Creating an Enhanced Service System through DMC-ODS: Riverside County

March 2019

Outline

- Background
- Previous System of Care
- Conceptual Elements of System Redesign
- New System Roll Out
- Lessons Learned
- Story Telling with Data
- Next Steps

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Background

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What is DMC-ODS?

- The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of healthcare services for Medicaid eligible individuals with a SUD. The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system healthcare costs.

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Essential Elements of DMC-ODS

- Provision of a continuum of care based on ASAM Criteria
- Increased local control & accountability
- Greater administrative oversight
- Creates utilization controls to improve care and efficient use of resources.
- Utilization of EPB in SUD treatment
- Increased coordination with other systems of care

DMC-ODS
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM
NEW Medi-Cal Addiction Treatment

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Waiver History

- First submitted to CMS on November 21, 2014
- California DHCS announced federal approval of the State's Drug Medi-Cal Organized Delivery System (DMC-ODS) on August 14, 2015
- Counties have option to opt-in or opt-out of the DMC-ODS
- Riverside and San Mateo Counties were first counties in California to go live with their plans – February 1, 2017

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Previous System of Care

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Riverside County System of Care

- 10 County operated Substance Abuse clinics providing prevention, outpatient, and intensive outpatient services
- 16 Contracted Providers located at 50+ sites around the County that provide the balance of service
  - Outpatient/Intensive Outpatient
  - Residential
  - Withdrawal Management
  - NTP/OTP

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Services covered previously under State Plan Amendment

- **Services reimbursable under DMC**
  - Outpatient Drug Free (ODF) – group counseling
  - Intensive Outpatient (IOT) – group counseling
  - NTP (methadone only)
  - Perinatal Residential
  - Individual Counseling Sessions (ODF & IOT)
    - Crisis Intervention
    - Collateral services
    - Other Individual Counseling sessions were not covered

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Services covered previously under State Plan Amendment

- **Services not reimbursable under DMC and billed to SAPT Block Grant**
  - Non-perinatal residential (adult and adolescent)
  - Medication Assisted Treatment (MAT)
  - Case Management
  - Individual Counseling Sessions (ODF and IOT) other than crisis intervention and collateral sessions
    - Family sessions
    - Weekly individual sessions
  - Withdrawal Management (Detox)

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Other limitations with State Plan Amendment

- Wait time for county funded residential beds anywhere from 3 weeks to 6 months
- SAPT-BG limited the number of available county funded beds
- Unable to provide therapy with Clinical Therapist
- Aftercare not available

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Conceptual Elements of System Redesign

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New Elements Reimbursable Under DMC-ODS Waiver

- Multiple Levels of Residential Care based on ASAM
- Multiple Levels of Withdrawal Management based on ASAM
- Multiple Levels of Outpatient Care based on ASAM
- Case Management Services
- Recovery Services (Aftercare)
- Physician Consultations
- Medication Assisted Treatment
- OTP/NTP – expanded drug selection
  - Buprenorphine
  - Naloxone
  - Disulfiram
  - Methadone

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ASAM Levels of Care

Level of Care	Description
0.5	Early Intervention
1.0	Outpatient
2.1	Intensive Outpatient
2.5	Partial Hospitalization
3.1	Low Intensity Residential (Clinically Managed)
3.3	Med. Intensity Residential (Population Specific; Clinically Managed)
3.5	High Intensity Residential (Clinically Managed)
OTP	Opiate Treatment Program (formerly NTP)

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ASAM Levels of Care (cont.)

Level of Care	Description
3.7	Intensive Inpatient Services (Medically Monitored)
4.0	Intensive Inpatient Services (Medically Managed)
1.0-WM	Ambulatory Withdrawal Management (w/o on-site monitoring)
2.0-WM	Ambulatory Withdrawal Management (with on-site monitoring)
3.2-WM	Clinically Managed Residential Withdrawal Management
3.7-WM	Medically Monitored Inpatient Withdrawal Management
4.0-WM	Medically Managed Inpatient Withdrawal Management

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Minimal Requirements for DMC-ODS Counties

Service	Required
Early Intervention	Level 0.5
Outpatient	Level 1.0 and Level 2.1
Residential	At least one ASAM level of services initially (3.1, 3.3, or 3.5)
NTP	Required (includes 4 drug options)
Withdrawal Management	At least one level of service
Recovery Services	
Case Management	
Physician Consultation	

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Additional Conceptual Elements

- 24-hour access hotline (required by waiver)
- Level of Care determined by ASAM
- Residential Placements controlled by County instead of providers
- Creation of ASAM Screening Tools
- Countywide Care Coordination Team to provide case management for residential and high risk consumers
- Peer and Clinical Therapist Involvement
- Provider involvement throughout the design process
- Service delivery in schools (prevention & treatment)

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Plan Development

- Behavioral Health Commission
- Interdisciplinary Care Team
- Youth Interagency Committee
- Contract Provider & Community Stakeholders
- Strategic Partner Committees (Residential, Outpatient, Adolescent Services, MAT/OTP)
- Internal Readiness Committee (Fiscal, Billing, EHR, Contracts, Program, QI, Compliance)

