California's Drug Medi-Cal Organized Delivery System

FY 2015–2016 Report

Evaluation of California's Section 1115 Demonstration Waiver

Prepared for the Department of Health Care Services
California Health and Human Services Agency

UCLA Integrated Substance Abuse Programs

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Note on Terminology

Individuals Receiving Services

Individuals who are eligible for, or are receiving, substance use or behavioral health services have been referred to as “clients,” “consumers,” “beneficiaries,” and “patients.” While “client” is still the dominant term in the substance use field, the increasing integration of behavioral health with physical health care means that clinicians will need to unify around standard terms. For consistency, we use the term “patients” throughout this report.

Modalities/Levels of Care

Currently, codes to identify the levels of care specified by the American Society of Addiction (ASAM) Criteria are still in the process of being implemented in billing systems, and so the treatment modalities in the state’s California Outcomes Measurement System - Treatment (CalOMS-Tx) have been used as an approximation in this report. The modalities that can be identified within CalOMS-Tx include detoxification, outpatient, intensive outpatient/day care rehabilitative, residential, and narcotic treatment programs (NTPs). These provide the best available approximations in existing data for the ASAM-defined services of withdrawal management, outpatient, intensive outpatient, residential, and opioid treatment programs, respectively.

Due to the movement of the field toward standard use of the ASAM Criteria, we use the term “withdrawal management” throughout the report to refer to services that are referred to in CalOMS-Tx as “detoxification.” Withdrawal management, as defined by ASAM, can also occur as a standalone service or within other settings. Similarly, we use the ASAM term “intensive outpatient” treatment to refer to services referred to in CalOMS-Tx as “Outpatient Day Program intensive / Day Care Rehabilitative” services.

Acronyms

A reference for all acronyms used in this report can be found in the appendix.

Executive Summary

This is the first annual report in UCLA's evaluation of California's Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration project under California's Section 1115 waiver, which is expected to transform the state's Drug Medi-Cal (DMC) substance use disorder (SUD) services. The goals of this report are to describe the "starting point" for DMC-ODS in terms of treatment access, quality, and coordination/integration, and to facilitate discussions with stakeholders regarding evaluation methods and data collection.

Baseline data is still being gathered due to the phased waiver rollout, and UCLA expects to gain access to additional data sources that will provide further baseline information in the near future.

Conclusions based on analyses of administrative data such as CalOMS-Tx is limited by the quality of data reporting. A combination of technical assistance to improve data reporting and a study that would enable adjustments for missing data in future analyses would be helpful.

Notable findings and preliminary recommendations are presented below.

Access

- *Methadone.* Use of methadone was much lower in Phase 4 counties, and smaller counties in general, than in other phases. This suggests a particular need to expand capacity to enable access to NTPs during this phase. Methadone programs typically require daily participation, which may render a regional model impractical, given the long travel distances that this might impose upon patients. Buprenorphine prescribed in outpatient settings may provide an alternative for some patients.
- *Expansion challenges.* According to survey respondents, the most challenging modality to expand was residential treatment, followed by NTP and withdrawal management. Facility certification and reimbursement rates were reported to be significant challenges across modalities. For NTP, community opposition (NIMBYism) was the top challenge. There is anecdotal evidence that certification processes may have improved somewhat since the survey, and reimbursement rates will change when counties participate in the demonstration project. UCLA will therefore continue to monitor these challenges in future surveys. NIMBYism has a long history in relation to the SUD field and is less likely to have changed in the last year.
- *Penetration rates.* Penetration rates for treatment among patients in California who need it are estimated to be below 10%, which is below national rates, leaving room for improvement. However, national surveys also suggest that most people who need treatment do not feel that they need specialty treatment. This suggests that although efforts to increase penetration rates can and should include expansion of physical capacity, efforts to change perceptions about

specialty treatment among prospective patients, and to reach patients in non-specialty settings, such as primary care, will also be necessary to substantially increase penetration rates.

Quality

- *ASAM Criteria.* Use of the ASAM Criteria to assess patients' needs and place them into the appropriate level of care will be a requirement under the DMC-ODS waiver; as of late 2015, ASAM assessment was at least partially available in less than half of California counties. There was considerable variation across counties in terms ASAM practices and preparations. As counties opt in to the DMC-ODS demonstration, use of ASAM Criteria-based tools is expected to increase, but implementation will remain challenging.
- *Patient engagement.* During calendar year 2015, about 70% of patients admitted to treatment (excluding withdrawal management) were successfully engaged in treatment (i.e., length of stay of 30 days or longer), though this varied somewhat by modality. Future changes in patient engagement as the waiver is implemented will be tracked as part of the evaluation.
- *Patient transitions along the continuum of SUD care.* More than 75% of admissions to non-NTP withdrawal management services and nearly 90% of admissions to residential treatment were not followed by additional treatment following discharge from these services. With the implementation of the DMC-ODS, the expectation is that patients will transition to different levels of care as needed, and UCLA will continue to monitor these practices.
- *Use of evidence-based practices.* According to survey respondents, treatment programs in slightly more than half of counties used at least two of the five evidence-based practices (EBPs) listed in the Special Terms and Conditions (STCs) of the DMC-ODS waiver. Use of two of the five will be required under DMC ODS. County administrators rated training for each of the five EBPs as a "medium" priority. It is anticipated that improvement will occur as providers receive more training and counties require their providers to implement these practices.
- *Patient quality-of-care perceptions.* The majority of counties already require SUD treatment providers to collect data on patient satisfaction/perceptions of care, typically using written surveys. As part of the evaluation of the waiver, patients will be surveyed to examine patterns in patients' perceptions of care over time.
- *Establishment of quality improvement committees and plans.* Most counties (63%) reported already having a quality improvement committee with SUD participation (which could include a behavioral health committee with mental health [MH] and SUD participation). However, only 21% of counties reported having a written quality improvement plan for their SUD treatment system at the time of the survey. Three-quarters of the respondents reported that the waiver has positively influenced quality improvement activities in their counties.

- *Patient outcomes.* According to CalOMS-Tx data, treatment was associated with improvements in alcohol or other drug use, social support, living arrangements, and employment, but about half of the data was missing at discharge, creating the potential for bias. UCLA recommends a patient follow-up study to measure outcomes for patients with missing data, which would enable use of statistical models to estimate (impute) the values of missing data in the future.
- *Effectiveness of levels of care – readmissions to withdrawal management and residential treatment.* During 2015, among patients who initially received non-NTP withdrawal management services, 10% were readmitted within 30 days. Of the patients who were initially admitted to residential treatment, 6% were readmitted to residential treatment within 30 days. Future analyses will examine whether implementation of the components of the DMC-ODS (e.g., use of the ASAM Criteria for assessment and placement) contributes to decreases in readmissions to withdrawal management services and residential treatment.

Integration/coordination

- *MOUs between SUD and managed care plans*: At the time of UCLA's County Administrator survey in 2015, no county had a signed MOU that met the waiver requirements. However, given that this is a requirement for counties to opt in to the waiver, this is expected to change. To meet DMC ODS requirements, a strategy that many counties are employing is to amend an existing MOU in place with managed care plans for specialty mental health.
- *Comprehensive substance use, physical health, and mental health screening*: Most counties have either a centralized system for screening and placement or a standardized screening and placement set of procedures for their providers, providing a mechanism through which future comprehensive screening may be implemented. ASAM Criteria incorporate both cognitive and biomedical assessments, so screening for physical and mental health problems is likely to become more common in SUD settings under DMC ODS.
- *Care coordination and effective communication among providers*: Integration of services is more advanced between SUD and MH providers than between SUD and primary care providers. County SUD and Medi-Cal managed care plan leaders both reported that coordination between SUD and primary care providers is relatively weak at the moment. Still, 44% of administrators reported that DMC ODS waiver planning has already had a positive impact on communication with physical health services in their county.
- *Facilitation and tracking of referrals*: Based on CalOMS-Tx data, withdrawal management receives more referrals from health care providers than from other modalities, followed by residential and intensive outpatient treatment. However, the number of referrals remains low overall across modalities, leaving substantial room for improvement in SUD referrals from the physical health care system. Integration efforts written into the DMC-ODS demonstration may facilitate this, and UCLA will continue to monitor trends in referrals.

I. Introduction

A. Overview: California's Medicaid Section 1115 Demonstration Waiver

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a demonstration project under California's Section 1115 waiver, approved by the Centers for Medicare and Medicaid Services (CMS) on August 13, 2015. Through the DMC-ODS, the state proposes to restructure Medi-Cal SUD services (Drug Medi-Cal [DMC]) in participating counties to operate as an Organized Delivery System that:

- provides a continuum of SUD care modeled after the American Society of Addiction Medicine's Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (ASAM Criteria);
- increases local control and accountability;
- creates mechanisms for greater administrative oversight;
- establishes utilization controls to improve care and promote efficient use of resources;
- facilitates the utilization of evidence-based practices (EBPs) in SUD treatment; and
- increases the coordination of SUD treatment with other systems of care (e.g., medical and mental health).

The principal aims of the DMC-ODS are to improve access to SUD services, improve the quality of SUD care, control costs, and facilitate greater service coordination and integration, both among SUD providers and between SUD providers and other parts of the health care system.

County participation in the waiver is voluntary. Counties that opt in to participate in the DMC-ODS are required to submit an implementation plan that describes how they will meet the waiver requirements. The timing of these county submissions is staggered based on regional phases.

The phases include:

- Phase 1: Bay Area counties
- Phase 2: Southern California counties
- Phase 3: Central California counties
- Phase 4: Northern California counties
- Phase 5: Tribal Partners

Figure 1 is a map of all California counties by implementation phase.

Figure 1: Map of waiver implementation phases.

This map is adapted from the California Behavioral Health Directors Association county regional map: http://www.cbhda.org/wp-content/uploads/2014/12/County-Region-Map.pdf

The University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP), under contract with DHCS, is evaluating the DMC-ODS demonstration project. The design of the DMC-ODS evaluation employs a multiple baseline approach, accommodating the multiple-phase rollout, and focuses on the four key areas of access, quality, cost, and integration, as well as coordination of SUD care both within the SUD system and with medical and mental health services.

Evaluation hypotheses include:

Hypothesis 1: Beneficiary access to treatment will increase in counties that opt in to the waiver compared to access in the same counties prior to waiver implementation and access in comparison counties that have not opted in.

Hypothesis 2: Quality of care will improve in counties that have opted in to the waiver compared to quality in the same counties prior to waiver implementation and quality in comparison counties that have not opted in.

Hypothesis 3: Health care costs will be more appropriate post-waiver implementation than pre-waiver among comparable patients; e.g., SUD treatment costs will be offset by reduced inpatient and emergency department use.

Hypothesis 4: SUD treatment coordination with primary care, mental health, and recovery support services will improve.

UCLA will utilize a mixed-methods approach to measure the impact of the waiver utilizing state-, county-, provider-, and patient-level data to test these proposed hypotheses. Both quantitative and qualitative measures will be used to mitigate the weaknesses of each. Quantitative methods will be used to analyze trends and the degree of changes over time, whereas qualitative methods will be used to help interpret and supplement the quantitative data within the broader context of stakeholder perceptions.

B. Status as of June 2016

Evaluation plan

UCLA's DMC-ODS evaluation plan was approved by CMS on June 20, 2016. [1]

[1] The evaluation plan is available online at: www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

County implementation plans

As of June 30, 2016, DHCS has opened the window for counties identified in Phase 1 (May 2015), Phase 2 (November 2015), and Phase 3 (March 2016) to submit implementation plans. As of the end of June 2016, 10 implementation plans were received and four were approved by DHCS. These counties are listed in Table 1.

Table 1: Timeline of county implementation plan (IP) approvals as of June 30, 2016.

County	Phase	IP submitted	DHCS approval
San Francisco	1	November 2015	June 2016
San Mateo	1	November 2015	April 2016
Santa Cruz	1	December 2015	June 2016
Riverside	2	December 2015	
Santa Clara	1	January 2016	June 2016
Marin	1	February 2016	
Los Angeles	2	February 2016	
Contra Costa	1	April 2016	
Napa	1	April 2016	
Monterey	1	May 2016	

Existing data sources

Although the evaluation plan was only recently approved, while it was under review, UCLA collected baseline data consistent with the plan, to the extent possible. Some data, however, was not available. The results and discussions presented in this report are based on the data directly collected by UCLA according to the evaluation timeline and data collected by the state that was available to UCLA as of June 30, 2016.

As of June 30, 2016, UCLA had received some, but not all, data from statewide administrative datasets. Most notably, Drug Medi-Cal and Medi-Cal data had not been released to UCLA at that time. These datasets will be critical to fully establish a baseline measure of the variables needed to measure access, quality, coordination/integration, and cost.

UCLA is also working with opt-in county administrators and state-level data extracted from the Prime system to obtain provider facilities information, which will allow UCLA to sample and survey SUD treatment providers of opt-in counties. This effort will continue as counties opt in, become approved to begin implementation activities, and submit their selected provider list.

Within this report, the administrative datasets that will be discussed are primarily the California Outcomes Measurement System – Treatment (CalOMS-Tx) collected by DHCS, and summary numbers from the National Survey on Drug Use and Health.

Status of new data collection (dependent on the stage of waiver implementation)

As of June 2016, only four counties had received preliminary approval of their implementation plan by DHCS and none had approved contracts enabling them to begin implementation. Therefore, no data is yet available on actual implementation activities. This report is therefore focused on baseline measurements taken as counties prepared for the waiver.

ASAM Criteria data is not available at this time for purposes of the evaluation, but UCLA has surveyed administrators about their county processes to collect ASAM assessment data. UCLA is working with DHCS and counties to develop a fast and free brief screening tool for counties to utilize for preliminary placement of patients into SUD treatment. (See "Use of ASAM Criteria-based tool(s) for patient placement and assessment" in the Quality of Care section of this report.)

UCLA Treatment Provider Surveys will be conducted as soon as approved counties submit contact information for providers that will participate in the demonstration project. UCLA plans to send surveys to a representative sample of providers in opt-in counties.

UCLA Patient Surveys are under development to measure patient perceptions of access to SUD treatment, the quality of care, and coordination/integration of care. UCLA has reviewed validated surveys that collect patients' experiences with and perceptions of SUD/MH care, and has been working with stakeholders, including county administrators, California Institute for Behavioral Health Solutions (CIBHS), the EQRO, and DHCS, to obtain their input.

Stakeholder Interviews with county SUD/BH administrators will be conducted soon after DHCS approval of their county's implementation plan (pre-implementation) and then again after implementation is underway (e.g., billing for DMC-ODS services). The purpose of the short pre-implementation interviews is to gain a better understanding of county administrators' experiences as they prepare for implementation, including challenges and successes as well as lessons learned and recommendations to help inform:

- other counties that are in the process of planning or preparing for the waiver;
- DHCS in its efforts to provide technical assistance; and
- UCLA for purposes of evaluating the waiver.

More in-depth interviews are planned approximately 4 to 5 months after implementation has begun. County administrators will be asked about what is working well and what challenges they are experiencing in the following areas: improving access to SUD services, patient flow along the continuum of SUD care, quality of SUD care, and coordination of SUD treatment with the physical health and mental health systems.

Status of new data collection (NOT dependent on the stage of waiver implementation)

The data collection activities that are NOT dependent on the stage of waiver implementation will supply most of the findings in this report.

County Administrator Survey. UCLA developed an online administrator survey to obtain information and insights from the SUD/BH administrators (regardless of opt-in status or intent). The survey addressed the following topics: access to care; screening and placement practices; services and training; quality of care; collaboration, coordination, and integration of services; and waiver implementation preparation/status. Data was collected from August through October 2015, with an 84% response rate (n=48), and was summarized in a report issued to DHCS in December 2015.[2] Additional qualitative data analysis of responses to open-ended questions in the survey was subsequently conducted for the present report.

