2020-2021 Statewide Annual Report

EXTERNAL QUALITY REVIEW REPORT

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

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

By Behavioral Health Concepts, Inc. (BHC)

BHC | Behavioral Health Concepts, Inc

Acknowledgements

Behavioral Health Concepts, Inc. (BHC) would like to acknowledge the many people who worked hard to serve the people of California this year with substance use disorders (SUDs) and their families, the providers of care, the County Substance Use Administrators and Behavioral Health Directors, the Public Health Officers, and the Department of Health Care Services.

The COVID-19 pandemic and related stressors have sadly contributed to a rise in overdose deaths and increased use of drugs and alcohol. To that end, it is even more important that the access, quality, and timeliness of the DMC-ODS services be available and continue to thrive. BHC would thus like to acknowledge the work of the 30 County DMC-ODS plans and the Regional Model Partnership Plan that took part in the California External Quality Review Organization (CalEQRO) reviews, including staff, volunteers, contract providers, key stakeholders, and many others. In particular, BHC acknowledges 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 in trainings and support of quality development statewide with California's Behavioral Health Directors Association (CBHDA). Both organizations worked to support efforts to foster quality of care and best practices for SUD services, working on 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 SUD licensing and Behavioral Health Medi-Cal programs 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 and provide some helpful direction for the next chapter in the Waiver process. It is also important to foster a statewide system of treatment that changes lives in creating positive health and wellness for the Medi-Cal members who depend on these services.

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Acronyms

CalEQRO Acronyms	
AAS	Alternate Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ASAM	American Society of Addiction Medicine
ASP	Application Service Provider
AUD	Alcohol Use Disorder
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts, Inc.
BHIS	Behavioral Health Information System
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
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	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee for Service
FTE	Full Time Equivalent
FQHC	Federally Qualified Health Center

CalEQRO Acronyms	
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIS	Health Information System
IMD	Institutions for Mental Diseases
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capacity Assessment
IT	Information Technology
ITWS	Information Technology Web Service
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
MHP	Mental Health Plan
MI	Motivational Interviewing
MMEF	Medi-Cal Master Eligibility File
MOU	Memorandum of Understanding
NA	Network Adequacy
NACT	Network Adequacy Certification Tool
NCQA	National Committee for Quality Assurance
NIDA	National Institute on Drug Abuse
NSDUH	National Survey of Drug Use and Health
NTP	Narcotic Treatment Program
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
QIP	Quality Improvement Plan

CalEQRO Acronyms	
RPT	Relapse Prevention Therapy/Treatment
RSS	Recovery Support Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT BG	Substance Abuse Prevention and Treatment Block Grant
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOC	System of Care
STCs	Special Terms and Conditions
SUD	Substance Use Disorders
TAR	Treatment Authorization Request
TPS	Treatment Perception Survey
WM	Withdrawal Management

2020-2021 BHC-CalEQRO DMC-ODS Statewide Annual Report

Executive Summary

Executive Summary

Progress and unique challenges in FY 2020-21, the fourth year of 1115 Waiver Services for SUD

Introduction

After reviewing the Drug Medi-Cal/ Organized Delivery System (DMC-ODS) counties for their fourth year of service delivery and the first year of reviewing the new Regional Model, it is clear that this new system of care is improving clients' access to treatment, enhancing timeliness to get into treatment, and adding key elements of quality that are benefiting the clients and substance use treatment as a whole. California's substance use disorder 1115 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 seen and documented across the counties and the Regional Model reviewed.

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

- Introduction
- Methods
- Access
- Network Adequacy
- Timeliness
- Quality
- Outcomes
- Performance Improvement Projects
- Structure & Operations

To understand these system changes in more depth, data from the initial 14 counties to launch—the "Pioneer Counties"-- were separated from the counties that newly launched their DMC-ODS services in the last 12 months to 18 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. The unexpected introduction of COVID-19 throughout this past FY 2020-21 and continuing wildfires devastating many counties across the state, have set back some of the progress being made, adding stress to local populations, and depleting local health and community resources. But despite these challenges most key performance measures (PMs) improved for services, and indicators of expansion and access continued though with a period of setbacks.

As counties demonstrated innovative approaches to addressing the challenges they faced and are still facing, they worked together to learn from each other's best practices and techniques. And the DHCS innovations will help with addressing some other system-wide challenges by policy or programmatic structural changes and revising requirements, or in more global ways as part of the broader California Advancing and Innovating Medi-Cal (CalAIM) efforts for improvement. There has been strong state leadership in health priorities from legislative and policy leaders, and this also has strong public support.

Timely Access to Appropriate Care

This Fiscal Year (FY) 2020-21 findings are from review of the 30 counties and the Regional Model which includes 7 counties. Data showed expanded service delivery across the American Society of Addiction Medicine (ASAM) levels of care (LOCs), for both historical and new Medi-Cal treatment services. The Pioneer Counties showed the most significant growth across the continuum of services. Newer counties and the Regional Model also expanded services, although to a more modest degree. For example, the Pioneer counties served 77,050 unduplicated clients with DMC-ODS Medi-Cal services in total in FY 2019-20, and 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 Pioneer counties to statewide data from all DMC-ODS Counties. (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 the DMC-ODS clients are getting. Below is a chart showing the growth by service type across the FYs for the 14 Pioneer Counties which began in FY 2017-18. While all LOCs expanded during the review period, some did so more rapidly than others. The strongest growth in the Waiver continuum was in residential treatment, intensive outpatient and outpatient, Narcotic Treatment Programs /Opioid Treatment Programs (NTP/OTPs), and case management. LOCs where growth has been much slower included recovery residence housing, recovery support services (RSS), 3.2 residential withdrawal management (WM), non-methadone Medication Assisted Treatment (MAT) both inside and outside the NTP/OTPs, ASAM levels 3.7 and 4.0 WM and inpatient care, and services for youth, especially residential. These LOCs continue to require more investment to meet client needs statewide. Even in counties with a full continuum of care there are often regions with are quite distant and still need more providers of various kinds to make access easy when the individual becomes motivated to enter treatment, and there are some counties where all their residential and WM programs are out of the county and in some cases at a significant distance discouraging enrollment.

Specific populations in some counties are also underserved and need novel approaches to access care, specifically Latino and Asian-American populations statewide are underrepresented in the services provided compared to their anticipated needs based on prevalence data. Also, as mentioned youth and seniors are also underserved groups in many communities but are sadly represented in overdose statistics and other indicators showing a definite need for engagement and care. There are some special cultural barriers within these populations and sub-populations that need to be addressed as part of making care feel welcoming and comfortable, especially for non-English speakers, and it would be helpful to have more detailed breakdown within the two broad categories of Latino and Asian-American is the needs can be quite different within these groups.

Many DMC-ODS counties also organized their systems in ways that made them much more accessible to clients, at every point from the initial client request to delivering treatment at the right LOC and with transitions in care and into the community. These best access practices and evidence-based practices (EBPs) included:

- Providing a 24/7 access center or beneficiary access line (BAL) doing ASAM screenings with call-center software support, three-way calling capacity, and real-time SUD resource directories to link clients to the appropriate LOC for services.
- Linkages to historic records to streamline assessments/screenings and referrals.
- Well-distributed program sites for convenient full ASAM assessments including telehealth assessments.

- Walk-in appointment hours for screening, assessments, information, and referral.
- Warm handoffs practices in transitions between LOCs including case management and ideally some overlap between providers assisting clients with building a therapeutic alliance with counselors at the new LOCs.
- Up-to-date appointment and vacancy information in the practice management system for convenience and coordination for the BAL staff and clinic/provider staff.
- Access to navigators or case managers to help clients access their first face-to-face appointment after making requests for services.
- Data tracking alerts when system services were full or overcapacity.

True access requires much more than offering an empty appointment or residential bed. In addition to time and space, it means an adequate skilled workforce is at all LOCs, with the licenses required for specific services, and supports to help the often stressed and ambivalent client come to the first service and engage in care. All counties and contractors that took part in BHC reviews named needing support to expand their SUD workforce. They requested help from state leadership for expanding college opportunities, training, and program capacity to bring more people into this important SUD field of clinical 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 LOC with welcoming, skilled counselors and providers.

Best practices to support timely access included skilled screenings at first contact, a full continuum of treatment options, and prompt linkages to the right LOC, along with engagement with someone who can help clients with their specific needs if needed, supporting them as they move forward through withdrawal to a suitable treatment environment. DMC-ODS counties have made progress in reducing the time to access care since beginning the Waiver. They continue to work on more options for prompt access by adding more treatment sites, staff and expanding their use of telehealth, mobile services, and treatment kiosk sites.

1115 Waiver Design Elements Supporting Quality & Outcomes

- Client-centered services in a complete Continuum of Care
- SUD workforce with diverse clinical and bi-lingual/bicultural skills
- Timely Access with Care coordination and recovery support services
- Infrastructure for Quality Improvement Systems

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 four years. A variety of data sources—ASAM LOC 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.

1115 Waiver Design Elements Supporting Quality of Care and Outcomes

- **Client-centered services** in a complete continuum of care
- Care coordination and recovery support services
- **Infrastructure** and requirements for Quality Plans and Evaluations

They include:

(1) Client-centered services in a complete continuum of care provided a solid foundation and a science-based model using EBPs with varied clinical intensity and a focus on progress over time.

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

(3) Infrastructure and oversight for quality of care based on best practices, scientific evidence, standards of care, and investments in continuous quality improvement, achieved through use of key tools such as EHRs, Quality Improvement Plans (QIPs), and data/evaluation/oversight systems.

Many examples of successful programs and activities in all three domains surfaced during this year's reviews, along with areas calling for added investment and potential system changes that can be addressed in CalAIM with collaborative care delivery systems.

The challenge is the large numbers of providers within the county DMC-ODS networks who are still unable to communicate client needs electronically, coordinate their care in real time, and use resources efficiently. Behavioral health continues to have significant unmet information system (IS) needs, primarily EHRs and interoperability between the county and its' network providers. This hinders communication across programs serving the same client and between behavioral health and health care in general.

This current gap also does not allow the contractors to function as full partners in the managed care system with the other programs and LOCs. It does not allow them to optimize their use of ASAM data, the TPS data, or other quality tools available to track and improve outcomes. Because they deliver approximately 80 percent of the care, this must be remedied to see the full quality of the care at its best for the clients and their families and the effectiveness of the system as a whole.

Recommendations and Next Steps

CalEQRO recommends that the DMC-ODS counties continue to develop new models that can be adapted by the small counties that are not currently part of the 1115 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. It creates challenges not having the services be available statewide.

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

State and local investments in IS should continue, but also be expanded with more funding. These Information system investments should prioritize the quality issues linked to EHR needs, interoperability, and provide a foundation for changes coming in CalAIM and more integrated care models.

Workforce expansion is needed with a focus on college program capacity and loan forgiveness options. Added graduates especially those from different lower income communities would help diversify the workforce, expand services to underserved groups, and meet critical capacity needs, and add bilingual workforce capacity. This could also include more training options and career ladders for peers at the junior college level if desired.

Continued expansion is needed to achieve statewide availability of all LOCs in all communities in need of SUD treatment. There are gaps in youth services, residential programs in counties that have none in close proximity and for programs like perinatal or WM proximity is critical, WM services including hospital WM, and ASAM levels 3.7 and 4.0, and non-methadone MAT services. While a solid foundation for services is in place in the Pioneer Counties others are just beginning to refine their networks and meet more of the critical needs including underserved populations. The Waiver has a solid start but the work is not over.

Recommendations

- 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 in workforce and health information systems
- Expand DMC-ODS full development of case management, WM, youth residential, recovery support services.
- Expand access to underserved populations such as ethnic minorities, non-English speakers, youth, and others.
- Support **affordable housing** initiatives to support clients and communities.

Like other investments in improving SUD systems of care, investments in SUD affordable housing have tremendous potential to improve outcomes for those in SUD treatment who are coming out of residential treatment or inpatient. Recovery residence housing is a critical resource for treatment transitions as more are not in stable housing.

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 their programs'—and clients'—success.

Chapter 1

Introduction

Introduction

DMC-ODS -Fourth Year of the Implementation Process & Environment: FY 2020-21

Overview

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 offered 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 (Medi-Cal in California) managed care programs. These rules require a review of the DMC-ODS and each Medi-Cal Mental Health Plan (MHP).

The 1115 Waiver began in 2015 but actual DMC-ODS treatment services did not begin until early 2017.

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

The state DHCS designed a staged approach and DHCS approved planned launches of DMC-ODS services from 2016 through the end of 2021 when the demonstration Waiver is set to expire. As of August 2020, the DHCS contracted with 30 DMC-ODS counties and one Regional Model group of seven counties to provide Drug Medi-Cal (DMC) treatment services, requiring an annual review for quality of care for each active DMC-ODS plan.

This report presents the fourth year of reviews in the first Waiver cycle. A separate 5-year report was done summarizing the entire review process from the 2017-18 reviews to 2020-21 reviews and is available at www.caleqro.com. This report captures many of these same findings as the final year. Again, the early counties known as the Pioneer Counties have different outcomes due to the stage of development they are related to their continuums of care and quality infrastructure.

Meeting Federal EQRO Requirements

Since the opt-in counties now function as PIHPs, the federal requirement for an EQRO review applies. CMS requires that external reviews be conducted by an independent, external contractor (CFR 42, Part 438). EQRO must conduct a review of each county on an annual basis to review access, timeliness, quality, and outcomes. BHC has reviewed the DMC-ODS Plans since they began services in February 2017 and concluded reviews under the current contract in June 2021. Reviews are retrospective for the prior year of services and thus the data being reviewed is from 2017 through May 2021. The review criteria are based on 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.
- Client satisfaction with the services received, measured through a survey and other mechanisms.

This annual report represents the fiscal year (FY) 2020-2021 DMC-ODS Report of the DMC-ODS programs by CalEQRO for this contract cycle for the 1115 Demonstration Waiver. There were 31 reviews this past FY for counties and the Regional Model which included seven counties in far northern area of California including several along the Oregon border. There were four new counties and the Regional Model who began services in the last year that were reviewed. These counties included: San Benito, Tulare, El Dorado, and Sacramento Counties and the Partnership Health Plan Regional Model representing Modoc, Mendocino, Siskiyou, Lassen, Solano, Humboldt, and Shasta Counties. These counties are in Year-One of their implementation processes. There are fourteen counties in the initial “Pioneer County Group” which began services from early FY 2017-18 through early FY 2018-19. There are twelve counties that were reviewed and launched in the later years including late FY 2018-19 and early FY 2019-20. These are referred to as Year-Two counties in the report as they have more years of implementation than Year-One, but still are in a beginning phase of development.

Goals of California’s Waiver

The Waiver’s overall goal was to improve substance use disorder (SUD) services and outcomes of care for California’s’ 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 health and social service systems. Other goals included reducing emergency department and hospital inpatient stays and placing clients in the least restrictive level of care (LOC) that was clinically appropriate. The Waiver model would require program and fiscal oversight, quality assurance activities, managed care model administrative systems, enhanced clinical workforce requirements and EQRs from an outside organization.

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

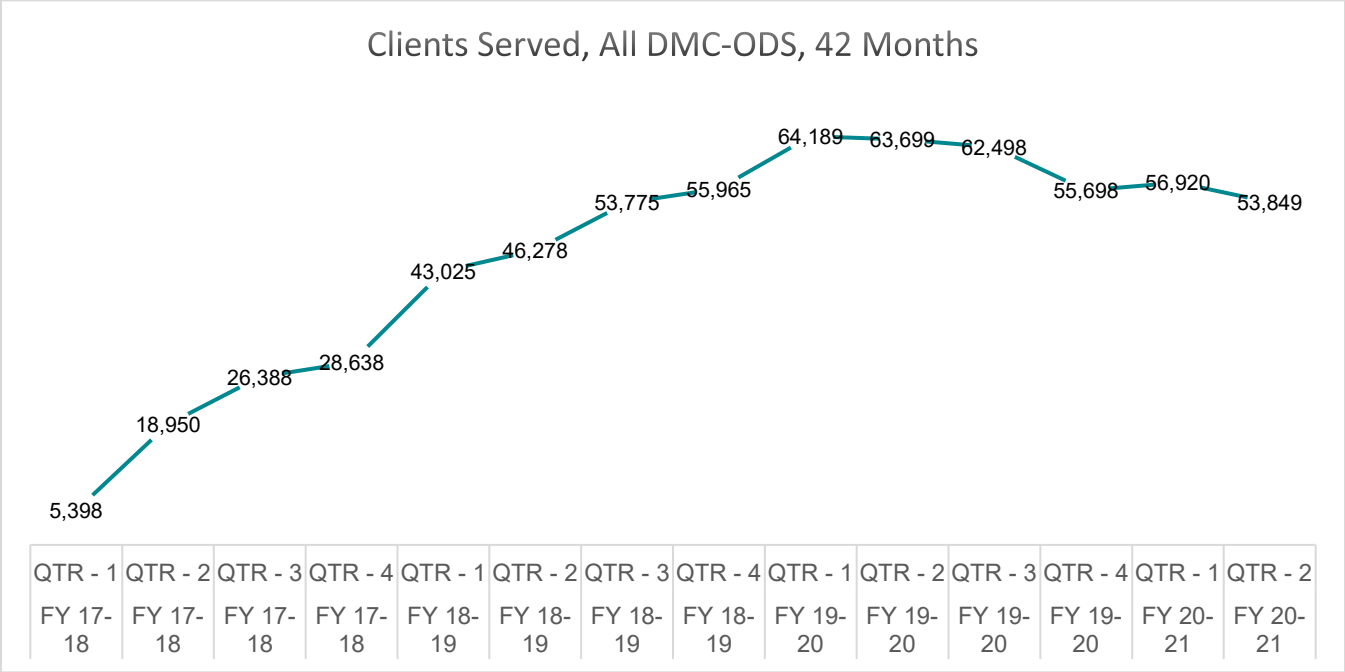
Trends Affecting the Quality EQRO Environment

COVID-19

On March 19, 2020, California's Governor issued Executive Order N-33-20, which directed all Californians to stay home in order to protect health and 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. This continued through all reviews in winter and spring of 2021. It is hoped that some normal review options, particularly client and family focus groups most impacted by the remote review requirement, can resume in late 2021. However, there were many impacts of COVID-19 on services as reflected in the 42 months of data analysis that will be shared. With new variants there is still uncertainty related to how and when in-person reviews may begin.

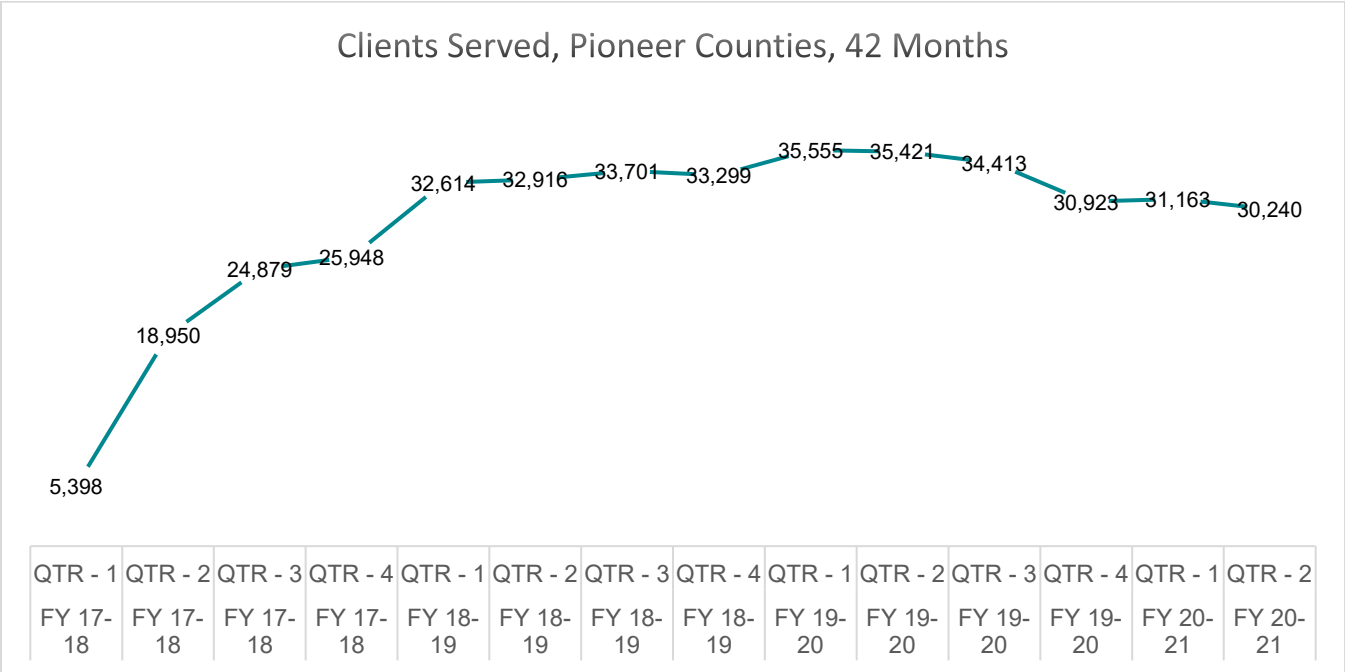
As reflected below in the quarterly data shown on unduplicated clients served from July, FY 2017-18 through December 2020, services from all DMC-ODS counties showed a steady increase as they launched their DMC-ODS services. In the first year with only three counties launched services until July 2017 and then many more were able to begin between July 2018 and January 2019. FY 2020-21 concluded with 30 counties and a Regional Model. However, in third quarter on FY 2019-20 when the Executive Order N-33-20 was issued there is a clear drop in persons served from 63,699 to 55,698 as Californians were directed to stay home and that service level still is lower but stabilized at the end of 2020. Unfortunately, claims data was not complete for January to June of 2021 to show the predicted improvements that were reported in the spring reviews of 2021.

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



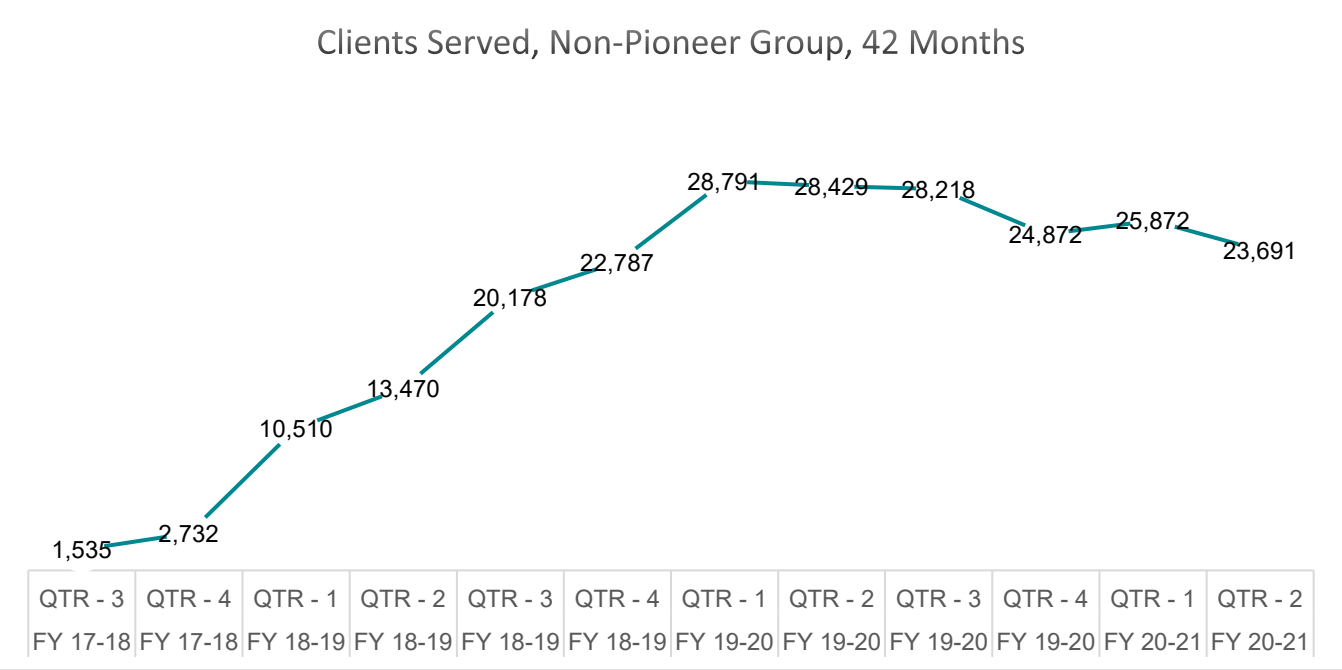
The drop in clients served was present for the Pioneer Counties who launched early in FY 2017-18 and were more stable when the COVID-19 order was issued as reflected below in Figure 1-3. The drop was still significant going from 34,413 to 30,923 but appeared to begin stabilizing quickly moving to 31,162 the next quarter and was able to continue improving in the spring but as reported that data is incomplete.

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



Clients served was also reviewed for all the Non-pioneer Counties and the Region Model that launched later and as anticipated there was a slow and steady launch as they began to serve clients, but also a drop from 28,218 to 24,872 clients and a modest recovery to 25,872 for the next quarter and then another decrease as winter approached to 23,691 as reflected in Figure 1-4.

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



COVID-19 Impacts on SUD Services and Levels of Care

There were definite impacts on the following face-to-face, and then telehealth services due to COVID-19:

- Residential treatment.
- Methadone narcotic treatment program/opioid treatment program (NTP/OTP) services which required a face-to-face physician visit to do an initial assessment and intake as well as daily dosing.
- Intensive outpatient which requires 3 hours on 3 days per week of services which is difficult to tolerate by telephone or video.
- In addition, many programs wanted individuals tested before they presented for assessments particularly in residential or NTP services. If they were positive, isolation options needed to be found even if they were homeless. To compound these challenges staff as well as contract providers had staff with health issues and exposure as well. Also, many clients do not have cell phones, internet, or enough minutes on their cell phone plans for long sessions or are homeless and have difficulty with access to the internet.

Rapid Expansion of Telehealth

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

California Trends

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

DHCS formally proposed the version of the 1115 Waiver known as 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 mental health services and SUD into one behavioral health managed care program. The 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.

The CalAIM Section 1115 demonstration application seeks to amend and renew the existing Medi-Cal 2020 Section 1115 demonstration waiver, approved through December 31, 2021. DHCS is requesting approval by December 2021 to enable implementation in July 2022. There are many phases to the implementation which also includes physical health and aligns quality to benefit clients with multiple disorders in as holistic a manner as possible with coordinated care.

Network Adequacy

In April 2016, CMS issued the Medicaid and Children's Health Insurance Program 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 (NA) 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 Assembly Bill (AB) 205 was signed into law on October 13, 2017, and codified California's NA standards (Chapter 738, Statutes of 2017). The NA standards are based on the population of each county.

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

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

- **NA 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 NA Certification Tool (NACT) to DHCS by April 1 each year.

This was the second year that NA data were reviewed during the annual EQRO review for DMC-ODS counties. BHC continues to work closely with DHCS on NA and on their Comprehensive Quality Strategy to align PMs and the focus of reviews on key issues of quality that are important to the success of the state quality strategy but also national goals for SUD and behavioral health in general.

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 included responding 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 to a brain science model that draws on researched population-based treatment and prevention approaches that have been found to be effective in addressing SUD issues.

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

approximately 1.7 million Americans suffering from an opioid use disorder[2] and more than 50,000 people died from an opioid overdose in 2019, a 4.6 percent increase from 2018.[3]

When physician prescriptions were no longer available, 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. The dangerous strengths of these new medications led to many overdoses annually, surpassing annual deaths from motor vehicle crashes.[4]

What is more concerning is the impact of 2020 with the pandemic, job loss and extra challenges with access to care. Preliminary data from Centers for Disease Control and Prevention (CDC) indicates a significant rise in overdose deaths nationwide and an increase in synthetic opioids in illegal drugs of all kinds including amphetamines resulting in an estimated death rate of over 93,000 individuals in 2019 based on CDC estimates and 2020 is looking to exceed this number. The synthtic opioids played a large role in these deaths and in California these were found in deaths of both those with opioid use and amphetamine use. The 2019 CDC data on national overdose statistics highlights the national profile of the 93,331 deaths and influence of fentanyl nationally.[5]

Given that individuals able to access treatment had beneficial experiences based on self report and data in many counties, it is even more important to enhance and improve access and quality of SUD treatment and outcomes for the people of California.

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[2] Center for Behavioral Health Statistics and Quality. *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

[3] 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

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

[5] 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/drug-topics/trends-statistics/overdose-death-rates

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 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 a review of each Medi-Cal DMC-ODS plan and each Medi-Cal MHP. Recently updated 2019 CMS protocols focused 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.

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, NA, Timeliness, Quality, Outcomes, PIPs, 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, and statewide PMs. Individual county PMs are in their county reports and comparisons by county groups are discussed in the chapters.

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

Counties and Populations

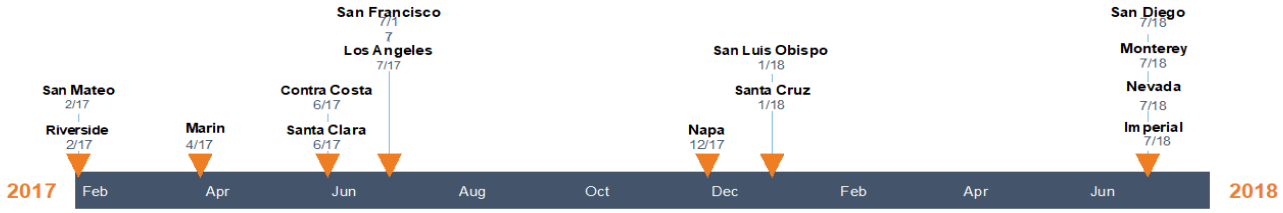
CalEQRO analyzes a specific subset of California's population linked to the counties that have completed a full year of services under the 1115 Demonstration Waiver for DMC-ODS. This is the fourth year of evaluation since the launch of treatment services under the Waiver and 30 counties and a Regional Model managed by Partnership Health Plan were evaluated. The groups of counties who launched treatment services from February 2017 to July 2020 shall be compared in three groups to identify key characteristics of their development, challenges and other issues that may be relevant by size or region though these appear to be minimal other than in the depth of resources the larger

counties have and in some specifics related to the rural nature of their county and challenges with access.

Pioneer Counties

The initial 14 counties that implemented the1115 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



Second Review Year Counties

An additional 12 counties implemented services in the year following the Pioneer Counties and includes Alameda, Kern, Merced, Ventura, Fresno, Stanislaus, Santa Barbara, San Joaquin, Orange, Yolo, Placer, and San Bernardino.

Figure 2-2: Go-live Dates for DMC-ODS for Second Year Counties

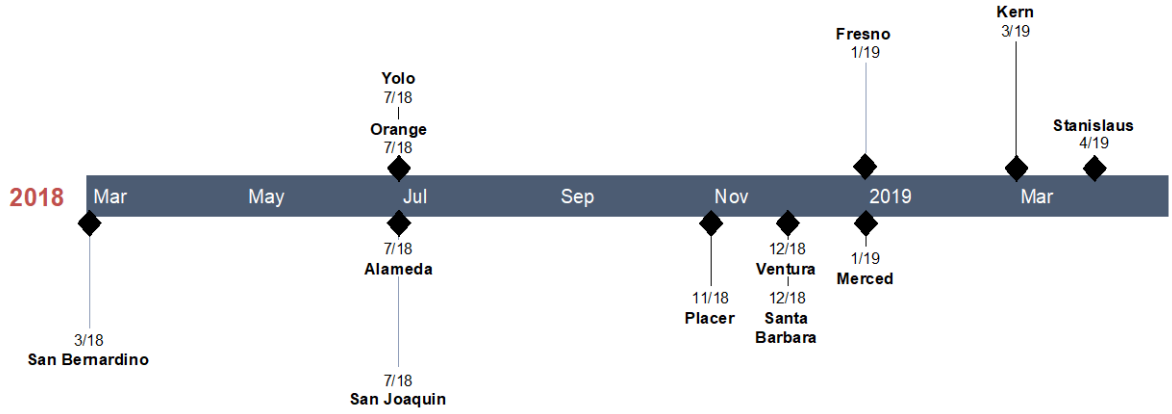


Figure 2-3: Map Showing Pioneer, Second & Year One Counties

Medi-Cal Populations

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 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. They also indicate certain groups with special needs such as foster care, disabled, or elderly and these are tracked separately in data analyses. Definitions used in PMs are included in the Appendix.

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, CalOMS, ASAM referral data required for all clients evaluated for care, TPS annual survey files, Medi-Cal provider files, NA files, and county submission documents. MMEF downloads are requested for the 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 and linked to MMEF data using unique identifiers. BHC refreshed the claims data from two to four times per year to try to obtain the most complete claims data set including older claims that have been denied and then corrected and resubmitted. BHC also uses the provider file and the NACT to determine the providers serving a particular county and the types of care they provide, the languages they offer, and the zip codes they provide services in.

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, UCLA, DHCS, and others. National measures from a wide range of sources were also reviewed including National Quality Forum, CMS, the Veteran's Administration, the Healthcare Effectiveness Data, and Information Set (HEDIS), ASAM, and others. Through this thorough process, CalEQRO identified, and DHCS approved, 12 PMs to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, TPS, CalOMS, and the ASAM LOC data for these measures. All final PMs were reviewed and approved by DHCS, and all evaluation activities are coordinated with UCLA.

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 LOCs based on ASAM assessments, and outcomes linked to wellness and positive SUD status.

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 reviews of specific program data, and documentation of key deliverables in the DMC-ODS Waiver Plan. Specific data is also gathered from each county in supplemental documents. The measures are as follows:

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being provided to unique clients with detailed demographics.
- 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 and age.
- Cultural competency of DMC-ODS services to beneficiaries.
- Penetration rates for beneficiaries, including ethnic groups, age, and risk factors (such as disabled and foster care aid codes groups).
- Coordination of care with physical health and mental health.
- Timely access to medication for those referred to Narcotics Treatment Program (NTP) services.
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured.
- Timely coordinated transitions of clients between LOCs, focused upon transitions to other services after leaving residential treatment.
- Availability of the 24-hour access call center line to screen & 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) based on percent of HCBs at 90 percent of statewide cost or higher, and
- Percentage of clients with three or more 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 and percent referred to recommended LOC (also required by DHCS for counties in their first year of implementation);[6]
- Initiation and engagement in DMC-ODS services across the whole ASAM continuum.
- Retention in DMC-ODS treatment services over time, and

[6] Counties are required to administer an ASAM-based assessment to determine the recommended LOC for clients. The ASAM criteria for screening/assessment and referral of clients examines the congruence rate of assessed LOC to referred LOC, and also tracks the reason(s) for noncongruence. ASAM LOC Data Collection System. Details available from: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf [6]

- Readmission into 3.2 residential WM within 30 days.

California Outcomes Measurement System (CalOMS)

Another important data set for quality improvement is CalOMS. Service providers who receive public funds for SUD treatment services and all NTPs are mandated to report CalOMS data to DHCS for each episode. Providers collect client information at admission and discharge from the treatment program to determine drug use, mental health (MH), living, employment, and legal status. At discharge, providers must indicate whether clients successfully completed treatment, made progress, or had an administrative discharge, meaning the client self-terminated services.[7]

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.[8] There is also a special TPS survey for youth which also measures therapeutic alliance. These are used to evaluate five dimensions of care for each county and statewide and can be linked to specific sites and LOCs. Many counties use these as part of contractor performance.

Data Documents for Counties to Complete

As part of the pre-review preparation, counties submit documents and information and materials for the CalEQRO review team. These are analyzed before the review and used to investigate issues in the sessions. These include:

- Response to prior-year recommendations
- Key changes and new initiatives including goals for the coming year
- Timeliness Assessment of prior year services related to routine, urgent, and NTP requirements, details on how they are measured, business rules and links to claims.
- PIPs (one clinical and one non-clinical)
- Completed ISCA on data systems
- DMC-ODS approved Implementation plan by CMS and DHCS
- QIP and minutes
- Quality Improvement (QI) results of annual evaluation
- Cultural Competency Plan (CCP)
- Organizational chart

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

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

- ASAM Continuum of Care Form current year with all LOC
- Access Call Center Key Indicators
- Provider Enrollment Division (PED) Pending Programs
- Grievance Quarterly Logs
- NA Form and with current NACT form and alternate access standards (AAS) form if appropriate
- Managed Care Plans Memorandum of Understanding (MOUs)

CalEQRO Review Activities

- Review activities onsite or virtually include client focus groups; stakeholder interviews; reviews of plans such as QIPs, CCPs, and PIPs; NA issues; ISCAs; and relationships with managed care health plan and other partners, such as the criminal justice system, access call center focus groups and staff interviews, new program site visits or focus groups, regional management or contract provider interviews, supervisor and line staff interviews, child welfare, criminal justice, hospital, primary care, and health plan focus groups, etc.
- 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 Statistical Analysis Software (SAS), with graphs and figures generated to highlight key findings. NVivo software 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.

Client focus groups include both surveys and client interviews and open questions related to key themes, a variety of LOCs and ethnic groups are sought for CFM groups with translators.

Drafts are reviewed by two parties and then compiles for processing for DHCS review within 30 days of the review. The core template for the report follows the general CMS protocol plus other areas of interest to DHCS within our scope of work and their Strategic Quality Plan and activities linked to goals in the Waiver. It is anticipated this will shift to CalAIM goals when the new Waiver is approved by CMS and the new Quality Strategy is approved and published as well.

2020-2021 BHC-CalEQRO DMC-ODS Statewide Annual Report

Chapter 3

Access

Access

Expanded Services in FY 2020-21 Waiver Programs

Introduction

The DMC-ODS 1115 Waiver has placed a high priority on 24-hour access to information and referral to treatment— critical ingredients for successful engagement of persons with SUD reaching out to seek care. All DMC-ODS programs must have a 24-hour beneficiary access line (BAL) available that is adequately staffed to provide information and screening to link individuals to SUD services. This requirement applies to those who have both routine and urgent conditions as well as 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.

Access requires:

- Outreach Engagement
- No Wrong Door
- Service Capacity

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 go directly to local clinics and non-profit providers of SUD treatment services. Based on community reputation and knowledge many ask for treatment directly though not always at the right LOC. In fact, many counties consider these networks of service providers a better option for community access if they have an adequate number and distribution across the county's geographic areas, easing access for local populations seeking care. These clinics or programs must be able to provide a comprehensive ASAM assessment to match individuals to programs that meet their individual treatment needs.

If they cannot do comprehensive SUD assessments, they cannot function as gateways into the SUD system of care (SOC). Use of the comprehensive ASAM assessment to match clients to their SUD needs and appropriate LOC is another core requirement of the STCs in the 1115 Waiver. For that reason extensive ASAM training in the principles of ASAM assessment and treatment planning services are required.

The 24-hour BAL and the no wrong door treatment approach (which uses both community treatment centers and clinics as gateways to access) are used in the vast majority of counties reviewed 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 LOC*. Is it available? Is there enough capacity? Is the service close to where the client lives, or would it require travel out of the county or 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 provider network, structured and integrated across a continuum based on levels of treatment and intensity, is intended to match the clinical needs of a full range of SUDs including 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 2019-20, both the number and percent of clients served in the 14 DMC-ODS Pioneer Counties increased substantially when compared with FY 2018-19, across all age groups. Trends for six months of data in FY 2020-21 appear to continue that trend as well, but existing data is not complete.

Finding 2 In Pioneer Counties, the number of clients served was also reflected in increased penetration rates for Medi-Cal clients across all age groups from FY 2018-19 to FY 2019-20. Based on the projection of existing data this trend appeared to continue in FY 2020-21 as well even though the data is not complete.

