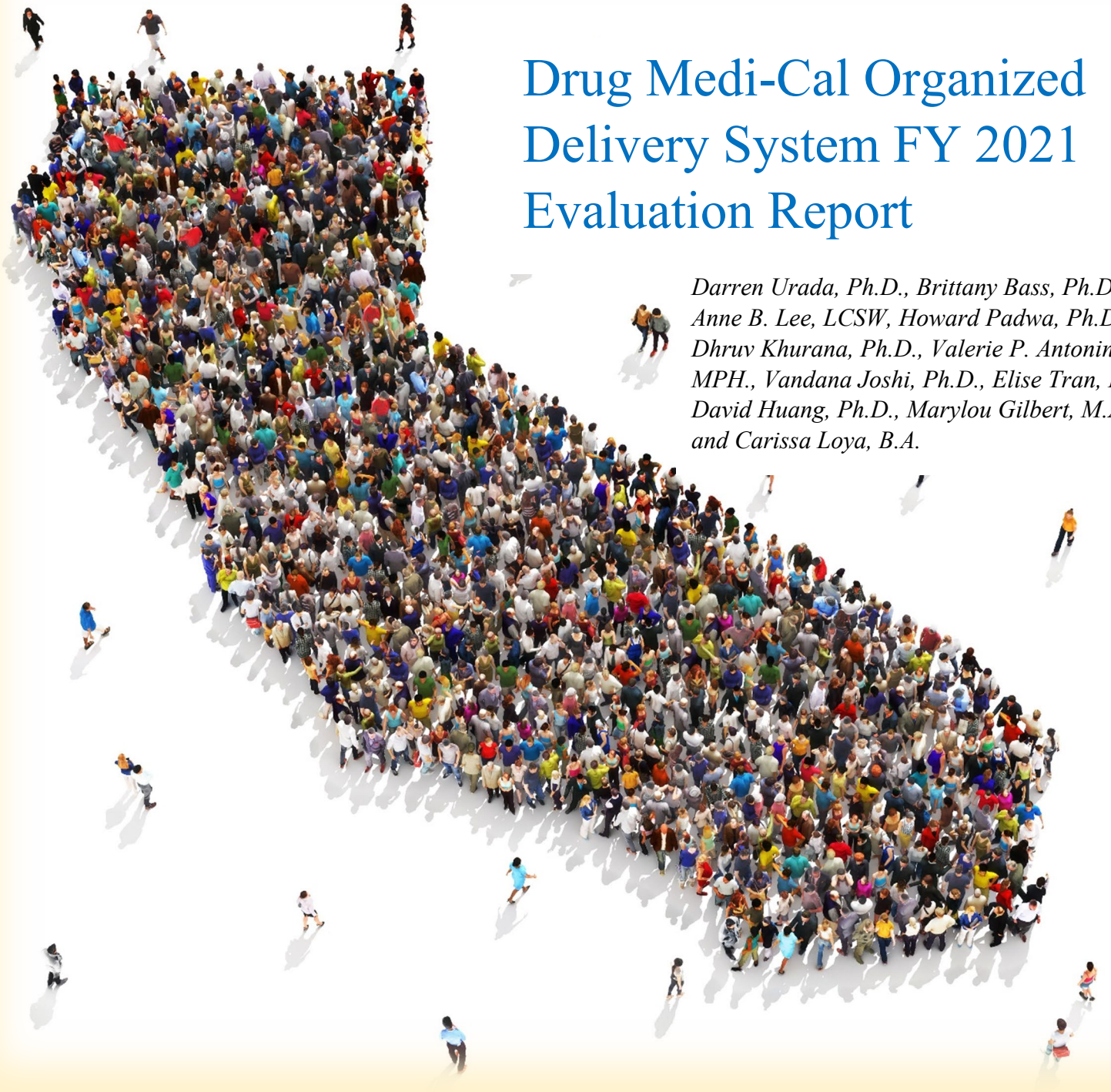

Drug Medi-Cal Organized Delivery System FY 2021 Evaluation Report

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

Submitted February 28, 2022

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Integrated Substance Abuse Programs

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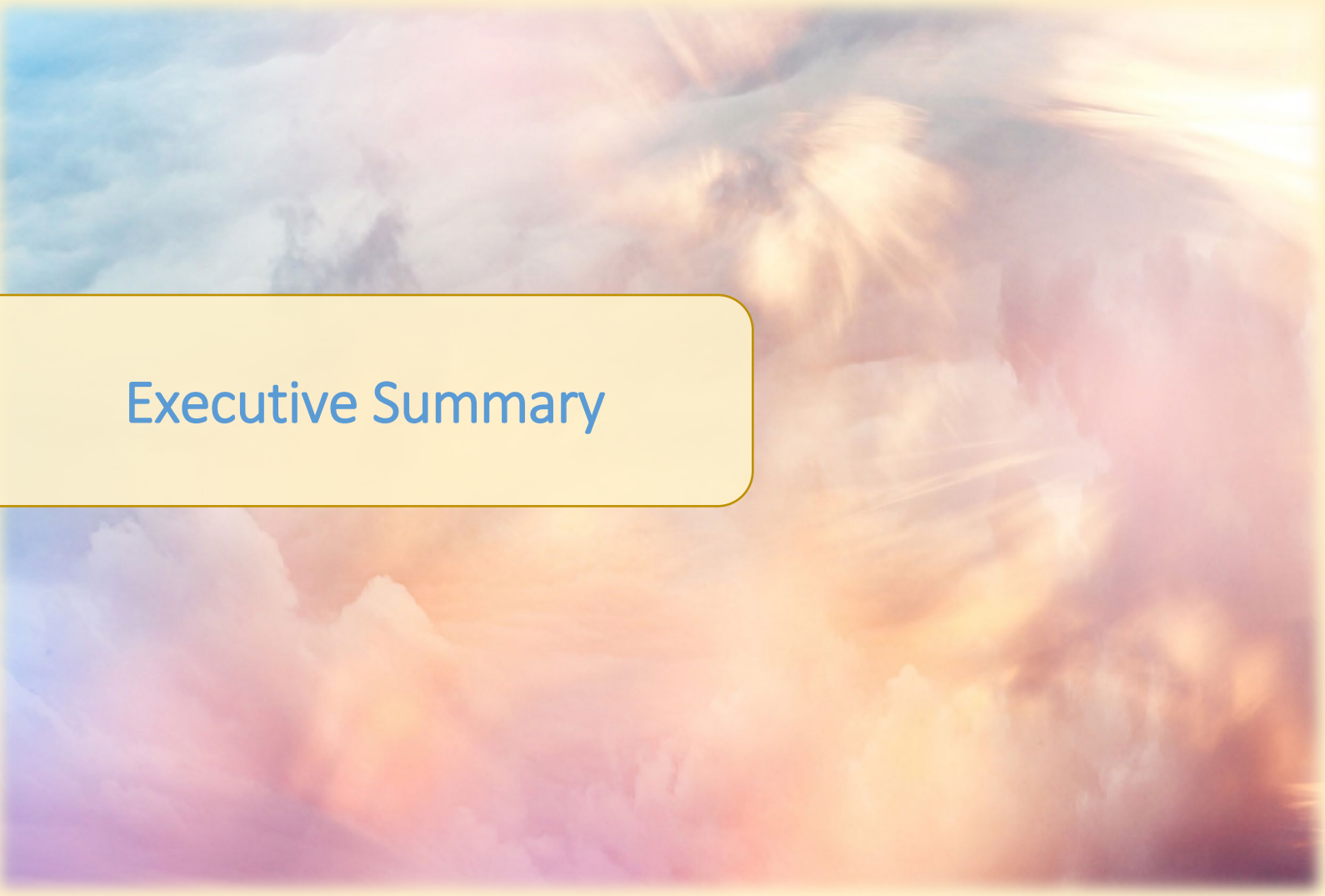
Note on Terminology

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.



Executive Summary

The DMC-ODS demonstration waiver improved access to treatment, quality of treatment, and coordination of care.

This is the summative evaluation report for the 2015-2021 Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 demonstration waiver evaluation. The DMC-ODS 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, the DMC-ODS waiver had been implemented in 37 counties containing most (95.9%) of California's population, with 21 small and rural counties not participating. In participating counties, the DMC-ODS waiver has improved access to treatment, treatment quality, and coordination of care, but challenges and opportunities lie ahead as the DMC-ODS transitions into a future as part of the California Advancing and Innovating Medi-Cal (CalAIM) efforts.

The latest findings from the evaluation are described below along with context from earlier reports, where relevant. Additional summaries of previous special topic chapters are also included below to provide an overview of evaluation findings on important emerging issues over the course of the demonstration.

Latest Findings

Access to Care

Eleven or more months after the introduction of the DMC-ODS waiver the number of unique patient admissions significantly increased by nearly 25 percent

The introduction of the DMC-ODS waiver significantly increased the number of people receiving DMC-funded services in waiver counties by 24.8 percent relative to State Plan counties. While there was not an immediate significant effect of the waiver on admissions across all funding sources, 11 or more months after the introduction of the DMC-ODS waiver, the number of unique patient admissions significantly increased by nearly 25 percent. County administrators and patients gave positive ratings to treatment access under the DMC-ODS waiver. Still, treatment penetration rates (2.6%) decreased due to a rapid increase in estimates of treatment need (partly due to a change in definition in the National Survey on Drug Use and Health). However, the penetration rate among those who thought they needed treatment was estimated at 52.0%. Data suggested access challenges specifically for youth and narcotic treatment programs, while workforce shortages hampered efforts to increase capacity. Use of the DMC-ODS recovery services continued to be hampered by confusion over the benefit. Overdoses from fentanyl use have skyrocketed in recent years, especially among Native American/Alaska Native and Black/African-American populations. Counties reported responding to the fentanyl problem with naloxone distribution and public education campaigns.

Overdoses from fentanyl use have skyrocketed in recent years, especially among Native American/Alaska Native and Black/African-American populations.

Earlier evaluation reports described challenges to capacity expansion that included a shortage of qualified medical directors, licensed practitioners of the healing arts, and bilingual staff, as well as challenges in expanding medical withdrawal management, and youth treatment in particular. Reports also documented that the waiver increased establishment of beneficiary access lines, and secret shopper ratings of access line staff were high, but that it was sometimes challenging for callers to find the correct access line phone number due to the existence of non-county websites that looked like county sites. A case study in the 2019 report described how Riverside County and Santa Clara County have implemented recovery services programs that successfully provide innovative services and are able to successfully bill DMC for them.

Recommendations

- Increase treatment penetration rates by working with primary care and other systems to promote screenings and referrals of patients who may not otherwise recognize their need for treatment.
- Continue support for naloxone distribution, education, training, and public education campaigns focused on fentanyl, and emphasize efforts benefitting Native American/Alaska Native and Black/African-American populations. Explore low rates of referrals to NTP/OTPs.
- Clarify the recovery services benefit, particularly by providing examples of allowable services that counties are using successfully.
- Explore ways to increase access for youth and to medical withdrawal management.
- Address workforce challenges by facilitating education and expedited certification licensing for staff entering or advancing in the field, providing training for staff and management in advanced clinical skills and addressing burnout, allowing MFT trainees to bill Medi-Cal, providing guidance on how to incorporate peer support staff, advocate for higher salaries and reimbursement, decrease documentation requirements, and promote policies (e.g. continue to allow telehealth for initial intake appointments) that will enable staff to telecommute to deliver services to high need areas and allow staff to live in areas with lower cost of living.

Quality of Care

In CY 2020 the DMC-ODS waiver continued to improve quality of care in participating counties by facilitating the creation of more complete continuums of care and the incorporation of critical services and supports such as case management and MAT into DMC-funded services. DMC-ODS counties regularly implemented evidence-based practices (EBPs), though counties reported that there is room for improvement in training and fidelity monitoring. Counties reported some

continued challenges implementing ASAM Criteria-based assessments, but ASAM LOC Referral Data and claims data indicated that counties have made strides in identifying patient needs using ASAM Criteria-based assessments and linking them to care in a timely manner. Over half of patients (53.1%) who received ASAM Criteria-based screenings and assessments were connected to care within 30 days in CY 2020, a substantial improvement over the timely indicated LOC linkage rate of 33.5% in CY 2019. It is unknown whether these improvements are a connected to changes due to COVID-19 such as increased use of telehealth and a reduced patient census. Counties requested standardized ASAM Criteria-based screening and assessment tools, which are now being addressed with new free tools such as Brief Questionnaire for Initial Placement screen, a paper-based ASAM-endorsed assessment tool, and an upcoming screening tool from Shatterproof. There are some disparities in timely linkage to care following screening/assessment for certain age groups (youth, older adults) and racial/ethnic minorities (Blacks, Hispanics), highlighting potential areas for improvement. On indicators of care quality such as treatment engagement, readmissions to withdrawal management, and patient satisfaction with treatment, data suggest that DMC-ODS providers continued to provide high-quality services to Medi-Cal beneficiaries in CY 2020.

On indicators of care quality such as treatment engagement, readmissions to withdrawal management, and patient satisfaction with treatment, data suggest that DMC-ODS providers continued to provide high-quality services to Medi-Cal beneficiaries in CY 2020.

Earlier reports suggested a need to re-institute the standard CalOMS-Tx reports that were available to counties before the dataset migrated to DHCS's Behavioral Health Information System as a way to track treatment outcomes and quality.

Recommendations

- Provide practical support on EBPs. In particular, resources that help counties track who receives EBP training, guidance on what trainings/curricula are reliable, affordable, and available, and resources to support fidelity monitoring.
- Further training and technical assistance to address disparities in the timely linkage of youth, older adults, Blacks, and Hispanics to their indicated LOC after brief screenings and assessments.
- Further research to understand and address lower engagement rates among older adults.
- Levels of patient-satisfaction were high on the Treatment Perception Survey, but slightly higher for adults than for youth. Further develop youth services to improve treatment satisfaction for youth patients.
- Re-initiate "CalOMS-Tx rewrite" efforts to better align CalOMS-Tx with the DMC-ODS waiver (e.g. incorporation of ASAM Levels of Care to replace older treatment modalities), and re-institute previously available standard CalOMS-Tx reports accessible to counties.

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. While more SUD treatment programs offer more on-site integration with MH services than PH services, the majority of programs are coordinating care at a distance. Challenges to integration of care include workforce shortages, complicated privacy rules, separate billing silos, lack of alignment between Medi-Cal requirements and certifications (specifically with MH), continued stigma toward SUD patients, and low referral rates from other health care and other community sources to SUD services.

Transitions of care within the SUD system remain relatively low and have not significantly changed over time. County administrators report that there is lack of real-time data on transitions tracking due to siloed EHRs minimizing the ability to intervene before patients are lost. Feedback from patients suggest that utilization of peers along with more case management and recovery support services during transitions could improve successful transitions of care. Having staff to conduct warm handoffs, facilitate the necessary information exchange, and complete the required documentation is also essential.

DMC claims data revealed 46.4% of patients had case management services billed in CY 2020, a slight increase from last year, CY 2019 (38.4%). Over half of the patients receiving outpatient treatment, residential treatment, and withdrawal management are receiving case management services under the waiver, while those in NTP/OTPs had much lower utilization of the benefit. Further, county administrators report that about half of case management services delivered are not billed, largely due to burden of documentation and continued lack of clarity regarding allowable activities. However, over time counties have overcome some of the challenges of implementation. Billing data reveal a steady increase of case management services claimed from year to year, particularly after three years of implementation.

County administrators credit the waiver with improving the integration and coordination of care in spite of ongoing struggles with documentation requirements, siloed systems, workforce shortages, and uncertainty around billing practices.

An earlier report (2019) included case studies that described successes in areas identified as challenging. Riverside County improved transitions from withdrawal management to treatment by 48% using a regional care coordination team. Los Angeles County detailed their successful efforts to provide a high percentage of patients with case management by emphasizing clear billing rules and procedural expectations to their providers, and demonstrated that compared to patients that did not receive case management, patients that did receive it were more likely to have a successful discharge status, be abstinent at discharge, and report improvement in their physical and mental health from admission to discharge. A program in Santa Cruz County (Encompass Community Services) explained how they achieved high patient ratings on care coordination.

Recommendations

- Provide guidance on best practices for navigating the privacy rules and information exchange policies between SUD-MH/SMI and SUD-PH programs, including use of release of information and consent forms.
- Provide guidance on formal protocols for referrals and tracking within and across SUD, PH, and MH systems.
- Support cross system MH/PH/SUD learning collaboratives, including cross system understanding of The ASAM Criteria and use of a universal screening tool.
- Provide performance incentives for multi-system management of beneficiaries.
- Standardize Medi-Cal MH and SUD assessment and billing and align documentation requirements.
- Address stigma toward SUD patients and programs.
- Allow peer support services and case management to be utilized as part of pre-diagnosis and post-treatment billing, removing the LOC modifier to facilitate successful transitions of care.

COVID-19 and Telehealth

Survey and CalOMS-Tx results show that COVID-19 had a substantial impact on DMC-ODS waiver counties during the first year and a half of the pandemic. Overall SUD treatment admissions decreased by 23.3%. Outpatient treatment services were most impacted, with admissions decreasing by 27.3%. The COVID-19 pandemic also 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. Additionally, nearly all counties are offering expanded take-home medications for stable NTP patients, and more complex and rigorous analyses of this flexibility are needed and ongoing.

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.

Residential Length of Stay

The residential length of stay in California is higher than the 30-day goal specified in the DMC-ODS waiver special terms and conditions, but is within several days of that target. Using a variety of approaches, the statewide average consistently fell in a narrow range between 35.7 days to 38.8 days regardless of the method used to measure it. While California needs to reduce the average, there does not appear to be a need to make severe cuts that may threaten to undermine treatment.

Recommendations

- Address outliers. An undetermined number of very lengthy case stays may be due to erroneous data. If outliers of 120 days or longer were removed, this alone would reduce the statewide average to 31.2 days Providing reports to counties on the lengths of stay in their provider networks so errors can be identified and corrected would be a good first step. UCLA has drafted reporting templates for this purpose.
- Gather and disseminate lessons learned from counties that are under 30 days already.
- Address spikes in discharges that suggest program- or funding- driven discharge schedules, particularly at 90 days, by disseminating best practices from counties that do not have dramatic spikes at these intervals.

Partnership HealthPlan of California Cost Study

Partnership HealthPlan of California Wellness & Recovery program involved seven PHC counties going live in the DMC-ODS waiver on July 1, 2020. Initial assessment of the impact of going live in the waiver from January 1, 2019 to April 30, 2021 shows a 290.3% increase in access to Residential Treatment for PHC W&R patients compared to State Plan counties, while other modalities did not show any significant changes. The probability of re-overdosing in PHC W&R is also substantially lower around 5.1 percentage points compared to State Plan counties. This difference represents an approximately 30% reduction in re-overdoses when compared to pre-waiver re-overdose rates for PHC W&R. Further, the probability of a re-overdose decreases if the patient has had access to residential treatment. A descriptive cost-effectiveness analysis from the payor's perspective showed that although the overall cost of increase in residential treatment outweighed the costs saved from avoided re-overdoses, it is still an investment worth studying. The study only measured the impact of increase in residential treatment on reduction in re-overdoses over a limited time period. However, Residential treatment has multiple potential benefits that may generate longer term savings that have not been explored in this study.

Recommendations

- Continue study of the impact of treatment on health costs for a more comprehensive assessment, especially using CalOMS-Tx data, using a longer time horizon, and conducting analyses in further detail (e.g. by treatment modalities, medications, and length of stay).
- Continue to expand access to residential treatment.

Summary of Special Topic Chapters from Previous Evaluation Reports

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, 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.

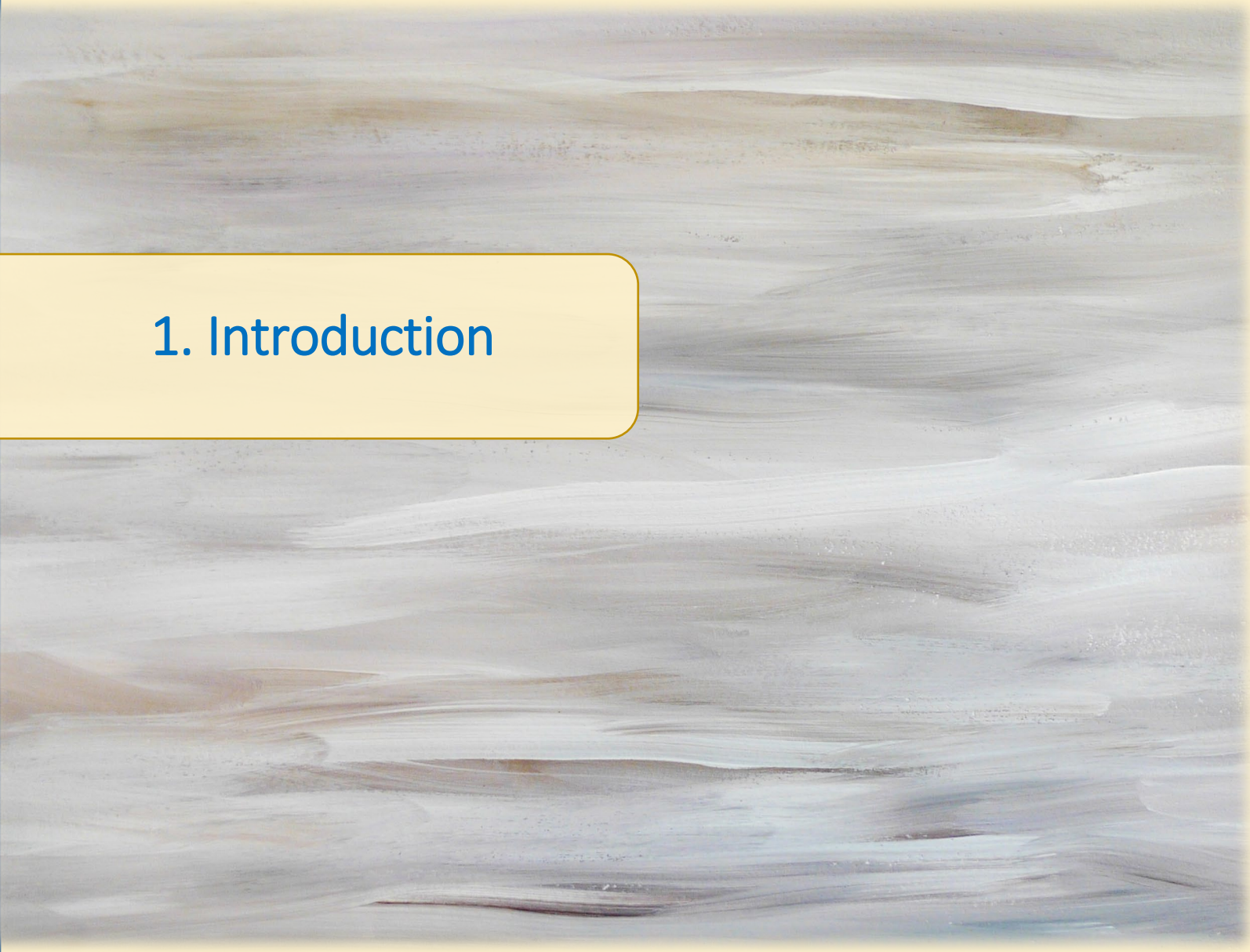
- Increase funding for Recovery Residences and Transitional Housing (RR/TH) with the recent augmentation to SABG funds.
- Enhance RR/TH capacity to serve PEH with co-occurring mental health disorders and those who use medications for addiction treatment.
- Develop an integrated, interagency response 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

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 current demonstration waiver ends December 31, 2021. DMC-ODS is expected to continue, with revisions, as part of California's new CalAIM 1115 and 1915b waivers starting January 1, 2022 and continuing through December 31, 2026.

This evaluation report primarily focuses on data collected in CY 2020, with additional data from 2021 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.

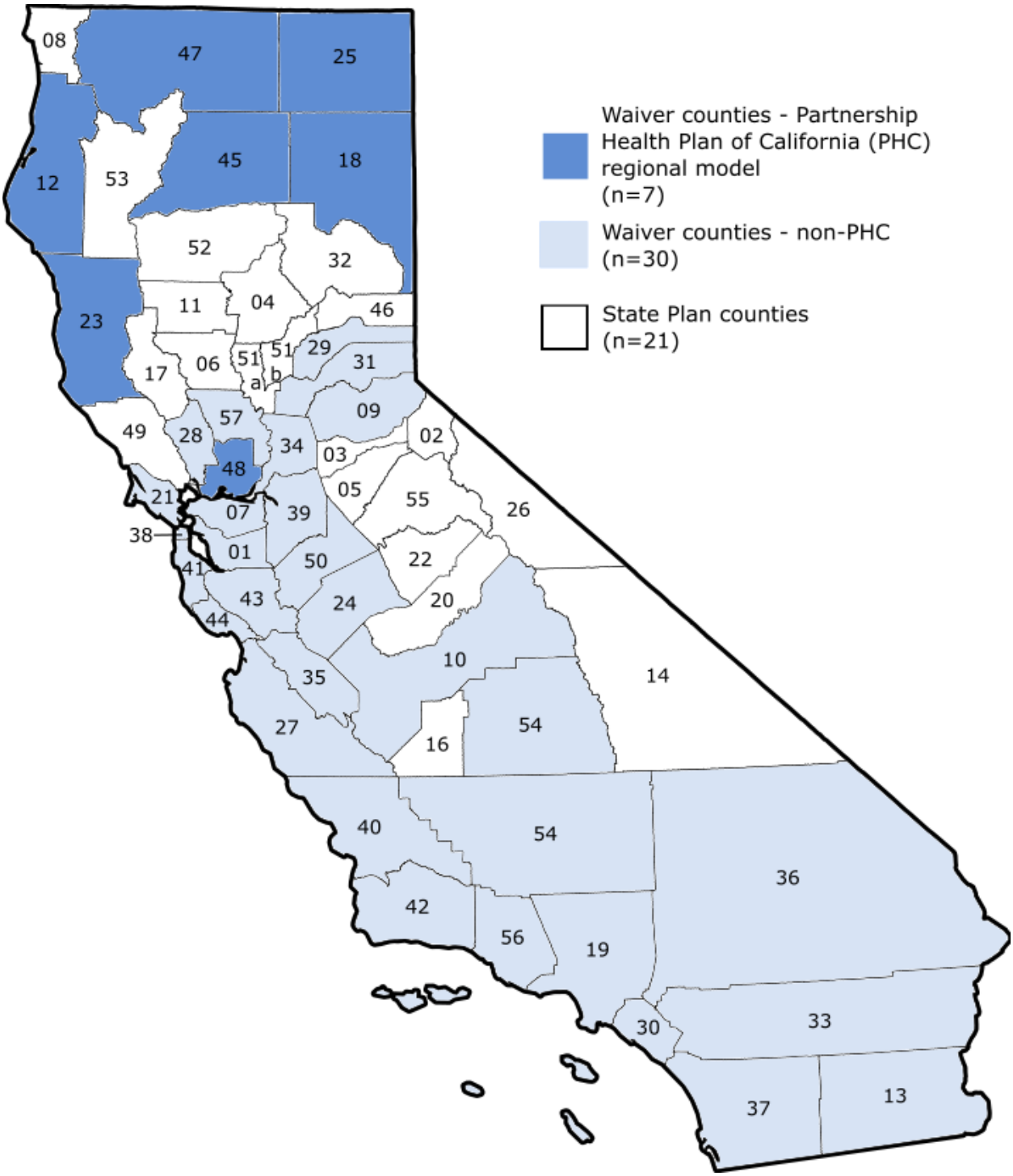


Figure 1.1[1]

[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 covered 95.9% of the state's population as of 2021.[2] Of those that have gone live, 70.3% are medium or large counties.[3] 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 waiver 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 2021: https://www.dof.ca.gov/Forecasting/Demographics/Estimates/e-4/2010-21/documents/E-4_2021InternetVersion.xlsx

[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 transitions between levels of care within the SUD system 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 analyses were conducted.

ASAM Criteria-based LOC Referral 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 LOC within 14 days of discharge from residential programs and residential withdrawal management programs, and readmission to residential withdrawal management within 30 days and discharge outcome status.

Target and Comparison Populations

Since administrative data (e.g. claims, CalOMS-Tx) for calendar 2021 were incomplete at the writing of this report, the cutoff for most analyses was December 31, 2020, except where otherwise noted. For analyses that ended in December 2020, full calendar-year data was used for the waiver-period counties, therefore the seven counties that joined in July 2020 under Partnership HealthPlan of California (PHC) are excluded. However, surveys and interview data were collected in 2021 that did include PHC counties, and a chapter specifically focused on PHC data is included in this report (Chapter 6).

In earlier reports, counties were divided into waves based on their "go live" dates, but exploratory analyses did not suggest substantial differences between the waves in 2020. Therefore, for simplicity, except where otherwise noted analyses in this report focus on only two groups: DMC-ODS Waiver and State Plan. Wherever PHC survey results diverged from other counties, this is noted in the results.

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 on December 31, 2021, though data sources did not all extend through that date 2021. A pre-waiver period extending back to CY 2016 is used where data sources allow (DMC claims, CalOMS-Tx, 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 detail in this report, but most have been covered in UCLA's series of evaluation reports.[7] In particular, cost measures are only partially covered because Medi-Cal Managed Care/Fee for service data was not available in time to be analyzed for this report. However, similar

[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] https://www.uclaisap.org/dmc-ods-eval/html/reports-presentations.html

data from PHC counties was, and was used to fulfill most of these measures instead. UCLA plans to complete and report additional statewide cost analyses in the months after submitting this report, particularly examining the last three items on the list of cost measures.

In many cases, measures that were not originally in the evaluation plan but were of interest have been added to the evaluation reports.

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)[8]
- 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
- 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

[8] 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

Cost Measures

Change in health care costs for individuals who receive residential care (pre/post and vs. comparable patients placed in other modalities)

- Change in emergency department utilization and costs
- Change in inpatient utilization and costs
- Change in SUD treatment utilization and costs
- Differences in health care costs associated with the use of different treatment modalities in costs
- Differences in health care costs associated with the different residential lengths of stay in costs
- Differences in health care costs among patients who receive SUD medications versus patients who do not, analyzed to the extent possible by location and type of medication

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, 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)
- Residential average length of stay
- Partnership Healthplan of California cost analysis

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.

Partnership HealthPlan of California Claims

Partnership HealthPlan of California (PHC) provided data on medical claims to DHCS. UCLA obtained this data from DHCS for the purpose of conducting a cost analysis on the implementation of DMC-ODS in the PHC counties.

UCLA evaluation data collection activities

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. BAL secret shopper calls ended following calls to the PHC counties in 2020.

County Administrator Surveys

UCLA developed an online County Administrator Survey to obtain information and insights from SUD/behavioral health administrators of counties participating in the waiver, including PHC W&R DMC-ODS counties. The annual 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 status.

UCLA last collected data from June 7, 2021 through October 1, 2021. Including partially completed surveys, responses were received from 36 out of 37 waiver counties (97% response rate). State Plan counties were not surveyed in 2021.

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). Provider surveys ended in 2020.

Integrated Practice Assessment Tool

To measure provider level of integration with MH and PH, questions from the Integrated Practice Assessment (IPAT)[9] 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 A 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

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

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 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.[10] 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 process of moving along a continuum of integrated care and inspire the undertaking of system transformation.[11]

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 as part of a major statewide undertaking by UCLA, counties, and providers 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.

[10] 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.

[11] 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

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.).

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).

In 2020 online and telephone-based data collection options were added, and TPS was conducted once more, collecting 13,530 TPS forms were received from 31 participating DMC-ODS waiver counties despite COVID-19-related disruptions.

A summary of the 2020 data analysis results is included in this report within the Quality section and in Appendix B. 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 September 20-24, 2021, but the results will be reported separately.

Analytic methods

Except where otherwise noted, descriptive 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.

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., PHC claims, 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 24 months or more prior to introduction to 24 months or more after the introduction. For analyzing overdoses in PHC W&R, the ES design allowed the effect of the waiver to vary on a monthly and quarterly basis.

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-Q1 2021 (unless otherwise noted), and controlled for time-invariant county effects, county-invariant time effects, and the severity of the COVID-19 pandemic, proxied by the county-level COVID-19 case rate per 100,000, and COVID-19 death rate per 100,000 for each month-year cell. All regressions were weighted by the county population, and standard errors are clustered at the county level.

Further for PHC W&R analyses related to utilization and costs, administrative data from PHC Claims for overdose, and DMC claims data for residential treatment were used.

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 7,541 unique patients receiving services in DMC claims from November 2016 to December 2016, then a subsequent increase of 8,777 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 LOC Referral Data includes 36 of the 37 waivered counties. There have been substantial improvements in ASAM LOC Referral Data collection from counties as compared with the previous year. The submitted ASAM LOC Referral Data for CY 2020 reflects screenings/assessments for 97% of waivered 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

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Patient Demographics

Table 3.1 shows CY 2016 and CY 2020 demographic and service modality number of admissions using CalOMS-Tx for patients receiving services in the 37 counties (including the 7 PHC counties) that implemented the DMC-ODS waiver from 2017-2020.

Table 3.1. *Number of admissions by demographics and service modality for DMC-ODS waiver counties. CalOMS-Tx (CY 2016 and CY 2020).*

	DMC-ODS Waiver Counties			
	2016		2020	
	N	Percent	N	Percent
Demographics				
Race				
White - Not Hispanic	46,497	42.6	41,523	40.9
Black - Not Hispanic	13,276	12.2	11,540	11.4
Hispanic	40,884	37.4	40,397	39.8
Asian	1,895	1.7	1,599	1.6
Pacific Islander	251	0.2	222	0.2
American Indian/Alaskan Native	1,385	1.3	1,069	1.1
Multiracial - Not Hispanic	2,843	2.6	2,613	2.6
Other Race - Not Hispanic	2,242	2.1	2,592	2.6
Total	109,273	100.0	101,555	100.0
Age				
12-17	7,422	6.8	3,487	3.4
18-25	16,917	15.5	11,804	11.6
26-35	37,057	33.9	39,092	38.5
36-45	22,028	20.2	23,977	23.6
46+	25,849	23.7	23,195	22.8
Total	109,273	100.0	101,555	100.0
Gender				
Female	45,162	41.3	41,012	40.4
Male	64,051	58.6	60,365	59.4
Other	60	0.1	178	0.2
Total	109,273	100.0	101,555	100.0
Service Modality				
Outpatient	45,690	41.8	37,833	37.3
Intensive Outpatient	5,225	4.8	9,823	9.7
Residential	21,963	20.1	26,371	26.0
NTP/OTP	19,829	18.2	15,775	15.5
Detox	16,566	15.2	11,753	11.6
Total	109,273	100.0	101,555	100.0

Table 3.1 shows that the demographics among patients receiving SUD treatment in DMC-ODS waiver counties remained fairly stable from 2016 to 2020. However, it is worth noting the 50% decline among ages 12-17. This was likely due to COVID-19 and schools closing, subsequently affecting school referrals. Additionally, admissions for 18-25 year olds declined by 25% from 2016 to 2020, potentially due in part to the passage of Proposition 64 in 2018, but additional research is needed to fully understand the driving forces behind this decline. Regarding service modality, the percentage of patients receiving outpatient, NTP/OTP, and detox services decreased, while the percentage of patients receiving intensive outpatient, and residential services increased, reflecting the DMC-ODS waiver's effect on the mix of services being delivered.

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 C Figure A displays the county-level figures using DMC claims data, Appendix C Figure B displays the county-level figures using CalOMS-Tx data, and Appendix D Figures A and B display the aggregated figures using DMC claims data and CalOMS-Tx data, respectively. According to Appendix C Figure A, there has been great variation between counties, with some increasing services immediately and others showing little change. However, in at least 20 of the 37 cases, there was a clear increase in the number of beneficiaries accessing DMC-ODS services following the county's Go Live date. In Appendix D Figure A, where all waiver counties are aggregated, this increase is also clear. This pattern of results is less apparent in Appendix C Figure B and Appendix D Figure B, but there is still evidence suggesting an increase in the number of patients admitted to treatment in 12 of the 37 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 waiver could have accounted for the difference. However, we tested 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 24.8 percent.

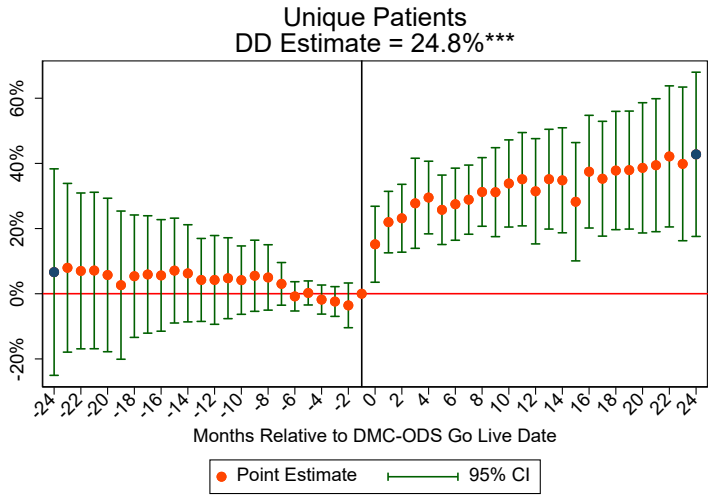

Figure 3.1. *Event study estimates of the effect of the DMC-ODS waiver on unique number of patients receiving services. Event study estimates (orange dots) and 95% confidence intervals (bars) of the effect of the DMC-ODS waiver on the natural log of the number of unique patients receiving services are shown. Data are from DMC claims for CY2016-Q12021. 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 patients 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 suggests that the introduction of the DMC-ODS waiver had a positive impact on the unique number of patients receiving DMC-funded services across all modalities. The DMC-ODS waiver significantly increased the number of unique outpatient patients in waiver counties by 26.7%, intensive outpatient patients in waiver counties by 47.5%, and residential patients in waiver counties by 402.7%, 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 patient admissions overall and by modality, respectively, using data from CalOMS-Tx.

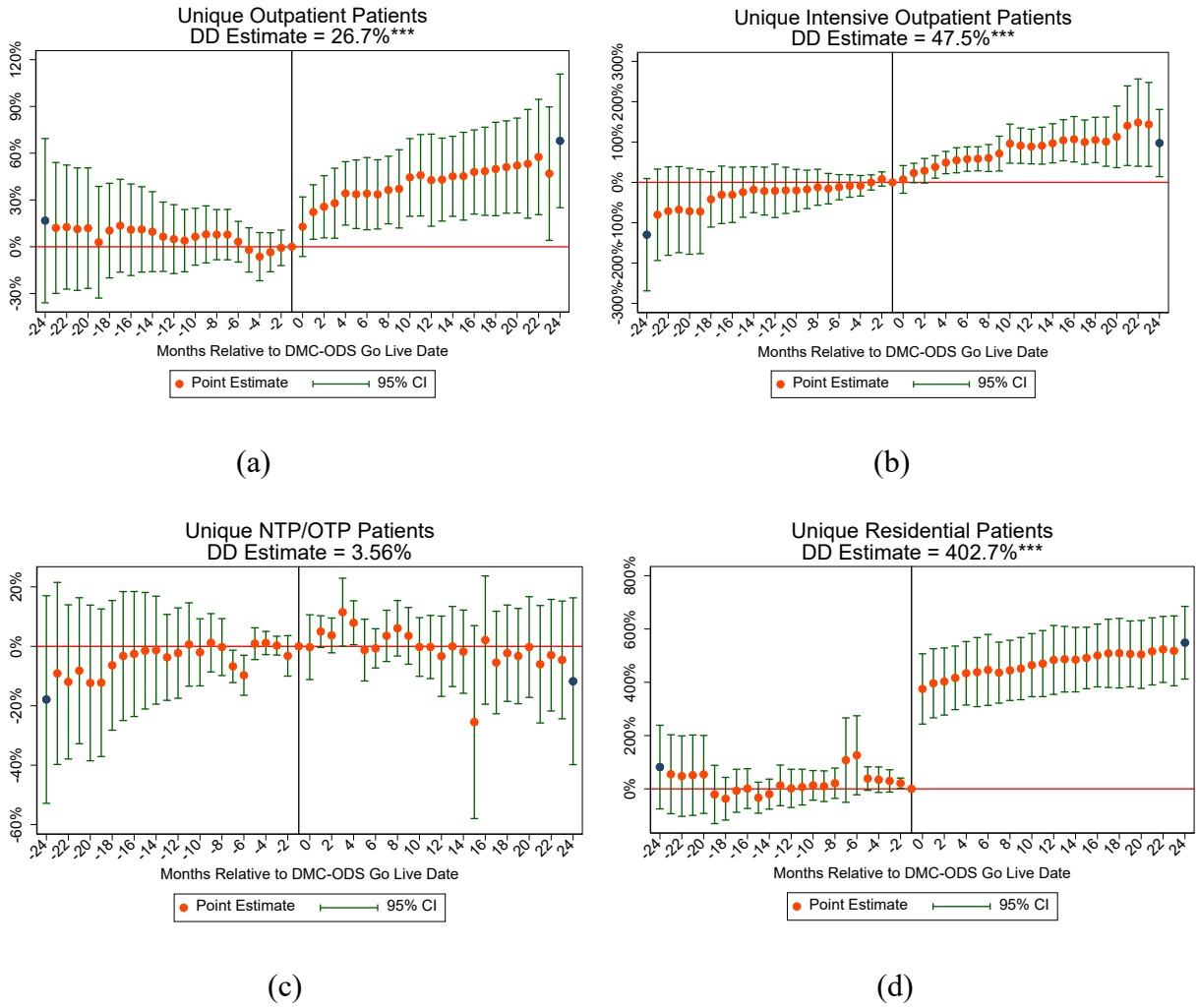

Figure 3.2. *Event study estimates of the effect of the DMC-ODS waiver on unique number of patients receiving services by modality. Event study estimates (orange dots) and 95% confidence intervals (bars) of the effect of the DMC-ODS waiver on the natural log of the number of unique patients receiving services by modality are shown. Panel (a) is OP, panel (b) is IOP, panel (c) is NTP/OTP, and panel (d) is residential. Data are from DMC claims for CY2016-Q12021. 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.*

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 waiver Go-Live Date), we find that eleven 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 25 percent.

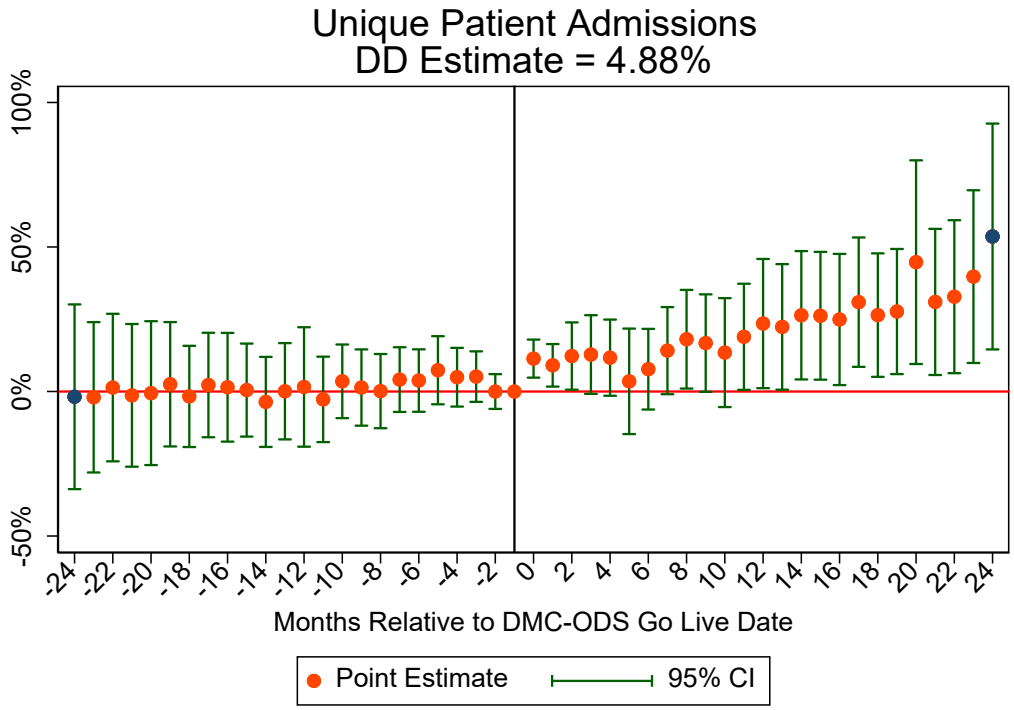

Figure 3.3. *Event study estimates of the effect of the DMC-ODS waiver on unique number of patients receiving services in CalOMS-Tx. Event study estimates (orange dots) and 95% confidence intervals (bars) of the effect of the DMC-ODS waiver on the natural log of the number of unique patient admissions are shown. Data are from CalOMS-Tx for CY2016-Q12021. All estimates are relative to the year prior to the Go Live date. The difference-in-difference estimate is 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 (d), we find a significant increase of nearly 30 percent in residential patient admissions immediately after the Go-Live date until 7 months post-DMC-ODS waiver introduction, and a subsequent steady increase in residential patient admissions 13 to 23 months after the waiver introduction of nearly 40 percent. Two or more years after the introduction of the DMC-ODS waiver (i.e., the final blue dot on the right-hand-side of (d)), the effect on admissions is no longer statistically significant. The statistical significance two or more years after the DMC-ODS waiver introduction could be affected by COVID-19, when admissions for all services across all counties began to decline (see the special topics COVID-19 chapter for more information).