Medi-Cal Managed Care Plan Survey. UCLA created an online survey intended to measure baseline perceptions of medical directors of Medi-Cal managed care plans (MCPs) regarding coordination of their MCPs with county SUD treatment systems prior to implementation of the waiver. Data was collected in December 2015 and January 2016, with a 59% response rate (n=13), and was summarized in a report issued to DHCS in January 2016.[3]

County/DHCS Audit. DHCS is in the process of designating ASAM levels of care (3.1, 3.3, and 3.5) for residential providers. UCLA received an aggregate report on this process at the end of June, and in the future, these designations will be reflected within Drug Medi-Cal claims data.

C. Roadmap of the Report

Based on available data, this report describes data from 2015 and 2016, prior to the start of DMC-ODS implementation. Its goals are to describe the "starting point" for DMC-ODS, to establish baseline measures for future comparisons, and to provide concrete data for obtaining stakeholder feedback on potential methods and measures. Data collection and analyses will continue as Phases 4 and 5 become active.

The report addresses the key areas in UCLA's Evaluation Plan: (1) access to care, (2) quality of care, and (3) the integration and coordination of SUD care. Cost will be addressed in future reports after sufficient Drug Medi-Cal and Medi-Cal data is available for cost analysis. Each key area will be discussed by defining the data sources, presenting results of baseline measures, summarizing preliminary findings, and describing evaluation plans for future years of the evaluation. A general discussion closes the report.

[2] Full reports on the results of the baseline County Administrator Survey and managed care plan survey is available at: http://www.uclaisap.org/ca-policy/html/evaluation.html
[3] See above footnote.

II. Access to Care

Lack of appropriate access to care can impact the health and well-being of individuals with SUDs. Over the course of the evaluation, UCLA will track changes in access to care using multiple measures. Partial data were available at baseline for the following measures: treatment admissions, use of medication-assisted treatment (MAT), penetration rates, network adequacy, and existence of a 24/7 beneficiary access phone number.

As new data become available in the future, these measures will be refined and expanded to include availability of services in languages other than English, availability of a provider directory, patient perceptions of access to care, initiation and engagement in treatment, and, potentially, other measures.

A. Data Sources

The baseline measures below reflect analysis of two main data sources. The first, the California Outcome Measurement System - Treatment (CalOMS-Tx), was the only administrative dataset available to the evaluators at the time of this report; future analyses will be conducted using Drug Medi-Cal claims and Medi-Cal Managed Care encounter data when those are made available. The second source is data that UCLA collected via the County Administrator Survey. Additionally, data from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH) is included in order to estimate baseline penetration rates.

B. Baseline Measures

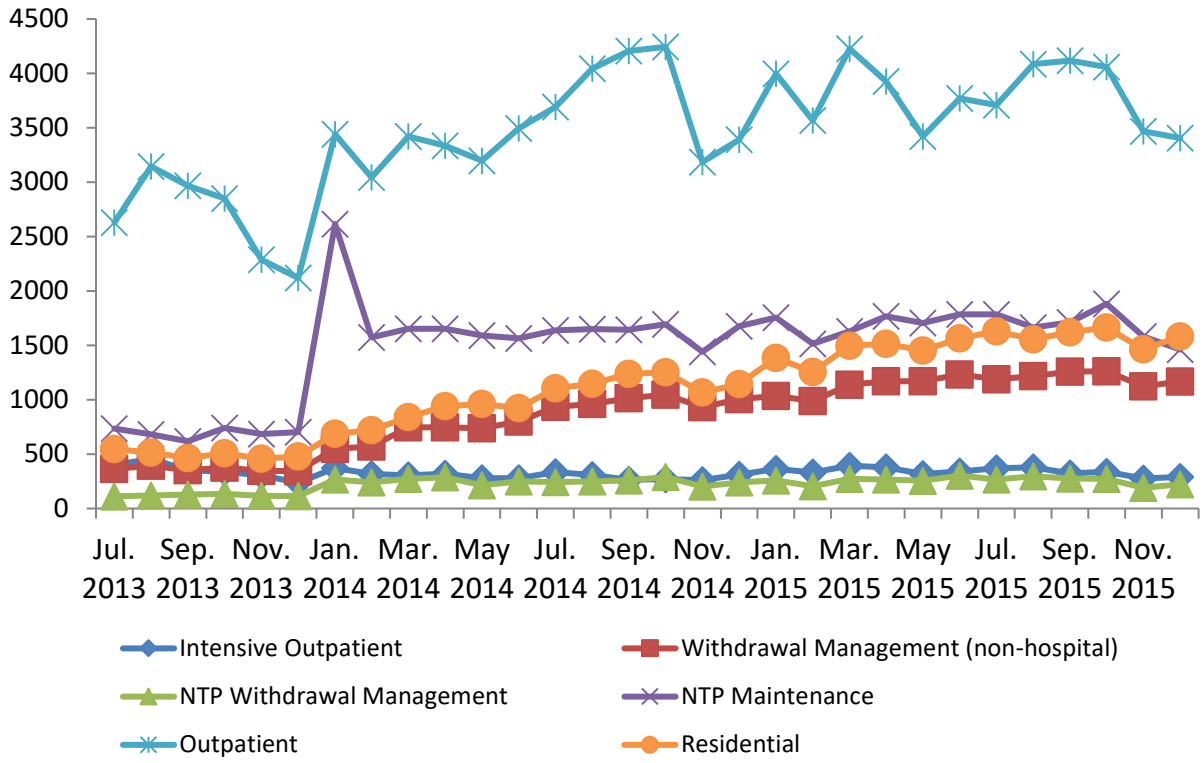
Availability and use of full required continuum of care: number of admissions

The purpose of this measure is to determine the extent to which all required levels of care are being used in county systems. In the future, Drug Medi-Cal claims data will provide a more accurate accounting of admissions to specific ASAM levels of care, but the codes that will identify these levels of care were still in the process of being implemented at the time of this report. Therefore, for this report, the treatment modalities in CalOMS-Tx will be used as a reasonable approximation. The modalities that can be identified within CalOMS-Tx include detoxification, outpatient, intensive outpatient/day care rehabilitative, residential, and narcotic treatment programs (NTPs). These provide the best available approximations in existing data for the ASAM-defined

services of withdrawal management, outpatient, intensive outpatient, residential, and opioid treatment programs, respectively.

During 2015, the calendar year prior to waiver implementation, the number of patients in specialty care who were also Medi-Cal beneficiaries (regardless of whether that payment source was used for the current treatment) was generally stable. This relative stability will make it easier for the evaluation to detect changes associated with waiver implementation in the future.[4] Statewide, outpatient treatment remained the dominant form of treatment, but all modalities were present (see Figure 2). In the future, admissions will be analyzed in greater depth for opt-in counties by the ASAM level of care indicated in Drug Medi-Cal claims.

Figure 2: Number of Medi-Cal beneficiaries by treatment modality.



Use of medication-assisted treatment (MAT)

Statewide, 33.2% of patients with heroin or other opiates as their primary drug problem were not treated with medications. Another 63.4% received methadone, 2.2% received

[4] Prior to 2015, large increases had occurred, particularly in January 2014 after the Medi-Cal expansion was implemented. These changes may have been due to a mix of data reporting issues and true new admissions. For further discussion of these changes, see Urada, Lovinger, Lim, & Ramirez (2015).

"other" medication, and 1.2% received buprenorphine (Subutex or Suboxone); see Table 2.

Table 2: Use of medications among patients with a primary drug of heroin or other opiates from January 1, 2014, to December 31, 2015.

	Phase 1 Counties (N=10,315)	Phase 2 Counties (N=27,610)	Phase 3 Counties (N=9,286)	Phase 4 Counties (N=2,301)
Medication used in drug treatment				
None	37.6%	32.4%	22.6%	72.5%
Methadone	60.8%	62.5%	76.2%	26.0%
Buprenorphine (Subutex)	0.9%	1.4%	1.0%	0.7%
Other	0.7%	3.7%	0.2%	0.8%

Marked differences between waiver phases were present in use of medications, however. In particular, use of methadone to treat opiate use disorders was much less common in Phase 4 counties, potentially due to a shortage of NTP providers (see the Network adequacy section for more on this). This also is consistent with prior DHCS findings that 28 of California's 58 counties do not have NTPs, and that this is particularly true of northern counties (DHCS, 2016), which are in Phase 4. This is of particular concern because a regional model, which could be used to facilitate access across county lines to certain types of scarce treatment modalities, would likely not work well for some NTP patients due to the long travel distances this may require for methadone maintenance, which generally requires daily attendance. Expansion of NTP sites and expansion of buprenorphine prescribing in NTPs and other modalities may help to address this.

Current use of buprenorphine within SUD treatment programs[5] was also low across the state according to CalOMS-Tx records, as, previously, the medication was not a covered benefit under DMC; however, under the DMC-ODS, physicians and licensed prescribers in DMC programs will now be reimbursed for the ordering, prescribing, administering, and monitoring of medication-assisted treatment, including buprenorphine.

Penetration rates

UCLA plans to examine trends in statewide penetration rates before and after waiver implementation based on the number of people entering treatment divided by estimates of the prevalence of dependence from SAMHSA's National Survey on Drug Use and

[5] Buprenorphine is also prescribed outside of specialty care (e.g., by physicians in primary care settings), but this is not captured in CalOMS-Tx.

Health (NSDUH). SAMHSA does not report data at the individual county level for all counties, however, and up-to-date substate data from SAMHSA that would be necessary for county-level or phase analysis is currently unavailable. UCLA therefore is taking an approach analogous to the "intention to treat" approach commonly used in research. This approach evaluates the statewide effect of making the waiver available, rather than examining only opt-in counties. Using this approach, the more counties that opt in, the more likely the penetration rates will change. Counties that do not opt in will not receive any of the benefits of the waiver and will therefore likely have unchanged penetration rates, just as patients who do not participate in treatment receive no effect in treatment studies.

Individuals with alcohol or illicit drug dependence or abuse are defined as having an SUD, and NSDUH classifies respondents as needing substance use treatment if they meet the criteria for SUD or if they received substance use treatment at a specialty facility in the past year (SAMHSA, 2014).

SAMHSA's most recent available NSDUH data for California (SAMHSA, 2016) indicates that in 2013–2014, an estimated 876,000 Californians age 12 and over needed treatment for illicit drug abuse or dependence, but that 791,000 of these did not receive treatment, suggesting that 85,000 received treatment, for a penetration rate of 9.7%.[6]

SAMHSA also estimates that 2,127,000 Californians age 12 and over needed treatment for alcohol abuse or dependence, but that 2,030,000 of these did not receive treatment, which suggests 97,000[7] did receive treatment, or a penetration rate of 4.7%.

For comparison, SAMHSA (2015) estimated that in 2014, 20.3% of individuals who needed treatment for illicit drug use and 8.9% of individuals who needed treatment for alcohol use received it, suggesting California penetration rates were below the national average prior to waiver implementation.

In 2014, 93.6% of people who needed treatment for an illicit drug problem and 97.1% of people who needed treatment for an alcohol problem nationally *did not feel they needed specialty treatment* (SAMHSA, 2015). This suggests that although efforts to increase penetration rates can and should include expansion of physical capacity, efforts to change perceptions about specialty treatment among prospective patients and to reach patients in non-specialty settings, such as primary care, will also be critically important to substantially increase penetration rates. The DMC-ODS waiver provides some opportunities to pursue these through improvements in quality and coordination/integration of care.

[6] In 2014, 131,982 individuals were admitted to treatment for illicit drug use according to CalOMS-Tx. The difference may be partially attributable to NSDUH's exclusion of non-household populations, e.g. homeless persons.

[7] In 2014, 46,202 individuals were admitted to treatment for alcohol use according to CalOMS-Tx. Although alcohol can be recorded as a primary, secondary, or tertiary drug problem in CalOMS-Tx, it may be underreported when the patient is using other drugs.

Network adequacy

Outpatient capacity

While there is a dataset available for tracking outpatient capacity, the Drug and Alcohol Treatment Access Report (DATAR), there is some concern among stakeholders that it may not always reflect the true capacity of outpatient or intensive outpatient programs. Capacity is inherently flexible in these levels of care, since programs can generally add or reduce treatment groups or the number of counselors at the site, or they can change operating hours to expand or contract capacity at any time.

In response to questions about DATAR on UCLA's administrator survey, some county administrators reported that DATAR is not a meaningful measure of capacity or access. While some smaller counties found DATAR to be acceptable, others indicated a lack of consistent standards for determining capacity and high drop-off from the waiting list for outpatient treatment. Some also reported that providers often do not find the numbers very useful, reducing the incentive to devote resources to maintaining this data.

Several counties mentioned attempting to track outpatient capacity through various other means, including centralized electronic health records or billing systems, and monitoring providers through regular reports or dashboards. In smaller counties with fewer patients, monitoring capacity or treatment slots has been easier to achieve through manual tracking.

However, in the absence of a well-accepted statewide measure of capacity, UCLA sought to develop an alternative measure (see Table 3). CalOMS-Tx was analyzed to determine the maximum patient census on any given day in treatment programs over the course of a year to provide an approximate picture of maximum utilization at that program as a proxy for capacity.[8] This measure is considered to be in a developmental stage, and UCLA plans to discuss these results with stakeholders to obtain feedback. Initial feedback suggests these estimates may be low. When UCLA receives Drug Medi-Cal claims data, this data source will also be used in place of CalOMS-Tx, if it is determined to be more accurate for these purposes.

The maximum utilization numbers suggest relatively low availability of withdrawal management statewide and low availability of NTP maintenance in Phase 4 counties. This is consistent with administrator reports of the availability of treatment collected by surveys (see Figure 3).

[8] Daily census was calculated by examining net admissions and discharges over a period of time. For most modalities, these calculations started with admissions that occurred up to 6 months prior to the period of study (calendar year 2015) in order to allow accurate calculation of the daily census at the beginning of 2015. However, for narcotic treatment programs (NTPs), where patients tend to receive treatment for much longer periods, calculations started with admissions that occurred up to 5 years prior to the period of study.

The lower availability of these services in later phases appears to be closely associated with county size, with smaller counties tending to be assigned to Phases 3 and 4 and to have lower availability of these services. As shown in Figure 4, withdrawal management and NTP are only partially available or not available in most small and Minimum Base Allocation (MBA)[9] counties.

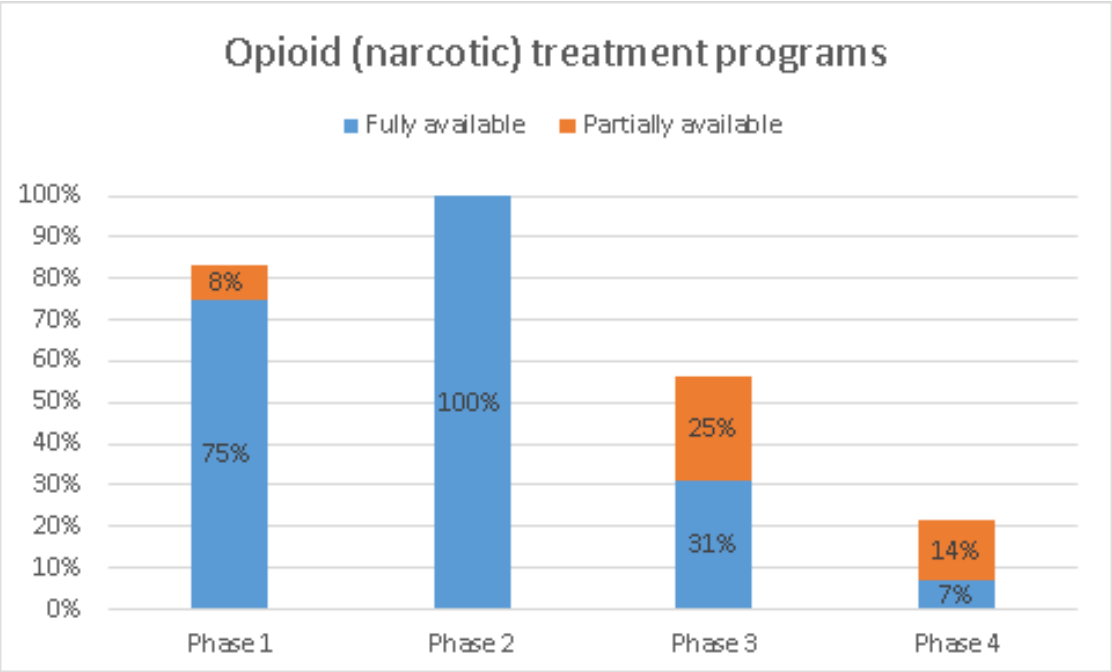
Table 3: Total estimated maximum treatment capacity of all providers within each county for outpatient (including intensive outpatient [IOP]) from 1/1/2015 to 12/31/2015.*

	Phase (2015 Population)			
Modality	**Phase 1 Counties** (8,333,973)	**Phase 2 Counties** (23,644,610)	**Phase 3 Counties** (5,357,610)	**Phase 4 Counties** (1,049,548)
Outpatient, Intensive Outpatient				
Providers	116	251	116	39
Max Patient Census	5,114	11,582	5,198	1,403
Max Census/100,000 Population*	61	49	97	34
Residential				
Providers	80	138	41	11
Max Patient Census	1,556	3,944	1,003	169
Max Census/100,000 Population	19	17	19	16
Withdrawal Management				
Providers	24	83	38	4
Max Patient Census	403	907	328	31
Max Census/100,000 Population	5	4	6	3
NTP Maintenance				
Providers	40	107	38	8
Max Patient Census	2,397	5,195	2,494	134
Max Census/100,000 Population	29	22	47	12

* Initial feedback suggests the above estimates may be low.