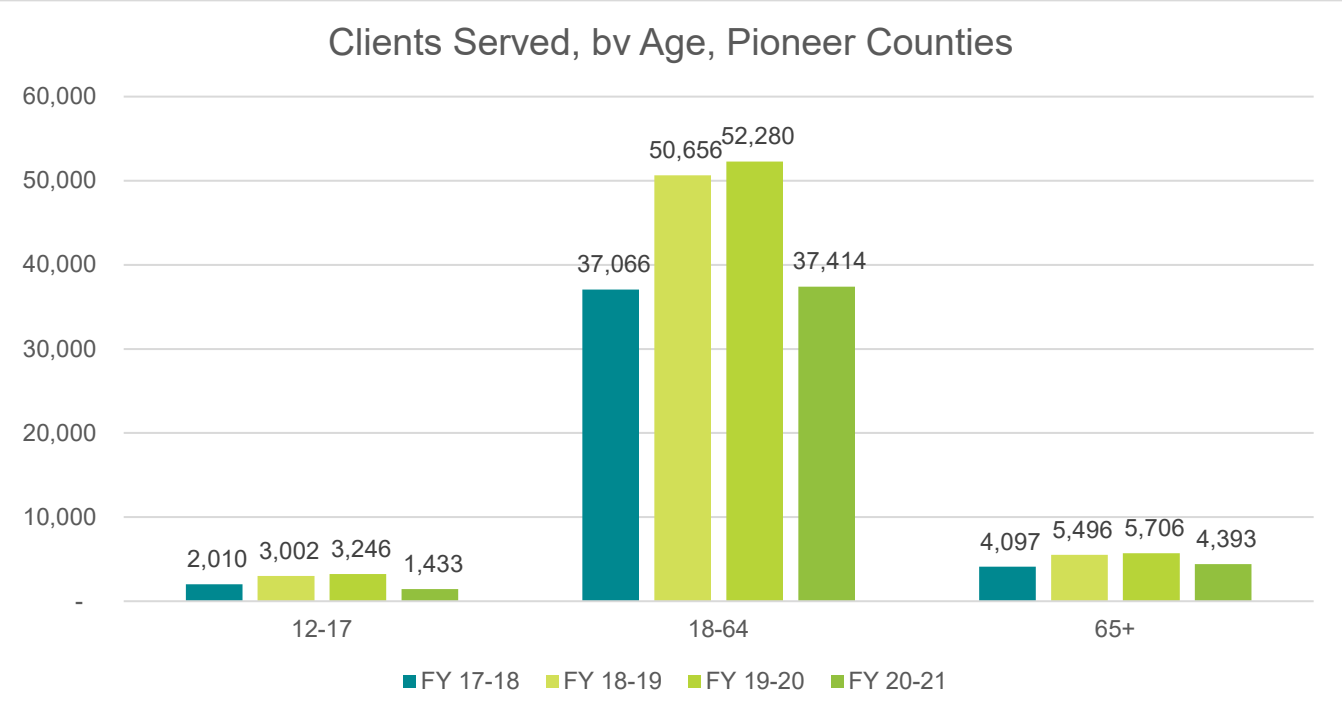
Finding 3 The increase in services for Medi-Cal clients in Pioneer Counties also was reflected across all race/ethnicity groups from FY 2017-18 to FY 2019-20 with the exception of the white population group which was flat in the final year.

Finding 4 COVID-19 impacted access during FY 2019-20 with reduced services but as counties and providers pivoted to telehealth and phone services to provide assessments and treatment, their access appeared to be rebounding back to normal or above normal in FY 2020-21 based on projections for the counties in total.

Finding 5 Clients in focus groups reported that phone and video services, as well as other new methods of getting treatment created by being flexible during COVID-19, such as take-home doses in NTP programs, were critical to keeping services available to SUD treatment in a challenging time. A typical quote from a client focus group was, “I needed my counselor more than ever and the calls and video counseling helped me cope.”

In FY 2019-20, the number of clients served in the 14 DMC-ODS Pioneer Counties continued to increase when compared with FY 2017-18 and 2018-19, across all age groups, as reflected in Figure 3-1. Based on projections, this trend appears to continue in FY 2020-21 though data is available only through December 2020. The increase during FY 2020-2021 has slowed with youth increasing 8 percent and adults and older adults increasing 3 percent. However, the pattern of growth has continued as counties continued to increase their SOC. The numbers of services have expanded each year, from the first to third years of the Waiver, as new services, capacity, and infrastructure have been added to enhance access and engagement. With only six months of data for FY 2020-21 it appears this year will exceed FY 2019-20.

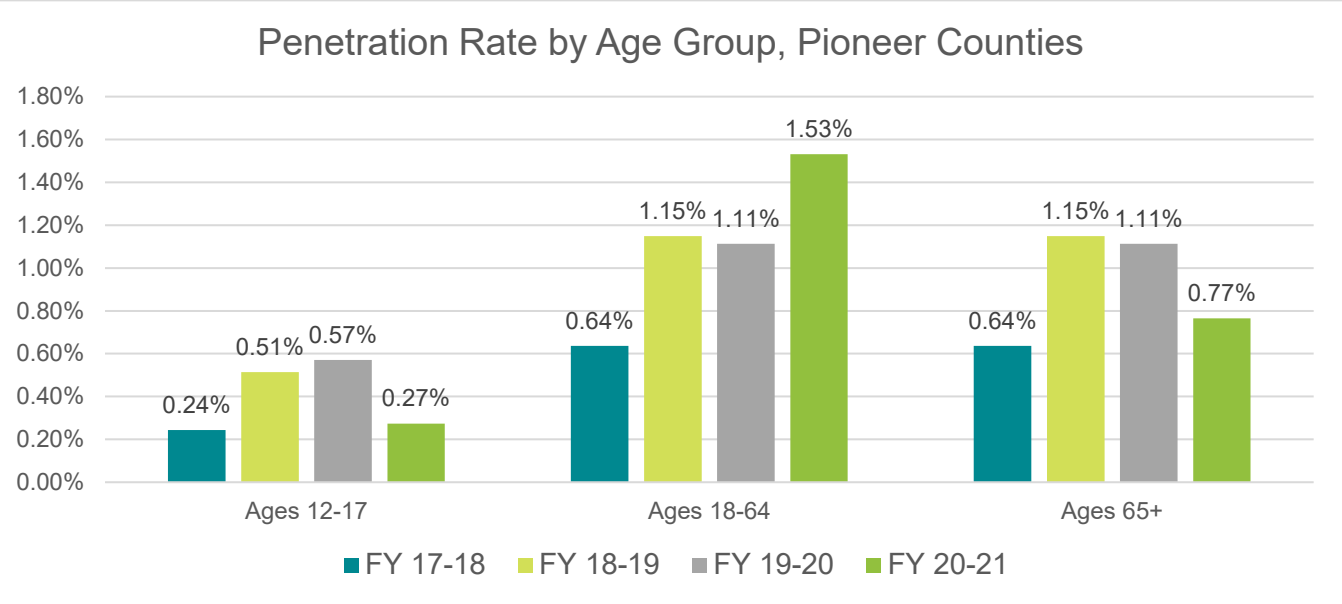
Figure 3-1: Medi-Cal Clients Served by Age Group in Pioneer Counties, FY 2017-21



Note: FY 2020-21 includes six months of data

In Pioneer Counties, expanded access was reflected in increased penetration rates for Medi-Cal youth clients but slightly decreased for adults and older adults from FY 2018-19 to FY 2019-20. Although FY 2020-21 only has six months of service data, it is surprising to see the adult penetration rate be so high. This reflects efforts to expand services in FY 2020-21 despite the pandemic, the addition of the Regional Model program, and four counties. The continued increase in the penetration rate for youth was anticipated. Pioneer Counties continue to expand their systems to better serve and expand care to the youth population. The adult and older adult population decrease is not reflected in overall numbers but seen more clearly in penetration rates by ethnic populations as shown below.

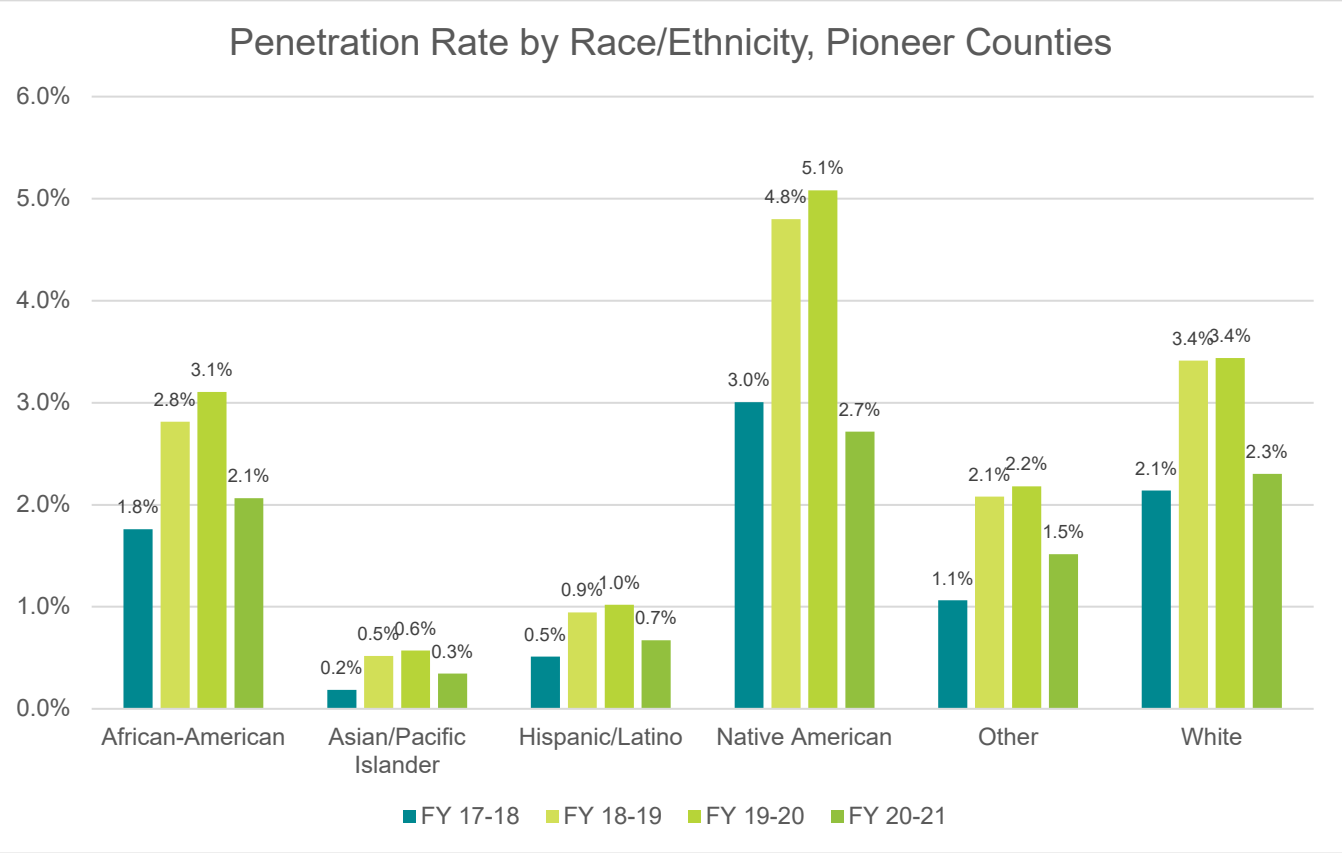
Figure 3-2: Penetration Rate by Age Group in Pioneer Counties, FY 2017-21



Note: FY 2020-21 only has six months of data available at the time of this report

The increase in services for Medi-Cal clients in Pioneer Counties was reflected across all underserved race/ethnicity groups (non-white) from FY 2017-18 to FY 2019-20, as reflected in Figure 3-3. This pattern reflects the targeted work of counties to expand services targeting specific ethnic populations who had previously been underserved. All race/ethnicity groups had some increase in penetration rate except White/Caucasian, a race/ethnicith group which is typically overserved. The growth in penetration rates for all other ethnic populations reflects DMC-ODS continuum of care expansions for specific populations to increase their access and timeliness to services. There was an increase in the number of PIPs focused on expanding services to these populations. Also, it appears that in FY 2020-21 the expansion in penetration rates is continuing but that will not be confirmed until final data is available.

Figure 3-3: Penetration Rate by Race/Ethnicity in Pioneer Counties, FY 2017-21



Note: FY 2020-21 only has six months of data available at the time of this report

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 LOCs 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, RSS, 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 have to operate like managed care plans in overseeing the quality of their networks, selective contracting, and service authorizations, billing, and cost reports. In addition, NA requirements were added in recent years to enhance access in remote areas, with defined time and distance standards.

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

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

Standard 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, naltrexone are required + other 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 MAT (optional)
	3.7 & 4.0 Medical Withdrawal & Inpatient (optional)

As observed over four 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.

Expanding Services to SUD Clients in FY 2020-21

The 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, third, and fourth years, efforts shifted to achieving the full continuum of clinical services with evidence of progress reaching more clients throughout the various regions of the state. Each year, counties make 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. Changes for FY 2020-21 included: increased non-methadone MAT, including seeing more linked to residential sites and coordinated with primary care and EDs; expanded case management; more recovery support services; and outpatient treatment. Smaller adjustments to other services varied across the counties, depending on needs of their continuum of care. The newly launched counties in the Regional Partnership and the four new counties were still working with PED on some of their sites and experiencing billing challenges which is typical of year one counties. Many new counties were trying to add 3.2 WM capacity, and several were attempting to add 3.7 and 4.0 WM but a lack of available or interested potential providers has been a barrier they are addressing. Finally, several counties are working with their hospitals, provider organizations, and DHCS to try to update Medi-Cal clinical protocols for voluntary hospital ED WM to allow for standard-of-practice alcohol use disorders (AUD) clinical assessments and billing processes.

County DMC Best Access Practices

County examples of best practices were plentiful. Starting with the BAL centers, counties such as **Riverside, Los Angeles, Contra Costa** and others invested in call center software that gave them enhanced capacity to manage their access processes and client flow into their care systems.

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.

Some best practices include:

- Many software standard reports provided managers complete caller information, wait times, dropped calls, volumes and times of day, and disposition information on calls, language, and location.
- Software can confirm Medi-Cal status and provide information to assist with accessing Medi-Cal eligibility if needed.

- ASAM-based screening software can triage and recommend/link clients to existing service providers at the appropriate LOC (usually OP or residential).
- BAL can access a real-time SUD resource database for SUD bed and outpatient capacity by location, language, and current vacancies to assist BAL staff in making appropriate client referrals.
- Call center software provides three-way calling capacity for appointments and dialogue with providers, Probation, other partners, and the client, to avoid 42CFR confidentiality issues and allow direct communication between the client and provider for appointments.
- Ability to record interviews for training and supervision.
- Software can include links to historical medical records, if appropriate.
- BAL ability to deploy case managers or recovery navigators to assist callers who need assistance to get to first appointments, especially urgent or high-risk callers who need extra care.

Persons needing residential treatment or WM often need care coordination from the first request for services and may need transportation resources as well as a recovery navigator. These resources are also available to some BALs if needed. **San Mateo** provides a unique engagement approach with specialized case managers embedded in primary care clinics and hospital EDs to support engagement in SUD treatment and MAT services. They have discretion to leave the facilities, and routinely do, when follow-up is required.

Two centers also made referrals for homeless clients to resources even if they did not need SUD treatment and coordinated with other resource banks that have a broad range of resources. The attitude of several counties was, “whatever it takes to get clients access to SUD care and their BAL center staffs, or BAL contractors, were empowered to be incredibly supportive of clients in these efforts. This encouragement from management led to extra coordination activities beyond just SUD referrals particularly with Mental Health, Child Welfare, food banks, and their homeless resource centers. **Orange** and **San Diego** had contractors operating their BAL centers who have ongoing relationships with both counties, and they have extensive knowledge of county operations and systems because of this history. **Kern** has developed a warm hand-off between BAL and provider staff.

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. If this contractor database partnership and infrastructure are well established, leading to systematic tracking, effective management of problems, and improved timeliness of services occurs over time.

It takes time to set up these timeliness tracking systems with a central database, train network staff to always capture this data, set up screening capacity using ASAM and assessment hours, or be able to offer warm handoffs to another site that could do the ASAM assessment if the providers are not able to do it because the client came to the wrong LOC. For most counties, this was a multi-year 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 care. Ideally, programs in the community need to be able to conduct ASAM screenings, assessments, and referrals if they themselves are not the right LOC for that particular client. The no wrong door approach is used in most county DMC-ODS programs but takes time to work smoothly for clients, providers, and the DMC-ODS to ensure the client is receiving the appropriate SUD treatment they need in a timely manner.

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

Kern is contracting with a professional firm to assist in the development of a county-wide awareness campaign to increase community knowledge and they have one of the best, more public-friendly websites, which is easy to understand and navigate. Often county information services design the websites, and it is often difficult to find critical access numbers on internally developed websites. CalEQRO has been having client or family members use the websites to find access numbers and services and provide feedback to EQRO on ease of access. EQRO has increased the number of recommendations to counties on developing user-friendly websites.

"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.

No wrong door services require these access components, full ASAM assessment capacity, and engagement with clients so that clients feel they are not 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 is a real barrier; many SUD clients become discouraged and then do not 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 quality benchmarks to track progress in engaging clients in care. As a result, "four in thirty" is commonly heard as an important quality measure in DMC-ODS counties.

In addition, **Santa Clara** is testing a new promising practice of offering case management as the first encounter to treatment to address each client's most pressing issues and needs. This will occur prior to the assessment. This engagement strategy, studied in a small pilot, showed potential to increase access through initial engagement as a part of the "4 in 30" strategy.

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. Counties expanding access to MAT are partnering with ED Bridge programs, which train physicians and staff in emergency departments (EDs) to screen for substance use disorder, start buprenorphine in the ED for patients with opioid use disorder, and link patients to appropriate SUD treatment. These collaborative initiatives were highlighted for CalEQRO and include **Fresno, Imperial, Alameda, San Joaquin, San Mateo, Santa Clara, Santa Barbara, Santa Cruz, San Diego and others.** These counties work closely with the EDs and other health care programs to better link clients receiving a first dose of non-methadone MAT and to the appropriate SUD treatment. **San Bernardino** is implementing a county-operated clinic pilot for outpatient WM, with a focus on symptom management and use of buprenorphine. They believe this LOC, used for appropriate

clients, will free up capacity in residential WM. They also plan to consider MAT options for clients needing assistance with methamphetamine withdrawal, a growing population in the county. **Marin** developed a robust WM residential program, which is ideal for stabilization and a pathway into treatment.

The findings show the current DMC-ODS programs have been moving in the right direction. Expansion of services, at all levels of care, was a theme in most counties during this fourth year. Youth access through expansion was a focus in **Monterey, Nevada, and Los Angeles. Fresno** expanded MAT access in rural areas. Recovery residences were expanded in **Nevada, Stanislaus, and Orange** though COVID-19 impacted some of the planned efforts by directing management resources to the pandemic.

Maintaining and building on the lessons learned is an important access issue for Waiver renewal. Keeping the core requirements for 24-hour BALs with language access linked to a robust provider network that meets NA standards is essential for the next phase of growth of this benefit.

The impact of COVID-19 occurred in the last quarter of FY 2019-20 as counties responded to state and local shut down orders, pivoted to alternatives to face-to-face treatment, and established telehealth and phone services. The pandemic's impact during one quarter of the FY becomes less visible in annual calculations. The impact varied across counties, but many responded quickly and in a brief time had the same number of contacts with clients but delivered services in new ways. Typical examples of county responses include **Fresno** and **Stanislaus** that deployed equipment to provide remote work capability to staff. This allowed staff to provide continued access to treatment through telehealth. They also offered safe in-person services as appropriate. **Tulare** provided curbside and outside services to accommodate clients. **Nevada** expanded their walk-in model to telephone and telehealth for increased access. DMC-ODS services included increased individual treatment, RSS, and case management services while outpatient, intensive outpatient treatment (IOT), and residential treatment decreased. The Waiver's expanded service continuum mitigated the impact of the pandemic by expanding services that previous to the Waiver were not part of the state plan.

Access Summary

Noteworthy progress in access expansion of SUD services has occurred in these initial 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 many positive design elements. 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 at capacity. Excess demands for treatment within a county's first year led to many expansions of provider networks and contracted services. In addition, the no-wrong-door approach to treatment required providers to document first contact as many clients prefer to seek treatment directly with a familiar organization. The prior, limited information system 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. COVID-19 began to impact access the last quarter of FY 2019-20 as a result of the initial response to state directives. These included having some

staff work remotely, transitioning to telehealth and phone services, and reduction in capacity of residential programs.

Core learnings from Access Call Centers, use of ASAM assessment principles, matching clients to appropriate treatment services (including MAT), and individualized care requirements continue to have 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 multi-year progression as counties build these new clinical services and learn to manage them. Many providers still cling to old models and have yet to fully understand ASAM or discontinue program-driven care, but it is a process.

Graduate and undergraduate curriculums need to evolve to include the latest science in SUD treatment methods for their students to bring this latest learning into practice in the field. Ideally this would, in time, benefit all licensed practitioners of the healing arts (LPHAs), MDs, SUD counselors, registered nurses (RNs), impact facility, professional licensing and certification bodies as well.

In addition to the need for continuing education of the workforce there is the need for expanding the workforce in general to meet the needs in all LOCs. Workforce shortages and access challenges co-exist, and this was a concern and barrier shared by all counties in all reviews. Development and expansion of the behavioral health workforce by bringing new students into the field is part of building an adequate continuum of care.

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Chapter 4

Network Adequacy

Network Adequacy

Introduction

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

Overview of Network Adequacy Findings in FY 2020-21

Finding 1 Most of FY 2019-20 ten DMC counties with approved AAS **added providers within their counties as well as in neighboring counties** to reduce time and distances for their Medi-Cal beneficiaries. These additional providers reduced the number of problematic zip codes and beneficiaries impacted by NA issues. Orange County no longer required any AAS approvals due to a new NTP provider in the south of the county.

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

Finding 3 All DMC-ODS Counties and the Regional Model were measuring timeliness to services, transitions between services, as well as other quality measures. SUD contractors without practice management systems and EHRs had difficulty tracking timeliness. Infrastructure improvements are needed to make these systems reliable and stable to meet these timeliness requirements and key NA measures.

Finding 4 **Limited internet access** for client services in remote and frontier areas is a serious barrier to quality care, affecting both telephone and video telehealth options, as well as coordination of care for clients and client engagement strategies.

Finding 5 **NTP access** for adults and youth accounted for the majority of the NA time and distance problems in the 2020 counties with ten counties and the Regional Plan needing AAS. Only three counties and the Regional Plan had zip codes requiring AAS for additional providers for youth and adult outpatient services to meet NA requirements.

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

To decide NA, each county submitted a detailed description of its network of providers—including their languages, locations, and capacity—in a document called the NACT. The NACTs were thoroughly reviewed by DHCS to find which counties met time or distance standards in 2019 and 2020 to identify which need to submit an AAS request or find and add new providers to meet the time and distance standards.

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

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

Timely Access	Within 10 business days from request to appointment
Time and Distance Standard: 15 miles/30 minutes	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara
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, NTP/OTP services must be provided within 3 business days of request. Outpatient SUD services must be offered within 10 business days for routine appointments, and 48 hours for urgent appointments without authorizations and 36 hours for services requiring authorization.

Best Practices to Expand Access in Remote Zip Codes

Over the last two FYs DMC-ODS Plans have implemented many strategies and mitigations to improve access for Medi-Cal residents in remote zip codes. These approaches are discussed in some depth in individual county reports, but several are highlighted here as examples of best practices for other counties or other Regional Models to consider.

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

1) Negotiated with existing outpatient or NTP providers within their network to expand and add new sites or add adult or youth populations to existing sites to meet NA and community needs.
2) Partnered with providers to identify property and locations to meet NA needs and worked with NTPs particularly on the land use permitting processes, including neighborhood meetings, court challenges, and assistance with rents and start-up costs.
3) Reached out to behavioral health and program directors in surrounding counties to partner with them by adding new or expanding existing programs near the borders of both counties, to enhance capacity and expand populations served in ways that benefited both counties' Medi-Cal members.

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

4) Where populations needing MAT were small and a full NTP/OTP was not feasible, sought medical partnerships with primary care and hospital providers to establish access to MAT clinics that could offer co-located SUD counseling and telehealth capacity and consultation, and also offer prescribing via X-Waivered prescribers for MAT.
5) Explored new service location options with input from 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. Focus groups also led to new sites in community centers, churches, and schools with unused space for limited days per week and some new mobile capacity.
6) Expanded knowledge through focus groups with potential out-of-network providers, and explored the desire for telemedicine, phone consultation, counseling options, and internet options for remote areas through schools and library supports, along with other opportunities to enhance other services such as residential. Also based for feedback added internet kiosks for health access.

County Best Practice Examples for Improvement Efforts

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

Partnership Regional Model is working with two NTP providers to add new sites and has created an extensive network of primary care providers doing non-methadone MAT and behavioral health outpatient counseling in the region. These providers assist with some of the remote access needs for those with opioid use disorder (OUD) while these other projects are in development. Also, active solicitation of new providers is part of their plan with the seven counties to expand their network across the ASAM continuum, not just in outpatient and NTP/OTP services. It is posted on an ongoing basis on their website.

Contra Costa DMC-ODS also worked with local providers to add needed outpatient services for youth and adults in some remote areas to address NA needs. They also worked with an NTP/OTP provider

who faced an exceedingly difficult land use issue trying to open a facility in Concord. The case went to court and the provider eventually won; they are now trying to open and become licensed and certified and when this occurs it can address their NTP needs. Contra Costa also has worked extensively with surrounding counties to add more providers and contracts closer to some residents on their border areas, 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 still working on some zip codes to meet time and distance standards to meet the NTP needs.

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 outpatient and NTP contracts with other counties to meet their members' needs in San Francisco, Santa Clara, Alameda, and will also add a contract in Santa Cruz to be more convenient for residents that work or live on border areas. They also have worked to add capacity on their coastal region which has some remote farming areas and to address their NTP need they are added the contract with Santa Cruz which is more convenient for members.

Next Steps for Network Adequacy Expansion

CalEQRO documented plans for more outreach and engagement activities by the 10 counties with AAS for FY 2020-21 and documented their plans and strategies for improvement in of capacity in the next year, hopefully without excessive COVID-19 pressures. The flexibility of telehealth and phone services and medication access via primary care and pharmacies were and are also helpful dimensions of access and are critical for isolated areas with little transportation, homebound elderly and disabled, and those without time because of intense traffic, work, or childcare limitations. Expanded telehealth options have made more reliable wireless internet access in remote areas more essential to services for all populations. However, there are areas where phone and internet access are poor. For these internet gap areas counties are working with schools, libraries and setting up some public kiosks to allow for access in some cases with other public services or health providers.

Key Timeliness Measures for Initial Appts & First Dose of Methadone

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 NA requirements for youth and adult populations. NTP/OTP and outpatient access are an important requirement for NA in the DMC-ODS plans.

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

Tracking all of the new managed care data including timeliness in the first few years of DMC-ODS services is very difficult with the many different systems and lack of EHRs at the contractor level and not shared database systems or interoperability. Also, some of the major behavioral health software programs cannot track offered appointments, and many contractors do not have EHRs making tracking of many basic metrics difficult. For counties that cannot track offered appointments they track requests to actual first face to face or billable visit, usually the ASAM assessment.

Table 4-3 below includes three primary measures: offered routine appointments, actual routine appointment times from request to actual first billable appointment, and methadone dose after evaluation measured in FY 2019-20 and again in FY 2020-21. As stated not all software can measure offered appointments and some counties have dispersed access systems with many points of entry making tracking requests extra challenging. A few counties have gates including with partner agencies such as Child Welfare, thus some do not have the offered appointment data. Nonetheless, 13 DMC-ODS programs improved their offered appointment times in FY 2020-21 and 15 improved in actual timeliness of first billable face to face or video appointments. These improvements were notable in that the time period of July 2020 through June 2021 was dominated by COVID-19 pandemic management. SUD service delivery involved extra challenges delaying access to such services as drug testing, in some cases requiring client isolation prior to access, and increased need for telehealth or telephonic access. System challenges also involved introduction of response procedures such as access to personal protective equipment (PPE), staff being ill or reassigned to emergency centers, and vaccine distribution.

In addition to the data on timeliness, client focus groups are specifically asked about timely access to care and the TPS also has questions related to this specific issue. Finally, BHC also reviews Quarterly Grievance Log Complaints which DMC-ODS programs are required to send to DHCS related to access. Combining these sources of information, it is often possible to find patterns of access or timeliness problems in specific programs. These findings generate recommendations for improvement and further inquiry.

Table 4-2: Average Timeliness for Routine Appointments in Days, Methadone Doses, FY 2019-21

County	FY 19-20 Time Offered	FY 20-21 Time Offered	FY 19-20 Time Face to Face	FY 20-21 Time Face to Face	FY 19-20 Methadone Dose	FY 20-21 Methadone Dose
Alameda	5	2.6	5	3.6	1	1
Contra Costa	8.3	5.6	9.4	6.4	1	1
Fresno	6.19	1.5	15.64	23	1	1
El Dorado	-	5.88	-	7.99		1
Imperial	15	10	18	8	1	1
Kern	-	-	8.72	5.2	1	1
Los Angeles	5	5	10.8	11	1	1
Marin	2.3	1.78	3.8	1.8	1	1
Merced	8	6.8	8	9.5	2	1
Monterey	4	3	6	4	1	1
Napa	5.4	-	14.7	8	1	1

County	FY 19-20 Time Offered	FY 20-21 Time Offered	FY 19-20 Time Face to Face	FY 20-21 Time Face to Face	FY 19-20 Methadone Dose	FY 20-21 Methadone Dose
Nevada	4	3	5	10	1	1
Orange	4.7	2.24	4.17	4.26	1	1
Partnership	-	-	-	5.15	-	1
Placer	-	-	39	20	1	1
Riverside	5.1	3.7	5.1	4.2	1	1
San Bernardino	-	-	39	28	1	1
San Diego	2.9	3.1	3.8	3.9	1	1
San Francisco	1.3	3	3.9	9	1	1
San Joaquin	-	1	2.9	1.9	1	1
San Luis Obispo	2.63	1.87	3.75	7	1	1
Sacramento	-	29	-	45		1
San Benito	-	5.18	-	5.6		1
San Mateo	-	1	31	30	1	1
Santa Barbara	5	5.2	6	5.3	1	1
Santa Clara	12	6	17	9	1	1
Santa Cruz	7.25	-	7.81	11.2	1	1
Stanislaus	7	4	8	5	1	1
Tulare	-	8	-	13		1
Ventura	-		13.6	21	1	1
Yolo	-		28	34	1	1
Average	**5.4 days offered**	**5.1**	**11.9 days**	**11.2**	**1 day**	**1**

Times to Access Initial Appointments

All of the DMC-ODS counties were able to meet requirements related to average times to methadone dosing within 3 days after assessment. 65 percent achieved average times for routine face-to-face outpatient appointments within ten business days in FY 2020-21, although some did not yet have software and infrastructure in place to track offered appointments. Based on FY 2020-21 ISCA data more than 50 percent of contract providers still lack EHRs. This situation was quite common in DMC-ODS counties. A rare commitment to county-wide EHR systems is that of Los Angeles, Sacramento, and Santa Cruz which funded Avatar for the contract agencies that did not have EHRs. Most DMC-ODS programs have this as a goal, but few have the resources to develop this capacity. Partnership Regional program also aided 50 percent of its providers to get EHRs to support managed care billing and quality metrics. As said in previous reports, this lack of infrastructure for EHRs and core data analytics remains a handicap for the DMC-ODS system at both the county and contract agency level, compared to what exists in primary health care and hospital systems which benefited significantly from federal meaningful use funding.

The most common NA issues of unmet needs 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 provider options for solving these remote zip code area issues than was the case with the NTP/OTP gaps. Out-of-network providers are easier to find or develop in outpatient than in NTP/OTP areas because of the different requirements.

Strategies used to address some of these time and distance challenges were described above. These are discussed in depth in individual county reports posted on the CalEQRO.com website. The Partnership Regional Plan has by far the largest number of zip codes with problematic time and distance issues related to NTP/OTP as for many years there were almost no NTP/OTP programs north of Sacramento in California. It was reported by many who attempted to open programs that much of this was due to stigma and a belief that if there were no methadone clinics, there would be no one using heroin in the area. So, there was political opposition to adding these programs. Since then, the region obtained a number of Hub and Spoke grants with extensive partnerships for non-methadone MAT with primary care clinics with case management services which have many clients taking part in them. Also, Native American Health Centers are providing non-methadone MAT.

Summary

During the first and second years of implementing NA, the DMC-ODS counties and Regional Model worked with their provider networks, other counties, out-of-network providers, primary care partners, and community leaders to improve their provider network sites through a variety of strategies. Through these efforts they were able in many cases to reduce the number of zip codes requiring AAS approvals for youth and adult services for outpatient and intensive outpatient, but also for NTP/OTP programs as well by some additions, but mostly by contracts in neighboring counties. Where it was not possible to add new NTP/OTPs they were frequently able to add access to telehealth MAT and/or primary care MAT or both including SUD counseling for local beneficiaries in remote and frontier areas. DHCS completed the review of the NACT and AAS forms on time and coordinated changes of standards with the counties as required including working on capacity issues. Published documents were on the internet site for DHCS and clearly defined the NA requirements. Regular trainings were also provided related to requirements and documentation, and these were required and posted by DHCS.

The DMC-ODS counties and the Regional Model were making efforts to track timeliness with their software and access systems which were still being refined to carry out this task especially linked to new providers coming into the network. NACT forms included all the required details of each county's provider networks in terms of legal entities, sites, and clinical staff and service estimates 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 with detailed mitigation efforts. 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. In each review these plans are followed up on to see what has been accomplished.

Each year, CalEQRO completes a thorough review of the NA plan and all NA documents from each DMC-ODS county and DHCS. Client focus groups and grievance reviews also are conducted to identify problems and efforts at improvement.

Cell phone coverage, cheap cell phone access for low-income and homeless individuals, and internet access in remote and rural areas would be an incredibly positive enhancement to these rural and frontier areas in terms of access to critical health services. If options become available in the infrastructure legislation for these it would be positive for health access.

CalEQRO will follow-up each year on the proposed changes in the AAS to enhance the network and expand access and document improvements and other findings.

Chapter 5

Timeliness

Timeliness

Progress in FY 2020-21 Waiver Counties

Introduction

The DMC-ODS continuum of care and the 1115 Waiver 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 primary concern in substance use treatment programs is that many individuals who are admitted do not return to begin the treatment program.[9] "Typically, the longer substance users have to wait to be admitted to treatment, the more likely they are to not follow through with treatment."[10] 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."[11]

Timeliness requires:

Infrastructure

Regular Data Review

Actions to Improve

In order to be successful in tracking 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 actions 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 that increases timeliness throughout the whole continuum of care including both county and contract providers.

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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Overview of Major Timeliness Findings

Finding 1 In FY 2020-21, **all counties report tracking timeliness of critical metrics** including initial requests, first face-to-face visit, and first dose of methadone, 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 the 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. A central system linked to all providers is essential for success to track key metrics.

Finding 4 The **COVID-19 pandemic** impacted timeliness during FY 2019-20 between early March through June because of forced closures of offices, reduced staffing, and program redesigns to provide telehealth and phone services. Residential delays were the most prevalent due to census reductions and testing delays for access occurring in many counties.

Finding 5 Despite COVID-19 pandemic impacts, timeliness improved in FY 2020-21 in many counties based on rates for the year at the time of the reviews.

Tracking Timeliness

Time to First Offered Appointment

Timeliness begins with the first contact from the potential client, which is usually a request for service. Data must be collected consistently at the first point of entry, whether that is at the BAL or at some other entry point in the system, such as a contract provider location or a drop-in clinic. The data below reflect the average time from first request to first offered appointment is 5.1 days, well below the standard of 10 business days, and a reduction of 0.5 days when compared to the prior year. The data show 85.3 percent of clients are offered an appointment within the 10 business days. The first offered appointment is important because it measures the system's responsiveness to supply a timely service. The data below represents the counties that were reviewed in FY 2019-20 and FY 2020-21; some had software that could not track offered appointments, but all counties were able to track the time from request to first actual clinical appointment which is a billable visit.

5.1

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

Table 5-1: Timeliness Metrics for Time from First Request to First Offered Appointment, All Counties, FY 2019-21

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

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 actual 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 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.

11.2

In FY 2020-21, average days from request to first face-to-face appointment was 11.2 days.

The first clinical service metric standard is measured as 10 business days from the initial request for service to the first billable service encounter. The data below represent all 37 counties that were reviewed in FY 2020-21 including those seven in the Regional Model.

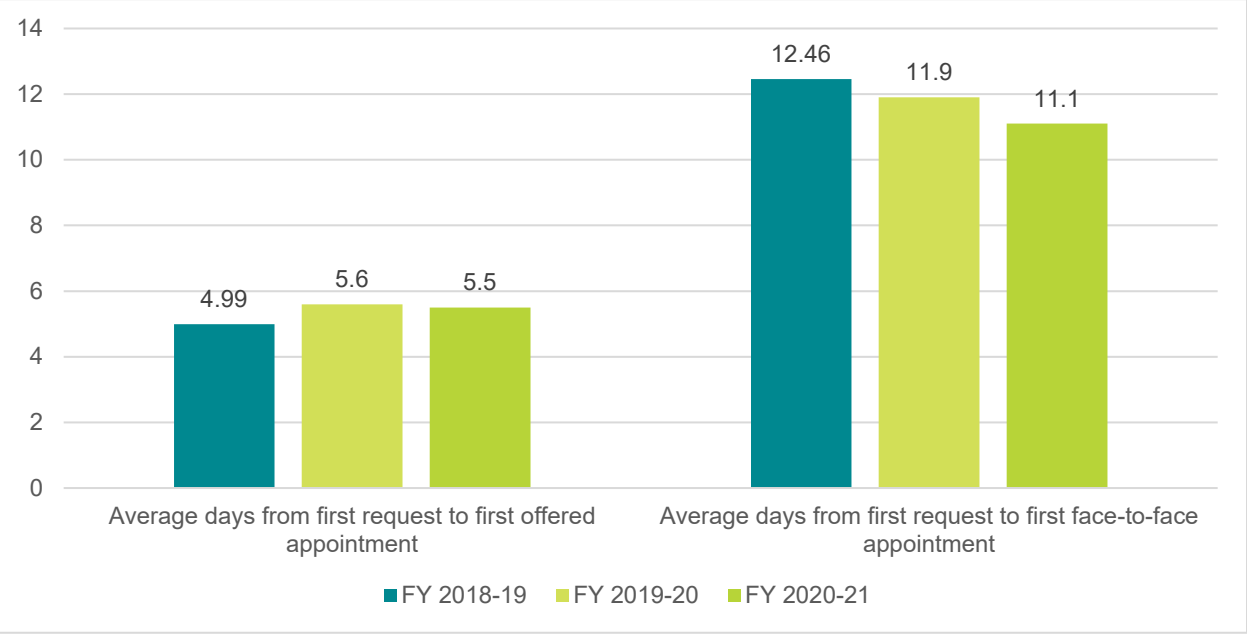
Table 5-2 below shows that the average of 11.2 calendar days from the first request to first face-to-face or video appointment is timelier than the standard of 14 calendar days or 10 business days. Of those served during the review year, 73.3 percent attended their first face-to-face or telehealth appointment within the ten business-day/14 calendar-day standard, while 26.7 percent did not. The trend over three years continues to move toward reducing the time to the first clinical service appointment.

Table 5-2: Timeliness Metrics for Time from First Request to First Face-to-Face Appointment, FY 2019-21

Average Time from First Request to First Appointment	FY 2019-20	FY 2020-21	Difference
Average length of time from first requested to first billable appointment (in days)	11.9	11.2	0.7
Timeliness Metrics and Percent Meeting the State Standard for FY 2020-21	**% Meeting the Standard**	**Minimum**	**Maximum**
First requested to first billable appointment (10 business day standard)	73.6%	26.0%	98.7%

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 2018-19, FY 2019-20, and FY 2020-21 as the time periods compared. This is reflected in in Figure 5-2, comparing the timeliness rates over a three-year period, and showing that overall, time to the first appointment decreased from 12.46 days to 11.2 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. Also, as counties add new providers and sites, their overall measures may go down for a while as those new providers adjust to timeliness monitoring and tracking systems and adjusting workflows to speed up admissions. It is also important to be able to measure timeliness of access to each specific program and site and LOC to easily find problems.

Figure 5-1: Comparison of Review Years, DMC-ODS Timeliness, FY 2018-21



Time to First Methadone Dose

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. Because individuals in need of medication are especially sensitive to delays, and any delay has the potential for treatment abandonment the metric for medication timeliness is shorter than that of routine appointments. The standard is measured as 3 days from first NTP assessment to first appointment for NTP medication services, which is also when they receive their first dose of medication.

