DRUG MEDI-CAL
ORGANIZED DELIVERY SYSTEM
EXTERNAL QUALITY REVIEW REPORT

FY 2018-19

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

By
Behavioral Health Concepts, Inc. (BHC)

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Table of Contents

Executive Summary ........................................................................................................... i

Section 1
Substance Use Disorders 1115 Waiver in California and External Quality Review Organization Methods for Review ................................................................. 1
  Introduction ................................................................................................................. 1
  History of the Drug Medi-Cal Organized Delivery System ..................................... 2
  National Context for the 1115 Waiver .................................................................... 4
  National Trends Affecting Quality and the EQRO Environment ......................... 4
  Uncertainty about the Affordable Care Act’s Future ............................................. 5
  A National Opioid Crisis ....................................................................................... 5
  Goals of California’s Waiver ................................................................................ 9
  Special Terms and Conditions ............................................................................ 9
  Meeting Federal EQRO Requirements ................................................................ 14
  CalEQRO Methods ............................................................................................ 15
  Validation of Performance Measures .................................................................. 15
  Performance and Quality Management Key Components .................................... 15
  Performance Improvement Projects ..................................................................... 15
  Evidence of Federal Data Integrity Requirements for Health Information Systems .................................................................................................................................................. 16
  Client, Family Member, and Other Stakeholder Perspectives ................................ 16
  Review of Recommendations and Assessment of DMC-ODS Strengths and Opportunities .......................................................................................................................................................... 16
  Coordination with UCLA .................................................................................. 17

Section 2
Performance Measures ................................................................................................. 18
  Background ............................................................................................................ 18
  Core Performance Measures for Year One and Year Two Counties .................... 19
  HIPAA Guidelines for Suppression Disclosure .................................................... 20
  DMC-ODS Clients Served, Penetration Rates, and Approved Claims Dollars per Beneficiary .......................................................................................................................... 21
  Timely Access to Methadone Medication in Narcotic Treatment Programs after First Client Contact ................................................................. 25
  Expanded Access to Non-Methadone MATs through DMC-ODS Providers ............ 26
  Services for Non-Methadone MATs Prescribed and Billed in Non-DMC-ODS Settings ........................................................................................................................ 27
  Transitions in Care Post-Residential Treatment .................................................. 28
  Access Line Quality and Timeliness .................................................................... 30
  High-Cost Beneficiaries ....................................................................................... 31
  Withdrawal Management Services with No Other Treatment ............................. 33
  Clients Served by Diagnostic Categories ............................................................. 33
  Core Performance Measures for Year Two Counties ............................................. 35
# TABLE OF CONTENTS

Use of ASAM Criteria in Referral Decisions ............................................. 35  
Initiating and Engaging in Treatment Services ........................................ 36  
Retention in Treatment ............................................................................ 39  
Withdrawal Management Readmissions .................................................. 40  
Trend Data for Year Two Counties ............................................................. 41  
Client Characteristics at Admission and Progress in Treatment at Discharge ............................................................................................................. 45  
Timeliness Measures Reported to CalEQRO by DMC Counties .............. 51  
Conclusions ............................................................................................... 54  

Section 3 ........................................................................................................ 57  

**Performance on Quality Management Key Components** .................. 57  

Introduction ................................................................................................ 57  

**Key Component 1: Access to Care** ..................................................... 58  
Subcomponent 1A: Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices ................................. 58  
Subcomponent 1B: Manages and Adapts Its Capacity to Meet SUD Client Service Needs ......................................................................................... 59  
Subcomponent 1C: Integration and/or Collaboration with Community-Based Services to Improve SUD Treatment Access ............................................................................................................. 61  

**Key Component 2: Timeliness to Services** ......................................... 64  
Subcomponent 2A: Tracks and Trends Access Data from Initial Contact to First Face-to-Face Appointment .............................................................. 64  
Subcomponent 2B: Tracks Access Data from Initial Contact to First MAT/NTP Appointment ........................................................................... 67  
Subcomponent 2C: Tracks Access Data for Timely Appointments for Urgent Conditions ................................................................. 69  
Subcomponent 2D: Tracks Timely Access to Follow-Up Appointments/Care After Discharge from Residential Treatment .............................. 72  
Subcomponent 2E: Tracks Data on Re-Admissions to Withdrawal Management Within 30 Days ................................................................. 74  
Subcomponent 2F: Tracks and Trends No-Shows .................................. 75  

**Key Component 3: Quality of SUD Care** ............................................ 77  
Subcomponent 3A: Quality Management and Performance Improvement are Organizational Priorities ................................................................. 77  
Subcomponent 3B: Data Are Used to Inform Management and Guide Decisions ............................................................................................................. 78  
Subcomponent 3C: Evidence of Effective Communication from DMC-ODS Administration, and Stakeholder Input on System Planning and Implementation ............................................................................................................. 80  
Subcomponent 3D: Evidence of a Systematic ASAM SUD Continuum of Care ............................................................................................................. 81  
Subcomponent 3E: MAT Services (Both Outpatient and NTP) Exist to Enhance Wellness and Recovery ................................................................. 82  
Subcomponent 3F: ASAM Training and Fidelity to Core Principles is Evident in Programs within the Continuum of Care ............................................. 84  
Subcomponent 3G: Measures Treatment and/or Functional Outcomes of Clients Served ................................................................................................. 86
# TABLE OF CONTENTS

Subcomponent 3H: Utilizes Information from Client Experience of Treatment (UCLA) Surveys ................................................................. 88
Summary of ASAM Levels of Care by County Size ........................................ 90

Section 4 ........................................................................................................ 96

Evolution of the Substance Use Disorder Service System and Infrastructure ................................................................. 96
Introduction ................................................................................................ 96
Development of Access to Care Elements ................................................. 96
Best Practices and Lessons Learned .......................................................... 97
Call Center and Access Challenge Areas ................................................ 99
Launch of DMC Services ......................................................................... 100
Themes in Growing SUD Treatment in DMC-ODS Counties ....................... 102
Development of MAT Treatment Models ................................................ 104
Expansion of NTPs ................................................................................ 104
Outpatient DMC Clinics .......................................................................... 105
MAT Partnerships with Primary Care Clinics ........................................... 105
Enhanced Engagement of EDs via ED Bridge and local DMC leadership engagement ................................................................. 108
Expanded Access to MATs in the Criminal Justice System ....................... 108
Opioid Safety Coalitions ......................................................................... 109
Quality Enhancements ............................................................................ 110
Case Management Services .................................................................... 110
Residential Treatment and Residential WM Models .................................... 112
Moving Ahead in Partnership with the Health Delivery System .................. 113

Section 5 ...................................................................................................... 116

Performance Improvement Projects .......................................................... 116
Introduction .............................................................................................. 116
Methods ................................................................................................... 117
Findings ................................................................................................... 120
Range of PIP Topics ................................................................................ 121
CalEQRO Ratings of Submitted PIPs ...................................................... 122
Technical Assistance ............................................................................... 123
Areas for Improvement in PIP Design/Implementation ............................... 125
Summary ................................................................................................. 125

Section 6 ...................................................................................................... 127

Client and Family Member Perceptions of Substance Use Disorder Care ................................................................. 127
Introduction .............................................................................................. 127
Methods ................................................................................................... 128
Themes from Client Focus Groups .......................................................... 131
Treatment Perception Survey .................................................................. 132
Strengths Based on Client/Family Feedback ............................................. 135
Opportunities for Improvements Based on Client/Family Feedback .......... 136
Key Themes from Clients and Families ..................................................... 137

Section 7 ...................................................................................................... 138
Information Systems Capabilities Assessment ........................................ 138
  Background, Goals and Methods .......................................................... 138
  Budget Allocations for Information Systems ........................................ 141
  Findings ............................................................................................... 143
  Health Information Systems by Vendor ............................................ 143
  Health Record ..................................................................................... 147
  Interoperability .................................................................................. 148
  Availability of Telehealth .................................................................... 150
  Electronic Consumer Outcome Measure Tools ............................... 152
  Conclusions ....................................................................................... 152

Section 8 ...................................................................................................... 154
Key Findings and Recommendations .................................................. 154
  SUD Care Enhancements Generated through the Waiver Design ....... 155
  Findings for Successful Implementations by DMC Counties .......... 159
  Challenges for DMC-ODS Delivery and Systems .......................... 163
  Recommendations from the Second Year of EQRs ...................... 168
  Conclusions ....................................................................................... 171

List of Tables

Table 1-1: Traditional DMC vs. DMC-ODS .................................................. 12
Table 2-1: Clients Served and Penetration Rates, by Age Group, for all DMC-ODS Counties, CY 2018 .......................................................... 21
Table 2-2: Clients Served and Penetration Rates by Race/Ethnicity for all DMC-ODS Counties, CY 2018 .......................................................... 22
Table 2-3: Clients Served and Penetration Rates, by Eligibility Category, for all DMC-ODS Counties, CY 2018 .......................................................... 24
Table 2-4: Access Call Center Critical Indicators, by County Size, CY 2018 .. 31
Table 2-5: HCBs at 90th Percentile or Higher, by County Size and for all DMC-ODS Counties, CY 2018 .......................................................... 33
Table 2-6: Use of ASAM Criteria Findings to Guide LOC Referrals for All DMC-ODS Counties, CY 2018 .......................................................... 36
Table 2-7: Client Housing Status at Treatment Admission, Like-Size Counties and Statewide, CY 2018 .......................................................... 46
Table 2-8: Client Legal Status at Treatment Admission, Like-Size Counties and Statewide, CY 2018 .......................................................... 47
Table 2-9: Client Employment Status at Treatment Admission, Like-Size Counties and Statewide, CY 2018 .......................................................... 48
Table 2-10: Discharge Types, Overall for All DMC-ODS Counties Statewide, CY 2018 .......................................................... 49
Table 2-11: Ratings of Client Progress at Discharge, Overall for All DMC-ODS Counties, CY 2018 .................................................................50
Table 2-12: Timeliness Tracking Capabilities, Overall for All DMC-ODS Counties, FY 2018-19 .................................................................................52
Table 3-1: Coordination of Care and Case Management ...........................................90
Table 3-2: Recovery Services ...........................................................................91
Table 3-3: Level 1 Outpatient ........................................................................91
Table 3-4: Level 2.1 Outpatient/Intensive ........................................................92
Table 3-5: Level 2.5 Partial Hospitalization .....................................................92
Table 3-6: Outpatient Withdrawal Management (Level 1 WM and Level 2 WM) 92
Table 3-7: Withdrawal Management Residential Beds (Level 3.2 WM) .......... 93
Table 3-8: NTP Programs ...............................................................................93
Table 3-9: Level 3.1 Residential .......................................................................94
Table 3-10: Level 3.3 Residential .....................................................................94
Table 3-11: Level 3.5 Residential .....................................................................95
Table 5-1: PIP Rating Steps ........................................................................... 118
Table 5-2: PIP Ratings Defined .......................................................................118
Table 5-3: PIP Status—Categories and Definitions ..........................................119
Table 5-4: PIP Status ......................................................................................120
Table 5-5: PIP Topics for Active and Ongoing/Completed PIPs .......................121
Table 5-6: Technical Assistance Provided by CalEQRO Outside of Onsite Reviews (FY 2018-19) .................................................................124
Table 6-1: Number and Types of Client Focus Groups, by DMC County Size . 129
Table 6-2: Mean Responses to Focus Group Questions by DMC County Size ..................130

List of Figures

Figure 1-1: National Drug Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2017 .................................................................7
Figure 1-2: National Drug Overdose Deaths in the United States, Number Among All Ages, by Gender, 1999-2017 .................................................................8
Figure 2-1: Average Approved Claims, by Age Group, for All DMC-ODS Counties, CY 2018 .................................................................22
Figure 2-2a: Percentage of All Clients Served, by Service Category, for all DMC-ODS Counties, CY 2018 ................................................................. 23
Figure 2-2b: Percentage of Youth Served, Ages 12-20, by Service Category for all DMC-ODS Counties, CY 2018 ................................................................. 24
Figure 2-3: Average Claims Dollars per Client by Eligibility Category for All DMC-ODS Counties, CY 2018 ................................................................. 25
Figure 2-4: Percentages of Clients with at Least One and with Three or More DMC-ODS Non-Methadone MAT Billed Visits for all DMC-ODS Counties, CY 2018 ................................................................. 27
Figure 2-5: Percent of Timely Transitions in Care Post-Residential Treatment for DMC-ODS Counties Reviewed, CY 2018 ................................................................. 29
Figure 2-6: HCBs at 90th Percentile or Higher, by County Size and for all DMC-ODS Counties, CY 2018 ................................................................. 32
Figure 2-7: Percentage Served by Diagnosis Codes for all DMC-ODS Counties, CY 2018 ................................................................. 34
Figure 2-8: Average Approved Claims by Diagnostic Categories for all DMC-ODS Counties, CY 2018 ................................................................. 34
Figure 2-9: Clients Initiating and Engaging in DMC-ODS Services by County and for All Year Two DMC-ODS Counties, CY 2018 ................................................................. 38
Figure 2-10: Initial DMC-ODS Service Used by Clients, by County and for all Year Two DMC-ODS Counties, CY 2018 ................................................................. 39
Figure 2-11: Cumulative LOS in DMC-ODS Services, by County and for All Year Two DMC-ODS Counties, CY 2018 ................................................................. 40
Figure 2-12: Claims Data-Based Rates of WM Readmissions, by County and for Each of the Year Two DMC-ODS Counties, FY 2017-181 ................................................................. 41
Figure 2-13: Clients Served by County by Year, CY 2017* – CY 2018 ................................................................. 42
Figure 2-14: Average Approved Claims by County by Year, CY 2017 – CY 2018 ................................................................. 42
Figure 2-15: Number Total DMC-ODS Clients with at Least One and at Least Three Non-Methadone MAT Billed Visits by County by Year, CY 2017 – CY 2018 ................................................................. 43
Figure 2-16: Timely Transitions in Care Post-Residential Treatment DMC-ODS by County by Year, CY 2017 – CY 2018 ................................................................. 45
Figure 2-17: Average Days from First Request to First Offered Appointment and First Face-to-Face Appointment, by County Size and Overall Statewide, CY 2018 ................................................................. 53
Figure 2-18: County-Reported Rates of WM Readmissions, by County Size and Overall for All DMC-ODS Counties, CY 2018 ................................................................. 54
Figure 3-1: Access to Care Key Component Ratings ................................................................. 63
Figure 3-2: Timeliness to Services Key Component Ratings ................................................................. 76
**TABLE OF CONTENTS**

Figure 3-3: Quality of Care Key Component Ratings ........................................ 89
Figure 5-1: Clinical PIP Ratings (14 counties).................................................. 122
Figure 5-2: Non-clinical PIP Ratings (14 counties)......................................... 123
Figure 6-1: Mean Responses to Client Focus Group Survey, by Domain and County Size ..................................................................................................... 131
Figure 6-2: Adult Results from the Final Report of the TPS Domains.............. 133
Figure 6-3: Youth Results for Treatment Perception Survey by Domain ........ 134
Figure 7-1: DMC-ODS Go-Live Dates.............................................................. 140
Figure 7-2: County-operated versus Contractor-operated Services .............. 141
Figure 7-3: Percentage of DMC-ODS Budgets Devoted to IS ....................... 143
Figure 7-4: DMC-ODS County EHR Systems ................................................. 144
Figure 7-5: County EHR Support .................................................................. 145
Figure 7-6: County EHR Replacement Status ............................................... 146
Figure 7-7: County EHR Functions ............................................................... 147
Figure 7-8: DMC-ODS County Chart Environment ........................................ 148
Figure 7-9: Data Exchange with Contract Providers ...................................... 149
Figure 7-10: County Telehealth Service Capacity ......................................... 150
Figure 7-11: Technology and Data Analytics Capacity ................................. 151
<table>
<thead>
<tr>
<th>Acronym</th>
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Executive Summary

Background

This external quality review (EQR) report summarizes the second year of county programs providing substance use disorder (SUD) services as part of the SUD 1115 Demonstration Waiver in California.

As of August 2019, 30 counties began implementation of the 1115 Demonstration Waiver. During 2018-19 Fiscal Year (FY), 14 active counties had been operational for at least 12 months, allowing for an EQR evaluation. For 11 counties, FY 2018-19 was their first year of DMC-ODS services; for purposes of the report, these counties are referred to as Year One counties. Three counties were completing their second year of services when they were reviewed and are referred to as Year Two counties. The Year One counties include San Luis Obispo, San Francisco, Los Angeles, Santa Clara, Santa Cruz, Monterey, San Diego, Imperial, Nevada, Napa, and Contra Costa. The Year Two counties include Marin, Riverside, and San Mateo.

In this year of quality reviews, CalEQRO reviewed a diverse range of county SUD models, ranging from Los Angeles County (which serves approximately one-third of the state’s population in both urban and rural environments) to Nevada County, which is a small rural county in the Sierra foothills. Many of the Year One counties benefited from lessons learned and best practices of the three counties that began the year before: Marin, Riverside, and San Mateo. Most reached out to request advice and support from these early adopters of the Waiver. Also, all counties continued to benefit from ongoing training and extensive technical assistance (TA) from DHCS. TA was offered both directly and through numerous contracts to keep building new clinical skills and capacity as well as refining some of the more complex issues arising with computer systems and new billing and cost reporting requirements.

The report includes highlights and best practices emerging from each area that CalEQRO evaluated in the county DMC reviews. These included performance measures (PM) related to access, continuity of care, and quality. Also reviewed are key components linked to optimal care and quality, observations of major shifts in the delivery systems, the performance improvement projects (PIPs) to enhance
areas related to clinical or administrative services, information system capacity assessments (ISCA) and their use for quality and administrative requirements, highlights from key stakeholder focus groups, and key findings and recommendations.

Performance Measures

CalEQRO analyses reveal many insights into DMC-ODS counties’ in setting up their systems of care and the infrastructure necessary to support them. After licensing and certifying programs based on new requirements, each DMC-ODS county also had to train its staff and contract providers to bill new DMC-ODS Medi-Cal services and produce the data summarized in this chapter. Counties varied (especially in start-up years) with software, billing systems, and charting requirements linked to billing, but they are all improving and the claim lag times are narrowing steadily.

The PM access-related data illustrate some important aspects of the DMC-ODS journey for counties and the clients they serve. Overall, there is a marked increase in the number of clients served and higher-than-average penetration rates for Medi-Cal clients in these counties. The utilization data also show an expected increase in some services not previously covered, such as intensive outpatient, case management, and non-methadone Medication Assisted Treatment (MAT) services. One area for continued improvement is expanding services to more individuals within subpopulations within the counties and recovery support services.

The timeliness-related data are also largely positive. This is particularly noteworthy because these systems of care did not have the infrastructure to track timeliness prior to the Waiver. Most people who contact the new Access Call Centers seem able to do so without undue wait times or abandoned calls. According to the data, most callers appear to be offered timely first appointments. Those who followed through also seemed to be receiving their first face-to-face sessions in a timely manner. This was especially the case for those seeking methadone from Narcotic Treatment Programs (NTPs). In contrast, longer wait times occurred for clients wishing to begin MAT with other addiction medications; however, their rollout is in early stages in most counties but growing steadily. All counties, both Year Two and Year One, were actively working on expanding MAT—both with NTPs and with outpatient programs—and prioritizing seeking more prescribers and partnerships to accomplish this.

The Waiver strongly promotes client-centered care; it includes innovative measures for determining how frequently and effectively this approach is being implemented. Screeners and assessors referred a high percentage of their clients into types of treatment that matched what the ASAM level of care (LOC) assessment recommended. The overall referral rate into ASAM-recommended care was over 80
percent and in some counties close to 90 percent. Clinical judgement and client preference were the most common reasons for variances; these are legitimate issues for consideration of alternatives.

PM results on initiation and engagement measures suggest that the programs were effective in keeping clients engaged in treatment at early phases, although they were only able to retain them in treatment for moderate lengths of time. Programs used the Treatment Perception Survey (TPS) in common to learn and improve from clients about how they experienced their care; with few exceptions, clients gave the programs high marks. Many counties were using the TPS to identify specific programs needing improvement because the data were identified back to the specific program sites. One area needing more evaluation and potential improvement was the continuity of care after residential treatment to other community-based treatment supports, such as outpatient, MAT, case management, and recovery support. Many counties were just beginning to bill some of these services so they may have been under-reported, but the current percentages based on claims are all under 20 percent.

CalEQRO included in its quantitative measures several that focus on client outcomes. PMs indicated that a low percentage of clients discharged from residential Withdrawal Management (WM) are readmitted within 30 days, although there is variability among counties with some showing room to lower their readmission rates further. Through the TPS, clients attributed their improved ability to function to the treatment they received. Many providers used the California Outcomes Measurement System (CalOMS) Discharge Summary Form to rate more than half their clients as either completing treatment successfully or leaving with satisfactory progress. However, the county and specific program averages varied widely, with some showing considerable room for improvement.

Overall, the PM results are rich with information chronicling the substantial progress of these counties in developing accountable systems of accessible, client-centered care for clients with SUD. In the midst of a deadly opioid epidemic, these positive developments are noteworthy and offer reasons to be hopeful for people suffering from these disorders as well as the treatment systems seeking to serve them more effectively.

Performance on Quality Management Key Components

Access to SUD Care Key Components
Counties generally performed strongly on access key components. Counties are moving towards a strong culturally and linguistically appropriate services (CLAS)
framework and are working on cultural competence plan (CCP) updates with more focus on SUD populations. All of the DMC-ODS counties reviewed demonstrated that they are engaged in ongoing evaluations of service capacity needs as they continue to track network requests for service, service delays, or back-ups in key regions. Most counties identified and developed action plans to address these issues as part of the expansion and refinement of their provider networks. Workforce and provider availability played a role in delaying implementations of some expansions in both rural and urban areas.

Tracking Timely Access to Services Key Components across the Network
Tracking time access was working well for routine appointments, but still needs work to track urgent appointments and no-shows. Most counties have active plans in place with computer vendors and their network partners to enhance data capture and tracking systems as well as training in tracking appointments. There was also significant attention to tracking capacity at all LOCs and needs of various regions and populations such as youth and clients coming out of hospitals or detention centers in need of treatment. Attention to meet client needs is a high priority and most counties were in the process of getting additional sites Medi-Cal certified or requesting proposals from contractors for additional services at different LOCs or locations in their counties.

ASAM Fidelity and Quality as an Organizational Priority
DMC-ODS county commitment to expansion of care and quality improvement and assurance is evident in the Quality Management Plans (QMP) and also in the materials seen in clinics and programs. Staff training and knowledge of ASAM and Medi-Cal and the Special Terms and Conditions (STCs) were discussed in staff focus groups. Counties collaborated with stakeholders and advisory groups to develop local implementation plans. There was general support for ASAM as a clinical model and move to more evidence-based practices and treatments. Stigma is still an issue in some communities and among the general public; stigma was mostly encountered when opening new sites or when families were being told their family member was being treated with MAT. Directors were aware of these issues and promoted educational events to raise awareness and counter stigma, but community fears are sometimes difficult to overcome. Nonetheless, the DMC-ODS role in the area of quality and education has been a positive and constructive one in all communities that have elected to become a DMC-ODS.

Evolution of the SUD Service System and Infrastructure
In this second year of DMC-ODS services, several best practices in the areas of access to care models, expansion of new DMC services, MAT, and quality enhancements have emerged that are worth highlighting.
Access Care Models

As the central point of access in many counties, 24-hour Access Call Centers can significantly affect clients’ ability to access care. Access Call Centers use a variety of software, but the best functionality included the capability to track the number and time of calls, wait times, talk times, dropped calls, disposition of calls, client satisfaction feedback, and links to a caller’s history. Some counties’ access systems also link clients to case managers to provide support to help them with treatment engagement and referral. Three-way calling capacity has been highly successful at Access Call Centers, allowing the Call Center screener to directly connect the client and provider to arrange an appointment and transfer some information in compliance with 42 CFR Part 2, minimizing opportunities for confusion and the need for extensive back-and-forth among the Call Center, client, and provider. Several counties also are using automated central systems to track daily provider capacity for new admissions, which reduces the time required for Access Call Center staff to find and make suitable referrals and for clients to obtain appointments. These elements are key strengths of access systems worth emulating in new DMC-ODS counties opting into the Waiver.

Another best practice is for programs to reserve blocks of time weekly for walk in assessments and screenings into treatment. This makes it easier for clients and referring staff from the Access center especially if a call comes in at night when the program is closed and can help program flexibility. Programs with reserved walk-in hours also often have better timeliness statistics for getting clients linked to care more quickly.

Expansion of DMC Services

This year, counties focused on expanding SUD service system capacity and types of services. Counties’ efforts targeted expansion to address long-standing barriers to treatment access in rural areas and in areas with limited transportation, to provide additional evidence-based treatments, or to offer a more complete system of SUD care. While the expansion efforts varied across the state according to the unique needs of the counties, some common themes emerged. Many counties expressed a need for additional capacity across all levels of withdrawal management (WM) and are issuing Requests for Proposals (RFPs) to expand capacity or build new capacity. Counties also expressed interest in expanding their networks to include medically monitored and medically managed inpatient WM, labeled by ASAM as WM 3.7 and 4.0 services and some are currently in negotiations. Youth are identified as an underserved population needing more engagement and services. Partial hospitalization and recovery residence capacity linked to outpatient care is also very important, as is additional MAT even in remote areas of the counties and desired in all LOCs. Each county approached expansion goals and challenges in unique ways, depending on existing partnerships, resources, and community needs. It is
anticipated this build-out of the system of SUD care will continue over the next three years to meet statewide needs and refine the systems of care that have been launched with the demonstration Waiver. Because of the importance in care of the therapeutic alliance, many provider organizations are interested in developing multiple LOCs to make transitions easier and more successful for clients. Long term support and engagement is linked to success in SUD treatment and so state support for this process and flexibility in models would be greatly appreciated by counties and provider organizations. This is likely to be part of future evolution of services.

MAT Evolution

Between the first and second years of DMC-ODS services, access to MAT began what has since become a steady expansion. CalEQRO identified six different MAT models expanding, with most counties supporting more than one model. These models for MAT services include: (1) NTP models, (2) outpatient DMC-ODS clinics, (3) MAT partnerships with primary care, (4) partnerships with emergency departments (EDs) through State ED Bridge funding, (5) partnerships with the criminal justice system, and (6) participation with public health on opioid safety coalitions.

Most counties support MAT expansion in multiple ways that are evident in the reviews of the 14 counties. Some program models were much more dominant than others, depending on leadership and existing infrastructure and clinical needs. MAT is expanding on many fronts and its value is more broadly accepted and understood in the medical community and in the criminal justice arena. It is important to note the change in staff focus groups as well, with attitudes shifting from some older model abstinence-only treatment staff seeing the benefits from MAT treatment. Stigma is not gone, but many of the focus group discussions reflected improvements in understanding the disease model and the potential of treatment with medication. This was articulated in meetings with judges, counselors, jail staff, family members, and in community settings. Educational processes are influencing a more nuanced, scientifically accurate understanding of SUD and its treatment. As a result, MAT for those with opioid use disorders and alcohol use disorders is more available also are becoming easier and more widespread.

Elements of Quality

Three program elements with strong links to quality and outcomes were related to best practices and lesson learned this year: case management, residential treatment programs, and partnerships with the physical health delivery system. Counties focused extensively on expanding case management services—linking clients into treatment and helping them with transitions in care. This year, many clients in focus groups noted the value and support of their case managers and the role they play in providing practical, ongoing help in their care. This was particularly true with
counties with models where case managers could follow the clients across the continuum of care and maintain ongoing relationships with their clients over time.

Counties also developed new residential treatment programs and expanded many existing ones—both in the numbers of available treatment sites, and adding family-oriented services, MAT, and incidental medical services.

Finally, efforts to coordinate treatment and integrate SUD programs were evident in DMC-ODS reviews throughout the state. Physical Health plans, primary care clinic organizations, hospital systems, and medical leadership across the spectrum actively participated in stakeholder groups and discussed interest in shared program models, linkages between SUD and their systems, and the ongoing need for more coordination and collaboration. Partnerships with the physical health delivery systems from hospitals to medical groups and public health represent a distinctly positive change from past practice.

Behavioral Health workgroups—linked to Mental Health Plans, community wellness, and homeless activities—were building new partnerships with DMC-ODS programs at the table, helping to identify needs and provide care.

**Performance Improvement Projects**

PIPs are specific projects to improve a problem or barrier affecting quality of care in a clinical or administrative area. All but one county submitted two PIPs for this year of reviews. Some were concept only, as they had not yet launched interventions. One county submitted only one PIP because it had a new Quality Improvement (QI) Director.

In this year of reviews, 27 out of 28 potential PIPs were submitted by the DMC counties. Twenty-one or 77 percent were rated as active and ongoing. The topics for the PIPs included: (1) increasing access for adolescents and persons with physical disabilities, (2) expanding MAT access in the criminal justice system and in outpatient settings, (3) improving outcomes for persons with co-occurring disorders through ongoing treatment in a specially designed program, (4) improving assessments and treatment planning for residential treatments, including discharge goals, (5) use of long acting Naltrexone for adults with alcohol use disorders and mental illness, (6) improvement in continuity of care from residential treatment to outpatient, (7) improvements in grievance and appeals processes, (8) improving timely access to SUD treatment after access line referrals, and (9) enhancing beneficiary engagement with four visits in 30 days through motivational interviewing calls after first visit. All of these topics were relevant to the SUD field and quality of care and based on local data as well as national research. For 11 counties, this was their first experience with a PIP; they did an impressive job working within the federal protocols, which can be difficult for many to interpret.
CalEQRO found strengths in the DMC-ODS programs and practices related to PIPs and general efforts targeting improvements in care and operations. The PIP projects are having a positive impact on the overall delivery system and elements that are important to quality of care for clients and families. In these same areas, CalEQRO also noted opportunities for improvement including use of data for identifying problems, better defining SUD interventions, and tracking the impact via related data and outcome indicators. These opportunities included expanding the basic data system analytics and knowledge to support PIPs and ongoing QI activities in general. More funding for training, computer tracking systems, and staffing in these areas also would be very helpful for long-term system improvements.

CalEQRO will continue to provide training to the DMC-ODS counties in this area and offer regular TA, especially for counties in their initial years of service delivery.

**Client and Family Member Perceptions of SUD Care**

Client and family member (CFM) voices and experiences are extremely important to the EQRO review process and findings.

Based on the focus groups this second year, clients continue to report high levels of satisfaction and better access with the expanded treatment services, as evidenced by the CFM focus groups and the TPS results. Counties continued to implement program expansion elements during this time period and actively set up improved access systems for the community and key stakeholders.

**Information Systems Capabilities Assessment**

In FY 2018-19, CalEQRO observed significant progress in launching DMC-ODS continuums, as well as challenges.

Fourteen DMC-ODS counties reviewed in FY 2018-19 are in different stages of standing up their EHRs and functioning claiming systems, and some are considering replacing/updating their information systems. The counties reviewed vary in size, deliver SUD services through different county/contractor program combinations, and have vastly dissimilar IS budgets and technology/analytics staffing.

A common but critical challenge shared by the counties is the interoperability between disparate health information systems (HIS). With many FQHCs providing non-methadone MAT and some beneficiaries ending up in EDs as a result of an overdose, it is paramount that county HIS communicate securely across departments while respecting confidentiality provisions in 42 CFR. This is also important for the contract providers, who render over 75 percent of SUD services delivered across the counties reviewed.
In summary, the information systems for DMC are working but fragile and not set up to operate an efficient managed care operation for DMC-ODS. This is not surprising in the second year, with counties still beginning to implement services and most services delivered via contractors. However, a strategic plan for statewide data infrastructure in SUD would be highly desirable to catch up with health and mental health systems in their EHR functionality and ability to communicate across systems. Funding streams in the past have been limited in this area, but to really optimize both quality of care and efficiency of care, investing in coordinated information systems across the network of care would be money well spent.

Key Findings and Recommendations

In conclusion, the California DMC-ODS STCs provide 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 across a diverse state like California is a massive undertaking. Key elements of the waiver design continue to show value in local service delivery: (1) individualize care based on ASAM principles and dimensions of assessment; (2) a system of care with levels of intensity and structure based on needs; (3) evidence-based practices, including MAT; (4) field- and community-based treatment; (5) addition of licensed staff; (6) standards for accessibility, timeliness, quality; (7) selective contracting for the network in a managed care framework; (8) integration with physical health and mental health systems; (9) phasing in programs with technical support and refinement of implementation challenges.