[9] "Minimum Base Allocation (MBA)" refers to the way in which federal Substance Abuse Prevention and Treatment (SAPT) block grant funds are distributed to the counties. MBA counties are the smallest in terms of population, each with a population under 100,000.

Figure 3: Availability of NTP and withdrawal management within counties by implementation phase: percentage of counties within each phase (from County Administrator Survey).



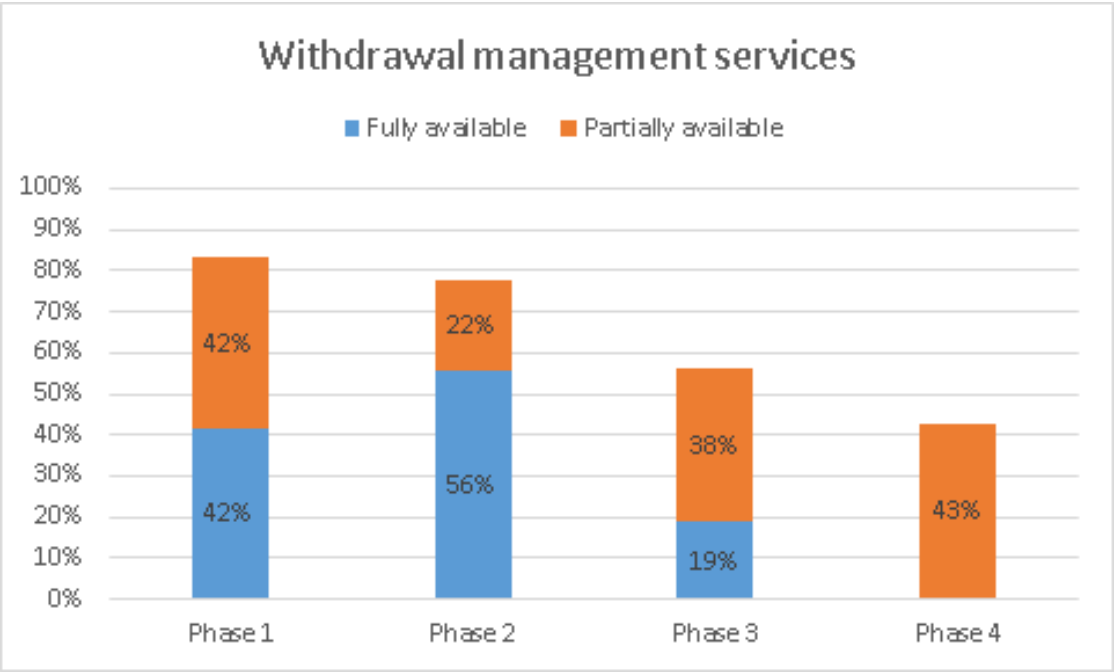
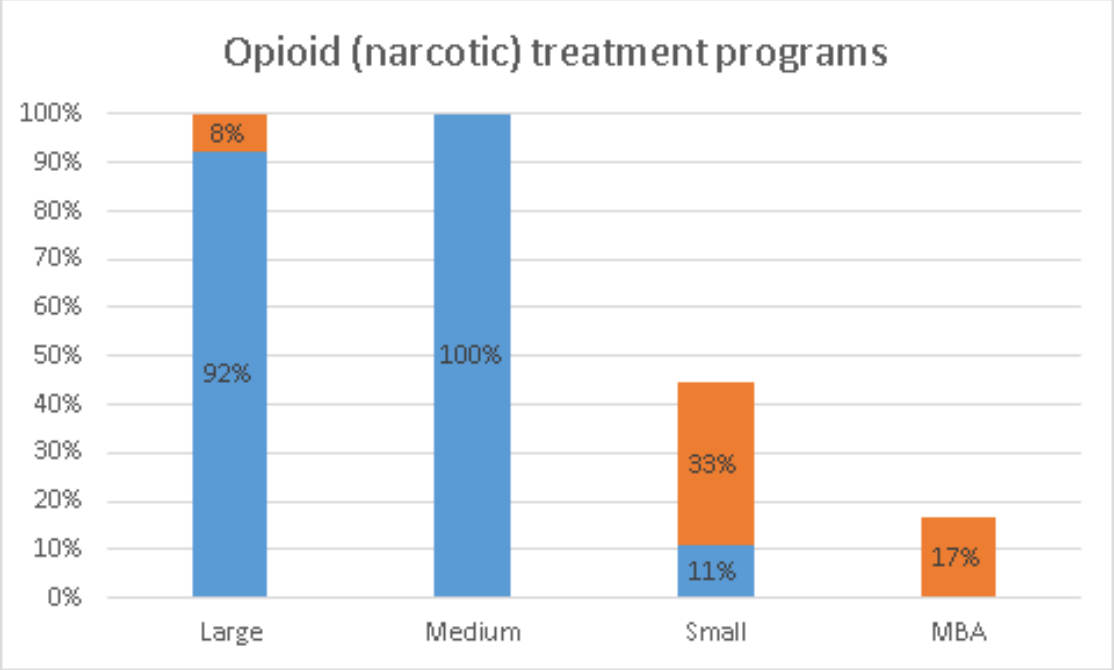
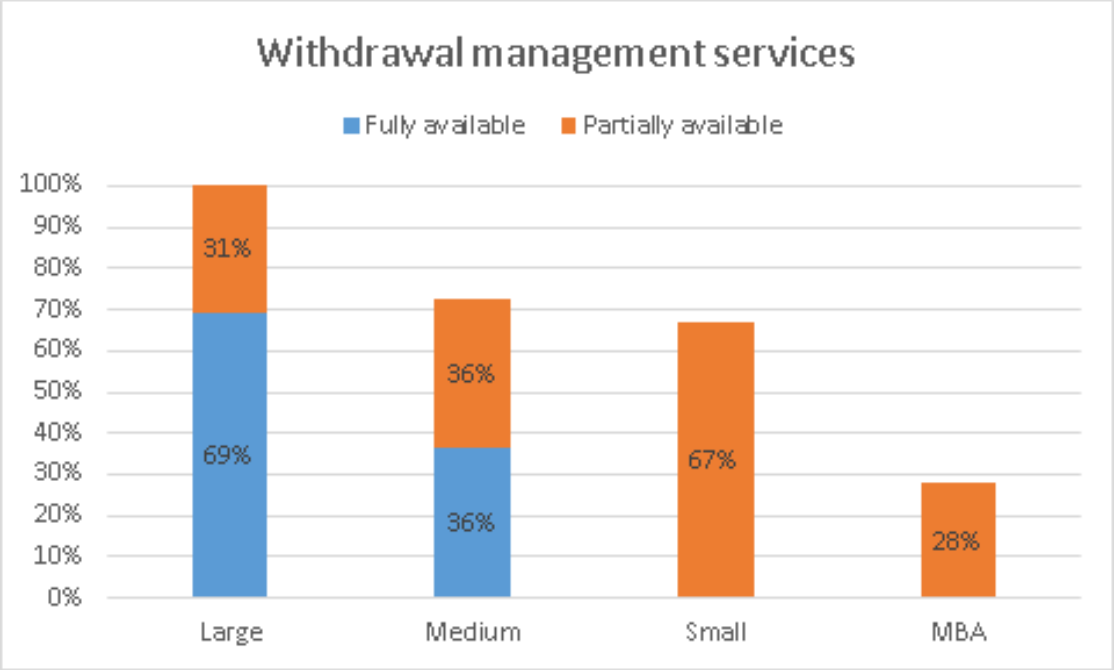


Figure 4: Availability of NTP and withdrawal management in counties by population size: percentage of counties within each size group (from County Administrator Survey).





Overall, according to administrator surveys, the modality that is most challenging to expand (either by creating new programs, increasing capacity at existing programs, or having existing programs become DMC certified) was residential (48%), followed by NTP (21%), and withdrawal management (19%).

Issues most commonly chosen as significant challenges in expanding capacity in each modality are listed in Table 4. Facility certification was reported as one of the four most significant challenges for expanding capacity in all five modalities. In addition, reimbursement rates were reported by at least 21 counties as being a significant challenge for expansion for all modalities except NTP.

Table 4: County administrator ratings of challenges faced in expanding capacity, by modality.

Ranking of Challenge	Residential	Withdrawal management	Intensive Outpatient	Outpatient	NTP
1	Reimburse-ment rates (*n* = 29)	Reimburse-ment rates (*n* = 27)	Facility certification (*n* = 21)	Reimburse-ment rates (*n* = 26)	Community opposition (i.e., NIMBY) (*n* = 18)
2	High up-front investment required/ financial risk (*n* = 28)	Space (*n* = 26)	Reimburse-ment rates (*n* = 21)	Facility certification (*n* = 18)	Facility certification (*n* = 16)
3	Space (*n* = 25)	Facility certification (*n* = 25)	Regulatory requirements (e.g., document-ation) (*n* = 20)	Regulatory requirements (e.g., document-ation) (*n* = 18)	Staff certification/ licensing (*n* = 14)
4	Facility certification (*n* = 25)	High up-front investment required/ financial risk (*n* = 23)	Staff certification/ licensing (*n* = 16)	Staff certification/ licensing (*n* = 15)	High up-front investment required/ financial risk (*n* = 14)

Achieving Drug Medi-Cal certification for services under the waiver and setting up the infrastructure (electronic health records, authorization and billing systems and procedures, etc.) were noted as general concerns in implementing the waiver.

In terms of preparing the county SUD system to provide treatment for youth patients, almost all administrators who wrote comments on the survey regarding youth noted that it is extremely challenging to provide options for withdrawal management and residential treatment for this population. One such comment out of many stated: "Residential for youth is considered a huge and impossible undertaking by our residential providers, who had to close an excellent program several years ago. Youth services are best integrated fully with MH, so asking programs to dissect the SUD services and bill separately would be a challenge."

Smaller counties in particular face significant challenges to expanding capacity, in that they lack the facilities, funds, qualified and willing providers, and economies of scale that make this model more feasible for larger counties. Comments include:

- *We have one treatment facility in this county so our capacity to prov[id]e the continuum of care is very challenging.*
- *[County] is too small, underfunded, and under staffed to do anything locally except outpatient and intensive outpatient services.*
- *There is a general lack of providers willing to provide this level of care for Medi-Cal reimbursement rates in our County, which is 21,000 square miles.*
- *Economies of scale for establishing a provider in rural areas with limited transportation and very limited capacity based on small surrounding population / limited medical beneficiaries to draw from.*
- *Economy of scale - we do not have the population to support an NTP, residential, or even detox (except perhaps coordinating with an MD for outpatient detox). We expect to contract with other counties for residential, NTP and detox.*

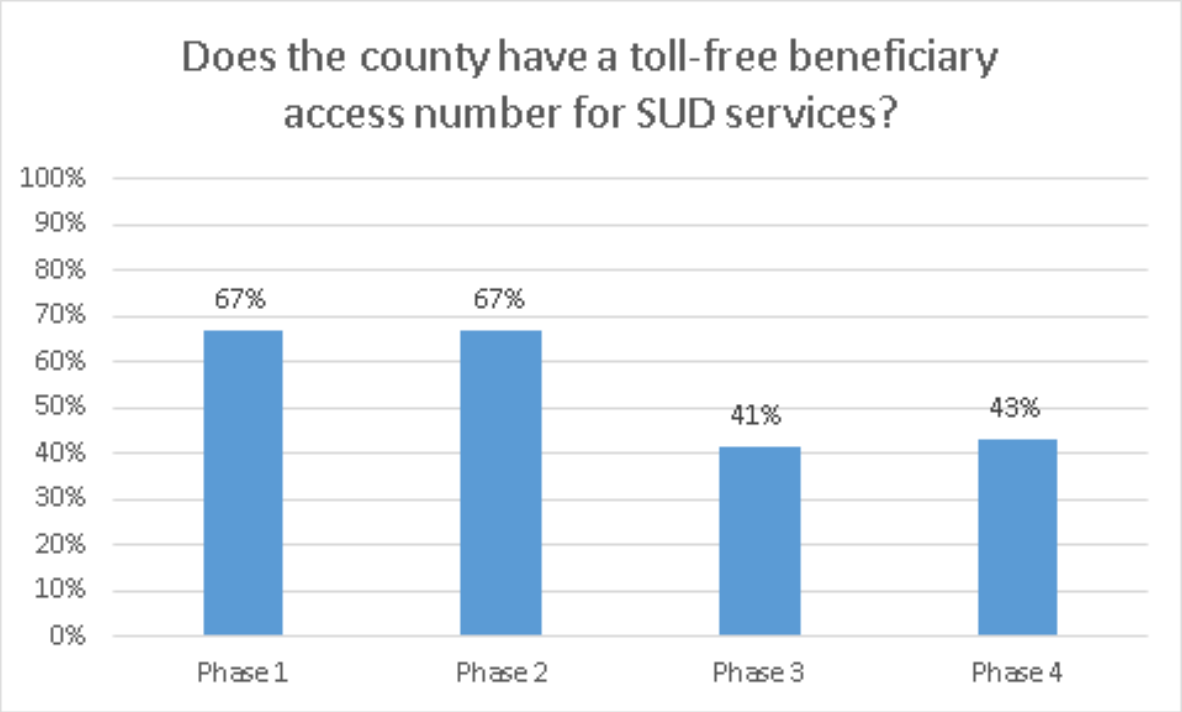
As noted in the last administrator comment, small counties may consider combining resources with other nearby counties in a regional model to make provision of the full continuum of services more feasible.

Beneficiary access line

Half of the respondents to UCLA's 2015 administrator survey (24 counties) reported that their county had a current toll-free beneficiary access number for SUD services, 19 counties (40%) were planning to have one, and five (10%) neither had a number nor had plans for one (see Figure 5). These five counties either stated that they would not be opting in to the waiver or were part of later phases. Counties in earlier phases were more likely to report having a beneficiary access number.

Of the 24 counties that had a beneficiary access number, 23 (96%) reported providing services in all threshold languages. Of the 19 counties that plan to have a beneficiary access number for SUDs, 15 (79%) expected their number to provide services in all threshold languages in their county.

Figure 5: Availability of a toll-free beneficiary access number for SUD services, by phase (% of counties within each phase).



C. Discussion and Next Steps

During 2015, the calendar year prior to waiver implementation, the number of patients in specialty care who were Medi-Cal beneficiaries was relatively stable, which will make it easier for the evaluation to detect changes associated with waiver implementation in the future.

Of particular importance for future implementation, use of methadone as a medication was much lower in Phase 4 counties than in other phase counties, potentially due to less access to NTP providers. Data suggest a particular need to expand NTP capacity during this phase and in small counties in general. Methadone programs typically require daily participation, which would render a regional model impractical, given the long travel distances that this might impose upon patients. In these cases, the prescribing of buprenorphine in outpatient settings may provide an alternative.

