Using Ongoing Data Feedback to Help States and Counties Improve Their Substance Use Treatment Systems of Care

NACBHDD Webinar

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Presenters

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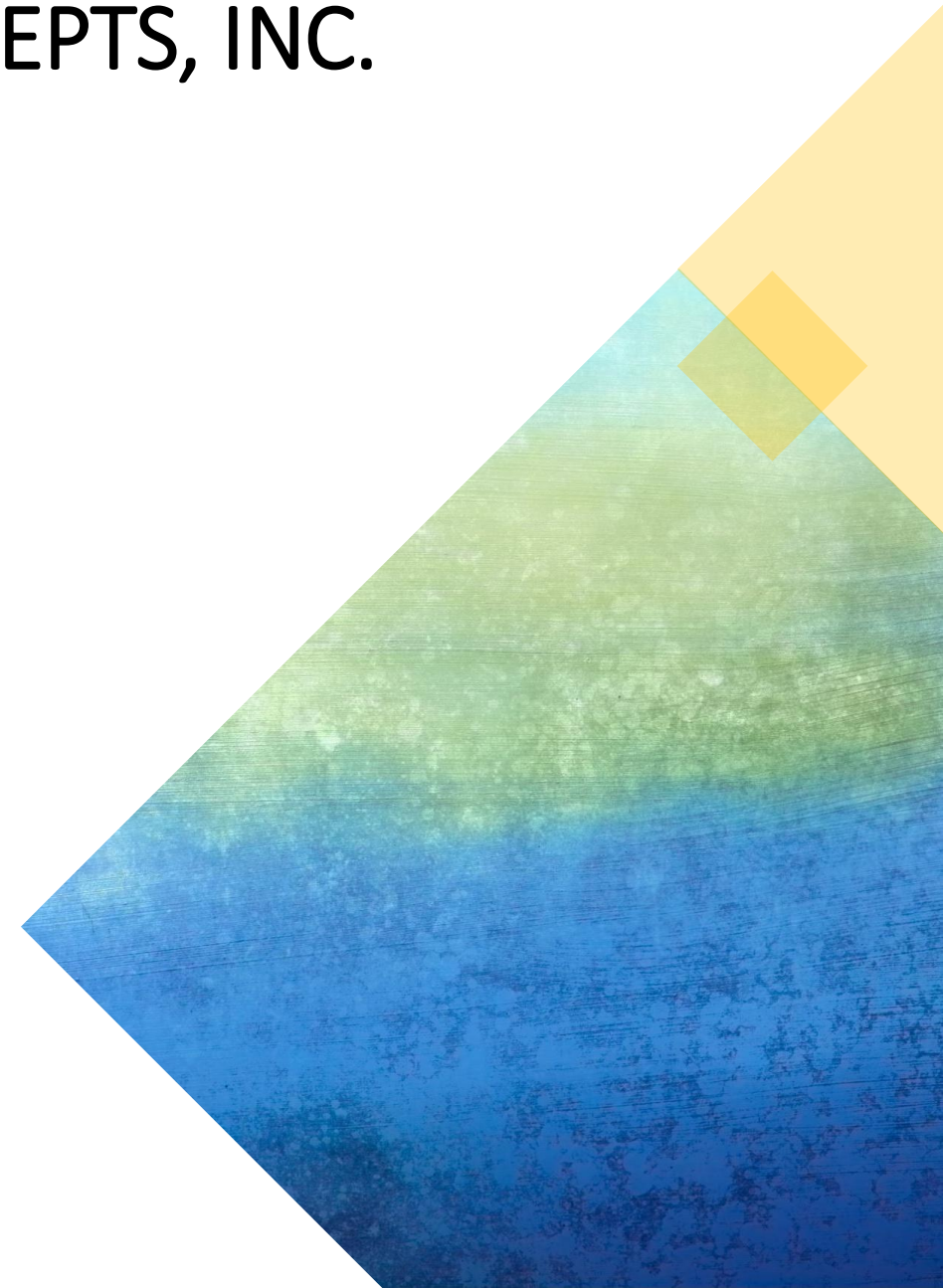
BEHAVIORAL HEALTH CONCEPTS, INC.

Founded in 1994 to provide behavioral health consulting and evaluation services

CMS-Certified Quality Improvement Organization (QIO)-Like

Conducts external quality reviews, currently with two large state contracts

- California Specialty Mental Health Services: 56 county-based plans
- California Drug-Medi-Cal Organized Delivery System (DMC-ODS): 30 county-based plans and one seven-county regional plan



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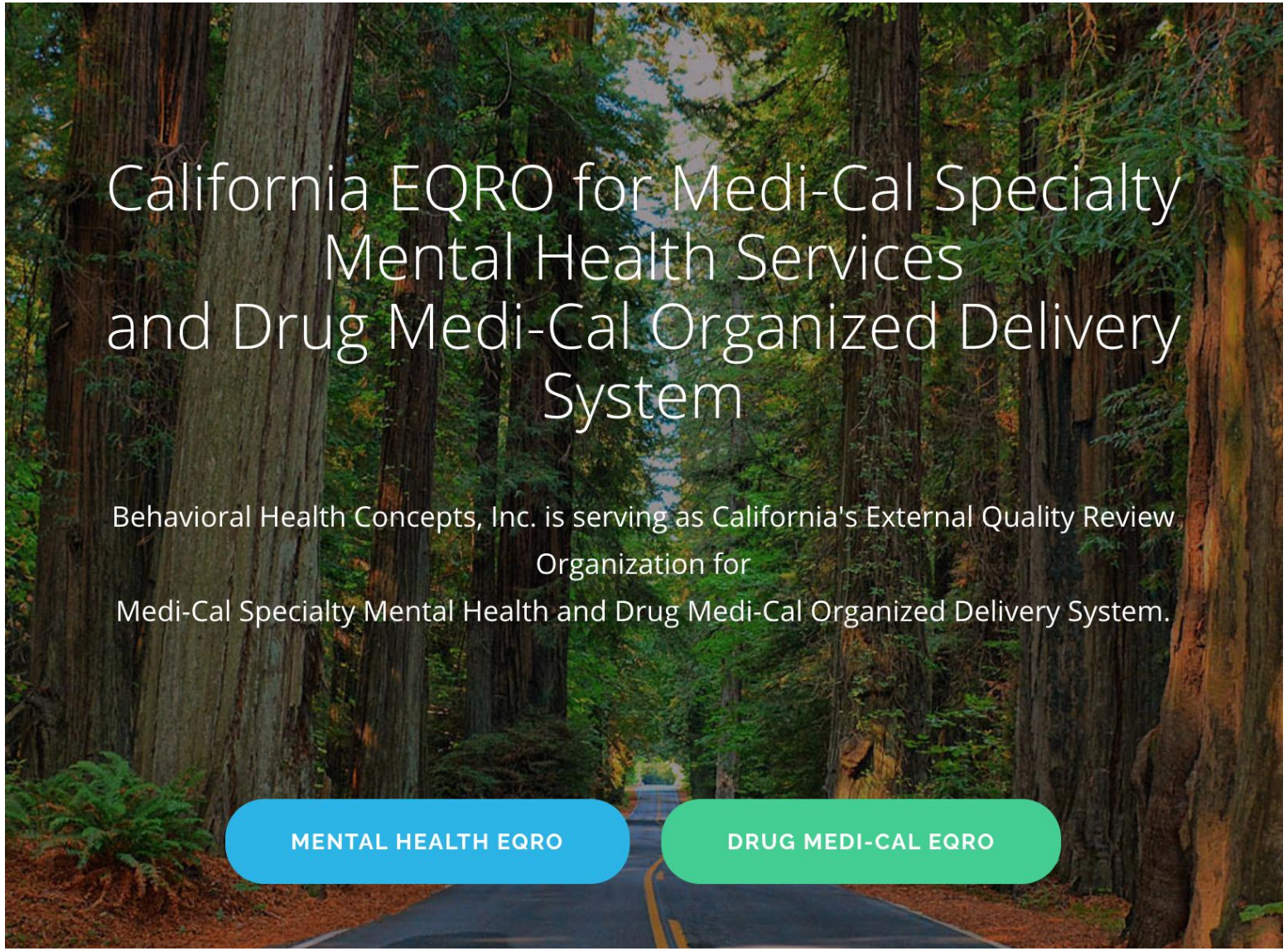
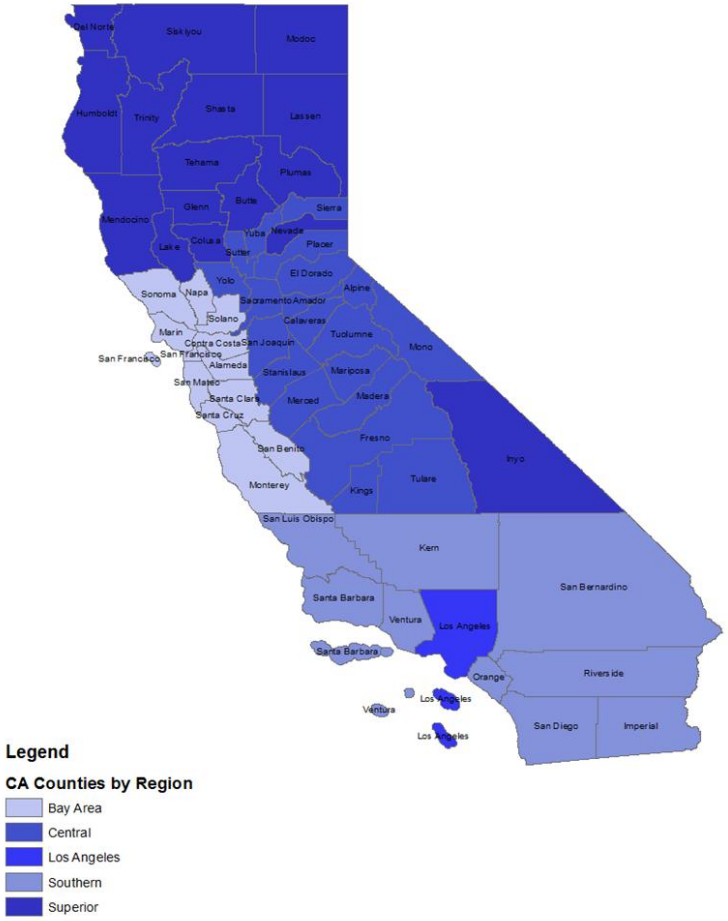