County leadership also demonstrated best practices in enhancing the model’s success at the local level by taking these actions: (1) educating the community about opportunities created by the SUD Waiver; (2) involving stakeholders from criminal justice, providers, client community, families, and ethnic communities to help develop local plans and phase in care in the implementation plans; (3) garnering support from the County Board of Supervisors related to financing and making the case for support and resources to launch new services while systems are established for reimbursement to create infrastructure, staff, and capacity; (4) hiring and training staff and contractors to create a full ASAM network of care; (5) establishing 24-hour Access Call Centers with language capacity and ASAM screening skills linked to the provider networks; (6) setting up new billing and cost report systems; (7) creating new QIPs and structures; and (8) working to address barriers in the communities from stigma, housing shortages, and workforce shortages.
Recommendations are based on what is making a difference already, but more resources are needed to continue to enhance the promising quality of care evident in the SUD systems launched (and still launching) statewide:

1. Continue public education on SUD and appropriate treatments based on science (such as MAT) to keep moving towards integration with the physical health and mental health systems and reduce SUD stigma.

2. Counties should continue to use the lessons learned from the best Access Call Center systems linked to open access community assessment sites to facilitate rapid access to appropriate care and support engagement in treatment including three way calling and capacity database tracking systems.

3. Continue expansion of MAT in residential treatment and availability at all LOCs so it is as easy as obtaining medications for any health condition available to clients as they move through treatment.

4. Continue support of coordinating MAT with ED Bridge project and primary care so warm hand-offs can occur and access to treatment can begin in multiple locations.

5. Develop plans to enhance EHR and HIS capacity for the DMC-ODS system to enhance coordination of care and capacity to be an efficient and effective managed care plan and having the functionality for all aspects of this model.

6. Work with DHCS and the California Department of Social Services (CDSS) to find a solution to 90-day waits for county-to-county Medi-Cal transfers so that access is not delayed.

7. Continue to provide excellent training on best practices, clinical documentation, and treatment planning based on ASAM principles including consideration of efficient use of tools.

8. Expand implementation of peer and recovery supports to enhance the ability of those coming out of residential or other programs to remain stable in the community with support in housing, jobs, education, SUD treatment, and socialization, and also to transition from residential and other treatments to lower LOCs.

9. Continue working with advocates to address 42 CFR, Part 2 confidentiality issues that hinder care coordination needs that support better client outcomes.

10. Get input from providers on issues that could improve the Waiver renewal to enhance both efficiency and effectiveness of care; align with health and mental
health where possible so programs can coordinate and integrate more effectively.

The DMC-ODS counties reviewed in this report that were in their first year of implementation of the Waiver, had learned useful lessons from the first three “pioneer” counties. The Waiver opportunities clearly catalyzed each of them to begin substantial transformations in their systems of care. While the challenges of launching new systems 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 CalEQRO observed and participated in this collaborative learning environment with the 14 counties as well as with DHCS, county administrators and managers, both county and contract providers, and clients and their family members. The CalEQRO is part of that environment, developing review protocols and PMs and trying to assist DMC-ODS counties on system transformation to benefit the many individuals and families suffering from the impact of SUD.
Section 1

Substance Use Disorders
1115 Waiver in California
and External Quality Review
Organization Methods for Review

Introduction

The United States Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid managed care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid managed care services. CMS rules (42 Code of Federal Regulations [CFR] §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid managed care programs. These rules require an onsite review or a desk review of each Medicaid (Medi-Cal in California) Drug Medi-Cal Organized Delivery system (DMC-ODS) and each Medi-Cal Mental Health Plan (MHP).

As of August 2019, the State of California Department of Health Care Services (DHCS) contracted with 30 DMC-ODS counties to provide Drug Medi-Cal (DMC) treatment services, requiring an annual review
for quality of care for each active DMC-ODS plan. DHCS also contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. Each MHP also requires an annual review.

History of the Drug Medi-Cal Organized Delivery System

The DMC-ODS is a voluntary pilot program that offers California counties the opportunity to provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use disorder (SUD) treatment services. To date, 40 of California’s 58 counties have indicated their interest in participating in the DMC-ODS, reaching nearly all of the state’s population. Thirty counties already have been approved to start offering DMC-ODS services, reaching 93.5 percent of the state’s population.

The DMC-ODS offers many opportunities to increase access to recovery services by supporting a new model of SUD service delivery within the overall health care delivery system. As is true of any major new program, changing infrastructure and administrative systems posed many challenges. For example, billing and electronic health record (EHR) infrastructure require significant support to function optimally in a managed care environment. Pent-up demand for needed SUD services stretched the capacity of Access Call Centers and new treatment services. Hiring and training the significant numbers of staff needed for implementation was also very difficult. And many in the field were learning new models of treatment and care developed by ASAM’s clinical leadership as they were implementing these new systems. Highlights of the lessons learned in quality implementation of services are the focus of this report. There were 14 counties reviewed in this report. Eleven counties were in their first year of implementation of services and will be referred to as Year One counties. Three counties were in their second year of implementation and will be referred to as Year Two counties.

To understand the DMC-ODS launch and early implementation, it is important to appreciate the Waiver’s history and the national context surrounding the current efforts.
Prior to 2015, the service delivery system in California for those who suffered from a SUD and were eligible Medi-Cal was not robust, with no continuity or continuum of SUD care.

A number of factors led the state to pursue a waiver in 2013. California was developing additional benefits under the Affordable Care Act (ACA) and changing the eligibility criteria to increase the number of Californians eligible for Medi-Cal. In July 2013, CNN and the Center for Investigative Reporting aired a story on fraud in Medi-Cal substance use programs. The story made national news and put a spotlight on the state’s substance use providers and services. At the time, CMS did not consider DMC to be a PIHP, which meant no quality assurance (QA) activities were required. This fiscal and quality problem, along with the opioid crisis, provided an opportunity to rethink the SUD services program as a whole.

The opioid crisis was becoming more visible at this same time and emerging as a major public health issue, highlighted by the Surgeon General’s 2016 Report on Addiction in America.¹ SUD treatment needs were also complicated by expanded problems of homelessness and rising housing costs. It is difficult to treat many mental health and SUD problems in general but doing so while people live on the streets is extremely difficult and small gains are often eroded by the stress and challenges of the homeless environment. This trend has created setbacks for many communities in their ability to promote and maintain wellness for those with SUD and other health disorders.

Also, national and statewide health care workforce shortages are well documented and projected to widen as the population grows and physicians and other clinical staff retire. California will lack about 4,700 primary care doctors by 2025, according to a recent report by the Health Workforce Center at the University of California, San Francisco. The Central Valley, Central Coast, and southern border areas will be hardest hit, according to the report.² This includes


behavioral health professionals in mental health and addiction medicine. Considering workforce needs in health has been identified as a priority issue for action by California’s new governor.

Significant stigma and shame continue to be associated with SUD problems. There is also a lack of understanding about the efficacy of Medication Assisted Treatment (MAT), combined with a reluctance to provide “addicts” with “drugs.” Shortages of physicians certified in addiction medicine was and continue to be severe, and more education about newer evidence-based treatments is needed in broader communities and within the treatment community itself.

In summary, California faced an increase in the number of Medi-Cal beneficiaries, creating a demand for expanding services just as the seriousness of the opioid crisis was becoming known. CMS was also concerned with the fraud allegations and the desire to expand the program. DHCS leadership made it a priority to work closely with CMS staff and was able to propose a redesign of the SUD system of care to address CMS’s major concerns for eliminating the fraud while expanding and improving benefits as well as fiscal and program accountability.

After much discussion with CMS and revisions of the Special Terms and Conditions (STCs), the 1115 Demonstration 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 changes and a new service delivery system for those suffering 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. Because the state is so large and the implementation represents such a dramatic change for counties and their providers, the state decided to implement the Waiver regionally in a phased approach.

National Context for the 1115 Waiver

National Trends Affecting Quality and the EQRO Environment

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

Uncertainty about the Affordable Care Act’s Future
The ACA’s expansion of Medicaid extended coverage for single, low-income adults, increasing access to SUD treatment significantly. Of the Medi-Cal patients served statewide in the counties reviewed in this report, approximately 60.4 percent of the clients served used ACA-linked Medi-Cal benefits. Even before California’s 1115 Waiver was approved, access was expanding in the prior model for SUD care in California which included limited outpatient, opioid replacement therapy (methadone), and perinatal care. This expanded enrollment in treatment was supported by the ACA’s eligibility for coverage. As the opioid crisis increased in both severity and visibility, this access to treatment provided by the ACA became even more critical.

Current legal challenges to the ACA are being made at the state level since the individual mandate to obtain health coverage was repealed by the current federal administration. It is likely this case will be eventually be appealed to the Supreme Court. If the ACA is overturned and eliminated, it will deeply impact the access to SUD treatment for low income single adults, as few states would be able to backfill the federal matching funds currently supported by the ACA benefit.

This uncertainty related to the future of ACA benefits has also caused problems related to recruitment of new service providers into SUD service delivery, especially when new programs require capital investment and significant infrastructure. New service providers are needed in many areas of California to meet network adequacy requirements and add additional levels of SUD treatment for adults and adolescents.

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 with a positive and hopeful paradigm change by the Surgeon General in the first national report on
Substance Use Disorders and Treatment in 2016. The report recommended a major shift to a clinical, scientifically based treatment approach similar to prior, successful efforts to address the toll of smoking and tobacco on the nation’s health. Just as tobacco addiction was understood to be the product of forces beyond individual choices and behaviors, SUD treatment could shift from a blame-oriented, criminally focused system that ascribes SUD problems to a lack of moral character, and instead towards a brain science model that draws on researched population-based treatment and prevention approaches that have been shown to work.

The Surgeon General’s report could not have come at a better time, because the rising tide of opioid-related deaths had reached a point of acute national crisis. Fueled by prescribing patterns that dispensed new, powerfully addictive medications for pain and framed pain as “the fifth vital sign” (thus warranting aggressive treatment), many Americans became addicted to opiates. As of 2017, there were approximately 1.7 million Americans suffering from an opioid use disorder and more than 47,590 people died from an opioid overdose in 2018.

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. The dangerous strengths of these new medications led to many

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overdoses annually, surpassing annual deaths from motor vehicle crashes.\textsuperscript{7}

The alarming and overlapping trends of opioid use and overdose deaths are well illustrated by National Institute on Drug Abuse (NIDA) research,\textsuperscript{8} as shown in Figures 1 and 2.

Figure 1-1: National Drug Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2017\textsuperscript{9}

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\textsuperscript{9} Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December 2018.
As the nation grapples with this new, crippling epidemic of drug addiction and mortality from overdoses, the medical community and policy makers continue to seek answers and potential solutions. National commissions and organizations have proposed priorities to address the opioid crisis, including enhanced access to treatment, expanded access to medications that reduce craving to support positive treatment outcomes, and reduced prescribing of these highly addictive medications. Criminal justice initiatives also have been proposed through increased use of drug treatment courts and efforts to stop the flow of illegal drugs—particularly Fentanyl, a new and highly lethal synthetic opiate.

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

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10 Ibid.
on science-based research approaches, and a full continuum of care that optimizes positive outcomes for clients.

In 2017 in California, 2,196 people died from opioid overdoses and 429 people died from fentanyl overdoses.\textsuperscript{11} During this same time period, there were 21,787,042 prescriptions for opioids, which is a reduction from prior years.

The overdose death rate continues to be above the state average in the following California counties: Modoc, Humboldt, Mendocino, Lake, Shasta, Lassen, Yuba, Del Norte, Siskiyou, and Ventura.\textsuperscript{12}

\textbf{Goals of California’s Waiver}

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

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

\textbf{Special Terms and Conditions}

The STCs outline the new service delivery system, requiring a tremendous system change for the counties and the contracted providers participating in the pilot as well as those that followed. In particular, the 1115 Demonstration Waiver prompted the counties that opted in to act more like managed care plans (MCPs). More federal requirements and safeguards would need to be implemented by the


\textsuperscript{12} Ibid.
counties for SUD services. Many of the new quality and documentation requirements were the same for the mental health system, so counties were able to use their existing mental health infrastructure to implement the requirements for the SUD system. Counties opting into the Waiver are required to have the following components in place:

- **Continuum of Care**: Establishing a continuum of care of SUD services to treat substance use, including early intervention, physician consultation, outpatient treatment, case management, MAT, recovery support services, recovery residences, withdrawal management (WM), and residential treatment.

- **Assessment Tool**: Establishing a comprehensive assessment tool using the latest addiction-related science and ASAM principles to determine the most appropriate LOC and set of services needed for each individual to optimize recovery and positive outcomes.

- **Case Management and Residency**: Providing case management services to ensure that clients are moving through the continuum of care and coordinating care for clients residing within the county.

- **Selective Provider Contracting**: Giving counties more authority to select quality providers through a thorough process. Safeguards include requiring 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**: Creating a provider contract appeals process where providers can appeal to the county and then the state. State appeals will focus solely on ensuring network adequacy.

- **Provider Certification**: Partnering with counties to certify DMC providers, with counties conducting application and onsite reviews, issuing provisional certification, and the state cross-checking the provider against its databases for final approval.

- **Clear County Roles**: Counties will be responsible for selection, oversight and monitoring of contract providers as specified in
their county contracts and in compliance with state and federal requirements and county contracts.

• Coordination: Supporting coordination and integration across systems, such as with the provision that counties develop a Memorandum of Understanding (MOUs) with managed care health plans and MHPs for referral and coordination. Other MOUs are encouraged but not required with key stakeholders such as school districts, criminal justice, child welfare services, and other stakeholders.

• Authorization and Utilization Management: Providing that counties authorize services, with residential treatment required and other services determined by need and ensuring utilization management.

• Workforce: Expanding service providers to include Licensed Practitioners of the Healing Arts (LPHAs) and Medical Directors for the assessment of beneficiaries and other functions within their scope of practice.

• Program and Quality Improvement (QI): Promoting a client focus driven system, using EBPs including expanded MAT services and increasing system capacity for youth services.

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

• Outpatient Counseling
• Intensive Outpatient Counseling
• Short Term Residential Treatment
• Withdrawal Management (WM)
• Narcotic Treatment Programs (NTPs), including non-methadone MAT
• Case Management
• Recovery Services
• Physician Consultation
Other optional services are Partial Hospitalization and additional MAT. Table 1-1, below, compares traditional DMC with DMC-ODS Waiver services.

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

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<tr>
<th>DMC</th>
<th>DMC-ODS</th>
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<td>Outpatient Drug-Free Treatment</td>
<td>Outpatient Services</td>
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<tr>
<td>Perinatal Intensive Outpatient Treatment</td>
<td>Intensive Outpatient Services</td>
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<tr>
<td>Perinatal Residential Treatment (16 beds only)</td>
<td>Residential Treatment Services (no bed limit)</td>
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<tr>
<td>Inpatient Hospital Detoxification</td>
<td>WM (residential 3.2)</td>
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<tr>
<td>Narcotic Treatment Program Services (methadone)</td>
<td>Narcotic Treatment Program Services with Methadone, Buprenorphine, Disulfiram, and Naloxone</td>
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Additional requirements in the STCs were that providers must be trained in ASAM-based assessment dimensions and LOC criteria. Residential treatment providers would need to have an ASAM designation level from DHCS before being able to provide the DMC-ODS services. All beneficiaries served in the opt-in counties must meet the ASAM criteria definition of medical necessity.

Coordination of care was also a critical component of the STCs. MOUs were required between the participating counties and their managed health care plans, including outlines of a dispute resolution process and the coordination of case management responsibilities.
The STCs required that clients could move effortlessly across both the SUD delivery system and physical health as well as mental health.

The STCs also 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” (STC Section 147. h.viii). An LPHA is a Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Registered Pharmacists, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor and license-eligible practitioners working under the supervision of licensed clinicians. This would provide 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. It also makes it easier to serve individuals with co-occurring disorders of mental health and SUD.

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 would have the ability to select which providers to contract with for the provision of services. Counties would have to meet standards for timely access and ensure that their beneficiaries would have access to all required DMC-ODS services. The STCs also required a 24-hour access number for potential beneficiaries to call to request services and receive screenings, information, and referrals. Beneficiaries also have appeal and grievance rights. Counties would have to report appeals and grievance data to the state on a quarterly basis.

Counties are required to develop a QI plan and would create a Quality Improvement Committee (QIC) with a structured work plan, including an annual evaluation of their activities and goals. Since this was a new requirement for the SUD programs, there was flexibility to integrate into existing mental health QICs or convene separate 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.
Meeting Federal EQRO Requirements

Since the opt-in counties would now function as PIHPs, the federal requirement for an EQRO review would apply. CMS requires that external reviews be conducted by an independent, external contractor (CFR 42, Part 438). Behavioral Health Concepts, Inc. (BHC) was awarded the contract to be the EQRO for California. EQRO is required to conduct an onsite visit to the county on an annual basis to review access, timeliness, quality, and outcomes. The review criteria are based on CMS 42 CFR Part 438, subpart E, which outlines four major requirements:

- Performance Measures (PMs) to evaluate clinical effectiveness and service activity
- Performance Improvement Projects (PIPs) that focus on clinical and administrative processes
- Information System Capacity Assessments (ISCAs) to focus on billing integrity, care management, and delivery systems
- Client satisfaction with the services received, measured through a survey and other mechanisms.

Because this was a new requirement and never had been required in the SUD system, BHC provided extensive training and technical assistance (TA) to the counties. In addition, BHC was to collaborate with UCLA on its evaluation of the DMC-ODS counties and coordinate data analytics and use of data for QI. BHC was also required to complete an annual report on its findings.

This EQR report represents the fiscal year (FY) 2018-19 Annual Report of the DMC-ODS programs by the California External Quality Review Organization (CalEQRO), BHC. There were 14 reviews this past FY for counties that had been operational for 12 months or more as a DMC-ODS. For 11 counties, this was their first year of DMC-ODS services. These will be referred to as Year One counties in the report. Three counties were completing their second year; they will be referred to as Year Two counties. Year Two counties have additional PMs and were in a different stage of developing in their networks and in many of their quality initiatives.

This report evaluates the quality of services in the Demonstration Waiver reform of SUD treatment. It includes DMC-ODS counties as large as Los Angeles and as small as Nevada County. The goal of this report is to describe the continued efforts of the three Year Two counties (Marin, Riverside, and San Mateo) and the start-up years of
the 11 additional counties (Napa, San Francisco, Nevada, Imperial, San Diego, Monterey, Santa Clara, Santa Cruz, San Luis Obispo, Contra Costa, and Los Angeles) in the context of EQRO quality requirements. Another important goal of the report is to evaluate the success of the Waiver in reaching some of the goals set forth in the STCs, as well as the model’s strengths and challenges at the county service delivery level.

CalEQRO Methods

This annual EQR technical report analyzes and aggregates data (both qualitative and quantitative) from the EQR activities throughout the year, as described below.

Validation of Performance Measures\textsuperscript{13}

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 included for all counties and 4 additional measures for counties in their second year of services and beyond. Details of each specific measure are set forth in the following chapter on PMs.

Performance and Quality Management Key Components

Other findings in this report include changes, progress, or milestones in the DMC-ODS counties’ approaches to performance management—such as emphasizing use of data, outcome tools and reports, 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).

Performance Improvement Projects\textsuperscript{14}

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review for validation through the EQRO review. The PIPs are discussed in detail later in this report.


Evidence of Federal Data Integrity Requirements for Health Information Systems\textsuperscript{15}

Using the ISCA protocol, the EQRO reviewed and analyzed the extent to which the DMC-ODS counties meet federal data integrity requirement for Health Information Systems (HIS), as identified in 42 CFR §438.242. 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. These are reviewed with counties and providers of service on site visits related to use for QI and follow-up actions on outlier scores.

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. Submitted documentation as well as focus groups with a variety of key staff, contracted providers, advisory groups, beneficiaries, 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.

Coordination with UCLA
BHC coordinated evaluation and outcome activities with UCLA on a weekly basis and takes a team approach to solving problems with unclear data and results, opportunities to improve services, and the evaluation and associated tools.

Two areas of very intense work together are the ASAM LOC referral data results by county and statewide, as well as the TPS results by county and statewide. Both teams evaluate these results for identification of findings and best practices. Another area of extensive coordination is valuation of claims and demographic evaluation.

The following chapters present the results of CalEQRO’s onsite reviews and data analyses in each of the areas listed above.
Section 2

Performance Measures

Background

CalEQRO carefully reviews both quantitative and qualitative data to formulate the conclusions and recommendations for the Annual Report. This chapter features the quantitative data, organized into tables and graphs with accompanying narratives to convey how counties are standing up their DMC-ODS for treating DMC beneficiaries. The section begins with a brief description of the PMs that CalEQRO used to organize the data into meaningful information. Most of these measures are based upon claims data; explanations are provided detailing how the data are derived and its specific limitations. This section also includes outcomes from client services using the California Outcomes Measurement System (CalOMS) as well as a presentation of timeliness data derived by the DMC-ODS counties' tracking of their beneficiaries' efforts to access SUD care.

The 14 DMC-ODS counties described in this chapter’s data tables and narratives are all in start-up phases as they each try to transform their fragmented continuum of SUD services into an ODS. They are striving to comply with the DMC-ODS Waiver STCs and fulfill the vision of SUD treatment that the STCs delineate. The DMC-ODS counties are in various phases of expanding their service offerings: developing processes to enable easier access to those services, improving the quality and coordination of care, and building an information technology (IT) and data analytic infrastructure that supports measuring how well they are achieving these objectives.

CalEQRO only reviews those counties with at least one year of experience implementing direct services as part of their DMC-ODS. Of the 14 counties featured in this report, 11 had completed their first year of DMC services implementation (Year One counties) and 3 counties had completed their second year (Year Two counties). CalEQRO used calendar year (CY) claims data for some counties and FY data for others, depending upon when the county began its implementation and
PERFORMANCE MEASURES

which 12-month period would maximize the amount of available DMC data to analyze.

In either case, there is a lag time between the date of a treatment service and the date when a claim is submitted by the DMC-ODS county to DHCS and first processed. Counties have six months to submit their claims and can apply for exceptions to delay some submissions even further. Delays can occur while treatment programs await approval of their application to become DMC-certified, before which their claims would not be accepted. Delays also can occur while treatment programs improve their ability to document services in charts according to DMC requirements, and/or until the county is confident of its ability to pass chart documentation audits. These factors limit the amount of available data. Therefore, CalEQRO includes in its data to be measured all claims that have been approved or pended by DHCS and excludes only those claims for which DHCS found a reason to deny payment. Nevertheless, it is prudent to note that the claims-based results in the ensuing tables do not always reflect the complete total of services provided by each DMC-ODS county.

Performance Measures for Year One and Year Two Counties

The purpose of the PMs is to foster access to treatment and quality of care by measuring SUD indicators that have 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 county behavioral health systems of care. Through this thorough process, CalEQRO recommended 12 PMs to use in the annual reviews of all DMC-ODS counties that completed their first year or more of services implementation.

The measures for all DMC-ODS counties reviewed are as follows:

- Total beneficiaries served by each DMC-ODS county to identify whether new and expanded services are being delivered to beneficiaries
- Number of days to first DMC-ODS service after client assessment
- Total costs per beneficiary served by each DMC-ODS county overall and by ethnic group
- Cultural competency of DMC-ODS services to beneficiaries
- Penetration rates for beneficiaries, including by race/ethnic groups, ages, and risk factors (such as disabled and foster care aid codes)
PERFORMANCE MEASURES

- Coordination of care with physical health and mental health
- Timely access to methadone 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 discharge from residential treatment
- Availability of the 24-hour Access Call Center line to link beneficiaries to full ASAM-based assessments and treatment (with description of Call Center metrics)
- Identification and coordination of the special needs of High Cost Beneficiaries (HCB)
- Percentage of clients with three or more WM episodes and no other treatment (focus on improving engagement).

Counties in their second year of implementation or more have four additional PMs. They are:

- Use of ASAM criteria in screening and referral of clients and the percent receiving recommended services (based upon clinical staff ratings) using ASAM LOC referral data) percentage of congruence between assessed need and recommended LOC
- Initiation and engagement in DMC-ODS services
- Retention in DMC-ODS treatment services using claims data across multiple LOCs
- Readmission into residential WM within 30 days.

HIPAA Guidelines for Suppression Disclosure

Values are suppressed on PM reports to protect confidentiality of the individuals summarized in the data sets where the beneficiary count is less than or equal to 11 (shown by an asterisk or blank cell). Where necessary, a complementary data cell is suppressed to prevent calculation of initially suppressed data. Additionally, suppression is required of corresponding percentages (n/a); and cells containing zero, missing data, or dollar amounts (-).
DMC-ODS Clients Served, Penetration Rates, and Approved Claims Dollars per Beneficiary

Table 2-1 summarizes the number of clients served and the penetration rate by age group for all DMC-ODS counties in CY 2018. Counties submitted DMC-ODS claims for nearly 50,000 DMC beneficiaries across the 14 reviewed counties that were either approved or pended by DHCS. In most counties, there were an undetermined additional number of beneficiaries who had received services but whose claims had not yet been submitted. The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly Medi-Cal enrollee count, averaged over a 12-month period. Counties are primarily serving adult clients in the 18- to-64 age group. Many counties have active initiatives and PIPs related to expanding services to youth, so the penetration rate for this age group is expected to increase in the near future.

Table 2-1: Clients Served and Penetration Rates, by Age Group, for all DMC-ODS Counties, CY 2018

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Average Number of Eligibles per Month</th>
<th>Number of Clients Served</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group 12-17</td>
<td>820,748</td>
<td>2,199</td>
<td>0.27%</td>
</tr>
<tr>
<td>Age Group 18-64</td>
<td>3,988,837</td>
<td>41,990</td>
<td>1.05%</td>
</tr>
<tr>
<td>Age Group 65+</td>
<td>781,869</td>
<td>4,764</td>
<td>0.61%</td>
</tr>
<tr>
<td>Total</td>
<td>5,591,441</td>
<td>48,953</td>
<td>0.88%</td>
</tr>
</tbody>
</table>

Table 2-2 below displays the clients served and penetration rates by race/ethnicity. Overall, the penetration rate for all race/ethnicity groups is 1.9 percent. There are differences by race/ethnicity, however, with Native American and White clients having the highest penetration rates (3.9 percent and 2.7 percent, respectively). The race/ethnicity groups with the lowest penetration rates are Latino/Hispanic and Asian/Pacific (0.7 percent and 0.4 percent).

CalEQRO penetration rates are linked to total Medi-Cal beneficiaries, but if one considers prevalence of SUD disorders using National Survey of Drug Use and Health (NSDUH) data such as UCLA data, the penetration rate of the DMC-ODS counties is 6.5 percent of the Waiver counties. The NSDUH 2016-2017 data rate was applied to 2018 data because it is the closest NSDUH rate. 2018 NSDUH data will not become available until late 2020.
Table 2-2: Clients Served and Penetration Rates by Race/Ethnicity for all DMC-ODS Counties, CY 2018

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Average Number of Eligibles per Month</th>
<th>Number of Clients Served</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>947,599</td>
<td>18,482</td>
<td>2.7%</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>2,854,445</td>
<td>17,449</td>
<td>0.7%</td>
</tr>
<tr>
<td>African American</td>
<td>464,567</td>
<td>5,359</td>
<td>2.0%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>647,449</td>
<td>837</td>
<td>0.4%</td>
</tr>
<tr>
<td>Native American</td>
<td>13,353</td>
<td>342</td>
<td>3.9%</td>
</tr>
<tr>
<td>Other</td>
<td>664,060</td>
<td>6,484</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total</td>
<td>5,591,473</td>
<td>48,953</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Figure 2-1 provides a picture of the average approved or pended claims costs for services by age group for all the combined DMC-ODS counties that were reviewed. Youth between the ages of 12 and 17 are the lowest-cost age group overall, at an average claim of $1,785. Youth have not accessed services at the same rates as adults in these first years of implementation; when youth do access services, it is primarily outpatient services, a comparatively less expensive LOC. Adults between the ages of 18 and 64 have the highest average approved claim at $3,820; they are also the age group most likely to be served.

Figure 2-1: Average Approved Claims, by Age Group, for All DMC-ODS Counties, CY 2018
Figure 2-2a reflects the percentage of clients served by each of the DMC-ODS service categories. This bar chart reflects unduplicated clients within each category, but some duplication exists across categories for clients who used more than one type of service during the year of measurement. In CY 2018, when most of the 14 counties reviewed in this report were in Year One of their DMC-ODS start-up, the most commonly used treatment services were methadone dosing in NTPs (38 percent), outpatient treatment services (28 percent), and residential treatment (24 percent). Intensive outpatient treatment, WM, and non-methadone MAT collectively made up the other 10 percent of total services delivered; however, many counties are still implementing and expanding their WM and MAT or were delayed in billing for those services. Thus, the actual number of those services may be understated. In future years, Medi-Cal client utilization of these services measured by claims will likely grow proportionately.

Figure 2-2b reflects only the percentage of youth ages 12 to 20 served by each of the DMC-ODS service categories. The statistics are based on both DMC-ODS claims and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) claims. The latter were only used when a SUD was the primary diagnosis. The majority of youth served received outpatient treatment services (72 percent), followed by intensive outpatient treatment (12 percent) and residential treatment (12 percent). The percentages in part reflect the availability of services in most counties, with the preponderance being outpatient treatment, with less capacity for intensive outpatient treatment and residential treatment. Many counties are building their capacity in these latter two service types. As with WM and MAT, in future years Medi-Cal client utilization measured by claims will likely grow proportionately.

Figure 2-2a: Percentage of All Clients Served, by Service Category, for all DMC-ODS Counties, CY 2018
Table 2-3 below shows the penetration rates for those receiving treatment by DMC eligibility categories for all DMC counties. Clients covered under ACA comprise 60.4 percent of all clients served, indicating the substantial impact of ACA expansion on this client population’s treatment services and access. Penetration rates above 1.0 percent of Medi-Cal eligibles for services included clients under the following categories: disabled, foster care, and ACA. In subsequent reports, the trends in penetration rates will be presented across the years of Waiver implementation, as well as within the individual year of measurement.

**Table 2-3: Clients Served and Penetration Rates, by Eligibility Category, for all DMC-ODS Counties, CY 2018**

<table>
<thead>
<tr>
<th>Eligibility Categories</th>
<th>Average Number of Eligibles per Month</th>
<th>Number of Clients Served</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled</td>
<td>567,252</td>
<td>9,182</td>
<td>1.62%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>17,109</td>
<td>370</td>
<td>2.16%</td>
</tr>
<tr>
<td>Other Child</td>
<td>515,647</td>
<td>1,462</td>
<td>0.28%</td>
</tr>
<tr>
<td>Family Adult</td>
<td>980,289</td>
<td>8,920</td>
<td>0.91%</td>
</tr>
<tr>
<td>Other Adult</td>
<td>1,002,960</td>
<td>819</td>
<td>0.08%</td>
</tr>
<tr>
<td>MCHIP</td>
<td>337,015</td>
<td>598</td>
<td>0.18%</td>
</tr>
<tr>
<td>ACA</td>
<td>2,173,933</td>
<td>29,744</td>
<td>1.37%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,591,441</strong></td>
<td><strong>49,227</strong></td>
<td><strong>0.88%</strong></td>
</tr>
</tbody>
</table>
Figure 2-3 below shows the average approved claims dollars per client by DMC eligibility category. ACA and family adult categories constituted the major groups incurring the most costs for SUD services. The group incurring the highest costs for services was clients covered by ACA.

**Figure 2-3: Average Claims Dollars per Client by Eligibility Category for All DMC-ODS Counties, CY 2018**

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Claims Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>$4,647</td>
</tr>
<tr>
<td>Family Adult</td>
<td>$3,403</td>
</tr>
<tr>
<td>Disabled</td>
<td>$2,998</td>
</tr>
<tr>
<td>Other Adult</td>
<td>$2,562</td>
</tr>
<tr>
<td>MCHIP</td>
<td>$1,496</td>
</tr>
<tr>
<td>Other Child</td>
<td>$1,277</td>
</tr>
<tr>
<td>Foster Care</td>
<td>$1,150</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 opioid addiction using a narcotic replacement therapy approach. Extensive research studies document that with daily dosing of methadone, many clients with otherwise intractable opioid 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 maintenance medication must first show a history of at least one year of opioid addiction and at least two unsuccessful attempts to quit using opioids through non-MAT approaches. They are likely to be conflicted about giving up their use of addictive opioid. Consequently, if they do not begin methadone medication soon after requesting it, they may soon resume opioid use and an addiction lifestyle that can be life-threatening. For these reasons, NTPs regard the request to begin treatment with methadone as time-sensitive.

CalEQRO learned that some differences in billing practices among NTP providers may affect measurements of timely access. Some providers do not bill until the client...
is admitted into treatment; consequently, the initial intake may not appear as the first request for treatment. Some NTP providers will not bill for services other than individual counseling or methadone dosing; in these situations, the medical history, physical exam, and blood testing required may not be billed and therefore may not be counted in this measure. Some clients may begin their initial sessions with an NTP provider in an adjoining county and then transfer to another in their county of residence, or vice versa. These and other inconsistencies in NTP billing practices can affect the results for this measure.

