Drug Medi-Cal Organized Delivery System

FY 2020 Evaluation Report

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

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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 suggests clinicians will need to unify around standard terms. Therefore, for consistency, we use the term "patients" throughout this report, except where "client" is used in a direct quote.

Acronyms

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

Executive Summary

Results to date show that the demonstration is improving access to treatment, quality of treatment, and coordination of care, but many challenges and opportunities lie ahead.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 demonstration waiver was created by the California Department of Health Care Services with the intent of improving the way substance use disorders (SUD) treatment is delivered in the state. As of July 1, 2020, DMC-ODS had been implemented in 37 counties containing the vast majority (95.9%) of California's population, but 21 small or small/rural counties are not participating. In participating counties, the DMC-ODS waiver has improved access to treatment, treatment quality, and coordination of care, but many challenges and opportunities lie ahead.

Access to Care

The DMC-ODS waiver significantly increased the number of people receiving DMC-funded services

Compared to State Plan counties, the introduction of the DMC-ODS waiver significantly increased the number of people receiving DMC-funded services in waiver counties by 18.3 percent. Across all funding sources, there was not a significant effect on admissions immediately upon implementation, which suggests some of the initial increase in patients receiving DMC-funded services may have been attributable to existing clients changing funding sources to DMC. However, seven or more months after the introduction of the DMC-ODS waiver, the number of unique patient admissions did significantly increase by nearly 30 percent. Some evidence also suggested an increase in the number of treatment providers occurred from 2016-2020. County administrators and patients generally gave positive ratings to treatment access under the DMC-ODS waiver. Still, treatment penetration rates (5.0%) decreased somewhat due to an increase in estimates of treatment need. However, the penetration rate among those who think they need treatment was estimated at 55.2%. Data suggest access challenges specifically for youth and narcotic treatment programs. Use of the DMC-ODS recovery services benefit seems to be hampered by confusion over the benefit.

Recommendations

- Increase penetration rates by working with primary care and other systems to identify and refer patients who do not currently recognize their need for treatment.
- Clarify the recovery services benefit.
- Further investigate the need for additional funding and support for youth and the causes of low referral rates to NTP/OTP.

Quality of Care

Data suggest that the DMC-ODS waiver is improving treatment quality. Overall patient satisfaction remains high, and county administrators continue to report that the DMC-ODS waiver has positively influenced quality improvement efforts.

Counties and SUD treatment providers report meeting and in many cases surpassing use of two evidence-based practices (EBPs), the minimum requirement under the DMC-ODS waiver. They also report widespread use of American Society of Addiction Medicine (ASAM) Criteria-based assessment tools to help determine level of care placement. Most patients were referred to the level of care indicated by their ASAM Criteria-based screenings or assessments, and a third of these patients went on to receive treatment at the referred providers within 30 days. About 58% of patients with a brief screening received the same or a different LOC within 30 days as compared with 81% of patients with an initial assessment. Rates of treatment engagement (three visits within the first 30 days) were higher among all modalities for CY 2019 (78.3%) compared to the CY 2016 pre-DMC-ODS waiver period (68.9%), although the rates varied across treatment modalities in both years. In addition, both providers (67.2%) and patients (87.2%) indicated that patients participated in developing patient treatment plans, suggesting patient-centered treatment planning was common, though not universal. Further, among patients admitted to withdrawal management, 80.0% were admitted only once, and 8.7% were readmitted to withdrawal management within 30 days.

Overall patient satisfaction remains high, and county administrators continue to report that the DMC-ODS waiver has positively influenced quality improvement effort.

Recommendations

- Provide technical assistance (e.g., tools, training) on assessing fidelity to EBPs as well as to the ASAM Criteria.
- Provide a standard ASAM Criteria-based assessment tool for use statewide.
- Consider allowing the use of and billing for case managers or peer specialists, when needed, to help patients access treatment services to which they have been referred in a timely manner, particularly following an ASAM Criteria-based brief screening.

Integration and Coordination of Care

County administrators report the DMC-ODS waiver has positively impacted the integration of mental health (MH), physical health (PH) and SUD services. Currently, SUD services are better coordinated or integrated with MH services than PH services. Challenges include barriers to sharing patient information, separate billing silos, lack of alignment between Medi-Cal requirements and certifications (specifically with MH), and continued stigma toward SUD patients (especially in PH settings).

Transitions of care within the SUD system are relatively low and have not significantly changed over time. While counties report having set QI goals to improve tracking transitions of care, not

all have the capacity to collect this data and analyze it. Providers indicated that starting early, getting client buy-in about engaging in the continuum of care, eliminating the concept of "graduation," and having formalized relationships between providers are significant factors toward successful transitions. In addition, having staff conduct warm handoffs, facilitate the communication/information exchange, and complete the required paperwork are also essential.

Utilization of the case management benefit remains low (9.5%). Consistent with this, stakeholders report that case management is often delivered but not billed due to confusion over billing and documentation requirements. Case management may be a useful tool to facilitate better integrated and coordinated care, but technical assistance to better utilize and bill for this service is needed.

Case management can be a useful tool to facilitate better integrated and coordinated care, but technical assistance to utilize and bill for this service is needed.

Recommendations

- Provide training and technical assistance on the case management benefit, addressing 1) billing issues and concerns of disallowances, 2) documentation requirements, and 3) strategies to provide case management services during transitions of care.
- Consider allowing billing for case management services before a beneficiary is admitted into treatment, given the amount of case management that occurs as part of the admission process.
- Provide training and technical assistance to providers on privacy regulations and best practices for information exchange between SUD-MH and SUD-PH programs, including use of release of information forms to facilitate referral and care coordination.
- Standardize Medi-Cal MH and SUD assessment and documentation requirements.
- Address stigma toward SUD patients and programs within the physical health system, with a particular emphasis on OTP/NTP patients.

COVID-19 and Telehealth

The COVID-19 pandemic caused a rapid shift from in-person services to telehealth. Both counties and patients reported high satisfaction with its use. However, significant barriers exist, specifically patient access to reliable internet services and tablets/phones. Also, early data suggest flexibilities related to take-home medications may have increased retention among methadone patients without increasing fatal overdoses. Counties want to continue this service, plus the use of telehealth past the COVID-19 pandemic. Furthermore, DMC-ODS waiver counties indicated that COVID-19 had an impact on the need for recovery residences, with counties citing the lack of availability to insufficient housing and bed supply.

Although these recommendations require funding, the COVID-19 relief bill passed in December 2020 provided expanded funding of the Substance Abuse Prevention and Treatment Block Grant that could be used to implement these recommendations.

Recommendations

- Extend flexibilities for the use of telehealth for SUD services beyond the pandemic. Flexibilities such as allowing the use of telehealth in 1915(c) waiver populations can be extended through a State Plan Amendment (SPA) or a modified 1915(c) waiver, or permanently extended through state action, according to CMS.
- Address barriers to telehealth use, possibly including efforts to facilitate linkage to the Lifeline program coupled with assistance with mobile data plans for people in treatment.
- Extend the flexibilities related to take-home medications beyond the pandemic.
- Expand efforts to increase recovery residence housing and bed supply.

Lessons Learned for Future Regional Models

Stakeholders appreciate that the Partnership HealthPlan of California's Wellness and Recovery (PHC W&R) Program covers all three service systems (PH, MH, SUD) and can do rapid triage to each with much-improved ability to follow through on care coordination. They are finding the program facilitates timely access to the most appropriate level of care. However, PHC W&R program administrators struggle with the varied regulatory requirements for SUD, MH, and PH. Additionally, there are challenges with perinatal services as perinatal services must be delivered in the county of residence. Stakeholders also appreciate the flexibility to provide contingency management and provider incentives under the program. An additional benefit of the program is that it offers significant administrative support for all the requirements of the DMC-ODS waiver. Importantly, discussions with PHC suggested a regional model like PHC W&R is only feasible in one-plan counties or County Organized Health Systems (COHS). In counties with multiple managed care plans, it is likely that the coordination required would be overwhelming.

Recommendations

- Weigh the ease of using fee-for-service against the use of per user per month payments like those used by PHC W&R, based on the abilities of participants in the model.
- Consider a planning process that includes a committee with DHCS, the managed care plan, and the counties to develop the fiscal plan and calculate anticipated costs.

What State Plan Counties Would Need to Join DMC-ODS

State Plan counties have a perception that there are many unfunded requirements in the DMC-ODS waiver, which has prevented them from joining the DMC-ODS waiver. Also, most State Plan counties do not have a full continuum of SUD care within their counties.

Recommendations

- Connect State Plan counties who want to join the DMC-ODS waiver with successful small DMC-ODS waiver counties or the PHC W&R program for planning purposes.
- Consider funding partnerships or learning collaboratives to facilitate information exchange.

- Deliver technical to State Plan counties to assist with
    - Expansion of provider networks
    - Transportation needs
    - A standardized assessment tool.
    - Implementing an EHR system that can keep up with regulatory changes and facilitate billing and inter-agency communications.

Stimulants – Current Practices and Future Needs

If the stimulant overdose death rate in 2020 Q2 (the most recent available) persists, about 3,000 people will die of stimulant-related overdoses in California every nine months, which is roughly equal to the total number of people who died in the four terrorist attacks on 9/11. Overdose death rates are more than twice as high for American Indian/Alaskan Natives than for Whites. Currently, stimulants, mostly methamphetamine, are implicated in more than half of all treatment admissions. Despite this, current efforts to prevent or treat stimulant use disorders in California are generally part of a broader effort to address substance use rather than targeted specifically at stimulants. Challenges frequently cited by respondents include a lack of medications to treat stimulant use disorders and a lack of funding for contingency management. Most county administrators believe contingency management would be helpful in treating stimulant use, and several innovative practices are underway in the state, including small contingency management projects in early stages.

Recommendations

- Provide assistance in the form of stimulant use disorder-related clinical guidelines, protocols, toolkits, and trainings.
- Facilitate use of contingency management.

DMC-ODS Services for People Experiencing Homelessness

As California's homeless population has risen over the past five years, so has the share of DMC patients who are experiencing homelessness at admission. At the beginning of 2015, 24.0% of DMC patients were experiencing homelessness at admission; this number grew to 32.7% by the end of 2019.

Compared to patients who are not experiencing homelessness, DMC patients who are experiencing homelessness (PEH) at admission are more likely to be male, White/non-Hispanic, and Black/non-Hispanic, and they are more likely to have alcohol, cocaine/crack, or methamphetamine as their primary substances. They are also significantly more likely to have co-occurring mental illnesses.

Statewide, homelessness is associated with lower rates of 30-day treatment retention and successful discharge status. Though PEH in DMC-ODS waiver counties are more likely than PEH in State Plan counties to receive residential treatment, retention and discharge outcomes for PEH are similar in DMC-ODS and State Plan counties.

Stakeholders report that insufficient funding for recovery residences (RR) and transitional housing (TH) create challenges serving PEH, as does the limited availability of RR/TH beds in their communities. The dearth of housing options for patients when they transition out of care (and are no longer eligible for RR/TH) remains a challenge as well.

Recommendations

- Increase training and technical assistance on evidence-based practices for serving PEH.
- Increase funding for Recovery Residences and Transitional Housing (RR/TH) with the recent augmentation to SABG funds.
- Enhance RR/TH capacity to serve PEH with co-occurring mental health disorders and those who use medications for addiction treatment.
- Develop an integrated, interagency response to the intertwined challenges of housing and treatment for PEH with SUD at the state level.

DMC-ODS Stakeholder Feedback on Current Waiver Requirements

Based on county and treatment provider feedback, major implementation challenges include clarity of guidance, requirements and funding, and consistency of policies between counties.

Recommendations

- Provide much clearer guidance and specific examples, especially on documentation requirements and billing for recovery services. This could address multiple problems by increasing use of the recovery services benefit, partially offsetting concerns about low rates by providing additional revenue to providers for a service many are already providing, and reducing concerns about proper documentation.
- Short term, provide new counties with support similar to that received by Sacramento County. Longer term, consider payment reform (e.g., capitation) that may give providers the flexibility that counties and the state want to provide while removing concerns from providers that claims for specific services may be disallowed.
- Participate in the SAPT+ meetings and facilitate collaborative learning efforts between counties. In particular, if new counties join the DMC-ODS waiver in the future, effort should be made to connect them with similar high-performing counties. All counties may also benefit from ongoing collaborative learning opportunities, however.
- Review all DMC-ODS waiver requirements to identify any that can be removed.
- Work with CBHDA and provider organizations to identify and requirements that can be standardized across counties (e.g. credentialing, training requirements, etc.).

1. Introduction

Elise Tran, B.A., and Darren Urada, Ph.D.

Overview of DMC-ODS waiver implementation in FY 2019-2020

Issues California is Addressing with the 1115 Demonstration Waiver

The Drug Medi-Cal (DMC) Organized Delivery System 1115 demonstration waiver (henceforth referred to as the DMC-ODS waiver) was created by the California Department of Health Care Services (DHCS) with the intent of improving many previously existing issues with the DMC system. Prior to the DMC-ODS waiver, the system was comprised of fragmented services, creating gaps that created challenges for patient access and success in treatment. Services were uncoordinated, making it difficult for patients to navigate the system. Providers indicated that many important services they provided or wished to provide for patients were not billable, were only reimbursable if delivered by a limited number of provider types, or were too limited to provide proper care to patients. Providers were not necessarily required to deliver evidence-based practices in line with current research, and counties lacked the authority to fully ensure the quality and accountability of their local providers.

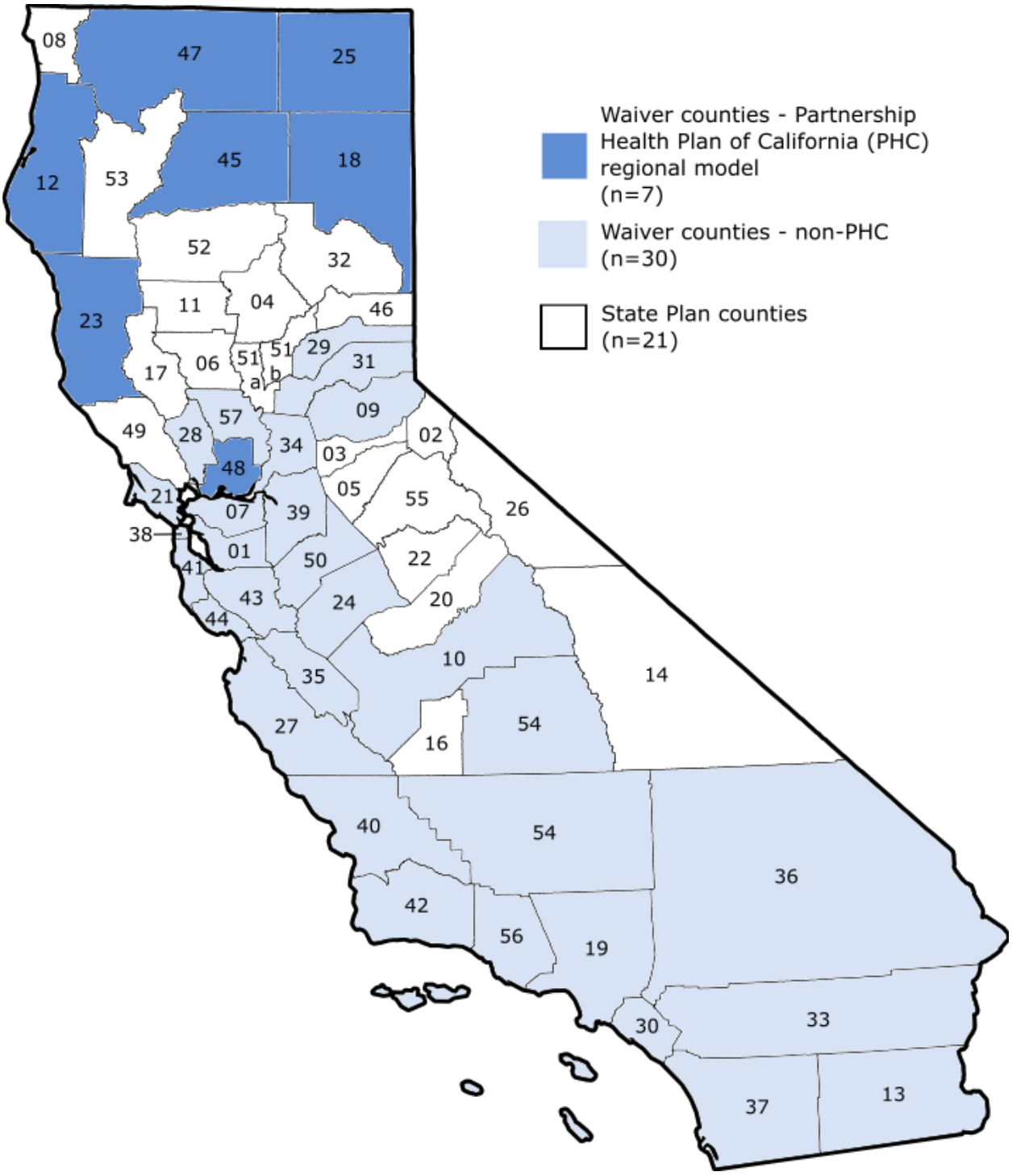
The DMC-ODS waiver was created to test the impact of organizing substance use disorder (SUD) services to improve service delivery to Medicaid-eligible individuals with SUD. The intent is to demonstrate how organized SUD care improves quality, access, and coordination/integration of treatment for beneficiaries while decreasing other health care system costs. Under the DMC-ODS waiver, care is organized according to the American Society of Addiction Medicine (ASAM) Criteria for SUD services. The ASAM Criteria are a set of guidelines developed by ASAM to set a standard for appropriate assessment, placement, and treatment planning of patients with SUD and co-occurring disorders. Services under the DMC-ODS waiver also create a continuum of care and create requirements allowing for local control, accountability, and greater administrative oversight.

Brief Description and History of DMC-ODS Waiver Implementation

The DMC-ODS waiver was approved by CMS in August 2015, and the UCLA evaluation plan was approved in June 2016. The planned active demonstration period was from December 30, 2015 through December 31, 2020. In response to the COVID-19 public health emergency, DHCS received approval from CMS for a one-year extension of the DMC-ODS waiver through December 31, 2021, which also entails a continuation of evaluation activities through the additional year.

This evaluation report primarily focuses on data collected in CY 2019, with additional data from 2020 and earlier periods where available. Now in its fifth year, the DMC-ODS waiver has been shaping changes in the 37 participating counties, including seven counties participating in the regional model under the Partnership HealthPlan of California (PHC), which went live on July 1, 2020. For a map of these counties, see Figure 1.1.

Figure 1.1 Map of California counties participating in the DMC-ODS waiver as of January 1, 2020.[1]



[1] DHCS and the EQRO use county codes which assign a number to each county ordered alphabetically. For consistency with this convention, maps within the report use this numbering system.

DMC-ODS waiver counties – non-PHC (n=30)	
1	Alameda
7	Contra Costa
9	El Dorado
10	Fresno
13	Imperial
15	Kern
19	Los Angeles
21	Marin
24	Merced
27	Monterey
28	Napa
29	Nevada
30	Orange
31	Placer
33	Riverside
34	Sacramento
35	San Benito
36	San Bernardino
37	San Diego
38	San Francisco
39	San Joaquin
40	San Luis Obispo
41	San Mateo
42	Santa Barbara
43	Santa Clara
44	Santa Cruz
50	Stanislaus
54	Tulare
56	Ventura
57	Yolo

DMC-ODS Waiver counties – PHC regional model (n=7)	
12	Humboldt (PHC)
18	Lassen (PHC)
23	Mendocino (PHC)
25	Modoc (PHC)
45	Shasta (PHC)
47	Siskiyou (PHC)
48	Solano (PHC)

State Plan counties (n=21)	
2	Alpine
3	Amador
4	Butte
5	Calaveras
6	Colusa
8	Del Norte
11	Glenn
14	Inyo
16	Kings
17	Lake
20	Madera
22	Mariposa
26	Mono
32	Plumas
46	Sierra
49	Sonoma
51a	Sutter
51b	Yuba
52	Tehama
53	Trinity
55	Tuolumne

The current live DMC-ODS waiver counties cover 95.9% of the state's population.[2] Of those that have gone live, 70.3% are medium or large counties.[3] After July 1, 2020, when the PHC went live, the total percentage of small or small rural counties increased from 16.7% to 29.7%. Significant challenges remain for smaller counties, many of which will be left out of changes brought about by the DMC-ODS waiver. Of the 21 State Plan counties, 90.5% are either small or small rural.

Population groups impacted by the demonstration

The DMC-ODS waiver targets Medicaid-eligible individuals with SUD. As described in the DMC-ODS waiver special terms and conditions (STCs), for counties that opt-in to the DMC-ODS waiver, beneficiaries must meet the medical necessity criteria and reside in a participating county to receive waiver services. In addition, individuals receiving services from tribally-operated and urban Indian health providers, and American Indian and Alaskan Native Medi-Cal beneficiaries will also be impacted by the DMC-ODS waiver.

Additional Information

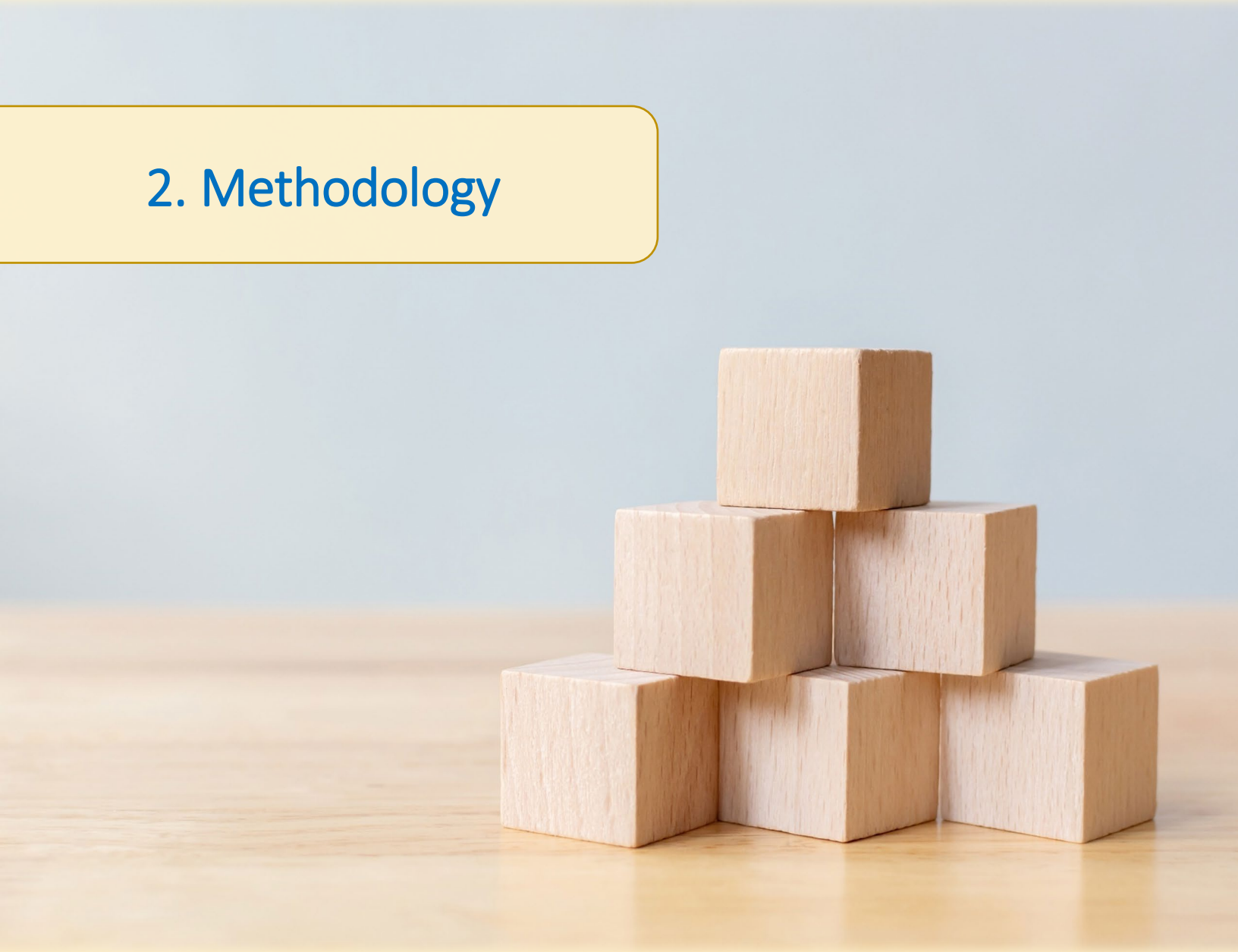
For a more detailed description of the DMC-ODS and an overview of earlier years of implementation, please refer to the previous evaluation reports submitted by UCLA in CYs 2016 through 2019.[4]

[2] Projections Prepared by Demographic Research Unit, California Department of Finance, January 2020: http://www.dof.ca.gov/Forecasting/Demographics/Projections/

[3]The following population cutoffs were used: Small Rural < 50,000, Small 50,000-199,999, Medium 200,000-749,000, Large 750,000-3,999,999, Very Large: 4,000,000+. These were based on: https://www.dhcs.ca.gov/services/MH/Documents/POS_PopBased_LargeCounty.pdf

[4] http://uclaisap.org/dmc-ods-eval/html/reports-presentations.html

2. Methodology



Evaluation Questions and Hypotheses

Evaluation hypotheses are organized into the following four categories:

Access to Care

Beneficiary access to treatment will increase in counties that opt into the DMC-ODS waiver compared to access in the same counties prior to DMC-ODS waiver implementation and in comparison to access in counties that have not opted in.

Quality of Care

Quality of care will improve in counties that have opted into the DMC-ODS waiver compared to quality in the same counties prior to DMC-ODS waiver implementation and in comparison to quality in counties that have not opted in.

Costs of Care

Health care costs will be more appropriate post-DMC-ODS waiver implementation compared to pre-implementation among comparable patients; e.g., SUD treatment costs will be offset by reduced inpatient and emergency department use.

Integration and Coordination of Care

SUD treatment coordination with physical health (PH), mental health (MH), and recovery support services will improve.

Evaluation Design

The evaluation uses a mixed-methods design that takes advantage of different comparisons based on the measure in question.

As discussed in the approved evaluation plan, administrative data from Drug Medi-Cal (DMC) claims and CalOMS-Tx was used for a difference-in-difference design (conceptually equivalent to a multiple baseline approach) to account for different county implementation periods, consistent with CMS recommendations for strong evaluation designs.[5] This approach essentially combines pre-post comparisons and comparisons across counties to test whether changes are detected when counties "go live" but not at the same time in other counties. In other cases (e.g.,

[5] Reschovsky, J.D. and Bradley, K. (2019). Planning Section 1115 Demonstration Implementation to Enable Strong Evaluation Designs. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/enable-strng-eval-dsgn.pdf

Provider Surveys, interviews, ASAM Criteria-based Level of Care), data was only available post-implementation, in which case post-only analysis was conducted.

ASAM Criteria-based Level of Care data was used with CalOMS-Tx treatment data and DMC claims data to understand treatment patterns related to access, care integration, transitions to a lower level of care within 14 days of discharge from residential programs and residential withdrawal management programs, readmission to residential withdrawal management within 30 days and discharge outcome status.

Target and Comparison Populations

Due to the normal lag between service delivery and data reporting, it was not possible to analyze data for all 37 counties that had gone live at the time of this report. For evaluation purposes, the first 30 counties to "go live" were therefore selected. For comparison, State Plan counties include all counties that had not gone live as of December 31, 2019, excluding the seven Partnership Health Plan counties. Since administrative data for 2020 were incomplete at the writing of this report, the cutoff for most analyses is December 31, 2019, except in special cases (e.g., COVID-19, Partnership Health Plan analyses). In previous reports, counties were divided into waves based on their "go live" dates, but exploratory analyses did not show substantial differences between the waves in 2019. Therefore, for simplicity, analyses in this report focus on only two groups: DMC-ODS Waiver and State Plan (SP).

Evaluation Period

The first DMC-ODS waiver counties began implementation on February 1, 2017, and new counties continued to join through July 1, 2019. The implementation period being evaluated is therefore best described as February 1, 2017 through the end of the DMC-ODS waiver, currently scheduled for December 31, 2021. A pre-waiver period extending back to CY 2015 is used where data sources allow (administrative data, County Administrator Surveys).

Evaluation Measures

The following measures are included in this report. For a fuller description of these measures, see the Evaluation Plan.[6] Due to data availability, not all measures described in the evaluation plan are included in this report. In particular, cost measures are not included because Medi-Cal Managed Care/Fee for service data was not available in time for this report. In other cases, additional measures that were not originally in the evaluation plan have been added.

Access Measures

- Patient demographics
- Number of patients served
- Number of providers
- Stakeholder perceptions of access to care
- Existence of a 24/7 functioning beneficiary access line, ratings from secret shopper calls
- Penetration rates
- Special population challenges
- Access to Medications for Addiction Treatment (MAT)[7]
- Access to Recovery Services

Quality Measures

- Quality improvement activities
- Use and monitoring of evidence-based practices
- Use of ASAM Criteria-based tool for patient placement and assessment

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[6] California Drug Medi-Cal Organized Delivery System: Proposed Evaluation for California's Section 1115 Demonstration Waiver. http://www.uclaisap.org/dmc-ods-eval/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

[7] MAT is commonly referred to as Medication-Assisted Treatment. Wakeman (2017) argues this contributes to stigma by treating addiction medications as secondary, and different from medications for other conditions. We therefore use the more neutral term Medications for Addiction Treatment.
Wakeman (2017). Medications for Addiction Treatment: Changing language to improve care. Journal of Addiction Medicine. 11(1):1–2

- Appropriate treatment placement within 30 days of ASAM Criteria-based screening/assessment
- Treatment engagement
- Patient participation in treatment planning
- Readmissions to withdrawal management within 30 days
- Patient perceptions of care

Coordination/Integration Measures

- Coordination/integration of care across health care systems (SUD, MH, and PH)
- Coordination and continuity of care within the SUD system
- Strategies to improve integration/coordination

Each measure draws on different data sources, described below. UCLA is generally the steward of these measures, except for engagement (NQF #0004).

Special Topics

In addition to the main evaluation measures above, this year's report focuses on several special topics that add additional context around current practices and which can potentially help improve future implementation of the DMC-ODS waiver. Interviews, survey items, and administrative data are used to provide information on:

- The impact of COVID-19 on treatment admissions and services (e.g., telehealth, recovery residences)
- Lessons learned from DMC-ODS's first regional model
- What State Plan (non-waiver) counties would need to join the DMC-ODS waiver in the future
- The impact of stimulant use
- The impact of homelessness
- Issues with current DMC-ODS waiver requirements, according to stakeholders.

Data Sources

Administrative data sources

California Outcome Measurement System, Treatment (CalOMS-Tx)

CalOMS-Tx is California's existing data collection and reporting system for all patients in publicly-funded SUD treatment services. Treatment providers collect information from patients at admission and discharge and send this data to DHCS each month. CalOMS-Tx provides

California's contribution to the Treatment Episode Dataset (TEDS) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA) and includes National Outcome Measures (NOMS). More information on CalOMS-Tx can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx

Drug Medi-Cal Claims (DMC Claims)

In California, Medicaid-funded SUD treatment is paid for through DMC claims. DMC is a carve-out for specialty care SUD treatment. For the UCLA evaluation, DMC claims data provided information on patient demographics, access to treatment after DMC-ODS waiver implementation, and types of services provided.

Mental Health Claims

In California, Medicaid-funded MH treatment is paid for through Short Doyle Medi-Cal claims (SD/MC). SD/MC is a carve-out for certain MH services to persons eligible for Medi-Cal. For the UCLA evaluation, SD/MC claims data provided information on the dates, types, and quantities of MH services provided.

Medi-Cal Eligibility Data System (MEDS)

The MEDS database provides information on all California Medi-Cal beneficiaries. These data, particularly the MEDS Monthly Extract File (MMEF), were used to calculate penetration rates.

Master Provider File (MPF)

The MPF is DHCS's comprehensive list of substance use disorder treatment programs in the state of California. The MPF includes information on all SUD provider facilities, including mailing addresses and DMC certification and decertification dates, among other provider-level information. This information was used to measure change in the number of providers, and as a tool to identify, sample, and contact providers for the Provider Survey.

National Survey on Drug Use and Health

SAMHSA's National Survey on Drug Use and Health (NSDUH) provides limited state-level estimates of substance use prevalence. These data were used for analyses of penetration rates.

UCLA evaluation data collection activities (ongoing)

ASAM Level of Care (LOC) Placement Data

Given that the ASAM Criteria are a defining feature of the DMC-ODS waiver, a large new data collection effort was initiated across DMC-ODS waiver counties to collect data on the use of ASAM Criteria-based LOC brief initial screenings, initial assessments, reassessments, and services delivered. This endeavor has been a collaborative effort between UCLA-ISAP, DHCS, and counties to collect these data. DHCS Information Notice 17-035 describing the requirements and procedures to collect ASAM Criteria-based LOC data was released in September 2017 and

was superseded by Information Notice 18-046 in October 1, 2018. These data include the date of screening or assessment, type (brief initial screen, initial assessment, follow-up assessment), indicated LOCs, actual placement decision(s), the reason for the difference between indicated and actual LOCs (if any), and the reason for delays in placement (if any). While a couple of counties have been experiencing technical issues in data collection/submission, data for 28 out of 30 counties for CY 2019 was submitted in time for inclusion in this report.

Data on three types of screenings or assessments are possible, defined as follows on the data collection instrument.

- Brief Initial Screen: a brief initial screening that preliminarily determines an LOC placement until a full assessment can be performed
- Initial Assessment: a longer comprehensive assessment meant to determine the LOC recommendation and establish medical necessity
- Follow-up Assessment: following an initial assessment, any re-assessment of the patient occurring during the same treatment episode

Up to three indicated and actual levels of care could be recorded, defined as:

- Indicated LOC initially recommended according to screening/assessment instrument prior to taking patient preference into account. For example, this would be listed under "Final Level of Care Recommendations" if using CONTINUUM™ software.
- Actual LOC/Withdrawal Management placement decision. This is the actual LOC decided upon after patient input and the LOC where the patient is referred.

The options for LOC, as worded in the LOC reporting template, are listed below. These included broad to be determined (TBD) options to allow for the results of brief initial screenings that may indicate a general treatment modality the patient should report to for further assessment (e.g., outpatient) without specifying the exact LOC to be received there (e.g., outpatient or intensive outpatient). The list also includes withdrawal management levels of treatment, which can be combined with other levels of care.

Level of Care

None
Outpatient/Intensive Outpatient (OP/IOP), exact level TBD
Residential, exact level TBD
Withdrawal Management (WM), exact level TBD
Ambulatory WM, exact level TBD
Residential/Inpatient WM, exact level TBD
Narcotic Treatment program/Opiate Treatment program (NTP/OTP)
0.5 Early Intervention
1.0 OP
2.1 IOP
2.5 Partial Hospitalization
3.1 Clinically Managed Low-Intensity Residential

3.3 Clinically Managed Population-Specific High-Intensity Residential
3.5 Clinically Managed High-Intensity Residential Services
3.7 Medically Monitored Intensive Inpatient Services
4.0 Medically Managed Intensive Inpatient Services
1-WM Ambulatory WM without Extended Onsite Monitoring
2-WM Ambulatory WM with Extended Onsite Monitoring
3.2-WM Clinically Managed Residential WM
3.7-WM Medically Monitored Inpatient WM
4-WM Medically Managed Intensive Inpatient WM

If at least one of the indicated and actual levels of care did not match, providers were asked to select the reason for the difference. The options were:

Reason for difference

Not applicable - no difference
Clinical judgment
Lack of insurance/payment source
Legal issues
Level of care not available
Managed care refusal
Patient preference
Geographic accessibility
Family responsibility
Language
Used two residential stays in a year already.
Other

Beneficiary Access Line Secret Shopper Calls

Beneficiary access lines (BALs) are an important point of access to SUD treatment. For many patients, the staff who answer calls to these lines may be the first person they speak to about their need for help. Furthermore, the beneficiary access line may be the only avenue patients are aware of to get help. For these reasons, these lines are vital to creating and maintaining access to care.

In order to evaluate the practical availability of county beneficiary access lines, a total of 269 secret shopper calls were made to these lines since implementation of the DMC-ODS waiver. Secret shopper calls were made to 37 counties (including single calls to PHC W&R program counties) that went live under the DMC-ODS waiver. With the exception of PHC W&R counties, each county was called at least once during regular business hours (between 8 am – 5 pm) and at least once after hours (between 5 pm – 7 am or on a weekend) for a total of between three to 18 calls to each BAL. PHC W&R counties had the same subcontractor (Beacon) who managed their BAL. PHC W&R counties were each called once. After each call, the same

county was not called again for a period of at least three weeks in order to capture an in-depth picture of the beneficiary access line performance over time. One hundred and eight of the calls were conducted in English, 121 were conducted in Spanish, and the remaining 40 calls were sent to an answering machine/voicemail or were otherwise not answered.

First, the secret shopper attempted to find the beneficiary access line phone number using an internet search. The relative ease of finding the correct number was rated on a ten-point scale, with one being hard and ten being easy. Before the call, the secret shopper selected one from eight possible scenarios (e.g., a 57-year-old man living in West Covina with an alcohol and marijuana use problem). The caller then called the beneficiary access line assuming the role of the person or an advocate of the person in the chosen scenario and measured the following: time until the call was answered (greater or less than 2 minutes), whether a person or automatic message answered the call, and the total length of the call. If the call was dropped, the caller called the number again after one minute. After the call, the caller rated the friendliness of the access line worker on a ten-point scale, with ten representing the friendliest score. Lastly, the secret shopper wrote notes on the qualitative experience of the call, noting irregularities or particular positives or negatives. All DMC-ODS waiver counties received feedback based on these secret shopper calls. Behavioral Health Concepts, the External Quality Review Organization for the DMC-ODS waiver, will assume responsibility for secret shopper calls going forward.

County Administrator Surveys

UCLA developed an online County Administrator Survey to obtain information and insights from all SUD/behavioral health administrators (regardless of DMC-ODS waiver opt-in status or intent). The survey addresses the following topics: access to care; screening and placement practices; services and training; quality of care; collaboration, coordination, and integration of services; and DMC-ODS waiver implementation preparation/status.

To track annual changes, UCLA collected data from February 28, 2020 through June 5, 2020. Including partially completed surveys, responses were received from 25 out of 30 non-PHC W&R DMC-ODS waiver counties (83% response rate).

State Plan county data were collected from July 23, 2020 to November 25, 2020. Responses were received from 14 of 21 State Plan counties (67% response rate). The same county administrator completed the response for both Sutter and Yuba counties.

PHC county survey responses were collected from November 17, 2020 to December 5, 2020. Responses were received from five of seven PHC counties (71% response rate).

Where appropriate, these survey results were compared with baseline survey data collected in CY 2015. Throughout the report, these surveys are referred to as the 2020 and 2015 surveys, respectively. These annual County Administrator Surveys contain items related to access, quality, and coordination of care. The 2020 surveys also included questions on COVID-19, telehealth, stimulants, homelessness, and recommendations for future implementation of the DMC-ODS waiver.

Key Informant Interviews

Administrators

Key Informant Interviews were conducted with: (a) county SUD/behavioral health administrators and SUD treatment program administrators from four counties that most recently began implementing the DMC-ODS waiver (June-July 2019), (b) a Partnership Health Care administrator of the Wellness and Recovery Program (a DMC-ODS regional model), and (c) administrators from three State Plan counties. The semi-structured individual and group interviews were conducted via video-conference call. Each lasted approximately one hour. The interviews were conducted from May through December 2020.

The purpose of the interviews with recently live county administrators was to deepen our understanding of the successes and challenges of counties implementing the DMC-ODS waiver approximately three years after the first counties went live, as well as provide recommendations to DHCS for additional guidance and technical assistance to counties. The interviews with the administrators also aimed to collect in-depth information on newly billable services under the DMC-ODS waiver (e.g., case management, recovery services). The recently live DMC-ODS waiver counties included:

- El Dorado County (Go-Live Date - 6/1/19)
- Tulare County (Go-Live Date - 7/1/19)
- San Benito County (Go-Live Date - 7/1/19)
- Sacramento County (Go-Live Date - 7/1/19)

The purpose of the interview with the Partnership HealthCare Wellness and Recovery (PHC W&R) program manager was to learn about the implementation of the only regional model of the DMC-ODS waiver to provide recommendations to DHCS in terms of the technical assistance needed, particularly should other counties have the opportunity in the future to participate in the DMC-ODS waiver using a similar model (e.g., CalAIM). Consistent with the county administrator interviews, the key informant interview with the PHC W&R program manager included questions inquiring about the newly billable services under the DMC-ODS waiver. PHC's regional approach to the DMC-ODS waiver includes Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties.

The goal of the interviews with administrators of State Plan counties was to understand the unique challenges and strengths of their SUD treatment delivery systems compared to DMC-ODS waivered counties and to explore the technical assistance needed should the opportunity to participate in future DMC-ODS related programs (e.g., CalAIM) arise. The State Plan county interviews were conducted with SUD/behavioral health administrators from:

- Amador County
- Glenn County
- Sierra County

During the interviews, all of the key informants were asked about the impact of COVID-19 on their SUD treatment systems (e.g., access, use of telehealth).

The audio recordings of the interviews were professionally transcribed and then analyzed using qualitative data analysis software (ATLAS.ti). The rich interview data were used to supplement and inform the interpretation of the quantitative survey results and administrative data for the DMC-ODS waiver evaluation.

Patients

Key Informant Interviews were conducted with 15 patients in residential care in Riverside County. The purpose of the interview was to learn more about the challenges to and facilitators of successfully transitioning from residential to lower levels of care (e.g., outpatient treatment) in the SUD system and recommendations to help improve these transitions. In addition, these exploratory interviews aimed to collect in-depth information on services and circumstances that have been either helpful or unhelpful in creating continuity of care for these individuals. The voluntary and anonymous semi-structured individual interviews were conducted via video-conference call. Each lasted approximately 20 minutes. Participants were provided with a $20 gift card for their participation.

The interviews were conducted from July through November 2020. The audio recordings were professionally transcribed and then analyzed using a qualitative data analysis software (ATLAS.ti) to develop a case study on transitions from residential care.

Provider Survey

UCLA conducted web-based surveys of a selected sample of providers at the care delivery unit level, defined as one treatment modality (outpatient/intensive outpatient, residential, detoxification/withdrawal management) delivered at one physical location. Organizations that had multiple sites or modalities were eligible to receive multiple surveys. The Provider Survey was addressed to the clinical director of this unit, and respondents were offered a $100 gift card for their time (39 minutes on average). The Provider Survey achieved a 59.8% response rate (137 responses / 229 invited). For simplicity, respondents are simply referred to as “providers” in this report.

Provider Surveys were sent to a representative sample of providers stratified by size, region, and LOC. Providers were drawn from each county’s list of treatment programs participating in their DMC-ODS waiver implementation, and surveys were administered following each county’s individual Go Live date.

Survey questions addressed different domains, including Access (e.g., treatment capacity), Quality (e.g., ASAM Criteria, evidence-based practices), and Coordination of Care (e.g., partnerships with other treatment providers, PH and MH care systems).

Integrated Practice Assessment Tool

To measure provider level of integration with MH and PH, questions from the Integrated Practice Assessment (IPAT)[8] tool were incorporated as a component within the Provider Survey. The IPAT was developed to help place provider practices on levels of integrated care as defined by the Standard Framework for Levels of Integrated Healthcare. The framework, released in 2013 by SAMHSA-HRSA Center for Integrated Health Solutions, identified three main overarching categories — Coordinated care, Co-located care, and Integrated care – with two levels within each category, producing a national standard of six levels of collaboration/integration ranging from Minimal Collaboration to Full Collaboration in a Transformed/Merged Integrated Practice.

SAMHSA Framework for Levels of Integrated Healthcare

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice

The IPAT uses a series of yes/no questions that cascade (like a decision tree) to one of the six levels of integrated care. See Appendix B for IPAT questions and decision tree. Because this tool was developed to assess the integration of behavioral health in primary care settings, in this evaluation it was necessary to adapt the IPAT questions to assess levels of integration for both MH and PH services in SUD settings. Thus, completion of the Provider Survey results in two IPAT ratings, one for each of the service systems pairings (SUD and MH, referred to as Mental Health integration; SUD and PH, referred to as PH integration). The categories and levels within each category are defined below (**note where the terms MH and primary care were interchanged based on the pairing of the service systems under assessment):*

Coordinated Care

Level 1: Minimal Collaboration: Communication between SUD providers and *primary care (**replace: MH*) providers is low and they operate in separate facilities with separate systems. Patients are given referrals to MH with little follow-up.

Level 2: Basic Collaboration at a Distance: Periodic communication between providers differentiates this level from the previous level, although physical and systems separation

[8] https://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf

is maintained. SUD and *primary care (**replace: MH*) providers may communicate occasionally about shared patients and view each other as resources in providing coordinated care.

Co-Located Care

Level 3: Basic Collaboration On-site: Closer proximity due to co-location of SUD and *primary care (**replace: MH*) providers allows for more frequent communication about shared patients. Providers may begin to feel like part of a larger team, and referrals are more likely to be successful due to reduced distance between providers in the same facility. However, SUD and *primary care (**replace: MH)* systems are still kept separate.

Level 4: Close Collaboration On-site with Some System Integration: SUD and *primary care (**replace: MH*) providers begin to share some systems, leading to greater integration. Increasing consultation and collaboration occurs between providers as they learn each other's roles and share information to help patients with multiple complex behavioral health issues.

Integrated Care (also referred to as Fully Integrated Care)

Level 5: Close Collaboration Approaching an Integrated Practice: SUD and *primary care (**replace: MH*) providers communicate frequently and regularly and have started to function more as a team, actively seeking solutions to integrate care for more of their patients. Certain barriers still exist but work is being done to create a more fully integrated system (such as through an integrated health record).

Level 6: Full Collaboration in a Transformed/Merged Integrated Practice: "Practice change" defines this level; systems and people are blended together so that they operate as one single practice and are recognized as such by both providers and patients. The system applies principles of whole health in treating the entire patient population.

The numerical ordering of levels suggests that the higher the level of collaboration/integration, the more potential for positive impact on health outcomes and patient experience. This belief remains a hypothesis and has not been empirically tested. However, the framework creates concrete descriptions and benchmarks defining the various strategies to implement integrated care. This framework allows organizations implementing integration to gauge their degree of integration against acknowledged benchmarks and serves as a foundation for comparing healthcare outcomes between integration levels.[9] States can use this data to monitor progress along the integration continuum, to conduct comparative analysis, to examine network readiness for integration, to establish thresholds for differential reimbursement, or to tailor technical assistance programs to a practice's needs. In addition, tools such as the IPAT help normalize the

[9] Heath B, Wise Romero P, and Reynolds K. (2013). A Standard Framework for Levels of Integrated Healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions.

process of moving along a continuum of integrated care and inspire the undertaking of system transformation.[10]

Treatment Perceptions Survey (TPS)

The TPS for adults was developed by UCLA based on San Francisco County's Treatment Satisfaction Survey, and the TPS for youth was based on Los Angeles County's Treatment Perceptions Survey (Youth). (Both survey questionnaires include items from the Mental Health Statistics Improvement Program, MHSIP.) Input on the survey development was solicited from and provided by: DHCS; the Substance Abuse Prevention Treatment+ Committee (SAPT+) of the County Behavioral Health Director's Association (CBHDA) of California; the DMC-ODS External Quality Review Organization (EQRO) Clinical Committee; Behavioral Health Concepts (BHC); the Youth System of Care Evaluation Team at Azusa Pacific University; and other stakeholders. The TPS was designed to serve multiple purposes. The first is to fulfill counties' EQRO requirement to conduct a patient satisfaction survey at least annually using a validated tool. The TPS also addresses the data collection needs for the CMS required evaluation of the DMC-ODS waiver. Lastly, the TPS supports DMC-ODS quality improvement efforts and provides key information on the impacts of the DMC-ODS waiver.

The TPS is administered annually during a specified five-day survey period. The survey for adults includes 14 statements addressing patient perceptions of access, quality, care coordination, outcome, and general satisfaction. The survey for youth includes 18 statements and the same five domains as the adult survey plus an additional domain: therapeutic alliance. Survey respondents indicate the extent to which they disagree or agree with statements using a 5-point Likert scale (1= Strongly disagree and 5= Strongly agree). The survey also collects demographic information (i.e., gender, age, race/ethnicity, and length of time receiving services at the treatment program).

TPS Adult Survey Items by Domain

Access

1. The location was convenient (public transportation, distance, parking, etc.).
2. Services were available when I needed them.

Quality

3. I chose the treatment goals with my provider's help.
4. Staff gave me enough time in my treatment sessions.
5. Staff treated me with respect.
6. Staff spoke to me in a way I understood.
7. Staff were sensitive to my cultural background (race, religion, language, etc.).

[10] Auxier, A. M., Hopkins, B. D., & Reins, A. E. (2015). Under Construction: One State's Approach to Creating Health Homes for Individuals with Serious Mental Illness. AIMS public health, 2(2), 163–182. doi:10.3934/publichealth.2015.2.163

Care Coordination

8. Staff here work with my PH care providers to support my wellness.
9. Staff here work with my MH care providers to support my wellness.

Outcome

10. As a direct result of the services I am receiving, I am better able to do things that I want to do.

General Satisfaction

11. I felt welcomed here.
12. Overall, I am satisfied with the services I received.
13. I was able to get all the help/services that I needed.
14. I would recommend this agency to a friend or family member

TPS Youth Survey Items by Domain

Access

1. The location of services was convenient for me.
2. Services were available at times that were convenient for me.
3. I had a good experience enrolling in treatment.

Therapeutic Alliance

4. My counselor and I work on treatment goals together.
5. I feel my counselor took the time to listen to what I had to say.
6. I developed a positive, trusting relationship with my counselor.
7. I feel my counselor was sincerely interested in me and understood me.
8. I like my counselor here.
9. My counselor is capable of helping me.

Quality

10. I received the right services.
11. Staff treated me with respect.
12. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).
13. My counselor provided necessary services for my family.

Care Coordination

14. Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.).
15. Staff here helped me with other issues and concerns I had related to legal/probation, family and educational systems.

Outcome

16. As a result of the services I received, I am better able to do things I want to do.

General Satisfaction

17. Overall, I am satisfied with the services I received.
18. I would recommend the services to a friend who is need of similar help.

TPS survey forms for both adults and youth are available in 13 languages (English, Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern Armenian, Western Armenian, Vietnamese, Cambodian) and in one-page and two-page (larger font) versions. The relevant MHSUD Information Notices, survey instructions, forms in multiple threshold languages, and other materials (i.e., Frequently Asked Questions, TPS Codebook, sample county and program summary reports) are available online at http://www.uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html.

County administrators coordinated the survey administration and data collection within their provider network and submitted the paper forms or electronic data files to UCLA for processing. The data were analyzed, and county- and provider-level summary reports were prepared and made available to participating counties. Counties were also given access to their raw data files and respondents' written comments.

Seven counties participated in the first TPS survey period for adults in November 2017 (Contra Costa, Marin, Riverside, San Francisco, San Mateo, Santa Clara, and January 2018 for Los Angeles). During the second survey period in October 2018, 19 live DMC-ODS waiver counties participated in the TPS for adults, including: Alameda, Contra Costa, Imperial, Los Angeles, Marin, Monterey, Napa, Nevada, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, and Yolo. Fourteen of these counties also administered the TPS survey for youth for the first time. Thirty (30) counties participated in the third TPS in October 2019, which included the 19 counties from the 2018 survey period plus the 11 new counties participating in the DMC-ODS waiver: El Dorado, Fresno, Kern, Merced, Placer, Sacramento, San Benito, Santa Barbara, Stanislaus, Tulare, and Ventura. Programs included outpatient/intensive outpatient treatment, Residential treatment, Opioid Treatment Programs/Narcotic Treatment Programs, and Withdrawal Management (standalone).