California's Public Behavioral Health System

- 58 counties responsible for "carved-out" specialty behavioral health services
- Diverse state:
  - 5 County Size
    - Small Rural (e.g., Alpine County, population 1,120)
    - Very Large (Los Angeles County, population 10,081,570)
  - 5 County Regions



CalEQRO Reviews

Assemble	Analyze	Review	Facilitate	Provide	Produce
Assemble review team members with county management background, IS expertise, and client/family member lived experience	Analyze county data compared to statewide averages and display in useful tables for the county	Review county documentation including responses to CalEQRO forms	Facilitate focused sessions with stakeholders, including county behavioral health leadership, staff, contract providers, and clients.	Provide verbal feedback and technical assistance	Produce a technical report that is comprehensive and strength-based with constructive recommenda-tions for quality improvements

PRIOR TO THE DMC-ODS WAIVER

- Limited and fragmented treatment continuum without a unifying system of care
- Counties relied on SAMHSA block grant funds to cover many SUD services
- Minimal coordination of care
- Lacking evidence–based practices
- No selective contracting of Medi-Cal providers by counties
- Little medication assisted treatment (MAT) other than methadone
- Minimal required quality improvement/quality management functions

Traditional DMC in California Compared to DMC-ODS Services

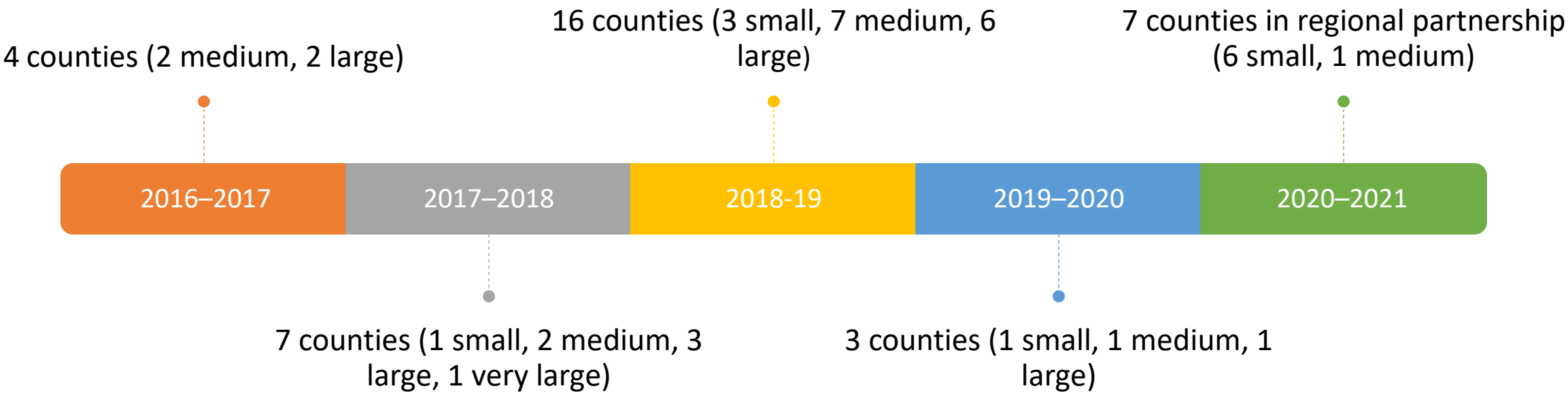
DMC State Plan	DMC-ODS
Outpatient Drug-Free Treatment	Outpatient Treatment Services
Perinatal Intensive Outpatient Treatment	Intensive Outpatient Treatment
Perinatal Residential Treatment (16 beds only)	Residential Treatment Services (no bed limit)3.1, 3.3,3.5
	WM (residential 3.2)
Narcotic Treatment Program Services (methadone)	NTP/OTP Services with Methadone, Buprenorphine, Disulfiram, and Naloxone
	Recovery Services
	Case Management
	Physician Consultation
	Additional MAT (optional)
	3.7 and 4.0 Inpatient and Withdrawal Management

California 1115 Waiver for the Drug Medi-Cal Organized Delivery System (DMC-ODS)

KEY Goals:

- Establish a science-based continuum of integrated SUD Care.
- Increase quality of care and workforce skills.
- Improve collaboration with mental and physical healthcare.
- Individualized treatment, not program driven treatment models.
- Enhanced efficiency and accountability.
- Evidence-based practices (EBPs) and data-based decisions to improve care.

Go-Live Dates by Fiscal Year



Definition of Pioneer and New Counties

The first 14 counties who implemented the DMC-ODS waiver are considered “pioneer” counties. The ”go-live” dates for these 14 counties spanned January 2017 to June 2018.

Jan. 2017 – June 2018

July 2018 – April 2019

The 12 counties who opted in later or who took more time to begin billing DMC-ODS services are considered “new” counties. The “go-live” dates were July 2018 through April 2019.

Key Themes in the Presentation

This presentation will use examples from California's county-based Medicaid 1115 Waiver for treatment of substance use disorders (SUD) to show how county-based and state-based systems of care can:

- Develop consensus on common performance measures.
- Establish large databases of common data elements.
- Arrange data analysts to conduct periodic data analyses using the databases, performance measures and comparisons for benchmarking.
- Share performance measure results with county-based systems of care in a constructive tone of learning, technical assistance and quality improvement.

The presentation will take us through different methods to put these processes into practice as they pertain to systemwide access to treatment, timeliness of services, quality of care, and outcomes.

Developing the Performance Measures

- Consider system of care performance goals for access, timeliness, quality and outcomes.
- Review nationally endorsed measures.
- Consider practical issues (e.g., available databases, ease or difficulty of data collection)
- Form a statewide committee to convey stakeholder learning interests, research expertise and practical knowledge of available data for collection and analysis.
- Arrange agreements for database access, hire computer programmers and data analytic team.
- Develop and implement the programming rules for data analysis.
- Design the graphs and tables for the data displays.
- Provide the performance measure results to counties and invite feedback.

12 Core Performance Measures

Total beneficiaries served
Number of days to first DMC-ODS service after client assessment and referral
Total costs per beneficiary served by ethnic group
Cultural competency of DMC-ODS services to beneficiaries
Penetration rates for beneficiaries, including ethnic groups and age
Coordination of care with physical health and mental health
Timely access to medication for Narcotics Treatment Program services
Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured
Timely coordinated transitions of clients between levels of care, focused upon transitions to other services after residential treatment
Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment
Identification and coordination of the special needs of high-cost beneficiaries
Percentage of clients with three or more Withdrawal Management episodes and no other treatment

