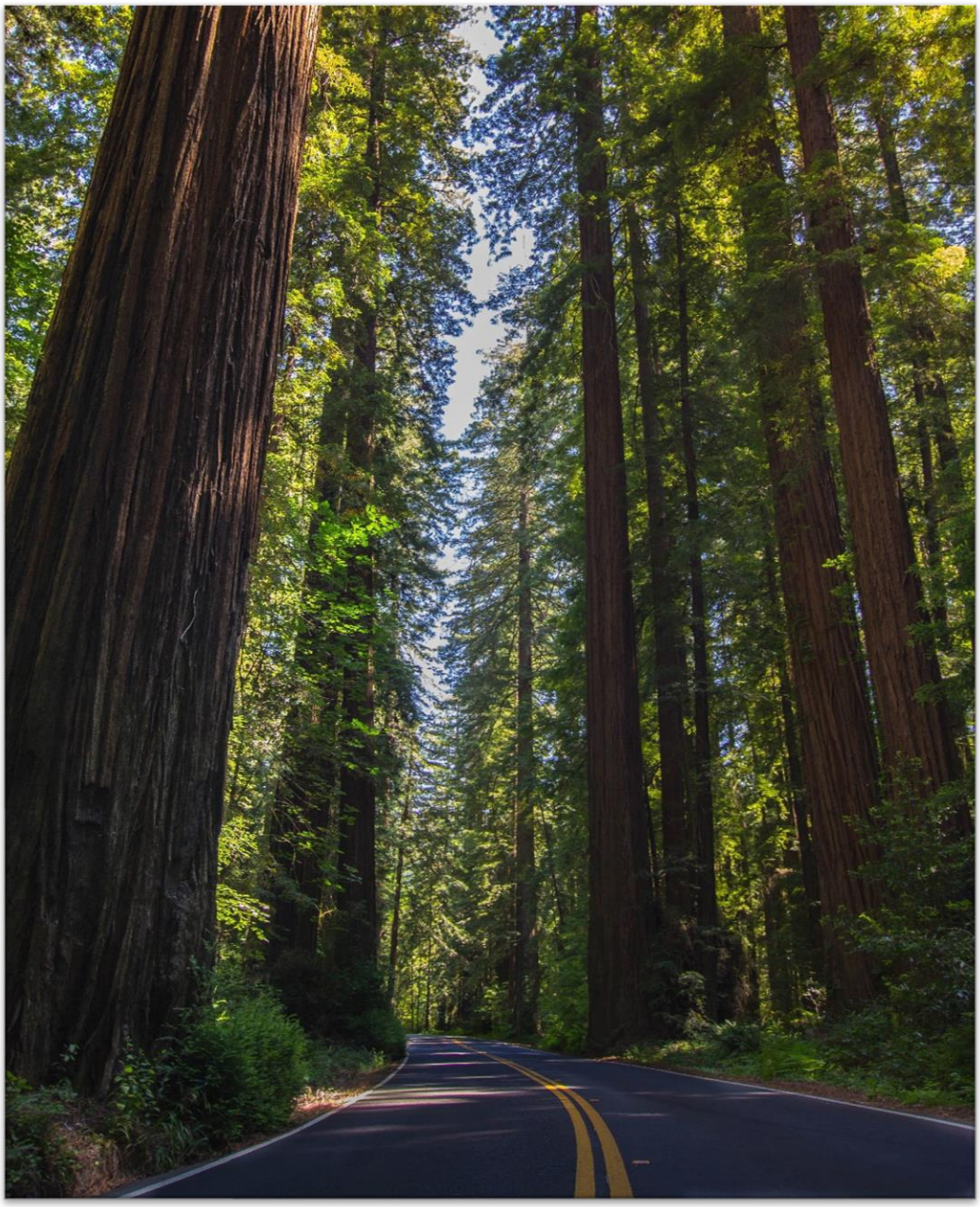

2021–2022 Statewide Annual Report

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)

April 26, 2023

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 (DHCS).

For more than two years, the effects of Coronavirus Disease-2019 (COVID-19) pandemic and related stressors have continued to be felt as they contributed to a rise in overdose deaths and increased use of alcohol and other drugs. This impact noted in a 2022 report from the Centers for Disease Control notes that while COVID-19 was the primary driver of a decline in American's life expectancy since 2019 (and accounted for about half of the drop in 2021), unintentional injuries (including drug overdoses) chronic liver disease, cirrhosis, and suicide also played a significant role. 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 31 County DMC-ODS plans 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 whose involvement in sharing their experience is essential to ensuring patient-centered care.

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 training and support of quality development statewide with California's Behavioral Health Directors Association, including the SUD specific sub-committee "SAPT+" which provides counties and interested stakeholders with information leadership and advocacy for this unique population. Both organizations supported efforts to foster quality of care and noteworthy practices for SUD services, working on models that optimize success for different client groups and families.

Also, the guidance of and collaboration with the 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.

Our goal is that the findings, noteworthy 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 essential to foster a statewide system of treatment that changes lives by 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
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set

CalEQRO Acronyms	
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
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

CalEQRO Acronyms	
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

Executive Summary

Introduction

California's 1115 Substance Use Disorder (SUD) Waiver was the first in the nation to respond to a dual national and statewide crisis. In January 2022, the managed care components of the Drug Medi-Cal Organized Delivery System (DMC-ODS) framework was incorporated into the California Advancing and Innovating Medi-Cal (CalAIM) Section 1915(b) Waiver. The benefits coverage of the DMC-ODS was incorporated into the State Plan while the CalAIM Section 1115 demonstration project continues to provide expenditure authority for covered services provided to members receiving short-term inpatient and residential substance use disorder treatment in qualifying institutions for mental diseases (IMDs). Meanwhile, counties continue to adjust and improve this young system of care. Despite the additional challenges posed by a global pandemic, results from the California External Quality Review Organization's (CalEQRO's) External Quality Reviews (EQRs) indicate progress towards improving clients' access to treatment, enhancing timeliness to get into treatment, and adding the key elements of quality that benefit clients and DMC-ODS systems. Many notable examples of these clinical and program improvements were observed and documented across all 31 DMC-ODS EQRs conducted in fiscal year (FY) 2021-22.

As is to be expected in a system under development, many challenges remain. The global impacts of the Coronavirus Disease 2019 (COVID-19) pandemic continued throughout FY 2021-22, which impacted care by requiring shifts in local health and community resources. Additionally, recurrent wildfires devastated many counties across the state, adding additional strain on communities. Coupled with recruitment and retention issues, most DMC-ODS plans and their contracted service providers faced serious challenges in maintaining a qualified workforce. Despite these barriers, most key indicators of performance remained steady or improved, along with associated indicators of expansion and access, often still prioritized in this challenging environment.

As counties demonstrated innovative approaches to addressing challenges, policy changes related to CalAIM added increased demands to DMC-ODS administrative and operational resources. Leveraging the unique aspects afforded under CalAIM, including the prioritization of health equity and quality, counties are focused on population health, with an even greater emphasis on prevention and wellness.

Timely Access to Appropriate Care

The FY 2021-22 review year showed continued expansion of service delivery options across the American Society of Addiction Medicine (ASAM) levels of care (LOC), for both historical and new Medi-Cal treatment services. The numbers of adults (age 18-64) served increased from 98,403 in calendar year (CY) 2020 to 100,430 in CY 2021. While the statewide Medi-Cal eligible population increased from 10,042,393 in 2020 to 12,750,890 in 2021, the overall penetration rate (PR) for DMC-ODS plans decreased from 1.06 percent to 0.85 percent. Age

specific factors influenced a 62 percent drop in penetration for youth and a 45 percent decrease for older adults.

In addition to numbers served, it is important to consider the types of SUD services DMC-ODS clients receive. Data indicates that while capacity has expanded in many LOCs, some reductions in utilization have also occurred. Intensive outpatient and outpatient Narcotic Treatment Programs/Opioid Treatment Programs (NTP/OTPs) all saw slight declines, influenced by telehealth use, return to in-person care, or even program closures due to COVID-19 outbreaks. By contrast, all new services under California's 1115 SUD Waiver saw increased utilization, including recovery support services (RSS), withdrawal management (WM), and case management. Given care coordination's association with client retention and positive clinical outcomes, year-over-year increases in services such as case management indicate that clinical support services to enhance recovery are a system priority. Data for CY 2021 showed the DMC-ODS framework provided 54,454 clients with case management services. Out of a total of 106,515 unduplicated clients served, 51.12 percent received this vital service.

Despite identified improvements and expansion, all LOCs require more investment to meet client needs statewide. Even in counties with a full continuum of care, there are often remote regions that present access challenges for clients. These regions often need more providers to ensure easy access when the individual becomes motivated to enter treatment. Finally, there are some counties where residential and WM programs are only available outside of the county, and sometimes at a significant distance, discouraging enrollment.

While a desire to reduce disparities is prevalent, and many DMC-ODS counties are utilizing targeted interventions to engage specific sub-populations, many remain underserved. Individual communities often require novel approaches to increase access to care. For example, the Hispanic/Latino and Asian-American populations are underrepresented in service delivery statewide compared to SUD prevalence data. African-Americans, youth, seniors, and LGBTQ are also underserved groups in many communities. Many of these groups show low levels of system access yet are disproportionately impacted by adverse impacts of substance use. Their involvement in the criminal justice system, social and health issues associated with SUD, and overdose statistics indicate a need for prioritized engagement and care. Some unique cultural barriers within these populations and sub-populations are a factor in making care feel welcoming and comfortable, especially for non-English speakers. Many DMC-ODS plans have taken meaningful steps to make health equity a priority.

DMC-ODS counties also organized their systems in ways to ease access, from the initial client request to delivering treatment at the right LOC, with transitions in care, and into the community. Some of 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 medical 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 hand-off 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 appropriate 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 over capacity.

Proper system access requires much more than offering an appointment or residential bed. In addition to time and space, true access means having an adequate and skilled workforce at all LOCs. Adequately prepared staff with the licenses required for specific services ensures the necessary support to help the often stressed and ambivalent client as they come to the first service and engage in care. All counties and contractors participating in EQRs noted a need for support to retain, recruit, or expand their SUD workforce. They requested help from state leadership to expand college opportunities, training, and program capacity to attract more individuals into the SUD field of clinical work.

To ensure engagement in DMC-ODS services, facilitating timely access is especially important because many clients are ambivalent or fearful about treatment. For individuals with an SUD, deciding to face substance withdrawal is a challenging and, in many cases, a painful experience. 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. Many DMC-ODS counties have instituted or are participating in projects that include “low barrier” access points to assist individuals who remain ambivalent about their commitment to recovery. Some counties have introduced a harm reduction model involving multiple agencies across the breadth of county services. The design of these models is to meet people “where they are" while reducing the harms associated with SUD. For those who eventually wish to enter treatment, these non-traditional access points can provide the necessary opportunity for someone who would otherwise never avail themselves of traditional access points. The reviews conducted by CalEQRO revealed noteworthy practices to support timely access, including skilled screenings at first contact, a full continuum of treatment options, and prompt linkages to the right LOC. These practices also included strategies that focused on engagement by providing incoming clients with someone who can address their specific needs and support them as they move through withdrawal to a suitable treatment environment. DMC-ODS counties have made progress in reducing the time to access care since beginning the Waiver by adding more treatment sites and staff and expanding the use of telehealth, mobile services, and treatment kiosk sites.

Quality of Care and Outcomes

CalEQRO's assessment and review tools suggest the quality of SUD services provided within the DMC-ODS framework is steadily improving. The various requirements and design elements incorporated into the 1115 Waiver for DMC-ODS have enhanced the quality of SUD services across California, as shown in the reviews since its inception. A variety of data sources—ASAM LOC referral data, Treatment Perception Survey (TPS) data, California Outcomes Measurement System (CalOMS) results, performance measures (PMs), and stakeholder and client feedback—document changes related to these elements of quality. Changes include:

- 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 focused on progress over time.
- Care coordination RSS connects and communicates needs from initial requests through the continuum of care and back into the community with support and assistance.
- Infrastructure and oversight for quality of care based on noteworthy practices, scientific evidence, standards of care, and investments in continuous quality improvement (QI), achieved through use of critical tools such as EHRs, Quality Improvement Plans (QIPs), and data/evaluation/oversight systems.

ASAM congruence data indicates quality of care with high ratings consistent with ASAM-based results. The ASAM results support the finding that screeners and assessors are paying close attention to validated placement criteria and relying upon them for referral decisions. Similarly, where there is a variance from the screening or assessment recommended placement, it is most often due to client preference. This variance is an indicator of each DMC-ODS' adherence to the principles of client-centered care, demonstrating respect and responsiveness to client preferences.

A challenge is a large number 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 needs for its information systems (IS), primarily EHRs, and interoperability between the county and its network providers. Given the extremely high percentage of contracted providers, the level of hindrance the current state of IS presents to effective communication and coordination across programs that serve the same client cannot be overstated.

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 despite a general desire by DMC-ODS plans to embrace that partnership. Because of the enormous cost/resources to establish a unified EHR, DMC-ODS counties (and their contract providers) have yet to optimize the use of ASAM, TPS, or CalOMS data, or other quality tools available to track and improve outcomes. Strategies and initiatives are necessary to correct this, as SUD contract providers provide approximately 80 percent of the care. Only then can the quality of the care be at its best for the clients and have a comprehensive method to gauge systemwide effectiveness.

Recommendations and Next Steps

CalEQRO recommends that DMC-ODS counties continue to develop new models of care that small counties, not currently part of the Waiver, can adopt. 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.

State and local investments in IS should expand and continue, but this requires additional resources to do so successfully. These IS investments should prioritize the quality issues linked to EHR needs and interoperability to provide a foundation for changes coming in CalAIM and more integrated care models.

Support for DMC-ODS plans is needed for those that are adopting the semi-statewide innovation-funded EHR. CalEQRO also recommends oversight to ensure that all aspects of a fully functioning information system can support the DMC-ODS reporting requirements and tracking standards by the California Mental Health Service Authority (CalMHSA) and the Department of Health Care Services (DHCS).

There is a pronounced need for workforce expansion focusing on college program capacity and loan forgiveness options. Added graduates, especially those from varied socioeconomic communities, would help diversify the workforce, expand services to underserved groups, meet critical capacity needs, and add bilingual workforce capacity.

More training to support paraprofessional workforce expansion, including system navigators, would also benefit systems struggling to recruit more academically prepared employees. Similarly, Peer Support projects which recruit and train individuals with lived experience can provide a credible voice to anxious clients and increase retention and level of care (LOC) transitions.

There is a need for the continued expansion of service providers to achieve statewide availability of all LOCs in all communities. CalEQRO reviews continue to reveal gaps in youth services and counties with no residential services or lack of proximity for beneficiaries to programs like perinatal treatment. For WM where proximity is critical, including those linked to hospital stays, services remain in high demand. Expanding WM levels to include 3.7 and 4.0 and increasing portals for non-methadone medication-assisted treatment (MAT) should be priorities. Expansion of MAT services in non-traditional settings, such as local jails, along with coordination with SUD service providers on re-entry, should continue. Adopting the precepts of population health and using harm reduction strategies and prevention are necessary adjuncts to making inroads and getting upstream to address social determinants of health. Working within multi-agency collaboratives to identify local solutions to address the overdose epidemic to complement SUD treatment is necessary and deemed a best practice in reducing fatalities.

Just as crucial as service expansion is supporting community education and engagement to reach those who may currently avoid reaching out for care due to stigma. The benefit of reaching those earlier in their progression of a SUD cannot be overstated. The DMC-ODS

plans must and often do acknowledge the need to speak to and shape local norms and the attitudes which affect their programs and clients' success.

Additionally, a leadership role that leans in to address health equity through the DMC-ODS' cultural competency efforts is important. Utilizing that framework to focus on racial and ethnic disparities and inherent consequences of internal phenomena like implicit bias would greatly benefit individuals seeking care. Many DMC-ODS systems and their County behavioral health departments have prioritized such initiatives.

Introduction

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 each of the DMC-ODS' and each Medi-Cal Mental Health Plan (MHP).

For context, the 1115 Waiver began in 2015 but actual DMC-ODS treatment services did not begin until early 2017. Utilizing a staged approach to implementation, DHCS approved planned launches of DMC-ODS services from 2016 through the end of 2021, when the demonstration Waiver was set to expire. By FY 2020-21, DHCS contracted with 31 active DMC-ODS plans, representing 30 individual counties and one Regional Model comprised of seven counties.

Meeting Federal EQRO Requirements

Since the opt-in counties now function as PIHPs, the federal requirement for an EQR applies. CMS requires that EQRs be conducted by an independent, external contractor (CFR 42, Part 438) on an annual basis to review access, timeliness, quality, and outcomes. BHC has served as the CalEQRO since the inception of the DMC-ODS. Reviews are retrospective for the prior year of services and the review criteria are based on CMS 42 CFR Part 438, subpart E, which outlines four major requirements:

- PMs to evaluate clinical effectiveness and service activity.
- Performance Improvement Projects (PIPs) that focus on clinical and non-clinical processes and outcomes of care.
- 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 aggregate findings of the FY 2021-22 DMC-ODS reviews conducted under the 1115 Demonstration Waiver and, as of January 2022, the bundled

1915(b) Waiver. In FY 2021-22 BHC completed 31 reviews comprised of 30 individual county plans and one regional model representing 7 counties located in Northern California.

Goals of California's Waiver

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

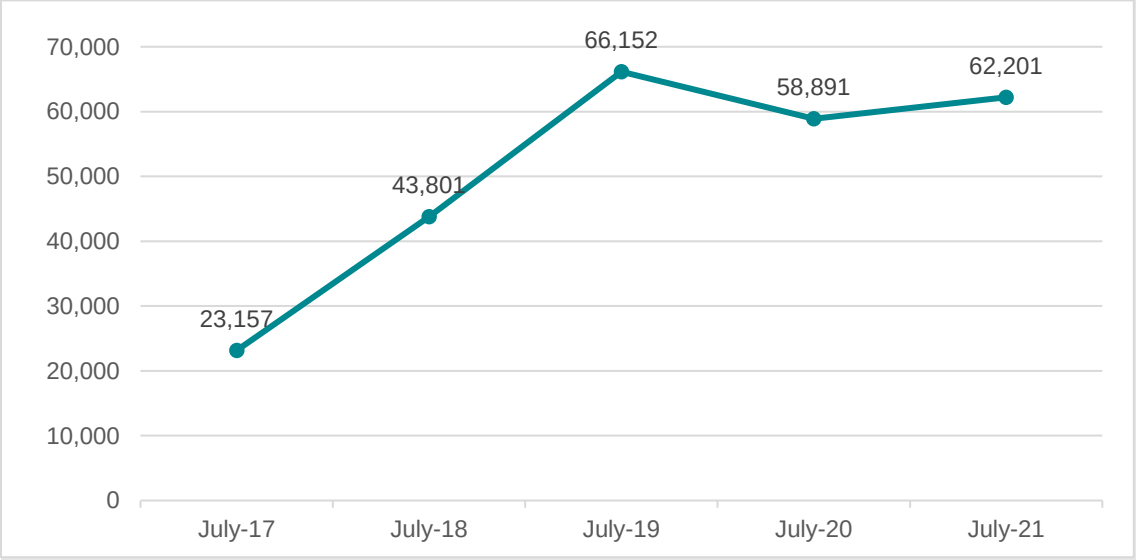
Trends Affecting the Quality EQRO Environment

COVID-19

Continued impacts of COVID-19 led to a shift away from on-site reviews with all reviews since mid-2020 being conducted by way of video conferencing. This practice has continued through all CalEQRO reviews in the past year, though it is hoped that some on-site review options can resume in late 2022. Impacts of COVID-19 persist, even as the pandemic recedes, as noted throughout this report.

The initial COVID outbreak resulted in a sharp decrease in clients in treatment, as shown in Figure 2-1 below.

Figure 2-1: Unduplicated Number of Clients Served, July 2017 – 2021



DMC-ODS plans showed a steady increase as they launched their DMC-ODS services until Executive Order N-33-20 was issued in March 2020, when Californians were required to stay at home in the early months of the pandemic. The subsequent 11 percent reduction in clients served began to rise again in 2021 but did not yet reach pre-pandemic service levels.

COVID-19 Impacts on SUD Services and Levels of Care

Certain impacts to specific LOC services involving face-to-face, along with the limits of telehealth, were noted due to COVID19:

- Residential treatment.
- NTP/OTP services, which required an in-person medical evaluation for newly admitted NTP patients receiving medications for opioid use disorders. Federal and state COVID-19 flexibilities permitted newly admitted NTP patients to receive buprenorphine without an in-person medical evaluation.
- Intensive outpatient, which requires 3 hours of services 3 days per week; this can be difficult to tolerate by telephone or video.
- In addition, many programs were negatively impacted as providers had staff and/or clients with health issues and COVID exposure, and the necessary public health restrictions resulted in impacts on consistent workforce availability. Also, while telehealth may be available, many clients need to attend a program site, including those who do not have cell phones, internet, or enough bandwidth to make linkage possible, including those who are homeless and have difficulty with access to the internet.

California Trends

DHCS formally proposed the version of the 1115 Waiver known as CalAIM in October 2019. 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 through care that is better integrated across systems and to reduce administrative burdens on the counties.

CalAIM implementation began in 2022. The implementation includes multiple phases, aligned with the DHCS 2022 Comprehensive Quality Strategy, designed to improve quality and health equity for beneficiaries with multiple conditions in as holistic a manner as possible with coordinated care across systems.

Network Adequacy

In April 2016, CMS issued the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which aligned the Medicaid managed care program with other health insurance programs. Included in the Final Rule was the requirement for states to establish network adequacy (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, signed into law on October 13, 2017, and California's NA standards (Chapter 738, Statutes of 2017). The NA standards are based on the population of each county.

BHC continues to work closely with DHCS on NA considering 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 and 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 noteworthy 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 Section 1115 demonstration for DMC-ODS, and since January 2022, the combined Section 1915(b) specialty waiver.

A National Opioid Crisis

The national impetus to develop an effective SUD treatment delivery system included responding to this serious health challenge in the United States. This was clearly articulated with a positive and hopeful paradigm change in 2016 by the report *Facing Addiction in America*, from the Surgeon General of the United States, the first national report from non-SUD and treatment.[1] 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. This required that SUD treatment shift from one that often attributes SUD problems to a lack of moral character or personal strength to a brain science model that draws on researched population-based treatment and prevention approaches determined to be effective in addressing SUD issues.

The Surgeon General's report could not have been more timely as the rising tide of opioid-related deaths had reached a point of acute national crisis. Fueled in part by prescribing patterns that dispensed new, highly addictive medications for pain and an increased emphasis on assessment of pain as "the fifth vital sign" (thus warranting aggressive treatment) in

[1] Facing Addiction, The Surgeon General's Focus on Opioids https://addiction.surgeongeneral.gov/ US Department of Health and Human Services, 2016/2018

healthcare settings, many Americans became addicted to opioids. According to Center for Disease Control (CDC) reporting, there are approximately 2.7 million Americans suffering from an opioid use disorder (OUD).[2]

Byproducts of the pandemic, including a rise in job loss, isolation, and depression have correlated with a significant rise in synthetic opioids and overdose deaths nationwide. The CDC's National Center for Health Statistics indicates that there were 100,306 confirmed drug overdose deaths in the United States in the 12 months ending in April 2021 – the first year of the COVID pandemic – an increase of 28.5 percent from the 78,056 deaths during the same period the year before. Estimated overdose deaths from opioids also increased by 35 percent to 75,673 for the same period, up from 56,064 the prior year. Overdose deaths from synthetic opioids (primarily fentanyl) and psychostimulants such as methamphetamine also increased in the same 12-month period.[3]

Given the apparent increased need for treatment, it is even more important to enhance and improve access and quality of SUD treatment and outcomes for the people of California.

[2] Opioid Use Disorders https://www.cdc.gov/dotw/opioid-use-disorder/ CDC Center for Disease Control and Prevention, August 2022

[3] Drug Overdose Deaths in the United States, CDC Center for Health Statistics November 2021 https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Methods

Introduction

As described in the previous chapter, the core elements of EQRO evaluations are mandated by federal law and associated regulations; CMS rules (42 CFR §438; Medicaid Program, EQR 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, and quality. 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, Timeliness, Quality, PIPs, Client Perceptions of Care, IS, and Recommendations. Each chapter includes tables and figures that capture the most relevant aggregate findings. Additional tables and figures can be found in the report's appendices: Medi-Cal Approved Claims Code Definitions and Data Sources and the statewide PMs. Individual county PMs and comparisons by county size are in the county-level reports.

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 fifth year of external quality reviews (EQRs) since the launch of treatment services under the Waiver. CalEQRO evaluated the performance of 30 individual DMC-ODS counties and a Regional Model DMC-ODS managed by Partnership Health Plan of seven counties (referred to henceforward as the Partnership Counties). Performance data for these 31 DMC-ODSs were analyzed and reported for both CY 2020 and CY 2021 data.

California Phase-in of County DMC-ODS Implementations

The first three counties to begin implementing 1115 Waiver services were Riverside, San Mateo, and Marin. They began their DMC-ODS implementations in FY 2016-17 with sufficient accumulated data to warrant an EQR in FY 2017-18. More recently, in FY 2021-22, they received their fifth EQR.

In FY 2018-19, CalEQRO provided a second annual EQR for these three counties. They also provided first reviews to 11 other counties who had begun their DMC-ODS implementations late in FY 2016-17 or in FY 2017-18: Santa Clara, Contra Costa, San Francisco, Los Angeles,

Napa, San Luis Obispo, Santa Cruz, San Diego, Monterey, Nevada, and Imperial. These latter 11 counties received their fourth EQR in FY 2021-22.

In FY 2019-20, CalEQRO continued to provide EQRs to the previously mentioned 14 counties, and also provided first reviews to 12 additional counties who had begun their DMC-ODS implementations in the prior year: San Bernardino, Yolo, Orange, Alameda, San Joaquin, Placer, Ventura, Santa Barbara, Fresno, Merced, Kern, and Stanislaus. The 12 additional counties continued to receive annual EQRs and received their third in FY 2021-22.

In FY 2020-21, CalEQRO provided EQRs to the previously mentioned 26 counties, and also provided first EQRs to four additional individual counties that had begun their DMC-ODS implementations in the prior year: San Benito, El Dorado, Sacramento, and Tulare. CalEQRO also provided a first EQR to the Partnership counties that had collectively begun their implementation as a single DMC-ODS the prior year under the management of Partnership Health Plan. The Partnership counties include Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano. The additional four individual counties and the Partnership Counties received their second EQR in FY 2021-22.

On the following page is a map of California depicting the phase-in period for each DMC-ODS county.

Figure 3-1: Map Showing Counties at Differing Stages of DMC-ODS Implementation

In FY 2021-22, no additional counties began implementations of a DMC-ODS. All 31 DMC-ODS implementations have been in place for at least three years and have received EQRs with performance data for at least two years. In the previous year's annual statewide report, performance data was compared between counties according to their phase-in period, hypothesizing that counties with more years of implementation would show more developed performance. However, it appeared that many other variables, including the COVID-19 pandemic, influenced the rate of progress in developing their DMC-ODS. In this report, all DMC-ODS counties' data will be aggregated in reporting results, and those results will be compared with data from the same counties from the previous year.

The data sources used in the analyses for this report are described below. Some of them, most notably Medi-Cal claims data, involve a lag time from the initial services delivered by providers and submission of the claims by the counties to the final approval decisions by DHCS. In order to report on the most recent time period for which there is relatively complete data, CalEQRO chose to incorporate CY 2021 data, where possible, comparing data from CY 2020.

Medi-Cal Populations

California counties serve many populations in need of SUD treatment services. The focus of the EQR evaluation is on services to anyone in the Medi-Cal covered population who needs SUD services and reside in the counties that are participating in the DMC-ODS. These include California residents of any age who meet Medi-Cal eligibility requirements as defined by Federal and State criteria. The term "eligible" is used to describe a person who is enrolled in Medi-Cal and eligible to receive services funded through Medi-Cal, irrespective of whether or not they needed or received DMC-ODS services. The term "client" is used to describe a person who is enrolled in Medi-Cal *and* has received one or more DMC-ODS services.

California's 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 separate analyses for these groups are presented. Definitions used in PMs are included in the Appendix.

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 16 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. CalEQRO refreshed the claims data twice during the year to try to obtain the most complete

claims data set, including older claims that have been denied and then corrected and resubmitted. CalEQRO uses only claims that are approved or pended status with DHCS, not claims that have been denied.

Performance Measures

The purpose of PMs is to measure access to treatment and quality of care by developing indicators with solid scientific links to health and wellness. CalEQRO conducted an extensive search of potential measures focused on SUD treatment from a wide range of sources including the National Quality Forum, CMS, Veteran's Administration, Healthcare Effectiveness Data, and Information Set (HEDIS®), ASAM, and others. These measures were then narrowed down and vetted through a clinical measures committee of over 60 subject matter experts, including medical directors and clinicians from California-based behavioral health programs, University of California at Los Angeles (UCLA) Integrated Substance Abuse Program (ISAP), DHCS, and others. Through this thorough process, CalEQRO identified, and DHCS approved, the following PMs to use in the annual reviews of all DMC-ODS counties. Data were available for these measures from statewide files for DMC-ODS claims, Medi-Cal eligibility, certified providers, TPS, CalOMS, and the ASAM Criteria-based LOC referrals. All final PMs were reviewed and approved by DHCS, and all evaluation activities are coordinated with UCLA ISAP.

- 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 screening or assessment and referral.
- Total approved claims per beneficiary served by each county DMC-ODS by ethnic group and age.
- Cultural competency of DMC-ODS services provided to beneficiaries.
- PRs for beneficiaries, including ethnic groups, age, and risk factors (such as disabled and foster care aid code groups).
- Coordination of care with physical health and mental health.
- Timely access to medication for those referred to 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 90th percentile of statewide cost or higher.
- Percentage of clients with three or more WM episodes and no other treatment, to improve engagement in necessary outpatient care.

- Use of ASAM criteria in screening and referral of clients and percent referred to the criteria-indicated LOC (also required by DHCS for counties in their first year of implementation).[4]
- Initiation and engagement in DMC-ODS services across the continuum of treatment services.
- Retention, or length of stay (LOS), across an uninterrupted sequence of treatment services within the DMC-ODS continuum of care, and
- Readmission into 3.2 residential WM within 30 days.

California Outcomes Measurement System (CalOMS)

Another important data set for QI 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 service episode. Providers collect client information at admission and discharge from the treatment program to determine drug use, drug-free social supports, mental health status, living status, employment status, and legal status. Any of these elements can be used by counties for pre/post treatment measures of client outcomes, and a few counties have begun doing so with some of these elements. At the annual review for each county, CalEQRO provides counties with their aggregated Admission Summary data on clients' living status, employment status, and legal status compared with the statewide averages. These data can be useful to DMC-ODS counties in resource planning for the special needs of their clients with SUDs.

At discharge, providers must indicate the type of discharge, including whether the client had an administrative discharge by self-terminating services without an exit interview. Providers must also rate whether their clients successfully completed treatment, made satisfactory progress without treatment completion, or did not make satisfactory progress. At the annual review for each county, CalEQRO provides counties with their aggregated Discharge Summary data compared to statewide averages. These data can be useful to DMC-ODS counties as indicators of the effectiveness of their treatment services and possible areas for improvement. To maximize the usefulness of the data, DHCS produced an instruction manual for providers on how to complete the ratings, which serves as a training tool for standardizing procedures and ensuring inter-rater reliability.

[4] 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

Treatment Perception Survey

The TPS is a survey designed to measure clients' perceptions of their care. The adult version consists of 14 items that yield findings in five domains of access to care, quality of care, care coordination, outcomes, and general satisfaction with services. The youth version consists of 18 items that yield findings in the same five domains as the adult version plus an additional domain of therapeutic alliance. Both instruments were developed with psychometric research that established their reliability and validity and the differentiation of the domains.[5]

DMC-ODS counties are required by DHCS to administer both forms of the TPS during one specified week during the fall of each CY to all clients in active treatment.[6] The counties collect the completed surveys and upload the entries to DHCS. The UCLA ISAP team is tasked with analyzing the data and sending a report of each county's results to the county's DMC-ODS; counties receive line level data that can be further stratified by demographic categories for additional analysis at the local level. The report includes the county's overall results for each item and domain, as well as a comparison with the statewide results; the report also contains the results by item for each provider program, age group, gender identification, race and ethnicity, and LOC in which the respondent was enrolled at the time of the survey. Counties can study the provider-differentiated results, identify outliers with lower performance as well as model programs with stronger performance, and use the data with the providers to promote QI efforts.

Data Documents for Counties to Complete

As part of the pre-review preparation, counties are required to submit documents and related information and materials to CalEQRO. The CalEQRO review team analyzes these materials prior to the review dates and uses them as guides to focus the questions during the review sessions. The review documents 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 representing delivered services
- PIPs (one clinical and one non-clinical)

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[5] Teruya, C., Joshi, V., Urada, D., Trabin, T., Iturrios-Fourzan, I., Huang, Y. (April 2022). Development and Measurement of the Treatment Perceptions Survey (TPS) for Clients with Substance Use Disorders. The Journal of Behavioral Health Services & Research (JBHS&R), 49 (2) 190-203.

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

- Completed Information System Capability Assessment (ISCA) on data systems
- DMC-ODS Implementation Plan approved by CMS and DHCS
- Current year QI Work Plan (QIWP) and previous year QIWP Evaluation
- Quality Improvement Committee (QIC) meeting minutes
- Cultural Competence Plan (CCP) and meeting minutes
- Organizational chart
- ASAM Continuum of Care Form for the current year, including all available LOCs
- Access Call Center and other Data Entry Points Key Indicators form
- List of pending programs awaiting DHCS Provider Enrollment Division (PED) certification for DMC-ODS
- Grievance and Appeal Quarterly Logs
- NA Form and with current NACT form and alternate access standards (AAS) form, if required
- Managed Care Plans Memorandum of Understanding (MOUs)

CalEQRO Review Activities

- Review activities onsite or virtually include but are not limited to: client focus groups; stakeholder interviews; reviews of ongoing plans and projects such as QIWPs, CCPs, and PIPs; NA issues; ISCAs; care coordination arrangements with managed health care plans and physical health service providers; coordination with other partners, such as the criminal justice system and child welfare systems; access call center staff interviews; new program site visits or focus groups; MAT provider group interviews; contract provider management interviews; supervisor and line staff interviews.
- All reviews conducted during the FY 2021-22 were under health safety precautions necessitated by the COVID-19 pandemic. Consequently, all client focus groups and group interviews with staff and providers that might have otherwise been conducted in person were held virtually through videoconferencing.
- The pre-review documents and onsite focus groups and stakeholder interviews are compiled and integrated for Key Component ratings. CalEQRO focuses upon 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 in the Key Components form can be found on the CalEQRO website, www.calegro.com.

Analysis Tools

For the Annual Statewide Report, most quantitative data are compiled and analyzed with Statistical Analysis Software (SAS). Graphs are displayed using Microsoft Excel, generated to highlight key findings. Analytic staff also manually extracted key themes from the vast amounts of qualitative data to highlight the most salient ones. This mixed methods approach is employed to generate highlights, key findings, noteworthy practices, and areas for improvement.

Client focus groups include surveys yielding quantitative data and follow-up group interviews for more nuanced and in-depth information related to key themes. The focus groups by design include clients from a variety of types of treatment programs, ages, and ethnic groups, including some clients for whom English is not their preferred language and translators are necessary.

CalEQRO works in teams to synthesize the wide range of quantitative and qualitative data into information that is effectively organized, clearly and concisely written, and useful. Preliminary drafts are iteratively reviewed and edited by internal staff. CalEQRO then sends the completed draft of this report to DHCS for their review and editing. The core template for the report follows the general CMS protocol plus other areas of interest to DHCS within the CalEQRO scope of work. It is anticipated this focus will gradually shift to increasingly incorporate the CalAIM goals and measures and the DHCS Comprehensive Quality Strategy that were approved by CMS during FY 2021-22.

Health Information Portability and Accountability Act Suppression Disclosure

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then “<11” is indicated to protect the confidentiality of DMC-ODS beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding penetration rate (PR) percentages.

Access

Introduction

The DMC-ODS 1115 Waiver has prioritized 24-hour access to information, screening, and referral to promote rapid access to appropriate treatment for clients needing care. The goal is immediate access followed by effective treatment, symptom relief, and positive outcomes. All DMC-ODS plans must have a 24-hour BAL available to provide information and screening to link individuals to appropriate SUD services. This requirement applies to individuals with both routine and urgent conditions, including those who seek help in threshold languages. These access requirements are among the Waiver Special Terms and Conditions (STCs), and the BAL constitutes one of the many gateways that DMC-ODS plans must establish to facilitate access to care. In addition, all DMC-ODS plans must establish NA as defined by CMS and state statute (California Welfare and Institutions Code Section 14197[7]) to meet the needs of their beneficiaries. NA includes adult and youth outpatient, residential, and MAT services, all within specific time and distance standards within the geographic area of the Plan.

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members that ultimately lead to improved beneficiary outcomes: examining culturally appropriate service accessibility and availability; system capacity; and integration and collaboration of services with other providers.

Each access component summarized in Table 4-1, is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met[8].

Table 4-1 shows the overall results of the Access components, each further detailed as follows.

[7] California Welfare and Institutions Code § 14197

[8] Detailed definitions for each of the review criteria in the Key Components form can be found on the CalEQRO website, www.calegro.com

Table 4-1: Summary of Access Key Components, Statewide

KC #	Key Components – Access	Met	Partially Met	Not Met
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	21	10	0
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	27	4	0
1C	Collaboration and Coordination of Care to Improve Access	28	3	0

Key component 1A assesses service accessibility related to cultural competence and systems being made available to different cultural groups with different needs for how services might be delivered or communicated. Results for this domain changed the most in the last review cycle, likely based on renewed shift and focus on issues pertaining to social justice, health equity, and engagement with communities of color. High profile incidents and resulting media coverage and social unrest raised awareness of the seriousness of racial issues, not just from these specific events, but the underlying impact on community health and well-being. Many counties held community forums, and many websites were updated and expanded to be more visible and inclusive of local communities. Outreach and plans shifted to have a local neighborhood focus. Many projects with local support included expanded funding for neighborhood engagement and outreach, SUD education, and school or mobile services to underserved communities. New teams were added and staff assigned to respond with, or instead of, police to certain 911 or social service calls. For example, **Los Angeles** made its SUD resources website directory with bed availability and appointment information public-facing. The DMC-ODS also facilitated a committee to consider treatment instead of drug possession charges to avoid incarceration, and enhanced the discharge planning from jail. This effort to advocate for SUD treatment instead of incarceration was evident in CalEQRO sessions that focused on coordination with criminal justice, the courts, probation, schools, and which were often attended by their allied partners.

Key component 1B relates to the improvement of the service continuum. Improved services occurred despite COVID-19, which took considerable resources and focus away from service expansion during most of the last two years. During the recent review years, DMC-ODS programs pivoted to telehealth and phone services to deliver care as quickly as possible, depending on existing infrastructure. The more flexible the clinical service was, the easier it was to adapt to the COVID-19 environment, with changes in requirements for safety for both staff and clients. More formally structured programs with extended contact with clients, such as residential and intensive outpatient, had the most challenges in the COVID-19 environment according to feedback from staff and clients. NTP/OTP MAT services also needed waivers from federal and state regulatory requirements to function and serve clients effectively and assure clinical stability.

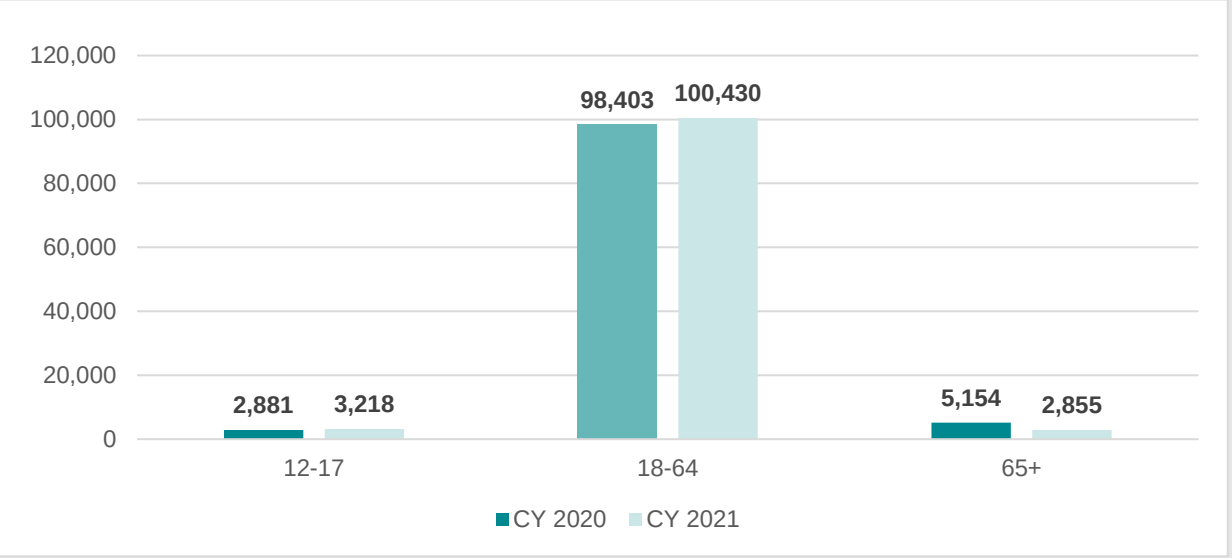
Several large counties and some medium counties had begun program expansions the year before the pandemic. These services opened in CY 2021 adding to capacity and increasing the number of clients served. Many counties increased case management and RSS through

the use of telehealth and phone services. Structured services with the most intense personal contact, however, did not expand. Based on review feedback from stakeholders, regulatory flexibility provided by state and federal governments assisted service providers in re-starting after quarantine, with an allowance to utilize video and phone visits along with take-home dose options for stable methadone patients. Clients in focus groups repeated their appreciation for the flexibility of these measures and having more opportunities for contact with their treatment staff.

