

EVALUATION SERVICES TO ENHANCE THE DATA MANAGEMENT SYSTEM IN CALIFORNIA (EnCAL)

2009-2010: A SERIES OF REPORTS

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Integrated Substance Abuse Programs

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Executive Summary

A top priority of the California Alcohol and Drug Programs (ADP) is to improve the accountability of the alcohol and other drug (AOD) treatment system in California in terms of ensuring quality services and effective client outcomes.

As the University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) and ADP have worked together over the last decade to evaluate and enhance data management of AOD services and client outcomes across California, as reflected within the CalOMS-Tx data system, more recent work from 2009–2011 is in support of establishing a more effective AOD system under a continuum-of-services (COSSR) framework. Within the proposed work plan, entitled “Evaluation Services to Enhance the Data Management System in California (EnCAL),” four objectives were identified to assist ADP in this effort to enhance the current system of care as we adapt to delivering substance use services under a chronic care model.

- Objective 1: Examine CalOMS Tx data to enhance AOD treatment services and client outcomes in California
- Objective 2: Enhance CalOMS Tx system to include performance measurement/management data.
- Objective 3: Enhance CalOMS Tx system to include performance and outcome measurement in support of the Continuum of Services System Re-engineering (COSSR)
- Objective 4: Increase the capacity of AOD stakeholders (California ADP, county administrators, and providers) to understand how to apply performance and outcome data to improving the quality of treatment services

Within this report, you will find a series of five reports summarizing findings from the first year of work (2009–2010) and recommendations to consider for future work. Each report addresses one or more of the objectives listed above and is organized with an Introduction, Processes and/or Findings, and Summary and Recommendations.

REPORT 1:

DATA ANALYSIS REPORT

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Integrated Substance Abuse Programs

1.1 INTRODUCTION

A top priority of the California Department of Alcohol and Drug Programs (ADP) is to improve the accountability of the alcohol and other drug (AOD) treatment system in California in terms of ensuring quality services and effective client outcomes. In 2009, ADP's Office of Applied Research and Analysis (OARA) approved a UCLA work plan designed to help ADP address several objectives in line with this priority. One of these objectives was to examine California Outcomes Measurement System – Treatment (CalOMS-Tx) data to enhance AOD treatment services and client outcomes in California. This report reviews the results of the first year of CalOMS-Tx data analysis. Additional work is planned for the second year and will be reported in 2011.

1.2 PROCESS / FINDINGS

Methods

Except where otherwise stated, analyses reported below were conducted with the treatment *admission* as the unit of analysis (as opposed to the unique client or episode). This unit of analysis was chosen because our focus was on describing the functioning of the treatment system. Although each client may appear more than once in the system, each admission represents a demand upon and a response by that system.

One exception to this rule occurred for analyses of transfers between services. In these cases, the unit of analysis was the treatment *episode*, defined as a series of two or more treatment “service sets” (admissions and discharges) separated by no more than 30 days between a discharge and an admission to a subsequent service. A “transfer” between services is said to occur when these conditions are met. However, for the purposes of these analyses, transfers to treatment were the key area of concern. Detoxification, in and of itself, does not constitute complete treatment. Therefore, occurrences of one detoxification service followed by another detoxification service were not counted as transfers to treatment.

Analyses were conducted on all admissions recorded in CalOMS-Tx that dated from July 1, 2008, through June 30, 2009, inclusive. All available discharges associated with these admissions were included in analyses. UCLA received the CalOMS-Tx data from ADP on December 15, 2009; therefore any discharges recorded in CalOMS-Tx after this date are not included in these analyses.

Results reported below are organized by the research questions posed by ADP in the order in which they appear in the revised research questions agreed upon in January 2010.

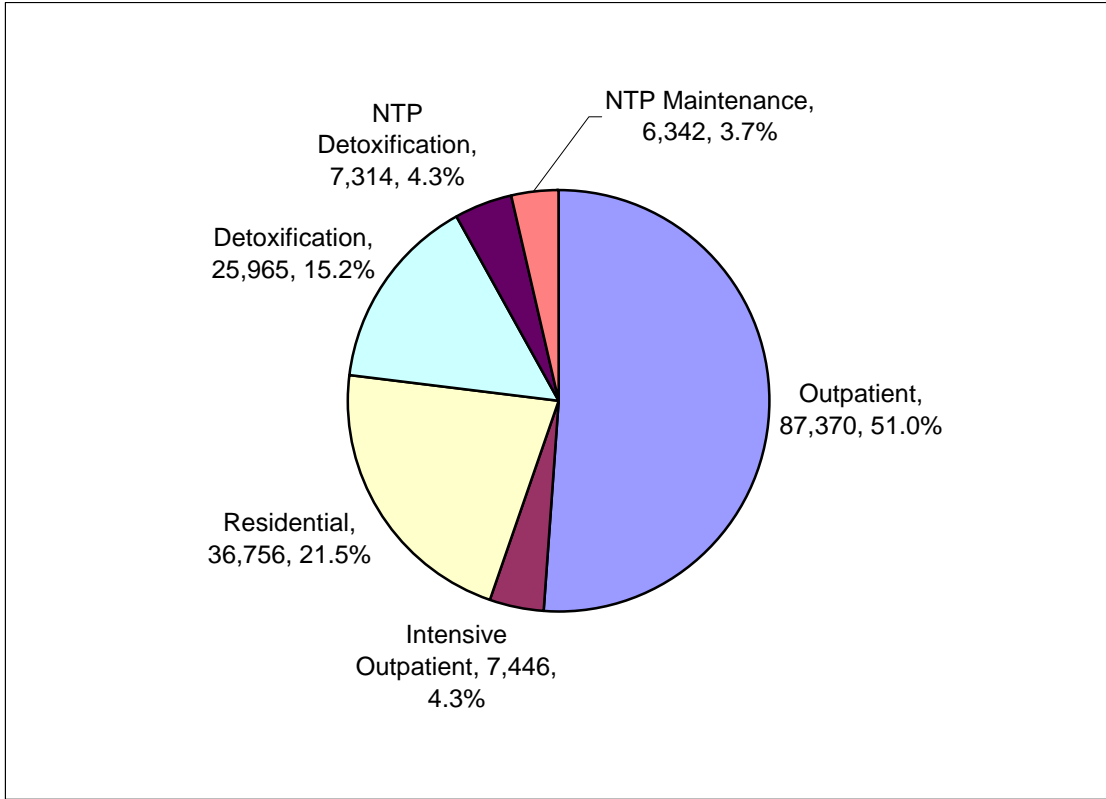
Results

What is the frequency of admissions for each type of service?

About half of all treatment admissions in FY 2008–2009 were to outpatient services, followed by

residential, detoxification, intensive outpatient, Narcotic Treatment Program (NTP) detoxification, and NTP maintenance (see Figure 1.1).

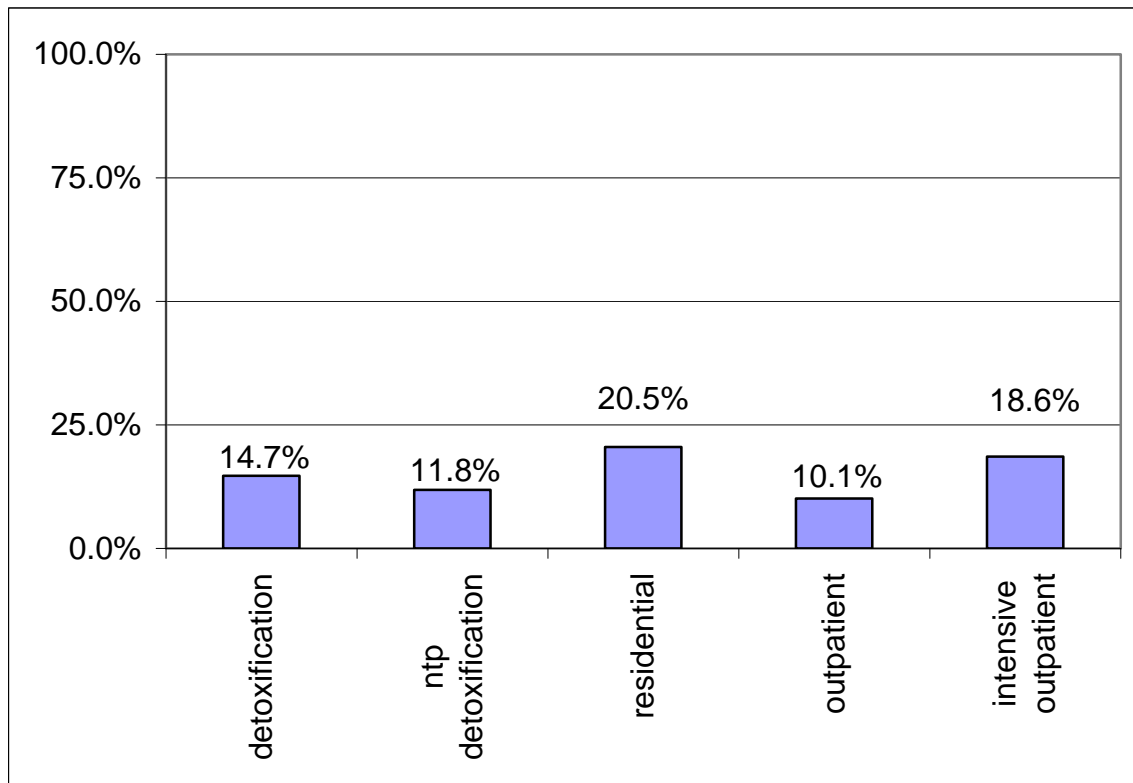
Figure 1.1. Frequency of admissions by type of service.



What percentage of service sets end in a transfer to another service within 30 days?

Transfers to another service were least common from outpatient treatment (10.1%) and most common from residential treatment (20.5%). See Figure 1.2.

Figure 1.2. Percentage of transfers within 30 days by initial treatment modality.



Note: detoxification-to-detoxification movements are not counted as “transfers.”

What percentage of admissions are transferred from specific service types to other specified types (e.g., from detoxification to outpatient, detoxification to residential, or detoxification to another detoxification)

Consistent with previous findings (Rawson et al., 2008), most treatment admissions did not result in a transfer to another treatment. As a proportion of admissions, the most common type of transfer from one modality to another was from intensive outpatient to outpatient treatment (12.1% of intensive outpatient admissions), followed by transfers from non-NTP detoxification to residential treatment (11.8%), transfers from residential treatment to outpatient treatment (9.9%), and transfers from NTP detoxification to NTP maintenance (9.6%). All of these represent logical progressions through a continuum of care from detoxification to treatment or from more to less intensive treatment. However, re-admissions to the same type of treatment also occurred for non-NTP detoxification (11.3%), NTP detoxification (9.7%), residential treatment (7.0%), and outpatient treatment (5.5%).

Anecdotal evidence suggests that an unknown number of treatment programs do provide both detoxification and residential treatment at one facility but do not submit a new CalOMS record when the transfer occurs. To the extent that this occurs, transfers may be underrepresented.

Table 1.1. Percentage of admissions transferred by types of service.

		Transferred to						
		NTP Maintenance	Non-NTP Detox	NTP Detox	Outpatient	Residential	Intensive Outpatient	Nothing
Transferred from	Non-NTP Detox	0.3%	11.3%	0.4%	2.7%	11.8%	0.2%	73.4%
	NTP Detox	9.6%	1.3%	9.7%	1.3%	0.8%	0.1%	77.2%
	Residential	0.2%	1.5%	0.1%	9.9%	7.0%	1.8%	79.5%
	Outpatient	0.2%	1.1%	0.1%	5.5%	2.7%	0.5%	89.9%
	Intensive Outpatient	0.2%	1.8%	0.0%	12.1%	4.4%	0.1%	81.4%

What percent receive only detoxification services? How many times do they cycle through detoxification only?

Eighty-five percent of detoxification and 88.2% of NTP detoxification admissions were detoxification-only (no transfer to a non-detoxification service). This represented 19.1% of all eligible admissions.

What is the median number of days between discharge from one service set and admission to the next, among those with episodes consisting of more than one service set? Compare these to Washington Circle recommendations.

The mean number of days between services sets during a transfer was 6.8. The median was 3.0 days. These are far below the Washington Circle definition of transfers from detoxification occurring within 14 days (Garnick et al., 2009). In part, the numbers are low because a portion of the transfers (5,083 out of 18,460) occurred when one treatment service set occurred entirely within another service set, for example in the sequence: Admission 1, Admission 2, Discharge 2, Discharge 1. In these cases, transfer times were considered to be zero days. If these cases are excluded, the mean number of days is 9.4. In either case, if the Washington Circle standard of 14 days were to be used, it would capture most of the transfers identified using the 30-day standard.

What are the discharge status and CalOMS-Tx outcome measures (substance use, criminal justice, employment/education, and social support involvement) for the first discharge within multiple-service episodes (i.e., when clients are being transferred)?

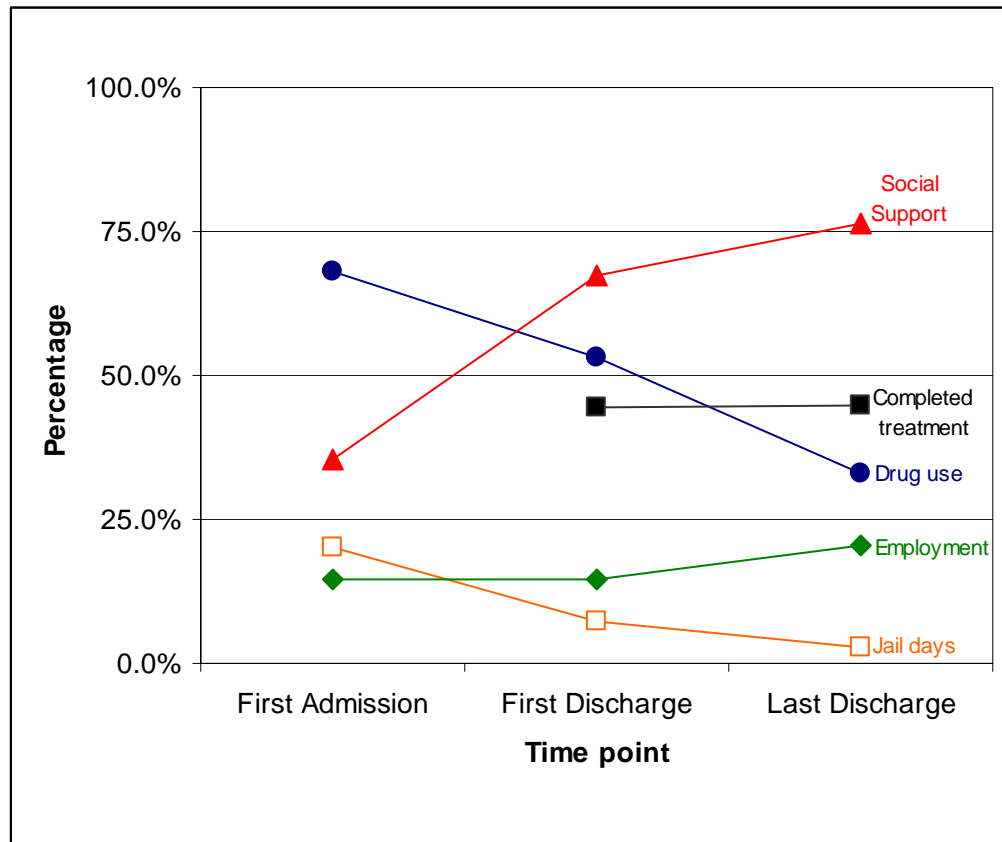
What are the discharge status and outcome measures for the last discharge within the multiple-service episode (i.e., when clients are being discharged for the last time)?

Figure 1.3 shows the trajectory of outcomes from the beginning of treatment (first admission), at the time of transfer during the treatment episode (first discharge), and at the end of treatment (last discharge). Across the episode, occurrences of social support¹ rose, drug use fell,

¹ “Social Support” is defined in CalOMS-Tx as the number of days in the last 30 days the client has participated in any social support recovery activities such as: 12-step meetings, other self-help meetings, religious/faith recovery or self-help meetings, meetings of organizations other than those listed above, or interactions with family members and/or friends supportive of recovery.

employment rose, and jail days decreased. This is consistent with progress expected as clients move through a continuum of care.

Figure 1.3. Outcome measures and discharge status for the first admission, first discharge, and last discharge within multiple-service episodes.



Do discharge and outcome measures differ depending on whether the transfer represented a step down (e.g., residential to outpatient), step up (e.g., outpatient to residential), or sideways move (e.g., residential to residential)? How do the above discharge and outcome measures compare to discharge status and outcome measures for clients discharged from single-service episodes (no transfers)?

Outcomes at the last discharge in the episode by treatment patterns are presented in Table 1.2.² The most common form of transfer was actually “sideways,” from one treatment type into the same (though potentially at a different location). The next most common was step-down (from a more intensive treatment to a less intensive one), followed by step-up. A smaller proportion transferred in multiple directions (e.g., up then down).

² This table focuses on a smaller subset of people than the previous tables and figures. Table 1.2 focuses on transfers from one treatment to another. Therefore detoxification and non-NTP detoxification, which are not considered to be treatments, are not included.

Table 1.2. Last episode discharge outcomes by treatment patterns in multiple-service treatment episodes.

	Step-Down	Sideways	Step-Up	Multiple transfer directions	Single Service
n*	2,368	4,864	1,247	940	128,156
Any drug use in 30 days prior to discharge	14.4%	21.8%	14.2%	16.8%	36.1%
Any jail days in 30 days prior to discharge	2.1%	3.1%	4.4%	3.6%	4.7%
Any social support in 30 days prior to discharge	72.2%	75.6%	89.3%	81.6%	65.5%
Employed full or part time	37.4%	25.6%	13.8%	23.3%	23.1%
Completed treatment	43.1%	41.4%	53.3%	45.6%	37.1%

* total n for treatment pattern. n's for specific measures were lower

The vast majority of clients were treated in a single service set, meaning they did not transfer to another service within 30 days of discharge. Single service clients also had the worst outcomes among any of the treatment groups. That is, compared to those who had transferred among services in any direction, single-service clients were the most likely to have used drugs, most likely to have spent time in jail, the least likely to have completed treatment, and the least likely to have received social support prior to discharge. They were also among the least likely to be employed. The only clients with lower employment were step-up clients, who were more likely by definition to have been discharged from residential treatment and therefore would be expected to have low employment as a byproduct.

The more positive outcomes among episodes with transfers suggests that transfers might be used as a proxy measure for successful “adaptive” care, meaning transfers occur as needed to adapt to clients’ current needs. The more positive outcomes among these clients suggests that such adaptive care is beneficial. However, an alternative explanation is that successful transfers tend to occur among certain types of clients (e.g., those who are more motivated or compliant), while clients with poorer prognoses drop out; the more positive outcomes of transferred clients are therefore a byproduct of selection effects rather than treatment effects. This explanation cannot be ruled out at this point. As a first step in addressing this issue, however, we describe differences in client characteristics between clients who transfer and who do not transfer in research question 5. Another, more conclusive step would be to perform a randomized controlled experiment comparing adaptive treatment and non-adaptive treatment outcomes. UCLA is in the planning stages of applying for federal funding to perform such a study.

How do the above discharge and outcome measures vary between counties? Which counties are at the top of the range?

Variations in discharge and outcome measures are shown in Tables 1.3a–1.3e. Accurately interpreting direct comparisons in outcomes across counties is difficult because each county has different types of clients and different combinations of treatment modalities, both of which can have an impact on outcome measures and discharge statuses. For more accurate comparisons, case mix adjustment needs to be used to statistically control for client characteristics, levels of functioning, environmental factors, and other variables. UCLA is currently developing case mix adjustments and will report on these efforts in the 2011 report.

With this caveat in mind, substantial variation was found between counties, in terms of not only outcomes but also in the quality of data reported at discharge. If a client died, was incarcerated, or otherwise stopped appearing for treatment and could not be located to complete a CalOMS discharge interview, an “administrative discharge” occurred. That is, providers were instructed not to guess at outcome data, and therefore only submitted a limited set of discharge information. No data was submitted on current employment or the 30-day outcome measures discussed in this section (drug use, jail days, social support) in these cases (California Department of Alcohol and Drug Programs, 2009). Counties varied widely in administrative discharge frequency, with the percentage of admissions with outcome data available at discharge ranging from as low as 17.0% to as high as 85.1%; this finding is among the variables discussed in this report. By comparison, nearly all clients had data on treatment completion (discharge status), which is submitted for both administrative and non-administrative discharges.

In counties where discharge data were available for a relatively small percentage of clients, the validity of the results below may be questionable. In particular, where large amounts of data are missing, results may be skewed in the positive direction because clients who stay in treatment are more likely to be represented in the data. Therefore, the high performing counties identified below were only among those counties that reported outcomes at treatment discharge for more than 50% of admissions. This does not mean that 50% is an optimal benchmark. This is a low number, but it is being used for this report because setting the bar higher would eliminate most counties. For example, among California’s 58 counties, only 25 reported drug use data for more than 60% of admissions and had more than 15 admissions. The lower the percentage reported under “% discharge data present” columns in Tables 1.3a–1.3e, the less confidence the reader should have in the associated outcome reported.

The county with the lowest prevalence of drug use in the 30 days preceding discharge as well discharge data reported for more than half of all admissions was El Dorado (10.6%, 59.8% reporting). The county with the highest report of drug use was Glenn (100%).

El Dorado was also the county with the lowest prevalence of jail incarceration in the 30 days preceding discharge (0.5%). The county with the highest reported jail incarceration was Del Norte (23.9%).

The county with the highest prevalence of social support in the 30 days preceding discharge was Humboldt (93.0%, 66% reporting), while the county with the lowest reported social support was Colusa (16.0%).

The county with the highest employment at discharge was Mariposa (54.0%, 63.3% reporting), while the county with the lowest reported employment was San Francisco (9.7%).

The county with the highest treatment completion rate was Marin (72.4%, 99.7% reporting). The county with the lowest reported completion rate was Del Norte (10.2%).

Table 1.3a. Drug use during 30 days prior to discharge by county

	Drug use, last 30 days	% Drug discharge data present
Tuolumne*	6.7%	23.3%
Modoc*	8.0%	39.2%
San Benito*	9.5%	35.4%
El Dorado	10.6%	59.8%
Siskiyou	11.4%	65.3%
Colusa	12.0%	58.1%
Lassen*	14.2%	38.2%
Madera*	16.1%	31.4%
Nevada	16.5%	65.8%
San Joaquin	17.4%	60.8%
Tehama*	18.0%	42.1%
Butte*	19.0%	36.4%
Yolo	19.8%	69.2%
Santa Clara	21.0%	57.1%
Yuba/Sutter	21.9%	60.2%
Kings	22.2%	51.1%
Lake*	22.5%	48.1%
Ventura	24.1%	54.5%
Calaveras	24.6%	70.4%
Mariposa	25.0%	63.3%
Placer	26.4%	65.3%
Merced*	27.2%	42.7%
Stanislaus	27.7%	64.5%
San Diego	29.1%	70.5%
Los Angeles	32.1%	51.3%
Fresno	32.3%	51.1%
Sacramento*	32.4%	43.3%
Tulare*	34.1%	47.3%
Riverside	37.0%	63.6%
Santa Cruz	37.1%	60.8%
San Bernardino*	38.1%	46.9%
Mendocino	38.4%	65.1%
Kern*	39.3%	34.5%
San Mateo	41.8%	61.9%
San Luis Obispo	42.5%	58.9%
Santa Barbara	43.2%	55.3%
Orange	43.7%	54.2%
Inyo	45.5%	75.0%
Shasta	49.6%	66.3%
Solano	50.2%	75.7%
Contra Costa	51.2%	72.8%
Napa	55.1%	78.6%
Imperial*	55.3%	27.4%
Del Norte*	57.4%	41.9%
Sonoma	61.2%	67.5%
Marin	62.7%	84.6%
San Francisco	63.1%	65.0%
Alameda	67.4%	61.5%
Monterey	70.0%	84.4%
Humboldt	75.3%	66.0%
Glenn*	100.0%	40.2%
Average	35.4%	56.3%

* These results are questionable due to relatively high % of missing data / administrative discharges.
 The following counties are not displayed because they reported data for 15 or fewer clients:
 Alpine, Amador, Mono, Plumas, Sierra, Trinity.

Table 1.3b. Jail days during 30 days prior to discharge by county

	Jail days, last 30 days	% Jail discharge data present
Modoc*	0.0%	39.2%
Kings*	0.0%	40.3%
El Dorado	0.5%	52.5%
San Mateo*	1.0%	33.2%
Santa Clara*	1.4%	46.0%
Humboldt*	1.6%	17.0%
Placer	1.7%	53.3%
Sacramento*	1.9%	29.8%
San Joaquin	2.4%	52.9%
Ventura*	2.6%	42.8%
Lake*	2.6%	35.5%
Sonoma*	2.6%	27.9%
Fresno*	2.7%	30.5%
Tehama*	2.8%	34.8%
Tulare*	2.9%	37.5%
Madera*	2.9%	25.9%
Mariposa	3.3%	62.8%
San Bernardino*	3.3%	39.5%
Riverside*	3.3%	48.7%
Marin*	3.7%	20.9%
San Benito*	3.8%	29.2%
Shasta*	4.1%	43.9%
Alameda*	4.3%	29.7%
Colusa	4.3%	53.5%
Yuba/Sutter	4.3%	60.7%
Tuolumne*	4.4%	23.3%
Santa Cruz	4.5%	56.8%
San Francisco*	4.6%	21.8%
Siskiyou	5.4%	61.2%
Los Angeles*	5.6%	49.1%
Orange*	5.8%	45.4%
Stanislaus	5.8%	62.9%
Mendocino	6.1%	55.2%
Contra Costa	6.1%	57.7%
Imperial*	6.1%	18.3%
Glenn*	6.3%	39.0%
Santa Barbara*	6.3%	29.5%
Lassen*	6.3%	26.7%
Nevada	6.4%	59.4%
San Diego*	6.5%	44.5%
Yolo	6.8%	68.1%
Butte*	7.0%	34.7%
Monterey	7.5%	57.1%
Solano*	8.0%	42.1%
Calaveras	8.7%	58.7%
San Luis Obispo	9.6%	61.1%
Merced*	10.1%	32.2%
Napa*	12.6%	39.6%
Kern*	18.1%	34.5%
Inyo	20.0%	68.2%
Del Norte*	23.9%	35.7%
Average	5.5%	42.6%

* These results are questionable due to relatively high % of missing data / administrative discharges. The following counties are not displayed because they reported data for 15 or fewer clients: Alpine, Amador, Mono, Plumas, Sierra, Trinity.

Table 1.3c. Social support during 30 days prior to discharge by county

	Social Support, last 30 days	% Social support discharge data present
Glenn*	100.0%	40.2%
Kern*	94.2%	34.5%
Humboldt	93.0%	66.0%
Yolo	90.7%	69.2%
Marin	90.5%	85.1%
Siskiyou	89.9%	65.3%
Kings	85.6%	51.1%
Tuolumne*	84.4%	23.3%
El Dorado	83.2%	60.9%
San Diego	83.1%	70.8%
Tehama*	83.0%	42.1%
Santa Cruz	81.5%	60.8%
Nevada	80.3%	65.8%
San Mateo	79.0%	62.9%
Yuba/Sutter	76.2%	61.1%
Del Norte*	75.9%	41.9%
Sacramento*	75.2%	43.5%
Sonoma	74.8%	67.6%
Stanislaus	74.7%	64.5%
Orange	73.3%	62.9%
San Bernardino*	73.1%	46.9%
Santa Clara	72.3%	57.2%
Lassen*	71.7%	38.2%
Mendocino	71.3%	66.6%
Calaveras	71.0%	70.4%
Tulare	69.3%	58.6%
Los Angeles	67.0%	51.9%
Riverside	65.7%	63.6%
Shasta	65.2%	66.3%
San Joaquin	64.2%	60.8%
San Francisco	62.0%	65.0%
Solano	61.7%	75.7%
Ventura	61.2%	54.5%
Madera*	60.1%	31.4%
Contra Costa	58.4%	72.8%
Butte	55.6%	36.4%
Mariposa	54.0%	63.3%
Santa Barbara	51.8%	55.3%
Placer	50.8%	67.6%
San Luis Obispo	49.0%	76.4%
Lake*	46.3%	48.1%
Alameda	45.7%	63.4%
Fresno	44.9%	54.2%
San Benito*	42.2%	36.0%
Napa	40.9%	78.6%
Merced*	39.3%	42.7%
Modoc	32.3%	60.8%
Imperial*	26.0%	40.6%
Inyo	24.2%	75.0%
Monterey	18.9%	84.4%
Colusa	16.0%	58.1%
Average	64.7%	58.0%

* These results are questionable due to relatively high % of missing data / administrative discharges.
 The following counties are not displayed because they reported data for 15 or fewer clients:
 Alpine, Amador, Mono, Plumas, Sierra, Trinity.

Table 1.3d. Employment at discharge by county

	Employed full or part time at discharge	% Employment discharge data present
Mariposa	54.0	63.3%
San Benito*	50.0	36.0%
San Luis Obispo	46.2	76.4%
Tuolumne*	44.4	23.3%
Glenn*	42.4	40.2%
Inyo	42.4	75.0%
San Bernardino*	36.9	46.9%
Ventura	36.2	54.5%
Orange	35.3	62.9%
Madera*	34.3	31.4%
Santa Barbara	31.8	55.3%
Calaveras	29.0	70.4%
Lake*	28.9	48.1%
San Diego	28.1	70.8%
Santa Clara	28.0	57.2%
Tulare	28.0	58.6%
Marin	27.1	85.1%
Modoc	25.8	60.8%
Mendocino	25.5	66.6%
Santa Cruz	25.2	60.8%
Placer	24.7	67.6%
Tehama*	24.4	42.1%
Colusa	24.0	58.1%
Butte*	23.8	36.4%
Yuba/Sutter	23.8	61.1%
Kings	23.7	51.1%
Nevada	23.6	65.8%
Sonoma	23.4	67.6%
Siskiyou	22.8	65.3%
Riverside	22.3	63.6%
Yolo	22.2	69.2%
Shasta	22.1	66.3%
Lassen*	22.1	38.2%
San Mateo	21.3	62.9%
Merced*	20.3	42.7%
Solano	20.2	75.7%
Kern*	19.1	34.5%
Alameda	18.9	63.4%
San Joaquin	18.9	60.8%
Sacramento*	16.2	43.5%
Fresno	15.5	54.2%
Stanislaus	15.0	64.5%
Los Angeles	15.0	51.9%
Del Norte*	14.8	41.9%
El Dorado	14.0	60.9%
Imperial*	13.8	40.6%
Monterey	13.8	84.4%
Napa	13.2	78.6%
Humboldt	13.2	66.0%
Contra Costa	11.6	72.8%
San Francisco	9.7	65.0%
Average	25.2	58.0%

* These results are questionable due to relatively high % of missing data / administrative discharges.

The following counties are not displayed because they reported data for 15 or fewer clients:

Alpine, Amador, Mono, Plumas, Sierra, Trinity.

Table 1.3e. Treatment completion by county

	Completed treatment	% Completion data present
Marin	72.4%	99.7%
Monterey	66.0%	99.8%
Mendocino	57.2%	99.8%
Mariposa	54.6%	100.0%
Contra Costa	51.9%	99.7%
Humboldt	51.7%	99.9%
Inyo	51.2%	97.7%
Sonoma	51.1%	99.1%
San Mateo	51.0%	99.1%
El Dorado	50.8%	100.0%
Siskiyou	50.4%	100.0%
Placer	48.9%	99.7%
Santa Clara	48.9%	99.8%
Amador	47.8%	100.0%
San Francisco	47.6%	99.6%
Solano	45.0%	99.8%
Kings	44.3%	100.0%
Stanislaus	44.0%	99.5%
Nevada	44.0%	99.3%
Santa Barbara	44.0%	99.8%
Mono	43.8%	100.0%
Santa Cruz	43.5%	99.6%
Modoc	43.1%	100.0%
Calaveras	41.2%	99.0%
Shasta	40.6%	99.4%
Orange	40.2%	99.7%
Fresno	40.1%	99.7%
San Diego	39.6%	99.7%
Yolo	39.5%	99.6%
San Joaquin	38.9%	99.4%
San Luis Obispo	38.7%	99.6%
Alameda	38.7%	98.7%
Yuba/Sutter	37.5%	99.8%
Riverside	37.0%	99.9%
San Bernardino	35.9%	99.3%
Sacramento	35.5%	99.6%
Los Angeles	32.2%	99.8%
Tulare	31.8%	99.6%
Lassen	31.4%	98.8%
Ventura	31.3%	99.9%
San Benito	30.3%	100.0%
Merced	28.7%	99.8%
Lake	27.6%	99.7%
Kern	24.8%	98.9%
Tehama	24.3%	99.8%
Colusa	23.3%	100.0%
Butte	22.7%	99.7%
Tuolumne	21.2%	100.0%
Glenn	20.7%	100.0%
Napa	20.2%	99.2%
Madera	19.1%	100.0%
Imperial	19.0%	99.9%
Trinity	10.3%	100.0%
Del Norte	10.2%	99.2%
Average	38.6%	99.6%

The following counties are not displayed because they reported data for 15 or fewer clients:
Alpine, Plumas, Sierra.

The counties that ranked highest in the single categories above (El Dorado, Humboldt, Mariposa, Marin) tended to rank high across categories. One exception to this pattern seemed to be in employment, which may be determined in part by local employment rates. On the other end of the spectrum, counties that ranked low also tended to do so across measures. Del Norte, for example, reported the highest jail incarceration and lowest completion rate.

What is the association between having a transfer (e.g., detox to treatment) and the background characteristics at admission?

As seen in Table 1.4a, female detoxification admissions (19.2) were more likely to result in a transfer to treatment than were male admissions (13.0%). Asians / Pacific Islanders (18.5%) and Hispanics (18.1%) were the most likely to be transferred, while Blacks / African Americans (12.3%) were the least likely. Based on living situations, homeless admissions (who accounted for the majority of detoxification admissions at 52.1%) were the least likely to result in a transfer to treatment (13.0%), while admissions of clients in dependent living situations³ were the most likely to result in a transfer (18.2%). Pregnant females had the highest rate of transfer to treatment (40.5%). Admissions of younger clients were more likely to result in a transfer than admissions of older clients. Admissions of clients whose primary drug was alcohol (11.8%) or cocaine/crack (12.6%) were the least likely to result in a transfer, while admissions of clients using methamphetamine were the most likely to result in a transfer (possibly because methamphetamine clients are disproportionately referred through the criminal justice system; see discussion of referral sources below).

Veterans appeared to be less likely to transfer to treatment (8.8%) than were non-veterans (15.5%), but this may be in part a data artifact. If an individual is admitted to a Veterans Administration (VA) treatment facility following detoxification, this treatment would not appear in CalOMS-Tx. Therefore, veteran transfer rates might be higher than 8.8% to an unknown extent if VA treatment could be taken into account.

³ Dependent living is defined in CalOMS-Tx as “Clients living in a supervised setting such as residential institutions, prison, jail, halfway houses or group homes, and children (under age 18) living with parents, relatives, guardians or in foster care.

Table 1.4a. Transfers from detoxification by client characteristics

	n	% transferred from detox
Sex		
Male	19,024	13.0%
Female	6,939	19.2%
Race / Ethnicity		
White (non-Hispanic)	14,020	14.1%
Hispanic	5,078	18.1%
Black / African American	5,340	12.3%
Asian / Pacific Islander	324	18.5%
American Indian / Alaskan Native	414	16.4%
Other	789	15.7%
Age		
<18	51	23.5%
18-26	2,956	18.0%
26-35	5,074	18.7%
36-45	8,097	14.8%
45+	9,787	11.4%
Pregnant at admission		
No (among females)	6,750	18.8%
Yes	126	40.5%
Living Situation		
Homeless	13,525	13.0%
Dependent living	6,739	18.2%
Independent living	5,701	14.6%
Veteran		
No	23,968	15.1%
Yes	1,934	8.8%
Injection Drug Users		
No	21,339	14.3%
Yes	4,626	16.4%
Previous Treatment Episode		
No	8,781	16.8%
Yes	17,184	13.6%
Primary Drug		
Heroin & other opiates	5,798	15.8%
Cocaine / Crack	3,851	12.6%
Methamphetamine	3,907	23.0%
Alcohol	11,670	11.8%
Marijuana / Hashish	473	16.9%
Other	266	17.7%

Table 1.4b shows transfers from detoxification by referral source and criminal justice status. Detoxification admissions that were the result of referrals through employers, SACPA, dependency drug courts, and child protective services were substantially more likely to result in a transfer to a treatment program. This may be due to the treatment requirements inherent in these programs. Likewise, admissions of clients with criminal justice involvement were more likely to result in a transfer from detoxification than were admissions of clients with no criminal justice involvement. The exceptions to this were referrals from Penal Code 1000 (PC 1000), which do not typically result in a transfer to treatment (8.0%). This can likely be attributed to the fact that most PC 1000 participants are typically only required to attend drug education classes, which would not necessarily appear in CalOMS-Tx as a transfer to treatment.

While a relatively high level of criminal justice clients in detoxification transfer to treatment, it should be noted that criminal justice clients are generally far less likely to have a detoxification service to begin with relative to non-criminal justice clients. The cause of this is unclear, but it is possible that criminal justice clients are more likely to have been “detoxified” during periods of incarceration and therefore to proceed directly to treatment without a detoxification admission.

Table 1.4b. Transfers from detoxification by referral and criminal justice status

	n	% transferred from detox
Referral Source		
Individual / Self	15,043	13.8%
Alcohol / Drug Abuse Program	5,000	11.3%
Other Health Care Provider	1,882	12.1%
Employer / EAP	18	27.8%
12 Step Mutual Aid	216	13.4%
SACPA / Prop 36 / OTP / Probation	1,000	35.6%
SACPA / Prop 36 / OTP / Parole	201	36.3%
Dependency Drug Court	25	24.0%
Non-SACPA Court / Criminal Justice	859	17.2%
Other Community Referral	1,598	16.5%
Child Protective Services	105	46.5%
Jail days > 0 at admission		
No	23,709	14.4%
Yes	2,256	17.6%
Legal status		
No criminal justice involvement	18,748	12.3%
Under parole supervision by CDCR	1,927	19.3%
On parole from any other jurisdiction	351	18.8%
On probation from any jurisdiction	4,664	21.9%
Court diversion: Penal Code 1000	50	8.0%
Incarcerated	18	11.1%
Awaiting trial, charges, or sentencing	161	23.0%

1.3 SUMMARY AND RECOMMENDATIONS

The CalOMS-Tx analyses reported in this report use CalOMS-Tx data to examine California's system of care in new ways. This demonstrates potential new uses for CalOMS-Tx, while simultaneously providing information on important limitations, such as the large amount of missing data for some outcome variables due to administrative discharges.

Measuring transfers was a key area of focus. In general, transfers to another service were rare, occurring following one out of ten outpatient treatment admissions and one out of five residential treatment admissions. Where transfers did occur, they were often "sideways" between the same service type. However, step-down transfers representing logical progressions through a continuum of care from detoxification to treatment or from more to less intensive treatment also represented a large proportion of the transfers.

