Drug Medi-Cal Organized Delivery System Evaluation: Baseline

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UCLA Integrated Substance Abuse Programs

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Evaluation Goals

- Evaluate the Organized Delivery System in terms of:
  - Access to care
  - Quality of care
  - Coordination of care
  - Costs
- Help inform implementation.
- Current status: BASELINE data collection

Planned Data Sources

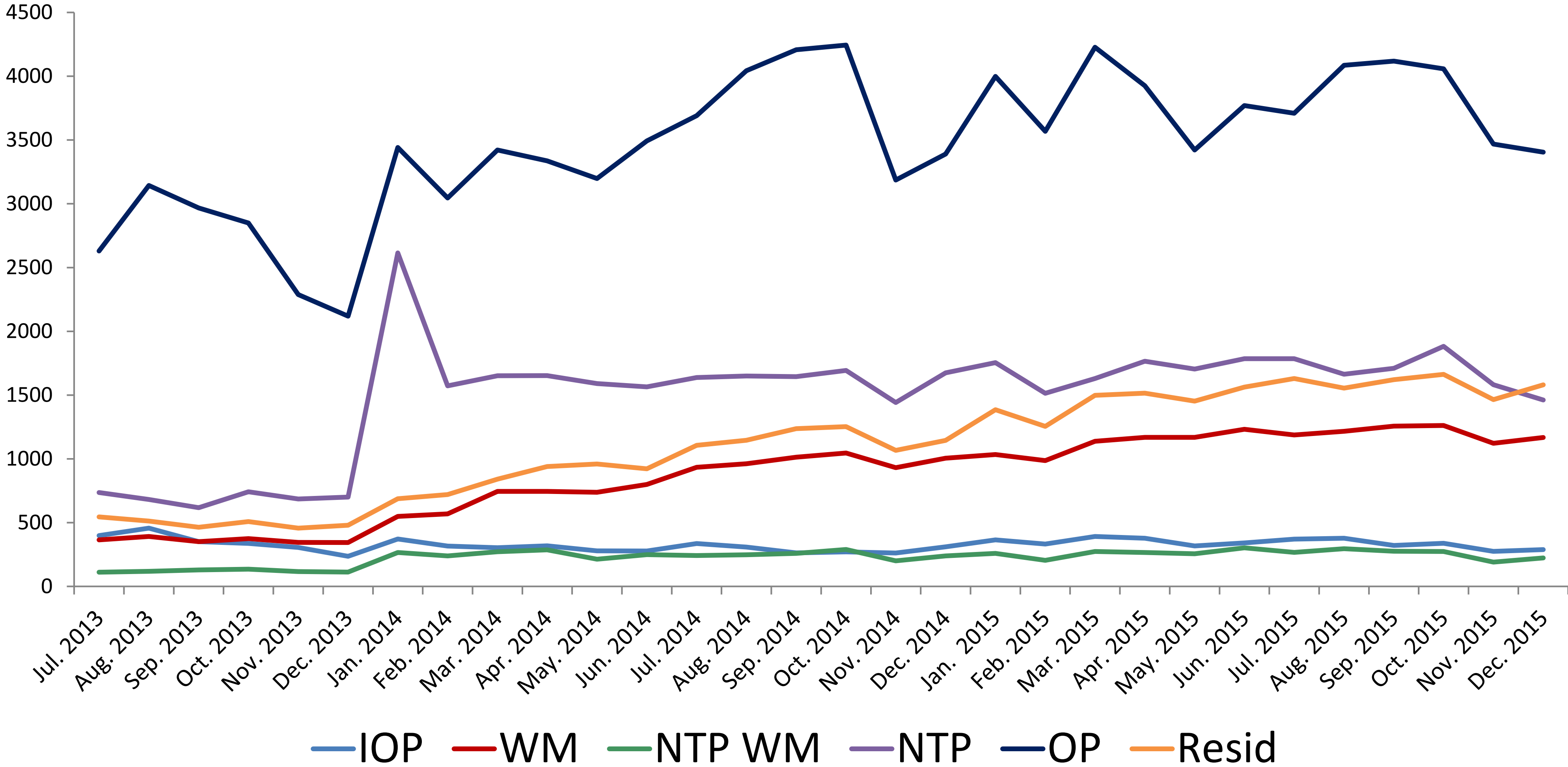
Existing Data
Drug Medi-Cal, Medi-Cal
California Outcome Measurement System – Treatment (CalOMS-Tx)
National Survey on Drug Use and Health
Potentially other sources
Document Reviews

