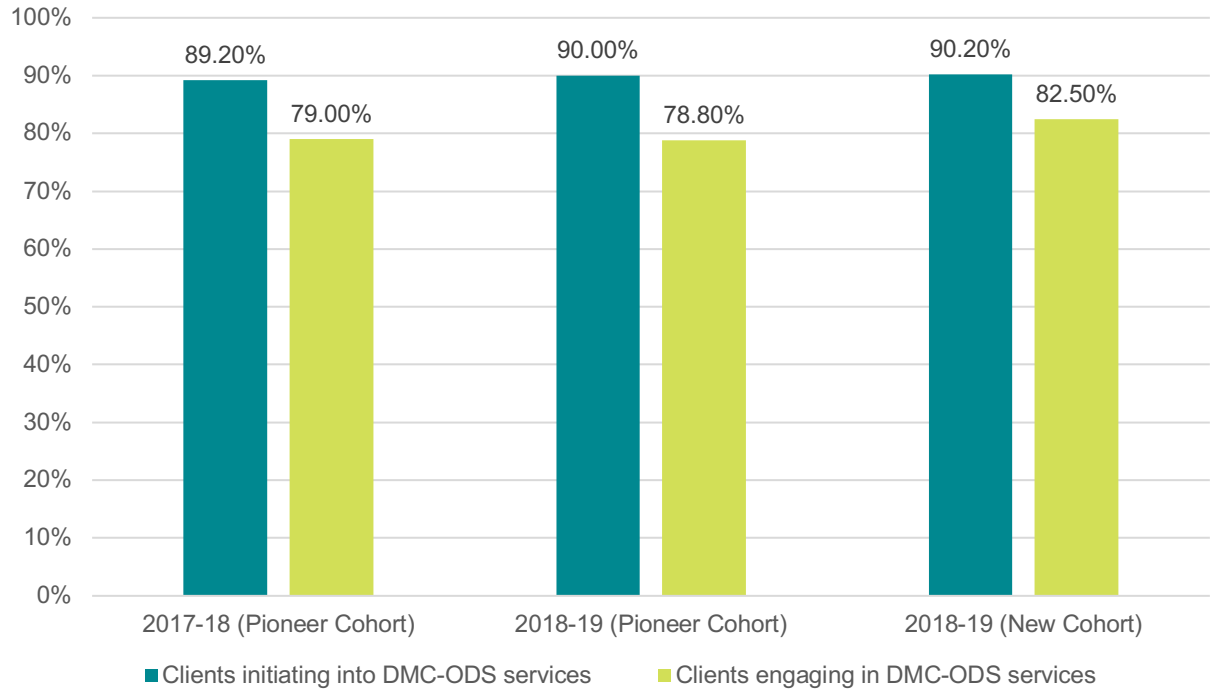
A Quality System of Care Focuses on Engagement and Retention of Clients in Treatment

A vital component of quality care for treating clients with addictions is the ability to engage and retain them in treatment. Many of these clients are initially ambivalent about ending their drug and alcohol use and changing their addiction lifestyle, so there can be high rates of initial dropout. 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 measures 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).

Based upon claims data analyzed by CalEQRO, among the clients served in FY 2017-18 by the first 14 DMC-ODS (pioneer) counties to implement the Waiver, 89.2 percent initiated into treatment (at least one session within 14 days of the initial assessment). Of those who initiated, 79 percent went on further to engage in treatment. In the subsequent fiscal year of FY 2018-19, the statistics for the pioneer counties were almost exactly the same with 90 percent initiating into treatment and 78.8 percent of those continuing further to engage in treatment. In the same fiscal year of FY 2018-19, the 12 counties in the new cohort group who were in their first year of Waiver implementation had similar results—92.2 percent initiated into treatment and 82.5 percent engaged in treatment. These are excellent levels; the goal would be to sustain them and track them further in terms of client retention beyond the six-week engagement measure.

Figure 6-6: Initiating and Engaging in DMC-ODS Services, FY 2017-18 and FY 2018-19



These rates of initiation and engagement are all quite high, suggesting that once counties form accountable systems of care, they perform accordingly and act to prevent clients from slipping through the cracks by dropping out of treatment. Several DMC-ODS counties were proactive in measuring their own effectiveness by using their client data to measure initiation and engagement. Some of the counties that did this included Santa Clara, San Diego, Santa Barbara, and Riverside. They went further to then review their results and consider opportunities for quality improvement. Riverside was particularly proactive in providing case management for clients who they thought might be at high risk of dropping out.

Care Coordination and Recovery Support Services

Implementing Models of Case Management and Care Coordination

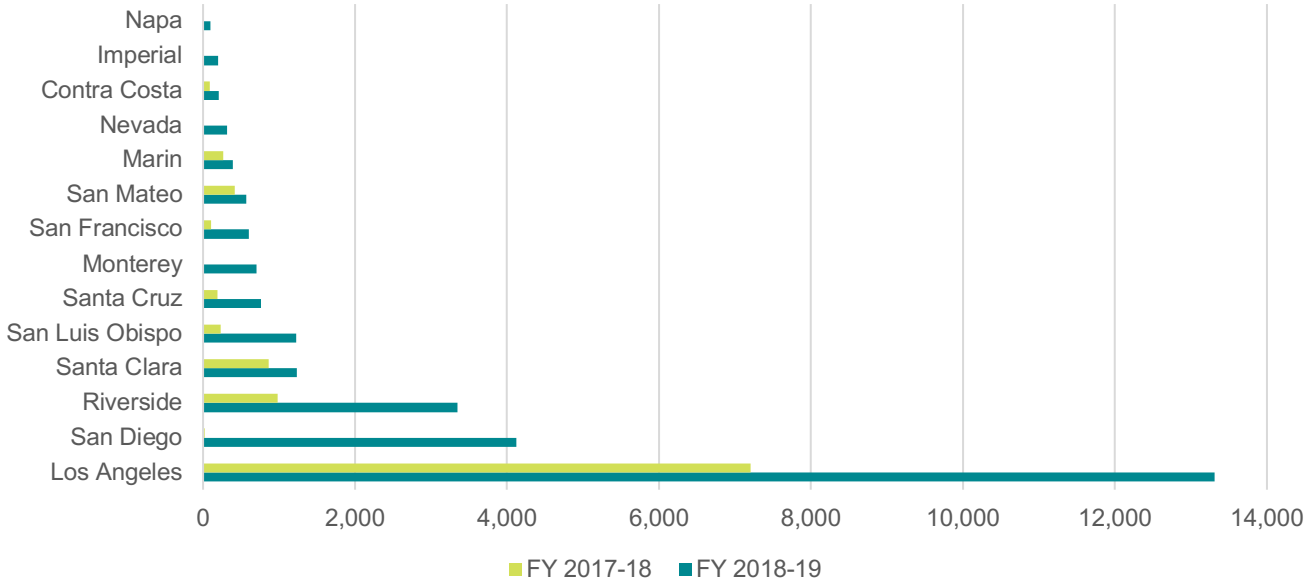
County-operated and county-contracted providers of SUD services have long recognized the high need among their clients for case management services. Their clients need assistance with linkages to other types of services including physical and mental health care, social services and child welfare, justice system, and supported housing and employment. Treatment providers overall had provided these case management support services with stretched resources and without reimbursement, and therefore in an inconsistent manner. 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 Waiver design was recognizing the importance of these case management services and building into the reimbursement system a mechanism for providers to bill for these services. There are specific billing codes for case management associated with any DMC-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. A few counties with county-operated outpatient clinics that are DMC-certified provide case management services to clients still preparing to engage in treatment and to clients who are getting treatment from different providers across the system of care over time. These long-term case management relationships can be very effective by building strong therapeutic alliances to support the client through the various stages of recovery.

Case Management Best Practices

Case management has expanded for county and contract providers over the last two years, as shown in Figure 6-7.

Figure 6-7: Expansion of Case Management Services in Pioneer Counties, FY 2017-18 to 2018-19



The models demonstrating the most accountability have ongoing long-term relationships between the case manager and the client across levels of care and over time. Whether they work for the county (as in Riverside's model) or for 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 the community at large. 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, for example. The core of their effectiveness lies in trust, good communication, and a strong therapeutic alliance.

Another best practice is to have special case management training and supervision for the staff and a channel to senior SUD managers for system problems and breakdowns. This allows case managers to see directly where the system is backing up, when admissions that should occur smoothly are bogged down, when staff who are supposed to be supportive of MAT are not accepting MAT clients, or individualized treatment is not yet established in a program's culture. 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. Using this information from case managers in real time is important and will improve quality. Best practice is to have leadership overseeing key case management functions to allow for this feedback and action.

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.

Ensuring case management navigation and support of clients from first request to first face-to-face appointment, as well as all transitions in care levels, empowers the case manager with resources for transportation, after-hours access, childcare help, and night and weekend hours if necessary—all of which make connections with clients and programs possible. To be effective, case managers need resources they can flexibly and quickly deploy on behalf of clients.

Most counties provide case management through staff located at the level of care in which the client is receiving treatment. Santa Clara provides this type of case management exclusively, with all clinicians/counselors at the provider site expected to deliver case management services in addition to counseling according to each client's needs. Santa Cruz case managers offer care coordination to assist with transfers to other levels of care. Each of the three largest contracted providers offer programs at multiple levels of care so that movement of clients can be as seamless as possible.

Some counties offer a hybrid case management model that combines both centralized and treatment setting-specific delivery systems. Kern offers centralized case management teams in metropolitan Bakersfield, while in outlying areas contracted providers offer case management services to individuals in treatment at their assigned site and other select sites, including NTPs near clients' locations. San Mateo offers case management integrated into its contracted SUD treatment programs, and separately through county-operated specialty case management teams such as the county's Intensive Medication Assistance Team.

Case Management Challenges

Some newly implementing DMC-ODS counties were slow to start the delivery, documentation, and billing of case management services. Documentation and billing for case management were new requirements necessitating new tasks and skills. In counties that had bundled them into day rates for residential-based services, some staff felt as if they now had an added responsibility without an easy way to track the added volume of tasks and receive due credit. This problem was particularly acute when no new staff were added with specific case management responsibilities. Counties that contracted in that way were often unable to track accurately the amount and type of case management services provided by residential treatment service providers because it was not tracked or documented separately.

Due to workforce shortages of Licensed Professionals of the Healing Arts (LPHAs) and certified SUD counselors, most providers support allowing training and supervising peers in recovery to be peer case managers. However, at this time, peer case managers in training are not allowed to bill for Medi-Cal reimbursement. Peers are only allowed to bill specific recovery support services after training and with supervision. Since LHPAs and SUD counselors are in great demand for other treatment services, hiring them for case management positions has been challenging.

Monitoring and Improving Transitions in Levels of Care

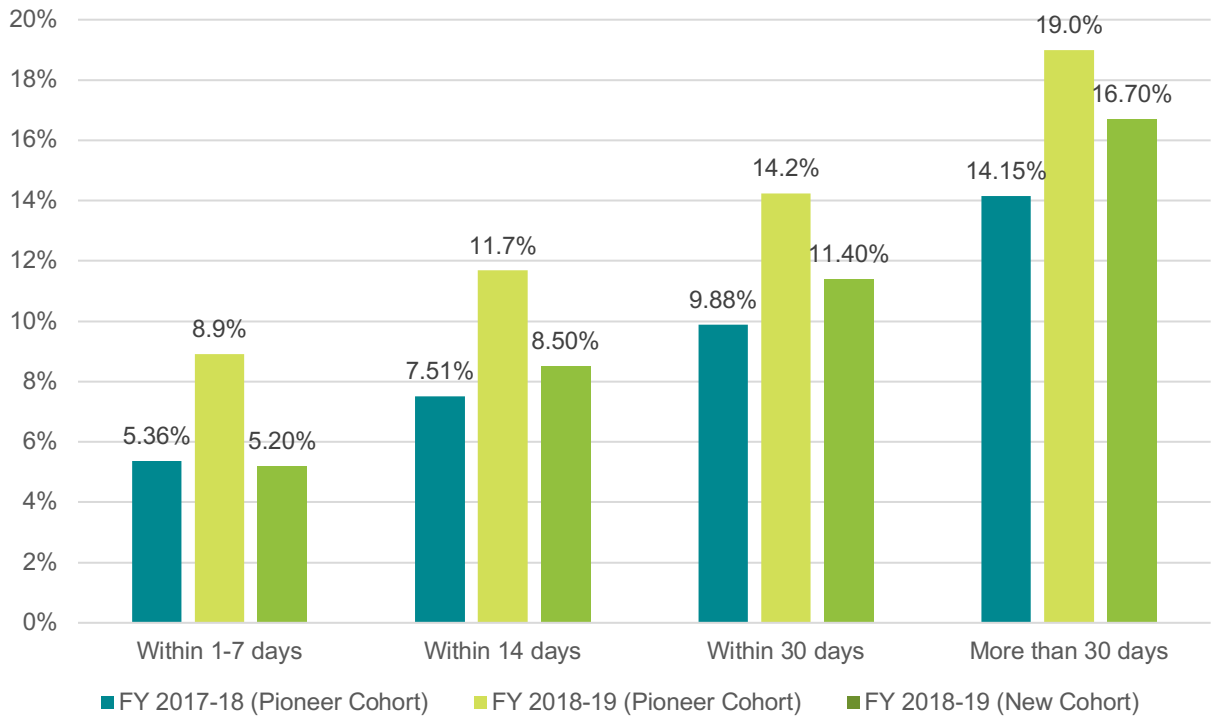
The DMC-ODS Waiver emphasizes client-centered care, one element of which is the expectation that treatment intensity and focus should change over time to match the client's changing condition and unique treatment needs and circumstances. This treatment philosophy is in marked contrast to a program-driven 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 level of care.

Figure 6-8 shows (1) the percentage of clients discharged from residential treatment who then received a follow-up treatment session at a step-down, non-residential level of care, 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 level of care within 7 days, 14 days, and 30 days after discharge from residential treatment. Also shown in each table are the percentage of clients who had follow-up treatment between 31-365 days after discharge and clients who had no follow-up within the DMC-ODS continuum of care in any billable service.

Follow-up services that are counted in this measure are based on DMC-ODS claims data and include outpatient, intensive outpatient treatment (IOT), partial hospital, MAT, NTP, outpatient WM, case management, recovery supports, 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 fee-for-service (FFS)/health plan Medi-Cal claims data at this time to track those whose treatment transitioned to MAT in a primary care setting.

Based upon claims data for FY 2017-18 and FY 2018-19, the 14 pioneer counties that first implemented the Waiver showed significant improvement in transitioning clients from residential treatment to less-intensive levels of care upon discharge between these two FYs. Their timeliness rates improved from 5.4 percent to 8.9 percent within 7 days of discharge, 7.5 percent to 11.7 percent within 14 days, 9.9 percent to 14.2 percent within 30 days, and 14.2 percent to 19 percent overall. The newer cohort of 12 implementing counties had lower percentages in each category for their first year of implementation compared to the pioneer counties in their second year. These comparisons suggest that this important function of transitioning clients takes time to manage and has not been part of the historic siloed system, but improves with skill, effort, and clinical oversight.

Figure 6-8: Timely Transitions in Step-down Care Following Residential Treatment



Although DMC-ODS counties are demonstrating improvements in their rate of successful client transitions upon discharge to less-intensive levels of care, 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 who leave treatment before completion for any one of a number of reasons and tend to be less amenable to a transition plan; (2) staff reluctance to transfer and clients feeling ready to return to community life and still believing old models that they have "graduated" and do not need more treatment; or (3) client reluctance after bonding with the residential treatment staff to begin establishing trust with new (for them) program and counseling staff.

Best Practices/Lessons Learned on Transitions in Care

Some DMC-ODS counties and their treatment programs have begun developing strategies to address these barriers. Santa Cruz contracts with a small number of provider organizations, each of which operates multiple levels of care, so clients can transition more seamlessly from one level to another within the same provider organization. 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 overlapped outpatient and residential sessions to allow for bonding to the new counselor and setting up new goals that both agree on before

discharge. Both programs cannot bill on the same day, but chances of a smooth transition are enhanced with this overlap strategy.

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.[22, 23] 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 recovery support (RS) services 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 recovery support sessions 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 RS: 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. 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 RS as an important component of the system of care by permitting this billing under a separate code for recovery support services.

Napa has had particular success with recovery services and is 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 recovery services if they did not initially accept them. This practice allows re-engagement and access to needed support for clients who are now struggling with issues of SUD in community settings. In addition, the county co-located recovery services center on a campus where it is easy to get benefits, job assistance, 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 very successful.

Some counties reported barriers to implementation because of lack of interest among clients in longer-term services, and others because of unclear understanding of documentation and billing

[22] 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/

[23] 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.x

requirements for providers. 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 recovery support services. 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 1,970. While it may be correct to assume that more RS 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 RS is in Napa County, which has provided it for two 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.

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."