Aside from the transfer measures, outcome measures at discharge were also examined. In particular, wide variations between counties were noted.

Reviews and recommendations derived from some of the key findings reported in this report are summarized below.

Eighty-five percent of detoxification and 88.2% of NTP detoxification admissions were detoxification-only (no transfer to a non-detoxification service). This represented 19.1% of all admissions examined.

Recommendation: Continue to examine the high prevalence of detoxification-only admissions and explore ways to increase the rate of transfer to treatment. Pilot projects on these topics are underway.

The mean number of days between services when a transfer occurred was 6.8.

Recommendation: Given that most transfers occur in far less time than the 30 days currently used to define these events, consider reducing the period defining episodes from 30 days to 14, in line with Washington Circle recommendations.

Detoxification admissions that were the result of referrals through employers, SACPA, drug courts, and child protective services were substantially more likely to result in a transfer to a treatment program. This may be due to the treatment requirements inherent in these programs. Likewise, admissions of clients with criminal justice involvement were more likely to result in a transfer than were admissions of clients with no criminal justice involvement (though they are less likely to be admitted to detoxification in the first place).

Recommendation: Continue to monitor these trends and seek funding to continue transfers to treatment. "Coerced" or "incentivized" treatment based on referrals from an employer, SACPA, drug court, and child protective services by their nature are more structured and have more explicit requirements than self-referred treatment, so these programs are in a prime position to lead the treatment system's development and use of protocols for a continuum of care. However,

recent cuts in SACPA and other funding may endanger this trend if treatment becomes less available.

Detoxification admissions were the least likely to result in a transfer to treatment if the client admitted was male, Black/African American, homeless, not pregnant, older, or reported alcohol as their primary drug. Detoxification admissions were most likely to result in a transfer if the client admitted was female, Asian/Pacific Islander, in dependent living, pregnant, young, reported methamphetamine as their primary drug, or was referred to detoxification by child protective services. Some of these, such as dependent living and methamphetamine use, may be more likely to result in transfers, in part, because they are associated with criminal justice populations.

Recommendation: Examine the causes of these disparities and whether they facilitate disparities in outcomes.

Transfers were generally associated with improvements in outcomes. Over the course of a treatment episode with transfers, outcomes improved from admission to initial discharge to final discharge. CalOMS-Tx outcome measures showed increases in occurrences of social support and employment and reductions in occurrences of drug use and jail incarceration. These patterns are consistent with the progress that is expected as clients move through a continuum of care. Likewise, single-service clients who were treated but had no transfers had the worst outcomes among any of the treatment groups. Compared to those who had transferred, in the 30 days prior to discharge, single-service clients were more likely to have used drugs, most likely to have spent time in jail, the least likely to have completed treatment, and the least likely to have received social support. They were also among the least likely to be employed. To the extent that transfers reflect care tailored to the client's needs, the better outcomes among transferred clients compared to single service clients suggests a beneficial effect of such "adaptive" care. However, alternative explanations based on self-selection into these "adaptive" groups (e.g., more motivated or compliant clients) cannot be ruled out based on this data alone.

Recommendation: Through more sophisticated analyses, continue to investigate whether transfers cause improved outcomes. This analysis would include monitoring of the scientific literature, and where funding becomes available, collection of primary data through experimental trials.

Recommendation: Examine the relationship between transfers and outcomes at the system level to discern whether county systems with higher levels of countywide transfers yield more favorable countywide outcomes. UCLA is in the process of analyzing this.

In terms of county outcomes, a few counties tended to rank higher (e.g., El Dorado, Humboldt, Mariposa, Marin) and some lower (e.g., Del Norte) than others in drug use, incarceration, social support, employment, outcomes, and treatment completion. However, non-treatment factors can affect these results. For example, employment may be determined in part by local employment rates rather than treatment quality. Furthermore, each county has different types of clients and a different combination of treatment modalities, both of which can affect outcomes and discharge statuses. For more accurate comparisons, case mix adjustment needs to be used to statistically

take these differences into account. UCLA is currently developing case mix adjustments and will report on these efforts in the 2011 report. Interpretation of outcomes are also made more difficult due to low reporting of discharge data in some counties.

Recommendation: Provide this data to the counties to get their feedback. Numbers should not be taken immediately at face value due to the challenges of case mix and low reporting, but should be considered a good starting point. Follow-up should occur, in particular, with counties that perform well (for lessons learned) and counties that perform poorly (for lessons learned and possible technical assistance).

Recommendation: Work with counties to improve data reporting. Some variables, such as drug use, suffer from levels of missing data that make it difficult to have confidence in the data from some counties. Consider using the percentage of missing data as a performance measure to reduce administrative discharges and increase data quality.

Next steps:

In addition to the steps mentioned above, the following research questions remain in UCLA's work plan and may be addressed in the 2011 report. Due to emerging priorities, this workplan is currently under review by ADP and may be revised.

Research Question 1(d)(i). Find out what those counties that have the highest transfer rates from detoxification are doing.

Research Question 3b. Review the literature for models of case mix adjustment, key variables. Discuss lessons learned from Los Angeles County where relevant.

Research Question 4. Examine unique client identifiers (CADDs UPI and CalOMS-Tx UPI – both in CalOMS-Tx) currently used by ADP to determine most accurate method for identifying and tracking clients.

Research Question 6. Identify ways of dealing with categories for discharge that fit within COSSR objectives, or discuss alternatives if discharge has lost relevance. In either case, the goal is to have mutually exclusive categories with clear definitions. Draw upon recent interviews conducted by the CADPAAC data/outcomes committee and by Rachel Gonzales.

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- Rawson, R.A., Gonzales, R., Brecht, M-L., Crèvecoeur-MacPhail, D., & Hemberg, J. (2008). *California Outcomes Measurement System (CalOMS-Tx): Final Report 2008*. Prepared for the Department of Alcohol and Drug Programs California Health and Human Services Agency. Los Angeles: University of California, Los Angeles, Integrated Substance Abuse Programs

REPORT 2:

STAKEHOLDER PROCESS REPORT

Darren Urada, Ph.D., Richard A. Rawson, Ph.D.

Prepared for the Department of Alcohol and Drug Programs,
California Health and Human Services Agency

UCLA

University of California, Los Angeles



Integrated Substance Abuse Programs

2.1 INTRODUCTION

CalOMS-Tx has formed the backbone of performance and outcome measurement for the California AOD system since it became the dataset of record starting on July 1, 2006. As with any data system, it is important to periodically review the advantages and limitations of the system and make changes where necessary to ensure that the data system meets the needs of the broader treatment system. Changes to CalOMS-Tx would affect a wide range of stakeholders, including the treatment providers that supply the data, county administrators tasked with monitoring data quality and who may use (or potentially use) the data system to monitor performance and outcomes, and other policymakers and researchers who analyze the data. Therefore, development of a stakeholder consensus process is an important phase in the discussion of potential changes to be implemented. UCLA, with input from ADP, has convened a new stakeholder group to develop consensus recommendations on the future of CalOMS-Tx. This chapter describes the formation of this group and summarizes the discussion that occurred on the group's first conference call.

2.2 PROCESS/FINDINGS

County administrators were recruited by asking for volunteers on a conference call of the County Alcohol and Drug Program Administrators Association of California (CADPAAC) Data/Outcomes Subcommittee. All of the county administrators on the call volunteered. However, the counties they represented were all medium or large in size. So, in an attempt to add balance, the leaders of the CADPAAC small counties and minimum base allocation (MBA) counties groups were also asked to ask for volunteers from their like-sized group committees at the May CADPAAC quarterly meeting, or ultimately to participate themselves. Chairpersons of each CADPAAC like-sized county group were also asked to seek their committee's input and suggest the names of treatment providers who might be interested in participating in the CalOMS stakeholder consensus committee.

Outside experts and leaders of key stakeholder groups (the California Association of Alcohol and Drug Program Executives (CAADPE), and the California Opioid Maintenance Providers) were also invited based on suggestions generated internally at UCLA or received from ADP.

The final list of invitees can be found in Appendix 2A. Invitees were formally contacted by e-mail on May 12, 2010, (see Appendix 2B: invitation letter) and asked to respond. One person (Gino Giannavola of Sonoma County) declined due to his impending retirement, but he suggested an alternate contact from his county.

On May 20, 2010, participants were asked via e-mail to provide information on their availability. Based on responses received via a third party website, meetingwizard.com, June 23, 2010, was identified as the date on which the greatest number of invitees could participate, and this was confirmed as the date for the first conference call. On the morning of June 23, 2010, an agenda was sent to all participants (see Appendix 2C). A total of 31 people participated in the call. Minutes from the call can be found in Appendix 2D. The minutes were distributed to all participants for corrections and comments on June 28, 2010. At this writing, the minutes are still

being reviewed and therefore the attached copy should be considered to be only a preliminary draft.

2.3 SUMMARY AND RECOMMENDATIONS

The main points taken from the first CalOMS-Tx stakeholder consensus call were as follows. For greater detail, see Appendix 2D.

- The current CalOMS-Tx is not adequate for 2014, when health care reform takes full effect.
- An encounter-level information system is needed. That is, a record is needed of each *individual* service the client received (e.g., group treatment, individual counseling, etc.) as opposed to only data collected at admission and discharge, which is currently the case.
- It may be possible to collect much of this encounter data from billing systems. Medi-Cal billing systems will capture this information for Medi-Cal clients, for example. However, many clients will receive substance use disorder (SUD) treatment through primary care rather than through the block grant after 2014, when health care reform is fully implemented. Whether and how this information would be integrated into AOD data systems has not been fully answered yet.
- The solution will likely be to obtain the information through health information exchanges currently being formed. AOD stakeholders must therefore work with larger groups developing standards for electronic health records and these health information exchanges (e.g., Cal eConnect⁴). This means that neither this consensus group nor ADP can set the data collection standards independently.
- For performance measures, the SUD measures already collected by health plans for the Healthcare Effectiveness Data and Information Set (HEDIS) are a good starting point. The current measures are identification, initiation, and engagement.
- Pending ADP approval, a Data Summit may be held at the end of this year (2010) to discuss issues with national experts working on these issues (e.g., the Substance Abuse and Mental Health Services Administration, private health maintenance organizations, information technology experts, etc).

⁴ The formation of Cal eConnect was announced on March 8, 2010, by Governor Arnold Schwarzenegger and California Health and Human Services (CHHS) Agency Secretary Kim Belshé. Cal eConnect is a new, independent non-profit entity with both public and private board members that will provide leadership and oversee a collaborative process to develop and support the Health Information Exchange services in California. The organization received a grant from, and will be accountable to, CHHS.
<http://www.ehealth.ca.gov/LinkClick.aspx?fileticket=frz7p75LzqI%3d&tabid=84>

APPENDIX 2A: INVITED STAKEHOLDER PARTICIPANTS

Stakeholder Consensus Group: Invited Participants

UCLA

Richard Rawson
Darren Urada
Desirée A. Crèvecoeur-McPhail
Valerie Pearce

ADP

Debra Connick
Theresa Gulley-Reed
Gigi Smith
Kevin Wortell
Marcia Yamamoto

Other Experts

Denzil Verardo, former ADP
Ellie McCance-Katz
Victor Kogler

Counties

Susan Bower, San Diego
Wayne Sugita, Los Angeles
Lily Alvarez, Kern
Star Graber, San Luis Obispo
Madeline Schlaepfer, Stanislaus
Alameda (team, by county's request)
 Tom Trabin
 Barry Hall
 Hazelton, Tracy
 Janet Biblin
Bob Garner, Santa Clara
Gino Giannavola / David Sheaves (Sonoma)
Catherine Condon (Marin)

Mark Bryan (CADPAAC Small county rep)
Sue McVean (CADPAAC's MBA rep)

Providers

Tina Sentner (Santa Clara)
Angela Rowe (San Diego)
John Phillips (Fresno) / Ge Yang (Fresno)
Michael Spielman (Sonoma)
Dan George (Matrix NTP) (Los Angeles)

CAADPE Al Senella, Jim Sorg
COMP Jason Kletter

APPENDIX 2B: STAKEHOLDER INVITATION LETTER

May 12, 2010

Dear <name>

UCLA, under contract with the Department of Alcohol and Drug Programs (ADP), is forming an independent stakeholder committee to provide recommendations to ADP on the direction of future changes to the California Outcomes Measurement System - Treatment (CalOMS-Tx). On the basis of your experience and expertise, UCLA would like to extend an invitation to you to participate in this committee.

The goal of the CalOMS-Tx Stakeholder Consensus Committee will be to provide recommendations to ADP which include but are not limited to:

- Recommending new data elements for CalOMS
- Recommending removal or changes to existing CalOMS features
- Recommending performance measures
- Producing recommendations on the incorporation of Electronic Health Records data into existing data systems.
- Producing other recommendations related to CalOMS.

By providing these recommendations, this committee will play an important role in the future of statewide performance and outcome measurement, which in turn will have an impact on the re-engineering of treatment systems. We therefore would like to have your input and hope that you will have an interest in participating.

We understand the value of your time, and will work to minimize the time commitment of this volunteer work wherever possible. We expect to conduct business primarily via conference calls scheduled approximately once per quarter and via e-mail as needed. If the group deems it necessary, one face to face meeting may be scheduled, in which case your travel expenses would be paid for.

Please let us know by May 17 if you would be willing to participate or would like to decline by e-mailing Darren Urada at durada@ucla.edu. We will contact those who have not declined at that time to coordinate the first conference call.

Thank you!

Sincerely,

Darren I. Urada, Ph.D.
UCLA Integrated Substance Abuse Programs

APPENDIX 2C: CONFERENCE CALL AGENDA

CalOMS-Tx Stakeholder Consensus Group

Conference Call

June 23, 2010; 11:00 AM
866-740-1260; Code 2675306#

- I) Roll call / Introductions
- II) Purpose and scope of the Stakeholder Consensus Process
- III) CalOMS impressions & needs
 - 1) CalOMS uses and limitations
 - 2) Possible changes
 - 1) Improving data quality
 - 2) Removal / addition / refinement of questions
 - 3) Integration with other data sets
 - 4) Appropriateness with evolving concepts of care (e.g. chronic care)
- IV) Next steps
- V) Next call

APPENDIX 2D: CONFERENCE CALL NOTES

CalOMS-Tx Stakeholder Consensus Group
PRELIMINARY / DRAFT
Conference Call Notes
June 23, 2010 11:00 AM

Executive Summary

- Current CalOMS-Tx is not adequate for 2014, when health care reform takes full effect.
- An encounter-level information system is needed.
- It may be possible to collect much of this encounter data from billing systems.
- Many clients will get SUD treatment through primary care rather than through the block grant after 2014. How would we get information on those clients?
- We can't set the data collection standards by ourselves. We must work with larger groups developing standards for electronic health records and health information exchanges (e.g., Cal eConnect).
- For performance measures, we should look into the SUD measures collected for HEDIS (identification, initiation, engagement).
- A Data Summit may be held at the end of this year to discuss issues with national experts working on these issues (e.g., SAMHSA, private HMOs, I.T. experts, etc.).

I. Participants

ADP: Craig Chaffee, Debra Connick, Cindy Guest (for Gigi Smith), Theresa Gulley-Reed, Tara Murphy, Kevin Wortell, Marcia Yamamoto

County Administrators: Lily Alvarez (Kern), Janet Biblin (Alameda), Susan Bower (San Diego), Mark Bryan (Yolo), Bob Garner (Santa Clara), Star Graber (San Luis Obispo), Barry Hall (Alameda), Tracy Hazelton (Alameda), Wayne Sugita (Los Angeles), Madeline Schlaepfer (Stanislaus), David Sheaves (Sonoma), Tom Trabin (Alameda)

Experts: Victor Kogler, Elinore McCance-Katz

Stakeholder Groups: Al Senella & Jim Sorg (CAADPE), Jason Kletter (COMP)

Treatment Providers: Dan George (Los Angeles) Tina Sentner (Santa Clara), Ge Yang (Fresno),

UCLA: Desirée A. Crèvecoeur-MacPhail, Valerie Pearce, Richard Rawson, Darren Urada

Unable to Attend

Catherine Condon (county administrator, Marin), Sue McVean (county administrator, Tehama), Angela Rowe (treatment provider, San Diego), Michael Spielman (treatment provider, Sonoma), Denzil Verardo (expert)

II. Purpose and scope of the Stakeholder Consensus Process

- Dr. Rawson provided a brief overview of the development of CalOMS-Tx, which became the database of record starting in FY 2006–2007. Historically, the data system has been driven by requirements from the federal government, including responding to NOMS (national outcome measures), which are covered by CalOMS-Tx.
- As with any data system, it's important to periodically review the data to see if it's giving us what we need. Emerging needs since the creation of CalOMS-Tx include:
 - A shift to the view of substance use disorders as a chronic disorder rather than an acute one.
 - Health care reform, which may change the ways that we capture data on AOD services, how it can link to other data systems, etc.
 - There is also interest in using CalOMS-Tx for performance measurement.
- This group will begin to discuss these issues. Options may range from “don't change anything” (e.g., due to expense) to “change things substantially.”
- Goal: collect all perspectives, and make recommendations to the state in one year about possible modifications in CalOMS-Tx.

III. CalOMS-Tx Impressions & Needs

- Bob Garner: Have to look at kind of system that will support us in 2014. CalOMS-Tx is not adequate. Need an encounter-level information system if we really want to evaluate what we do. In 2014, virtually all clients will have insurance. We're only treating about 10% of those who have a problem, another 90% will be linked into primary care.⁵ There will be a lot more consultation, brief intervention, etc., and it will be Medi-Cal driven. Block grant dollars have the potential of being eliminated or reduced. Can we link into the billing system that has to go to Health Services under Medi-Cal since that is encounter-level data? Need to link to other systems because continuing funding for CalOMS-Tx is unlikely.
- David Sheaves: Do all of our systems use the same CalOMS-Tx system for our own internal billing? If we don't, we may get data for Medi-Cal encounters, but there are a lot of other funding sources. Sonoma system has capacity to get encounter data but other counties may not.
- Al Senella: Agrees with Bob, CalOMS-Tx is driven by block grant. Even if it survives, it's only going to be serving a very small portion of the population, and what are we doing with

⁵ After the call, Craig Chaffee of ADP noted that there are other barriers to getting people into treatment besides a lack of health care coverage. Specifically, Chaffee noted, while the National Survey on Drug Use and Health cites "No health insurance/treatment cost" as the number one reason for not seeking treatment, the #2 most cited reason is "Not ready to stop use" and the #3 reason is "able to handle problem without treatment." Lack of transportation and stigma are other potential reasons.

the rest of the population that will be coming in with insurance? Do they all do CalOMS-Tx, or are they going to be outside of the database?

- Susan Bower: AI raises a huge issue. We've never had good data from private providers, but under health care reform we will need to.
- Victor Kogler: Suggested we might look at the model DMH used when replacing their old system 6–7 years ago to manage services in a new environment. However, Tom Trabin, who was involved in the process reported “very mixed feelings” about using that process as a model because it was undertaken in an ambitious mode that exceeded their resources, and standards were already being developed nationally that had more influence. Wouldn't recommend ADP or CADPAAC, etc., try to set standards for electronic health records for AOD because we can't act alone, we're going to have to interact with all of health care. However, there are things we should do that are pieces of it.
 - SAMHSA came out last week with a useful FAQ document⁶ on how 42 CFR Part 2 should be implemented through health organizations.
 - We need to be involved at the state level with (California Health and Human Services Deputy Secretary) Jonah Frohlich regarding the standards being set for health information exchanges.
 - With regard to performance measures, NQF standards require encounter level data. We need to help with this.
 - With people coming in and out of private and public systems, we need to re-examine our concept of an “episode” to encompass all levels.
 - We need interoperability with public and private systems, and we need to be at the table in the development of that.
 - Our providers will need a lot of help to get them ready. Steep learning curve ahead. Maybe we can get it from the HITECH act?
- Lily Alvarez: Doesn't disagree with anything said, but wants to assume survival of the block grant and that CalOMS-Tx is tied to that. However, does it give us what we want? There is a desire to move toward performance measures, e.g, CalOMS-Tx can do length of stay. It would be good to look at a list of measures recommended by the National Quality Forum to see what we can and cannot get from CalOMS-Tx and whether it would take a lot to change that. In terms of health care reform, we don't yet know what the practices will be in Federally Qualified Health Centers (FQHCs) and accountable care organizations, but they will be collecting information that doesn't belong to us and they may not have SUD reporting requirements at all.
- ?: Are we only concerned about public outcomes? If not, how can we require private providers to enter CalOMS-Tx data?
- Jim Sorg: Something that needs to be part of the process is the Health Information Exchange, which is part of health reform. It's a framework that could tie us to private data

⁶ The FAQ Tom referred to is here <http://www.samhsa.gov/newsroom/advisories/1006165837.aspx>

and public data. If we get involved soon through Cal e-connect⁷ and through existing health information exchanges around the state we could shape what develops in beneficial ways.

- Rick Rawson: Seconds Jim's point. From conversations with Mady Chalk, understands that at SAMHSA, Wesley Clark is in charge of a big IT initiative with health care reform but in terms of NOMS, SAMHSA isn't doing anything right now and this group would have a significant opportunity to provide input on how this is set up for the future and would like to see if we can get out in front of it rather than waiting for something to come down from Washington that might not be optimal for us.
- Question: Is ADP involved in the state's efforts around health information exchanges?
 - IMSD Deputy director (Gigi Smith) sits on the Agency-wide HIE committee run by Kim Belshe. They're looking at it across the whole HHS Agency. ADP will make sure Gigi can be on the next call to give an update.
- Tom Trabin - Less concerned about counties that are under behavioral health (can draw on MHSA funds) than those that are not. Might be useful to hear how some of these counties could share how they have made progress without MHSA.
 - Madeline Schlaepfer says that in Stanislaus, MHSA helped with getting hardware but the whole AOD part has to be funded in a different way from MHSA.
- Rick Rawson – right now there are a lot of people getting buprenorphine from primary care doctors but they are not in CalOMS-Tx. In 2014 how will that work? What if someone shows up at an FQHC and gets treated for SUD there, how does that get captured?
 - ? - It would belong to the commercial plan. That's why we need a broader scope than just CalOMS-Tx.
 - Al - They don't collect this type of data. There probably will be a standard definition of what needs to be collected under health care reform, but it won't look like CalOMS-Tx. Will come from health information exchange and access will be based on what network you are in and information sharing agreements. But this won't necessarily feed back into a statewide system.
 - Might be data available like that currently available from DHCS (Medi-Cal), e.g. how many claims were submitted for SBIRT or buprenorphine codes?
 - Regarding performance measures, health plans have to report HEDIS data so that success could be compared.
 - Tom Trabin – The NQF measures started with adoption at NCQA for HEDIS. Identification, initiation, engagement were in HEDIS. Believes they are still there unless they have been phased out.⁸

⁷ The formation of Cal eConnect was announced on March 8, 2010, by Governor Arnold Schwarzenegger and California Health and Human Services (CHHS) Agency Secretary Kim Belshé. Cal eConnect is a new, independent non-profit entity with both public and private board members that will provide leadership and oversee a collaborative process to develop and support the Health Information Exchange services in California. The organization received a grant from, and will be accountable to, CHHS.
<http://www.ehealth.ca.gov/LinkClick.aspx?fileticket=frz7p75LzqI%3d&tabid=84>

- Lily Alvarez – just embarking on electronic medical records (encounter data linked to billing). Wants to maintain what Kern has for the most part and build capacity among providers to master the EMR. Anytime there's a change, it costs money to implement. Advocates for a minimal, conservative approach at the moment, see if we can use the EMR to create performance measures. Hopes that existing tx will continue as specialty care that is very different from what FQHCs can ever do.
- Darren Urada – is Kern collecting the EMR data as, say, Santa Clara?
 - Lily Alvarez – we've never taken inventory across counties but it should be very similar because we're all operating off of Title 22 (has to be an assessment, plan, diagnosis, etc.).
 - What drives what we collect is payment. Depending on new billing requirements, we might get more encounter data.

IV. Next steps

- Pending ADP approval, a Data Summit may be held in mid-November 2010 to discuss what is needed to be ready for 2014, integration, parity, health care reform. What do we need to know to prepare CA to be in line with larger movement on integration, parity, and health care reform?
 - Possible invitees
 - SAMSHA representatives
 - Federal Government
 - Private HMOs
 - Health researchers such as Connie Weisner
 - VA representatives
 - IT experts
 - Mental health directors
 - Please send additional ideas for speakers, attendees, agenda items to Darren Urada durada@ucla.edu
 - Committee expressed strong support for the idea of the data summit.
- Additional steps UCLA will pursue:
 - UCLA will gather information on current efforts related to health information exchanges, HEDIS, and determine how this group can get involved.
 - For short-term purposes, UCLA will continue to examine whether the current version of CalOMS-Tx data can be used for performance purposes.

⁸ Identification, Initiation, and Engagement are still mentioned in this 2010 HEDIS document http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2010/2010_Measures.pdf

REPORT 3:

**ORGANIZATIONAL TREATMENT
FACTORS REPORT**

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Integrated Substance Abuse Programs

3.1 Introduction

The meaning of “Performance Improvement” from the perspective of county alcohol and other drug (AOD) administrators and treatment program managers was recently documented using data collected during the COSSR Evaluation (Herbeck et al., in press). To evaluate the degree that California county AOD administrators and treatment program managers are preparing to adapt to a data monitoring system focused on the chronic nature of substance abuse, surveys were distributed to and collected from a sample of these groups in 2008–2009. Herbeck et al. (in press) reported that while over half of county AOD administrators routinely use performance and/or outcome measures in their decision making, there was substantial variation in the degree that treatment program managers used performance management practices. Program managers were found to require varying levels of technical assistance to adopt these practices.

The purpose of the work delineated in the original Organizational Treatment Factors component (Objective 1.3) of the EnCAL Evaluation work plan was to assess program utilization of measures of organizational functioning. The level of effective organizational functioning within a program is closely linked to its readiness to use data-driven performance measures and empirically based interventions to improve clinical practices and client outcomes. Much of the groundwork assessing treatment program managers’ perspectives on routine use of performance measures and empirically supported treatment interventions was previously conducted in the COSSR Evaluation and reported in Herbeck et al. (2010, in press; Appendix 3A).

To move the evaluation forward and to gain a clearer understanding of how to assess measures of organizational functioning in a manner that would be relevant to and useful for treatment providers, we sought advice from experts in the field of organizational change, adaptation, and innovation within the substance abuse treatment research field. As a result of consultation with these experts, UCLA has begun to conduct semi-structured site visits among Los Angeles County treatment programs. Through these preliminary visits, we have gained insight into the variability among treatment providers’ readiness to use program and client data to assess their performance and to make strategic plans and improvements within their organizations.

The following section of this chapter provides a brief summary of the research literature on provider perceptions of organizational change, adaptation, and innovation, and efforts to assist substance abuse treatment providers improve management practices and client outcomes. This review is followed by a description of instruments related to elements of effective treatment, quality assurance, and organizational readiness for change/implementation of process improvement practices. A subsequent report of process and findings describes UCLA’s consultation with experts in the field of organizational change, adaptation, and innovation who informed our exploratory efforts. Preliminary findings of semi-structured, open-ended key informant interviews and site visits are described, followed by an overall summary and recommendations to ADP.

3.2 PROCESS/FINDINGS

Literature Review

Previous work has surveyed treatment providers' perspectives on the effectiveness of empirically supported treatment interventions, finding that while providers tend to view psychosocial interventions—including Motivational Enhancement Therapy, Solution-Focused Therapy, Community Reinforcement Approach, Supportive Expressive Psychotherapy, and the Matrix model—as effective forms of treatment, there is substantial variability in their use of these empirically based interventions (Herbeck et al., 2008). Benishek and colleagues (2010) also found a gap between providers' perceptions of the effectiveness of empirically supported treatments and their routine use. Use of these interventions was positively correlated with training resources and providers' perceptions of their effectiveness (Herbeck et al., 2008). Commonly reported barriers to their use include a lack of administrative support and staff time, funding/resource limitations, cost concerns, the need for expert consultation, and limitations in the skills needed to implement the intervention (Benishek et al., 2010).

In addition to these barriers, providers who make clinical decisions primarily based on their own clinical and management experience have expressed skepticism or uncertainty about empirically supported interventions (Herbeck, in press). This skepticism can partly be attributed to program managers' belief that over-emphasis on performance measures and their relationship to client outcomes ignores important other factors that influence client outcomes, including program differences in client characteristics, needs, and severity. A study surveying a random sample of outpatient program managers in Pennsylvania found that a substantial number (40%) believed that clinical experience carried more weight than research findings in guiding clinical practice, and nearly the same percentage “believed that empirically-supported treatments could be implemented without specific training (Benishek et al., 2010).”

While management and clinical experience are perceived as vital traits needed to improve program quality and performance, little research has been done on “the business of addiction treatment” (McConnell et al., 2009), or how providers actually make clinical and program decisions. Within the field of substance abuse treatment, McConnell and colleagues (2009) sought to operationalize management practices among substance abuse programs and found that the following traditional business practices have a significant positive relationship with reducing days to treatment: (1) attention/effort given to client intake, (2) structure of quality improvement, (3) types of data collected, (4) feedback within the agency, (5) range of goals set for the program, and (6) clarity of goals set for the program.

Along with incorporating these management strategies and principles, drawing on and validating the prior experiences of program managers may facilitate process improvement efforts. The examination of “expertise-based intuition” within organizations is a new area of study in the management field that may help explain the process of decision-making among treatment program leadership (Salas et al., 2010). This type of “educated intuition” may enhance program managers' ability to learn and adapt by drawing on prior experience to make critical decisions. It may also help managers quickly identify smaller adjustments to organizational functioning that can improve program operations and performance outcomes.

Instruments and Guides

Instruments and literature assessing organizational readiness for change and quality of care were collected. These include the Texas Christian University Organizational Readiness for Change (Treatment Staff Version and Treatment Director Version; TCU ORC-S and TCU ORS-D), and the National Institute on Drug Abuse (NIDA) Substance Abuse Treatment – Employee Survey. Simpson and Dansereau (2007) describe the availability of comprehensive resources and training on how to use these instruments, which assess organizational functioning as a step toward innovation. In addition, we found *Treating Teens: A Guide to Adolescent Drug Programs* (Drug Strategies, 2003) to be a useful model on how to present information on effective treatment programs. The guide identifies nine key elements for successful programs treating teens and provides information on 144 successful teen programs. These nine elements pertain to organizational functioning and include: Assessment and Treatment Matching; Comprehensive, Integrated Treatment Approach; Family Involvement in Treatment; Developmentally Appropriate Program; Engage and Retain Teens in Treatment; Qualified Staff; Gender and Cultural Competence; Continuing Care; and Treatment Outcomes.

Consultation with Experts in the Organizational Change, Innovation, and Adaptation Field of Substance Abuse Treatment

Consultation with Dr. Dwayne Simpson

A brief telephone consultation with Dr. Dwayne Simpson—Distinguished Professor of Psychology and Addiction Research at Texas Christian University (TCU) and Emeritus Director of the Institute of Behavioral Research (IBR)—occurred on December 17, 2009. Dr. Simpson has conducted research on assessments of service delivery process, and the influence of organizational functioning on treatment engagement and retention rates, stages of recovery, and long-term outcomes. The TCU IBR team has developed the Organizational Readiness for Change (TCU ORC) assessments and strategic treatment planning seminars to provide technical assistance to treatment providers who use TCU resources.

Dr. Simpson emphasized two main areas that warrant consideration for evaluation. The first was evaluating the internal operations of treatment programs at the staff level and the second was researching how clients respond to care. Dr. Simpson considers this second area to be a measure of “client-provider rapport” and the “golden indicator.” These two areas of investigation are important in assessing organizational functioning and program quality. Dr. Simpson recommended conducting a cross-sectional assessment that would be done within a 2-week period, and having the data collected in an autonomous manner.

Consultation with Dr. Paul Roman

UCLA first briefly consulted with Dr. Paul M. Roman from the University of Georgia on December 8, 2009, by telephone to inform the organizational component of the EnCAL Evaluation. Dr. Roman is a nationally recognized expert in the field of organizational change and adaptation in national samples of public and private substance abuse treatment organizations. UCLA discussed key elements of effective treatment programs with Dr. Roman. Dr. Roman

explained that the performance issue is multifaceted and pointed out that because evaluating performance measurement is complex, the quality of the program may not be seen in client outcomes. For example, a treatment program could have the best quality, but the population that it serves may be in such dire need of wraparound services that client outcomes appear to be not as good as those of comparable quality programs.

Dr. Roman found that the one performance standard that has been found to make a difference in effective operation of substance abuse treatment programs is *strategic planning*, such as identifying specific areas of improvement and adopting strategic plans to address and resolve possible barriers to effective treatment programming. The careful management practices that programs are engaged in during *strategic planning* relate positively to all other performance measures. After discussing characteristics of effective treatment programs, an idea that was introduced was the creation of a model of quality assurance for substance abuse treatment similar to how the Better Business Bureau functions for small businesses. From a system level perspective, this would fill a void in the substance abuse treatment field and encourage adoption of best practices among substance abuse providers. Consumers would also benefit by gaining access to information about providers and their quality of service, as well as have the opportunity to submit feedback on their experiences with these providers.

UCLA arranged a formal consulting agreement with Dr. Paul Roman to further inform the EnCAL Evaluation on processes for organizational change, adaptation, and adoption of innovative ways of measuring performance in the field of substance abuse treatment. Dr. Roman visited the UCLA EnCAL Team on April 8 & 9, 2010. Dr. Roman's expertise provided UCLA with vital information on current health services research and on the interplay of political, research, and treatment systems, which affect the delivery of substance abuse treatment. Dr. Roman addressed questions about the diffusion, adoption, and implementation of innovations, intra-organizational processes, and inter-organizational relationships. He then provided recommendations for additional longitudinal research on the workforce engaged in substance use disorder treatment that may shed light on why counselors tend to stay in the field of substance abuse treatment, despite relatively high counselor turnover within programs. Insights gleaned from discussion with Dr. Roman are guiding ongoing work toward identifying ways to operationalize measures and develop guides to promote the use of data in strategic clinical and program decision-making.

Dr. Roman provided consultation specific to organizational change and adaptation within substance abuse treatment programs. He recommended using an exploratory and indigenous approach to investigating how treatment programs measure their own performance and adopt/adapt to organizational changes to improve performance. Dr. Roman also suggested either organizing focus groups or key informant interviews with treatment program directors to explore elements that are instrumental to how programs strategically measure their own performance and implement changes based on their performance data.

Key Informant Interviews

To assess possible ways that treatment providers use data in their day-to-day practices, a key informant interview was conducted with a program manager of a Narcotic Treatment Program

(NTP) on July 28, 2010, and on March 10, 2010. During the first loosely structured interview, the program manager recommended the adoption of statewide standardized training to lessen the confusion on how to define terms that are used in California's AOD treatment client data collection system (CalOMS-Tx). A need for consolidated paperwork across agencies was also expressed.

In a follow-up interview on March 10, 2010, the key informant was asked more specifically about how data collected from clients is used. The key informant explained that the organization uses the data collected from clients to find out if it is eliminating barriers to access, to track outcome performance measures such as time in treatment and abstinence percentages, and to assess client satisfaction.

An important point made by the key informant was that staff do not perceive statewide data collection systems as clinical tools because they do not receive feedback. To get staff to buy-in to a system-wide data collection system, staff perceptions must change so that they see its direct relevance to them and benefit to their clients, similar to a Network for the Improvement of Addiction Treatment (NIATx) approach, where a relevant issue is addressed and feedback relayed back to the frontline staff. Another key lesson learned by the key informant was that while it is important to disseminate information back to staff, it is also important to foster provider-client engagement by keeping clients in the feedback loop.

Exploratory Site Visits

A few days prior to Dr. Roman's consultation visit with UCLA, an informal site visit was made to another NTP treatment provider in Los Angeles County to explore how the program director and staff used data in their clinical and program decision-making. The following is a brief summary of the informal visit.

UCLA researchers met with program managers at a large multi-modality treatment facility. The organization collects some "real time" operational data that is accessible to treatment and administrative staff; this data lets staff know where clients are located in the facility and the status of their clients' treatment plans.

The facility also regularly reviews data included in annual reports with quarterly data points for strategic planning purposes, and assesses client engagement and satisfaction by administering the Perception of Care (POC) instrument to clients. The program has Performance Improvement Teams (PIT) that review the data to implement strategic changes. The organization is JCAHO-accredited and has patient and medical oversight committees.

Due to time, resource, and logistical constraints, in lieu of arranging focus groups with program directors, which would require development of a focus group protocol, obtaining approval from the UCLA and State Institutional Review Boards, and drawing 8–10 program directors away from their program duties to participate in a two-hour discussion, UCLA used Dr. Roman's

consultation recommendations to conduct exploratory site visits among Los Angeles County treatment providers.

Programs were selected as potential site visit locations by modality – Narcotic Treatment Program (NTP), Residential, and Outpatient Drug Free (ODF), by size – over 60 clients admitted in the first and second fiscal quarters of 2009, and by their relatively high or low levels of engagement and retention (Source: Los Angeles County Participant Reporting System October – December 2009 Site Reports).

Programs with *relatively low engagement* were defined as having less than 45% of their clients remain in the program 30 or more days. Programs with *relatively high engagement* retained at least 80% of their clients 30 or more days. Programs with *relatively low retention* retained fewer than 30% of their clients at least 90 days, or had reported exit interviews for fewer than 30% of their clients. Programs with *relatively high retention* reported keeping at least 80% of their clients 90 or more days, or reported exit interviews for at least 80% of their clients.

Two to three programs in each modality and engagement/retention category were identified as potential sites to visit. A research assistant called, and if e-mail addresses were available, e-mailed the program directors to schedule the visits.

A flexible semi-structured site visit protocol was developed to guide each visit with the program manager/director. The protocol included seven components: 1. Tour of the program’s facilities, 2. The program’s “yardstick” for measuring its success, 3. How the program deals with big changes, 4. The program’s current experience with performance measurement, 5. The program’s current experience with performance management, 6. Specific training desires, and 7. A brief visit with counselors and other program staff.

(See Appendix 3B, Enhancing California’s AOD Data Management System (EnCAL): Learning from Treatment Programs – The Clinical and Program Decision-making Process)

Preliminary Findings

As of June 8, 2010, three site visits to programs of diverse treatment modalities were conducted. The programs visited included one NTP program with *relatively high engagement and retention*, one ODF program with *relatively low engagement and retention*, and one Residential program with *relatively low engagement and retention*.

As expected, there was great variability among the programs visited. In addition to its distinct treatment modality, each program we visited served different client populations, depended on different primary and secondary sources of funding affecting resource allocation, possessed a different level of sophistication in using data to make decisions related to monitoring and measuring performance, and had a unique organizational culture.

Because of the variability of needs among programs, developing program-specific strategic plans, based on best-practices and management principles rather than on rigid rules and regulations, are

appropriate. The following are preliminary observations of elements of effective organizational functioning that may help programs engage and retain clients.

Development of an “open-door” policy where clients feel comfortable speaking with the program director/manager and/or counselors.

One main element that may contribute to relatively high client engagement and retention is having a program director and counseling staff who foster respect for clients by letting them know that they are available to speak with them, even if it is just for a few minutes. Clients develop a bond with the program management and staff, and want to “check-in,” even when things are going OK.