Key Component 1C documented LOC coordination and care integration, and denotes the highest scoring area statewide in the last two year cycles. Many plans reported the pandemic enhanced the need for more coordination and integration of care, particularly in healthcare. From a practical standpoint, it was needed to keep clients safe as programs attempted to offer SUD treatment during the pandemic.

As DMC-ODS plans improved their use of new telehealth and phone services in CY 2021, counts of Medi-Cal clients served increased slightly after dramatic decreases in early CY 2020. In CY 2020, the total unduplicated clients served in DMC-ODS plans was 106,438, and in CY 2021 the total unduplicated clients served was 106,503.

Figure 4-1: Clients Served, CY 2020 & CY 2021 by Age Group



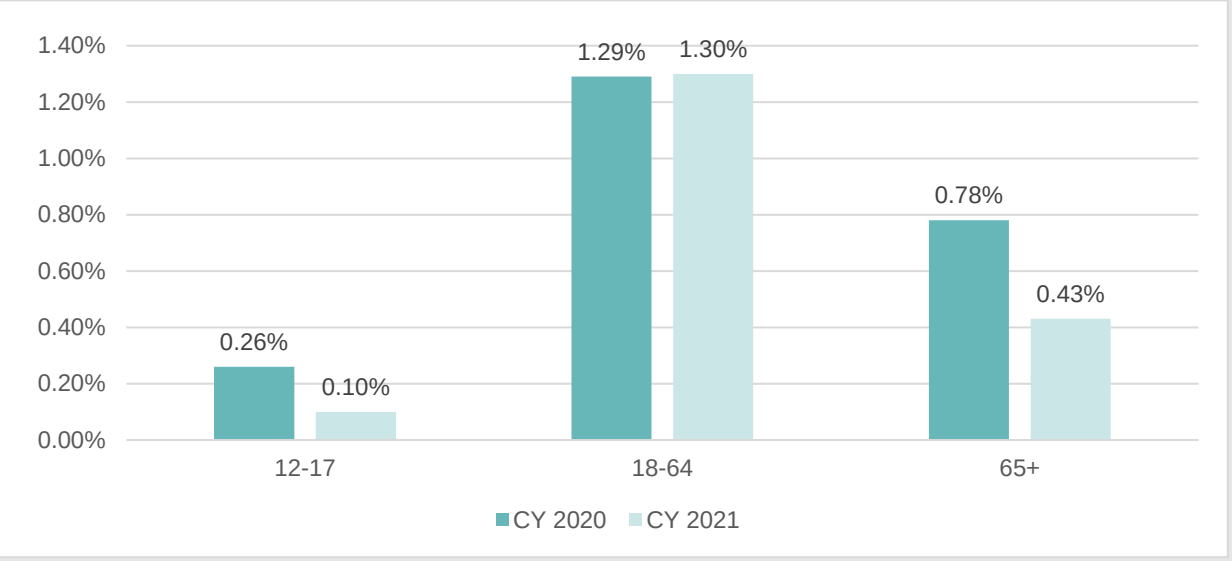
In CY 2021, as school access began to improve and programs began to open, the numbers of clients aged 12-17 increased by 11.8 percent; nevertheless, numbers served remain extremely low statewide. Input to CalEQRO indicates that most DMC-ODS plans have set goals to improve and increase services to youth, given local reports of COVID-19 impacts on adolescent mental health and high use of substances in 2021 and 2022.

Adult access to SUD treatment also increased slightly, though community impacts indicate that the numbers of fatal overdose incidents dramatically increased in most counties. The increasing supply and use of fentanyl has driven the fatality rate much higher and created significant nationwide attention and concern. It is clear that urgent treatment access, and

disproportionate impacts especially within communities of color and rural areas, require additional opportunities to engage in treatment early.

Services delivered to older adults decreased by 44.6 percent from CY 2020 to CY 2021. Many DMC-ODS programs report continued hesitancies by seniors entering care settings due to COVID-19 vulnerability, likely contributing to this change. More mobile or remote approaches for senior populations were requested by clients until there was more security related to the virus.

Figure 4-2: Penetration Rate by Age Group, CY 2020 and CY 2021

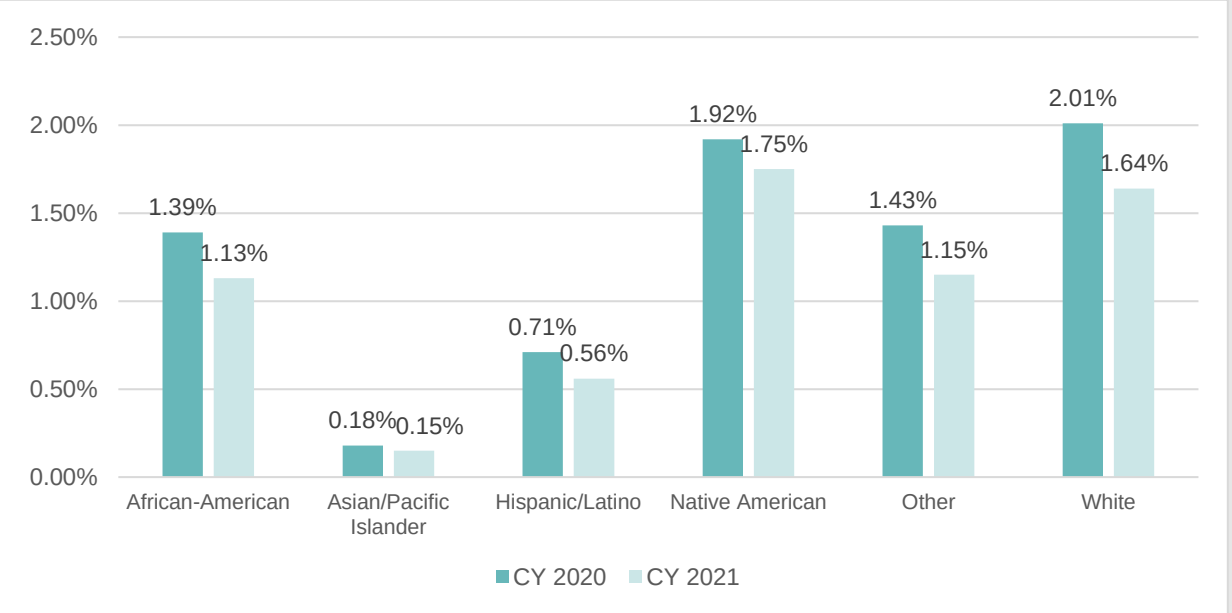


Due to the pandemic, many individuals lost employment, and Medi-Cal eligibility rose from an average of 10,042,393 individuals statewide to 12,750,890 individuals statewide in 2021. The PR for persons receiving SUD services from DMC-ODS plans reduced from 1.06 percent in CY 2020 to 0.85 percent in CY 2021 overall linked in part to this surge in eligibility. Figure 4-2 shows a drop in the PR related to age groups, particularly youth, as most schools closed completely without any vaccines, and access to treatment for youth was more challenging.

Adults showed a PR improvement as the access flexibility in outpatient, MAT, case management, RSS, and more kiosks began. Older adult levels of engagement, however, remained low, and these trends did not improve until some of the most recent service data was available in late FY 2021-22.

Figure 4-3 shows the PR changes between CY 2020 and CY 2021 for race/ethnicity groups.

Figure 4-3: Penetration Rate by Race/Ethnicity for CY 2020 & CY 2021



News reports at the time indicated that the working class were adversely impacted, often the first to lose their jobs and become unemployed in the pandemic, then becoming Medi-Cal eligible. As many were persons of color, an increasing number would be represented in these groups needing Medi-Cal for healthcare. Even though the numbers of eligibles in many of these groups did rise, the numbers in treatment as reflected in PRs did not, which is concerning. Due to quarantine orders, outreach and engagement in care in traditional ways during the pandemic were particularly difficult. Also, stigma related to engagement in SUD services is powerful in many of these communities, creating additional barriers to access.

Table 4-2 shows average approved claims amounts by eligibility group.

Table 4-2: Average Approved Claims by Eligibility Category, CY 2020 & 2021

Statewide Eligibility Categories	AACB CY 2020	AACB CY 2021
Disabled	$4,788	$5,549
Foster Care	$2,236	$2,826
Other Child	$2,767	$3,460
Family Adult	$4,486	$5,010
Other Adult	$3,502	$4,547
MCHIP*	$2,923	$3,783
ACA	$5,439	$5,999
Overall Average	$5,190	$5,821

**Maternal and Child Health Integrated Program*

DMC-ODS plans spent more on providing SUD services based on the average cost per beneficiary for all eligibility groups during CY 2020 to 2021 statewide. According to local administrators, the challenges with social distancing in programs and added expenses for masks, screenings, isolation housing, and testing, impacted service rates. Other new costs were telehealth and phone services equipment, training for pandemic-related safety issues, the lower census in residential programs and any programs with face-to-face contact, and more staff overtime due to sick leave and coverage issues. The challenges continued and varied across 2021 in work environments and the different LOCs serving vulnerable populations.

Evaluating Client Needs for Services

SUD treatment initiation is most successful when the person's individual needs and readiness to change are accurately evaluated and services are matched to those needs when they ask for help. The ASAM screening and assessment process is designed to accomplish these goals.

Table 4-3 shows congruence with referrals of clients' assessed needs and the referral of clients to services in the care system in CY 2021. This evaluation may be in the initial screening, a full assessment, or a follow-up assessment. A reason is identified when the referral differs from the results of the evaluation. Overall, for those clients receiving a brief screening, 90.63 percent of the clients are referred to the LOC assigned through the ASAM. Upon initial assessment, however, the percentage decreases to 79.17 percent, where patient preference and clinical judgment result in referrals to alternate LOC. For those clients receiving a follow-up assessment, clinical judgment is the primary reason for assignment to a different LOC.

Table 4-3: Congruence with ASAM Assessment LOC Recommendations CY 2021

Category	Brief Screening		Initial Assessment		Follow-up Assessment	
	# of Beneficiaries Served	% of Eligibles	# of Beneficiaries Served	% of Eligibles	# of Beneficiaries Served	% of Eligibles
Placement Decision Match	41,502	90.63%	59,917	79.17%	33,559	88.69%
Reasons for Placement Decision mismatch						
Patient Preference	2,373	5.18%	6,126	8.09%	1,037	2.74%
Level of Care Not Available	70	0.15%	354	0.47%	150	0.40%
Clinical Judgment	882	1.93%	5,510	7.28%	1,920	5.07%
Geographic Accessibility	29	0.06%	97	0.13%	20	0.05%
Family Responsibilities *	40	0.09%	151	0.20%	23	0.06%
Legal Issues	133	0.29%	174	0.23%	23	0.06%
Lack of Insurance/ Payment **	68	0.15%	42	0.06%	17	0.04%
Language	15	0.03%	0	0.00%	0	0.00%
Other	683	1.49%	3,312	4.38%	1,088	2.88%
Total	**45,795**	**100.00%**	**75,683**	**100.00%**	**37,837**	**100.00%**

* Family responsibilities refers to obligations to family members (e.g., childcare) that may conflict with a recommended LOC, such as residential treatment or the schedule of an intensive outpatient program.

** Lack of insurance generally applies to individuals with private insurance or Medi-Cal with a share of cost. ASAM and CalOMS data are submitted to the State for all clients in treatment, whether or not they are Medi-Cal eligibles.

Table 4-3 compares ASAM data from 2021 related to matching referrals from the BAL centers and network providers doing brief screenings (though some counties do not screen, such as Riverside and San Francisco who are doing complete assessments at initiation), using ASAM criteria to match clients to the appropriate service level. While the number of DMC-ODS plans using ASAM screenings in their BALs and by providers with first contacts has increased, more utilization would be optimal. Client input provided to CalEQRO during focus groups indicates a desire by consumers for an immediate treatment option. Eleven BALs continue to only provide information on SUD services and set up centralized appointments. Clients are directed for additional screenings or assessments before starting treatment, a process that can be inefficient for acutely indicated but limited residential beds. Other BALs just provide incoming clients with several phone numbers to call, which has led to high no-show rates. Immediate ASAM evaluations and warm hand-offs with a navigator or case management support have

been linked to improved timeliness and access[9]. Without timely screening and linkage to treatment, there is a lost opportunity for engagement. No shows on first visits are monitored as part of timeliness. It's noteworthy that some DMC-ODS systems have lower no-show rates by having instituted rapid screening and timely linkage to treatment with the addition of transportation and navigator supports.

It is worth emphasizing that the rapid engagement of the client in a meaningful therapeutic alliance through screenings that match their clinical needs is essential. Fast access can begin the process of managing the powerful and arduous process of substance withdrawal and initial stabilization. Research has supported the importance of this effort to produce meaningful change for those in SUD treatment.[10]

Table 4-3 above clearly describes the positive efforts of the DMC-ODS plans to work with the clients to match their clinical needs at the BAL centers using the ASAM assessment tool with its six dimensions, which include treatment readiness and other needs. Overall, the scores represented a good understanding of the tools and clinical oversight regarding placement determinations. Provider training on this clinical tool is required for use and the results continue to be used as a key guideline in treatment planning. Further, its value for assessment and for evaluating both needs and readiness for transitions to and between different LOCs is evident. Electronic tools are also available, and many are being embedded in the EHRs.

Tracking Network Adequacy & Capacity

A key measure of access to care is whether individuals can gain access to services recommended in their ASAM screening in a reasonable time and at each LOC indicated. In other words, was the treatment available and within a reasonable time and a reasonable distance? Service accessibility is critical if it is a daily or a frequently scheduled service such as MAT or Intensive Outpatient (IOT) or an urgent service such as WM. Thus, all DMC-ODS plans have their capacity and their site locations for outpatient, MAT, and residential evaluated for NA. This evaluation by DHCS is based on the CMS and state requirements and, if required, the DMC-ODS must submit plans of correction or requests for AAS. This process ensures that they meet these important standards to make access reasonable and viable relative to the clients' needs. The EQR process assists with these facets of access or related issues as part of annual reviews.

Table 4-4 shows small overall growth in clients served by LOC at the DMC-ODS programs.

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[9] Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010). A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study. *The American journal of psychiatry*, *167*(2), 151–159. https://doi.org/10.1176/appi.ajp.2009.09050691

[10] (Marianne Stallvik, David R. Gastfriend & Hans M. Nordahl (2015) Matching patients with substance use disorder to optimal level of care with the ASAM Criteria. software, Journal of Substance Use, 20:6, 389-398, DOI: 10.3109/14659891.2014.934305 https://doi.org/10.3109/14659891.2014.934305

Table 4-4: Statewide Beneficiaries Served by LOC, CY 2020 and 2021

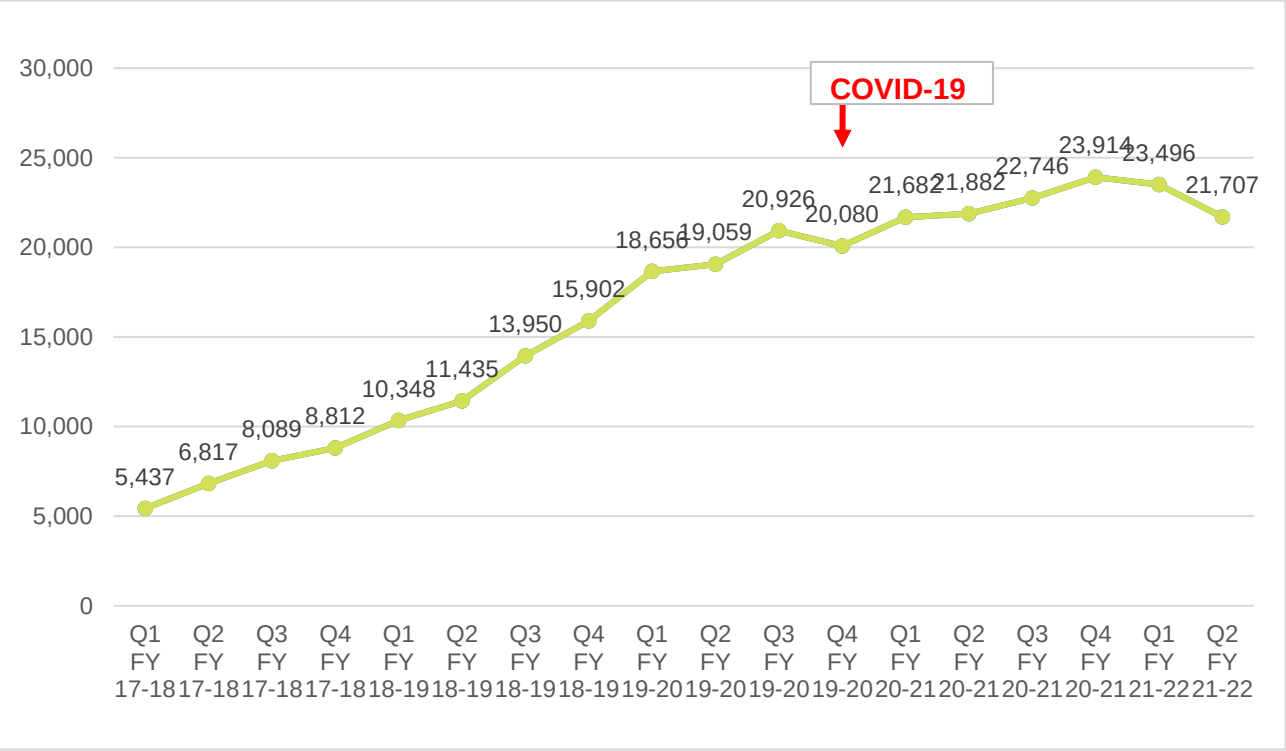
Statewide DMC-ODS Services				
	CY 2020		CY 2021	
DMC-ODS Service Modality	# of Beneficiaries Served	% of Eligibles	# of Beneficiaries Served	% of Eligibles
Outpatient treatment	33,211	31.2%	32,847	30.8%
Intensive outpatient treatment	7,783	7.3%	8,230	7.7%
NTP/OTP	38,701	36.4%	36,665	34.4%
Non-methadone MAT	2,368	2.2%	2,333	2.2%
Ambulatory Withdrawal Management	20	0.02%	-	-
Partial hospitalization	14	0.01%	≤ 11	-
Residential treatment	17,148	16.1%	18,188	17.1%
WM	4,764	4.5%	5,063	4.7%
RSS	2,438	2.3%	3,165	3.0%
Total	**106,447**	**100.0%**	**106,515**	**100.0%**

The above table shows an overall decrease in numbers served from 2020 to 2021, possibly an impact of the COVID-19 pandemic. More clients were served in WM, residential treatment, and IOT due to increased program capacity and the addition of new sites. Other services, such as RSS, grew because they were very flexible, could add new staff, were well-adapted to telehealth in the COVID-19 environment, and were in high demand due to client needs for additional support. These services allowed clients to remain in contact with clinical staff and peer support even during quarantine periods using phones and video technology. According to input from CalEQRO sessions, while many DMC-ODS systems had been planning even more service expansions, the pandemic tapped resources and staffing in unexpected ways. For example, many county employees were re-deployed to staff the emergency centers, vaccine distribution, illness, and other emergency services.

Notably, use of non-methadone MAT in the DMC-ODS did not change between 2020 and 2021. Clients receiving non-methadone MAT through the Medi-Cal managed care system – as opposed to through the DMC-ODS system – are not reflected in the DMC-ODS data presented in this report. It appears that more people receive non-methadone MAT in the medical systems of care rather than the DMC-ODS. The analysis of the DMC-ODS non-methadone MAT is an analysis of the service type and does not include analysis of the medications prescribed or whether those medications were actually filled.

Figure 4-4 represents CY 2020 and CY 2021 service level data specific to the utilization of case management services.

Figure 4-4: Statewide Beneficiaries Serviced by Case Management, FY 2017-18 to FY 2021-22

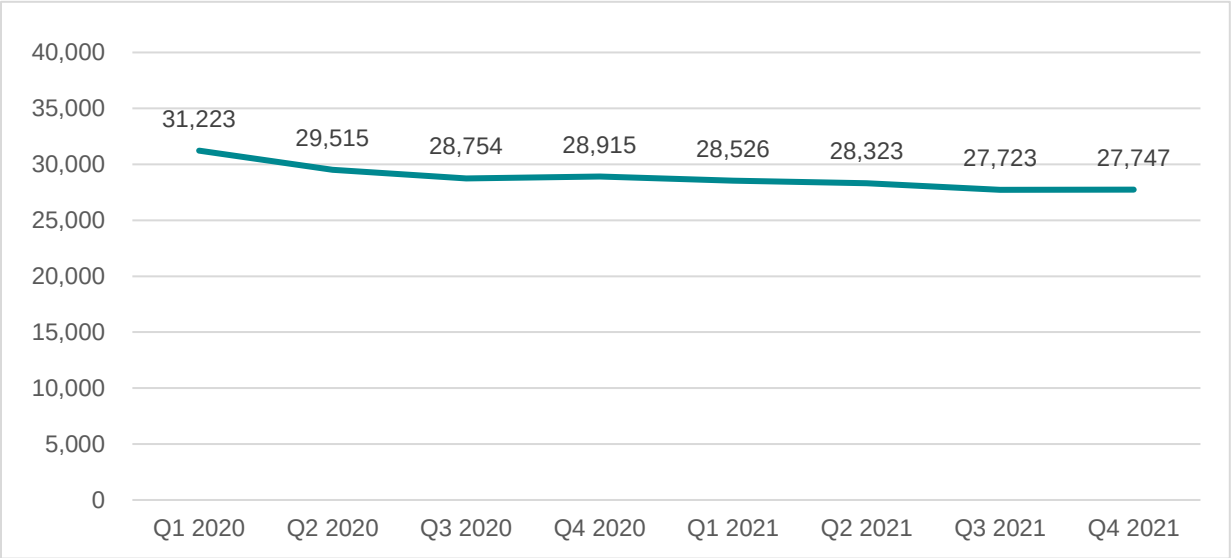


Data in this Figure shows the overall increase in case management services over the four-year period. Case management, available for all billable services and linked to all LOCs in the DMC-ODS, is provided to clients associated with strong initial engagement in care and effective transitions between the LOC. From an annual perspective, in CY 2020, case management was received by 50,439 clients out of 106,447 unduplicated clients, or 47.38 percent statewide. In CY 2021, 54,454 clients were provided case management services out of 106,515 unduplicated clients, or 51.12 percent. The trend documents increasing care coordination during early access and are validated as well by client focus group feedback. Data also indicates that case management billing is linked most often to outpatient and residential treatment.

These trends statewide are reinforced by data from **Los Angeles** which has been tracking case management utilization data since its second year of services under the DMC-ODS framework. They report that data indicates more positive outcomes for those who receive the service compared to those who do not. Based on CalOMS treatment outcomes, 2021 data indicates 59 percent treatment adherence with case management versus 43.5 percent without it.

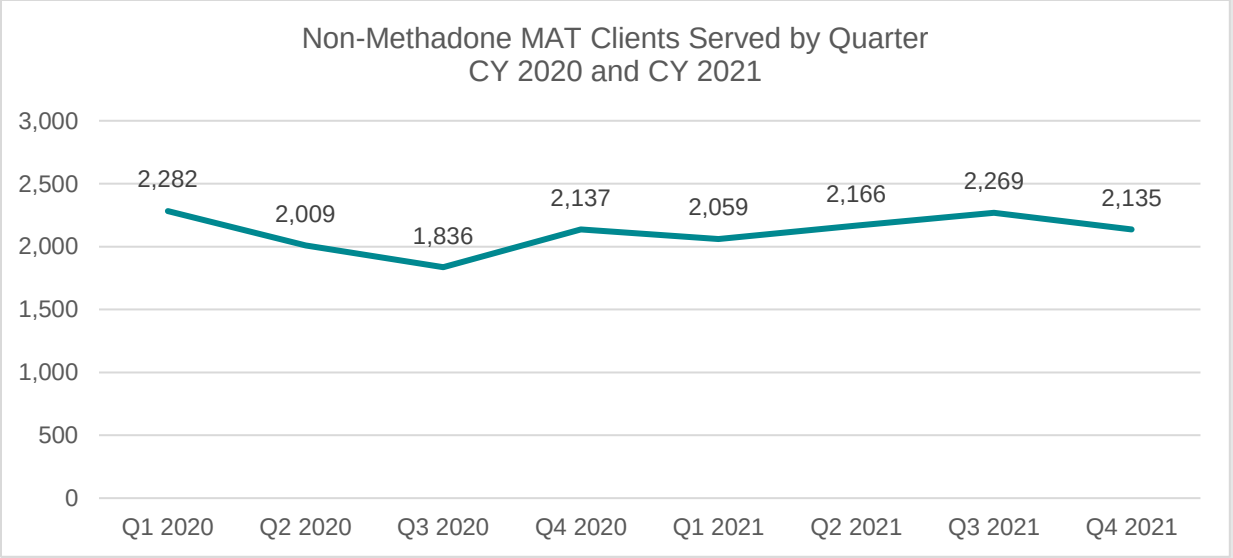
Figure 4-5 denotes year over year the number of methadone clients served.

Figure 4-5: Methadone Clients Served by Quarter CY 2020 and CY 2021



A face-to-face visit with a physician during the pandemic was still required of incoming clients to begin methadone services, likely reducing initiations on methadone.[11] Figure 4-6 provides numbers of non-methadone MAT clients served by quarter.

Figure 4-6: Non-Methadone MAT Clients Served by Quarter CY 2020 and CY 2021



[11] California Healthcare Foundation, 2022 Edition of Substance Use in California Valentine, Allison: and Brassil, Molly. Aurrera Health Group. https://www.chcf.org.publications/2022-edition--substance-use-california/#related-links-links-and-downloans

As a recognized best practice, there has also been a general trend toward increasing MAT services. A comprehensive review of non-methadone MAT service data has been more difficult to obtain, as services provided in the Medi-Cal managed care system are not visible in the DMC-ODS claims analysis, and CalEQRO does not have access to the Medi-Cal managed care system data sets. Also, while the data available to CalEQRO does not show significant increases in MAT, the California Healthcare Foundation, which examines all data sources including Medicaid and Medicare, documented an expansion of MAT across the state.[12]

Despite the limited statewide growth represented in the data, county specific data charts have shown some growth in access to non--methadone MAT, specifically within outpatient programs in multiple large counties. However, as noted elsewhere in this report, the impacts of COVID-19 restrictions likely reduced medication MAT growth overall. It is noteworthy that while CalEQRO does not have access to the FQHC or other health plan service data, multiple county DMC-ODS plans have established an ability to track their data jointly with the federally qualified health center (FQHC) partners.

Network Adequacy

State DHCS requirements for NA were added in July 2018 per CMS requirements to enhance access in remote areas and to ensure adequate capacity, with defined time and distance standards. Annually, each DMC-ODS plan has submitted a detailed NACT to DHCS for evaluation pertaining to key standards related to important time, distance, and capacity standards. The NACT is a description of its network of providers—including their language capacity, locations, service levels, and capacity. The NACTs are thoroughly reviewed annually by DHCS to identify which Plans meet time or distance standards along with DMC-ODS estimates of services to be delivered. If there is an access problem in a particular zip code, the DMC-ODS plan may need to add providers or consider other options such as expanded telehealth to meet local needs. The Plan may also propose an AAS when the facilitation of traditional clinic based services is not feasible, often because of extremely low population levels or circumstances, such as frontier areas with low population density, large geographic areas, or the presence national forests and deserts, etc.

Table 4-5 denotes DMC-ODS time and distance standards generally calculated by population and geographic area.

[12] California Healthcare Foundation, 2022 Edition of Substance Use in California Valentine, Allison: and Brassil, Molly. Aurrera Health Group. https://www.chcf.org.publications/2022-edition--substance-use-california/#related-links-links-and-downloans

Table 4-5: NA Timely Access Standards for DMC-ODS Counties

Timely Access	Within ten business days from request to routine offered 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

Based on legislative findings, counties must meet varied standards due to their populations and density, as reflected in the table above. Also related to timeliness of services, NTP/OTP services must be provided within three business days of an initial request and outpatient SUD services must be offered within ten business days for routine appointments.

Specific DMC-ODS treatment services are measured within the time and distance standards. These services include outpatient services, both regular and intensive for adults and youth, and NTP/MAT services for adults and youth. Each zip code is evaluated for [access by adults and youth and for each of these services. The numbers of Medi-Cal eligibles in each zip code impacted by the lack of services, or services too far away in terms of time or distance, must also be evaluated. Each Plan must be approved for both adult and youth services for outpatient and NTP/OTP MAT services in all areas of the county.

During the 2020 year, nine DMC-ODS plans submitted AAS requests for zip codes with time or distance challenges. Ultimately these were approved by DHCS with the largest number of AAS submitted for opioid treatment primarily, though four also had outpatient time and distance issues. A range of solutions were developed with SUD providers, including transportation resources to address the needs of clients living within these remote zip codes to access care, adding telepsychiatry with X-waivered physicians, and enhanced coordination with FQHC primary care clinics, which already have locations in more remote areas. Additionally, solutions in some areas included Hub and Spoke grants with more out-of-network providers (OONs) which may offer system navigators and other clinical service supports. Similarly, some DMC-ODS plans developed single case agreements with providers in surrounding counties or areas to accommodate treatment needs, telepsychiatry MAT, and outpatient services with the consent of the involved clients. Often these agreements would include capacity for service delivery in multiple languages and transportation support as needed. Some have utilized mobile services or obtained reasonable modifications from DHCS of the time or distance standards based on service type, area, and population.

During the 2021 Annual Network Certification, DHCS approved 14 AAS requests from 14 DMC-ODS counties, impacted also by providers in several counties that had closed due to COVID-19 impacts. **Tulare** and **El Dorado** had just launched their programs in the past year, and both needed to submit AAS requests for areas where they were still developing new services.

Overall, there were several distinct differences between 2020 and 2021. First, as has been noted, there were many challenges due to COVID-19 impacts on providers and Plans with their networks. Notably **Riverside** and **Los Angeles** noted closure of some program locations, though Riverside did not need an AAS in 2020. However, many counties did still improve in addressing all outpatient issues from the prior year in terms of NA. Time and distance issues pertained primarily to youth NTP/OTP access, with just a few exceptions. For 2021, of the DMC-ODS plans submitting requests for AAS, just a single small county was continuing its attempts to address outpatient issues for time and distance. Also, only four of the county Plans had an area where adult NTP/OTP had problems with time and distance issues, as most related to youth access.

Access approaches were similar to those seen in 2020, with even more expanded partnerships with primary care, hospitals, and co-located staff in primary care. Some mobile team response capacity for DMC-ODS was developed and was designed similarly to, or more often, working in tandem with, mental health (MH) teams in both crisis and routine response. Many of these acute response teams have care navigation and can access an expanding peer support service model. Housing efforts expanded this year but so did the challenges to accessing housing as costs rose. CalEQRO focus groups documented longer LOS in residential as placement into homeless housing options was not accessible due to recurring public health restrictions. As NTP/OTP provider access for youth was limited, this created many of the gaps documented in both 2020 and 2021 for that LOC. Fortunately, local primary care providers were an access point to serve youth in need of MAT, especially if they were X-waivered and had SUD counselors and other providers of youth services onsite.

The Capacity of Provider Networks

The ability to reach more clients needing SUD treatment with appropriate types of care remains one of the critical goals of the DMC-ODS Medi-Cal program. This is one of the mandated PMs reviewed in each DMC-ODS plan EQR review for youth and adults every year.

The list below includes DMC-ODS service expansion actions noted in CalEQRO reviews to both improve ease of access and match local needs. Indications of both need and response is reflected in the Continuum of Care data form and compared between CY 2020 and 2021. Additional context is obtained in the review's ISCA sessions that discuss billing changes by LOC and unit of service data, along with expansions put on NACT conditions (year over year), in the numbers of program sites, clinical staff, and bed capacity:

- Expansion of non-methadone MAT slots and some sites, directly and via partnerships with FQHC clinics, reflected in clients served, prescriptions, and sites.

- Expanded capacity and sites for WM residential and residential beds based on clients served and number of sites.
- Expanded use of case management and navigators to provide critical support, especially in transitions in care based on clients served, Emergency Department (ED) Bridge program expansions, and linkage to early treatment engagement.
- Expanded RSS with more clients served and more units of service.
- Expanded telehealth and calling kiosks for assessment and outpatient treatments, based on clients served, providers, and service units.
- Expanded access coordination with criminal justice programs, hospitals, and social services based on stakeholder focus groups and additional joint programs, and PIPs on this topic.
- Expanded BAL capacity to do immediate first contact screening, assessment, and link to treatment sites, based on access focus group changes, and staff interviews from the prior year, impacting timeliness positively.
- Expansion of recovery residence housing options as reflected in new beds available or in development.

Challenges for Access and NA included:

- Workforce availability and skills (particularly bilingual & licensed) to maintain staffing in critical clinics, residential staffing ratios, and programs.
- Neighborhood resistance to adding treatment sites in their neighborhoods.
- Start-up funds to provide services until full licensing and certification requirements are met.
- Lack of hospital access for acute clients with alcohol use disorders (AUD).
- DMC-ODS Plan Access Noteworthy Practices.

County examples of noteworthy practices were plentiful. Starting with the BAL centers, counties such as **Riverside, San Diego, Los Angeles, Contra Costa, Napa, Nevada,** and others invested in call center software, enhanced workforce, and public-facing website enhancements. These actions improved the management of their access processes and client supports as they enter into the care system.

Some access noteworthy practices include:

- The best BAL software included standard reports for complete caller information, wait times, dropped calls, volumes by day and times of day, and disposition information on all calls, including language, special needs, legal status, and locations.
- Access software that can confirm Medi-Cal status and provide information to assist with accessing Medi-Cal eligibility, if needed.
- ASAM-based screening software in BAL and links to electronic health records (EHRs) for triage and to support referrals to available providers at the appropriate LOCs.

- BAL access to a real-time SUD Provider database for available SUD beds, and assessment capacity by location, language, and cultural needs to make optimal client referrals.
- BAL software which provides a three-way calling capability for appointment scheduling and dialogue with providers, Probation, other partners, as well as the client, to avoid 42 CFR confidentiality issues and to allow direct communication between the client and provider.
- Providers who have the walk-in capacity to do assessments and screening linked to referrals, including after hours and weekends.
- BAL that can 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 assistance.
- Counties identified above have more details about these BAL and access strategies and associated timeliness improvements in their annual reports online at www.calegro.com. Some unique examples are described below.

Orange and **San Diego** work with a single contractor operating their BAL centers who have ongoing relationships and extensive knowledge of both county operations and systems. This created efficiency and effectiveness in access.

Contra Costa developed a real-time resource database and made it available as a phone application to make it easy to check available resources for clients in the field for access and transitions in care. They also have a special transition team to work with hospitals and the BAL to support and link clients to care.

Riverside has special support at the University of California (UC) Riverside hospital system for screenings, engagement, and referral to resources in the community, 12 hours per day, seven days per week.

Many DMC-ODS and Behavioral Health Plans have developed mobile services linked to law enforcement to respond to emergency requests with SUD or mental health needs.

Many DMC-ODS plans have also reduced the number of AAS required for zip codes with mobile clinics in community centers, home visits, telehealth kiosks, partnerships with FQHC primary care partners to have a joint site for care, and other innovative partnership strategies.

Plans have worked with DHCS and surrounding counties when there are few alternatives to develop AAS to adjust time and distance standards for very low-density frontier areas. California has many of these areas due to its desert and mountain terrain. These AAS are allowed for frontier areas with exceptionally low densities of populations and fewer Medi-Cal beneficiaries, where the Plan is willing to make special arrangements to meet the needs of these individuals.

Access Summary

Core learnings from the BAL programs include the use of ASAM assessment principles and rapid screenings, matching clients to appropriate treatment services (including MAT) and maintaining adequate bilingual staffing and resources for first visits, all have positive impacts on shifting care to be more client-centered to achieve successful engagement.

Challenges remain in bringing all these systems and services to their full potential. Youth services and non-English speaking services are still not adequately represented relative to the need. Rural services have additional challenges for access due to lack of internet and, in some areas, cell capacity. Workforce numbers for SUD counselors and licensed behavioral health professionals are not adequate for the need in most public sector programs, based on reports from reviews. Despite these challenges, CY 2021 service levels and expansions of the provider networks in most counties improved slightly over CY 2020.

CalAIM changes in medical necessity are bringing more clients into care, and more rapidly, according to BAL programs and outreach teams. Mobile services, in partnership with both law enforcement and health teams, have expanded, with a focus on linkage to healthcare and treatment instead of incarceration wherever possible. NA efforts, flexibility, and new infrastructure efforts are assisting rural areas with fiber optics and new sites for access to care. Continuing efforts at the levels of policy and education systems are needed to support workforce expansion in the field of behavioral health as an attractive and affordable career choice.

Timeliness

Introduction

The DMC-ODS continuum of care and the 1115 Waiver (and since January 2022, the combined 1915(b) specialty waiver) place a priority on timely access to treatment—a critical element for successful treatment engagement. Perhaps even more so than other healthcare services, the timely response to requests for SUD services is essential for the initial engagement into treatment and is generally noted to be a factor regarding favorable outcomes in SUD treatment. The need for a system to respond immediately cannot be overstated. This occurs through an appropriately engaging first contact (usually a screening or brief assessment), and a timely first appointment for a comprehensive evaluation of needs using the ASAM. Given that many individuals seeking SUD services are ambivalent and have often had prior unsuccessful treatment efforts, small barriers can be perceived as insurmountable and deter an individual from moving forward. Understanding that only 10 percent of individuals with an SUD engage in treatment, every request is critical.

In order to appropriately track timely access to SUD treatment, counties require infrastructure to:

- Collect the relevant data
- Review and analyze the findings with clinical and operational context
- Oversee implementation of strategies toward improvement when necessary

As is consistent across all areas of the CalEQRO review, a continuous QI model underlies the review and analysis of this material for purposes of this statewide analysis and throughout the individual EQRs.

The county DMC-ODS Plans' oversight systems need this infrastructure so that when performance trends change, they are observed and then remedied in near-real time. This can be challenging when data is often delayed, coming from a variety of sources when the service delivery system is not on a common electronic record – instead of collecting data from the Access phone lines and other points of entry, such as spreadsheets from provider agencies and programs. Contracted providers may be structured with small programs that lack data collection or data extraction capabilities, creating difficulties in reporting accurate and complete information in a timely manner to the county DMC-ODS. Additionally, the larger and more decentralized a service continuum is, the more complex it can be to compile and track this information.

Routine data review will identify high and low performance areas, where high performance may provide valuable lessons for areas with poor performance. Poor performance in timeliness can suggest workflow issues or identify areas requiring additional service capacity – either additional staff or additional programs or contracts – to meet the beneficiary need.

CalEQRO evaluates timeliness performance based upon two main sources: 1) the DMC-ODS report of actual wait times through the ATA, which asks that counties submit the raw data as well as average wait times and percentage of appointments and services that met either DHCS or self-defined standards, at key points in care, and 2) Key Component 2A through 2F. The ATA and the KC items correspond in their review of six metrics:

- Initial non-urgent outpatient SUD service
- Initial non-urgent outpatient MAT/OTP service
- Urgent services
- Follow-up post residential treatment
- Withdrawal management readmissions
- Outpatient no-show rates

Based upon processes in place as defined in the Key Components document[13], CalEQRO evaluates the DMC-ODS' oversight of timely access to care. Specifically, the Key Components evaluate whether the DMC-ODS sets a standard, routinely tracks and trends the data, evaluates its performance through routine data analysis, and initiates performance improvement processes.

The two methods of evaluation may result in different findings associated with the same timeliness metric. For example, a county may submit its ATA with data that shows compliance with the DHCS timeliness standard, yet the county provided no evidence that it routinely tracks and trends this data or initiates necessary performance improvement processes at any point outside of the EQR preparation. In that scenario, the Key Component rating may be Not Met despite the annual reporting showing timely service access. Conversely, a county may not have met the timeliness standard, but it demonstrated robust tracking mechanisms, routine data review, and rigorous performance improvement processes to improve timely access. In that scenario, the Key Component rating may be Met, despite not meeting timely access standards.

Overall, DMC-ODSs have prioritized reporting on at least some of the timeliness metrics, as this has been an expectation of the EQRO review for several years. The quality of this reporting, and the activities that follow upon review of poor timeliness results, varies tremendously and is a key factor in the Key Component ratings.

Each timeliness component summarized in Table 5-1 is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met.