According to County Administrator Survey respondents, the most challenging modalities to expand were residential (48%), followed by NTP (21%), and withdrawal management (19%). Facility certification was reported as a significant challenge for expanding capacity in all five modalities. In addition, reimbursement rates were a concern for expansion for all modalities except for NTP. For NTP, community opposition (NIMBYism) was the top challenge. These surveys were collected prior to the establishment of new rates for DMC-ODS and during efforts to improve the certification process. UCLA will collect this data again in the fall of 2016 to check for changes in these responses.

SAMHSA's NSDUH survey data suggest California's treatment penetration rates among people who need treatment are 9.7% for illicit drug use and 4.7% for alcohol use. These are below the national penetration rates, suggesting ample room for improvement as the DMC-ODS waiver is implemented. However, nationally in 2014, 93.6% of people who needed treatment for an illicit drug problem and 97.1% of people who needed treatment for an alcohol problem *did not feel they needed specialty treatment* (SAMHSA, 2015). This suggests that while expansion of physical capacity is necessary, it should not be the sole focus. Rather, efforts to change perceptions about specialty treatment among prospective patients and to reach patients in non-specialty settings, such as primary care, will also be important to substantially increase penetration rates.

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III. Quality of Care

According to the Institute of Medicine, quality of care can be defined as "[t]he degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[10] UCLA analyzed data available during the first year of the waiver to evaluate the quality of SUD care at baseline on multiple measures, including:

- use of an ASAM Criteria-based tool for patient placement and assessment;
- successful treatment engagement based on length of stay;
- successful transitions along the continuum of SUD care;
- successful discharge; use of evidence-based practices;
- patient quality-of-care perceptions;
- establishment of quality improvement committees and plans;
- patient outcomes (alcohol or other drug use, social support recovery activities, living arrangements/housing situation, employment); and
- readmissions to withdrawal management and residential treatment.

These and other measures for which data was not yet available will be analyzed and tracked over time to identify changes in the quality of SUD care provided under the waiver.

A. Data Sources

The data sources available for conducting the analyses at baseline included the California Outcome Measurement System - Treatment (CalOMS-Tx), UCLA's County Administrator Survey, stakeholder (e.g., county administrator) input on ASAM Criteria-based placement and assessment tools, and the External Quality Review Organization (EQRO) survey (two ASAM assessment-related items). UCLA expects the following additional data sources to become available in the future for evaluating the quality of SUD care: county ASAM data; DHCS ASAM audits; a treatment provider survey; Medi-Cal claims; patient satisfaction/perception of care survey; and grievance reports.

[10] For more, see: http://www.nationalacademies.org/hmd/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx

B. Baseline Measures

Use of ASAM Criteria-based tool(s) for patient placement and assessment

As part of the demonstration of an organized delivery system for SUD services, the ASAM Criteria provides a common standard for assessing patient needs, improving placement decisions, determining medical necessity, and documenting the appropriateness of reimbursement. The ASAM Criteria facilitates the appropriate matching of a patient's severity of SUD illness along six dimensions with levels along a continuum of SUD treatment. While use of an ASAM-based assessment is a requirement of the waiver, counties have discretion over decisions about which ASAM-based assessment tools best meet their needs.

County Administrator Survey respondents indicated that ASAM assessment and placement into level of care were currently available either fully or partially in fewer than half of the counties that responded (20 out of 48 counties, 42%), although 46% (22 counties) anticipated that they would be available within 12 months. In addition, more than half of the counties (58%; 28 out of 48 counties) that responded reported either currently collecting ASAM Criteria data from assessment centers and/or treatment providers or planning to collect it within the next year. Upon further examination of respondents' written comments, UCLA estimated that 10 counties (21%) were currently collecting some form of ASAM Criteria data from assessment centers and/or treatment providers at the time of the survey. As more counties opt in to the waiver, the expectation is that the use of the ASAM Criteria for assessment and placement and county collection of ASAM data will increase.

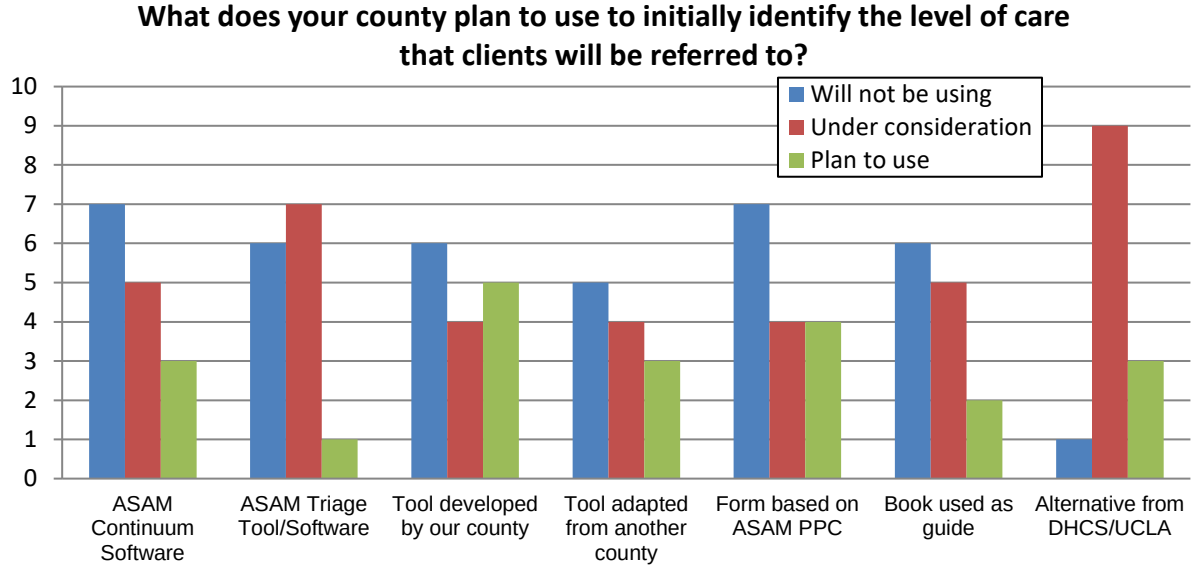
A separate survey conducted by Behavioral Health Concepts, California's External Quality Review Organization (EQRO) in April 2016 included questions requested by UCLA that asked about the tools counties are considering using to initially identify the level of care (with a full ASAM-based multidimensional assessment to be conducted at intake to treatment). Preliminary responses suggested considerable variation across counties. The majority of respondents (9 out of 13) indicated that they would consider using alternative tools developed jointly by DHCS and UCLA (see Figure 6).

Below are comments that respondents to the EQRO survey wrote in, which provide insight into some of the ASAM tool-related activities counties are involved in and some of the challenges they are experiencing.

- *We have forms designed with guidance from our consultant, Dr. David Mee-Lee. We have begun installing those forms into our EHR products.*
- *We plan on using the Santa Clara adaptation of the ASAM [to develop] a 15–20 phone triage. We are interested in UCLA's upcoming work on developing a brief ASAM screener, and we are exploring use of the ASAM assessment software to do a full ASAM assessment at intake.*
- *Looking at using the Addiction Severity Index (Adult & Youth versions) in conjunction with the Patient Placement Crosswalk (Adult & Youth versions).*

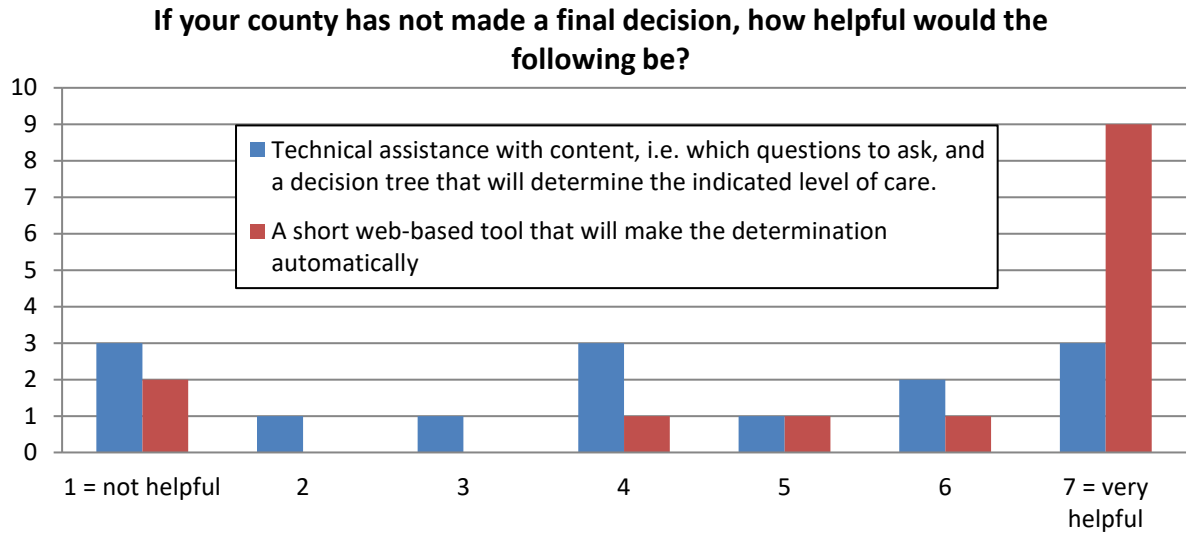
- *We are in active discussion to purchase Continuum with the tracking system, but [it is] difficult because [it] will not coordinate with Avatar.*
- *Unfortunately, Cerner [Electronic Medical Record] is not supporting the ASAM software at this time. Different options are being considered as having a separate stand-alone system from the current EHR will not allow seamless merger of information in one record or accessibility.*

Figure 6: Counties' use or planned use of tools to identify ASAM level of care.



Counties that had not yet made a final decision on the ASAM tool to be used were also asked how helpful (a) technical assistance with the content of the tool, and (b) a short web-based tool to automatically determine the level of care, would be. Responses suggested that a wide range of perspectives exist regarding the helpfulness of such support among county administrators, whereas the majority of responses (9 out of 14) indicated that a web-based tool would be "very helpful" (see Figure 7).

Figure 7: Counties' ratings of how helpful various TA activities would be toward implementing an ASAM Criteria-based assessment tool.



The survey results above, as well as anecdotal evidence, suggest that multiple counties are simultaneously in the process of developing their own placement tools, although many are interested in using the short tool being developed and validated by UCLA with DHCS. Document review of drafts of eight brief screening tools for initial placement that counties shared with UCLA also highlighted the diversity in the tools being developed by various counties. Seven of the tools included all six ASAM dimensions; six included severity/risk ratings; two included a checklist for determining provisional *Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders* (DSM) diagnoses; and three included a key/decision tree/grid to determine the initial level of care. In addition, the length of the tools ranged from two to nine pages, and several appeared to be electronic (rather than paper-based) forms.

As part of a collaborative process to develop a short screening tool for placement, which counties could use if they wished to do so and at no cost, UCLA hosted a webinar/call to obtain stakeholder (e.g., county administrators) input. During the discussion, which included more than 30 participants, stakeholders emphasized the importance of including all six ASAM dimensions along with severity/risk ratings, in keeping with the "spirit" of the ASAM and the goal of placing individuals in the most appropriate level of care. However, there was some interest in a "lite" version (fewer than six dimensions) that could be used to determine the level of care needed by a patient very quickly over the phone, depending on the new tool's validation test results. Further, stakeholders expressed interest in moving toward an electronic algorithm for determining the appropriate level of care. According to stakeholders, a "short" assessment should take 10–15 minutes, with the understanding that it may take more or less time depending on the patient.

Counties appear to be at various stages with regard to deciding which tools to use to screen for initial level of care placement and to conduct the full ASAM-based

assessment. Some counties are developing their own tools, some are considering using the Continuum software, and others are still contemplating their options given their counties' needs and resources. To minimize duplication of effort, it is important to address these critical issues raised by stakeholders as counties prepare for the implementation of the waiver.

Percentage of patients with successful treatment engagement

Patient engagement is essential for treatment success. The Washington Circle defines treatment engagement as the patient having two additional SUD treatments within 30 days after initiating treatment. In the absence of Drug Medi-Cal claims data, UCLA used CalOMS-Tx data to track lengths of stay of at least 30 days as a proxy for engagement once patients enter treatment. During calendar year 2015, the majority of treatment admissions (excluding withdrawal management) resulted in lengths of stay 30 days or longer, including NTP maintenance (70%), outpatient (74%), intensive outpatient (69%), and residential (57%).

The percentage of treatments with lengths of stay of 30 days or longer were approximately consistent among the four phases.

The median length of treatment for admissions during the baseline year was 38 days for residential treatment, 83 days for NTP maintenance, 80 days for outpatient, and 62 days for intensive outpatient. Patients in withdrawal management (non-hospital) and NTP withdrawal management had relatively shorter lengths of stay, averaging 5 days and 14 days, respectively.

"Successful" discharge

Admissions in 2015 resulted in discharges with reported treatment completion or satisfactory progress at the following rates: 81.7% for non-hospital withdrawal management, 62.3% for residential, 50.5% for NTP withdrawal management, 49.7% for outpatient, and 46.5% for intensive outpatient.[11] The reliability and validity of the discharge status variable has been called into question for a variety of reasons, and should be interpreted with caution. Treatment discharge status of each treatment modality was stable over time (i.e., little fluctuation) across the years of 2013, 2014, and 2015, and UCLA will monitor it for changes during waiver implementation.

Patient transitions along the continuum of SUD care

<u>Successful care transitions</u>

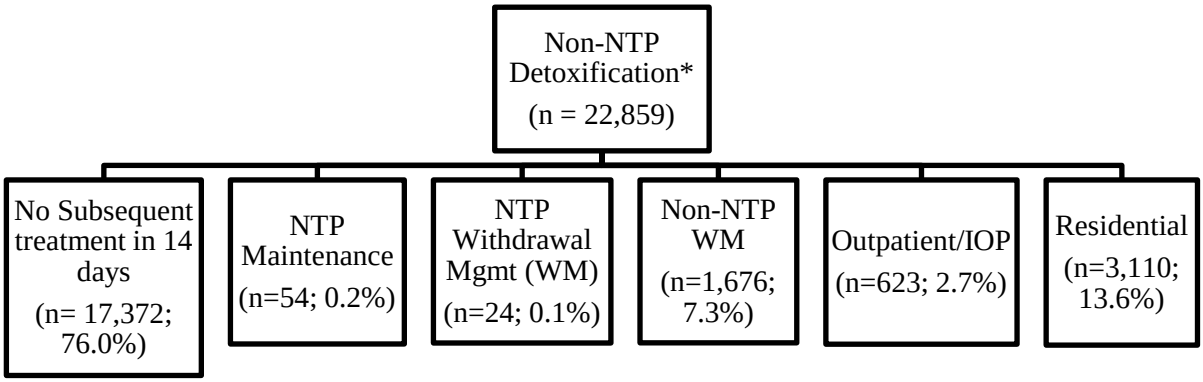
Patients are expected to move along the continuum of SUD care in an organized delivery system for SUD services. The Washington Circle defines continuity of care as

[11] Relative to other modalities, discharge status is generally a less meaningful measure for NTP maintenance, since this modality is aimed at long-term maintenance. Discharge statuses for this modality would reflect short-term drop-outs, which would be misleading since patients who remain in treatment as intended would not be reflected. For these reasons, UCLA is not reporting discharge status for NTP maintenance. Length of stay is a more useful measure and is included within this report.

when a patient receives additional services within a 14-day period after discharge from either withdrawal management or residential treatment. CalOMS-Tx data during calendar year 2015 was analyzed to measure, at baseline, whether patients were moving along the continuum of care in a timely manner.