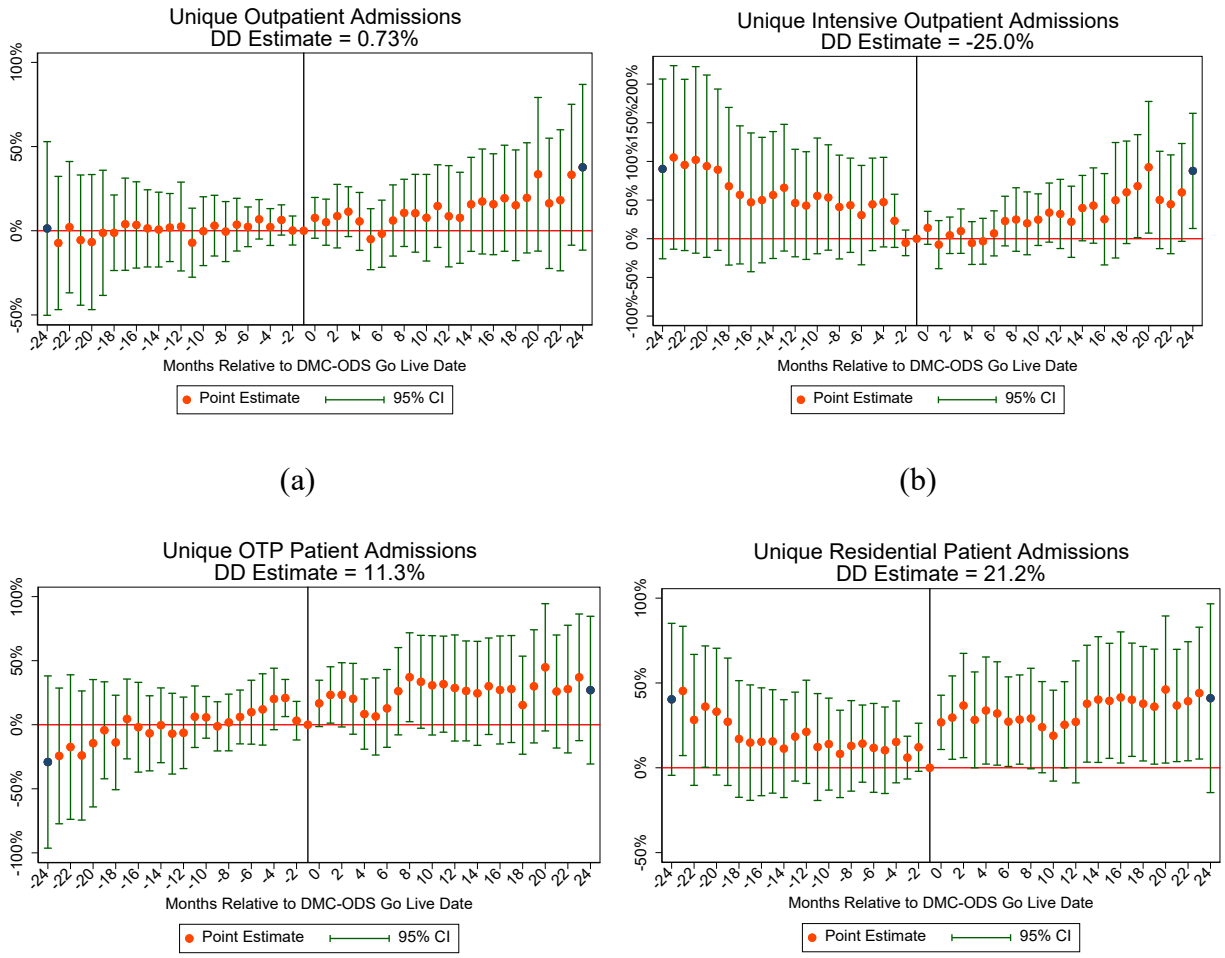

Figure 3.4. *Event study estimates of the effect of the DMC-ODS waiver on unique number of patient admissions in CalOMS-Tx, by modality. Event study estimates (orange dots) and 95% confidence intervals (bars) of the effect of the DMC-ODS waiver on the natural log of the number of unique patient admissions by modality are shown. Panel (a) is OP, panel (b) is IOP, panel (c) is NTP/OTP, and panel (d) is residential. Data are from CalOMS-Tx for CY2016-Q12021. All estimates are relative to the year prior to the Go Live date. The difference-in-difference estimates are also shown.*

Finally, we analyzed if the introduction of the DMC-ODS waiver affected the unique number of patient admissions in CalOMS-Tx and the unique number of patients 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, 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.[12] In CalOMS-Tx, we found that the introduction of the DMC-ODS waiver had no significant effect on admissions across any

[12] 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.

of the demographic groups. Analyzing DMC claims data, we found a statistically significant increase in the unique number of patients receiving services across both genders and all races/ethnicities (with the exception of AI/AN and Asian/Pacific Islanders), with estimates ranging from a 13.4% increase for Hispanics to a 16.5% increase for Blacks.

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	5.0%	7.0%	8.7%	5.5%	-4.6%	2.3%	7.0%	1.7%	-5.9%
Panel II: DMC Claims	Male	Female	AI/AN	Asian/ Pacific Islander	Black	Hispanic	White		
DMC-ODS Waiver	15.1%***	17.2%***	11.90%	26.0%	16.5%***	13.4%**	14.9%***		

*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). *** 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 (97.0%). Most patients in DMC-ODS counties also provided fairly favorable ratings on access. In the 2020 Treatment Perceptions Survey, most adult patients from DMC-ODS waiver counties agreed with 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 similar (86.3% and 89.6%, respectively), which represented a substantial increase from 2019 (75.2% and 77.8%), possibly due to greater use of telehealth in 2020. They also tended to agree with the youth-specific TPS question, "I had a good experience enrolling in treatment." (82.5% agreement).

Penetration Rates

According to the most recently available (CY 2019-2020) NSDUH state estimates[13] 15.79% of California's 2020 age 12 and over population of 33,940,532[14], or 5,359,210 had an SUD. Since NSDUH is based on a household population, we applied an adjustment for the estimated 161,548 homeless persons in the state[15] , applying a 50.5% SUD estimate (for more information on this

[13] Importantly, NSDUH SUD data in 2020 are based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), whereas NSDUH data in 2019 are based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). Thus, California SUD estimates produced by NSDUH are not directly comparable from 2019 to 2020.
https://www.samhsa.gov/data/sites/default/files/reports/rpt35339/NSDUH%20Attachments/NSDUH%20Attachments/NSDUHsaePercents2020.pdf

[14] https://www.dof.ca.gov/Forecasting/Demographics/projections/documents/P1B_State_Age.xlsx

[15] https://www.usich.gov/homelessness-statistics/ca/

adjustment, see UCLA's 2018 DMC-ODS evaluation report[16]). This meant the household need estimate was (33,940,532 - 161,548) x 15.79% = 5,333,701, while the homeless need estimate was 161,548 x 50.5% = 81,581. Adding these together produces 5,415,282. Dividing this by the age 12 and over population of 33,940,532 yields an SUD rate of 15.96%.

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 (11,671,001) to obtain a need estimate of 11,671,001 x 15.96% = 1,862,691. In these counties, an average of 48,215 patients per month received DMC-ODS services in 2020 in the months after going live (or all 12 months for counties that went live in 2017, 2018, and 2019), according to DMC claims. This suggests a penetration rate of 48,215 / 1,862,691 = 2.59% 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 in 2017, the next 12 counties to begin services in 2018, and the following 11 counties to begin services in 2019 was 2.06%, 3.34%, and 2.59%, respectively, down from the 4.00%, 6.31%, and 6.70% rate, respectively, estimated in the California DMC-ODS 2019 Evaluation Report. This was primarily due to an increase in estimated treatment need from 9.0% to 15.96%.[17]

These penetration rates do not take into account people receiving treatment outside of the DMC-ODS waiver (e.g., MAT occurring in primary care). Some counties have made a major effort in these areas to complement their DMC-ODS waiver 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 Medi-Cal population than the general population.[18] 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 (2021) estimated that nationally 6.5% of people who needed SUD specialty treatment actually received it. Importantly, SAMHSA also estimated that among the people who did not receive treatment, 97.5% felt they did not need treatment.[19]

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[16] 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

[17] A portion of the increase in estimated treatment need from 9.0% t0 15.96% was likely due to NSDUH changing the criteria for which SUD is based on in 2020. SUD 2020 data from NSDUH is based on the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), whereas SUD 2019 data was based on the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). SAMHSA concluded that, "the change from DSM-IV to DSM-5 criteria for estimating SUD would lead to breaks in the comparability of 2020 SUD estimates with estimates from prior years." More information about this change can be found here: https://www.samhsa.gov/data/sites/default/files/reports/rpt35330/2020NSDUHMethodSummDefs091721.pdf

[18] 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).

[19] Substance Abuse and Mental Health Services Administration. (2021). https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

Assuming the same pattern in California DMC-ODS waiver counties, this suggests 1,862,691-48,215 = 1,814,476 people needed treatment but did not get it, but only 1,814,476 x 2.5% = 45,361 of people who did not receive treatment felt they needed it. Put differently, the penetration rate may have been about 48,215 / (48,215+ 45,361) = 52.0% 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.

Special Population Challenges

Youth

According to an earlier version the DMC-ODS waiver County Administrator Survey, 68% of respondents indicated that the DMC-ODS waiver had not increased access specifically to youth services due to school systems providing their own in-house services, funding deficiencies, and a shortage of support from the state (see 2020 report).[20] These challenges were exacerbated by COVID-19, leading to financial impacts and subsequent reductions in capacity that sometimes exceeded 75%, according to a 2020 survey of youth treatment providers.[21] These responses are consistent with the large decrease in youth admissions found in 2020. For more on the impact of COVID-19 on youth, particularly with regard to telehealth, see Chapter 4.

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 finding existed before the waiver, however. Current State Plan counties tend to be smaller and therefore have fewer NTPs/OTPs, which are generally

[20] https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf

[21] Gonzales-Castaneda, R., Padwa, H., Valdovinos, I., Larkins, S., Farber, J. 2021. COVID-19 Impact on Behavioral Health Services Systems that Treat Youth Populations with Substance Use Disorders. *Journal of Pharmacy and Drug Innovations*, *2*(5). doi:03.2020/1.1030

located in areas with greater population density. Over time, however, 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.[22] 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. CalOMS-Tx.*

	CY 2016		CY 2020	
	DMC-ODS Waiver Counties	**State Plan counties**	**DMC-ODS Waiver Counties**	**State Plan counties**
Methadone	66.6%	34.1%	47.9%	52.5%
Buprenorphine	0.7%	1.1%	9.2%	7.0%
Other medication	1.7%	0.3%	3.0%	0.9%
Total	69.0%	35.4%	60.1%	60.4%

It is likely that some patients are increasingly choosing to receive MAT outside of NTP/OTP settings (e.g., buprenorphine prescribed through primary care). Treatment in primary care would not be captured by CalOMS-Tx data, and therefore the MAT numbers in the table above understate actual receipt of medications across systems. According to data from California's Prescription Drug Monitoring Program,[23] in CY 2016 there were 528,109 prescriptions for buprenorphine outside of NTP/OTP settings. Prescriptions increased to a high of 589,364 in CY 2018 before falling back to 528,368 in CY 2020, possibly due to COVID-19-related disruptions. However, trends in primary care prescriptions would not explain why the percentage of patients in CalOMS-Tx (in specialty care) has decreased over time.

Low referral numbers could in part reflect a bias against NTP/OTP referrals at the screening level. NTP/OTP stakeholders have expressed concern that they receive few referrals from the DMC-ODS waiver beneficiary access lines. ASAM LOC Referral Data generally support this concern. NTP/OTP was only indicated on 5.2% of brief screenings (likely beneficiary access line screenings) where an indicated LOC was present in DMC-ODS waiver counties from CY 2017-2020. For context, in CY 2020 15.5% of all actual admissions were to NTPs/OTPs, which suggests most NTP/OTP patients were not referred from beneficiary access lines.

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

[23] California Department of Justice, Controlled Substance Utilization Review and Evaluation System (CURES), California's Prescription Drug Monitoring Program (PDMP). https://skylab.cdph.ca.gov/ODdash/

Access to Services related to Fentanyl

According to the California Overdose Surveillance Dashboard, [24] fentanyl-related overdose deaths in California have skyrocketed from 239 in CY 2016 to 3,946 in CY 2020, representing an increase of 1,551% in only four years. Overdose death rates were four times higher among males than females and were highest among Native Americans/Alaska Natives and Black/African Americans, as shown in Figure 3.5. Rates were also high among Whites. This suggests an urgent need to increase treatment access as well as harm reduction efforts for these groups.

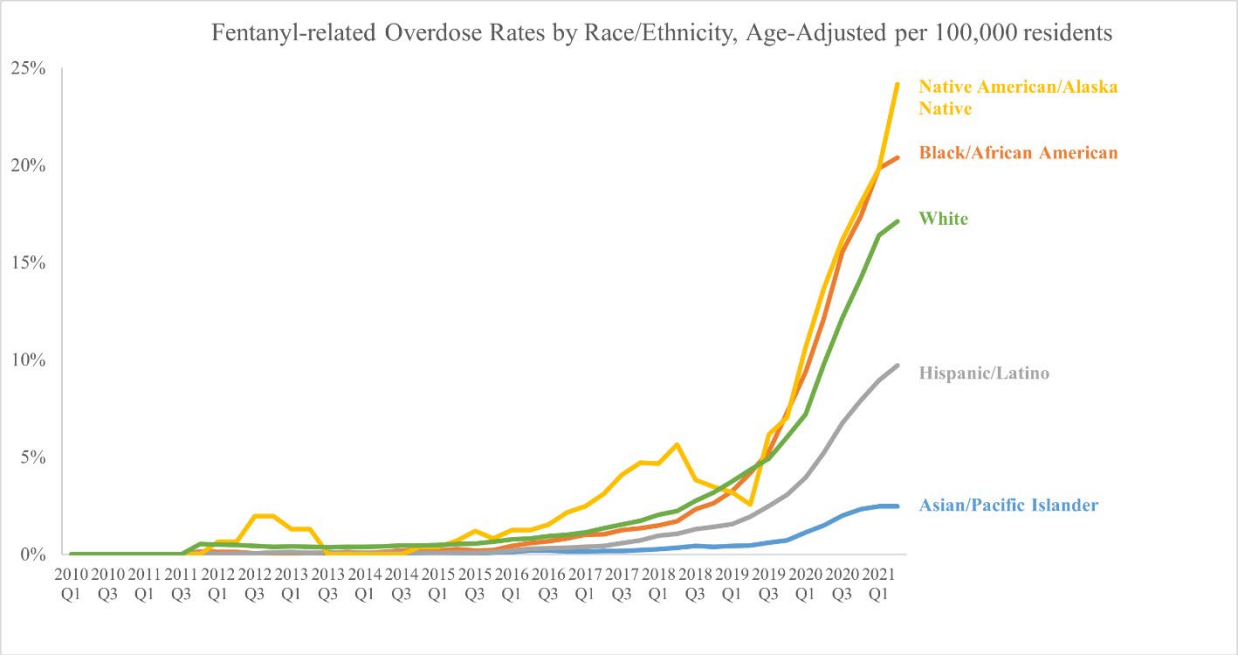

Figure 3.5. *Fentanyl-related overdose rates by Race/Ethnicity, Age-Adjusted per 100,000 residents. Multiple Cause of Death and California Comprehensive Death Files.*

Treatment services are not specifically targeted for fentanyl, but counties did report using a number of harm reduction strategies to address increasing fentanyl overdoses, as shown in Figure 3.6. The most common strategy reported was naloxone distribution (93.9%) followed by patient education (75.8%), and public education campaigns (63.6%). When county administrators were asked which strategy had been most helpful, 70.3% of respondents mentioned naloxone and 37.0% mentioned education.

[24] 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, Substance and Addiction Prevention Branch. https://skylab.cdph.ca.gov/ODdash/

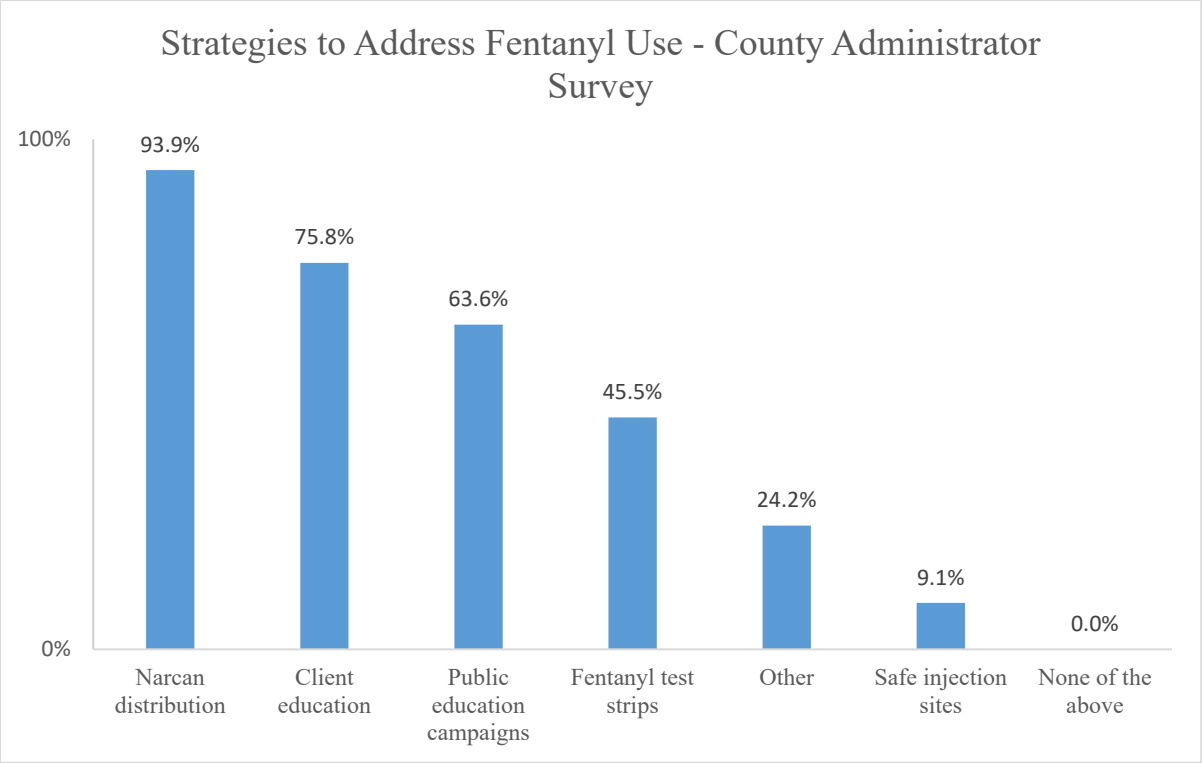

Figure 3.6. *Which of the following strategies is your county using to address fentanyl use? County Administrator Survey.*

Similarly, when administrators were asked how DHCS could help counties address challenges associated with fentanyl, many responses explicitly mentioned continuing support for naloxone distribution (44.4%) and education/training (50.0%), including help with public education campaigns.

Suggestions also included help with fentanyl test strips (16.6%), including clarification on federal rules:

> "Fund fentanyl test strips, and put out an information notice that provides clarity that DMC-ODS programs can indeed distribute fentanyl test strips. There has been some confusion about this, and some concern that this could possibly violate the federal prohibition on using federal funds to promote unlawful use of drugs."

This confusion extends beyond federal rules to state laws as well. At this writing there is a proposed assembly bill, AB 1598, that would amend Section 11014.5 of California's Health and Safety Code to clarify that drug paraphernalia "does not include any testing equipment designed, marketed, intended to be used, or used, to test a substance for the presence of fentanyl or any analog of fentanyl.[25]

[25] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1598

Access to Recovery Services

Although 76% of county administrators responding to UCLA's 2020 County Administrator Survey agreed that the DMC-ODS waiver had positively impacted the delivery of recovery services in their county, historically counties have suggested that confusion over billing and documentation requirements have caused the benefit to be underutilized.

In response, on May 14, 2021 DHCS issued Behavioral Health Information Notice 21-020, which sought to clarify the recovery services benefit. County administrators were asked to characterize their provider's understanding of recovery services following this notice on a 5-point scale ranging from "much more clarification on recovery services is needed" to "no further clarification on recovery services is needed." As shown in Figure 3.7, among administrators that could answer, only 6.9% of respondents indicated that no further clarification was needed, while 31.0% indicated that "much more clarification on recovery services is still needed." An additional four administrators indicated that they could not answer the question because they had not had a chance to discuss it with their providers yet at the time of the survey, which they received only three weeks after the BHIN 21-020 was released.

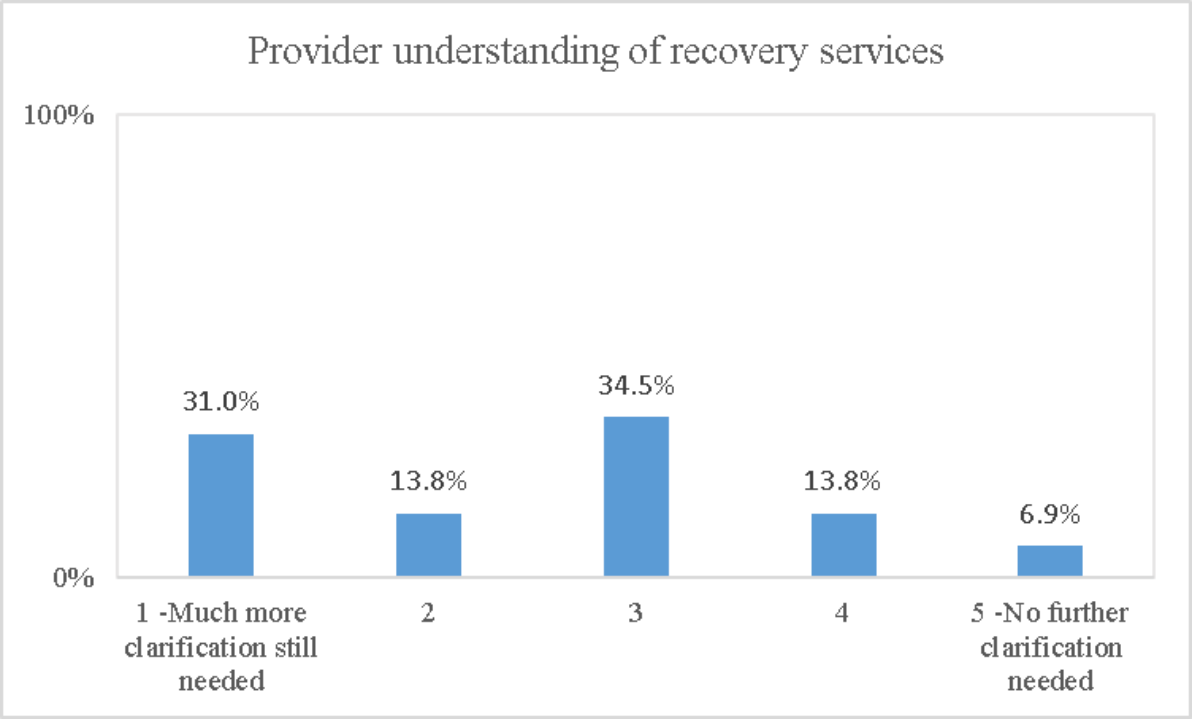

Figure 3.7. *How would you characterize your providers' understanding of recovery services following (BHIN 21-020)? County Administrator Survey.*

Comments suggested additional clarification and training would be helpful.

> "On CBHDA SAPT calls, the consensus appears to be that this info notice caused much more confusion than it did clarity. . . this info notice made us worried that we're not doing this correctly -- despite successful claiming and positive feedback from EQRO."

"Notice created additional questions - not sure how to bill for concurrent services - how to bill for both a treatment modality and recovery services concurrently when recovery services requires a remission code."

"It would be helpful to have some other examples of what types of services other Counties are doing, e.g. structured phone follow-ups, face-to-face "alumnae" groups, etc."

"Suggest DHCS make clear that while it makes sense for providers to offer recovery services during transition periods at the beginning and end of episodes, it does not make sense to offer clients recovery services in the middle of treatment episodes, as recovery services are not intended to be additional services on top of the billable DMC-ODS treatment services."

Based on county administrator estimates that were previously reported from 2020 survey data, about two-thirds of patients needed recovery services, but 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, claims for recovery services were present for only about 3.4% of patients in DMC claims in 2020.

Administrators were asked to indicate the most common reason patients did not receive recovery services (see Figure 3.8). Most administrators indicated "client preference" followed by "lack of staff training."

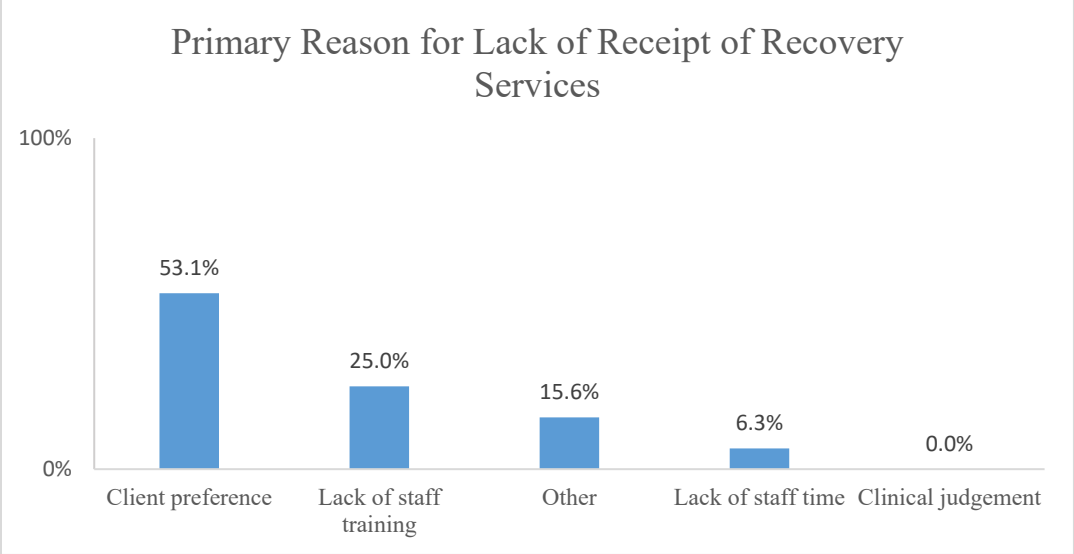

Figure 3.8. *For those who don't receive recovery services, please indicate the primary or most common reason. County Administrator Survey.*

County administrators estimated that on average 47.6% of recovery services delivered were submitted as claims to Drug Medi-Cal, and cited confusion over allowable activities, documentation, and fears of disallowances (see Figure 3.9).

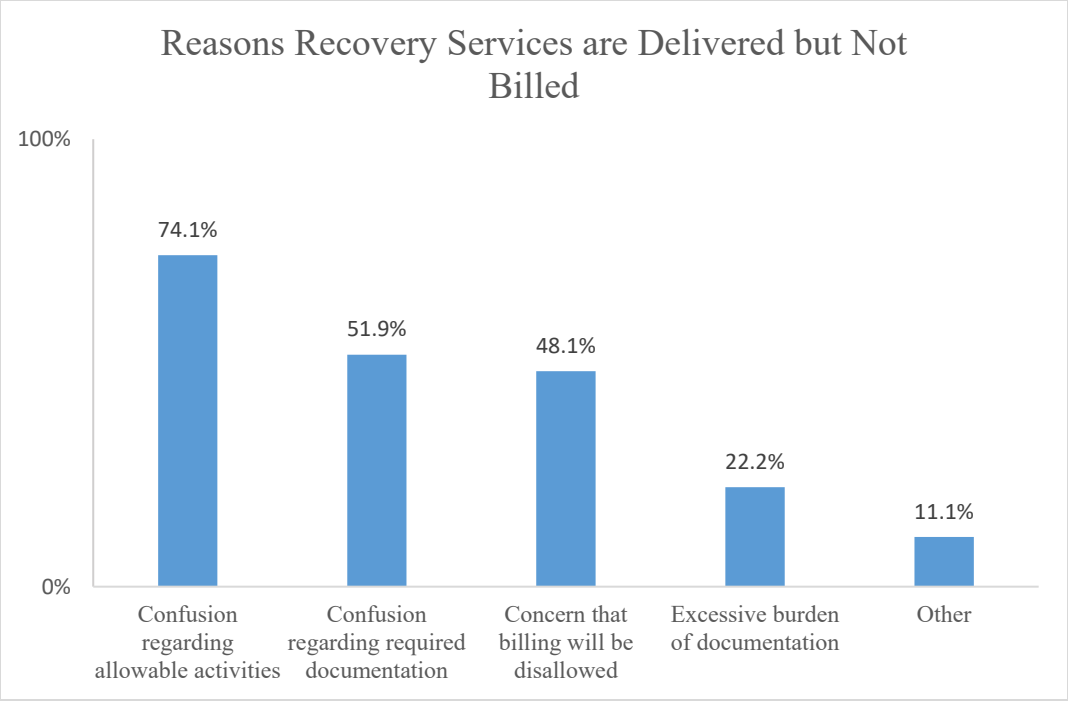

Figure 3.9. *For recovery services that are delivered but not billed, please indicate the reasons: (Check all that apply). County Administrator Survey.*

This very low overall result is similar to previous findings. In light of these small recovery service numbers, county administrators were asked to indicate the most common reason people do not receive recovery services. The most common reason selected was patient preference (53.1%), followed by "lack of staff training" (25.0%). Three of the "other" responses cited staff time, e.g. "Many providers don't offer this because they don't staff to the level needed to offer this service."

When asked if they had any additional thoughts about the implementation of recovery services under the DMC-ODS waiver, administrators suggested allowing peers to provide all or most components of recovery services. One administrator suggested "DHCS can help by offering learning collaborative to provide additional structured training and support to counties and providers . . . perhaps a statewide PIP focused on developing RS that counties can opt into."

UCLA's 2019 DMC-ODS waiver evaluation report[26] discusses 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 a small percentage of people treated. A different approach with greater clarity is needed, and DHCS is seeking to clarify this benefit in the future.

[26] 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

Workforce Challenges

Over 75% of administrators reported workforce shortages during the COVID-19 pandemic (for more information on COVID-19-specific workforce challenges see Chapter 4). When asked how DHCS could help address the workforce challenges they faced, county administrators brought up many suggestions, including:

- Increase focused support specifically for SUD workforce development that is distinct from mental health workforce development.
- Provide DHCS funding for the education and certification of AOD counselors, including paid internships, stipends, and tuition reimbursement for coursework towards certification and Masters Degrees.
- Work with credentialing and certification entities to expedite applications and licensing for staff entering or advancing in the field of SUD service delivery.
- Provide training for existing staff in management and advanced clinical skills.
- Provide a specific training and curriculum to decrease burnout among SUD workforce
- Allow MFT trainees to bill Medi-Cal just as Registered Alcohol and Drug Treatment counselors currently do.
- Provide guidance on how to hire, train and incorporate peer support staff into service delivery.
- Advocate for policies that will result in higher salaries, higher reimbursement rates (particularly for high need, high risk populations).
- Advocate for policies that will decrease documentation requirements. One county administrator reported that they had lost SUD staff due to the overwhelming demands of documentation.
- Promote policies that will permanently enable SUD staff to telecommute in order to deliver services to high need areas and to allow staff to live in regions with lower cost of living. One county administrator suggested that DHCS advocate with CMS to continue to allow telehealth visits for initial intake appointments which would facilitate the ability to offer staff permanent telecommuting.

Access Conclusions

According to claims data, access to DMC-funded SUD treatment increased as a result of the DMC-ODS waiver, particularly for residential treatment. However, according to CalOMS-Tx data, overall access to treatment regardless of funding source did not happen over night, but rather typically built up over the course of many months after each county went live. This increase is a success story for the DMC-ODS waiver. Unfortunately, need for treatment has also climbed during implementation of the DMC-ODS waiver, so there is still a wide gap between the number of people who need treatment and those who receive it.

Recommendations

- Continue expanding access, including to MAT services and harm reduction efforts targeted at fentanyl use, especially among AI/AN and Black/African American communities.
- Clarify rules for recovery services.
- Increase penetration rates by working with other systems to identify and refer patients who do not currently recognize their need for treatment.
- Investigate need for additional services for youth, causes of low referral rates to NTP/OTP.
- Support workforce development by providing stipends, grants and higher pay to attract people to the SUD workforce, and pair with providers and credentialing agencies to facilitate entry to the field. Allow PSS to deliver clearly defined billable services.
- Retain the current workforce by continuing to support telehealth, offering more training and TA focused on reducing burnout, and offering higher reimbursement rates for work with highest risk communities.

Quality of Care

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DMC-ODS' Impact on Quality of Care

On the 2021 County Administrator Survey, the vast majority of DMC-ODS waiver counties (97.0%) reported that the DMC-ODS waiver has positively impacted the quality of SUD services they provide to patients. This rate was similar to rates reported in 2015 (91.3%) and 2020 (95.7%).

Survey comments from 27 county administrators highlighted how the DMC-ODS waiver demonstration project has improved care quality in their counties. In particular, over half of administrators (51.5%) highlighted how the DMC-ODS waiver improved care quality by creating a complete continuum of care that is equipped to provide the right level and configuration of services for patients with diverse treatment needs. The DMC-ODS waiver gave counties the "ability to cover services for all beneficiaries" and "improved (the) continuum of care immensely" by "expand(ing) provider networks (so there could be) more choice and approaches" to treatment for Medi-Cal beneficiaries. Able to provide multiple sublevels of care and treatment for special populations, counties reported that the DMC-ODS waiver gave "clients…more options to find a program that is a best (or better) fit for them" instead of making them settle for "the first available bed/spot" as they had in the past. "We no longer try to fit consumers into what we offer," elaborated one administrator. "Instead, we are (now) client-centered and able to build a program that fits their specific needs."

County administrators also mentioned other ways that the DMC-ODS waiver improved treatment quality, including: case management services; increased MAT availability; smoother transitions between levels of care; the implementation of medical necessity criteria to inform clinical decision-making; and the standardization of screening and assessment procedures. Administrators also mentioned the increased use of data to inform quality improvement efforts, and the routinization of quality improvement at both the county and program levels.

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. On the 2021 County Administrator Survey, all DMC-ODS waiver counties reported that they use EBPs, with 94.2% reporting that they use MI, 88.6% using CBT, 72.7% using relapse prevention, 72.7% using trauma-informed treatment, and 63.6% reported using psycho-education.

Administrators who completed the County Administrator Survey in 2021 reported that EBP implementation has been somewhat challenging. Mean scores on the question about how difficult it has been to implement at least 2 EBPs to meet the DMC-ODS waiver requirement were 2.27 (on a 5-point Likert scale, with higher numbers indicating more difficulty) in 2021, remaining relatively steady when compared to the mean of 2.25 on the 2020 County Administrator Survey. In 2021, county administrators reported that the most important barriers to effective EBP implementation in their counties related to the availability of EBP training (mentioned by 51.4% of counties) and ensuring EBP fidelity (mentioned by 37.1% of counties). County administrators reported that training-related barriers to EBP implementation included the cost of EBP training, difficulty providing skills-based hands-on training due to COVID-19 restrictions on in-person gatherings, trouble tracking who receives EBP training, lack of guidance on what trainings and curricula are reliable, and copyright challenges that make it difficult to duplicate materials for "train the trainer" approaches. Commonly reported challenges related to EBP fidelity included insufficient knowledge of how to monitor fidelity, resources to support fidelity of review, and a lack of supervisors and managers who are capable of conducting fidelity assessments.

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

The ASAM Criteria[27] provide 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 SUD illness severity along six dimensions with levels of care 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 they utilize.

ASAM Criteria-based Assessments

Both published research[28] and UCLA-ISAP's previous reports noted the heterogeneity of ASAM Criteria-based assessments being used in California and called for greater standardization of ASAM Criteria-based assessments across counties. When asked what they would like DHCS to know about the implementation of ASAM Criteria-based assessments on the 2021 County Administrator Survey, five county administrators echoed these calls for standardization. Writing that they would like DHCS to support a "standardized" or "universal" tool to facilitate patient placement. "Not having standardized forms and standardized trainings from the beginning created a lot of nuance between counties," elaborated one administrator, highlighting how

[27] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. (2012). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies.

[28] Padwa, H., Mark, T. L., & Wondimu, B. (2020). What's in an" ASAM-based Assessment?" Variations in Assessment and Level of Care Determination in Systems Required to Use ASAM Patient Placement Criteria. *Journal of Addiction Medicine*.

differences in assessment procedures could lead to divergent assessment and placement practices depending on the county where each beneficiary resides.

Three county administrators mentioned the proprietary nature of ASAM Criteria-based assessments creating challenges for their counties, and voiced concern that the expense of ASAM-endorsed software for ASAM Criteria-based assessments (compared to other multidimensional assessments) were not worth the cost. As one of these administrators wrote:

> "Please be mindful of ASAM establishing a monopoly and benefiting from their ASAM Criteria and various assessment products at the expense of public funds. ASAM's Criteria and multidimensional assessment is something that medical schools and training programs for other clinicians (social workers, psychologists, etc) have taught for decades, and packaging it into the ASAM Criteria does not fundamentally change the value of multidimensional assessments, so the benefits of the commercialization of the ASAM Criteria need to be weighed against the financial drawbacks of paying for something of questionable proprietary value."

Other issues that county administrators mentioned regarding ASAM Criteria-based assessments included:

- Challenges for providers who contract with multiple counties and are required to utilize different assessments for beneficiaries from different counties
- The need for assessments tailored for use with adolescents and designed to recommend levels of care that are currently available to adolescents
- Confusion about how to differentiate between ASAM Residential levels 3.1 and 3.5
- Concern that assessments are written with too much technical language to be accessible for patients and counselors, since language seems to be "geared towards LPHA-level staff"
- Cost of ASAM Criteria training now that DHCS is no longer providing free ASAM training
- The redundancy of ASAM Criteria-based assessments for OTP admissions given the extensive evaluation required for OTP assessments under Title 9

UCLA-ISAP and ASAM partnered to create a paper-based interview tool, The ASAM Criteria Assessment Interview Guide for adults, which is free for public use. The dissemination of this tool should help address many of the aforementioned concerns about consistency in assessment across counties and cost. On the 2021 County Administrator Survey, 29 out of 31 counties (93.5%) indicated that they were interested in learning more about this tool when it is released. This suggests most counties will at least consider using the UCLA/ASAM tool, potentially leading to greater standardization of assessment quality across California. The tool was released on February 16, 2022 and is available on the ASAM website.[29]

Two county administrators highlighted the importance of having this new tool be easily translatable into electronic health record (EHR) formats. "Most counties use an electronic

[29] https://www.asam.org/asam-criteria/criteria-intake-assessment-form

ASAM [Criteria-based assessment] that has been created in their EHR," summarized one administrator. "So even though a standard tool is desired, converting to a paper tool that cannot be standardized into reports from our EHR is not appealing." ASAM confirms that the paper-based ASAM Criteria Assessment Interview Guide for Adults can be programmed into EHRs, provided that it is programmed as written and no algorithms or clinical decision support is added to the tool.

Brief Initial Screening Tools

The 2021 County Administrator Survey also collected information about the usage of brief initial screening tools to determine preliminary LOC placements before full ASAM Criteria-based assessments are conducted. Thirty of thirty-two counties reported using some type of brief screening tool to facilitate placement prior to complete ASAM Criteria-based assessments. Most counties reported using a tool that they created themselves (40.6%), other tools such as the DAST, AUDIT, or S2BI screening tools (21.9%), or tools adapted from those used in other counties (18.8%) for these purposes.

As with full ASAM Criteria-based assessments, an SUD screening tool has been created by UCLA that is freely available to counties, the Brief Questionnaire for Initial Placement (BQuIP). The BQuIP is a screening tool, is not a replacement for full assessments, and the appropriateness of the provisional placement recommendations it generates need to be confirmed through comprehensive ASAM Criteria-based assessments. Though the BQuIP screener is currently in a beta version (with programming and algorithms continually being refined), the tool is currently freely available to California counties at https://www.uclaisap.org/bquiptool/index.html. In the future, California is also expected to join Shatterproof's Addiction Treatment Locator, Assessment, and Standards platform (ATLAS).[30]

ASAM Level of Care Referral Data

The ASAM Criteria are a defining feature of the DMC-ODS waiver. Counties are required to collect and submit ASAM LOC Referral Data to DHCS, and have developed various systems to collect these data.

In CY 2020, 36 out of 37 DMC-ODS waiver counties (97.3%) collected and submitted ASAM LOC Referral Data. This was similar to the share of counties that collected and submitted ASAM LOC Referral Data data in CY 2019 (29 out of 30 – 97%). Approximately one-quarter (27.5%) of CY 2020 ASAM LOC Referral Data submissions were for brief screenings, 41.5% were for initial assessments, and 31.1% were for follow-up assessments. This distribution was similar to ASAM LOC Referral Data submitted in 2019. Out of the 36 counties, 30 (83.3%) submitted ASAM LOC Referral Data from brief screenings, 34 (94.4%) submitted ASAM LOC Referral Data from initial assessments, and 32 (88.9%) submitted ASAM LOC Referral Data from follow-up assessments.

[30] https://www.shatterproof.org/press/40-percent-us-population-will-soon-be-state-access-free-transparent-information-addiction

Difference between indicated and LOC placement decision

As shown in Figure 3.10, most treatment referrals in CY 2020 were made to the same LOC (81.3%) as indicated by an ASAM Criteria-based assessment across all screenings and assessments. Compared to CY 2019, LOC matching for brief screenings and follow-up assessments increased slightly in CY 2020. Overall LOC matches decreased slightly (from 82.9% to 81.3%) and LOC matches on initial assessments dipped from (82.1% to 77.6%), while matches on brief screenings (83.6% to 85.6%) and follow-up assessments (83.3% to 84.9%) improved slightly.

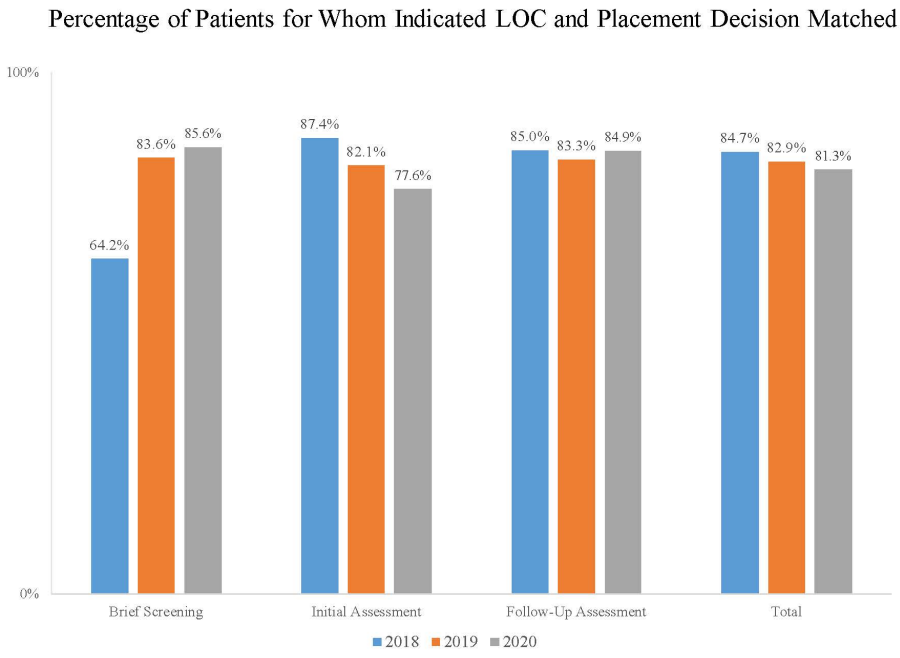

Figure 3.10. *Percentage of patients for whom indicated LOC and placement decision matched.*

Reasons for differences between indicated LOC and LOC placement decisions

As shown in Table 3.4, the reasons for indicated by assessments and actual LOCs not matching differed slightly depending on the type of assessment. As in CY 2019, the most common reason for unmatched LOC among all three screening/assessment types was patient preference (accounting for 27.1% of cases where there was no match), and the second most common reason was clinical judgment (accounting for 19.2% of cases where there was no match).

