Drug Medi-Cal Organized Delivery System

External Quality Review Report FY 2017-18

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

By Behavioral Health Concepts, Inc. (BHC)

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<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>ASAM</td>
<td>American Society of Addiction Medicine</td>
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<tr>
<td>BHC</td>
<td>Behavioral Health Concepts, Inc.</td>
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<tr>
<td>CalEQRO</td>
<td>California External Quality Review Organization</td>
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<tr>
<td>CalOMS</td>
<td>California Outcomes Measurement System</td>
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<tr>
<td>CFM</td>
<td>Client and Family Member</td>
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<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>DMC-ODS</td>
<td>Drug Medi-Cal Organized Delivery System</td>
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<tr>
<td>EBP</td>
<td>Evidence-based Program or Practice</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<td>EQR</td>
<td>External Quality Review</td>
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<td>EQRO</td>
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<tr>
<td>FFS</td>
<td>Fee for Service</td>
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<tr>
<td>HCB</td>
<td>High-Cost Beneficiary</td>
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<tr>
<td>HIE</td>
<td>Health Information Exchange</td>
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<td>Inpatient Consolidation Claims</td>
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<td>ISCA</td>
<td>Information Systems Capacity Assessment</td>
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<tr>
<td>IMAT</td>
<td>Intensive Medication Assisted Treatment</td>
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<td>IMD</td>
<td>Institute of Mental Disease</td>
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<td>IT</td>
<td>Information Technology</td>
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<tr>
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<td>Levels of Care</td>
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<tr>
<td>LPHA</td>
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<td>National Survey on Drug Use and Health</td>
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<td>SUD</td>
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<td>WM</td>
<td>Withdrawal Management</td>
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Executive Summary

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). The External Quality Review (EQR) process is the analysis and evaluation of aggregate information on quality, timeliness, and access to health services provided by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of state Medicaid services. CMS rules specify the requirements for EQR evaluation of Medicaid managed care plans as reflected in the Federal Code of Regulations 42 CFR 438. They require an annual onsite review of each Medicaid (Medi-Cal in California) PIHP, including the Drug Medi-Cal Organized Delivery System (DMC-ODS) counties as well as each Mental Health Plan (MHP).

Behavior Health Concepts Inc. (BHC) provides the required EQR quality reviews of the DMC-ODS counties for the California Department of Health Care Services (DHCS). As of October 2018, there are 20 active counties that have received approval from CMS and DHCS to provide DMC-ODS services. During the 2017-18 Fiscal Year (FY), there were three active counties that had been in operation for 12 months, allowing for an EQR evaluation. Based on required federal protocols, the California EQR (CalEQRO) reviews the specific quality metrics, including Performance Measures (PMs), Performance Improvement Projects (PIPs), an information system capacity assessment (ISCA), key stakeholder focus groups, and other indicators of quality including access to care, timeliness of services, quality of care, and outcomes from care.
Year One of the DMC-ODS 1115 Waiver Services

Three counties launched new and expanded services beginning in early 2017 as part of the DMC-ODS Waiver: Riverside, San Mateo, and Marin. In Year One, the initial focus of the EQR report was launching the comprehensive redesign of the substance use disorder (SUD) care system. This includes treatment, operations, and administrative aspects of the Waiver. Some key elements included moving from outdated treatment approaches to a comprehensive model developed by the American Society of Addiction Medicine (ASAM). This approach was based on up-to-date science related to the biological impacts of SUD and evidence-based approaches to treatment, including medication assisted treatment (MAT). DMC-ODS includes an assessment linked to a continuum of care based on individualized client needs and optimal treatment service matching. The redesign also includes new systems of program and fiscal accountability and controls based on a managed care model. Additional important background information is included in Section 2, describing activities in the federal and state environments affecting SUD treatment and the development process for the DMC-ODS Waiver design.

CalEQRO staff conducted onsite reviews from April through June 2018 and reviewed claims, eligibility, and quality-related data provided by DHCS and the University of California, Los Angeles (UCLA), as well as other information on programs and services, access to services, and quality plans from the DMC-ODS counties. Preparation for each review included a 90-day process of data and information exchange as well as planning for onsite client and family focus groups and meetings with stakeholders such as courts, hospitals, health plans, mental health, and local advocacy organizations. Staff sessions at all levels were also conducted including fiscal, clinical, medical staff, and administration. The developments of individual county reports were based on the information gathered by CalEQRO teams. The annual report is a summation of key findings and issues from those reviews.

The executive summary highlights the strengths and challenges of the current Waiver based on the experiences and data from the three “live” counties. In addition, specific strengths and challenges were identified at the county level related to the Waiver’s implementation and launch. The negative stigma with SUD must also be taken into consideration in opening new treatment sites, access to housing, jobs, and treatment. All important lessons identified are streamlined to ensure the information is communicated.
Strengths

Core Waiver Design Strengths

Elements of the Waiver’s design have proven successful in Year One of DMC-ODS service delivery. All strengths identified in this section were to help others launch their county DMC-ODS programs as well as DHCS policy makers.

A. Designing a standard of DMC service delivery with a continuum of care.

DHCS, with CMS support, designed a model of care based on ASAM criteria, organized to meet the needs of clients with SUD. The Waiver takes separate and siloed programs and organizes a system of care with added supportive services based on the latest science in addiction medicine. This design enhances continuity of care with case management and recovery support services. All counties are required to operate their DMC services based on Waiver Special Terms and Conditions (STCs), including a Quality Improvement (QI) plan.

B. Individualized treatment and a client-centered approach.

These are foundational elements of the design and move away from historic program-driven service structures, in which “graduation” indicates rehabilitation. A cornerstone of the new system of care’s design is individualized responsive care over time for a chronic disorder, subject to potential relapse based on a variety of stressors and triggers. The DMC-ODS Waiver puts client-centered, individualized care at the heart of its model for California. Each of the three counties has been monitoring individualized treatment fidelity as a key part of its QI programs, looking at lengths of stay (LOS), timely access based on an ASAM assessment, and tracking transitions along the continuum of care.

C. Evidence-based MAT.

Each of the three counties includes MAT in billable treatment options. Medications include buprenorphine, methadone, disulfiram, for treatment of SUD. Naloxone is administered for reversing the effects of an opioid overdose. Treatment is not solely limited to medication but also inclusive of counseling and medical support. Treatment referrals are individually accessed based on the ASAM dimensions of care. These dimensions include risks, motivational level of care, and co-occurring disorders. These key components provide a solid foundation for counties working with primary care providers for better treatment services.


These are key components to the Waiver development and design. The origins of SUD, its impacts on the brain, and effective treatment methods are addressed in the
Surgeon General’s report\(^1\) and are incorporated into the clinical design of the Waiver processes and services. The evaluation for treatment options are inclusive of new medications approved by the Food and Drug Administration (FDA) and current treatment methodologies.

**E. Field and community-based treatment services** are included in the design of the Waiver and enable programs to seek out the most vulnerable and at-risk populations with a SUD for engagement and treatment. These include the elderly, homeless, isolated disabled individuals, and youth who have limited ability to come to clinic sites to begin care. These options to provide services in client homes and community settings allow counselors and case managers to keep clients linked to care and engaged in support groups and activities. Staff can also provide assistance with benefits and family therapy and social support issues. This community-based approach also allows outcome-oriented and cost-effective service delivery to reduce reliance on emergency department services and other acute care systems. All of the counties shared positive experiences with client care and engagement based on this element of the Waiver.

**F. Access to pharmacy medications.** To ensure effective treatment methods are available for Medi-Cal recipients, DHCS collaborated to add newly FDA approved medications to the Medi-Cal formulary. DHCS worked to approve important and newer MAT pharmaceuticals in the Medi-Cal formulary system. Medications to help with cravings would have been too expensive for most low-income or uninsured clients to access on a self-pay basis. Without support for inclusion of these medications in the Medi-Cal formulary, many clients would not be able to access critical MAT services to support their wellness and recovery.

**G. The addition of licensed clinicians and medical directors.** These new workforce requirements are part of program certification and enhance the quality of services in the SUD care system. An expansion of the total workforce occurred in all three counties, as well as more integration with mental health and physical health care systems. Providing licensed medical and behavioral health oversight supports a range of SUD treatment options and allows for more clinical capacity and interdisciplinary teamwork.

**H. Established standards for accessibility, timeliness, and quality of treatment services,** as well as accountability for counties to meet the standards. These standards are central checks and balances for any managed care system. The Waiver STCs establish many expectations for how the standards will be achieved,

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including a 24-hour Access Call Center, data systems to track client flow related to timeliness and generate reports, an authorization process for residential treatment, a QI plan, and both training and monitoring of providers in evidence-based practices (EBPs).

I. IMD exclusion waiver so residential facilities could be Medi-Cal-certified. This specific IMD exception to the historic rule that no facilities over 16 beds can bill Medi-Cal is critical to the Waiver. Approximately 80 percent of the residential facilities in California would not have qualified for Medi-Cal reimbursement, thus severely limiting treatment options. Waiving the IMD exclusion rule allows Substance Abuse Prevention and Treatment (SAPT) federal block grant funds and county funds to be used for other treatment needs not covered by Medi-Cal, such as recovery residences, room and board costs for residential treatment, and prevention activities.

J. Selective contracting and county responsibility in a managed care framework. This is an important and positive addition to the DMC-ODS Waiver as reflected by activities in the three counties. Prior to the Waiver, any willing and qualified provider could get a contract. After the Waiver, counties used their competitive bidding processes to identify the best providers and set capacity levels for each of them so that the overall quality and capacity needs of the SUD provider network could be met. This framework creates fiscal and program requirements and responsibilities at the county level. The STCs outline these specific new accountability systems.

K. Required mental health and public health coordination as part of the managed care framework. DHCS includes important integration and coordination requirements in the STCs that have led to MOUs and working procedures between the DMC-ODS counties and their mental health and health plan partners. The goal is to enhance the wellness of the beneficiary overall—in terms of health, mental health, and SUD. Each of these areas is enhanced as well in the counties’ Whole Person Care (WPC) grants, which support coordination and integration of care for high-need, complex clients, many of whom have SUD or mental health treatment needs.

County DMC-ODS Delivery System Strengths
The structure and design of the Waiver provides details in the STCs and in contracts between DHCS and the counties, approved by CMS. Included in the intergovernmental contracts are county-specific implementation plans on how each DMC-ODS county would operationalize the new core services and STC requirements in the initial years of the Waiver. The three counties reviewed this past year all had strong plans for implementation and a willingness to be flexible and
creative as unforeseen challenges and problems emerged in the implementation of these complex systems. It is important to note that this effort goes well beyond adding new services. It encompasses a major philosophical and treatment model change, which the directors in each county needed to promote, educate, and support with legacy providers, criminal justice systems, and outdated models of care. Below is a summary of core strengths identified in the DMC-ODS programs shared among the three counties.

A. Leadership with effective communication with stakeholders, elected officials, clients, and the community at large is critical to successful implementation. Because of the complexity and breadth of the SUD services redesign, leadership with strong and effective communication is a central trait required in each county. It includes many levels and phases of communication:

(1) Educating the community about the new program philosophy and opportunities.

(2) Involving stakeholders from criminal justice, providers, and client groups from many ethnic and economic backgrounds in the design of their local plan and the change to individualized treatment instead of program-driven treatment.

(3) Educating the Board of Supervisors and elected officials about the new structure of the Waiver finances and getting resources for planning, infrastructure, and launching of services.

(4) Developing staff expertise in complex new billing and quality improvement and accountability systems required by DHCS as well as CMS.

(5) Most important, providing training and education in the ASAM model of care with individualized treatment as its foundation.

All participating DMC-ODS counties must ensure availability and access to the range of services in the Waiver as reflected in their intergovernmental agreements. Without solid visible leadership as well as effective communication and working relationships (inside and outside the county), implementing the Waiver would be very difficult, if not impossible.

B. Expansion of DMC-ODS services to clients with SUD in a new and effective model is central to the Waiver. Each of the counties saw expansion of unduplicated clients served from the prior FYs in the Medi-Cal program, taking into account the fact that Riverside and San Mateo were only in DMC-
ODS service delivery for 11 months and Marin for only nine months. Access expanded during these active DMC-ODS months between two and three percent compared to the prior year, on average, without extrapolating the data for the full year. This was based on unduplicated clients in paid claims for the period of February through December 2017. Counties shared there were still pending claims not yet processed at the time of the download for the report. In addition, counties continue to work on expanding capacity and new programs as part of their second year of Waiver implementation. The California Outcomes Measurement System (CalOMS) reflected an increase of 7.4 percent overall for the three counties based on the UCLA evaluation report. CalOMS tracks total client services regardless of coverage, so it includes clients with other payer sources besides Medi-Cal.

C. The launch of new and expanded services is critical to meet network adequacy and prevent delays in access to care. All three counties demonstrated this in a variety of ways. For example, Riverside increased clients’ access to residential treatment from 2,154 clients in FY 2014-15 to 3,419 in FY 2017-18. There was also an 84 percent increase in that same time in residential bed days available, from 56,485 to 120,714. Additionally, in Riverside’s monthly capacity for Withdrawal Management (WM), 86 clients were served in February 2017 (at the beginning of the Waiver) and 158 served in June 2018. San Mateo expanded MAT in partnership with a local Federally Qualified Health Center (FQHC) and their emergency department, serving 109 clients in their outpatient program that includes MAT and associated counseling and supports.

The treatment completion rates increased for this group of clients to 92 percent for those in residential treatment on MAT and 79 percent for those in outpatient treatment on MAT. This was significantly higher than completion rates for clients not using MAT as one of their treatment tools. The research study on the San Mateo MAT program also showed a $155,106 reduction in health plan costs for clients in the program, which was 55 percent lower than costs the prior year for this group of clients. This was achieved through a reduction in emergency department visits and inpatient hospitalizations. Meanwhile, costs increased for outpatient treatment, which was appropriate for addressing those clients’ healthcare needs. Marin increased unduplicated clients seen by 14 percent in this first year of the Waiver (based on nine months of services) and added a new residential treatment site for adolescents, among other expanded services.

D. New DMC licensing and certification expansion in each of the three counties was significant. Marin added nine new facilities to the Medi-Cal
program in the county, representing 18 different clinical programs at 21 different sites. In San Mateo, 22 providers with various sites and levels of care (LOC) were certified for DMC-ODS services and three sites are still pending certification. Riverside had 27 provider sites included in their services as part of the Waiver and six more are pending DMC certifications. All of the counties also have additional out-of-county contracts as needed for special needs and unique access arrangements.

**E. Training** is required in many areas with the change to ASAM assessment and treatment models, increased use of EBPs, and the shift to individualized treatment from program-driven services. All three counties mounted major training efforts with the California Institute for Behavioral Health Solutions (CIBHS), DHCS, and train-the-trainer models to enhance and reinforce new approaches to treatment. Even with these efforts, staff and contractors are still seeking more support as they learn to document Medi-Cal qualified treatment plans with ASAM criteria-focused goals and objectives.

**F. Access Call Centers and timeliness.** All three counties laid a solid foundation for improving access to care. The designs and services include the 24-hour Access Call Center program in Riverside, which receives an average of 3,200 calls per month; Marin’s integrated mental health and SUD call center with walk-in capacity for assessments; and San Mateo’s 26 walk-in sites, where assessments can be done, as well as its 24-hour Access Call Center staffed during the day by licensed county staff and after hours in partnership with a residential provider. All three counties are monitoring timeliness of access to care. In narcotic treatment programs (NTPs) for all three counties, the first methadone medication dose was administered in 3.5 days or less. To meet state guidelines an expedited 48-hour authorization process was implemented for quicker residential access. Tracking of these timeliness measures is noteworthy considering limited and varied software systems, dispersed provider networks, and some access occurring through decentralized walk-in programs.

**G. Performance Measures.** All three counties worked with CalEQRO to review the reporting results of the new PMs and understand the implications of the results for this initial year. Other than when service data were not available in the DMC-ODS claim system, most PMs positively covered the issues anticipated by the EQRO Clinical Advisory Committee and laid a foundation for helpful PMs linked to quality outcomes for SUD treatment. Among the PM results, initial access to medication (methadone) dosing through NTPs was rapid in all three counties (three-and-a-half days or less). It was rare for any clients to use WM for three or more episodes without other SUD treatment,
suggesting that these high-risk clients are more engaged in treatment. Baselines were also set for residential transitions to other LOC and Access Call Center key indicators. As claims data become more complete, the PMs will be rerun to capture all activities and services. Current data in the annual report are from a July 25, 2018 download. Each county shared they had some billing that was still pending.

H. PIP work on outcomes and quality. Each of the three counties had two active PIPs, reflecting a variety of positive focuses in terms of learning for the Waiver. Riverside had a PIP on expansion of youth services linked to schools, County Social Services, and Probation, with tracking of outcomes through CalOMS discharge ratings. Their other PIP examined transitions in care for clients being discharged from residential treatment. CalOMS discharge information was used with this outcome as well. Marin had a PIP focusing on treatment of clients with both mental health disorders and SUD and used multiple evaluation measures, including the Treatment Perception Survey (TPS) and Comprehensive Health Outcome Information System (CHOIS). Marin’s other PIP was focused on reducing the number of readmissions to WM within 30 days by enhancing their care coordinator outreach from pre-discharge through follow-up to first outpatient appointment. Finally, San Mateo’s active PIPs involved adding ASAM criteria-based assessments and recommendations to the courts and care management for post-release from detention to enhance post-release engagement in treatment and positive outcomes for criminal justice clients. Their second active PIP focused on providing WM assessments using ASAM criteria, linking clients to their next LOC with discharge planning supports, and tracking readmissions. All of these focus on important system changes to enhance outcomes of care and effective use of treatment resources.

I. New billing and cost reporting systems. As part of the new design of the Waiver, each of the counties launched billing and fiscal tracking systems within months of beginning direct services. This occurred despite the challenges with complex new modifier codes; clarifications on some billing requirements and lock-outs still being refined; and testing of the state computer processing of these new claims, TPS forms, and ASAM LOC referral tracking data. These new systems involved significant technical work for the counties and DHCS staff; refinement of complex computer claiming and scrubbing systems; resubmission of bills that were rejected due to a variety of issues from the master provider file to definitions linked to lock-outs; development of highly complex billing workflows with contractors who were billing Medi-Cal for the first time; and information technology (IT) systems handling of the claims output. Counties that have waited to begin their DMC-
ODS have benefited from the work of these early counties in the billing and information systems arenas, since many issues and problems were resolved through the teamwork between DHCS staff and the three Year One counties.

J. **Flexibility and innovation.** Each county demonstrated flexibility, created a learning-oriented environment for programs and staff, and demonstrated “can-do” attitudes working towards the success of the programs in meeting client needs and having the administrative infrastructure in place to successfully carry out Waiver requirements. Without these efforts, systems and progress would have stalled at many points, as new and unforeseen issues were common, although in some cases unique to each county and its network and billing systems. This flexibility and innovation were noteworthy in each county among both contractors and county staff.

K. **New partnership with criminal justice.** One of the most significant system redesigns evolved from the partnership with criminal justice. Prior to the Waiver, courts had routinely court-ordered outpatient or residential treatment without assessments and recommendations from SUD treatment staff. This was not a clinically effective approach to treatment and in many cases did not meet either medical necessity criteria for the services or individual client needs. With the SUD treatment network moving into a DMC-ODS framework and set of requirements, the counties’ leaders had to engage with and persuade the courts to allow a full ASAM criteria-based assessment with treatment recommendations and care management. This new process allows individual assessment of treatment services ensuring optimal care. The Outcomes data is continuously tracked, and reported to the courts. Outcomes in San Mateo are particularly positive in the Drug Court, with high levels of treatment engagement and completion particularly for those with MAT.

L. **Looking to continuous QI and outcomes.** Each of the counties also demonstrated QI as a core value in the way they approached their delivery systems. All three counties were able to present strong QI plans and demonstrate improvement efforts through their meeting notes. The counties were able to present PIPs for review and demonstrated a clear dedication to quality as an overall organizational priority. Challenges were mostly in the area of data tracking systems, particularly with dispersed networks with “no wrong door” walk-in programs.

M. **Becoming an equal partner with other county agencies in service coordination.** The development of the DMC-ODS within each of the reviewed counties brought a change regarding how other county agencies perceived their SUD service system. This change helped to recognize the
detrimental effects of SUD on clients, and sharing effective methodologies between agencies. The DMC-ODS STCs encouraged reaching out to these other service agencies; the overtures were well received. Their status changed from a siloed department or program to an equal partner with other agency service systems. Collaboration between each county’s DMC-ODS and its other service systems has been of great benefit to the clients served.

Challenges for DMC-ODS Delivery and Systems

A. Out-of-county Medi-Cal transfers take up to 90 days to successfully change to a new county. This challenge was experienced by all three counties; despite efforts to work with local Social Services Department benefits staff, the process of transferring Medi-Cal enrollment to a new county of residency took up to 90 days and was not retroactive. Because the host county cannot bill for services until the Medi-Cal residency code is linked to its county, delays in access to care are common. If the county gives up the option of billing for the Medi-Cal services during this initial 90-day period, clients may begin services. All three counties allow urgent cases and pregnancy cases to begin care covered by local funding. The counties suggested several options for solving this problem, all of which would require state policy changes: (1) Medi-Cal retroactive billing, starting the date of relocation/application for transfer, similar to SSDI (Social Security Disability Insurance) application cases and hospital emergency department cases; or (2) reconcile units of service at cost report settlement time. The resolutions identified, were recognized by the counties to be more effective and efficient.

B. Provision of physician consultation to support optimal care/access to MAT. Physician consultation is covered as a billable service under DMC-ODS only when the consulting physician works for a DMC-ODS program provider and consults with a provider who is also DMC-certified. However, the greatest need for this consultation service comes from provider organizations particularly primary care and emergency departments. To expand MAT capacity with new medical staff, physicians, and mid-level providers, consultation from DMC-ODS physicians who are addiction-trained specialists would be very beneficial. The Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Service Administration (SAMHSA) have released grants to add more funding for MAT to primary care sites. Without adequate training from addiction-trained specialists, physicians have difficulties in inductions, and first dosing during the initial phases of SUD treatment.

C. Expanded access to MAT treatments. There are some billing and pharmacy challenges for current non-methadone MATs both in NTPs and in
outpatient sites. For NTPs, billing is in bundled payments which requires National Drug Code (NDC) medication numbers and only one can be billed per claim. As clients phase into the new medications, they may need to use incrementally higher doses (such as an eight milligram (mg) and an additional four mg buprenorphine dose), but only one NDC medication number can be billed per claim. This means the provider cannot bill for all medication used, which presents a fiscal problem, throws off cost report accuracy, and can contribute to medication reconciliation issues. Clarification of these issues, which are potential barriers to successful billing in NTPs, would be helpful.

In addition, expansion of buprenorphine treatment as well as the other required medications was seen as challenging for the NTPs based on their current hours, work flows, and computer systems. There is a desire to expand these medications and support to assist in this effort is recommended.

D. Barriers to client transitions along the continuum of care and continuity of care. One of the most important factors contributing to positive treatment outcomes is the strength of the therapeutic alliance between the client and his or her treatment staff, per Dr. David Mee-Lee, chief editor of the ASAM criteria and textbook.\(^2\) When clients are transferring between residential to other LOCs with different treatment staff, a best practice is to try to bridge between the two LOCs by introducing the client to the new treatment staff at least twice before discharge from the higher LOC. Currently, the lock-out between residential and outpatient does not allow a billing overlap wherein counselors from both programs can bill for services rendered on the same day—despite the potential benefit of smoothing the transitions for clients across the continuum of care. Based on engagement rates in a new LOC after residential treatment, as reflected in PMs that were 20 percent or less, additional support for engagement at lower LOCs are needed. Some overlap in services is in the best interest of clients and their recovery. Outpatient visits not covered by DMC-ODS could be provided using SAPT block grant funds to enhance these transitions in care.

E. Limits of a maximum of two residential treatment episodes can sometimes conflict with individualized treatment. Many clients leave in the first week of residential treatment because they are not ready for that level of commitment to treatment. In reviewing program data, many clients appear

to drop out within the first 10 days. Data from UCLA on this topic were reviewed and discussed at several EQR Clinical Committee meetings. DHCS allows with medical necessity an additional 30 days of treatment. Counties expressed concerns about episode and length of stay limitations related to some clients, both youth and adults. The individualized treatment focus of ASAM criteria recommends residential treatment for stabilization of more severe SUD issues and then transfer to partial hospital or intensive outpatient options, but it does not include limits of two residential episodes per year. Optimal clinical outcomes could be bolstered by adjustments to episode rules if the Waiver is renewed.

F. Case management models. Case management is an important service for continuity and quality of care. It can also help with initial engagement and enhance retention in transitions between LOCs. In the three counties evaluated, it was clear that contract providers focus primarily on case management related to discharge from their facilities and not on client needs across the entire continuum of care. The centralized case management model used in Riverside tracks and advocates for clients across the entire system of care, including sharing insights and influence with all providers who might be seen by SUD clients. This model increases monitoring of providers, early identification of system challenges for clients and families, and direct feedback to the senior leadership of the county for continuity of care issues. County staff shared that ideally, a hybrid arrangement for case management is best, in which case management can be provided as needed through central coordination by county case managers and through contract provider programs during discharge planning and coordination of transfers to other services.

G. Technology infrastructures in contract provider programs, DMC-ODS counties, and for telemedicine. The current IT infrastructure is not adequate in a managed care environment to track all the measures and key metrics linked to quality of care. The biggest challenges in QI as seen with these three counties lie in the interfaces across multiple different data collection systems (both county and contract) and a central data collection site where analysis of quality metrics can be performed and reported back to the system for quality feedback.

Besides the interface issues, equipment and software are outdated and in some cases non-existent, particularly for electronic health records (EHRs) in many contract providers. Coordination and systematic documentation of clinical treatment plans, notes, releases, ASAM criteria-based assessments, ASAM LOC referral data, TPS surveys, CalOMS, and referral documents are
needed. To make efficient use of staff resources, automation of these systems in a coordinated way would be very positive. A plan for development of these resources for enhanced technology systems with interface capacity is highly desirable.

**H. Integration of ASAM LOC referral data collection processes.** This is an important process for the Waiver, documenting a comprehensive assessment and recommended LOC. Ideally, it would be automated and integrated into routine intake workflows and technology systems. The two counties that had added the ASAM LOC data collection in their EHRs and intake workflows were much more successful at capturing and transmitting these data in a timely way to DHCS and UCLA. This is of course dependent on having access to an EHR or intake data collection system that can extract the required data elements. Unfortunately, many contract providers do not have EHRs and some others have systems that differ from the one implemented by the county DMC-ODS. The DMC-ODS Waiver requires entry, collection, storage, and analysis of the ASAM criteria-based assessment findings, referral actions, and eventual placement information.