Because of the billing inconsistencies, CalEQRO decided to use the median rather than the mean (average) to describe the performance of the DMC-ODS counties for this measure. The median is the number at the 50th percentile—that is to say, for this measure, the amount of time it took after their first request for methadone for 50 percent of clients to receive their first dose, while the other 50 percent underwent a longer wait time. This statistic avoids the undue influence of a few extreme outliers whose measured time to first dose might have taken particularly long, thereby skewing the mean (average) statistic. Overall and separately for each county, it takes less than one day from first visit to first dose, based on the median; this is timely access.

**Expanded Access to Non-Methadone MAT through DMC-ODS NTP Providers**

Some people with opioid addictions are interested in newer-generation addiction medicines such as buprenorphine and suboxone. The DMC-ODS Waiver requires NTPs to offer methadone, buprenorphine, disulfiram, and naloxone. The Waiver also encourages MAT access in outpatient and other levels of SUD care. Many new and long-acting medications are being offered or are in development, which may help with alcohol or opioid addiction.

Several challenges have slowed prescribing of non-methadone MAT by DMC-ODS programs. Most programs were unaccustomed to providing these MAT; during their initial year of services, they were focused first on meeting new regulatory requirements from the Waiver applicable to their ongoing treatment services. Those who were early adopters awaited guidance on new protocols while learning new billing codes and systems. Although the NTPs were newly required by the Waiver STCs to provide some of the non-methadone MAT, it took time for them to set up new workflows and assessment protocols, meet Drug Enforcement Agency (DEA) requirements, and modify their billing systems. The residential treatment programs were given the option of prescribing non-methadone MAT, but first had to obtain an Incidental Medical Services approval that took time and required additional training, staffing, and expenses. These challenges are all now being addressed by counties and their providers, but in the short term the expanded services and requirements
slowed the development of new access points for clients to access these MAT services.

Figure 2-4 shows the percentage of all DMC-ODS clients who received at least one non-methadone MAT billed visit and clients who received at least three or more non-methadone MAT billed visits. The former statistic is an indicator of how accessible non-methadone MAT is to DMC-eligible beneficiaries in DMC-ODS counties and how effective the DMC-ODS counties have been in promoting its use to clients. The latter is a measure of how effectively the DMC-ODS counties engaged clients in non-methadone MAT once they began treatment. These statistics are based on submitted claims from DMC-ODS providers, so the data may be an understatement of the total services that were provided in the year of measurement. According to the data in Figure 5, 3.95 percent of all DMC-ODS clients served by the 14 reviewed counties had at least one MAT billed visit and fewer than half of those clients (1.68 percent of all DMC-ODS clients) continued their treatment for at least three MAT billed visits. Compared to Year One of MAT services, this represents substantial expansion. Additional context for MAT growth is found in Section 4 of this report.

Figure 2-4: Percentages of Clients with at Least One and with Three or More DMC-ODS Non-Methadone MAT Billed Visits for all DMC-ODS Counties, CY 2018

Services for Non-Methadone MAT Prescribed and Billed in Non-DMC-ODS Settings

Non-methadone MAT can be prescribed and administered by physicians and other qualified medical staff in medical settings rather than in NTPs or specialty DMC-ODS treatment programs. These medical settings can include primary care clinics, hospital-based clinics, and private physician practices. These settings can feel more
comfortable to some people for whom SUD specialty clinics are associated with stigma. Also, some of the non-methadone MAT for opioid or alcohol addictions have the advantages of requiring fewer appointments for regular dosing than in an NTP.

Prescribers of buprenorphine must first obtain specialized training (DATA 2000 Waiver), which can be completed in eight hours. However, many physicians feel they need additional and ongoing consultation beyond the initial training in case complications arise in the dosing or in associated case management for other problems their clients might face. Some also feel they need added back-up support from behavioral health clinicians and/or physician extenders for the additional time it may take to properly adjust the initial dosing and to address other behavioral health problems that may arise. For these reasons, expanded physician prescribing is definitely increasing but slowly as staff gain experience.

Demonstration projects in other states, most notably Vermont, have shown several types of system-level supports that combine effectively to promote access to addiction MAT for opioid addiction, specifically buprenorphine, and support of prescribers. These supports are promoted in California through several DHCS grant initiatives, the best known being the Hub and Spoke grants. According to reports from the reviewed counties whose providers are grant awardees and from a statewide evaluation of grantees, medical settings are gradually increasing access to buprenorphine for opioid addiction through the added supports of the Hub and Spoke grants and other related initiatives. DMC-ODS counties working with these initiatives have enhanced and expanding access to MAT. (Some of these other initiatives and models are described in Section 4 of this report.)

Most of the DMC-ODS in the reviewed counties report no access to claims data from medical settings, but there is active coordination of client care with these important health partners. The UCLA evaluation team for the statewide Hub and Spoke grantees reports annually on these efforts.

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 conditions 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 the program (e.g. Week One, Week Two, etc.).

Figure 2-5 shows two aspects of this 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. Figure 5 shows the cumulative percent of clients for all DMC-ODS counties who began a new LOC within 7 days, 14 days, 30 days, and within any
number of days after discharge from residential treatment during the year being measured. While only 4.5 percent received their next treatment session with 7 days of discharge from residential treatment, 14 percent did eventually receive a service following their residential treatment. There was notable variation across counties, with the lowest follow-up rate in any days at 5.4 percent and the highest at 23 percent.

These percentages are low, suggesting that the DMC-ODS counties may not yet be facilitating the desired step-downs in treatment and coordination of care transitions that the Waiver sought to promote. However, some qualifying interpretations are in order. Because the results are based entirely on claims for DMC services, they do not account for the many types of support services that are not being billed to DMC. Some of these services will qualify for DMC-ODS coverage as Recovery Support Services but are not yet being billed as such and instead are considered as SUD Alumni Support Services. Other types of community support services, such as Alcoholics Anonymous, Narcotics Anonymous, and faith-based support programs, are also not billable and will not become so. However, this is definitely an area for potential improvement in the programs and more engagement on this issue of continuity of care is needed.

Figure 2-5: Percent of Timely Transitions in Care Post-Residential Treatment for DMC-ODS Counties Reviewed, CY 2018

![Bar chart showing the percentage of timely transitions in care post-residential treatment for DMC-ODS counties reviewed, CY 2018. The chart indicates that 4.5% transitioned within 7 days, 7.0% within 14 days, 10.2% within 30 days, and 14.0% within any days.](chart)
Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUD are understandably ambivalent about engaging in treatment and making fundamental changes in their lives. The moment when a person reaches out for help to address a SUD represents a critical juncture in that person’s life, and the opportunity may pass quickly if barriers to access treatment are high. DMC-ODS counties are responsible for making initial access easy for prospective clients by directing them to the most appropriate treatment for their particular needs. For some people, access lines may be of great assistance in finding the best treatment match within systems that can otherwise be confusing to navigate. For others, access lines may be perceived as impersonal or otherwise off-putting because of long telephone wait times. For these reasons, it is critical that all DMC-ODS counties monitor their Access Lines for performance using critical indicators.

Table 2-4 summarizes Access Call Center critical indicators by county size. During the initial implementation year, some counties struggled to provide accurate data on the self-reported Access Call Center Critical Indicators Form, resulting in incomplete data for some data elements. In the narrative summary of results below, CalEQRO noted different approaches and measurement methods among some of the counties.

DMC-ODS counties were expected to track their Access Call Center’s accessibility for information, screening, and referrals. With the exception of the smallest counties, most counties purchased software that allow them to track indicators such as call volume, dropped calls, and average wait times. Call volume varied by county size, understandably showing higher numbers for larger counties. With the exception of one small county, all of the counties reported their dropped call rate to be below 8 percent. Counties varied somewhat in how they measured wait times to talk to a live person. The small counties lacked the Call Center software to track it; most of the other counties reported a wait time of less than a minute to speak to a live person and one county reported a longer average wait time of 3.2 minutes to reach appropriate counselors for clinical screenings or assessments.

DMC-ODS counties also were expected to track the disposition of their calls, especially those involving screening, referrals, and treatment authorizations. Counties varied by size in terms of the average number of monthly authorizations they approved—an average of one per month for small counties compared to 2,400 for the very large county. Lastly, counties’ reports of the percentage of calls they referred to treatment varied between 17.8 percent and 62.5 percent, though the average level of referrals to treatment settings was typically between 25 and 35 percent. Their differences did not seem to conform to a pattern based upon county size. It is likely based in part on how they advertised their Access Call Center number, how easy it was to find, whether it was given directly to key partners to use.
(e.g., to jail inmates and self-help groups), as well as how they tracked and counted their calls. For instance, some counties counted all calls (including ones from telemarketers and robocalls) while other counties counted only the calls that resulted in clinical screenings. CalEQRO plans to provide additional TA and instructions to counties next year to ensure that responses follow more standardized specifications. Some of the best practices of the Access Call Centers are highlighted in Section 4 of this Annual Report.

Table 2-4: Access Call Center Critical Indicators, by County Size, CY 2018

<table>
<thead>
<tr>
<th></th>
<th>Small n=3</th>
<th>Medium n=5</th>
<th>Large n=5</th>
<th>Very Large n=1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Monthly Volume of Calls</td>
<td>89</td>
<td>685</td>
<td>1,903</td>
<td>2,467</td>
</tr>
<tr>
<td>Average % Dropped Calls</td>
<td>28%(^1)</td>
<td>5.2%</td>
<td>6.0%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Average Wait Time to Speak to a Live Person for Screening (minutes)</td>
<td>n/a(^2)</td>
<td>0.6</td>
<td>3.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Average Monthly Authorizations for Residential Treatment</td>
<td>1.0</td>
<td>31.7</td>
<td>261</td>
<td>2,400</td>
</tr>
<tr>
<td>% of Calls Referred to Treatment/Program Site</td>
<td>62.5%</td>
<td>33%(^3)</td>
<td>17.8%</td>
<td>31.0%</td>
</tr>
</tbody>
</table>

\(^1\) Only Napa County reported this metric for small counties.
\(^2\) None of the small counties had software that would assist in tracking this metric.
\(^3\) Marin County was the only medium-sized county that reported a number for this metric. San Mateo County reported that 100% of callers are referred to services, which is inaccurate because they are only including persons screened for care and not those who call for information, telemarketers, etc.

High-Cost Beneficiaries (HCBs)

Figure 2-6 and Table 2-5 provide information on clients who use a substantial amount of higher cost DMC-ODS services. These persons, labeled in this table as HCBs, are defined as those who incur SUD treatment costs at the 90\(^{th}\) percentile or higher statewide, which equates to at least $11,172 in approved claims for CY 2018. On average, across all DMC-ODS counties, fewer than 5 percent of clients meet the criteria for HCBs. Small counties had a much smaller percentage for CY 2018 (0.4 percent) and the very large county had the highest percentage (8.9 percent). These clients often have special needs and require case management and additional support services. They are identified to allow for QI efforts and case reviews.
While the percentage of HCBs is fairly low, the total costs they incur for services is in the top 10 percent statewide. Table 2-5 summarizes the average approved claims dollars per HCB and what percentage that comprises of the total HCB claims dollars, by county size. The average approved claims dollars incurred by an HCB increase steadily as county size goes up ($14,487 for small counties to $26,155 for the very large county). The percentage of total claims dollars that HCB clients incur also goes up with county size. For small counties, HCB claims dollars are only 3 percent of the total claims’ dollars. For medium and large counties, HCB claims dollars comprise nearly a third of total claims dollars. For the very large county, HCB claims dollars comprise half of total claims dollars, even though HCBs are only 9 percent of all clients served. The larger the county, the more resources there are to provide more LOCs at higher levels and of higher intensity such as residential WM and residential treatment. Also, larger counties have more densely populated urban areas with associated higher costs of living than many of the rural and frontier areas, which translates to higher costs of services. Thus, one must look beyond costs to determine patterns of services for these beneficiaries and design optimal clinical services to support them in improving their health and outcomes.
Table 2-5: HCBs at 90th Percentile or Higher, by County Size and for all DMC-ODS Counties, CY 2018

<table>
<thead>
<tr>
<th>County Size</th>
<th>Average Approved Claims per HCB</th>
<th>Total Approved Claims</th>
<th>HCB Total Claims</th>
<th>HCB % by Total Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>$14,487</td>
<td>$2,146,041</td>
<td>$67,917</td>
<td>3%</td>
</tr>
<tr>
<td>Medium</td>
<td>$16,603</td>
<td>$25,976,781</td>
<td>$7,057,796</td>
<td>27%</td>
</tr>
<tr>
<td>Large</td>
<td>$19,245</td>
<td>$66,262,942</td>
<td>$19,049,716</td>
<td>29%</td>
</tr>
<tr>
<td>Very Large</td>
<td>$26,155</td>
<td>$101,625,291</td>
<td>$51,054,207</td>
<td>50%</td>
</tr>
<tr>
<td>All DMC-ODS</td>
<td>$19,122</td>
<td>$196,011,055</td>
<td>$77,229,636</td>
<td>39%</td>
</tr>
</tbody>
</table>

Withdrawal Management Services with No Other Treatment

This PM tracks lack of engagement in DMC-ODS treatment after WM, which leaves clients at high risk for relapse, overdose, and frequent readmissions. Prior to the Waiver, many of the smaller counties did not provide in-county WM and none of the counties billed for WM because it was not a DMC-covered service. At this early stage of implementation, it was not meaningful to compare across counties by size for this measure, since several counties had yet to bill for their residential WM programs and/or had their applications for DMC certification still pending. Overall, across all 14 counties reviewed, 3,368 WM clients were served and only 1.2 percent of them had three or more episodes with no other service. This low percentage of clients not engaging in follow-up treatment is encouraging. It suggests that the counties newly implementing their DMC-ODS are already actively using the new DMC-ODS reimbursement coverage for case management to help link clients discharging from WM to follow-up treatment.

Clients Served by Diagnostic Categories

Figures 2-7 compares the percentage of beneficiaries served by diagnostic categories. For CY 2018, opioid, alcohol, and stimulant disorders were the most prominent types of SUDs addressed by DMC-ODS treatment providers. However, this is based on claims data rather than public health epidemiological surveys to determine prevalence rates. Prior to the onset of the Waiver, the state DMC plan covered very few LOCs, with NTPs representing the dominant modality. Nearly 100 percent of NTP clients at that time were treated for opioid use disorders. The legacy of the NTPs will remain until DMC-ODS counties build out their other service categories, which treat a wider range of SUDs.
Figure 2-7: Percentage Served by Diagnosis Codes for all DMC-ODS Counties, CY 2018

Figure 2-8 shows the average cost for treating each type of SUD. It is interesting to note the lack of correlation between the results of this figure and the preceding one. Although opioid disorders were shown in Figure 8 to be the most common, they also are shown in Figure 9 to be among the least costly to treat. In contrast, sedative/hypnotic abuse was shown in Figure 8 to be among the least common SUD to be treated but is shown in Figure 9 to be the costliest to treat. There were a number of complex medical issues related to tapering and treatment of hypnotic medications (e.g., with benzodiazepines) identified by DMC counties.

Figure 2-8: Average Approved Claims by Diagnostic Categories for all DMC-ODS Counties, CY 2018
Performance Measures for Year Two Counties

Use of ASAM Criteria in Referral Decisions

A clinical cornerstone of the DMC-ODS Waiver is use of ASAM criteria for initial and ongoing LOC placements to optimize individualized treatment services for client needs. DMC programs doing screenings and assessments based on ASAM principles are required to record data for each client, documenting the congruence between their findings from the screening or assessment and the treatment services to which they referred the client. When the referral is not congruent with the LOC indicated by ASAM criteria findings, the reason is documented. No county had done this tracking prior to the Waiver and very few had used the ASAM criteria for assessment and treatment planning or referral decision making. Therefore, DHCS approved this as a measure for Year Two counties, to allow time for them to train their workforce in use of the ASAM criteria-based assessments, treatment planning, and referrals. ASAM LOC referral information is a required reporting element for all DMC counties, so data are also included from counties in their first year of Waiver services.

Table 2-6 below shows the percent congruence between ASAM findings and subsequent referral at the times of initial screening (if applicable), initial assessment, and follow-up (if applicable). Initial screenings occurred at centralized Call Centers, which most counties offered as optional entry points into treatment. Some of the Call Centers conducted ASAM criteria-based screenings and referrals and entered their results for later analyses, while others provided more perfunctory information and referrals to assessment centers. In the latter case, the results were entered as “actual referral missing.”

Table 2-6 indicates that nearly 90 percent of clients referred to treatment through screenings, assessments, or reassessments were referred to LOCs congruent with what the ASAM criteria-based findings would suggest. When exceptions were made, the primary reason given (in about 3 percent of cases) was patient preference—which is aligned with the ASAM principle of client-centered care.

At the time of this report, the availability and quality of these data were uneven across the participating counties. One county’s Call Center conducted extensive assessments by phone, so these were categorized as such rather than as screenings, while the other county Call Centers conducted initial screenings. Some counties had a full 12 months of data available, while some others had only a few months. Three counties did not yet have their data available for analysis.

PMs often serve multiple functions. Most obviously, they provide performance data regarding vital system of care functions that can be used for accountability and
quality improvement purposes; this clearly applies to the information in Table 6. Of the other potential uses of a PM, one that stands out for this measure is that it focuses a system of care's attention on processes considered to be important. All screeners and assessors are expected to enter data for this measure, and this expectation underscores for them the importance of using ASAM criteria to match clients with the appropriate treatment on an ongoing basis.

Table 2-6: Use of ASAM Criteria Findings to Guide LOC Referrals for All DMC-ODS Counties, CY 2018

<table>
<thead>
<tr>
<th>ASAM LOC Referrals</th>
<th>Initial Screening</th>
<th>Initial Assessment</th>
<th>Follow-up Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>January-December 2018</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Not Applicable - No Difference</td>
<td>44.01%</td>
<td>87.58%</td>
<td>88.01%</td>
</tr>
<tr>
<td>Patient Preference</td>
<td>3.78%</td>
<td>3.32%</td>
<td>3.14%</td>
</tr>
<tr>
<td>LOC Not Available</td>
<td>3.02%</td>
<td>0.66%</td>
<td>0.67%</td>
</tr>
<tr>
<td>Clinical Judgement</td>
<td>2.48%</td>
<td>0.62%</td>
<td>1.32%</td>
</tr>
<tr>
<td>Geographic Accessibility</td>
<td>0.32%</td>
<td>0.08%</td>
<td>0.03%</td>
</tr>
<tr>
<td>Family Responsibility</td>
<td>0.00%</td>
<td>0.08%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Legal Issues</td>
<td>0.00%</td>
<td>0.04%</td>
<td>0.11%</td>
</tr>
<tr>
<td>Lack of Insurance/Payment Source</td>
<td>0.00%</td>
<td>0.11%</td>
<td>0.11%</td>
</tr>
<tr>
<td>Other</td>
<td>0.65%</td>
<td>1.71%</td>
<td>3.45%</td>
</tr>
<tr>
<td>Actual Referral Missing</td>
<td>45.95%</td>
<td>5.82%</td>
<td>3.56%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Initiating and Engaging in Treatment Services

Figure 2-9 displays results of measures for two early and vital phases of treatment: initiating treatment and then engaging in treatment services. These PMs are part of a set of newly adopted measures by CalEQRO for counties in their second year of DMC-ODS implementation. An effective system of care helps people who request treatment for their addiction to both initiate treatment services and then continue further to become engaged in services over time. Many clients with SUDs are understandably ambivalent about treatment at the outset, contemplating a challenging commitment to behavior change that includes an entire lifestyle accompanied by physical as well as psychological dependence. Research suggests that those who are able to engage in the early stages of treatment services successfully are likely to continue their treatment and enter into a recovery process
with positive outcomes. Several federal agencies and national organizations have encouraged and supported the widespread use of these basic measures for many years.

The method for measuring the number of clients who initiate treatment begins with identifying the initial visit in which the client’s SUD is identified. Since CalEQRO does this through claims data, the “initial DMC-ODS service” refers to the first approved claim for a client that is not preceded by any services within the previous 30 days. For the Year Two counties, of those with an initial DMC-ODS service in CY 2018, 88.6 percent had a second billed DMC-ODS day or visit within 14 days after the initial service. This second day or visit is what in this measure is defined as “initiating” treatment.

CalEQRO’s method of measuring engagement in services is to include in the measure only those clients who met the requirement for initiating services described in the previous paragraph. Of those clients included in the engagement measure, CalEQRO included in the “successful engaged group” all of those clients who had at least two additional billed DMC-ODS days or visits between the 15th and 45th day following the initial DMC-ODS service. Using this method of measurement, CalEQRO found that 75.3 percent of clients for the Year Two counties who had initiated treatment continued onto engaging in treatment. There is some variation in engagement rates by county, with San Mateo showing the highest rate of engagement. These definitions of initiation and engagement were based on research and analysis by the Washington Circle group of SUD experts from a variety of agencies and organizations. The definitions have since been adopted by many organizations nationwide, including the National Committee on Quality Assurance’s Healthcare Effectiveness Data and Information Set (HEDIS) and the National Quality Foundation (NQF). CalEQRO adhered to the basic principles of these measures but modified the specifications for the DMC-ODS measure to include all of the services in the DMC-ODS Waiver, not just outpatient (which was used in the original measures used by others).
Figure 2-10 below identifies the initial DMC-ODS service used by clients when they first accessed DMC-ODS treatment services. This would be considered the gateway service of where they entered treatment and shows the diversity of entry points into the continuum of care. Based on this initiation and engagement data, clients most commonly began treatment through an NTP/Opioid Treatment Program (OTP) (43 percent) with opioid addiction, second most commonly through an outpatient treatment program (29.6 percent) and third most commonly through residential treatment (16.3 percent). With the exception of partial hospitalization and ambulatory WM, which are optional Waiver services, DMC-ODS clients who initiated treatment did so through various treatment levels across the service continuum. These may be based on Access Call Center screenings or, in counties with a no-wrong-door approach, the clients may have directly approached a local SUD service provider for services recommended by a family member or friend. No-wrong-door models of access are very common in healthcare and imply that the client or patient should be able to approach any provider of care and be screened (at least) and directed to an appropriate treatment setting or provided direct care. It is considered particularly important with SUD, as individuals often experience fluctuating motivation to work on treatment of addiction issues. It is crucial to engage them when they ask for help and provide it with knowledge and with significant support. Most DMC counties use this model, but link the field-based request to a central data tracking system to manage
overall system capacity and their network. This is most often done in connection with the Access Call Center or a centralized database.

Figure 2-10: Initial DMC-ODS Service Used by Clients, by County and for all Year Two DMC-ODS Counties, CY 2018

Retention in Treatment

Figure 2-11 below is a measure of how long the DMC system of care is able to retain clients in its DMC-ODS services. The measure counts the average number of days that clients were involved in billable treatment services across the continuum of DMC-ODS care. This measure includes any types of services the clients received sequentially without an interruption of more than 30 days. Clients must have received at least one service every 30 days to be considered as continuing in treatment. Defined sequentially and cumulatively in this way, research suggests that retention in treatment and recovery services is predictive of positive SUD outcomes.

To analyze the data for this measure, CalEQRO first identified all the discharges during the measurement year, defined as the last billed service after which no further service activity was billed for over 30 days. Then, for these clients, CalEQRO identified the beginning date of the service episode by counting back in time to the date before which there was no treatment at all for at least 30 days. The beginning date goes back as far as six months prior to the year of measurement, so the data set covers up to 18 months. All types of DMC-billable services are counted, including WM, recovery support services, and case management.
Across the Year Two counties, 46.4 percent of clients had at least a 90-day length of stay (LOS). The number drops to 23.9 percent for at least a 180-day LOS, and to 16 percent for a 270-day LOS or higher. Because the data go back only six months prior to the year of measurement, the LOS may be inadvertently truncated for some clients whose discharge date fell during the first quarter of the year of measurement. Also, most DMC-ODS counties have yet to fully bill for their recovery support services, further truncating the trackable LOS. Consequently, the percent of clients with a 270-day LOS or greater is likely to be understated. CY 2018 is the baseline year for this new measure. It will be tracked over time to encourage longer LOS in treatment or recovery support for this chronic disease and to assist with care management across the system of care.

**Figure 2-11: Cumulative LOS in DMC-ODS Services, by County and for All Year Two DMC-ODS Counties, CY 2018**

<table>
<thead>
<tr>
<th>Clients with at least 90 days</th>
<th>Clients with at least 180 days</th>
<th>Clients with at least 270 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marin</td>
<td>Riverside</td>
<td>San Mateo</td>
</tr>
<tr>
<td>55.9%</td>
<td>36.8%</td>
<td>26.7%</td>
</tr>
<tr>
<td>41.3%</td>
<td>19.3%</td>
<td>10.5%</td>
</tr>
<tr>
<td>45.6%</td>
<td>23.3%</td>
<td>12.9%</td>
</tr>
<tr>
<td>46.4%</td>
<td>23.9%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Statewide</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Withdrawal Management Readmissions**

Figure 2-12 below displays the number and percentage of WM readmissions within 30 days of discharge, based upon analyses of claims data for the three Year Two DMC-ODS counties. San Mateo did not submit billings for their CY 2018 WM services as there was a delay in receiving approval for their DMC certification. Therefore, only data from Marin and Riverside are presented here. Marin had a higher percentage of total admissions going to residential WM, due partly to having a higher per capita number of residential WM beds available within the county. This may also partly explain Marin’s higher rate of readmissions within 30 days of discharge. However, Marin may have opportunities for improvement in this area. Marin has an active and ongoing PIP to improve their discharge planning and follow-up support and treatment processes for clients served in WM. The intent of the PIP is to increase clients’ subsequent admissions into SUD treatments and recovery residences, thus reducing their readmissions into WM.
Figure 2-12: Claims Data-Based Rates of WM Readmissions, by County and for Each of the Year Two DMC-ODS Counties, FY 2017-18

* San Mateo County is not included in the chart because it did not have data for this measure.

**Trend Data for Year Two Counties**

Figure 2-13 shows that the number of clients increased significantly from 6,817 in CY 2017 to 8,992 in CY 2018. CalEQRO attributes these substantial increases primarily to the increased DMC-ODS initiatives documented in their reviews, which focused on: outreach efforts, accessibility due to the robust Access Call Centers, case management models to facilitate linkages to treatment, capacity expansions in existing services, and capacity additions in new services. Some of the increases are also attributable to increased billing of services by providers who were awaiting approval of their DMC certification the previous year and thus had not yet billed for treatment.
As counties enter into their second year of services implementation, they are typically expanding their service array, including more expensive LOCs such as residential treatment and outpatient MAT services, while also submitting claims in a timelier way. These result in a higher approved cost of claims for CY 2018, reflected here in Figure 2-14. Average claims costs increased substantially from CY 2017 to CY 2018—from $3,408 to $6,159.

Figure 2-14: Average Approved Claims by County by Year, CY 2017 – CY 2018
Another trend to feature is the change from CY 2017 to CY 2018 in timeliness of methadone dosing. Using the median score, each county’s timeliness performance from first session to first dosing is less than one day. This statistic remained stable from CY 2017 to 2018, so no figure is shown.

Figure 2-15 looks at the year-to-year comparison of non-methadone MAT visits, whether delivered in NTP or non-NTP settings. Counties are still standing up their non-methadone MAT services in all settings and the numbers for both years reflect this stage of MAT implementation. The number of clients treated for these services did not increase as much from the previous year as did the number of clients treated across all SUD treatment services, so the percentages treated for non-methadone MAT are slightly lower. Given the initiatives to increase clients referred for these treatments, it is expected that MAT will continue to grow over time. Several counties had also lost key medical staff to outside provider groups, contributing to lower numbers and reported workforce competition being particularly fierce for prescribers, as described by the local DMC medical leadership.

Figure 2-15: Number Total DMC-ODS Clients with at Least One and at Least Three Non-Methadone MAT Billed Visits by County by Year, CY 2017 – CY 2018

Figure 2-16 below summarizes timely transitions from residential treatment upon discharge to other LOCs. Overall, Year Two counties are providing an aftercare support service to about 17 percent of their clients upon discharge from residential treatment. Prior to the Waiver implementation, the most common follow-up service received by clients after discharge from residential treatment was known as “after
care” or “alumni groups.” This service was provided by the residential treatment facilities without separate billing. The Waiver now permits and even encourages billing for these services under the category of “recovery support services.” However, most DMC-ODS counties have yet to bill for these services, so the statistics based on claims data probably understate the follow-up services actually provided. Billing for these services is essential if this is going to be the preferred support by clients for after care, but it needed to become a formal recovery support program if treatment is really needed in an outpatient program. This has been a subject of discussion with all of the counties looking at continuity of care within their systems.

It is noteworthy that the three Year Two counties collectively had a 30 percent increase in the number of clients they discharged from residential treatment from their first year of implementation (3,106) to their second year (4,068). Although the number of clients they successfully transitioned to another LOC increased in the second year of implementation, the much larger increase in discharges during the second year made the percentage of successfully transitioned clients appear to decrease somewhat. It may be too soon in the start-up phase for these counties to determine definitive trends. CalEQRO plans to conduct a further trend analysis next year with more stabilized claims data and three years of data to analyze.

Based on ASAM models of the continuum of care, it would be expected that many clients would be referred to outpatient treatment. Thus, the percentages appear lower than would be desired in the context of the Waiver aspirations and incentives. Furthermore, the percentages have not improved from the previous year. These statistics would suggest opportunities for focused interventions and improvements.
Client Characteristics at Admission and Progress in Treatment at Discharge

Federal and state regulations require that all SUD providers receiving public funds must collect standard client data at treatment admission and discharge. In California, these data are collected through CalOMS, which includes forms to be completed at admission and discharge. The admission data provide useful information for DMC-ODS counties on the special needs of their clients, with implications for how treatment-related resources are designed. The data forms include measures of frequency and type of drug use, frequency of drug-free social supports, and status of housing, criminal justice involvement, and employment. DHCS produced an extensive manual for how the forms are to be completed by providers for each client. The data provide rich information to plan services, prioritize resources, and evaluate client progress. Counties are required to collect these data for all clients irrespective of funding streams, so it extends beyond those covered by Medi-Cal.

Table 2-7 displays the housing status of clients at the time of their admission into treatment during CY 2018, differentiated by like-size county groupings and overall. These findings are useful as indicators of counties’ relative need to address housing issues for their clients during treatment. The data indicates that clients across all the
DMC-ODS counties are fairly evenly distributed in living status when admitted into SUD treatment, with 31 percent homeless, 27 percent in dependent living (which is living in someone’s home), and 42 percent in independent living. There are some differences according to county size, with the smallest counties averaging 18 percent homeless and the very largest county showing 35 percent homeless. The very largest county also shows the highest percent of clients in dependent living, at 21 percent. These trends reflect a growing homeless rate throughout California that is most endemic in large urban areas. Counties with less of the population in independent living need to pay special attention to the housing needs of their clients in order to support them in their recovery process.

Table 2-7: Client Housing Status at Treatment Admission, Like-Size Counties and Statewide, CY 2018

<table>
<thead>
<tr>
<th>Admission Living Status</th>
<th>Small n=2,141</th>
<th>Medium n=5,279</th>
<th>Large n=30,238</th>
<th>Very Large N=23,709</th>
<th>All Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>18%</td>
<td>32%</td>
<td>29%</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>Dependent Living</td>
<td>35%</td>
<td>22%</td>
<td>32%</td>
<td>21%</td>
<td>27%</td>
</tr>
<tr>
<td>Independent Living</td>
<td>47%</td>
<td>46%</td>
<td>39%</td>
<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2-8 displays the legal status of clients at the time of their admission into treatment during CY 2018, differentiated by like-size county groupings and overall. These findings are useful as indicators of counties’ relative need to address criminal justice referrals and issues for their clients during treatment. The data indicate that a majority of the client population in most DMC-ODS counties at the time of admission into SUD treatment are not involved in the criminal justice system (63 percent), but the remaining numbers who are involved are substantial (37 percent). There is some variance according to county size, with the very largest county showing the highest percentage with no criminal justice involvement (69 percent, with a remaining 31 percent who are criminal justice-involved) and the medium-size counties showing the lowest percentage with no criminal justice involvement (49 percent, with a remaining 51 percent who are criminal justice-involved).

Counties were consistent, irrespective of size, in showing that the most common type of criminal justice involvement for their SUD clients is related to AB 109. This Assembly Bill is unique to California’s prison reform initiative and provides a realignment of some prison funding to the counties for early prison release, with many types of county-sponsored follow-up supports to encourage successful re-entry into the community. The supports include probation and, as needed, assistance with housing, employment or education, social services, physical health
care, and behavioral health care. AB 109 strongly encourages the counties using these funds to combine them with other funds that are similarly purposed and coordinate an array of service supports to successfully stabilize clients in their communities and in their recovery.