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 RS services in the coming year. Some had begun developing their RS 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 RS services.

Quality Improvement Infrastructure and Supports

Information System and Data Analytic Tools for Quality of Care

A county-based DMC-ODS relies on many quality-linked managed care functions that require IS and data analytic supports, ranging from the provision and coordination of clinical care to the processing and transmission of claims and invoices. To be accountable for the quality of these and other related functions, a DMC-ODS must be able to monitor them through data collection, storage, lookups, analyses, and reporting. Core functions include practice management, accounts payable and receivable, network management, a robust EHR for direct services based on specialty and level of care, telehealth, pharmacy and lab management, ancillary services management, transportation management, beneficiary management, and more. Quality management overlays these systems and tracks key metrics linked to the National Quality Forum, HEDIS, the National Committee for Quality Assurance (NCQA), SAMHSA, and whatever is linked to the best science in the field to promote and link to best experiences and outcomes for the client.

Comprehensive EHRs are available to support a wide range of functions specific to California DMC-ODS counties, but there are still too few and they were generally designed for physical or mental health care systems. Customizations are needed to address elements unique to specialty substance use care. Also, technological solutions are needed for care coordination between various substance use treatment providers with each other and with other essential services outside the DMC-ODS; the solutions must address the special regulations that protect data privacy and security for substance use treatment data. These and related considerations are addressed in more depth within the chapter of this report on IS capabilities. In this section, we will focus only on review findings related to IS and data analytics that support quality of care.

Best Practices to Enhance System Approaches to EHRs

Most counties and their network providers to do not have complete EHR systems that can exchange information, though that is the goal for many. Here are some best practices that counties are using in the journey to achieve more comprehensive, timely information exchange:

- Develop a clinical users' group to advise county leadership and the software vendors they use on EHR design elements, so they streamline and enhance clinical workflow and documentation
- Include contract providers in the EHR solution, because in most DMC-ODS counties those providers comprise most of the delivery system and need to coordinate and communicate with the DMC-ODS program, access call center, and other programs
- Add sufficient IS and data analytic staff to support the development and implementation work necessary to meet DMC-ODS needs, including those of partner contractors, to optimize billing, clinical quality, and key metrics linked to quality

> **"Our EHR is a great warehouse of clinical and program data that no one here in Behavioral Health has the key to, and more easy reports and communication are needed."**

- Acquire and use data analytic software with data visualization functionality so that managers can more easily use and generate data dashboards and related reports that clinical staff understand and can motivate change.

There are many examples of counties implementing some of these suggested strategies. Several counties have begun adding more staff in development, analytics, and QI functions. Santa Clara is working with its EHR vendor on streamlining documentation. Santa Barbara and San Luis Obispo are each incorporating new data fields into their EHRs for entry of ASAM criteria-related data. San Joaquin incorporated electronic consents into its EHR, especially designed for clients with co-occurring

disorders who are receiving concurrent treatment for both disorders. Several counties have contracted with data analytic software vendors to develop data dashboards and more flexible reporting. However, as one county clinic supervisor stated, their EHR "is a great warehouse of clinical and program data that no one here in Behavioral Health has the key to, and more easy reports and communication are needed."

Quality Improvement Monitoring and Activities

QI activities are a Waiver requirement and a key component for supporting system improvement to benefit clients' health. Participating DMC-ODS counties are required to create a Quality Improvement Committee (QIC) with a structured QIP, including an annual evaluation of measurable goals.

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 QIP. 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.

Best Practices and Tools for Success

Successful counties shared several essential elements:

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

(2) The QIP's goals and objectives are clearly written, measurable, with assigned responsibility.

(3) The QIP provides clear examples of how the county's QI efforts affect decision making and affect the quality, effectiveness, efficiency, and the cost of care.

(4) QI efforts are supported by adequate staff.

(5) Evaluation resources are deployed effectively.

(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.

Each of the 26 counties had QICs responsible for performing QI activities according to the QIP. Committee membership varied. Some were limited to mental health administration and staff, while others cultivated broader representation from stakeholders and the community. The frequency of meetings (monthly; quarterly), location of meetings, and required duties presented challenges to members, especially for those with limited time available for meetings or travel. Most had converted to virtual meeting in response to COVID, but others (such as Contra Costa) already had increased meeting attendance using virtual meetings before shelter-in-place orders, due to long and difficult travel challenges.

Kern County has encouraged and maintained a diverse QIC membership, keeping a core committee engaged whose members attend each meeting; subcommittees (e.g., Cultural Competency) or special

initiative work groups report remotely. Kern County's QIP and minutes of QI meetings reflect the organizational norm of recruiting contract providers, stakeholders, consumers, and family members to participate in regular and task-specific meetings, work groups, project planning committees, and informational input through survey methods.

In San Francisco, QI staff regularly attend contract provider QI meetings to get input, provide data, and respond to feedback. A client advisory council provides feedback on all public documents and other issues where the client perspective is important for program success. For example, this group helped develop TPS questions. In Fresno County, "Our hard work with engaging stakeholders, from the county healthcare, mental health, criminal justice, and administration, was important. But more important was engaging our providers and the community with focus groups and a place at the table in our planning and quality improvement committees."

"Our hard work with engaging stakeholders, from the county healthcare, mental health, criminal justice, and administration, was important. But more important was engaging our providers and the community with focus groups and a place at the table in our planning and quality improvement committees."

Meeting membership and participation are important, but without structure to support reliable fidelity to QI goals and objectives, meetings can lose focus and meaning. The measure of a QIC's healthy functioning is found in its minutes. As noted above, a measure of success is whether "the QIP describes meaningful, clearly stated goals, each with measurable objectives and assigned responsibility. These are easily tracked with progress included as a regular, recorded part of the monthly QIC meetings. San Diego's QIC minutes include a review of unfinished business from the previous meeting followed by reports and action items that are either linked to measurable QIP goals and objectives or describe an emerging quality of care issue. Reading these minutes gives a clear, seamless narrative of the actions taken and current status of QI initiatives in the QIP. They link clearly to work on overdose issues, prevention issues, education of providers, efforts in the EDs, etc.

Data are the essential ingredient for the secret sauce of QI. However, data collection in itself is of little value unless it feeds into robust QI planning and execution, leading to meaningful action. Technology infrastructure, effective business processes, and staff skills in extracting and using data for analysis also must be present. For example, Merced County expressed several aspirations for productive data analyses to support quality improvements. They acknowledged they would like to do much more in data analysis and outcome measurement but lack sufficient data analytic staff to do so.

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 additional analytics staff were very common in reports.

San Diego makes good use of a well-developed data collection and reporting process that includes partnerships with local academic institutions such as the UC San Diego Health Services Research Center and an ongoing relationship with Optum Health for the BAL and other data functions. SUD services dashboards also provide timely analyses each month. Some include indicators for providers or contract liaisons reflecting whether a given area has a status of positive, needs review, or raises specific concerns. These documents and reports clearly indicate that San Diego's data are aiding and guiding the ODS decision making regarding multiple areas of QI across the system of care.

Riverside tracks clients' improvement in risk-rating change post-treatment across the six ASAM dimensions, along with other key measures and trends of the DMC-ODS. These key measures and outcome reports are shared with staff, management, contractors, stakeholders, and the Board of Supervisors and are regularly used to guide planning, decision making, and enhancing SUD treatment and operations. Having a long-term academic partner is particularly helpful, as their knowledge of the county's work and systems can evolve over time to include more sophisticated trending and assessment of program strengths and challenges.

Monitoring and Improving Culturally Competent Services

Providing culturally competent services is the responsibility of each DMC-ODS service provider. Providers must ensure that their policies, procedures, and practices are consistent with the enhanced National Culturally and Linguistically Appropriate Services (CLAS) standards and are embedded in the organizational structure, as well as being upheld in day-to- day operations. Translation services must be available for beneficiaries, as needed. This is a critical issue for quality of care.

Integrated CCPs need to reflect balanced attention to mental health and SUD issues.

Cultural competency activities include CCP development and activity reporting, which generally are incorporated into the counties' QIP. Strengths universally seen in the county CCPs that were reviewed included adopting CLAS standards, consistently using outreach and educational activities in the community, and employing methods to improve threshold language resources. A majority of the CCPs are integrated plans that present a combined mental health and SUD focus. However, in most cases the focus of these integrated plans was primarily if not entirely on mental health issues and activities, so many need to add a focus on SUD for balance. Whether CCPs are integrated or exclusive to SUD, they should include at least some cultural competency-building initiatives specific to SUD. The plans should also include action items that are relevant to communities, with timed and measurable goals and objectives. While most counties should enhance the SUD focus of their CCPs, several counties exhibited quality CCP initiatives including:

- Creating and maintaining a strong, culturally diverse workforce including culturally representative administrative, service, and peer staff. Kern County advertised positions

at community outreach activities, on internet-based community information boards, and through job fairs at local high school and colleges.

- Establishing language-appropriate information and feedback channels. For example, Los Angeles County developed a number of interactive web pages that communicate SUD treatment and recovery information translated in English and threshold languages.
- Providing outreach in a variety of creative forms into the community. A Contra Costa NTP conducted periodic open houses with food and beverages, inviting the community to learn more about opioid services.
- Conducting staff and community training (didactic and interactive) and the monitoring of DMC-ODS contract providers plans to enhance the cultural competency of services. For example, San Luis Obispo updated its cultural competence plan, adding specific strategies to engage underserved beneficiaries with a focus on language capacity as a priority. A survey was sent to solicit feedback from clients in the lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities, yielding over 400 online responses and six specific focus groups. The mental health team responded with training for staff and providers on cultural competence strategies.

A theme in most counties and among contract providers is the challenge of hiring and maintaining a culturally and linguistically diverse workforce. A comment repeated in several CalEQRO client focus groups tells the story: “We need more counselors who speak Spanish and more groups where we can speak Spanish.”

Communications Between DMC-ODS County Administration and Treatment Providers for DMC-ODS Planning and Implementation

Meaningful QI requires good data, but data are meaningless without sound QI planning and execution.

Because of the complexity and breadth of transformational change accompanying the DMC-ODS SUD services redesign, leadership with an inclusive style and strong and effective communication practices is essential in each county. The planning, organizing and coalition building required for both pre- and post-implementation include many levels and phases of communication with the existing system of care, especially providers for DMC-ODS SUD services. Without communication that builds global and shared consensus, providers will be slower to adopt new treatment and documentation practices essential for the success of the DMC-ODS and improved client services.

During the planning and early implementation of DMC-ODS, counties put a lot of effort into ensuring good communication and involvement in planning and implementation between DMC-ODS administration and SUD treatment providers. Providers were included in planning meetings and participated in focus groups, surveys, and specialized committees. Information was shared through

multiple channels to better ensure everyone was kept informed and feedback could be received. Of the 26 counties reviewed, 65 percent or 17 counties fully met the criteria for addressing this important component, and 9 partially met the criteria. Counties that partially met these criteria were generally deficient in consistently communicating with members. For example, provider staff in several counties said they were not included in planning or decision making and only received information secondhand. County challenges and successes in this key component of Waiver implementation seemed to depend upon the leadership team and the human resources available, rather than on county size or length of time in Waiver implementation.

To partner effectively with providers when starting DMC-ODS services:

- **Hold regular meetings that include administrative and clinical line staff**
- **Be accessible and transparent**
- **Communicate frequently and be good listeners**
- **Ensure feedback loops**

Best practices of successful counties included increasing accessibility by using flexible, multichannel (face-to-face and media-facilitated) approaches to communicating. Including both administrative and line staff in meetings was valued, but face-to-face participation was a challenge, especially for counties where distance or other factors interfered with attending frequent meetings. In those instances, ensuring that clear and transparent information was distributed in a timely manner was important. Equally important was the ability to provide feedback and having sources accessible to answer any process, planning, or implementation questions. For example, providers in Santa Barbara commented positively on how communication with the county and ability to participate in decision making increased during the launch of the DMC-ODS. Fresno County providers commented on how easy it has become for them to approach the county with problems and feel they will be received with willingness to find a solution rather than judgment or criticism.

Inclusion in the form of membership in action groups such as QI or CCP committees was important, as was creating organizationally structured channels for continuing communication with providers. Inclusion took effort; sustained inclusion took sustained effort. Kern County's QIP and meeting minutes reflect an organizational norm of recruiting contract providers, stakeholders, consumers, and family members to participate in regular and task-specific meetings, work groups, project planning committees, and informational input through a variety of methods.

Kern used its strong connections with providers to assist in adapting treatment resources during COVID. The use of telehealth was in the Kern DMC-ODS plan, but not all providers had begun to take advantage of this option prior to COVID. During the COVID crisis, the implementation of telehealth was accelerated. Those providers using telehealth for mental health visits were able to shift quickly to SUD telehealth, allowing therapists to meet timeliness requirements for assessment, with other providers following suit.

Feedback from Clients on Their Perceptions of Care to Improve Quality

Positive client feedback also included information about unmet needs:

- **Longer length of stay in residential treatment**
- **More bilingual counselors**
- **More assistance with housing and employment**

CalEQRO regards the client perspective as an essential component 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. Ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction. Graphs showing comprehensive results across these domains are included in this report's appendices. 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 6-9 shows the average TPS ratings by item and by domain on a five-point scale, aggregated across all 26 counties 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 6-9: Mean Score on Perception of Care Survey Items by Domain, CY 2019 (26 Counties)

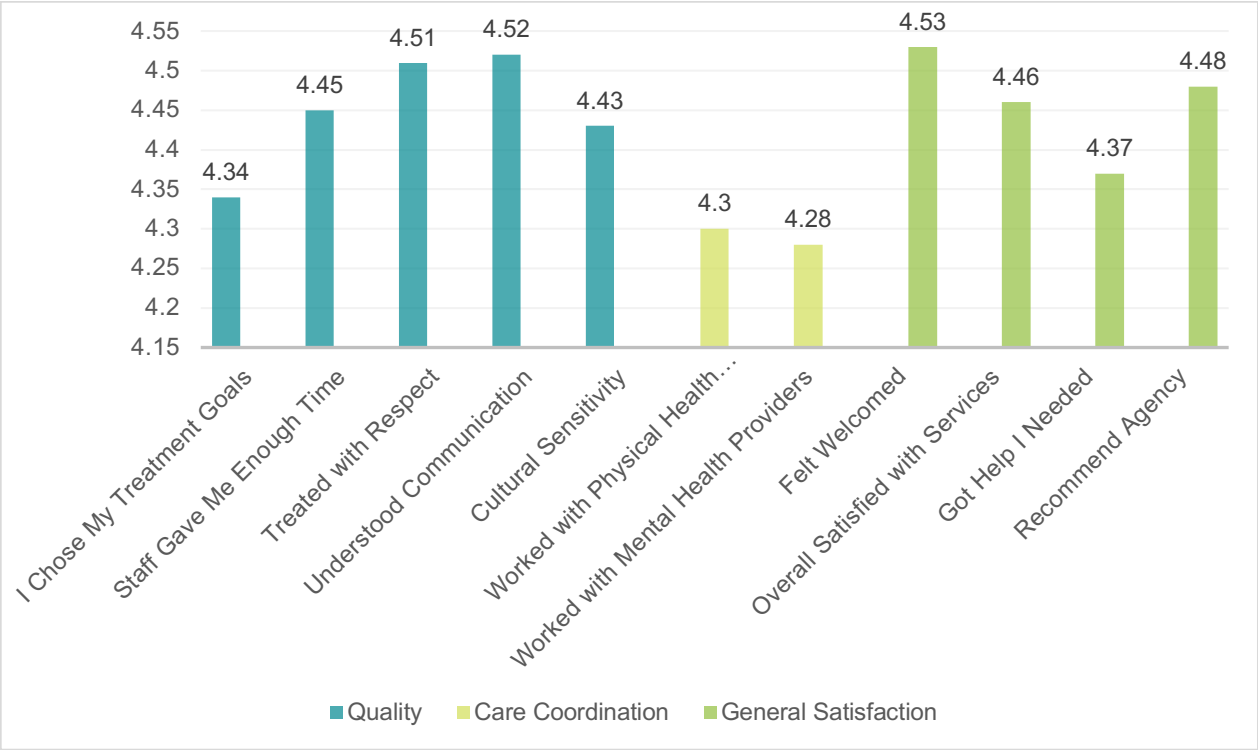
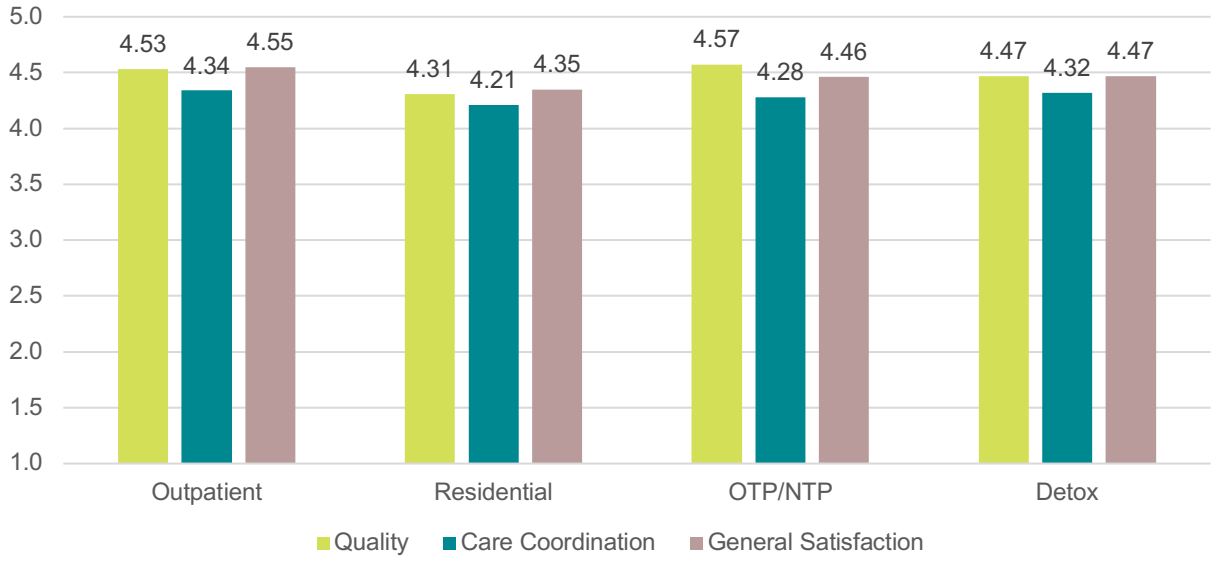


Figure 6-10 shows the average TPS ratings by domain on the same five-point scale, differentiated by type of treatment program. While still uniformly high, the ratings show somewhat more differentiation; ratings by clients in residential treatment are slightly lower than those by clients in the other 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 lengths of stay, which constituted a major historical change.