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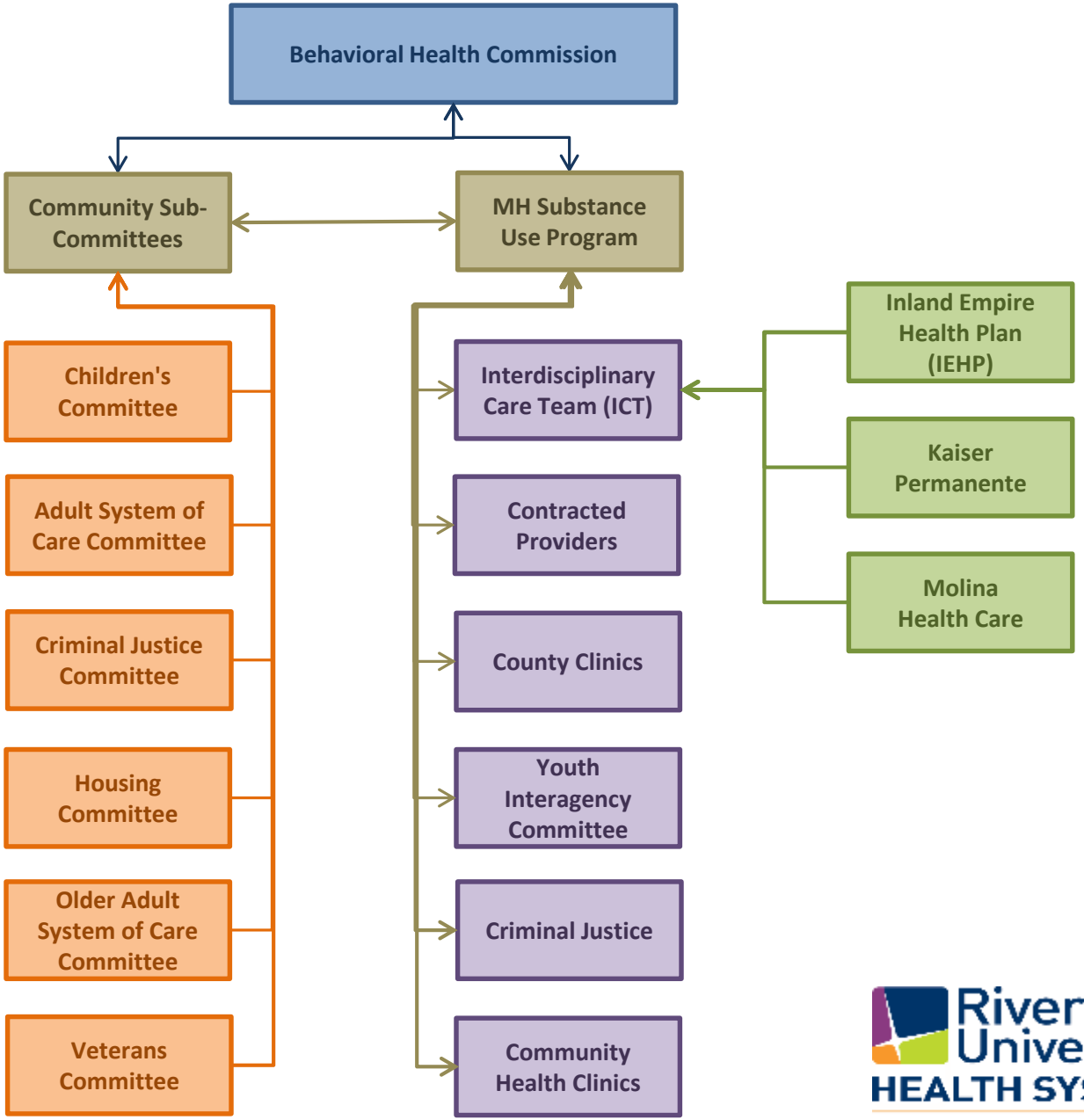

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Substance Use Community Access Referral Evaluation & Support Line (SU CARES)

- 24 Hour informational line as required by Waiver
- This team is responsible for all residential withdrawal management and residential treatment placement in County
- Calls initially answered by clerical staff which gather demographic information about client and check for Medi-Cal Availability. Call then passed on to Counselor for ASAM Screening and placement

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SU CARES (cont.)

- System was tested out for a full year before going live with clients referred from County Managed Care Plan – Inland Empire Health Plan (IEHP)
- Original team consisted of Supervisor, one clerical staff, and 2 counselors

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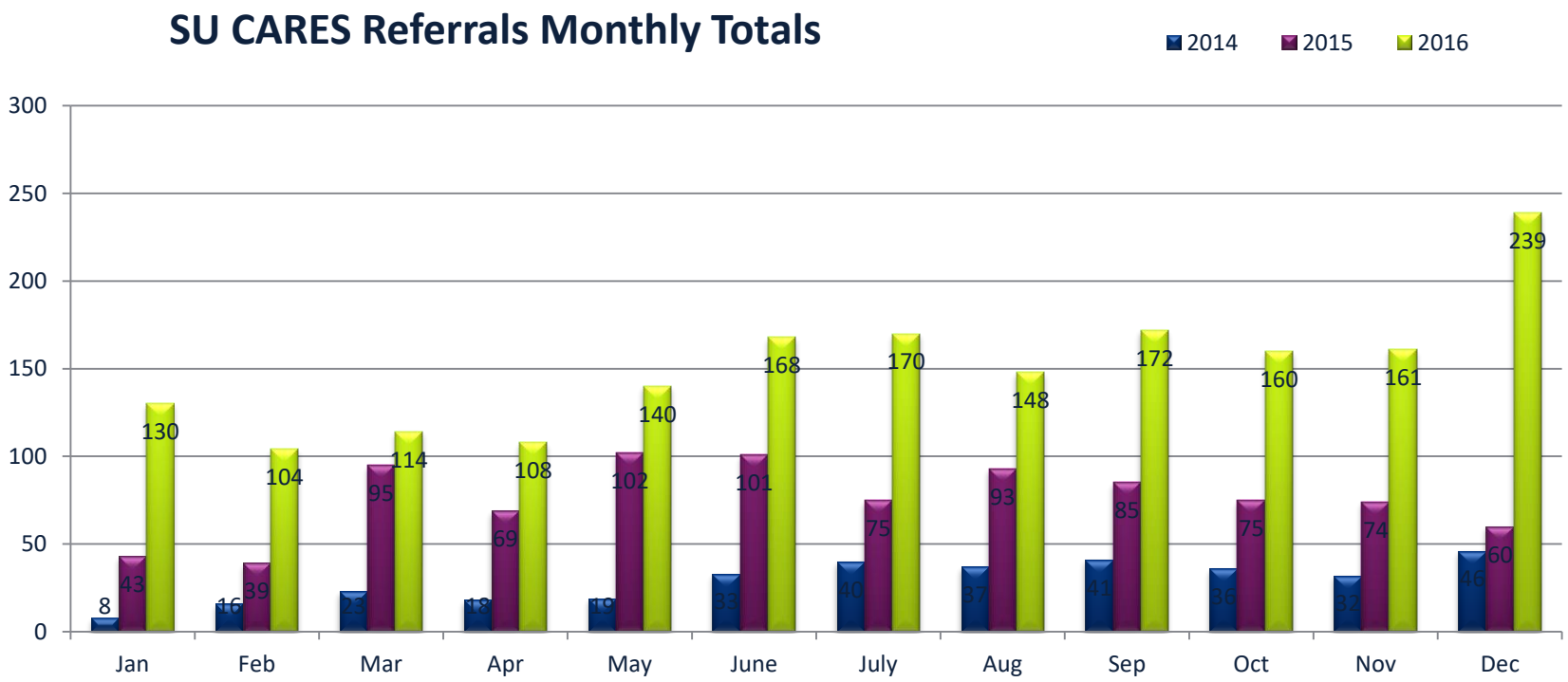
SU CARES Volume by Month Beta Test