Building staff capacity may be related to improving organizational functioning.

An unexpected finding that was observed was that the program with relatively high engagement and retention also happened to have relatively low staff turnover, with the “youngest” (non-intern) staff person employed at the program for three years. In general, substance abuse treatment programs experience high rates of staff turnover. However, substance abuse treatment counseling staff tend to stay in the field of substance abuse treatment for relatively long periods of time, shifting from program to program laterally (Roman, 4/9/2010). Building capacity among staff is an organizational trait that may provide stability and cohesion within the program and may be related to higher morale, more effective communication, and an increased desire to improve program performance

Abiding by the program’s mission statement in daily practices can contribute to organizational cohesion.

The degree to which program leadership and staff adhere to the organization’s mission statement may contribute to the level of organizational cohesion and sense of purpose among the treatment team. A question to consider is, “How are the program director and staff internalizing the principles in the mission statement?” For example, if the program’s mission statement states that it seeks to promote self-reliance among its clients, is this worked into the treatment plans of each of the clients?

Since addiction treatment programs are not one-size-fits-all shops, developing tailored process improvement plans with specific organizational goals can be helpful for addressing program needs and priorities.

Each treatment program will have different needs and priorities, depending on its client and staff characteristics, sources of funding, and organizational culture and philosophy. Since programs will vary according to their stage of “organizational readiness” to adopt empirically based interventions or process improvements, the following is a non-exhaustive list of some key elements for programs to consider when developing tailored process improvement plans.

1. number and characteristics of clients served
2. number and characteristics of full-time staff

3. number of healthcare staff (nurses, doctors, LCSWs)
4. medium and content of client case planning and tracking systems (paper-based, computer-based, types of data fields, e.g., length of stay, abstinence results, client demographics, etc.)
5. primary and secondary funding sources and resource allocation
6. type of organizational culture and philosophy
7. type of accreditation

3.3 SUMMARY AND RECOMMENDATIONS

In our preliminary and exploratory effort to find out how treatment programs use client data to track their performance, we selected programs based on their relatively low or high levels of client engagement and retention. Our next step is to continue to visit sites and identify elements of effective organizational functioning across programs that have been identified according to their levels of engagement and retention. While engagement and retention are concrete performance measures that appear to be straightforward to collect, we suspect that some treatment providers may have limited experience in collecting these data and therefore may need additional technical assistance to accurately collect and report client admissions and discharges from which engagement and retention are computed.

Provide regularly scheduled standardized training to define terms and procedures.

While we observed that treatment programs differ in their degree of organizational functioning, one commonly expressed need was standardized definitions of commonly used data terms and collection and reporting procedures. The dissemination of the “How to do CalOMS-Tx” webinar would help address this need. To enhance data quality, we recommend that ADP roll out the webinar along with additional technical assistance (e.g., hotline number with answers to frequently asked questions and a live “online” help desk) to all providers as soon as possible to ensure that they are “on the same page” with respect to their understanding of commonly used terminology and data collection and reporting procedures.

Provide technical assistance to providers on how to use data to improve organizational functioning by making process improvements.

Once providers are trained on how to accurately acquire client data, they are ready to learn how to use these data to improve their organizational functioning and to make tailored plans to track performance. We recommend developing a technical assistance module (which includes a feedback mechanism) to teach providers how to use and interpret engagement and retention data.

Make data relevant to program managers and their staff and clients.

When program managers and staff feel that a system-wide data collection system tracking their clients continuum of care is relevant to them, they will begin to feel an interest in using client data to monitor and improve organizational functioning. Timely and appropriate feedback after technical assistance sessions will help providers feel more invested in using data to track client

engagement, retention, and encounters. We recommend developing a mechanism for regular communication with and input from providers that would involve them in the process of identifying ways to use clinical data to improve organizational functioning.

Explore a client-provider “rapport” measure.

It is beneficial for providers to know how to collect, report, and use data, such as admission and discharge data and the engagement and retention levels computed from admission and discharge data, to make strategic decisions for their programs. Other “interpersonal” measures, such as “developing rapport” or having an “open-door” policy that measure client-provider engagement, while less researched and potentially more challenging to operationalize, are just as important in influencing engagement and retention.

Performance Improvement in Addiction Treatment: Efforts in California

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Abstract—This article examines performance data improvement efforts among alcohol and other drug (AOD) county and program stakeholders within California’s publicly-funded treatment system. County AOD system administrators from approximately two-thirds of California counties (N = 37) and a random sample of treatment program managers (N = 63) were surveyed about practices and priorities related to using performance data to improve service delivery. Survey results showed that over half (56.8%) of the county administrators reported using performance and/or outcome measures to guide decision-making about the treatment programs with which they contract. Measures of treatment engagement and retention were most frequently reported as high priorities for performance data collection. Treatment providers reported considerable variation with their use of performance measures to improve practices. Overall, findings from this study suggest that many programs and counties are taking steps toward adopting practices of performance measurement and management for treatment improvement, although they still require assistance and support in establishing, collecting, and using performance data.

Keywords—addiction treatment, performance measurement, system improvement

In recent years, increasing attention has been placed on system improvement in the addiction field. With diminishing fiscal resources for treatment, a primary concern among leaders in the field has been ensuring the efficient use of public dollars in providing quality care and achieving the best possible outcomes among the clients served. Increasingly, performance measurement has been accepted as an effective tool not only for managing the delivery of quality services, but also for monitoring whether desired outcomes have been achieved (Durman, Lucking & Robertson 2008).

Performance measures are potentially powerful tools for state-funded providers and other organizations to use to improve quality of care by setting targets and making changes to meet these targets for delivery of alcohol and other drug (AOD) services (Garnick, Horgan & Chalk 2006). The use of administrative databases to assess performance has been tested across public sector substance abuse treatment agencies in several U.S. states (Garnick et al. 2009) and in managed care organizations (Garnick, Horgan & Chalk 2006), indicating that comparisons of organizations' performance is feasible, meaningful, and informative. However, state and local agencies face numerous challenges in implementing performance measurement, including resource constraints, lack of encounter-level data, and leadership instability, each of which might erode ongoing support (Garnick et al. 2009). The ability of addiction treatment programs to collect and use data has been examined in a qualitative study, and findings suggest agencies were able to implement short-term data collection methods to make improvements in their systems, but longer-term diffusion and management of data was more challenging (Wisdom et al. 2006).

There has been statewide interest within California's publicly-funded AOD treatment system in understanding how to better monitor the activities performed and services delivered by treatment providers. However, as described by Wisdom and colleagues (2006), challenges to

implementing performance measures may include insufficient technological infrastructure, lack of staff buy-in and receptivity to moving in a data-focused direction, and insufficient agency expertise.

A widely used resource initiated in 2003 to support performance improvement efforts is the Network for the Improvement of Addiction Treatment (NIATx). NIATx is a process improvement initiative aimed at assisting treatment providers in using limited resources more efficiently and sharing strategies and tools for improving access to and retention in addiction treatment (McCarty et al. 2009). Research supports the idea that using NIATx procedures can significantly improve providers' abilities to make organizational changes and use performance data to improve the management of clinical and administrative processes that affect client access, engagement, and continuation in care (McCarty et al. 2007).

This article examines the adoption of performance measurement and management practices by California's county administrators and a sample of treatment providers throughout the state. Specifically, county and program stakeholders' perspectives and level of awareness concerning performance measurement and management practices are assessed, as well as participation in performance improvement activities, including NIATx. Factors that serve to facilitate or limit system improvement efforts in California's AOD treatment system are explored.

METHODS

The study surveyed a sample of 37 county administrators overseeing AOD services and a random sample of treatment program managers (N = 63) throughout California. Administrators and program managers were surveyed about practices and priorities related to using performance

data to improve service delivery, as well as factors that contribute to service improvement efforts. All evaluation activities reported in this study were approved by the California Department of Alcohol and Drug Programs (ADP) and University of California, Los Angeles (UCLA) Institutional Review Boards.

Measurement

County survey. An evaluation work group from UCLA and ADP developed an eight-item survey to assess the following areas: (1) the importance and use of performance/outcome measures to make decisions about treatment programs among county administrators; (2) how the county agency responds to programs that are not meeting performance/outcomes expectations; (3) priority data measures for assessing program performance and client outcomes; and (4) county agency efforts and recommendations related to system improvement. Specifically, the survey included two items with response options of *yes/no*: (a) Does your agency make routine use of specific measures of treatment program performance to make decisions regarding individual treatment programs? and (b) Has your county started efforts related to moving the treatment infrastructure toward a chronic care model? The survey also included six open-ended items: (1) If *yes* [to (a)] describe the measures you use; (2) If the measures [in question (1)] show that a treatment provider is performing more poorly than others, how does your agency respond to this information? (3) In your opinion, what performance measures would be most important to collect? (4) In your opinion, what outcome measures would be most important to collect? (5) If *yes* [to (b)] please describe the activities your county has done or is doing; and (6) If you were to redesign the current evaluation system to fit a chronic care continuum-of-services model, how

would you change it? Examples and/or background information were also provided for most of these items.

Program survey. UCLA and ADP evaluation staff developed a separate survey for program providers. The survey assessed: (1) performance practices (i.e., documentation of waiting lists, client assessment, client participation in treatment, and use of evidence-based practices); (2) experiences with performance improvement efforts; and (3) perceptions about system improvement. Providers were asked the following eight questions with *yes/no* response options: (1) Have you received training in the past year on how to practice certain types of treatment? (2) In your opinion, are there specific evidence-based practices (EBPs) that you feel are most effective with your clients? (3) Currently, does your program use any standards or criteria to decide which type of treatment the client needs at admission? (4) Currently, does your program use any standards or criteria for transferring or referring clients to another level of care upon discharge? (5) Does your program record information for clients who are put on a waiting list at admission? (6) Does your program collect information on the number of visits or sessions a client receives after admission to your program? (7) Have you heard of the Network for the Improvement of Addiction Treatment (NIATx)? and (8) Has your program implemented NIATx process improvement procedures? If the respondent answered *yes*, an open-ended question followed each of these items except for items 7 and 8. Coinciding with items 1-6, respondents were asked to describe the types of training they attended; list the EBPs for item 2; list specific standards used (for items 3 and 4); and how information is collected/recorded (items 5 and 6). As with the county survey, background information and examples were provided. In addition, all respondents were asked the open-ended question, “From your experience, how do you define ‘evidence-based practices’?”

County Study Procedures

Evaluation staff from UCLA electronically sent county surveys to administrators of AOD services in all 58 California counties via email. Surveys were formatted so that administrators could complete and return them to UCLA electronically. Surveys were also made available on the Internet, and paper copies were mailed to counties upon request. Follow-up telephone calls were conducted with each county administrator to ensure that the survey was received and to answer any questions about it. A total of 37 of the 58 AOD administrators (63.8%) completed the survey between December 2008 and March 2009. Respondents were sent a letter thanking them for their participation and, if allowed, a \$25 money order was also sent.

Program Study Procedures

UCLA evaluation staff mailed printed copies of the program survey to a random sample of publicly-funded treatment providers. A total of 63 of the 101 eligible programs (62.4%) from 25 counties returned completed surveys. Prior to mailing the surveys, evaluation staff contacted programs by phone to verify mailing addresses and obtain the names of the program directors to whom the surveys were to be addressed. Providers completed and returned the surveys in December 2008 through February 2009. Survey respondents were sent a letter thanking them for their participation, and a \$75 money order was sent, if allowed.

Data Analysis

Quantitative response frequencies were examined using the Statistical Package for Social Sciences (SPSS) version 16.0. Responses to open-ended items were read and reread multiple

times in order to identify themes, commonalities, and differences that emerged directly from the data, and first-level codes were noted. Data corresponding to each of the codes were reviewed, and several subcodes were established. Next, we evaluated the prevalence of the themes across respondents. Counts were taken of how often identical or comparable responses were endorsed. This approach allowed the key themes to emerge directly from the respondents' experiences but also allowed for counts to determine the prevalence and variability of themes across respondents.

RESULTS

County administrator survey results are first reported, describing performance and outcome measures used and identified as priorities for data collection, followed by county-wide practices and recommendations related to system improvement. Next, results of the provider survey are presented, describing program practices related to process improvement (e.g., documenting wait-lists, client assessment, perceptions and use of evidence-based practices), and involvement in process improvement procedures.

County Use of Performance/Outcome Measures

Slightly over half (56.8%) of the county administrators reported routinely using performance and outcome measures to make decisions about individual programs. Commonly tracked performance measures included: (1) utilization of services, i.e., "occupancy vs. capacity;" (2) client engagement, attendance, and participation in treatment, and (3) client's treatment compliance, retention, and program completion. County administrator survey respondents indicated that some of the performance data used came from the state data system

(California Outcomes Measurement System [CalOMS]). Data are also gathered from routine site visits (meetings) with providers, program attendance records, measures of treatment participation, completion rates, and drug testing results. Specific outcome measures used for decision-making included drug use, crime, employment, housing, and social support.

The majority of county administrators indicated that they respond to “poor performance” by initially providing programs with technical assistance (61.9%) or working with providers to develop a process/quality improvement plan (47.6%). In addition, about half (47.6%) of county administrators indicated that they have reduced or cancelled contracts, or have considered implementing funding reductions in response to poor program performance and/or poor client outcomes. Administrators in rural or less populated counties reported difficulties in using this type of performance decision-making as there tends to be only one outpatient provider in the county (which is sometimes the county agency itself).

Performance measure priorities. AOD county agency representatives identified the following items as the most important to collect to monitor program performance: measures of retention, show rates/attendance, and client engagement (see details in Table 1). In addition, some agency administrators indicated the need to monitor “client progress in treatment,” more so than measures of length in treatment or completing a period of time in treatment. Those who listed client progress as a measure of importance also indicated that measures of progress should focus on the following domains: abstinence from substance use, employment, medical care, mental health, family reunification and relationships, education, housing stability, social support, involvement in recovery groups (faith-based and/or 12-Step), and clients being integrated into the community by volunteering and accessing community resources.

Respondents also expressed the importance of collecting client satisfaction data; though one respondent stated these data should be collected only “if they could be administered in a way to ensure meaningful results.” Collecting program occupancy measures and tracking the number of clients entering and exiting treatment were also noted as priorities. Other performance measures identified as most important were programs’ ability to link clients to other needed services; program’s ability to adhere to contractual obligations and budgets; routine audits of programs and their administrative functions; clients’ level of re-entry after relapse; and use of best practices models (evidence-based).

Outcome measure priorities. Priority outcome measures expressed by county administrators are listed in Table 2. As shown, county respondents indicated that the outcomes most important to collect among clients exiting treatment include drug and alcohol use, as well as clients’ overall functioning and stability. Several administrators expressed the importance of collecting long-term follow-up outcome measures to track the sustainability of treatment outcomes. Other important outcome measures alluded to were: clients’ level of involvement with Child Protective Services (CPS) and reasons for termination from treatment.

County-Driven System Improvement Efforts

Almost half of the administrators (48.6%) indicated their counties are moving toward a chronic care model. Consistent with this model, several administrators reported that clients receive secondary prevention services (i.e., follow-up after initial care); receive individualized “treatment packages” based on clients’ level of chronicity; and have access to referral networks with local community health clinics and social service agencies. In contrast, over half of the respondents indicated there was no movement toward a chronic care model, and one reported

having “no knowledge of this model,” as it is “not currently a high priority for our county.” Several respondents reported that staff shortages and budget cuts are major reasons for the lack of such movement. One respondent indicated budget cuts have resulted in addiction services becoming “in some ways, an assembly line type of treatment . . . and limit our ability to provide services that accommodate a chronic care model.” Likewise, another respondent reported that “budget cuts have resulted in our county’s show rates declining by 40%.”

Although several counties reported collecting and using performance and outcome measures to monitor the performance of individual programs, information gathered is used to inform larger county-wide improvement efforts. For example, performance data from some programs indicated poor client show rates; however the county required all county programs to provide reminder telephone calls to each client to attend his/her initial treatment session to address the issue of client treatment attendance system-wide. Several counties reported embracing the NIATx process improvement model and focusing on performance measures of access (reduced wait times and no shows), capacity/utilization (increased admissions), and engagement/retention (continuation in treatment). Other system improvement efforts reported by some administrators included: allowing flexibility in length of stay, allowing clients to move back and forth between different levels of care, and participating in pilot projects that institute a system change effort, such as providing continuing care services or bundled services over time that accommodate a chronic care service model.

Recommendations. County administrators were asked how they would improve the current AOD system (and accommodate a continuum-of-services system model), if they were given the opportunity to redesign it. Twenty-one respondents provided recommendations for

system changes in several areas. The remaining respondents (43.2%) were unsure, had no comment, indicated the chronic care model was not applicable, or left the question blank.

Suggested changes focused on the need to improve the data system by enabling it to monitor program performance. The majority of administrators noted the importance of collecting and monitoring performance “encounter data” to evaluate program quality and redirect efforts at treatment service improvement rather than solely focusing on client outcomes (where program improvement is not central). Respondents also expressed the importance of tracking client movement between levels of care, being able to reassess clients when needed, and suggested conducting midpoint or more frequent client assessments during treatment to determine whether a different level of care is needed. In addition, county respondents noted that discharge categories in their current form needed to be modified and expanded. For example, administrators indicated that measures associated with “completion” should be reconsidered as they are not consistent with a chronic illness paradigm of care.

Program Performance Measurement Practices

Treatment access and assessment. Data from the treatment provider survey indicate 51.8% of program directors collect and record client information for those put on a wait list. Of those that do not, 12.5% indicated their program does not have a wait list, though one respondent stated a wait list is needed. Program managers reported client information (e.g., names, date of contact, contact information, referral source) is collected in-person or by phone, and is recorded in electronic databases and spreadsheets (n = 8), or on paper (n = 7) using client logs, sign-in sheets and tracking sheets. Four programs reported that a case manager, intake department, or administrative staff collect fairly extensive screening information pertaining to past drug use and

criminal and treatment history. Other programs reported only client names and dates are collected on handwritten program sign-in sheets.

Regarding client assessment, the majority of providers indicated using specific standards or criteria to decide which type of treatment clients need at admission (60.7%) and at discharge/transfer to another level of care (62.5%). Of these respondents, 35.1% indicated using the Addiction Severity Index (ASI), and 21.6% used the American Society of Addiction Medicine Patient Placement Criteria ASAM PPC criteria. Only one program used the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). A program manager reported that clients with previous failures in outpatient settings are considered for placement in residential treatment. Assessment practices at discharge also include referring clients back to the county's assessment center for re-assessment (n = 7) and conducting assessments in staff meetings to address client needs (n = 8).

Treatment participation. The majority of program providers (84.5%) reported collecting information on the number of visits or sessions clients receive after admission. While many collected this information through their county database billing systems, others reported it is solely kept in the client's chart or on a client tracking sheet. Specifically, programs reported using electronic county-based databases (n = 16), paper forms, e.g., attendance sign-in sheets, tracking sheets, or progress notes (n = 9); and activity logs, case notes, and tracking sheets (electronic or paper was unspecified; n = 18). Some program directors reported using Web-based systems, whereas others operate on a desktop platform. Twelve respondents reported session/visit information is documented in the client's case file, and seven respondents reported that a tracking sheet is used to document client visits.

Perceptions of evidence-based practices. Providers defined evidence-based practices as effective/successful practices and/or as based on science. Most responses fell into one or more of the categories outlined in Table 3.

Overall, about one-third (32.7%) of providers indicated there were no specific evidence-based practices effective with their client population, or expressed confusion, uncertainty, or skepticism about such practices. For example, one provider noted that, “there are no evidence-based practices, and since clients self-select programs, outcomes are suspect.” Another provider stated evidence-based practices are based on past practices and what has worked for programs previously.

Perceptions of effective treatment approaches. A total of 73.5% of providers indicated specific treatment approaches are most effective with client populations receiving treatment in their programs. Practices that respondents identified as most effective are listed in Table 4. Although not all practices may necessarily be considered evidence-based, these practices are what treatment providers perceived to be evidenced-based and most effective. The percent of providers who attended training on each of these approaches is also presented in Table 4.

Provider Experiences with Performance Improvement

About two-thirds (64.3%) of program managers reported they were familiar with NIATx, and 42.3% had implemented NIATx process improvement procedures in their programs. Overall, three-fourths of program managers (75.9%) reported attending one or more training sessions in the past year; of those attending any training, 42.3% attended training related to process improvement. Most of the process improvement trainings were described as related to NIATx.

DISCUSSION

While survey results are encouraging, showing that some counties and programs are taking steps toward adopting performance measurement and management practices, further work to involve counties and programs in these efforts is needed. Both providers and county administrators reported considerable variation in terms of their current progress in establishing, collecting, and using performance measures. About half of the counties use performance and outcome measures to make decisions about programs. At the program level, variation was observed in the extent of data collected that could inform program performance, such as waiting-list information and client session data. For example, some programs collected detailed information from clients on waiting lists and used Web-based systems, whereas others obtained little or no client information prior to intake. Client assessment procedures and use of evidence-based practices also varied considerably.

Providers listed a wide array of treatment practices they viewed as effective and for which they received training, and county administrators reported numerous performance and outcome measures they perceived as most important. These findings suggest there is not a clear consensus in these areas, which may present challenges to state, county, and program administrators regarding use of specific measures and evidence-based practices. While some providers report using treatment approaches included in SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), others endorsed practices with little empirical support. Although many providers received training on empirically supported treatment interventions and indicated using evidence-based practices, approximately one-third indicated confusion and uncertainty regarding such practices. Findings also indicate that while many

counties and treatment providers understand the chronic nature of addiction and the need for quality improvement, a large proportion are underprepared for the demands of a data-driven performance management system based on a chronic care model.

Improving systems of care has proven to be very challenging across a variety of chronic illness conditions. A study by Lin and colleagues (2005) suggest that how treatment providers perceive organizational commitment, climate, and management's implicit endorsement of quality improvement activities affects their efforts to improve care. Similarly, using data to improve quality requires having an organizational culture compatible with quality improvement. Thorough and efficient implementation of performance management activities (i.e., developing performance measures, gathering performance data, and using data to improve services) will require adequate and ongoing training, resources, buy-in, and active participation from all stakeholders (Durman, Lucking & Robertson 2008). Similarly, findings from this study suggest organizational factors such as insufficient funding, data system incapacities (as evidenced by reliance on paper forms to track client sessions and wait lists), and varying levels of knowledge and use of evidence-based practices may affect the extent that process improvement efforts are implemented at the local level. Moreover, county administrators expressed serious concerns regarding system improvement, as the current state budget crisis may further reduce critical resources needed to implement system changes. Fewer resources, together with what Bodenheimer, Wagner and Grumbach (2002) describe as the "tyranny of the urgent" (i.e., patients' acute symptoms and concerns) present significant challenges to optimal system improvement and management. However, having fewer resources creates an even greater need to focus on quality and efficiency. Lefkowitz and colleagues (2009) assert that, "In this unforgiving

economic environment, addiction treatment providers must exhibit optimal financial, operational, and clinical performances to survive and thrive.”

Programs’ treatment philosophies may also affect performance management. Although scarce treatment resources and time constraints may be primary reasons for minimal documentation observed among some programs, it is important to consider whether program philosophies are in agreement with prospective change efforts and the greater documentation necessary for meaningful performance measurement. Limited documentation, i.e., record keeping via a factsheet/progress report as compared to a complete case management file, is consistent with a social model philosophy (Kaskutas et al. 1998). The treatment philosophies of programs that reported limited documentation of client sessions on progress notes and tracking sheets may be at odds with data collection and system changes needed for performance measurement. Attitudes toward change efforts may be influenced by factors unrelated to the actual innovation, but stemming from the organizational culture and treatment philosophy.

Other programmatic factors to consider when implementing change efforts are treatment staff characteristics, the level of work burden, management-staff relations, and readiness to change (Aarons 2004). Accordingly, factors that may shape the extent that performance improvement activities are implemented include staff education level, licensure and certification, training, administrative policies, and staff turnover rates. Previous program survey data indicate approximately half (49%) of the treatment staff providing services in programs reporting to CalOMS were licensed and/or certified; 16% held Master’s degrees; and an average of three staff persons terminated their positions or were replaced in the past year (Rawson et al. 2008).

Programs that demonstrate shorter wait times, less staff turnover, higher staff education and training levels, and administrative policies that support a chronic illness model will likely be

better able to implement process improvement activities relative to programs without these resources. These survey findings support the importance of investigating knowledge of, and attitudes toward, specific process improvement activities and program change efforts prior to attempting to implement such efforts.

Despite numerous challenges, study findings suggest many programs and counties are actively pursuing efforts to improve program performance and manage the chronic nature of substance abuse problems more effectively. These findings, however, should be considered tentative, as this study is limited by the somewhat small sample sizes of administrators and providers, and the open-ended format of the surveys may have resulted in greater contributions to the dataset from respondents who were more motivated to express their views and opinions and/or were more committed to performance management and efforts to shift addiction treatment to a chronic care model.

Policy Implications

Assisting individual programs in tailoring performance management activities to their needs is an important initial step in the diffusion of system improvement efforts. Managers and administrators involved in NIATx may be further along in their ability to examine their program's performance by looking at rates of service use, where and why people are dropping out of treatment, how rates may differ among gender or ethnic groups, and what changes can be made to improve retention and program performance. Future steps to promote an effective "system shift" toward adopting program performance measurement and management accordingly must take into account county and program priorities, skills, and organizational culture.

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TABLE 1
Performance Measure(s) County AOD Administrators (N = 37) Identified as Most Important*

Measure	% (n)
Retention/Length of Stay	35.1% (13)
Engagement Rates and Program Participation	21.6% (8)
Show Rates/Consistent Attendance	18.9% (7)
Program Completion Rates	18.9% (7)
Client Progress in Various Domains	16.2% (6)
Client Satisfaction with Treatment	10.8% (4)
Compliance/Follow Through with Legal Obligations	5.4% (2)
Referrals to Other Agencies/Services	5.4% (2)
Program Occupancy	5.4% (2)

*Several respondents identified more than one measure.

TABLE 2
Outcome Measures County AOD Administrators (N = 37) Identified as Most Important*

Measures	% (n)
Client Abstinence/Drug Use Reduction	40.5% (15)
Recidivism/Decreased Criminal Justice Involvement	32.4% (12)
Employment	27.0% (10)
Living Arrangements/Stable Housing	24.3% (9)
Treatment Completion	18.9% (7)
Retention and Program Attendance	16.2% (6)
Participation in Self Help/Social Support	13.5% (5)
Education	8.1% (3)
Improved Relationships/Family Reunification	8.1% (3)
Long Term Outcomes (1-5 Years) and Analysis Over Multiple Time Points	8.1% (3)
Posttreatment Contact and Follow Up with Clients	5.4% (2)

*Several respondents identified more than one measure.

TABLE 3
Provider (N = 63) Definitions of “Evidence-Based Practices”*

Definition	% (n)
Based on Science/Research/Clinical Studies	36.5% (23)
Effective/Successful Practices, Practices That Result In High Treatment Completion Rates	33.3% (21)
Based on Outcome/Follow Up Studies	22.2% (14)
Based on Practices That Can Be Measured	11.1% (7)
Specific to The Needs of Certain Populations	9.5% (6)
Based on Statistics/Data	7.9% (5)
Practices Identified by SAMHSA, UCLA and/or the State of California ADP	4.8% (3)
As Exemplified by Motivational Enhancement Therapy, Matrix Model, and/or Rational Emotive Therapy	3.2% (2)

*Several respondents provided multiple definitions.

TABLE 4
Percent of Providers (N = 63) Who (a) Identified Specific Treatment Practices as Most Effective with Clients in their Programs, and (b) Who Attended Training on the Treatment Practice in the Past Year*

Treatment Practice	(a) Providers who Identified the Treatment Practice as Most Effective % (n)	(b) Providers who Attended Training for the Treatment Practice in the Past Year % (n)
Motivational Enhancement Therapy/ Motivational Interviewing	27.0% (17)	31.7% (20)
Matrix Model	15.9% (10)	6.3% (4)
Cognitive Behavioral Therapy	9.5% (6)	7.9% (5)
Twelve Step Approach	7.9% (5)	1.6% (1)
Rational Emotive Therapy	4.8% (3)	1.6% (1)
Drug Testing	4.8% (3)	--
Living in Balance (Hazelden)	4.8% (3)	--
Relapse Prevention	4.8% (3)	--
Seeking Safety	4.8% (3)	6.3% (4)
Client-Centered Treatment	3.2% (2)	--
Dialectical Behavior Therapy	1.6% (1)	3.2% (2)
Solution Focused Therapy	1.6% (1)	3.2% (2)
Behavior Modification	--	3.2% (2)

*Other practices providers identified as most effective were: Celebrating Families (n = 1), Therapeutic Communities (n = 1), family therapy (n = 1), incentives and flash incarceration (n = 1), encounter groups (n = 1), and offender specific treatment (n = 1). Providers also received training on: Rational Recovery (n = 1) and art therapy (n = 1). Several respondents identified more than one treatment practice.

APPENDIX 3B:

Enhancing California's AOD Data Management System (EnCAL) Learning from Treatment Programs – the Clinical and Program Decision-Making Process

UCLA Integrated Substance Abuse Programs (ISAP) has been working on a component of a California Department of Alcohol and Drug Programs (ADP)–contracted evaluation that seeks to find out more about how treatment providers in California make clinical and program decisions.

We would like to learn about strategies/measures that providers are using to measure success within their programs. In short, we would like to visit your site to gain insight on your perspectives on how you are making treatment work, whether you have experienced any big changes in your organization within the last year, and ways that you have adapted to these changes. The following is a flexible sample “agenda” for the site visit. **The questions under sections II through VI are directed to Program Directors (approximately 45 minutes).**

I. Tour of Program Facilities (20-30 minutes)

We'd love to see your program in action to help us get a sense of your program dynamics.

II. Your “yardstick” for measuring program success

1. What measures do you use to track your program success?
2. Do you have a board of directors that provides feedback?
3. How helpful are standardized assessments for you in tracking your program successes?

III. Dealing with big changes in your program

1. Have you experienced a big change in your program over the last year?
2. How have you dealt with significant changes in the direction of your program?
3. What types of plans have you implemented in dealing with program changes?

IV. Current Experience with Performance Measurement

1. What is your knowledge about performance measurement?
2. What type(s) of information would you like to receive to improve your understanding of performance measurement?

V. Current Experience with Performance Management

1. What is your knowledge about performance management?
2. What type(s) of information would you like to receive to improve your knowledge of performance management?

VI. Specific Training Desires

1. What are some specific trainings you would like to receive related to the understanding and use of data?

VII. Brief visit with counselors and other program staff (15 minutes)

1. What measures and strategies do you use to track client and program success?
2. What are some specific trainings you would like to receive related to the understanding and use of data?

Thank you for hosting this site visit!

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REPORT 4:

PILOT REPORT

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Integrated Substance Abuse Programs

Preface

A top priority of the California Alcohol and Drug Programs (ADP) is to improve the accountability of the alcohol and other drug (AOD) treatment system in California in terms of ensuring quality services and effective client outcomes.

Within the proposed work plan, entitled “Evaluation Services to Enhance the Data Management System in California (EnCAL),” two of the four objectives were directed at piloting innovative methods and strategies to inform ADP on this effort toward a continuum of services under a chronic care model:

- Objective 2: Enhance CalOMS-Tx system to include performance measurement/management data.
- Objective 3: Enhance CalOMS-Tx system to include performance and outcome measurement in support of the Continuum of Services System Re-engineering (COSSR)

Initially 15 counties volunteered to assist ADP and UCLA ISAP in this endeavor. Across the course of this past year, two counties determined that participation was not feasible at this time; therefore, 13 county pilots will be discussed within this report. This report synthesizes the pilot project activities, resources, and relevant literature (published and unpublished) in an effort to address Objectives 2 and 3 listed above.

Over the course of Year 1, *pre-planning*, *implementation*, and *evaluation* activities took place within each county pilot.

Pre-planning activities

Through ongoing site visits and teleconferencing, a series of planning sessions were conducted with each county pilot to (1) identify specific priorities and directions that were currently on their county AOD agendas, (2) determine which priorities were relevant under the COSSR initiative, and (3) explore strategies to enhance performance measurement and/or system-change efforts within their existing county system.

Implementation Phase

During the implementation phase, preliminary pre-pilot AOD treatment data auditing and evaluation were conducted using 2008–09 CalOMS-Tx and local county data, if available. These initial data evaluation efforts were intended to address two issues: (1) to identify how accurately the CalOMS-Tx data system reflected what was occurring within the county’s treatment delivery, and (2) to explore data analytical methods for identifying preliminary performance measures of continuity of care (transfer rates across levels of care), and retention (across levels of care and by primary drug) within the CalOMS-Tx data system.

Using the pre-planning and data auditing processes, UCLA ISAP identified and focused on five relevant themes that address the two objectives under the EnCAL work plan—performance measurement/management and system change.

1. Performance Measurement Using Data to Measure Access, Engagement, Retention, Perception of Care, and Continuity of Care (Linkage)
2. Enhancing Treatment Services Through Performance Management and/or Performance Contracting
3. Measuring Cross-Discipline Linkages and Service Delivery
4. Enhancing the Continuum of Services (Prevention, Intervention, Treatment, Recovery)
5. Measurement of Recovery Services

UCLA ISAP worked with each volunteer county to determine a goal and objectives for their pilot under the respective theme. Work plans, timelines, and activities were developed for the first year to guide the progression through the implementation and evaluation phases.

Evaluation phase

At the end of Year 1, the status and progress of each pilot vary due to the differing timelines. At this stage, however, the lessons learned from the progress to date of each pilot effort are invaluable. They help UCLA ISAP to continue to make data-driven decisions and provide recommendations for Year 2. They also enhance ADP's understanding of the real-world complexities and practicalities of system change.

For widespread dissemination, UCLA ISAP has set up a website as a communication venue so that all counties (pilots and non-pilots) can be informed on project activities and lessons learned. The website includes descriptions of the pilot projects, updates on news and findings from the pilots, a description of the five themes, updates on available trainings related to performance measurement, use of AOD treatment data, process improvement, as well as resources for other state and federal hot topics. The website can be found at: www.uclaisap.org/cosr-pilots.

Organization of the Report

This Pilot Project Report is divided into 5 chapters/themes that address Objectives 2 and 3 of the EnCAL work plan. Chapter 1 reviews findings from Theme 1 on performance measurement for adoption in California (Fresno, Orange, Sonoma, and Ventura counties). Chapter 2 provides a summary of Theme 2 county pilot activities that enhance treatment services through performance management and/or performance contracting (Alameda and Los Angeles counties). Chapter 3 discusses pilot activities under Theme 3 that measure cross-discipline linkages and service delivery (Lassen and Marin counties), while Chapter 4 focuses on Theme 4, enhancing the continuum of services—prevention, treatment, and recovery (Solano county). Finally, Chapter 5 discusses pilot activities working toward documenting and/or measuring recovery services after treatment, which fall outside of the CalOMS-Tx system (San Bernardino, Mariposa, San Mateo and Santa Clara counties). Each chapter closes with an overall summary of each theme, with recommendations for ongoing work under these objectives.

4.1 CHAPTER ONE

Theme 1: Performance Measurement Using Data to Measure Access, Engagement, Retention, Perception of Care, and Continuity of Care (Linkage)

4.1.1 INTRODUCTION

Theme Overview

The use of performance measures has become increasingly important to improve the accountability and quality of publicly funded substance abuse treatment. Historically, alcohol and other drug (AOD) treatment program measurement has focused solely on changes in client outcomes from short-lived treatment (typically 90 days or less) (McLellan, Chalk, & Bartlett, 2007). Researchers and policy makers have begun to shift their attention toward understanding the role of “performance measurement” as an important concept in assessing the benefits provided by AOD treatment (McKay, 2005). Performance measures are used to estimate and monitor the extent to which the actions of a treatment provider conform to best practices or other standards of quality. Establishing a set of performance measures for substance use treatment is a priority for developing accountability within the AOD treatment system (McCorry et al., 2000).

At present, seven performance measures have been adopted by a number of national, state, and local entities. Research studies examining the relationship between these performance measures and substance abuse treatment outcomes to date, however, have been limited. As measures continue to be adapted and modified with further testing and research, these measures are being expanded upon and improved.

Relevance to the COSSR Framework

The California Department of Alcohol and Drug Programs (ADP) has initiated a restructuring of the AOD system from a fragmented set of treatment services that deliver acute care treatment episodes, into a system of care that promotes ongoing care across a continuum of services. This initiative has been titled the Continuum of Service System Redesign (COSSR) initiative. Within this COSSR framework, a primary principle is to redefine treatment effectiveness and emphasize a coordinated system of care. In addition, effective treatment is defined by a set of program performance measures that are known to be associated with improved client outcomes. Potential performance measures include:

1. Immediate treatment access,
2. Treatment engagement (Simpson et al., 2007; Garnick et al., 2007),
3. Treatment retention (DATOS studies - Hubbard et al., 2003; Simpson et al., 2004),
4. Use of evidence-based practices, including both psychotherapeutic and pharmacotherapy (NQF, 2007),
5. Receiving supplemental/ancillary services for medical, psychiatric, and/or family problems (McLellan et al., 2008),
6. Promoting the participation in mutual self-help groups (McKay, 2005),

7. Ensuring care continuity post-initial treatment (Dennis et al., 2006; Godley et al., 2008).

Useful performance measures can be collected frequently with minimal data burden, allow for immediate program changes and improvement, and they are controllable at the program level. There is a need to further apply these measures within real-world AOD treatment settings. UCLA is promoting the application of performance measurement strategies within the AOD system in a manner that also promotes the goals of the COSSR initiative. UCLA has partnered with a number of California counties throughout the state on a set of pilot projects to explore the usefulness of various forms of performance measurements.

Pilot Purpose

UCLA ISAP identified four participating counties to contribute to the work under this EnCAL-COSSR theme: “Performance Measurement Using Data to Measure Access, Engagement, Retention, Perception of Care, and Continuity of Care (Linkage)”:

- 1) Fresno County, Dennis Koch
- 2) Orange County, Brett O’Brien
- 3) Sonoma County, Gino Giannavola
- 4) Ventura County, Patrick Zarate

The objectives of the pilots that fall under this theme are as follows:

- 1) To assist counties that are working toward enhancing their local AOD data systems to incorporate valid and meaningful performance measurement efforts;
- 2) To further investigate the relevance and reliability of performance measures for quality treatment in real-world settings;
- 3) To identify potential strategies to improve performance outcomes;
- 4) To report on potential deficits in the CalOMS-Tx system for performance measurement and to make recommendations for future system enhancements;
- 5) To provide technical assistance and training to counties to facilitate performance measurement.

The following section compiles the Process and/or Findings from the four county pilots contributing work toward this theme. Details from each county pilot effort are described within a Performance Pilot Year 1 Summary Report. The summary reports include the following sections:

- Introduction
- Goals and Objectives
- Methods
- Preliminary Observations and Findings
- Lessons Learned
- Next Steps for Year 2

Following the individual county pilot summary reports is a section describing an overall summary of lessons learned from the pilot work under this theme and recommendations for future work.