Figure 6-10: Mean Score on Perception of Care by Domain and Treatment Setting, CY 2019 (26 Counties)



In the report sent by UCLA to each DMC-ODS county, results also are displayed for each specific treatment program. 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 performance issues. One county launched a redesign of its referral and coordination processes between substance use and mental health services.

CalEQRO conducted over 40 focus groups during the 26 DMC-ODS county reviews 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 approximately eight clients. Most groups were for adult clients, and some for youth. 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.

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 emerging as recurrent themes. Many clients across all levels of care commented they had not received much initial information and guidance regarding MATs. After being in treatment for a while, they expressed the wish for more guidance and support in how to sustain their recovery from addiction over the long-term. Clients in residential

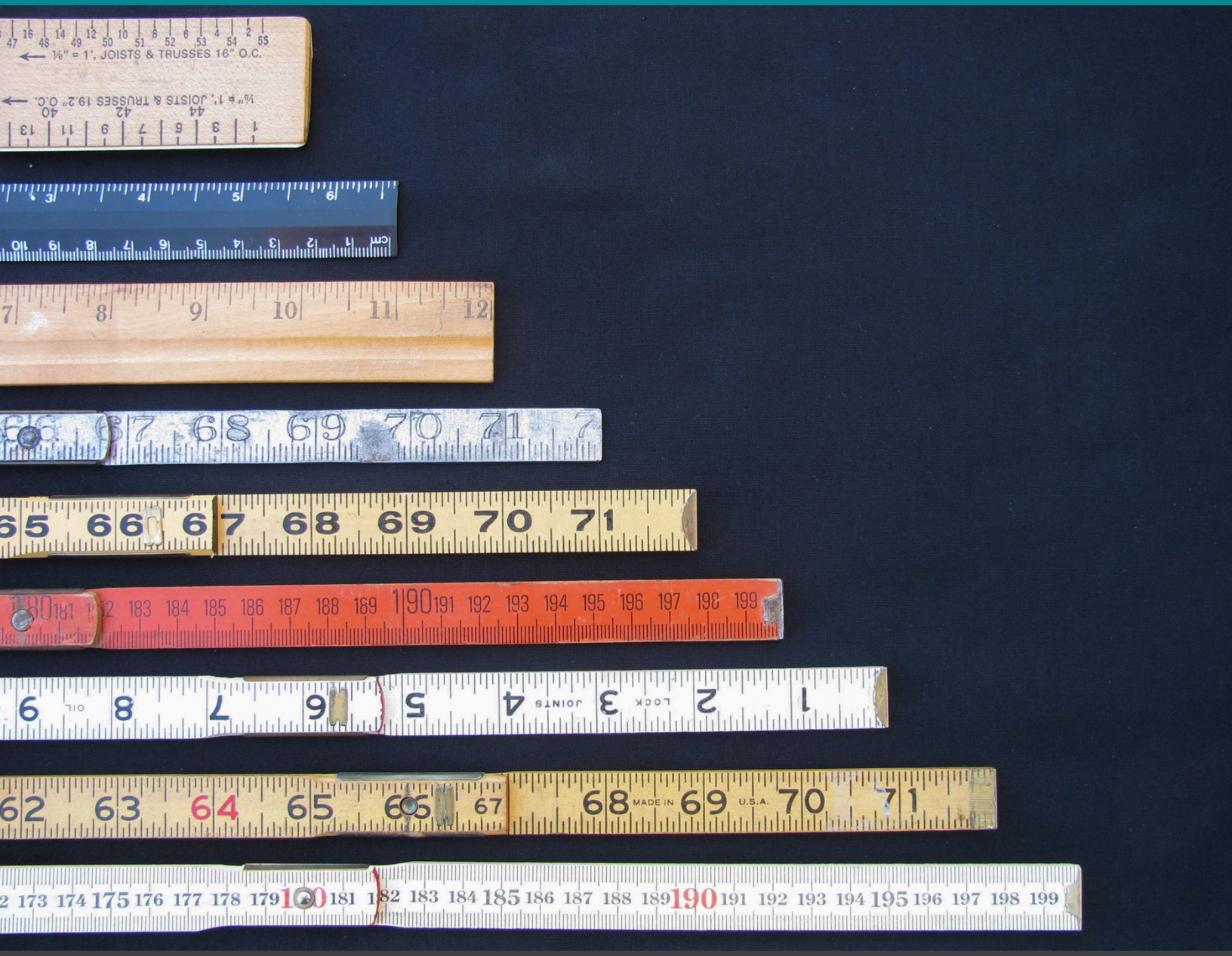
treatment suggested that some may need longer lengths of stay in that level of care than are currently being authorized. The most recurring theme in feedback was suggestions for more guidance and support in finding suitable housing and employment, particularly for those in residential treatment. Clients across all treatment modalities expressed the need for more assistance with their relationships and family supports. Many also expressed appreciation for case managers and wanted more time and help from them with community issues and re-entry into community living.

Concluding Themes and Recommendations

DMC-ODS counties have made substantial progress in expanding their continuum of care in breadth of services and 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 substantial 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, although they can expand their use of non-methadone medications. They also improved their focus on the quality of therapeutic alliances established with clients, since the results of these relationships are monitored through client feedback forms and through treatment initiation and engagement measures that are generally positive. DMC-ODS counties have adopted a philosophy of client-treatment matching based upon ASAM criteria, although many counties need to strengthen these efforts at the initial screening level with more access staff and focused training.

DMC-ODS counties have needed time to develop expertise in several new areas. They are incrementally building capacity in case management for care coordination among SUD treatment programs with each other, between those programs and physical and mental health programs, and between those programs with services in other county departments. The results of some of these efforts are measured through client feedback forms and through rates of successful stepdown transitions from residential treatment and WM.

Many managed care quality measurements require substantial infrastructure building and focus through IS development and a heightened SUD focus on QI and CCPs. Some DMC-ODS counties began these developments several years prior to implementing the Waiver and these pioneer counties are showing some of the benefits in their systems, and others began later. Comprehensive quality reform with associated infrastructure require multiyear efforts, and CalEQRO reviews provide technical assistance, direction, and encouragement for DMC-ODS counties toward continuing these QI goals and objects.



Chapter 7

Outcomes

Outcomes

How DMC-ODS Counties are Improving Outcomes for People with Substance Use Disorders

Introduction

Outcomes data provide essential information for analyzing and determining program performance and clinical benefits for those in treatment. These data answer essential questions: "What is working?" and "What is making a difference in these individuals' lives to improve their SUD conditions?" Outcomes data are generated from facts in evaluation forms that have use and meaning regarding efficacy of the services provided.

> **"We are just beginning a long-overdue journey serving this group of individuals with so many compelling needs—and treating substance use like an illness we can treat as part of the healthcare system."**

The standardized data sets from which outcomes information and reporting are derived for DMC-ODS by CalEQRO include the TPS, the Retention in SUD Care PM, and CalOMS progress in treatment. In addition, CalEQRO gathers self-reports of improvements in symptoms, life circumstances, and functioning through client focus groups and surveys. Together, these two sources of feedback form a positive picture of SUD improvement during this last year of reviews, due to new and expanded access to treatments and associated supports. Clients' views as well as data sources indicated that there are areas of DMC-ODS services and systems where opportunities for improvement and challenges still exist and should be addressed in the future. Still, without exception, the feedback from clients and community stakeholders was positive about the impact of services and the desire to continue moving forward by making improvements. As one Director of a large agency said, "We are just beginning a long-overdue journey serving this group of individuals with so many compelling needs—and treating substance use like an illness we can treat as part of the healthcare system."

Overview of Major Outcomes Findings

Finding 1: TPS Findings

All 26 of the DMC-ODS counties reviewed fulfilled the requirements related to administration of the TPS through the county and contracted SUD programs, with robust participation and a slight improvement within the Outcomes domain overall from 86.1 in 2018 to 87.1 percent in 2019 related to "being able to do things better."

The TPS results also show that clients were consistently positive about the outcome of care overall, but variance was noted within the level of care. Residential findings scored lower and outpatient program and NTPs scored higher in outcome satisfaction findings related to helping the client feel they are able to function and do things better in their lives.

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). This length of stay measure is new.

Finding 3: CalOMS Findings

Standard Discharge ratings indicated positive progress for clients in treatment, increasing in FY 2018-19 compared to FY 2017-18.

Administrative Discharge ratings indicate a positive reduction in client elopement and likely correlates with both an improved level of retention and planned exits for clients from treatment in FY 2018-19 compared to FY 2017-18.

CalOMS Satisfactory discharges are up, including among new first-year counties. While treatment completions are down, satisfactory discharges are up and unsatisfactory exits before completion are down in FY 2018-19 compared to FY 2017-18, indicating that more clients are leaving treatment having made positive treatment progress.

In year-over-year comparison data from CalOMS, the original 14 DMC-ODS pioneer counties saw improvement in standard discharges, showing progress in treatment during the second year of Waiver services as well as a reduction in unsatisfactory and administrative discharges.

Key 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." This rating is linked to the specific program and site where clients receive treatment in the DMC-ODS, so client perceptions 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 recovery services. Retention data include a count of the cumulative time that clients were involved in sequential SUD treatment and recovery services received without an interruption of more than 30 days. Defined sequentially and cumulatively in this way, length of stay in treatment has been found to be a significant predictor of positive post-treatment outcomes, such as decreases in unemployment and crime. Optimal quality and maximum benefit from recovery resources are linked to skilled utilization of treatment and support services, appropriately extending the total length of stay in some type of SUD treatment and supports.

Importantly and contrary to general thinking, the goal of measuring client retention is not to reduce utilization or save on costs, but rather to reduce the inappropriate use of important, limited resources (e.g., residential care) and to provide beneficiaries the treatment that best fits their needs. 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 level of care and moving clients toward improved outcomes 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 level of care, 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 should be considered an essential management aide in guiding effectiveness discussions and presents an opportunity to strengthen consistency.

Outcomes by Data Source, with County Examples

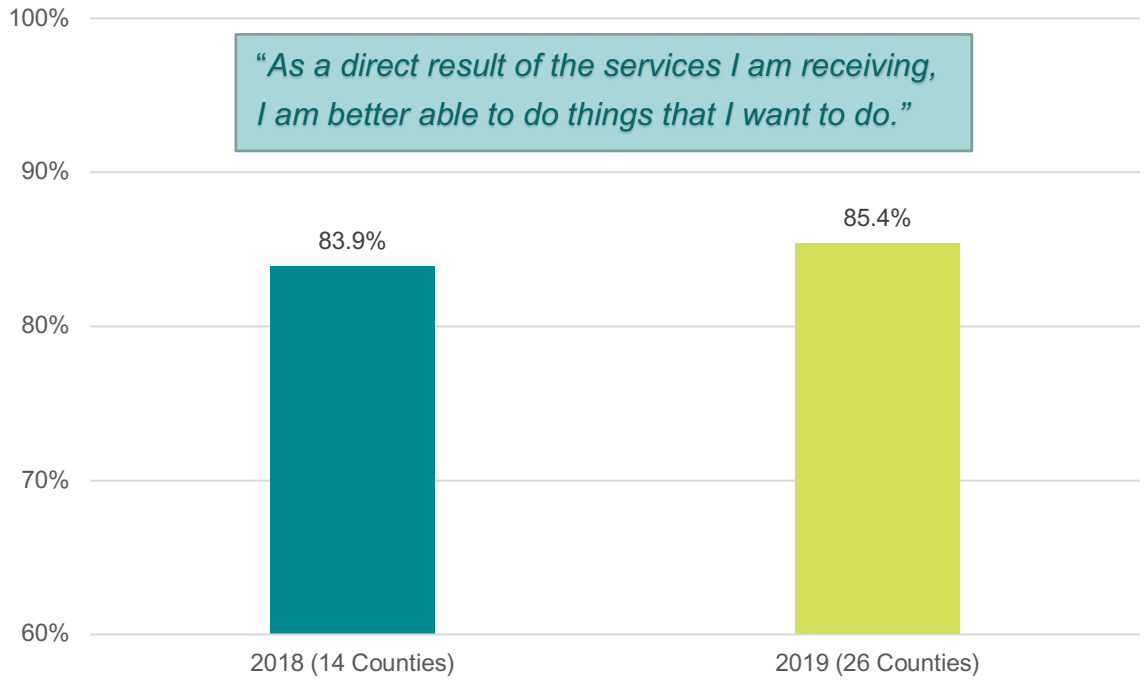
TPS Findings and Themes

All 26 of the DMC-ODS counties reviewed fulfilled their EQRO requirements related to annual administration of the TPS through the county and contracted SUD programs, noting a slight improvement within the Outcomes domain measure overall from 86.1 in 2018 to 87.1 percent in 2019. This measured whether the program was helping the individual to be able to do things better in their lives and focused on improved functioning and coping skills.

Survey completion was generally robust, supported by the persistence of county staff. In most cases, the overall number of TPS surveys administered by each DMC-ODS county increased overall. The survey results provided by UCLA showed a slight improvement for the Outcomes domain from 2018 rated at 86.1 percent to 87.1 percent in 2019.

Figure 7-1 illustrates the percentage of clients who responded in agreement rating with the Outcome domain of the TPS.