4 Additional Performance Measures

USE OF ASAM CRITERIA IN SCREENING AND REFERRAL OF CLIENTS

INITIATION AND ENGAGEMENT IN DMC-ODS SERVICES

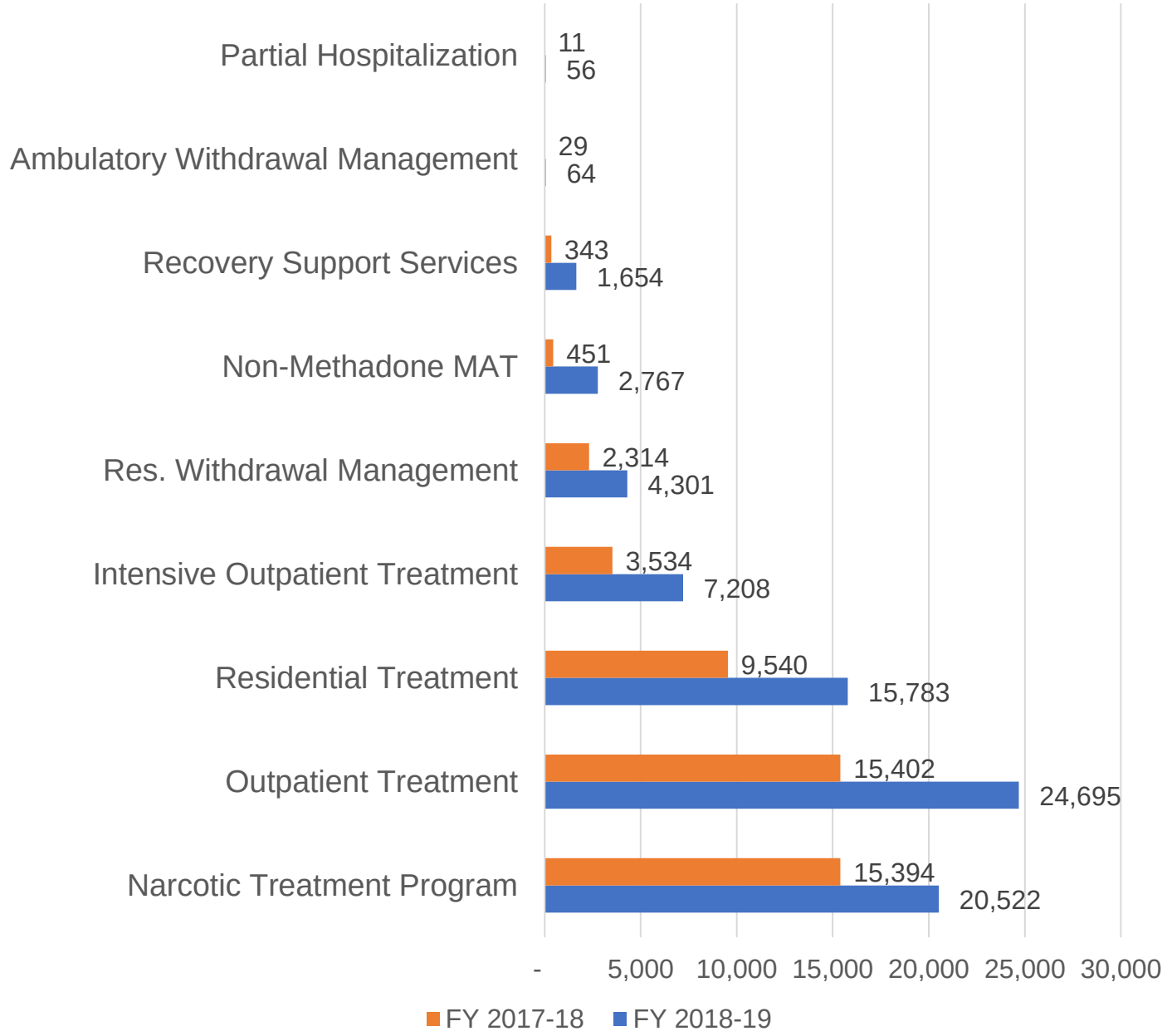
RETENTION IN DMC-ODS TREATMENT SERVICES

READMISSION INTO RESIDENTIAL WITHDRAWAL MANAGEMENT WITHIN 30 DAYS

Measuring Access for a Newly Developing System of Care

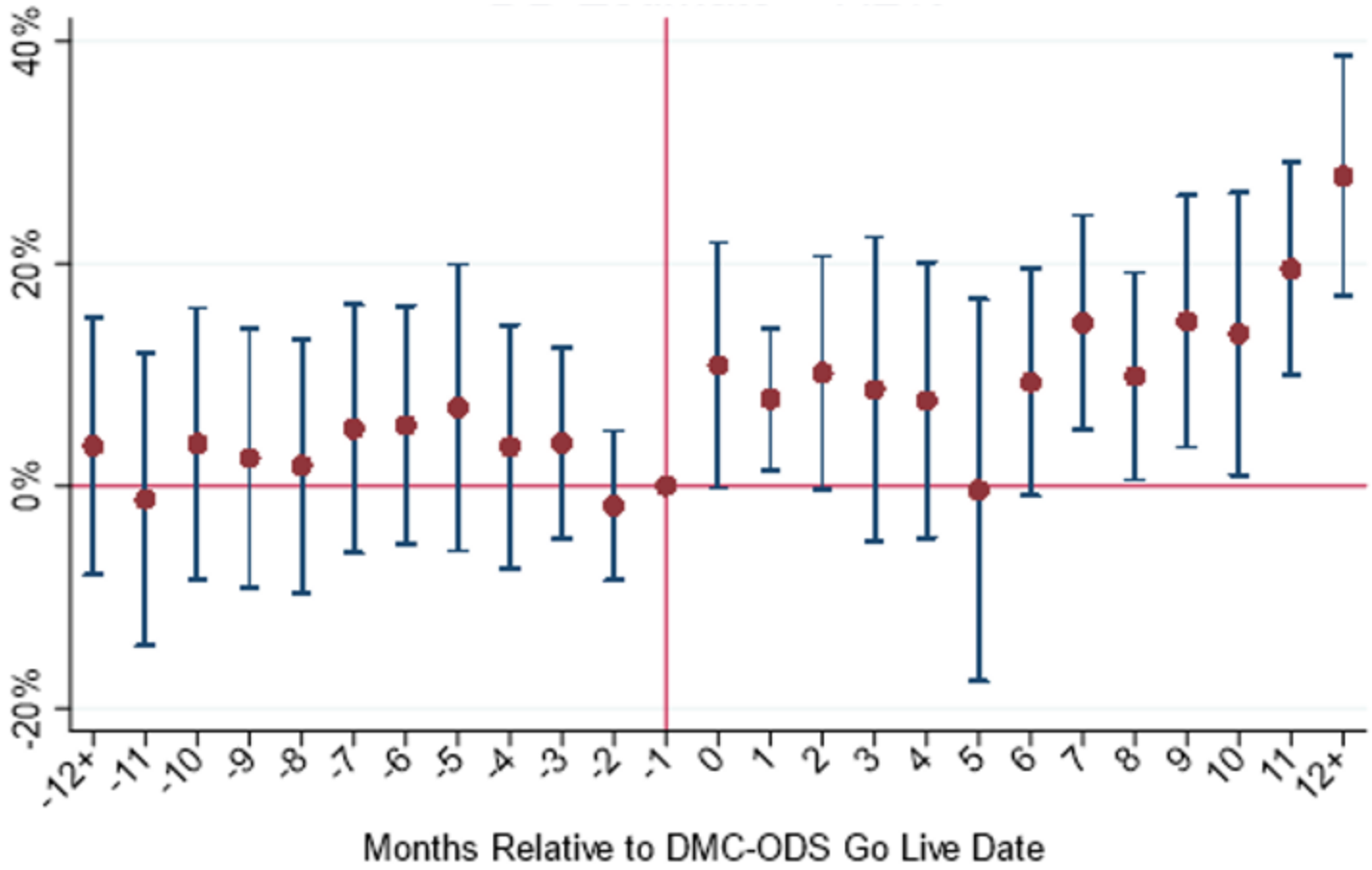
- For penetration rates, how to measure the Medicaid eligible population when it keeps changing?
- For penetration rates and utilization, how to use Medicaid claims data when there are lag times for submission and approval, and when not all claims are approved?
- How to determine whether increases in Medicaid clients served are due to shifts in coverage or actual increases in clients served?
- How to determine the extent to which some client services are delivered but not detected?
- How to determine whether some subgroups are underserved?

Units of Service Across Levels of Care in FY 2017-18 and FY 2018-19, DMC-ODS Pioneer Counties