1.0

In FY 2020-21, average days from assessment to first MAT appointment in an NTP was 1.0 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, naltrexone, and disulfiram. Methadone has been a standard in the field for many years and is 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. Methadone can be started immediately, even when the person is not fully withdrawn from opioids, and Buprenorphine also allows for start-up without tapering off current opioids. However, some MAT medications require a delay before beginning medication so the client can be tapered off their current opioid.

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 in how they operationalized 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. Some definitions rely on federal priority populations (such as pregnant and IV drug users), some on ASAM criteria of severity, and some on locally developed criteria, such as hospital referrals. The Waiver requires a clear, local definition to track requests coming from multiple sites. Counties continue to develop and revise the definition of urgent appointments, a critical step in tracking urgent services. Some definitions appear to be more like acute care definitions and require an acute care response, others are so loose it is not easy to determine if the call or request fits the definition of urgent for staff at the BAL or program.

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 the other timeliness measures in the EHR or other established tracking mechanisms. The data in Table 5-3, Urgent Requests, below represents 19 of the 26 counties that were reviewed in FY 2019-20, and 33 of the 37 counties in FY 2020-21 reviewed. This continues to be an area of growth for counties. Of the counties reviewed in FY 2019-20, the EQRO scored ten counties as meeting this requirement to track urgent appointments, six that partially met this requirement, and ten that did not yet have this measure operational.

In Table 5-3 below, for FY 2020-21 the average length of time from request of an urgent appointment to the appointment was 5.74 days, a reduction of 7.66 days compared with the prior year. The average

length of time does not meet the standard for this metric of 48 hours although there was considerable improvement. Further review shows that only 51 percent of clients requesting an urgent appointment were seen within 48 hours. All but four of the new counties, were tracking timeliness for urgent appointments.

Counties have made progress in defining urgent requests, with 90 percent of urgent visits tracked based on their specific county definition, but that does not mean there is not continued confusion based on these definitions, and what counts as a successful response. Additional key tasks for successful tracking of urgent requests are as follows:

- Train staff on the process of identifying and documenting urgent conditions and needed appropriate treatments including potential barriers.
- Develop data systems to capture urgent requests and urgent appointments or contacts. (Sometimes mobile case management or counselors are deployed as a response to requests to help the client meet their needs.)
- Develop reporting systems for staff to enter data and capture these services and efforts.
- Add quality review systems with regular data reviews to monitor progress.
- Evaluate what changes are necessary so clients with urgent conditions can be identified quickly and seen within 48 hours.
- If definitions are determined to be acute and not appropriate as urgent, consider a modification.

Table 5-3: Average Length of Time for Urgent Appointment, FY 2019-21, All DMC Requests

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

Infrastructure Development

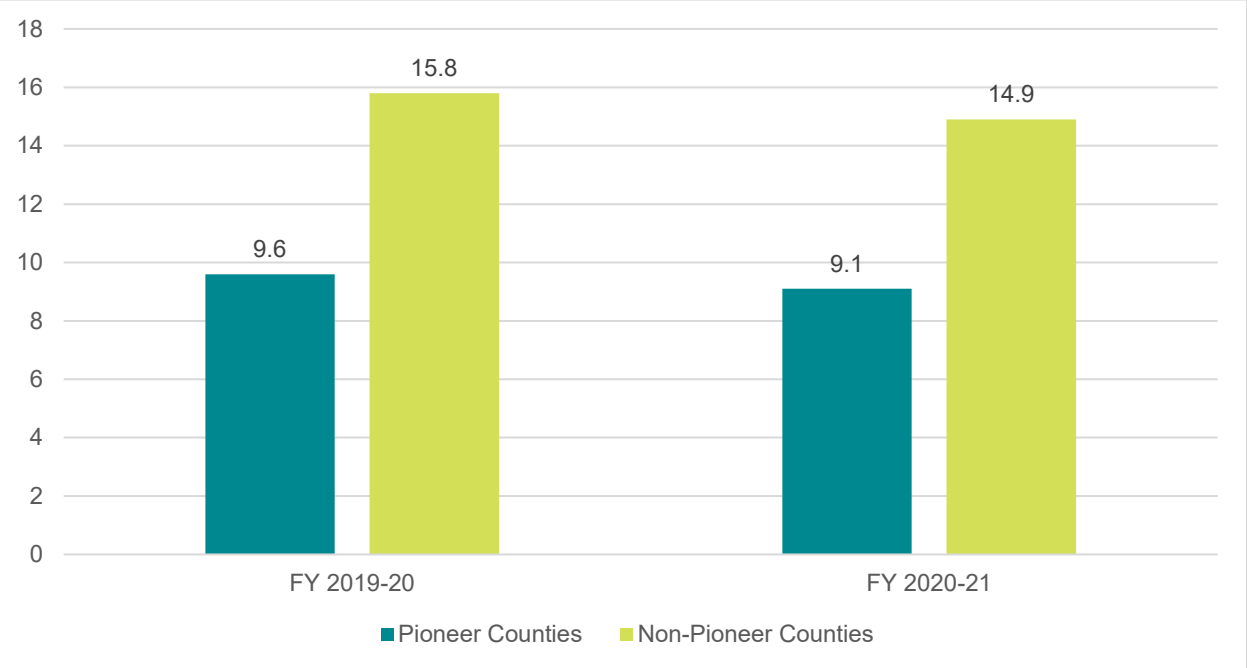
Many counties developed mechanisms to capture required metrics as part of preparations for their first year of implementation, but many counties took the first year or more to further develop basic infrastructure to track the new Waver required timeliness measures for access to treatment. Infrastructure is critical to collect available data to improve timely access to appropriate care and manage clinical service capacity across the provider network. These requirements were all new to the DMC Medi-Cal system and needed to be planned with providers given over 80 percent of services are delivered by contractor providers, not the counties.

Infrastructure building continues to improve the quality of timeliness data.

An example of this developmental process is to compare the Pioneer Counties to the non-Pioneer counties using the metric of the average number of days from request to the first face-to-face or telehealth 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 to increase consistency in reporting.
- Increasing tracking mechanisms for all providers across the SOC.
- Administrative changes to reduce the time of specific service functions and add for intake capacity.
- 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 Non-Pioneer Counties, FY 2019-21



In the individual county reviews, many counties showed an increased number and quality of timeliness metrics year-over-year. Metrics can be in place and still need refinement so tracking that occurs across

the system, program by program, site by site requires dashboards. Even if the measurement is in place in the first year, it may take that entire year or the next year to ensure that reports are distributed regularly so that staff and management can review the timeliness data and put in place system interventions/changes necessary to increase timely access to treatment services. Barriers must be identified and removed systematically.

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, often site-specific actions to address timeliness as needed.
- Brief screening (which usually differentiates between outpatient and residential) to get to the correct LOC as quickly as possible.
- Expedited processes (including case management and transportation if needed) to the appropriate LOC for ASAM assessment and treatment to begin.

Without a brief screening, consistent delays occur in access to treatment, resulting in an increased number of beneficiaries who leave services. Counties with centralized assessment programs often experience delays in providing appointments and increased numbers of potential clients abandoning attempts to enter treatment. 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 for Timely Access to Treatment

Infrastructure best practices include (1) the development of ongoing reports and dashboards that are regularly available; (2) review timeliness dashboards by county and contract provider staff; and (3) use data for clinical and administrative process improvements. Examples of county infrastructure development include:

- **San Diego** set up timeliness tracking to create monthly reports that track year- to- date average time to access for each provider site location. They use this data as a tool to increase timely access to services across the system.
- **Merced** created a functioning data committee and process to support reporting functions (dashboards and other reports needed). They facilitate collaboration between program managers, data analysts and IT staff, disseminate reports to managers, staff and other stakeholders, and discuss barriers and supports for clients and programs.

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 decide the general LOC needed. Clients have historically gone directly to community providers for service; many counties have developed systems that ensure this practice is tracked and put into a central database as a service request. This requires developing systems that track clients starting at the BAL as well as multiple provider sites or drop-in clinics across the whole continuum of care.

Developing an electronic database standard for all these service requests that can track across the entire continuum of care is critical. Many counties have linked these databases to a systemwide authorization system which ties all the providers together for other functions such as billing or exchange of information. If the county and providers share an EHR or ASAM tools, those can also be used as the

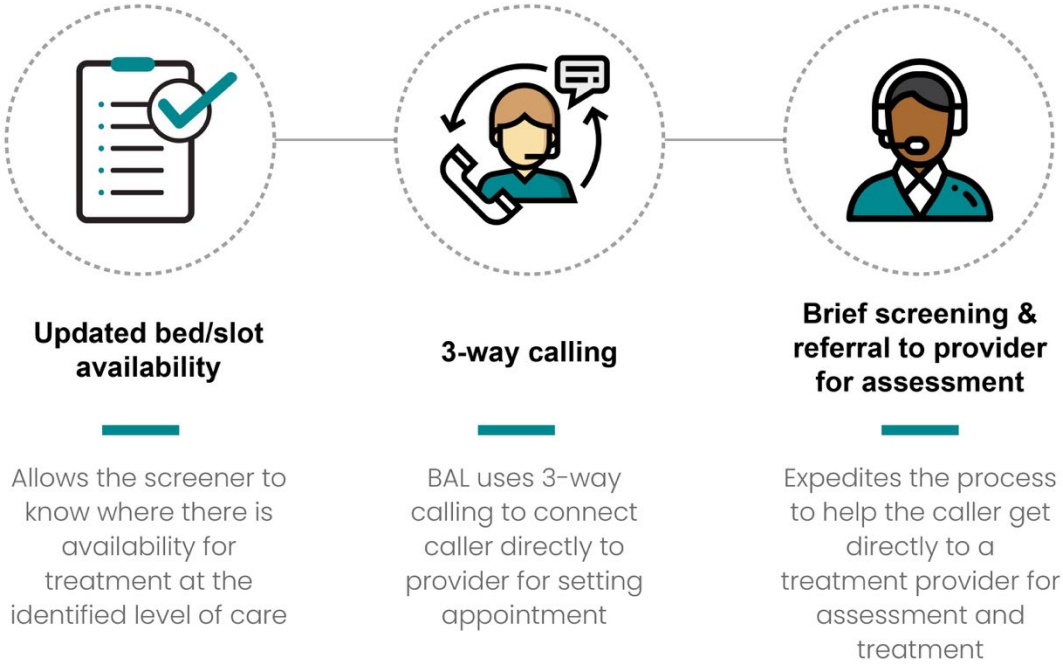
platform for the shared database. However, adding timeliness to these tools has taken county resources and planning to develop. It is challenging because most of the continuum in DMC-ODS is operated by small nonprofit providers with limited IS infrastructure and limited connectivity to county systems.

Examples of excellent cross-network databases for capturing service requests include the Service and Bed Availability Tool in **Los Angeles County** and the **Contra Costa** SUD resource database application for tracking daily capacity at all 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. They also document all requests and utilize the BAL to help with transfer options, and the BAL in **Contra Costa** is linked to a Transition Team to help clients gets where they need to be and remove barriers.

Additional strategies include developing linkages between clients and treatment providers. These can include multiple access points for clients, linkage of potential clients through EDs to services, hospitals, or health clinics to SUD treatment. Peer mentors can also provide clinical assistance to assist client linkage and increase timeliness. In addition, county or provider operated walk-in clinics that offer same day assessment and referral to treatment can increase timeliness.

The brief screening process used by many counties expedites the client to the appropriate LOC where a full assessment takes place. The use of brief screening tools has been increasing within counties that have previously completed a registration process and then offered a full assessment. When the county completes the full assessment, this ensures 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. There are pros and cons to all models and each county must consider its own dynamics and resources for the model that best fits their circumstances. All models require excellent communication between counties and providers and a true focus on individualized treatment for the client based on their unique needs.

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



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

- Brief screening to determine initial LOC. **Santa Clara** has an excellent tool in place and UCLA's Brief Questionnaire for Initial Placement is also available for free. These brief screening tools usually differentiate between outpatient LOCs and residential LOCs.
- 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 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 system seamlessly as treatment begins.

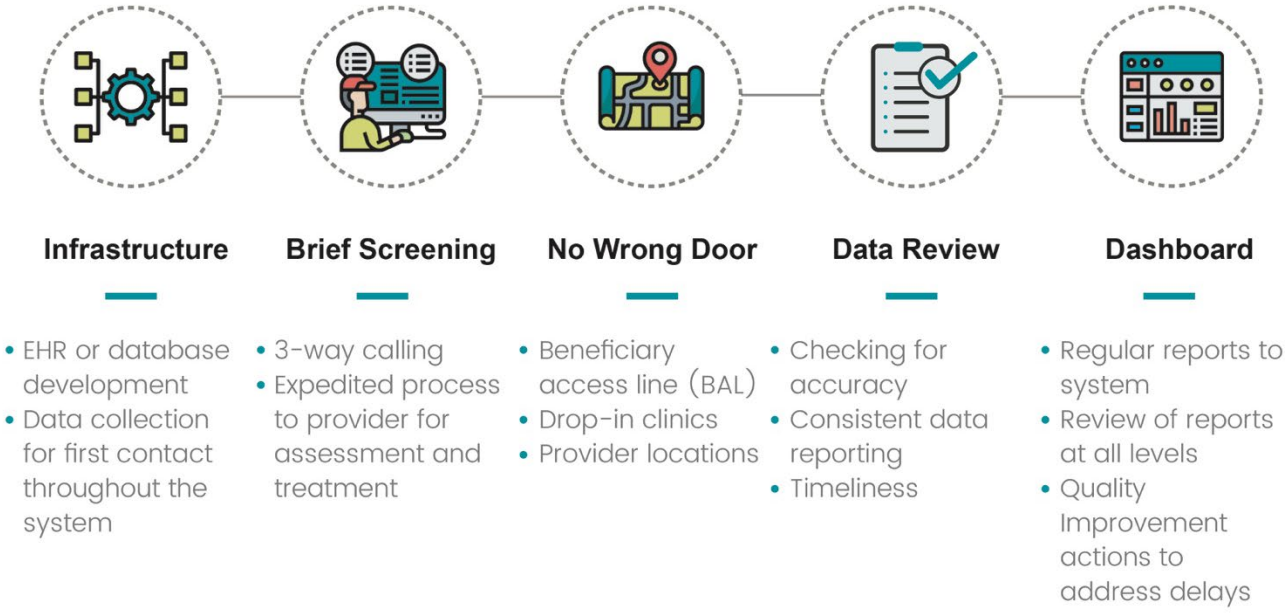
Multiple models work, in both centralized and decentralized systems, to achieve timely services. However, they require coordinated infrastructure and communication systems. Centralized systems can sometimes over-manage the flow of clients, resulting in bottlenecks and decreased timeliness. Decentralized systems must develop strong first-contact reporting systems at the provider site; if not, links to timeliness and services cannot be tracked.

Examples of best practices include:

- **Monterey** developed a first-contact form which enables tracking timeliness data for clients who access services directly through provider contact. This is an EHR- based form and the county provides training and support to improve the data captured from provider contact into the SOC.
- Walk-in clinic models in **San Luis Obispo** and **San Joaquin** for SUD, allow easy access to brief assessment and referral to treatment, and work well in both this medium and this large-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. It is particularly 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.

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



Lessons Learned

One barrier to infrastructure is the different EHR systems that are used by counties and the network of contract providers. These systems vary in sophistication and many use paper charts instead of EHRs. 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, but in a managed care environment they are essential.

Counties lacking a software infrastructure and dedicated staffing are not as successful at tracking timeliness, authorizations, critical billing, or quality metrics which often lead to many challenges. 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 possibly not counting all events with 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 has caused delays for many counties to achieve tracking and timely responses to urgent conditions in their first year of implementation. This is not as large an issue as it is in physical health and may require different definitions for different age groups, but it is important to keep working at this refinement for the benefit of individuals seeking services.

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 shift for counties and providers in tracking the entire treatment episode for a client, rather than each treatment LOC and service separately in a siloed fashion. It requires coordination among multiple treatment providers and the county to ensure clients can continue to receive the proper LOC in a comprehensive way. This requires enhanced care coordination to ensure prompt treatment for clients during any transition between LOCs and a knowledge of the care system and ASAM. This is still evolving but especially important as case management increases each year as one of the new services.

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

COVID-19 reduced DMC-ODS capacity in all counties as a result, in part, of staff working from home, staff reductions due to illness, staff childcare issues, and staff personal choice. Timeliness was affected by the reduction in the number of residential beds in facilities due to required social distancing for safety. The duration of the transition to telehealth, and impact on counties beginning March 2019, was varied depending on each county's readiness for such a change.

County Examples: Working to Improve Timeliness

Youth SUD treatment expansion was a focus in **Contra Costa, San Diego, and Monterey**. Timely access can only occur if there is sufficient availability of services. Youth services were limited in many counties initially, but expansion, outreach, and engagement are seen in multiple counties.

Los Angeles, San Joaquin, Ventura, San Mateo, and Stanislaus are focused on improving timeliness from their access points for all age groups. **Los Angeles**, a centralized system, has continued to focus on its Substance Abuse Services Helpline, with quality monitoring, client feedback, addition of more providers, and efforts to increase timeliness by streamlining the transitions for clients into care.

San Mateo regards requests for NTP and other MAT services as urgent and sets a high standard of 24 hours from initial request to first appointment. They also track timeliness from referral by the hospital ED for MAT to first appointment at the primary care clinic. This is unusual for a DMC-ODS to track, since the providers are not certified and are not billing within the DMC-ODS system. San Mateo stations a team of case managers at the ED and deploys them into the community with a heavy focus on MAT engagement including those with AUD on injectable medications plus counseling and other supports. They also funded two formal outcome research studies on the impacts of the integrated medication assisted treatment program on hospital EDs and admissions with positive results.

Fresno is deploying an access data dashboard that will give system providers current information on key metrics on timely access. This will allow them to work together to coordinate timely access.

Timeliness Summary

Timeliness is a core element of quality of care, especially for those with SUD whose motivation to engage in treatment care fluctuates quickly with circumstances. It is critical to make access to the appropriate LOC 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 can begin to benefit with understanding their SUD and have greater potential to make progress in managing their illness.

The DMC-ODS STCs have set clear timeliness expectations for all county and Regional Model plans for offered appointments, both routine and urgent, and for NTP/OTP assessment 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 meeting state standards. While challenges remain, counties are making progress and improvements.

Challenges linked to quality can be improved upon by working together with DHCS partners as well as local providers. Provider infrastructure is a barrier which will be noted in several areas of quality of this annual report besides timeliness. DHCS as part of its Quality Strategy could prioritize unspent SAPT block grant funds for this type of infrastructure development in the SUD non-profit systems focused on improvements linked to quality such as timeliness tracking, access BALs, and EHRs that link key providers to the county networks that lack EHRs. Aid for more HIE and interoperability funding as well as EHRs for the small non-profits would also be a positive development.

Another enhancement to support timeliness and quality would be to focus on expanded access to case management and care coordination for the clients and remove as many barriers as possible for the provision of case management by staff, including interns with bilingual skills, and peers with appropriate training and lived experience.

In summary, counties are addressing the many hurdles related to timeliness to services, with each county designing systems and processes that meet the unique needs, populations, and geographic issues of their particular county. With continued effort increasingly timely access with be available to those with SUD conditions which is a very positive outcome.

2020-2021 BHC-CalEQRO DMC-ODS Statewide Annual Report

Chapter 6

Quality

Quality

Improvements in Care in FY 2020-21

Introduction

The DMC-ODS 1115 Waiver STCs define and promote a model of care based on principles of individualized treatment across a system of science-based treatment options that are accountable for the quality of the care they provide. The STCs include many specific quality-oriented requirements and EBPs. This chapter highlights those activities essential for successful treatment of SUD, some of the challenges that DMC-ODS counties have faced in establishing and monitoring SUD quality care, best practices and successful strategies they demonstrated, and important opportunities for improvement. These will be reviewed at the system level for this last year of reviews, including the efforts of the new Regional Model and some specific LOCs with challenging issues.

Overview of Major Quality Findings

Finding 1 In FY2020-21, counties and the Regional Model expanded client-centered treatment to add more types and capacity of SUD services within the continuum of care based on ASAM models, even with the COVID-19 challenges.

Finding 2 Care coordination and recovery support are linking services and clients, though the full potential of these services in the SOC is yet to be realized.

Finding 3 Counties continue to enhance Quality Improvement Committees (QICs) with plans and monitoring systems to improve care quality and meet meaning goals overall including those linked to cultural competence and underserved populations. The securing of accurate and complete data must include efforts to fix fragmented infrastructure and supports that were not required for SUD services prior to the 1115 Waiver.

Client-Centered Treatment

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 isolated silos. Each of the 30 DMC-ODS counties and Regional Model reviewed by CalEQRO in FY 2020-21 experienced a variety of challenges to meet the Waiver's requirements for a full continuum of care in FY 2020-21. This was needed so the DMC-ODS plan could offer services customized to clients' individualized SUD conditions and needs. All counties did share challenges this year related to workforce issues and COVID-19. Others also had challenges with expanding and adding new sites due to resource competition and more neighborhood issues. However, many were able to expand in modest ways, and all made great strides in conversion to telehealth technology and new methods of engagement in care themselves and with their provider network.

As indicated in this report's Access Chapter, the predominant types of DMC-covered LOCs treatment services prior to the Waiver were NTPs and outpatient treatment. All the DMC-ODS counties have or are setting up DMC-certified residential treatment at one or more levels as well as residential WM programs, expanding outpatient and intensive outpatient, physician consultation, case management, and expanding MAT medications at the NTPs, and RSS. Established DMC-ODS counties that are not in their start-up years are adding Waiver-optional programs including MAT outpatient, more levels of residential care and expanded capacity, youth services across the continuum, and inpatient medically monitored and medically managed WM programs for adults, youth, and perinatal populations (ASAM levels 3.7 and 4.0), and a few are opening partial hospital and outpatient WM. This slow but steady expansion has given clients and families more choices, more local and regional options, and improved timeliness of access. Because of COVID-19 as well as distance, transportation challenges, and mobility issues, many clients have liked the flexibility of having telehealth options as well.

Below is a summary in Table 6-1 of the Waiver options versus the original State Plan DMC Medi-Cal program services. Partial Hospital is not listed but is also an optional DMC-ODS service as is additional MAT options, particularly non-methadone MAT linked to outpatient or residential programs which is expanding.

This does not include the many partnerships and joint projects with the primary care clinics, particularly the federally qualified health centers (FQHCs).

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

DMC	DMC-ODS
Outpatient Drug-Free Treatment	Outpatient Services
Perinatal Intensive Outpatient Treatment	Intensive Outpatient Services
Perinatal Residential Treatment (16 beds only)	Residential Treatment Services 3.1,3.3,3.5 (No bed limit)
Inpatient Hospital ED Vol Detoxification	WM (residential 3.2)
Narcotic Treatment Program Services (methadone)	NTP Services with Methadone, Buprenorphine, Disulfiram, and Naltrexone
	Recovery Support Services
	Case Management
	Physical Consultation
	Additional MAT (optional)
	3.7 & 4.0 Withdrawal Management & Hospital

Some key areas needing further development include all levels of WM, RSS, case management, recovery residence housing, youth services at all LOCs, and ASAM 3.7 and 4.0 LOCs. All these services appear to be under capacity in terms of prevalence of need if National Survey on Drug Use and Health (NSDUH) data are used to determent prevalence and need for county youth populations.[12]

Client focus groups and stakeholder groups of providers also echo these themes in most counties reviewed this year. For example, clients note that having a case manager has been extremely helpful in removing barriers to treatment and service level transitions. Many DMC-ODS counties are still just developing their case management services and only a small percent of clients has access to this service. County and contractor efforts to expand new SUD program sites have also been challenging due to neighborhood resistance and stigma, along with ongoing difficulty with the state certification process as expressed by counties and providers.

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

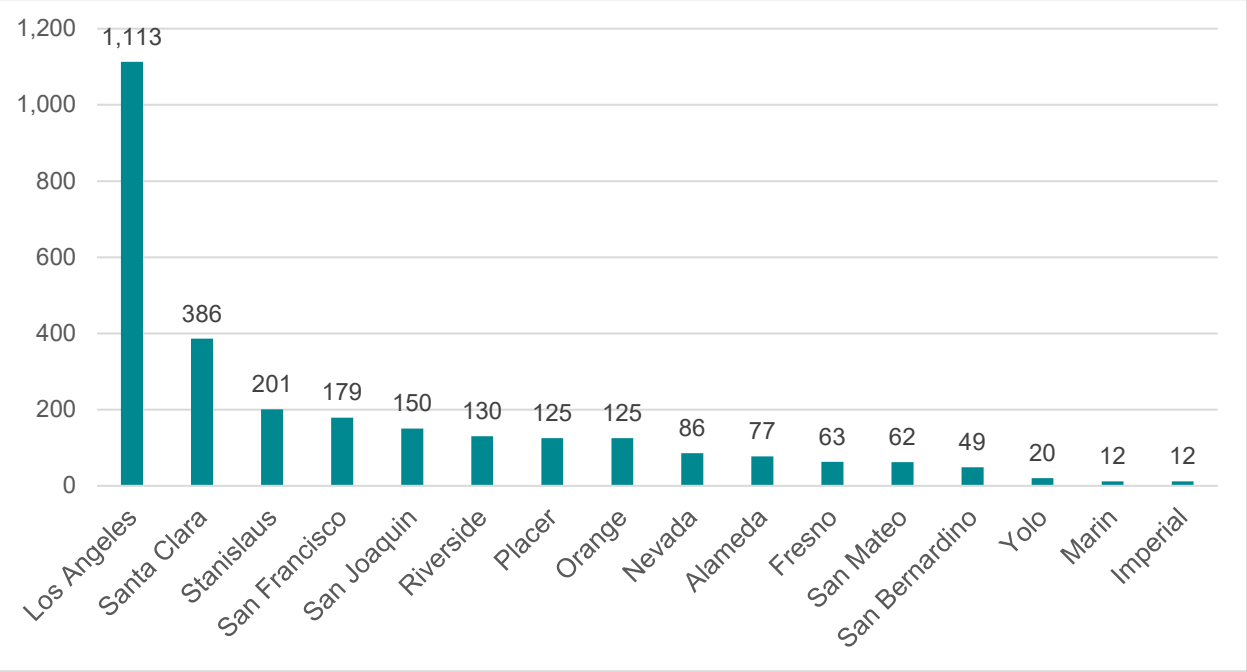
Access to recovery residence housing is a particularly important part of the continuum of care which was an issue in every county visited. Where housing costs were higher and shortages of available housing were more acute, the issue was exceedingly difficult and impacting the care system at many levels.

[12]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.

California obtained approval from SAMHSA to use some of its Substance Abuse Treatment Block Grant funds for recovery residences in combination with treatment. Likewise, some DMC-ODS counties have been able to add beds utilizing funds from criminal justice reform programs AB 109, Proposition 47, and other local sources in partnership with key referral partners whose clients frequently need SUD services. Many DMC-ODS counties have established or expanded these recovery residences to help stabilize clients in their recovery process.

Los Angeles has the largest number, reporting 1,113 beds, an increase from the 956 beds when they were reviewed the prior year. Los Angeles also saw an increase in need with a reported 8 percent increase during the COVID-19 pandemic, providing 18,654 bed days per month. **Santa Clara** led the way for the rest of the DMC-ODS counties, with 386 beds followed by Stanislaus which has 201, including 79 beds for women with children and one site with six beds for men with children. Finally, while **Nevada** has just 86 beds, for a small county this equates to one recovery residence bed for every eight DMC beneficiaries receiving services, while **Los Angeles'** ratio is one bed for every 22 clients served. While proportional bed availability varies between counties, each DMC-ODS continues to seek bed capacity based on need. Quality and security of recovery residence facilities has been enhanced in some DMC-ODS counties where, often in partnership with outside entities or other county agencies, written standards have been established and sites are subject to routine monitoring to secure funding. 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 stabilization, successful ongoing transitions to outpatient, and participation in outpatient care. 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



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 adult residential programs, partnerships, and co-locations with FQHC clinics for treatment, and a contract for Residential 3.7 WM care. Since beginning DMC-ODS services in February 2017, Riverside has continued to add capacity in many regions and LOCs to meet local needs as demands for

treatment have increased and changed. Riverside was the first county to launch DMC-ODS services and has continued to show many best practices benefitting other counties.

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

The DMC-ODS demonstration Waiver sets up a continuum of care modeled after the ASAM principles and criteria for treating SUD disorders, based on the SUD field's latest clinical science. The ASAM criteria create an objective set of standards for SUD assessment and treatment, giving clinicians guidelines for individualized treatment assessment, and for identifying the least restrictive treatment services to provide a safe, supportive recovery environment for individuals to improve their symptoms and enhance functioning and wellness.

Early opt-in counties understood the importance of initiating DMC-ODS services with an ASAM-capable workforce and began training early. At implementation, clinicians needed to be able to evaluate clients accurately and efficiently for medical necessity, establish which SUD-specific services would benefit the individual the most and make LOC treatment 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 the client-centered, chronic care management model of behavior change. This extensive training and use of the six ASAM dimensions to assess clients and develop individual treatment plans and goals has helped to address outdated, program-driven models and beliefs, including those from large referral sources such as the court system.

The Partnership Counties particularly discussed using ASAM training to educate criminal justice and child welfare workers. It has helped to bring them into the DMC-ODS SOC as partners in community health improvement efforts. 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 SOC 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. Several 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.

Assessment accuracy and proper use of LOC recommendations are measured by congruence between ASAM findings and subsequent referral at the times of initial screening and full 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 adherence to the principles of client-centered care. In addition, the ASAM principles address individually tailoring treatment to address the changing needs of each client over time through periodic reassessment.

Pioneer Counties have had the most experience matching client initial screening with their program continuums and in general Pioneer Counties have developed the most complete range of treatment options. Nevertheless, all three groups matched recommended LOCs from 76 to 90.6 percent of the time. While experience or missing data may account for some variations, overall, the results for matching clients to expressed and assessed needs is high.

Table 6-2: Congruence of LOC Referrals with ASAM-based Screening Findings, Pioneer, Year 2, and Year 1 County Comparison

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

Best Practices Using ASAM

Santa Clara and **Santa Cruz** designed Assessment and LOC and ASAM reassessment tools in their EHRs to make it easier for staff to use and integrate ASAM into daily workflows and clinical skills. Many other counties also are following this model and working with software vendors to add these tools into their EHRs. The DMC-ODS Treatment Plan tool in EHRs can identify the linkages between the ASAM dimensions and severity ratings and the associated identified problems and goals/objectives. These counties' QI staff conduct monthly monitoring of sampled charts, focusing on the use of ASAM criteria for LOC treatment planning, service delivery, and ASAM-indicated transitions of care.

Sacramento, a first-year implementation county has recently moved to the ASAM- based assessment and data indicates a very strong level of congruence at all three points of intake into the care system. Sacramento had high congruence between ASAM LOC referrals and LOC placements in initial assessment (94.8 percent) and follow-up assessment (97.1 percent) in FY 2019-20, well above the congruence findings statewide. While the congruence was lower in initial screening (82.6 percent) this was due to patient preference. Sacramento has since introduced an ASAM -based screening tool and is continuing to train and review assessment results through both active contract content monitoring of providers and a PIP.

Los Angeles uses ASAM Triage and Continuum software linked to its EHR which is available systemwide including to all its providers. 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 much more complete and more detailed than tools used in other counties. More analysis will yield many helpful insights, including learning more about treatment effectiveness of services for different populations.

ASAM criteria and clinical model encourages treating relapse as a learning experience as well as ensuring access to all beneficial and evidence-based treatments, including MAT for OUDs and AUDs. DMC-ODS counties have made policy changes to require treatment programs to accept clients who need MAT and continue seeking ways to continue working with clients who have relapsed, or to temporarily transfer them to a more intensive, appropriate LOC (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 MAT

In addition to COVID-19, California counties remain in a public health crisis because of opioid addiction and overdoses. Fatal overdoses are at their highest rates since the beginning of the opioid epidemic, with a steep climb noted in 2017[13], thus making rapid availability of MAT to treat opioid use disorders more important than ever. Methadone and buprenorphine are drugs used to treat OUDs and have been

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

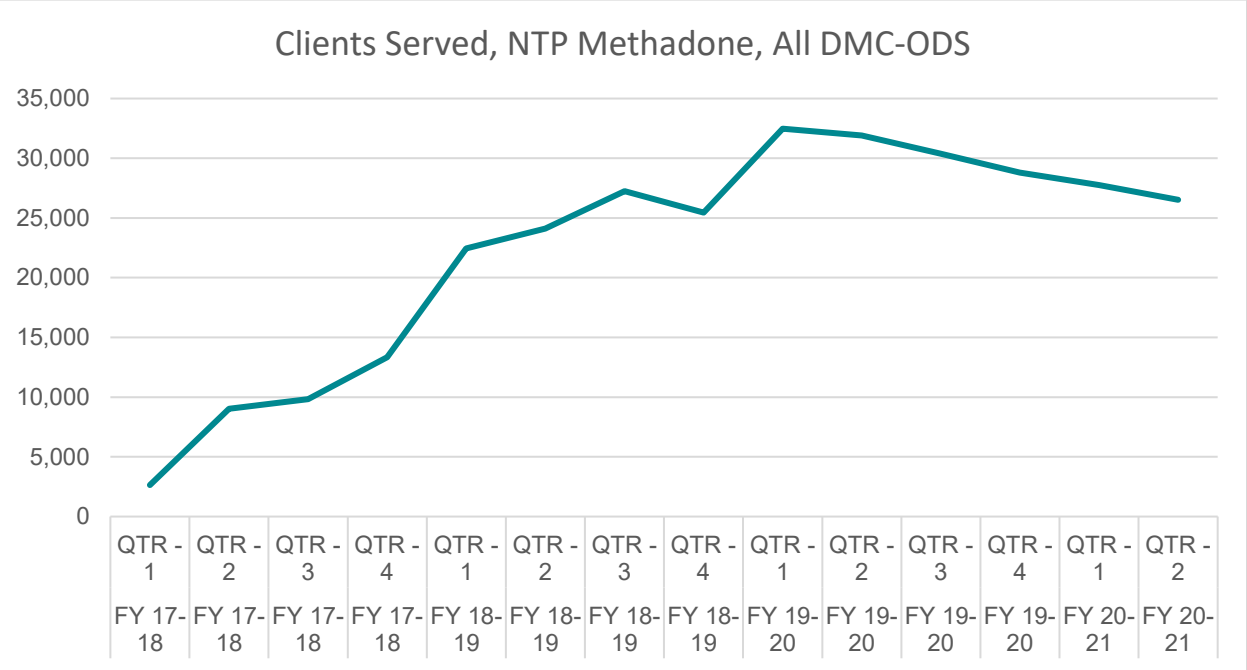
[13]Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Vital Statistics Rapid Release. Provisional Drug Overdose Death Counts. Accessed from: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

established as the gold standard of treatment by the National Institutes of Health.

Despite many challenges, the California DMC-ODS counties have made steady progress through a variety of different programs and approaches to increase access to MAT. The move to increase and expand MAT services has been slower for some counties, especially those with limited providers. It is worth noting that **Nevada C**ounty, 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 the provider, Aegis. They have established a medication outpatient unit in Grass Valley and for clients who would benefit from additional clinic services utilized transportation services through the local health plan, which is rated highly by both the provider and clients to access those outpatient MAT services in a remote rural area.

Individual counties noted that in FY 2019-20, despite changes to allow for increased home dosing, many NTP clinics saw a drop in enrollments at the onset of the COVID-19 pandemic. Figure 6-2 shows clients served in NTP programs using claims data from July 2017 to December 2020 per quarter and the steady growth of these services. There are two impacts that lowered the numbers in the Medi-Cal claiming numbers. First, was the introduction of NTP/OTP coverage by Medicare as a primary payer of services and approximately 18 percent of clients statewide did have Medicare as well as Medi-Cal due to disability or age. While this varied by county it did impact the number of persons showing up in the Medi-Cal claims numbers starting in 2019 and 2020 as providers obtained Medicare certification and billing capacity. Additionally, the start of COVID-19 in the first quarter of FY 2020-21 with the mandatory quarantine lowered the number of persons served. Programming changes in the future will allow the Medicare primary group to be tracked by adding new fields so the total number of primary Medi-Cal and Medicare/Medi-Cal clients can be monitored. It is also important to note that regulations do require a face-to-face examination with a physician for entry into the Methadone program, other services can be done with telehealth, but this service does involve a physical examination, and this caused delays in access after the quarantine order was issued.

Figure 6-2: Clients Served, NTP Methadone, All DMC-ODS, FY 2017-21



Despite this drop in utilization of methadone, every DMC-ODS county surveyed demonstrated overall access improvement and improved adoption of MAT, including many non-methadone forms, particularly overdose prevention medications. Access to non-methadone MAT, particularly buprenorphine and other FDA approved medications was enhanced by partnerships with FQHCs, county health plans, grant-funded projects in EDs and jail collaborative programs. Statewide there has been an increased number of X-Waivered physicians and midlevel providers (nurse practitioners and physician's assistants) who prescribe in the community and many are linked to county and community clinics.

Several counties such as **Orange** and **Imperial** have or are in the process of establishing MAT services within county-run sites. In these cases, the clinic expansions of MAT were championed by strong medical directors, support from department leaderships, and utilizing the psychiatry staff of an integrated behavioral health department. Orange also has formal assessment protocols for the use of MAT for those clients enrolled in its DUI program and like many other counties have well developed projects to locate inmates with SUD histories within their detention health programs. They provide MAT screening and induction for qualified candidates prior to release. Overall, timeliness was excellent on average with NTPs in counties able to provide dosing in one day or less after admission.

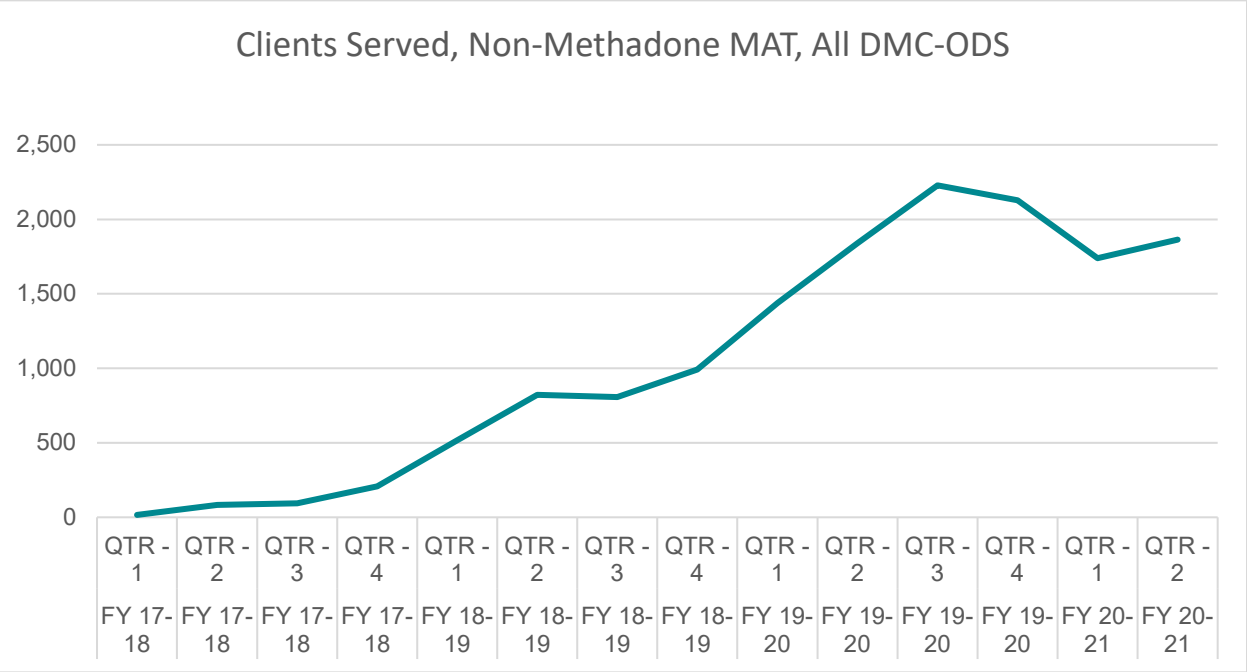
Penetration rates for non-methadone services was difficult to accurately determine because many MAT services are provided through Medi-Cal managed care, fee-for-service (FFS), or programs that do not bill DMC-ODS and thus there are no claims data available. Many DMC-ODS counties tried to gather basic numbers as they are frequently coordinating care and providing counseling.