Table 2-8: Client Legal Status at Treatment Admission, Like-Size Counties and Statewide, CY 2018

<table>
<thead>
<tr>
<th>Admission Living Status</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
<th>Very Large</th>
<th>All Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Criminal Justice Involvement</td>
<td>57%</td>
<td>49%</td>
<td>60%</td>
<td>69%</td>
<td>63%</td>
</tr>
<tr>
<td>Under Parole Supervision by CDCR</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>On Parole from any other jurisdiction</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Post release supervision - AB 109</td>
<td>34%</td>
<td>39%</td>
<td>32%</td>
<td>19%</td>
<td>27%</td>
</tr>
<tr>
<td>Court Diversion CA Penal Code 1000</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>0%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Awaiting Trial</td>
<td>7%</td>
<td>6%</td>
<td>4%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2-9 displays the employment status of clients at the time of their admission into treatment during CY 2017, differentiated by like-size county groupings and overall. These findings are useful as indicators of counties’ relative need to address employment issues for their clients during treatment. The data indicates that most SUD clients across the DMC-ODS counties were unemployed at the time of admission (80 percent overall, with a range by county size of 76 percent to 84 percent). Among those who were unemployed at the time of treatment admission, it is useful to differentiate between those “looking for work” and those “not in the labor force and not seeking work.” Many of those in the latter category have given up hope of employment because of a severe disability. Another reason may be a perceived unavailability of employment opportunities, especially in the smallest counties. While many of those clients who are unemployed will likely benefit from supported employment services, the clients who are still hopeful and looking for work would especially benefit from such services.
Table 2-9: Client Employment Status at Treatment Admission, Like-Size Counties and Statewide, CY 2018

<table>
<thead>
<tr>
<th>Current Employment Status</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
<th>Very Large</th>
<th>All Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed Full Time - 35 hours or more</td>
<td>10%</td>
<td>15%</td>
<td>15%</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>Employed Part Time - Less than 35 hours</td>
<td>6%</td>
<td>9%</td>
<td>8%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Unemployed - Looking for work</td>
<td>23%</td>
<td>30%</td>
<td>31%</td>
<td>35%</td>
<td>32%</td>
</tr>
<tr>
<td>Unemployed - Not in the labor force and not seeking work</td>
<td>61%</td>
<td>46%</td>
<td>46%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The type of information displayed in Tables 2-9 and 2-10 focuses on the status of clients at discharge and how they might have changed through their treatment. Table 10 gives some indication to the reader of how variable the accuracy might be of the outcome ratings displayed in Table 2-9. Of special interest in Table 2-9 are the percentages of clients whose discharges were “administrative”—i.e., clients who left treatment before completion without notifying their counselors. Without prior notification of a client’s departure, counselors are unable to conduct an exit interview and fully evaluate the client’s progress or, for that matter, attempt to persuade the client to complete treatment. Without the benefit of an exit interview, providers are limited in how accurately they can rate their clients’ discharge status.

Table 2-10 displays the percentage of administrative discharges and of other types of discharges across 13 DMC-ODS counties statewide, excluding Los Angeles (for which the data were unavailable). Approximately one-third of all discharges were administrative, which limited the information that providers could use in entering their outcome ratings. Table 2-9 also displays the lowest percentage and the highest percentage that a county obtained for each type of discharge. This data display illustrates how differently counties approach accomplishing this important rating task. During each DMC-ODS county’s EQR, CalEQRO shows them these results compared to the statewide aggregate for all DMC-ODS counties. The comparisons underscore the diligence of some counties in initiating careful discharge planning processes and exit interviews with most clients, and the need for improvement in some counties with high percentages of administrative discharges.
Table 2-10: Discharge Types, Overall for All DMC-ODS Counties Statewide, CY 2018

<table>
<thead>
<tr>
<th>Discharge Types</th>
<th>Average Percent</th>
<th>Minimum Percent</th>
<th>Maximum Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Adult Discharges</td>
<td>52%</td>
<td>13%</td>
<td>71%</td>
</tr>
<tr>
<td>Administrative Adult Discharges</td>
<td>34%</td>
<td>10%</td>
<td>63%</td>
</tr>
<tr>
<td>Detox Discharges</td>
<td>11%</td>
<td>0%</td>
<td>42%</td>
</tr>
<tr>
<td>Youth Discharges</td>
<td>3%</td>
<td>0%</td>
<td>21%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Data for Los Angeles County were missing for this measure. The table reflects the averages for the remaining 13 counties.

Table 2-11 displays the eight rating options in the CalOMS discharge summary form that counselors used to evaluate their clients’ progress in treatment. These are the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for clients with SUDs.

The first four rating options are positive. “Completed Treatment” means the client met all their treatment goals and/or the client learned what the program intended for clients to learn at that LOC.

“Left Treatment with Satisfactory Progress” means the client was actively participating in treatment and making progress, but left before completion for various possible reasons other than relapse, which might include transfer to a different LOC closer to home, job demands, etc.

The last four rating options indicate lack of satisfactory progress for different reasons. CalEQRO learning during the onsite reviews that there is some variability in how providers are trained to differentiate between the four positive ratings, so we recommend the reader focuses on the subtotal row that consolidates the four positive outcome ratings compared to the four negative outcome ratings. Table 10 also includes the lowest percent rating by a county for each category and the highest percent rating by a county for each category, to give the reader an idea of the variability by county.

As the table indicates, providers across all 14 DMC-ODS counties rated 60 percent of their clients at the time of discharge as having made positive progress (i.e., any of the first four subcategories). This seems realistically positive for a client population facing substantial challenges with a chronic disease, undertaking a profound set of changes in habits and lifestyle, and also coping with challenging life circumstances.
For each of the four subcategories of positive progress, the provider ratings ranged widely, as one would expect for accurately reflecting client outcomes for SUD treatment. The aggregated provider ratings per county also showed substantial differences, as evidenced by the minimum and maximum percentages. The subjective ratings by providers of unsatisfactory progress also showed substantial differences between counties, as evidenced by the minimum and maximum scores. During each DMC-ODS county’s EQR, CalEQRO shows them their CalOMS results compared to the statewide aggregate for all DMC-ODS counties. The comparisons shine a light on a counties’ strengths in treatment effectiveness as well as opportunities for improvement.

Table 2-11: Ratings of Client Progress at Discharge, Overall for All DMC-ODS Counties, CY 2018

<table>
<thead>
<tr>
<th>Discharge Types</th>
<th>Average Percent</th>
<th>Minimum Percent</th>
<th>Maximum Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed Treatment - Referred</td>
<td>13%</td>
<td>2%</td>
<td>24%</td>
</tr>
<tr>
<td>Completed Treatment - Not Referred</td>
<td>27%</td>
<td>2%</td>
<td>48%</td>
</tr>
<tr>
<td>Left Before Completion with Satisfactory Progress - Standard Questions</td>
<td>15%</td>
<td>5%</td>
<td>55%</td>
</tr>
<tr>
<td>Left Before Completion with Satisfactory Progress – Administrative Questions</td>
<td>6%</td>
<td>0%</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Subtotal of Positive Outcome Ratings</strong></td>
<td><strong>60%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Before Completion with Unsatisfactory Progress - Standard Questions</td>
<td>21%</td>
<td>7%</td>
<td>27%</td>
</tr>
<tr>
<td>Left Before Completion with Unsatisfactory Progress - Administrative</td>
<td>18%</td>
<td>1%</td>
<td>53%</td>
</tr>
<tr>
<td>Death</td>
<td>&lt;1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Incarceration</td>
<td>1%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Subtotal of Negative Outcome Ratings</strong></td>
<td><strong>40%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At the time of treatment discharge, providers are required to rate their clients’ status on other dimensions, including frequency of drug use, frequency of involvement in drug-free social support activities, housing status, criminal justice involvements, and employment status. These are the same types of client status ratings that providers are required to enter at the time of their clients’ admission to treatment. The similarity of these data entry requirements invites a pre-post analysis for measuring client outcomes, which was an original intent of CalOMS. A few of the counties
reviewed by CalEQRO conducted some of these analyses. These present opportunities for all the counties to undertake similar analyses in the future.

**Timeliness Measures Reported to CalEQRO by DMC Counties**

CalEQRO identifies several components as necessary to support a full-service delivery system that provides timely access to DMC-ODS services. This ensures successful engagement with clients and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Prior to each onsite review by CalEQRO, counties complete a timeliness assessment form. The first part of the form asks counties to self-report their data system capacity to track various timeliness indicators. The second part of the form asks for specific timeliness metrics.

Table 2-12 summarizes the 14 counties’ capacity to track various timeliness components. Ten of the counties indicated that their timeliness self-assessment (TSA) included contract providers’ data. Four of the counties, including Los Angeles, stated that the self-assessment did not include contract provider capacity. In their first year of implementation, with their new computer systems plus launching, access, and their network capacity database, the contractors did not have software or systems to track timeliness of requests, only visits. Computer systems of the contract providers are very limited and rarely interface with the county systems. This area is discussed in depth in the ISCA chapter.

The majority of counties have increased their capacity to track many of the timeliness measures, with 100 percent of counties able to track the length of time from initial request to first face-to-face visit and 86 percent able to track the length of time from initial request to first offered appointment and percentage of residential discharged beneficiaries who receive a follow-up care encounter within 7 days. Counties are still struggling to track no-show rates (for MAT and other counselors) as well as ASAM assessment for MAT to first kept MAT appointment at both NTPs and non-NTP sites for MAT. These measures are not required but are considered good practice to track.
<table>
<thead>
<tr>
<th>Timeliness Metric</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The DMC-ODS is able to record the time of initial requests by new beneficiaries.</td>
<td>14</td>
<td>100%</td>
</tr>
<tr>
<td>The DMC-ODS is able to match initial request to any follow-up appointment.</td>
<td>11</td>
<td>79%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the length of time from initial request to <em>first offered</em> appointment (including assessment).</td>
<td>12</td>
<td>86%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the length of time from initial request to <em>first accepted</em> appointment.</td>
<td>10</td>
<td>71%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the length of time from initial request to <em>first face-to-face visit (including assessments)</em>.</td>
<td>14</td>
<td>100%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the length of time from initial request to ASAM assessment.</td>
<td>9</td>
<td>64%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the length of time between ASAM assessment and <em>first DMC clinical service</em> appointment (at any LOC).</td>
<td>10</td>
<td>71%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the length of time between ASAM assessment for MAT to first MAT appointment kept for methadone or non-methadone MAT.</td>
<td>8</td>
<td>57%</td>
</tr>
<tr>
<td>The DMC-ODS tracks timeliness of first dose for patients on opioid requesting methadone.</td>
<td>10</td>
<td>71%</td>
</tr>
<tr>
<td>The DMC-ODS has a definition for an urgent appointment.</td>
<td>11</td>
<td>79%</td>
</tr>
<tr>
<td>The DMC-ODS is able to record the time of <em>urgent</em> appointment requests.</td>
<td>10</td>
<td>79%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the length of time between the request for <em>urgent appointment to initial face to face contact</em>.</td>
<td>10</td>
<td>79%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the <em>percentage</em> of residential discharged beneficiaries who receive a follow-up care encounter within 7 days.</td>
<td>12</td>
<td>86%</td>
</tr>
<tr>
<td>The DMC-ODS tracks the <em>percentage</em> of WM discharged beneficiaries who get detoxed again within 30 days.</td>
<td>11</td>
<td>79%</td>
</tr>
<tr>
<td>The DMC-ODS tracks its <em>No Show rates for MAT</em> appointments (MDs, NPs, PAs only, including tele-medicine).</td>
<td>8</td>
<td>57%</td>
</tr>
<tr>
<td>The DMC-ODS tracks its <em>no-Show rates for other counselor</em> appointments (non-MDs, licensed professionals).</td>
<td>7</td>
<td>50%</td>
</tr>
</tbody>
</table>
Figure 2-17 below illustrates the counties’ self-reported timeliness data for average number of days from first request to first offered appointment and average number of days from first request to first face-to-face appointment. The time to first offered appointment reflects the capacity of the DMC-ODS to facilitate easy and timely access for clients into treatment. The time to first face-to-face session reflects the added consideration of what the client chose as convenient. For instance, instead of accepting a mid-day appointment offer in four days, a client working full-time and going on vacation may instead choose an appointment in the evening three weeks later.

All data systems are able to count calendar days, but most were struggling to convert to business days, since many holidays vary by provider organization. For the purposes of this reporting period, calendar days are still used as the common metric. Overall, the counties reported an average of 4.8 calendar days from first request to first offered appointment, and 14.5 calendar days from the first request to first face-to-face appointment. The large counties reported the shortest average time from first request to keeping a face-to-face appointment (6.5 calendar days), while one county reported the longest average time of 22.3 calendar days from initial request to first face-to-face visit. The county with this longer time selected this as a target for one of their PIPs.

Figure 2-17: Average Days from First Request to First Offered Appointment and First Face-to-Face Appointment, by County Size and Overall Statewide, CY 2018
Figure 2-18 depicts the rate of WM readmissions within 30 days, as reported by each of the 14 DMC-ODS counties. Readmission rates should be low if the county is successfully linking clients to other services after discharge from WM. Overall, the rate is 4.6 percent; however, medium-sized counties report a higher aggregate rate of 9.6 percent. Some of the small and medium-sized counties contracted with WM facilities out-of-county and had challenges tracking the data for this measure.

**Figure 2-18: County-Reported Rates of WM Readmissions, by County Size and Overall for All DMC-ODS Counties, CY 2018**

![Bar chart showing readmission rates by county size]

Conclusions

CalEQRO developed PMs to determine the accessibility of DMC-ODS counties’ treatment services, timeliness of their access processes, quality of their delivery of client-centered care, and differences made in client outcomes. The data for most of the measures were derived from California’s statewide Medi-Cal claims database and Medi-Cal Eligibility Files. Some of the measures were derived from three other databases analyzed by the Waiver’s statewide evaluation team at UCLA: ASAM LOC Referral Data, TPS survey results, and CalOMS ratings. In addition, a few of the timeliness measures were derived from data the DMC-ODS counties generated, tracked, and reported to CalEQRO.

CalEQRO analyses reveal many insights into DMC-ODS counties’ trials and tribulations in setting up their systems of care and the infrastructure necessary to
support them. DHCS created entire new sets of billing codes and data entry instructions; each DMC-ODS county had to then train its staff and providers to actively bill Medi-Cal accordingly and produce the data summarized in this chapter. Counties varied in terms of how up-to-date they were in meeting their billing and other data entry requirements, but they are all improving and the lag times are steadily narrowing.

The access-related data illustrate some important aspects of the DMC-ODS journey for counties and the clients they serve. Overall, there is a marked increase in the number of clients served, although some counties’ penetration rates show proportionately less provision of services to some subpopulations than others, indicating some opportunities for improvement. The utilization data show an expected increase in some services not previously covered, such as intensive outpatient and non-methadone MAT services.

The timeliness-related data are largely positive. Prior to the Waiver, many counties did not have the infrastructure to track timeliness. Most people who contact the new Access Call Centers seem able to do so without undue wait times or abandoned calls. According to the data, most callers appear to be offered timely first appointments. Those who follow through are receiving their first face-to-face sessions in a timely manner. Data, in particular, showed that those seeking methadone from NTPs received services in a timely manner. In contrast, somewhat lengthy wait times occur for clients to begin MAT with other addiction medications that were previously less common; their rollout is in early stages in most counties but growing steadily.

The Waiver strongly promotes client-centered care; California was innovative in developing measures for determining how frequently and effectively this approach is being implemented. Screeners and assessors referred a high percentage of their clients into types of treatment that matched what the ASAM criteria-based findings indicated.

Data suggest that the programs were effective in keeping clients engaged in treatment at early phases, although they were only able to retain them in treatment for moderate lengths of time. They transitioned a low percentage of clients from residential treatment to less-intensive outpatient treatment, leaving room for improvement. Programs used the TPS in common to learn and improve from clients about how they experienced their care; with few exceptions, the clients gave the programs high marks. See Section 7 on Client and Family Member (CFM) perceptions of SUD care for more details on the TPS ratings.

CalEQRO included in its quantitative measures several that focus on client outcomes. Claims data indicated that a low percentage of clients discharged from
residential WM are readmitted within 30 days, although there is variability among counties with some showing room to lower their readmission rates further. Through the TPS, clients attributed their improved ability to function to the treatment they received. Providers used the CalOMS Discharge Summary Form to rate more than half their clients as either completing treatment successfully or at least leaving with satisfactory progress. However, the county averages varied widely, with some showing considerable room for improvement.

Overall, the PM results are rich with information chronicling the substantial progress of these counties in developing accountable systems of accessible, client-centered care for clients with SUD. In the midst of a deadly opioid epidemic, these positive developments are especially noteworthy and give reasons to be hopeful for people suffering from these disorders, their families and caregivers, and the treatment systems seeking to serve them more effectively.
Section 3

Performance on Quality Management Key Components

Introduction

CalEQRO emphasizes the DMC-ODS counties’ use of data to promote quality and improve performance. The elements widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs.

In this section of the annual report, CalEQRO organizes these elements into three key components: 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 fully met, partially met, or not met, based on a set of criteria assigned to each. In addition to this quantitative designation, comments are included in the reports to provide context and a more complete picture of the issues linked to the quality measure.

This chapter includes the findings for the 14 counties’ DMC-ODS performance, structured by each key component and its respective subcomponents. For each subcomponent, CalEQRO provides a performance rating across all counties and a brief summary of assessed performance, along with any noteworthy accomplishments.
or challenge areas. As a result, the key component section findings reflect both quantifiable data and qualitative analysis.

At the end of each key component section, CalEQRO provides a brief summary pertaining to the three counties that are now in Year Two of providing Waiver services. This is to provide context for viewing the evolution of the DMC-ODS system of SUD care over time.

**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 clients and their family members. 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:

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

Subcomponent 1A emphasizes the extent to which the DMC-ODS county assesses, identifies, and implements strategies to address the clinical, cultural, or linguistic needs of the DMC beneficiary, a population known for its diversity. Generally, each DMC-ODS county conducted outreach and promoted the linkage of services to meet the needs of clients with linguistic or cultural needs. Activities to address service accessibility and availability, varied from sophisticated identification of underserved areas using geo-mapping, to new program sites in traditionally underserved areas, and efforts to hire and retain bilingual staff and provide programs in threshold languages such as Spanish.

Examples of prioritizing the need to ensure that services are reflective of cultural competence principles and practices include making the ethnic service manager a member of the leadership team and establishing an equity office or cultural advisory board that specifically provides input to the county, informing decisions on its continuum of care and barriers to access. Challenges in addressing cultural competency remain for three counties, with two ranked as Partially Met and one that did not meet the standard. These were characterized by only recent inclusion of cultural competency efforts,
lack of coordinated outreach or messaging, or treatment providers working toward basic standards such as recruiting bilingual staff or programming in threshold language(s). While the specific ratings varied, counties overall were moving towards a strong culturally and linguistically appropriate services (CLAS) framework. This core framework, which is described in counties’ Cultural Competency Plans (CCPs), is essential.

In addition, Nevada and Imperial counties have a Hispanic/Latino penetration rate well above the state average. The linguistic and cultural needs identified and addressed by those counties that have multiple threshold languages, such as San Diego and Los Angeles, are also very noteworthy.

Summary of Findings Subcomponent 1A in Year Two DMC-ODS Counties
While all the counties were rated as Met for this subcomponent in the first year of implementation, two of three were rated as Fully Met for this component in the second year of implementation. The county rated as Partially Met appeared challenged in fully realizing targeted service delivery, which was reflected in low penetration rates despite ongoing efforts to conduct outreach to diverse communities. While messaging efforts to these communities were profiled as favorable in the prior year’s report, the county had not instituted any mechanism to determine whether these activities were effective. In addition, the existing CCP did not have specific targets for the DMC-ODS separate from mental health. As a result, CalEQRO recommended initiatives directed at the SUD population along with formalizing treatment provider accountability to CLAS standards.

Subcomponent 1B: Manages and Adapts its Capacity to Meet SUD Client Service Needs
Subcomponent 1B emphasizes the extent to which the DMC-ODS county assesses, identifies, and implements strategies to ensure provision of the appropriate types and numbers of SUD staff that are necessary to meet the clinical, cultural, or linguistic service needs of the DMC beneficiary.

Generally, each DMC-ODS county had engaged in some form of system-wide review or capacity assessment, which often resulted in identification of demands for service found in specific areas of the county. Tools such as geo-mapping the location of residences for
current clients or that of existing county Medi-Cal beneficiaries helped inform DMC-ODS counties on potential pockets of need or validated the location of existing service providers. In addition, some counties also reviewed system capacity based on the ASAM criteria and the federal Managed Care Final Rule. This form of cross tabulating algorithm assisted in identification of service needs, with most counties noting service gaps specific to regions (both densely but most often sparsely populated). The use of timeliness data gave counties an indication of the need for shifting resources or expanding program hours or capacity. Small counties have been seeking nontraditional ways to create service capacity for the various LOCs. Imperial has had to overcome sparsely populated geographic factors along with funding limitations by instituting a centralized service model for most of its core outpatient programs. While these are located primarily in one large population center, the county sought agreements with out-of-county providers to secure the full range of services required under the Waiver.

Strategies included development of new program sites in regions of a county not traditionally served or expansion of bed capacity for WM, residential, outpatient, or youth treatment programs, including those that have bilingual capacity. As counties have developed the ASAM-based continuum of care with shorter residential stays, they have noted a high level of need for recovery residences or other housing options. This is especially the case for many counties that struggle in finding housing options for clients enrolled in nonresidential forms of care. As more clients have access to WM or residential treatment, there is a need for more post-acute treatment placements. This poses challenges for expanding recovery residences, which were noted in a variety of the DMC-ODS counties due to general housing costs, lack of available and affordable options, funding constraints, and neighborhood opposition. In an attempt to institute quality standards into the recovery beds it offers, San Diego’s DMC-ODS has fostered the creation of an owner-led Recovery Residence association, which includes application requirements to be eligible for county funding. This is an example of a best practice to be encouraged statewide.

Of note was the identification by several of the DMC-ODS that capacity may be expanded by adjusting the format of existing SUD programs. While San Francisco has a robust system of care, not all residential programs are able or willing to become part of the DMC-ODS. However, San Francisco County creatively worked with
providers to use this valuable residential space to create sober living and recovery residences to support the overall system of SUD care. In contrast, the influx of co-occurring disorder clients with more pronounced mental health needs has led to stepped-up training and the need for experienced clinical staff in Riverside County and other DMC-ODS as they introduce more specialized care for this traditionally unidentified, underserved population.

**Summary of Findings Subcomponent 1B**

Of the DMC-ODS counties reviewed this year, 86 percent of the counties were rated as Fully Met for this standard. Of note, for the two DMC-ODS counties that did not fully meet the standard, this was primarily due to the slow launch of its continuum and challenges in data collection and tracking. All of the DMC-ODS counties reviewed demonstrated that they are engaged in ongoing evaluation of service capacity needs as they continue to track network requests for service, service delays, or back-ups in key regions. Most have already identified and developed action plans to address these as part of expansion and refinement of their provider networks.

**Summary Subcomponent 1B in Year Two DMC-ODS Counties**

Analysis of first-year to second-year data for this subcomponent indicates significant improvement. In Year One, a single DMC-ODS county was rated as Fully Met, with 66 percent of DMC-ODS counties rated as Partially Met. In Year Two of services, only a single DMC-ODS county was rated as Partially Met, while 66 percent were rated as Fully Met. County RFPs and other access system responses to Year One capacity issues contributed to this shift in ratings.

**Subcomponent 1C: Integration and/or Collaboration with Community-Based Services to Improve SUD Treatment Access**

Subcomponent 1C emphasizes the extent to which the DMC-ODS county has adopted a model of integrated services with partner stakeholders and other public and private agencies to better serve the clinical, cultural, and other needs of its Medi-Cal beneficiaries. Given the complexity of associated functional and social service issues presented by the SUD population, an extension of service provision through collaborative partnerships in the community can directly benefit those in need of treatment.
Generally, all DMC-ODS counties have strong and historical collaborations with both community-based organizations and partner agencies through criminal justice or the FQHCs and health plans. Activities through these coordinated efforts included access points in EDs, specialty courts, or inmate services. Similarly, access improvement for those SUD clients needing MAT was enhanced by such coordination with the identification, assessment, induction, and follow-up of some DMC-ODS counties. In many medium-sized and larger counties, there were initiatives including funding by MHPs to increase the available pool of x-waivered physicians and linkage of those physicians to drug treatment services. This shared commitment to addressing the needs of clients addicted to opioid drugs was well supported in both Monterey County and Santa Cruz County, which share the same county organized health plan and have been disproportionately impacted by the opioid epidemic.

Prioritized use of collaborative models in larger counties, despite the inherent complexity, should be noted as one of the indicators of providing quality service. An example is the establishment of the San Francisco High Priority Case Review, which implemented an integrated response framework in order to better serve persons who are enrolled in multiple systems. Once identified, they are prioritized as a high-needs case by all the partners serving them.

Efforts to enhance or provide alternate venues for communication between SUD services and collaborators are also seen in DMC-ODS counties to avoid misunderstandings and better coordinate care. Of note is Monterey County’s DMC-ODS, where regular meetings are held at multiple levels of the county and provider network to identify problems and reach solutions. An example is the Change Agent meeting that includes provider line staff who offer suggestions on how to improve the new system. San Diego County also established a single point of contact for its justice partners, weekly trouble-shooting meetings, and a criminal justice override for cases where the court insisted on placements outside the LOC recommended by ASAM placement criteria, but efforts continue to engage the client in optimal SUD treatment options. In parallel, San Diego continued to educate the courts and tracked these override cases, finding that they are now diminishing in number and more closely match what is clinically indicated and optimally best for the clients.
Summary of Findings Subcomponent 1C
Analysis of this subcomponent by size indicated that medium and large DMC-ODS counties Met this standard, along with Los Angeles County. The county that had challenges was small and has struggled to maintain a full workforce or an adequate provider network. This county is under new agency leadership and due to its small size should benefit from the steps being taken toward more integration with mental health.

Summary Subcomponent 1C in Year Two DMC-ODS Counties
Analysis of year-over-year data for this subcomponent provides strong evidence of consistent attention. In Years One and Two, all three of the DMC-ODS counties were rated as Fully Met. Endemic to these Year Two Waiver counties is a well-established and comprehensive treatment continuum within the broader community, with meaningful and well-developed partnerships and collaborations.

Figure 3-1 below summaries all the counties based on their ratings for these access key components.

Figure 3-1: Access to Care Key Component Ratings
Key Component 2: Timeliness to Services

A full continuum of DMC service components with timely access is necessary to support optimal treatment and outcomes for SUD clients. The demonstrated ability of a DMC-ODS county to provide services in a timely manner ensures improved access, client retention, and consumer satisfaction, which are likely to lead to improved clinical outcomes. Motivation for challenging behavior change can fluctuate; being able to provide treatment on demand when motivation is high can result in an improved experience of care for the client.

The subcomponents of timely access listed below are reviewed in the broader context of submitted documents from the county and onsite discussions with stakeholders (such as line staff, managers, and participants in the CFM focus groups).

The following subcomponents comprised the timeliness key component.

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

This subcomponent emphasizes the extent a DMC-ODS county has established a methodology to collect data related to initial contact to first appointment and trends such data in order to positively impact wait times for service. An ability to track and trend first contact data across systems of care appeared to present challenges for certain counties, though most who contracted with a vendor to provide Access Line support use telephonic software and met this standard. However, use of the software was not universal, as some counties found the majority of clients continued to seek treatment at individual program sites and did not use the centralized phone access system. Coordination with clinics or providers to collect and track these data as well as return daily or weekly reporting so it could be entered into a shared database was challenging and in some cases was not consistently occurring.

The no-wrong-door approach also appeared be used more by clients in counties where local community awareness of SUD care was linked to specific provider treatment organizations and sites. For many community members with SUD, approaching a local provider known for SUD treatment felt more familiar than using an impersonal Access
Call Center line, based on feedback from client focus groups. However, this presents more challenges in capturing key data on services requests and referrals for treatment and assessment.

San Diego incorporated the Access Line mandate into its established Optum operated 24-hour mental health Access Line and screens all incoming clients for both their mental health and SUD needs with experienced clinicians. While clients can access care directly through the provider network, calls are consistently logged by contractors and reported back to Optum to be entered into a centralized database. San Diego is also planning development of a real-time vacancy and capacity interface to replace reports, allowing for more expedient placement determinations. San Diego County is an example of a best practice Access Call Center with solid system wide tracking system for access and timeliness.

Tracking and trending of timely requests for service have led to the identification of other issues, such as accuracy in the application of program resources or the variations found in existing protocols for access. In one DMC-ODS county where all incoming callers had been given an appointment, there was the unanticipated consequence of backlogged appointments. In several DMC-ODS counties, timeliness data were reviewed, and active steps were taken to address lag times in the assessment process. Several counties included the establishment of walk-in capability and intake group sessions, yielding the desired effect in improving prompt access to care (as documented in quarterly data provided through its QIC). Other improved systems used daily logs of beds and available intakes at the contract provider level. As the complex systems have begun implementation, these types of issues are being identified and addressed.

Another standout is Riverside County, which uses sophisticated call center software to track many types of data regarding caller access. The reports generated from these data are reviewed frequently for trends and performance. Access Call Center data are entered into Avatar EHR, nearly in real time, for linkage to track time to first face-to-face appointments. This is coupled with the deployment of a case manager, who coordinates with providers and clients to ensure they make their first appointment. Riverside County reports that the average time from initial request to first face-to-face session is 4.43 days and that 90.7 percent of those requesting treatment have their first face-to-face appointment within 10 days. This is a remarkable
achievement, as the call volume prior to the onset of the Waiver was under 250 per month and since the launch has routinely exceeded several thousand calls for service. Similarly, Nevada County reports meeting its established standard for first appointments within 14 days 97 percent of the time. Riverside County also moved the authorization of residential treatment admissions to the 24-hour Call Center to speed up rapid assessment and disposition of these requests.

Summary of Findings for Subcomponent 2A: Tracking from Initial Contact to First Face-to-Face Contact
Analysis of tracking initial contact to first face-to-face appointment found that many of the counties rated as only Partially Met and some as Not Met. CalEQRO found that larger counties had more challenges with this than smaller counties did. Despite technology limitations, the smaller counties have fewer numbers of clients and their providers made the most basic tracking capacity sufficient to meet client demand. Larger counties with significant numbers of contractors and fewer county-operated services experienced more challenges tracking activities of direct walk-ins and calls at the contract provider level. Counties attempted to set procedures to track these events, but often contractors were inconsistent in completing the requested documentation and/or submitting it promptly. Many recommendations were made related to these issues to enhance data capture and consistency in the next year of services.

Summary Subcomponent 2A in Year Two DMC-ODS Counties
The positive effects of a year of additional Waiver development activities were evident in this subcomponent, with improvements in all three counties. Marin County generated a Met rating in Year One and increased its tracking capability in Year Two. Riverside and San Mateo Counties were rated as Partially Met for this component in Year One; both were able to implement tracking processes that allowed increased reporting of data in Year Two. This allowed all counties to meet the goal of tracking initial contact request date to first face-to-face appointment. The increase in access and service data also allowed counties to track trends and address issues identified through that process. One important insight from the onsite reviews is the length of time it takes to fully build out the knowledge as well as the administrative and clinical systems to accomplish the Waiver’s goals. Based on experience so far, it is anticipated that it will take three to four years to see a fully established statewide SUD care system with needed infrastructure, managed care tools, and
workforces as new counties and communities are still stepping up to begin the process of implementing DMC care.

**Subcomponent 2B: Tracks Access Data from Initial Contact to First MAT/NTP Appointment**

DMC-ODS counties reviewed met this standard regarding the tracking and reporting of initial contact to first appointment for their contracted NTP providers. In most cases, methadone dosing had begun within a few days of that first contact, and NTP providers were tracking the time it takes to initiate medication as part of their contracts.

Tracking non-methadone forms of MAT is complicated by the different alternative access points for clients. DMC-certified outpatient clinics, DMC residential programs with incidental medical services, NTP sites, local FQHC clinics (ten are DMC-certified and many others are not), primary care physicians, psychiatrists in the MHPs, or as part of other DMC treatment programs such as intensive outpatient or partial hospitalization all serve as alternative access points for clients. With a myriad of relatively new Waiver-driven or grant-driven access points for MAT, there is expanded MAT access over Year One’s reviews, but all counties reported MAT billing data to be incomplete due to delays in billing, certification, or that it was primarily in the fee-for-service health system. In some cases, new providers are waiting for certification to bill retroactively.

Based on focus groups with clients and prescribers of MAT, there was ample evidence that MAT is being used and plans for expansion exist in all counties reviewed. At least two DMC-ODS counties are addressing some aspect of this subcomponent through a PIP. Also, NTP providers in San Diego have been engaged to provide training on all forms of MAT. Printed information (including intake documents) are used to educate clients about non-methadone forms of MAT as well as methadone. A PIP in San Francisco is expanding MAT in a co-occurring disorders program and another is linked to their seven NTP providers, which will allow for more non-methadone MAT and the capacity and skills to bill for these services.