However, the share of cases where patient preference and clinical judgment accounted for differences between indicated LOC and placement decisions differed depending on the type of screening/assessment. Patient preference accounted for 46.5% of the cases where indicated LOC and placement decisions did not match for brief screenings, whereas it accounted for 26.3% of the cases where there was not a match with initial assessments, and 16.7% of cases where it did

not match follow-up assessments. Compared to CY 2019, the share of cases where indicated LOC did not match placement was higher in 2020 for brief screenings (increasing from 37.5% to 46.5%), while it was lower for initial assessments (decreasing from 36.2% to 26.3%) and follow-up assessments (decreasing from 33.5% to 16.7%). This indicates that counties increasingly faced patient preference as a barrier to placement in indicated LOCs on brief screenings (possibly due to COVID-19), while patient preference has declined as a reason for placements to not match LOCs on initial and follow-up assessments.

Clinical judgment accounted for 13.5% of the cases where brief screening results did not match treatment placements, whereas it accounted for 24.7% of mismatches with initial assessments and 10.9% of mismatches with follow-up assessments. This was a slight increase from 2019 rates of clinical judgment causing differences between indicated LOC and patient placements on brief screenings (from 9.3% to 13.5%), but a decrease in the share of initial assessments (34.9% in CY 2019 to 24.7% in CY 2020) and follow-up assessments (from 30.7% in CY 2019 to 10.9% in CY 2020) where mismatches could be attributed to clinical judgment. This indicates that from CY 2019 to CY 2020, counties saw improvements in implementing initial and follow-up assessments in a manner where their recommendations accorded with clinical judgment.

The decrease in the overall percentage of cases where LOC placements matched initial assessments (Figure 3.1) is concerning. In the most common reasons for initial assessments to not match LOC placements was "Other." The share of cases where LOC placements did not match initial assessments for "Other" reasons grew from 14.5% in CY 2019 to 44.0% in CY 2020. Further research is needed to understand why discordance between LOC placements and initial assessments has been increasing by examining what these "Other" differences are.

Table 3.4. *Reasons for differences between indicated LOC and LOC placement decisions.*

Reasons	Brief Screening	Initial Assessment	Follow-Up Assessment
Patient preference	46.5%	26.3%	16.7%
Clinical judgment	13.5%	24.7%	10.9%
Family responsibility	0.4%	0.5%	0.3%
Geographic accessibility	2.9%	0.5%	0.9%
Lack of insurance	2.1%	0.0%	0.0%
Legal issues	4.4%	0.7%	2.0%
LOC not available	4.6%	3.2%	4.1%
Other	25.2%	44.0%	65.0%

These changes indicate that as counties and providers have gained experience conducting ASAM Criteria-based assessments, they have been able to improve the degree to which initial and follow-up assessments truly capture the perspectives of both patients and providers concerning treatment placement. Research has demonstrated that structured assessments such as The ASAM Criteria can lead to LOC recommendations that are inaccurate if assessments are conducted before patients are ready to disclose sensitive information, and that they can sometimes generate recommendations that are inconsistent with clinical judgment. However, providers can use engagement strategies to help patients feel more comfortable during assessments and encourage more thoughtful and accurate responses by building rapport and showing empathy throughout the assessment process.[31] The decrease in the share of cases where patient preference and clinical judgement differed from LOC recommendations indicates that over time, providers have become more adept at conducting assessments in a manner that facilitates LOC recommendations that are more patient-centered, and aligned with clinician impressions of what services would be most beneficial for each individual patient. However, among brief screenings, both patient preference and clinical judgment began to account for more of the cases where indicated LOC and patient placement did not match. It is possible that this could be a result of the COVID-19 pandemic, and resulting shifts in patient preference and clinical judgment (e.g. preferring more telehealth services, being reluctant to present for in-person care, preferring not to go to congregate settings like residential treatment). It could also indicate that further training and technical assistance is needed to teach counties how to conduct brief screenings that more accurately reflect patient and provider perspectives. In the future, DHCS may consider supporting research on what strategies counties used to increase the degree to which LOC recommendations from initial and follow-up assessments accorded with patient and provider choice, and implement similar strategies to improve brief screening processes.

Another notable shift from CY 2019 to CY 2020 was in the degree to which barriers related to access and service availability decreased. The share of cases where service availability ("LOC not available") accounted for differences between indicated LOCs and placement decisions decreased from 20.5% in CY 2019 to 4.6% in CY 2020 among brief screenings, from 7.9% in CY 2019 to 3.2% in CY 2020 among initial assessments, and 10.2% in CY 2019 to 4.1% in 2020 among follow-up assessments. Similarly, the share of cases where geographic accessibility was the reason for differences between indicated LOC and placement decisions decreased for brief screenings (from 4.4% in CY 2019 to 2.9% in CY 2020), initial assessments (from 1.9% in CY 2019 to 0.5% in CY 2020), and follow-up assessments (from 2.5% in CY 2019 to 0.8% in CY 2020). These shifts suggest that from CY 2019 to CY 2020, counties were able to develop their systems of care so that services beneficiaries needed became more available and accessible. It is possible that increased use of telehealth in 2020 played a role in making these services more accessible (see chapter 4), but extent to which it may account for these results is unknown.

[31] Padwa, H., Treiman, K., Mark, T. L., Tzeng, J., & Gilbert, M. (2021). Assessing Assessments: Substance use disorder treatment providers' perceptions of intake assessments. *Substance abuse*, 1-7. doi: 10.1080/08897077.2021.1946891

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

Though the match rate between ASAM Criteria-indicated LOCs and placement decisions has been improving, there are still many patients who do not actually receive treatment from the provider to whom they were referred in a timely manner. To determine how successful DMC-ODS waiver counties have been in completing timely receipt of clinically indicated services, CY 2020 DMC claims data were merged with ASAM LOC Referral Data for analysis.

In CY 2020, 53.1% of patients who were screened or assessed received treatment in the LOC to which they were referred within 30 days. This is a substantial improvement from 2019, when only 33.5% of patients received indicated treatment within 30 days. This may be a product of improved capacity to link patients to their recommended LOC, or at least an increased abilty to place people in their indicated LOC while admissions were reduced due to COVID-19 (see chapter 4). In CY 2019, 38.0% of patients received treatment within 30 days of assessment, but not at the recommended LOC. In 2020, this share dropped to 9.9%. The percentage of patients who received treatment over 30 days after screening/assessment (8.0% in CY 2019, 6.0% in CY 2020) and those who did not receive any treatment (19.6% in CY 2019, 24.8% in CY 2020) remained relatively stable. Consequently, it can be concluded that from CY 2019-CY 2020, the main driver of improved timely receipt of ASAM Criteria-indicated LOC has been increased ability among counties to link patients to indicated levels of care—and not just the first treatment slot available—within 30 days of screening and assessment.

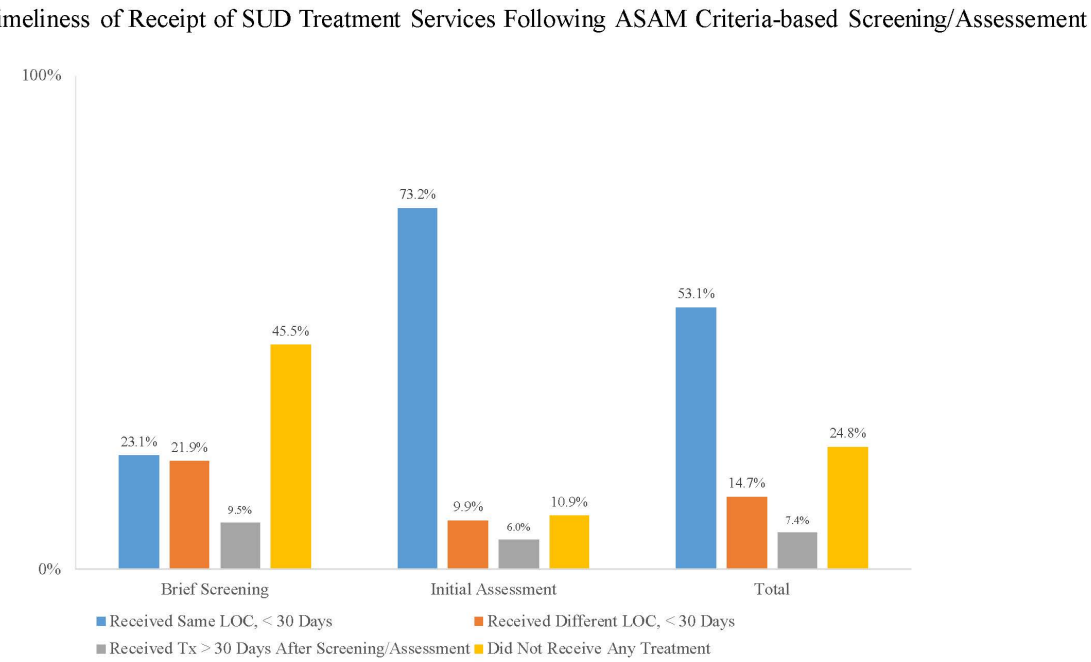

Figure 3.11. *Timeliness of receipt of SUD treatment services following ASAM Criteria-based screening/assessment. ASAM LOC Referral Data and DMC Claims.*

As in CY 2019, rates of successful timely linkage to indicated levels of care were highest among patients receiving initial assessments (73.2%), and lowest among those receiving brief screenings (23.1%). This makes sense, since brief screenings often occur over the phone (e.g. through beneficiary access lines) then beneficiaries need to accept the referral then go to the program. By contrast, patients typically receive initial assessmens in person at a treatment program, so naturually their rate of receiving services immediately is much higher. Providers also typically spend more time conducting initial assessments than they do on brief screenings and follow-up assessments. It is possible that this extra time allows for greater rapport building and therapeutic alliance development, thus increasing the likelihood patients will initiate treatment following their initial assessments.

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

There were some notable disparities in the timeliness of receipt of indicated services following brief screenings (Figure 3.12). Following brief screenings, youth were appreciably more likely to not receive any treatment (66.7%) compared to adults (44.7%) and older adults (48.9%). Youth were also less likely to receive services in their indicated LOC within 30 days (19.3%) than adults (23.2%) and older adults (24.0%). This is particularly striking since in CY 2019, over 70% of youth were successfully linked to treatment in their indicated LOC within 30 days. This is consistent with the previously noted decrease in youth admissions (see Table 3.1), which in turn may be related to COVID-19. Further research is needed, however, to explore why exactly this translated into lower rates of successful linkage among youth who were screened, and what can be done to address the decrease. Anecdotally, when asked about this pattern among youth LOC placements specifically, one county administrator responded,

> "We attribute the lower numbers of those going to the indicated level of care to COVID . . .
>
> Our residential capacity, specifically, was decreased due to social distancing standards and all programs struggled with staffing impacts throughout the year."

Only 7.7% of youth received services in a LOC that was not indicated following their brief screenings, compared to 22.3% of adults and 19.9% of older adults. This indicates that while brief screenings for youth were less likely to lead to successful care linkages, the youth who did receive timely services following brief screenings were more likely to receive treatment at an LOC that matched their ASAM Criteria-indicated LOC.

There were also some differences in brief screening and follow-up receipt of treatment by race/ethnicity. Rates of timely linkage to indicated LOCs after brief screenings were higher for Non-Hispanic Whites (26.8%) than for Hispanics (22.7%) and Black/African Americans (19.5%). Blacks (29.8%) and Hispanics (25.6%) were more likely than Whites (21.8%) to receive treatment in a LOC other than that indicated by ASAM Criteria-based screenings. Thus, compared to Whites, Blacks and Hispanics were less likely to receive services that were timely or matched the ASAM Criteria-indicated LOC recommendations.

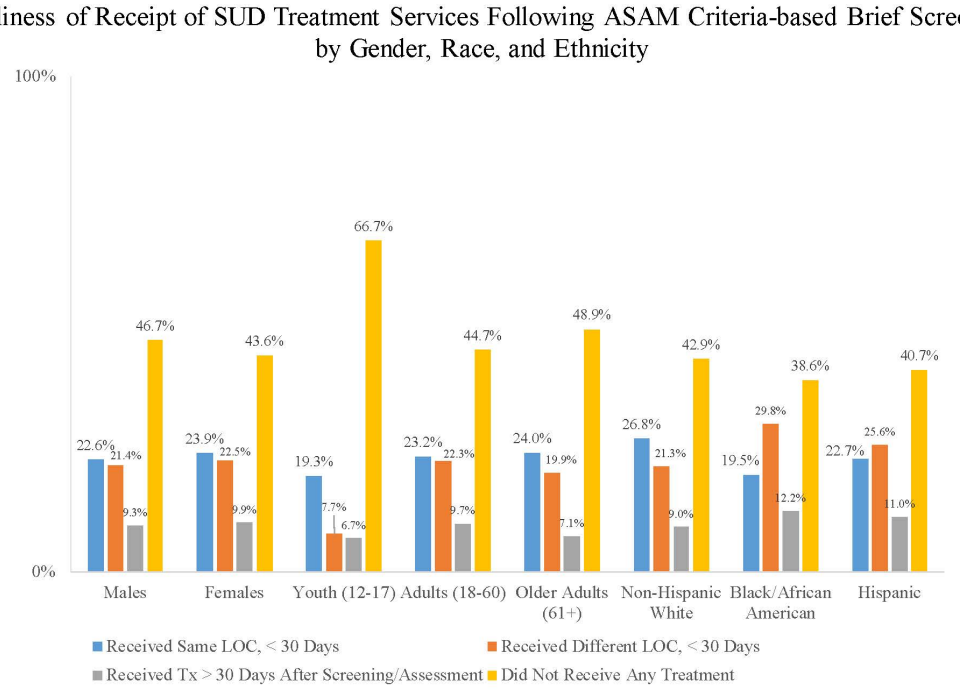

Figure 3.12. *Timeliness of receipt of SUD treatment services following ASAM Criteria-based Brief Screenings by Gender, Race, and Ethnicity. ASAM LOC Referral Data and DMC claims.*

Timely receipt of ASAM Criteria-indicated services following initial assessments did not show as much variation by gender, age, or race/ethnicity as brief assessments (see Figure 3.12). The most notable difference was among age groups, as youth were more likely to receive services in their indicated LOC within 30 days (82.9%) than adults (73.3%) and older adults (67.3%). Conversely, 16.5% of older adults did not receive any treatment following initial assessments, compared to 10.7% of adults and 4.3% of youth. Blacks were more likely to not receive treatment after initial assessments (13.4%) than Hispanics (11.8%) and Whites (9.6%). Whites were more likely to receive timely treatment, but not at the ASAM Criteria-indicated LOC, following initial assessments (11.0%) than Hispanics (9.4%) and Blacks (8.6%). This disparity is surprising given that following brief screenings, Whites were more likely than other groups to receive care that matched ASAM Criteria-indicated LOC recommendations.

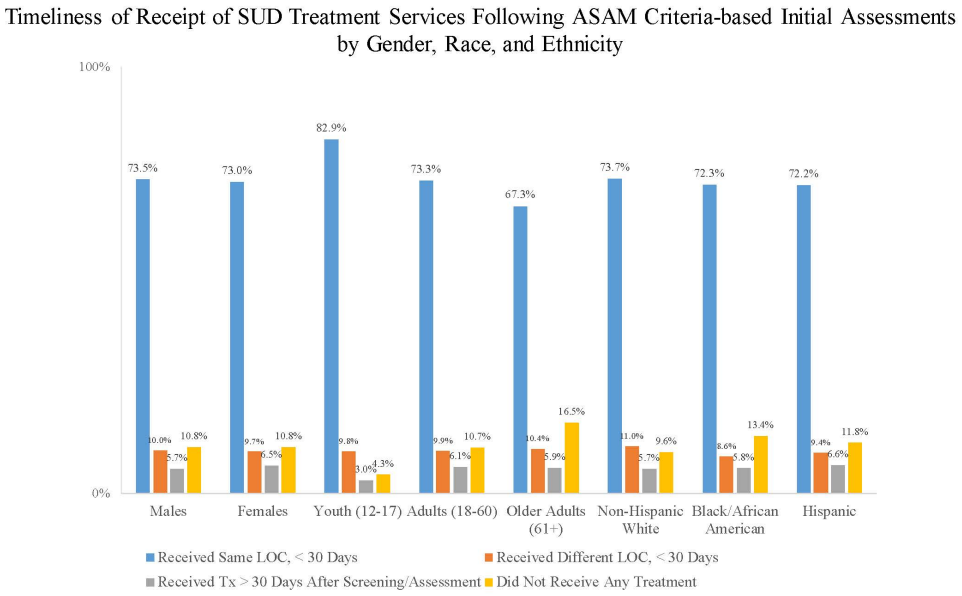

Figure 3.13. *Timeliness of receipt of SUD treatment services following ASAM Criteria-based Initial Assessments by Gender, Race, and Ethnicity. ASAM LOC Referral Data and DMC claims.*

Treatment Engagement (DMC Claims)

DMC claims data for DMC-ODS waiver counties for CY 2016 (pre-waiver) and CY 2020 (post-waiver) were used to track treatment engagement, as measured by three visits within the first 34 days as opposed to the previously used criterion of three visits within the first 30 days. As shown in Figure 3.14, engagement rates varied across treatment modalities in both years. Engagement rates were higher in the post-waiver period for NTP/OTP. Treatment engagement rates were somewhat lower for intensive outpatient treatment post-waiver.

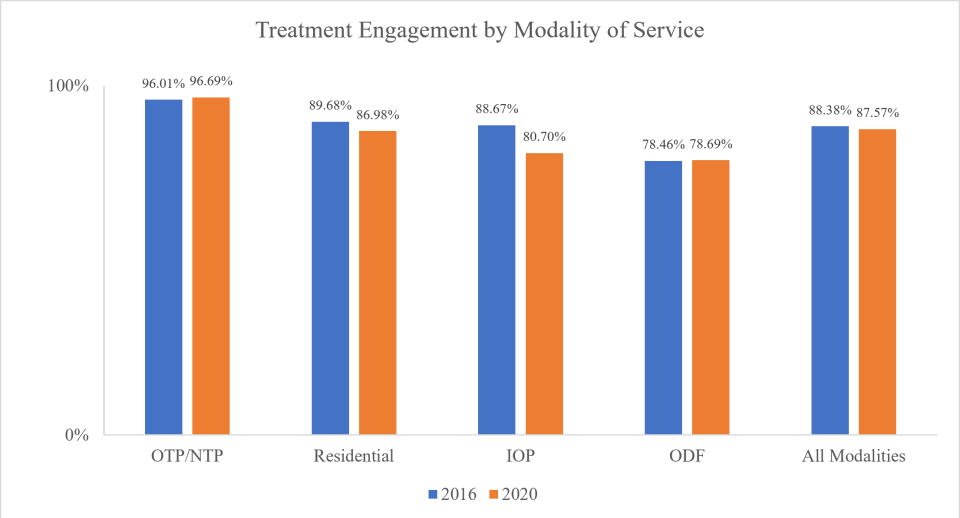

Figure 3.14. *Treatment engagement rates were lower for intensive outpatient post-waiver - DMC claims (CY 2016, and 2020).*

DMC claims data for CY 2016 through CY 2020 were also used to track and compare treatment engagement among 30 DMC-ODS waiver counties, 7 PHC counties, and State Plan counties. Figure 3.15 displays the trend in treatment engagement over time for each set of counties. Compared to 2016, treatment engagement rates were lower for DMC-ODS waiver (89.0% v. 88.1%), and State Plan counties (82.1% v. 79.5%) in 2020. However, for the seven PHC counties, treatment engagement rates went up in 2020 (82.5%) compared to 2016 (80.5%). This increase is significant at 5% level.

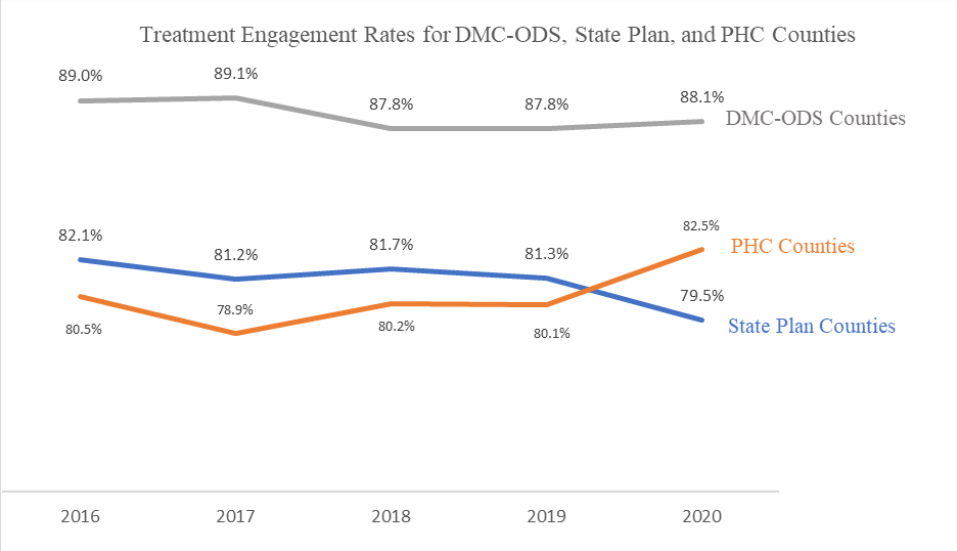

Figure 3.15. *Compared to 2016, treatment engagement rates were lower for DMC-ODS waiver, and State Plan counties in 2020. However, for the regional PHC model, treatment engagement rates went up in 2020 compared to 2016. DMC claims (CY 2016 to CY 2020).*

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 found that the introduction of the DMC-ODS waiver significantly increased the probability of treatment engagement among 22- to 26-year-old patients in DMC-ODS waiver counties by 5.7% compared to State Plan counties. We also found that the introduction of the DMC-ODS waiver significantly decreased treatment engagement among 57- to 61-year-old patients by 3.2%, among 62- to 65-year-old patients by 4.3%, and among 65 and older patients by 6.0%.

Readmissions to Withdrawal Management (DMC Claims)

According to DMC claims data for CY 2020, overall, there were 11,931 WM admissions. Among this group, 82.5% were not readmitted. This was similar to the proportion of WM patients who were not readmitted in CY 2019 (80.0%). Approximately 11.0% of admissions to WM led to readmissions within 30 days, and 17.5% led to readmissions within 90 days.

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

Patients' perceptions of care and satisfaction with SUD services are critical components of care quality, and often associated with treatment outcomes[32] (See Appendix B 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 2020 survey period, a total of 13,530 TPS forms were received from 30 participating DMC-ODS waiver counties and one regional model county. This was a 43.1% decrease from CY 2019's TPS. Counties reported that decreased patient census due to COVID-19 during the survey period was the primary reason for the lower response rate. In addition, some programs may have been closed due to a federal holiday (Veterans Day) that coincided with the survey period.

The overall response rate for TPS surveys in 2020 was 35.4%, an appreciable drop from the 2019 response rate of 58.7% in 2019 and 60.9% in 2018. The response rate was calculated as the number of surveys received divided by the number of patients that received services during the survey period in participating counties as reflected in the administrative DMC claims database. If programs collected TPS forms from non-Medi-Cal beneficiaries, this may have inflated the rate. According to CalOMS-Tx data, 18.0% of patients served in CY 2020 were not Medi-Cal beneficiaries.

Adults accounted for the majority of survey forms received (97.3%), and youth accounted for 2.7% of surveys received. The highest share of adult survey forms was received from respondents receiving OP/IOP services (43.0%), followed by NTP/OTPs (28.8%), and residential programs (25.2%), and standalone WM programs accounted for just 1.2% of adult surveys. In contrast, 86.1% of youth surveys were from OP/IOP programs, and 7.9% of youth surveys were from residential programs. Due to missing data, 1.8% of adult and 6.0% of youth respondents could not be linked to a specific program.

Most adults who completed TPS surveys did so on paper (64.2%), while almost one-third (31.9%) completed surveys online and 3.9% completed surveys by phone. In contrast, slightly more than half of youth respondents (52.9%) completed surveys online, 46.3% completed surveys on paper, and under 1% (0.8%) completed surveys by phone. No meaningful differences

[32] 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; 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; 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; 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.

in responses or average scores were observed between online and paper surveys both for adults and youth, indicating that the transition from paper to online surveys did not skew survey results.

Demographics

Consistent with previous years of the TPS, the majority of adult survey respondents (56.2%) identified as male, 38.2% identified as female, and 0.5% identified as transgender or having another gender identity. Likewise, most youth survey respondents (63.8%) identified as male, 28.9% identified as female, and 1.9% identified as transgender or having another gender identity.

The most common race/ethnicity among adult survey respondents was White (34.3%), followed by Latinx (15.9%), Other (8.7%), Black/African American (7.1%) and American Indian/Alaska Native (2.7%). The lowest percentage of adult respondents identified as Asian (1.8%) or Native Hawaiian/Pacific Islander (1.1%). Among youth, the highest share of respondents identified as Latinx (39.0%), followed by White (16.6%), Other (10.9%), Black/African American (5.7%), American Indian/Alaska Native (3.0%, Asian (2.5%), and Native Hawaiian/Pacific Islander (1.4%).

Most adult (97.0%) and youth surveys (98.9%) were returned in English, with most of the remaining forms being returned in Spanish. Patients who completed surveys in languages other than English were twice as likely as English-language respondents to return paper forms instead of online.

Percent Agreement for Survey Items by Domain

Survey respondents used a 5-point Likert scale (strongly disagree to strongly agree), with higher numbers indicating more positive perceptions of care/satisfaction. In this section, a respondent is considered to have "agreed" with a statement if they indicated 3 or higher on the 5-point Likert scale.

Adults

As shown in Figure X, the percent of responses in agreement with each of the 14 TPS items was at least 85.4%, indicating overall favorable perceptions of care among adult survey respondents. As in 2019, the two items with the highest percentage in agreement in 2020 were "understood communication" (93.6%) in the Quality domain "felt welcomed" (93.6%) in the General Satisfaction domain. The two lowest scores – "work with mental health providers" (85.4%) and "work with physical health providers" (86.0%) were in the Care Coordination domain. This also was consistent with results from the 2019 TPS.

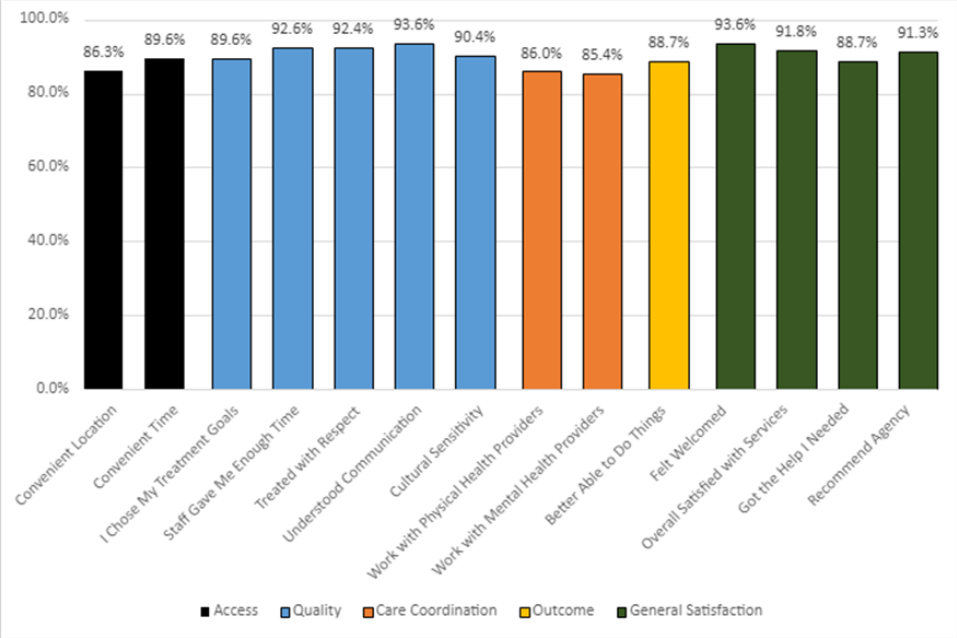

Figure 3.16. *Percent in agreement for each survey item by domain. Adult Treatment Perceptions Survey.*

Youth

As shown in Figure 3.17 below, among youth respondents, at least 80.6% endorsed each of the 18 TPS survey items in 2020. This was a marked improvement from 2019, when some items were endorsed by under 70% of respondents. The survey items showing the highest level of agreement were "counselor listened" (93.2%) in the Therapeutic Alliance domain and "treated with respect" (93.0%) in the Quality domain. The items with the lowest percentage agreement were "provided family services" (76.9%) and "cultural sensitivity" (78.7%), both in the Quality domain. These two items were also the lowest rated by youth on the 2019 TPS survey as well.

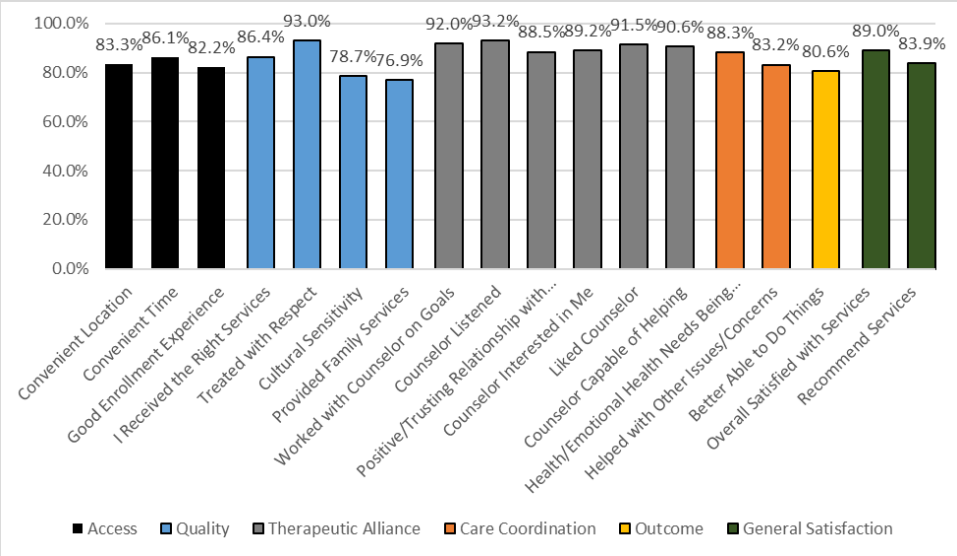

Figure 3.17. *Percent in agreement for each survey item by domain. Youth Treatment Perceptions Survey.*

Average Perceptions of Care/Satisfaction Scores by Treatment Setting

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

Adults

The overall average score for adult survey respondents across treatment settings was 4.4, similar to 2019. Overall average scores for OP/IOP programs were 4.5, for NTP/OTP and WM (standalone) they were 4.4, and for residential they were 4.3. These findings suggest that as in 2019, while overall satisfaction is high among adults, there is most room for improvement in residential levels of care.

Youth

Among youth survey respondents, overall average scores were 4.4, with OP/IOP programs averaging 4.4 and residential programs averaging 4.1. This suggests that as with adults, there is the most potential to improve treatment services for youth in residential settings.

Average Perceptions of Care/Satisfaction Score by Domain

Among adult respondents, the overall average scores for each of the five domains were high. The Quality and General Satisfaction domains yielded the highest scores (4.5), followed by the Outcome (4.4), Access (4.3) and Care Coordination (4.3). Among youth respondents, average scores were also high across domains, with the highest average scores in Therapeutic Alliance (4.4), followed by Quality (4.3), Care Coordination (4.3), General Satisfaction (4.2), Access (4.2) and Outcomes (4.2).

The highest average scores for adult respondents in OP/IOP setting were in the Quality and General Satisfaction domains (both 4.6) and the lowest average scores were in the Access and Care Coordination domains (both 4.4). Similarly, in residential settings, the highest average scores among adults were for Quality and General Satisfaction (both 4.4), and Access, Care Coordination, and Outcome scores were slightly lower (4.3). In NTP/OTP settings, the Quality, Outcome, and General Satisfaction domains all yielded average scores of 4.5, while Access and Care Coordination had average scores of 4.3. For WM settings, the highest average scores were in the Quality and General Satisfaction domains (both 4.5), and the lowest average score was for the Outcome domain (4.3). Shorter length of stay in residential and WM settings, which are meant to provide services that "stabilize" patients before stepping down to other levels of care may contribute to patient perceptions that these levels of care do not produce positive outcomes as much as OP/IOP services. The lower scores for Access in NTP/OTP and residential settings suggest that improved access could be an area for improvement in these levels of care.

Among youth survey respondents, Therapeutic Alliance had the highest average scores in both OP/IOP and residential settings (4.5 and 4.2, respectively), and the Outcome single-item domain had the lowest scores in both settings (4.2 and 3.7, respectively). The lower Therapeutic Alliance and Outcome scores in residential settings for youth could be, as for adults, a product of the short

lengths of stay and limited opportunities to develop lasting rapport with providers in residential treatment.

Summary: Quality of Care

In CY 2020 the DMC-ODS waiver continued to improve quality of care in participating counties by facilitating the creation of more complete continuums of care and the incorporation of critical services and supports such as case management and MAT into DMC-funded services. DMC-ODS counties regularly implemented evidence-based practices (EBPs), though counties reported that there is room for improvement in training and fidelity monitoring. Counties reported some continued challenges implementing ASAM Criteria-based assessments, but ASAM LOC Referral Data and claims data indicated that counties have made strides in identifying patient needs using ASAM Criteria-based assessments and linking them to care in a timely manner. Over half of patients (53.1%) who received ASAM Criteria-based screenings and assessments were connected to care within 30 days in CY 2020, a substantial improvement over the timely indicated LOC linkage rate of 33.5% in CY 2019. It is unknown whether these improvements are a connected to changes due to COVID-19 such as increased use of telehealth and a reduced patient census. Counties requested standardized ASAM Criteria-based screening and assessment tools, which are now being addressed with new free tools such as Brief Questionnaire for Initial Placement screen, a paper-based ASAM-endorsed assessment tool, and an upcoming screening tool from Shatterproof. There are some disparities in timely linkage to care following screening/assessment for certain age groups (youth, older adults) and racial/ethnic minorities (Blacks, Hispanics), highlighting potential areas for improvement. On indicators of care quality such as treatment engagement, readmissions to withdrawal management, and patient satisfaction with treatment, data suggest that DMC-ODS providers continued to provide high-quality services to Medi-Cal beneficiaries in CY 2020.

Recommendations

- Provide practical support on EBPs. In particular, resources that help counties track who receives EBP training, guidance on what trainings/curricula are reliable, affordable, and available, and resources to support fidelity monitoring.
- Further training and technical assistance to address disparities in the timely linkage of youth, older adults, Blacks, and Hispanics to their indicated LOC after brief screenings and assessments.
- Further research to understand and address lower engagement rates among older adults.
- Levels of patient-satisfaction were high on the Treatment Perception Survey, but slightly higher for adults than for youth. Further develop youth services to improve treatment satisfaction for youth patients.

Integration and Coordination of Care

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

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. Providing integrated care historically has been challenging for counties and providers due to the siloed SUD, MH and PH service systems. However, the DMC-ODS waiver aimed to shift practices and procedures encouraging better integrated and coordinated care, particularly with the addition of the case management service benefit. Case management services have shown to be a critical tool to facilitate care coordination, which to date has been absorbed at the program and county level to support the delivery of SUD treatment.

Progress toward a more integrated and coordinated SUD system of care was measured using results from the following data sources:

- County Administrator Surveys,
- Provider Surveys,
- Treatment Perceptions Surveys,
- CalOMS-Tx administrative data, and
- DMC claims administrative data

This chapter is organized to show the impact of the DMC-ODS waiver over time. Focusing on facilitating factors and barriers for:

1) Coordinating/Integrating Care Across the Health Care System
2) Coordination and Continuity of Care within the SUD System

This will be followed by a discussion of:

3) Strategies to improve integration/coordination, with a focus on the case management benefit

Coordinating/Integrating Care Across the Health Care System

SUD Service System as Defined by the SAMHSA Integration Framework

To understand the landscape of the integration of MH and PH care within the SUD system, UCLA previously surveyed SUD treatment programs delivering services under the DMC-ODS waiver, as part of the Provider Survey.

With regard to SUD-MH service system integration, responses revealed that 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.

For the SUD-PH service system pairing, 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%).

Overall, SUD-MH services tended to be more integrated than SUD-PH services. More SUD treatment programs also offered on-site MH services than on-site PH services.

The Provider Survey was designed to capture elements specified by the SAMHSA Framework to measure how MH and PH integration is occurring within DMC-ODS waivered SUD treatment programs. Utilizing the benchmarks identified in the SAMHSA Integration Framework can be a useful tool for programs to set strategic and realistic goals organizationally to improve integration of services. A full description of these exploratory findings can be found in the 2020 report.[33]

Cross-System Referrals into the SUD system

Referrals from MH and PH

Given that a majority of the SUD treatment programs are not providing onsite MH or PH services, the degree to which patients are referred to SUD treatment from these systems can be used as a measure of cross-system coordination. CalOMS-Tx data records the source of referral to SUD care for each patient's admission. The 2020 CalOMS-Tx data show that among waiver counties (n=30), 3.3% of admissions to SUD treatment services came from "other health care providers", compared to 3.2% in 2016. This is slightly higher than rates in State Plan counties (2.1% in 2020 and 2.4% in 2016). However, these data reveal that incoming referrals from MH and PH systems remain very low and suggest minimal impact from the DMC-ODS waiver.

Referrals from Other Service Systems

CY 2020 CalOMS-Tx revealed that for waivered counties (n=30) self-referral continues to be the most common way for individuals to access the SUD system (51.4%), followed by referrals from the criminal justice system (16.7%) and other SUD programs/12 Step (13.4%). Comparing to CY 2016 (as shown in Figure 3.18), the referral rates dropped in CY 2020 from schools, criminal justice systems, and CPS/Dependency Drug Courts, which could be related to the impact of COVID-19. Referral data from State Plan counties (not shown in figure) in CY 2020 did not reveal any meaningful differences as well, but waiver counties referral rates were slightly higher among other SUD programs, health care providers, and other community referrals.

[33] See p. 71 and Appendix F, Urada et al. (2020). Drug Medi-Cal Organized Delivery System 2020 Evaluation Report https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf

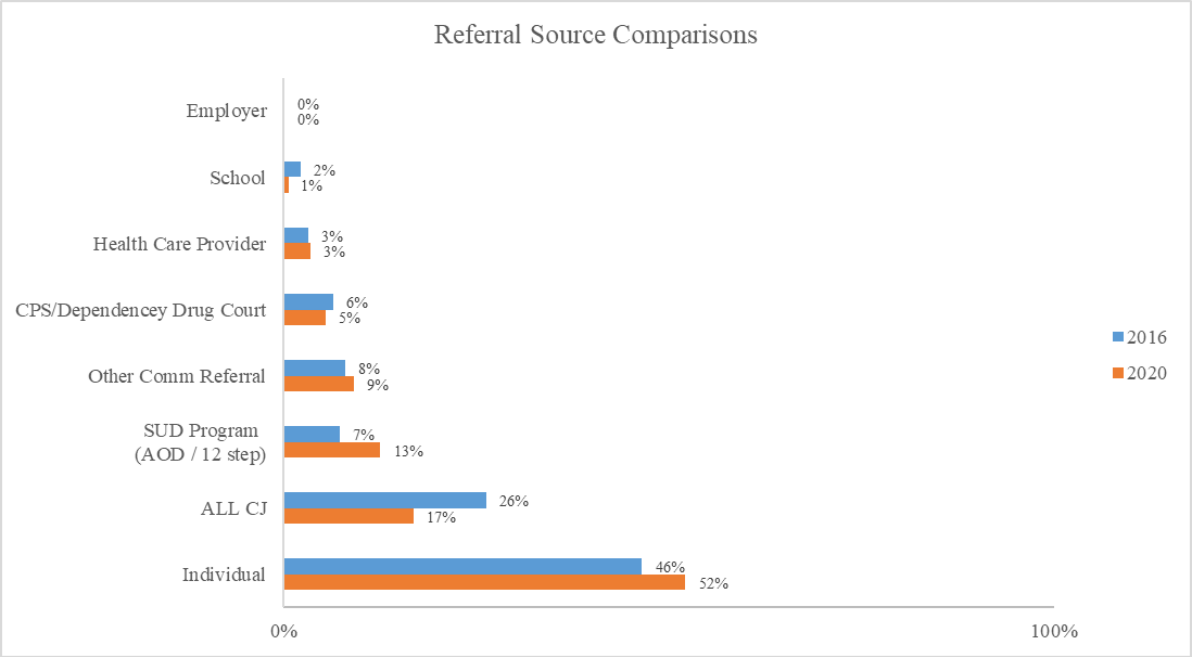

Figure 3.18 *Referral source comparisons for new admissions into SUD treatment. CalOMS-Tx (CY 2020).*

When county administrators were asked what proportion of the individuals needing treatment in emergency departments, jails, prisons, and schools were referred to SUD treatment, their responses varied widely. On average, however, county administrators reported the highest perceived referral rates from jails at 44.4%, followed by prisons at 36.3%, then school/education systems at 33.0% and emergency departments at 30.8%. Comments suggest EDs with navigators do better, which suggests programs like CA Bridge are having an impact. While there is room for improvement (one county reported zero) 30.8 may represent progress. See Table 3.5.

Table 3.5. *Of the individuals in each of the following systems who need treatment, what proportion do you think are referred to SUD treatment? County Administrator Survey.*

Service System	Min (%)	Max (%)	Mean (%)
Emergency Departments	0	100	30.8
Jails	10	80	44.6
Prisons	0	70	36.3
Schools/Education	0	100	33

Impact of AB 2265 on Referrals from MH

On January 1, 2021 AB 2265 went into effect which allows Mental Health Services Act (MHSA) funds to be used for SUD treatment with a co-occurring mental disorder. When asked if referrals from the MH system increased since the passage of AB 2265, only 15.5% of all waivered county administrators (N=37) responded yes.

In their comments, county administrators indicated that they anticipate receiving more referrals via this mechanism as time progresses. One county administrator suggested that additional training on the provisions of AB 2265 would be helpful. Other administrators reported that while AB 2265 allows MHSA funds to be used for SUD, it does not require these funds to be shared. They note that an institutional paradigm shift needs to happen in order to increase referrals to SUD. Specifically, "MHSA funds are not yet being used to help support SUD services because there is no incentive for MH providers to refer out."

Reported Barriers

As part of the County Administrator Survey, administrators were asked why referrals from PH and MH providers were so low. County administrators felt that MH and PH care providers did not want to assess SUD or did not have SUD assessment skills, and they lacked awareness of what SUD services were available. They also reported being inhibited by communication barriers including a lack of a shared EHR. Additionally, COVID-19 protocols caused a reduction in cross-system referrals.

County administrators also felt that patients needed more support with referrals to SUD services to promote treatment engagement. Further, in some counties, patients were referred from PH care to SUD treatment, but were then found to be ineligible for Medi-Cal.

Some county administrators felt that MH providers wanted to keep co-occurring patients within the MH system, and not refer out. County administrators also suspected that patients often stated that they self-referred even if a PH or MH provider had referred them. One county administrator emphasized the need for DHCS to, "expand on the mechanisms to compensate this critical SUD engagement and navigation work" that facilitates PH patients engaging in the SUD care they need.

Finally, stigma is another barrier to cross-system referrals, as explained by one administrator:

> "[SUD diagnoses] can be minimized if the mental health provider isn't sure what to do on how to make the referral, or doesn't think it's an issue big enough risking a disturbance to … rapport. My sense is that SUD stigma is at the heart of it."

Perceived Impact of the DMC ODS Waiver on Integration and Coordination of Services

County Administrator Perceptions

In 2021, when asked if the DMC-ODS waiver positively impacted the integration of SUD and MH services in their county, 66.7% of waivered county administrators (n=30) agreed that the

DMC-ODS waiver improved SUD integration with MH services, reduced from 76% in 2020. PHC counties (n=7) reported a 50% agreement rate.

When asked if the DMC-ODS waiver positively impacted the integration of SUD and PH services in their county, 70.4% of all other waivered county administrators (n=30) reported yes, down from 88% in 2020. PHC counties (n=7) also reported a 50% agreement rate. For the 30 DMC-ODS waiver counties not including PHC, these results are consistent with findings from prior years[34], in that modest ratings seem to reflect a better understanding of challenges they were not aware of before implementing the DMC-ODS waiver.

Facilitators to SUD-MH integration

2021 qualitative comments from county administrators explained that the integration of SUD and MH care was facilitated by the DMC-ODS waiver because it enabled capacity building.