While many counties have not secured FFS non-methadone MAT pharmacy estimates, **Los Angeles** has been able to secure usage and prescriber data, year over year for **Los Angeles** Medi-Cal FFS Pharmacy Data. In 2010 there were 30 patients who received 149 prescriptions for buprenorphine, which rose to 1,472 patients in 2015 receiving 5,677 prescriptions. The most recent FFS data indicates that 4,096 patients received over 23,000 prescriptions for buprenorphine in 2019.

Similarly, **Los Angeles** reported a marked increase in non-methadone MAT clients within its SUD SOC, from 62 persons in FY 2017-18 to 712 in FY 2019-20, a rise of 1,048 percent. **Los Angeles** also monitors the increase in X-Waivered prescribers, by discipline, noting just 793 physicians in 2016 which rose to 1,715 in 2020. While there were no X-Waivered nurse practitioners in the county in 2016, there were 218 in place for 2020. Beyond the capability to track and trend these improvements, Los Angeles has actively participated in medical training and orientation for physical health on SUD and the benefits of MAT within the healthcare system.

In Figure 6-3 the clients served with non-methadone MAT is also shown demonstrating a slow and steady rise in services during the Waiver. More details on the breakdown of the medications prescribed is provided in the charts provided by National Drug Code (NDC). It is important to note that many counties have extensive partnerships with FQHC primary care clinics providing non-methadone MAT and their data which is billed through the FFS Medi-Cal system is not available to BHC at this time. Thus, it is important to remember this DMC-ODS non-methadone service is only a portion of the non-methadone MAT provided through the Medi-Cal program.

Figure 6-3: Clients Served MAT, Non-Methadone, All DMC-ODS, FY 2017-2021



As a best practice, all these MAT examples were 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 medical inductions for clinic referrals with support and MAT education.
- 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 the MAT expansion project initiatives.
- Integrated criminal justice behavioral health services and referral into SUD community clinics and programs.
- Access Call Centers, including FQHC clinics providing MAT in their resource directory for referrals for programs and the public.
- Inmate facilities incorporating the use of MAT prior to and upon release from custody.
- Referrals for MAT assessment for individuals with an alcohol dependence diagnosis or recurrent DUI episodes.

A powerful resource for continued adoption of MAT is leadership in the community. Beyond the capability to track and trend the improvements noted above, **Los Angeles** has actively participated in medical training and orientation for physical health on SUD and the benefits of MAT within the healthcare system. They have actively engaged with SUD counselor certifying organizations to ensure adequate focus on MAT in their curriculums and have established local MAT learning collaboratives within its own SUD system and in the broader healthcare system, including primary care. **Los Angeles** has taken leadership in training allied agencies within the county on the importance of MAT and

messaged the community through targeted education campaigns designed to promote MAT utilization across the county. This has been enabled through the development of public service announcements, web-based media platforms and mobile-friendly access tools for anyone needing SUD services. Finally, as MAT represents the most effective treatment in most circumstances for opioid dependent clients, Los Angeles requires that providers establish formal referral relationships with MAT programs and acceptance, or refusals be documented in patient charts.

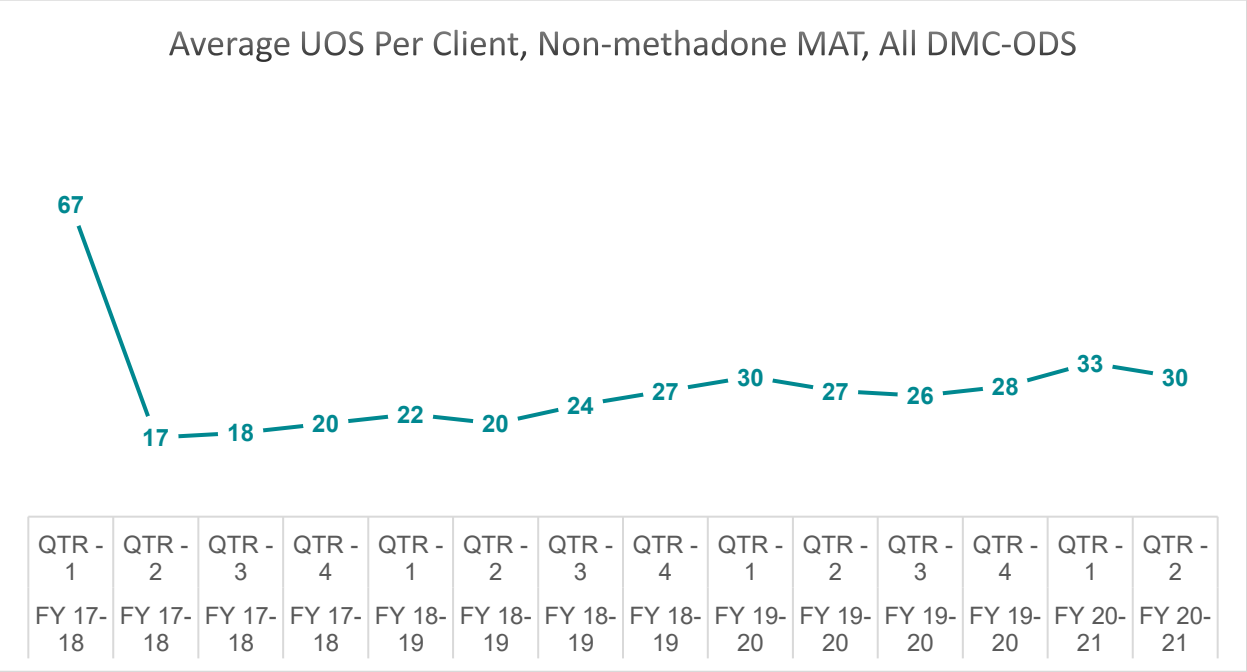
Leadership from local physicians and healthcare is also a key part of coordinating MAT expansion. **Santa Cruz** has worked with its local public health partners to provide many trainings for prescribers. Physician groups have set up a mutual support group that involves X-Waivered doctors who have experience to work with newly certified practitioners to supply clinical support and assuage hesitancy to use MAT. The local County Organized Health Plan, Central Coast Alliance, also developed a care-based incentive program to encourage primary care physicians to sign up to become X-waivered while also bringing in pain specialists to review current best practices and reduce over-prescribing.

As noted in the last Annual Report**, 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. San Luis Obispo, like many counties, distributes naloxone to clients receiving treatment for opioid use disorder, should an overdose rescue be required. They do regular trainings for overdose prevention and involve the public.

In addition to securing standard client access to naloxone , the overdose reversal agent, many DMC-ODS counties lead or actively participate in community- wide opioid safety coalitions. Such coalitions often have identified primary target areas and measure impacts of initiatives that focus on education, prevention, and promoting use of MAT and other SUD services. Because of the multi-agency representation often found in these groups, they present an opportunity to share expertise and reduce stigma regarding the nature of addiction. Information garnered from allied agencies has allowed DMC-ODS to review overdose data, information on the nature and agents involved in overdose fatalities, and understand local trends, giving them early notice on shifts in the overdose epidemic such as the surge of methamphetamine and drug traffic patterns for lethal drugs such as synthetic opioids like fentanyl. There is strong support for these coalitions that are often also working on prevention, overdose, and treatment issues related to other drugs as well, particularly methamphetamines and alcohol.

Figure 6-4 shows the average units of service for non-methadone MAT medications per quarter, and this includes prevention medications, such are Narcan, which are being broadly distributed through grants to clients and caregivers to prevent overdose deaths.

Figure 6-4: Average UOS for Clients, Non-methadone MAT, All DMC-ODS, FY 2017-2021



Implementing Evidence-based Practices (EBPs)

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 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 SOC, the Waiver required that providers implement at least two of the following EBPs: Motivational Interviewing (MI); Cognitive Behavioral Therapy (CBT); Relapse Prevention Therapy/Treatment (RPT); trauma-informed treatment; and/or psychoeducation.

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

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, **Kern** has sponsored extensive training for county and contract agency staff utilizing EBP's such as MI, CBT, and Seeking Safety. There has also been a focus on training on individualized treatment planning, addressing co-occurring disorders, and understanding the indicators for and benefits of MAT. Kern has also integrated its providers into an online instruction platform which gives them access to web-based on-demand training. Using systems like this also allow the DMC-ODS to monitor training patterns, review performance metrics, identify knowledge gaps and address both individual staff and program level needs. **Sacramento** has established a protocol by which programs who desire to add a new practice or EBP must submit to a written process by which proposals will be assessed to meet current standards and practices, including the need for building in fidelity measures or checks. The strongest evidence is heard from beneficiaries who frequently comment about the quality of the treatment and satisfaction with the help they received from specific programming. Many DMC-DS counties will pull these comments from the results of the TPS survey which they administer annually and share them with staff, programs, advisory boards, and system leadership.

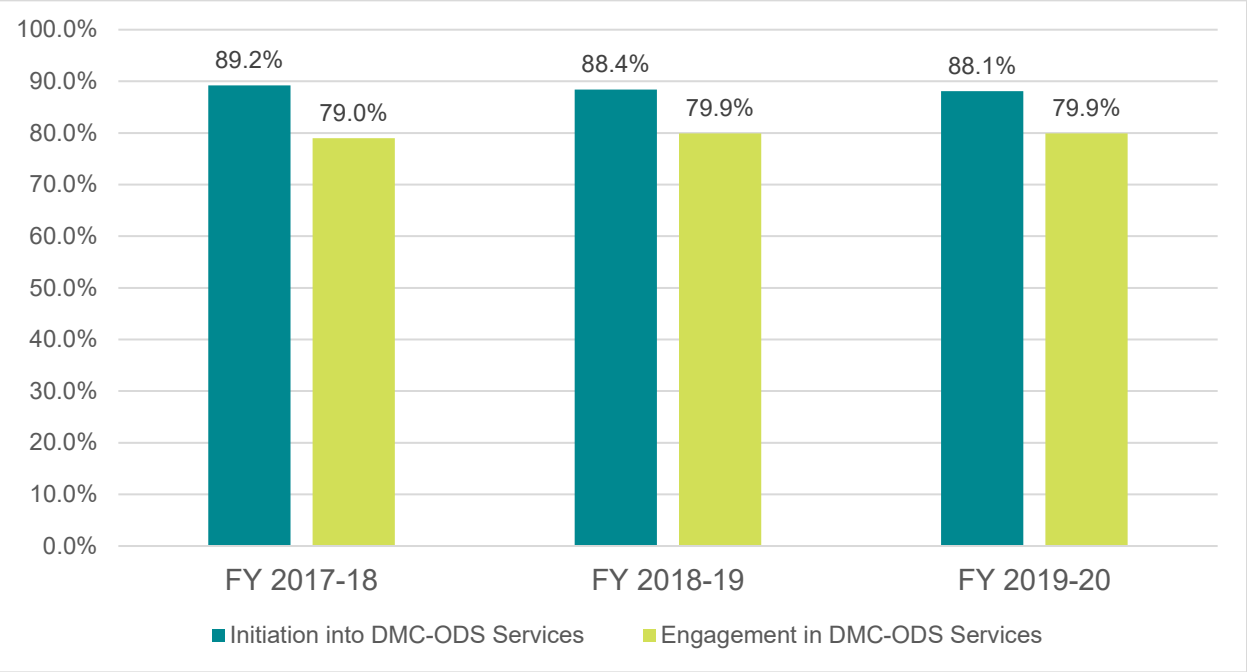
A Quality System of Care Focuses on Engagement of Clients in Treatment

A vital component of quality care for treating clients with addictions is the ability to engage and retain them in treatment and it is an important PM. 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 preliminary stages of treatment. The measures were adapted from similar ones used nationally in the National Committee for Quality Assurance's (NCQA) HEDIS quality data measures and from the National Quality Forum. The measures are known as "initiation into treatment," (percentage of clients who have at least one visit or day in treatment within 14 days of their initial assessment) and "engagement in treatment" (percentage 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 from FY 2017-18 to FY 2019-20 there has been steady positive achievement of both initiation and engagement outcomes by the Pioneer Counties. They are tracked across all the levels of DMC-ODS care. These are excellent levels; the goal would be to sustain clients in treatment and track them further in terms of client retention beyond the six-week engagement measures.

Figure 6-5: Pioneer County Initiating & Engaging in DMC-ODS Services, FY 2017-20



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 measure their own effectiveness by using their client data to measure initiation and engagement overall and by program. 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

Providers of substance use 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 beyond SUD core treatment including physical and mental health care, social services and child welfare, the justice system, supportive housing, and employment. Treatment providers have provided some of these case management support services—always with stretched resources and without reimbursement, and therefore in an inconsistent manner. Case management services can make all the difference in preventing clients from a crisis with community stability triggering relapse 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 it into the reimbursement policies for the Waiver services. There are specific billing codes for case management associated with each 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 so they are not billed separately but in general they are a separately billed service.

Some counties with county-operated outpatient clinics across their counties have organized and operated centralized case management services to clients, linked to the county plan across all LOCs. These often start when the client first request services, even if it is not billable to help the client link to care and navigate the system, and through transitions in care. There is a strong focus on the therapeutic alliance and continuity across time with support. Even if the client is receiving care from other providers this case manager is their advocate and support and coordinator to help with overall service coordination. This model works well if there are enough staff for support. Some counties use this model only for clients with an elevated level of need or for entry and transitions primarily. These case managers tend to be full time and community based and more like the mental health case managers with more outreach and engagement activities with the client in the community. These long-term case management relationships can be highly effective by building strong therapeutic alliances to support the client through the various stages of recovery. This model is similar to use for mental health in many counties and crosses all LOC.

Case Management Best Practices

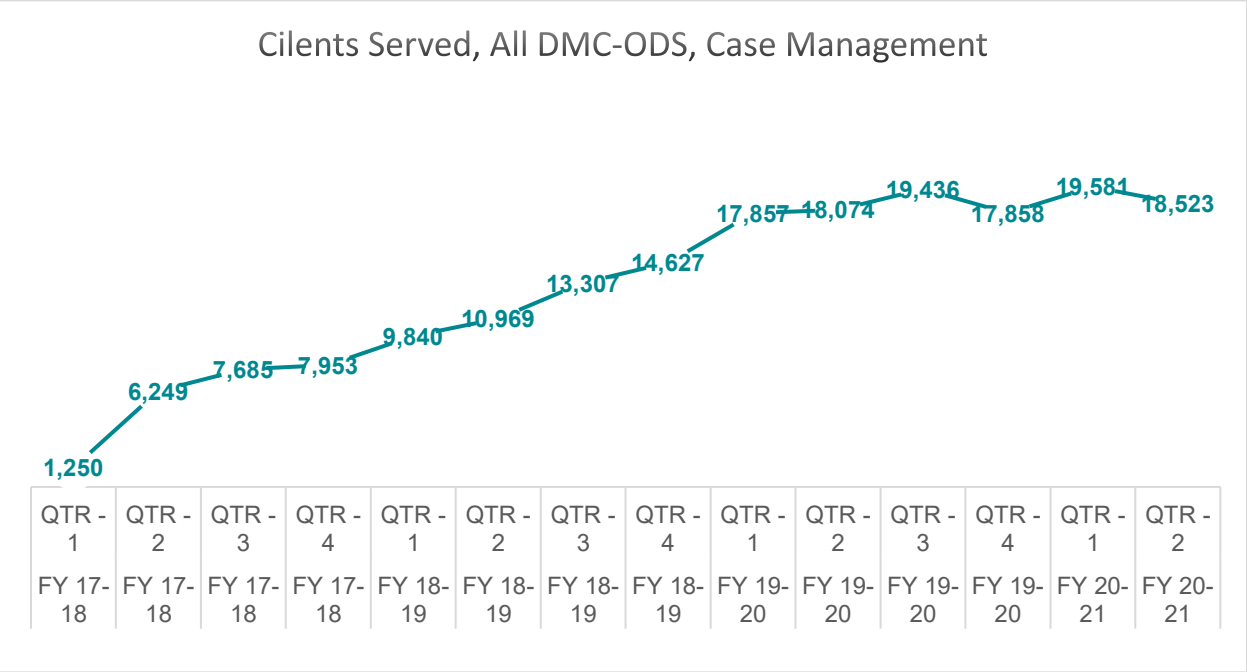
Growth of case management services is shown on Figure 6-6-in terms of clients served. This does not include those counties who chose to include case management in bundled rates for residential treatment as it does not show up separately in billing. It does show that more clients, year over year, were getting case management. The two LOCs providing the most case management are outpatient and residential treatment.

The residential programs with the most case management clients served, and units of service are focusing this effort on persons with multiple diagnoses and more complex problem areas such as homelessness, mental health needs, and physical health challenges with their SUD. This was evident in claims volume and diagnoses, as well as in staff sessions describing services to their populations receiving case management services.

Each county's LOCs has a slightly different pattern of delivering case management. Having case management as well as other treatment does appear to positively impact progress on CalOMS discharge ratings to some degree, as it was positively associated with positive outcomes according to UCLA data in their last annual report, particularly for persons with multiple co-occurring disorders. Given this association, it is important to provide case management to as many clients as possible with multiple disorders and who meet medical necessity with complex challenges. UCLA is continuing to track this linkage in their research. As expected with other services, there was also a dip in case management services at the onset of COVID-19 quarantine time, but case management as a flexible and mobile service rapidly returned to full and expanded utilization.

As a very flexible service, the COVID-19 pandemic did not have much impact on the clients served or volumes of care as this service appears to meet many needs in this difficult and isolating time.

Figure 6-6: Case Management Clients Served, All DMC-ODS



The models demonstrating the most proficient use of case management have ongoing established long-term relationships between the case manager and the client across LOCs 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. In most cases where case managers have other counseling assignments, service levels for case management have struggled. The core of the case managers' effectiveness, per the LA staff, lies in trust, excellent communication, and a strong therapeutic alliance. **Los Angeles** has an effective regional model, called the Client Engagement and Navigation System (CENS) teams that embeds system navigators and case managers into 104 community service portals and co-located sites, regionally through contract providers who specialize in this service. This model is well outside the traditional storefront clinic model, which allows them to reach those at-risk populations that may need a longer period of engagement, affording case managers the ability to guide clients as their circumstances require through benefit systems and various barriers into SUD care.

The **Los Angeles** model includes regionally coordinated case management contractors through the CENS (although this is not currently billed under DMC-ODS). Other case management services are provided by the specific DMC-ODS network providers in each region when the client is in care. The CENS also provide some specialty case management efforts linked to other high need populations such as clients in jail, homeless, in drug courts, emergency psychiatric centers, and youth in child welfare programs. These clients are often not yet open to the DMC-ODS system but are identified as having SUD and/or mental health issues or both. Based on client focus groups the challenges are when clients are between services and there are no open episodes of care, unless they are in a high need population such as someone who is homeless or in the child welfare system, they would not have a case manager.

These gaps where transitions in care occur have been reported as a regular problem in terms of support or “falling through the cracks” and having relapses. The centralized system does not seem to have this issue as the cases are not closed based on episodes.

Another best practice is providing special case management training and supervision for staff with a channel to senior SUD managers for identification of system problems and breakdowns. Case management staff who work across multiple LOCs can be the eyes and ears of the system in its operations and functioning in real time. They can identify problems for managers who can initiate action to fix problems before they become serious. In complex systems, it is important to identify issues and initiate performance and quality improvements in a responsive manner. Several counties have “Fix It” committees where clinical staff can send alerts of problems that are regularly impacting client care in a negative manner or wasting staff time and resources that are needed it other areas. These have been immensely helpful in solving a variety of problems involving other departments, paperwork bottlenecks causing access problems, transportation issues impacting access, and many other issues related to capacity and care.

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

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 needing 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 a straightforward way to track the added volume of tasks and receive due credit. This problem was particularly acute when no additional staff were added with specific case management responsibilities.

As with most DMC-ODS counties, face-to-face based case management service delivery became a challenge due to the public health restrictions introduced due to the COVID-19 pandemic. In many cases, including Los Angeles, case management activities increased even though they were conducted through virtual telehealth platforms and telephonically. Noting the need to address vulnerable populations and provide individuals with face-to-face contact when clinically indicated (or for persons with limited access to technology), many programs returned to in-person contacts as soon as safety restrictions allowed. Contacts with clients were often sustained by case managers with regular check-in calls or videos. While there are individual successes, it is unclear what the ongoing effects of the pandemic on service delivery are, particularly in remote areas or in populations with technology challenges. Many counties are surveying clients to determine preferred methods of service and access to learn from the COVID-19 quarantine period and be prepared if it happens again how to best serve different groups.

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 LOC.

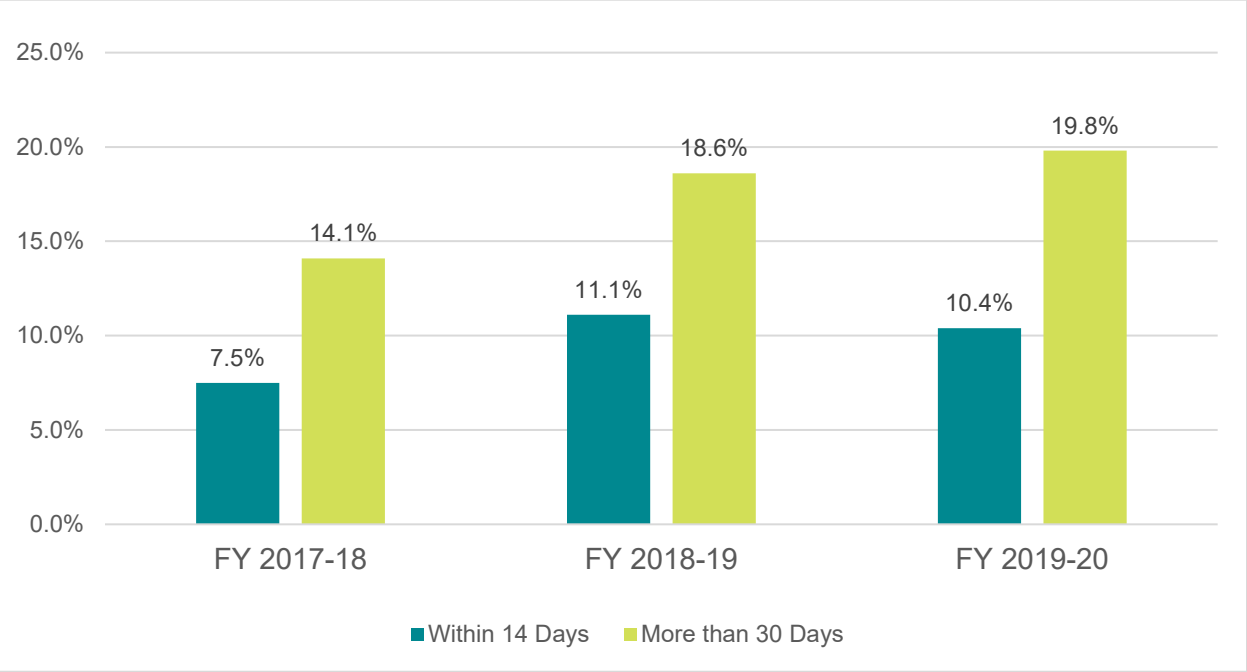
Figure 6-7 shows (1) the percentage of clients discharged from residential treatment who then received a follow-up treatment session at a step-down non-residential LOC, and (2) the timeliness with which that was accomplished for those who were transitioned. The figure shows the percentage of clients who began a new LOC within 14 days and more than 30 days after discharge from residential treatment.

Follow-up services that are counted in this measure are based on DMC-ODS claims data and include outpatient, IOT, partial hospitalization, MAT, NTP, outpatient WM, case management, RSS, and physician consultation. CalEQRO does not count re-admission to residential treatment or a transfer to residential WM in this measure. Additionally, CalEQRO was not able to obtain and calculate 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 which would be a positive transition but could not be tracked.

The transitions in care improved overall in the first two years of reviews but less so in the third year when twenty-six counties were reviewed, which included twelve new counties that launched their DMC services. In FY 2020-21 there was the **Regional Model** and four independent counties with new services, and they had the added challenge of implementing when the entire period was dominated by COVID-19 restrictions as well as wildfires. The Regional Model and **Sacramento** also implemented new EHRs at the contract provider level, 50 percent in the Regional Model and 100 percent of providers were included in the Sacramento implementation linking providers to the county Avatar system to coordinate care. This added challenge was significant in addition to the new billing requirements and managed care metrics to be implemented, but it was felt than overall for quality and financial sustainability it was critical to have these systems in place.

Case management is a critical intervention used to support successful transitions in care. Data for FY 2020-21 is not yet complete and from individual reviews it appears mixed. Some counties were improving their transitions based on their prior year experience and some did not because discharges from residential were difficult because of COVID-19 and limited housing resources available for discharge. No clients in any programs were discharged to homelessness in any county reviewed as a matter of policy. LOS in residential may have increased in FY 2020-21 due to waiting for workable discharge plans to avoid homeless conditions as many shelters were closed and all counties have limited recovery residence housing, and some have none. Even with “project room key” beds in local hotels there often were delays.

Figure 6-7 Timely Transitions in Step-down Care Following Residential Treatment, FY 2017-20



Based upon claims data for FY 2018-19 and FY 2019-20, several of the Pioneer Counties that first implemented the Waiver showed improvement in transitioning clients from residential treatment to less-intensive levels of care upon discharge. However, overall performance between these two FYs saw a slight decrease in transition rates. Transitions within 14 days saw a reduction from 11.7 percent to 9.11 percent, though six counties saw rates of timely transition reaching 10 percent or higher, with **Santa Clara** reaching 15.63 percent. Timely transitions within 30 days fell from 14.2 percent to 11.58 percent, though five of the Pioneer Counties did see rates of 15 percent or higher, and as high as 23.19 percent. Finally, the overall rate of timely transition from residential dropped somewhat from 19 percent to 17.27 percent though most of the counties reached 20 percent or above, with 33.16 percent realized by **Santa Clara**.

Although DMC-ODS counties are showing improvements in their rate of successful client transitions upon discharge to less-intensive LOC, 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 find barriers. They include: (1) clients who leave treatment before completion for a variety of reasons and who 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 the 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.

It is also worth noting that the rates represented in this report are sourced from claims data and most counties self-report significantly higher levels of prompt transitions. In discussions with CalEQRO, it appears that this is due to non- billable options such as alumni groups, non-billable peer services and differing interpretations of timely contacts and transitions that may not fall within the formulary parameters of billing. This data is similar to reports gathered from administrator surveys by UCLA.

Best Practices/Lessons Learned on Transitions in Care

Some DMC-ODS counties and their treatment programs have begun developing strategies to address these barriers. **San Mateo** is one of the Pioneer Counties and transitions clients within 7 days at a rate well above the statewide average. In part this has been achieved when they developed a MOU to support provider-to-provider care coordination and utilized their electronic health system to improve referrals and care transitions among programs. Electronic referral enhancements enable the data entry needed to track follow-up services by the discharging provider and linkages to the referred/receiving provider, even when the client does not show for a scheduled appointment. Inclusion of residential staff in monthly intake and access meetings allow for real-time input to support and facilitate warm hand-offs between providers.

San Diego who also has a high rate of seven-day transitions, has developed and formalized protocols and workflows that all providers are required to adhere that establish communication lines and timeliness expectations between programs. There are also efforts to address transitions directly with the clients and have a contact prior to exit with the receiving program. **San Diego** believes the ideal is a joint session or meeting with the providers and the client face to face, telephonically or virtually, and define a successful transition as confirmation that the client has engaged, and an initial appointment has occurred. Indeed, 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 like the approach for managing other chronic conditions.[14] 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 SOC that includes RSS for clients whose SUD is in remission following treatment. Clients transitioning from the treatment phase with their SUD in remission can benefit greatly from longer-term intermittent 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 an unbillable aftercare/alumni group. The Waiver expanded and formalized the types of clinical services beyond the aftercare group model to include as RSS: recovery monitoring, coaching, and support through outreach and linkage activities; peer-to-peer support services; case management assistance and empowerment linked to community resources and needs such as housing, education, jobs, and limited outpatient counseling. To qualify for billing, these services must be provided within the context of an individualized client plan that is documented according to DMC guidelines. The Waiver validated RSS as an important component of the SOC by permitting this billing under a separate code for RSS. DHCS also clarified this can continue while the client is in NTP services and getting outpatient MAT (non-methadone) as

[14] 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

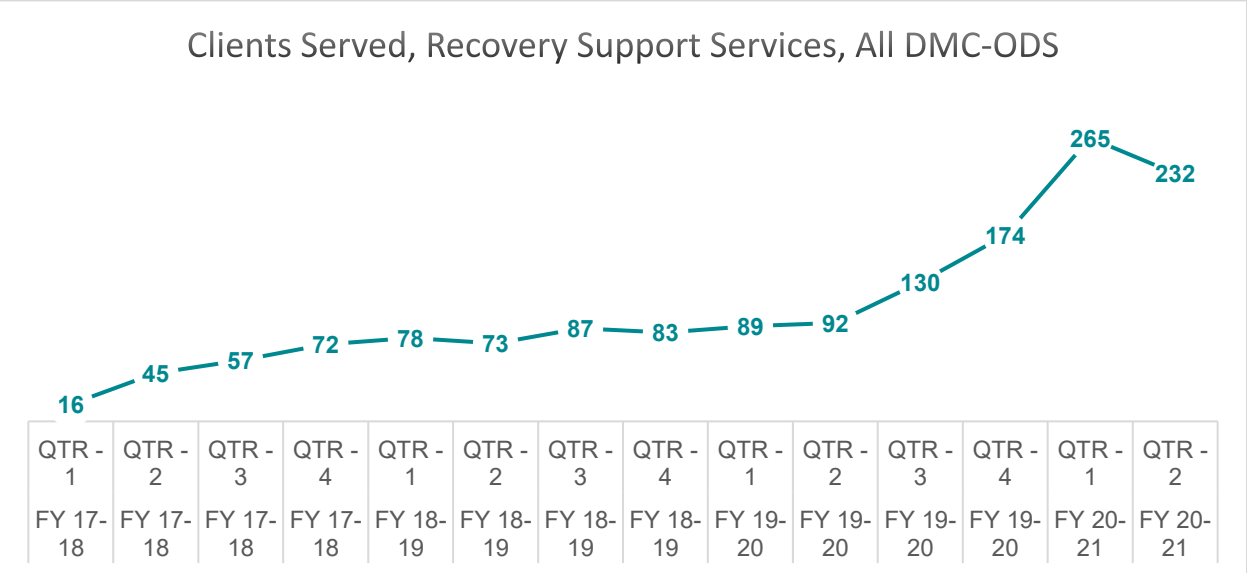
well, and allow for smooth transitions into community life, or allow for support when a relapse is possible or at risk when the client is under significant stress and reaches out for support after discharge. It is a flexible service with significant potential to benefit those with SUD long term.

Orange has designed their recovery services model to be used as a step-down, or a long-term recovery support within its SOC, and it is integrated into their providers' services. These services are offered to clients who have completed a treatment program and are living in recovery from SUD, and who may require a support system and assistance with maintaining their recovery. Components of this model include re-assessments for group counseling to stabilize and determine if further care is needed. There is recovery monitoring, which is provided in person, via the telephone or through a virtual platform. Life skills, family support, vocational assistance, and peer-to-peer services to assist with relapse prevention help to make this a well- utilized service averaging 12,166 billed units from ten legal entities each month.

Napa and Santa Barbara have also developed successful RSS programs with models well integrated with outpatient programs and offer individualized and flexible support for the SUD client community with goals that are jointly developed in a plan or their success in the community. They empower clients to sustain their recovery and achieve personal goals and build a solid support system in the community. Both counties have key contacts in QI who provide details of their programs to other counties and presented at the state SUD Integrated conference in 2020.

Based on data displayed in Figure 6-8 there is a slow growth in clients served over the period displayed. As the number of counties with multiple years of implementation grew, the numbers of counties implementing RSS grew as well, although the pandemic did impact growth, but the data trends after this pandemic dip do appear to show rapid stabilization.

Figure 6-8: Clients Served, Recovery Support Services, All DMC-ODS, FY 2017-21



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 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. While it may be correct to assume that more RSS were provided and more beneficiaries served, the lack of claims data prevents

a full evaluation of their quality and impact on outcomes. Given the service levels and comprehensive nature of its offerings, mirrored with an extremely robust utilization of case management, counties like **Orange** which has a robust RSS program should be reviewed to determine its positive impact on the client population it serves.

CalEQRO discovered in its FY 2020-21 reviews that many DMC-ODS counties had prioritized other elements of their DMC-ODS for initial development and have now begun to focus on adopting, enhancing, or increasing the use of RSS in the coming year. Some had begun developing their RSS 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, **Los Angeles**, noting the small level of RSS utilization has initiated a clinical PIP that will support ten pilot program sites as they introduce a standardized approach to enhance provider RSS enrollments, along with providing ongoing technical assistance and other workflow adjustments designed to improve the transition rate of beneficiaries into RSS.

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, analyses, and reporting, and then implement change. Core functions include practice management, accounts payable and receivable, network management, a robust EHR for direct services based on specialty and LOC, 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, NCQA/HEDIS, Substance Abuse Mental Health Administration (SAMHSA), ASAM, the Veteran's Administration, and new measures linked to the best science in the field to promote and enhance better treatment 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 utilized in California counties and provider organizations. They were generally designed for physical or mental health care systems and enhanced over time with state and federal funding streams. 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 and with other essential services outside the DMC-ODS. All 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 issues linked to data analytics and tools that support quality of care.

Best Practices to Enhance System Approaches to EHRs

Most counties and their network providers 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 to improve their systems.
- Include contract providers in the EHR solutions, because in most DMC-ODS counties those providers comprise most if not all the delivery system and need to coordinate and communicate with the DMC-ODS program, BAL, 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.
- 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 be used to motivate change.
- Develop and adhere to regular scheduled meeting formats to share and discuss data and related analyses. Utilize data findings to highlight above average performance, support best practices and identify solutions to address challenge areas. Set a tone consistent from monitoring to contract deliverables that includes utilization of program data to attain stated performance expectations and desired clinical outcomes.

> **"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."**

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 QIC with a structured QIP, including an annual evaluation of the measurable goals of the annual plan accomplishments of the prior year.

Erecting a QI program can be challenging and complex. 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 because 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. The challenge has been getting enough SUD clinical expertise on the QIP committee and staff in general to design and implement a solid plan which uses the best science to oversee and implement the new ASAM tools and principles. However, each year this has improved in the reviews, including FY 2020-21 and the education and experience with new models of SUD care have expanded and included more EBPs.

Best Practices and Tools for Success

Successful counties, the Regional Model, and some advanced providers have shared several essential elements to work on this challenging area:

- SUD initiatives are using science-based research to drive treatment designs and methods.
- The QIP's goals and objectives are clearly written, measurable, with assigned responsibility.
- 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. These are communicated to staff and policy makers in clear and effective ways.
- QI efforts are supported by adequate staff.
- Evaluation resources are deployed effectively and documented in easy-to-understand regular reports and updates.
- 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 counties and the **Regional Model** had QICs responsible for performing SUD QI activities according to the QIP. Committee membership varied. Some committees were limited to DMC-ODS county administration and staff, while others have cultivated broader representation from contracted providers, allied agencies, other stakeholders, clients, family members, 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. Some, while their charters call for family, consumer, or provider input, remain challenged in obtaining participants, at least on a regular basis. Most had converted to virtual meetings in response to COVID-19, but others already had increased meeting attendance using virtual meetings due to long and difficult travel challenges.

Marin has a diverse QIC membership, including administrative and clinical representation along with peers, family members, patient advocates, contracted staff, providers, and allied partners. Committees from the QIC also promote active participation and represent workgroups engaged to address initiatives in the Quality workplan. This includes the Cultural Competency Advisory Board consumers and leadership from community, ethnic organizations, and sectors. Similarly**,** **Santa Barbara** has a range of disciplines, leadership, and contract provider representation along with community representatives and consumers. The DMC-ODS has goals that ensure monitoring and review of key access points that include the access call center, access team and a care coordination project designed to aid incoming clients who present with complex needs. Clients with complex needs require extra support and system navigation to decrease barriers and secure the right LOC. Stating the impact of quality system monitoring, one consumer of local services simply said, "They answer their phones!"

> **"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 should be tracked with progress included as a regular, recorded part of the monthly QIC meetings. **Marin's** QIC minutes include a review of old and new business along with standing items and data presentation, where discrepancies or adjustments are recommended that pertain to the QIP work plan. **Santa Barbara's** QIC minutes clearly delineate responsible individuals with dates for reporting back on unfinished business, as well as supplying each QIC committee an opportunity to report out on specific activities and needs.

Data, quantitative and qualitative, are the essential ingredients for problem identification, analysis, and investigation for QI. However, data collection 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. While some counties have only been able to express aspirations for enhanced data analyses to support quality improvements, many have moved to add or at least demarcate dedicated staff resources to support their SUD system needs. Such additions have allowed these DMC-ODS counties to begin to do much more in data analysis and outcome measurement. Unfortunately, COVID-19 has had an impact on such resources as data and analytic staff have been pulled by counties specifically to handle everything from public health tracking to measures and reports needed for vaccination roll outs.

Often because of not having an EHR, many of the DMC-ODS counties are collecting data to report on client outcomes in cumbersome ways and remain hampered by the disparate software for requiring workarounds and hand generated reports to obtain analysis. Likewise, other persistent challenges include staff skills in using the CalOMS dataset, TPS, and mechanisms for extracting data from their own data systems. Obtaining a complete, timely and accurate use of the data sets sourced for outcomes and performance has become a priority for some DMC-ODS that have come to realize both data and analysis is diminished without having a unified EHR or warehouse to store this data in.

Sacramento has turned its focus on training and monitoring to ensure that it has a well-developed data collection and reporting process. Despite the challenges of also introducing a new EHR during its initial year of DMC-ODS Waiver implementation, priority training modules for providers have been ongoing despite impacts on priorities by the pandemic. In part this is because Sacramento believes that to focus on and provide a better understanding of system challenges, providers must have an EHR with CalOMS integrated and correct. These changes along with support from its contract monitoring and analytics from its research, evaluation and performance unit will see gains and improvements desired.

Riverside continues to track and report on a variety of areas which directly change or reflect client improvements. This past cycle, they presented a 12-month Recovery Residence evaluation, which in addition to usage levels and demographic characteristics the report noted which LOCs are taking part and using recovery residences while clients take part in treatment. Most critical were the evaluation questions of clients staying (retention), what are the average LOSs (persistence in care), are they improving (using functional indicators such as employment status) and do participants in recovery residences realize better outcomes. The 2020 evaluation showed that clients using a recovery residence have a 32.6 percent higher rate of positive discharge than those who are not accessing those services as part of their treatment process. Riverside continues to receive help from the resources it has developed as well as academic and data support partners which show the impact of its programs on client improvement.

Since recommendations for additional analytics staff continue to be common in CalEQRO reports, work toward standardizing systems, increasing adherence of programs to data collection protocols, use of reports for program monitoring and system adjustments along with the necessary resources to realize these 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.

Monitoring & 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 and access to appropriate care.