Figure 7-1: Percentage of Clients Agreeing with Outcome in TPS, CY 2018 (14 counties) and CY 2019 (26 counties)

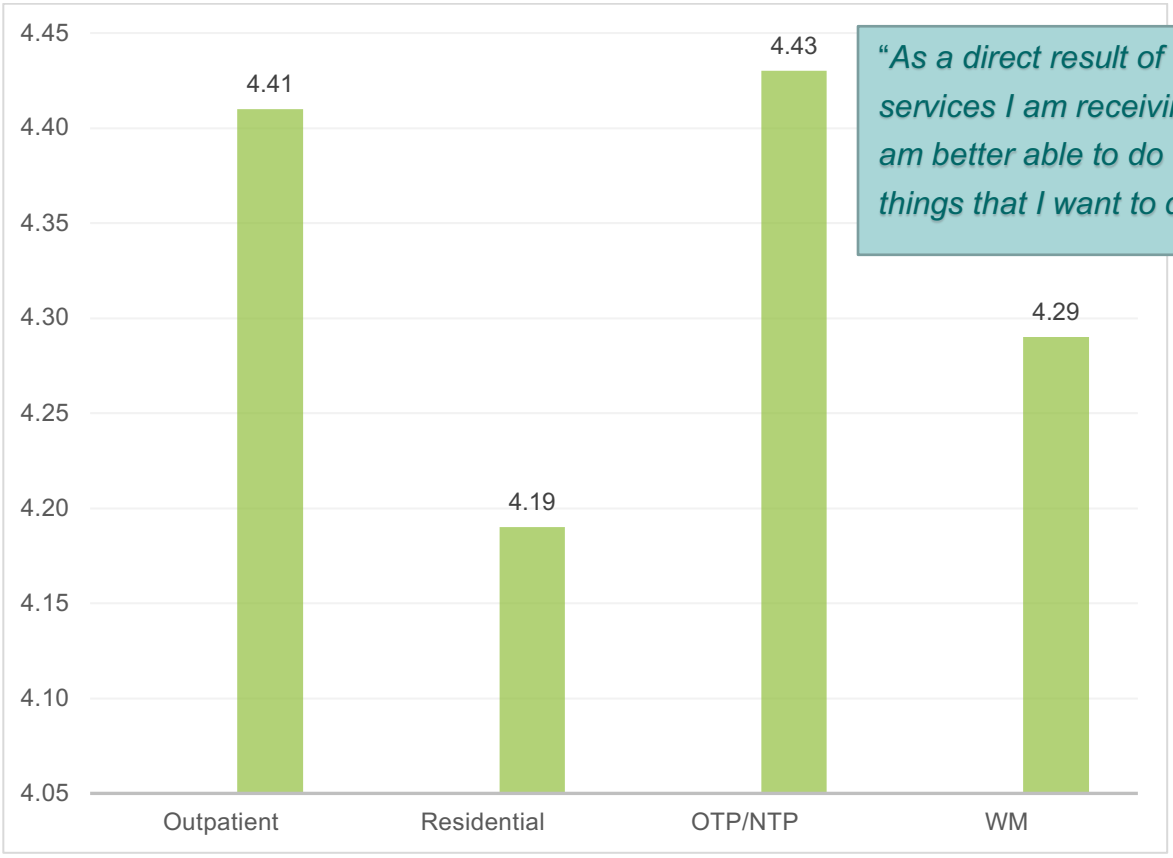


Of the 26 DMC-ODS counties reviewed by CalEQRO in FY 2019-20, 14 were in their second or third year of Waiver implementation. This meant that in the more recent review cycle, 12 additional counties were in their first year of DMC-ODS services and participating in their first EQRO review. As represented in the above table, client- reported perceptions of an improved ability to "be better able to do things" were rated at 83.9 percent in the 14 counties reviewed in 2018. This rated perception improved to 85.4 percent in 2019. The exact wording for this question in the TPS instrument is, "As a direct result of the services I am receiving, I am better able to do things that I want to do."

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 level of care, 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.

For example, shorter lengths of stay in WM (average 4 days) and residential treatment (average 42 days) may contribute to perception of less impact on ability to "do things better." In focus groups, it has also been common for clients in residential programs to raise the most concerns about a variety of treatment and lifestyle issues, including not staying long enough. There is nothing wrong with this, but the 24-hour nature of the program and the increased structure often trigger more concerns and difficulties with individual needs or desires. The outpatient and NTP programs often had longer lengths of stay in treatment and more time to engage and make substantial changes in lifestyle and health.

Best Practices for Feedback-Informed Care

Best practices in determining client outcomes are demonstrated by counties that use multiple methods of obtaining client feedback and use that information to inform services and improve treatment. TPS is one such tool. The TPS survey is required and performed by each county in compliance with that requirement, but the more forward-functioning counties gather client feedback from multiple survey sources on an ongoing basis, including the TPS and CalEQRO CFM focus groups. These counties ensure that clients are included in advisory groups, county SUD services planning groups, and are part of performance improvement projects. In addition, and most importantly, they include TPS and other client feedback, especially outcome data, in regular QI studies and use that information to guide decisions that improve the provision of treatment services.

Best practices in determining client outcomes are demonstrated by counties that use multiple methods of obtaining client feedback and use that information to inform services and improve treatment. TPS is one such tool.

Examples of best practices for feedback-informed care include:

In **San Luis Obispo County**, TPS data are sorted by site, with the expectation that each supervisor makes changes based on the rated feedback. This can be highly individualized, such as one San Luis Obispo clinic installing a water cooler in response to TPS scores and comments. When lower TPS scores (76.1 percent in FY 2018-19) were identified regarding coordination with mental health, San Luis Obispo redesigned its brief screening form and referral procedures so that both mental health and substance use screeners could refer directly to the other system for assessments. Ratings for "Work with Mental Health Providers" increased in FY 2019-20 to 78 percent. San Luis Obispo also recorded a nominal increase in beneficiaries rating they are "better able to do things," rising to 79 percent in FY 2019-20 from 77 percent in FY 2018-19.

Santa Barbara analyzed its data to understand several critical types of outcomes for quality improvement purposes. In analyzing their encounter data, they found a high rate of clients (87 percent) who engaged in services after assessment. CalEQRO analyzed Santa Barbara's CalOMS data and found that providers rated 67 percent of their clients at discharge as having made successful progress in treatment, which was substantially higher than the combined average for all DMC-ODS counties statewide. Santa Barbara noted that treatment encounter data showed a high level of engagement and retention statistics for clients as indicated by 87 percent who engaged in services and that 67 percent had a successful completion of treatment. Correlation is noted with the review of the results for TPS analyzed by the UCLA Integrated Substance Abuse Program (ISAP), in that Santa Barbara found that clients rated their treatment

as highly instrumental (89.1 percent) in helping them accomplish what they want in their lives. Staff focused on the therapeutic alliance as a core part of SUD treatment, which was identified as a key to retention in treatment.

Napa noted the TPS ratings at a contract program were particularly low on many indicators; clients added many comments and examples sharing concerns related to treatment issues and the environment. Napa Alcohol and Other Drug leadership instituted intensive weekly training and supervision to address the issues that were raised by the clients and made numerous physical plant and personnel changes to address concerns. Within the next year, they conducted another TPS just for the program to see whether the experience of the residential clients had improved, which indeed it had. This was an ideal example of use of how the TPS tool can be used to improve care in a focused and proactive way. Clients also shared in focus groups an experience of staff caring about their personal success in treatment. Several reported coming back to treatment because they knew the staff in their program did know and care about them, and they had not experienced this before.

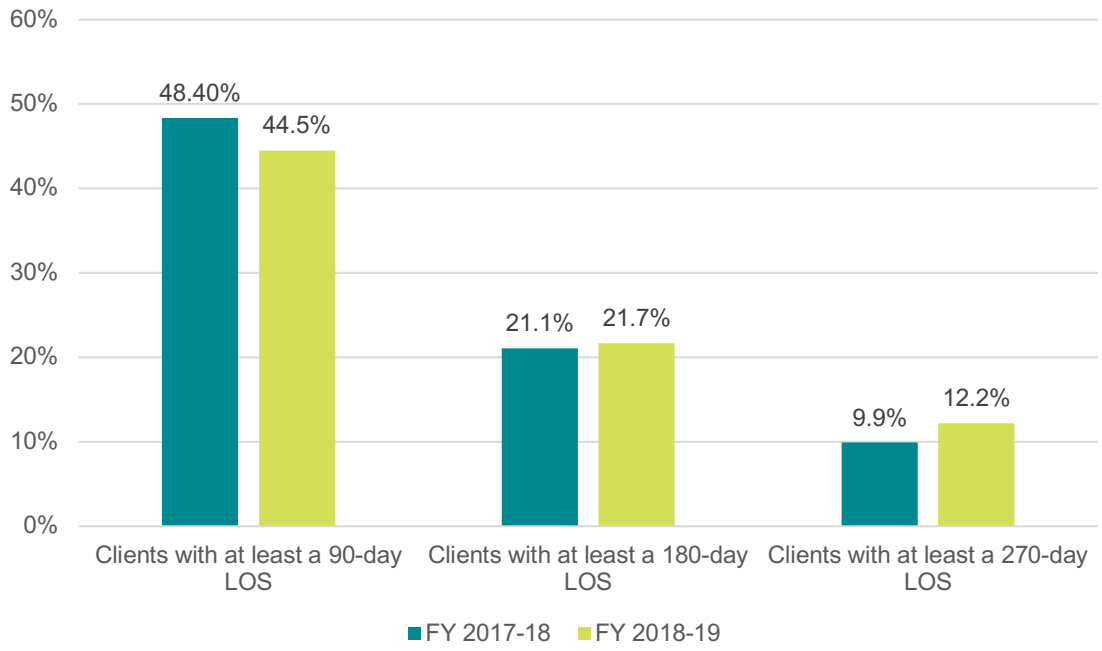
Retention in Care Performance Measure Findings and Implications

Total length of stay in treatment, or the retention in care measure, is a measure applied only for counties in their second to fifth years of the DMC-ODS. This measure tracks participation in services across the entire continuum of care; clients must have at least one billable visit per month to have their retention measure 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 levels of care, and reduction in client elopement. This is a small increase on average; as a new measure by counties, but it is promising. As systems mature and the three longer-term DMC-ODS clinical services expand to serve more clients (recovery services, recovery 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.

Figure 7-3 illustrates client length of stay for both FY 2017-18 and FY 2018-19. The length of stay indicates engagement in treatment at any DMC-ODS level of care.

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



The CMS-mandated length of stay capitations on residential treatment, which were included in all state Waivers for SUD services, are managed by most counties authorizing residential admission in 30-day increments, each requiring an ASAM assessment and utilization management clinical review. The average residential length of stay for most counties is in the 45- to 60-day range. Transitions in care, reviewed in the Quality chapter of this report, are still low, generally affecting fewer than 20 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 at least a 90-day length of stay. The slight increase in clients with at least 180- and 270-day lengths of stay may be attributed to increases most counties experienced in NPT/OTP treatment. When MAT and NTP/OTP clients engage in treatment, they generally remain for 150 days or longer.[24]

Improving retention requires proactive 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."

Marin County uses a number of data sources, including CalOMS and TPS, to measure client treatment access, engagement, retention, and discharge outcomes. With a specific focus on improving retention in the SUD system of care, Marin uses Care Coordinators with lived experience in recovery to act as recovery

[24]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.

coaches and assist clients with linkages and transitions in care. These Care Coordinators assist with scheduling assessments, transportation to and from appointments, case management between levels of care and can also provide recovery support. Their effectiveness is reflected in the mean (average) length of stay for Marin clients of 176 days (median 108 days). This is significantly higher that the statewide mean of 128 days (median 84 days): 55 percent of clients had at least a 90-day length of stay; 38 percent had at least a 180-day stay, and 25 percent had at least a 270-day length of stay.

Research indicates these longer lengths of stay produce more positive treatment outcome perspectives, including sustained abstinence and improved functioning in health and self-sustainability domains.[25] Marin's data analysis also showed that clients with serious mental illness (SMI) and SUD were not satisfied with the SUD treatment programs and, as reflected in CalOMS, were not being retained in any meaningful length of treatment. Marin developed a PIP implementing client-centered and feedback-informed treatment approaches to improve client satisfaction, engagement, and retention in treatment. The impact on clients as a result of this PIP included increase in satisfaction in TPS ratings and focus group reports; increased retention in treatment (with a mean length of stay from 89 to 158 days); and increase in positive (successful) CalOMS treatment from 15.2 percent to 40 percent.

Examples of successful care coordination include:

- Using a variety of engagement and retention data references, **Santa Barbara** reports high engagement and retention statistics for clients, with 87 percent engaged in services and 67 percent reporting a successful completion of treatment. Similarly, TPS results show that clients rated their treatment as highly instrumental in helping them accomplish what they want in their lives.
- Several DMC-ODS counties have used strategies as intervention points to positively impact both engagement and client retention patterns. For example, **San Luis Obispo** initiated a clinical PIP designed to improve client retention in outpatient services. The PIP provides for increased individual counseling following a relapse or positive drug test result and also is designed to reduce the number of discharges that result from an undisclosed relapse.
- **Los Angeles** Substance Abuse Prevention and Control (SAPC) has worked to improve client retention by addressing engagement and client needs from the time of contact with its system through its Client Engagement and Navigation Services (CENS) and Recovery Bridge Housing. CENS is an outreach and coordination project in place at approved sites throughout the region, allowing Los Angeles SAPC to help individuals with motivation for treatment. CENS assists clients using engagement and a warm handoff to treatment when indicated. Designated CENS staff work well with other community programs, health system workers, housing, criminal justice, and various agencies' outreach staff, such as Whole Person Care, to engage and link clients to

[25]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).

treatment. Staff believe that their approach of addressing core needs beyond just those presenting with a SUD disorder, along with engagement and persuasion strategies, will improve retention and eventually clinical outcomes as reflected in CalOMS. CENS staff function as “super case managers” as well as outreach staff within the SAPC system.

CalOMS Findings and Themes

Standard discharge ratings indicating positive progress for clients in treatment has increased in FY 2018-19 compared to FY 2017-18.

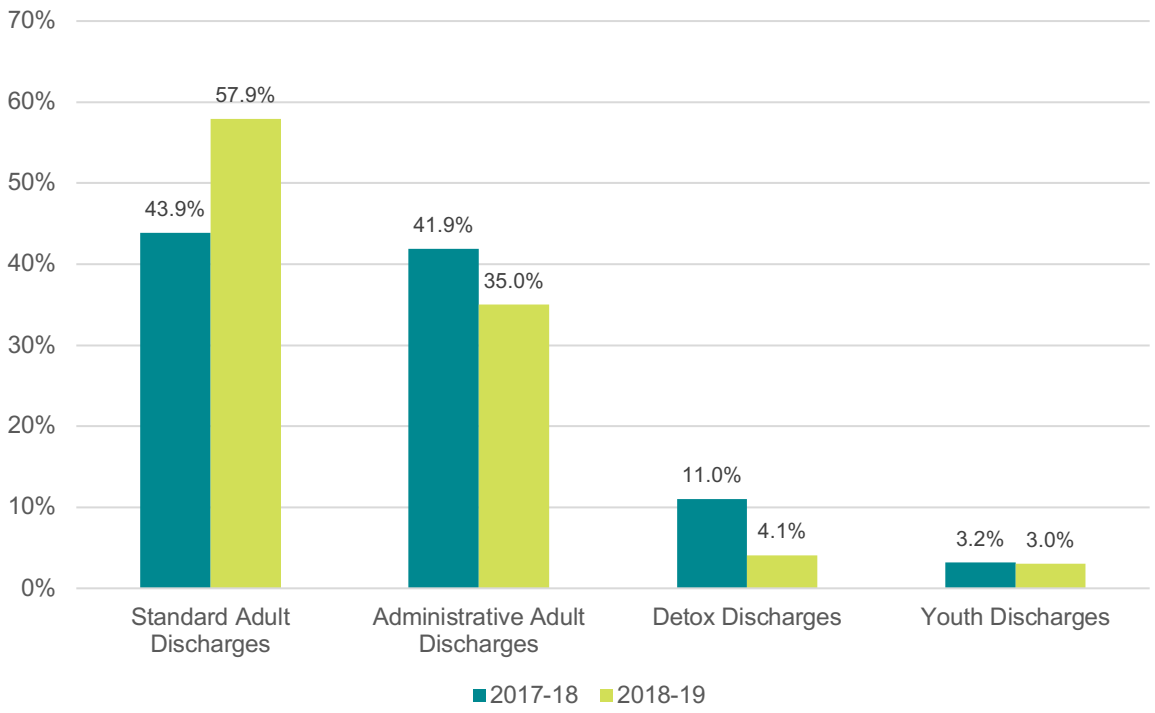
2018-19 Standard Adult Discharges increased to 57.9% from 43.9% in 2017-18; in the same period, Administrative Discharges (left with no notice) decreased from 41.9% to 35%

Data are collected from the rating options in the CalOMS discharge summary form, which allows counselors to evaluate their clients’ progress in treatment. The data below indicate the DMC-ODS system has seen a significant improvement in clinical outcomes, year over year. While evaluations in the past have focused solely on completions, this no doubt has some inherent limitations. By using the four positive ratings found in the discharge form, standard discharges include completions where a client met all their treatment goals as well as those clients who leave for any number of reasons with satisfactory progress.

While there are variations from county to county, it is worth noting that in FY 2018-19, nine of the counties had CalOMS ratings that exceeded the statewide average for standard discharge. In seven of these counties, the positive difference exceeded ten percentage points. This improved positive discharge rating was most evident in Santa Barbara, with 63.9 percent, and Alameda at 74.0 percent, compared to 49.6 percent statewide among other DMC-ODS counties.

In the past review year, some of the counties that are not realizing 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.

Figure 7-4: Standard Discharge Progress in Treatment from FY 2017-18 to FY 2018-19 in DMC-ODS Counties



CalOMS Overall Major Outcomes Finding

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.

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.[26]

[26]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

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. Therefore, the current trend of reducing these administrative exits is both clinically beneficial to the individual client and also provides a more robust data set by which CalOMS can be used to measure outcomes and program performance.

Efforts to maintain strong engagement with clients produce better outcomes and more robust CalOMS data . . . then the system must have the resources to review and analyze the data.

Selected ratings from the CalOMS discharge summary shown in aggregate reflect treatment effectiveness. In addition to strategies used by providers to improve client retention and discharge planning, CalEQRO notes that in several counties, greater attention to data management is prioritized as well. Across all counties, there is a desire to use CalOMS outcomes to measure program efficacy, but this has been limited due to both internal and external factors. Internally, there may be a lack of dedicated analytical resources and no current way to extract or mine data from EHRs. Externally, while there may be a history of pulling and using CalOMS data from the state by way of the Information Technology Web Service (ITWS) access portal, this source has not been accessible since the state moved these data under the Behavioral Health Information System. DHCS has expressed its intent to re-establish this access, but it has not happened yet. In the meantime, many counties feel unable to perform the analyses they need.

