California County Administrator Survey 2015 Results

UCLA Integrated Substance Abuse Programs

Key Findings:

- Of the 47 counties that responded, almost three quarters indicated they intend to opt in to the DMC-ODS waiver. Those that did not or were unsure cited reasons such as complex waiver requirements, lack of county resources, lack of access to residential treatment, uncertainty regarding reimbursement rates, and small size of county.
- Counties reported that the most challenging modality to expand was residential treatment, followed by NTP and detoxification. About a quarter of counties (27%) indicated that NTPs were not available and would not be in the next 12 months. Facility certification and reimbursement rates were common barriers to expanding capacity across almost all modalities of treatment.
- Sharing/tracking/monitoring client data along the continuum of care and withdrawal management services were also rated as challenging implementation issues.
- A centralized system for screening and placing clients into treatment exists for at least some services in 82% of counties, and is used for all services in 40%. Based on written descriptions, UCLA estimated that 10 counties are currently collecting some form of ASAM criteria data.
- Overall, county SUD departments/divisions and providers were better integrated with their corresponding entities for mental health than with physical health. At the time of the survey, no counties had signed MOUs with managed care plans that met all requirements of the DMC-ODS waiver, but many had mental health MOUs that will be amended to meet DMC-ODS requirements.

Based on the results of this baseline survey, significant challenges exist, but there are also promising practices around the state that may inform county waiver implementation (relevant materials are being distributed separately). UCLA plans to repeat similar surveys at regular intervals to track progress toward an organized delivery system as the waiver is implemented.

Introduction

As part of baseline data collection for the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver evaluation, UCLA conducted an online survey of behavioral health directors and substance use disorder administrators from each county in California. The survey addressed the following topics: access to care; screening and placement practices; quality of care; collaboration, coordination, and integration; services and training; and waiver implementation preparation/status.

Method

UCLA developed the survey internally with feedback from DHCS as well as the evaluation advisory group, which is composed of representatives from large, medium, and small counties; treatment providers; and experts in evaluation, policy, and training. The survey was distributed online via SurveyMonkey. UCLA invited one county administrator in each county by e-mail to participate (n = 57; the counties of Sutter and Yuba share one administrator).

Results

From September 4, 2015 through October 13, 2015, UCLA received 47 completed responses (82%) and 1 partial response (2%), with 9 responses missing (16%).

UCLA presented a preliminary discussion of the results of this survey at the California County Behavioral Health Directors Association (CBHDA) Substance Abuse Prevention and Treatment (SAPT)+ Committee Quarterly Meeting in Sacramento, CA on September 24, 2015. The results discussed in this document have been updated based on further clarifications received from counties and from additional responses received after the initial presentation.

Waiver Status

Opt-in Status

Thirty-four respondents (71%) indicated that their county intends to opt in to the DMC-ODS waiver, 2 (4%) indicated their county does not intend to opt in, and 11 (23%) were uncertain. Of the undecided counties, 4 are "likely" to opt in, and 7 are "neutral". Ten counties either did not complete the survey or did not respond to questions about waiver opt-in status; therefore, their status is currently unknown.

Counties that were unsure or that do not intend to opt in to the waiver cited barriers such as complex waiver requirements, lack of county resources, lack of access to residential treatment, fiscal uncertainty regarding reimbursement rates, and small size of county. Others noted that a regional model of implementation would increase their likelihood of opting in.

Access to Care

Beneficiary Access

Half of the respondents (n = 24, 50%) reported that their county has a current toll-free beneficiary access number for SUD services, while 19 (40%) are planning to have one and 5 (10%) do not have a number and do not have plans for one.

Of the 24 counties that have a beneficiary access number, 23 of them (96%) provide services in all threshold languages in the county and 1 does not (4%).

Of the 19 counties that plan to have a beneficiary access number for SUD, 15 (79%) expect their number to provide services in all threshold languages in their county, 1 (5%) does not expect it to provide services in all threshold languages, 2 (11%) did not know, and 1 (5%) did not respond.

Capacity Measurement

When asked how confident they are in the accuracy of the numbers being reported to the DHCS Drug and Alcohol Treatment Access Report (DATAR) system for outpatient treatment in their

counties, on average, respondents were "moderately confident" (*M* = 3.11, on a 1-5 scale from 1 = *not at all confident* to 5 = *completely confident*).