Of all admissions that initially were to non-NTP withdrawal management, about 24% were moving along the continuum of care in a timely manner (i.e., a referral/transfer within 14 days); see Figure 8. Approximately 13.6% and 2.7% of patients in non-NTP withdrawal management continued receiving services in residential treatment and outpatient/Day Care Rehabilitation, respectively. Another 7.3% of the patients stayed with the same treatment modality (i.e., non-NTP withdrawal management). These findings suggest that most of the time, patients receiving non-NTP withdrawal management services did not move along the continuum of care to receive additional treatment, and, therefore, there is substantial room for growth of continuity of care within the DMC-ODS. With the implementation of the waiver, it is anticipated that patients will receive timely and appropriate treatment as they transition to different levels of treatment along the continuum of SUD care.

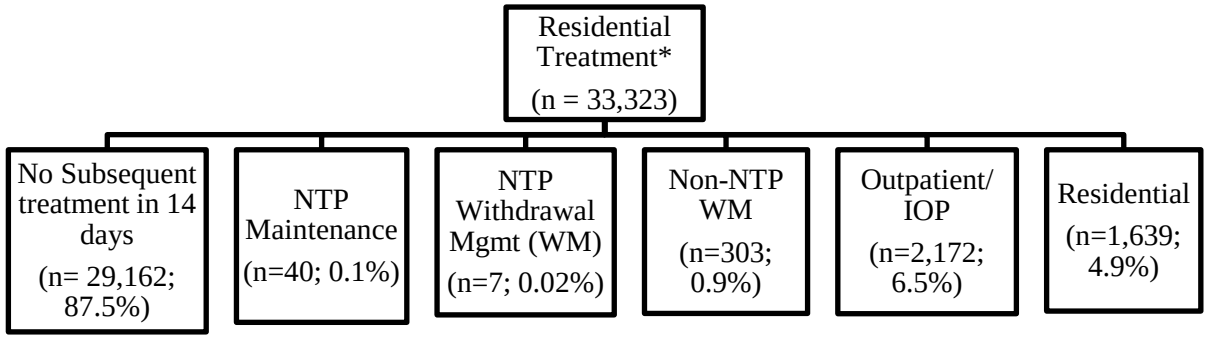
Figure 8: Service delivery following non-NTP withdrawal management (transition within 14 days).



* Admissions during Jan. 1 – Dec. 31, 2015, for which non-NTP withdrawal management was the first admission in a treatment episode.
** Patient was either still in treatment or a discharge record was not available as of May 1, 2016.

About 12.3% of patients in initial residential treatment moved along the continuum of care in a timely manner (i.e., a referral/transfer within 14 days); 6.5% of these patients subsequently received services in outpatient/Day Care Rehabilitation and 4.9% of them continued receiving additional episodes of residential treatment (see Figure 9). Similar to patients receiving non-NTP withdrawal management services, the majority of the time, patients initially receiving residential treatment did not step down to additional lower-level treatment (e.g., outpatient treatment); thus, the DMC-ODS waiver provides a great opportunity for improving patient transitions from residential to other treatment services along the continuum of care.

Figure 9: Service delivery following a residential service (transition within 14 days).



*Admissions Jan. 1 – Dec. 31, 2015, in which residential was the first admission in a treatment episode.
**Patient was either still in treatment or a discharge record was not available as of May 1, 2016.

Care coordination and information exchange between SUD treatment providers

As patients move to different levels of treatment within an organized delivery system, it is important that care be coordinated and essential that SUD treatment providers communicate effectively with each other to facilitate the transition. At the time of this report, baseline levels of care coordination and effective communication among providers have been examined only at the county level through the County Administrator Survey. UCLA inquired about county requirements of their SUD providers to establish formal procedures with other SUD providers to facilitate patient transfers and information exchange (two critical elements for care coordination and effective communication).

Twelve counties (25%) indicated that they require SUD providers to establish formal procedures with other SUD providers (e.g., MOUs between residential and outpatient providers), while 36 (75%) do not. Of the counties without explicit requirements, 19 counties (40%) reported establishing recommended procedures to encourage effective patient transfers and information exchange between levels of care, 14 (30%) reported doing other activities (e.g., “assuring that proper release of information exists between providers to assure smooth transitions between treatment modalities”), 5 (11%) reported doing nothing at this time, and 2 (4%) reported providing funding support or incentives.

To track referrals and patient movement within the SUD system of care, 21 counties (45%) reported using an electronic database, 19 (40%) reported using a paper-based method (such as fax or mail), 17 (36%) reported using phone calls, 10 (21%) reported using none at this time, and 7 (15%) reported some other method (e.g., “collaborative meetings to transfer cases”).

Analysis of the 15 responses to an open-ended survey question inquiring about the greatest challenges, if any, with patient transfer/information exchange between SUD providers in other levels of care shed some light on the quantitative findings above. Three respondents indicated that the lack of a shared electronic database makes "*real time information…difficult to share*," particularly due to reliance on telephones, faxes, and paper-based forms that need to be scanned (e.g., patient release of information and authorizations to exchange information). Five counties reported other challenges, including "*case management*," "*disruption of patient care and accurate assessment*," "*limited resources and service in this rural area,*" "*42 CFR*," and "*finalizing on the ROI form*." On the other hand, seven respondents indicated that there were no challenges in this area, with one respondent commenting, that "*there are more challenges with transferring care to primary care providers*" than between SUD providers.

As part of an ODS, treatment providers will be expected to transition/refer patients to the most appropriate level of care. The efficient and effective movement of patients along the continuum of SUD care will most likely require timely communication between providers as well as formal procedures and shared electronic databases. Findings from the administrator survey suggest that there is ample room for improvement in this area.

Use of evidence-based practices

Use of evidence-based practices is required under the DMC-ODS waiver. Responses to the 2015 County Administrator Survey indicated that treatment programs in only about half of the responding counties (27, 56%) used at least two of the five evidence-based practices (EBPs) listed in the Special Terms and Conditions (STCs) of the DMC-ODS waiver (see Table 5). On average, county administrators rated the level of priority for training for each of the five EBPs as "medium," indicating that there is a need for training.

Table 5: County administrator average ratings of training priority for evidence-based practices, from low priority (1) to high priority (5).

	Mean
Trauma-informed treatment	3.49
Motivational interviewing	3.40
Cognitive-behavioral therapy	3.28
Relapse prevention	3.19
Psycho-education	2.89

Patient quality-of-care perceptions

Patients' perceptions of the quality of care they receive are essential for gauging and improving such care. Results of the 2015 County Administrator Survey showed that 31

counties (65% of respondents) required SUD treatment providers to collect data on patient satisfaction / perceptions of quality of care, 11 (23%) plan to, and 6 (13%) have no plans to in the immediate future. Among the counties that have this requirement, the most common method of collecting the data was written surveys (*n* = 29, 94%). Twenty-seven out of the 31 counties required this data to be collected at least yearly, and many required it to be collected more frequently. While collection of data on patient perceptions of quality of care is not a direct requirement for counties opting in to the waiver, this may change due to the establishment of an External Quality Review Organization (EQRO) under the DMC-ODS STCs, if the EQRO follows practices similar to those used for mental health.[12] If this occurs, counties appear to be generally prepared to comply based on current practices or future plans.[13]

Establishment of quality improvement committees and plans

Responses to the County Administrator Survey indicate that 30 counties (63% of respondents) have a quality improvement committee with SUD participation (which could include a behavioral health committee with MH and SUD participation), and 17 counties (35%) plan to have one. One county (2%) reported not having a quality improvement committee with SUD participation nor having plans for one. As the intergovernmental agreement with the state and counties that opt in to the waiver requires a Quality Improvement Committee (QIC), it is anticipated that the number of counties with a QIC will likely increase.

Ten counties (21%) reported having a written SUD treatment system quality improvement plan, 34 (71%) reported planning to have one, and 4 (8%) reported no plans to have one. Similar to the QIC mentioned above, counties participating in the waiver are required to have a Quality Improvement Plan (QIP); thus, it is expected that as counties prepare to submit their implementation plans for approval, the number of counties with QIPs will rise.

When asked if the waiver has positively influenced the above quality improvement activities for SUDs, three quarters of county administrators (36; 75%) responded affirmatively. Qualitative analysis of the comments regarding the survey question above revealed that nine of the respondents perceived the waiver as already having a noticeable impact, as illustrated by the following quotations:

- *Major shift to improved quality (e.g., documentation, client-centered care with ASAM Criteria, EBPs, etc.).*
- *Pushed integration to one whole QI [Committee] for both MH and SU.*
- *The merger of AOD with Mental Health is an outcome influenced by the waiver along with coordination of quality improvement.*

[12] The EQRO selected, Behavioral Health Concepts, is the same organization that serves as the EQRO for mental health in California.

[13] The content of the surveys and the potential need to standardize them for the various purposes of evaluation, quality review, and county operations is a topic of ongoing discussion between UCLA, the EQRO, and the counties.

- *Driven the improvement of QI/QA activities and collaboration with MH.*
- *It has created the necessity for them if we are to participate in the waiver.*
- *The ODS waiver has positively influenced everything in our current system of care, though our current system of care is largely successful.*
- *Our quality management department has been more active in looking at their SUD activities, and asking for input in how to meet the SUD EQRO.*
- *We are increasingly professionalizing our SUD services and system.*
- *The development of a QA/UM plan.*

Several (three) other respondents briefly commented on their current quality improvement activities that have been influenced by the waiver.

- *We are working to increase quality improvement activities and actively recruit representatives from SUD programs for the quality improvement committee.*
- *Our MH quality improvement plan includes several PIPs [performance improvement projects] around integrating care…Also looking at improvements in policy development and program and fiscal monitoring. Expanding performance measures for our contracted providers.*
- *As an integrated BH, we are working on updating various MH plans (QI, Cultural Competence, […] etc.) to fully incorporate both MH and SU system requirements for improvement.*

It is notable that four respondents indicated that the positive influences were "*unknown,*" "*not applicable,*" or "*not yet*" apparent, as the counties are in the later phases of the implementation, with one respondent writing, "*I would imagine that the waiver will create opportunities to change some practices.*" In addition, a few respondents expressed some reservations regarding the positive influence of the waiver on quality improvement activities. One respondent wrote, "*technically 'yes' but total integration hasn't occurred yet,*" whereas another respondent reported "*high concerns about staff to complete and monitor this [quality improvement] process.*"

Patient outcome measures

CalOMS-Tx data were analyzed to measure patient outcomes (alcohol or other drug use, social support/social connectedness, living arrangements/housing situation, employment in the past 30 days) for purposes of tracking changes, if any, over time during the implementation of the waiver. Our ability to draw conclusions from differences on these measures between admission and discharge is limited by at least two factors:

- Patients in controlled environments prior to admission: Some patients are admitted to treatment after spending time in controlled environments such as jail, prison, or residential treatment. In these cases, alcohol or other drug use and employment in the 30 days prior to admission are likely to be low or even nonexistent. This can bias pre/post outcome comparisons by making the differences appear smaller than they otherwise might be (e.g., drug use cannot decline if it was not happening at admission).

- Missing discharge data. Data is frequently missing at discharge, often as a result of patients stopping treatment early and therefore not being available for a discharge interview. It is likely that these patients have worse outcomes in the 30 days prior to discharge than patients who were available for the interview. This means the missing data could bias pre/post outcome comparisons by making the differences appear more positive than they would if discharge outcome data were available for all patients.

The degree to which these limitations is offset is not currently known. Therefore, UCLA urges caution in the interpretation of absolute values reported below. To the extent that these biases remain constant, meaningful trends may still be discernable over time.

Alcohol or other drug (AOD) use

Using CalOMS-Tx data (07/01/2013–12/31/2015), the number of days the patient's primary drug was used in the last 30 days prior to admission and prior to discharge was calculated, and the change in average days of drug use between admission and after discharge from treatment was tracked by modality.

Prior to treatment admission, the average number of days of primary drug (i.e., alcohol or a drug) use was 10. On average, a reduction of 5 days of drug use was observed after treatment. Residential treatment, compared to other treatment modalities, was usually associated with a decrease of more than 5 days of drug use. The level of decrease in the number of days of drug use was relatively stable over time across years 2013, 2014, and 2015.

Data was missing for 51% of discharges on this variable.

Social support/social connectedness

CalOMS-Tx data for calendar year 2015 was used to calculate the average number of days in the last 30 days that a patient participated in any social support recovery activities (e.g., 12-step meetings, interactions with a family member and/or friend supportive of recovery), and to track changes between admission and discharge by modality.

The number of days that patients received social support services in the 30 days prior to treatment was only about 5. With treatment, the number of days that patients received social support services increased by 5 to 11. Social support rose the most in residential treatment. Increases were relatively stable over time across the years 2013, 2014, and 2015.

Outcome data on this variable was missing for 50% of discharges.

Living arrangements/housing situation

CalOMS-Tx data for calendar year 2015 was also used to calculate the percentage of patients with different living arrangements/housing situations (dependent living, homeless, independent living) at admission and discharge from treatment.

Treatment was associated with small improvements in patients' living arrangements. The percentage of patients living independently changed from 35% prior to treatment to 39% after treatment.

Outcome data on this variable was missing for 50% of discharges.

Employment

Available CalOMS-Tx data for calendar year 2015 suggests that employment status improved slightly from 30 days prior to treatment admission to 30 days prior to discharge. Patients' rate of full- or part-time employment was 16% pre-treatment and 21% post-treatment.

Outcome data on this variable was missing for 50% of discharges.

Effectiveness of levels of care—readmissions to withdrawal management and residential treatment

CalOMS-Tx data was used to track readmissions to withdrawal management and residential treatment. Readmissions were analyzed both at 30 days (common in medical care) and at 90 days, consistent with a measure discussed by ASAM. (In describing their measure, ASAM made the point that in SUD withdrawal management and treatment, waiting lists are common, which justifies allowing a longer period for the person to be readmitted.)

During 2015, among patients who were initially admitted to non-NTP withdrawal management, 10.4% were re-admitted to non-NTP withdrawal management within 30 days and 15.2% of patients were re-admitted to withdrawal management within 90 days.

Of the patients who were initially admitted to residential treatment, 6.2% were readmitted to residential and 1.3% were subsequently admitted to non-NTP withdrawal management within 30 days. Further, 8.5% were readmitted to residential treatment and 1.9% were admitted to non-NTP withdrawal management within 90 days. It is worth noting that under the STCs for the DMC-ODS, residential treatment is limited to two non-continuous regimens in a 1-year period.

C. Discussion and Next Steps

For purposes of the evaluation of the DMC-ODS, it is hypothesized that the quality of care will improve in counties that opt in to the waiver compared to the quality of care in the same counties prior to waiver implementation and quality of care in comparison counties that do not opt in. As the state demonstration of the waiver is still in the early stages, and counties have yet to implement their own plans, this report necessarily presents baseline data on the quality of care using primarily CalOMS-Tx and County Administrator Survey data (both quantitative and qualitative), responses to several items from on EQRO survey, and stakeholder input on the development of a short placement tool. Future data collected will be compared to the baseline data to examine changes over time. The following is understood about the status of quality measures upon the first year of DMC-ODS waiver implementation:

- *Use of ASAM Criteria-based tools for placement and assessment*. Utilization of the ASAM Criteria as a common standard for assessing patients' needs and as the basis for appropriate placement into level of care and treatment planning is a requirement under the DMC-ODS. However, less than half of the counties that responded to the County Administrator Survey indicated that the ASAM assessment is already fully or partially available, and less than one quarter of the counties reported currently collecting ASAM data from assessment centers and/or treatment providers. Baseline data also suggested that there is considerable variation across counties in terms of the initial screening tools and full ASAM-based assessment tools that counties are developing themselves or are considering or planning to use. As more counties opt in to the waiver and begin implementing their plans, it is anticipated that use of the ASAM Criteria based tools and collection of ASAM data will increase.
- *Patient engagement.* During calendar year 2015, the majority of patients admitted to treatment (excluding withdrawal management) were successfully engaged in treatment (i.e., length of stay 30 days or longer). The median length of treatment for admissions during the baseline year was highest for NTP maintenance (83 days), followed by outpatient (80 days), intensive outpatient (62 days), and residential (38 days). Changes in patient engagement as the waiver is implemented in the opt-in counties will be tracked over time as part of the evaluation.
- *Patient transitions along the continuum of SUD care.* Most of the time during calendar year 2015, patients receiving non-NTP withdrawal management services did not move along the continuum of care to receive additional treatment. Similarly, the vast majority of patients initially receiving residential treatment did not step down to additional lower-level treatment (e.g., outpatient). Baseline data highlight care transitions as a priority area, which an organized delivery system that includes a full continuum of SUD care is expected to address. In addition, the County Administrator survey showed that only one-quarter of the counties reported requiring SUD providers to establish formal procedures with other SUD providers to facilitate transfers and information exchange. With the implementation of the DMC-ODS, the expectation is that

patients will transition to different levels of care along the continuum of SUD treatment, as appropriate and in a timely manner. Thus, effective care coordination and timely information exchange between SUD treatment providers will be important areas to examine in subsequent years of the evaluation.