The analytic sample for the October 2019 TPS included 22,838 adult respondents and 927 youth respondents. A summary of the data analysis results is included in this report within the Quality section and in Appendix C. TPS results are also referenced and/or included in other relevant DMC-ODS waiver evaluation domains (i.e., Access and Coordination of Care) in this report. Another survey was conducted in October 2020, but the results were not ready for this report and will be reported separately.

Analytic methods

Except where otherwise noted, descriptive and multivariate analyses were used. Due to the size of California's population, comparisons using inferential statistics on many of the datasets used in this report would yield statistical significance even when these differences were small and not meaningful. Furthermore, inferential statistics, as the name suggests, are meant to make inferences about a population from a random sample taken from that population. However, many of the datasets used in this evaluation (e.g., DMC claims, CalOMS-Tx) represented data on essentially the population of interest rather than a random sample. Therefore, where appropriate, descriptive statistics are included rather than inferential statistics. Still, advanced statistics were used to examine multivariate relationships and difference-in-difference analyses.

Logistic regression was used to predict satisfactory discharge after treatment and treatment engagement controlling for covariates such as background characteristics, living situation, employment status, utilization of case management benefits, received ASAM Criteria-based screening/assessment, and received treatment within 30 days of ASAM Criteria-based screening/assessment. Wherever sample size was sufficient, multivariate analyses were conducted separately for residential and outpatient programs.

Event study (ES) and difference-in-difference (DD) designs were used to analyze whether the introduction of the DMC-ODS waiver causally affected certain outcomes of interest. Specifically, we used these designs when analyzing administrative data (e.g., DMC claims and CalOMS-Tx) for some outcomes related to Access and Quality. Given the staggered introduction of the DMC-ODS waiver across counties in California over time, exploiting this variation within the ES and DD designs allowed us to estimate a causal effect of the DMC-ODS waiver. Specifically, the DD design compared the posttreatment (e.g., post-DMC-ODS waiver implementation) difference in the outcomes of interest between DMC-ODS waiver and State Plan counties to the pretreatment (e.g., pre-DMC-ODS implementation) difference in the outcomes of interest between DMC-ODS waiver and State Plan counties. The ES design is similar to the DD design but allows the effect of the DMC-ODS waiver to vary from 12 months or more prior to introduction to 12 months or more after the introduction.

All ES and DD models used data from either DMC claims or CalOMS-Tx at the county-month-year-level for the calendar years 2016-2019 (unless otherwise noted), and controlled for time-invariant county effects and county-invariant time effects. All regressions were weighted by the county population, and standard errors are clustered at the county level.

Methodological Limitations

The California Administrative data sets used in this evaluation have many of the same shortcomings as other administrative data sets, particularly related to inconsistent reporting and missing data (see, for example, Evans et al., 2010 for a discussion of CalOMS-Tx). Delays in data reporting also limit analyses of recent data. UCLA has attempted to address these issues by

only analyzing CalOMS-Tx and DMC claims data through December 2019 or earlier. Beyond these dates, the data was not sufficiently complete to provide accurate counts.

CalOMS-Tx data is partly reliant on self-reported data, particularly with respect to outcome questions (e.g., drug use in the last 30 days). Some terms are also somewhat subjective, like discharge status terms (e.g., completed treatment, satisfactory progress, and unsatisfactory progress). To partly ameliorate this problem, these categories were combined into "successful" (completed, satisfactory progress) and "unsuccessful" (unsatisfactory progress) discharges. CalOMS-Tx also shifted from being hosted on one data system to another during this reporting period, resulting in some disruption of the data.

DMC claims data tend to be more complete than CalOMS-Tx data because providers are more motivated to submit them quickly for payment, but this is not universally true. In some cases, it appears billable services such as case management and recovery services may be being delivered but DMC claims are not being submitted, in part due to confusion over what is allowable.

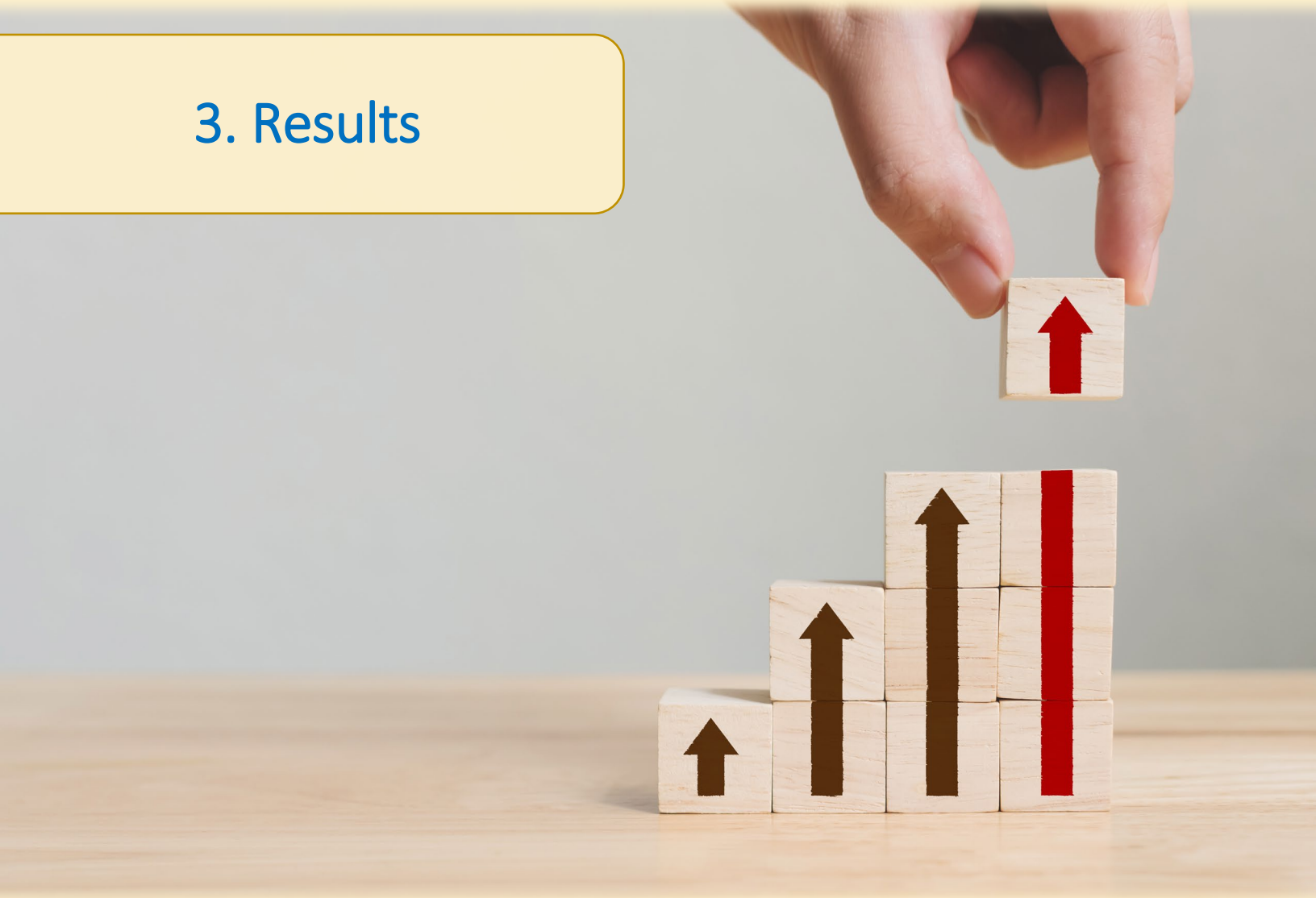
Additionally, to address issues of data completeness, mean imputation was used for DMC claims or CalOMS-Tx when the unique number of patients receiving services or admitted was below or above 50% of the previous and next months' values, and a similar decrease/increase was not observed in the corresponding dataset. For example, Los Angeles County saw a decrease of 7,538 unique patients receiving services in DMC claims from November 2016 to December 2016, then a subsequent increase of 7,778 patients in January 2017. A similar decrease in the number of patients was not observed in CalOMS-Tx. Thus the December 2016 value in DMC Claims was imputed by taking the average of the number of unique patients in November 2016 and January 2017 in Los Angeles County.

ASAM Criteria-based Level of Care referral data was limited by incomplete data from 2 out of the 30 waivered counties. As with any new data collection system, there have been issues with the collection and submission of data due to a variety of technical and human factors. While there have been substantial improvements in ASAM Criteria-based LOC data collection from counties as compared with the previous year, the submitted ASAM Criteria-based LOC data for CY 2019 reflects screenings/assessments for approximately 80% of the patients served in 2019. Refinement of ASAM Criteria-based LOC data collection/completion process is an ongoing effort between UCLA, DHCS, and the counties.

Interview and survey data are limited by the honesty of respondents and the response rate.

Where possible, different types of data were examined in parallel in an attempt to converge on underlying constructs being measured and thereby mitigate the limitations of each dataset.

3. Results



Access to Care

Darren Urada, Ph.D., Brittany Bass, Ph.D., Vandana Joshi, Ph.D., Anne B. Lee, LCSW, Cheryl Teruya, Ph.D., David Huang, Ph.D.

Patient Demographics

Table 3.1 shows CY 2019 demographic and LOC breakdowns using DMC Claims for patients by county group. Compared to State Plan counties, DMC-ODS waiver county patients tended to have lower percentages of Whites, more males, and used a wider array of levels of care.

Table 3.1. Demographics for DMC-ODS waiver and State Plan counties- CY 2019.

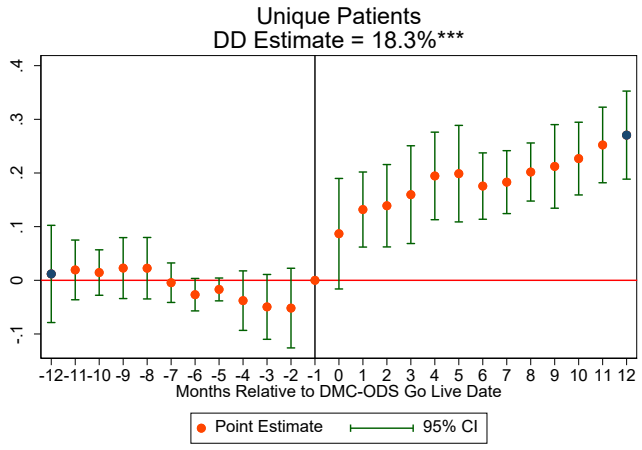
	DMC-ODS waiver Counties		State Plan Counties	
	Number	Percent	Number	Percent
Race/Ethnicity				
White	42,652	38.5%	4,828	65.6%
Latinx	37,853	34.1%	1,057	14.4%
Black/African American	11,567	10.4%	353	4.8%
Asian/Pacific Islander	2,247	2.0%	99	1.3%
American Indian/Alaskan Native	832	0.8%	210	2.9%
Missing/Unknown	7,151	6.4%	446	6.1%
Other	8,567	7.7%	371	5.0%
Age Group				
12-17	5,898	5.3%	210	2.9%
18-25	11,978	10.8%	852	11.6%
26-35	35,571	32.1%	2705	36.7%
36-45	23,063	20.8%	1706	23.2%
46+	34,359	31.0%	1891	25.7%
Gender				
Males	65,993	59.5%	3,915	53.2%
Females	44,876	40.5%	3,449	46.8%
Primary Language				
English	104,520	94.3%	7,196	97.7%
Spanish	4,978	4.5%	128	1.7%
Other	1,371	1.2%	40	0.5%
DMC-Funded Level of Care				
Outpatient	35,583	32.1%	4,160	56.5%
Intensive Outpatient	6,725	6.1%	297	4.0%
NTP/OTP	41,294	37.2%	2,820	38.3%
Residential 3.1	17,527	15.8%	70	0.9%
Residential 3.3	75	0.1%	0	0.0%
Residential 3.5	6,227	5.6%	13	0.2%
Withdrawal Management 3.2	3,438	3.1%	4	0.1%

Number of Patients Served

To begin the analysis of the number of patients served, we descriptively display the unique number of patients receiving services (DMC claims data) or admitted (CalOMS-Tx data) before and after the Go Live date by county, and in the aggregate, for all DMC-ODS waiver counties. Appendix D Figure A displays the county-level figures using DMC claims data, Appendix D Figure B displays the county-level figures using CalOMS-Tx data, and Appendix E Figures A and B display the aggregated figures using DMC claims data and CalOMS-Tx data, respectively. According to Appendix D Figure A, there has been great variation between counties, with some increasing services immediately and others showing little change. However, in at least 13 of the 30 cases, there was a clear increase in the number of beneficiaries accessing DMC-ODS services following the county's Go Live date. In Appendix E Figure A, where all waiver counties are aggregated, this increase is also clear. This pattern of results is less apparent in Appendix D Figure B and Appendix E Figure B, but there is still evidence suggesting an increase in the number of patients admitted to treatment in nine of the 30 cases, and in the aggregate. These sets of graphs show that each county's increases generally coincided with the Go Live date specific to that county, which tends to rule out the alternative explanation that broader changes external to DMC-ODS could have accounted for the difference. However, we test this explanation with the following ES and DD analyses.

Figure 3.1 presents the ES estimates and the overall DD estimate of the effect of the DMC-ODS waiver introduction on the natural log of the unique number of patients receiving services. The natural log of the unique number of patients receiving services is taken to reduce the skewness of the outcome, and for ease of interpretation of the coefficients. The figure indicates a sharp increase in the unique number of patients receiving services after the introduction of the DMC-ODS waiver. The DD coefficient suggests that, compared to State Plan counties, the introduction of the DMC-ODS waiver significantly increased the unique number of patients receiving DMC-funded services in DMC waiver counties by 18.3 percent.

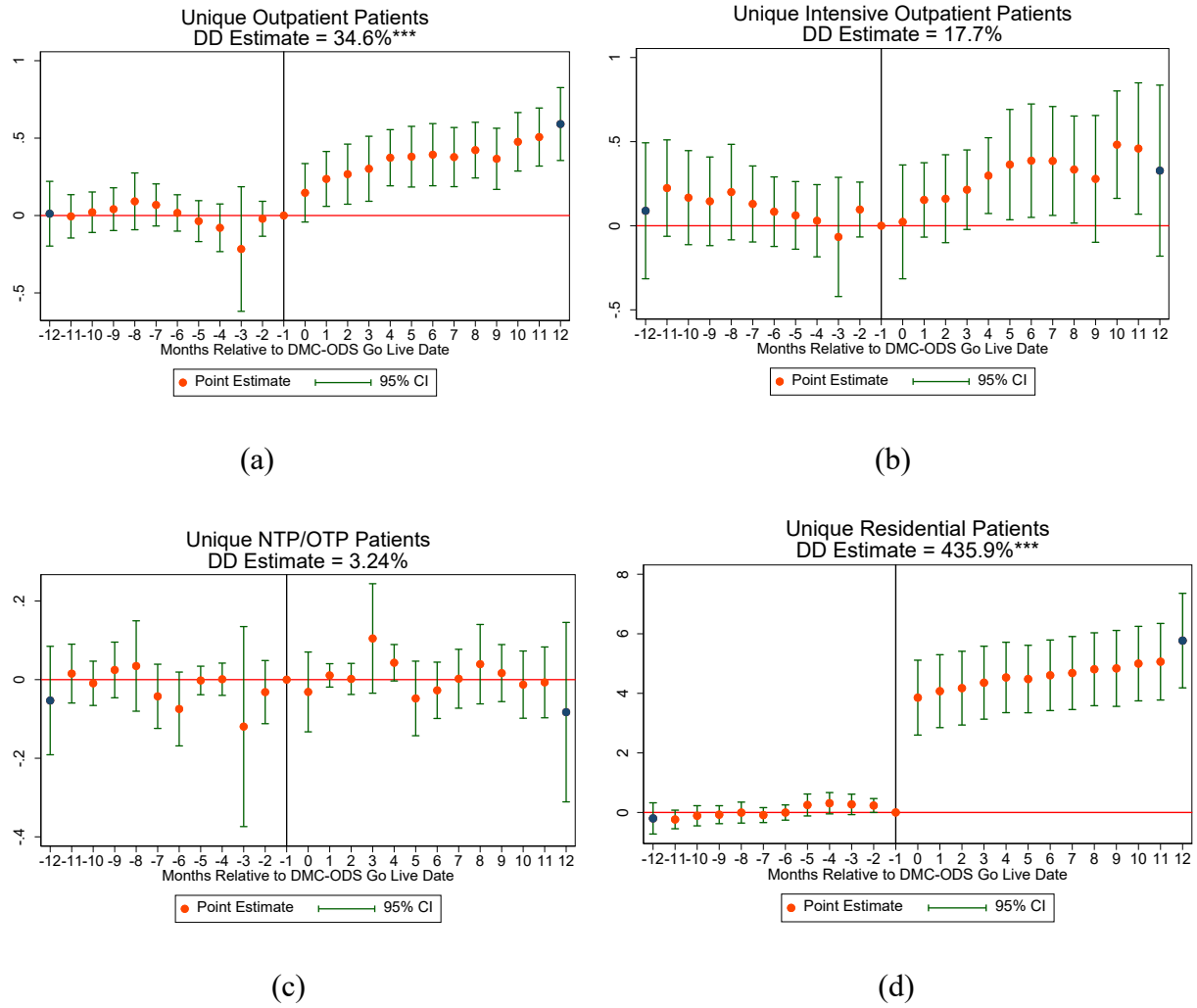
Figure 3.1. Event study estimates of the effect of the DMC-ODS waiver on unique number of patients receiving services.



Notes: Event study estimates (orange dots) (as described in the Methodology section) and 95% confidence intervals (bars) of the effect of the DMC-ODS waiver on the natural log of the number of unique patients receiving services are shown. The Y-axis can be interpreted in terms of %s by multiplying the values by 100. Data are from DMC Claims for CY2016-CY2019. All estimates are relative to the year prior to the Go Live date. The difference-in-difference estimate is also shown. *** indicates statistical significance at the 1% level.

To determine if the introduction of the DMC-ODS waiver affected the number of clients receiving services by modality, separate ES and DD models were estimated for OP services, IOP services, NTP/OTP services, and residential services. Figure 3.2 panels (a)-(d) present the ES estimates and DD estimates by modality, respectively.

Figure 3.2. Event study estimates of the effect of the DMC-ODS waiver on unique number of patients receiving services by modality.



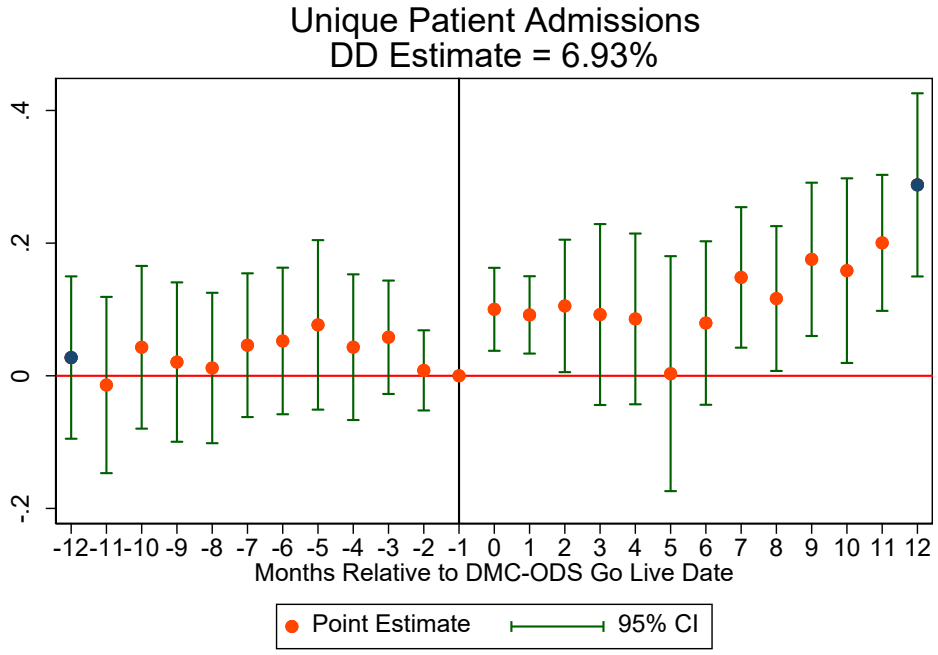
Notes: Event study estimates (orange dots) and 95% confidence intervals (bars) of the effect of the DMC-ODS waiver on the natural log of the number of unique patients receiving services by modality are shown. Panel (a) is OP, panel (b) is IOP, panel (c) is NTP/OTP, and panel (d) is residential. The Y-axis can be interpreted in terms of %s by multiplying the values by 100. Data are from DMC Claims for CY2016-CY2019. All estimates are relative to the year prior to the Go Live date. The difference-in-difference estimates are also shown. *** indicates statistical significance at the 1% level.

Figure 3.2 suggests that the introduction of the DMC-ODS waiver had a positive impact on the unique number of clients receiving DMC-funded services across all modalities. The DMC-ODS waiver significantly increased the number of unique OP patients in waiver counties by 34.6% and residential patients in waiver counties by 435.9%, compared to State Plan counties.

Analyzing the increase in CalOMS-Tx is an important next step to determine the degree to which the increases represent an overall change in access, as opposed to people changing to Medi-Cal from another funding source (e.g., the federal Substance Abuse Prevention and Treatment block grant). Figure 3.3 and Figure 3.4 present the ES and DD estimates of the effect of the DMC-ODS waiver introduction on the natural log of the unique number of patients receiving services overall and by modality, respectively, using data from CalOMS-Tx.

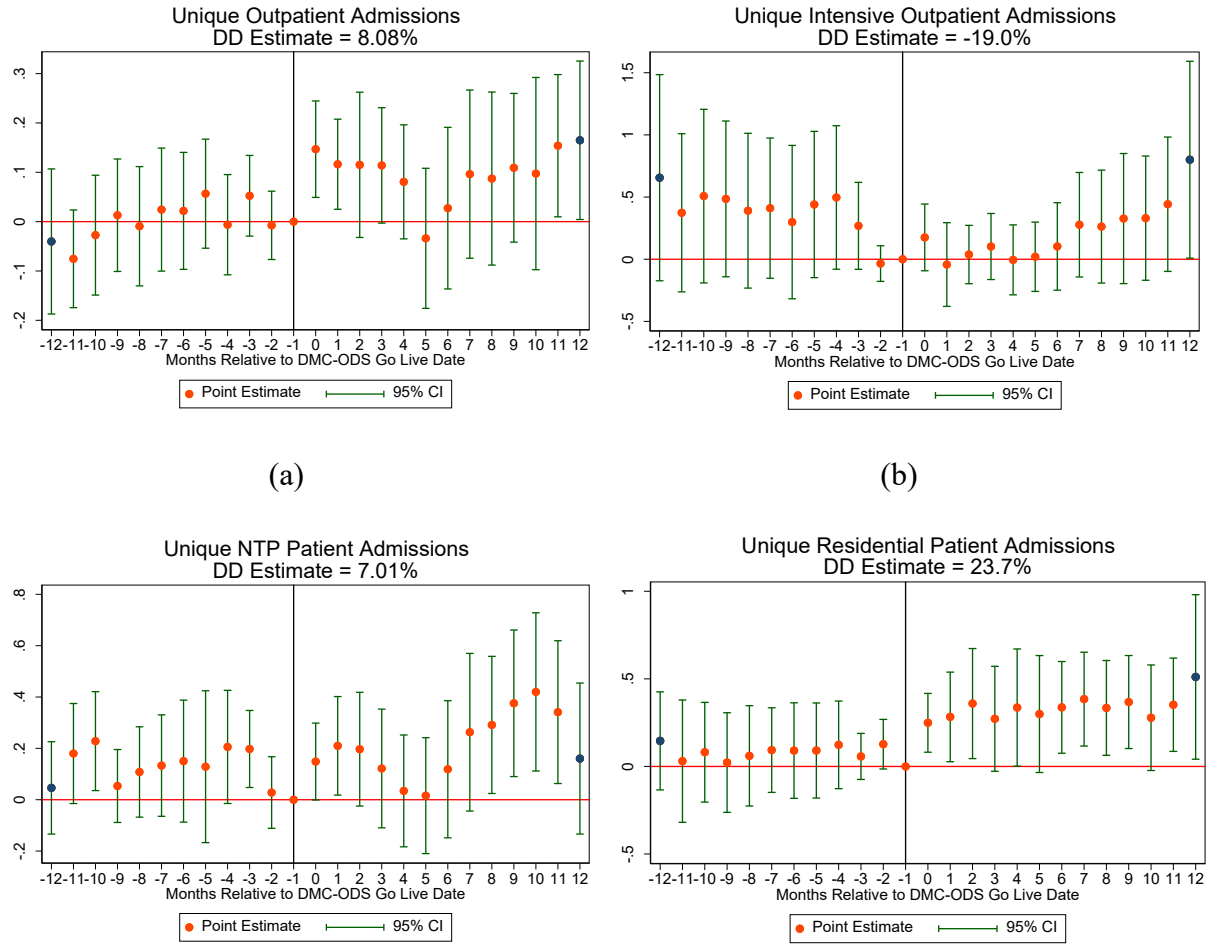
The DD estimate presented in Figure 3.3 suggests that the introduction of the DMC-ODS waiver had no statistically significant effect on the number of unique patient admissions in aggregate (i.e., the DD estimate is not statistically different from zero). However, it could be the case that a change in new patient admissions resulting from the introduction of the DMC-ODS waiver may take time to unfold. Figure 3.3 indicates that this is the case. Focusing on the right-hand side of Figure 3.3 (i.e., months post-DMC-ODS Go Live Date), we find that seven or more months after the introduction of the DMC-ODS waiver, the number of unique patient admissions appears to significantly increase (the 95% confidence interval bars do not cross 0) by nearly 20 percent.

Figure 3.3. Event study estimates of the effect of the DMC-ODS waiver on unique number of patients receiving services in CalOMS-Tx.



Notes: Event study estimates (orange dots) and 95% confidence intervals (bars) of the effect of the DMC-ODS waiver on the natural log of the number of unique patients receiving services are shown. The Y-axis can be interpreted in terms of %s by multiplying the values by 100. Data are from CalOMS-Tx for CY2016-CY2019. All estimates are relative to the year prior to the Go Live date. The difference-in-difference estimate is also shown.

Figure 3.4. Event study estimates of the effect of the DMC-ODS waiver on unique number of patients receiving services in CalOMS-Tx, by modality.



Notes: Event study estimates (orange dots) and 95% confidence intervals (bars) of the effect of the DMC-ODS waiver on the natural log of the number of unique patients receiving services by modality are shown. Panel (a) is OP, panel (b) is IOP, panel (c) is NTP/OTP, and panel (d) is residential. The Y-axis can be interpreted in terms of %s by multiplying the values by 100. Data are from CalOMS-Tx for CY2016-CY2019. All estimates are relative to the year prior to the Go Live date. The difference-in-difference estimates are also shown.

Figure 3.4 suggests that the introduction of the DMC-ODS waiver had no significant impact on the unique number of patient admissions by modality in aggregate. However, in panel (a) we see a significant increase in OP patient admissions immediately after the Go Live date, and then a drop back to zero. In panel (d), we find a significant increase in residential patient admissions beginning six months after DMC-ODS waiver introduction between 25-50 percent (with the exception of 10 months post-introduction, though this estimate is statistically significant at the 10% level).

Finally, we analyze if the introduction of the DMC-ODS waiver affected the unique number of patient admissions in CalOMS-Tx and the unique number of clients receiving services in DMC claims by race/ethnicity and gender. Separate DD models were estimated for males, females, American Indian/Alaskan Natives, Asian/Pacific Islanders, Black/African Americans, Hispanics/Latinx, Multiracial – Not Hispanic, and Whites. Panel I of Table 3.2 presents the DD results for CalOMS-Tx, and Panel II presents the DD results for DMC claims.[11] In CalOMS-Tx, we find that the introduction of the DMC-ODS waiver had a positive impact on the unique number of patient admissions, although only the effect on American Indian/Alaskan Natives (AI/AN) (18.1% increase) is statistically significant. Analyzing DMC claims data, we find a statistically significant increase in the unique number of patients receiving services across both genders and all races/ethnicities, with estimates ranging from a 13.1% increase for AI/AN to a 41.1% increase for Asian/Pacific Islanders.

Table 3.2. Difference-in-difference estimates of the effect of the introduction of the DMC-ODS waiver on unique number of patients, by gender and race/ethnicity.

Panel I: CalOMS-Tx	Male	Female	AI/AN	Asian	Black	Hispanic	White	Pacific Islander	Multiracial-Not Hispanic
DMC-ODS Waiver	7.3%	6.1%	18.1%***	7.1%	0.3%	6.2%	10.0%	12.2%	-6.3%

Panel II: DMC Claims	Male	Female	AI/AN	Asian/ Pacific Islander	Black	LatinX	White
DMC-ODS Waiver	17.5%***	18.4%***	13.1%**	41.1%**	22.0%***	19.0%***	16.2%***

Notes: Effect of the introduction of the DMC-ODS Waiver on number of unique patient admission in CalOMS-Tx (Panel I), and on the unique number of patients receiving services in DMC Claims (Panel II), by race/ethnicity and gender. *** indicates statistical significance at the 1% level, ** indicates statistical significance at the 5% level.

Consistent with the DMC claims and CalOMS-Tx, county administrators overwhelmingly reported the DMC-ODS waiver increased access to services in their county (84.0%). Most patients in DMC-ODS counties also provided fairly favorable ratings on access. In the TPS, adult patients from DMC-ODS waivered counties were asked two items about access: "The location was convenient (public transportation, distance, parking, etc.)." (84.5% agreement) and "Services were available when I needed them." (88.1% agreement). Youth agreement was somewhat lower for these questions, but the majority of youth still agreed with these questions (75.2% and 77.8%, respectively). They also tended to agree with a question added for youth, "I had a good experience enrolling in treatment." (78.3% agreement). While the lower agreement among youth compared to adults may have reflected lower availability of youth services, youth ratings were also generally lower than adult ratings across all survey questions, not just the ones pertaining to treatment access. For more information, see the full TPS report in Appendix C.

[11] DMC Claims data combines Asian and Pacific Islander patients, therefore separate estimates for each race cannot be presented as in CalOMS-Tx. Similarly, DMC Claims does not distinguish between Hispanics and Latinx patients, nor does CalOMS-Tx distinguish between Hispanic and Latinx patients.

Number of Providers

In order to determine if the number of DMC certified providers increased from the pre-DMC-ODS waiver period to the post-DMC-ODS waiver period, we analyzed data on DMC certified providers from the Master Provider File (MPF) from 2016 and 2020. Comparing the number of DMC certified providers in 2016 (747) to the number of DMC certified providers in 2020 (912), we find an overall increase of 165 DMC certified providers statewide, representing a 22.1% increase. Analyses also conducted using Drug Medi-Cal claims, but not CalOMS-Tx generated similar results.

Beneficiary Access Line

Stakeholder Perceptions: County Administrators

County administrators were asked, "Do you think a 24/7 beneficiary access line BAL is important to increase access in your county?" Most respondents (84.0%) answered yes.

Administrators were also asked, "Out of all clients receiving services in your county, approximately what percentage used the BAL?" The responses to this question averaged 41.3%, but answers ranged widely, from 0% to 80%. The county that reported zero commented that "42 CFR prevents the warm hand off that DHCS wants." All other counties, however, reported at least some people had used the BAL.

Some counties expressed generally that the BAL implementation was a very big challenge.

> "BAL is one of the most difficult things we implemented, and manage. Still lots of room for improvement."
>
> "It's a monster."

Multiple counties also reported that while their current BAL referrals were currently low, they anticipated that the BAL would account for a greater portion of referrals over time.

> "Over time I think the BAL will receive a greater portion of our overall system referrals. At this point, we have many access points, and word of mouth referrals often go directly to an OP provider. Provider to provider referrals also are handled through a different process."

One county reported that their BAL had integrated mental health and SUD staff and that this had worked well.

> "Our BAL has integrated staff: mental health and SUD, this makes it easier for the beneficiary, they particularly appreciate this feature."

At least one other county was moving in this direction at the time of the survey but reported that it was too early to provide information on it. The relative success of integrated BALs compared to SUD-only BALs may be an important implementation factor to track as these systems continue to evolve.

Secret Shopper Calls

For the 131 secret shopper calls completed in FY 2019-2020:

- On average, secret shoppers rated the difficulty of finding beneficiary access line phone numbers seven out of 10, indicating it was fairly easy, similar to 2018-2019 data. BAL phone numbers that were neither highlighted nor near the top of county websites, as well as misleading non-county websites in the search results prevented this rating from being higher.
- In FY 2019-2020, beneficiary access line staff were rated as friendly, with an average score of 9.3 out of ten, essentially the same as last year.
- For only 10.7% of the calls, the wait time for an answer was over two minutes; for the rest, it was less than two minutes. This is an improvement from 2018-2019 data, which showed 24.7% of calls had a wait time of over two minutes.

Penetration Rates

According to the most recently available (CY 2018-2019) NSDUH state estimates[12] 8.8% of California's 2019 age 12 and over population of 34,000,388[13], or 2,992,034 had an SUD. Since NSDUH is based on a household population, we applied an adjustment for the estimated 151,278 homeless persons in the state[14] , applying a 50.5% SUD estimate (for more information on this adjustment, see UCLA's 2018 DMC-ODS evaluation report[15]). This meant the household need estimate was (34,000,388-151,278) x 8.8% = 2,978,721, while the homeless need estimate was 151,278 x 50.5% = 76,395. Adding these together produces 3,055,116. Dividing this by the age 12 and over population of 34,000,388 yields an SUD rate of 9.0%.

This rate was applied to the average monthly number of Medi-Cal eligible beneficiaries in all DMC-ODS waiver counties according to the California Medi-Cal Eligibility Data System Monthly Extract File (11,049,760) to obtain a need estimate of 11,050,862 x 9.0% = 994,577. In these counties, an average of 49,987 patients per month received DMC-ODS services in 2019 in the months after going live (or all 12 months for counties that went live in 2017 and 2018),

[12] https://www.samhsa.gov/data/report/2018-2019-nsduh-state-prevalence-estimates
[13] https://www.dof.ca.gov/Forecasting/Demographics/projections/documents/P1B_State_Age.xlsx
[14] https://www.usich.gov/homelessness-statistics/ca/
[15] Urada, D., Teruya, C., Antonini, V. P., Joshi, V., Padwa, H., Huang, D., Lee, A.B., Castro-Moino, K., & Tran, E. (2018). California Drug Medi-Cal Organized Delivery System, 2018 Evaluation Report. Los Angeles, CA: UCLA Integrated Substance Abuse Programs. Available at: http://uclaisap.org/dmc-ods-eval/assets/documents/2017-2018%20UCLA%20DMC-ODS%20Evaluation%20Report%2011192018.pdf

according to DMC claims. This suggests a penetration rate of 49,987 / 994,577 = 5.0% based on the total Medi-Cal eligible population across these DMC-ODS waiver counties. The penetration rate in the first seven counties to begin DMC-ODS services and the next 12 counties to begin services was 4.0% and 6.3%, respectively, down from the 6.0% and 7.3% rate, respectively, estimated in the California DMC-ODS 2019 Evaluation Report. This was primarily due to an increase in estimated treatment need from 7.7% to 9.0%.

These penetration rates do not take into account people receiving treatment outside of the DMC-ODS system (e.g., MAT occurring in primary care). Some counties have made a major effort in these areas to complement their DMC-ODS system, so this penetration rate may somewhat understate the true treatment penetration. True need may also be higher (and thus penetration rates may be lower) since SUD rates are likely higher among the Med-Cal population than the general population.[16] A more sophisticated calculation of penetration rates is possible but is unlikely to change the conclusion that rates overall are low.

While DMC penetration remained relatively low in California DMC-ODS waiver counties, the same is also true nationally. SAMHSA (2020) estimated that nationally 12.2% of people who needed SUD specialty treatment actually received it. Importantly, SAMHSA also estimated that among the people who did not receive treatment, 95.7% felt they did not need treatment.[17] Assuming the same pattern in California DMC-ODS waiver counties, this suggests 994,577-49,987 = 944,590 people needed treatment but did not get it, but only 944,590 x 4.3% = 40,617 of people who did not receive treatment felt they needed it. Put differently, the penetration rate may have been about 49,987 / (49,987 + 40,617) = 55.2% of Medi-Cal eligible patients who thought they needed treatment. While this number is considerably higher, emphasizing it risks obscuring the need to engage people who don't think they need treatment.

Efforts to increase penetration rates can and should include expansion of SUD specialty care capacity, but efforts to reach out to patients in other settings to engage patients who do not currently recognize their need for treatment will also be critically important to increase penetration rates. This includes coordination with the MH and PH care systems, to be discussed in the Coordination of Care section of this chapter.

In our 2019 report, we indicated that more than half of surveyed providers had plans to expand capacity. However, the increase in estimated need appears to have outstripped any provider efforts at expansion. In 2020 it is likely that COVID-19 had an impact on both need for treatment and capacity. See the COVID-19 special issue chapter included in this report for additional details.

[16] Adelmann, P.K. (2003). Mental health and substance use disorders among Medicaid recipients: Prevalence estimates from two national surveys, Administration and Policy in Mental Health, 31(2).

[17] Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Special Population Challenges

Youth:

According to the DMC-ODS waiver County Administrator Survey, 68% of DMC-ODS waiver counties indicated that the DMC-ODS waiver had not increased access specifically to youth services. Counties cited the lack of expansion was due to school systems providing their own in-house servicers, funding deficiencies, and a shortage of support from the state. Examples of comments include:

> "Youth services have been slow to implement because counties are not receiving enough support from the state; focus continues to be on adult treatment population."
>
> "For youth treatment expansion, our county does not have enough funding for the match, services for adolescents just like for perinatal require a specialization and activities which are not reimbursed for by Medi-Cal."

Comments from the Provider Survey echo the results found in the County Administrator Survey. One provider stated:

"...rates are not adequate for residential for adolescents when you need at least two staff on every shift for a 10-bed program. Supervision is intense with minors...Also, the length of stay for adolescent residential needs to be longer as engagement takes time, many youth have never been in treatment before, and families need services longer for change to occur within the family system."

Perinatal:

Among respondents to the County Administrator Survey, 60% of DMC-ODS waiver counties indicated that the DMC-ODS waiver had not increased access specifically to perinatal services. Counties primarily stated that access to and funding for perinatal services had been strong historically and prior to the DMC-ODS waiver implementation. Examples of comments include:

> "We had robust perinatal care already, it was covered under DMC before ODS and has a set aside with SABG. "
>
> "[County] was fortunate to have a substantial Women & Children's Perinatal Residential funding allocation prior to the DMC-ODS."

Among the counties that stated access to perinatal services had increased, one county commented, "DMC-ODS has increased access to Perinatal because we can now provide perinatal services in residential treatment programs."

Out-of-county patients:

Respondents to the County Administrator Survey were also asked about experiences with administrative challenges with patients presenting for treatment that are not in-county residents.

Among DMC-ODS waiver county respondents, 84% indicated they experience administrative challenges with out-of-county patients. When asked about strategies used to manage these challenges, a majority of DMC-ODS waiver counties indicated they refer the patient back to their county of residence and/or they provide the option to transfer the patient's Medi-Cal. Another option would be for the provider to treat the person under contract with the other county, but many responses to the Provider Survey suggest contracting with different counties is very challenging: Examples include:

> "Multiple county requirements as a result of working with multiple counties causes a large negative impact on staff time and patient care."
>
> "Every county has come up with their own interpretation of the [DMC-ODS] waiver... When the county is questioned about a new rule or a new form, they simply state that this is at the request of the state. Yet the state monitors report they have not requested or relayed such information or requests."

Although DHCS has provided each county with flexibility, it may be worthwhile to work with county and provider organizations on a voluntary basis to seek consensus on the interpretations of requirements and reduce differences in requirements across counties.

Access to Medications for Addiction Treatment

Overall use of methadone and medications is much higher in DMC-ODS waiver counties, primarily due to the use of methadone. This is consistent with the tendency for State Plan counties to have fewer NTPs/OTPs, which are generally located in areas with greater population density. However, over time the percentage of people with opioid problems receiving methadone in DMC-ODS waiver counties has decreased while the number receiving buprenorphine has increased. This may be attributable to initiatives to promote access to buprenorphine, including the MAT Expansion Projects funded by DHCS.[18] The increase in buprenorphine, however, has not been enough to offset the decline in methadone, meaning the overall percentage of people with opioid problems receiving medications declined over time in DMC-ODS waiver counties, but not in State Plan counties. See Table 3.3.

Table 3.3. Access to MAT among patients in treatment with an opioid as their primary drug.

	CY 2016		July-Dec 2019	
	DMC-ODS Waiver Counties (n=30)	State Plan counties (n=28)	DMC-ODS Waiver Counties (n=30)	State Plan counties (n=28)
Methadone	66.6%	34.1%	52.2%	36.4%
Buprenorphine	0.7%	1.1%	5.2%	7.8%
Other medication	1.7%	0.3%	2.7%	0.9%
Total	69.0%	35.38%	60.1%	45.1%

[18] California MAT Expansion Project website: http://www.californiamat.org/

NTP/OTP stakeholders have expressed concern that they receive few referrals from the DMC-ODS beneficiary access lines. ASAM Criteria-based Level of Care data generally support this concern. NTP/OTP was only the indicated level of care on 3.1% of brief screenings (likely BAL screenings) in DMC-ODS waiver counties from CY 2017-2020. For context, in the second half of 2019 (after all 30 counties had begun DMC-ODS waiver implementation), 29.8% of Medi-Cal beneficiary admissions to treatment had an opioid designated as the primary drug problem, and 16.7% of all actual admissions were to NTPs/OTPs. This suggests most NTP/OTP patients were not referred from the BAL. It is possible patients may be increasingly choosing to receive MAT outside of NTP/OTP settings (e.g., buprenorphine prescribed through primary care), and therefore the MAT numbers in the table above understate actual receipt of medications. However, the low referral numbers may also indicate a bias against NTP/OTP referrals at the screening level.

At the treatment level, providers from all treatment modalities were asked to rate the acceptability of MAT with the question, "To you as a treatment professional, how acceptable is the use of buprenorphine (Suboxone) and methadone as treatment techniques for opioid use disorders?" (1= Completely unacceptable, 7= Very acceptable). About two-thirds of providers indicated it was very acceptable, and responses averaged 6.1 out of a possible 7.0 overall. Only 6.8% of providers gave a rating of 3 or below. This suggests some stigma against MAT remains within the SUD treatment system, though the majority find it very acceptable.

Access to Recovery Services

Most county administrators (76%) agreed that the DMC-ODS waiver had positively impacted the delivery of recovery services in their county. County comments suggested these services were valued:

> "We have been able to see a difference on those who may relapse while in Recovery Support and then are able to access treatment more immediately."

However, there were some issues with billing:

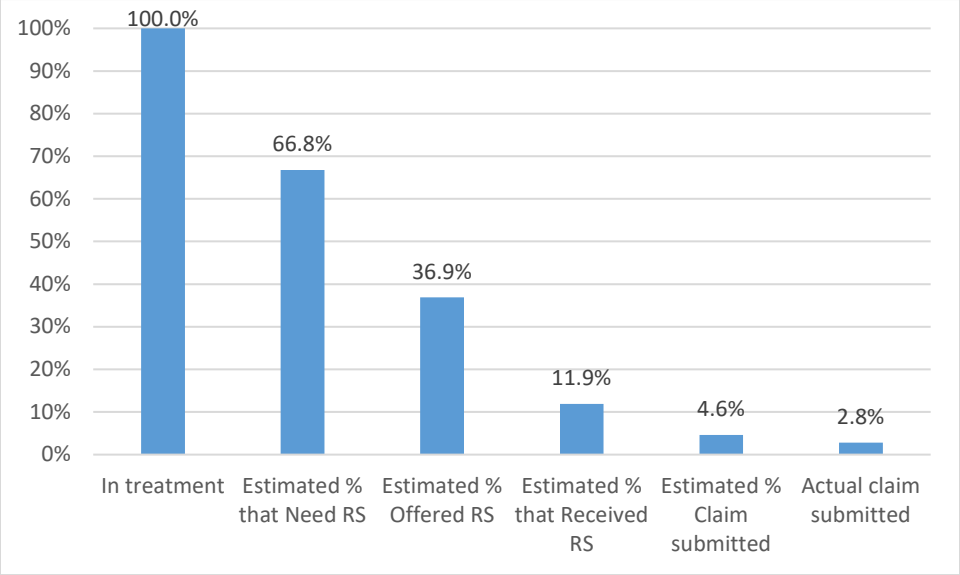
> "Many providers are opting to offer outside of the DMC-ODS due to the documentation requirements."
>
> "The billing structure of recovery support services is complicated and inhibits the ability of providers to bill for Medi-Cal."
>
> "We need to make the documentation burden for this service lighter, so it doesn't feel like a continuation of treatment. (e.g., not having to have a treatment plan, etc.). It feels too much like a continuation or prolongation of treatment in the way it is set up."

In a series of survey questions, county administrators were asked to estimate what percentages of patients needed, were offered, and received recovery services, and what percentage led to a

DMC claim being submitted. Their perceptions, as well as the actual level of billing found in DMC data, is shown in Figure 3.5.

County administrators estimated that on average, about two-thirds of patients needed recovery services, but that only a little more than half of those patients were actually offered these services, and less than a third of those were estimated to actually have received it. Even when services were delivered, administrators suggested that, in most cases, a claim was not submitted. Ultimately, administrators' estimates pointed to only 4.6% of people in treatment receiving recovery services, which was fairly close to the actual percentage of 2.8% found in DMC claims.

Figure 3.5. Reductions in recovery services from treatment to claims.



This very low overall result is similar to previous findings. In light of these minuscule recovery service numbers, county administrators were asked to indicate the most common reason people do not receive recovery services. The second most common reason selected was patient preference (37.5%), but the most common was actually "Other" (45.8%). Counties then wrote in comments that suggested a need for greater clarity.

> "Capacity and lack of clarity from DHCS."
>
> "We need a more structured "program" for Recovery Support Services, including Peers."
>
> "Frontline providers not offering or aware of RSS despite it being in the Provider Manual and various meetings to discuss this benefit."

Likewise, when asked if they had "Any additional thoughts about the implementation of recovery services under the DMC-ODS waiver," administrators provided answers again suggesting a need for clarification or reduced documentation.

"Insufficient Recovery Services direction available from the state. Providers are wary of providing this service then having the money recouped by the state. The county is working on developing its own policies and procedures."

"Reduce documentation burden for Recovery Services"

UCLA's 2019 report[19] and Chapter 9 in this report discuss these issues in greater depth. Briefly, DHCS wishes to allow flexibility in an effort to encourage innovation. However, this flexibility has led to uncertainty among providers and counties that appears to be inhibiting use of the benefit. At a minimum, this is likely reducing the percentages of patients being offered recovery services and the number of claims submitted, ultimately resulting in a benefit that is used for only 2.8% of people treated. A different approach with greater clarity is needed, and DHCS is seeking to clarify this benefit in the future.

[19] See p. 41, Urada et al.(2019). Drug Medi-Cal Organized Delivery System 2019 Evaluation Report http://www.uclaisap.org/dmc-ods-eval/assets/documents/DMC-ODS-Year-4-Evaluation-Report-FY-2018-19.pdf

Quality of Care

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Quality Improvement Activities

The percentage of county administrators agreeing that the DMC-ODS waiver positively impacted counties' quality improvement (QI) efforts on the 2020 County Administrator Survey was high and showed no significant changes over time (91.3% in 2015 and 95.7% in 2020).

Survey comments from 20 county administrators provided examples of how various aspects of the DMC-ODS waiver positively influenced their counties' quality improvement activities. According to some administrators, one of the areas in which the DMC-ODS waiver has had an impact is on increasing the number of SUD quality improvement/management staff in their respective counties. For example, one county administrator wrote, "For the first time we have QI staff that are dedicated to SUD activities.

Comments from several other county administrators also highlighted the increased focus on quality improvement in the SUD system of care brought about by the DMC-ODS waiver, which they reported "has helped to implement new requirements" and "allowed the behavioral health department to place more emphasis on our practices and look at ways to improve access for all beneficiaries in our county." In addition, county administrators mentioned other QI activities that have been favorably impacted by the DMC-ODS waiver, including: increased oversight (e.g., annual audits and site visits of providers); collaboration with treatment providers to improve care (e.g., timeliness to services and addressing barriers to access), coordination of care between physical health care and mental health care, and cultural competency; improved transitions of LOC; addressed clinical needs of patients via performance improvement plans (PIPs); bed management; and individualized treatment/treatment planning. Another administrator similarly explained, "the requirement to have two active PIPs has ensured [our county] is always working toward QI. Additionally, the documentation requirements under the DMC-ODS waiver are so rigorous, it is essential that we do constant training to ensure the requirements are met."

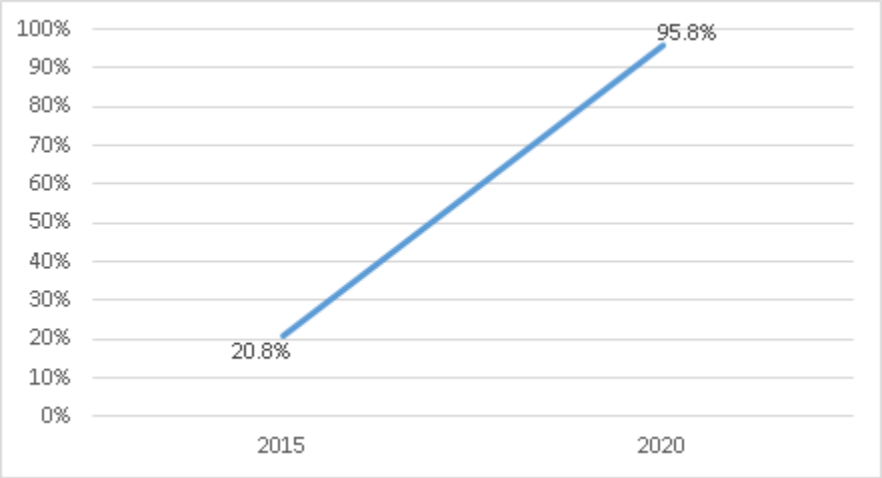
It is notable that while some counties have had to create a new SUD QI program, other counties have been able to use their mental health plans as the basis to develop their DMC-ODS waiver QI activities. For example, one of the administrators interviewed from a county that had recently gone live explained, "We leveraged a lot from the mental health plan. We already had our QIC, our Quality Improvement Committee, running very positively with regards to the mental health plan work…Shifting that so that it can be inclusive of all the DMC-ODS waiver requirements as well. It was a pretty easy transition for us, because we already had a lot of the quality management structure in place."

Establishment of Quality Improvement Committees and Plans

According to the County Administrator Survey results, while all of the DMC-ODS waiver counties have a Quality Improvement Committee, among counties that completed the survey in both 2015 and 2020 there was a significant increase in the percentage with a written SUD

treatment quality improvement plan over time (see Figure 3.6). One county administrator briefly described the usefulness of having the written plan by commenting, "We have a clear QI Work Plan which serves as a guidepost and vehicle for continuously evaluating and adapting the work." This sentiment was echoed in an interview with an administrator of a county that recently went live, who said, "Quality is important. I like all that that comes with it. It's just a lot of work. We have the framework now, which we would've never had if we hadn't gone to ODS."