New Data
County Administrator Surveys
Provider Surveys
Patient Surveys
Managed Care Surveys
Stakeholder Interviews / Focus Groups
"Secret Shopper" Calls
ASAM Data

DMC-ODS Evaluation plan: www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

ACCESS

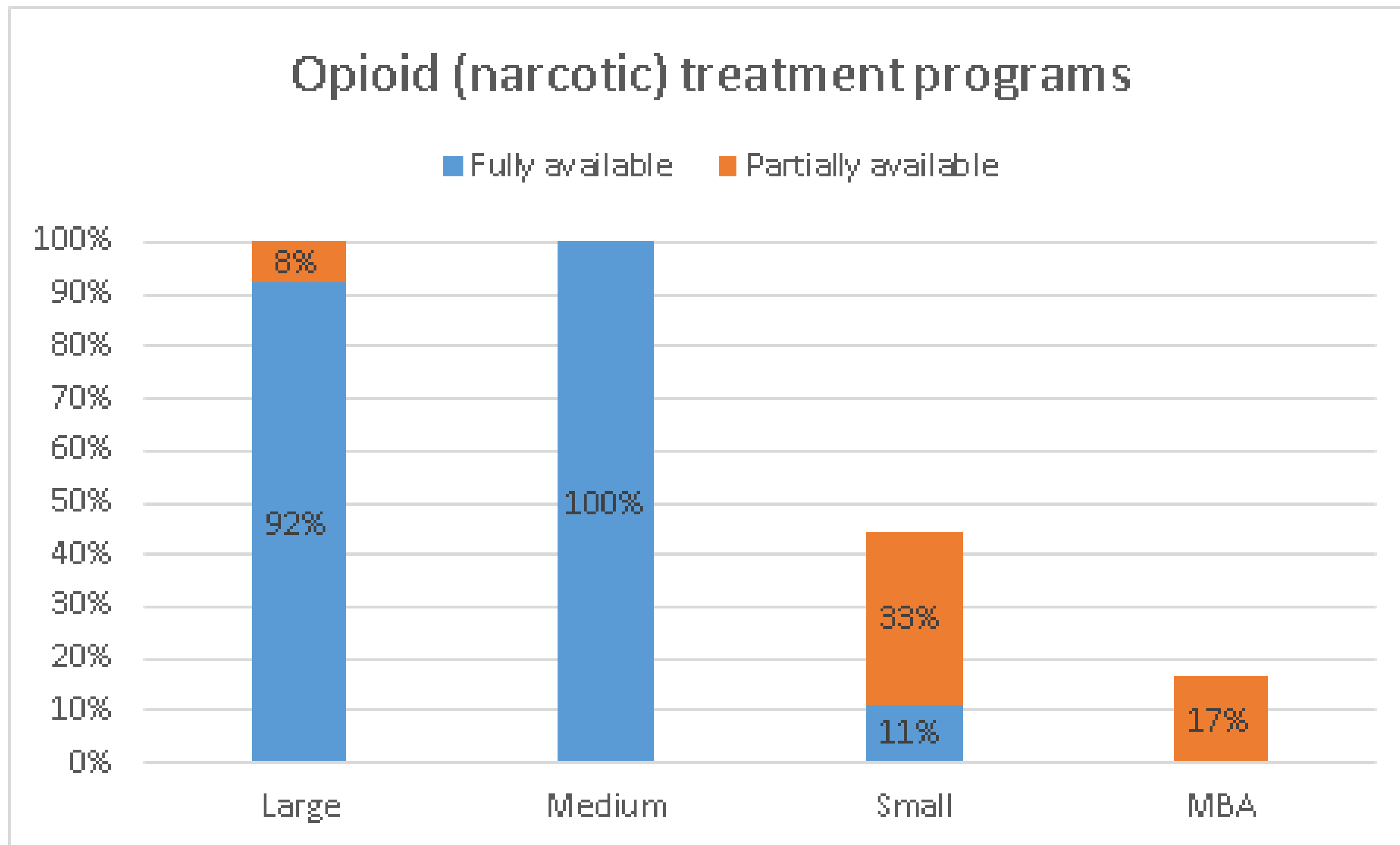
Number Of Medi-Cal Beneficiaries By Tx Modality (CalOMS-Tx)