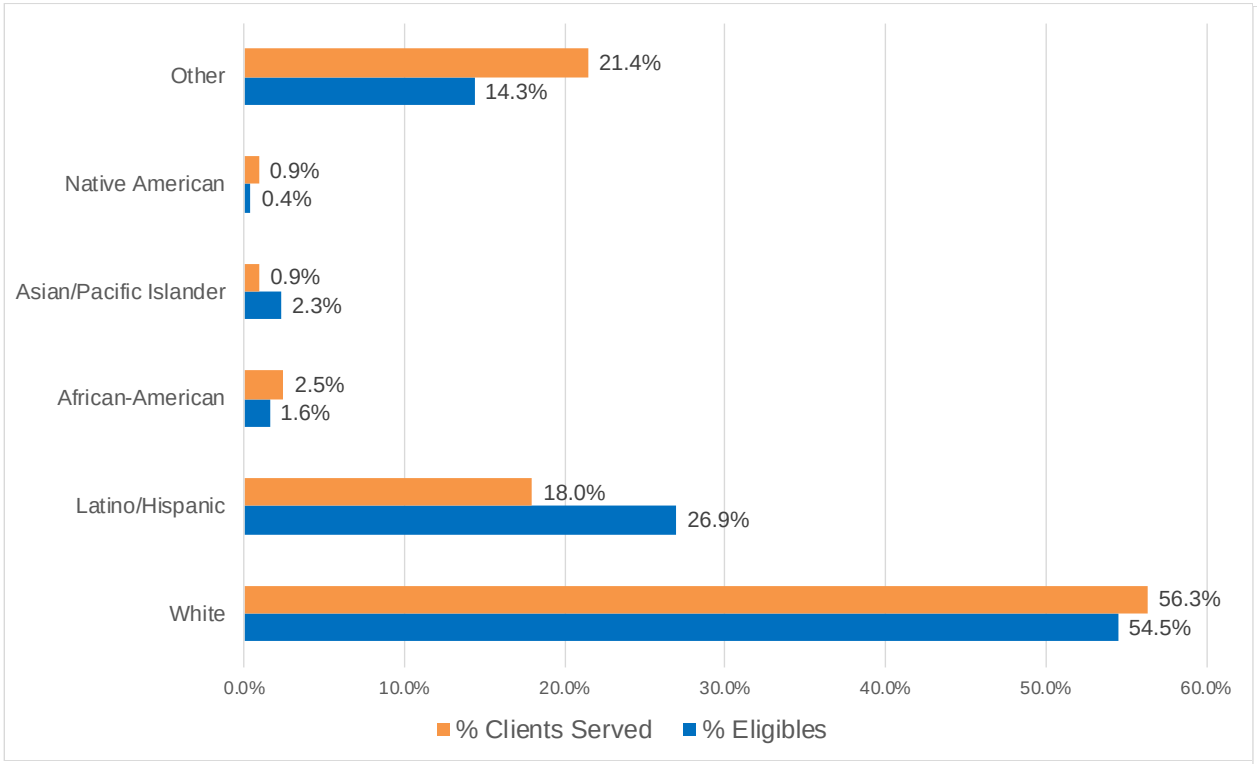
Number of Clients Served

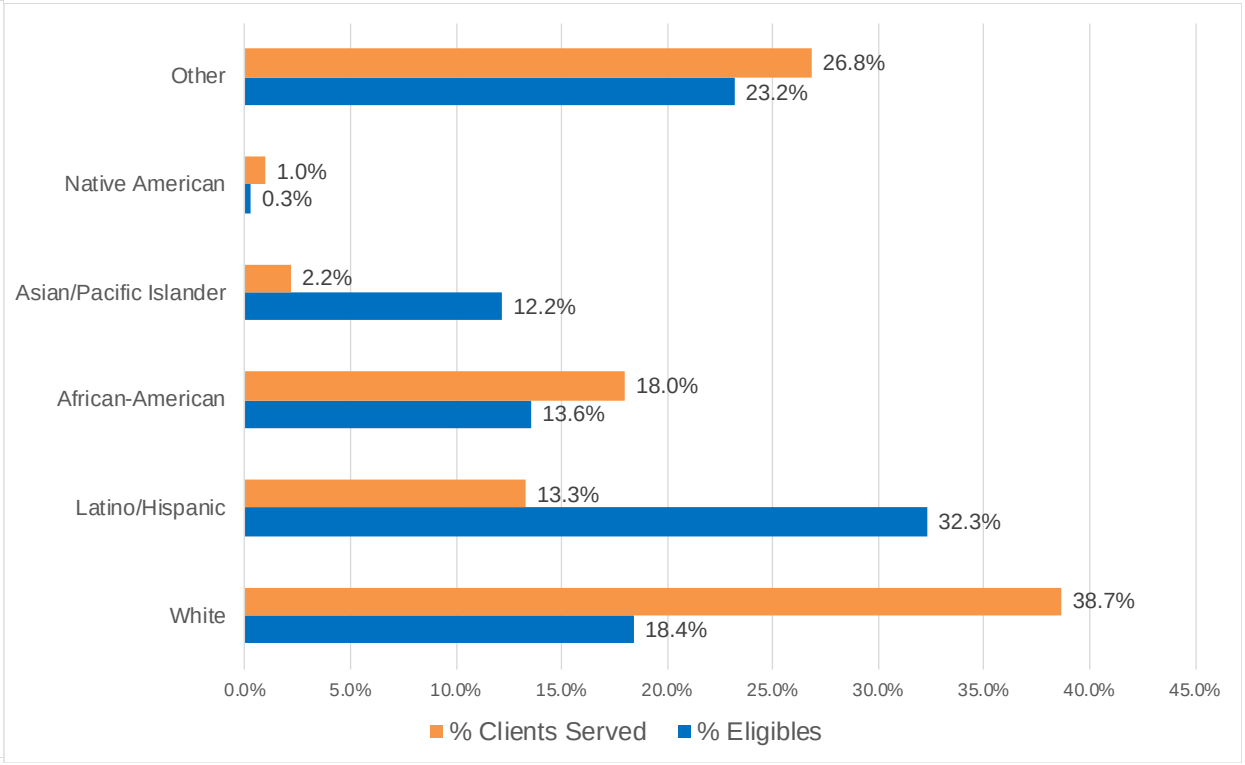
Event study estimates of the effect of the DMC-ODS waiver on unique number of clients receiving services in the California Outcome Measurement System (CalOMS)



- On average, no statistically significant increase for new admissions at go live date, but a significant increase at 7 months and beyond

Comparison of Proportionality by Race/Ethnicity





Access: What We Learned About Best Practices

- 24/7 access line with call center software to monitor response timeliness.
- Online real-time appointment and vacancy information for treatment programs.
- Linkages to historic client records to streamline screenings, assessments and referrals
- Well-trained screeners and assessors in applying American Society of Addiction Medicine (ASAM) patient placement criteria.
- Three-way call referrals from the access line to providers.
- Peer navigators and case managers to help clients connect to first intake and other services.
- Well-distributed program sites that can receive direct referrals and provide full assessments.
- Warm handoffs for all client transitions.

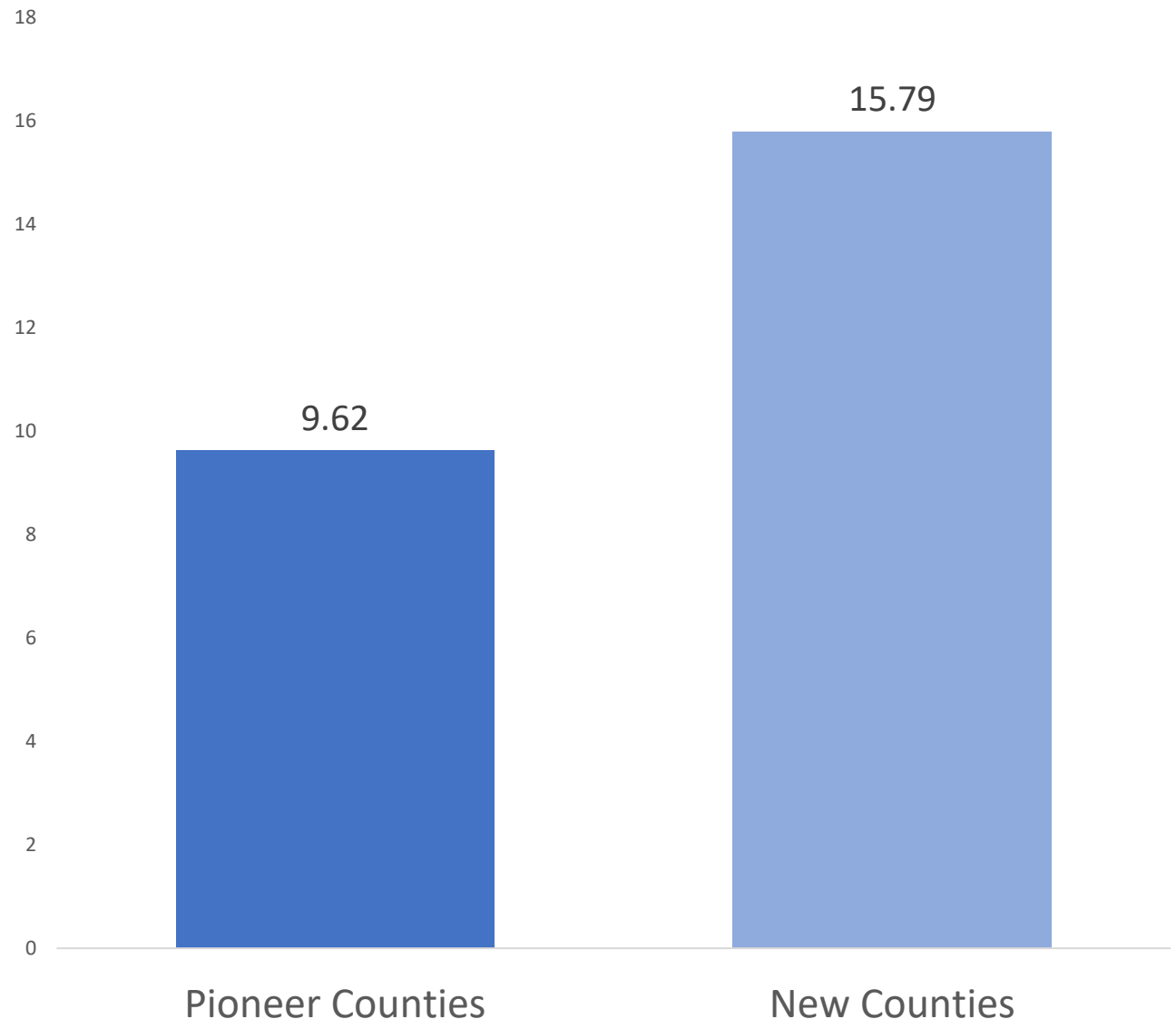
Measuring Timeliness for a System of Care

- Access Call Line software to streamline screenings with prompts for standardized questions and entry fields for referral decisions and for log dates of first request and first offered appointments.
- Electronically link Access Call Line log information to provider electronic health record (EHR) for timeliness to first actual intake.
- Provider software for entry of date client first requested treatment if not through the Access Call Line, and date of first offered and first actual appointment.
- Access for contracted treatment providers to the county EHR for data entry related to first session.
- Recognition that developing and improving IS infrastructure, data dashboards and measuring and improving timeliness are incremental and ongoing works in progress.

Timeliness Metrics for Time from First Request to First Face-to-Face Appointment, FY 2018-19 Across All Implementing Counties

Average Time from First Request to First Face-to-Face Appointment	Average	Minimum	Maximum
Average length of time from first requested to first face-to-face appointment (in days)	11.9	2.9	39
Timeliness Metrics and Percent Meeting the State Standard	% Meeting the Standard	Minimum	Maximum
First requested to first face-to-face appointment (10 business day standard)	65.6%	24.0%	98.5%

Average Days from First Request to First Face-to-Face Appointment, Pioneer Compared to New Counties, FY 2018-19 visits



DMC-ODS- Key Elements for Timeliness Access Tracking and System Improvements

Infrastructure

- EHR or database development
- Data collection for first contact throughout the system

Brief Screening

- 3-way calling
- Expedited process to provider for assessment and treatment

No Wrong Door

- Beneficiary access line (BAL)
- Drop-in clinics
- Provider locations

Data Review

- Checking for accuracy
- Consistent data reporting
- Timeliness

Dashboard

- Regular reports to system
- Review of reports at all levels
- Quality Improvement actions to address delays