[13] Detailed definitions for each of the review criteria in the Key Components form can be found on the CalEQRO website, www.calegro.com

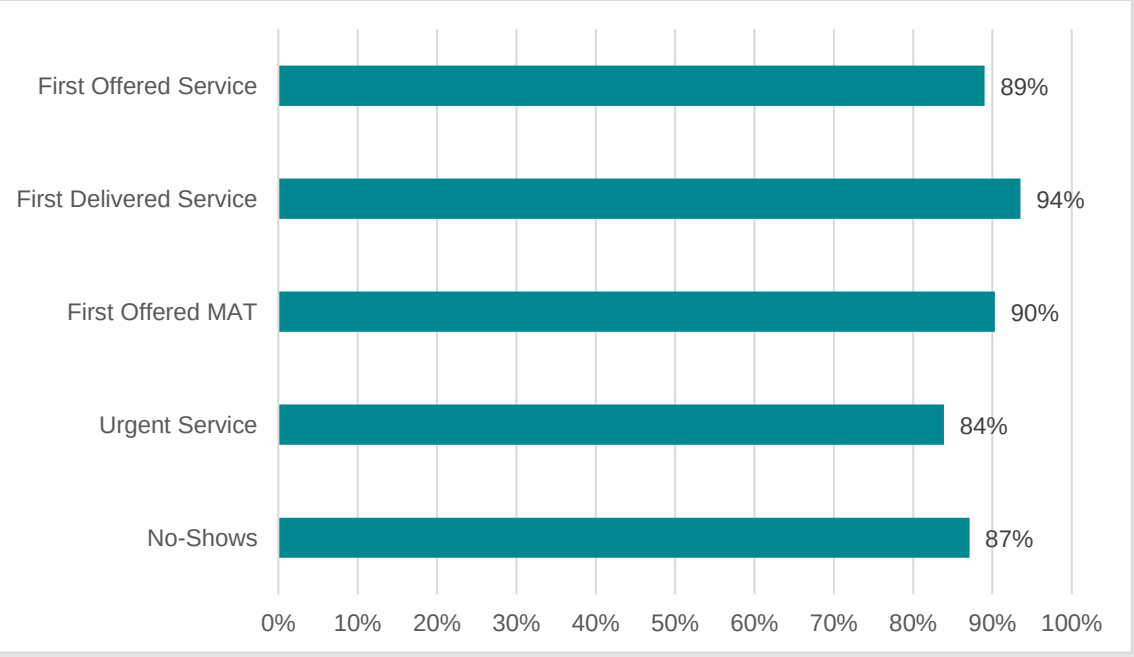
Table 5-1: Summary of Timeliness Key Components, Statewide

KC #	Key Components – Timeliness Oversight	Met	Partially Met	Not Met
2A	First Non-Urgent Request to First Offered Appointment	21	6	4
2B	First Non-Urgent Request to First Offered MAT/OTP Appointment	20	9	2
2C	First Urgent Appointment Offered	15	13	3
2D	Follow-up from Residential Treatment	25	4	2
2E	Withdrawal Management Readmissions	25	2	4
2F	No-Show and Cancel Tracking	12	9	10

Tracking Timeliness

Most of the DMC-ODS plans track most of the timeliness metrics, but full reporting across all ATA metrics did not occur in FY 2021-22. Eight DMC-ODS plans are unable to report on one or more of the metrics below, most often urgent services, with five plans reporting no data for this metric. More counties did not have the necessary infrastructure to track urgent services compared to non-urgent initial services. Additionally, while Plans reported some aspect of no-show tracking, few had capacity to do so comprehensively – detailed later in this chapter. Figure 5-1 shows the percentage of counties with sufficient infrastructure to report timeliness metrics in FY 2021-22.

Figure 5-1: Percentage of Counties with Infrastructure to Report Timeliness Metrics on ATA



Time to First Offered Appointment

Timeliness measurement begins with the first contact from a potential client; this is most often a request for service the phone but also can also occur in-person at service sites. The data below reflects the average time from first request to first offered, non-urgent appointment is 4.9 days, roughly half the time allotted by the DHCS 10-business day standard. This performance reflects a slight improvement over the 5.1-day average reported in FY 2020-21. The first offered appointment is important because it measures the system's responsiveness to supply the necessary service in a timely manner. The average wait time by county ranged from less than one day to nine days, with a median of 3.75 days.

With nearly 60,000 service requests reported to CalEQRO, 89 percent of them were offered a timely appointment – across DMC-ODS plans, the lowest on this metric was 36 percent, the highest 100 percent, and the median 91 percent. Four plans, all of which began waiver participation in FY 2019-20 or later, were unable to report on this measure. Of the 27 DMC-ODS' reporting, 25 met the 10-business day standard at least 70 percent of the time.

Key Component 2A evaluates whether the county has a mechanism for tracking first offered non-urgent appointment, evidence of routine analysis of this data, and evidence that improvement activities are implemented when warranted based on actual performance. Four DMC-ODSs rated "Not Met" on this item, and six rated "Partially Met", generally because the plan has not initiated improvement activities based upon the findings.

Overall, the DMC-ODS plans are quite successful at offering a timely initial service. This may be due to improved Access Line responses, tracking of available capacity, as well as expanded service capacity. **Merced** implemented new call center software to create a more efficient workflow for offering timely appointments. Similarly, **Imperial** improved its timeliness through an improved pre-screening process followed by near immediate treatment referrals. In addition, **Nevada** offered a "walk-in" intake, as well as telephone or telehealth, with no appointment necessary for screening and assessment. **Monterey** was developing an electronic referral report in order to track available capacity more efficiently at residential and outpatient providers; this is due for implementation by the end of 2022. Many counties were adding programs to fill in gaps in LOC, especially for youth services. **San Benito**, for example, added an intensive outpatient contract for both youth and adults, as well as a youth residential program. **Kern** was piloting a centralized assessment for MH and SUD with two providers to improve engagement rates.

Time to First Service Delivered

Timeliness tracking from first request to first face-to-face contact is an important measure of actual initiation of treatment, usually after a screening, depending upon the DMC-ODS's screening and intake workflow. This is critical for engagement and treatment of SUD, and since many individuals are ambivalent about seeking care, the time of first request often represents a narrow window for successful treatment initiation.

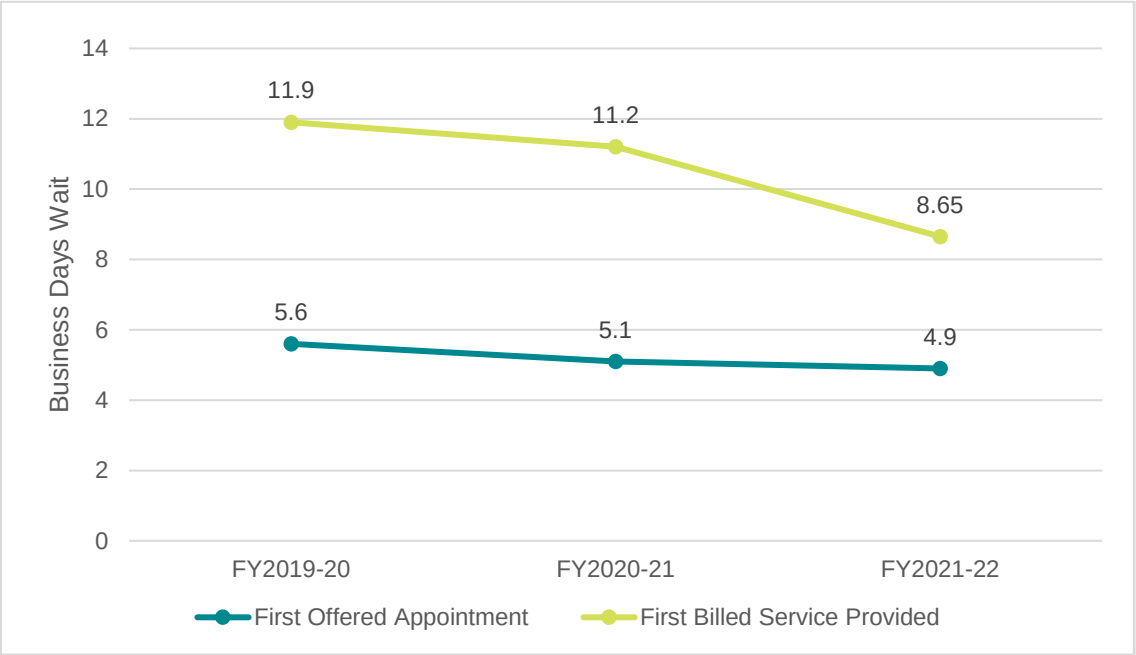
Engagement data provided by the DMC-ODSs for the first billed service averaged 8.6 days, much improved over the reported FY 2020-21 average of 11.2 days. With a range of 2 days up to 44 days, the median for all plans is 6.18 days. Eleven DMC-ODS plans had average wait times of less than five days, and five showed average wait times longer than 10 days. It is also important to note that while 27 of 31 DMC-ODSs reported on the offered appointment metric described above, 29 reported on this metric for actual service delivered. Of those who attended an appointment, 71 percent were reported to have been provided a service within 10-business days. This metric ranged from 23 percent to 95 percent across the DMC-ODSs.

With an overall target of 70 percent, 75.5 percent of the individuals offered an appointment received a billed service, slightly improved over 73.3 percent in the prior year. However, this data should be reviewed with caution since there is some difference in which counties reported data for both measures. At a minimum, the data submitted suggests that at least 26.7 percent of individuals who are offered an appointment do not show for that appointment. This is a challenge for DMC-ODSs because many factors impact whether a client follows through with initiating services. While many factors are person-specific, there are systemic factors that the DMC-ODS can influence:

- Ensuring that the initial contact was conducted in an engaging client-driven manner, efficient yet not rushed, and free of judgment, are all critical elements. Offering appointment times on varied days of the week and at varied times, and Screening or assessing appropriately so that the referral is made to the appropriate LOC, are also important.
- Inquiring to the potential client as to whether the program location is convenient and at a time that is both realistic and acceptable to the client – and considers stated preferences and other factors such as transportation, employment, school, or family obligations – can impact the show rate.

Figure 5-2 shows the three-year trend for the average wait time for both the offered and actual service. With a few exceptions in FY 2021-22, DMC-ODS plans reported on the prior FY in the submitted ATA.

Figure 5-2: DMC-ODS Timeliness, Comparison over Review Years FY 2019-22



Time to First MAT/OTP Service

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. This is particularly relevant if an individual moves from another county or had initiated MAT while incarcerated, as preventing gaps in medication care is critical.

While in the prior year the average wait time was reported as 1 day, the addition of other large counties to the data set submitted showed a significant increase in the average wait for MAT. One county reported an average wait time of 37.2 days, and another reported an average wait time of 19.1 days – strongly influencing the overall average. NTP providers in some counties have long histories of contracting directly with DHCS and reporting their information to the county may have required lines of communication that did not previously exist.

Based upon the 28 DMC-ODS plans that reported on this metric, the average wait time was as short as 0 days and the median across counties was 2.19 days. Eighteen of the 28 counties that reported this metric met the 3-day standard at least 70 percent of the time; nine plans showed wait times of 1 day or less for MAT.

Especially for opioid treatment, MAT is an important treatment modality and is most successful when offered swiftly. It drastically improves the potential for successful treatment by easing a person's physical discomfort and reducing cravings so that treatment can support the learning of recovery skills. Because of this physiological factor, individuals in need of MAT are especially sensitive to delays, and any delay has the potential for treatment abandonment.

Medications offered in this metric primarily address opioid dependence, including methadone (the most common medication), buprenorphine, and naltrexone. Methadone has been a standard of care in the field for many years and is a proven and effective way to treat opioid addiction; together with the addition of other forms of MAT, they are considered a best practice. For example, while buprenorphine has a potential for diversion and abuse, it has advantages such as its ease of use, provider flexibility, and duration of treatment compared to methadone. Providers should evaluate which MAT option is the most suitable medication for a given client, and ultimately determine which medication is best on an individualized basis.

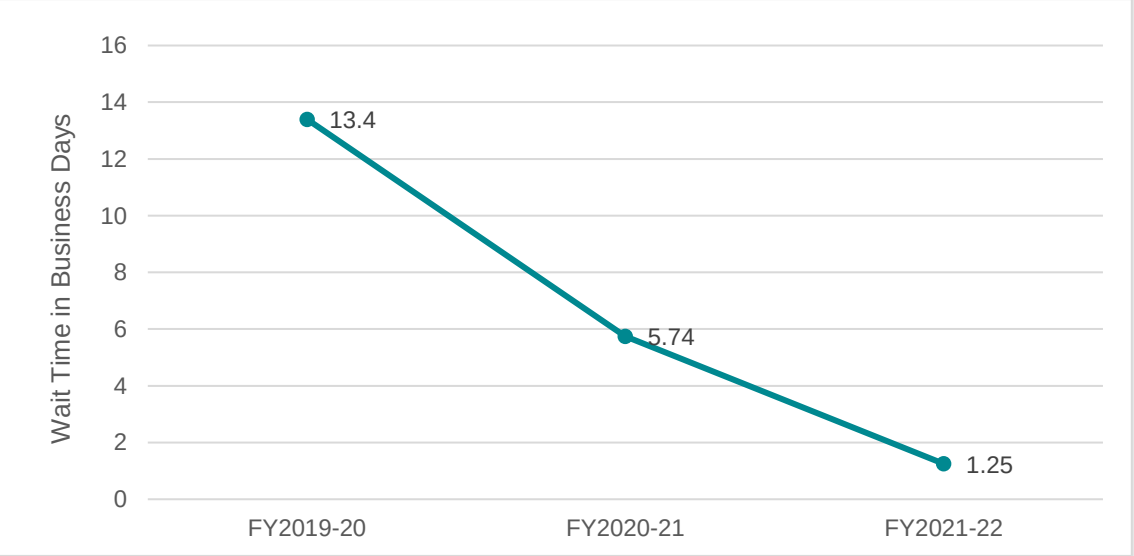
Timeliness to Urgent Appointments

As part of the DMC-ODS Waiver, counties are required to create operational definitions of urgent client need. While counties have latitude in operationalizing urgent appointments, services are required to be offered within 48 hours. Definitions vary across Plans; some define urgent conditions narrowly, inclusive of only clients who are pregnant opioid users, and others have more expansive definitions, including all WM NTP, or client self-report of urgency. Some definitions rely on federal priority populations (such as pregnant, HIV positive, and IV drug users), some on ASAM criteria of severity, and some on locally developed criteria, such as hospital or criminal justice referrals.

Counties continue to develop and revise the definition of urgent appointments, a critical step in tracking urgent services. It is unclear the degree to which improvements displayed in the figure below are a result of better system responsiveness, changes in definitions, or both. The degree to which the data is comparable across years, let alone across the DMC-ODS plans within a year, is highly variable.

Figure 5-3 shows wait times for timely access for urgent services as reported across the last three review years.

Figure 5-3: DMC-ODS Timeliness for Urgent Services, Comparison over Review Years FY 2019-22



While this metric is expected to be measured in hours, with a 48-hour goal, Figure 5-3 displays the wait time in days to show the three-year trend. At 1.25 days, FY 2021-22 is the first year in which the data submitted showed urgent care meeting the 48-hour standard overall. Across the various DMC-ODS plans, the average wait times ranged from “no wait” to 4.5 days.

Twenty-six plans reported on this metric in FY 2021-22, and 17 (65 percent) met the 70 percent target. Performance ranged from 8 percent to 98 percent, with a median wait time of 20.9 hours. Across the state, almost 12,000 service requests were identified and tracked as urgent. Some counties identified very few service requests as urgent, and therefore, this data may be an under-representation of true urgent service need. It is important for counties to define clinical urgency clearly so that the definition can be applied at call centers and other points of access in a consistent manner such that urgent response is provided when clinically warranted; otherwise, client engagement, and potentially clinical outcomes, is likely to suffer.

Follow-up from Residential Treatment

Timely transition from residential treatment to an appropriate level of outpatient care is critical for ongoing care and treatment success. It is important to track both the timely transition and attrition after residential treatment. The transition from a highly structured setting to a community setting can be a very challenging one for an individual in early recovery. Performance on this Key Component shows that 25 of the 31 DMC-ODSs (81 percent) were consistently collecting this data, reviewing it routinely, and implementing improvement strategies where warranted. Of the remaining six plans, four were partially addressing these elements and two did not track this element at all.

Based upon data provided in the ATA submissions, 27 DMC-ODSs reported a total of 31,058 residential admissions. Of 29,807 adult residential admissions, 32.7 percent of them were reported to have received outpatient care within 30 days of discharge. Using the 7-day HEDIS target, 26.3 percent of the adult discharges met this metric. Of the 358 youth admissions to residential treatment, 19.6 percent and 33.5 percent connected to outpatient care within 7 and 30 days, respectively – showing equitable performance at 30-days, but 21 percent lower performance for youth using the 7-day standard. It is noted that locally monitored data may include services that are documented but not approved by Medi-Cal; this may account for the difference between data reported by counties and data reflected in the DMC-ODS claims analysis. Data submitted by counties shows higher rates of follow-up than is demonstrated in the approved claims analysis. Linkage to appropriate outpatient care upon residential discharge is an area warranting significant attention and improvement, especially when case management services can be made available to promote successful transitions between LOC. More detailed analysis on this PM using approved claims data is detailed in the Quality chapter of this report.

Readmission to Withdrawal Management

Tracking admissions and 30-day readmissions to WM helps to identify those clients with need for ongoing care. As seen in residential follow-up, 25 DMC-ODS’s were successfully tracking this metric, reviewing the data, and initiating improvement activities when warranted.

DMC-ODSs reported 16,664 WM admissions and a 30-day readmission rate of 11.5 percent. Engagement in residential or outpatient care is encouraged while a client is in a WM program, but it is not always something that the client is interested in pursuing. It is not uncommon for a client to admit themselves to WM for a few days and then return home without additional treatment though most DMC-ODS plans have increased efforts to enhance client engagement and address issues of motivation Successful reductions of readmission rates and increased care transitions are often the result of strategies that set clear expectations for clients admitted into WM programs; facilities that have residential or outpatient LOCs within their program's continuum; and the use of system navigation staff.

Performance regarding the readmissions to WM through approved claims analysis detailed in the Quality chapter of this report.

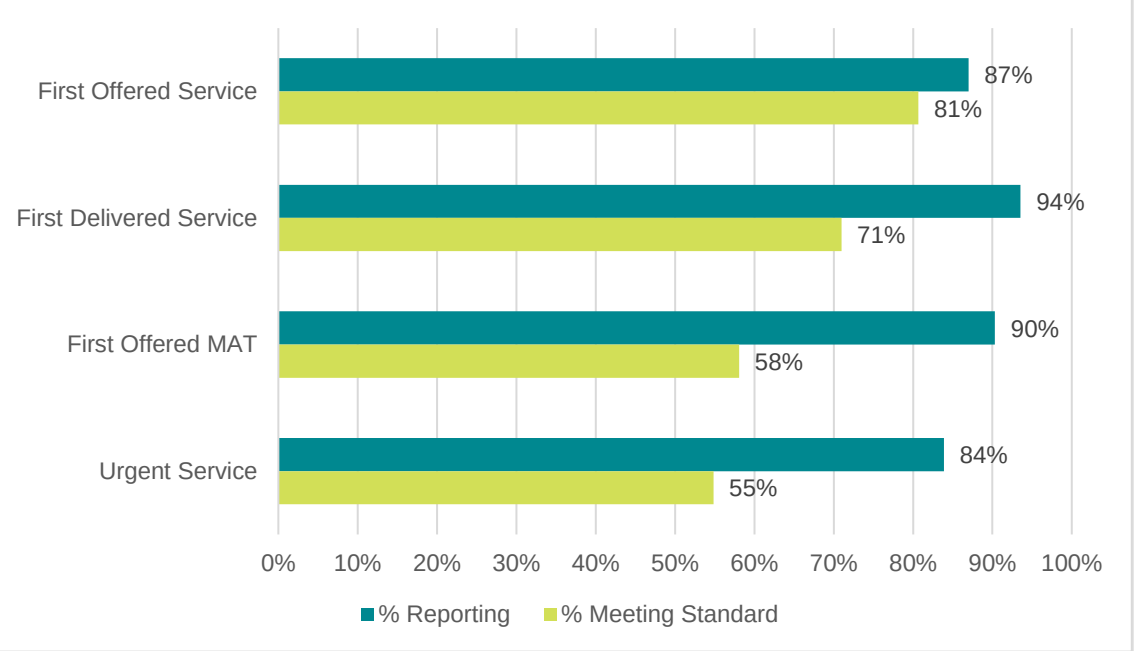
No-Show Tracking

The DMC-ODS plan's performance was highly variable on the component which rates their monitoring of no-show rates. Eight plans did not provide any no-show data for review and only four DMC-ODSs reported data for all service types collected on the ATA: the initial service at outpatient, intensive outpatient, recovery services, NTP, residential, and WM. Some counties reported no-shows for the initial service and others indicated that they tracked all scheduled appointments.

In total, based upon the data set reported, DMC-ODSs showed an average 7 percent no-show rate. This is clearly an under-report of no-shows that occur across programs and requires the most development in infrastructure for tracking and monitoring. Because no-shows are reflective of poor treatment engagement, early identification of patterns are important to promote successful treatment engagement and outcomes. Additionally, programs with lower no-show rates than others in the same LOC might be utilizing successful interventions that could be replicated elsewhere.

Timeliness Summary

Figure 5-4: Percent SUD-ODS Plans that Met 70 Percent Timeliness Standards Compared to Percent Reporting



Overall, performance reporting on timeliness is impacted by the lack of reporting by all DMC-ODS plans, and the improvements shown in timeliness may be attributed in combination to new tracking mechanisms in addition to more timely performance. Given that some counties did not report on some of the measures, especially urgent service delivery, extrapolating the timeliness performance in counties to a statewide perspective should be done with some caution. Plans which contract for most of their services have noted that lack of interoperability has limited their ability to secure complete and accurate data, acknowledging issues with data integrity. Even so, the majority of counties are meeting timeliness standards with a minimum expectation of 70 percent timely services.

Quality

Introduction

The DMC-ODS is built on a quality-of-care framework that is applied to guide and hold entities jointly accountable for improving care and outcomes for the treatment of SUDs. This chapter describes those structural elements and quality-related activities that are essential for the successful treatment of SUD:

- Providing client-centered treatment in a continuum of care.
- Establishing care coordination and recovery support; treatment based on noteworthy practices and standards of equitable, culturally competent care.
- Building an infrastructure dedicated to continuous QI and a focus on measurable outcomes management.

A variety of sources document the changes related to these elements representing quality care: ASAM LOC referral data, TPS data, CalOMS results, Medi-Cal Claims, and stakeholder and client feedback. CalEQRO uses these data sources as well as program and client focus group interviews to evaluate quality of care in a DMC-ODS program.

CalEQRO identifies eight subcomponents of SUD service quality that are important to achieve a high level of quality care and improve outcomes for beneficiaries. Each of these subcomponents of the Quality Key Component is comprised of individual criteria which collectively determine an overall key component rating: Met, Partially Met, or Not Met.

Table 6-1 describes the eight key subcomponents and summarizes rating results aggregated for the 30 counties and one Regional Model reviewed in FY 2021-22.[14]

[14] Detailed definitions for each of the review criteria in the Key Components form can be found on the CalEQRO website, www.calegro.com

Table 6-1: Summary of Quality Key Components, Statewide

KC #	Key Components – Access	Met	Partially Met	Not Met
3A	Quality Assessment and Performance Improvement are Organizational Priorities	26	5	0
3B	Data is Used to Inform Management and Guide Decisions	22	8	1
3C	Communication from DMC-ODS Administration, and Stakeholder Input and Involvement in System Planning and Implementation	16	14	1
3D	Evidence of an ASAM Continuum of Care	21	10	0
3E	MAT Services (both NTP and non-NTP) Exist to Enhance Wellness and Recovery	26	5	0
3F	ASAM Training and Fidelity to Core Principles Is Evident in Programs within the Continuum of Care	25	6	0
3G	Measures Clinical and/or Functional Outcomes of Clients Served	21	6	4
3H	Utilizes Information from Client Perception of Care Surveys to Improve Care	20	10	1

Quality Key Component 3A relates to the DMC-ODS QI efforts and accomplishments to establish a systematic, organization-wide approach for improving the quality of care. The counties reviewed had well-defined management organizations that included clear lines of responsibility and authority for planning and conducting their quality assurance and improvement activities. QIC membership varied with regard to having representation from consumers. With few exceptions, quality improvement work plans (QIWPs) were integrated MH/SUD plans with adequate focus on SUD goals and objectives. QIWPs were updated annually, and most counties prepared an evaluation of their prior year's plan.

Key Component 3B is a summary measure of how a county collects, analyzes, and uses reliable and valid data to identify strengths and determine areas for improvement. Counties varied in the quantity and depth of data and analytic resources available. There was evidence that they prioritized monitoring and evaluating areas of access and timeliness. Outside of QIWP goals relating to DHCS established compliance thresholds (e.g., timeliness), there were few established quantitative benchmarks and quantitative goals for quality or evidence of developing correction plans when such goals were not being met.

Key Component 3C relates to the demonstrated bi-directional communications between DMC-ODS administration and stakeholder groups, especially in areas of system planning and policy development. Most counties conducted information sharing and planning activities through QICs, either in full committee or subcommittee meetings. The membership composition of the QICs and quality-related subcommittees varied among counties with the broadest stakeholder representation seen in the Cultural Competence Committees. COVID-19 concerns persisted through CY 2021 and disrupted the normal ways of meeting and

communicating. Counties made adaptive efforts to maintain open and frequent communications, but many stakeholders found video conferencing and emails insufficient to address the volume and complexity of issues such as COVID-19 related policy modifications and CalAIM planning.

Key Component 3D evaluates evidence of a sufficient, well-functioning continuum of care. Even the small counties have built a system of care with fidelity to the DMC-ODS waiver requirements. Some counties do not have in-county residential treatment or WM providers and must rely on contracted, out-of-county resources. Even in counties that have a full continuum, the need frequently exceeds capacity for residential WM (ASAM 3.2) and residential treatment at ASAM levels 3.1 and 3.5. Counties are continuing to grow their capacity, but there is still a great need for expansion of MAT services, recovery residences (RR), youth services at all LOC, and improved utilization of both RSS and case management. The COVID-19 pandemic, a series of large and recurrent wildfires, a surge in the drug overdose and opioid epidemic, along with county management turnover and staffing challenges, have impacted the ability to grow services and develop additional programs throughout the state.

Key Component 3E assesses the service availability and level of quality monitoring for MAT services. There was evidence of increased availability and access to services for both methadone and non-methadone medications. When possible, counties have integrated MAT services in county clinics. The greatest advances in MAT have come through improving care coordination with FQHCs and grant funded MAT Expansion projects such as the Bridge Clinic programs.

Key Component 3F describes quality management functions related to client experiences in the continuum of care. There was consistent evidence of successful staff training and supervision on use of the ASAM Criteria for assessment of client needs and clinically appropriate LOC placement. County QI teams annually monitor treatment providers for program fidelity to principles of client-centered care and use of noteworthy practices. The best Quality Management (QM) monitoring programs included requirements for corrective action plans for deficiencies found and contract implications for serious or continuing issues. Evidence of clinically oriented QI activities was inconsistent among the contract providers.

Key Component 3G reflects the tracking and analysis of data related to beneficiary outcomes. Counties have used training and technical assistance (TA) to improve their systemwide CalOMS reporting. Most counties are collecting and analyzing their CalOMS data and many have used this data to develop a treatment outcome-related PIP. A few counties analyze clinical outcome data for specific programs or special populations or use that information to drive QI efforts.

Key Component 3H measures activities around collecting, tracking, and analyzing TPS data. Counties are uniform in working with providers to distribute and collect TPS surveys; some counties are more vigilant over the process, assertive with providers, and have more success than others. Some counties demonstrated conscientious and innovative ways to improve quality care through communicating TPS findings and by using the TPS more frequently in the context of PIPs. These examples are featured in the chapter on Client Perceptions of Care.

Client-Centered Treatment and Care Coordination

Progress in Developing a Well-Coordinated Clinical Continuum of SUD Care

Client-centered care is a way of providing treatment that is respectful of and responsive to an individual's preferences and values and treats clients as equal partners in the planning, developing, and monitoring of their health care to ensure that it meets their needs. This approach recognizes that a client's needs change as they progress through treatment, and the corresponding LOC and treatment approaches should be customized accordingly. The approach also considers that clients may need more than one type of service concurrently, so referrals to other services and coordination among them is provided. Modeled after the ASAM Criteria for SUD treatment services, the DMC-ODS continuum of care is a client-centered approach that includes quality measures and utilization controls designed to continuously improve care, support the efficient use of resources, apply EBPs, and promote access to and coordination of services.

The DMC-ODS system of care is built around the ASAM Criteria's four broad levels of treatment: Level 1, Outpatient; Level 2, Intensive Outpatient and Partial Hospitalization; Level 3, Residential, with three graded intensity levels and Inpatient with two graded intensity levels. The DMC-ODS system of care also includes outpatient NTP/MAT services and five levels of WM. These levels of outpatient and residential services vary in the specialty of therapeutic interventions and clinical services provided (medical and clinical versus clinical only), the type and level of staffing, and the frequency and duration of treatment services.

In this prescribed manner, the LOC are designed to be a match for clients with characteristically similar clinical presentations and needs.[15] While each person entering SUD treatment has unique needs, some may have conditions that require intensive residential care. Others may be able to find success in a part-time outpatient setting. And frequently, clients may need both types of treatment at various times in their recovery journey. True to its client-centered philosophy, the DMC-ODS is a flexible system, in which people with a SUD can engage at the LOC most suitable to their needs and preferences, and when it is appropriate or needed, they can smoothly transition up or down in treatment intensity.

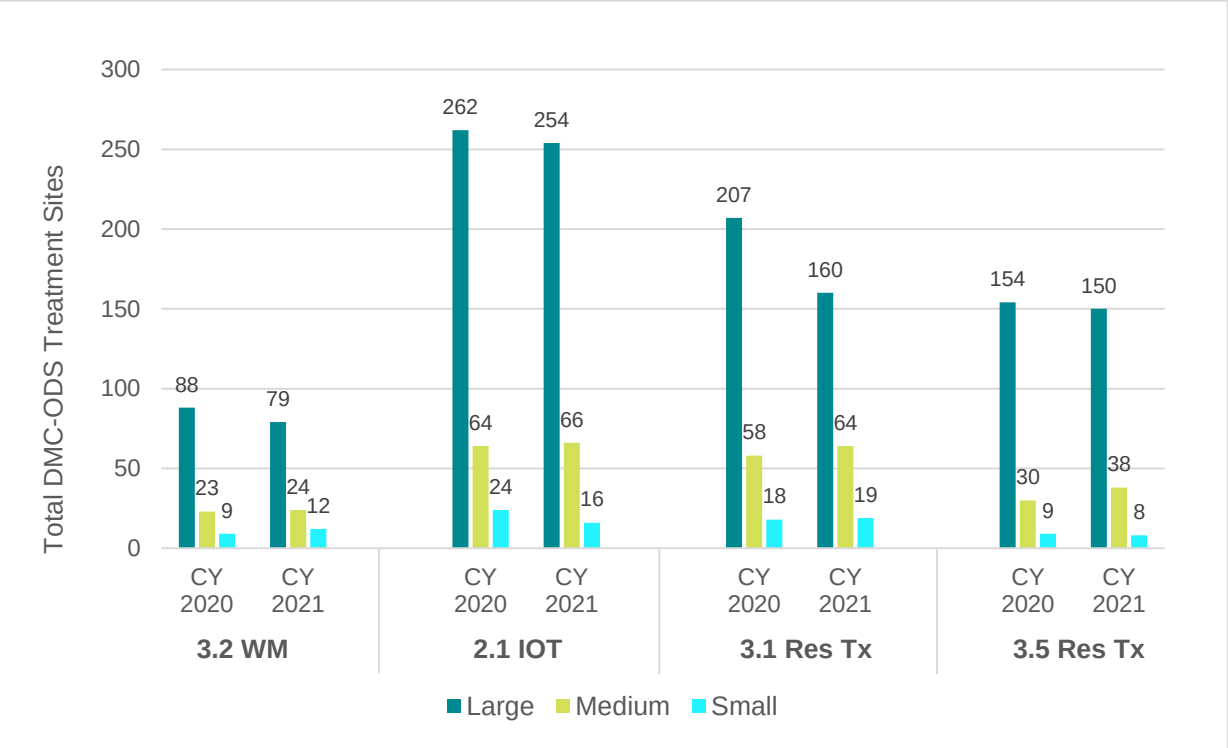
As described in the Access Chapter of this report, each of the DMC-ODS counties and the Regional Model reviewed in FY 2021-22 had developed their SUD continuum of care to meet the DMC-ODS 1115 Waiver requirements and met their NA Certification Requirements for time, distance, and capacity. The slow, albeit steady, expansion of services that was seen in

[15] Mee-Lee, D., and Shulman, G.D. The ASAM placement criteria and matching patients to treatment. In: Graham, et.al. *Principles of Addiction Medicine,* Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, 2003, pp. 453–465.

CY 2020 continued into CY 2021. Several counties described CY 2021 as a daunting challenge to maintain their continuum of care and level of services as some of their providers found it difficult, from a fiscal and staffing perspective, to sustain operations. Others were able to expand some of their existing services and even add waiver-optional programs including MAT outpatient and additional levels of residential treatment.

Figure 6-1 below displays a year-to-year comparison of LOC by number of treatment sites.

Figure 6-1: Levels of Care Comparison – Treatment Sites, CY 2020, and CY 2021



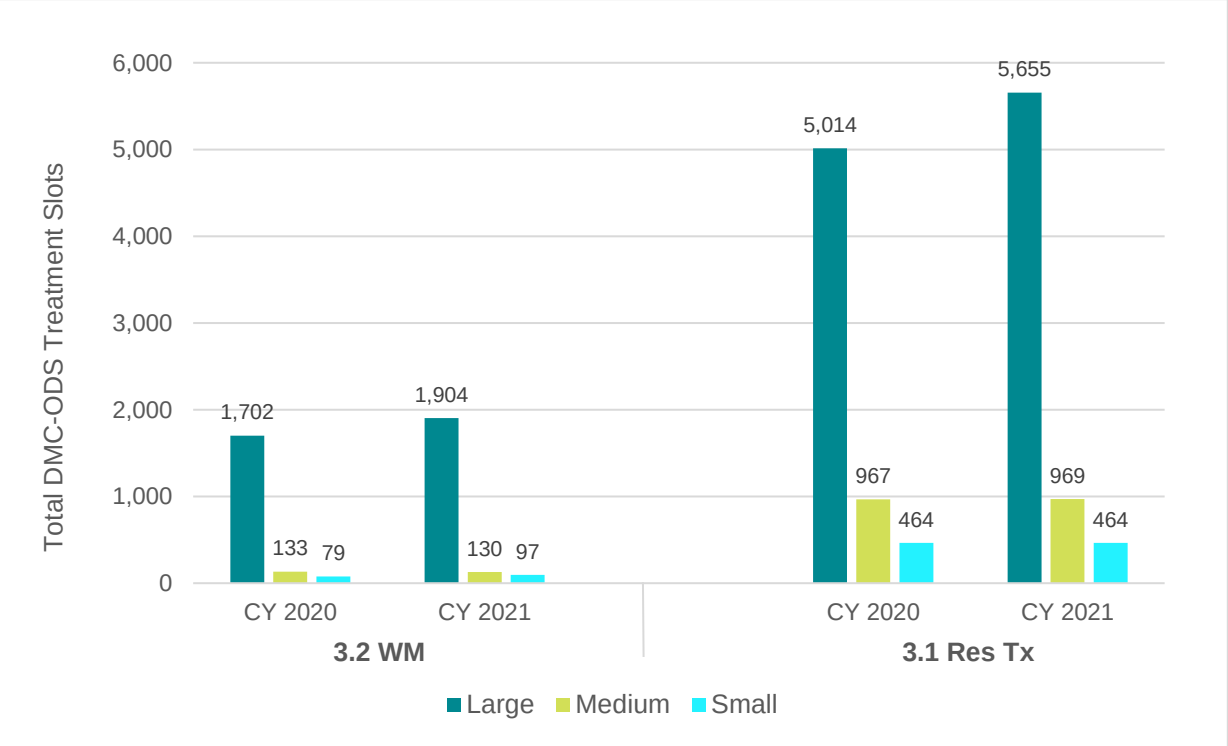
This comparative display of DMC-ODS counties shows there was a modest decrease in the number of 3.2 WM, 2.1 IOT, and 3.1 residential treatment sites. The sites counted were a total of both county-operated and contract provider sites reported in the annual EQR Continuum of Care form.

The largest and most consistent decrease was in the large county group, with Los Angeles County accounting for a major portion of the variance in the 3.1 LOC. The medium-sized counties saw the least amount of change, showing modest increases in each of the four LOC surveyed. The small counties gained some sites in their 3.2 WM while decreasing most in 2.1 IOT programs. Decreases in IOT sites may have been a response to the decline in the reported average daily client census and units of service provided. These declines were linked to the increased number of clients who needed stable housing to successfully progress in the 2.1 level of outpatient care but were not able to secure housing due to shortages of affordable housing and the low inventory of RR beds.

Residential 3.5 showed a slight decline in sites in both the large and small counties, and a notable increase in the medium counties (increasing from 30 to 38 sites). For the most part, these changes were in response to utilization and demand experiences and each county's analysis of how to allocate resources to best meet the assessed needs of beneficiaries. This is supported by the fact that even when the number of sites declined, the number of treatment slots, available in each modality, a truer measure of capacity, increased.

Figure 6-2 below displays the change in treatment capacity within residential WM and residential treatment programs from CY 2020 to CY 2021.

Figure 6-2: Comparison - Treatment Slots, CY 2020, and CY 2021



The table indicates that treatment slots in 3.2 WM increased by 11.34 percent due to the gains achieved in both large and small counties. Three of the large counties, Los Angeles, San Francisco, and Fresno, accounted for a majority of this increase. The other large counties have, on average, 36 3.2 WM contracted treatment slots. The small and medium counties average approximately 15 3.2 WM beds, and there are counties such as Merced, San Luis Obispo, and Imperial that do not have in-county residential WM. These counties rely on either hospitals or an out-of-county provider for their 3.2 WM services. Clinically managed WM (3.2 WM) is an important, at times essential, entryway or return to recovery for individuals with moderate to severe SUD withdrawal. It is a LOC deserving attention and opportunities to expand. A similar increase of 9.98 percent was measured in the 3.1 Residential LOC, but this increase was almost totally from the large counties. The majority of level 3.5 treatment is provided in facilities certified to provide both 3.1 and 3.5 LOC. As a practice, their treatment slots may be used as either 3.1 or 3.5, depending on the client's needs. In these facilities, the 3.5 slots are included in the total count of 3.1 slots.

Other Service Levels

Complete information about MAT, RR, and case management services is difficult to capture because many of the providers do not contract with or bill claims through the DMC-ODS. From the information that is available, both MAT and case management services have expanded in CY 2021. Some counties have been able to add RR beds, but the need continues to exceed supply in virtually every DMC-ODS county. NTPs are a required DMC-ODS service, and while methadone remains the primary MAT dispensed through the NTPs, counties have been working with their NTP/OTP providers to ensure they inform and, when appropriate, encourage the use of the non-methadone medications available. As noted above, most of the expansion of MAT services is through community medical centers, hospital bridge programs, FQHCs, and local primary care physicians. MAT services are provided as standalone SUD treatment or concurrently with treatment at another LOC. In this, MAT services are a prime example of how the DMC-ODS provides patient-centered care: the care is integrated and connected, not separated as in the treatment silos of past years. While not primarily occurring within the DMC-ODS, it should be noted that this model is flexible to meet individual preferences and needs. As the opioid epidemic continues to evolve, the importance of expanding and strengthening MAT services throughout all of the healthcare system is elevated.

Case management is a required service and is provided in all DMC-ODS counties (the 30 individual counties and the seven Partnership counties). Each county has developed its own model for delivering case management, which seems to evolve as its system of care grows and changes. In **Placer County's** centralized model, clients are assigned a primary case manager when initiating services. That case manager helps them navigate and coordinate care within the system, remaining with them until they are discharged.

Other counties decentralize case management, relying on treatment providers to supply the needed coordination of care. However, the majority of counties have a hybrid model with some limited case management provided by the centralized county system and other case management provided by providers. For example, **San Mateo County** has case management teams that specialize in facilitating transitions from residential treatment, linkages to MAT, coordination of care for co-occurring disorders, and coordination with Drug Court. These teams provide case management to targeted, high-risk individuals while working collaboratively with treatment program staff and any case management they provide.

Regardless of the model, case management is the primary tool in the continuum of care used to expand and connect the network of services available to clients. Several county PIPs have demonstrated that case management has a positive impact on client engagement in treatment, and according to UCLA data, it is positively associated with improved outcomes, particularly for persons with co-occurring disorders.

SUD service providers have long recognized the real need for case management services to support and coordinate client care, though these efforts traditionally stretched resources, and were delivered without reimbursement, often in an inconsistent manner. Though reimbursements are now possible in the DMC-ODS, there has been slow ramp up due to confusion about the guidelines and other barriers (i.e., not anticipating costs in initial rate setting, workforce shortage, etc.), sometimes limiting access to case management services.

And, at the provider level, case management work can still stretch their limited resources and become inconsistently applied or viewed merely as an adjunctive or discharge planning activity instead of a valuable intervention throughout treatment. It is worth noting that there are counties expanding case management using substance use navigators and peer navigators, placing them at critical junctures in the system of care when a client's motivation may be more fragile or the transition in care challenging. County QI programs have recognized this need, demonstrated by the fact that 21 of the DMC-ODSs (20 of the individual counties and the Regional Model of the seven Partnership counties) have developed a PIP which includes a case management component as an intervention to improve care.

