Appendix A:

Report Acronyms

Report Acronyms

42 CFR (Part 2)	42 Code of Federal Regulations, Part 2 (concerning Confidentiality of Substance Use Disorder Patient Records)
ASAM (Criteria)	American Society of Addiction Medicine
BHC	Behavioral Health Concepts
CalOMS-Tx	California Outcome Measurement System, Treatment
CBHDA	County Behavioral Health Director's Association
CBT	cognitive-behavioral therapy
CCT	Care Coordination Team
CMS	Centers for Medicare and Medicaid Services
CRM	continuous relapse monitoring
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS (waiver)	Drug Medi-Cal Organized Delivery System
EHR	electronic health record
EQRO	External Quality Review Organization
HIE	Health Information Exchange
HRSA	Health Resources and Services Administration
IOP	intensive outpatient
IPAT	Integrated Practice Assessment
LOC	level of care
LPHA	Licensed Practitioner of the Healing Arts
MAT	medications for addiction treatment
MEDS	Medi-Cal Eligibility Data System
MH	mental health
MHSIP	Mental Health Statistics Improvement Program
MI	motivational interviewing
MITI	Motivational Interviewing Treatment Integrity
MMEF	MEDS Monthly Extract File
MOU	memorandum of understanding
NOMS	National Outcome Measures
NQF (measures)	National Quality Forum
NSDUH	National Survey on Drug Use and Health

NTP	narcotic treatment program
ODF	Outpatient Drug Free (also see OP)
OP	outpatient
OTP	opioid treatment program
PH	physical health
PSS	peer support specialist
ROI	Release of Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT+	Substance Abuse Prevention Treatment
SD/MC (claims)	Short Doyle Medi-Cal
START	Substance Abuse Treatment and Recovery Team
STCs	Standard Terms and Conditions
SUD	substance use disorder
SUTS	County of Santa Clara Health System - Substance Use Treatment Services
TBD	to be determined
TEDS	Treatment Episode Dataset
TPS	Treatment Perceptions Survey
UCLA(-ISAP)	University of California, Los Angeles (Integrated Substance Abuse Programs)
WM	withdrawal management

Appendix B:

UCLA DMC-ODS Waiver Evaluation Plan

California Drug Medi-Cal Organized Delivery System: Proposed Evaluation for California's Section 1115 Demonstration Waiver

Approved by CMS June 20, 2016

UCLA ISAP

Table of Contents

1. Demonstration Background

Substance Use Disorders (SUD)s substantially impact both individual and public health, and are major drivers of health care costs among publicly insured populations. Individuals with untreated SUDs utilize an excess of costly inpatient and emergency services. Improving access to a full array of evidence-based SUD treatment has the potential to improve the health of Medicaid beneficiaries while significantly reducing their overall medical costs.

In California, SUD services for Medi-Cal beneficiaries have historically covered only five modes of treatment: outpatient drug-free services, narcotic replacement therapy (methadone), naltrexone services, day care rehabilitation (intensive outpatient care) for pregnant women, and perinatal residential services for pregnant and postpartum women. In addition, there was a limited fee-for-service DMC benefit for interventions provided by licensed physicians and for inpatient withdrawal management services. They did not include many essential services, such as widely available residential treatment, that can assist individuals with SUDs in achieving and sustaining recovery. Other challenges included lack of access to evidence-based medications, poor coordination with mental health and physical health services, and limited flexibility to select providers and hold them accountable.

The DMC-ODS demonstration has the potential to address the aforementioned limitations on California's DMC-funded services. It will provide access to treatment modalities and services previously not covered by DMC benefits, making available a full continuum of evidence-based SUD treatment and thus increasing the likelihood that beneficiaries will be able to achieve and sustain long-term recovery. See Table 1 below (adapted from STCs, updated 6/24/2016).

In addition, the DMC-ODS demonstration will facilitate increased coordination and integration of SUD services with physical health and mental health care, potentially leading to improved clinical and fiscal outcomes. Furthermore, by enhancing counties' ability to selectively contract with providers and expanding the provider types included in the SUD workforce, the DMC-ODS demonstration can address limitations that have hampered the delivery of effective SUD services to Medi-Cal beneficiaries (see Table 2). Consequently, it is anticipated that the implementation of the DMC-ODS demonstration will lead to improvements in four key areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and with medical and mental health services.

Table 1: State Plan and DMC-ODS Services Available to DMS-ODS Participants (with Expenditure Authority and Units of Service)				
DMC-ODS Service	**Current State Plan**	**Allow-able 1905(a) svcs – not covered in State Plan***	**Costs Not Other-wise Match-able**	**Units Of Service**
Early Intervention (Note: SBIRT services are paid for and provided by the managed care plans or by fee-for- service primary care providers.)	x (preventive service; physician services)			Annual screen, up to 4 brief interventions
Outpatient Drug Free	x (rehab services)			Counseling: 15 minute increments
Intensive Outpatient	x (rehab services)			15 minute increments
Partial Hospitalization		x		Diagnosis- related Group (DRG)/Certified Public Expenditures (CPE)
Withdrawal management General Acute Care Hospital (VID, INVID) (non-IMD)	x inpatient services			DRG/CPE
CDRH/Free Standing Psych (IMD)			x	DRG/CPE
Residential (perinatal, non-IMD)	x (rehab services)			Per day/bed rate
(all pop., non-IMD)		x		Per day/bed rate
(IMD)			x	Per day/bed rate
NTP	x (rehab services)			Per day dosing; 10 minute increments
Additional MAT (drug products)	x (pharmacy)			Drug cost
(physician services)	x (physician services; rehab)			Per visit or 15 minute increments
Recovery Services		x		Counseling: 15 minute increments
Case Management	x (TCM)	x**		15 minute increments
Physician Consultation		x		15 minute increments

TABLE 2 CHANGES TO SERVICE DELIVERY AND SYSTEM ORGANIZATION UNDER THE DMC-ODS DEMONSTRATION	
Change	**Description**
Assessment and Placement	The DMC-ODS will facilitate the utilization of the American Society of Addiction Medicine (ASAM) assessment tool to determine the most appropriate level of care, so that clients can enter the service system at an appropriate level and step up or step down depending on their response to treatment.
Care Coordination and Residency	Counties will coordinate care for individuals residing within the county.
Selective Provider Contracting	Counties will have more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.
Provider Appeals Process	The DMC-ODS will create a provider contract appeal process where providers can appeal to the county and the state. State appeals will focus solely on ensuring network adequacy.
Clear State and County Roles	Counties will be responsible for oversight and monitoring of providers as specified in their county contract.
Coordination	Supporting coordination and integration across systems, such as with the provision that counties enter into Memoranda of Understanding (MOUs) with managed care health plans for referrals and coordination, providing that county substance use programs collaborate with criminal justice partners.
Authorization and Utilization Management	Providing that counties authorize services, with preauthorization for residential treatment required, and ensuring utilization management.
Workforce	Expanding service providers to include Licensed Practitioners of the Healing Arts for the assessment of beneficiaries, and other functions within their scope of practice.
Program Improvement	Promoting a consumer-focus, using evidence-based practices including medication assisted treatment services and increasing system capacity for youth services.

2. Demonstration Requirements

County participation in the DMC-ODS demonstration project will be voluntary. In participating counties, the DMC-ODS will bring about the following changes in the delivery, structure, content, and organization of Medicaid-funded SUD services:

1. **Service Eligibility**

   There will be no age restrictions on DMC-ODS services. For adults over 21, medical necessity for DMC-ODS services will be determined using definitions from the American

Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the ASAM Criteria. For youth under 21, medical necessity will be determined by an assessment for risk of developing SUD. Counties or county-contracted providers will determine eligibility for DMC-ODS benefits, and eligibility for ongoing receipt of DMC-ODS services will be determined at least every six months through a reauthorization process.

2. Benefits

DMC-ODS beneficiaries will have access to all of the following services:

- Outpatient Services: Recovery and motivational enhancement therapies and strategies, given for less than nine hours per week for adults and less than six hours per week for adolescents. These services will be provided in facilities certified as Outpatient Facilities by the California Department of Health Care Services (DHCS).
- Intensive Outpatient Services: These services will be given for nine or more hours per week for adults, and six or more hours per week for adolescents, and will be provided in facilities certified as Intensive Outpatient Facilities by DHCS.
- Residential Services: Initially, at least one level of residential services, as defined in the ASAM Criteria. Counties will be required to provide all three levels of residential services as defined in the ASAM Criteria within three years of opting in to the waiver.
- Withdrawal Management Services: At least one level of Withdrawal Management Services, as defined in the ASAM Criteria.
- Opioid Treatment: Daily or several times a week, medication (methadone, buprenorphine, naloxone, disulfiram) and counseling will be available to help individuals with severe opioid use disorders maintain stability. These services will be delivered by DHCS-licensed Narcotic/Opioid Treatment Providers.
- Recovery Services: Services that emphasize beneficiaries' role in managing their health, and teach them to use effective self-management support strategies.
- Case Management Services: Assistance for beneficiaries who need help accessing needed medical, educational, social, prevocational, vocational, rehabilitative, and other community services; coordination of SUD care with other services; assistance in interactions with the criminal justice system.

In addition, counties participating in the DMC-ODS will have the option to provide:

- Partial Hospitalization Services: 20 or more hours of treatment per week of services for individuals who do not require full-time care.
- Additional Residential Services: More than one level of residential services (three levels of residential service become required after three years).
- Additional Withdrawal Management Services: More than one level of withdrawal management services.

- Additional MAT: SUD medications (buprenorphine, naloxone, disulfiram, injectable naltrexone) in all DMC settings and clinically necessary adjunctive services for beneficiaries with opioid and/or alcohol use disorders.

3. Provider Specifications

Professional staff delivering DMC-ODS services will need to be licensed, registered, certified, or recognized under the California State scope of practice statutes. In DMC-ODS counties, the SUD workforce will be expanded to include Licensed Practitioners of the Healing Arts, such as physicians, nurse practitioners, physician assistants, registered nurses, registered pharmacists, licensed clinical psychologists, licensed clinical social workers, licensed clinical professional counselors, and licensed marriage and family therapists.

All professional and nonprofessional staff will be required to have appropriate experience and necessary training before they begin delivering services. In addition, Counties will require contracted providers to be capable of providing culturally competent services, MAT, and at least two EBPs.

4. County Responsibilities

Counties that participate in the DMC-ODS will have the following responsibilities:

- Implementation Plan: Counties will create and submit a DMC-ODS implementation plan to the State.
- Selective Provider Contracting: Counties will choose which providers will participate in the DMC-ODS benefit, and will be required to ensure that all beneficiaries have access to services and a choice of providers that are geographically accessible to them. Counties will be responsible for maintaining and monitoring a network of providers that is appropriate for the anticipated number of DMC-ODS clients, the expected utilization of SUD services, and the expected number and types of providers needed to meet beneficiaries' SUD service needs. Counties will need to have written policies and procedures for selecting, retaining, credentialing, and re-credentialing providers, and contract requirements will need to stipulate that providers must provide services that are safe, effective, patient-centered, timely, efficient, and equitable.
- Residential Service Authorization: To assure appropriate utilization of residential services, counties will be responsible for authorizing their utilization. Counties will need to provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.
- Beneficiary Access Number: Counties will have a toll-free number for prospective beneficiaries to call to access DMC-ODS services. Counties will be required to make oral interpretation services available to beneficiaries as needed.
- Coordination with Managed Care Plans: To facilitate clinical integration, counties will enter into a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS in their county. MOUs will, at a minimum, include bidirectional referral protocols between plans, the availability of clinical consultation, management of beneficiaries' care, procedures for the exchange of

medical information, and a process to ensure that beneficiaries receive medically necessary services uninterrupted in the event of disputes between counties and Medi-Cal managed care plans.

- Quality Improvement Plan: Counties that participate in the DMC-ODS demonstration will be required to have a Quality Improvement plan that monitors service delivery, service capacity, and the types and geographic distribution of SUD services. A Quality Improvement committee will review the quality of SUD services provided to beneficiaries, recommend policies, ensure and follow-up Quality Improvement processes, and evaluate the results of Quality Improvement Activities.
- Utilization Management: Counties will assure that beneficiaries have appropriate access to different levels of SUD care, as needed. They will also assure that medical necessity has been established for each beneficiary, that they are placed in the appropriate level of care, and that the services given are appropriate for beneficiaries' diagnosis and level of care.
- Financing: Counties will propose county-specific rates to be approved by the State. If the State denies proposed rates, counties will have an opportunity to adjust rates and resubmit to the State.

5. State Oversight, Monitoring, and Reporting

State responsibilities will be as follows:

- The State will maintain a plan for oversight and monitoring of DMC-ODS providers and counties in order to assure compliance and facilitate corrective action when necessary. In particular, the State will ensure that DMC-ODS services facilitate timely access to care, and it will monitor provider activities in order to identify and address suspicious or fraudulent activity.
- The State will monitor and report DMC-ODS enrollment information, operational issues, and policy developments.
- The State will conduct Triennial reviews of the status of quality improvement and county monitoring activities.

Proposed Evaluation

1. Evaluation Purpose

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program under California's Section 1115 demonstration waiver, originally approved by the Centers for Medicare and Medicaid Services (CMS) on August 13, 2015.

Through the DMC-ODS, the State will restructure Medi-Cal SUD services (Drug Medi-Cal, DMC) in participating counties to operate as a DMC Organized Delivery System (DMC-ODS) that: (1) provides a continuum of SUD care modeled after the American Society of Addiction Medicine's Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (ASAM Criteria); (2) increases local control and accountability; (3) creates mechanisms for greater administrative oversight; (4) establishes utilization controls to improve care and promote efficient use of resources; (5) facilitates the utilization of evidence-based practices (EBPs) in SUD treatment; and (6) increases the coordination of SUD treatment with other systems of care (e.g. physical health and mental health). The principal aims of the DMC-ODS will be to improve access to SUD services, improve the quality of SUD care, control costs, and facilitate greater service coordination and integration, both among SUD providers and between SUD providers and other parts of the health care system.

The DMC-ODS will be consistent with the Center for Medicare and Medicaid Services (CMS) guidance issued in the July 27, 2015 State Medicaid Directors letter on new service delivery opportunities for individuals with SUD.[1] California's DMC-ODS demonstration is the first to be approved under CMS' recent guidance, and meets many of the standards set forth in the July 2015 letter, including: an evidence-based benefit design covering a full continuum of SUD care, requirements for providers to meet industry standards of care, a strategy to coordinate and integrate services across systems of care, reporting of specific quality measures, program integrity safeguards and a benefit management strategy, and other programmatic expectations. Counties that participate in the DMC-ODS demonstration will be able to selectively contract with providers in a managed care environment in order to deliver a full array of services consistent with the ASAM Criteria, including recovery supports and services.

The University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) will conduct an evaluation to measure and monitor outcomes of the DMC-ODS demonstration project. The evaluation will focus on four areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and with medical and mental health services. UCLA will utilize data gathered from a number of existing state data sources as well as new data collected specifically for the evaluation.

[1] SMD Letter #15-003, Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

2. Evaluation Strategy

A. Goals and Objectives

The primary goals of the DMC-ODS waiver demonstration are enhanced access to SUD treatment, quality of care, and coordination of care while maintaining cost neutrality for the Medicaid program. The evaluation will examine each of these goals using a variety of measures, which will be discussed further in the Methods section.

An aim of the evaluation is to be as comprehensive and useful as possible within practical constraints by following several principles:

- Analyze existing state administrative datasets where possible.
- Align measures with existing or expected future data requirements.
- Where necessary, collect new data while minimizing the burden on stakeholders.
- Provide results to stakeholders quickly to inform ongoing implementation efforts.

Both quantitative and qualitative measures will be used to mitigate the weaknesses of each. Quantitative methods will be used to analyze trends and the degree of changes over time, while qualitative methods will be used to help interpret quantitative data within the broader context of stakeholder perceptions.

B. Hypotheses

Evaluation hypotheses can be organized into the following four categories, or domains:

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

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

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

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

C. Design

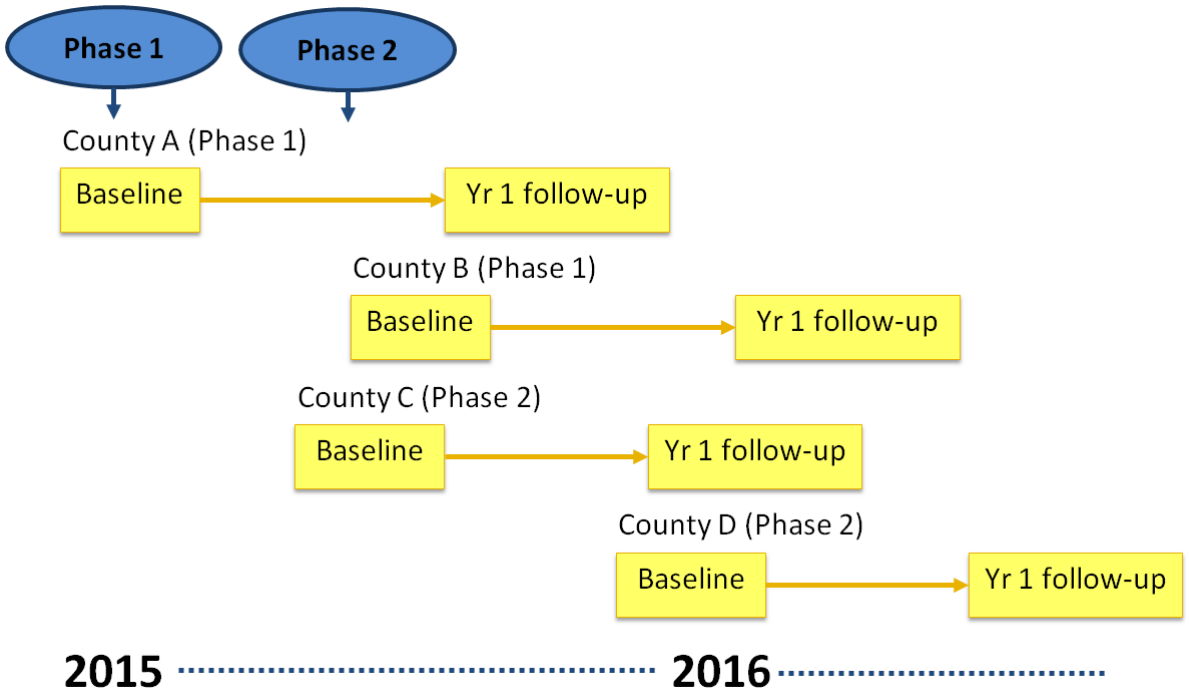
1. Model discussion and approach

In principle, a randomized controlled trial would be the best approach to determine the causal effect of the DMC-ODS waiver. Unfortunately, this would require random assignment of

counties or providers to determine whether they participate in the waiver rather than allowing them to participate based on their own readiness and willingness to do so. Such random assignment in this case would be not be feasible and may even be considered unethical due to the randomly assigned denial of certain services that would be necessary; therefore, such an evaluation design has been eliminated as a possibility.

When considering alternative designs, a significant consideration is the important role of counties in waiver implementation, the uncertainty in the number of counties that will opt in, and the timing of each county's participation. A recent survey by UCLA suggests that the majority of California's 58 counties may opt in. On this survey, only two counties responded that they do not plan to opt in, but many are uncertain. However, it is unclear when the counties will opt in during the five-year waiver period. The state will open participation in the waiver to counties in regional phases, but counties will not be required to begin immediately when their phase opens. Therefore, it is likely that implementation will not be tightly tied to phases, and instead may occur as depicted in Figure 1. As shown, a phase 2 county could actually begin participating before a phase 1 county. Due to this likely overlap between phases, the start dates used in data collection or analyses will be based on each county's individual implementation start date, as defined by final approval of its implementation plan, rather than by the county's phase.

Figure 1- Hypothetical scenario: overlapping phases and start dates.

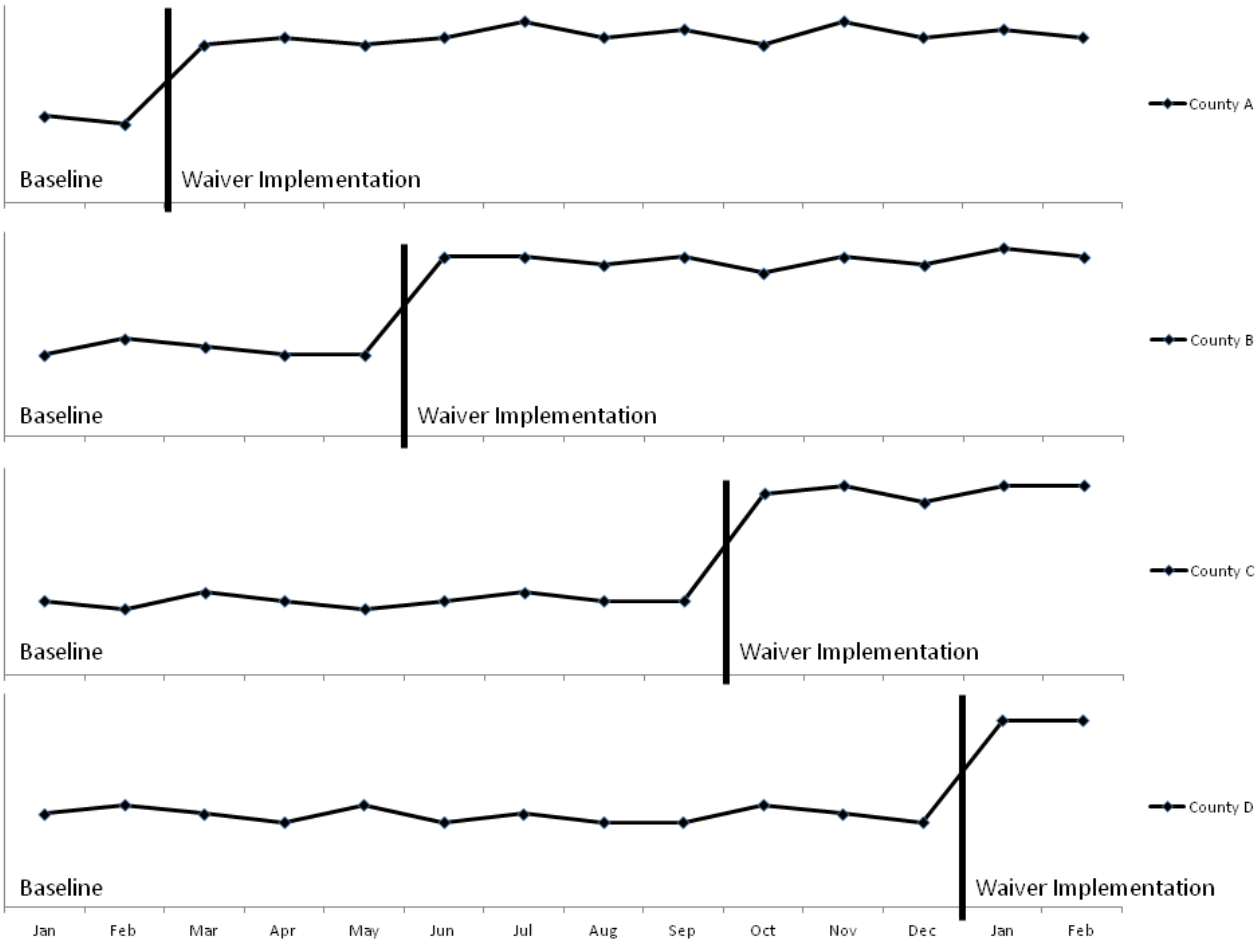


The likely staggered nature of implementation presents both challenges and potential advantages for evaluation purposes. If the entire state were to begin implementation at the same time, a regression discontinuity analysis similar to the one proposed for the Arkansas

1115 waiver evaluation (Arkansas Center for Health Improvement, 2014) would be one reasonable evaluation approach. In California's case, however, there is an opportunity to take advantage of the expected county-by-county implementation using a different approach.

The proposed evaluation will use a relatively new type of design known as a stepped wedge or multiple baseline design (for clarity, this latter term will be used). This method is similar to an interrupted time series design except that, under a multiple baseline design, groups receive the intervention (in this case, waiver implementation) at multiple points staggered over time, matching the expected scenario in California. Figure 2 illustrates this design using an example of four counties. The hypothetical outcome could, for example, be a measure of treatment access or quality.

Figure 2- Example of a multiple baseline design measuring a hypothetical outcome in four counties.



Examining implementation of the intervention across time in different counties will enable the evaluation to monitor the possible influence of extraneous variables (e.g. statewide policies, changes in the state's economy, etc.) on outcome measures with sufficient data. Similar

changes in outcomes following waiver implementation in each county, coupled with the absence of changes in other counties that had not yet opted in at that point in time, suggests that the change observed resulted from the waiver.

While an ideal implementation of this design would include random assignment of the timing of county participation (Hawkins et al., 2007; Sanson-Fisher, 2015), as discussed above, this is not feasible. However, the multiple baseline design can still be used to study the "natural experiment" created by the waiver. Recent examples of such applications of the multiple baseline design include Fell et al. (2014) and Fedeli et al. (2015).

2. Logic Model

The primary goals of the DMC-ODS demonstration are improved access to care, improved quality of care, and better coordination/integration of care, while maintaining cost neutrality for the Medicaid program. These ultimate impacts are reflected in the evaluation logic model (see Appendix A).