> "[The DMC-ODS waiver] Allowed us to develop our first County-operated outpatient program, which serves beneficiaries with co-occurring SUD/SMI."

> "We have counselors co-located at mental health clinics, have developed procedures for identifying and coordinating care with mental health, created guidelines for sharing information through EHR, trained LPHAs on DMC-ODS, SU and ASAM."

The DMC-ODS waiver also increased staff awareness of co-occurring disease and resources by enabling SUD providers to hire licensed MH professionals. They report that implementing ASAM Criteria-based assessments "has brought more awareness to the need for SUD and MH providers to assess and address the need for specialty care."

Additionally, the DMC-ODS waiver, along with other parallel efforts like Whole Person Care, may be moving counties toward implementation of a more universal EHR in some counties. When asked how the DMC-ODS waiver impacted integration, administrators responded:

> "We have the same electronic health record and are able to speak some of the same language, such as level of care, BAL/Access, Quality Assurance...."

> "Whole Person Care has positive affected integration by creating a Community Health Record in our county. We are gradually adding SUD providers to be able to access the CHR."

It also facilitated more effective policies and procedures for cross-system care; "Without the site-specific restrictions, we are better able to meet clients where they are, including in the MH Access offices."

[34] See p. 68, Urada et al. (2020). Drug Medi-Cal Organized Delivery System 2020 Evaluation Report https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf

Barriers to SUD-MH integration

There is still more work to do. The most common challenges to SUD-MH integration reported include a bifurcated system for SMI and mild/moderate MH services;

> "MH services still are largely provided by the county specialty MHP for SMI...or by our Health Plan for mild to moderate. ... Some of our providers provide both MH ... and SUD services, but generally must then open two charts, two assessments, two treatment plans on different timelines. ... too much complexity and variability is hard for staff and clients alike to navigate."

> "[Specialty Mental Health Services] and DMC-ODS remain two very separate systems.... if we are working with a client who has a mild to moderate MH [diagnosis], we can't refer to [Specialty Mental Health], but we can't treat the [diagnosis] either. There NEEDS to be increased flexibility for DMC-ODS plans to bill for MH counseling . . ."

There were also challenges presented by separate funding streams, and differing policies for MH and SUD services that inhibited integration,

> "Since the rules for DMC-ODS and MH are often different, we had to actually back away from some of the integration efforts we were making prior to joining the DMC-ODS [waiver]"

Communication barriers due to confidentiality requirements also inhibited SUD-MH integration. And county administrators noted that while integration of care is an explicit goal of the DMC-ODS waiver, there is no new resource or funding specifically ear-marked to promote that goal.

Facilitators to SUD-PH integration

County administrators cite the following as successes under the DMC-ODS waiver: it increased funding and added more flexibility with billing, expanded the SBIRT benefit, and increased SUD-PH communication. Specifically, one county administrator noted, "It has helped build some dialogue between the SUD providers and the FQHCs." Additionally, increased oversight from county monitors helped to assure that referrals were being provided and releases of information were being completed. County administrators felt that the DMC-ODS waiver increased awareness of PH needs which caused SUD providers to reach out to hospitals and primary care providers more frequently. One County Administrator commented, "Prior to implementing the ASAM [Criteria], physical health was never addressed."

Barriers to SUD-PH integration

County administrators report that integrating and coordinating PH care with SUD services can be difficult for a variety of reasons. Administrators reported that PH appointments were hard to get, that PH providers were slow to respond, and that even when they did respond there were communication barriers due to privacy rules. "It is still challenging to get clients to access medical care. One of the largest deficiencies in chart reviews remains the physical examination." One administrator noted that they would love to share case management and medication lists but

cannot do so “mostly due to privacy rules,” while another complained that “stigma and 42 CFR Part 2 are constant barriers.”

County administrators also reported that reimbursement concerns, particularly in residential treatment settings, inhibited the integration of PH care with SUD services because, “Providers are concerned about ‘time away’ from treatment and that clients won't get enough (treatment) hours and risk non-payment or disallowance.”

Administrators also stated that in spite of some improvement, there was insufficient SUD staff education on PH needs; “SUD providers could benefit from more education about common physical health issues and risks for health.”

Provider and Patient Perceptions of Care Coordination

Provider Perceptions of Care Coordination

Overall, providers reported that 69.6% agree that their patients receive adequate care coordination (See Figure 3.19). While this is a positive reporting, there is still work to be done to improve experiences of the 30.4% who did not agree, and assure appropriate reimbursement for the coordination services provided.

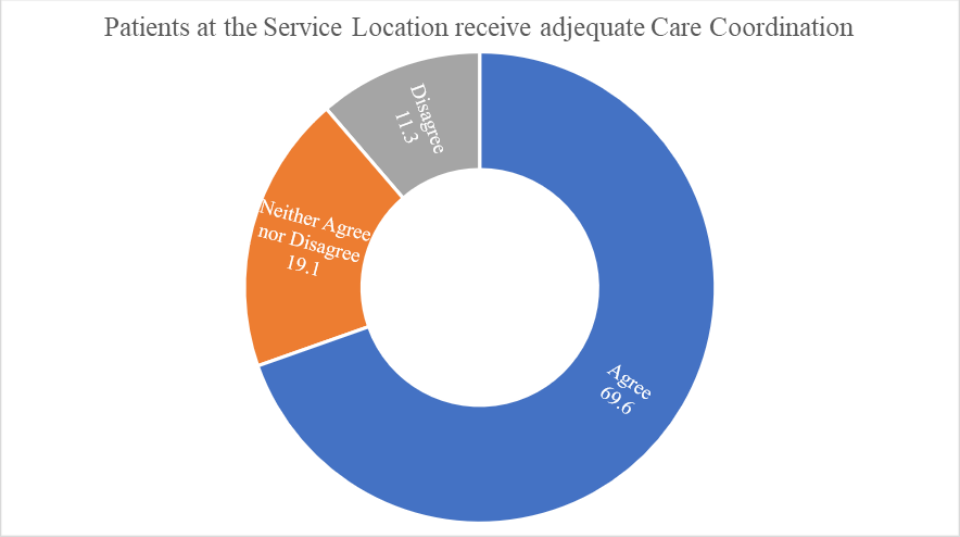

Figure 3.19. *Percent Agreement that Patients at their service location receive adequate care coordination. Provider Survey.*

Patient Perceptions of Care Coordination

Patient perceptions of care coordination was measured as part of the 2020 Treatment Perceptions Survey (TPS). Patients from DMC-ODS waiver counties were asked two items about care coordination/integration. Overall perceptions were favorable (86.0% agreed with the statement “staff here work with my PH care providers to support my wellness” and 85.4% agreed that “staff here work with my MH care providers to support my wellness). These percentages increased slightly from the previous year, however, remain as 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 chapter.

Coordination and Continuity of Care within the SUD System

Transitions of Care

Administrative Data Measures

Improving effective transitions between levels of care is a critical component in developing a SUD treatment system that addresses the chronic nature of SUD. Over the course of the DMC-ODS waiver demonstration project, administrative data measures (CalOMS-Tx and DMC claims data) have not revealed any dramatic changes from 2016 to 2020. Still, a slight increase in the rate of residential transitions to outpatient was found, increasing from 7.1% in 2016 to 9.5% in 2020 among waiver counties, even as rates fell to 2.8% in state plan counties (see Figure 3.20). A modestly lower rate of patients returning to Withdrawal Management (WM) within 14 days of WM discharge was also found (5.1% in 2016 to 4.4% in 2020), and there was a higher transfer rate from WM to Residential when compared to State Plan counties in 2020 (20.2% vs 8.0% respectively), as shown in Figure 3.21. These data include counties (n= 30) that were implementing services under the DMC-ODS waiver for the full calendar year and thus do not include PHC counties. Reduction in the rate of return to WM services may be closely tied to the improvement in transitions from WM to residential treatment, since providing patients with treatment is more likely to be effective than WM alone.

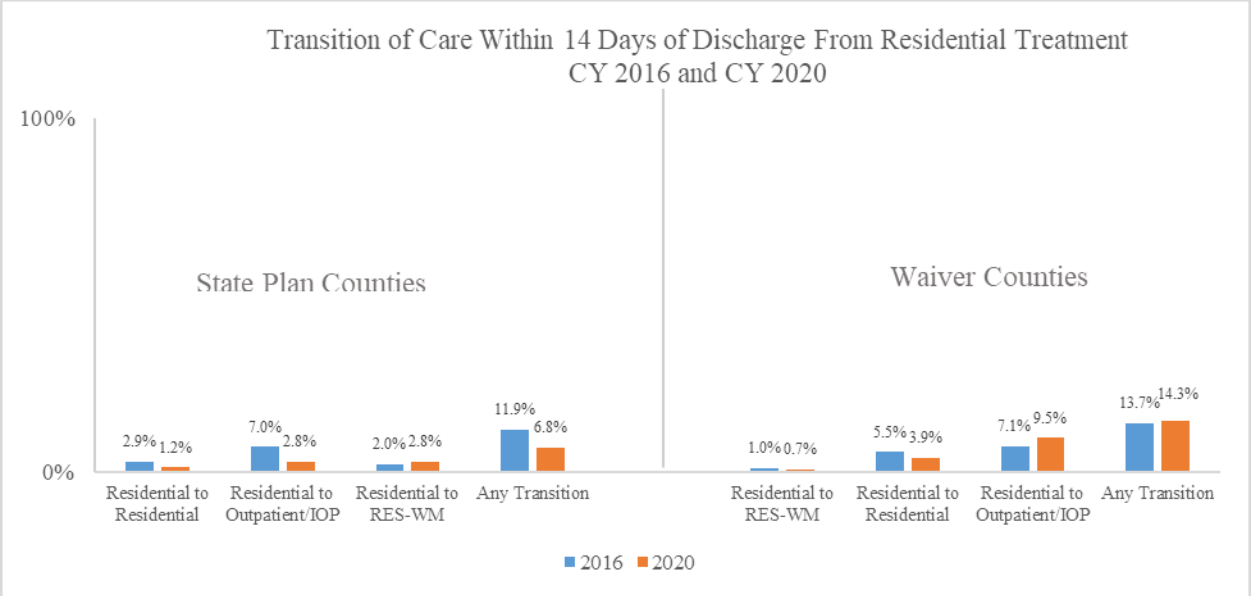

Figure 3.20. *Transition of care within 14 days of discharge from residential treatment. CalOMS-Tx (CY 2016 and CY 2020).*

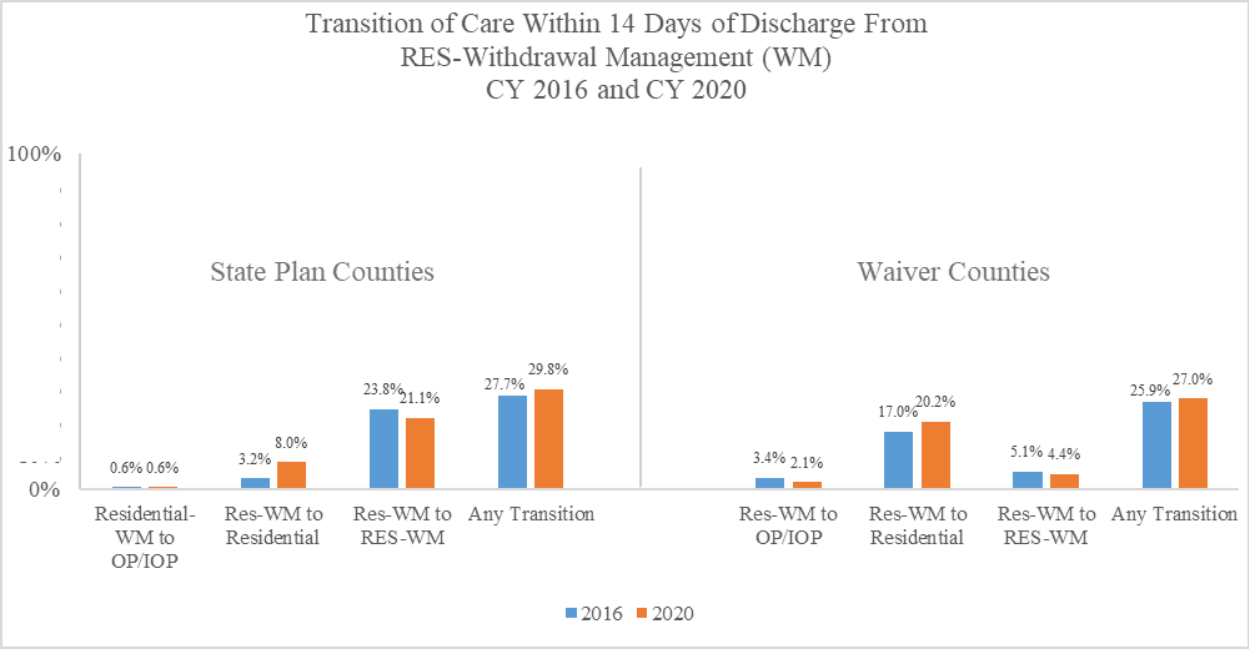

Figure 3.21. *Transition of care within 14 days of discharge from withdrawal management (WM). CalOMS-Tx (CY 2016 and CY 2020).*

County, Provider, and Patient Perceptions

While there are limitations to tracking patient transitions through administrative data, it appears the needle has not moved much in this area of the SUD treatment system. Further exploration was conducted at the county level to understand tracking challenges and why patients do not transition more between levels of care.

DMC-ODS waiver county administrators (N=37) were asked to rate how well their county tracks referrals and patient movement within the SUD system. 2021 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 = 3.3), similar to last year.

County administrator commented that siloed EHRs limited the ability to track transitions; and that there is lack of real-time data on transitions,

> "We are able to measure whether clients were connected to their next level of care, but that is not in real time, and it makes it challenging to intervene before the client disappears."

Additionally, county administrators felt that tracking is "very difficult and time consuming."

Reported in the 2020 Report[35], 83.0% of providers reported having formal protocols to facilitate a successful transfer, but on average they reported obtaining confirmation of a successful transfer only "sometimes." Variation across modalities was small.

To explore patients' perspectives on transitions in care, a case study was conducted with patients in three residential programs in Riverside County (also reported in full detail in the 2020 Report[36]). Patients preparing to transition from residential to another level of care volunteered to be interviewed for their opinions on the barriers and facilitators to continuing recommended treatment after discharge, and to their opinions on how to improve successful transitions across the SUD service continuum.

Patients identified the following as barriers to continuing treatment beyond their residential stay:

- Some had expectations to be "done" with treatment in 30 days and weren't prepared to engage in further treatment;
- Some felt that their judgement about whether and how to extend treatment was clouded by ongoing domestic violence at home, they reported that they needed more support to make better decisions about transitions in care;
- Some believed they needed a different recovery environment than the LOC and services they were expected to transition to (i.e.: they preferred to have a recovery residence that was close to the OP program or their family);
- Some felt that in order to engage in outpatient care, they needed more help to build a stable life outside of the program (i.e.: maintaining sober friendships, accessing reliable transportation, going to school, finding childcare)
- Patients worried that committing to more treatment would interfere with their ability to support themselves and their families. They reported that vocational assistance before and after discharge would support engagement in ongoing treatment.
- Some didn't want to leave their counselors and peers who knew them so well. Getting to know a new counselor at a different LOC seemed like a waste of time or duplicative experience which may not have the same bond.

These interviews suggested that services including case management, peer support services, recovery support services, and recovery residences can support successful transitions in care.

Recommendations to Improve Transitions of Care

DMC-ODS waiver county administrators reported various strategies used to facilitate or monitor transitions to another level of care. These included case management to provide a warm handoff where SUD staff actively coordinate transition of care.

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[35] See p. 75-76, Urada et al. (2020). Drug Medi-Cal Organized Delivery System 2020 Evaluation Report https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf

[36] See p. 79-83, Urada et al. (2020). Drug Medi-Cal Organized Delivery System 2020 Evaluation Report https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf

> "We provide an ASAM [Criteria-based] assessment and case management to help the client get to the correct facility. We then work with that facility during discharge to help the client come back into outpatient services or to the new level of care needed."

One county administrator commented that a dedicated tracking staff successfully monitored their transitions in care;

> "[We have] a staff member assigned at Research and Evaluation who is tasked to compile all data received on levels of care, transitions, admissions, and other services related data to continuously improve program design...."

Provider survey respondents reported that the most important factors for the success of patient transitions included:

- Collaboration/discussion
  - Communication and successful transfer of relevant information and treatment history between providers.
  - "Warm handoff" and clinician-to-clinician discussion
- Starting early
  - Setting expectations at beginning on treatment about the continuum of care and the need for ongoing treatment including step-downs;
  - Eliminating the concept of "graduation"
- Case management
  - Counselors/case managers reaching out; making calls and following up
  - Case management on both the referring and receiving sides
- Availability of services (beds) with minimal wait times
- Formalizing relationship between providers
- Patient buy-in
- Dedicated and motivated staff 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

Strategies to Improve Integration/Coordination

Case Management Benefit: DMC Claims Data

Statewide Use of the Benefit

Case management services are commonly used to coordinate care within and across systems, and these services are a new benefit under the DMC-ODS waiver. The rollout of this benefit has built over time, and counties have reported challenges related to implementation and billing. Still,

according to the DMC claims data among 30 DMC-ODS waiver counties that implemented services under the DMC-ODS waiver for the full 2020 calendar year, 46.4% of patients had case management services billed in CY 2020, an increase from last year, CY 2019 (38.4%).[37]

To gain insights into how counties progressed over time, further exploration was conducted to assess average percent of patients with case management claims as counties went live under the DMC-ODS waiver. Previous reports refer to these groupings as waves 1 (n=7 counties), 2 (n=14 counties), 3 (n=11), and 4 (PHC counties). Table 3.6 shows this grouped data by wave comparing percent of patients receiving case management each year following a full year of implementing the benefit under the DMC-ODS waiver. There was a steady increase of case management services claimed from year to year, particularly after three years of implementation (see the blue highlighted boxes in waves 1 and 2 of the table). These trends suggest that utilization rates among counties in waves 3 and 4 will likely increase in coming years similar to waves 1 and 2.

Table 3.6. *Percent of patients who received case management, by wave, over time (since going live). DMC claims.*

	2017	2018	2019	2020
Wave 1 (n=7)	26.3% (year 1)	44.7%	47.9%	50.7%
Wave 2 (n=14)		16.5% (year 1)	36.6%	49%
Wave 3 (n=11)			24.5% (year 1)	35.7%
Wave 4 PHP (n=7)				15.4% (year 1)

Case Management services by Modality

From CY 2020, Figure 3.22 shows that over half of the patients receiving outpatient treatment, residential treatment, and withdrawal management are receiving case management services under the waiver (OP 65.9% and IOP 63.8%, Res 57.6%, WM 52.9%), while those in NTP/OTPs had much lower utilization of the benefit. UCLA reached out to an NTP/OTP provider who explained the pattern this way:

> "Because the case management funding is cost reimbursement and requires cost reporting applied to all DMC services, most NTPs are unwilling to do it. We would love to have

[37] These numbers are higher than reported in previous reports due to a correction in calculation methods.

access to all the new ODS services (recovery support, peer, contingency management, etc.) but because of the antiquated reimbursement structure and onerous reporting requirements, we don't do it. (We) would love to see payment reform fix this so NTPs and our patients could benefit from these new services."

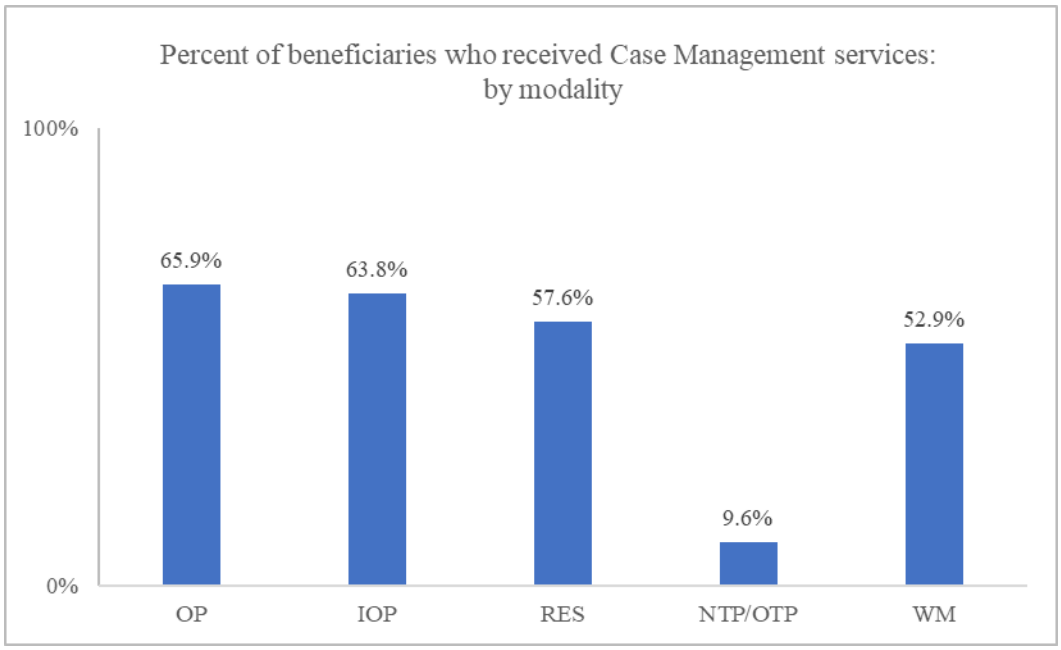


Figure 3.22. *Percent of patients that received case management services within each modality. DMC claims (CY 2020).*

Demographics of Patients receiving Case Management Services

Table 3.7 shows the characteristics of the patients in CY 2020 utilizing case management services. The benefit is being utilized equally among males and females. Well over half of youth and young adult patients receive case management services, with utilization of the benefit decreasing steadily as patient age increases. A similar pattern was found in treatment engagement (see Quality of Care section). Older adults are more likely to stop treatment early, which may explain why they are less likely to receive case management. Alternatively, a lack of case management could contribute to lower engagement rates, or a third variable could explain both patterns. Additional research is needed to clarify the nature of this association. Black/African American patients were the most likely to receive case management (50.7%), while American Indian/Alaska Native patients, along with those in the "other" group, were the least likely (41.6%). Further research is needed to understand the reasons for this pattern.

Table 3.7. *Patients who received and billed for case management within each category. DMC claims (CY 2020).*

Characteristic	Percent
Gender	
Female	46.6%
Male	46.4%
Age Group	
Less than 18	66.9%
18-25	58.3%
26-35	50.3%
36-45	48.5%
46-55	42.7%
56-65	28.0%
66 +	14.5%
Race/Ethnicity	
(Multiple Responses Allowed)	
American Indian/Alaska Native	41.6%
Asian/Pacific Islander	49.8%
Black/African American	50.7%
Latinx	45.3%
White	43.1%
Other	41.6%

Case Management Services by County

Further analysis was conducted to identify if there were any differences in utilization of the benefit by county characteristics. Table 3.8 shows the percent of case management services billed in the CY 2020 DMC claims data by county size (small, medium, large). Small counties are utilizing the benefit for their patients at the highest proportion (57.6%), compared to medium (52.3) and large counties (36.2%). The reasons for this pattern are unclear and require further exploration. The largest counties by population (Los Angeles, San Diego, Orange) all have above average case management rates, but the other large counties have below-average rates, so absolute size alone does not explain the pattern.

Table 3.8. *Average percent of unique patients receiving case management services, by county. DMC claims (CY 2020).*

County	Total Unique Clients	Case Management Clients	Case Management Percent
Small Counties (avg: 57.6%)			
San Benito	244	188	77.0
Nevada	696	429	61.6
Napa	436	256	58.7
El Dorado	427	227	53.2
Imperial	935	348	37.2
Medium Counties (avg: 52.3%)			
Monterey	1,396	1,077	77.1
San Luis Obispo	1,650	1,128	68.4
Santa Cruz	1,265	823	65.1
Marin	717	393	54.8
Merced	963	496	51.5
Santa Barbara	2,317	1,079	46.6
Placer	1,018	471	46.3
Tulare	1,905	864	45.3
Stanislaus	2,918	1,313	44.0
Yolo	666	154	23.1
Large Counties (avg: 36.2%)			
San Diego	11,615	8,111	69.8
Los Angeles	23,366	14,099	60.3
Orange	5,782	3,390	58.6
Riverside	7,465	3,386	45.4
San Mateo	1,040	442	42.5
Santa Clara	3,168	1,345	42.5
Ventura	3,053	1,273	41.7
Contra Costa	2,416	899	37.2
Fresno	4,332	1,454	33.6
Alameda	4,250	1,080	25.4
Kern	3,726	892	23.9
Sacramento	5,675	1,220	21.5
San Francisco	3,822	693	18.1
San Bernardino	4,367	511	11.7
San Joaquin	2,965	322	10.9

Case Management: County Administrator Perceptions of the Benefit

Delivery of Case Management Services

Previously, county administrators overwhelmingly reported that the DMC-ODS waiver positively impacted the delivery of case management services in their counties (88.0% in 2020). As a new benefit for providers to bill, this is not surprising. In 2021, county administrators among the 30-waiver county group estimated that about 62.8% of patients in OP/IOP receive case management services, 60.4% of patients receiving residential treatment, and 36.2% of NTP/OTP patients, regardless of whether the service was billed for reimbursement.

Barriers to Bill for Delivered Case Management Services

While county administrator estimates were similar to the level of case management billing in CY 2020 DMC claims data (aside from NTP/OTP) county administrators also reported that generally 50% of the case management services delivered were not submitted as a DMC claim. Taken together, these results suggest county administrators may be underestimating the degree to which delivered case management services were billed. Still, the challenges experienced by providers are still informative, even if they were overcome.

When asked the primary reasons for not billing, the top endorsed responses among county administrators included:

- Excessive burden of documentation (55.6%)
- Lack of clarity regarding allowable activities (40.7%)
- Concern that billing will be disallowed (37.0%)
- Lack of clarity regarding required documentation (25.9%)
- Other (18.5%)
- Case management services are covered by another funding source (14.8%)

The reasons listed as "Other" included:

- Service provided outside of a treatment episode (not attached to a LOC)
- Mistakes such as an incorrect service code or LOC associated with the progress note.

Barriers to the Delivery of Case Management Services to Patients

When asked what the primary reason was for patients NOT receiving case management services, the top endorsed responses included the reasons shown in Figure 3.23.

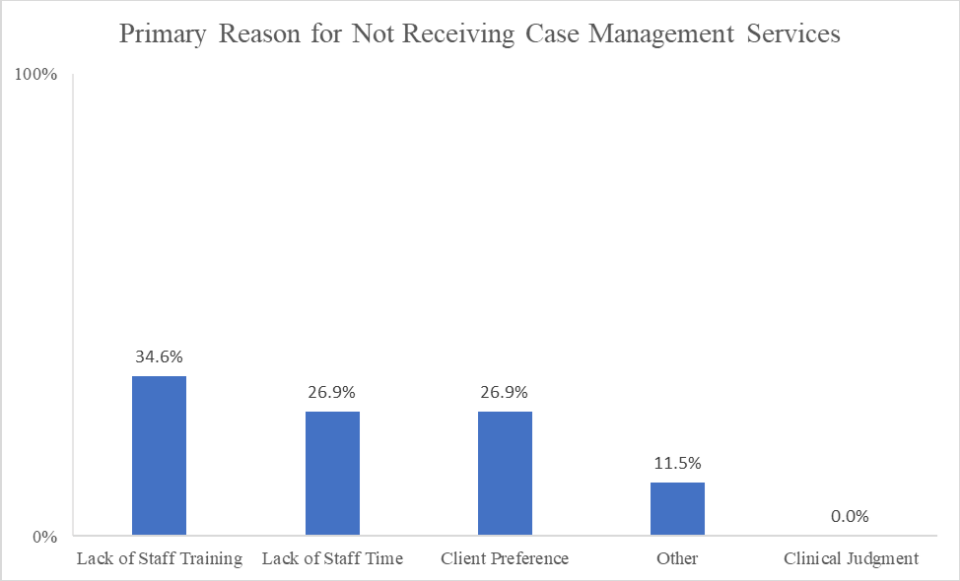


Figure 3.23. *For those who don't receive case management services, please indicate the primary or most common reason. County Administrator Survey.*

"Other" responses included both staff time and staff training. "Many providers offer but don't document based on some confusion and the time it takes."

When asked generally about the implementation of case management under the waiver, county administrators responded that they needed more training or a learning collaborative covering best case management practices, ongoing support and a deeper understanding of barriers for SUD providers:

- "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….".
- "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."
- "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."

Summary: Integration/Coordination

Over the course of the DMC-ODS waiver demonstration project, progress has been made on the integration of services and care coordination, but this shift will take more time and more policy reform to actualize across the service systems. Referrals from MH and PH to SUD services remain low overall, yet county administrators report that referrals from emergency departments with Care Navigators are rising. The passage of AB 2265, which allows MHSA dollars to be used for SUD treatment, has had a minimal impact in raising MH to SUD referral rates so far,

but county administrators anticipate this will increase with time and education. County administrators report that the overall service capacity in SUD, PH and MH services is still inadequate to provide fully integrated and coordinated care. On top of this, SUD stigma, workforce shortages and lack of clarity about the best practices to employ peer support specialists and case managers all hinder cross-system integration and coordination. Additionally, SUD, PH and MH systems (as well as the bifurcated SMI/moderate-mild MH system) remain siloed due to funding sources, billing and documentation requirements, and privacy rules, which continue to challenge care coordination and integration.

In spite of these challenges, county administrators credit the waiver with creating more flexibility and resources to expand capacity and address the challenges. In response to the DMC-ODS waiver, one county created a new countywide electronic health system, another created a new co-located co-occurring disorder program, and other counties report much greater cross-system awareness and communication among stakeholders, in part due to the adoption of the ASAM Criteria. Case management was one tool that facilitated integration and coordination across systems and within the SUD system but was used unevenly in counties under the waiver largely due to lack of staff time and training and by patient preference to opt out of case management. Another barrier to case management was caused by the billing rule that case management must be attached to a LOC in order to be reimbursed.

While foundational shifts in the delivery of treatment services take time, progress is expected to continue under California Advancing and Innovating Medi-Cal (CalAIM). Lessons learned from the experiences under the DMC-ODS waiver demonstration project have led to the following recommendations for DHCS consideration:

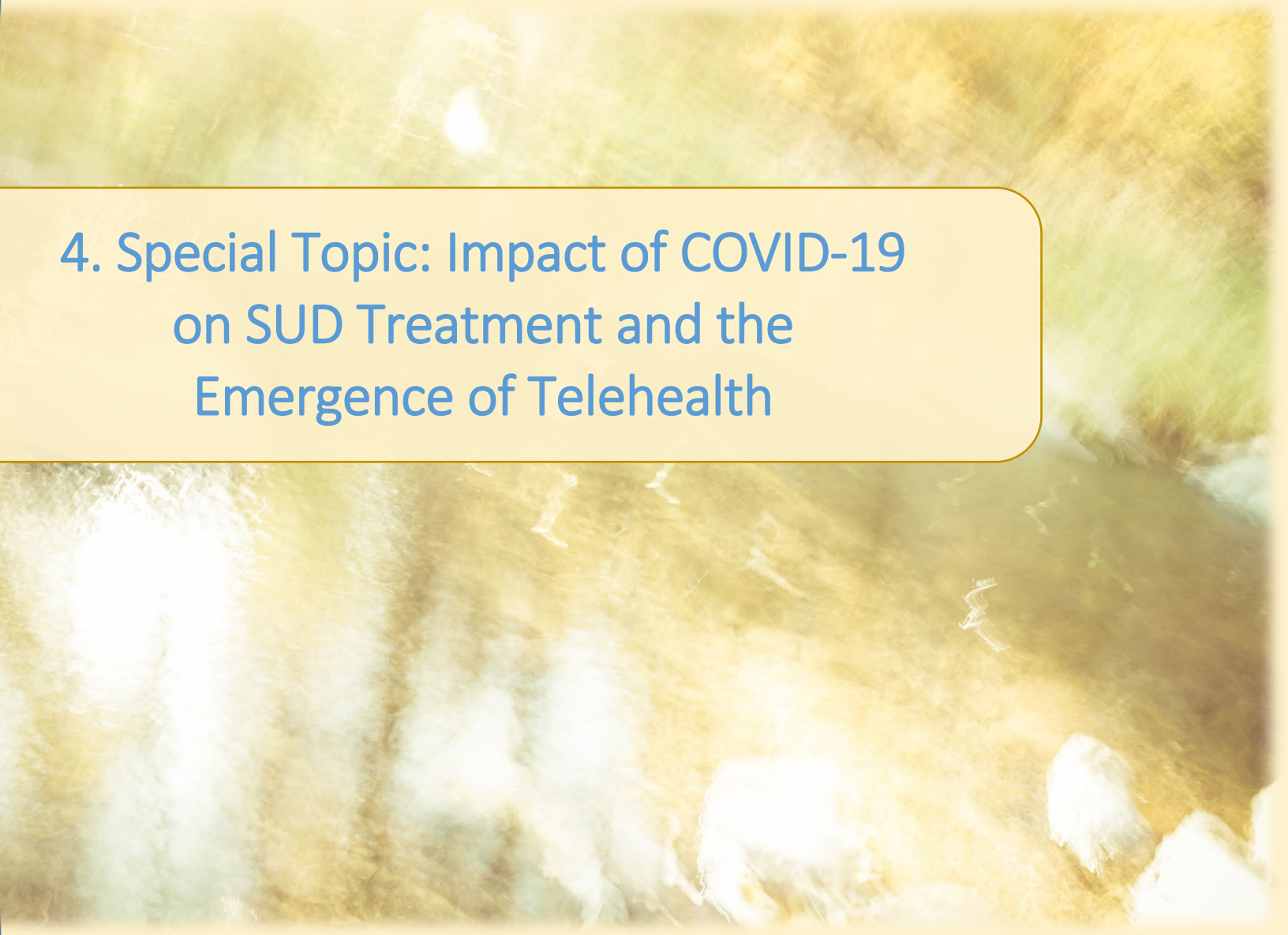
Recommendations to facilitate integration and coordination of cross-system care

- Eliminate systemic silos and increase cross-system parity (including the SMI service system) for the following;
    - Screening policies and procedures; promote use of a Universal Behavioral Health Screening tool
    - Assessment
    - Billing codes
    - Funding
    - Communication; support universal EHR and consent forms
    - Provider licensure/certification
    - Administrative documentation, auditing, and monitoring requirements
- Continue ASAM Criteria training; emphasize training and TA specific to the ASAM Criteria and cross-system issues (e.g., provide more in-depth MH/PH ASAM Criteria assessment training to SUD providers).
- Address staffing shortages.
- "Put more teeth" in the PH to SUD referral requirements;
    - Require tracking data regarding health outcomes impacted by SUDs to show the PH cost of untreated SUDs.

    - Establish formal MOUs between PH and SUD service providers with specific requirements and procedures for bi-directional referrals. One county administrator commented, “Lots of medical providers still don’t know how to refer, or aren't able/willing to do the work....”
- Initiate Performance Incentives for providers; one county administrator suggested a multi-system contingency management with incentives to better manage patients in OP settings.
- Provide stigma reduction training for non-SUD providers and administrators who are uneasy with addressing SUD patients and services.
- Provide a best practice model and curriculum that integrates PH/MH/SUD including technical assistance such as webinars, trainings, and templates for standard operating procedures; support learning collaboratives to test out models and share lessons learned.
- Increase service capacity for both SUD and PH. For example, increase outreach efforts like SUD co-location in primary care and the ED and add mobile PH clinics for visiting SUD providers.

Recommendations to facilitate care coordination

- Provide clearer case management guidelines around billing and best practices
- Provide specific training on DMC documentation for case managers
- Allow Peer Support Staff to bill for case management.
- Allow case management to be utilized as part of pre-diagnosis and post-treatment billing
- Remove the requirement of a claim code for case management to have a LOC modifier to enable case management between levels of care.
- Provide best practices training on tracking and supporting transitions of care



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, Howard Padwa, Ph.D., Elise Tran, B.A.

Introduction

The COVID-19 pandemic created unprecedented challenges for California's SUD treatment system in 2020. Substance use has been a common method for coping with COVID-19-related stress[38], and research has demonstrated that SUD programs experienced dramatic fluctuations in patient flow, staffing shortages, and challenges adapting to telehealth over the course of the pandemic[39]. This chapter describes the impact of COVID-19 on the SUD treatment landscape in California in 2020, and adaptations that have emerged across the state as providers and patients have adjusted to the stresses and constraints brought on by the pandemic.

Methods

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

To supplement the county-reported survey data, we augmented our analysis of the impact of COVID-19 with data on patient admissions from CalOMS-Tx and service utilization from DMC claims. Specifically, using CalOMS-Tx data from CY2019-Q12021 and a difference-in-difference design as described in the Methodology section, we determined the impact of the March 4, 2020 state of emergency declaration, which is used as a proxy for the beginning of the COVID-19 pandemic, on admissions to SUD treatment.[40] Using DMC claims data from CY2019-Q12021, we descriptively explored the association between the March 19, 2020 updated narcotic treatment program guidance, that allowed states to request blanket exceptions for all stable patients in an NTP to receive 28 days of take-home doses of the patient's

[38] Czeisler, M. É., Lane, R. I., Wiley, J. F., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M. (2021). Follow-up survey of US adult reports of mental health, substance use, and suicidal ideation during the COVID-19 pandemic, September 2020. *JAMA network open*, *4*(2), e2037665-e2037665.

[39] Pagano, A., Hosakote, S., Kapiteni, K., Straus, E. R., Wong, J., & Guydish, J. R. (2021). Impacts of COVID-19 on residential treatment programs for substance use disorder. *Journal of Substance Abuse Treatment*, *123*, 108255.

Lin, C., Clingan, S. E., Cousins, S. J., Valdez, J., Mooney, L. J., & Hser, Y. I. (2022). The impact of COVID-19 on substance use disorder treatment in California: Service providers' perspectives. *Journal of Substance Abuse Treatment*, *133*, 108544.

Mark, T. L., Gibbons, B., Barnosky, A., Padwa, H., & Joshi, V. (2021). Changes in Admissions to Specialty Addiction Treatment Facilities in California During the COVID-19 Pandemic. *JAMA Network Open*, *4*(7), e2117029-e2117029.

Henretty, K., Padwa, H., Treiman, K., Gilbert, M., & Mark, T. L. (2021). Impact of the Coronavirus Pandemic on Substance Use Disorder Treatment: Findings from a Survey of Specialty Providers in California. *Substance abuse: research and treatment*, *15*, 11782218211028655.

[40] We begin the analysis on March 4, the first day of the state of emergency declaration issued by Governor Newsom. https://www.gov.ca.gov/wp-content/uploads/2020/03/3.4.20-Coronavirus-SOE-Proclamation.pdf

medication for opioid use disorder, and the number of methadone patients receiving 28 or more days of take-home doses.

We focused 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

On the County Administrator survey, DMC-ODS waiver counties indicated that access to and demand for SUD services had primarily decreased as a result of COVID-19 from July 2020 until summer 2021 (see Figure 4.1). Counties indicated that, due to physical distancing requirements, access to residential treatment substantially decreased. However, some counties reported that service utilization increased due to the implementation of telehealth services.

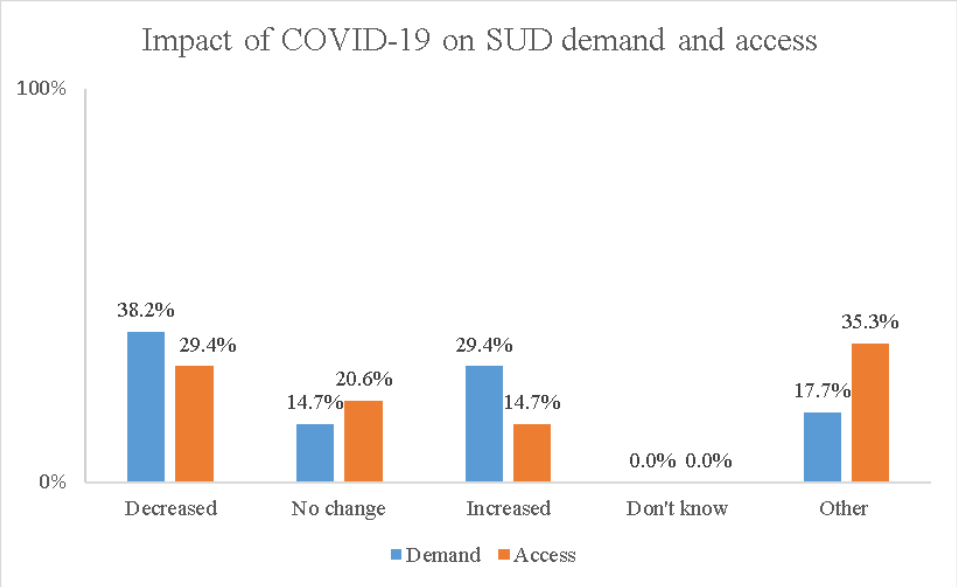


Figure 4.1. *Impact of COVID-19 on SUD demand and access. County Administrator Survey.*

In their comments, county administrators responded that the impact of COVID-19 on demand for care varied by provider, LOC, and patient population. Initially, county administrators reported that access to all levels of care were limited due to social distancing requirements that required decreased group sizes and reduced bed capacity in residential settings. In some counties, these challenges were exacerbated by COVID-testing requirements (when tests were difficult to find), and by the implementation of isolation/quarantine measures when patients or staff became infected.

For individuals who have historically been linked to services through referrals from other service systems (e.g., schools, criminal justice), treatment access has continued to be limited. In part this is because some of these settings (schools) experienced closures that limited their ability to

interact with youth, detect their substance use, and link them to services. In criminal justice programs and courts, agency closures, limited staffing, programming changes (e.g., temporary suspension of drug testing in some counties), and inability to visit correctional facilities because of tightened restrictions on outside visitors limited SUD providers' ability to identify and engage prospective patients and generate referrals.

Over time, counties reported that innovations and policy changes helped increase access and utilization for some levels of care. For example, the development and widespread implementation of telehealth helped increase utilization of outpatient services, while expanded take-home methadone doses and telephone intakes for buprenorphine helped make NTP and other MAT services more accessible.

County Administrators reported that these flexibilities have been highly beneficial, and many wrote that they would like to see them extended beyond the public health emergency and incorporated into regular practice. Regarding telehealth, as one County Administrator wrote, "clients like the safety, convenience, and flexibility of doing an intake, counseling, and treatment virtually." while another noted how "telephone-based counseling has greatly increased access" to care. Similarly, County Administrators praised the benefits of increased flexibility around MAT. "These flexibilities have been tremendous in ensuring access to critical services" wrote one County Administrator, while another elaborated that increased methadone take-homes have been "a welcome change...that has been beneficial to client progress with very few negative outcomes."

Impact of COVID-19 vaccines on demand and access to SUD services

Since December 2020, COVID-19 vaccines have been available under emergency use authorization for individuals 16 years and older (FDA, 2021)[41]. County administrators reported that the availability of the vaccine did not substantially affect demand or access to outpatient or residential treatment services (see Figures 4.2 and 4.3). However, some counties indicated that the vaccine produced an increased desire for in-person services, as people are" less scared" to receive in-person services.

[41] Food and Drug Administration. "FDA approves first COVID-19 vaccine: Approval signifies key achievement for public health." (2021).