The goal is to ensure clients are getting optimal treatment matching their needs. As previously stated, capturing this data into workflows and technology supports is highly desirable for efficiency and accuracy.

**I. 42 CFR Part 2 challenges for coordination of care.** Without specific written releases, 42 CFR Part 2 has created significant challenges for smooth transitions in care and the admissions process. Access Call Centers cannot convey referral information to providers without written consent from clients and cannot obtain that consent immediately in writing, as 42 CFR.2 requires.

Continued advocacy in this area would be helpful to improve care and make it more efficient.

**J. Stigma persists in communities** related to: (1) use of medications to help with SUD treatments, (2) using ASAM assessment criteria to support optimal care, versus court orders not driven by client clinical needs, and (3) support for new and expanded sites for service delivery (e.g., NIMBY or “not in my back yard”). Continued education and work with media, the public, and community leadership is needed to push back on these biases and beliefs. These also create barriers for clients needing housing, jobs, childcare, and other services.

**K. Workforce recruitment, training, and retention.** The expanded workforce, including Licensed Practitioners of the Healing Arts (LPHAs) and medical
providers, is very positive for SUD treatment, but also very challenging. Options for improvement suggested by the counties included more college and graduate program capacity in nursing, medicine, mental health, and SUD programs; loan forgiveness; and approaches that expand training and scopes of practice. One example of this challenge is illustrated by Riverside County, which chose to develop the Access Call Center, case management, and a variety of key functions with county staff. After obtaining approval for 70 new positions, the Behavioral Health Department is still trying to fill all of its positions due to recruitment challenges.

L. Homelessness affects smooth transitions in care and increases relapse. As discussed in Section 2, homeless issues are prominent nationwide; California has more homeless people than any other state. This is a particular challenge for individuals who want to obtain treatment and then remain substance-free. All three counties are part of local coalitions and are involved in a range of other efforts to work on access to affordable housing. They regard addressing homelessness as imperative for sustained recovery and wellness for persons with SUD. For example, Marin arranges to give priority status to SUD clients for affordable housing. Each of the counties regards the newly available use of SAPT block grant funds for recovery residences as a viable opportunity to provide some transitional housing for SUD clients who are actively participating in outpatient SUD treatment.

M. Addition of more medically monitored levels of ASAM care. The ASAM LOCs include more intensive service levels than are usually available through providers in most counties. The Waiver encourages the establishment of network capacity at these levels, such as WM 3.7 and WM 4.0. These LOCs require maintaining an expensive infrastructure and are usually hospital-based. In addition, current Medi-Cal billing procedures make it challenging for facilities with these programs to obtain reimbursement. A systematic effort to address these important LOCs is needed. Individual counties have limited options and need help resolving Medi-Cal billing and process issues that appear to limit reimbursement and thus development of new programs.

Recommendations

The annual reviews for the three counties culminated in recommendations for next steps for the Waiver, building upon the considerable strengths of current “Live-Waiver counties” to further develop their systems of care. Live-Waiver counties are delivering services under the DMC-ODS Waiver and their lessons learned will be helpful for the “Pre-Implementation-Waiver” counties in the earlier stages of
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preparation. Pre-Implementation-Waiver counties have an approved implementation plan and are preparing to begin DMC-ODS services. Key lessons learned, themes, and recommendations are also likely to be of interest to DHCS and the County Behavioral Health Directors’ Association (CBHDA), whose staff are positioned to help the counties in a variety of ways and make any future adjustments to the Waiver.

The highest priority recommendations linked to quality SUD improvements in a managed care environment are provided below. These may also be read as a list of likely next steps for Pre-Implementation-Waiver counties and their stakeholders to consider as they transform their SUD network into dynamic, accountable, and well-organized delivery systems under DMC-ODS.

1. California’s DMC-ODS Waiver made an excellent start with a science-based design and expanded treatment options for Medi-Cal beneficiaries and others with SUD needs. DHCS and CMS should work together on renewing the Waiver to assure support for the continuation of the Pilot, and to identify areas of improvement within the STCs to successfully help counties reach Waiver’s goals. This would include enhancing service capacity in areas such as physician consultation, and other challenge areas mentioned where adjustments would benefit client treatment outcomes.

2. Infrastructure for EHR and related health IT systems is needed to provide support for managed systems of care, specifically timely access to care, clinical documentation, coordination of care, billing capacity, and quality/integrity/accountability systems. Both physical health and mental health have had historical sources of funds to build this EHR infrastructure, but not addiction medicine. IT infrastructure, combined with training and quality dashboards, can help with coordination and efficiency in SUD care. This is a long-term but important component of clinical and fiscal success for a managed care plan.

3. All DMC-ODS programs will benefit from developing strong political and community partnerships to educate and expand understanding of SUD and appropriate treatment methods that are science-based and help reduce stigma for those with SUD. Public engagement and education are critical contributors to Waiver success and to shifting the paradigm of the treatment programs from outdated methods of providing care.

4. In subsequent years, the counties reviewed plan to focus on refinement of Access Call Center systems/software and development of interfaces with the provider networks for referrals is recommended, including integrating provider programs with “no wrong door” policies into the DMC-ODS data tracking systems. Evaluation of these new and developing tracking systems will help with
smooth transitions to treatment, prevent treatment delays, and allow analyses of network capacity and logjams in specific services or regions.

5. More flexible access to MAT in residential programs and detention centers is recommended to allow for supervised treatment prior to re-entering the community. Many counties are just starting to offer outpatient MAT and have not been able to conduct assessments and induction in residential or detention settings. To fulfill MAT’s potential for those with opioid and alcohol use disorders, it is important to reach into these 24-hour structured settings as a positive environment for beginning treatment. Funds from SAMHSA and HRSA are becoming available to expand access to other environments and with more flexibility, specifically targeting MAT expansion.

6. DHCS and county leadership should identify and address eligibility and billing system issues that emerged in Year One of service implementation as impediments to client access to care, client continuity in care, MAT consultation, and other processes related to achieving the best possible outcomes for clients. This should include exploring solutions to the 90-day transfer timeline issue for inter-county transfers of residency for Medi-Cal.

7. Based on the reviews, the importance of provider training is essential in all components of clinical documentation, how the components interface with one another, and how often to document changes in client status. The training should include the frameworks of ASAM models of client-centered care and meet state and federal regulatory requirements.

8. It is also recommended that training and collaborative learning approaches be used to enhance implementation of client-centered care, including client continuity and transitions along the continuum of SUD care. This is particularly needed in residential treatment and residential WM settings where older approaches are still being used by some staff in care planning. DMC-ODS counties should regularly analyze their data regarding client transitions between levels of care to inform their engagement efforts. This recommendation builds on best practices in optimizing use of the ASAM continuum of care.

9. The Waiver includes requirements for coordination with physical and mental health programs that necessitate increased exchange of client information between their providers across previously siloed systems. The current 42 CFR.2 regulatory requirements for privacy of SUD client records is among the most stringent of any health care privacy regulations and presents challenges for the information sharing necessary to facilitate care coordination. Each county needs to continue working with its county counsel and learning from other counties about how to find practical solutions for information sharing within the current 42 CFR.2 regulatory framework. Counties also should work with their state and
national associations to explore possible regulatory changes that will help facilitate the increased information exchange that a DMC-ODS needs to function.

10. The Waiver STCs recognize the importance of recovery supports for clients during and after a formal treatment phase. These supports include recovery support services and recovery residences. Counties have tended to focus during the initial startup of the DMC-ODS on the more traditional treatment services. During Year Two of service implementation and in subsequent years, each has plans for these recovery-oriented services that will contribute vital components to its continuum of care.

11. Technical assistance on barriers to expansion of non-methadone MAT options is recommended for the NTPs. This technical assistance is related to the work flows and the claiming processes linked to FDA-approved medications required in the STCs: buprenorphine and disulfiram, and naloxone. The treatment medications (buprenorphine, methadone and disulfiram) will provide more opportunities for positive outcomes for clients with alcohol use disorders and opioid disorders. Naloxone is administered to reverse the effects of an opioid overdose and has shown to be very effective in saving lives.

In conclusion, the California DMC-ODS STCs are a blueprint for transforming fragmented services into a managed and well-organized delivery system of accessible, timely, and effective treatments for clients with SUD. Translating the STCs into a living, dynamic reality that improves care for clients is a massive undertaking. The Waiver opportunities prompted each of the three pilot counties to successfully begin substantial transformations to their systems of care, albeit with more to do. While the challenges they face are not easy, they are working within a cooperative environment that is supported with increased state and federal funding, technical assistance (TA) from many sources, and a sense that the changes will be of great benefit to their communities and their clients.

The CalEQRO observed and participated in a collaborative learning environment in the three Pilot counties with DHCS, county administrators and managers, both county and contract providers, other county agencies, and clients and their family members. As part of that learning environment, the CalEQRO developed review protocols and PMs, and provided TA to the counties prior to their reviews, and tried to assist DMC-ODS counties on system transformation linked to quality to benefit the many people suffering from the impact of SUD. It is a privilege to be part of this important and positive transformation in the system for care for clients with SUD.
Section 1

Substance Use Disorders in California and External Quality Review Organization Methods for Review

Drug Medi-Cal Organized Delivery System

To understand the Drug Medi-Cal Organized Delivery System (DMC-ODS) initial year of services and findings, it is important to appreciate California’s history of substance use disorder (SUD) services, the Waiver’s history, and the national context surrounding the current efforts.

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

The pioneer DMC-ODS counties (Riverside, San Mateo, and Marin) set the stage for the evolution of a new statewide SUD system. Once fully implemented, the system will reach up to 97 percent of California’s population with new and expanded treatment services in a
clinical framework based on addiction medicine’s best and most current science.

In FY 2017-18, seven counties launched their DMC-ODS systems; three were reviewed by the California External Quality Review Organization (CalEQRO) for their annual evaluation of quality of care. Each of the three counties has contended with local, state, and national forces in their implementation efforts.

**Affordable Care Act’s Future and Role in SUD Access**

The Affordable Care Act (ACA) expansion of Medicaid extended coverage for single, low-income adults, increasing access to SUD treatment. Even before California’s 1115 Waiver was approved, access was extended by the ACA’s new, expanded eligibility for coverage. As the opioid crisis increased in both severity and visibility, this access to treatment became even more critical. The performance measures (PM) section of the report includes four years of baseline, pre-Waiver services data showing the significant growth of persons with ACA coverage accessing SUD care.

In the last two years, a number of federal actions have weakened the insurance environment in which the ACA operates. The individual mandate was eliminated, insurance subsidies for low-income individuals’ private insurance were periodically suspended, and there are no efforts at this time to legally defend the ACA’s requirement for essential health benefits, which include mental health and SUD treatment. New minimum coverage plans—limited to coverage for catastrophic health events—have been encouraged.

Under any reform scenario, health care providers likely will experience spikes in uncompensated care. Under a repeal scenario, uninsured rates likely will wind up higher than they were before the ACA passed. Changes to the Medicaid program, undertaken in either repeal or replace scenarios, could have long-lasting and significant effects on many providers and on access to SUD treatment.

State and local politics will become even more important if the ACA eligibility is eliminated or reduced. As federal funding shrinks, the fate of providers and patients will depend more on decisions made at the local and state levels. Some states may have the funds to fill the gap.
in federal funding and will use them to do so, while many states may be unable or unwilling. Maintaining coverage is critical to reaching the population most in need of SUD treatment and to avoid worsening the current crisis.

A National Opioid Crisis

The national impetus to develop an effective SUD treatment delivery system responds to a serious health challenge in the United States. This was clearly articulated by the Surgeon General in the first national report on SUD and treatment in 2016, *Facing Addiction in America.*\(^3\) The report recommended a major shift to a clinical, scientifically based treatment approach similar to efforts to prior, successful efforts to address the toll of smoking and tobacco on the nation’s health. Just as tobacco addiction was understood to be the product of forces beyond individual choices and behaviors, SUD treatment could shift from a blame-oriented, criminally focused system that ascribes substance use problems to a lack of moral character and move towards a brain science foundation that draws on researched public health population-based treatment and prevention approaches.

The Surgeon General’s report could not have come at a better time, because the rising tide of opioid-related deaths had reached a point of acute national crisis. Fueled by prescribing patterns that freely dispensed new, powerfully addictive medications for pain and framed pain as “the fifth vital sign” (thus warranting aggressive treatment), many Americans became addicted to opiates. When physician prescriptions were no longer available to them, many of these patients turned instead to heroin and other illegal opiate drugs. Recent studies in prescribing patterns indicate that 80 percent of the world’s prescribed opiates are being used in the United States.\(^4\)

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dangerous strength of these new medications led to many overdoses annually, surpassing deaths from motor vehicle crashes.

The alarming trend of overdose deaths is well illustrated by National Institute on Drug Abuse (NIDA) research, as shown in Figure 1-1.\(^5\)

**Figure 1-1: National Overdose Deaths (NIDA)**

As the nation grapples with this new, crippling epidemic of drug addiction and mortality from overdoses, the medical community and policy makers have sought answers and potential solutions. National commissions and organizations proposed priorities to address the opioid crisis, including enhanced access to treatment, expanded access to medications that reduce craving to support positive SUD treatment outcomes, and reduced opiate prescribing of these highly addictive medications. Criminal justice initiatives also have been proposed through increased use of drug treatment courts and efforts to stop the flow of illegal drugs—particularly Fentanyl, a new and highly lethal synthetic opiate.

While each state has explored different ways to address the opioid crisis and add priority treatment access, California worked to develop a system of SUD treatment built on the ASAM continuum of care model.

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History of SUD Treatment and the 1115 DMC-ODS Waiver

Prior to 2015, the service delivery system in California for those who suffered from a SUD and were eligible for Medi-Cal was not robust, with no continuity or continuum of care.

A number of factors led the state to pursue a Waiver in 2013. California was developing additional benefits under the ACA and wanted to change the eligibility criteria to increase the number of Californians eligible for Medi-Cal. In July 2013, CNN and the Center for Investigating Reporting aired a story on widespread fraud in the Medi-Cal rehabilitation program. For example, there were allegations of ghost clients, program directors who were convicted felons, and services billed for but were never provided. The story made national news and put a spotlight on the delivery system. At the time, CMS did not consider the DMC program to be a PIHP, which meant no quality assurance (QA) activities were required.

The former state Department of Alcohol and Drug Programs contracted with counties to administer the services either directly or through a subcontract. Counties’ participation in the DMC program was not mandatory. As a result, the state would contract with any “willing and able” provider to ensure clients had access to these services. Services were limited to outpatient treatment, narcotic treatment programs (for methadone only) and perinatal services.

In addition to the limited array of services, the reimbursement rates were low. One of the benefits that the state wanted to offer under DMC was residential treatment. However, any facility over 16 beds would be classified by CMS as an Institute of Mental Disease (IMD), which is excluded from billing Medi-Cal for services. Ninety percent of California’s residential capacity is considered an IMD and not eligible to be reimbursed for services. To develop an effective treatment model, this barrier needed to be removed so clients could access residential treatment programs.

In 2012 and 2013, the state legislature eliminated the Departments of Mental Health and Alcohol and Drug Programs, transitioning them to the California Department of Health Care Services (DHCS). One of the goals for this transition was to integrate mental health with SUD services and also primary health. The majority of the counties had
already integrated their mental health and SUD departments; it was time for the state to do the same.

As previously mentioned, the number of drug overdoses had become the leading cause of injury, causing more deaths than motor vehicle crashes. According to the California Department of Public Health, the state has approximately 2,000 overdose deaths a year. In 2017, there were 21,787,042 prescriptions for opioids, 4,281 emergency department visits for opioid overdoses and 373 deaths due to Fentanyl.6

Homelessness, Stigma, and Workforce Factors

Homelessness, stigma, and workforce shortages were also among the critical issues counties were facing during this time.

More than one-quarter of the total homeless population nationwide lives in California, and this number continues to rise. The vast majority are “unsheltered”—a more bureaucratic term used to describe the thousands living on the streets, under freeways, and tucked into grassy fields and parks in cities all around the state.7 Los Angeles County leads the surge with more than 55,000 homeless individuals, an increase of more than 13,000 compared with last year.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), between 20 and 25 percent of the homeless population in the United States suffers from some form of SUD or serious mental illness. In comparison, only six percent of Americans are severely mentally ill.8

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Workforce shortages also pose significant challenges. National and statewide health care staffing shortages are well documented and projected to widen as the population grows and physicians retire. The state will lack about 4,700 primary care doctors by 2025, according to a recent report by the Health Workforce Center at University of California, San Francisco. The Central Valley, Central Coast, and southern border areas will be hardest hit, according to the report. This includes behavioral health professionals in mental health and addiction medicine.

The overall picture is one of an aging pool of qualified physicians who are distributed unevenly across the state’s rural and urban areas. Additionally, the researchers found that doctors were more likely to accept patients with any type of health insurance over uninsured patients, but they tended to accept other types of health insurance over Medi-Cal. Key highlights include:

- Fewer than half (61,196) of the state’s licensed medical doctors provided patient care for more than 20 hours per week.
- Latinos and African Americans were substantially underrepresented in the workforce; only 5 percent of doctors identified as Latino, a group that constitutes 38 percent of California’s general population.
- The distribution of both primary and specialty care physicians, including psychiatry and addiction medicine, was uneven across the state, with the Inland Empire and San Joaquin Valley regions having half as many physicians per 100,000 residents as the Greater Bay Area.

Many areas, particularly in rural parts of the state, do not have enough psychiatrists, physicians with addiction experience and other behavioral health providers to serve their communities. This creates a burden for those who need treatment who may have to travel long distances for mental health or substance abuse treatment.

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Challenges Leading to the DMC-ODS Waiver

Historically, a number of counties did not provide any DMC services and some counties refused to contract with any NTPs. A lack of understanding about the efficacy of medication assisted treatment (MAT), combined with a reluctance to provide “addicts” with “drugs,” continues to be a barrier for treatment. The workforce in substance use treatment was considered to be paraprofessional; the only licensed clinical provider who could diagnose SUD was a medical doctor. This was very limiting as it was very difficult to recruit and retain licensed physicians, let alone licensed physicians trained in addiction medicine.

In summary, the state was facing an increase in the number of beneficiaries, creating a demand for expanding services just as allegations of fraud were raised. The state was also transitioning programs into DHCS—the state Medi-Cal agency that is the only entity authorized to bill the federal government for Medi-Cal services. CMS was also concerned with the allegations of fraud and the desire to expand the program. The Director of DHCS was able to propose a system redesign to eliminate the fraud while expanding benefits, addressing CMS’ major concerns.

DHCS held a number of meetings with SUD stakeholders, advocates, providers, counties, associations, and legislative staff to redesign the system from the client’s perspective. From this work, Special Terms and Conditions (STCs) were developed for the DMC-ODS. The state had decided to pursue an 1115 Waiver that would amend the current Bridge to Reform Waiver to include the DMC-ODS. The 1115 Waivers are pilot programs that provide a framework for innovation. Because of the Waiver’s demonstration status, counties could volunteer to participate.

After much discussion with CMS and revisions of the STCs, the Waiver was approved in August 2015. Because of this innovative redesign of the service delivery system, CMS issued a guidance letter on July 27, 2015 to all states about the opportunity to design and test innovative policy and a new service delivery system for those who suffer from a SUD.
California was the first state in the nation to receive approval for its proposed Waiver, which established a model for other states to follow. California used a tiered approach to implementation and divided the state into five phases (Bay Area, Southern California, Central Valley, Northern California, and Native American/Indian).

**Goals of the Waiver**

The Waiver’s overall goal is to improve SUD services for California beneficiaries. The services are to be client-focused, providing evidence-based practices (EBPs) to improve quality outcomes and to support integration and coordination of care across systems. Other goals include reducing emergency room and hospital inpatient stays and placing clients in the least restrictive level of care (LOC). The Waiver also includes program oversight, quality assurance (QA) activities, and external quality reviews (EQRs).

In addition, the Waiver requires appropriate standards of care based on American Society of Addiction Medicine (ASAM) criteria, which were chosen mainly because they reflect a national set of guidelines for appropriate placement of care for clients who suffer from a SUD. The criteria provide a common language for the LOCs in the continuum of services. ASAM criteria were recommended by stakeholders and were already in use by providers in several counties.

**Special Terms and Conditions**

The STCs outline the new service delivery system and require a tremendous system change for the counties and their contracted providers participating in the pilot. The paradigm shift driven by the 1115 Waiver was to prompt the counties that opted into act more like managed care plans. More federal requirements and safeguards need to be implemented by the counties for DMC-ODS SUD services. Many of the requirements are the same for the mental health system, so counties are able to use their existing mental health infrastructure to implement the requirements for the SUD system. The Waiver requires many new components and activities. Some elements are part of county service delivery and oversight and others are DHCS responsibilities, as discussed below:
• **Continuum of Care**: Counties shall implement a continuum of care of all required services to address substance use, including early intervention, physician consultation, outpatient treatment, case management, MAT, recovery services, recovery residence, withdrawal management, and residential treatment.

• **Assessment Tool**: Counties shall utilize an ASAM assessment-based tool to determine the most appropriate LOC so that clients can enter the system at the appropriate level and move through the continuum of care when appropriate.

• **Case Management**: Counties shall provide case management services to ensure that clients are moving through the continuum of care and coordinate care for clients residing within the county.

• **Selective Provider Contracting**: Counties have more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access to services required in the Waiver.

• **Provider Appeals Process**: Create a provider contract appeals process where providers can appeal to the county and then the state. State appeals focus on ensuring a county followed its contracting process and maintained network adequacy requirements.

• **Provider Certification**: State Provider Enrollment Division (PED) to certify DMC providers for DMC-ODS services.

• **Clear State and County Roles**: Counties will be responsible for oversight and monitoring of providers as specified in their county contracts. PED does certification and DHCS does compliance reviews related to STCs.

• **Coordination**: Support coordination and integration across systems, such as with the provision that counties develop Memoranda of Understanding (MOUs) with managed care health plans and mental health for referral and coordination.

• **Authorization and Utilization Management**: Provide that counties authorize residential treatment and ensure medical necessity and utilization management.
• **Workforce**: Expand service providers to include Licensed Professionals in the Healing Arts (LPHAs) for the assessment of beneficiaries and other functions within their scope of practice.

• **Program Improvement**: Promote a client focus, using EBPs (including MAT services) and increasing system capacity for youth services.

The STCs described the comprehensive evidence-based system design with a full continuum of care based on ASAM. The following services are required to be provided:

- Outpatient Counseling
- Intensive Outpatient Counseling
- Short-term Residential Treatment
- Withdrawal Management (WM)
- NTPs
- Case Management
- Recovery Services
- Physician Consultation

Other optional services are Partial Hospitalization and additional MAT. Table 1-1 compares traditional DMC and DMC-ODS.

**Table 1-1: Traditional DMC and DMC-ODS**

<table>
<thead>
<tr>
<th>DMC</th>
<th>DMC-ODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Drug-Free Treatment</td>
<td>Outpatient Services</td>
</tr>
<tr>
<td>Perinatal Intensive Outpatient Treatment</td>
<td>Intensive Outpatient Services</td>
</tr>
<tr>
<td>Perinatal Residential Treatment (16 beds Only)</td>
<td>Residential Treatment Services (no bed limit)</td>
</tr>
<tr>
<td>Inpatient Hospital Detoxification (limited)</td>
<td>WM (Continuum)</td>
</tr>
<tr>
<td>Narcotic Treatment Program Services (methadone)</td>
<td>NTP Services including many FDA medications for SUD- buprenorphine, methadone, naloxone, disulfiram</td>
</tr>
<tr>
<td></td>
<td>Recovery Services</td>
</tr>
<tr>
<td></td>
<td>Case Management</td>
</tr>
<tr>
<td></td>
<td>Physical Consultation</td>
</tr>
<tr>
<td></td>
<td>Additional MAT (optional)</td>
</tr>
<tr>
<td></td>
<td>Partial Hospitalization (optional)</td>
</tr>
</tbody>
</table>

The STCs required that providers must be trained in ASAM criteria. Residential treatment providers (ASAM levels 3.1, 3.3, 3.5) would need to have an ASAM designation level from DHCS before being
able to provide DMC-ODS services. All beneficiaries served in the opt-in counties must meet the ASAM criteria definition of medical necessity.

Coordination of care is a critical component of the STCs. MOUs are required between the participating counties and their managed health care plans, including descriptions of a dispute resolution process and the coordination of case management responsibilities. The STCs require system designs that support clients moving across both the SUD delivery system and physical health. For example, having a SUD increases the risk of developing specific medical conditions, such as liver disease and cardiovascular disease. Having a medical home and coordination with primary and specialty care is critical to meet these important health needs.

Because of the Waiver and the need for residential treatment as part of the continuum of care, counties would be able to bill Medi-Cal for services that were previously billed to their Substance Abuse Prevention and Treatment Block Grant (SAPT BG). As a result, this would free up SAPT BG money for the counties that opt into the Waiver. SAMHSA gave permission to California to utilize SAPT BG funds for room and board in order to provide clients with safe and sober environments to support their recovery.

The STCs expanded the workforce by allowing LPHAs to assess, diagnose, and support clients' individualized treatment plans. An LPHA is defined as "professional staff who is licensed, registered, certified or recognized under California state scope of practice statues." An LPHA may be a Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor or license-eligible practitioner working under the supervision of licensed clinicians. This provides counties and their providers with an opportunity to expand their workforce. Another advantage to expanding to LPHAs is that it aligns with the current mental health system, thus promoting easier integration.

Another key component in the redesign of the service delivery system was to develop more program integrity and QA activities. The STCs required that counties provide oversight and monitoring to their local delivery system, while the state would also maintain a plan for oversight and monitoring of the entire system. Counties have the ability to select which providers to contract with for the provision of services. Counties must meet standards for timely access and ensure that their beneficiaries would have access to all required DMC-ODS services. The STCs also require a 24-hour access number for potential beneficiaries to call to request services. Beneficiaries also have appeal and grievance rights. Counties would have to report service and grievance data to the state on a regular basis.

Counties are also required to develop a Quality Improvement (QI) plan and create a Quality Improvement Committee (QIC) with a structured work plan, including an annual evaluation of their activities. Since this was a new requirement for the counties, there has been flexibility to integrate into existing mental health QICs. Counties had the option of expanding certain activities already in place in mental health to add in SUD requirements and focus on SUD clinical practices and requirements.

Since the opt-in counties would now function as Prepaid Inpatient Health Plans (PIHPs), the federal requirement for an EQRO review would apply. CMS requires that an independent, external contractor (CFR 42, Part 438) conduct external reviews.

**CalEQRO Review Methods and Federal Protocols**

The annual EQR technical report analyzes and aggregates data (both qualitative and quantitative) from the EQR activities throughout the prior year for each DMC-ODS county, as described below:

**Validation of Performance Measures**

This report contains the results of the EQRO’s validation of PMs as defined by DHCS for the 1115 DMC Waiver. There are 12 PMs that

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are discussed in depth in the PM section of this report. All measures are linked to access, timeliness, quality, and outcomes and were researched and proposed by the EQR Clinical Committee and approved by DHCS.