- *Successful discharge.* Admissions in 2015 resulted in discharges with reported treatment completion or satisfactory progress at the following rates: 81.7% for non-hospital detox, 62.3% for residential, 50.5% for NTP withdrawal management, 49.7% for outpatient, and 46.5% for intensive outpatient. This pattern was also observed across years 2013 and 2014. Discharge data will continue to be tracked over the course of the waiver to examine changes in the pattern after the implementation of the waiver.
- *Use of evidence-based practices.* Responses to the 2015 County Administrator Survey indicated that treatment programs in slightly more than half of the responding counties used at least two of the five evidence-based practices (EBPs) listed in the Special Terms and Conditions (STCs) of the DMC-ODS waiver; the level of priority for training for each of the five EBPs was rated as "medium." As use of EBPs is a requirement of the waiver, it is anticipated that improvement will be evident as providers receive more training in the opt-in counties, which in turn is expected to have an impact on quality of care.
- *Patient quality-of-care perceptions.* Results of the 2015 County Administrator Survey showed that the majority of counties that responded already require SUD treatment providers to collect data on patient satisfaction/perceptions of care, typically using written surveys. As part of the evaluation of the waiver, patients will be surveyed at multiple time points to examine patterns in patients' perceptions of the quality of their care over time.
- *Establishment of quality improvement committees and plans.* Responses to the County Administrator Survey indicated that most of the responding counties already have a quality improvement committee with SUD participation (which could include a behavioral health committee with MH and SUD participation). However, only 21% of counties reported having a written SUD treatment system quality improvement plan at the time of the survey. Three-quarters of the respondents reported that the waiver has positively influenced quality improvement activities in their counties.
- *Patient outcomes at baseline.* CalOMS-Tx data was analyzed to establish a baseline with which to track changes and patterns in patient outcomes over the course of the implementation of the waiver. Improvements from admission to discharge appeared for alcohol and other drug use, social support, living arrangements, and employment. About half of the data was missing at discharge, however, creating the potential for bias. UCLA recommends a patient follow-up study to measure outcomes for patients with missing data, which would enable use of statistical models to estimate (impute) the values of this missing data in the future.

- *Effectiveness of levels of care—readmissions to withdrawal management and residential treatment.* During calendar year 2015, among patients who initially received non-NTP withdrawal management services, 10.4% were readmitted within 30 days and 15.2% were readmitted to non-NTP withdrawal management within 90 days. Of the patients who were initially admitted to residential treatment, 6.2% were readmitted to residential treatment and 1.3% were subsequently admitted to non-NTP withdrawal management within 30 days. Further, 8.5% were readmitted to residential treatment and 1.9% were admitted to non-NTP withdrawal management within 90 days. It is notable that under the STCs for the DMC-ODS, only two non-continuous regimens of residential treatment will be authorized in a 1-year period. Future analyses will examine whether implementation of the components of the DMC-ODS (e.g., use of the ASAM Criteria for assessment and placement, having access to a full continuum of SUD care) contributes toward decreasing the rate of readmissions to withdrawal management services and residential treatment.

UCLA plans to obtain access to and/or acquire additional data sources (e.g., county ASAM data, Medi-Cal claims, grievance reports), collect additional data via surveys (e.g., treatment provider, patient satisfaction/perception of care) and qualitative interviews (e.g., county administrators), and conduct further analyses (e.g., analyzing baseline data from additional sources, tracking changes over time, comparing opt-in and non-opt-in counties) in the upcoming years to examine if and how the implementation of the waiver influences the quality of the SUD care provided to patients within an organized delivery system.

IV. Integration/Coordination of Care

Another aim of the DMC-ODS waiver is to facilitate greater coordination and integration between SUD providers and other parts of the health care system. Coordination of care is crucial to ensure effective treatment of individuals with co-occurring health concerns.

Greater coordination of care for beneficiaries receiving SUD treatment as they step up/down across the various levels of care within the SUD continuum is a key component of an organized system of care. For purposes of this report, we have incorporated discussions of such "within system coordination" into the quality-of-care section, while the focus of this section is on the integration/coordination of SUD treatment with primary care and mental health.

To facilitate cross-system integration and coordination of care, the DMC-ODS terms and conditions include a requirement that participating counties enter into a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS in their county. The established MOUs are required to promote, at minimum, bidirectional referral protocols between county SUD systems and Medi-Cal managed care plans, the availability of clinical consultation, management of beneficiaries' care, procedures for the exchange of medical information, and a process to ensure that beneficiaries receive medically necessary services uninterrupted in the event of disputes between counties and Medi-Cal managed care plans. DHCS will confirm the existence of the MOUs and examine the degree to which these MOUs meet the minimum components.

As part of the DMC-ODS evaluation, UCLA will examine the following coordination goals: (1) comprehensive substance use, physical health, and mental health screening, (2) beneficiary engagement and participation in an integrated care program as needed, (3) shared development of care plans by the beneficiary, caregivers, and all providers, (4) care coordination and effective communication among providers, (5) navigation support for patients and caregivers, and (6) facilitation and tracking of referrals between systems. Where possible, UCLA will examine referrals to and from primary care and mental health, referrals to and from recovery services paid for by the DMC-ODS, SUD identification in the health care system, and follow-up after discharge from the emergency department for alcohol or other drug use.

A. Data Sources

UCLA conducted a literature search on published articles, reports, and other resources from leading integrated health care organizations and initiatives (e.g., Substance Abuse and Mental Health Services Administration – Health Resources and Services Administration [SAMHSA-HRSA] Center for Integrated Health Solutions [CIHS], Agency for Healthcare Research and Quality [AHRQ], National Quality Forum [NQF], Care Coordination Institute [CCI], California Mental Health Services Authority [CalMHSA], etc.) and found that there are few validated measures of integration of services and coordination of care focused on SUD integration. UCLA will therefore rely partly on survey items developed specifically for this evaluation (i.e., county, managed care plan, and provider-level surveys). We will also conduct document reviews of MOUs and approved DMC-ODS County Implementation Plans, and utilize CalOMS-Tx and Medi-Cal claims data when possible to examine referrals between systems and conduct qualitative interviews.

At the time of this report, available data to build the baseline measures included primarily survey data (including quantitative and qualitative responses) at the county level (county administrators and managed care plan medical directors), 10 county Implementation Plans, and some CalOMS-Tx data. Medi-Cal claims data and MOUs are not yet available to UCLA. In the future, the evaluation will rely more heavily on provider/program-level data to determine how well counties and their providers are meeting their integration and coordination goals.

B. Baseline Measures

Memorandums of Understanding (MOUs)

SUDs and Medi-Cal managed care plans

Fully executed MOUs were not available for document review in time for this report. Therefore, our baseline measures on MOUs are currently limited to data collected through stakeholder surveys.

In the 2015 County Administrator survey, UCLA inquired about their coordination efforts and formalized agreements with managed care plans, with a specific emphasis on SUD service coordination. Of the 40 counties that responded, none reported MOUs with their Medi-Cal managed care plans that met all requirements of the DMC-ODS waiver. Given the requirement to establish at least one MOU between SUD and managed care plans for counties that opt in to the waiver, it is certain that in the coming year, this will change. A strategy that many counties are employing is to amend the current MOU that some counties have in place with managed care plans for specialty mental health to meet the DMC-ODS waiver requirements.

Responses written in the comments section of the survey suggested that the MOU requirement was helpful for coordination and integration efforts between SUD and health services. For example, one county administrator noted that *"it has brought up the need to include SUD in MOU discussions that were previously MH focused."*

Comprehensive substance use, physical health, and mental health screening

Delivery of integrated services typically begins with a comprehensive screening process addressing substance use, physical health, and mental health. The degree to which comprehensive screening is conducted as part of standardized SUD service delivery will be more thoroughly examined at the provider level, and will be included as part of the upcoming provider survey. However, through the County Administrator Survey, UCLA explored how screening and placement for care is systematically conducted across counties at baseline. Administrators were asked about screening practices and whether centralized and/or standardized screening practices are used. Most counties (39 out of the 48, 81%) had a centralized system for screening and placing patients into treatment for some or all SUD services. Among those without centralized screening (9, 19%), most had standardized screening and placement procedures across all treatment providers (i.e., there is a uniform procedure and set of questions used across the county).

Qualitative analysis of additional remarks about screening practices indicated that the waiver has been a factor for some counties in moving to centralized screening for SUD services. For example, one administrator wrote that "*currently [it is available] for residential placement only; in the ODS this will be centralized for all offered services.*" In addition, some respondents indicated that their counties are integrating their screening for substance use with centralized mental health screening due to the waiver, with one person writing "*In anticipation for the Waiver this might be a function integrated under the umbrella of BH Services which already centralizes screening and placement*."

Centralizing or standardizing screening procedures at the county level does not necessarily identify whether such procedures include comprehensive screening tools, but it does indicate the presence of a mechanism by which a standard comprehensive assessment could be administered. DMC-ODS will require such an assessment in the form of ASAM Criteria, which incorporates both cognitive and biomedical assessments. It is therefore anticipated that more comprehensive screening for physical and mental health problems will occur as counties join the DMC-ODS demonstration project. See Section 2 for more information about baseline measures for ASAM utilization.

State-sponsored trainings have been and continue to be made available to counties in order to support the standardized utilization of the ASAM criteria for SUD screening, placement, and treatment plan development. However, UCLA's qualitative review of the currently approved DMC-ODS County Implementation plans (n=10) suggested that integration and coordinated care efforts could be improved by additional workforce development efforts outside of the SUD system. As one county administrator stated, "*Workforce training on best practices for patient screening, problem and risk identification, brief intervention for substance use problems, and patient engagement in SUD service are need[ed] for the MH and physical health workforce."*

Cross-system care coordination and effective communication among providers

Baseline measures of coordination and communication were examined at the county level through the county administrator and managed care plan surveys. In the future, provider- and patient-level survey data will be incorporated as well.

UCLA asked county administrators to rate the degree to which their SUD and mental health (MH) departments/divisions were integrated, as well the degree to which their SUD and physical health services departments/divisions were integrated. On a 1–5 Likert scale from "very poorly integrated" to "very well integrated," counties, on average, rated MH services to be well integrated with SUD services (mean = 3.59), whereas health service integration was rated as only "somewhat well" integrated with SUD services (mean = 2.72). These results suggest that integration of services is further along between SUD and MH than between SUD and primary care. One DMC-ODS objective is to improve and facilitate integrated and care coordination, so these ratings are expected to improve over time.

Within DMC-ODS County Implementation plans, counties described how they plan to implement integrated and coordinated care under the waiver. Document review of the 10 approved plans revealed a variety of strategies that counties plan to employ once plans are fully implemented in order to improve integrated and coordinated care. Counties also identified the anticipated challenges ahead and how they plan to address these issues at the local level. Many efforts are well underway through provider level trainings and education as well as, for example, initiating cross-system learning collaboratives at the leadership level to discuss and develop new procedures and practices. Discussion about these communication practices are further described below (Department/Division communication/collaboration). Beyond these local efforts, many counties shared common problem areas for which state-level technical assistance was requested. These include:

1) Patient data-sharing practices and information exchange
   - "*Because of the confidentiality regulations required by 42 Code of Federal Regulations (CFR) Part 2 and HIPAA, [many counties] anticipate challenges coordinating beneficiary information sharing between all caregivers and providers, including mental health and physical health. Data sharing between these entities, especially in regard to telehealth, is likely to be resource-intensive and require additional legal and technical assistance."*
   - *"The challenges currently anticipated are ensuring that all physical health and mental health partners and beneficiaries understand the requirements related to 42 CFR Part 2 and that procedures and forms are updated to effectively enable the communication necessary for effective care coordination, shared plan development, and collaborative treatment planning."*
   - *"State advocacy to revise or waive these requirements for the Waiver demonstration would allow more effective and efficient care coordination practices."*

2) Interdepartmental system-information exchange capabilities / multiple EHR platforms.
   - *"While [SUD, MH and PH] partners are committed to participating in integrated and collaborative services – and substance use treatment providers already have 42 CFR Part 2 projections in place – the infrastructure is currently not in place for all partners and will require technical assistance."*
   - "*EHR platforms differ across systems (health care, mental health and SUD). While IT divisions can evaluate the local EHR system needs/electronic platforms [many counties] would benefit from recommended models that are used in other counties."*

3) Collaborative treatment planning with managed care
   - *"Clients referred to other services can be burdened with multiple treatment plans and at times duplicative services."*
   - *"[*Counties*] would welcome the development of a professional learning community to explore strategies for improving cross-system capacity to better manage the coordination and tracking of client referrals and care…""*
   - *"[*Counties*] would be interested in information and/or technical assistance on models of care coordination with managed care plans."*
   - "*Training in care coordination is needed by all three workforces.*"

4) Medi-Cal billing procedures and payment for shared patients across systems
   - *"Current Medi-Cal payment systems for mental health, physical health and SUD services are cumbersome, and discourage effective and efficient coordinated or integrated care approaches."*
   - "*The changes to permit same-day billing for Medi-Cal reimbursed services…is a significant step to improving and supporting cross-system coordinated and integrated care and should be maintained."*
   - *"Payment and provider enrollment incentives for Medi-Cal providers with coordinated and integrated care approaches to service delivery would further promote the adoption of such approaches as the standard for statewide service delivery."*

As part of the DMC-ODS evaluation, UCLA will continue to monitor these shared system-level problem areas, identify successful strategies at the local level, and communicate county technical-assistance needs to the state.

<u>Department/Division communication and collaboration</u>

UCLA's surveys also inquired at the county level about communication and collaboration practices between departments/divisions, as well how counties promote the development of provider partnerships across their SUD, mental health, and physical health providers.

Within each DMC-ODS County Implementation Plan, counties were asked to indicate how the waiver impacted their county's meeting practices across SUD, MH, and

physical health service departments/divisions. Among the 10 counties with approved implementation plans at the end of June 2016, most of the counties (8) reported that SUD, MH, and physical health service departments/divisions have been holding regular meetings to discuss other topics prior to waiver discussions, one county reported that these meetings have increased in frequency or intensity as a result of the waiver, and one county reported that there were no regular meetings between departments and the waiver planning was a catalyst for new planning meetings. This is an indication that the waiver has already had some impact on the communication and collaborative processes at the county level.