4.1.2 PROCESS AND/OR FINDINGS

PERFORMANCE PILOT YEAR 1 SUMMARY

Theme 1: Performance Measurement

Pilot County: Fresno

Pilot County Administrator: Dennis Koch

Pilot Theme: Performance Measurement Using Data to Measure Access, Engagement, Retention, Perception of Care, and Continuity of Care (Linkage)

Pilot Title: Movement of Clients Across the System of Care: Residential to Outpatient Treatment

INTRODUCTION

At the start of Year 1 of the EnCAL-COSSR pilot, Fresno County's Department of Behavioral Health, Substance Abuse Services expressed interest in enhancing its alcohol and other drug (AOD) treatment data system to include AOD treatment episode data and linkage to billing to prepare for the county's shift to a performance-based contracting model. Over the course of the EnCAL-COSSR pilot-planning phase and as project goals evolved, UCLA and Fresno County AOD staff determined that prior to implementing performance-based contracting it would be prudent to assess county and provider readiness for performance measurement and management. Through ongoing discussions, it became clear that Fresno County has a large and comprehensive treatment system and that while measures have been implemented to collect data, assistance is needed to move from data collection to a systematic process of evaluating performance measures to improve client and program level outcomes. In addition, it appeared that provider understanding of how to deliver services within a chronic care framework and knowledge of performance measurement was low. As a result of these early discussions, UCLA and Fresno County revised Fresno's Year 1 pilot goals and objectives to address these issues.

GOALS AND OBJECTIVES

Goal

To assist Fresno County to use CalOMS-Tx data, as well as the local data system, to begin the utilization of performance data for program improvement and to increase the County's movement toward a chronic care model.

Objectives:

- Create data reports using CalOMS-Tx and local data system data.
- Orient county providers to the chronic care model.

- Evaluate dosage of service in outpatient care settings by analyzing encounter data.

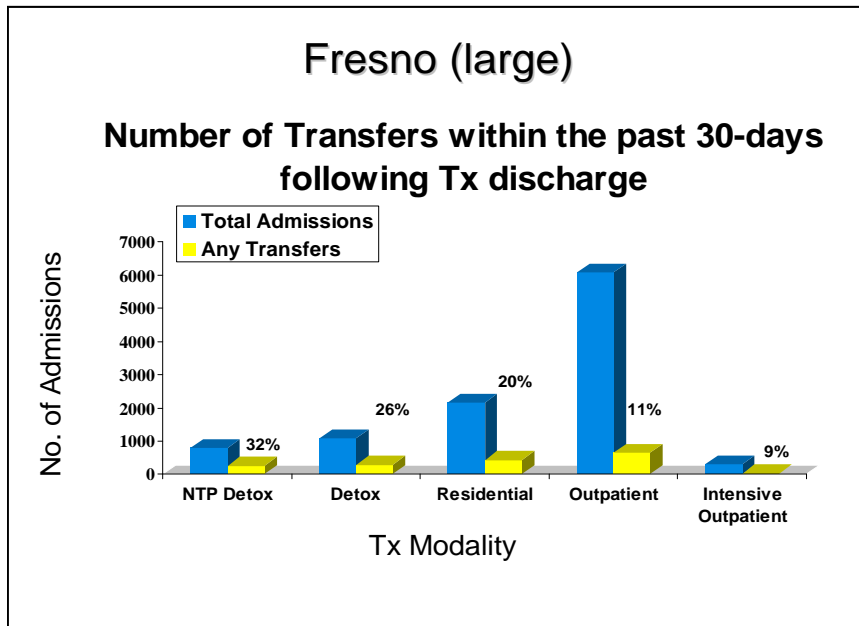
METHODS

- UCLA assisted Fresno County’s Department of Behavioral Health, Substance Abuse Services staff to use CalOMS-Tx data to assess client transfer rates (i.e., the percentage of clients who transferred from one level of care to another within 30 days of discharge), with a focus on transfers from residential treatment to other treatment modalities.
- UCLA provided technical assistance training on providing substance use treatment services within a chronic care framework to Fresno County administrative staff and treatment program leaders. During the training, UCLA introduced CalOMS-Tx transfer rate performance data, with an emphasis on transfer rates from residential services to any other service.
- Fresno County selected three residential providers to pilot an intervention to increase transfer rates from residential programs to outpatient programs. In Year 2, UCLA will facilitate the discussion between the county administrator, the selected residential providers, and selected outpatient providers in order to provide any needed technical assistance to assure a systematic approach that is agreeable to all entities.
- UCLA and Fresno County staff hypothesized that client transfer rates to outpatient services would increase after implementation of technical assistance and the piloted intervention.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

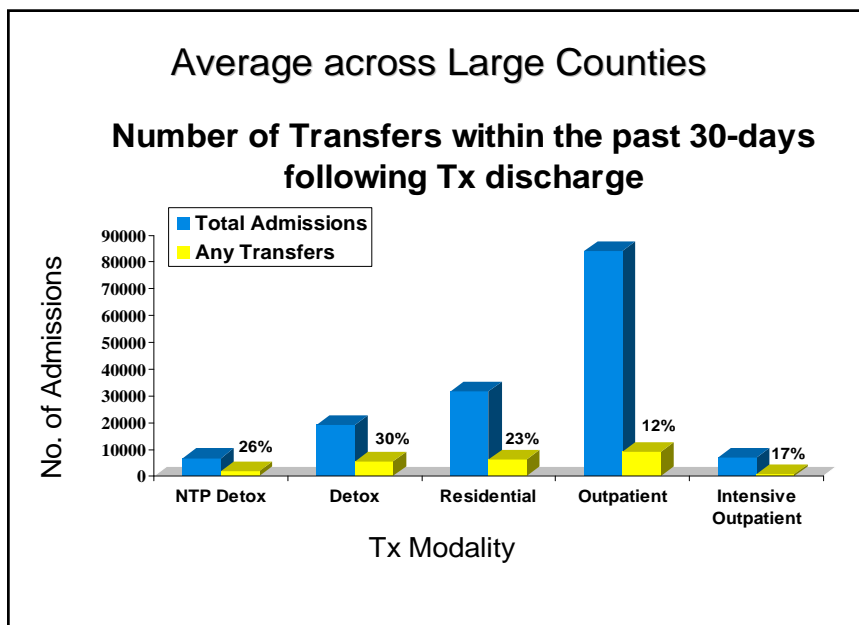
- **Preliminary Findings on Transfer Rates in Fresno County**
 - 20% of all client admissions to residential treatment in Fresno County between 2008 and 2009 transferred to another service within 30 days of discharge from residential treatment (Table 1).
 - Although Fresno County’s transfer rates were similar to the average transfer rates for other counties of similar size (Table 2), transfer rates were lower than desired for continuity of care within a chronic care model.
 - Of clients who transferred from a residential service to another service within the same treatment episode (within 30 days), 11% transferred to an outpatient program, 8% transferred to another residential program, 7% transferred to a detox service, and 1% transferred into an intensive outpatient program (Figure 1).

Table 1: Transfer Rates by Service Type for Fresno County*



* Transfer rates were determined by using the CalOMS-Tx 2008-09 data and calculating the percentage of treatment admissions that resulted in a new admission to another level of care within 30 days of the treatment discharge.

Table 2: Transfer Rates by Service Type for All Large California Counties*



Transfers from Residential Fresno

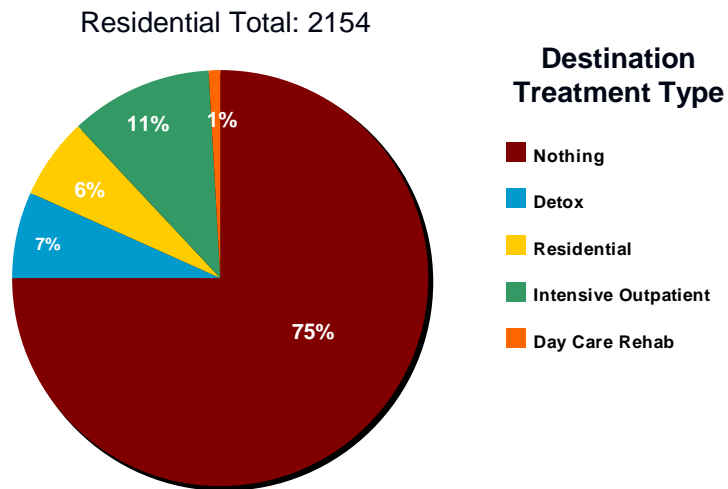


Figure 1: Distribution of Transfers from Residential Programs in Fresno

LESSONS LEARNED

- **Using transfer rates as a performance measure of continuity of care in Fresno County is feasible but may have some limitations.**
 - Fresno County has a large and comprehensive treatment system. Residential care, outpatient treatment, and narcotic treatment programs (NTPs) are available for individuals with substance use disorders.
 - Preliminary transfer rates suggest that programs operate relatively independently, with little interaction or referral between programs. Improving provider connectedness may improve transfer rates.
 - According to county staff members, Fresno County has many providers that do not necessarily view outpatient treatment as a next step after residential treatment. Technical assistance to orient the clinical staff toward a chronic care model and encourage continuity of care may improve this outcome, but additional follow-up and incentives may be required.

- It may be difficult to increase transfer rates for residential treatment clients referred by the criminal justice system for 30-day treatment, as these clients typically deny outpatient services.
- Budget cuts reduced the ability for the county to purchase any detox beds for fiscal year 2009-10, therefore eliminating any continuity-of-care pilot measurement within the detox service modality.
- **There may be barriers to use of data and performance measures in Fresno County.**
 - As in many counties, it appears that the use of data among providers is low. Providers rarely see their data after input.
 - Data reports from the upgraded billing system have not been available and are still in development, which has delayed any pilot efforts using encounter data.

NEXT STEPS FOR YEAR 2

- **Identify strategies to improve transfer rates from residential programs.**
 - Provide additional training and technical assistance on the selected strategies.
 - Identify data source for measuring pilot impact (i.e., CalOMS-Tx and/or Fresno's local data system).
 - Review county reports from the upgraded billing system to work toward integrating encounter data into the pilot effort.
 - Improve the reliability and validity of the transfer rate analysis algorithm.

RELEVANT LITERATURE AND RESOURCES

Garnick, D.W., Lee, M.T., Horgan, C.M., Acevedo, A., Washington Circle Public Sector Workgroup. (2009). Adapting Washington Circle performance measures for public sector substance abuse treatment systems. *Journal of Substance Abuse Treatment*, 36, 265-277.

McLellan, A.T., Chalk, M., & Bartlett, J. (2007). Outcomes, performance, and quality – what's the difference? *Journal of Substance Abuse Treatment*, 32, 331-340.

McLellan, T.A., Lewis, D.C., O'Brien, C.P., & Klebert, H.D. (2000) Drug dependence, a chronic medical illness. *JAMA*, 284(13), 1689-1695.

PERFORMANCE PILOT YEAR 1 SUMMARY

Theme 1: Performance Measurement

Pilot County: Orange

Pilot County Administrator: Brett O'Brien

Pilot Theme: Improving Performance Measurement: Access, Engagement, Retention, Perception of Care, and Continuity of Care (Linkage)

Pilot Title: Using CESI/CEST (Motivation/Engagement) Data as a Performance Measure to Enhance Treatment and Improve Retention

INTRODUCTION

In 2005, Orange County Health Care Agency (OCHCA), Alcohol and Drug Abuse Services (ADAS) was looking for a new measure of client readiness for change. They were using the Addiction Severity Index (ASI) as their primary client assessment tool, but wanted a less time-intensive measure that would reveal information about client functioning and readiness for treatment. OCHCA eventually replaced the ASI with Texas Christian University's "Client Evaluations of Self and Intake/Treatment (CESI/CEST)." The CESI measures client motivation at intake, as indicated by client problem recognition, desire for help, and treatment readiness. The CEST measures client engagement in treatment, as indicated by counseling rapport, treatment participation, and peer and social support.

CESI/CEST data can be used at the provider level as an overall measure of training needs and as a measure of performance (e.g., changes in motivation and engagement throughout treatment), and also at the counselor level to determine clients' needs for interventions to improve motivation and engagement and to track changes throughout treatment. Studies suggest that longer retention in treatment is a predictor of favorable drug abuse outcomes and that higher motivation at intake is related to better engagement with counselors; better engagement with counselors is related to higher session attendance; and higher session attendance and engagement with counselors are related to longer retention in treatment (Simpson, Joe, Rowan-Szal, & Greener, 1997).

Every alcohol and other drug (AOD) client who receives services provided by OCHCA or one of its contracted providers completes the CESI at intake and the CEST at various time points during treatment as well as at discharge. With nearly 11,000 new clients admitted to AOD treatment each year, OCHCA has a substantial amount of motivation and engagement data. Although OCHCA compiles annual reports for providers that show aggregated motivation and engagement data, county staff are not certain if the reports are helpful to providers. Moreover, although providers have been given an electronic scoring worksheet, which can be used by counselors/clinicians to immediately calculate client motivation and engagement scores, it is unclear to what degree that scoring worksheet is used. Through discussions with UCLA, OCHCA decided to focus its performance pilot on educating program leaders and counselors on

the use of CESI/CEST data in assessment and treatment planning, as well as how those data can be used to measure program performance.

GOALS AND OBJECTIVES

Goals

- To increase provider awareness of how data can be used to inform provider-level and client-level decision-making and treatment planning.
- To increase use of CESI/CEST data at the program leader and counselor level.
- To increase client retention.

Objectives

Provide a pilot training to one contract provider in Orange County to:

- Familiarize staff with the general concept of using data to inform provider-level and client-level decisions.
- Demonstrate for staff the relationship between measures of motivation and engagement, as measured by the CESI/CEST, and client retention, as measured in CalOMS-Tx.
- Train staff on ways to use CESI/CEST data to measure provider-level performance and client-level treatment needs.
- Help staff identify technical assistance needs based on CESI/CEST data.
- Measure changes in staff attitudes toward using data to make treatment and programming decisions.
- Measure changes in client retention following data training (and subsequent technical assistance training, if needed).

METHODS

Pilot Development

- UCLA and OCHCA staff participated in conference calls and meetings to identify an area of interest for the Orange County performance pilot.
- OCHCA research staff analyzed their data to examine associations between motivation and engagement, as measured by the CESI/CEST, and retention, as measured by CalOMS-Tx.

- UCLA and OCHCA collaborated on the development of a workplan and training slides, and on logistical arrangements for the training.
- OCHCA used CESI and CEST data to identify a contract provider that had clients with lower than the national and county averages for client motivation at intake and discharge. Orange County is currently planning the training at one contract provider with sites at three separate locations.

Training

- **Using Client Motivation and Engagement Data (CESI/CEST) to Enhance Treatment: Session 1.** OCHCA and UCLA will provide Session 1 of the training at three separate locations. The Session 1 agenda is as follows (please see training slides for more detailed information):
 1. Introduction
 - a. What is COSSR?
 - b. What is Your “Data Stage of Change?” (i.e., pre-test of attitudes toward using data)
 - c. What is/are Data?
 - d. Data in Everyday Life
 2. What Do CESI/CEST Data Tell Us?
 3. Why are Motivation and Engagement Important?
 4. Presentation of Orange County FY08-09 CESI/CEST Data
 - a. Motivation and Engagement Predict Retention
 - b. Motivation at Intake Predicts Engagement at Follow-up
 - c. Provider Motivation and Engagement Scores Compared to Local and National Norms
 - d. Changes in Motivation Over the Course of Treatment
 5. How You Can Use CESI/CEST Data to Improve Treatment?
 6. Demonstration/Overview of Existing Annual CESI/CEST Provider-Level Reports and Scoring Worksheet for Calculating Individual Client Scores
- **Between-Session Brainstorming Exercise:** Participants of the training will complete a brainstorming exercise to work together as a team to come up with a strategy for using motivation and engagement data to identify possible changes at the program or counselor level. OCHCA ADAS and research staff will participate in a parallel brainstorming session.

- **Using Client Motivation and Engagement Data (CESI/CEST) to Enhance Treatment: Session 2.** OCHCA and UCLA staff will return to the training sites for the second and final session. The Session 2 agenda is as follows:
 1. Review Project and Brainstorming Exercise Goals
 2. Discuss Results of Brainstorming Project (for both provider and ADAS staff)
 3. *Now* What is Your “Data Stage of Change?” (post-test)
 4. Making a Change
 - a. Choose One Change/Improvement
 - b. Identify Timeline for Making Change
 - c. 6-Month Follow-up
 - i. Post-test #2 of Data Use Attitude
 - ii. Examination of Client Changes in Motivation, Engagement, and Retention (as appropriate based on change implemented)

Measurement

- Changes in retention (per CalOMS-Tx): compare retention prior to and in the months following the pilot.
- Changes in attitudes toward using data to make treatment planning and program decisions: comparison of data use attitude prior to and after the training (i.e., at beginning of Session 1, at end of Session 2, and 6 months after training).

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **CESI/CEST Data Issues**
 - OCHCA noted that, for many providers, collection of motivation and engagement data at points between intake and discharge were inconsistent, making it difficult to evaluate changes in motivation from intake to midpoint and from midpoint to discharge.
 - Motivation data from discharge may not be as useful as motivation data from other points in treatment because (a) discharge data are primarily collected for clients who graduate from the program, and (b) measuring treatment readiness and desire for help may be lower and not as useful at discharge because clients are getting ready to leave treatment.

- To make CESI/CEST motivation and engagement data more useful as a performance measure, providers might consider increasing data collection at midpoint (or possibly at multiple points).
- **Participant Receptiveness to Data Training**
 - *Qualitative description of participant receptiveness to training is forthcoming in Year 2 activities.*
- **Outcome of Brainstorming Exercises**
 - *Qualitative description of brainstorming exercises to training is forthcoming in Year 2 activities.*
- **Changes in Client Retention**
 - *Description of changes in retention following training is forthcoming in Year 2 activities.*

LESSONS LEARNED

- **There may be limitations to CESI/CEST data.**
 - If providers are not able to increase collection of data at points other than intake and discharge, usefulness of CESI/CEST data as a performance measure may be limited.
 - Motivation data at discharge may not be as useful as motivation data from intake and points during treatment. Readiness-for-treatment and desire-for-help scores at discharge could actually be lower than at intake or midpoint because clients are ready to leave treatment and may perceive they need less help.

NEXT STEPS FOR YEAR 2

- **Provide OCHHCA with training/technical assistance.**
 - UCLA and OCHCA staff will provide the “Using Client Motivation and Engagement Data (CESI/T) to Enhance Treatment” training to program leaders and counselors at a selected contract provider.
 - If the provider identifies technical assistance training as an outcome of its brainstorming exercise, OCHCA will collaborate with UCLA and the Pacific Southwest Addiction Technology Transfer Center (PSATTC) to provide training to staff of this facility.
- **Identify and analyze data for performance measurement.**

- OCHCA staff will monitor changes in client retention at this provider at regular intervals following the training and compare them to pre-training retention rates.
- OCHCA staff will monitor changes in data collection activities at points other than intake and discharge.

RELEVANT LITERATURE AND RESOURCES

Client Evaluation of Self and Treatment: Intake Version (CESI) (2005). Fort Worth: Texas Christian University Institute of Behavioral Research.

Client Evaluation of Self and Treatment: Treatment Version (CEST) (2005). Fort Worth: Texas Christian University Institute of Behavioral Research.

EnCAL Pilot Training Slides: *Using Client Motivation and Engagement Data (CESI/T) to Enhance Treatment. Developed by UCLA and Orange County Health Care Administration, 2010.*

Simpson, D.D., & Bartholomew, N.G. (2008.) *Using Client Assessments to Plan and Monitor Treatment: A Guide for Using the TCU Client Evaluations of Self and Treatment (CEST) in Individual and Group Counseling Sessions.* Fort Worth: Texas Christian University Institute of Behavioral Research.

Simpson, D. D., Joe, G. W., Rowan-Szal, G. A., & Greener, J. M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment, 14*(6), 565-57.

Texas Christian University, Institute of Behavioral Research assessments and training materials: <http://www.ibr.tcu.edu/> .

PERFORMANCE PILOT YEAR 1 SUMMARY

Theme 1: Performance Measurement

Pilot County: Sonoma

Pilot County Administrator: Gino Giannavola

Pilot Theme: Performance Measurement Using Data to Measure Access, Engagement, Retention, Perception of Care, and Continuity of Care (Linkage)

Pilot Title: The Utilization of Encounter Data as a Performance Measure to Improve Engagement and/or Retention

INTRODUCTION

At the start of Year 1, Sonoma County's Alcohol and Other Drug Division (AODS) expressed interest in utilizing AOD encounter data to measure engagement as a performance outcome in their treatment system. Encounter data essentially is raw data captured at the client level documenting the number of times a client experiences a treatment process or engages with the treatment system (i.e.: clinic visit, individual session, group session, urine test, etc.). Programs can select which types of encounters to collect based on what outcomes are chosen to measure. Sonoma County uses the California Web Infrastructure for Treatment Services (SWITS) data system, which is also used for provider billing. The current database maintains not only AOD group rosters and participation data, but also treatment progress notes, which can provide the encounter data required to measure engagement. As of January 1, 2010, all AOD services billed to Sonoma County required an associated encounter note to receive reimbursement. Through ongoing discussions with the county administrator and the lead data analyst, it was clear that this mechanism of linking provider reimbursement to the submission of performance data could be useful as a pilot project to improve provider data awareness and utilization as well as to measure the impact on client engagement and retention rates.

GOALS AND OBJECTIVES

Goal

To assist Sonoma County's movement toward a chronic care model and explore methods of accessing encounter data from the local data system to begin the utilization of performance measurement/management and, possibly, performance contracting for program improvement.

Objectives

- Audit or evaluate whether the CalOMS-Tx system accurately reflects what is occurring within the county's treatment delivery system.
- Orient county providers to the chronic care model.

- Evaluate how linking encounter data with provider reimbursement may impact program performance (i.e., treatment engagement and retention).

METHODS

- UCLA assisted Sonoma County’s Alcohol and Other Drug Division (AODS) to evaluate CalOMS-Tx data to assess their current system’s continuity of care (i.e., client transfer and retention rates).
- Sonoma County compared CalOMS-Tx data to local system data to verify the accuracy of the CalOMS-Tx database.
- Sonoma County implemented the requirement of entering encounter notes for all provider reimbursements in January 2010.
- UCLA provided technical assistance training on providing substance abuse treatment services within a chronic care framework to Sonoma County administrative staff and treatment program leaders. During the training, UCLA introduced the relevance of performance measurement, monitoring, and contracting.
- In Year 2, UCLA will assist the county to analyze the data before and after the encounter data requirement to measure the impact on provider performance and client outcomes.
- UCLA and Sonoma County staff hypothesized that client engagement and retention would increase after implementation of technical assistance and the piloted intervention.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **Preliminary Findings on Transfer Rates in Sonoma County**
 - Although Sonoma County’s transfer rates were similar, if not slightly higher, than the average transfer rates for other counties of similar size (Tables 1 and 2), transfer rates were lower than desired for continuity of care within a chronic care model.
 - An interesting system finding specific to Sonoma County was identified among clients who transferred from a detox service to another service within the same treatment episode (within 30 days); 29% of clients who were discharged from a detox facility were admitted into another detox program within 30 days (Figure 1).
 - This data was confirmed by the county and could be the result of 85% of Sonoma County’s AOD treatment population being referrals from the criminal justice system. Sonoma noted that detox is not currently qualified as “treatment” within their AOD system. Instead, most of the clients who enter detox do so as an alternative to jail, not a first step in a continuum of care. As a result, only about

15-20% of the clients who enter detox enter formal treatment. These rates are also probably lower now due to decreased treatment capacity.

- Analyzing the retention data by primary drug has led the team to potentially seek further clarity of the treatment of marijuana users within the county (Table 3).
- Analyzing the retention data by treatment modality led the team to potentially seek further clarity of length of stay among treatment modalities by primary drug users (Table 4).
- Sonoma County confirmed that these preliminary data from CalOMS-Tx appear to reflect the data within the local data system.
- Their providers varied in data expertise; therefore, a training was requested for all providers and administrative staff to build a better understanding of the chronic care model, the significance of performance data, and how it relates to the county’s implementation of linking encounter notices with reimbursement.

Table 1: Transfer Rates by Service Type for Sonoma County*

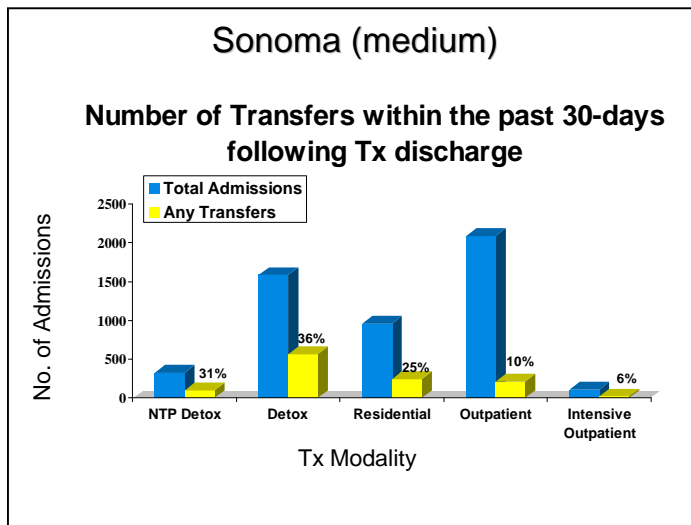


Table 2: Transfer Rates by Service Type for all Medium California Counties*

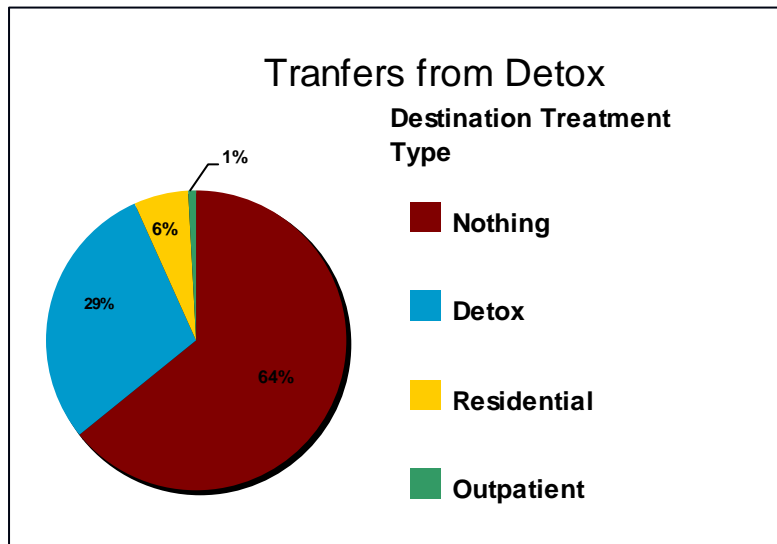
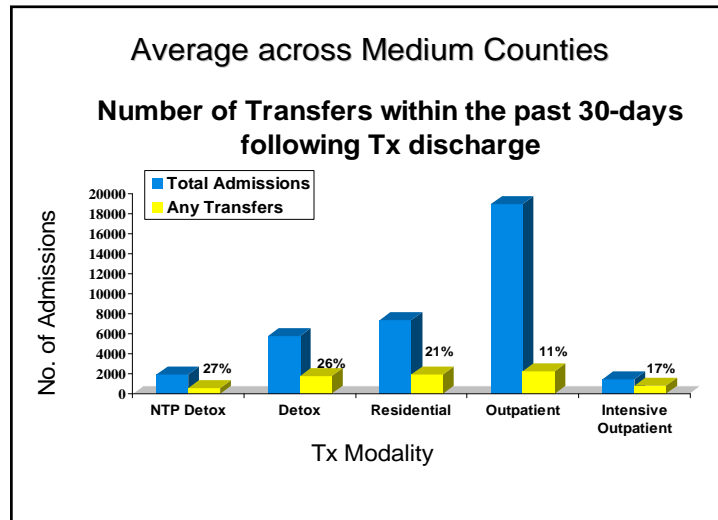
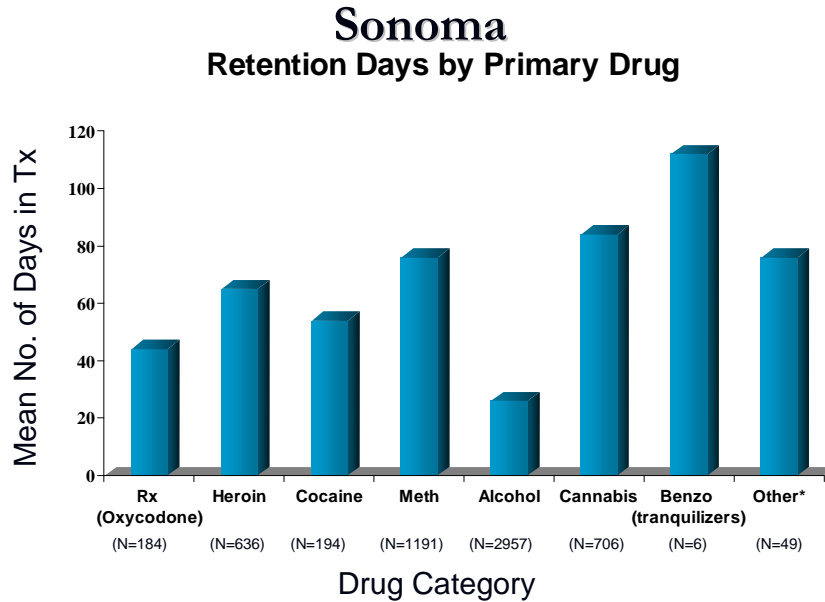


Figure 1: Distribution of Transfers from Detox Programs in Sonoma County

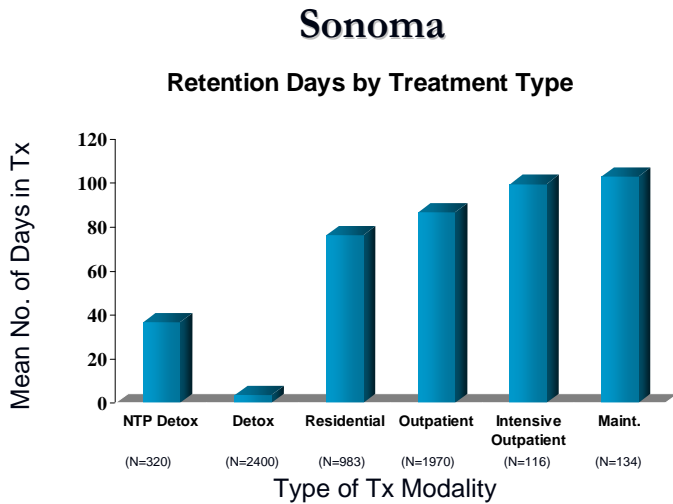
* Transfer rates were determined by using the CalOMS-Tx 2008-09 data and calculating the percentage of treatment admissions that result in a new admission to another level of care within 30 days of the treatment discharge.

Table 3: Retention Rates by primary drug in Sonoma County



*Other = barbiturates, PCP, inhalants, ecstasy, hallucinogens, club drugs, and other stimulants and tranquilizers

Table 4: Retention Rates by Treatment Modality in Sonoma County



LESSONS LEARNED

- Preliminary efforts toward using CalOMS-Tx data for performance measurement can identify county-specific system intricacies and generate discussions for system improvement.

- Sonoma County's AOD treatment system is 85% Criminal Justice related; thus, several clients in detox, in particular, are considered "frequent flyers" who are difficult to engage into the treatment system since the detox is being used as punishment, not as a first step in a continuum of care.
 - Due to budget cuts, the number of county-paid detox beds was cut in half, which reduced the feasibility of focusing any pilots efforts on increasing the link from detox to rehabilitation services (Note: due to low utilization when the facility had 30 beds, client impact was none to minimal. The data may show the impact but, given the low utilization, even the data impact may be insignificant.)
 - Preliminary transfer rates suggest that programs operate relatively independently with little interaction or referral between programs. Improving provider connectedness may improve transfer rates.
 - Of those clients who entered residential treatment, the proportion that transferred to outpatient treatment seemed relatively low. The county confirmed that most of the residential programs have an aftercare program within the facility. However, these aftercare activities are not captured in the CalOMS-Tx database.
- **Conducting ongoing and regular data improvement discussions and trainings with providers and clinical staff is instrumental to improving the quality of data from the programs.**
 - The county has been conducting monthly (switched to quarterly in January 2009) SWITS Users Meeting with all providers since May 2008. The primary purpose of these meetings is data quality intervention/training. These meetings have resulted in overall improvement of data entry among their providers.
 - The training on providing substance abuse treatment services within a chronic care framework allowed Sonoma's administrative staff and treatment program leaders to collaborate on strategies to improve transfer rates within their system for future implementation.

NEXT STEPS FOR YEAR 2

- **Identify strategies to improve engagement and/or retention through the use of encounter data.**
 - UCLA and Sonoma County to allow for time of the encounter note/reimbursement intervention to be well established within the county's local data system.
 - UCLA will assist in any further technical assistance on the chronic care model.

- UCLA will assist the county to measure the impact of the encounter note/reimbursement intervention by comparing changes in length of stay, outcomes, and the number of admissions/discharges among their clients in the county's local and CalOMS-Tx database.

RELEVANT LITERATURE AND RESOURCES

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PERFORMANCE PILOT YEAR 1 SUMMARY

Theme 1: Performance Measurement

Pilot County: Ventura

Pilot County Administrator: Patrick Zarate

Pilot Theme: Performance Measurement Using Data to Measure Access, Engagement, Retention, Perception of Care, and Continuity of Care (Linkage)

Pilot Title: Implementation of the “Promoting Awareness of Motivational Incentives” (PAMI) Model to Improve the Linkage of Services from Detox to Rehab

INTRODUCTION

As a COSSR pilot effort set forth prior to the start of the EnCAL-COSSR pilot activities, Ventura County Behavioral Health Alcohol and Drug Programs (ADP) contracted with Tarzana Treatment Center (TTC) to provide medical detox services for those who were assessed for detox service at the Ventura County ADP Centers (Ventura, Oxnard, and Simi). This inter-county agreement provided Ventura County with the ability to provide medical detox services for county clients at an out-of-county facility. Since Ventura County had already implemented an innovative way to link services across a continuum of care, discussion on how to improve the engagement and retention rate of patients linked to rehabilitative services ensued. With further collaboration and evaluation, UCLA and Ventura County concluded that contingency management could be an effective strategy with which to increase the number of clients who stay in treatment and to extend the duration of their stay. UCLA subsequently proposed the “Promoting Awareness of Motivational Incentives” (PAMI) as an effective practice to further enhance their COSSR-EnCAL pilot effort and perhaps utilize it in other areas of their ADP system.

GOALS AND OBJECTIVES

Goal

To use an evidence-based practice to improve continuity of care within Ventura County’s ADP system, with an emphasis on linkage to post-detoxification rehabilitation services.

Objectives

- Identify current transfer rates (linkage) between detox and rehabilitation services using local and CalOMS-Tx data reports.
- Conduct a case study to document the TTC detox protocol and system processes within a county setting (see SARC Special Issue *Journal of Psychoactive Drugs*, 2010).

- Orient county staff and providers to the strategy to improve program performance (continuity of care and retention) within rehabilitation services.
- Evaluate the impact of performance improvement strategy using local and CalOMS-Tx data reports.

METHODS

- UCLA assisted Ventura County ADP staff to examine CalOMS-Tx data on the percentage of clients who transferred from medical detoxification services to rehabilitation services within 30 days of discharge from medical detoxification.
- UCLA assisted Ventura County in documenting the feasibility of incorporating a cross-county contract mechanism to provide detox services (see SARC Special Issue *Journal of Psychoactive Drugs*, 2010).
- UCLA provided Ventura County ADP staff and treatment program leaders with technical assistance training on the core concepts of the evidence-based practice (EBP) “Promoting Awareness of Motivational Incentives” (PAMI).
- Ventura County ADP staff developed a protocol to implement PAMI in two different sites: an adolescent clinic and an outpatient program in their adult intensive outpatient (IOP) program.
- UCLA will provide Ventura County ADP staff with a site-specific PAMI training for each program that will implement the PAMI model.
- UCLA and Ventura County ADP staff hypothesized that client transfer rates and retention would increase after implementation of PAMI.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **Ventura County Transfer Rates, as Indicated by CalOMS-Tx Data**
 - Ventura County’s transfer rate from NTP detox to any other services was 26% (Table 1).
 - Although Ventura County’s transfer rates were similar to the average transfer rates for other counties of similar size (Table 2), transfer rates were lower than desired.
 - Utilizing Ventura’s local data system and focusing on pilot client activity over the last two years, the following finding was identified: Of the 117 clients admitted into detox, the county placed 70 clients in some form of follow-up alcohol and drug treatment within 30 days of discharge, for a post-detoxification treatment

enrollment rate of 60%; of those that enrolled in a rehabilitation service, many dropped out after the first visit.

- **An Evidenced-Based Practice to Improve the Linkage of Services from Detox to Rehab**

- After continued consultation and collaboration among Ventura County ADP leaders, administrative staff, and providers, the use of PAMI was identified as an effective EBP that could be readily adapted to improve linkage of clients between NTP detoxification and rehabilitative services.

Table 1: Transfer Rates by Service Type for Ventura County*

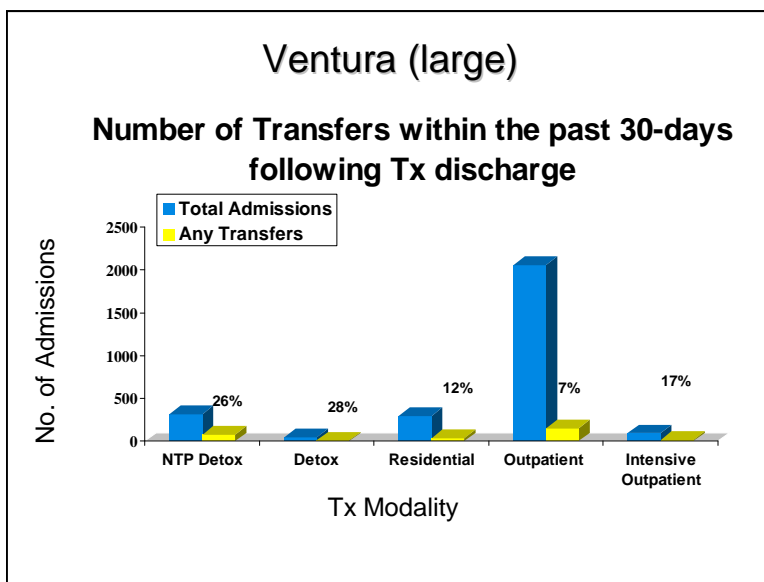
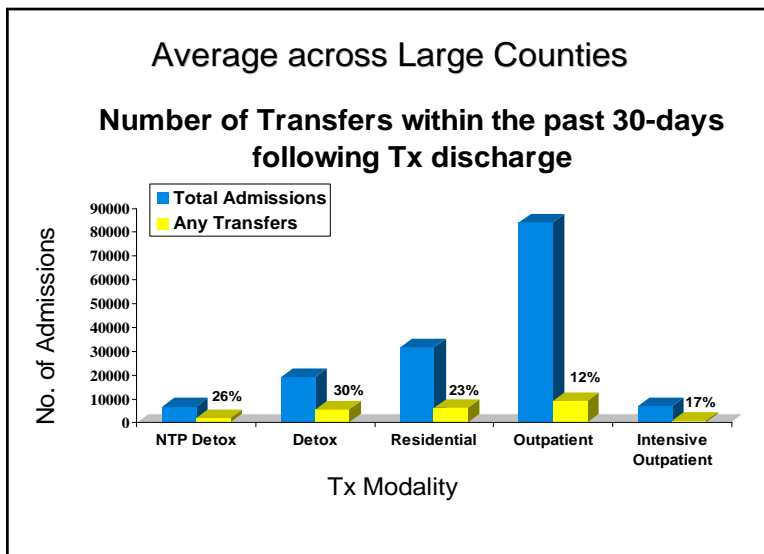


Table 2: Transfer Rates by Service Type for all Large California Counties*



* Transfer rates were determined by using the CalOMS-Tx 2008-09 data and calculating by the percentage of treatment admissions that result in a new admission to another level of care within 30 days of the treatment discharge.