Exceptional work has been done by individual DMC-ODS counties to manage CalOMS data locally. Following a Year One recommendation, concerted effort was reflected in the CalEQRO report on Contra Costa where "the county was working on improving accuracy of CalOMS data" with a goal to "more extensively" use the data to measure outcomes. It was noted that Contra Costa's attention to improved accuracy at discharge resulted in an administrative discharge rate "significantly below the statewide average" and "signifies a likelihood of greater reliability" with data from CalOMS.

Santa Barbara also experienced a high level of standard discharges and a lower than statewide percentage of administrative discharges. According to the CalEQRO report, this first year DMC-ODS county took specific and meaningful steps to clear up unreconciled, fragmented, and rejected CalOMS data to such an extent that "they now have confidence in the accuracy and reliability of the data for use in measuring outcomes."

While implementation and management of the CalOMS data set vary depending on local priorities and analytical and IS support, the value of having more complete data is universally recognized. An ability to secure more immediate impressions of current state data from the reports once available from

Health and Human Services Agency. UCLA, ISAP April 2007. Available from: http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf

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.

CalOMS Major Outcomes Finding: Progress in Treatment

Standard discharge ratings indicate positive progress for clients in treatment has increased in FY 2018-19 compared to FY 2017-18.

CalOMS admission data provide useful information for DMC-ODS counties about their clients' special needs. Admission data also provide a foundation for establishing a baseline when measured against the discharge summaries completed at the end of a distinct treatment episode. The reviews showed that CalOMS are the only statewide data universally collected by all counties.

The CalOMS discharge data forms denote either satisfactory progress or lack of satisfactory progress by clients. Clients who leave the program without prior notification and without an exit interview limit any designation of their progress in treatment, regardless of their length of stay. These limitations on gauging both client and program effectiveness highlight the importance of engagement, retention, and discharge planning to secure more formal and routine exits from treatment. Leaving without warning are labeled "administrative discharges" and compromise the ability to understand the program's effectiveness.

The CalOMS outcomes data noted on the discharge data forms and aggregated by county, state, and provider can assist both programs and administration in determining the efficacy and impact associated with treatment across a system or within a specific clinic.

Data are collected from the rating options in the CalOMS discharge summary form. This form allows counselors to evaluate their clients' progress in treatment. The data below indicate the DMC-ODS system has seen a significant improvement in clinical outcomes, year over year. While evaluations in the past have focused solely on successful program completions, this approach has some inherent limitations. By using the four positive ratings found in the discharge form, standard discharges include completions where a client met all their treatment goals as well as those clients who leave (for any number of reasons) with satisfactory progress.

While there are variations from county to county, it is worth noting that in FY 2018-19, nine of the DMC-ODS counties had CalOMS ratings that exceeded the statewide average for standard discharge. In seven of these counties, the positive difference exceeded 10 percentage points. This improved positive discharge rating was most evident in Santa Barbara with 63.9 percent and Alameda at 74.0 percent compared to 49.6 percent statewide amongst other DMC-ODS counties. Some of the counties who are not realizing the outcomes they desire have in the past review year, designed, and implemented PIPs to increase client engagement and retention anticipating measured improvement in the CalOMS discharge ratings.

CalOMS Outcomes Findings: Satisfactory Discharges from Care

Satisfactory discharges from care have increased, including new first-year DMC-ODS counties.

While treatment completions have decreased, satisfactory discharges have increased and unsatisfactory exits before completion have decreased in FY 2018-19, compared to FY 2017-18. These trends indicate that more clients are leaving treatment having made positive progress.

While the discharge status ratings found in Table 7-1 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. More clients are now leaving programs with satisfactory progress even as completions are somewhat lower in the last review cycle. Although program completions were once the standard by which outcomes were measured, the improved percentage of clients leaving prior to completion with satisfactory progress is likely an indicator that they are transitioning to another level of care and staying in treatment longer. Similarly, the reduced percentage of unsatisfactory discharges may well be another indicator of improved treatment performance.

A noteworthy distinction between the two FYs represented in Table 7-1 is that FY 2018-19 includes the addition of 12 first-year DMC-ODS counties. Counties in their first year of services have near-universal program and data challenges that are consistent with implementation and likely account for declines in standard discharges.

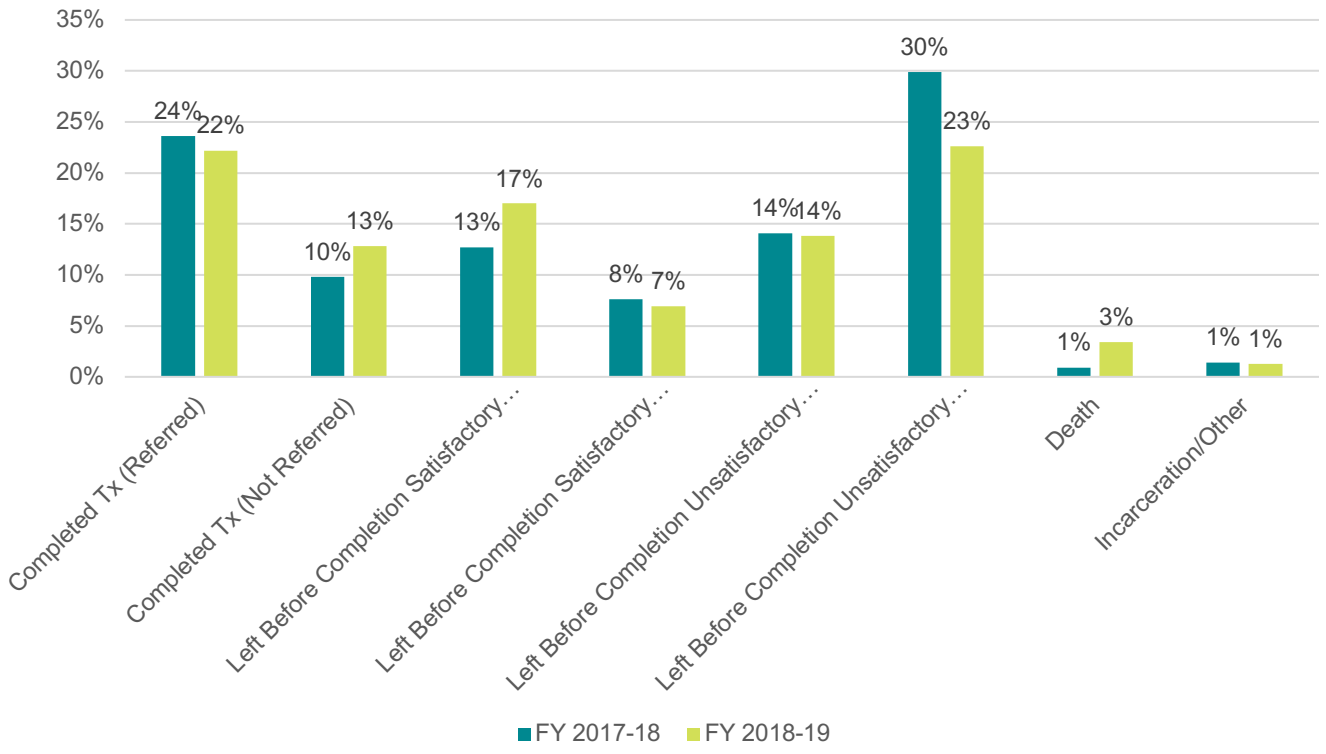
Table 7-1: CalOMS Discharge Status Ratings, Year-to-Year Comparison

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

Pioneer County CalOMS Experience with Discharge Outcomes Findings

In year-over-year comparison data from CalOMS, the original 14 DMC-ODS counties saw improvement in standard discharges during the second year of the Waiver as well as a reduction in unsatisfactory and administrative discharges, as shown in Figure 7-5.

Figure 7-5: Comparative Discharge Status, 14 Original DMC-ODS Counties, FY 2017-18 and FY 2018-19



In the aggregate, it is apparent that DMC-ODS counties in their second (or third) 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, 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 level of care transition planning, it is likely these second-year counties also have taken steps to improve data collection, submissions, service capacity, client-centered ASAM skills, and overall integrity.

Experience counts.
Counties with 2 to 3 years DMC-ODS experience showed the most improvement in increasing satisfactory treatment progress in outcomes.

Based on CalEQRO reporting, results from these efforts do vary widely between the different DMC-ODS counties. Some have taken major steps to improve data, train staff, and use quality resources to coach or oversee CalOMS adherence. Other counties have taken steps to improve the visibility of CalOMS performance data for their program providers, along with re-setting expectations. Los Angeles, for example, reinforces its CalOMS training with a focus on interrater reliability and data dashboards to both monitor and drive outcome improvement efforts. 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.

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.

CalOMS Barriers and Challenges

As noted above, the 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. Additional state reports for county users that were historically available and are not currently available on the new platform should be restored as soon as feasible.

Summary of Outcome Strengths, Opportunities, and Recommendations

Strengths: What is Working?

CalOMS

DMC-ODS counties continue to engage treatment providers and clinical staff with training about the documentation necessary to meet Waiver standards. Most also have placed renewed emphasis on securing accurate and timely CalOMS submissions to enhance tracking quality and outcomes. Counties that have been able more consistently use and administer the data set are able to use performance and outcome data from CalOMS to identify issues or support systems change. Consistent use of the CalOMS data also has been achieved through work groups and collaboration between Quality Management teams and clinicians. This combination of training and focused attention also has been beneficial when combined with dedicated analytic and IS support.

Efforts by DMC-ODS counties indicate that there is no single solution to improved outcomes. Instead, multiple fronts must be addressed to benefit clients across treatment episodes and improve the standard discharge rates.

In addition to the proper administration, collection, and submission of CalOMS data, DMC-ODS counties have focused on various clinical aspects that have led to an increase in standard discharges and corresponding reduction in administrative discharges. This include engagement and retention strategies, often formalized through the use of PIPs. Strategies may include the use of motivational interviewing, system navigators, enhanced communication with clients and receiving programs through the intake process; case managers, specialized teams, or units to work with clients as they engage treatment services; and improved discharge planning. In addition to improving client retention, this has likely allowed some DMC-ODS counties to address summary discharges, known to be associated with higher rates of relapse and readmission. Efforts by DMC-ODS counties indicate that there is no single solution to improved outcomes. Instead, multiple fronts must be addressed to benefit clients across treatment episodes and improve the standard discharge rates.

In the few DMC-ODS counties that have functional data and IS, visibility of CalOMS data enhances their capacity to make service adjustments. 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 DMC-ODS 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 are a useful indicator for which programs are doing well, in which domains, and which programs need assistance. For example, San Francisco posts TPS survey results on the Behavioral Health Services web page, providing the overall ratings as well as an option to sort by youth/adult, gender, and ethnicity. All results also are sorted and posted by the provider program. San Francisco also provides all TPS comments to each appropriate provider, with an expectation that this information will be used to inform programs regarding where and how they are doing well and where they need to apply QI measures.

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 allows for actions to be taken to improve services in a meaningful way and to engage providers while issues and feedback are fresh.

Retention

Even though the capacity for internal analysis of the various factors from intake to discharge varies widely across the DMC-ODS counties, there is general commitment to increasing client engagement, prompt access to care, and providing the necessary supports to adjunct services to meet clients “where they are,” including using harm reduction. These, in turn, can lead to a significant difference in those clients who see the added value of treatment and those that elect to self-discharge.

Clinical improvement strategies that focus on providing system engagement, navigation, and linkage are consistently being reviewed and are the focus of improvement efforts. In most of the DMC-ODS counties, these efforts start with the county-operated services and those linked to urgent care needs. Monitoring access and capacity necessitates efficient use of engagement, assessment, and linkage efforts. These efforts are supported by the research literature, which clearly indicates that clients who persist in treatment are much more likely to experience favorable outcomes.

The data provided to CalEQRO indicates that the percentage of clients with lengths of stay longer than 90 days has increased over the last two years. 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 recovery supports available to clients (including those that target high-risk population such as the homeless and those with co-occurring conditions) may be benefitting from some decrease in elopement as seen in an improved length of stay. Expanded MAT utilization also seems to correlate with those clients who are having longer lengths of stay and engagement across multiple levels of care.

Summary and Recommendations for Improving Treatments

CalOMS

Prioritize and standardize CalOMS staff training.

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.

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

While CalOMS outcome reports are not consistently used to guide system improvements, DMC-ODS counties are generally interested in improving the awareness and utility of this data set to improve it and link it more closely to ASAM levels of care. The CalOMS data can be of use to counties whose QIPs currently lack measurable goals and whose initiatives are clinical in nature. Local analytic resources are either shared or at low levels, so additional supports would be needed should reports become more available to the DMC-ODS. IS infrastructure and analytic staff support at the state and county levels needs to be enhanced to accomplish this, based on observations of current resource levels.

Data reporting capability of CalOMS by the state to counties should be prioritized.

When DHCS moved CalOMS from ITWS to its current 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 from ITWS. 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.

TPS

Boost response rate among treatment subpopulations and all program levels to accurately represent DMC-ODS beneficiaries to enhance benefit of TPS findings.

While the TPS surveys are administered annually and completed and analyzed as required, wide variability in the patterns of response continues. Some DMC-ODS counties show a large percentage of TPS response in specific levels of care and not others. Programs with a high 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 to 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 length of stay 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.

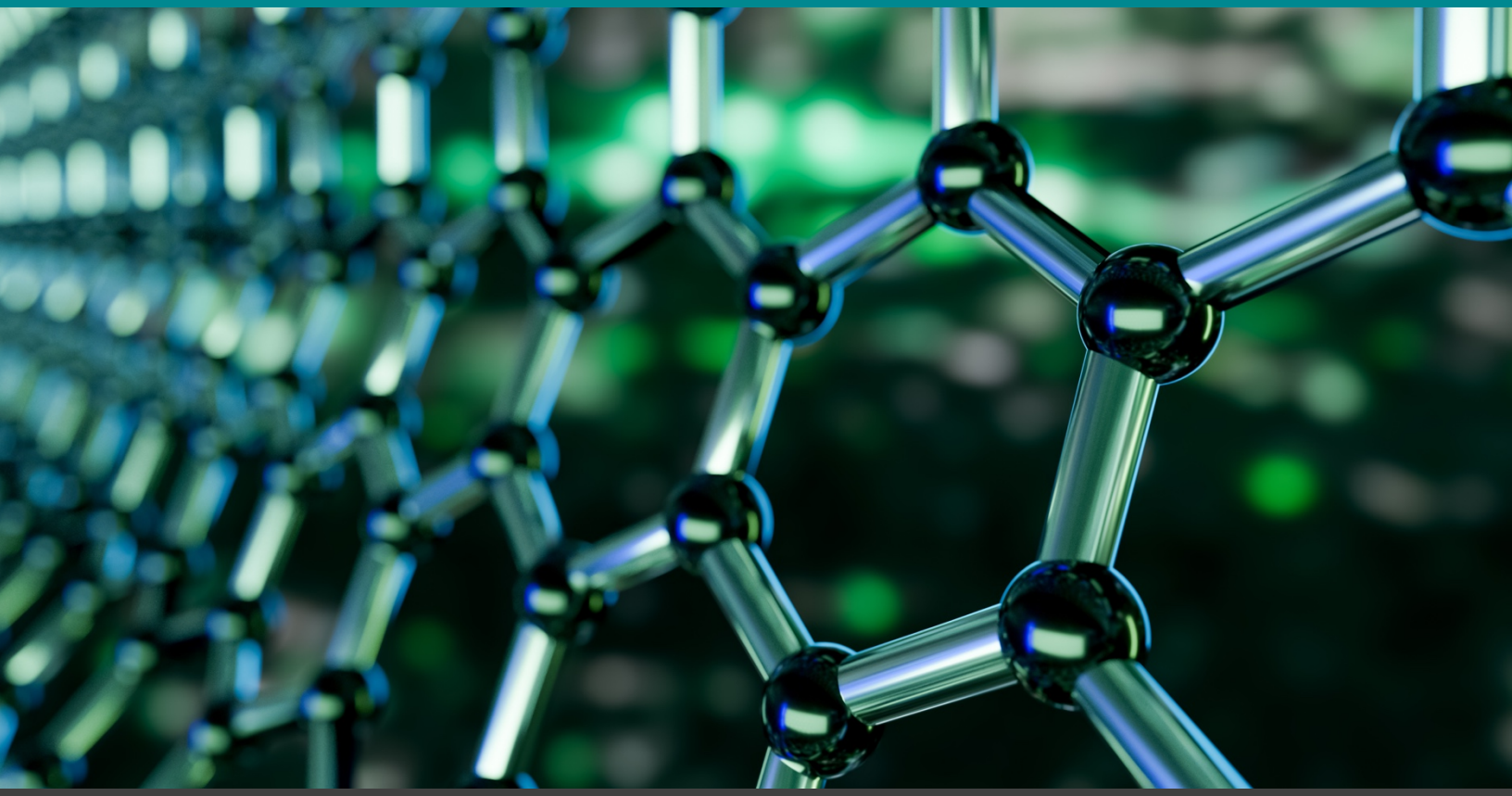
Address lingering caps on treatment lengths of stay to focus on individual treatment needs

Most clients receiving care continue to stay for the traditional 90 days. 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 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. Of note, CalEQRO found that clients and programs were concerned about extended lengths of stay in residential treatment due to the cap on the number of admissions allowed in the course of 12 months for any individual client. In other words, the preponderance of a 90-day length of stay reflected in the data may also be artificially inflated due to the limits set on residential treatment episodes. Nonetheless, for treatment to be individualized, letting go of fixed lengths of stay 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 have 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.