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Care Coordination Teams

- Case management team assigned to consumers placed in residential withdrawal management and residential treatment. Case managers follow clients through entire residential episode
- Originally had 3 CCT teams and 1 START team located in 3 distinct geographic regions of County

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Additional Preparations

- Development of ASAM screening tools (adult and adolescent)
- 4 levels of ASAM training offered to counseling staff: (A, B, C, Continuum of Care)
- Training on Evidence Based Practices for counseling staff: MI, CBT, Relapse Prevention
- EBP Curriculum training for counseling staff: Living in Balance, Matrix (Adult & Adolescent), CBT for PTSD, Coping with Stress: Teens and Trauma

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Services Directly in Schools

- Idea was to be able to provide services for high risk youth directly at school sites
- Created MOU with SELPA – this allowed us to be active in any district serviced by SELPA
- Providing Indicated Prevention Services (funded through SAPT-BG) and Treatment Services (DMC-ODS) as a satellite service from closest county operated SAPT clinic; same counselor provides both services
- Currently active in 4 districts and 8 schools

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New System Rollout

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New System Rollout

- System live at 7:00 am on February 1, 2017. Riverside and Santa Clara County were the first in California to roll-out waiver. New contracts started on that day; Riverside County rolled out all services on that day

- County SAPT program had 132 FTEs in April 2015 and 218 FTEs on February 1, 2017 (approximately 68 positions unfilled – 150 working)

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Medical Necessity

- One of biggest challenges of rollout centered on the paradigm shift that treatment level of care should be based on medical necessity
- Lots of pushback from courts, probation, DPSS, etc. that had mandated clients receive a specific regiment of treatment
- Great effort launched to prepare and educate our community partners of this change, which made the transition much smoother

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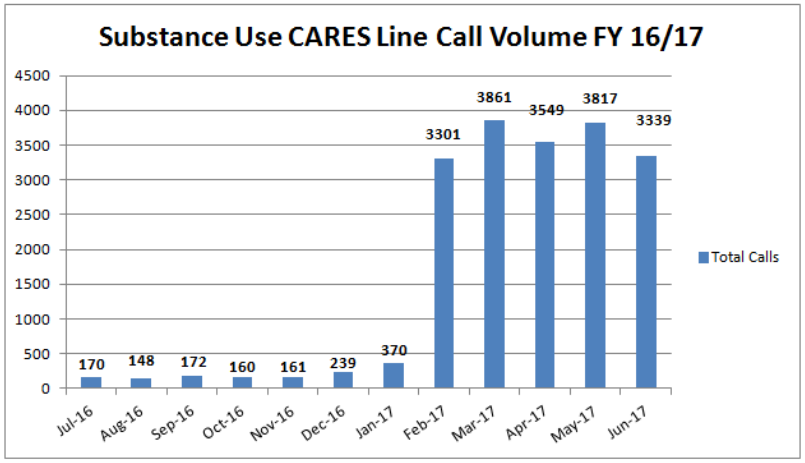
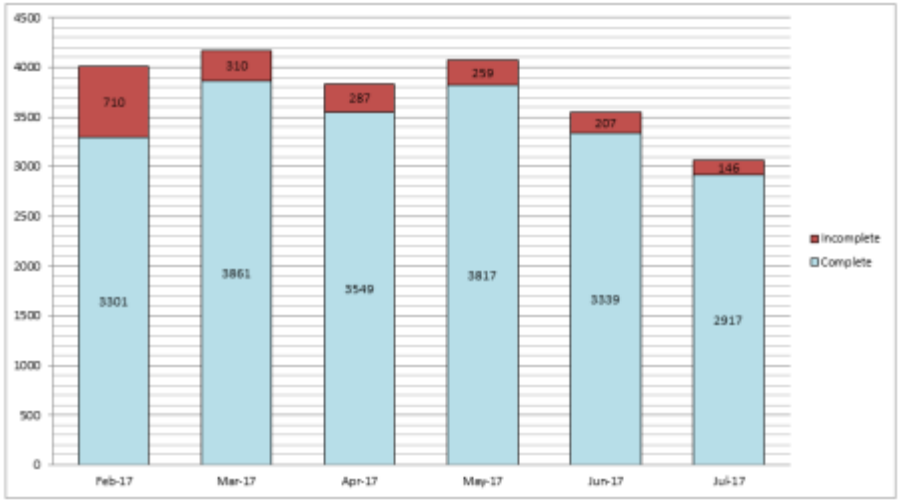
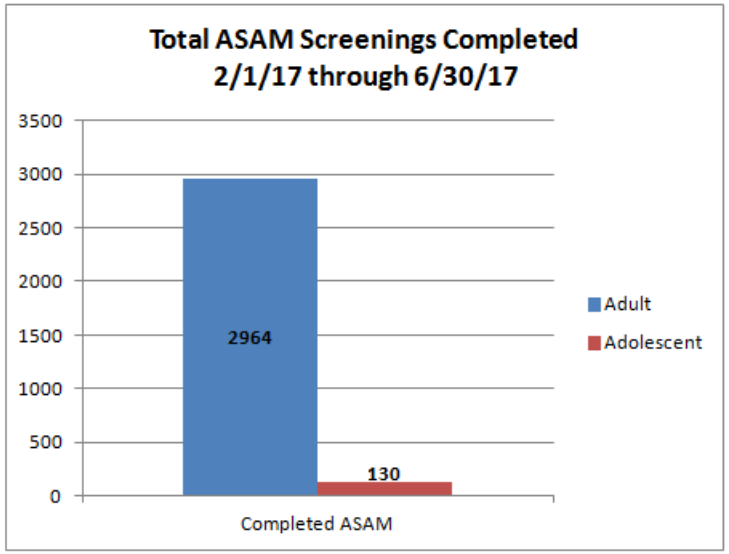
SU CARES Line Challenges







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Initial Staffing Inadequate for SU CARES Line