Implementation of the waiver will lead to multiple system changes, including selective provider contracting, treatment authorization, and a beneficiary access line; the development of a continuum of care with recovery support services; use of EBPs; requirements for MOUs supporting the facilitation of MAT and physician consultation and coordination of SUD treatment with physical and mental health service; and quality improvement planning.

To determine whether these changes have been effective in supporting an organized system of care, UCLA will examine the availability of services along the full continuum of SUD care, patient placement in treatment according to ASAM Criteria assessment, care transitions and discharges within the SUD continuum of care, coordination and referrals to mental health and medical services, use of EBPs and MAT in SUD treatment, and any health care cost offsets resulting from appropriate use of SUD services. Further description of these measures are described in the following Methods section.

3. Methods

The proposed methods can be divided into four broad domains: Access, Quality, Cost, and Coordination of Care. The measures we are proposing for each of these domains is described below. **The data sources cited in this section are described in further detail in the Data Sources section that follows.**

A. Access Measures

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

Access will be determined in the aggregate at the county level, or a regional level if multiple small counties choose to use the regional option available to them. Access will be evaluated using the following measures:

Availability and use of full required continuum of care –Data will be used to determine whether all required levels of care are being used in county systems.,For periods prior to implementation CalOMS-Tx will be used as an approximation. CalOMS-Tx provides data on withdrawal management (outpatient, residential hospital, residential non-hospital), outpatient, intensive outpatient/day care rehabilitative, and residential treatment. During waiver implementation, Drug Medi-Cal data will be used to obtain a more exact measure of ASAM levels of care. DHCS is currently adding HCPCS codes and modifiers to identify these ASAM levels of care.

a) Use of MAT - DMC and Medi-Cal claims will be analyzed to examine changes in MAT.[2]

b) Number of Admissions (DMC Claims, CalOMS-Tx) – DMC claims and CalOMS-Tx data will both be examined to determine changes in the number of admissions by level of care, to determine whether the number of patients accessing care is increasing, decreasing, or remaining the same.

c) Penetration rates – UCLA will examine trends in statewide penetration rates before and after waiver implementation based on CalOMS-Tx data on the number of people entering treatment divided by estimates of the prevalence of dependence from SAMHSA's National Survey on Drug Use and Health (NSDUH). SAMHSA does not report data at the county level, however, and substate data from SAMHSA that would be necessary for county-level analysis is currently unavailable. UCLA therefore proposes to evaluate the waiver with an approach analogous to the "intention to treat" approach commonly used in research. This approach would evaluate the statewide effect of making the waiver available, rather than examining only counties in which it has been implemented. Using this approach, the more counties opt in, the more likely the penetration rates will change. Counties that do not opt in

[2] In the STCs, there are two measures that have been combined here due to their overlap. The original measures were Number of Admissions and Numbers and trends by type of service.

will not receive any of the benefits of the waiver and will therefore likely have unchanged penetration rates, just as patients who drop out in treatment studies receive no treatment effect. Based on SAMHSA data currently available, UCLA will be able to estimate penetration rates by alcohol and separately by other illicit drugs.

d) Adequacy of network – UCLA will approach network adequacy using multiple measures:
    - Availability of first appointments: UCLA will call withdrawal management, residential, outpatient, and narcotic treatment program (NTP) treatment providers in counties that do not have a central access point to determine whether treatment is available and how long wait times for admission, if any, are estimated to be. In centralized counties, UCLA will call the centralized number and ask when the first available admission would be. We will also ask when the first available assessment appointment is, if applicable. This will be done in each county at least annually. Amount of time spent on hold will also be recorded.
    - Average distance to provider – UCLA will use patient address information from the Medi-Cal Eligibility Data System (MEDS) and provider address information from DHCS's Prime database to estimate whether a subset of patients live within a 15-mile radius from the treatment provider where they received services.
        i. UCLA will acquire ASAM data from all opt-in counties via DHCS. This data will minimally include the level of care indicated, the level of care the patient was placed in, the reason for the discrepancy, if any, and dates of the assessment. These will be compared to the dates of admission from CalOMS-Tx. Using this data, UCLA will be able to calculate the time from ASAM assessment to admission and the percentage of admissions that match the ASAM level indicated by the assessment. To the extent that there are mismatches, UCLA will determine what percentage of these are due to unavailability of the indicated level of care.
    - Residential, withdrawal management, and NTP capacity – UCLA will analyze data from DHCS's Drug and Alcohol Treatment Access Report (DATAR) or state licensing data to determine whether the waiver was associated with changes in residential, withdrawal management, and NTP capacity (number of beds/slots).
    - Outpatient capacity – While DATAR data is available for outpatient treatment, there is concern that it may not always reflect the true capacity of outpatient or intensive outpatient programs. Capacity is inherently flexible in these levels of care, since programs can generally add or reduce treatment groups, the number of counselors at the site, or change operating hours to expand or contract capacity at any time. UCLA will therefore use CalOMS-Tx or Medi-Cal billing data to determine the maximum patient census on any given day in these programs over the course of a year to provide an approximate picture of maximum utilization as a proxy for capacity. If other capacity data becomes available during the evaluation, these alternative sources will be used instead if they are determined to be more accurate.

e) Existence of a 24/7 functioning beneficiary access phone number - UCLA will survey all counties (whether they have opted in or not) to determine whether they have a number and whether it provides services in languages other than English. The number will be called to confirm it is functioning.

f) Availability of services in languages other than English - Providers will be surveyed about the languages they provide services in, and patients will be surveyed about whether staff is sensitive to their cultural/ethnic background (e.g., race, religion, language).

g) Availability of provider directory to patients - UCLA will ask county administrators to provide this to the evaluation team.

h) Patient perceptions of access to care
   - Cross-sectional patient surveys will be administered at multiple time points. Items adapted from the MHSIP or similar survey may be used to measure consumer perceptions of access to care (e.g., *location is convenient, services are available when I need them, I am able to see a counselor when I want to*). (See data sources below.)

i) **Initiation/engagement –** DHCS will report the Medicaid Adult and Children's Quality Measures for individuals with SUD Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004). Initiation is defined as the percentage of patients who initiate treatment within 14 days of the diagnosis. Engagement is defined as the percentage of patients who initiated treatment and who had two or more additional services within 30 days of the initiation visit.

B. Quality Measures

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

Quality will be evaluated using the following measures:

a) Use of ASAM criteria-based tool for patient placement and assessment
   County administrator and treatment provider surveys will include questions inquiring about the status of the ASAM criteria for placing patients in the appropriate level of care and assessment.

b) Appropriate placement - UCLA will acquire ASAM data from all of the opt-in counties (via DHCS) to examine placement using multiple measures.
   - Percent of individuals receiving ASAM criteria-based assessment prior to an admission in level of care. UCLA will acquire ASAM data from all opt-in counties. This data will minimally include the level of care indicated, the level of care the patient was placed in, and dates of the assessment. These will be compared to the dates of admission from CalOMS-Tx data. Using this data, UCLA will be able to calculate the percentage of patients for which the ASAM assessment has been used as the basis to determine the level of care prior to treatment admission.
   - Comparison of ASAM indicated level of care and actual placement and reasons documented for the difference if they do not match - ASAM and CalOMS-Tx data will be analyzed to calculate the percentage of matches between ASAM indicated

level of care and actual placement. Among the cases where there are mismatches, UCLA will calculate the percentage of assessments that have documented reasons for the mismatch. Reasons for mismatches will be analyzed to identify patterns that may indicate quality of care issues (e.g., timeliness of placement, effective ASAM assessment, patient-centered focus). Changes will be tracked before and after waiver implementation, annually over the course of the evaluation, and by modality (residential, NTP, withdrawal management, outpatient) to examine whether the match between the ASAM indicated level of care and actual placement is improving over time and whether the reasons for the mismatches change over time.

- Use of continuing ASAM assessments, appropriate movement - UCLA will analyze ASAM assessment data (including dates of assessments, indicated levels of care, and actual placements) to track whether and how frequently ongoing ASAM assessments are being conducted for patients in treatment and the time between assessment and placement in a different level of care, if indicated. UCLA will also track movement to different levels of care (e.g., residential to outpatient) to examine whether and how effectively and efficiently patients are moving along the continuum of care.

c) Appropriate treatment consistent with level of care after placement, residential:
   - ASAM Audits - County ASAM data will be compared to DHCS ASAM audits, which will determine the level of care being provided by residential treatment programs. This will enable the evaluation team to determine how well the ASAM-indicated level of treatment (e.g. 3.1, 3.3) matched with the actual treatment level received.
   - Percentage of referrals with successful treatment engagement (based on length of stay) among patients for whom treatment was indicated according to an ASAM assessment. The Washington Circle defines treatment engagement as having two additional SUD treatments within 30 days after initiating treatment. At a minimum UCLA will use CalOMS-Tx data to examine admission and discharge dates to track treatment engagement/retention in treatment[3] and length of stay (at least 30 days). Alternatively, if feasible, DMC claims data will be used to count the number of encounters during the 30-day period to provide a more precise measure.

d) Successful care transitions - The Washington Circle defines continuity of care as receiving additional services within a 14-day period after discharge from either withdrawal management or residential treatment. UCLA will analyze CalOMS-Tx or DMC claims data to measure whether patients are moving along the continuum based on the ASAM scores within a timely manner. In addition, questions asking about care coordination practices will be included in the Treatment Provider surveys and care coordination experiences will be included in patient surveys. To the extent possible, Medi-Cal pharmacy data will also be used to determine whether and when SUD medications were filled (billed) following discharge.

e) Successful discharge
   - UCLA will track the number of patients who left before completion of treatment with unsatisfactory progress in CalOMS-Tx, which are is the closest measure

[3] In the STCs, this was originally listed under Access.

available for discharges against medical advice. Changes will be tracked before and after waiver implementation, and over the course of the evaluation in order to determine changes over time. Discharges will also be compared to counties that have not opted in.

f) Use and monitoring of evidence based practices
   - Where possible, the evaluation will collect data from county EBP monitoring and assess the adequacy of such monitoring. The nature of the efforts counties will use to monitor this is unknown at the time of this evaluation plan but will be included in the county implementation plans for opt-in counties. UCLA will develop a plan for assessing county efforts based on the approved implementation plans.

g) Patient perceptions of quality of care
   - Cross-sectional patient surveys will be administered at multiple time points. Selected items from the MHSIP or other surveys will be used to measure consumer perceptions of the quality of care (e.g., staff is sensitive to my cultural/ethnic background, staff helps me get the information I need to manage my illness, I, not staff, decide my treatment goals.)

h) Establishment of quality improvement committees and plans

i) County administrator surveys (see data sources below) will inquire about counties' quality improvement practices, committees, and plans. Both county administrator and treatment provider surveys will include questions asking about the collection of patient satisfaction/perceptions of care.

j) Outcome Measures
   - CalOMS-Tx, Patient surveys
     i. Alcohol or other drug (AOD) use - UCLA will use CalOMS-Tx data to calculate the number of days the patient's primary drug was used in the last 30 days prior to admission and prior to discharge.
     ii. Social support/social connectedness - UCLA will use CalOMS-Tx data to calculate the average number of days in the last 30 days the patient participated in any social support recovery activities (e.g., 12-step meetings, interactions with family member and/or friend supportive of recovery). UCLA will track changes between admission and discharge, and aggregate trends over the course of the waiver.
     iii. Living arrangements/housing situation - UCLA will use CalOMS-Tx data to calculate the percentage of patients with the following living arrangement: currently homeless, dependent living, independent living.
     iv. Employment – CalOMS-Tx data will be used to calculate the percentage of patients reporting their current employment status as the following: employed full time (35 hours or more), employed part time (less than 35 hours), unemployed/looking for work, unemployed/not in the labor force/not seeking, not in the labor force/not seeking.

v. To the extent that patient outcome questions may be included in the patient perceptions of care survey (see data sources), UCLA analyze changes over time on those measures.

k) Grievance reports - The number of grievances received by the state will be tracked by type (e.g., access, benefits/coverage, quality of care/services) and modality.

l) Effectiveness of all levels of care
   - Readmissions to withdrawal management, residential and intensive outpatient treatment will be tracked using CalOMS-Tx and/or DMC claims data. We will analyze readmissions both at 30 days (common in medical care) and 90 days, consistent with a measure discussed by ASAM. In describing their measure, ASAM made the point that in SUD withdrawal management and treatment, waiting lists are common, which justifies allowing a longer period for the person to be readmitted.
   - The following questions will be addressed using CalOMS-Tx outcomes (e.g. emergency room use in the last 30 days), and Medi-Cal claims to determine which health services have been billed.
     i. Are there differences that are associated with the use of different treatment modalities in health outcomes?
     ii. Are there differences that are associated with the different residential lengths of stay in health outcomes?

C. Cost Measures

Hypothesis: Health costs will be more appropriate pre/post waiver implementation among comparable patients.

Cost offsets will be evaluated based on Drug Medi-Cal and Medi-Cal data. Where data is available under fee for service, we will have the actual dollar amounts in a paid amount field. Under managed care, encounters and charges will appear, the latter of which aren't necessarily equal to what was paid. To estimate costs in these cases, UCLA plans to conduct "shadow pricing" by using FFS rates to aggregate rates into a diagnosis related group, then assume the cost of the office visit in managed Medi-Cal is the same. UCLA will collaborate closely with DHCS on these efforts. The following measures will be examined:

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

b) Change in ED utilization and costs

c) Change in inpatient utilization and costs

d) Change in SUD treatment utilization and costs

e) Differences in health care costs that are associated with the use of different treatment modalities in costs

f) Differences in health care costs that are associated with the different residential lengths of stay in costs

g) Differences in health care costs among patients who receive SUD medications versus patients who do not receive SUD medications, analyzed to the extent possible by location and type of medication.

Overall cost neutrality will be analyzed separately from this evaluation as part of the larger Medi-Cal 2020 waiver evaluation.

D. Coordination Measures

> Hypothesis: There will be improved SUD treatment coordination for beneficiaries both within the SUD continuum of services as well as with primary care, mental health, and recovery support services.

Two levels of assessment are required to evaluate the integration and coordination of care component:

1. Activities within the SUD continuum of services
2. Activities across the healthcare service systems (i.e., SUD with MH and SUD with PC)

To date, there have been limited validated measures in the field on the measurement of integration of services and coordination of care, and even less so specifically focused on SUD integration and/or at the SUD system of care level. UCLA conducted a literature search on published articles, reports, and other resources from leading integrated health care organizations and initiatives (e.g., SAMHSA-HRSA CIHS, AHRQ, NQF, CCI, CalMHSA, etc). Surveys will be informed by these resources (UCLA is also a leading organization in this area). For example, the following will be collected from county administrators: (1) collaboration and communication protocols or activities between departments/divisions; (2) the existence of formal agreements and partnerships across department/divisions; (3) policies or guidelines to their providers to establish formal procedures to partner with MH or PC providers outside of the SUD system; (4) policies or guidelines provided to their providers to establish formal procedures with other SUD providers offering different modalities; and (5) methods in place to track referrals and movement within the SUD continuum of care.

UCLA will measure coordination of care and integration of services within the SUD continuum of services and across the broader health care service systems (MH and PC) by evaluating the following measures:

a) Using document reviews where possible, coupled with administrator surveys, UCLA will assess the existence of required MOUs with:
   - Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 Screening, Brief Intervention, and Referral to Treatment (SBIRT) services;

- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Delineation of case management responsibilities;
- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures for exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems including bidirectional referral protocols.

In addition, the evaluation team will conduct additional surveys and/or interviews to determine whether and how these required MOU items are actually being implemented. This will include administrator, provider, health plan, and patient surveys (see data sources section below).

b) Assessment of coordination goals: The following will be assessed using stakeholder surveys and interviews (e.g., health plan, administrator, provider, patient).
   - Comprehensive substance use, physical, and mental health screening. This will be assessed using health plan surveys and SUD program surveys;
   - Beneficiary engagement and participation in an integrated care program as needed. This will be assessed using SUD treatment provider surveys and patient surveys.
   - Shared development of care plans by the beneficiary, caregivers and all providers. This will be assessed using SUD treatment provider surveys and patient surveys.
   - Care coordination and effective communication among providers. This will be assessed using county administrator and SUD treatment provider surveys.
   - Navigation support for patients and caregivers. This will be assessed using county administrator and SUD treatment provider surveys.
   - Facilitation and tracking of referrals between systems. This will be assessed using county administrator surveys and treatment program surveys.

c) Referrals to and from primary care and mental health - quantified using information from CalOMS-Tx on whether patients were referred from other health care providers, coupled with surveys and interviews with SUD administrators, providers, and health plan stakeholders.

d) Referrals to and from recovery services paid for by the DMC-ODS - Although claims may help to quantify these recovery services, there are no existing datasets that track referrals to

and from these services. Therefore, UCLA will use stakeholder surveys and/or interviews to understand current and emerging practices.

e) SUD identification in the health care system. To the extent possible, Medi-Cal diagnosis codes will be used to examine trends in SUD identification in the health system.

f) Follow-up after discharge from the Emergency Department for Alcohol or other drug use. To the extent possible Medi-Cal diagnosis codes and Drug Medi-Cal claims data will be used to measure the extent to which patients with SUD begin SUD treatment.

4. Data Sources

The data sources below will be used to create the measures described above.

See Appendix B for the list of data sources (below) organized by domain, and Appendix C for a timeline for data collection.

1. **Administrative data sources**[4]

- **CalOMS-Tx** – CalOMS Treatment (CalOMS-Tx) is California's existing data collection and reporting system for all patients in publicly-funded substance use disorder (SUD) treatment services (data will be linked to Drug Medi-Cal claims to identify patients whose treatment is funded by this source specifically). Treatment providers collect information from patients at admission and discharge, and send this data to DHCS each month. This treatment data includes patient information on alcohol/drug use, employment and education, legal/criminal justice, medical/physical health, mental health, and social/family life. CalOMS-Tx meets national requirements for the Treatment Episode Dataset (TEDS) maintained by the Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (SAMHSA) and includes National Outcome Measures (NOMS). More information on CalOMS-Tx can be found at:
  http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx
  To the extent possible CalOMS-Tx and Drug Medi-Cal claims data will be examined together to check for inconsistencies and conduct data cleaning as necessary.

[4] These data sets have many of the same shortcomings as other administrative data sets, particularly related to inconsistent reporting and missing data (see for example Evans, et al, 2010 for a discussion of CalOMS-Tx). However, while these factors inject noise and potential biases due to underreporting into the data, as long as these factors are largely consistent over time and across large numbers of counties, the important comparisons in this design can still be carried out. For example, outcome data (e.g. drug use in the last 30 days) is sometimes missing at discharge, particularly among patients in outpatient treatment who do not complete their treatment. This means the absolute percentage of patients using drugs at discharge may be understated if one takes CalOMS-Tx data at face value. However, when comparing data from the same county (or statewide) over time, as long as the same bias is present at both time points (which can be checked, and adjusted for if necessary), the relative difference between the two time points can still be measured (i.e., if drug use at discharge is rising or falling, even if the absolute level may be unclear). Consistent with this, CalOMS-Tx data has been used in a large number of peer-reviewed publications.

- **DATAR** – Drug and Alcohol Treatment Access Report (DATAR) is the DHCS statewide system to collect data on SUD treatment capacity and waiting lists. DATAR is useful for measuring treatment capacity where capacity is easily measured by beds or slots. For more information on DATAR, see http://www.dhcs.ca.gov/provgovpart/Pages/DATAR.aspx. Where possible, DATAR will also be compared to program licensing data to check for discrepancies. If discrepancies are found, UCLA will discuss this with DHCS to determine the best course of action.

- **Medi-Cal Eligibility Data System (MEDS)** – The MEDS contains data on all Medi-Cal beneficiaries statewide, including demographic information and residential addresses.

- **Medi-Cal/DMC Claims Data** – The evaluation will use California's data for Medicaid claims in addition to the MEDS, which provides identifying information on Medi-Cal eligible beneficiaries that can allow linkage to other datasets (e.g., CalOMS-Tx).

- **NSDUH** – SAMHSA's National Survey on Drug Use and Health (NSDUH). This national survey provides limited conservative state-level estimates of alcohol and illicit drug use prevalence.

- **Prime –** DHCS's Prime system contains information on all SUD provider facilities, including mailing addresses and DMC certification and decertification dates, among other provider-level information.

In addition to the above datasets, UCLA will evaluate others, e.g. data from the California Office of Statewide Health Planning and Development (OSHPD) or any other datasets that may become available during the evaluation to determine whether they would add substantially to the planned analyses. If so, these datasets will be incorporated into the evaluation to the extent possible.

2. New data collection activities (specific for the evaluation)

Where secondary analysis of existing datasets will not adequately address the hypotheses, UCLA will supplement this data with additional primary data collection:

ASAM Criteria Data

Counties that have opted in to the waiver will collect ASAM criteria data as part of their medical necessity determination under DMC ODS. Data from all assessments will be sent to DHCS, which will then share it with UCLA for evaluation purposes. The total sample size will depend on the number of counties opting in and the number of clients seeking treatment in those counties, but is exected to be substantial. At a minimum this data will include the date of the assessment, the type of treatment indicated, the type of treatment the patient was actually referred to, the reason for the difference (if any), and sufficient identifying information to enable data matching to other data sources (e.g., to CalOMS-Tx, to determine

whether and where the patient actually entered treatment). ASAM data will be used to address access and quality of care measures as described in the previous section, as well as to satisfy state reporting requirements as described in the STCs. ASAM criteria data is not expected to be available before waiver implementation or in counties that are not participating in the waiver, so it will be a used for descriptive purposes and to track trends during the course of the demonstration.

Stakeholder Surveys

The stakeholder surveys will address multiple needs. For example, the treatment provider surveys will include questions on access to care, quality of care, and coordination of services within and outside of the SUD system of care (e.g. with primary care). These questions will supplement the administrative data analyses we will be conducting on these same issues.

UCLA County Administrator Survey - UCLA will collect information from county administrators in both opt-in and non-opt-in counties through this web-based survey, with items pertaining to three of the four evaluation domains: access to care; quality of care; and coordination of care within the SUD continuum of care and with the physical health and mental health systems. UCLA will also inquire about implementation challenges and training/technical assistance needs to help inform State level implementation activities. This information will supplement information submitted by administrators in their County Implementation Plans.

UCLA Treatment Provider Survey - UCLA will conduct web-based surveys of a selected sample of providers at the service delivery unit (SDU) level. An SDU refers to a treatment modality (e.g., inpatient, outpatient, methadone maintenance) at a specific site. UCLA has adopted this terminology in order to avoid ambiguity associated with the term "treatment program," which may indicate different levels depending on provider type.

The SDU-level survey will contain questions relating to services provided at the SDU and will be directed toward the clinical director of the SDU. Data pertinent to answering the research questions in the Access (e.g., treatment capacity), Quality (e.g., ASAM criteria, electronic health records) and Coordination of Care (e.g., partnerships with other treatment and recovery support providers, levels of integration with physical and mental health scare systems) domains of the evaluation will be collected.

UCLA Managed Care Plan Survey - UCLA will conduct short web-based surveys of Medi-Cal managed care plan representatives to assess perspectives and practices relevant to coordination of care with SUD treatment systems, including: prevalence of early intervention practices (e.g., screening, brief intervention, referral to specialty SUD services); perceptions about the extent to which substance use conditions among their members contributes to the costs of medical care; coordination activities with SUD treatment providers; and use of data to track the medical costs of members with SUD diagnoses and the impact of substance use treatment on medical costs.

UCLA Patient Survey - Discussions are ongoing with DHCS and other stakeholders regarding use of an adapted (simplified) version of the Mental Health Statistics Improvement Program (MHSIP) survey[5] or other similar survey to collect data on consumer experiences with and perceptions of care. Specific items or components from validated surveys widely used with consumers receiving behavioral health services, including SUD (e.g., Modular Survey, Treatment Effectiveness Assessment, Experience of Care and Health Outcomes [ECHO]), will be reviewed and incorporated into the survey to collect data needed to answer the evaluation's research questions while balancing this against practical considerations, in recognition that this survey could lay the groundwork for ongoing surveys of this nature in SUD programs in California.

As county behavioral health departments receiving MHBG funds are already familiar with and experienced in administering the MHSIP survey, with some counties incorporating the results into their quality improvement efforts (e.g., external quality reviews, performance improvement projects) for specialty mental health services, the current adult MHSIP form (to be used for ages 18 and over) is a candidate for adaptation to address SUD services for purposes. The survey would be shortened but also include an additional construct: perception of coordination and integration of care. UCLA is aware of at least two counties in California that are using the MHSIP survey with consumers receiving services in both SUD and MH publicly funded treatment programs. In addition, several other counties are including adaptations of the MHSIP survey in their SUD patient surveys. Further, a search of the Internet shows that at least two states (Connecticut and Nebraska) are using the MHSIP survey for consumers in both their SUD and MH treatment systems. However, because the MHSIP survey was developed for and is widely used with consumers receiving services in publicly funded mental health systems, to our knowledge, data on the reliability and validity of the instrument for consumers receiving services in SUD treatment facilities have not been established (e.g., published). UCLA will conduct a stakeholder engagement process to determine how to collect this data and provide results using procedures that are most useful and least burdensome to stakeholders, while still addressing evaluation needs.