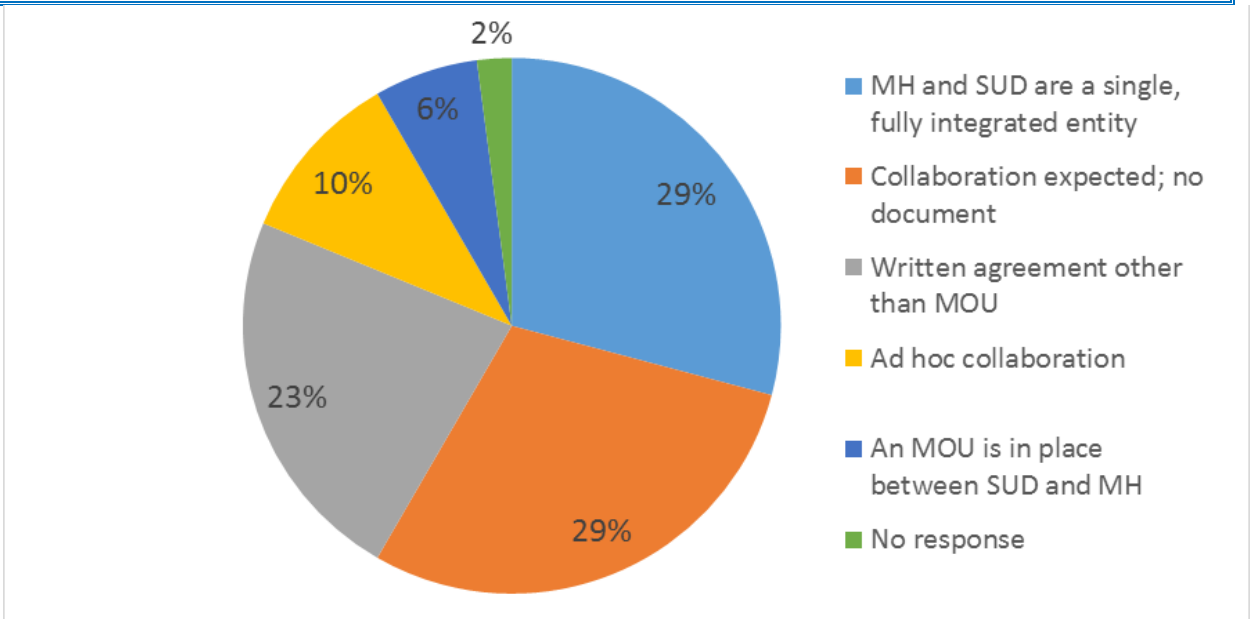
Responses from the County Administrator Survey indicated that the majority of counties had SUD departments/divisions that met regularly with mental health and physical health services counterparts for collaboration purposes (some via scheduled meetings, some via informal email exchange and by ad hoc project needs). However, 21% of SUD administrators did not believe that SUD and MH leadership met frequently enough to support an organized system of care, compared to 58% who did not believe that SUD and physical health leadership met frequently enough.

Overall, qualitative comments from county administrators confirmed that meetings are necessary to communicate and collaborate in order to support an organized and coordinated delivery system; however, many reported that it is important to keep meetings focused with specific goals and objectives:

- *"More meetings with integrative focus to accomplish particular outcomes in the timeframes would be helpful*."
- *"We spend a lot of time in meetings, but without specific goals and objectives for improved integration, the meetings lack direction."*

SUD and MH departments/divisions. County administrators were asked how their SUD and MH departments/divisions have approached collaboration and whether formal agreements were a part of the collaborations (see Figure 10). Fourteen counties (29%) reported that MH and SUD are a single, fully integrated entity, which indicates full collaboration. Three counties (6%) indicated that an MOU is in place between SUD and MH that defines goals and objectives for partnering and collaboration. Eleven counties (23%) have a written agreement other than an MOU that defines goals and objectives for partnering and collaboration. Fourteen counties (29%) expect collaboration and do not require or need a formal document to define goals and objectives for partnering and collaboration. Five counties (10%) reported that no formal collaboration occurs, or that it occurs ad hoc.

Figure 10: Baseline distribution of behavioral health department collaboration approaches – all counties.



County administrators were also asked if they believed the waiver positively influenced collaboration and communication across SUD and MH services in their county. After removing counties who reported a single, fully integrated entity for SUD/MH services (n=32, from 48), 63% responded affirmatively that the waiver positively influenced county-level activities for both collaboration and communication.

Qualitative analysis of the comments that some respondents provided on the survey revealed that for some counties, the waiver has already had a noticeable impact, as illustrated by the following quotations.

- *"Communication between SUD and MH will be enhanced as a result of the waiver and development of the continuum."*
- *"[It has] created more focused discussions."*
- *"[It has] increased communication about integrating access and QI/UR functions."*
- *"There are some meetings that still "forget" about one side or the other. But this is happening less and less."*
- *"Although we are integrated, various divisions are looking at their SUD activities: the contract development, the contract monitoring, the Quality Improvement, the compliance, billing, etc."*

Alternatively, some commented that there was no effect since SUD/MH collaboration and that communication was already well underway.

- *"We were already 'there.'"*

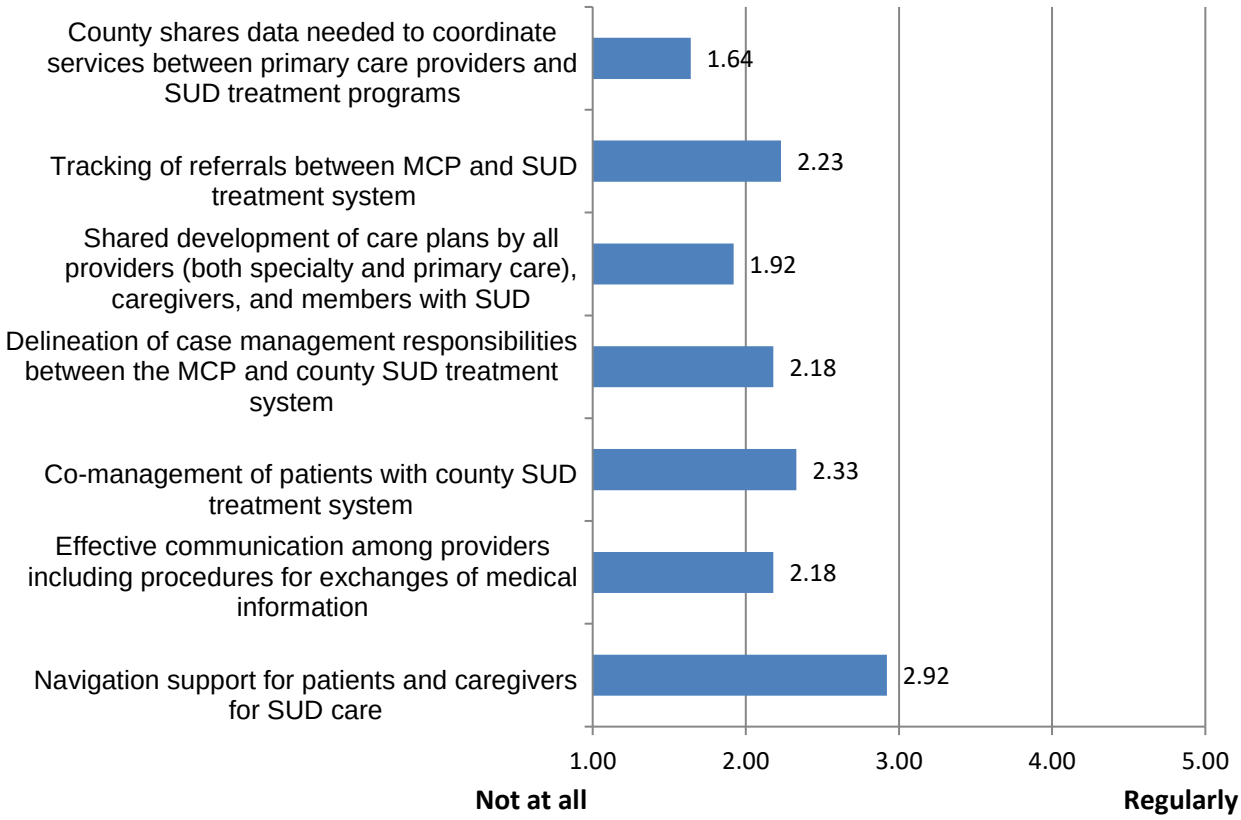
- *"We have been working on this for years*."
- *"I think we would be in the same place regardless of the waiver*."
- *"Since it isn't an issue, the waiver had no effect*."

Notably, there were also responses clarifying that not enough time had passed to report either way, but expressing hope. For example, one respondent wrote, *"Not yet-but expect it to,"* whereas another wrote, "*I believe it will as soon as we make some of the changes operational."*

SUD and physical health service departments/divisions. County administrators were also asked about collaboration and communication practices at the department/division level between SUD and health services. Responses suggested that coordination had begun, but strategies to accomplish this varied across counties. Although no County Administrator Survey respondents had a current MOU in place that met criteria requirements for the waiver, eight counties (17%) reported having an MOU in place (albeit not meeting all the requirements of the DMC-ODS waiver) with at least one Medi-Cal managed care plan in their county. In addition, 20 county administrators (41%) reported that "coordination of services with Medi-Cal managed care plans" is currently fully or partially available, whereas 22 (46%) expect this to become available in the next year. These are promising figures for the expansion efforts supported under the waiver.

To further explore SUD/physical health service coordination and collaboration, UCLA also surveyed managed care plan (MCP) medical directors in December 2015–January 2016 about their perspectives on and experience with the SUD system (13 of 22 MCPs in California responded). Respondents were asked to rate on a 1–5 Likert scale how regularly certain care coordination activities occur. Respondents generally gave low ratings to how regularly counties share information and coordinate treatment with them when their MCP members are referred to county SUD treatment systems. On a scale from 1 (*not at all*) to 5 (*regularly*), the average rating for counties sharing data that was needed to coordinate services between primary care providers and SUD treatment programs was 1.64. Other care coordination activities, such as shared development of care plans by providers and communication between providers, were also given low ratings, as indicated in Figure 11.

Figure 11: Managed care plan medical directors' perceptions of how regularly elements of coordination occur with the substance use treatment system.



There is strong agreement among MCP survey respondents that SUD conditions among MCP members contribute substantially to the costs of medical care, with an average rating of 4.77 on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). However, barriers reported, such as *"[p]rivacy protection regulations [which] present a challenge for data exchange and care coordination*" and "*counties['] reluctan[ce] to share information*" continue to exist. MCP survey respondents expressed a desire to achieve greater coordination of care for patients with SUDs, but as noted by one respondent, *"[w]ithout a clear system of care, systematic monitoring is difficult.*" These baseline data suggest that MCPs could be willing partners under the right conditions, and that opportunities therefore exist for progress toward better care coordination between SUD and physical health services.

County administrators (n=48) were also asked if they believed the waiver positively influenced communication across SUD and physical health services in their county. Forty-four percent (44%) responded affirmatively. Qualitative responses provided by some administrators who reported positively included:

- *"A primary care/behavioral health integration collaborative has been established in the past six months. The hope of increased SUD treatment resources through the Waiver was one motivation to establish the collaborative."*
- *"Planning for the upcoming organization and integration of SUD services has involved educating and involving health-related service in our county."*
- *"There are meetings with health care providers and mental health; however, SUD providers have historically not been part of the meeting."*
- *"{It is} forcing case management, warm handoffs, and follow-up through continuum."*
- *"We have developed, in anticipation of the waiver, a referral process from managed care as well as other health providers."*

Some respondents who did not positively endorse this question included comments explaining that the impact was minimal due to previous progress.

- *"Communication was already good, and continues to get better all the time."*
- *"SUD has historically been under the umbrella of Health Services in [our county]; however, there is now recognition about the need for further collaboration with us."*
- *"Communication has been regular and consistent."*
- *"Both health care reform and prison reform have done so prior to the waiver approval. Further progress, prompted by the waiver, will probably soon happen."*

Overall, it seems that communication occurs and collaborative efforts are made at the department/division level, and the process of applying for waiver participation has already been shown to improve these practices. However, further investigation is needed to better understand the communication and collaboration activities at the county level, and this will be explored in the future through qualitative interviews with county administrators.

Promoting Provider Partnerships

In the County Administrator Survey, UCLA inquired whether counties required their SUD providers to establish formal procedures with mental health providers to *facilitate patient transfers* and *information exchange* (two critical elements for care coordination and effective communication). Nineteen counties (40%) have guidelines or requirements for SUD providers to partner with mental health providers and 20 counties (42%) are planning to have guidelines or requirements.

A comparatively lower number of counties (15, or 31%) have guidelines or requirements for SUD providers to partner with primary care providers and 26 (54%) have plans to implement such guidelines or requirements. However, only 14 counties (21%) reported having procedures to monitor the establishment or utilization of either of the above types of partnerships.

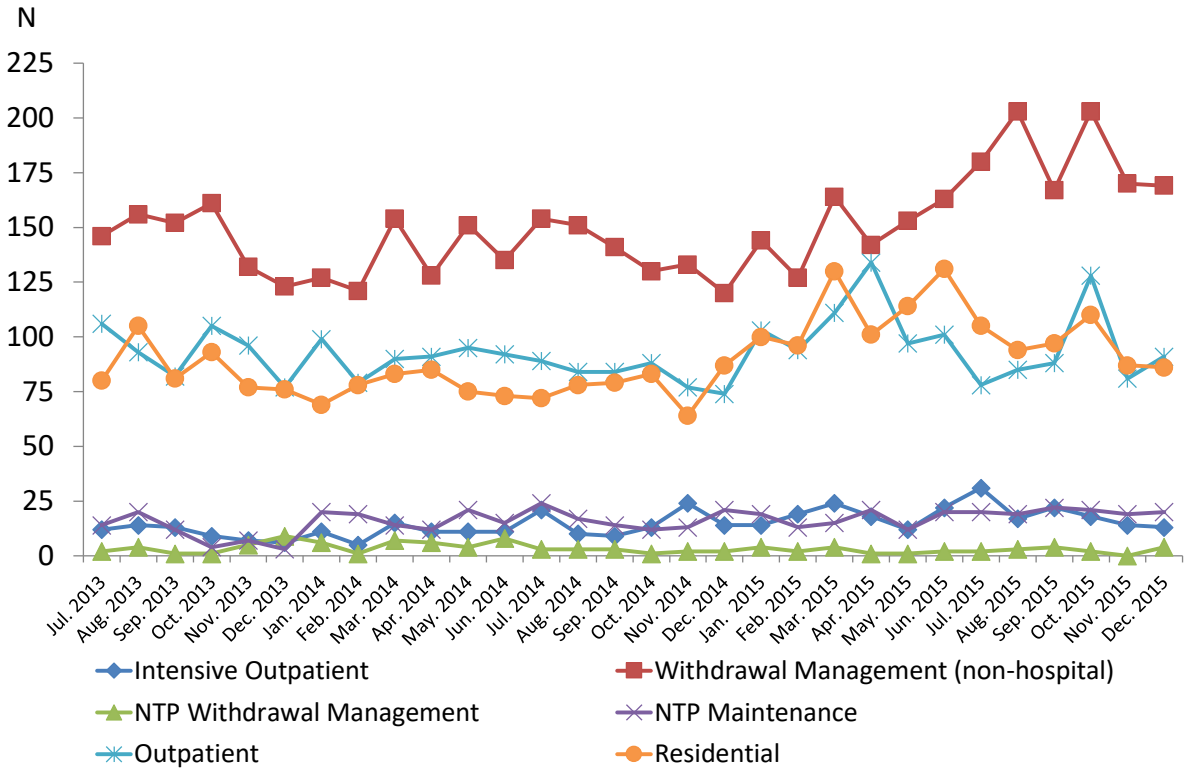
Provider partnerships can play a significant role in the delivery of integrated care and improve care coordination between systems. Further examination will be conducted at the provider level to better understand current practices and how these practices facilitate successful patient transfers and effective information exchange.

Facilitation and tracking of referrals between systems

The degree of facilitation and tracking of referrals between systems is another measure by which cross-system integration and coordination can be gauged. This will be further explored though provider- and patient-level surveys in the future, as well as with claims data; however, UCLA began this investigation by examining available data in CalOMS-Tx.

Referrals from primary care and mental health providers can be quantified using information from CalOMS-Tx on whether patients were referred from other health care providers. Withdrawal management (non-hospital) programs receive the highest number of referrals and percentage of referrals from health care providers followed by residential and intensive outpatient providers. However, the numbers remain relatively low. These referrals resulted in 150 to 175 withdrawal management referrals per month statewide (about 8% of admissions), and 75 to 100 residential and outpatient admissions per month (less than 5% of admissions for each modality; see Figure 12).

Figure 12: Number of referrals from health care providers by modality from July 1, 2013, to December 31, 2015.



These results suggest that there is significant room for improvement with regard to the facilitation of SUD referrals from the physical health care system.

