

Evaluation, Training, and Technical Assistance for Substance Use Disorder Services Integration (ETTA)

2014 Report

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Executive Summary

The date January 1, 2014, marked a major milestone in substance use disorder (SUD) and mental health (MH) services in California. Coverage for SUD and MH treatment was expanded to millions of Californians through Medi-Cal and private plans offered through Covered California. A new screening, brief intervention, and referral to treatment (SBIRT) benefit was also implemented on this date. Still, while these changes were critically important, they were only first steps. A number of barriers to the actual expansion and delivery of such services still need to be addressed before these policy changes will be able to reach their full and intended potential. The goal of this report is to provide information that will be useful to policymakers and practitioners in their efforts to improve the delivery of behavioral health services and integrated or coordinated care.

Chapter 1: Data Analysis: Understanding the Changing Field of SUD Services

Narcotic treatment program maintenance admissions appear to have risen as a result of the changes that took effect on January 1, 2014, but similar increases were not found in other treatment modalities. A number of barriers may have impeded referrals to and delivery of newly covered SUD services in the first quarter of 2014, including delays in federal approval of the State Plan Amendment and associated issues with the Institutions for Mental Disease exclusion, treatment program certification and recertification challenges, local variations in Medi-Cal enrollment, and the need to train providers and change primary care processes to provide SBIRT. The effect of these policy changes may therefore only become apparent gradually over time.

A proposed Drug Medi-Cal (DMC) waiver provides California with the potential to dramatically reshape the field. Santa Clara County has a system that has adopted many of the features in the proposed waiver, and therefore can provide valuable information on how waiver provisions can be implemented and what their effects may be. Preliminary analyses suggest that such systems have the potential to lead to better care as well as cost savings.

Repeated use of detoxification appears to be a problem statewide. If depot naltrexone is covered under the DMC waiver, care might be improved and the costs of repeated detoxification might be reduced, particularly by treating alcohol patients with this long-acting medication wherever possible.

Combining or using MH and SUD data and systems together and collaborating on measures will improve the usefulness of behavioral health data statewide. It may be helpful for the California Department of Health Care Services (DHCS) to facilitate communication on this during a session dedicated to it at a future annual DHCS conference.

Chapter 2: Health Care Reform and the Integration of SUD Services with Mental Health and Primary Care

Integration of the fields of SUD, MH, and physical health care has continued to develop throughout the past year. State agencies, providers, and other stakeholders in the integration of

care for MH disorders and SUDs face continuing challenges related to financing and reimbursement for services, determining ways to organize services to support integrated care, building the health information technology (HIT) infrastructure necessary to exchange information for care coordination, and developing an adequate and well-trained workforce ready to deliver culturally competent and comprehensive care.

Many lessons can be learned from county- and provider-level pilot projects, but long-term integration of health care service delivery can only occur when the system at large can facilitate cohesion between service delivery policies, regulations, and funding. The state has recently taken a step in this direction with the recent release of the draft Drug Medi-Cal Waiver Special Terms and Conditions (DHCS, 2014b), which contains language aimed at facilitating integration. Progress has been made this past year, but there is more work to do, requiring ongoing training and technical assistance at all levels.

It is critical that the state continue its efforts to improve payment structures to facilitate integrated care. Data from the Accountable Care Organization and Coordinated Care Organization demonstration pilots in other states suggest these models can be effective for financing integrated services, and may inform the future development of more integrated delivery models in California.

Health homes can provide enhanced care coordination for individuals with complex behavioral health needs, but changes in state regulations are needed to support the development of this promising model. The state should capitalize on opportunities provided by Section 2703, which specifically addresses integrated behavioral health care within the health home.

Broader adoption of evidence-based practices has the potential to greatly improve care for SUDs and MH disorders. Additional training and technical assistance is needed to support dissemination and implementation of effective practices.

Behavioral health providers often face special challenges when adopting electronic health records and collecting and sharing patient information through health information exchanges. Increased funding and technical assistance for providers to support the development of behavioral health-specific health information technologies, policies, and infrastructure are necessary to further the progress in record keeping and documentation.

Workforce development will continue to be critical as the Affordable Care Act implementation continues. Further technical assistance and allocated funds are needed to develop the content of the behavioral health workforce curriculum to train the current SUD workforce in regard to current and future changes in the field.

Chapter 3: State/System-Level Technical Assistance: Strategic Planning Activities and Recommendations

With an emphasis on issues related to integrating and improving SUD services within the current and changing health care delivery-service system, the University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) has worked to provide technical assistance

to DHCS in its efforts to develop an integrated drug-treatment delivery system in California. In collaboration with DHCS, UCLA ISAP provided strategic planning recommendations in several areas this past year, including workforce development, SBIRT benefit analysis, Drug Medi-Cal Waiver and Evaluation planning, Drug Medi-Cal audit recommendations, participation in the DHCS Behavioral Health Forum and Subcommittees, and providing a visionary plan for Los Angeles County. Submitted reports and recommendations for each topic are enclosed within the Appendices (end of report). However, we intend to continue our investigations of these topics to inform the state with current and evidence-based information and recommendations.