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



Chapter 8

Structure, Operations, & Information Systems

Structure, Operations, and Information Systems

How structure, operations, and informations systems affect quality in DMC-ODS plans

Introduction

Health Information Systems (HIS) play an important 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 substance use systems, particularly in operations and the ability to manage quality of care and efficient operations. The HIS has 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.

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

- HIS infrastructure
- EHRs
- Telehealth services (particularly post-COVID-19)
- 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.

Overview of Major Structure, Operations, and Information Systems Findings

Finding 1 In FY 2019-20, CalEQRO observed progress as counties expanded their continuum of new or existing services to meet local needs associated with the 1115 Waiver. Counties were serving more clients and adding critical capacity, but with some challenges, particularly in **billing and infrastructure operations**, which were exacerbated by the COVID-19 crisis impacts.

Finding 2 The statewide average **DMC-ODS budget devoted to information systems was 2.4 percent**—lower than the 3 to 6 percent industry benchmark for healthcare.

Finding 3 A critical challenge to be addressed is **interoperability** among different EHR systems in county departments, hospitals, primary care, and contract providers. With many beneficiaries receiving non-methadone medications from primary care and linked to EDs that are critical for overdose prevention and referrals, coordination of care has become even more important for the healthcare system. It is paramount that county HIS have capacity to securely communicate across departments and with contract providers, while respecting provisions of 42 CFR Part Two.

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, and these could also be reconsidered.

Finding 6 Billing systems for 3.7/4.0 services to support **residential hospitalization and hospital WM** remains a work in progress for DMC-ODS programs.

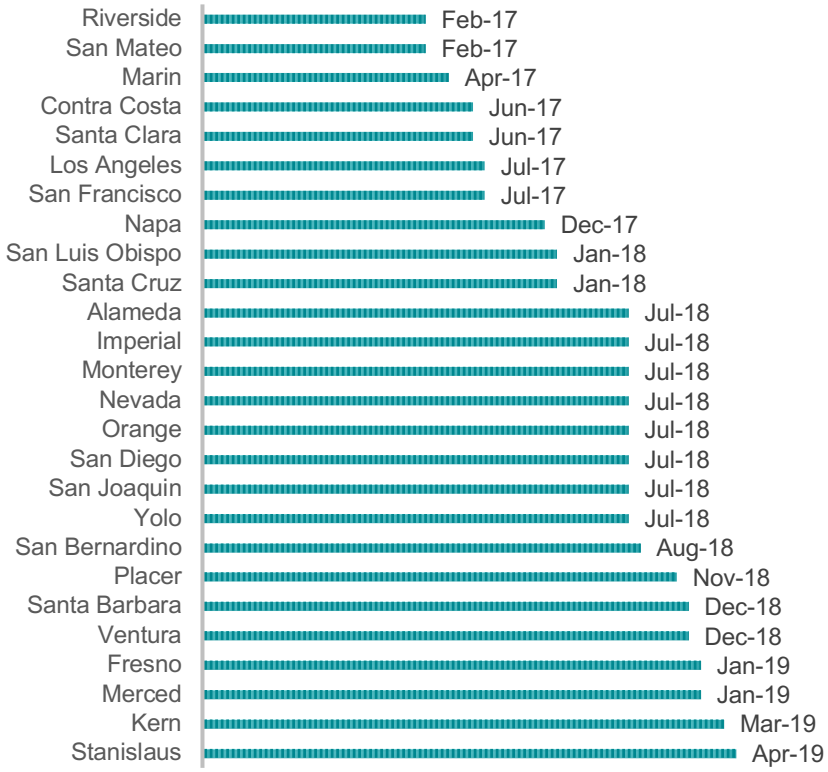
How Structure and Operations Affect Quality

The Structure and Operations chapter includes many key elements of support linked to foundational elements needed for 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/information systems, Finance, Operations, and QI subject matter expert staff. Responses are returned to CalEQRO before the DMC-ODS onsite review. DHCS data sources also are used to assess information systems and include: Short-Doyle/Medi-Cal (SDMC) for DMC-ODS, the MMEF, ASAM level of care referral data, TPS data, CalOMS and the Master Provider File (MPF).

This annual report focuses on ISCA results for the 26 counties that implemented DMC-ODS between July 2019 and June 2020. Their go-live dates are 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 over the next 18 months. Below is the chart indicating their start of service delivery.

Figure 81: DMC-ODS Services Go-Live Dates, February 2017 – April 2019

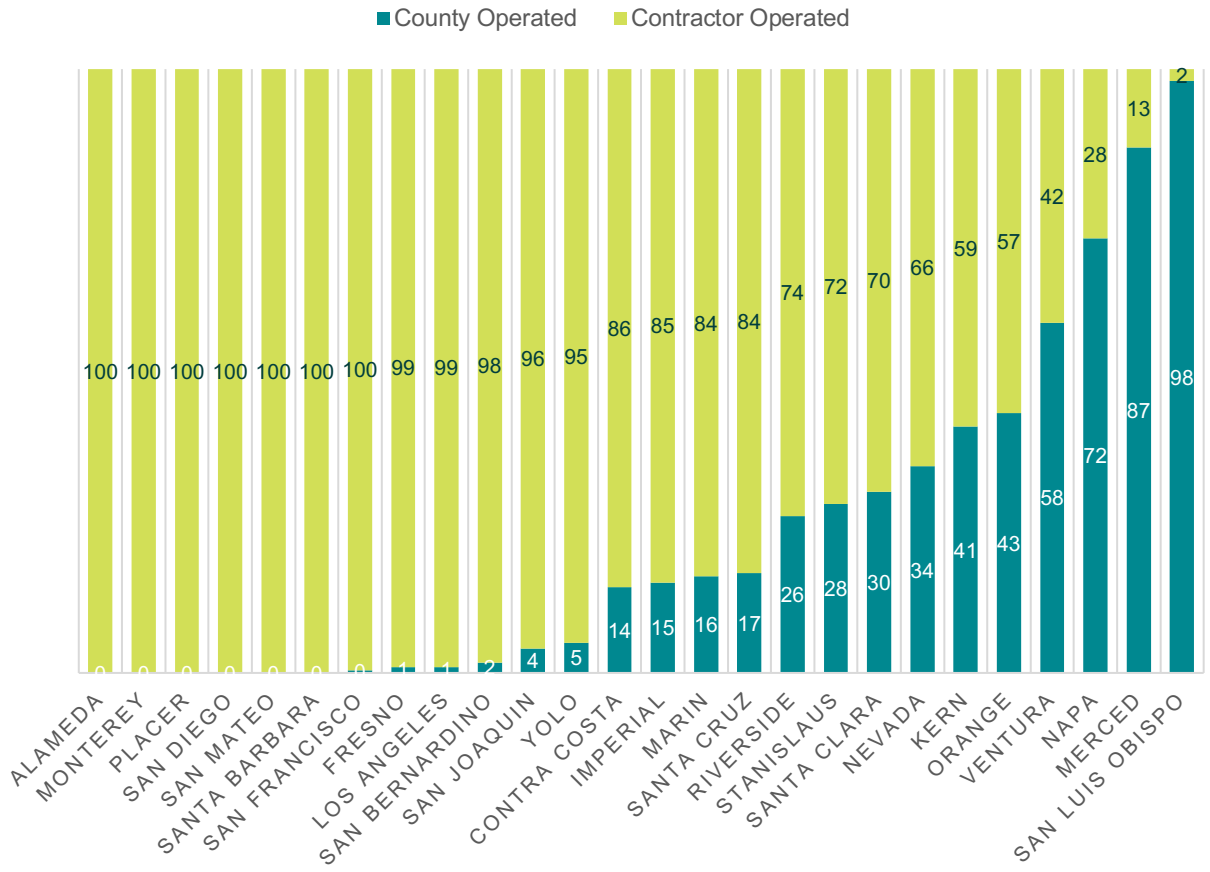


There is a large variance in how SUD services are delivered in DMC-ODS counties, ranging from 100 percent contractor-operated in the counties of Alameda, Monterey, Placer, San Diego, San Mateo, Santa Barbara, and San Francisco to 98 percent county-operated in San Luis Obispo. The results were based on a single point-in-time estimate prior to the CalEQRO onsite 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 community needs, but also face challenges in terms of needing more extensive integration of data systems, information sharing, and communication. These challenges can be overcome with strong positive leadership, teamwork, and interoperability. Figure 8-2 summarizes county-operated versus contractor-operated DMC-ODS services.

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



Many factors play a role in how counties deliver DMC-ODS services: geography, system of care infrastructure, workforce availability, resources, and implementation approach. It will take time for ODS to develop fully in each county and Figure 8-2 may look very different in a few years. Several counties that are fully contracted are now considering doing some direct services, particularly case management, and vice versa.

The number and size of the organizations in the provider network also can play a major role in the needs of the HIS 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 software systems to provide both practice management and EHR functions that can be different from each other and different from the central county DMC-ODS. It is also not uncommon to see paper charts in SUD programs, both within county and contract agencies.

Health Information Systems by Vendor

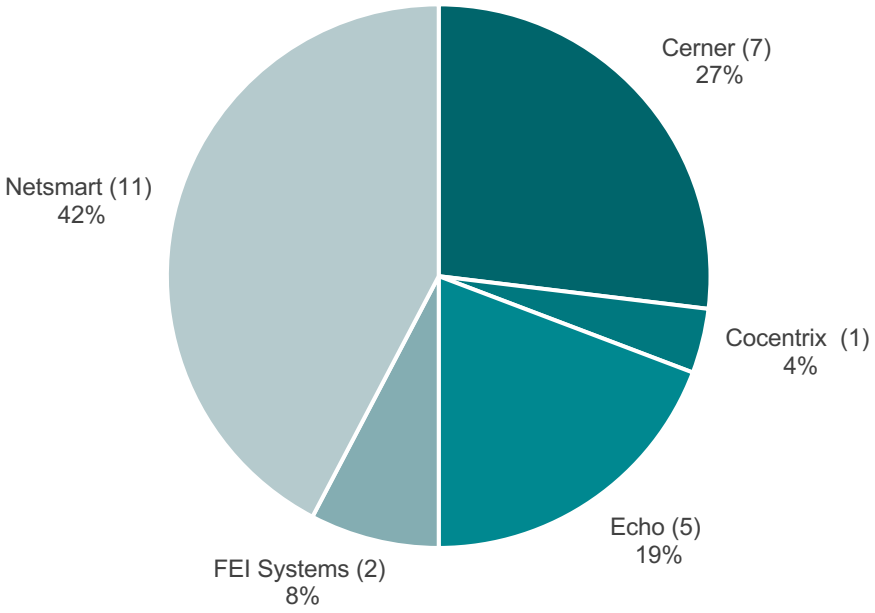
California counties have primarily relied on five technology vendors to support HIS in behavioral health: Cerner Corporation, Harris Healthcare Group (Cocentrix), The Echo Group, Netsmart Technologies, and FEI Systems. This narrow range of vendors is a consequence of California's unique Medicaid claims processing business rules. The vendor systems have core functionality for SUD billing and state-mandated reporting requirements.

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.

Eleven counties use Netsmart myAvatar: Fresno, Imperial, Los Angeles, Monterey, Placer, Riverside, San Francisco, San Mateo, Santa Cruz, Ventura, and Yolo. Six counties use Cerner Community Behavioral Health: Kern, Merced, Napa, Nevada, San Luis Obispo, and Stanislaus.; Orange County uses Cerner's Millennium system. Five counties use Echo InSyst/ShareCare for practice management: Alameda, Contra Costa, San Bernardino, San Joaquin, and Santa Barbara. Two counties—Marin and San Diego—use the FEI Systems/WITS. Santa Clara County's EHR is Cocentrix Pro-Filer. Currently, Santa Clara County is implementing Netsmart myAvatar to replace Pro-Filer.

Figure 8-3 summarizes DMC-ODS county system vendors.

Figure 8-3: DMC-ODS County System Vendors



Electronic Health Record Support

Hosting systems at an Application Service Provider (ASP) reduces the need for local information technology (IT) staff to provide 24/7 operational support. ASP 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' 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 ASP hosting, the cost-benefit ratio generally makes for a compelling case.

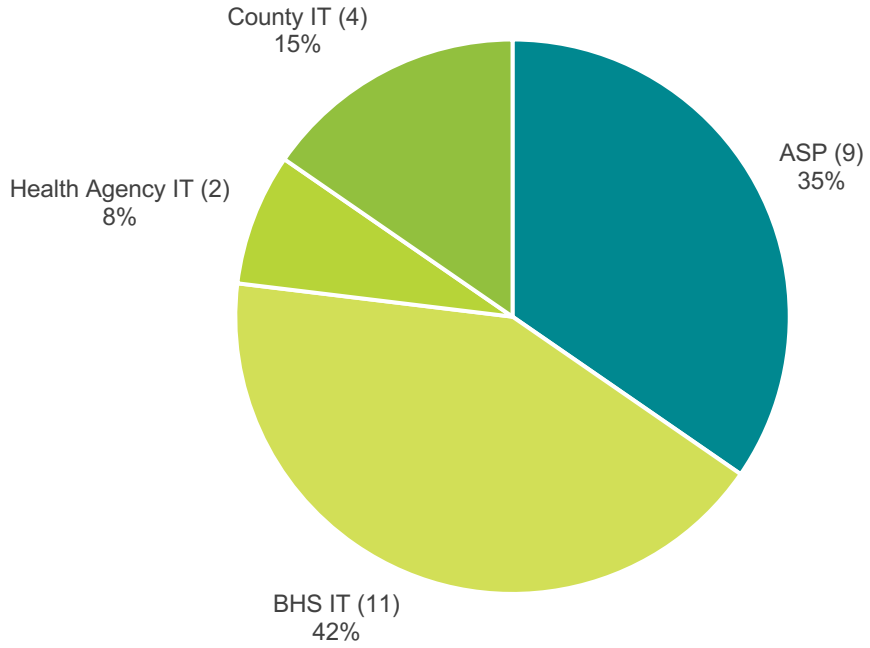
Nine DMC-ODS counties have core systems supported by ASPs, 2 counties have their systems supported by health agency IT staff, 4 counties have support from county IT and 11 counties have support from behavioral health IT.

ASP-supported counties vary in size and include Fresno, Los Angeles, Marin, Monterey, Napa, Nevada, San Diego, Santa Cruz, and Ventura 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 as well).

Figure 8-4 summarizes current county EHR support status.

Figure 8-4: DMC-ODS County EHR Support



Electronic Health Record Replacement or Creation Efforts

Napa, Nevada, and Orange are implementing Cerner Millennium, while San Bernardino and Santa Clara are implementing Netsmart myAvatar.

Kern and Stanislaus are considering new systems.

Imperial, Los Angeles, Marin, Monterey, Placer, Riverside, San Diego, San Luis Obispo, Santa Cruz, Ventura, and Yolo have no plans to change their information systems.