**Performance and Key Quality Components**

Other findings in this report include changes, progress, or milestones in the DMC-ODS counties’ approaches to performance management and clinical quality, including ASAM fidelity—emphasizing the use of data, outcome tools and reports, EBPs, and activities designed to manage and improve quality. Findings include implications and impact for each key component (access to care, timeliness of services, and quality of care). Many of these are similar to STCs and key elements of the design of the DMC-ODS system.

**Performance Improvement Projects**

Each DMC-ODS is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review for validation through the EQRO review. The PIPs are discussed in detail later in this report. These PIPs must include one clinical and one administrative improvement that benefit clients and their SUD treatment and care experience. Key areas of focus include initiation and engagement of clients into treatment, retention in treatment, therapeutic alliance, functional and life quality improvements, enhancement in administrative systems, and client experience of care improvements.

**Evidence of Federal Data Integrity Requirements for Health Information Systems**

Using the Information Systems Capacity Assessment (ISCA) protocol, the EQRO reviewed and analyzed the extent to which each of the DMC-ODS counties meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242.

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This evaluation included review of the DMC-ODS counties’ reporting systems and methodologies for calculating and tracking key PMs.

**Client, Family Member, and Other Stakeholder Perspectives**

The EQRO examines available client satisfaction surveys conducted by DHCS or its subcontractors. The annual Treatment Perception Survey (TPS) is a DHCS-required client experience of care survey with a variety of domains linked to quality and satisfaction. San Francisco County and UCLA worked to develop and test this client experience of care survey. These results are analyzed by UCLA and reviewed onsite with the DMC-ODS by CalEQRO.

CalEQRO also conducts client focus groups with beneficiaries and/or family members from each DMC-ODS to obtain direct qualitative evidence from beneficiaries. The number of such focus groups varied between two and five, depending on the DMC-ODS county’s size. The DMC-ODS documentation, claims and benefits data, as well as focus groups with a variety of key staff, contracted providers, advisory groups, health plans, and other stakeholders serve to inform the evaluation of each DMC-ODS county’s performance within the domains of access, timeliness, and quality.

**Review of Recommendations and Assessment of DMC-ODS Strengths and Opportunities**

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

Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com. The website also includes training materials in written and video formats to help DMC-ODS counties prepare for the reviews.
Section 2

Performance Measures

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

The first six PMs will be used in each year of the Waiver for all DMC-ODS counties and statewide. The additional PMs are based on research linked to positive health outcomes for clients with SUD and related to access, timeliness, engagement, retention in services, placement at optimal LOCs based on ASAM assessments, and outcomes. The additional six measures could be modified in future years if better, more useful metrics are needed or identified.

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

- Total beneficiaries served by each county DMC-ODS to identify whether new and expanded services are being delivered to beneficiaries
- Number of days to first DMC-ODS service after client assessment and referral
- Total costs per beneficiary served by each county DMC-ODS, by ethnic group
- Cultural competency of DMC-ODS services to beneficiaries
• Penetration rates for clients, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes)
• Coordination of care with physical health and mental health
• Timely access to medication for 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 residential treatment
• Availability of the 24-hour Access Call Center line to link clients to full ASAM-based assessments and treatment (with description of call center metrics)
• Identification and coordination of the special needs of HCBs
• Percentage of clients with three or more residential WM episodes and no other treatment to improve engagement.

Fiscal Years 2013-14 through 2016-17 Baseline Data

To evaluate the impact of the DMC program and Waiver, baseline data were analyzed for the three DMC-ODS counties reviewed in FY 2017-18, using their claims data for the four years prior to the beginning of their implementations. The data for the three counties were consolidated for this report and presented in the Figures 2-1 through 2-9.\(^\text{14}\)

Figure 2-1 includes claims data from FY 2013-14 through most of FY 2016-17 and reflects a steady expansion of services for the three counties prior to when they each began implementation of their DMC-ODS. The number of unique beneficiaries served increased from 2,326 in FY 2013-14 to 6,620 in FY 2016-17—almost triple the volume. Several factors contributed to this increase. First and foremost was the advent of the ACA, especially with the shift away from a physical health or mental health disability requirement for eligibility, effective January 2014. This resulted in a dramatic expansion of coverage to many low-income adults with an SUD who had previously been uninsured. Second was the opioid crisis that sparked the need for more treatment, particularly from NTPs. Third was the preparation for the DMC-ODS

\(^{14}\) HIPAA Suppression Disclosure: Values in tables and charts are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).
Waiver, which included improved clinical documentation and a related increase in billing for Medi-Cal covered services early in FY 2016-17, prior to the start of the Waiver.

**Figure 2-1: Total Beneficiaries Served- Baseline Years**

There was a dramatic increase in adults serviced with small growth in youth and older adult services in the baseline years as reflected in Figure 2-2.
County DMC plans prior to the Waiver did not include a comprehensive services plan and continuum of care that covered specialized services for youth and older adults. This may explain why Figure 2-2 shows the relatively flat utilization by these two age groups over the previous several years, in contrast to substantial increases in utilization for the general adult age group. As shown in Figure 2-3 below, there were no gender differences in the increasing utilization during the past several years.
Whites and Hispanic populations showed significant growth and received more services overall than other ethnic groups, as shown in Figure 2-4. Increased services were evident in all groups over time, except for Asian/Pacific Islanders. This trend is noted in a subsequent graph depicting penetration rates.

**Figure 2-4: Total Beneficiaries Served, by Race/Ethnicity- Baseline Years**

![Graph showing total beneficiaries served by race/ethnicity.](image)

In Figure 2-5, PEMC is pregnancy/emergency/minor consent. Increases in these services were significant in ACA, followed by the “other adult” and “disabled” categories. Youth services as reflected by Foster Care, Other Child, and Medical Children’s Health Insurance Program (MCHIP) eligibility were much lower.
In Figure 2-6, which reflects service patterns pre-Waiver, NTP-Methadone was the service category with the most beneficiaries served. The purpose of the Waiver, in part, was to expand the continuum of care and ensure beneficiaries would have LOC to step up to and down from, based on assessed need and optimal treatment.

It is worth noting that because the Waiver started in FY 2017, the data reflect only a partial year for FY 2016-17, which helps explain the drop-in clients for Outpatient Drug-free (ODF) Individual and Group Counseling.
Figure 2-6: Total Beneficiaries Served, by Service Category - Baseline Years

Figure 2-7 shows a steady increase in the average approved claims per beneficiary from FY 2013-14 through FY 2015-16. This trend is primarily due to the impact of ACA and also to the spreading opioid epidemic. The slight decrease in FY 2016-17 is because the data are only for a partial year of seven months for San Mateo and Riverside, and nine months for Marin. After that period, these three counties began their DMC-ODS.
Figure 2-7: Average Approved Claims, Total- Baseline Years

Figure 2-8: Average Approved Claims, by Eligibility Category- Baseline Years

Figure 2-8 shows significant increases in the average approved claims per beneficiary who had coverage in either the categories of Disabled, ACA, Family Adult, or Other Adult over the period of the baseline years. The exception is FY 2016-17, where the year is a partial one, reflecting the services before the counties launched their DMC-ODS programs. San Mateo and Riverside began in February 2017 and Marin in April 2017.
Figure 2-9 shows the baseline pre-implementation trends in average approved claims per beneficiary by service category, with the most notable being the increase in methadone dosing by NTPs. This is likely a result of the opioid crisis, with more individuals experiencing addiction to prescription opioids and heroin.

In FY 2013-14, Perinatal Intensive Outpatient Treatment was covered under the State DMC Plan under the label of Perinatal Day Care Habilitative. The name was subsequently changed in FY 2014-15. Approved claims for this service in FY 2013-14 were included under its subsequently changed label of Perinatal Intensive Outpatient Treatment.

**Figure 2-9: Average Approved Claims, by Service Category- Baseline Years**

![Graph showing average approved claims by service category for baseline years]
Discussion of Baseline Data Trends and Implications

Overall access to treatment increased steadily during the four pre-Waiver years, due primarily to changes in Medi-Cal eligibility through the ACA that began in January 2014. Increases in the use of opioid replacement therapies and counseling during this same period are likely linked to the crisis driven by opioid prescribing and use of opioid street drugs. Both the California opioid overdose dashboard data and diagnostic information for clients in this baseline period show similar trends.

The age group with the least utilization of care was youth, which is to be expected; however, counties will need to ensure that the continuum of care for substance use is robust enough to serve this vulnerable population.

Average costs per beneficiary nearly doubled between FY 2013-14 and FY 2015-16. The average cost per beneficiary across all age groups in FY 2013-14 was $1,679, nearly doubled to $3,107 by FY 2015-16, and was on a trend towards over $4,000 in FY 2016-17 if counties had not shifted to the DMC-ODS.

Calendar Year 2017—Year One of Waiver Services

Performance Measures

Data for the next section of this chapter on PMs were obtained by CalEQRO from the DHCS database for claims, eligibility, and provider files and from counties on their Access Call Center performance. Each PM is discussed below, along with highlights of results for the first year of implementation and an analysis of the implications.

The time period covers the months during which each county implemented its DMC-ODS from inception in early CY 2017 through December 2017. Riverside rolled out its DMC-ODS services in February 2017, San Mateo in February 2017, and Marin in April 2017. Therefore, even with the July 2018 refresh in data, the CY 2017 data reflect 9-11 months of DMC-ODS services in the three counties reviewed.

There is a lag time between when services are delivered, when the claims are submitted, and when the claims are approved. The data in the PM section of this chapter include all the DMC-ODS services delivered during CY 2017 for which claims were submitted and approved by June 2018. Because of this lag time, CalEQRO waits until a year after the start of the DMC-ODS direct services (in this case, during CY 2017) to conduct the first formal EQRO review.

Several factors inherent in the start-up year of implementation are worth noting for their impact on the data. DMC-ODS county providers must obtain the appropriate
licenses and certifications before billing DMC for services and must meet DMC documentation requirements for bills to be approved. Counties varied in their timing for bringing on new DMC-ODS certified services during the first implementation year. In addition, counties delayed billing for some services until provider documentation skills were up to DMC-ODS standards, and even then had up to six months to bill for services. Consequently, the claims-based data for the following PMs in this section do not reflect a full year of services for each type of treatment.

Table 2-1 reflects the number of people eligible for DMC services compared to the unduplicated number of beneficiaries who received services in Year One of the Waiver in Marin, San Mateo, and Riverside.

**Table 2-1: DMC-ODS Beneficiaries Served**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Average Monthly Unduplicated DMC-ODS Eligibles</th>
<th>Unduplicated Annual Count of Beneficiaries Served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Marin</td>
<td>San Mateo</td>
</tr>
<tr>
<td>White</td>
<td>15,622</td>
<td>19,364</td>
</tr>
<tr>
<td>Latino Hispanic</td>
<td>19,675</td>
<td>65,362</td>
</tr>
<tr>
<td>African American</td>
<td>2,118</td>
<td>4,142</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>2,570</td>
<td>29,084</td>
</tr>
<tr>
<td>Native American</td>
<td>78</td>
<td>232</td>
</tr>
<tr>
<td>Other</td>
<td>3,306</td>
<td>19,378</td>
</tr>
<tr>
<td>Total</td>
<td>43,364</td>
<td>137,561</td>
</tr>
</tbody>
</table>

The race/ethnicity results in this table can be analyzed to show how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS. If all groups showed similar patterns, one would expect the proportions they constitute of the total population of DMC-ODS enrollees to match the proportions they constitute of the total clients served. Instead, the table shows distinct differences. White beneficiaries are being served at about double (Marin and Riverside) or triple (San Mateo) the expected rate. Latino and Asian/Pacific Islanders are receiving fewer services compared to their enrollment status, while African Americans have high rates of service two of the three counties (Marin and San Mateo).

The penetration rates are calculated by using as the numerator the unduplicated count of beneficiaries receiving at least one billed session from a DMC-ODS-certified
treatment provider. The denominator used is the average monthly count of Medi-Cal eligibles entitled to receive DMC coverage during CY 2017.

Figure 2-10 shows the overall penetration rates for the DMC-ODS counties in CY 2017.

**Figure 2-10: Overall Medi-Cal Penetration Rates, by County**

This reflects baseline Year One service data for the DMC-ODS counties; as the network of ASAM services expands and the continuum of care is filled out in Years Two and Three of the counties’ DMC-ODS implementation, the penetration rate is expected to rise of Medi-Cal clients served as a proportion of persons eligible for DMC services.

CY 2017 was the start-up year for each county. The penetration rate results are affected significantly by the differences in each county’s ability to implement networks of providers so they can successfully bill DMC for new DMC-ODS services. The overall penetration rates in this graph and other more detailed breakdowns of the rate by subgroups will take on more meaning in subsequent years beyond the start-up. In subsequent years, it is expected that network providers’ treatment services and billing practices will begin to stabilize. It is difficult to determine whether the higher penetration rate for Marin reflects an actual difference in percent of clients served, a more rapid stand-up of treatment services and billing practices, or a combination of these and other factors.
In its 2018 annual evaluation report of the DMC-ODS, the UCLA Integrated Substance Use Team reported on penetration rates using a different method of calculation than CalEQRO used, which yielded different rates. The UCLA Team sought to first determine the percentage of DMC-ODS beneficiaries estimated to need DMC-ODS services, and then measured what percentage of that smaller group actually received DMC-ODS services. SAMHSA data from the National Survey on Drug Use and Health (NSDUH) study were used to determine need and the new calculations showed Marin at a 9 percent penetration rate, Riverside at 6.2 percent and San Mateo at 4.4 percent. The penetration rate overall for the three counties was 6.5 percent using the methodology based on need for SUD treatment, rather than a rate based on total Medi-Cal beneficiaries.

Table 2-2 shows that, not surprisingly, the 18- to 64-year-old age group accessed DMC-ODS services at the highest rate across the three counties. Children and youth ages 12 to 17 accessed DMC-ODS services at a much lower rate. Some counties selected increasing the DMC-ODS services to youth as a focus for one of their PIPs. All three counties set as a future priority expanding their prevention and treatment services for youth.

Table 2-2: DMC-ODS Beneficiaries Served, by Age, CY 2017

| Age Groups | Marin | | San Mateo | | Riverside | |
|------------|-------|---|------------|---|-------------|
|             | Average Number of Eligibles per Month | Number Beneficiary Served | Average Number of Eligibles per Month | Number Beneficiary Served | Average Number of Eligibles per Month | Number Beneficiary Served |
| Total       | 43,367 | 585 | 137,562 | 870 | 729,319 | 5,336 |
| 12-17       | 10,561 | 27 | 33,714 | 28 | 233,998 | 269 |
| 18-64       | 26,219 | 492 | 78,312 | 779 | 408,775 | 4,782 |
| 65+         | 6,587 | 66 | 25,536 | 63 | 86,546 | 285 |

The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Table 2-3 and Figure 2-11 below indicate that the age group with the highest average approved claims costs is the 65+ age group, reflecting that members of the older age group are needing more intensive and lengthier substance use treatment in addition to more physical health care because of their more complex medical conditions.

The three counties all have higher average claims costs per beneficiary than the combined average for all the counties that began implementing the DMC-ODS
Table 2-3: Average Approved Claims, by Age

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Approved Claims</td>
<td>Approved Claims per Beneficiary Served</td>
<td>Total Approved Claims</td>
<td>Approved Claims per Beneficiary Served</td>
</tr>
<tr>
<td>Total</td>
<td>$2,101,535</td>
<td>$3,592</td>
<td>$3,209,282</td>
<td>$3,689</td>
</tr>
<tr>
<td>12-17</td>
<td>$74,458</td>
<td>$2,758</td>
<td>$34,879</td>
<td>$1,246</td>
</tr>
<tr>
<td>18-64</td>
<td>$1,780,563</td>
<td>$3,619</td>
<td>$2,907,772</td>
<td>$3,733</td>
</tr>
<tr>
<td>65+</td>
<td>$246,513</td>
<td>$3,735</td>
<td>$266,630</td>
<td>$4,232</td>
</tr>
</tbody>
</table>

Figure 2-11: Average Approved Claims, by Age

Table 2-4 shows beneficiaries served by eligibility category. Clearly, ACA eligibility was an important factor in access to treatment. Costs across these groups showed the eligibility category of “Other Adult” as one of the most expensive groups.
Seniors largely populate this group, and they often experience higher costs linked to complex medical conditions that in turn drive approaches to their SUD treatment.

Table 2-4: Approved Claims by Eligibility Category

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Number of Beneficiaries Served</th>
<th>Approved Claims per Beneficiary Served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Marin</td>
<td>San Mateo</td>
</tr>
<tr>
<td>ACA</td>
<td>366</td>
<td>530</td>
</tr>
<tr>
<td>Disabled</td>
<td>117</td>
<td>182</td>
</tr>
<tr>
<td>Foster Care</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Other Child</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Family Adult</td>
<td>75</td>
<td>140</td>
</tr>
<tr>
<td>Other Adult</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>MCHIP</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>599</td>
<td>891</td>
</tr>
</tbody>
</table>

Timely Access to Methadone Medication in Narcotic Treatment Programs after First Client Contact

Methadone is a well-established EBP for treatment of opiate addiction using a narcotic replacement therapy approach. Extensive research studies document that with daily methadone dosing, many clients with otherwise intractable opiate addictions are able to stabilize and live productive lives at work, with family, and in independent housing. However, the treatment can be associated with stigma, and usually requires a regular regimen of daily dosing at an NTP site.

Persons seeking methadone medication have often tried other treatments without success. Consequently, if they do not begin methadone medication soon after requesting it, they are likely to go back to opiate use, which can be life threatening. For these reasons, NTPs regard the request to begin treatment with methadone as urgent and requiring a timely response. Tables 3-5 and 3-6 show the average number of days from triage/assessment contact to the first dose of NTP services for opioid use disorder (OUD) diagnoses, first by age groups and then by race/ethnicity.

Table 2-5 shows that all of the counties reviewed had timely access to medication in NTPs. The 3.25 days to access medication in NTP services in Riverside is due to
the longer distances required to reach NTPs in some of the rural areas, and the extreme heat clients endure during some parts of the year to travel there.

Both Marin and San Mateo are close to the one-day statewide average for first dose at an NTP site, while Riverside has a three-day average overall, and almost five days for the Hispanic/Latino population. Isolated communities in the vast area covered by Riverside County have greater transportation and access needs. This, combined with periods of the year where heat poses serious health risks, make one-day access to medication appointments difficult. County staff suggested in two of the three counties that pharmacy controlled and accessed methadone would reduce wait times.

It is important to understand that while the CalEQRO looked at timely access to methadone dosing in Year One, there are other required medications which had very limited prescribing going on in this first year of the waiver. These medications are an important part of the DMC-ODS plan and as reflected in the next measure are not being prescribed regularly or in high volumes by the NTPs.

Table 2-5: Number of Days to First Dose of Methadone at NTPs, by Age

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Count</td>
<td>231</td>
<td>1.33</td>
<td>281</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Age Group 12-17</td>
<td>0</td>
<td>n/a</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Age Group 18-64</td>
<td>187</td>
<td>1.6</td>
<td>236</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Age Group 65+</td>
<td>44</td>
<td>&lt;1</td>
<td>45</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

Table 2-6: Number of Days to First Dose of Methadone at NTPs, by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Count</td>
<td>231</td>
<td>1.33</td>
<td>281</td>
<td>&lt;1</td>
</tr>
<tr>
<td>White</td>
<td>185</td>
<td>1.58</td>
<td>144</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Hispanic/ Latino</td>
<td>15</td>
<td>&lt;1</td>
<td>33</td>
<td>&lt;1</td>
</tr>
<tr>
<td>African-American</td>
<td>15</td>
<td>&lt;1</td>
<td>38</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Asian/Pacific-Islander</td>
<td>*</td>
<td>&lt;1</td>
<td>*</td>
<td>n/a</td>
</tr>
<tr>
<td>Native American</td>
<td>*</td>
<td>&lt;1</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Other</td>
<td>*</td>
<td>&lt;1</td>
<td>56</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>
Expanded Access to FDA Approved Medication-Assisted Treatment

Tables 2-7 through 2-9 display the number and percentage of clients receiving three or more non-methadone MAT visits per year from DMC-ODS providers in Marin, San Mateo, Riverside, and consolidated statewide for all DMC-ODS counties. The threshold of three or more visits was selected to identify clients who were getting a series of MAT treatments rather than just an evaluation with perhaps a single trial dose. This paid claims data can be from NTPs which are providing medications other than methadone as well as DMC certified outpatient clinics billing through DMC, not fee-for-service.

The data are based on approved DMC-ODS claims and reflect only a partial sample of the total number of beneficiaries receiving non-methadone MAT services. Many beneficiaries who received these services did so through primary care clinics and physicians who billed Medi-Cal fee-for-service managed care plans, yielding data not systematically accessible to CalEQRO for this report. Also, each county was in the early stages of training and supporting the community, its primary care physicians, and other allowed prescribers to proactively prescribe SUD medications. For example, San Mateo has a robust non-methadone MAT program in full partnership with a Federally Qualified Health Center (FQHC) via a provider contract, which has an expansive MAT program for a variety of medications. These data were not directly available to the EQRO at this time.

Table 2-7: Three or More Non-Methadone MAT Visits Billed by DMC-ODS Providers

<table>
<thead>
<tr>
<th></th>
<th># of Total DMC-ODS Clients</th>
<th># of Clients with Any MAT Visit</th>
<th>% of any Visits</th>
<th>% of 3+ MAT Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6,791</td>
<td>50</td>
<td>0.74%</td>
<td>0.57%</td>
</tr>
<tr>
<td>Marin</td>
<td>585</td>
<td>29</td>
<td>4.95%</td>
<td>3.42%</td>
</tr>
<tr>
<td>San Mateo</td>
<td>870</td>
<td>*</td>
<td>0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Riverside</td>
<td>5,336</td>
<td>*</td>
<td>0.39%</td>
<td>0.36%</td>
</tr>
</tbody>
</table>
Table 2-8: Three or More Non-Methadone MAT Visits, By Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Marin # of Total DMC-ODS Clients</th>
<th>% 3 or More Visits</th>
<th>San Mateo # of Total DMC-ODS Clients</th>
<th>% 3 or More Visits</th>
<th>Riverside # of Total DMC-ODS Clients</th>
<th>% 3 or More Visits</th>
<th>Statewide # of Total DMC-ODS Clients</th>
<th>% 3 or More Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>585</td>
<td>3.42%</td>
<td>870</td>
<td>0.0%</td>
<td>5,336</td>
<td>0.36%</td>
<td>29,226</td>
<td>0.27%</td>
</tr>
<tr>
<td>12-17</td>
<td>27</td>
<td>n/a</td>
<td>28</td>
<td>0.0%</td>
<td>269</td>
<td>n/a</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>18-64</td>
<td>492</td>
<td>3.86%</td>
<td>779</td>
<td>0.0%</td>
<td>4,782</td>
<td>0.40%</td>
<td>24,304</td>
<td>0.31%</td>
</tr>
<tr>
<td>65+</td>
<td>66</td>
<td>1.52%</td>
<td>63</td>
<td>0.0%</td>
<td>285</td>
<td>n/a</td>
<td>3,349</td>
<td>0.15%</td>
</tr>
</tbody>
</table>

Table 2-9: Three or More non-Methadone MAT Visits, by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Marin # of Clients</th>
<th>% 3 or More Visits</th>
<th>San Mateo # of Clients</th>
<th>% 3 or More Visits</th>
<th>Riverside # of Clients</th>
<th>% 3 or More Visits</th>
<th>Statewide # of Clients</th>
<th>% 3 or More Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>585</td>
<td>3.42%</td>
<td>870</td>
<td>0.0%</td>
<td>5,336</td>
<td>0.36%</td>
<td>29,226</td>
<td>0.27%</td>
</tr>
<tr>
<td>White</td>
<td>399</td>
<td>4.51%</td>
<td>369</td>
<td>0.0%</td>
<td>2,387</td>
<td>0.54%</td>
<td>10,596</td>
<td>0.49%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>85</td>
<td>0%</td>
<td>176</td>
<td>0.0%</td>
<td>2,080</td>
<td>0.24%</td>
<td>10,401</td>
<td>0.12%</td>
</tr>
<tr>
<td>African-American</td>
<td>45</td>
<td>4.44%</td>
<td>103</td>
<td>0.0%</td>
<td>358</td>
<td>0.28%</td>
<td>3,659</td>
<td>0.11%</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>*</td>
<td>0%</td>
<td>49</td>
<td>0.0%</td>
<td>41</td>
<td>0%</td>
<td>593</td>
<td>0.51%</td>
</tr>
<tr>
<td>Native American</td>
<td>*</td>
<td>0%</td>
<td>*</td>
<td>0.0%</td>
<td>29</td>
<td>0%</td>
<td>190</td>
<td>0.53%</td>
</tr>
<tr>
<td>Other</td>
<td>40</td>
<td>0%</td>
<td>164</td>
<td>0.0%</td>
<td>441</td>
<td>0%</td>
<td>3,409</td>
<td>0.21%</td>
</tr>
</tbody>
</table>
At this point, this measure is robust only for Marin, which was able to increase its non-methadone MAT treatment services delivered through DMC-ODS providers. San Mateo was able to launch a successful non-methadone MAT set of services, but exclusively through its FQHC primary care clinics. Riverside was also partnering with NTPs and FQHC primary care clinics for services and their data is currently not available through the FQHC to CalEQRO. The data the county collected on the results of its efforts were not available through DMC-ODS databases to populate the fields in these tables, but San Mateo did obtain the data through a research project they then shared with CalEQRO for the San Mateo’s DMC-ODS CalEQRO report.

Transitions in Care Post-Residential Treatment

The DMC-ODS Waiver emphasizes client-centered care, one element of which is the expectation that treatment intensity should change over time to match the client’s changing condition and treatment needs. This treatment philosophy is in marked contrast to a program-driven approach, in which treatment would be standardized for clients according to their time in treatment (e.g. a fixed program for week one, week two, and so on).

Tables 2-10 and 2-11 show two aspects of this ASAM treatment expectation: (1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. Table 3-10 shows the percent of clients who began a new LOC within seven days, 14 days, and 30 days after discharge from residential treatment. Table 3-11 shows similar information from the perspective of statewide data for DMC-ODS counties. Also shown in each table are the percentage of clients who received follow-up treatment from 31 to 365 days, and clients who received no follow-up within the DMC-ODS Medi-Cal system.