Available claims data shows evidence of modest movement toward adoption of non-methadone forms of MAT in Monterey County and Santa Cruz County, which share the same County Organized Health Plan (the Central California Alliance for Health). The Alliance provided information on its coordinated support to increase MAT through
strategies such as incentivizing their primary care physicians and mental health contract providers to become x-waivered and also adding financial rate incentives to encourage them to see and induct qualified patients on to MAT. In Santa Cruz County, hiring an experienced NTP employee by an FQHC ensures care coordination of MAT inductees with the DMC-ODS county and the full system of care options. The Alliance, with DMC support, also has established a MAT advisory group for prescribers. This group provides clinical consultation by connecting new waivered staff able with more experienced MAT providers. In each of these DMC-ODS counties, the discussions with health partners continues on how to overcome data-sharing limitations. In one small DMC-ODS county, new formalized protocols with its FQHC partner are expected to allow capture of relevant data to better meet this standard for coordination of care.

An excellent example of client-friendly access to MAT is the San Francisco Office-based Buprenorphine Induction Clinic (OBIC), which is located in the same building as a pharmacy that can provide induction for buprenorphine to clients and assist them as they transition to ongoing comprehensive SUD care. Methadone services are also available at this site, which is in the same building as their Behavioral Health Access Center (BHAC) and Treatment Access Program (TAP) staff for SUD clients. Clients and clinical staff praised this OBIC and the model of pharmacy support as ideal for helping with MAT access and treatment. The San Francisco standard for time to a MAT appointment is three days and this standard is met close to 100 percent of the time.

Summary of Findings for Subcomponent 2B Time to First MAT Appointment
CalEQRO found that a variety of factors affected counties’ ability to meet or be challenged by this timeliness subcomponent, particularly for non-methadone MAT. The most obvious appeared to be data sharing, complicated by differing electronic systems and persistent challenges presented by federal confidentiality rules. Claims data utilized by CalEQRO were incomplete at best because many of the MAT access points were outside the purview of DMC-ODS, with the claims data in the fee-for-service billing system and not visible. Efforts via PIPs and expansion strategies should continue to show progress in the DMC-claimed MAT, both methadone and non-methadone.

While each of the DMC-ODS counties demonstrated a full commitment to increasing both methadone and alternate forms of
MAT, some specific challenges were noted. One of the small DMC-ODS counties has no local NTP provider, with beneficiaries obtaining methadone in an adjacent county. However, this county does have an effective and expanding non-methadone MAT program at the county-operated FQHC clinic. This access point shows the strong alliance the DMC-ODS has established with many local FQHCs, some of which are billing through the DMC-ODS.

Summary Subcomponent 2B in Year Two DMC-ODS Counties
While two of the counties were rated as only Partially Met for this component in Year One, all three of the counties were rated as Met in Year Two. The two counties that met this component for the first time in Year Two are tracking and trending data from first contact to first NTP/MAT dose. This allows all counties in Year Two to analyze the data and to address issues that are discovered through this process. The DMC-ODS non-methadone MAT services are slowly ramping up, as can be expected of a new program requiring medical expertise and knowledge of SUD treatment. The DMC counties’ tracking continues to identify issues and solutions that are developed to address tracking concerns, many of which involve programming linked to their practice management and EHR products.

Subcomponent 2C: Tracks Access Data for Timely Appointments for Urgent Conditions
Many of the counties that were reviewed have not yet fully implemented tracking systems and operationally clear definitions for urgent conditions. Many delayed these efforts to their second year of services or recently established urgent appointment tracking and procedures, except in the Access Call Centers. Where a clear operational definition of an urgent condition exists, there may yet be discussion or review pending a reasonable set of clear procedures. Many counties feel there is a need for unique procedures depending on the type of urgent request presented. Where some parts of the system (such as Access Call Centers) may have a standard for urgent appointment requests and track them, other parts of the SUD care system (e.g., those with walk-ins or client requests by phone) have yet to incorporate clear urgent appointment procedures into their workflows. Provider sites strongly encourage staff to use clinical judgement, so clients’ needs are addressed (even when there is no clear definition), but many of the contract agencies did not have the capacity to flag requests or referrals as urgent within their data systems, other than in narrative clinical notes if they used an EHR.
Difficulties in tracking and trending may be complicated by lack of software or incomplete data tracking capacity; many IT systems can only track by day, not by hour. Variance in the urgent definition appears to be based on confusion as to what if any parameters their system will be held to. Several trends have emerged with these urgent definitions: client self-defined as urgent (no matter what the request), referrals with hospitals and EDs, clients in medical distress due to withdrawal, pregnant women, and those discharged with WM or residential referrals. The variability in clinical presentation makes it hard to track from a data perspective, as well as for training staff at all sites where clients might present or call.

While continuing to develop its EHR’s capability to track timeliness, San Diego County developed an urgent tracking system and reasonable standard that others may consider implementing. A request for service is deemed urgent based on what the client perceives to be urgent but is also clinically informed within specific parameters. Calls are designated as urgent if the client relates non-life-threatening conditions that would benefit from an expedited response; these clients are offered an appointment within 24 to 48 hours. Since the San Diego Access Care Line is also designated as a behavioral health crisis line, incoming calls are given the same priority as 911. If needs arise during calls to the Access Care Line, there are qualified clinical staff available 24 hours per day to triage them accordingly.

To address timely appointments for urgent conditions, Nevada County sends designated SUD staff to interact with outgoing clients in the local ED, hospital, and jail, which positively affected timely access for urgent care requests. Monterey County uses a similar client-driven definition of urgent with clinical review, similar to San Diego’s approach. Monterey County, Riverside County, and San Mateo County have worked with an IT contractor to enhance the capacity of their Avatar systems to capture more of the data needed for managed care operations. These IT enhancement needs were frequently discussed on review and were not limited to the Avatar software.
Summary of Findings for Subcomponent 2C Timeliness for Urgent Requests for Services
This subcomponent illustrates the implementation of new standards in the Waiver for new and expanded SUD services. Tracking of urgent condition timeliness was the subcomponent with the highest number of DMC-ODS counties rated as Not Met. Six of the total review cohort of 14 did not meet this standard, but all were working on it via tracking or definition refinement and training. The most common challenges noted were lack of clear urgent condition definitions to track and train, the inability of IT systems to track this type of service request, and in some cases both. All counties reviewed were responsive to the onsite requests of CalEQRO to define a standard and take active steps to track progress. This was a common recommendation for improvement.

Summary Subcomponent 2C in Year Two DMC-ODS Counties
The results for both years were the same for Marin, San Mateo, and Riverside.: 66 percent were rated as Met and 33 percent as Not Met. In Year One, San Mateo County and Riverside County had developed definitions of an urgent condition. San Mateo County tracked urgent appointments but referred to providers who did not track them. As a result, they worked with their software vendor to develop a better tracking system. In the second year, ongoing work with the vendor for tracking continued, but the software upgrades had not been completed. Riverside County was tracking urgent conditions in both years, but the response times did not meet the expectations for an urgent condition. Marin County did not track timeliness for urgent conditions in its start-up year but has defined them and begun tracking in Year Two. However, they have not yet analyzed the results of the data tracking. These counties were aware of the importance of urgent request tracking and were all working to address barriers to timeliness, consistent tracking, and training of staff to use these definitions.
Subcomponent 2D: Tracks Timely Access to Follow-Up Appointments/Care After Discharge from Residential Treatment

This subcomponent emphasizes the importance of treatment across the LOCs by trending timely follow-up appointments from one LOC to another within the DMC-ODS county. While there is consistent attention paid to the 7-day best practice standard and attempts to track treatment at lower LOC, some counties have not been able to fully implement all the necessary elements of these data in the billing system because not all the aftercare services are being billed. At present, tracking and trending across most counties show between 10 and 30 percent of client transitions occurring within the prescribed timeline. (For more details on this measure, see Section 2 on PM data.)

These levels of aftercare treatment could also suggest that mechanisms for capturing the post-residential transitions and follow-up appointments are not in place, leading to the impression that discharge planning needs improvement. Modest evidence of meeting this standard in the available claims data may also have more to do with low billing rates as opposed to poor performance. This measurement also includes clients who left within the first 10 days of residential treatment and were not ready to commit to treatment and abstinence. This can account for as many as 35 percent of the admissions to residential treatment. Those who leave residential treatment early are a difficult group to engage in other treatment, when the severity of the SUD diagnosis indicated they needed residential care and treatment to address their SUD condition.

County analyses of this performance metric has led to most counties attempting to address this timeliness standard. They have done so by adding post-residential efforts to a PIP, stepping up monitoring of data entry and integrity, and proposing improvements to their information systems to better capture transitions of care and appointments. To increase adherence along with more successful tracking of follow-up services (both billed and unbilled), some counties are enhancing quality review protocols to ensure they are not losing clients in transition. For example, Monterey County increased monitoring of client medical records (both paper and electronic) specific to the presence of a documented discharge or transition plan as clients leave the program.
Of note, San Mateo County and Marin County deploy recovery coaches to act as care coordinators in order to provide assistance in linking clients to treatment and other services as part of discharge planning. In order to determine the efficacy of this approach, they have made this into a non-clinical PIP. Separately, a San Mateo County DMC-ODS Senior Program Associate tracks transitions of clients manually from residential treatment to other types of treatment.

Riverside County has a central case management system in addition to transition activities undertaken by its contract providers. Case managers are assigned at admission and track support and transition needs of clients over time at all LOCs. They are also able to establish effective and ongoing therapeutic alliances with the clients, which was highlighted in CFM focus groups as an important clinical and life skill support appreciated by the clients. This approach has many benefits, as discussed in Section 4 Evolution of the SUD system of the report.

Summary of Findings for Subcomponent 2D
Both large and very large DMC-ODS counties were rated as Fully Met for this subcomponent, likely owing to the robust nature of their databases, reporting capabilities, and enhancement of software that allowed for more consistent tracking and trending. In one large county, assigning clients by functional status allowed for a high level of post-residential and WM placement for those deemed acute enough to participate in a PIP project that enhanced resources for care coordination. Medium and small counties that rated as either Partially Met or Not Met might consider working with their IT managers or software vendors to add fields that allow computerized tracking of the timeliness with which clients transition out of residential treatment to other LOCs.

Summary Subcomponent 2D in Year Two DMC-ODS Counties
All counties in Year One rated as fully Met for this subcomponent in Year One and continued to do so in Year Two. San Mateo County initially met this component with manual tracking, but in Year Two was able to do so in their EHR. Riverside County used a PIP to focus on strategies that would increase the percent of clients who would reach follow-up services within seven days. Marin County and San Mateo County track this data and also use staff who are deployed to assist clients to connect to their next treatment after completing residential treatment.
Subcomponent 2E: Tracks Data on Re-Admissions to Withdrawal Management Within 30 Days

Tracking and trending of recidivistic admissions within 30 days of discharge from WM demonstrated a high proportion of DMC-ODS counties who Met this standard. The subcomponent is critical to demonstrating that while an important initial step, detoxification from substances does not, by itself, necessarily result in long-term benefits for those who successfully complete it. Counties need to develop a system to track admissions to other forms of care post-detoxification to avoid relapse and the need for a quick readmission.

Lack of a licensed provider under the purview of one DMC-ODS county was stated as the reason for not tracking these data, though they anticipated developing a system to do so once a new residential/WM provider begins to provide DMC-billable services. DMC-ODS counties that track readmissions electronically also noted proactive involvement of staff who act as care coordinators, assuring linkage and follow-up to treatment providers and thereby averting the need to return for WM. Monterey County, for example, tracks readmissions through its EHR to determine the number of clients with readmissions within 30 days. Additional post-WM discharge supports through either a proposed or active PIP are being tried in at least three of the reviewed DMC-ODS counties, with interventions that include case management strategies along with documentation of specified follow-up efforts. Counties that lack local programs and contract with out-of-county providers have an added layer of difficulty in tracking and trending readmissions. While some DMC-ODS counties such as Nevada County track the discharges, no clients have sought enrollment after residential WM to other LOCs this past year (even though this would be beneficial), so they are planning more case management to encourage engagement. Imperial County hopes to improve linkages in a timely fashion as they institute a PIP that will introduce case management to arrange more expedient access to the next LOC.

Of note, Riverside County reported that 3.3 percent of its residential WM clients are readmitted into WM within 30 days of discharge. This is approximately half the rate for the combined average of all DMC-ODS counties statewide. The lower readmission rate supports the focus on case management follow-ups after discharge from residential WM and the impact of the clinical PIP interventions to link clients into treatment.
Summary of Findings for Subcomponent 2E
Analysis shows that the tracking and trending of readmissions within 30 days of WM was generally rated as Met. Of the counties that were rated as Not Met or Partially Met, the challenges appeared to be related to either lacking a formal mechanism to track or trend, or a local provider within the DMC-ODS county’s network. In both cases, raising visibility and enhancing post-detoxification supports were deemed priorities by the DMC-ODS.

Summary Subcomponent 2E in Year Two DMC-ODS Counties
All counties that were rated as Fully Met were tracking readmissions to WM in both their first and second years of services. This is an area of focus for counties that are all tracking the data through their data systems. Marin County and San Mateo County also deploy outreach staff to enhance care coordination. Riverside County has focused intensively on this issue, resulting in a very low WM readmission rate.

Subcomponent 2F: Tracks and Trends No-Shows
Tracking and trending no-shows to scheduled appointments is not a requirement of the STCs, but is a best practice for clinical care. All the DMC-ODS counties with legacy computer systems experienced challenges tracking no-shows, particularly for field-based services. Tracking no-shows illustrates the developmental process required to create and implement new managed care tracking capacity. Knowledge of no-show trends alerts DMC-ODS counties to problem areas that some programs may have with engaging clients. While many were tracking for one program type (such as outpatient or NTP), they were not doing so for other forms of care within their continuum. While NTP appointment status may be tracked, tracking no-shows for other forms of MAT scheduling was not within the capability of most DMC-ODS counties at this time.

Most often, the difficulty stemmed from fragmented or early roll-out of the data systems’ capacity to support DMC-ODS counties, which led to the inability to electronically capture the no-show data. Counties such as Marin, San Mateo, San Francisco, and Santa Clara all have plans for developing and installing software updates that would allow providers to begin entering no-show data alongside completed visit data.

Summary of Findings for Subcomponent 2F
Analysis of this subcomponent revealed the lowest proportion of DMC-ODS counties meeting this standard. Regardless of size, no
county was rated as Fully Met. No DMC-ODS currently is able to systematically collect no-show data across its diverse network of providers, which requires detailed scheduling software and an ability to integrate it centrally, by program type and site. Over time, this information may be standardized across the continuum of program providers. For now, however, this challenge reflects system wide electronic implementation issues due to an early phase of development.

Summary Subcomponent 2F in Year Two DMC-ODS Counties
All counties were rated as Not Met for this component in their first year of services. In their second year, 33 percent of the counties were rated as Partially Met, while the remaining 66 percent continued to be rated as Not Met. Riverside County was rated as Partially Met for this subcomponent by tracking no-shows for clients receiving MAT outpatient visit services. Marin County and San Mateo County continue to work with their IT vendors and provider networks to set up a system to track of no-shows. Marin County has data fields installed and expects providers to begin using this tracking system by the beginning of its next year of implementation.

Figure 3-2 below summaries all the counties based on their ratings for these timeliness key components.

Figure 3-2: Timeliness to Services Key Component Ratings
Key Component 3: Quality of SUD 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 working in information systems, 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 following subcomponents comprised the quality of care key component.

Subcomponent 3A: Quality Management and Performance Improvement are Organizational Priorities

Given that most of the DMC-ODS counties reviewed in this cohort were in their first year of services implementation each county made quality management a priority. This is clearly evident in their QI improvement plans (QIPs). In most counties, these plans identify and address DMC compliance issues and Waiver requirements pertaining to performance measures, billing, or documentation, but they also included several quality initiatives specific to the SUD population. For DMC-ODS counties that experienced significant change (e.g., staff turnover in leadership or QI management), a shared QI plan with mental health led to a limited set of integrated key initiatives. Some of these key initiatives included outreach to Latino populations and special prevention and outreach efforts to faith communities related to the access line, service information in Spanish, ads on Spanish radio, and other youth materials. However, in these integrated plans, it was difficult to determine which initiatives applied specifically to SUD. CalEQRO recommended revisions to integrated plans to focus more on quality issues affecting DMC-ODS populations and programs.

Excellent examples of QIPs whether integrated or separate from mental health, included a description of how the DMC-ODS would structure its change model, QIC meetings that are structured to monitor progress in meeting the QIP objectives, and evidence of data being used for decision making and evaluation of change efforts. Large counties such as Riverside, San Diego, San Francisco, Santa Clara, and Los Angeles (which is a Very Large county) varied in terms
of whether their plans were integrated or separate, shared these essential elements. They offered examples of how work from the QIP affected their decision making and would support future initiatives. Riverside County and San Francisco County, with integrated QIPs, had SUD initiatives on equal footing with mental health, with clearly written and measurable goals and objectives. Communication of data from the QI efforts in San Diego County are visually represented to target audiences in ways that ensure easy comprehension and accountability. Santa Clara County, which also met these standards, authored a QIP separate from mental health and was identified by CalEQRO as an example to be used when training other counties for completeness and adherence to ASAM principles of care.

Summary of Findings for Subcomponent 3A
The subcomponent indicating quality management and performance improvement as an organizational priority resulted in 100 percent of large and very large counties rated as Fully Met for this subcomponent. While small counties were rated as Partially Met, 80 percent of the medium counties were rated as Met. Changes in leadership, quality management staff, and the inherent complexity of an integrated or stand-alone QIP were potential barriers to performance, but county efforts to deliver DMC-ODS services on the whole continued to validate a strong commitment to quality.

Summary Subcomponent 3A in Year Two DMC-ODS Counties
Analysis of year-over-year data for this subcomponent provides strong evidence of consistent attention to this subcomponent. In the first and second years of DMC-ODS implementation, Riverside County, San Mateo County, and Marin County were rated as Met. Well-defined QI initiatives and data-guided decision making appears to be endemic to these initial launch counties. Each has grown or made use of its own well-established evaluation resources or leveraged relationships with academia, as well as demonstrating an ongoing commitment to QI.

Subcomponent 3B: Data Are Used to Inform Management and Guide Decisions
Subcomponent 3B evaluates the extent to which the DMC-ODS QI functions serve to collect, analyze, and provide data to identify good practices, explain patterns of care, and identify issues in the provision of care that help management determine priority areas for improvement. Generally, DMC-ODS counties reviewed showed an
understanding of the necessary strong collaborations required to support these functions. In most cases, data collection and reporting pertaining to quality and outcomes are in place. Regular review and reporting of data have been used to gauge quality and effectiveness in DMC-ODS counties that have been rated as Met for this subcomponent. For those that were rated as Partially Met or Not Met, challenges included changes in quality management leadership, organizational restructuring that has reduced in-house analytic capacity, and difficulties securing credible data due to adherence issues with clinical and contractor staff regarding data collection protocols. Some counties that used data to aid in management decisions could benefit from increasing stakeholder input or adding specific tools such as data visualization software to help communicate data findings. As noted in the ISCA section (Section 7), analytics staffing enhancements are needed in many counties to optimize the data systems they currently have to make quality-related decisions.

Monterey County enhanced analytics staffing by adding an epidemiologist to its QI team to assist with data analysis. Data are posted on each program’s web page, with detailed program outcomes shown across the system of care. DMC-ODS counties that invested in or established relationships with research and evaluation entities (such as Riverside County and San Diego County) have shown how data-driven decisions influence the quality of care, along with addressing capacity and application of system resources. Likewise, Los Angeles County and Santa Clara County provided examples of how data are being used to improve care by enhancing SUD treatment and operations.

Summary of Findings for Subcomponent 3B
The counties meeting standards for this subcomponent continue to be primarily large ones. Small and medium counties faced more challenges, due to more limited resources. In addition to the challenges previously noted, the technical ability to systematically extract and report on findings, along with analytic capacity, posed barriers to the DMC-ODS in counties that did not fully meet criteria for this subcomponent. Given the system wide effort and resources required to fully institute measurable and meaningful data findings comprehensive enough to guide a system, larger DMC-ODS counties likely benefit from prior commitment to data systems, financial resources for quality management, and their established relationships with local evaluation or academic institutions.
Subcomponent 3C: Evidence of Effective Communication from DMC-ODS Administration, and Stakeholder Input on System Planning and Implementation

Subcomponent 3C evaluates the extent to which there is a consistent and formal process for the DMC to communicate with stakeholders and obtain input into the planning and delivery of services. Most DMC-ODS counties continued to sustain levels of communication necessitated by the planning for Waiver implementation. This is evidenced by regular scheduled meetings, workgroups, or forums for input across most DMC-ODS counties reviewed. In focus groups conducted with consumers and staff, CalEQRO heard that communication was sought and considered and that the open nature of communication helped to improve problem-solving and mitigate some of the uneasiness about the many system changes due to the Waiver. In some cases, subcommittees or stakeholder advisory groups were designed to provide formal input to the DMC-ODS county, such as in Imperial County. In the best of such relationships, mutual respect and a sense of being a full partner were expressed. In DMC-ODS counties challenged by the immense changes required by the Waiver on providers, staff expressed frustration, reported inconsistent messaging from the county, and noted change fatigue.

Santa Clara County established an Innovative Partnership meeting, which creates a venue for communication with its contract providers and staff to regularly meet, confer, and problem solve. Los Angeles County has numerous channels for communication with its provider network, stakeholders from other departments and the MHPs, as well as CFMs, including a new Provider Advisory Board established in 2019 to allow for high-level decision making related to management of the network and services overall. Given the scope and size of Los Angeles County's 351 sites serving persons with SUD, many different mechanisms for communication are being identified, used, and enhanced.

Summary of Findings for Subcomponent 3C

While not the highest-rated of the subcomponents, all DMC-ODS counties were rated at Met or Partially Met. Overall, 71 percent of all counties were rated as Met. The large counties had the most challenges, as indicated by 40 percent rated as Partially Met. Both leadership teams and other stakeholders consistently noted the importance of ongoing communication.
Summary Subcomponent 3C in Year Two DMC-ODS Counties
All three of the DMC-ODS counties were rated as Met in communication with stakeholders and providers. Consistent themes of working with providers, community-based organizations, and other allied care providers were noted both in results from DMC-ODS counties as well focus groups and sessions conducted onsite by CalEQRO. Active and alternate forums for communication appeared to play a role as each of these initial launch counties appeared to welcome and incorporate feedback and involvement of stakeholders.

Subcomponent 3D: Evidence of a Systematic ASAM SUD Continuum of Care
Subcomponent 3D evaluates the extent to which the DMC-ODS county established a system of care that includes a required spectrum of services necessary to address the individual treatment needs according to ASAM placement criteria and denoted by the Waiver. Strong evidence suggests that DMC-ODS counties had implemented using the ASAM criteria for individualized placement and treatment planning. This was most often illustrated by various systems to document and track LOC determinations subsequent to assessments conducted or overseen by qualified LPHAs. In some DMC-ODS counties, data tracking or reporting of such determinations were affected by manual tracking, limits to the existing data system or EHR, and the degree of emphasis or resources available for care coordination. Tracking transitions across the continuum also presented challenges depending on EHR capabilities, with constraints often noted in partially implemented EHRs.

Strong congruence with the ASAM Continuum of Care LOC and principles were documented in the vast majority of DMC-ODS counties. Several early counties benefited from early adoption of the ASAM criteria in assessment and placement that preceded the Waiver. Los Angeles County demonstrated a commitment to individualized placement and treatment planning by use of Continuum software to conduct comprehensive assessments. Continuum allows the DMC-ODS county to track numerous issues on the resulting client profile and thus accurately determine the needs of those entering services. Los Angeles County, like several other Waiver counties, has continued to work with nationally recognized ASAM experts to enhance the skills of clinicians as well as client care and outcomes with training and consultation. Finally, each county reviewed available assessment and placement data to help detect any apparent client
and capacity needs to expand services in the continuum of care. Numerous RFPs were in process to expand services and LOCs with new or existing providers.

Summary of Findings for Subcomponent 3D
An analysis of the continuum of care subcomponent shows that most DMC-ODS counties were rated as Met. A small DMC-ODS county did not successfully meet criteria because it was unable to secure the mandated continuum of services. Significant effort has been undertaken by this DMC-ODS county in the months since the review to remediate this issue. It has opened new LOCs or secured regionally based contracts to be able to offer beneficiaries a more complete range of treatment options. Most DMC-ODS counties are engaged in actions to ensure adherence to the ASAM criteria in placement and secure necessary service levels accordingly.

Summary Subcomponent 3D in Year Two DMC-ODS Counties
Analysis of year-over-year data shows a shift upward for ASAM fidelity. In Year One, 66 percent of the DMC-ODS were rated as Met. In Year Two, 100 percent have been rated as Met. Addressing issues that pertained primarily to LOC gaps in their network’s accounts for the improved rating.

Subcomponent 3E: MAT Services (Both Outpatient and NTP) Exist to Enhance Wellness and Recovery
Subcomponent 3E evaluates the extent to which clients have access to and support for using MAT, including non-methadone forms. Most of the DMC-ODS counties demonstrated overall access improvement and adoption of the use of MAT, including non-methadone forms. Most counties reviewed shared more integration of NTP providers and their clients in their continuum of care, which has enhanced communication and understanding of the benefits of MAT. Additionally, NTP providers are now offering non-methadone forms of MAT, with some DMC-ODS counties also using them to provide in-service training to staff on the value of all MAT.

Expanded use of MAT frequently involves the local health plan and primary care clinics, which often support training and reimbursement incentives to assure that primary care physicians are screening for SUD and providing MAT when clinically appropriate. Several DMC-ODS counties also participate in ED Bridge Project through MAT expansion grants that target identified medical facilities and work
collaboratively to provide linkage of newly initiated MAT clients to SUD services. San Diego’s County’s DMC-ODS program provides educational materials, physician training, and an ED tool kit to help foster use of SUD services and MAT.

While much anecdotal information was provided by individual DMC-ODS, a challenge persists in representing these efforts through data or billing claims. Despite the general acceptance of MAT as part of the DMC-ODS continuum, stigma also persists. In one county, participants in a CalEQRO focus group for women with children described that despite their success using MAT, they now felt compelled to discontinue it due to a local recovery residences refusing to take clients on MAT. Recovery residences, sometimes called sober living homes, have been the most resistant to including persons on MAT in those living environments.

Some outpatient programs (such as those in Imperial) already have medical staff who identify, assess, and prescribe medications. Working with the local FQHC MAT unit that shares the same county campus location, Napa County has assigned staff to identify, assess, refer and follow up with the unit to provide an integrated support model.

Santa Clara County has excellent medical leadership with three key physicians staffing the county-run NTP and MAT outpatient services. They are working with others to expand MAT and have already made it a mobile service with visits and medications for residential settings. Expansion into detention is expected next year, which would include induction and maintenance on medications. Los Angeles County’s Substance Abuse Prevention and Control (SAPC) has a master plan to expand MAT within the county and has approximately 1,000 physicians to support prescribing of buprenorphine and other medications. The Medical Director for Los Angeles County and other leaders are carrying the message of MAT to the larger health care system and the community. Los Angeles County’s efforts are increasing physician prescribers through new policies, training, consultation, and partnerships with other departments, including detention medical services, the Homeless Authority, and Whole Person Care program services.

San Francisco County has historically done a lot of work to successfully reduce the stigma for methadone and other MAT in SUD services. Staff and clients validated this in CalEQRO focus groups.
reporting that medication is accepted in all programs and clients are free to choose what works best for them.

**Summary of Findings for Subcomponent 3E**
Analysis of the MAT services subcomponent indicated that the majority of all DMC-ODS counties were rated as Met. Strong medical leadership, MAT education, long-term relationships with local NTP providers, and working collaboratively with health plans and FQHCs were consistent themes among those DMC-ODS that have made meaningful strides in expanding MAT access.

**Summary Subcomponent 3E in Year Two DMC-ODS Counties**
Analysis of year-over-year data provides strong evidence of consistent attention to access to MAT. In Year One reviews, 66 percent of the DMC-ODS counties were rated as Met. In Year Two, all three of the DMC-ODS Met this rating. It is clear that each of the three initial counties embraced the use of MAT in all forms and expanded non-methadone access portals. Prescriber education on the value of MAT and participation in a Hub and Spoke grant activities were part of this positive movement.

**Subcomponent 3F: ASAM Training and Fidelity to Core Principles is Evident in Programs within the Continuum of Care**
Subcomponent 3F evaluates the which ASAM treatment principles are used and supported, as evidenced by training along with adoption of client-centered care, LOC placement patterns, and the extent to which ongoing evaluation is done to measure client response to treatment and need for treatment intervention adjustments in participating counties. Very strong evidence was shared showing that DMC-ODS counties train and monitor care to the core principles of the ASAM practice recommendations. This is consistently seen in the early DMC-ODS counties through an adoption of ASAM that often preceded the local implementation of the Waiver, in some cases by years.

Training cycles that include both web-based curricula as well as hands-on, in-person training by national experts (including David Mee-Lee, the co-author of ASAM) were in place in many counties. In most cases, staff training is recurrent and reinforced by quality management efforts, clinical guidance, group or individual
supervisions, use of champions to lead clinic efforts, and policy changes leading to complete adoption of ASAM principles.

Overcoming old placement scenarios, including those from large referral sources such as the court system, has presented challenges for some DMC-ODS counties still hesitant to drop court-related residential determinations. Good examples are found in Santa Cruz County, San Mateo County, and San Diego County, all of which have targeted efforts to improve communication and educate justice partners. In some cases, a specific court liaison is assigned as the single point of contact to help solve problems through weekly or daily communication about individuals with SUD before the courts.

Program providers who had their own format for assessment and were able to make unilateral admission determinations in the past have, in some cases, struggled to accept this new standard (though it appears most have adopted it). Most contract providers report being more challenged by the number and complexity of Waiver requirements that impacted client care, such as documentation required to meet DMC-ODS standards.

Amongst DMC-ODS counties rated as Met for this subcomponent, such as Nevada County, many instituted periodic quality monitoring of ASAM-based placement criteria. This reinforces adherence to individualized care parameters. In addition, those who screen or assess clients and refer for treatment are trained to enter the required data into DHCS’ ASAM LOC Referral spreadsheet. Data analytic staff then conduct periodic analyses and generate reports on the degree of concordance between ASAM-based indications for LOC placement and actual referrals, with an accompanying analysis of the reasons for the discordances, when applicable. Incremental adoption of changes in the years leading up to the launch of DMC-ODS treatment as initiated in Marin County may have helped avoid change fatigue—a common complaint heard during facilitated CalEQRO interviews.

At the core of ASAM criteria are the principles of client-centered care, with treatment individually tailored to address the changing needs of each client over time. In addition, ASAM encourages a “no blame” approach to treatment and working with relapse as a learning experience as well as ensuring access to all beneficial treatments, including MAT in appropriate. Thus, DMC-ODS counties have made policy changes to encourage treatment programs to accept clients who need MAT, continue seeking ways to work with clients who have
relapsed, or temporarily transfer them to a more intensive LOC (such as WM) rather than summarily terminating them from treatment, and seek ways to keep clients engaged and working towards recovery.

**Summary of Findings for Subcomponent 3F**

Analyses indicates that those DMC-ODS with extensive experience, training, and orientation to the ASAM treatment models and criteria have achieved significant success in adopting these parameters. Many had begun using ASAM criteria prior to the Waiver’s onset in their counties. The majority of DMC-ODS demonstrated commitment in adopting these requirements, earning a rating of Met, while the remaining counties also achieved a Partially Met rating.

**Summary Subcomponent 3F in Year Two DMC-ODS Counties**

Analysis of two years of data provides strong evidence of consistent attention to ASAM criteria, with all three of the DMC-ODS counties rated as Met in both years. All three of the initial Waiver launch counties trained as well as monitored fidelity in their adoption of ASAM criteria. They had made significant strides in adjusting to a client-centered treatment program model, allowing for the shift to clinically indicated care. Well established systems of clinical oversight and guidance and support of staff by way of quality management reinforced these changes and provided a foundation for success.

**Subcomponent 3G: Measures Treatment and/or Functional Outcomes of Clients Served**

Subcomponent 3G evaluates the extent to which quality management of a DMC-ODS county is tracking and analyzing client-level outcome data on a system-wide basis. Most of the DMC-ODS counties are collecting data to report on client outcomes but remain hampered by the software for generating reports and analysis. Persistent challenges include staff skills in using the CalOMS dataset, TPS, and mechanisms for extracting data from their data systems. In relation to the CalOMS dataset, most DMC-ODS counties have relied heavily on reports formerly available through the DHCS system, which is currently in transition and not accessible. Relying on their own capability and resources to modify their CalOMS data has not proven to be very successful, particularly for small counties. DHCS is working to restore some of the state-generated reports for CalOMS. Without an access portal to standardized reports, many of the DMC-ODS counties will continue to struggle in this area due to a lack of local
knowledge or capacity to modify systems, limited analytic staff resources, and competing priorities.