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

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 on mental health issues and activities, so many need to add more focus on SUD issues and populations for balance including youth with SUD issues and coordinate with the SUD prevention plan activities. Whether CCPs are integrated or exclusive to SUD, they should include some cultural competency-building initiatives specific to SUD. The plans should also include action items that are relevant to SUD impacted communities, with timed and measurable goals and objectives. While many counties need to enhance the SUD focus of their CCPs, some counties already exhibited quality CCP initiatives with SUD priorities including:

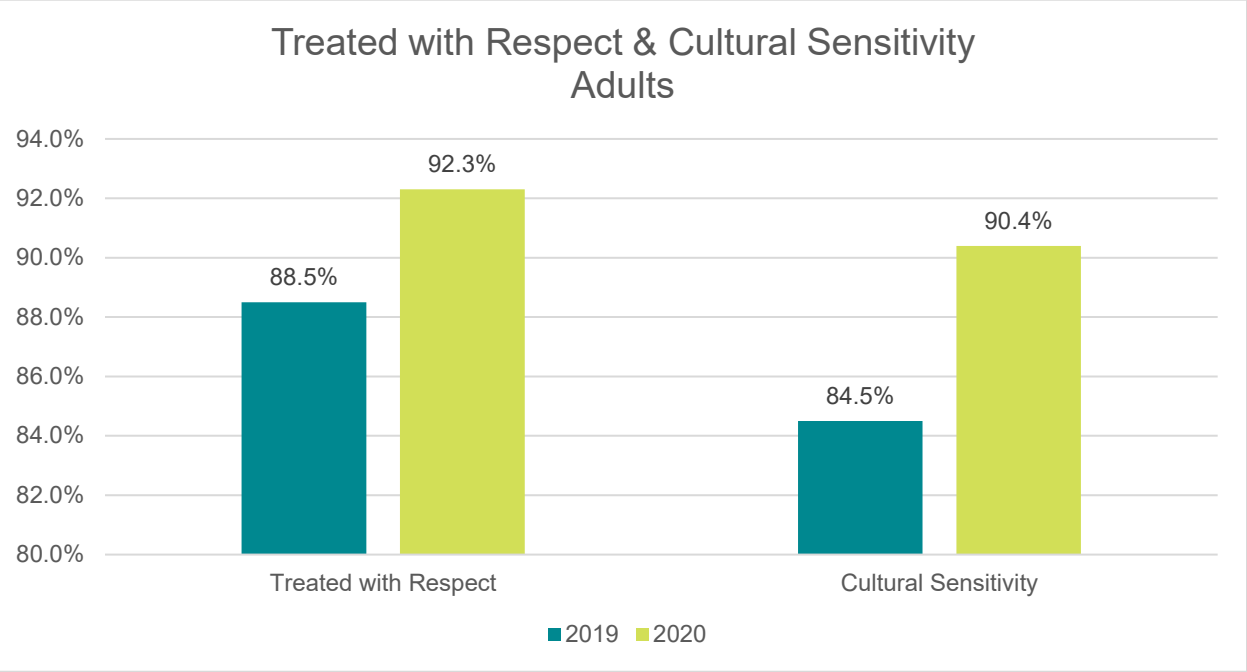
- Creating and maintaining a strong, culturally diverse workforce including culturally representative administrative, service, and peer staff with lived SUD experience. With seven threshold languages, **Sacramento** has initiated continuous recruitment efforts to improve on the diversity of its workforce. These efforts are reinforced by formal review of the staff linguistic and cultural response capacity along with training forums such as the Health Equity and Multicultural Diversity Foundation Training, mandated for all provider and program staff.
- Establishing language-appropriate information and feedback channels. For example, **Nevada** initiated a community campaign to address concerns related to opioid use amongst youth, communicating to the public that SUD program sites were open to young people and that MAT treatment along with the overdose reversal agent, naloxone, were available. Information was developed with the target audience specific to youth, education partners, and parents in English and threshold languages. Similar education initiatives are under way to address Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) goals to increase enrollments for both the veteran and injection drug-user populations in Nevada County.
- Overseeing or conducting staff and community training along with setting contract expectations and the monitoring of DMC-ODS providers is an effort that will continue to

enhance the provision of culturally competent services. For example**, Los Angeles** in addition to updating its cultural competence plan, has continued to provide targeted strategies to engage underserved beneficiaries with a focus on language capacity as a priority. In addition, culturally responsive education, community forums and presentations by nationally recognized experts were facilitated in response to local civil unrest in this past year to bring to light issues such as implicit bias and disparities in healthcare and the efforts by Los Angeles to address them. Along with collecting reliable and accurate data on health equity patterns and outcomes, a cultural responsiveness summary report was provided to leadership, completed in cooperation with the California Institute for Behavioral Health Solutions. This report gave a review of status, but also listed a variety of proposals and targets which included considering an eventual establishment of an accountability framework to measure improvements and provider needs for technical help.

A theme found in most counties during 2020 has been a renewed focus on health equity following the unprecedented attention on ethnic and racial divides and protracted social unrest experienced during the past year. Counties have provided staff, providers, and the community with access to forums to discuss those divides and specifically what they have meant regarding access to healthcare and SUD services. **Riverside**, for example, sponsored sessions to aid staff in understanding the historical and present-day impacts of cultural trauma on African Americans and set specific targets to increase enrollments in the community, including the African American LGBTQ population. **Sacramento** is part of an opioid education campaign, “See Her Bloom” which focuses on Black women and works to reduce stigma and addresses unique issues of trust by assuring that clients are part of the conversations in designing culturally appropriate aspects of care. Finally, counties had the opportunity to attend a myriad of statewide education sessions in 2020 that focused on health equity and developing knowledge, tools, and leadership to identify and address issues across a variety of racial and ethnic communities.

Data from the TPS also shows that counties have made strides in the provision of culturally proficient services. Figure 6-9 illustrates that the added focus and efforts have been observed by clients who note they are treated with respect 92.3 percent of the time in 2020 compared to 88.5 percent in 2019. Cultural sensitivity in the delivery of service saw the largest gain, moving up from 84.5 percent of TPS respondents indicating a positive experience in 2019 to 90.4 percent in 2020.

Figure 6-9 TPS Survey Measures, Respect & Cultural Sensitivity Rating Adults, 2019 and 2020



Communications Between County Administration & Providers for Planning and Implementation

Because of the complexity and breadth of change in the DMC-ODS services redesign, leadership with an inclusive style and effective communication practices were essential in each county. There was vital planning, organizing and coalition building required for both pre- and post-implementation with many stakeholders and the providers who would become the network in the new managed care structure. Without communication that builds global and shared consensus, providers will be hesitant to adopt new treatment and documentation practices essential for the success of the DMC-ODS and improved client services. Many counties did experience problems with providers not being willing to take part and are still challenged with an inadequate provider network.

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

During FY 2020-21 **the Regional Model** and four independent counties launched their services. Stakeholder focus groups noted that counties put extensive effort into ensuring excellent communication and involvement in planning and implementation that involved 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. Communication was also focused on key stakeholders and Medi-Cal members with newsletters and forums and community meetings. **Partnership** set up special meetings for the public and stakeholders in all seven counties and made special efforts to meet with key departments such as criminal justice and child welfare to provide information and support related to their concerns with the new model.

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.

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. Review of DMC-ODS meeting minutes reflect that these communication channels work best in counties when an organizational norm of recruiting contract providers, stakeholders, consumers, and family members to participate has been set. Minutes then reflect clearly said tasks, scheduled and recurrent participation by membership, work groups, and project or system development discussions that are bi-directional in nature.

San Diego leveraged existing pathways of communication, long since established for quality improvement and other administrative activities to address information and system response needs due to COVID-19. The resulting planning team addressed public health restrictions and developed a portal for providers, migration to teleworking for staff, introduced distancing requirements yet assured services would be available for clients, including those on MAT or other forms of medication. Changing guidelines required multiple weekly teleconferencing sessions, updates from public health specific to SUD services, county, and state direction, along with formatting FAQs that providers could access online. When providers were assured and supported, services continued, and system adjustments were made in a manner that reflects a strong connection and relationship with providers, evidenced by preexisting formal paths of communication.

Feedback from Clients on Perceptions of Care to Improve Quality

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 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 and the Regional Model. Ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction. In this chapter, the graphs include the domain results pertaining directly to quality of care, which are Quality, Coordination of Care, and General Satisfaction.

Positive client feedback also included information about unmet needs:

- Longer stays in residential treatment
- More bilingual counselors
- More assistance with housing and employment
- More family therapy & support

Figure 6-10 shows the average TPS ratings by item and by domain on a five-point scale, aggregated across all 30 counties and the Regional Plan reviewed during the previous year. The results are uniformly high when aggregated across all counties and types of treatment, which masks differences when comparing the results of specific treatment programs.

Pioneer Counties with more experience developing their services generally score higher than counties just starting their DMC-ODS programs, though there can be some differences. More detail by county should be reviewed to understand the differences and then also by specific site or program type. For example, outpatient and NTPs generally score higher overall in terms of satisfaction and ratings by clients, and residential and residential WM lower. Pioneer Counties have significantly more residential capacity than the counties just starting DMC-ODS. Access may be lower for the Pioneer counties because of the large percent of residential programs and the impact of COVID-19 on bed access with the reduction in beds and challenges with discharge because of not wanting to release anyone who did not have confirmed housing due to COVID-19 and limited recovery residence housing. The ratio of residential in Pioneer Counties was much higher than in Non-pioneer.

Figure 6-10: Mean Score on TPS Domains, Pioneer Counties Compared to Non-Pioneer Counties, CY 2020

Figure 6-11 shows the average TPS ratings by domain on the same five-point scale, differentiated by type of treatment program. While still uniformly high, the ratings show more differentiation; ratings by clients in residential treatment are slightly lower than those by clients in the other types of treatment programs. Client participants in residential treatment focus groups voiced a recurring sentiment that they did not have a sufficient length of time in that treatment program to complete their goals. The Waiver STCs introduced tighter limits on residential treatment lengths of stay, which was a major historical change. Residential treatment has the shortest LOS, particularly for youth, and outpatient and MAT in NTP/OTP programs have the longest lengths of stay overall. These scores also vary by county and by individual program site, so it is difficult to generalize, but this is true with very few exceptions overall.

Figure 6-11: Mean Score on TPS by Domain and Treatment Setting, Pioneer Counties, CY 2020

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 this past review cycle, CalEQRO explored with each DMC-ODS county how they communicated and used the TPS results to identify quality improvement opportunities for individual programs. CalEQRO learned that because of TPS feedback some counties worked directly with specific providers on performance improvement issues related to specific domains and concerns of clients.

CalEQRO continued to conduct focus groups though in most cases this was done on a virtual platform, due to COVID-19 related restrictions. Despite these limitations, 38 focus groups occurred during 30 DMC-ODS county reviews and the Regional Model, down slightly from the previous year when 40 occurred. Unfortunately, 12 counties were unable to facilitate focus groups though a few of these did submit the client surveys to give input on services. Each of the groups were 40 to 90 minutes in duration. Numbers of participants ranged from eight or more clients to just one or two at times. Most groups were for adult clients, and some for youth. Most included a mix of male and female clients, although some were for perinatal female groups only. 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. Despite these technology challenges, the individual effort by the clients, county, or provider staff along with the CalEQRO client -family member (CFM) consultant helped to overcome these issues.

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. Some remarked that the programs were absolutely what they needed, staff had their best interest at heart, and they felt very supported in their recovery efforts. For others they noted only finding about a program through word of mouth, while some were admitted within a few days due to efficient access points and

referral workflows. Many clients on MAT noted that improved access to counseling staff had occurred since the bulk of services were now being facilitated by phone or teleconference software. Additionally, barriers such as time of day, transportation, and daily dosing had been reduced due to home dosing of up to a 30-day supply.

However, concern was raised in client focus groups across more than half of the counties about the lack of MAT information provided to clients, related to the use and benefits for MAT, so education still is needed. Focus group participants also reported that some recovery residence programs are still refusing to accept individuals on MAT. Clients in certain counties echoed that while prescription opioids and heroin use was known to be a concern, the increasing impacts and risks of emerging drugs as such fentanyl and methamphetamine has become much more pervasive. In some residential focus groups, some clients noted reduced access, with long waits for residential services since the onset of the pandemic, while some noted “thinking twice now about relapse” as the isolation process due to COVID-19 (necessary during much of the year) was difficult and they wanted to avoid relapsing again. Clients in several groups discussed the need to address co-occurring mental health disorders. It was positive also that more clients were open about having mental health as well as SUD and having some regular psychiatry access which has been increasing. While some clients found support even in groups of identifying and managing issues like PTSD or depression, others found the referrals for mental health needs complex or lacking.

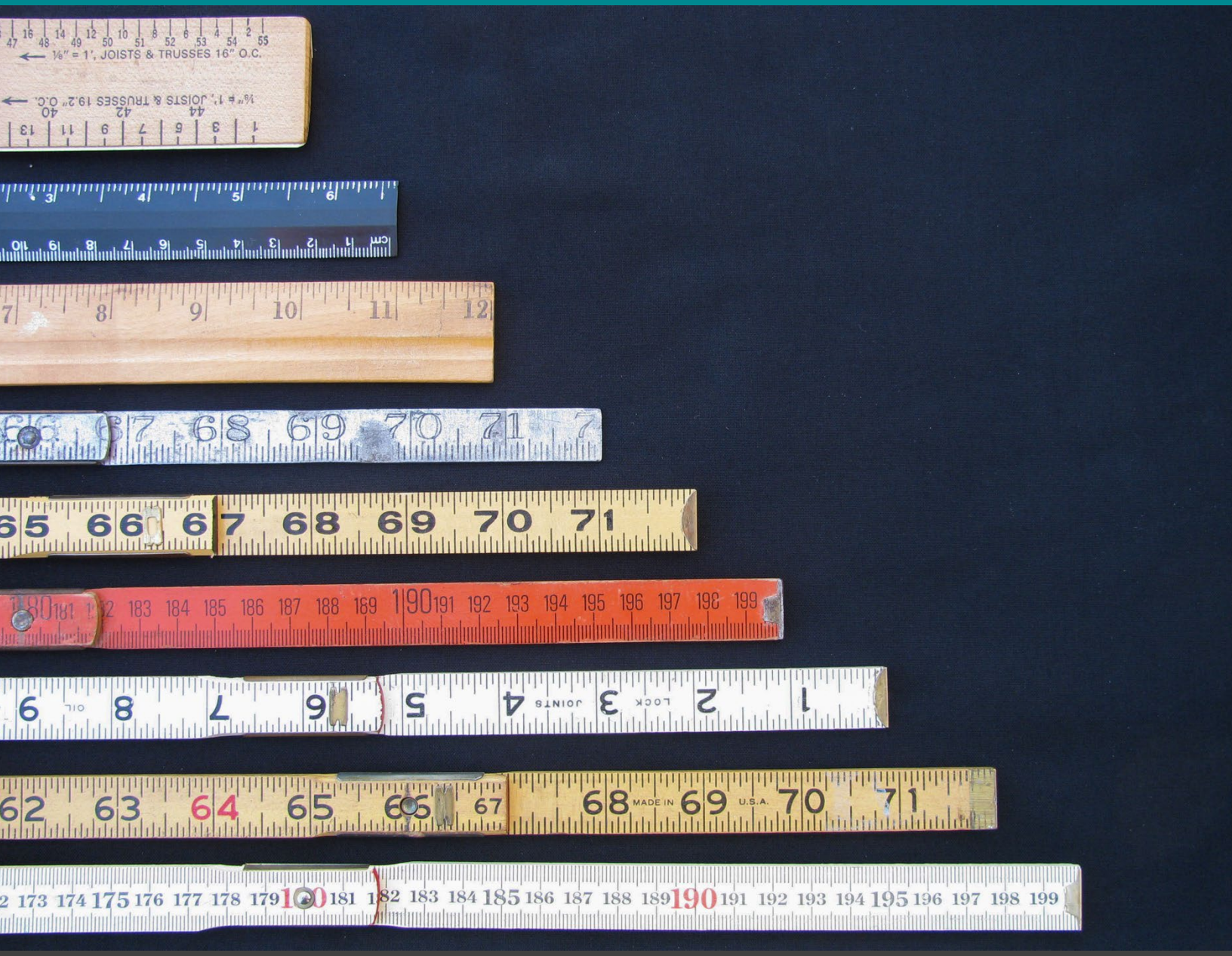
Clients in residential treatment continued to suggest that longer LOS in that LOC are desired. Linkage to appropriate services and preparation for discharge ranged from very well regarded to clients feeling they were not getting the guidance or support needed once they returned to the community. In some counties, the lack of transitional or recovery housing is acutely felt by clients though it was nearly universal that they viewed their staff and programs with high regard despite individual limitations. Housing was a universal theme in every county in virtually every focus group as it has so many challenges associated with it post discharge and in terms of stability and safety.

Concluding Quality Themes and Recommendations

Despite the impacts and restrictions of a world-wide pandemic, the DMC-ODS counties have again made progress in expanding the numbers of clients they have been able to serve and their continuums of care in LOCs and service capacity in FY 2020-21 in many counties and the Regional Model. 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 made meaningful adaptations to both in-person and virtual forms of service delivery necessitated to overcome system-wide limitations imposed by COVID-19. 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 the full potential of non-methadone medications will only be realized as they continue the necessary work to expand its use and education of clients and the community. 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, again despite the effects of the public health emergency. 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 first screening level with more access staff, focused ASAM training, and case management linkages for first appointments especially for urgent cases.

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, between those programs and physical and mental health programs, and between those programs with services in other county departments. The results of these efforts are measured through client feedback forms and through rates of successful stepdown transitions from residential treatment and WM to lower LOCs including RSS which is very underutilized at this point.

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 these benefits in their systems, and others began later. Comprehensive quality reform with associated infrastructure requires multiyear efforts, and CalEQRO reviews provide technical assistance, direction, and encouragement for DMC-ODS counties toward continuing these QI goals and objects. DHCS through its Strategic Quality Plan and CalAIM can continue these efforts as well with a focus on key quality measures linked to national standards, continuity and coordination of care, and best practices.



Chapter 7

Outcomes

Outcomes

"My MAT made the difference in holding on to my recovery, it gave me the time I needed."

Quote from CFM Group

Introduction

DMC-ODS programs continue to seek answers to the key question, "Are programs and services making a difference in their clients' SUD and in their lives?" Measuring and tracking these impacts is part of making the system accountable for the care that is delivered. Outcome data are generated from facts in the tested evaluation tools that have use and meaning regarding efficacy of delivered SUD services. Clinical outcomes generated by these data are measurable changes in health, function or quality of life that result from the care received. Constant review of such outcomes establishes standards for continuous quality improvement which will inform clinical practice. Outcomes measures are also reported by the clients who are receiving services. Client surveys measure treatment outcomes from the client perspective. Survey responses are an important part of outcomes measurement because they provide a client-centered assessment of health, function, and satisfaction with care.

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

The standardized data sets that provide outcomes information and reporting derived for DMC-ODS 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 picture of SUD impacts from care 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 for clients who were accessing services and the desire to continue moving forward by making improvements was strong.

Overview of Major Outcomes Findings

Finding 1: TPS Findings

All of the DMC-ODS counties and Regional Model reviewed fulfilled the requirements related to administration of the 2020 TPS through the county and contracted SUD programs, despite changes in the service delivery system limiting face-to-face contact with clients. Both adult and youth results continued to be high in the domains overall, though youth survey response was lower than the prior year.

Finding 2: Highest Impact of Ability to Change

It was notable that MAT had the highest score by clients and the longest length of stay in treatment and was associated with both satisfaction and the ability to make life changes and improvements based on TPS findings.

Finding 3: 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 LOS in the SUD care systems is associated with improved outcomes in functioning and reduced relapse events (such as loss of employment, arrests, rehospitalizations, and readmissions). This LOS measure is a newer measure looking at retention across the continuum of care as a whole.

Finding 4: 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 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.

Generally, there was no clear improvement patterns overall in FY 2019-20 with the addition Regional Model and four independent counties plus COVID-19 the overall ratings showed similar standard discharges, and administrative discharges were slightly higher implying elopements increased. Given the challenges with those external factors related to telehealth and COVID-19 some retention issues were expected.

Key Data Sources for Outcomes

Treatment Perception Survey

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 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 beginning treatment of being "better able to do things." This rating is linked to the specific program and site where clients have been receiving treatment in the DMC-ODS, so client perceptions can be used to gain insights and information about 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 a client stays in the system of DMC-ODS care. Retention data include a count of the cumulative time that clients participated in sequential SUD treatment and recovery services received without an interruption of more than 30 days. Defined sequentially and cumulatively in this way, LOS in treatment has been found to be a significant predictor of positive post-treatment outcomes, such as decreases in unemployment and crime. Optimal quality and maximum benefit from recovery resources are linked to skilled use of treatment and support services, appropriately extending the total LOS in some level 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 to provide beneficiaries the treatment that best fits their needs. Providing the right level and combinations of care at the right time is the goal. Persistence in care has high value for evaluating SUD treatment and so is information gathered to monitor the client's progression of care. Sustained engagement at the proper LOC and moving clients toward improved outcomes adds value to programs clinically and ultimately reduces costs and risks of relapse.

California Outcomes Measurement System

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 CalOMS. Client characteristics, drug use factors, mental health, health factors, and sociodemographic characteristics are collected through a series of defined questions and responses, along with clinical outcomes and program performance indicators.

With the institution of a standardized assessment and tool for matching the placement of individuals into the right LOC, the implementation of the DMC-ODS Waiver shows favorable improvements in

clinical outcomes. Proper matching of treatment settings and types of individualized services supplied 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 provides 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 valued an essential management aide in guiding effectiveness discussions and is an opportunity to strengthen consistency.

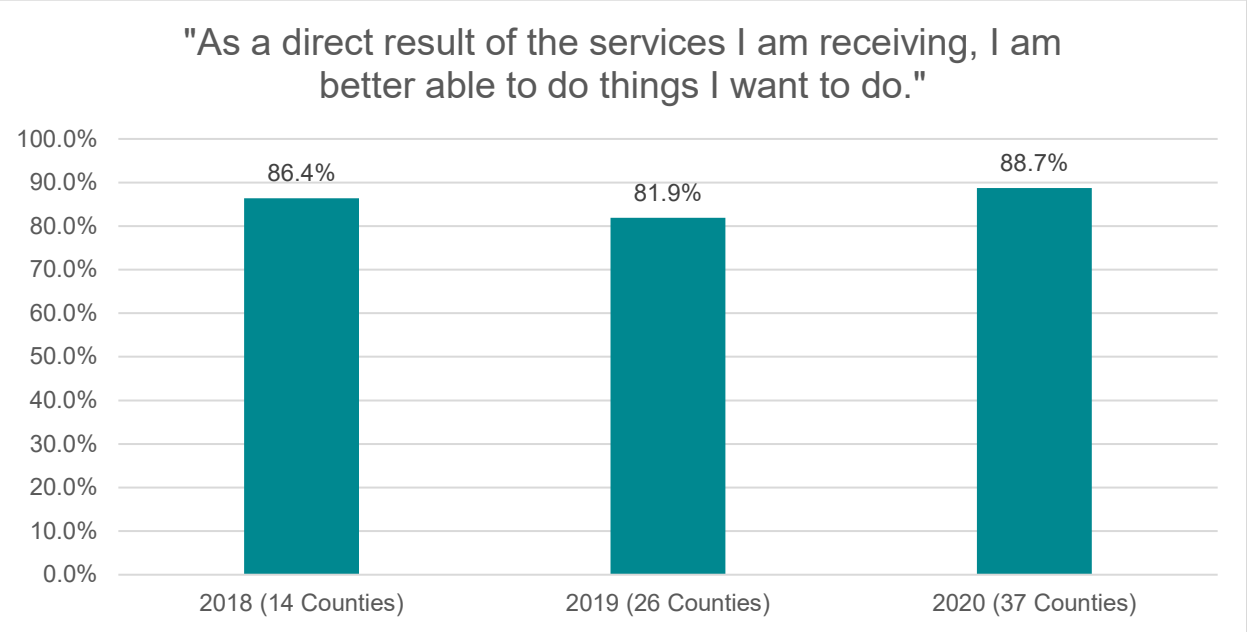
Outcomes by Data Source with County Examples

TPS Findings and Themes

All counties and the Regional Model participated in the TPS and as noted and there is one specific question linked to outcomes improvements. Results are displayed on Figure 7-1 below. There was a slight improvement within the Outcomes domain measure overall from 86.1 in 2018 to 87.1 percent in 2019. From 2019 to 2020 the percent increased to 88.7 percent with all Waiver counties and the Regional Model participating. This measured whether the program services were helping the individual be better able to do things in their lives and focused on improved functioning and coping skills. Given the number of new counties and the external stressors of this year, this was a positive result.

Survey completion was generally robust, except for youth in many counties, supported by the persistence of county staff.

Figure 7-1: Percentage of Clients in Agreement Rating with the Outcome Domain of the TPS, CY 2018-20

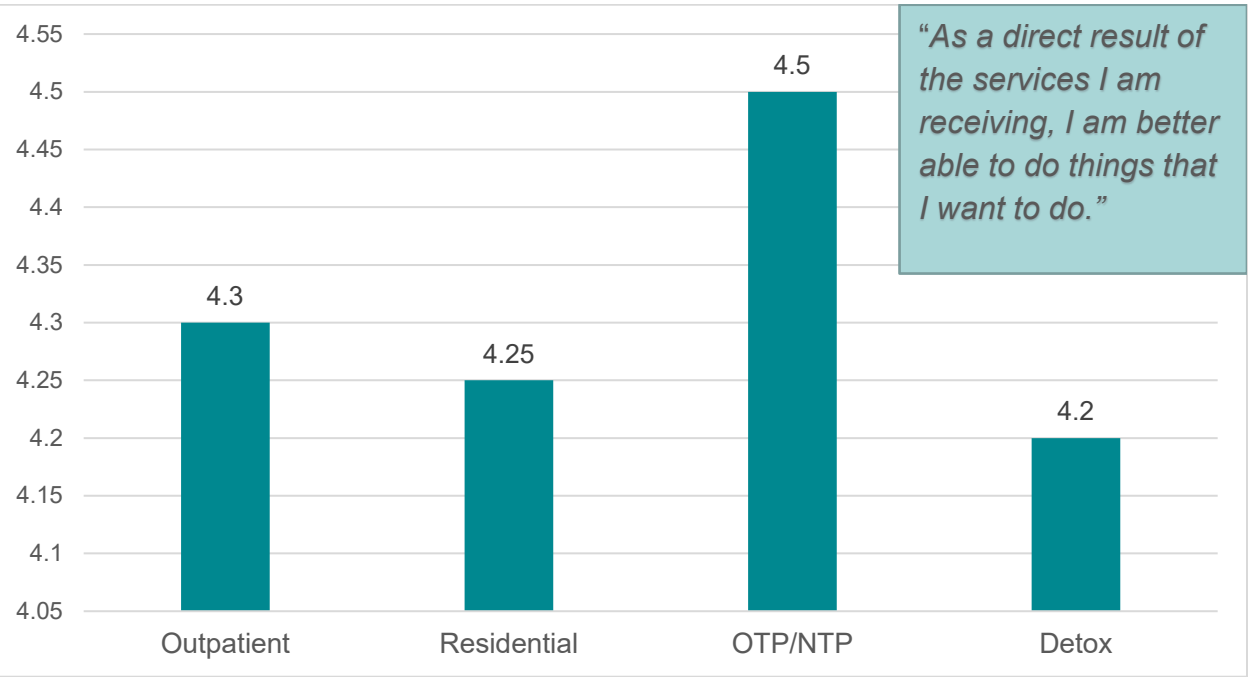


In 2020, 30 counties and the Regional Model took part in the TPS survey. Also, four individual counties began services in FY 2019-20 and the Partnership Regional Model began in FY 2020-21 so had little opportunity to influence a change in outcomes. Also, 2020 was the peak of the COVID-19 quarantine period. As represented in the above table, client-reported beliefs of an improved ability to "be better able to do things" were rated at 88.7 percent in the counties reviewed in 2020. The rating for 26 counties was 81.9 percent in 2019 but included 12 counties in their first year where typically the data is not showing as positive results. 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 positive about the outcome of care, with some variance noted within the LOC with longer treatment programs doing better, as shown in Figure 7-2. MAT is the LOC associated with the client's feelings of the best outcomes, and it also has the longest lengths of stay.

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



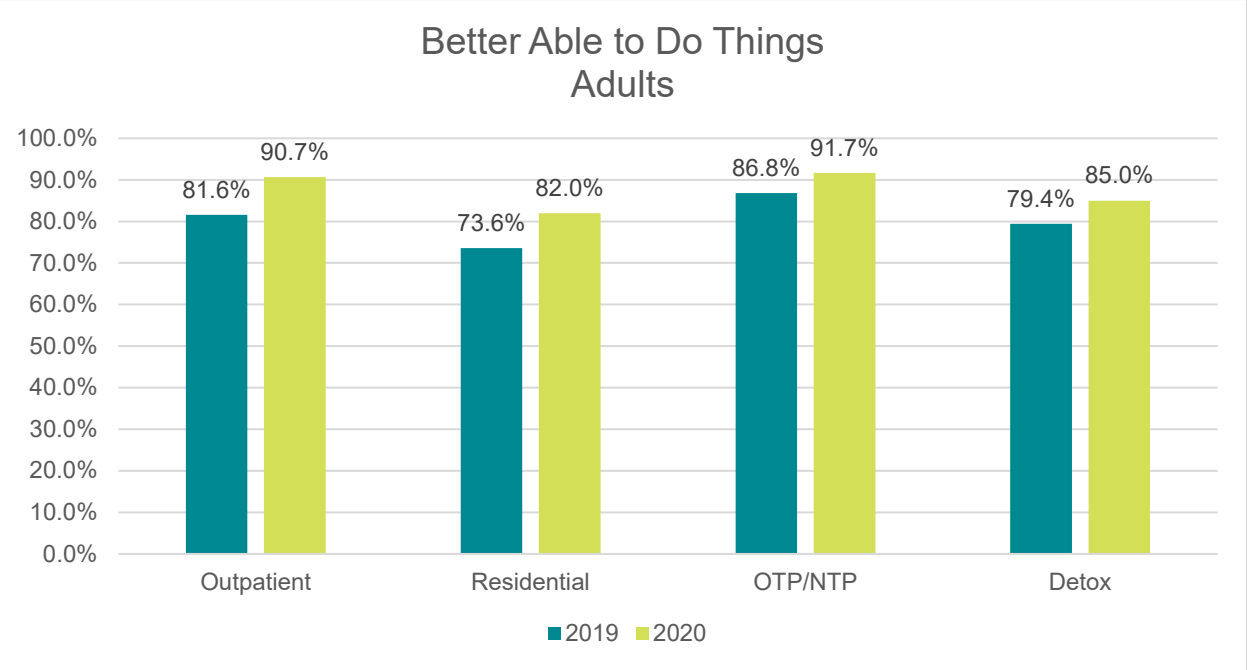
MAT services received the highest outcome marks from clients.

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 influenced by individual factors, by site, or county but length of engagement in treatment and stability did correlate with better outcomes and satisfaction with MAT scoring highest.

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. This trend of longer LOS influencing better outcomes has been regularly sited in ASAM research studies, compiled in *The ASAM Principles of Addiction Medicine* (Ries, Fiellin, Miller, Saitz.2014).

Year-over-year improvement was seen, however, across all the LOCs provided under the DMC-ODS Waiver, as illustrated in Figure 7-3, while NTP programs had the highest overall rating, whereas residential and outpatient LOCs had the largest increase between TPS administrations. In focus groups clients who have ongoing MAT services from NTP/OTP providers or outpatient non-methadone MAT providers for either AUD or OUD often report great benefit in terms on long term stability, less cravings, ability to work and improved functioning overall.

Figure 7-3: Mean Scores from TPS of the 0-5 Scale Regarding Favorable Client Responses on the Outcome Domain, Segregated by Treatment Setting by CY 2019-20



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, although some counties have limited youth response, but several counties gather client feedback from multiple survey sources on an ongoing basis, including the TPS, other survey tools, and CFM focus groups. These counties ensure that clients are included in advisory groups, county SUD services planning groups, and are part of PIPs. In addition, and most importantly, these counties QI systems 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.

Other Best Practice examples include:

San Mateo has participated in TPS administration cycles four times since 2017. While many counties saw a drop in the number of surveys due to the COVID-19 pandemic, San Mateo took additional steps to secure as complete a response rate as possible. In noting that a few programs had no TPS response at all, they came to realize that some had collected paper surveys and they sought a way to get these results to UCLA. San Mateo also saw improved scores from the prior year's cycle in several areas including access, despite the public health restrictions on service delivery. For example, convenient location had risen to 93.3 percent up from 89.7 the prior year. Convenient time also rose to 90.8

percent, up from 89.7 percent. Satisfaction with services was up across all services for questions within that domain and client outcomes improved from 86.7 percent of clients agreeing they were now better able to do things to 89.4 percent. By adding a telehealth question, San Mateo found that 86.3 percent of those surveyed received part or all of their services through telehealth and the ratings improved from the previous year in 11 of the 14 areas, meaning telehealth solutions were working well for at least some of the clients. San Mateo plans to explore how to retain the benefits of telehealth services even as the COVID-19 pandemic begins to recede.

Sacramento, whose system is primarily provided through contractors, realized that because of a low response rate to the TPS survey, the data it had to secure quantitative client impressions was compromised. Baseline data from the last TPS administration noted that just 4.3 percent of the enrolled youth were responded to the survey. Adult responses had also fallen to just 16.7 percent. By comparison, a 2019 report by UCLA noted that the overall response rate for all adult and youth of the California counties who administered TPS was 60.9 percent in 2018 and 58.7 percent in 2019. Sacramento formulated a PIP with interventions in part informed by a stakeholder group that works with adolescents so barriers could be found along with age specific interventions. Similarly, the county staff worked with their providers to impress on them the value of TPS survey results and training needs were also addressed. As defined within the PIP framework, the improvements will consist of enhanced administrative processes and youth engagement methods that are targeted toward communication pathways used most frequently by youth. County staff will ensure that all youth providers are taking part in a consistent manner with the implementation of these interventions and have added a “test” TPS administration to ensure adherence and measure effectiveness. Ultimately, a larger TPS sample will assist Sacramento in gaining an understanding of youth beneficiaries’ perception of access to SUD treatment and the quality of care provided through their DMC-ODS service network.

Los Angeles obtained TPS responses from nearly 200 SUD providers which yielded almost 6,000 results. With such a diverse set of programs, it has been quite an achievement that TPS results were formatted and used to improve care. One way that TPS have been used is by clear and targeted visual representation and analysis of the data, across LOCs and down to the individual providers. These representations have included year-over-year comparisons with both numeric and percentages indicating if providers are meeting, exceeding, or falling short of established expectations. For example, Los Angeles expectations of a 50 percent response rate is delineated and identified by program site so it can be a focus for QI activities if needed. With specific outlier sites identified through outcomes results, needs, support, systemic contract monitoring, and quality work groups can work with providers to address areas of improvement. Comparative data of individual domain questions between the three TPS administration cycles shows improvement in all 14 survey areas, including year-over-year improvement of 2.4 percent in care coordination efforts with physical health, very often an area that lags in most county DMC-ODS TPS ratings. With such a vast representation of system access and quality of care, data which is well organized and represented to both county leadership and programs has allowed Los Angeles to utilize data to seek system improvements.

Retention in Care Findings and Implications

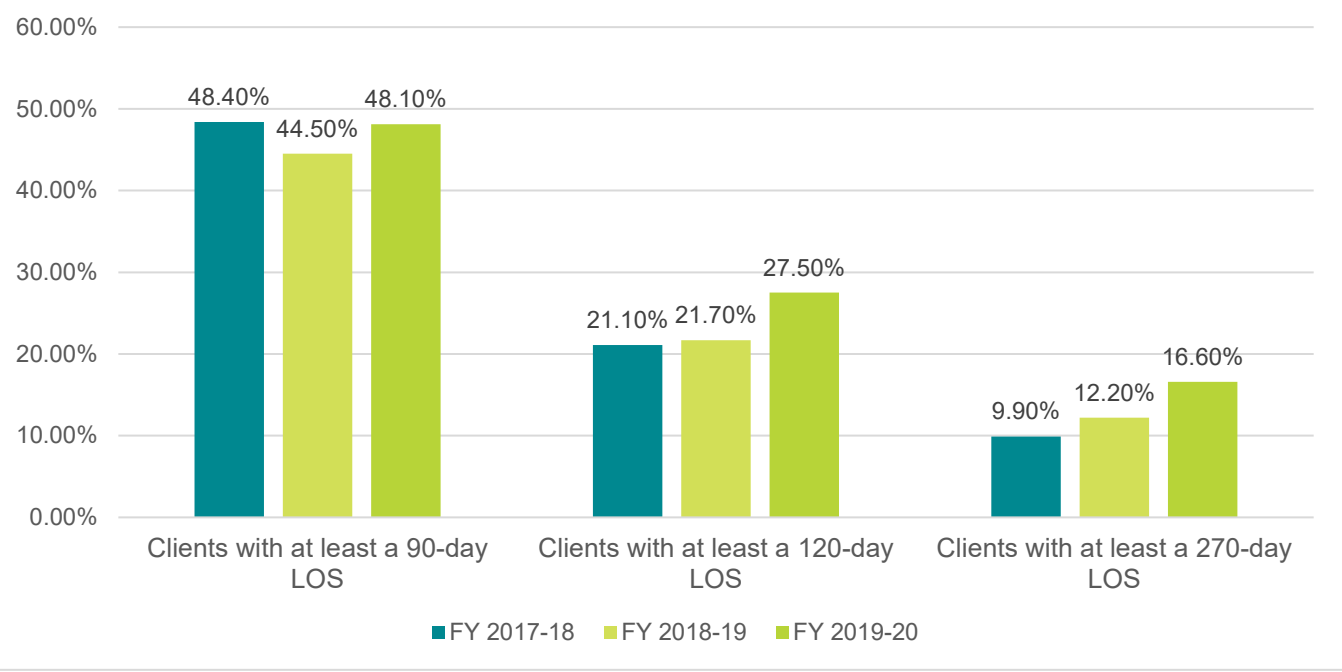
This measure tracks participation in SUD services across the entire continuum of care; clients must have at least one billable visit per 30 days to have their retention counted for that month. The percentage of clients who are retained in treatment beyond 90 days has increased for the Pioneer Counties, which would likely be a positive factor in improved discharge status with treatment progress, transitions to other LOCs, and reduction in client elopement. This is a minor increase on average as a new measure for DMC-ODS plans, but it is promising and establishes a principle linked to ongoing research associated LOS with better outcomes in SUD. As systems mature and the longer-term DMC-ODS clinical services expand to serve more clients (RSS, recovery residence housing, and ongoing MAT), it is the goal of many counties to see these long-term systems of support extended for clients after they are stable, but also to continue to be available for setbacks and to assist with stabilization treatments whenever clients need them. With the exception of recovery resident housing, they are billable services and would count in this measure. The LOS indicates engagement in treatment at any DMC-ODS LOC. Figure 7-4 illustrates Pioneer County Client Average LOS in Treatment.

Improving retention requires motivational engagement at three stages:

- Engage in initial LOC
- Engage for transitions in the SOC
- Engage in recovery support

Care coordination is the "glue" that links care across the SOC MAT assists with retention and is associated with better outcomes.

Figure 7-4: Client Length of Stay, Pioneer Counties, FY 2017-20



The CMS-mandated average LOS limits on residential treatment, which were included in all state Waivers for SUD services, are managed by most counties authorizing residential admission in no more than 30-day increments, each requiring an updated ASAM assessment and utilization management clinical review. The average residential LOS for most counties was in the 32-40-day range at the end of

FY 2020-21, but many are not yet billing for their residential WM services and others are not adding these services because they currently do not have enough capacity.

Transitions in care, an important PM, reviewed in the Quality Chapter of this report, are still relatively low, generally impacting fewer than 25 percent of residential care clients. These two factors, the decrease in authorized residential treatment days and low transitions in care rates, both contribute to the decrease in clients with at least a 90-day LOS. The slight increase in clients with at least 180- and 270-day LOSs may be attributed to increases most counties experienced in NPT/OTP treatment and non-methadone MAT which are both increasing and have longer LOS without any restrictions. When MAT and NTP/OTP clients engage in treatment, they generally remain for 150 days or longer.[15] Research indicates these longer lengths of stay produce more positive treatment outcomes, including sustained abstinence and improved functioning in health and self-sustainability domains.[16]

CalOMS Findings and Themes

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 in the initial years of the Waiver. 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. The focus for CalEQRO related to this measure has been satisfactory progress.

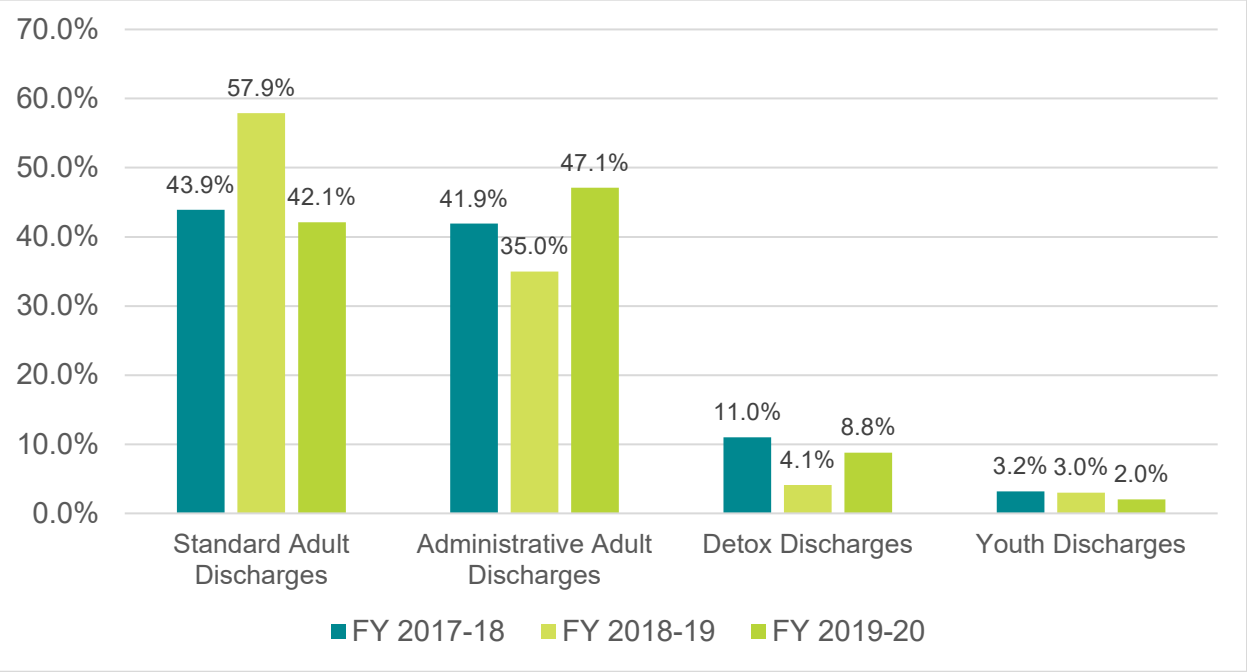
While prior years had shown slow but consistent progress in many areas, CalOMS results in the last year were mixed across the counties and the Regional Model. It appeared that external factors were impacting client progress in treatment services.