The California Institute for Behavioral Health Solutions (CIBHS) is the current contractor responsible for coordinating the collection of MHSIP data twice a year, as part of the California DHCS' Performance Outcomes and Quality Improvement program, for purposes of annually reporting National Outcomes Measures for mental health services required by SAMHSA for states receiving MHBG funds. There are four types of forms available: adult, older adult, youth services survey, and youth services survey for families. Each of these

[5] The MHSIP was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services. It has been nationally standardized and is in wide use by 55 states and territories, including California. Survey results can be compared across states over time. States that receive Mental Health Block Grant (MHBG) funds from SAMHSA routinely collect adult consumer survey data using the MHSIP to fulfill federal requirements for reporting indicators of outcomes. Various versions of the MHSIP survey that are available in the public domain ask consumers to report on their experiences with behavioral health care and cover the following domains: general satisfaction; perception of access; perception of quality and appropriateness; perception of participation in treatment planning; perception of outcomes of services; perception of functioning; and perception of social connectedness.

forms is available in seven languages (English, Spanish, Chinese, Russian, Vietnamese, Tagalog, and Hmong).

CIBHS has agreed to serve as consultants to UCLA to modify the form and protocol for the SUD treatment system. (See Appendix D for the current adult MHSIP form.) Data from the survey will be used for the current evaluation to measure consumer perceptions of access, quality of care, and coordination/integration of care. As part of the evaluation, MHSIP data will be collected once during the first year of the evaluation, with at least one follow-up survey toward the end of the waiver. UCLA will select providers to participate from a representative subsample of Treatment Provider Survey respondents (see above).

Stakeholder Survey Sampling Strategies - County administrator surveys will be targeted toward the full population of 57 administrators (although there are 58 counties, Yuba and Sutter counties are administratively combined for SUD purposes, leaving a total of 57).

Treatment provider surveys will be administered to a representative sample of providers stratified by size, region, and level of care. Surveys will be conducted at the service delivery unit (SDU) level, i.e. one treatment level at one location. Baseline surveys will be administered upon implementation plan approval (these surveys require sampling and therefore the baseline sampling will occur after implementation plan approval (and approval of this evaluation plan) in order to allow us to determine which counties are opt-in vs opt-out (or early opt in vs later opt in, as the case may be). We believe implementation will not occur immediately, so it will still be possible to take a "baseline" measure shortly after implementation plan approval.

For patient surveys, if the MHSIP survey is used, sampling may be generally consistent with current mental health practices, which involve surveying the population of patients present in participating programs during a designated time frame. The data collection methods will be discussed during the stakeholder engagement process on this topic, and procedures may be adjusted accordingly. For evaluation purposes, a subset of the sample of treatment provider survey respondents will be used.

Qualitative Stakeholder Interviews

The evaluation team will conduct key informant interviews and/or focus groups (group interviews) with stakeholders (e.g., county administrators, managed care plan representatives) concurrently with the survey data collection and administrative data analysis at baseline and at multiple time points throughout the waiver demonstration. Although UCLA does not plan to conduct systematic statewide interviews with consumer stakeholders due to resource constraints, if the consumer and/or treatment provider perspective is needed to help evaluators interpret the consumer and/or treatment provider survey results, several focus groups will be held for this purpose.

Interviews and/or focus groups will be conducted with stakeholder groups (e.g., county administrators, managed care plan representatives) following the initial round of survey administration and at several time points after implementation of the waiver (e.g., several months after county implementation plans are approved and again during the waiver period). The purpose of the individual and group interviews is to collect in-depth and emerging data on a range of stakeholders' experiences with and perceptions of the waiver implementation,

including factors facilitating and impeding the implementation, and recommendations for improving the implementation, particularly in terms of access to care, quality of care, and coordination/integration of care. The information-rich data will be used to complement the quantitative data collected for purposes of corroboration/triangulation as well as to provide more in-depth information that affords a deeper understanding of stakeholders' perspectives and experiences. This information will help with the interpretation of the quantitative data, reveal lessons learned from the stakeholder perspectives to inform the State's and counties' implementation efforts, identify emerging areas for further examination, and ultimately contribute toward answering the research questions. Selected samples of county administrators (e.g., the first five counties that obtain implementation plan approval in each of the Phases), managed care plan representatives, and other key stakeholders will initially be interviewed early on during the implementation of counties' approved implementation plans. This qualitative work will help inform other counties' and the State's planning and implementation efforts (e.g., implementation barriers, strategies to overcome barriers, promising practices, lessons learned, training and technical assistance needs, unintended/unanticipated consequences of the waiver).

Experienced qualitative interviewers will use semi-structured interview guides, which will include probing questions tailored to the stakeholder group (e.g., questions for each county administrator based on that county's survey responses and approved implementation plan). Interviews will be conducted in person or by phone and will last approximately 60 minutes, and focus groups 60-90 minutes. Individual and group interviews will be audio recorded and transcribed. Interviews will be conducted at several time points during the evaluation. The initial interview protocols will be modified prior to subsequent interviews to address new issues that may emerge during the course of the waiver evaluation.

3. Document Review

UCLA will review county implementation plans and county MOUs with managed care plans, and may review other documents such as grievance reports, in order to inform evaluation activities. UCLA will obtain these documents from DHCS and intends to use the information collected to gain background on county practices and specific plans for implementation, inform sampling procedures, and help develop stakeholder surveys and guides for qualitative interviews. These activities will complement but not duplicate DHCS's planned review process, which is intended to ensure that baseline requirements from the STCs are met in order for counties to begin implementation.

5. Analysis Plan

A. Statistical Data Analysis

Multivariate regression models using indicator variables for county opt-in status (counties have or have not yet opted in) along with other possible confounding factors will be used to control for differences based on characteristics (e.g. potentially Medi-Cal enrollment, race, age, geographic region). It is also possible to test for interactions between these confounding variables and opt-in status. When looking at binary outcomes, it is possible to account for the differences using logistic regression. For example, there might be overall differences in gender in an outcome, yet the difference may be more pronounced on the opt-in counties than those who have not or have not yet opted in. Interaction terms between the opt-in status and gender, in this case, could detect that difference.

When longitudinal quantitative data is available annually (e.g. administrative data, survey data), generalized linear models (mixed effects models) will be used to model changes over time. This is similar to the multivariate regression model above. Mixed effects regression models can account for the correlation seen between years within the same county. For instance, if one county is better at transitioning those coming out of withdrawal management to another level of care, then that will influence the next year's measurement within that county. Generalized linear models can also handle the clustering or hierarchical nature of treatment providers within counties. When looking at provider level data from surveys, it is necessary to account for differences that are at a county level, such as some counties having a centralized placement system or having specific transition policies in places while other counties may not have these. An analogous set of analyses can be conducted using a logistic mixed model to account for binary outcomes over time.

Where data (e.g., administrative data) is sufficient, a multiple baseline approach (also known as a *discontinuity mixed model* or *piecewise mixed model*) may be applied to account for different implementation periods and comparisons among the two county types (e.g., looking at data pre-implementation, partial implementation when some counties have implemented the waiver and some are yet to do so, and post-implementation, using a separate mixed effects model for each piece of the data).

An interrupted time series analysis (intervention model) is another way to account for the pre-implementation and post-implementation differences. This uses a specialized autoregressive integrated moving-average (ARIMA). ARIMA models take into account previous values to predict the next one in the series. ARIMA models can only be applied whenever the data has a sufficient number of data points equally spaced across time. Therefore, this model may not be applicable to some measures. For instance, when looking at utilization of residential programs in Phase I counties, monthly numbers can be calculated from CalOMS. The ARIMA model will enable accounting for seasonal changes over multiple years, the correlated nature of the repeated measure, and help determine if there has been overall growth over the duration of the waiver. If more appropriate, the piecewise model discussed above will be used instead.

In some cases, data may be insufficient for the analyses described above, e.g. due to an insufficient number of time points, low number of participating counties during early analyses, or severe violations of underlying statistical requirements, e.g. normality. In these cases repeated measures methods will be used to compare baseline to any specific later observation or composite of later observations. If necessary, methods that are robust to violations of normality or equality of variance can be employed.

Power analysis

Since statistical significance is a way of evaluating the likelihood that differences found in a sample would be found in the full population, in the case of the main administrative data analyses statistical power will not come into play because we are analyzing the data from essentially the full population. The same is true of surveys of county administrators and managed care organizations, since we will be surveying the entire populations. For surveys of treatment providers, however, it will become a consideration, since we will be conducting surveys on a sample of providers.

Although the number may be adjusted up or down based on resource availability, our current proposed sample size of 300 provider surveys will be able to detect a small effect size (d) of 0.16 in estimating the pre-and-post change of a continuous outcome. In testing a change of an outcome status between baseline and the year 1 follow-up (i.e., McNemar test for ratio of discordant: $p_{12}/p_{21}=1$), the detectable ratio (p_{12}/p_{21}) will be 2.24, 1.84, 1.72 and 1.61 when proportion of discordant pairs in the studied sample is 20%, 30%, 40% and 50%, respectively.

Additionally, the proposed sample will provide adequate statistical power in two-group comparisons (i.e., opted-in vs. opted-out counties). The sample size will be allowed for detecting an effect size (d) of 0.32 given a balanced sample in the two groups (i.e., opted-in vs. opted-out counties). Even in comparison of two groups with an unbalanced sample, a moderate effect size of 0.34 and 0.43 is still detectable given a sample of 100 vs. 150 and a sample of 50 vs. 250, respectively. The detectable difference in measures associated with rates (%) with a balanced sample in the two groups will range from 12% to 16% when the rate in the study population is 50%-10%. With an unbalanced sample of 50 vs. 250, the detectable difference in rates will be 17-21% when the rate in the study population is 50%-10%.

In multiple regression analysis, which defines opted-in vs. opted-out as the main independent covariate and baseline measures as other controlling covariates, the sample will detect R^2 of 0.06 with 15 covariates. Using logistic regression to assess predictors of a binary outcome, the sample will allow for the detection of odds ratios of 1.54-1.81 for a predictor controlling for other predictors, assuming moderate correlations of 0.1-0.5 among controlling predictors with the outcome and about 20% successful outcome rate.

All analyses above were computed with a two-sided alpha of .05 and power of .80.

B. Qualitative Analysis

The qualitative data collected from the different stakeholder groups (e.g., county administrators, managed care plan representatives, treatment providers) will be analyzed separately as well as across the different groups, by phase of implementation, and over time (e.g., early vs. later in the implementation of the waiver) to identify themes and patterns. As the interviews and/or focus groups with county administrators and managed care plan medical directors will be conducted after they have completed the baseline surveys (prior to submission of counties' implementation plans) and after counties have obtained approval of their implementation plans, the rich detailed information will give a deeper understanding of stakeholders' experiences, which will be used to supplement and expand on the survey data to answer the research questions.

In addition, the evaluation team will systematically review results from both the qualitative (e.g., semi-structured interviews, focus groups, responses to open-ended survey questions, documents) and quantitative (e.g., survey, administrative) data sets, consider how they contribute to answering the research questions in the relevant domains, and examine whether and where the results from the data sets converge, complement one another, and expand on one another (Palinkas et al., 2011).

Data analyses and interpretation will begin as soon as qualitative data collection and document review start, and will continue in a systematic and iterative process according to established and accepted procedures for qualitative research (Cresswell, 2003; Glaser & Strauss, 1967; Patton 1990). This process involves the repeated reading of the transcripts and notes, developing code lists, and coding the data to identify, compare and contrast emerging patterns and themes using the constant comparative method (Glasser & Strauss, 1967).

Preliminary code lists will be guided by three of the evaluation domains of focus - access, quality, and coordination of care. Examples of preliminary codes include: major environmental changes, barriers/challenges to implementation, training/technical assistance needs, promising practices, unintended/unanticipated consequences of the waiver, client flow, lessons learned, capacity, MAT, recovery services, ASAM criteria, staffing, data collection and monitoring, care coordination with mental health, care coordination with physical health. In addition, inductive codes that emerge from the data collected will be added, and adjustments and refinements will be made to the initial code lists using an iterative process as the data are collected to develop primary and secondary codes. ATLAS.ti, a computerized qualitative data management and analysis software program, will be used to organize the data and conduct these analyses. Portions of coded transcripts will be randomly and independently coded by two researchers to ensure that the codes are being applied consistently and have acceptable levels of agreement indicating good reliability. The evaluation team will meet regularly to share insights and observations from the interviews and/or focus groups throughout the evaluation and discuss emerging themes. Multiple researchers will review the analytic findings, qualitative data will be triangulated with survey and other quantitative data, and preliminary findings will be shared with the Evaluation Advisory Board and other stakeholder groups (e.g., CBHDA, consumer focus groups, treatment providers), and their input solicited to help interpret the findings.

6. Evaluation Implementation

A. Independent Evaluation

The evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met for the interim and final evaluations are use of best available data and controls for and reporting of the limitations of data and their effects on results and the generalizability of results. Treatment and control or comparison groups will be used, and appropriate methods will be used to account and control for confounding variables. The evaluation design and interpretation of findings will include triangulation of various analyses, wherein conclusions are informed by all results with a full explanation of the analytic limitations and differences.

B. Additional Data

CMS is exploring availability of additional state data from a comparable state to be used for comparison. If these data become available, the evaluation team will work with CMS to include these data in the evaluation.

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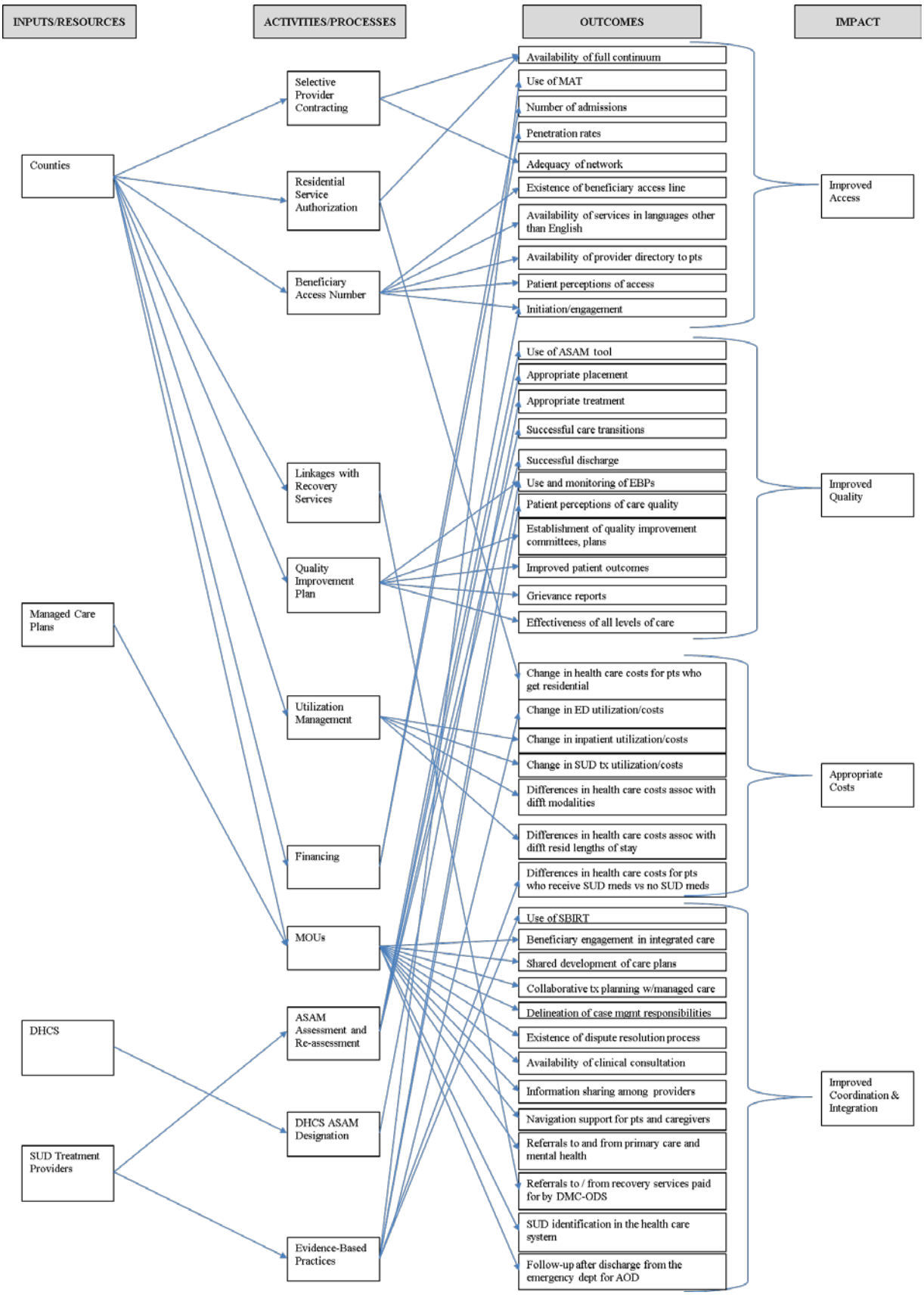
Appendices

Appendix A: Logic Model



Appendix B: Data Sources by domain

ACCESS	QUALITY	COORDINATION /INTEGRATION	COST
Administrative Data Sources			
CalOMS-Tx ● Availability and use of required continuum of care ● Use of medication assisted treatment ● Number of admissions ● Statewide penetration rates ● Maximum utilization (see also DMC Claims)	**CalOMS-Tx** ● Successful care transitions ● Successful discharge vs. discharges against medical advice ● Patient AOD use ● Patient social support ● Patient living arrangements ● Patient employment	**CalOMS-Tx** ● Referrals to and from primary care and mental health (also using DMC billing data)	
Drug Medi-Cal Claims ● Use of medication assisted treatment (also see CalOMS-Tx) ● Number of admissions (also see CalOMS-Tx) ● Maximum utilization (also see CalOMS-Tx)		**Drug Medi-Cal Claims** ● Referrals to and from recovery services paid for by the DMC-ODS	**Drug Medi-Cal Claims** ● SUD treatment utilization and costs
DATAR ● Capacity in state-licensed residential treatment, withdrawal management, and NTP			
	OSHPD ● Chemical Dependency Recovery Hospitals and		

	freestanding psych (in conjunction with Medi-Cal claims, or surveys as necessary)		
Medi-Cal Claims ● # admissions, # patients receiving MAT, telehealth billing, use of other services (ER, hospital inpatient days, MH)	**Medi-Cal Claims** ● ER and psychiatric emergency visits; hospital inpatient days		**Medi-Cal Claims** ● Health care utilization and costs
NSDUH ● Prevalence of dependence			
MEDS ● Average distance to provider (using patient address information)			
Prime ● Average distance to provider (see MEDS)			
New Data Collection			
Stakeholder Surveys and/or Interviews	**Stakeholder Surveys and/or Interviews**	**Stakeholder Surveys and/or Interviews**	
	Patient Surveys ● Care transition experiences ● Patient perceptions of care ● Social support (see CalOMS-Tx) ● Living arrangements (see CalOMS-Tx) ● Quality of life/functioning	**Patient Surveys** ● Patient perceptions of coordinated care	

ASAM Data ● Level of care indicated and actual placed level of care	**ASAM Data** ● Appropriate placement		
	DHCS Audits ● Appropriate treatment consistent with level of care after placement		
Document Review ● Existence of a 24/7 functioning beneficiary access number ● Existence of a 24/7 functioning beneficiary access number in languages other than English ● Availability of services in language other than English ● Availability of provider directory to patients	**Document Review** ● Grievance reports	**Document Review** ● Existence of required MOUs	
Participant Observation ● Availability of first appointments ● Time on hold			

Appendix C: DMC-ODS Waiver Evaluation Activities Timeline

Planned Activities by County Stage of Waiver Implementation
(Analysis dependent on implementation stage)

	Pre-Implementation Plan Approval	Upon Implementation Plan Approval (0-12 months)	Annual Follow-ups
Administrative Data:			
CalOMS-Tx	X	X	X
DATAR	X	X	X
OSHPD	X	X	X
MEDS	X	X	X
Medi-Cal/Drug Medi-Cal Claims	X	X	X
NSDUH	X	X	X
Prime	X	X	X
New Data Collection:			
ASAM Criteria Data		X	X
UCLA Treatment Provider Survey		X	X[1]
UCLA Patient Survey		X	X
Stakeholder Interviews		X	X

X = Activity to occur at least one time during stage

X[1] = Treatment Provider Surveys will be conducted every two years after the initial round.

Planned Activities by Waiver Demonstration Year

(Analysis NOT dependent on implementation stage)

	Year 1	Year 2	Year 3	Year 4	Year 5
New Data Collection:					
UCLA County Administrator Survey	X	X	X	X	X
UCLA Managed Care Plan Survey	X	X	X	X	X
County/DHCS Audit	X	X	X	X	X

X = Activity to occur at least one time during year period

DHCS California Department of HealthCareServices

ADULT SURVEY
Spring 2015

ENGLISH
Without QOL

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you receive. **For each survey item below, please fill in the circle that corresponds to your choice. Please fill in the circle completely.** *EXAMPLE:* Correct ● Incorrect ✖ ✔

MHSIP Consumer Survey*:

Please answer the following questions based on the **LAST 6 MONTHS** OR if you have not received services for 6 months, just give answers based on the services you have received so far. Indicate if you **Strongly Agree**, **Agree**, are **Neutral**, **Disagree**, or **Strongly Disagree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply to you.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	O	O	O	O	O	O
2. If I had other choices, I would still get services from this agency.	O	O	O	O	O	O
3. I would recommend this agency to a friend or family member.	O	O	O	O	O	O
4. The location of services was convenient (parking, public transportation, distance, etc).	O	O	O	O	O	O
5. Staff were willing to see me as often as I felt it was necessary.	O	O	O	O	O	O
6. Staff returned my calls within 24 hours.	O	O	O	O	O	O
7. Services were available at times that were good for me.	O	O	O	O	O	O
8. I was able to get all the services I thought I needed.	O	O	O	O	O	O
9. I was able to see a psychiatrist when I wanted to.	O	O	O	O	O	O
10. Staff here believe that I can grow, change and recover.	O	O	O	O	O	O
11. I felt comfortable asking questions about my treatment and medication.	O	O	O	O	O	O
12. I felt free to complain.	O	O	O	O	O	O
13. I was given information about my rights.	O	O	O	O	O	O
14. Staff encouraged me to take responsibility for how I live my life.	O	O	O	O	O	O
15. Staff told me what side effects to watch out for.	O	O	O	O	O	O
16. Staff respected my wishes about who is, and who is not to be given information about my treatment.	O	O	O	O	O	O
17. I, not staff, decided my treatment goals.	O	O	O	O	O	O
18. Staff were sensitive to my cultural background (race, religion, language, etc).	O	O	O	O	O	O
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	O	O	O	O	O	O
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	O	O	O	O	O	O

As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I deal more effectively with daily problems.	O	O	O	O	O	O
22. I am better able to control my life.	O	O	O	O	O	O

*The MHSIP Consumer Survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

CONTINUED ON NEXT PAGE...

CSI County Client Number
Must be entered on EVERY page

ENGLISH
Without QOL

As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
23. I am better able to deal with crisis.	O	O	O	O	O	O
24. I am getting along better with my family.	O	O	O	O	O	O
25. I do better in social situations.	O	O	O	O	O	O
26. I do better in school and /or work.	O	O	O	O	O	O
27. My housing situation has improved.	O	O	O	O	O	O
28. My symptoms are not bothering me as much.	O	O	O	O	O	O
29. I do things that are more meaningful to me.	O	O	O	O	O	O
30. I am better able to take care of my needs.	O	O	O	O	O	O
31. I am better able to handle things when they go wrong.	O	O	O	O	O	O
32. I am better able to do things that I want to do.	O	O	O	O	O	O

For Questions #33-36, please answer for relationships with persons other than your mental health provider(s). As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
33. I am happy with the friendships I have.	O	O	O	O	O	O
34. I have people with whom I can do enjoyable things.	O	O	O	O	O	O
35. I feel I belong in my community.	O	O	O	O	O	O
36. In a crisis, I would have the support I need from family or friends.	O	O	O	O	O	O

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CSI County Client Number
Must be entered on EVERY page

20612

Please answer the following questions to let us know how you are doing.

1. **Approximately, how long have you received services here?**
   - O This is my first visit here.
   - O I have had more than one visit but I have received services for less than one month.
   - O 1 - 2 Months
   - O 3 - 5 Months
   - O 6 months to 1 year
   - O More than 1 year

Please answer Questions #2 - 4, below, if you have been receiving services for ONE YEAR OR LESS. If you have been receiving services for "MORE THAN ONE YEAR," please SKIP to Questions #5.

2. **Were you arrested since you began to receive mental health services?** O Yes O No
3. **Were you arrested during the 12 months prior to that?** O Yes O No
4. **Since you began to receive mental health services, have your encounters with the police . . .**
   - O been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program)
   - O stayed the same
   - O increased
   - O not applicable (I had no police encounters this year or last year)

SKIP to Question #8, below

Please answer Questions #5 - 7 only if you have been receiving mental health services for "MORE THAN ONE YEAR."

5. **Were you arrested during the last 12 months?** O Yes O No
6. **Were you arrested during the 12 months prior to that?** O Yes O No
7. **Over the last year, have your encounters with the police . . .**
   - O been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program)
   - O stayed the same
   - O increased
   - O not applicable (I had no police encounters this year or last year)

Please answer the following questions to let us know a little about you.