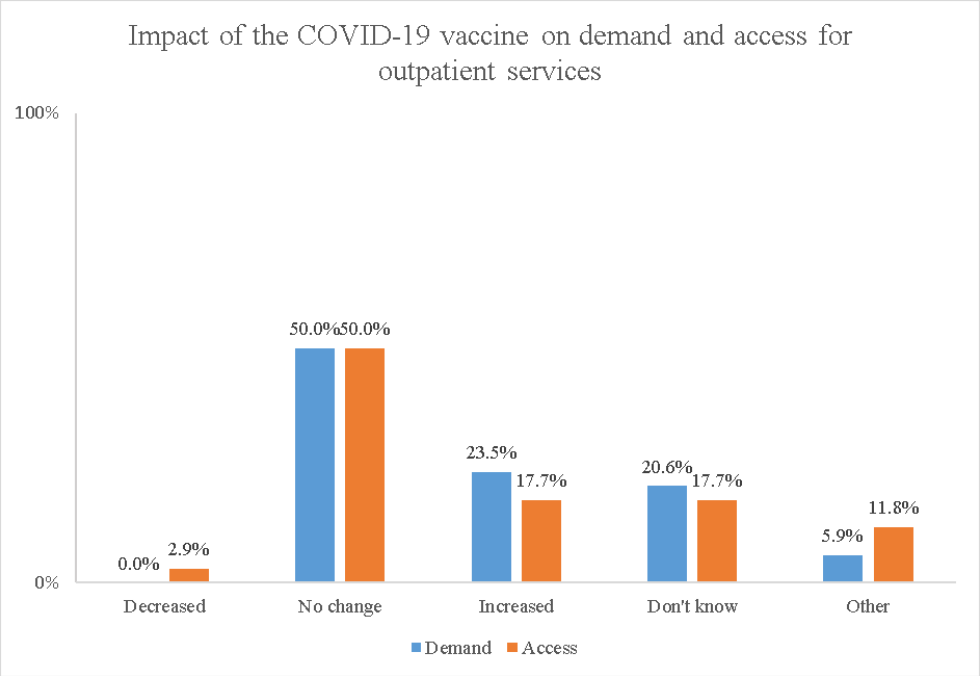


Figure 4.2. *Impact of the COVID-19 vaccine on demand and access for outpatient services. County Administrator Survey.*

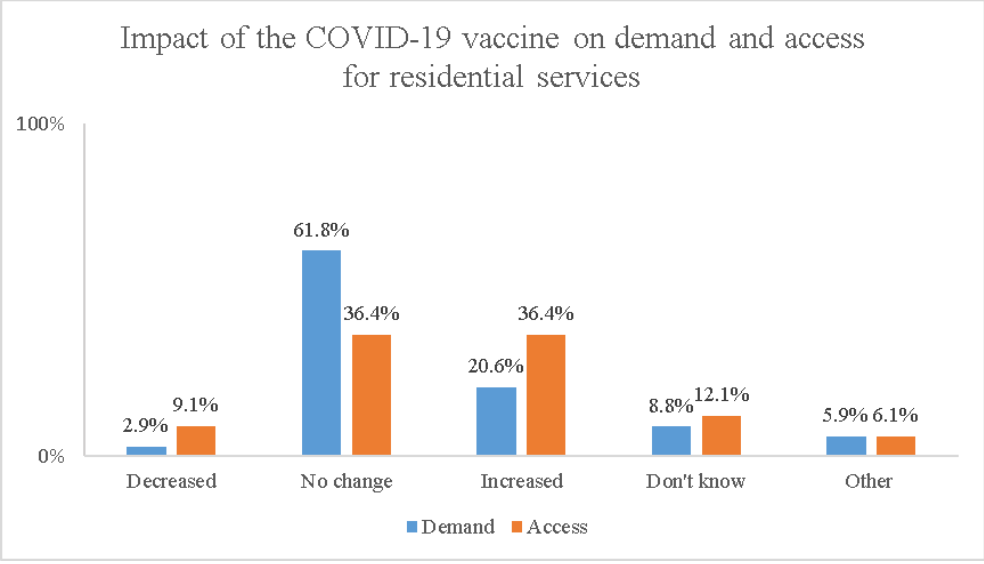


Figure 4.3. *Impact of the COVID-19 vaccine on demand and access for residential services. County Administrator Survey.*

Impact of the COVID-19 state of emergency declaration on admissions

Analysis of admissions records from CalOMS-Tx for CY2019-Q12021 support the survey feedback. Figure 4.4 plots the unique number of admissions for all service modalities by week for 2019, 2020, and Q1 of 2021. The red vertical line marks the state of emergency (SOE) declaration in CA effective March 4, 2020 (week 10). According to Figure 4.4, there was a sizable reduction in admissions at the start of COVID-19 compared to the same time period in 2019. In subsequent weeks in 2020, admissions appear to increase slightly, but do not return to pre-pandemic levels.

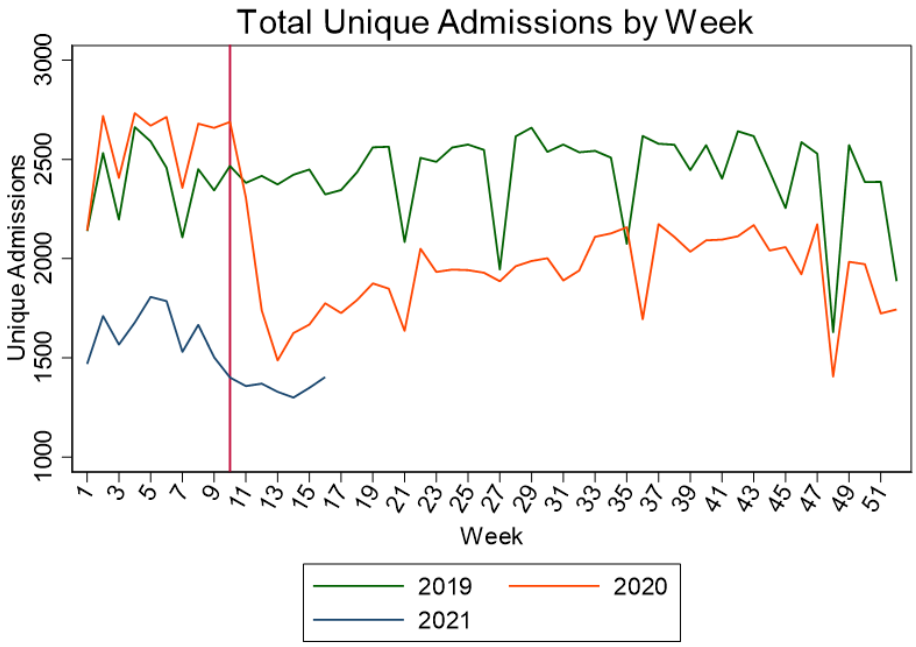


Figure 4.4. *Unique patient admissions by week and year. CalOMS-Tx.*

Next, we use a more rigorous approach to determine the degree to which the state of emergency declaration affected SUD treatment admissions overall, and by modality. We use a difference-in-difference design as described in the Methodology section, and compare county-level SUD treatment admissions in 2019 to weekly county-level SUD treatment admissions in 2020 and 2021 both before and after California's SOE declaration went into effect. We also control for the impact of the DMC-ODS waiver and the severity of the pandemic, proxied by the county-level week-year COVID-19 case and death rate per 100,000. Table 4.1 presents the difference-in-difference results.

Table 4.1. *Impact of the March 4, 2020 state of emergency declaration on SUD treatment admissions.*

	All	Residential	Outpatient	Intensive Outpatient	NTP/OTP
SAH	-0.2325***	-0.1337**	-0.2731***	-0.1076**	-0.1011**
	(0.0451)	(0.540)	(0.0509)	(0.0482)	(0.0458)
N	6552	6552	6552	6552	6552

*Notes: OLS estimates from a log-linear difference-in-difference model are presented. Data on admissions come from CalOMS-Tx for the years 2016-Q12021. Observations are at the county-week-year level. Each column is a separate regression, and the natural log of each outcome is taken. Regressions include controls for DMC-ODS waiver status, COVID-19 case and death rate, and week, year, and county fixed effects. Standard errors clustered at the county level are reported in parentheses. *** p<0.01, ** p<0.05.*

According to Table 4.1, SUD treatment admissions were negatively affected by the SOE declaration. Overall SUD treatment admissions decreased by 23.3% after the SOE declaration went into effect. Analyzing the effect of the SOE declaration by service modality, we find that outpatient treatment services were most impacted by the SOE declaration, with admissions decreasing by 27.3%, Residential services were also significantly impacted, with admissions decreasing by 13.4%. The SOE declaration also affected intensive outpatient and NTP/OTP admissions to a lesser degree, with admissions decreasing by 10.8% and 10.1%, respectively.

It is surprising that the SOE declaration's greatest impact was on outpatient service utilization since outpatient programs were able to adapt to the pandemic by shifting from in-person to telehealth service delivery. Many new flexibilities, including HIPAA-compliant applications to provide telehealth, were made available to treatment providers by the associated federal declaration of a Public Health Emergency. According to results from the County Administrator Survey, a rapid shift in the delivery of treatment services from in-person to telehealth occurred among all counties in our sample, primarily for the delivery of outpatient individual and group counseling services. Yet in spite of these developments, outpatient services still experienced the largest decline following the SOE declaration. This could be because of significant challenges that patients and providers faced shifting from in-person to telehealth services (described below). These decreases also speak to the possibility that access to outpatient services was not a consequence of reduced availability of SUD services, but rather reluctance among patients to access treatment during the pandemic, due to fear of contracting COVID-19 or because some of the usual barriers to treatment (e.g., transportation, caregiving responsibilities) were exacerbated by the pandemic. Further research is needed to better understand the reasons outpatient utilization in particular declined so dramatically following the SOE declaration order.

Regarding residential treatment, it is difficult to disentangle the driving force behind the decline in admissions seen in Table 4.1. County administrators report that the decline in admissions is, at least in part, due to physical distancing, quarantining, and testing requirements which limited the supply of and access to residential treatment beds. However, patients' reluctance to enter into

residential services cannot be discounted. Additionally, responses from the County Administrator Survey are mixed regarding the demand for SUD treatment as a result of COVID-19, with some counties indicating an increase in demand for residential care, while others reported a decrease. Unfortunately, we are unable to directly measure treatment service demand with the CalOMS-Tx administrative data to empirically dissect this result further.

Impact of COVID-19 on Service Delivery

In response to COVID-19, providers in DMC-ODS waiver counties made a number of changes to their services provided. According to the 2020 County Administrator Survey, 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.

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 methadone services for NTP/OTP patients (Urada et. al., 2021). As they implemented these changes, counties also experienced significant workforce shortages and challenges collaborating with other counties, which also impacted the delivery of services during the pandemic.

Telehealth

Among the services provided by DMC-ODS waiver counties, on average, over half of OP/IOP/NTP groups, OP/IOP/NTP individual counseling, and medication management visits with prescribers were provided by telehealth (see Figure 4.5). Nearly half of case management services were provided by telehealth, and 38 percent of peer support services were provided by telehealth. A much smaller percentage of residential groups and residential individual counseling was provided by telehealth compared to other non-residential services.

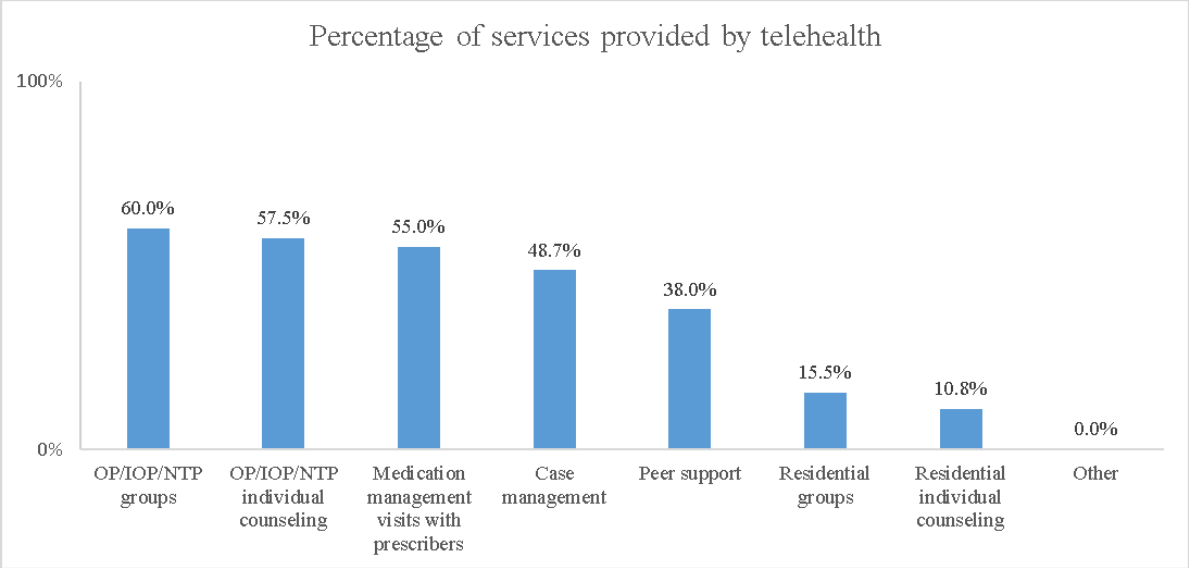


Figure 4.5. *Percentage of services provided by telehealth. County Administrator Survey.*

Counties experienced significant barriers towards telehealth when delivering SUD services (see Figure 4.6). When asked to rate how challenging barriers were to the delivery of telehealth, counties rated lack of patient access to telehealth technology the highest. Other challenging obstacles were reliable internet access, lack of IT staff, cost of equipment, and concern about the effectiveness of telehealth compared to in-person treatment. Additionally, counties overwhelmingly stated that additional funding assistance from DHCS would help with their use of telehealth, particularly for telehealth equipment that can be used for patients.

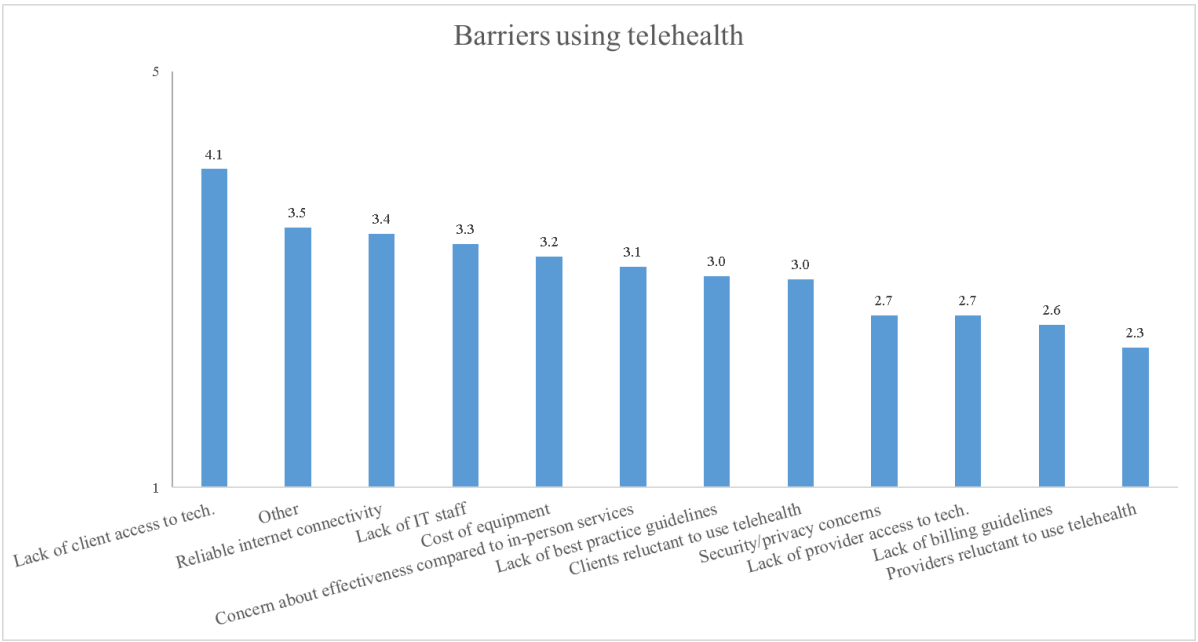


Figure 4.6. *Barriers using telehealth. County Administrator Survey.*

County administrators overwhelmingly indicated in-person settings were preferred for all services (Figure 4.7). For all services, video conferencing was the next most preferred type of delivery. 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, internet and/or phone access, and transportation).

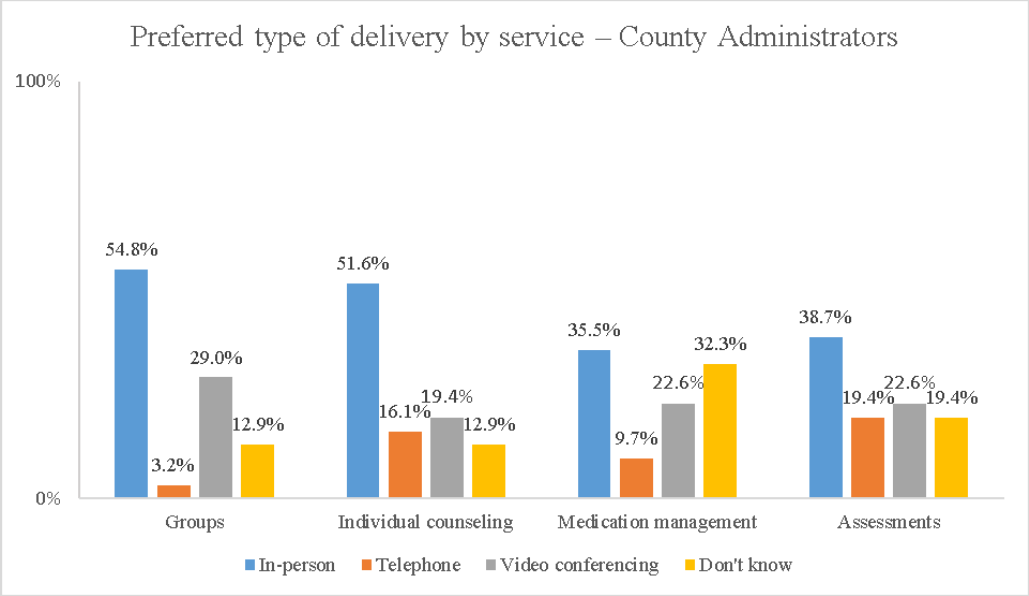


Figure 4.7. *Preferred type of delivery by service by County Administrators. County Administrator Survey.*

Figures 4.7 and 4.8 show data from the Treatment Perceptions Survey (described in Chapter X above) regarding telehealth services. In all domains (access, quality, care coordination, outcomes, general satisfaction), adults' satisfaction scores were slightly higher when all services were delivered via telehealth. For youth, average scores among all domains were also highest when services were exclusively performed by telehealth (see Figure 4.8). These results suggest that the transition of services to telehealth due to COVID-19 did not have a negative effect on patients' treatment satisfaction.

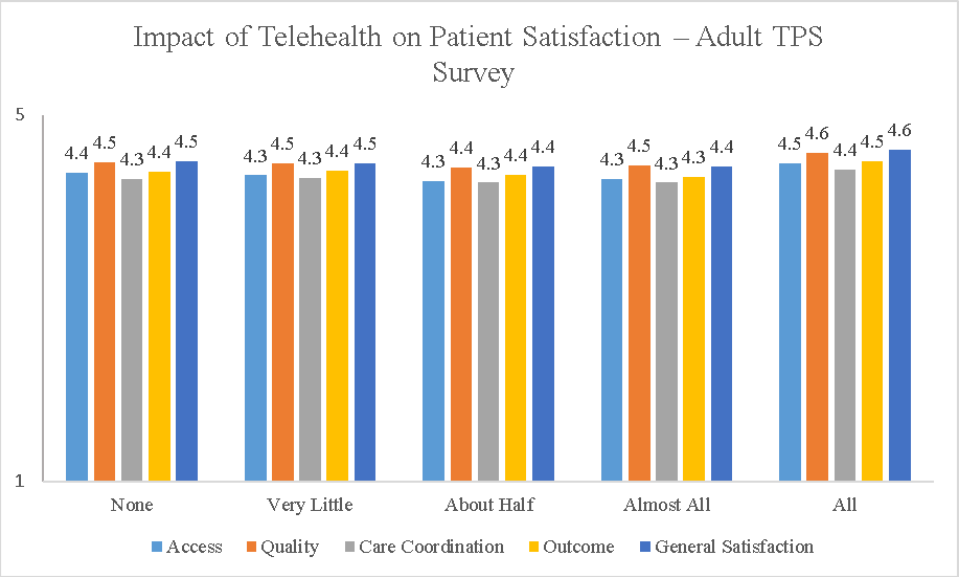


Figure 4.7. *Impact of telehealth on patient satisfaction. Adult Treatment Perceptions Survey.*

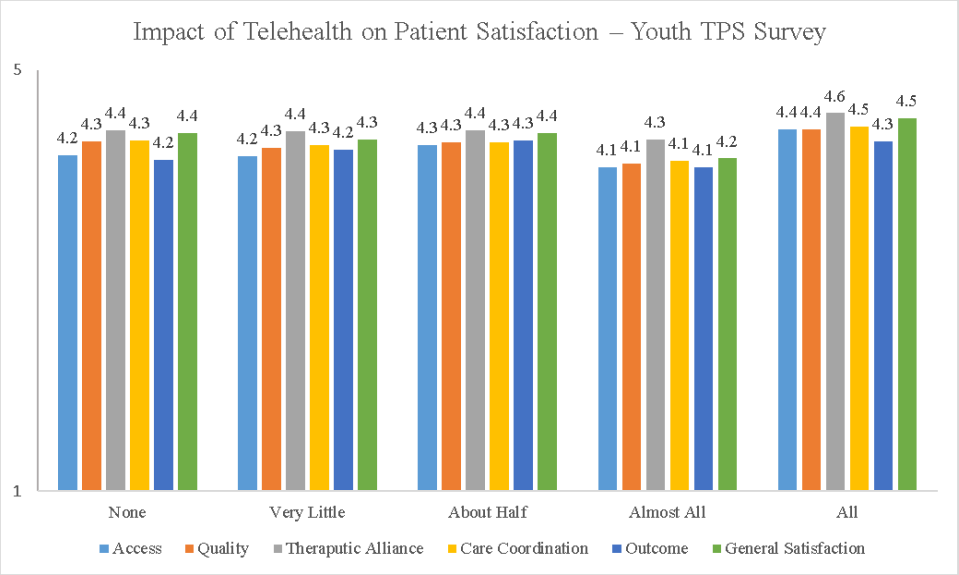


Figure 4.8. *Impact of telehealth on patient satisfaction. Youth Treatment Perceptions Survey.*

On surveys, some patients described their experiences with telehealth in spaces that allowed for general comments. Many respondents explained that services provided by phone or video instead of in person were more "convenient," "easier," "accessible", and/or "helpful." In addition, respondents indicated that they would like telehealth services to continue as options after the pandemic subsides.

However, other respondents reported that telehealth was problematic. For some, telehealth made it difficult to emotionally connect in treatment, mentioning a "loss of intimacy" or that "there is no personal touch" when services are delivered by telehealth. As one patient elaborated, telehealth felt like it "remove(d) the human side of treatment." Other respondents voiced concerns about the technology and logistics of telehealth services, noting that they had problems related to internet connections, did not have phones needed to utilize telehealth, and challenges keeping updated when meeting times changes. Many of these patients reported that they were looking forward to returning to in-person services instead of telehealth.

Take home medications

On March 19, 2020, SAMHSA issued updated narcotic treatment program (NTP) guidance indicating that states may request blanket exceptions for all stable patients in an NTP to receive 28 days of take-home doses of the patient's medication for opioid use disorder. On the county administrator survey, 94.1% of counties reported that they are currently using the new flexibility made available by the COVID-19 public health emergency to offer expanded take-home medications to stable patients.

To supplement the County Administrator Survey data regarding expanded access to take-home medications, we use DMC claims administrative data to descriptively explore the association between the March 19, 2020 updated NTP guidance on take-home medications and the number of methadone patients receiving 28 or more days of take-home doses.

Figure 4.9 plots the unique number of methadone patients receiving 28 or more doses by week for 2019, 2020, and Q1 of 2021.[42] The red vertical line marks the date of the updated NTP guidance effective March 19, 2020 (week 12). According to Figure 4.13, patients who received 28 or more days of take-home doses shifted their receipt of the doses out by 1 week (the spike in the number of unique patients receiving 28+ days of doses occurred in week 14 of 2020 compared to week 13 of 2019). This 1-week shift may have been due to providers closing immediately at the start of the pandemic due to physical distancing requirements, staff shortages, the transition to telehealth, etc. Also, Figure 4.9 suggests that the number of unique methadone patients receiving 28 or more doses may have increased after the start of the pandemic (week 14), but then subsequently decreased in all following weeks, compared to 2019. Additional analyses are needed (and are ongoing) to determine if the March 19, 2020 flexibility significantly affected the number of patients receiving take-home doses, and if the flexibility affected patients' outcomes, such as length of stay and successful discharge.

[42] We also plotted the unique number of methadone patients receiving 14 or more doses by week for 2019, 2020, and Q1 of 2021, and the new guidelines also stated that the state may request up to 14 days of take-homes for less stable patients. A very similar pattern of results emerged.

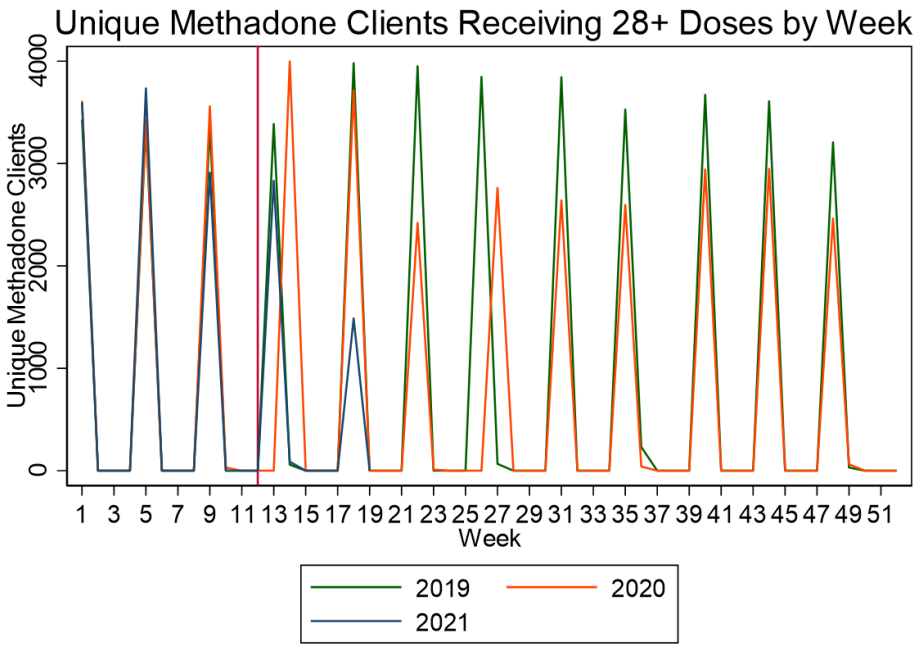


Figure 4.9. *Unique methadone patients receiving 28 or more doses, by week. DMC claims.*

Workforce

Over half of county administrators reported that prior to the start of the COVID-19 pandemic, they experienced a workforce shortage that impacted access to SUD services, and these shortages became more acute with the onset of the pandemic. In survey comments, county administrators described multiple ways that the COVID-19pandemic exacerbated workforce shortages. Administrators reported that when the pandemic began, treatment staff took leaves of absence, resigned, retired, or moved to areas with lower cost of living. COVID-19 –related budget concerns caused county hiring freezes so that the pre-existing vacancies were unfilled, and county-wide (non-SUD) staff shortages and backlogs in other departments (IT, HR, credentialing) delayed or prevented hiring, onboarding, and equipping new SUD staff hires. In addition, some staff were reassigned from specialty SUD treatment services to support their county's COVID-19 public health response, leading to further declines in the available SUD workforce.

When asked what could be done to help address COVID-related workforce challenges on the county administrator survey, administrators suggested more general steps DHCS could take to help develop the state's SUD workforce, as described above in Chapter 3 (Access).

Collaboration with other counties

At times, SUD treatment delivery is provided in collaboration with other counties or other service systems within the same county. When asked about the impact of COVID-19 on these collaborations, 69.4% of county administrators responded that COVID-19 negatively impacted their ability to collaborate within or outside of their counties to deliver a full continuum of SUD

care. Specifically, collaboration across counties to deliver SUD services was negatively impacted for 19.4% of DMC-ODS waiver counties, (particularly if the neighboring counties were in different COVID-19 "risk tiers"). Collaboration within counties with other services systems (e.g., child welfare, schools, ED, criminal justice) was negatively impacted by COVID-19 in 47.2% of DMC-ODS waiver counties. 2.8% of counties responded they experienced an "other" negative impact. Their comments indicated that Supportive Housing did not provide shelter-in-place beds for Medi-Cal patients being discharged from Residential treatment, so these patients stayed in residential beds to shelter-in-place.

Conclusions

Taken together, the survey and CalOMS-Tx results show that COVID-19 had a substantial impact on DMC-ODS waiver counties during the first year and a half of the pandemic. 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, nearly all counties are offering expanded take-home medications for stable NTP patients, and more complex and rigorous analyses of this flexibility are needed and ongoing.

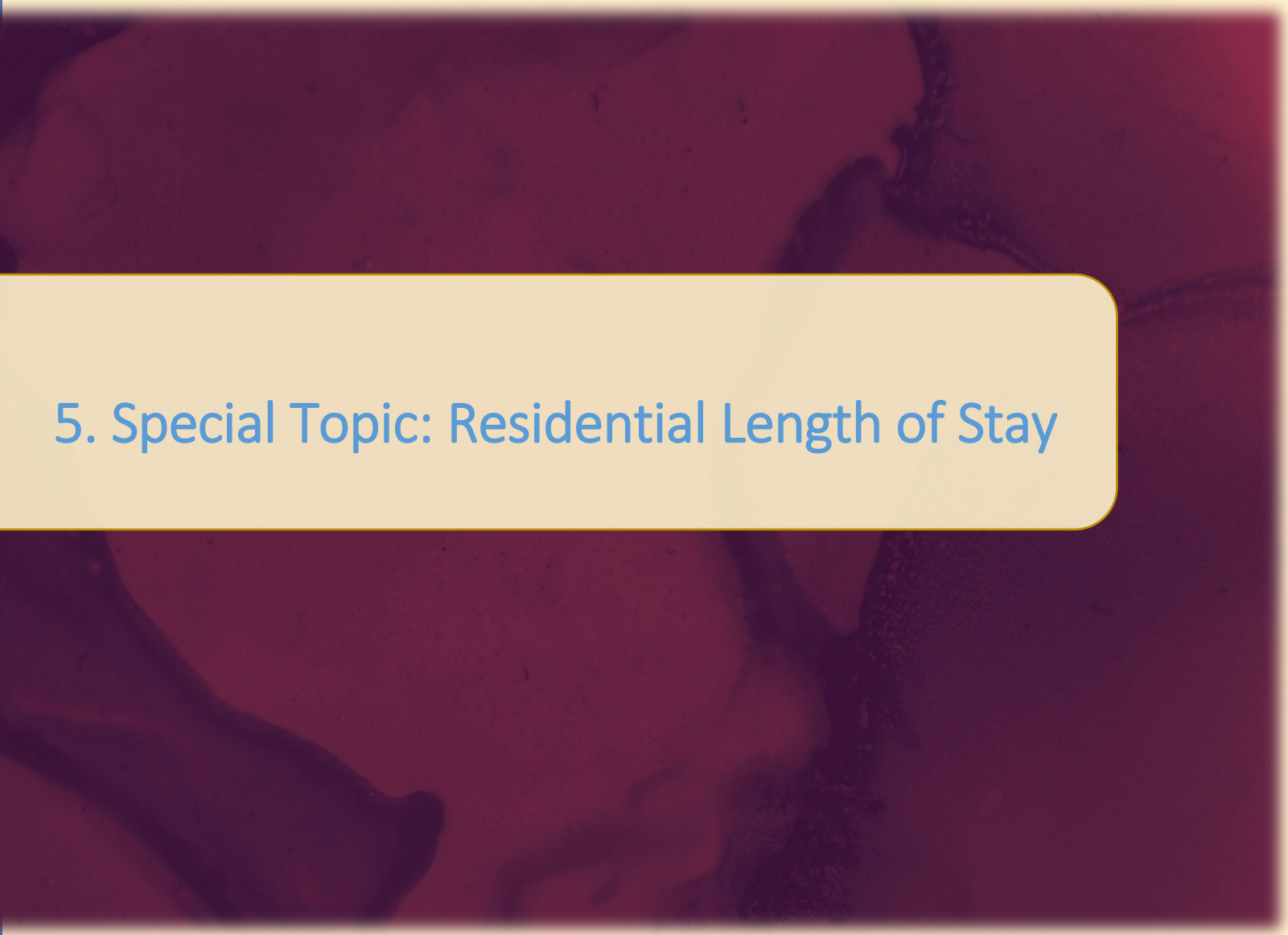
Although these recommendations require funding, the COVID-19 relief bill passed in December 2020 provided expanded funding of the SAPT block grant[43] that could potentially be used to implement these recommendations.

Recommendations

- 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. [44]
- 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.

[43] 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

[44] 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: Residential Length of Stay

Darren Urada, Ph.D., Brittany Bass, Ph.D., Howard Padwa, Ph.D., David Huang, Ph.D., Vandana Joshi, Ph.D., and Carissa Loya B.A.

Introduction

CMS State Medicaid Director letter #17-003[45] and the special terms and conditions for DMC-ODS[46, 47] direct California to "aim for a residential treatment statewide average LOS of 30 days" or less. This chapter provides analyses on the residential length of stay during the pre-COVID period (2019) and provides recommendations to move the state's average toward the target of 30 days or less.

Methods

DHCS directed UCLA to focus on lengths of stay for patients at Institutions for Mental Diseases (IMDs)[48] specifically. The DMC-ODS waiver provides federal reimbursement for Medi-Cal services for short-term residents of IMDs and CMS requires a standard 1115 waiver monitoring metric defined to calculate length of stay in IMDs specifically. Therefore, on May 14, 2021, DHCS provided UCLA with a list of all residential and withdrawal management facilities statewide that met IMD criteria. The list consisted of 281 facilities, including both residential treatment and withdrawal management levels of care. The list did not contain provider identification numbers that would facilitate direct linkage to CalOMS-Tx or DMC claims data for the calculation of length of stay, however. The list was therefore manually matched by provider name and address to DHCS's Master Provider File, which supplied a provider number that is used in CalOMS-Tx. Out of the 281 IMDs on the list, 175 were found in the Master Provider File (62.3%), enabling data matching to CalOMS-Tx, while the remainder were dropped. A second effort was made to identify the IMDs by manually looking up the name and address of the providers in the U.S. Health and Human Services National Provider Identifier (NPI) Registry.[49] Out of the 281 IMDs, 232 NPI numbers were found (82.6%) using this method, enabling matching to Drug Medi-Cal Claims, while the remainder were dropped.

After linkage to CalOMS-Tx and DMC claims, analyses were conducted to determine the average length of stay at both statewide and county levels.

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[45] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[46] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-medi-cal-2020-ca.pdf

[47] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf

[48] "Institution for Mental Disease means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." From: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-K/subject-group-ECFR87e8ed6bfd3adb9/section-435.1010

[49] https://npiregistry.cms.hhs.gov/

CalOMS-Tx analyses examined all Medi-Cal beneficiaries discharged from residential treatment or residential withdrawal management from the identified IMDs in the full calendar year 2019 in the 30 counties that were live waiver participants at any point during that year.

DMC claims analyses examined DMC claims for all patients in residential treatment or residential withdrawal management from the identified IMDs in the full calendar year 2019 in the 30 counties that were participants at any point during that year. Residential episodes were defined as a string of claims with no change in LOC and no gaps between claims greater than 14 days.

Averages and length of stay distributions were calculated for each data source.

Results

Using CalOMS-Tx data, the average time in treatment was 35.8 days. Using DMC claims, the average was 37.2 days. Further analyses suggested CalOMS-Tx data contained a substantially higher proportion of withdrawal management (33%) than DMC claims (19%). The reason for the relatively low number of withdrawal management claims is unclear, but may be related to difficulties in billing for withdrawal management,[50, 51] and lacking codes to bill for WM levels 3.7 and 4.0 in 2019. Providers may have used other funds (e.g. block grant) to fund these services in 2019 so these episodes did not appear in claims at the time. Due to this apparent missing data and the similarity between overall averages between the two data sources, CalOMS-Tx was selected for further analyses.

Table 5.1 shows the average, minimum, and maximum length of stay by county using 2019 CalOMS-Tx data with the IMD restriction. Lengths of stay varied widely across patients, perhaps in part due to outliers. One patient's length of stay reached 1,109 days. Potentially inaccurate data may account for an undetermined number of these outliers. Nearly all patients (97.3%) are discharged within 120 days, which is the normal non-perinatal maximum (initial 90-day authorization plus one 30-day extension). If outliers of 120 days or longer were removed, the statewide average length of stay would be reduced to 31.2 days, nearly brining the average to the 30-day target.

County averages varied widely from 12.1 to 74.5 days. Counties on the low end tend to have averages dominated by withdrawal management, possibly due to missing data for treatment IMDs.

[50] https://www.uclaisap.org/dmc-ods-eval/assets/documents/DMC-ODS-Evaluation-Report-FY-2016-2017%20final.pdf
[51] https://www.uclaisap.org/dmc-ods-eval/assets/documents/2017-2018%20UCLA%20DMC-ODS%20Evaluation%20Report%2011192018.pdf

Table 5.1. *Length of stay by county discharged from IMDs in 2019.*

County*	N	Mean	Min	Max
Alameda	2,701	12.1	0	287
Contra Costa	1,198	21.4	0	121
El Dorado	217	50.2	0	644
Fresno	757	46.6	0	146
Kern	389	23.6	0	97
Los Angeles	6,082	47.8	0	560
Marin	687	22.5	0	251
Merced	150	48.2	0	246
Monterey	398	41.9	0	438
Napa	428	16.4	0	121
Nevada	224	24.9	1	94
Orange	1,575	22.8	0	178
Placer	301	31.2	0	104
Riverside	1,959	39.7	0	241
Sacramento	701	39.5	0	1,109
San Bernardino	3,314	35.2	0	872
San Diego	4,592	49.3	0	752
San Francisco	2,013	28.0	0	354
San Joaquin	528	36.4	0	316
San Mateo	333	27.3	0	372
Santa Barbara	113	39.3	0	189
Santa Clara	662	23.7	0	184
Santa Cruz	373	57.0	0	442
Shasta	442	30.0	0	368
Solano	50	72.5	2	344
Stanislaus	744	15.7	1	79
Tulare	611	27.6	0	593
Yolo	137	74.5	1	720

Table 5.1. *Length of stay by county discharged from IMDs in 2019. Some counties and cases are missing due to lack of an IMD facility on the DHCS list or an inability to identify the IMD facility to CalOMS-Tx.*

Figure 5.1 shows the CalOMS-Tx distribution of lengths of stay statewide. After the initial spike associated with withdrawal management, additional spikes are notable at 30-day intervals, and especially at 90 days, which represents the maximum length of stay under the DMC-ODS waiver special terms and conditions unless a one-time additional 30-day extension is approved. This pattern of results suggests lengths of stay are partly being driven by funding or by program policies falling at 30, 60, 90, and 120 days rather than tailoring lengths of stay on an individualized basis. Individual counties varied widely on the degree to which their lengths of stays contained spikes at these intervals.

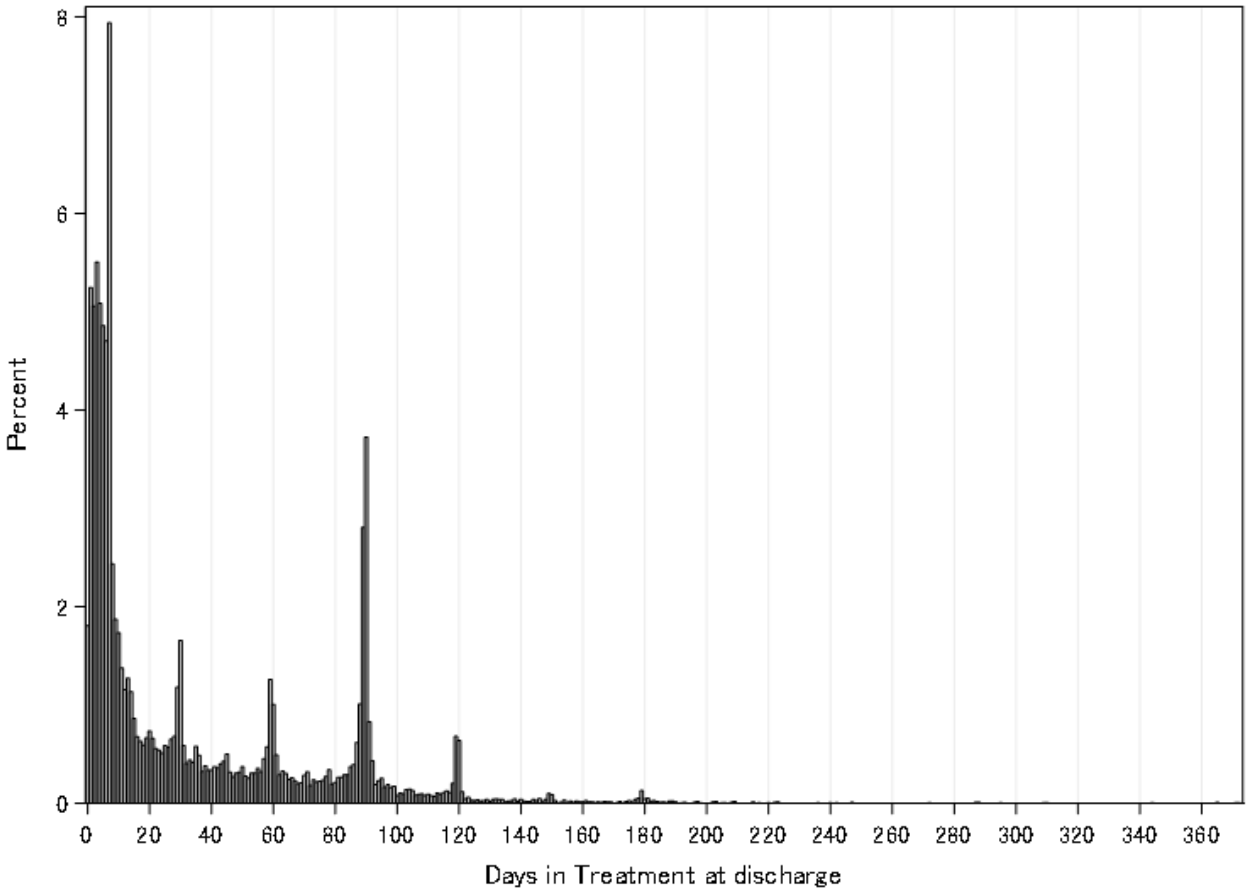


Figure 5.1 *Statewide Days in Treatment at Discharge. CalOMS-Tx (2019).*

Sensitivity analyses were conducted to determine the degree to which results were robust to changes in analysis parameters. Removing the relatively small number of pregnant patients had little effect, changing the average from 35.8 to 35.7 days. Using CY 2020 data rather than CY 2019 data raised the average slightly from 35.8 to 37.0 days, possibly due to a COVID-19 effect. Calculating the 2019 average across all residential treatment providers rather than just IMDs slightly increased the average from 35.8 to 36.5 days. Using claims data, changing the definition of residential episodes to allow for a 30 day break instead of 14 days changed the average stay from 37.2 to 38.8 days. Allowing for only a 7-day break lowered the claims-based average from 37.2 to 35.8 days. Overall, these results suggest the averages are robust. Using a variety of methods and data sources, the statewide average consistently fell in a narrow range between 35.7 days to 38.8 days.

Conclusions

The residential length of stay in California is higher than the 30-day goal specified in the DMC-ODS waiver special terms and conditions, but is within several days of that target, regardless of the method used to measure it. While California needs to reduce the average, there does not appear to be a need to make any severe cuts that may threaten to undermine treatment.

Recommendations

- Address outliers. An undetermined number of very lengthy case stays may be due to erroneous data. Providing reports to counties on the lengths of stay in their provider networks so errors can be identified and corrected would be a good first step. UCLA has drafted reporting templates for this purpose.
- Gather and disseminate lessons learned from counties that are under 30 days already.
- Address spikes in discharges that suggest program- or funding- driven discharge schedules, particularly at 90 days, by disseminating best practices from counties that do not have dramatic spikes at these intervals. For example, Stanislaus County, which does not have large spikes in their averages, requires programs to use an on-going LOC indicator form within 21 days of admission to assess and justify the need for an additional 30 days of residential treatment, and requires the same again at within 42 days of admission, if needed. For more information on Stanislaus County's practices, see Appendices E and F.

6. Special Topic: Partnership HealthPlan Cost Study

Dhruv Khurana, Ph.D., Darren Urada, Ph.D., Brittany Bass, Ph.D., Vandana Joshi, Ph.D.

Introduction

On July 1, 2020, seven counties joined the DMC-ODS waiver as a regional model known as the Partnership HealthPlan of California Wellness and Recovery Program (PHC W&R). To date, this is the only regional program in the DMC-ODS waiver, and the only one administered by a managed care plan rather than by an individual county. PHC W&R therefore provides a unique model for consideration by State Plan counties that may be unable or unwilling to join DMC-ODS individually. For more on PHC W&R implementation and lessons learned for future regional models, see Chapter 5 of the 2021 report.[52] For more information on what State Plan counties report they would need to join the DMC-ODS waiver, see Chapter 6 of the same report.

The seven PHC W&R counties include: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.

As a health plan, PHC has direct access both to claims data on SUD treatment access and data from other parts of the physical health system, including emergency room, ambulance, and hospital claims. This data was available more quickly than Medi-Cal managed care/fee for service data that captured similar information on a statewide basis. Therefore, UCLA, PHC, and DHCS collaborated to facilitate the data sharing needed to perform the cost analysis reported in this chapter using Drug Medi-Cal claims with PHC's managed care data. PHC state plan counties were used as a comparison group. In the following chapter, state plan counties refer to PHC state plan counties wherever mentioned.