LESSONS LEARNED

- **Cross-county contracting is a feasible strategy when counties face limited services or a lack of specific services.**
 - Public investment in inpatient detoxification services seems to be an effective means to ameliorate both individual and societal costs of addiction, and suggests the need for strategies to improve treatment linkage and retention through cross-county contracts.

- **Lack of control over facility and patient-level factors may interfere with client transfers.**
 - Although a desired performance measure (transfer rate) and an intervention to engage clients and increase transfer rates (PAMI) have been identified, a barrier within all performance measurement is its probabilistic nature. External factors such as client characteristics and environmental influences beyond the treatment program's control affect client outcomes, which make it difficult for performance measures to be a reliable measure of quality treatment (McCorry et al., 2000). Neither a single performance measure nor an intervention can address all possible factors that might interfere with client transfers. Nevertheless, performance measures are a positive step toward monitoring program performance in a continuity-of-care context (McLellan, Chalk, & Bartlett, 2007). Furthermore, performance measures allow for immediate program changes and improvement that are controllable at the program level.

- **Due to an absence of clear guidelines for implementing and adapting evidence-based practices, programs must develop clear, site-specific protocols.**
 - Although contingency management is an EBP that has been shown to improve service delivery and client outcomes, there is no consensus on the criteria that constitute an intervention as an EBP (Glasner-Edwards & Rawson, in press). Further, there is no delineated process for how an EBP should be implemented (Roman & Johnson, 2002). Across providers, varying cultures and organizational structures exist that require the adoption and implementation of an EBP to be adjusted according to the parameters of the programs. Ventura County ADP strategized to identify the appropriate target population, target behavior, reinforcer, and the magnitude, frequency, and duration of the incentive to best adapt the PAMI model for their programs. The protocol, however, may continue to be modified as resources and/or needs of the program change. Preliminary responses and reactions from clients may also demonstrate the need for further revisions.

NEXT STEPS FOR YEAR 2

- **PAMI Protocol: Ventura County ADP and UCLA will implement the PAMI protocol in the two identified programs.**
- **UCLA will assess with Ventura County ADP staff any need for further technical assistance and training on data collection procedures and data interpretation to enhance meaningful outcomes of this pilot.**
- **Utilize performance and outcome measures to assess the effects of the PAMI.**
 - UCLA will examine changes in transfer rates before and after the implementation of PAMI.
 - In addition to measuring changes in the transfer rate performance measure, UCLA will compare additional performance measures, such as retention before and after the implementation of PAMI.
 - UCLA will examine whether the PAMI intervention affects session attendance, urine test results, and discharge rates.

RELEVANT LITERATURE AND RESOURCES

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4.1.3 SUMMARY AND RECOMMENDATIONS

The knowledge gained from this first year of pilot work is crucial to understanding the obstacles within the California AOD treatment system to facilitating and encouraging performance measurement. With greater calls for accountability in the treatment of substance use disorders, performance measurement is becoming an important indicator of program value.

Pilot work conducted under Theme 1 generated knowledge about specific strategies to employ as performance measures, as well as barriers to performance measurement implementation.

- *The adoption of performance measurement and management practices among AOD county and provider stakeholders is slow and ongoing technical assistance is needed.* Through our pilot work with counties and providers, it has become apparent that although their hands-on experience with implementing performance measurement and management practices is limited, the desire to learn about performance measurement is very strong. We recommend that efforts to promote performance measurement and management continue. However, because the AOD field is still in the early stages of developing sound and empirically supported performance measures, we recommend an ongoing program of technical assistance to help counties use the best and most effective performance measures.
- *The ability of AOD treatment programs to collect and use data should be improved.* Findings from the pilot work show that the practice of using performance data to make decisions at the county and provider levels is relatively modest in most counties. Over the past year, many counties have taken steps toward adopting performance measurement and management practices for treatment improvement. Pilot counties have initiated trainings with their providers on the use of CalOMS-Tx data to instill a new culture of system development using data to guide decision making. We recommend continued technical assistance efforts with counties and programs focused on encouraging staff buy-in and receptivity to moving in a data-focused direction and enhancing program and county expertise in various data collection and analysis methods.
- *Using data to improve quality requires having a statewide technological culture compatible with quality improvement (Lin et al., 2005).* Findings from the pilot work indicate many counties have limited data systems to organize their CalOMS-Tx and other data (e.g., encounter data) into meaningful reports to allow these data to be used in performance measurement efforts. In addition, it seemed that, overall, county administrators relied more on their local data systems for reports, rather than the CalOMS-Tx online system. General feedback regarding the CalOMS-Tx data system revealed a general lack of usage of the system. To address this challenge, we recommend that efforts be focused on improving the availability of a sufficient and user-friendly technological (data) infrastructure and tailoring trainings and technical assistance to focus on obtaining and using CalOMS-Tx reports.
- *Under the COSSR initiative a major emphasis is placed on creating “coordinated systems of care.”* Results from the pilot work indicate that the CalOMS-Tx data system allows for measuring the linkages between levels of care (treatment programs) within the AOD county system. This preliminary and basic analysis of a performance measure can serve as a

potentially powerful tool for the state and county to monitor providers' performance in improving "AOD care coordination," or continuity of care. Specifically, we examined the percentage of discharges that led to a new admission within 30 days of the discharge, and deemed this to be a "transfer." To continue to explore this area and identify feasible measures of system performance, we recommend that work continue in this area of measurement exploration; in addition, work should be initiated to help us gain insight into the actual level of provider connectedness over and beyond calculating the percentage of discharges through CalOMS-Tx data.

- *While pilot results are encouraging, showing that some counties and programs are taking steps toward adopting performance measurement and management practices, further work to distinguish differences in adoption practices between counties of different sizes is needed.* Preliminary results revealed that among larger counties that provide a wide range of services across a diverse and expansive population, there was relatively little service coordination between different service providers. In general, the data revealed overall low levels of transfers across levels of care and between providers. We recommend that further study be conducted to answer several remaining questions about the use of transfer rates as a measure of provider connectedness and/or continuity of care:
 1. Do transfer rates actually reflect reciprocal connections (or lack of reciprocal connections) between treatment providers within county systems?
 2. What other, perhaps less tangible factors at the county or system level, such as the level of involvement of county agencies in coordinating treatment integration, unreported transfers to lower-intensity treatment within multi-service providers, or the geographic distance between patients and the programs to which they are referred, influence transfer rates?
 3. Do provider and patient characteristics influence county-level transfer rates?
 4. Are county-level transfer rates associated with aggregated, county-level patient outcomes and with individual patient outcomes?
- *Assisting individual programs in tailoring performance management activities to their needs is an important initial step in the diffusion of system improvement efforts.* A need for additional training and technical assistance on the meaning and purpose of performance measurement was clear. Although many county leaders were aware of performance measures and the purpose of utilizing this type of data, provider and program level staff were far less knowledgeable. We recommend that continued training efforts focus on moving addiction treatment toward the principles of the COSSR initiative and orienting counties and providers on how data can facilitate the process of improving treatment effectiveness. Pilot counties are beginning to create an environment that can potentially support performance measurement, management, and/or contracting.
- *The implications of health care reform are tremendous to the application of a COSSR framework within the current AOD system as it will come with both foreseeable and unexpected changes.* Performance measurement (and management) will continue to serve as an important approach to ensure that as health care reform is implemented in California, there is a way to measure the ongoing effectiveness of the California AOD

treatment system. We recommend that the training and technical assistance plan, with a focus on performance measurement and management, be continued and be adapted as health care reform reshapes the treatment delivery system.

- *Performance measurement is complex.* Through our pilot work, we have learned that while “access, engagement, retention, perception of care, and continuity of care” are priority performance measures, they each have measurement complexities. Our pilot work has allowed us to begin the process of identifying definitions of select performance measures, the data that needs to be collected/captured, and the most effective methods of analysis; however, we recommend that continued pilot work be carried out with such AOD programs to learn how to facilitate this process in conjunction with other services. The process of defining accurate and appropriate performance measures will therefore need to consider the future environment of the AOD treatment field, where services will no longer function as “silos” separated from other parts of the health care system. As the pilot projects are testing the adaptability and suitability of various performance measures in a diverse California AOD treatment system, they will need to further examine the greater diversity that exists when working with other systems of care.

4.2 CHAPTER TWO

Theme 2: Enhancing Treatment Services Through Performance Management and/or Performance Contracting

4.2.1 INTRODUCTION

Theme Overview

As the AOD treatment field moves toward utilizing performance measurement and management strategies, AOD treatment providers must develop sound performance measures that are associated with positive client outcomes. Performance management provides a framework for using performance measures to improve the efficiency and effectiveness of organizations through appropriate monitoring and feedback (Landrum & Baker, 2004). Performance improvement can be achieved by establishing performance objectives, and collecting, analyzing, and reporting performance data. One specific performance management approach that has been utilized to achieve better quality assurance and effective services is performance-based contracting (PBC). Performance contracting links service funding to indicated program performance measures, and treatment programs are incentivized to meet specific performance criteria. Theme 1 examines the following potentially valuable performance measures: access, engagement, retention, perception of care, and continuity of care.

Relevance to COSSR Framework

The COSSR initiative emphasizes the importance of effectively and efficiently engaging individuals with substance use disorders into treatment, retaining them for clinically meaningful periods of time and transferring them across levels of care as clinically indicated to create a functional continuum of care. The pilots in the following section are collecting performance measures to better evaluate their services. In addition to developing effective performance measures, programs must employ a data system and use the data to develop a systematic performance management process. Once these steps are achieved, programs will be able to use data to evaluate their performance with specific standards and goals consistent with COSSR. Not only does performance management enhance the overall treatment received by clients but it provides a strategy for programs to make use of the data they are collecting for program improvement and accountability (McCarty, 2007; McLellan, Chalk, & Bartlett, 2007).

Pilot Purpose

UCLA ISAP identified two participating counties to contribute to the work under this EnCAL-COSSR theme: “Enhancing Treatment Services Through Performance Management and/or Performance Contracting”:

- 5) Alameda County, Tom Trabin
- 6) Los Angeles County, John Viernes

The objectives of the pilots that fall under this theme are as follows:

- 6) To assist counties that are working toward enhancing their local AOD data systems to translate program performance and client outcome goals into measures that can be assessed, tracked, and reported within and across agencies;
- 7) To further investigate whether program goals are in line with performance measures to meet performance goals;
- 8) To develop contract language, data and billing systems, and performance standards that will support performance-based program management and contracting;
- 9) To analyze data from the CalOMS-Tx system and the county system to assess outcome measures for performance targets;
- 10) To provide technical assistance and training to counties to facilitate performance management and/or performance contracting.

The following section compiles the Process and/or Findings from the two county pilots contributing work toward this theme. Details from each county pilot effort are described within a Performance Pilot Year 1 Summary Report. The summary reports include the following sections:

- Introduction
- Goals and Objectives
- Methods
- Preliminary Observations and Findings
- Lessons Learned
- Next Steps for Year 2

Following the individual county pilot summary reports is a section describing an overall summary of lessons learned from the pilot work under this theme and recommendations for future work.

4.2.2 PROCESS AND/OR FINDINGS

PERFORMANCE PILOT YEAR 1 SUMMARY Theme 2: Performance Management/Contracting

Pilot County: Alameda

Pilot County Administrator: Tom Trabin, Ph.D.

Pilot Theme: Enhancing Treatment Services Through Performance Management and/or Performance Contracting

Pilot Title: Using Data to Implement Performance Management Benchmarks

INTRODUCTION

At the start of Year 1 of the EnCAL-COSSR pilot, Alameda County expressed interest in embarking on efforts to develop a system of care for their alcohol and other drug (AOD) services. It was initially discussed that the theme for the pilot work in Alameda County would focus on standardizing assessment instruments and protocols within the AOD system. Further discussion and progress revealed, however, that this area of focus could not be finalized until the county completed additional strategizing and received full input from stakeholder task forces. Alameda therefore decided to work with existing providers on utilizing data to inform the county on strategies to move their current system toward a chronic care model. More specifically, Alameda wanted to define the specific system-change performance measures for monitoring provider performance. Finding the most effective way to map the data available would be a demanding yet necessary process to progress toward their future system-wide goals. As a result, UCLA and Alameda County revised Alameda's Year 1 pilot goals to focus on using data to implement performance benchmarks.

GOALS AND OBJECTIVES

Goal

To facilitate the use of new and existing data for performance measurement purposes that is consistent with COSSR principles.

Objectives

- Measure transfers from detoxification to treatment using existing data, and examine the validity and reliability of such a measure for performance purposes.
- Enhance the detoxification-to-treatment transfer rate.
- Implement measurement of initiation and engagement as performance measures for treatment providers.

METHODS

- UCLA generated transfer rates using data from the California Outcomes Measurement System (CalOMS-Tx), while Alameda generated rates using local Insyst data. Rates did not always match. Alameda's Janet Biblin and UCLA's Darren Urada have had several in-depth conversations and correspondence regarding methods used and possible reasons for differences in the transfer rates. UCLA also received feedback from Barry Hall, Tracy Hazelton, and members of the County Alcohol and Drug program Administrators Association of California (CADPAAC) Data/Outcomes Subcommittee on the strengths and weaknesses of these measures.
- Alameda provided UCLA with a copy of the program used to generate the Insyst transfer rates, and UCLA has been working to convert this program for use on CalOMS-Tx data and also to alter UCLA's current program to perform similar calculations. By doing so, the sources of the differences between UCLA and Alameda calculations are becoming clearer.
- Alameda has been working on an enhanced detox transfer ("handoff") measure with a small task force. The county has met three times and gone through the following steps:
 1. Explored the range of possible referral processes during detox (e.g., levels of staff efforts to refer, types of referrals) and possible landing places within 30 days after discharge (e.g., treatment in AOD, mental health and/or medical settings; types of housing) about which data could be collected.
 2. Explored the range of data analyses that could be conducted using the data elements considered.
 3. Discussed the limits of the county's and the contracted detox provider's resources to conduct the data collection and the analyses.
 4. Discussed what compromise solutions might be used to collect data and conduct analyses more ambitious than the minimum already done, but less ambitious than all that were considered as interesting and useful.
- Alameda and the contracted detox provider discussed a compromise proposal during this budget crisis time. The following extremely preliminary plan was considered (but is currently on hold):
 1. The detox contractor will work with the county to design a Microsoft Access database that will enable them to send data to the county periodically that can be cross-analyzed with the county's own encounter data without requiring the county to do any direct data entry.
 2. The detox contractor will develop criteria for selecting a subgroup of those discharges for which a follow-up call might make a difference in their presenting for treatment. For those clients, the contractor will obtain consent for the follow-up and contact information.

3. The detox contractor will make a follow-up call to this subgroup (and possibly more than one contact call) to determine if clients have connected with AOD treatment and mental health treatment, and whether they have found housing.
 4. The detox contractor will periodically send the data to the county for analyses.
 5. The county will analyze the data along with its own AOD encounter data, including a cross-check for encounters in the mental health system.
 6. The goals of this mini-study are to determine if the follow-up calls make a difference and what role housing plays in the success of clients' status post-discharge. The more distal goals are to make the case and thereby set the stage for eventual funding of selected case management and housing services for detox clients in the county system.
- UCLA provided Alameda with information from a UCLA pilot project as well as from the NIATx website describing promising practices related to Alameda's plans. Specifically, case studies were shared in which telephone reminder calls were used to reduce no-shows. These cases differed somewhat from the preliminary Alameda plan, however, in that the calls typically were placed by the treatment provider the client was going to, rather than by a detox or treatment provider from which the client was departing. This could be important, since this method gives the destination treatment provider an opportunity to answer questions and hear concerns the client may have, and reassures the clients that they will know someone at the program when they walk in the door. Tom Trabin responded by suggesting to his staff that key treatment providers receiving referrals share in phone call responsibilities for these reasons and to underscore that successful transfers are a system issue to be shared by all relevant providers, not just detox providers.
 - Alameda began deploying statistics on initiation and engagement measures for outpatient and day treatment providers and is analyzing the data by program/funding stream. Data is being analyzed this way because it is assumed that individuals who are in specialized programs have more of an incentive to remain in treatment as compared to the general population. Therefore, in an effort to compare similar programs to each other, initiation and engagement analyses are broken down into these categories:
 1. Non-Forensic Outpatient/Day Treatment (Tx) (i.e.: clients not associated with the legal system)
 2. SACPA Outpatient/Day Tx
 3. BASN Outpatient
 4. Perinatal Outpatient/Day Tx
 5. Youth Outpatient
 - These statistics are currently being regularly disseminated via treatment provider meetings to collect feedback.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **Measuring Transfers From Detoxification To Treatment**

- Alameda calculates detox hand-off rates at approximately 19%, while UCLA had initially calculated the rate at 36%. A large part of this difference was traced to methodological reasons. Specifically, Alameda removed “recidivism” (transfers from detox into detox again). UCLA agreed with the county that this is a good policy and adjusted its algorithm to also remove these cases, resulting in a rate of 12.5%. While this is lower than Alameda’s calculated rate, there are reasons to believe that Alameda’s rate is more accurate. Transfers can sometimes occur and will be detected in the County’s Insyst data system but not in CalOMS-Tx. For example, sometimes a client will be discharged but then still receive services. If these services occur after a round of detox, this would be detected in Insyst’s encounter-level data and appropriately seen as a transfer, but it would not be detected in CalOMS-Tx (which does not have encounter-level service data). In theory, CalOMS-Tx would capture this if all providers strictly followed ADP’s CalOMS-Tx discharge procedures (i.e., a discharge date equaling the date of the last face-to-face service), but data available in Insyst allows Alameda to detect when these complicated rules are not strictly adhered to in the real-world settings. This makes systems like Alameda’s superior to CalOMS-Tx for performance measurement purposes.
 - In response to a question by Alameda County, UCLA also calculated the transfer rate between counties using CalOMS-Tx data, concluding that approximately 1 out of 10 of the transfers that do occur from Alameda detoxification to treatment are the result of a client transferring to treatment in a neighboring county (Insyst may not be detecting these). These transfers occur most often to San Mateo, followed by San Francisco and Contra Costa. This calculation should be considered preliminary, as it was performed prior to the subsequent change to remove detox-to-detox transfers.
- **Enhancing the Detoxification-to-Treatment Transfer Rate**
 - Due to recent budget cuts, there has been some resistance to rolling out this effort at this time. Plans are currently “on hold.”
 - **Implementing Measures of Initiation and Engagement:**
 - Alameda’s Tracy Hazelton and Tom Trabin have reported that this measure has been well received by the treatment providers.

LESSONS LEARNED

- **Alameda County BHCS management and staff have innovative ideas as well as the dedication and skill to implement them.**

- With enthusiastic and skilled personnel (e.g., Alameda's Tracy Hazelton), implementation of performance measures such as initiation and engagement can and have been well received by treatment providers.
- Counties that have sophisticated data systems and data managers/statisticians such as Alameda County have the ability to measure and analyze performance data in ways that are superior to that which can be achieved using CalOMS-Tx.
- As in the rest of the state, unfortunately, budget cuts are a major impediment to innovation.
- **By comparing CalOMS-Tx measures to Alameda County data, CalOMS-Tx performance measurement can be improved.**
 - Significant variation in data collection practices may continue to be a barrier to valid comparisons of CalOMS-Tx data between counties.
- **One advantage CalOMS does have over local data systems is the ability to examine client movement across counties.**
 - CalOMS-Tx can be used to detect transfers that begin in one county and end in another.
- **Via discussions with treatment providers, Alameda has learned that meaningful handoffs not noted in current county data include the following:**
 - Admissions to AOD or mental health treatment providers out of county, since these are not registered in the Insyst system
 - Admissions to mental health treatment providers in Alameda County, because the database registers them under a different I.D. number and therefore would have to be searched for manually.
 - Admissions to sober living centers, since these are not registered in the Insyst system.
 - A task force is being organized to review what other kinds of meaningful handoffs are being missed in the way they are currently calculated, what additional resources would be required to capture this data, and whether the county can/wants to dedicate those resources to this.

NEXT STEPS FOR YEAR 2 WORKPLAN

- UCLA will continue refining CalOMS-Tx analyses using Janet Biblin's program and/or other comparisons between CalOMS-Tx and Insyst.

- UCLA will continue work on an “ideal” site report, and an improved “Info Brief” (a one-page document showing transfer rates) and share these with Alameda to get feedback.
- Alameda will continue the use of initiation and engagement measure reports.
- Alameda will continue discussions with providers about ways to measure and increase transfers between detox and treatment.

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PERFORMANCE PILOT YEAR 1 SUMMARY
Theme 2: Performance Management/Contracting

Pilot County: Los Angeles

Pilot County Administrator: John Viernes, Jr.

Pilot Theme: Enhancing Treatment Services through Performance Management and/or Performance Contracting

Pilot Title: Performance-Based Pilot Project

INTRODUCTION

Los Angeles County has engaged in a form of performance management for the last several years with the development and implementation of provider site reports. What has been missing from these site reports is any sort of goal or standard that programs could aspire to (aside from the county averages included in each report). To address this issue and to begin the process of preparing for the implementation of performance-based contracting (PBC), a pilot project was designed and implemented – Performance-Based Pilot Project (PBPP). This pilot project aimed to gather encounter data (number, type and frequency of treatment sessions) over the course of six months and then examine this information to ascertain what type and frequency of treatment leads to the best outcomes. Analysis of the data gathered thus far indicates that there is a certain level of intensity in the first 30 days that appears to be related to the best outcomes.

GOALS AND OBJECTIVES

Goal

To examine what system and programmatic changes would be needed to implement a system that tracks encounters for performance management.

Objectives

- Ascertain the frequency and types of encounters that clients receive in outpatient counseling treatment.
- Determine if the type and frequency of encounters in the first 30 days has any relationship to client outcomes at discharge.

METHODS

- Agencies were contacted by the county and asked if they were interested in volunteering to participate in this pilot. No additional funding was made available but training and technical assistance was provided.

- Fourteen agencies participated: eleven outpatient counseling and three narcotic treatment programs.
- The Los Angeles County Substance Abuse Prevention and Control (SAPC) and UCLA modified the existing web-based system to include additional data elements specifically for the pilot project: date the assessment was completed; date the initial treatment plan was completed; and dates of individual counseling sessions, group counseling sessions, case management, drug tests and dosing (for narcotic treatment programs).
- A total of 1,360 (100%) clients were admitted to the programs that participated in the pilot project. Demographics are similar to what one would find in the overall population of those entering treatment in Los Angeles County.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **Preliminary Findings on Pilot Data from All Clients Admitted to Either Outpatient Counseling or Narcotic Treatment Programs**
 - Clients in treatment between 1 and 30 days received on average about two individual counseling sessions, four group counseling sessions, and one drug test, or a total of eight contacts (total number of clinical or therapeutic contacts which include any and all of the encounters noted above) while in treatment.
 - Clients in treatment up to 60 days received on average over four individual counseling sessions, just over 11 group counseling sessions, and three drug tests, or a total of about 21 contacts while in treatment.
 - Clients who remained in treatment at least 90 days or more received on average over six individual counseling sessions, over 16 group counseling sessions, and more than four drug tests, or a total of over 30 contacts for that three-month period.
 - *Please note that the findings above "round off" the actual statistics. For example, two group sessions may be more like 2.5 individual sessions, and one drug test is more likely to be 1.7 drug tests. In addition, the total number of contacts listed above includes other services not specified (such as case management sessions).*
- **Specific Findings for Outpatient Counseling Programs**
 - When comparing the first 30 days of treatment, clients with the longer length of stay received more group sessions, slightly more drug tests, and had more overall contacts in the first 30 days.
 - More group sessions predicted abstinence at discharge.

- Reductions in primary substance use were correlated to the number of group counseling sessions a client participated in, drug tests, total encounters (all counseling sessions regardless of type and purpose) and length of stay, whereby better outcomes were noted when clients remained in treatment longer and received more services.
- Changes in social support were also correlated to total encounters.
- **Specific Findings for Narcotic Treatment Programs**
 - Instead of focusing on treatment outcomes, which are only available when clients are discharged, the pilot project focused on retention in treatment.
 - NTP clients received fewer counseling related services when compared to outpatient counseling (OC) clients; however, when taking into consideration medication dosing, the NTP clients received significantly more encounters or contacts.
 - When comparing those clients in treatment at 90 days with those who had been discharged, NTP clients with the longer length of stay received more services in their first 30 days of treatment (similar to the results noted for OC). However, it was not the counseling that made the difference; rather it was the number of doses and contacts in the first 30 days that was the significant indicator of difference between these two groups.

LESSONS LEARNED

- **There are insufficient data systems and capacity available.**
 - Both pilots were very data-collection heavy endeavors for the providers. In the future, additional funds to help with data collection is needed. In addition, the system does not currently collect this information, and as such, although the first pilot revealed significant findings (and it is expected that the second will as well), implementation of such a system across the board is not yet possible. Los Angeles County is working to revise its data collection system to collect this information, but such changes are at least a year off.
- **Encouraging provider buy-in and collaboration is necessary for performance-based contracting.**
 - One of the best aspects of this project was learning more about the system and ways to interpret the data received. SAPC and UCLA met with providers on a monthly basis (at least) to discuss the data, perceived inconsistencies, and ways to improve its quality. This helped to encourage provider buy-in. Providers seemed

to be more willing to do the work because they had a say in how the data were analyzed and presented, and they helped to interpret the information.

NEXT STEPS FOR YEAR 2

- **Reevaluate and analyze the data from a second pilot project.**
 - A second pilot examining the same variables and research questions was implemented in small- and medium-sized outpatient counseling programs. The second pilot participants are entering the last of the pilot data, so analysis begins soon.
 - It is hoped that analysis of the data from the small- to medium-sized programs will reveal similar results. However, preliminary review of the data indicates that there are some significant differences in the frequency of services offered in the small- to medium-sized programs.

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4.2.3 SUMMARY AND RECOMMENDATIONS

As described above, both of the participating pilot counties (Alameda and Los Angeles) are well underway in the planning phases for the implementation of performance measurement/management models within their AOD county systems. Major lessons learned from the pilots during the past year are provided below and are intended to inform larger statewide efforts at implementing effective performance management strategies, including performance-based contracting.

- *There is a nexus between performance measurement and performance management.* Through our pilot work, it was evident that provider and county staff have varying levels of knowledge regarding this nexus—i.e., that a major purpose of performance management initiatives (such as performance-based contracting) is to use performance measures (mainly via service encounter data) to inform clinical practice and improve performance service areas (access, engagement, retention, and continuity of care) of treatment programs. Because the effective adoption and implementation of performance management strategies (including contracting) requires dedicated and skilled personnel at both the provider and county levels, we recommend that county leaders consider identifying in-house dedicated and skilled staff in data (technological sophistication) for implementing performance measurement and management efforts. This will lead to greater sustainability of performance measurement within counties as these county staff can guide/direct providers on a regular basis through ongoing performance data report discussions and data interpretation demonstrations. This will also serve to increase the buy-in for using performance data to make treatment decisions as they relate to improved outcomes.
- *There are county-wide system challenges to implementing performance measurement and management at the local level.* Through our work with the pilot counties, we learned that improved buy-in for the use of performance data among treatment programs is a critical component of successful performance measurement and management. AOD treatment providers need to recognize that the data they are asked to collect are useful. In essence, this means that it is necessary to create a culture that appreciates the usefulness of data and understands the importance of using data in decision making. Within this type of organizational culture, data can be used to identify problems, develop new strategies to address problematic issues, and make informed decisions to improve service delivery. To that end, we recommend ongoing training and technical assistance such as creating learning collaboratives directed to promote and sustain a culture of data appreciation.
- *Implementing performance measurement and management models requires a sophisticated local county data system.* Through our pilot work, we have learned that as counties work toward identifying effective performance measurement and management models to implement, the need for a sophisticated data system that has the ability to measure and analyze performance data is critical. For example, Los Angeles County is working on enhancing their in-house built data collection and reporting system in a way that allows for the assessment of administrative data (service encounters) rather than solely client-based data from the CalOMS-Tx system. However, we have observed that the purchase and implementation of data program enhancements at the county level is a slow and costly process. The utilization of new technology brings forth the need for further training and

technical assistance to assist the county in creating strategies in which to communicate and transfer the technical information to their providers. Creating meaningful reports and interpreting the results requires careful attention to the capacity of the audience. As shown through our pilot efforts, data-heavy endeavors are challenging for providers, as technological capacity and sophistication at the provider level is relatively low. In addition, the process in which to verify consistent data collection practices and provide trainings on accurate data collection practices are also time consuming. To address these challenges, we recommend identifying sources of additional funding for data system enhancements as well as continuing training and technical assistance at both the county and provider levels.

- *Performance management, especially performance contracting models, is a promising mechanism to ensure an efficient and accountable treatment system.* Introducing county and program staff to a performance management environment enables system improvement; however, through our pilot work we have learned that county and program leaders (i.e., administrators, directors, managers, etc.) need to clarify expectations and incentivize goals that they want programs to accomplish. We recommend that prior to implementing performance management strategies at the local level, there needs to be system-wide consensus on performance measurement standards and these standards need to be transparent to programs. We also recommend continuing efforts toward training and technical assistance for counties and providers to address the processes of organizational change and the implications of shifting toward a different business model as defined by performance contracting.
- *The creation of a viable statewide performance-management system will be a learning process that will require constant revision and growth.* Through our pilot efforts this past year, a major lesson learned is that AOD providers and performance measurement of those providers will have to include measures of linkages with other systems (e.g., mental health, primary care, social services). Because change fatigue can significantly affect provider buy-in and adoption rates, we recommend the continued use of expert consultants and technical assistance. Through such mechanisms, providers will be exposed to constant training to teach them new data collection and interpretation skills, thereby enhancing their motivations to keep up with such change. In addition, we recommend that counties start introducing future expectations and foreseeable changes as early as possible to prepare for a transition toward system integration. A receptive and ready community of providers will be the only way to enhance technology, instill new concepts, and make the existing treatment system more congruent with the COSSR framework and other systems of care.

4.3 CHAPTER THREE

Theme 3: Measuring Cross-Discipline Linkages and Service Delivery

4.3.1 INTRODUCTION

Theme Overview

Many patients with substance use disorders also have pressing physical and mental health problems (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2006; Samet, Friedman, & Saitz, 2001), yet services for these patients often are delivered in a fragmented way that does not address the complexity of patients' overall needs (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2001, 2006). In many instances, patients' co-occurring problems may even be overlooked due to failure of health care providers and/or social service agencies to screen for other problems or disorders and to refer patients for appropriate treatment (Saitz, Mulvey, A, & Samet, 1997). For example, healthcare providers often do not screen or provide treatment or referral for substance use or mental health disorders despite the fact that these disorders often present together and that healthcare providers are in a unique position to identify stigmatized disorders that might otherwise go untreated. Similarly, patients in treatment for substance use disorders may also have HIV infection, hepatitis C, or depression, all of which may go undetected if proper screening and referral protocols are not in place (Samet et al., 2001). In general, linked service organizations are thought to be more effective at providing a complex array of services than when services are provided in a separate, fragmented way (Alter & Hage, 1993; Provan & Milward, 2001). Coordination of integrated, linked care for chronic substance use, health, and mental health disorders is the cornerstone of provision of services within a chronic care model (Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 2006) and thus is highly relevant to the overall mission of COSSR.

Relevance to COSSR Framework

The primary aim of COSSR is to continuously improve upon “a comprehensive and integrated continuum of alcohol and other drug (AOD) services system based on a chronic care model” (California Department of Alcohol and Drug Programs, 2006). Although the current focus of COSSR is to facilitate change toward a chronic care model within the AOD system, major changes in healthcare and funding for AOD services as well as a national emphasis on coordination of care for co-occurring health, mental health, and substance use disorders are paving the way for a broader integration of services that includes collaboration between healthcare, mental health, and substance use disorder providers (Samet et al., 2001).

California counties are beginning to respond to the call for integration of services out of a desire to improve the quality of services for patients with substance use disorders and out of financial necessity. For example, several AOD counselors in Lassen County have moved to the Department of Mental Health to provide AOD services; in Marin County, a variety of service organizations such as jails, shelters, and other health service areas are beginning to conduct

Screening, Brief Intervention and Referral to Treatment (SBIRT) interventions for all clients. These activities, while slightly outside of the COSSR purview initially set forth by the California Department of Alcohol and Drug Programs (ADP), are highly relevant to creating a continuum of services for patients with substance use disorders and to coordination of services within a chronic care model.

Pilot Purpose

UCLA ISAP identified two participating counties to contribute to the work under this EnCAL-COSSR theme: “Measuring Cross-Discipline Linkages and Service Delivery”:

- 11) Lassen County, Lyle Dornon
- 12) Marin County, D.J. Pierce

The objectives of the pilots that fall under this theme are as follows:

- 1) To assist counties that are linking and integrating AOD screening and treatment with other services to develop systems of measurement for tracking client service utilization and outcomes;
- 2) To report on potential deficits in the CalOMS-Tx system for tracking integrated AOD services and to make recommendations for future performance and outcomes measurement of these services;
- 3) To report on current efforts of California counties to link and integrate services across disciplines in order to share integration and linkage models and experiences with counties throughout the state; and
- 4) To provide technical assistance and training to counties to facilitate the service integration process.

The following section compiles the Process and/or Findings from the two county pilots contributing work toward this theme. Details from each county pilot effort are described within a Performance Pilot Year 1 Summary Report. The summary reports include the following sections:

- Introduction
- Goals and Objectives
- Methods
- Preliminary Observations and Findings
- Lessons Learned
- Next Steps for Year 2

Following the individual county pilot summary reports is a section describing an overall summary of lessons learned from the pilot work under this theme and recommendations for future work.

4.3.2 PROCESS AND/OR FINDINGS

PERFORMANCE PILOT YEAR 1 SUMMARY

Theme 3: Cross-Discipline Linkages

Pilot County: Lassen

Pilot County Administrator: Lyle Dornon

Pilot Theme: Measuring Cross-Discipline Linkages and Service Delivery

Pilot Title: Measuring and Tracking Integrated AOD Services

INTRODUCTION

In 2009, the Lassen County Health and Social Services (HSS) Alcohol and Other Drug (AOD) Programs Department faced massive funding cuts that threatened to drastically reduce substance use services to clients of all HSS departments and to the community as a whole. As a result, HSS leadership began to explore options to maintain AOD treatment and possibly to expand treatment outside of the AOD Department. After multiple special planning sessions, the county decided to move forward with evidence-based system integration strategies that could not only keep substance use treatment services intact, but could greatly increase Lassen County's capacity to serve clients in a variety of settings and make access to treatment easier and more convenient to clients throughout the HSS system. (Research conducted by the HSS Quality Improvement Department indicates that substance use is the most prevalent problem for clients throughout the HSS system.) The ultimate goal of Lassen County's integration plan is to set up a multidisciplinary team within each HSS department, with AOD team members having equal influence and respect. (Please see Lassen County's AOD Integration Plan for further details on integration strategies.)

Given the importance of Lassen's service integration efforts to preserving AOD treatment in the county, the AOD Department, through discussions with UCLA, decided to focus its performance pilot on measuring and tracking integrated services, with a specific focus on its current effort to integrate AOD counselors into the Mental Health Department. During the pilot development process, the county and UCLA realized that a prudent first step, prior to setting up a measurement system, would be to provide technical assistance training to mental health and AOD staff on how to prepare a mental health facility to be dual-diagnosis capable and how (and why) to assess co-occurring mental health and AOD disorders.

GOALS AND OBJECTIVES

Goal

To help Lassen County prepare for integration of services into the County Mental Health Department and to track and measure AOD services upon integration first into Mental Health and later into other departments.

Objectives

- Provide technical assistance to Lassen County to prepare mental health and AOD program leaders and counselors/clinicians for integration of AOD services into the Mental Health Department and other non-AOD departments.
- Identify ways to measure AOD treatment within the Mental Health Department and other non-AOD settings and assist with setting up a measurement system.

METHODS

- UCLA and Lassen County leadership, i.e., the directors of the AOD Department, the Mental Health Department, and Lassen County HSS, and the director of Quality Improvement, met to discuss system integration needs and possible methods for measuring AOD services provided in non-AOD departments.
- UCLA, the Lassen County AOD Department Director, and the HSS Quality Improvement Director worked together to develop the pilot work plan and technical assistance trainings.
- Lassen County AOD staff provided a two-hour, introductory training to 30 clinicians and program leaders on substance use and on the history of treatment for substance use disorders.
- UCLA provided a two-hour webinar to 30 clinicians and program leaders on evidence-based, integrated substance use assessment and treatment for patients with co-occurring disorders (COD), specifically for AOD and mental health co-morbidity.
- UCLA will visit Lassen County on July 22-23 to conduct a two-day training on how to use the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) assessment tool to measure and track COD capability in a mental health setting. This assessment helps service organizations assess their capability (or capacity) to provide treatment to people diagnosed with co-occurring substance use disorders and mental disorders and to develop and implement a plan to do so with increasing capacity over time. The training will serve two purposes:
 1. Increase readiness of the Mental Health Department to provide AOD screening and treatment to substance using patients; and
 2. Develop a measurement infrastructure by training Lassen County staff to use the DDCMHT assessment tool to assess and monitor changes in capability and recommend areas for improvement.

- During the DDCMHT training, UCLA trainers, along with Lassen County staff, will conduct an assessment of the Mental Health Department’s dual-diagnosis capability and develop a baseline score. Lassen County and UCLA will make recommendations for improvement based on initial DDCMHT scores.
- UCLA and Lassen County will evaluate follow-up DDCMHT data to determine improvements in dual-diagnosis capability over time.
- UCLA is working with Lassen County to determine additional ways to measure and track AOD services being provided in the Mental Health Department and elsewhere.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **Technical Assistance toward an Integrated AOD/Mental Health System**

- A large amount of work has been done to prepare the Lassen HHS Departments for system integration, a major change in service delivery. Training agreements between Lassen HSS and UC Davis provided a facilitator to work with Lassen’s leadership team and its newly formed Quality Council to develop communication and a “working team” environment to overcome resistance to change and to get “buy in” from the heads and line staff from the two departments. This has been a successful endeavor resulting in an AOD Integration Charter that has been agreed to by all participating departments.
- The initial webinar training and ongoing communications with UCLA have prepared the change team and the Quality Council with the necessary evidence-based practices (EBP) and training materials to effectively prepare both the administration and line staff with the necessary skills to move the project forward. With AOD services integrated into the Mental Health Department, it will be very useful to apply the DDCMHT to the system to help measure effectiveness and fidelity to EBP.