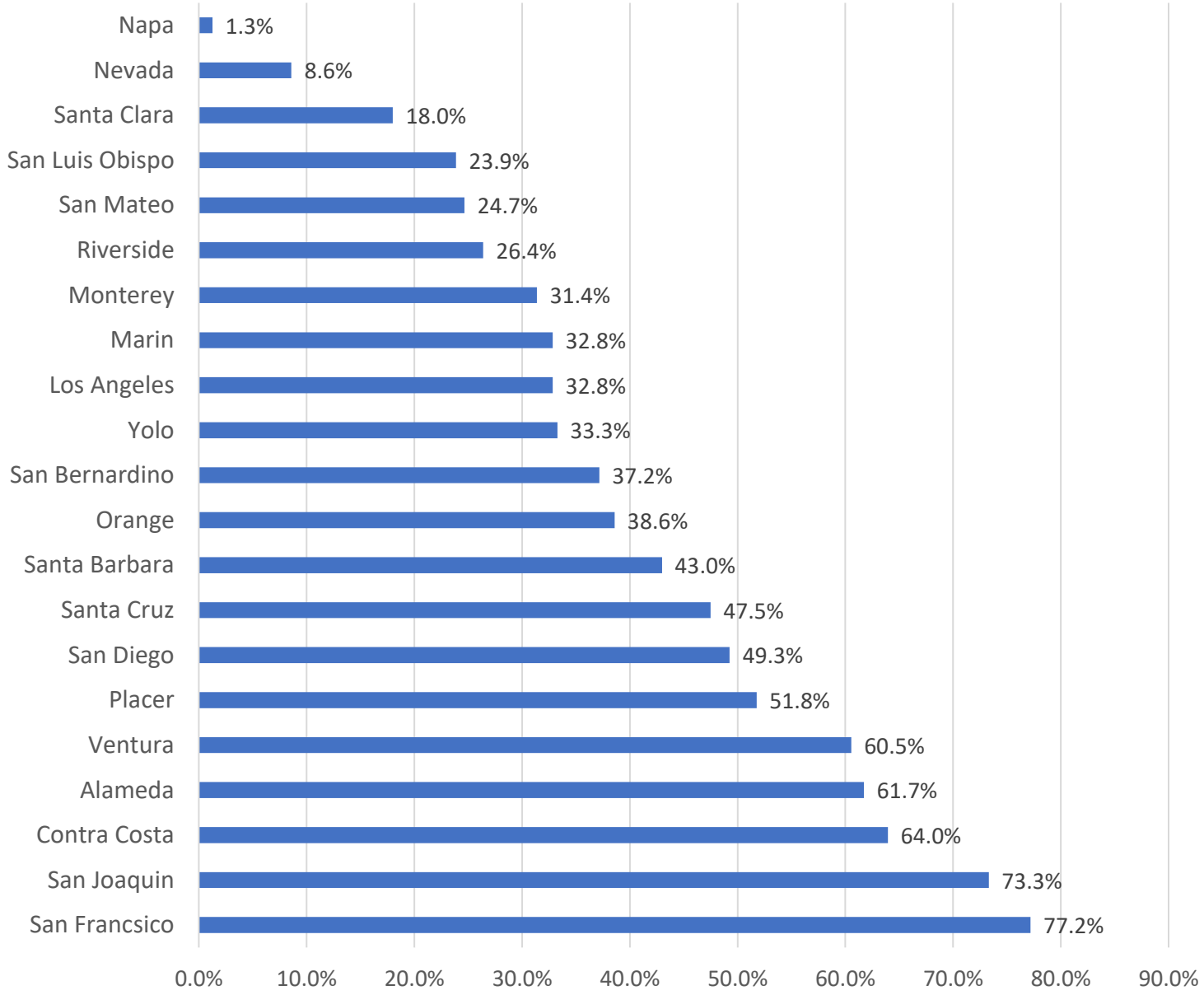
Measurement and Data Feedback Issues for Quality

- How well did clinical staff apply ASAM criteria-based findings to treatment referral decisions?
- How well did the system of care implement clinical EBPs such as MAT?
- How well did clients initiate and engage in treatment, transition from one level of care to another, and length of stay in treatment?
- How did clients perceive the quality of their treatment?

Congruence of Level of Care Referrals with ASAM Criteria-Based Screening and Assessment Findings, Statewide

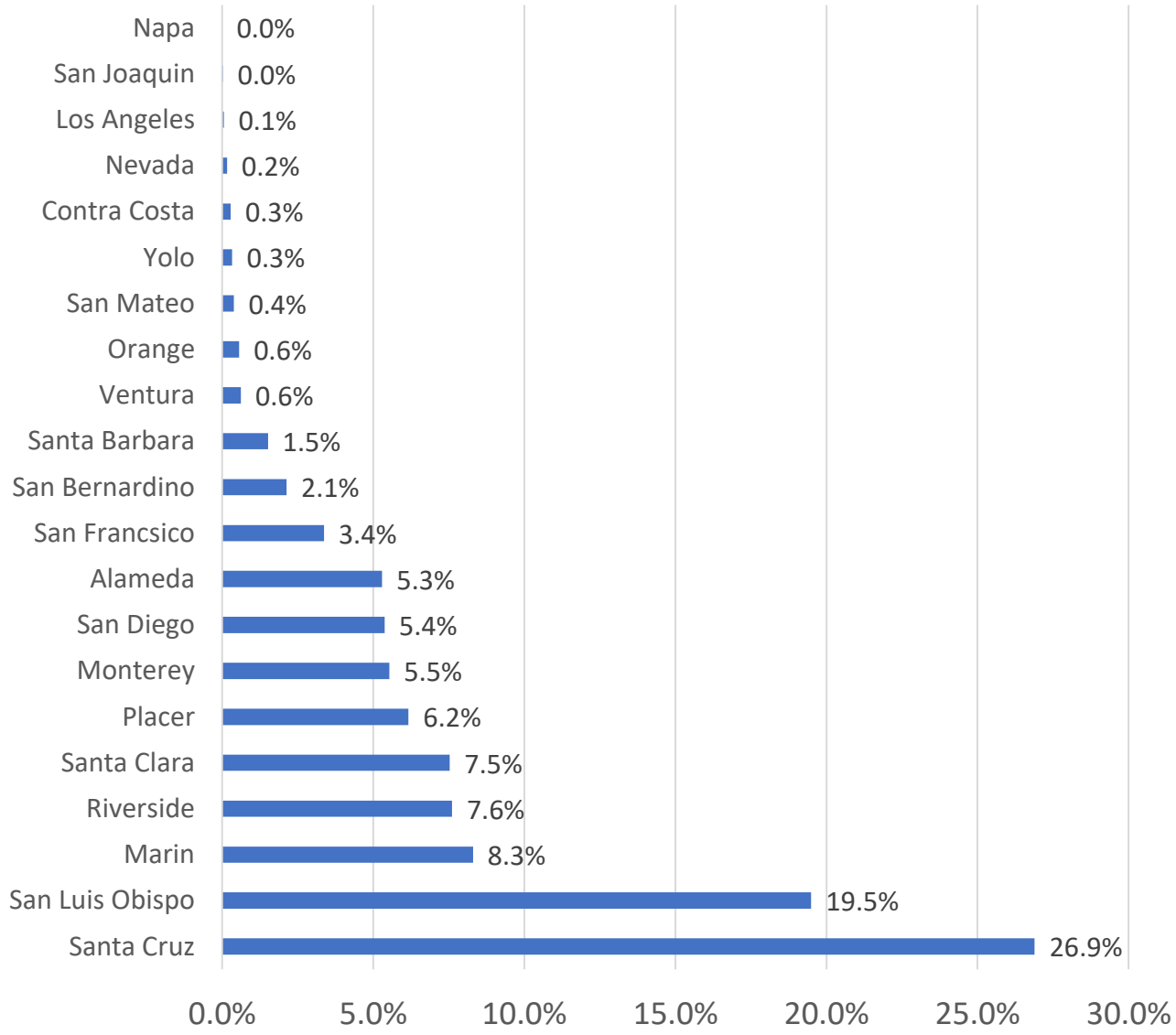
ASAM Level of Care (LOC) Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
Dates of Screenings: FY 2018-2019	#	%	#	%	#	%
Not Applicable / No Difference	37,269	81.30%	76,413	81.2%	33,355	84.8%
Patient Preference	2,507	5.47%	5,395	5.74%	1,854	4.71%
Level of Care Not Available	911	1.99%	878	0.93%	350	0.89%
Clinical Judgement	665	1.45%	3,598	3.82%	1,306	3.32%
Geographic Accessibility	139	0.30%	76	0.1%	42	0.11%
Family Responsibility	21	0.05%	129	0.14%	14	0.04%
Legal Issues	427	0.93%	511	0.54%	277	0.70%
Lack of Insurance / Payment Source	55	0.12%	78	0.1%	34	0.09%
Other	1,439	3.14%	3,960	4.2%	1,170	2.97%
Actual Referral Missing	2,410	5.26%	3,030	3.22%	950	2.41%
Total	45,843	100.0%	94,068	100.0%	39,352	100.0%

Introducing New EBPs into the System of Care: Percentage of Total Medi-Cal Clients Served Who Received Methadone in NTPs, FY 2018-19