Limitations: Drug Medi-Cal claims only capture treatment funded by Medi-Cal. It is likely that some treatment was delivered to patients in counties using non-Medi-Cal funds (e.g., Substance Abuse Treatment and Prevention block grant funds). Therefore, analyses of access may overstate the degree to which the DMC-ODS waiver increased total access to care. Cost analyses were limited only to residential treatment, since this was the area of greatest expansion according to DMC claims data, and a topic of particular interest to CMS, since expansion of the residential treatment benefit was a major component of the DMC-ODS waiver. UCLA plans to refine and expand the scope of these analyses, and the results of these analyses will be included in a separate report.

Methods

The primary focus of this analysis is on the major cost driving factors in the pre-waiver period and how they evolved post-waiver. Understanding that ER-usage on average costs more than other modalities for a single episode, we focus on individuals who used ER services owing to a drug overdose in the pre-waiver period. If implementing the waiver results in increased access to

[52] https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf

residential treatment, we can expect a larger proportion of these patients to receive treatment in the post-waiver period in PHC W&R counties. If residential treatment successfully reduces substance use, this could then potentially shift costs from ER to residential treatment.

To conduct a descriptive cost-effectiveness analysis of the PHC W&R, we first begin our analysis by determining the effect of the waiver on access to residential treatment services. Then, we measure the impact of the waiver on the number of overdoses. Ideally, we would expect to see an increase in the number of patients receiving residential treatment and a decrease in the number of overdoses post-waiver for live PHC counties compared to the State Plan counties.

Once causality has been established in the overall effect of the waiver on residential treatment and overdoses, we move to our descriptive cost-effectiveness analysis by focusing on the impact of going live on re-overdoses. Finally, we provide a conditional probability tree to better understand the post-waiver utilization behavior of the patients who overdosed in the pre-waiver period.

We use data from Drug Medi-Cal Claims from January 2019 to April 2021 to estimate the impact of implementing the DMC-ODS waiver for the seven PHC counties on the number of unique beneficiaries serviced in Residential Treatment. Analyses on Overdose deaths were based on data provided by PHC for the periods January 2019 to April 2021.

For unique patients served in Residential Treatment, we used HCPCS Healthcare Common Procedure Coding System (HCPCS) codes and Modifier Codes. HCPCS is a collection of standardized codes that represent medical procedures, supplies, products and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers. For Residential Services, we used HCPCS code H0019: Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem. With the introduction of the waiver, providers shifted to Modifier Codes, U1, U2, and U3 for billing Residential Services. For overdose and ER usage, we used ICD-10 codes from T40 to T52 that pertained to an overdose episode. A complete list of these ICD-10 codes has been provided in Table A in Appendix F.

We exploit the canonical difference-in-difference design (DD) to causally identify the effect of waiver implementation, i.e., going live on July 1, 2020 for the seven PHC W&R counties compared to PHC State plan counties. Specifically, the DD design compared the post-DMC-ODS waiver implementation difference in access to residential treatment between the seven PHC W&R (DMC-ODS waiver) and State Plan counties to the pre-DMC-ODS implementation difference in access to residential treatment between the seven PHC W&R and State Plan counties. The Event Study (ES) design is similar to the DD design but allows the effect of the DMC-ODS waiver to vary from 18 months prior to introduction to 10 months after the introduction. For more on ES and DD methods see the analytic methods section of Chapter 2.

All ES and DD models used data from DMC claims for Residential Treatment and from data provided by PHC for Overdose deaths at the county-month-year-level for the calendar years 2019-Q1 2021, and controlled for time-invariant county effects, county-invariant time effects, and the severity of the COVID-19 pandemic, proxied by the county-level COVID-19 case rate per

100,000, and COVID-19 death rate per 100,000 for each month-year cell. All regression analyses were also weighted by county population and standard errors were clustered at the county level.

Results

Figure 6.1 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 residential treatment services. The natural log of the unique number of patients receiving residential treatment 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 Residential Treatment in DMC-waiver PHC counties by 290.3 percent. This effect is significant at 1% level.

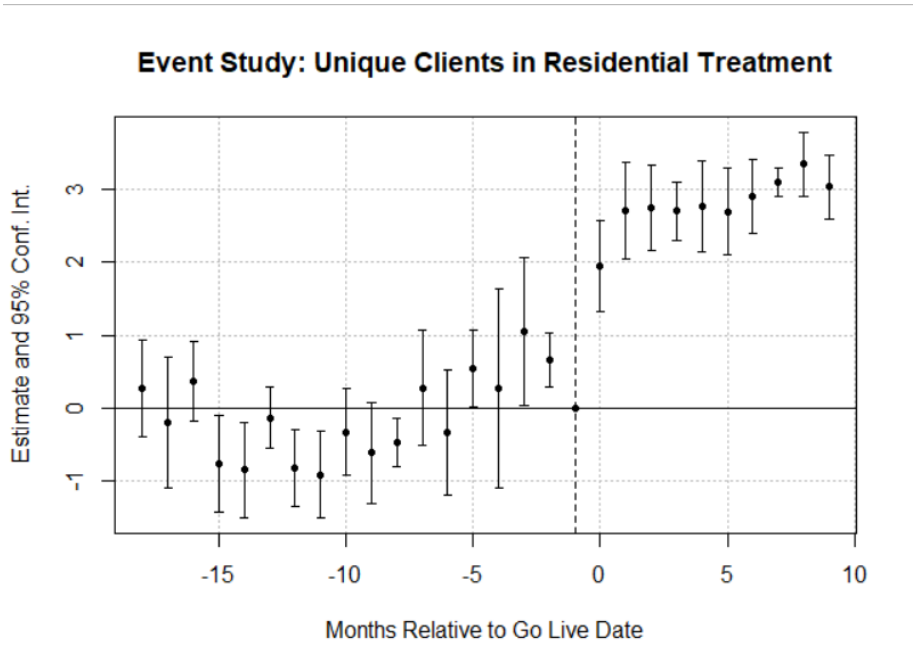


Figure 6.1. *Event study estimates showing an increase in the unique number of patients receiving Residential Treatment in the seven PHC counties that went live on July 1, 2020 by 290.3%. Data are from DMC claims for CY 2019-Q1 2021. All estimates are relative to the month prior to the Go Live date.*

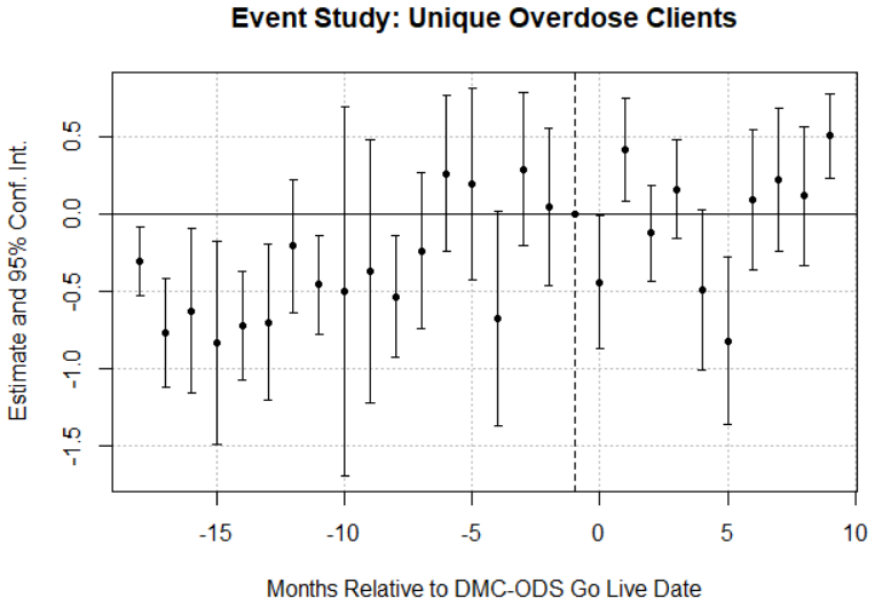


Figure 6.2. *Event study estimates of the effect of the DMC-ODS waiver on unique overdosing patients in seven PHC counties that went live on July 1, 2020. The event study estimates show no statistically significant impact of the waiver overall on unique overdoses. Data are from DMC claims for CY 2019-Q1 2021. All estimates are relative to the month prior to the Go Live date.*

Figure 6.2 presents the ES estimates of the effect of the DMC-ODS waiver on the number of unique overdosing patients in the PHC W&R counties. The event study estimates do not show a statistically significant impact of the waiver on the number of unique overdoses. The overall treatment effect is also insignificant. Upon a closer look, there appear to be a few months relative to the Go Live Date when there are a statistically significantly fewer number of overdose deaths in PHC W&R counties compared to the State Plan counties. However, the lack of clarity in this overall relationship can be attributed to the fact that the State Plan counties may not be a good control group for the seven live PHC counties. As shown in Figure A in Appendix G, the pre-treatment trend for number of Overdose Deaths for PHC versus State Plan counties does not evolve in a similar manner, which is a crucial assumption, called the Parallel Trends assumption, for the Difference-in-Difference design to yield plausible results.

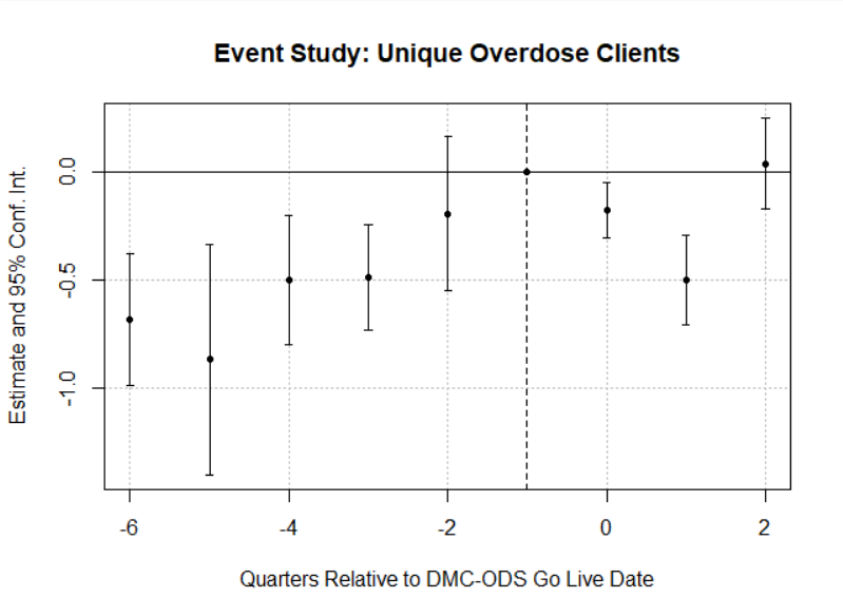


Figure 6.3. *Event study estimates when number of Overdose patients are aggregated quarterly. Compared to April, May, and June 2020 (quarter preceding the Go Live Date quarter), fewer patients overdosed in live PHC counties on average for the time prior to the Go Live Date and most cases after treatment.*

We further tested this concern by aggregating the unique number of overdoses on a quarterly basis as presented in Figure 6.3. As shown there, compared to April, May, and June 2020 (quarter preceding the Go Live Date quarter), fewer patients overdosed in live PHC W&R counties on average for the time prior to the Go Live Date and most cases after treatment. The lack of statistical significance in the post-treatment time period is more clearly visible in the quarterly aggregated estimates.

We also conducted ES analyses to estimate the change in the number of unique patients in Outpatient, Intensive Outpatient, and NTP/OTP. However, the estimates did not yield any statistically significant changes in the PHC W&R counties compared to State Plan counties in the post-waiver period. These figures (figures B, C, and D) are included in Appendix G.

Considering that there has been an increase in residential treatment as a result of implementing the DMC-ODS waiver for the PHC W&R counties but no significant changes in overdose related-ER usage, we continued our analysis to understand the utilization behavior of pre-waiver overdose patients in the post-waiver period.

We divided our time period into three periods of nine months each. Period one included patients from January 1, 2019 to September 30, 2019, period two included patients from October 1, 2019 to June 30, 2020, and period three included patients from July 1, 2020 to March 31, 2021. Essentially, we observed overdose behavior of patients in two nine-month intervals pre-waiver and one nine-month interval post-waiver.

Table 6.1. *Probability of re-overdose in PHC W&R and State Plan Counties before and after implementation of the DMC-ODS waiver.*

	Pre-waiver	Post-waiver	Difference
PHC W&R	16.55%	16.48%	-0.07
State Plan Counties	18.02%	23.16%	5.14
Difference	-1.47%	-6.68%	-5.21

For the PHC W&R counties, we identified 145 individuals who overdosed and received ER, Ambulance, Inpatient, or Outpatient Hospital services in period one, i.e., from January 1, 2019 to September 30, 2019. Out of which, 24 overdosed again in period two, i.e., from October 1, 2019 to June 30, 2020. Thus, the probability of re-overdose in the pre-waiver period came out to 16.55%.

Following the same methodology, we identified 176 individuals who overdosed and received ER, Ambulance, Inpatient, or Outpatient Hospital services in pre-waiver period two, and out of which, 29 overdosed again post-waiver. The probability of re-overdose came down to 16.48% for the PHC W&R counties in the post-waiver period. A 0.07 percentage point reduction in re-overdose following the implementation of the waiver may not sound as encouraging when evaluating the impact of the waiver. However, the probability for the state-plan counties differed vastly compared to the PHC W&R counties.

For the state plan counties, 111 patients overdosed in period one from January 1, 2019 to September 30, 2019, out of which 20 overdosed again in period two with a re-overdose rate of about 18 percent. The probability of re-overdose went up to 23.16% in the post-waiver period compared to the second pre-waiver period with 22 patients re-overdosing in the post-waiver period given that they had overdosed in the second pre-waiver period. The difference in probabilities of re-overdose for the state-plan counties is an increase of 5.14 percentage points.

The difference-in-difference of these probabilities, however, is an overall decrease of 5.21 percentage points in PHC W&R counties when compared to the change in re-overdose rate for State Plan counties. Compared to the initial rate of overdose in the pre-treatment period of 16.6%, this 5.21 percentage point decrease corresponds to a 30.6% decrease in re-overdoses in PHC W&R counties as a result of implementing the waiver.

For the purposes of analyzing any cost effectiveness from the payor perspective, we calculated the average cost per person, using DMC claims, of receiving services in the ER, Ambulance, Inpatient Hospital, or Outpatient Hospital for an overdose incident to be $3,221. With an overall reduction of 5.1% in re-overdoses avoided due to the intervention for our pre-waiver cohort of 176 overdosing patients, this amounts to $28,751 avoided costs. Given that the intervention led

to an increase in access to Residential Treatment, the per-person residential treatment costs were calculated to be $1,288. Given that 43 individuals received treatment in the post-waiver period, the total amount spent comes out to $55,384.

Although the costs incurred outweigh the costs avoided, it is important to note that this is the total cost attributed to implementing the waiver for the purposes of this analysis. This analysis does not consider a one-to-one mapping of patients who received treatment and avoided a re-overdose since the number of observations becomes much smaller when following specific individuals' re-overdose behavior with and without treatment, as depicted in the following analysis.

We analyzed re-overdose rates starting with individuals who overdosed in the pre-waiver period in PHC W&R counties (Jan 1, 2019 to June 30, 2020). This additional analysis is presented in Figure 6.4, which displays a probability tree that shows the decision pathways of pre-waiver Overdose patients in the post-waiver period.

We identified 297 patients who overdosed and received ER, Ambulance, Inpatient Hospital, or Outpatient Hospital services in the pre-waiver period from Jan 1, 2019 to June 30, 2020 in the PHC W&R counties. Out of which, 254 did not receive any residential treatment (85.5%) whereas 43 received residential treatment after the Go Live Date. 88.3% of these individuals received treatment before another overdose episode in the post-waiver period under analysis (i.e., July 1, 2020 to April 30, 2021). Out of whom, 13.1% overdosed again. The total probability of an individual overdosing after receiving treatment in the post-waiver period is 2.7% (N=8)[53] given that they overdosed in the pre-waiver period, whereas those who did not receive any treatment in the post-waiver period had an overall overdose rate of 9.1% (N=27) given that they overdosed in the pre-waiver period.

For the State Plan counties, there were 186 patients who overdosed and sought services in ER/Ambulance/Inpatient Hospital/Outpatient Hospital in the pre-waiver period from Jan 1, 2019 to June 30, 2020. None of these individuals received any residential treatment in the post-waiver period. A total of 36 of these patients overdosed again in the post-waiver period with an overall probability of 19.4%.

[53] Note: 5 of these patients overdosed after treatment and had received received treatment before another overdose episode (Pre-waiver OD -> Post-waiver Res Tx -> OD after Tx) whereas 3 of these patients followed the following path: Pre-waiver OD -> Post-waiver OD -> Res Tx after second OD -> OD after Tx.

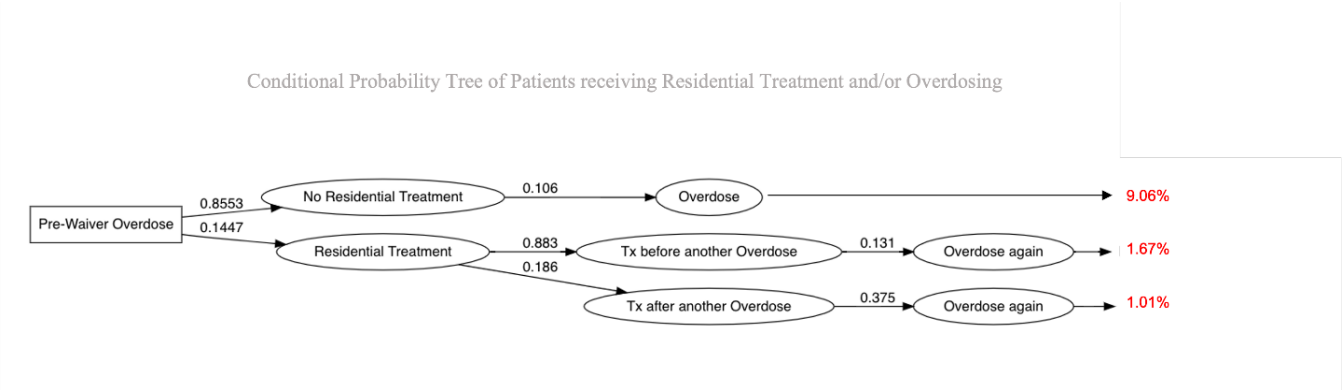


Figure 6.4. *Conditional Probability Tree depicting the utilization of ER and Residential Treatment in the post-waiver period, of patients who overdosed in the pre-waiver period.*

It is important to note that the increase in ER utilization for OD patients for PHC W&R counties post-waiver may be attributed to COVID-19 given that perceptions about the severity of COVID-19 may have influenced the patients' demand for inpatient services in a hospital setting. Similarly, a shortage in the supply of hospital beds may have made it difficult for an OD patient to seek alternate services. However, we do not see this pattern for State plan counties, which weakens our hypothesis of the effect of COVID-19.

Understanding that the costs incurred for increased residential services outweighed the costs avoided from re-overdose, we recommend continuing to research the impact of increased access to residential treatment. The benefits realized from residential treatment are multifold given the multitude of services potentially received, including individual counseling, group counseling, case management, and access to medications. These services may have longer term benefits that reduced costs beyond the span of time that we analyzed in this chapter, especially if patients were transitioned to additional services (e.g., outpatient treatment, recovery services, recovery residences) following discharge from residential treatment.

Conclusions

Initial assessment of the impact of implementing the waiver from January 1, 2019 to April 30, 2021 shows a 290.3% increase in access to residential treatment for PHC W&R patients compared to State Plan counties, while other modalities did not show any significant changes. The probability of re-overdosing in PHC W&R is also substantially lower, around 5.1 percentage points compared to State Plan counties. This difference represents an approximate 30% reduction in re-overdoses when compared to pre-waiver re-overdose rates for PHC W&R. Further, the probability of a re-overdose decreases if the patient has had access to residential treatment. A descriptive cost-effectiveness analysis from the payor's perspective showed that although the overall cost of increase to residential treatment outweighed the costs saved from avoided re-overdoses, it is still an investment worth studying. This study only measured the impact of increase in residential treatment on reduction in re-overdoses over a limited time period. However, residential treatment may generate longer-term savings that have not been explored in this study.

Future Research Plan

Given the recent advancements in the field of econometrics and causal inference, we intend to further expand this study with more data in both pre- and post-treatment periods by employing a Generalized Synthetic Control design. A Generalized Synthetic Control design relaxes the often-violated assumption of Parallel Trends as shown above in the case of overdose patients. It imputes counterfactuals for each treated unit using control group information based on a linear interactive fixed-effects model, which incorporates unit-specific intercepts interacted with time-varying coefficients.

In other words, it is a reweighting scheme that takes the value of treated units in the pre-treatment periods to choose weights, which are then used to predict or construct a "synthetic" control group based on cross-sectional correlations between treated and control units. In simple words, this method assumes that post-treatment treated data is "missing" and predicts the values of the counterfactuals based on imputations from an interactive fixed-effects model.

To comprehensively measure the impact of increase in residential treatment, we will merge our claims data for patients from PHC W&R and State Plan counties with CalOMS-Tx data. This will allow us to also control for primary drug, frequency of use, injection drug use, length of use, criminal justice involvement, mental illness, etc., especially while comparing to matched controls who received services in an outpatient facility.

Future analyses will also be expanded to a statewide DMC-ODS analysis using managed care/fee for service data from DHCS. These analyses will mirror the analyses used for the PHC W&R counties, and also expand to examine the following comparisons, consistent with UCLA's evaluation plan:

- Differences in health care costs associated with the use of different treatment modalities in costs
- Differences in health care costs associated with the different residential lengths of stay in costs
- Differences in health care costs among patients who receive SUD medications versus patients who do not, analyzed to the extent possible by location and type of medication.

Recommendations

- Continue to study the impact of treatment on health costs for a more comprehensive assessment, especially using CalOMS-Tx data, using a longer time horizon, and conducting analyses in further detail (e.g., by treatment modalities, medications, and length of stay).
- Continue to expand access to residential treatment.

7. Overall Conclusions and Recommendations

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 fentanyl 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).

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 Referral Data, 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.
- Continue support for naloxone distribution, education, training, and public education campaigns focused on fentanyl, and emphasize efforts benefitting Native American/Alaska Native and Black/African-American populations. Explore low rates of referrals to NTP/OTPs.
- Clarify the recovery services benefit, particularly by providing examples of allowable services that counties are using successfully.
- Explore ways to increase access for youth and to increase access to medical withdrawal management.
- Address workforce challenges by facilitating education and expedited certification licensing for staff entering or advancing in the field, providing training for staff and management in advanced clinical skills and addressing burnout, allowing MFT trainees to bill Medi-Cal, providing guidance on how to incorporate peer support staff, advocate for higher salaries and reimbursement, decrease documentation requirements, and promote policies (e.g. continue to allow telehealth for initial intake appointments) that will enable staff to telecommute to deliver services to high need areas and allow staff to live in areas with lower cost of living.

Quality

- Provide practical support on EBPs. In particular, resources that help counties track who receives EBP training, guidance on what trainings/curricula are reliable, affordable, and available, and resources to support fidelity monitoring.
- Further training and technical assistance to address disparities in the timely linkage of youth, older adults, Blacks, and Hispanics to their indicated LOC after brief screenings and assessments.
- Further research to understand and address lower engagement rates among older adults.
- Levels of patient-satisfaction were high on the Treatment Perception Survey, but slightly higher for adults than for youth. Further develop youth services to improve treatment satisfaction for youth patients.
- Re-initiate “CalOMS-Tx rewrite” efforts to better align CalOMS-Tx with the DMC-ODS waiver (e.g. incorporation of ASAM LOCs to replace older treatment modalities), and re-institute previously available standard CalOMS-Tx reports accessible to counties.

Integration/Coordination

- Facilitate formal protocols for cross-system referrals and support the creation of MOUs for the coordination of care across SUD, PH, and MH providers.

- Allow peer support services and case management to be utilized as part of pre-diagnosis and post-treatment billing, removing the LOC modifier to facilitate successful transitions of care.
- Address the siloed PH/MH/SUD system structure; provide training and technical assistance to providers on best practices for information exchange between SUD-MH/SMI and SUD-PH programs, including use of release of information forms to facilitate referral and care coordination and guidance, for the cross-system implementation of a Universal Screening Tool.
- Standardize Medi-Cal MH and SUD assessment and reduce documentation requirements.
- Address stigma toward SUD patients and programs.
- Support cross system MH/PH/SUD learning collaboratives.
- Address overall MH/PH/SUD service capacity and SUD workforce shortages.
- Provide performance incentives for multi-system management of beneficiaries.

Costs

- Continue study of the impact of treatment on health costs for a more comprehensive assessment, especially using CalOMS-Tx data, using a longer time horizon, and conducting analyses in further detail (e.g. by treatment modalities, medications, and length of stay).
- Continue to expand access to residential treatment

COVID-19

- Extend and expand current 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.

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

- Provide 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[54] 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, as discussed in the Access section of the results chapter of this report. 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 state initiatives 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.

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

Appendices

APPENDIX A:
IPAT: Integrated Practice Assessment Tool

VERSION 2.0

IPAT©

INTEGRATED PRACTICE ASSESSMENT TOOL

Jeanette Waxmonsky, Ph.D.
Andrea Auxier, Ph.D.
Pam Wise Romero, Ph.D.
Bern Heath, Ph.D.

In April 2013 the SAMHSA-HRSA Center for Integrated Health Solutions released *A Standard Framework for Levels of Integrated Healthcare* authored by Bern Heath, Pam Wise Romero and Kathy Reynolds. This issue brief expanded, updated and re-conceptualized the initial work of Doherty, McDaniel, and Baird (1996) to produce a national standard with six levels of collaboration/integration that run from Minimal Collaboration to Full Collaboration in a Transformed/Merged Integrated Practice. In presenting this framework, the authors developed three tables. The first table provides Core Descriptions of each level, the second table introduces the Key Differentiators for each level (categorized as Clinical Delivery, Patient Experience, Practice/Organization and Business Model), and the third table discusses the Advantages and Weaknesses of each level. Despite the degree of detail provided in these tables, the subjective placement of practices on the continuum of the six levels has been inconsistent between practices and has fallen short of establishing an objective and reliable categorization of practices by level.

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL 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 Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

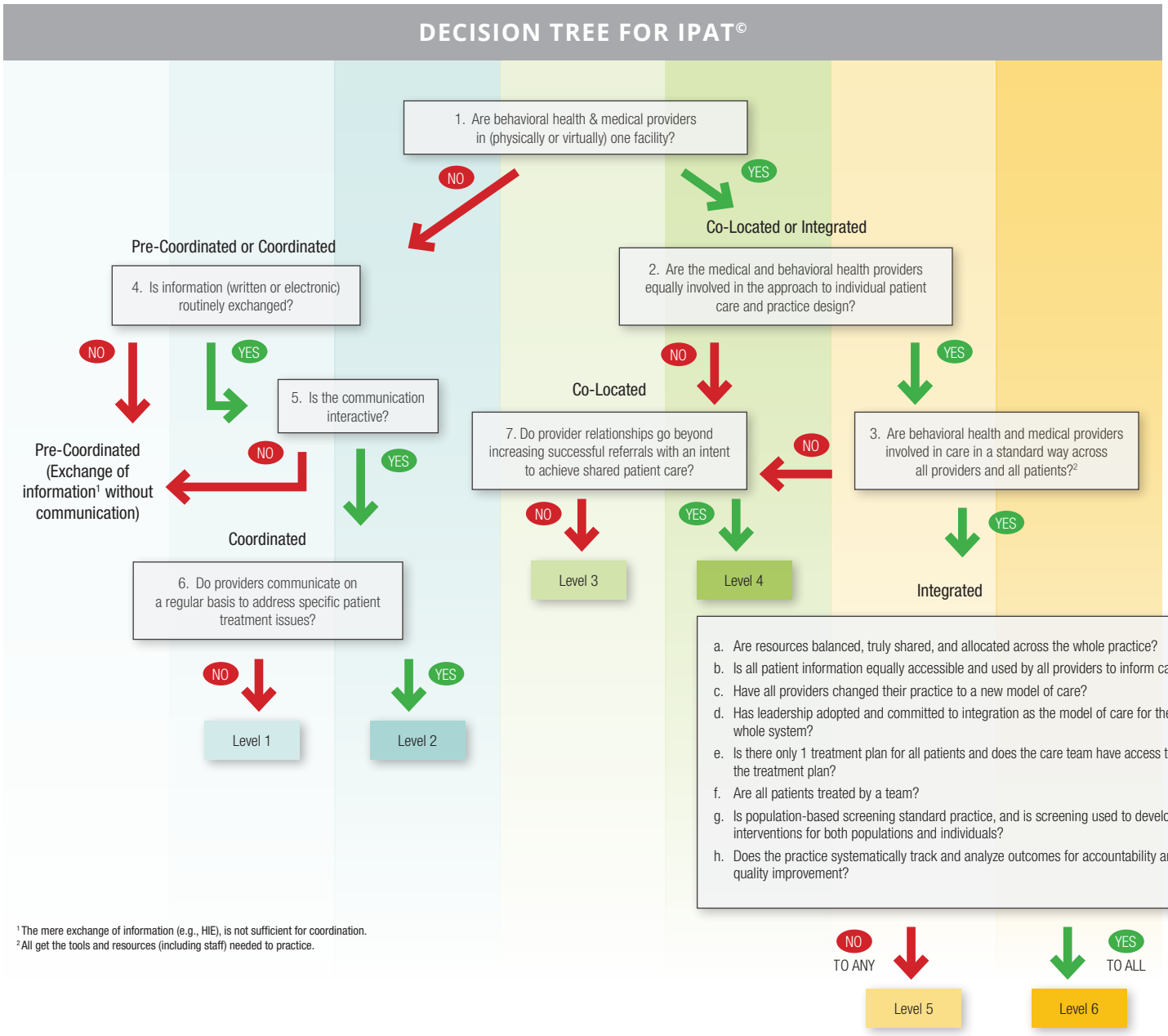
Description of the Instrument

The authors of the Integrated Practice Assessment Tool (IPAT) have devised this tool to place practices on the level of collaboration/integration defined by *A Standard Framework for Levels of Integrated Healthcare* issue brief. The IPAT uses a decision tree model rather than a metric model. This more accurately mirrors the issue brief tables, and avoids the need to weigh responses to questions, which may result in an in-between assessment score (e.g., a 3.75 co-location). The decision tree model uses a series of yes/no questions that cascade to a specific Level of Integrated Healthcare determination.

Directions >>

Responses to the questions can vary depending upon the level of knowledge of both on-the-ground operation and conceptual understanding of integration. The questions are framed as yes/no but will raise the question; "Is this 'partially', 'mostly' or 'completely' a yes or a no response?" A "yes" response is recorded only if it is *completely* a yes response. Anything less must be considered a "no" response – even understanding that there is good progress toward a "yes."

The IPAT is designed to be simple to use. There are a total of 8 questions (the 8th being a compound question) in the full decision tree, but responses to no more than 4 questions will determine the level of integration. The IPAT is best completed collaboratively by 2 or more persons (whether or not a formal care team), who are intimately knowledgeable about the operation of the practice.



INTEGRATED PRACTICE ASSESSMENT TOOL (IPAT)© VERSION 2.0

1. Do you have behavioral health and medical providers physically or virtually located at your facility? ☐ "No" - Go to question 4 ☐ "Yes" - Go to question 2	"Virtual" refers to the provision of telehealth services; and the "virtual" provider must provide direct care services to the patient, not just a consult, meaning that the provider visually sees the patient via televideo and vice versa.
2. Are medical and behavioral health providers equally involved in the approach to individual patient care and practice design? ☐ "No" - Go to question 7 ☐ "Yes" - Go to question 3	EXAMPLE: Is there a team approach for patient care that involves both behavioral health and medical health providers?
3. Are behavioral health and medical providers involved in care in a standard way across ALL providers and ALL patients? ☐ "No" - Go to question 7 ☐ "Yes" - Go to question 8	EXAMPLE: Does the practice use the PHQ-9 to systematically screen for depression, and then assure that every patient with a PHQ-9 > or = 15 receives behavioral health treatment and medical care? All get the tools and resources (including staff) needed to practice.
4. Do you routinely exchange patient information with other provider types (primary care, behavioral health, other)? ☐ No", then pre-coordination - **STOP** ☐ "Yes" - Go to question 5	EXAMPLE: Behavioral health provider and medical provider engage in a "two way" email exchange or a phone call conversation to coordinate care.
5. Do providers engage in discussions with other treatment providers about individual patient information? ☐ "No", then pre-coordination - **STOP** ☐ "Yes" - Go to question 6	In other words, is the exchange interactive?
6. Do providers personally communicate on a regular basis to address specific patient treatment issues? ☐ "No", then Level 1 coordinated - **STOP** ☐ "Yes", then Level 2 coordinated - **STOP**	EXAMPLE: Some form of ongoing communication via weekly/monthly calls or conferences to review treatment issues regarding shared patients: use of a registry tool to communicate which patients are not responding to treatment, so that behavioral health providers can adjust treatment accordingly based on evidenced based guidelines.
7. Do provider relationships go beyond increasing successful referrals with an intent to achieve shared patient care? ☐ "No", then Level 3 co-located - **STOP** ☐ "Yes", then Level 4 co-located - **STOP**	EXAMPLES can include: coordinated service planning, shared training, team meetings, use of shared patient registries to monitor treatment progress.
8. Has integration been sufficiently adopted at the provider and practice level as a principal/ fundamental model of care so that the following are in place?	
a. Are resources balanced, truly shared, and allocated across the whole practice?	NOTE: In other words, all providers (behavioral health AND medical) receive the tools and resources they need in order to practice.
b. Is all patient information equally accessible and used by all providers to inform care?	EXAMPLE: All providers can access the behavioral health record and medical record.
c. Have all providers changed their practice to a new model of care?	EXAMPLES: Primary Care Providers (PCPs) are prescribing antidepressants and following evidenced based depression care guidelines; PCPs are trained in motivational interviewing; behavioral health providers are included in the PCP visit.
d. Has leadership adopted and committed to integration as the model of care for the whole system?	EXAMPLES: Leadership ensures that system changes are made to document all PHQ-9 scores in the electronic health record (EHR); leadership decides to hire a behavioral health provider for a primary care clinic after grant funding ends.
e. Is there only 1 treatment plan for all patients and does the care team have access to the treatment plan?	NOTE: Treatment plan includes behavioral AND medical health information. EXAMPLE: Even though there may be a medical record and a behavioral health record (separate EHRs),the treatment plan is included in both and is accessible in real time by all providers.
f. Are all patients treated by a team?	A care team requires membership from all disciplines.
g. Is population-based screening standard practice, and is screening used to develop interventions for both populations and individuals?	EXAMPLE: All patients are screened for tobacco use, and then offered tobacco cessation at the facility. All patients are screened for body mass index (BMI) and then offered weight loss interventions by their primary care provider, or referred to a health coach or wellness program. EXAMPLE: Facility reviews cardio-metabolic monitoring for all patients on atypical antipsychotics and determines which patients need screening and additional supports to reduce cardio-metabolic risk factors; primary care clinic screens all diabetics for depression and refers to behavioral health provider, then primary care provider.
h. Does the practice systematically track and analyze outcomes related for accountability and quality improvement? ☐ "No" to any, then Level 5 integrated - **STOP** ☐ "Yes" to all, then Level 6 integrated - **STOP**	Population-based measures and outcomes are used in improving population health.

Assessment Summary >>

Practice/Location:_____Date:_____

Current Level of Integration: (Circle one)

Pre-Coordinated	LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice

Assessment Team Completing IPAT: (Names/Position at Practice)

Name:_____Position :_____

Name:_____Position :_____

Name:_____Position :_____

Name:_____Position :_____

Notes/Comments:

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APPENDIX B:
2020 Treatment Perceptions Survey (TPS) Report

2020 Treatment Perceptions Survey (TPS) Report

UCLA Integrated Substance Abuse Programs

June 10, 2021

Contents

2020 Treatment Perceptions Survey (TPS) Report

The Treatment Perceptions Survey (TPS) was administered during November 9-13, 2020 in 30 counties and a regional model (including seven counties) participating in the DMC-ODS Waiver. This was the fourth administration of the annual survey under the waiver. Due to the COVID-19 and the increase in services provided to patients via telehealth (telephone and video-conferencing), online and automated phone surveys were developed and made available to the counties/providers in addition to the paper-based survey. Also, a new question was added to the surveys to gauge patient receipt of services using telehealth.

TPS results showed an overall decrease in the number of both adult and youth survey respondents compared to the prior year most likely due to the pandemic. However, patient perceptions of/satisfaction with services generally continued to be very favorable in all of the domains measured - Access to Care, Quality of Care, Therapeutic Alliance (youth only), Care Coordination, Perceived Outcome, and General Satisfaction - among both adults and youth, as in previous survey periods.

No meaningful differences were observed in the average scores of the survey's domains between the online and paper surveys, which indicate that introducing the online survey did not skew the results. Similarly, no meaningful differences were found in patients' perceptions of care/satisfaction between telehealth and in-person services, which supports continued use of telehealth.

Background

The Treatment Perceptions Survey (TPS) for adults was developed by UCLA based on San Francisco County's Treatment Satisfaction Survey, and the TPS for youth, introduced a year later, 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 development of the surveys was solicited from and provided by: the California Department of Health Care Services (DHCS); the Substance Abuse Prevention Treatment+ Committee (SAPT+) of the County Behavioral Health Director's Association (CBHDA) of California; the Drug Medi-Cal Organized Delivery System (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: 1) fulfill counties' EQRO requirement related to conducting a patient satisfaction survey at least annually using a validated tool; 2) address the data collection needs for the CMS required evaluation of the DMC-ODS waiver; and 3) support DMC-ODS quality improvement efforts and provides key information on the impacts of the waiver.

Data Collection Methods

The TPS is administered annually during a specified five-day survey period determined by DHCS. The TPS had been strictly paper-based (one-page and large print versions) during the first three survey periods in calendar years (CYs) 2017, 2018, and 2019. However, due to the COVID-19 pandemic, online and automated phone surveys were added as data collection options in CY 2020.

The paper-based and online surveys are available in the 13 languages (English, Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern Armenian, Western Armenian, Vietnamese, and Cambodian) for both adults and youth. The automated phone surveys are available in only English and Spanish for both adults and youth at this time.

Survey items and domains

The survey for adults includes 14 statements addressing patient perceptions in five domains that are comprised 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. There is also a section on the paper and online surveys where patients may write comments. As the use of telehealth to deliver services to patients had increased due to the pandemic, a new telehealth item was added to the surveys (paper, online and phone formats) in 2020. The surveys also collect demographic information (i.e., gender, age, race/ethnicity, and length of time receiving services at the treatment program).

TPS Adult Survey Items by Domain

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).

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.).

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

Telehealth

15. Now thinking about the services you received, how much of it was by telehealth (by telephone or video-conferencing)? (Response options: None, Very little, About half, Almost all, All)

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.

Telehealth

19. Now thinking about the services you received, how much of it was by telehealth (by telephone or video-conferencing)? (Response options: None, Very little, About half, Almost all, All)

Survey administration

The relevant MHSUD Information Notices, survey instructions, forms in multiple threshold languages, and other materials (i.e., frequently asked questions, TPS codebook, and sample county and program summary reports) are available online at http://www.uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html.

County and regional model administrators coordinated the survey administration and data collection with providers in their respective provider networks and entered the data from paper forms locally. Data from the online surveys were submitted directly to UCLA, and anonymous responses from the phone surveys were sent to UCLA from a third party vendor. The data were analyzed and regional- county- and provider-level summary reports were prepared and made available to participating counties/regional model. Counties were also given access to their raw data files and respondents' written comments.

Thirty (30) counties and the Partnership HealthPlan of California Wellness and Recovery Program (PHC W&R Program, regional model comprised of seven counties, including Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties) participated in the fourth TPS during November 9-13, 2020 survey period. Programs included outpatient/intensive outpatient (OP/IOP), Residential, Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP), and Withdrawal Management (WM, standalone) treatment settings.

Approximately two weeks after the survey period, a link to a short TPS County Feedback Survey was sent to the county TPS coordinators to inquire about the new data collection methods offered (e.g., preferences, satisfaction, how links were disseminated to patients), what worked well, and suggestions for improving county administrators' experience with conducting the TPS. A total of 29 responses were received, representing 24 unique counties and PHC. (See the TPS County Feedback Survey Report in Appendix A.)

Results

TPS records submitted

In the CY 2020 survey period a total of 13,530 TPS forms from both adults and youth were received from 30 participating counties and one regional model. Adults accounted for the majority of the survey forms at 97.3% (n = 13,163), and youth accounted for 2.7% (n= 367). The number of respondents was only slightly more than half of those who responded to the CY 2019 survey (N= 23,765) with most of the respondents to the TPS County Feedback Survey indicating the COVID-19 as the primary reason for the lower response. In addition, some programs may have been closed due to a federal holiday (Veterans Day) that was observed

during the survey period. All 30 counties and the regional model returned adult forms whereas only 22 counties and the regional model also returned youth forms. (Please see Appendix B for additional TPS data.)

The highest percentage of adult survey forms was received from respondents in OP/IOP programs (43.0%), NTPs/OTPs at 28.8%, followed by residential programs (25.2%), as compared to standalone WM programs (1.2%). In contrast, the vast majority of surveys from youth respondents (86.1%) were returned from OP/IOP programs, while only 7.9% of surveys were returned from residential programs. (Due to missing data, 1.8% of adult and 6.0% of youth respondents could not be linked to a specific program.)

The majority of adult respondents completed the survey on paper (64.2%), followed by online (31.9%) and phone (3.9%). In contrast, slightly more than half of the youth respondents completed the survey online (52.9%), followed by paper (46.3%), and phone (0.8%). No meaningful difference were observed between the online and paper surveys in the average scores by domain among both adults and youth. This finding suggests that the transition to the online survey did not skew the survey results.

Demographics

Consistent with previous years of the TPS, the majority of adult survey respondents identified as male (56.2%); 38.2% identified as female; and 0.5% identified as transgender or having other gender identity. Likewise, most youth survey respondents identified as male (63.8%); 28.9% identified as female; and 1.9% identified having other gender identity.

By race/ethnicity, the highest percentage of adult survey respondents identified as White (34.3%), followed by Latinx (15.9%), Other (8.7%), Black/African American (7.1%), and American Indian/Alaska Native (2.7%). The lowest percentage of adult respondents identified as Asian (1.8) or Native Hawaiian/Pacific Islander (1.1%). Among youth survey respondents, the highest percentage identified as Latinx (39.0%), followed by White (16.6%), Other (10.9%), and Black/African American (5.7%). The lowest percentage of youth respondents identified as American Indian/Alaska Native (3.0%), Asian (2.5%), and Native Hawaiian/Pacific Islander (1.4%).

The adult survey forms were returned overwhelmingly in English (97.0%) with only 2.9% returned in Spanish. Correspondingly, almost all (98.9%) of the youth survey forms were returned in English (n = 363) and 1.1% were returned in Spanish. Patients were twice as likely to return paper compared to online survey forms in Spanish and languages other than English.