Use of Medications, Patients w/Opiate Primary Drug
(CalOMS-Tx, 2015)

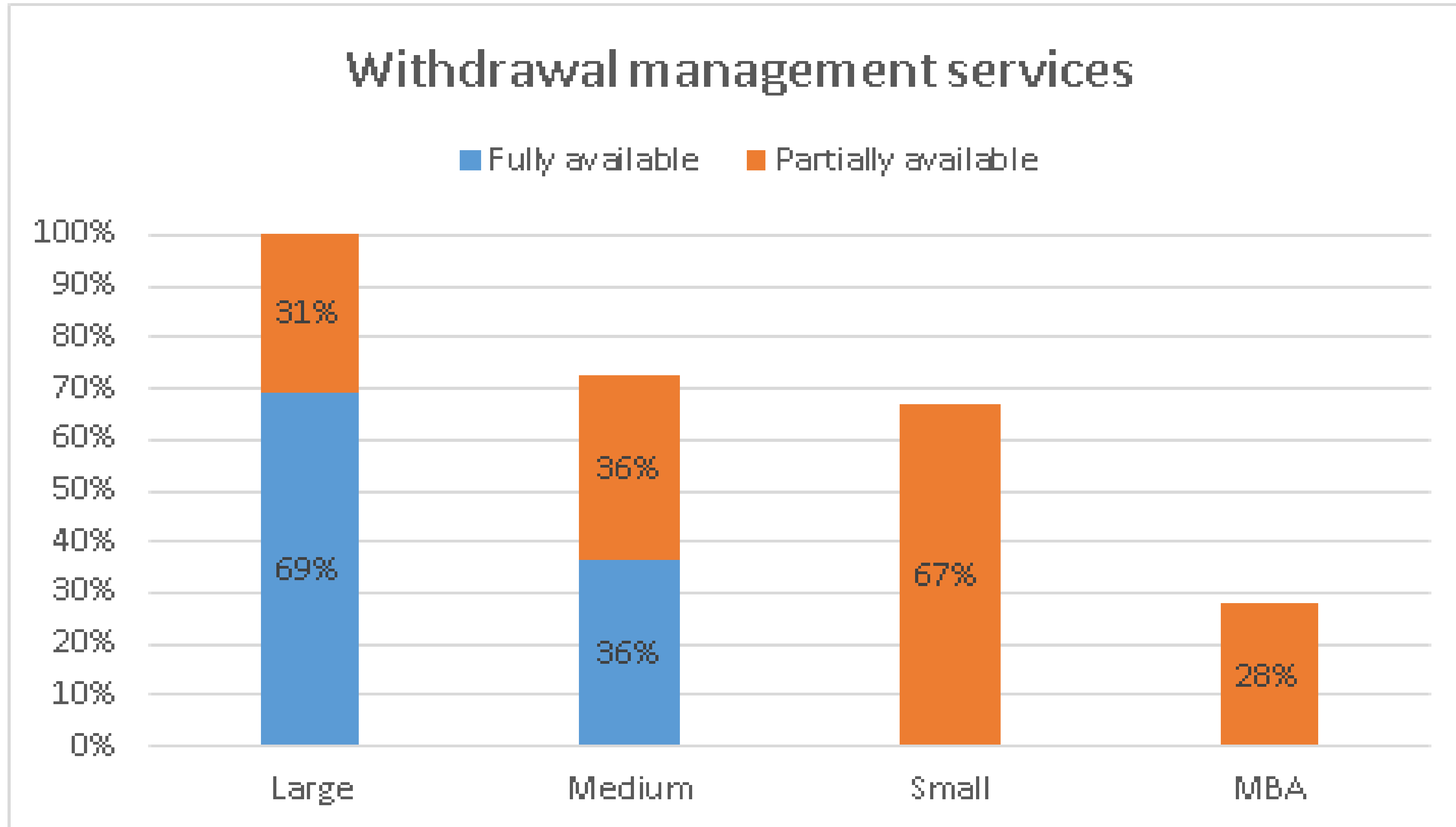
	Phase 1 Counties (N=10,315)	Phase 2 Counties (N=27,610)	Phase 3 Counties (N=9,286)	Phase 4 Counties (N=2,301)
Medication used in drug treatment				
None	37.6%	32.4%	22.6%	72.5%
Methadone	60.8%	62.5%	76.2%	26.0%
Buprenorphine (Subutex)	0.9%	1.4%	1.0%	0.7%
Other	0.7%	3.7%	0.2%	0.8%

Availability of NTPs
(Administrator Survey)



Availability of Withdrawal Management / Detox

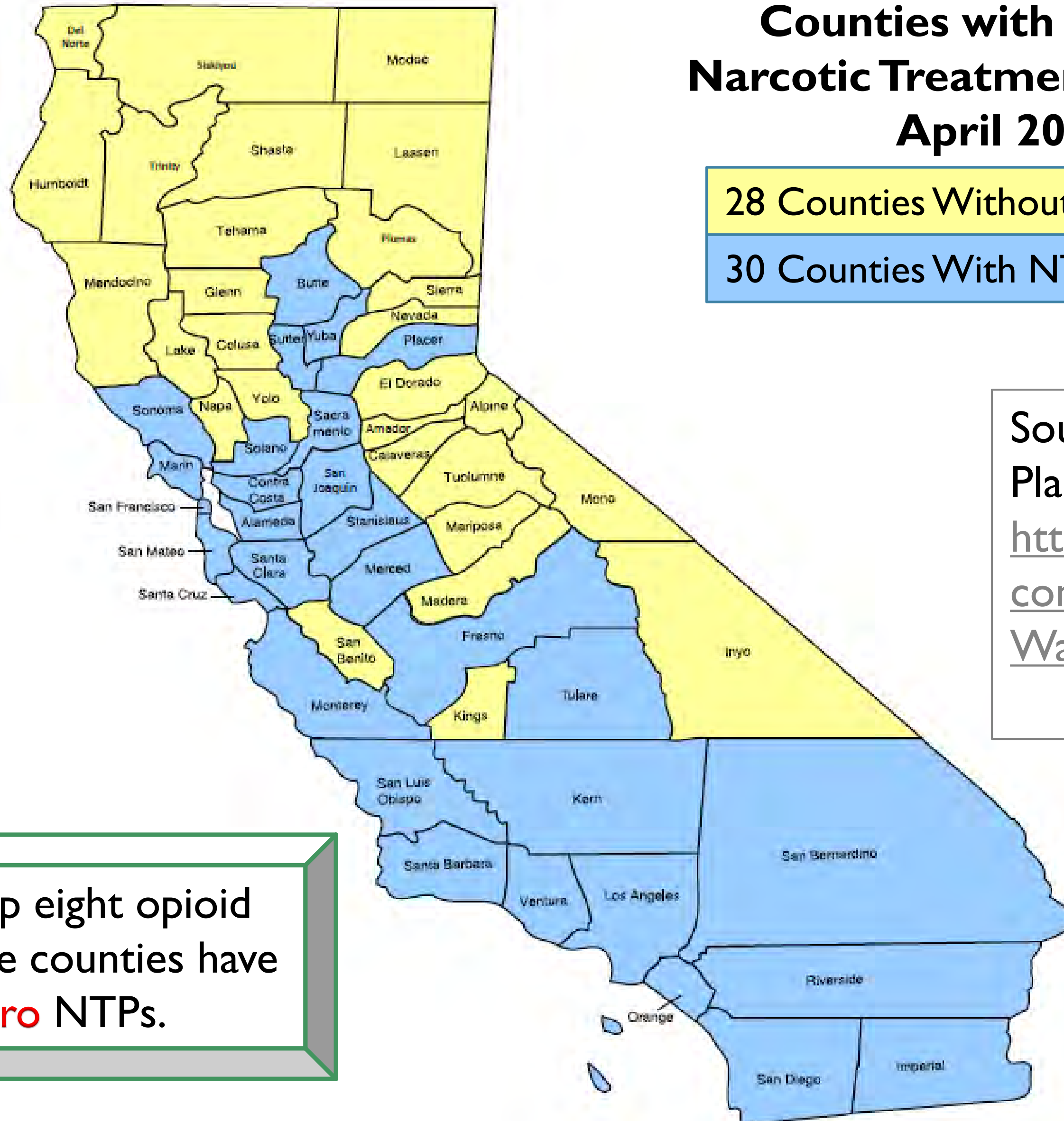
(Administrator Survey)



DHCS
California Department of
HealthCareServices

Counties with Licensed Narcotic Treatment Programs April 2016

28 Counties Without NTP Services
30 Counties With NTP Services



Source: DHCS (2016). Small County Strategic Planning. May 25, 2016 Available at: http://www.cbhda.org/wp-content/uploads/2014/12/DMC_ODS_Demo_Waiver_Pres._5-17-16.pptx

The top eight opioid overdose counties have zero NTPs.

Expansion Challenges
(Administrator Survey)

- Most challenging modalities to expand:
  1. Residential
  2. NTP
  3. Withdrawal management (detox)
- Facility certification and reimbursement rates were top challenges across modalities (may be improving)
- For NTP, community opposition (NIMBY-ism) was the top challenge.

Penetration Rates

(2013-2014, National Survey on Drug Use and Health, CA Sample)

- Penetration rates for treatment among patients who need tx are estimated to be below 10%, and below national rates, leaving room for improvement.
- Most people who needed treatment did not feel they needed specialty treatment. This suggests that although efforts to increase penetration rates can and should include expansion of physical capacity, efforts to change perceptions about specialty treatment and to reach patients in non-specialty settings, such as primary care.

Capacity / Maximum Utilization
(CalOMS-Tx, 2015)

Modality	Phase (2015 Population)			
	Phase 1 Counties (8,333,973)	**Phase 2 Counties** (23,644,610)	**Phase 3 Counties** (5,357,610)	**Phase 4 Counties** (1,049,548)
Outpatient, Intensive Outpatient				
Providers	116	251	116	39
Max Patient Census	5,114	11,582	5,198	1,403
Max Census/100,000 Popn	61	49	97	34
Residential				
Providers	80	138	41	11
Max Patient Census	1,556	3,944	1,003	169
Max Census/100,000 Popn	19	17	19	16
Withdrawal Management				
Providers	24	83	38	4
Max Patient Census	403	907	328	31
Max Census/100,000 Popn	5	4	6	3
NTP Maintenance				
Providers	40	107	38	8
Max Patient Census	2,397	5,195	2,494	134
Max Census/100,000 Popn	29	22	47	12

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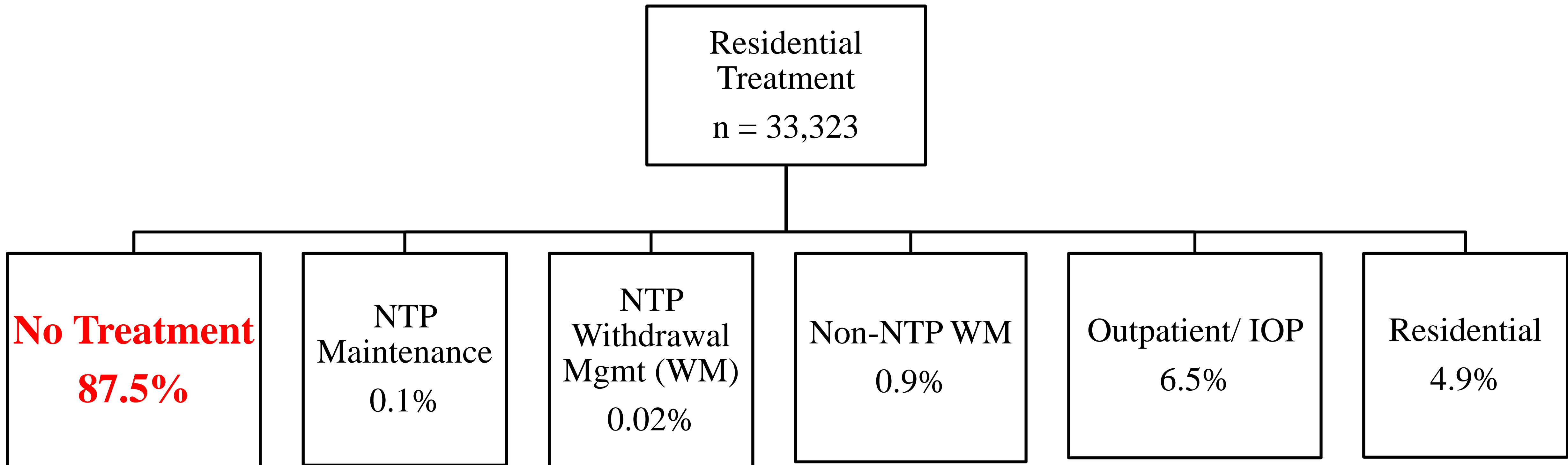
Service Delivery Following Withdrawal Management
(Transition Within 14 Days, CalOMS-Tx)

Non-NTP Withdrawal Mgmt (WM)
(n = 22,859)

- **No Treatment 76.0%**
- NTP Maintenance 0.2%
- NTP WM 0.1%
- Non-NTP WM 7.3%
- Outpatient/IOP 2.7%
- Residential 13.6%

Service Delivery Following Residential Treatment
(Transition Within 14 Days, CalOMS-Tx)



Quality Findings

- *Patient quality of care perceptions.* Most counties (65%) require SUD treatment providers to collect patient satisfaction/perceptions of care data, typically written surveys.
- *Establishment of quality improvement (QI) committees and plans* Most counties (63%) had a QI committee with SUD participation, but only 21% had a written SUD QI plan.
- *Patient outcomes at baseline.* CalOMS-Tx data suggest patients improved from treatment admission to discharge for AOD use, social support, living arrangements, and employment. *UCLA has concerns about data quality and completeness, however.*
- *Readmissions to withdrawal management and residential treatment.*
  - Among patients who initially received WM, **10.4%** were re-admitted within 30 days of discharge
  - Among patients who initially received residential tx, **6.2%** were re-admitted within 30 days of discharge.
  - Readmissions may actually be higher. For now this is based on CalOMS-Tx.
  - Context: 30-day all-cause hospital admissions for heart attacks and pneumonia: 17-18%*
- Retention: 57% of admissions to long term residential treatment surpassed 30 days. 69%-70% for NTP, OP, IOP.
- **75% of county administrators reported that the waiver has positively influenced quality improvement activities in their counties.**

*Source: http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/

Quotes on Waiver Impact

"Pushed integration to one whole QI [Committee] for both MH and SU."

"The merger of AOD with Mental Health is an outcome influenced by the waiver along with coordination of quality improvement."

"The ODS waiver has positively influenced everything in our current system of care, though our current system of care is largely successful."

"Our quality management department has been more active in looking at their SUD activities, and asking for input in how to meet the SUD EQRO."

INTEGRATION &
COORDINATION

Coordination

- *MOUs between SUD and managed care plans*: At the time of UCLA's County Administrator survey in 2015, no county had a signed MOU that met all waiver requirements. (this has changed)
- *Referrals from Health Care*: Referrals remain very low (~3% of admissions). Where they do occur, it tends to be for withdrawal management followed by residential, intensive outpatient.
- 44% of administrators reported that DMC ODS waiver planning had already had a positive impact on communication with physical health services in their county.