Counties such as Marin and San Francisco made staff training on CalOMS and other data collection a priority, while others have attempted to strategically target, monitor, and address data quality issues through PIPs. Napa County addresses its CalOMS administrative discharge issues by instituting a workflow protocol requiring staff to consult with a clinical supervisor in order to secure approval prior to release of a client file with an administrative discharge. Marin makes strong efforts to meet with clients near the time they are expected to leave treatment to obtain discharge status information and help clients with their next steps in recovery, whether that turns out to be another level of treatment or recovery support services. Marin County’s rate of administrative discharges, when clients leave abruptly without notice with no opportunity for follow-up, was 12 percent, which was considerably lower than the statewide average of 39.4 percent for all DMC-ODS counties combined. This percentage was also much lower than the 25 percent administrative discharge rate at the time of the CalEQRO review the previous year, demonstrating a commitment to continued improvement. Marin County staff train each provider, whether county or contracted, in how to complete the CalOMS ratings. Marin County analyzes the data and uses it to measure outcomes regarding housing and employment status, use of drug-free social support activities, and overall progress in treatment. The system in place related to CalOMS data in Marin County should be considered a best practice for obtaining meaningful outcome data from this source.

Alternate quality indicators provided by the TPS are being used by DMC-ODS counties as well. Santa Clara County uses the client self-report ratings on the TPS to determine treatment effectiveness. One of the PIPs developed in Santa Clara County expands use of the TPS to measure the client’s experience of care and administers it at the fourth visit to measure therapeutic alliance, whether the client feels culturally respected, and whether the services are having a positive impact. Likewise, San Diego County uses client self-report ratings on the TPS outcome-related items to determine treatment effectiveness. San Diego County provided CalEQRO with reports based upon the TPS rating results that had been used to discuss findings with its providers, leadership, and advisory board.
Summary of Findings for Subcomponent 3G
Among the quality subcomponents, the tracking and analyzing of data pertaining to client outcomes yielded the fewest number of Met ratings, at only 57 percent. This challenge was found in counties of all sizes. Success in meeting this standard was consistently found in DMC-ODS counties that had made the collection of accurate and complete data a system-wide priority. This prioritization was enhanced with ongoing training to standardize data collection as well as devoting adequate resources to analytic and information systems support.

Summary Subcomponent 3G in Year Two DMC-ODS Counties
There continues to be evidence of consistent attention to this subcomponent by all three original DMC-ODS counties, but the lack of a system-wide distribution of clinical outcome reporting accounts for this reduction to Partially Met for one DMC-ODS county.

Subcomponent 3H: Utilizes Information from Client Experience of Treatment (UCLA) Surveys
Subcomponent 3H reviews the extent a DMC-ODS county adheres to the administration of the annual TPS, communicating and using data on a system wide basis to identify and address areas in need of improvement. CalEQRO found universally that DMC-ODS counties administer the TPS to clients as required and that the results provided to them measure domains in clients’ experiences of care across the domains of access, quality, outcomes, care coordination, and satisfaction. Response rates returned to the DMC-ODS counties indicated that clients seem to be particularly engaged by the instrument, adding many handwritten comments in addition to rating the items. Collectively, DMC-ODS provider networks across the state received generally high scores averaging approximately 82 percent, some modest variation by domain or individual program site. Active use of these results was found amongst all the DMC-ODS counties, with some simply sharing findings with providers while others, such as San Diego County, reformatted the results into graphic representations targeting specific audiences with the intent to inform their system and stakeholders, and make decisions. Additionally, several DMC-ODS counties have used both higher or lower scored areas to identify areas for specific programs or system improvement.
Summary of Findings for Subcomponent 3G
Among all the subcomponents, the use by DMC-ODS counties of information or data based on client perception surveys demonstrated the highest Met ratings. In addition to timely and complete administration of the TPS, returned to UCLA by the DMC-ODS counties for analysis, counties fully embraced the use of client feedback to inform their systems and appreciated the analytic reports from UCLA on each county and its program sites by domain. Results provided to the DMC-ODS counties were not just reported to leadership or QICs, but also to clinics, programs, contract providers, stakeholders, and in some cases clients. Many DMC-ODS counties have used the TPS more frequently than required or extracted specific questions to be an area of focus, indicating this tool’s value and relevance.

Summary Subcomponent 3H in Year Two DMC-ODS Counties
In the Year Two analysis for this subcomponent, results provide strong evidence of consistent attention to use of TPS. In Years One and Two, all three of the DMC-ODS counties were rated as Met. Timely completion of the TPS survey and its use with a broad range of programs and consumers helped to reinforce the importance of the client experience for program providers. Each of the three DMC-ODS counties has shown the ability and willingness to use the data to inform best practice or guide course corrections for outlier programs with poor ratings.

Figure 3-3: Quality of Care Key Component Ratings
Key components are important for assessing the quality and improvements of the DMC-ODS counties. Most counties have not established baselines for their first year; with action steps linked to recommendations, they can continue to enhance their performance. Year Two counties were able to see improvements in most areas that were identified and continue to work on some of these improvements in areas where new computer infrastructure and staff or program resources are being added or developed.

To evaluate some of the build out of these clinical systems and programs, a master list by LOC is also used and discussed below.

**Summary of ASAM Levels of Care by County Size**

To support the ratings related to the levels of treatment in each DMC-ODS county, an additional analysis was generated based on program data gathered. It includes key information on treatment resources for each type of treatment in the Waiver. Some description is also included to provide background or comments. It is organized by county size.

**Table 3-1: Coordination of Care and Case Management**

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<thead>
<tr>
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<th>Small</th>
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<tbody>
<tr>
<td>Counties with a no-wrong-door policy</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
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<tr>
<td>24-hour Access Line county-operated all or most of the time</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>24-hour Access Line run by contractors some of the time</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>24-hour Access Line run entirely by contractors</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Monthly estimated billed hours of case management (mean top/range bottom)</td>
<td>189 (29-500)</td>
<td>1,976 (81-8784)</td>
<td>2,054 (207-4,332)</td>
<td>5,100 (5,100-5,100)</td>
</tr>
</tbody>
</table>
Contributing Factors: DMC-ODS counties approached organization of their Access Call Centers very differently depending on factors including size, availability of regional county clinics to assist in this function, staff and technology resources, and availability of appropriate 24-hour partner agencies. They also used case management services very differently to link clients to treatment and facilitate transitions between LOCs.

Table 3-2: Recovery Services

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</thead>
<tbody>
<tr>
<td>Legal entities offering recovery services</td>
<td>15</td>
<td>34</td>
<td>40</td>
<td>77</td>
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<tr>
<td>Estimated billed hours per month (mean top/range bottom)</td>
<td>0</td>
<td>1,598.</td>
<td>No data</td>
<td>4</td>
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</tbody>
</table>

Contributing Factors: This new service is just getting started in most DMC-ODS counties. Approaches differ depending on the availability of specialized recovery providers or resources available and training programs to deliver this service. Knowledge of Medi-Cal billing is also a factor.

Table 3-3: Level 1 Outpatient

<table>
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</thead>
<tbody>
<tr>
<td>Total number of legal entities</td>
<td>15</td>
<td>15</td>
<td>23</td>
<td>43</td>
</tr>
<tr>
<td>Total sites for all legal entities</td>
<td>16</td>
<td>22</td>
<td>84</td>
<td>76</td>
</tr>
<tr>
<td>Estimated billed hours per month (mean top/range bottom)</td>
<td>31,260 (44-93,600)</td>
<td>23,067 (345-103,618)</td>
<td>2,160 (442-8,089)</td>
<td>6,345 (6,345-6,345)</td>
</tr>
</tbody>
</table>

Contributing Factors: Historic experience with outpatient services has contributed to these services being more widely available.
Table 3-4: Level 2.1 Outpatient/Intensive

<table>
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<tr>
<td>Total number of legal entities</td>
<td>15</td>
<td>19</td>
<td>30</td>
<td>55</td>
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<tr>
<td>Total sites for all legal entities</td>
<td>16</td>
<td>34</td>
<td>101</td>
<td>104</td>
</tr>
<tr>
<td>Estimated billed hours per month (mean top/range bottom)</td>
<td>18,998 (389-56,150)</td>
<td>51,335 (142-242,671)</td>
<td>5,703 (776-22,324)</td>
<td>11,100 (11,100-11,100)</td>
</tr>
</tbody>
</table>

Contributing Factors: Historic experience with intensive outpatient has contributed to more availability at this LOC.

Table 3-5: Level 2.5 Partial Hospitalization

<table>
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<tbody>
<tr>
<td>Total number of legal entities</td>
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<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total sites for all legal entities</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total average client capacity per day</td>
<td>0</td>
<td>No data</td>
<td>28</td>
<td>0</td>
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</table>

Contributing Factors: Limited capacity was available at time of the reviews, but several counties are in an expanded development phase. This is not a mandated service at this time.

Table 3-6: Outpatient Withdrawal Management (Level 1 WM and Level 2 WM)

<table>
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<tr>
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<th>Small</th>
<th>Medium</th>
<th>Large</th>
<th>Extra Large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counties implementing</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Implementing via NTP</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>[Missing]</td>
</tr>
<tr>
<td>Implementing via outpatient</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Implementing via primary care sites</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>[Missing]</td>
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</tbody>
</table>
Contributing Factors: This service is not robust in DMC-ODS counties as it is not required at this time, and WM is primarily offered as part of the residential WM 3.2 beds. NTPs are the only outpatient DMC programs that are doing some limited outpatient WM from opioids. In a few counties, primary care is offering some WM and supporting clients with access, but these services are primarily billed through the fee-for-service Medi-Cal system, not the DMC-ODS Waiver.

Table 3-7: Withdrawal Management Residential Beds (Level 3.2 WM)

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<thead>
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<th>Small</th>
<th>Medium</th>
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</thead>
<tbody>
<tr>
<td>Number of sites</td>
<td>3</td>
<td>7</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td>Estimated billed days per month (mean top number, range bottom)</td>
<td>110 (0-300)</td>
<td>865 (0-1855)</td>
<td>2,332 (0-5908)</td>
<td>16,856 (16,856-16,856)</td>
</tr>
</tbody>
</table>

Contributing Factors: This required LOC is available in DMC-ODS counties via contract and used as the primary source for WM. Many DMC-ODS counties are trying to expand capacity at this LOC and report it is difficult to find contract providers willing to develop new sites. Contractors report the process of becoming Medi-Cal certified and training and hiring staff for care and documentation is challenging and difficult. Also, significant resistance from neighbors and law enforcement is common with new sites.

Table 3-8: NTP Programs

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</thead>
<tbody>
<tr>
<td>Number of slots (in-county)</td>
<td>539</td>
<td>1,960</td>
<td>12,625</td>
<td>7,757</td>
</tr>
<tr>
<td>Number of sites (in-county)</td>
<td>3</td>
<td>7</td>
<td>29</td>
<td>38</td>
</tr>
<tr>
<td>Number of legal entities</td>
<td>4</td>
<td>7</td>
<td>14</td>
<td>15</td>
</tr>
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</table>

Contributing Factors: NTP programs are also expanding to have more sites and offer other FDA medications other than methadone. They are often experiencing community resistance, as are other SUD programs opening sites in new communities, due to historic stigma related to individuals suffering from SUD. Many are considering space expansions to accommodate needed capacity for other FDA MAT.
Table 3-9: Level 3.1 Residential

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</thead>
<tbody>
<tr>
<td>Number of sites</td>
<td>4</td>
<td>22</td>
<td>62</td>
<td>34</td>
</tr>
<tr>
<td>Number of legal entities</td>
<td>6</td>
<td>15</td>
<td>40</td>
<td>34</td>
</tr>
<tr>
<td>Total bed capacity</td>
<td>92</td>
<td>338</td>
<td>1,287</td>
<td>2,050</td>
</tr>
</tbody>
</table>

Contributing Factors: This is a common LOC for residential SUD treatment and is less intensive and restrictive than level 3.3 and 3.5. Many programs have both LOCs for treatment so that individuals who improve and stabilize can begin more community integration rehabilitative activities. Many counties are expanding this LOC and many residential programs are also adding IMS to their programs to be able to support clients on MAT.

Table 3-10: Level 3.3 Residential

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</thead>
<tbody>
<tr>
<td>Number of sites</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Number of legal entities</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total bed capacity</td>
<td>*</td>
<td>*</td>
<td>34</td>
<td>58</td>
</tr>
</tbody>
</table>

* Bed total is flexed with level 3.5

Contributing Factors: This ASAM LOC provides residential treatment for those with cognitive disorders and other physical health problems that require additional staffing with specialized skills. Many DMC-ODS counties have expressed interest in adding this to their continuum of care, but often do not have the need for a full 3.3 residential program or are concerned no SUD contract providers would be willing or interested in opening new programs at this LOC. Even with these challenges, there has been some expansion at this LOC; regional approaches are being considered to support cost-effective models.
Table 3-11: Level 3.5 Residential

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</thead>
<tbody>
<tr>
<td>Total number of sites</td>
<td>6</td>
<td>16</td>
<td>40</td>
<td>56</td>
</tr>
<tr>
<td>Total number of legal entities</td>
<td>6</td>
<td>11</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>Total bed capacity</td>
<td>52</td>
<td>196</td>
<td>1,347</td>
<td>1,247</td>
</tr>
</tbody>
</table>

Contributing Factors: This is also a very common level of residential treatment that is more intensive than 3.1 and has more restrictions on clients related to community access and activities, unless they are medical in nature. Again, many DMC-ODS counties were seeking to expand these services and coordinate them with a range of the treatment options during and after residential treatment is completed (such as MAT, outpatient and intensive outpatient, recovery support, and case management).

ASAM 3.7 and 4.0 LOCs are not currently available for DMC-ODS clients in any of the counties reviewed this year, but many DMC-ODS leaders support expanding services to include these LOCs and are actively negotiating with potential providers to try to add these to their networks.

This section discussed the advancing efforts to address key components of quality SUD care based on the second year of DMC-ODS services. Baselines were identified for the DMC-ODS counties that delivered their first year of services. Progress and trends improved for the three DMC-ODS counties in their second year of services.

The ASAM LOC chart developed from documents gathered at the county level shows a solid start for SUD systems of care in most of the counties reviewed. Smaller counties experienced more challenges in this their first year of DMC-ODS services. Larger counties faced different challenges, mainly from coordinating across large, dispersed networks of providers, in many cases over vast distances and in frontier/rural areas.
Section 4

Evolution of the Substance Use Disorder Service System and Infrastructure

Introduction

With counties actively implementing DMC-ODS services within the Demonstration Waiver specifications for the second year in a row, CalEQRO had the opportunity to reflect on key observations about changes in the service system so far. Eleven of the 14 counties evaluated this year were in their first year of launching direct services based on their approved DMC-ODS implementation plans. They had clearly benefitted from some of the knowledge and lessons learned from the first three “pioneer” counties, which are now in their second implementation year. Also, DHCS continued extensive TA efforts and provided clarifications of complex billing and data requirements to make these local implementations smoother and more successful.

Development of Access to Care Elements

As reflected in the data gathered in the PM section of the report on the 14 counties reviewed, 9 expanded DMC-ODS services over their baseline or prior years’ levels based on available service data. The other five Year One counties only had limited, partial-year services data available, so it was not possible to determine the full extent of their DMC-ODS service levels, capacity, and utilization. Also, 11 of the counties reviewed were over the statewide DMC-ODS county average for penetration rates.

At least half of the Year One counties faced serious billing challenges; their claims lagged between 6 and 12 months behind the dates of services,
depending on the provider. Other factors the counties encountered that affected billing were delays with their DHCS certification status, computer configuration issues, and training and oversight of staff on new charting requirements to ensure appropriate Medi-Cal documentation. For these counties, CalOMS data (based upon all services) indicated that services were at or above prior years, but the DMC claims (based only on DMC-ODS services) did not reflect this.

**Best Practices and Lessons Learned**

Most counties reviewed had robust centralized Access Call Centers with specialized call center software for key metrics. Some complemented county-staffed Call Center operations during the day with a contractor on nights and weekends, while others were 24-hour county- or contractor-operated. All counties implemented procedures for clients and families who called contracted providers directly to obtain services and used various strategies to try to capture their initial requests for information and appointment scheduling. These service models are called no-wrong-door systems because a person in need is able to seek services at any treatment location and be admitted or directed to an appropriate site.

No-wrong-door systems pose definite challenges in terms of capturing all key data elements for tracking timeliness for first offered appointment and first face-to-face appointment across large numbers of dispersed contractors and sites, since they are mostly using different computer systems. CalEQRO found these challenges with tracking timeliness to be a key focus of the onsite reviews, involving discussion of centralized databases linked to Access systems, appointment-tracking software, and other approaches for tracking requests and first appointments that have been successful in several counties.

Network providers designated by the DMC-ODS to do full assessments used ASAM criteria and admitted clients to services or referred them to the recommended LOC they needed. If the referral did come from the Access Call Center, a brief ASAM-based screening is the recommended best practice for the Access Call Center to ensure the client’s service needs are matched to the location where they are being sent for full evaluation of their care needs.

Three-way calling capacity as part of the Access Call Center is also a best practice by which the Call Center screener, the client, and the provider receiving the referral are all connected together on the same
call to facilitate the referral. This arrangement enables the client with the Call Center screener to connect directly to the program that will do the assessment for arrangement of an appointment or walk-in times, and some transfer of information in compliance with 42 CFR Part 2 from the client to the provider.

The Access Call Centers used many types of software with diverse ranges of functionality, particularly in many of the larger counties reviewed. The best functionality included the capability to track the number and time of calls, wait times, talk times, dropped calls, disposition of calls, client satisfaction feedback, linkage to the history of the caller (if they were a current client), and more. Cisco, Avaya, and other vendors offer these functions, which enhance the management of the Call Center’s responsiveness to callers and improve customer service. All first year CalEQRO visits include a site visit to the Access Call Center, interviews with staff, and review of the data metrics available. If challenges with operations or measures were found, follow-up CalEQRO visits are planned for the coming year and recommendations for improvement are included in the county report.

Several counties are using automated central systems for tracking daily provider capacity for new admissions, including: availability of network provider residential and WM beds; open outpatient, NTP, and other MAT program slots; and assessment appointments available that week. This is a best practice that reduces the time it takes for Access Call Center staff to find and make suitable referrals and for clients to obtain appointments. The counties that set up these systems are working with network providers to keep their crucial access availability data up-to-date, because these systems only work with daily updates of capacity changes.

Designated walk-in hours at key program sites for ASAM assessments are another best practice found to add flexibility and ease of access for clients. Many of the counties with more rapid timely access metrics had walk-in hours at one or more sites and LOCs, which also reduced no-show appointments. This practice also helps with serving the homeless populations and persons leaving EDs and jail settings needing rapid access to care.

Many counties also had set up special access systems for persons whose situations might be considered urgent, such as hospital and ED discharges with priority assessment and treatment access.
Call Center and Access Challenge Areas

Access systems in many counties also encountered some challenges. As previously mentioned, most of the no-wrong-door systems had difficulty capturing data regarding the date/time of first call and type of request at many of their dispersed contractor sites, complicated by most of those sites each having different software systems.

Another common problem, DMC-ODS counties had with the design of access processes was the number of steps in the process and its complexity. This was often due to manual workarounds created because of limited software, and staff could not capture all the information needed for managed care requirements and ASAM assessment and medical necessity needs. Other times, it was because the Call Center line was answered by clerical staff who did the first level of screening to see whether clients were calling for behavioral health services, confirmed Medi-Cal, and then referred to clinical staff, who sometimes needed assistance with languages or were only doing information and referral, rather than screenings and appointments. As a result, clients often felt discouraged and hung up or did not show up for follow-up, in-person screenings and referrals. CalEQRO made many recommendations in this area to enhance Call Center functionality and the client experience.

In some client focus groups, clients complained about having to tell their story over and over when referred to multiple sites; they felt as if no one read their histories or knew why they were there. Although some intake sites saw themselves as the initial entry for multiple services, clients felt it was hard to just get the services they wanted—which was “to talk to a SUD counselor, not do lots of paperwork like applying for Medi-Cal or food stamps or get flu shots.”

Some of the small and medium-sized counties had regional Call Center approaches with walk-in clinics at county-operated sites. There was a central Call Center number, but for screenings and assessments, callers were transferred to their regional clinic that had dedicated staff to screen and conduct full assessments into care. All but three counties contracted for call screening services after hours and on weekends for both mental health and SUD treatment. While these arrangements clearly offered some advantages—particularly convenience and walk-in capacity—they also created challenges with tracking requests unless the contractor entered requests into the same database, and referring to contractor sites with resultant no-
shows. Again, most of the contractors were on different computer systems, though some small and medium-sized counties had set a goal of getting all mental health and SUD contractors on the same software or establishing easier access to shared databases for coordination and mutual support of clients.

With some notable exceptions, most of the county SUD websites needed significant work to make Access Call Center numbers easier to find. Some, however, had done an excellent job with public advertising and education related to services and the Access Call Center system. Many had brochures and flyers available to share with the public. Many counties had already identified this as an issue and were working to enhance the visibility of the Access Call Center number and services linked to the DMC-ODS.

**Launch of DMC-ODS Services**

Since the launch in 2017 of DMC-ODS services, the counties reviewed have been working to expand DMC-ODS services by getting their existing providers to become DMC-certified and to find new providers through the required request for proposals (RFP) mechanisms. While each county has a unique set of needs, some definite patterns have emerged in the expansions reviewed this last year.

Some SUD treatment programs were reluctant or refused to obtain DMC certification because of the risks they perceived related to their own charting deficiencies, the start-up costs they related to new staffing requirements or facility modifications, and/or their focus on serving primarily private insurance clients. This refusal meant they could not be part of the DMC-ODS network. In rural and frontier areas of the state, providers of SUD services and the health workforce in general are limited in number, so launching a new major system of service programs can be very challenging.

In reviews of the first- and second-year counties delivering DMC-ODS services, CalEQRO noted a variety of ongoing efforts the counties used to expand services that included:

1. Recruiting and adding new providers and LOCs
2. Adding new locations of providers to enhance access, particularly for remote areas
(3) Adding to the capacity of existing providers by adding new beds, staffing and staff hours, and technology

(4) Enhancing systems of service coordination across providers, the DMC-ODS, MHP, and Medi-Cal Health Plans.

Some of the DMC-ODS counties’ expansion efforts addressed longstanding barriers to treatment access that emerged anew through the recent federal Network Adequacy requirements. Other expansion initiatives were prompted by the Waiver’s requirements for a more complete system of care with multiple levels of treatment, as defined by the ASAM criteria.

The DMC-ODS counties also were prompted to expand their services by Waiver requirements that they provide evidence-based treatments such as MAT and cognitive behavioral therapies (CBT) that were not in the skill sets of their current provider networks. This included efforts to hire more licensed and credentialed staff with specific training and skills.

Other unique efforts to add new services were underway across the state as well:

- Three of the counties (Riverside, Los Angeles, and San Mateo) were in negotiations with 24-hour providers to add ASAM levels 3.7 or 4.0, which include medical supervision and oversight for WM.

- Santa Clara County was working to develop SUD Partial Hospital Services.

- San Francisco County has a mobile MAT team.

- Many of the 14 counties were exploring partnerships for expanded space to add capacity for co-located services to enhance coordination and access.

- In addition, approximately one-third of the counties provided funding for construction of new facilities or renovation of facilities to bring more services within their counties or for specific regions. For example, San Luis Obispo County is building a new residential treatment and WM program to eliminate the need to send local residents out of the county for these treatment services, unless there are unusual medical needs. They also increased staffing significantly to address a
variety of needs related to services and managed care requirements.

Other efforts and approaches to expanding access to care were modeled by a range of counties reviewed. Some examples of these are described below.

- San Luis Obispo County established many entry points into treatment: an Access Call Center, five outpatient clinics that offer advance appointments and walk-ins, and an NTP that is open seven days per week. Clients remarked during the client focus groups that they find access to services to be welcoming and easy for outpatient treatment, intensive outpatient treatment, and MAT. These comments came from youth and adults alike.

- Los Angeles’ SAPC expanded services to create a network of 79 treatment organizations in the DMC-ODS with 351 different sites of SUD treatment and prevention services throughout the county. They used client-centered principles and CLAS standards to add capacity for different ethnic groups and specialty populations.

- People in San Francisco County requesting SUD services can call or drop into the Access Center for Behavioral Health Monday through Friday from 8 a.m. to 5 p.m. as an easy way to be assessed and provided access to treatment. A contracted, nonprofit Call Center assists individuals with screening and linkage to treatment after hours. Most drop-in clients are able to see SUD staff the same day for a SUD assessment and, if appropriate, obtain authorization for residential services within 24 hours. Other health and benefit services are also onsite to make access to care more coordinated and comprehensive.

Themes in Growing SUD Treatment in DMC-ODS Counties
As with any new complex system of care, building out the levels recommended by the ASAM clinical models and criteria and meeting Waiver requirements across a state as diverse and large as California is challenging. It was evident from site visits that each county DMC-ODS experienced both unique assets for service delivery and
challenges. The models of care and phases of implementing services have been tailored to these unique needs and strengths.

There were, however, some overall themes shared by the counties in terms of areas needing to expand capacity. All DMC-ODS counties reviewed expressed interest in expanding their network to include medically monitored and medically managed inpatient WM, labeled by ASAM as WM 3.7 and 4.0 services. This was particularly important for individuals with other medical conditions and for youth with complex withdrawal needs. Several counties are actively working with local hospitals and networks to try to develop this access. DHCS was helpful in developing information notices and options for these services to be provided by the DMC-ODS programs or via the Medi-Cal Health Plan systems.

Many of the counties reviewed expressed a need for additional capacity across all levels of WM. These counties throughout the state are issuing RFPs to expand capacity or build new capacity. Many of the larger counties are expanding to have more accessible sites throughout all their geographic regions.

In their expansion efforts, counties also are focusing on underserved populations. For some counties with large rural areas (such as Riverside County), focus on the underserved translates into building out service capacity in remote areas. Many living in these remote areas are also primarily Spanish-speaking, so language capacity is also very important.

For most of the counties, youth are an underserved population they commonly identify as needing more services. This low utilization is reflected in the PMs. Some counties have incorporated these expansion efforts into PIPS and other quality efforts. Youth services are important as research shows early intervention, education, and treatment can make a difference in later life related to having a chronic, disabling SUD.

It is anticipated these efforts for expansion of capacity and services to target populations will still take four to five years before they are fully realized in DMC-ODS counties across the state. Even after they are in place, they will still require coordination and sustained resources.
Development of MAT Treatment Models

Between the first and second years of counties implementing Waiver services, access to MAT began what has since become a steady expansion. Numerous efforts by DHCS, county health and behavioral health leadership, primary care organizations, and SUD network providers contributed to expansion of MAT and changes that were highlighted on the DMC-ODS reviews.

CalEQRO identified six different MAT models expanding in the counties reviewed. Most counties were using more than one of these models to provide care and support MAT expansion in their communities. They include: (1) NTP models, (2) outpatient DMC-ODS clinics, (3) MAT partnerships with primary care, (4) partnerships with EDs, (5) partnerships with the criminal justice system, and (6) participation with public health in opioid safety coalitions. Examples of these models are as follows:

Expansion of NTPs

NTP expansion beyond methadone replacement therapy, adding other medications including buprenorphine, disulfiram, and naloxone (used to reverse an opioid overdose) is a required element of the Waiver. Additional FDA approved medications are also an option for services through the NTPs.

NTP expansion models included a variety of approaches in different counties. Many had robust referrals and many requests for both methadone and other FDA-approved addiction medications. Some had physician capacity to conduct assessments of clients living in residential programs at their treatment sites and supported access to buprenorphine and other FDA-approved addiction medications for these clients, including coordinating pharmacy access. Santa Clara County is an example of a county-operated NTP maintaining and expanding services throughout their NTP sites and linking to residential treatment centers, other DMC-ODS treatment programs, and the county detention services.

CalEQRO visited many NTPs that also participated in the DHCS Hub and Spoke treatment grants. The grants enabled these NTPs to develop linkages with a range of community prescribers who were supportive of outpatient MAT treatment and willing to take referrals.
San Francisco County was proactive in developing its MAT initiatives and supports a robust NTP provider network of seven providers and increased MAT at these sites. A PIP was implemented to assist with the many process changes that must occur for NTP providers to deliver alternatives to methadone.

Many of the reviewed DMC-ODS counties provided MAT to substantial percentages of their beneficiaries through NTPs, such as San Luis Obispo County. Contra Costa County’s NTPs were notable in delivering both methadone and non-methadone MAT to many of the county’s DMC-ODS beneficiaries.

Outpatient Clinics
DMC-ODS counties developed and launched DMC-certified outpatient clinics with a primary focus on MAT programs, in conjunction with counseling and other support options. San Luis Obispo, Nevada, and Marin counties have these clinics, which are community-based, accessible, and a core part of their DMC-ODS delivery systems. It should be noted that both medical leadership and community support are needed to bring these services into communities. These programs also partner with other treatment programs, such as residential treatment and recovery support, to ensure access at all LOCs to MAT in the continuum.

Marin County was also proactive in developing MAT initiatives before Waiver implementation to facilitate easier client access to addiction medicines. They developed a strategic plan to accelerate these initiatives through RxSafe Marin beginning in 2013 (see www.rxsafemarin.org). They provide outpatient, clinic-based services; DMC-ODS-funded MAT services; and follow up to offer treatment services to those who have had an overdose and been stabilized by local EDs.

CalEQRO applies a treatment engagement measure for non-methadone MAT: the percentage of those to whom it is being prescribed who have at least three dosing sessions. In Marin, fully 80 percent of those prescribed buprenorphine had at least three visits, far higher than the average of 47 percent who had three or more visits across all DMC-ODS counties statewide.

MAT Partnerships with Primary Care Clinics
More county DMC-ODS staff and primary care staff are working together to offer outreach, engagement, and initiation into MAT
services as well as counseling, case management, and pharmacy coordination. This DMC-primary care array of services has become an emerging model, benefiting clients and building on the strengths of both organizations.

Primary care partnership models for MAT and ancillary SUD services are increasing rapidly as compared to the previous year. Ten primary care clinics became DMC-certified and others remained fee-for-service. Many are co-locating DMC-ODS staff in shared or adjacent space to provide SUD counseling, outreach, and recovery supports. One of the most valuable elements of the primary care partnerships is the availability of numerous prescribers serving high-risk and low-income populations who often have SUD needs. Many primary care clinics nationwide are beginning to deliver MAT and ambulatory WM. This has been encouraged by federal SUD grants from the Health Resources and Services Administration (HRSA).

Most counties are actively working to create clinical partnerships with their FQHC primary care clinics, if they did not already have them in place. Some of the FQHC clinics are county-operated and others are non-profit clinic organizations. In many rural areas, the FQHC clinics are the main source of health care for Medi-Cal and low-income populations.

Some examples of these efforts are as follows:

- FQHCs have sought assistance from San Luis Obispo County in applying for HRSA grants to help jumpstart their effort to build MAT prescribing capacity. This would expand capacity for MAT, especially among people who are comfortable visiting their primary care clinic rather than specialty behavioral health. San Luis Obispo County would then offer consultation and training with SUD medical staff and coordinate other care needs for clients across their SUD system of care. In most counties, medical consultation services are occurring with both DMC-ODS programs, primary care clinics, and some EDs.

- Contra Costa County is ahead of many counties in its expansion of MAT services through its health care system. The county-operated Choosing Change program delivers non-methadone MAT through the five county-operated FQHCs to persons who can benefit from buprenorphine. The program
collaborates closely with the Contra Costa County SUD service continuum of care and is identified as a best practice model that is producing positive results for clients with opioid disorders.

- Los Angeles SAPC also focused on expanding capacity for MAT through its primary care clinics across the county by providing training and consultation to physicians through SAPC medical leadership. More than 1,000 medical providers have been trained and approved with X-waivers to provide buprenorphine services.

- San Mateo County is in its second year of partnership with HealthRight 360 primary care programs to develop MAT for opioids and alcohol use disorders. The county team of case managers, nurses, and SUD counselors does the outreach, engagement, and case management to bring clients from community settings into the primary care clinic for MAT medications. This county team’s headquarters are at the county ED; they work with this other arm of healthcare as well for initiation and maintenance of MAT. Their report includes a formal research study on this special program, called Intensive Medication Assisted Treatment (IMAT), which assesses and treats hundreds of clients on MAT and coordinates their overall care. The study showed positive impacts on number of ED visits and hospitalizations and increased program success among the community SUD providers, including residential and outpatient treatment.

- San Francisco County has a street outreach medical program that is providing buprenorphine to persons experiencing homelessness, including both induction and ongoing medication. While this pilot was initially funded by county funding, it links clients to DMC-ODS-funded programs and supports for ongoing services. At the time of the review, they had served 400 individuals and had a growing ongoing caseload of 150. The positive results from this team have resulted in a recommendation for further expansion to the Board of Supervisors. This program reaches people who would not be interested in coming to a clinic site (e.g., DMC or FQHC)
but are receptive to medications when they are delivered to them directly to treat their opioid disorders.