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

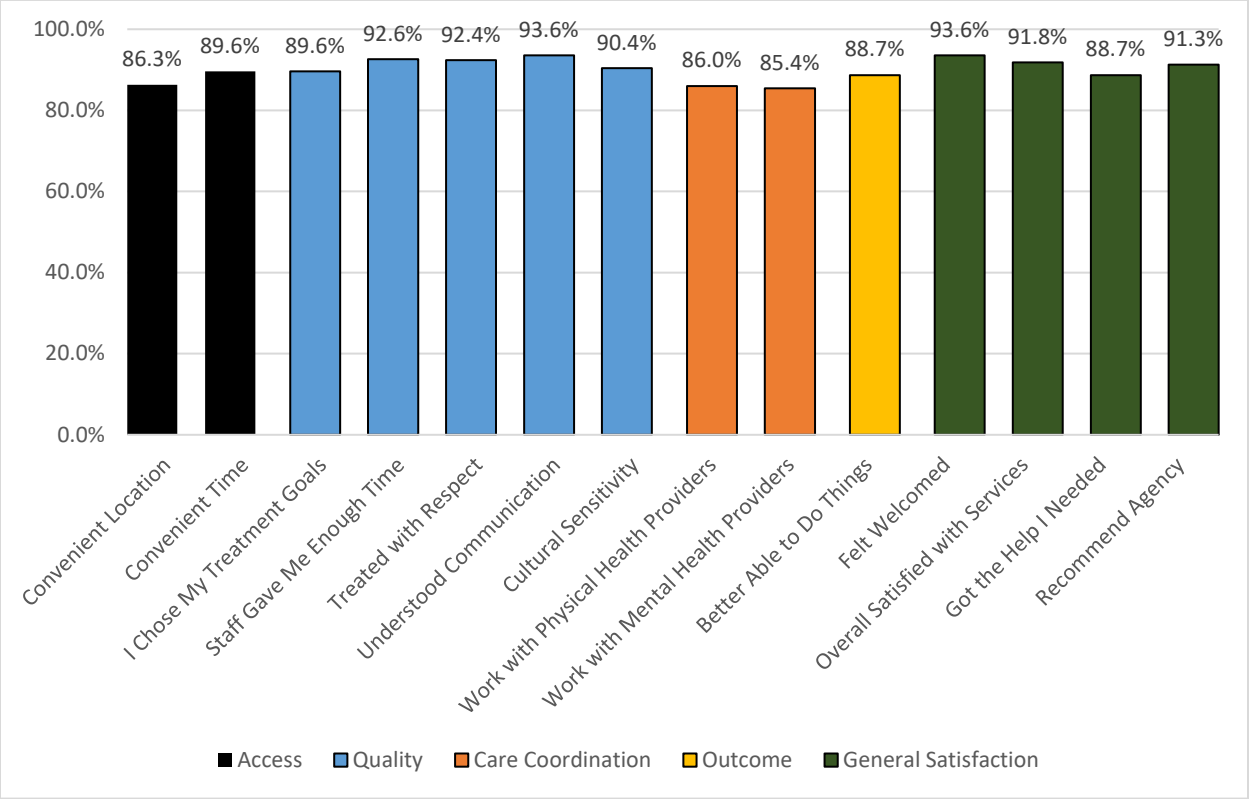
Youth

Among youth survey respondents, the overall average score across OP/IOP and residential treatment settings was 4.4, with the average score for OP/IOP at 4.4 and for residential settings at 4.1. The findings suggest youth respondents perceived there are opportunities for improving treatment services, particularly in residential settings.

Adults

As shown in Figure 1 below, the percent of responses in agreement for each of the 14 survey items was at least 85.4%, indicating overall favorable perceptions of care among adult survey respondents. Among the two questions with the highest percentages in agreement (both 93.6%), one was in the Quality domain ("understood communication"), and the other was in the General Satisfaction domain ("felt welcomed"). The two items with the lowest percentages in agreement ("staff here work with my mental health care providers to support my wellness," at 85.4% and "staff here work with my physical health care providers to support my wellness" at 86.0%) were in the Care Coordination domain, similar to previous years.

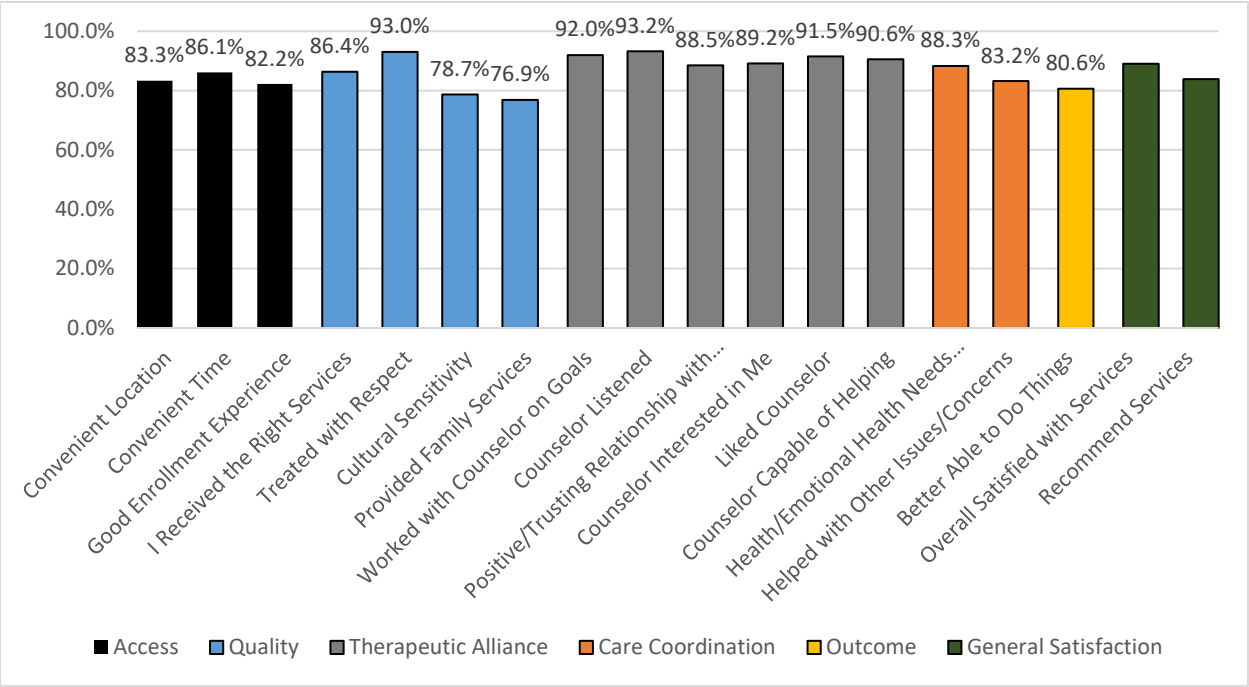
Figure 1. Percent in agreement for each survey item by domain – Adults



Youth

Among youth respondents, the percent of responses in agreement for each of the 18 survey items were at least 76.9%. (See Figure 2 below.) The survey items showing the highest percentages in agreement were "counselor listened" (93.2%, Therapeutic Alliance domain) and "treated with respect" (93.0%, Quality domain). The items with the lowest percentages in agreement, both in the Quality domain as observed in prior survey periods, were "provided family services" (76.9%) and "cultural sensitivity" (78.7%).

Figure 2. Percent in agreement for each survey item by domain – Youth



Average perceptions of care/satisfaction score by domain

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

While at the statewide level wide 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, the regional model and counties received their own region-, 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 setting and domain

The highest average score statewide for adult respondents in OP/IOP settings was observed for the Quality and General Satisfaction domains (both 4.6) and the lowest average score was for the Access and Care Coordination domains (both 4.4). (See Appendix B.) Similarly, in the residential settings, the highest average score was for the Quality and General Satisfaction

domains (both 4.4), however the lowest average scores were for the Access, Care Coordination and Outcome domains (all 4.3). In NTP/OTP settings, the Quality, Outcome, and General Satisfaction domains yielded the highest average scores (all 4.5), while the Access and Care Coordination domains had the lowest average scores (both 4.3). For WM settings the highest average score was shown for the Quality and General Satisfaction domains (both 4.5), and the lowest average score was for the Outcome domain (4.3). 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. The lower scores for Access in NTP/OTP and residential settings suggest that these are areas for improvement, whereas the Quality and General Satisfaction domains received the highest scores across all the treatment settings.

Among youth survey respondents, Therapeutic Alliance had the highest average scores in both OP/IOP and residential settings (4.5 and 4.2, respectively) and the Outcome single-item domain showed the lowest scores in both settings (4.2 and 3.7, respectively).

Receipt of services using telehealth

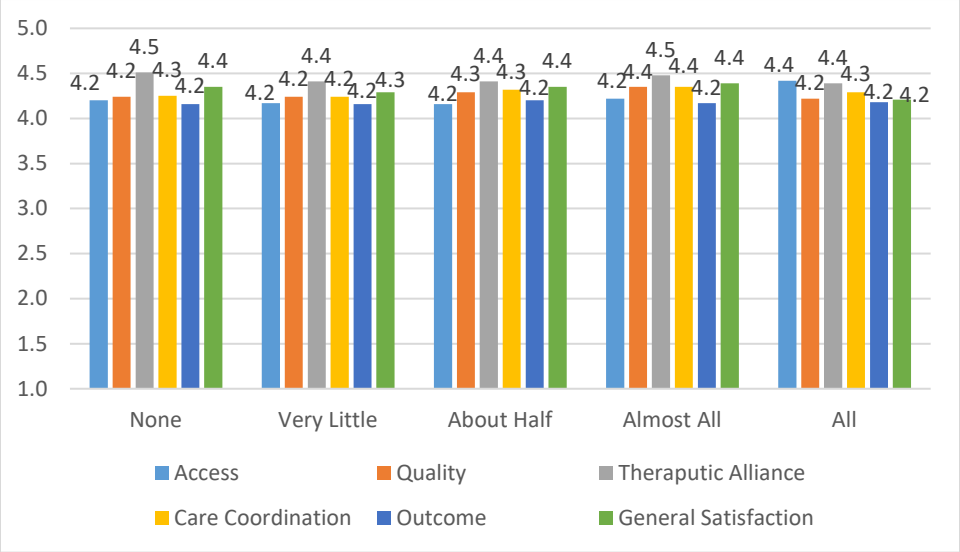
Due to the COVID-19 and the increased need to provide services via telehealth (telephone or video-conferencing platforms), a question was added to the 2020 TPS asking, "How much of the services you received was by telehealth?" Among adult respondents, 71.9% reported receiving at least some (very little to all) services by telehealth. Respondents in OPIOP settings showed the highest percentage of patients that had at least some telehealth (76.9%), followed by NTP/OTP at 71.5%, residential at 66.2%, and WM at 56.1%. Among youth, 72.8% reported receiving at least some services by telehealth, with the highest percentage observed among respondents in OP/IOP at 74.4% followed by those in residential at 48.3%.

Effect of telehealth on perceptions of care/satisfaction by domain

In addition, among all domains, average adult scores were highest when services were exclusively provided by telehealth (see Figure 3 below), though the differences by degree of telehealth use were very small. For youth, the Access showed the highest average score when "All" of the services received were via telehealth, and Quality received the highest average score when "Almost All" services were received via telehealth, whereas Therapeutic Alliance yielded the highest average score when either all of the services were received in-person ("None") or "Almost All" of the services were received via telehealth. (See Figure 4 below.) Care Coordination had the highest average score when "Almost All" of the services were received via telehealth, average scores for perceived Outcome were the same across all degrees of telehealth use, and highest average scores for General Satisfaction were observed when "None," "Almost Half" or "Almost All" of the services received were via telehealth.

Figure 3. Average scores by degree of telehealth use and by domain - Adults

Figure 4. Average scores by degree of telehealth use and by domain - Youth



Similar to adults, the differences by degree of telehealth use among youth were very small, and there were no meaningful differences in patient perceptions of care/satisfaction between telehealth and in-person services, which supports continued use of telehealth. These results suggest that the transition of services to telehealth due to COVID-19 did not have a negative effect on treatment perceptions/satisfaction with services.

Survey respondent comments regarding telehealth services

Some patients used the Comments box on the survey forms to describe their experiences with receiving services via telehealth. For example, some respondents expressed that services (e.g., individual or counseling) provided by phone or video compared to in-person were more

"convenient," "easier," "accessible," and/or "helpful." In addition, respondents commented that they would like telehealth services to continue as an option beyond the pandemic. However, other respondents mentioned that telehealth services "remove the human side of treatment," or that there is a "loss of intimacy," or that "there is no personal touch [sic]." Examples of issues cited in respondents' comments were technical in nature (e.g., internet problems, not having their own phone) or were related to how the video meetings were run (e.g., one-hour breaks, three-hour groups, not keeping patients updated on changes to meeting times). Many of these patients were looking forward to returning to in-person individual counseling and group sessions.

APPENDIX A:
TPS County/Regional Model
Feedback Report

Treatment Perceptions Survey 2020: County/Regional Model Feedback

Background

As part of the DMC-ODS waiver evaluation, participating counties and regional models are required to have their network of providers administer the client Treatment Perceptions Survey (TPS). The information collected is used to measure adult and youth clients' perceptions of access to services and quality of care. The TPS is required to fulfill the county External Quality Review Organization (EQRO) requirement related to having a valid client survey. The data may also be used by counties and regional models (and service providers) to evaluate and improve the quality of care and client experience. The TPS dissemination period for 2020 took place the week of Monday, November 9 through Friday, November 13.

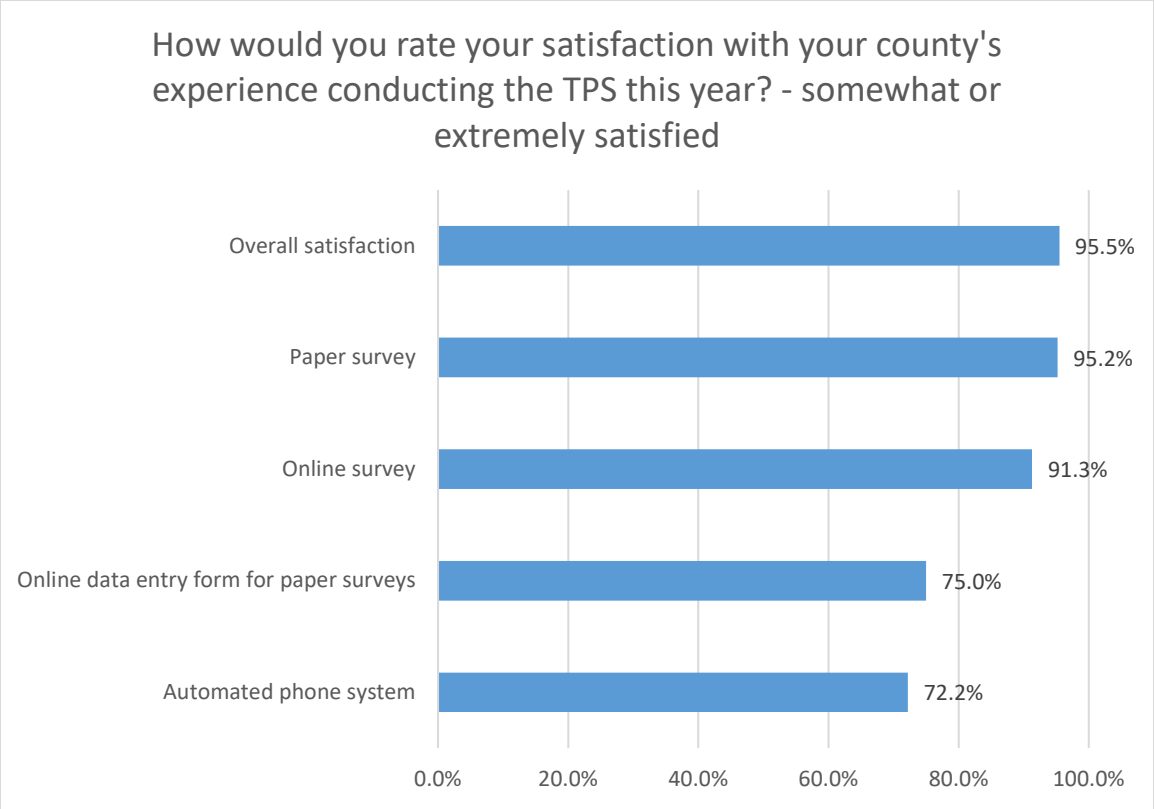
Due to the public health emergency caused by the COVID-19 pandemic, many services shifted to being provided using telehealth rather than in person, and as a result, the TPS was offered in online and automated phone survey formats in addition to the traditional paper forms. Counties and regional models were asked to enter client responses using the online data entry links provided to them rather than send the forms to UCLA-ISAP for scanning as in prior years.

In order to collect feedback on the use of the multiple data collection methods to inform UCLA-ISAP's ongoing efforts to support counties/regional models in administering the TPS, the online TPS County/Regional Model Feedback Survey was disseminated to county TPS contacts on December 8, 2020. Data collection took place from December 2020 through mid-January 2021. A total of 29 responses were received, including from 24 unique counties and Partnership HealthPlan of California (PHC; a regional model that includes seven counties).

Results

Overall satisfaction

Respondents to the feedback survey were generally very satisfied with their experience conducting the TPS in 2020: 95.5% were either "somewhat" or "extremely" satisfied when reporting on overall satisfaction. Satisfaction with the paper survey (95.5%) and online survey (95.2%) were higher overall than with the online data entry form for paper surveys (75%) and the automated phone system (72.2%).



What factors contributed to your county's choice of data collection methods?

In written comments, many respondents indicated that they allowed providers to select which data collection methods they wanted to use. Respondents also indicated they appreciated having a variety of options available to use.

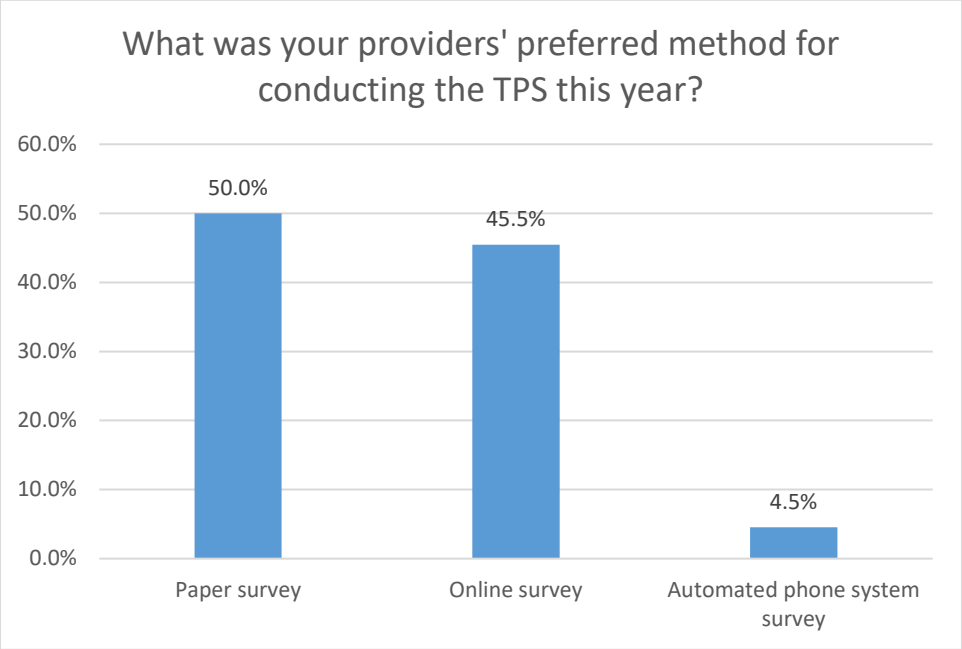
Respondents noted different factors played a role in the choice of data collection methods among providers:

- Paper surveys:
  - Some respondents noted that residential providers that do not allow clients to use cell phones relied heavily on paper surveys.
  - Limited client access to technology in general played a role in encouraging use of paper surveys.
  - The ability to ensure that clients were completing the paper surveys, compared to other methods, swayed many programs towards preferring paper surveys.
- Online surveys:
  - Where the majority of staff were working remotely, counties/regional model opted to use the online and phone surveys.
- Online data entry form for paper surveys:
  - Respondents noted that early on, they did not understand the difference between the online data entry form and the online surveys.

- Automated phone survey:
    - Counties/regional model that wanted the ability to administer supplemental questions opted not to use the phone version.
    - Counties/regional model also noted that having the phone survey as an option was good, but that they would like to have more real-time data on the number of phone survey participants.

What was your providers' preferred method for conducting the TPS this year?

Respondents indicated that their providers' preferred method for conducting the TPS in 2020 was the paper survey (50%), closely followed by the online survey (45.5%). The automated phone system survey was the least preferred, with only 4.5% of respondents indicating their providers preferred this method.



Why do you think this method for conducting the TPS was your providers' preferred method?

Respondents described different reasons for providers' preferences, which seemed to take into account client needs and access to technology.

- Paper survey: The benefits of the paper survey were a much higher response rate and assurance that clients would complete the surveys. Residential treatment programs and opioid/narcotic treatment programs may have also preferred the paper survey due to lack of client access to technology or lack of time with patients when dosing to provide information about online surveys.

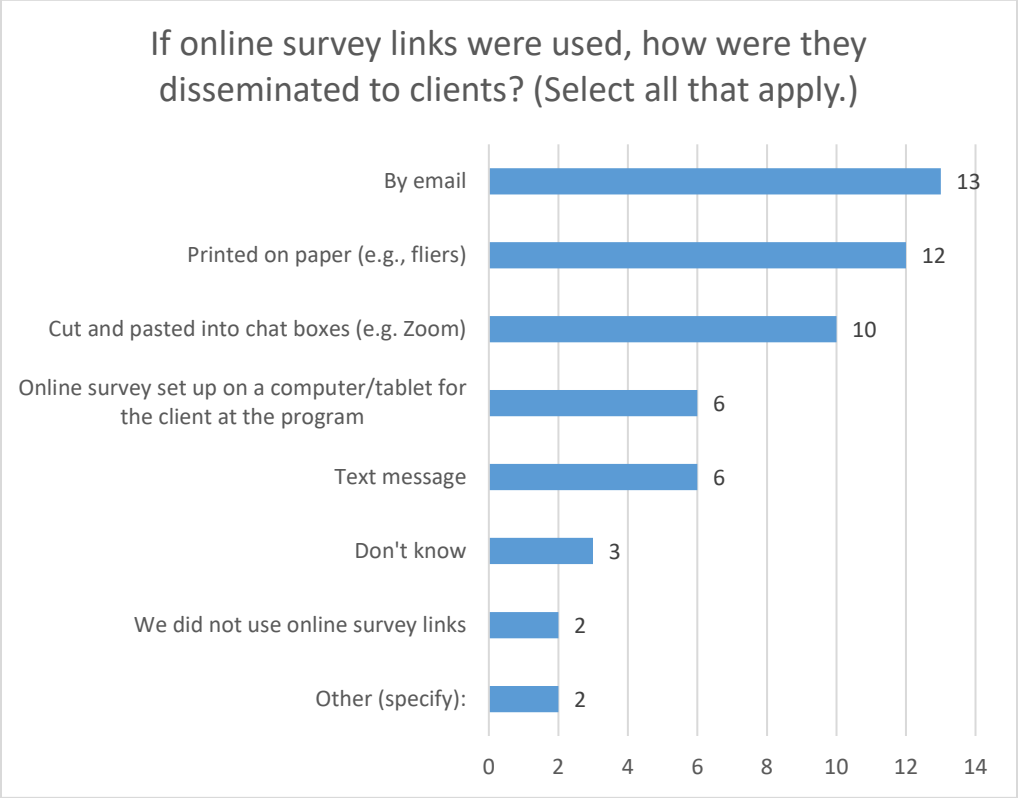
- Online survey: Benefits of the online survey for providers included ease of use and convenience, especially for providers delivering remote services, including many outpatient providers. Data entry not being needed with online surveys was a benefit. One downside noted was that it was difficult to ensure that clients would actually fill in the surveys.
- Automated phone system: One respondent indicated that it was easier to provide a phone number for clients to call, as some clients do not have access to a computer or the internet.

If online survey links were used, how were they disseminated to clients? (Select all that apply.)

The most common methods to disseminate online survey links to clients was by e-mail (n=13), printed on paper such as fliers (n=12), and cut and pasted into chat boxes such as on Zoom (n=10).

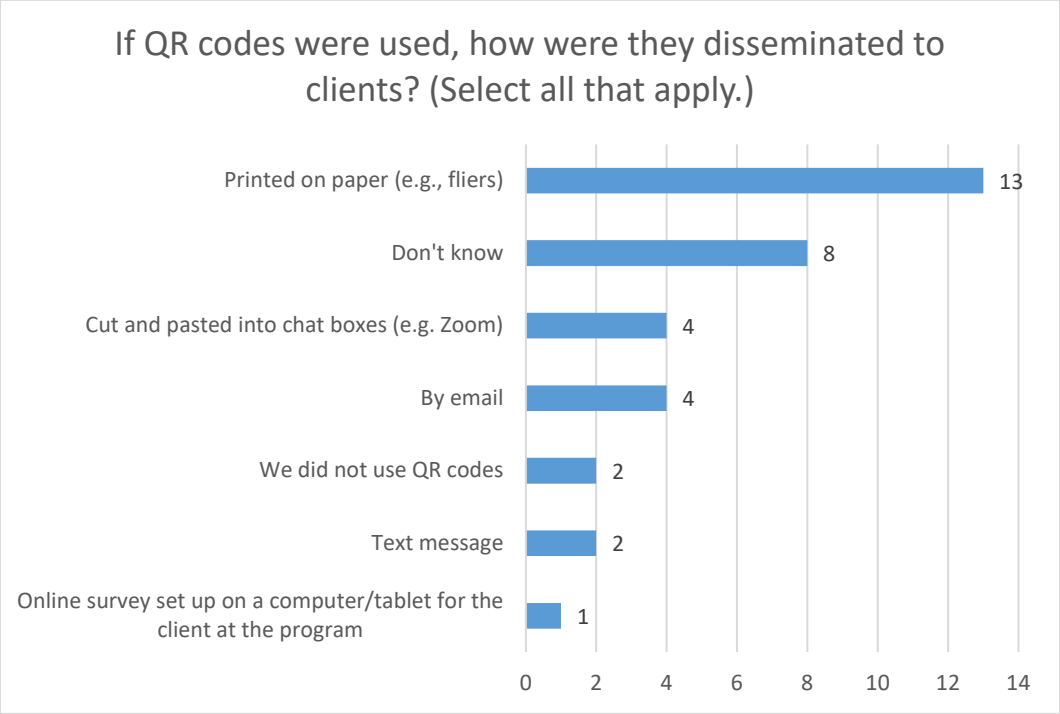
"Other" methods reported included the following:

- On paper then transferred online
- Staff contacted clients via telephone to remind them, and to ask if they had questions about the survey process and if they would like help completing the survey online



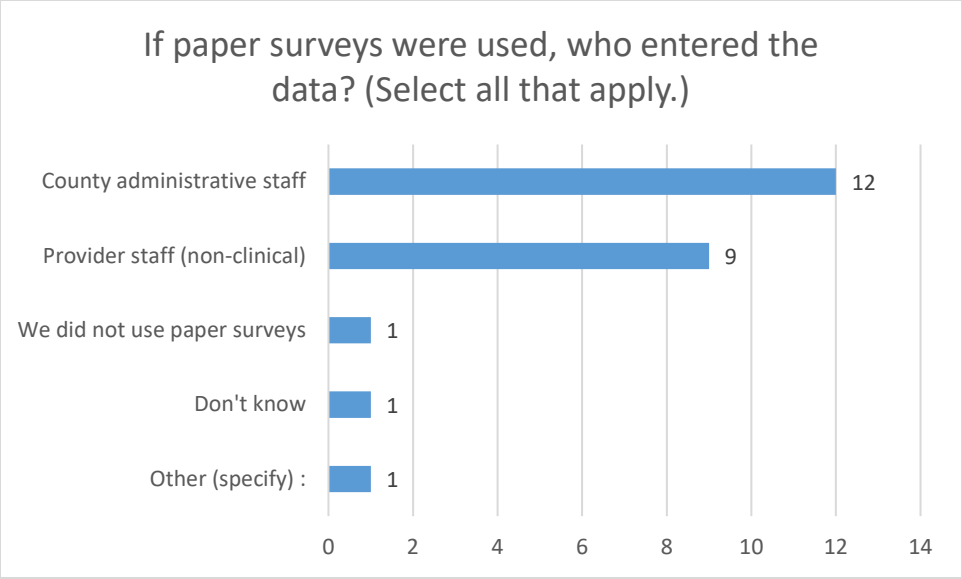
If QR codes were used, how were they disseminated to clients? (Select all that apply.)

The most common methods to disseminate QR codes to clients was printed on paper such as fliers (n=13), cut and pasted into chat boxes such as Zoom (n=4), and by email (n=4). However, a large number of respondents (n=8) indicated they did not know whether QR codes were used or not.



If paper surveys were used, who entered the data? (Select all that apply.)

Where paper surveys were used, 12 respondents indicated that county administrative staff entered the data, 9 indicated that non-clinical provider staff entered the data, and 1 respondent (indicating "Other") responded that PHC (regional model) staff entered the data.

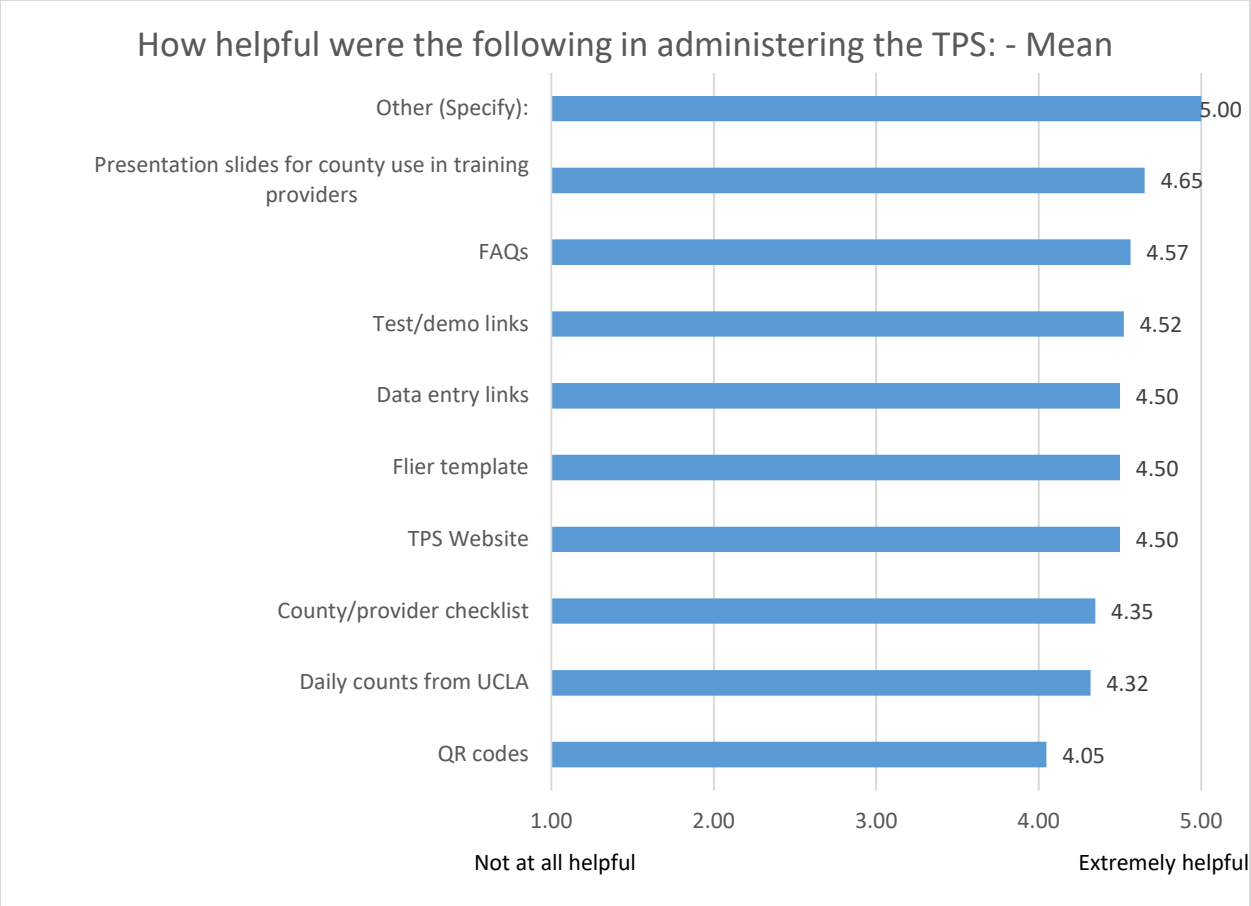


How helpful were the following in administering the TPS:

Respondents found multiple forms of TPS assistance helpful in administering the TPS. The most highly rated forms of assistance include presentation slides for county use in training providers (mean rating of 4.65 on a scale of 1=not at all helpful to 5=extremely helpful), FAQs (mean rating of 4.57), and test/demo links (mean rating of 4.52).

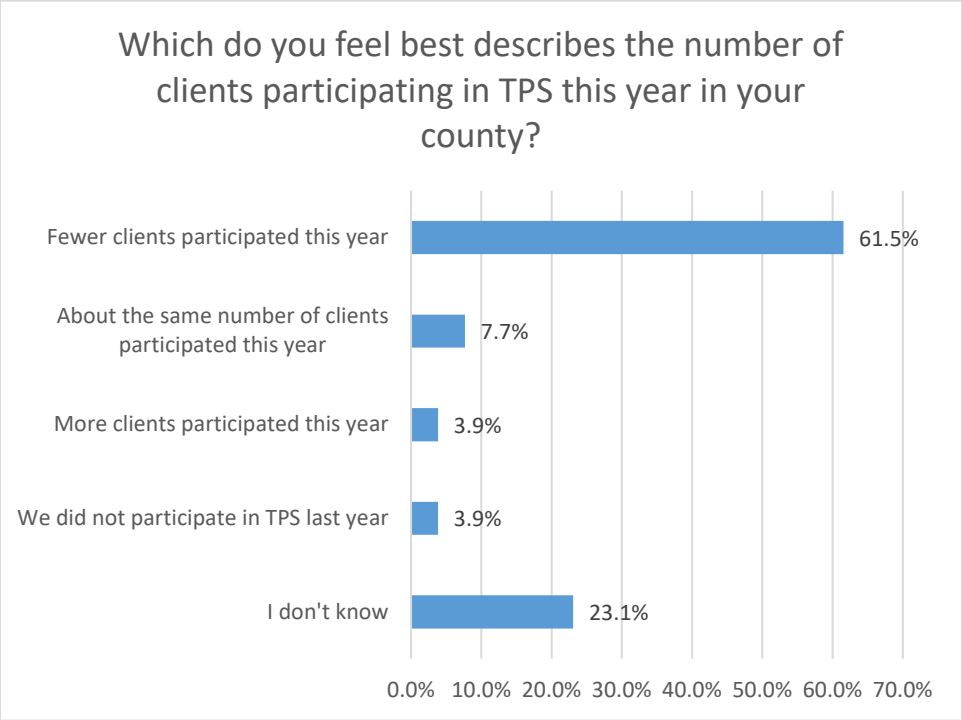
Respondents indicating "Other" noted that the following were also helpful:

- "UCLA check-ins and response turnaround"
- "Program specific codes"
- "Our county contact [name] was always very helpful and responsive"
- "Communication"



Which do you feel best describes the number of clients participating in the TPS this year in your county?

The majority of respondents (61.5%) indicated that fewer clients participated in 2020 than in prior years.



If the number of clients was higher or lower this year, why do you think that is?

For respondents who thought that the number of clients participating in the TPS was lower this year in their county, most cited the COVID-19 pandemic as a primary reason, resulting in:

- Fewer clients/referrals overall
- Fewer clients being seen face-to-face
- Less ability to engage with clients overall
- Reduced ability to use paper form (due to remote services) resulting in decreased response rate

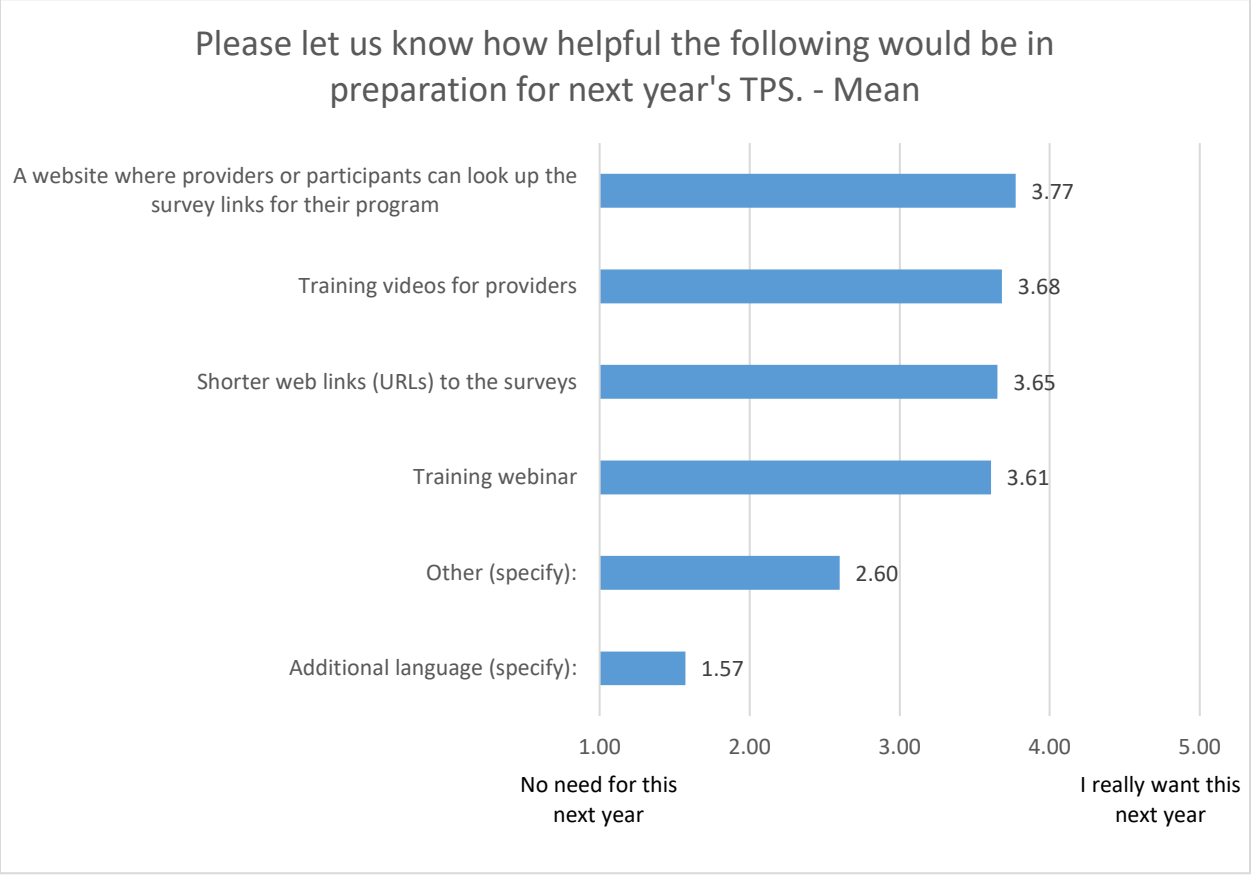
Respondents noted that clients might have experienced challenges utilizing the new survey methods and that providers had a short amount of preparation time in order to conduct the TPS.

Please let us know how helpful the following would be in preparation for next year's TPS.

Respondents indicated that the most helpful types of assistance for the 2021 TPS implementation would be: a website where providers or participants can look up the survey links for their program (mean of 3.77, on a scale from 1=no need for this next year to 5=I really want this next year); training videos for providers (mean of 3.68), and shorter web links to the surveys (mean of 3.65). Additional suggestions included:

- Phone codes available sooner
- Daily counts on phone surveys

- Advice on best methods to encourage clients to take the online surveys
- A website, although the respondent questioned what could be done to make sure the providers/participants get to the correct program link
- Training webinar to be used for staff/providers

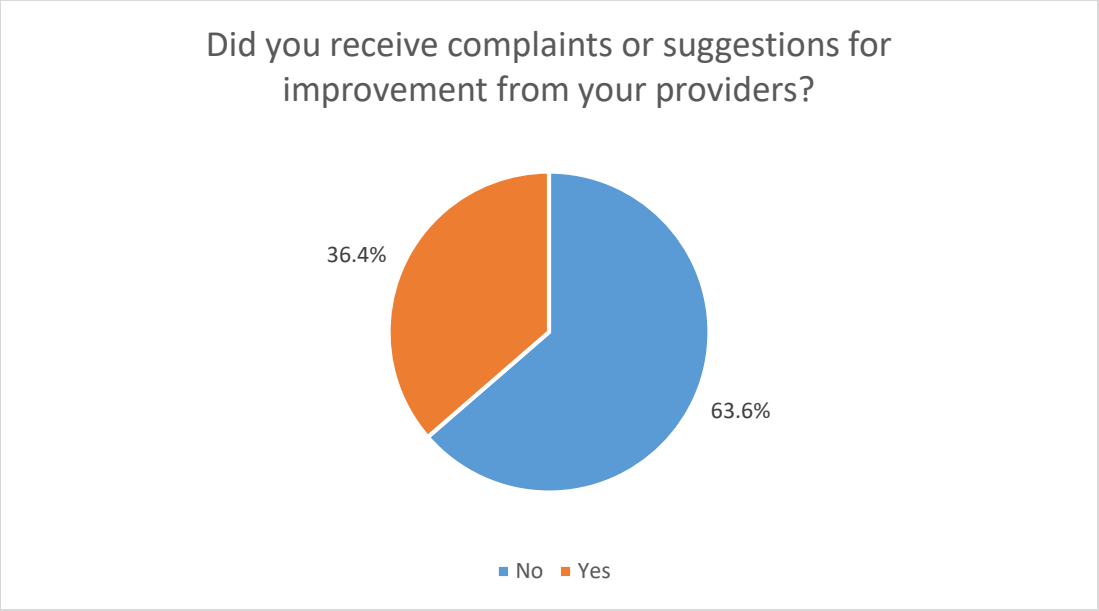


Did you receive complaints or suggestions for improvement from your providers?

The majority of respondents indicated they did not receive complaints or suggestions from improvement from their providers.

Among the suggestions for improvement were the following:

- Providers requested shorter URL links so that clients could enter the URLs more easily than using the long generated Qualtrics survey URLs.
- One respondent noted that clients may have concerns about privacy or data security when using an online survey, and suggested UCLA come up with a solution to help clients feel more comfortable taking the online survey.
- One provider experienced issues with the online data entry form for entering paper surveys – the website would time out on some surveys but not others.



From the county, provider, and/or client perspective(s), what worked well (e.g., training providers, preparing the paper surveys, surveying Zoom groups, fliers, multiple options)?

UCLA-ISAP's role in the TPS administration was frequently praised by survey respondents. Aspects of the implementation that were helpful or worked well included:

- Having multiple survey options available (online, paper, phone)
- Customized program codes
- Training materials (webinar and PowerPoint slides)
- Communication/responsiveness of UCLA-ISAP in answering questions
- Ability to add supplemental questions to the survey
- Flier templates
- Short length of the TPS

What could UCLA do to help improve county administrators' experience of conducting the TPS?

Suggestions from respondents included:

- Allow more than one county staff person to have access to Box to receive open-ended comments.
- Provide greater advance notice with information to prepare providers (earlier dissemination of links and phone access numbers).
- Consider methods to increase client engagement in the online survey.
- Consider other communication forms such as webinars to discuss process.

- Continue to allow the flexibility to administer supplemental questions in future years.
- Update the slides as needed.
- Provide shorter online survey links.
- Provide fliers for each clinic.

Next steps

The feedback provided by county/regional model TPS teams will used to improve the survey data collection methods, administration procedures, and regional model/county/provider resource materials for the 2021 and subsequent survey periods.

APPENDIX B:
Additional Figures and Tables

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

County	Number of Respondents	Percent
Alameda	430	3.2%
Contra Costa	294	2.2%
El Dorado	70	0.5%
Fresno	263	1.9%
Imperial	187	1.4%
Kern	564	4.2%
Los Angeles	3,740	27.6%
Marin	112	0.8%
Merced	91	0.7%
Monterey	234	1.7%
Napa	81	0.6%
Nevada	50	0.4%
Orange	473	3.5%
Placer	3	0.0%
Riverside	1,035	7.6%
Sacramento	497	3.7%
San Benito	22	0.2%
San Bernardino	563	4.2%
San Diego	1,370	10.1%
San Francisco	802	5.9%
San Joaquin	184	1.4%
San Luis Obispo	213	1.6%
San Mateo	181	1.3%
Santa Barbara	375	2.8%
Santa Clara	59	0.4%
Santa Cruz	172	1.3%
Stanislaus	411	3.0%
Tulare	177	1.3%
Ventura	239	1.8%
Yolo	96	0.7%
PHC Regional Model	388	2.9%
Missing county name	154	1.1%
Total	13,530	100.0%

Table 2. Survey Responses by Treatment Program – Adults

	N	Percent
Treatment Program*		
Outpatient/intensive outpatient	352	47.2%
Residential	237	31.8%
Narcotic/opioid treatment program	124	16.6%
Withdrawal management (standalone)	29	3.9%
Missing**	3	0.4%
Total	745	100.0%
Number of respondents		
Outpatient/intensive outpatient	5,659	43.0%
Residential	3,318	25.2%
Narcotic/Opioid treatment program	3,796	28.8%
Withdrawal management (standalone)	157	1.2%
Missing**	233	1.8%
Total	13,163	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.

**Includes records where CalOMS-Treatment Provider ID or treatment setting were missing in the phone or the online survey.

Table 3. Survey Respondents by Treatment Program – Youth

	N	Percent
Treatment Program*		
Outpatient/intensive outpatient	69	87.3%
Residential	9	11.4%
Missing**	1	1.3%
Total	79	100.0%
Number of respondents		
Outpatient/intensive outpatient	316	86.1%
Residential	29	7.9%
Missing**	22	6.0%
Total	367	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.