8. **What is your gender?** O Female O Male O Other
9. **Are you of Mexican / Hispanic / Latino origin?** O Yes O No O Unknown
10. **What is your race? (Please mark all that apply.)**
    - O American Indian / Alaskan Native
    - O Asian
    - O Black / African American
    - O Native Hawaiian / Other Pacific Islander
    - O White / Caucasian
    - O Other
    - O Unknown

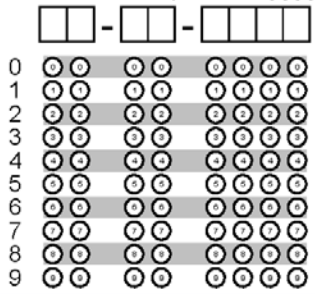
CONTINUED ON NEXT PAGE...

CSI County Client Number
****Must be entered on EVERY page****

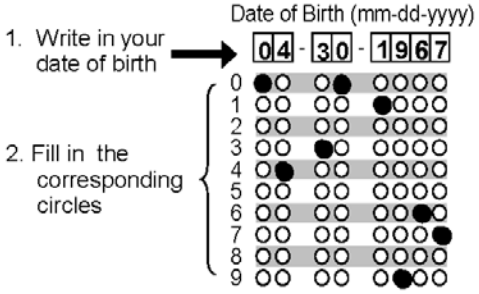
20612

11. What is your date of birth? (Write it in the boxes AND fill in the circles that correspond. See Example.)

Date of Birth (mm-dd-yyyy)



EXAMPLE: Date of birth on April 30, 1967:



12. Were the services you received provided in the language you prefer? O Yes O No

13. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer? O Yes O No

14. What was the primary reason you became involved with this program? (Mark one):

O I decided to come in on my own.
O Someone else recommended that I come in.
O I came in against my will.

15. Please identify who helped you complete any part of this survey (Mark all that apply):

O I did not need any help.
O A professional interviewer helped me.
O A mental health advocate / volunteer helped me.
O My clinician / case manager helped me.
O Another mental health consumer helped me.
O A staff member other than my clinician or case manager helped me.
O A member of my family helped me.
O Someone else helped me. Who?: _____

16. Please provide comments here and /or on the back of this form, if needed. We are interested in both positive and negative feedback. Also, if there are areas which were not covered by this questionnaire which you feel should have been, please write them here. Thank you for your time and cooperation in completing this questionnaire.

Thank you for taking the time to answer these questions!

FOR OFFICE USE ONLY:

REQUIRED Information:

County Code: ☐☐

Date of Survey Administration: 05 - ☐☐ - 2015

Reason (if applicable):

O Ref O Imp O Lan O Oth

Make sure the same CSI County Client Number is written on all pages of this survey.

☐☐☐☐☐☐☐☐☐☐

CSI County Client Number
****Must be entered on EVERY page****

Optional County Questions:

County Question #1 (mark only ONE bubble):

O 01 O 02 O 03 O 04 O 05 O 06 O 07 O 08 O 09 O 10
O 11 O 12 O 13 O 14 O 15 O 16 O 17 O 18 O 19 O 20

County Question #2 (mark only ONE bubble):

O 01 O 02 O 03 O 04 O 05 O 06 O 07 O 08 O 09 O 10
O 11 O 12 O 13 O 14 O 15 O 16 O 17 O 18 O 19 O 20

County Question #3 (mark only ONE bubble):

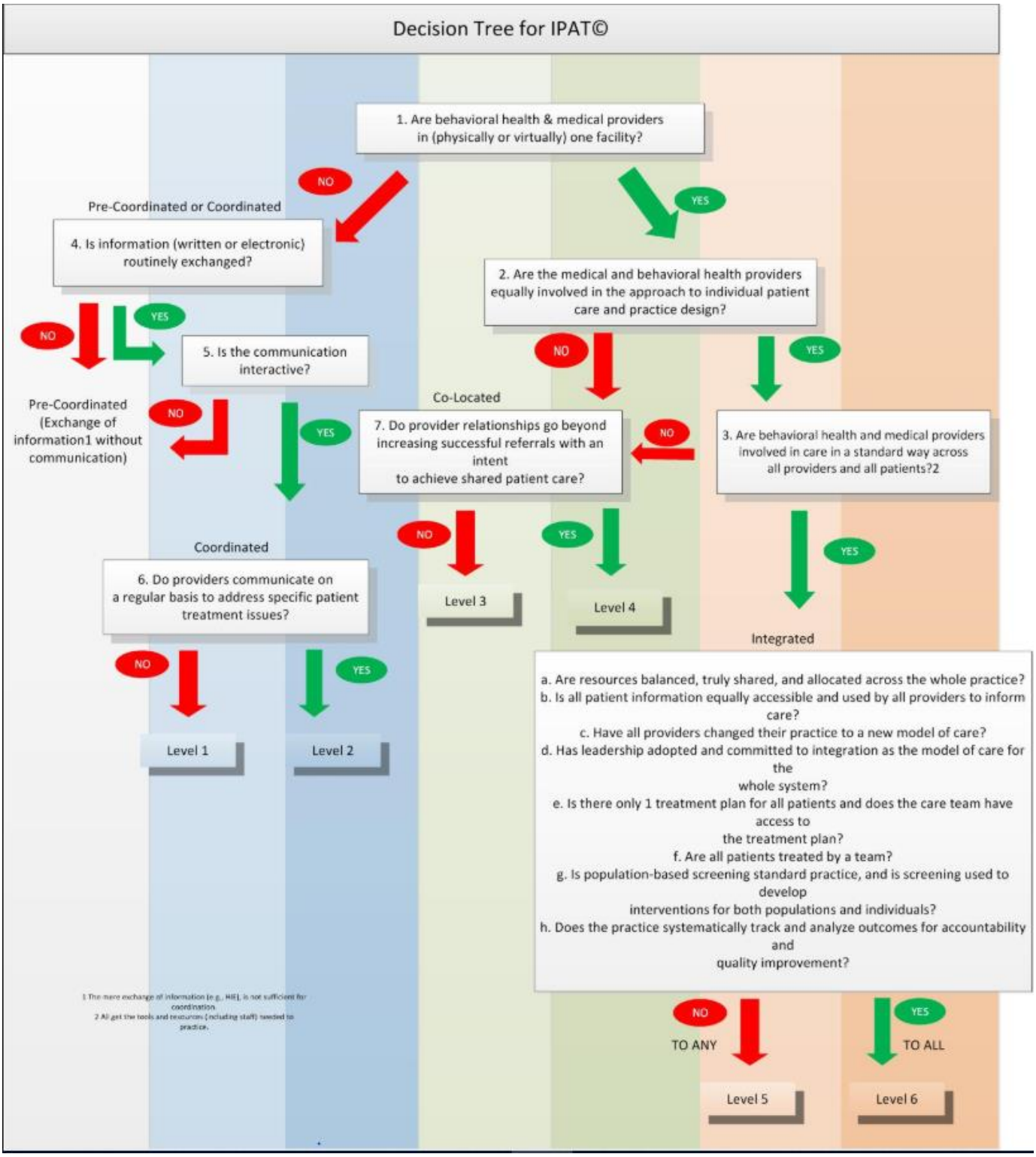
O 01 O 02 O 03 O 04 O 05 O 06 O 07 O 08 O 09 O 10
O 11 O 12 O 13 O 14 O 15 O 16 O 17 O 18 O 19 O 20

County Reporting Unit: ☐☐☐☐☐☐☐☐

20612

Appendix C:

IPAT Questions and Decision Tree



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

Appendix D:

Treatment Perceptions Survey (TPS) Report

Treatment Perceptions Survey

Statewide 2018 Report

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

	Number of Respondents	Percent	County Response Rates
First Wave			
Contra Costa	759	8.2%	73.2%
Los Angeles	4,978	52.3%	88.6%
Marin	229	2.4%	76.8%
Riverside	728	7.7%	31.3%
San Francisco	1,848	19.4%	82.5%
San Mateo	408	4.3%	100%
Santa Clara	562	5.9%	66.9%
Total	9,512	100.0%	74.6%
Second Wave			
Alameda	990	15.8%	48.1%
Imperial	346	5.4%	88.0%
Monterey	210	3.3%	52.1%
Napa	46	0.7%	100.0%
Nevada	108	1.7%	55.4%
Orange	944	14.8%	55.6%
San Bernardino	650	10.2%	38.1%
San Diego	1,744	27.3%	50.4%
San Joaquin	576	9.0%	30.2%
San Luis Obispo	317	5.0%	47.1%
Santa Cruz	239	3.7%	38.7%
Yolo	223	3.5%	86.4%
Total	6,393	100.0%	47.7%

Table 2. Survey Responses by Treatment Program and Wave

Adults

	First Wave		Second Wave		Total	
	N	**Percent**	**N**	**Percent**	**N**	**Percent**
Treatment Program*						
Outpatient/intensive outpatient	156	44.7%	102	49.0%	258	46.3%
Residential	116	33.2%	55	26.4%	171	30.7%
Opioid/narcotic treatment program	59	16.9%	44	21.2%	103	18.5%
Withdrawal management (standalone)	16	4.6%	7	3.4%	23	4.1%
Other/missing	2	0.6%	–	–	2	40.0%
Total	349	100.0%	208	100.0%	557	100.0%
Number of respondents						
Outpatient/intensive outpatient	3,073	33.7%	2,702	44.0%	5,775	37.8%
Residential	2,185	23.9%	1,151	18.8%	3,336	21.9%
Opioid/narcotic treatment program	3,674	40.3%	2,205	35.9%	5,879	38.5%
Withdrawal management (standalone)	160	1.8%	78	1.3%	238	1.6%
Other/missing	31	0.3%	–	–	31	0.2%
Total	9,123	100.0%	6,136	100.0%	15,259	100.0%

Youth

	First Wave		Second Wave		Total	
	N	**Percent**	**N**	**Percent**	**N**	**Percent**
Treatment Program*						
Outpatient/intensive outpatient/partial hospitalization	51	87.9%	33	91.7%	84	89.4%
Residential	7	12.1%	3	8.3%	10	10.6%
Total	58	100.0%	36	100.0%	94	100.0%
Number of respondents						
Outpatient/intensive outpatient/partial hospitalization	350	90.0%	259	92.5%	609	91.0%
Residential	39	10.0%	21	7.5%	60	9.0%
Total	389	100.0%	280	100.0%	669	100.0%

*In this report, the term "treatment program" is defined as a unit having a unique combination of CalOMS-Tx Provider ID and treatment setting and/or Program Reporting Unit ID (if required by the county) as indicated on the survey forms or in the data file submitted to UCLA.

Table 3. Demographic Characteristics by Wave –Adults (N=15,259)

	First Wave		Second Wave		Total	
	N	Percent	N	Percent	N	Percent
Gender (Multiple responses allowed)						
Female	3,319	36.4%	2,423	39.5%	5,742	37.6%
Male	5,226	57.3%	3,412	55.6%	8,638	56.6%
Transgender	57	0.6%	30	0.5%	87	0.6%
Other gender Identity	48	0.5%	22	0.4%	70	0.5%
Decline to answer/missing	525	5.8%	275	4.5%	800	5.2%
Age Group						
18-25	767	8.4%	612	10.0%	1,379	9.0%
26-35	2,669	29.3%	1,768	28.8%	4,437	29.1%
36-45	1,931	21.2%	1,447	23.6%	3,378	22.1%
46-55	1,605	17.6%	1,137	18.5%	2,742	18.0%
56+	1,548	17.0%	862	14.1%	2,410	15.8%
Missing	603	6.6%	310	5.1%	913	6.0%
Race/ethnicity (Multiple responses allowed)						
American Indian/Alaska Native	461	5.1%	267	4.4%	728	4.8%
Asian	222	2.4%	142	2.3%	364	2.4%
Black/African American	1,456	16.0%	787	12.9%	2,243	14.7%
Latino	2,970	32.6%	1,989	32.4%	4,959	32.5%
Native Hawaiian/Pacific Islander	158	1.7%	96	1.6%	254	1.7%
White	3,474	38.1%	2,725	44.4%	6,199	40.6%
Other	804	8.8%	447	7.3%	1,251	8.2%
Missing	544	6.0%	292	4.8%	836	5.5%
How long received services here						
First visit/day	467	5.1%	349	5.7%	816	5.3%
2 weeks or less	826	9.1%	646	10.5%	1,472	10.0%
More than 2 weeks	7,433	81.5%	4,961	80.9%	12,394	84.4%
Missing	397	4.4%	180	2.9%	577	3.8%
Surveys received by language						
English	8,811	96.6%	5,963	97.2%	14,774	96.8%
Spanish	311	3.4%	172	2.8%	483	3.2%

Table 4. Demographic Characteristics by Wave—Youth (N = 669)

	First Wave		Second Wave		Total	
	N	Percent	N	Percent	N	Percent
Gender (Multiple responses allowed)						
Female	84	21.6%	79	28.2%	163	24.4%
Male	202	51.9%	188	67.1%	390	58.3%
Transgender	19	9.4%	–	—	19	2.8%
Other gender Identity	60	15.4%	1	0.4%	61	9.1%
Decline to answer/missing	19	4.9%	14	5.0%	33	4.9%
Age Group						
12	1	0.3%	1	0.4%	2	0.3%
13	12	3.1%	5	1.8%	17	2.5%
14	30	7.7%	16	5.7%	46	6.9%
15	64	16.5%	56	20.0%	120	17.9%
16	113	29.0%	74	26.4%	187	28.0%
17-18	137	35.2%	104	37.1%	241	36.0%
Missing	32	8.3%	24	8.6%	56	8.4%
Race/ethnicity (Multiple responses allowed)						
American Indian/Alaska Native	11	2.8%	8	2.9%	19	2.8%
Asian	20	5.1%	14	5.0%	34	5.1%
Black/African American	89	22.9%	18	6.4%	107	16.0%
Latino	227	58.4%	170	60.7%	397	59.3%
Native Hawaiian/Pacific Islander	11	2.8%	2	0.7%	13	1.9%
White	46	11.8%	56	20.0%	102	15.3%
Other	21	5.4%	14	5.0%	35	5.2%
Missing	26	6.7%	27	9.6%	53	7.9%
How long received services here						
Less than 1 month	105	27.0%	98	35.0%	203	30.3%
1-5 months	178	45.8%	119	42.5%	297	44.4%
6 months or more	84	21.6%	44	15.7%	128	19.3%
Missing	22	5.7%	19	6.8%	41	6.1%
Surveys received by language						
English	383	98.4%	277	98.9%	660	98.6%
Spanish	6	1.6%	3	1.9%	9	1.4%

Table 5. Average Score and Percent of Positive Scores by Treatment Setting and Wave –Adults

	First Wave	Second Wave	Total
Average score*			
(Standard deviation)			
Outpatient/intensive outpatient	4.5	4.4	4.5
	(0.6)	(0.6)	(0.6)
Residential	4.3	4.3	4.3
	(0.7)	(0.7)	(0.7)
Opioid/narcotic treatment program	4.4	4.4	4.4
	(0.6)	(0.6)	(0.6)
Withdrawal management (standalone)	4.5	4.3	4.5
	(0.5)	(0.7)	(0.6)
Total	4.4	4.4	4.4
	(0.6)	(0.7)	(0.6)
Percent of respondents with positive score**			
Outpatient/intensive outpatient	94.3%	93.5%	93.9%
Residential	89.9%	87.9%	89.2%
Opioid/narcotic treatment program	93.6%	94.7%	94.0%
Withdrawal management (standalone)	97.8%	88.4%	94.7%
Total	93.9%	91.1%	92.9%

*All 14 questions were used to calculate the overall average scores and standard deviation. Scores ranged from 1.0 to 5.0 with higher scores indicating greater satisfaction. Only respondent who answered all 14 questions were included (N=13,797)

**Overall positive scores was calculated using all 14 questions. Survey with an overall average score of 3.5 or higher were counted as having a POSITVE score. Only respondents who answered all 14 questions were included (N=13,797)

Table 6. Average Score for Perception of Care by Treatment Setting—Youth

	First Wave	Second Wave	Total
Average score*			
(Standard deviation)			
Outpatient/intensive outpatient/partial hospitalization	4.2	4.2	4.2
	(0.6)	(0.6)	(0.6)
Residential	4.1	3.6	3.9
	(0.7)	(0.7)	(0.7)
Total	4.2	4.2	4.2
	(0.6)	(0.6)	(0.6)
Percent of respondents with positive score**			
Outpatient/intensive outpatient/partial hospitalization	85.3%	87.6%	86.3%
Residential	88.2%	55.6%	76.9%
Total	85.6%	85.3%	85.5%

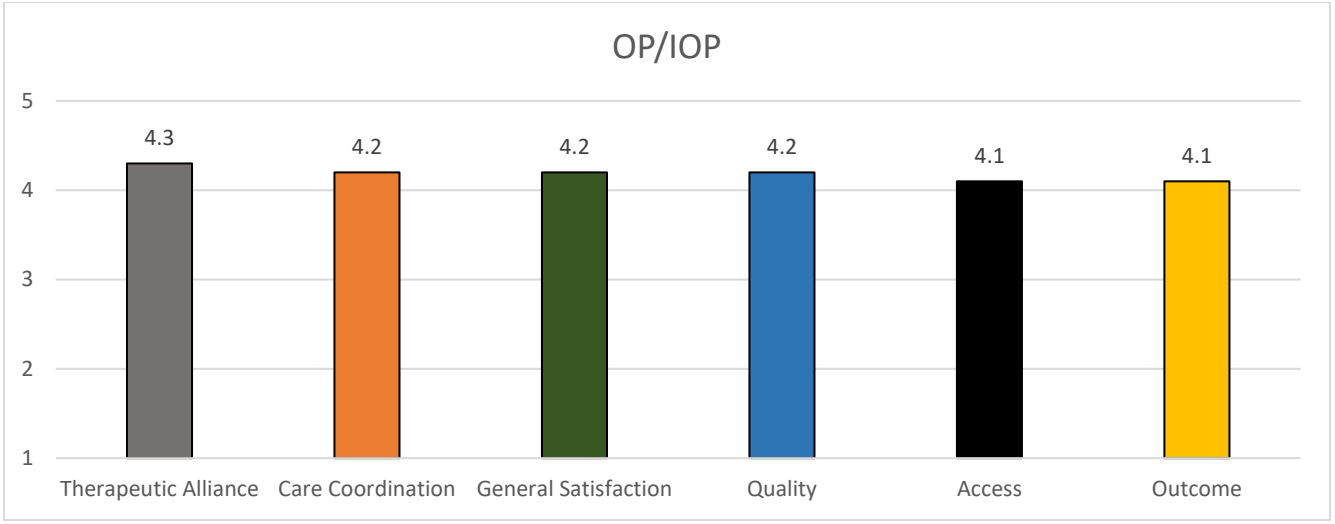
*All 18 questions were used to calculate the average score (and standard deviation). Scores ranged from 1.5 to 5.0 with higher scores indicating greater satisfaction. Only clients who responded to all 18 questions were included (N=592).

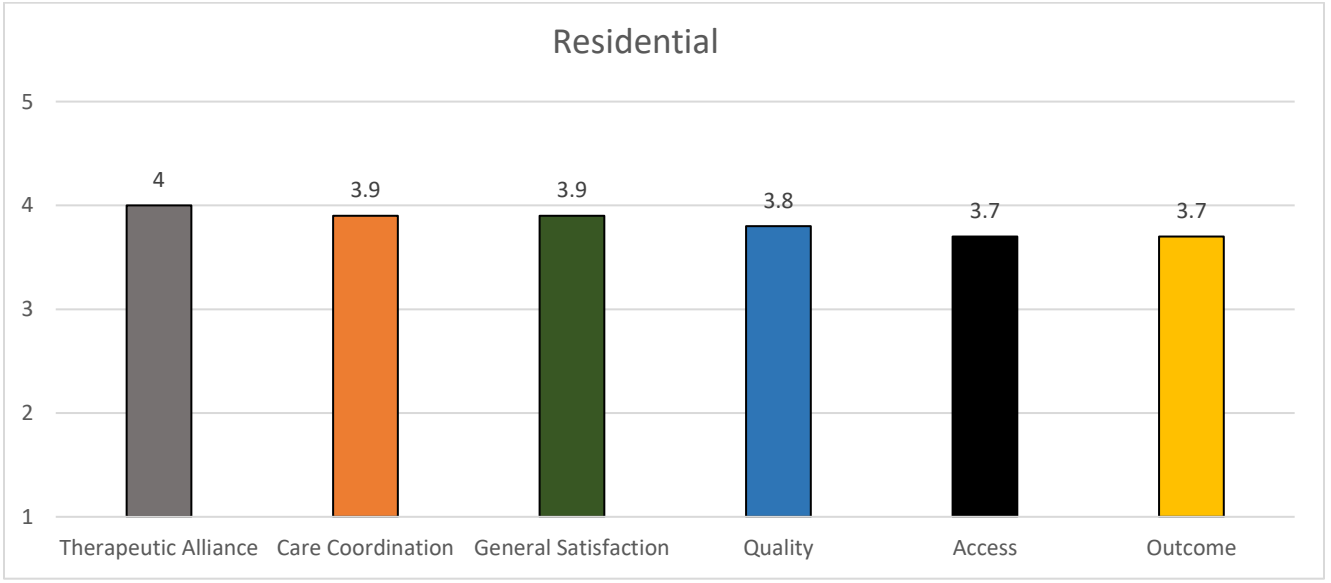
**Overall positive rating was calculated using all 18 questions. Surveys with an average rating of 3.5 or higher were counted as having a POSITIVE rating. Only clients who responded to all 14 questions were included (N=592).

Figure 1. Average Scores of All Counties by Treatment Setting and Domain—Adults

(Highest to Lowest)

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





Appendix E:

E1• PSS Role and Duty Statement Substance Abuse & Forensics Programs

E2• SAPT Peer Support Specialist Workflow

E3• SUD Peer Support Training Plan (March 2017)

Riverside University HEALTH SYSTEM Behavioral Health

PSS Role and Duty Statement Substance Abuse & Forensics Programs

The Peer Support Specialist (PSS) works as a member of the clinic/program team. The PSS brings unique experiences and perspective as a consumer, and someone in recovery themselves. This Peer assists the team in the development and provision of culturally competent and recovery oriented behavioral health/substance abuse services. The Peer Support Specialist contributes their personal experience, appropriate self disclosure and empathy to outreach, network, support and engage with consumers of the agency.

The Peer Support Specialist also adds the consumer experience and perspective to the development of programming, service delivery, formulation of treatment strategies, review of program efficacy and recovery planning. The experience of having "walked the same path" as other consumers while partnering with staff, enriches the culture of the agency and improves program effectiveness.

DUTY STATEMENT: The role of the Peer Support Specialist is to provide any of the following services:

1. Assist clinics/programs in providing a welcoming environment that reflects cultural/ethnic awareness and sensitivity
    a. Provide input regarding the lobby, group rooms and any other areas utilized by consumers, to assure that these areas are free from barriers to service/recovery
    b. Welcome/greet consumers in lobby or welcoming center
    c. Follow up with new consumers (face to face or by phone) within the first 30 days of services, to encourage consumer's active participation in their individual recovery and to identify and resolve barriers to treatment and services

2. Work both individually or in groups to promote awareness and help consumers link/access regarding:
    a. Community resources
    b. County services
    c. Recovery and wellness concepts and principles
    d. Educational opportunities
    e. Vocational services, supports and job opportunities
    f. Co-occurring disorders and dual recovery options
    g. How to avoid re-hospitalization
    h. Accessing Interpretation/translation services
    i. Achieve long term abstinence/recovery

3. Assist consumers in learning skills and activities around daily living
    a. Assist consumers with shopping budget, accompany on shopping trips to assist consumers in identifying and developing related life and problem-solving skills
    b. Assist consumers in learning how to use a bus schedule, accompany them on the bus, in order to model and support confidence building and life skills
    c. Supply consumers with information on health and nutrition and encourage clients to take care of themselves physically and medically, including exploring options and choices for medical care
    d. Financial planning: assist consumer to identify and develop life skills and problem-solving skills related to money management, paying bills, bank accounts, etc.
    e. Assist consumers in learning how to maintain their living environment

4. Outreach to unengaged consumers, face-to-face or by phone
    a. Visit clinic/program consumers in hospital
    b. Visit new consumers in hospital and link to outpatient program
    c. Visit and support consumers in the IMDs
    d. Contact/visit consumers in shelters (e.g. The Place)
    e. Contact consumers who have missed MD appointments
    f. Contact consumers who have been referred, to encourage them to seek help
    g. Contact new consumers to follow up services within 30 days
    h. Engage homeless consumers with outreach team
    i. Present information about mental health services/recovery in the community (Churches, senior centers, community centers, hospitals, health fairs, jails, Mental Health Court, educational system, etc.)