- Were not prepared for high number of calls into system
  - Needed to bring in CCT Team in to assist with calls
  - Needed to use clinic personnel from around the county to assist with calls as well
- Staffing of SU CARES line now includes 3 clerical and 7 counselors along with supervisor

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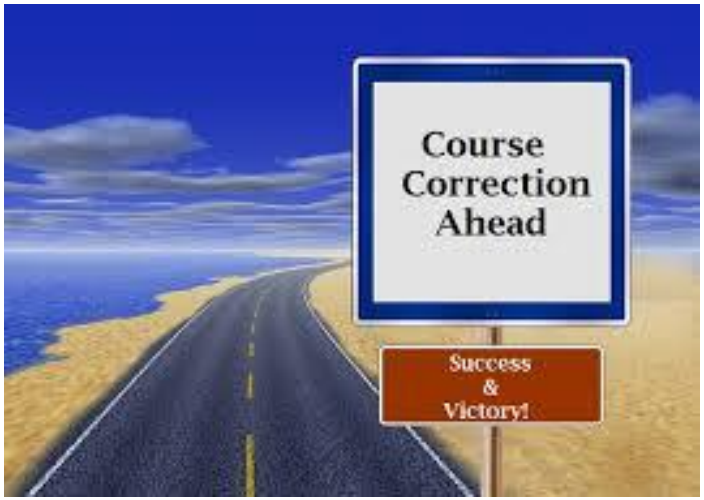
SAPT Care Coordination Team Changes and Caseloads

- Mid-County CCT Dissolved
- Desert CCT: Blythe Addition, START
- Riverside CCT Increase Staffing
- Adolescent Specific County Wide

- 93% Medi-Cal (DMC)
- Increased Consumer Interaction
- Less Drive Time
- Increased Engagement



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Other Challenges

- Keeping up with staffing - difficulty in increasing workforce and training workforce
- 88 hours training every 6 month for the first 18 months that began 6 month before live date
- Staff mastery of the ASAM has been one of the more challenging components
- Also, trying to get staff to change their concept of treatment from a non-medical one to one based on an ASAM standpoint

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Lessons Learned

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Contingency Plan

- Don’t get caught off-guard – plan for contingency operations
  - Electronic documents should be available as printed versions
  - Computer systems crash – just plan on that happening
- Plan on having staffing snafus

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Document Content of all Calls

- Calls into SU CARES line should be logged into EHR and call content recorded
- This is necessary since sometimes it takes several calls to gather all information on client and previous counselor may not be available at time of call back
- Also important if call is accidentally dropped
- This way everyone that interacts with consumer has all pertinent information available

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Call Center Should Have Library of Local Resources

- Many of calls coming in to SU CARES line are for information.
- Having library of local resources makes it easy to connect consumers with services
- Often, consumers going into residential treatment need to have certain issues addressed before treatment - local resource library helps with this
- Also important to have contact information for SUD offices of other counties in area – especially important when consumers present with out-of-county Medi-Cal coverage

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Wait Times Reduced or Eliminated

- Once County took over bed placement for residential and withdrawal management services, providers committed to providing more beds and wait time for placement were reduced significantly or eliminated all together
- Residential beds for adolescents and beds for withdrawal management are scarce, so wait times can be around 2 weeks
- Many clients can be placed into a residential bed on same day or next day

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Story Telling with Data

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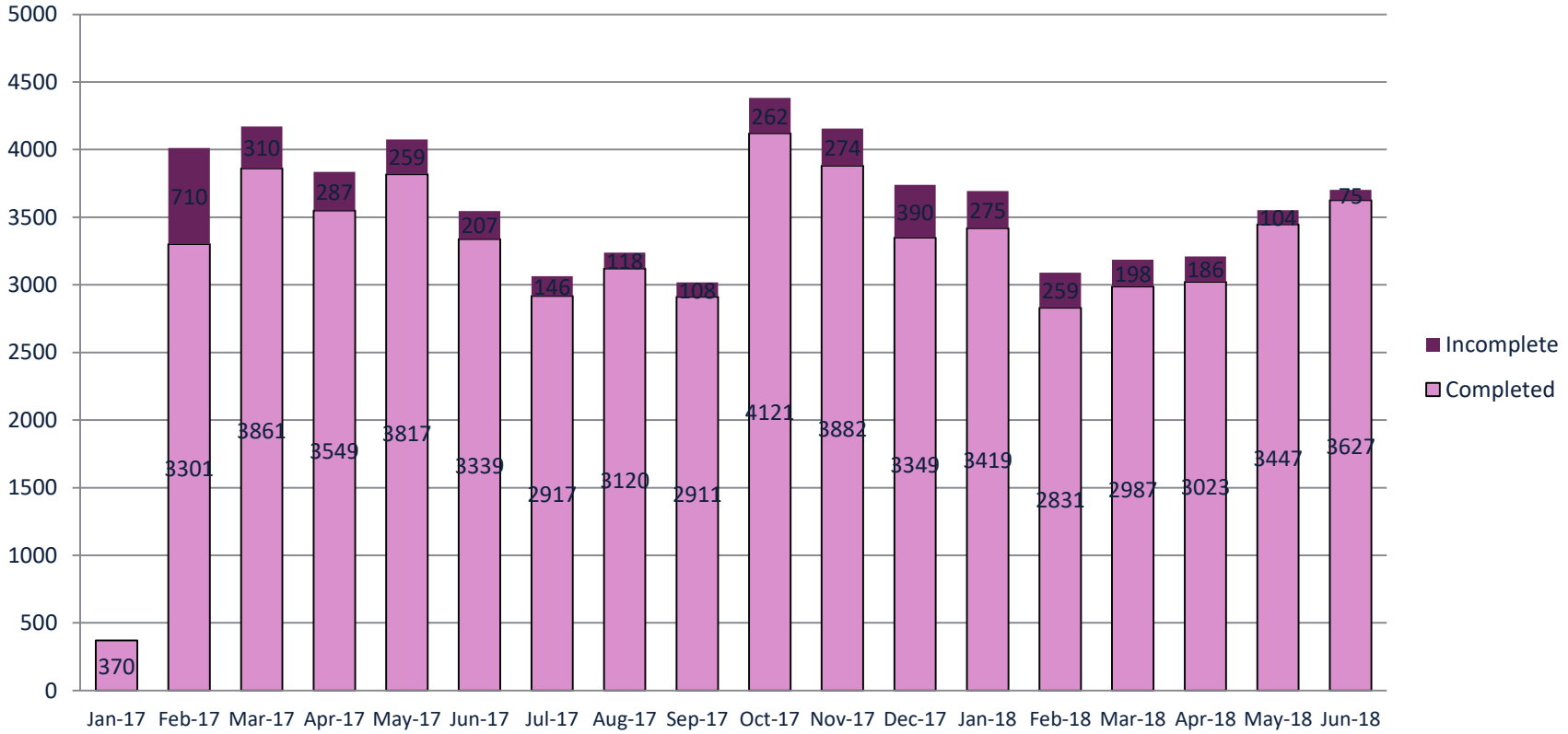
SU CARES Line Monthly Call Volume