Chapter 4: County/Provider-level Training and Technical Assistance

Over the past year, UCLA ISAP provided trainings and technical assistance to facilitate integration across the state. This included in-person trainings, webinars, technical assistance to counties, and technical assistance for the California Institute for Mental Health's Care Integration Collaborative. UCLA ISAP also participated in the BHbusiness Learning Network. Training and technical assistance needs related to integration persist throughout the state and will continue as health care reform is implemented.

Chapter 5: Conclusions and Recommendations

As expected, expansion of California's SUD treatment system and admissions did not leap out of the gate as a result of the 2014 coverage expansion alone. There is some reason for optimism, however, as initial challenges are beginning to resolve and the state is developing a Drug Medi-Cal waiver that could potentially lead to a substantial improvement of California's SUD treatment system. While many details remain to be resolved, as currently written, the proposed waiver and associated efforts attempt to address a number of barriers described in this report (e.g., appropriate movement of patients through a continuum of care, use of evidence-based practices, coordination with primary care, training and technical assistance, telehealth, Institutions for Mental Diseases exclusion). Furthermore, early stakeholder responses appear to be positive, which bodes well for buy-in, commitment, and partnerships, which are key to the success of integration efforts. Therefore, while many challenges lie ahead, there is a path toward success. To further facilitate successful treatment expansion, improvement, and integration, UCLA ISAP has provided a list of 24 specific recommendations (see Chapter 5).

Preface

Darren Urada, Ph.D., and Valerie Antonini, M.P.H.

The date January 1, 2014, marked a major milestone in the treatment of substance use disorders (SUDs) and mental health services in California. Coverage for SUD and MH treatment was expanded to millions of Californians through Medi-Cal and private plans offered through Covered California. Still, while this coverage is critically important, the expansion was only a step in expanding access to high quality SUD treatment for individuals in need. Delivering such care, particularly in coordination with primary care, requires overcoming a wide array of implementation challenges ranging from federal regulations to patient perceptions. The goal of this report is to provide information that will be useful to policymakers and practitioners in their efforts to improve the delivery of coordinated or integrated services.

This is the second of three annual reports from the Evaluation, Treatment, and Technical Assistance for Substance Use Disorder Services Integration (ETTA) interagency agreement between the University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) and the California Department of Health Care Services (DHCS). The workplan built across the 3-year agreement consists of conducting qualitative and quantitative research/evaluation efforts as well as training and technical assistance focused on SUD service delivery and integration activities, especially as they relate to policy changes such as the Affordable Care Act (ACA) and its associated parity provisions, Assembly Bill 109 (“Public Safety Realignment”) and Medi-Cal “Bridge to Reform” 1115 Waiver.

Workplan objectives addressed within this report are as follows:

1. Examine how ongoing policy changes are affecting who receives SUD treatment and how access, services, costs, and quality of care are being affected. Make recommendations to improve policies, practices, and data quality.
2. Refine program performance and patient outcome measures.
3. Collect and disseminate cutting-edge information on the integration of SUD services with mental health and primary care services.
4. Recommend strategic-planning principles to guide the development of an integrated drug treatment delivery system in California in the context of health care reform.
5. Coordinate and facilitate an interactive forum (Learning Collaborative) with county administrators and other key stakeholders to discuss SUD integration.
6. Conduct case study/pilot evaluations.
7. Provide training at the county level on strategies to prepare for health care reform.
8. Provide technical assistance at the county level to facilitate integration following the implementation of major health care reforms in 2014.

In addition, based on discussions with DHCS, UCLA ISAP shifted efforts as described in the original workplan to providing technical assistance to DHCS related to their preparations for an 1115 demonstration waiver for Drug Medi-Cal (described further in Chapters 1 and 3)

This agreement originated with the California Department of Alcohol and Drug Programs before it became part of DHCS, and the original scope of work was therefore focused on SUD treatment, in particular, and its coordination or integration with mental health and primary care services. However, coordination of mental health services with primary care often occurs in the same locations and typically involve the same behavioral health staff, so challenges and lessons learned from one of those efforts often extend to the other. As a result, in the spirit of integration between systems, where relevant, we have extended our discussions beyond integration of SUD services to include lessons learned from integration or coordination of mental health services with primary care as well.