5. Assist consumers in navigating the system of care
    a. Facilitate/participate in new client orientation
    b. Assist consumers to understand the system and help them reduce barriers accessing services
    c. Provide information and help link consumers to county services
    d. Follow up with new consumers (face-to-face or by phone) within the first 30 days of service

6. Assist and promote consumers in engaging in supportive networks and activities outside the mental health system.
    a. Provide information about 12 step groups, support groups, free or low cost counseling and community activities, etc.
    b. Attend 12 step groups, support groups and community activities with clients

7. Facilitate peer self help/recovery groups (e.g. WRAP and FACING UP)
    a. Outreach to and support members of self help/recovery groups
    b. Call to remind consumers about group
    c. Call/contact members who miss groups
    d. Assist in skill building
    e. Managing big feelings
    f. Coping with difficult side effects
    g. Problem solving
    h. Improve daily living skills

8. Refer consumer to a licensed clinician/Drug & Alcohol Counselor whenever imminent risk, danger or abuse is suspected by the Peer Specialist or reported by others. These situations include but are not limited to:
    a. Threats to harm identified victims (Tarasoff situations)
    b. Suspicion of being dangerous to self (including suicidal thoughts), danger to others, or grave disability (5150 criteria)
    c. Elder or dependent adult abuse, neglect or exploitations
    d. Child abuse or neglect
    e. Patient abuse or violations of patient's rights
    f. Adverse incident reporting (Department Policy #248)

9. Communicate, represent and promote consumer/recovery perspective
    a. Present information on recovery to co-workers (e.g. Keeping Recovery Skills Alive)
    b. Share the consumer perspective during member conferences, staff meetings, supervision and training. Clarify client choices and recovery values
    c. Share personal recovery story (one on one or in a group) to accomplish the duties of this position
    d. Collaborate with staff to improve recovery practices in all levels of service
    e. Value and respect the opinions of others, meeting each individual where they are

10. Attend and participate in special events, conferences, workshops and trainings with the behavioral health system and in the community
    a. Attend Monthly Peer Training and Support meetings
    b. May is Mental Health Month Events
    c. Recovery Happens Events

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11. Facilitate communication between staff and the consumer to further their engagement in services and to promote recovery

12. Document services provided on time and in a manner that complies with county policies, State and Federal regulations

13. Assist and support consumers in crisis, especially to promote hope and minimize severity of relapse

14. Assist consumers with individual recovery planning (e.g. WRAP)

15. Provide emotional support to consumers who need an advocate at community appointments.
    a. Assist consumer in developing self-advocacy skills

16. Comply with State and Federal confidentiality regulations, mandated reporting laws and county policies.

17. Maintain ethical and professional standards, including the separation of personal recovery issues from the consumer's recovery

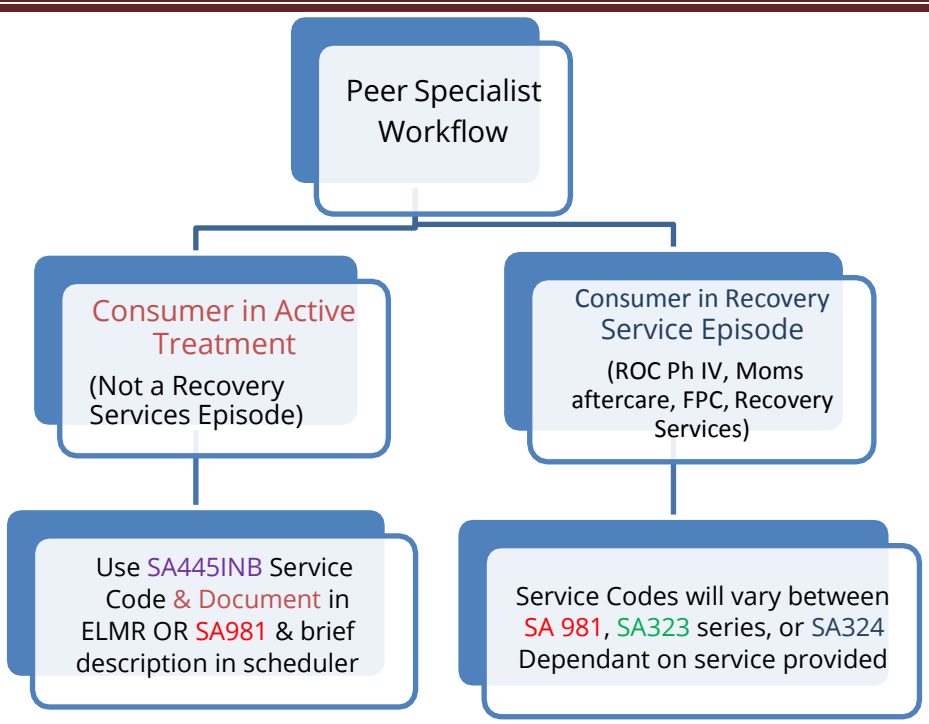
18. Actively seek supervision/consultation weekly or as needed
    a. With clinic/program supervisor
    b. With Senior Peer Support Specialist
    c. With Peer Policy and Planning Specialist as needed

19. Validate the experience of the consumer while modeling and promoting recovery

20. Utilize recovery/empowering language with staff and consumers

21. Other duties as assigned

SAPT Peer Support Specialist Workflow



Peer Individual Substance Abuse Assistance Services for Consumers in Recovery Services: (Service Code SA323 Series)

- Build mutual, empowering relationships with staff and consumers, sharing their personal recovery story, to build hope, encouragement, and rapport.
- Assist consumers with community linkage to 12 step groups (i.e. take to a 12 step group).
- Support and Assist/Model and Mentor Substance Abuse members in life skill building to avoid lapse/relapse, including exploring new hobbies, obtaining new relationships among their peers/support groups, gambling education etc. (i.e life skills of grocery shopping, housing, computer skills, GED/College enrollment, money management, impulse control, other solutions to Drugs/Alcohol use & Criminal behavior) explore barriers to recovery, making valued contributions to society, family reunification, and other goals the individual wants to work on in their recovery. Promoting socialization, recovery, self-sufficiency, self-advocacy, development & maintenance of skills learned in support services.
- Support and assist members in getting to needed appointments, (i.e. Physician, lab work, CPS, DPSS, Probation, Court, etc) including mentorship, role modeling and moral support.
- Reduce stigma of Behavioral Health challenges by providing education to consumers and families.
- Support and assist members to an inpatient setting, if a higher level of care is agreed upon.
- Provide individualized support, coaching, facilitation and education to the people we serve.
- Follow up with consumers after completion to capture outcomes (30/60/90 days and 6/9/12 months)

Peer Group Substance Abuse Assistance for Consumers in Recovery Services: (Service Code SA324 Series)

- Facilitate Facing Up to Whole Health, WRAP Group, Substance Abuse Education, Co-Practitioner in Seeking Safety, and other Groups pertaining to the individual's treatment with Behavioral Health.

Peer Individual Substance Abuse Assistance for Consumers in Active Treatment Modality (Service Code SA445INB)

- Any individual service provided to the consumer while in IOT/OT/CCT modality. Documentation required for staff time accounting (direct time) and to capture ALL the services being provided to the individual.

Peer Group Substance Abuse Assistance for Consumers in Active Treatment Modality (Service Code SA981)

- Facilitate Orientation Group, Re-engagement Group, or give Peer Perspective in IOT/OT Groups

SUD Peer Support Training Plan

A Response to the Department of Health Care Services

RUHS BH Substance Abuse Prevention and Treatment Program

March 2017

1. Consumer Plan Development, Documentation, Supervision, and Oversight:

A. How SUD peer support services are provided within the context of a comprehensive, individualized client plan that includes specific goals. The amount, duration, and scope of the services must be specified in the client's plan.

Treatment Plans (TXP) are developed to meet the needs of each individual seeking services in RUHS – Behavioral Health clinics and programs by LPHA or AOD staff. These TXP's are individualized with the goals of the client. PSS help support those goals by engaging in a system of mutual learning founded on the key principles of respect, shared responsibility, and mutual agreements of what is helpful. This includes therapeutic interactions between people who have a shared lived experience of the impact of substance abuse and behavioral health challenges. Each TXP details the challenge each person is working on, staff role, client role, and family role (if available) utilizing goals which are specific, measureable, attainable, realistic, and time-bound (SMART). Below is an example of a TXP goal for SUD Peer Support Services.

Example Problem Area: *Client will attend groups and individual sessions with a Peer Support Specialist to understand relapse prevention support strategies to use in ongoing recovery.*
Example Goal: *Client will develop self-regulation skills to identify triggers to relapse and develop strengths to continue in a life of sobriety.*
Example Action Step: *PSS and consumer will engage in linkage activities to outside community resources for Recovery and work on development of shares strategies through group and individual interaction.*

B. Implementation of a person-centered treatment planning process to promote beneficiary participation in the development and implementation of the client plan.

RUHS – Behavioral Health provides person-centered treatment services which includes treatment planning. Clients are involved in their treatment planning from intake through discharge. Treatment plans are developed in order to meet each client's unique individual needs. Each TXP are signed by the both the client and the provider indicating that both parties were involved in the development of the goals and are willing to work collaboratively on the recovery plan.

C. Peer support staff actively engages and empowers the beneficiary, and/or individuals selected by the beneficiary, in leading and directing the design of the client plan, ensuring that the plan reflects the needs and preferences of the beneficiary in achieving specific, individualized goals that have measurable results.

Collaboration between the client and the PSS are essential in the development and implementation of each client's TXP. The TXP can be directly tied to the needs assessment of each client. The mutual relationship between the PSS and the client allows for personal accountability on the part of the client as well as the PSS. The PSS role assists in modeling personal responsibility and recovery.

D. The supervision provided to SUD peer support staff

Peer Support Specialists (PSS) are jointly supervised and mentored by Senior Peer Support Specialists (SPSS) and SAPT Clinic Program Supervisors. Professional development, client interactions, documentation, and the provision of direct services is the primary objective of supervision and mentorship. SPSS are Peer Support Specialists who have shown exemplary skills at delivering person-centered services for a minimum of two years in clinics and program throughout Riverside County. SPSS are supervised by executive management and are kept up to date on the latest treatment implementations through ongoing training provided by the Workforce and Education Team. Supervisor provides feedback on performance, including attendance, productivity, and the needs of the program. The SPSS provides support and empowerment to help meet the program needs including, group facilitation skills, client interactions, building working relationships, and individualized consultation with each PSS to assist in professional development. Consultation generally occurs on a weekly basis with both Supervisor and SPSS.

2. Training and Designation:

A. Describe the county's process to ensure SUD peer support staff complete training and receive a county SUD Peer Support designation.

Peer Support Specialists attend and graduate from an intensive two-week (76-hour) interactive Certified Peer Support Specialist Training (CPSST) which focuses on the following competencies: ***1)*** *Developing peer support skills for use in the workplace,* ***2)*** *The exploration and development of personal recovery, and* ***3)*** *Supporting individuals in recognizing their strengths, responsibilities and accountability as certified peers. The training includes training in recovery and peer support principles, communications skills, cultural diversity, ethics and boundaries, substance abuse, trauma and resilience, and conflict resolution. The curriculum was developed by META Services, Inc. and is facilitated by RI*

International, Inc. through a contract with RUHS – Behavioral Health. These trainings are held six times a year. The curriculum is competency based, meaning that students will have ample opportunity to demonstrate their proficiency in the skills learned through role-play and evaluation. A certificate is issued upon completion of the course. Training prerequisites include a High School Diploma or GED equivalent, and lived experience with recovery.

All individuals hired to work as Peer Support Specialists are required to attend and successfully complete the CPSST prior to the delivery of services. The State of California does not require certification for Peer Support Specialists. At this time, there is no requirement for continued education. However, RUHS – Behavioral Health maintains ongoing training through monthly Peer Support Meetings. Information delivered in these meetings includes; the use of reflective listing skills, responding to crisis, building hopeful environments, using empathy, facilitation skills, recognizing recovery, boundaries and ethics, building self-esteem, spirituality, sharing the "peer perspective", and much more.

B. Outline a methodology which assures that SUD peer support staff obtains a basic set of competencies necessary to perform and document the peer support function.

In addition to the CPSST, RUHS – Behavioral Health employees are required to complete agency mandated trainings within the first six months of hire; Employee Harassment Prevention; Electronic Media & Use; Information Security Training; Standards of Ethical Conduct to Address Fraud, Waste, & Abuse; and Compliance with HIPAA Requirements. Other agency mandated trainings include; Disability Awareness, Repetitive Motion Injury, and Employee Workplace Violence. All county employees, including PSS are eligible to complete trainings based on increasing and improving their skills in the delivery of services such as; Law, ethics, and boundaries; Mental Health 101; Understanding the DSM; Mental Health Risk Training; Non-violent crisis intervention; Recovery Practices in Leading and Coaching; Psychopharmacology; Advance Peer Practices; Group Facilitation Skills; Wellness Recovery Action Plan Facilitation; Recovery Coaching; Co-Occurring Life of Recovery; and Recovery Focused Service Delivery. PSS staff also completes documentation training designed to introduce staff to the electronic management of records system utilized throughout County clinics and programs. More intensive documentation training is provided one-on-one as the individual begins delivering services.

C. Describe the county's method to evaluate the peer's ability to support the recovery of beneficiaries from SUDs.

Peer Support Specialists are evaluated at six months from date of hire, and then at one year. Annual reviews occur to review each PSS for their performance based on productivity, attendance, and working relationships. Additionally, Sr. PSS staff will conduct focus groups with consumers and sit in on service delivery sessions on a periodic basis as a means to assess effectiveness of peer services delivered.

Appendix F:

F1• : Santa Clara County Recovery Services Brief Description

F2• Continuous Recovery Monitoring (CRM) Call Record

Modality	Recovery Services
ASAM level	NA
Population	Adult & Youth
IGA/DHCS Description	Recovery Services can be utilized when the beneficiary is triggered, when the beneficiary has relapsed or simply as a measure to prevent relapse. Services may include: • Group or individual counseling • Recovery monitoring • Substance abuse assistance • Education and job skills linkage • Family support • Support groups • Ancillary services such as housing assistance, transportation, case management and individual services coordination
SUTS description	This service is available only to clients who have successfully completed outpatient services or Additional Medication Assisted Therapy (MAT). Recovery Services shall be available for beneficiaries/clients who are in partial or full remission. Based on the individualized recovery plan, the beneficiary may receive a variety of services such as individual, group counseling, recovering monitoring and coaching, relapse prevention, education and job skills, family support, recovery case management, and other ancillary services.
Targeted case management	Recovery case management is similar to Targeted Case Management. Recovery case management involves linkage to medical, social, educational, vocational, rehabilitative, transportation or other community services for a beneficiary. Recovery case management follows the recovery plan in determining the beneficiary's need for communication, coordination and referrals for support activities and services that promote recovery and wellness. Recovery case management services are stated in the recovery plan and are provided under the direction of a LPHA. The primary counselor advocates for and monitors the beneficiaries progress of the linkages to physical and mental health care and other services, supporting and transitioning them to a higher or lower levels of care, as needed. Services can be face-to-face, telephone or telehealth, as long as the counselor is attached to a DHCS certified treatment site. Case

	management services can be offered in the community or at the licensed site. The beneficiary must meet medical necessity criteria every 6 months and the services must be tailored to client need.
EBPs	Required: At least 2 of the following per modality : Cognitive behavioral Therapy Motivational Interviewing Trauma-informed treatment Psycho-education Relapse Prevention Other services that may be provided as part of recovery services include: WRAP Telephone monitoring
Provider requirements	**Credentialed/registered providers under the direction of a LPHA**
Authorization	Not required
Admission requirements	Includes all paperwork & actions required to admit a client into tx: Verification of Medi-Cal eligibility Determination of payor Consents Client registration Verification of county residency (Note: services for clients from other waiver opt-in counties are not reimbursable. Providers need to contact the home county of the clients to transfer them.).
Intake definition	First face to face with counselor (same as outpatient)
Intake requirements	Establishment of medical necessity Establish remission risk Determine whether client wants Relapse Prevention, WRAP or telephone monitoring
Medical necessity for Recovery Services not met	Call QI for consultation
Move to another level of care	ALOC replaces CoC (Continuum of Care form). If ALOC indicates a higher level of care, client should be transferred to the indicated level of care.
CalOMS	Not required

CalOMS admission form completion	**Not applicable**
Billable services	43300 – Recovery Case Management SUTS 43310 – Recovery Monitoring SUTS 43340 – Recovery Individual Counseling SUTS 43350 – Recovery Group Counseling SUTS
Services billing	In 15 minutes increments
Length of stay	No prescribed time limit. Medical necessity must be established every six months
Group services	Same as OP
Documentation of Services	The actual service date, beginning time, ending time, duration and type of service must be documented. For specifics of clinical documentation, refer to the Clinical Documentation Manual.
Changes in SRD	Recovery services items have been added to the SRD.
Discharge CalOMS	**Not applicable**
Recording EBPs	In progress notes
Performance measurement	None at this time

CONTINUOUS RECOVERY MONITORING (CRM)

CRM CALL RECORD

Client Name		Counselor	
UNICARE ID		Agency	_____
Tel No		Tel No	

Call number									
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

Instructions		
Indicate who initiated the call. Circle the response.	**Call initiated by:**	☐ **Counselor** ☐ **Client**
Write the date of the call in the space provided.	**Call date**	**mm/dd/yy**
Circle the appropriate response.	**Was the client contacted?**	☐ **YES** ☐ **NO**
Please record Start Time for each phone <u>regardless of whether you spoke to the client</u>.	**Write the start time of the phone call.**	**Hr: min**
Record verbal ORS scores (Scale from 1 to 10)	**Personal**	
	Interpersonal	
	Social	
	Overall	
	Total score	
Enter the number for the appropriate outcome –Status of recovery effort (SRE). Codes for each are shown below.		
No use; no urges - 1		
Occasional urges; no use - 2		
Slipped; regained sobriety - 3		
Regular use; no negative consequences - 4		
Regular use; negative consequences - 5	**Enter number here →**	
Record the action the counselor took after the call.	**Outcome = 1 OR 2, schedule telephone call. Write date:**	**mm/dd/yy**
	Record time for next call:	**Hr: min**
If SRE is <u>1 or 2,</u> go to next page and ask the client satisfaction question. If SRE is 3, 4 OR 5, administer the Immediate Needs Profile and record the response in the appropriate column.		
INP=Immediate Needs Profile Assessment	**Acute Intoxication &/or Withdrawal Potential**	**1a** ☐ **Yes** ☐ **No**
		1b ☐ **Yes** ☐ **No**
		1c ☐ **Yes** ☐ **No**

CONTINUOUS RECOVERY MONITORING (CRM)

INP=Immediate Needs Profile Assessment- Write YES OR NO	**Biomedical conditions/complications**	**2a ☐ Yes ☐ No**
	Emotional/Behavioral/ Cognitive Conditions/ Complications	**3a ☐ Yes ☐ No**
		3b ☐ Yes ☐ No
		3c ☐ Yes ☐ No
		3d ☐ Yes ☐ No
	Readiness for change	**4a ☐ Yes ☐ No**
	Relapse/Continued	**5a ☐ Yes ☐ No**
	Use/Continued Problem	**5b ☐ Yes ☐ No**
	Potential	**5c ☐ Yes ☐ No**
	Recovery environment	**6a ☐ Yes ☐ No**
Record action for treatment. Codes for action are shown below.	***Action***	
Individual treatment with primary counselor-telephone-1		
Individual treatment with primary counselor-in person - 2		
Outpatient - 3		
Residential - 4		
Detox - 5		
Other - 6 Specify	**Enter code here →**	
Ask the customer satisfaction question: Enter a number between 1 and 10.	**On a scale of 1 to 10, how helpful overall do you find this service?**	
Please record the End Time of the call	**Write the end time of the phone call.**	**Hr: min**
Counselor Notes:		

CONTINUOUS RECOVERY MONITORING (CRM)

Appendix G:

Preliminary Exploration of Care Delivery Differences Based on Integration Categories of the SAMHSA Framework for Integrated Healthcare

Preliminary Exploration of Care Delivery Differences Based on Integration Categories of the SAMHSA Framework for Integrated Healthcare

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Introduction

As part of the effort to evaluate how the DMC-ODS waiver may impact integration of services and coordination of care across the SUD, mental health and physical health services delivery systems, UCLA utilized the Integrated Practice Assessment (IPAT) tool[1] as a component within the Provider Survey to assess integration/collaboration activities among SUD providers at the point of service delivery.

The IPAT was developed to help place provider practices on levels of integrated care as defined by the *Standard Framework for Levels of Integrated Healthcare*. The Framework, released in 2013 by SAMHSA-HRSA Center for Integrated Health Solutions, identified three main overarching categories — Coordinated Care, Co-located Care, and Integrated Care – with two levels within each category, producing a national standard with six levels of collaboration/integration ranging from Minimal Collaboration to Full Collaboration in a Transformed/Merged Integrated Practice. The IPAT uses a series of yes/no questions that cascade (like a decision tree) to a specific level of integrated primary care and behavioral health care. The tool can be re-taken to track progress over time and incorporates the following key components and facilitators of coordination and integration: physical proximity of services, interactive communication and processes of information exchange, provider and patient relationships, and leadership and organizational infrastructure. (Appendix X – IPAT tool and questions).

By implication, the numbering of levels suggests the higher the level of collaboration/integration, the more potential for positive impact on health outcomes and patient experience. This belief remains a hypothesis and has not been empirically tested. However, the framework creates concrete descriptions and benchmarks defining the various strategies to implement integrated care.[2] This cataloguing can allow organizations implementing integration to gauge their degree of integration against acknowledged benchmarks and serves as a foundation for comparing healthcare outcomes between integration levels. States can use this data to monitor progress along the integration continuum, to conduct comparative analysis, to examine network readiness for integration, to establish thresholds for differential reimbursement, or to tailor technical assistance programs to a practice's needs. In addition, tools such as the IPAT help normalize the process of moving along a continuum of integrated care and inspire the undertaking of system transformation[3].

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

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

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

Following the set of questions from the IPAT, providers were asked additional questions about screening practices, on-site service availability, referral practices, and perceptions of meeting the health needs of their patient populations and of effective coordination practices for their patient population. Exploratory analysis was conducted to learn more about the SUD service system landscape and how clinical delivery and care coordination differ based on IPAT categorizations.

Methods

For the purposes of this DMC-ODS waiver evaluation, it was necessary to adapt the IPAT questions to assess levels of collaboration/integration of both mental health (MH) and physical health (PH) services in SUD settings. Thus, completion of the Provider Survey resulted in two IPAT ratings, one for each of the service systems pairings (SUD and MH, referred to as Behavioral Health integration; SUD and PH, referred to as Physical Health integration). Each IPAT rating defined the level of integration based on the SAMHSA Framework of each surveyed Treatment Program. The categories and levels within each category are defined below: **note where the terms mental health and primary care were interchanged based on the pairing of the service systems under assessment*:

Coordinated Care:

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

Level Two: Basic Collaboration at a Distance: Periodic communication between providers differentiates this level from the previous level, although physical and systems separation is maintained. SUD and *primary care (**replace: mental health*) providers may communicate occasionally about shared patients and view each other as resources in providing coordinated care.

Co-Located Care

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

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

Integrated Care (also referred to as Fully Integrated Care)

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

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

Although data collection was partially completed at the time of this report, results from the Provider Survey collected thus far (N=62) provide a preliminary description of the current landscape of the SUD system and service delivery with regard to collaboration/integration as defined by the Framework. For the analysis, the IPAT results of levels 1-6 were collapsed into the three main overarching integration categories (Coordinated Care, Co-located Care, and Integrated Care) and descriptive analysis was conducted.

Findings

Of the 62 surveys, 50% were from outpatient programs, 17.7% were from opioid treatment programs, and 32.3% were from residential programs. Provider organizations from thirteen counties, all providing services under the DMC-ODS waiver, have contributed to this initial dataset.

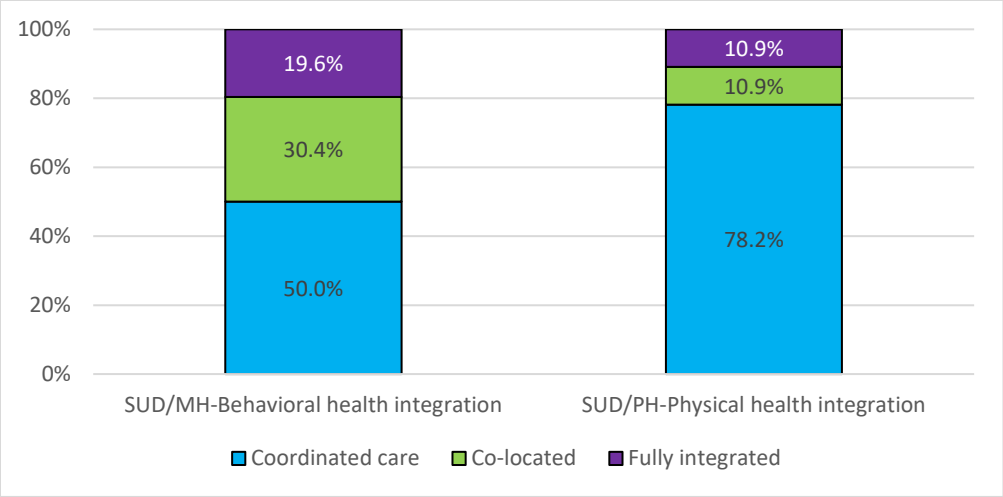
<u>Distribution of SUD Programs along the SAMHSA Framework:</u>

For the SUD-MH service system paring (behavioral health integration), half of the SUD Treatment Programs (50%; n=28) rated in the Coordinated Care category, followed by 30.4% (n=17) in the Co-located Care category and 19.6% (n=11) in the Fully Integrated Care category. Six respondents did not submit all answers to calculate the IPAT rating.