Counties that indicated less confidence in DATAR provided the following comments:

- *Many providers do not have a consistent way of capturing data related to the first call for assistance.*
- *Most clients do not wait for treatment, so the drop-off from the waiting list is very high. This makes DATAR a poor measure of capacity or access.*
- *It is useless to the providers, so we have to keep reminding them to do DATAR. We use it to give a yearly report to the Board of Supervisors, but that's all it's used for.*
- *A standard for determining capacity is very unclear.*

Meanwhile, comments from counties indicating greater confidence in DATAR included the following:

- *Our provider contracts require input into DATAR by the 5th of each month. We have staff who monitor timeliness of this data input.*
- *There are OP numbers in DATAR since there is no wait.*
- *Being a very small county, it is very simple to determine this.*
- *We are the only provider reporting in DATAR.*

Twenty-one (21) counties (44%) indicated that they maintained some other form of data, in addition to DATAR, measuring outpatient treatment capacity or the amount of currently available treatment slots, while 27 counties (56%) did not. Additionally, 23 counties (48%) reported maintaining some form of data on the ratio of clients to counselors, while 25 did not (52%).

Expanding Capacity

The modality most commonly selected by the counties as most challenging to expand (either by creating new programs, increasing capacity at existing programs, or having existing programs become DMC certified) was residential (*n* = 23, 48%), followed by NTP (*n* = 10, 21%) and detoxification (*n* = 7, 19%). No counties selected outpatient treatment as the most challenging modality to expand.

Issues most commonly chosen as significant challenges in expanding capacity in each modality are listed in the table below. Facility certification was reported as one of the four most significant challenges for expanding capacity in all 5 modalities. In addition, reimbursement rates were reported by at least 21 counties as being a significant challenge for expansion for all modalities except for NTP.

Ranking of Challenge	Residential	Detoxification	Intensive Outpatient	Outpatient	NTP
1	Reimbursement rates (*n* = 29)	Reimbursement rates (*n* = 27)	Facility certification (*n* = 21)	Reimbursement rates (*n* = 26)	Community opposition (i.e., NIMBY) (*n* = 18)
2	High upfront investment required/financial risk (*n* = 28)	Space (*n* = 26)	Reimbursement rates (*n* = 21)	Facility certification (*n* = 18)	Facility certification (*n* = 16)
3	Space (*n* = 25)	Facility certification (*n* = 25)	Regulatory requirements (e.g., documentation) (*n* = 20)	Regulatory requirements (e.g., documentation) (*n* = 18)	Staff certification/licensing (*n* = 14)
4	Facility certification (*n* = 25)	High upfront investment required/financial risk (*n* = 23)	Staff certification/licensing (*n* = 16)	Staff certification/licensing (*n* = 15)	High upfront investment required/financial risk (*n* = 14)

Screening and Placement

Data Systems

Nineteen counties (40%) have a centralized system for screening and placing clients into treatment for all SUD services, while 20 (42%) have a system for some SUD services (such as residential).

Nine (19%) counties do not have a centralized system for screening and placing clients into treatment. Of these 9, 5 (56%) have standardized screening and placement procedures across all treatment providers (i.e., there is a uniform procedure and set of questions used across the county), while 4 (44%) do not.

ASAM Criteria

Of the 48 counties that responded to this item on the survey, 28 (42%) reported either currently collecting ASAM criteria data from assessment centers and/or treatment providers, or planning to collect it within the next year. UCLA examined respondents' written comments and estimated that 10 counties (21%) are currently collecting some form of ASAM criteria data from assessment centers and/or treatment providers.

Quality of Care

Quality Improvement

Thirty counties (63%) reported having a quality improvement committee with SUD participation (which could include a behavioral health committee with MH and SUD participation), and 17 reported planning to have one (35%). One county (2%) reported not having a quality improvement committee with SUD participation nor having plans for one.

Ten counties (21%) reported having a written substance use disorder treatment system quality improvement plan, 34 (71%) reported planning to have one, and 4 reported no plans to have one (8%).

Client Satisfaction

Thirty-one counties (65%) reported requiring SUD treatment providers to collect client satisfaction/perceptions of care data, 11 (23%) reported planning to, and 6 (13%) reported no plans in the immediate future.

Among the counties with these requirements for SUD treatment providers, the most common method of collecting the data was written surveys (*n* = 29, 94%), and the most common frequency for collection was at least yearly (*n* = 16, 52%).