In the past review year FY 2019-20, 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. **San Luis Obispo's** PIP focused on engagement strategies for the treatment population, identifying relapse factors which should reduce summary discharges. Fresno enhanced engagement efforts to reduce no-shows, improve persistence/retention in care, and improve outcomes of SUD clients. **Riverside** identified individuals in outpatient who would benefit from more consistent access to individual sessions to reduce administrative discharges and improve client functioning, allowing them to complete treatment at a higher rate. Additionally, several counties have begun to expand their QI initiatives beyond compliance areas into those with a more clinical and outcomes focus, including setting expectations with providers on the necessity to address lagging CalOMS where data indicates the need.

[15]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.

[16]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 Review.* 2014 January; 35(2).

Figure 7-5: CalOMS Standard Discharge Progress in Treatment in all DMC-ODS Counties, FY 2017-20



CalOMS Overall Major Outcomes Finding

The prior year's administrative discharge ratings which indicated a positive downward level of client elopement has rebounded upward to 47.1 percent in FY 2019-20 compared to just 35 percent seen in FY 2018-19. While DMC-ODS counties have prioritized engagement, retention and planned exits for clients leaving a LOC or treatment, efforts that saw reduced administrative exits, just over 5 percent from 2017-18, current data indicates administrative discharges have increased in this last difficult year.

Summary exits, or "dropouts" by clients without notice are documented as administrative discharges and are of great concern in SUD treatment, indicating a programs' performance in engagement needs attention and suggests that more effort is needed to address vacillating client motivation, as well as being sure that it is the appropriate LOC for that client. The research literature notes that those clients who persist in treatment have better long-term outcomes than those who leave prematurely. 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. With sudden and unplanned exits the opportunity to maintain clients in care, at any level, is diminished and a cycle of recurrent admits, discharge, and readmits begins which puts clients that are not fully in engaged in treatment at risk for relapse and ancillary consequences of being outside the system. Therefore, working to reduce these administrative exits is both clinically beneficial to the individual client, allows for greater system improvement, and provides a more robust CalOMS data set that can be effectively used to measure outcomes and program performance.

Efforts to maintain strong engagement with clients produce better outcomes and more robust CalOMS data, but then the system must have the resources to capture and analyze the data to use it to improve care.

Administrative discharges, while seeing an undesired upward trend, when disaggregated, there are promising results found within individual counties. In FY 2019-20, 12 of the counties had CalOMS administrative exit ratings that were at 35 percent, well below the statewide average of 47.1 percent. In five of these counties, the positive difference exceeded 27 percentage points. Reduction in summary administrative discharges was most evident in **Napa** at 19.2 percent, **San Mateo** at 17.9 percent, **Marin** at 16.8 percent and **Alameda** at just 11.6 percent. The reduced administrative status represented a likely improvement in program performance and attention to effective care transition at discharge. The efficacy of care providers in these counties is also indicated by higher rates of clients exiting with a satisfactory discharge. For example, Marin rated standard discharges at 79.6 percent, well above the statewide average of 45.8 percent.

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. 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 (BHIS).

Exceptional work has been done by individual DMC-ODS counties to manage CalOMS data locally. **Marin**, who was noted above for its elevated level of standard discharges along with a low level of administrative discharges, utilizes data in a dashboard format, updated data monthly to provide feedback to its providers for what is reflected in their CalOMS data set. Continuous monitoring and improvement strategies on obtaining accurate and complete submissions of CalOMS data along with initiatives to engage, retain and support clients in their programs has provided Marin with utility in its data to identify problems, make decisions, monitor effectiveness of interventions, and improve care and outcomes. In addition to tracking CalOMS discharge status, Marin QI tracks and monitors to baseline standards which include the percent of decrease in criminal justice involvement, decrease in hospitalizations, and increases in employment and housing status.

Alameda also has a low level of administrative discharges, well below the statewide percentage. Although Alameda's data and analytic staff resources were impacted by COVID-19, securing a path for increased access to data for its providers remains a system priority. Alameda has invested in a proprietary data analytics tool that allows them to provide reports and dashboards for its system providers along with continuous monitoring. CalOMS discharge code results are included on client discharge summary forms and provide some direction to providers on further follow-up when needed. Some of the CalOMS data elements are part of dashboard reports, shared with providers to review outcomes at a systems level. In addition, there is a monthly PowerPoint report with CalOMS data, such as the Completion Status Report, which is used to determine overall trends in treatment completion and referrals to another LOC.

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 CalOMS through ITWS would reduce the burden on individual DMC-ODS counties. Contemporaneous visibility would create both a systemwide and site-specific baseline to effect local changes. Sadly, many counties do not have the internal resource that would allow development of internal reports to replace the state reports and analysis.

CalOMS Major Outcomes Finding: Progress in Treatment

While standard discharge ratings indicate rates of positive progress for clients in treatment for FY 2019-20 that are consistent with those in the prior year, adult standard positive discharges have dropped. This decrease, from 57.9 percent to 42.1 percent compared to FY 2019-20 is correlated with the onset of the COVID-19 pandemic.

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. With the introduction of several "newer" counties into the DMC-ODS system, lowered rates of satisfactory discharge are consistent with the challenges faced by newer counties over the course of the Waiver.

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 LOS. 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. Again, this may well have been accelerated with the onset of the COVID-19 pandemic, though most counties have now seen a return to near pre-pandemic census levels.

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.

CalOMS Outcomes Findings: Satisfactory Discharges from Care

This year saw a year-over-year increase in satisfactory discharges. While 14.8 percent in FY 2019-20 represents an improvement from the rate of 13.1 percent in FY 2018-19, treatment completions have dropped somewhat. Treatment completions occurred just 17.6 percent of the time compared to 19.3 percent in the prior year. This is the second year that clients completing treatment has decreased from a baseline established in FY 2017-18 of 22.7 percent. These data are significant as improved services and engagement efforts would usually indicate that more clients are leaving treatment have 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 remained relatively constant year over year in terms of the slight reduction of unsatisfactory discharges and small increase in administrative discharges.

It is worth noting that the data represented in Figure 7-6 for FY 2019-20 includes the addition of four first-year DMC-ODS counties and the impact of COVID-19 on enrollments and client exits. First-year counties have near-universal program and data challenges that are consistent with implementation.

It is hoped that a post COVID-19 environment will provide more opportunities for both treatment access and an easier evaluation of the programs without as many external variables to consider.

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

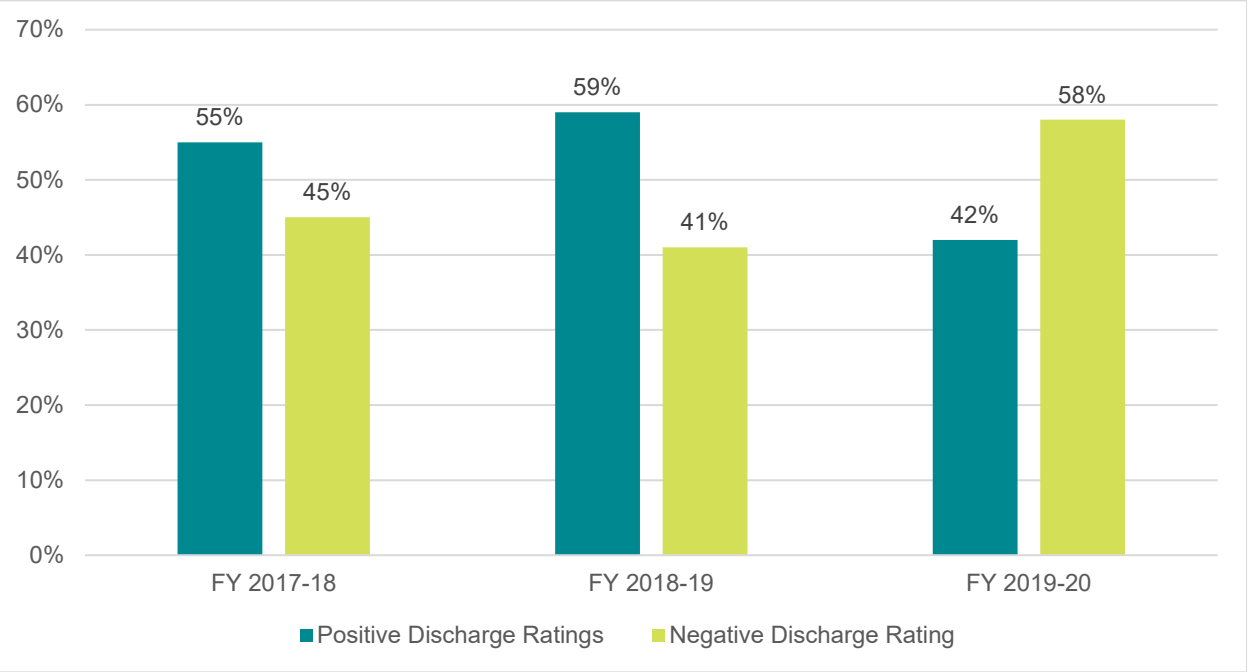
Discharge Status	2017-18	2018-19	2019-20
Completed Treatment - Referred	22.7%	19.3%	17.6%
Completed Treatment - Not Referred	7.8%	6.3%	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	11.1%	13.1%	14.8%
Left Before Completion with Satisfactory Progress - Administrative Questions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

Pioneer County CalOMS Experience with Discharge Outcomes Findings

After improving in FY 2018-29, the original Pioneer Counties saw reduction in positive discharge ratings during FY 2019-20. The reduction was significant with just 42 percent of clients exiting with a positive designation in FY 2019-20 compared to 59 percent in FY 2018-19. While this result may have been the experienced during the first few months of the COVID-19 pandemic. FY 2017-18 saw more positive treatment exits at 55 percent, well above the current year. Last year had a 4 percent decrease in unsatisfactory exits from the prior year. However, this year had a substantial increase in negative discharge ratings at 58 percent compared to just 41 percent in FY 2018-19 as reflected in Figure 7-6.

When breaking it down more than half of them actually did do well but some very large counties did not and more analysis of all the factors will need to be done.

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



While CalOMS outcomes data for FY 2019-20 indicates a decline in positive client discharges along with an increase in those rated negative, of the 14 Pioneer cohort, 9 counties are far exceeding the statewide average of 42.1 percent in positive discharges. Of those more than half saw positive outcomes 10 percentage points above the state rating. **Riverside** at 53.4 percent**, San Mateo** at 55.6 percent, **San Bernardino** at 63.3 percent, **Nevada** at 68.3 percent, and **San Francisco** at 65.9 percent represent strength in improvements made within the Waiver's managed care environment. In addition to the areas of engagement, retention, system navigation, case management, and discharge or LOC transition planning, it is likely these fourth-year counties also have taken steps to improve data collection, submissions, service capacity, and client-centered ASAM skills.

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. As the entire cohort moves past the very consuming aspects of systemwide Waiver implementation and very real impacts of COVID-19, positive improvements in outcomes, such as those shown in the Pioneer Counties, should be anticipated.

Experience has made a difference with some of the early Waiver counties in CalOMS outcomes, some of the original counites have positive outcomes 10 percent or more above state averages.

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 and increase the number of counties able to rapidly utilize CalOMS data to improve practices. Contemporaneous visibility would create both a systemwide and site-specific baseline from which to effect local changes. Additionally, it is recommended 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 on 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 staff.

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 showing progress in care and also continuation at lower levels of care.

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 includes engagement and retention strategies, often formalized using PIPs. Strategies have included the use of motivational interviewing, system navigators, enhanced communication between clients and receiving programs through the intake process; case managers, specialized teams, or recovery navigators to work with clients as they engage in 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 improvements. In most cases, there are positive indicators that retention and standard discharge rates are improving as is confidence in data reliability. Likewise, an intentional local

plan to manage data and reduce errors, omissions, rejected files, or large numbers of unreconciled CalOMS rejections have made targeted improvement strategies possible and effective.

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 specific provider, with an expectation that this information will be used to inform programs on where and how they are doing well and where they need to apply and improve QI measures.

UCLA also provides the counties 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 actions to be taken to improve services in a meaningful way and to engage providers while issues and feedback are fresh.

Opportunities for improvement include expanding the number of surveys for all sites and for persons of different ethnic groups and non-English speakers to increase their voices in survey results.

Retention in Care

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 significant differences between 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 with 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 LOS 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 longer and transition or complete treatment with satisfactory progress. 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 populations such as the homeless and those with co-occurring conditions, seem to have more clients stay longer in treatment. Expanded MAT utilization also seems to correlate with clients who have longer lengths of stay and engagement across multiple levels of care.

Summary and Recommendations for Improving Treatment Outcomes

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. Where and when DHCS makes changes, those trainings should be standardized and made available statewide.

Prioritize obtaining a full CalOMS data set.

Timely, accurate and complete CalOMS data collection is needed to assure the veracity of the data represented for each of the DMC-ODS counties for both performance and clinical outcomes. At present, oversight in obtaining complete CalOMS cycles each month for every program and clinic site varies between counties. Some of the DMC-ODS counties who have prioritized system monitoring provide feedback on rejected or incomplete data along with analysis to determine training needs, such as the level of assistance many providers still require to better represent the efficacy of care provided.

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 now seen as necessary though additional supports would be needed should reports become more available. Restoration of the state reports for CalOMS is recommended, alignment of the CalOMS structure with the ASAM LOC, and funds for health infrastructure in general for SUD health information development are needed.

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.

TPS

Boost response rates among treatment subpopulations and all program levels to accurately represent DMC-ODS beneficiaries to enhance the 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 sizable percentage of TPS response in specific levels of care and not others. Programs with an elevated 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 many physical surveys were provided to SUD program sites. Requesting additional efforts to increase TPS response rates amongst certain LOC levels, with youth and non-English speaking populations have been consistently part of CalEQRO's recommendations.

Retention in Care

Prioritize and standardize retention and engagement strategies.

Process improvement strategies that track and address indicators of retention problems (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.

Lack of focus on individual treatment needs and goals

Most clients receiving care continue to stay for the traditional 90 days as reflected on treatment plan authorizations, not reflecting individualized treatment. While the number of clients with 90-day stays are 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 fixed 90-day program-driven models and benchmarks. This holdover to the 90-day model may be due to individual hesitancy of staff, programs, or even primary referral sources such as criminal justice. Nonetheless, for treatment to be truly individualized and customized to meet individual needs, letting go of fixed LOS and program models is needed. If paperwork requirements and fiscal rules and incentives create 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 treatment goals that lead to recovery, the clearer the benefit of SUD treatments will be. If all or most clients have the same LOS and similar treatment plans, that should be a warning sign that the program is not doing individualized treatment or treatment planning, and services should be examined.

Seek client feedback to identify access and treatment retention 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 and access issue and cultural issues related to relevant care. This has included drilling down on specific program issues, such as hours of operations, easy access, childcare, work, 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. Long engagement in treatment 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 dropouts of treatment and provides mechanisms to re-engage clients who have left or have different needs.

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

Chapter 8

Performance Improvement Projects

Performance Improvement Projects

Introduction

A Performance Improvement Project (PIP) is "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner."[17] Each PIP is expected to produce beneficiary-focused outcomes. The CMS *Validating Performance Improvement Projects* protocol specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, or were completed during the reporting year.[18] Accordingly, for this Annual Report, CalEQRO examined projects that were underway at some time during the 12 months preceding the FY 2020-21 reviews.

During the 12 months preceding the review, each DMC-ODS is required to conduct two PIPs: one clinical and one non-clinical. The clinical PIP is expected to focus on treatment interventions to improve outcomes and client experiences, while the nonclinical PIP is expected to focus on administrative or systemic processes that improve care and the client experience. The goal of both PIPs is to address problems or barriers in care where, if successful, the outcome will positively impact clients.

A clinical PIP might target some of the following types of issues:

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

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

- Coordination of care with pharmacy and ancillary care providers
- Timeliness and convenience of service improvements
- Improvements in customer service and initial engagement in care
- Member services and processes that are barriers to optimal beneficiary outcomes and satisfaction
- Improvement in access or authorization processes

[17] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). *Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0*, October.2019 Washington, DC: Author.

[18] Ibid.

- Member services and processes that could be barriers to optimal client outcomes and satisfaction

Methods

The PIP Implementation and Submission Tool (also referred to as the PIP Development Outline) is a template provided by CalEQRO for the DMC-ODS plans to use when drafting their PIP narratives.[19] Prior to the onsite review, the DMC-ODS plans are to submit both PIPs to CalEQRO. The designated CalEQRO Quality Reviewer and the CalEQRO PIP Consultant review all submitted PIPs for clarity, applicability, and relevance to the DMC-ODS's population, methodology used, and data findings, among other features.

During the review, the CalEQRO team conducts two PIP sessions with the DMC-ODS plan to discuss the documentation provided. During these sessions, the team provides feedback and technical support for strengthening the submitted PIPs. Following the review, DMC-ODS staff are allowed to resubmit their PIPs with any changes or additions discussed during the onsite review. The CalEQRO Quality Reviewer reviews and validates any resubmitted PIPs in accordance with the requirements of CMS Protocol 1.[20] All PIPs are rated based on their completeness and compliance with the standards found in the CMS protocol.[21] Each of the nine PIP steps includes subsections containing standards that are rated according to the PIP Validation Tool.[22]

The PIP rating steps are shown in Table 8-1, below:

Table 8-1: PIP Steps

Step	PIP Section
1	Identify PIP Topic
2	Develop the Aim Statement
3	Define the PIP Population
4	Describe the Sampling Plan
5	Select the PIP Variables (Indicators) and PMs
6	Describe the Improvement Strategy (Interventions) and Implementation Plan
7	Describe Data Collection Procedures
8	Describe Data Analysis and Interpretation of PIP Results
9	Address Likelihood of Significant and Sustained Improvement through the PIP

[19] To view the PIP Development Outline, visit CalEQRO's website: http://caleqro.com/#!california_eqro_resources/. The tool is found under Notification Materials/DMC Notification Materials Review Preparation Materials.

[20] Ibid.

[21] Ibid.

[22] The PIP Validation Tool and PIP Submission Tool is available from CalEQRO's Website, www.caleqro.com.

Table 8-2 shows the categories of PIP Status and their definitions.

A PIP will have satisfied PIP requirements (i.e., met the standard) if the PIP is either Active and Ongoing or has been completed. A PIP that has been submitted for approval or is in the planning phase is not yet active and does not meet the PIP requirements. To be considered in the Implementation phase, a PIP must have baseline data on some indicators or PIP variables and some improvement strategies must be started. During the Baseline phase, a strategy has begun and refinements in the baseline measurements may be occurring, but there will not yet be a first measurement. A PIP in the First Remeasurement phase will be measuring the impact of the improvement strategy on the key indicators or PIP variables relative to the baseline and the goal, a Second Remeasurement phase would follow. Some PIPs have more remeasurement periods and so they fall in the "Other" phase.

Table 8-2: PIP Status Terminology

PIP Status Terminology through 2019 – 2020 review year	PIP Status Terminology 2020-2021	Definition
Concept Only, Not Yet Active – This is NOT an active PIP.	PIP Submitted for Approval	The DMC-ODS submitted the PIP concept for review by CalEQRO
	Planning Phase	PIP is not yet active, the DMC-ODS is preparing to implement the PIP.
Active and Ongoing	Implementation Phase	The DMC-ODS has established baseline data on at least some of the indicators, and at least some strategies for improvement have started. Any combination of these is acceptable.
	Baseline Year	A strategy for improvement has begun and the DMC-ODS is establishing or refining a baseline measurement.
	First Remeasurement	Baseline has been established and one or more strategy is being remeasured for the first year/period.
	Second Remeasurement	The success of strategy(s) is being measured for the second year/measurement period.
Completed	Other	In the past 12 months or since the prior EQR the work on the PIP has been completed. This meets the submission standard.
Inactive, Developed in a Prior Year	Other	Rated last year and not rated this year. DMC-ODS has done planning, but intervention/strategy had not yet started. This is NOT an active PIP.

Sixty-One PIPs were submitted for review from the 31 DMC-ODS plans reviewed. Of these, 56 PIPs were rated as active and ongoing or completed (88.7 percent). Four were rated in the Concept phase (6.5 percent), these PIPs were concept only, not yet active. One additional PIP was determined not to be a viable PIP (1.6 percent). These ratings were determined based on the PIP Status as described above. Of the 56 PIPs that were rated as active and ongoing or completed, five PIPs were in the Baseline Phase, fifteen PIPs were in the Implementation Phase, nineteen PIPs were in the first re-measurement phase, six PIPs were in the second re-measurement phase and eleven were in the "Other" phase with three or more re-measurements.

In FY 2019-20 CalEQRO reviewed 26 DMC-ODS plans who had begun services under the 1115 Waiver the prior two years. For FY 2019-20, 53 PIPs were submitted (one county submitted three) and 43 were active or completed (80 percent). FY 2020-21 showed improvement in active or completed PIPs submitted.

Below is a chart for FY 2020-21 breakdown of the PIPs submitted: FY 2020-21 many counties were transitioning to the new CMS forms for their PIPs that were not near completion.

Table 8-3: PIP Submission Status, FY 2019-21

Submission Status	FY 2019-20	FY 2019 -20 Percent	FY 2020-21	FY 2020-21 Percent
PIPs submitted	53	98%	61	98%
Active / Ongoing	43	80%	55	88.7%
Concept Only, Not Yet Active	9	19%	4	6.5%
Completed	0	0%	1	1.6%
Submission determined not to be a PIP	1	1%	1	1.6%
No PIP submitted, but required	0	0%	1	1.6%
Inactive developed prior year	0	0%	0	0%
Total possible PIPs	54		62	

Trends and TA in PIP Submissions

This year, there was an increase in active and completed PIPs versus concept only PIPs. During FY 2019-20 there were nine concept-only PIPs and one determined not to be a viable PIP. In FY 2020-21 there were four concept-only and one determined not to be a viable PIP. In FY 2019-20 the percentage of active and completed PIPs was 80 percent (43 out of 53 submitted) and in FY 2020-21 the percent was 88.7 percent plus 1.6 percent for a total of 90.3 percent (56 out of 61); a 10.3 percentage point increase over the prior year, the actual percentage increase is 14.7. This was due to increased experience and training with the new CMS forms and additional experience of the DMC-ODS QI and SUD staff with the process for developing and implementing PIPs.

FY 2020-21 had a smaller number of counties launching new DMC-ODS services during that year, which is often the most challenging PIP year for new programs. The year had four independent counties and the Regional Program launching new Waiver services. Two of these programs had strong QIC programs with SUD experienced leadership, therefore they did not have as many challenges as can be typical of first-year counties with PIPs or other implementation issues.

Overall, the confidence level of the counties with their PIPs has improved. The counties have more clarity in their data collection and analysis plans, selection of PMs, and the foundational research of the problems they are identifying for the PIP. It is important to remember that this is only the fourth year of Waiver implementation. Limited numbers of county substance use staff have experience with PIPs for four years (only three counties); in fact, for most it is their second year of PIP implementation due to staggered waiver implementation times, and for nine counties it is their third year of development.

In FY 2017-2018 three counties were reviewed and six active PIPs were submitted, in FY 2018-19 CalEQRO reviewed 14 counties (including the three original counties) and received 28 PIPs, in FY 2019-20 there were 26 counties reviewed and 53 PIP submitted, and in FY 2020-21 there were 30 counties reviewed and a Regional Plan and 61 PIPs were submitted.

However, some of the technical aspects of the PIPs are still presenting challenges. Further, interruptions to routine business processes in response to COVID-19 also impacted many PIP interventions in the middle of their evaluations, thereby requiring the redesign of many PIP interventions. The implementation of data collection processes and tasks linked to each PIP needs to be extremely clear and built into workflows effectively to have accurate data.

Range of PIP Topics & Key Themes

Below is a chart of all the PIP topics included in submitted viable PIPs, both clinical and non-clinical, by the counties and Regional Model this FY. The PIP topics are organized by Access to Care, Timeliness of Care, Quality of Care and Outcomes. With 23 PIPs submitted, Access to Care PIPs included the submission of 6 clinical and 17 non-clinical PIPs. The Access to Care PIPs had a variety of themes many of which are linked to the initial engagement and screening phase or linkage with the first phase of treatment and the BAL or Access Call Center functions. The six clinical PIP topics focused on issues such as engagement in MAT, continuity of care between residential and lower levels of care, case management services and teams, and access to residential treatment. Since case management is a newly implemented service for many DMC-ODS plans to provide and bill for, there are new PIP models being tried based on various theoretical approaches to case management that support ongoing retention in care. In the initial years of the waiver, many PIPs focused on achieving basic managed care requirements but now many PIPs are shifting to ASAM-based clinical goals and other quality goals or best practices.

Table 8-4: PIP Topics Access - Clinical and Non-Clinical

PIP Topic	PIP Titles	Clinical	Non-Clinical
Access to Care	Increasing Client Engagement and Retention (and reducing Client Dropout rate at initial services)	**Napa**	
	Increasing Referrals to Substance Use Residential Treatment for Zuckerberg San Francisco General Hospital Patients with Severe Substance Use Concerns	**San Francisco**	
	Increasing Residential Admission Rates	**San Mateo**	
	Increasing Access to Screening and Referral	**Santa Barbara**	
	Using Case Management to Increase Client Engagement	**Santa Clara**	
	Clinical Care Coordination Team (CCT)	**Stanislaus**	
	Substance Use Disorder (SUD) 24/7 Access Line		**Fresno**
	Increasing Client Linkage to Assessment Appointments		**Kern**
	Improving Access to SUD Treatment from Substance Abuse Helpline (SASH)		**Los Angeles**
	Access to Care Using Case Management (CM)		**Marin**
	Access to SUD Treatment for Adolescents		**Merced**
	Increase Beneficiary Access to SUD Services Eastern Nevada County		**Nevada**
	Substance Use Navigation Enhancement Project Increasing Consumer Engagement with SU Navigators at the Hospital		**Riverside**
	Text Appointment Reminders		**San Benito**
	Increasing Youth Enrollments in SUD Services through Mental Health Care Coordination		**San Bernardino**
	Streamlining Access to Services		**San Francisco**
	Improving Access to SUD Treatment from Substance Abuse Helpline (SASH)		**San Joaquin**
	Increasing Outpatient (OP)/Intensive Outpatient (IOP) Show Rates		**San Mateo**
	Increasing Access to Screening and Referral		**Santa Barbara**
	Using a Hybrid Delivery Model to Improve Client Engagement in Partial Hospitalization Services (PHS)		**Santa Clara**
	Increasing Outpatient (OP)/Intensive Outpatient (IOP) Show Rates		**Santa Cruz**
	Improving NTP/OTP Access		**Stanislaus**
	Improving Timely Access to residential treatment		**Yolo**

The amount of Timeliness of Care PIPs that were submitted is smaller than previous years, however these types of PIPs are still a substantial number with ten in total, seven non-clinical and three clinical. The non-clinical PIPs are focused on meeting specific timeliness requirements related to routine first appointments at residential and outpatient and first appointments for assessments, and timely coordination at intake. The clinical PIPs are focused on specific challenges in timely access to treatment in residential care, post-traumatic stress disorder (PTSD) issues related to impact on timely access in SUD, and a similar issue with MAT in shared decision-making to engage clients in a timely way. It has been positive to see the counties exploring social, cultural, and emotional barriers to engagement of different SUD populations and groups of clients. Counties are focusing on ways to overcome these barriers clinically with staff and environments as part of their PIPs and quality care in general. As counties have resolved timeliness issues successfully this type of PIP has been seen less frequently.

Table 8-5: PIP Topics Timeliness - Clinical and Non-Clinical

PIP Topic	PIP Titles	Clinical	Non-Clinical
Timeliness of Care	Improving Timely Access to Residential Treatment	**Alameda**	
	Addressing High Rates of PTSD Among Clients Enrolled in SUD Services	**Orange**	
	Increasing Client Engagement in Medication-Assisted Treatment (MAT) through a Shared Decision-Making Approach	**San Bernardino**	
	Coordination of Care		**Contra Costa**
	Direct Intake Scheduling		**El Dorado**
	Improving the Timeliness of Routine Appointments		**Imperial**
	Improving Efficiency of the Residential Treatment Admissions Process		**San Francisco**
	Decreasing the Time Between Initial Contact and Completed Intake for Outpatient and Intensive Outpatient Treatment (IOT)		**Tulare**
	Study of Timeliness from First Contact to Assessment		**Ventura**
	Improving Timely Access to and Engagement in SUD Residential Treatment Services		**Yolo**

Quality of Care is the largest PIP topic area this year with 25 PIPs, 20 are clinical PIPs and five and non-clinical. Three of non-clinical PIPs look at use of specific tools and how to improve the use of the TPS, CalOMS, and ASAM-based reassessments. Two of the non-clinical PIPs focused on the processes of linkage between two levels of care and how to improve transfers. The clinical PIPs have a wide range of topics which is much broader than the prior year. One is focused on the new ASAM residential LOC designation clinical standards. Several PIPs focus on the clinical tools to enhance client retention in SUD care at various LOCs which is linked with better outcomes. Several PIPs focused on assessment and services for those with co-occurring mental health needs. Another focused-on linkage to care for those who have experienced a near fatal overdose. Several focused on engaged case management and transitions in care across the care system, others on integration with behavioral

health and primary services for meeting client needs beyond SUD, and treatment modality shifts due to COVID-19. All have the potential to teach the field important lessons on improving SUD services if results are shared for those that are successful and those that are not if the analysis is thorough and done well.

Table 8-6: PIP Topics Quality - Clinical and Non-Clinical

PIP Topic	PIP Titles	Clinical	Non-Clinical
Quality of Care	Clinical Linkage to Primary and Behavioral Health Care	**El Dorado**	
	Enhancing Engagement and Retention	**Imperial**	
	Seeking Safety Implementation	**Kern**	
	Improving Care Transitions to Recovery Support Services (RSS)	**Los Angeles**	
	Residential Case Management	**Merced**	
	Reducing the Risk of Fatal Opioid Overdose for Youth and Adult Beneficiaries	**Monterey**	
	Implementing Interventions Targeted for Individuals at the Beginning of Their Residential Treatment to Improve Client Retention	**Nevada**	
	Care Coordination of Co-occurring Needs	**Placer**	
	Increasing Successful Completions of SUD Treatment	**Riverside**	
	American Society of Addiction Medicine (ASAM) Level of Care Designation	**Sacramento**	
	Reducing Drop-out Rate	**San Benito**	
	Treatment Modality Shifts due to COVID-19	**Santa Cruz**	
	Connections After Discharge with Referral	**San Diego**	
	Individual Services to Improve Client Retention	**San Luis Obispo**	
	Increasing Continuing Care Between Residential and Outpatient/IOT	**Tulare**	
	Study of Care Coordination Post-Discharge	**Ventura**	
	Identification of Co-occurring Disorders and Linkage to Treatment	**Yolo**	
	Recovery Coach Services for Clients leaving Residential WM Needing Care		**Alameda**
	SUD Reassessment Tool		**Monterey**
	Increasing CalOMS Data Integrity Resulting in a Better Client Experience of Care		**Partnership**
	Treatment Perception Survey (TPS)		**Sacramento**
	Connection to SUD Services after Psychiatric Emergency Response Team (PERT) Connection		**San Diego**

Finally, the shortest list is the Outcomes of Care PIP topic area, there are eight PIPs focused on outcomes with three non-clinical and five clinical. The clinical PIPs look at specific outcomes from case managers on services, on recidivism in jail, on engagement in treatment, and linkage to other services. The non-clinical PIPs focused on the impact on clients in engagement and retention from recovery services, motivational interviewing, and choice in the continuum of care. Again, all have potential for learning new insights about SUD treatment and best practices in care if done if a consistent and well-designed manner.

Table 8-7: PIP Topics Outcomes - Clinical and Non-Clinical

PIP Topic	PIP Titles	Clinical	Non-Clinical
Outcomes	Increasing Case Management Through County SUD Navigators	**Contra Costa**	
	Client Engagement: Residential & Outpatient Continuation	**Fresno**	
	Non-Fatal Opioid Overdose Connection to Treatment	**Marin**	
	Increasing Case Management Through County SUD Navigators	**Partnership**	
	Linkage to Outpatient Following Residential Discharge	**San Joaquin**	
	Recovery Services Enrollment and its Impact on Recidivism to Higher Levels of Care		**Napa**
	Increasing Engagement and Retention Through Motivational Interviewing		**Orange**
	Continuum of Treatment Services		**Placer**

In summary, 61 PIPs were submitted and 55 are currently active, the four in the planning phase will be active within the year. One of the greatest challenges for the DMC-ODS plans has been adapting to video and phone service delivery because of COVID-19. This impacted almost all SUD services, lasted most of the year and was disruptive to the usual clinical interactions and especially disruptive to day programs such as intensive outpatient. So, many of the PIP improvement strategy interventions had to change. Many DMC-ODS plans surveyed clients regarding their capacity and willingness to do phone or video sessions. DMC-ODS plans converted back to in person sessions if possible or if phone or video was not working for the client, they also tried some home sessions at a distance or at a community center. Many reported clients dropping out of care. Others had some positive responses with higher functioning clients who had transportation challenges and more capacity with technology and ability to use smart phone or computers.

PIP Technical Assistance

CalEQRO offers TA onsite, via e-mail, telephone, video, and webinar to all DMC-ODS and MHPs. The intention is to help the DMC-ODS programs produce qualified PIPs, with TA ranging from helping to develop measurable aim statements to a comprehensive evaluation of all PIP validation steps.
All 30 counties and the regional partnership model took advantage of the technical assistance in the development and support of the stages of their PIPs. The number of PIPs provided to CalEQRO are almost 100 percent each year and while there are still technical issues to resolve, there is an interest in

learning and improving their programs especially as part of the Demonstration Waiver. Also, change to requirements of having LPHA staff to oversee the clinical programs and sign off on diagnoses and medical records has increased the level of technical support internally for doing evaluations of clinical studies, literature reviews, and evaluations of data in the PIP process.

One of the areas that CalEQRO has spent time with counties on this year is showing them how to use their available core data sets to evaluate improvement including TPS, ASAM, Claims, CalOMS, and the county MMEF and NSDUH data which is available. With knowledge of these data sets it is possible to design evaluations that are sound but not too complex and that related to the principal issues of access to care, timeliness of care, quality of care, and outcomes to care. Many DMC-ODS plans also have excellent access data from their call center software to evaluate access flow and dispositions and this is a critical function of any managed care organization. Training in these functions is important for local programs to take on these important business roles and optimize quality of care for clients.

Outside of the review process, in FY 2020-21 CalEQRO provided a total of 806 hours of individual TA to those 31 DMC-ODS plans. The TA consisted of assistance in attempting to construct PIPs, perform data analysis, modify PIPs due to COVID-19 impacts, and converting PIPS from the old CMS format to the new one. Some plans also had difficulties collecting and using data to design PIPs that target a specific problem in their geographical area.

Table 8-8 details the TA provided to all DMC-ODS plans during the review year. In addition to onsite TA, during the FY 2020-21 review year, CalEQRO provided PIP clinic webinars and in-person presentations that focused on PIP development.

Table 8-8: Technical Assistance Provided via PIP Webinars by CalEQRO, FY 2020-21

Type of TA Provided	Title	Location	Date
PIP Webinar	PIP Development and Implementation Tool	Online	July 30, 2020
PIP Webinar	Using the Tools to Develop a Successful PIP	Online	December 17, 2021
PIP Webinar	How to Address Disparities – Could a PIP Help?	Online	March 17, 2021
PIP Webinar	Foundations of a PIP	Online	June 30, 2021

Goals for FY 2021-22

With the beginning of CalAIM in January of 2022, CalEQRO will encourage counties to think about new PIPs that will focus on quality issues linked with CalAIM. These changes will include updated behavioral health policies that may improve access to preventative and early intervention services. This could help build a more prevention oriented SOC for SUD that would be particularly beneficial for youth with SUD. Youth are one of the underserved populations in almost every county and need to be a focus for more access to care PIPs.

Also, peers may have expanded roles in the workforce and that could provide opportunties to evaluate quality of care in new initiatives that focus on gaps in access, continuity of care, support services, and other initiatives.

Integration is also a focus of CalAIM and many clients have multiple problems needing this approach, this could also provide PIP opportunities for improvement strategies. Several PIPs are working coordination of care with physcial health already and evaluating impacts on ED visits and hospitalizations.

Continued hands on training and support is needed especially for the newer counties. Assistance with data system issues and changes linked to quality will enable them to be effective in their evaluation efforts and this will be a focus for next year as well. These are difficult areas for the less experienced DMC QIC staff and particularly smaller counties with limited data capacity.

Also more counties are preparing for EHRs for contractors and the DMC programs are trying to make sure there is good interoperability between their systems. These are positive efforts that could improve quality in their systems and benefit clients in coordination of care. These will also provide PIP opportunties for improvement and evaluation which can be linked to these new coordinated data expansions. The lack of EHRs has been a challenge since the beginning of the Waiver five year ago.

There will also be a focus on making recommendations to meet key timeliness and access standards, improve PMs, and address issues of equity related to underserved populations. Also to monitor and stay aligned with National and state quality standards for SUD and behavioral health with the plan for statewide Quality of Care and other key documents such as those on NA and Health Disparities.

2020-2021 BHC-CalEQRO DMC-ODS Statewide Annual Report

Chapter 9

Structure, Operations, and Information Systems

Structure, Operations, and Information Systems

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 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 or practice management systems
- Telehealth services
- Use of data for Quality Improvement

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.

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/IS, Finance, Operations, and QI subject matter expert staff. Responses are returned to CalEQRO before the DMC-ODS review. DHCS data sources also are used to assess IS and include Short-Doyle/Medi-Cal for DMC-ODS, the MMEF, ASAM LOC referral data, TPS data, CalOMS, and the provider file.