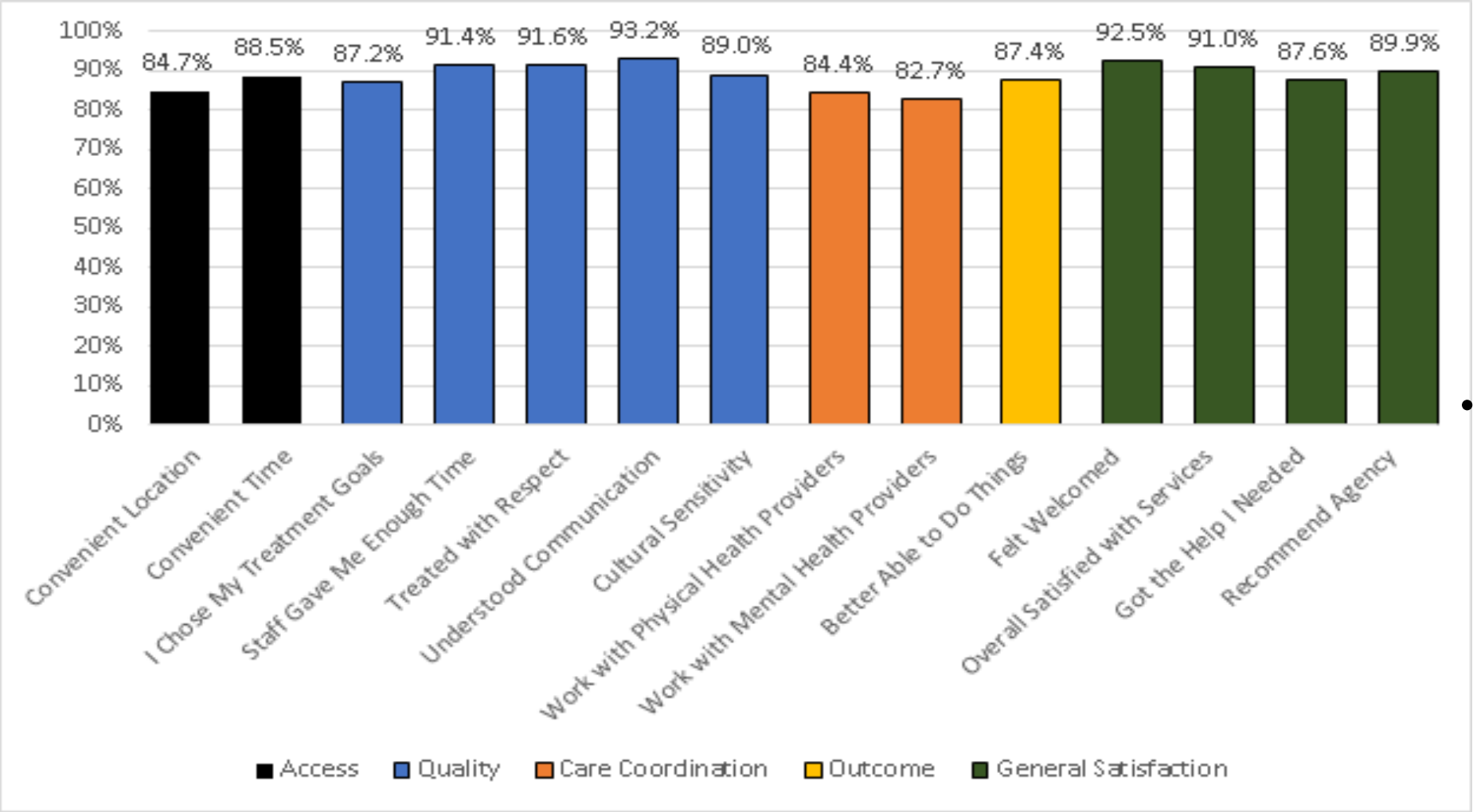
Introducing new EBPs into the System of Care: Percentage of Total Clients Served Who Received Non-Methadone MAT as Outpatients, FY 2018-19

Note: Data was unavailable for fee-for-service MAT delivered by primary care clinics and hospitals



2019 Treatment Perceptions Survey (TPS)

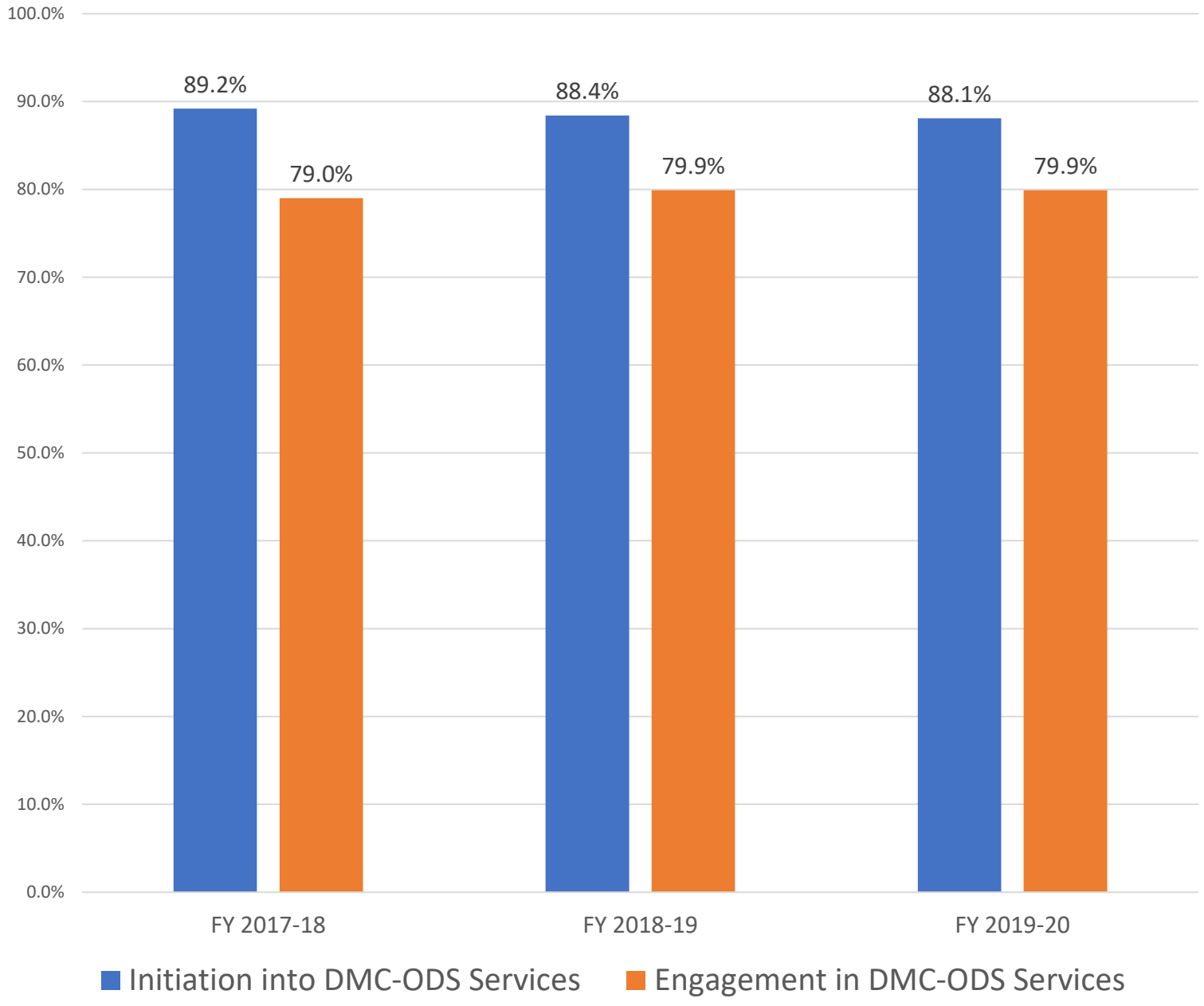
Percent in agreement for each survey item by domain – Adults



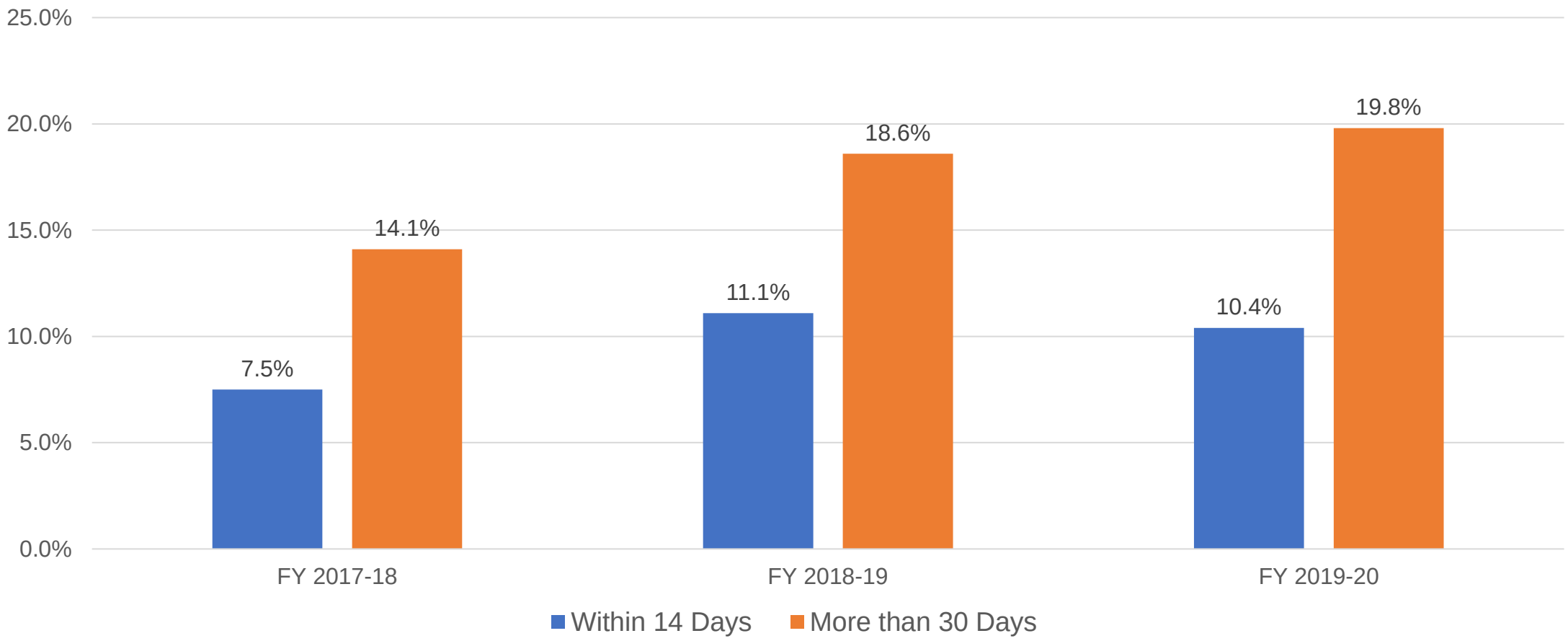
- Among Adults, satisfaction is high with at least 83% agreement across items in all domains