Figure 3.6. Percentage of counties with a written SUD treatment quality improvement plan.



Use of Evidence-Based Practices

Counties opting in to the DMC-ODS waiver are required to use two of the five evidence-based practices (EBPs) listed in the Special Terms and Conditions (STCs), which include trauma-informed treatment, motivational interviewing (MI), cognitive-behavioral therapy (CBT), relapse prevention, and psycho-education. Responses from the 2020 County Administrator Survey showed that at least 72% of counties (N=20) are using a combination of MI, CBT, relapse prevention, and trauma-informed care. Another 64% are using psycho-education.

Administrators that completed the County Administrator Survey in both 2015 and 2020 continued to report that the implementation of the EBP requirement has remained somewhat challenging (2.0 and 2.25, respectively, on a 5-point Likert scale, with a higher number indicating more difficulty) over the course of the DMC-ODS waiver. It is important to note that the 2019 County Administrator Survey results indicated that while counties reported meeting the requirements for EBPs, assessing fidelity was identified as an area for improvement. In addition, while some counties reported assessing fidelity, the tools and strategies appeared to vary widely (e.g., chart reviews, monitoring of adherence to provider's plan for assessing fidelity). County administrators requested training on best practices for and tools/measures to assess fidelity. Apparently, assessing fidelity to EBPs remains as an area of need, with one administrator survey respondent in 2020 specifically requesting "training on EBPs, but as it relates to fidelity."

Further, although contingency management is not one of the five EBPs listed in the STCs, county administers were asked in the 2020 County Administrator Survey whether they thought it

would be helpful in treating stimulant use. See Chapter 7 for more information on contingency management and stimulants.

Similar to the county administrators, the majority of the providers surveyed reported using MI (86.1%), relapse prevention (82.5%), CBT (78%), psycho-education (68%), and trauma-informed treatment (67.4%). Almost half (46.1%) of the providers reported that their use of EBPs increased in preparation for the DMC-ODS waiver.

Use of American Society of Addiction Medicine (ASAM) Criteria-based tool(s) for Patient Placement and Assessment

The ASAM Criteria[20] provides a common standard for assessing patient needs, improving placement decisions, and documenting the appropriateness of placement. They facilitate 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 Criteria-based assessment is a requirement under the DMC-ODS waiver, counties have discretion over which assessment tools best meet their needs.

Development and Use of ASAM Criteria-based Assessments

DMC-ODS Waiver County Administrators

ASAM Criteria-based Assessment Tools

While all administrators of counties participating in the DMC-ODS waiver reported using an ASAM Criteria-based tool to assess patients, all but one created their own assessment tool or adapted one from another county. (Los Angeles County was the exception in using the ASAM CONTINUUM™ tool.)

Administrators from several counties recommended that DHCS provide a standard ASAM Criteria-based assessment tool for use statewide. One administrator wrote, "A lot of counties have various models of ASAM [Criteria-based assessments], I would like to see if the state can offer a uniform assessment tool for all counties to implement," while another suggested:

> "Given DHCS's strict standards regarding what an ASAM [Criteria-based assessment] should contain, I feel strongly that there should be a state-wide tool (separate from Continuum/FEI Systems) released by the state for counties to use. It seems odd to me that counties are essentially reinventing the wheel every time one of us creates or amends our own ASAM [Criteria-based assessment]."

Yet another administrator echoed this sentiment, and went further by suggesting that all counties be "mandated" to use such an assessment tool that also "includes the DHCS health questionnaire,

[20] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. (2013). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies

social rec, employment history, etc. requirements, but only if counties are allowed to model it into their EHR [electronic health records] system."

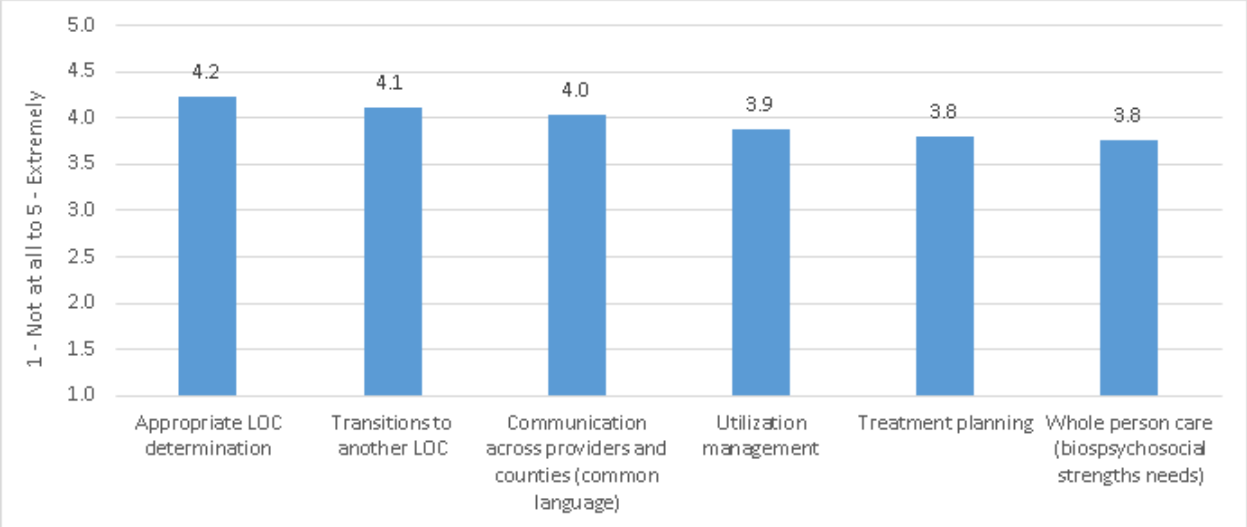
Researchers at UCLA in collaboration with a Patient-Centered Outcomes Research Institute-funded project to improve understanding of implementation of ASAM Criteria-based assessment found significant variation in the information collected by assessment tools in 29 DMC-ODS waiver counties and in how the assessments were used. Their findings reinforce the results from the County Administrator Survey, and suggest the need for fidelity standards, training, and standard ASAM Criteria-based assessment tools that are consistent across counties.[21]

Given the apparent need for a standard ASAM Criteria-based assessment tool that counties/providers may use, under a DHCS contract, UCLA has been collaborating with ASAM to develop a paper-based assessment tool that will be free and publicly available. It will be available in 2021.

Use of ASAM Criteria-based Assessments for Improving the Quality of Care

County administrators indicated that the ASAM Criteria-based assessments have been instrumental in improving the quality of care in multiple areas, especially in determining the appropriate LOC (4.2) and in transitions to another LOC (4.1). See Figure 3.7.

Figure 3.7. Average rating of county administrator responses to "Compared to before ASAM assessments were implemented, how helpful have ASAM Criteria-based assessments been in the following processes?"



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

While counties and providers are using various ASAM Criteria-based assessment tools, they are continuing to work on specific areas of implementation. For example, one respondent commented on the County Administrator Survey, "It's been difficult for providers to understand that a client may not necessarily be appropriate for their level of care, even if county refers them there. Seems as though clinical determinations remain challenging." Another administrator wrote, "ASAM [Criteria-based assessment] implementation has been very positive in standardizing LOC, however increasing the frequency of assessments would improve the process. We are still working with providers to follow the continuous evaluation standards," while a third administrator explained, "We continue to focus on inter-rater reliability across provider agencies."

Notably, Riverside County's (one of the first counties to implement the DMC-ODS waiver) efforts have moved beyond implementation to tracking changes in patients' ASAM Criteria dimensional severity scores between initial screenings administered prior to admission and transitional screenings administered within 14 days of discharge. The county has reported more improvements than regressions across all ASAM Criteria dimensions among patients discharged between 7/1/2019 and 6/30/2020, indicating the effectiveness of behavioral health treatment provided to these patients.

Similar to the EBPs in the previous section, while some counties reported in the 2019 County Administrator Survey that they assess fidelity to the ASAM Criteria, the strategies varied (e.g., review of claims data, focus groups, review of the application of the ASAM Criteria by utilization review specialists). The majority of administrators reported the need for technical assistance to assess fidelity to the ASAM Criteria, particularly for instruments/tools and focusing on inter-rater reliability. It is recommended that technical assistance, including tools and guidance on assessing fidelity to the ASAM Criteria, be provided to ensure consistency across providers and counties and to maximize the use of best practices to improve the quality of care and patient outcomes.

Use of ASAM Criteria-based Assessments in State Plan Counties

Although SUD treatment programs in State Plan counties are not currently required to use the ASAM Criteria, the majority (66%) of the State Plan Administrator Survey respondents reported using the ASAM CONTINUUM™ or an ASAM Criteria-based assessment tool that typically was adapted from another county. These results are encouraging given that treatment programs will be required to adopt ASAM Criteria as the minimum standard to be eligible for a California rehabilitation center license or to renew a license effective January 2023, given the passage of Senate Bill 823 in 2018 and Assembly Bill 920 in 2019. (Half of State Plan counties indicated they use the Addiction Severity Index, and another county uses an assessment tool developed by the county.)

Administrators were more likely to indicate (72.7%) that it is worthwhile to do a full ASAM Criteria-based assessment even if they did not have all the levels of care available in their county. Several administrators commented that even if they do not offer the levels of care within the county, they use the ASAM Criteria-based assessment tool to refer patients out of the county

for services (e.g., residential). Further, while a few administrators acknowledged the usefulness of such a tool (e.g., "The dimensions in the tool give a bigger picture of the client not just drug and alcohol use."), administrators struggle with implementation. One administrator explained, "I see value in the ASAM [Criteria-based assessment] and love the idea of using it, we have struggled with how to implement it given we lack the resources to provide [all] the various levels of care," while another administrator commented, "We would like assistance with an actual electronic tool to use in our EHR. We are using an outdated paper copy and are concerned about getting something in the EHR because of copy[right] issues. Is there a standardized assessment form available to counties?" In addition, some State Plan Survey respondents (41.7%) indicated that ASAM Criteria-based assessment and placement is a high priority for training or technical assistance.

The findings highlight the importance of making an ASAM endorsed assessment tool widely available and continuing to offer ASAM Criteria-based assessment training statewide.

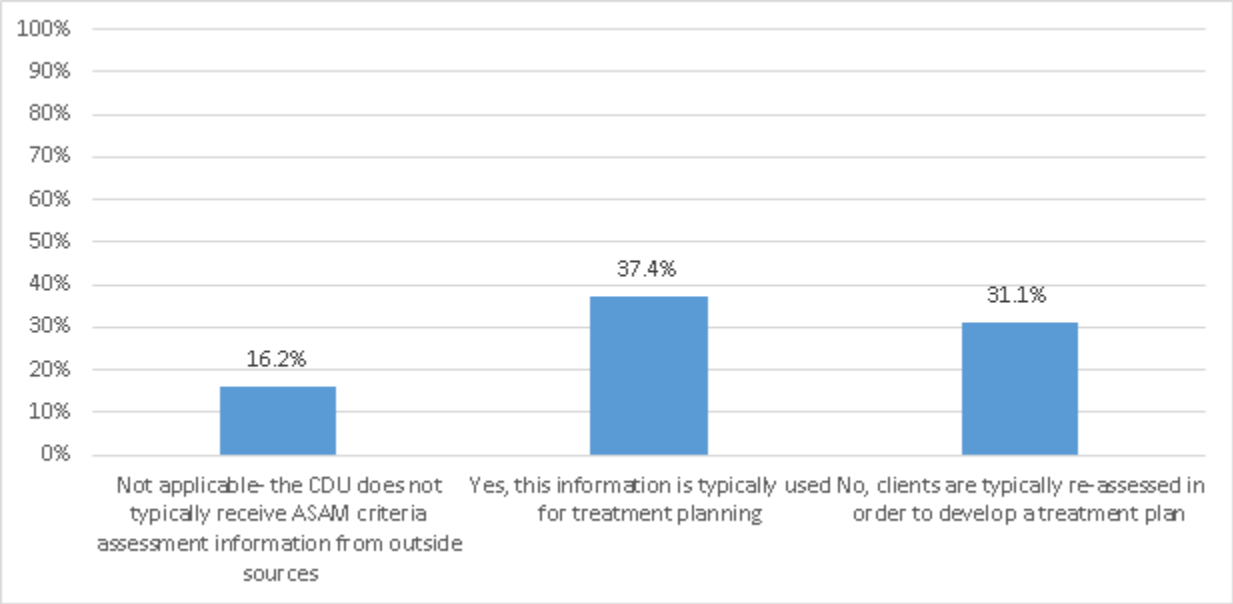
DMC-ODS Waiver SUD Providers

Most DMC-ODS Provider Survey respondents reported that they are or are planning to assess patients using an ASAM Criteria-based assessment tool (84.7%). Of the respondents whose programs also serve youth patients, about three-quarters (72.1%) reported that they use an ASAM Criteria-based assessment tool that is specifically tailored for this population. Further, among respondents that indicated they used an ASAM Criteria-based assessment tool, on average the DMC-ODS waiver was highly influential in their using such a tool (4.4 on a 1-5 scale; 1= not at all, and 5=significantly [primary influence]).

Among the respondents who affirmed they are using an ASAM Criteria-based assessment tool, almost all (97.3%) reported using it for new patient intake, over three quarters (79.9%) are using it to transition patients to another LOC, almost three-quarters (70.8%) are using it to discharge or transition the patient to another LOC; more than half (57.3%) use it when a significant event requires a new treatment plan. In addition, half of the providers (52.9%) reported using this tool every 90 days while the patient was in treatment, while almost one quarter (21.7%) indicated using the tool at other intervals (e.g., NTPs/OTPs reporting use of the assessment tool annually, residential providers typically using it every 30 days at minimum, an OP/IOP] providers in one county using it weekly or bi-weekly). These results indicate that providers and patients may be at risk of becoming overburdened with the frequency of assessments. However, it is unclear if these are full or abbreviated (e.g., updated) assessments.

As shown in Figure 3.8, slightly more than a third of providers who use an ASAM Criteria-based assessment tool reported that they typically use the information they receive for treatment planning. However, almost a third routinely re-assess patients suggesting a substantial proportion of patients are being subjected to two lengthy and very similar assessments in quick succession.

Figure 3.8. Treatment program responses to "When a client transfers to your treatment program from another LOC or from an external assessment center, is the ASAM criteria assessment information from these sources used in treatment planning?"



When providers were asked in the past 12 months, how many patients referred to your program from another LOC or from an external assessment center did not seem to be appropriate for the LOC your program, on average the rating was 1.76 on a scale of 1 to 4 (1=none and 4=all), indicating that many if not most of the referrals seemed appropriate for the LOC, which indicates that providers may be needlessly reassessing patients and increasing the burden of completing multiple assessments on patients.

Unnecessary reassessments may be onerous for some patients as well. UCLA researchers in collaboration with a Patient Centered Outcomes Research Institute-funded project conducted interviews to better understand patients' experiences in receiving ASAM Criteria-based assessments at intake. Their findings indicate that while some patients reported that answering the detailed assessment questions (e.g., substance use, mental health) gave them insights that were helpful, for others, the questions were perceived as being intrusive, exhausting, and anxiety producing.[22]

Even though providers are currently conducting assessments with their patients, reportedly there is an ongoing need for training. When asked to select among a list of 21 topics with the highest priority for training and technical assistance, ASAM Criteria-based assessment and placement was selected most often (38%) by Provider Survey respondents.

[22] Treiman K, Padwa H, Mark T, Tzeng J, and Gilbert M. (In press). "The assessment really helps you with the first step in recovery." What Do Clients Think Substance Use Disorder Treatment Intake Assessment Should Look Like? *WSUB Substance Abuse.*

ASAM Level of Care Placement Data

The ASAM Criteria are a defining feature of the DMC-ODS waiver. Counties are required to collect and submit ASAM Criteria-based LOC placement data to DHCS, and have developed various systems to collect the data. Counties are moving towards integrating ASAM Criteria-based LOC data collection with their EHR systems. In 2021, the external quality review organization for the DMC-ODS waiver is planning to add a question about this as part of counties' Information System Capacity Assessment submission.

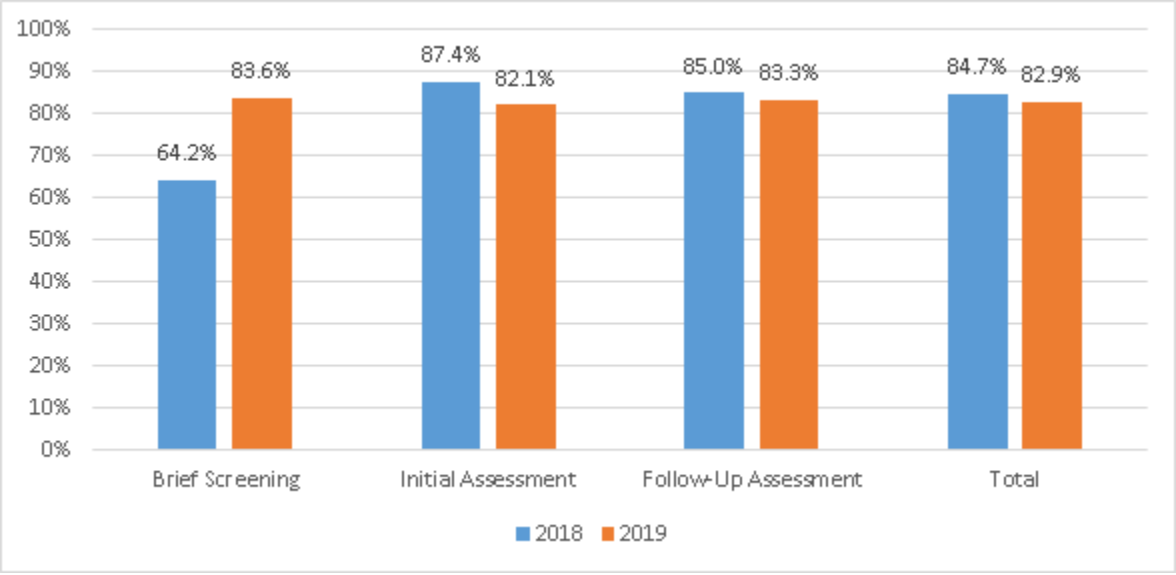
In CY 2018, 13 out of the 19 (68%) DMC-ODS waivered counties had collected and submitted ASAM Criteria-based LOC data. By CY 2019, 29 out of the 30 (97%) DMC-ODS waivered counties were regularly collecting and submitting ASAM Criteria-based LOC data.

The majority of the ASAM Criteria-based LOC placement data submitted from the 13 counties for CY 2018 was for initial assessments (71.1%) with substantially less data for brief initial screenings (9.7%) and follow-up assessments (19.2%). In CY 2019, 26.1% of the ASAM Criteria-based LOC placement data were for brief screenings, 40.3% for initial assessments, and 33.6% for follow-up assessments. All counties conduct initial assessments, but not all conduct brief initial screenings, and not all patients receive a follow-up assessment (e.g., people who leave treatment early). The distribution of the types of screenings/assessments is consistent with these practices, but it is unclear to what extent, if any, data collection challenges may also bias these numbers. In CY 2019, 67.6% of all patients had received at least one screening/assessment.

Difference between indicated and LOC placement decision

As shown in Figure 3.9, similar to CY 2018, most treatment referrals in CY 2019 were made to the same LOC (82.9%) as indicated across all screenings and assessments. Matching of the placement decisions improved significantly for brief screenings from CY 2018 (64.2%) to CY 2019 (83.6%) but declined by 5.3% for initial assessments.

Figure 3.9. Percentage of patients for whom indicated LOC and placement decision matched.



Reasons for the difference between indicated LOC and LOC placement decision

As shown in Table 3.4, the reasons for the indicated and actual LOC not matching (excluding cases where the reason for the difference was missing) differed depending on the type of assessment. In CY 2019, the most common reason for unmatched LOC among all three screening/assessment types was patient preference. About 20% of brief screenings were unmatched due to the LOC not being available, followed by other reasons (e.g., patient is currently working full time, childcare) at 19.8%, clinical judgement at 9.3%, legal issues at 7.2% and geographic availability at 4.4%. Among initial and follow-up assessments, a third were unmatched due to clinical judgement, 18% for other reasons (e.g., patient transitioning to new level of care, client work schedule), and between 8% and 10% due to LOC not being available. The adjustments to the LOC based on patient preference indicated for the three types of screening/assessments may be a reflection of patient engagement and patient-centered care. In addition, as counselors/clinicians are more apt to conduct full ASAM Criteria-based assessments than brief initial screenings, the higher percentage for clinical judgement as the reason for difference is not surprising.

Table 3.4. Reasons for difference between indicated LOC and placement decision, CY2019.

Reasons	Brief Screening	Initial Assessment	Follow-Up Assessment
Patient preference	37.5%	36.2%	33.5%
Clinical judgement	9.3%	34.9%	30.7%
Family responsibility	0.4%	0.7%	0.5%
Geographic accessibility	4.4%	1.9%	2.4%
Lack of insurance	0.8%	0.3%	0.5%
Legal issues	7.2%	3.5%	4.4%
LOC not available	20.5%	7.9%	10.2%
Used two residential stays in a year already	0.1%	0.1	0
Other	19.4%	14.5%	20.4%

It makes sense that "LOC not available" and "geographic accessibility" were higher for brief screening than at initial and follow-up assessments because these latter types of assessments are typically performed after the patient has already arrived at a LOC.

Residential two-stay limit

It is notable that "used two residential stays in a year already" was rarely reported as a reason a patient did not receive residential treatment. This DMC-ODS restriction is under discussion for the next version of the DMC-ODS waiver, and the ASAM LOC placement data suggest removing it may not make a large difference in treatment placement. While it was possible that beneficiaries who had used their two stays would be shifted to another funding source, that does not appear to be the case. In CalOMS-Tx admission data, only 1.3% of residential clients had more than two admissions in 2019. Still, stakeholders have long suggested the change would be

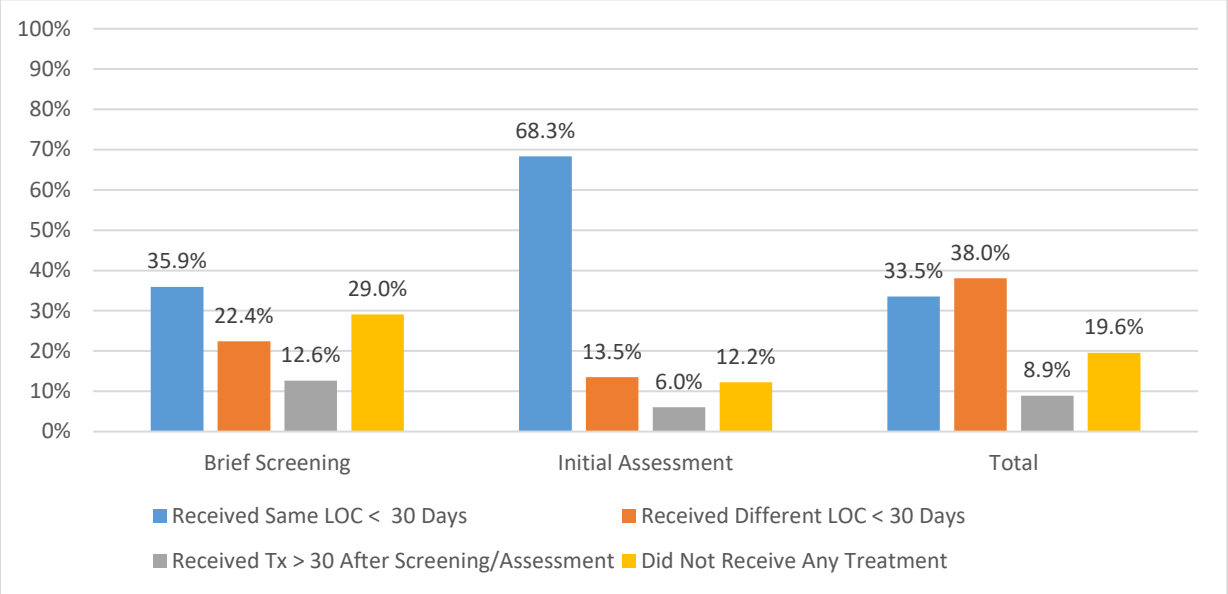
very helpful in managing patients. Together, this suggests the change is unlikely to have a large impact on costs.

Timeliness of receipt of SUD treatment services following ASAM Criteria-based screening/assessment

Although the indicated LOC and placement decisions had a high match rate, patients who were screened or assessed did not always successfully navigate the next step by actually receiving treatment at the provider to which they were referred. To measure the success rate of this step, DMC claims data for CY 2019 were used.

Overall, 33.5% of patients who were screened or assessed initially actually received treatment in the LOC that they were referred to within 30 days. (See Figure 3.10.) However, rates were substantially lower for brief initial screenings. About 35.9% of patients with a brief screening received the same LOC within 30 days as compared with 68.3% of patients with an initial assessment. These screenings often occur over the phone, so it is not surprising that rates are lower compared to initial assessments or follow-up assessments that tend to occur at a treatment provider, where it is easier to immediately begin treatment (or continue it, if appropriate, in the case of follow-up assessments). It is notable that overall, 19.6% of patients did not receive any treatment after a brief screening or an initial assessment. This was significantly higher for patients with a brief screening at 29.0% as compared with patients with an initial assessment at 12.2%. Case managers or peer specialists may help patients, especially those who have just received a brief screening over the phone, follow through with referrals to SUD services (e.g., an ASAM Criteria-based assessment at a treatment program).

Figure 3.10. Timeliness of receipt of SUD treatment services following ASAM Criteria-based screening/assessment, CY2019.

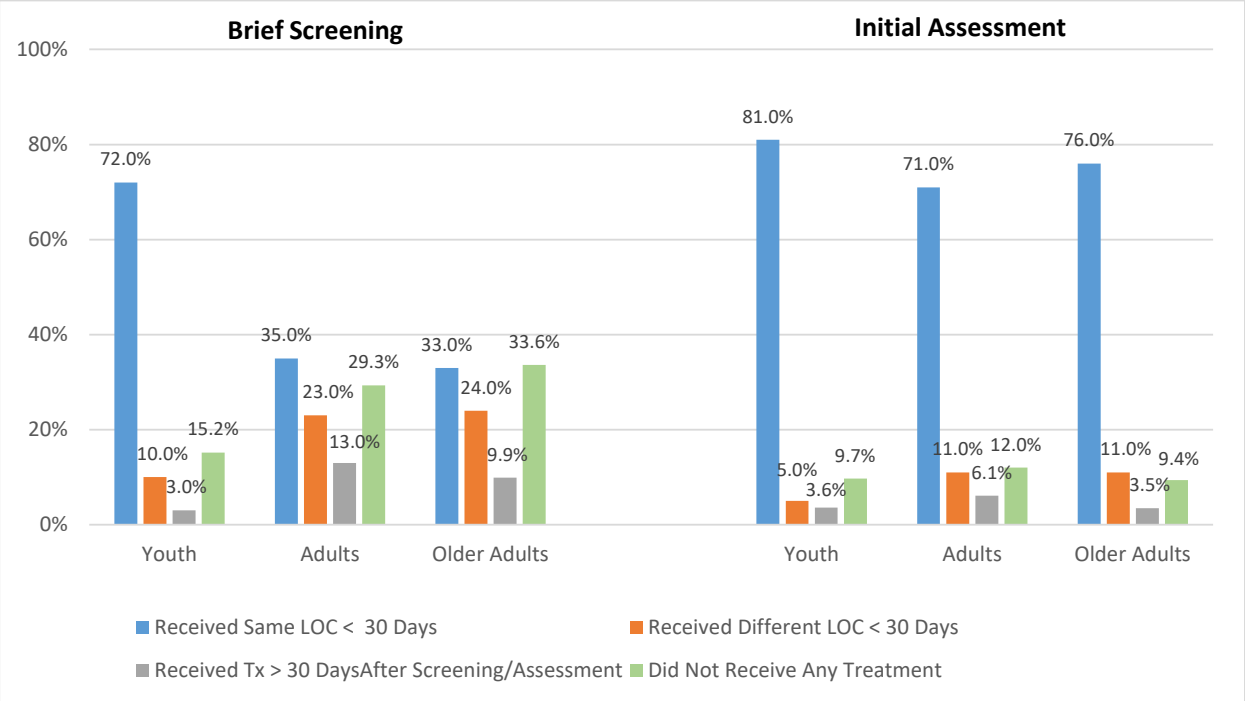


Timeliness of receipt of SUD treatment services following ASAM Criteria-based screening/assessment by race/ethnicity and by age group

There were no significant differences in timeliness of receiving treatment services after a brief screening or initial assessment by race/ethnicity and gender. Nearly 82.2% of both male and female patients and approximately 79.7% of patients in each racial/ethnic group received treatment services within 30 days of an ASAM Criteria-based screening/assessment.

However, there were some differences by age group for brief screenings (Figure 3.11). A significantly higher proportion of youth received the same level of care as referred to within 30 days of brief screening at 72% as compared with 35% among adults. More investigation is needed to understand better these findings and what they may mean in terms of access to as well as the timeliness of receiving services in the most appropriate LOC.

Figure 3.11. Timeliness of receipt of SUD treatment services after ASAM Criteria-based screening/assessment by age group, CY2019.

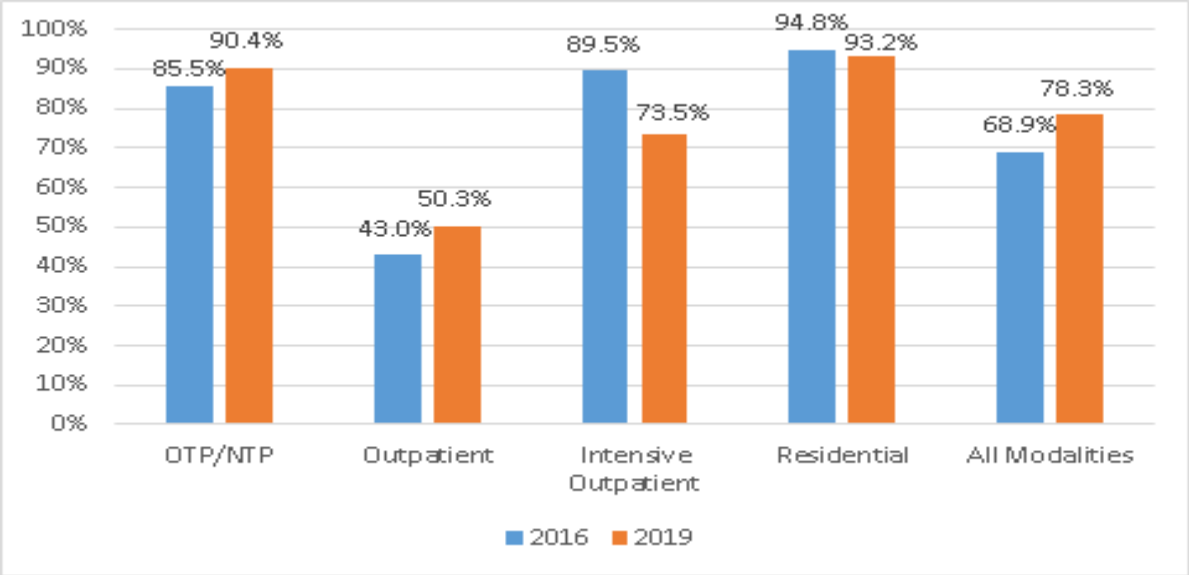


Treatment Engagement

DMC claims data for DMC-ODS waiver counties for CY 2016 (pre-waiver) and CY 2019 (post-waiver) were used to track treatment engagement, as measured by three visits within the first 30 days. As shown in Figure 3.12, engagement rates were higher among all modalities for CY 2019 (78.3%) compared to the CY 2016 pre-waiver period (68.9%), although engagement rates varied across treatment modalities in both years. Engagement rates were higher in the post-waiver period for NTP/OTP and outpatient compared to the pre-waiver period. However, treatment engagement rates were lower for intensive outpatient and residential post-waiver. Overall,

California treatment engagement rates are consistent with engagement rates in the literature. For example, Garnick et al. reported outpatient engagement rates of 47% averaged across five states, with states ranging from 24% to 67%. California's rate of 50.3% in CY 2019 is in that same range and slightly above the average. The same study reported an average of 62% engagement in intensive outpatient across three states (range: 34%- 75%). California's rate of 73.5% in CY 2019 exceeds the average, but is within the range.

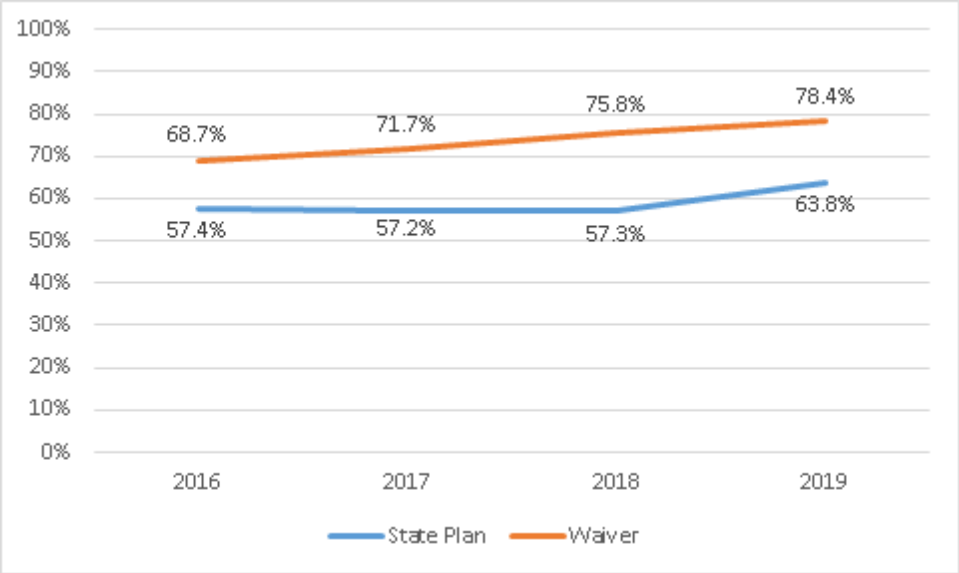
Figure 3.12. Successful treatment engagement by modality of service by year.



DMC claims data for CY 2016 through CY 2019 were also used to track and compare treatment engagement among DMC-ODS waiver counties and State Plan counties. Figure 3.13 displays the trend in treatment engagement over time for each set of counties. Treatment engagement rates are significantly higher for DMC-ODS waiver counties across all years, ranging from 68.9% to 78.3%, compared to State Plan counties, ranging from 57.4% to 63.8%.

Furthermore, we analyzed the effect of the introduction of the DMC-ODS waiver on treatment engagement using a difference-in-difference design, as described in the Methodology section. We find the introduction of the DMC-ODS waiver significantly increased the probability of treatment engagement among all clients in DMC-ODS waiver counties by 4.4% compared to State Plan counties. We next explore the differential effects of the DMC-ODS waiver on treatment engagement by gender and race. We find the aggregate result is driven exclusively by the increase in treatment engagement among males, with the introduction of the DMC-ODS waiver significantly increasing the probability of treatment engagement of males by 6.1% (compared to an insignificant increase of 2.4% for females). We also find that the introduction of the DMC-ODS waiver significantly increased treatment engagement among Whites and Latinx by 3.6% and 4.1%, respectively, with no significant impact on any other race.

Figure 3.13. Treatment engagement rates for DMC-ODS waiver counties and State Plan counties.



Patient Participation in Treatment Planning

To assess patient participation in treatment planning, Provider Survey respondents were asked to rate the extent to which patients contribute as equal partners to the development of their treatment plan. A majority of providers (67.2%) reported this occurs often or always. The provider perceptions of patient participation in treatment planning generally mirrored those of the patients. The Treatment Perceptions Survey asked adults how much they agreed with the statement: "I chose the treatment goals with my provider's help." Survey results showed an 87.2% agreement rate on the item. Similarly, 85.0% of youth survey respondents agreed with the statement, "My counselor and I worked on treatment goals together." Data collected from both providers and patients suggest that in general, patients are highly engaged in developing their treatment plans, which reflects patient-centered care.

Readmissions to Withdrawal Management

According to DMC claims data for CY 2019, overall, there were 7,858 WM admissions. Among this group, 80.0% (n=6,286) were admitted only once. Approximately 8.7% of the admissions in WM were readmitted within 30 days, and 14.5% (1,135/7,858) were readmitted within 90 days.

Patients' Perceptions of Care/Satisfaction with SUD Treatment Services: The Treatment Perceptions Survey (TPS)

Patients' perceptions of care/satisfaction with the SUD services they are receiving are essential in assessing the quality of care and informing efforts to improve such care, as they may be

associated with treatment outcomes[23, 24, 25, 26] (See Appendix C for the TPS statewide report and the TPS section in the Methodology section of this report.)

TPS Forms Returned and Response Rates

In the CY 2019 survey period a total of 23,765 TPS forms were received from 30 participating counties for both adults and youth. Adults accounted for the majority of the survey forms at 96% (n = 22,838), and youth accounted for 4% (n= 927), with percentages similar to the CY 2018 survey. All 30 counties returned adult forms whereas only 25 also returned youth forms.

The overall response rate for all adult and youth surveys was high at 58.7%. This was similar to the response rate of the 2018 survey (60.9%), which included 19 participating counties. The response rate was calculated as the number of surveys received divided by the number of patients that received services during the survey period as reflected in the administrative DMC claims database. If programs collected TPS forms from non-Medi-Cal beneficiaries, this may have inflated the rate. However, according to CalOMS-Tx data, 19.4% of patients were not Medi-Cal beneficiaries in CY 2019.

The highest percentage of adult survey forms was received from respondents in narcotic treatment programs/opioid treatment programs (NTPs/OTPs) at 44.0%, followed by OP/IOP programs (36.8%) and residential programs (18.2%), as compared to standalone WM programs (1.1%). In contrast, the vast majority of surveys from youth respondents (96.40%) were returned from OP/IOP programs, while only 3.3% of surveys were returned from residential programs and 0.1% were returned from an NTP/OTP.

Demographics

Consistent with previous years of the TPS, the majority of adult survey respondents identified as male (55.3%); 39.2% identified as female; and 1.0% identified as transgender or having other gender identity. Likewise, among youth survey respondents most identified as male (64.7%); 29.8% identified as female; and 1.0% identified as transgender or having other gender identity.

By race/ethnicity, the highest percentage of adult survey respondents identified as White (44.6%), followed by Latinx (31.3%), Black/African American (12.3%), Other (7.1%), and American Indian/Alaskan Native (4.4%). The lowest percentage of adult respondents identified as Asian (2.8) or Native Hawaiian/Pacific Islander (1.7%). Among youth survey respondents, the highest percentage identified as Latinx (61.4%), followed by White (15.4%), Black/African

[23] Carlson, M. J., & Gabriel, R. M. (2001). Patient satisfaction, use of services, and one-year outcomes in publicly funded substance abuse treatment. Psychiatric Services, 52(9), 1230-6.
[24] Garnick, D. W., Lee, M. T., Horgan, C. M., Acevedo, A., & the Washington Circle Public Sector Workgroup. (2009). Adapting Washington Circle Performance Measures for Public Sector Substance Abuse Treatment Systems. Journal of Substance Abuse Treatment, 36(3), 265–277.
[25] Shafer, A., & Ang, R. (2018). The mental health statistics improvement program (MHSIP) adult consumer satisfaction survey factor structure and relation to external criteria. Journal of Behavioral Health Services and Research
[26] Zhang, Z., Gerstein, D. R., & Friedmann, P.D. (2008). Patient satisfaction and sustained outcomes of drug abuse treatment. Journal of Health Psychology, 13(2), 388-400.

American (15.0%), and Other (8.1%). The lowest percentage of youth respondents identified as Asian (4.0%), American Indian/Alaskan Native (3.3%), and Native Hawaiian/Pacific Islander (1.8%).

The adult survey forms were overwhelmingly returned in English (n = 22,140, 96.9%) with only 3.0% returned in Spanish (n = 688). Correspondingly, almost all (98.8%) of the youth survey forms were returned in English (n = 916) and 1.2% were returned in Spanish (n = 11).

Average Perceptions of Care/Satisfaction Score by Treatment Setting

Survey respondents used a 5-point Likert scale (strongly disagree to strongly agree) scale where higher numbers indicated more positive perceptions of care/satisfaction.

Adults:

The overall average score for adult survey respondents across the different treatment settings was 4.4. The overall average scores by treatment modality were: 4.5 for OP/IOP; 4.4 for both NTP/OTP and WM (standalone); 4.3 for residential. The findings suggest that adult survey respondents in residential settings compared to other treatment settings, perceived that there is room for improvement.

Youth:

Among youth survey respondents, the overall average score was 4.2 across both OP/IOP and residential settings. The findings suggest youth respondents also perceived there are opportunities for improving treatment services.

Percent in Agreement for Each Survey Item by Domain

Adults:

As shown in Figure 3.14, the percent of responses in agreement for each of the 14 survey items was at least 82%, indicating overall favorable perceptions of care among adult survey respondents. Among the two survey items with the highest percentage in agreement, one was in the Quality domain (93.2% for "understood communication"), and the other was in the General Satisfaction domain (92.5% for "felt welcomed"). The two lowest (84.4% for "staff here work with my physical health care providers to support my wellness" and 82.7% for "staff here work with my mental health care providers to support my wellness") were in the Care Coordination domain.

Youth:

Among youth respondents, the percent of responses in agreement for each of the 18 survey items was at least 68.4%. The survey items showing the highest and lowest percent in agreement were both observed in the Quality domain with 88.5% in agreement with "staff treated me with respect," in contrast to the 68.4% in agreement with "my counselor provided necessary services for my family." See Figure 3.15.

Figure 3.14. Percent in agreement for each survey item by domain – Adults.

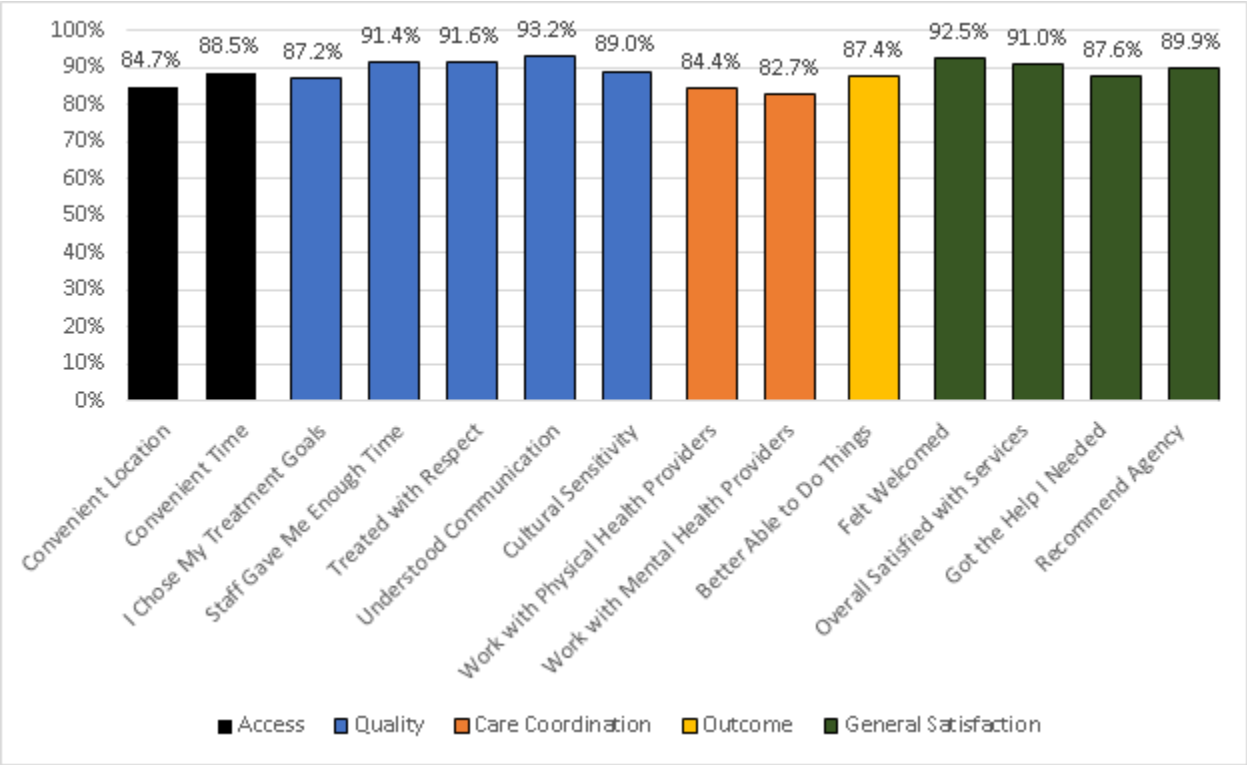
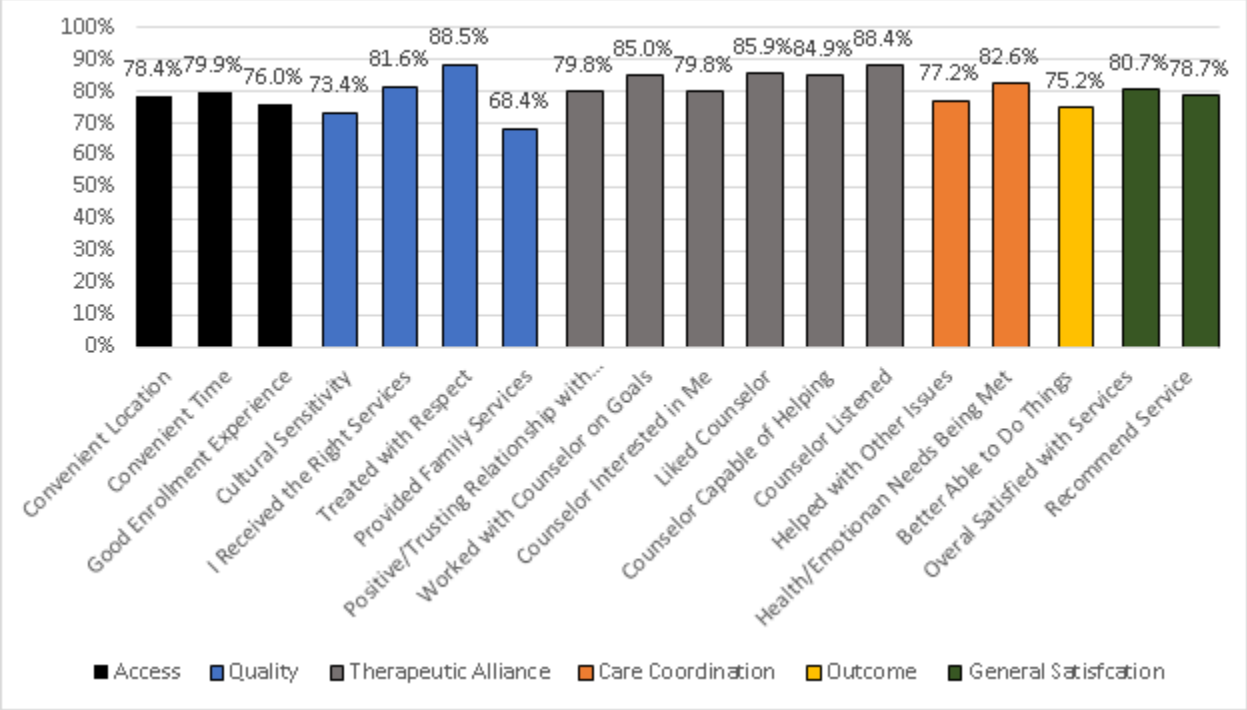


Figure 3.15. Percent in agreement for each survey item by domain – Youth.



Average Perceptions of Care/Satisfaction Score by Domain

Overall, among adult respondents, the average scores for each of the five domains were high, with both General Satisfaction and Quality yielding the highest scores (4.5), followed by Outcome (4.4), and Access and Care Coordination (both 4.3). Among the youth respondents, the average scores for the domains were also high with Therapeutic Alliance showing the highest score (4.3) followed by General Satisfaction and Care Coordination (both 4.2), and Quality, Access, and Outcome (all 4.1).

While at the statewide level, extensive variation was not evident in the average perceptions of care/satisfaction scores, slightly more variation was observed at the county level, with more diversity at the provider level and by survey item. As part of the evaluation, counties received their own county- and provider-level summary reports as well as their raw data and patient comments to help inform their quality improvement efforts. (Sample TPS reports are available on the TPS website at http://uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html.)

Average Perceptions of Care/Satisfaction Score by Treatment Modality and Domain

The highest average score statewide for adult respondents in OP/IOP settings was observed for the Outcome single-item domain ("As a result of the services I received, I am better able to do things I want to do." (4.6) and the lowest was for the Care Coordination domain (4.3). For Residential and WM settings, the highest average scores were for the General Satisfaction domain (4.4. and 4.5, respectively), whereas the lowest average scores were for the Care Coordination and Outcome domains (both 4.2 and 4.3, respectively). This suggests that patients in OP/IOP and NTP/OTP settings compared to residential and WM perceive their outcomes more positively. Shorter lengths of stay in residential and WM settings that are meant to provide a level of care to "stabilize" the patient before stepping them down to other levels of care (e.g., OP/IOP) may contribute to patients' perceptions of their outcomes. By contrast, among youth survey respondents, Therapeutic Alliance had the highest average scores in both OP/IOP and Residential settings (4.3 and 4.4, respectively). The lowest scores observed in OP/IOP were in the Quality and Access domains (both 4.1), whereas the lowest scores in Residential were in the Access and Quality domains showed the lowest average scores (both 4.0).

Average Perceptions of Care/Satisfaction Scores by Domain and Individual Survey Items Over Time

Among the first seven counties to go live with the DMC-ODS waiver (Contra Costa, Los Angeles, Marin, Riverside, San Francisco, San Mateo, and Santa Clara counties,) the overall average scores for adult respondents by domain were essentially the same across CY2017, 2018 and 2019 survey periods, suggesting stability of favorable patient perceptions over time. The average scores by domain ranged between 4.2 and 4.4.

Patient Survey Respondents' Comments

Many patients used the Comments box on the survey form to express their gratitude to treatment providers and counselors, offer suggestions for improvement, express their concerns and frustrations with staff and/or program policies, describe their personal accomplishments since entering the program, and convey their hopes for their futures.

The following selected quotations provide examples of how treatment has impacted the lives of both adult and youth patients.

- "This program has helped me get back on track. I have been sober six months and I'm currently going to college to get my AA [Associate of Arts] after dropping out of college 10 years ago. I am very hopeful of my future." (OP/IOP adult patient)
- "[The treatment program] saved my life in my opinion. I believe I would have been dead by now from an overdose. My counselor supports me in every aspect of my treatment. I feel comfortable here." (NTP/OTP adult patient)
- "This program keeps me sober, focused and supported. I would not be able to stay off of heroin if it wasn't for this program and I've been trying to quit for over 20 years." (NTP/OTP adult patient)
- "This program has started a profound change in my life, I've seen growth in myself I never imagined possible." (Residential adult patient)
- "This place was a god send to me. They are responsible for helping me get my kids back, and earning there [sic] respect again." (Residential adult patient)
- "The important thing is that their [sic] helping kids stay clean and staying out of jail." (OP/IOP youth patient)
- "They helped us get cleaned & focus on what realy [sic] matters in life." (OP/IOP youth patient)
- "I like the way it focuses on personal goals because the goals actually feel doable." (OP/IOP youth patient)

The selected quotations below are illustrative of suggestions provided by patients to improve treatment services.