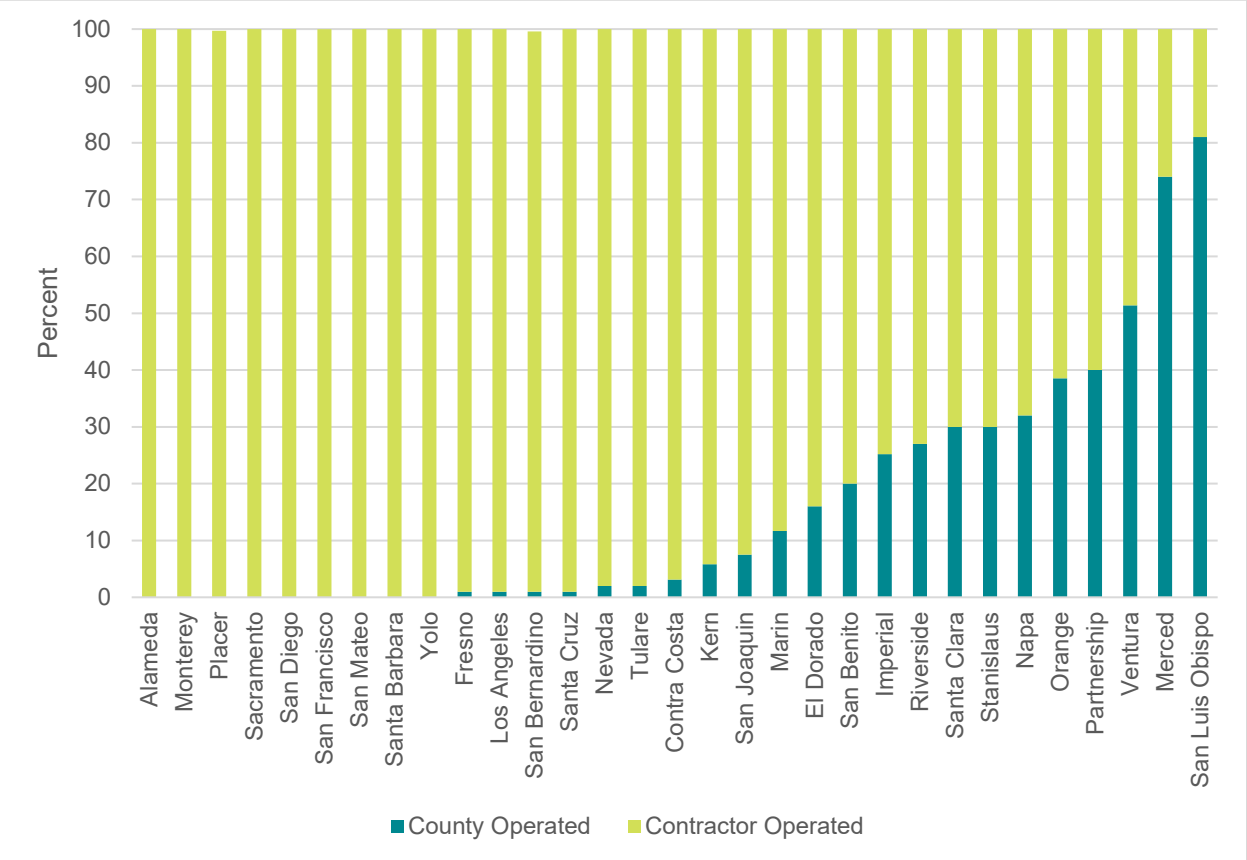
This annual report focuses on ISCA results for the 30 counties and a Regional Model of seven counties participating in a partnership that implemented DMC-ODS between July 2020 and June 2021.

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, Sacramento, San Diego, San Francisco, San Mateo, Santa Barbara, and Yolo to 81 percent county-operated in San Luis Obispo. The results were based on a single point-in-time estimate prior to the CalEQRO review and may have changed since then.

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

Mixed systems seem to have additional flexibility to meet 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 9-1 summarizes county-operated versus contractor-operated DMC-ODS services.

Figure 9-1: County DMC-ODS-operated vs. Contractor-operated DMC-ODS Clinical Services



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

The number and size of the organizations in the provider network also can play a significant role in the needs of the health IS and the level of complexity needed for smooth coordination and communication systems. Core areas where communication is critical for quality and business functions include clinical care, claims, intake and assessment functions, case management, and transitions in care. It is also not unusual for contract providers to use multiple different computer systems to provide both practice

management and EHR functions that can be different from each other and different from the county DMC-ODS.

HIS by Vendor

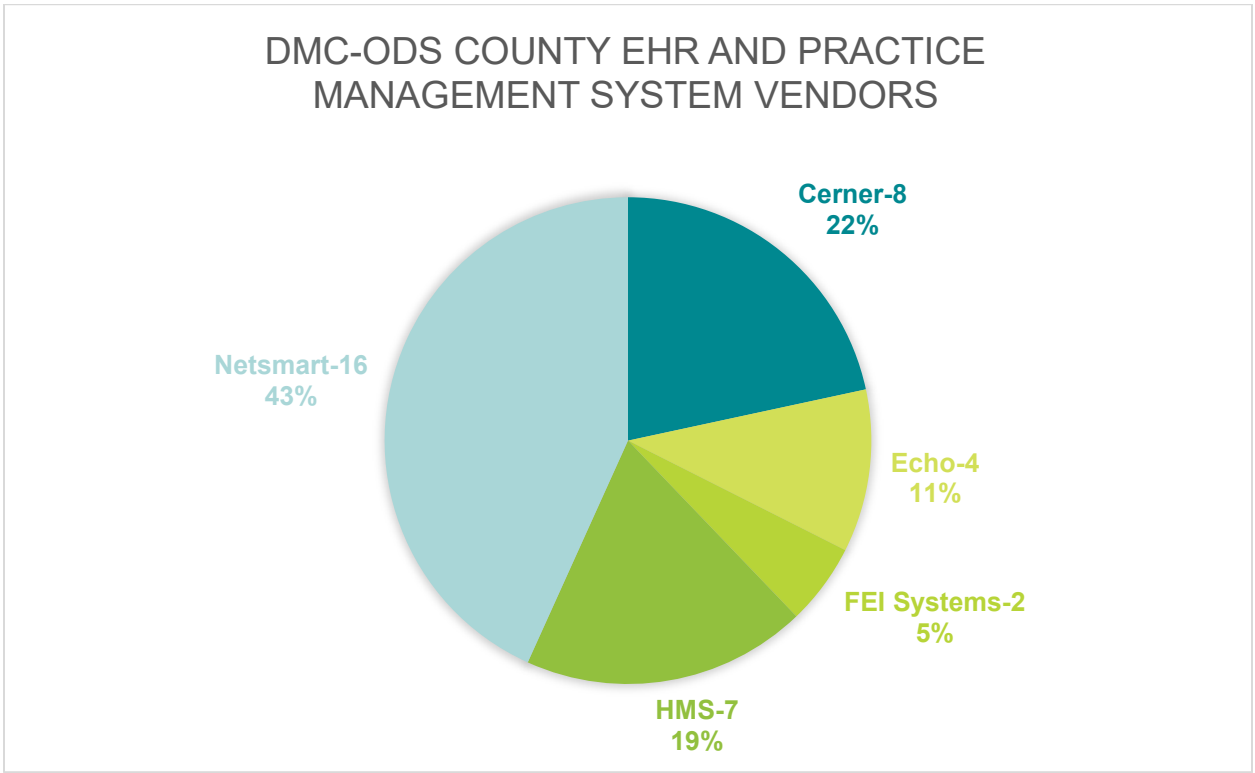
California counties have primarily relied on five technology vendors to support HIS in behavioral health: Netsmart Technologies, Cerner Corporation, The Echo Group, FEI Systems and HMS Healthcare. This narrow range of vendors is a consequence of California's unique Medicaid claims processing business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

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

Sixteen counties use Netsmart myAvatar: El Dorado, Fresno, Imperial, Los Angeles, Monterey, Placer, Riverside, Sacramento, San Bernardino, San Francisco, San Mateo, Santa Clara, Santa Cruz, Tulare, Ventura, and Yolo. Seven counties use Cerner Community Behavioral Health: Kern, Merced, Napa, Nevada, San Benito, San Luis Obispo, and Stanislaus; Orange County uses Cerner's Millennium system. Alameda, Contra Costa, San Joaquin, and Santa Barbara use Echo ShareCare or InSyst for practice management operations. Two counties—Marin and San Diego—use the FEI Systems/WITS. Seven counties in the Partnership use HMS Healthcare's Essette system for case management and utilization management.

Figure 9-2 summarizes DMC-ODS county system vendors.

Figure 9-2: DMC-ODS County System Vendors



Electronic Health Record and Practice Management Systems Hosting

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

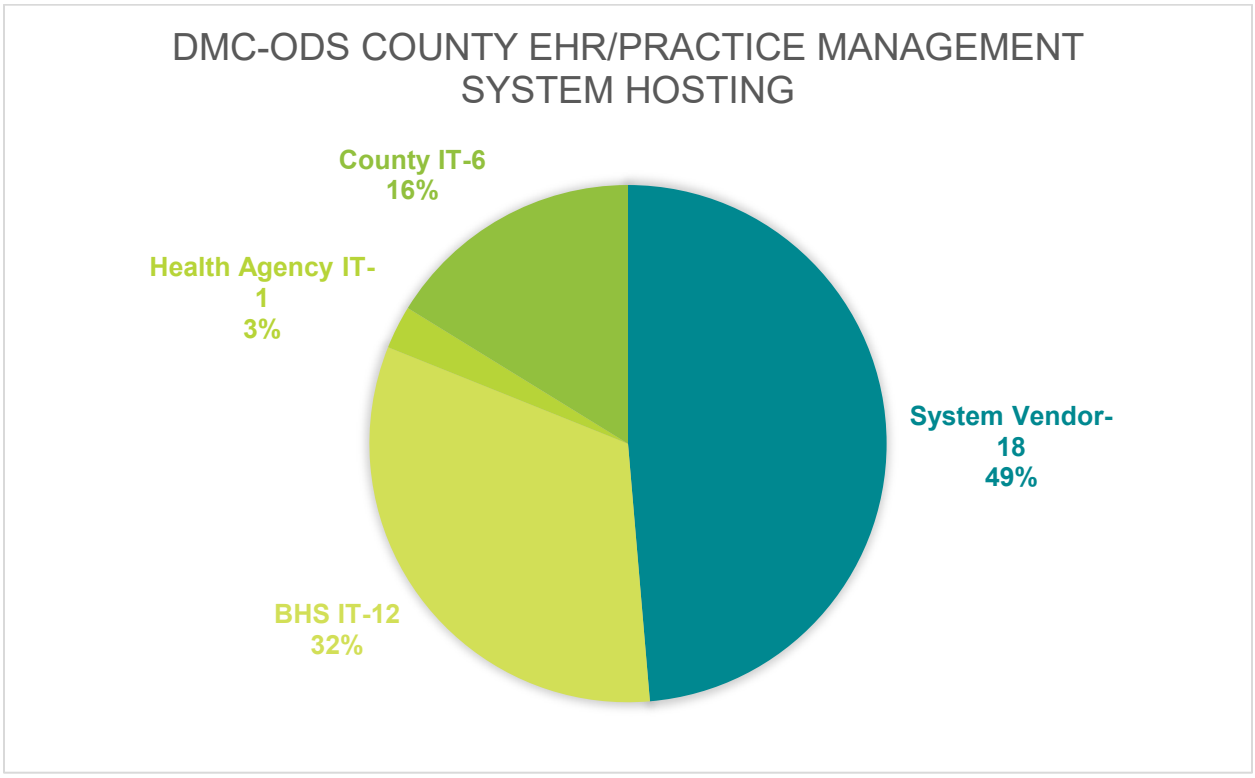
There are 18 DMC-ODS counties with core systems hosted by vendors, a single county has its system hosted by the health agency information system staff, 6 counties have hosting support from central county IT and 12 counties have hosting support from behavioral health IT.

Vendor-hosting counties vary in size and include El Dorado, Fresno, Imperial, Los Angeles, Marin, Monterey, Napa, Nevada, Orange, Sacramento, San Benito, San Diego, San Mateo, Santa Clara, Santa Cruz, Tulare, Ventura, and Yolo counties.

Most counties have implemented, or are in the process of implementing, a system that has core components that support EHR functionalities for DMC-ODS (and often mental health services as well) but counties themselves only deliver 20 percent of the services statewide at this time.

Figure 9-3 summarizes current county EHR/practice management system hosting status.

Figure 9-3: DMC-ODS County EHR/Practice Management System Hosting



Electronic Health Record Replacement or Creation Efforts

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

Contra Costa, Imperial, Kern, Napa, San Benito, Stanislaus, and Tulare are considering a new system.

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

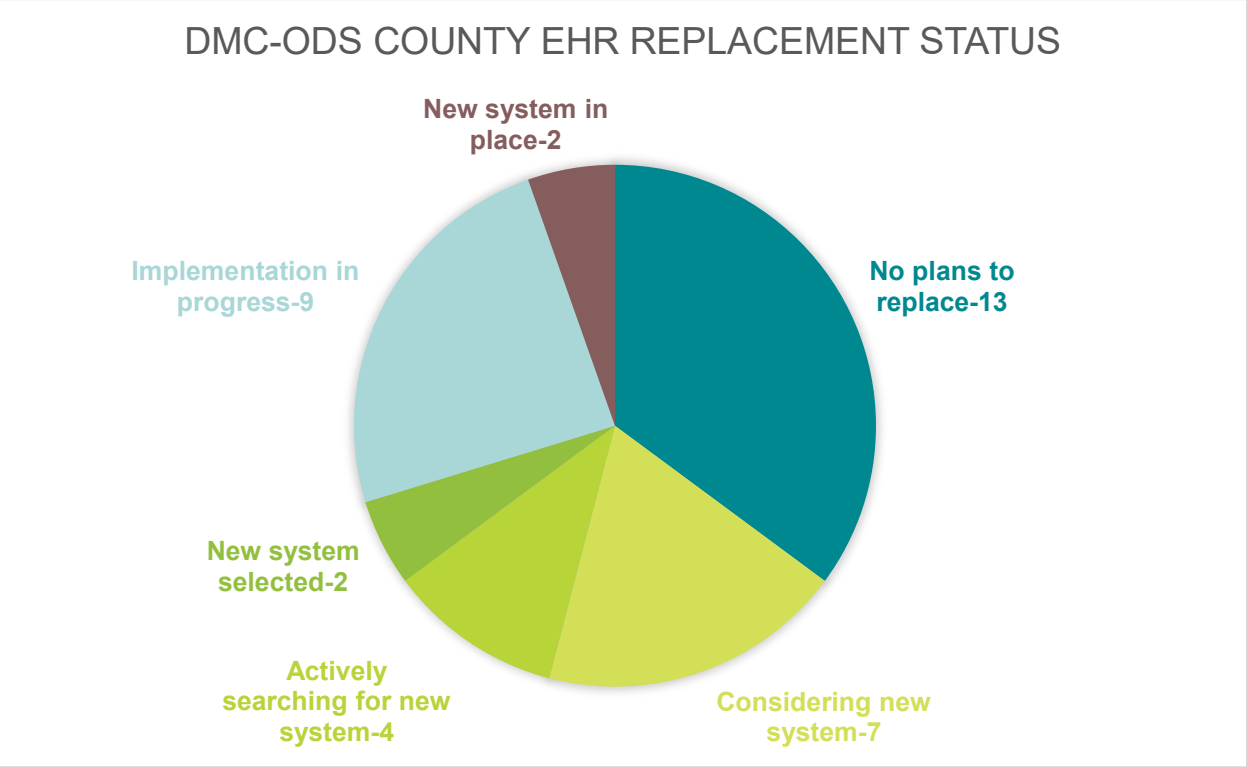
Counties that have selected new systems but have not yet implemented them include Alameda and San Francisco.

San Joaquin has integrated ShareCare with Clinician's Gateway and Santa Clara has switched from Cocentrix Pro-Filer to Netsmart myAvatar.

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

Figure 9-4 summarizes current EHR upgrade/replacement efforts.

Figure 9-4: DMC-ODS County EHR Replacement Status



Electronic Health Record Functionality

Collectively, only 58 percent of EHR core functions are present or partially present in county behavioral health systems, which significantly affects staff workflow. It is critical to note that this does not imply that their provider network of contractors have this level of EHR functionality; quite the contrary, as many of the contractors continue to rely on paper medical records. Many continue to struggle with new documentation standards and tracking requirements for timeliness and authorizations.

Only 58 percent of EHR core functions are present or partially present in **county behavioral health systems**, which significantly affects staff workflow.

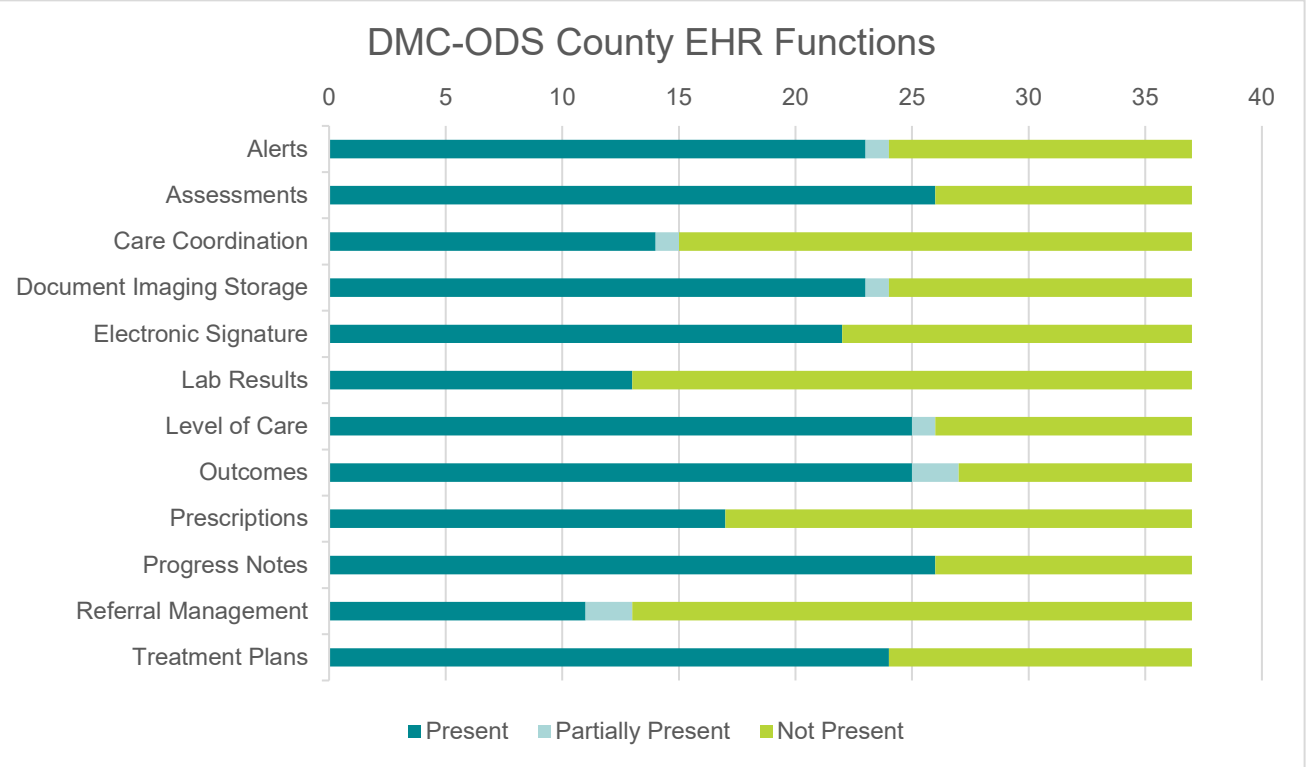
For those contract providers with local EHRs, the ability to electronically exchange client-level clinical transactions with county EHRs is generally lacking or is limited to service transactions. Most contract providers with local EHRs also need to enter practice management data—demographic, clinical,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

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

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

As Figure 9-5 indicates, referral management, care coordination and laboratory result functions are generally not present in DMC-ODS county EHRs. However, assessments, LOC and outcome tools, progress notes, and treatment plans are present in support of services billing in most systems. DMC-ODS counties continually work to expand the functionality of their EHRs and referral management and care coordination functionality will be an important focus with CalAIM's emphasis on integration.

Figure 9-5: DMC-ODS County EHR Functions



Interoperability

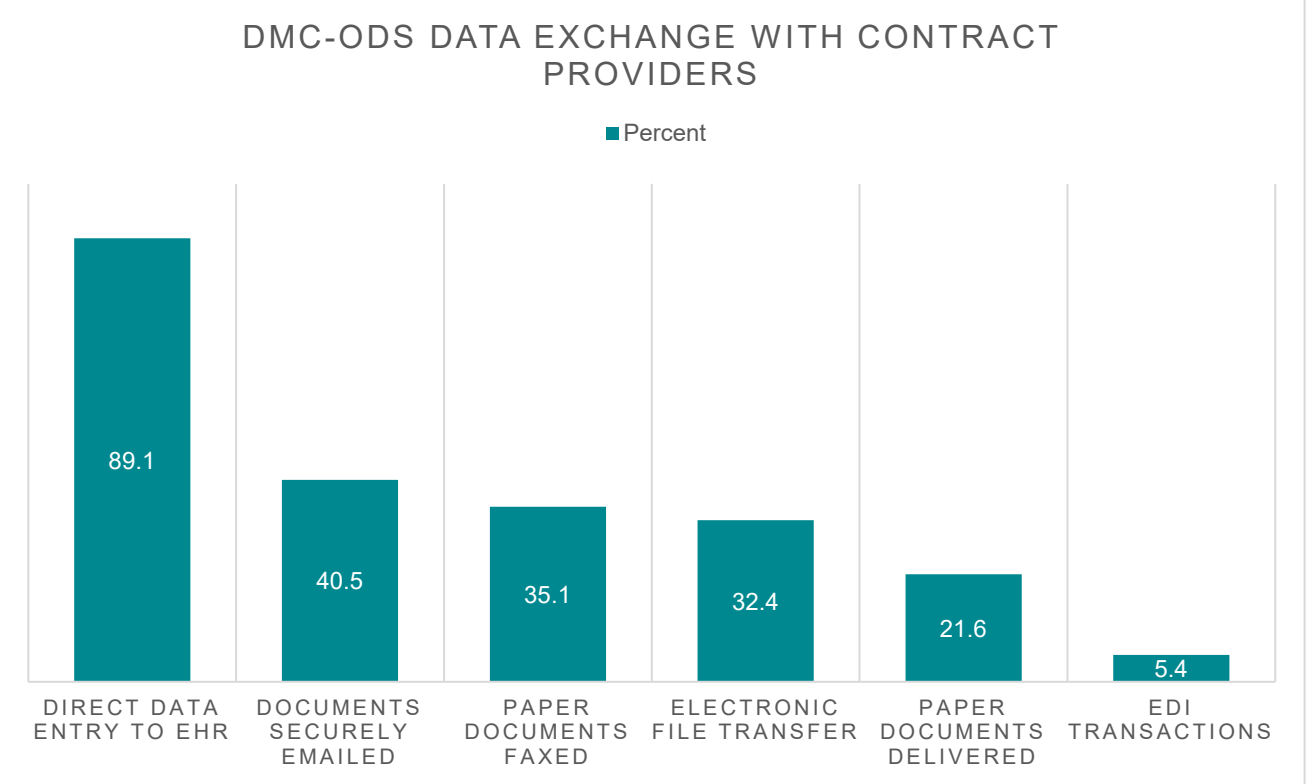
An overarching issue associated with implementing an EHR has been the integration of DMC-ODS services provided by contract providers into county systems. Generally, counties provide contract providers two or more submittal methods to exchange client information.

Currently, none of the 30 DMC-ODS counties and Regional Model 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.

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

Figure 9-6 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 33 counties (89.1 percent) indicated contract providers enter data directly into their systems.

Figure 9-6: DMC-ODS Data Exchange with Contract Providers



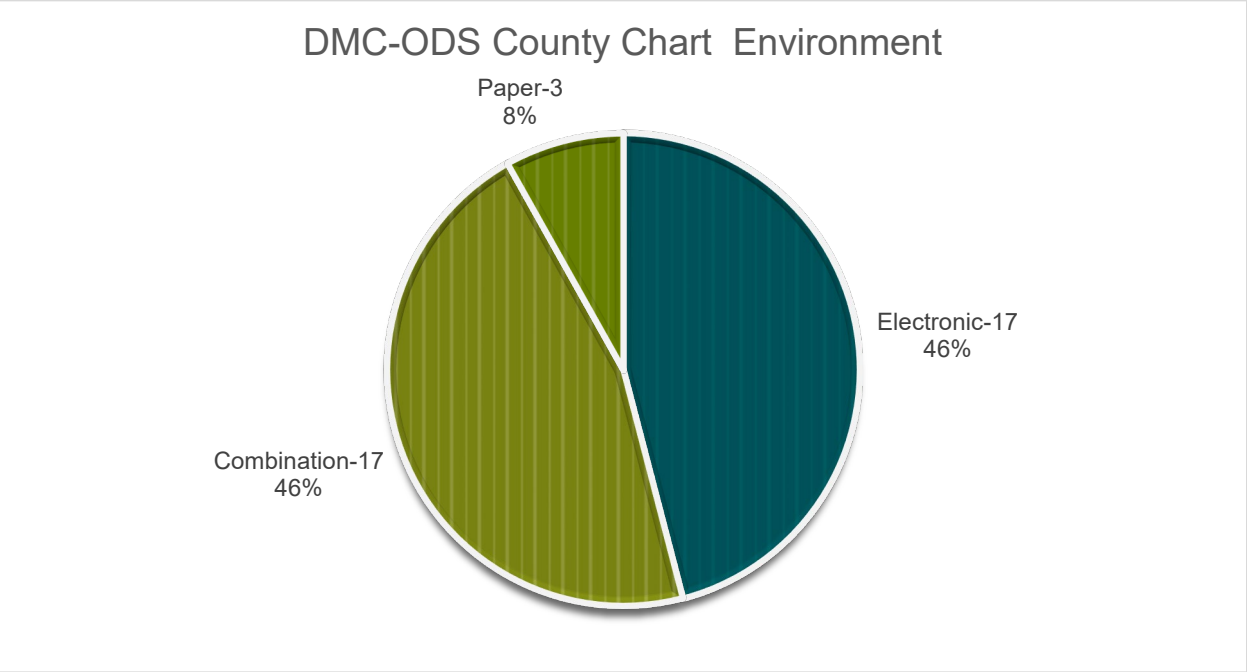
Interoperability continues to pose challenges for most DMC-ODS counties because it requires a level of resources, infrastructure, and skill sets not uniformly available to them. For the time being, for most DMC-ODS counties, some level of double data entry will continue to be required. Some counties 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 9-7 shows 17 counties reported having an electronic chart of record: El Dorado, Los Angeles, Monterey, Napa, Nevada, seven counties in the Partnership, Riverside, Sacramento, San Benito, San Mateo and Santa Clara. Counties reporting paper records are Contra Costa, Fresno, and San Bernardino. Counties reporting a combination of electronic and paper records are Alameda, Imperial, Kern, Marin, Merced, Orange, Placer, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, Ventura, and Yolo. This represents the majority of counties. Discussions with contract agencies showed that the preponderance of paper charts was much higher.

Figure 9-7: DMC-ODS County Chart Environment



It is expected that as DMC-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 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 IS

The percentage of DMC-ODS budget devoted to IS 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 three to five percent being considered the minimum necessary in health care organizations with a full-featured EHR.

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

- Large (n=13)—Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Ventura.
- Medium (n=19)—Marin, Merced, Monterey, Partnership (seven counties: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano), Placer, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Yolo.
- Small (n=5)—El Dorado, Imperial, Napa, Nevada, and San Benito.

However, there is more to consider than the percentage of the DMC-ODS budget devoted to the 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 2020-21 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.

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

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

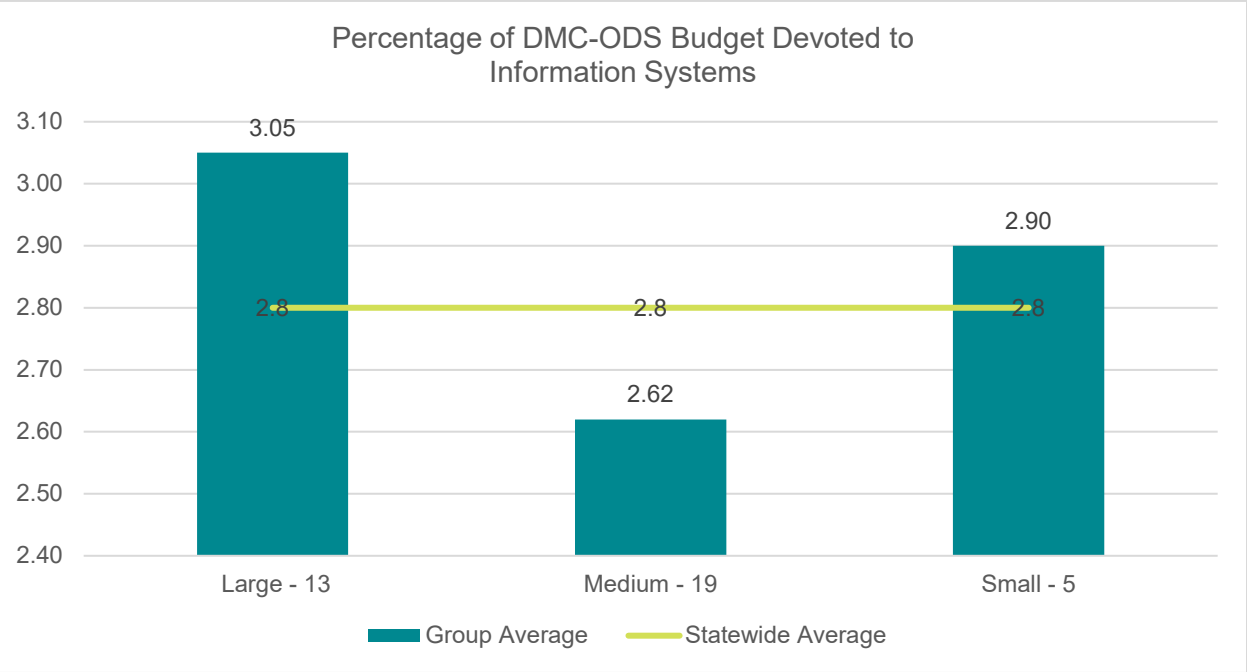
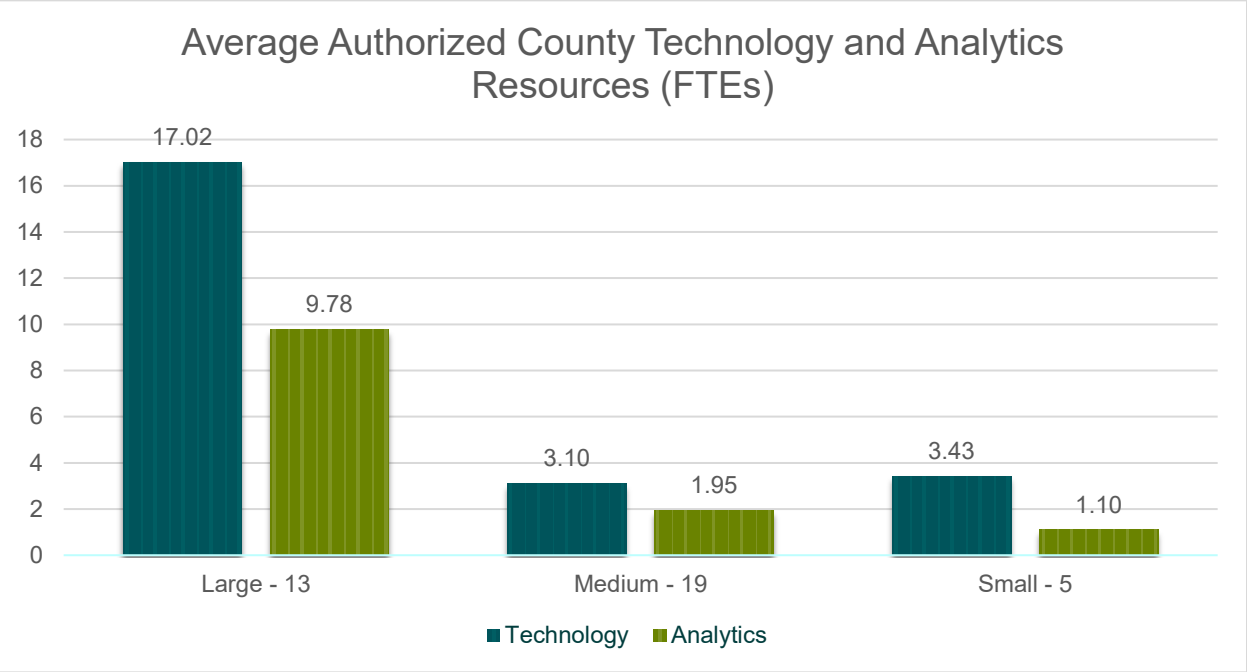


Figure 9-9 shows the FY 2020-21 average authorized technology and analytical resources in DMC-ODS counties, measured in FTEs (full time equivalent). The medium-size counties group, on average, has only 3.10 technology FTEs and 1.95 analytics FTEs. These are low numbers in view of all the challenges involved with setting up an information system and meeting reporting requirements during DMC-ODS implementation.

Figure 9-9: 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 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.

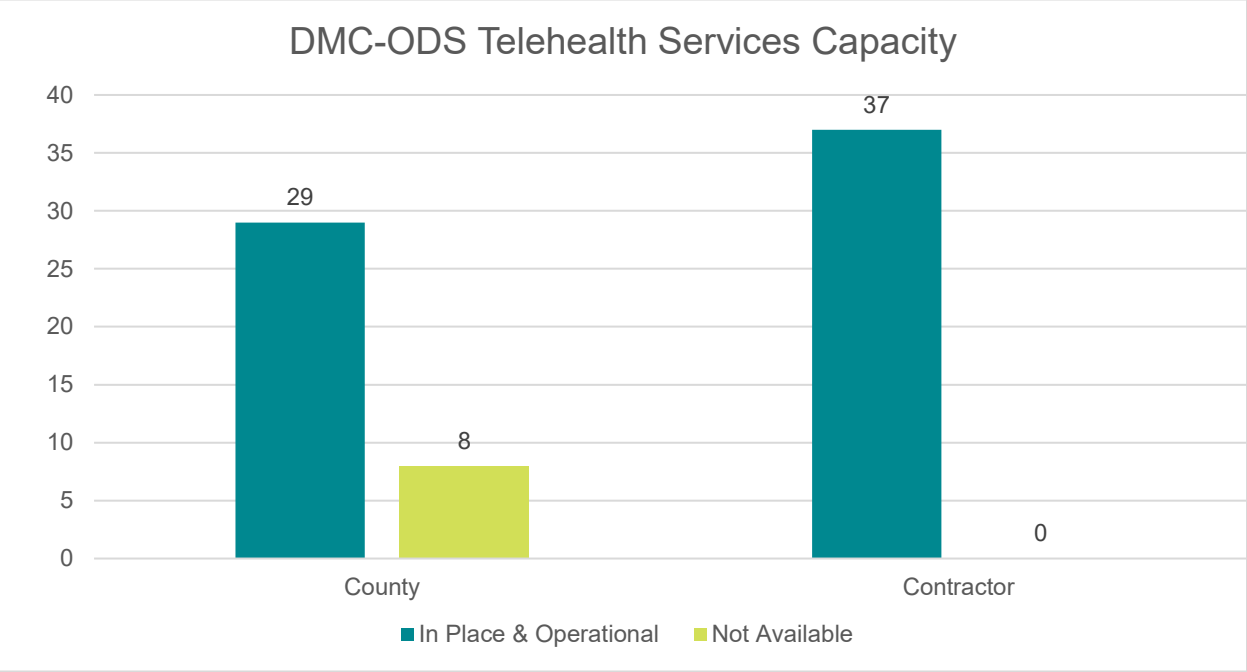
Availability of Telehealth

Delivering services via telehealth benefits both the client and healthcare practitioner, during the COVID-19 public health emergency. For the client, telehealth expands access to care by overcoming the transportation challenges that are often a barrier to services. For providers, telehealth allows for the convenience of service delivery from existing locations and may allow them to more efficiently serve clients. It also helps to support NA requirements and offers more flexibility to both clients and providers who are in remote areas of California. Figure 9-10 shows that for 29 counties (Contra Costa, El Dorado, Imperial, Kern, Los Angeles, Marin, Merced, Napa, Nevada, Orange, Partnership (7 counties), Placer, Riverside, San Benito, San Bernardino, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Stanislaus, Tulare and Ventura) there is currently technology in place to support SUD services at a distance. Those counties that do not offer telehealth services contract out all SUD services to agency providers.

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

Contract providers in all 37 DMC-ODS counties reported that they offer telehealth services to beneficiaries.

Figure 9-10: DMC-ODS Telehealth Services Capacity



Based on surveys conducted as part of UCLA's evaluation of the California Hub and Spoke MAT Expansion Project, only 23 percent of the providers offered telehealth service before COVID-19. Now, all of them are offering services using telehealth technology, both video and phone. CalEQRO reviews also showed rapid deployment of telehealth in counties reviewed in FY 2020-21. 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.

Barriers the NTPs reported in implementing telehealth services include: no telehealth systems in place, internet bandwidth issues, clients have no internet access or limited data plans on their phones. 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 LOC assessments are a critical component of the DMC-ODS assessment and service delivery model.

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

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. Annually, UCLA and CalEQRO collaborate on evaluating PMs findings to review the progress of DMC-ODS implementation in the State.

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.

Summary

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

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

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.2. This is also important for the network of contract providers, who render 84 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.

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 positive and high-quality manner.

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 IS, 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, Sacramento, Santa Cruz, and San Mateo are attempting to move in this direction with their systems. It will take time to develop this vision but integrating contractors into the county EHR as full partners has the potential to create a seamless and positive interface to serve the clients' needs in 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 effective communication systems. Timing is important because California will soon be updating its Medicaid Waiver, which will likely change many requirements that affect county IS. Finally, telehealth and mobile service delivery enhancements in bandwidth, equipment, training, client supports, and systems cannot wait until added resources are available, since SUD overdoses as well as mental health crises are rising in the Medi-Cal and general populations. These behavioral health services are needed now.

2020-2021 BHC-CalEQRO DMC-ODS Statewide Annual Report

Chapter 10

Conclusions and Recommendations

Conclusion and Recommendations

Key Issues of CalEQRO's FY 2020-21 Reviews

Introduction

Reviews in FY 2020-21 had several dominant themes. The year was overshadowed with worries and concerns related to COVID-19. Since County Behavioral Health Departments were a core part of the pandemic response, this was always impacting the environment, despite noble efforts to keep services operational and address the needs of beneficiaries and families with SUD needs. Even now as counties enter the next cycle of reviews, there is heightened anxiety related to another variant, Delta, and possible new impacts on services while vaccination efforts are underway. Despite best efforts to maintain services through the pandemic, contractor and county staff have reported a profound level of exhaustion with the extended crisis and its impact on staff and programs. Existing workforce resources are over-tapped; stress and burnout levels are high, as some counties are reporting more retirements, leaves due to illness, and obstacles to hiring.

On a more positive note, the new counties, including the Regional Model, stepped up to launch solid programs and have been doing excellent work carrying out first-year tasks associated with the requirements, STCs, and needed LOCs. They are having some of the same problems with PED, billing, and with finding providers as the Pioneer Counties, but things are clearer and more defined. New policies from DHCS related to recovery services and residential treatment are providing more guidance and flexibility for the programs.

Also, programs are generally looking forward with optimism to changes anticipated with CalAIM related to peers, medical necessity, and working on finance reforms, and expanded case management models with more positive partnerships with healthcare. The optimism and support for improving services for youth and persons with mental illness and SUD is very encouraging.

Generally, there is a strong commitment to the field and the Medi-Cal population, particularly to the most vulnerable subpopulations. Quality is also supported in concept as long as it focuses on outcomes, the therapeutic alliance, and concrete results of individuals getting better and less on paperwork which was very burdensome with some of the cumulative documentation and data requirements of DMC-ODS. However, staff continue to streamline CalOMS data linked to ASAM, develop other ideas to improve care, and consider suggestions from the QIC committees around the state on ideas for data improvements.

Aside from the environment and feedback, the counties, from the Pioneer Counties to those in the years that followed, did some impressive work at stabilization and expansion. Experience made a difference in how fast they could come back from COVID-19 impacts but also continue the journey of

refining their networks with expansions and capacity changes and attracting new providers, working on their frail computer systems, and developing new strategies to build the workforce and infrastructure to prepare for CalAIM. Once claims are completed for FY 2020-21, we anticipate a significant increase in services to more clients as compared to the previous fiscal year. Given the environment, which includes devasting wildfires as well as COVID-19, that is quite an achievement.

DMC-ODS programs noted the impact of the drug overdose epidemic as evidenced by rebounding overdose fatalities. Largely this was attributed to the widespread presence of fentanyl being found in virtually every illegal drug. CalEQRO discussed local realities in every county and noted what strategies other than education were being employed to mitigate these impacts. Many counties also distributed fentanyl strips and focused on overdose reversal training, naloxone distribution and community messaging through social media, billboards, and community forums. There were discussions with the courts and local law enforcement related to current drug trafficking, efforts of interdiction and focus on areas such as illicit drug distribution aimed specifically to children in high schools. However, this is a genuine problem many communities are facing now with alarm and needing to confront. In one recent review, staff reported that a young girl died because fentanyl had been put in marijuana purchased on the black market. While this struggle with fentanyl is documented by the EQRO, it does not have easy answers. DMC-ODS directors are focusing on prevention and access to care in an effort to protect targeted individuals.