January 2017 – June 2018



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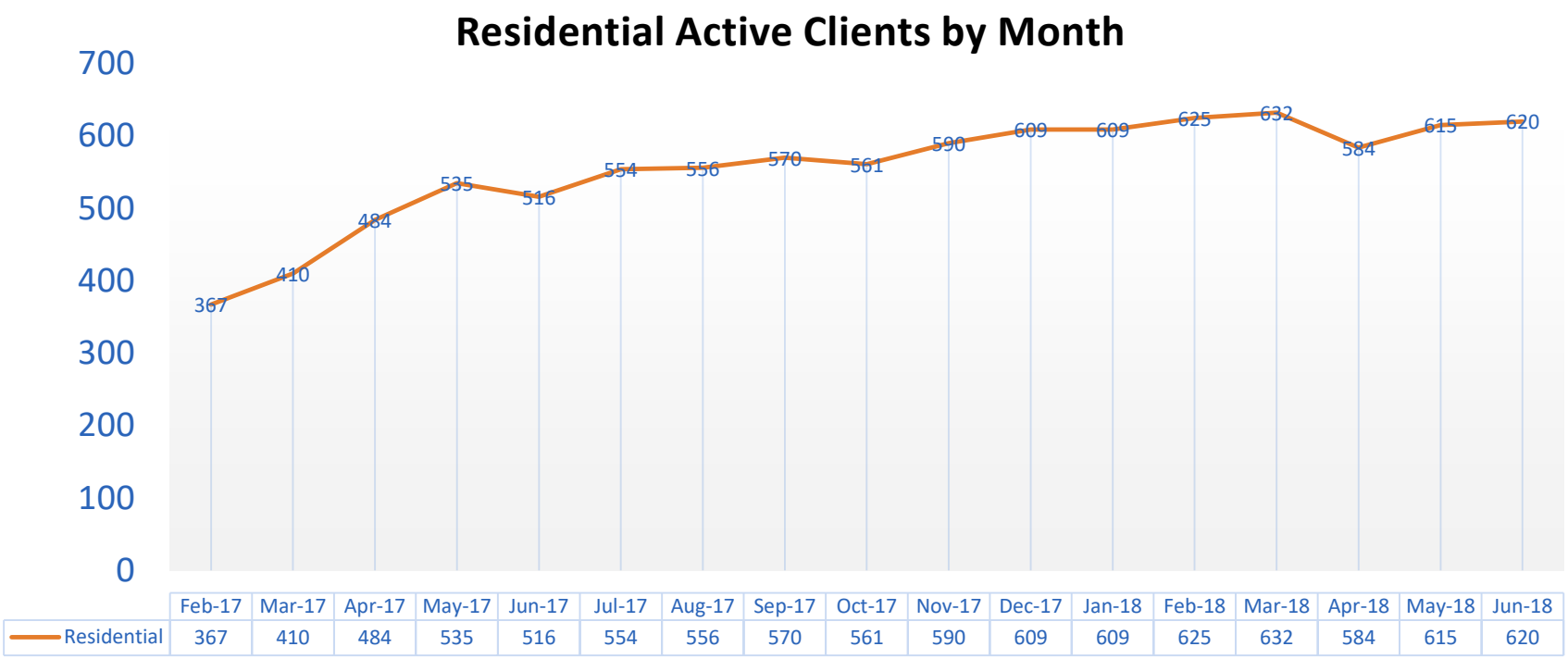
Residential Active Clients by Month



	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Residential	367	410	484	535	516	554	556	570	561	590	609	609	625	632	584	615	620

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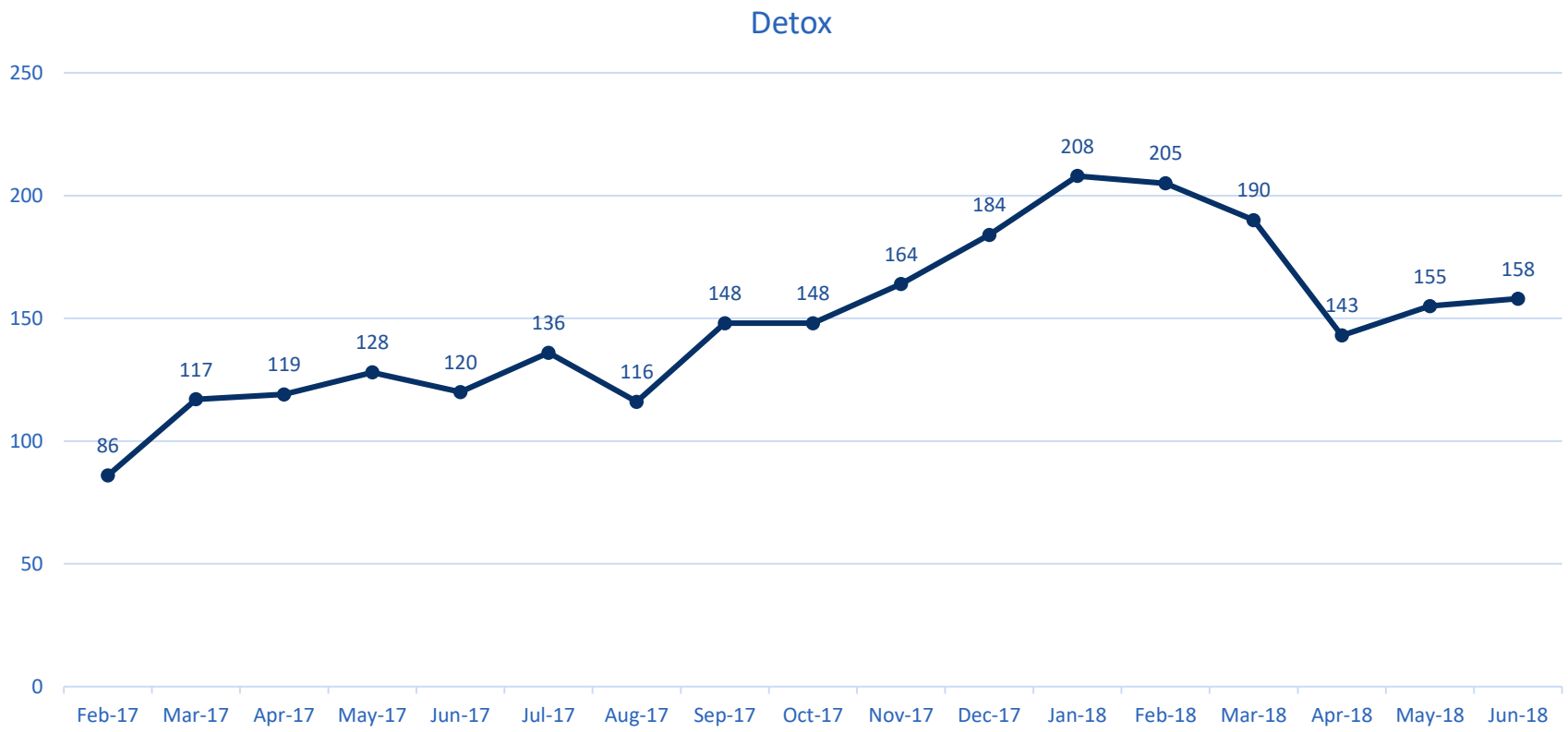
WM Active Clients by Month