For the SUD-PH service system paring (physical health integration), the majority of SUD Treatment Programs (78.2%; n=43) rated in the Coordinated Care category, followed by 10.9% (n=6) in the Co-located Care category and 10.9% (n=6) in the Fully Integrated Care category. Seven respondents did not submit all answers to calculate an IPAT rating.

See Figure 1 for a preliminary look at the distribution of IPAT ratings for both behavioral health integration and physical health integration within this snapshot of the SUD system of care.

Figure 1. IPAT rating of MH and PH service integration in SUD programs



Overall, behavioral health integration showed a more diverse spread across the three implementation categories than physical health integration. Although most SUD providers placed in the Coordinated Care category (i.e., "minimal/basic integration at a distance") across both service system pairings, there were more SUD providers offering on-site mental health services than on-site physical health services.

The SAMHSA Framework defines the physical proximity of service delivery (e.g., providing on-site services) as the key element to move beyond the Coordinated Care integration category. The key element to becoming fully integrated is to achieve practice change with a transformation of the program's business model. Based on this preliminary dataset, there were more SUD practices delivering services as Fully Integrated behavioral health programs, which is likely due to the overarching efforts from the state and counties to transition, where possible, from siloed MH and SUD departments/infrastructures toward integrated behavioral health departments/infrastructures.

<u>Screening practices:</u>
Overall, systematic screening occurred more for mental health than physical health, and the most systematic screening occurred in the Fully Integrated care level. It was notable that some providers in the Coordinated Care and Co-located Care categories reported they do not systematically screen for mental or physical health. See figures 2 and 3.

Remarkable, while SUD programs implementing Co-located behavioral health integration showed more systematic mental health screening than those in the Coordinated Care level, programs implementing Co-located physical health integration did not show this same trend. In fact, programs implementing Co-located physical health integration had the lowest rates of systematic screening practices for all of the selected health conditions (hypertension, diabetes, and chronic pain). The data, however, indicated that regardless of the integration category, if a program systematically screens for one health condition, for example depression, they would likely use a comprehensive screen addressing multiple mental health conditions (including anxiety and trauma). The same was consistent for physical health screening practices.

Figure 2. % endorsing the systematic screening practice for the following mental health conditions by integration category

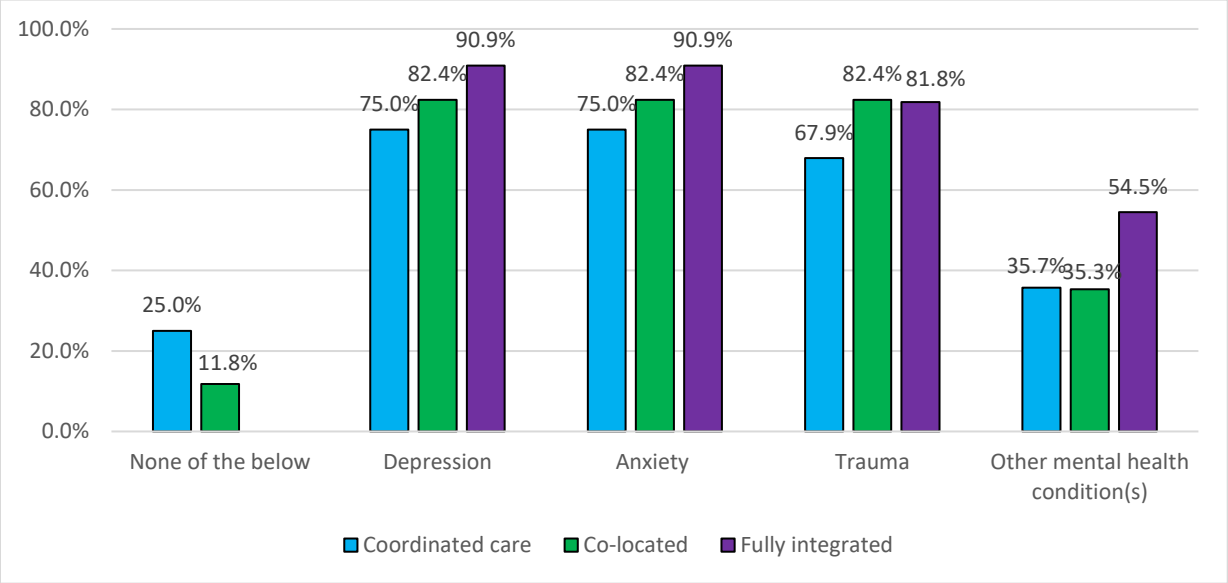
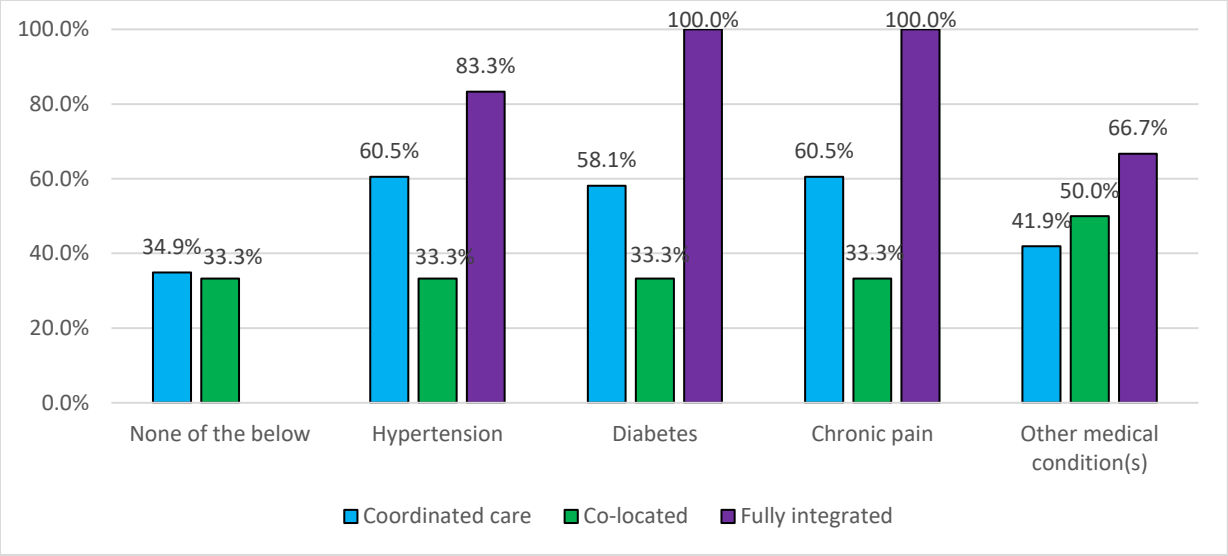


Figure 3. % endorsing the systematic screening practice for the following physical health conditions by integration category



<u>Health Needs of patient population</u>

Providers were asked to estimate the proportion of their patient population with mental and physical health needs and then, of those, how many receive treatment for those problems. Across the three integration categories, the perception that most or all of their patients had mental health needs was higher than the perception that most or all of their patents had physical health needs. However, the perception of needs of patients showed to be higher the more the programs were implementing Fully Integrated care. Strikingly, perceptions of physical health needs were lower than the rising trend for mental health needs in the Co-located

Category, which could be a result of the lower rates of systematic screening for physical health problems, as noted above.

Providers were then asked to estimate the proportion of their patient population with other health needs that actually receive treatment. Ideally the reported perceptions should be 100%. However, perceptions of meeting needs were much lower, indicating a need for more service coordination. For example, as shown in figure 4, 50% of the providers from Treatment Programs implementing Coordinated behavioral health reported most or all of their patients have MH needs, yet only 39.3% reported most/all of their patients with MH needs are receiving treatment (as shown in figure 5). Interestingly, perceptions seemed to be higher for meeting treatment needs for physical health treatment among the integration categories, except for programs implementing Co-located physical health.

Figure 4. Provider perceptions of the proportion of their patient population with other health needs by integration category

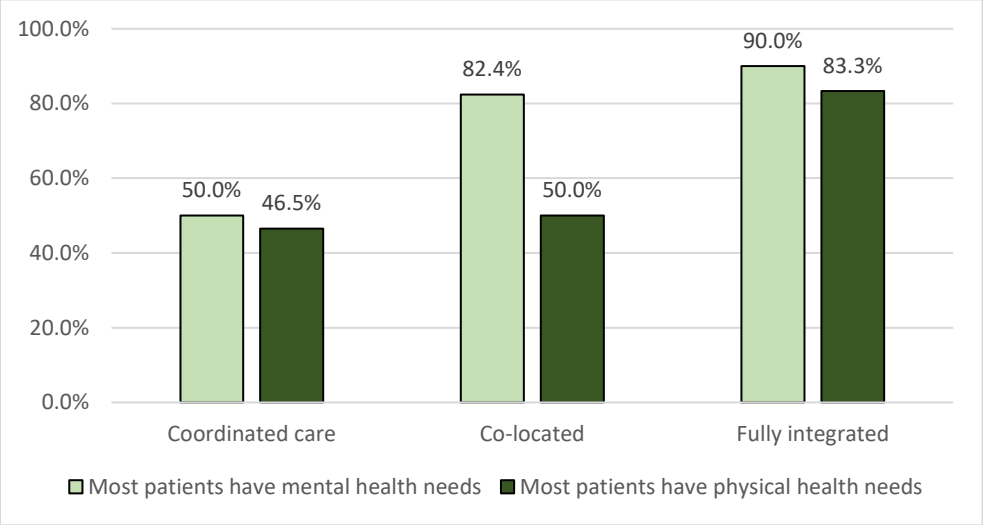
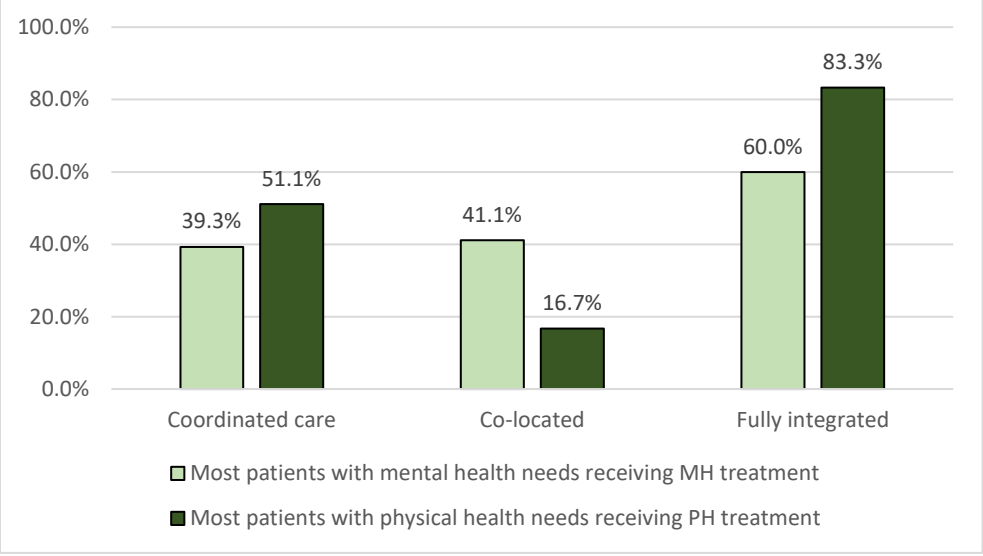


Figure 5. Provider perceptions of the proportion of their patient population with other health needs who receive treatment by integration category



On-site service availability

Providers, excluding those that rated in the Coordinated Care categories (by definition of the integration level), were asked to endorse the types of services available on-site either in person or virtually. Figures 6 and 7 clearly show more expertise was available on-site at the Fully Integrated programs than at the Co-located programs for both MH and PH. Unsurprisingly, Figure 8 shows survey respondents in Fully Integrated programs also perceived they met the needs of the patients and the organization much more so than Co-located programs. A notable difference arose between SUD programs implementing Co-located mental health and Co-located physical health. The capacity to treat patients with moderately complex problems on-site was higher in Co-located mental health programs than in Co-located physical health programs. A possible explanations could be the incidental medical services policy for SUD settings or perhaps workforce or billing challenges.

Figure 6. Array of mental health services and expertise available on-site by integration category

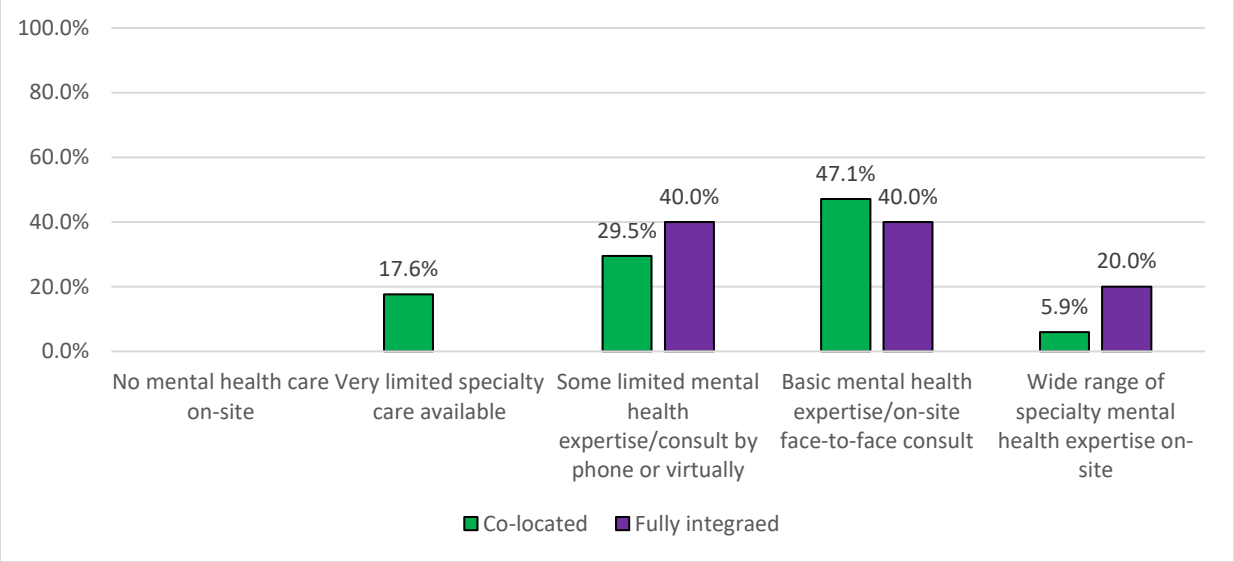


Figure 7. Array of physical health services and expertise available on-site by integration category

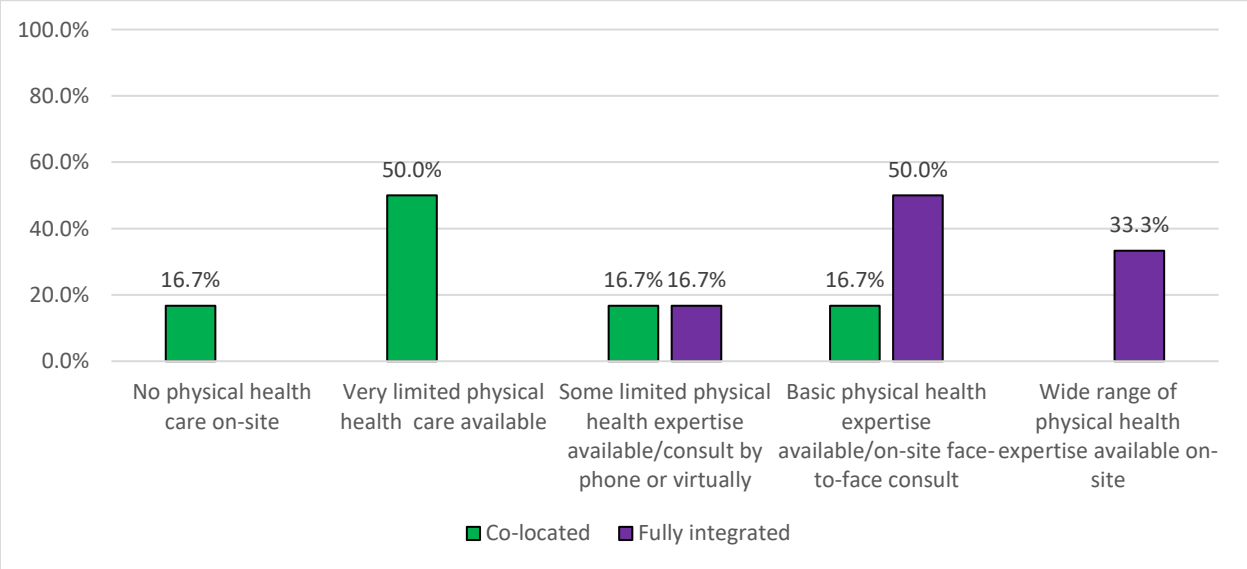
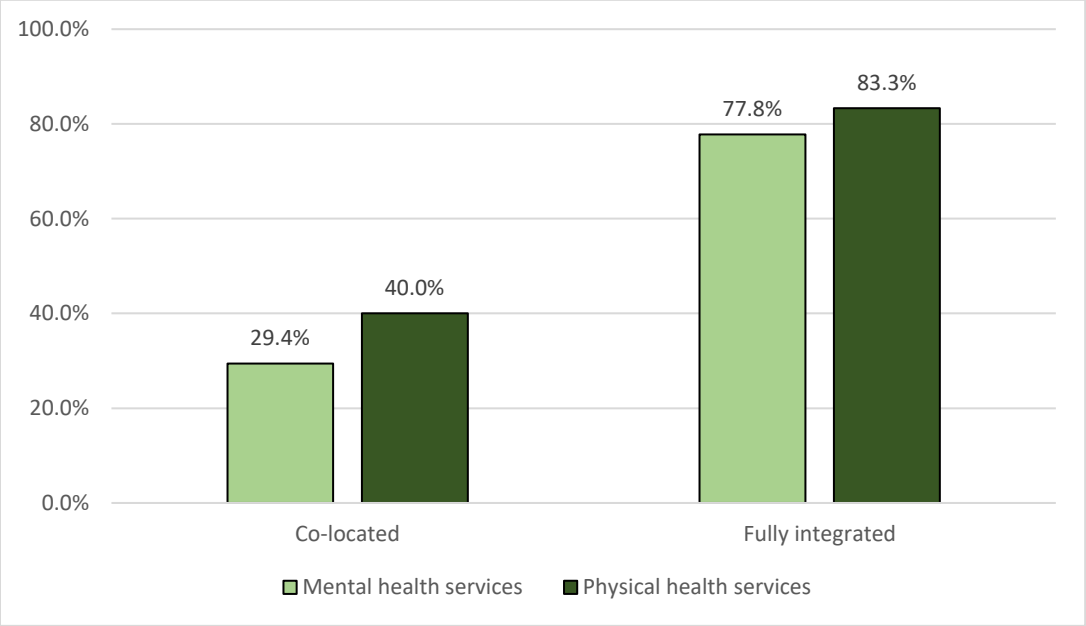


Figure 8. % Agreement that on-site services meeting patient and organization needs by integration category



Referral practices and partnerships managing on- or off-site referrals

On-site or off-site, linking patients to mental health and physical health service providers can be facilitated by formalizing partnerships and procedures. Information exchange and communication is critical to successfully link patients to these services. Figure 9 revealed that programs further along on the integration framework had the administrative supports of formal collaborations with MH or PH partners with defined and documented referral practices. In additional, providers endorsed having more formal collaborations supporting physical health integration than mental health integration. Qualitative comments indicated that providers from counties with integrated behavioral health departments had a reduced need to formalize collaborations with mental health providers; however, the need for release of information consents (ROIs) and protocols for referral practices and follow-ups were still challenging if not defined formally with both entities. Additionally, Figure 10 highlighted another area where Co-located integration may be more challenging, as this implementation strategy showed the lowest agreement rate with the notion that these collaborations met the needs of patients and organizations for both behavioral and physical health integration.

Figure 9. % Agreement of having formalized collaborations with documented referral practices by integration category

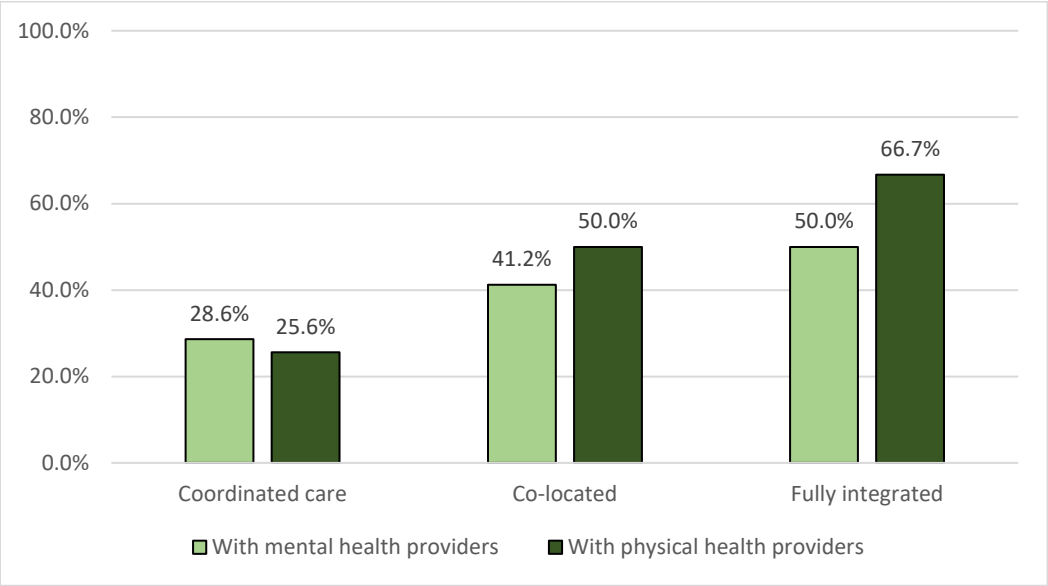
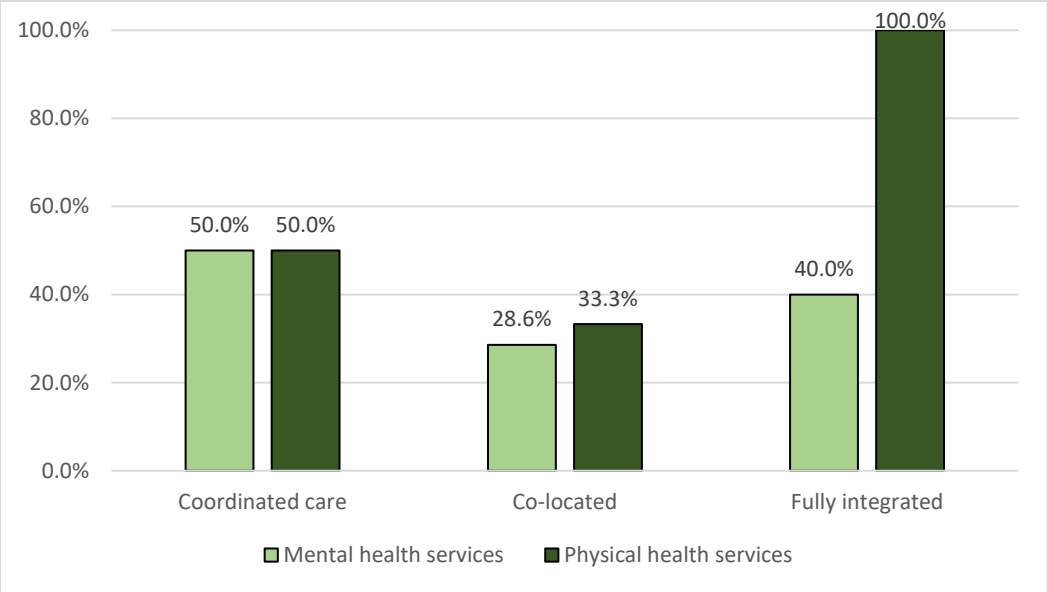


Figure 10. % Agreement of collaborations meeting patient and organization needs by integration category



<u>Care Coordination</u>

Overall, the majority of providers reported counselors on staff provide case management when needed for both behavioral and physical health coordination. Programs implementing Fully Integrated Care also more often reported having dedicated staff performing case management as their primary role than programs in the Coordinated or Co-located Care categories). Across the three integration categories, more Treatment Program administrators reported

coordinating care with physical health providers than with mental health providers. One hundred percent of treatment program administrators implementing Fully Integrated physical health services reported coordinating care for most/all of their patients. Only 60% implementing Co-located physical health reported coordinating care for most/all of their patients, fewer than those in the Coordinated Care category (79.9%). When asked if patients in their Treatment Programs are receiving adequate care coordination, providers reported on average a higher agreement rate for mental health integration than physical health integration. However, Co-located physical health revealed the lowest agreement rate.