Access to Care

Based on review of available data for FY 2020-21, CalEQRO projects expanded service delivery in the number of clients served and an increase in the services delivered at many LOCs. Over the years of the Waiver the data shows gradual improvements that these services are demonstrating their potential for SUD recovery and wellness for the clients served and their community support and integration.

However, as previously stated, some DMC-ODS treatment services still need to expand to reach their full potential for improving client outcomes in the community. Many services need expansion. RSS are just beginning to be utilized to support clients with community integration and ongoing support. Service for youth, generally, need to be expanded, but there is a particular need for residential treatment. WM services are often full or at capacity in many counties, as are residential treatment, particularly level 3.3 for those with special needs. Case management appears to have very positive effects on outcomes and coordination across LOCs but is still not available in many counties. MAT has improved statewide in both NTPs and in non-methadone MAT access, yet the NA requirements show many zip codes where NTPs are needed to meet NA requirements. Clients are continuing to express concern they are not being told about MAT information or are not being allowed into certain programs, such as recovery residences if they are on MAT. Recovery housing also continues to be a critical access 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.

Finally, and importantly there are clearly underserved populations in specific ethnic groups, non-English speakers, disabled groups, and elders with specific access and cultural linguistic needs that must be met for access to occur. Data clearly shows these areas needing improvement and they will continue to be monitored in the renewal of the Waiver and any Medicaid Plans that are approved.

Besides the specific service gaps themselves, workforce challenges persist for physicians, prescribers, LPHAs, and SUD counselors. As shared, every county and every contractor leadership group identified workforce as a key challenge in this years' stakeholder groups. They felt that institutions need to expand their capacity to increase the number of graduates and meet this need. Only state legislators

could fund this and make this a priority. Load forgiveness was critical to make these careers attractive because pay was not as great as other fields. There were years of intern status before you could become licensed. Also, peers with lived experience, training, and work experience, but without degrees are underutilized in the workforce; they could play a supportive role as navigators, in motivational interviewing, and assisting with transitions in care and case management functions.

Continued support for COVID-19 access flexibilities like telehealth and methadone take home doses was also recommended to increase access and program participation. This was seen as a positive development for the many rural and frontier areas of California and the weak and difficult transportation options in many areas of the state as well.

Timeliness and Network Adequacy

Like access findings, timeliness and NA showed improvements in these initial years of the Waiver and in FY 2020-21, particularly among the Pioneer Counties that had four years to refine their continuums of care and their HIS systems to track timeliness with their network providers. 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. A core recommendation continues to be to look systematically at the HIS 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 the same, they are both critical for good client care—and both are now extremely 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 from DHCS and the field, so it is easier to measure and easier to define when it is achieved. 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 a range of 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 LOC. 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 LOCs. This also touched on the issue of voluntary WM at the EDs which is a Medi-Cal benefit which many believe is not accurately defined in the regulations and needs improvement to be accurately used. It can be a service for persons with very acute alcohol withdrawal and so can be quite emergent. The recommendation is to review the regulations and determine if clarification is needed.

> It is recommended that a plan be developed for **HIS funding for behavioral health integration with provider networks, for EHRs, and interoperability**, to support real time communication and coordination with physical health and hospital systems to improve client care for SUD and mental health.

Another consequence of the telehealth and telephone service expansion is enhanced timeliness and less stress related to travel and NA 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 65 percent of the clinical and non-clinical PIPs were active focusing on a range of issues in access, transitions in care, timeliness, and quality.

Quality evaluation utilized the following tools: completeness of the continuum of care as a key to matching clients SUD needs; accuracy of the ASAM congruence with assessment findings to recommended treatment needs; PMs linked to research for recovery and improvements or adverse outcomes to be avoided; CalOMS; TPS results in specific dimensions, and; client and stakeholder focus groups. Also evaluated was 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 competence 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 recent 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, and they added more in the next budget year with the counties. Many counties worked to address billing and charting issues in their second and third years and redesigned workflows and documentation as much as possible to make it less duplicative.

Housing affordability, access, 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 LOC linked to ongoing MAT outpatient services.

Integration with other systems through the MAT expansion grants—particularly expansions linked to the EDs, hospitals, and criminal justice—showed incredibly positive impacts. CalEQRO strongly recommends these efforts continue; the impacts on the lives of clients, the communities, and the other two systems are encouraging and shared in many stakeholder and client groups. Currently, the DMC-ODS system is strengthening its connections to hospital EDs and criminal justice systems, through the ED Bridge grants and the new criminal justice collaboratives. 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 the DMC-ODS services and support systems is an effective and promising development.

CalEQRO recommends state and local **support for access to affordable housing—and specifically recovery housing**—as a needed LOC linked to ongoing MAT and outpatient services.

Case management and coordination of care really gained visibility in the DMC-ODS systems reviewed this last year especially with COVID-19. Last year many case managers rarely left their programs, and it was mostly phone referrals. With new case managers following clients across LOCs 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 (ACT) 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. In the Partnership Regional Model this was the type of case management the small counties asked for and wanted from their providers. They needed them to change from the SUD older models of not leaving their programs to do field services and wanted a similar approach to mental health. It was inspiring to see the group of providers, counties and the Regional Plan working together to discuss the models that work best in their rural region for their clients and discuss how to change their historic programs in new ways. This was a positive example of the potential of this regional model for a set of smaller counties.

Across multiple client focus groups, case managers were praised as helpful, practical, and good problem solvers. In several county focus groups, clients were requesting case managers, not just counselors. Evidence of change in case management models appeared both in data and in human experiences shared during examples of what case managers had done to help in groups. Continued support of case management's evolution in this flexible, client-centered direction is highly recommended to enhance quality.

Expansion of **case management in this flexible, client-centered direction** is highly recommended to enhance quality. Those with multiple disorders particularly benefited from having this service.

Counties did ask that there be billing options for clients just for case management to get into treatment when they call the access center and it is clear they have an SUD, and in between LOCs when they are not yet open to the new service but have been closed at their prior LOC, an overlap provision for case management for 30 to 60 days to make sure the connection happens to the next LOC.

Outcomes

The data points that support analysis of outcomes which include 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 also 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.

There is also another FY 2020-21 special study not yet complete with LA county funded by Blue Shield to look in depth with UCLA at cost offsets with Criminal Justice and Child Welfare System of the DMC-ODS program. CalEQRO is advising on this study in the analysis. This is to evaluate another desired outcome goal which is to assess the impact on numbers and costs of arrests, jail, and prison stays and implications for the child welfare system, of parents with SUD issues, and of course their children.

CalEQRO has a number of recommendations related to improvements in the outcomes area for the DMC-ODS program. First, the number of TPS surveys collected annually needs expanding to capture more programs, more ethnic groups representative of all the populations, and include all contractors providing services to the county. It is recommended these changes be included in contract requirements.

Another area of potential improvement involves CalOMS. The first recommendation is that the reports DHCS formerly provided to counties should be restored in the system that were available. The second recommendation is to streamline, as originally planned, CalOMS to be aligned with ASAM levels of care plus the other billable levels DHCS added, and whenever possible not repeat questions when they have not changed or have that be an option so it is not so burdensome as clients can change LOCs often. Many organizations were willing to volunteer and help with this task. 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 foundational recommendations related to structure and operations are made throughout the report and in this conclusion. Due to a variety of historical factors, the DMC-ODS IS systems (and particularly their contract agencies) do not have an adequate HIS infrastructure to function as managed care systems in an efficient manner. The vast majority of the programs are still on paper charts and cannot communicate electronically between the network providers and county related to client care in real time manner. A plan for HIS investments is recommended as part of the DMC-ODS expansion and if possible, Waiver renewal. This would move in some incremental fashion to align the DMC-ODS health systems with standards in place in other parts of the health universe such as primary care and hospital systems.

A plan for system investments in IS, especially EHRs, interoperability, and HIEs is recommended.

Interoperability among different EHR systems in county departments, hospitals, primary care, and contract providers is a critical challenge and they share many patients where this communication is critical. 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. This is a real challenge and continued advocacy for legislative flexibility in life and death risk situations is needed.

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, and health systems in general.

Improvements in Billing Efficiency

Double data entry to record contract provider services remains an operational challenge and barrier for counties. The next generation of EHRs should support integration and/or data exchange with primary care and other 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 of Recommendations

Progress continues to be made by DMC-ODS counties on access, timeliness, quality, and in several early indicators of outcomes. Many 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) SUD services needing expansion and additional capacity to meet needs in many counties include recovery services, recovery residence housing, non-methadone MAT, youth services, NTP services in NA identified zip codes, 3.3 residential, 3.7 and 4.0 WM and Inpatient, and (in many areas of the state) WM and ED voluntary WM.
2) Underserved populations need to be addressed in many counties, ensuring equitable access to culturally- and linguistically-competent services to underrepresented race/ethnicity groups, non-English speakers, individuals with disabilities, and older adults.
3) 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.
4) 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.
5) Continued and ongoing telehealth use and flexible service models from COVID-19 related adaptations for services in NTPs have proven incredibly positive for clients and have increased positive engagement and access. These need to be continued to meet the needs of some client groups.
6) 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 particularly EHRs, interoperability, and HIE options are needed.

7) Continued development of quality and outcome-tracking tools to assist in quality work is needed. Examples include reports for CalOMS, broader distribution of TPS to all contractors and ethnic groups, and new opportunities for client input in feedback-informed care models.
8) 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 continued support and care coordination during transitions to all levels of care.
9) Housing and especially recovery residence housing options including for those with children are essential for those stepping out of intensive programs for ongoing outpatient and MAT treatment who are able to access stable housing.
10) 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. Counties should continue educating their communities on SUD to reduce stigma.
11) 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 are particularly noted in the MAT expansion program which has been highly effective in building bridges into the DMC-ODS continuum.

These recommendations are based on the reviews of the 30 county DMC-ODS programs and the Regional Model with Partnership Health and their seven county partners, their data, and the voices of the clients, their provider networks, 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.

Other Considerations

The Centers for Medicare & Medicaid Services (CMS) issued a letter to the Department of Health Care Services on November 16, 2021, noting areas of non-compliance with 42 CFR Part 438 Subpart D and QAPI standards in the EQRO technical reports. To remedy these deficiencies, DHCS and the BH EQRO have initiated an amendment to the EQRO Contract. The new effective date will be July 1, 2022. The new contract requirements will be tailored to remediate some of the CMS findings in future technical reports. Because of the timing of CMS' feedback and the DHCS' audit cycle, and the necessity for a contract amendment, full compliance with federal statutory references will be achieved over the course of the next few reporting cycles.

2020-2021 BHC-CalEQRO DMC-ODS Statewide Annual Report

Appendix

Performance Measures CY 2020

Appendix

Performance Measures CY 2020

Table 1: Clients Served and Penetration Rates by Age Groups, CY 2020

Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate
Ages12-17	1,579,638	3,980	0.25%
Ages 18-64	7,124,759	89,545	1.26%
Ages 65+	1,338,068	10,277	0.77%
TOTAL	**10,042,465**	**103,802**	**1.03%**

Figure 1: Average Approved Claims by Age Group, CY 2020

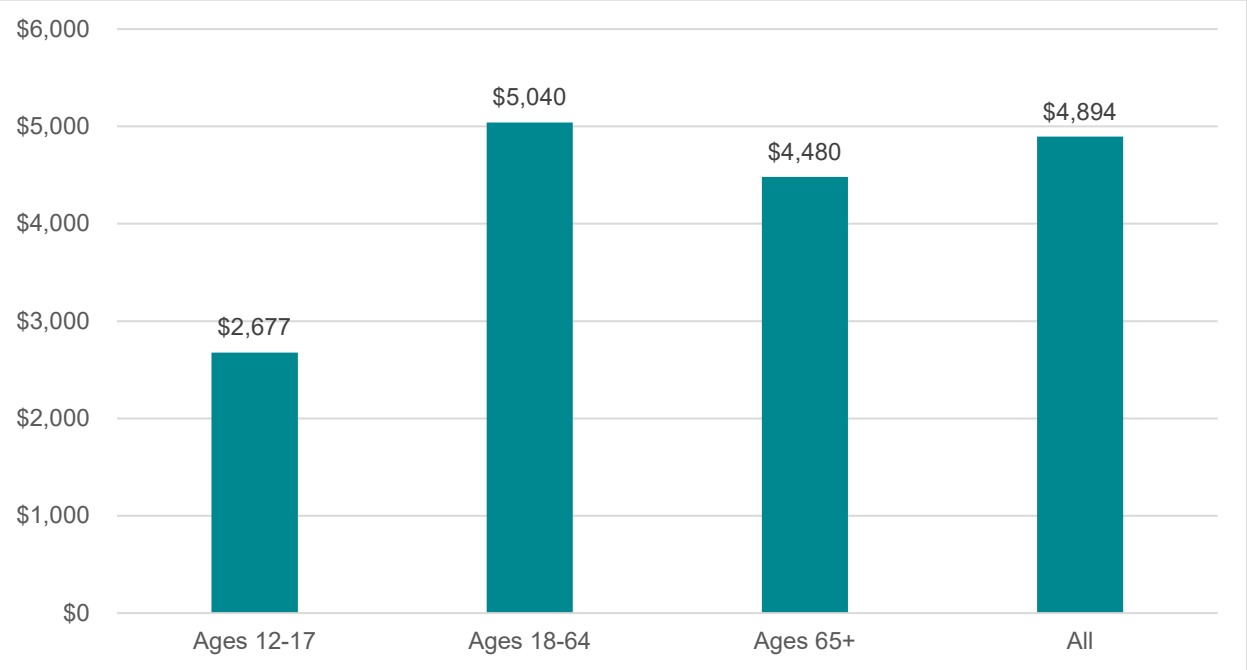


Figure 2: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2018-19

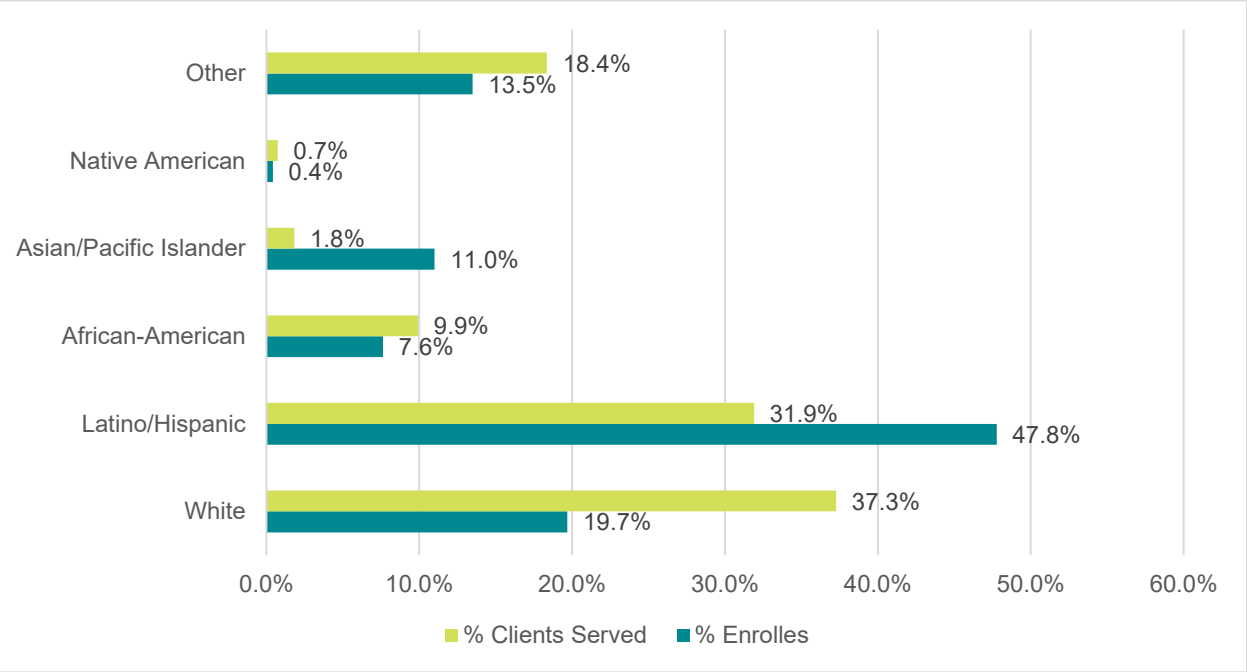


Table 2: Penetration Rates by Race/Ethnicity, CY 2020

Race/Ethnicity	Average # of Eligibles per Month	# of Clients Served	Penetration Rate
White	1,977,201	38,685	1.96%
Latino/Hispanic	4,797,436	33,112	0.69%
African-American	766,626	10,299	1.34%
Asian/Pacific Islander	1,105,009	1,888	0.17%
Native American	41,817	767	1.83%
Other	1,354,456	19,051	1.41%
Total	**10,042,545**	**103,802**	**1.03%**

Table 3: Clients Served and Penetration Rates by Eligibility Category, CY 2020

Eligibility Categories	Average # of Eligibles per Month	# of Clients Served	Penetration Rate
Disabled	1,036,580	18,527	1.79%
Foster Care	33,507	782	2.33%
Other Child	994,866	2,618	0.26%
Family Adult	1,882,039	20,486	1.09%
Other Adult	1,592,149	1,838	0.12%
MCHIP	622,864	1,184	0.19%
ACA	3,834,418	62,218	1.62%

Figure 3: Percentage of Clients Served by Eligibility Category, CY 2020

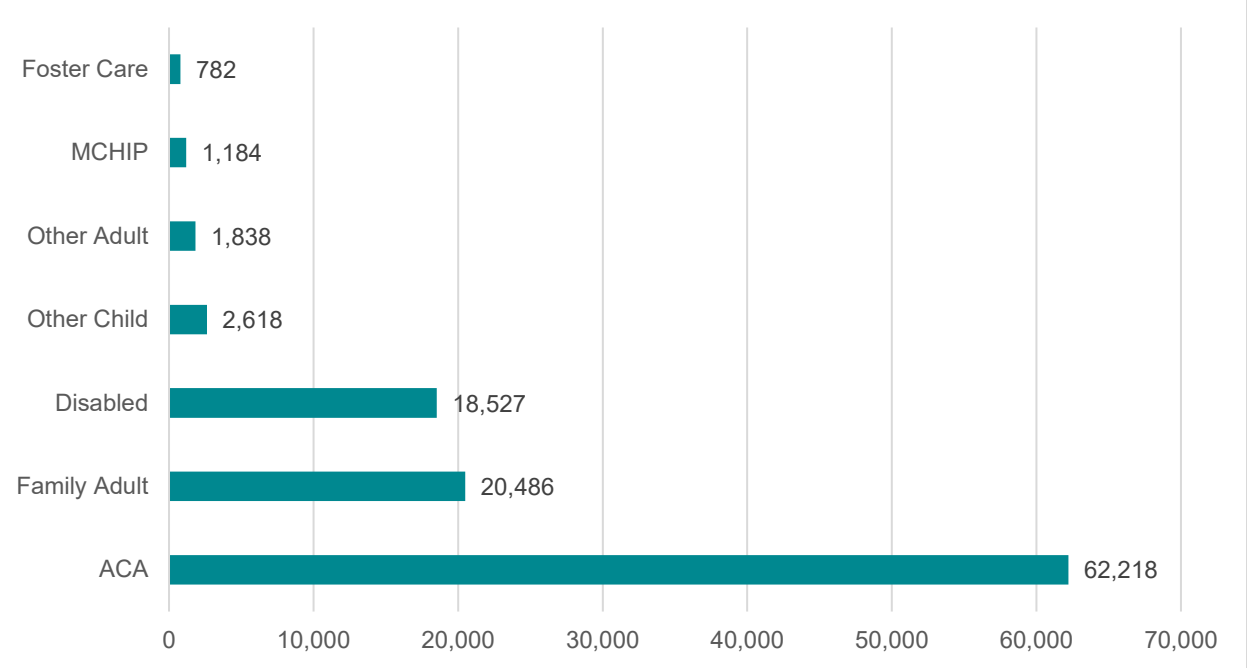


Figure 4: Average Approved Claims by Eligibility Category, CY 2020

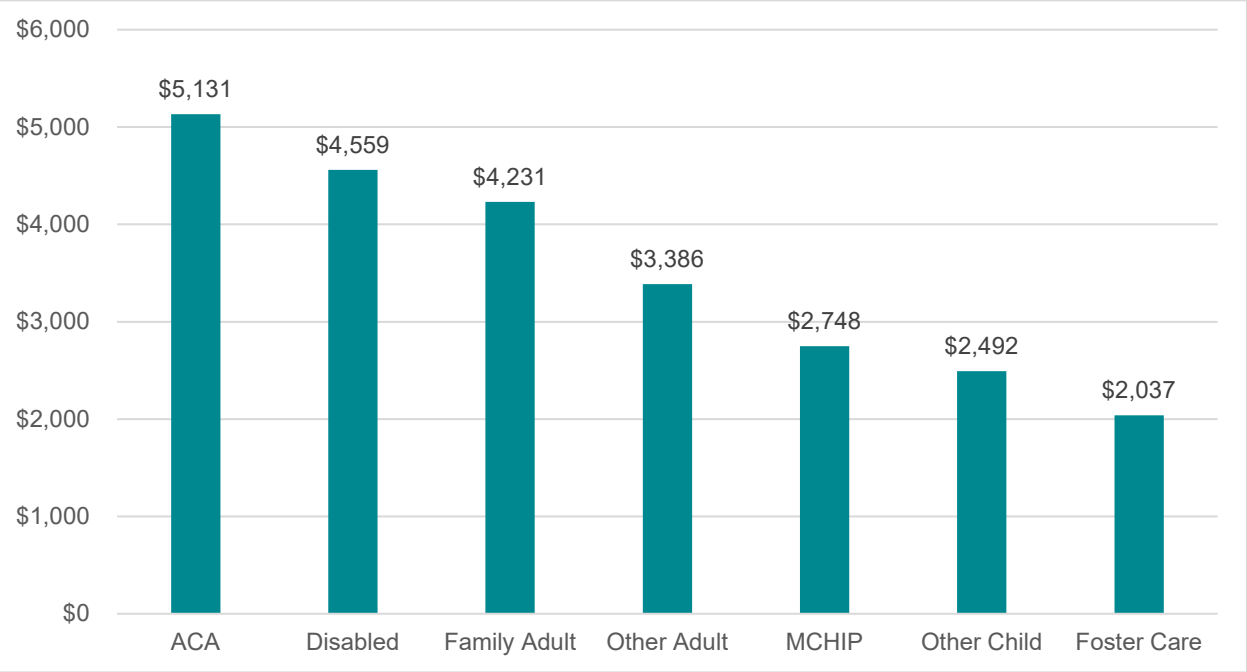


Table 4: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2018-19

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	41,822	30.7%	$4,097
Residential Treatment	23,860	17.5%	$8,846
Res. Withdrawal Mgmt.	9,306	6.8%	$2,057
Ambulatory Withdrawal Mgmt.	29	0.02%	$654
Non-Methadone MAT	7,022	5.2%	$1,093
Recovery Support Services	3,625	2.7%	$1,521
Partial Hospitalization	42	0.03%	$1,926
Intensive Outpatient Tx.	8,665	6.4%	$966
Outpatient Drug Free	41,636	30.6%	$2,037
TOTAL	**136,007**	**100.0%**	**$4,894**

Figure 5: Percentage of Clients Served by Service Categories, CY 2020

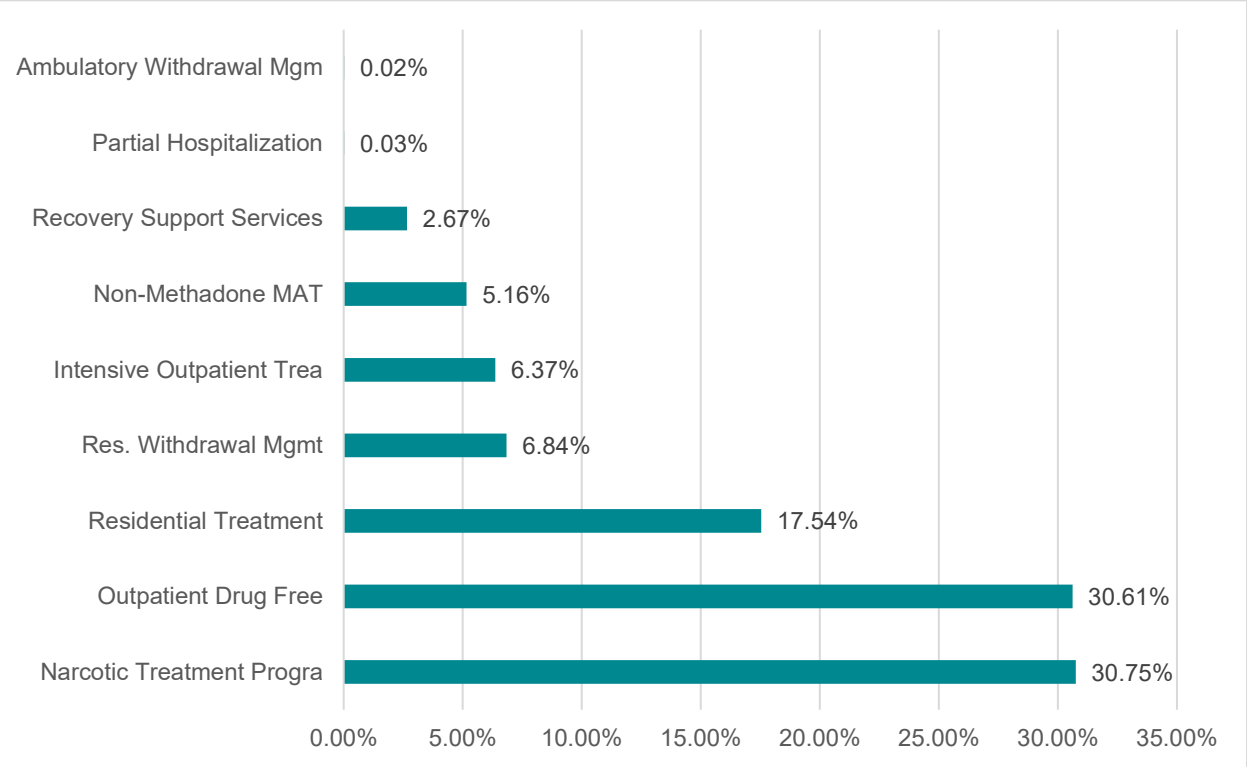


Table 5: Clients Served and Median Days to First Dose of Methadone, CY 2020

Age Groups	Clients	%	Median Days
Ages 18-64	33,027	80.4%	<1
Ages 65+	8,056	19.6%	<1
TOTAL	**41,083**	**100.0%**	**<1**

Figure 6: Percentage of Clients with at Least One and with Three or More DMC-ODS Non-Methadone MAT Billed Visits for all DMC-ODS Counties, CY 2020

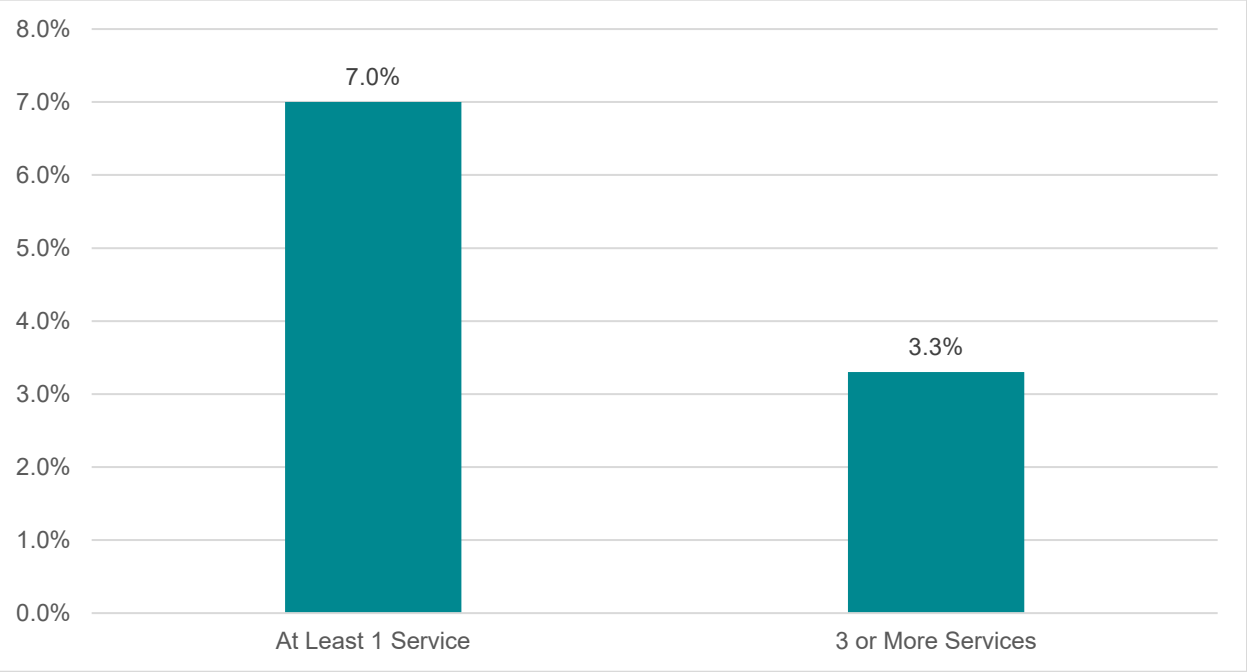


Figure 7: Percentage of Timely Transitions in Care Post-Residential Treatment for DMC-ODS Counties, CY 2020

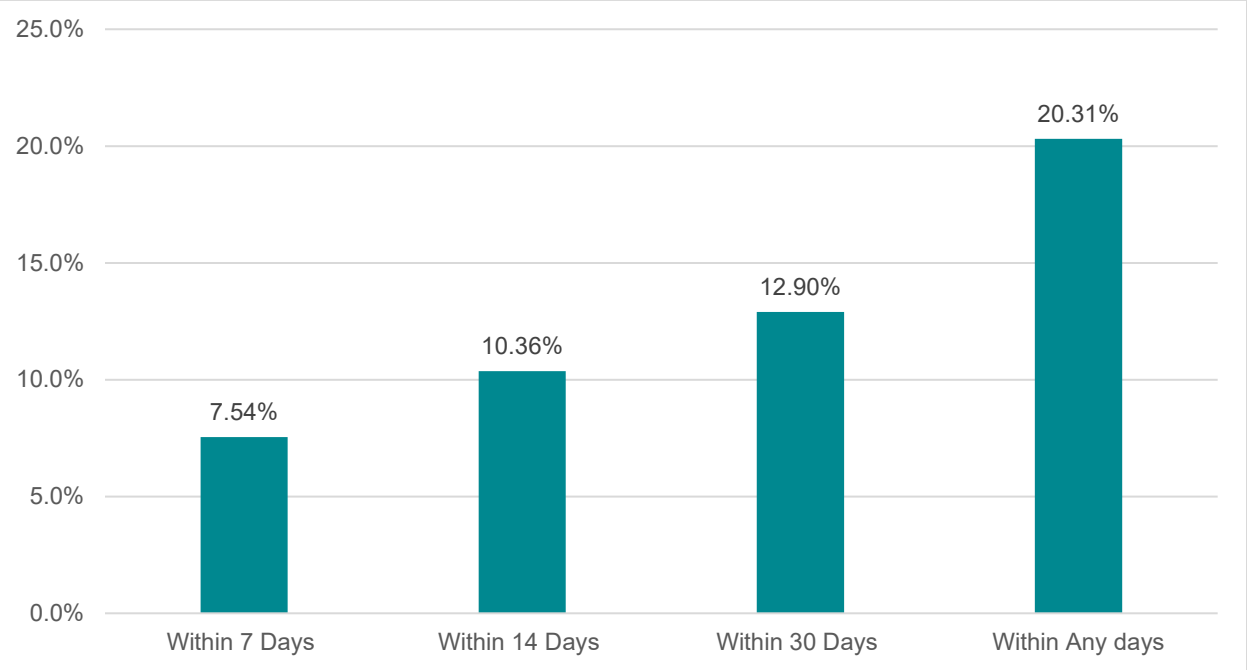


Table 6: High-Cost Beneficiaries by Age, CY 2020

Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims
Ages 12-17	3,980	53	1.33%	$19,547	$1,036,014
Ages 18-64	89,545	5,355	5.98%	$20,688	$110,786,886
Ages 65+	10,277	217	2.11%	$20,676	$4,486,743
TOTAL	**103,802**	**5,625**	**5.42%**	**$20,677**	**$116,309,644**

Table 7: Residential Withdrawal Management with No Other Treatment, CY 2020

DMC-ODS Counties	
# WM Clients	% 3+ Episodes & no other services
8,824	3.34%

Figure 8: Initiating and Engaging in DMC-ODS Services, CY 2020

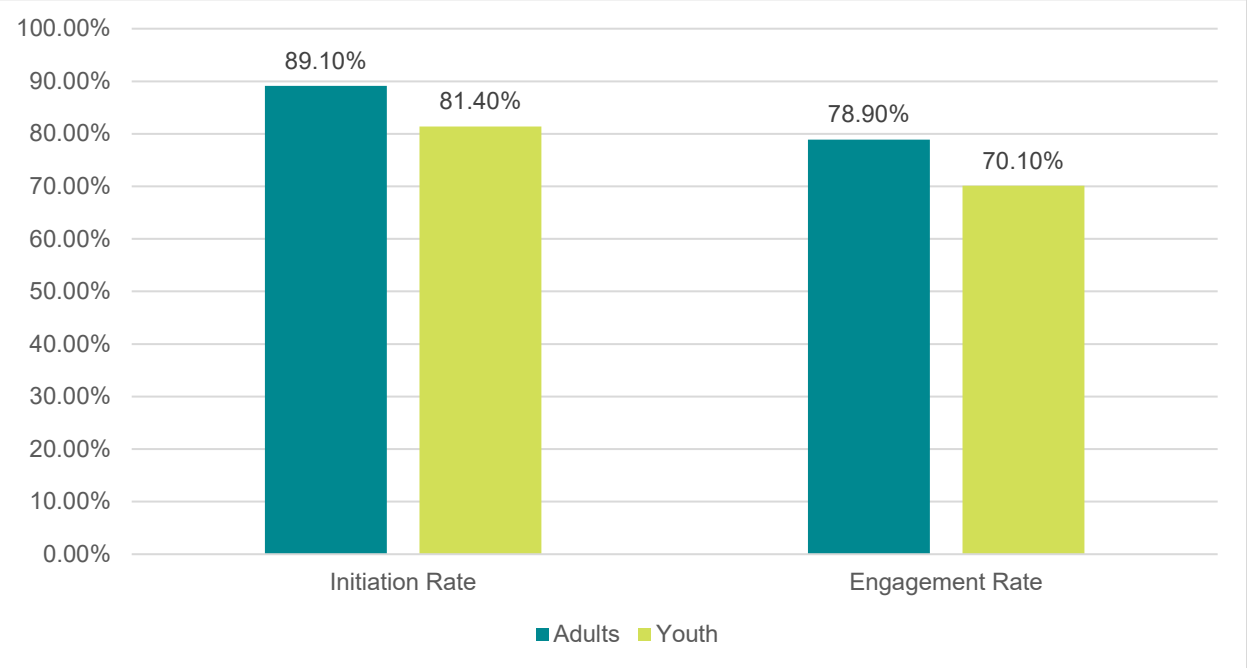


Figure 9: Initial DMC-ODS Service Used by Clients, CY 2020

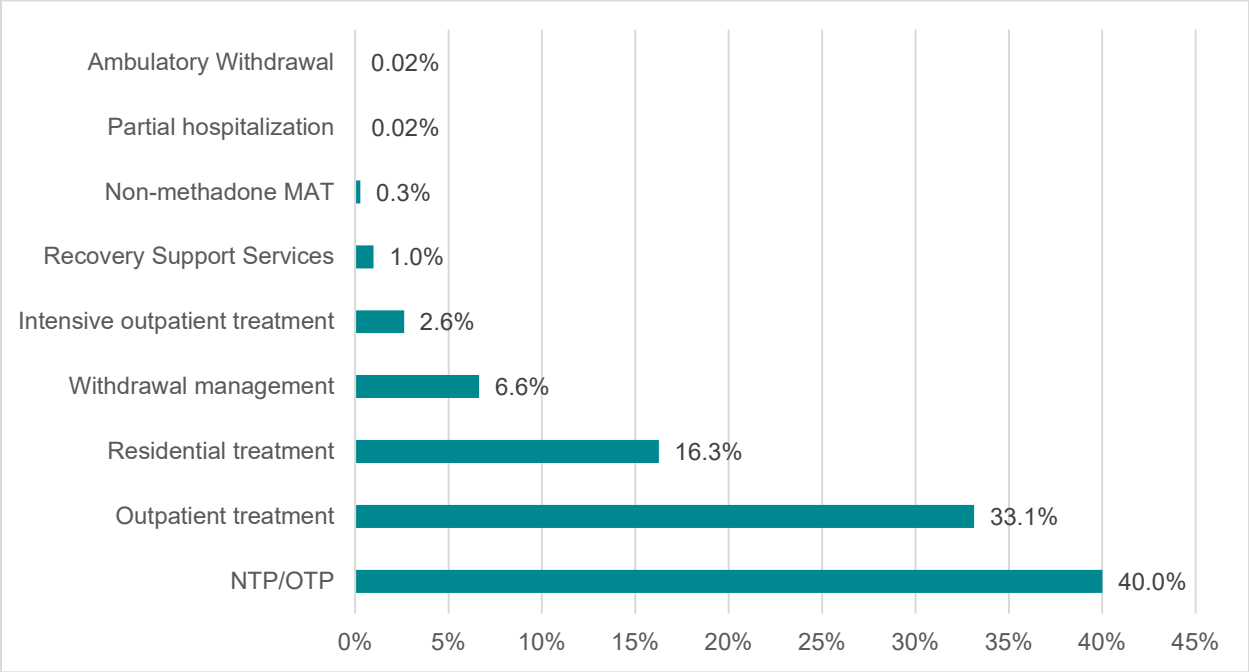


Figure 10: Cumulative Length of Stay (LOS) in DMC-ODS Services, CY 2020

Table 8: Residential Withdrawal Management (WM) Readmissions, CY 2020

14 Pioneer Counties		
Total DMC-ODS clients who were admitted into WM		11,647
Clients admitted into WM who were readmitted within 30 days of discharge	1,291	11.1%

Table 9: CalOMS Living Status at Admission, CY 2020

Admission Living Status	Statewide	
	#	%
Homeless	21,737	27.9%
Dependent Living	19,900	25.5%
Independent Living	36,372	46.6%
TOTAL	**78,009**	**100.0%**

Table 10: CalOMS Legal Status at Admission, CY 2020

Admission Legal Status	Statewide	
	#	%
No Criminal Justice Involvement	49,154	63.0%
Under Parole Supervision by CDCR	1,676	2.1%
On Parole from any other jurisdiction	1,023	1.3%
Post release supervision - AB 109	21,128	27.1%
Court Diversion CA Penal Code 1000	1,122	1.4%
Incarcerated	384	0.5%
Awaiting Trial	3,496	4.5%
TOTAL	**77,983**	**100.0%**

Table 11: CalOMS Employment Status at Admission, CY 2020

Current Employment Status	Statewide	
	#	%
Employed Full Time - 35 hours or more	8,939	11.8%
Employed Part Time - Less than 35 hours	5,819	7.8%
Unemployed - Looking for work	23,736	29.7%
Unemployed - not in the labor force and not seeking	39,515	50.6%
TOTAL	**78,009**	**100.0%**

Table 12: CalOMS Types of Discharges, CY 2020

Discharge Types	Statewide	
	#	%
Standard Adult Discharges	33,835	45.5%
Administrative Adult Discharges	31,361	42.2%
Detox Discharges	7,879	10.6%
Youth Discharges	1,297	1.7%
TOTAL	**74,372**	**100.0%**

Table 13: CalOMS Discharge Status Ratings, CY 2020

Discharge Status	Statewide	
	#	%
Completed Treatment - Referred	13,699	18.70%
Completed Treatment - Not Referred	4,039	5.50%
Left Before Completion with Satisfactory Progress - Standard Questions	12,675	17.30%
Left Before Completion with Satisfactory Progress – Administrative Questions	6,059	8.30%
Subtotal	*36,472*	*49.80%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	11,751	16.10%
Left Before Completion with Unsatisfactory Progress - Administrative	24,233	33.10%
Death	142	0.20%
Incarceration	551	0.70%
Subtotal	*36,677*	*50.10%*
TOTAL	**73,149**	**100.00%**