- "Seek charity donation for clothes, and books (reading materials) Assisting with public transportation when exiting the detox." (Detox/WM adult patient)
- "The only thing I would change is the dispensing hours. I have to leave some jobs because I had to decide between work and medicating. It would be of great help if they had afternoon hours too." (NTP/OTP adult patient)
- "They need cultural sensitivity training (the staff), to be educated about transgender issues, etc." (OP/IOP adult patient)
- "Offer more services like housing or job placement or skill building." (Residential adult patient)
- "In the future I would hope to see a working line as the non-workers are the majority making people with jobs late even if we come early." (NTP/OTP adult patient)
- "This program needs a nurse, a gym, and transportation care." (Residential adult patient)

- "More flexible class/group schedule. 12-5pm is very inconvenient to being able to work. Testing 3-6 is also difficult." (OP/IOP adult patient)
- "I think we should get food for good work." (OP/IOP youth patient)

Use of Patient Perceptions of Care/Satisfaction for Quality Improvement

Similar to last year, the majority (84%) reported on the 2020 DMC-ODS Waiver County Administrator Survey that they used TPS results for quality improvement purposes. When asked how the county used the TPS reports/data, administrators indicated they use them: to provide feedback to individual providers (85%); for performance measurement and quality improvement planning (both 70%); to inform performance improvement projects (PIPs, i.e., Marin County, Napa County; 45%); for re-allocation of resources (15%); and to provide "feedback to the overall system and Board" (10%).

Comparable to the County Administrator Survey, the Provider Survey data showed the majority of providers (71.6%) reported that they collect patient satisfaction or perceptions data (e.g., surveys, focus groups) and use it to improve services.

Integration and Coordination of Care

Valerie P Antonini, MPH, Vandana Joshi, Ph.D., Anne B Lee, LCSW, Darren Urada, Ph.D., Elise Tran, B.A.

Integrated care is a commonly accepted goal, but confusion over what it means is also common. What does effective integrated care look like? What are the key operational requirements to achieve integrated care? How can MH and PH integration be measured in SUD programs? Within this report, integrated care is defined as bringing together key aspects in the design and delivery of care systems that are fragmented.[27] Coordination of care is defined as the deliberate organization of patient care and communication among all the participants responsible for a patient's care.[28] Integrated care cannot be delivered without effective coordination of services. The two go hand in hand. One of the goals of the DMC-ODS waiver is to improve the coordination and integration of SUD treatment services with PH and MH services, as well as improve coordination of services across the SUD continuum of care.

Progress toward a more integrated and coordinated SUD system of care was measured using results from the County Administrator Survey, Provider Survey, TPS, CalOMS-Tx, and DMC and Mental Health claims data. Results are organized to describe 1) integration of MH and PH with SUD (across the health care systems), 2) coordination and continuity of care within the SUD system, and 3) strategies to improve integration/coordination.

Included within this chapter is a case study exploring processes and promising practices of patient transitions from a residential program from the perspective of patients in Residential SUD care.

Coordinating/Integrating Care Across the Health Care System

General Ratings of Integrated and Coordinated Services

County Administrator Perceptions

County SUD administrators were asked to rate the degree to which their SUD and MH services were integrated and the degree to which their SUD and PH services were integrated. County administrators used a 5-point Likert scale ranging from "1 -Very poorly integrated" to "5 -Very well-integrated" to rate each system pairing. The ratings were then compared between DMC-ODS waiver and State Plan county groups. Responses were also compared over time among those who reported at both time points (CY 2015 and CY 2020).

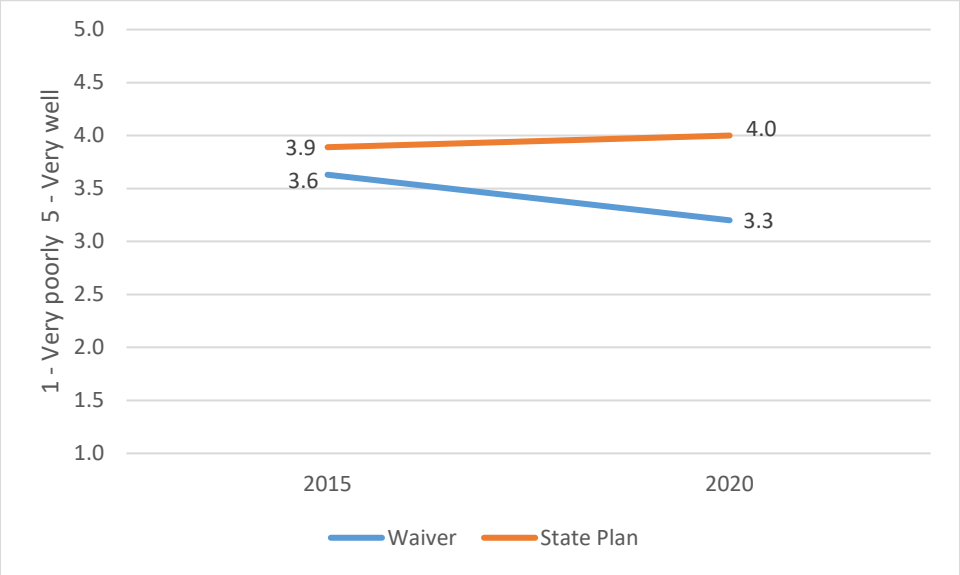
Among DMC-ODS waiver and State Plan counties that reported at both time periods (waiver n=24 of 30, State Plan n=9 of 21), there was a marginal decline in SUD-MH integration ratings from 2015 to 2020 among waiver counties (3.6 to 3.3, p=.0951; "somewhat well") and a slight (statistically non-significant) increase among the State Plan counties (3.9 to 4.0, "well"). Overall,

[27] Goodwin N. Understanding Integrated Care. Int J Integr Care. 2016 Oct 28;16(4):6. doi: 10.5334/ijic.2530. PMID: 28316546; PMCID: PMC5354214.

[28] https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

State Plan counties reported higher rates of SUD-MH integration than waiver counties at both time periods, and in CY 2020, waiver counties reported significantly lower than State Plan counties (3.3 vs. 4.0, $p<0.01$). (See Figure 3.16.)

Figure 3.16. Ratings of the degree to which SUD and MH departments/divisions are integrated within their counties.



Among DMC-ODS waiver counties, the decrease in SUD-MH integration ratings over time can be perceived as counterintuitive to progress. However, the lower ratings seem to reveal a better understanding of challenges they were not aware of before implementing the DMC-ODS waiver. These results are consistent with findings from prior years. DMC-ODS waiver counties consistently rate integration lower after implementing the waiver, with administrators explaining: "I think sometimes people don't realize what a significant change it's gonna be, until it goes into effect," and "We thought our system worked better than it did before we started." (2016 report[29]). "MH and SUD staff need more time and bandwidth to facilitate integrated care... [this] leads some to push back on integration and collaboration" (2017 report[30]).

In CY 2020, DMC-ODS waiver county administrators further supported this trend of a declined SUD-MH rating, yet qualitative comments support that progress is well underway:

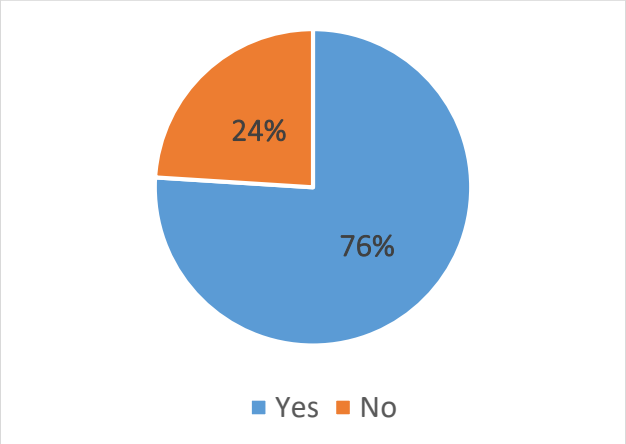
> "It's getting better. We have a lot more work to do."
>
> "While not integrated care, there has been increased awareness and screening for mental health and more referrals are being made"

[29] http://uclaisap.org/dmc-ods-eval/assets/documents/DMC-ODS-Evaluation-Report-FY-2016-2017%20final.pdf
[30] http://uclaisap.org/dmc-ods-eval/assets/documents/2017-2018%20UCLA%20DMC-ODS%20Evaluation%20Report%2011192018.pdf

"DMC-ODS County Care Coordination role and Res Authorization process,[and] utilization review has illuminated places where SUD provider did not adequately identify need, or did not refer client…with MH/SUD provider for services…"

Further, when asked if the DMC-ODS waiver positively impacted the integration of SUD and MH services in their county, 76% of waivered county administrators reported yes (see Figure 3.17).

Figure 3.17. Percent of county endorsement that the DMC-ODS waiver positively impacted SUD-MH integration.



Qualitative comments from DMC-ODS waiver county administrators explained:

"DMC-ODS has brought specialty SUD systems in greater alignment with specialty MH systems, and is a step in the right direction, consistent with the direction of CalAIM"

"Increased collaboration and communication"

"Forced us all to play in the same sandbox"

There is still more work to do. The most common challenges and comments reported include:

- Separate funding steams and billing silos
  "Separate funding streams encourage segregation in practice, if not in theory"
- Communication across systems

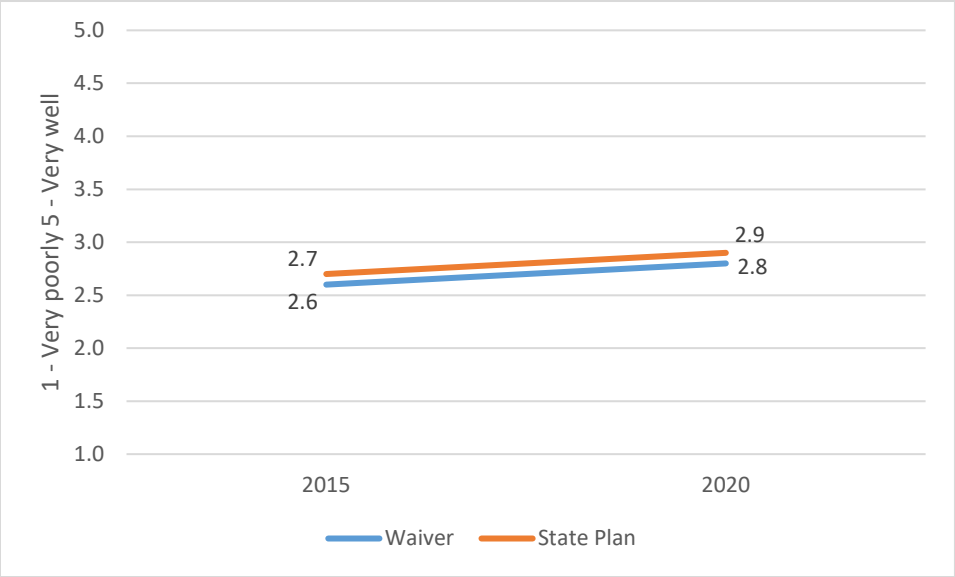
  "Privacy Regulations being different between DMC and MH have made it more difficult to communicate between the systems"
- The various Medi-Cal requirements between systems need more parity and integration.

  "When patients enter into a mental health system, they have to get an assessment on the mental health side, and then they have to get another assessment on the SUD side"

"Providers need to have two different Medi-Cal certifications. They have to meet two different set of documentation requirements. It's just sort of really bureaucratically burdensome"

For SUD-PH integration, there were no significant differences between waiver (n=25) and State Plan counties (n=9) at either time period or over time. See Figure 3.18.

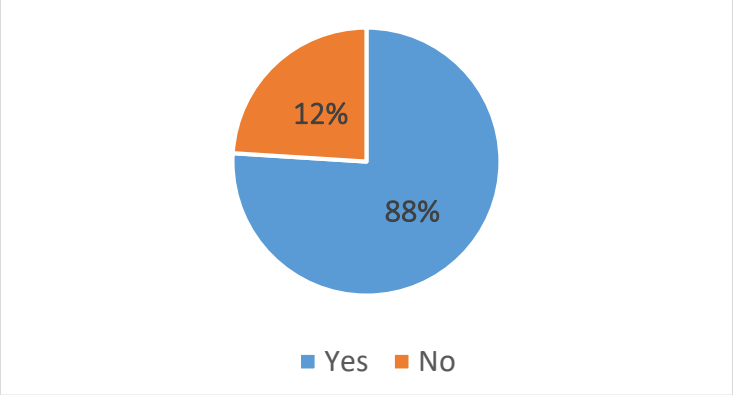
Figure 3.18. Ratings of the degree to which SUD and MH departments/divisions are integrated within their counties.



Statewide, SUD-PH integration continues to rate lower than SUD-MH integration, which is not surprising given that most counties have combined behavioral health (SUD-MH) departments.

For SUD-PH integration, while minimal changes occurred from 2015 to 2020 in this rating, when asked if the waiver positively impacted the integration of SUD and PH services in their county, 88% of waiver county administrators reported yes (see Figure 3.19).

Figure 3.19. Percent of county endorsement that the DMC-ODS waiver positively impacted SUD-PH integration.



Qualitative comments from DMC-ODS waiver county administrators further support the impact of the DMC-ODS waiver on SUD-PH integration.

- "With DMC-ODS, the emphasis on care coordination, and the ability to have DMC reimbursement for case management/care coordination our system of care has increased an understanding of the importance of collaboration with physical health care."
- "The requirement for a PE [physical exam] upon starting treatment has ensured that [our county] collaborates closely with its FQHC."
- "Case management staff help clients connect to care, and more and more questions on access are coming from hospitals and FQHCs"
- "Integration of MAT services in FQHCs, and Psych Emergency Room, also strong collaboration with the managed care plan which exist under the Health Services Department"

The most common challenges and comments reported include:

- Stigma within the physical health system

  "Still quite a bit of stigma with SUD patients trying to access physical health services"

- Patient information exchange barriers

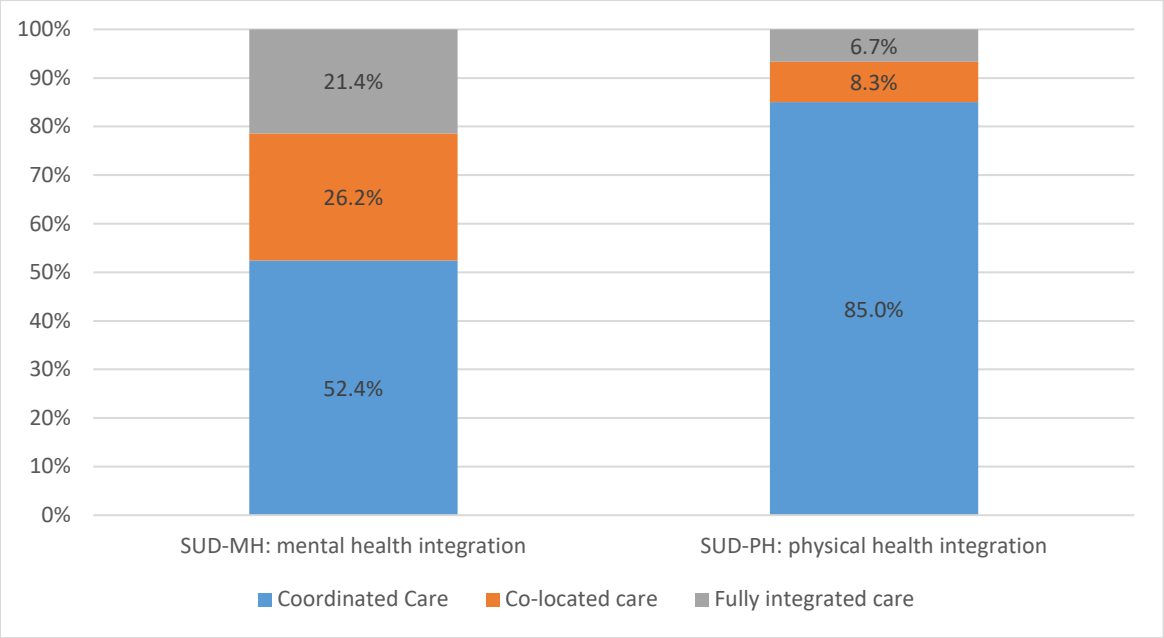
  "We are not yet able to obtain data from the physical health services system and there are still 42CFR part 2 restrictions that hinder integration. Additional strategies at the federal and state level are needed to address these barriers"

Integrated Practice Assessment (IPAT) Ratings

To further assess cross-system integration and collaboration, SUD treatment programs (one modality/one location) providing services under the DMC-ODS waiver were sampled and surveyed to learn how and how well integration/collaboration was being implemented at the point of service delivery. Questions from the Integrated Practice Assessment (IPAT) tool were incorporated as a component within the Provider Survey. Each program that completed the survey received an auto-calculated IPAT rating for MH integration (SUD-MH) and an IPAT rating for PH integration (SUD-PH) based on responses to the adapted IPAT questions.

Treatment programs from the 30 DMC-ODS waiver counties have contributed to this dataset, with a 59.8% response rate. Results from the Provider Survey (N=137) provide a description of the current landscape of the SUD system and service delivery under the DMC-ODS waiver with regard to collaboration/integration as defined by the SAMHSA Framework. For purposes of this report, IPAT level ratings 1-6 were collapsed and analyzed by the three main overarching categories: Coordinated Care, Co-located Care, and Fully Integrated Care. Of the 137 survey responses, 51.1% were from outpatient programs, 18.7% were from opioid treatment programs/narcotic treatment programs, and 30.7% were from residential programs. Figure 3.20 shows the distribution of IPAT ratings for both MH integration and PH integration within this snapshot of the SUD system of care.

Figure 3.20. IPAT rating of MH and PH service integration in SUD programs.



For the SUD-MH service system pairing (MH integration, n=126), about half of the SUD treatment programs (52.4%) rated in the Coordinated Care category (i.e., "minimal/basic integration at a distance"), followed by 26.2% in the Co-located Care category and 21.4% in the Fully Integrated Care category. Eleven providers did not submit all answers to calculate the IPAT rating.

For the SUD-PH service system pairing (PH integration, n=120), the majority of SUD providers (85.0%) rated in the Coordinated Care category, followed by relatively few in the Co-located Care category (8.3%) or in the Fully Integrated Care category (6.7%). Seventeen providers did not submit all answers to calculate an IPAT rating.

Overall, SUD-MH integration was distributed more broadly across the three implementation categories than SUD-PH integration. Although most treatment programs placed in the Coordinated Care category across both service system pairings, more treatment programs offered on-site MH services than on-site PH services.

The SAMHSA Framework defines physical proximity of service delivery (e.g., providing on-site services) as the key element to move beyond the Coordinated Care integration category. The key element to becoming fully integrated is to achieve practice change with a transformation of the program's business model. Based on this dataset, more SUD treatment programs deliver services as Fully Integrated SUD-MH programs than Fully Integrated SUD-PH treatment programs. This finding is consistent with county SUD efforts generally being organized within behavioral health departments that include both MH and SUD but not PH.

Further data exploration was conducted to determine integration category trends among treatment modalities (grouped by OP/IOP, residential, NTP/OTP). While each modality had the highest proportion of their programs operating in the coordinated care category (at a distance) for

both MH and PH integration, OP/IOP programs rated the highest proportion providing co-located MH and Co-located PH care (69.7% and 60.0%, respectively), where residential programs rated the highest proportion providing fully integrated MH and fully integrated PH care (60.0% and 75.0%, respectively).

The Provider Survey is the first set of data applying the SAMHSA Framework using the IPAT tool (adapted) to measure how MH and PH integration is occurring within DMC-ODS waivered SUD treatment programs. As such, additional questions were included, following the questions determining the IPAT score, to explore key aspects of their program that are known to facilitate more integrated/collaborative care and compare responses by integration categories (coordinated care, co-located care, and fully integrated care) for SUD-MH and SUD-PH integration. Key aspects of service delivery targeted in the survey included: screening practices, on-site service availability, referral practices. Overall, the exploratory analysis revealed intuitive results. More integrated programs (coordinated-at-a-distance, co-located, or fully integrated) tend to have more screening, a broader array of services, and more collaborations/referral procedures. However, data from the Provider Survey suggest that provision of Co-located services may have additional implementation challenges and have lower ratings of meeting the needs of patients and organizations, particularly of co-located physical health. Co-location reduces time spent traveling from one practitioner to another, but does not guarantee integration. While a relevant benchmark and facilitator for integrated care, Co-located services has its challenges to meet the needs of both the patients and organizational integration goals. Providers can be co-located and have no integration of their healthcare services. Each provider can still practice independently without communicating with others and without an integrated healthcare plan. These findings are important to note when programs are evaluating next steps for integrating services. Utilizing the benchmarks identified in the SAMHSA Integration Framework is a useful tool to set strategically realistic goals to improve integration of services. A full interpretation of these findings is included in Appendix F.

Patient Perceptions

Patient perceptions of care coordination was measured as part of the Treatment Perceptions Survey (TPS). Patients from DMC-ODS waiver counties were asked two items about care coordination/integration. Overall perceptions were favorable (84.4% for “staff here work with my PH care providers to support my wellness” and 82.7% for “staff here work with my MH care providers to support my wellness). However, these represented the lowest rates of agreement among all questions on the survey, suggesting room for improvement. See more results about the TPS in the Quality of Care section.

Cross-system Coordination

Administrative data measures

Analysis of CY 2019 DMC claims and SD/MC (mental health) claims data, among the 19 DMC-ODS waiver counties implementing over the full calendar year, revealed that 25% of SUD

patients received both SD/MC MH and DMC SUD services in the same calendar year. For context, 64.6% of providers report that most/all of their patients have MH needs, according to Provider Survey results. Since only patients with severe MH disorders will have SD/MC claims, it may be that patients with mild/moderate symptoms are having their MH problems addressed at SUD programs that integrate and deliver MH services or in primary care settings, neither of which would appear in SD/MC claims. Medi-Cal Managed Care/Fee for service data for the DMC-ODS waiver period was not available at the time of this report, so we could not confirm this, nor examine overlap between SUD and PH services. However, Provider Survey data reveal that 54.4% of SUD providers report that most/all of their patients have PH needs.

CalOMS-Tx has a source of referral question that can also be used as a measure of cross-system coordination. Overall, the data show that 2.9% of admissions to SUD treatment services came from other health care providers. This data is similar to previous years, suggesting no growth of incoming referrals from MH or PH systems. However, further exploration revealed that among patients admitted to SUD treatment who indicated ever having a mental illness diagnosis, 4.5% were referred from health care providers, compared to 1.9% of patients with no mental illness diagnosis. This suggests referrals into the SUD system may be more likely to occur when comorbidities exist, though more work is needed to improve these cross-system coordination practices. As one surveyed DMC-ODS waiver county administrator explained,

> "(Our) healthcare community has become progressively involved in receiving/referring beneficiaries with co-occurring disorders. The implementation of the waiver has required the general promotion of holistic/whole-person care among different departments/systems."

Coordination and Continuity of Care within the SUD System

General Ratings of Effective Transitions of Care

County Administrator Perceptions

Improving effective transitions between levels of care is a critical component to create a SUD treatment system that addresses the chronic nature of SUD.

DMC-ODS waiver county administrators were asked to rate how well their county tracks referrals and patient movement within the SUD system. 2020 DMC-ODS Waiver County Administrator Survey respondents used a 5-point Likert scale ranging from 1="Very poorly" to 5="Very well". On average, waiver counties reported just above "Somewhat well." (mean = 3.4), with 48% reporting "well" or "very well".

DMC-ODS waiver county administrators reported through qualitative comments various strategies used to facilitate or monitor transitions to another level of care. These included:

- "County tracks transition for the highest risk clients quite well -- with county assigned case manager. Lower risk clients work with contract providers, which are good at transitioning client within the providers own agency services."
- "Many struggle with stepping up/down to services at another provider site. Over the past year our county worked with providers to develop relationships and MOU with each other to facilitate improve client transition and care coordination."
- "We developed a level of care review request form."
- "The county tracks beneficiary transitions through our electronic health record. Creating an enhanced system that allows for tracking of placements/referrals/transitions to care is an ongoing project in QI."

Most commonly reported challenges include:

- "We are not yet fully staffed and haven't been able to fully implement the total QM work plan."
- "We have a decrease in our IT department so the data that is collected has not been able to be analyzed."
- "We have the ability to capture this data; however, we do not have a means to easily analyze or utilize the data. We have dashboards in development."

Provider Practices

In Tables 3.5, 3.6, and 3.7 below, Provider Survey data reveal that 83.0% of programs have formal protocols to facilitate a successful transfer, yet on average only "sometimes" will providers obtain confirmation of a successful transfer. In general, variation across modalities is small.

Table 3.5. Treatment program responses to: "My program has a formal protocol to facilitate successful transfers along the SUD continuum of care?"

Treatment modality	Agreement rate (%)
OP/IOP	83.3%
Residential	**90.0%**
NTP/OTP	72.7%
Total	**83.0%**

Table 3.6. Treatment program responses to: "Upon discharge, the frequency in which patients are transferred to other levels of care within 14 days of discharge?" (mean, 1=Never, 5=Always)

OP/IOP to:			
OP/IOP	Residential	NTP/OTP maintenance	WM
3.4	3.3	3.3	3.2
Residential to			
OP/IOP	Residential	NTP/OTP maintenance	WM
4.1	3.2	2.9	3.0
NTP/OTP to:			
OP/IOP	Residential	NTP/OTP maintenance	WM
2.8	2.9	**3.7**	2.5

Table 3.7. Treatment program responses to: "When transitioning a client to another level of care, how often does your program obtain confirmation of a successful admission?" (mean, 1=Never, 5=Always)

Treatment modality	**Agreement rate (mean)**
OP/IOP	**3.7**
Residential	3.6
NTP/OTP	3.5
Total	**3.6**

Provider survey respondents reported through qualitative comments the most significant factors on the success of patient transfers. These included:

- Collaboration/discussion
  - Communication and successful transfer of relevant information and treatment history.
  - "Warm handoff" and clinician-to-clinician discussion
- Start early
  - Culture set at beginning on treatment about the continuum of care and the need for ongoing treatment including step-downs; Cite statistics to improved outcomes
  - Eliminating the concept of "graduation"
- Case Management
  - Counselors/case managers reaching out; making calls and following up
  - Case management on both sides
- Availability of services (beds) with minimal wait times
- Formalized relationship between providers

- Client buy-in
- Regardless of the waiver or not, success is most dependent upon individual staff.
    - Because the paperwork is massive now, it takes dedicated and motivated staff to really make the transfer work.

When exploring these comments by treatment modality, NTP/OTP providers added the following in addition to the items above:

- Patient adjusting to new routine; Ensuring that the patient is ready
- Transportation

Transitions of Care within the SUD system

Administrative Data Measures

In Figures 3.21 and 3.22 below, transitions of care from residential treatment and withdrawal management were analyzed using CalOMS-Tx admissions data comparing two time periods (CY 2016 to CY 2019). The 19 waiver counties implementing under the DMC-ODS waiver for the full 2019 calendar year were used in this analysis to evaluate for impact from the DMC-ODS waiver. While these data show minimal change over time, the data reveal a positive impact for DMC-ODS waiver counties. Figure 3.21 indicates residential transitions to outpatient increased from 6.6% in 2016 to 8.0% in 2019). In addition, Figure 3.22 shows lower relapse rates in Withdrawal Management (WM) (5.6% in 2016 to 5.3% in 2019) and overall higher transfer rates from WM to Residential (17% in Waiver counties compared with 7% in State Plan counties).

Figure 3.21. Transition of care within 14 days of discharge from residential treatment: CY 2016 and CY 2019.

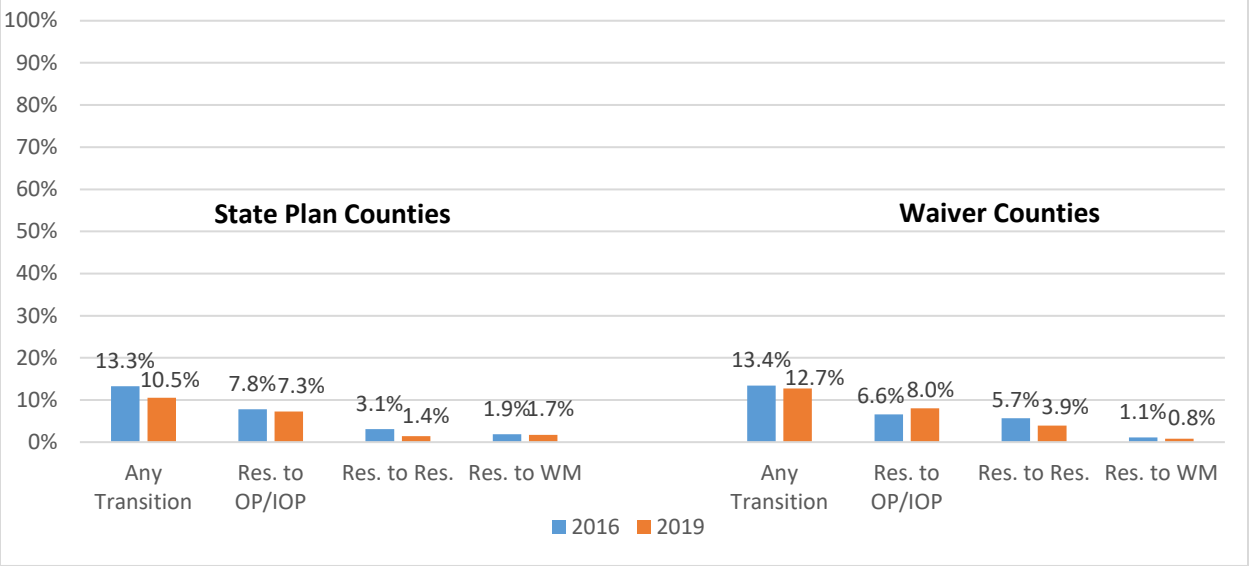
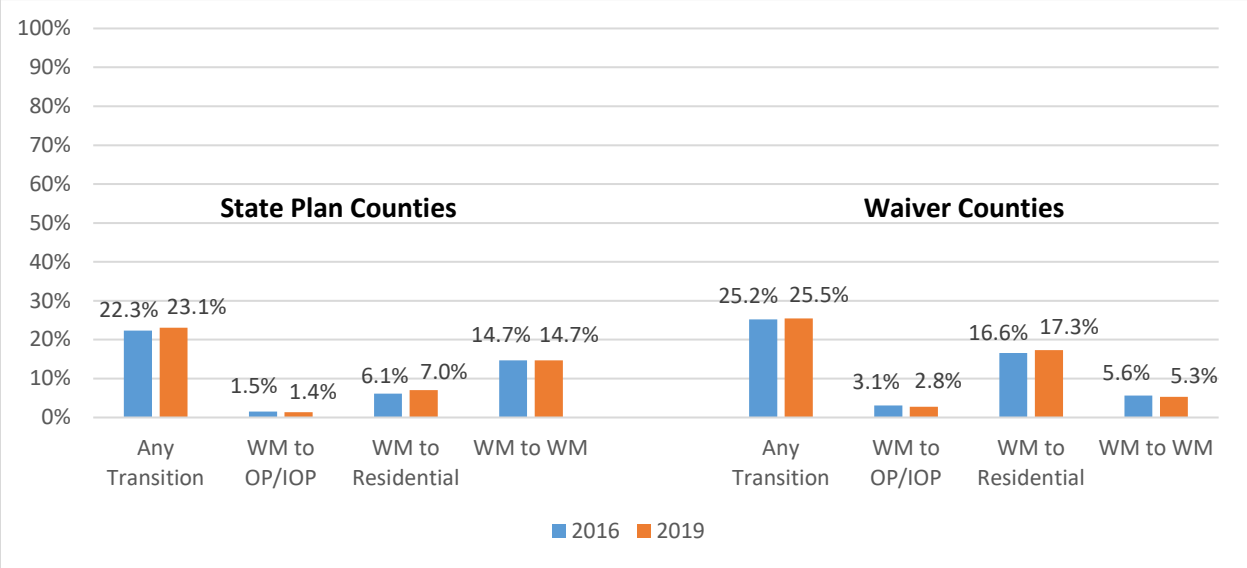


Figure 3.22. Transition of care within 14 days of discharge from withdrawal management (WM): CY 2016 and CY 2019.



Tracking patient transitions through CalOMS-Tx data has limitations, and survey and anecdotal responses from county administrators indicate that local tracking of patient transitions show higher transition rates (as noted in the section above). UCLA will investigate this discrepancy further. Further exploration is also needed to determine why patients do not accept or are not offered additional services.

A case study was conducted with patients in three residential programs in Riverside County. Patients preparing to transition to another level of care were asked to volunteer to be interviewed for their opinions on the barriers and facilitators to continuing recommended treatment after discharge from residential treatment, and to potentially identify promising practices to address this. See summary below.

Transitions of Care from Residential – Case Study

Method: Qualitative Interviews

Objective: To learn about the services and supports patients in residential feel are most helpful in assisting them to successfully transition from residential to the next appropriate level of care.

Organization/County: MFI Recovery Center, VARP Incorporated, and The Ranch Recovery Centers Hacienda Valdez residential treatment programs in Riverside County

Interviewees: Ten women and five men receiving residential SUD care

Background: The DMC-ODS Waiver is intended to facilitate beneficiaries' access to the full continuum of SUD care to support optimal client outcomes. Relapse risk is increased when clients do not have this type of continuity of care. However, according to CalOMS-Tx data in 2019, 86.6% of patients in the DMC-ODS waiver did not engage in any other level of care within 14 days of discharge from residential treatment (see figure 3.21). It is therefore important to understand the barriers and facilitators to increase this transition rate and ultimately improve patient outcomes.

UCLA-ISAP approached Riverside County as a source of interview participants as Riverside County had previously completed a two-year Performance Improvement Project (PIP)[31] to improve linkage and engagement of patients in a full continuum of care using a regional Care Coordination Team (CCT) approach. The county found significant improvements for adults transitioning after discharge from WM to either residential or OP services. However, transition rates from residential to OP services remained stable or decreased[32] despite these efforts.

UCLA ISAP interviewed patients to discover factors that could help DHCS and county administrators improve this rate.

Participants included 15 men and women who volunteered to be interviewed and were given a $20 gift card for their time. Seven respondents shared their ages, which ranged from 26 to 44 years.

[31] Implementation of a clinical PIP is one of the External Quality Review Organization (EQRO) requirements under the DMC-ODS waiver.

[32] The results were extracted from the Riverside County PIP document.

Barriers to Successful Treatment Transitions

Interviewees described the following challenges to successful transitions:

Managing Expectations of Treatment and Recovery

Many patients enter residential treatment expecting to be "done" in 30 days, that after discharge from Residential, they will return to their previous lives without making many changes.

> "I think that a lot of clients come in thinking that 30 days is a long time. They [have to] get worked up to [the idea of] 60, and then just 90, and maybe even 120 [days in treatment]. I don't think a lot of people have a full understanding of what is involved in recovery to stay recovered. I think it needs to be a lifetime thing, not just a short-term thing. I don't think everybody understands that at first." (male)

Duration of Residential Treatment

Patients commented that spending more time in Residential helped them make better decisions about ongoing SUD treatment. Cognitive impairment is usually most severe during the first weeks of abstinence, perhaps making it difficult for some patients to benefit from treatment.[33] Patients in early abstinence may have poorer decision-making skills when it comes to continuing recommended SUD treatment.[34]

> "Whether you're coming off of alcohol or heroin or meth—probably the three big ones that we deal with in recovery. … I think in each of those cases, I think in 30 days, you're just starting to get . . . back to where you're pretty much normal. Then, you can start learning from there on." (male)

Domestic Violence

Two respondents revealed that domestic violence made it difficult for them to make thoughtful choices about treatment. They reported that they needed ongoing support to maintain safety and sobriety after discharge. Fear for personal safety may impact decisions about how, where, and if these patients continue treatment.

> "I was in a very abusive relationship. I couldn't leave. I just couldn't leave whenever I wanted to it was like. I asked, and I was so far into my addiction, I prayed. I said, "God, just open a door where I know I'm going to be safe and taken care of and really cared for where I could work myself as well as you know, or I could work on getting my

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[33] https://pubs.niaaa.nih.gov/publications/aa53.htm NIAA, Alcohol Alert. No. 53, July 2001

[34] Rapeli P, Kivisaari R, Autti T, Kähkönen S, Puuskari V, Jokela O, Kalska H. Cognitive function during early abstinence from opioid dependence: a comparison to age, gender, and verbal intelligence matched controls. BMC Psychiatry. 2006 Feb 24;6:9. doi: 10.1186/1471-244X-6-9. PMID: 16504127; PMCID: PMC1489929.

children back." They did that here. They work with the CFS workers, and they work with the county. They work with everybody to where once we complete this program, we have more opportunities when we leave here. For me, it's a safe haven 'cause I know I couldn't be harmed here, and I'm taken very, very care of, and I know I'm loved and taken care of here" (female)

Facilitators to Successful Treatment Transitions

According to interviewees, keys to success include:

Peer Community/ Peer Support

Patients reported that Peer Support staff were important role models for continuing SUD treatment after discharge from Residential, that treatment and recovery is an ongoing process.

> "[Peer Support staff] have a more social relationship with the clients. They're showing that they actually have to live their recovery in order to keep it. I think that's important for them to have that experience…. They just talk to the guys and interact with them and give them more one-on-one time. I think they got some relationship in that regard and say, "Well, how did you do it?" That's an important question tool sort of asking the question of how did you make it? How did you stay sober and clean? That's when it has … impact." (male)

Patients made supportive friendships in Residential and felt that they would be more motivated to continue in recommended treatment if they could maintain these relationships.

> "I think that's really helpful for guys 'cause—especially people that don't know people that are in recovery. If everybody you knew was drinking or using before you came in here, you're not gonna know anybody to hang out with that is safe when you get out of here except for the guys that were in here with you." (male)

Family Counseling

Patients felt that family counseling was vital to ongoing engagement in SUD treatment. Family involvement in treatment made them feel more supported and less alone. They wanted their families to know that SUD recovery is a long ongoing process that may cause changes and even disrupt the family dynamic. Patients want their families to be proactively engaged so they can problem-solve family issues prior to transitioning treatment to another level of care.

> "Yeah, I think so because a lotta times we, as addicts and alcoholics, feel alone, but when our family comes to the ward, we feel as though we're not alone anymore." (Female)

> "Other obligations, of course, is their financial needs and they have to go split those needs if they have a job. If they've got a family, then they have to take time out for their

family. Families don't—they expect you to come back cured *[laughter]* and you don't, but they don't understand necessarily there's giving a lot of time still to stay in recovery once you get out." (Male)

"[I recommend] a family program where they brought families in with the counselor or psychiatrist and had groups together with them. These families need to be aware of what their part in helping the client stay recovered is. …Their part is understanding that the client does have to have these commitments. I know when I first got recovered for the first time—and I was married back then—I did the 90 and 90 and that really made her very angry. She didn't understand that I was gonna relapse if I didn't run a strict program. She just was like, 'Well, you've been gone for all this time.' It was only a month back then, and 'You've got a son and a wife. We expect you to spend that with us.' " (Male)

"A lot of people have a hard time with their family. It's still very tense. Re-entering into their family dynamic can set really big triggers." (Female)

Case Management and Linkages

Patients universally wanted case management. They wanted help connecting to all the services they will need after they leave Residential: mental health, educational, social, vocational, MAT, recovery residences, and other community services.

"I think [it would help] if [patients] had help with school or transportation or getting a job, because they might not have ever had a job. They've been doing this for a while. Even if they come in here young or old, they need access to that. A lot of 'em don't have a driver's license. They need to go to DMV."(Female)

<u>Orientation to OP/IOP services.</u> Patients wanted to visit the provider where they were being referred and attend groups run by IOP staff for graduating Residential patients.

"I don't think most people know what IOP is going to entail. Is it gonna be a repetition of the same thing that they've had here? ….Maybe a little bit of education about what IOP is. Maybe taking those guys that are in their last four weeks and having one IOP [group]. Maybe even have an IOP person come here and start IOP before they leave. Say, "Hey, I'm your IOP counselor. I'm gonna do a group once a week with you guys. When you get out as anything for myself where someone that I work with all the time here seen me at the IOP and there's a lot of people that do IOP are gonna go to MFI IOP." (male)

Linkages to job training and job hunting-support. Patients discharging from Residential were especially concerned with their finances returning to work and/or getting a GED. Patients worried that committing to more treatment would interfere with their ability to support themselves and their families. Patients reported that vocational assistance before and after discharge would support engagement in treatment.

> " [a job coach]That was a great resource for transitioning people because the stress of not having money and running out of money and finding for a job and maybe not finding the right job is pretty harsh on some people." (male)

Recovery Residences

Patients reported the need for transportation, childcare, and comfortable, stable housing close to their home communities and work. Patients stated that recovery residences are key to staying in treatment. However, if the recovery residence is too far from work or family, it is not conducive to continuing treatment in OP/IOP. Those who had a prior history of returning to SUD treatment after relapse believe it was because they did not have a supportive recovery residence.

> "[The last time I discharged from residential] it was either [to] a homeless shelter or you had a family member to go to. Either one of those options really don't work. I had family, and I relapsed. I went to a homeless shelter, and there was a liquor store right around the corner, and I relapsed." (Female)

Conclusion: Patient interviews revealed that services including case management, peer support services, recovery support services, and recovery residences support successful transitions in care.

Strategies to Improve Integration/Coordination

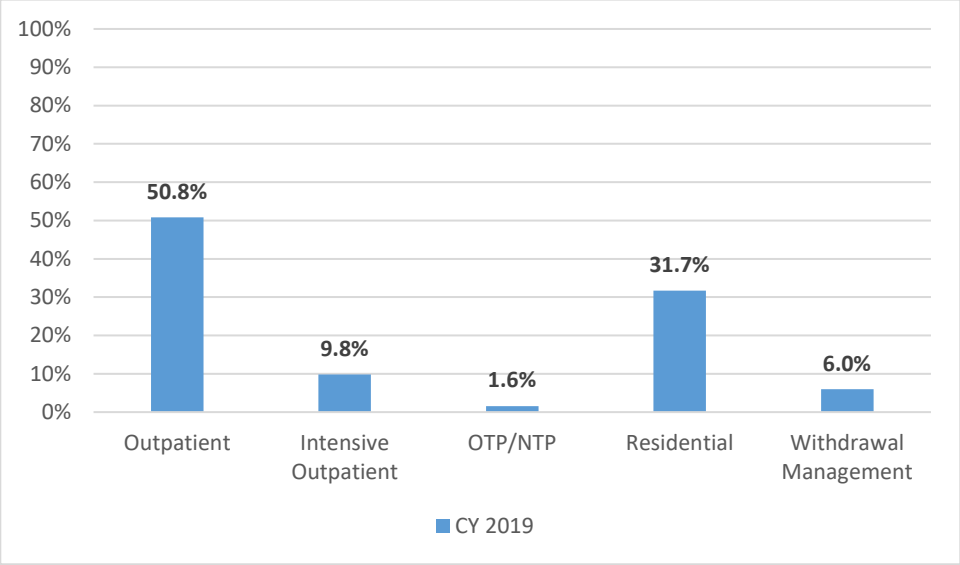
Case Management Benefit

Utilization of the Benefit

Case management services are commonly used to coordinate care, and these services are a new benefit under the DMC-ODS waiver. However, according to the DMC claims data of 19 DMC-ODS waiver counties (those that were live for the full calendar year), 9.5% of beneficiaries have case management services billed in CY 2019.

Among those who did receive case management in CY 2019, most of the billed case management services were billed through outpatient (50.8%) and residential treatment (31.7%). (See Figure 3.23). Demographically, there were no significant differences by ethnicity or gender as it relates to patients with billed case management services.

Figure 3.23. Among patients who received case management services, distribution by modality.

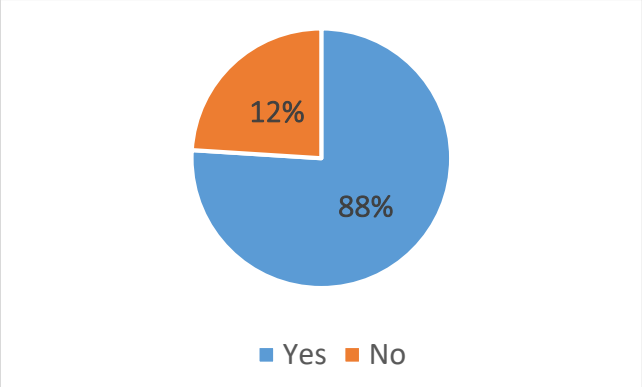


Note: Data are from DMC Claims for the 19 waiver counties that were live for the full CY 2019.

County Administrator Perceptions

County administrators overwhelmingly reported that the DMC-ODS waiver positively impacted the delivery of case management services in their counties (88.0%). See Figure 3.24.

Figure 3.24. Percent of county endorsement that the DMC-ODS waiver positively impacted the delivery of case management services.



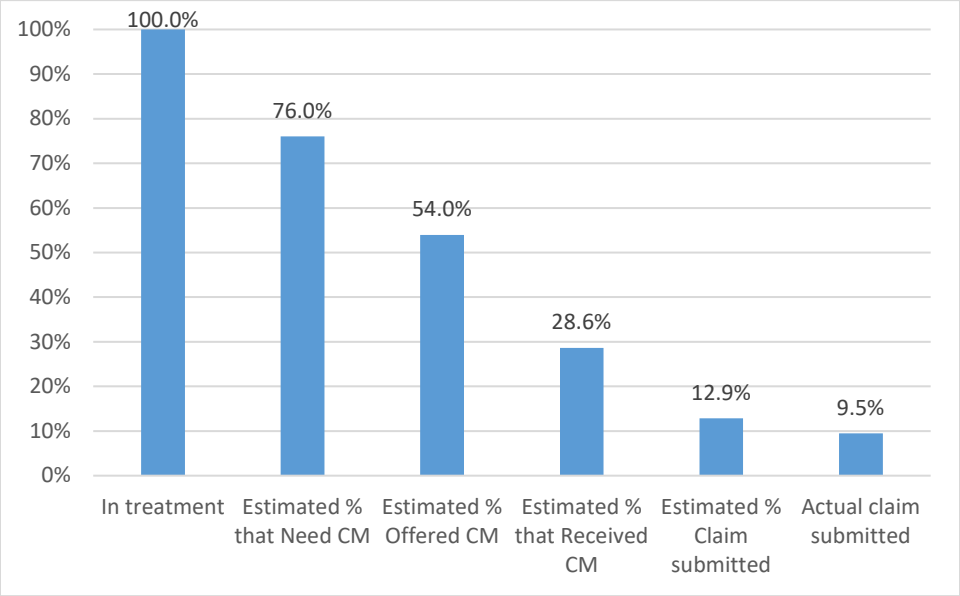
County administrators provided additional comments describing the impact of this benefit.

- "Case management was never tracked as a billable service. Now that it is an enhanced DMC ODS service our SUD counselors are utilizing case management often for linkages to care and transitions to other levels of treatment."
- "Case management has been made available at all levels of care, and it is having positive results in linking to MH care, supportive services, vocational and housing supports".
- "CM has impacted us the most in our use and formation of our Care Coordination Teams and movement of consumer through Residential and connecting to IOP/OT/RS. Has also impacted our ability to imbed SUD staff with MH teams for CM purposes (ex: Homeless outreach teams, Crisis Response Teams)".
- "Reimbursement for this activity [allows us]...to give proper training and attention to case management services for our beneficiaries."

In a series of survey questions, county administrators were asked to estimate what percentages of patients needed, were offered, and received case management services, and what percentage led to a DMC claim being submitted. Their perceptions, as well as the actual level of billing found in DMC data, is shown in Figure 3.25.

DMC-ODS waiver county administrators were asked to estimate the need, provision, and billing of case management services. On average, DMC-ODS waiver county administrators reported that 76% of their SUD patients need case management, yet about two-thirds of those patients are offered case management. About half of those receive case management, and under half submit a DMC claim for the service (12.9%), which was fairly close to the actual percentage of 9.5% found in DMC claims.

Figure 3.25: Reductions in case management services from treatment to claims.



County administrators were asked to indicate the most common reason people do not receive case management services. The second most common reason selected was patient preference (45.5%), but the most common was actually "Other" (54.5%).

The most common themes included:

- The lack of understanding the need for case management among both provider and patients.
- The difficult billing structure mechanism lending to the lack of documentation of the case management.

When asked if they had "Any additional thoughts about the implementation of case management under the DMC-ODS waiver," administrators provided answers again suggesting a need for clarification or reduced documentation.

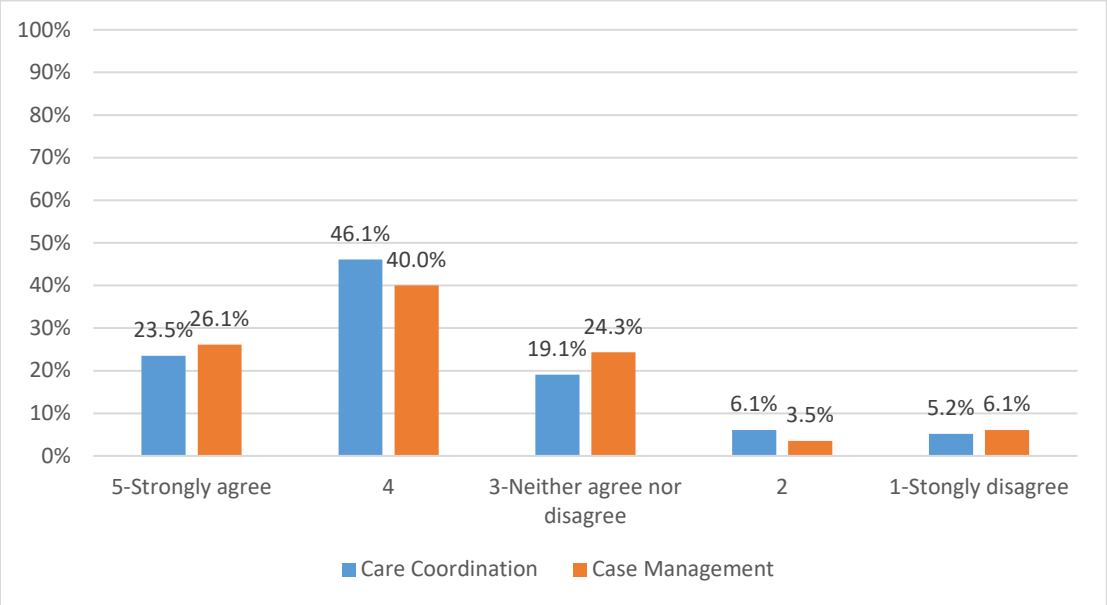
- "The structure of CM under DMC billing is not simple, just like Recovery Support Services this inhibits participation of providers, for a much needed set of services….".
- "SUD Providers have been overwhelmed with the documentation requirements of DMC and report that they do not have enough time to document these services. As a result, they often render this service yet do not receive reimbursement."
- "There is a substantial amount of case management provided before a beneficiary is admitted into treatment. I continue to recommend that it be claimable in the next iteration of the DMC-ODS (CalAIM). It is encouraging to see that those conversations are taking place."

- “It appears that Case Managers are "very busy", but I don't think they are claiming all of the services. This is due to either lack of documentation on the Case Managers part or because the service they are providing to the client doesn't seem to be billable (phone messages for example, letter writing, no show for appointments).”
- “Case management TA and training to the [providers] is helpful, because there is a high potential for disallowances due to insufficient documentation or “CM” services that are actually administrative functions and non-billable."
- “Helping providers understand how their counseling role is similar and different from case management. Some providers seem to be possessive about clients that receive services at their locations, while we try to emphasize that there is a lot of assistance that is needed.”
- “Providers are struggling with implementation. It would be beneficial if DHCS allowed centralized case management programs to be DMC certified for billing purposes so case managers could work with clients through the continuum of care.”