Collaboration, Coordination and Integration

Provider Coordination

Twelve counties (25%) currently require SUD providers to establish formal procedures with other SUD providers to facilitate client transfer and information exchange (e.g. MOUs between residential and outpatient providers), while 36 (75%) do not. Of the counties without explicit requirements, 19 counties (40%) reported establishing recommended procedures to encourage effective client transfers and information exchange between levels of care, 14 (30%) reported doing other activities, 5 (11%) reported doing nothing at this time, and 2 (4%) reported providing funding support or incentives.

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

Nineteen counties (40%) have guidelines or requirements for SUD providers to partner with mental health providers and 20 counties (42%) are planning to have guidelines or requirements, while 15 counties (31%) have guidelines or requirements for SUD providers to partner with physical health providers and 26 (54%) have plans to implement such guidelines or requiremetns. Fourteen counties (21%) reported having procedures to monitor the establishment or utilization of either of the above types of partnerships.

Coordination with Managed Care Plans

The average reported number of Medi-Cal managed care plans operating in each county is 1.77, with the number ranging from 1 to 5. The majority of counties reported no MOUs with their Medi-Cal managed care plans that meet all requirements of the DMC-ODS waiver (*n* = 36, 75%), though 8 counties (17%) reported having such MOUs with at least one Medi-Cal managed care plan in their county. Four counties did not respond (8%).

Further correspondence with counties clarified that none of their existing MOUs currently meet all the requirements of the DMC-ODS waiver, although many counties have MOUs in place with managed care plans for specialty mental health, and several counties reported currently having MOUs in place for DMC services, which may be amended to meet the DMC-ODS waiver requirements.

Leadership Collaboration

Overall, counties rated the degree to which their SUD and mental health departments/divisions are integrated greater than the degree to which their SUD and health services departments/divisions are integrated. On a 1-5 Likert scale between "very poorly" and "very well" integrated, counties on average rated MH to be well integrated with SUD (mean = 3.59) whereas health services was rated as only "somewhat well" with SUD (mean = 2.72).

Regarding collaboration between MH and SUD, three counties (6%) indicated that an MOU is in place between SUD and MH defining goals and objectives for partnering and collaboration. Eleven counties (23%) have a written agreement other than an MOU defining goals and objectives for partnering and collaboration. Fourteen counties (29%) expect collaboration and do not require or need a formal document to define goals and objectives for partnering and collaboration. Five counties (10%) reported that no formal collaboration occurs, or that it occurs ad hoc.

Fourteen counties (29%) reported that MH and SUD are a single, fully integrated entity. UCLA intended this response option to represent counties in which staff are responsible for both mental health and SUD (without departmental divisions), such as very small counties. However, as some large and medium-sized counties selected this response, it may indicate that this response option was interpreted differently and these counties may actually belong in the other groups discussed above.

The majority of counties (n = 26, 54%) reported that SUD and MH leadership communicates regularly for collaboration purposes via scheduled face-to-face meetings and/or conference calls, and 4 counties (8%) reported that SUD and MH leadership communicates regularly for collaboration purposes via informal email exchange and by ad hoc project needs. Three counties responded "other" (6%), of which two noted that they had small behavioral health departments that share leadership and staff. Of the 26 counties reporting scheduled meetings, SUD and MH leadership met frequently, with the majority of counties having meetings at least weekly (n = 16, 62%). Others reported that meetings occur monthly (n = 9, 35%) or quarterly (n = 1, 4%).

Similarly, the majority of counties (n = 28, 58%) reported that SUD and health services leadership communicates regularly for collaboration purposes via scheduled face-to-face meetings and/or conference calls, 6 counties (13%) reported that SUD and MH leadership

communicates regularly for collaboration purposes via informal email exchange and by ad hoc project needs, and 7 (15%) reported that leadership does not communicate regularly but receives written updates of other dept/division activities through email blasts or listserv notices. Six counties (13%) reported some other type of communication. Of the 28 counties reporting scheduled meetings between SUD and health services leadership, 15 counties reported meeting monthly (54%), 6 reported meeting quarterly (21%), and 7 reported some other frequency (25%).