Figure 11. % Endorsed they are coordinating care for most or all of their patients by integration category

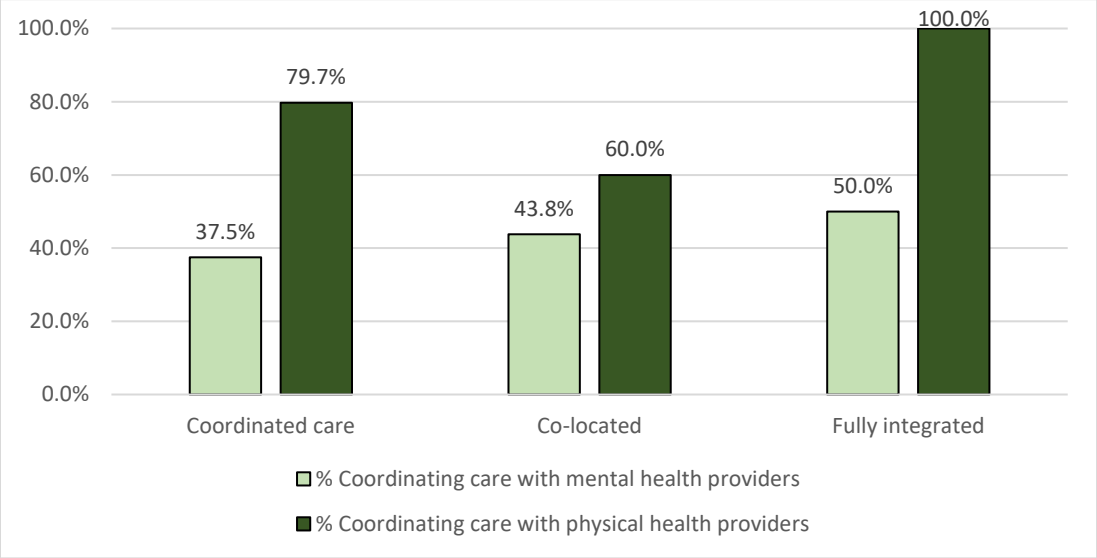
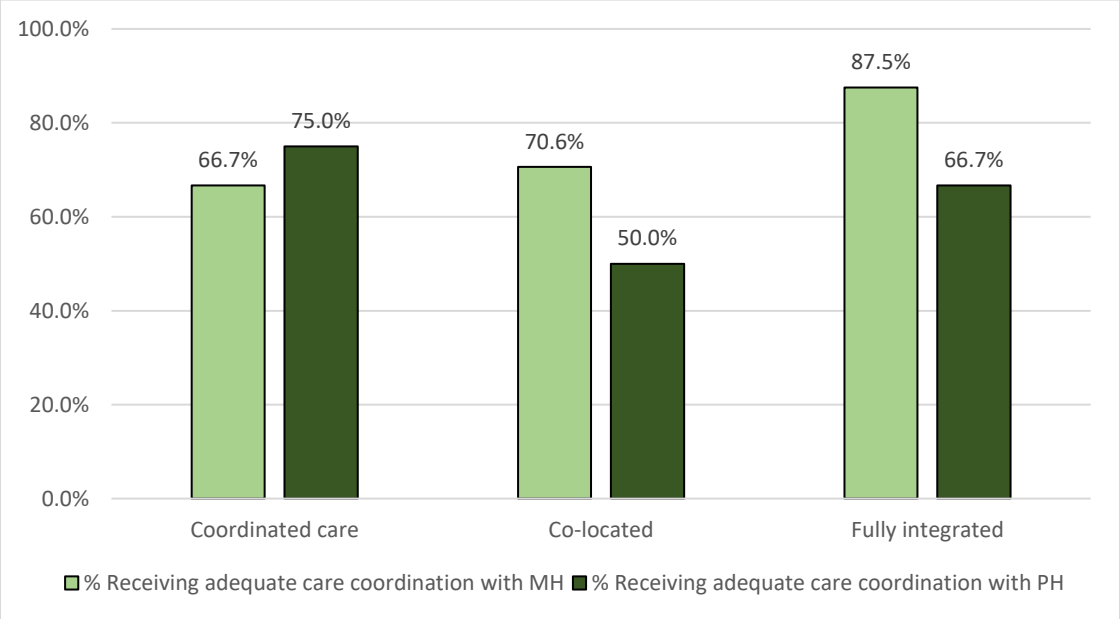


Figure 12. % Endorsed that patients are receiving adequate care coordination by integration category



Summary and Conclusions

As the first set of data applying the SAMHSA Framework and adapting the IPAT Tool to measure how integration is occurring within DMC-ODS waivered SUD treatment programs, the findings presented here should be perceived as a starting point that can be monitored over time. Although a full randomized sample of Provider Survey data has not yet been completed, this cursory and exploratory look at how services are delivered based on the SAMHSA Integration Framework can help identify barriers for technical assistance guidance.

Overall, findings from this preliminary analysis indicated that while most programs offer integrated services "at a distance" (in the Coordinated Care category), there are more programs offering on-site mental health services than on-site physical health services. Moreover, there are more programs with Fully Integrated MH services than Fully Integrated PH services.

Generally and unsurprisingly, the more a Treatment Program is integrated, according to the SAMHSA Framework, the more it is systematically and comprehensively screening for MH and PH service needs, the more capacity the program has to treat patients on-site, and the more partnerships it has in place to refer patients off-site when needed. However, a common theme surfaced around the provision of Co-locating services as an integration strategy, particularly Co-locating physical health services.

Broadly, programs providing Co-located services did not show the incremental progression along the SAMHSA Framework noted above on the following items. Programs with Co-located services reported low ratings that their on-site services met the needs of the patients and organizations. In addition, programs with Co-located services reported the lowest ratings that their off-site collaborations met the needs of their patients and organizations.

These data also highlight additional challenges for Co-locating physical health services as compared to Co-locating mental health services. For example, systematic screening for physical health conditions was lowest among programs Co-locating physical health services, which was not consistent with the growing progression of MH screening practices across the SAMHSA Framework. In addition, provider perceptions of physical health needs were the lowest among the Co-located physical health category as well as providers' perceptions that patients actually received the treatment they needed. Another notable difference appeared when comparing capacity to treat on-site patients with MH and PH problems with Co-located services. Programs providing Co-located services seemed to have a lower capacity to treat moderately complex PH conditions than moderately complex MH conditions on-site. Finally, when asked if patients were receiving adequate care coordination, programs providing Co-located physical health services reported the lowest agreement rating among all three integration categories.

Co-location reduces time spent travelling from one practitioner to another, but does not guarantee integration. While a relevant benchmark and facilitator for integrated care, Co-located services has its challenges to meet the needs of both the patients and organizational integration goals. Providers can be co-located and have no integration of their healthcare services. Each provider can still practice independently without communicating with others and without an integrated healthcare plan. These findings are important to note when programs are

evaluating next steps for integrating services. Utilizing the benchmarks identified in the SAMHSA Integration Framework is a useful tool to set strategically realistic goals to improve integration of services.

Recommendations

While these data are preliminary, recommended technical assistance resulting from this exploratory analysis include:

- Guidelines for universal screening tools and practices for physical health conditions in SUD settings that includes issues addressing the workforce needed to conduct the screening and applicable billing codes in both residential and outpatient SUD settings
- Technical assistance on the development of memos of understanding (MOUs) to establish formal collaborations for both behavioral health and physical health partners, including the importance and practice of obtaining consent for release of information forms (ROIs) to facilitate referral and care coordination

Appendix H:

H1• Riverside County Care Coordination Team 2019 Master Training Schedule

H2• SAPT Care Coordination Team – Assignment to Intake Workflow

H3• SAPT Care Coordination Team Discharges

H4• Case Management Needs Assessment

RUHS-BH Staff
2019 Master Training Schedule

Rev. 5/20/2019

ASAM B	ASAM C	Adult ASAM Tune-Up	Adolescent ASAM Tune-Up	ASAM Continuum of Care
Mon. Jan 14 Mon. Mar 25 Mon. May 20 Mon. July 15 Mon. Sept 23 Mon. Nov 18 **(8:00-5:00)** **2085 Rustin Ave. Riverside** Tues. Apr 23 (8:00-5:00) Mon. Oct 14 (8:00-5:00) **The Ranch - Desert Hot Springs** **7885 Annandale Avenue**	Tues. Jan 15 Tues. Mar 26 Tues. May 21 Tues. July 16 Tues. Sept 24 Tues. Nov 19 **(8:00-5:00)** **2085 Rustin Ave. Riverside** Wed. Apr 24 (8:00-5:00) Tues. Oct 15 (8:00-5:00) **The Ranch - Desert Hot Springs** **7885 Annandale Avenue**	Thurs. Jan 17 (1:00 - 4:00) Thurs. Mar 28 (9:00 - 12:00) Thurs. May 23 (9:00 - 12:00) Thurs. July 18 (1:00 - 4:00) Thurs. Sept 26 (9:00 - 12:00) Thurs. Nov 21 (1:00 - 4:00) **2085 Rustin Ave. Riverside** Thur. Apr 25 (1:00-4:00) Wed. Oct 16 (1:00-4:00) **The Ranch - Desert Hot Springs** **7885 Annandale Avenue**	Thurs. Jan 17 (9:00 - 12:00) Thurs. Mar 28 (1:00 - 4:00) Thurs. May 23 (1:00 - 4:00) Thurs. July 18 (9:00 - 12:00) Thurs. Sept 26 (1:00 - 4:00) Thurs. Nov 21 (9:00 - 12:00) **2085 Rustin Ave. Riverside** Thur. Apr 25 (9:00-12:00) Wed. Oct 16 (9:00-12:00) **The Ranch - Desert Hot Springs** **7885 Annandale Avenue**	Tues. July 23 Wed. Nov 13 **(9:00-4:00)** **2085 Rustin Ave. Riverside** Tues. Feb 26 (9:00-4:00) **14320 Palm Drive** **Desert Hot Springs**
Case Mgmt/Rec. Services	**Progress Notes**	**Treatment Planning**	**D/C Planning & Special Forms**	**Intake/Assess**
Thurs. May 2 (1:00-4:00) 2085 Rustin Ave. Riverside Wed. Feb 6 (1:00-4:00) Tues. Nov 5 (1:00-4:00) 14320 Palm Drive Desert Hot Springs Thurs. Aug 29 (1:00-4:00) **31764 Casino Drive, Ste. 200** **Lake Elsinore**	Wed. Jan 9 (8:30-4:30) Wed. Mar 20 (8:30-4:30) Wed. May 15 (8:30-4:30) Wed. July 10 (8:30-4:30) Wed. Sept 18 (8:30-4:30) Wed. Nov 13 (1:00-4:30) **2085 Rustin Ave. Riverside**	Tues. Jan 8 (8:30-4:30) Tues. Mar 19 (8:30-4:30) Tues. May 14 (8:30-4:30) Tues. Jul 9 (8:30-4:30) Tues. Sept 17 (8:30-4:30) Wed. Nov 13 (8:30-12:00) **2085 Rustin Ave. Riverside**	Thurs. Jan 10 Thurs: Mar 21 Thurs. May 16 Thurs. July 11 Thurs. Sept 19 Thurs. Nov 14 **(8:30-4:30)** **2085 Rustin Ave. Riverside**	Mon. Jan 7 Mon. Mar 18 Mon. May 13 Mon. Jul 8 Mon. Sept 16 Tues. Nov 12 **(8:30-4:30)** **2085 Rustin Ave. Riverside**
CalOMS	**HIPAA/42 CFR**	**DMC Waivered County Compliance**	**Motivational Interviewing**	**Living in Balance**
Mon. Sept 9 **(9:00-4:00)** **2085 Rustin Ave. Riverside** Wed. Mar 6 (1:00-4:00) **14320 Palm Drive** **Desert Hot Springs**	Wed. Oct 23 **(9:00-4:00)** **2085 Rustin Ave. Riverside**	Tues. Oct 29 **(9:00-12:00)** **2085 Rustin Ave. Riverside** Tues. Apr 16 (9:00-12:00) **14320 Palm Drive** **Desert Hot Springs**	Tues. Jan 29 Thurs. Jul 25 **(8:30-4:00)** **2085 Rustin Ave. Riverside** Wed. Apr 10 (8:30-4:00) Tues. Oct 8 (8:30-4:00) **14320 Palm Drive** **Desert Hot Springs**	**2 Day Training** Mon. Feb 25 - Tues. Feb 26 Mon. May 6 - Tues. May 7 **(8:30-4:00)** **2085 Rustin Ave. Riverside**
Adolescent/Adult Matrix	**CBT for PTSD for Adults**	**Coping w/Stress: Teen CBT**		
2 Day Training Wed. June 5 - Thurs. June 6 **(9:00-4:00)** **2085 Rustin Ave. Riverside**	**2 Day Training** Tues. Sept 10 - Wed. Sept 11 **(9:00-3:30)** **14320 Palm Drive** **Desert Hot Springs**	**2 Day Training** Mon. Oct 21 - Tues. Oct 22 **(9:00-3:30)** **2085 Rustin Ave. Riverside**	**To Register Email:** **SAPTTraining@ruhealth.org**	

SAPT Care Coordination Team – Assignment to Intake

SU CARES Notifies CCT Case Manager (CM) & Office Assistant (OA) of Consumer assignment via Notify User in the DAS SAPT Placement Referral form in ELMR

Office Assistant

(Review To-Do List in ELMR Daily)

- Contact within 24-Hours of Notification w/Tx Facility
- Update "Disposition" in Placement Referral form, when applicable
- Notify Case Manager (No Show = Re-Engage / Appt. Met = Open CCT/START episode)

Case Manager

(Review To-Do List in ELMR Daily)

- Contact within 24-Hours of Notification w/Consumer
- Review ASAM & Contact Log
- Review Episode History
- Use Care Coordination Log until episode opening

Consumer has enrolled in Tx Prg – CCT Prg notified?

- No / Pending Admission
- Yes

Case Manager

- Follow-Up with Consumer within 48-Hours (complete Care Coordination Log)
- No Contact after 1 attempt? Allow for a 10 day response - Indicate in Care Coordination Log
- Continue Case Management Services (follow Continuum of Care instructions)

(Utilizing the "**Scheduling Calendar**", record services by using **SA712** service code and documenting each service in the "**DAS Care Coordination Log**")

Office Assistant

(Open Case Management Episode in ELMR)

- Open Case Management episode to match "referred to" program admission/intake date – found in Episode History in ELMR and/or verified by tx facility contact.
- Verify DMC Eligibility for **intake month** and file in ELMR and Monthly Binder
- Obtain tx facility intake documents (Health Questionnaire, Medical & Substance History) (follow intake process instructions) – File in ELMR

Continuum of Care

Continuum of Care

(Case Management Episode is "Active" in ELMR)

- **OA:** Verify DMC Eligibility **monthly** file in ELMR and Monthly Binder
- **OA:** Ensure tx facility intake documents received/scanned in ELMR
- **OA**: Schedule Clinical Therapist (CT) appointment within 7 days of intake date (*Diagnosis Entry*)
- **CM & OA:** Follow-up on Insurance Eligibility status (*Out of County, OHC, Restricted Medi-Cal*)
- **CM:** Create Txt Plan, no later than 14 days of intake date (*7 days is ideal*)
- **CM:** Begin/Continue Case Management Services w/Consumer at Tx facility or phone (*weekly at minimum*)
- CM: Transport, as needed
- CM: Provide/Refer for additional MH services, as needed
- CM: Create Exit Plan w/Consumer (*offer OT/IOT services*)

(Utilizing the "**Scheduling Calendar**", record service by using the appropriate service code SA468... vs SA445... (series) and documenting each service in the "**DAS Progress Notes**" (See Code Description below)

Transition To Next Level of Care

Case Manager

- Coordinate with exiting Tx facility on transitioning steps. Ensure Tx facility completed Transition ASAM
- Assist with outpatient/next level of care appointments (if transitioning in to a County Clinic – Appointment MUST be secured)
- Continue services, up to 2 weeks in to Outpatient enrollment or Case-by-Case
- Transport, if needed
- Provide other transitional services, as needed
- Follow-up w/Consumer of transition appointment (stable housing)

Consumer Left Treatment Facility

Case Manager

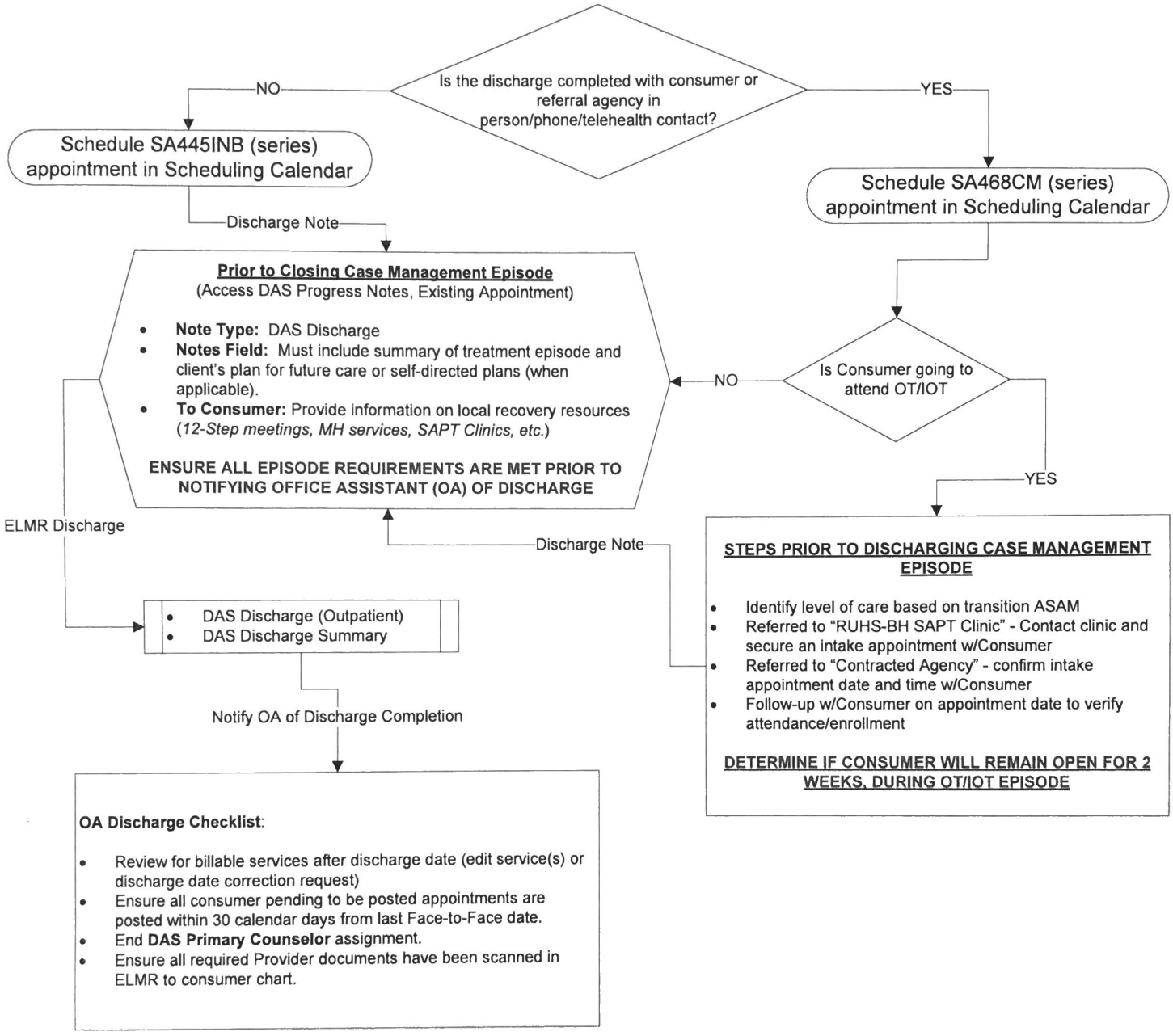
- Attempt Contact with Consumer within 48-Hours
- Re-engage Consumer in to Treatment
- No Contact after 1 attempt? Allow for a 10 day response – Indicate in DAS Progress Note and record with appropriate service code series. (See **Code Description** below)

CODE DESCRIPTION
SA468... series service code (Billable)
SA445... series service code (Non-Billable

(Reference "Procedure Code Manual" for code definition)

SAPT Care Coordination Team Discharges

NOTE: Discharge from the CCT program should be within 2 weeks of the consumer entering outpatient (IOT, ODF or RS) treatment or as determined and noted in chart based on consumer needs.



RIVERSIDE UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH

Case Management Needs Assessment

Provider:	Date:	CID#:
Case Manager:		

Dimension 1: Acute Intoxication and/or Withdrawal Potential	
Do you need a referral for Medication Assisted Treatment?	☐ Yes ☐ No
Dimension 2: Biomedical Conditions and Complications	
Do you need assistance with establishing a primary care physician?	☐ Yes ☐ No
Have you been referred for a screening for Hep C and HIV?	☐ Yes ☐ No
Have you received a referral to receive education and assistance with smoking or other tobacco products cessation?	☐ Yes ☐ No
Do you need help finding a dentist?	☐ Yes ☐ No
Do you need assistance with a pharmacy getting medications filled or transferring pharmacies?	☐ Yes ☐ No
Do you need help finding an optometrist?	☐ Yes ☐ No
Do you need referral and linkage to guidance on nutrition and/or how to prepare healthy meals?	☐ Yes ☐ No
Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications	
Do you need referral to be assessed for trauma, domestic violence or other mental health services?	☐ Yes ☐ No
Dimension 4: Readiness to Change	
Are you interested in a referral for individual counseling services?	☐ Yes ☐ No
Do you need a referral to self-help groups such as AA, NA, religious, Co-dependency, over eaters, gambling groups, or sex addiction groups?	☐ Yes ☐ No
Dimension 5: Relapse, Continued Use or Continued Problem Potential	
Are you comfortable in your current level of care?	☐ Yes ☐ No
Dimension 6: Recovery Environment	
Do you need assistance with any legal concerns such as; traffic tickets, warrants ect?	☐ Yes ☐ No
Do you need assistance with family law or CPS?	☐ Yes ☐ No
Do you currently have a case manager for other mental health services or with another agency?	☐ Yes ☐ No

RIVERSIDE UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH

Case Management Needs Assessment

Are you currently involved with the collaborative court systems such as JUST, FPC, Drug Court, Veteran Court, etc.?	☐ Yes ☐ No
Do you need assistance with safe and affordable housing during and after treatment through referrals to sober living or supportive housing?	☐ Yes ☐ No
Do you need referral and linkage to help with transportation services; such as access and information on public transportation, advocating with other agencies such as DPSS, probation or parole for bus passes?	☐ Yes ☐ No
Do you need a referral and linkage to educational or vocational services such as GED classes, a local community college, or literacy programs in the community?	☐ Yes ☐ No
Do you need supporting skills development in learning how to budget, meal plan, practice hygiene and personal care, and housekeeping skills?	☐ Yes ☐ No
Do you need a referral and linkage to services that can maximize independence and support recovery goals such as employment resources like linkage to EDD, resume services, help with completing a job application, and felony friendly agencies, as applicable?	☐ Yes ☐ No
Do you need a referral or assistance with learning computer skills?	☐ Yes ☐ No
Do you need a referral and linkage for evaluation and assistance with health and social benefit applications?	☐ Yes ☐ No
Do you need assistance with obtaining a Driver's License, ID Card, Social Security Card or Birth certificate?	☐ Yes ☐ No
Do you have benefits available through the military or VA?	☐ Yes ☐ No
Case Manager Reminders (not necessarily for initial appointment)	
Are you participating in regular meetings with program staff and other members of the care team, if available to discuss the consumer's progress and focus areas?	☐ Yes ☐ No
Is the consumer receiving services to re-access, are you facilitating transition between levels of care, setting up an assessment appointment, sending necessary documentation to receiving agency and providing a warm-hand off?	☐ Yes ☐ No

Appendix I:

I1• LA County Substance Use Disorder Treatment Services Provider Manual v4.0

I2• LA County Report: Benefits of Case Management

START-ODS

SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County's Substance Use Disorder Organized Delivery System

SUBSTANCE USE DISORDER TREATMENT SERVICES

PROVIDER MANUAL

December 2018

Version 4.0

Los Angeles County
Department of Public Health

Substance Abuse Prevention and Control

Case Management

Case Management is a collaborative and coordinated approach to the delivery of health and social services that links patients with appropriate services to address specific needs and achieve treatment goals. Case Management is a patient-centered service that is intended to complement clinical services, such as individual and group counseling, to address areas in an individual's life that may negatively impact treatment success and overall quality of life. Case Management offers support services to patients to increase self-efficacy, self-advocacy, basic life skills, coping strategies, self-management of biopsychosocial needs, benefits and resources, and reintegration into the community.

Guiding principles[1] for Case Management are the following:

- Case Management is patient-centered and should be primarily focused on meeting the varied needs of patients;
- Case Management provides a point of contact between health and social services;
- Case Management provides advocacy by acting in the patient's best interests;
- Case Management helps patients navigate and obtain community resources, and integrate into the community after discharge from inpatient or residential services;
- Case Management is culturally sensitive;
- Case Management must be flexible; and
- Case Management is anticipatory and understands that SUDs may be chronic and relapsing.

Case Management is available to all patients who enter the SUD treatment system. This service is available throughout the treatment episode and may be continued during Recovery Support Services. Case Management services may be provided face-to-face or by telephone, with the patient.