There are many elements to the waiver that were purposefully designed to lift barriers and facilitate information exchange, care coordination, and multi-system case management. There is, therefore, hope that this level of coordination and integration may change over the next few years, particularly since key stakeholders on both sides appear to be motivated and ready to improve coordination.

C. Discussion and Next Steps

Through the DMC-ODS, it is anticipated that participating counties will deliver services to their beneficiaries with an increase in coordination of SUD services across the treatment continuum as well as with other systems of care (e.g., physical and mental health). It is well understood that service integration and care coordination has many implementation challenges under the current system of care. Measures selected to monitor improvement for this evaluation include: (1) existence of SUD and managed care plan MOUs and the degree to which they meet the minimum requirements to facilitate integration and coordinated care, and (2) the degree to which counties and providers meet the various coordination goals identified by UCLA, DHCS, and CMS.

At the time of this report, baseline data (county, provider, and patient-level) is still in the collection process, a process that will continue as county phases are rolled out. In addition, access to DMC claims data has not yet been made available to the UCLA evaluators. This data, once received, will allow for a more comprehensive understanding of baseline SUD service delivery for beneficiaries.

Using primarily county administrator and managed care stakeholder survey data, county implementation plans, and CalOMS-Tx data, the following is understood about the status of integration and care coordination upon the first year of DMC-ODS waiver implementation:

- *MOUs between SUD and Managed Care Plans*: At this time, no county has an established MOU that meets the DHCS requirements. Given that this is a requirement for counties to opt in to the waiver, we know this situation will change as county implementation plans are approved. To meet the DMC-ODS waiver requirements, a strategy that many counties are employing to address this is to amend the current MOU that some counties have in place with managed care plans for specialty mental health.
- *Comprehensive substance use, physical health, and mental health screening*: Most counties have either a centralized system for screening and placement or a standardized screening and placement set of procedures for their providers. Although centralizing or standardizing screening procedures at the county level does not necessarily identify whether such procedures include comprehensive screening tools, it does show a feasible mechanism in which to utilize a comprehensive tool. Through the DMC-ODS requirement to utilize ASAM Criteria for placement and assessment, which incorporates both cognitive and biomedical assessments, we can anticipate more comprehensive screening for physical and mental health problems as part of standard practice in SUD settings. See Section 2 for more information about baseline measures for ASAM utilization.
- *Care coordination and effective communication among providers*: The baseline data reported by county administrators supported previous research suggesting that integration of services is further along between SUD and MH services than between SUD and physical health services. The waiver's requirement to establish MOUs between SUD and managed care plans in order to improve

integrated and coordinated care has already started to improve collaboration and communication at the county level. However, barriers such as privacy protection regulations, interdepartmental information exchange barriers, and multiple EHR platforms, continue to hinder effective information exchange. In addition, counties report a need for technical assistance and recommended models of case management or care coordination with managed care plans. County administrators generally report that they perceive that communication occurs and collaborative efforts are made across SUD, MH, and health care departments, but it is evident that collaboration strategies and service reach vary widely; county size and departmental makeup certainly are factors in how counties approach collaboration and communicate across departments/divisions. Across all counties, it is consistently noted that it is important to hold meetings with all parties present, but to be effective and well managed, the meetings need to be structured with goals and objectives. Many county administrators have reported that preparation for the waiver resulted in some change toward better cross-system collaboration and communication, particularly from counties with integrated behavioral health departments, and some report that not enough time has passed to know if the waiver will impact department practices. However, most positively remarked about the promise of improved communication practices under the waiver, and UCLA will continue to measure change over time.

- *Facilitation and tracking of referrals*: Based on CalOMS-Tx data alone, withdrawal management (non-hospital) providers receive the highest number and percentage of referrals from health care providers, followed by residential and intensive outpatient providers. However, the numbers remain relatively low. This data suggests that there is significant room for improvement with regard to the facilitation of SUD referrals from the physical health care system. More data is needed to build this baseline measure to include referrals from SUD into the health care system, as well as to include referral data to and from the mental health system.

Specific measures that were not addressed in this year's report, due to lack of available data, include: beneficiary engagement and participation; shared development of care plans by beneficiaries, caregivers, and all providers; and navigation support for patients and caregivers.

Given that not all data are available or collected at this time, we do not yet have a clear picture of how all systems are integrating services and coordinating care systematically, but there are several indications that the SUD system and the participating counties, by way of this DMC-ODS waiver, are positioning themselves to systematically improve such integration and coordination. Many elements of the waiver were purposefully designed to lift barriers and facilitate information exchange, care coordination, and multi-system case management. Upcoming activities (i.e.: county administrator interviews, provider- and patient-level surveys) will explore these areas in order to further assess the baseline levels and monitor improvement of the delivery of coordinated and integrated care for DMC beneficiaries.

V. Conclusion

A. Summary and Recommendations

Across the domains described in this report—access, quality, and coordination/integration—a consistent pattern emerged: There is room for improvement on most measures and there is *potential* for the DMC-ODS demonstration to facilitate this improvement. The following are areas that stakeholders should consider focusing on:

Access

- Focus on ensuring the availability of methadone or other medications for opiate use disorders in small counties. Use of methadone as a medication was much lower in Phase 4 counties, and in smaller counties in general. This suggests a particular need to expand capacity to enable access to NTP during this phase. The prescribing of buprenorphine in outpatient settings may provide a partial alternative in regions where NTP expansion is insufficient. The STCs also encourage counties to "Extend NTP/OTP programs to remote locations using mobile units and contracted pharmacies which may have onsite counseling and urinalysis."
- Continue removing barriers to capacity expansion. In particular, program certification was reported to be one of the most significant challenges for expanding capacity across all modalities. There is anecdotal evidence that certification processes have improved to some degree, but efforts to remove barriers must continue. One concrete suggestion UCLA has made previously is that certifications should be expedited for sites that are already Short-Doyle certified (providing mental health services under Medi-Cal) and for new sites that belong to organizations that already have current Drug Medi-Cal certification. In both of these cases, the organization would have already been vetted by the state, so although some review of the specific site seeking certification may be necessary, it would be logical to assume that at least some of the review focused on the organization could be streamlined.
- Look beyond physical capacity to increase penetration rates. Penetration rates for treatment among patients who need it in California are low, but national surveys also suggest that most people who need treatment *do not feel they need specialty treatment*. This suggests that although efforts to increase penetration rates can and should include expansion of physical capacity, efforts are also needed to change perceptions about specialty treatment among prospective patients, and to reach patients in non-specialty settings such as primary care.

Quality

- Provide guidance on ASAM tools. Counties have been given great flexibility in how they implement ASAM screenings and assessments, and for a demonstration project such as DMC-ODS, this may be beneficial. However, more guidance would be helpful to standardize requirements on how ASAM data is to

be collected and reported to the state and for evaluation purposes, and to understand exactly what the required elements of these processes are to enable billing for assessments without fear of losing this revenue in future audits. UCLA will attempt to assist in these areas.

- Improve patient transitions along the continuum of SUD care. Most of the time during calendar year 2015, patients receiving non-NTP withdrawal management services did not move along the continuum of care to receive treatment. Similarly, the vast majority of patients receiving their initial residential treatment did not step down to less intense additional treatment (e.g., outpatient). These transitions form the foundation of the "organized delivery system" that the DMC-ODS demonstration is seeking to create. There are myriad reasons this may not be occurring, including patient resistance, a shortage of provider capacity to accept referrals, and deficiencies in processes such as "warm hand-offs" and data sharing, each of which demand a different response. UCLA will continue to study the barriers to transitions to inform future recommendations.
- More accurately estimate patient outcomes. Although treatment appeared to be associated with improvements in alcohol or other drug use, social support, living arrangements, and employment, these findings are undermined by potential bias from high levels of missing data. UCLA recommends additional training and technical assistance to improve data reporting and a patient follow-up study to measure outcomes for patients with missing data, which would enable use of statistical models to estimate (impute) the values of this missing data in the future.
- Reduce readmissions to withdrawal management. During 2015, among patients who initially received non-NTP withdrawal management services, 10% were readmitted within 30 days and 15% were readmitted within 90 days. This puts a strain on already thin withdrawal management resources, as well as on the patient. Focusing on transitions to treatment following withdrawal management, as described above, may help to lower these rates. In some cases, it may be appropriate to consider medications such as depot naltrexone (Vivitrol), for example, for patients with alcohol use disorders who have had repeated relapses and readmissions to withdrawal management.

Integration/coordination

- Data sharing practices and information exchange. Data sharing and information exchange continues to be a challenge at the county level. The issues are twofold: (1) Ensuring that all physical health and mental health partners and beneficiaries understand the requirements related to 42 CFR Part 2 and that procedures and forms are updated to effectively enable the communication necessary for effective care coordination. The current requirements of 42 CFR Part 2 make sharing of patient information between systems cumbersome. State advocacy to revise or waive these requirements for the waiver demonstration would allow more effective and efficient care coordination practices. (2) The challenges of differing EHR platforms across systems (health care, mental health, and SUD) and limited interdepartmental information exchange capabilities. Counties would

welcome recommended models of how other counties are navigating this issue while continuing to evaluate the local EHR system needs.

- Create coordination/integration pilot projects. There is consensus both among SUD treatment administrators and Medi-Cal managed care plans that integration/coordination is currently fairly weak between the SUD and physical health care systems. Payment reform and information exchange pilot projects are currently being considered by DHCS to address this. Literature on payment reform suggests that incentives need to be applied to both the referring and receiving entities to provide both a "push and pull" to facilitate referrals. The literature also suggests that any financial incentives must be aligned with performance requirements contained in the providers' contracts. Furthermore, some research suggests that integration is most effective when targeted at patients with SUD-related medical conditions (health conditions that are caused or exacerbated by drug or alcohol use). Pilot projects that adhere to these principles will have a greater chance of succeeding. In addition, many counties are seeking technical assistance on case management strategies and care coordination with managed care plans.
- Facilitate referrals from the broader health system: Trainings on SBIRT, including how to make effective warm handoffs, and reform of the way that SBIRT is reimbursed would be helpful. UCLA is currently working on a report on this topic that will contain more detailed recommendations
- Cross-system workforce development: The workforces in mental health, physical health, and SUD service networks have limited expertise in identifying and addressing multiple co-occurring conditions. Workforce training on best practices for patient screening, problem and risk identification, brief intervention for substance use problems, and patient engagement in SUD services are needed for the MH and physical health workforce.

B. Limitations

While the results from the first year of waiver implementation might be helpful to policymakers and those who are working to implement the waiver, there are important considerations to be kept in mind while interpreting these results.

The waiver is being implemented in phases and no counties have fully approved state-county contracts at this point. This is, therefore, a baseline report, rather than a report on implementation progress. As implementation proceeds, the results presented here will be updated and expanded.

Implementation limitations

In addition to DHCS and CMS approval of county implementation plans, approval from each county's board of supervisors, execution of the state-county intergovernmental agreement, and CMS approval of these terms is required for counties to formally begin billing for services under the waiver. The task of demarcating "baseline" and "implementation" for each county is therefore difficult. Use of the effective date on the

intergovernmental agreement as the demarcation may be the most straightforward solution, but UCLA also acknowledges that counties will have made progress toward implementation and potentially improving access, quality, and coordination/integration of care throughout the earlier stages of the approval process. Since much of the data discussed in this report (CalOMS-Tx, County Administrator Survey) were collected in 2015, these measures reflect a pre-implementation plan approval baseline. Still, even the process of preparing the implementation plans appear to have created some changes on county processes, as reflected in some of the county comments on coordination, in particular. The description of "baseline" here is therefore, by necessity, approximate, given the lack of a completely "pure" implementation start date.

Data limitations

The quality of administrative data is limited by the quality of data reporting from stakeholders. In particular, outcomes reporting from CalOMS-Tx is limited by missing data from patients who are administratively discharged (i.e., who leave treatment without providing a discharge interview). UCLA is in discussions with stakeholders about conducting a patient follow-up study that would provide the data necessary to facilitate future imputation of missing data. CalOMS-Tx may also be limited by missing data from providers that fail to comply with reporting requirements. UCLA believes the extent of this will become clearer once Drug Medi-Cal data becomes available, since providers will need to submit Drug Medi-Cal claims in order to receive payment. Where feasible, results based on Drug Medi-Cal data may therefore replace results from CalOMS-Tx in future reports.

C. Plans for FY 2016-2017

Future activities to be conducted by UCLA include:

- Confirming the existence of a 24/7 functioning beneficiary access phone number for counties.
- Confirming the availability of a provider directory for counties.
- Gathering data on the availability of first appointments, either collecting data through phone calls to central access points and withdrawal management, residential, outpatient, and narcotic treatment program (NTP) treatment providers in counties that do not have a central access point, or by obtaining data directly from counties that collect this data as part of their quality improvement activities
- Verification of existence of and components of MOUs between SUD and managed care plans.
- Conducting provider surveys as counties are approved for waiver implementation to further evaluate access, quality, and coordination/integration of care as defined in the evaluation plan.
- Administering cross-sectional patient surveys at multiple time points to measure consumer perceptions of access, quality, and coordination/integration of care as defined in the evaluation plan. Conducting qualitative interviews with county administrators at various stages of waiver implementation not only to further identify key findings for the evaluation, but also to inform the state, counties, and providers of real-time findings during the phased rollout and waiver implementation.
- Receiving and analyzing Drug Medi-Cal and Medi-Cal data to further evaluate and enhance the baseline findings on several measures of access, quality, and coordination/integration of care.
- Receiving and analyzing patient address information from the Medi-Cal Eligibility Data System (MEDS) and provider address information from DHCS's Prime database to estimate network capacity.
- Receiving and analyzing ASAM data, including ASAM audit data, to build on network adequacy data, as well as other access, placement, transfer, and quality of care domains.
- Continuing annual stakeholder survey activities with county administrators and managed care medical directors.
- Coordinating activities with California's EQRO to maximize evaluation efforts consistent with DHCS priorities.

VI. Appendices

A. Figures and Tables

Figures

Tables

B. Acronyms

AHRQ	Agency for Healthcare Research and Quality
AOD	Alcohol and other drug
ASAM	American Society of Addiction Medicine
BH	Behavioral health
CalMHSA	California Mental Health Services Authority
CalOMS-Tx	California Outcomes Measurement System - Treatment
CCI	(California) Coordinated Care Initiative
CIBHS	California Institute for Behavioral Health Solutions
CIHS	SAMHSA-HRSA Center for Integrated Health Solutions
CMS	Centers for Medicare and Medicaid Services
DATAR	Drug and Alcohol Treatment Access Report
DCH	Day care habilitative (treatment); see IOP
DHCS	(California) Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBP	Evidence-based practice
EHR	Electronic health record
EQRO	External Quality Review Organization
HCPCS	Healthcare Common Procedure Coding System
HRSA	Health Resources and Services Administration
IOP	Intensive outpatient treatment; see DCH
ISAP	(UCLA) Integrated Substance Abuse Programs
MCP	Managed care plan (non-SUD, non-MH)
MEDS	Medi-Cal Eligibility Data System
MH	Mental health
MHSIP	Mental Health Statistics Improvement Program
MOU	Memorandum of understanding
NIMBY	"Not In My Back Yard"

NQF	National Quality Forum
NSDUH	National Survey on Drug Use and Health
NTP	Narcotic Treatment Program
OSHPD	Office of Statewide Health Planning and Development
PIP	Performance improvement project
QA	Quality assurance
QI	Quality improvement
QIC	Quality Improvement Committee
QIP	Quality Improvement Plan
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening, brief intervention, and referral to treatment
STCs	Special Terms and Conditions
SU	Substance use
SUD	Substance use disorder

C. Further Resources

- UCLA's approved evaluation plan is available online at: www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

- UCLA's 2015 county administrator survey report and 2015 managed care plan medical director survey report, as well as additional evaluation materials, will be available at: http://www.uclaisap.org/ca-policy/html/evaluation.html

- The waiver STCs, approved county implementation plans, FAQs, and other helpful resources and documentation can be found on DHCS's waiver site: http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx