

California DMC-ODS Waiver Evaluation: 2019 Report Highlights

Darren Urada, Ph.D., Cheryl Teruya, Ph.D., Valerie P. Antonini, M.P.H.,
Vandana Joshi, Ph.D., David Huang, Ph.D., Isabel Iturrios-Fourzan, M.A., Anne
B. Lee, M.A., L.C.S.W., Elise Tran, Eva Vazquez
UCLA Integrated Substance Abuse Programs

DHCS/EQRO/UCLA Quarterly Meeting
October 11, 2019
Sacramento, CA

All opinions expressed are those of Dr. Urada and do not necessarily represent those of UCLA or the California Department of Health Care Services

Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS) Overview

- Expansion of coverage for services previously not covered, e.g. residential treatment, case management, recovery support services, MAT.
- Continuum of SUD treatment based on ASAM Criteria.
- Facilitate increased coordination/integration of SUD services with physical and mental health care
- County-by-county implementation.



Evaluation Data Sources (partial list)

- Administrative Data Analysis
 - Drug Medi-Cal Claims / Short Doyle Mental Health
 - CalOMS-Tx
 - Managed Care / Fee for Service (soon?)
- UCLA Data Collection, in collaboration w/ others
 - Surveys (County Administrator, Provider, Patient)
 - Key Informant Interviews
 - Case Studies
 - “Secret Shopper” Calls
 - ASAM Level of Care Placement Data

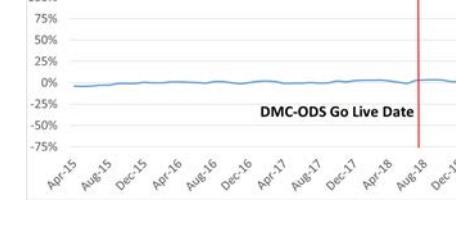
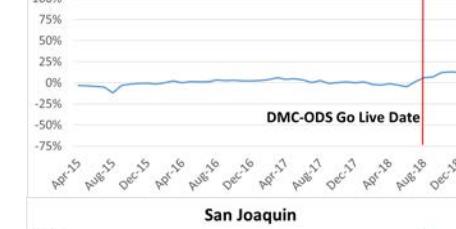
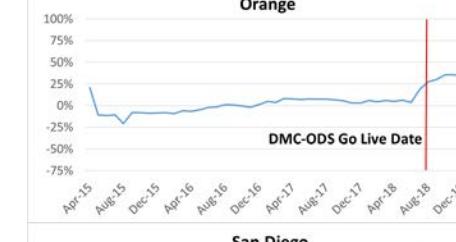
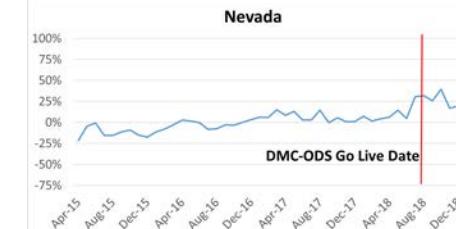
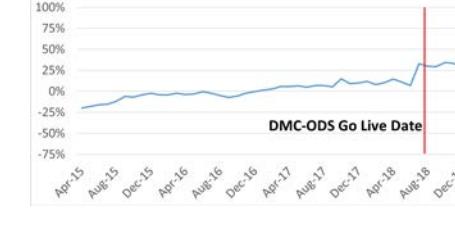
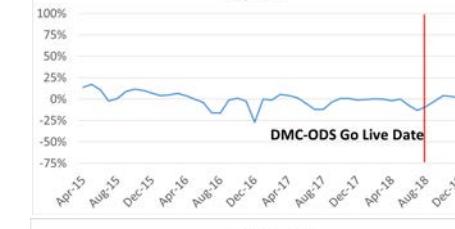
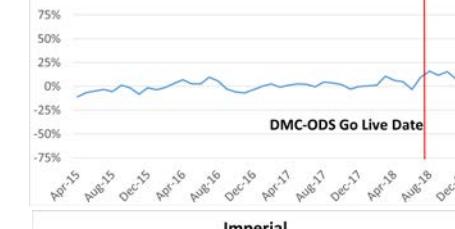
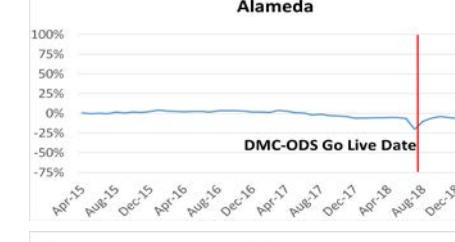
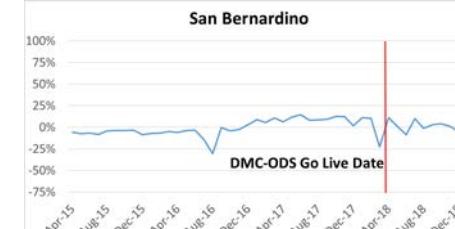
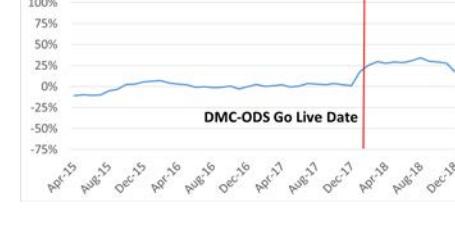
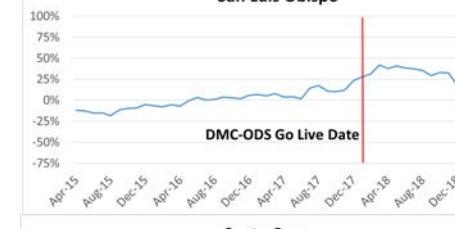
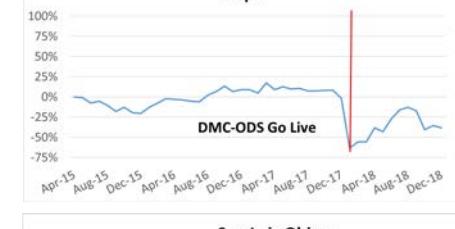
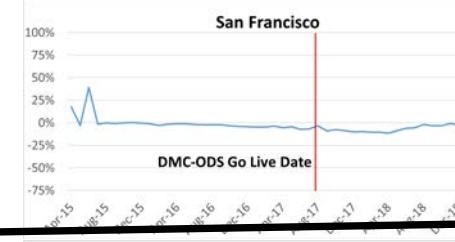
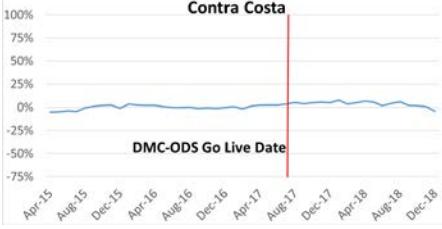
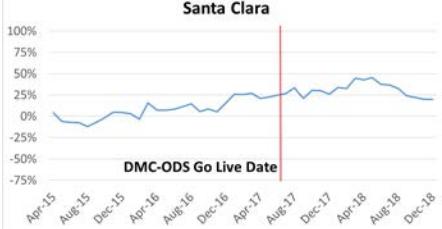
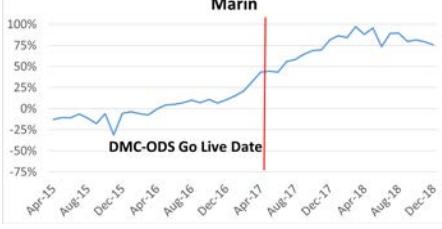
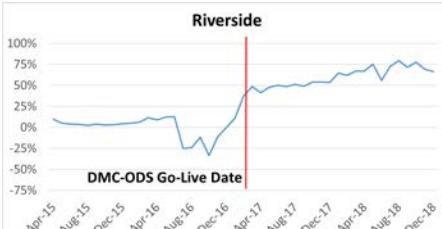
Beneficiary Access Lines (BAL)

- Finding BAL phone numbers was easy (rated 8.5 out of 10) , but misleading non-county websites in search results prevented a higher rating.
- For 24.7% of the calls, the wait time for an answer was over two minutes
- Beneficiary access line staff were rated as friendly (9.8 out of 10).
- Spanish results were worse

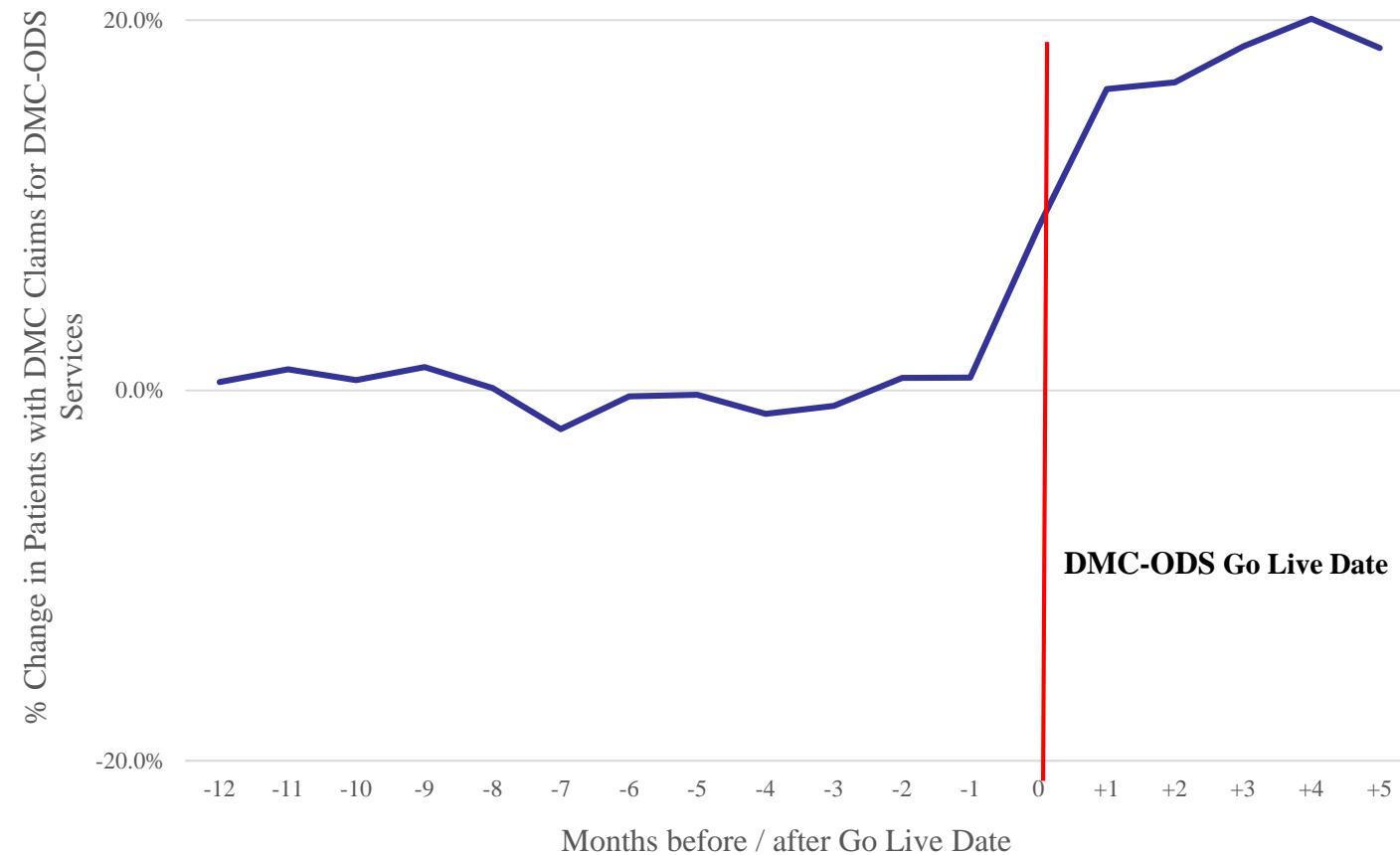
Penetration Rate

- 6.5% of Medi-Cal eligible beneficiaries
- May underestimate true penetration if referred to primary care for MAT
- National estimate: 10.8%
- Among people who do not receive treatment, 95.5% feel they don't need it.
- 60.6% penetration among Medi-Cal eligible patients who *thought they needed treatment.*

Huge County Variation (Tiny County Graphs)



Claims Data: Number of patients receiving Drug Medi-Cal services (all levels of care)



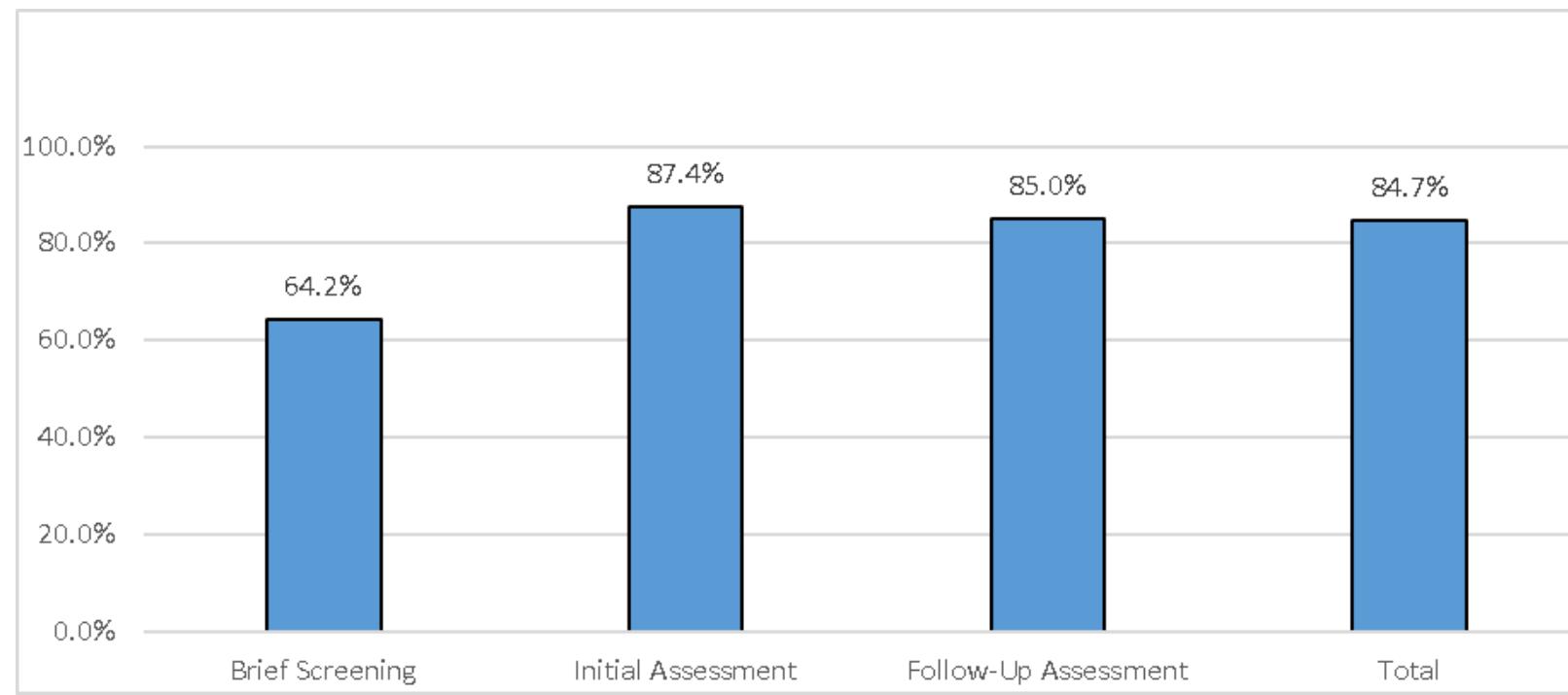
Is Increased Residential Treatment Appropriate? Level of Care Data

A Date of Screening or Assessment (MM/DD/YYYY)	B Medi-Cal Client Index Number (CIN)	C Client First Name	D Client Last Name	E Client Date of Birth (MM/DD/YYYY)	F Type of Screen / Assessment	G Indicated Level of Care/WM	H Additional Indicated Level of Care/WM, if any	I Additional Indicated Level of Care/WM, if any	J Actual LOC/WM placement decision
9/8/2016	12345678A	John	Doe	1/1/1996	Brief Initial Screen	Residential, exact level TBD	Withdrawal Mgmt, exact ASAM level unspecified		Residential, exact level TBD
9/9/2016	12345678A	John	Doe	1/1/1996	Initial Assessment	3.2-WM Clinically managed residential WM			3.2-WM Clinically managed residential WM
9/28/2016	98765432B	Mickey	Mouse	11/18/1928	Brief Initial Screen	Residential, exact level TBD	Residential, exact level TBD Withdrawal Mgmt, exact level TBD Ambulatory Withdrawal Mgmt, exact level TBD Residential/inpatient WM, exact level TBD Narcotic Tx Program/Opiate Tx Program 0.5 Early Intervention 1 Outpatient 2.1 Intensive Outpatient		2.1 Intensive Outpatient
12/1/2016	12345678A	John	Doe	1/1/1996	Followup Assessment	1 Outpatient			1 Outpatient

← To add rows, right click the row number to the left of this box, then select Insert
(click here for more info)

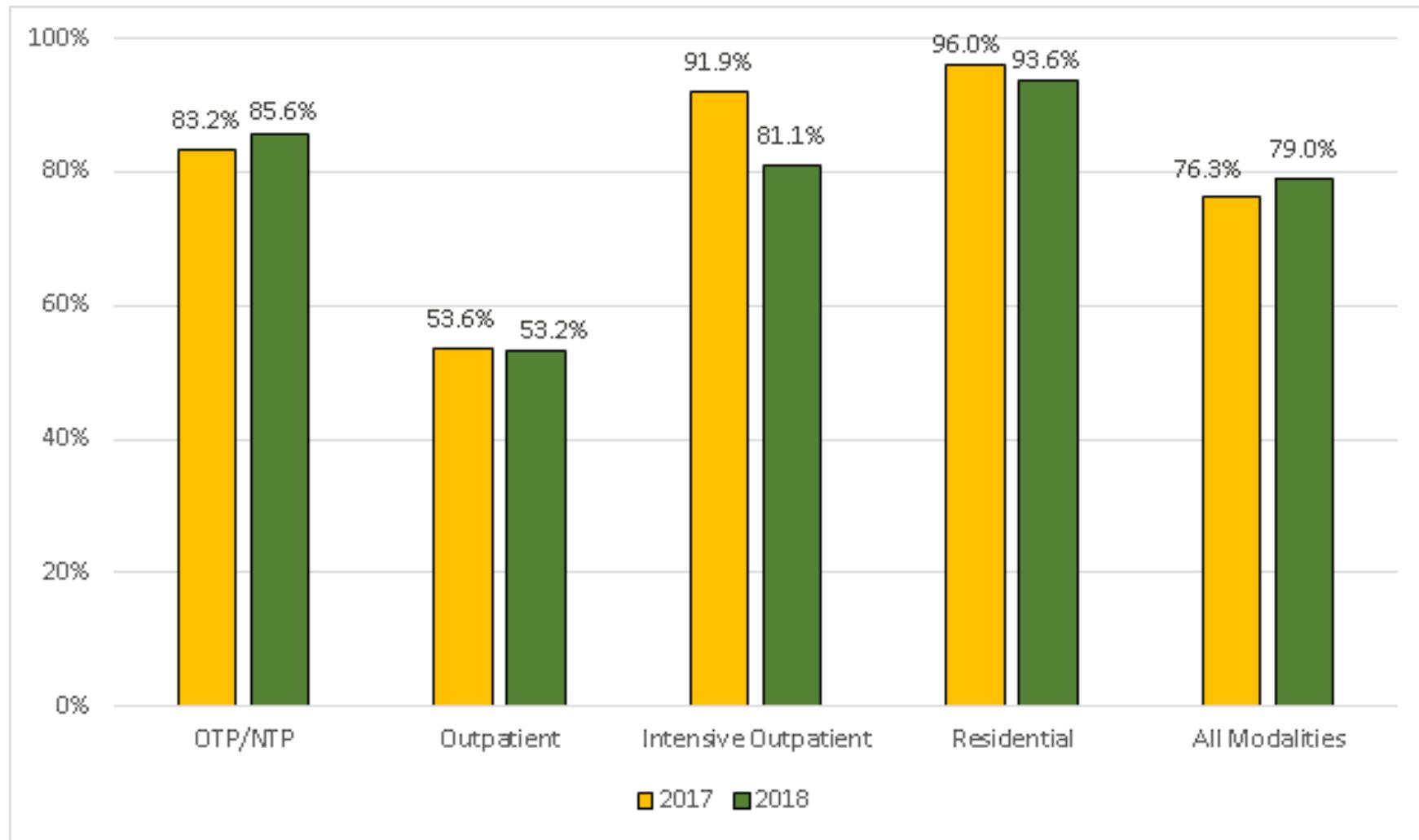
Placements Appear to be Appropriate (so far)

Percentage of clients for whom indicated LOC and placement decision matched (Preliminary)



Treatment Engagement

(3 visits in 30 days)





Treatment Perceptions Survey (Adult)

Print PDF as needed.
Do not photocopy!

County / Provider Use Only

CalOMS Provider ID (required) Program Reporting Unit (if required by your county):

Treatment Setting (required): OP/IOP Residential OTP/NTP Detox/WM (standalone) Partial hospitalization

• Please answer these questions about your experience at this program.

• If the question is about something you have not experienced, fill in the circle for "Not Applicable".

• **DO NOT WRITE YOUR NAME ON THIS FORM.**

• Your answers must be able to be read by a computer. Therefore, please use a pen, fill in the circle completely, and choose only one answer for each question.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. The location was convenient (public transportation, distance, parking, etc.).	<input type="radio"/>					
2. Services were available when I needed them.	<input type="radio"/>					
3. I chose the treatment goals with my provider's help.	<input type="radio"/>					
4. Staff gave me enough time in my treatment sessions.	<input type="radio"/>					
5. Staff treated me with respect.	<input type="radio"/>					
6. Staff spoke to me in a way I understood.	<input type="radio"/>					
7. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	<input type="radio"/>					
8. Staff here work with my physical health care providers to support my wellness.	<input type="radio"/>					
9. Staff here work with my mental health care providers to support my wellness.	<input type="radio"/>					
10. As a direct result of the services I am receiving, I am better able to do things that I want to do.	<input type="radio"/>					
11. I felt welcomed here.	<input type="radio"/>					
12. Overall, I am satisfied with the services I received.	<input type="radio"/>					
13. I was able to get all the help/services that I needed.	<input type="radio"/>					
14. I would recommend this agency to a friend or family member.	<input type="radio"/>					

Comments
Please do not write any information that may identify you, including but not limited to your name and/or phone number.

Please answer the following questions.

1. How long have you received services here?

First visit/day 2 weeks or less More than 2 weeks

2. Gender Identity (Please mark all that apply):

Female Male Transgender Other gender identity Decline to answer

3. Race/Ethnicity (Please mark all that apply):

<input type="radio"/> American Indian/Alaskan Native	<input type="radio"/> Latino	<input type="radio"/> Other
<input type="radio"/> Asian	<input type="radio"/> Native Hawaiian/Pacific Islander	
<input type="radio"/> Black/African American	<input type="radio"/> White/Caucasian	<input type="radio"/> Unknown

4. Age Range: 18-25 26-35 36-45 46-55 56+

Thank you for taking the time to answer these questions!



55494

Print PDF as needed.
Do not photocopy!

County / Provider Use Only

CalOMS Provider ID (required) Program Reporting Unit (if required by your county):

Treatment Setting (required): OP/IOP Residential OTP/NTP Detox/WM (standalone) Partial hospitalization

• Please answer these questions about your experience at this program.

• If the question is about something you have not experienced, fill in the circle for "Not Applicable."

• **DO NOT WRITE YOUR NAME ON THIS FORM.**

• Your answers must be able to be read by a computer. Therefore, please use a pen, fill in the circle completely, and choose only one answer for each question.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. The location of services was convenient for me.	<input type="radio"/>					
2. Services were available at times that were convenient for me.	<input type="radio"/>					
3. I had a good experience enrolling in treatment.	<input type="radio"/>					
4. My counselor and I worked on treatment goals together.	<input type="radio"/>					
5. I received services that were right for me.	<input type="radio"/>					
6. Staff treated me with respect.	<input type="radio"/>					
7. I feel my counselor took the time to listen to what I had to say.	<input type="radio"/>					
8. I developed a positive, trusting relationship with my counselor.	<input type="radio"/>					
9. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	<input type="radio"/>					
10. I feel my counselor was sincerely interested in me and understood me.	<input type="radio"/>					
11. I liked my counselor here.	<input type="radio"/>					
12. My counselor is capable of helping me.	<input type="radio"/>					
13. Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.).	<input type="radio"/>					
14. Staff here helped me with other issues and concerns I had related to legal/probation, family and educational systems.	<input type="radio"/>					
15. My counselor provided necessary services for my family.	<input type="radio"/>					
16. As a result of the services I received, I am better able to do things I want to do.	<input type="radio"/>					
17. Overall, I am satisfied with the services I received.	<input type="radio"/>					
18. I would recommend the services to a friend who is in need of similar help.	<input type="radio"/>					

Comments
Please do not write any information that may identify you, including but not limited to your name and/or phone number.

Please answer the following questions.

1. How long have you received services here?

Less than 1 month 1 - 5 months 6 months or more

2. Gender Identity (Please mark all that apply):

Female Male Transgender Other gender identity Decline to answer

3. Race/Ethnicity (Please mark all that apply):

<input type="radio"/> American Indian/Alaskan Native	<input type="radio"/> Latino	<input type="radio"/> Other
<input type="radio"/> Asian	<input type="radio"/> Native Hawaiian/Pacific Islander	
<input type="radio"/> Black/African American	<input type="radio"/> White/Caucasian	<input type="radio"/> Unknown

4. Age:

Thank you for taking the time to answer these questions!



54470





Treatment Perception Surveys (TPS)

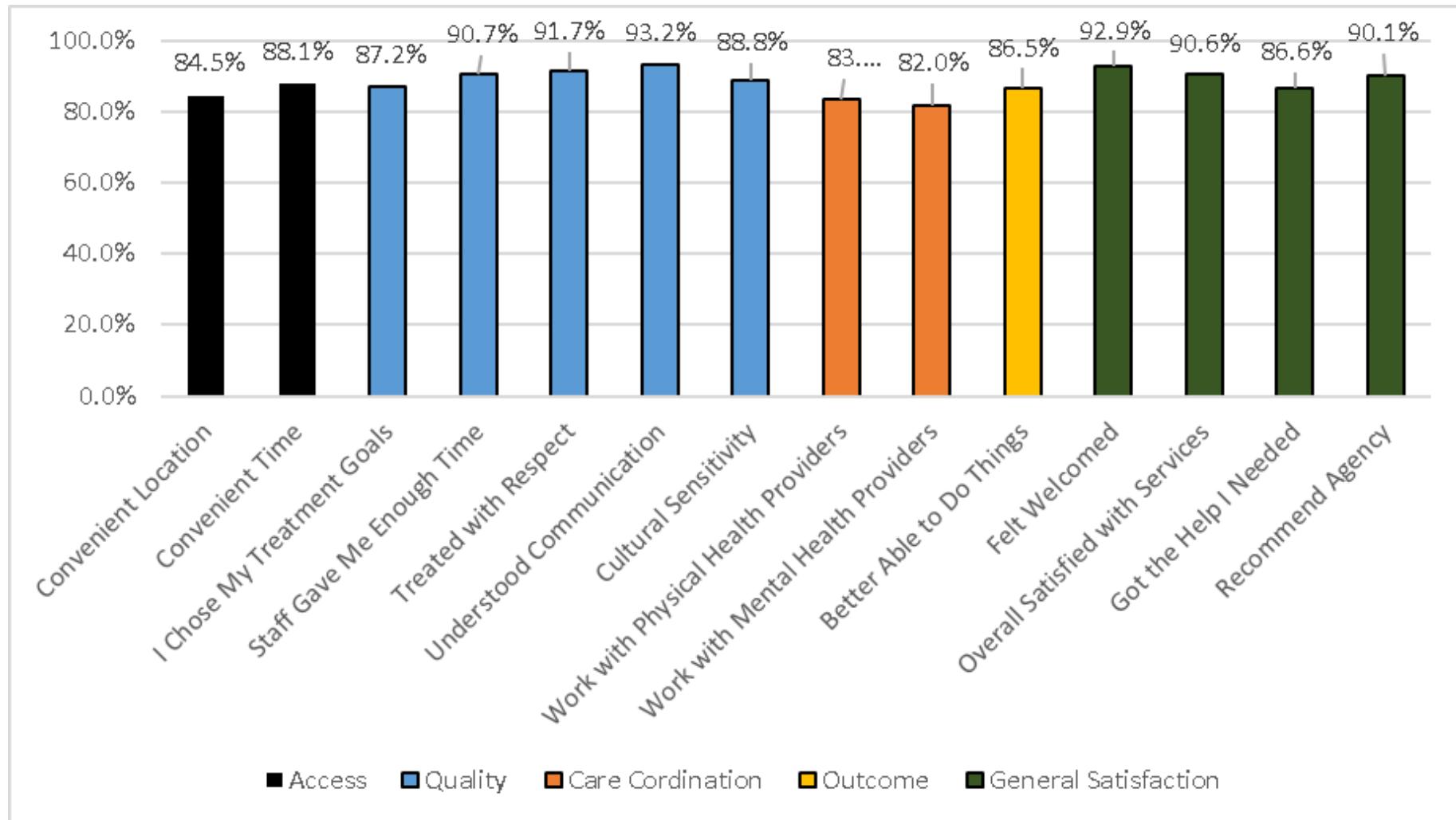
- 2018: 15,928 TPS forms from 19 counties
- adults (96%) and youth (4%)
- Response rate: 60.9%
- Individual reports returned to counties within 3 months
- First Wave Counties use TPS data more than Second Wave counties for:
 - quality improvement (86% to 73%)
 - quality improvement planning (100% vs. 50%)
 - feedback to individual providers (83% vs. 37%)
 - re-allocation of resources (17% vs. 12%).

<http://uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html>



TPS Results (adult)

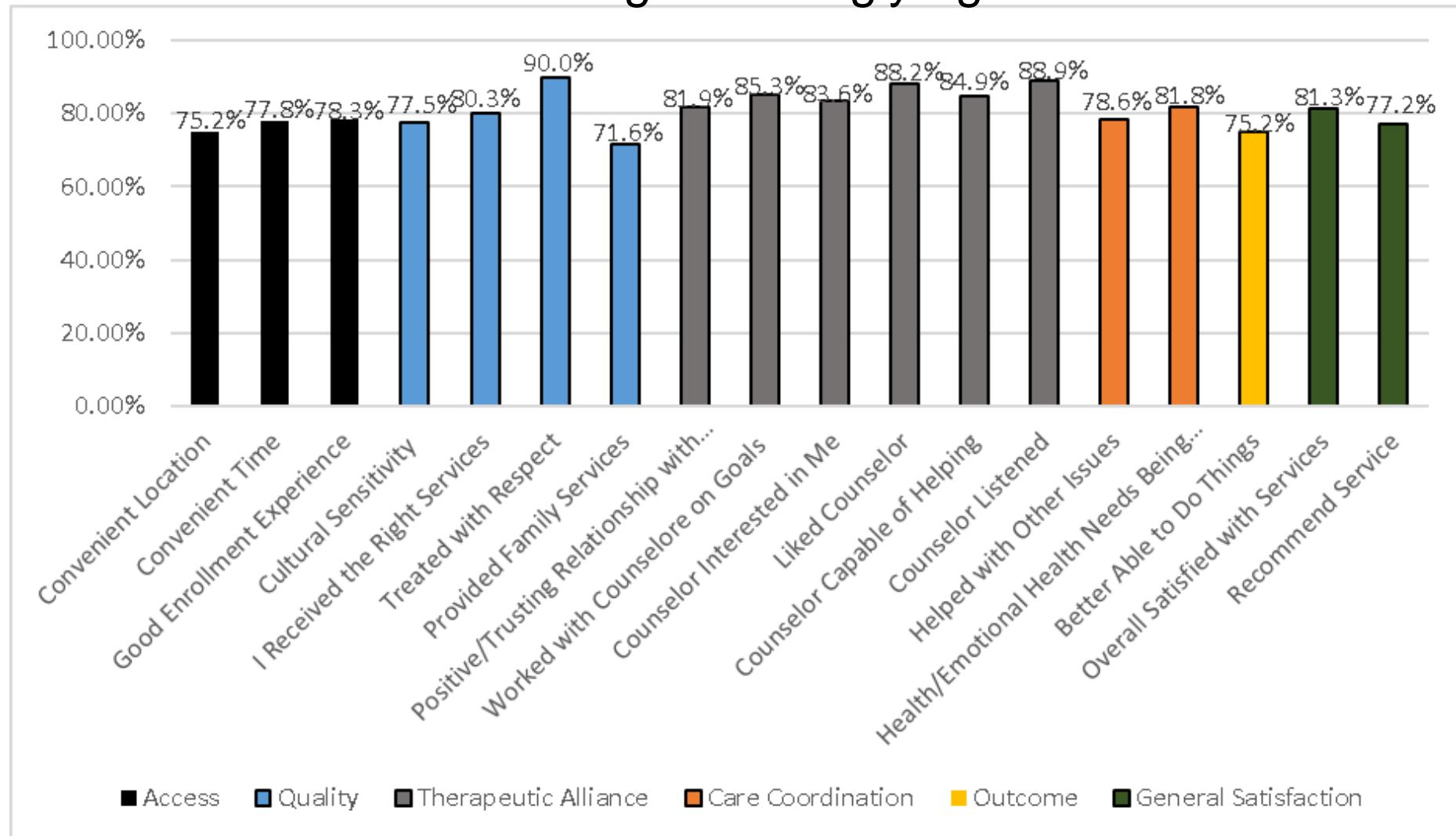
% agree/strongly agree





TPS Results (youth)

% agree/strongly agree



Beyond the Annual TPS

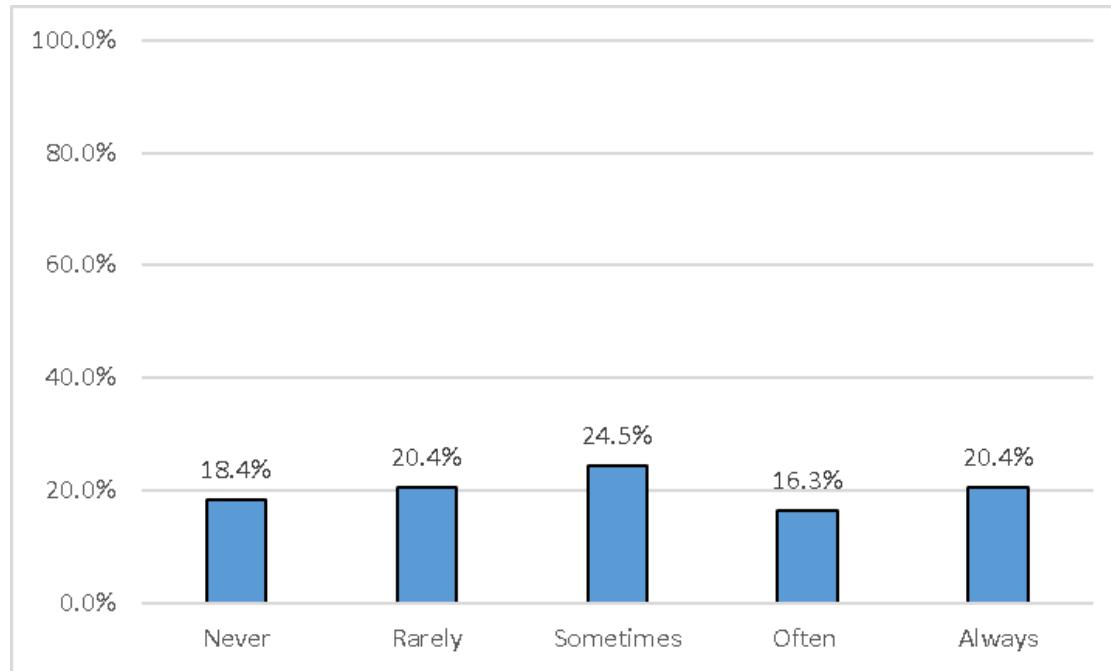
- At least a few counties are (or are considering) administering the TPS on an ongoing basis (e.g., Santa Clara)
- At least a few counties have piloted or are considering piloting the TPS in their mental health systems (in addition to using the MHSIP; e.g., Monterey, Ventura)



Recovery Support Services

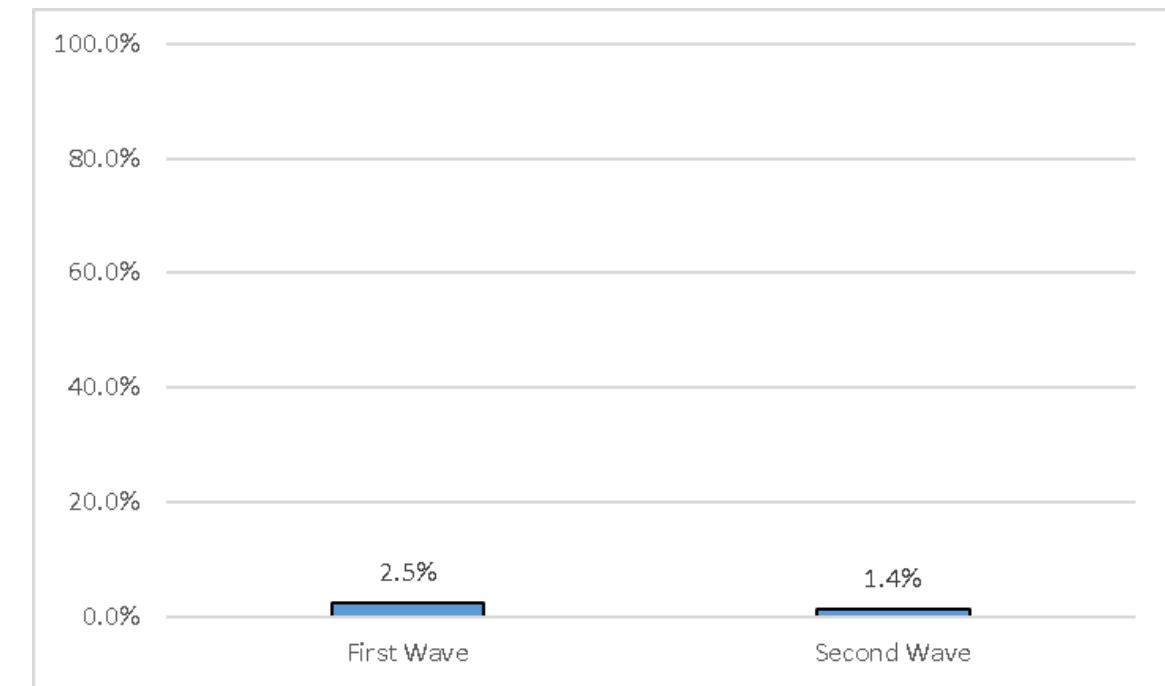
Treatment Provider Survey:

How often does your treatment program deliver recovery support services after discharge?



Claims data:

% patients that received recovery support services in CY 2018



Recovery/Peer Services

- Feedback from administrators:
 - “The ability of providers to build out this component of the benefit has been challenging, particularly with restrictions on use of peers.”
 - “. . . [lack of] understanding how billing will work is a problem”
 - “. . . lots of questions linger about [recovery support] service model, and about what pieces of this service peers can deliver under "substance use assistance"
 - “development/submission of Peer Recovery Support Plan to DHCS for review/approval - still waiting for a response from DHCS.”
 - “We have not received answers to critical questions . . . about how to implement this service.”

Recovery/Peer Services

- Technical Assistance Requests:
 - “Recommendations for, or actual development of, a standardized curriculum for peer certification”
 - “How to do peer certification”
 - “Development of Peer Training Program; how to build capacity of a peer led/run non-profit to be able to obtain and delivery RS as a managed care provider. We don't want to undermine current provider, looking to support/sustain their work in future under DMC ODS RS...but am interested in strategies for building their org capacity to operate as a managed care health provider.”
 - “We are especially interested in assistance on what qualifies a best practice training plan for peers to be part of the recovery services delivery.”



Case Study: Recovery Services with Peer Support Specialists - Riverside County

At least one Peer Support Specialist in almost every county clinic.

“Don’t hire peers because of their lived experience . . . hire peers because of their recovery from their lived experience. They have to be the evidence that recovery is possible.”

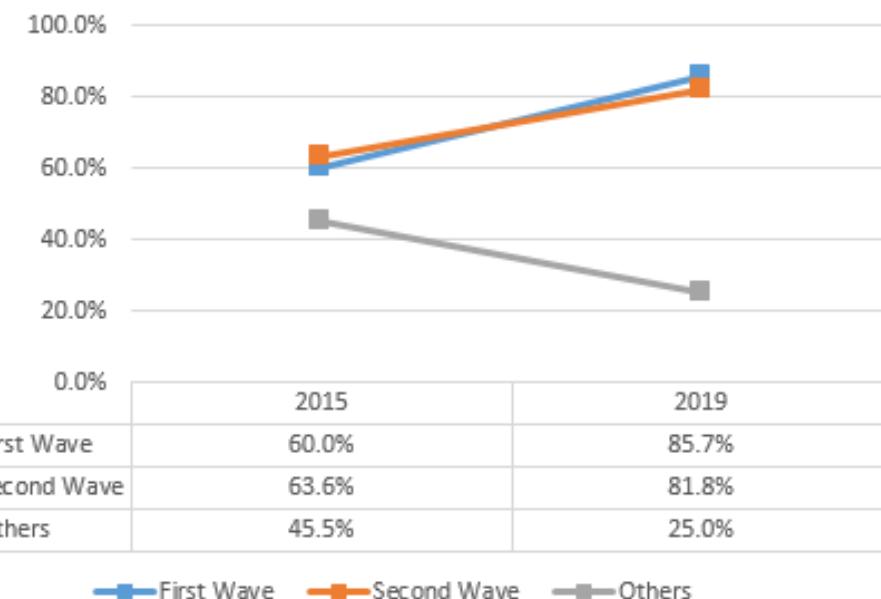
Case Study: Recovery Support Services - Santa Clara County

- Relatively unstructured approach, gives providers “a lot of freedom” to be creative in developing recovery plans with their clients (i.e., phone call once a month, case management, alumni groups)
- “Fewer rules around recovery services,” which “drives some of the hesitancy in using that particular modality”. But “that’s the refreshing aspect of recovery services.”
- Key to success: Training in Recovery Services

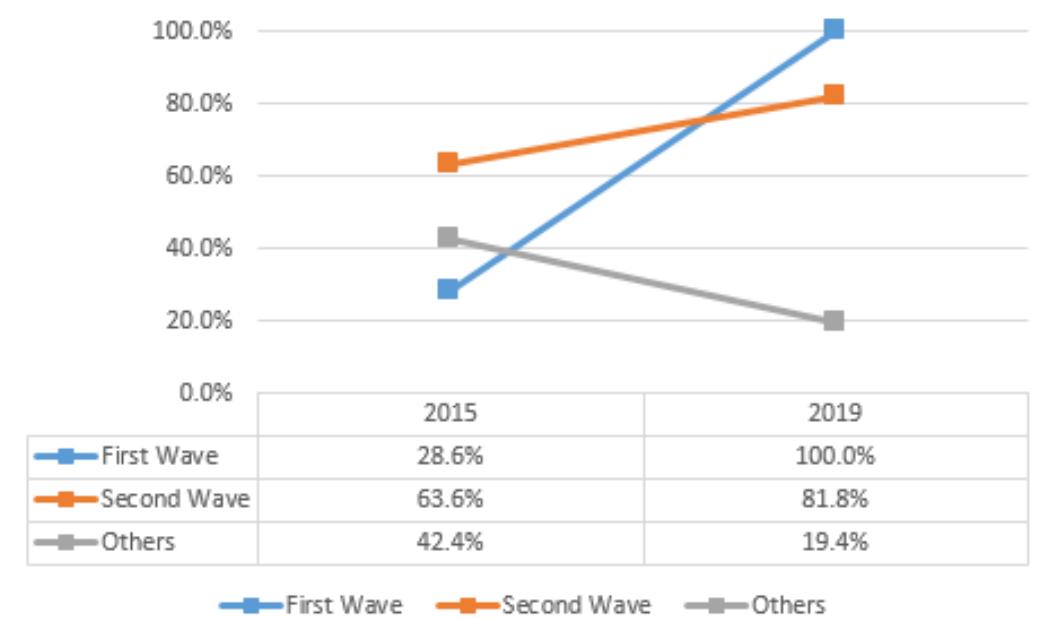
Assessment of cross-system integration and collaboration

Communication with MH and PH

Percentage of county administrators reporting the waiver had positive influence on communication between SUD and MH



Percentage of county administrators reporting the waiver had positive influence on communication between SUD and PH



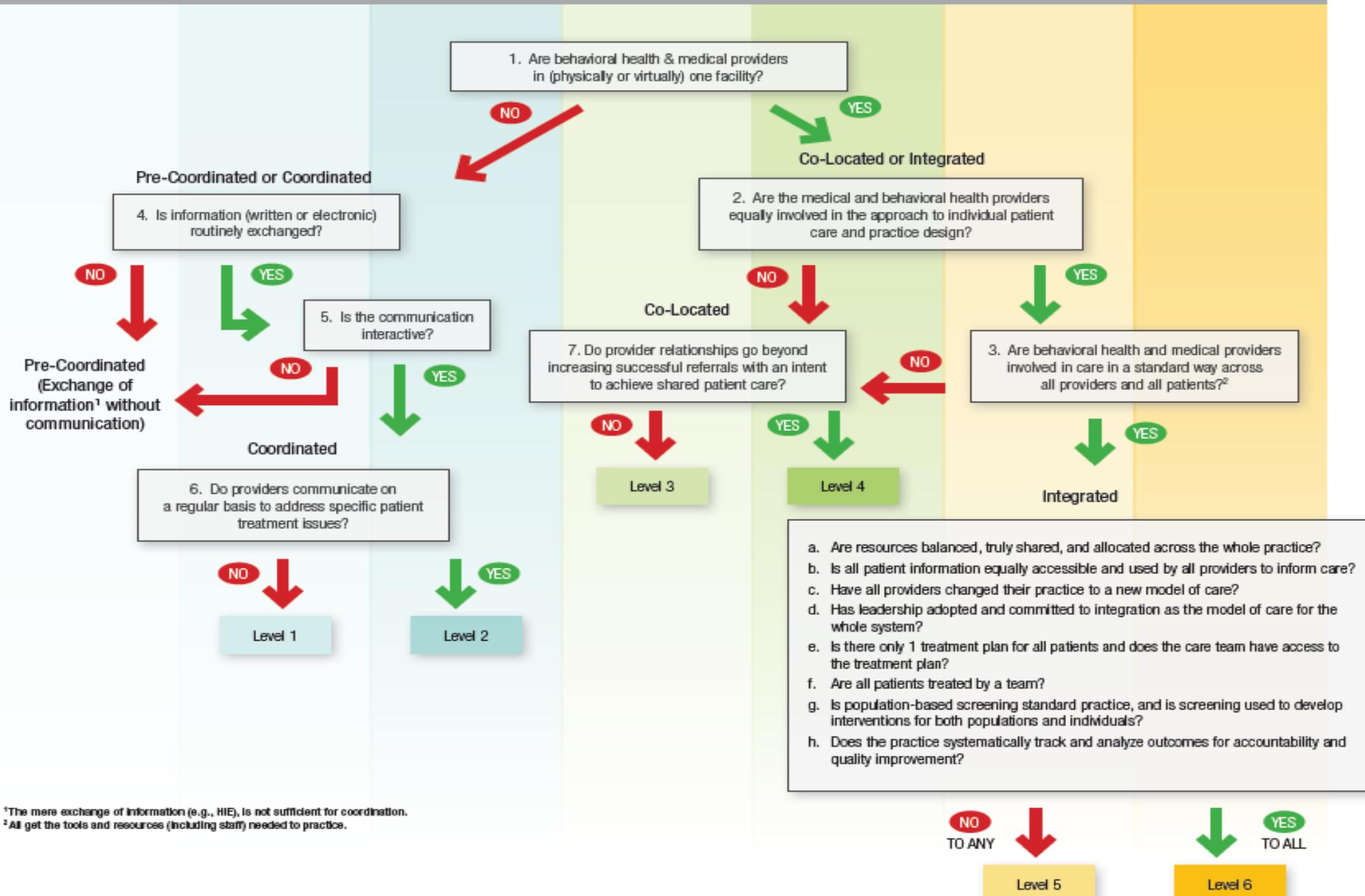
Assessment of cross-system integration and collaboration

- IPAT: Integrated Practice Assessment Tool for providers
 - Developed by SAMHSA-HRSA Center for Integrated Health Solutions
 - Adapted to assess SUD-MH and SUD-PH integration using **SAMHSA Framework for Levels of Integrated Healthcare (6 levels)**

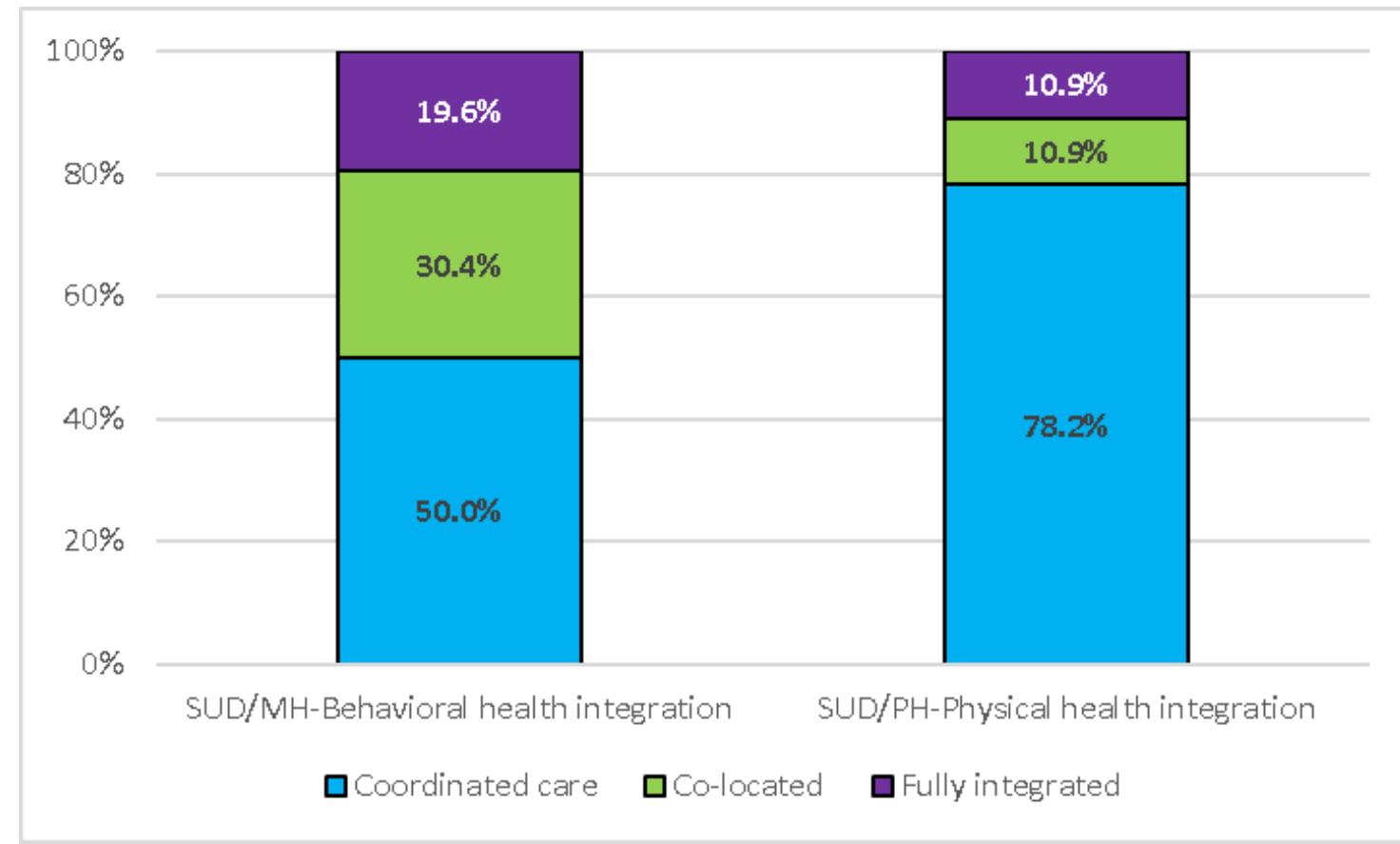
Coordinated		Co-Located		Integrated	
Key Element: Communication		Key Element: Physical Proximity		Key Element: Practice Change	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Merged Integrated Practice

DECISION TREE FOR IPAT®

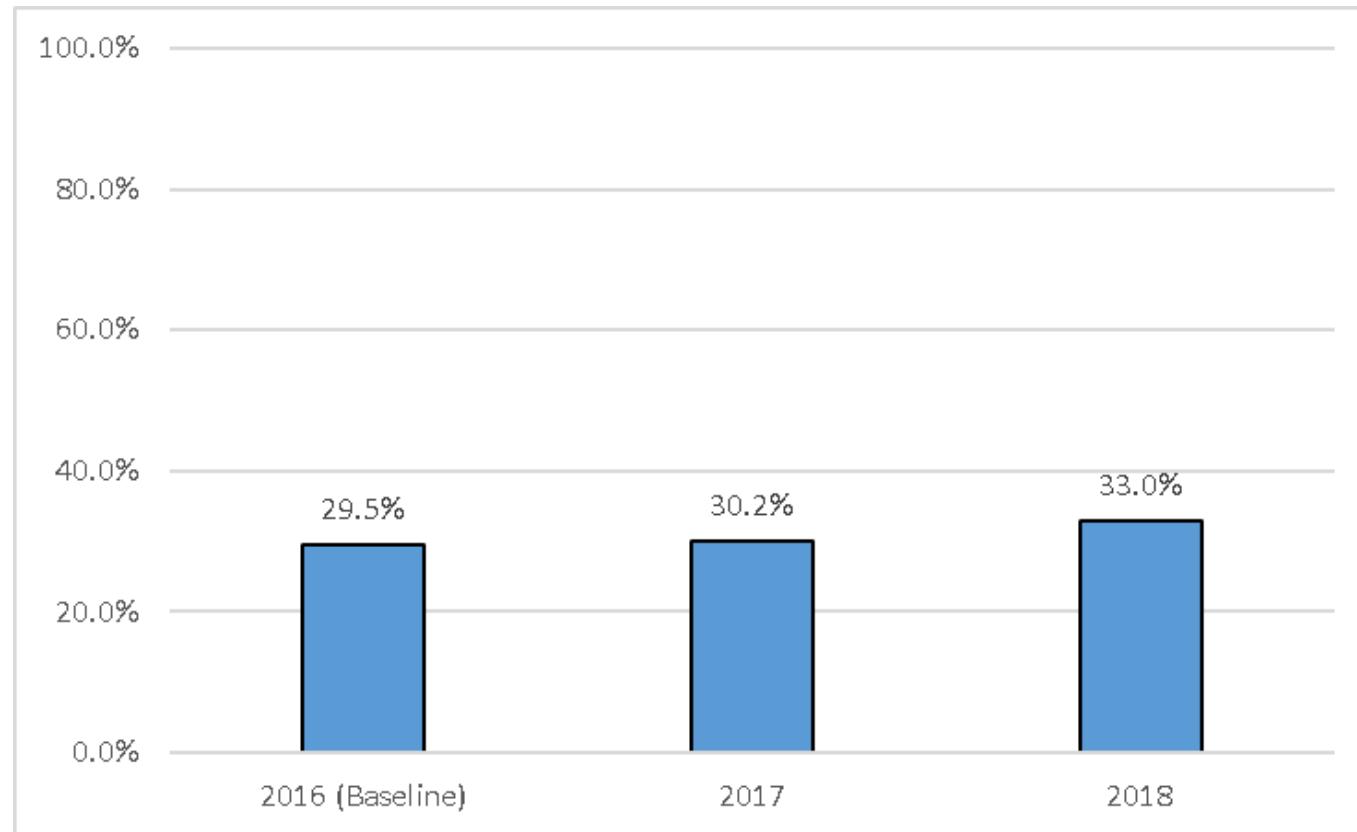
- Minimum of 4 qs and maximum of 8 questions to determine Levels 1-6
- Self-Assessment tool from provider leadership