This report addresses each of the objectives listed above, with the findings organized within the following chapters:

- Chapter 1 explores the latest data on patients entering specialty SUD treatment, examines referrals from the health care system, proposes next steps in terms of using performance and outcome measurement across SUD and mental health data systems, and provides an update on efforts to overcome the challenges of identifying AB 109 individuals in SUD treatment data. Note that UCLA ISAP received California Outcome Measurement System Treatment (CalOMS-Tx) data 28 days before submitting this report, so due to time limitations, analyses in this chapter were limited to the high priority issues of determining the initial impact of ACA-related policy changes on the SUD treatment system, and providing information that might be useful in planning for the Drug Medi-Cal waiver.
- Chapter 2 discusses current efforts to integrate SUDs within the health care system itself, both nationally and across the state.
- Chapter 3 discusses State/System-Level Technical Assistance, specifically for state-level strategic planning purposes, on topics such as: workforce development, SBIRT benefit analysis, Drug Medi-Cal Audit recommendations, behavioral health integration strategies, and the Drug Medi-Cal waiver.
- Chapter 4 discusses the county/provider-level training and technical assistance activities UCLA ISAP has engaged in to help address county needs.
- Chapter 5 summarizes key findings and recommendations from this report.

For further information, see <http://www.uclaisap.org/integration/> or contact:

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Chapter 1: Data Analysis: Understanding the Changing Field

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The ACA coverage expansion was associated with an increase in narcotic treatment program maintenance, but did not appear to have a substantial impact on other modalities statewide. A number of barriers may have impeded implementation in the first quarter of 2014.

Likewise, a new screening, brief intervention, and referral to treatment (SBIRT) benefit became available on January 1, 2014, but has not yet led to detectable changes in referrals from health care to specialty SUD treatment programs. It is likely that it will take organizations time to change their processes and train their workforce to implement SBIRT.

A proposed Drug Medi-Cal (DMC) waiver provides California with the potential to dramatically reshape the field. Santa Clara County has a system that has adopted many of the features in the proposed waiver, and therefore can provide valuable information on how waiver provisions can be implemented and what their effects may be. Preliminary analyses begin to suggest that such systems have the potential to lead to better care as well as cost savings.

Repeated use of detoxification appears to be a problem statewide. If depot naltrexone is covered under the DMC waiver, care might be improved and the costs of repeated detoxification might be reduced, particularly by treating alcohol patients with this long-acting medication wherever possible.

Combining or using MH and SUD data and systems together and collaborating on measures will improve the usefulness of behavioral health data.

I. Introduction

The long awaited Medi-Cal expansion associated with the Affordable Care Act arrived on January 1, 2014, along with expansions in the number of individuals covered by private health care insurance plans purchased through Covered California. Newly insured individuals can now pay for and access treatment for substance use disorders (SUDs) using these payment sources, whereas only relatively limited amounts of publicly funded treatment were available previously. This chapter provides our first look at the changes in patterns of SUD treatment admissions and referrals around this date.