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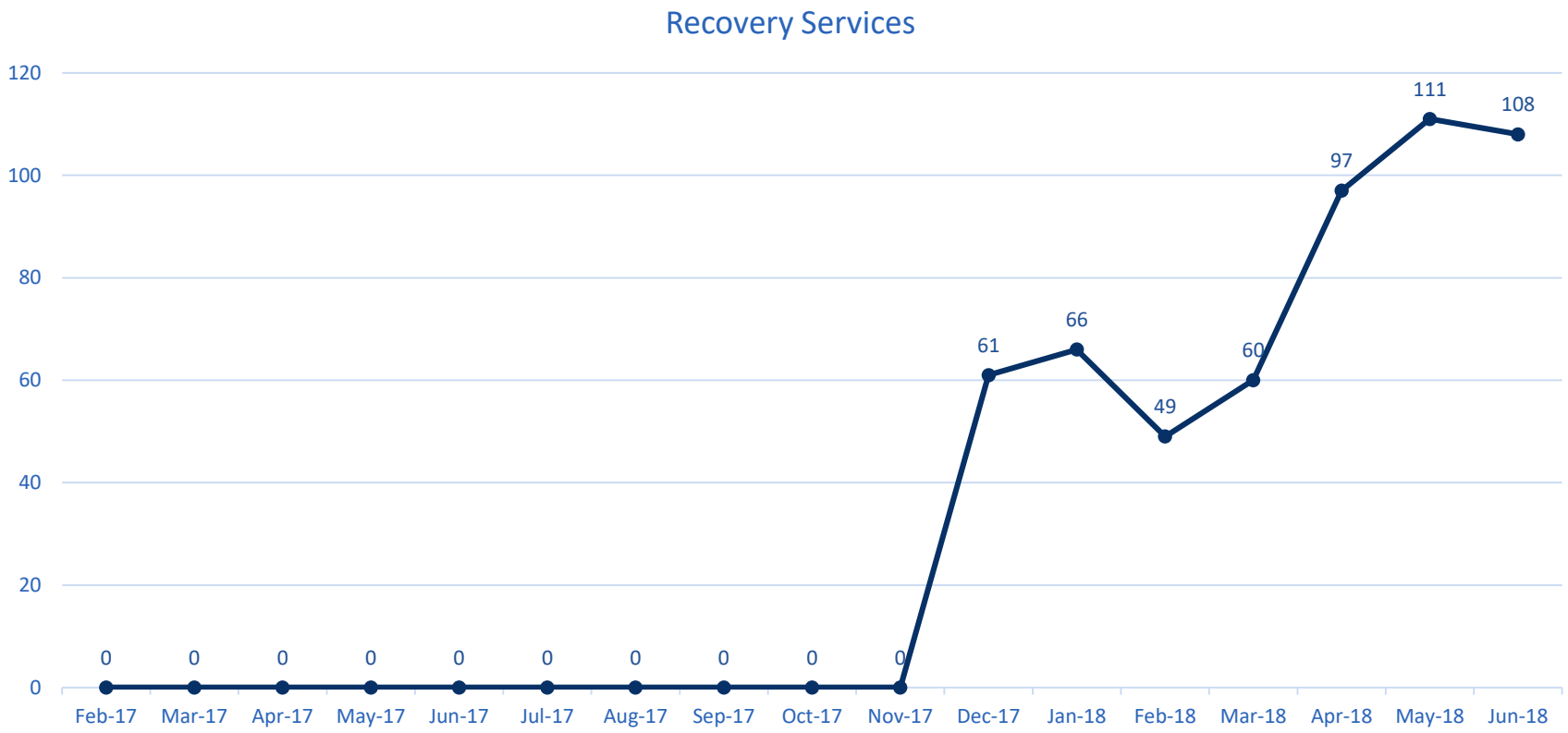
RS Active Clients by Month