Provider Perceptions

As shown in Figure 3.26, Provider Survey responses were compared rating whether patients in their treatment program received adequate care coordination and adequate case management, using a 5-point Likert scale (1= Strongly disagree; 5= Strongly agree). Generally, rates were the same, with an average mean of 3.8 for both measures. This is a good indication that care coordination will improve as use of case management services increase. It is also a good indication that there is quite a bit of case management provided that does not get submitted as a claim.

Figure 3.26. Percent agreement that patients receive adequate case management services and care coordination at their location.



Exploratory Analysis of Case Management benefit and Patient Outcomes

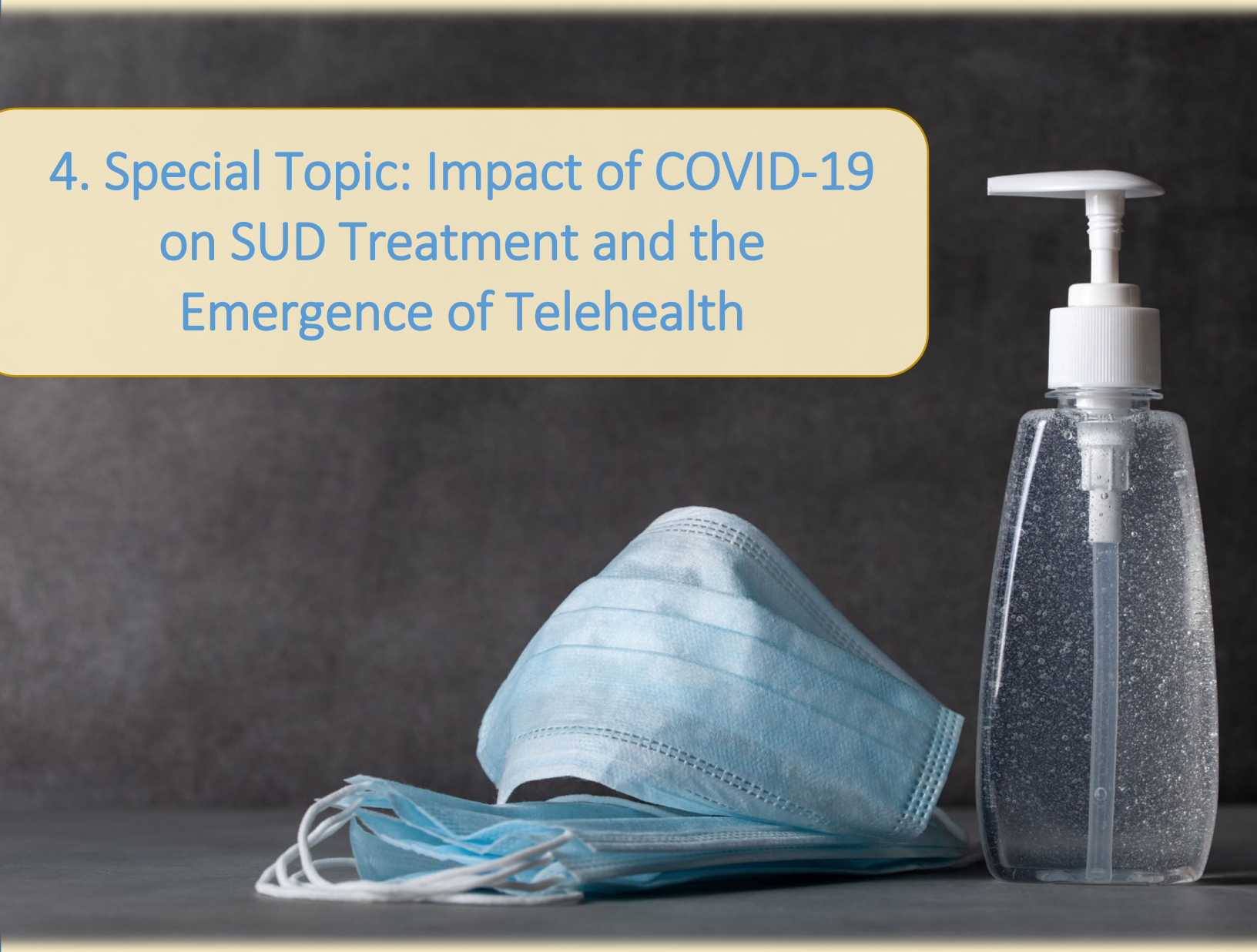
While utilization of the benefit continues to be low, further exploration was conducted to see if there were any trends regarding how counties are using the benefit and how counties can use this benefit in a meaningful way. There were slightly higher rates of case management provided to patients who had a mental health diagnosis and were receiving county mental health services, who had successful discharges, and who successfully transitioned to any level of care within 14 days after discharge. The size of these effects were very small (in the range of 1%-2%), and further analyses are needed to explore whether these effects may be due to factors other than case management, or alternatively whether the effects are being understated because unbilled case management is present to some extent in the "non-case management" comparison group.

Other Strategies to Improve Coordination

To improve coordination of care across the three systems (SUD, MH, and PH), it is important for counties to prioritize care coordination and develop plans toward improvement. In the 2020 DMC-ODS Waiver County Administrator Survey, 68.0% of counties reported conducting specific activities to improve coordination across the three systems (SUD, MH, and PH). While counties reported many challenges in coordinating care across systems, and most programs operate within a "coordinated care" IPAT level, qualitative comments yielded the following strategies to share with other counties to improve coordination across the three systems:

- Bring partners together regularly to collaborate, including health plan, FQHCs, ER patient navigator, DMC-ODS, and MHP. Discuss coordination, data exchange, MAT, conduct case conferences.
- Include physical exams on Treatment Plans.
- Include case management services as part of the screening. When level of care is determined, offer case management at that point where appropriate.
- Hire staff (case managers, build Care Coordination teams).
- Develop a Health Information Exchange (HIE) and utilize it to flag high utilizers for case management services.
- Develop care coordination policies and procedures, and conduct trainings on release of information, cross-system trainings, outcome measures, client engagement, and care coordination.

4. Special Topic: Impact of COVID-19 on SUD Treatment and the Emergence of Telehealth



Brittany Bass, Ph.D., Darren Urada, Ph.D., Anne B. Lee, LCSW, Cheryl Teruya, Ph.D., Vandana Joshi, Ph.D.

Introduction

The unprecedented COVID-19 pandemic has presented unique challenges, specifically with respect to SUD treatment. Data from the Centers for Disease Control and Prevention (CDC) suggest people have started or increased substance use to cope with stress or emotions related to COVID-19,[35] even as SUD treatment programs have themselves been affected by the virus.[36] Early data presented by Tarzana Treatment Centers suggested a large drop in demand followed by a return to normal by the summer.[37] This chapter describes the impact of COVID-19 and the field's adjustments to it.

Methods

To understand the impact of COVID-19 on DMC-ODS waiver county operations and patients, we analyze data from the COVID-19 County Administrator Survey, and Treatment Perceptions Survey.

To supplement the county-reported survey data, we augment our analysis of the impact of COVID-19 with data on patient admissions and discharges from CalOMS-Tx, comparing patient outcomes at admission and discharge from the pre-COVID period of March 19, 2019-May 31, 2019 to outcomes at admission and discharge from the post-COVID period of March 19, 2020-May 31, 2020.[38] Due to year 2020 data limitations, we are unable to extend the analysis past the month of May. Measures at admission include referral source, and service modality. Measures at discharge include unique discharges, and average time in treatment by service modality.

We focus on results from the surveys and CalOMS-Tx data for DMC-ODS waiver counties, as the results were generally similar, both quantitatively and qualitatively, for State Plan counties.

Results

Impact of COVID-19 on Treatment Admissions

DMC-ODS waiver counties indicated that access to and demand for SUD services had primarily decreased or remained unchanged as a result of COVID-19 (see Figure 4.1). Counties indicated

[35] CDC (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

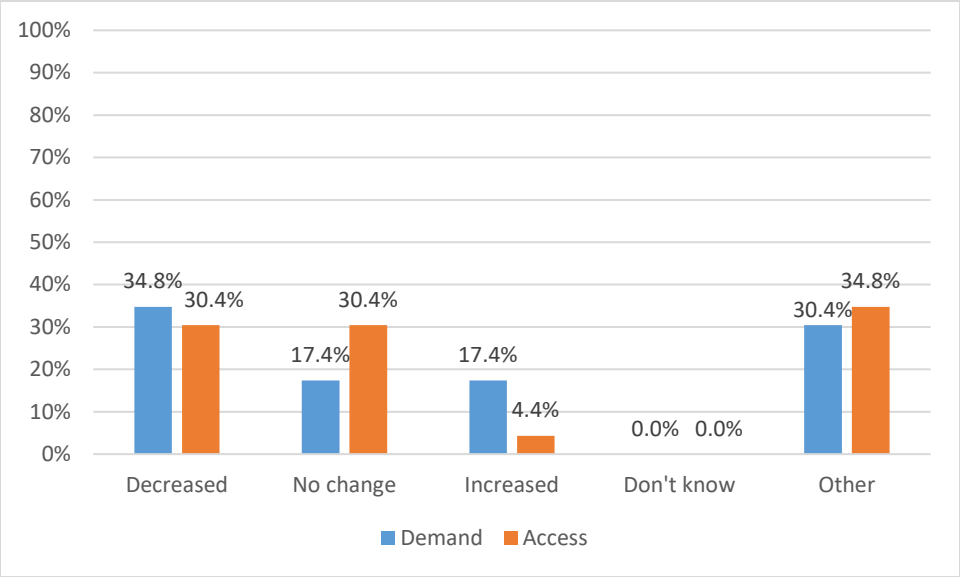
[36] COVID-19 Cases Reported in Behavioral Health Facilities. https://www.dhcs.ca.gov/dataandstats/Pages/COVID-19-DHCS-BH-Certified-Facilities.aspx

[37] Salazar, J. (2020). Impact of COVID-19 on Alcohol Consumption, Demand, and Access to Substance Use Disorder (SUD) Treatment Services. Webinar, October 29, 2020.

[38] We begin the analysis on March 19, the first day of the stat-at-home order issued by Governor Newsom. https://www.gov.ca.gov/2020/03/19/governor-gavin-newsom-issues-stay-at-home-order/

that, due to physical distancing requirements, access to residential treatment substantially decreased. However, some counties did report that demand for services seemingly increased during the later months of the early-pandemic stage (May 2020).

Figure 4.1. Impact of COVID-19 on demand and access.



Examples of comments include:

> "Several programs saw major increases in demand, majority saw decreases over time. Especially residential due to physical distancing requirements that limited the # of people a program could take in."

> "Once a COVID positive person- mostly staff- is found, the facility is quarantined as well which reduces ability to admit."

Analysis of admissions records from CalOMS-Tx support the survey feedback. There was a sizable reduction in admissions in March-May 2020 compared to the same period in 2019 (20,637 vs 29,349). This included reductions across all modalities, though intensive outpatient was less affected than other service types (see Table 4.1).

We also found large decreases in referrals across all referral sources. Referrals from schools, employers, and DUI/DWI sources saw the largest decrease in referrals at 84%, 71%, and 74%, respectively. Survey responses suggest county systems went through a very challenging period early in the pandemic, but that adjustments and innovations have helped mitigate these to some extent.

> "Working with schools . . . has been challenging as everything related to those services had to make the change to virtual platforms. There was an early "learning curve" with that. Also, Collaborative Court work was challenged as well due to lack of court accountability early in the pandemic and the suspension of drug testing during the early

months. Within the last 4-6 weeks we have seen a return to normalcy with the Collaborative Court Programs."

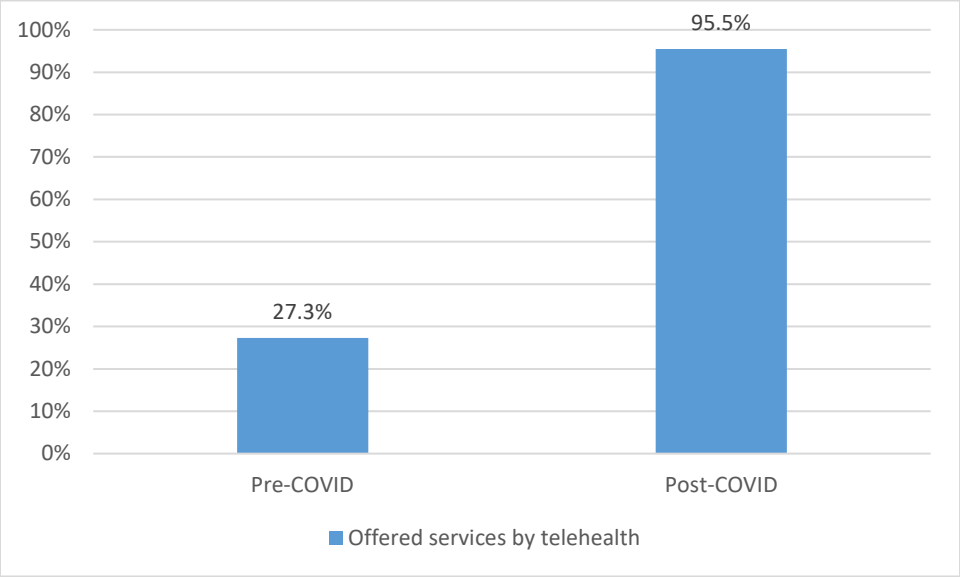
Table 4.1. Frequency of admissions pre- and post-COVID-19 by referral source and service modality.

	March 19, 2019 - May 31, 2019	March 19, 2020 - May 31, 2020	*% Change*
Outcomes - Admission			
Referral Source			
Individual	12,174	8,007	*-34%*
Alcohol/Drug Abuse Program	2,546	1,740	*-32%*
Other Health Care Provider	682	487	*-29%*
School/Educational	312	49	*-84%*
Employer/EAP	24	7	*-71%*
12 Step Mutual Aid	44	28	*-36%*
Probation or Parole	1,522	898	*-41%*
Post-Release Community Supervision	883	442	*-50%*
DUI/DWI	61	16	*-74%*
Adult Felon Drug Court	229	118	*-48%*
Dependency Drug Court	123	55	*-55%*
Court/Criminal Justice	1,874	885	*-53%*
Other Community Referral	2,470	1,531	*-38%*
Child Protective Services	1,023	820	*-20%*
Service Modality (Frequency)			
Intensive Outpatient	1,623	1,479	*-9%*
Outpatient	13,205	8,205	*-38%*
Narcotic Treatment Program (NTP/OTP)	4,005	2,506	*-37%*
Residential	5,762	3,660	*-36%*
Admission Observations	*29,349*	*20,637*	*-30%*

Impact of COVID-19 on Treatment Delivery

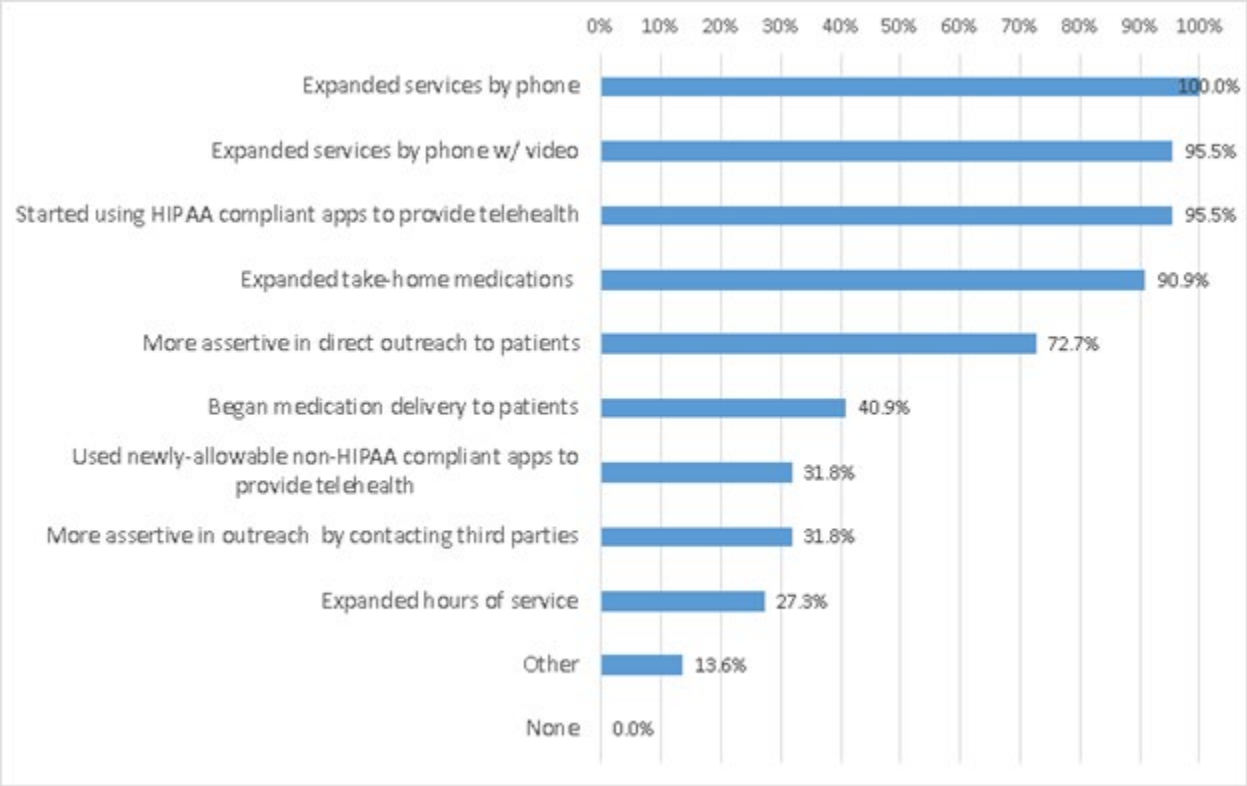
In response to COVID-19, providers in DMC-ODS waiver counties made a number of changes to their services provided. Figure 4.2 shows that nearly 100% of DMC-ODS waiver counties expanded services by telehealth. Prior to COVID-19, only 27.3% of DMC-ODS waiver counties indicated they offered treatment by telehealth.

Figure 4.2. Telehealth service offering pre- and post-COVID-19.



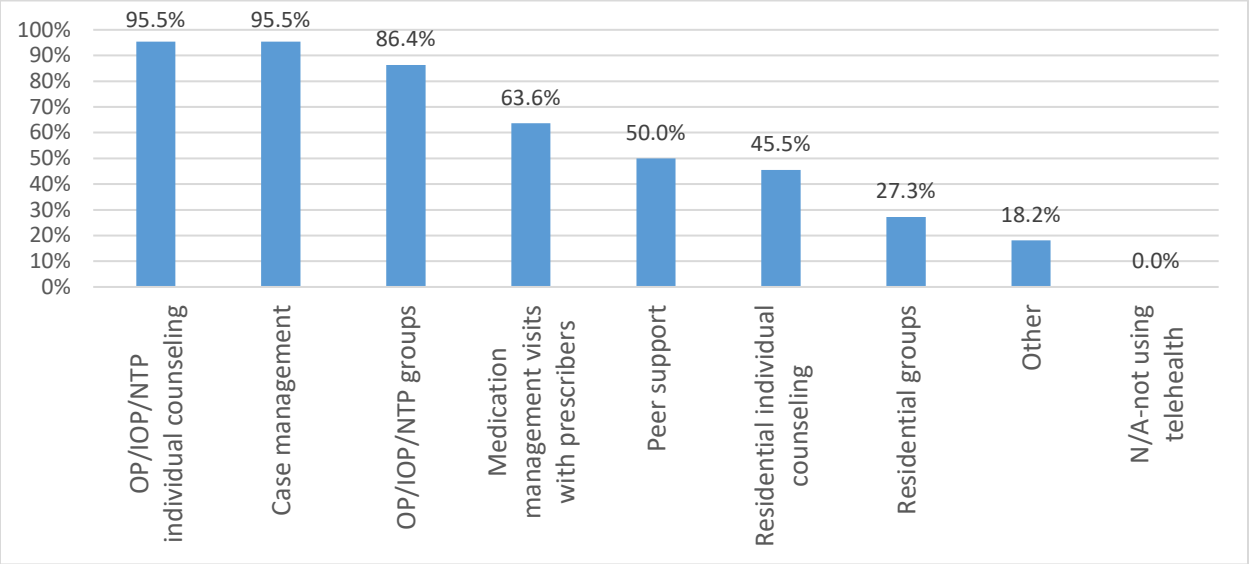
In response to COVID-19 and new flexibilities made available by the associated federal declaration of a Public Health Emergency, nearly all counties began using HIPAA-compliant applications to provide telehealth and expanded take-home medications for stable patients. Nearly three quarters reported becoming more assertive in direct outreach to patients by phone, email, or text. A smaller percentage of counties implemented medication delivery to patients, began using non-HIPAA compliant applications to provide telehealth, were more assertive in outreach to patients by contacting third parties, and expanded hours of service. See Figure 4.3.

Figure 4.3. Changes made by DMC-ODS waiver counties in response to COVID-19.



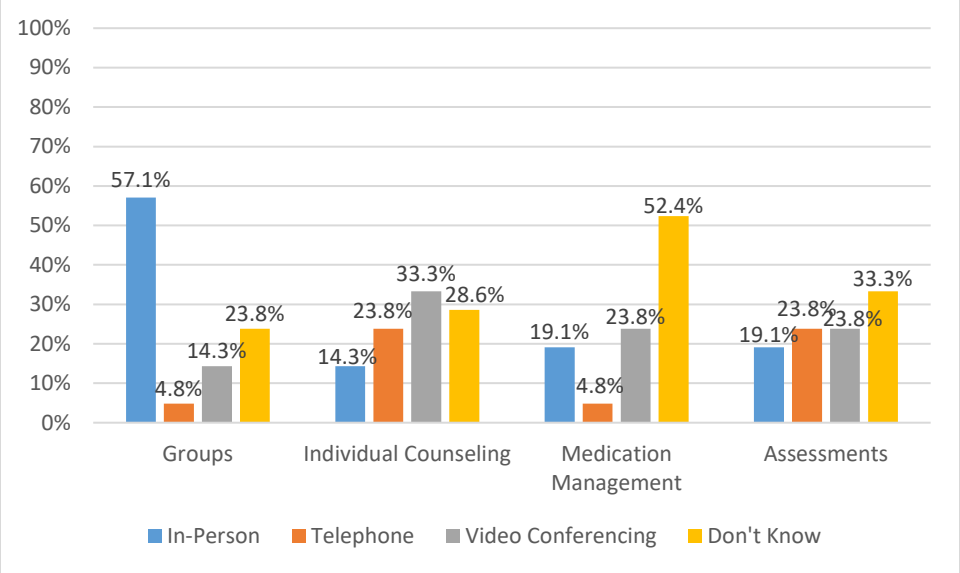
Regarding primary uses of telehealth by DMC-ODS waiver counties (see Figure 4.4), nearly all counties indicated telehealth was used for outpatient individual and group counseling as well as for case management. Nearly two-thirds use it for medication management visits with prescribers, and half use it for peer support.

Figure 4.4. How providers are using telehealth.



Concerning preferred type of delivery for certain services (Figure 4.5), DMC-ODS waiver counties overwhelmingly indicated in-person settings were preferred for groups, while telehealth (telephone or video conferencing) was less preferred for groups. For individual counseling telehealth was actually preferred over in-person settings. Counties also reported that delivery preferences varied depending on the patient population (e.g., youth vs adult) and barriers for the patient (e.g., accountability and privacy, and internet and/or phone access).

Figure 4.5. Preferred type of delivery by service.



Examples of comments included:

> "We hear both sides of all of these except groups: so far people say everyone prefers groups to be in person."
>
> "It really depends on the population. For our DUI clients, video conferencing and telephone are preferred over in-person. For non-perinatal adult SUD patients, telephone or video conferencing is preferred for most services but our perinatal and youth populations have been struggling with telehealth services."

Importantly, among all domains, average adult Treatment Perception Survey scores were highest when services were exclusively performed by telehealth (see Figure 4.6), though the differences by degree of telehealth use were very small. For youth, average scores among all domains, with the exception of Access, were highest when about half of services were performed by telehealth (see Figure 4.7). These results suggest that the transition of services to telehealth due to COVID-19 did not have a negative effect on treatment perceptions.

Figure 4.6. TPS adult by telehealth.

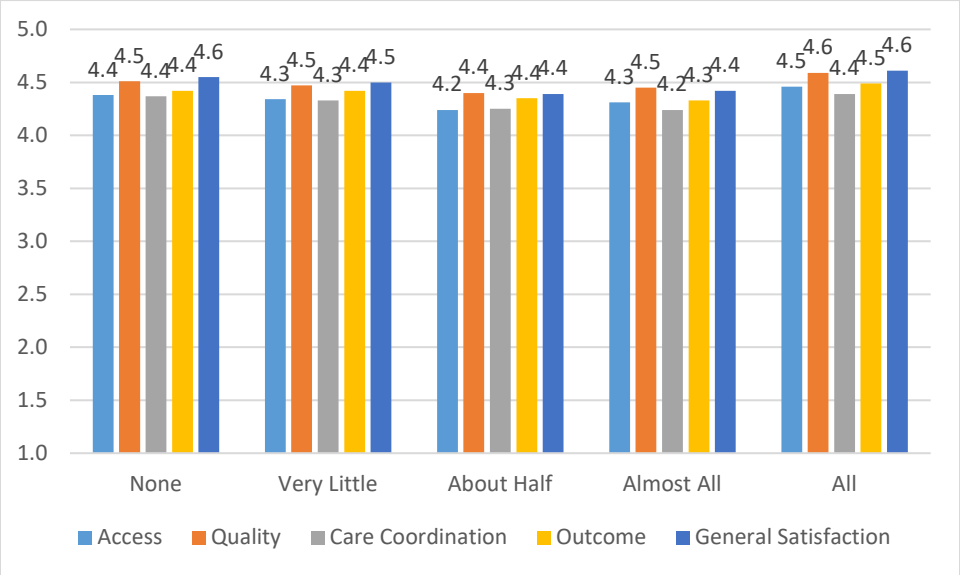
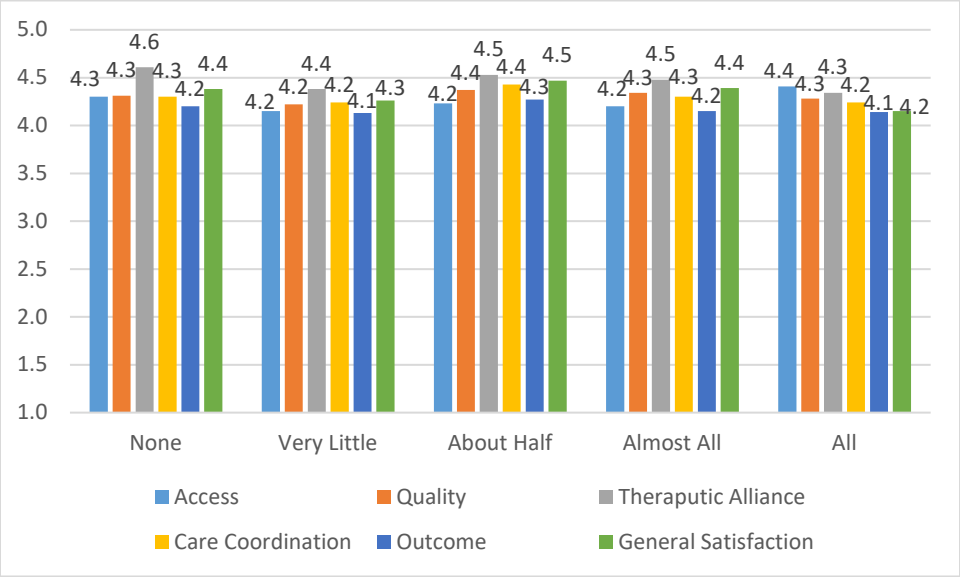
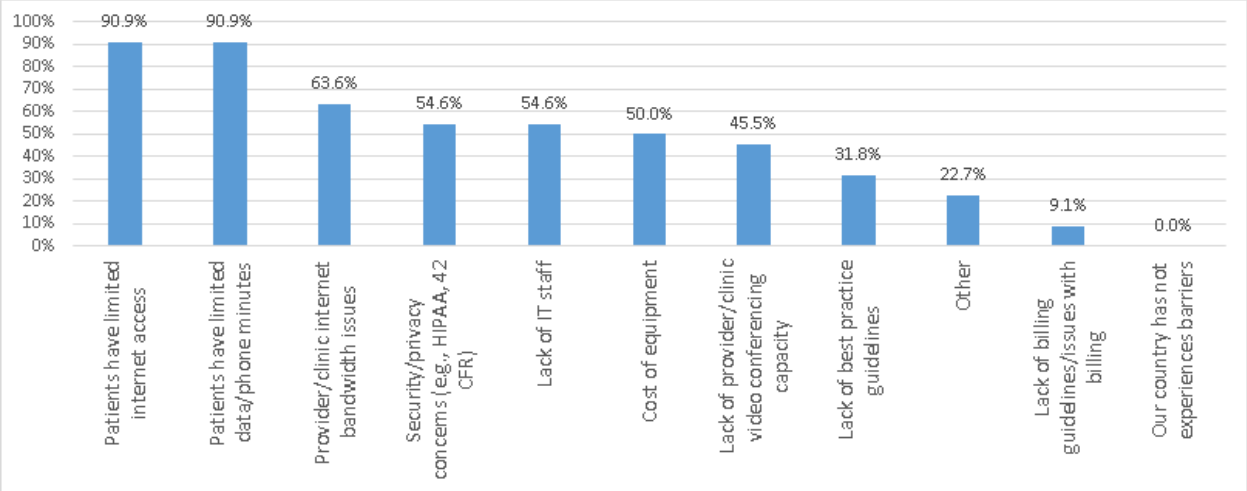


Figure 4.7. TPS youth by telehealth.



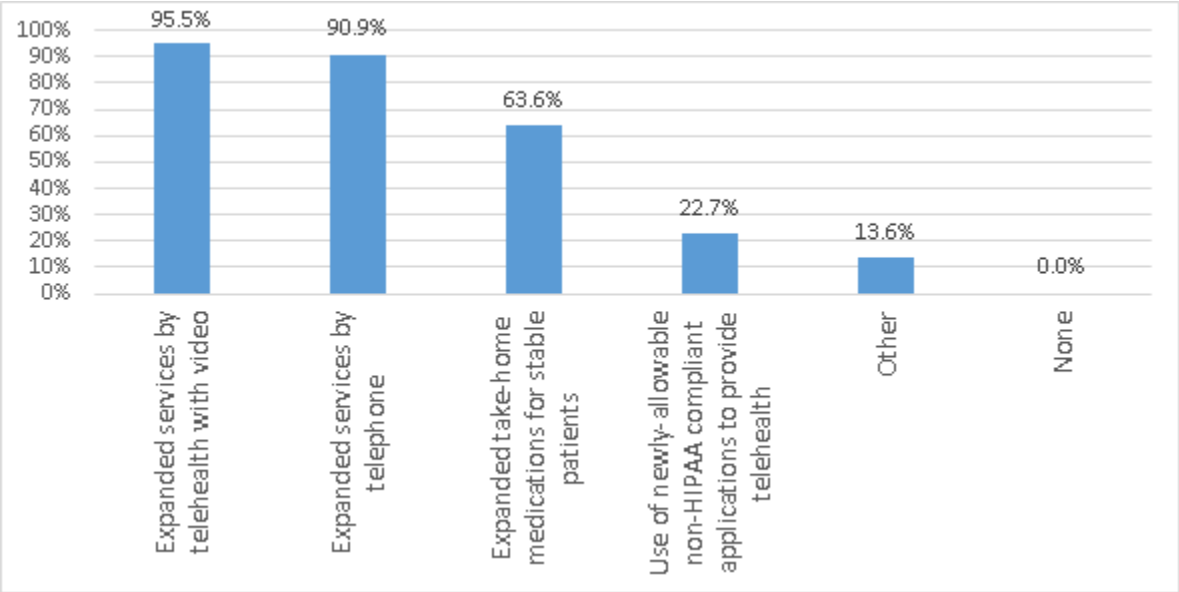
Despite the rapid increase in the use of telehealth due to COVID-19, counties experienced significant barriers towards telehealth when delivering SUD services (see Figure 4.8). The two main obstacles were limited patient internet access and data/phone minutes. Provider/clinic internet bandwidth, security and privacy concerns, lack of IT staff, cost of equipment, provider/clinic video conferencing capacity, and lack of best practice guidelines also presented issues. Additionally, counties stated that a lack of patient access to phones or tablets impeded the use of telehealth. Moreover, 77.3% of counties stated they would like to receive clinical training or technical assistance (e.g., establishing rapport, how to effectively deliver treatment via telehealth) on delivering services by telehealth.

Figure 4.8. Barriers using telehealth.



Nearly all DMC-ODS waiver counties indicated that they would plan to continue services by telephone and telehealth with video, and nearly two-thirds would continue take-home medications for stable patients beyond the COVID-19 pandemic if allowed (see Figure 4.9).

Figure 4.9. Continue service past COVID-19 if allowed.



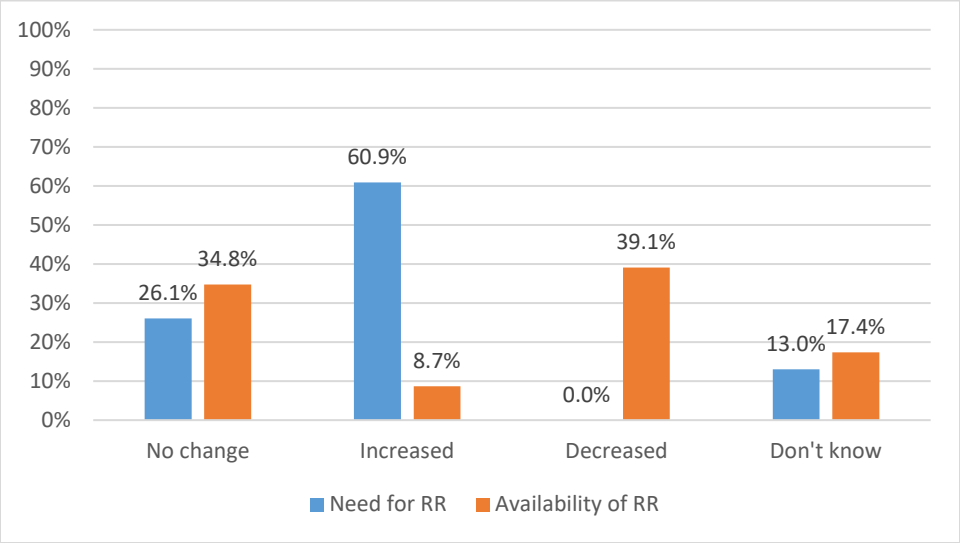
Also, 63.6% of county administrator survey respondents indicated a lapse in these temporary flexibilities during the COVID-19 pandemic would significantly impact their counties. Specifically, respondents stated that flexibilities related to telehealth have "been paramount to ensuring continuity of care and access to services", and a loss of telehealth would inhibit counties from providing necessary services to their patients.

Recovery Residences

A majority of DMC-ODS waiver counties indicated the *need* for recovery residences has increased due to COVID-19, while the *availability* of recovery residences has primarily decreased or remained unchanged (see Figure 4.10). When asked if there are enough recovery residences to meet the need for these services during the pandemic, 87% of DMC-ODS waiver counties stated no, and cited insufficient housing or bed supply as the primary reasons. One county described trying to increase availability but still falling short:

> "Despite increasing the availability--both by funding additional beds and providing "emergency" funding to continue a higher subsidy if beneficiaries lost income due to COVID--there is still insufficient SLE capacity to meet the needs."

Figure 4.10. Impact of COVID-19 on the need and availability of recovery residences.



For more on recovery residences and homelessness, see Chapter 8 in this report.

Outcomes

Panel I of Table 4.2 presents the frequencies and percentage change over time for outcomes at discharge. Compared to the pre-COVID period, the number of unique patient discharges decreased by about 3,000. Breaking down time in treatment by service modality, there was an increase in the average number of days patients spent in intensive outpatient programs, outpatient programs, and residential treatment post-COVID compared to the pre-COVID period. This increase in length of stay could be driven by the expansion of telehealth services, and take-home medications for stable clients.

Panel II of Table 4.2 presents frequencies for methadone patients at admission and discharge pre- and post-COVID. Specifically, the number of patients admitted who received methadone between January and March of 2019 and 2020, and the number of methadone patients who were admitted during that time period and then subsequently discharged between April and May of 2019 and 2020 are presented. There was a decrease in the number of methadone patient admissions post-COVID, and a decrease in the number of methadone patients discharged post-COVID. These results may suggest that the availability of take-home medications made staying in treatment easier for these patients. Additionally, there was no evidence that deaths increased post-COVID, suggesting that take-home medications did not increase the probability of a fatal overdose.

Table 4.2. Frequency of discharges pre- and post-COVID-19.

Panel I: Outcomes - Discharge	**March 19, 2019 - May 31, 2019**	**March 19, 2020 - May 31, 2020**	***% Change***
# Unique Discharges	20,086	13,682	*-32%*
# Total Discharges	21,729	14,613	*-33%*
Retention by Service Modality (Average Days)			
Intensive Outpatient	67.5	88.5	*31%*
Outpatient	138.2	141.9	*3%*
Narcotic Treatment Program (NTP)	270.4	258.6	*-4%*
Residential	51.2	54.5	*6%*
Panel II: Methadone Patients	**Pre-COVID (2019)**	**Post-COVID (2020)**	
# patients admitted and put on methadone (Jan-Mar)	5,917	5,156	*-13%*
# methadone patients discharged Apr-May	899	623	*-31%*
% discharged	15.2%	12.0%	*-21%*
Notes: Number of observations at discharge differ based on outcomes, thus not reported. The sample is for Medi-Cal beneficiaries only.			

Conclusions

Taken together, the survey and CalOMS-Tx results show that COVID-19 had a substantial impact on DMC-ODS waiver counties during the three-month period we were able to examine. Specifically, the COVID-19 pandemic caused a rapid shift in the delivery of treatment services from in-person to telehealth. Both counties and patients reported a high satisfaction with the use of telehealth, and counties hope to continue its use beyond the COVID-19 pandemic. However, significant patient barriers exist, specifically regarding access to reliable internet services and tablets/phones. Additionally, there was suggestive evidence that flexibilities related to take-home medications may have increased retention among methadone patients, without increasing fatal overdoses. Counties also appear eager to continue this service past the COVID-19 pandemic.

Furthermore, DMC-ODS waiver counties indicated that COVID-19 has considerably impacted the need and availability of recovery residences, with counties attributing the lack of availability to insufficient housing and bed supply.

Although these recommendations require funding, the COVID-19 relief bill passed in December 2020 provided expanded funding of the SAPT block grant[39] that could potentially be used to implement these recommendations.

Recommendations for DHCS:

[39] Knopf (2021). $2.3 trillion spending bill includes COVID-19 relief, adding $1.65 billion to SAPT BG. Available at: https://onlinelibrary.wiley.com/doi/full/10.1002/adaw.32933?campaign=woletoc

- Extend the flexibilities surrounding the use of telehealth for SUD services beyond the pandemic. Flexibilities such as allowing the use of telehealth in 1915(c) waiver populations can be extended through a State Plan Amendment (SPA) or a modified 1915(c) waiver, or permanently extended through state action, according to CMS. [40]
- Address barriers patients experience with the use of telehealth, possibly including efforts to facilitate linkage to the Lifeline program coupled with assistance with mobile data plans for people in treatment, for example.
- Extend the flexibilities related to take-home medication for stable patients beyond the pandemic.
- Expand efforts to increase recovery residence housing and bed supply.

[40] CMS (2020). Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf

5. Special Topic: Lessons for Future DMC-ODS Regional Models

Anne B. Lee, LCSW, Cheryl Teruya, Ph.D., Darren Urada, Ph.D., Elise Tran, B.A.

Introduction

This chapter focuses on the Partnership HealthPlan of California (PHC) Wellness and Recovery Program (the first and only DMC-ODS regional model to date) which was launched on July 1, 2020. Throughout this chapter it will be referred to as the PHC W&R Program. Partnership HealthPlan of California (PHC) is a non-profit community-based health care organization that contracts with the State of California and local counties to administer Medi-Cal benefits. PHC came together with the seven member counties to create the Wellness and Recovery Program regional model.

This chapter focuses the unique challenges and strengths of the PHC W&R Program regional model of SUD treatment delivery from the perspective of the PHC W&R program manager. UCLA ISAP conducted an interview with the W& R program manager which was analyzed for themes regarding recommendations for implementation of a regional model in the future with other counties. Additionally, data collected with the PHC W&R County Administrator Survey from five of the seven PHC W&R Program Counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) is used to explore the following topics: access to care; screening and placement practices; services and training; quality of care; collaboration, coordination, and integration of services; and DMC-ODS waiver implementation preparation/status.

Methods

Between May through December 2020, Key Informant Interviews were conducted with county and regional model administrators. PHC W&R County Administrator Survey responses were collected from November to December, 2020. Responses were received from five of seven PHC W&R counties (71% response rate), including one incomplete survey. For information on the methods please refer to the Methodology chapter (Chapter 2) subsection “UCLA evaluation data collection activities”.

Results

Background of Partnership Health Care Plan Regional Model

In the PHC W& R program model, PHC provided all the administrative support and administered all of the managed care responsibilities for the W&R program. PHC then contracted with the counties and providers to provide all SUD treatment. There is a central BAL call center run by Beacon, and patients can receive treatment in any county in the PHC W&R program, with the exception of perinatal services, which are tethered to the county of residence.

According to the PHC W&R program manager, the program launch was delayed due to several reasons. First, PHC had difficulty getting approval for their proposed fiscal plan from DHCS, as it was the first regional model under the DMC-ODS waiver and was very different from the single-county plans used by every other county to date. Second, there was difficulty getting multiple county service delivery systems on the same page regarding their expectations of how

the PHC W&R program would work. Third, the fiscal model proposed in the PHC W&R program may have made some counties feel uncertain about the cost effectiveness of joining the PHC plan.

For example, when counties dropped out of the regional model it was largely due to concerns about costs and loss of fiscal control. These concerns may inhibit future counties from considering a regional model for themselves. The PHC W&R program manager explained;

"I think some of [the reason counties dropped out of the regional model] was fiscal because they were concerned that it was going to cost them more money. Honestly, I think that some of it was control because the counties rely on us to set up the network, determine medical necessity, get people into treatment, and so there was some loss of control there about the money. On the one hand, we're drawing down more federal dollars for them because we've got the structure in place and it's uniformly applied everywhere."

Adding to concerns about costs was the fact that counties had to project their beneficiaries' service needs based on limited information so they could not make informed comparisons about the effect of joining the DMC-ODS Waiver via the PHC W&R Program versus how cost effective it was to remain a State Plan county. One PHC W&R county administrator commented on the PHC W&R Program County Administrator Survey, "All of the financials were based on speculative models and this could be a very expensive system that is not sustainable. In her Key Informant Interview, the PHC W&R program manager explained:

> "It's difficult for [counties] to project their usage. We had no idea how many people were going to be using the benefit. … The documentation that the state was planning to rely on to determine usage, which was the cost reports ... in some cases they weren't really accurate. … We really couldn't rely on those things. We made our best guess at what usage was going to be and some of the counties I think, were more risk averse, especially some of the small counties. They have such a small pot of money to work with, that they were concerned about giving up control."

Stakeholder feelings are mixed about the per use, per month plan (PUPM) used by PHC W&R. While some stakeholders liked it, one stakeholder also suggested future regional models may not want to use the PUPM. While it appropriately puts responsibility of keeping costs down on providers, counties have struggled with it, and it may be easier for them to provide fee for service. A stakeholder also suggested that an ideal planning process for future regional models would include a committee with DHCS, the managed care plan, and counties at the table to figure out the fiscal plan as well as anticipated cost.

However, one remedy for the initial hesitation to participate in the regional model was that several county administrators were champions of the model and communicated its potential financial benefits to stakeholders. The PHC W&R program manager posited that it would be important for future counties to recruit local champions as well, to smooth the implementation process.

> "[Counties] really were nervous about the fiscal structure especially. [Our local champions] were the ones who really spent the time to explain it to the behavioral health director, the HHS director, at the different counties to keep them interested."

Importantly, discussions with PHC suggested a regional model like PHC W&R is only feasible in one-plan counties or County Organized Health Systems (COHS). In counties with multiple managed care plans, it is likely that the coordination required would be overwhelming.

Strengths and Challenges of the PHC W&R Plan

Strengths

The W&R program manager and county administrators identified several strengths of the regional model. PHC manages physical health, SUD, and mild to moderate mental health care services (individual counties manage care for beneficiaries with SMI). The PHC W&R program manager maintained that the benefit of this design is that it enables PHC W&R counties to deliver co-located MH and SUD care for beneficiaries.

> "The only service we [PHC] are not responsible for is county-level mental health services. If somebody's on Partnership and they come in with a mental illness or mental health symptoms, we expect the SUD provider to reach out to the Beacon provider. ... We've also encouraged our SUD providers to get an LCSW or an LMFT, who is a Beacon provider to co-locate in their facility. Then, all of the mental health services they provide can be billed to Beacon. Then, they can case plan with the SUD treatment program for that individual. The person gets all their services in one location."

Additionally, according to the program manager, the PHC W&R program allows rapid triage to the appropriate level of care by leveraging resources in all PHC W&R member counties.

> "It's also been super helpful that somebody from Modoc County who needs to get into residential can get connected to a treatment provider in Humboldt and just make that happen. Because we're all in one regional pot and there's not a lot of discussion about, well, do we have to get a contract with them? How would that work? It takes 12 months to get a contract with this county and all of that stuff that happens. All of that goes away."

Also, PHC W&R program allows for more flexibility to provide evidenced based practices like contingency management that might otherwise be impossible to fund through standard State Plan channels. The program manager explained:

> "Contingency management [is a] great idea, but I cannot imagine [another] county going to their Board of Supervisors and saying, 'We want to buy Starbucks cards that we're going to give to these people who are using substances.' Having it done through Partnership, there's a separation. The contract is between us and the county. We don't tell them how we're spending every dime. We just turn around and contract with the

> provider, and we can build into it, incentives for contingency management. It never goes to the Board of Supervisors."

Another benefit of the PHC W&R program was that PHC W&R member counties did not have the heavy lift of implementing new policies and procedures or hiring new staff for requirements like quality improvement activities, as PHC already had those policies, procedures and staff in place. According to the PHC W&R program manager:

> "In regard to the quality improvement committee and plan structure, Partnership already does that. … That's something that's been really easy for us to put together. … I don't think it was so easy for [member counties] to really wrap their head around quality activities. Partnership was already used to … meet[ing] certain requirements on these measures."

Generally, respondents to the PHC W&R County Administrator Survey agreed with the PHC program manager's perspective. One PHC W&R county administrator wrote: "Not only would the network adequacy requirements have made this impossible, the administrative requirements would have been so demanding on our system we would have had to completely reorganize and this may not have been fiscally viable." In fact, only one member county administrator felt they could have been part of the DMC-ODS waiver without the administrative support of the regional model.

Respondents to the PHC W&R County Administrator Survey shared other advantages of being a part of the PHC W&R program, including:

- "Seven really great counties to work with"
- "Strong collaboration with DHCS and PHC"
- "Less burden on providers from multiple monitoring visits"
- "Streamlined services for clients and access to all levels of treatment for all beneficiaries"
- "Administrative support"
- "My job is easier since Partnership does so many administrative tasks"

Challenges

The PHC W&R program manager also reflected on challenges inherent in the PHC W&R program, and had many recommendations to facilitate future implementation of a regional model in other counties. For example, policies and procedures should be streamlined and consistent across all three care delivery systems, MH, PH and SUD.

> "There's the rules on the physical health side, and then there's the rules on mental health and substance use. . .. An example is grievances. . .. [on the MH/SUD side] we have to report within 15 days of the end of the quarter, where on the physical health side, we report [within] like 30 days. There are categories on the physical health side of grievances that have no relation to the categories on the substance use side. . . I asked in the last meeting we had with the state if they could coordinate so that their categories are

the same. Or at least a subset of the ones on the physical health side. This was the first they had heard that new categories were being developed for grievances on the physical health side. If they would talk to one another, that'd be great."

Also, the system DHCS uses to communicate with counties about the DMC-ODS waiver is not oriented to working with a managed care plan that covers several counties in a regional model. The W&R program administration had difficulty establishing direct communication about the DMC-ODS waiver with DHCS, rather than communications going through the individual counties first.

> "DHCS needs to change the perception of who their audience is. They send e-mails to the counties. They do not send e-mails to Partnership [W&R]…. Then, the counties have to forward them to us….There are other partners that need to be included. … There are just so many people who say, "Well, I have to talk to the counties. The county is my customer." It just gets frustrating because then the counties turn around [to PHC] and say, "They're asking us this thing and we don't know what the answer is."

The PHC W&R program manager also recommends standardizing and clarifying the process of moving a beneficiary's Medi-Cal county of residence from one county to another.

> "The way that the eligibility issues are dealt with by the state, where it's all driven by the local counties, some of which are going to transfer their Medi-Cal quickly, and some of which are not going to transfer their Medi-Cal for months, it is really a problem. I wish that they would address that instead of relying on the counties to figure out how they're going to deal with it. Some counties say, 'Sure, any county can start the process to get your Medi-Cal moved to a different county.' Other counties say, "No, no, it has to be the sending county."

> "People are much more mobile than the state acknowledges. It's caused problems for us. We have one provider in Lake County whose right across the border from Mendocino. Mendocino is one of the regional model counties and Lake is not."

Regional SUD Service Delivery under the DMC-ODS Waiver

Access to care

All four respondents to the PHC W&R County Administrator Surveys agreed that the DMC-ODS waiver increased access to SUD services in their region. In qualitative survey responses, PHC W&R county administrators reported that specifically, the DMC-ODS waiver has lowered barriers to treatment and increased access to detox and residential services. Also, since beneficiaries can now immediately access the appropriate LOC, rather than only the LOC that is available in their county, the PHC W&R program has shifted the patient census into different modalities than were utilized prior to the DMC-ODS waiver.

> "[The DMC-ODS waiver] has helped with residential and adding outpatient services, but we have actually decreased [delivery of] outpatient services from what we had pre-ODS, probably because we were serving [patients who needed] a residential LOC in outpatient under State Plan DMC."

Three out of four respondents to the PHC W&R County Administrator Survey agreed that the DMC-ODS waiver increased access to youth SUD services in their region. While two out of four respondents agreed that the DMC-ODS waiver increased access to perinatal SUD services, W&R county administrators report that a regional approach for perinatal services has challenges. One administrator wrote that perinatal care delivery is difficult as for perinatal patients, "only the SUD treatment is authorized for another county, the MH and medical care still must be provided in county of residence."

Beneficiary Access Line

As required all DMC-ODS waiver counties, PHC W&R program created a BAL. Two of four respondents to the PHC W&R County Administrator Survey felt that a 24/7 telephone beneficiary access line (BAL) was important to increase access to SUD services in the county, while one felt it was not important and another responded they were "not sure" of the importance of a BAL line.

On average, respondents to the PHC W&R County Administrator Survey estimated that 63% (range= 40% to 100%) of beneficiaries in used the BAL to access SUD services.

According to W&R county administrators, the BAL in PHC W&R counties has had a few challenges. First, beneficiaries had some confusion about what the BAL offered. Second, W&R county administrators would have preferred that Beacon could have managed all three services systems, mental health, physical health as well as SUD. Third, having a BAL that covers such a large geographical area, inhibits the ability of Beacon to have deep knowledge of local services.