- **Performance Measurement**

- The DDCMHT will serve as a useful measure to track and monitor the capability of the Mental Health Department to deliver services to clients with dual AOD and mental health diagnoses. Data are forthcoming.
- Possibilities for measuring and tracking AOD services in non-AOD settings include the following:
 - ShareCare System: Several departments currently use a system called “ShareCare,” but it is not designed to track substance abuse processes or outcomes. This system could potentially be retooled to capture AOD services in other settings.

- CalOMS-Tx: Although ADP has indicated that CalOMS-Tx only accepts data from those facilities that receive Substance Abuse Prevention and Treatment Block Grant (SAPT) or Drug Medi-Cal (DMC) funding for AOD services, or those that are licensed by California Alcohol and Drug Programs (ADP), a possibility is for Lassen to build its system to include these data in case future business rules change.

LESSONS LEARNED

- **Lassen County’s integration plan and its performance measurement pilot may eventually serve as a model for other counties desiring to integrate AOD services into other settings (or doing so out of necessity).**
 - As mentioned in the Lassen County System Integration Plan, “[system integration] has been a theme and recommendation for Best Practices at both the Federal and State levels but has not been supported through regulation or by dedicated or easily accessed funding mechanisms.”
 - Although Lassen’s integration plan was developed out of fiscal necessity, the plan is at the forefront of current healthcare reform issues and reflects an overall trend to integrate AOD services with other social, health, and mental health services. Although the plan does not contain provisions for AOD integration into primary care settings at this time, Lassen County plans to explore this option at a later date.
- **Measuring and Tracking AOD Services Outside of Traditional AOD Settings May Be Challenging.**
 - As noted above, opening a CalOMS for clients receiving AOD services outside of a SAPT, DMC, or ADP a facility is not currently an option.
 - Although a local data system (e.g., “ShareCare”) may be modified to track AOD services in non-AOD settings, it is not clear whether these data can be incorporated into statewide data that tracks AOD needs and services.
 - Efforts to track current AOD services within non-AOD settings eventually may be superseded by healthcare reform. Full system integration, including integration of AOD treatment into primary care settings, ultimately will have to face the advent of electronic medical records. While this may facilitate coordination of care and more accurate tracking of AOD disorders and services, some controversy exists around maintaining privacy protection for AOD clients.

NEXT STEPS FOR YEAR 2

- **Technical Assistance**
 - UCLA will provide the DDCMHT training to Lassen County staff.

- As part of the DDCMHT training, UCLA, with Lassen County staff, will conduct a baseline assessment of the capability of the Mental Health Department to screen for and treat AOD disorders.
- **Performance Measurement**
 - Using follow up DDCMHT assessments, UCLA and Lassen County staff will assess changes in the capability of the Mental Health Department to screen for and treat AOD disorders.
 - UCLA and Lassen County staff will continue to work together to determine a method for measuring and tracking AOD services provided in the Mental Health Departments and other county departments.

RELEVANT LITERATURE AND RESOURCES

DDCMHT/DDCAT resources and articles: <http://dms.dartmouth.edu/prc/dual/atsr/>

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PERFORMANCE PILOT YEAR 1 SUMMARY
Theme 3: Cross-Discipline Linkages

Pilot County: Marin

Pilot County Administrator: D.J. Pierce

Pilot Theme: Measuring Cross-Discipline Linkages and Service Delivery

Pilot Title: Integrating SBIRT into Healthcare and Other Community Settings: A Case Study

INTRODUCTION

Marin County's Alcohol, Drug and Tobacco programs initiated a five-year strategic planning process which started in early Spring 2009. Their mission is to plan, coordinate, and provide a continuum of publicly funded alcohol, tobacco, and other drug prevention, intervention, treatment, and recovery services that are responsive to the needs of the community of Marin County. With a rapidly changing environment, Marin experienced various setbacks in completing their strategic planning process but expect it to be internally approved by the end of June 2010. Once finalized, Marin will begin taking various steps toward achieving their goals. One component embedded within their strategic plan, the integration of Screening, Brief Intervention, Referral and Treatment (SBIRT) in their community, has developed into the beginnings of Marin's pilot project. Marin intends to utilize SBIRT to (1) provide early identification and intervention to prevent the progression of problems related to substance use and more severe consequences; and (2) enhance and facilitate access to treatment and other ancillary services. Marin County intends to incorporate SBIRT within several settings including health, justice, and other community services. This allows for a great opportunity to document the process of cross-discipline integration, which is a key component in the move toward health care reform.

GOALS AND OBJECTIVES

Goal

To create a case study report of Marin County's integration process of implementing SBIRT in various community settings and how it facilitates their preparation for health care reform.

Objectives

- Assist Marin County administrators in their strategic planning process as they work toward an integrated and comprehensive alcohol and other drug (AOD) treatment system.
- Provide technical assistance on SBIRT protocols, assessment tools, and implementation procedures in various environments.

- Document the integration process within the county as SBIRT is implemented in various settings (i.e., primary health, shelters, justice).

METHODS

- UCLA reviewed the developing five-year strategic plan with Marin County Division of Alcohol, Drug and Tobacco Programs staff. The goal of the strategic plan is to create an integrated system of care in which patients move across levels of care in a way that promotes the prevention of substance use problems, as well as approaches treatment and longer term recovery in a manner that addresses the chronicity of addiction.
- UCLA will provide Marin with technical assistance on SBIRT protocols, assessment tools, and implementation procedures in various environments.
- Through qualitative methods, UCLA will assess and document processes, successes, and challenges of this initiative, while emphasizing the integration process with other service sectors (primary care, mental health, social services).

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **Marin County and UCLA identified the SBIRT initiative to be the focus of the pilot project.**
 - Due to the relevance of SBIRT within the upcoming health care reform priorities, it will allow for exploration into other service environments and potentially increase access into their treatment system.
 - Funding for this initiative was redirected from referral lines and outreach as it appeared to be a better method to screen people and get them into the appropriate form of treatment.
 - Determining the appropriate assessment tool, protocol, and procedures across differing settings involved highly complicated and political discussions.
 - As discussions ensued to approach Federally Qualified Health Centers (FQHCs), it was revealed that the Department of Mental Health already implements an SBIRT model within that setting. Further investigation of the model and its implementation plan is underway to devise a plan for cross-discipline service coordination.

LESSONS LEARNED

- **Strategic Planning is a necessary first step in performance management.**
 - Strategic planning, “a continuous and systematic process where the guiding members of an organization make decisions about its future, develop the

necessary procedures and operations to achieve that future, and determine how success is to be measured,” is a necessary first step in performance management (Artley et al., 2001).

- Through this process, Marin identified their need to integrate SBIRT into multiple settings. Task forces with representatives beyond the AOD system fostered the collaboration necessary for integration.

- **Coordination with multiple agencies is needed for system integration.**
 - The effective use of strategies to strengthen the interface between social services, criminal justice, mental health, and addiction sectors requires a sound understanding of the differing histories, cultures, and approaches from which these agencies are modeled. Due to differing governing procedures and requirements, leverage over the implementation of new policies can be difficult to manage. The process of attaining commitment to the change process from all stakeholders proved to be slow and challenging in Marin.

 - Progress in engaging leadership and cooperation is still in development and necessitates the clear articulation of the role and specific responsibilities for the provision of SBIRT. Further technical assistance is needed to identify how SBIRT can be successfully implemented and administered in different settings.

- **Funding is a barrier in the process of developing cross-discipline linkages and service delivery.**
 - The identification of the financial mechanism that will support additional activity or changes within a system is critical for sustainment. Increase in access to treatment does not directly translate to guaranteed entrance and availability of treatment.

 - As health care reform alters treatment coverage requirements and funding streams, Marin County is limited in their ability to foresee how health care reform will change the scope and availability of treatment dollars to accommodate the greater number of clients in need.

NEXT STEPS FOR YEAR 2

- **Provide technical assistance to differing agencies that require additional knowledge and training in substance abuse treatment.**

- UCLA will provide Marin County with SBIRT trainings to staff in the several identified county environments, such as shelters, criminal justice, mental health, and/or primary care settings. .
- **Continue the administrative, collaborative, and operational procedures necessary for system integration.**
 - Marin will keep UCLA abreast of significant developments within their SBIRT implementation process. Marin will keep UCLA informed about any public meetings that UCLA can attend on this topic and provide developing resources/documents for UCLA to gather further information.
 - UCLA will develop a descriptive chronicle about how Marin goes about restructuring their system as an informative case study on how one county reorganizes itself to integrate AOD knowledge into other systems.

RELEVANT LITERATURE AND RESOURCES

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4.3.3 SUMMARY AND RECOMMENDATIONS

Theme 3 pilots focused on creating linkages between substance use disorders, mental health, and primary care treatment with the goal of facilitating the development of integrated systems of care that address the complexity of patients' needs. While COSSR goals emphasize the provision of AOD treatment across a continuum of care, these pilots broadened the scope of services to be inclusive of additional systems. As such, they are consistent with moving AOD services toward a chronic care model while also preparing counties to coordinate care across multiple systems outside of traditional AOD services. In an effort to facilitate service integration, participating pilot counties (Marin and Lassen) have begun to investigate various integration tools and models. Below are the overall lessons learned from these two pilot efforts:

- *A large percentage of clients receiving services from almost every department in the social service system has a co-occurring AOD and mental health disorder.* Many substance using patients with co-occurring disorders (COD) require additional services that entail treatment expertise from other fields. Cross-discipline linkage is an important component of quality treatment for the large majority of clients who have COD. In an effort to provide such clients with a comprehensive set of services that will lead to more successful and sustained outcomes, pilot counties are investigating different approaches to integration that work well across county departments and systems. Pilot efforts have demonstrated the benefits of thorough strategic planning and assessment prior to implementation of any integration model or plan, starting with an evaluation of AOD and mental health systems to determine how to most efficiently enhance COD capability.
- *Although many effective SBIRT models are available, there are significant barriers to implementation.* Physicians do not screen for a number of reasons, such as a lack of adequate training on AOD, skepticism about its effectiveness, patient resistance, discomfort discussing substance use disorders, time constraints, and a lack of insurance coverage (CASA, 2000). Pilot work conducted to address these issues in Marin County is aimed at removing barriers to effective integration of SBIRT in various settings across their county. Due to different governing bodies that tend to lead and make decisions within separately functioning organizations and fields, Marin has started building a network of exchange through joint meetings and interactions to break down boundaries and remove any reluctance to accepting the effective practices of AOD treatment. Screening, brief intervention, and referral to treatment (SBIRT) for the identification and treatment of substance use problems has been effectively implemented in a variety of settings (Cuijpers et al., 2004). SBIRT is an evidenced-based practice that has demonstrated associated reductions in alcohol use, health care utilization, criminal justice involvement, and societal costs. When a large number of clients who seek primary care treatment are left undiagnosed and untreated for an associated substance use disorder, they tend to seek higher levels of care in the future, leading to higher medical costs and rehospitalizations. While effective AOD screening and treatment models are available, they are not generally used in primary care settings. An important preliminary step is to thoroughly assess the current needs and barriers impeding the utilization of SBIRT and to initiate an action plan for integration.

- Providing training on AOD assessment and/or service needs to mental health and other service providers can help reduce stigma, increase knowledge, and prepare departments and primary care settings for service integration.* Pilot counties are establishing training agreements to provide department heads and line staff with the technical assistance they need to prepare for integration. For example, Lassen County provided a training for mental health providers to introduce them to the prevalence of AOD problems in clients with mental health disorders and a training to help program leaders increase the capability of the mental health department to provide services to AOD clients. Marin has taken various steps to strategically plan for the integration of SBIRT into their community including identifying a protocol appropriate to the county's culture and needs and establishing ongoing communication and relationship-building with county departments. Ongoing training and technical assistance will be critical to creating an environment that fosters change. These pilots have confirmed that preliminary introductions to system changes and shifts in work culture are necessary for promoting awareness and preventing resistance. It is our recommendation that counties begin to investigate various tools and models appropriate for integrating AOD services across systems. Counties can then identify appropriate experts to help initiate implementation.
- Thorough research of existing data systems is allowing pilot counties to assess how to track the more wide-ranging services AOD clients receive.* By developing systems of measurement for tracking client service utilization and outcomes, pilot counties not only can assess how AOD screening and treatment can be integrated into other systems but also can track client outcomes. Through these initial pilot efforts, counties have identified that the CalOMS-Tx system, as it is currently designed, cannot track clients who receive services outside of the AOD system. Counties may wish to establish recommendations for expanding the capability of CalOMS-Tx to track clients receiving integrated services. Counties also may want to begin examining data collection systems within primary care and other settings to assess the capacity of these systems to include additional AOD-related data elements. Data systems that link information from different programs or funding source requirements can facilitate the coordination and support of data accessibility. Clients often need services from related departments. Pilot work has demonstrated that departments operating independently of each other inhibit effective and efficient coordination of data collection and service delivery. To promote data sharing, we recommend the development of policies and infrastructure to support data system linkages and standard collection/reporting requirements.
- Embedding certified AOD counselors and providers in different settings can facilitate the acceptance of AOD services into other systems.* Efforts directed toward integrating AOD treatment into non-AOD settings and measuring the cross-coordination of these services requires familiarizing providers with an integrated culture of treatment. Staff from non-AOD settings will need additional training and assistance on providing an AOD service since that is much less customary. After introductory ideas are established to cultivate efforts toward integration, additional barriers will also arise, creating a continuous need for training and collaboration. Pilot efforts and research have demonstrated the utility of placing an AOD expert in non-AOD settings (such as primary and mental health) to build trust and to establish routine expectations for AOD screening to occur outside of the AOD system. Counties might consider establishing AOD involvement in other systems to begin the process of reducing barriers and resistance to integrated treatment.

- *System integration will be an integral part of AOD treatment services in the future, not only out of financial necessity and service delivery changes driven by health care reform, but also due to desires to broaden our abilities to reach more clients earlier.* We recommend that counties become familiar with the integration efforts of pilot counties, and reach out to other service organizations and primary care providers to establish relationships on which to build in the future. Important first steps to integration are understanding other systems' cultures and attitudes toward AOD services and being open to integration.

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4.4 CHAPTER FOUR

Theme 4: Enhancing the Continuum of Services (Prevention, Intervention, Treatment, Recovery)

4.4.1 INTRODUCTION

Theme Overview

The chronic illness approach for substance use disorders requires an alcohol and other drug (AOD) continuum-of-services system model that shifts the emphasis away from acute symptom stabilization (episodic treatment) toward a continuum including prevention, intervention, treatment, and long-term recovery support (Flaherty, 2006; Kipnis & Killar, n.d.). This continuum is characterized by an individualized and flexible array of essential services to address the substance use spectrum: no problem use, problem use, abuse, and dependence (Flaherty, 2005). This new paradigm presumes that substance use disorders can be compared to other chronic illnesses, as they typically begin during adolescence (referred to as an adolescent onset disorder; Dennis et al., 2002), and last for several decades (Hser, Longshore & Anglin, 2007). It also presumes that recovery from substance use disorders is a long-term process, with remissions in illness, but periodic exacerbations that may require continuous service system exposure over the lifetime for most individuals (Dennis et al., 2003, 2005; Dennis & Scott, 2007; Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Hser et al., 2007; McLellan, 2002; McLellan & Weisner, 1996). Please reference UCLA ISAP's 2009 Continuum of Services System Re-Engineering (COSSR) Final Report for a full description of the continuum-of-services model and its components. Below is a general overview:

The *prevention* stage of the continuum comprises activities intended to raise general awareness of substance use disorders as well as target high-risk individuals and groups for more focused interventions.

The *intervention* component of the continuum-of-service system model largely involves screening for the identification of substance use problems and brief interventions to address such problems (i.e., secondary prevention strategies). Initiatives, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), expand and enhance the continuum to address substance use disorders as chronic conditions by providing prevention and, when needed, earlier intervention services to address a problem before greater acuity, morbidity, and true chronicity take hold.

Treatment can be defined as any planned intervention in the health, behavior, personal, and/or family life of an individual who is *dependent* on alcohol or other illicit drugs (ASAM, 2001). Under a continuum-of-services model, the time point in which one would move from the intervention stage to the treatment stage can be difficult to ascertain. Therefore, careful assessment of a client's severity level between use, abuse, and dependence is necessary to make informed treatment decisions (Laudet, 2008b). The definition of substance dependence implies

chronicity and requires intensive, long-term treatment, whereas use and abuse generally result in referral to a brief intervention or brief treatment with further assessment (APA, 1994).

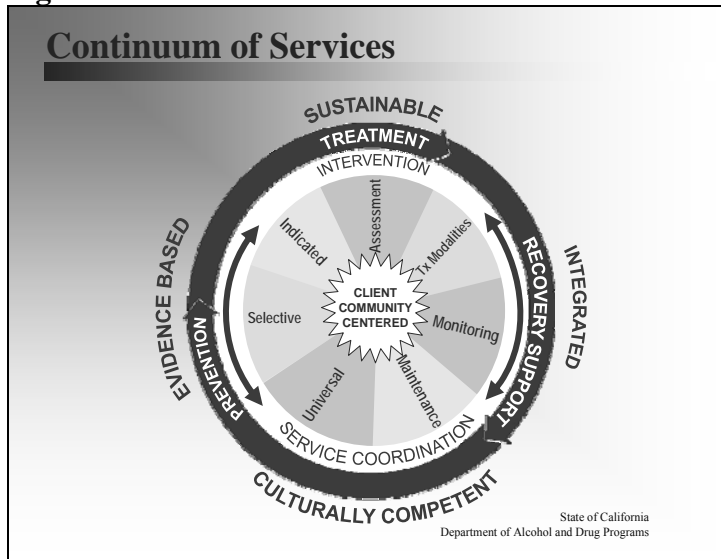
Recovery support is a key component of the continuum as it facilitates a service model that best supports a continuous healing relationship that leads to improved wellness and successful recovery. Recovery support services can consist of assertive continuing care, continuous telephone recovery monitoring, home visits, medication, recovery management, recovery centers, and traditional counseling and self/mutual-help programs. Of the varying recovery services, each can be utilized to continuously monitor the client's status to provide needed early intervention and referrals to necessary services (including returning to formal treatment or more intense services). Typical use of these services varies across clients, but is likely to be for extended periods of time. *Reference Chapter 5 for a more thorough discussion of recovery support services.*

Promoting system change efforts to integrate these AOD service components as a continuum of care is essential to successfully shift addiction treatment from an acute model of care to a chronic care model. As there are several state initiatives underway, unique challenges are present for each state system depending on state policies around issues such as (1) funding mechanisms for specific continuum components, (2) geographic feasibility to offer a continuum of services (i.e., size and number of counties/regions/districts, availability of service providers within county/regions/districts, etc.), (3) coordination and communication strategies within the state's AOD treatment and prevention departments as well among local providers, and/or (4) data collection priorities and sharing capabilities.

Relevance to the COSSR Framework

Within California, re-engineering toward a continuum of AOD services that incorporates a comprehensive and integrated system of care has been challenging across and within each service component. (See COSSR Framework Figure 1). The challenge that seems to be at the forefront in designing such a system may be simply thinking in terms of a "system" of services for substance use disorders as opposed to an idiosyncratic, fragmented, and disconnected collection of silos of prevention, intervention, treatment, and recovery services.

Figure 1: COSSR Framework



Under this new type of service system, rather than addressing substance use disorders as acute problems via admission into treatment with the goal of discharge, the goal is to provide a continuous response that promotes self-care and recovery. Enhancements to current treatment systems would involve (Whitter, 2008):

- ongoing prevention and early intervention
- chronic care approaches (e.g., continuing care and recovery management)
- recovery support services (including clinical and non-clinical supports)
- individualized and flexible menu of services, and
- coordination of multiple systems

Across the course of the year, each volunteer county demonstrated significant efforts toward enhancing their AOD system toward a continuum of services, as each theme relates to this effort inherently. However, with this particular theme, we intended to focus on how counties could create a stronger bridge or link between the four components (prevention, integration, treatment, and recovery). As Chapter 5/Theme 5 maintains emphasis on the links to recovery, focusing on the link between prevention and intervention/treatment under this theme was relevant. Preventative models such as the Brief Risk Reduction Interview and Intervention Model (BRRIMM), which has been conducted in Riverside County, are relevant protocols to study to identify how well these types of programs address early stages of use or abuse in order to avoid the need for further intervention and treatment, if use progresses. Brief treatments are also potential program options in that a person presenting with abuse problems may be better suited for brief treatment, rather than a full treatment episode and entry into a recovery based continuum of care. Solano County is piloting a brief treatment model implemented within one of their central assessment units as a strategy to improve access to the treatment component while offering an opportunity to address clients' co-occurring needs in a more efficient manner.

Pilot Purpose

UCLA ISAP identified one participating county to contribute to the work under this EnCAL-COSSR theme: “Enhancing the Continuum of Services (Prevention, Intervention, Treatment, and Recovery)”:

- 1) Solano County, Del Royer

The objectives of the pilot that falls under this theme are as follows:

- 1) To assist the county to work toward enhancing its local AOD data system when faced with delays in access to the treatment system.
- 2) To evaluate the feasibility of incorporating a brief treatment model within a central assessment unit.
- 3) To identify potential strategies to measure performance outcomes.
- 4) To provide technical assistance and training to facilitate performance measurement.

The following section compiles the Process and/or Findings from the county pilot contributing work toward this theme. Details from the county pilot effort are described within a Performance Pilot Year 1 Summary Report. The summary report includes the following sections:

- Introduction
- Goals and Objectives
- Methods
- Preliminary Observations and Findings
- Lessons Learned
- Next Steps for Year 2

Following the county pilot summary report is a section describing an overall summary of lessons learned from the pilot work under this theme and recommendations for future work.

4.4.2 PROCESS AND/OR FINDINGS

PERFORMANCE PILOT YEAR 1 SUMMARY Theme 4: Enhancing the Continuum of Services

Pilot County: Solano

Pilot County Administrator: Del Royer

Pilot Theme: Enhancing the Continuum of Services (Prevention, Intervention, Treatment, Recovery)

Pilot Title: Brief Treatment Evaluation Using Client Perception and Outcomes

INTRODUCTION

At the start of Year 1 of the EnCAL-COSSR pilot, Solano County's Health & Social Services/Substance Abuse Department expressed an interest in expanding access to services and measuring continuity of care. As pilot goals evolved and discussions regarding the long waiting lists at their centralized treatment unit (CTU) ensued, the county decided to focus its pilot efforts on bringing a brief treatment intervention to the wait-list groups at the CTU. The implementation of brief treatment services to CTU wait-list clients could (1) provide another level of care for clients who would otherwise be kept on wait lists for a long period of time until treatment slots opened; (2) provide a stabilization track for clients with co-occurring disorders that would lengthen the assessment period, stabilize clients on medications, and allow time for collaboration with the Mental Health and Public Health Departments to determine which system would provide the most appropriate services; and (3) allow Solano County to become Drug Medi-Cal (DMC) certified and pursue federally qualified health center (FQHC) billing to generate revenue. Moreover, an evaluation of the effect of a brief treatment intervention on client perceptions of care and on client outcomes would contribute to the small but important literature on brief treatment interventions.

GOALS AND OBJECTIVES

Goal

To develop and implement a brief treatment intervention protocol and measure its impact on client perceptions of care and on performance outcomes.

Objectives

- Assist Solano County in the development of the brief treatment intervention protocol.
- Provide technical assistance to Solano County on the implementation of the perception of care survey (i.e., the "Modular Survey") for wait list clients.

- Measure and analyze the impact of brief treatment on client perceptions of care by comparing perception-of-care survey data before and after the intervention.
- If possible, link perception-of-care survey data to CalOMS-Tx data to measure the impact of the brief treatment intervention on performance outcomes, such as access, retention, and engagement.

METHODS

- Solano developed a brief treatment intervention protocol based upon the Matrix treatment model. The manual is based in cognitive behavioral therapy with structured topics for each group.
- Prior to the implementation of the brief treatment intervention, Solano administered the perception-of-care survey to clients on the wait list. (The same perception-of-care survey will be distributed to wait list clients three months after the brief treatment intervention is fully functioning within the wait-list group. Wait-list clients' perceptions of care who did not receive a brief intervention will be compared with clients' perceptions of care who did).
- To establish additional comparison groups, Solano collected perceptions-of-care data from clients receiving formal outpatient treatment services.
- After collecting baseline perception-of-care data, Solano implemented the brief treatment intervention.
- UCLA provided technical assistance to Solano on data collection and entered and analyzed perception-of-care data.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **Preliminary Observations about Client Perceptions of Care in Solano County**
 - Average perception-of-care scores for wait-list clients at baseline (prior to receiving the brief intervention) were slightly lower than perception-of-care scores for clients receiving formal outpatient services (Table 1). The difference between the total scores of the two groups was 3.66.

Table 1: Comparison of Average Perception of Care Questionnaire Scores between Wait List Clients and Outpatient Clients

	Quality Domain (range: 0-24)	Perceived Outcomes Domain (range: 0-24)	Social Connectedness Domain (range: 0-24)	Commitment to Change Domain (range: 0-8)	Total score (range: 0-80)
Wait List Clients (at Baseline) (n=34)	11.68	11.23	13.91	4.14	41.55
Outpatient Clients (n=78)	13.39	14.00	13.94	3.88	45.21

LESSONS LEARNED

- **Providing a brief treatment intervention to wait list clients may be a feasible option for enhancing the continuum of care for clients.**
 - Although brief treatment is most commonly used as an intervention with non-dependent substance users, it may also be useful as a form of early treatment for clients waiting to be placed in formal treatment. As counties face severe budget issues and the closure of programs, longer wait lists are inevitable. Utilizing brief treatment during the early stage of assessment and placement may preempt worsening of substance abuse disorders, prevent premature dropout, and triage clients into services that match their needs.
- **Client perceptions of care may be useful as a provider-level performance measure.**
 - The importance of consumer perspective in evaluating the quality of services and care has long been recognized (Doucette, 2008; McCorry, 2007). The “Modular Survey” of perceptions of care is the most widely used measurement of client perceptions of care in substance abuse treatment settings. Comparing how clients’ perceptions of care vary by the type of treatment they receive will allow Solano to evaluate the performance of their services. While perception-of-care data is only one possible performance measure, Solano has established a process for using data to determine satisfactory performance, improve services, and inform decisions for improving quality of care.

NEXT STEPS FOR YEAR 2

- **Re-administration of the Perception of Care Survey**
 - After implementation of the brief treatment protocol, UCLA and Solano will plan for the re-administration of the perception-of-care survey.

- **Data Analysis and Measurement**

- UCLA will examine the CalOMS-Tx data for changes in areas such as drug use and retention in clients who received the brief intervention and those who did not.
- UCLA also will correlate perception-of-care outcome data with CalOMS-Tx data to further evaluate the validity of the perceptions-of-care data as a performance measure.

RELEVANT LITERATURE AND RESOURCES

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4.4.3 SUMMARY AND RECOMMENDATIONS

Through the COSSR initiative and the existing momentum toward treating addiction as a chronic disorder, there is statewide recognition about the importance of enhancing the AOD service system to accommodate a continuum-of-services model. However, developing pilot projects under this theme came as a challenge to several counties. Multiple barriers were identified. Foremost among them was accepting that this continuum-of-services model represents a major shift in the way the AOD system operates. Currently, AOD treatment is provided in single modalities, usually without options for screening/brief interventions or recovery support/continuing care services. Therefore, coordinating services at the local level across the prevention, intervention, treatment, and recovery components seemed too premature since these components are not sufficiently coordinated and supported at the system level. Experience gained from the first year of pilot work under this theme provides a preliminary model for identifying ways to enhance the spectrum of services at the local level under the COSSR framework.

- *There is lack of coordination and communication between key AOD stakeholders who represent the components of the continuum (prevention, intervention/treatment, and recovery) at the county system level.* Through initial pilot-planning activities, we identified several obstacles and challenges at the system level that can hinder progress toward improved coordination and communication, particularly with regard to prevention and recovery. We recommend that system level protocols be implemented that contain strategic planning to address how the AOD county system can coordinate and communicate information across the continuum components at the local level.
- *Developing strategies to enhance the linkages between the prevention and treatment components require further education and information gathering at the local level.* After consultation with the ADP prevention representatives as well as Los Angeles County prevention leaders, we found that prevention and treatment departments have differing service delivery priorities, strategies, and outcome measures. We learned that these differences lead to differing data-capturing priorities and measures; hence the two data systems (CalOMS-Pv and CalOMS-Tx) appear to be incompatible and they are not set up to inform each other of outputs in order to make preparedness or improvement decisions systematically. Additionally, a cultural barrier exists between the two service components, mostly involving language terms that have indications toward funding streams (i.e.: intervention vs. treatment). We recommend that in order to promote a continuum-of-services model at the local level, the pilot work needs to continue to identify best practices and empirically based approaches that can bridge the prevention-treatment link (i.e., specific screening, brief intervention, and brief treatments in AOD and non-AOD settings). Another recommendation is to work on identifying these barriers in order to tailor steps to improve the discordance between the two service components.
- *Recovery: Understanding recovery trajectories is an important component of supporting a continuum-of-services model.* Given that the CalOMS-Tx data system does not capture information post initial-treatment, documenting the effectiveness of a continuum-of-services model is challenging for counties and providers. It is our recommendation to continue efforts

toward developing strategies and methods to document client recovery (and or services) within the CalOMS-Tx system. As referenced in the introduction section, our work toward understanding the recovery component is further addressed in Theme 5.

- *Adopting a continuum-of-services system change is driven by progressive leadership and greater acceptability of the chronicity of substance use disorders at the local level.* A major lesson learned from our pilot work is that there is a lack of coordination and communication among local treatment providers. Through qualitative interviews and discussions with county staff about how well their local system supported a continuum-of-services model, it appeared that although there was a general recognition of the necessity to provide a continuum of services to elicit better outcomes, there seemed to be minimal capabilities built into local systems to facilitate a continuum platform. We recommend that county leaders provide transparent goals and objectives for implementing a continuum-of-services model in order to create a conducive environment for “buying-in” to such efforts.
- *Another important feature of a continuum-of-services model is the development of linkages between treatment services, or providing coordinated services.* We learned that although providers have a tendency to refer clients upon discharge, they generally do not take the extra step to facilitate a successful “active” transfer. The onus typically falls on the client to maintain their motivation to continue their treatment at the next level of care. Considering that motivation within the AOD-using population can be fleeting, we recommend that county leaders transfer this responsibility to the providers and clinical staff by implementing performance management (incentivizing models) to improve this practice. In addition, because this shift requires providers to become familiar with their surrounding providers and support services, we recommend that counties implement a “mapping protocol,” whereby a reference tool is created that outlines all county programs and services—with the intent to ultimately build a continuum-of-services model through system-wide provider connectedness.
- *Recent literature supports the notion that provider connectedness can be an indicator of continuity of care.* Through our pilot work, we identified that capacity issues may prevent counties and programs from interacting and building provider connectedness. However, given that there is minimal research on the use of this measure (provider connectedness) in the substance use field, it is our recommendation to continue research in this area, as provider connectedness could serve as a potential measure of system performance. One idea would be to implement learning collaboratives with key representatives from each treatment program to work together to share information via interactive website/dashboards or meetings. This type of communication and coordination between service programs could serve to improve the overall delivery of the continuum of services within the AOD system.
- *Waiting for appropriate care is a common phenomenon across the healthcare system.* Through our pilot work with Solano County, it was clear that county and program stakeholders recognized that brief interventions and/or brief treatments can serve as a feasible strategy to improve access to treatment and/or prevention services more efficiently. Being able to provide a menu of treatment services as opposed to providing care in an acute, episodic manner is an important feature of a continuum-of-services model. In light of the minimal research on brief treatment models in the extant AOD field as well as the costs of

providing the infrastructure necessary to effectively manage individuals with substance use disorders (including the range and level of clinical expertise), a more practical first step may be to examine a couple of alternatives before making large system-wide changes. Hence, we recommend continued study in this area in order to identify effective brief treatments for clients entering treatment with varying degrees of severity and need.

- *Waiting for treatment has also been shown to negatively affect a client's perception of care with regard to the usefulness of treatment and general satisfaction with care.* As part of our pilot work with Solano County, we implemented the use of a standard measure of client perceptions of care in order to allow programs to identify quality care versus sub-standard care through client perceptions. We recommend that the county continues to monitor client perceptions of the care they receive to be able to detect problems early and assist clients in obtaining the necessary care they need following a continuum-of-services model (rather than a one-size-fits-all model). In other words, such research will provide counties with information about clients who respond with perceptions of poor care (and thereby may require different types of care—i.e., more or less intense).

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4.5 CHAPTER FIVE

Theme 5: Measurement of Recovery Services

4.5.1 INTRODUCTION

Theme Overview

The work under Theme 5 *Measurement of Recovery Services* seeks to (1) better understand the organizational and service components that characterize recovery services in order to (2) develop strategies to measure recovery support service delivery and performance/outcomes. As the alcohol and drug treatment field shifts from viewing addiction as an acute, curable disorder to viewing it as a relapsing and chronic disease, funding models are needed that include posttreatment extended recovery support (McLellan, 2002). In light of these changes, researchers and policy makers are beginning to shift their attention toward understanding the role of recovery services throughout the treatment process (pre and post) and developing program performance and client outcome measures to monitor their efficacy (McKay, 2005).

Recovery support includes, but is not limited to, the following types of services:

- Assertive continuing care;
- Continuous telephone recovery monitoring;
- Home visits;
- Medication;
- Recovery management;
- Recovery centers; and
- Traditional counseling and self/mutual-help programs.

Within the four pilot counties participating under Theme 5, we studied three recovery support services: recovery centers, recovery management, and continuous telephone recovery monitoring. Each type of service is defined as follows:

- *Recovery Centers (Mariposa and San Bernardino Counties)*: Recovery centers are “... often referred to as recovery community centers, are a ‘recovery hub’ gathering place, and are a peer-based service center for people seeking or in recovery and for their family members. These centers serve a clubhouse function in terms of recovery fellowship, but offer a much wider spectrum of recovery support services than would be available in a typical AA clubhouse” (White, 2008). There is limited literature on the efficacy of recovery centers.
- *Recovery Management (San Mateo County)*: Recovery management is “a system of support for professionally-directed treatment which emphasizes the experiences, needs and aspirations of the individual and/or families experiencing substance use disorders” (White, 2008). There are three phases of recovery management: (1) engagement and recovery priming; (2) recovery initiation and stabilization; and (3) recovery maintenance.

This recovery management model usually emphasizes “post-treatment monitoring and support; long-term, stage appropriate recovery education; peer-based recovery coaching; assertive linkage to communities of recovery; and when needed, early re-intervention” (White, Kurtz, & Sanders, 2006). The following studies have examined the efficacy of recovery management: Dennis, Scott, & Funk, 2003; McKay, 2009; and McKay, Carise, Dennis, Dupont, Humphreys, Kemp, et al., 2009.

- *Continuous Telephone Recovery Monitoring (Santa Clara County)*: Continuous recovery monitoring provides recovery check-ups monitoring to clients who completed treatment over the telephone. Several studies have shown the efficacy of posttreatment telephone recovery monitoring, as follows: Cacciolia, Camilleri, Carise, Rikoon, McKay, et al., 2008; McKay, Lynch, Shepard & Pettini, 2005; McKay et al., 2009, and McLellan & McKay, 2005.

For a more comprehensive literature review on recovery support services, please refer to UCLA’s 2009 COSSR Report, entitled *Evaluation Services to Facilitate the Re-engineering of a Performance and Outcomes Management System in Support of a Continuum of Services Model*.

Relevance to the COSSR Framework

The COSSR emphasis on providing continuing care for clients both during and after traditional treatment has highlighted the importance of understanding and documenting recovery support services. Despite the fact that recovery services are not tracked within the CalOMS-Tx database and are not reimbursed by the state, efforts across California to provide recovery services outside of the formal treatment system are surprisingly extensive. As such, current pilot activities to describe recovery services throughout the state and to make recommendations for performance and outcome measurement are highly relevant to COSSR. In order to ensure a successful continuum-of-services system (prevention, intervention, treatment, and recovery), each service component along the continuum must work in parallel and service units must communicate and collaborate with one another on the various services available as well as on the performance and outcomes of such services. Understanding and measuring recovery services across the state will contribute to the provision of a high quality continuum of care for AOD clients.

Pilot Purpose

UCLA ISAP identified four counties to contribute to the work under this EnCAL-COSSR theme: “Measurement of Recovery Services”:

- 1) Mariposa County, Linda Murdock;
- 2) San Bernardino County, Gary Atkins;
- 3) San Mateo County, Steve Kaplan; and
- 4) Santa Clara County, Bob Garner.

The objectives of the pilots that fall under this theme are as follows:

- 5) To assist counties in documenting the organizational structure, implementation, and service components provided through recovery support services;
- 6) To further investigate how providers can most easily and efficiently record recovery services that are not captured within the CalOMS-Tx data system;
- 7) To explore which performance/outcome measures are relevant to determine impact of recovery support services;
- 8) To provide recommendations to the State Department of Alcohol and Drug Programs (ADP) on strategies to measure recovery support service delivery, client outcomes, and program performance of these services that occur beyond the formal CalOMS-Tx system treatment framework.

The following section compiles the Process and/or Findings from the four county pilots contributing work toward this theme. Details from each county pilot effort are described within a Performance Pilot Year 1 Summary Report. The summary reports include the following sections:

- Introduction
- Goals and Objectives
- Methods
- Preliminary Observations and Findings
- Lessons Learned
- Next Steps for Year 2

Following the individual county pilot summary reports is a section describing an overall summary of lessons learned from the pilot work under this theme and recommendations for future work.

4.5.2 PROCESS AND/OR FINDINGS

PERFORMANCE PILOT YEAR 1 SUMMARY

Theme 5: Recovery Services

Pilot County: Mariposa County

Pilot County Administrator: Linda Murdock

Pilot Theme: Measurement of Recovery Services

Pilot Title: Building Recovery Services: The Role of Recovery Centers

INTRODUCTION

In the start of Year 1 (July 2009) of the EnCAL-COSSR pilot, Mariposa County's Behavioral Health and Recovery Services Alcohol and Other Drug (AOD) Programs expressed an interest in changing its AOD system to incorporate a continuum-of-care model with a focus on prevention. Mariposa County had already implemented the Celebrating Families Program, a manualized 12-week intervention for families with parents in recovery, but funding cuts resulted in a discontinuation of the program. Another option for the county to increase the continuum of care for clients was to assess the linkage of clients to treatment services in neighboring counties, with the goal of improving the percentage of clients who transfer across different levels of care. However, Mariposa reported that due to funding reductions created by the defunding of the Substance Abuse and Crime Prevention Act (SACPA) program, all contracting for out-of-county services would soon be discontinued. UCLA staff and the Mariposa County administrator determined that a relevant and more feasible pilot would be to conduct a case study of the functionality and impact of their recovery centers. Understanding the services provided by recovery centers is a critical step toward measuring and developing performance measures for services that occur along the treatment/recovery continuum but are outside of AOD services documented by the CalOMS-Tx data system.