Preliminary IPAT rating of MH and PH service integration in SUD programs



Percentage of SUD patients with MH and SUD services (claims data, First Wave)





Case Study: Care Coordination

Encompass Community Services-Santa Cruz County

- Encompass had high care coordination ratings on the client Treatment Perceptions Survey, especially outpatient, without being part of a fully integrated system. Their keys to success:
- Start on day one: Assess need for care coordination with PH/MH at first contact.
- Meet with MH/PH providers: met weekly at first to establish workflows. e.g. *“How do we make sure that we are providing continuity when people transfer . . . between agencies?”*

Case Study: Case Management Los Angeles County

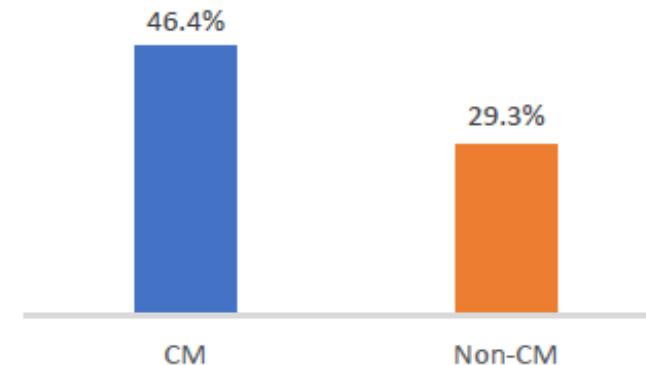
In LA, about 53% of clients receive CM, leading the state.

Keys to success:

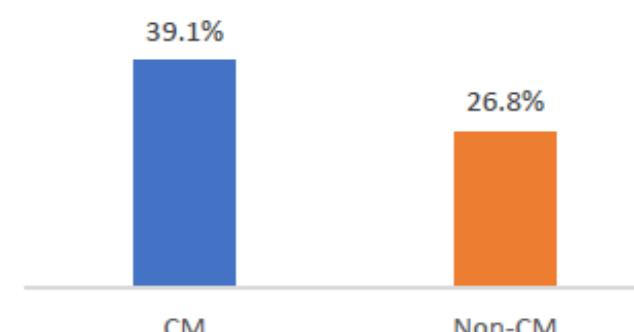
- Communicate with providers in advance, often and in multiple ways. (e.g. provider manuals, technical assistance, training, and guidance)
- *“Everybody is offered case management and everybody should receive it.”*
- Be flexible: Adjusted billing cap as needed.
- Connect to other County service delivery systems

Treatment Effectiveness between CM vs Non-CM clients

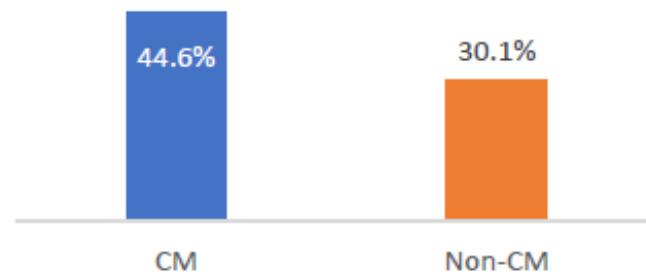
% of clients who reported improvement in personal responsibility from admission to discharge



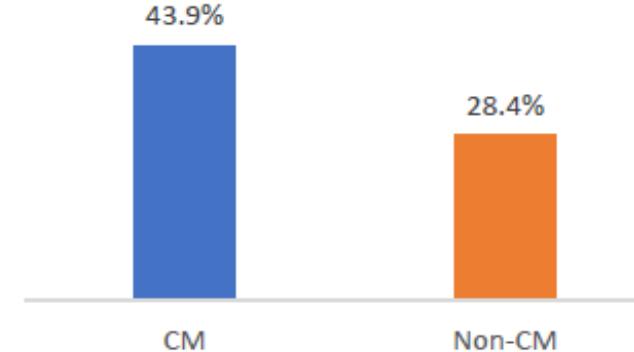
% of clients who reported improvement in their AOD use from admission to discharge



% 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?)

Transitions along the SUD Continuum

UCLA will update 2018 statistics when CalOMS-Tx issues are resolved.

In CY 2017:

- 86.4% of patients did not receive further treatment within 14 days after residential treatment discharge
- 72.6% did not receive treatment within 14 days after withdrawal management discharge

Case Study: Transitions from Withdrawal Management - Riverside County

- Riverside County used a regional Care Coordination Team approach to link patients from WM to treatment. The number of cases transitioning from WM to residential or OP care increased 48% from baseline.
- Keys to success:
 - Case management
 - Thorough initial assessments
 - Developing rapport and good relationships with providers
 - Providing all the information to the provider before the patients transition to avoid patients being sent away because something is missing.



Recommendations

- Provide greater clarity on what activities are billable for recovery support services and case management, and what documentation is needed.
 - Providing lists of practices that have successfully been approved, as well as those that have not, with the understanding that actual claim approval or denial depends on the exact details of the implementation, would be a good start.
- Re-institute the standard CalOMS-Tx reports that were available before BHIS transition.
- Re-initiate “CalOMS-Tx rewrite” efforts to better align CalOMS-Tx with the DMC-ODS waiver (e.g. incorporation of ASAM levels of care to replace older treatment modalities).
- Promote screening for SUD in MH and PH settings and linkage to onsite or well-coordinated SUD treatment to increase treatment penetration rates.
- Continue to address MAT stigma among providers.

Technical Assistance areas include:

- Data collection and submission:
 - Provide technical assistance to counties regarding the data to be collected and submitted under the waiver (e.g., ASAM LOC, claims), monitor whether the data are being submitted in a timely fashion, and give initial feedback to minimize missing or inaccurate data.
- ASAM Criteria:
 - Provide technical assistance to counties on how to implement various aspects of the ASAM Criteria (e.g., brief screening, initial assessment, follow-up assessment, treatment planning), including optional DHCS-approved ASAM Criteria-based screening/assessment tools, and guidance for assessing fidelity to the ASAM Criteria, while allowing room for flexibility to address each county's unique needs.
- Evidence-based practices:
 - How to assess fidelity to evidence-based practices.
- EHR systems:
 - (e.g., to incorporating ASAM Criteria-based assessments, ASAM LOC data collection, billing, flag high utilizers).
- Memorandums of understanding (MOUs):
 - Provide sample MOUs to establish formal collaborations for both BH and PH partners.

Technical Assistance areas include (cont.):

- 42 CFR privacy regulation:
 - Provide additional guidance and examples of 42 CFR-compliant Release of Information forms to facilitate referrals and care coordination
- Tracking referrals:
 - Provide examples from other counties that have systemized tracking referrals (that show actual movement in EHRs) and other existing practices that have been helpful
- Case management and Recovery support services:
 - Provide clearer guidance and examples of case management and recovery support service implementation from counties.
- Curriculum for certifying staff in case management core competencies:
 - e.g. how much case management a patient should receive, how to approach reimbursement for clients who have been assessed but not treated.
- Youth treatment practices:
 - ASAM criteria assessment for youth, and evidence-based practices for youth treatment.



Results to date show that the demonstration is improving access to treatment, quality of treatment, and coordination of care, but there are also many challenges to overcome. The case studies featured in this report provide examples of how some innovative stakeholders are taking on these challenges.

Questions? Comments?

Darren Urada, Ph.D.

DUrada@mednet.ucla.edu

DMC-ODS Evaluation Reports:

<http://uclaisap.org/dmc-ods-eval/html/reports-presentations.html>



Brief Questionnaire for Initial Placement (BQuIP) Demonstration