Percentage of adult clients Initiating and Engaging in DMC-ODS Services

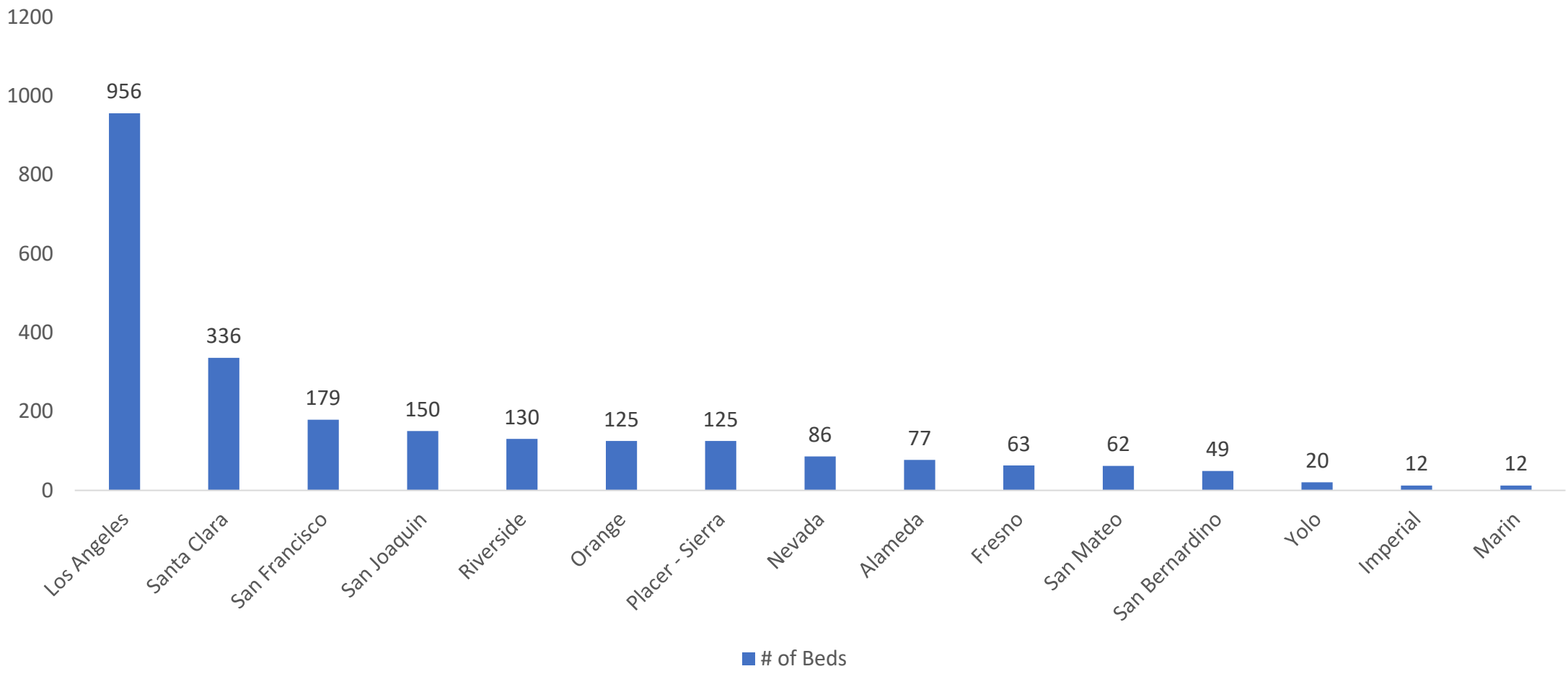
Note: Anchor event was first billed intake, not first called request for services



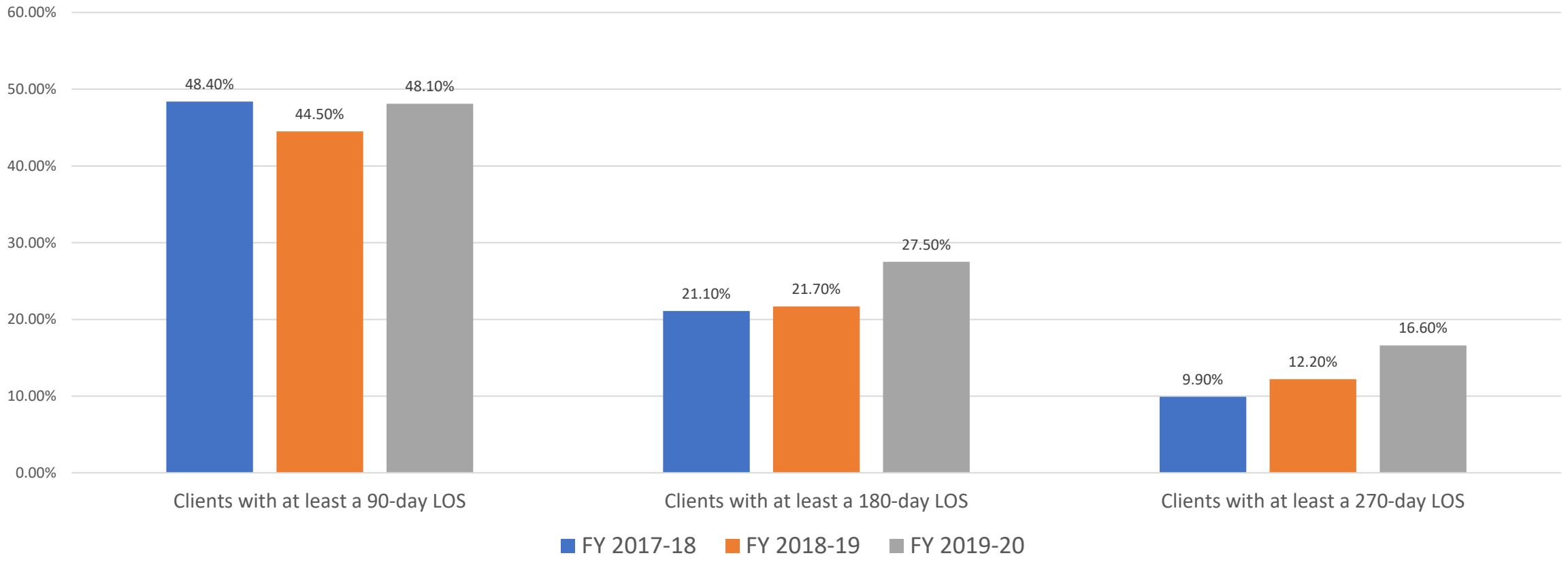
Percent of Clients with Timely Transitions in Step-down Care Following Residential Treatment



Recovery Residence Beds, FY 2019-20



Clients' Length of Stay across all DMC-ODS services



Key Elements for Improving Quality of Care

- Ongoing training in use of ASAM criteria.
- Promote EBPs such as MAT with feedback on utilization compared to statewide averages
- Ongoing feedback on comparative rates of treatment initiation and engagement, stepdown transitions in care, and retention in treatment.
- Expand types and capacities of services to meet local needs and ensure care is client-centered.
- Care coordination and recovery support to link clients to services they need.
- Use of Performance Improvement Projects (PIPs) to apply quality improvement methods for focused development and refinement of administrative and clinical processes.
- Use QI Workplans and Quality Improvement Committees (QICs) to prioritize QI monitoring tasks.
- Ensure sufficient QI and data analytic staff for responding to the many QI requirements of the 1115 Waiver.

Measurement Issues for Outcomes

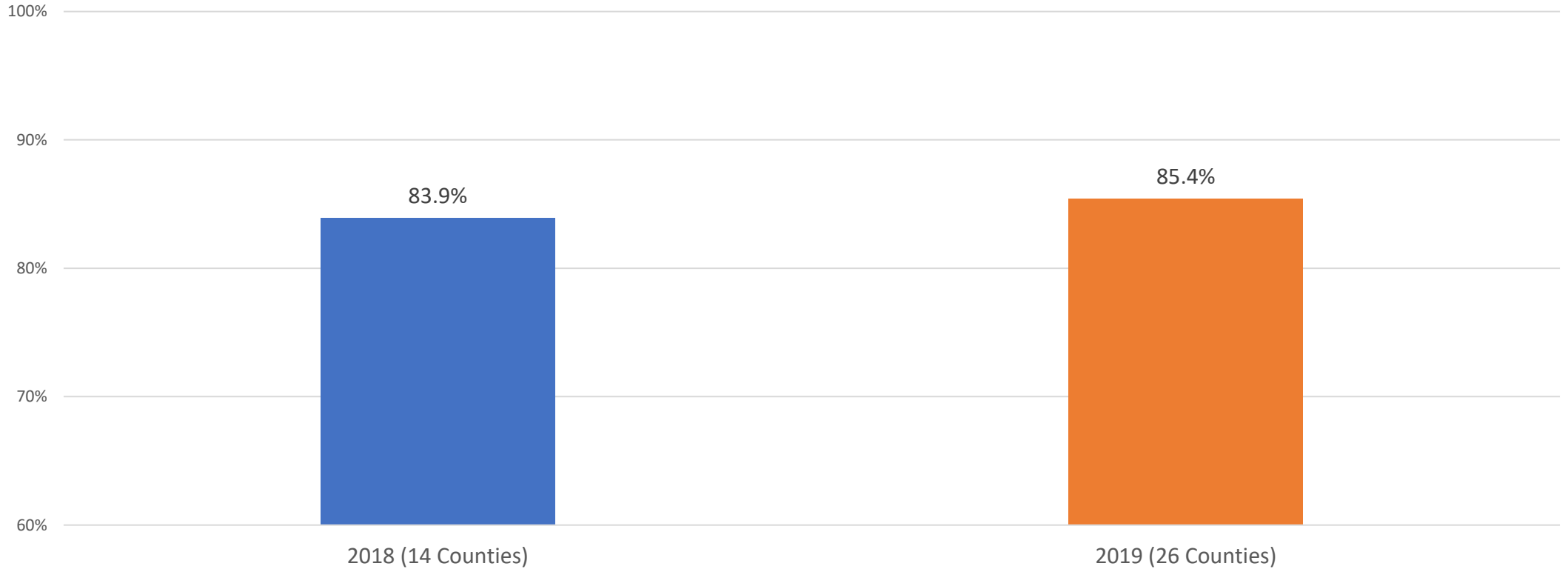
- What types of utilization data can serve as outcome measures, and how can feedback about the results be used to improve care?
- How can client ratings of their perceived outcomes from treatment be elicited and yield comparative results useful for quality improvement?
- How can provider ratings of client progress be elicited and yield comparative results useful for quality improvement?