GOALS AND OBJECTIVES

Goal

To better understand the organizational and service components that characterize recovery centers in order to develop strategies to measure recovery support service delivery and performance/outcomes.

Objectives

- Document the organizational structure of, and recovery support services provided by, recovery centers.

- Investigate how providers can most easily and efficiently document recovery services that are not captured within the CalOMS-Tx data system.
- Explore which performance/outcome measures are relevant to determine impact of recovery support services.
- Provide recommendations to the state Department of Alcohol and Drug Programs (ADP) on strategies to measure recovery support service delivery and outcomes of these services that occur beyond the formal CalOMS-Tx system treatment framework.

METHODS

- UCLA conducted extensive literature reviews and formative research to assess out-of-state recovery centers' infrastructure, service components, and data elements.
- UCLA collected data about recovery centers through the administration of surveys and through key informant interviews with county administrators, providers, and staff.
- In Year 2, UCLA will assist the county to implement and analyze the recovery center service data to measure provider performance and/or client outcomes and determine the feasibility of measurement activities.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **General Observations:** In 2001, Mariposa County's Kings View Behavioral Health observed that members of Mariposa's rural recovering community needed a sober place to congregate and subsequently opened a recovery center to serve the community. Since then, Mariposa County took over ownership of the recovery center, but was able to retain its original staff and thus also retained the center's original mission and culture.
- **Recovery Center Infrastructure:** Formative research analysis revealed that out-of-state models (Vermont, Philadelphia, Connecticut, and Massachusetts) have common infrastructure, service components, and data elements. UCLA used these domains to assess the infrastructure, service components, and data collection activities of the Mariposa County recovery center. Mariposa County's recovery center is a stand-alone facility that offers a variety of recovery groups and sober social activities. For a more detailed description of the recovery center's infrastructure and service components, please refer to Appendix 5A.
- **Recovery Center Services:** The recovery center in Mariposa County provides peer counseling, support services, life skills, GED preparation, referral services, employment services, treatment locator, 12-step programs, and social activities. In addition to serving the "recoverees," recovery center services are open to general members of the local community. For a more detailed description of the recovery center's infrastructure and service components, please refer to Appendix 5A. Participants, objectives, and procedures associated with each service component are as follows:

- Life Skills
Participants include members of the recovery community. The objective is to improve life skills for community members through peer-led meetings, individual sessions, peer-modeling, and the utilization of center resources, such as G.E.D. preparatory materials and job search support. Life skills are guided by both trained recovery center staff, volunteers, and peers in recovery.
- Peer Counseling
Participants include members of the recovery community. The objective is to provide social and emotional support for continued change through personal sharing, problem solving, helping others, and self governance. Peer counseling is provided by recovery center staff; however, guidance is also provided by peers in recovery, with oversight by the program coordinator.
- Drug Training Education
Participants include members of the recovery community. The objective is to provide educational resources on medical aspects of substance abuse, alcohol/drugs and the law, family dynamics, and other issues through resource sharing, peer support, and individual peer counseling. Services are provided through 12-step programs, medication groups, and individual sessions.
- Recreational and Social Activities
Participants include friends and family of community members in recovery, senior recovering community associates, and recovery center staff and volunteers. Objectives are to provide peer-led opportunities for substance-free recreation and to encourage clients to repay society through community service. Recoverees are encouraged to attend recovery center events such as dances and barbeques. The recovery center also provides links to 12-step sponsored activities such as camping, hiking, and fishing.
- **Mariposa Recovery Center Data Collection:** Since its inception, the recovery center has collected only a minimal amount of data but has made some effort to track the growth of the services over time. Since the start of the EnCAL pilot, the recovery center has independently made strides toward measuring the utilization and impact of its services. The recovery center now collects the following data (Table 1):
 - Access: Number of visitors per day, month, and year. The center is also in the process of developing documentation of services provided per client.
 - Quality of Services: The recovery center is in the process of developing a survey on client satisfaction with services provided, staff, and facility.

Table 1. Data Collection within Mariposa Recovery Center

Type of Data Collected						
Recovery Center	Access			Quality of Services		Recovery Skills
	Visitors per day, month and year	Attendance numbers by group	Client identifiers per recovery activity or group	Client Satisfaction: Staff and Facility	Client Satisfaction: Groups and Services	Changes in Client Recovery Skills
Case Study 1	✓		<i>In development</i>	<i>In development</i>		

LESSONS LEARNED

- **Recovery centers offer an extension of traditional alcohol and drug treatment services that provides clients with a more complete continuum of care.** Despite its lack of funding, Mariposa County has long recognized the value of its recovery center. The recovery center provides pre-recovery support services to enhance recovery readiness, in-treatment recovery support services to enhance the recovery and post-treatment recovery support services to enhance the sustaining recovery. In addition recovery centers provide linkages to formal treatment, peer-support, sober social activities, advocacy, resources to increase recovery capital and linkage to auxiliary services, all at no cost to the client. The county’s recovery center seems to be a useful tool within the continuum. The center is in a unique position to identify clients who are either contemplating an initial phase of treatment or who may need additional posttreatment recovery support services. For clients contemplating an initial phase of treatment, the center may offer pre-treatment services that induct clients into the treatment process and provide referrals to formal treatment. Similarly, the center can identify at-risk clients or clients who relapse posttreatment in order to quickly intervene and provide a link to additional recovery services.
- **Collecting recovery center data to develop performance and outcome measures is feasible but will require some changes at the county and provider level.**
 - Although out-of-state recovery center models exist, there are no clearly defined methods on measuring recovery center outcomes and performance within California. In addition, formal research and literature on the efficacy of recovery center facilities is limited.
 - Mariposa County is developing recovery center measurement methods and continues to explore measurement goals. The recovery center’s data collection efforts are commendable and are very useful to the county; however, because data collection methods are not standardized, it may be difficult to interpret the results accurately. It is difficult to determine if the data measures and collection

procedures currently used is the best with which to measure recovery center efficacy.

- As in many counties, it appears that the collection of recovery data at the Mariposa recovery center is low. Providers rarely see their data after input and have little training on data collection methods, procedures, and analysis.
- There is a culture of anonymity within recovery centers which may limit the ability to create identifiers that could be linked to a CalOMS-Tx data base. Program staff noted the following reasons for their hesitation to collect data that may identify the client:
 - Those who access recovery center services do so for the benefit of anonymity. Documenting recovery center services by name might result in a decrease of utilization of services and number of those served.
 - Tracking identifiers/names simply conflicts with philosophies and the purpose of the recovery center.
 - Capturing data takes time away from providing vital recovery support services.
 - Documenting services takes away valuable time from providing services to recovery center guests.
 - Lack of adequate number of staff to collect and maintain data.
 - (Note: Since starting the EnCAL pilot, Mariposa County began documenting first names of clients receiving recovery center services, a first step toward linking treatment and recovery within the CalOMS-Tx system.)
- **Unstable funding continues to be an issue for recovery centers.** Mariposa County's budget challenges may reduce its ability to provide recovery center services, therefore, possibly leading to the elimination of any continuity-of-care pilot measurement project.

NEXT STEPS FOR YEAR 2

- **Performance / Outcome Measurement**
 - UCLA will continue to explore recovery models and the definition of recovery in order to select outcome and performance measures appropriate for measuring recovery center success.

- Mariposa County and UCLA will continue to investigate which outcome and performance measures can most easily and efficiently document recovery center services that are not currently captured within the CalOMS-Tx data system.

- **Training Activities**

- UCLA will provide trainings to improve upon and standardize existing data measures and data collection procedures to ensure that the excellent work of the recovery centers is documented accurately.
- Additional county and provider training and technical assistance recommendations include a UCLA training entitled, “The System of Care for Substance Use as a Chronic Health Problem” to continue to enhance the county’s efforts to provide recovery services within a continuing care model

RELEVANT LITERATURE AND RESOURCES

Connecticut Community for Addiction Recovery. <http://www.ccar.us/> (accessed November 2009)

Flaherty, M. (2006). *A unified vision for the prevention and management of substance use disorders: Building resiliency, wellness and recovery - A shift from an acute care to a sustained care recovery management model*. Pittsburg, PA: Institute for Research, Education and Training in Addictions (IRETA).

Grasmere, J., Martelle, J., Andersen R., & Parker, D. *How to Build Your Own Peer-to-Peer Recovery Center From The Ground Up!* (2006) The RECOVER Project, www.recoverproject.org

McLellan, A.T. Lewis, D.C., O'Brien C.P, & Kleber H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA*, 284, 1689–1695.

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Personal Correspondence with Michael Flaherty of IRETA (January 2010)

Personal Correspondence with Stephan Gumby, Brown University (February 2010)

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White, W. L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices. Recovery management: Continuing care following acute treatment.* Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Center, and the Philadelphia Department of Behavioral Health/Mental Retardation Services.

White, W.L. (2007). *Ethical Guidelines for Delivery of Peer-based Recovery Support Services.* <http://www.bhrm.org/recoverysupport/EthicsPaperFinal6-8-07.pdf>

PERFORMANCE PILOT YEAR 1 SUMMARY
Theme 5: Recovery Services

Pilot County: San Bernardino

Pilot County Deputy Director of Program Operations: Gary Atkins

Pilot Theme: Measurement of Recovery Services

Pilot Title: Building Recovery Services: The Role of Recovery Centers

INTRODUCTION

In the start of Year 1 (July 2009) of the EnCAL-COSSR pilot, San Bernardino's County's Department of Behavioral Health expressed interest in increasing its focus on the treatment/recovery continuum. In another COSSR pilot project that the county started prior to the start of EnCAL, San Bernardino sought to institute a point-of-contact model (i.e., a medical home model) in which a lead agency would coordinate all client services, including client engagement in any of six recovery centers throughout the county. This pilot was initiated as an effort to inform the state about effective models for understanding continuing care activities that support recovery-oriented services and reimbursement models.

As EnCAL-COSSR project goals evolved, UCLA staff and the San Bernardino County Alcohol and Other Drug (AOD) Deputy Director determined that while the medical home model was in its initial development stages, UCLA would focus on better documenting the organizational and service components that characterize the county's recovery centers. Understanding the services provided by recovery centers is a critical step toward measuring and developing performance measures for services that occur along the treatment/recovery continuum but are outside of AOD services documented by the CalOMS-Tx data system.

GOALS AND OBJECTIVES

Goal

To better understand the organizational and service components that characterize recovery centers in order to develop strategies to measure recovery support service delivery and performance/outcomes.

Objectives

- Document the organizational structure of, and recovery support services provided by, recovery centers.
- Investigate how providers can most easily and efficiently document recovery services.

- Explore which performance/outcome measures are relevant to determine impact of recovery support services.
- Provide recommendations to the state Department of Alcohol and Drug Programs (ADP) on strategies to measure recovery support service delivery and outcomes of these services that occur beyond the formal CalOMS-Tx system treatment framework.

METHODS

- UCLA conducted extensive literature reviews and formative research to assess out-of-state recovery centers' infrastructure, service components, and data elements.
- UCLA collected data about recovery centers through the administration of surveys and through key informant interviews with county administrators, providers, and staff.
- In Year 2, UCLA will assist the county to analyze recovery center service data to measure provider performance and/or client outcomes and to determine the feasibility of further measurement activities.

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **General Observations:** San Bernardino County identified the need to provide services and support to clients outside of the formal treatment system. Recovery centers provide services to increase individuals' recovery capital in a client-centered, peer-supported, community-allied facility that focuses on rebuilding clients' lives within the community. At this time, services provided by recovery centers are not tracked within the CalOMS-Tx database and are not reimbursable by the state. Each recovery center is a non-profit organization, holds an outpatient services certification, and has adapted independently to provide and measure services with oversight by the county to meet the needs of the surrounding communities.
- **Recovery Center Infrastructure:** Formative research analysis revealed that out-of-state recovery centers (Vermont, Philadelphia, Connecticut, and Massachusetts) have common infrastructure, service components, and data elements. UCLA used these domains to assess the infrastructure, service components, and data collection activities within San Bernardino County recovery centers (Table 1).

Table 1. General* Structure of Recovery Centers within San Bernardino County

Recovery Models	<ul style="list-style-type: none"> • Stand-alone facilities • Within an outpatient treatment center • Mobile Resource Unit 		
Facility	<ul style="list-style-type: none"> • Group Room • Social/Activities Room • Clinical Staff office / records 		
Staffing	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><i>Typical Staffing</i></p> <ul style="list-style-type: none"> • Addiction Certified Specialist / Program Manager • Volunteers <p><i>Pending Funding:</i></p> <ul style="list-style-type: none"> • Administration • Program/Activity Coordinator • Interns </td> <td style="width: 50%; vertical-align: top;"> <p><i>Additional Resources Pending Facility Location:</i></p> <ul style="list-style-type: none"> • Case Manager (Outpatient/Residential) • Intake Coordinator (Outpatient) • Clinical Director (Outpatient) • Additional clinical staff as needed (Example: Medical Staff within a Residential Treatment) </td> </tr> </table>	<p><i>Typical Staffing</i></p> <ul style="list-style-type: none"> • Addiction Certified Specialist / Program Manager • Volunteers <p><i>Pending Funding:</i></p> <ul style="list-style-type: none"> • Administration • Program/Activity Coordinator • Interns 	<p><i>Additional Resources Pending Facility Location:</i></p> <ul style="list-style-type: none"> • Case Manager (Outpatient/Residential) • Intake Coordinator (Outpatient) • Clinical Director (Outpatient) • Additional clinical staff as needed (Example: Medical Staff within a Residential Treatment)
<p><i>Typical Staffing</i></p> <ul style="list-style-type: none"> • Addiction Certified Specialist / Program Manager • Volunteers <p><i>Pending Funding:</i></p> <ul style="list-style-type: none"> • Administration • Program/Activity Coordinator • Interns 	<p><i>Additional Resources Pending Facility Location:</i></p> <ul style="list-style-type: none"> • Case Manager (Outpatient/Residential) • Intake Coordinator (Outpatient) • Clinical Director (Outpatient) • Additional clinical staff as needed (Example: Medical Staff within a Residential Treatment) 		
Services	A variety of recovery support services, such as relapse prevention, parenting, anger management, meditation, job enrichment, life skills, sober social activities, peer-mentoring and other recovery support / community groups.		
Target Population & Eligibility	The surrounding local community is eligible to utilize recovery center services regardless of their recovery state or if they status. <i>See case studies for specifics on variations between recovery centers.</i>		

**For a more detailed description of the infrastructure and service components of each recovery center case study, please refer to Appendix 5B.*

- **Recovery Center Service Components:** The county mandates that its funded recovery centers offer the following specific service components: Life skills, drug training education, tobacco smoking cessation, recreational and social activities, parent education, and aftercare. In addition to serving the “recoverees,” most recovery center services are open to members of the local community. Participants, objectives, and procedures associated with each service component at each of the six recovery centers are as follows:
 - Life Skills
Participants include members of the recovery community. Objectives are to provide peer-led social and emotional support for motivation and facilitation of continued change. Procedures include personal sharing, group problem-solving, helping oneself by helping others, and self-governance. These courses are led by members of the recovery community.
 - Drug Training Education
Participants include members of the recovery community and recovery center staff. Objectives are to provide educational resources on medical aspects of substance abuse, alcohol/drugs and the law, family dynamics, and other issues. The courses are led by trained recovery center staff for a minimum of 12 weeks.

- Tobacco Smoking Cessation
Participants include members of the recovery community. Objectives are to assist community members to quit smoking, provide information about the nature and dangers of nicotine, enhance treatment outcomes, and reduce the risk of relapse for chemically dependent participants. The course is led by a trained individual and offers a program that combines elements of behavioral therapy and 12-step philosophy.
- Recreational and Social Activities
Participants include friends and family of community members in recovery, senior recovering community associates, and recovery center staff and volunteers. Some recovery centers open their recreational and social activities to the greater surrounding community, while others do not. Objectives are to provide peer-led opportunities for substance-free recreation and to encourage clients to repay society through community service. Recoverees are encouraged to attend community events such as dances, barbecues, karaoke, movie nights, and off-site activities such as golfing, bowling, and music events.
- Parent Education
Participants include friends and family of community members in recovery, senior recovering community associates, and recovery center staff and volunteers. The main objective is to increase parenting competencies in parents of children and adolescents. The parent project works specifically on reducing destructive adolescent behaviors such as poor school attendance and performance, emotional and behavioral problems, criminal activity, gang affiliation, or arrest. Parent education consists of a 10-week, topic focused, facilitated support group to refine parenting skills and provide emotional and practical support to families making changes. Parent education is led by a trained recovery center staff.
- Aftercare
Participants often include graduates of a recovery program, peers, and recovery center staff. The objective is to offer concrete models of successful recovery that are based on experience and guidance to increase client success in maintenance of recovery. Aftercare programs use evidence-based practices such as Gorski Relapse Prevention and Hazelden’s 12-Step Facilitation Outpatient Program. Aftercare is led by a trained recovery center staff member and may include a co-leader who is in long-term recovery.
- **Recovery Center Data Collection:** Recovery centers collect a variety of data which they compile in quarterly reports to inform the San Bernardino County Department of Behavioral Health of the utilization and impact of recovery center services (Table 2). Recovery centers have developed site-specific data collection methods and forms. Recovery centers generally collect three types of data as follows:
 - Access: Data indicating how many individuals (and, in some cases, which clients) are accessing the recovery centers, activities, and groups.

- Quality of Service: Client satisfaction with the facility, staff, or the services provided at the center.
- Recovery Skills: Data on clients' perceptions of their own recovery skills before and after attending recovery center groups and activities.

Table 2. Data Collection within San Bernardino Recovery Centers

Type of Data Collected						
Recovery Centers	Access			Quality of Services		Recovery Skills
	Visitors per day, month and year	Attendance numbers by group	Client identifiers per recovery activity or group	Client Satisfaction: Staff and Facility	Client Satisfaction: Groups and Services	Changes in Client Recovery Skills
Case Study 1	✓	✓		✓	✓	✓
Case Study 2	✓			✓		✓
Case Study 3	✓	✓	✓	✓	✓	✓
Case Study 4	✓	✓	✓	✓		✓
Case Study 5*	✓					
Case Study 6	✓	✓	✓ ¹			✓ ¹

*Recovery Center not yet fully operational, pending outpatient certification

¹Names/identifiers are recorded for some groups and activities, not all.

LESSONS LEARNED

- **Recovery centers offer an extension of traditional alcohol and drug treatment services that provides clients with a more complete continuum of care.** Despite having little funding, San Bernardino County had the forethought to address the needs of the community. Recovery centers provide pre-recovery support services to enhance recovery readiness, in-treatment recovery support services to enhance the recovery and post-treatment recovery support services to enhance the sustaining recovery. In addition recovery centers provide linkages to formal treatment when needed, peer-support, sober social activities, advocacy, resources to increase recovery capital and linkage to auxiliary services, all at no cost to the client. Centers are in a unique position to identify clients who are either contemplating an initial phase of treatment or who may need additional posttreatment recovery support services. For community members contemplating an initial phase of treatment, recovery centers may offer pre-treatment services that induct an individual into the treatment process and provide referrals to formal treatment. Similarly, recovery centers can identify at-risk individuals or those who relapse posttreatment in order to quickly intervene and provide a link to additional recovery services.

- **Collecting recovery center data to develop outcome and performance measures is feasible but will require some changes at the county and provider level.**
 - Although out-of-state recovery center models exist, there are no clearly defined methods on measuring recovery center outcomes and performance within California. In addition, formal research and literature on the efficacy of recovery center facilities is limited.
 - Although recovery centers within the county have independently developed site-specific data collection methods and forms with which to collect outcome data, data collection methods are different across centers and surveys are not standardized, making it difficult to interpret results accurately and to compare results across centers.
 - The county has made many attempts to collect data from recovery centers. As in many counties, it appears that the collection of recovery center performance / outcome data in San Bernardino County is low. Providers rarely see their data after input and have little training on data collection methods, procedures, and analysis.
 - There is a culture of anonymity within recovery centers which may limit the ability to create identifiers that could be linked to a CalOMS-Tx data base.
 - Fifty percent (50 %) of the recovery centers within San Bernardino did not document individual names or identifiers of those accessing recovery center services, such as community groups, making the link between treatment and recovery within the CalOMS-Tx system, challenging. Providers noted the following reasons:
 - Guests, who do not seek formal treatment, may seek out recovery center services because they want an alternative to treatment (regardless of the ability to pay). Therefore, documenting recovery center services by name would result in a decrease of utilization of services.
 - Tracking identifiers/names simply conflicts with philosophies and the purpose of the recovery center.
 - The need for tracking individuals' identifiers is not apparent.
 - Given the challenges listed above, it may be beneficial to initially direct measurement efforts towards program performance. However continuing to work through patient privacy issues, workforce limitations, and data system capacities is crucial to begin measuring client outcomes within the recovery support services.

- **Unstable funding continues to be an issue for recovery centers.** Recovery centers that had a high proportion of criminal justice clients saw a drop in their recovery center service utilization due to cuts to Substance Abuse and Crime Prevention Act (SACPA) programs and the subsequent reduction in criminal justice clients accessing primary treatment. As a result, some recovery centers have identified the need to make better use of non-criminal justice networks to ensure full utilization of the recovery center.

NEXT STEPS FOR YEAR 2

- **Performance / Outcome Measurement**
 - UCLA will continue to explore recovery models and definitions in order to select outcome and performance measures appropriate for measuring recovery center success.
 - San Bernardino County and UCLA will continue to investigate which outcome and performance measures can most easily and efficiently document recovery center services that are not currently captured within the CalOMS-Tx data system.
- **Training Activities**
 - UCLA will provide trainings to improve upon and standardize existing data measures and data collection procedures to ensure that the excellent work of the recovery centers is documented accurately.
 - Additional county and provider training and technical assistance recommendations may be based on the UCLA training entitled “System of Care for Substance Use as a Chronic Health Problem” to continue to enhance the county’s efforts to provide recovery services within a continuing care model
- **Adjunct Pilot Activities - Medical Home Model**
 - UCLA will continue discussion with San Bernardino County to revisit possible application of the medical home model.

RELEVANT LITERATURE AND RESOURCES

Connecticut Community for Addiction Recovery. <http://www.ccar.us/> (accessed November 2009)

Flaherty, M. (2006). *A unified vision for the prevention and management of substance use disorders: Building resiliency, wellness and recovery - A shift from an acute care to a sustained care recovery management model*. Pittsburg, PA: Institute for Research, Education and Training in Addictions (IRETA).

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PERFORMANCE PILOT YEAR 1 SUMMARY
Theme 5: Recovery Services

Pilot County: San Mateo

Pilot County Administrator: Stephen Kaplan

Pilot Theme: Measurement of Recovery Services

Pilot Title: Building Recovery Services: The Role of Recovery Management/Recovery Coaching within a Capitated Reimbursement Model

INTRODUCTION

In the start of Year 1 (July 2009) of the EnCAL-COSSR pilot, San Mateo County's Behavioral Health and Recovery Services Alcohol and Other Drug Services (AOD) had already volunteered to participate in the COSSR Continuum Change Pilots with a focus on the treatment/recovery continuum. Throughout the previous two years, San Mateo County developed and implemented a capitated case-rate pilot study with a selected recovery center, the Women's Recovery Association (WRA). The case-rate model offers a fixed amount of money to treat an individual client over the course of a year. This offers WRA and other treatment providers the opportunity to focus on the care of the client using the most effective and efficient use of their full continuum of treatment services and modalities. The purpose of the pilot was to assess whether a capitated case-rate model of funding for a group of clients with complex co-occurring disorders would (1) increase access to a full range of services on an as-needed, individually tailored basis; (2) be more cost efficient, due to streamlined billing and administrative procedures; and (3) provide more effective services since services would be better integrated across levels of care, continued for a full year, and would support long-term engagement between clients and the recovery program. One of the unique elements of this pilot study was the added role of a recovery coach. Utilizing a recovery management model, the recovery coach functioned as the primary and ongoing point of contact for clients and assisted in moving clients across levels of care during each client's year-long pilot participation, which began at WRA treatment intake. The recovery coach provided ongoing support and advocacy for the client, offered case management services when needed, and initiated contact with clients in an effort to increase engagement and retention.

Over the course of the EnCAL pilot planning phase and as EnCAL project goals evolved, UCLA staff and the San Mateo County AOD administrator determined that while the capitated case-rate pilot system was in process and data collection was underway, UCLA would focus on better understanding the role and service components that characterize recovery coaching. Understanding the services provided by recovery coaches is a critical step toward measuring and developing performance measures for recovery services that occur along the treatment/recovery continuum but are outside of AOD services documented by the CalOMS-Tx data system.

GOALS AND OBJECTIVES

Goals

To better understand the role and service components that characterize recovery coaching within a recovery management model and to develop strategies to measure recovery service delivery, performance, and outcomes of recovery coaching.

Objectives

- Document the organizational structure of, and recovery support services provided by, recovery coaches within a recovery management model.
- Investigate how providers can most easily and efficiently document recovery services that are not captured within the CalOMS-Tx data system.
- Explore methods to measure the impact of the recovery coach on performance/client outcomes.

METHODS

- UCLA conducted site visits, focus groups, and key informant interviews to document and characterize the role of a recovery coach.
- San Mateo County requested that UCLA conduct a focus group to better understand the organizational impact of the pilot project, which included the capitated payment system and recovery management model implemented at WRA. The focus group sought to understand staff perspectives on how the pilot project affected (1) WRA staff teams, (2) the organization as a whole, and (3) WRA clients.
- UCLA attended San Mateo's bimonthly quality improvement meetings to provide guidance and technical assistance on pilot measurement efforts.
- UCLA assisted the county in writing a journal article to document the initial findings of its case-rate model (SARC Special Issue of the *Journal of Psychoactive Drugs*, 2010).

PRELIMINARY OBSERVATIONS AND FINDINGS (YEAR 1)

- **Role of the Recovery Coach**
 - Key informant interviews and the organizational impact focus group revealed that the role of the recovery coach was perceived by staff and by the recovery coach as an added benefit to the treatment team because the role (1) focuses on “life after treatment;” (2) embodies the characteristics of a 12-step community “super-sponsor;” and (3) offers the services of a trained individual who understands clients' dynamic recovery experience. The initial recovery coach reported that the

role is like a cross between a medical case manager and a trained addiction sponsor. Staff were very positive about the recovery coach role and considered it very useful for the recovery process.

- Because the recovery coach role was different from and did not conflict with the roles of clinical and house staff, the dynamics among staff worked well during treatment planning. Perceptions of clients' reactions to the recovery coach were positive overall. Staff recounted stories of active clients engaging with the recovery coach and contacting her for continued recovery support.
- For further findings Organizational Impacts of the San Mateo Pilot Project, refer to Appendix 5C. In addition, a full description of their pilot project is described in the upcoming SARC Special Issue of the *Journal of Psychoactive Drugs*, 2010.

- **Organizational Impact of the Pilot Project**

- Impact on organizational functioning/operations: During the initial implementation of the project, staff reported feeling pressure to meet expectations from external and internal entities whose objectives, at times, appeared to be at odds with each other. These competing objectives were identified as: (1) reducing the length of stay; (2) retaining clients for the full year; (3) maintaining individually tailored treatment; and (4) determining measurable client outcomes.
- Impact on site staff teams and their roles: Overall, staff welcomed the pilot project as an exciting and important project that was modeled on recent research literature. However, staff also reported initial uncertainty and worries about its feasibility and impact on the organization-at-large (how it would actually work, new procedures, etc). Upon implementing the project, the staff reported feeling pressure from competing objectives to ensure program success. Specifically they felt that (1) their integrity as counselors was being compromised and (2) they were unable to fully recognize and address the clients' "agendas" (see General Themes, Clients' Perceived Reactions in Appendix 5C). Clinical treatment planning staff questioned the appropriateness of reducing length of treatment to less than 90 days of inpatient treatment.
- Impact on clients' treatment experiences (from staff perspectives): As a result of the organization's tolerance of some pilot clients' noncompliance with treatment program rules, which would normally result in discharge, non-pilot clients complained to staff of being treated unfairly, as rules were not enforced the same for everyone. Staff also reported that some clients may have agreed to participate in the pilot project in order to get into treatment faster and have a reduced length of stay in the inpatient facility.
- Concurrent influences on organizational pressure: In addition to the pilot project, WRA undertook several significant and simultaneous organizational changes,

including (1) the expansion of the perinatal program, (2) the admittance of re-entry women from jails, and/or (3) concurrent pressures regarding retention and engagement per AOD's co-occurring disorder initiative. As a result, staff reported that they were not clear if the pilot project resulted in significant external pressure on staff members, or if the pressure was felt as a result of multiple concurrent changes experienced by the organization.

- Please see Appendix 5C for a description of findings of the Organizational Impacts of the San Mateo Pilot Project.

- **Quality Improvement Process**

- San Mateo's Quality Improvement (QI) meetings are essential in fine-tuning the process of the pilot program. Ongoing discussion revealed that the following topic areas are important issues:
 - Staff Turnover: Because coach/client relationships need to be able to transfer if staffing changes, the QI group encourage the link to the organization rather than individual staff person.
 - Recovery Coaches on Call: San Mateo implemented a new process where the recovery coach will be on call 24 hours a day, 7 days a week, in case of any pressing emergencies that require coach consultation.
 - Broadening Communication: The recovery coach began to utilize text messaging as one of ways to communicate and keep in contact with clients, which greatly improved the level of engagement and interaction among younger clients.
 - Pilot Cohort Groups: San Mateo's pilot project resulted in the development of a cohort group, which took part in social and art activities.
 - Length of Stay: Because the issue of structure (formal 90-day treatment episode) vs. personalization (individualized treatment episode) in treatment continued to be an issue, the QI group created a script for the initial point of entry to better communicate that WRA and the client will identify the appropriate length of stay for *each* individual.
 - Challenges/Successes: The pilot resulted in the development of a standardized protocol to add a family component as clients transition back home. Although this was initially met with resistance by some counselors, this was soon resolved and embraced.
 - Process of Measurement and Administrative Forms: Ongoing discussion fine-tuned and reviewed pilot project tools such as the Consent and Locator Form, Session Form, Recovery Action Plan (baseline and follow-

up), Pilot Client Progress Notes, New Directions Referral Form, BDI, LOCUS, and ASI.

- Other topics included data point measurement, utilizing the LOCUS, retention, engagement, drop-outs, contracting clients, low transfers, bimonthly client updates, menstrual cycle and treatment effects, and age.
- **Documenting the Efficacy of a Case-Rate Model**
 - UCLA reviewed and provided feedback for San Mateo’s manuscript, *A Field Experiment in Capitated Payment Systems and Recovery Management: The WRA Pilot Study* to document the initial findings of its case-rate model. Please see the SARC Special Issue of the *Journal of Psychoactive Drugs*, 2010 for results.

LESSONS LEARNED

- **Recovery monitoring by recovery coaches may be a feasible way to extend a continuum of care.** Recovery monitoring may be a useful tool to keep clients engaged in treatment. Recovery coaches were able to intervene to assist clients with recovery goals, other needs, and/or return to treatment. However, measurement efforts are needed to test the relationship between recovery coaching and longer-term client outcomes.
- **Organizational factors need careful consideration when implementing a new recovery and reimbursement model.** Lessons learned from the focus group include (a) recognizing and addressing client agendas is important for engaging clients in treatment, recovery, and pilot-project activities; (b) having pilot project staff dedicated to the project is important to implementation; (c) over time, a flexible treatment planning process became the norm; (d) the right recovery coaching personality is key to keeping clients engaged; (e) too many procedures can result in loss of rapport with clients when in combination with particular personalities; and (f) adapting the data collection and administrative mechanics of the protocol is important to the implementation of the project.
- **Measuring recovery monitoring and management may be feasible but has limitations.** The case-rate model may allow for maximum flexibility in treatment planning and increased attention to the development of innovative treatment methods that improve retention and promote recovery. Under this approach, the provider is urged to “do whatever it takes” to maintain contact with the client for a year regardless of their treatment needs or circumstances. This method promoted continuing recovery management, a higher quality of care, administrative efficiencies, and greater accountability. However, pilot clients did not always experience the weekly contact as supportive; at times, the prospect of a year of involvement with WRA felt potentially intrusive and overwhelming. The treatment site was unable to engage and retain some clients, and staff felt highly scrutinized in those situations. Focus group participants

reported that some clients may have agreed to participate in the pilot project in order to get into treatment faster and have a reduced length of stay in the inpatient facility.

- **Ongoing communication among the county leaders, provider leaders, and pilot managers is a key component to successful implementation.** Quality Improvement Meetings were conducted every other month, beginning at the inception of the program, to review pilot program progress. This type of ongoing communication with key staff and management proved to be imperative for protocol fine tuning and organizational adaptation.

NEXT STEPS FOR YEAR 2

- **Performance / Outcome Measurement**
 - UCLA will continue to explore recovery models and the definitions of recovery in order to select outcome and performance measures appropriate for measuring recovery services successes.
 - San Mateo County and UCLA will continue to investigate which outcome and performance measures can most easily and efficiently document recovery services that are not currently captured within the CalOMS-Tx data system.
- **Adjunct Pilot Activities – Health Care Reform**
 - UCLA will explore health care reform priorities and consider how to incorporate elements into the work conducted within San Mateo County.

RELEVANT LITERATURE AND RESOURCES

Dennis, M.L., Scott, K.C., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance abuse disorders. *Evaluation and Program Planning*, 26, 339-352.

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PERFORMANCE PILOT YEAR 1 SUMMARY

Theme 5: Recovery Services

Pilot County: Santa Clara

Pilot County Administrator: Bob Garner

Pilot Theme: Measurement of Recovery Services

Pilot Title: Chronic Care and Addictions Treatment: A Feasibility Study on the Implementation of Post -Treatment Continuous Recovery Monitoring

INTRODUCTION

Prior to the start of the EnCAL-COSSR pilot, Santa Clara County's Department of Alcohol and Drug Services (DADS) volunteered to participate in a Continuum Change Pilot with a focus on the treatment/recovery continuum. Santa Clara has designed and pilot tested a telephone follow-up model and risk assessments to be implemented across the entire system of care. The pilot study tested the feasibility of implementing continuous recovery monitoring (CRM) by providing clients who completed treatment with post-discharge telephone check-ups. The aims of the study were to: (1) develop a model for continuous recovery monitoring befitting the system of care, (2) gather data on the model's utility including identifying organizational and logistical challenges and, (3) describe the changes needed in the system of care and organizational levels to bring continuing care to the continuum of care. The pilot was developed in consultation with the county's System Improvement Meeting (SIM) group as the model for implementing post-discharge monitoring.

During the planning phase for the current EnCAL-COSSR pilot, UCLA and Santa Clara DADS administrators determined that initial EnCAL pilot efforts would be to document the process and feasibility of implementing the CRM pilot within their county system (see SARC Special Issue of the *Journal of Psychoactive Drugs*, 2010). To continue the research effort, UCLA and Santa Clara County could also explore grant funding opportunities to evaluate the efficacy of the CRM telephone follow-up model in a full capacity, multi-site research project. In addition, UCLA and Santa Clara decided that a further relevant endeavor could consist of documenting the extensive system-change process that occurred in Santa Clara County over the past decade to serve as a model for other counties as they work toward a more coordinated system of care.

GOALS AND OBJECTIVES

Goal

To better understand the role and service components that characterize a continuous recovery monitoring (CRM) model within a coordinated system of care and examine methods of recovery service delivery and outcome measurement.

Objectives

- Identify current transfer rates (linkage) within the Santa Clara County system of care using the CalOMS-Tx data system.
- Conduct a case study to document the CRM protocol and system processes within a county setting (see SARC Special Issue of the *Journal of Psychoactive Drugs*, 2010).
- Investigate how providers can most easily and efficiently document recovery services that are not captured within the CalOMS-Tx data system.
- Explore grant funding opportunities to test the efficacy of the telephone follow-up model in a full capacity, multi-site research project.

METHODS

- UCLA assisted Santa Clara County's DADS staff to evaluate CalOMS-Tx data to assess the current system's continuity of care (i.e., client transfer rates across all levels of care).
- UCLA assisted Santa Clara County DADS staff in documenting the historical process that occurred over the last decade within the Santa Clara DADS's well coordinated system of care.
- UCLA assisted Santa Clara County in documenting the feasibility of incorporating a post-discharge follow-up "level of care" within Santa Clara's treatment system (see SARC Special Issue of the *Journal of Psychoactive Drugs*, 2010).
- UCLA will explore funding avenues to study efficacy and impact of the CRM model.

PRELIMINARY FINDINGS (YEAR 1)

- **Santa Clara County Transfer Rates, as Indicated by CalOMS-Tx Data**
 - Transfer Rates appeared to be significantly higher than the average large county transfer rates, which may reflect the well-coordinated systematic efforts led by the county staff.

Table 1: Transfer Rates by Service Type for Santa Clara County*

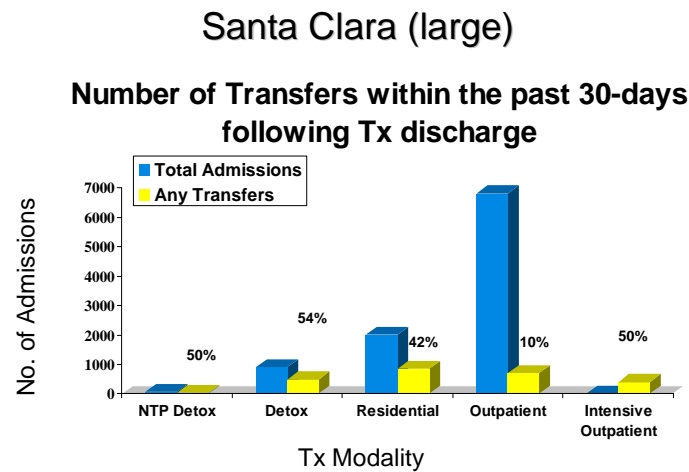
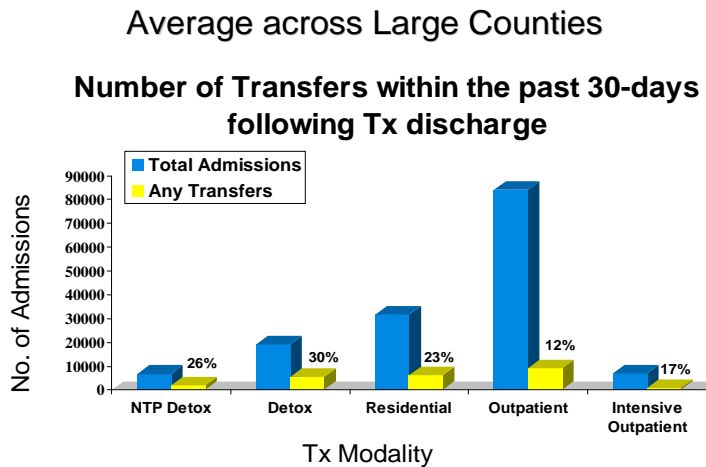


Table 2: Transfer Rates by Service Type for all Large California Counties*



* Transfer rates were determined by using the CalOMS-Tx 2008-09 data and calculating by the percentage of treatment admissions that result in a new admission to another level of care within 30 days of the treatment discharge.