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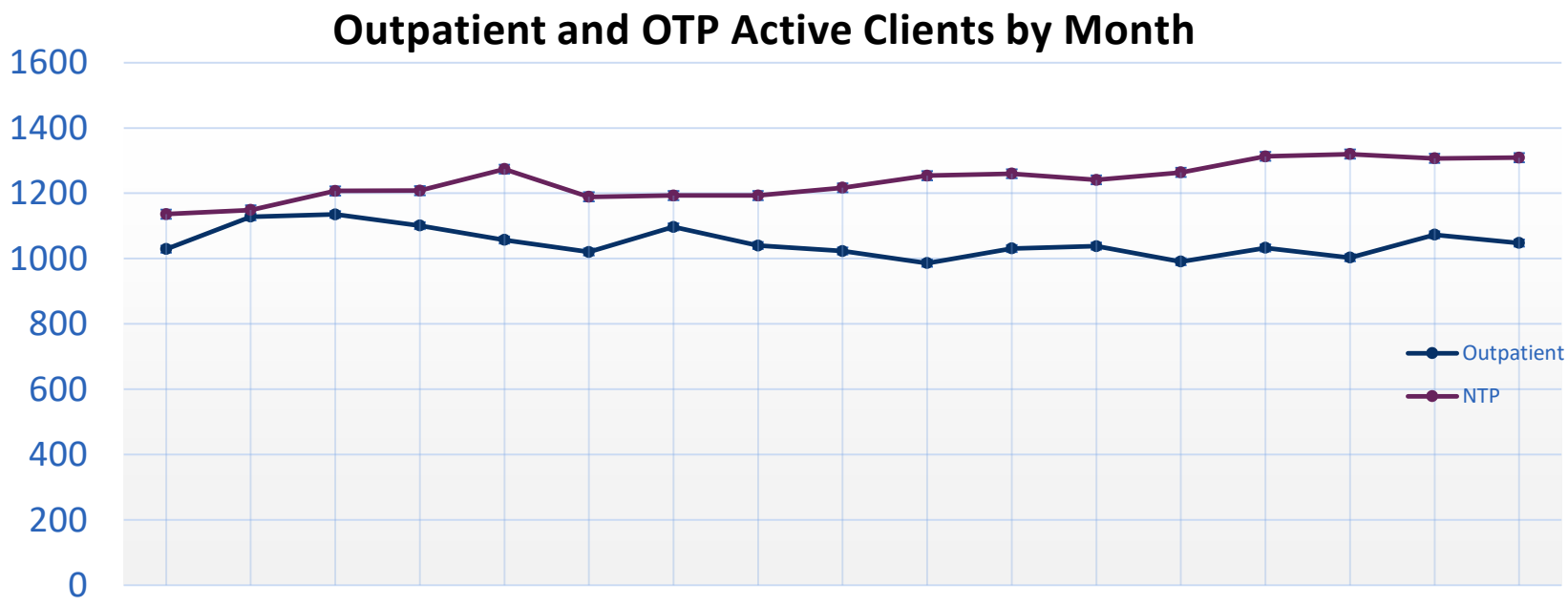
OT and OTP Active Clients



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Outpatient	1029	1128	1135	1101	1057	1020	1097	1040	1023	986	1031	1038	991	1033	1003	1073	1048
NTP	1136	1149	1207	1208	1274	1189	1193	1193	1217	1254	1260	1241	1264	1313	1320	1307	1309

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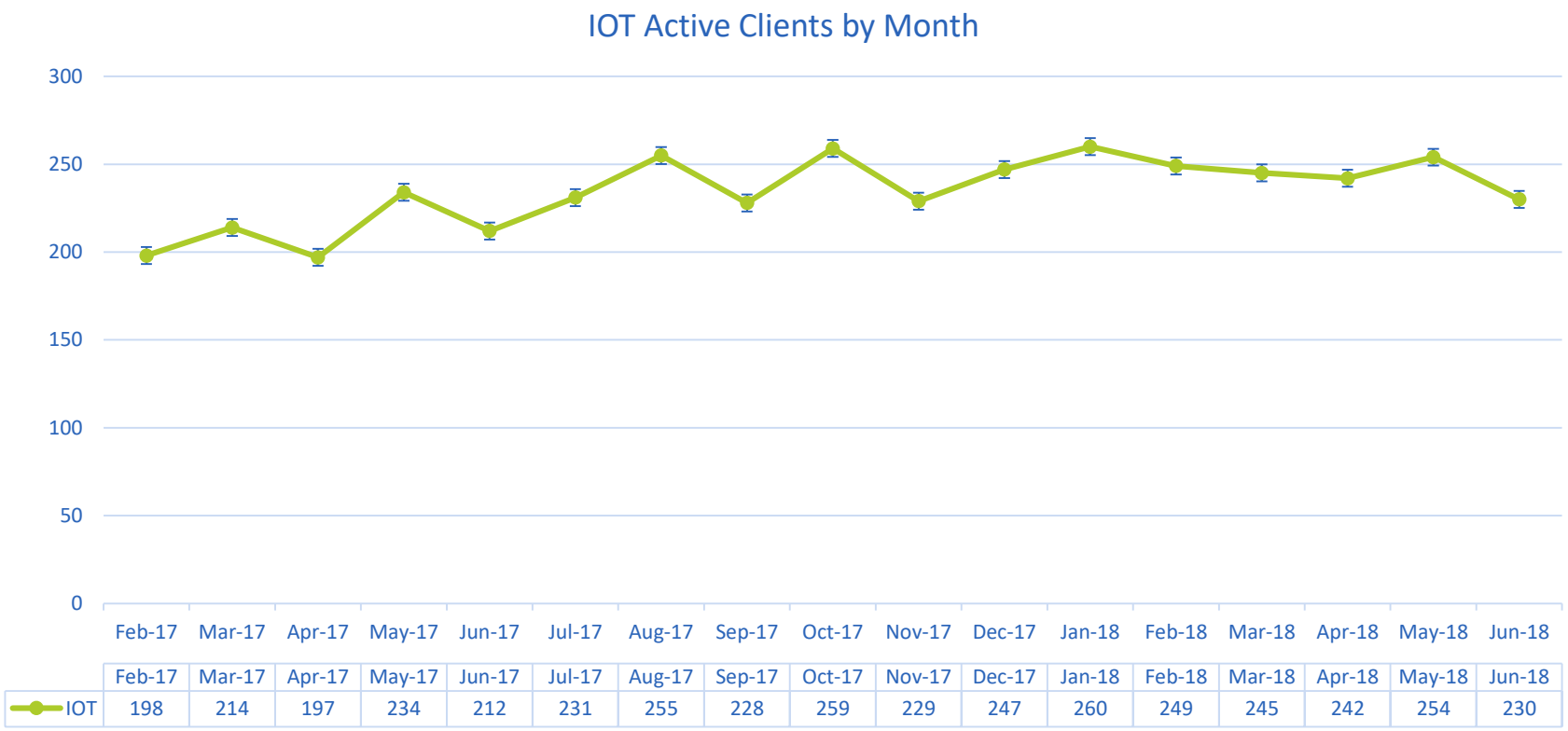
IOT Active Clients by Month