Follow-up services that are counted in this measure are based entirely on DMC-ODS claims data and include outpatient, intensive outpatient, partial hospital, MAT, NTP, WM, case management, and recovery supports. CalEQRO does not count readmission to residential treatment in this measure or changes in residential LOC. CalEQRO was not able to obtain and count fee-for-service (FFS) health plan Medi-Cal claims data at this time. Also affecting the calculation of these data, counties continued to provide aftercare services and had yet to set them up as DMC-ODS billable recovery support services that could be counted.
Table 2-10: Transitions in Care, Post-Residential Treatment DMC-ODS

<table>
<thead>
<tr>
<th></th>
<th>Marin</th>
<th></th>
<th>San Mateo</th>
<th></th>
<th>Riverside</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Transfer Admits</td>
<td>%</td>
<td>Total</td>
<td>Transfer Admits</td>
<td>%</td>
</tr>
<tr>
<td>Within 7 days</td>
<td>91</td>
<td>9</td>
<td>10%</td>
<td>214</td>
<td>27</td>
<td>13%</td>
</tr>
<tr>
<td>Within 14 days</td>
<td>91</td>
<td>14</td>
<td>15%</td>
<td>214</td>
<td>30</td>
<td>15%</td>
</tr>
<tr>
<td>Within 30 days</td>
<td>91</td>
<td>20</td>
<td>22%</td>
<td>214</td>
<td>37</td>
<td>18%</td>
</tr>
<tr>
<td>Any Days</td>
<td>91</td>
<td>28</td>
<td>31%</td>
<td>214</td>
<td>48</td>
<td>22%</td>
</tr>
<tr>
<td>Total Transfer Admits, Post Residential</td>
<td>91</td>
<td>28</td>
<td>31%</td>
<td>214</td>
<td>48</td>
<td>22%</td>
</tr>
</tbody>
</table>

Table 2-11: Transitions in Care, Post-Residential Treatment DMC-ODS, Statewide

<table>
<thead>
<tr>
<th></th>
<th>Statewide</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 12-17</td>
<td></td>
<td>Age 18-64</td>
<td></td>
<td>Age 65+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>Transfer Admits</td>
<td>%</td>
<td>Total</td>
<td>Transfer Admits</td>
<td>%</td>
</tr>
<tr>
<td>Within 7 days</td>
<td>105</td>
<td>*</td>
<td>n/a</td>
<td>5,133</td>
<td>388</td>
<td>8%</td>
</tr>
<tr>
<td>Within 14 days</td>
<td>105</td>
<td>*</td>
<td>n/a</td>
<td>5,133</td>
<td>516</td>
<td>10%</td>
</tr>
<tr>
<td>Within 30 days</td>
<td>105</td>
<td>*</td>
<td>n/a</td>
<td>5,133</td>
<td>641</td>
<td>13%</td>
</tr>
<tr>
<td>Any Days</td>
<td>105</td>
<td>*</td>
<td>n/a</td>
<td>5,133</td>
<td>817</td>
<td>16%</td>
</tr>
<tr>
<td>Total Transfer Admits, Post Residential</td>
<td>105</td>
<td>*</td>
<td>n/a</td>
<td>5,133</td>
<td>817</td>
<td>16%</td>
</tr>
</tbody>
</table>

Based on the data in Table 2-10, the consolidated statewide average among the DMC-ODS counties for percentage of transfer admits, post-residential, is 16 percent. This is a low percentage that in part reflects the pre-Waiver, program-driven approach that clients stay with the treatment program in which they began their treatment until the time comes for aftercare. In part, it also reflects the ongoing practice of aftercare or “alumni” groups that are not billed to Medi-Cal and therefore do not appear in the data. The DMC-ODS Waiver allows for billing some of these
services through recovery support, but most counties will not start this until their second year of implementation. We would expect the statewide average to increase substantially in future years.

Compared to the statewide average of 16 percent, Marin is doing well at 31 percent of all clients who are discharged from residential treatment and then receive follow up services. San Mateo is at 22 percent. Riverside is at 16 percent, which corresponds to the statewide average.

This measure, while constituting important information, is groundbreaking and without much data available for comparison in the research literature. The results reported here afford a valuable baseline for future measurement and targeted improvements. NIDA was considering this measure as well and looked forward to coordination of results with California’s data, allowing nationwide comparisons of this measure. As data are collected across California and the country, more opportunities will emerge to develop baseline data for benchmarking and improvements in transitions in care.

**Access Line Quality and Timeliness**

Table 2-12 shows access line critical indicators for Marin, San Mateo, and Riverside. Technical assistance (TA) is needed in Year Two of their Waiver service implementation to ensure that counties are completing this required form consistently for data comparison purposes. Each of the counties implemented responsive and professional Access Call Center lines using ASAM-based screen methods to link clients to services. San Mateo had an unusual pattern in that 26 sites in the county were trained and approved to conduct ASAM assessments, including both county and contract treatment providers. The majority of the requests for services went directly to these sites, but data systems were not in place yet to capture the time of the walk-in or call and subsequent treatment visits. Thus, Access Call Center volumes were lower because community members were using other access points.
Table 2-12: Access Line Critical Indicators

<table>
<thead>
<tr>
<th></th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Volume</td>
<td>508 calls per month</td>
<td>14 calls per month (only screening and referrals were counted)</td>
<td>3,466 calls per month</td>
</tr>
<tr>
<td>% Dropped Calls</td>
<td>5.3%</td>
<td>5.5%</td>
<td>7.45%</td>
</tr>
<tr>
<td>Time to answer calls</td>
<td>9.6 seconds</td>
<td>22 seconds</td>
<td>No data reported</td>
</tr>
<tr>
<td>Monthly authorizations for residential treatment</td>
<td>24.4</td>
<td>54.4</td>
<td>291</td>
</tr>
<tr>
<td>% of calls referred to a treatment program for care, including residential authorizations</td>
<td>20%</td>
<td>Only screening and referral calls were tracked, so the percent of total calls is unknown</td>
<td>12.27%</td>
</tr>
<tr>
<td>Non-English capacity</td>
<td>4.0 FTE Access Line staff are bilingual (English/Spanish) and the County has contracts with two language vendors.</td>
<td>Staff who speak Spanish, Mandarin, and Korean</td>
<td>Spanish capacity; TTY/711 for hard of hearing</td>
</tr>
<tr>
<td>Software Used</td>
<td>Avaya</td>
<td>Netsmart</td>
<td>Cisco</td>
</tr>
</tbody>
</table>

High-Cost Beneficiaries

Table 2-13 provides several types of information on the group of clients who use higher amounts of DMC-ODS services. The totals include all required services from DMC-ODS Medi-Cal claims, but not ancillary SAPT funds. These clients, labeled in this table as HCBs, are defined as those who incur substance use treatment costs at the 90th percentile or higher statewide, which equates to at least $5,721 in approved claims per year (as of the July 2018 claims data refresh). Table 2-13 also lists the average approved claims costs for the year for HCBs in the three DMC ODS counties compared with the statewide average. DMC-ODS counties are expected to find multiple uses for these data. For example, they can use the data to determine how the percentage of their HCBs compares to the statewide average and how the average cost of their HCBs compares to the statewide average. They may also use the data to decide whether to initiate their own special study of whether their HCBs are receiving individualized effective treatment to optimize positive outcomes and develop new case management approaches to further enhance treatment outcomes.

The statewide comparison group data and county data are developmental, change regularly, and will be of limited usefulness until most DMC-ODS counties have generated at least one year of DMC-ODS services data. At that point, the data will stabilize and become more useful as a benchmark. In the meantime, each county
may still find it useful to study the characteristics and needs of their HCBs to improve their care plans and care coordination.

Table 2-13 shows the percentage of total beneficiaries who meet the statewide HCB cutoff, with Riverside having the lowest (14 percent) and San Mateo the highest (21 percent). This contrasts with the statewide average of 9 percent. These tables also show the average cost of HCBs in each county as compared to the statewide average for HCBs. Riverside has the highest cost, exceeding the statewide average for HCBs, and Marin the lowest, with San Mateo closest to the statewide average. This is also a new measure for use in SUD quality initiatives.

Table 2-13: HCBs at 90th Percentile or Higher including all DMC-ODS Program Types

<table>
<thead>
<tr>
<th></th>
<th>Total Beneficiary Count</th>
<th>HCB Count</th>
<th>HCB % by Count</th>
<th>Average Approved Claims per HCB</th>
<th>HCB Total Claims</th>
<th>HCB % of Total Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>36,763</td>
<td>2,992</td>
<td>8%</td>
<td>$16,543</td>
<td>$49,497,265</td>
<td>36%</td>
</tr>
<tr>
<td>Marin</td>
<td>761</td>
<td>154</td>
<td>20%</td>
<td>$11,398</td>
<td>$ 1,755,322</td>
<td>40%</td>
</tr>
<tr>
<td>San Mateo</td>
<td>1,084</td>
<td>160</td>
<td>15%</td>
<td>$10,552</td>
<td>$ 2,281,673</td>
<td>44%</td>
</tr>
<tr>
<td>Riverside</td>
<td>5,461</td>
<td>670</td>
<td>12%</td>
<td>$13,435</td>
<td>$ 9,718,479</td>
<td>47%</td>
</tr>
</tbody>
</table>

Withdrawal Management with No Other Treatment

Table 2-14 reflects findings from the measure of clients discharged from WM who receive no follow-up treatment. This is an important measure of whether the treatment system engages clients in treatment to prevent further episodes requiring urgent care related to substance use treatment, such as WM.
Table 2-14: Three or More Withdrawal Management Episodes Without Other Treatment, by Age

<table>
<thead>
<tr>
<th>WM by Age Group</th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td># WM Clients</td>
<td></td>
<td># WM Clients</td>
<td>% 3+ Episodes &amp; no other services</td>
<td>% 3+ Episodes &amp; no other services</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>n/a</td>
<td>662</td>
<td>970</td>
</tr>
<tr>
<td>12-17</td>
<td>*</td>
<td>n/a</td>
<td>*</td>
<td>n/a</td>
</tr>
<tr>
<td>18-64</td>
<td>39</td>
<td>0.0%</td>
<td>640</td>
<td>933</td>
</tr>
<tr>
<td>65+</td>
<td>*</td>
<td>n/a</td>
<td>*</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Marin DMC-ODS did not fully implement and begin claiming its residential WM services until late in their first implementation year, so the data are not an accurate reflection of the total numbers of clients served in residential WM. San Mateo was still working to get its WM provider certified for DMC services by the end of its implementation year, so no data are available for San Mateo. For Riverside, less than one percent of WM clients overall had received three or more episodes without the benefit of any follow-up treatment services. It is positive that clients who are utilizing WM are getting linked to treatment and that the percentage who do not have some other treatment engagement is very low.

**Diagnostic Categories**

Table 2-15 summarizes the diagnostic billing codes used statewide by DMC-ODS counties, separated by major diagnostic categories.

Table 2-15: Diagnosis Codes

<table>
<thead>
<tr>
<th>Diagnosis Category – ICD 10</th>
<th>Diagnosis Codes (for dates of service on or after October 1, 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use Disorder</td>
<td>F1010, F10120, F10129, F1020, F1021, F10220, F10229, F10230, F10239, F10920, F10929</td>
</tr>
<tr>
<td>Cannabis Use</td>
<td>F1210, F12120, F12129, F1220, F1221, F12220, F12229, F1290, F12920, F12929</td>
</tr>
<tr>
<td>Cocaine Abuse or Dependence</td>
<td>F1410, F14120, F14129, F1420, F1421, F14220, F14229, F1423, F1490, F14920, F14929</td>
</tr>
<tr>
<td>Hallucinogen Dependence or Unspecified</td>
<td>F1610, F16120, F16129, F1620, F1621, F16220, F16229, F1690, F16920, F16929</td>
</tr>
</tbody>
</table>
Diagnosis Category – ICD 10 | Diagnosis Codes (for dates of service on or after October 1, 2015)
---|---
Inhalant Abuse/Dependence/Unspecified | F1821, F1810, F18120, F18129, F1820, F18220, F18229, F1890, F18920, F18929
Opioid | F1110, F11120, F11129, F1120, F1121, F11220, F11229, F1123, F1190, F11920, F11929, F1193
Other Stimulant Abuse/Dependence | F1510, F15120, F15129, F1520, F1521, F15220, F15229, F1523, F1590, F15920, F15929, F1593
Other Psychoactive Substance | F1910, F19120, F19129, F1920, F1921, F19220, F19229, F19230, F19239, F1990, F19920, F19929
Sedative, Hypnotic Abuse/Dependence | F1310, F13120, F13129, F1320, F1321, F13220, F13229, F13230, F13239, F1390, F13920, F13921, F13929, F13930, F13939

Table 2-16 compares the breakdown by diagnostic category of the statewide and county numbers of beneficiaries served and total approved claims amounts, respectively, for CY 2017. The primary drug of choice among those treated in DMC-ODS counties is opioids, followed by stimulants and then alcohol. An exception is Marin, where alcohol is the second primary drug of choice and stimulants the third.

These data do not necessarily reflect the relative prevalence of types of drug use in the population, but rather the types of drugs used among those treated in the DMC-ODS counties. Until the advent of the Waiver, few types of services were covered by DMC and the predominant covered service was methadone-based narcotic replacement treatment. It will take some time for this legacy to be balanced by the impact of the many services newly covered by DMC that address a wider variety of SUDs than opioid addictions. During this initial year of services, 58.6 percent of funds statewide focused on treatment of opioid use disorders.

Table 2-16: Percentage Served and Average Cost, by Diagnosis Code

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Served</td>
<td>Average Cost</td>
<td>% Served</td>
<td>Average Cost</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>$3,864</td>
<td>100%</td>
<td>$3,171</td>
</tr>
<tr>
<td>Alcohol Use Disorder</td>
<td>19.6%</td>
<td>$3,360</td>
<td>19%</td>
<td>$3,269</td>
</tr>
<tr>
<td>Cannabis Use</td>
<td>6.5%</td>
<td>$1,598</td>
<td>5.5%</td>
<td>$1,997</td>
</tr>
</tbody>
</table>
## PERFORMANCE MEASURES

<table>
<thead>
<tr>
<th>Substance Category</th>
<th>2017 %</th>
<th>2018 %</th>
<th>2017 $</th>
<th>2018 $</th>
<th>2017 %</th>
<th>2018 %</th>
<th>2017 $</th>
<th>2018 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine Abuse or Dependence</td>
<td>1.6%</td>
<td>2.9%</td>
<td>$3,598</td>
<td>$2,126</td>
<td>1.2%</td>
<td>1.7%</td>
<td>$2,104</td>
<td>$2,705</td>
</tr>
<tr>
<td>Hallucinogen Dependence</td>
<td>0</td>
<td>0.0%</td>
<td>$0</td>
<td>$0</td>
<td>0.1%</td>
<td>0.4%</td>
<td>$659</td>
<td>$2,388</td>
</tr>
<tr>
<td>Inhalant Abuse</td>
<td>0</td>
<td>0.0%</td>
<td>$0</td>
<td>$0</td>
<td>0.0%</td>
<td>0.0%</td>
<td>$55</td>
<td>$739</td>
</tr>
<tr>
<td>Opioid</td>
<td>53.2%</td>
<td>46.4%</td>
<td>$4,634</td>
<td>$2,678</td>
<td>41.0%</td>
<td>58.6%</td>
<td>$2,109</td>
<td>$3,221</td>
</tr>
<tr>
<td>Other Stimulant Abuse</td>
<td>18.4%</td>
<td>20.4%</td>
<td>$2,991</td>
<td>$2,953</td>
<td>31.7%</td>
<td>20.3%</td>
<td>$2,149</td>
<td>$2,521</td>
</tr>
<tr>
<td>Other Psychoactive Substance</td>
<td>0.4%</td>
<td>5.2%</td>
<td>$4,130</td>
<td>$9,805</td>
<td>0.0%</td>
<td>1.1%</td>
<td>$1,829</td>
<td>$2,684</td>
</tr>
<tr>
<td>Sedative, Hypnotic Abuse</td>
<td>0.4%</td>
<td>0.5%</td>
<td>$4,063</td>
<td>$3,414</td>
<td>0.6%</td>
<td>0.3%</td>
<td>$2,143</td>
<td>$2,831</td>
</tr>
</tbody>
</table>
Self-Assessment of Timely Access

The tables in this section are based upon county-generated self-assessment data. The DMC-ODS counties assessed the extent to which they met their own standards for several important types of timeliness measures.

Counties reported access within the 14-day standard they set for timely offers of first appointments. The network adequacy standard for outpatient for DMC-ODS is 10 business days, which is different, but with weekend days included it is similar in timeliness. The average length of time from first request to first offered appointment measure is based upon data logged at the time of first request for treatment, whether it occurs through a client’s phone call to a centralized access center call line requesting guidance for how to get into treatment, a phone call to a treatment provider requesting an appointment, or a walk-in to an access center or treatment program requesting treatment. Entering the time and date of first request for treatment is part of a new responsibility associated with beginning the DMC-ODS.
The table indicates the DMC-ODS counties have set appropriate standards for themselves. Marin and Riverside have set up data entry and tracking systems, which is no small feat, and San Mateo tracked Access Call Center activity but did not track the other 26 access sites, since data systems were not in place in Year One of the Waiver’s service implementation. Both Marin and Riverside appear to be effective in meeting this timeliness standard, although Riverside might investigate how to improve its timeliness performance for children’s services.

**Table 2-17: Average Length of Time from First Request to First Offered Appointment**

<table>
<thead>
<tr>
<th></th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Services</td>
<td>Adult Services</td>
<td>Child Services</td>
</tr>
<tr>
<td>Number of days (mean)</td>
<td>2.37</td>
<td>2.29</td>
<td>4.58</td>
</tr>
<tr>
<td>Range</td>
<td>0-24</td>
<td>0-24</td>
<td>1-11</td>
</tr>
<tr>
<td>DMC-ODS standard or goal</td>
<td>&lt;10 business days</td>
<td>&lt;10 business days</td>
<td>&lt;10 business days</td>
</tr>
<tr>
<td>% met standard</td>
<td>98%</td>
<td>98.1%</td>
<td>96.2%</td>
</tr>
</tbody>
</table>

**Table 2-18: Average Length of Time from First Request to First Face-to-face Session**

<table>
<thead>
<tr>
<th></th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Services</td>
<td>Adult Services</td>
<td>Child Services</td>
</tr>
<tr>
<td>Number of days (mean)</td>
<td>2.67</td>
<td>2.60</td>
<td>4.58</td>
</tr>
<tr>
<td>Range</td>
<td>0-31</td>
<td>0-31</td>
<td>1-11</td>
</tr>
<tr>
<td>DMC-ODS standard or goal</td>
<td>&lt;10 business days</td>
<td>&lt;10 business days</td>
<td>&lt;10 business days</td>
</tr>
<tr>
<td>% met standard</td>
<td>98%</td>
<td>98.1%</td>
<td>96.2%</td>
</tr>
</tbody>
</table>
Average length of time from first request to first face-to-face session is a challenging measure to track; it requires an electronic linkage between the date/time a call for the initial request for treatment is logged, and the date/time that the client has his or her first session in a treatment program. The logged calls at the Access Call Center line are usually entered into a different software and database than the software used for storing electronic health record (EHR) information. In fact, paper technology is still commonly used by contracted treatment provider programs to log calls. All three DMC-ODS counties seem to be tracking this measure. Marin and Riverside are operating well within their standards. San Mateo is tracking the data but its performance is well over its standard, indicating this is a function its teams might focus upon for QI.

Table 2-19: Average Length of Time from Initial Request to Urgent Session

<table>
<thead>
<tr>
<th></th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult</td>
<td>Adult</td>
<td>Adult</td>
</tr>
<tr>
<td></td>
<td>Service</td>
<td>Service</td>
<td>Service</td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td>Child</td>
<td>Child</td>
</tr>
<tr>
<td></td>
<td>Service</td>
<td>Service</td>
<td>Service</td>
</tr>
<tr>
<td>Number of days (mean)</td>
<td>--</td>
<td>--</td>
<td>8.80</td>
</tr>
<tr>
<td></td>
<td>--</td>
<td>--</td>
<td>8.80</td>
</tr>
<tr>
<td></td>
<td>--</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Range</td>
<td>--</td>
<td>--</td>
<td>0-20 days</td>
</tr>
<tr>
<td></td>
<td>--</td>
<td>--</td>
<td>0-20 days</td>
</tr>
<tr>
<td></td>
<td>--</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>DMC-ODS standard or goal</td>
<td>--</td>
<td>--</td>
<td>3 days</td>
</tr>
<tr>
<td></td>
<td>--</td>
<td>--</td>
<td>3 days</td>
</tr>
<tr>
<td></td>
<td>--</td>
<td>n/a</td>
<td>3 days</td>
</tr>
<tr>
<td>% met standard</td>
<td>--</td>
<td>--</td>
<td>26.7 %</td>
</tr>
<tr>
<td></td>
<td>--</td>
<td>--</td>
<td>26.7 %</td>
</tr>
<tr>
<td></td>
<td>--</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Urgent treatment access is a more difficult measure to track. A county DMC-ODS must first decide how to operationalize “urgent,” which usually entails a clinical need for WM or some form of MAT, or the need for treatment of perinatal women for whom pregnancy or the health of newborns may be at risk due to a SUD. The DMC-ODS must then track when the request first came and when treatment began. Neither Marin nor San Mateo tracked this measure in Year One of service implementation; however, both have that task as a goal for Year Two of their DMC-ODS Waiver service implementation. Riverside indicates it is tracking its performance, and has yet to achieve a timely practice that meets its standard. Riverside is investigating this issue and believe that staff are counting different types of visits under urgent or are trying to access hospital based WM which is not readily available. More investigation is needed to confirm this issue with urgent services.
Table 2-20: Withdrawal Management Readmission Rates Within 30 Days

<table>
<thead>
<tr>
<th></th>
<th>Marin</th>
<th>San Mateo</th>
<th>Riverside</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Services</td>
<td>Adult Services</td>
<td>Child Services</td>
</tr>
<tr>
<td>Total number of withdrawal management admissions</td>
<td>652</td>
<td>652</td>
<td>n/a</td>
</tr>
<tr>
<td>Total number with readmission within 30 days</td>
<td>112</td>
<td>112</td>
<td>n/a</td>
</tr>
<tr>
<td>Readmission rate (30 days)</td>
<td>17%</td>
<td>17%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Marin and Riverside were slow to start billing for this LOC, and San Mateo was still working with its contracted provider for this service to obtain DMC certification.

Riverside’s data indicated an appropriately low readmission rate, whereas Marin’s was somewhat higher. This measure was not used previously, and so comparative data are not available. Marin is focusing on improvement of its follow-up to WM as a PIP. These data provide a baseline that can be tracked over time for QI.

**CalOMS Intake and Discharge Data**

CalOMS provides a rich data source for profiling the needs of clients at admission across the entire system and a potentially useful data source for measuring outcomes at discharge. There are methodological problems in its administration across counties that can compromise data integrity, especially when it comes to discharge data. Clients commonly leave without a termination interview, either when relapsing or when successful, so client status at that time can be difficult to rate and clients are considered “administrative discharges.” Also, providers are not all thoroughly and consistently trained in the CalOMS rating system, raising questions of inter-rater reliability, particularly regarding discharge data.

Figure 2-13 reflects status at admission of clients’ living arrangements. The incidence of homelessness is a predictive factor for treatment outcomes and is important to address when present. These data show a higher incidence of homelessness among clients in treatment for SUD in San Mateo, and next most present in Marin. There is a strikingly lower incidence in Riverside, possibly due to the availability of more affordable housing.
Figure 2-13: Client Living Arrangement at Admission to Treatment, by County

Figure 2-14 depicts the types of discharges. As mentioned above, administrative discharges can compromise the extent and accuracy of discharge information that a provider can knowledgeably enter. They comprise a minority of the discharges in each county, so each DMC-ODS county has found a way to mitigate the number of administrative discharges to some degree. Marin has a particularly low rate of administrative discharges. It is consequently more able to use CalOMS discharge data for outcome measurement, and does so.
Efforts by DHCS to refine and improve CalOMS are in process and should allow for more refined use of this measurement system to track outcomes and accurate profiles of key characteristics of clients served.

Performance Measures Findings—Impact and Implications

Overview

Data in many sectors showed a robust launch of programs, but a staggered implementation schedule and lags in billing resulted in partial performance data for Year One services. Examples of these challenges were as follows:

- The baseline data covers the four FYs prior to the three counties beginning their DMC-ODS. Of those years, FY 2016-17 covered only the months of that year that each county was still operating under the state plan prior to their start of the DMC-ODS Waiver, so it represents only partial year data.

- The PM data for statewide performance are a consolidation of the approved claims data for each DMC-ODS county that began its implementation during CY 2017, including the three counties that were reviewed along with several others. The start date for the live counties during CY 2017 ranged from early to late in the CY. Consequently, the statewide data in some of the tables fluctuate on an ongoing basis as the counties expanded their implementation. The statewide data will further fluctuate in the next year, as many more counties begin their implementation. These statewide data can be expected
to stabilize for comparison purposes in January 2020, after all the DMC-ODS counties have had one year of implementation experience.

Access to Care Issues

- Claims data from baseline to CY 2017 reflect a steady expansion of services for DMC-ODS and an increase in beneficiaries served to 6,620 in CY 2017, nearly tripling the volume during FY 2013-14 of 2,326. These reflect counties’ positive responses to the changing opportunities brought about by ACA when they actively encouraged substantial new enrollments in Medi-Cal. They also reflect the rapid and proactive efforts of Marin, San Mateo, and Riverside to prepare for implementation of a DMC-ODS for their beneficiaries, thereby broadening access to a range of previously and newly covered DMC services.

- Across the counties, Caucasian and African-American enrollees had a relatively higher rate of access to services than did the Latino/Hispanic and Asian/Pacific Islander enrollees. The exception to this trend is for African Americans in Riverside, whose penetration rate is 0.7 percent, close to the Latino/Hispanic penetration rate of 0.5 percent.

- Across age groups, the 18-to-64 age group had the highest penetration rate. The average claims costs for the 65+ age group is higher at $3,864 than the 18-64 group at $3,581, reflecting that the older age group needs more intensive and lengthier substance use treatment, in addition to more physical health care as a result of their more complex medical conditions.

- Marin, San Mateo, and Riverside continued to treat a substantial number of their beneficiaries through their NTPs, with methadone as the primary type of MAT. The counties’ NTPs are beginning to ramp up their provision of other types of MAT such as buprenorphine, and disulfiram for treatment. Also available at NTPs is naloxone, which is administered when someone is having an overdose. It saves lives and is a required medication to have available. NTPs have reported billing and work flow problems in trying to prescribe these other medications. Additional information and communication are needed to paint a more complete picture of access to care for the billing challenges creating barriers. Many services are also being delivered through FFS Medi-Cal in primary care; these claims were not available to CalEQRO at this time.