Description of Case Management and Services

The primary goal of Case Management is to ensure patients in SUD treatment receive the necessary support and services available to be successful in meeting treatment and recovery goals. Since patients in SUD treatment have an array of service needs and interact with multiple systems, one barrier to successfully completing treatment may be a lack of communication and established referral procedures between health and social systems. Case Management is effective at keeping individuals engaged in treatment and moving toward recovery by addressing other problems concurrently with substance use.[2] Case Management services are especially important for patients with chronic health problems, co-occurring disorders, those experiencing homelessness or who are involved with the criminal justice system.

To successfully link patients to services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate resources, both at the system and the service levels, to refer patients to relevant networks of support. Services

[1] SAMHSA (US); 2000. (Treatment Improvement Protocol (TIP) Series, No. 27.) Chapter 2 – Applying Case Management to Substance Abuse Treatment.

[2] SAMHSA (US); 2000. (Treatment Improvement Protocol (TIP) Series, No. 27.) Chapter 4 – Evaluation and Quality Assurance of Case Management Services.

provided through Case Management are thus tailored to facilitate continuity of care across all systems of care and provide extensive assessment and documentation of patient progress toward self-management and autonomy.

Although an important component of Case Management in SUD treatment is connecting patients to outside systems of care, such as physical and mental health systems, Case Management is equally important in transitioning patients through the SUD system of care. Comprehensive SUD treatment often requires that patients move to different levels of care within the SUD continuum, and case managers help to facilitate those transitions.

There are three (3) core Case Management functions that providers should perform to ensure successful treatment outcomes and recovery: **Connection, Coordination, and Communication**. Although not an exhaustive list, please see **Table 8** for a list of the three (3) functions and the respective activities that can be performed and billed under Case Management.

- **Connection:** Establishing connections through referrals that link patients to housing, educational, social, prevocational, vocational, rehabilitative, or other community services. This includes providing high-quality referrals and linkages for patients to necessary resources and services as identified in the Treatment Plan, which includes Case Management needs. High-quality referrals and linkages require the case manager to play an active role to reduce access barriers and ensure patients have 'actual' access to needed services. This means going beyond the distribution of resource lists to patients, and actively establishing relationships and protocols with external providers to ensure patients will be connected with agencies—and served upon referral.

  In addition, case managers must assist patients with applying for and maintaining health and public benefits (e.g., Medi-Cal, My Health LA, General Relief and Los Angeles County (County) funded programs/projects). This includes helping patients who have moved and must transfer their Medi-Cal benefits from their previous county of residence to Los Angeles County.

- **Coordination:** Care coordination is intended to address fragmentation of care, and help patients better navigate and access treatment across the different systems of care. Case managers perform care coordination by acting as a bridge between health and human service providers to ensure that information is appropriately exchanged, and patients are successfully linked to needed resources/services. Activities include helping patients set up medical appointments, ensuring that SUD providers at the treating agency are aware of services being conducted by other health providers, and following up with patients in service transition or notable events. For example, case managers should follow up with patients within a few days of an emergency room visit, hospital discharge, or discharge from a residential facility. As SUD patients interact with multiple systems, it is the responsibility of case managers to help improve the accessibility of services for the patient by reducing barriers between care delivery settings.

  Additionally, case managers should coordinate successful transitions between SUD levels of care, including setting up an assessment appointment, transferring necessary documentation to the receiving treatment agency, and providing a warm hand-off for necessary services. If patients are transitioned to a higher or lower level of care at a different treatment agency, the case manager should use the SBAT to identify providers

that meet the individualized needs of the patient. Case managers are expected to schedule appointments and monitor referrals until obtaining confirmation that patients have been enrolled at the receiving treatment agency.

- **Communication: Communication is the primary way in which care coordination activities are successfully performed.** Patients in the SUD system of care receive services from various service providers, and it is the responsibility of case managers to be a line of communication between patients and others. Communication may include telephone, emails, letters, and progress notes and/or reports to the County, State, and other service providers on behalf of the patient. For example, a patient may need a letter sent to a judge verifying that they are participating in SUD treatment. At times, case managers must also advocate on behalf of patients. If patients' service needs are not being met, case managers will educate patients on their rights and advocate for patients with their service providers

Table 8. Core Functions of Case Management

The 3 C's of Case Management

1. CONNECTION: Referrals that link patients to housing, educational, social, prevocational, vocational, rehabilitative, or other community services
 	
• **Establishing & Maintaining Benefits**
  ○ Helping patients to apply for, and maintain health and public benefits (e.g., Medi-Cal, My Health LA, General Relief, Perinatal, Housing, etc.).
  ○ Conducting the Coordinated Entry System (CES) Survey Packet including: Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) for adults; or the Next Step Tool for youth.
  ○ Transferring benefits from the previous county of residence to Los Angeles County for patients who have moved.
• **Community Resources**
  ○ Linking patients to community resources and services that can maximize independence and support recovery goals, including: referrals to local food banks and/or community churches for groceries and meals; clothing assistance; transportation services; vocational services; support for employment; and education.

2. COORDINATION: Acting as a liaison to aid transitions of care and arranging for health services and social services.
 	
• **Transitioning between SUD Levels of Care**
  ○ Facilitating necessary transitions in SUD levels of care (e.g., from residential to intensive outpatient treatment, outpatient to Recovery Support Services, etc.), including initiating referrals to the next level of care, and coordinating with and forwarding necessary documentation to the accepting treatment agency.
• **Health Services**
  ○ Coordinating care with physical health (including managed care health plans such as L.A. Care and Health Net), community health clinics and providers, and mental

health providers to ensure a coordinated approach to whole person health service delivery.

- **Social Services**
  - Coordinating with state and County entities (DPSS, DCFS, Probation, Superior Courts, Housing Providers, etc.) to ensure the social aspects of health and well-being are being coordinated with health services.

3. **COMMUNICATION:** Correspondence, including emails, letters, and reporting documentation, by the case manager to the County, state, and other service providers on behalf of the patient.

- **Health Providers**
  - Communicating with physical health (including managed care health plans such as L.A. Care and Health Net), community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.
  - Monitoring and following up with other agencies regarding scheduled services and/or services received by patients.
- **Service Partners**
  - Communicating with Department of Public Social Services (DPSS) workers, Department of Children and Family Services (DCFS) social workers, Department of Mental Health (DMH) workers, Los Angeles Superior Court, Probation Officers, Housing Providers, etc., to align objectives and activities.
- **Advocacy**
  - Advocating for patients with health/social service providers, County and community partners, and others (such as officials at schools, juvenile or adult court hearings and/or meetings with corrections staff, and Student Attendance Review Boards or other school-related hearings) in the best interests of patients (e.g., respectfully advocating for necessary services to be provided in a timely manner).

Case Management Considerations for People in Vulnerable Groups

People with special needs require more intensive Case Management activities. Moreover, County agencies (DCFS, DPSS, Law Enforcement, Los Angeles Superior Court, etc.) may require providers to submit additional documentation and perform additional activities (e.g. attending court hearings or meeting with case workers to advocate on the patient's behalf).

These groups include people with HIV/AIDS, mental illnesses, homelessness, perinatal women, adolescents, and the criminal justice-involved. Each population will require coordination activities to help an individual effectively navigate, access, and participate in an appropriate SUD level of care, access health and mental health services, secure housing, and obtain other supportive services.

Patients Experiencing Homelessness

Housing and an individual's living environment are oftentimes a critical component of the ability to achieve and maintain recovery from SUDs. Therefore, case managers should identify patients in need of housing assistance and perform connection and coordination activities according to available resources. For providers that are trained and have the capacity to deliver housing services, billable Case Management services include the following:

- **Completing the Coordinated Entry System (CES) Survey Packet,** including the **Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)** for adults, and the **Next Step Tool** for youth.
- Entering and updating patient information in **HMIS**.
- Connecting patients to CES agencies for adults, youth and families
- Coordinating housing activities with CES Housing Navigators, such as gathering necessary documents, completing housing applications, choosing potential housing sites, applying for move-in resources and re-integration into the community.

See ***the Homeless Services*** section for more information.

Criminal Justice-Involved Patients

Case managers should communicate with criminal justice staff (i.e., Probation, Sheriff, Los Angeles Superior Courts, etc.) to ensure that Case Management activities meet criminal justice supervision requirements. As needed, case managers may be asked to perform the following activities:

- Attend court hearings to report progress in treatment.
- Arrange letters, phone calls, and/or direct face-to-face meetings with law enforcement agencies (Probation Department, Sheriff's Department, and Parole) and courts (Superior Courts) about patients.
- Enter data into non-Sage electronic systems (e.g., Treatment Court Probation eXChange (TCPX) and Drug Court Management Information System (DCMIS), Probation Department web-based reporting system).

See ***Los Angeles County Superior Court Referrals*** and ***Los Angeles County Sheriff's Referrals*** sections for more information.

Children and Family Services

For patients that participate in County funded programs for children and family services, one of the primary focuses for providers should be the family unit (e.g., helping patients meet requirements set forth in their family reunification plan). Therefore, Case Management activities should help patients gain access to services and resources that take into account family needs. Case Management activities for this group may include linkage to parenting classes, child care, food and clothing assistance, and family planning services.

When working with children, families, and perinatal women, the case manager should confer with the patient's DPSS worker, DCFS social worker, DMH worker, etc., at least once to ensure that the objectives and activities developed in Case Management are consistent and don't unintentionally overwhelm the patient.

See the ***Department of Public Social Services (DPSS) – California Work Opportunity and Responsibility to Kids (CalWORKs) Referrals***, ***Department of Children and Family Services (DCFS) – Promoting Safe and Stable Families Time-Limited Family Reunification (PSSF-TLFR)***, ***Department of Children and Family Services – Family Dependency Drug Court (FDDC)***, ***and Pregnant and Parenting Women*** sections to learn more about these populations and requirements.

Service Requirements and Components

Eligibility Criteria for Case Management Services

Case Management services are available to all patients who are enrolled in all levels of care under the Drug Medi-Cal Organized Delivery System (DMC-ODS). Reimbursement eligibility criteria for Case Management services are the same as DMC-ODS enrollment criteria. The beneficiary must:

- Have Los Angeles as their County of Residence and be treated at a SAPC-contracted treatment facility; Be eligible for Medi-Cal or My Health LA, or concurrently participating in other County funded programs/projects such as AB 109, CalWORKs, GR, JJCPA, PSSF-TLFR, or Title IV-E;
- Meet medical necessity criteria based upon ASAM criteria or be determined to be at-risk for developing SUD for ages 12 to 20, if applicable; and
- Be enrolled in a treatment level of care or recovery support services

Staffing Requirement

Various members of the treatment team can function as the case manager, including registered/certified SUD counselors and Licensed Practitioners of the Healing Arts.

Documentation

Planning and documentation are important to a structured and integrated Case Management model. Following the comprehensive and multidimensional ASAM Continuum or SAPC Youth ASAM assessment, which should include a patient's Case Management needs, a case manager must discuss the results and collaborate with the patient to develop a plan that includes the patient's Case Management needs. The plan for how to address a patient's Case Management needs should be incorporated into the Treatment Plan.

The Case Management component of the Treatment Plan must be able to track key components of service, including Case Management needs, Connection/Coordination/Communication activities, and advocacy efforts. Regular Miscellaneous Notes clearly documenting Case Management activities are critical to demonstrating the rationale and details of the activities performed. Case managers are responsible for working with patients to implement the Case Management component of the Treatment Plan and monitor the patient's progress.

The Case Management component of the Treatment Plan must describe the patient's relevant resources and prioritized service needs and must include a quantifiable statement of the patient's short-term and long-term goals, planned activities, desired outcomes, and target completion dates. When appropriate, the Treatment Plan must identify barriers, contingencies for anticipated complications, or alternative plans to achieve stated objectives on which the case manager should focus.

Although evaluating for Case Management needs, discussing the Case Management component of the Treatment Plan, and carrying out Case Management activities as outlined in the Treatment Plan can be billed under Case Management, Treatment Plan development and updates are not a part of Case Management and should only be billed under Treatment Plan.

Service Hour Requirements

Up to ten (10) hours of Case Management services per month, per level of care, may be provided for all patients served in the County specialty SUD system (adults, young adults, and youth) except for Outpatient At-Risk and Recovery Support Services.

Case Management service hours for At-Risk youth and young adults are combined with other treatment services (Group Counseling, Patient Education, and Individual Counseling) and cannot exceed 40 units or ten (10) hours per 60-days (inclusive of intake services). Patients are allowed up to two (2) episodes per calendar year.

Case Management service hours for Recovery Support Services are also combined with other treatment services (Individual Counseling, Group Counseling, Recovery Monitoring, and Substance Abuse Assistance). Combined services cannot exceed six (6) hours per month for youth (age 12-17), and seven (7) hours per month for adults (age 18+).

Case Management services shall be consistent with and shall not violate confidentiality of patients as set forth in 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records; CFR 438 Managed Care; HIPAA; California Code of Regulations (CCR) Title 9 Counselor Certification the California Code of Regulations; and CCR Title 22 Drug Medi-Cal.

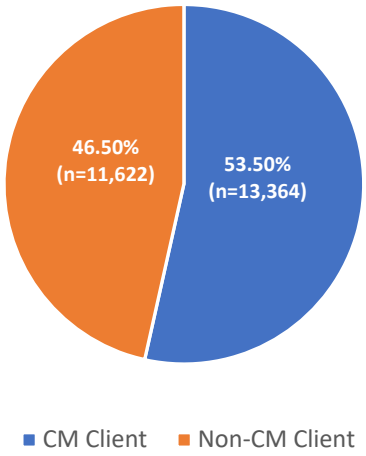
Case Management References

Case Management Scenarios		
***Note**: Although not an exhaustive list, these scenarios are meant to help providers distinguish between the types of services that are and are **NOT** billable under Case Management. The non-billable scenarios listed include activities that **should be conducted**, when appropriate, but **cannot be billed** under Case Management.*		
	Billable	**Non-Billable**
Connection	• Actively helping patients apply for Medi-Cal • Completing the Coordinated Entry System Survey Packet including the Vulnerability Index - Service Prioritization Decision Assistance Tool for adults, or the Next Step Tool for youth; and linking patients to housing resources. • Transferring Medi-Cal benefits for patients who have moved, from the previous county of residence to Los Angeles County. • Linking patients to community resources such as food and clothing assistance.	• Providing transportation for patients to scheduled appointments. **Providers should arrange transportation for patients to and from appointments and attend scheduled appointments, if patient consent is given. However, the time spent traveling to and from appointments is non-billable (except for patients in Residential Treatment, which is covered in the day rate and Perinatal patients in the Perinatal Practice Guidelines).**
Coordination	• Identifying a referral agency by using the Service and Bed Availability Tool (SBAT) and scheduling an appointment for a level of care transition (e.g., from Intensive Outpatient or ASAM 2.1 to Low Intensity Residential or ASAM 3.1, etc.). • Coordinating action plans with mental health providers to ensure patients are provided complementary services.	• Documenting case management activities in Miscellaneous Notes, including information regarding recent primary care and specialist visits, emergency room visits, auxiliary treatment services (e.g., dialysis), and any community resources received. **Although providers are expected to conduct these activities, time spent documenting these activities are non-billable.**
Communication	• Entering and updating data into the Treatment Court Probation eXChange (TCPX), Drug Court Management Information System (DCMIS), and Clarity Homeless Management Information System (HMIS). • Data entry into Probation Department's web-based reporting system for JJCPA referrals • Time spent communicating with service providers, county workers, judges, etc., either face-to-face or by phone (e.g., meeting with patient and doctor during a primary care visit). • Following up with other agencies regarding scheduled services and/or services received by patients. • Providing written or verbal status reports to health and mental health providers, and county partners (e.g., Department of Children and Family Services, Probation Department).	• Entering data into Sage (pre-authorizations, authorizations, progress notes, etc.). • Attempting, but not successfully contacting service providers either by phone or face-to-face. **Providers should only bill for Case Management if they are successful in communicating with other service providers on the patients' behalf.**

Case Management Checklist			
***Note**: This checklist is a reference tool for use during Case Management sessions to ensure that core functions of case management, and their respective activities, are being performed. This is not meant to be an exhaustive list of case management activities. This table is intended to offer examples of activities that should be covered in sessions, when applicable, and can be billed as Case Management.*			
Topics		**Potential Activities**	**Performed in session? (Y/N)**
Connection	**Establishing & Maintaining Benefit**	Actively help patients to apply for and maintain health and public benefits (e.g., Medi-Cal, My Health LA, General Relief, Perinatal, Housing, etc.).	
		Transfer Medi-Cal benefits from the previous county of residence to Los Angeles County for patients who have moved.	
	Community Resources	Link patients to community resources and services (e.g., transportation, food and clothing assistance, family planning services, legal assistance, educational services, vocational services, housing, etc.)	
Coordination	**Transitions in SUD LOC's**	Facilitate necessary transitions in substance use disorder levels of care (e.g., initiating referrals to the next level of care, coordinating with and forwarding necessary documentation to the accepting treatment agency, etc.).	
	Health Services	Coordinate care with physical health, community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.	
	Social Services	Coordinate activities with state, County and community (e.g., DPSS, DCFS, Probation, Superior Courts, Housing Providers, etc.) entities.	
Communication	**Other Health Providers**	Communicate face-to-face or by phone with physical health, community health clinics and providers, and mental health providers	
	Service Partners	Communicate face-to-face or by phone with Department of Public Social Services (DPSS) workers, Department of Children and Family Services (DCFS) social workers, Department of Mental Health (DMH) workers, Probation Officers, Housing Providers, etc.	
	Advocacy	Advocate for patients with health/social service providers, County and community partners, and others in the best interests of patients.	

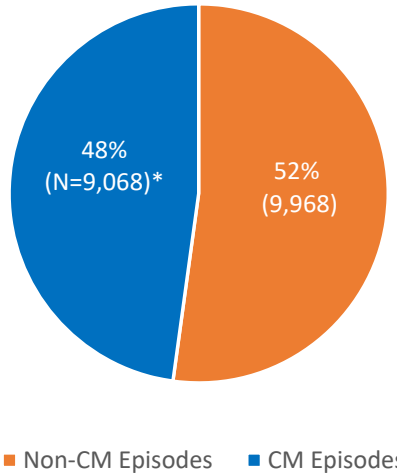
Benefits of Case Management

Unique clients with CM vs Non-CM services per Billing
(N=24,896 unique clients), 7/2018-5/2019



*Unique CM Clients in billing matched with CalOMS discharge data

Number of clients (episodes) discharged per CalOMS
(N=19,036), 7/2018-5/2019



- According to billing data (7/2018-5/2019), 53.5% of unique clients (n=13,364) submitted at least one unit of CM service claims (CM clients).
- 90% (12,018) of those unique CM clients (13,364) were matched with CalOMS data accounting for 16,667 episodes; 54% (9,068) of those matched CM clients (episodes) were discharged after July 2018.
- Final analysis sample: 48% (9,068) CM clients (episodes) and 52% (9,968) non-CM clients (episodes) among 19,036 total discharged clients (episodes) during July 2018 to May 2019;

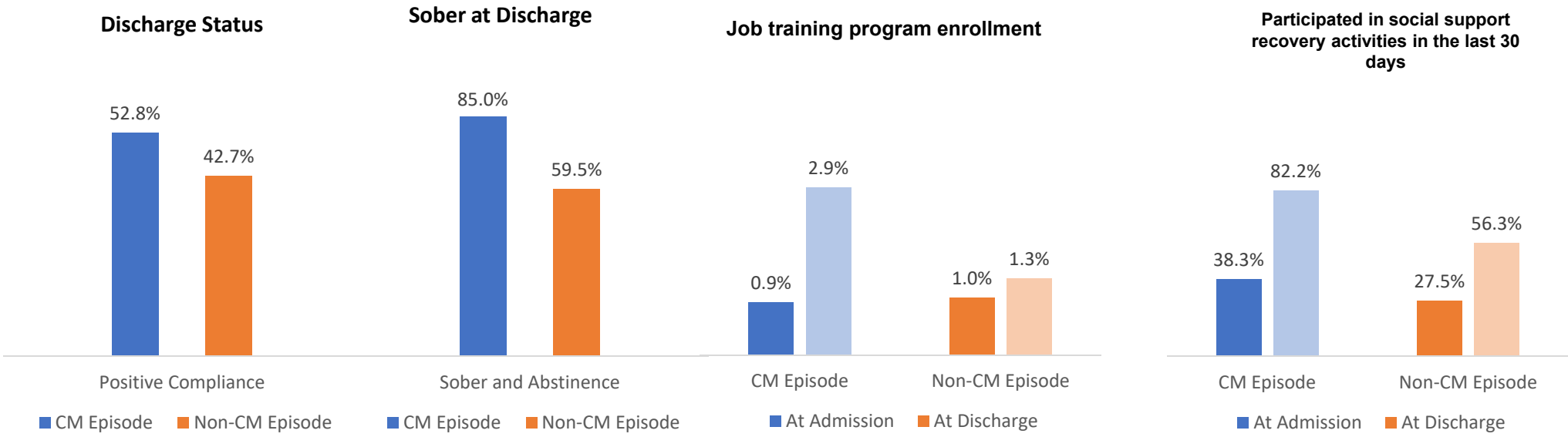
Source: Sage billing claims data and Los Angeles County California Outcome Measurement System (CalOMS) data. Substance Abuse Prevention and Control, Los Angeles County Department of Public Health.

Client Characteristics at admission (7/2018-5/2019)

	CM Clients (9,068 episodes)	Non-CM Clients (9,968 episodes)
Homelessness	36.0%	25.2%
Been sexually abused in the last 30 days	21.9%	14.8%
Been physically abused in the last 30 days	30.0%	20.6%
Been in jail in the last 30 days	18.3%	11.2%
Experiencing mental health problems in the last 30 days	35.0%	31.3%

Notes: Percentages based on non-missing values.
Source: Los Angeles County California Outcome Measurement System (CalOMS) data. Substance Abuse Prevention and Control, Los Angeles County Department of Public Health.

Outcomes between CM vs non-CM clients (episodes)

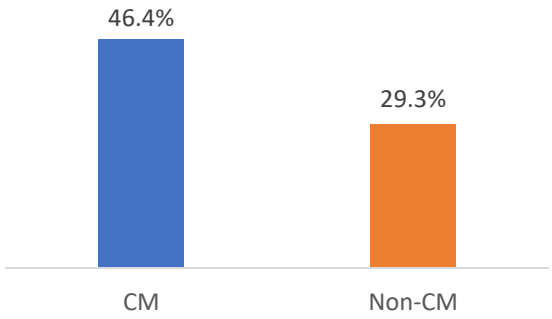


- CM clients were more likely to have positive treatment compliance, to be sober/abstinent at discharge; more enrolled in job training (222% increase from admission), and participated in social support recovery activities (115% increase from admission) at discharge.

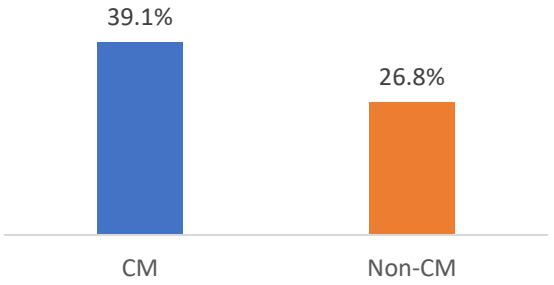
Notes: Percentages based on non-missing values.
Source: Los Angeles County California Outcome Measurement System (CalOMS) data. Substance Abuse Prevention and Control, Los Angeles County Department of Public Health.

Treatment Effectiveness between CM vs Non-CM clients

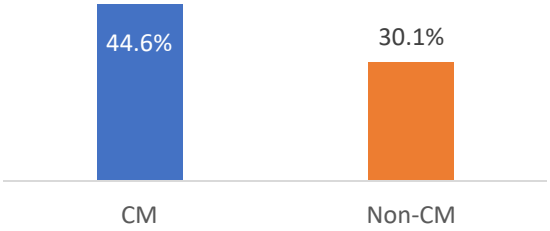
% of clients who reported improvement in personal responsibility from admission to discharge



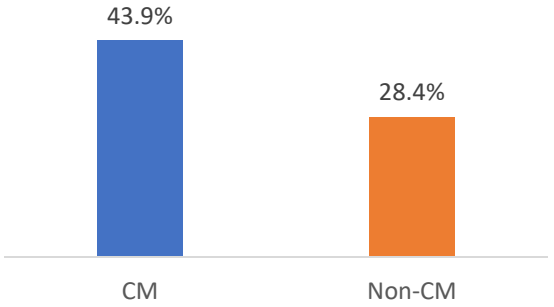
% of clients who reported improvement in their AOD use from admission to discharge



% of clients who reported improvement in their physical health from admission to discharge



% of clients who reported improvement in their Mental Health from admission to discharge



- CM clients were more likely to report improvement in personal responsibility, AOD use, physical health and mental health at discharge compared to at admission (measured at two time points)

Personal Responsibility: How good are you in taking care of personal responsibilities (e.g., paying bills, following through on personal or professional commitments)?
Alcohol and Drug Use: How good are you with drug and alcohol use? (e.g., the frequency and amount of use, money spent on drugs, amount of drug craving, being sick, etc.)
Physical Health: How good is your physical health? (e.g., are you eating and sleeping properly, exercising, taking care of health or dental problems)
Mental Health: How good is your mental health? (e.g., are you feeling good about yourself?)