- Napa County addressed the need to offer expanded MAT services, which has been realized by co-locating DMC-ODS services and a local FQHC on the same campus. In addition, Napa County links clients to a certified MAT telehealth provider, Bright Heart, if requested.

- Monterey County hired an experienced, board-certified addiction psychiatrist as Chief of Addiction Medicine. He is active in training physicians to prescribe MAT and has enlisted 57 physicians across physical health and behavioral health to support these efforts. Monterey County reported that during the first year of implementing the Waiver, 45 clients were treated with non-methadone addiction medicines—41 with buprenorphine and 4 with disulfiram.

These are but a few examples of DMC-ODS efforts to expand all types of MAT in partnership with primary care. As coordination and integration continue, it is expected these joint programs and service models will grow and spread to more counties as well.

Enhanced Engagement of EDs via ED Bridge and local DMC leadership engagement

DHCS, in partnership with foundations, developed and launched a program to train and fund efforts to expand SUD services in hospital EDs. This program, described in detail on the DHCS website, is very successful and expanding. In San Mateo hospital, for example, having a system to bridge care from the ED to ongoing community treatment is critical for those who have experienced an overdose and been treated and stabilized. They have a team linked to the ED, but also field-based and linked to an outpatient MAT clinic to support follow-up for clients who begin treatment for SUD in the hospital. Follow-up care is vital to ensure that these clients have easily accessible options for treatment and recovery support and avoid future overdose deaths.

Expanded Access to MAT in the Criminal Justice System

DMC-ODS county collaborations with the criminal justice system are beginning to expand SUD treatment by including MAT in a variety of
options available to clients who interact with the criminal justice system. Examples include:

- Assessments of inmates with SUDs are now including attention to ASAM criteria from SUD staff, who then make their treatment recommendations to the court system based on those criteria;

- In some of the jail detention centers, both SUD counseling and MAT (including methadone and other addiction medications) are beginning to be prescribed specifically for opioid disorders and chronic and severe alcohol use disorders (AUD). In some cases, there is a contract with an NTP for these services; in other cases, the non-methadone medications are dispensed by detention medical staff. Some are only provided medications to prepare for release and transfers. Others are beginning initiation and maintenance of these medications in the detention settings and continuing them when individuals are released from jail.

- Criminal justice system representatives and stakeholders are becoming aware of the benefits gained through MAT and counseling for those with SUD histories, to promote recovery from drug addiction and thereby reduce jail recidivism. These new efforts were discussed and described in many of the focus groups with criminal justice representatives that included sheriffs, probation officers, judges, public defenders, and district attorneys. These significant improvements (compared to past practice of little or no access to treatment of SUD in detention settings) in access to ASAM assessments and treatment were attributable to leaders in DHCS, county DMC-ODS, Sheriff’s Departments, behavioral health departments, the California Department of Corrections and Rehabilitation, California Health Care Foundation (CHCF), and county medical leadership.

### Opioid Safety Coalitions

Opioid safety coalitions, originally funded by CHCF, have expanded to most counties and regions throughout the state.
The opioid safety coalitions bring many critical partners together to examine access to opioids (both prescribed and illegal), root causes of addiction, overdose deaths, expanding access to treatment at all LOCs, and community education. Public health agencies as well as key physicians and leaders in the health delivery system are often involved, along with the county DMC-ODS staff, primary care, and a broad set of leaders from the criminal justice system such as the coroner/medical examiner, sheriff, and other partners.

These coalitions have and continue to affect medical practice related to prescribing opiates; coordination across providers for those with SUDs; and education of the general community via websites, events, and news articles on treatment options and successes as well as highlighting dangers in drug use, both legal and illegal. They have worked hand-in-hand with the DMC-ODS counties and enhanced the success of the Access Call Centers, program capacity, and development of resources for treatment.

Many coalitions received grants to expand naloxone access for patients, caregivers, first responders, and others. Strong active opioid safety coalitions are a best practice for enhancing the success of the DMC-ODS programs in reaching clients and their families.

Establishing or working within a coalition is a best practice for any DMC-ODS county to be optimally effective in preventing SUD and overdose deaths, as well as integrating systems to increase treatment access.

Quality Enhancements

Three program elements with strong links to quality and outcomes showed important changes related to best practices and lesson learned this year: case management, residential treatment programs, and partnerships with the health delivery system, particularly primary care and mental health. These program elements are important markers in the evolution of the SUD care system and its quality and outcomes for clients served.

Case Management Services

Many clinical and administrative practices contribute to quality and better outcomes of care for clients. Good communication between clients and treatment staff is the foundation of the therapeutic alliance
central to personal changes in health. Also important is communication across providers and on behalf of the client with health systems. One of the changes seen across the majority of counties this year was the extensive focus on expansion of case management services—particularly linking clients into treatment and helping them with transitions in care. Both clients and treatment program staff commented on the difference that these supports for service access and follow-up have made, especially at these vulnerable junctures in the treatment process. Case management and recovery support services were new services added in the Waiver and are proving very helpful for individuals working on sustaining their treatment outcomes.

Below are a few examples of these efforts in the counties, drawn from their reviews:

- Monterey County takes steps to facilitate coordination of care for clients during any transition between LOCs, especially from the initial Access Line referral to the beginning of treatment. They contract with four care coordinators who are recovery coaches with lived experience as persons with SUDs in recovery. These care coordinators assist prospective clients and ongoing clients with scheduling assessments, timely transitions between LOCs, transportation to and from appointments, reminders, and recovery support. They help beneficiaries to access a full array of ancillary services including needed medical, mental health, vocational, rehabilitative, and/or other community services.

- Riverside County has a Continuity of Care Team (CCT) whose members act as case managers to link clients after initial contact at the Access Call Center. CCT members work to engage the client and support them in accessing their needed treatment services and all transitions of care over time. They work for the county and develop long-term support relationships that include advocacy and a broad range of support services. Appreciation of the case manager as an advocate and support was shared by clients and programs alike.
Residential Treatment and Residential WM Models

Many residential treatment programs became Medi-Cal-certified during this second year, with more emphasis on including DHCS approval for IMS. This expanding service and clinical capacity can make it possible for clients to continue MAT services onsite at the residential treatment, if appropriate, as part of the treatment plan. This was a goal for many programs after they had met basic requirements under the DMC-ODS.

In both years of EQR reviews, clients had expressed a desire to access or maintain MAT in residential treatment and other LOCs, so this development is very positive. In addition, residential programs were expanding their skills to better serve individuals with co-occurring mental health issues and adding more “co-occurring competent” groups into their clinical programming, using LPHA staff and others. Residential programs were also adding more elements of individual and family therapies, especially for those re-unifying with family members. This was requested often by clients in focus groups as something they felt would enhance and support sustaining their gains in treatment.

Many DMC-ODS county leaders and programs reported new relationships with schools to expand services for youth. This included residential programs and other LOCs for youth in need of more intensive SUD treatment. As noted above, expansion of youth treatment is a goal for many counties.

The program managers and DMC-ODS county administrators are continuing to advocate for changes to the two-episode annual limit for residential treatment. Many of those interviewed by CalEQRO during the onsite reviews expressed the opinion that this benefit limit conflicted in some situations with the requirement to provide beneficiaries with medically necessary care. They expressed particular concern about clients not ready for residential treatment who leave within a week of their first time coming to residential treatment. This happens frequently with clients newly confronting their SUD problems and responding to the need for substantial change.

In summary, there has been new development of residential treatment programs and expansion of existing ones—both in the numbers of programs and also, in the scope of services, including MAT and other IMS. Residential WM programs also have been expanding but have
been doing so more slowly and seem to face more challenges from both neighborhood groups and identifying interested and experienced providers. Nonetheless, the counties are pushing forward to expand these LOCs and also partner with hospitals for levels WM 3.7 and 4.0 services.

**Moving Ahead in Partnership with the Physical Health Delivery System**

One of the most positive and encouraging developments of the Waiver, evident in each of the counties reviewed, is the breadth and extent of new involvement with the health delivery system at multiple levels. Prior to the Waiver, SUD services and clients were siloed and seen as social model programs for a troubled population with character problems rather than medical ones. With scientific advances championed by the last two Surgeon Generals, the slow integration of SUD and mental health treatment into the mainstream of medicine and health has made considerable headway. Efforts to coordinate and integrate formerly siloed programs were evident in DMC reviews throughout the state. MCPs, primary care clinic organizations, hospital systems, and medical leadership across the spectrum actively participated in stakeholder groups and discussed shared program models, linkages between SUD and their systems, the ongoing need for more coordination and collaboration, and visions for the future in their communities.

The following are a few examples of collaboration to benefit those with SUD through collaboration with the county DMC-ODS programs:

- San Mateo’s county hospital housed the DMC IMAT team of nurses and case managers who identify, and case manage those with SUD most likely to benefit from MAT and broader SUD treatment. Even though the DMC IMAT team is housed at the ED to help with referrals and triage of clients, they are also mobile, and more than half the team spent time in community settings doing outreach, engagement, case management, counseling, and follow-up care, including with their FQHC partner who provides prescribing services and medical management of those on outpatient MAT medications, primarily buprenorphine and Vivitrol. The IMAT team seeks out clients at homeless shelters and other sites as well and actively links clients to services throughout the county’s DMC-ODS. The MCP and Whole Person Care project help to pay for part
of the IMAT team and these efforts. Each year, an independent research study is conducted to track impacts on the health system of these collaborative efforts, while DMC tracks SUD treatment outcomes through CalOMS discharge ratings. The results of these annual studies suggest substantial benefits accrue to the clients served and to the system as a whole.

- Contra Costa County’s DMC clinical staff work closely with its MCP and the network of six county clinics for MAT access and medical management, facilitating counseling and coordination of care. The buprenorphine caseload of the county primary care clinics was at last review over 700 cases, with over half coming from the DMC-ODS access team referrals. The shared service model among these entities simplifies provider coordination and information sharing in support of client care. With these results, the partnerships also have helped to expand the prescribing and counseling sites throughout the county where clients can receive their coordinated treatment services.

- Riverside County is working with its Health and Hospital system (which is linked to UC Riverside) and their primary care clinics to co-locate SUD treatment staff at clinic sites throughout the region, expanding access to SUD treatment and coordinating care for clients with both SUD and health conditions. DMC-ODS services and HRSA grants have helped with this process of service co-location and collaboration.

Each community DMC-ODS county has approached these relationships in unique ways to build on the strengths in their community health systems and find ways to integrate SUD treatment into a mainstream of the overall health care delivery system. From Los Angeles County to Nevada County, many different and creative approaches were being explored to build out the care systems to reach at-risk populations with SUD who often had other challenges with health, housing, education, and jobs. Many of the health partners and SUD administrators noted the development of these new joint partnerships as among the best overall results of the DMC-ODS Waiver.
Most counties reviewed had Whole Person Care grants and their efforts often include expanded coordination with SUD clients who had complex health needs. The ODS leaders in each of these counties were part of the leadership team designing care linkages across the systems to improve outcomes. Many targeted intervention efforts in these counties were designed to support the SUD population with using MAT, coordinate case management, prioritized housing efforts, and other system-wide or structural solutions.

By design, Waivers are intended to test and highlight innovative approaches with implications for larger system-wide application. The coordination and integration sparked by the Waiver in these 14 counties are important areas for enhanced quality throughout the DMC-ODS. They show early and strong potential to benefit clients and will be monitored over time for the many best practices emerging from these new joint efforts.
Section 5

Performance Improvement Projects

Introduction

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

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

A clinical PIP might target some of the following:

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

A non-clinical PIP might target some of the following:
• Coordination of care with pharmacy and ancillary care providers
• Timeliness and convenience of service improvements
• Improvements in customer service and initial engagement in care
• Addition of customized SUD services for home-bound disabled clients
• Improvement in access or authorization processes
• 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.16 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.

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. All PIPs are rated based on their completeness and compliance with the standards found in the CMS protocols. Each of the nine PIP steps includes subsections with standards that are rated according to the PIP Validation Tool.

The PIP rating steps and definitions are shown in Tables 5-1 and 5-2, below:

**Table 5-1: 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 5-2: 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>
</tbody>
</table>

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17 Ibid.
18 Ibid.
19 The PIP Validation Tool is available from CalEQRO’s Website, www.CalEQRO.com.
### PIP Rating

<table>
<thead>
<tr>
<th>PIP Rating</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<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:

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

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

**Table 5-3: 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

Twenty-seven PIPs were submitted for review. Of these, 21 PIPs (77 percent) were rated as active and ongoing, thereby meeting the submission standard, as shown in Table 5-4.

Table 5-4: 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 Non-clinical PIPs Submitted</th>
<th>Status of Non-clinical 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>
<tr>
<td>Santa Clara</td>
<td>Large</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Not yet started/Concept</td>
</tr>
<tr>
<td>San Luis Obispo</td>
<td>Medium</td>
<td>1</td>
<td>Not viable PIP</td>
<td>1</td>
<td>Not viable PIP</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>Ex Large</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Active and Ongoing</td>
</tr>
<tr>
<td>San Francisco</td>
<td>Large</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Active and Ongoing</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>Medium</td>
<td>0</td>
<td></td>
<td>1</td>
<td>Active and Ongoing</td>
</tr>
<tr>
<td>Contra Costa</td>
<td>Large</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Active and Ongoing</td>
</tr>
<tr>
<td>Monterey</td>
<td>Medium</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Active and Ongoing</td>
</tr>
<tr>
<td>Napa</td>
<td>Small</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Not yet started/concept only</td>
</tr>
<tr>
<td>San Diego</td>
<td>Large</td>
<td>1</td>
<td>Active and Ongoing</td>
<td>1</td>
<td>Active and ongoing</td>
</tr>
<tr>
<td>Nevada</td>
<td>Small</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 5-5: PIP Topics for Active and Ongoing/Completed PIPs**

<table>
<thead>
<tr>
<th>PIP Topic</th>
<th>PIP Focus</th>
<th>Clinical</th>
<th>Non-Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>Increasing Access and Treatment Services to Special Populations (adolescents in one, physically disabled in another)</td>
<td>Riverside, Los Angeles</td>
<td></td>
</tr>
<tr>
<td>Access to Care</td>
<td>Expanding Access to MAT in NTP/OTPs and Criminal Justice and expanding buprenorphine in Outpatient settings</td>
<td>San Francisco</td>
<td>San Mateo</td>
</tr>
<tr>
<td>Access to Care</td>
<td>Access to MH treatment for clients with two or more criteria in ASAM dimensions linked to MH/Health disorders, improving MH functioning through co-occurring access to treatment</td>
<td>Santa Cruz Contra Costa</td>
<td></td>
</tr>
<tr>
<td>Access to Care</td>
<td>Improving access to ongoing treatment for those needing residential treatment through better clinical assessments</td>
<td>Nevada</td>
<td>Monterey</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Engagement and retention in concurrent treatment of MH and SUD co-occurring disorders including with Vivitrol for AUD</td>
<td>Marin</td>
<td>San Francisco</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Transitions from WM or Residential Treatment to additional SUD services, Improving Grievance and Appeals processes for clients</td>
<td>San Mateo Nevada Monterey</td>
<td>Marin Riverside San Diego</td>
</tr>
</tbody>
</table>
### Performance Improvement Projects

<table>
<thead>
<tr>
<th>PIP Topic</th>
<th>PIP Focus</th>
<th>Clinical</th>
<th>Non-Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness</td>
<td>Improving timely access to SUD treatment from SUD Helpline (SASH), and access systems</td>
<td>Los Angeles, Contra Costa</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Boosting Beneficiary Treatment through engagement -4 visits in 30 days, and retention in care past 30 days</td>
<td>Santa Clara, Napa</td>
<td>Nevada</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 5-1 (for clinical PIPs) and 5-2 (for non-clinical PIPs).

**Figure 5-1: Clinical PIP Ratings (14 counties)**
Technical Assistance

During the FY 2018-19 review year, CalEQRO provided PIP clinic webinars, YouTube training videos, and individual consultation that focused on PIP development. Table 5-6 details the TA provided to all counties during the review year. The DMC-ODS EQR web site at www.CalEQRO.com includes a PIP library with videos specifically made for DMC-ODS counties and examples.

CalEQRO will use the findings from the review process to provide additional PIP clinic webinars and presentations focused on the areas identified in this report as well as new quality opportunities identified in the SUD field, working individually with all counties requiring assistance in the development of PIPs. Twenty-seven counties are being reviewed in FY 2019-20 and most have begun working with CalEQRO on their PIP designs and methodology. Many are focusing on access, timeliness, continuity of care, services to persons with co-occurring disorders, expanding MAT services and access to ASAM assessments, case management models, EBPs, treatment in criminal justice settings and in aftercare, reductions in overdose deaths, and other pertinent topics in the SUD field.
Table 5-6: Technical Assistance Provided by CalEQRO Outside of Onsite Reviews (FY 2018-19)

<table>
<thead>
<tr>
<th>Type of TA Provided</th>
<th>Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIP &amp; EQR presentation and later YouTube</td>
<td>In-Person and Online</td>
<td>February 2018</td>
</tr>
<tr>
<td>PIP Webinar PIP &amp; DMC</td>
<td>In Person at CalQIC</td>
<td>March 2018</td>
</tr>
<tr>
<td>PIP webinar</td>
<td>Online</td>
<td>July 2018</td>
</tr>
<tr>
<td>PIP Webinar</td>
<td>Online</td>
<td>June 2019</td>
</tr>
</tbody>
</table>

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

Outside of the onsite review process, CalEQRO provided individual TA to 21 counties for a total of 425 hours. One of the most common areas of assistance involved PIP study question formulation and assisting counties in the development of a new PIP concept. Many focused on challenges with capturing timeliness data (particularly at contract provider sites with outdated computer systems and limited IT interfaces with central county systems), expansion of services to at-risk populations such as perinatal and youth, introduction of new MAT services, stigma and individualized treatment methods, continuity of care post-discharge from WM and residential treatment, and use of the full continuum of care to meet client needs.

Each of the 14 counties selected PIPs with implications for the launch of the DMC-ODS Waiver and the fundamental shift to an ASAM-driven system of care, with comprehensive assessments and individualized treatment models. There was also a shift to EBPs, access, and engagement. Many other counties that are beginning services under the DMC-ODS have chosen to focus on similar issues. While not all of the PIP designs or studies were successful, each county with TA has reported a good learning experience related to the process of (1) identifying problems, (2) conducting data analysis of those problems or issues, (3) studying indicators and establishing baseline data and goals, and (4) identifying possible interventions to improve care and outcomes affecting the clients using services. Continued TA is available to assist in these efforts to refine and enhance quality in the DMC-ODS counties through the PIP process.
Areas for Improvement in PIP Design/Implementation

- DMC-ODS counties with ongoing active PIPs should continue to modify existing interventions without impacts or add new interventions each year to refine their impacts/outcomes. Continuous efforts to improve quality are important.

- DMC-ODS counties should refine their knowledge and use of their key data sources, including the new data sources such as ASAM LOC referral data and TPS data to improve care for clients. These are powerful new tools for identifying both problems and strengths in the system of care. Current knowledge about them among both data and clinical staff is limited.

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

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

- Counties invest time and resources in developing systems that not only collect data, but also generate helpful and user-friendly reports for clinicians and key managers that can be used to track improvements or problem issues in meaningful ways. This should continue with new counties joining the DMC-ODS program.

- It is recommended that the counties participate in TA provided by CalEQRO and other sources to improve their ability to collect, analyze, and use data as soon as their county is approved to participate in the DMC-ODS.

Summary

During this reporting year, CalEQRO found strengths in the DMC-ODS programs and practices related to PIPs and general efforts targeting improvements in care and operations. The PIP projects are having a positive impact on the overall delivery system and elements that are important to quality of care for clients and families. In these same areas, CalEQRO also noted opportunities for continuing to
expand the QI focus and support of the system changes which could be improved with effective PIPs identifying problems, potential interventions, and tracking the impact via related indicators. These opportunities included expanding the basic data system analytics and knowledge to support PIPs and ongoing QI activities in general. More funding for training, IT systems, and staffing in these areas would be very helpful for long-term system improvements.
Section 6

Client and Family Member Perceptions of Substance Use Disorder Care

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

Introduction

CFM voices are an integral part of the CalEQRO review process. The county-developed DMC-ODS required an extensive and continuous feedback process from CFMs and stakeholders in the design and deployment of services to assure that access processes and services were designed to meet their needs. CFM feedback is built into the DMC-ODS systems through feedback at many levels of the county and provider organizations. The CalEQRO evaluation process solicits specific feedback through focus groups that include a variety of stakeholders in the DMC-ODS.

A CFM stakeholder is any individual whose life is affected by substance use and addiction, including adults, youth, and families of adults and youth experiencing addiction. Other stakeholders include community organizations, law enforcement, the education system, social services, veterans, providers of alcohol and drug services, housing and vocational resources, and 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 DMC-ODS counties.
Methods

During FY 2018-19, CalEQRO used CFM consultants to facilitate 23 focus groups with 191 participants in 14 counties, with a focus on the client’s experience of care in perinatal services, residential treatment, outpatient services, MAT in NTPs and community settings, youth-specific treatment programs, and WM. Groups were conducted in Spanish and English during first year reviews and planned for additional languages in future reviews. One adult group also was convened for criminal justice involved persons and for parents/caretakers of persons in treatment. The group participants were diverse in gender, age, race, and ethnicity.

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

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

Counties are grouped by population size as follows:

- Small: Napa, Imperial, and Nevada
- Medium: San Louis Obispo, Marin, San Mateo, Monterey, and Santa Cruz
- Large: Riverside, Contra Costa, Santa Clara, and San Diego
- Very Large: Los Angeles
Table 6-1 identifies the number and focus of client and CFM focus groups that were held in each county size group. Across the counties, there was a focus on feedback from people in the following groups receiving services: perinatal, youth, MAT, outpatient, and residential services.

### Table 6-1: Number and Types of Client Focus Groups, by DMC County Size

<table>
<thead>
<tr>
<th>Total Groups</th>
<th># of Small County Groups</th>
<th># of Medium County Groups</th>
<th># of Large County Groups</th>
<th># of Very Large County Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Perinatal</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adult Residential</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Adult</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Youth</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NTP MAT Group</td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Adult Spanish Speaking Group</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Adult SUD caretaker and family members of consumers</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6-2 identifies the mean score of the answers to the client satisfaction focus group questions, by size of county. Answers range from 1 to 5, with 5 being the best.

Table 6-2: Mean Responses to Focus Group Questions by DMC County Size

<table>
<thead>
<tr>
<th></th>
<th>Small County</th>
<th>Medium County</th>
<th>Large County</th>
<th>Extra Large County</th>
<th>All DMC-ODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easily found treatment services as needed</td>
<td>4.30</td>
<td>4.13</td>
<td>4.30</td>
<td>4.34</td>
<td>4.23</td>
</tr>
<tr>
<td>I got my assessment appointment at a time and date I wanted</td>
<td>4.30</td>
<td>4.22</td>
<td>4.06</td>
<td>4.40</td>
<td>4.20</td>
</tr>
<tr>
<td>It did not take long to begin treatment soon after my first appointment</td>
<td>4.00</td>
<td>4.23</td>
<td>4.37</td>
<td>4.55</td>
<td>4.33</td>
</tr>
<tr>
<td>I feel comfortable calling my program for help with an urgent problem</td>
<td>4.00</td>
<td>4.33</td>
<td>4.20</td>
<td>4.27</td>
<td>4.26</td>
</tr>
<tr>
<td>Has anyone discussed with you (or your family) benefits of new medications for addiction and cravings?</td>
<td>2.70</td>
<td>3.65</td>
<td>3.72</td>
<td>4.12</td>
<td>3.71</td>
</tr>
<tr>
<td>My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)</td>
<td>4.20</td>
<td>4.19</td>
<td>4.10</td>
<td>4.24</td>
<td>4.17</td>
</tr>
<tr>
<td>I found it helpful to work with my counselor(s) on solving problems in my life</td>
<td>4.30</td>
<td>4.35</td>
<td>4.46</td>
<td>4.55</td>
<td>4.42</td>
</tr>
<tr>
<td>Because of the services I am receiving, I am better able to do things that I want</td>
<td>3.90</td>
<td>4.11</td>
<td>4.36</td>
<td>4.37</td>
<td>4.23</td>
</tr>
<tr>
<td>I feel like I can recommend my counselor(s) to friends and family if they need support and help</td>
<td>4.50</td>
<td>4.37</td>
<td>4.53</td>
<td>4.51</td>
<td>4.46</td>
</tr>
</tbody>
</table>
Themes from Client Focus Groups

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

- Services were more easily accessible
- Services were life-saving and helping with SUD recovery
- Received help with problem solving
- Counselors and therapists were caring, supportive and culturally sensitive
- “If they don’t have what you need [for recovery and wellness] they will try to get it and provide it.”
- “I feel that I was given the tools I need to succeed.”
- “I know I can talk to my counselor about my feelings.”

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

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

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

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

Results from the FY 2018-19 TPS results for the 14 counties reviewed show overall great satisfaction with services received during the second year of the DMC-ODS implementation. Scores are ranked on a satisfaction range from 1 to 5, with 5 being the most satisfied. Areas measured cover access, quality, care coordination, outcomes, and general satisfaction.

Figure 6-2 below shows the adult survey scores for all of the counties by question and domains of access, quality, care coordination, outcomes, and general satisfaction.
Overall, for adults, the statements about “feeling understood by staff” and “feeling welcomed into services” were rated the highest. Areas of lower scores related to care coordination with mental health and physical health, though all ratings were above 80 percent.
Figure 6-3: Youth Results for Treatment Perception Survey by Domain

<table>
<thead>
<tr>
<th>Access</th>
<th>Quality</th>
<th>Therapeutic Alliance</th>
<th>Care Coordination</th>
<th>Outcome</th>
<th>General Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenient Location</td>
<td>Convenient Time</td>
<td>Good Enrollment Experience</td>
<td>Received the Right Services</td>
<td>Treatment with Respect</td>
<td>Cultural Sensitivity</td>
</tr>
<tr>
<td>76.0%</td>
<td>78.8%</td>
<td>78.7%</td>
<td>80.8%</td>
<td>91.5%</td>
<td>78.1%</td>
</tr>
</tbody>
</table>

The youth TPS survey had 18 questions linked to 6 domains. The highest rankings were linked to “treatment with respect” in the quality domain and “my counselor listened” in the therapeutic alliance domain. The lowest ratings overall linked to “provision of family services” in the quality domain and “able to do things better” in the outcome’s domain. All DMC-ODS counties are provided their results by specific provider and site location so they can follow up and target QI activities to specific domains at specific sites. Part of the CalEQRO review involves discussing and formulating QI activities based on TPS results and suggesting design options of potential PIPs linked to the TPS results, or other appropriate actions related to improving the quality of care.
Strengths Based on Client/Family Feedback

Many counties have multiple entry points into care to enhance access. A large number of clients are referred through friends, family, or word-of-mouth and they frequently go directly to provider sites to request services. If they go to a provider site training in ASAM assessment protocols, they are evaluated and, if clinically appropriate, admitted. If not, they are referred to the appropriate ASAM level directly or through the Access Call Center. This no-wrong-door approach is the most common county design. Clients and families report liking this approach, though it may mean they need to be referred to another program, depending on the results of their ASAM assessment. Counties that have built this into their plans increase convenience of access to services for clients, even though referrals and transfers to another program may be required.

The majority of clients in focus groups reported that finding treatment is now easier with DMC-ODS. Among those who had been in treatment before, many observed that services had changed. Some had used the Access Call Center lines for help with success. Some also had used the Access Call Center line to get information for family or friends about SUD issues and treatment.

Wait times for all services were significantly reduced in the DMC-ODS, with services usually available within two weeks and sometimes within 24 hours. Once a client’s ASAM assessment was completed, it was generally reported that they could get into programs quickly.

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

Clients appreciated the range of skills they were taught as part of their SUD treatment program, which included not only recovery-specific aids but also life skills that would support their recovery process and help them with family issues and vocational planning.

Many clients described MAT services as being available in many counties. In most cases, programs and clients were supported to maintain their involvement in this treatment. Many clients reported receiving information on the benefits of MAT services when they began treatment, and that they were supported to take advantage of this treatment.

Peer mentor programs that existed in a few counties showed particularly positive impact to both mentors and mentees during and after treatment programs.
Family and individual therapy is a strong component in some counties’ programs and was deeply appreciated by clients as a means to support them in their recovery. This could be a practice to expand in other programs and services.

**Opportunities for Improvements Based on Client/Family Feedback**

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

For some clients, access to MAT in all areas of the county and service settings was a concern. Counties continue to work with some providers to increase MAT services across the entire continuum of care, including some residential treatment programs, recovery residences, and other step-down programs. Availability of prescribers with knowledge of SUD treatment and MAT is still very limited, but increased this year over the first year of services.

Many clients voiced requests for more family involvement in treatment. Some counties are working to expand services to include family-specific treatment education and family groups to support clients in recovery. This service could be expanded to more counties as a key support for successful recovery.

Many clients (and administrators) believe more staff are needed in treatment programs as a result of the increased focus on documentation that is reducing the amount of time counselors and therapists can make available for client treatment services.

Many counties need to expand WM services, as evidenced by client and staff reports related to timely access and capacity issues. Many counties are in process of expanding these services through RFPs; some are converting a portion of available residential beds for residential WM to help to meet this gap in service.

There is a growing demand for more flexible programs (particularly residential and intensive outpatient) to allow persons who are trying to work, particularly when close to discharge while still attending treatment. In addition, flexible programming would also address the increased programming of some residential programs that is not allowing clients to coordinate ancillary care and visitors while in residential treatment.
Night and weekend hours for persons working to continue outpatient treatment is also needed.

Increased client supports in the transition from residential to step-down programs is a need in many counties where housing resources are very limited, particularly for women with children.

Out-of-county Medi-Cal, for clients who live in a new county and are attempting to access treatment, remains a significant barrier to treatment.

Many clients and families report that yearly limits on residential treatment services do not make sense for persons with a chronic and relapsing disease, and some individuals need more time to get well and stable.

**Key Themes from Clients and Families**

In the DMC-ODS programs reviewed, CFMs continue to report high levels of satisfaction with the expanded treatment services as evidenced by the CFM focus surveys, groups and the TPS results. Counties continued to implement program expansion elements during this time period and actively set up improved access systems for the community and key stakeholders.

Across Year Two counties, CFMs asked for some key things from the SUD programs. Examples are quoted below:

- **Help with housing, especially after residential treatment such as recovery residences and other step-down housing programs, especially for women with children.**

- **Increased family support and treatment programs as a core part of the continuum of care.**

- **Expanded access and support to WM and MAT treatment to meet the increasing demand for MAT services in all treatment programs.**

- **Have enough staff to meet my counseling, case management and support needs, even with new requirements, and show flexibility to support individual situations and challenges for success.**
Section 7

Information Systems Capabilities Assessment

Background, Goals and Methods

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
- Telehealth services
- Use of data

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

For FY 2018-19, CalEQRO developed an ISCA specifically for DMC-ODS purposes. The ISCA has five sections (with multiple questions in each section) and collects data in the following 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 information system department, makeup of information system 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 information system users.

- **Section C—DMC 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 system 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 and 42 CFR Part B, which specifically related to SUD program requirements for confidentiality and exchange/release of information.

- **Section E—Data access, usage, and analysis**
  In this section, CalEQRO collects information about staff most responsible for analyzing data, their capacity 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 commonly requires input from multiple areas of the organization such as IT/information systems, Finance, Operations, and QI subject matter expert staff. Responses are returned to CalEQRO before the DMC-ODS onsite review. DHCS data sources also are used to assess information systems and include: Short-Doyle/Medi-Cal (SDMC) for DMC-ODS, Monthly Medi-Cal Eligibility File (MMEF), ASAM LOC Referral Data, TPS data, and Master Provider File (MPF).

This annual report focuses on ISCA results for the 14 counties that implemented DMC-ODS between February 2017 and July 2018. Their go-live dates are shown in Figure 1, below.
There is a large variance in how SUD services are delivered in DMC-ODS counties, ranging from 100 percent contractor-operated in Monterey County, San Diego County, and San Mateo County to 99 percent county-operated in San Luis Obispo County. The results were based on a single point-in-time estimate prior to the CalEQRO onsite review and may have changed since then.

Many factors play a role in how counties deliver DMC-ODS services: geography, system of care infrastructure, workforce availability, resources and implementation approach. It will take time for ODS to develop fully in each county and Figure 7-2 may look very different in a few years. Many counties that are fully contracted are now considering doing some direct services and vice versa.
Figure 7-2: County-operated versus Contractor-operated Services

Budget Allocations for Information Systems

The percentage of the DMC-ODS county’s budget devoted to information systems is a simple indicator of the level of IT resources and capabilities available to support the administration and delivery of SUD services. Although there are no standards for the percentage of budget devoted to IT, there are literature references to 3 to 5 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 the information system. For instance, in a county where the core system is used for more than SUD (such as mental health), it may not be possible to clearly identify the SUD component of the overall system cost. In reviewing the data received in FY 2018-19 ISCAs, situations like this may have affected some of the budget percentages. The results should be viewed as a rough indicator that requires more detail to be fully informative. In addition, counties have varying relationships with their contractors related to information system support and interfaces. Some support a unified system across the county and contract providers. Others support county functions as a DMC-ODS and request data.
through interfaces with contractors of various kinds, and some are hybrids. All of these scenarios can affect the budget and resources needed to support information systems.