- The Access Call Center lines in each county are using appropriate call center software to track key indicators and provide dashboards on a periodic basis for managers to monitor performance and identify performance improvement areas. The DMC-ODS counties vary in how completely they have used these reports to date, with Marin and Riverside being the strongest. The DMC-ODS
counties appear to be managing their 24-hour Access Call Centers well, with relatively low caller wait times and call abandonment rates.

- The diagnostic data for beneficiaries served indicates the primary drug of choice to be opioids. The next most common diagnostic category for primary drug of choice is stimulants, and alcohol is a close third. The exception to this ranking is Marin, where the second most common drug of primary choice is alcohol—slightly more common than stimulants.

**Timeliness of Services Issues**

- DMC-ODS clients statewide are receiving timely methadone dosing from NTPs following their first request for NTP treatment, within an average time period of less than a day. Clients in Marin and San Mateo are experiencing timely first dosing at this rate. Clients in Riverside experienced a somewhat longer average time to first dosing, at 3.26 days, probably due to being a geographically large county with longer travel distances for some people, and periodic times of extremely hot weather that makes transportation even more difficult. The data on non-methadone timely access was limited due to claims volumes and will continue to be tracked as services increase.

- The launch of the DMC Waiver requires many new and substantial data tracking responsibilities. Counties must now enter the date and time of first request for treatment and date and time of first offered appointment, and must subsequently be able to link those data to the date and time when the requestor had a first face-to-face session and formally entered the SUD treatment system. This not only requires diligence in entering these data, but also new software tracking systems, installations, and implementations. This is particularly the case for contracted providers, who comprise most of the DMC-ODS network in the three reviewed counties. Marin and Riverside have done extensive work to set up most of these data entry and tracking systems, while San Mateo is at more initial stages in this work. Both Marin and Riverside seem to be effective in tracking and meeting their timeliness standards for first offered appointment, although Riverside is investigating how to improve their timeliness performance for children’s services. All three counties are tracking timeliness to first actual appointment, although San Mateo is well over their standard and was encouraged to focus upon this as an area for QI in year two.

- Each of the three DMC-ODS counties under review is challenged to address tracking and meeting standards for timeliness of urgent treatment requests. A county DMC-ODS must first decide how to clearly operationalize “urgent.” This can entail a variety of circumstances, including the need for WM, some forms of MAT, or residential treatment for perinatal women for whom pregnancy or the health of newborns may be at risk due to a SUD. The DMC-
ODS must then track when the request first came. Neither Marin nor San Mateo has been tracking this measure; both have this task as a goal for year two of their DMC-ODS Waiver service implementation. Riverside indicates it is tracking its performance, but has not yet met its standard.

- The counties are still developing their tracking systems for no-shows. Marin is tracking this measure for MATs and appears to have a low rate within its NTP. As noted above, since NTP services are highly regulated and usually requires daily dosing, it is to be expected that clients would be highly engaged and the no-show rate would be low. The consequences for missed dosing can be a return to a dangerous opiate addiction lifestyle with illegal street drugs.

**Quality of Care Issues**

- A central principle of the DMC-ODS Waiver STCs is that client care should shift from a program-driven focus to one that is client-centered. The STCs indicate this should be operationalized by reassessing clients’ needs on an ongoing basis, and adjusting treatment accordingly. Instead of clients remaining in one LOC throughout their treatment episode, under the DMC-ODS, it is expected that many clients will change LOCs during their treatment. In the first year of DMC-ODS implementation, the claims data from the three counties showed that on average, 19.3 percent of clients discharged from residential treatment were subsequently admitted into another LOC. It is unclear whether to interpret the data as meaning that the remaining 80.7 percent of clients do not have follow-up care, or that some became engaged in treatment outside the DMC-ODS-certified services. For instance, the participating counties were not billing for recovery support services, except Riverside and it was very limited. They also had yet to expand their recovery residences, which will provide powerful incentives for many people to engage in outpatient services. It is anticipated that in the ensuing years, these DMC-ODS counties will increase their deployment of non-residential treatments and their billing for these services, and this will enhance their shift to a more client-centered treatment that involves multiple levels of care to support sustained recovery.

- Clients are at a crucial point when discharged from residential WM, more open to treatment yet also extremely vulnerable to relapse. Riverside’s data indicates an appropriately low readmission rate, whereas Marin’s is somewhat higher. Marin is focusing its nonclinical PIP on case management follow-ups to residential WM to reduced readmissions to WM. To track case management follow-ups from and readmissions to residential WM, counties have to be able to bill DMC so the data are available for analysis. WM is a LOC not covered by DMC prior to the Waiver. Marin and Riverside were slow
to start billing for this LOC; San Mateo was still working with its contracted provider for this service to obtain DMC certification at the time of the CalEQRO onsite review. These types of infrastructure developments will be subjects of review in the second year of EQRO review.

**Client/Consumer Outcomes Issues**

- The three counties use CalOMS data to measure progress by time of discharge. Marin was the most thorough in training every staff member in each contracted provider program in CalOMS data ratings to ensure inter-rater reliability and data integrity. For larger counties, this essential training can be more daunting to accomplish on a regular basis for every new provider.

- CalOMS data are designed in part to provide pre-post outcome data on such elements as frequency of substance use, frequency of drug-free social supports, employment status, living arrangements, family relationships, and criminal justice involvements. However, all counties face the common challenge of how to rate clients at discharge who fade away rather than plan, fully coordinating with their counselor and including a termination interview. In such cases, the counselor completes an “administrative discharge” that does not include many of these items potentially useful for measuring treatment outcomes. For the three counties under review, approximately 32 percent of clients were discharged administratively in Riverside and San Mateo and 16 percent in Marin. The lower percentage in Marin enabled the county to more actively use CalOMS data for outcomes measurement, which it is doing.

- CalOMS admission data indicated a wide range of homelessness, from 17.5 percent in Riverside to 37 percent in San Mateo. These data reflect differences in affordable housing among the counties, among other factors. Housing status is also a potential focus for future efforts to measure outcomes.

- Each county administered the TPS to clients and received back from UCLA an analysis of results. (See Figure 5-1 in the client family member (CFM) perspectives section of this report.) The TPS results yield scores on five dimensions, including client outcomes. These results were positive for each county, averaging four or above on each dimension. In particular, Marin looked at the results by specific programs, found significant variations, and worked with the few programs with lower ratings to identify opportunities for QI.
Section 3

Performance on Quality Management Key Components

CalEQRO emphasizes the DMC-ODS’ 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. In this section of the annual report, CalEQRO organizes these elements into three Key Components (KCs): Access to Care, Timeliness of Care, and Quality of Care. Each of these three components is divided into several specific subcomponents for the purpose of quantitative performance ratings and qualitative descriptions and explanations. The ratings describe whether each subcomponent was Met, Partially Met, or Not Met.

Following are the findings for each of the three county DMC-ODS’ performance, structured by the KCs and their respective subcomponents. For each KC’s subcomponents in this section, CalEQRO provides a performance rating for each county, a description of the county’s accomplishments and challenges, and a brief summary of trends across the three counties. At the end of each KC section, CalEQRO provides a further summary of the overall performance of the three counties across the various subcomponents for that KC.
Key Component 1: Access to Care

Access to Care components are those CalEQRO considers representative of a broad service delivery system that provides access to consumer family members (CFMs). An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services, which are measured by review of each subcomponent as follows:

1A Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices

1B Manages and Adapts its Capacity to Meet SUD Client Service Needs

1C Integration and/or Collaboration with Community-based Services to Improve Access and Care

1A: Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices

San Mateo (Met)
San Mateo has a strong and extensive cultural competence plan; its multiple goals are being managed with specialty populations to ensure access to care. San Mateo leadership will soon update the plan with input from the SUD client and family community, providers, and partner agencies.

The DMC-ODS has a strong partnership with the San Mateo Health Plan, the County hospital, and primary care providers. They are working together to reach at-risk populations with SUD, and particularly those whose SUD is complicated by HIV or high-risk pregnancies. One of San Mateo’s primary concerns is to expand treatment access and capacity through contracts, especially MAT, in a rural part of the county that is primarily agricultural. Telemedicine and other strategies are being considered as a solution.

Riverside (Met)
Riverside’s DMC-ODS was actively tracking access related to their threshold language (Spanish) and the number of individuals
accessing services. They periodically share with the public a
standard report on the extent to which each treatment program serves
Spanish-speaking clients. Fewer than 40 percent of the clients
served were Caucasian. Of the others, the majority were Latino,
followed by African American and then others of mixed race and
Asian/Pacific Islanders. The Cultural Competence Plan reflected a
culturally and linguistically appropriate services (CLAS) focus in goals
and objectives, as well as outreach. The DMC-ODS conducted and
documented many unique outreach efforts and events, but did not
track how effectively they linked people to treatment services.

Marin (Met)
Marin included tracking reports in its Timeliness Self-Assessment
(TSA) form that demonstrated timely access to services. Their
assertions were corroborated by client reports in the adult client focus
group conducted during the onsite review.

Summary of Findings for Key Component 1A
All three DMC-ODS counties met this subcomponent, demonstrating
an understanding of the populations they serve and a commitment to
meeting the needs of those with unique cultural and linguistic issues.
Where gaps in structure or services exist, the leadership of each
county demonstrated a commitment to accessible treatment services
by addressing these in their planning.

1B: Manages and Adapts its Capacity to Meet
SUD Client Service Needs

San Mateo (Partially Met)
The DMC-ODS has tracking systems in place to monitor residential
bed capacity, NTP slot capacity, and slots at other LOCs. Fourteen
staff from various organizations coordinated referrals from primary
care, emergency departments, shelters, withdrawal management
programs, etc. Challenges occurred for care coordinators and clients
when programs were full. San Mateo has out-of-county contracts with
San Francisco and Santa Clara counties to add some NTP capacity
for this initial year. The system has areas of stress where access
needs attention. Staff and contractors had different views of the most
critical areas for further expansion. A request for proposal (RFP) for
new capacity was planned for the summer of 2018.
Riverside (Partially Met)
Riverside’s robust Access Call Center, SUCARES, has been an excellent source of data for service requests by region and type. Based on these requests for care and the assessments completed by SUCARES staff, significant efforts are underway to identify matching services, first within the county and, if none are available, then in adjacent counties. The senior leadership, in partnership with a residential youth provider, recently opened two adolescent six-bed facilities. They continue to evaluate needs in their outlying regions and with different levels of care, with additional contracts and services being considered as part of FY 2018-19 budgets. The commitment to access is commendable, given the depth and volume of care being delivered. More capacity was being considered for MAT via NTPs and partnerships with FQHC clinics as well as more school-based engagement and treatment. Also, an older facility was being remodeled to include beds for 20 in residential care linked to supported-housing services for SUD and persons with co-occurring disorders in the desert area near Palm Springs.

Marin (Met)
Marin managed and adapted its capacity to meet SUD client service needs. They added a youth residential treatment program, expanded capacity at a number of current providers, and are still working on adding three additional providers to DMC-ODS to enhance capacity.

Summary of Findings for Key Component 1B
Two of the three DMC-ODS counties were only able to partially meet the requirements for this subcomponent category. The expansion of their access portals may have increased demand beyond capacity in this first year. In response, each of the counties demonstrated commitments to expand services where able, leverage resources with existing or new partners, and take adequate steps to identify gaps.

1C: Integration and/or Collaboration with Community-based Services to Improve Access and Care

San Mateo (Met)
Strong evidence of collaboration was evident in numerous program efforts to expand and improve care and outcomes with health plans, hospitals, primary care, mental health, and contract agencies. The San Mateo program is part of a collaborative to improve computer
interfaces for coordination of care and client needs by allowing smoother access to treatment plans, goals, allergies, medications, lab work, and eventually notes (with appropriate legal access). These coordination and collaboration efforts include the development of a Health Information Exchange (HIE) and review of software options for all county programs, and eventually those used by contractors as well.

**Riverside (Met)**

Riverside County has two plans serving the physical health care needs of its Medi-Cal clients and has updated MOUs with both of them to address access and service coordination. These plans worked with primary care clinics in remote and rural areas as well as a low-income population center to support both medical and behavioral health access, and dental care where possible. The health plans are responsible for covering treatment for those with mild to moderate behavioral health conditions, while the county is responsible for addressing more severe and acute behavioral health conditions. Since severity of these conditions can fluctuate, the primary care clinics are eager to have both county MHP and DMC-ODS services onsite and must address the accompanying billing complexities and staff licensing requirements. Similar to other counties offering DMC-ODS services, Riverside is working closely with both health and behavioral health stakeholders to facilitate access. Training needs were noted, especially for residential SUD providers who expressed the need for more knowledge of serious mental illness, management of symptoms, and use of medications.

**Marin (Met)**

Marin continued a history of close collaboration with county agencies, network providers, and community stakeholders for both strategic planning and implementation of new programs and initiatives. Using the training of their board certified physician in addiction medicine, more than 50 providers were trained in the benefits of MAT and the brain science related to SUD.

**Summary of Findings for Key Component 1C**

All three DMC-ODS counties met the standard for this subcomponent. Recognizing the impact that SUD have on many other areas of daily life functioning, the three DMC-ODS counties worked in close collaboration with many community agencies and health clinics to improve access to and coordination of care across all the agencies, in
spite of the challenges of complex billing procedures and constraints on information sharing from electronic record limitations. Opportunities also arose for continuing education and a sense of shared (or coordinated) responsibilities among collaborating agencies and programs, which in the end benefitted the client.

### Key Component 1: Overall Summary of Consolidated Subcomponent Findings

Overall, CalEQRO rated all three DMC-ODS counties as having met or partially met Access to Care component categories. Two of the three subcomponents were fully met by all three counties, while one subcomponent was fully met by only one county and partially met by the other two. The latter subcomponent—Adapting Resources to Meet Service Capacity Needs—demonstrates the substantial challenge of standing up a system that all counties launching DMC-ODS will likely face. Overall, the Access performance ratings were mostly met and reflect innovative and creative commitment by leadership to addressing a variety of challenges inherent in launching their DMC-ODS for treating SUD.

### Key Component 2: Timeliness of Services

CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to SUD services. This ensures successful engagement with CFMs and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery, as follows:

2A Tracks and Trends Access Data from Initial Contact to First Face-to-Face Appointment

2B Tracks and Trends Access Data from Initial Contact to First MAT/NTP Appointment

2C Tracks and Trends Access Data for Timely Appointments for Urgent Conditions

2D Tracks and Trends Timely Access to Follow-up Appointments after Residential

2E Tracks and Trends Data on Readmissions to Withdrawal Management within 30 days
2F Tracks and Trends No-shows

2A: Tracks and Trends Access Data from Initial Contact to First Face-to-Face Appointment

San Mateo (Partially Met)
The Access Call Center tracks routine and urgent requests and enters referrals into their electronic health record (her) system. Call Center staff also conduct ASAM criteria-based brief evaluations and make referrals to appropriate treatment sites. Successful referrals are identified manually at this time via claims data for the referred client and the provider doing the assessment. Walk-ins or phone calls at contractor sites for service requests are not logged into the database used by the Access Call Center, although an ASAM criteria-based assessment is completed for the client requesting services at that contract site. The ASAM criteria-based assessment visit generates a bill, which is tracked for billing and timeliness, but the client’s initial request is not tracked unless he or she was referred by the Access Call Center. To track access and timeliness from the first request to actual face-to-face evaluation, it is important for the DMC-ODS to link requests logged into the Access Call Center system with billable first session data entered later by contract providers into their EHR. For non-urgent requests, the DMC-ODS standard is 10 business days or timely access. Actual length of time for Access Call Center requests to first face-to-face contract is a mean of 29.89 days, with a median of 12 days and standard deviation of 43.16 days. This may improve when contract requests (walk-in and calls) are integrated into the metrics and counted as part of the database for timely routine access.

Riverside (Partially Met)
The Access Call Center logs requests and referrals into its EHR system and also conducts ASAM criteria-based evaluations and makes referrals to treatment sites. Residential treatment referrals also are reviewed by the quality assurance (QA) program for authorization of residential care. The standard for routine access is 14 days; the current average is 7.39 days, with 83.5 percent of the appointments meeting this standard. Urgent appointments were documented as taking 8.80 days to the first appointment, with a standard of three days. Only 26.7 percent of appointments met this standard. Thus, it is important to investigate the definition of and barriers for urgent appointments. Performance on other timeliness measures was strong.
Marin (Met)
Timely access is demonstrated by Marin tracking reports in the TPS form, and supported by client reports in the adult client focus group.

Summary of Findings for Key Component 2A
Only one DMC-ODS was rated as fully meeting the standards for this subcomponent, while the other two were rated as partially meeting the standards. DMC-ODS counties face a complex set of tasks to produce data that helps them track the time from each person’s initial request for treatment to their first in-person appointment. Counties are further challenged by the limitations of their legacy data systems. Nonetheless, they must find ways to collect these data, create linkages between access data from diverse information systems, and analyze the results to identify system trends that might warrant quality improvement efforts. Each county will find different ways of approaching these challenges. Examples include standardized software and protocols shared across most county and contract providers, customized software solutions, and newly clarified responsibilities for types of client contact data that must be collected.

2B: Tracks and Trends Access Data from Initial Contact to First MAT/NTP Appointment

San Mateo (Partially Met)
The DMC-ODS reports that persons calling the Access Call Center are logged, assessed, and referred if appropriate to the treatment site. Claims data are used to track when referrals successfully result in clients coming to programs to be assessed. For the NTP program, many clients begin by contacting the program directly rather than contacting the Access Call Center. Data from claims shows they are evaluated and, if admitted to the NTP, dosed within 24-48 hours. Claims data regarding MAT visits billed by the FQHC through FFS Medi-Cal and the health plans were not directly available to CalEQRO, although summary data were made available by San Mateo via their independent research report.

Details on the MAT program also were gathered during the CalEQRO onsite review via the MAT staff focus group, which included HealthRIGHT 360 medical staff and county nursing and care managers conducting outreach and engagement. CalEQRO learned about the Intensive Medication-Assisted Treatment (IMAT) program, in which care managers proactively conduct outreach and
engagement activities with people in the community who may have an SUD and then bring some of them to the HealthRIGHT 360 site for assessment for regular MAT services. When MAT is appropriate, providers will call in prescriptions to a local pharmacy. Care managers also help provide support for prescriptions and injections offered at the clinic site. San Mateo and the county’s medical leadership set a goal of expanding IMAT to more sites and populations. The top priority now is high-risk and high-need clients, but San Mateo’s goal is to have enough MAT access for all sites and areas of the county to have timely access. This requires more prescriber capacity and supports, so plans are under consideration for physician education and mentoring as well as other strategies, such as telemedicine.

Riverside (Partially Met)
Riverside logs the calls to the Access Call Center, screens those calling, and refers them to the appropriate treatment site. Claims data are used to track whether referrals succeed in getting clients to come to a program for a full assessment. For the NTP programs, many clients go there directly rather than first contacting the call center (SUCARES). If they present directly to the program, they call into SUCARES, at which point the contact is logged and the client is screened for appropriate care. The outlying contractors want a special provision to “cut in line” when someone is waiting at their site, to avoid having prospective clients walk out and not get evaluated for treatment.

Riverside, encourages FQHC clinics and requires their NTPs to provide FDA approved medications including buprenorphine and, disulfiram for treatment. Naloxone is also available to reverse overdoses. The FQHC primary care clinics are also developing their capacity to deliver MAT services; data on their prescribing practices were not readily available for review. A representative group of MAT providers during an onsite review session indicated they were prescribing MAT in the FQHCs and NTPs. They were requesting some assistance from the county to increase their capacity due to claiming problems. Among the DMC-certified programs, only 20 units of MAT doses were billed due to these billing challenges.

Marin (Met)
As indicated in PM data tables in this report based upon claims data, Marin enters the data necessary to track timeliness from first contact
to first dosing. NTPs usually begin dosing within a day of first contact, which is timely. Their NTP also requested support related to billing challenges.

**Summary of Findings for Key Component 2B**

Various factors affected the two counties that were unable to fully meet this subcomponent, including disparate data and billing systems. Other counties face similar challenges in obtaining and using non-methadone MAT data, since these data are often in the form of claims generated by non-DMC-ODS providers and processed through the health plans. However, the three DMC-ODS counties demonstrated a full commitment to increasing MAT, including with medications other than methadone. This is especially needed in the context of the opioid epidemic. Counties understand the NTPs are required to provide MAT services and providing technical assistance to help remove barriers in coordination with DHCS.

**2C: Tracks and Trends Access Data for Timely Appointments for Urgent Conditions**

**San Mateo (Met)**
The Access Call Center tracks urgent condition requests for treatment and makes appropriate referrals, but contract agencies directly receiving urgent calls or walk-in requests do not track them. San Mateo is working with its EHR software vendor to add software elements for tracking purposes. In addition, expanded access by contractors to clinical notes would be helpful for them in coordination with San Mateo and the Access Call Center. Another barrier to tracking urgent requests is an element of subjectivity related to the definition and assessment of urgency. The timeliness standard for the county is one day from a request for an urgent appointment to the first session. For those persons identified as requesting an urgent appointment, 83 percent met San Mateo’s timeliness standard.

**Riverside (Met)**
As reflected above, Riverside tracks this process for timeliness. The current average is 8.8 days from first request to actual session. In contrast, the standard is three days. Riverside is investigating barriers to timely access and is trying to clarify how providers are defining urgency.

**Marin (Not Met)**
Marin does not currently track this subcomponent. They are working with their WITS software vendor to develop the fields and reporting capabilities to do so. WITS is a software product developed by SAMHSA for SUD providers.

Summary of Findings for Key Component 2C
Two of the three DMC-ODS counties met this subcomponent and one has yet to do so. All of them cited challenges, most notably lack of clarity in defining “urgent” and field modifications in their EHRs to accommodate urgency-specific data entries for first request and first appointment.

2D: Tracks and Trends Timely Access to Follow-up Appointments after Residential

San Mateo (Met)
San Mateo tracks this process manually. They are working with their software vendor to obtain enhancements that would allow it to be tracked through their EHR.

Riverside (Met)
Riverside is tracking this process, with an average of 8.7 days to follow-up appointments after discharge from residential treatment across 947 episodes. The standard is seven days. For the first year of the DMC-ODS implementation, this is a notable achievement. Riverside has the potential with system of care refinements to meet their standard in the second year.

Marin (Met)
Marin tracks these data through WITS software for residential withdrawal management, and also deploys an enhanced staff of care coordinators to provide screening, brief interventions, and referrals to treatment as an integral part of discharge planning. They have made this into a focus for improvement through a nonclinical PIP.

Separately, a DMC-ODS senior program associate tracks transitions of clients manually from residential treatment to other types of treatment. She brings to the attention of the Marin team any individual client problems or systemic trends for problem solving. Marin might consider working with its WITS software vendor to add fields enabling computerized tracking of the timeliness with which clients transition out of residential treatment to other LOCs.
Summary of Findings for Key Component 2D
Noting the scarcity of residential treatment beds and need for post-discharge follow-up as a key way to ensure good clinical outcomes, it is noteworthy that the three DMC-ODS counties have fully met this subcomponent. They each deploy a variety of mechanisms, including staff assigned to review the processes and to identify and address problem areas. The counties are working with their software vendors to enhance their EHR capabilities to support more automated tracking and alert mechanisms.

2E: Tracks and Trends Data on Readmissions to Withdrawal Management within 30 Days

San Mateo (Met)
The DMC-ODS is tracking data and trends pertaining to WM. To reduce readmissions, they also track ASAM-based assessments and related referrals from WM to follow-up treatment, as well as whether the referrals resulted in completed transfers. They have made the case management of these follow-up processes the subject of a PIP.

Riverside (Met)
The DMC-ODS tracks these and other related data and trends pertaining to WM. It is noteworthy that their average readmission rate to withdrawal management within 30 days of discharge is a low 3.08 percent.

Marin (Met)
Marin tracks readmissions through entries in the WITS database and separately through the proactive involvement by care coordinators in follow-ups. The nonclinical PIP incorporates data on readmissions as one of several outcome measures for the PIP. While Marin readily uses WITS for tracking readmissions to WM, its team might consider working with their WITS software vendor to add routine reporting capabilities, enabling computerized tracking of readmissions to residential treatment as well.

Summary of Findings for Key Component 2E
Each of the three DMC-ODS counties fully met this measurement and operational requirement. Considering that this is the first year of a substantial system of care startup, it is noteworthy that these counties were able to facilitate transfers to and coordination of care across
multiple treatment programs and use data to track their successes and challenges in doing so.

2F: Tracks and Trends No-shows

San Mateo (Not Met)
The data collection systems at this point cannot easily track no-shows because 85 percent of the direct services are delivered by contract providers who have only limited Avatar functionality. The contract providers who deliver the other 15 percent are either using other software products that do not connect easily with Avatar or are using paper charting. San Mateo’s goal is to enhance contractor and county DMC-ODS information system capacities, especially in the EHR documentation systems.

Riverside (Not Met)
The data collection systems at this point cannot easily track no-shows as most of the direct services are delivered by contract providers who use Avatar with limited functionality, other software that does not connect well with Avatar, or (the majority) paper charting. Also, only prescribers are using the Avatar scheduler, which allows tracking of no-shows. To fully review the possible no-shows, all clinicians with scheduled appointments would need to use the scheduler. Riverside is working with its Avatar software vendor to enhance contractor and county DMC-ODS information system (IS) capacities, especially regarding its EHR documentation systems.

Marin (Not Met)
Marin did not have the capability to collect these data systematically. They worked with their WITS software vendor to create the data fields that would make routine tracking of no-shows possible and anticipate the new data fields and reporting capabilities will be completed and implemented in the first quarter of FY 2018-19. EQR will follow up on this capacity in the next review.

Summary of Findings for Key Component 2F
Tracking and reporting of no-shows represents the single timeliness and access subcomponent that all three DMC-ODS counties were unable to meet. In spite of local variations by county, some common threads were evident. The DMC-ODS counties have legacy information systems that were not originally designed to support tracking of no-shows and must be reconfigured with help from the
software vendors to do so. Furthermore, the preponderance of contract providers in the provider network is a major barrier, since most of these providers are either not using the county software or are unable to link to it easily. Both the DMC-ODS counties and the contract providers have to invest in new (for them) software or upgrade their current software, receive training in how to use its full functionality, create electronic interfaces for data uploading from contract sites to county databases, and fully implement the new or upgraded software. Without these changes, DMC-ODS counties will likely continue to miss the opportunity to use this and other related tracking capabilities, limiting the extent to which they can assess and improve their processes for initiating and engaging clients in treatment.

Overall Summary of Timeliness Findings for Key Component 2

All three DMC-ODS counties fully met two of the six subcomponent categories of timeliness of service. These two subcomponents are important ones that reflect the DMC-ODS counties’ abilities to step clients down from residential WM and residential treatment to less intensive levels of care, track the timeliness of those step-downs, and, in so doing, to manage their limited resources for higher-intensity levels of care. However, the timeliness component overall included the lowest percentage of fully met ratings, with several partially met and one subcomponent (tracking no-shows) that was not met by any of the three counties. These difficulties reflect challenges in the DMC-ODS counties’ IT infrastructures, particularly with legacy data systems that are difficult to modify.