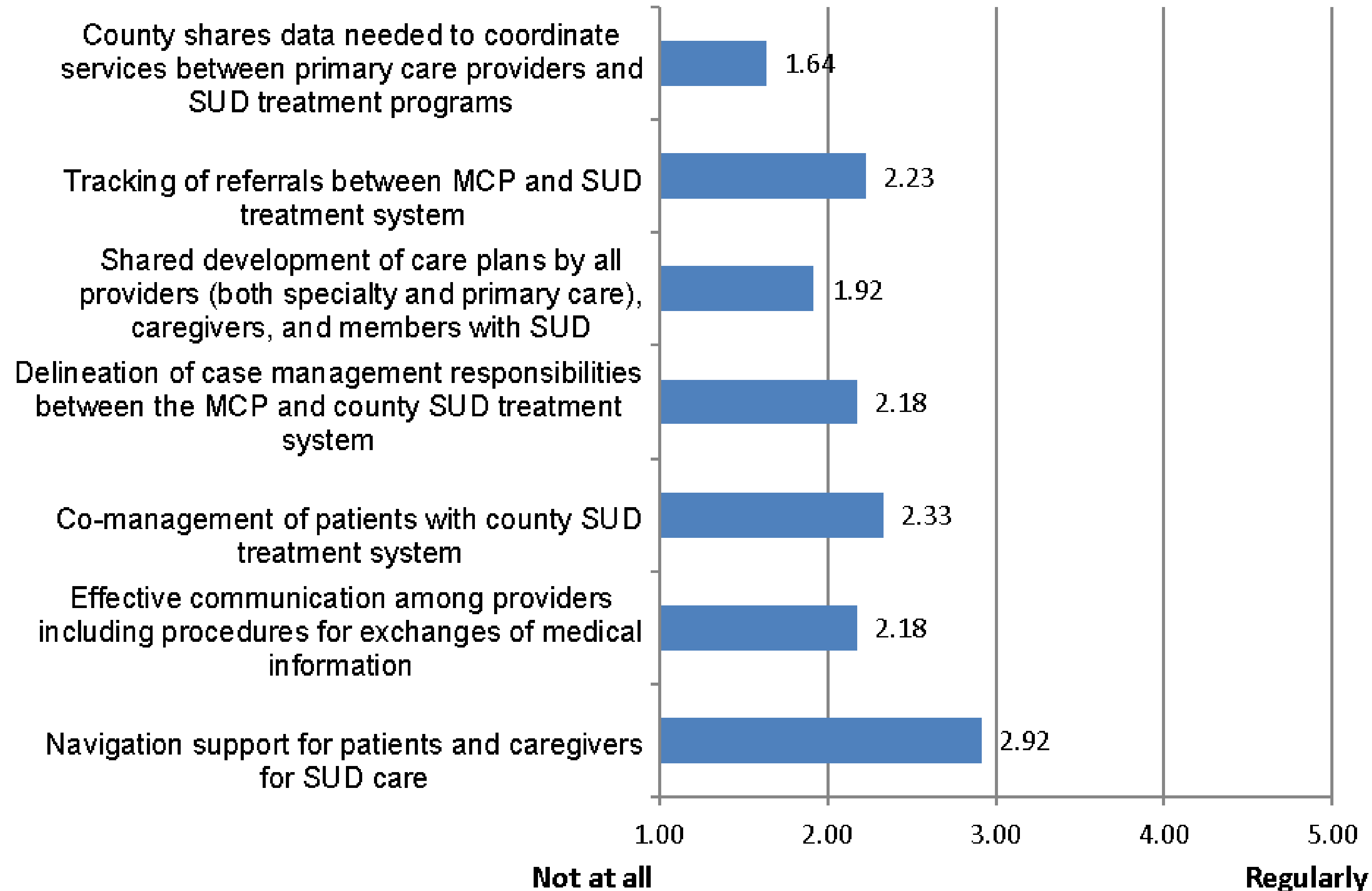
Quotes on Waiver Impact

“Communication between SUD and MH will be enhanced as a result of the waiver and development of the continuum.”

“There are some meetings that still “forget” about one side or the other. But this is happening less and less.”

“ We were already “there.” ”

Managed Care Plan Medical Directors' Ratings: How Regularly Coordination Occurs with the SUD Tx System



Recommendations

Access

- Ensure the availability of withdrawal management and methadone / other medications for opiate use in small/MBA counties. Consider buprenorphine & WM in outpatient settings or as part of incidental medical services in residential settings.
- Remove barriers to capacity expansion. Program certification was a significant challenge across modalities. Expedite certifications for sites that are already Short Doyle certified (providing mental health), and for new sites that belong to organizations that already have DMC certification.
- Look beyond physical capacity to increase penetration rates. Penetration rates in California are low, but most people who need treatment *do not feel they need specialty treatment*. Need to change perceptions about specialty treatment among prospective patients, and to reach patients in non-specialty settings such as primary care.

Recommendations

Quality

- Improve continuum of care transitions. Patients receiving WM or residential treatment generally do not step-down into treatment afterward. There are many reasons this may not be occurring, each of which requires a different response.
- More accurately estimate patient outcomes. Treatment appeared to be associated with improvements in outcomes, but findings are undermined by questionable data quality. UCLA recommends a patient follow-up study to measure outcomes for patients with missing data, CalOMS-Tx data quality improvement efforts.
- Reduce readmissions to withdrawal management. Depending on the case, improving transitions to treatment, (including MAT), coordinating with recovery residences may help.

Recommendations

Integration/coordination

- Coordination/integration pilot projects – Coordination between SUD and physical health care systems is currently weak. Payment reform and information exchange pilot projects are currently being considered by DHCS to address this.
- Increase referrals from the broader health system: Embed counselors in primary care, reform the way SBIRT is reimbursed. UCLA is currently working on a report on this topic.

QUESTIONS? COMMENTS?

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