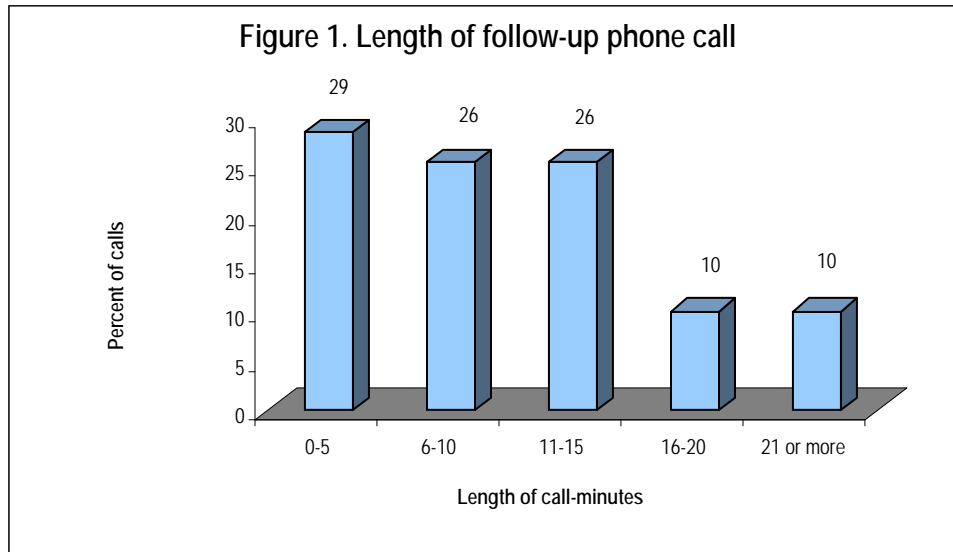
- **Initial findings from Santa Clara County’s coordinated system of care**
 - A common clinical language was adopted by all treatment programs within the provider network so that there could be continuity of care and so that programs could speak the same language when caring for patients they had in common

- The development of a “single point of entry” system, called Gateway, where persons inquiring about treatment were screened, assessed, and placed by a clinically determined patient placement criteria.
 - A quality improvement division (QI) that monitors clinical quality assurances at the provider sites was established, which helped programs integrate new changes into routine practice standards including evidence-based practices, and assured that all of the treatment services function as a single system of care.
 - As a result of a managed and coordinated system of care with a network of providers participating as a single organization, DADS developed a continuum of care where clients can move across different levels of care and treatment modalities (i.e., from residential to outpatient, or the other direction, depending on progress in treatment and severity of addiction) and it is still considered a single-treatment episode
 - The local system data revealed that recidivism continued to be a chronic problem despite more efficient allocation of treatment resources, incorporation of evidence-based treatments, and treatment assessments. This led the county to determine that the next logical step, in light of the growing awareness of the chronic nature of substance use disorders, is to implement some type of post-discharge monitoring of clients (i.e., continuous recovery monitoring (CRM)).
- **Findings from the CRM Telephone Monitoring protocol**
 - Overview: The duration of the CRM project was approximately 13 months, from March 2008 to April 2009. A System Improvement Meeting (SIM) group was utilized to develop telephone scripts, protocol, and data measurement. Three treatment programs—two county and one contract provider site—participated in the CRM project. Nine counselors volunteered to conduct post-discharge check-up calls to their clients. The counselors made a total of 138 phone calls during the study period; 32 volunteer Clients who had successfully completed treatment participated in the CRM protocol.
 - Protocol: Counselors initiated calls to clients post discharge from their treatment episode. Using a telephone-based risk assessment tool created by the SIM group, counselors contacted clients at an agreed upon schedule and the intensity and frequency of subsequent follow-up calls were determined by the disposition of each risk assessment. The SIM Group developed data measurement forms that were intended to be simple and easy to administer.
 - The Data Collection Form gathered the following data: Client name, client identification code, counselor’s name, treatment program, acute-phase discharge date (from outpatient treatment), last date of substance use and telephone numbers. Space was created for the counselor to take notes.

- The Telephone Call Form contained the following elements: call date, begin and end times, contact made or not, scores on a 4-item client outcome rating scale (ORS; scored between 1-10 for individual items) and total ORS scores, status of recovery effort (scored from 1 to 5), counselor action (based on the status of recovery effort), telephone call scheduled, Immediate Needs Profile score, and a customer satisfaction scale (from 1-10). The questions on the telephone call form were ordered to follow (approximately) the telephone script given to counselors.

- **Counselors’ Time and Length of Telephone Continuous Recovery Management**

- To better determine the feasibility of the CRM, the SIM group evaluated the amount of time counselors spent in adding a CRM component to the system of care. An important question for the SIM group was the frequency of contact between client and counselor. The target length of the phone call was approximately 5 minutes, because it was intended as a check-up phone call and to prevent the check-up call from turning into a telephone counseling session. Nine counselors made a total of 138 phone calls during the feasibility study period. Calls logged during the feasibility study had a mean length of 12.8 minutes, mode of 15 minutes, and ranged from 1-60 minutes. Figure 1 describe proportion of length of call logged. Results showed that though most calls were less than 10 minutes in duration, a substantial minority of calls took longer than anticipated.



- **Documenting the Feasibility of the CRM Protocol**

- UCLA reviewed and provided feedback for Santa Clara’s manuscript, *Chronic Care and Addictions Treatment: A Feasibility Study on the Implementation of Post -Treatment Continuous Recovery Monitoring* document the initial findings of

implementing CRM. Please see the SARC Special Issue of the *Journal of Psychoactive Drugs*, 2010 for results.

- **Further Measuring the Efficacy and Impact of the CRM Protocol**

- UCLA and Santa Clara conferred with investigators conducting a NIDA-funded telephone continuing care study, *Four Models of Telephone Support for Stimulant Recovery*, to explore the feasibility of NIDA funding opportunities to test the efficacy of the CRM model in a full capacity, multi-site research project.

LESSONS LEARNED

- **Santa Clara County’s preliminary analysis revealed that telephone monitoring may be a useful tool to identify clients who had relapsed or were at risk for doing so.**

- Primary counselors were able to intervene quickly after a client relapsed and assist them to return to treatment.
- The CRM protocol extended the existing system of care beyond discharge and provided a means for ongoing monitoring of clients.
- As the drug and alcohol field moves its clinical practice from an acute care model to a chronic care or continuing recovery model, it will come up against the vast array of regulatory, fiscal, and policy systems that are based on the acute care model and these systems will have to be changed to reflect the new clinical direction.

- **Piloting a study in a small setting is critical to test for feasibility of incorporating a post-discharge follow-up level of care within an existing system.** Using a feasibility study, Santa Clara examined how an existing system of care could integrate a continuing care model into its infrastructure. In order to test the efficacy and impact of the CRM model, a larger, multi-site research study is necessary to measure efficacy outcomes.

NEXT STEPS FOR YEAR 2

- **Performance / Outcome Measures**

- UCLA will further explore the system change efforts that have taken place within Santa Clara County over the last decade.
- Further investigate the telephone monitoring measurement procedures to identify recommendations for how the state can capture recovery activities within the CalOMS-Tx data system.

- **Efficacy of Telephone Monitoring**

- UCLA will continue to assist the county in identifying a funding mechanism to expand on their continuous recovery monitoring efforts. (i.e., NIDA).

RELEVANT LITERATURE AND RESOURCES

McKay, J.R. (2009). Continuing care research: What we have learned and where we are going. *Journal of Substance Abuse Treatment*, 36(2), 131-45.

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4.5.3 SUMMARY AND RECOMMENDATIONS

The knowledge gained from this first year of pilot work under Theme 5 “Measurement of Recovery Support Services” has been critical in developing the next steps toward enhancing the standardization of recovery support service (RSS) delivery across California, defining fundable RSS units, and identifying measures for efficacy. Several barriers were identified and lessons learned that will require further research and pilot testing in order to achieve the overall mission of COSSR.

- *There is a significant lack of funding for Recovery Support Services (RSSs) in California, which may limit the ability of counties to provide and measure the efficacy of RSSs.* Despite the fact that counties within the COSSR-EnCAL pilot project recognize the value of RSSs, funding for RSSs is severely lacking. Some counties within the state have developed mechanisms to fund their RSSs, but others continue to face challenges in sustaining and obtaining funding. There is evidence that providing RSSs results in increased access to services and reduced preventable re-admissions, which ultimately can lower overall treatment costs and other societal consequences that arise from AOD disorders. Several pilot counties are interested in measuring the efficacy of their services, yet the lack of funding results in fewer resources to provide and record RSS data. In order to further support the movement toward providing a continuum of services incorporating performance measurement, it is imperative that California continues to explore mechanisms for RSS funding as well as methods to develop an effective data measurement system.
- *The definition of recovery continues to be unclear across counties.* The meaning of “recovery” is largely in flux within the substance abuse community (COSSR Final Report, 2009). The Betty Ford Consensus Process Panel’s definition that “*recovery is a voluntarily maintained lifestyle comprised of sobriety, personal health and citizenship,*” may be the most encompassing definition of recovery and provides specific domains of RSS measurement (Betty Ford Consensus Process, 2007 & McLellan, 2010). In order to best capture RSS data and clearly understand RSS efficacy, it may be fruitful for the state to consider promoting a unified definition of “recovery” from which to derive measurable recovery domains.
- *Collecting and using data within RSSs appears to be challenging; ongoing technical assistance is needed to build the workforce’s capacity to collect RSS data.* Findings from our pilot work revealed several barriers to implementing data collection procedures within the RSS environments: (1) some organizational cultures support complete anonymity and are therefore resistant to collecting any information that identifies clients, which makes a database link between prevention, treatment, and recovery difficult, (2) some RSS staff indicated that taking the time to record performance/outcome data takes away from valuable time with clients and; (3) some staff had limited training on good data collection and measurement practices. The use of technical assistance and training with RSS providers and staff can be an important strategy to introduce concepts, communicate potential data collection expectations, and to demystify the data collection process. Recommended training topics for RSS staff may include: (1) Introduction to the chronic care disease model, emphasizing the relevance of RSSs and their role within a continuum of services; (2) Data collection practices in a recovery setting; and (3) Interpreting and understanding what RSS

data mean for their recovery setting. Helping RSS providers understand what data they are collecting, how to collect it, and why they are collecting it ultimately will increase data collection buy-in. Increasing staff buy-in will help facilitate the implementation process, sustainability, and quality of the data being collected.

- *Currently, there are no clear guidelines on RSS measurement and there are few standardized performance/outcome measures to test the efficacy of RSSs.* The need still exists to identify RSS performance/outcome measures to capture the efficacy of recovery services. While pilot counties' data collection efforts are commendable and are very useful to the respective counties, data collection methods are not standardized. As such, it may be difficult to interpret the results accurately and to compare them across RSSs. In order to assist California counties in developing data measurement guidelines, we recommend that the state continues efforts toward identifying recovery measures as well as testing the feasibility of standardizing data collection efforts in RSS settings.
- *Lessons learned from existing RSS models implemented in other states will provide crucial guidelines for planning the next steps for recovery services and measurement in California.* Through our work with the county pilots, we learned that several states (e.g., AZ, CT, PA, VT, and MA) are funding new peer-based recovery support projects. From this work, we can gain insight into funding strategies, data measurement, and workforce development. As healthcare reform rolls out nationwide, each state will need to reevaluate funding streams not only for treatment services, but for recovery services as well. As we move toward healthcare reform, it is important to continue networking with other states in our efforts to further develop recovery services and measurement.

APPENDIX 4A: Infrastructure and Service Components of One Case Study within Mariposa County

<i>CASE STUDY</i>
<i>Mission:</i> Offer individual and group support for prevention and abstinence of alcohol and other drugs.
<i>Organizational Setting:</i> Operated by the county; stand-alone facility
<i>Facility Components:</i> 1 sitting room, 2 counselor/center records, 1 full kitchen (stove, microwave, coffee maker, sink, fridge), 1 computer room/resource, library, 2 group rooms, 1 front and backyard porch for social events, 1 play room with attached observation area
<i>Staff:</i> Paid Staff – 1 Program Manager; Unpaid Staff – 1 Intern, 2 Long-Term Volunteers (Additional short-term volunteers become available during holiday and social activities)
<i>Service Elements:</i> (1) Peer counseling (2) Life Skills (G.E.D. preparation, job searches, housing, etc.) (3) Referral Services (4) 12-step Information Meetings (5) Meditation group (6) Social Activities (barbeques, gardening, and links to 12-step sponsored camping, hiking, fishing, etc)
<i>Service Eligibility:</i> Anyone within the surrounding community

APPENDIX 4B: Infrastructure and Service Components of Six Case Studies in San Bernardino County

CASE STUDY 1
Mission: A one-stop shop for services for those in the community. The center provides a clean and sober environment for people to socialize and offers a variety of services.
Organization Setting: Non-profit; stand-alone facility within a larger network of treatment centers.
Facility Components: 1 group/resource room, kitchen/snack bar, counselor/records office, activities room that contains pool table, large-screen TV, couches, and 2 computers.
Staff: Paid Staff – 1 Program Manager, 1 Program Coordinator; Unpaid Staff – 1 Intern, 0 Long-term Volunteers (short-term volunteers become available during holiday and social activities)
Service Elements: Resource center for groups within the community: (1) life skills, (2) Smoking Cessation, (3) Anger Management, (4) NA/AA, (5) Nutrition, (6) Healthy Relationships, (7) Communication/Conflict, (8) Social Activities (Arts & Crafts, Dances, large holiday gatherings)
Service Eligibility: Anyone within the surrounding community
CASE STUDY 2
Mission: To break the cycle of addiction and mend the lives of those suffering from behavioral health conditions
Organizational Setting: Non-profit; housed within an outpatient facility which is operated by a treatment center offering residential, outpatient, Prop 36 services.
Facility Components: Two group meeting rooms, counselor rooms, lobby, offices, three arcade games, one pool table, one large coffee shop, Serenity Book shop.
Staff: Paid Staff -1 Activities Coordinator/Coffee Shop Host; Unpaid staff – 0 Interns, 0 Long-term Volunteers (short-term volunteers become available during holiday and social activities)
Service Elements: (1) Aftercare; (2) 12-Step groups; (3) Social Activities (Karaoke, Pool Tournaments, Video Game competitions, Movie Night); (4) Recovery Readiness (Pre-Treatment); (5) Smoking Cessation
Service Eligibility: Anyone within the surrounding community.
CASE STUDY 3
Mission: The mission of recovery center is in accord with the values of its sponsor, The Brothers of St. John of God, which is to continue the healing mission of Jesus as did St. John of God by providing a community in which people can live and work together with dignity and hope. Therefore, the recovery center is committed to: Hospitality, Respect and Healing. Note: Treatment and recovery services are not religious.
Organizational Setting: Non-profit, stand-alone facility that is operated by a larger residential treatment provider.
Facility Components: 3 Make-shift classrooms, 1 computer lab (3 computers for job and educational purposes), 2 bathrooms, 2 administration offices, 1 Great room (air hockey table, T.V. , stereo, DVD player, fold-out chairs), 1 kitchen (stove, sink, coffee, fridge)
Staff: Paid Staff – 1 Program Manager; Unpaid staff – 1 Intern, 0 Long-term Volunteers (short-term volunteers become available during holiday and social activities); Note: Administration, case managers are also housed within the facility. Psychiatrists are also available.
Service Elements: (1) Aftercare, (2) 12-Step Informational Meetings, (3) Sober Cinema, (4) Community Relapse Prevention, (5) Job Skills, (6) GED, (7) Anger management, (8) Holiday and Social Functions
Service Eligibility: Anyone within the community may utilize recovery center resources. Those who attend “Aftercare” receive a formal posttreatment plan. Therefore, eligibility is restricted within the “Aftercare” groups to those who have completed a previous treatment episode.

CASE STUDY 4
Mission: Improving the lives of individuals, families, and communities impacted by substance use disorder and behavioral health disorders. To provide innovative treatment, recovery and prevention services, which changes, impacts and improves the quality of life for our clients, families and the communities in which we all live.
Organizational Setting: Non-profit set within an outpatient alcohol/drug treatment facility for adults and families, which also serves Drug Court and Prop 36.
Facility Components: 1 Great room (T.V., three couches, tables, chairs, child play-area), 4 Group rooms, 1 Large 12-Step/special functions room 1 Kitchen (fridge, sink, stove)
Staff: Paid Staff – 1 Program Manager, 2 part-time administrators, 1 Full-time Counselor, 4 part-time counselors; Unpaid staff – 0 Interns, 0 Long-term Volunteers Volunteers (Short-term volunteers become available during holiday and social activities)
Service Elements: (1) Pre-Treatment, (2) Anger management, (3) Community Relapse Prevention, (4) Parenting (English and Spanish), (5) Family, (6) Holiday Activities, (7) Nurturing Fathers
Service Eligibility: Anyone within the surrounding community. Clients who have no funding source may attend a 12-week “Pre-Treatment” curriculum. Regardless of funding, clients may supplement the “Pre-Treatment” curriculum with “Community Relapse Prevention” (Should funding be acquired for treatment, clients utilize “Community Relapse Prevention” classes as ongoing recovery support posttreatment)
CASE STUDY 5
Mission: To break the cycle of addiction and mend the lives of those suffering from behavioral health conditions
Organizational Setting: Non-profit; A stand-alone recovery center that offers social activities and 12-steps (pending outpatient certification)
Facility Components: 1 Waiting Room, 4 Arcade Games, 1 T.V., 2 Coaches, 1 Pool Table, 3 Tables/Chairs, 1 12-Step Room,
Staff: Paid Staff – 1 Program Manger, 1 Activities Director; Unpaid staff – 0 Interns, 0 Long-Term Volunteers (short-term volunteers become available during holiday and social activities)
Service Elements: 12-Step Meetings
Service Eligibility: Anyone within the surrounding community
CASE STUDY 6
Mission: To provide the best quality of service, both pre- and posttreatment, to empower individuals and their families with substance use disorder to attain stability, dignity, recovery and an enhanced quality of life.
Organizational Setting: Non-profit; free-Standing Mobile Unit. Recovery center groups are also held at the outpatient facility.
Facility Components: Mobile Resource Center (MRC) travels throughout the Rim communities, which spans 118 square miles and has an approximate population of 20,000. Provides services on a regular weekly schedule and at community events. The MRC offers a table, couch, T.V and VCR for drop-ins. Outpatient facility components open for recovery center services include 1 group room, lobby, restroom and front porch for social activities.
Staff: Paid Staff – 1 Part-time addiction counselor, 1 Part-time Parent Educator; Unpaid staff – 0 Interns, 0 Long-Term Volunteers (short-term volunteers become available during holiday and social activities)
Service Elements: (1) Life Skills (group and individual), (2) Parents Education (group and individual - Parents as Teachers, SFP for Elementary and Teens), (3) Relapse Prevention (group), (4) Smoking Cessation Group, (5) Family Group, (6) Social MRC Activities, (7) MRC Daily Outreach.
Service Eligibility: Anyone within the community may utilize recovery center resources. Eligibility is restricted within the “Aftercare Groups” to only those who have completed a previous treatment episode. Family Group is open to the community, but excludes any members that are <i>currently</i> enrolled in on-going treatment groups (i.e., outpatient services and so forth)

APPENDIX 4C: Organizational Impacts of the San Mateo Pilot Project

GENERAL SUMMARY		
Organizational Operations	Staff Roles/Experiences	Clients' Perceived Reactions
<p>General themes:</p> <ul style="list-style-type: none"> • During the initial implementation of the project, staff reported feeling pressure to meet expectations from external and internal entities whose objectives, at times, appeared to be at odds with each other. • These competing objectives were identified as: <ol style="list-style-type: none"> (1) reducing the length of stay (2) retaining clients for the full year (3) maintaining individually tailored treatment (4) determining measurable outcomes <p>The Recovery Coach:</p> <ul style="list-style-type: none"> • The role of the Recovery Coach (RC) within the organizational structure was perceived as an added benefit to the treatment team because (1) the RC role focuses on "life after treatment" and (2) the RC role embodies the characteristics of a 12-step community "super-sponsor", as well as a trained individual who understands the client's dynamic recovery experience. • As a result, this unique role was seen as an added tool and resource to attain clients' treatment goals. <p>Key Lessons Learned:</p> <ul style="list-style-type: none"> • Integrating a new program into an existing program generated stress and tension within the organization, but also provided the opportunity for organizational adaptation and innovation. • The process of program refinement and staff adaptation during early implementation is essential to identify, develop, and establish strategies and protocols to address program needs (i.e., for the organization, staff, and clients). • Through time and by means of ongoing discussion, collaboration, and assessment of staff and organizational needs, useful organizational protocols can be established. • The pilot project resulted in a renewed emphasis on client-centered treatment-planning processes within the entire organization. 	<p>General themes:</p> <ul style="list-style-type: none"> • Overall, staff welcomed the Pilot Project as an exciting and important project modeled after the current research literature. However, staff also reported initial anticipation, uncertainty and worries about its feasibility and impact on the organization-at-large (how it would actually work, new procedures, etc). • Perceived pressure from competing objectives to ensure program success was felt by the staff. Specifically they felt that (1) their integrity as counselors was being compromised and (2) they were unable to fully recognize and address the clients' "agendas" (see General Themes, Clients' Perceived Reactions). • Clinical treatment planning staff questioned the appropriateness of reducing length of treatment to less than 90 days of inpatient treatment. • Staff raised concerns about retaining clients who would normally be discharged for noncompliance. <p>The Recovery Coach:</p> <ul style="list-style-type: none"> • Staff reported that the new role of a Recovery Coach (RC) was very positive and considered it very useful for the recovery process. They also reported that the role is somewhat like a medical case manager and a trained addiction sponsor. • The RC role was not the same as the clinical staff or the house staff. Therefore the new dynamic worked well during treatment planning. <p>Key Lessons Learned:</p> <ul style="list-style-type: none"> • Having dedicated pilot project line staff with clearly defined roles is important to successful implementation. • The right recovery coaching personality is the key to keeping clients engaged. The RC must be creative, think outside of the box, and maintain program structure and rapport with clients. 	<p>General themes:</p> <ul style="list-style-type: none"> • As a result of the organization's tolerance of some pilot clients' noncompliance with treatment program rules, which would normally result in discharge, non-pilot clients complained to staff of being treated unfairly, as rules were not enforced the same for everyone. • It was reported that some clients may have agreed to participate in the pilot project in order to get into treatment faster and have a reduced length of stay in the inpatient facility. <p>The Recovery Coach:</p> <ul style="list-style-type: none"> • Perceptions of clients' reaction to the RC were positive overall. There were several recounted stories of active clients engaging with the RC and contacting the RC for continued recovery support. • Staff reported that clients perceived the role of the RC as being an additional resource and/or an advocate within their treatment experience. <p>Key lessons Learned:</p> <ul style="list-style-type: none"> • Not assessed at this focus group (no findings)

**Potential confounder: In addition to the Pilot Program, the selected treatment site was undertaking other significant and simultaneous organizational changes, including (1) the expansion of the perinatal program, (2) the admittance of re-entry women from jails, and/or (3) concurrent pressures regarding retention and engagement per AOD's co-occurring disorder initiative.*

REPORT 5:

**TECHNICAL ASSISTANCE/TRAINING
REPORT**

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Integrated Substance Abuse Programs

5.1 INTRODUCTION

This report describes the Technical Assistance (TA)/Training-related activities that occurred during the first year (Sept 2009–June 2010) of the EnCAL interagency agreement between UCLA ISAP and ADP addressing Objective 4 – “Increasing the capacity of AOD stakeholders (state ADP, county administrators and providers) to understand how to use and apply data (performance and outcome) for purposes of improving the quality of treatment services.”

An in-depth needs assessment was conducted with AOD stakeholders (California ADP, county administrators, and providers) during the initial phase of the contract work to identify priority TA/training topics to focus on for AOD workforce development (see Appendix 5A for Needs Assessment). Based on needs assessment information gathered from AOD stakeholders, the following two web-based TA/trainings were developed: (1) How to collect CalOMS-Tx Data and (2) System of Care for Substance Use as a Chronic Health Problem. The following sections describe the development processes of both webinars, followed by a summary and recommendations for future work.

5.2 WEBINAR DEVELOPMENT

EnCAL TA/Training Webinar #1

The first TA/training webinar developed was *How to Collect CalOMS-Tx Data*.

Overview

The goal of this TA/training is to ensure that the CalOMS-Tx data collected across the state from various county programs is valid and reliable. To ensure valid and reliable data collection across all reporting agencies, the material used to develop the training is based on two standard data collection protocols created by the California Department of Alcohol and Drug Program (ADP): (1) the CalOMS-Tx Data Collection Guide and (2) CalOMS-Tx Data Dictionary, both available at:

www.adp.ca.gov/CalOMS/pdf/CalOMS_Data_Collection_Guide.pdf

Purpose

The purpose of the TA/training is to provide the alcohol and other drug (AOD) workforce (county and program staff) hands-on training for “how to collect CalOMS-Tx data.” This is important given that data collection varies at admission, discharge, and annual updates (when applicable). Also, counties and providers have different data collection business rules and processes, and different understandings about what the individual CalOMS-TX questions mean. Hence, the focus of this TA/training is to provide AOD stakeholders who collect and report

CalOMS-Tx data with a working knowledge (and common language) on the proper data collection protocol to follow, including the definitions of data measures.

Pilot Testing

This TA/training was initially developed into a PowerPoint model for purposes of pilot-testing the material with various AOD stakeholders. Specifically, the PowerPoint presentation was sent to key ADP staff as well as select data representatives from county agencies for review and comment on the material. Based on feedback, the material in the TA/training was revised and turned into a packaged product, consisting of the following components: an overview, four lessons (with quizzes), a certificate of completion, and opportunity for obtaining continuing education.

Implementation

Given the key provisions of the recent Licensing and Certification Bill put forth by ADP on February 3, 2010, that “require counselors to complete thirty (30) hours of education in law and ethics, and forty-eight (48) hours of education in the screening for co-occurring disorders and referral processes, training in the use of client placement criteria, and training in data collection systems, including California Outcomes Measurement System (CalOMS-Tx), or equivalent,” the PowerPoint presentation was developed into a web-based TA/training using ADP formatting guidelines for uploading onto the ADP website (i.e., material was converted from PowerPoint into Word and Excel documents) and disseminated to the intended target audience (county and program users of CalOMS-Tx data system).

Lessons

The TA/training begins with an overview and orientation to the webinar, followed by four lessons. Quizzes are built into the end of each lesson. The lessons are designed in a way that requires participants to successfully pass each of the quizzes before being able to progress through the webinar. The webinar is designed to take approximately three hours to complete (depending on the participant). Below is an outline of the TA/training:

Overview

This component of the TA/training welcomes the participants to the CalOMS-Tx Data Collection web-based Training and provides an overview of the lessons.

Lesson 1: Introduction to CalOMS-Tx Data Collection

This lesson is intended to provide participants with an overview about the importance of CalOMS-Tx data collection. By the end of the lesson, participants are expected to understand what CalOMS-Tx data collection entails; identify the types of CalOMS-Tx data collection forms; and distinguish the various “alternative values” commonly used for CalOMS-Tx data collection. The lesson is divided into the following 3 chapters:

- Chapter 1: CalOMS-Tx Data Collection
- Chapter 2: Overview of CalOMS-Tx Data Collection Forms
- Chapter 3: Review of CalOMS-Tx Data Collection Values and Codes

Lesson 2: How to Collect CalOMS-Tx Data at Treatment Admission

This lesson is intended to give participants an overview of how to collect CalOMS-Tx data at admission. By the end of the lesson, participants are expected to understand the importance of CalOMS-Tx data collection at admission; identify the various types of CalOMS-Tx data measures collected at admission; and distinguish between administrative and client level data collected at admission. The lesson is divided into the following 10 chapters (which all pertain to CalOMS-Tx Admission data collection):

- Chapter 1: Overview
- Chapter 2: Administrative Information
- Chapter 3: Client Treatment Entry/Unique Client Identifier Data
- Chapter 4: Client Demographics
- Chapter 5: Client Alcohol/Drug Use Data
- Chapter 6: Client Employment/Education Data
- Chapter 7: Client Legal/Criminal Justice Data
- Chapter 8: Client Medical/Physical Health Data
- Chapter 9: Client Mental Health Data
- Chapter 10: Client Social and Family Data

Lesson 3: How to do CalOMS-Tx Discharge Data Collection

The purpose of this lesson is to provide participants with an overview about the importance of CalOMS-Tx discharge data collection. Participants are expected to understand what CalOMS-Tx discharge data collection consists of; identify what constitutes a CalOMS-Tx standard discharge versus an administrative discharge; and be able to distinguish between the various types of discharge scenarios commonly faced when discharging clients. The lesson is divided into the following 4 chapters (which all pertain to CalOMS-Tx discharge data collection):

- Chapter 1: Overview
- Chapter 2: Standard Discharges
- Chapter 3: Administrative Discharges
- Chapter 4: Scenarios for CalOMS-Tx Discharges

Lesson 4: How to do CalOMS-Tx Data Collection for Annual Updates

This lesson provides participants with information about CalOMS-Tx data collection associated with the Annual Update (when applicable for clients). Participants are expected to understand what the CalOMS-Tx Annual Update is; identify how to complete the CalOMS-Tx Annual Update; and distinguish the resources for completing the CalOMS-Tx Annual Update. The lesson is divided into the following 3 chapters (which all have to do with the CalOMS-Tx Annual Update):

- Chapter 1: Importance
- Chapter 2: Completing the CalOMS-Tx Annual Update
- Chapter 3: Resources

Certificate of Completion & Continuing Education

Upon completion of the entire webinar (all four lessons), each participant can download and print a *Completion Certificate*. In addition, eligible participants are given the opportunity to earn 3 units of Continuing Education Units (CEUs) administered by the UCLA ISAP Training department. UCLA Integrated Substance Abuse Programs (ISAP) is an approved provider of continuing education for MFTs and LCSWs.⁹ Participants who wish to obtain continuing education units or credit will be required to download a two-page course evaluation and send it via fax or mail to the UCLA ISAP Training department. A continuing education certificate will be sent to participants within 4–6 weeks of receipt of their completed paperwork.

EnCAL TA/Training Webinar #2

The second webinar developed was *A System of Care for Substance Abuse as a Chronic Health Problem*.

Overview

This TA/training is currently under development. All content has been first developed into a PowerPoint model for purposes of pilot-testing the material with various AOD stakeholders (provider and county staff).

Purpose

This TA/training provides the alcohol and other drug (AOD) workforce (county and program staff) with information on substance abuse as a chronic illness in terms of system response. With the changing state of health care, reformers are aiming to improve the way substance abuse services are delivered and monitored/measured; hence the purpose of this TA/training is to

⁹ CA Board of Behavioral Sciences, PCE 2001), C.A.D.C.s I/II (CAADAC, 2N-00-445-1111), C.A.T.C.s (CAADE, CP 20 809 C 0710), and C.A.S.s (BCAS/CAARR, 5033)

ensure that AOD stakeholders (county and program staff) are informed about the impact of this reform for (1) service delivery and (2) data collection monitoring/measurement practices.

Implementation

The TA/training PowerPoint begins with a historical overview of substance abuse in terms of how it has been viewed over time. Specifically, participants are taken through a series of slides that orient them to the pioneering neurobiological and longitudinal research that has been conducted over the past three decades to support addiction as what we know it as today—a chronic health problem. Participants are given an in-depth review on service delivery and measurement in terms of how the addiction field has traditionally responded and where the field needs to go to accommodate addiction as a chronic health problem. Here the focus shifts from an acute service paradigm, where client outcomes are the measurement goal, to a chronic care system model with an emphasis on continuity of care. At this point, the presentation becomes interactive. Specifically, the audience is given copies of actual CalOMS-Tx data that show continuity-of-care patterns in their respective counties (compared to California averages). See Appendix 5B for an example template of what is distributed (CalOMS-Tx Info Brief). Participants are given the opportunity to discuss what the data means to them and how they can work to improve their referral (continuity-of-care) practices. The presentation ends with giving participants tips on how to begin the process of building a system of care (and measurement practices) that responds to addiction as a chronic health problem using a NIATx framework:

- **Encourage:** client engagement in continued treatment *as part of the routine tx planning*
- **Be Active:** actively “hand-off” clients to the another level of care
- **Network:** If not in your network (agency), then *establish linkages* with other providers in the area
- **Be Prepared:** in order to bypass barriers, which always arise, identify what needs to be done (plan) for making the link (referral/transfer). Examples: Obtain a pre-authorization for the type of transfer that is needed and know the necessary transfer paperwork that is involved
- **Address client uncertainty:** ensure that clients are informed (by alumni or staff) about what to expect at admission (in terms of the next level of care)

Pilot Testing

To date, this TA/training has been delivered at provider meetings coordinated by Los Angeles, Fresno, and Sonoma counties. In-person interactive presentations were conducted to solicit provider and county staff feedback on the material presented and how to improve the TA/training. The following recommendations were obtained:

- ADP Bulletin 10-8 was brought up as a deterrent to moving system response and measurement toward a chronic care model, as ADP is now requiring that providers no longer allow clients to be discharged from outpatient treatment with the status “completed treatment, referred,” during CalOMS-Tx data collection.
- Providers indicated that all of their residential transfers are probably not captured within CalOMS-Tx. Since their residential programs are stand-alone programs, with aftercare services embedded within, clients are never “transferred” in CalOMS-Tx when they are actually receiving another level of care.
- Providers expressed frustration with the lack of funding for continuing care/support services. They suggested incorporating 12-step and other similar type programs (considered recovery support) as part of routine data collection in the CalOMS-Tx system; however, this type of data collection may be difficult within the current recovery support services culture. Therefore, this is not only a funding issue, but also an issue of additional training/TA of recovery support staff being required to facilitate this process.
- When working with clients, providers recommended not using “discharge” language that holds the connotation of treatment completion. Using other words such as “reassessment” or “levels of care” would help clients view their treatment as a recovery process.
- Providers recommended the tip of “setting-up appointments for their clients to enter the next level of treatment prior to discharge from their current treatment.” This would allow clients to be prepared and ready to enter another level of care even before completing their current level of treatment.

5.3 SUMMARY AND RECOMMENDATIONS

The TA/training agenda and work conducted over the past year was designed to be responsive to AOD stakeholder needs (as described in the needs assessment). However, given the current state of health care reform and the many questions that are being raised among the AOD workforce around system integration, we recommend that the TA/training agenda for the upcoming year (under Objective 4) be integrated into the Technical Assistance Interagency Agreement (IA). This may be a better fit, given that the work plan under the IA will focus on developing an overall plan for preparing the State of California's substance abuse treatment system for health care reform.

We learned through our pilot work that the current AOD public state system in California is configured as stand-alone treatment programs; therefore, it is largely disconnected from the health care system. Through national discussions and key informant interviews with our technical expert (Treatment Research Institute), we anticipate that many changes required by health care reform and parity to occur at the state level will also need to be addressed at the local levels (with counties and programs). From a workforce development perspective, some of the major areas to be considered for upcoming TA/training (and under review within the proposed IA) include:

- *Performance measurement for medical accountability*

A major TA/training area of importance is preparing the AOD workforce for new data collection activities that address performance measurement/management environments needed in the era of health care reform and parity.

- *Data management improvements to accommodate health information technology systems*

One focus of TA/training should be helping counties and programs develop and understand electronic data systems to allow for better accountability and participation in the new health care environment.

- *System integration with primary health care including issues around fiscal responsibility and reimbursement*

A critical area of work that needs to be done is the development of models and implementation plans for integrating AOD treatment into the larger healthcare system. These models include (but are not limited to): screening and brief intervention and brief treatment plans delivered by AOD staff in a variety of health settings, development of brief treatment models for delivery in primary care settings, and developing medication-counseling-recovery partnerships across healthcare and AOD treatment systems.

- *The future status of public assistance (the Block Grant) within a recovery oriented environment of care*

Another area of TA/training should focus on assisting counties and programs with developing models and strategies for expanding recovery services and ensuring their connection to the AOD treatment system.

Given the changing nature of health care delivery under reform, these topics should continue to be defined in collaboration with ADP priorities. For this, the initial months of Year 2 should be focused on developing a strategic TA/training agenda around the areas identified above. Our recommendation is to first provide general TA/training to the larger AOD workforce around the state regarding each of these areas, followed by the development of a learning collaborative model, where interested and motivated counties/programs would be selected to participate under thematic domains. This format will allow for the delivery of more structured technical assistance activities and rapid implementation.

APPENDIX 5A: TA/TRAINING NEEDS ASSESSMENT

This TA/training needs assessment is to be used with each of the consumer stakeholders (ADP, county administrators, and program providers). The purpose of this TA/training needs assessment will inform the development of trainings for each consumer group.

I. Current Experience with Data Collection

1. Tell me about some of your experiences with CalOMS data collection and what type(s) of information would you like to receive related to improving your understanding of CalOMS data/collection?

II. Current Experience with COSSR effort

4. What is your knowledge about the current California COSSR effort?
5. What type(s) of information would you like to receive to improve your awareness of the COSSR effort?

III. Current Experience with Data Quality

4. From your experience, do you trust the quality of the CalOMS data?
5. Can you tell me about the challenges you face with collecting CalOMS data?
6. Can you tell me about how you have been involved in data quality efforts (related to CalOMS data)?

IV. Current Experience with Performance Measurement

3. What is your knowledge about performance measurement?
4. What type(s) of information would you like to receive to improve your understanding of performance measurement?

V. Current Experience with Performance Management

3. What is your knowledge about performance management?
4. What type(s) of information would you like to receive to improve your knowledge of performance management?

VI. Specific TA/Training Desires

2. What are some specific TA/training(s) you would like to receive related to the understanding and use of data?

This concludes our needs assessment. Thank you again for helping us.

APPENDIX 5B: CALOMS-TX INFO BRIEF – CONTINUITY OF CARE PATTERNS

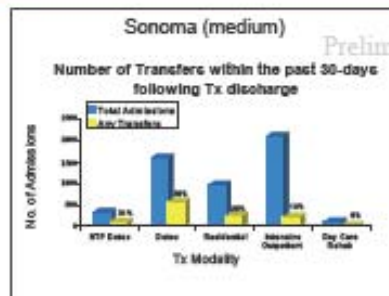


SHIFTING TOWARDS A CONTINUUM OF CARE IN CALIFORNIA

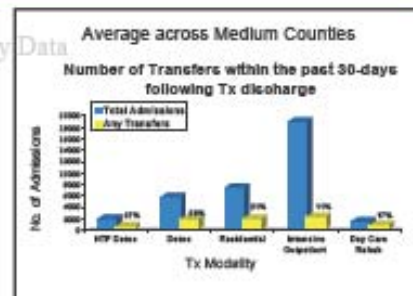


With addiction moving toward a chronic illness model, continuity of care should be promoted within AOD treatment systems. One way counties can assess how well they provide continuity of care is by looking at the percentage of admissions who transfer across treatment modalities.

Comparing **TRANSFER RATES** within your county to the average rates among other like-size counties in California can be an indication of continuity of care within your treatment system!



V.



- In a system of care within a chronic illness model, higher percentages of clients should be transferred across levels of care.
- To improve transfer numbers, treatment agencies may want to consider training and technical assistance to bring in new strategies and skills for provider/program staff.

WHAT'S NEXT?

Do these transfer rates help you identify changes that need to be made in your county?
How might you begin making changes?