Residential Withdrawal Management Readmission Rates: Statewide Comparisons for Counties

Statewide	%
3+ WM Episodes with no other services	1.95%
Clients admitted into WM who were readmitted within 30 days of discharge	6.2%

Percentage of Clients Agreeing with Outcome Question in TPS: CY 2018 (14 counties) and CY 2019 (26 counties)

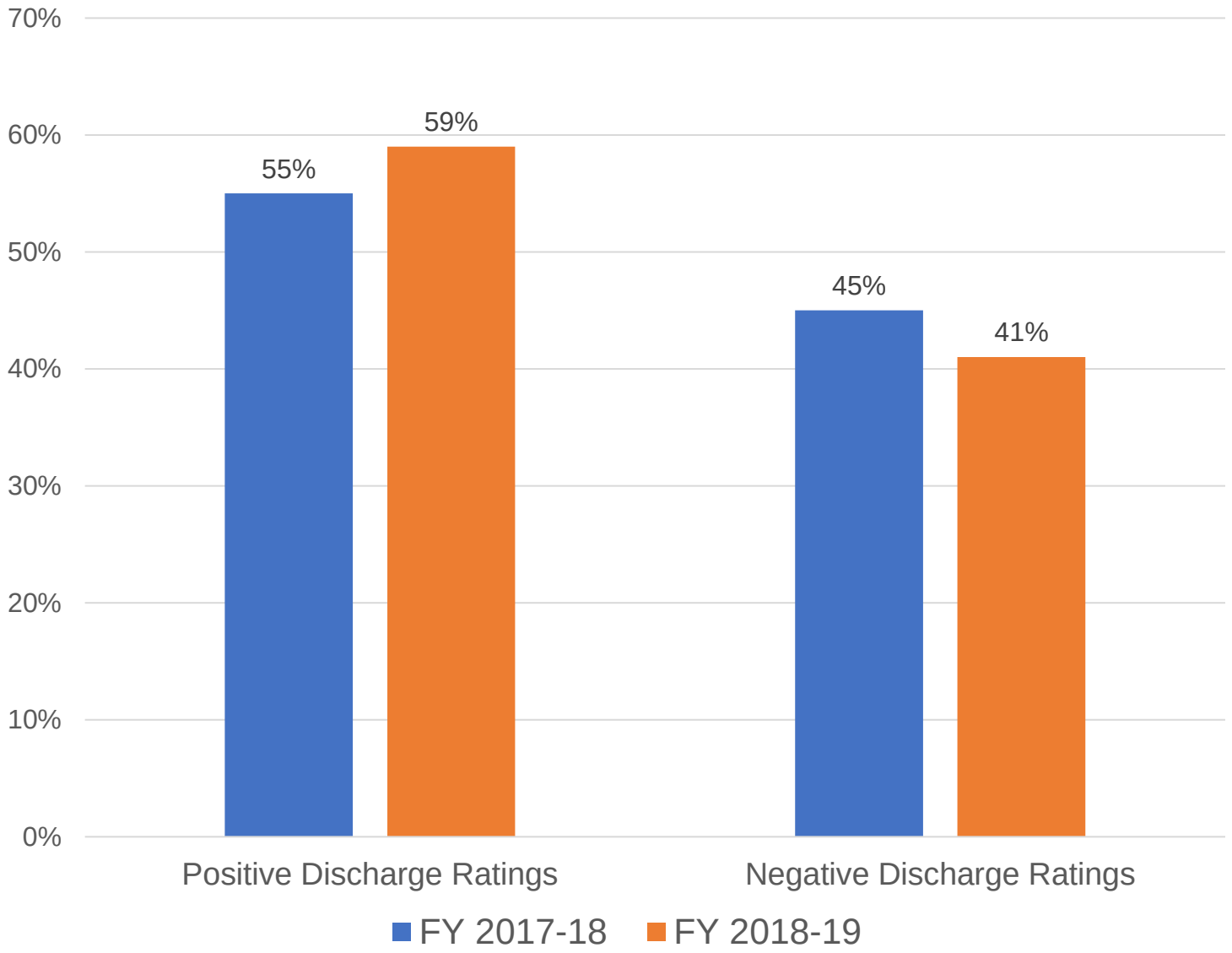
"As a direct result of the services I am receiving, I am better able to do things that I want to do."



CalOMS Discharge Status Ratings, Year-to-Year Comparison

Discharge Status	2017-18	2018-19	2019-20
Completed Treatment - Referred	22.7%	19.3%	17.6%
Completed Treatment - Not Referred	7.8%	6.3%	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	11.1%	13.1%	14.8%
Left Before Completion with Satisfactory Progress - Administrative Questions	8.1%	7.1%	7.6%
Subtotal for Positive Progress	***49.7%***	***45.8%***	***45.8%***
Left Before Completion with Unsatisfactory Progress - Standard Questions	16.5%	14.6%	14.4%
Left Before Completion with Unsatisfactory Progress - Administrative	32.1%	38.2%	38.6%
Death	0.2%	0.2%	0.2%
Incarceration	1.5%	1.2%	0.9%
Subtotal for Lack of Progress	*50.3%*	*54.2%*	*54.2%*
TOTAL	**100.0%**	**100.0%**	**100.0%**

Comparative Discharge Status, 14 Pioneer DMC-ODS Counties, FY 2017-18 and FY 2018-19



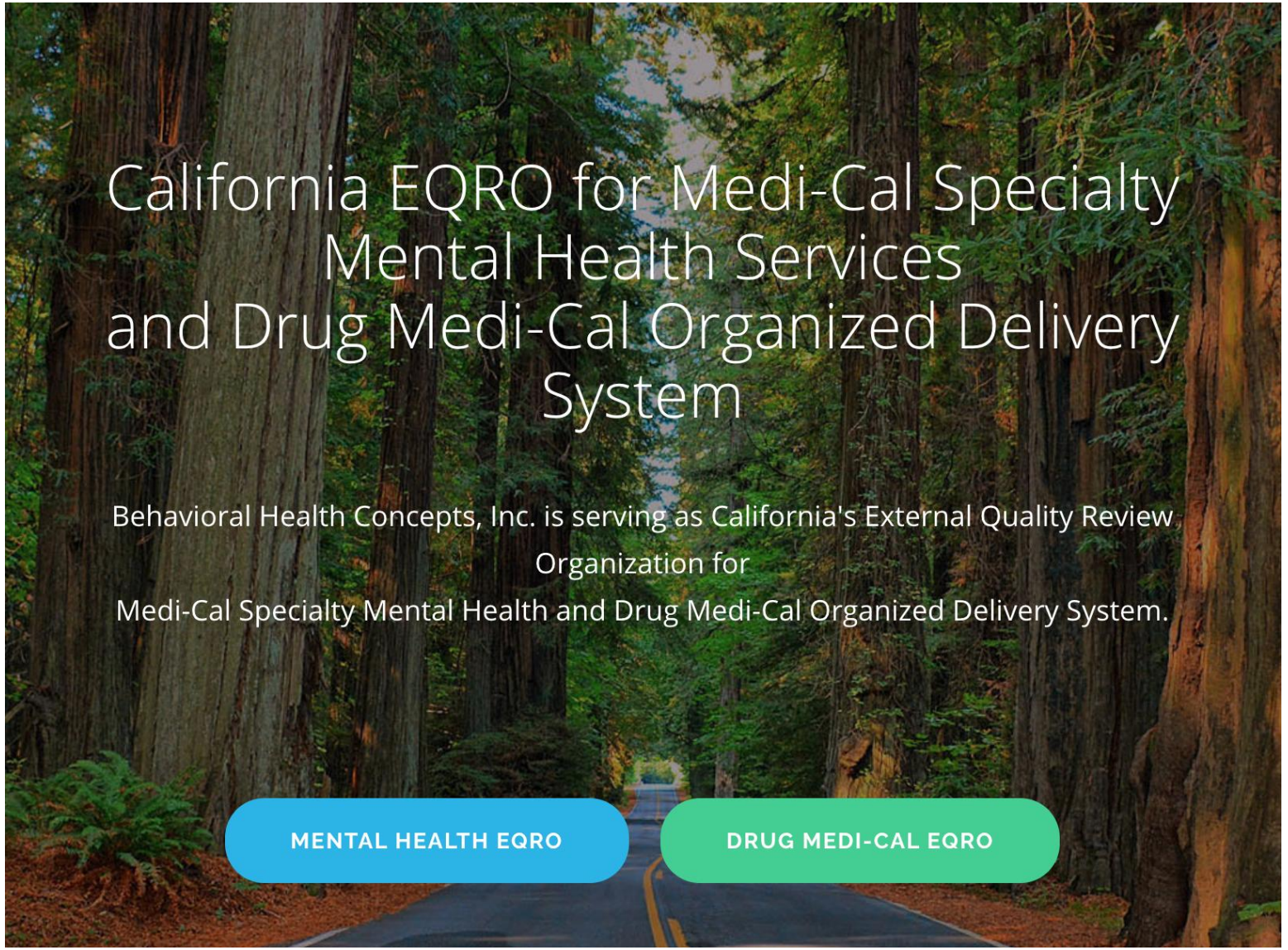
Best Practices for Outcome Measures

Readmission rates to residential withdrawal management suggest opportunities to improve discharge planning and case management follow-up to help connect clients to treatment.

Client experience of care surveys received high marks from client respondents for the brevity and clarity of questions and the opportunity to also include narrative comments.

Standardized CalOMS questions yielded outcome measures that enabled comparisons across counties and with statewide averages.

Review our in-depth DMC reports at: caleqro.com/dmc-eqro



Questions???

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