Key Component 3: Quality of Care

CalEQRO identifies the components of an organization that are dedicated to overall quality of care. Effective QI activities and data-driven decision making require strong collaboration among staff (including CFM staff) working in IS, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and using data for analysis must be present. Behavioral health uses both research and evidence-based practices as well as assessment and feedback tools to monitor progress in care and
outcomes. The individual Quality of Care subcomponents are as follows:

3A Quality Management and Performance Improvement are Organizational Priorities

3B Data Are Used to Inform Management and Guide Decisions

3C Evidence of Effective Communication from DMC-ODS Administration and SUD Stakeholder Input and Involvement on System Planning and Implementation

3D Evidence of an ASAM Continuum of Care

3E MAT Services—Both Outpatient and NTP—Exist to Enhance Wellness and Recovery

3F ASAM Training and Fidelity to Core Principles Are Evident in Programs within the Continuum of Care

3G Measures Clinical and/or Functional Outcomes for Clients Served

3H Utilizes Information from Client Perception of Care Surveys to Improve Care

3A: Quality Management and Performance Improvement are Organizational Priorities

San Mateo (Met)
San Mateo DMC-ODS presented a strong Quality Management (QM) Plan with an orientation towards addressing the implementation of the Waiver. Their QI Plan and supportive documentation (e.g., QI meeting minutes) were thorough and made use of existing QM structures in their integrated Behavioral Health Department. It was clear, and further confirmed through focus group feedback, that both contractor and county staff understood quality was a value held by the organization and that the results of programs should be “making the system work to benefit the clients.” Of note was a discussion that brought together multiple county staff from across the San Mateo Health Care System, where the goal of creating one universal, integrated treatment/care plan for one client was discussed.
Riverside (Met)
Riverside DMC-ODS has a strong QM Plan that is oriented to aggressively implementing the service implementation plan. This is remarkable in the case of Riverside, given the geographic size of the region and the degree to which they expanded ASAM services (both capacity and treatment levels) to start off their first year of the Waiver. Contractor and county staff espoused client-centered values, which they translate through the DMC-ODS as a fundamental focus on benefitting clients in treatment. CFMs in focus groups confirmed that these values seem to pervade the implementation. Riverside made use of multiple consultants and external organizations (Harbage Consulting, the California Institute for Behavioral Health Solutions (CIBHS), and Klynveld, Pear, Marwick and Goerdeler (KPMG) to address training needs, continuum of care issues, and the efficiency and optimization of service delivery. The DMC-ODS has an extensive and diverse training schedule and is receptive to addressing areas that are of concern to providers in the system.

Marin (Met)
The Marin DMC-ODS QM Plan is a standalone plan separate from the county mental health QM Plan. The DMC-ODS QM Plan is well organized and concise, with a measurable format of clearly stated goals and objectives. Feedback from staff focus groups at various levels revealed that the DMC-ODS is clearly and consistently communicating the values of QM. Of note was the DMC-ODS effort to use CalOMS data for client outcomes tracking—an indicator that not only is the DMC-ODS focused on QI efforts, but it also is using innovative data analytic methods to bring QI directly to client outcomes.

Summary of Findings for Key Component 3A
All three counties produced QM plans that were strong and specifically focused on the first year of implementation of the Waiver. Focus groups held during each county’s review validated the strength of each county’s commitment to quality throughout the respective organizations. Focus group members (including line staff, clients, and management) were able to discuss their experiences of being collaboratively involved in the QM Plan process as well as articulate a common approach to providing quality for beneficiaries.
3B: Data Are Used to Inform Management and Guide Decisions

San Mateo (Met)
The DMC-ODS consistently uses and reviews data to guide decision making. CalOMS, Access Call Center, criminal justice system, and health system data are all being used routinely. The DMC-ODS has plans to integrate data from multiple providers in the health care system to address provision of SUD treatment and consultation services as part of its Whole Person Care (WPC) initiative.

Riverside (Met)
Data are being used to track access, capacity, and clients’ experience of care. Review of system reports and meeting minutes indicated use of data from CalOMS, the criminal justice system (for the drug courts and for the AB109 prison reform initiatives), the Access Call Center, and from reports indicating youth engagement in treatment.

Marin (Met)
Data are being used consistently and, in some instances, innovatively by the DMC-ODS. Reviews indicate that the DMC-ODS uses data from CalOMS, the criminal justice system, the Access Call Center, and the contract providers and health care system. Of note was their use of data presentations using graphical formats in their reporting of performance results to stakeholders and to aid management in decision making for QI. Among the types of QI decisions were those based on TPS data to address performance deficiencies among a few providers.

Summary of Findings for Key Component 3B
Data are being used regularly in each of the reviewed counties. Common data sources were CalOMS, county-specific Access Call Center data, and criminal justice system/AB109 data. Two counties were able to take advantage of some integration with their health plans and begin data sharing efforts to support beneficiaries across the health care system.

3C: Evidence of Effective Communication from DMC-ODS Administration and SUD
Stakeholder Input and Involvement on System Planning and Implementation

San Mateo (Met)
During the onsite reviews, various focus group participants were united in their feedback that the DMC-ODS had created effective pathways for communication with stakeholders about the Waiver implementation changes and collaborative processes that have ensued. Of note were repeated comments from contract staff that county management staff were available and always helpful. Feedback from the focus groups was also very clear in describing the community-wide process, with broad participation, that supported the planning and development of the Waiver plan. Some line staff expressed dissatisfaction with the Waiver’s managed care approach, seeing it as prompting treatment decisions based on financial considerations instead of needed care. Another concern was that the use of ASAM criteria for LOC placements (especially residential) was taking placement decisions out of the hands of experienced counselors and relying instead on a more academic decision process. This was being addressed not only with additional training, but also “special priority work groups” to look at streamlining some of the paperwork burden and show the positive outcomes of individualized care under ASAM.

Riverside (Met)
As in any organization and system of care, both formal and informal lines of communication exist in the DMC-ODS. Both clients and staff in EQRO review focus groups described with appreciation a culture of open communication with management. Multiple and varied stakeholder groups were involved in the development and planning process of the Waiver roll-out. The overwhelming influx of call center activity in the first weeks following their go-live is a testament to how well the management staff planned a responsive set of meaningful services and communicated the roll-out. As was reported in San Mateo (and was true for Marin) the culture shifts from traditional, program-driven treatment to more client-centered, individualized and clinically oriented approaches that use ASAM criteria was profound. Many expressed fervent wishes that the strong communication channels established in the first year of the Waiver continue in subsequent years so that issues surrounding the shift to a managed system of care can be further addressed.
Marin (Met)
Focus group feedback of both staff (including contractors) and clients was consistently positive and enthusiastic about how county management is handling the Waiver challenges and communicating with county and contractor staff. As in the other counties reviewed for this report, some negative feedback surfaced about managed care in general and authorization processes. However, multiple staff went out of their way to clarify that they had no problem with county management and even described them as “wonderful.” County staff offered to add more training and support related to understanding of managed care and look at options for streamlining systems to reduce any perceived barriers.

CFMs participate on the QIC and the county Substance Use Advisory Board. The planning and implementation of the Waiver involved both community members and multiple stakeholders.

Summary of Findings for Key Component 3C
Focus group feedback from all levels of each county was consistently positive and enthusiastic regarding how each of these counties communicated through the system planning stages of the Waiver and communicates currently across the entire DMC-ODS as implementation unfolds. Despite some staff negativity about the use of ASAM criteria and the Waiver’s managed care structure, the feedback regarding ODS administration communication was remarkably positive across all three counties.

3D: Evidence of an ASAM Continuum of Care
San Mateo (Partially Met)
WM, while available, was not DMC-certified for billing at the time of the review. In residential treatment, only level 3.3-Residential Services for Special Populations was not offered. The county is currently considering possible populations to address (e.g., serious physical illness, dementia, traumatic brain injury) with level 3.3 for the future. In the outpatient LOCs, only partial hospitalization was not available at the time of the review. The county has a planned RFP for the first quarter of FY 2018-19 to increase targeted areas of capacity within the system, which is now in process. In general, capacity numbers across the county demonstrate adequate coverage. Recovery residence (transitional drug-free housing) was cited by both staff and clients as an area of strong need in the county. San Mateo
actively supports the use of ASAM principles and provides both trainings and readily available TA to providers on various aspects of using ASAM criteria in assessments and referrals.

**Riverside (Met)**
The ASAM Continuum of Care in Riverside successfully meets the requirements set forth in their approved DMC-ODS plan. WM only lacks the medically managed level (which is not required) and in outpatient lacks only partial hospitalization (which also is not required). Review of their data reports indicates they have adequate capacity in all offered LOCs to meet demand. They have an RFP release planned this year to add WM services in certified outpatient sites.

**Marin (Met)**
Marin launched an ASAM Continuum of Care consistent with its first year approved DMC-ODS Implementation Plan. Of note, the county offers an outpatient, partial hospitalization program specifically for mental health clients with serious mental illness (SMI) and co-occurring SUD. Marin actively promotes the ASAM principles of practice through its varied training offerings, as well as through the availability of several specific QM staff who provide ongoing TA to clinical staff (both county and contractor) regarding clinical practice and documentation issues. Many of these issues are inherent to the implementation of such a different system and are presenting problems in authorizations, documentation, and treatment planning. By providing this readily available and consistent training where the clinicians are actively working, the system is effectively addressing the need for ongoing QI in adoption of the new clinical approach to SUD treatment.

**Summary of Findings for Key Component 3D**
Each county plans to add service levels in the next year. Each county has an active ASAM training plan in place, ensuring that staff were prepared at go-live as well as continuing to evolve their understanding of the uses of ASAM. A common theme in the CFM focus groups regarding the DMC-ODS LOC in each county focused on the need for significantly more recovery residence capacity to support the transition from residential care to outpatient levels.
3E: MAT Services—Both Outpatient and NTP—Exist to Enhance Wellness and Recovery

San Mateo (Partially Met)
County residents have access to an NTP in the southern county region and contracts with South San Francisco in the north county region as well as Alameda County. Outpatient MAT is also available through a contract and partnership with HealthRIGHT 360’s primary care clinic. Line staff noted in the focus group that capacity needs to increase to take all possible referrals. San Mateo was aware of the increased demand for MAT and was seeking to add more prescribers and capacity to both NTPs and their outpatient clinic. Their NTP in south county was not yet providing buprenorphine, disulfiram, or naloxone per the administrator as it was a goal for year two of services.

Riverside (Met)
One OTP/NTP site is dually DMC-certified for outpatient and MAT. The same provider also received a Hub and Spoke grant from DHCS and has 11 spokes in clinics set up in various types of sites. The other provider has five outpatient-certified sites that also provide MAT services.

Marin (Met)
Marin County residents have access to MAT services through selected outpatient programs and NTPs. The county is involved in Hub and Spoke grant efforts to expand MAT services. Much of this is relatively new; indeed, one large NTP provider commented they had their first buprenorphine MAT client the week of the review. However, it is supported by clear plans and direction from the DMC-ODS. Staff and clients spoke about widespread stigma being an issue for clients accessing MAT services. Marin’s approach has been to hire, and use across multiple health care settings, a board-certified addiction psychiatrist who is carrying the message of MAT to the larger health care system and the community as well as to the NTP. He is increasing physician prescribers through new policies, training, consultation, and partnerships with other departments in the health care system (e.g., the public health department).

Summary of Findings for Key Component 3E
In this first year of the Waiver, all three counties reviewed fully met this subcomponent. Stigma and bias against MAT (including
methadone) were cited by all clients in the focus groups for each county as well as being frankly and openly discussed with the administrative staff in each county. Everyone agreed there is much ground to cover in addressing the stigma that presents a real barrier to the widespread availability of MAT in the health care system. Of note was Marin’s approach, where they described years of large-scale attempts to promote MAT. Marin recently gained significant ground by hiring a board-certified addiction psychiatrist who is working with multiple county departments to establish relationships and promote the use of MAT and addiction treatment science.

3F: ASAM Training and Fidelity to Core Principles are Evident in Programs within the Continuum of Care

San Mateo (Met)
The DMC-ODS included a list of ASAM trainings provided to the system as well as proposed and scheduled trainings. It was clear from focus group feedback from clients and clinical staff of varied classifications that they had all received orientations to the ASAM Six Dimensions and the ASAM LOC. The DMC-ODS monitors the fidelity with which ASAM criteria are implemented by reviewing documentation of assessments, treatment plans, and progress notes. They also monitor fidelity through the authorization process, during which county QI staff review provider assessments for residential treatment and their referral decisions, checking for the concordance between severity ratings on the ASAM Six Dimensions and the resulting rationale for LOC referrals.

Clinicians in the focus groups reported that QI staff responsible for authorizations were helpful in teaching ASAM principles and were not simply “interested in denying services.” The core principles of individualized, client-centered care are not easily explained to clinicians, much less the skills to implement these concepts in treatment. Clinicians seemed to interpret ASAM principles as in conflict with “good treatment” and attributed this result to the advent of a managed care system. Continuing trainings in ASAM to clinical staff are necessary, but the DMC-ODS should also help the clinical supervisors learn how to weave ASAM into day-to-day clinical work and supervision. Additionally, clinical staff would benefit from some trainings where the principles and techniques of value-based care,
managed care, evidence-based practices, and client-driven treatment all converge with the aim of improving outcomes and client experience.

**Riverside (Met)**
Staff were provided with 80 to 90 hours of training over an extended period to generate a full understanding of ASAM values and clinical principles. In addition, extensive training for both county and contractor staff was provided on ASAM and other core clinical tools in the provision of SUD treatment. Trainings provide an academic and theoretical foundation for clinicians and are essential when they are new to the system. However, over time, the systems attempting to produce actual practice to ASAM core principles need to diversify their training approaches. One such effort provides specialized training to clinical supervisors, helping them learn how to then train their clinical staff supervisees in how to apply the basic ASAM principles when providing assessments, referrals, and treatment to their clients.

Clients expressed a serious concern with stigma/bias against MAT that to them seems prevalent in the surrounding society and somewhat in the DMC-ODS. It is not easy to correct the misconceptions upon which prejudice against MAT is based, especially given that the prejudices exist even within the SUD system of care. The DMC-ODS should create venues through which these issues can be explored more thoroughly, and generate multiple, persistent approaches to fighting stigma.

**Marin (Met)**
Marin County’s substance use treatment system began making changes to its system of care and treatment approaches several years prior to the Waiver proposal. This was part of a system evaluation conducted for public review and to set a course for improvement in the department. Many of these changes embraced concepts similar to the basic core principles of ASAM. One pre-Waiver change involved writing language into provider contracts prohibiting discharge simply because a client had relapsed or slipped. They also began working with providers to accept clients into treatment who were receiving NTP treatment. Marin has provided multiple trainings for all provider staff on the application of ASAM criteria and related principles. Additionally, several QI staff are specifically assigned to provide clinical training, guidance, and
oversight to the clinical staff on application of ASAM principles throughout the system. One staff member provides regular focused meetings for line staff and for clinical supervisors where ongoing ASAM criteria-related issues are discussed. Clinical staff also receive direction from the access staff for referrals and QI Director and staff from whom residential treatment authorizations are provided.

Summary of Findings for Key Component 3F
All three counties supplied their ASAM training schedules for preparing staff for go-live operations as part of the Waiver process. All three counties have established ongoing training schedules for their staff. Fidelity to ASAM criteria is largely accomplished through the authorization process for residential treatment approvals. Additionally, fidelity to the use of ASAM criteria in LOC decision-making was reviewed during chart audit scenarios. Line staff feedback in focus groups was extremely positive in terms of clinical support for using the ASAM criteria in real life situations.

3G: Measures Clinical and/or Functional Outcomes for Clients Served

San Mateo (Met)
San Mateo is using the TPS, CalOMS, and ASAM LOC placement dataset to track client outcomes and functional improvements. CalOMS is used to monitor discharge status, housing, job/school participation, and arrests. ASAM LOC placement data were available in total and by screening/assessment site. San Mateo County also makes use of the California Opioid Overdose Surveillance Dashboard, which tracks overdoses by year, number of prescriptions of opioids, and opioid-linked hospital events, including emergency room visits, hospitalizations, and deaths. Comparison data from this database are available for other counties and statewide.

Riverside (Met)
Similar to San Mateo, Riverside is using the TPS, CalOMS, and ASAM dataset to track client outcomes and functional improvements. CalOMS is used to monitor discharge status, housing, job/school participation, and arrests. CalOMS is also being used in the youth and adult PIPs for tracking improvements in functioning and SUD. Riverside also makes use of the California Opioid Overdose Surveillance Dashboard.
Marin (Met)
Of note is Marin County’s approach to the use of widely available datasets. Marin uses the typical TPS, CalOMS, and ASAM datasets. Marin has attempted to combine specific items within each of these measures (as well as others) to create outcomes measures or measures of treatment progress. Marin uses the TPS survey data in general, but also uses the specific self-report ratings on the TPS outcome-related items to determine treatment effectiveness. In addition, they use CalOMS data to measure outcomes relative to housing, employment status, use of drug-free social support activities, and overall progress in treatment. Marin also is piloting the use of client-directed outcome measures in their novel co-occurring (SMI and SUD) treatment program. These measures are used in their clinical PIP.

Summary of Findings for Key Component 3G
All three counties use the following datasets for measuring client outcomes: TPS, CalOMS, their own ASAM dataset information, and the California Opioid Overdose database. The counties have attempted to use the CalOMS discharge criteria in different ways to measure treatment outcomes, mainly by examining the areas of discharge status, housing, criminal justice (arrests), and job/school participation and improvements in SUD conditions. Of note is Marin County’s piloting of client-directed outcome measures in their co-occurring outpatient program. (See Marin County’s clinical PIP for more details.)

3H: Utilizes Information from Client Perception of Care Surveys to Improve Care

San Mateo (Met)
TPS scores are identified by specific provider site/program in San Mateo County. The County was aware of specific outliers and was able to describe efforts to address these instances with providers. Items on the TPS cover a wide range of factors involved in a client’s experience of care. San Mateo County scores, on average, were 4 or higher on a scale of 1 to 5. Use of these data was evident in their QIC documentation and in their contract monitoring and oversight processes.

Riverside (Met)
Similar to San Mateo, Riverside TPS scores are identified by specific provider site/program. Riverside worked with providers to identify problems and consider different training efforts to make improvements. Riverside County scores were high across all domains. Use of these data was evident in their quality oversight and in their contract monitoring and oversight processes. One of the challenges this first year was that some providers did not complete their identifying site data correctly and this will be pre-filled next October to avoid this problem.

Marin (Met)
Marin County administers the TPS to clients as required. Scores, in general, were within the range established across all counties reporting TPS scores to the state. TPS scores are identified by provider site/program and a few programs received relatively lower ratings. Evidence supplied in the review demonstrated that Marin County’s DMC-ODS followed up with the providers in these instances and, when necessary, established a corrective action plan to improve the quality of care.

Summary of Findings for Key Component 3H
All three counties administered the TPS survey at the required times, received the results from UCLA, and used them for QI purposes. When direct follow-up was required with a specific provider as a result of problematically low scores and/or written client feedback, the county was able to describe taking such actions. In general, the TPS scores were high across all three counties, averaging in the 4 range on a scale of 1 to 5.

Key Component 3: Overall Summary of Timeliness Findings
All three of the DMC-ODS counties initiated profound shifts in clinical philosophy and approach to treatment as part of implementing the system changes associated with the Waiver. They found the use of ASAM criteria to guide treatment planning with a client-centered, highly individualized approach differs markedly from the traditional program-driven treatment philosophy so prevalent across the state of California.

Inevitably, the DMC-ODS counties that CalEQRO reviewed for this report found themselves confronted with numerous challenges prompted by these shifts in treatment and treatment coordination.
approaches. The providers (especially contractors) in the focus groups vehemently expressed their concerns with managed system of care approaches and techniques in the SUD treatment system, the imposition of ASAM criteria as decisive in place of their more “experience-based” clinical decisions, and other quality management decisions using a more clinical-based approach to care. Nevertheless, these same clinical line staff also were enthusiastic supporters of the county DMC-ODS management’s communication, planning, roll-out, training, and collaboration related to the Waiver implementation.
Section 4

Performance Improvement Projects

Introduction

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

Counties are expected to initiate and be at one or more of these stages with two PIPs, each of which is clinical and one is non-clinical.

The clinical PIP is expected to focus on treatment interventions to improve outcomes and client experiences, while the other (nonclinical PIP) is expected to focus on more administrative processes that improve care and the client experience. Both PIPs are expected to address processes that, if successful, will positively affect clients.

During the 12 months preceding the review, each county is required to conduct two PIPs: one clinical and one nonclinical.

A clinical PIP might target some of the following:

- Prevention and treatment of a specific SUD
• High-volume services
• High-risk procedures and services

A nonclinical PIP might target some of the following:
• Coordination of care
• Appeals and grievances processes
• 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 counties to use when drafting their PIP narratives.\textsuperscript{15} Prior to the onsite review, each DMC-ODS is to submit both PIPs to CalEQRO. The designated CalEQRO quality reviewer and the CalEQRO PIP consultant review all submitted PIPs for clarity, applicability, and relevance to the county’s population, methodology used, and appropriateness of data and data collection tools, among other items.

During the onsite review, the CalEQRO team conducts two PIP sessions with the county to discuss the documentation provided. During these onsite sessions, the team provides feedback and TA for strengthening the submitted PIPs. Following the onsite review, counties are allowed to resubmit their PIPs with any changes or additions discussed during the onsite review. The CalEQRO quality reviewer analyzes and validates any resubmitted PIPs in accordance with the requirements of CMS Protocol 3.\textsuperscript{16} All PIPs are rated based on their completeness and compliance with the standards found in the CMS protocols.\textsuperscript{17} Each of the nine PIP steps includes subsections with standards that are rated according to the PIP Validation Tool.\textsuperscript{18}

\textsuperscript{15}To view the PIP Development Tool/Outline, visit CalEQRO’s website: http://caleqro.com/#/california_eqro_resources/. The tool is found under Notification Materials/MHP Notification Materials__Review Preparation Materials.
\textsuperscript{16} Ibid.
\textsuperscript{17} Ibid.
\textsuperscript{18} The PIP Validation Tool is available from CalEQRO’s Website, www.CalEQRO.com.
The PIP rating steps and definitions are shown in Tables 4-1 and 4-2, below:

**Table 4-1: PIP Rating Steps**

<table>
<thead>
<tr>
<th>Step</th>
<th>PIP Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Selected Study Topics</td>
</tr>
<tr>
<td>2</td>
<td>Study Question</td>
</tr>
<tr>
<td>3</td>
<td>Study Population</td>
</tr>
<tr>
<td>4</td>
<td>Study Indicators</td>
</tr>
<tr>
<td>5</td>
<td>Sampling Methods</td>
</tr>
<tr>
<td>6</td>
<td>Data Collection Procedures</td>
</tr>
<tr>
<td>7</td>
<td>Assess Improvement Strategies</td>
</tr>
<tr>
<td>8</td>
<td>Analysis and Interpretation of Study Results</td>
</tr>
<tr>
<td>9</td>
<td>Validity of Improvement</td>
</tr>
</tbody>
</table>

**Table 4-2: PIP Ratings Defined**

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

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

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

\[
\frac{(\text{Number Met} \times 2) + (\text{Number Partially Met})}{\text{Number of Applicable Items} \times 2}
\]
Table 4-3 shows the categories and definitions of PIP status. Only active or completed PIPs are rated. PIP submissions that were rated as Concept Only, Not Yet Active (and did not receive ratings for each PIP step) are not included in the tabulations in the figures and tables in this section.

Table 4-3: PIP Status—Categories and Definitions

<table>
<thead>
<tr>
<th>PIP Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active and Ongoing</td>
<td>Baseline established on at least some of the indicators and at least some interventions have started. Any combination of these is acceptable.</td>
</tr>
<tr>
<td>Completed</td>
<td>In the past 12 months or since the prior EQR, the work on the PIP has been completed.</td>
</tr>
<tr>
<td>Concept Only, Not Yet Active</td>
<td>Baseline may have been established, but interventions have not started. This is NOT an active PIP.</td>
</tr>
<tr>
<td>Inactive, Developed in a Prior Year</td>
<td>Rated last year and not rated this year. MHP has done work on it, but it has not yet started, or it has been suspended for some reason. This is NOT an active PIP.</td>
</tr>
<tr>
<td>Submission Determined Not to be a PIP</td>
<td>The write-up does not contain a plan, data, and/or has no indication where data will come from. This is NOT an active PIP.</td>
</tr>
</tbody>
</table>
Findings

Six PIPs were submitted for review. Of the six PIPs required, six PIPs (100 percent) were rated as Active and Ongoing, thereby meeting the submission standard, as shown in Table 4-4.

Table 4-4: PIP Status

<table>
<thead>
<tr>
<th>DMC-ODS</th>
<th>Size</th>
<th>Number of Clinical PIPs Submitted</th>
<th>Status of Clinical PIPs</th>
<th>Number of Nonclinical PIPs Submitted</th>
<th>Status of Nonclinical PIPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marin</td>
<td>Small</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Active and Ongoing</td>
</tr>
<tr>
<td>San Mateo</td>
<td>Medium</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Active and Ongoing</td>
</tr>
<tr>
<td>Riverside</td>
<td>Large</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Active and Ongoing</td>
</tr>
</tbody>
</table>

Range of PIP Topics

Table 4-5: PIP Topics for Active and Ongoing/Completed PIPs

<table>
<thead>
<tr>
<th>PIP Topic</th>
<th>PIP Focus</th>
<th>Clinical</th>
<th>Nonclinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access To Care</td>
<td>Increasing Access and Treatment Services to Special Populations (adolescents in one, and individuals exiting criminal justice system in the other)</td>
<td>Riverside</td>
<td>San Mateo</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Engagement and retention in concurrent treatment of MH and SUD co-occurring disorders</td>
<td>Marin</td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Transitions from WM or Residential Treatment to additional SUD services</td>
<td>San Mateo</td>
<td>Marin Riverside</td>
</tr>
</tbody>
</table>
CalEQRO Ratings of Submitted PIPs

Only those PIPs rated as Active and Ongoing are included in the figures below. The cumulative results of the scores received by the counties are contained in Figures 4-1 and 4-2.

**Figure 4-1: Clinical PIP Ratings**

- Marin: 91%
- San Mateo: 71%
- Riverside: 78%

**Figure 4-2: Nonclinical PIP Ratings**

- Marin: 85%
- San Mateo: 83%
- Riverside: 80%
Technical Assistance

During the FY 2017-18 review year, CalEQRO provided PIP clinic webinars, YouTube training videos, and individual consultation that focused on PIP development. Table 4-6 details the TA provided to all counties during the review year.