> "Beacon has been contracted to run the BAL by Partnership for our seven counties. There have been challenges and misunderstandings for our beneficiaries. There has also been confusion about the services being requested by the clients. It would be amazing if the BAL, run by Partnership, could also help coordinate care for a client's MH and medical needs."

> "The BAL that is centralized with the regional plan is not great since it spans so many regions; it is not specific to the local needs of the callers."

Referrals

PHC W&R county administrators were asked about other entry points for SUD treatment and all four respondents replied that they have established referral proceeds from emergency departments and jails, while none have an established referral process from prisons. On average, PHC W&R county administrators felt that about that only about half (53%, range 10%-90%) of patients who need SUD treatment are getting referred from the jails and emergency departments.

Quality

Only half of the respondents to the PHC W&R County Administrator Survey agreed that the DMC-ODS waiver positively impacted quality improvement (QI) activities for SUD. The administrators who reported that it was helpful added, "by implementing the ASAM [Criteria-based assessments] we are addressing the client as a whole, meaning physical health as well, which was really never addressed" and another respondent reported that the "simplification of contracting for providers", "training and monitoring resources," and "standardization of processes" was helpful.

The PHC W&R program manager reported that the regional model allows the PHC W&R to incentivize higher quality service which would not be possible outside of a managed care plan.

> "We just rolled out a QIP, a quality incentive program this morning. Our board approved a million dollars that will go to these SUD providers if they meet certain benchmarks in serving people with co-occurring conditions. That's kind of the way that Partnership does quality is we incentivize certain preferred activity. … We reward the behavior that we want. I do think we're taking a much different approach to quality….It is because the county could never do something like that. It would go to the board of supervisors and the board would shoot it down in a minute. We don't have those kinds of restrictions on us being a managed care plan. That is another benefit I think of working through a managed care plan."

ASAM Criteria-based Screening and Assessment

Half of respondents to the PHC W&R County Administrator Survey reported that they used ASAM Continuum® Triage as a brief initial screen. The other half reported that Brief initials screens were performed by the subcontractor Beacon Health with a screener developed by Beacon.

Two of four of respondents reported that they used the ASAM Continuum® as a full ASAM multi-dimensional bio-psychosocial assessment while one county reported using an ASAM Criteria-based tool developed within their county and another respondent reported they used and ASAM Criteria-based tool adapted from another county.

Training and Technical Assistance

According to four respondents to the W&R County Administrator Survey, the following topics are the highest priority for training or technical assistance:

- CalOMS-Tx data collection and data integrity
- DMC-ODS waiver requirements
- Drug Medi-Cal billing
- Medical necessity and utilization review procedures
- Relapse prevention
- Trauma-informed treatment
- Buprenorphine

- Naloxone
- ASAM Criteria-based assessment and placement
- Case management
- Cultural competency
- Youth services
- Cannabis
- Perinatal services
- Methamphetamine
- Contingency management

Care Coordination & Cross County Collaboration

Three out of four respondents reported that they did not have administrative challenges with patients presenting for treatment that are not residents of their county. When asked what strategies have been used to manage these challenges, PHC W&R county administrators wrote,

> "We are using this first year of our pilot to determine who may present for care that is not a beneficiary of our county. If it is a question of eligibility, we help them get connected appropriately. If it is a question of residency, we will use our network to help determine appropriate connections to services."

All four PHC W&R County Administrator Survey respondents reported that their county conducted activities to improve coordination across the three systems of SUD, MH, and physical health (e.g., regular meetings, health information exchange [HIE], universal release of information [ROI], case conferences, cross-system trainings). PHC W&R County Administrator Survey respondents wrote, "We have not established formal processes, just found what works on a client by client basis. Multi-party bi-directional ROI, case conferences, some HIE (in conjunction with our Whole Person Care pilot) and cross-system training has been beneficial.

While three out of four respondents report that their county tracked patients "well" or "very well" within the SUD system since joining the DMC-ODS waiver, one county administrator in the PHC W&R program felt they tracked patients "poorly". One respondent wrote that a benefit of the PHC W&R program was much improved ability to follow through care coordination.

> "Partnership Health Plan [PHC] is able to monitor the engagement in services between the various levels. Instead of just tracking a referral made, they are able to also monitor the follow through. There are still gaps in our providers' ability/knowledge about utilizing the levels of care effectively and making timely referrals and handoffs."

All respondents felt that SUD and MH services are "well" or "very well" integrated in their county. None of the respondents reported that the DMC-ODS waiver positively impacted the integration of SUD and MH services in their counties as they "have always been integrated with MH".

While MH and SUD care is reported to be more integrated than PH and SUD in PHC plan counties, there may be more integration developing as the PHC member counties become more experienced with the PHC regional model.

Only one out of four PHC County Administrator Survey respondents agreed that the DMC-ODS waiver positively impacted the integration of SUD and physical health services in their counties. One PHC W&R county administrator explained,

> "There has been good collaboration and coordination, but not yet true integration. Many of the FQHCs are providing MAT services but not as part of DMC-ODS. As we are only 5 months or so into our DMC-ODS experience we are just finding ways to better collaborate for both physical and MH services with our SUD clients."

Conclusions

Recommendations for DHCS to Support Future Regional Model Plans

The following recommendations were drawn from the W&R program administrator Key Informant Interview and the W&R County Administrator Survey

- Assist counties with implementation plans and rate setting so they can be approved and go live more quickly.
- Identify and engage local county champions to assist in development and implementation of the regional model.
- Assist counties with projecting usage and doing the cost benefit analysis of joining DMC-ODS waiver under a regional managed care plan to be confident that joining is cost-effective.
- Streamline and create consistent DHCS requirements, policies, and procedures across all three care delivery systems, MH, PH and SUD; as well as for eligibility issues and moving beneficiaries from one county to another in order to facilitate managed care plans administration of the regional model.
- Include managed care plan administrators in statewide communication regarding the DMC-ODS waiver.
- Invest in technology and infrastructure to improve telehealth delivery in poor rural counties where there are insufficient IT staff, lack of bandwidth, and lack of access to devices.
- Address portability of perinatal care to be available throughout regional model counties, not just the county of residence.
- Support regional models in providing contingency management, provider incentives and other quality improvement activities that have historically been successful practices in managed care plans.

6. Special Topic: What Current State Plan Counties Would Need to Join DMC-ODS

Anne B. Lee, LCSW, Cheryl Teruya, Ph.D., Darren Urada, Ph.D., Elise Tran, B.A.

Introduction

This chapter focuses on the unique Key Informant Interview responses of four State Plan county administrators and staff from three counties. The primary goal of the Key Informant Interviews with administrators of State Plan counties was to understand the challenges and strengths of State Plan SUD treatment delivery systems compared to DMC-ODS waivered counties. Another goal of these interviews was to explore the support they would need if they were to participate in future DMC-ODS waiver related programs (e.g., CalAIM). In addition to the Key Informant Interview data, some of the State Plan Administrator Survey results (N=12) are used to clarify interviewees' statements or illustrate context.

Methods

Between May through December 2020, Key Informant Interviews were conducted with State Plan county administrators. For information on the methods please refer to the Methodology chapter (Chapter 2) "Key informant Interviews" section.

Results

Background

In order to understand the unique needs of State Plan counties, it is important to understand the context in which the SUD service system functions, as well as how their overall county population and resources contrast with larger DMC-ODS waiver counties.

The table below illustrates the services available in the 12 State Plan counties who responded to the State Plan County Administrator Survey. It is notable that all of the State Plan counties are missing at least one of the important services that are taken for granted in larger counties such as primary care, inpatient mental health, and public transportation.

Similarly, in all three counties where Key Informant Interviews were conducted, State Plan administrators reported limited access to many types of services (not only SUD) within their counties as compared to larger, DMC-ODS waivered counties. State Plan beneficiaries are forced to go out of county to get many of their needs met, not just for SUD services. For example, one of the three counties does not have primary care doctors within the county. Another county reported not having a bank in the county.

> "We are fortunate to have a dentist. There isn't a gas station in this area. There isn't a bank in this area, just to give you some understanding of what it's like to be a resident in Sierra County. People live here because either they can't get out or they love it here…."

Table 6.1. Services Available in State Plan Counties (N=12)

Which services did you have in your county prior to the COVID-19 pandemic?	N	%
Primary care for physical health	8	66.7%
Mental health outpatient	11	91.7%
Mental health inpatient	3	25.0%
Emergency Department	10	83.3%
Public transportation	9	75.0%
Sober living residences	6	50.0%
Residential SUD services	2	16.7%
Intensive outpatient SUD services	7	58.3%
Outpatient SUD services	11	91.7%
Withdrawal Management (Detox)	3	25.0%
Drug/behavioral health court	8	66.7%
Other: IOP Perinatal	1	8.33%

Note: As recorded in the State Plan Administrators Survey, 2020.

Furthermore, even when a service is technically available, there are not enough staff or not enough funding for residents to be able to receive the service in a timely way.

> "I have had feedback from clients and even just community members, which said, "I went to the immediate care, and they said they couldn't help me, because they didn't have a doctor on duty." …. it's a beautiful clinic, but there's just not the sustainability of providers. ….Our psychiatrists that we have here at behavioral health, are the only psychiatrists in the county. If somebody doesn't need medical necessity to be treated at our clinic, or if they have private insurance, they have to go out of county for psychiatry."

In many ways State Plan counties are similar to counties in the PHC W&R program, residents here are largely rural, white, (although with more American Indian / Alaskan Native residents than DMC-ODS waiver counties), and English speaking. These similarities may be helpful in generalizing results from the PHC W&R program to State Plan counties should they join a regional model.

Strengths and Challenges of the State Plan

Care Coordination & Cross County Collaboration

While providing all SUD services within a small county is not always possible, all four State Plan county administrators report some benefits to providing services in a small community, as it is easier to attend to the needs of a familiar and small population. They report that they leverage their connections with other agencies and neighboring counties to provide care. Often multiple systems are aware of the same beneficiaries (sometimes multiple generations from the same family) and with few exceptions, these systems coordinate well to create wraparound services for beneficiaries, even if they have to refer out of the county.

> "We're able to refer and get that person connected to that mental health need or that public health need, or domestic violence, or a type of testing within that day. We could walk people across the street and get them connected to another service … eligibility to get your Medi-Cal, all those things within hours, if not minutes. Even though we are small, we seem to be very efficient."
>
> "It's a blessing being in a small county because …there isn't any really days on waitlists. There isn't really any time that lapses a person is not getting a service. We are able to get them connected really quickly. There are a lot of benefits to being small."

In fact, in some State Plan counties SUD and mental health services are located in the same building or campus which facilitates overall access to care. One administrator reported, "We can walk down the hall and talk to a mental health clinician if we're concerned about a client."

According to respondents to the State Plan Administrator Survey, at least four out of 12 counties reported that SUD and mental health services were co-located in the same building or campus. 91% reported that the SUD and mental health services were "well" or "very well" integrated.

Given their reported successes networking with agencies within and outside their counties, State Plan administrators express concern that the DMC ODS requirements would not necessarily improve patient care but would definitely increase overall administrative responsibilities and operating expenses. One county described the SUD system of care in their county as similar to "a small provider," and as such, would not want to be burdened with "the same regulatory requirements as a health plan" because the county does not have the workforce and funding to achieve it, nor the level of patient need to justify it. However, all State Plan counties interviewed agreed that they would benefit from joining the DMC-ODS waiver if it is affordable, if it increases access to all SUD services and if it improves quality of care.

Workforce

State Plan counties report that is difficult to maintain the mental health, physical health and SUD workforce within the county and may need DHCS support to expand it enough to confidently join the DMC-ODS waiver.

> "There's always a shortage of primary care doctors. That's always an issue that we hear about. We do have an FQHC that came in a couple of years ago…They have a difficult time getting, and keeping providers. There's supposed to be an integrated behavioral health as well [as] … SUD services, medical, and dental. They had a psychiatrist part - time, that was one day a week, and then they were gone, and they've had a hard time replacing them."

State Plan administrators maintain that there is not just a shortage of staff but there is also a shortage of money to hire staff, even if the staff were available, which is a potential barrier to joining the DMC-ODS waiver.

> "There's not a lot [of job applicants] to choose from in a rural county. …. If we needed to expand our workforce on the SUD side … there's not a lot of people that are applying. I think just there's a workforce shortage in general, so trying to get folks in is hard. Right now, we're fully staffed based on what our budget allows. If we were to start getting more clients, then we would have to try to find a way to expand our workforce, and then we're back to the budget issue again. I think its two –fold."

Additionally, State Plan administrators report that they particularly need assistance to develop the workforce to deliver co-occurring services for their clients with mental health conditions.

> "A priority for us is the dual diagnosis component, really understanding the co-occurrence between mental health impairments and SUD and being able to have staff that can really do that and program to that. ... We need to really build that dual diagnosis component."

Provider Network

In order to join the DMC-ODS waiver, many counties would have to build their provider network in order to fulfill DMC-ODS waiver requirements. However, State Plan counties report that they sometimes have an uphill battle getting support and resources from local politicians when trying to develop their SUD provider network. They report that the Boards of Supervisors are conservative and that SUD patients and services are stigmatized which creates barriers to providing a full continuum of SUD services, particularly MAT.

> "The feeling about substance use disorder services in the community as a whole is not super positive. There is a clinic that's been in the process of being built for a couple of years now, and it's supposed to be an urgent care on one side. Then, medically assisted treatment on the other side. There's been lots of negative social media discussions … about, 'It's going to bring all these druggies to our county …and it's too close to the school. Then you'll have all these bad people around.' … I think we're such a conservative county, the political views are not very positive for substance use services, unfortunately."

In addition to managing NIMBYism and public relations difficulties, State Plan counties report needing both technical assistance for potential providers to become certified, and incentives to make Medi-Cal certification worthwhile.

> "Technical assistance …to help develop the providers. We can't develop the network. We can't incentivize mom and pop to make a treatment center. We don't have that capacity. … They get private pay from the community that we can't [pay]."

As part of provider network development, State Plan counties report the need for assistance with Electronic Health Records. Some State Plan counties have difficulty getting the EHR software that can encompass all the needs for record-keeping and billing, as well as flexibility to make changes to the EHR when the systems or policies change. Others are having difficulty converting to an EHR from existing paper records. They expressed the need for a standardized system that is flexible enough to keep up with regulatory changes without creating a problem for billing or inter-agency communications.

ASAM Criteria-based screening and assessment

State Plan counties want guidance from DHCS on implementation of a standardized assessment tool to assist in treatment planning, and establishing the need for medical necessity. One administrator felt that an ASAM Criteria-based assessment could be a good tool for that, especially as it focuses on current immediate treatment needs (as opposed to patient history). However, a full ASAM Criteria-based assessment can result in recommendation of a level of care that a State Plan county does not have in their county, and therefore a full ASAM Criteria-based assessment may not be as useful or efficient in State Plan counties who do not have all levels of care available. "We've looked at ASAM for a while and just thought, 'I don't understand why we would implement it here if we don't have the levels of services to offer them.'"

Transportation

All three counties who responded to State Plan County Administrator Survey questions about transportation reported that transportation to SUD treatment is a barrier for beneficiaries as the distance to providers from their homes can be far, especially for services they can only receive out-of-county. Many of the beneficiaries do not have cars, nor is there convenient public transportation.

> "We have a [public] transit that has limited routes. They used to come here …. multiple times a day. Now, it's one drop- off and one pick -up and that's it. If folks need to come in for an appointment, and they don't have their own transportation … the bus service isn't super effective, because there's not enough options for people. That would be a barrier to access."

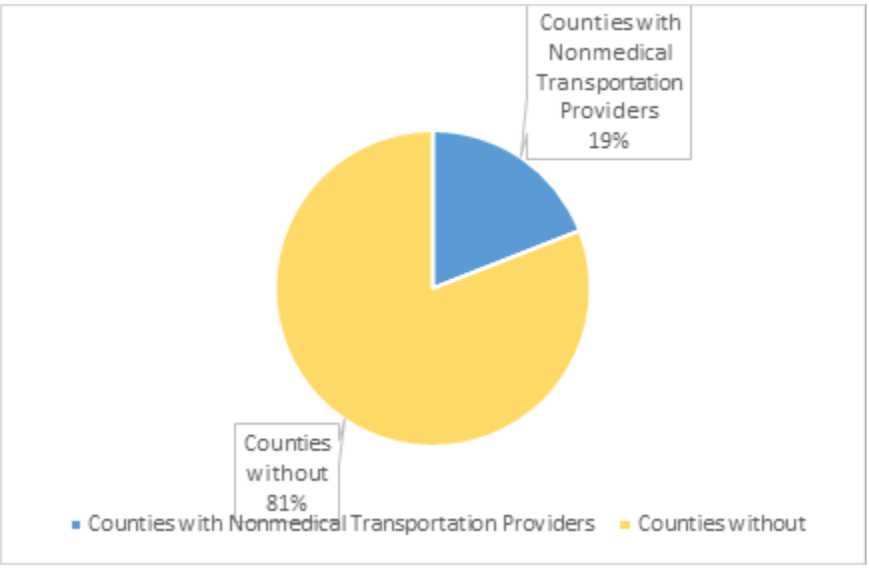
In response, administrators tell us that they use transportation services from their patients' other service systems like child welfare or mental health. At times, case managers have transported beneficiaries.

"We also partner with mental health with mental health funding for transportation. If somebody has a co -occurring disorder and they really have an SMI, then we can have mental health transportation help them."

"We have county vehicles here. We've either done the case management in order to ensure that they have a ride there. I know our counselors have taken people to treatment before."

While there is Medi-Cal funding for Non-Medical Transportation, there are no approved Nonmedical Transportation Providers in 17 of 21 State Plan counties.[41]

Figure 6.1. Percentage of State Plan counties with a DHCS approved nonmedical transportation provider.



Additionally, in the four State Plan counties where there are approved transportation providers (Amador, Del Norte, Sonoma, Sutter), there was only one approved transporter in each county, which may be an additional barrier to being able to access transportation for beneficiaries.

Requirements and funding

Currently, State Plan counties report leveraging funds from many sources in order to provide sufficient SUD care.

[41] DHCS (2021). List of Approved Nonmedical Transportation Providers. Available at: https://www.dhcs.ca.gov/services/medi-cal/Documents/List-of-Approved-Nonmedical-Transportation-Providers.pdf

> "We're going to pay with drug court realignment for individuals or collaborative courts grant funding for individuals, and we'll put them in more groups, more outpatient services, and more interaction with the counselor."

> "Our health and human services director, he participates in the CCP, which is like probation, sheriff's department, DA's office. They actually help support our psychiatrist. They give us funding, a yearly amount to increase the psychiatrist's, … salary, and that's how we had to … recruit a psychiatrist, because it took us four years to get one. Then … our psychiatrist goes to the jail one half a day a week as well."

> "We are basically utilizing [funds] depending on whatever funding sources the client is going there for. If it's social services, or if it's probation, AB 109, we're billing those sources or … if possible. We're basically utilizing all the different types of funding sources that we have to pay for that residential treatment."

There is concern in State Plan counties that the DMC-ODS waiver reimbursement rate would be insufficient to make it worthwhile for State Plan counties to join, as the current State Plan rate provides insufficient funding for SUD services. Also, the State Plan rate may be more cost effective as the State Plan has less administrative requirements than the DMC-ODS waiver.

> "What we get reimbursed for Drug Medi-Cal is not sufficient. It doesn't pay for the costs and doesn't make the dollar whole because so many of our beneficiaries, it's a 50 to 80 percent reimbursement from the state."

State Plan county administrators are also concerned about taking too many realignment dollars for SUD from other much needed services in the county. One county administrator explained that the county is using behavioral health realignment dollars, but lamented that it, "gets really sticky when you start taking realignment from children's mental health." Additionally, in order to consider joining the DMC-ODS waiver, State Plan counties need assistance in figuring out how multiple funding sources (e.g., realignment and reimbursement) will work under the DMC-ODS waiver. They would need help anticipating how to maximize efficiency using these different funding streams.

> "There may be some things [in the DMC-ODS waiver] that could be possible for us, but we don't have the capacity sometimes to even really entertain it.... The fiscal people get really just like, 'No. It's not possible.' I think that has to do with the realignment. We would get to set our rates, right? Rate setting, we would need assistance, I think. Even regional rate setting. I've talked with my counterparts in the other counties. What would be helpful? Could we have regional rate setting? If the rate setting would include the county portion, I don't know. How much realignment could we offset through the rates?"

State Plans are concerned that there are many unfunded mandates in the DMC-ODS waiver requirements and they don't know how to create a fiscal plan that manages all their funding streams.

> "There's a huge DMC problem. The rate is not adequate. It doesn't provide any quality assurance. It's such this contradiction to do all this, provide all this quality assurance, and there's no payment for it."

State Plan county administrators are reluctant to bill for anything that might possibly get disallowed. When counties provide and bill for services that ultimately are disallowed by DHCS (and therefore not reimbursed) it wastes staff time and provider resources.

Conclusions

The following are recommendations to facilitate future participation of State Plan Counties in the DMC-ODS Waiver

- Offer TA to help State Plan counties calculate the financial burden/benefit of joining the DMC-ODS waiver to determine whether or not it would be cost effective.
- Offer TA for providers, incentives for providers to get DMC certified.
- Offer TA for billing screenings and assessments.
- Offer clarification on how and what to bill so that fewer claims are disallowed.
- Implement a standardized, off-the-shelf, ASAM Criteria-based screening and assessment.
- Provide TA in choosing and implementing an EHR system, as well as ensuring it meets requirements for billing and QI.
- Offer more support and funding for administration of the DMC-ODS waiver
- Offer TA for creating standardized regional policies and procedures that meet DMC-ODS waiver requirements for informal regional model.
- Reduce burden of QI/QA and compliance. State Plan counties feel it is too expensive and time consuming for so few staff, and too expensive to outsource to managed care plan. Consider funding a regional position to handle administration of a regional model.
- To reduce stigma, provide education re: stigma as stigma is a barrier to SUD capacity building.
- Increase re-imbursement rates.
- Offer TA develop the workforce to implement all components of the DMC-ODS waiver.
- Promote development of more approved nonmedical transportation providers in all counties.

While some of the technical assistance described above can be provided directly by DHCS, county interviews suggest learning from other counties is very valuable. Therefore, connecting State Plan counties to successful small DMC-ODS waiver counties early in the process could be useful.

7. Special Topic: Stimulants – Current Practices and Future Needs

Darren Urada, Ph.D., Elise Tran, B.A., Brittany Bass, Ph.D., Anne B. Lee, LCSW

Introduction

Stimulant use has historically been high, and overdose deaths from stimulants in California are similar to overdose deaths from opioids. This chapter summarizes recent results from multiple 2020 County Administrator Surveys covering stimulant use. These results are statewide, not limited to DMC-ODS.

Methods

The results below are summarized from an aggregation of three County Administrator Surveys conducted by the UCLA Integrated Substance Abuse Programs and one conducted by the California Department of Health Care Services between March and December 2020.

Survey	Dates	Invited Counties	Responses (counties)*
DHCS Stimulant Use Disorder Survey	9/2/2020-9/29/2020	58	21 (22)
UCLA DMC-ODS waiver county survey	3/9/2020-6/5/2020	30	25 (25)
UCLA State Plan county survey	7/23/2020-8/31/2020	21	11 (12)
UCLA Partnership counties survey	11/17/2020-12/2/2020	7	5 (5)

* Sutter and Yuba counties respond together.

Analyses from CalOMS-Tx are also included. For more information on the UCLA surveys or CalOMS-Tx, see the methodology chapter. The DHCS survey was designed and conducted by DHCS in September 2020, then UCLA was provided access to the data after the survey was complete.

Results

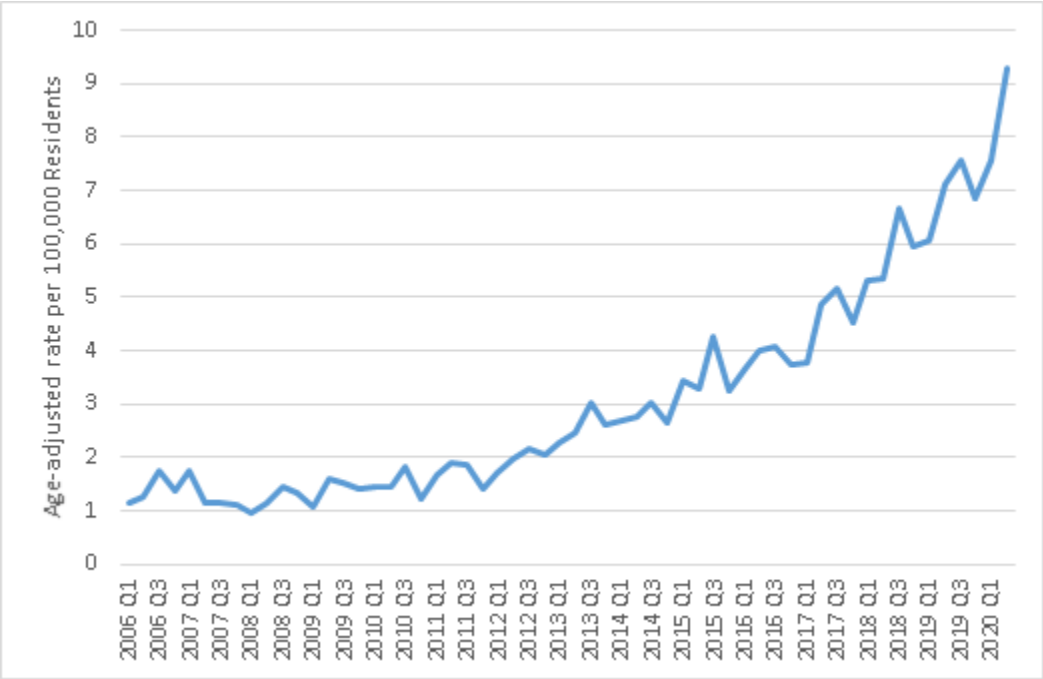
Impact of stimulant use on counties

In 2019, 67,424 unique clients, representing 57.2% of all admissions in CalOMS-Tx, reported a stimulant as their primary or secondary drug problem at admission. Among people reporting stimulant problems, 89.5% (60,337) identified methamphetamine as their primary or secondary problem, 12.6% reported cocaine/crack as a problem (8,499), and other stimulants were cited among the remaining 1.1% (765). The number of admissions for stimulant use has been stable in recent years. Admissions were 67,596 in 2016 compared to 67,424 in 2019. These findings are consistent with survey responses from county administrators, which indicated that use of stimulants was widespread, that stimulants were the primary or secondary drug of choice for

many clients, but administrators were unsure whether there had been an increase in patients in the last year.

Even as treatment admissions held steady, however, overdose deaths did not. Figure 7.1 shows overdose death rates from the California Department of Public Health (CDPH). During the most recent quarter of data available, there were 957 deaths related to stimulants.

Figure 7.1. Psychostimulant with abuse potential-related overdose deaths (excludes cocaine).



Source: CDPH Center for Health Statistics and Informatics Vital Statistics - Multiple Cause of Death and California Comprehensive Death Files Prepared by: California Department of Public Health - Injury and Violence Prevention Branch (formerly the Safe and Active Communities Branch).

Despite the skyrocketing rates, this actually underestimates stimulant deaths because CDPH's definition of psychostimulants excludes cocaine. Cocaine overdose death rates have also increased rapidly, doubling from 2018 Q4 to 2020 Q2. The annualized rate was 3.0 per 100,000 residents in 2020 Q2, or 314 people. The psychostimulant and cocaine rates cannot be added directly because that could result in double-counting some deaths. However, we can say that the total stimulant deaths were between 957 and 957+314 = 1,271. Even on the lower end of the range, if this death rate persists, about 3,000 people will die of stimulant-related overdoses in California every nine months, which is roughly equal to the number of people who died in the events of 9/11.

According to CDPH's dashboard,[42] overdose death rates for psychostimulants were much higher for AI/AN (20.5 age-adjusted per 100,000 population in 2019) than for any other racial/ethnic

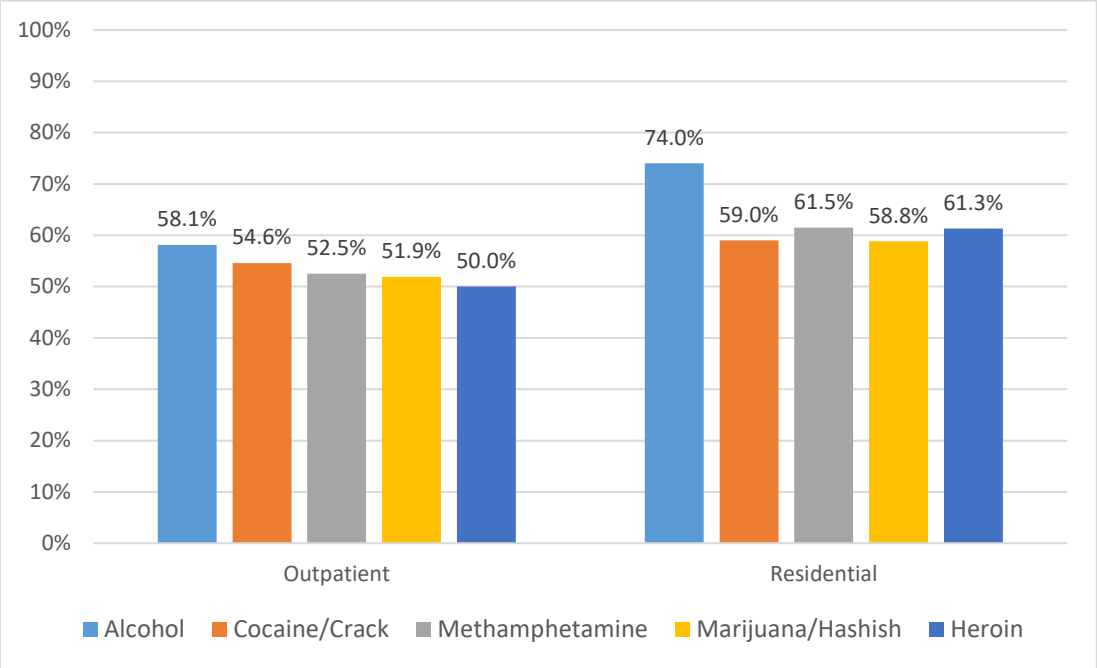
[42] CDPH (2021). California Opioid Overdose Surveillance Dashboard. Available at: https://skylab.cdph.ca.gov/ODdash/

group. This rate was more than double the rate among Whites (10.0), and is in addition to AI/AN also having the highest overdose death rates for opioids.

Recent data on stimulant use rates in California were not available from the National Survey on Drug Use and Health. However, the finding that treatment admissions have been steady suggests at least some of the increase in overdose deaths may be due to increased potency or contamination as opposed to rapidly increasing numbers of people using stimulants. UCLA will continue to investigate this issue.

County administrators noted that stimulant use is often difficult to treat. The most frequent challenges cited by respondents were lack of medications to treat stimulant use disorders and lack of funding for contingency management. CalOMS-Tx analyses suggested a more mixed picture. Patients with a stimulant as their primary drug had a successful discharge (completed treatment or left with satisfactory progress) at similar rates as users of other illicit drugs, though below the rates for patients reporting alcohol as their primary drug. Figure 7.2 shows these rates for outpatient and residential treatment, the two most common modalities for stimulant users.

Figure 7.2. Successful discharge by primary drug and modality.



County system and funding

Many counties offer stimulant use disorder services embedded within general SUD prevention, treatment, and recovery services, but do not offer stimulant use disorder-specific services:

- "With the exception of (our) Opioid Safety Coalition, no prevention services are aimed at any one single substance, including stimulants."

- "(Stimulants are) Embedded and addressed within the existing services, not specifically singled out or identified in any one portion of treatment."
- "Prevention efforts have been centered around opioids and marijuana for adults due to rising overdose rates and a ban on recreational marijuana locally. No specific prevention strategies have been launched for stimulants."

Prevention and treatment are often overseen by different entities in the county.

- "County contracts the prevention program through public health. The County offers IOP, ODF [OP], and prenatal within Behavioral Health."
- "Prevention Division is separate. Treatment and Recovery Services are within the Drug and Alcohol Services Division under Behavioral Health Department."

Although counties most commonly reported funding stimulant services with Drug Medi-Cal and SAPT block grant funds, counties also reported using a variety of other sources, including:

- Drug Medi-Cal (State Plan or DMC-ODS)
- SAPT block grant
- Realignment funds
- County general funds
- Private funding
- CalWORKS
- AB109
- MHSA
- Prop 47

Strategies to address stimulant use

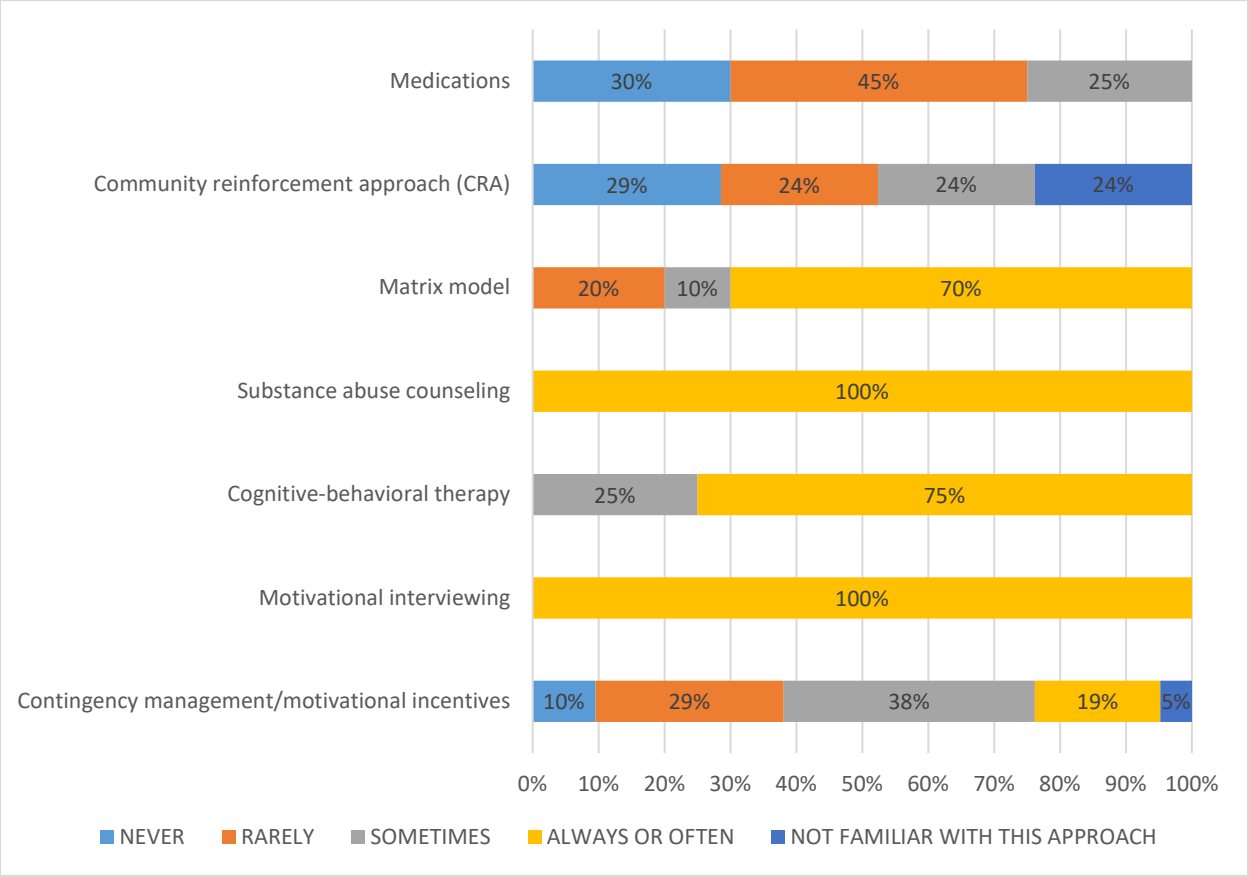
Prevention

Most counties cited education and outreach as a prevention strategies for addressing substance use, including stimulants. Specific activities mentioned include Botvin Life Skills, Friday Night Live, Club Live, Public Service Announcements, peer groups, support groups, and screening, brief intervention, and referral to treatment (SBIRT). These programs are aimed primarily at school-aged youth.

Treatment

County administrators were asked to rate several clinical/therapeutic approaches on how often they were used, from "Never" to "Always or Often." Motivational interviewing, SUD counseling, and cognitive behavior therapy were among the approaches most commonly used for treatment of stimulant use disorders. Medications, contingency management, and community reinforcement approach (CRA) were used less frequently, with many counties reporting them being used "never" or "rarely" (See Figure 7.3).

Figure 7.3. Approaches currently used to treat stimulant use disorders.

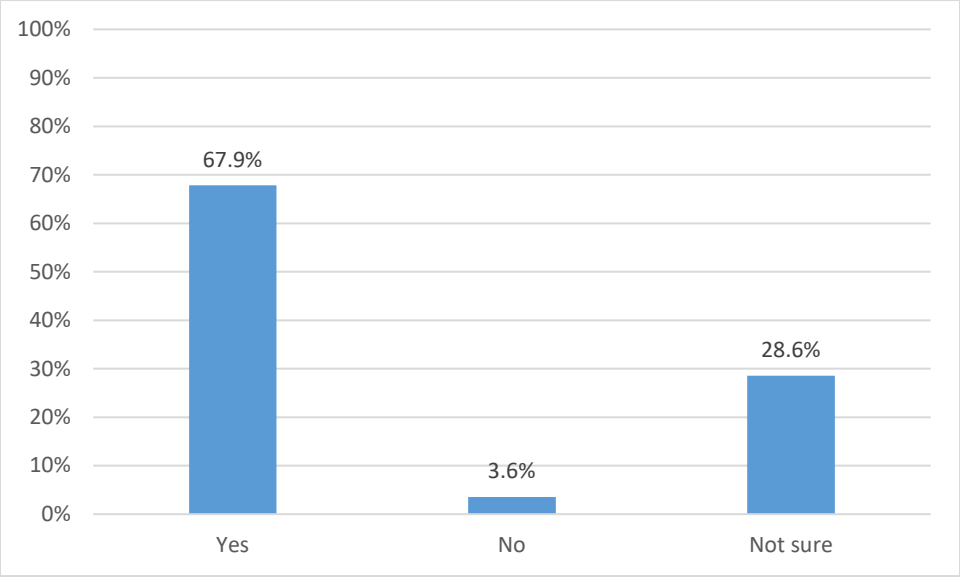


Contingency management

The majority of respondents (67.9%) believe contingency management would be helpful in treating methamphetamine use, while 28.6% were not sure (See Figure 7.4).

Respondents noted that there is a lack of clear guidance on funding for incentives used in contingency management, and that administration is a challenge. However, there is a desire and willingness to explore using contingency management to engage and retain clients in treatment. A few counties are actively involved in research projects or programs aimed at using contingency management.

Figure 7.4. Perceptions of contingency management.



Innovative practices

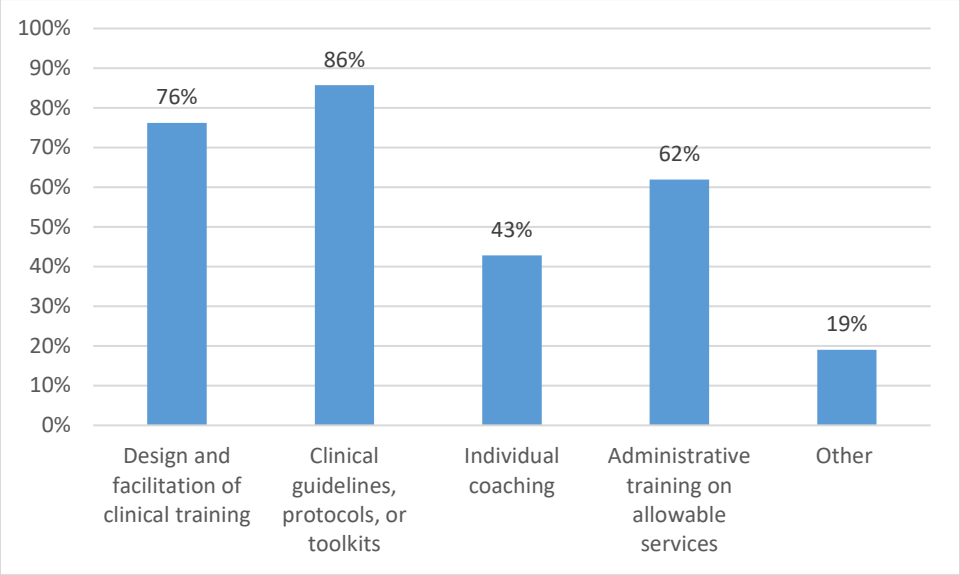
Counties reported using a wide variety of innovations to address stimulant use disorders. Multiple counties reported efforts in the following categories:

- Withdrawal management and residential capacity expansion
- Collaborative partnerships with multiple systems (e.g., meth coalition, mental health, probation; child and family services)
- Sobering centers
- Methamphetamine awareness campaigns
- Contingency management project implementation or planning

County "wish list"

Counties indicated strong interest in assistance from DHCS in the form of clinical guidelines, protocols, and toolkits for addressing stimulant use disorder (86%), as well as design and facilitation of clinical training (76%), and administrative training on allowable services (62%). See Figure 7.5.

Figure 7.5. Responses to: "What type(s) of further support would you like DHCS to provide to better assist your county in delivering stimulant use disorder services?" (select all that apply)



Additional requests from counties to DHCS included:

- Guidance on how to bill for contingency management; funding for incentives
- Training and information on best practices/EBPs for treatment of stimulant use disorders
- Funding to pay for recovery residence housing for those engaged in treatment
- Expansion of MAT to include medications that are not FDA-approved for stimulants but can be prescribed to alleviate symptoms of withdrawal, depression, craving
- Equipment for telehealth/virtual services

Counties indicated an interest in expanding stimulant disorder services if funding were available. The following are services cited by multiple counties as areas they would like to expand if funding were available:

- Contingency management
- Sober living/recovery residences
- Telehealth and telephone services (including providing equipment to clients so they can access telehealth services)
- Case management
- Workforce training (e.g., clinical guidelines, EBPs, training on engaging clients via telehealth, Rational Emotive Behavioral Therapy training)
- Peer-based services
- MAT for individuals with stimulant use disorders
- Residential treatment

Conclusions

Survey respondents and analysis of CalOMS-Tx records indicated the use of stimulants, and the need for services to treat people with stimulant use disorders, was widespread.

Currently, outpatient and residential treatment are the most common treatment modalities, and services also extend into recovery services and prevention services. Funding for these services comes from a multitude of sources, but most commonly Drug Medi-Cal and the SAPT Block grant. Often these services are part of a broader effort to address substance use rather than targeted specifically at stimulants.

Current prevention strategies include education and outreach, including working with schools, while treatment typically includes motivational interviewing, counseling, and cognitive behavior therapy. Medications, contingency management, and community reinforcement approach were not used frequently, but the majority of respondents (67%) believe contingency management would be helpful in treating methamphetamine use and a handful of counties are exploring its use.

Challenges frequently cited by respondents include a lack of medications to treat stimulant use disorders and lack of funding for contingency management.

Still, innovative practices can be found around the state, including:

- Withdrawal management and residential capacity expansion
- Collaborative partnerships with multiple systems (e.g., meth coalition, mental health, probation; child and family services)
- Sobering centers
- Methamphetamine awareness campaigns
- Contingency management project implementation or planning

Counties indicated strong interest in assistance from DHCS in the form of clinical guidelines, protocols, and toolkits for addressing stimulant use disorder (88%), as well as design and facilitation of clinical training (80%), and administrative training on allowable services (68%).

Recommendations

Many of the items on the county "wish lists" were for general assistance related to treatment services and recovery residences. The following two items, however, are specific to addressing stimulant use disorders:

- Assistance in the form of stimulant use disorder-related clinical guidelines, protocols, toolkits, and trainings.
- Facilitation of contingency management.

In response to these needs, a joint effort between UCLA ISAP, Advocates for Human Potential, and DHCS will test the Treatment and Recovery for Users of Stimulants (TRUST), [43] a manualized treatment approach that includes contingency management. This may partially begin to address these recommendations, but further exploration of the feasibility of adding reimbursable contingency management to CalAIM are also recommended.

[43] http://www.uclaisap.org/oasis-tta/docs/Stimulant-Treatment-Project-TRUST-RFA.pdf

8. Special Topic: DMC-ODS Services for People Experiencing Homelessness

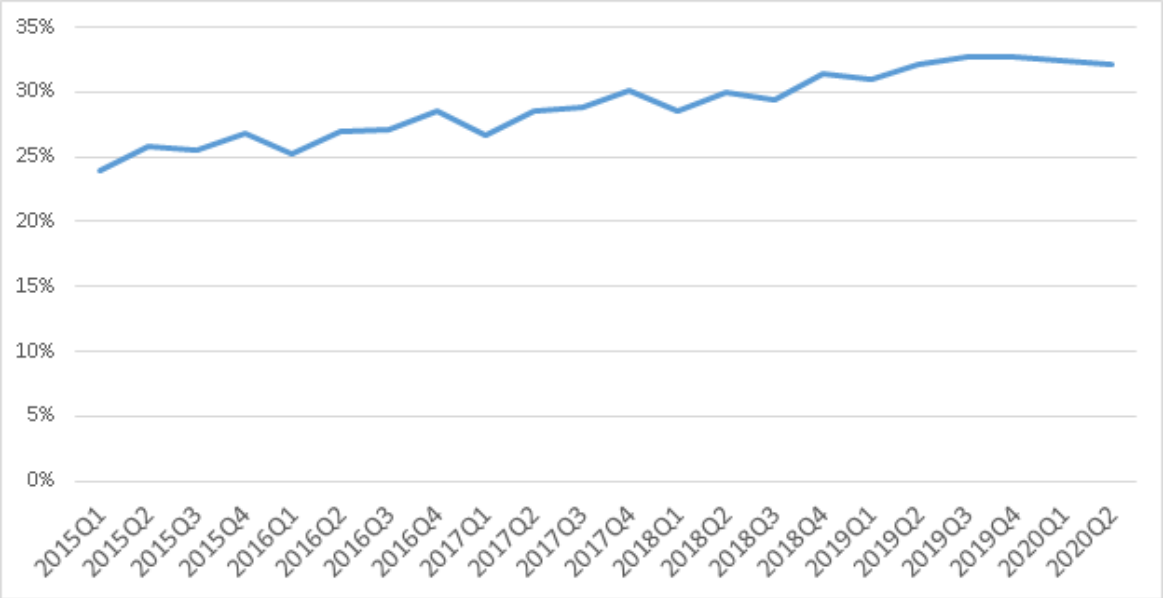
Howard Padwa, Ph.D., Brittany Bass, Ph.D., Anne B. Lee, LCSW, Darren Urada, Ph.D.

Introduction

Homelessness has become one of the most pressing challenges facing California communities in recent years. The state's homeless population increased by 31% between 2015 and 2019, and over 151,000 Californians experienced homeless on an average night in 2019.[44] Despite initiatives to provide emergency shelter and permanent housing as part of the state's COVID-19 response, it is anticipated that the economic downturn caused by the pandemic will lead to further increases in homelessness across California in 2020 and beyond.[45]

As California's homeless population has risen, so has the proportion of people experiencing homelessness (PEH) when they enter DMC treatment. From 2015-2019, the share of DMC patients who experienced homeless at admission grew from 24.0% to 32.7% (see Figure 8.1).

Figure 8.1. % DMC patients experiencing homelessness at admission, 2015-2020.



Note: Data from CalOMS-Tx, CY2015-Q2 of 2020.

This chapter will present an overview of SUD services and outcomes for PEH and findings concerning the DMC-ODS waiver's impact on treatment for PEH. In particular, the chapter will present findings concerning:

- Characteristics of PEH compared to non-PEH (e.g., demographic differences, differences in substances used, differences in the co-occurrence of mental illness) across the state;

[44] National Alliance to End Homelessness: Homelessness Statistics. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-dashboards/?State=California. Accessed January 13, 2021.
[45] Community Solutions. Analysis on Unemployment Projects 40-45% Increase in Homelessness This Year. https://community.solutions/analysis-on-unemployment-projects-40-45-increase-in-homelessness-this-year/ Accessed January 13, 2021.

- Analysis of differences in treatment modalities utilized and outcomes between PEH and non-PEH;
- A comparison of treatment modalities utilized and outcomes for PEH and non-PEH in DMC-ODS and State Plan counties;
- Perspectives of county administrators on providing services for PEH, and how these services can be improved;
- Recommendations on steps that DHCS can take to help counties improve housing and treatment outcomes for PEH, both in DMC-ODS waiver and State Plan counties.

Methods

Data concerning the characteristics of PEH and non-PEH treatment outcomes were collected from CalOMS-Tx for CY 2016-2019. Data concerning county administrators' and key informants' perspectives were collected in the County Administrator Survey, county administrator Key Informant Interviews, and other Key Informant Interviews. For further details on these data sources and statistical methods, see Chapter 2. All measures of statistical significance are at the 5% ($p<0.05$) level.

Results

Differences Between PEH and non-PEH Patients Receiving DMC Services

Baseline Characteristics

See Table 8.1 for an overview of differences between PEH and non-PEH who received DMC services in 2019 at admission.

People experiencing homelessness were more likely to be male (64.0% vs. 57.4%), White/Non-Hispanic (45.1% vs. 41.1%), Black/Non-Hispanic (15.1% vs. 9.4%), and Multiracial/Non-Hispanic (3.0% vs. 2.5%) than non-PEH, whereas non-PEH were more likely to report that they were Hispanic (41.2% vs. 31.4%), or Other Race/Non-Hispanic (2.2% vs. 2.8%). Alcohol, cocaine/crack, and methamphetamine were more likely to be the primary drug for PEH than non-PEH, with the most notable difference being in rates of methamphetamine as the primary drug (41.6% for homeless, compared to 29.4% for non-homeless). Non-PEH were more likely to have marijuana/hashish (12.5% vs. 4.4%), heroin (27.4% vs. 22.5%), or other drugs (7.6% vs. 3.1%) as their primary drug compared to PEH. On average, PEH reported over two more days of past-month use of their primary substance when entering treatment than their non-homeless counterparts (14.9 days vs. 12.6 days). For secondary drugs, PEH were more likely to have alcohol, cocaine/crack, heroin, marijuana/hashish, and methamphetamine than non-homeless patients, and they were less likely to have no secondary drug or another substance as their secondary drug.

Table 8.1. Comparison of PEH and non-PEH DMC admissions, CY 2019.

	PEH	Non-PEH
Demographics		
% Male	64.0*	57.4
Age (mean)	38.8*	35.8
% White, Non-Hispanic	45.1*	41.1
% Black, Non-Hispanic	15.1*	9.4
% Hispanic	31.4*	41.2
% Multiracial, Non-Hispanic	3.0*	2.5
% Asian	1.6	1.7
% Pacific Islander	0.3*	0.2
% American Indian/Alaskan Native	1.3*	1.1
% Other Race, Non-Hispanic	2.2*	2.8
Primary Drug		
% Alcohol	24.2*	20.8
% Cocaine/Crack	4.1*	2.3
% Heroin	22.5*	27.4
% Marijuana/Hashish	4.4*	12.5
% Methamphetamine	41.6*	29.4
% Other	3.1*	7.6
Secondary Drug		
% Alcohol	11.6*	10.6
% Cocaine/Crack	3.9*	3.3
% Heroin	4.4*	2.6
% Marijuana/Hashish	16.8*	15.1
% Methamphetamine	22.0*	18.1
% None	37.6*	44.8
% Other	3.6*	5.4
Other Characteristics		
% with Mental Illness	51.2*	38.9
% Unemployed	90.8*	72.8
Primary Drug Frequency Prev. 30 Days (Mean)	14.9*	12.6
# ER Visits Previous 30 Days (Mean)	0.4*	0.2
# Hospital Overnights Prev. 30 Days (Mean)	0.4*	0.3
# Arrests Previous 30 Days (Mean)	0.2*	0.1
# Prison Days Previous 30 Days (Mean)	0.2*	0.1
# Jail Days Previous 30 Days (Mean)	2.6*	1.4
Note: Data come from CalOMS-Tx. P-values (not included) are from a two-sample t-test of means between PEH and non-PEH populations. Asterisks indicate statistically significant ($p<0.05$) differences between PEH and non-PEH populations.		