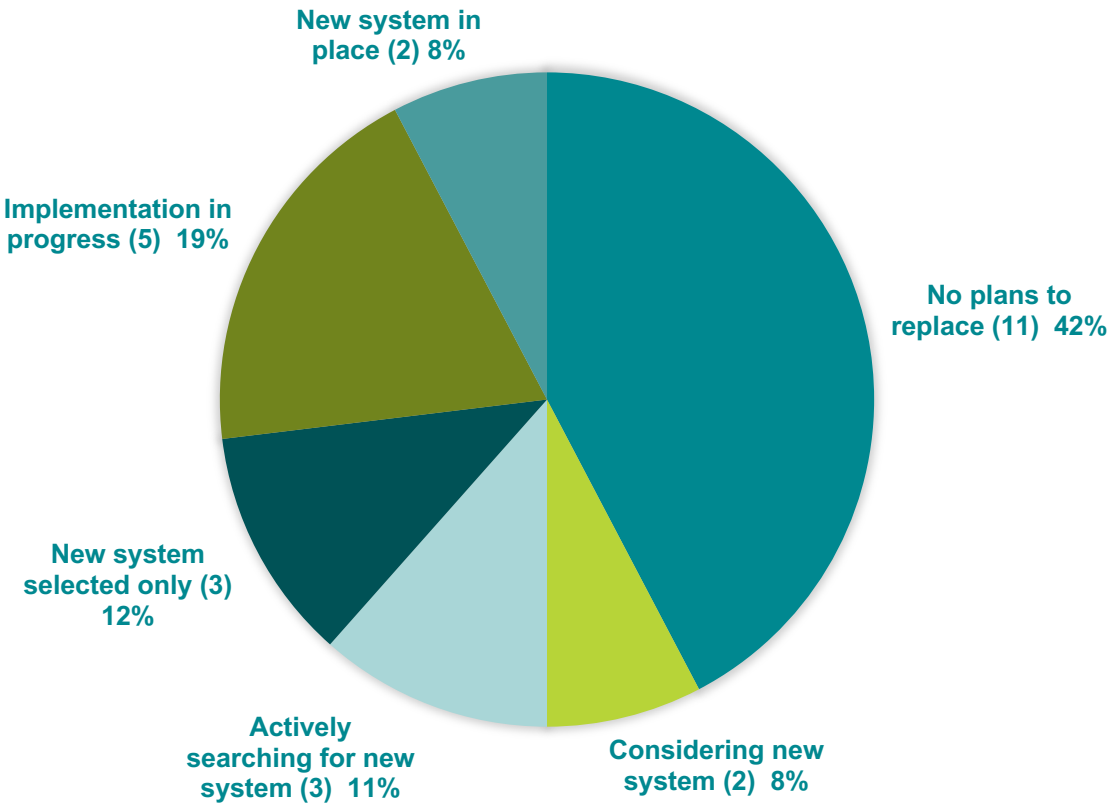
Counties that have selected new systems but have not yet implemented them include Merced for Cerner Millennium, San Francisco for Epic, and San Mateo for Avatar NX.

Contra Costa has upgraded to Echo ShareCare and San Joaquin has integrated ShareCare with Clinician's Gateway.

Alameda, Fresno, and Santa Barbara were actively searching for new information systems. 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 65 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, the majority of contractors continue to rely on paper medical records. In the prior year, 75 percent of the contractors visited were using paper charts. Many were struggling with new documentation standards and tracking requirements for timeliness and authorizations.

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. 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 very common at this point of the ODS Waiver implementation phase.

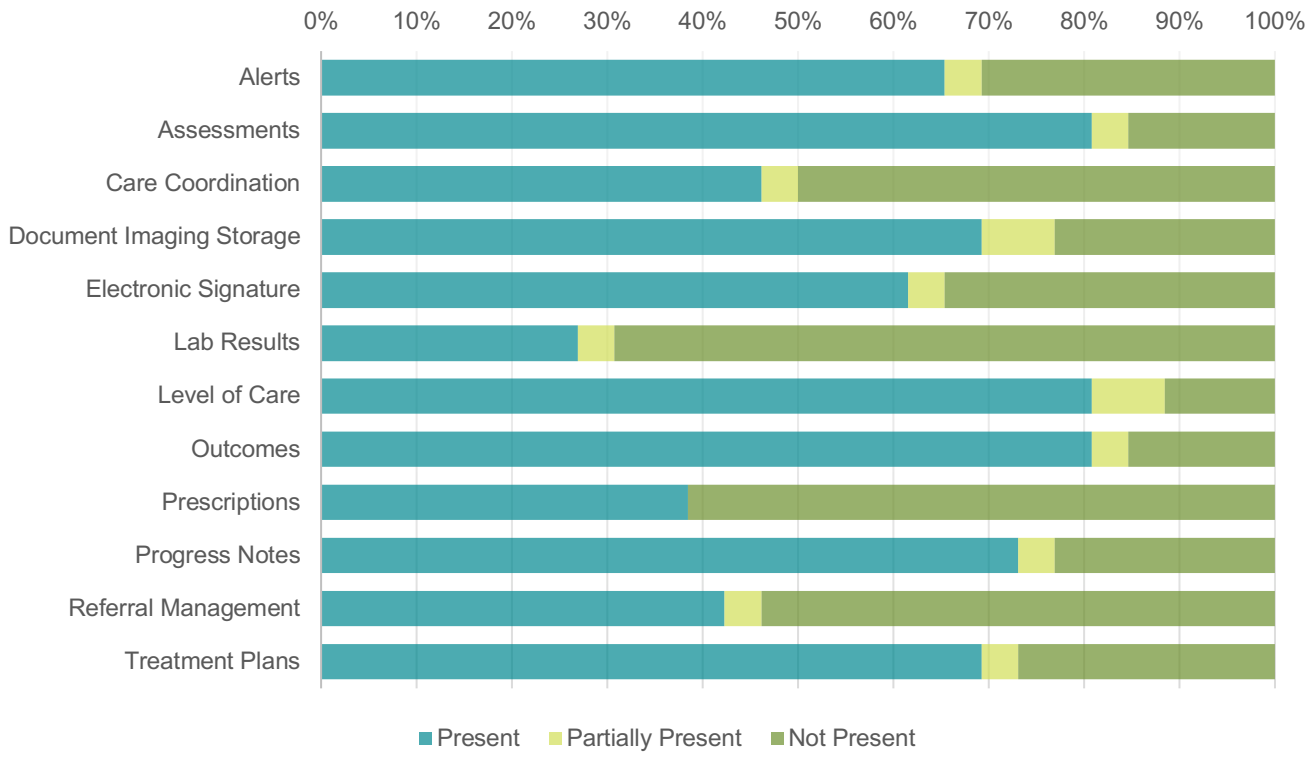
Only 65 percent of EHR core functions are present or partially present in **county behavioral health systems**, which significantly affects staff workflow.

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 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 in DMC-ODS county EHRs. However, assessments, level of care 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

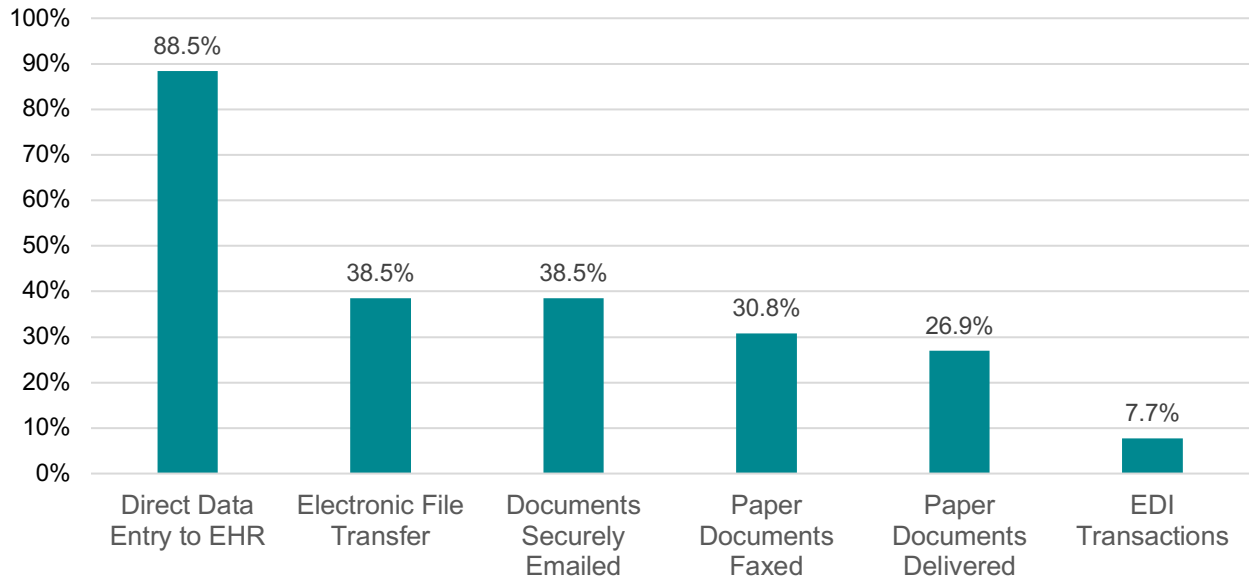
Currently, none of the 26 DMC-ODS counties reviewed uses a **Health Information Exchange (HIE).**

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 two or more submittal methods to exchange client information.

Currently, none of the 26 DMC-ODS counties reviewed uses a Health Information Exchange (HIE), which is a more efficient method for two-way exchange of client data between EHR systems. Special confidentiality requirements make this protocol very 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 more changes might be forthcoming in 2021.

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. It is noteworthy that 23 counties (88.5 percent) indicated contract providers enter data directly into their systems.

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



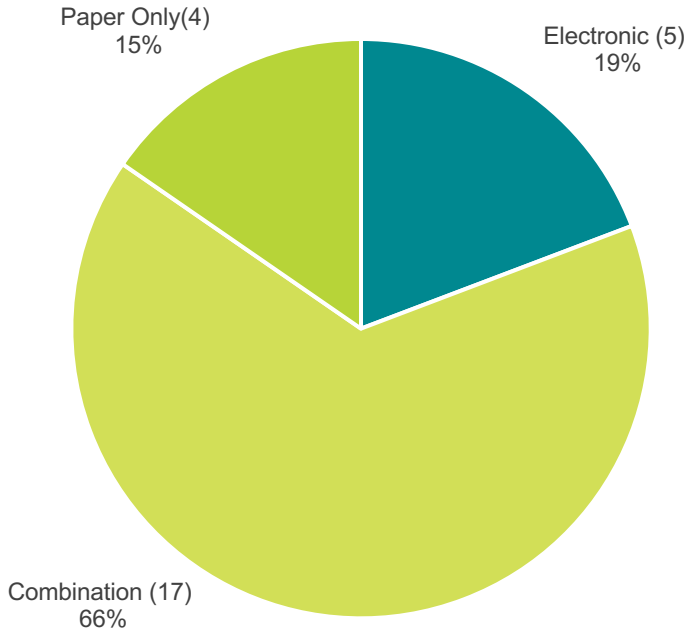
Interoperability continues to pose challenges for most DMC-ODS counties because it requires a level of resources, infrastructure, and skill sets not uniformly available to them. For the time being, for most DMC-ODS counties, some level of double data entry will continue to be required. Some counties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

Health Records

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 five counties reported having an electronic chart of record: Los Angeles, Monterey, Napa, Riverside, and San Mateo. Counties reporting paper records are Contra Costa, Fresno, Imperial, and San Bernardino. Counties reporting a combination of electronic and paper records are Alameda, Kern, Marin, Merced, Nevada, Orange, Placer, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Santa Cruz, Stanislaus, Ventura, and Yolo. This represents the majority of counties. Visits to 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, and facilitates the establishment of client portals to help motivate clients to manage their own health. It is very difficult to support and manage key quality functions and systems tracking using paper records and maintain ease of access for coordination, supervision, authorizations, 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.

Budget Allocations for Information Systems

The percentage of DMC-ODS budget devoted to information systems is a simple indicator of the level of IT resources and capabilities available to support the administration and delivery of SUD services. Although there are no standards for the percentage of 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 small for data analysis and discussion, as follows:

- Large (n=12)—Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, and Ventura.
- Medium (n=11)—Marin, Merced, Monterey, Placer, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Stanislaus, and Yolo.
- Small (n=3)—Imperial, Napa, and Nevada.

However, there is more to consider than the percentage of the DMC-ODS budget devoted to the information system. 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 2019-20 ISCAs, situations like this may have affected some of the budget percentages. The results should be viewed as a rough indicator that requires more detail to be fully informative. In addition, counties have varying relationships with their contractors related to information system support and interfaces. Some support a unified system across the county and contract providers, while others support county functions as a DMC-ODS and request data through interfaces with contractors of various kinds, and still others are hybrids. All of these scenarios can affect the budget and resources needed to support information systems and the staff who serve complex groups of clients and programs that are increasingly field-based.

Figure 8-9 shows the FY 2019-20 statewide average of DMC-ODS budgets devoted to information systems as 2.4 percent, which is lower than the 3 to 5 percent minimum necessary to maintain and improve on EHR functionality. Only the large counties group, with a 3.09 percent average, are within the minimum range. The rest (medium and small counties) are below 3 percent.

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

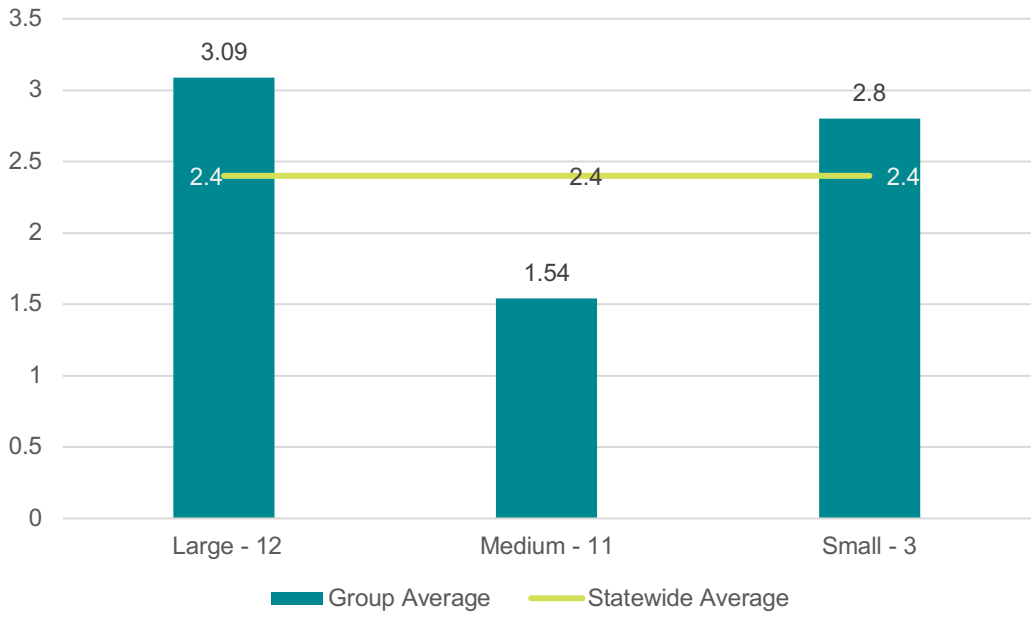
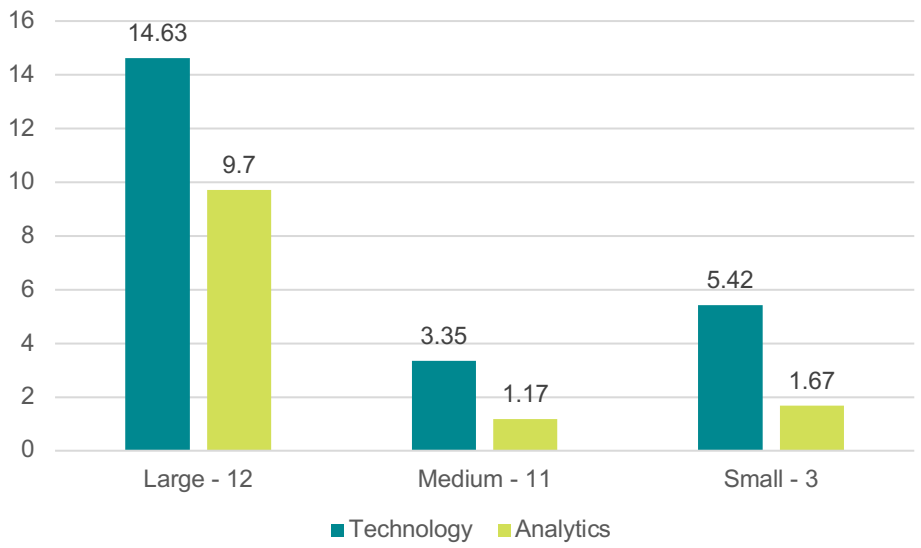


Figure 8-10 shows the FY 2019-20 average authorized technology and analytical resources in DMC-ODS counties, measured in FTEs. The medium-size counties group, on average, has only 3.35 technology FTEs and 1.17 analytics FTEs. These are low numbers in view of all the challenges involved with setting up 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 FTE numbers.
- In some counties, technology and analytics resources are maintained within the health agency and are not dedicated to support SUD services, with negative consequences for the program’s capacity.
- Some counties share technology and analytics resources between mental health and SUD services, but did not report separate FTE numbers for SUD for staff who have skills with some of the unique data sets (such as CalOMS).
- Some counties have relationships with universities, consulting organizations, or even their system vendors. These organizations provide data analytics services that the DMC-ODS cannot reliably maintain; the DMC-ODS counties are getting good value from their information system investment as a result. For example, San Diego County contracts with UC San Diego’s research institute for data analysis for support on TPS data.