**Includes records where CalOMS-Treatment Provider ID or treatment setting were missing in the phone or the online survey.

Table 3. Demographic Characteristics - Adults (N=13,163)

	N	Percent
Gender (Multiple responses allowed)		
Female	5,032	38.2%
Male	7,398	56.2%
Transgender	65	0.5%
Other gender identity	67	0.5%
Decline to answer/missing	638	4.8%
Age Group		
18-25	1,039	7.9%
26-35	4,249	32.3%
36-45	3,242	24.6%
46-55	2,032	15.4%
56+	1,831	13.9%
Decline to answer/ missing	770	5.8%
Race/ethnicity (Multiple responses allowed)		
American Indian/Alaska Native	359	2.7%
Asian	233	1.8%
Black/African American	928	7.1%
Latinx	2,093	15.9%
Native Hawaiian/Pacific Islander	142	1.1%
White	4,520	34.3%
Other	1,141	8.7%
Missing	4,483	34.1%
How long received services here		
First visit/day	531	4.0%
2 weeks or less	1,315	10.0%
More than 2 weeks	10,747	81.6%
Missing	570	4.3%
Surveys received by language		
Eastern Armenian	1	0.0%
English	12,773	97.0%
Hmong	1	0.0%
Spanish	387	2.9%
Vietnamese	1	0.0%

Table 5. Demographic Characteristics – Youth (N=367)

	N	Percent
Gender (Multiple responses allowed)		
Female	106	28.9%
Male	234	63.8%
Other gender identity	7	1.9%
Decline to answer/missing	21	5.7%
Age Group		
12-14	31	8.4%
15-16	165	45.0%
17+	139	37.9%
Missing*	32	8.7%
Race/ethnicity (Multiple responses allowed)		
American Indian/Alaska Native	11	3.0%
Asian	9	2.5%
Black/African American	21	5.7%
Latinx	143	39.0%
Native Hawaiian/Pacific Islander	5	1.4%
White	61	16.6%
Other	40	10.9%
Unknown/missing	110	30.0%
How long received services here		
Less than 1 month	73	21.5%
1-5 months	160	47.1%
6 months or more	89	26.2%
Missing	18	5.3%
Surveys received by language		
English	363	98.9%
Spanish	4	1.1%

*Includes EPSDT youth ages 18-20 who received services in youth programs

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 (0.5)	95.9%
Residential	4.3 (0.7)	89.6%
Narcotic/opioid treatment program	4.4 (0.6)	94.7%
Withdrawal management (standalone)	4.4 (0.6)	94.3%
Total	4.4 (0.6)	94.0%

*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=11,644).

**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=11,644).

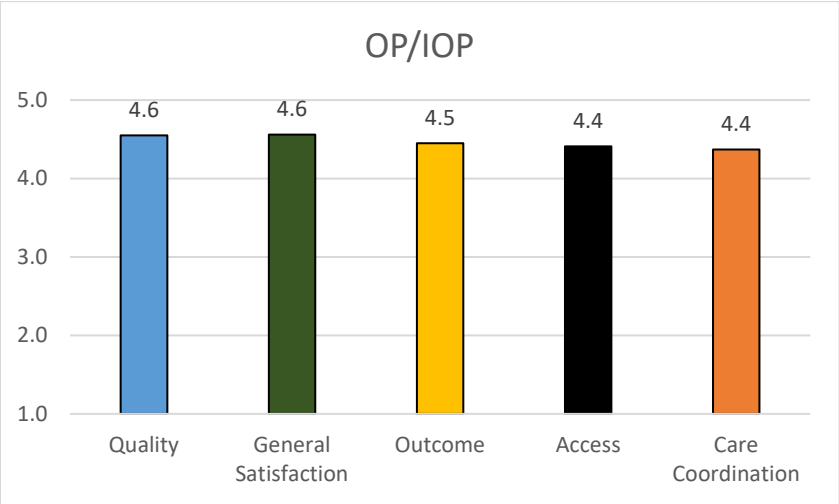
Table 7. Average Score and Percent of Positive Scores by Treatment Setting –Youth

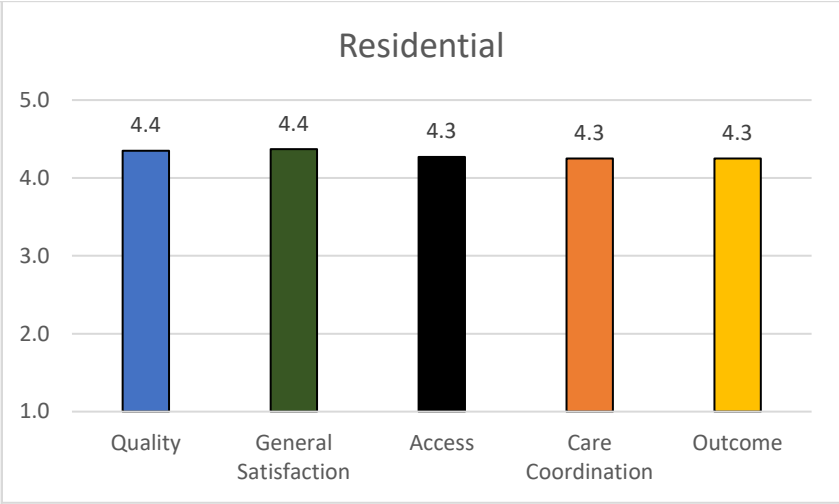
	Average score* (Standard deviation)	Percent of respondents with positive score**
Outpatient/intensive outpatient	4.4 (0.5)	93.9%
Residential	4.1 (0.7)	80.0%
Total	4.4 (0.6)	93.2%

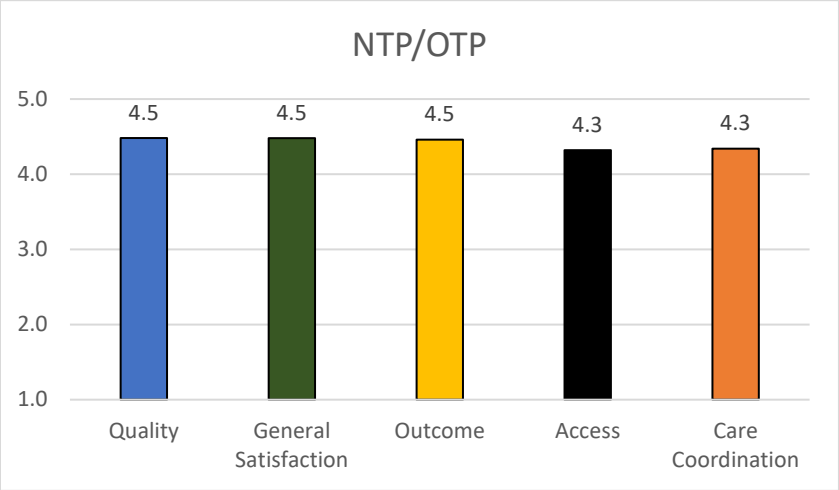
*All 18 questions were used to calculate the average score (and standard deviation). Scores ranged from 1.5 to 5.0 with higher scores indicating greater satisfaction. Only clients who responded to all 18 questions were included (N=308).

**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=308).

Figure 1. Average Scores of All Counties by Treatment Setting and Domain–Adults
(Highest to Lowest)







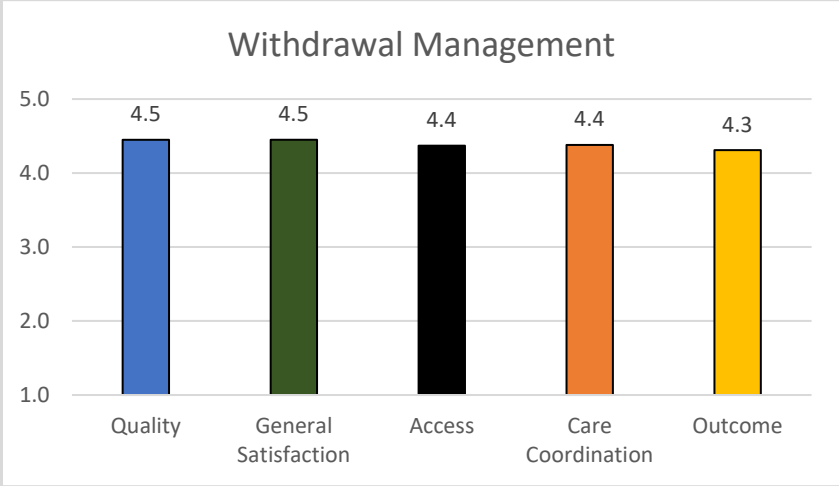
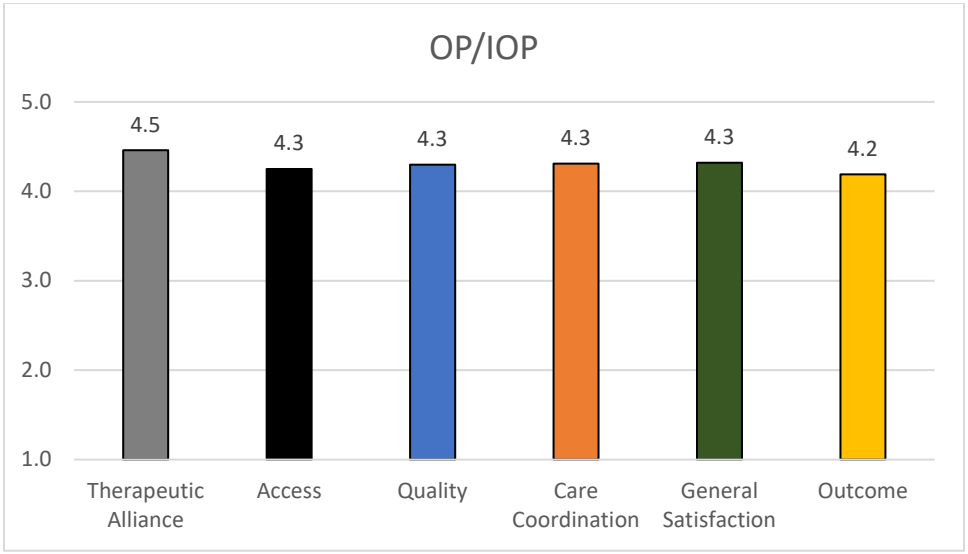
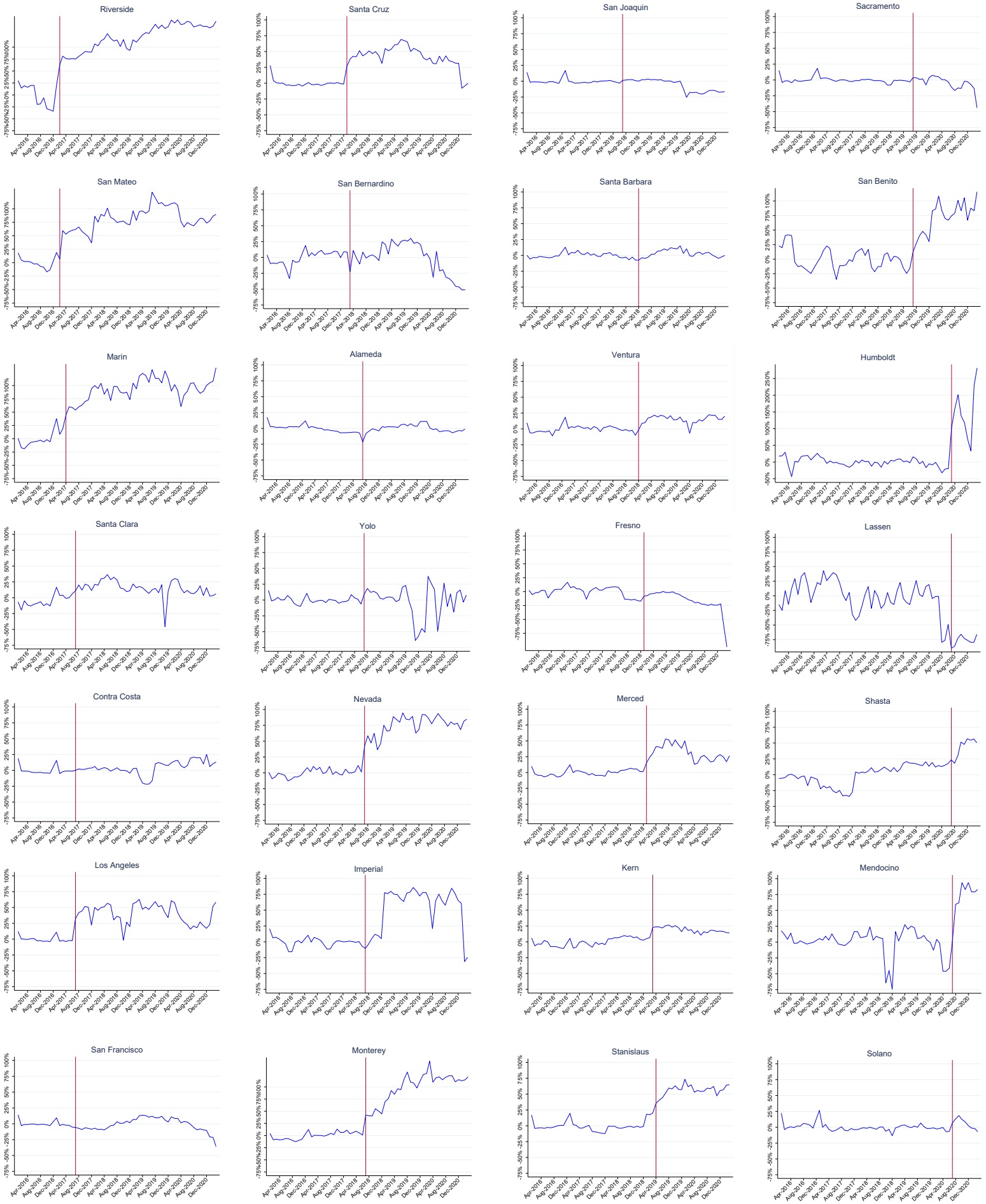


Figure 2. Average Scores of All Counties by Treatment Setting and Domain–Youth (Highest to Lowest)



APPENDIX C:
Drug Medi-Cal Claims and CalOMS Graphs

Figure A: Unique number of patients receiving services before and after Go Live date by county – DMC Claims.

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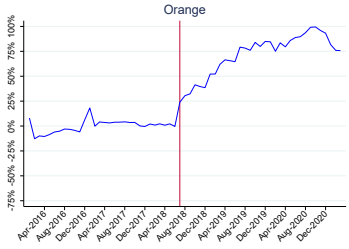
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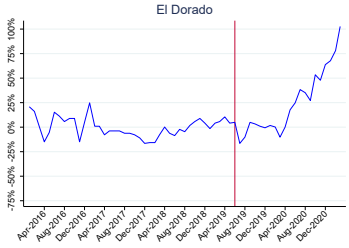
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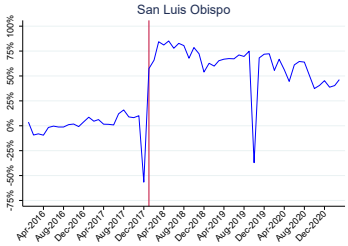
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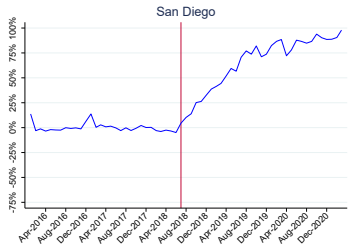
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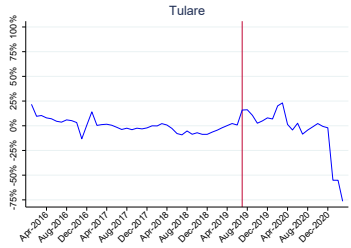
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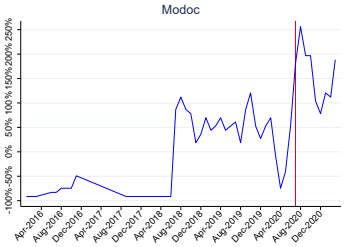
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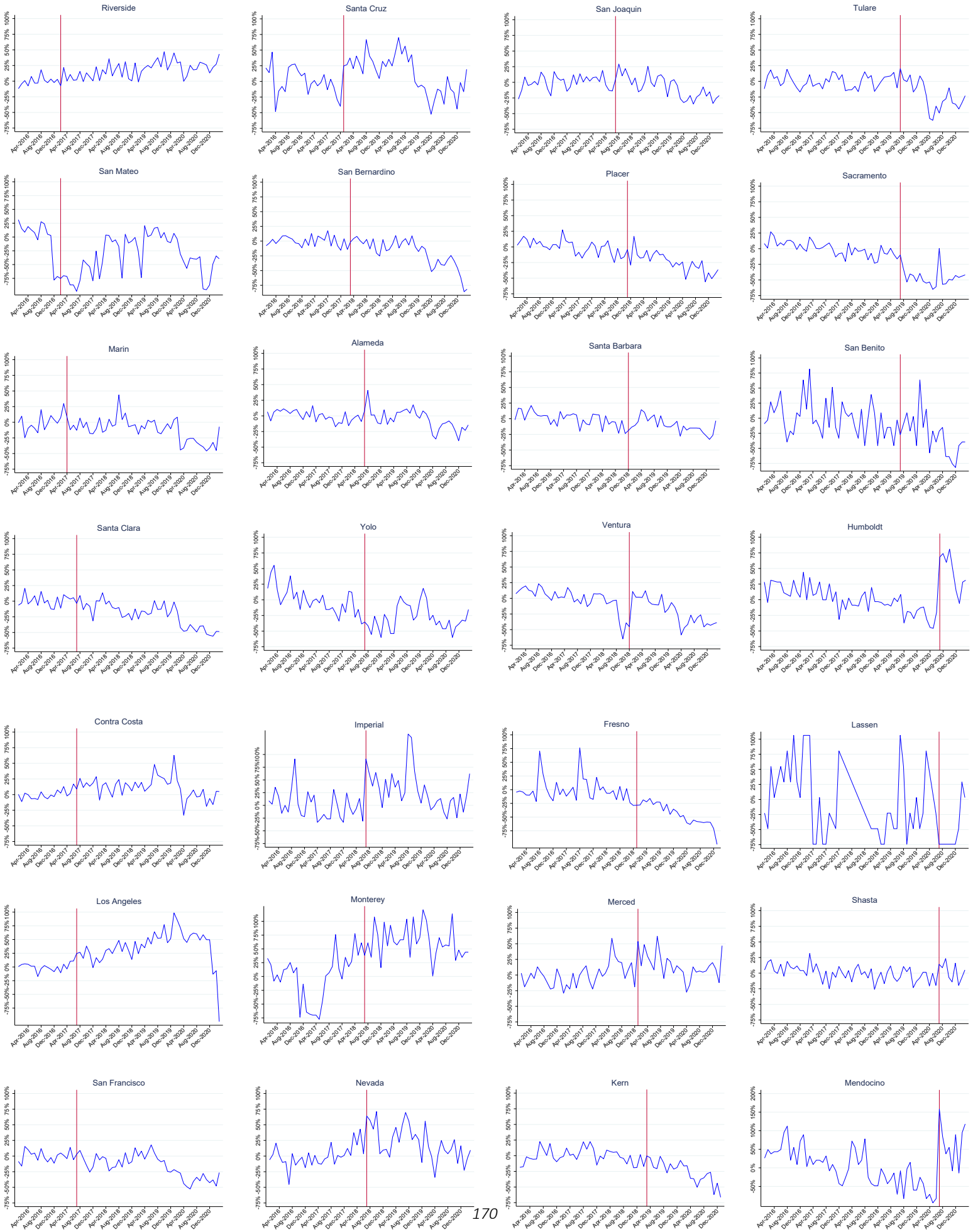
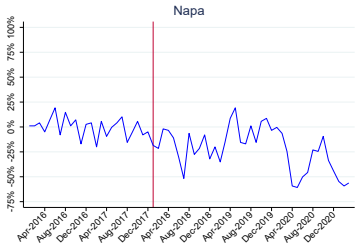
Figure B: Unique number of patients receiving services before and after Go Live date by county – CalOMS-Tx.

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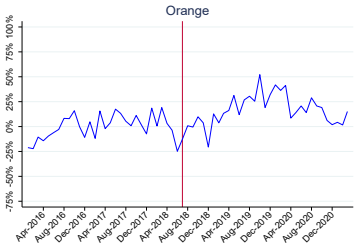
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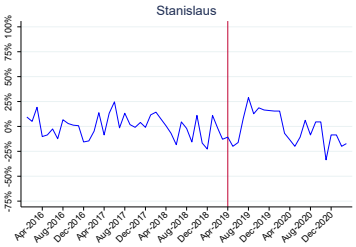
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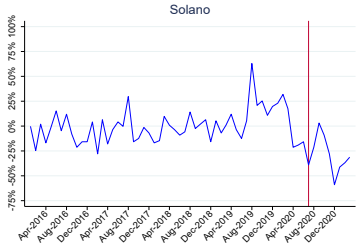
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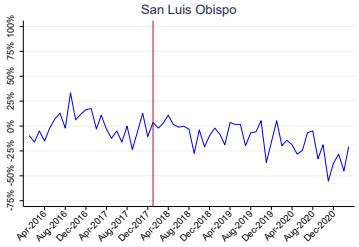
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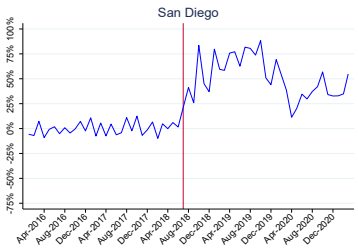
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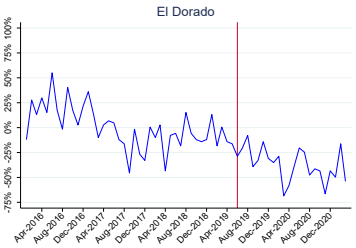
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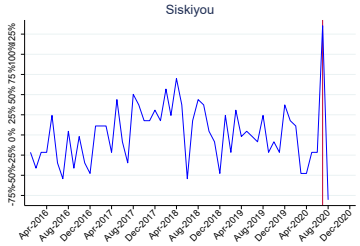
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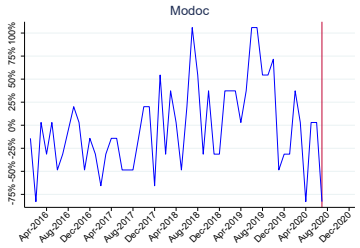
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APPENDIX D:
Aggregated Access Figures

Figure A. Unique number of patients receiving services before and after Go Live date aggregated over all DMC-ODS waiver counties – DMC claims data

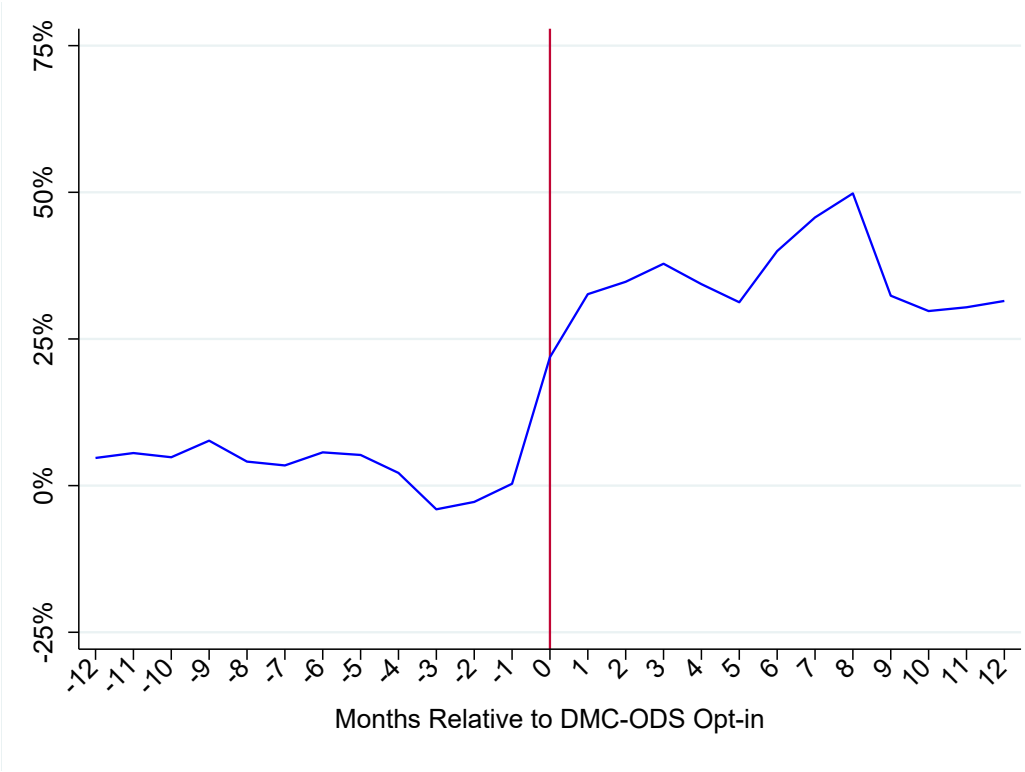
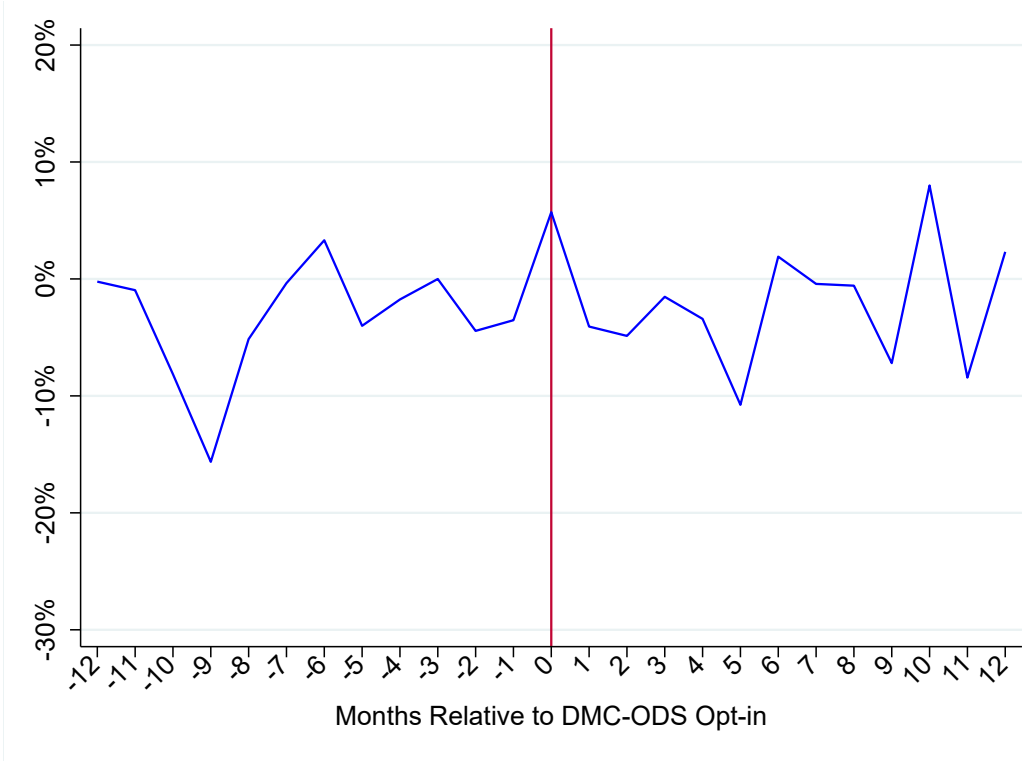


Figure B. Unique number of patients receiving services before and after Go Live date aggregated over all DMC-ODS waiver counties – CalOMS-Tx data



APPENDIX E:
Stanislaus County Continuity of Care

Continuity of Care

Stanislaus County Behavioral Health and Recovery Services (BHRS) will utilize Case Management services; specifically care coordination, and the Care Coordination Team (CCT) for continuity of care throughout the Drug Medi-Cal Organized Delivery System (DMC-ODS.) The CCT and providers will utilize care coordination services to ensure seamless and successful transitions between levels of care without disruption of services and ensure that beneficiaries have access to recovery supports and services necessary with the goal of sustained engagement and long-term retention in treatment.

BHRS utilizes the "no wrong door" approach for beneficiary access to services and is equipped to generate a referral for DMC-ODS services from various entry points including the BHRS Access Line, community agency referral, walk-ins to treatment programs and through outreach and engagement services. Beneficiaries, no matter their entry point, will be triaged by trained staff using the Level of Care Indicator- Brief Screen (LOCI-brief) and will be scheduled for a comprehensive assessment appointment. The beneficiary will be offered the first available appointment however appointment scheduling and location can also be based on possible service referral indicated through the LOCI-Brief screening (i.e.: Medication Assisted Treatment, Perinatal, etc.,) as well as client preference.

Qualified staff will conduct a SUD comprehensive assessment to identify and determine medical necessity and level of care for treatment placement. The assessor, in collaboration with the treatment provider, will make arrangements for the beneficiary's intake into the appropriate level of care.

Upon entering treatment, at any level of care, qualified staff will work with the beneficiary to develop a treatment plan based on individualized needs for SUD treatment as well as other areas of concern (i.e.: example: medical care, mental health, housing/living environment, and social support.) The beneficiary's treatment plan will be revised as needed (change to area of concern, to add or remove areas, and at level of care changes.)

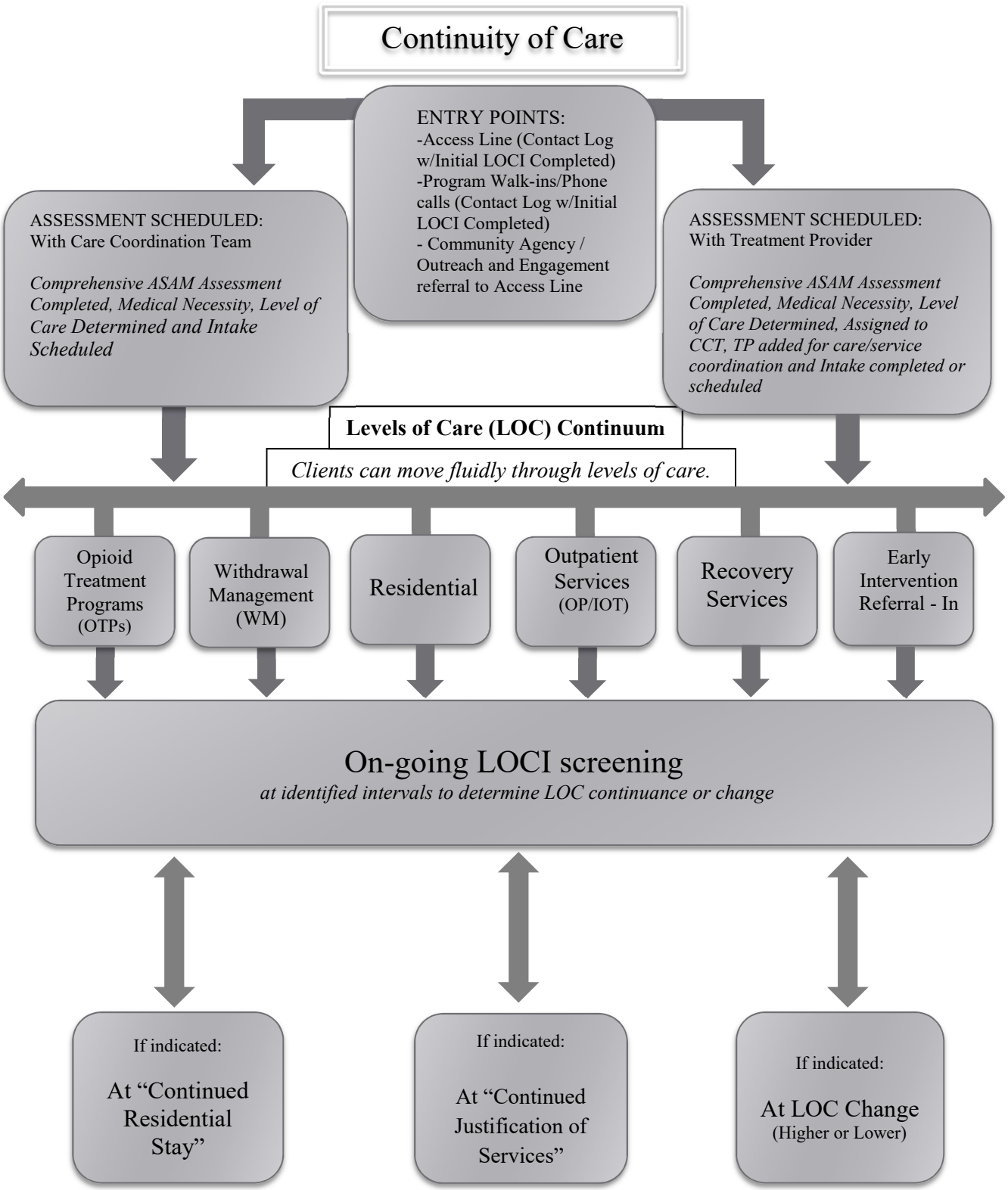
The follow-up LOCI-Brief Screening will also be completed at counselor's discretion and at required intervals as follows:

- Continued residential stay request (see Residential Authorization Request Flow Chart & Process)
- Making a change to either a higher or lower level of care
- When the Continued Justification of Services Assessment is conducted. For all outpatient programs at 5-6 months, and for opioid treatment program at 11-12 months. (See Documentation Timeline Document for details)

When it is indicated that a beneficiary would benefit from transitioning to another level of care (higher or lower) staff will use a "warm hand-off" referral to successfully transition the beneficiary to the new provider.

Continuity of Care

Throughout the beneficiary's treatment episode providers, as well as the CCT, will provide care coordination services as they transition throughout the continuum of care. These services will help ensure beneficiaries are effectively navigating the system of care and are intended to encourage client engagement and to improve success in treatment episodes and overall wellness.



Continuity of Care

*****DISCLAIMER*****

These guidelines are a living document and will be amended as needed, based on changes made by DHCS as well as any internal program requirements implemented. Please keep in mind that DHCS sets the minimum requirements and the County can impose standards above and beyond DHCS' guidance. These guidelines are based on the current understanding of DHCS regulations as well as the County's agreement with the State on what will be provided.

03/01/19 dv

APPENDIX F:
Stanislaus County Residential Authorization Process

Substance Use Disorders (SUD) Residential Authorization Process

****For Medi-Cal Beneficiaries Only****

Initial SUD Residential Authorization Request from SUD assessment to UM

- Client has been screened, assessed, and it has been determined that the client needs SUD residential level of care according to ASAM and DSM V medical necessity. Including LPHA confirmation of medical necessity.
- Requesting program will inquire if the client has received Residential services in the current calendar year, noting dates, and quantity of residential stays. If client has used max residential stays for the year, program will consider other appropriate treatment levels.
- *SUD UMAD (SUD UM Authorization Review)* is initiated by the requesting program, requesting SUD residential authorization by adding the **UM SUD Authorizer 7720** as a signatory.
- Requesting program will check authorizations in the EHR within one business day to ensure one has been entered.

UM Authorization process

- Upon receiving *SUD UMAD (SUD UM Authorization Review)*, UM staff will review residential episodes for the current calendar year to determine eligibility for a new authorization.
- Residential authorization must be completed by the designated BHRS UM staff within 24 hours of request for authorization.
- If client is eligible for a residential stay, UM will enter an authorization for 90 days. (Please note that residential stays beyond 30 days, requires continued stay review)
- If Residential Authorization is not approved the BHRS UM staff will complete the *SUD UMAD (SUD UM Authorization Review)*, documenting that the authorization was denied due to max stays in the calendar year and a send out appropriate NOABD. UM will then assign the **SUD Residential Review 7070** to the *SUD Residential Review Form* triggering the designated staff to review client's case for eligibility of alternative funding.

Authorization Denied Due to Max Stays- Care Coordination LPHA role

- The **SUD Residential Review 7070** will review the UM denials daily, reviewing each client case to determine if use of other funding source is appropriate.

- If it is determined that another funding source is appropriate the Residential Review designee will notate decision on the *SUD Residential Review Form* and final approve.
- Residential Review designee will then enter appropriate funding source authorization and update financials to reflect appropriate funding source. Residential Review designee will assign a point person to follow up with financials upon conclusion of the residential stay.
- If it is determined that another funding source is not appropriate, the Residential Review designee will then respond to the program accordingly.

Requesting a Continued Residential Stay- Contract Monitor for contractors and BHRS programs internal program review

- Requesting program will review and determine the need for continued residential stay within 21 days of admission. Once it has been determined that a continued residential stay is necessary and medical necessity is confirmed the requesting staff/program will:
    - Completed and final approve Level of Care Indicator-Brief.
    - Complete *SUD Residential Review Form* including justification for the need of additional 30 days of residential treatment.
    - Contract programs will email the Contract Monitor with MR#, requesting a review of the SUD Residential Review.
    - BHRS programs will assign the program LPHA to review internally.
- The Contract Monitor or BHRS program LPHA will document decision for continued stay request in the *SUD Residential Review Form.*
- Second extension requests will follow the above process and must be requested within 42 days of admission, if needed.

The Authorization Period

- The authorization will remain open through the length of the authorization period if client remains open to Care Coordination. Clients meeting criteria, are able enter any Stanislaus County DMC-ODS residential facility within the 90-day authorized period.

Substance Use Disorders (SUD) Residential Authorization Process

For Medi-Cal Beneficiaries Only

- One authorized period will be considered one residential stay.
- If client is closed from a program, prior to the end of the 90 authorization, staff will need to close the assignment, but leave the authorization untouched, as the authorization will automatically end day 90.
- If the client returns to treatment within the 90 days of authorization and is open to Care Coordination, staff will do the following:
    - Complete a Level of Care Indicator-Brief, establishing need for level of care.
    - Complete the client assignment to the appropriate Residential subunit.
    - No other authorization steps will need to be completed by staff as authorization will already be in the system.

APPENDIX G:
Partnership HealthPlan of California (PHC)
Table and Figures

Table A

- T40.0 Poisoning by, adverse effect of and underdosing of opium
- T40.1 Poisoning by and adverse effect of heroin
- T40.2 Poisoning by, adverse effect of and underdosing of other opioids
- T40.3 Poisoning by, adverse effect of and underdosing of methadone
- T40.4 Poisoning by, adverse effect of and underdosing of other synthetic narcotics
- T40.5 Poisoning by, adverse effect of and underdosing of cocaine
- T40.6 Poisoning by, adverse effect of and underdosing of other and unspecified narcotics
- T40.7 Poisoning by, adverse effect of and underdosing of cannabis (derivatives)
- T40.8 Poisoning by and adverse effect of lysergide [LSD]
- T40.9 Poisoning by, adverse effect of and underdosing of other and unspecified psychodysleptics [hallucinogens]
- T42.3 Poisoning by, adverse effect of and underdosing of barbiturates
- T42.4 Poisoning by, adverse effect of and underdosing of benzodiazepines
- T43.62 Poisoning by, adverse effect of and underdosing of amphetamines
- T43.63 Poisoning by, adverse effect of and underdosing of methylphenidate
- T51.0 Toxic effect of ethanol
- T51.9 Toxic effect of unspecified alcohol

Figure A

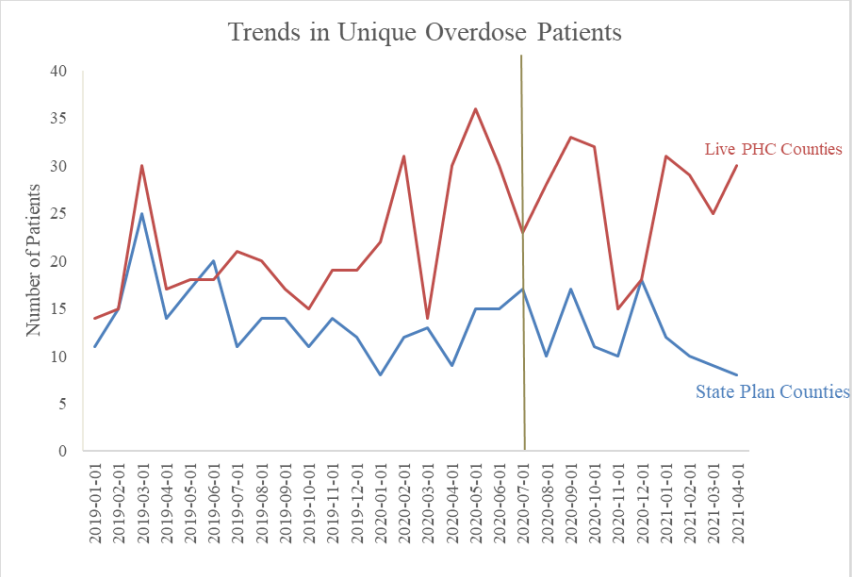


Figure B

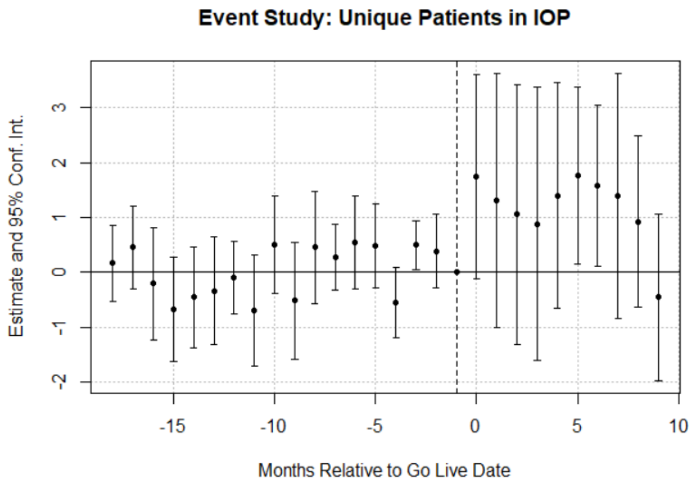


Figure C

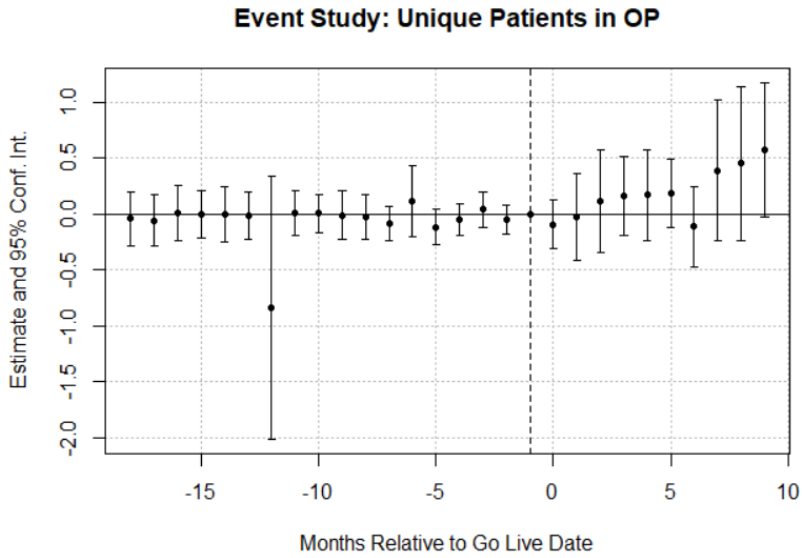
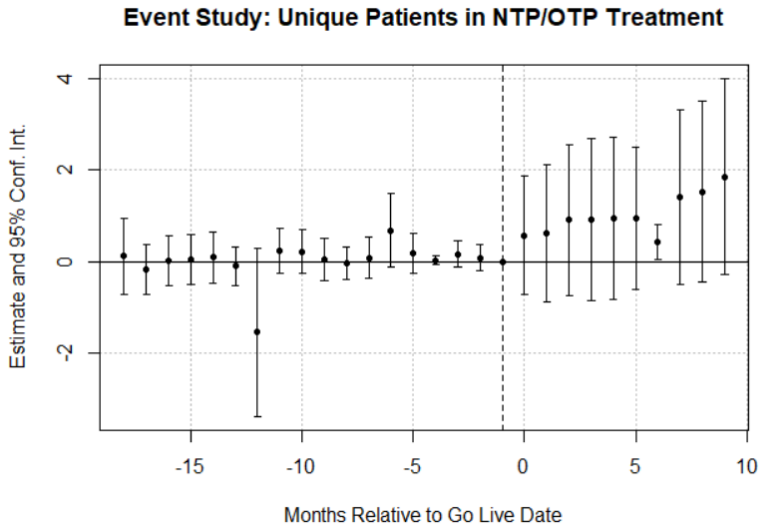


Figure D


Event Study: Unique Patients in NTP/OTP Treatment
Estimate and 95% Conf. Int.
4
2
0
-2
-15
-10
-5
0
5
10
Months Relative to Go Live Date