	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
IOT	198	214	197	234	212	231	255	228	259	229	247	260	249	245	242	254	230

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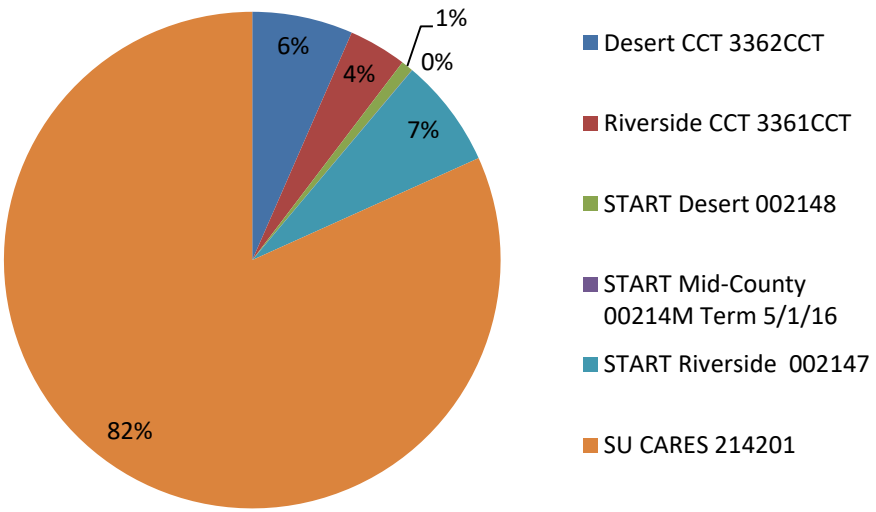
Total ASAMs completed by SU CARES and CCT Teams

Total ASAMs Completed



Program	ASAM Count
Desert CCT 3362CCT	351
Riverside CCT 3361CCT	202
START Desert 002148	42
START Mid-County 00214M Term 5/1/16	1
START Riverside 002147	381
SU CARES 214201	4372
Grand Total	5349

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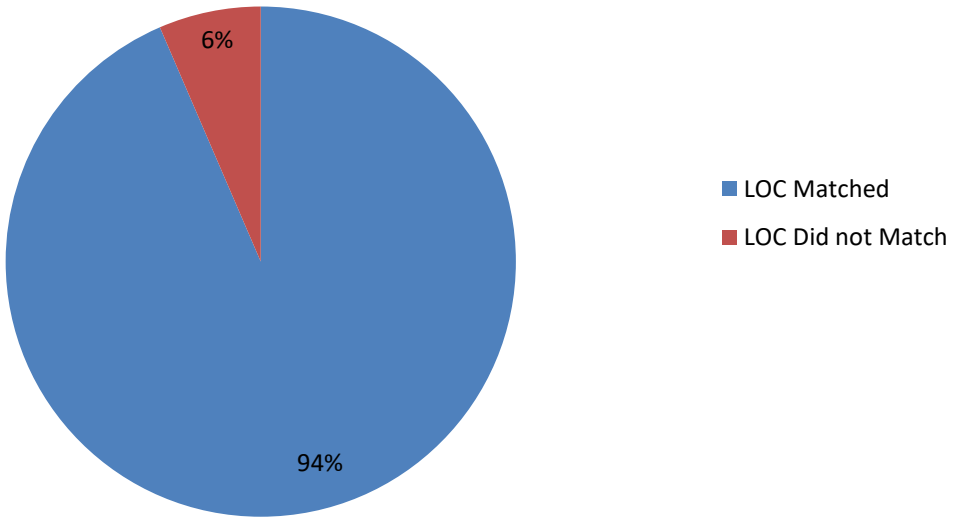
ASAMs matching LOC



Level of Care	Count
LOC Matched	15379
LOC Did not Match	1064
Total	16443

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Performance Improvement Plan

#	Describe Performance Indicator	Numerator	Denominator	Baseline for Performance Indicator (number)	Goal (number)
1	Number of days from a Withdrawal management discharge to another treatment modality	Number and % of WM episodes transitioning to another level of care within 14 days of discharge.	Total Number of WM episodes	FY16/17 Q1-75/175=42.8% Q2-66/153=43.1%	Increase 17 percentage points from 43% to 60%
2	Number of days from a residential discharge to another treatment modality.	Number and % of Residential episodes transitioning to an outpatient level of care within 14 days of discharge.	Total number of Residential episodes	FY16/17 Q1-95/535=17.7% Q2-105/502=20.9%	Increase 20 percentage points from 20% to 40%
3	Percentage of consumers re-admitted to Residential care or withdrawal management within 16 to 90 and 16 to 180 days of a residential discharge.	Number of Residential discharges with a re-admission within 16 to 90 days and 16 to 180 days of discharge.	Total number of residential episodes	90 Day-4.63% 180 Day-7.6%	Decrease to 3%

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Results from Year 1

Indicator	Baseline	Goal	Result
% of clients that successfully transitioned from 3.2WM to either outpatient or residential LOC within 14 days of discharge	43%	17% increase	Q4 FY16/17 = 66.9% (55% increase) Q2 FY17/18 = 64.9% (51% increase)
% of clients transitioning from Residential to an outpatient level of care within 14 days of discharge from Residential	20.9%	19.1% increase	Q4 FY16/17 = 15.4% (26% decrease) Q2 FY17/18 = 20.0% (4.3% decrease)
Number of residential discharges with a re-admission within 16-90 days and within 16-180- days	90 day = 4.63% 180 day = 7.6%	Decrease to 3%	Q2 FY 17/18 90 day = 3.21% (30.2% decrease) 180 day = 4.86% (36.1% decrease)

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Next Steps

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Service Expansion

- Plans to release new RFP for Service Providers before end of year 2018 for services to begin for FY 19/20
- Looking to potentially expand services to include the following additional levels of care
  - Level 2.5 – Partial Hospitalization
  - Levels 1.0-WM and 2.0-WM
  - Levels 3.7-WM and 4.0-WM

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Additional Steps

- Analyze outcomes
- Analyze Referral Sources and trends
- Analyze PIP's and Data to make system changes

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Questions???

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