In Figures 7-3 and 7-11, counties are grouped by size into very large, large, medium, and small for data analysis and discussion:

- Very Large—Los Angeles.
- Small—Imperial, Napa, and Nevada.

Figure 7-3 shows the FY 2018-19 statewide average of DMC-ODS budgets devoted to information systems as 3.16 percent, which is close to the low end of the 3 to 5 percent minimum requirement. Only the large counties group, with a 4.32 percent average, is within the minimum requirement range. The rest (very large, medium and small counties) are below 3 percent.
Findings

Health Information Systems by Vendor

California counties have primarily relied on four technology vendors to support HIS in behavioral health: Cerner Corporation, Harris’ Healthcare Group, The Echo Group, and Netsmart Technologies. This narrow range of vendors is a consequence of California’s unique Medicaid claims processing business rules. These vendors all have core expertise for SDMC claims processing and state-mandated reporting requirements. A fifth vendor, Fei Systems, has joined the DMC-ODS EHR landscape with its Web Infrastructure for Treatment Services (WITS) product.

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.
Figure 7-4 shows what EHR systems are used by the 14 DMC-ODS counties reviewed in FY 2018-19.

**Figure 7-4: DMC-ODS County EHR Systems**

Seven counties use Netsmart myAvatar: Imperial, Los Angeles, Monterey, San Francisco, San Mateo, Santa Cruz, and Riverside. Three counties use the Cerner Community Behavioral Health System: Napa, Nevada, and San Luis Obispo. Two counties use the Fei Systems/WITS: Marin and San Diego. Santa Clara County’s EHR is Cocentrix Pro-Filer and Contra Costa County was using the Echo InSyst system for performance management at the time of their review. Currently, Santa Clara County and Contra Costa County are implementing plans to replace these legacy systems.
Figure 7-5 shows the varied hosting and operation arrangements for DMC-ODS core systems.

**Figure 7-5: County EHR Support**

![Pie chart showing the distribution of EHR support by type: ASP 70%, Health Agency IT 30%, County IT 10%, BHS IT 10%]

Hosting systems at an Application Service Provider (ASP) is driven by the lack of local IT staff expertise to support 24/7 operational support. ASP hosting usually includes benefits such as heightened system security, business continuity assurances, and 24-hour staffing by qualified technicians. The changing IT services market also plays a role in 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.

Seven DMC-ODS counties have core systems supported by application vendors, five counties have their systems supported by health agency IT staff, one county has support from county IT and one county has support from behavioral health IT.

ASP-supported counties vary in size and include Imperial, Los Angeles, Marin, Monterey, Nevada, San Diego, and Santa Cruz counties.

Most counties have implemented or are in the process of implementing a system that has core components that support EHR functionalities for DMC-ODS (and often mental health as well).
Figure 7-6 summarizes current EHR upgrade/replacement efforts. Santa Clara and Los Angeles are implementing Netsmart myAvatar, while San Diego is implementing Fei Systems/WITS (only supports ODS operations). Contra Costa, Imperial, and Marin are considering new systems. Monterey, Riverside, and Santa Cruz have no plans to replace their current Netsmart systems. Counties that have selected new systems but have not yet implemented them include: Napa, Nevada, and San Luis Obispo for Cerner Millenium; San Francisco for Epic, and San Mateo for Netsmart myAvatar NX, a non-Java based system.

Figure 7-6: County EHR Replacement Status

An information system is a group of integrated hardware and software components designed to collect, organize, store, process, and report information. Information system 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.

As Figure 7-7 indicates, referral management, care coordination, and client electronic signature functions are generally under-deployed in DMC-ODS county EHRs. However, assessments, outcomes and LOC functions are present in most systems.

Collectively, only 68 percent of EHR core functions are present or partially present in county behavioral health systems, which significantly affects how staff work. It is critical to note that this does not imply that their provider network of contractors has
this level of EHR functionality; quite the contrary, the majority are using paper medical records.

Figure 7-7: County EHR Functions

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

Health Record
Health records are rated functionally as electronic, paper, or a combination of electronic and paper, and for clients to easily be able to access their own health information.

Figure 7-8 shows six counties reported to have an electronic chart of record: Los Angeles, Monterey, Napa, Riverside, Santa Cruz, and San Mateo. Counties
reported to have paper records are Contra Costa and Imperial. Counties reported to have a combination of electronic and paper records are Marin, Nevada, San Diego, San Francisco, San Luis Obispo, and Santa Clara.

**Figure 7-8: DMC-ODS County Chart Environment**

![Pie chart showing electronic, combination, and paper records](image)

It is expected that as ODS evolves, more counties and their network of contract providers will shift towards electronic charting. An EHR environment supports better communication and coordination of care among providers, including physical health providers, and facilitates the establishment of client portals to help motivate clients to manage their own health.

**Interoperability**

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

Currently, none of the 14 DMC-ODS counties reviewed uses a Health Information Exchange (HIE), which is a more efficient method of exchanging client data bilaterally. Special confidentiality requirements make this very difficult. At this point in development, providers are prioritizing work with the county to get core systems for billing and requirements in place.
Figure 7-9 shows current data exchange options available to DMC-ODS contract providers from EDI transactions to sending documents attached to secured e-mails. Where “Direct data entry to EHR” is noted, it almost always means that contract provider employees are entering the client data into their own EHRs, then logging into the county EHR to enter the same data there. This is inefficient, generally slows down the availability of data, is an ongoing drain on contract provider resources, and is a frequent source of data entry errors. It is noteworthy that 12 counties (86 percent) indicated contract providers enter data directly into their systems.

Interoperability continues to pose challenges for most DMC-ODS counties because it requires a level of resources, infrastructure, and skill sets not uniformly available to them. For the time being, for most DMC-ODS counties, some level of double data entry will continue to be required. Some counties 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.
**Availability of Telehealth**

Service delivery via telehealth benefits both the client and healthcare practitioner. For the client, telehealth expands access to care by overcoming the barrier of distance from established SUD services. For providers, telehealth allows for the convenience of service delivery from their existing locations and may allow them to more efficiently serve clients. It can also help with network adequacy requirements and offer more flexibility to both clients and providers who are in remote areas of California. Figure 7-10 shows that only four counties—Monterey, San Luis Obispo, San Mateo, and Riverside—currently have technology in place to support SUD services at a distance.

**Figure 7-10: County Telehealth Service Capacity**

Figure 7-11 shows the FY 2018-19 average authorized technology and analytical resources in DMC-ODS counties, measured in FTEs. It appears these resources are proportional to county size, with small counties’ technology staffing being an outlier. Also, with the exception of the very large counties group, small, medium and large counties have more technology than analytics staffing. The small counties group, on average, has only 0.33 analytics FTE, which seems low in view of all the reporting and data analysis needs involved with DMC-ODS implementation.
In addition to a more widely available health record, EHRs offer data about the entire population served by the DMC-ODS. The DMC-ODS’ staff can see outcomes at the population and target population levels; trends by race/ethnicity, gender or age; provider level performance; timeliness of services; and a great deal more. However, this is only the case if the DMC-ODS employs an adequate number of people with the right data analysis skills.

Below a certain threshold of data analytics staff capacity, DMC-ODS counties will not be able to realize the potential benefits of their EHRs or their practice management systems. Numbers matter, especially as the DMC-ODS county operations become more complex. The basic skill set demands the ability to analyze data effectively and work with clinical and program staff to study issues, identify trends and problems, and design and monitor interventions to improve care. The numbers alone do not tell the whole story. Below are some scenarios to consider:

- Some counties included analytics staff in reported technology FTE numbers.
- In some counties, technology and analytics resources are within the health agency and are not dedicated to support SUD services, with negative consequences for the program’s capacity.
• Some counties share technology and analytics resources between mental health and SUD services, but did not report separate FTE numbers for SUD for staff who have skills with some of the unique data sets (such as CalOMS).

• Some counties have relationships with universities, consulting organizations, or even their system vendors. These organizations provide data analytics services that the DMC-ODS cannot reliably maintain; the DMC-ODS counties are getting good value from their information system investment as a result. For example, San Diego County contracts with UC San Diego’s research institute for data analysis support on TPS data.

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 14 counties reviewed this year captured the ASAM-recommended LOC recommendations, referrals, and admissions for clients in their EHRs. In all counties, 94.5 percent of clients who request treatment through the DMC-ODS are screened for LOC placement using the ASAM tool.

Conclusions
In FY 2018-19, CalEQRO observed significant progress in launching DMC-ODS continuums, as well as challenges.

• Fourteen DMC-ODS counties reviewed in FY 2018-19 are in different stages of standing up their EHRs, and some are considering replacing/updating their information systems. These counties vary in size, deliver SUD services through different county/contractor program combinations, and have vastly dissimilar information system budgets and technology/analytics staffing.

• A common but critical challenge shared by the counties is the interoperability between disparate HIS. With many FQHCs providing non-methadone MAT and some beneficiaries ending up in EDs as a result of an overdose, it is paramount that county HIS communicate securely across departments while respecting provisions in 42 CFR. This is also important for the contract providers, who render over 75 percent of SUD services delivered across the counties.

• In the absence of HIEs, contract providers are often users of the DMC-ODS counties’ EHRs. They either enter client and service data directly into the county systems or send batch/paper files to process the data into county systems for billing.
and reporting. If the contract providers have their own information systems, they may have to do double entry of the same data into two systems, which is highly undesirable, inefficient, and easily prone to error.
Section 8

Key Findings and Recommendations

The 2018-19 report provides an important perspective on the second year of services expansion of the 1115 Demonstration Waiver for the DMC-ODS. Eleven of the 14 counties reviewed were launching their first year of DMC-ODS services as part of their approved plans. The Waiver incorporates a blueprint for how SUD treatment services 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 new infrastructure necessary to achieve these goals through an enhanced workforce, implementation of new managed care elements of IT, and data analytic reporting that supports accountability for quality management, cost effectiveness, and ongoing QI.

While the Waiver offers the potential of significant benefits for clients, it also poses many challenges and considerable risks for the counties that decide to implement this pilot opportunity. The summary of findings and recommendations in this section may guide leaders working to implement these new and complex systems in their counties.

In this final section, CalEQRO summarizes the key findings from the report and formulates recommendations for the future. The key findings begin with a focus on how the Waiver design opened up positive opportunities for improving and transforming community SUD treatment systems of care. The next set of findings focuses on the creative ways that counties stepped up to expand service opportunities, invested time and resources, and built out their systems to enhance care for their communities. These sets of findings also highlight which transformation
KEY FINDINGS AND RECOMMENDATIONS

efforts and methods are working well, the emerging best practices for service delivery and organization, and what remains as continuing learning opportunities. The section then transitions to the salient challenges in implementing the Waiver and recommendations for enhancing services in the future.

SUD Care Enhancements Generated through the Waiver Design

In many respects, the DMC-ODS Waiver STCs provide a detailed blueprint for designing an ideal SUD system of care for California’s Medi-Cal population. This subsection elaborates on components of that blueprint and how 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 and reflects aspirations that involve huge local and state undertakings. Most counties needed several years of preparation to get their basic infrastructure and program components sufficiently in place to begin. Giving the Waiver model a full test will require more time. Waiver renewal is required by the end of 2020, which represents a common timeframe for complex Medicaid system redesigns. Key stakeholders are sharing their appreciation of the DMC-ODS with leadership at DHCS as well as suggestions for enhancements. Any changes to the design also will be of great interest outside California, particularly for the 25 other states that have applied for similar Waivers.

The following Waiver components impacted SUD services in the counties reviewed in many positive ways:

A. Designing a formal model of DMC service delivery with a continuum of care. DHCS, with support, designed a model of care based on the ASAM criteria and levels of SUD care, organized to meet the individual needs of clients with SUD. Billing supports core services levels, including removing the institutions for mental diseases (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 the Waiver STCs, including a QI plan and many other managed care and accountability elements.

B. **Individualized treatment and a client-centered approach.** These are foundational elements of the design and move away from historic program-driven service structures with fixed graduation dates, 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. Referrals to SUD 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 well as other treatments that are part of the continuum of care. Review results showed that counties have begun monitoring individualized treatment fidelity as part of their QI programs, timely access based on ASAM assessment recommendations, and tracking transitions along the continuum of care.

C. **Evidence-based MAT.** The counties approached expansion of MAT with a variety of different partnerships. The Waiver requires that the NTPs expand their services to include new medications. Accordingly, the NTP network providers are changing workflows, computer systems, and pharmacy arrangements to add new FDA-approved medications. Treatment is not limited to medication but includes counseling and other medical and supportive treatments. The DMC-ODS counties also expanded or opened new outpatient MAT clinics, began offering new MAT services in some residential treatment facilities, and established partnerships with primary care clinics, EDs, and criminal justice system to enhance access to MAT and other treatment. Through this combination of efforts, MAT services are becoming more available throughout California. State leadership also enhanced access by releasing a number of innovative grants to strengthen partnerships with primary care, EDs, and MAT programs.
D. **Evidence-based SUD treatment requirements.** Evaluation of the best science for treatment and outcomes was central to the Waiver’s development and design. The Surgeon General’s report\(^{20}\) addressed the origins of SUDs, impacts on the brain, and effectiveness of treatments. The findings were incorporated into the clinical design of the Waiver processes and services. The Waiver specified several EBPs for widespread adoption and the mechanisms for DMC-ODS counties to use in establishing their implementation throughout their SUD treatment workforce. As new medications or other treatments are identified, these too 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. The community-based services include school-based clinics for youth and widespread case management services external to clinic settings for clients of all age groups. This approach encourages outcome-oriented and cost-effective SUD service delivery to reduce reliance on ED services and other acute care systems. Both clients and providers shared positive experiences with client care and engagement based on this element of the Waiver.

F. **Addition of licensed clinicians (LPHAs) and Medical Directors.** These new workforce requirements were incorporated into DMC certification requirements for treatment programs to enhance the quality of services in the SUD care system. An expansion of the total workforce occurred in all counties’ networks, as well as more care 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 as well as supervision of treatment quality.

G. **Standards for accessibility, timeliness, and quality of treatment services** and accountability for counties to meet the standards. These standards and their accompanying accountability

requirements serve as central checks and balances for any managed care system. The Waiver STCs establish many expectations for how the standards will be achieved, including 24-hour Access Call Lines, data systems to track client flow related to timeliness and generate reports, an authorization process for residential treatment, a QIP, and required ASAM training and monitoring of providers in EBPs.

H. Fiscal Waiver so IMD residential facilities of 16 beds or more could be Medi-Cal-certified. The fiscal waiver of this rule allows for Medi-Cal certification and billing in residential treatment facilities for the treatment costs which would have not been able to be reimbursed. Approximately 80 percent of the facilities would not have been able to serve individuals in California as they are over 16 beds in capacity.

I. 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 all of the counties reviewed. 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 and county contracts outline these specific new accountability systems.

J. Required mental health and public health coordination as part of the managed care framework. DHCS included 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 MCPs. The goal of these requirements is to enhance the wellness of the beneficiary overall—in terms of health, mental health, and recovery from addiction. Most of the reviewed counties in this report had Whole Person Care grants in place, which further supported their focus on these goals, especially for Medi-Cal clients with complex health care needs that commonly include SUD or mental health treatment.
Findings 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 counties reviewed this past year all had approved plans for implementation. Counties experienced challenges with launching services as originally designed and worked with DHCS on changes. Many were successful in meeting and even exceeding goals set out in their plans. A critical success factor is a willingness to be flexible and creative, as unforeseen challenges and problems inevitably emerge in the implementation and redesign of these complex systems. It is important to note that county implementations had to go beyond adding new services and capacity. The Waiver required implementation of major changes in how their systems of care function, including the interventions and methods of their treatment services to address client needs. Directors in each county needed to promote, educate, and support these changes with legacy providers, criminal justice systems, and other stakeholders still attached to outdated models of care. Below is a summary of some of the core strengths found in the DMC-ODS programs that contributed to achieving these changes for the benefit of SUD clients and the communities overall.

A. Leadership with effective communication that engages 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, strong and effective communication is a central trait required in each county, particularly in the first two years of service delivery and change. It requires reaching many important audiences and phases of communication including:

1. Educating the community about the new program philosophy and opportunities for expanded access to SUD treatment.

2. Involving stakeholders from the criminal justice system, DMC-ODS treatment providers, and client groups from many ethnic and economic backgrounds in the design of the
DMC-ODS county plan and the shift to individualized client-centered treatment instead of program-driven treatment structures and methods.

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

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

(5) Most important, training and education in the ASAM principles of SUD 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 and state agreements. Without solid, visible leadership as well as effective communication and working relationships (inside and outside the county), implementing the Waiver is very difficult. Three of the 14 counties experienced leadership changes at the director and middle management levels, which led to delays in certification, contracting, training and billing activities.

B. Expansion of DMC-ODS services to clients with SUD in a new and effective model is central to the Waiver. The Medi-Cal clients served increased from the prior year in 9 of the 14 counties. Other had billing delays that made it difficult to validate the level of new services based on claiming data. Eleven of the 14 counties also had higher levels of service based on their penetration rates (linked to overall Medi-Cal eligibility) compared with statewide DMC penetration rates.

C. Launch of new DMC-certified and expanded services is critical to meet Network Adequacy standards and to ensure there are no undue delays in access to care. Most of the first-year counties were still awaiting DMC certification for some of their programs while others were continuing to expand into new regions and adding new LOCs. Only one county has providers who did not want to become DMC-certified and thus had to issue public RFPs to seek new
providers. Rural areas and smaller counties were also seeking contractors in neighboring regions to support their continuum of care.

D. **Training** is required in many areas in response to ASAM assessment and treatment models, increased use of EBPs, expanded use of MAT, and the shift to individualized treatment from program-driven services. All counties provided evidence of training efforts by staff from both contracted and county treatment programs. Many also used training by California Institute for Behavioral Health Solutions and train-the-trainer models to enhance and reinforce new approaches to treatment, clinical documentation, and other STC compliance requirements. Even with these efforts, staff and contractors are still seeking more support in their work to meet DMC-ODS documentation requirements for all aspects of clinical charting.

E. **Access Call Centers and timeliness.** As discussed in Section 4 of the report, all counties had Access Call Center systems that were available 24 hours a day, 7 days a week and could accommodate different languages. Four of the largest counties had state-of-the-art software and staffing patterns to accommodate and track the data for large call volumes. Most had systems that also supported individuals going directly to SUD programs for assessments. Some small and medium-sized counties had challenges with tracking data and successful linkages to treatment. Older call systems without three-way communication systems with providers were more challenged in capturing key data and facilitating warm hand-offs of clients into care. Details of several best practices are provided in Section 4 and are recommended to counties considering ways to improve this component of access.

F. **Performance Measures.** The PMs are designed to also show the extent to which improved quality and outcomes are achieved for the system as a whole over time. Implementation plans often phase in additional LOCs and capacity in future years as the plans often start with core required services and add others over time. Except when service data were not available in the DMC-ODS claim system, most of the PMs yielded positive results for the processes they were designed to measure. As documented in Section 2 of the report, many of the PM results were positive for counties with more complete data sets. The PM results indicated some areas for improvement including enhancing continuity of care through facilitating more efficient transitions (e.g., from initial screening to
initiating treatment, from one LOC to another, and coordinating with other primary and specialty care providers). The PM results suggest a few other treatment improvement opportunities, such as continuing to expand non-methadone MAT services and expanding services to youth and some ethnic groups.

G. **PIP activities on outcomes and quality.** All the PIPs in conceptual or active stages focused on key clinical or administrative issues regarding access, timeliness, or outcomes. Among the 14 counties, there were 28 potential PIPs. Of these, 27 PIPs were submitted, 21 were classified as Active, and 4 were Concept Only. Key issues for PIPs were care coordination between LOCs, expanding access to youth and physically disabled adults, enhancing customer service and timely Access Call Center functions, and reducing program drop-outs (with strategies to improve client engagement and therapeutic alliances, grievance processes and procedures, and the discharge processes from residential treatment and WM so that readmissions back into those LOCs decrease).

H. **New billing and cost reporting systems.** As part of the design of the Waiver, the counties launched new billing and fiscal tracking systems within months of beginning direct services. The new systems required significant technical work for the counties; 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 issues linked to diagnosis codes; development of highly complex Medi-Cal billing workflows with contractors who were billing Medi-Cal for the first time; and IT systems handling of the claims output. Counties that waited to begin their DMC-ODS benefited from the work of the Year One counties and DHCS in the refinement and clarification of billing and documentation requirements.

I. **Expanding partnerships with criminal justice.** One of the most significant system redesigns evolved from the partnership with criminal justice. In the past, 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, county leaders engaged with
and persuaded the courts to allow full SUD clinically based assessments with specific treatment recommendations and care management. These new processes help individually match clients to services based on ASAM criteria, making optimal treatment and outcomes possible. In the counties reviewed, more activities were evident that embraced the new clinical models of care, including the provision of MAT in detention centers and the manner in which counseling and treatment discharge planning was conducted. Many new joint efforts are also occurring in diversion programs and prevention, including prescription drug donation programs for unused medications, community education events, and shared coalitions focused on the additive impact of opioids and methamphetamines.

**J. Looking ahead to continuous QI and outcomes.** All 14 counties have QI/Quality Management Plans, Cultural Competence Plans, and specific goals to measure in both plans over the year. Most counties documented specific actions plans to achieve the goals, including their PIPs. Most of the QICs were integrated with both mental health and SUD treatment programs; the focus to more SUD-general quality goals and action plans were still emerging. However, each county was actively working on beneficiary rights, grievances, and overall compliance issues, which were a priority focus in each plan.

**Challenges for DMC-ODS Delivery and Systems**

CalEQRO learned from the clients in SUD care, and DMC-ODS counties of some challenges that they could not easily remedy themselves. Some of these challenges seemed to be created inadvertently. Others grew out of different state departments’ procedures when these did not take into account DMC regulations. Some challenges are longstanding, historical issues 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 descriptions of progress made by the DMC-ODS counties in addressing them.

**A. Client transitions along the continuum of SUD care and continuity of care.** SUD is a chronic disease that requires regular support over time, often at different LOCs to sustain important
behavior change and abstinence. One of the most important factors contributing to positive treatment outcomes is the strength of the therapeutic alliance between the client and their treatment staff, per Dr. David Mee-Lee, editor of the ASAM criteria and textbook.\textsuperscript{21}

When clients are transferring between residential LOCs to other LOCs with different treatment staff, a best practice is to bridge between the two LOCs by introducing the client to the new treatment staff at least twice before discharge from the higher-level residential 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. Continuity of care rates for all counties from residential to non-residential treatment were below 30 percent (and significantly lower in some counties). Additional support for these transitions to lower LOCs with both case management and some overlap in counseling staff would be helpful for treatment engagement and long-term outcomes. Without continuing support, many individuals are at risk of relapse.

B. Treatment needs of some SUD clients can conflict with the limits of a maximum of two residential treatment episodes per year. Residential treatment and all other SUD care treatment episodes would ideally be based on medical necessity. The current limit of two treatment episodes per year conflicts with the treatment needs of some youth and adults with SUD. Many clients leave during the first week of residential treatment because they are not ready for that level of commitment to treatment. In reviewing service data, approximately 20 percent of clients leave residential treatment within the first 10 days. (In some counties, it was reported to be as high as 35 percent.) CalEQRO heard concerns expressed by clients, providers, and county management that these episode limitations can affect client success in SUD treatment for some youth and adults.

C. DMC-ODS physician consultation to support optimal care/access to MAT. Physician consultation by DMC-ODS staff has some limitations that reduce opportunities to expand MAT across the physical and behavioral health care system for SUD treatment. Consultation is covered as a billable service under DMC-ODS only when the consulting physician works for a DMC-ODS-certified provider and consults with a provider who is also DMC-ODS.

certified—and the client is Medi-Cal eligible. As discussed in Section 4 of the report, one of the greatest needs and overwhelming requests for this consultation service comes from provider organizations that are not certified by DMC-ODS—namely, primary care, EDs, and medical staff in detention health centers. To expand MAT capacity to the broader health delivery system, consultation from DMC-ODS physicians who are addiction-trained specialists would be very beneficial. HRSA and SAMHSA have grants designed to add more funding for MAT to primary care sites. Without training and consultation from addiction-trained specialists, physicians often can find induction and phase-in of MAT medications to be difficult, especially in the initial phases of their learning to treat SUD with MAT. Thus, it would improve the quality of SUD treatment system to the community as a whole to include a broader definition of allowable physician consultation for Medi-Cal beneficiaries.

D. Medi-Cal transfers from another county take up to 90 days by State Social Services to obtain eligibility in the new county where the client has relocated. This challenge was experienced by all counties and has been creating a barrier to access for clients who move. Despite efforts to work with local social services department benefits staff, the process of transferring Medi-Cal enrollment to a new county of residency can take up to 90 days and is not retroactive to the county where the client moved from their application date. 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. Many counties allow urgent cases and pregnancy cases to begin care and use county funds for payment. Others are waiting for the new Medi-Cal residency to be established as required for billing. The counties suggested several options for solving this problem, all of which would require state policy changes:

(1) Allow billing and reimbursement to take place retroactive to the date of relocation/application for transfer by the Medi-Cal eligible individuals to the new county, similar to SSI application cases and hospital ED cases; or

(2) Reconcile units of service for relocated clients at cost report time.
Other solutions may be possible as well, but these two were identified by DMC-ODS counties as potentially most effective and efficient.

E. Technology infrastructures in contract provider programs, DMC-ODS counties, and for telemedicine. As discussed in the ISCA section of the report (Section 7), the current IT infrastructure in most counties and among contract providers is not adequate for the new managed care environment that requires tracking all the measures and key metrics linked to accessibility and quality of care. The biggest challenges in QI lie in the lack of interfaces across multiple different data collection systems and limited central data collection capacity to perform quality metrics across the managed care network or documented in an EHR. Many extremely labor-intensive workarounds have been created to try to meet requirements, but they are prone to error and stretch already limited administrative and clinical staff resources. Systematic investment in new systems is needed over time to remedy this.

F. Besides the coordination and data exchange issues, equipment and software are outdated and, in some cases, non-existent, particularly for EHRs in many contract providers’ programs. To support care coordination, each DMC-ODS needs an electronically facilitated exchange of documentation that encompasses clinical treatment plans, notes, release of information forms, SUD assessments, ASAM LOC referral data, requests for authorizations for treatment, TPS, CalOMS, and referral documents. To make efficient use of staff resources, automation of these types of information exchanges in a coordinated way would be highly beneficial. Some coordinated efforts towards this goal would be highly beneficial at both the state and local levels.

G. 42 CFR Part 2 challenges for coordination of care. Provisions in 42 CFR Part 2 have created significant challenges for smooth transitions in care across the SUD system and between health care and social services. Without written releases with specific limitations, case management processes across the physical health care system and the admissions process are affected. 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. Some counties have developed workarounds such as three-way calling when making referrals. These calls include the client, the Access Call Center referrer, and
the provider to whom the client is being referred. When this occurs, the client can talk directly to the treatment program about their needs. However, that solution is not always feasible, so other solutions to facilitate initial referrals are needed to improve timely access to care processes. Solutions to these barriers to care will require federal policy changes as it is not possible to resolve them solely with technology or with state regulatory changes.

H. Workforce recruitment, training, and retention. The expanded workforce, including LPHAs and medical providers, is very positive for SUD treatment, but also is very challenging. DMC-ODS counties suggested 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 trying to fill all of its positions due to recruitment challenges. Another example, shared by many counties, is their challenge in obtaining approval from their County Board of Supervisors to hire more positions.

I. Addition of more medically monitored levels of SUD care. A full continuum of SUD care includes more medically supervised or managed treatment services that are currently not available in any counties reviewed. The desire to have hospital and specialized partners for these service levels was expressed in many counties. The Waiver encourages the establishment of network capacity at these levels, such as WM 3.7 and WM 4.0 (as described in the ASAM continuum of care). These LOCs require maintaining an expensive infrastructure and are usually hospital-based. A systematic effort to address these important LOCs is needed. Individual counties have limited options with current providers; they need both financing assistance with their initial start-up of these LOCs and/or billing incentives once the LOCs are operational to establish them on a stable financial footing.

J. Stigma regarding SUDs persists in communities and impedes: (1) use of medications to help with SUD treatments; (2) use of 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” opposition). Continued education and work with media, the public, and community leaders are needed to push back on these
biases and beliefs, which otherwise create barriers for clients to obtain housing, jobs, childcare, and other services.

K. Homelessness affects smooth transitions in care and increases the risk of 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. Most counties reviewed are part of local coalitions and are involved in a range of efforts to work on access to affordable housing. Addressing homelessness is imperative for sustained recovery and wellness for persons with SUD. Marin County gives priority status to SUD homeless 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.

Recommendations from the Second Year of EQRs
The annual reviews for each of the 14 counties included county-specific recommendations for next steps towards improving their access, timeliness, quality, and outcomes of care. Building upon the considerable strengths of the 3 counties among the 14 who were in their second year of services, many of the other 11 counties who began services approximately one year ago worked strategically to have successful launches of their required DMC-ODS services. While each county is unique in many respects, common themes were identified among them that were highlighted in recommendations. These themes are likely to be applicable to many of the other counties preparing to become Waiver counties or in the earlier stages of their implementation who have yet to be reviewed.

The highest-priority recommendations linked to quality DMC-ODS improvements are provided below. These recommended improvements could be considered as 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.

California’s DMC-ODS Waiver completed its second year of county-based implementations that use a science-based design and expanded treatment options for Medi-Cal beneficiaries and others with SUD needs. The number of counties opting into the Waiver continues to
grow, with 30 counties now actively in various stages of implementation. County and provider support for renewing the Waiver is strong, and clients and family members’ experiences of care have been very positive as reflected in confidential surveys and focus groups. Some of the challenges noted in the findings and recommendations could be addressed in working on Waiver renewal in 2020.

A. Develop and expand 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, reducing community stigma towards those with SUD, and increasing use of MAT.

B. Focus on refinement of Access Call Center systems/software and development of three-way calling capacity with the provider networks to facilitate the referral process for assessments and treatment access. It is also recommended to establish (if not already in place) a central tracking system for requests for services and referrals for assessments that include contract providers with no-wrong-door policies. Evaluation of these new and developing access to care 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.

C. Continue expansion of MAT access in residential treatment programs and detention centers. These efforts will enhance client outcomes in treatment and for detention releases could prevent potential deaths from overdose and recidivism.

D. Support expanded access and collaboration by coordinating MAT efforts with EDs and primary care settings. MAT coordination of care efforts with EDs and primary care are also valuable to clients, improve access to and outcomes in treatment, and enhance coordination of care with the whole health delivery system.

E. Strengthen EHR and related health IT systems. These systems are essential for managed systems of care, specifically for tracking timely access to care, clinical documentation, coordination of care, services capacity, and integrity/accountability systems. Both physical health and mental health have had historical sources of funds to build this EHR infrastructure, but SUD services have not. IT
infrastructure, combined with training and quality dashboards, can help with coordination and efficiency in SUD care. This is a long-term project for all counties, but an important component of clinical and fiscal success for an MCP.

F. Work with DHCS and Social Services to explore solutions to the 90-day transfer timeline issue for inter-county transfers of residency for Medi-Cal eligibles to reduce access problems.

G. Provide frequent, comprehensive provider training. Based on the reviews, provider training is essential in all components of clinical documentation, including how the components interface with one another and how often to document changes in client status. The training should include the models and elements of client-centered care and focus on unique needs of clients wanting more case management and individual and family therapies as part of their care.

H. DMC-ODS counties should regularly analyze their data regarding client transitions between LOCs to inform their training efforts. Training and supervision are still needed in residential treatment and residential WM settings where older approaches with long-term residential treatment are still being used by some staff in treatment and care planning. This recommendation builds on best practices in optimizing successful transitions to lower LOCs and transfer of therapeutic alliance to treatment staff who can support clients in their next phase of recovery.

I. Each county needs to continue working with its county counsel and learn from other counties about finding practical solutions for information sharing within the current 42 CFR.2 Part 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. 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 Part 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.
J. Expand recovery support services as clients move from treatment to community stability. This new service is essential for wellness but is not yet deployed in many counties. 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.

Conclusions

In conclusion, the California DMC-ODS STCs provide 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 14 DMC ODS counties reviewed in this report were the first wave to implement the Waiver STCs, learning useful lessons from the first three “pioneer” counties. 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 with the 14 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. It is a privilege to be part of this important and positive transformation in the system of care for clients with SUD.