CalEQRO will use the findings from the review process to provide PIP clinic webinars and presentations focused on the areas identified in this report, working individually with all counties requiring assistance in the development of PIPs. Fourteen counties are being reviewed in the new FY and most have begun working with CalEQRO on their PIP designs and methodology.

Table 4-6: Technical Assistance Provided by CalEQRO Outside of Onsite Reviews (FY 2017-18)

<table>
<thead>
<tr>
<th>Type of TA Provided</th>
<th>Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIP YouTube</td>
<td>Online</td>
<td>June 2016</td>
</tr>
<tr>
<td>PIP YouTube 2</td>
<td>Online</td>
<td>January 2017</td>
</tr>
<tr>
<td>PIP Presentation</td>
<td>CalQIC</td>
<td>March 2017</td>
</tr>
<tr>
<td>PIP YouTube 3</td>
<td>Online</td>
<td>May 2017</td>
</tr>
</tbody>
</table>

In addition to the TA detailed in Table 4-6, CalEQRO provided one-on-one TA to many counties before and after their onsite reviews. This TA ranged from helping to develop measurable study questions to a comprehensive evaluation of all PIP validation steps.

Outside of the onsite review process, CalEQRO provided individual TA to 19 counties for a total of 307 hours. One of the most common areas of assistance involved PIP study question formulation and assisting counties in the development of a new PIP concept. Many were focusing on new access points, expansion of services to at-risk populations such as youth, introduction of new clinical assessments and individualized treatment methods central to the ASAM assessment and referral process, continuity of care post discharge from WM and residential treatment, and use of the full continuum of care to meet client needs.

Each of the three counties picked PIPs that have implications for the launch of the DMC-ODS and the fundamental shift to an ASAM-driven
system of care, with comprehensive assessments and individualized treatment models as well as a focus on evidence-based practices, access, and engagement. Many other counties that are beginning services under the DMC-ODS have chosen to focus on similar issues.

Areas for Improvement in PIP Design/Implementation

Recommendations

• DMC-ODS counties should add new interventions each year for an active PIP to continue and refine their impacts/outcomes.

• Counties should consider implementing PIPs in stages to ensure that a larger population of consumers benefits from them. Bringing some interventions and program changes to scale takes time, and counties can use the PIP process to do this.

• The PIP process should continue to be embedded in the counties’ QI initiatives, whereby the county has a regular mechanism for:
  o Defining the problem
  o Asking stakeholders what should be done about the problem
  o Designing interventions to address the problem
  o Implementing those interventions
  o Measuring the effect those interventions have on the problem

• Counties invest time and resources in developing systems that not only collect data, but also generate reports that can be used to analyze the data in meaningful ways. This should continue with new counties joining the DMC-ODS program.

• It is recommended that the counties participate in TA provided by CalEQRO and other sources to improve their ability to collect, analyze, and use data.
Summary

During FY 2017-18, CalEQRO found strengths in the DMC-ODS programs and practices with a significant impact on the overall delivery system and key issues that are important to quality of care for DMC-ODS. In these same areas, CalEQRO also noted opportunities for continuing to expand the QI focus and support of the ASAM system changes developed for the DMC-ODS program.
Section 5

Client and Family Member Feedback

This section presents findings from the CFM focus groups. A CFM is a person with lived experience in the substance use treatment public health sector as clients, caretakers, or family members of clients.

Introduction

CFM voices are an integral part of the CalEQRO review process. The county-developed DMC-ODS system has been built with continuous feedback from CFMs to assure that the system is designed to meet the needs of clients. CFM feedback is built into the system through feedback at many levels of county and provider organizations. The CalEQRO solicits specific feedback through focus groups that include a variety of stakeholders in the DMC-ODS system.

A stakeholder is any individual whose life is affected by substance use and addiction, including adults, youth, and families of adults and youth experiencing addiction. Stakeholders also include providers of services, law enforcement, the education system, social services, veterans, providers of alcohol and drug services, mental health and health care organizations. Stakeholder involvement in the review process elevates CalEQRO’s findings and incorporates first-hand knowledge in a meaningful way into the success of the local substance use DMC-ODS.

In this section of the report, methods are reviewed for how the EQRO elicits feedback from clients and family members. These include focus groups and periodic surveys. In addition to a review of methods, this section reviews the qualitative and quantitative data.
findings. This section ends with a brief summary and conclusions from feedback.

Methods

During FY 2017-18, CalEQRO used CFM consultants to facilitate eight focus groups with 54 participants in three counties, including four adult groups, two women-specific groups, one adult group for participants who preferred to speak Spanish, and one group of parents/caretakers of youth in treatment. The group participants were diverse in gender, age, race, and ethnicity.

CalEQRO developed an interview guide that was followed during each focus group session. The questions were printed and handed out to participants, with a Likert scale that includes visual faces from agreement to disagreement. This allowed people of all reading abilities and levels of comfort with public speaking to give feedback on their treatment experiences. The guided group discussion provided feedback in the areas of access to services, timeliness, quality, and outcomes. CFM consultants used their own lived experience along with their training to effectively gather data reflective of beneficiaries' experiences within the DMC-ODS system. CalEQRO also collected demographic information from CFM focus group participants. Findings were included in each DMC-ODS Review report.

Following is a summary of the CFM focus group findings. Findings from the three county focus groups were reviewed and analyzed to determine strengths, challenges, and recommendations in the first year of implementation.

Access, Timeliness, Quality, and Outcomes

Feedback from Client Focus Groups

Strengths

- Access to care, particularly for routine appointments, was easy and within appropriate timelines across all three counties.
- Recovery coaches were perceived as very helpful to clients’ recovery, adding a critical element to the treatment continuum.
- Most clients in treatment for 12 months or more felt they had benefited from care and expressed support and appreciation for most treatment staff.
Analysis of TPS survey responses showed high marks in most domains.

Challenges

• Timeliness was an issue when out-of-county Medi-Cal was involved with the transfer process, limiting timely access—especially to medication prescriptions.

• Special group and individual supports were deemed necessary for clients using methadone and other MATs.

• Education about methadone and other MAT treatments in general is needed in some parts of the treatment system and for criminal justice and other partners. It is understood that shifting long standing views related to MAT for those working on their SUD is going to take time, but a priority needed to benefit clients.

• Ongoing training needs exist for some staff.

• There is a need for ongoing development of the youth treatment continuum of care, including youth-specific training.

Specific Strengths and Challenges

San Mateo

• Successful recovery experiences were enhanced by pro-social drug and alcohol-free community activities; clients requested more of these.

• Lack of housing options affects sustained recovery, creating stress for clients that puts their recovery at risk.

Riverside

• Counselors and case managers were perceived as positive and supportive.

• After-hours treatment options are needed for clients who are working and trying to attend treatment.

• Program length and treatment flexibility are needed to respond to individual treatment needs.

Marin
• The web page was identified as providing easy to access information on substance use issues and specific information on local programs.

• Phone and walk-in assessment hours were experienced as client friendly and helpful.

• Additional bilingual counselors and Spanish-language materials would reduce barriers and increase access for clients who speak Spanish and perceived language barriers.

Treatment Perception Survey

In addition to the CFM feedback received by CalEQRO during the onsite reviews, the DMC-ODS Waiver requires the submission of a client experience of care/satisfaction survey. The CalEQRO, in coordination with UCLA, is required to review client satisfaction surveys conducted by counties participating in the DMC-ODS Waiver. Each county, as part of its assessment of client satisfaction, conducts annual surveys of clients at the provider sites within the county network, using a valid client satisfaction survey.

The information gathered from the surveys supports DMC-ODS QI efforts and provides key information on the effects of the new continuum of care. Counties administer the TPS at least once annually, on a schedule determined by DHCS. However, as a best practice, counties may conduct more frequent client satisfaction surveys and/or include additional survey questions if the standard TPS is used.

Results from the TPS show overall great satisfaction with services received during the first year the DMC-ODS implementation. Scores are ranked on a satisfaction range from 1 to 5, with 5 being the most satisfied. Areas of this survey measured access, quality, care coordination, outcomes, and general satisfaction. San Mateo, Riverside, and Marin received 1,134 surveys from 85 programs. The largest percentage of returned surveys came from outpatient programs, with response rates ranging from 52 to 56 percent.

Figure 5-1, below, shows the range of scores for each of the three counties in the critical domains of access, quality, care coordination, outcomes, and general satisfaction.
CFM feedback was positive for the first three counties implementing DMC ODS. They stated that the new system provides client-centered care that is timely, an expanded continuum of care expected to result in improved outcomes, and high satisfaction reported by clients. The systems will benefit by addressing the issue of Medi-Cal transfer delays and increased training of clinical staff to support the new system design.
Section 6

Information Systems Capabilities Assessment

Introduction

Health Information Systems (HIS) play an important role in the effectiveness and efficiency of public substance use service systems. CMS regulations require EQRO organizations to examine the role of the HIS in the substance use system. The HIS has three primary functions: (1) collection and storage of data, (2) analysis of data to support decision making, and (3) assistance with operational business processes.

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

- HIS
- EHRs
- Telemedicine services
- Use of data

Methods

CalEQRO developed the ISCA tool, which can be found on the CalEQRO website (www.CalEQRO.com). The ISCA is an evolving document, normally updated yearly to reflect the evolution of DMC-ODS IS with respect to changes and enhancements, data collection, and regulation changes. The ISCA also examines financial, business, and clinical areas as they relate to information systems (IS).
For FY 2017-18, CalEQRO developed an ISCA specifically for DMC-ODS purposes.

ISCA V1.0 was a 27-page document divided into six sections, with multiple questions in each section. The ISCA collects data in six domains:

- **Section A—General information**

  In this section, data are collected on the status of the current modules included in the HIS, top priorities of the IS department, makeup of IS users, relative percentage of Medi-Cal versus non-Medi-Cal services provided, percentage of county-operated programs versus contract agencies and network providers, plans for future system changes, and availability and use of teleservices.

- **Section B—Data collection and processing**

  This section includes questions concerning policies and procedures specific to data timeliness and accuracy of data entry, system table maintenance, training capacity, access to and analysis of data, and communication with IS users.

- **Section C—Drug Medi-Cal claims processing**

  Policies and procedures surrounding the DMC-ODS claims process are the focus of this section, including eligibility determination, payment processing, and denials.

- **Section D—Information systems security and controls**

  Security issues relevant to the HIS are addressed in this section, including consideration of Health Insurance Portability and Accountability Act (HIPAA) requirements.

- **Section E—Data access, usage, and analysis**

  In this section, CalEQRO collects information about staff most responsible for analyzing data, capability to interface or exchange data with other systems, reporting tools used to
analyze data, the measurement of consumer outcomes, and ability to produce penetration rate analyses to measure outreach and engagement efforts.

The ISCA is to be completed primarily by the DMC-ODS IS manager and billing/claims processing subject matter expert staff and returned to CalEQRO before the DMC-ODS onsite review. DHCS data sources also are used to assess information systems and include: Short-Doyle/Medi-Cal (SDMC), Inpatient Consolidation Claims (IPC), Monthly Medi-Cal Eligibility File (MMEF), and provider files. Details of these are provided in Section 2 of this report.

**Budget Allocations for Information Systems**

The percentage of the DMC-ODS’ budget devoted to IT is a simple indicator of the level of IT resources and capabilities available to support the administration and delivery of mental health services. IT budgets for FY 2017-18 ranged from 1 percent to 3 percent, as shown in Figure 6-1. Although there are no standards for percentage of budget devoted to IT, there are literature references to 3 percent being considered the minimum necessary in health care organizations with a full-featured EHR.

However, there is more to consider than the percentage of the DMC-ODS budget devoted to IT. For instance, in a county where the core system is used for more than substance use (such as mental health), it may not be possible to clearly identify the substance use component of the overall system cost. In reviewing the data received in the FY 2017-18 ISCA, situations like this may have affected some of the higher and lower budget percentages. This should be viewed as a rough indicator that requires more detail to be fully informative.

As shown in Figure 6-1, Riverside dedicates a smaller percentage of its budget to IT compared to Marin (a small county) and San Mateo (a medium-sized county). This is potentially due to an economy of scale issue, but also may suggest that counties dedicating less than 3 percent of their budgets to IT may have a difficult time using IT effectively to address DMC-ODS requirements and priorities.
Findings

Health Information Systems by Vendor

For years, California counties have relied on four technology vendors to support health information systems. This narrow range of vendors is a consequence of California’s unique Medicaid claims processing rules. These vendors all have core expertise for SDMC claims processing and state-mandated reporting requirements: Cerner Corporation, Harris’ Healthcare Group, The Echo Group, and Netsmart Technologies.

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 using CMS Meaningful Use protocols and standards to improve healthcare professionals’ workflow processes and efficiencies for substance use services.

San Mateo and Riverside both currently use Netsmart/Avatar for their EHRs, while Marin uses FEI/WITS. Marin is in the process of evaluating its EHR capabilities and needs to determine whether to migrate to a new EHR or work with FEI to improve WITS for DMC-ODS purposes.
Information Systems Replacement Status

Most counties have implemented or are in the process of implementing a system that has core components that support EHR functionalities. San Mateo and Riverside are not considering a replacement, while Marin is in the process of determining whether its current system can meet the needs of the Waiver requirements.

Current EHR Functionality

Table 6-1 summarizes the ratings given to the counties for EHR functionality.

Table 6-1: Current EHR Functionality

<table>
<thead>
<tr>
<th>Function</th>
<th>Present</th>
<th>Not Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alerts</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Assessments</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Care coordination</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Document imaging</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Electronic signatures</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Laboratory results (eLab)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Outcomes</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Prescriptions (eRx)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Progress notes</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Referral management</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Treatment plans</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Progress and issues associated with implementing an EHR over the past year are noted below.

- Progress notes, assessments, and document imaging are the only functions that are consistent across the three reviewed counties.

- However, most of the services in these counties (and statewide) are provided by contract providers, who do not have direct access to the EHR and, in some cases, do not have look-up only status.
Information System Functionality
An IS is a group of integrated hardware and software components designed to collect, organize, store, process, and report information. IS functionality, from a user perspective, is the ease of use of those integrated components, often in terms of the availability of the software designed to support daily workflow.

Health records are rated functionally as electronic, paper, or a combination of electronic and paper. Two of the counties have electronic health records systems, while one has a combination.

Interoperability
In Table 6-2, where “Direct data entry into EHR” is noted, it almost always means that contract provider employees are entering the client data into their own EHRs, then logging into the DMC-ODS’ EHR to enter the same data there. This is terribly inefficient, generally slows down the availability of data, is a chronic drain on contract provider resources, and is a frequent source of data errors.

Riverside and San Mateo Counties have achieved some level of electronic data interchange with contract providers and other business partners.

Interoperability continues to pose challenges for most DMC-ODS counties because it requires a level of resources and skill sets not uniformly available to them. For the time being, for most DMC-ODS counties, some level of double data entry will continue to be required. Some MHPs continue to receive paper documents sent by contract providers for input and processing, which continues to be the most inefficient and error-prone option available. Since many DMC-ODS counties use more than one submittal method to receive client data from contract providers, the results for Table 6-2 do not sum to three DMC-ODS counties.
Table 6-2: Exchange Client Data from Contract Providers to DMC-ODS EHR

<table>
<thead>
<tr>
<th>Status</th>
<th>Riverside</th>
<th>San Mateo</th>
<th>Marin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct data entry into EHR</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Electronic batch file transfer directly into EHR</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>EDI transactions directly into EHR</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Electronic files sent to ODS for input and processing</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Paper documents sent to ODS for review, input and processing</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Currently, no ODS are using an HIE.

Availability of Telemedicine
Service delivery via telemedicine benefits both the client and the practitioner. For the client, telemedicine expands access to care by overcoming the barrier of distance from established substance use services. For providers, telemedicine allows for the convenience of service delivery from their existing locations and may allow them to serve more clients.

Riverside is the only county at this point to have technology in place to support substance use services at a distance. Twenty-three telemedicine encounters took place in Riverside last year.

Table 6-3 shows the varied hosting and operation arrangement for DMC-ODS core systems.

Table 6-3: System Hosting/Operation Locations, by County

<table>
<thead>
<tr>
<th>Status</th>
<th>Riverside</th>
<th>San Mateo</th>
<th>Marin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Service Provider (ASP) Model - hosted by ASP</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>County IS site</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Agency IS site</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Hosting systems at an Application Service Provider (ASP) is most often driven by cost benefits, but even where there is no great cost benefit, ASP hosting usually includes benefits such as heightened system security, business continuity assurances, and 24-hour staffing by qualified technicians. The changing IT services market also plays a role in hosting and operation decisions made by counties. When the challenges of hiring, training, and retaining qualified technical staff are added to the equation along with the known benefits of ASP hosting, the cost-benefit ratio generally makes for a compelling case.

**IS and Data Analytic Capacity**

Data analytic resources are not tied to substance use service delivery operations in the same direct way that IT resources are, but they are connected directly to whether the DMC-ODS is getting full value from its EHR. If the EHR merely replaces the paper health record with an on-screen version, the record becomes more widely available within the organization and perhaps even with business partners, but that alone might not justify the cost of obtaining, implementing, supporting and maintaining an EHR.

What the EHR offers in addition to a more widely available health record is data about the entire population served by the DMC-ODS. The DMC-ODS’ staff can see outcomes at the population level; trends by race/ethnicity, gender or age; provider level performance; timeliness of services; and a great deal more, but only if the DMC-ODS employs an adequate number of people with the right data analysis skills.

- For the three counties reviewed for CY 2017, only Riverside increased its number of IS and data analytic staff. They hired six new FTEs to support DMC-ODS, with 19 FTE IS employees and 32 FTE data analysts.
- San Mateo, the medium-sized county in this review, did not hire new staff and reported four FTE IS staff and two FTE data analysts.
- Marin, while a small county, only reported a 0.5 FTE IS position and a 0.25 FTE data analyst, with no increase from the previous year.
- Below a certain threshold of data analytic staff capacity, DMC-ODS counties will not be able to realize the potential benefits of their EHRs. Numbers matter, especially as the DMC-ODS counties get larger, but a basic skill set also is required to analyze data effectively. The numbers alone do not tell the whole story. For example, some counties have relationships with universities, consulting organizations, or even their system vendors. These organizations provide data analytic services the DMC-ODS cannot reliably maintain and the DMC-ODS counties are getting good value from their IS investment as a result. For example, Marin utilizes its county epidemiology division to help analyze data, provide background analysis, and support decision making.

**Electronic Consumer Outcome Measure Tools**

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

All three counties reviewed this year captured the ASAM-recommended LOC recommendations, referrals, and admissions for clients in their EHRs. In all counties, 100 percent of clients who request treatment through the DMC-ODS are screened for level of care placement.

**Conclusions**

In CY 2017, CalEQRO observed remarkable progress in launching DMC-ODS continuums, as well as challenges. The IT conclusions are:

- With the percentage of DMC-ODS budgets devoted to IT ranging from one percent to three percent, it may be informative to correlate the percentage of budget devoted to IT with other performance measures with two purposes:
Establish whether there is a correlation between the percentage of DMC-ODS budget devoted to IT and overall DMC-ODS performance.

Explore whether there is a level of IT funding below which DMC-ODS performance clearly falls below other similarly sized DMC-ODS counties.

- EHRs are high-maintenance tools. Without adequate IT resources, the investment in hardware and software is compromised. The difficulties the counties generally experience in the hiring and retaining of IT staff remains a barrier to sustaining experienced and proficient IT departments.

- Interoperability between disparate HIS remains a significant and ongoing challenge across the state. Coordination of care is a critical component of a strong continuum of care. With many FQHCs providing non-methadone MAT, and with some beneficiaries ending up in Emergency Departments as a result of an overdose, it is paramount that county HIS communicate across systems. This is also important for the contract providers, who provide over 75 percent of all substance use services across the three counties reviewed. Further, counties estimate that between 40 to 70 percent of their beneficiaries with SUD also have a co-occurring mental health disorder.

- In the absence of electronic data interchanges with contract providers, contract providers are most often users of the DMC-ODS counties’ EHRs. As such, they require support, training, and regular communications, just like internal DMC-ODS staff users. This burden draws resources from projects that could otherwise move the organization and its service delivery forward.

- Internet infrastructure across the state continues to be an obstacle to progress, with rural areas experiencing the greatest Internet connectivity problems. In many, if not most, counties visited in FY 2017-18, there were reports of expanding field-based services. With those reports came discussions about the difficulties of providing adequate connectivity to the EHR for field-based employees.
Section 7

Key Findings and Recommendations

In this report, CalEQRO provides the first in-depth review of how California counties are implementing the lofty aspirations embodied in the DMC-ODS Waiver. The Waiver incorporates a blueprint for how SUD treatment services in the public sector can emerge from decades-old practices with limited effectiveness to well-managed and coordinated systems of care that offer client-centered care with evidence-based treatments to more effectively improve client outcomes. The blueprint also provides guidelines for the infrastructure building necessary to achieve these aspirations through a skillful and caring workforce, implementation of new types of health IT, and data analytic reporting that supports accountability for QM, cost effectiveness, and ongoing QI.

While the Waiver offers the potential of tremendous benefits for clients, it also poses many challenges and considerable risks for the counties that decide to try this Pilot opportunity. The summary of findings and recommendations in this section may provide inspiration and guidance not only to the first few counties who implemented the Waiver and were reviewed by EQRO, but also to the counties following in their footsteps.

In this final section, CalEQRO summarizes the key findings from the report and formulates recommendations for the future. The key findings in this summary section begin with a focus on how the Waiver design opened up opportunities and benefits to the counties for improving and transforming their SUD treatment systems of care. The next set of findings focuses on the creative ways that counties stepped up to these opportunities, invested time and resources, and built out their systems to enhance care for their clients. These sets of findings also highlight
which transformation efforts in the DMC-ODS counties are working well, the lessons being learned, and what remains as continuing learning opportunities. The section then transitions to the salient challenges in implementing the Waiver and recommendations for the future.

Positive Opportunities Generated through the Waiver Design

In many respects, DMC-ODS Waiver STCs read like a blueprint of how to design an ideal SUD system of care for California’s Medi-Cal population. This subsection elaborates on key components of that blueprint and how the DMC-ODS counties under review are using them to change the way they organize and deliver treatment services for the clients they serve.

The Waiver design was groundbreaking—the first of its kind—and reflects lofty aspirations that involve huge undertakings. Most counties needed several years of preparation to get their infrastructure sufficiently in place to begin, so giving the Pilot a full test will require more time. However, as an 1115 Medicaid Waiver, it is limited to a five-year period unless renewed. It will be of great interest in California to determine whether the Waiver is having a sufficient desired effect that warrants renewal and, if so, how the STCs could be improved. It will also be of great interest outside California, particularly for the 25 other states that have applied for a similar Waiver.

A. Designing a standard of DMC service delivery with a continuum of care. DHCS, with CMS support, designed a model of care based on the ASAM criteria, organized to meet the needs of clients with SUD. Billing supports core services, including removing the IMD exclusion obstacle for residential treatment services, and provides a well-designed managed care structure for administrative oversight. The Waiver takes separate and siloed programs and organizes a system of care with added supportive services based on the latest science in addiction medicine. This design enhances continuity of care with case management and recovery support services. All counties are required to operate their DMC services based on Waiver STCs, including a QI plan.

B. Individualized treatment and a client-centered approach. These are foundational elements of the design and move away from historic program-driven service structures, in which “graduation” implies that once a client’s treatment is over, the client is cured. A key
cornerstone of the new system of care’s design is individualized responsive care over time for a chronic disorder, subject to potential relapse based on a variety of stressors and triggers. The DMC-ODS Waiver puts client-centered, individualized care at the heart of its model for California. Each of the three counties has been monitoring individualized treatment fidelity as a key part of its QI programs, looking at LOS, timely access based on an ASAM assessment, and tracking transitions along the continuum of care.

C. Evidence-based MAT. Each of the three counties includes MAT in billable treatment options. Medications at the NTPs per the STCs include methadone, buprenorphine, and disulfiram for treatment. Naloxone, which can reverse the effects of an opioid overdose is also required to be provided by the NTPs. These are important treatment tools for opioid and alcohol use disorders. Treatment is not limited to medication, but includes counseling and other medical and supportive treatments. Referrals to these treatments are based on a set of ASAM assessment dimensions including risks, motivation level, and co-occurring disorders. These assessments include evaluation of potential benefits from MAT as an important component of treatment. These design elements provide a solid foundation for the counties and all are working with primary care providers as partners in service delivery of this modality of treatment.

D. Science- and evidence-based approaches to SUD treatment. These are central to the Waiver’s development and design. The origins of SUD, impacts on the brain, and effectiveness of treatments are addressed in the Surgeon General’s report\textsuperscript{19} and are incorporated into the clinical design of the Waiver processes and services. As new medications or other treatments are identified, these will be evaluated for inclusion in treatment options.

E. Field and community-based treatment services are included in the Waiver’s design and enable programs to seek out the most vulnerable and at-risk populations with a SUD for engagement and treatment. These include the elderly, homeless, isolated disabled individuals, and youth who have limited ability to come to clinic sites to begin care. These options to provide services in client homes and

community settings allow counselors and case managers to keep clients linked to care and engaged in support groups and activities. Staff can also provide assistance to clients in how to access their benefits, make the best use of family counseling, and access social supports when needed. This community-based approach also allows outcome-oriented and cost-effective service delivery to reduce reliance on emergency department services and other acute care systems. All of the counties shared positive experiences with client care and engagement based on this element of the Waiver.

F. Access to pharmacy medications. DHCS worked to approve important and newer MAT pharmaceuticals in the Medi-Cal formulary system. Medications to help with cravings would have been too expensive for most low-income or uninsured clients to access on a self-pay basis. Without support for inclusion of these medications in the Medi-Cal formulary, many clients would not be able to access critical MAT services to support their wellness and recovery.

G. The addition of licensed clinicians and medical directors. These new workforce requirements are part of program certification and enhance the quality of services in the SUD care system. An expansion of the total workforce occurred in all three counties, as well as more integration with mental health and physical health care systems. Providing licensed medical and behavioral health oversight supports a range of SUD treatment options and also allows for more clinical capacity and interdisciplinary teamwork.

H. Established standards for accessibility, timeliness, and quality of treatment services, as well as accountability for counties to meet the standards. These standards are central checks and balances for any managed care system. The Waiver STCs establish many expectations for how the standards will be achieved, including a 24-hour Access Call Center, data systems to track client flow related to timeliness and generate reports, an authorization process for residential treatment, a QI plan, and both training and monitoring of providers in EBPs.