Availability of Telehealth

Delivering services via telehealth benefits both the client and healthcare practitioner, especially 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 DMC-ODS plans to efficiently serve clients who are disabled or with transportation challenges. It also helps to support compliance with NA requirements and offers more flexibility to both clients and providers who are in remote areas of California. Figure 8-11 shows that eight counties (Fresno, Kern, Marin, Merced, Riverside, San Luis Obispo, San Mateo, and Santa Barbara) currently had technology in place to support SUD services at a distance, prior to COVID-19. Now all counties have some telehealth and phone services in place which were reviewed.

Delivering services via telehealth benefits both the client and healthcare practitioner, especially during the COVID public health emergency.

Contract providers in six DMC-ODS counties (Marin, Merced, Riverside, San Luis Obispo, Santa Barbara, and Ventura) reported that they offered telehealth services to clients prior to COVID-19.

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, nearly all of them—99 percent—are offering services using telehealth technology, both video and phone. CalEQRO reviews also showed 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 having 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, but all counties shared their best practices and learnings in this area with each other. In addition, NCQA just published a general quality guide for telehealth services that should prove helpful in the future development of this important tool for behavior health and health.

Barriers the NTPs reported in implementing telehealth services were: 11 percent 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, though increases in take-home doses has helped considerably with compliance and access.

Electronic Consumer Outcome Measure Tools

Initial as well as ongoing treatment can involve the use and tracking over time of outcome measures to assist in the assessment of client progress. ASAM level of care assessments are an important component of the DMC-ODS assessment and service delivery model.

All 26 counties reviewed in FY 2019-20 captured the ASAM-recommended level of care recommendations, referrals, and admissions for clients in their EHRs. In all DMC-ODS counties, 93 percent of clients who requested treatment were screened for level of care placement using the ASAM tool.

TPS and CalOMS data also are used to assist with outcomes for clients, but staff members devoted to analytics of these tools are limited in many counties. Fortunately, UCLA assists 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. DHCS has expressed the goal of restoring the reports in the new platform, but there is no specific timing for doing so at this time.

Summary

In FY 2019-20, CalEQRO observed significant progress in launching DMC-ODS continuums of new and expanded clinical services, improved billing, and quality systems, as well as experiencing 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 very positive and high-quality manner.

The 26 DMC-ODS counties reviewed are in different stages of implementing their EHRs; some are considering replacing or updating the current IS vendors 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 information systems was 2.4 percent—lower than the 3 to 6 percent industry benchmark for healthcare.

A common but critical challenge shared by the counties is the interoperability between disparate EHR systems. With many FQHC primary care clinic partners providing non-methadone MAT and some beneficiaries ending up in EDs as a result of an overdoses or other SUD needs, it is paramount that county HIS have the capacity to communicate securely across departments while respecting provisions in 42 CFR Part Two. This is also important for the network of contract providers, who render 77 percent of SUD services delivered across the counties to be able to communicate with county partners and others to coordinate care and facilitate administrative functions, such as billing and authorizations. They, too, need to be able to securely communicate with the DMC-ODS important clinical and fiscal information in a timely manner. At this time, this capacity among contract providers is 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 system HIS to support uniform access to an EHR. Contract providers either enter client and service data directly into the county systems or send batch/paper files to process the data into county systems for billing and reporting. If the contract providers have their own information systems, they may have to enter the same data into two systems, which is highly undesirable, inefficient, and prone to error.

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, Santa Cruz, and Alameda 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 a very positive and high-quality manner.

Building expertise for Medi-Cal billing and documentation has taken time and requires significant staff resources but is currently in process. Historical investment in infrastructure in SUD treatment services or administration were limited due to realignment budget constraints. As a result, major gaps had to be filled in order for counties to function as managed care plans and service providers. This remains a

fundamental barrier to achieving a fully functional EHR that supports interoperability with primary care provider systems.

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 good 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 new 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.

Chapter 9

Conclusion and Recommendations

Conclusion and Recommendations

Implications of CalEQRO's FY 2019-20 Review

Introduction

Results to date show the Waiver and the DMC-ODS counties are improving access to treatment and the timeliness, quality, and coordination of care. Still, many challenges and opportunities for improvement remain. The best practices illustrated in each of the chapters developed by the DMC-ODS counties. Through PIPs and innovative planning and investments, the DMC-ODS counties have implemented best practices that have broken new ground in SUD service delivery. They also have built new bridges and strong partnerships that will benefit individual clients and entire systems of care. Some descriptions of the county program models also show efforts to take on the challenges documented throughout the report. At the same time, new ideas are being proposed in the Waiver renewal to refine current requirements and models so they will yield the optimal clinical impact.

Access to Care

CalEQRO review results from FY 2019-20 show expanded service delivery, which is very encouraging. However, services still need to expand significantly to reach their full potential for improving client outcomes in the community. Services that need to expand include Recovery Support services, which are just beginning to be leveraged. Gradually, these services are demonstrating their potential for community support and integration of clients who have reached a level of stability with their SUD. Recovery housing also continues to be a critical gap for those with unstable housing who need outpatient and intensive outpatient treatment—particularly those stepping down from intensive episodes of treatment at higher levels of care. The other services that still appear to be limited (based on service utilization data and focus group feedback from clients and stakeholders) include non-methadone MAT medication services and case management service models that coordinate across and between levels of care. In many counties, WM is still very limited and not available in a timely way. Finally, youth services overall and particularly residential youth services are still in a start-up phase in virtually all counties.

Besides the specific service gaps themselves, workforce challenges persist for physicians, prescribers, and LPHAs. Over 60 percent of contract staff who participated in focus groups cited workforce shortages of nurses and certified SUD counselors as key issues affecting access and program capacity. Competition for these valuable behavioral health employees was expected to intensify even

more as more providers see the value of integrated healthcare, but few if any academic institutions are expanding their capacity to increase the number of graduates and meet this need.

As shared in the Access chapter, one of the sole benefits of COVID-19's impact on access is the rapid deployment and use of telehealth and telephone technology to work with clients, which has led to providing care in a more flexible way. Revised and relaxed requirements, including for the NTP clinics, helped keep these opioid replacement clinics serving their clients with more take-home options and use of non-methadone medications for new clients, if a physician was not available for intake. Continued support for these practices is recommended.

Finally, problems remain with the transfer of Medi-Cal from one county to another. In these situations, the 90-day delay does not allow billing for SUD services (including MAT medications) in the client's new county of residency for three months. In client focus groups, clients noted that it is not possible for them to return to their prior county of residence to get services for the 90 days it takes to get their Medi-Cal enrollment reassigned. An administrative resolution should be found to resolve this issue, so care is not delayed or interrupted for any client relocating to a different county.

Timeliness and Network Adequacy

A core recommendation continues to be to **look systematically at the IS infrastructure funding and options for behavioral health integration with provider networks**, as well as strengthening communication and coordination with physical health and hospital systems.

Similar to access findings, timeliness and network adequacy showed improvements in these initial years of the Waiver, particularly among the pioneer counties that had two (or, in a few cases, three) years to refine some of their systems in their respective areas. Specific examples include counties working to overcome challenges of distances and driving times, as well as working to develop the infrastructure and systems required to track timeliness. None of these efforts was easy or inexpensive for counties to accomplish. The challenges often converge for smaller counties, which typically have limited resources, more contractors continuing to use paper charts, and many still on different practice management systems. The varied infrastructure makes it difficult to manage timeliness tracking and dashboards; likewise, clinician notes to help with intakes and case management and coordination are also dispersed. A core recommendation continues to be to look systematically at the IS infrastructure funding and options for behavioral health integration with provider networks, as well as strengthening communication and coordination with physical health and hospital systems. Even though these infrastructure needs are not exactly the same, they are both critical for good client care—and both are now very limited and underfunded.

Many counties also faced challenges with urgent appointments. Understanding these challenges is complicated, because definitions vary, and tracking systems are unclear and inconsistent. This is an area that would benefit from clarifications on several fronts. A related area requiring assistance

(possibly from DHCS) is defining services for public inebriation. Like urgent appointments overall, these are sometimes labeled urgent, or emergent, or not, depending on various factors, which has contributed significantly to the confusion. During the review process, many stakeholders wanted to discuss broader options for WM that would not result in many individuals being sent to the ED and instead being managed at a lower level of care. This particular issue did not fall within the EQRO review's scope but may be of interest in the Waiver renewal process in the context of discussions about appropriate levels of care.

Another consequence of the telehealth and telephone service expansion is enhanced timeliness and less stress related to travel and network adequacy issues. Many clients reported liking the regular calls and visits, as well as avoiding bus trips or the search for other transportation. The only barriers were reported by those who had limited minutes on their phones' plans, limited internet, or no phones at all. Many counties were surveying clients about their personal access to technology, including asking about who and what they liked and did not like when using technology instead of face-to-face contact, issues related to virtual group sessions, use of tablets and computers, and issues related to seeing people virtually, privacy, loneliness, and family or roommate conflicts related to finding neutral spaces for sessions. These inquiries will likely lead to new quality recommendations related to this model of service delivery overall, as well as implications for specific populations, age, and demographic groups.

Quality of Care

The tools used in the reviews to understand quality of SUD services in the DMC-ODS counties indicate a positive trend overall for the Waiver counties, supported by evidence of change from TPS, CalOMS, and most PMs. In addition, over 60 percent of the clinical and non-clinical PIPs were active. Among PIPs that had reached a point where one or more quarters of data could be analyzed, two-thirds showed positive trending results in clinical or non-clinical goals set for the PIP.

Quality was evaluated in a number of ways. These included analyzing key research-based PMs, the TPS with its different dimensions of how clients perceived their treatment, and the degree to which ASAM principles and quality of care requirements were built into the care system with training and oversight. Requiring a full menu of MAT as well as SUD EBPs in the STCs also supported quality, as did requiring culturally competent case treatment systems using CLAS standards, with yearly reviews of these. Feedback from client and family focus groups provided insights about the quality of care they received and the impact their treatment was having (or not having) on their lives and treatment goals.

While the trends in these indicators were generally positive, the stakeholders, clients, clinicians, and managers also shared some of the challenges they were experiencing. Some challenges were anticipated, and others were surprises, but these review participants shared a desire to see them fixed. They realized the new programs yielded better outcomes and could be even more effective once other supports or changes were implemented. For example, many of the contract directors initially did not realize how complex the Medi-Cal billing system and charting requirements were, so did not build in enough staff and infrastructure to support these tasks. This issue was raised frequently. Many counties worked to address billing and charting issues in their second and third years, to the extent possible.

Housing affordability, access issues, and stigma clients faced (in their searches for jobs and housing) also came up as challenges that hampered rehabilitation and community success. With a new focus on individualized treatment, help with jobs, housing, and family support is now part of the SUD rehabilitation and case management process. These services and supports were frequently requested by SUD clients in groups, particularly those in post-residential treatment who were working on community integration. Similar to last year, CalEQRO recommends continued efforts to address SUD stigma and support access to affordable housing—and specifically recovery housing—as a needed level of care linked to outpatient services.

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Integration with other systems—particularly expansions linked to the EDs, hospitals, and criminal justice—showed very positive trends. CalEQRO strongly recommends these efforts continue; the positive impacts on the lives of clients, the communities, and the other two systems are encouraging. Currently, the DMC-ODS system is at the beginning of strengthening its connections to hospital EDs and criminal justice systems, in partnership with the ED Bridge grants and the new criminal justice collaboratives. The potential to improve lives and systems is significant, as both hospitals and jails engage with SUD populations. Until recently, few tools have been available to systematically treat and exit these clients from the revolving door of EDs and jails. Linking more of them to community care and support systems is a promising development.

Case management and coordination of care—a new billable service to SUD—really gained visibility in the DMC-ODS systems reviewed this last year, especially when case management or navigator positions were created. Last year, "case management" was often an extra duty assigned to a counselor or administrative staff member who rarely left the program site and just defined these services as admission or discharge coordination. With new case managers following clients across levels of care and conducting extensive outreach to help engage them in treatment, a broader range of case management/social work services began. In many ways, their approach has been similar to mental health's Assertive Community Treatment models, particularly for homeless clients with complex needs. It was very encouraging to see these new types of case managers and case management models throughout the DMC-ODS programs. Across multiple client focus groups, case managers were praised as helpful, practical, and good problem solvers. In several counties, clients were specifically requesting case managers, not just counselors. Evidence of change in case management models appeared both in data and in human experiences shared during focus groups. Continued support of case management's evolution in this flexible, client-centered direction is highly recommended to enhance quality.

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For the future, it would help to see quality ratings shift from process-based indicators to more outcome-based tools to track long-term impacts for the clients in their daily lives and for the community as a whole.

Outcomes

As discussed, the data do not provide extensive tools to measure outcomes. The data points that support analysis of outcomes—mainly TPS, CalOMS, and PMs for initiation and engagement and length of stay/retention—are again positive and moving in the right direction. In partnership with UCLA, DHCS, and Partnership Health Plan, CalEQRO plans to examine health data this year to assess health offsets due to good SUD treatment. This may take time but is a desired outcome goal. Another desired outcome goal is to assess the impact on numbers and costs of arrests, jail, and prison stays by addressing SUD issues outside the criminal justice system (i.e., in the SUD health system) whenever possible. If effective treatment is available earlier, this has potential benefits and implications for the child welfare system, parents with SUD issues, and of course their children.

Based on our current tools, CalEQRO recommends that the number of TPS survey used in the counties be expanded to capture more programs and more ethnic groups to be more representative of all the populations using services.

Another area of potential improvement involves CalOMS; the reports DHCS formerly provided to counties should be restored in the system that was previously available. Whenever possible, the excellent idea of streamlining CalOMS and having it better match the ASAM continuum of care would make the data more valuable. Both of these recommendations to improve outcomes data would be a positive enhancement to CalOMS.

Finally, as part of CalAIM and integration efforts, CalEQRO recommends a continued emphasis on opportunities to offset costs and use outcome-oriented PMs to evaluate managed care plans' effectiveness.

Structure and Operations

Several key foundational recommendations are related to structure and operations. Due to a variety of historical factors, the DMC-ODS IS systems (and particularly their contract agencies) do not have an adequate infrastructure to function as managed care systems in an efficient manner. The vast majority of the systems are still on paper charts and cannot communicate electronically between the network providers and county related to client care in real time. A plan for system investments in infrastructure is recommended as part of the Waiver renewal. This would move in some incremental fashion to align the DMC-ODS IS with standards in place in other parts of the health system.

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A critical challenge to be addressed continues to be interoperability among different EHR systems in county departments, hospitals, primary care, and contract providers. With many beneficiaries receiving non-methadone medications from primary care and linked to EDs that are critical for overdose prevention and referrals, coordination of care has become even more important for the healthcare system. It is paramount that county HIS have capacity to securely communicate across departments and with contract providers, while respecting provisions of 42 CFR.2.

Telehealth and the Future

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 capacity. It is strongly recommended this remain a priority for this next year for the DMC-ODS systems.

Improvements in Billing Efficiency

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 as part of system change to see if streamlining is possible or other uses of technology could assist.

Summary

Progress continues to be made by DMC-ODS counties on access, timeliness, quality, and in several early indicators of outcomes. Many key best practices in these areas have been identified by counties that have demonstrated particularly outstanding metrics in these areas. Training and education on these best practices are needed, along with support for activities to address areas that continue to present challenges. This support is included in the recommendations in sections above and summarized briefly below:

(1) Services in the ASAM continuum still needing expansion and additional capacity to meet needs in many counties include **recovery services, recovery housing, non-methadone MAT, youth services, and (in some areas of the state) WM**.

(2) **Workforce** issues need continued attention at the academic level to meet statewide needs at multiple levels and disciplines: **physicians, midlevel providers, LPHAs, and SUD counselors**.

(3) Use of **peers** as a potential support within a variety of services is underdeveloped and an asset that could enhance services, particularly for navigator and case management functions.

(4) Continued and ongoing **telehealth** use and **flexible service models** from COVID-related adaptations for services in NTP/OTPs have proven very positive for clients and have increased positive engagement and access. These need to be continued to meet the needs of some client groups.

(5) **Core IS infrastructure and interoperability between counties and their networks of providers**, as well as with health and hospital systems, require a concrete plan and major investments in order to improve quality and efficient use of resources.

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

(7) **Care coordination,** including transitions from high to lower levels of care, has improved but still needs more focus and effort. Treating SUD as a chronic disease warrants some level of ongoing support.

(8) SUD **stigma** persists as a barrier, affecting clients and the development of new services in the community as well as access to housing, jobs, and other aspects of quality of life.

(9) **Partnerships** with criminal justice, health and hospital systems, and child welfare linked to SUD are worthy investments with positive benefits for clients, the families, and the community at large.

These recommendations are based on the reviews of the 26 county DMC-ODS programs, their data, and the voices of the clients, stakeholders, and family members who participated in the reviews. CalEQRO appreciated the time, effort, and dedication of the staff and programs who assisted in these reviews, without which we would not have been able to do this work and identify these important findings.