Twenty-three respondents (48%) agreed that their counties' SUD and MH department/division staff meet frequently enough to support an organized and integrated delivery system at the county level, while 10 (21%) disagreed. Meanwhile, 19 respondents (40%) agreed that their counties' SUD and health services department/division staff meet frequently enough to support an organized and integrated delivery system at the county level and 28 (58%) disagreed. However, it is not possible to compare the differences between county administrator perceptions of the adequacy of the frequencies of their meetings, as the results from rating SUD and MH department/division meeting frequency adequacy do not include the 14 respondents who reported that mental health and SUD function as a single, fully integrated entity in their counties (these respondents were not shown the question due to a skip pattern built into the survey).

Services and Training

Service Status

Respondents were asked about the availability of various elements of the DMC-ODS waiver within their counties. In over half of the counties (n = 27, 56%), use of at least 2 of the 5 evidence-based practices (EBPs) listed in the waiver Standard Terms and Conditions were indicated as fully available. Meanwhile, 13 counties (27%) indicated that NTPs were not available and would not be available within the next 12 months.

ASAM assessment and placement, another aspect of the waiver, is currently available either fully or partially in fewer than half of the counties that responded (n = 20, 42%), though 46% (n = 22) anticipate that it will be available within 12 months. Additionally, coordination of services with Medi-Cal managed care plans is available in 41% of counties (n = 20) and is expected by 46% (n = 22) to be fully available within 12 months.

Counties' assessments of the status of these and other services within their counties is provided in the table below.

	Fully available	Partially available	Will be available within 12 months	Will not be available within 12 months
ASAM assessment and placement	10 (21%)	10 (21%)	22 (46%)	5 (10%)
Utilization management	7 (15%)	15 (31%)	21 (44%)	4 (8%)
Case management	10 (21%)	26 (54%)	10 (21%)	1 (2%)
Use of at least 2 of the 5 EBPs listed in the waiver	27 (56%)	15 (31%)	4 (8%)	1 (2%)
Coordination of services with Medi-Cal managed care plans	3 (6%)	17 (35%)	22 (46%)	5 (10%)
Sharing/tracking/monitoring client data along the continuum of care	4 (8%)	23 (48%)	15 (31%)	5 (10%)
NTPs	24 (50%)	6 (13%)	4 (8%)	13 (27%)
Withdrawal management	13 (27%)	17 (35%)	6 (13%)	11 (23%)
Residential services	20 (42%)	16 (33%)	5 (10%)	6 (13%)
Recovery services	13 (27%)	17 (35%)	13 (27%)	4 (8%)
LPHAs	8 (17%)	26 (54%)	8 (17%)	5 (10%)
Physician consultation	11 (23%)	19 (40%)	15 (31%)	2 (4%)
DMC billing for services	21 (44%)	13 (27%)	8 (17%)	3 (6%)

Implementation Challenge

The most challenging aspects of the waiver to implement were (in order of more to less challenging): sharing/tracking/monitoring client data along the continuum of care; withdrawal management services; residential services; utilization management; and Licensed Practitioners of the Healing Arts (LPHAs). The least challenging was use of at least 2 of the 5 EBPs listed in the DMC-ODS waiver, although this aspect was still considered "somewhat challenging".

Training Priorities

Respondents rated topics by level of priority for training in their county (5 = *high priority*, 3 = *medium priority*, 1 = *low priority*). On average, the topics of highest priority were ASAM assessment and placement (M = 4.19), utilization management (M = 4.02) and DMC billing for services (M = 3.96). A full table of average ratings is provided below.

	Mean
ASAM assessment and placement	4.19
Utilization management	4.02
DMC billing for services	3.96
Naloxone	3.62
Trauma-informed treatment	3.49
Cultural competency	3.49
Buprenorphine	3.48
Motivational interviewing	3.40
Naltrexone	3.38
Case management	3.35
Cognitive-behavioral therapy	3.28
Relapse prevention	3.19
Psycho-education	2.89
Methadone	2.78

Summary and Next Steps

Based on the results of this initial survey, there is evidence of both promising practices and room for improvement in counties' readiness for implementation of the DMC-ODS waiver. The majority of counties that responded intend to opt in to the DMC-ODS waiver, while counties that were uncertain or did not intend to opt in cite challenges such complex waiver requirements, lack of county resources, lack of access to residential treatment, and fiscal uncertainty regarding reimbursement rates. ASAM assessment and placement and coordination of services with Medi-Cal managed care plans are expected to have wider implementation in the next 12 months. Follow-up surveys are planned for the future as part of UCLA's continuing evaluation of the effects of the DMC-ODS waiver.