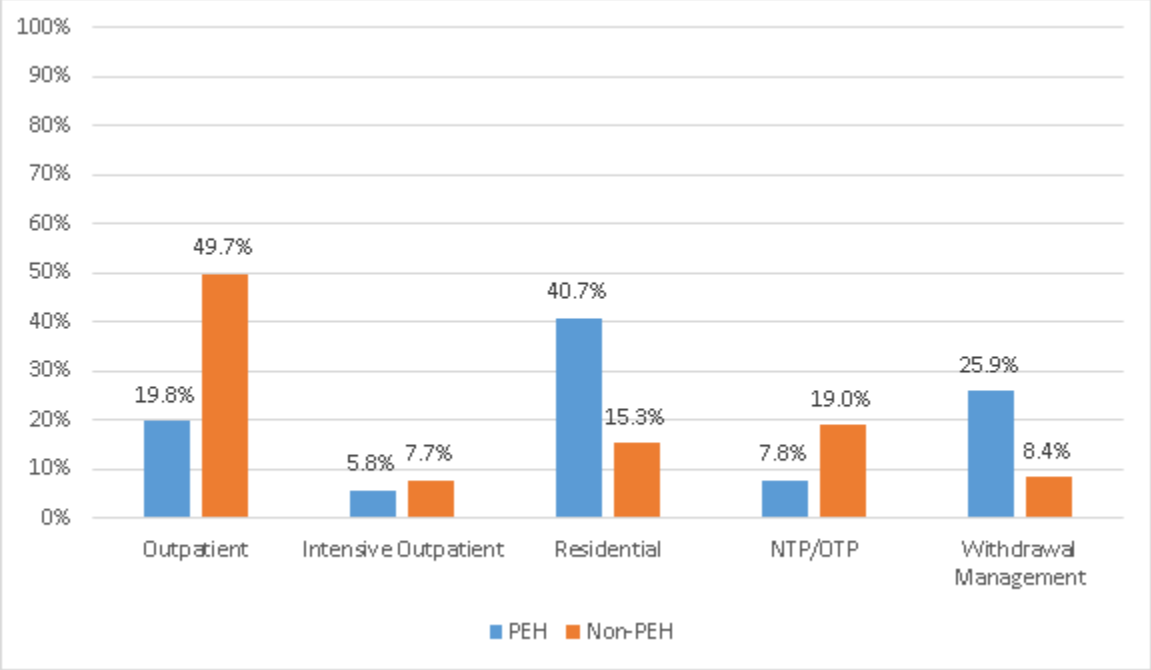
Homelessness increased the likelihood that patients would face challenges that could further complicate their treatment and recovery. Over half of PEH in 2019 (51.2%) had a co-occurring mental illness, compared to 38.9% of non-PEH, and PEH also had slightly more past-month ER

visits and overnight hospital stays than non-PEH. PEH had more past-month criminal justice involvement than non-PEH (more arrests, more jail days, more prison days), and they were significantly more likely to be unemployed (90.8% for PEH vs. 72.8% for non-PEH).

Treatment Modalities Utilized

See Figure 8.2 for an overview of the treatment modalities utilized by PEH and non-PEH in 2019. PEH were significantly more likely to receive care in residential and withdrawal management than PEH, and non-PEH were significantly more likely to be treated in outpatient, intensive outpatient, and NTP/OTP treatment modalities. All of these differences were statistically significant at the 5% level ($p<.05$).

Figure 8.2. Treatment modalities for PEH and non-PEH DMC patients, CY 2019.



Note: Data come from CalOMS-Tx. P-values (not included) are from a two-sample t-test of means between homeless and non-homeless populations.

Outcomes

We ran regression analyses to measure the degree to which homelessness accounted for differences in outcomes (30-day retention, successful discharge status.[46]) when controlling for differences in gender, age, race/ethnicity, substances used, mental illness, and criminal justice involvement. Analyses were conducted for all CY 2016-2019 admissions, and only included patients served in outpatient, intensive outpatient, and residential treatment modalities. We did not include withdrawal management levels of care because it is not generally regarded as a treatment on its own, and we would not expect patients to remain in withdrawal management for

[46] We define a discharge as "successful" if CalOMS-Tx shows that the patient completed treatment or left treatment before completion with satisfactory progress.

30 days typically. We also did not include NTP/OTP treatment because maintenance patients do not generally have planned discharges comparable to those in other modalities.

Overall, homelessness was associated with worse outcomes for both 30-day treatment retention and successful discharge status. The following differences were statistically significant at the 5% level ($p<.05$) unless otherwise indicated:

- PEH were 11.8% less likely to remain in treatment for 30 days compared to non-PEH, and they were 19.2% less likely to have a successful discharge status compared to non-PEH.
- In outpatient treatment modalities, PEH were 5.4% less likely to remain in treatment for 30 days compared to non-PEH, and they were 10.1% less likely to have a successful discharge status compared to non-PEH.
- In intensive outpatient modalities, PEH were 9.1% less likely to remain in treatment for 30 days compared to non-PEH, and they 6.7% less likely to have a successful discharge status compared to non-PEH. While the differences in retention were statistically significant, the difference between PEH and non-PEH on successful discharge status was not statistically significant at the 5% ($p<.05$) level.
- In residential treatment modalities, PEH were 15.7% less to remain in treatment for 30 days compared to non-PEH, and they were 25.3% less likely to have a successful discharge status compared to non-PEH.

Comparisons of Services and Outcomes for PEH in DMC-ODS Waiver and State Plan Counties

Baseline Characteristics

See Table 8.2 for an overview of differences between populations of PEH served in DMC-ODS waiver and State Plan counties. People experiencing homelessness in DMC-ODS waiver counties were slightly younger, more likely to be Black/Non-Hispanic (15.7% vs. 7.0%), and Hispanic (32.9% vs. 13.2%), whereas PEH in State Plan counties were more likely to be White/Non-Hispanic (68.6% vs. 43.2%), American Indian / Alaskan Native (4.2% vs. 1.0%), and Multiracial/Non-Hispanic (4.3% vs. 2.9%).

People experiencing homelessness in DMC-ODS waiver counties were also significantly less likely to report alcohol as their primary substance, and significantly more likely to report cocaine/crack, heroin, or marijuana/hashish as their primary substance when compared to PEH in State Plan counties. For secondary drugs, PEH in DMC-ODS waiver counties were more likely to report cocaine/crack and less likely to report heroin as their secondary drug than PEH in State Plan counties. People experiencing homelessness in DMC-ODS waiver counties had fewer ER visits, arrests, and days spent in prison during the 30 days before treatment compared to PEH in State Plan counties. On average, PEH in DMC-ODS waiver counties had slightly less primary drug use in the 30 days before entering treatment compared to PEH in State Plan counties (14.8 days vs. 15.5 days).

Table 8.2. Comparison of PEH in DMC-ODS waiver and State Plan counties, CY 2019.

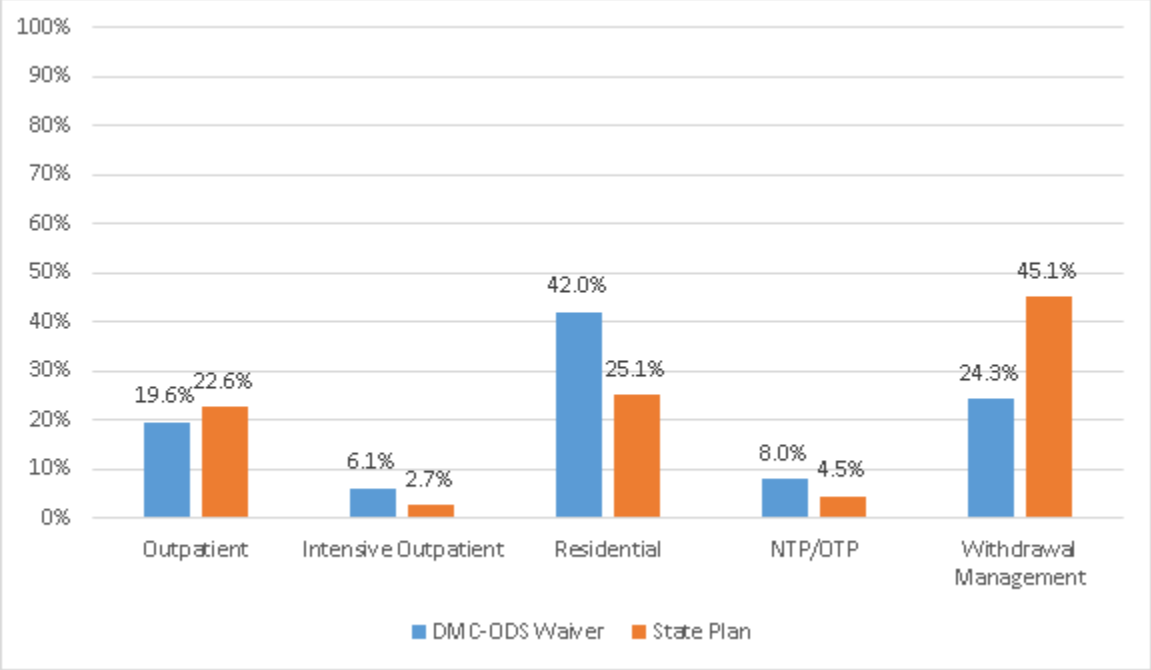
	DMC-ODS Waiver	State Plan
Demographics		
% Male	64.1	63.5
Age (mean)	38.7*	40.1
% White/Non-Hispanic	43.2*	68.6
% Black/Non-Hispanic	15.7*	7.0
% Hispanic	32.9*	13.2
% Multiracial/Non-Hispanic	2.9*	4.3
% Asian	1.6*	1.0
% Pacific Islander	0.3*	0.1
% American Indian/Alaskan Native	1.0*	4.2
% Other Race/Non-Hispanic	2.2*	1.7
Primary Drug		
% Alcohol	23.6*	31.9
% Cocaine/Crack	4.4*	0.6
% Heroin	22.8*	18.4
% Marijuana/Hashish	4.5*	3.3
% Methamphetamine	41.5	42.8
% Other	3.1	2.9
Secondary Drug		
% Alcohol	11.6	11.8
% Cocaine/Crack	4.1*	1.9
% Heroin	4.3*	5.2
% Marijuana/Hashish	16.9	16.5
% Methamphetamine	21.9	23.2
% None	37.6	37.9
% Other	3.7	3.5
Other Characteristics		
% with Mental Illness	51.0	52.6
% Unemployed	90.8	90.2
Primary Drug Frequency Prev. 30 Days (Mean)	14.8*	15.5
# ER Visits Previous 30 Days (Mean)	0.4*	0.6
# Hospital Overnights Prev. 30 Days (Mean)	0.4	0.4
# Arrests Previous 30 Days (Mean)	0.1*	0.2
# Prison Days Previous 30 Days (Mean)	0.2*	0.4
# Jail Days Previous 30 Days (Mean)	2.6	2.7

Note: Data come from CalOMS-Tw. P-values (not included) are from a two-sample t-test of means between PEH populations in DMC-ODS waiver and State Plan counties. Asterisks indicate statistically significant ($p<0.05$) differences between DMC-ODS waiver and State Plan counties.

Treatment Modalities Utilized

See Figure 8.3 for a comparison of the treatment modalities utilized by PEH in DMC-ODS waiver and State Plan counties. In DMC-ODS waiver counties, PEH were significantly more likely to receive treatment in intensive outpatient (6.1% vs. 2.7%), residential (42.0% vs. 25.1%), and NTP/OTP (8.0% vs. 4.5%) modalities than in State Plan counties. PEH in State Plan counties were more likely to receive treatment in outpatient (22.6% vs. 19.6%) and withdrawal management (45.1% vs. 24.3%) modalities compared to PEH in DMC-ODS waiver counties. All of these differences were statistically significant at the 5% ($p<.05$) level.

Figure 8.3. Treatment modalities for PEH in DMC-ODS waiver and State Plan counties, CY 2019.



Note: Data come from CalOMS-Tx. P-values (not included) are from a two-sample t-test of means between homeless and non-homeless populations.

Outcomes

We ran regression analyses to measure the degree to which there were different outcomes (30-day retention, satisfactory discharge status) for PEH in DMC-ODS waiver and State Plan counties when controlling for differences in gender, age, race, substances used, mental illness, and criminal justice involvement. Analyses were conducted for all CY 2016-2019 admissions, and only included patients served in outpatient, intensive outpatient, and residential treatment modalities. We did not include withdrawal management levels of care because it is not generally regarded as a treatment on its own, and we would not expect patients to typically remain in withdrawal management for 30 days. We also did not include NTP/OTP because maintenance patients do not generally have planned discharges comparable to those in other modalities.

Overall, there were no statistically significant differences at the 5% level ($p<.05$) between outcomes in DMC-ODS waiver and State Plan counties for PEH.

County Administrator and Key Informant Interviewees' Perspectives

In county administrator and key informant interviews, participants consistently reported a large unmet need for housing for DMC clients. In particular, respondents reported that it is difficult to find housing for PEH who do not meet criteria for placement from other service systems or funding streams (e.g., child welfare programs, programs for criminal justice populations). Furthermore, residential treatment, while able to provide shelter to patients who meet medical necessity criteria while they are in treatment, is only a temporary housing solution, as patients often do not have housing available to them after discharge from treatment.

Counties have the flexibility to use Substance Abuse Prevention and Treatment Block Grant (SABG) funds or other sources of local funding to support recovery residences (RR) and transitional housing (TH) for patients who are participating in outpatient treatment. However, most counties reported that they do not have sufficient capacity to provide these services. In the DMC-ODS waiver County Administrator Survey, 72.2% of respondents (26 of 36) reported that they do not have sufficient RR/TH capacity in their counties. Though most respondents to the DMC-ODS Waiver County Administrator Survey (68.0%) reported that they had agreements in place with RR programs, these counties reported insufficient capacity at a rate similar to that of survey respondents from State Plan counties (72.0% in DMC-ODS waiver counties, 72.7% in State Plan counties). On the County Administrator Survey and in key informant interviews, respondents reported that the main obstacles to RR/TH utilization are insufficient funding and lack of available RR/TH beds.

Comments concerning the lack of funding for RR/TH beds include:

- "We have not had enough clients or finances to make a SLE [sober living environment] feasible for us, although we would like to and there is a need."
- "We do not have any SABG funds to pay for this [RR] since it all goes to residential room and board."
- "Given that this is a non-DMC reimbursable service, the County can only pay for the beds it can afford, and the need greatly outstrips the County's ability to pay for recovery residences."
- "Increased SABG funding is needed to help facilitate this [RR/TH]"
- "Providers and the county do not have sufficient financial means to allow for expansion of the current number of SLEs."

Comments concerning the lack of available RR/TH beds include:

- "We experience a shortage of available recovery residences and often experience challenges related to bed availability."

- "As we can only use SABG for non-profits, there are very few recovery residences we are able to contract with for these services."
- "We don't have any certified recovery residences currently. There are two SLEs in the county, but they usually have a long waitlist."
- "[We have a] need for capacity building [for RR/TH]"
- "We are working on increasing [this service], but our recovery residences are at capacity and it is difficult to site more due primarily to NIMBY ["not in my back yard" – community opposition][47]
- "We need more beds overall. We need bets that will accept COD [co-occurring mental health disorder] clients with mild psychotropic medications. We finally have some movement on facilities accepting MAT clients, but that is still problematic."

One state-level stakeholder pointed out that another challenge facing RR/TH programs is difficulty ensuring that services are used for appropriate patients. The COVID-19 pandemic has led many counties and municipalities to prioritize immediately housing PEH to limit the disease's spread. As a result, many PEH who would benefit greatly from housing in a RR/TH program while they receive outpatient services are instead placed in the first housing option (e.g., shelter, Project Roomkey hotel) that is available. Conversely, in some communities, PEH who are known to have issues related to substance use are being placed into RR/TH programs, but without assurance that they are actively engaging in outpatient treatment or are willing to abstain from substance use or follow RR/TH rules. Thus, while RR/TH services are limited, they are also not being used as efficiently or effectively as they could be.

The other significant challenge pointed out by interviewees was housing patients once they leave RR/TH programs. While RR/TH programs are good housing options for patients to transition to as they leave residential care, there are no such housing options for patients when they complete outpatient treatment. RR/TH programs require their residents to be engaged in SUD treatment or recovery support activities.[48] Consequently, once patients no longer meet medical necessity criteria for treatment or recovery supports, there are no housing options available to them. The fear of losing housing once completing treatment can cause significant anxiety that impedes recovery for many clients. It can also serve as a disincentive for patients to exit treatment once they no longer need it.

Conclusions

The DMC-ODS waiver has not had an appreciable impact on treatment outcomes for PEH beyond outcomes observed in State Plan counties.

[47] As reported by the California Consortium of Addiction Programs and Professionals in a July 7, 2020 letter to California Attorney General Xavier Becerra, there are local ordinances in place or pending to limit the development and placement of RR/TH facilities across California at both the city (e.g., Anaheim, Costa Mesa, Yucaipa, Fresno, Lagunia Niguel, Fresno, Dana Point) and county (e.g., Kern, Los Angeles, Orange, Sacramento) levels.
[48] DHCS Information Notice 18-058, Substance Use Prevention and Treatment Block Grant Funded Room and Board for Transitional Housing, Recovery Residences, and Residential Treatment Services. December 2018.

To improve outcomes, DHCS can consider providing counties and providers with training and technical assistance to facilitate the greater use of promising and evidence-based practices for serving PEH. These practices include the following,[49] all of which can be adapted to address the needs of PEH:

- the use of incentives (e.g., food, transportation, benefits)
- access to primary medical care
- motivational interviewing
- integrated treatment for co-occurring mental health disorders
- peer support
- intensive case management
- critical time intervention
- contingency management
- assertive community treatment
- illness self-management
- medications for addiction treatment
- cognitive-behavioral interventions.

According to county administrators and key informants, SABG funding is insufficient to provide the RR/TH services counties need. DHCS could consider ways to leverage other funds to support RR/TH services or strategies to collaborate with other state agencies that can provide funding to support RR/TH services. The December 2020 augmentation of SABG funding[50] has created an opportunity that can be used to increase funding for RR/TH services.

County administrators and key informants also reported that there are not enough RR/TH services available to meet demand. DHCS can consider ways to encourage providers and local communities to develop sufficient RR/TH program capacity to meet the need statewide.

There is concern that RR/TH programs are not currently capable of serving PEH with co-occurring mental health disorders or those who are receiving medications for addiction treatment. DHCS can address this issue by providing training and technical assistance specifically for RR/TH programs to help them better meet the needs of PEH with mental health disorders and those who use medications for addiction treatment.

County administrators and key informants reported concern that some PEH who would benefit from RR/TH services are being housed in other programs, while other PEH who are not appropriate for RR/TH are being placed in them anyway. To address this issue, DHCS could create a tool that counties, service providers, and RR/TH programs could use to determine RR/TH programs' appropriateness for different patients. This tool could be integrated into

[49] Substance Abuse and Mental Health Services Administration. Behavioral Health Services for People Who Are Homeless. Treatment Improvement Protocol (TIP) Series 55. HHS Publication No. (SMA) 13-4734. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
[50] Knopf (2021). $2.3 trillion spending bill includes COVID-19 relief, adding $1.65 billion to SAPT BG. Available at: https://onlinelibrary.wiley.com/doi/full/10.1002/adaw.32933?campaign=woletoc

ASAM Criteria-based assessments in DMC-ODS waiver counties to minimize administrative and paperwork burden.

Though the aforementioned recommendations would help address the needs of PEH, the intertwined problems of homelessness and SUD among the patients that DHCS serves may require a more sweeping and coordinated response. At the federal level, there is currently a proposal for an Excellence in Recovery Housing Act, which would develop guidelines for high-quality recovery housing, provide grants to states to implement these guidelines, authorize the National Academy of Sciences to study the issue in detail, and create an interagency workgroup of SAMHSA and HUD to increase interagency collaboration on recovery housing.[51] This integrated, interagency approach could serve as a model that DHCS could emulate at the state level. To encourage the development and utilization of effective RR/TH services, DHCS could develop guidelines for high-quality recovery housing and provide grants to localities to develop RR/TH programs. There is currently a Little Hoover Commission examining the impact of COVID-19 on housing in California. DHCS could collaborate with the Commission to focus on housing issues as they relate to SUD treatment.[52] DHCS could also establish a workgroup with the California Department of Housing and Community Development to collaboratively develop an interagency plan to promote the development and sustainability of RR and TH services across the state.

[51] For details, see Rep. David Trone's press release on the Excellence in Recovery Housing Act, available at https://trone.house.gov/sites/trone.house.gov/files/wysiwyg_uploaded/Recovery%20Housing%20One-Pager%20%283%29.pdf. Accessed January 26, 2021.
[52] Little Hoover Commission, Overview: COVID-19 Impact on Housing. https://lhc.ca.gov/report/covid-19-impact-housing. Accessed January 26, 2021.

9. Special Topic: Stakeholder Feedback on Current Waiver Requirements

Darren Urada, Ph.D., Anne B. Lee, LCSW, Cheryl Teruya, Ph.D., Brittany Bass, Ph.D.

Introduction

Providers in DMC-ODS waivered counties were asked for suggestions for improving waiver implementation as part of a survey, and DMC-ODS waivered county administrators were asked a similar question as part of key informant interviews (see Methodology chapter). The following is a summary of common responses.

Methods

The following findings are based on County Administrator Surveys, Provider Surveys, and key informant interviews. See Chapter 2 (Methodology) chapter for more details on these methods.

Results

Guidance

DMC-ODS providers were asked via survey, "What suggestions do you have for the state, county, or other treatment organizations for improving DMC-ODS waiver implementation?"

The most common category of responses focused around training. Twenty four providers brought this up in open-ended responses, primarily in reference to DMC-ODS waiver requirements, policies, and protocols. The need for clarity and specificity from the county and state was a recurring theme:

> "Don't make language vague, make specific forms"
>
> "A clear understanding of documentation needs"

Consistent with this, seven providers complained that clarity from their counties was lacking, stating, for example:

> "Our county had no idea what they were doing. Everyone was in new positions and gave conflicting information."
>
> "I think our county is trying and are willing to work with us, but they seem to have more questions than answers."

However, counties likewise had parallel complaints about lack of specificity from the state:

> "I felt like there were often times where they'd say, "Well, it's up to you guys to figure it out," and then I'd submit something to them and they'd say no and not give any advice and say, "Well, it's up to you guys to figure it out."

> "We need consistent regulations with consistent interpretation. The state analyst each have their own interpretation of the regulations and it causes inconsistencies."

Some counties expressed interest in getting concrete examples and contacts that they can use:

> "A presentation that gives maybe specifics and examples of what providers are using . . . would be great."

> "DHCS could link providers with county staffs like, here's a list of five providers that have said that they would welcome any inquiry or tour of their program. These providers in these counties say that other counties can call them. Just stuff like that."

> "Looking at trainings in the future, we really need those tangible tools that we can walk away from and use."

One of the DMC-ODS county key informants explained that they were hesitant to tell their providers to do recovery services in particular a certain way because they feared they would end up rigidly doing it that way, whereas they wanted the services tailored to the needs of the people in treatment.

> "And so, we're like—we're hesitant to tell you to do it that way, because then you're actually gonna do it that way. . . . so no, really look at catering it to the needs of the consumers of what they need during their recovery journey, for as long as they need it. And so when I say that . . . they just look me like, "What do you mean?" . . . That's where talking to the state kinda helps, 'cause they can—they kind of um, helped us wrap our heads around that idea. . . It was just, um, [DHCS] just told us the reason why the state left that—some of that stuff open, because they wanted the counties to have that flexibility to do what needed to be done . . .they agreed that it was a little vague, but reassured us that the reason why, was just to give the counties themselves some flexibility to cater that program to the needs of our beneficiaries."

Despite their efforts to explain this to providers, the message may not have resonated with providers from this county. We received only three provider surveys from this county, so the numbers must be interpreted with caution, but those who responded provided strikingly low agreement with the statement "Training and technical assistance to prepare our [treatment program] for DMC-ODS waiver implementation is sufficient" (1.7 for this county, 3.1 statewide) and "Communication and collaboration between treatment providers and the county/counties regarding DMC-ODS waiver implementation is sufficient" (2.3 for this county, 3.3 statewide). In our 2019 DMC-ODS waiver evaluation report we reported similar issues, particularly around recovery services. It appears that despite DHCS's well-intended effort to allow great flexibility, clearer guidance is needed.

As reported in Chapter 1, claims for recovery services are being submitted for only 2.8% of people receiving DMC-ODS treatment, despite programs delivering these services to a much larger percentage of patients.

On the other side of the spectrum, one county, Sacramento, appeared to benefit greatly from support received from DHCS, according to both the county and providers. In a key informant interview with the county, it was explained:

> "I think that DHCS was very helpful when they came out. . . we had three documentation trainings where they specifically outlined case management what to bill for, recovery support services, and the difference between the two. We have a couple of analysts at the state that have been hugely supportive in the various areas. They were calling monthly and were able to get feedback from them. As they went out and did the annual compliance reviews with other counties, they would share some tips and tricks with us that they had gleaned from those meetings. It really enhanced our services, and was really helpful to us to see if we could put some of those suggestions in place."

While the number of Sacramento respondents to our provider survey is small (5), compared to the rest of the state, Sacramento providers tended to rate their agreement higher to the statements "Training and technical assistance to prepare our CDU [treatment program] for DMC-ODS waiver implementation is sufficient" (4.0 for Sacramento providers, 3.0 for the rest of the state) and "Communication and collaboration between treatment providers and the county/counties regarding DMC-ODS waiver implementation is sufficient"(3.8 compared to 3.2), suggesting increased assistance to the county may have improved the information the counties then passed on to its providers. Not all counties received this level of assistance, however. As another county stated:

> "We didn't necessarily have a ton of DHCS technical assistance, which I think maybe would have helped a little bit more."

In addition to receiving assistance from DHCS, county interviewees noted that talking to other counties, either in regional groups or through the CBHDA SAPT+ committee, was extremely helpful.

> "Because I think the times that have been very helpful for our county has been either in that small, regional group, where you can talk through processes, or it's that one, you know, very small, three people that can really consult and look at defining, you know, what certain things mean. So, that might be beneficial in the future.
>
> "[The CBHDA SAPT+ meetings] used to be helpful with DHCS going for a little bit . . . that was a good forum . . . [to] discuss some of our issues with other counties, and figure out what they're doing."

Recommendation: Provide clearer guidance, especially on documentation requirements, billing and recovery services. Continue to participate in the SAPT+ meetings (assuming they resume in person) and facilitate collaborative learning efforts between counties. In particular, if new counties join the DMC-ODS waiver, effort should be made to connect them with similar experienced DMC-ODS waiver counties that are high-performing. Both new and experienced counties may also benefit from collaborative learning opportunities.

Requirements and funding

The next most common group of responses from providers were complaints about what they felt were onerous requirements", and rates that were too low to meet the regulatory burden while also providing treatment.

> "Due to low payment rates, documentation requirements, and risk of recoupments, many eligible programs not pursuing Drug Medi-Cal certification. "
>
> "Agree to a fee structure that is adequate given the tremendous amount of paperwork required"
>
> "The contract demanded a ton of attention, and we had to front costs which put us into financial hardship. I think moving forward the process will get easier because there will be historical information to forecast the future."
>
> "More time for documentation. We have less time for clients"

As in the past, both providers and counties singled out DHCS's Provider Enrollment Division (PED) in their comments.

> "DHCS [DMC-PED] should create a far less difficult and onerous application process for DMC certification" (provider)
>
> "I still recommend that [DHCS] put together some sort of a how-to manual for new providers coming into the space, that if they want to get Medi-Cal certified that there's some technical assistance, rather detailed technical assistance. . . .Because that's how complicated the Medi-Cal certification process is to providers that are wanting to come into this space. I am concerned about that it still remains sort of a magical, you know, behind-the-scenes process. . . ." (county)

Recommendation: Review all requirements and consider which can be removed. UCLA will do the same in terms of evaluation requirements. Provide TA for providers seeking Medi-Cal certification.

Consistency between counties

Another theme found across provider surveys, county surveys, and county interviews centered on the issue of providers trying to navigate requirements from multiple counties. Among DMC-ODS waiver county respondents, 84% of county administrators indicated they experience administrative challenges with out-of-county patients. Options include referring the patient back to their county of residence or they providing the option to transfer the patient's Medi-Cal. As one provider survey respondent explained, the remedy of changing the person's county of residence is not simple.

> "Most of the patients from different counties are working far away from home or staying with families to seek treatment. It is difficult for patients to transfer Medi-Cal to the county where they receive SUD services while all other needs [primary care, dentist, prenatal, etc.] has to be obtained in the home county"

Another option is for the treatment program to treat the person under contract with the county the person resides in, but that creates a need for the programs to manage contracts with multiple counties, which treatment programs and counties alike acknowledge can result in multiple sets of requirements.

> "Consistency is needed across counties in implementing the DMC-ODS waiver regulations. Every county has a different interpretation of the same language." (provider)

> "We have one provider with three counties feeding into it. We didn't want to give them three different forms, three different rules . . ." (county)

Facilitating consistency between counties is one way to facilitate such contracting. Recommendation: Work with CBHDA and provider organizations to identify high-impact requirements that can be standardized across counties (e.g. credentialing, training requirements, Medi-Cal eligibility issues, etc.).

Conclusions

Recommendations

Based on the findings presented above, the following are recommended to improve DMC-ODS waiver implementation:

- Provide much clearer guidance and specific examples, especially on documentation requirements and billing for recovery services. This could address multiple problems by increasing use of the recovery services benefit, partially offsetting concerns about low rates by providing additional revenue to providers for a service many are already providing, and reducing concerns about proper documentation.
- Short term, provide all new counties support similar to that received by Sacramento county. Longer term, consider payment reform (e.g. capitation) that may give providers the flexibility that counties and the state want to provide while removing concerns from providers that claims for specific services may be disallowed.
- Participate in the SAPT+ meetings (assuming these resume in person) and facilitate collaborative learning efforts between counties. In particular, if new counties join the DMC-ODS waiver in the future, effort should be made to connect them with similar high-performing counties. All counties may also benefit from ongoing collaborative learning opportunities, however.
- Review all DMC-ODS waiver requirements to identify any that can be removed. UCLA will do the same in terms of evaluation requirements.
- Work with CBHDA and provider organizations to identify requirements that can be standardized across counties (e.g. credentialing, training requirements, etc.).

10. Conclusions

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Overall, the DMC-ODS waiver demonstration project has been a success at improving treatment access, quality, and coordination/integration of care. Since its inception it has expanded to cover 95.9% of California's population. Still, many challenges remain. Penetration rates can be improved. Confusion over certain benefits remain. Needs for technical assistance, training, and tools on several topics remain high. The treatment system is struggling with COVID-19, rising stimulant and opioid overdoses, working across silos of care, and rising rates of homelessness.

Still, 21 mostly small and rural counties remain that are not part of the DMC-ODS waiver, and waiver requirements present many challenges for these counties. Addressing their concerns about DMC-ODS waiver requirements may help, and lessons on how to build a regional model can be taken from experiences of PHC W&R.

Looking ahead, there are several initiatives that will shape DMC-ODS in the near future. First, use of telehealth and take-home medications expanded tremendously during the COVID-19 public health emergency, and there is interest in continuing use of these measures in the future. Second, by law DHCS will be required to seek federal approval to establish Peer Specialist as a provider type. Third, the DMC-ODS waiver itself is subject to expiration at the end of 2021. Current plans call for the current 1115 waiver to be replaced by California Advancing and Innovating Medi-Cal (CalAIM).

UCLA's data support specific changes DHCS is currently considering proposing for CalAIM:

- **Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period**. ASAM LOC Placement data and CalOMS-Tx data suggest allowing more than two residential treatment episodes is unlikely to make a large difference in admissions (see Chapter 3, Quality section, Table 3.4 and associated discussion). However, stakeholders have consistently argued that the change would help them better serve patients, especially those who drop out of treatment early and thereby use up one of their two stays. Taken together, the data suggest this change can be made to meet stakeholder concerns without having much of an impact on residential admissions.

- **Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis is determined**. This is consistent with timely access to care and funding activities that are currently carried out but not reimbursed.

- **Clarify the recovery services benefit**. - This has been a consistent and high-priority need, according to stakeholder feedback and claims data. Clarification could address multiple challenges by increasing currently minimal use of the recovery services benefit and thereby improving care, providing additional revenue to providers, and reducing

stakeholder concerns over proper documentation (see Chapter 3, Access section, Access to Recovery Services, and Chapter 9).

- **Expand access to MAT**. High rates of opioid overdoses in California continue to make MAT expansion a high priority (see Chapter 3, Access section, Table 3.3 and associated discussion).

- **Increase access to SUD treatment for American Indians and Alaska Natives (AI/AN).** The number of AI/AN accessing services has increased significantly under DMC-ODS (see Chapter 3, Table 3.2), but AI/AN were highest in overdoses from both stimulants and opioids (see Chapter 7).

- **Expand access to contingency management (CM) for treatment of stimulant use disorders.** Contingency management is the most promising evidence-based practice for the treatment of stimulant use, and most counties expressed interest in using contingency management (see Chapter 7), if it were made allowable under DMC-ODS.

In addition to these proposed changes, the data in this report support several other recommendations, which are summarized in the next section.

Lessons Learned and Recommendations

Recommendations for DHCS and other states interested in implementing a similar approach

Recommendation for other states:

- Use patient perceptions of care/satisfaction surveys. One-page forms can be administered successfully with good response rates, and counties and providers have found the survey data to be helpful in informing their quality improvement efforts
- Provide technical assistance to counties early on in the demonstration regarding data to be collected and submitted under the DMC-ODS waiver (e.g., ASAM LOC, claims), monitor whether the data are being submitted in a timely fashion, and give initial feedback to minimize missing or inaccurate data.
- Balance the minimum requirements for voluntary participation in the DMC-ODS waiver against the potential resulting exclusion of smaller, less populated areas.

Recommendations for DHCS

Access

- Increase penetration rates by working with primary care and other systems to identify and refer patients who do not currently recognize their need for treatment.
- Clarify the recovery services benefit.
- Further investigate the need for additional funding and support for youth, and the causes of low referral rates to NTP/OTP.

Quality

- Provide technical assistance (e.g., tools, training) on assessing fidelity to the EBPs identified in the STCs as well as to the ASAM Criteria.
- Provide a standard ASAM Criteria-based assessment tool for use statewide.
- Consider allowing the use of and billing for case managers or peer specialists, when needed, to help patients access treatment services to which they have been referred in a timely manner, particularly following an ASAM Criteria-based brief screening.

Integration/Coordination

- Provide training and technical assistance on the case management benefit, addressing 1) billing issues and concerns of disallowances, 2) documentation requirements, and 3) strategies to provide case management services during transitions of care.
- Consider allowing billing for case management services before a beneficiary is admitted into treatment, given the amount of case management that occurs as part of the admission process.
- Provide training and technical assistance to providers on privacy regulations and best practices for information exchange between SUD-MH and SUD-PH programs, including use of release of information forms to facilitate referral and care coordination.
- Standardize Medi-Cal MH and SUD assessment and documentation requirements.
- Address stigma toward SUD patients and programs within the physical health system, with a particular emphasis on OTP/NTP patients.

COVID-19

- Extend flexibilities for the use of telehealth for SUD services beyond the pandemic. Flexibilities such as allowing the use of telehealth in 1915(c) waiver populations can be extended through a State Plan Amendment (SPA) or a modified 1915(c) waiver, or permanently extended through state action, according to CMS.
- Address barriers to telehealth use, possibly including efforts to facilitate linkage to the Lifeline program coupled with assistance with mobile data plans for people in treatment.
- Extend the flexibilities related to take-home medications beyond the pandemic.
- Expand efforts to increase recovery residence housing and bed supply.

Lessons Learned for Future Regional Models

- Weigh the ease of using fee for service against the use of per use per month (PUPM) payments like those used by PHC W&R, depending on the abilities of participants in the model.
- Consider a planning process that would include a committee with DHCS, the managed care plan, and the counties at the table to figure out the fiscal plan as well as anticipated costs.

What State Plan Counties Would Need to Join DMC-ODS

- Connect State Plan counties who want to join the DMC-ODS waiver to successful small DMC-ODS waiver counties or the PHC W&R program for planning purposes.
- Consider funding partnerships or learning collaboratives to facilitate information exchange.
- Deliver technical to State Plan counties to assist with
    - Expansion of provider networks
    - Transportation needs
    - A standardized assessment tool.
    - Implementing an EHR system that can keep up with regulatory changes and facilitate billing and inter-agency communications.

Stimulants

- Assistance in the form of stimulant use disorder-related clinical guidelines, protocols, toolkits, and trainings. Facilitating use of contingency management.

People Experiencing Homelessness (PEH)

- Increase training and technical assistance on evidence-based practices for serving PEH
- Increase funding for Recovery Residences and Transitional Housing (RR/TH) with the recent augmentation to SABG funds;
- Enhance RR/TH capacity to serve PEH with co-occurring mental health disorders and those who use medications for addiction treatment;
- Develop an integrated, interagency response to the intertwined challenges of housing and treatment for PEH with SUD at the state level.

Stakeholder Feedback on Current Waiver Requirements

- Provide much clearer guidance and specific examples, especially on documentation requirements and billing for recovery services. This could address multiple problems by increasing use of the recovery services benefit, partially offsetting concerns about low rates by providing additional revenue to providers for a service many are already providing, and reducing concerns about proper documentation.

- Short term, provide new counties with support similar to that received by Sacramento county. Longer term, consider payment reform (e.g. capitation) that may give providers the flexibility that counties and the state want to provide while removing concerns from providers that claims for specific services may be disallowed.
- Participate in the SAPT+ meetings (assuming these resume in person) and facilitate collaborative learning efforts between counties. In particular, if new counties join the DMC-ODS waiver in the future, effort should be made to connect them with similar high-performing counties. All counties may also benefit from ongoing collaborative learning opportunities, however.
- Review all DMC-ODS waiver requirements to identify any that can be removed. UCLA will do the same in terms of evaluation requirements.
- Work with CBHDA and provider organizations to identify requirements that can be standardized across counties (e.g. credentialing, training requirements, etc.).

Implementation of the DMC-ODS waiver is still unfolding, and by all accounts the DMC-ODS waiver has required profound changes in practices and culture shifts that take time to develop. UCLA will continue reporting evaluation results through December 2021.

Interpretations, Policy Implications, and Interactions with Other State Initiatives

There are a number of other efforts in California that might have an impact on specialty SUD treatment. The endeavor most direct and likely to have an effect would be the extensive MAT Expansion Project[53] funded by SAMHSA's State Targeted Response and State Opioid Response grants. This enterprise would mainly have an impact on the treatment of opioid use disorder, which may have played a role in the increased use of MAT, particularly the increase in buprenorphine prescribing in narcotic treatment program/opioid treatment program settings, in the state. Since the DMC-ODS waiver and the MAT Expansion Project share the goal of making buprenorphine available, these complimentary efforts are difficult to disentangle. Still, there is good evidence that the DMC-ODS waiver had an effect independent of other external influences. This effect is demonstrated by the increase in DMC-ODS services delivered when individual counties went live, even though counties went live in different months. Even if the MAT Expansion Project or other efforts were having an overarching effect, there appeared to be an independent effect of the DMC-ODS waiver. Likewise, when stakeholders were asked directly about the effect of the DMC-ODS waiver on quality and care coordination, they indicated that the DMC-ODS specifically had a positive impact. It is important that such data continue to be collected in order to measure the effect of the DMC-ODS waiver, both in California and in other states that implement similar waivers.

[53] http://www.californiamat.org/

Appendices

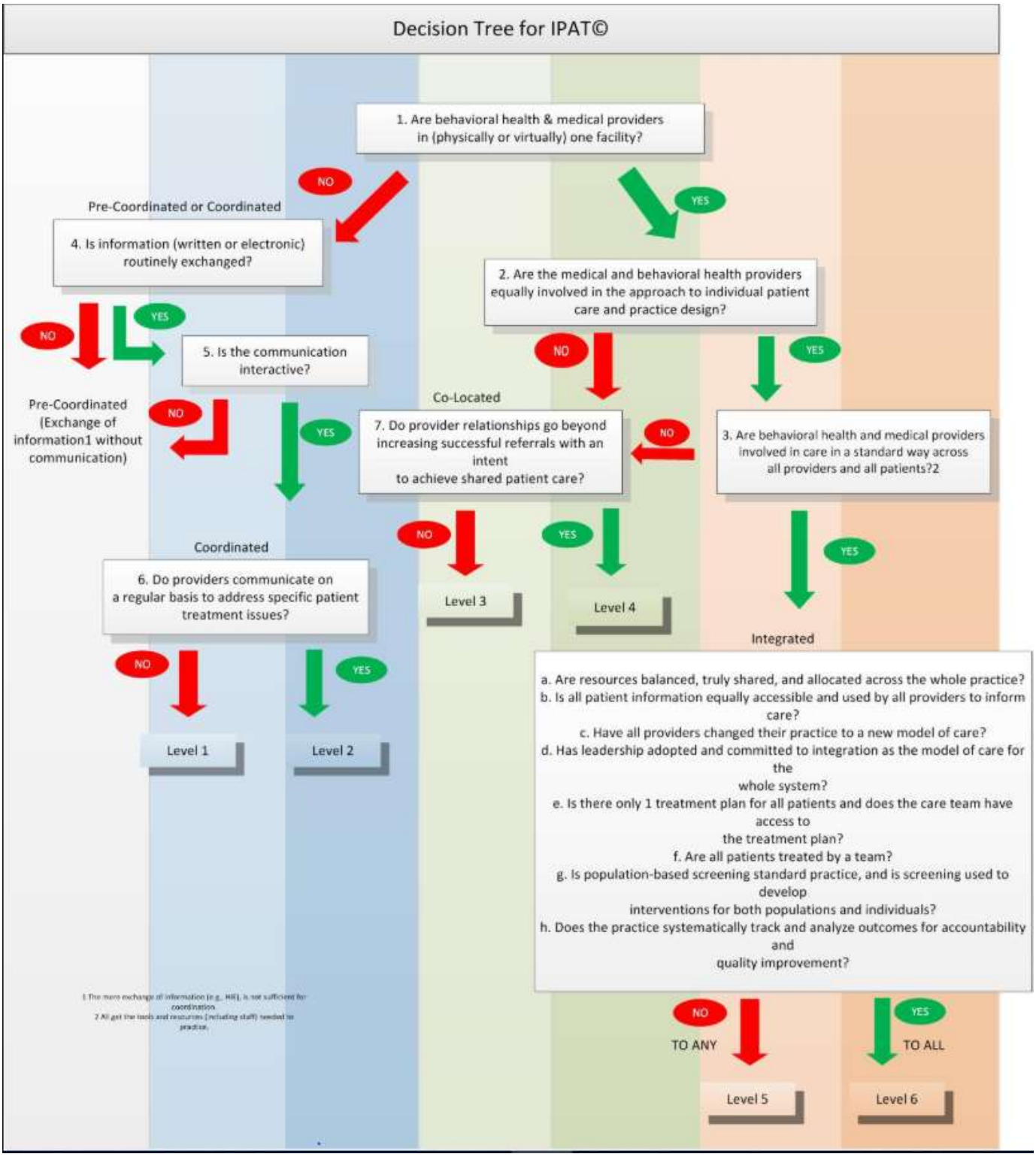
Appendix A:
Report Acronyms

Report Acronyms

42 CFR (Part 2)	42 Code of Federal Regulations, Part 2 (concerning Confidentiality of Substance Use Disorder Patient Records)
ASAM (Criteria)	American Society of Addiction Medicine
BHC	Behavioral Health Concepts
CalOMS-Tx	California Outcome Measurement System, Treatment
CBHDA	County Behavioral Health Director's Association of California
CBT	cognitive-behavioral therapy
CCT	Care Coordination Team
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
CRM	continuous relapse monitoring
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS (waiver)	Drug Medi-Cal Organized Delivery System
DUI	Driving Under the Influence
EHR	electronic health record
EQRO	External Quality Review Organization
HIE	Health Information Exchange
HIPAA	Health Insurance Portability & Accountability Act of 1996
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
IOP	intensive outpatient
IPAT	Integrated Practice Assessment
IT	Information Technology
LOC	level of care
LPHA	Licensed Practitioner of the Healing Arts
MAT	medications for addiction treatment
MEDS	Medi-Cal Eligibility Data System
MH	mental health
MHSIP	Mental Health Statistics Improvement Program
MI	motivational interviewing

MITI	Motivational Interviewing Treatment Integrity
MMEF	MEDS Monthly Extract File
MOU	memorandum of understanding
MPF	Maser Provider File
NOMS	National Outcome Measures
NQF (measures)	National Quality Forum
NSDUH	National Survey on Drug Use and Health
NTP	narcotic treatment program
ODF	Outpatient Drug Free (also see OP)
OP	outpatient
OTP	opioid treatment program
PED	Provider Enrollment Division
PH	physical health
PSS	peer support specialist
ROI	Release of Information
RR	Recovery Residence
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention & Treatment
SAPT+	Substance Abuse Prevention Treatment committee and quarterly meeting CBHDA holds to talk about SAPT issues
SD/MC (claims)	Short Doyle Medi-Cal
SPA	State Plan Amendment
START	Substance Abuse Treatment and Recovery Team
STCs	Standard Terms and Conditions
SUD	substance use disorder
SUTS	County of Santa Clara Health System - Substance Use Treatment Services
TA	Technical Assistance
TBD	to be determined
TEDS	Treatment Episode Dataset
TH	Transitional Housing
TPS	Treatment Perceptions Survey
UCLA(-ISAP)	University of California, Los Angeles (Integrated Substance Abuse Programs)
WM	withdrawal management

Appendix B:
IPAT Decision Tree



Reference: https://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf

Appendix C:
TPS Report

Table 1. Responses to Treatment Perception Survey by County–Adults and Youth

County	Number of Respondents	Percent	County Response Rates
Alameda	1,017	4.3%	47.5%
Contra Costa	572	2.4%	55.5%
El Dorado*	103	0.4%	100.0%
Fresno	598	2.5%	25.6%
Imperial	357	1.5%	81.5%
Kern	461	2.0%	28.2%
Los Angeles	5,909	25.1%	78.8%
Marin	136	0.6%	53.8%
Merced	293	1.2%	75.7%
Monterey	256	1.1%	52.7%
Napa*	115	0.5%	100.0%
Nevada	151	0.6%	82.5%
Orange	805	3.4%	43.8%
Placer	348	1.5%	96.4%
Riverside	1,019	4.3%	39.3%
Sacramento	1,370	5.8%	44.9%
San Benito	33	0.1%	63.5%
San Bernardino	893	3.8%	43.8%
San Diego	2,558	10.9%	79.6%
San Francisco	1,951	8.3%	85.1%
San Joaquin	541	2.3%	30.1%
San Luis Obispo*	596	2.5%	100.0%
San Mateo	248	1.1%	62.8%
Santa Barbara	538	2.3%	57.7%
Santa Clara	405	1.7%	53.9%
Santa Cruz	189	0.8%	29.5%
Stanislaus	855	3.6%	70.1%
Tulare	322	1.4%	40.0%
Ventura	681	2.9%	63.6%
Yolo*	247	1.0%	100.0%
Total	23,567	100.0%	58.7%

* The number of surveys submitted was greater than the number of unique clients in the CY2019 Short-Doyle DMC claims database used for this report. The response rate was capped at 100%.

Table 2. Survey Responses by Treatment Program – Adults

	N	Percent
Treatment Program*		
Outpatient/intensive outpatient	360	47.6%
Residential	235	31.1%
Opioid/narcotic treatment program	135	17.9%
Withdrawal management (standalone)	25	3.3%
Partial hospitalization	1	0.1%
Total	756	100.0%
Number of respondents		
Outpatient/intensive outpatient	8,392	36.8%
Residential	4,156	18.2%
Opioid/narcotic treatment program	10,039	44.0%
Withdrawal management (standalone)	250	1.1%
Partial hospitalization	1	0.0%
Total	22,838	100.0%

*In this report, the term "treatment program" is defined as a unit having a unique combination of CalOMS-Treatment Provider ID and treatment setting and/or Program Reporting Unit ID (if required by the county) as indicated on the survey forms or in the data file submitted to UCLA

Table 3. Survey Respondents by Treatment Program – Youth

	N	Percent
Treatment Program*		
Outpatient/intensive outpatient	132	93.0%
Opioid/narcotic treatment program	1	0.7%
Residential	8	5.6%
Other/missing	1	0.7%
Total	142	100.0%
Number of respondents		
Outpatient/intensive outpatient	894	96.4%
Opioid/narcotic treatment program	1	0.1%
Residential	31	3.3%
Other/missing	0	0.0%
Total	927	100.0%

*In this report, the term "treatment program" is defined as a unit having a unique combination of CalOMS-Treatment Provider ID and treatment setting and/or Program Reporting Unit ID (if required by the county) as indicated on the survey forms or in the data file submitted to UCLA.

Table 3. Demographic Characteristics - Adults (N=22,838)

	N	Percent
Gender (Multiple responses allowed)		
Female	8,957	39.2%
Male	12,619	55.3%
Transgender	136	0.6%
Other gender identity	91	0.4%
Decline to answer/missing	1,133	5.0%
Age Group		
18-25	1,898	8.3%
26-35	7,074	31.0%
36-45	5,117	22.4%
46-55	3,839	16.8%
56+	3,652	16.0%
Missing	1,258	5.5%
Race/ethnicity (Multiple responses allowed)		
American Indian/Alaska Native	1,009	4.4%
Asian	632	2.8%
Black/African American	2,811	12.3%
Latinx	7,146	31.3%
Native Hawaiian/Pacific Islander	389	1.7%
White	10,175	44.6%
Other	1,619	7.1%
Missing	1,295	5.7%
How long received services here		
First visit/day	1,164	5.1%
2 weeks or less	2,006	8.8%
More than 2 weeks	18,954	83.0%
Missing	714	3.1%
Surveys received by language		
Chinese	3	0.0%
English	22,140	96.9%
Hmong	2	0.0%
Russian	1	0.0%
Spanish	688	3.0%
Vietnamese	4	0.0%

Table 5. Demographic Characteristics – Youth (N=927)

	N	Percent
Gender (Multiple responses allowed)		
Female	276	29.8%
Male	600	64.7%
Transgender	6	0.7%
Other gender identity	3	0.3%
Decline to answer/missing	47	5.1%
Age Group		
12-14	134	14.5%
15-16	423	45.6%
17+	297	32.0%
Missing	73	7.9%
Race/ethnicity (Multiple responses allowed)		
American Indian/Alaska Native	31	3.3%
Asian	37	4.0%
Black/African American	139	15.0%
Latinx	569	61.4%
Native Hawaiian/Pacific Islander	17	1.8%
White	143	15.4%
Other	75	8.1%
Unknown/missing	70	7.6%
How long received services here		
Less than 1 month	284	30.6%
1-5 months	465	50.2%
6 months or more	137	14.8%
Missing	41	4.4%
Surveys received by language		
English	916	98.8%
Spanish	11	1.2%

Table 6. Average Score and Percent of Positive Scores by Treatment Setting – Adults

	Average Score* (Standard Deviation)	Percent of Respondents with Positive Score**
Outpatient/intensive outpatient	4.5 (0.6)	94.7%
Residential	4.3 (0.7)	88.0%
Opioid/narcotic treatment program	4.4 (0.6)	93.9%
Withdrawal management (standalone)	4.4 (0.6)	91.5%
Total	4.4 (0.6)	93.1%

*All 14 questions were used to calculate the overall average scores and standard deviation. Scores ranged from 1.0 to 5.0 with higher scores indicating greater satisfaction. Only respondent who answered all 14 questions were included (N=20,848)

**Overall positive scores was calculated using all 14 questions. Survey with an overall average score of 3.5 or higher were counted as having a POSITVE score. Only respondents who answered all 14 questions were included (N=20,848).