RSS, like case management, have been implemented in a variety of formats with many following the traditional SUD treatment model of adding a provider-organized aftercare support group program. As was noted with case management, RSS program rollouts were also plagued with confusion regarding new guidelines and reimbursement questions. While many concerns have been resolved, RSS remains underutilized within the continuum of care. That said, counties are recognizing the challenges and are working, including through PIPs, to improve and expand RSS in their system of care. In **San Luis Obispo County**, RSS is available to all clients at each outpatient site and includes support provided by "Peer-to-Peer" volunteers. These peer volunteers link up with active treatment clients within 60 days of completion to encourage the transition into the RSS activities. RSS Peer-to-Peer volunteers provide information and resources, organize recovery-oriented events, and invite clients into a recovery community of former treatment clients. **Los Angeles** requires the contracted providers to provide information on the benefits of RSS at treatment initiation and throughout the clients' care. As treatment concludes, provider staff are expected to introduce clients to the RSS counselor, ensuring a warm hand-off. Los Angeles also saw a 33 percent increase in monthly clients served and a 90 percent increase in monthly claims for RSS during COVID-19 compared to pre-COVID. This strong commitment to the value of RSS is evident as Los Angeles develops a clinical PIP to improve RSS utilization following discharge from SUD treatment.

Though not required as part of the DMC-ODS framework, transitional or recovery residence (RR) housing is a particularly important part of the continuum of care and was an issue in virtually every county reviewed by CalEQRO. Where available housing is short and costs are higher, housing issues are more acute and may impact the system of care at many levels. Counties are funding some RR housing for clients in treatment using Substance Abuse Prevention and Treatment Block Grant funds, along with some funds from the AB109 and Proposition 47 criminal justice reform programs. The limited fiscal resources available for RR are a poor match for the challenges: there are too few buildings available for conversion to RRs, and those that are available are too expensive; there are too few providers to run quality residences; and there are too many clients who lack stable, secure housing. For the clients who are working to build their recovery in outpatient services, or those transitioning from residential care into outpatient and community living, safe and secure housing is critical. For example, COVID-19 related factors along with the current housing and RR crisis have contributed to the declines in IOT utilization as clients who could otherwise function at a level appropriate for IOT can only do so with stable housing. Counties have been adding RR slots as they become available, but it is a challenging work in progress. For counties such as **Imperial**, where they have a robust and highly functional system of outpatient and MAT

services in the county (with low use of out-of-county providers for residential services) having an equally robust RR component to complement and meet the needs of those clients obtaining service locally would benefit a beneficiary pool that struggles with housing. At present Imperial has two programs with five sites which have a total of just 16 beds. **Los Angeles** has the largest number, reporting 1113 RR beds, the same number they reported having in CY 2020. **Santa Clara, Contra Costa, and Fresno** followed, with 386, 373, and 350 beds respectively. While **Nevada** has just 86 RR beds as a small county, though this equates to one for every eight DMC beneficiaries receiving services; while **San Francisco** has a larger number of beds, the ratio is one bed for every 21 clients served.

In CY 2020 all counties experienced challenges related to COVID-19 and its impact on managing client safety and services. Many agencies, state, local, and federal, contributed support, but without the COVID modifications from DHCS, the flexibility needed to provide a full continuum of services would not have been possible. However, the COVID pandemic with its variants remains, and the DMC-ODS counties continue to experience varying periods of lockdowns or face-to-face contact restrictions. Despite the major impact on service delivery and access, the pandemic has accelerated adoption of telehealth and virtual visit solutions, critical to maintaining care continuity which have become an expected and value-added means for clients to engage in their treatment.

Fires have also negatively impacted services in many counties: **Placer and El Dorado** (Caldor fire); **Santa Barbara** (Alisal fire); and **Siskiyou** (McCash and Tennant fires). Similar to the impact of COVID-19, facilities had to suspend or limit operations, and client care was adjusted and managed in the most client-centered manner possible. Added challenges were presented by the severe fentanyl epidemic, increased homelessness, and the understandable but challenging procession of changes in healthcare policies and practices. A clear and consistently reported impact from each of these stressors has been on the DMC-ODS workforce, especially at the line staff level.

Perhaps the most important and largest challenge to client-centered treatment and the continuum of care is the staffing crisis. Hiring bilingual, bicultural staff has been a long-standing problem, especially in the licensed clinical and certified counselor positions. The impact from rising inflation and high-cost, difficult to find housing have compounded the stress COVID-19 has brought to the workforce. Some workers have been reluctant to return to on-site work; others have resigned, often preferring to take work that allows for continued remote employment. Counties that are able to offer higher wages and more comprehensive benefits have done better than the community based organization (CBO) providers, many of whom are non-profit operations with limited budgets. Regardless of whether programs were county operated or through contract providers, staff shortages and difficulty finding, hiring, and retaining SUD treatment employees was consistently communicated across the state.

Noteworthy Practices

San Luis Obispo has implemented a well-balanced LOC system that has closed most of their historical service gaps. Their relationships with valuable resources such as local hospitals and the criminal justice system have dramatically improved. The DMC-ODS is expanding its site and services at the Paso Robles clinic, the fastest-growing area of the county. The site will

become a health care campus, including Mental Health and Public Health programs, Social Services, and a Community Health Center clinic. The SUD program will include a 9-bed 3.2 WM program along with ASAM 3.1, 3.3, and 3.5 residential LOC.

Contra Costa has used grant resources to expand services and enhance their continuum of care, securing needed funding and staff resources, in one case targeting youth in Antioch, a remote area of the county, by designing a bridge between prevention and treatment services. Also, they received a large grant to fund SUD treatment and discharge planning staff within the county's detention medical services program. These staff will link detainees to SUD treatment within the jail and as they are released from custody with case managers. Contra Costa has demonstrated a strong commitment to expanding access to vulnerable populations.

Santa Cruz integrates case management services into each treatment program and regards the services as integral to their continuum of care for addressing the comprehensive care needs of clients. Santa Cruz reported that case management services continue to be highly utilized every year; in FY 2020-21 they averaged 983 billed 15-minute units of case management services that covered 86.1 percent of all clients.

Kern has case management activities that bring services to the client in the field. The staff are equipped with mobile equipment (computers, mobile hot spots for internet connectivity, and cell phones). Outlying area providers in Lake Isabella and Ridgecrest provide outreach to homeless individuals in remote terrain (mountainous and desert areas), including an SUD treatment group in the remote area of Ridgecrest.

Implementing ASAM Assessment Criteria to Match Client Needs with Treatment Services

A continuum of care, however complete, is of limited value if it is not used on a consistent basis to match clients with the care that can best address their treatment needs. In the past, substance use treatment was noted for using a "cookie cutter" approach, providing "one size fits all" treatment methods based more on anecdotal rather than research-tested success. When treatment "worked," the methods were credited; when treatment "failed" (relapse happened), the client readiness or motivation was blamed.

The ASAM criteria represent a form of objective, consensus-based and research-validated clinical standards for SUD assessment and treatment. The criteria give clinicians a set of guidelines for the individualized assessment of clinical needs and facilitate the matching of a client's SUD severity along six dimensions with the appropriate LOC in the treatment continuum.[16] The use of an ASAM Criteria-based assessment is a requirement under the DMC-ODS waiver. However, counties are free to choose the specific assessment tool they want to use. A unifying requirement is that the assessment tools must be constructed using the

[16] Marianne Stallvik, David R. Gastfriend & Hans M. Nordahl (2015) Matching patients with substance use disorder to optimal level of care with the ASAM Criteria software, Journal of Substance Use, 20:6, 389-398

six biopsychosocial dimensions found in the ASAM Criteria. Now under CalAIM, DMC-ODS counties have additional flexibility including a 30-day period for assessments (60 days for homeless or youth) and can provide interim services during this expanded timeframe."

Most of the DMC-ODS counties have either borrowed a tool from another county or developed an ASAM-based version of their own. Possible variance among the many assessment tools has raised concerns about validity, and prompted a call for a statewide, research-tested ASAM Criteria-based tool to be developed and distributed for use by all DMC-ODS counties.[17] In early 2022, ASAM released a free standard assessment tool in collaboration with UCLA. Further with DHCS support, UCLA recently released a free screening for initial and provisional LOC determinations. These concerns notwithstanding, each of the ASAM Criteria-based assessment tools are constructed using ASAM-styled queries that are framed in the same six dimensions found in the ASAM Criteria. Furthermore, the assessment findings are formalized using the standardized ASAM Criteria-based severity scoring system.

Most DMC-ODS counties train their newly hired staff during their onboarding process and subsequently in annual booster sessions to use of the ASAM Criteria with fidelity to the assessment process and the scoring system. The widely used ASAM video training modules adopted by many counties emphasize fidelity to the ASAM Criteria throughout the interview, assessment, and severity rating processes. Ensuring consistency and improving inter-rater reliability across providers remains a goal and a challenge. However, the general consensus across counties is that ASAM Criteria-based assessment implementations are having a positive impact in standardizing LOC determinations while improving client satisfaction, quality of care, and client outcomes.

Table 6-2 displays the congruence between the preferred LOC indications based upon ASAM findings and the actual referral made.

[17] Padwa H, Mark TL, and Wondimu B. (In press). What's in an "ASAM-based Assessment?" Variations in Assessment and Level of Care Determination Systems Required to Use ASAM Patient Placement Criteria. Journal of Addiction Medicine.

Table 6-2: Congruence of LOC Referrals with ASAM-Based Findings from Screenings, Assessments and Follow-up Assessments, CY 2021

Reasons for Incongruence	Brief Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
Not Applicable (Referral Matches ASAM Placement)	41,502	90.63%	59,917	79.17%	33,559	88.69%
Patient Preference	2,373	5.18%	6,126	8.09%	1,037	2.74%
Level of Care Not Available	70	0.15%	354	0.47%	150	0.40%
Clinical Judgment	882	1.93%	5,510	7.28%	1,920	5.07%
Geographic Accessibility	29	0.06%	97	0.13%	20	0.05%
Family Responsibilities*	40	0.09%	151	0.20%	23	0.06%
Legal Issues	133	0.29%	174	0.23%	23	0.06%
Lack of Insurance/Payment	68	0.15%	42	0.06%	17	0.04%
Language	15	0.03%	0	0.00%	0	0.00%
Other	683	1.49%	3,312	4.38%	1,088	2.88%
Total	**45,795**	**100.00%**	**75,683**	**100.00%**	**37,837**	**100.00%**

** Conflicts with obligations associated with providing care to family members*

The table reflects high congruence ratings seen across counties which support the finding that screeners and assessors are paying close attention to ASAM Criteria and relying upon them for their referral decisions. Where there is a variance from the screening or assessment recommended placement, it is most frequently due to patient preference. This is an indicator of each DMC-ODS' adherence to the principles of client-centered care, demonstrating respect and responsiveness to client preferences.

Congruence of the LOC referral with the ASAM findings was highest during the initial Brief Screening category. Where there was variance between the ASAM findings and the referral, the primary reason given was patient preference and secondarily due to clinical judgment. These results were expected because the screening process does not have the clinical or utilization review that could produce higher levels of variance for reasons of clinical judgment.

In the Initial Assessment category, a full ASAM assessment is conducted, and it is subject to a clinical and, when required, a residential treatment authorization review. As expected, there is less congruence than during the screenings. When variance occurs, again, the primary reason is the clients' preference. Clinical judgment is a moderately high reason for variance, which may indicate a need for increased staff training in conducting and scoring ASAM assessments. Counties that were significantly higher than the statewide average received a recommendation to improve ASAM training efforts.

Following the Initial Assessment, subsequent Follow-up Assessments may take place. These follow-up assessments are predominantly conducted to fulfill the requirements for extending a residential treatment stay. Other follow-up assessments may be conducted to determine the appropriate LOC for a planned transition in care. Recognizing the chronic nature of SUDs and high relapse potential, DMC-ODS Plans have gradually shifted from an episodic and program-driven approach to one that is individually customized and clinically driven. In this way, clients are guided to the right treatment at the right LOC for the right amount of time. For Follow-up Assessments, there was little variance due to patient preference. This might be expected when a client is motivated to continue care and is prompting the follow-up assessment. The moderately high variance seen in the clinical judgment category may again be a training issue.

The volume of initial assessments is higher than the volume for screenings, indicating that not everyone entering into the DMC-ODS is screened. This is especially the case in counties with decentralized points of entry into the system of care. When prospective clients contact a program directly for an intake, they are frequently routed directly into a full assessment without pre-screening, which is an allowable process. Also, the tracking of pre-screenings usually occurs outside of the EHR because the caller is not yet a registered client, and many counties have yet to develop effective solutions for linking the screening data for prospective clients with treatment data in the county EHR. Consequently, the Brief Screening numbers may be an under-representation of screenings that occurred. Additionally, several counties need to add to or customize their existing software, so it easily captures substance use-specific data related to the ASAM criteria.

Noteworthy Practices

San Luis Obispo has strengthened relationships with healthcare partners and stakeholders such as hospitals, clinics, and the criminal justice system. The use of the ASAM Criteria brings a common language to the systems. Establishing an Assessment Team at all five county-operated clinics and implementing the ASAM assessment tool to determine established LOC has proved essential for ease of operations and improved client care.

In September 2021, the Co-Triage Screening tool was launched and was quickly adopted by **Kern County** to streamline and improve their screening process. The previous screening tool took approximately 30-40 minutes to complete. With the use of the new screening tool, screenings now take 15 minutes or less, allowing for faster referral and linkage to providers for an ASAM assessment.

Santa Clara and **Santa Cruz** designed Brief Screening, Initial Assessment, and Follow-up Assessment tools in their EHRs to make it easier for staff to use and integrate ASAM Criteria into daily workflows and clinical skills development. 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.

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 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 the most detailed and is linked to thousands of research-based algorithms to guide referral recommendations. Additional analyses are being conducted to learn more about the effectiveness of treatment services for clients with varied SUD conditions.

Monitoring and Improving Transitions in Levels of Care

In the process of a client's ASAM-based assessment, certain problems and priorities are identified as justifying admission to a particular DMC-ODS LOC. This is a process where the nature and severity of the client's needs and level of functioning are matched to the ASAM LOC which offers the intensity and types of services appropriate for the client's presenting conditions. Unlike when SUD treatment was program-driven, meaning a completed LOS marked when treatment had been successfully completed, DMC-ODS client-centered care is clinically driven.

The LOC placement should be the least intensive, least restrictive level, consistent with sound clinical judgment. Additionally, the duration of treatment should be increased or decreased based on the client's clinical needs, support system, and functioning status, among other factors. Longer stays in a continuous sequence of treatments, which are related to better outcomes, are accomplished by transitioning clients into and out of differing LOCs in the continuum as clinically appropriate.[18] Resolution of or significant improvement in identified problems determines when a client can appropriately be treated at a lower LOC. As with other chronic conditions, effective treatment is provided through a continuum of care, consistent with the client-centered principle of providing the right treatment for the right amount of time to address the client's needs. Without the ability to transition to less or more intensive LOC in response to changing clinical needs and treatment goals, individuals with SUD face a higher risk of relapse and negative behavioral/physical health outcomes.

Figure 6-3 shows, as reflected in the DMC-ODS claims data, (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 in which that transition in care was accomplished, whether it is within 7 days or 30 days.

Follow-up services that are counted in this measure are based on DMC-ODS claims data for services delivered in less intensive LOCs than residential treatment including partial hospitalization, IOT, outpatient, NTP and RSS. CalEQRO does not count re-admission to

[18] 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).

residential treatment or a transfer to residential WM in this measure. CalEQRO does not have access to health plan Medi-Cal claims data which would include treatment transitioned to MAT in a primary care setting.

Figure 6-3 Timely Transitions in Step-down Care in the DMC-ODS System Following Residential Treatment, CY 2020 – CY 2021

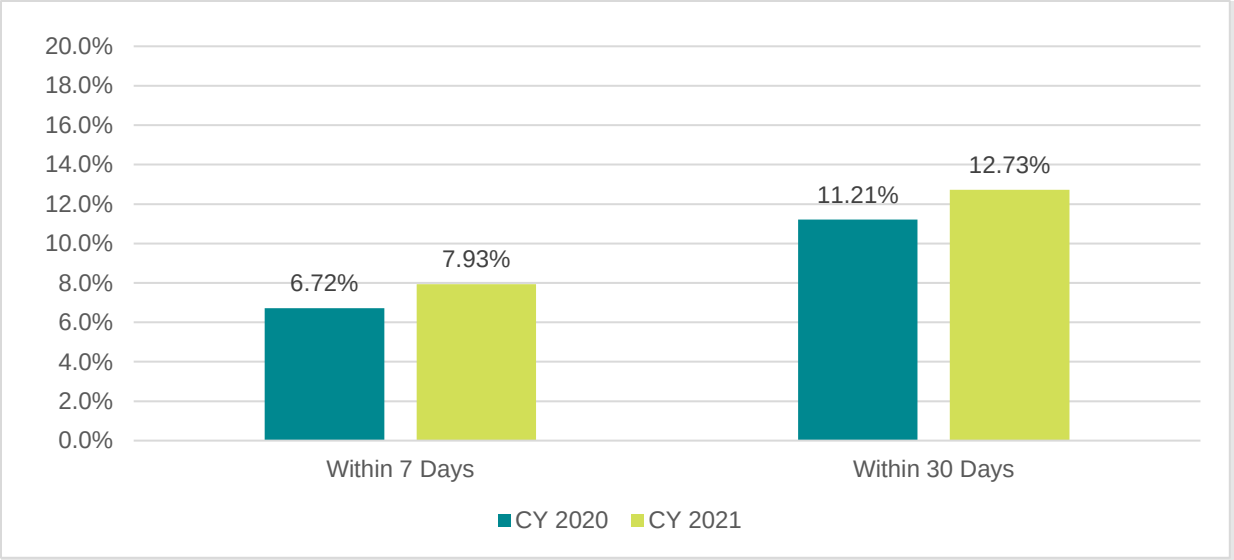


Figure 6-3 indicates that the transitions in care in 7 days increased by 18 percent (to 7.93 percent) and in 30 days increased by 13.6 percent (to 12.73 percent), the low transition rates leave much room for improvement. Many counties were still working on expanding services, especially in WM, RSS, and recovery residences. As noted earlier in this report, their efforts to expand transition options were hindered by both COVID-19 and wildfires. Also, discharges from residential were sometimes due to outbreaks of COVID-19 at facilities, which may have increased the residential LOS due to barriers in creating workable discharge plans to avoid homeless conditions. Many shelters were closed, and most counties have limited recovery residence housing; some have none. Even with “project room key” beds in local hotels, a State-funded program to house the homeless at risk of COVID-19, there were often long wait lists and delays in access.

Client-related factors that predict unsuccessful transitions in care include having significant unmet basic needs, reluctance to switch to new counselors and treatment programs, or insufficient social support. There are also program barriers such as poor communication and coordination across the components of the system; cumbersome, repetitive paperwork as they leave and then enroll in another LOC; inconvenient times or location of services; and wait times for services that are exacerbated by staffing shortages. A study of programs that have greater success facilitating transitions showed that they include some or all of the following characteristics: the treatment organization provides multiple LOC with some continuity of counseling staff; they provide timely, well-coordinated access; treatment is client-centered and individualized; and they offer EBPs including case management and MAT services. Additionally, at every level, these programs communicate that SUD treatment is a journey that includes multiple episodes of care at different LOCs. Better programs use analytics to develop a

more effective referral system, including the recent enhanced use of telehealth, and there is a priority on keeping clients, providers, family members, peers, and other caregivers engaged. [19]

Noteworthy Practices

Contra Costa focuses on Care Coordination, using case management strategies in facilitating movement and transitions in LOC. Improvements have been reflected in the increase of admissions into Outpatient Treatment after discharge from a residential treatment episode. They further enhanced this process by increasing their Recovery Residence capacity for clients without a safe and drug-free place to live. Also, by adding the CBO Portal within their EHR to the functions of Care Coordination, counselors were more readily able to identify and communicate with other professionals or Care Teams involved in the health care needs of their clients.

Placer has a continuum of care with most LOCs very well developed. They found that having provider organizations designed to offer multiple LOC makes client transitions across LOCs more effective.

Riverside found that a centralized coordination of care program with professional and peer support services providing ongoing care coordination across all LOCs offers dedicated support for clients trying to navigate the system of care. Riverside is working on a new model of recovery support with the creation of two Recovery Villages in two of the most underserved communities – Hemet and Coachella. These will provide housing integrated with a range of SUD and MH treatment and support services for those with SUD and MH treatment needs and represents innovative and novel approaches to care coordination.

Engagement and Retention of Clients in Treatment

While the primary goal of treatment is addressing the adverse impacts of alcohol or other drug abuse, the objective of treatment is to return people to a state of productive functioning within the family, workplace, and community. According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social, and psychological functioning.[20] The exact length of time an individual needs to be in treatment seems to vary. However, several studies have confirmed LOS as a reliable predictor of positive

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[19] Timkoa C, Schultz N, Britta J, Cucciare M, Transitioning from Detoxification to Substance Use Disorder Treatment: Facilitators and Barriers. J Subst Abuse Treat. 2016 November; 70: 64-72.

[20] Institute of Medicine (US) Committee for the Substance Abuse Coverage Study; Gerstein DR, Harwood HJ, editors. Treating Drug Problems: Volume 1: A Study of the Evolution, Effectiveness, and Financing of Public and Private Drug Treatment Systems. Washington (DC): National Academies Press (US); 1990. 5, The Effectiveness of Treatment.

change in measures of well-being.[21] Therefore, an indicator of quality care and a vital component of effective SUD treatment is the ability to engage and retain clients for a sufficient LOS to support ongoing recovery.

The literature indicates that both individual and provider factors can influence initiation, engagement, and retention in SUD treatment. Individual factors include attitude and beliefs toward SUD treatment need and efficacy; type of SUD; the age of the client; sociodemographic factors; and co-occurring mental and physical health conditions. System and provider factors include many qualitative factors, including wait times; stigma; ease of receiving services (time and proximity), the availability of case management and efficacy of treatment.[22] Additionally, the quantity and quality of services, such as using EBPs and establishing a strong therapeutic alliance with clients during the early stages of treatment, positively influence client satisfaction and engagement in the first 30 days of treatment.[23]

Initiating and Engaging in Treatment

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. One measure, known as "initiation into treatment," is measured as the percentage of clients who have at least one visit or day in treatment within 14 days of their first billed visit. The second measure, known as "engagement in treatment," is measured as the percentage of clients who have at least two more visits or days in treatment between 14 and 30 days after their initiation into treatment.

This measure differs from the operational definition of the similar HEDIS measure, which uses clients identified as having a need for SUD treatment as the denominator. This point in care is not necessarily tracked by counties and is not reflected in the approved claims data available. Therefore, CalEQRO uses the first intake assessment as the denominator for this measure.

[21] Turner, Brie, Deane, Frank: Length of stay as a predictor of reliable change in psychological recovery and well-being following residential substance abuse treatment. The International Journal of Therapeutic Communities. 37: 112-120, 2016

[22] Hser YI, Evans, L, Teruya, C, et al: The California Treatment Outcome Project (CalTOP): Final Report. Los Angeles, University of California, Integrated Substance Abuse Programs, California Department of Alcohol and Drug Programs, 2002

[23] Simpson DD: Modeling treatment process and outcomes. Addiction 96:207–211, 2001

Figure 6-4: Initiating and Engaging Adults in Treatment, CY 2020, and CY 2021

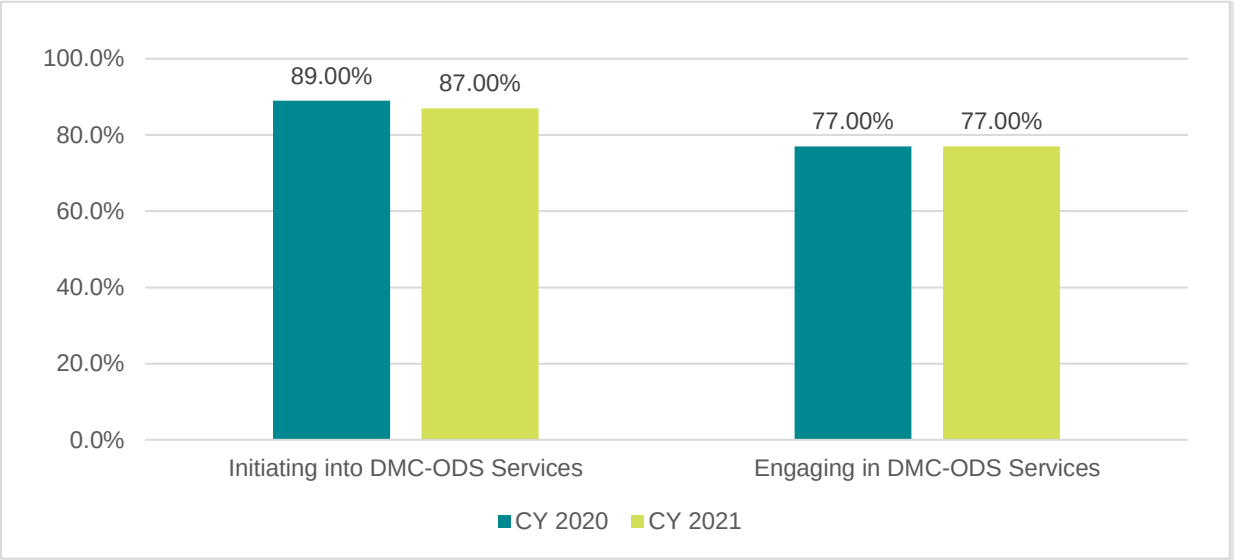
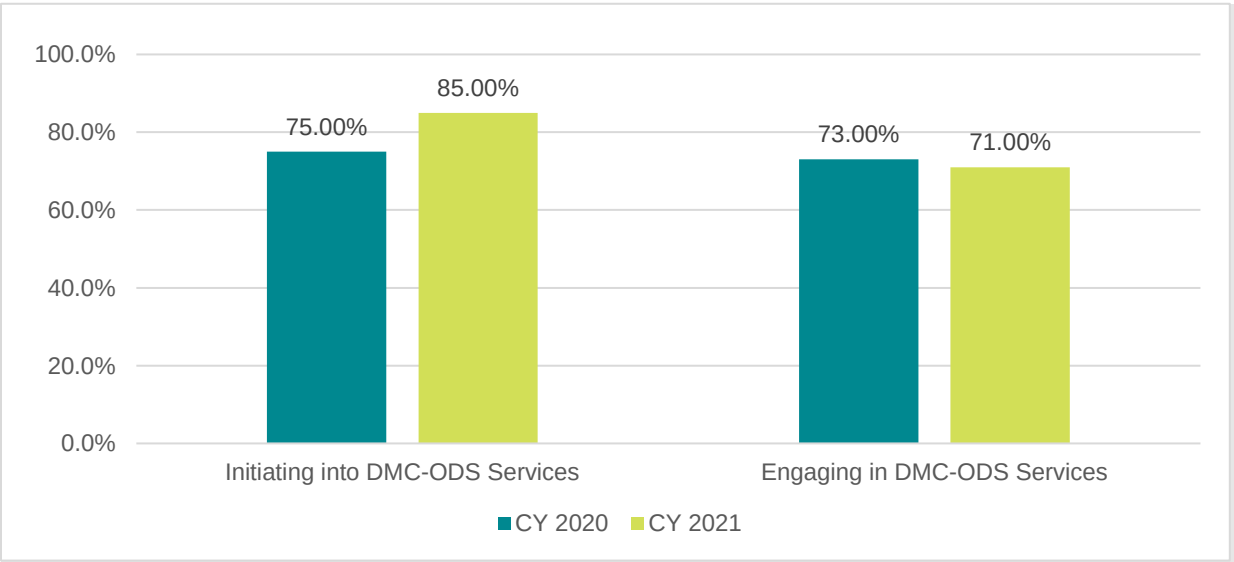


Figure 6-4 compares the rates of initiation into treatment and engagement into treatment for adults in CY 2020 to CY 2021.

In CY 2021, after receiving an intake, 87 percent of clients obtained another DMC-ODS service, slightly lower than the 89 percent in CY 2020. The slight year-to-year decline in adult initiation rates does not reach significance and may be attributed, in part, to the challenges COVID containment placed on providing behavioral health services. The engagement rates are also high, with 77 percent of clients who initiated care going on to receive two more services between days 14 and 30, demonstrating that counties have improved client-centered care practices that positively motivate and sustain treatment engagement.

Figure 6-5: Initiating and Engaging Youth in Treatment, CY 2020, and CY 2021



While overall treatment numbers for youth decreased as referrals from schools and juvenile justice declined, there was a notable increase in the percentage of those youth who successfully initiated treatment, increasing from 75 percent in CY 2020 to 85 percent in 2021. For youth, there was a small decline in the engagement phase, showing 73 percent engagement in CY 2020 and 71 percent in CY 2021, again, possibly also due to COVID-related influences.

Without the rapid, effective implementation of telehealth services in response to the COVID pandemic, many clients would not have connected and engaged in treatment. A critical foundation of treatment – regardless of the pandemic – is the development of a meaningful therapeutic relationship with their provider(s).

Noteworthy Practices

Several DMC-ODS counties (e.g., **Santa Barbara and Riverside**) evaluated their programs' effectiveness in part by using their adult and youth client data to measure initiation and engagement overall and by each program. They have used this data to identify opportunities for QI at specific programs or LOC.

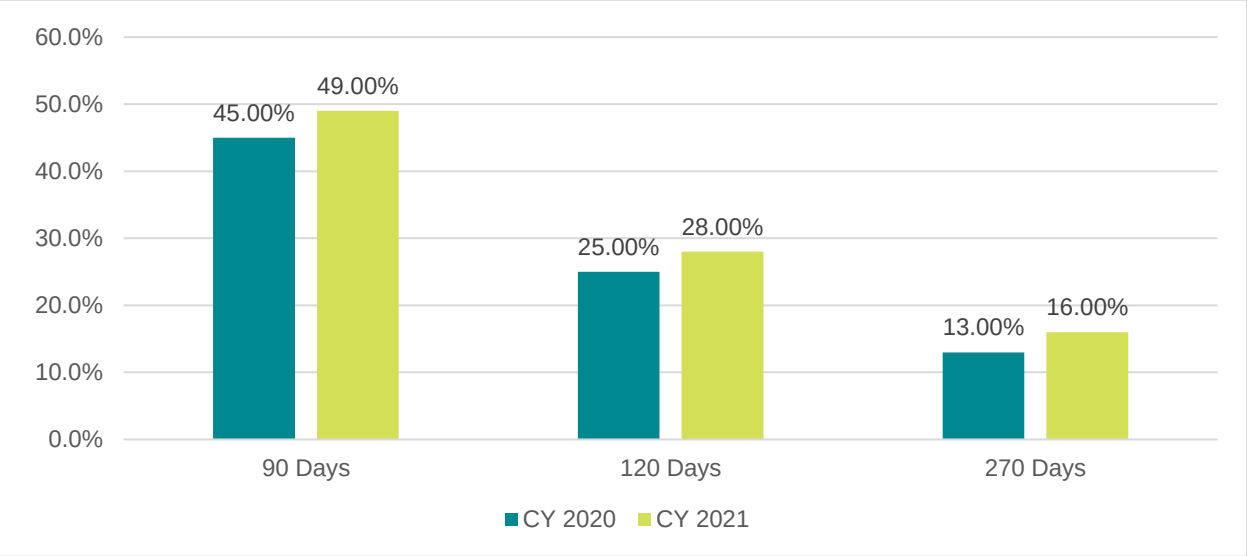
Retention in Treatment

To measure retention in treatment, CalEQRO utilizes Medi-Cal claims data that demonstrates continuous treatment in some aspect of the system, with no interruption in care longer than 30 days. Length of time in treatment has been the most consistent and important predictor of favorable treatment outcomes. Improved outcomes reduce relapses, improve well-being, and ultimately reduce overall costs of healthcare.[24]

Figure 6-6 displays an indicator of how long the system of care retains clients in its DMC-ODS services, measured upon their discharge from services. It denotes the cumulative time that clients were engaged, irrespective of the number and types of treatment services they received. It is calculated sequentially until there is an interruption of more than 30 days (i.e., discharge), tracking LOS across the entire continuum of care necessary for treatment.

[24] McLellan AT, Alterman AI, Cacciola J, et al: A new measure of substance abuse treatment: initial studies of the treatment services review. Journal of Nervous and Mental Disease 180:101–110, 1992

Figure 6-6: Client Length of Stay in Treatment – All Clients



The percentage of clients who are retained in treatment at and beyond 90 days has increased for counties, which suggests improved discharge status with treatment progress, increased transitions to other LOCs, and a reduction in client attrition. These are minor increases on average, but they are promising given the strong research linking LOS with better outcomes in SUD.

Noteworthy Practices

San Joaquin developed an impressive dashboard to track and improve trends in quality and outcomes of care. They measure initiation, engagement, and retention in treatment and use this information to drive performance improvement efforts. San Joaquin provided more timely transition to care post-residential treatment for its beneficiaries than statewide. Their claims data indicate that 13.55 percent of clients discharging from residential treatment received follow-up care within 7 days in contrast to the statewide rate of 7.54 percent.

San Francisco links assertive case management and community treatment interventions to enhance rates of mental health and substance abuse treatment engagement and retention of individuals in treatment. San Francisco reported that the average LOS for clients staying in treatment was 148 days (median 100 days), compared to the statewide average of 133 (median 87 days). There were 53.8 percent of clients with at least a 90-day LOS; 33.9 percent with at least a 180-day stay, and 22.2 percent with at least a 270-day LOS. Each of these percentages were higher than the average for all DMC-ODS counties statewide.

Contra Costa focused on training providers in the use of client centered EBPs, specifically Motivational Interviewing (MI) and Seeking Safety, as a strategy to improve client initiation and engagement in treatment. Contra Costa's adult and youth clients showed good rates of initiating DMC-ODS services at 93.5 and 79.8 percent, respectively. Both adult and youth clients also had higher rates of treatment engagement compared to the statewide averages of 83.0 percent for adults and 67.6 percent for youth.

Implementing Evidence-based Practices

The DMC-ODS was built on a foundation of a clinically evidence-based, culturally competent approach to treating SUDs, including the guiding principles for client-centered care found in the ASAM Criteria. Evidence-based treatment is a perspective on clinical decision-making that has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients … [by] integrating individual clinical expertise with the best available external clinical evidence from systematic research"[25] Within the DMC-ODS framework several medical and behavioral EBPs are required.

Behavioral healthcare EBPs evolved from evidence-based medicine, which was established for the same reason: to encourage the use of safe, effective treatment as opposed to poorly studied, ineffective, or unsafe options. Using EBPs is a means to reduce low-value or no-value care, preserving resources for care that will be more effective at saving lives and promoting recovery. Clients who are seeking help expect that the treatment offered has been studied and that the person treating them is knowledgeable and utilizing effective treatment interventions. Additionally, systems of care should continue to advance the field of SUD treatment by applying these practices to positively impact client outcomes and program performance.

Promoting and Implementing MAT Programs

California counties continue to experience a public health crisis due to patterns of opioid misuse and related overdoses and fatalities. The number of overdose deaths in California increased by 24.4 percent in the past year, from 5,502 in CY 2020 to 6,843 in CY 2021.[26] While other drugs have continued to be represented in these fatalities, a majority of these deaths were due to fentanyl and other opioids, making rapid access to MAT services more important than ever. MAT treatments for OUD include methadone, buprenorphine, and naltrexone. MAT medications for AUD include naltrexone, disulfiram, and acamprosate. Consistent with the approach used for other chronic diseases, treatment plans for OUD are patient-specific and created with input from the patient, the prescriber, and other members of the health care team.

California DMC-ODS counties use a variety of programs and approaches to continue their steady progress to increase access to MAT services. The DMC-ODS waiver requires NTP/OTPs to dispense all three OUD medications, though methadone remains the primary MAT medication they provide.

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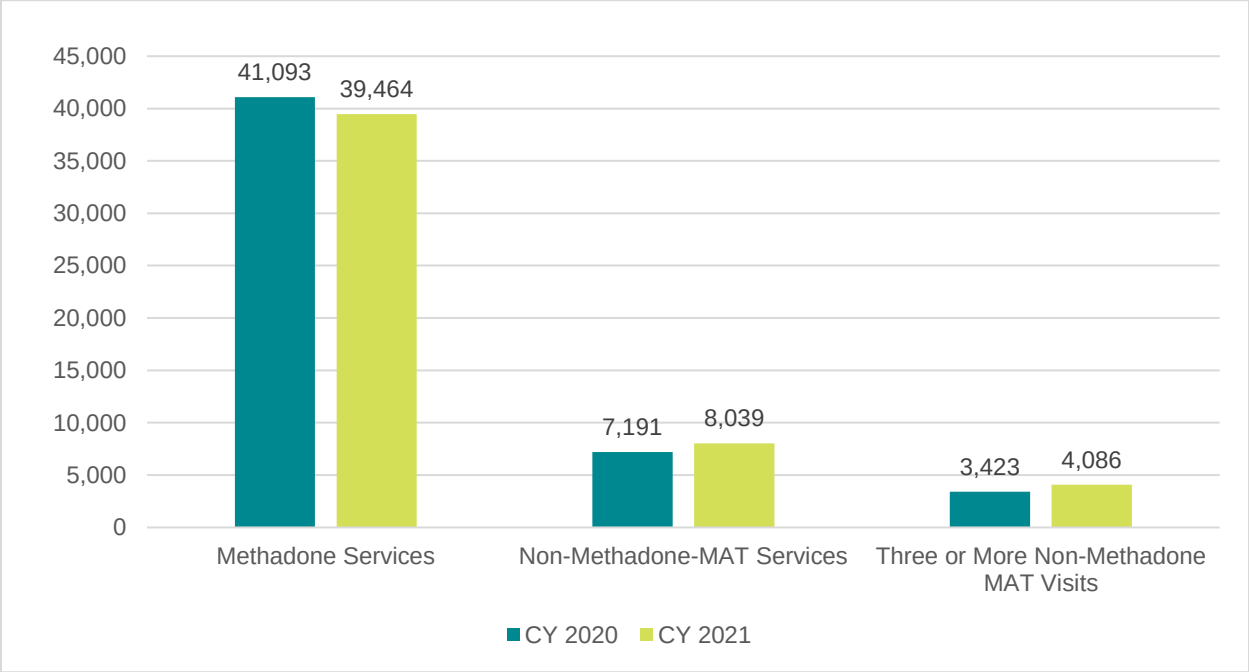
[25] Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. Evidence-based medicine: What it is and what it isn't. *Article based on an editorial in the British Medical Journal*, 1996. 312, 71 72.

[26] California Overdose Surveillance Dashboard, Available Online. https://skylab.cdph.ca.gov/ODdash/

Figure 6-7 represents clients served with MAT, both methadone and non-methadone during CY 2020 and CY 2021.

Figure 6-7: Clients Served MAT, Methadone and Non-Methadone, All DMC-ODS, CY 2020 and CY 2021



Despite pandemic changes to allow for increased home dosing, many NTP clinics have seen a decrease in enrollments. Figure 6-7 shows clients served in NTP programs declined 3.96 percent, most likely due to continued impacts from COVID-19 on the community. NTP clinics quickly adapted their intake process to ensure staff and client safety procedures were practiced. Many clinics offered telehealth solutions whenever practical and take-home dosing requirements as well as monthly counseling minutes were allowed additional flexibilities. Still, there were clients who were reluctant to engage in services. NTPs in some counties reported that a number of clients were not able to successfully manage their MAT recovery without the structure offered from daily clinic dosing visits and face-to-face session with a counselor. Despite efforts from the NTPs, some of these clients dropped out of treatment.

While there was a slight drop in methadone MAT clients, DMC-ODS counties saw an overall increase in the adoption of the non-methadone MAT. In Figure 6-7 the clients served with non-methadone MAT show an 11.79 percent rise in the number of clients receiving at least one service in CY 2021 compared to CY 2020. Also, there was a 19.37 percent increase in the number of non-methadone MAT clients who received three or more MAT visits, indicating a substantial increase among those receiving MAT who remained engaged in the treatment.

The appropriate duration for clients to utilize MAT depends on the type and degree of the client's problems and their needs. Research indicates that most addicted individuals need at least three months in treatment to significantly reduce or stop their drug use, and that the best

outcomes occur with longer durations of treatment.[27] ASAM recommends maintaining buprenorphine for at least one to two years, after which voluntary slow tapers can be attempted.[28] Psychosocial behavioral health treatment is recommended in conjunction with all drug therapies for OUD. Patients receiving psychosocial treatment have better outcomes than patients who do not receive medications without those services.

Noteworthy Practices

The few DMC-ODS counties that implemented the most effective delivery of non-methadone MATs described their noteworthy practices as:

- Screening and referral to MAT starts at first contact.
- Referrals for MAT included in the assessment of individuals with an alcohol dependence diagnosis or recurrent driving under the influence episodes.
- Inmate facilities incorporate the use of MAT prior to and upon release from custody.
- Leadership in the community provides stigma reduction through community education and vocal support for MAT services.

In addition to ensuring client access to naloxone, the overdose reversal agent, many DMC-ODS counties lead or actively participate in community-wide opioid safety coalitions. Such coalitions focus on overdose prevention while educating the community regarding the use of MAT and other SUD services. Because of the multi-agency representation found in these groups, they are a positive force to reducing stigma regarding addiction and participation in MAT services. Additionally, they educate the community regarding risks associated with prescribed opioid use.

San Francisco, in collaboration with county hospitals and FQHCs, supports a set of MAT approaches that are innovative and help reduce OUD overdoses. Some of their standout programs include an Office Based Buprenorphine Induction Clinic that is allied with a county-operated pharmacy and an innovative overdose prevention, buprenorphine program that has a low barrier, medication first approach which involves using telehealth.

San Luis Obispo continues to provide a robust non-methadone MAT program that also distributes naloxone to clients receiving OUD treatment, should an overdose rescue be required. In conjunction with MAT services, they require that clients also engage in non-MAT outpatient treatment to address changes in their addiction lifestyles.

Santa Cruz is most notable for the widespread offerings of MAT services to its clients and the high degree of integration of MAT services with other levels of SUD treatment. Both the

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[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4007701/

[28] Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition), National Institute on Drug Abuse. January 2018

percentages of their clients who received at least one non-methadone MAT service and who are successfully engaged in non-methadone MAT for at least three sessions are substantially higher than the statewide average. In addition, many people receive ongoing MAT services through the FQHCs (3,489 prescriptions reported in FY 2020-21).

Implementing other Evidence-based Practices

While the importance and influence of MAT in addiction treatment and recovery continue to grow, the bulk of treatment for SUDs is provided through behavioral interventions. The DMC-ODS Waiver STCs require that providers receive training with at least two of the following EBPs: MI; Cognitive Behavioral Therapy (CBT); Relapse Prevention Therapy/Treatment (RPT); trauma-informed treatment; and/or psychoeducation. Other behavioral EBPs increased use and value in SUD treatment are Matrix treatment, multi-systemic family therapy, and contingency management. MAT in combination with therapy is the most effective intervention to treat OUD – more effective than either behavioral interventions or medication alone. MAT significantly reduces illicit opioid use compared with non-medication approaches, and increased access to these therapies can reduce overdose fatalities.[29]

Ensuring that EBPs are provided with absolute fidelity would require studies beyond the scope and capability of many county QI programs and may provide limited value. Yet CalEQRO found that counties are including EBP adherence in their contract monitoring activities and look for fidelity monitoring and ongoing training. There is continued professional growth amongst the DMC-ODS treatment providers, as SUD clinicians have embraced a more science-based approach to recovery. Reviews of each county's training calendar shows that EBP-related training continues, ensuring that new staff are trained and that experienced staff have their skills reinforced. Interest and excitement in learning new and better treatment methods and ideas are evident from the positive staff comments and requests for continued training voiced during review sessions with clinical line staff.

Furthermore, clients frequently talk about how program elements like the trauma-informed Seeking Safety curriculum are benefiting their recovery. Another EBP, Contingency Management, is emerging as a promising intervention for SUDs, especially for stimulant use disorders. Contingency Management is an operant-based intervention that involves rewarding explicitly defined and objectively verifiable target behaviors in an attempt to increase the frequency of those behaviors. Several DMC-ODS counties plan to participate in the launch of the new contingency management based "Recovery Incentives Program" in 2023 as a part of the CalAIM 1115 Demonstration. Finally, the implementation and use of telehealth as a mode of service delivery has been increasing and can be integrated into standard practices,

[29] Richard P. Mattick et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," *Cochrane Database of Systematic Reviews* 3 (2009)

providing a low-barrier pathway for clients and providers to connect to assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care.

Noteworthy Practices

Santa Cruz has a substantial ongoing initiative to train and monitor the implementation of EBPs. The initiative goes beyond what most counties do by monitoring chart notes in all SUD programs for indications that EBPs were delivered with fidelity.

The **Ventura County** DMC-ODS was able to expand consent for treatment to include telehealth and verbal options, along with obtaining an electronic consent for care coordination. These additions have enhanced the ability to continue to serve clients during the COVID-19 pandemic.

With the reduction in COVID-19 risks, programs in **Riverside County** are re-engaging clients to come in-person to outpatient clinics and residential programs. However, for those living in remote and frontier areas, homebound, or out of reach of transportation resources, telehealth sessions remain an important, if not necessary, treatment option. Recent technology grants have provided some support to meet the technology needs of this population. Riverside continues to seek opportunities to improve and expand access to telehealth as appropriate.

Quality Improvement Infrastructure and Supports

Quality Improvement Monitoring and Activities

The contract between the DMC-ODSs and DHCS requires the DMC-ODSs to implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services furnished to beneficiaries. The contract further requires that the DMC-ODS' quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement."

With few exceptions, counties have developed their QI program as an integrated Behavioral Health QI program encompassing mental health and SUD QI. Integrated Plans make good sense because they fit well with the integrated, collaborative focus of behavioral health systems and provide potential economies of scale when resources are frequently limited. Similarly, 26 of the 31 DMC-ODSs described organizing their quality management programs, including Quality Assessment (QA)/compliance and utilization management, under county executive leadership within behavioral health. The QI program is connected with the QA/Compliance and utilization management programs such that data, information, decisions, policies, and procedures of one program are aligned with the others.

While some organizational differences exist across the state, all counties monitor their quality processes through a QIC, the QIWP, and the annual work plan evaluation. Membership in QICs generally includes representatives from a diverse group of stakeholders including

DMC-ODS and MHP administration and staff, clinical program and contract provider staff, consumer and family members, and community partners. Engaging members of the community, especially those with lived experience was a predominant feature in QIC membership in 28 of the 31 DMC-ODSs. To provide focus and manageability to important QI areas such as cultural competence, most QICs form subcommittees that invite greater stakeholder and consumer input and report regularly to the full QIC. QIC meetings are held monthly in 18 of the individual DMC-ODS counties and in the seven-county Partnership collaborative. The remaining 12 individual counties have either a bi-monthly or quarterly QIC meeting schedule. The impact of COVID was also experienced in the QICs. There were periods when meetings were virtual or sometimes canceled due to the prevailing restrictions and staff absences. Of the QICs who schedule to meet monthly, most met ten times, predominantly in a virtual format. The QICs that schedule bi-monthly or quarterly meetings had few cancellations but did have times where they met on a virtual platform.

Among the counties reviewed in FY 2021-22, all counties except one had current year QIWPs and had prepared evaluations of their prior year's QIWP. Counties with integrated MH-SUD QAPIs also developed integrated QIWPs. Both the integrated and SUD-only QIWPs addressed the required areas stipulated in the DMC-ODS Waiver STCs. However, those in their beginning years of DMC-ODS implementation tended to do so primarily from a compliance orientation, setting goals and objectives that focused on increasing the number of compliance activities and laying the infrastructure for diverse types of data monitoring. With urging from CalEQRO, the DMC-ODS counties have been gradually evolving their QIWPs to:

- Include goals and objectives that are specific to the unique needs of SUD services and the population they serve.
- Ensure that goals and objectives are clearly written, quantitatively measurable, with accompanying action plans and staff assigned to oversee them.
- Focus upon improvements in how the system of care is impacting clients' experiences with the accessibility, timeliness, quality, and effectiveness of treatment services.
- Deploy evaluation and analytic resources effectively and document progress, outcomes, and follow-up work in regular reports and QIC minutes.
- Produce an annual QIWP evaluation and communicate the results to staff, providers, and policymakers regarding how the county's QI efforts affect the quality, effectiveness, efficiency, and the cost of care.

Noteworthy Practices

Alameda has developed QI goals that are clear, measurable, and align with their strategic plan. Effective communications and access and engagement in treatment were key goals in their work plan. Alameda uses the TPS, CalOMS, ASAM LOC data, client satisfaction, and outcomes tools as data sources to inform QI monitoring efforts and to make decisions about areas requiring improvement.

San Joaquin has over the years developed a data-driven approach to decision-making and QI that enables them to systematically identify problems followed by instituting measurable goals

and solutions. As an example, the clinical outcomes in CalOMS discharge data indicated there was room for improvement. In response, San Joaquin initiated efforts to improve the quality and effectiveness of treatment services through enhanced clinical supervision and increased provision of concurrent MH treatment for clients with co-occurring MH and SUD. They recently launched a clinical PIP that focuses on these efforts with measures of progress in residential treatment settings.

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 support, 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 when improvement is necessary. 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 they remain underutilized in California counties and provider organizations. Most of the current systems were generally designed for physical or mental health care applications and have been enhanced over time with customizations needed to address elements unique to specialty SUD care.

Also, technological solutions are needed for care coordination between various substance use treatment providers and other essential services outside the DMC-ODS. All the solutions must address the special regulations that protect data privacy and security for SUD treatment data. These and related considerations are addressed in more depth within the chapter of this report on IS capabilities. This section will focus only on review findings related to issues linked to data analytics and tools that support quality of care.

Noteworthy Practices

Most counties and their network providers do not have a fully realized a unified information system which in turn limits the electronic exchange of information. However, they continue to utilize their current vendor to add design elements to streamline and enhance clinical workflow and documentation. Several counties have decided to change their EHR vendor and are in the planning or implementation phase, anticipating contract provider access and often involving them in designing EHR solutions to meet systemwide needs.

Despite these limitations, an increasing number of counties are creatively using data analytic software with data visualization functionality to generate data dashboards and related reports that provide valuable, real-time, information to QAPI staff, supervisors, and managers, and ultimately to clinical staff. Dashboards have been most useful in tracking information related to indicators of care processes, resource use, outcomes, and client satisfaction. For example, **Los Angeles** has developed a Service and Bed Availability Dashboard to track treatment program vacancies and intake capacity. This information is made available online to the public, staff, and other providers.

Despite the potential for technology to support QI efforts, implementation of such programs is often challenging and may result in less than satisfactory results. Counties that are most successful in advancing technological solutions to support treatment and care coordination invest their time and resources to adequately staff and support these efforts. They invite input from staff and stakeholders at multiple levels of the system of care regarding what will constitute user-friendliness, compatibility with organizational values, and the complex details necessary for the technology to support and document excellent care. Attention to these factors is essential to ensure that system of care leaders will adopt the innovative technologies and use them effectively to support decision making and QI. Too often, technology solutions tend to be over-simplified, poorly prototyped, and inappropriately customized, which can result in early rejection and underutilization[30].

Data sharing is the common thread running through every interaction between patients, providers, and payers, uniting them in a value-based approach that has the potential to lower healthcare costs, improve healthcare quality and outcomes, and create a more patient--centered care experience.

In **Santa Barbara**, both county staff and contract providers have access to an EHR which supports standardized data entries and enables diligent tracking of access and treatment processes with regularly produced data dashboards. Evaluations to measure and monitor client initiation, engagement, and retention in SUD treatment is conducted quarterly, and more frequently as needed. Additionally, CalOMS admission and discharge data are used to measure transitions between LOC and successful completion of treatment. Santa Barbara's Department of Research and Evaluation team analyzes provider-specific data that are then shared with providers for review. Quarterly reporting requires each provider to report on rates of client initiation, engagement, retention, and successful completion. The quarterly reporting process allows for providers to identify system of care gaps and request TA. Quarterly reports are also reviewed by the QIC and Alcohol and Drug Program staff to identify system of care gaps in order to take steps to improve outcomes.

[30] van Gemert-Pijnen JEWC, Nijland N, van Limburg M, Ossebaard HC, Kelders SM, Eysenbach G, et al. A holistic framework to improve the uptake and impact of eHealth technologies. J Med Internet Res. 2011;13(4):1–18.

Alameda demonstrates a strong use of data to improve care quality by the use of Yellowfin dashboards across the continuum, designed to enhance coordination and continuity of care with other agencies and proactively work with providers on CalAIM data systems.

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.

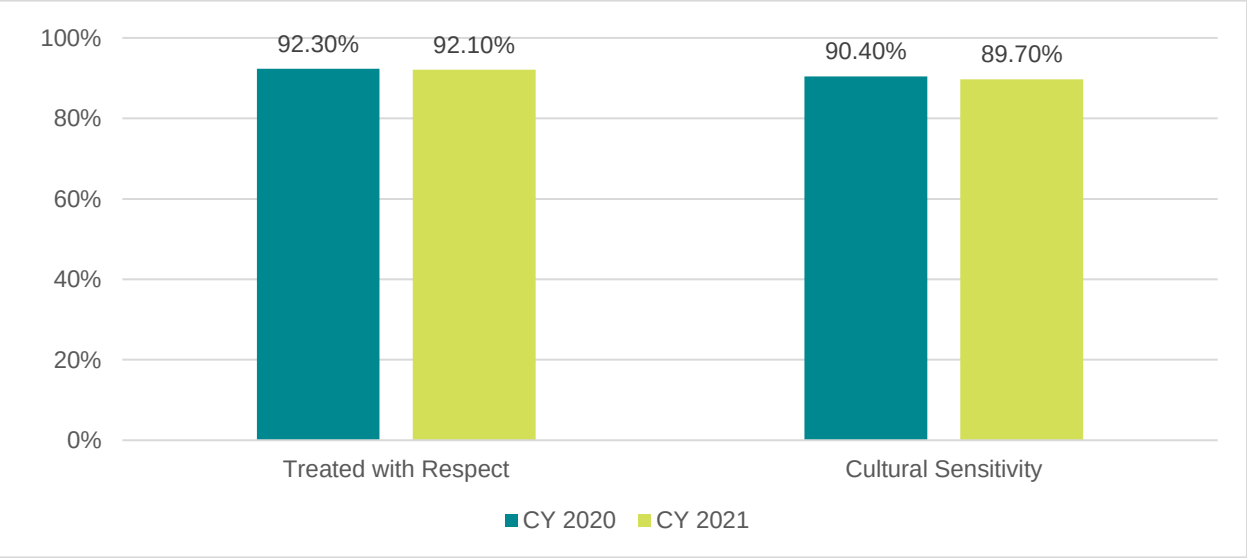
Strengths seen in the CCPs included the adoption of CLAS standards, consistently using outreach and educational activities in the community, and employing methods to improve threshold language resources. A majority of the CCPs are integrated plans that present a combined mental health and SUD focus. While attempting to provide balance, the focus of these integrated plans was primarily on mental health issues and activities. Most counties were consistent in providing an annual update of CCP-related activities, but most counties are awaiting new statewide guidelines on CCPs before embarking on an update of their entire CCP. CalEQRO made recommendations to many counties to add more focus on addressing the diversity, equity, and inclusion challenges unique to their SUD systems of care. Furthermore, CalEQRO recommended that they update their plans to include action items that are relevant to SUD-impacted communities, with timed and measurable goals and objectives.

Healthcare equity and the social determinants of health were themes seen in 2020 and continued in 2021 as a part of culturally competent strategic planning. 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. For example, **Fresno** secured a training entitled Racial Equity Impact Assessment (REIA) for 20 mid-level to supervisory level staff. This opportunity provided a REIA framework and tools to support health practices through an equity and inclusion lens. Participants have set goals to assist Fresno in formally adopting this approach in areas like program development, community engagement, needs assessments, and a variety of other ways to ensure equity. Workgroups have formed from this training and continue to meet monthly.

Sacramento has continued its successful opioid education campaign, “See Her Bloom,” which focuses on Black women. By assuring that these clients are a part of the conversation in designing culturally appropriate aspects of care, the program addresses unique issues of trust and stigma.

Figure 6-8 represents results from the TPS Survey Measures, for Respect & Cultural Sensitivity Rating Adults comparing CY 2020 and CY 2021.

Figure 6-8: TPS Survey Measures, Respect & Cultural Sensitivity Rating Adults, CY 2020 and CY 2021



Data from the TPS shows that counties have largely maintained strides in the provision of culturally competent services. Figure 6-8 illustrates that 92.1 percent of clients feel they are treated with respect, comparable to the 92.3 percent seen in CY 2020. Cultural sensitivity in the delivery of service saw only a slight drop, decreasing from 90.4 percent of respondents indicating a positive experience in 2020 to 89.7 percent in CY 2021. This is still well above the 84.5 percent rating from the CY 2019 TPS.

Results from surveys like the TPS reinforce that at the core of both client-centeredness and cultural competence is the ability to see the client as a unique person; to maintain unconditional positive regard; to build effective rapport; to explore individual beliefs, values, and meaning of illness; and, to find common ground regarding treatment plans. Accurate and useful measurement of equity indicators as found in the TPS client survey are essential to system efforts to improve health equity.

Noteworthy Practices

While many counties need to enhance the SUD focus of their CCPs, some counties already exhibited quality CCP initiatives with SUD priorities as exemplified in the following:

Imperial County's CCP adapted CLAS standards to establish strategies and measurable goals and objectives. As a result of the county's efforts to build a workforce reflective of the community, 77 percent of all administrative, licensed, unlicensed and support services staff identify as Hispanic/Latino and 55 percent of staff are fluent in Spanish. This nearly matches the Hispanic/Latino representation in the beneficiary population and allows Imperial to consistently provide Spanish-speaker resources for outreach and engagement efforts.

Santa Barbara developed an accessible treatment system, with a PR twice the statewide average. They developed an excellent CCP with attention to substance use issues that can serve as a model for other counties.

Monterey has initiated in-depth training on cultural competence and included behavioral health and contract provider staff at all levels of the organization. The Monterey Data Driven Decisions report not only tracks the overall SUD LOC but also each provider site, with data that include client counts, discharge disposition and outcomes, gender and language preference, service types, health equities, and ten-year trends.

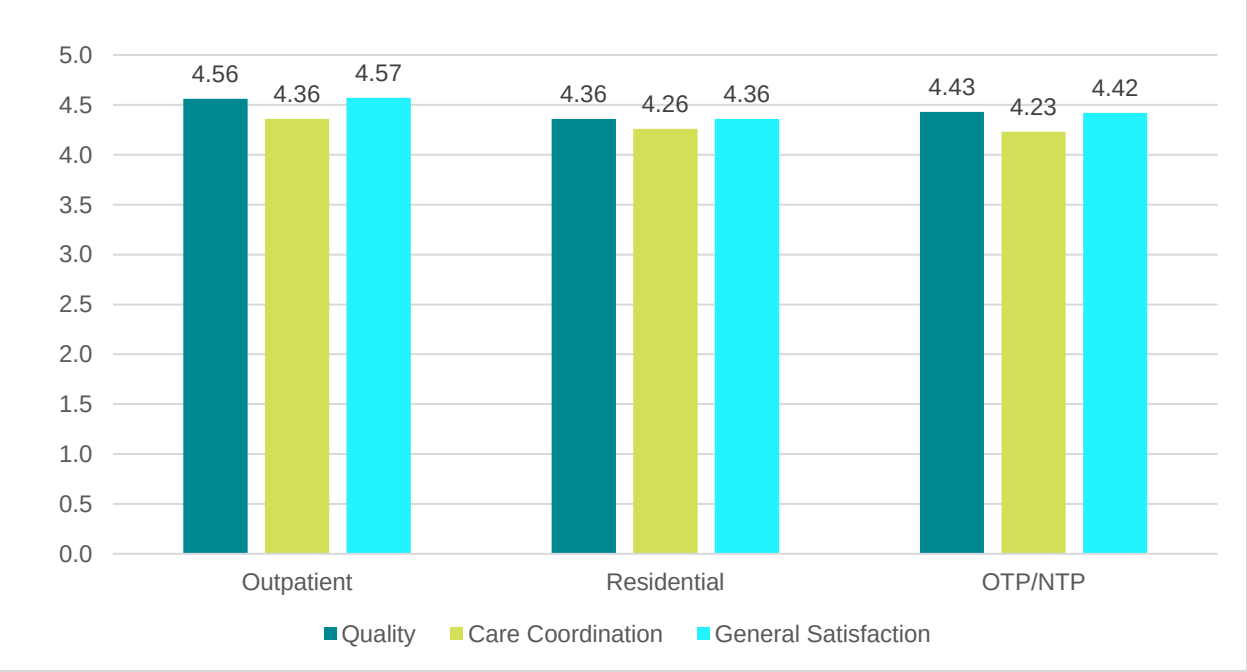
Feedback from Clients on Perceptions of Care to Improve Quality

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. The methodology for deriving and analyzing these data is described in the Methodology Chapter of this report, and the overall findings are described in depth in the Client Perception of Care Chapter.

The TPS item ratings can be clustered into several well-differentiated content domains. Among them are three domains that are particularly germane to the Quality sections of this chapter: Quality of Care, Care Coordination, and General Satisfaction.

Figure 6-9 below depicts the mean rating for each of these relevant domains by clients in three different treatment settings: Outpatient, Residential Treatment, and NTP.

Figure 6-9: Mean Ratings by Adult Clients to the TPS Items by Domain within Treatment Settings, CY 2020 and CY 2021



The figure indicates that in each setting the patterns are similar, with relatively higher ratings for Quality of Care and General Satisfaction and somewhat lower ratings for Care Coordination. This pattern is similar to the pattern for the overall group of responding clients across all treatment settings that is featured later in the Client Perception of Care Chapter.

It is noteworthy that the clients in outpatient treatment rated each domain higher than the clients in residential treatment and in NTPs. This may be due primarily to the items in these three domains being focused on the quality of the clients' interactions with their counselors. It follows that outpatient treatment is less demanding of clients' time but involves the most individual counseling. Residential treatment was the most demanding of clients' time and the most severely impacted by the COVID pandemic, with high staff turnover that left clients reporting they wanted more opportunities for individual counseling. NTPs require regular visits for medications but usually do not involve as much participation in individual or group counseling as do the other settings.

In addition to the TPS, CalEQRO used other methods to elicit client feedback on the quality of their care. They held small focus groups for more in-depth discussions of clients' experiences in care and, before the groups convened, asked the clients to complete a brief, nine-item survey. Several of the items addressed elements of their relationships with their counselors: client comfort requesting help in urgent situations, counselor sensitivity to their culture, counselor helpfulness in problem-solving, and client inclination to recommend the counselor to others. Those items all received high ratings, which is congruent with the TPS findings. The lowest rated item was whether clients had received information about the benefits and availability of MAT, which suggests an area with room for improvement.

Clients corroborated their survey ratings during the focus groups. They tended to speak highly of their counselors' caring manner. Many reported their sense that programs had high staff turnover rates and were consequently short-staffed, thereby limiting time for individual counseling and the development of strong connections. Some expressed concern that counselors were stretched too thin and were getting burned out.

Outcomes

One of most important yet challenging questions for DMC-ODS counties to address is whether or not the services they are delivering are effective and leading to favorable clinical outcomes. SUDs are commonly acknowledged to be chronic conditions for which recovery can be a lifelong process with intermittent setbacks including relapses. Clients in long-term recovery must practice self-management of behavior change similar in some respects to clients with other chronic conditions such as diabetes or hypertension. Therefore, treatment programs must measure outcomes in terms of incremental progress rather than as final "cures" and must consider both short- and long-term outcomes. More complex than some other chronic medical conditions, SUDs tend to have ripple effects in many areas of a person's life and of others around them, and so progress must be measured in more areas than just immediate symptoms and functioning.

Prior to the implementation of the DMC-ODS Waiver, outcome measurement could generally only be assessed by looking at individually selected treatment programs because a

comprehensive system of care did not exist. With the advent of the Waiver, it became possible to standardize and use measures for monitoring outcomes across all treatment programs through claims, CalOMS and TPS data. With access to the statewide databases for these data sources, CalEQRO and the UCLA ISAP teams are both able to analyze the data, display county-specific results in comparison with statewide results, and share them with counties as useful information to support and guide program decisions and QI efforts. CalEQRO also uses its annual EQR visits with each county as an opportunity to delve more deeply into the meanings and implications of the results for QI opportunities.

Counties responded positively to CalEQRO sharing of their outcome data during their annual EQRs. For many it was the first time they had an outside agency analyzing their data, comparing it with statewide averages, interpreting it to them, and suggesting follow-up QI activities. These interchanges seem to inspire most counties to pursue more interim data analyses themselves between the annual EQRs, which is essential for maintaining real-time QI efforts. However, to do so requires data monitoring and data analytic staff, as well as data analytic software, that many counties have yet to fully develop.

Key Data Sources for Measuring Outcomes

Treatment Perception Survey

The TPS is the primary data source for measuring client outcomes in the clients' own "voice." Clients seem to appreciate the TPS as an opportunity to provide their input regarding treatment services. They have expressed consistently positive remarks to their counties about the TPS, including that the survey is not too lengthy (14 items for adults, 18 for youth) and the items are easily understandable and seem meaningful. DMC-ODS counties are required by DHCS to administer the TPS to clients in treatment during a week-long period in the fall of each year. During the 2020 data under review for this report, 16,193 adults completed the adult version, and 488 youths completed the youth version.

The Methods Chapter of this report reviews how the TPS was developed based on psychometric research to establish its validity and reliability. A factor analysis yielded five domains for the adult version and six for the youth version. Among the domains in both versions is an Outcome Domain, the findings for which will be discussed in this section. The broader findings are discussed at some depth in the Client Perception of Care chapter.

California Outcomes Measurement System

The Substance Abuse and Mental Health Services (SAMHSA) developed a National Outcomes Measurement System (NOMS) to address the primary measures they deemed most important for each state to track. All states using SAMHSA federal block grant funds to help fund their SUDS treatment programs are required to develop a state-specific version of NOMS and implement it for all treatment services. California's version is called CalOMS, and includes forms for an Admissions Summary, Discharge Summary, and Annual Treatment Summary (for those clients continuing in a single uninterrupted episode of treatment for a full year). All treatment providers must complete these forms for their clients, preferably in consultation with their clients if possible.

The CalOMS Discharge Summary includes a provider rating of a client's progress at the time of discharge using eight rating options, four of which endorse positive progress in treatment and four of which do not. CalEQRO provides each county with an analysis of their aggregated results compared to the statewide average on each of the eight rating options. In addition, counties may use any of several items from the Admission and Discharge summary for pre/post analyses of changes in scores. Very few counties have done this, and most are hoping that DHCS will provide such analyses in an automated reporting package within the Behavioral Health Information System (BHIS) as they had in the former Information Technology Web Services (ITWS) platform. The item-specific data available for their use in pre-post analyses are discussed in the Methods Chapter of this report.

Client Focus Groups and Participant Surveys

CalEQRO collaborates with counties to arrange client focus groups as an in-depth method of obtaining client perspectives on the accessibility, timeliness, quality, and effectiveness of care. On average during the COVID-19 pandemic, each EQR features two client focus groups that are conducted through videoconferencing. Prior to the convening of the group, participants are asked to respond to a nine-item online survey. In combination, the quantitative data from the surveys followed by the qualitative data from the focus groups provide an in-depth view into clients' perspectives on their county's DMC-ODS services. The methods for analyzing both of these data sets are described in the Method Chapter of this report.

The survey questions include a question regarding client outcomes. The lead facilitator of the follow-up client focus group asks about the impact that treatment has had on their lives and gathers further insights into their perceptions of their treatment outcomes.

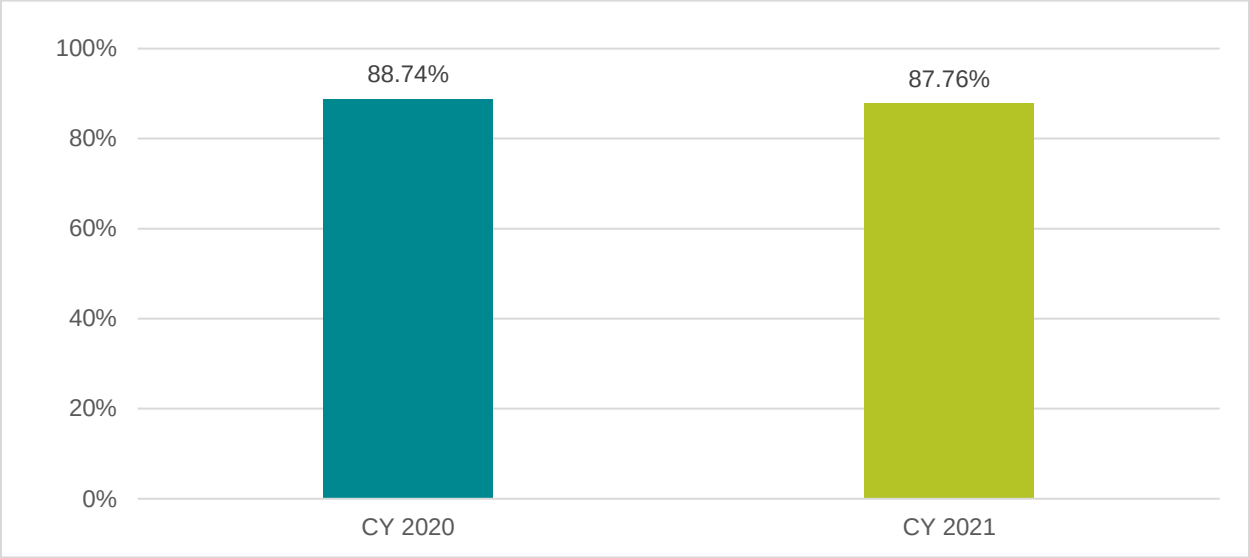
Outcomes by Data Source

TPS Findings and Themes

As mentioned in an earlier section of this chapter, the TPS items factored into several content domains. Among them is an Outcome Domain consisting of a single item, "As a direct result of services I am receiving, I am better able to do things I want to do." The item was carefully designed after many years of research on more mental health-oriented consumer surveys previously funded through SAMHSA. The item wording focuses on client attainment of their expressed goals, recognizing from previous research the linkage between collaborative goal setting between counselor and client and successful engagement of the client in treatment. Additionally, client responses denote the likely linkage between treatment engagement and treatment retention, and the linkage between retention in treatment and long-term recovery. Since this is a retrospective measure without the benefit of an experimental research design, the client attribution of outcomes to treatment is an important connection to establish for the analysis.

Figure 6-10 displays the percentage of clients attesting to positive outcomes as a direct result of treatment.

Figure 6-10: Percentage of Positive Ratings by Adult Clients to the TPS Outcome Item, CY 2020, and CY 2021



Previous annual reports indicated the percent of positive responses to this item among adults was 86.4 percent in CY 2018 with 14 DMC-ODS counties, 81.9 percent in CY 2019 with 26 DMC-ODS counties, and 88.7 percent in CY 2020 with the full complement of 30 individual counties and seven Partnership counties. The slight decrease to 87.8 percent in CY 2021 is unremarkable and may be due to the limiting external factors prompted by the COVID-19 pandemic. What is most noteworthy is that the overall percentage remains quite high.

Figure 6-11 differentiates the extent to which clients express positive outcomes according to the LOC in which they were participating.

Figure 6-11: Percentage of Positive Ratings by Adult Clients to the TPS Outcome Item Differentiated by Level of Care, CY 2020 and CY 2021

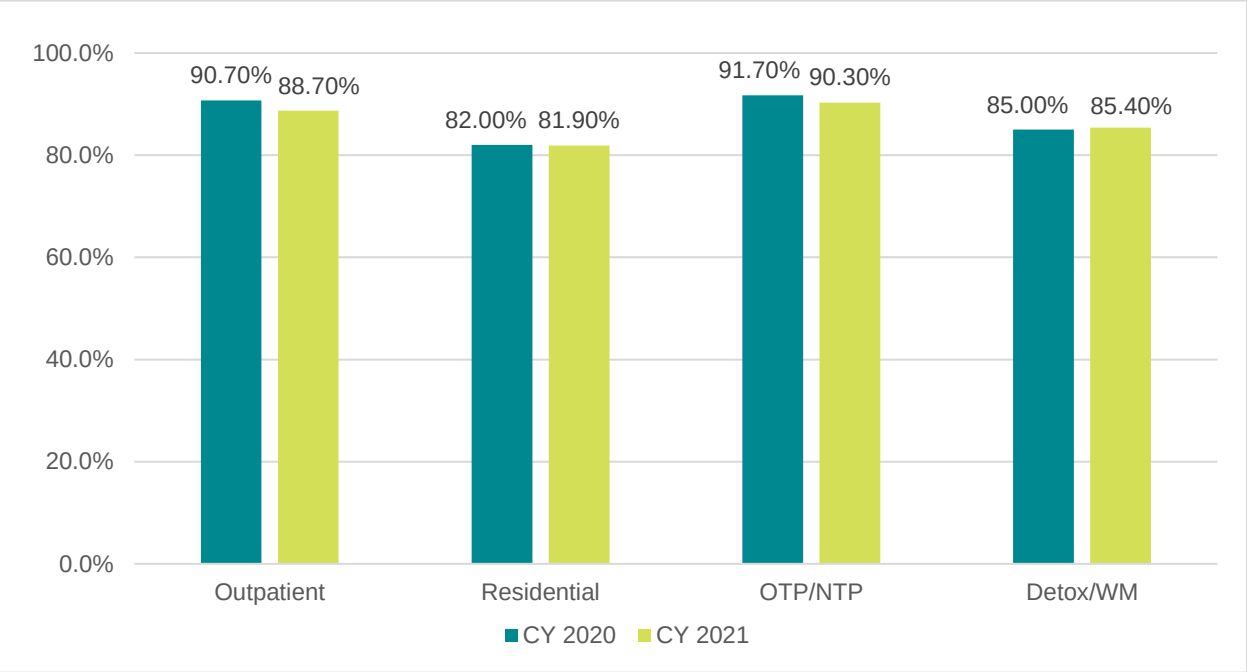


Figure 6-11 represents slight changes from CY 2020 to CY 2021, with slightly greater year-to-year differences among those in Outpatient and NTP programs than in Residential Treatment and Residential WM programs.

What seems more noteworthy are the pronounced differences in ratings, irrespective of year, between those in Outpatient and NTP programs compared to those in Residential Treatment and Residential Detox. The former two groups are experiencing less acute symptoms, are in less confining treatment settings, and would therefore be assumed to have a greater likelihood of attaining their short-term goals. Certainly, this is what the results appear to demonstrate.

CalOMS Findings and Themes

As counties have become more familiar with the CalOMS outcome results, they have become more focused on ensuring data accuracy and completeness. This shows in the significant reduction of administrative discharge rates from 46.8 percent in CY 2020 to 40.0 percent in CY 2021. It is important to note that the overall number of discharges shown for CY 2020 is complete while the number for CY 2021 includes data submitted by counties to DHCS through December 2021. There is always a substantial lag time in submitting and uploading this data so a later data refresh, not yet available to CalEQRO at the time of this report, will show a substantial increase with more complete data. Thus, CY 2021 data in Table 6-3 is not a complete reflection of discharges from 2021.

Counties also report more careful quality management efforts to ensure data accuracy in CalOMS discharge ratings. In response to information and encouragement from CalEQRO, many counties have increased their training offerings based upon the DHCS Manual for

CalOMS. While the manual is standardized, counties vary in their training approaches based upon the manual. Some simply encourage new counselors to study it, some add TA-and training from county QI staff, and some encourage DHCS-hosted online training. Many counties require that all newly employed counselors receive CalOMS training. Some counties go further and require that all counselors receive a training refresh each year. Most counties monitor attendance at these trainings, at least for new counselors.

Table 6-3: CalOMS Types of Discharges, CY 2020 and CY 2021

Discharge Types	CY 2020		CY 2021*	
	#	%	#	%
Standard Adult Discharges	47,627	44.0%	30,192	48.4%
Administrative Adult Discharges	50,688	46.8%	24,951	40.0%
Detox Discharges	8,184	7.5%	6,418	10.3%
Youth Discharges	1,818	1.7%	759	1.2%
Total	**108,317**	**100.0%**	**62,320**	**100.0%**

**CY 2021 CalOMS data as of 12/31/2021*

The table denotes the special attention CalEQRO gives to the percentage of administrative discharges as reported in CalOMS. These types of discharges are not based upon an exit interview, but instead reflect client "dropouts" without notifying their counselors. The program usually tries to contact the client in such instances but, when unable to connect, they complete an administrative discharge based upon limited information. Dropouts can indicate that a program may need to give more attention to the clinical appropriateness of their program for some clients, and to how they engage clients in treatment after admission into the program. For all these reasons, counties and their treatment programs must always work to keep their administrative discharge numbers low. CalEQRO conveys this message during EQRs, especially to counties whose administrative discharge rate is higher than the statewide average.

Table 6-4 represents the CalOMS Discharge Types for CY 2020 and 2021, as defined by the DHCS CalOMS Data Collection Guide[31] and the DHCS CalOMS CalOMS Tx Data Dictionary[32], with county-specific results in both numbers and percentages.

[31] https://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

[32] https://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Dictionary__JANUARY_2014.pdf

Table 6-4: CalOMS Discharge Status Ratings, CY 2020 and CY 2021

Discharge Status	CY 2020		CY 2021*	
	#	%	#	%
Completed Treatment – Referred	19,637	18.1%	11,892	19.1%
Completed Treatment – Not Referred	7,293	6.7%	3,798	6.1%
Left Before Completion with Satisfactory Progress – Standard Questions	14,881	13.7%	10,888	17.5%
Left Before Completion with Satisfactory Progress – Administrative Questions	8,865	8.2%	4,643	7.4%
Satisfactory Progress Subtotal	*50,676*	*46.8%*	*31,221*	*50.1%*
Left Before Completion with Unsatisfactory Progress – Standard Questions	15,818	14.6%	10,791	17.3%
Left Before Completion with Unsatisfactory Progress – Administrative	40,128	37.0%	18,522	29.7%
Death	866	0.8%	1,301	2.1%
Incarceration	829	0.8%	485	0.8%
Unsatisfactory Progress Subtotal	*57,641*	*53.2%*	*31,099*	*49.9%*
Total CalOMS Discharges	**108,317**	**100.0%**	**62,320**	**100.0%**

**CY 2021 CalOMS data as of 12/31/2021*

Counselors may at times have difficulty deciding what constitutes “Completed Treatment” compared to “Left Before Completion with Satisfactory Progress.” However, they find it much more straightforward to decide on one of the top four positive ratings versus one of the lower four. Therefore, CalEQRO added a subtotal row for the top four ratings, which is the most commonly studied statistic among counties. For CY 2021, the statewide average for positive ratings increased by 7.05 percent from the CY 2020 rate of 46.8 percent to the CY 2021 rate of 50.1 percent. This shows a positive improvement in provider ratings of their clients’ progress in treatment. However, the overall rate of 50.1 percent is not high and is a testament to the severity of impairments among Medi-Cal clients with SUDs and the challenges of successfully engaging them in a path to recovery. Similar to the consideration for Table 6-3, based on timing, the data in Table 6-4 is incomplete and accounts for approximately 2/3 of the total number of clients with CalOMS discharge data for CY 2021. DMC-ODS counties that have a paucity of informatic resources lack an ability to mine their CalOMS data, certainly at a program level. Feedback from providers and management provided to CalEQRO indicate previously available state-authored reports once accessible through the ITWS system are sorely missed.

It is important to place these statistics in a clinical context. As mentioned previously in this chapter, clients with SUDs are regarded as having a chronic illness for which recovery is a long-term process with intermittent setbacks. Treatment is conceived, in part, as client training in how to change a deeply embedded substance-focused lifestyle. ASAM Criteria suggest that this may involve a sequence of treatments at differing LOC with, ideally, smooth transitions between them. However, the CalOMS Admission and Discharge Summaries from which these data are derived must be completed at the beginning and end of participation in each program. A client may for varied reasons progress slowly or not at all during one LOC, and progress more successfully at a subsequent level.

Noteworthy Practices

Counties varied widely in their administrative discharge rates to produce the statewide averages of 46.8 percent in CY 2020 and 40.0 percent in CY 2021. Among the counties managing to keep their rates much lower were **San Francisco** at 6.9 percent and **Santa Barbara** at 12.2 percent. As would be expected, counties also varied widely in the percent of their clients who their providers rated as having made satisfactory progress in treatment. Substantially surpassing the statewide averages of 46.8 percent in CY 2020 and 50.1 percent in CY 2021, **Santa Barbara's** rate was 74.6 percent and **San Francisco's** was 63.1 percent.

San Diego has an impressive set of data analytic teams that work together with program management and stakeholders to develop many data dashboards. They use data visualization software to make the data presentable as useful information for management and stakeholders. They work closely with the QI team who monitor the data entry processes to ensure data integrity. As an example of what can be done beyond basic analyses, the team produced a dashboard comparing CalOMS Admission and Discharge data in two separate years for changes in several types of client statuses. They found a dramatic decrease in homelessness from 44.7 percent at admission to 12.8 percent at discharge, and a similar decrease in unemployment from 69.65 percent at admission to 35.5 percent at discharge.

San Joaquin analyzed its CalOMS data in innovative ways to provide more information for understanding outcomes and supporting management decision making. They analyzed and displayed CalOMS discharge ratings overall by providers across a period of several years to observe annual trends, and monthly within the previous twelve months to monitor monthly trends. They conducted a similar trend analysis for CalOMS discharge ratings differentiated by LOC to help clarify where QI efforts might be needed. They also analyzed and trended change scores between admission and discharge for the important outcomes of reduced frequency of primary drug use, increased frequency of drug-free social supports, and decreased homelessness.

Recommendations for Improving Treatment Quality and Outcomes

Quality

Continuum of Care

Continue to expand DMC-ODS services and providers as identified by community needs. System-wide services requiring attention include increase outreach and services to youth; increase 3.2 WM capacity; establish more recovery residence housing linked to outpatient supports with MAT access; and strengthen case management linkages between programs and services.

Evidence-Based Services

Provide clinical leadership on non-methadone MAT to the county and contract providers as a means to develop and implement strategies to expand non-methadone MAT resources, reduce stigma, and improve non-methadone MAT care coordination between the DMC-ODS and other agencies. Counties should continue enhancing Opioid Safety Coalition activities to monitor and reduce the rate of opioid-related deaths.

Client Transitions and Retention in Care

Process improvement strategies that track indicators of transitions in care and client engagement and retention problems (such as no-shows, cancellations, and client feedback surveys) would likely lead to a better understanding of how to improve these processes. DMC-ODS counties should consider setting local standards to establish targets by which to measure when improvement strategies need to be initiated for client engagement, transitions and overall retention in care. Counties should also review and apply the lessons learned from current SUD research findings and relevant PIPs that have demonstrated success in improving transitions in care and retention, in turn improving treatment outcomes.

Quality Improvement Infrastructure

DMC-ODS Counties should further build upon the data-driven infrastructure they have already begun developing. They should further refine their QIWPs to set measurable goals and objectives for improving clients' experiences with the accessibility, timeliness, quality, and effectiveness of treatment. To support these efforts, they should increase their use of innovative data analytic software to make useful data reports readily available for QI purposes.

Recruitment and Retention of Staff

Counties should increase efforts to staff at optimal levels and especially in critical areas of clinical care, quality management initiatives, IS, and fiscal management. As much as possible, counties should partner with contract providers to develop recruitment and retention strategies

that benefit the entire DMC-ODS system of care with employees who are educated, experienced, and represent the diversity in the community they serve.

Outcomes

CalOMS Training

Periodic and standardized staff training in CalOMS data entry is critical to ensure accuracy and inter-rater reliability. Ample training materials are available to download, most notably the DHCS-produced CalOMS Manual that includes case examples to inform discharge rating decisions. DHCS-produced online training modules are also available. These training options should be combined by each county with requirements for and monitoring of staff participation, and TA from clinical supervisors. Training should be prioritized and standardized across the DMC-ODS. Some counties also assign to selected supervisors the task of checking completed CalOMS discharge summaries to ensure accuracy.

Data Analysis

Annual CalOMS reports provided by CalEQRO engaged county interest and in some counties inspired efforts to conduct more county-wide and program-level data analyses to use for QI. To support ongoing QI efforts using CalOMS data, counties must deploy their own data analytic resources to study outcome data on a quarterly or even monthly basis at specific LOC and treatment program levels. Specific, detailed, and frequent interactions with programs on CalOMS results have been effective in increasing positive outcomes.

Counties have repeatedly bemoaned the cessation of automated reports from the previous DHCS-hosted ITWS platform and continue their requests for a restart of the reports in the replacement BHIS platform. It would be helpful if DHCS collaborated with counties to design a new automated reporting system that each county could then use with their own data compared to statewide results.

Use of TPS Results

The TPS is a psychometrically researched and client-friendly tool to obtain clients' perspectives on how well the DMC-ODS is functioning. Some counties make more extensive use of the TPS beyond the basic requirements, a model for other counties. Many counties study the treatment program results from the annual report, share them with the program providers, point to areas where there is room for improvement, and work with providers to develop QI action plans. A few counties have begun administering the TPS on a quarterly basis and use the data more frequently to monitor outcomes and the effectiveness of the new treatment approaches they are implementing.

Performance Improvement Projects

Introduction

A 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."[33] 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 county that have been initiated, are underway, or were completed during the reporting year.[34] Accordingly, for this Annual Report, CalEQRO examined projects that were underway at some time during the 12 months preceding the FY 2021-22 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 non-clinical 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 which, if successful, will positively impact client outcomes.

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

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[33] 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.

[34] Ibid.

- Member services and processes that are barriers to optimal beneficiary outcomes and satisfaction
- Improvement in access or authorization processes
- Member services and processes that could be barriers to optimal client outcomes and satisfaction

Methods

The PIP Implementation and Submission Tool is a template provided by CalEQRO for the DMC-ODS plans to use when drafting their PIP narratives.[35] Prior to the EQR, the DMC-ODS plans are expected 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 EQR, the CalEQRO team discusses the documentation provided by the DMC-ODS plan. During these sessions, the team provides feedback and TA for strengthening the submitted PIPs. Following the review, DMC-ODS staff may resubmit their PIPs with any changes or additions based upon review discussions. CalEQRO then reviews and validates any resubmitted PIPs, also following the requirements of CMS Protocol 1.[36] All PIPs are rated based on their completeness and adherence to the standards found in the CMS protocol.[37] Each of the nine PIP steps includes subsections containing standards that are rated according to the PIP Validation Tool;[38] the steps are shown in Table 7-1 below:

[35] 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.

[36] Ibid.

[37] Ibid.

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

Table 7-1: 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

To meet the standards set forth in the DMC-ODS' contract with DHCS, the PIP must be either in active implementation – one of four stages: implementation, baseline, first remeasurement, or second remeasurement – or was completed in the 12 months prior to the review. A PIP that has been submitted for initial approval or is in the planning phase is considered not yet active and does not meet the PIP requirements. To be considered in the Implementation phase, a PIP must have (1) baseline data on some indicators or PIP variables and (2) some improvement strategies must have started. During the Baseline Year, 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 per the key indicators and then preparing for the Second Remeasurement. Some PIPs have more remeasurement periods and would fall in the Other phase.

Table 7-2 shows the categories of PIP Status, their definitions, and a crosswalk which shows how the CMS Protocol changed the status definitions in the FY 2021-22 review year.

Table 7-2: PIP Status Terminology

PIP Status Terminology through 2019 – 2020 review year	PIP Status Terminology 2021-2022	Definition
Concept Only, Not Yet Active –	PIP Submitted for Approval	The DMC-ODS submitted the PIP concept for review by CalEQRO
Not an Active PIP.	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

PIP Status Terminology through 2019 – 2020 review year	PIP Status Terminology 2021-2022	Definition
		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.
Inactive, Developed in a Prior Year	Other	Rated last year and not rated this year due to lack of any activities in the past year.

In addition to rating the status of each PIP, CalEQRO assesses its relative validity. Validity ratings are based on the degree to which the PIP adheres to acceptable methodology in study design, data collection, analysis, and interpretation of results. Each PIP is subsequently assigned a rating of high, moderate, low, or no confidence.[39]

Findings

In FY2021-22, the 31 DMC-ODS plans submitted a total of 59 (95 percent) of the required 62 PIPs. This is a slight decrease from FY 2020-21, wherein DMC-ODS plans submitted 61 PIPs for validation. Detailed PIP findings across the past three years are reflected in Table 7-3 below.

[39] CMS Protocol 1

Table 7-3: PIP Submission Status, FY 2019-22

Submission Status	FY 2019-20		FY 2020-21		FY 2021-22	
	#	%	#	%	#	%
Active/Ongoing	43	80%	55	89%	41	66%
Completed	0	0%	1	2%	15	24%
Concept Only, Not Yet Active	9	16%	4	6%	3	5%
Submission determined not to be a PIP	1	2%	1	2%	0	0%
Inactive, developed in a prior year	0	0%	0	0%	0	0%
Total PIPs submitted	*53*	*98%*	*61*	98%	*59*	*95%*
No PIP submitted	1	2%	1	2%	3	5%
Total Possible PIPs	**54**	**100%**	**62**	**100%**	**62**	**100%**

- There was a substantial reduction in the number of "not yet active" PIPs which fell from 19 percent of all submissions in FY 2019-20 to just 5 percent in FY 2021-22.
- Nearly one-fourth of all PIPs submitted had reached completion in FY 2021-22, compared to just 2 percent the previous year.

Table 7-4: PIP Validation Ratings, FY 2020-21 – FY 2021-22

Validation Rating	FY 2020-21		FY 2021-22	
	#	%	#	%
No Confidence	10	16%	1	2%
Low Confidence	19	31%	27	45%
Moderate Confidence	22	36%	24	41%
High Confidence	10	16%	7	12%
Total PIPs Submitted	**61**	**99%***	**59**	**100%**

** Does not add up to 100% due to rounding of whole numbers.*

- For FY 2021-22, the predominant validity rating for the PIPs submitted (45 percent) was Low Confidence. These PIPs were often in the early stages of development and did not have data to validate the success of the interventions; or the PIPs contained errors in logic or contradictory information that led the CalEQRO to question whether the desired results could be achieved.
- There was an increase in PIPs that were rated as Low Confidence in FY 2021-22 over FY 2020-21; however, there was a similar decrease in PIPs that were rated as No Confidence.
- No Confidence ratings are assigned to PIPs that did not contain enough documentation to determine whether credible, reliable, and valid methods were employed.

- For FY 2021-22, although 95 percent of PIPs submitted were considered eligible for validation (Table 8-3), only 12 percent were found to have a High Confidence validity rating.

Trends in PIP Submissions

This year, there was a consistent rate of submission for active and completed PIPs versus PIPs in earlier planning phases. This consistency was due to ongoing 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.

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. This is the fifth year of Waiver implementation, though only three counties have experience with PIPs across those five years. Due to the staggered waiver implementation, for most staff it was the third year of PIP implementation, and for nine counties it was their fourth year of development.

However, some of the technical aspects of the PIPs are still presenting challenges. 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 need to be extremely clear and built into workflows effectively to have accurate data.

PIP Topics

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.

Table 7-5: PIP Domain by Category and Type, FY 2020-21 – FY 2021-22

Domain	FY 2020-21			FY 2021-22		
	% by Domain	# Clinical	# Non-Clinical	% by Domain	# Clinical	# Non-Clinical
Access to Care	36.5%	6	17	33.9%	7	13
Timeliness of Care	15.9%	3	7	11.9%	1	6
Quality of Care	34.9%	17	5	25.4%	10	5
Outcomes of Care	12.7%	5	3	28.8%	13	4

Access to Care

The Access to Care PIPs, representing 33.9 percent of all PIPs submitted in FY 2021-22, 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 PIP topics focused on issues such as continuity of care between residential and lower LOC, case management services and teams, and access to residential treatment. As a newly implemented billable service for many DMC-ODS plans, CalEQRO notes new PIP models being tried based on various theoretical approaches to case management and interventions 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 noteworthy practices.

Table 7-6: PIP Topics Access to Care - Clinical and Non-Clinical

Access PIP Titles	Clinical	Non-Clinical
Increasing Referrals and Access to Recovery Support Services	Los Angeles	
Connections After Discharge with Referral	San Diego	
Increasing Residential Treatment Admission Rates	San Mateo	
Increasing Referrals to Substance Use Residential Treatment for Zuckerberg San Francisco General Hospital (ZSFG) Patients with Severe Substance Use Concerns	San Francisco	
COVID – 19	Santa Cruz	
Targeted Case Management/Comprehensive Community Treatment (CM/CCT) following Assessment to Increase SUD Treatment Enrollments	Stanislaus	
Improving Screening and Assessment of Co-Occurring Disorders (COD) for Beneficiaries	Yolo	
Provider Education for MAT (Medication-Assisted Treatment) Use in Alcohol Use Disorder		Contra Costa
Increasing Linkage to Lower Level of Care LOC Following Residential Discharge		Kern
Improving Client Access to Ancillary Care		Los Angeles
Access to Treatment		Marin
Access to SUD Treatment for Adolescents		Merced
Increase Beneficiary Access to SUD Services in Eastern Nevada County		Nevada
Utilizing the Youth Screening Brief Intervention, and Referral to Treatment (YSBIRT) Evidence-Based Approach		San Bernardino

Access PIP Titles	Clinical	Non-Clinical
Connections to SUD Services After Psychiatric Emergency Response Team (PERT) Contact		San Diego
Streamlining Access to Services		San Joaquin
Increasing Outpatient/Intensive Outpatient Show Rates		San Mateo
Addressing Outpatient/Intensive Outpatient DMC-ODS Admissions Decline		Santa Cruz
Narcotic Treatment Program/Opioid Treatment Program Access		Stanislaus
Reducing No-shows to Assessment Appointments for Outpatient Care		Ventura

Timeliness of Care

While PIPs pertaining to Timeliness of Care represent the lowest number assigned to a topic area, it is still a substantial number with seven in total, six non-clinical and one 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 PIP focused on specific challenges in timely access to treatment in residential care, post-traumatic stress disorder (PTSD) issues related to timely access in SUD, and shared decision-making to engage MAT clients in a timely way. As counties have resolved timeliness issues successfully this type of PIP continues to be seen less frequently.

Table 7-7: PIP Topics Timeliness - Clinical and Non-Clinical

Timeliness PIP Titles	Clinical	Non-Clinical
Non-Fatal Opioid Overdose Connection to Treatment	Marin	
Improving Timely Access to Residential Treatment		Alameda
Direct Intake Scheduling		El Dorado
Text Message Appointment Reminders		San Benito
Improving Efficiency of the Residential Treatment Admissions Process		San Francisco
Improving Timeliness and reducing Attrition from Access screening to Intake in SUD outpatient services.		Santa Barbara
Decreasing the Time Between Initial Contact and Completed Intake for Outpatient and Intensive Outpatient Treatment		Tulare

Quality of Care

The Quality of Care topic area had 15 PIP submissions this year, 10 were clinical and five were non-clinical. Three of non-clinical PIPs assessed the 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 LOCs and how to improve transfers. The clinical PIPs have a wide range of topics, much broader than the prior year. One is focused on the new ASAM residential LOC designation clinical standards. Several PIPs focused on retention in SUD care within various LOCs, a practice that is associated with better clinical outcomes. Multiple PIPs focused on assessment and services for those with co-occurring mental health needs. Several focused on engaging clients with case management care coordination to improve transitions in care across the system of care. In addition, other PIPs focused on improving integrated care between behavioral and physical health, assuring services that benefit the client beyond SUD treatment.

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

Quality PIP Titles	Clinical	Non-Clinical
Increase Linkage to Primary Health Care and Mental Health Care via Residential Assessment and Treatment Planning	El Dorado	
Enhancing Engagement and Retention	Imperial	
Seeking Safety Implementation	Kern	
Residential Case Management	Merced	
Interventions Targeted at Individuals at the Beginning of Residential Treatment to Prevent Early Departure	Nevada	
Increasing Case Management Services through added Focus on Transitions in Care	Partnership	
Residential Treatment Re-engagement Groups	Riverside	
Case Management at First Contact to Increase Client Engagement.	Santa Clara	
ASAM Level of Care Determination	Sacramento	
Increasing Continuing Care Between Residential and Outpatient/Intensive Outpatient Treatment and Recovery Services	Tulare	
Improving Continuity of Care following NTP Narcotic Treatment Program		Imperial
Leveraging California Outcomes Measurement System Improvements to Support Transitions in Care throughout the DMC-ODS Continuum		Partnership
Substance Use Navigator Enhancement Project		Riverside

Quality PIP Titles	Clinical	Non-Clinical
Treatment Perception Survey		Sacramento
Health Integration		San Luis Obispo

Outcomes of Care

For the Outcomes of Care PIP topic area, there are a total of 17 PIPs focused on outcomes with 13 clinical and 4 non-clinical. The clinical PIPs sought to utilize case management to improve individual client outcomes by improving rates of engagement or linkage to ancillary service. The non-clinical PIPs focused on the impact on clients in engagement and retention resulting from recovery services, MI, and client choice in the continuum of care. Each of the PIP documents submitted have the potential to provide new insights about treatment delivery and noteworthy practices in SUD care if implemented in a consistent and well-designed manner.

Table 7-9: PIP Topics Outcomes - Clinical and Non-Clinical

PIP Titles	Clinical	Non-Clinical
Recovery Coaches for Withdrawal Management	Alameda	
Transition Team Case Management	Contra Costa	
Client Engagement: Residential and Outpatient Continuation	Fresno	
Enhancing Care for Clients in Residential Withdrawal Management	Napa	
Addressing High Rates of Post-Traumatic Stress Disorder (PTSD) among Clients Enrolled in Substance Use Disorder Services	Orange	
Early Engagement with Intensive Outpatient Treatment	Placer	
“Reducing Drop-Out Rates & Improving Continuity of Care.”	San Benito	
Utilizing a Shared Decision-making Approach to Increase Medication Assisted Treatment (MAT) Engagement and Engagement in Non-methadone MAT	San Bernardino	
Improving Client Perception of Residential Treatment Programs by Developing Clinical Practices	San Joaquin	
Individual Services to Improve Client Retention	San Luis Obispo	
Timely Transitions in Care Following Residential Treatment	Santa Barbara	

PIP Titles	Clinical	Non-Clinical
Bridging a Gap: Improving Transitions of Care from Residential to Recovery Services	Monterey	
Study of Client Engagement and Retention in Early Outpatient Treatment	Ventura	
Level of Care Transition Improvement		Fresno
Increasing Youth Engagement in SUD Treatment Services		Monterey
Increasing Engagement and Retention Through MI		Orange
Continuum of Treatment Services		Placer

In summary, 59 PIPs were submitted and 41 are currently active; the two in the planning phase will be active within the year. One of the greatest challenges for the DMC-ODS Plans continues to be adapting to video and phone service delivery because of COVID-19. This impacted almost all SUD services over the last two years and was disruptive to the traditional face-to-face clinical interactions such as group, a modality which was less effective via teleconferencing. These changes in the service delivery system were especially disruptive to day programs such as intensive outpatient. As a consequence, many of the PIP improvement strategies and interventions had to change. Many DMC-ODS plans are still determining client demand and willingness to do phone or video sessions. Although many DMC-ODS Plans converted back to in-person service delivery, they are continuing home sessions at a physical distance, or at a community location. Due to telehealth, many counties reported clients dropping out of care, though clients who had transportation challenges reported benefitting from telehealth implementation.

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.

Twenty-four DMC-ODS plans (77 percent) utilized TA from CalEQRO in the development and support of their PIPs. One area in which CalEQRO provided TA was how to use available core data sets to evaluate improvement including TPS, ASAM, Claims, CalOMS, and the county MMEF and NSDUH data. With knowledge of these data sets, it is possible to design evaluations that are sound, but not too complex, and that relate to the principal issues of access, timeliness, quality, and outcomes of 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 to optimize quality of care for clients.

Outside of the review process, in FY 2021-22 CalEQRO provided a total of 302 hours of individual TA to those 24 DMC-ODS plans, averaging nearly 13 hours of TA per DMC-ODS. The TA consisted of assistance in attempting to construct PIPs, perform data analysis, modify PIPs due to COVID-19 impacts, and feedback from CalEQRO on PIP design. Some plans also had difficulties collecting and using data to design PIPs that target a specific problem in their geographical area.

Table 7-10 details the TA provided to all DMC-ODS Plans during the review year. In addition to onsite TA, during the FY 2021-22 review year, CalEQRO provided PIP clinic webinars and in-person presentations that focused on PIP development.

Table 7-10: Technical Assistance Provided via PIP Webinars by CalEQRO, FY 2021-22

Title of Webinar	Date
PIP Tools: PIP Development and Validation Tools	September 24, 2021
PIP Library Updates	December 14, 2021
Establishing a PIP Problem; Conducting a Barrier Analysis; and Utilizing Stakeholder Input	March 8, 2022
BHQIP PIP Opportunities	June 29, 2022

Summary

In summary, 59 PIPs were submitted: 56 are currently active and 3 were in the planning phase and are expected to be active within the year. The most common topic of PIPs in FY 2021-22 was outcomes of care, reflecting 39 percent of all submitted PIPs.

CalEQRO heard consistently throughout the year that COVID-19 continued to impact many services and was disruptive to the existing service delivery system and customary clinical processes. As a result, many PIP strategies had to change; this may have contributed to the 46 percent of PIPs that received a Low Confidence Rating.

Technical aspects of PIPs continue to present challenges, particularly in terms of local data collection capabilities and obtaining the necessary resource allocation to successfully conduct all required components of a PIP. These underlying obstacles pertain to limitations of fundamental infrastructure and are seen throughout this report.

Despite these barriers, counties worked hard to implement projects that positively impact access, timeliness, quality, and outcomes for beneficiaries.

With the onset of CalAIM, CalEQRO will encourage DMC-ODS Plans to take advantage of the opportunity to join in the statewide effort to improve CalAIM BHQIP Milestone 3d. “Leverage improved data exchange capabilities to improve quality and coordination of care” by developing PIPs that target the three HEDIS measures identified in this CalAIM Milestone: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence;-Follow-up After Emergency Department Visit for Mental Illness; and

Pharmacotherapy for OUD. This will enable counties to meet their DHCS CalAIM requirements and PIP requirements with the same project. This ongoing project will allow for enhanced healthcare collaboration as counties across the state embark on this new concept.

Client Perceptions of Care

Introduction

The primary purpose of implementing the DMC-ODS framework is to better serve clients. While the review of the various data and measures noted elsewhere in this report are critical to gaining an understanding of system performance, the client "voice" is essential in obtaining a comprehensive evaluation of the accessibility, timeliness, quality, and outcomes of the services being provided. CalEQRO arranged three primary sources of data to feature the client voice in the EQRs—client ratings from the annually administered TPS, client ratings from the brief surveys preceding their participation in client focus groups, and in-depth client comments during the focus groups.

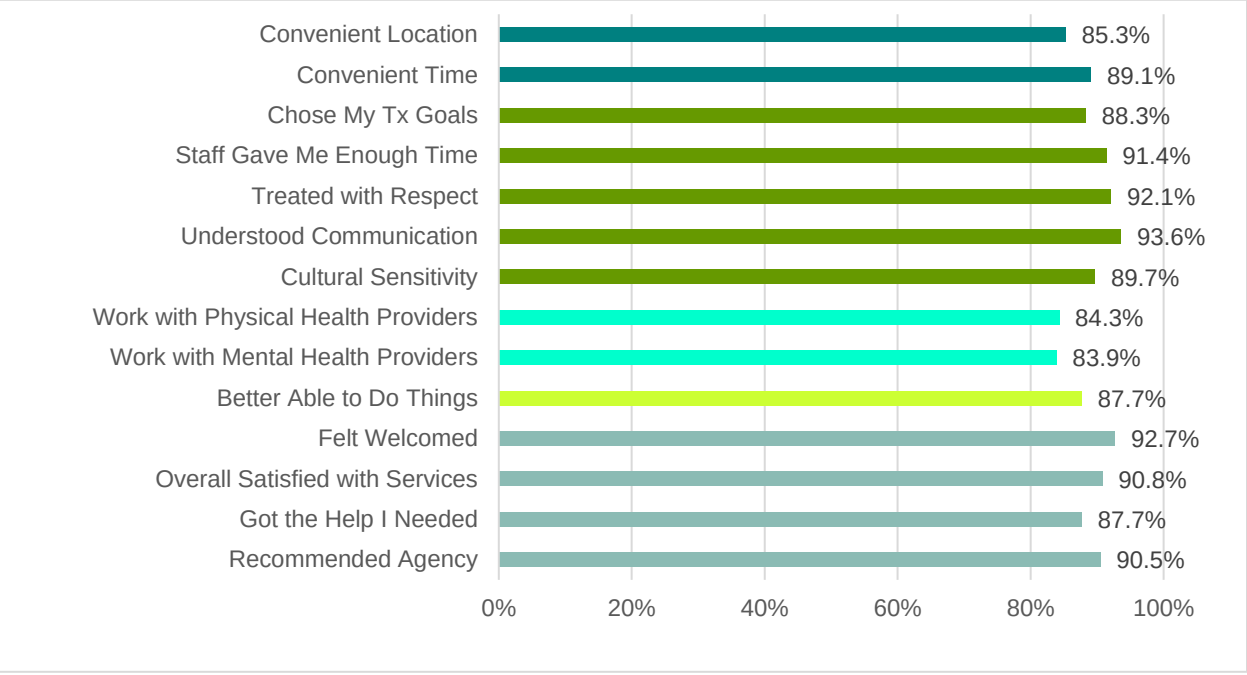
Treatment Perception Survey

The University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) provides a client survey to be administered annually by counties for measuring and monitoring outcomes of the DMC-ODS demonstration project. The TPS for adult clients is comprised of 14 questions focused upon five content domains: (1) access to care, (2) quality, (3) outcomes, (4) care coordination, and (5) general satisfaction. Providers within the network of each county/regional model participating in the DMC-ODS waiver are required to administer the TPS on an annual basis. The TPS for youth clients is comprised of the same questions as the adult version with four additional questions and one additional content domain of therapeutic alliance. The TPS is designed to fulfill the CMS requirement for the state to collect and evaluate data through each participating county on client perceptions of their access to treatment and the quality and impact of that treatment. UCLA ISAP analyzes the data and provides the results to each county in a report that supports each DMC-ODS' QI efforts.

During the FY 2021-22, the TPS was administered October 17-21, 2021. This was the fifth annual administration of the TPS for the DMC-ODS waiver. The TPS was administered to both adult and youth clients, and the results are reported separately in this report.

Figure 8-1provides the statewide results of that survey for adult clients.

Figure 8-1: Percent of Adult Clients Endorsing TPS Items and Domains, CY 2021



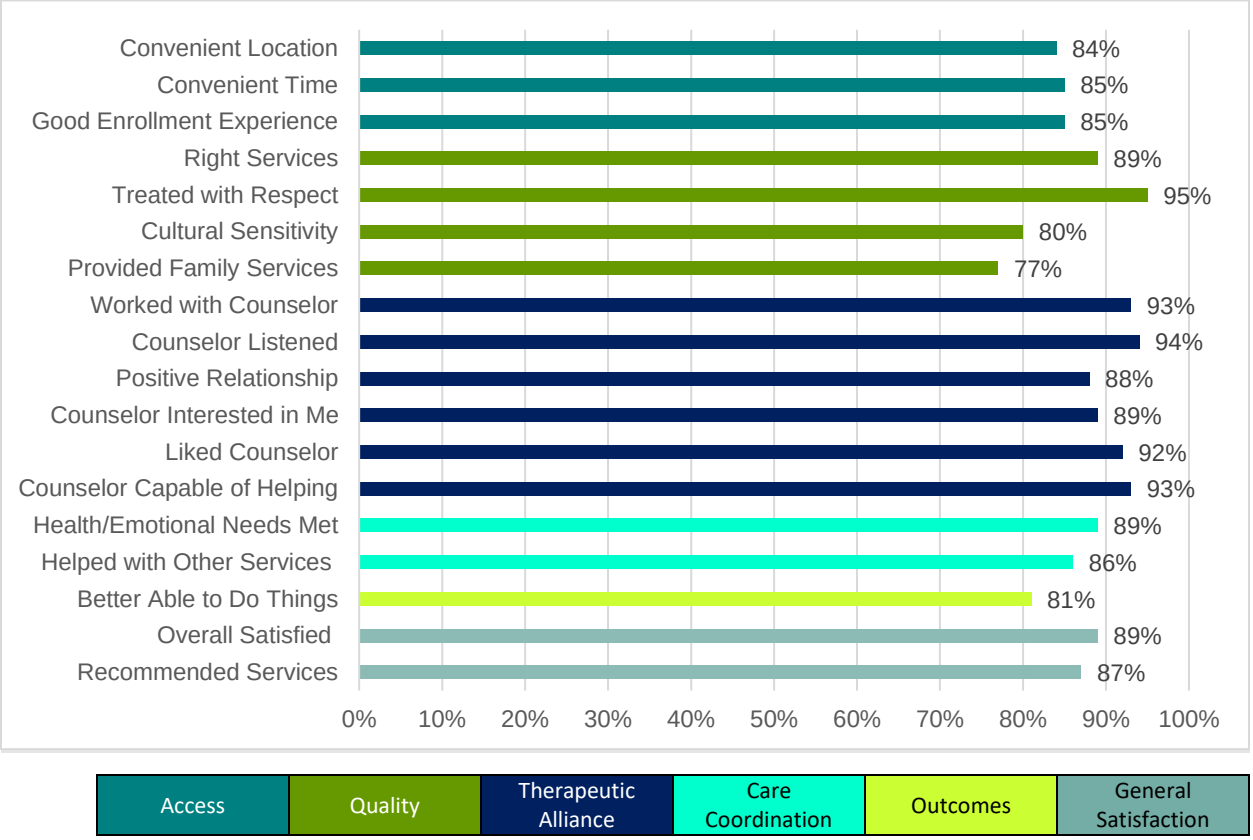
There were 16,193 adult respondents, with more than 80 percent responding positively to each item. The item that received the largest number of positive responses (93.6 percent) was focused upon feeling understood by the counselor. That item was in the quality domain that clustered around positive relationships with counselors, which is a researched factor often predictive of positive outcomes. The collective items in this domain received the highest percentage of positive endorsements compared to the other four domains. The item with the lowest percentage of positive endorsements at 83.9 percent—still a high percentage--was coordination with mental health services. This item is part of the domain of care coordination, which also includes an item focused on coordination with physical health care services. The low scores in this category suggest that DMC-ODS counties, while intent on developing their substance use systems of care, also have room for improvement in coordinating their services with other closely allied treatment systems that their clients need. However, the level of positive endorsements for coordination of care is still respectable at approximately 84 percent.

The impact of the COVID-19 pandemic deepened in CY 2021, and this was reflected in differences between the results displayed in the above figure and those from the previous CY 2020. The following questions showed a decrease in positive endorsement between 2020 and 2021:

- “Better Able to Do Things” declined from 91.3 percent to 87.7 percent
- “Work with Mental Health” declined from 87.0 percent to 83.9 percent
- “Convenient Time” declined from 92.0 percent to 89.1 percent

The one exception was for the item “Understood Communication” which improved slightly from 92.8 percent in CY 2020 to 93.6 percent in CY 2021.

Figure 8-2: Percent of Youth Clients Endorsing TPS Items and Domains, CY 2021



There were only 435 respondents, which in part reflects the significantly fewer number of youths served throughout the DMC-ODS counties. The DMC-ODS Waiver STCs introduced coverage for many types of youth treatment services that were not covered in the prior Drug Medi-Cal State Plan, and DMC-ODS counties are all in the process of building their youth treatment programs. School systems were a primary source for outreach and referrals, and the temporary closure of in-person schooling during the COVID-19 pandemic slowed progress in outreaching to and engaging youth in substance use treatment.

The youth respondents to the survey endorsed all the items, with more than 75 percent responding positively to each item and 85 to 95 percent responding positively to 15 of the 18 items. The item that received the largest percent of positive responses (95 percent) was “Treated with Respect,” closely followed by “Counselor Listened to Me” (94 percent), “Counselor Was Capable of Helping Me” (93 percent), and “Liked Counselor” (92 percent). Most of these items clustered in the domain of Therapeutic Alliance, which is crucial to engaging clients and encouraging positive outcomes.

The item that received the least percent of positive responses (77 percent) was “Provided Family Services.” This suggests that DMC-ODS counties, while building their systems of

substance use treatment for youth, should give special attention to inclusion of family members when feasible.

Best Practice Examples of How DMC-ODS Counties Used the TPS for QI

All counties administered the TPS, submitted the data to UCLA for data analysis, and received from UCLA a complete report of their results in a standardized format. The report included the results formatted similarly to Figure 8-2 above, with the DMC-ODS county's specific data. In addition, UCLA provided separate analyses for youth overall, adults overall, and by each provider program. UCLA also provided statewide overall results as comparison data.

The most common way that counties used the results from the UCLA analyses for QI was to separately share with each provider program their provider-specific results. While the overall results for each county tended to be uniformly positive, there were usually a small number of specific provider programs whose results showed room for improvement. These findings were rarely a surprise to county QI staff, but they remarked that the data sharing was helpful and reinforced the need for QI attention.

For example, **Marin**, a medium size county, used the TPS as one of several ways they evaluate treatment programs. They used the grid from the UCLA report that shows the average ratings by item for each separate program. While most programs have uniformly high ratings, a few outliers showed problems in some performance areas. When they showed these programs their clients' ratings compared to other programs, they found the programs to be highly responsive to suggestions for improvements. In addition to these efforts, Marin shares the aggregate results with providers in their regularly scheduled provider meetings, and with leadership and multiple stakeholders in the monthly QIC Plan and Evaluation meetings.

A second way for DMC-ODS counties to use the TPS findings for QI was to produce slide presentations with graphical displays of the results and share them with behavioral health department leadership, contract providers, other county agencies and stakeholders, and clients and family members. DMC-ODS counties with data visualization software were particularly adept at this. Some counties reported using these presentations as evidence to support the need for specific QI efforts they intended to launch or had recently launched. They also used the presentations to display what was going well in their delivery of services.

Imperial, a small county, produced a presentation of results from UCLA's analysis of both the TPS Adult and TPS Youth data. The presentation included analyses of responses by language, gender, age, race, LOC, and length of services within each LOC. The presentation included comparisons of ratings across the previous three years with differences in percentage ratings by domain and client comments attributed to specific programs. Although youth responses were much lower than adults, the youth part of the presentation was also treated with importance. The results of the TPS were provided to leadership and QM and shared with programs. The report includes graphs, tables, and narratives on TPS results using visualization software that made the presentations easy to understand and engaging.

A third QI approach used by a small number of counties was to incorporate the TPS into one of their PIPs or other QI studies as an outcome measure. The TPS can be a convenient and practical selection for an outcome measure in that it is brief and can be easily administered on a more frequent basis. Also, UCLA ISAP conducted and published research to establish its psychometric validity and reliability. Some counties have administered the TPS quarterly to the clients in one or more of their PIP studies as a measure of treatment progress, and some used it for each client at intake and discharge as a pre/post outcome measure.

San Joaquin, a large county, used client ratings on several adult TPS items as PMs for their clinical PIP, "Improving Client Perception of Residential Treatment Programs by Developing Clinical Practices." They selected 8 of the 14 items that addressed the domains under study of quality, coordination of care, overall satisfaction, and outcomes. They used the CY 2020 TPS results as their baseline performance data and began in September 2021 to administer the same eight TPS items on a quarterly basis to monitor whether their newly designed interventions in residential treatment were making a difference in client perceptions of care. Their initial experiences were that the TPS items served as practical, reliable, and valid measures, and their findings were that the PIP interventions were effective in measurably improving clients' perception of care. They plan to continue the PIP through June 2023.

Consumer Family Member Focus Groups

Consumer and family member (CFM) focus groups are a vital component of the CalEQRO site/virtual/desk review process. The direct feedback from clients who receive services provides valuable feedback regarding quality, access, timeliness, and outcomes. The CalEQRO reviewers who facilitate the group discussions have lived experience as previous substance use clients and/or family members of a client. They facilitate the groups with structured questions to invite client feedback at a greater depth than can be gleaned from a survey questionnaire alone. The questions focused on timely access to care, the availability of MAT, recovery-oriented peer support, interpersonal and cultural sensitivity of the counselors, and improvements in client functioning as a result of treatment. CalEQRO provided gift cards to client participants in the focus groups as an expression of appreciation for their participation and contributions.

CalEQRO coordinated the CFM focus group parameters and logistics with the DMC-ODS county, beginning with a collaborative decision between them as to the type of treatment programs that the clients will represent. Most counties hosted two client focus groups during their reviews, with a total of 53 groups held. Of them, 25 were for adult clients in residential treatment, 22 for adult clients in outpatient treatment, and 6 for clients in some other form of treatment (e.g., adult clients in NTP or other MAT programs, adult clients in mixed types of treatment programs, or clients in youth outpatient programs).

CalEQRO requested that each county recruit a diverse group of six to eight clients who initiated treatment services from the DMC-ODS in the preceding 12 months. In some groups a language interpreter was arranged, while in most groups it was not needed. Due to the unprecedented circumstances precipitated by the COVID-19 pandemic, CalEQRO conducted the focus groups using videoconferencing. This new reality necessitated additional assistance

from the DMC-ODS county review coordinator in organizing the logistics of the beneficiary focus group(s).

CalEQRO provided instructions for participants to complete an online survey prior to the focus group. The instructions were given to the DMC-ODS contact who in turn conveyed the materials to the treatment providers for handoff to the participants. The survey included nine items for participants to rate on a five-point scale range using feeling facial expressions with the happiest expression scored as five (5) and the most unhappy as one (1). The instructions explain the goal of the survey is to understand the clients' experiences in accessing and engaging in treatment.

CFM Focus Group Survey Responses for All Levels of Care

CalEQRO conducted 53 CFM focus groups statewide with an average of six clients per group and a total of 319 clients overall. A total of 281 clients completed the CalEQRO nine-item survey, of whom 78 participated in outpatient treatment focus groups, 180 in residential treatment focus groups, and 23 in NTP or mixed outpatient and residential groups. The analysis of item responses was conducted first for the overall set of 281 respondents, and then reanalyzed separately for the subset of 78 clients from the outpatient programs compared to the subset of 180 clients from the residential treatment programs. The ratings by each of the two subsets were so similar to the overall group that they are not reported separately in this report. The focus group discussions often revealed that most clients had been in treatment intermittently throughout their lives in several LOC and may have responded to the survey items prior to the focus group without differentiating between programs. The focus group provided a better venue for that differentiation, which is portrayed in the summary of their focus group comments in a subsequent section of this chapter.

Table 8-1: CFM Survey Question Results for All Groups

Question	Average
1. I easily found the treatment services I needed.	4.48
2. I got my assessment appointment at a time and date I wanted.	4.35
3. It did not take long to begin treatment soon after my first appointment.	4.53
4. I feel comfortable calling my program for help with an urgent problem.	4.63
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.89
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.57
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.68
8. Because of the services I am receiving, I am better able to do things that I want.	4.59
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.70

Table 8-1 denotes ratings across the complete set of 281 online respondents. Item 9 would recommend this agency to others, had the highest rating of 4.7, and most other items were endorsed at a similarly high level. The other highly rated items included those focused on timely access (easily found treatment, timely assessment, time to enter into treatment), therapeutic alliance (felt comfortable asking for help, culturally informed care, staff was helpful), and achieving positive outcomes (client felt better able to do things). These ratings are congruent with those rendered by the larger group of clients who completed comparable items on the TPS.

The one item rated substantially lower than the others was “Informed about MAT,” which received an average agreement rating of 3.89. This suggests that more than a few clients reported they had not received information at their intake or assessment regarding the option and potential benefits of including a MAT regimen as part of their treatment. This may in part reflect an informal preselection process, in that many clients who seek MAT will go directly to one of the county’s NTPs. This would be consistent with admission diagnosis where most DMC-ODS’ report a higher level of methamphetamine where MAT is not indicated – however, statewide diagnoses show OUD as the highest diagnostic category. To address this, one of the intents of the DMC-ODS waiver is to encourage delivery of MATs among other EBPs, given the research support for that intervention. Anecdotes provided by consumers and clinical line staff indicate that while MAT is embraced in many settings, increased education on the benefits and success of MAT in treatment may remain a challenge. These mixed reports by clients in the survey regarding MATs was further reflected by their verbal comments during the focus groups, which are described in the narrative section below. The ratings and related comments suggest this is an area wherein DMC-ODS counties can focus their QI efforts.

Summary of Participants' Feedback from Client Focus Groups

This section includes a summary of client feedback within the focus group sessions that was elicited by the group facilitator using many of the questions from the survey and a few others. The focus group was regarded as an opportunity to obtain more in-depth and nuanced feedback directly from clients.

The information provided in this section was obtained through a qualitative database of client comments from each of the 53 focus group sessions. The comments were then categorized by themes and the most common ones were paraphrased in this section as most widely reflective of client perceptions of care. When client perceptions differed according to their levels of acuity, attention was given to clarifying which comments came from those in outpatient as compared to residential treatment programs. It was not feasible to differentiate the comments of those from large counties and substantial treatment resources versus those from smaller counties with fewer treatment resources.

Client reports on the timeliness of entry into treatment ranged widely from same-day admissions to "several months of wait." Many clients described the assessment process as too lengthy and involving needless duplication of questions that could be streamlined. Many clients also described delays in obtaining mental health appointments for mental health services and with physicians for medications. Clients also suggested that the discharge planning process could begin earlier in treatment, which would help facilitate more timely transitions to step-down treatment and/or RSS.

Those recounting longer wait times to access treatment commonly explained they were due to lack of readily available openings in residential treatment and required interim placements in outpatient treatment. Some remarked that the temporary placement in outpatient was not always helpful when a more intensive LOC was indicated, and sometimes resulted in relapse. Clients noted there were too few beds available for residential WM as well. Some clients in counties reliant on out-of-county residential treatment facilities expressed reluctance to be placed there and instead opted for a lesser recommended LOC placement in the county while waiting for a local bed.

Clients expressed appreciation for care coordination services and regarded this service as instrumental in their ongoing successful recovery. They described these services as linking them to transportation; assisting with appointments for mental health, medical, and legal services; housing and recovery residences, and MAT. They also described care coordination as helping them navigate the substance use treatment system and facilitate smoother transitions from one LOC to the next. Clients were especially dependent upon these services while in residential treatment for transportation to external appointments and help with medical needs. They also remarked how important it was to obtain help from staff with care coordination when an urgent situation or crisis occurred, and they needed staff support and case management assistance to stabilize their recovery.

Clients praised their counseling staff for being compassionate and committed to helping clients with their recovery. Clients expressed special appreciation for staff who were also in recovery because they can relate to the clients' experiences and not make them feel ashamed, particularly regarding relapse. Clients perceived the counseling staff and programs as sensitive to their culture-specific needs, providing client-centered care, and especially perceptive and considerate when clients were at risk for or in relapse. Notwithstanding these positive comments, most clients expressed concern that the treatment programs were short-staffed with high turnover. They consequently found it difficult to access counselors for individual sessions, inclusion of family sessions, and to find a consistent counselor who could be relied upon to remain assigned to the same clients, Clients see their counseling staff as overworked and burned out because there are not enough staff and those who remain seem to have too much paperwork. Their treatment sessions were reported to feel rushed.

Many clients expressed disgruntlement with how residential treatment staff set limits and consequences for breaking those limits. Some of the client remarks pertained to the confinement of residential treatment, exacerbated by further restrictions related to COVID-19 related health safety precautions. Clients were particularly sensitive about perceived inconsistencies or "favoritism" shown by some staff. Some clients remarked that those with serious mental illnesses seemed at times to get away with behaviors that would not otherwise be tolerated for others. Some clients remarked that they perceived some clients "getting high" and avoiding notice while others get caught and have to endure consequences. Clients in the focus groups emphasized that this behavior by these clients was disruptive to the therapeutic milieu and impacted the recovery of others. Clients suggested that consistent relapse prevention policies across the programs will decrease confusion among clients and help those who relapse to feel safe and willing to come back into treatment.

Some clients who had been in and out of treatment for many years remarked that they saw improvements in how care is being delivered since the implementation of the DMC-ODS. Clients commented on areas of quality care which they thought could be improved. Outpatient clients remarked that more in-depth counseling could be available if counseling staff were to obtain training in trauma-informed care and in treatment of co-occurring mental health and SUDs. Some residential treatment clients said they would appreciate a more well-rounded curriculum with updated information and visuals. Some clients expressed the wish for more materials in Spanish for both outpatient and residential services, particularly for the intake/assessment process. Although the DMC-ODS Waiver promotes MATs, many clients maintained that they were not informed of the options and benefits of MAT adjunctive to their other treatments.

Clients expressed appreciation for staff and the programs across all LOC. They remarked that, because of their treatment, they had improved in their abilities to manage and cope with life. Many of them described how they improved in their ability to organize their everyday responsibilities, manage anxiety and cravings, improve relationships with family and friends, and connect with their community. Many of them explained how they have become more adept at accessing suitable recovery-oriented housing, education or employment, and long-needed medical services. They maintained that their treatment stabilized their recovery and helped them establish a viable support network.

Summary of Participants' Recommendations from Client Focus Groups

The findings in this chapter provide valuable feedback on perceptions of care from people who sought treatment and recovery for their SUDs through a DMC-ODS. Client participants in the focus groups were also asked if they had suggestions for improvements to the DMC-ODS in their counties. Following are the suggestions they offered most frequently, ordered by the flow of processes they encountered as clients entering into and experiencing the system of care:

- Streamline the preliminary screening, assessment, and intake processes. Many clients described their vulnerable and ambivalent states at the time of first requesting treatment, and consequently how important it is that the screening, assessment, and intake processes be conducted in a timely manner. In particular, some clients remarked that there may be room for streamlining the number and length of forms and amount of paperwork.
- Increase capacity for WM and residential facilities with a preference for in-county programs. Many clients reported extensive wait times for residential WM and residential treatment. They report that the DMC-ODS will place clients in an alternative LOC rather than wait for the indicated one and remarked that this can create problems. When clients needing residential WM are instead admitted to residential treatment, some of those in treatment feel at greater risk of relapse in close proximity to persons still under the influence of drugs or alcohol. When clients needing residential treatment or WM instead placed in outpatient treatment programs, they can experience anxiety and instability with negative impacts on their efforts to sustain recovery.
- Manage staff to client ratio caseloads and increase one on one counseling sessions. Clients were in consensus that some of the basic requirements of effective treatment were individual counseling to complement group counseling, and continuity of counselor assignments to clients for building the therapeutic relationship. Clients were also in consensus that many programs were too short-staffed to provide these basics, thereby compromising the effectiveness of care. Although clients perceived existing counselor staff to be caring, they also perceived them as being burnt out. Clients attributed the short staffing to the COVID-19 pandemic, resulting in high turnover, and challenges recruiting additional staff. They urged concerted efforts at provider, county, and state levels to improve staff recruitment and retention.
- Focus on professional training for co-occurring disorders and EBP. Clients acknowledged the prevalence of co-occurring mental health disorders and lack of training among SUD counseling staff in how to address them. They urged more training of their counselors in how to identify and address signs of mental health disorders. They also expressed appreciation for the effectiveness of several types of EBPs for SUDs, such as MI, Seeking Safety, Relapse Prevention and Cognitive Behavioral treatments. They suggested more focused training for staff on developing the skill sets to deliver these EBPs, including ongoing case supervision. Many clients also expressed an appreciation of Stages of Change approaches to client-centered care and suggested more training for counseling staff on these approaches.

- Provide case management for linkage to ancillary services and care coordination throughout the continuum of care. Many clients spoke highly of case management services for both linkage to ancillary services (e.g., transportation, housing, legal system) and coordination of care (e.g., step-down transitions to lower levels of SUD treatment, referrals to physical and mental health services). They urged the DMC-ODS to make these services as available in outpatient programs as they are in residential treatment programs. They also suggested that the DMC-ODS begin the discharge planning process sooner in treatment to prepare clients for transitions in care.
- Improve access to MH services for SUD clients experiencing co-occurring disorders. Many clients reported challenges in obtaining timely access to their county's MH treatment services while in SUD treatment. Especially because of the prevalence of co-occurring MH disorders in the population of SUD clients, they urged DMC-ODS counties to find ways to improve the access processes.

Information Systems

Introduction

CalEQRO assesses the extent to which the DMC-ODS and its subcontracting providers meet the Federal data integrity requirements for HIS, as identified in 42 CFR §438.242. DMC-ODS Plans submit a completed Information Systems Capability Assessment (ISCA), available at www.calegro.com, prior to the EQR. The ISCA commonly requires input from multiple areas of the organization, such as IT/IS, Finance, Operations, and QM. Specifically, CalEQRO utilizes the ISCA protocol to review the DMC-ODS' EHR, IT, claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs, and whether the DMC-ODS and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the QAPI program.

Information Systems Statewide

In this chapter, CalEQRO examines the functionalities of the EHR systems that were in place during FY 2021-22, along with IT budget, staffing, and other planned IS changes. There is considerable 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. However, in general, the counties rely more on contract providers on the SUD side of the behavioral health services (BHS), and that makes it critical to examine their access to the county EHR system, data submittal methods, and utilizing the county EHR functionalities. The results were based on the status at the time of the review and may have changed since then.

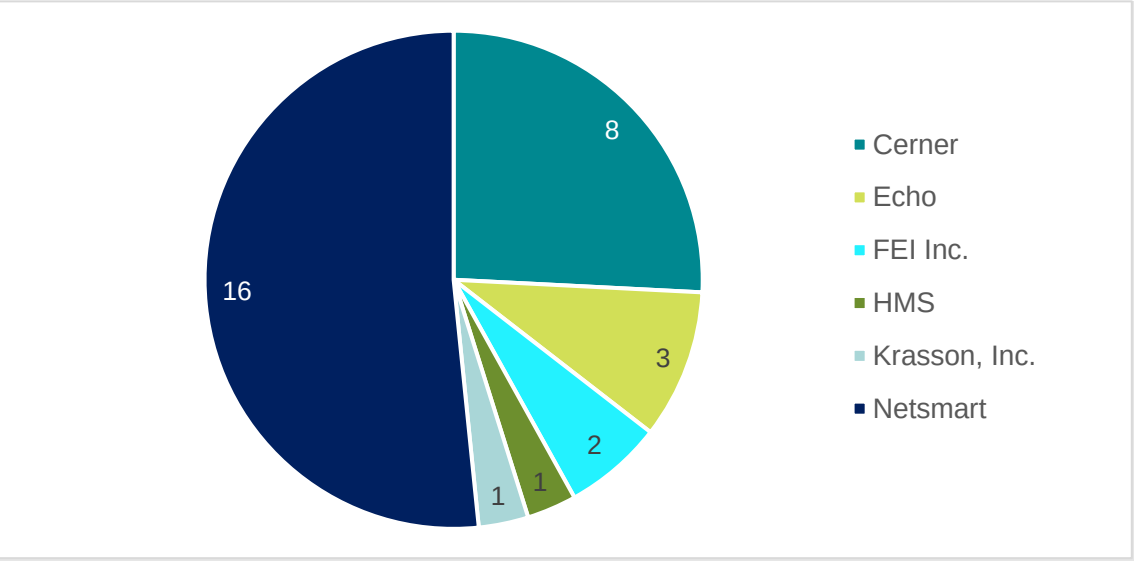
In FY 2021-22, DHCS implemented the CalAIM Behavioral Health Quality Improvement Program (BHQIP), an incentive program available to counties until FY 2023-24, that provides an opportunity for DMC-ODS plans to meet interoperability requirements specified in BHIN 22-068[40]. MHPs and DMC-ODS plans may earn incentive payment by completing specific deliverables tied to program milestones, including technology and infrastructure. DHCS encourages and financially incentivizes DMC-ODSs to pursue this opportunity, although participation is not required.

[40] https://www.dhcs.ca.gov/Documents/BHIN-22-068-Interoperability-and-Patient-Access-Final-Rule.pdf

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. Figure 9-1 summarizes DMC-ODS system vendors.

Figure 9-1: DMC-ODS County System Vendors



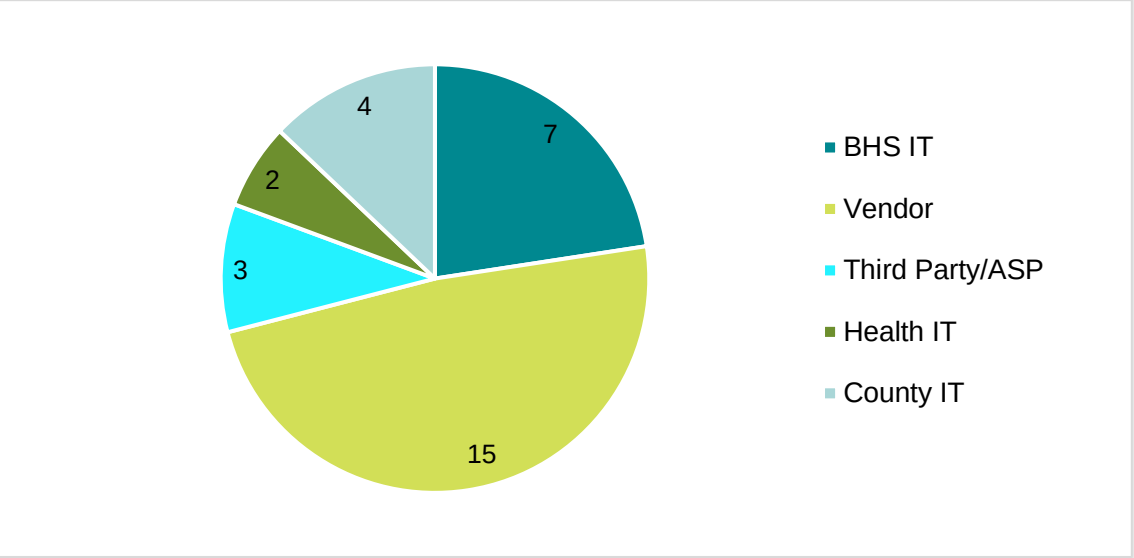
Netsmart and Cerner account for two-thirds of the EHR vendors serving the 31 DMC-ODS plans. Of these, 16 counties use Netsmart Avatar, and 7 counties use Cerner Community Behavioral Health (CCBH) EHR. One county uses Cerner's Millennium system. Partnership DMC-ODS plan, which includes for seven counties, uses the HMS Healthcare's Essette EHR. Of the rest of the DMC-ODS plan vendors include the Echo Insyst, which is used by three counties, FEI/WITTS by two counties, and Krasson system by a single county.

As pointed out in the FY 2020-21 EQRO annual report, 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. However, during the FY 2021-22 reviews, CalEQRO noted that several counties were actively negotiating with new EHR vendors or planning to implement new EHRs in the next two years. This includes the CalMHSA proposal to bring counties together into a semi-statewide collaborative to design, procure and implement a new Enterprise EHR solution that will support both current and future behavioral health business needs. These new vendors are promising to meet the needs of better systems integration and health information exchange (HIE) with other adjunct service providers.

Hosting of County EHR Systems

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. With the challenges of system change hiring, and retaining qualified technical staff are added to the equation the cost-benefit ratio generally makes for a compelling case. Vendor-hosting counties vary in size and most have implemented, or are in the process of implementing, a system that has core components that support EHR functionalities for the DMC-ODS even as counties themselves only deliver 20 percent of the services statewide at this time.

Figure 9-2: DMC-ODS County EHR/Practice Management System Hosting

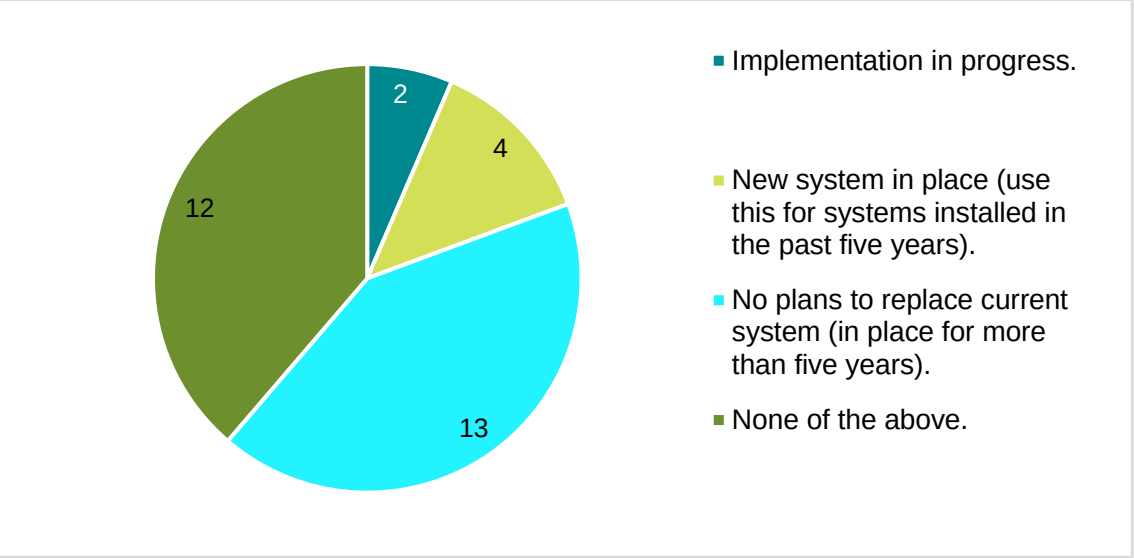


The largest group of counties (48 percent) rely on the EHR vendor to host their HIS. Another thirteen counties (42 percent) rely upon County staff, whether it be the County IT Department, Health Agency, or BH. The remaining 10 percent rely upon a third party.

A number of factors including cost-benefit and risk management are considered in deciding the best hosting arrangements for the EHRs. Typically, large and medium counties that have more robust staffing and infrastructure are able to host their own systems at the BHS, health IT, or the county IT level. Smaller counties are more likely to employ the EHR vendor or an ASP to host and manage their EHRs.

EHR Replacement Status

Figure 9-3: DMC-ODS County EHR Replacement Status



During the FY 2021-22 review cycle, CalEQRO observed significant changes in the BHS EHR landscape in California. While 42 percent of the DMC-ODS counties indicated that they have no plans to replace their current EHRs, 39 percent indicated in their ISCA that none of the categories apply to them. During the reviews, CalEQRO found that these counties are considering EHR changes with no firm plans or contracts in place yet. Additionally, 13 percent of the counties indicated that they have a new system in place in the previous five years, and another 6 percent were actively implementing a new EHR.

Those counties that use the CCBH EHR including those whose EHR is hosted by Kingsview, are forced to consider new EHRs since Cerner announced the end of software updates and support for its CCBH EHR by the end of 2023. Coupled with this, there is also an impetus to bring the EHRs up to the standards that will be needed to conform to many of the CalAIM requirements for HIE and integrated care. Multiple counties anticipate moving to the CalMHSA innovation project EHR noted earlier in this report. Further, the EHR platforms often lack one or more of the functionalities discussed below, a situation that needs to be remedied to improve care and making sure that ASAM transitions are seamlessly recorded in EHRs.

Availability of Telehealth

The past two years of the pandemic have clearly shown that delivering services via telehealth benefits both the client and healthcare practitioner. For the client, telehealth expands access to care by overcoming the transportation challenges that are often a barrier to services. For providers, telehealth allows for the convenience of service delivery from existing locations and may allow them to serve clients more efficiently. Counties have shifted to a variety of telehealth models, taking advantage of state and federal flexibilities/waivers, adjusting service delivery models to include both in-person and video conferencing, and when possible, providing

technology to clients who could not otherwise afford it. Telehealth also helps to support NA requirements and offers more flexibility to both clients and providers who are in remote areas of California.

All DMC-ODS plans offered some telehealth services. The 31 DMC-ODS plans had ramped up their telehealth services since the beginning of the pandemic in 2020. CalEQRO had observed in the FY 2020-21 annual report that contract providers in all counties had some telehealth capabilities depending on the suitability of such for any given modality of services.

While CalEQRO noted a rapid deployment of telehealth in counties with many committing to making it an important service portal going forward, some challenges remain. These are due in part to outdated computers, phones with limited bandwidth, clients' access limited due to cost to access, sub-populations such as the homeless who have very limited access.

Information Systems Key Components

CalEQRO identifies the following Key Components related to DMC-ODS system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. This section reviews the extent to which DMC-ODSs are fully using their EHR technology, both for accurate Medi-Cal claiming and for using that data to inform understanding of the service delivery. Optimal use of an EHR includes interoperability and use of the EHR as the medical record across the entire service delivery system. If the EHR does not include all services provided to a beneficiary, treatment planning and analytics based on services are limited in usefulness. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SUD delivery system and organizational operations. It also requires that the technology and program leadership work closely to mutually understand the data needs and accurately define what data needs to be extracted for the stated programmatic purpose.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.[41]

[41] Detailed definitions for each of the review criteria in the Key Components form can be found on the CalEQRO website, www.calegro.com

Table 9-1: Summary of IS Key Components, Statewide

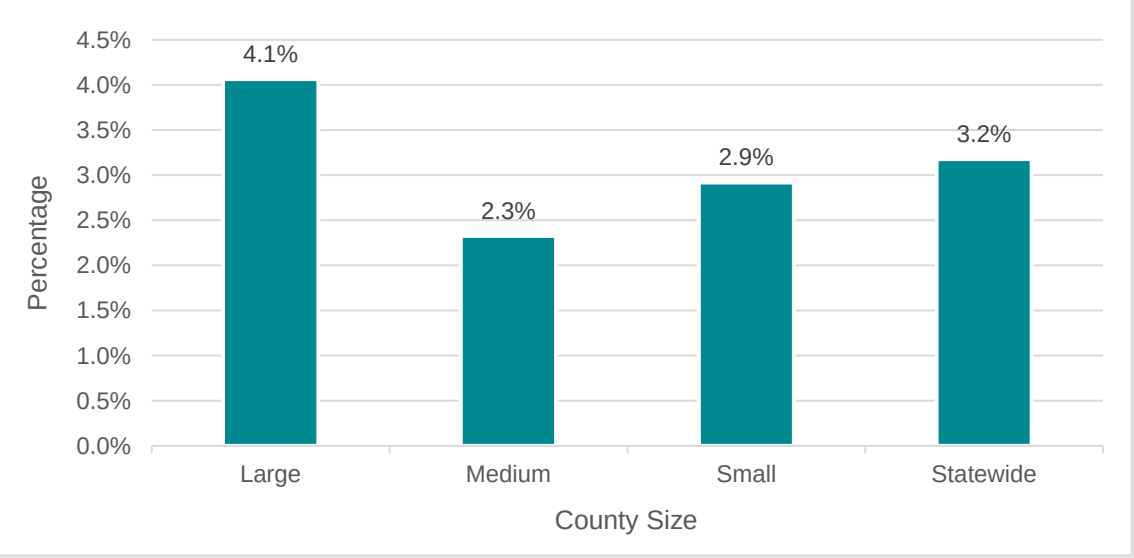
KC #	Key Components – Access	Met	Partially Met	Not Met
4A	Investment in IT Infrastructure and Resources is a Priority	27	2	2
4B	Integrity of Data Collection and Processing	15	16	0
4C	Integrity of Medi-Cal Claims Process	25	6	0
4D	EHR Functionality	23	2	6
4E	Security and Controls	18	13	0
4F	Interoperability	17	11	3

Four DMC-ODS plans (13 percent) – **Alameda**, **Kern**, **Merced**, and **San Mateo** – met all six Key Components related to IS.

Investment in IT Infrastructure

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

Figure 9-4: IT Budget by County Size, FY 2021-22



Statewide the DMC-ODS plans spent an average of 3.2 percent of their total budget on IS. But there were some variations by county size. Large counties spent the highest percentage at 4.1 percent, while the medium counties spent the least with an average of 2.3 percent, the least

amount statewide. By contrast, small counties spent 2.9 percent of their total budget on IS, which is the closest to the overall statewide average.

The percent allocated for IS within a budget is likely an indicator of some factors regarding their decisions about hosting the systems that a county made. Large counties are more likely to host their own EHRs which allows them to tailor IS functions to their unique need, but this can also be a more expensive option. Counties relying on their vendor or an ASP to host their EHRs may be a more cost-effective option for them given their needs or limited funding.

The percentages also show that regardless of the scale of operation and the number of beneficiaries served, IS costs cannot be lower than a baseline. That baseline appears as a higher percentage of the total budget in the case of small counties.

Figure 9-5 shows the FY 2020-21 average authorized technology and analytical resources in DMC-ODS counties, measured in FTEs (full time equivalent).

Figure 9-5: Technology and Analytics Average Staffing by County Size, FY 2021-22

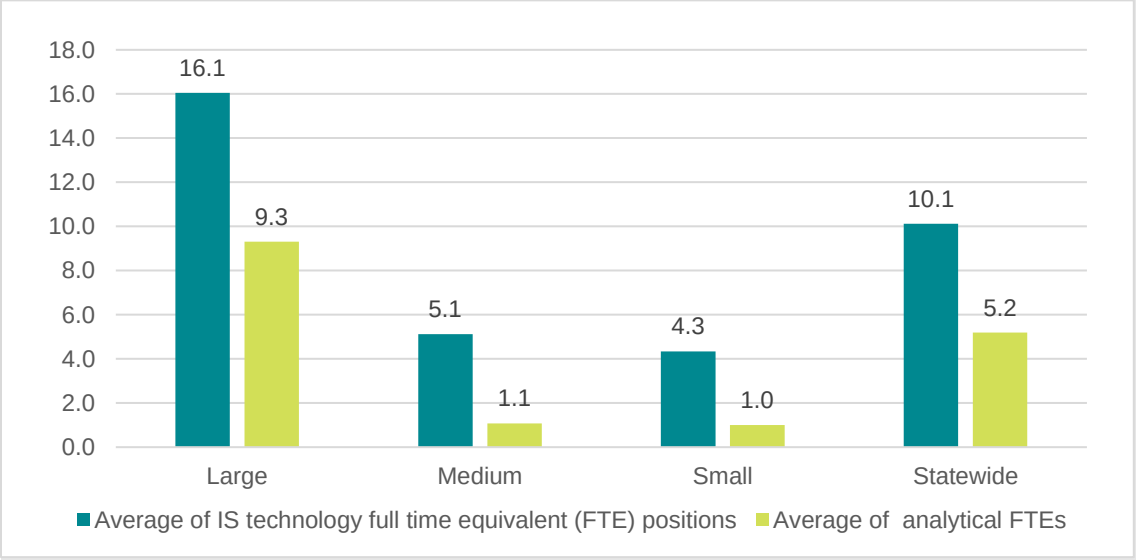


Figure 9-5 above denotes that regardless of county size, DMC-ODS plans typically have more IT personnel than analytical staff. Staff allocations for analytical staff FTEs is exactly half of the IT FTEs on average, statewide. The gap is larger for medium and small counties, but less pronounced among the large counties. This is reflective of more in-house data analytics capacity among larger counties that CalEQRO has generally noted.

Not surprisingly, large counties have the highest number of FTEs in both categories, and significantly more than the medium and small counties. Although the small counties as a percentage of their total budget spend more on their IS, their IT FTE is still slightly smaller than the medium counties and the analytical FTE is the same as the medium counties. This indicates that the higher percentage does not translate to more dollars since the small counties' total budget is typically significantly less than that of the medium counties.

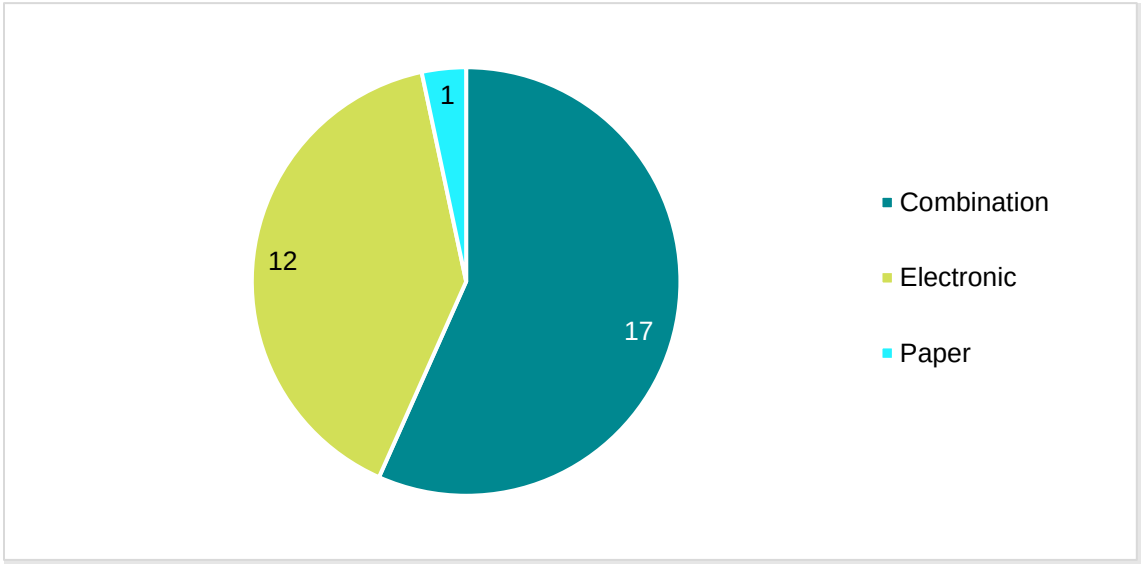
It is generally acknowledged that below a certain threshold of IT and data analytics staff capacity, DMC-ODS counties will not be able to realize the potential benefits of their EHRs or their practice management systems. Numbers matter, especially as the DMC-ODS county operations become more complex. However, the numbers alone noted above may not tell the full story. Some small counties have long-term legacy staff and while limited in number carry added value in their experience and expertise. Likewise, some counties may include analytics staff in other technology or quality divisions or units. If part of a larger agency some analytics and technology staff resources at the agency level, while not dedicated to DMC-ODS, can be tapped to provide necessary supports. Finally, some counties have relationships with universities, consulting organizations, or even their system vendors. These organizations provide data analytics services that may have added resources of corporate or academic institutions and provide the DMC-ODS counties with good value and results.

Data Integrity

Data integrity refers to the overall accuracy, completeness, and consistency of data. It is maintained by a collection of processes, rules, and standards implemented to support core EHR functionality. When the integrity of data is secure, the information stored in a database will remain complete, accurate, and reliable no matter how long it is stored or how often it is accessed.

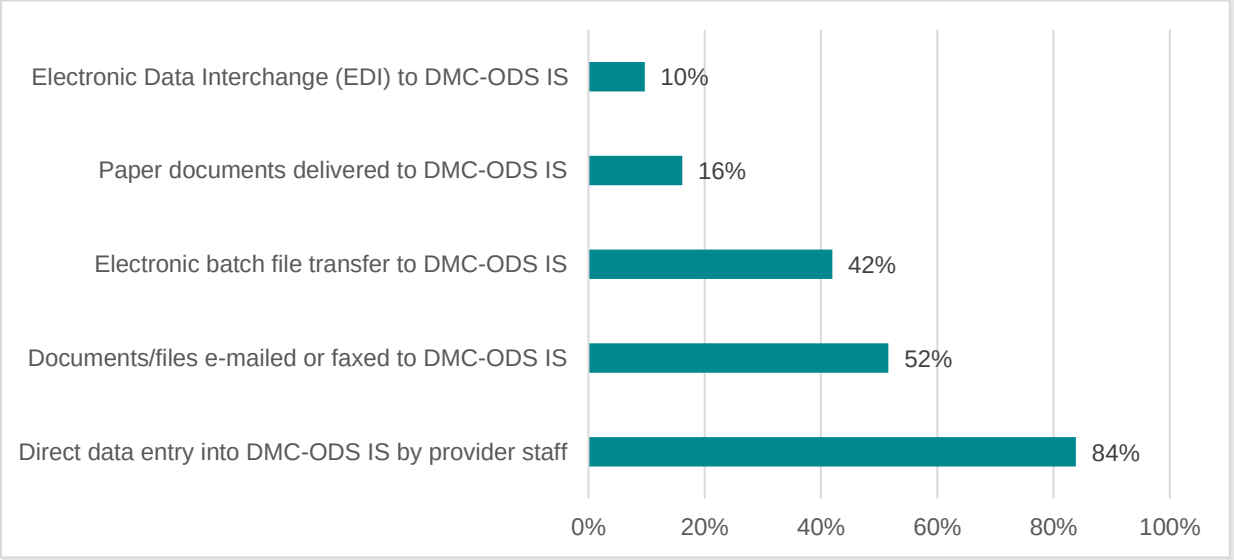
Health records are rated functionally as electronic, paper, or a hybrid which has both electronic and paper that support clinical operations. The most efficient method for clinic operations is a fully EHR model. The other two models require providers to initiate requests for a client's health record from a chartroom and review paper record documents along with viewing EHR screens for an overview of the client's treatment history. When the data transfer processes are not fully automated, this often leads to manual solutions to data submission, extraction, and analytics for fulfilling reporting requirements.

Figure 9-6: DMC-ODS County Chart Environment



In FY 2020-21, 40 percent of the DMC-ODS plans (12) indicated that their client charts are fully electronic. The largest group of counties, 57 percent (17), maintain the records in a combination of both electronic and paper formats. Only one DMC-ODS plan reported having their beneficiary charts in a fully paper format. This is down from three counties that reported paper charts of record for the previous year; the two counties that converted away from a paper chart have moved to a fully electronic record.

Figure 9-7: Contract Providers Data Submission Modalities, FY 2021-22



Note: *The percentages do not add up to 100 percent because many DMC-ODS plans employ multiple modalities of data submission. Rather, each bar represents the percentage of DMC-ODS plans that utilize that particular modality of data submission.*

Data submission methods vary by both the DMC-ODS plan and the contract provider technological and staffing capabilities. For more than 80 percent of the DMC-ODS plans, contract providers can input their beneficiary data directly into the county DMC-ODS EHRs. For more than 50 percent of the plans, the contract providers can send the data by email; for 42 percent of the plans, they can transmit data through electronic batch transfers; and for another 10 percent of the plans, the contract providers can submit data through EDI. For less than 20 percent of the plans, some contract providers still deliver paper documents to the county DMC-ODS plans. However, it should be noted that within the same county, different data transmittal or entry methods may be simultaneously used by different contract providers.

Medi-Cal Claiming Integrity

The integrity of the Medi-Cal claims requires data integrity, rated above, and further examines that claims processing includes the presence of policies and procedures to administer the Medi-Cal claims process effectively, eligibility verification procedures in place to ensure appropriate Medi-Cal services are claimed, and that claims are submitted in a timely and accurate manner. The claims denial rate is an objective measure of the integrity of DMC-ODS' claims processing.

Of the 31 DMC-ODS plans, 81 percent (25) met the key component that evaluates claiming integrity, and the remaining 19 percent (6) warranted a partially met rating. A well-managed claims system with proper documentation lowers the risk of denied claims from the state, as well as that associated with any future audits.

For counties in the process of new EHR implementation, and those planning to do so in the near future, maintaining a strong process for the integrity of the Medi-Cal claims is critical for generating accurate and timely revenue production throughout implementation.

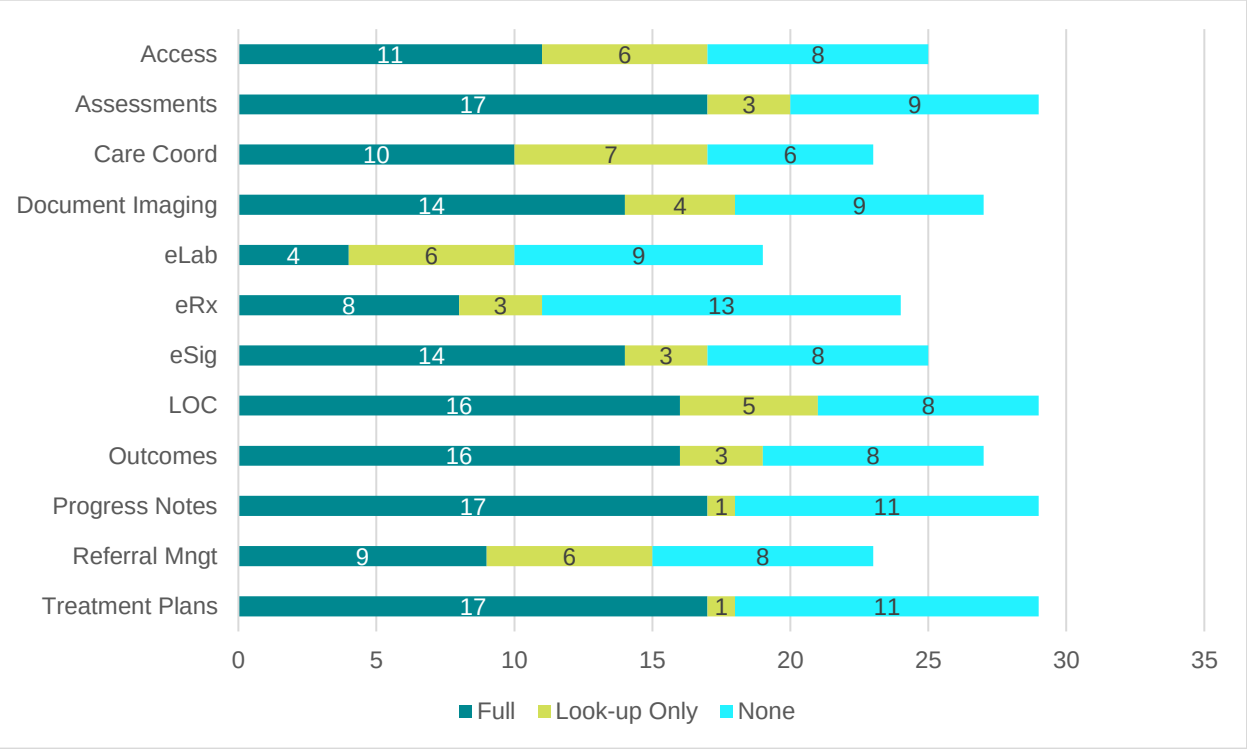
EHR Functionality

While most DMC-ODS EHRs have some degree of core EHR functionality in place, 19 percent (6) received a Not Met rating on Key Component 4D (Table 9-1). Moreover, the DMC-ODS provider network of contractors generally does not 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 for that reason.

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, along with manual tracking is very common which in turn has implications for full reporting and tracking of the necessary areas designed to gauge system performance.

Figure 9-8 describes the levels of EHR functions present across the DMC-ODS counties.

Figure 9-8: DMC-ODS County EHR Functions



Assessments, treatment plans, and progress notes are the common functionalities that most counties provide their contract providers full access to, followed very closely by LOC and outcomes. All of these functionalities account for over 50 percent of contract providers' full access. When the look-up access is added, LOC was the most commonly afforded functionality followed closely by assessments.

In contrast, electronic lab orders (eLab), prescriptions (eRx), and referral management were the functionalities with limited contract provider access. The lack of these functionalities, or contract provider access to them, point toward more manual or mechanical transmission of these information.

Security

CalEQRO evaluates the safeguards or counter measures present in DMC-ODS IS to avoid, detect, counteract, or minimize security risks to physical property, information, computer systems, or other assets. Of the 31 DMC-ODS plans, 58 percent (18) met the key component that evaluates IS security, and the remaining 42 percent (13) warranted a partially met rating.

In general, the DMC-ODSs have strong security and controls over their systems. For many MHPs, this is a bifurcated function reliant on both the EHR vendor or the ASP, and the county operations at the MHP, agency, or county levels. Often the EHR back-up and restoration process after any maintenance or interruption events are the responsibilities of the vendor or the ASP. The MHP, larger integrated agency, or the county is often responsible for the

maintenance of other critical functionalities including internet security, network connections, e-mails, and other communications.

During the FY 2021-22 reviews, CalEQRO found that DMC-ODS IT departments do not always maintain their own business continuity plans (BCPs) in the event of a natural disaster or cybersecurity issues. In some instances, the DMC-ODS was unaware of current BCPs maintained by the county IT departments that may be called upon in the event of such untoward events. CalEQRO made several recommendations on this issue to several DMC-ODS'. This landscape explains a large percentage of partially met ratings for this key component. Given the state's experiences with fires that have interrupted internet capabilities in affected areas, the need for a BCP has become clearer to DMC-ODS leaders over the last few years.

Interoperability

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

In FY 2021-22, none of the 31 DMC-ODS plans used an HIE, which is a more efficient method for two-way exchange of client data between EHR systems. While counties and vendors are prioritizing work to implement core systems for billing and state data reporting requirements, lingering concerns regarding federal confidentiality laws pertaining to SUD remain a barrier to a more fully integrated information system.

Information Systems Summary

As the DMC-ODS plans continue to evolve, their EHR operations have continue to develop further. One of the main aspects of this has been a surge in the number of counties implementing new EHRs and those actively considering or searching for a new EHR. Alongside the new demands for data exchange and systems integration requirements of CalAIM, DMC-ODS plans are looking ahead to a better EHR infrastructure that will enable them to improve quality of care, while at the same time enhance their reporting of data for both external and internal stakeholders. One of the major EHR systems getting close to its end of vendor support has also been a catalyst for EHR changes for a number of the counties that currently use that EHR.

Another change has been in the area of conversion of more information and beneficiary records to electronic format. At least two counties have been able to move from only paper-based to fully EHRs. A majority of the DMC-ODS counties have the basic functionalities such as assessment, progress notes, treatment plans, outcomes, LOC in their EHRs, and provide full or look-up access to the contract providers.

Contract providers are a major part of the DMC-ODS service delivery system, and as such, their access to EHR is a critical component of ensuring quality of care and care transition of the beneficiaries. Integrating contractors into the county EHR as full partners has the potential

to create a more seamless interface that can only benefit the DMC-ODS system and the clients they serve. Capacity for this remains very limited across the state. Counties also continue to lag behind in e-prescription and e-lab functionalities in their EHRs.

In terms of meeting the infrastructural needs as evidenced by budget and staffing, the large DMC-ODS plan have an edge in both with higher percentages of budget allocations for IS, and higher numbers of both IT and analytical FTEs. However, the small and medium counties make up for their lower spending and staffing through their EHR hosting decisions and ensuring greater efficiencies at a lower cost.

Telehealth continued to be a significant mode of service delivery as the pandemic situation stayed volatile during FY 2021-22. The significant investment that the counties made in telehealth infrastructure, has made all DMC-ODS plan counties to be flexible in switching between telehealth and face-to-face services. Telehealth infrastructure has also afforded additional access to outpatient services for individuals residing in remote areas or with significant transportation challenges.

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. Given the implications of CalAIM the promise of the semi-statewide EHR overseen by CalMHSA aspires to provide for these essential upgrades in 2023. Finally, as SUD overdoses as well as mental health crises are rising in the Medi-Cal and general populations, system supports for these critical behavioral health services have never been more needed.

Conclusion and Recommendations

Introduction

CalEQRO reviews were characterized by multiple common themes. In addition to the lingering impacts of the COVID-19 pandemic and associated public health restrictions, recurrent outbreaks impacted some counties with high infection rates to the extent that all programs within the DMC-ODS had go into quarantine, restrict client access, shut down or handle staff shortages due to illness. Despite best efforts to maintain services through the pandemic, contractor and county staff have continued to report a profound level of exhaustion with the extended crisis and its impact on staff and programs. As noted earlier, external factors were not limited to the pandemic and have included recurrent catastrophic wildfires and the impact of regional response on communities, staff, and programs.

During this past review cycle a universal shortage of workforce resources was also noted. Some counties noting “we have the funds, but we just can’t find anyone to take the positions.” Many legacy staff, having worked remotely for more than two years, sought employment elsewhere to retain a remote work lifestyle. Additionally, there is a shortage of qualified and experienced staff. Many providers reported training newly “registered” (unlicensed) staff only to see them leave for better paying jobs once some experience is gained. For the remaining staff, reviews noted (not just from county administrators and programs, but the clients interviewed in focus groups) that employees are over-tapped with large caseloads, job duty expansion and the resulting stress and burnout levels are noted in may programs as high. Additionally, some counties are reporting more retirements, leaves due to illness, and obstacles to hiring.

Recognizing the significance of the behavioral health workforce crisis, DHCS sponsored the 2021 California Behavioral Health Workforce Assessment, wherein 1,602 mental health and substance use professionals and paraprofessionals participated; the report contains valuable information, insights, and recommendations to address this crisis.[42]

On a more positive note, policies from DHCS related to recovery services and residential treatment are providing more guidance and flexibility for the programs. This even as DMC-ODS counties take steps to increase capacity and interest (by both staff and clients) in securing Waiver-based adjuncts to care such as RSS and case management. There is also a general sense of optimism with changes anticipated with CalAIM as 2022 has required administrative and operational resources to meet new milestones of implementation. For SUD providers, changes related to peers, medical necessity, and working on finance reforms, and

[42] *2021 California Behavioral Health Workforce Assessment*, Center for Applied Research Solutions

expanded case management models foretell even more positive collaborative efforts with healthcare partners. The optimism and support for improving services for youth and persons with mental illness and SUD is very encouraging.

Consistent with a strong commitment to the field and the Medi-Cal population, there is increased focus particularly toward the most vulnerable subpopulations. CalEQRO notes that QI efforts are supported with a greater focus on outcomes, the therapeutic alliance, and concrete results of individuals getting better. However, system utilization down to the program and staff level of data linked to CalOMS or the ASAM continue to indicate a need for further development or pathways to improve care. Many of concerns are either linked to care coordination or visibility of patient information limited by lack of unified EHR and/or federal confidentiality regulations that oversee SUD treatment.

Aside from these system and external challenges counties have continued to do some impressive work at both stabilization and expansion of their DMC-ODS system of care. Beyond their own networks, coordinated projects with key partners such as FQHCs and inmate services have yielded a de facto expansion in capacity within each county for Medi-Cal beneficiaries. And despite labor challenges, new strategies to build the workforce and infrastructure to prepare for CalAIM are underway.

DMC-ODS plans have continued to take an active role within their respective communities to bring awareness and actively work on mitigating the impact of the drug overdose epidemic. As noted earlier in this report, nationally as well as in California there has been a surge in overdose fatalities, largely attributed to the increasing and presence of fentanyl. CalEQRO discussed local realities in every county and noted many are active in distribution of fentanyl strips, overdose reversal training, naloxone distribution and community messaging. While this struggle with fentanyl and other drugs also contributes to the unintentional deaths is clear, this epidemic does not have easy answers. However, DMC-ODS Plans are working in unison with local opioid safety coalitions, with a clear focus on prevention and access to care in an effort to provide life-saving treatment and MAT.

Access to Care

Based on review of available data for FY 2021-22, along with receding restrictions from the COVID-19 pandemic, and the system enhancement afforded under CalAIM, CalEQRO projects continued expansion of service delivery capacity, an increase in the number of clients served and an overall increase in the services delivered across many LOCs. This is consistent with results and data since the onset of the DMC-ODS Waiver which indicates ongoing gradual improvements demonstrating their potential for SUD recovery and wellness for the clients served.

However, as stated earlier in this report, some DMC-ODS treatment services have yet to reach their full potential for improving client outcomes. Services such as RSS are just beginning to be utilized to support clients with community integration and ongoing support, with many DMC-ODS Plans having only fledgling support from both programs and clients to access them. Treatment for youth in most DMC-ODS Plans remains markedly underutilized, expansion of which will require re-engagement of key partners such as probation and the schools along with

in-place prevention projects. 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 and the upswing in utilization remains encouraging, though it is still not accessed or available in some counties. MAT has improved statewide in both NTPs and in non-methadone MAT outpatient programs, yet the NA requirements show many zip codes where NTPs are needed to meet NA requirements. Similarly, a gap in visibility because of the structure in Medi-Cal billing limits CalEQRO from having full view of the coordinated effort that may be occurring between the DMC-ODS and its healthcare partners. Despite gains in recovery housing local shortages of available options continue to be a critical access gap for those clients stepping down from intensive episodes of treatment to lower LOC.

The underserved populations in specific ethnic groups, non-English speakers, disabled groups, and older adults have specific access and cultural linguistic needs that must be met for access to occur. Efforts and initiatives by DMC-ODS Plans to outreach and engage clients to mitigate health equity issues are often well documented in their cultural response plans though data clearly shows these areas continue to need improvement. Incorporation of telehealth as a routine way to deliver services (when and where clinically appropriate) along with efforts to streamline access protocols or institute low barrier access points have also been a promising development as the DMC-ODS' gain years of experience in service delivery.

Besides the specific service gaps themselves, workforce challenges persist for physicians, prescribers, LPHAs, and SUD counselors. This was a common theme shared with CalEQRO at nearly every county and contractor leadership session. Local efforts which have identified workforce as a key challenge have made some inroads, but broader support at a state level appears indicated. As noted earlier in this report, the use of paraprofessional system navigators or peer projects which provide training to those with lived experience, remain an underutilized part of most local workforces; they could play a supportive role as navigators, in MI, and assisting with transitions in care and case management functions.

Timeliness and Network Adequacy

Like access, overall the timeliness metrics which are tracked by the DMC-ODS have improved over the past review year, though exceptions are noted in some of the areas tracked including initial appointments, urgent service requests and transitions of care. As noted earlier in this report, challenges often converge for smaller counties, which typically have limited resources, or systems with more contractors limited by paper charts, and many still on different practice management systems. Consistent with past CalEQRO annual reports, a core recommendation continues to be to look systematically at the HIS infrastructure funding and options for behavioral health integration of information systems. DMC-ODS' that have signed on to the semi-statewide EHR project spearheaded by CalMHSA are anticipating that such data tracking and reporting needs will be satisfied with the new system comes online in 2023.

The challenges with urgent appointments remain complicated because definitions vary, and tracking systems are unclear and inconsistent. With just a general standard for direction, based on the paucity of contacts meeting their criteria, some DMC-ODS' are very likely

under-reporting on this critical care metric. This is an area that would benefit from new or more detailed clarifications from DHCS, so it is easier to measure consistently and easier to define when it is achieved. Similarly, follow-up activities and service for clients who exit residential treatment vary across the DMC-ODS counties, with some showing low levels of successful engagement, given the available approved claims data. More clarity on what should constitute a post discharge contact would be helpful, while at the same time balancing the high value of current strategies for follow-up that may be not Medi-Cal billable.

Each DMC-ODS Plan annually has submitted a detailed NACT to DHCS for evaluation of key standards related to important time, distance and capacity standards. Over the last year DMC-ODS Plans submitted AAS requested for zip codes with time or distance challenges outside of the standard requirements. Ultimately these were approved, often pertaining to limited access for opioid treatment for youth. CalEQRO noted a range of solutions which were developed with providers, and transportation resources to address the needs of clients living within remote areas. Strategies included telehealth, telepsychiatry with X-waivered physicians, and cooperatives with FQHC primary care clinics often sited in more remote areas. Residential service closures by adolescent treatment programs required many DMC-ODS counties to obtain agreements with providers in surrounding counties or areas to accommodate treatment needs even as they continued to solicit for local providers to fill the gap. Telehealth as noted above has become a regular part of the service delivery model, though limitations on its value is felt most acutely by groups who often have limited resources and access to technology.

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, including some modest gains in certain areas supported by evidence of change from TPS, CalOMS, and most PMs.

As noted earlier in this report, quality evaluation included a review of the system’s capacity to provide services across all LOC as well as determinations for placement. This revolved around the accuracy of the ASAM congruence with assessment findings to recommended treatment needs. Over the past review cycle counties continued to make modest gains in expanding the capacity and types of services available in their continuum of care to best meet the assessed needs in their community with ASAM results indicated that less than one percent of clients were placed in an alternate LOC due to lack of resources.

TPS results client stakeholder focus groups are also part of the evaluation and remain a strong indicator that clients are securing the help they need. So, even as DMC-ODS continued to seek an increase in responses to the TPS administration, current year results indicate that the overall percentage of clients attest to positive outcomes. Surveys results have remained high despite the many COVID-related disruptions to clinical care limiting face-to-face contact with counselors and support groups. Utilization of EBPs such as MAT may be correlated to such satisfaction, as year over year increase of non-methadone MAT saw an 11.8 percent increase. 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. Primarily as noted earlier, this took form in workforce recruitment and retention issues across all the disciplines present in DMC-ODS programs. Impacts were noted by clients in focus groups who saw staff being pulled in many ways, unable to manage an expanding workload as they shared their own inability to secure needed services. Counties have continued to press forward in attempting to address their vacancy rates but note a general shortage of qualified counselors and clinicians.

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—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 were shared by many stakeholders and clients. 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.

Case management and coordination of care gained visibility in the DMC-ODS systems reviewed this last year, especially due to COVID-19. Case manager activities frequently involve following clients across LOCs and conducting extensive outreach to help them to either engage or stay engaged in treatment. In many ways, their approach has been more intensive than the past clinical model of case management. The more intensive case management activities, along with an increase in its use, has led to improving the smooth and seamless transitions in care as the percentage of clients successfully transitioning from residential treatment to a lower LOC increased from CY 2020 to CY 2021. Continued support of case management evolution in this flexible, client-centered direction is highly recommended to enhance quality.

Outcomes

The data points that support analysis of outcomes which include TPS, CalOMS, and PMs for initiation and engagement and LOS /retention are again positive and moving in the right direction. As noted earlier in this report, the percent of clients with longer lengths of stay in an uninterrupted sequence of treatments increased year over year at the defined markers of 90,

180 and 270 days. These gains may have been due in part to the focus on these important treatment elements in the Waiver STCs and in CalEQRO measures and feedback.

CalEQRO has a number of recommendations related to improvements in the outcomes area for the DMC-ODS program. First, consistent with prior year's recommendations, the number of TPS surveys collected annually should continue to expand to capture more programs, more ethnic groups representative of local communities, and include all contractors providing services and their LOCs. In order to prompt contracted providers, CalEQRO recommends these changes be included as a deliverable in local contract requirements.

Another area of potential improvement involves CalOMS. Counties have repeatedly bemoaned the cessation of automated reports from the previous DHCS-hosted ITWS platform and continue their requests for a restart of the reports in the replacement BHIS platform. It would be helpful if DHCS collaborated with counties to design a new automated reporting system that each county could then use with their own county-specific data compared to statewide results. Annual CalOMS reports provided by CalEQRO engaged county interest and in some counties inspired efforts to conduct more county-wide and program-level data analyses to use for QI. Standardized easily accessed CalOMS reporting will only increase system knowledge and necessary quality adjustments.

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.

Information Systems

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. A majority of the programs are still on paper charts or have a hybrid with some electronic capacity. However, this limits their ability to communicate electronically between the network providers and county related to client care in real time manner. A plan for HIS investments is recommended to move in the DMC-ODS health systems with standards in place in other parts of the health universe such as primary care and hospital systems. While the CalMHSA project noted before includes many DMC-ODS plans, support should be given to those who did not opt in.

Information sharing across healthcare and their respective EHR systems is a critical challenge as they share many patients where this communication is critical. For example, with many beneficiaries receiving non-methadone medications from primary care and EDs, coordination of care has become even more important for the healthcare system. This is a real challenge and continued advocacy for legislative flexibility in life and death risk situations is needed. The new HEDIS performance measure standards to be introduced for ED follow-up should be closely monitored and supported to facilitate full support of the necessary information sharing they imply.

Improvements in Billing Efficiency

Double data entry to record contract provider services remains an operational challenge and barrier for counties lacking a unified system wide information system that most county providers can access. 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. The CalMHSA semi-statewide EHR should have continued oversight by DHCS to ensure operability for all DMC-ODS functions in order to achieve data tracking and billing efficiencies.

Summary of Recommendations

Progress continues to be made by DMC-ODS counties on access, timeliness, quality, and in several early indicators of outcomes. Many noteworthy practices in these areas have been identified by counties that have demonstrated particularly outstanding metrics in these areas. Support for activities to address areas that present challenges are necessary at all levels. An articulation of this is included in the recommendations made throughout this report with select areas emphasized briefly below:

- SUD services needing expansion and added capacity to meet needs in many counties include case management**,** RSS, recovery residence housing, non-methadone MAT, youth services, and NTP services in NA identified zip codes, residential, and WM.
- Outreach and health equity efforts to reach underserved populations need to be addressed in many counties, reducing disparities in access and to assure culturally- and linguistically competent services to underrepresented race/ethnicity groups, non-English speakers, individuals with disabilities, youth, LGBTQ and older adults.
- Statewide workforce issues for this field need continued attention at various levels including the academic and state levels to meet hiring and retention needs across multiple levels and disciplines.
- Use of paraprofessionals and peers as supports within a variety of services is underdeveloped and an asset that could enhance services, particularly for navigator, engagement, and case management functions.
- Continued and ongoing use of telehealth use and flexible service models triggered by pandemic-related adaptations should continue to expand access points and reduce barriers to engagement and increase referrals to services.
- Core IS infrastructure and interoperability between counties and their networks of providers, as well as with health and hospital systems, major investments are needed in order to improve quality particularly EHRs, interoperability, and HIE options. Full support and state-level oversight are needed to ensure DMC-ODS system needs are met for those counties which have opted into the CalMHSA semi-statewide information system.
- Continued development of quality and access to outcome-tracking tools to assist in quality work is needed. Examples include the suggested re-introduction of state reports

for CalOMS, a broader distribution of TPS to all contractors and ethnic groups, and strategies to increase response rates for TPS when administered.

- Care coordination, including both RSS and case management-facilitated transitions from high to lower LOC need more focus and utilization. Treating SUD as a chronic disease warrants continued support and care coordination during transitions to all LOC.
- Affordable housing, and especially support for expanding the array of recovery residence housing options, including for those clients with children and for those stepping out of intensive programs are essential for those needing to continue their care in outpatient and MAT treatment.
- SUD stigma persists as a barrier, affecting clients and the development of new services in the community, as well as clients' access to housing, jobs, and other aspects of quality of life. Counties should continue educating their communities on SUD to reduce stigma.
- Coordinated or collaborative efforts should be supported with alternate or continued grant funding to support 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. The MAT expansion project has been highly effective in building bridges into the DMC-ODS continuum, as has more recent low barrier efforts with community partners which include sobering stations or staff working street based initiatives with homeless populations.

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 and subsequent recommendations.

Other Considerations

CMS issued a letter to DHCS 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 amended the current Behavioral Health EQRO contract with an effective date of July 1, 2022. The new contract requirements are tailored to remediate some of the CMS findings and achieve full compliance with federal statutory references related to quality assessment and performance improvement standards.

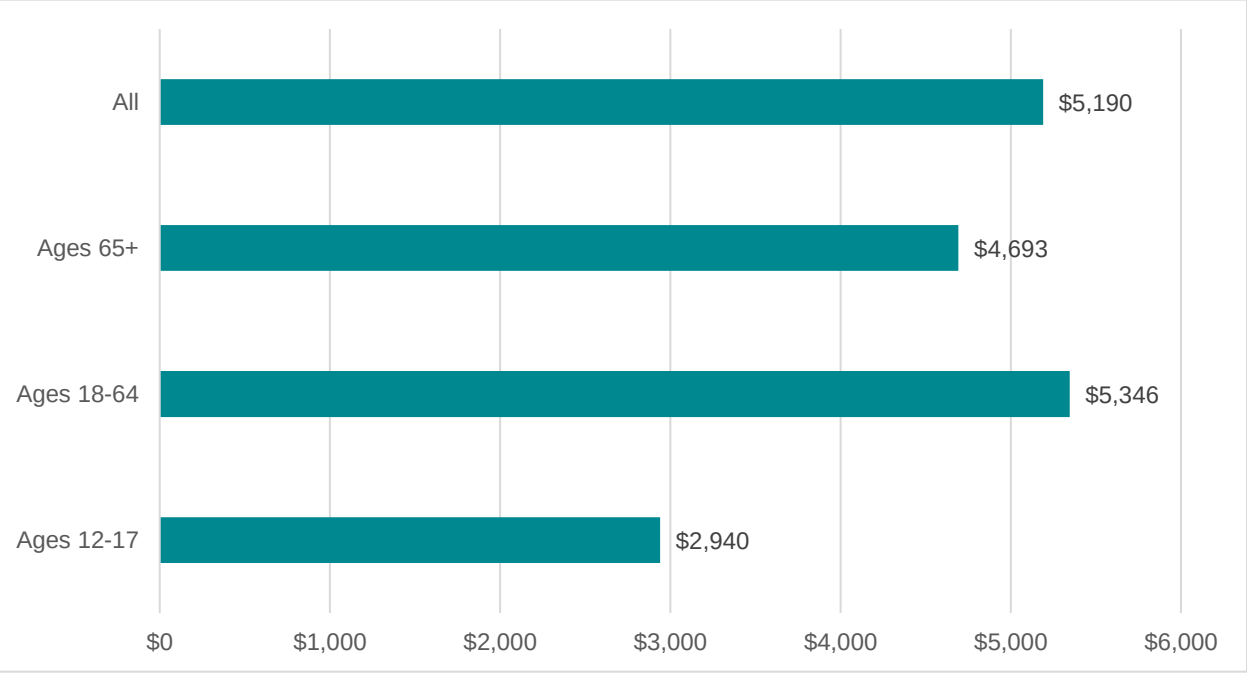
Appendix

Performance Measures Used in FY 2021-22 EQRs

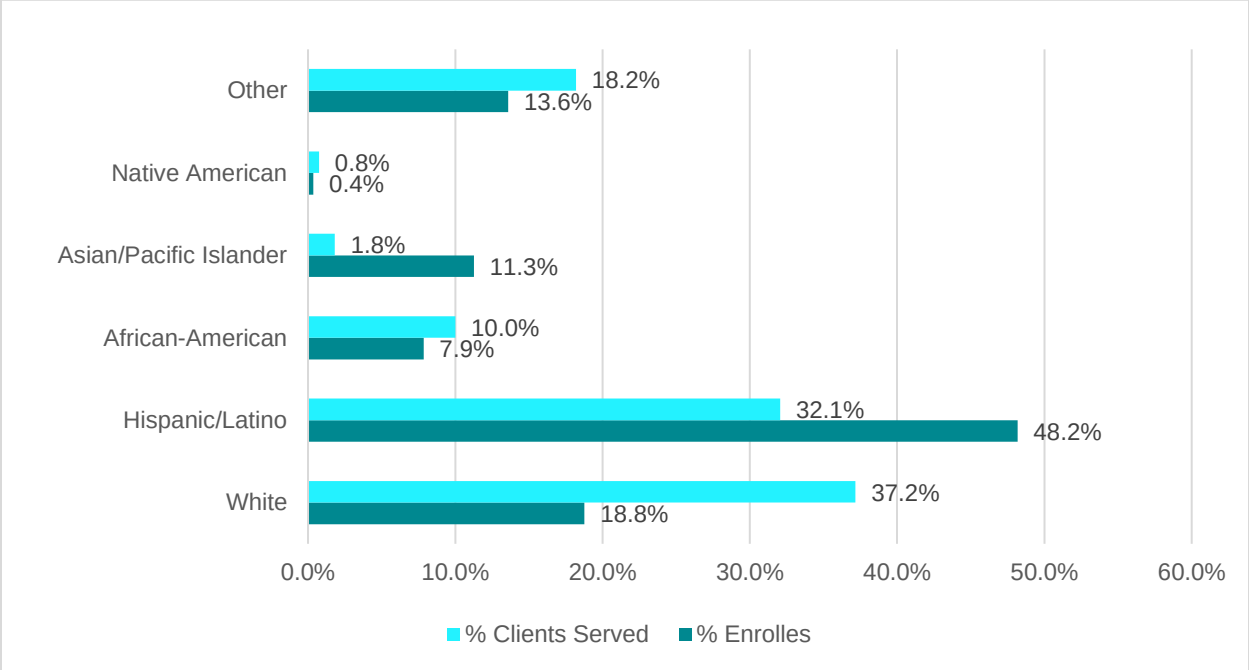
PM Table 1: Clients Served and Penetration Rates by Age Group, CY 2020

Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate
Ages12-17	1,513,060	4,107	0.27%
Ages 18-64	6,833,256	91,885	1.34%
Ages 65+	1,293,729	10,368	0.80%
Total	**9,640,015**	**106,360**	**1.10%**

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



PM Figure 2: Percentage of Eligibles and Clients Served by Race/Ethnicity, CY 2020



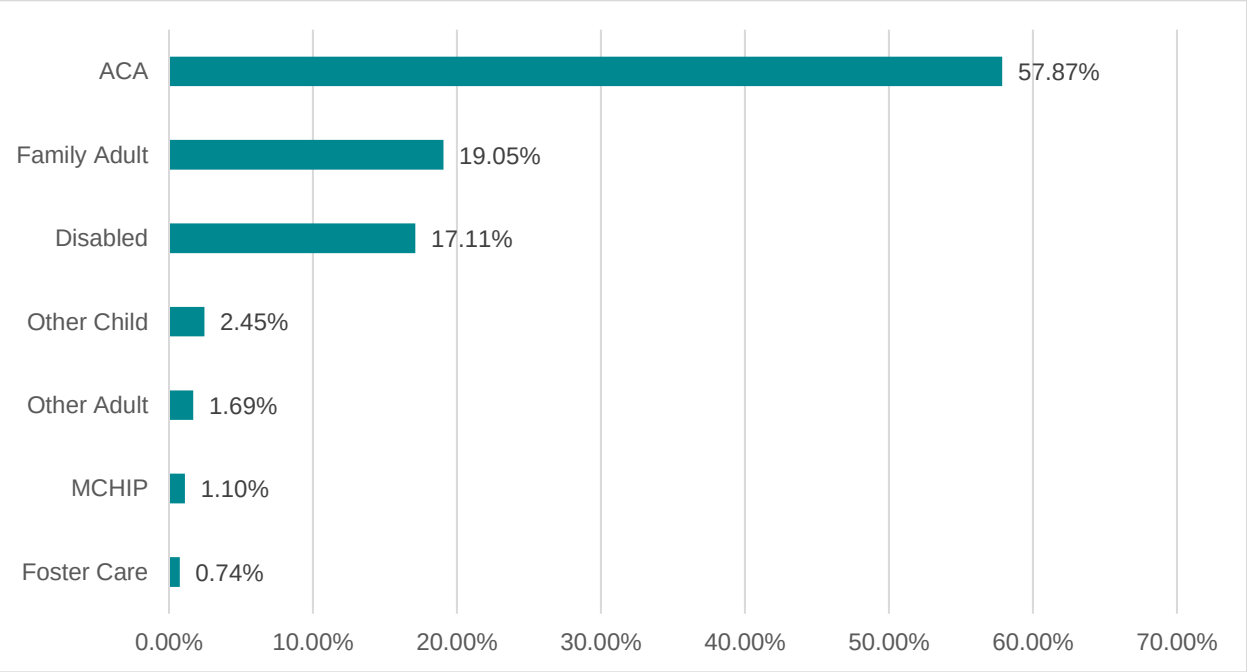
PM Table 2: Penetration Rates by Race/Ethnicity, CY 2020

Race/Ethnicity	Average # of Enrollees per Month	# of Clients Served	Penetration Rate
White	1,809,241	39,538	2.19%
Hispanic/Latino	4,643,868	34,093	0.73%
African-American	757,105	10,635	1.40%
Asian/Pacific Islander	1,085,513	1,938	0.18%
Native American	34,800	798	2.29%
Other	1,309,570	19,358	1.48%
Total	**9,640,097**	**106,360**	**1.10%**

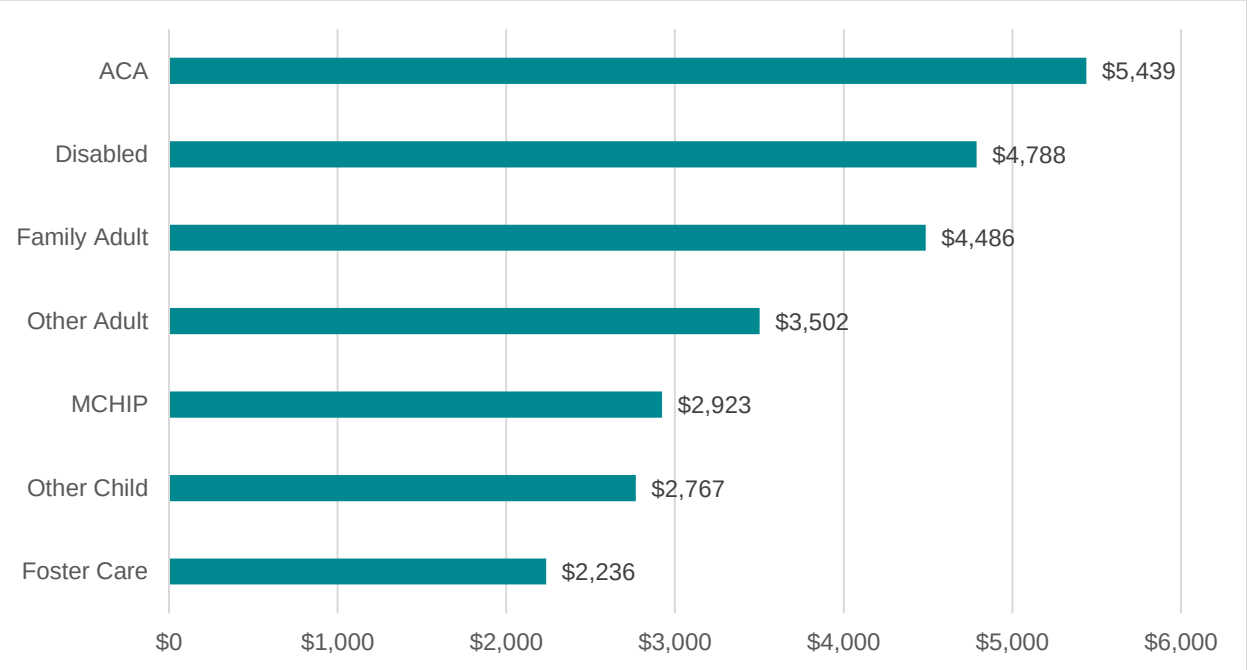
PM Table 3: Clients Served and Penetration Rates by Eligibility Category, CY 2020

Eligibility Categories	Average # of Eligibles per Month	# of Clients Served	Penetration Rate
Disabled	982,703	18,905	1.92%
Foster Care	31,942	815	2.55%
Other Child	953,877	2,705	0.28%
Family Adult	1,797,853	21,041	1.17%
Other Adult	1,544,499	1,862	0.12%
MCHIP	595,415	1,217	0.20%
ACA	3,688,402	63,930	1.73%
Total	**9,594,691**	**110,475**	**1.15%**

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



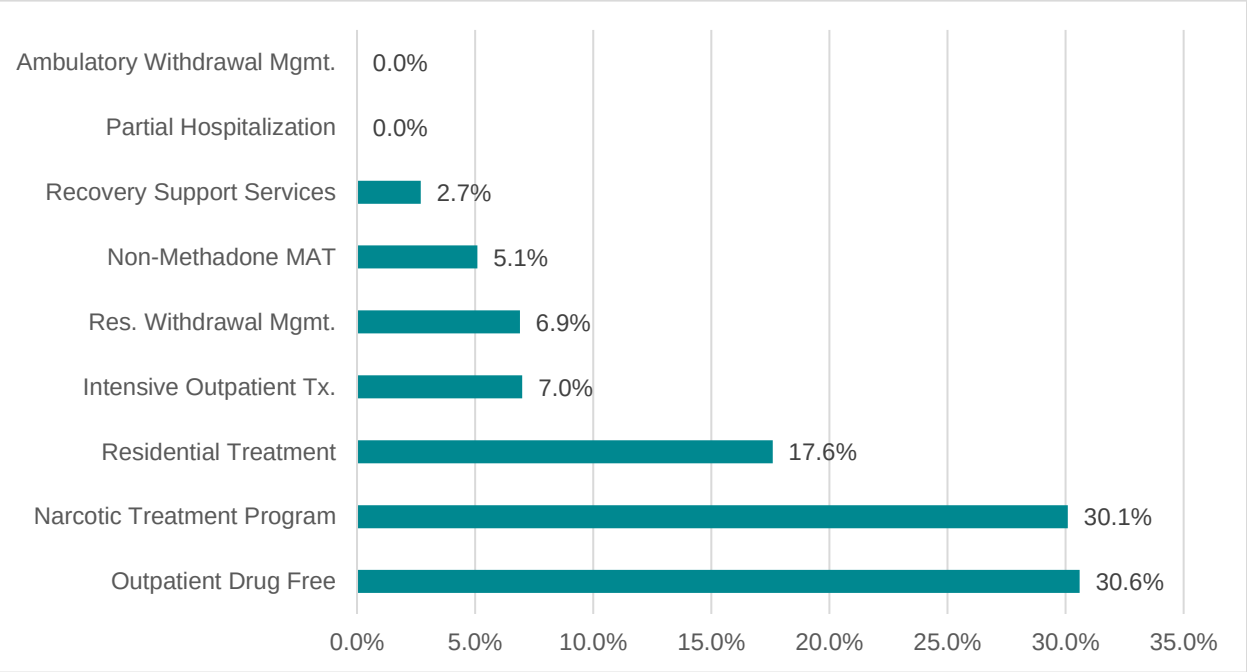
PM Figure 4: Average Approved Claims by Eligibility Category, CY 2020



PM Table 4: Percentage of Clients Served and Average Approved Claims by Service Category

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	42,257	30.1%	$4,269
Residential Treatment	24,734	17.6%	$9,368
Res. Withdrawal Mgmt.	9,672	6.9%	$2,207
Ambulatory Withdrawal Mgmt.	30	0.0%	$660
Non-Methadone MAT	7,159	5.1%	$1,271
Recovery Support Services	3,797	2.7%	$1,565
Partial Hospitalization	43	0.0%	$2,243
Intensive Outpatient Tx.	9,875	7.0%	$1,084
Outpatient Drug Free	42,979	30.6%	$2,159
Total	**140,546**	**100.0%**	**$5,190**

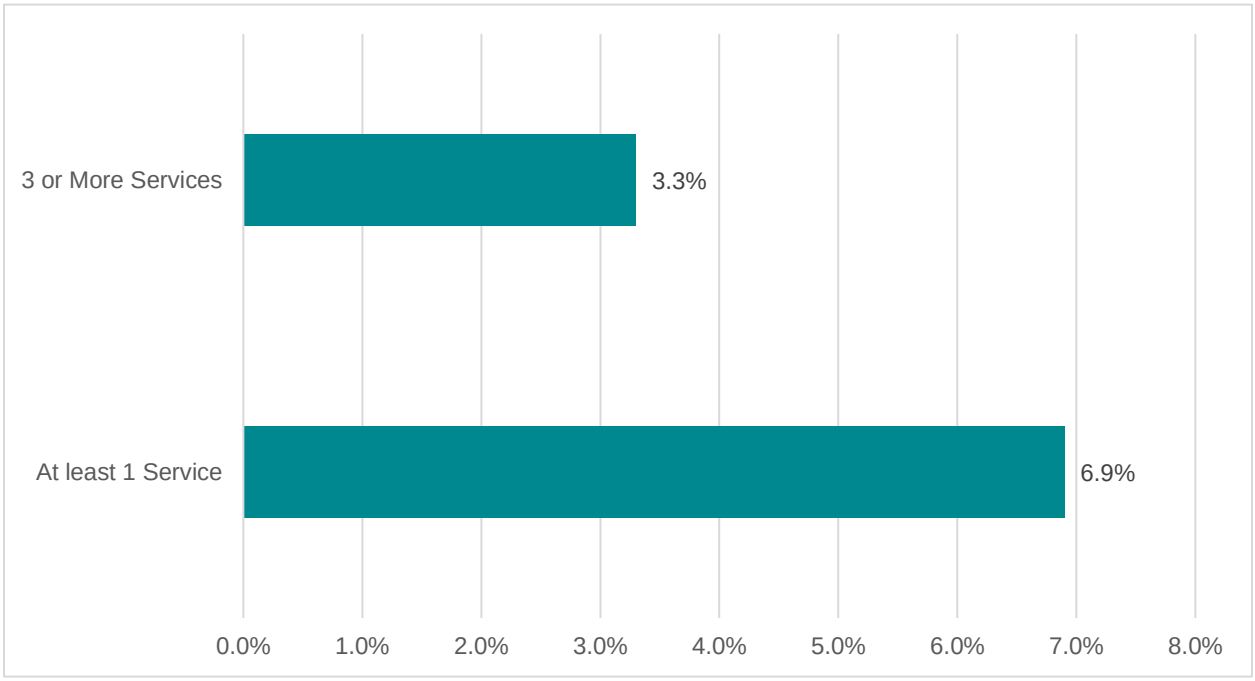
PM Figure 5: Percentage of Clients Served by Service Category, CY 2020



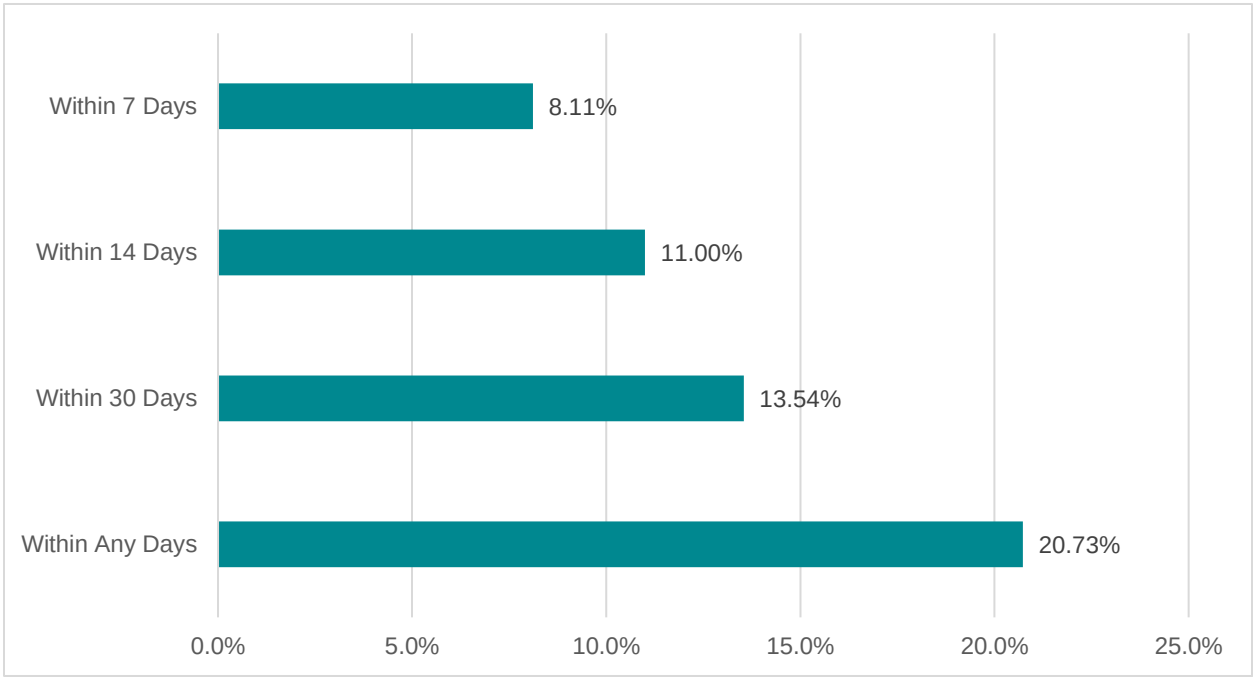
PM Table 5: Clients Served and Median Days to First Dose of Methadone, CY 2020

Age Groups	Clients	%	Median Days
Ages 18-64	33,506	80.5%	<1
Ages 65+	8,094	19.5%	<1
Total	**41,600**	**100.0%**	**<1**

PM 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



PM Figure 7: Percentage of Timely Transitions in Care Post-Residential Treatment, CY 2020



PM 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	4,108	71	1.73%	$20,373	$1,446,472
Ages 18-64	90,664	5,256	5.80%	$22,121	$116,267,388
Ages 65+	10,297	209	2.03%	$21,812	$4,558,798
Total	**105,069**	**5,536**	**5.27%**	**$20,087**	**$122,272,658**

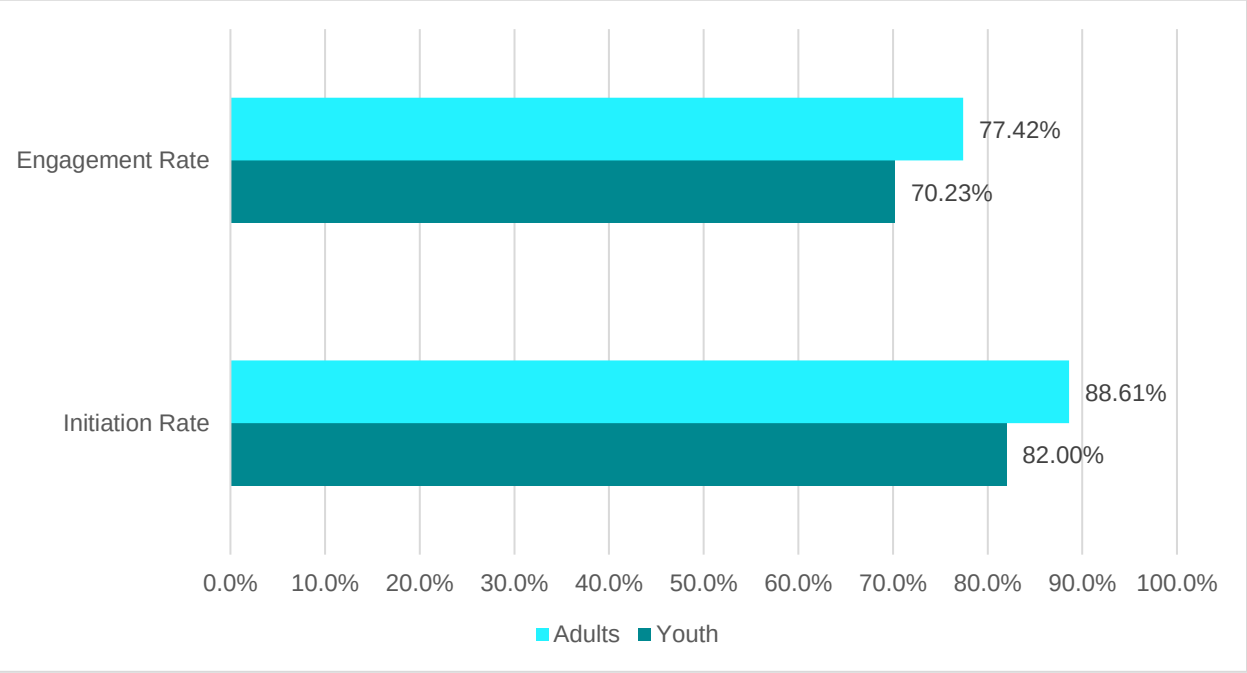
PM Table 7: Residential Withdrawal Management with No Other Treatment, CY 2020

DMC-ODS Counties	
# WM Clients	**% 3+ Episodes & no other services**
9,553	3.53%

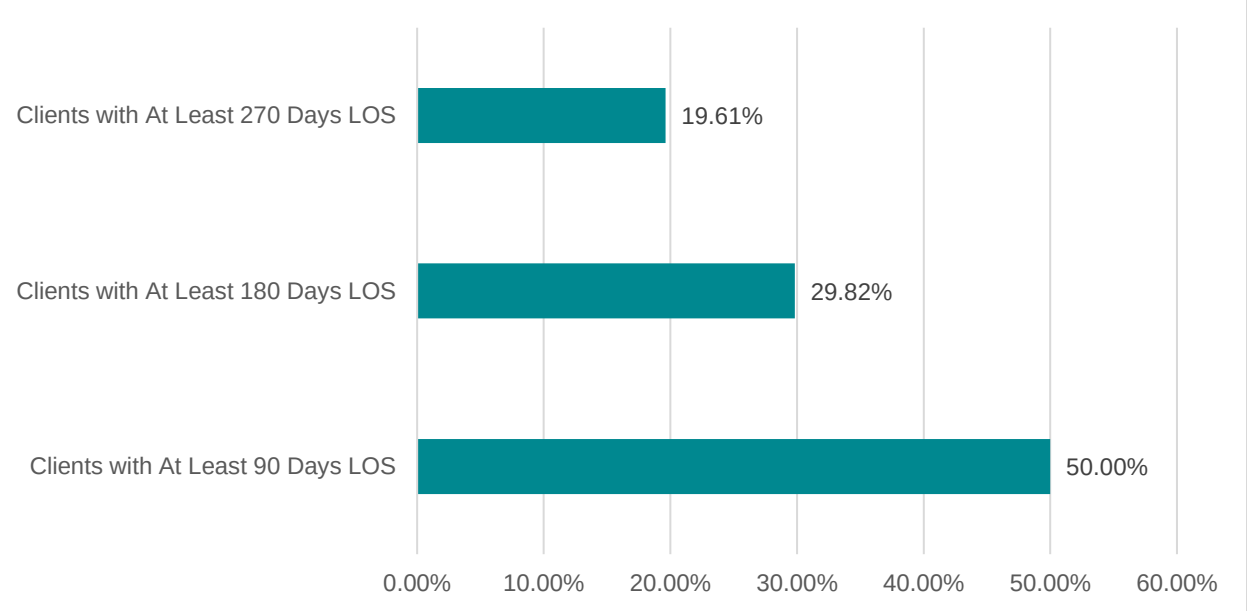
PM Table 8: Residential Withdrawal Management Readmissions, CY 2020

DMC-ODS Counties		
Total DMC-ODS clients who were admitted into WM		12,584
Clients admitted into WM who were readmitted within 30 days of discharge	1,342	10.7%

PM Figure 8: Initiating and Engaging in Services, CY 2020



PM Figure 9: Cumulative Length of Stay, CY 2020



PM Table 9: CalOMS Living Status at Admission, CY 2020

Admission Living Status	Statewide	
	#	%
Homeless	25,645	27.67%
Dependent Living	23,035	24.85%
Independent Living	44,001	47.48%
Total	**92,681**	**100.00%**

PM Table 10: CalOMS Legal Status at Admission, CY 2020

Admission Legal Status	Statewide	
	#	%
No Criminal Justice Involvement	59,347	64.07%
Under Parole Supervision by CDCR	1,855	2.00%
On Parole from any other jurisdiction	1,312	1.42%
Post release supervision - AB 109	23,933	25.84%
Court Diversion CA Penal Code 1000	1,376	1.49%
Incarcerated	437	0.47%
Awaiting Trial	4,369	4.72%
Total	**92,629**	**100.00%**

PM Table 11: CalOMS Employment Status at Admission, CY 2020

Current Employment Status	Statewide	
	#	%
Employed Full Time - 35 hours or more	10,526	11.36%
Employed Part Time - Less than 35 hours	6,799	7.34%
Unemployed - Looking for work	28,972	31.26%
Unemployed - not in the labor force and not seeking	46,384	50.05%
Total	**92,681**	**100.00%**

PM Table 12: CalOMS Types of Discharges, CY 2020

Discharge Types	Statewide	
	#	%
Standard Adult Discharges	45,800	43.82%
Administrative Adult Discharges	48,980	46.86%
Detox Discharges	7,982	7.64%
Youth Discharges	1,764	1.68%
Total	**104,526**	**100.00%**