I. Waiver of IMD exclusion so residential facilities could be Medi-Cal-certified. This specific IMD exception to the historic rule that no facilities over 16 beds can bill Medi-Cal is critical to the Waiver. Approximately 80 percent of the residential facilities in California would not have qualified for Medi-Cal reimbursement, thus severely limiting treatment options. Waiving the IMD exclusion rule allows
SAPT BG funds and county funds to be used for other treatment needs not covered by Medi-Cal, such as recovery residences, room and board costs for residential treatment, and prevention activities.

J. **Selective contracting and county responsibility in a managed care framework.** This is an important and positive addition to the DMC-ODS Waiver as reflected by activities in the three counties. Prior to the Waiver, any willing and qualified provider could get a contract. After the Waiver, counties used their competitive bidding processes to identify the best providers and set capacity levels for each of them so that the overall quality and capacity needs of the SUD provider network could be met. This framework creates fiscal and program requirements and responsibilities at the county level. The STCs outline these specific new accountability systems.

K. **Required mental health and public health coordination as part of the managed care framework.** DHCS includes important integration and coordination requirements in the STCs that have led to MOUs and working procedures between the DMC-ODS counties and their mental health and health plan partners. The goal is to enhance the wellness of the beneficiary overall—in terms of health, mental health, and SUD. Each of these areas is enhanced as well in the counties’ WPC grants, which support coordination and integration of care for high-need, complex clients, many of whom have SUD or mental health treatment needs.

**Essential Ingredients for Successful Implementations by DMC Counties**

The structure and design of the Waiver is detailed in the STCs and in contracts between DHCS and the counties, approved by CMS. Included in the intergovernmental contracts are county-specific implementation plans on how each DMC-ODS county would take the new core services and STC requirements and operationalize them in the initial years of the Waiver. The three counties reviewed this past year all had strong plans for implementation and a willingness to be flexible and creative as unforeseen challenges and problems emerged in the implementation for these complex systems. It is important to note that this effort went well beyond adding new services. It encompasses a major philosophical and treatment model change, which the directors in each county needed to promote, educate, and support with legacy providers, criminal justice systems, and outdated models of care. Below is a summary of some of
the core strengths observed in these DMC-ODS programs that are shared among the three counties.

A. **Leadership with effective communication** with stakeholders, elected officials, clients, and the community at large are critical to successful implementation. Because of the complexity and breadth of the SUD services redesign, leadership with strong and effective communication is a central trait required in each county. It includes many levels and phases of communication:

(1) Educating the community about the new program philosophy and opportunities.

(2) Involving stakeholders from criminal justice, providers, and client groups from many ethnic and economic backgrounds in the design of their local plan and the change to individualized treatment instead of program-driven treatment.

(3) Education of the Board of Supervisors and elected officials related to the new structure of the Waiver finances and getting resources for planning, infrastructure, and launching of services.

(4) Development of staff expertise in complex new billing and quality improvement and accountability systems required by DHCS as well as CMS.

(5) Most important, training and education in the ASAM model of care with individualized treatment as its foundation.

All participating DMC-ODS counties must ensure availability and access to the range of services in the Waiver as reflected in their implementation plans. Without solid visible leadership as well as effective communication and working relationships (inside and outside the county), implementing the Waiver would be very difficult, if not impossible.

B. **Expansion of DMC-ODS services to clients with SUD** in a new and effective model is central to the Waiver. Each of the counties saw expansion of unduplicated clients served from the prior FYs in the Medi-Cal program, considering the fact that Riverside and San Mateo were only in DMC-ODS service delivery for 11 months and Marin for only nine months. Access expanded
during these active DMC months between two and three percent compared to the prior year, on average, without extrapolating the data for the full year. This was based on unduplicated clients in paid claims for the period of February through December 2017. Counties shared there were still pending claims not yet processed at the time of the data download for the report. In addition, counties continue to work on expanding capacity and new programs as part of their second year of Waiver implementation. CalOMS reflected an increase of 7.4 percent overall for the three counties based on the UCLA evaluation report. CalOMS tracks total client services regardless of coverage, so it includes clients with other payer sources besides Medi-Cal.

C. **Launch of new and expanded services** is critical to meet network adequacy and to ensure there are no undue delays in access to care. All three counties demonstrated this in a variety of ways. For example, Riverside increased clients getting residential treatment from 2,154 in FY 2014-15 to 3,419 in FY 2017-18. There was an 84 percent increase in that same time in residential bed days available, from 56,485 to 120,714. Also, in Riverside’s monthly capacity for WM, 86 clients were served in February 2017 (at the beginning of the Waiver) and 158 served in June 2018. San Mateo expanded MAT in partnership with a local FQHC and their emergency department, serving 109 clients in their MAT outpatient program. The treatment completion rates in terms of services increased for this group of clients to 92 percent for those in residential treatment on MAT and 79 percent for those in outpatient treatment on MAT. This was significantly higher than completion rates for clients not using MAT as one of their treatment tools. The research study on the San Mateo MAT program also showed a $155,106 reduction in health plan costs for clients in the program, which was 55 percent lower than costs the prior year. This was achieved through a reduction in emergency department visits and inpatient hospitalizations. Meanwhile, costs increased in outpatient treatment, which was appropriate for addressing those clients’ healthcare needs. Marin increased unduplicated clients seen by 14 percent in this first year of the Waiver (based on nine months of services) and added a new residential treatment site for adolescents, among other expanded services.
D. **New DMC licensing and certification expansion** in each of the three counties was significant. Marin added nine new facilities to the Medi-Cal program in the county, representing 18 different clinical programs at 21 different sites. In San Mateo, 22 providers with various sites and LOC were certified for DMC-ODS services and three sites are still pending certification. Riverside had 27 provider sites included in their services as part of the Waiver and six more are pending DMC licensing and certifications. All of the counties also have additional out-of-county contracts as needed for special needs and unique access arrangements.

E. **Training** is required in many areas with the change to ASAM assessment and treatment models, increased use of EBPs, and the shift to individualized treatment from program-driven services. All three counties mounted major training efforts with CIBHS, DHCS, and train-the-trainer models to enhance and reinforce new approaches to treatment. Even with these efforts, staff and contractors are still seeking more support as they learn to document Medi-Cal qualified treatment plans with ASAM criteria-focused goals and objectives.

F. **Access Call Centers and timeliness.** All three counties laid a solid foundation for improving access to care with three 24-hour call centers. The designs and services include the county operated 24-hour Access Call Center program in Riverside, which receives an average of 3,200 calls per month; Marin’s integrated mental health and SUD Access Call Center with walk-in capacity for assessments; and San Mateo’s 26 walk-in sites, where assessments can be done, as well as its 24-hour Access Call Center staffed during the day by licensed county staff and after hours in partnership with a residential provider. All three counties are monitoring timeliness of access to care. The first dose of methadone medication in NTPs occurred within 3.5 days or fewer in all three counties, and the median was within one day. Residential access was occurring within the state network adequacy guidelines, with rapid 48-hour authorization processes. Tracking these timeliness measures is noteworthy considering limited and varied software systems, dispersed provider networks, and some access occurring through decentralized walk-in programs.
G. **Performance Measures.** All three counties worked with EQRO to review the reporting results of the new PMs and understand the implications of the results for this initial year. Other than when service data were not available in the DMC-ODS claim system, most PMs positively covered the issues anticipated by the EQRO Clinical Advisory Committee and laid a foundation for helpful PMs linked to quality outcomes for SUD treatment. Among the PM results, initial access to methadone medication dosing through NTPs was rapid in all three counties (3.5 days or less). Access to other medications in the NTPs was low as reflected in the PM for other MAT and needs to be increased. There were some billing challenges which may account for some of the low visits for buprenorphine and disulfiram. Additional technical assistance and support is needed to allow for expanded use of other medications.

Also, it was rare for any clients to use WM for three or more episodes without other SUD treatment, suggesting that these high-risk clients are becoming engaged in treatment. Baselines were also set for residential transitions to other LOC and Access Call Center key indicators. As claims data becomes more complete, the PMs will be updated to try to capture all the activities and services. Current data in the annual report are from a July 25, 2018 download. Each county shared they had additional 2017 billing that was still pending.

H. **PIP work on outcomes and quality.** All three counties had two active PIPs, reflecting a variety of positive focuses in terms of learning for the Waiver. Riverside had a PIP on expansion of youth services linked to schools, County Social Services, and Probation, with tracking of outcomes through CalOMS discharge ratings. Their other PIP examined transitions in care for clients being discharged from residential treatment. CalOMS discharge information was used with this outcome as well. Marin had a PIP focusing on treatment of clients with both mental health and SUD disorders and used multiple evaluation measures, including the TPS and the Comprehensive Health Outcome Information System (CHOIS). Marin’s other PIP was focused on reducing the number of readmissions to WM within 30 days by enhancing their care coordinator outreach from pre-discharge through follow-up to first outpatient appointment. Finally, San Mateo’s active PIPs involved adding ASAM criteria-based assessments and
recommendations to the courts and care management for post-release from detention to enhance post-release engagement in treatment and positive outcomes for criminal justice clients. Their second active PIP focused on providing WM assessments using ASAM criteria, linking clients to their next LOC with discharge planning supports, and tracking readmissions. All of these focus on important system changes to enhance outcomes of care and effective use of treatment resources.

I. New billing and cost reporting systems. As part of the new design of the Waiver, each of the counties launched billing and fiscal tracking systems within months of beginning direct services. This occurred despite the challenges with complex new modifier codes; clarifications on some billing requirements and lock-outs still being refined; and testing of the state computer processing of these new claims, TPS forms, and ASAM LOC referral tracking data. These new systems involved significant technical work for the counties and DHCS staff; refinement of complex computer claiming and scrubbing systems; resubmission of bills that were rejected due to a variety of issues from the master provider file to definitions linked to lock-outs; development of highly complex billing workflows with contractors who were billing Medi-Cal for the first time; and IT systems handling of the claims output. Counties that have waited to begin their DMC-ODS have benefited from the work of these early counties in the billing and information systems arenas, since many issues and problems were resolved through the teamwork between DHCS staff and the three counties.

J. Flexibility and innovation. Each county demonstrated flexibility, created a learning-oriented environment for programs and staff, and demonstrated “can-do” attitudes working towards the success of the programs in meeting client needs and having the administrative infrastructure to successfully carry out Waiver requirements. Without these efforts, systems and progress would have stalled at many points as new and unforeseen issues were common, although in some cases unique to each county and its network and billing systems. This flexibility and innovation were noteworthy in each county among both contractors and county staff.
K. **New partnership with criminal justice.** One of the most significant system redesigns evolved from the partnership with criminal justice. Courts had routinely court-ordered outpatient or residential treatment without assessments and recommendations from SUD treatment staff. This was not a clinically effective approach to treatment and in many cases did not meet either medical necessity criteria for the services or individual client needs. With the SUD treatment network moving into a DMC-ODS framework and set of requirements, the counties’ leaders had to engage with and persuade the courts to allow a full ASAM criteria-based assessment with treatment recommendations and care management. This new process allows clients to be individually matched to services, making optimal treatment possible. Outcomes are tracked and continue to be reported to the courts. Outcomes in San Mateo are particularly positive in the Drug Court, with high levels of treatment engagement and completion particularly for those with MAT.

L. **Looking to continuous QI and outcomes.** All three counties also demonstrated QI as a core value in the way they approached their delivery systems. The three counties were able to present strong QI/QM plans and demonstrate improvement efforts through their meeting notes. The counties were able to present PIPs for review and demonstrated a clear dedication to quality as an overall organizational priority. Challenges were mostly in the area of data tracking systems, particularly with dispersed networks with “no wrong door” walk-in programs.

M. **Becoming an equal partner with other county agencies in service coordination.** The development of the DMC-ODS within each of the reviewed counties changed how other county agencies perceived their SUD service systems. Other agencies more clearly recognized the deleterious influence of SUD on the clients they serve and the vital contribution of SUD treatment in addressing SUD. The DMC-ODS STCs encouraged reaching out to these other service agencies; these overtures were well received. Their status changed from a program with low levels of joint coordination with mental health to an equal partner with other agency service systems. Collaboration between each county’s DMC-ODS and its other service systems has been of great benefit to the clients served.
Challenges for DMC-ODS Delivery and Systems

CalEQRO learned from the DMC-ODS counties it reviewed of numerous ongoing challenges that the counties could not easily remedy by themselves. Some of these challenges seemed to be created inadvertently by some of the STCs and others by federal or state regulations. Some are historical and are thus taking time to overcome, such as underfunded technology infrastructures, workforce shortages and training needs, stigma and discrimination, and homelessness. These challenges are described below, along with some progress made by the DMC-ODS counties in addressing them.

A. Out-of-county Medi-Cal transfers take up to 90 days to successfully change to a new county. This challenge was experienced by all three counties. Despite efforts to work with local Social Services Department benefits staff, the process of transferring Medi-Cal enrollment to a new county of residency took up to 90 days and was not retroactive. Because the host county cannot bill for services until the Medi-Cal residency code is linked to its county, delays in access to care are common. If the county gives up the option of billing for the Medi-Cal services during this initial 90-day period, clients may begin services. All three counties allow urgent cases and pregnancy cases to begin care. The counties suggested several options for solving this problem, all of which would require state policy changes: (1) allow retroactive Medi-Cal to date of relocation/application for transfer, similar to SSI application cases and hospital emergency department cases; or (2) reconcile units of service at cost report time. Other solutions may be possible as well, but these two were identified by counties as potentially most effective and efficient.

B. Provision of physician consultation to support optimal care/access to MAT. Physician consultation is covered as a billable service under DMC-ODS only when the consulting physician works for a DMC-ODS-certified program provider and consults with a provider who is also DMC-ODS certified. However, the greatest need for this consultation service comes from provider organizations that are not certified by DMC-ODS—namely, primary care and emergency departments. To expand
MAT capacity with new medical staff, physicians and mid-level providers, consultation from DMC-ODS physicians who are addiction-trained specialists would be very beneficial. The Health Resources and Services Administration (HRSA) and SAMHSA have grants to add more funding for MAT to primary care sites. Without training and consultation from addiction-trained specialists, physicians can find induction and phase-in of medications to be difficult, especially in the initial phases of their learning to treat SUD with medications.

C. Client transitions along the continuum of care and continuity of care. One of the most important factors contributing to positive treatment outcomes is the strength of the therapeutic alliance between the client and his or her treatment staff, per Dr. David Mee-Lee, editor of the ASAM criteria and textbook.20 When clients are transferring between residential to other LOCs with different treatment staff, a best practice is to try to bridge between the two LOCs by introducing the client to the new treatment staff at least twice before discharge from the higher LOC. Currently, the billing system does not allow a billing overlap between residential treatment and outpatient counseling treatment wherein counselors from both programs can bill for services rendered on the same day. Based on engagement rates in new LOCs after residential treatment, as reflected in PMs that were 20 percent or less, additional support for engagement at lower LOCs are needed. Some overlap in services is in the best interest of clients and their recovery. As a potential solution, it is allowed to have the outpatient services overlapping visit be billed to SAPT block grant to enhance this engagement.

D. Treatment approaches for some clients can conflict with limits of a maximum of two residential treatment episodes. Many clients leave in the first week of residential treatment because they are not ready for that level of commitment to treatment. In reviewing program data, many clients appear to drop out within the first 10 days. Data from UCLA on this topic were reviewed and discussed at several EQR Clinical Committee meetings. There is concern that these episode limitations can

impact client success in SUD treatment for some youth and adults. Extensions are allowed with medical necessity documented to have an additional 30 days of care. ASAM criteria recommends residential treatment for stabilization of more severe SUD issues and then transfer to partial hospital or intensive outpatient options. Optimal clinical outcomes could be bolstered by consideration of adjustments to these limitations if the Waiver is renewed.

E. Case management models. Case management is an important service for continuity and quality of care. It can also help with initial engagement and enhance retention in transitions between LOCs. In the three counties evaluated, it was clear that contract providers focus primarily on case management related to discharge from their facilities and not on client needs across the entire continuum of care. The centralized case management model used in Riverside tracks and advocates for clients across the entire system of care, including sharing insights and influence with all providers who might be seen by SUD clients. This model increases monitoring of providers, early identification of system challenges for clients and families, and direct feedback to the senior leadership of the DMC-ODS for continuity of care issues. County staff shared that ideally, a hybrid arrangement for case management is best, in which case management can be provided as needed through central coordination by county case managers and also through contract provider programs during discharge planning and coordination of transfers to other services.

F. Technology infrastructures in contract provider programs, DMC-ODS counties, and for telemedicine. The current IT infrastructure is not adequate in a managed care environment to track all the measures and key metrics linked to quality of care. The biggest challenges in QI as seen with these three counties lie in the interfaces across multiple different data collection systems (both county and contract) and a central data collection site where analysis of quality metrics can be performed and reported back to the system for quality feedback.

Besides the interface issues, equipment and software are outdated and, in some cases, non-existent, particularly for EHRs in many contract providers’ programs. Coordination and
systematic documentation of clinical treatment plans, notes, releases, ASAM criteria-based assessments, ASAM LOC referral data, TPS, CalOMS, and referral documents are needed. To make efficient use of staff resources, automation of these systems in a coordinated way would be very positive. A plan for development of these resources for enhanced technology systems with interface capacity is highly desirable.

G. Integration of ASAM LOC referral data collection processes. This is an important process for the Waiver, documenting a comprehensive assessment and recommended LOC. Ideally, it would be automated and integrated into routine intake work flows and technology systems. The two counties that had added the ASAM LOC data collection in their EHRs and intake work flows were much more successful at capturing and transmitting these data in a timely way to DHCS and UCLA. This is of course dependent on having access to an EHR or intake data collection system that can extract the required data elements. Unfortunately, many contract providers do not have EHRs and some others have systems that differ from the one implemented by the county DMC-ODS. The DMC-ODS Waiver requires entry, collection, storage, and analysis of the ASAM criteria-based assessment findings, referral actions, and eventual placement information.

The goal is to ensure clients are getting optimal treatment matching their needs. As previously stated, capturing these data into work flows and technology supports is highly desirable for efficiency and accuracy.

H. Stigma persists in communities related to: (1) use of medications to help with SUD treatments, (2) using ASAM assessment criteria to support optimal care, versus court orders not driven by clients’ clinical needs, and (3) support for new and expanded sites for service delivery (e.g., NIMBY or “not in my back yard”). Continued education and work with media, the public, and community leaders are needed to push back on these biases and beliefs. These also create barriers for clients needing housing, jobs, childcare, and other services.

I. 42 CFR Part 2 challenges for coordination of care. Without specific written releases, 42 CFR Part 2 has created significant challenges for smooth transitions in care and the admissions
process. Access Call Centers cannot convey referral information to providers without written consent from clients and cannot obtain that consent immediately in writing, as 42 CFR.2 requires. Continued advocacy in this area would be helpful to improve care and make it more efficient.

**J. Workforce recruitment, training, and retention.** The expanded workforce, including LPHAs and medical providers, is very positive for SUD treatment, but also is very challenging. Options for improvement suggested by the counties included more college and graduate program capacity in nursing, medicine, mental health and SUD programs, loan forgiveness, and approaches that expand training and scopes of practice. One example of this challenge is illustrated by Riverside County, which chose to develop the Access Call Center, case management, and a variety of key functions with county staff. After obtaining approval for 70 new positions, the Behavioral Health Department is still trying to fill all of its positions due to recruitment challenges.

**K. Homelessness** affects smooth transitions in care and increases relapse. As discussed in Section 1, homeless issues persist nationwide; California has more homeless people than any other state. This is a particular challenge for individuals who want to obtain treatment and then remain substance-free. All three counties are part of local coalitions and are involved in a range of other efforts to work on access to affordable housing. They regard addressing homelessness as imperative for sustained recovery and wellness for persons with SUD. For example, Marin arranges to give priority status to SUD clients for affordable housing. Each of the counties regards the newly available use of SAPT BG funds for recovery residences as a viable opportunity to provide some transitional housing for SUD clients who are actively participating in outpatient SUD treatment.

**L. Addition of more medically monitored levels of ASAM care.** The ASAM LOCs include more intensive service levels than are usually available through providers in most counties. The Waiver encourages the establishment of network capacity at these levels, such as WM 3.7 and WM 4.0. These LOCs require maintaining an expensive infrastructure and are usually hospital-based. In addition, current Medi-Cal billing procedures make it
challenging for facilities with these programs to obtain reimbursement. A systematic effort to address these important LOCs is needed. Individual counties have limited options and need help resolving Medi-Cal billing and process issues that appear to limit reimbursement and thus development of new programs.

M. Challenges with expanded MAT at the Narcotic Treatment Programs. Many of the NTPs are experiencing challenges with launching additional medications at their facilities for a variety of reasons. These include buprenorphine and disulfiram. Barriers include billing issues and workflow challenges. Additional assistance and training in these areas are needed for the NTPs. Claiming and processing guidelines related to these issues may also need to be reviewed.

Recommendations from Year One Findings of DMC-ODS Waiver Services—EQR Review

The annual reviews for the three counties culminated in recommendations for next steps for the Waiver, building upon the considerable strengths of current “Live-Waiver counties” to further develop their DMC-ODS systems. While each county is unique in many respects, common themes were identified among them. These themes are likely to be applicable to many of the other “In-Preparation-Waiver” counties in the earlier stages of their implementation. They are also likely to be of interest to DHCS and the County Behavioral Health Directors’ Association (CBHDA), whose staff are positioned to help the counties in a variety of ways and make any future adjustments to the Waiver.

The highest-priority recommendations linked to quality SUD improvements in a managed care environment are provided below. The steps listed below could be preliminary for the next steps for “In-Preparation Waiver” counties and their stakeholders to consider as they transform their SUD networks into dynamic, accountable, and well-organized delivery systems under the DMC-ODS Waiver.
1. California’s DMC-ODS Waiver made an excellent start with a science-based design and expanded treatment options for Medi-Cal beneficiaries and others with SUD needs. DHCS and CMS should work together on renewing the Waiver to assure support for the continuation of the Pilot, and to identify areas of improvement within the STCs to successfully help counties reach Waiver’s goals. This would include enhancing service capacity in areas such as physician consultation, and other challenge areas mentioned where adjustments would benefit client treatment outcomes.

2. Infrastructure for EHR and related health IT systems is needed to provide support for managed systems of care, specifically timely access to care, clinical documentation, coordination of care, billing capacity, and quality/integrity/accountability systems. Both physical health and mental health have had historical sources of funds to build this EHR infrastructure, but not addiction medicine. IT infrastructure, combined with training and quality dashboards, can help with coordination and efficiency in SUD care. This is a long-term but important component of clinical and fiscal success for a managed care plan.

3. All DMC-ODS programs will benefit from developing strong political and community partnerships to educate and expand understanding of SUD and appropriate treatment methods that are science-based and help reduce stigma for those with SUD. Public engagement and education are critical contributors to Waiver success and to shifting the paradigm of the treatment programs from outdated methods of providing care.

4. In subsequent years, the counties reviewed plan to focus on refinement of Access Call Center systems/software and development of interfaces with the provider networks for referrals is recommended, including integrating provider programs with “no wrong door” policies into the DMC-ODS data tracking systems. Evaluation of these new and developing tracking systems will help with smooth transitions to treatment, prevent treatment delays, and allow analyses of network capacity and logjams in specific services or regions.

5. More flexible access to MAT in residential programs and detention centers is recommended to allow for supervised treatment prior to re-entering the community. Many counties are just starting to offer outpatient MAT and have not been able to conduct assessments and induction in residential or detention settings. To fulfill MAT’s
potential for those with opioid and alcohol use disorders, it is important to reach into these 24-hour structured settings as a positive environment for beginning treatment. Funds from SAMHSA and HRSA are becoming available to expand access to other environments and with more flexibility, specifically targeting MAT expansion.

6. DHCS and county leadership should identify and address eligibility and billing system issues that emerged in Year One of service implementation as impediments to client access to care, client continuity in care, MAT consultation, and other processes related to achieving the best possible outcomes for clients. This should include exploring solutions to the 90-day transfer timeline issue for inter-county transfers of residency for Medi-Cal.

7. Based on the reviews, the importance of provider training is essential in all components of clinical documentation, how the components interface with one another, and how often to document changes in client status. The training should include the frameworks of ASAM models of client-centered care and meet state and federal regulatory requirements.

8. It is also recommended that training and collaborative learning approaches be used to enhance implementation of client-centered care, including client continuity and transitions along the continuum of SUD care. This is particularly needed in residential treatment and residential WM settings where older approaches are still being used by some staff in care planning. DMC-ODS counties should regularly analyze their data regarding client transitions between levels of care to inform their engagement efforts. This recommendation builds on best practices in optimizing use of the ASAM continuum of care and the need for successful transitions to lower levels of care.

9. The Waiver includes requirements for coordination with physical and mental health programs that necessitate increased exchange of client information between their providers across previously siloed systems. The current 42 CFR.2 regulatory requirements for privacy of SUD client records is among the most stringent of any health care privacy regulations and presents challenges for the information sharing necessary to facilitate care coordination. Each county needs to continue working with its county counsel and learning from other counties about how to find practical solutions for information sharing within the current 42 CFR.2 regulatory framework. Counties also should work with their state and national associations to explore
possible regulatory changes that will help facilitate the increased information exchange that a DMC-ODS needs to function.

10. The Waiver STCs recognize the importance of recovery supports for clients during and after a formal treatment phase. These supports include recovery support services and recovery residences. Counties have tended to focus during the initial startup of the DMC-ODSs on the more traditional treatment services. During Year Two of service implementation and in subsequent years, each has plans for these recovery-oriented services that will contribute vital components to its continuum of care.

11. Technical assistance and changes in claims guidelines as well as processing are needed to remove barriers for the NTPs to be able to do bundled billing for buprenorphine and disulfiram for treatment. NTPs are also required to provide naloxone, which can be utilized to reverse the effects of an opioid overdose. These additional required medications are an important part of the Waiver and offer improved treatment outcomes for many clients.

Conclusions

In conclusion, the California DMC-ODS STCs are a blueprint for transformation of fragmented services into a managed and well-organized delivery system of accessible, timely, and effective treatments for clients with SUD. Translating the STCs into a living, dynamic reality that improves care for clients is a massive undertaking. The three DMC ODS counties reviewed in this report were the first to implement the Waiver STCs. The Waiver opportunities clearly catalyzed each of them to begin substantial transformations in their systems of care. While the challenges they face are not easy, they are working within a cooperative and learning environment that is supported by increased federal and state funding, TA from many sources, and a sense that the changes will be of great benefit to their clients.

The EQRO observed and participated in this collaborative learning environment at all levels in the three Pilot counties as well as with DHCS, county administrators and managers, both county and contract providers, other county agencies, and clients and their family members. The EQRO is part of that environment, developing our review protocols and PMs and trying to assist DMC-ODS counties on system transformation to benefit the many people suffering from the impact of
SUD. It is a privilege to be part of this important and positive transformation in the system of care for clients with SUD.