Table 7. Average Score and Percent of Positive Scores by Treatment Setting –Youth

	Average score* (Standard deviation)	Percent of respondents with positive score**
Outpatient/intensive outpatient	4.2 (0.6)	85.9%
Residential	4.2 (0.6)	81.5%
Total	4.2 (0.6)	85.8%

*All 18 questions were used to calculate the average score (and standard deviation). Scores ranged from 1.5 to 5.0 with higher scores indicating greater satisfaction. Only clients who responded to all 18 questions were included (N=801).

**Overall positive rating was calculated using all 18 questions. Surveys with an average rating of 3.5 or higher were counted as having a POSITIVE rating. Only clients who responded to all 14 questions were included (N=801).

Figure 1. Average Scores of All Counties by Treatment Setting and Domain–Adults
(Highest to Lowest)

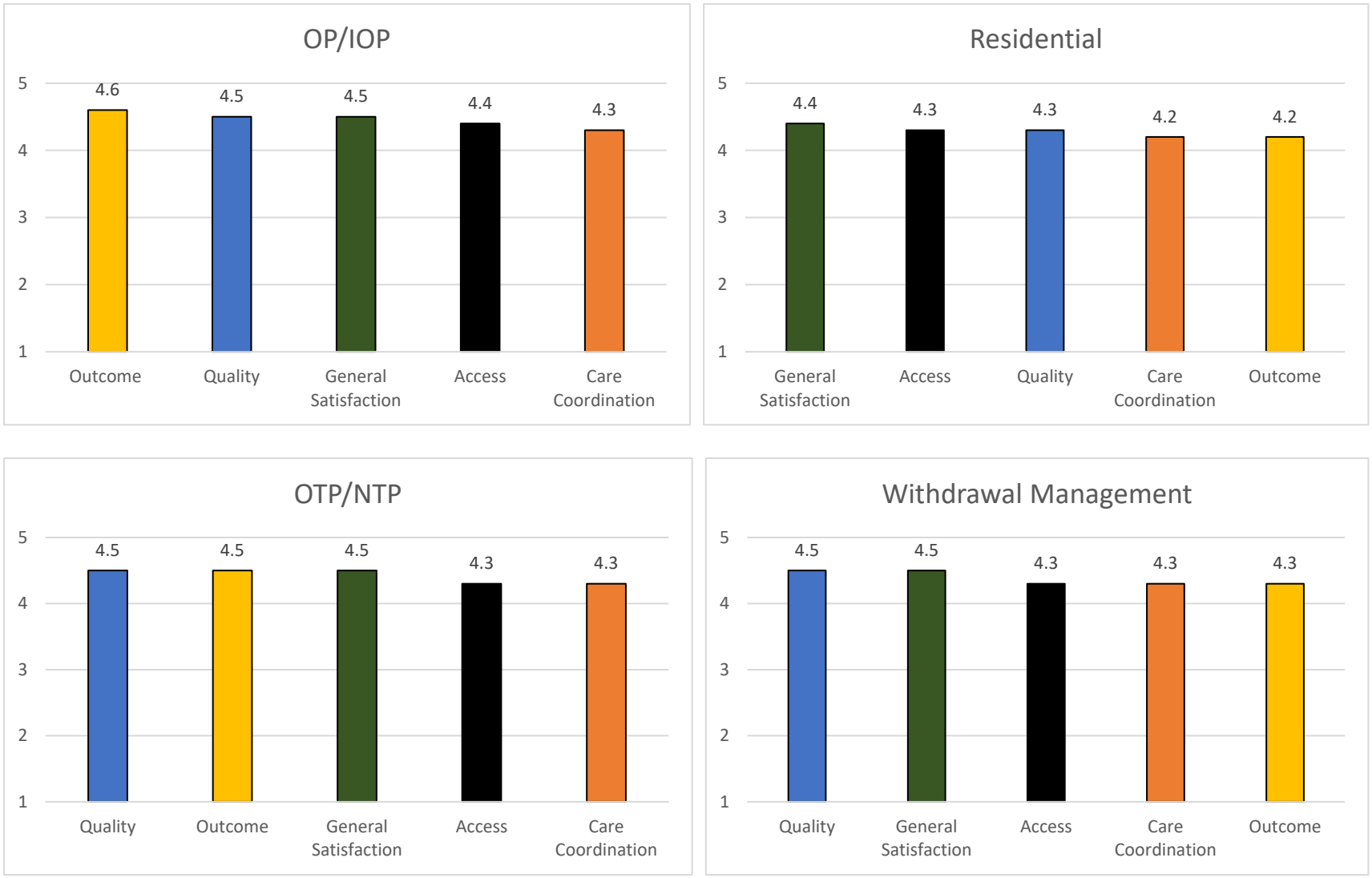
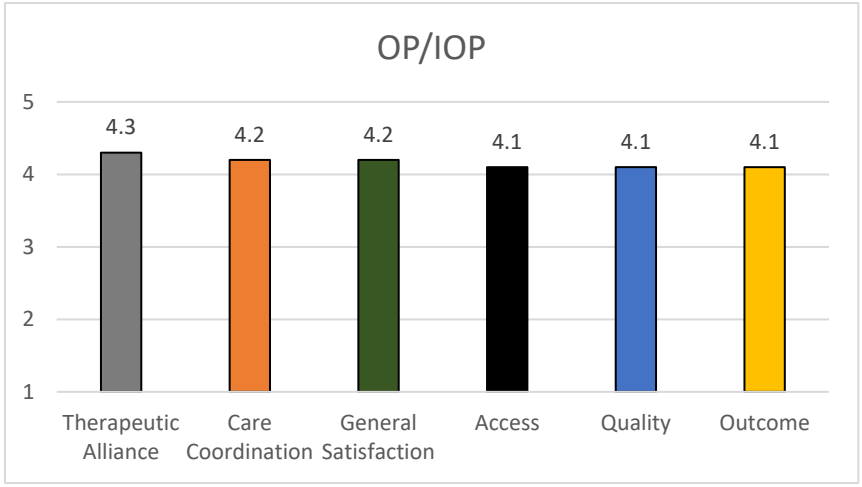
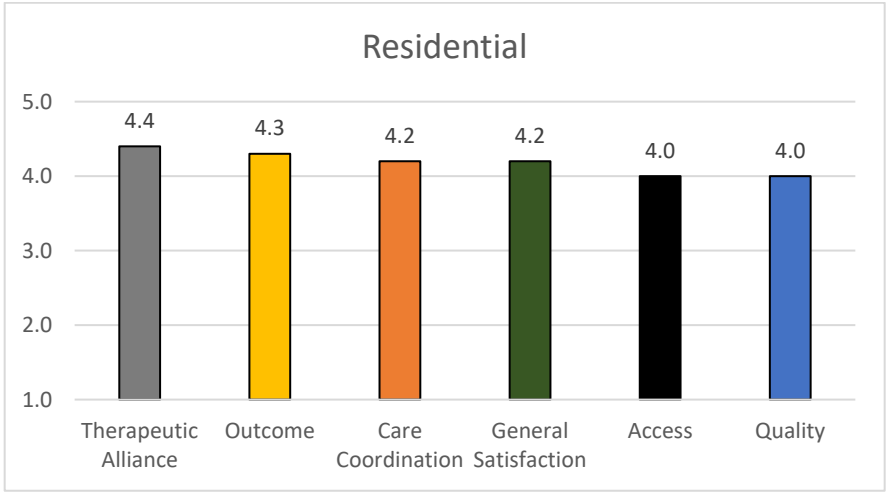


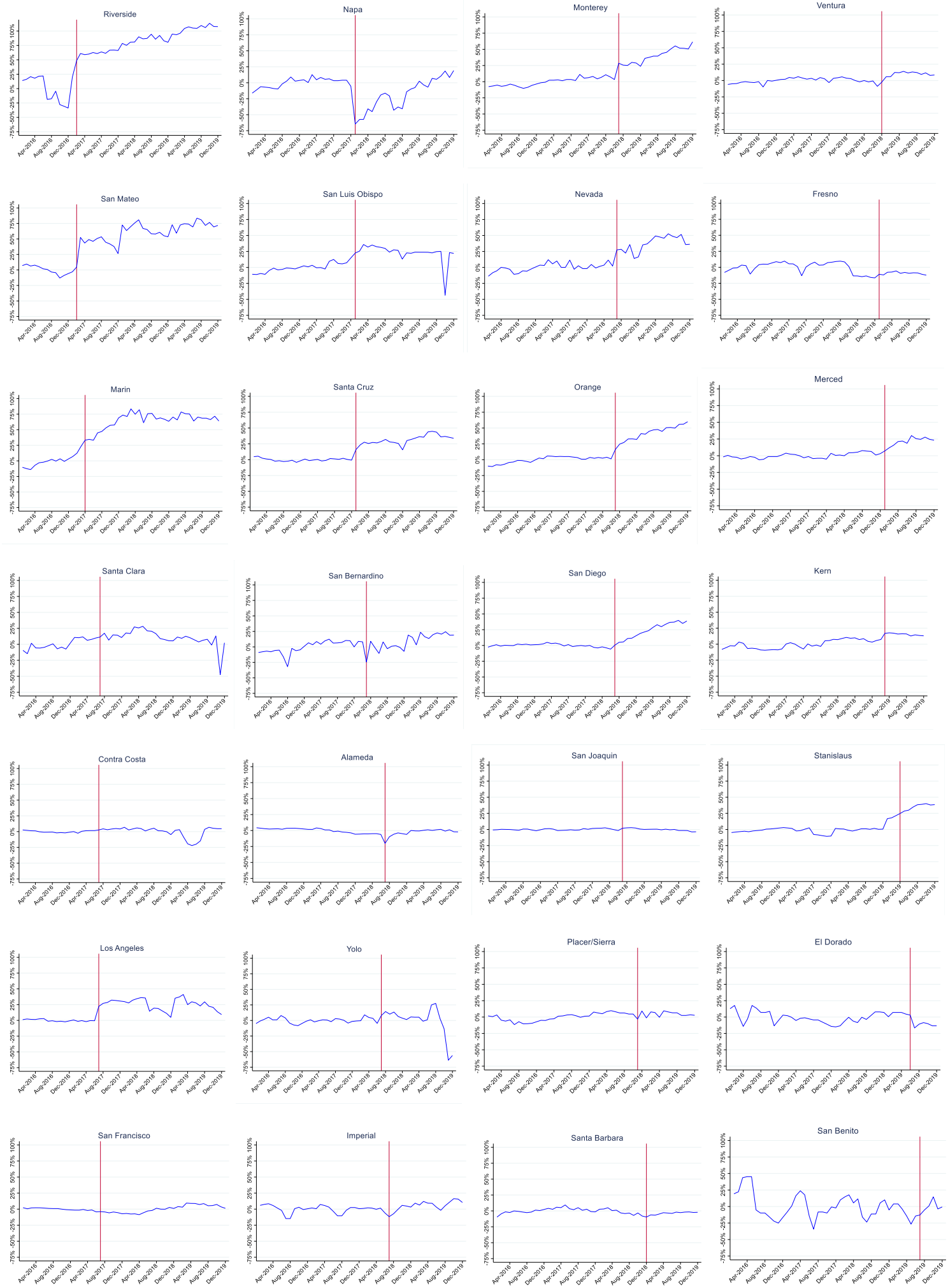
Figure 2. Average Scores of All Counties by Treatment Setting and Domain–Youth (Highest to Lowest)

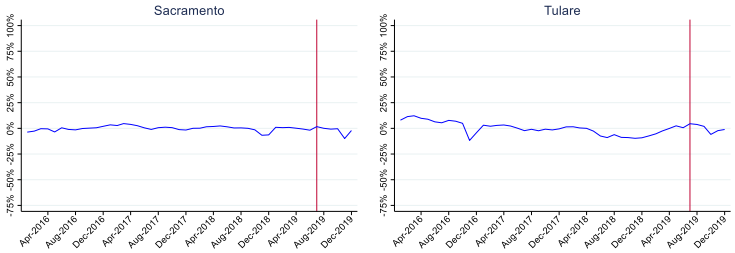




Appendix D:
County Graphs

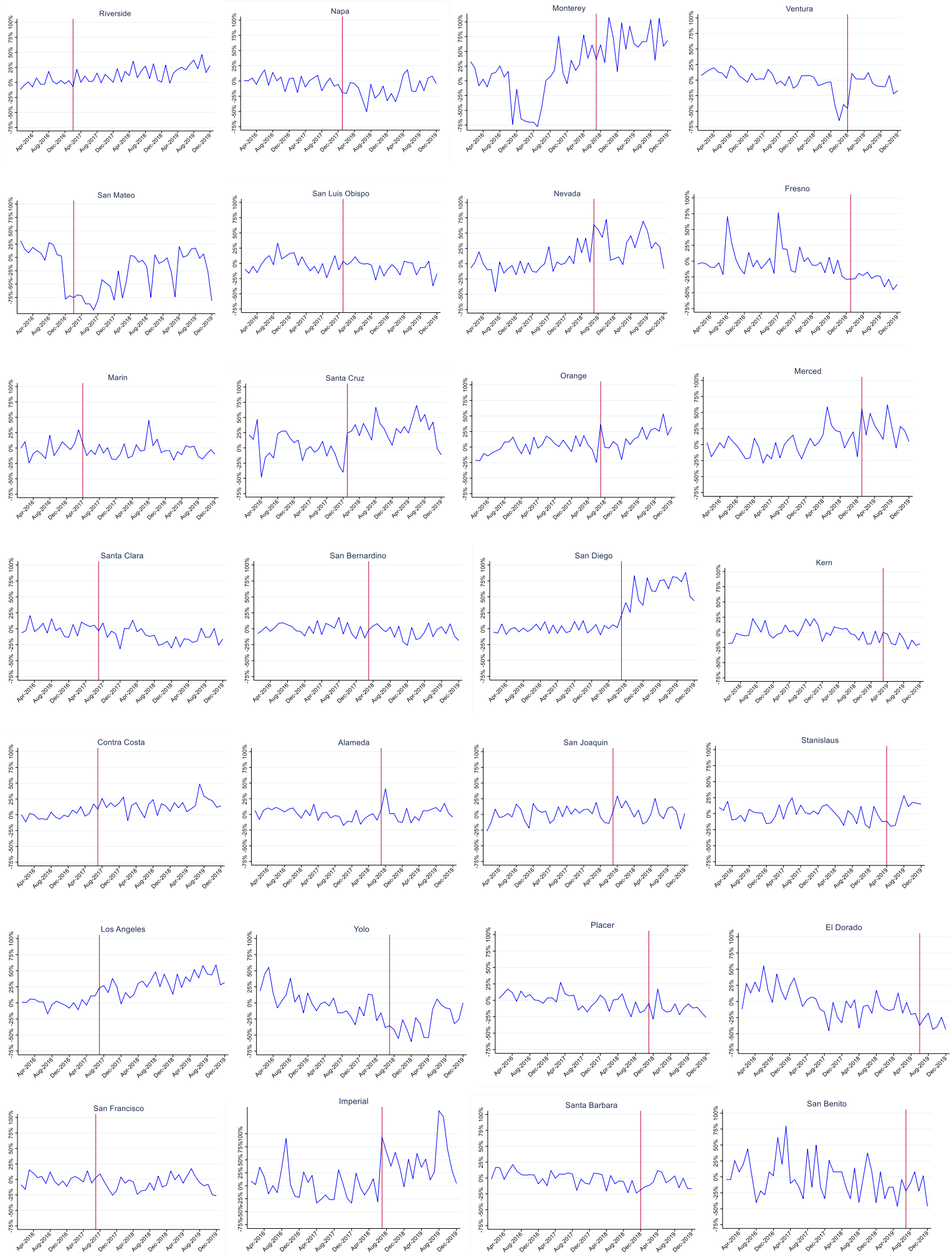
Appendix Figure A: Unique number of patients receiving services before and after Go Live date by county – DMC Claims.

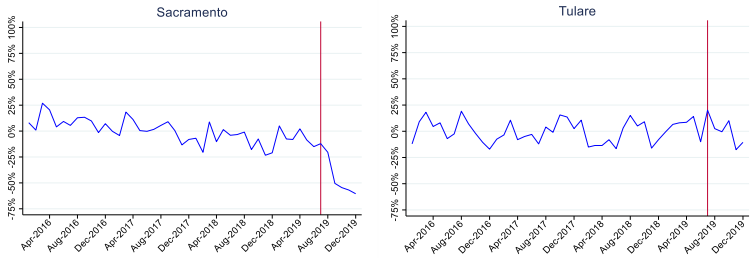




Notes: Percentage change in the unique number of patients receiving services relative to the average number of unique patients receiving services in each county before the DMC-ODS Go Live date. Data are from DMC Claims for CY2016-CY2019. The red verticle line indicates each county's Go Live date.

Appendix Figure B: Unique number of patients receiving services before and after Go Live date by county – CalOMS-Tx.





Notes: Percentage change in the unique number of patients receiving services relative to the average number of unique patients receiving services in each county before the DMC-ODS Go Live date. Data are from CalOMS-Tx for CY2016-CY2019. The red verticle line indicates each county's Go Live date.

Appendix E:
Aggregated Access Figures

Figure A. Unique number of patients receiving services before and after Go Live date aggregated over all DMC-ODS waiver counties – DMC claims data

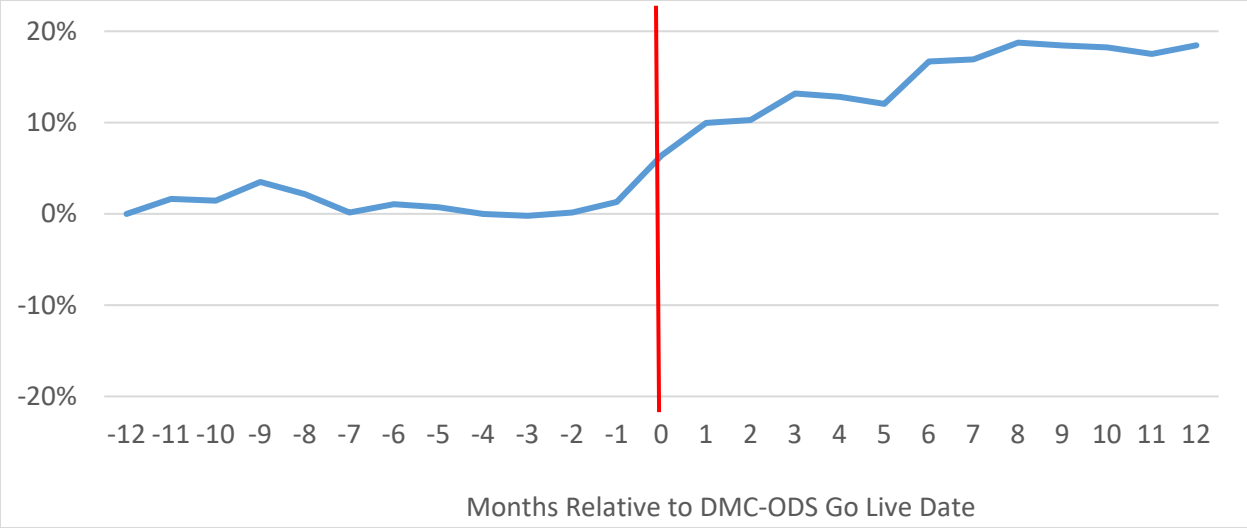
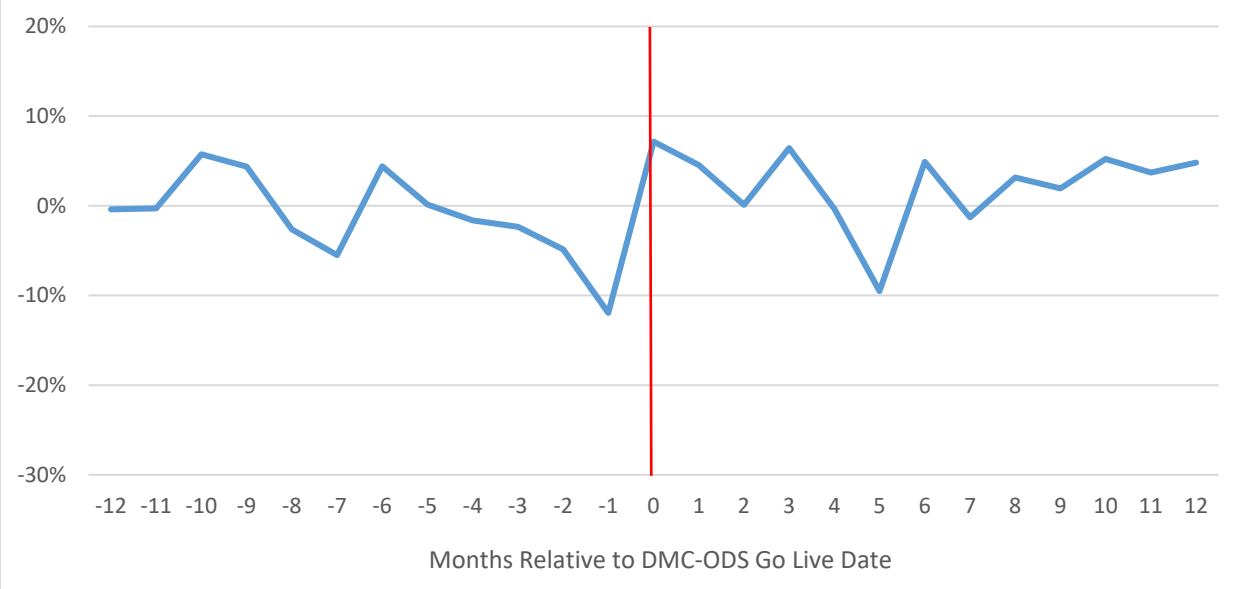


Figure B. Unique number of patients receiving services before and after Go Live date aggregated over all DMC-ODS waiver counties – CalOMS-Tx data



Appendix F:
Exploring Integration/collaboration at the Program Level using the SAMHSA Framework/IPAT Ratings

Exploring Integration/collaboration at the Program Level using the SAMHSA Framework/IPAT Ratings

Valerie P. Antonini, M.P.H., Isabel Iturrios-Fourzan, M.A.

About the Integrated Practice Assessment (IPAT) and SAMHSA Framework for Levels of Integrated Healthcare

To measure provider level of integration with MH and PH, questions from the Integrated Practice Assessment (IPAT) tool[1] were incorporated as a component within the Provider Survey. The IPAT was developed to help place provider practices on levels of integrated care as defined by the Standard Framework for Levels of Integrated Healthcare. The framework, released in 2013 by SAMHSA-HRSA Center for Integrated Health Solutions, identified three main overarching categories —Coordinated care, Co-located care, and Integrated care –with two levels within each category, producing a national standard of six levels of collaboration/integration ranging from Minimal Collaboration to Full Collaboration in a Transformed/Merged Integrated Practice.

SAMHSA Framework for Levels of Integrated Healthcare

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice

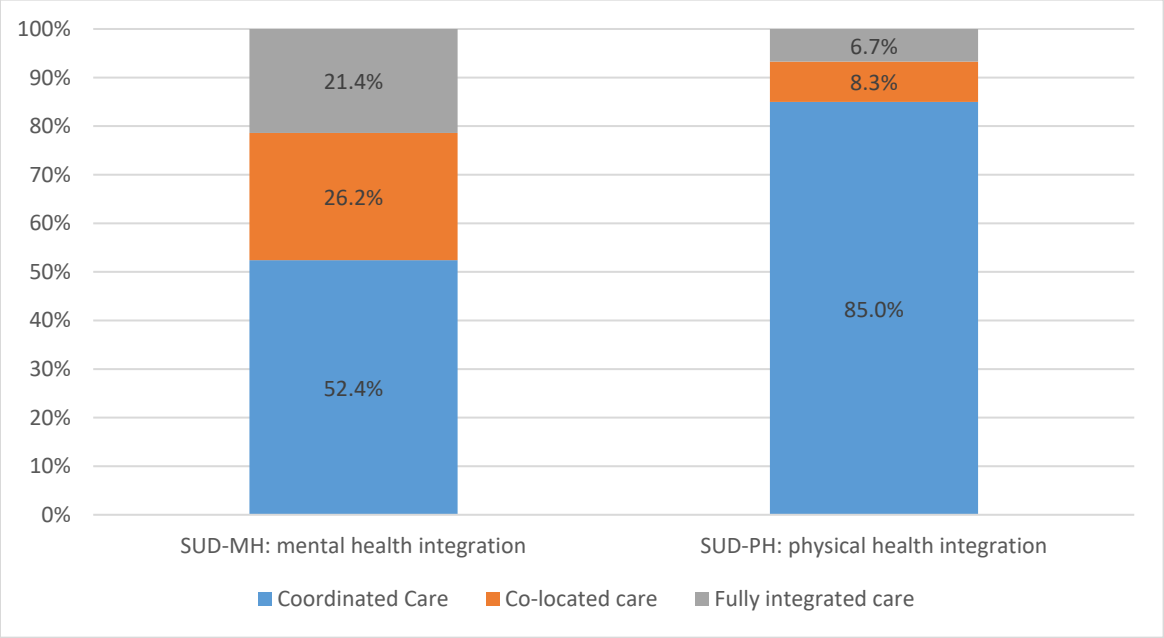
SUD treatment programs (one modality/one location) providing services under the DMC-ODS waiver were sampled and surveyed (with the Provider Survey) to learn how and how well integration/collaboration was being implemented at the point of service delivery. The IPAT uses a series of yes/no questions that cascade (like a decision tree) to one of the six levels of integrated care. See Appendix B for IPAT questions and decision tree. Each program that completed the Provider Survey received an auto-calculated IPAT rating for mental health integration (SUD-MH) and an IPAT rating for physical health integration (SUD-PH) based on responses to the adapted IPAT questions. For purposes of this report, IPAT level ratings 1-6 were collapsed and analyzed by the three main overarching categories: Coordinated Care, Co-located Care, and Fully Integrated Care.

[1] https://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf

IPAT Ratings

Treatment programs from the 30 DMC-ODS waiver counties have contributed to this dataset, with a 60% response rate. Results from the Provider Survey (N=137) provide a description of the current landscape of the SUD system and service delivery under the DMC-ODS waiver with regard to collaboration/integration as defined by the SAMHSA Framework. For purposes of this report, IPAT level ratings 1-6 were collapsed and analyzed by the three main overarching categories: Coordinated Care, Co-located Care, and Fully Integrated Care. Of the 137 survey responses, 51.1% were from outpatient programs, 18.7% were from opioid treatment programs/narcotic treatment programs, and 30.7% were from residential programs. Figure 1 shows the distribution of IPAT ratings for both MH integration and PH integration within this snapshot of the SUD system of care.

Figure 1. IPAT rating of MH and PH service integration in SUD programs



For the SUD-MH service system pairing (MH integration, n=126), about half of the SUD treatment programs (52.4%) rated in the Coordinated Care category (i.e., "minimal/basic integration at a distance"), followed by 26.2% in the Co-located Care category and 21.4% in the Fully Integrated Care category. Eleven providers did not submit all answers to calculate the IPAT rating.

For the SUD-PH service system pairing (PH integration, n=120), the majority of SUD providers (85.0%) rated in the Coordinated Care category, followed by relatively few in the Co-located Care category (8.3%) or in the Fully Integrated Care category (6.7%). Seventeen providers did not submit all answers to calculate an IPAT rating.

Overall, SUD-MH integration was distributed more broadly across the three implementation categories than SUD-PH integration. Although most treatment programs placed in the

Coordinated Care category across both service system pairings, there were more treatment programs offering on-site MH services than on-site PH services.

The SAMHSA Framework defines physical proximity of service delivery (e.g., providing on-site services) as the key element to move beyond the Coordinated Care integration category. The key element to becoming fully integrated is to achieve practice change with a transformation of the program's business model. Based on this dataset, there were more SUD treatment programs delivering services as Fully Integrated SUD-MH programs compared to Fully Integrated SUD-PH treatment programs, which may be due to county SUD efforts generally being overseen by integrated behavioral health that includes both MH and SUD but not PH.

Integration category trends were also explored by treatment modalities (grouped by OP/IOP, residential, NTP/OTP). While each modality had the highest proportion of their programs operating in the coordinated care category (at a distance) for both MH and PH integration, OP/IOP programs rated the highest proportion providing co-located MH and Co-located PH care (69.7% and 60.0%, respectively), where residential programs rated the highest proportion providing fully integrated MH and fully integrated PH care (60.0% and 75.0%, respectively).

The Provider Survey is the first set of data applying the SAMHSA Framework using the IPAT tool (adapted) to measure how MH and PH integration is occurring within DMC-ODS waivered SUD treatment programs. As such, additional questions were included, following the questions determining the IPAT score, to explore key aspects of their program that are known to facilitate more integrated/collaborative care and compare responses by integration categories (coordinated care, co-located care, and fully integrated care) for SUD-MH and SUD-PH integration. Key aspects of service delivery targeted in the survey included: (a) screening practices, (b) on-site service availability, (c) referral practices/partnerships.

Screening practices:

Overall, systematic screening occurred more for mental health than physical health, and the most systematic screening occurred in the Fully Integrated care level. "Systematically" was defined as every client is screened on a regular basis. More providers in the Coordinated Care and Co-located Care categories reported they do not systematically screen for mental or physical health. Further exploration would be required to understand or clarify reports of no systematic screening for the selected MH conditions in programs that are fully integrated with mental health services. See figures 2 and 3.

While SUD programs implementing Co-located MH integration showed more systematic mental health screening than those in the Coordinated Care level, programs implementing Co-located physical health integration did not show this same trend. In fact, programs implementing Co-located physical health integration had the lowest rates of systematic screening practices for all of the selected health conditions (hypertension, diabetes, and chronic pain). The data, however, indicated that regardless of the integration category, if a program systematically screens for one health condition, for example depression, they would likely use a comprehensive screen addressing multiple mental health conditions (including anxiety and trauma). The same was consistent for physical health screening practices.

Figure 2. Percent of provider endorsement of systematic screening practices for these mental health conditions (by IPAT integration category)

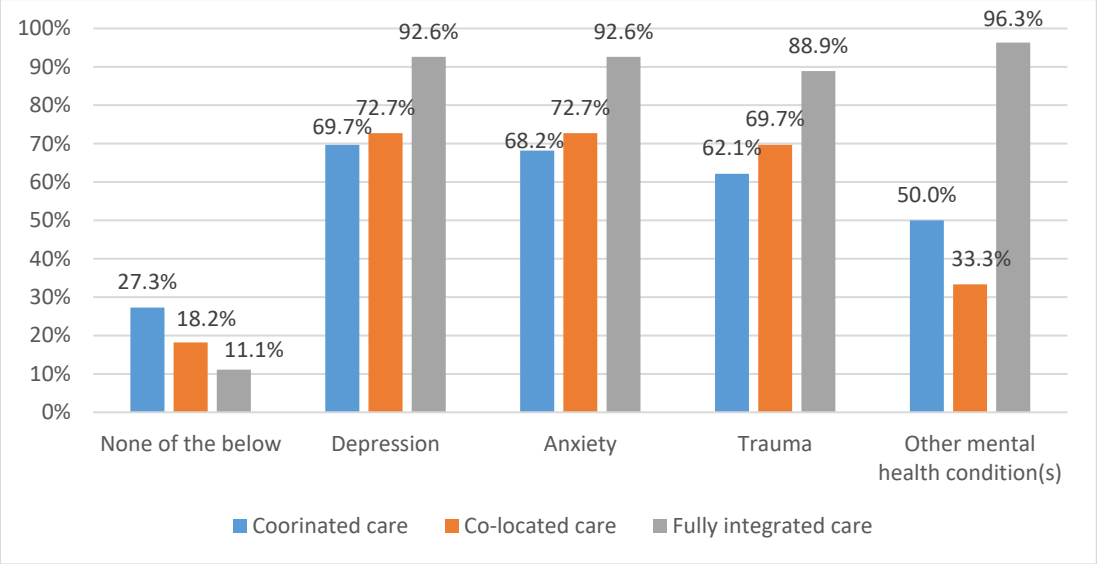
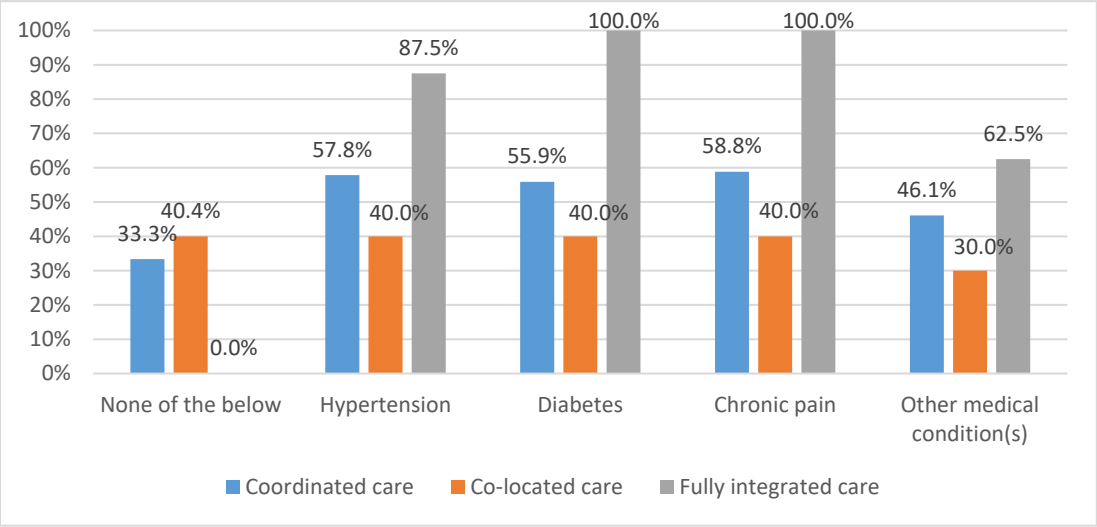


Figure 3. Percent provider of endorsement to the systematic screening practice for these physical health conditions (by IPAT integration category)



On-site service availability

Providers, excluding those that rated in the Coordinated Care categories (which by definition do not have on-site services), were asked to endorse the types of services available on-site either in person or virtually. Figures 4 and 5 show that MH and PH basic expertise/onsite face-to-face consult was the highest endorsed service type available in SUD programs, regardless if operating as co-located or fully integrated. However, and not surprisingly, there are more SUD programs

reporting a broader range of expertise available on-site when identified as a fully integrated program, particularly for integrated PH services. A notable difference arose between SUD programs implementing Co-located mental health and Co-located physical health. The capacity to treat patients with moderately complex problems on-site was higher in Co-located mental health programs than in Co-located physical health programs. Possible explanations could include the incidental medical services policy for SUD settings, which limits medical services to those related to SUD, as well as challenges in maintaining health care staff and facilities needed to provide health care services on-site.

Figure 6 shows that Provider Survey respondents in Fully Integrated programs also perceived they met the needs of the patients and the organization much more so than Co-located programs.

Figure 4. Array of mental health services and expertise available on-site (by IPAT integration category)

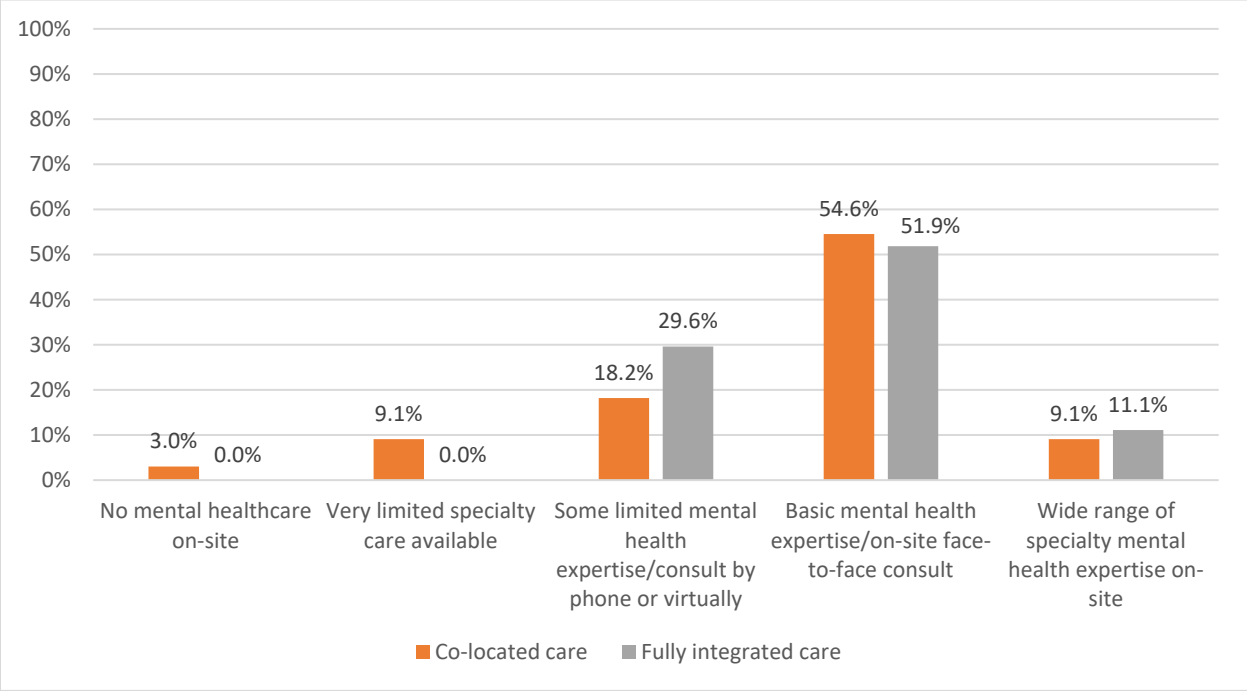


Figure 5. Array of physical health services and expertise available on-site (by IPAT integration category)

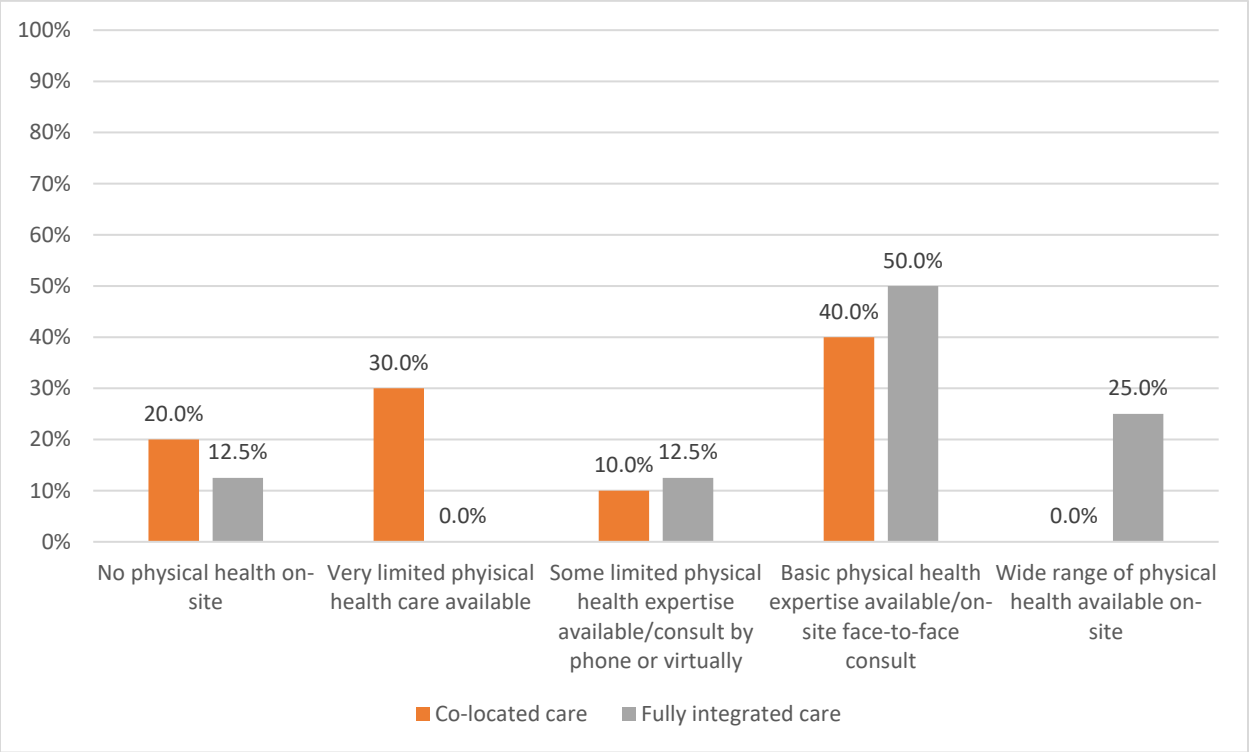
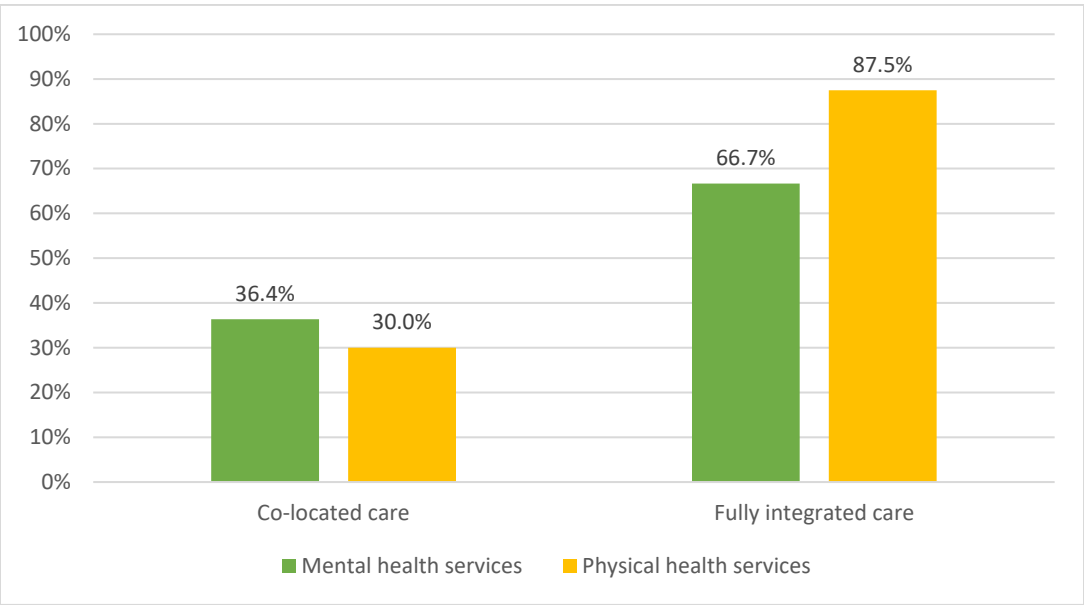


Figure 6. Percent providers agree that on-site services (MH and PH) meet patient and organization needs (by IPAT integration category



Referral practices and partnerships managing on- or off-site referrals

On-site or off-site, linking patients to mental health and physical health service providers can be facilitated by formalizing partnerships and procedures. Information exchange and communication is critical to successfully link patients to these services. As shown in Figure 7, programs higher on the integration framework had formal collaborations with MH or PH partners with defined and documented referral practices. In addition, these providers endorsed having more formal collaborations in place to support physical health integration than mental health integration.

Additionally, as shown in Figure 8, the collaborations currently in place generally do not meet the PH needs of their patients and organization, except in fully integrated PH category. It highlights another area where Co-located integration may be more challenging to implement, as this integration implementation strategy showed the lowest agreement rate that these collaborations met the needs of patients and organizations for both mental and physical health integration.

Qualitative comments indicated that the need for formal collaborations with MH are not always necessary, but generally it is more difficult for SUD providers to engage with PH providers/system to build the relationship.

According to SUD providers, the most commonly reported practices for successful collaborations include the following steps:

- Obtain Release of Information (ROI) to facilitate information sharing
- Assist with initial referral/contact via email or phone
- Assign case manager or counselor to conduct "warm hand-off" and make direct contact with provider to review efficacy and provide necessary input and additional referrals as deemed necessary (psycho-pharmaceutical interventions, etc.)
- Provide transportation when needed
- Set up weekly or monthly collaborative meetings/frequent communication

Reported challenges, included:

- Lack of administrative capacity or time to build relationships and set up MOUs or formal procedures is.
- Limited dedicated PH providers in their local area that are willing to collaborate and with sufficient knowledge of SUD.
    - “It is more difficult to initiate discussions and collaborate with PH providers than MH providers”.
- Stigma continues to be a barrier to partnering with MH and PH partners, especially with NTP/OTP providers.

- "They don't want to treat people on methadone, or generally look down on SUD patients".
- "Some patients do not want their medical providers knowing that they are in treatment, and therefore do not provide consent on the ROIs".

Figure 7. Providers reporting formalized collaborations and documented referral practices with MH and PH partners (by IPAT integration category)

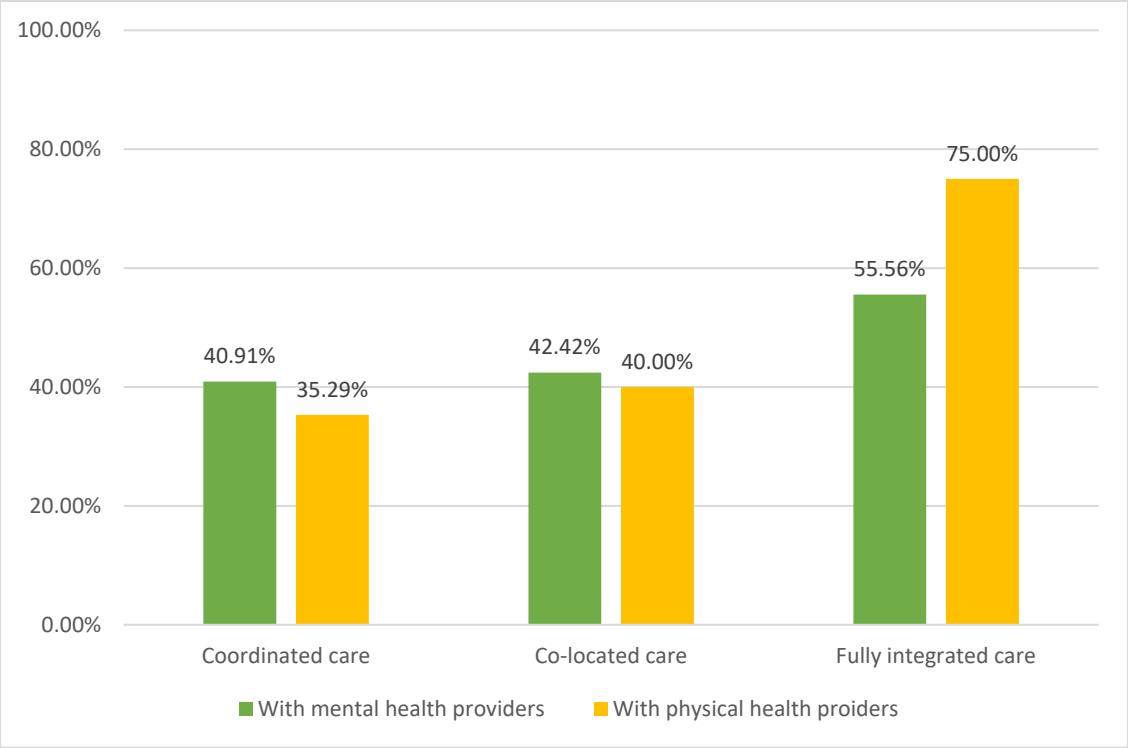
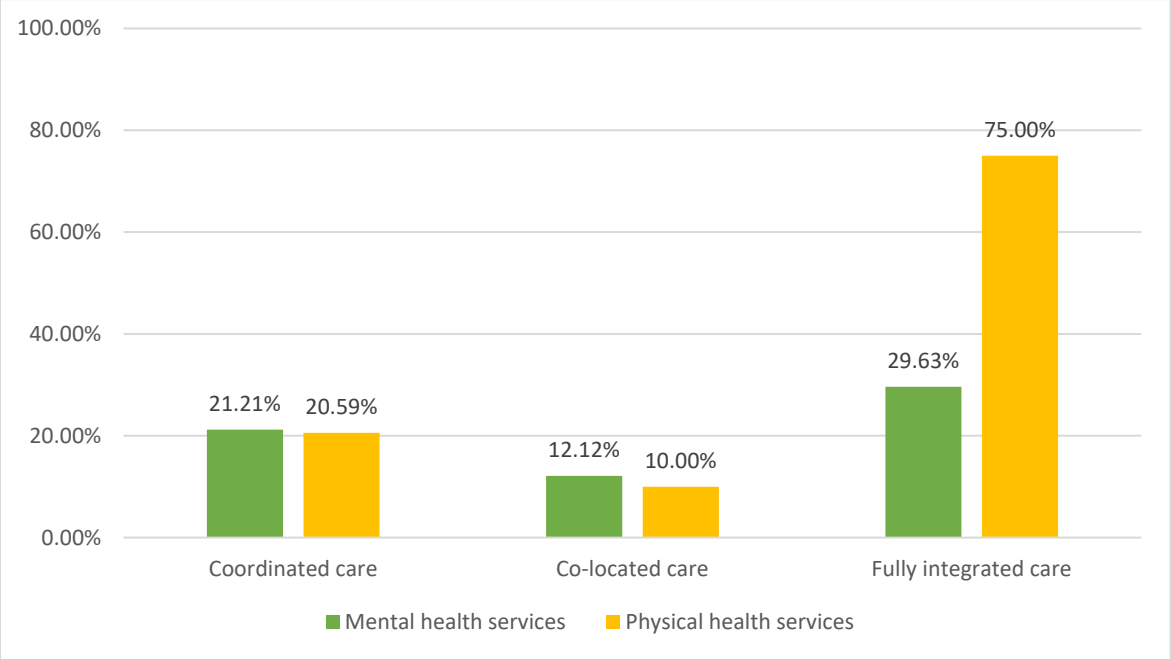


Figure 8. Percent providers agree that collaborations (MH and PH) meet patient and organization needs (by IPAT integration category)



Overall, the exploratory analysis revealed intuitive results. More integrated programs (coordinated-at a distance, co-located, or fully integrated) tend to have more screening, a broader array of services, and more collaborations/referral procedures. However, data from the Provider Survey suggest that provision of Co-located services may have additional implementation challenges and have lower ratings of meeting the needs of patients and organizations, particularly of co-located physical health. Co-location reduces time spent travelling from one practitioner to another, but does not guarantee integration. While a relevant benchmark and facilitator for integrated care, Co-located services has its challenges to meet the needs of both the patients and organizational integration goals. Providers can be co-located and have no integration of their healthcare services. Each provider can still practice independently without communicating with others and without an integrated healthcare plan. These findings are important to note when programs are evaluating next steps for integrating services. Utilizing the benchmarks identified in the SAMHSA Integration Framework is a useful tool to set strategically realistic goals to improve integration of services.