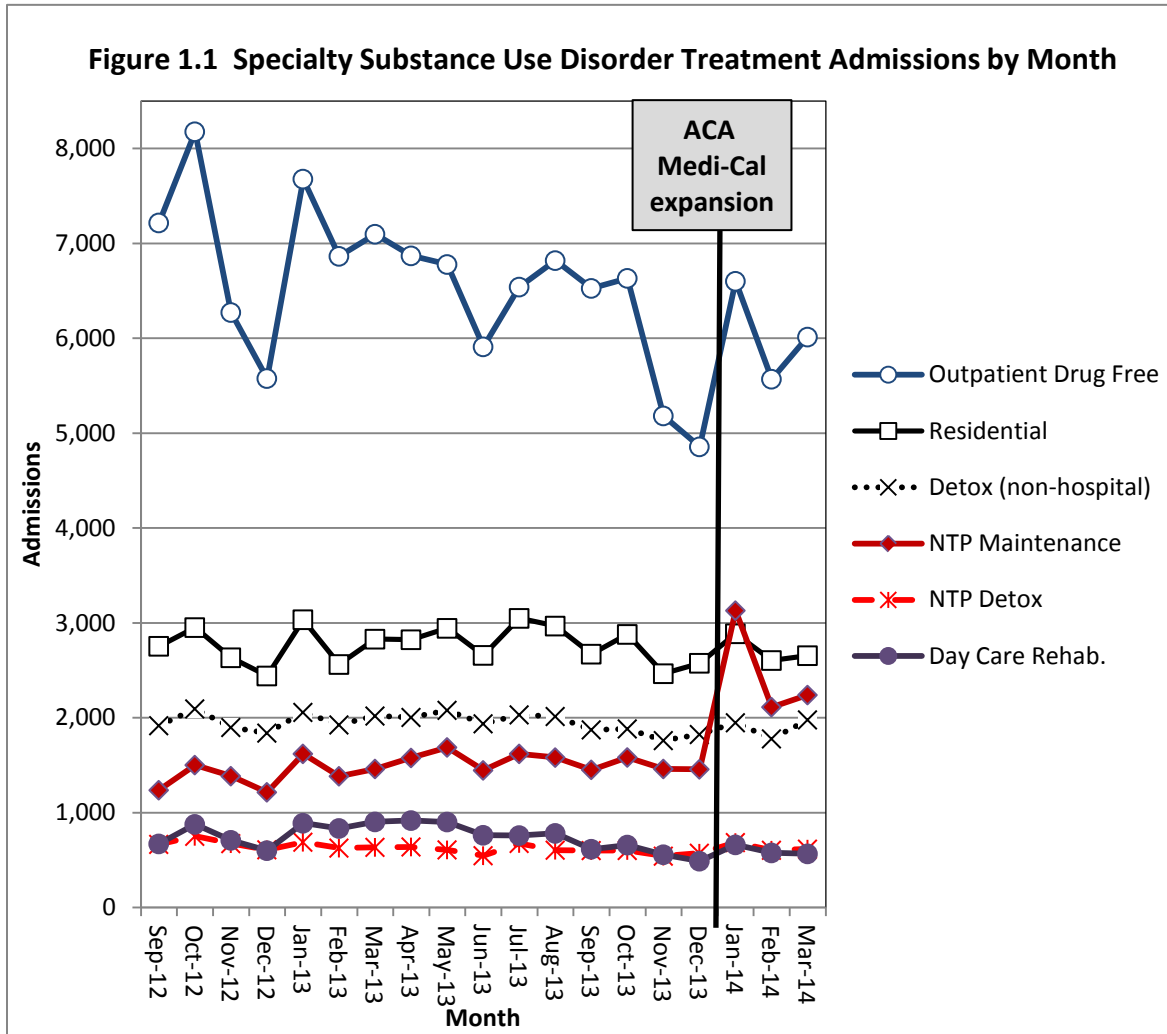
II. Chapter Organization

- A. Impact of Policy Changes on the SUD Treatment System
 - Admission Trends and the Affordable Care Act
 - Referrals from Health Care to Specialty SUD Treatment
- B. Building an Organized Delivery System under the Proposed Drug Medi-Cal Waiver
- C. AB 109 and SUD Treatment update
- D. Program Performance and Patient Outcome Measurement
- E. Chapter Summary and Recommendations

III. Findings

A. Impact of Policy Changes on the SUD Treatment System

Admission Trends and the Affordable Care Act



The large increase in narcotic treatment program (NTP) maintenance admissions in January 2014 was unprecedented. From December 2013 to January 2014, NTP maintenance admissions more than doubled before dropping back to a level that was lower, but still substantially higher than the pre-ACA average. Based on anecdotal discussions with treatment providers, some of this increase may be due to providers submitting a new CalOMS-Tx admission record when changing patients from self-pay to Drug Medi-Cal status. While providers are technically required to submit CalOMS-Tx records for all patients regardless of payment source, some providers have not been regularly reporting CalOMS-Tx data for self-pay patients. Therefore some of the increase may be an artifact of data-reporting issues. However, there appears to be some consensus among providers that pent-up demand for treatment from individuals who were waiting for the coverage expansion also has played a role in the increase in admissions.

Partial information on the extent to which each factor may have played a role comes from a January 2014 Integration Learning Collaborative meeting facilitated by the UCLA Integrated Substance Abuse Programs (UCLA ISAP; see Chapter 2), during which one large NTP maintenance provider, Aegis Medical Systems, Inc., reported that about 700 existing patients at Aegis had shifted from self-pay to DMC coverage, and 200 more were becoming DMC qualified, but also that the system was seeing 2.5 times as many intakes than usual for the month of January. At the same meeting, Alameda and Sacramento counties also reported increased demand for NTP treatment. This suggests that while some of the January spike in the NTP data might be an artifact of data reporting, a substantial portion of the increase is also real and the result of the Medi-Cal expansion.

The results for all other modalities are less clear. While the coverage expansion of January 1, 2014, did coincide with a large increase in outpatient treatment, this actually appears to be attributable to a seasonal pattern. On the left side of Figure 1.1, a similar spike can be seen between December 2012 and January 2013, and UCLA ISAP has confirmed that the same pattern also occurs in earlier data (not shown above) between December 2011 and January 2012. Therefore, aside from NTP maintenance, there have not been dramatic changes in utilization.

Early challenges that may have reduced DMC-covered admissions

The State Plan Amendment (SPA) allowing expanded services to be paid for by the DMC had not been approved by the federal government during the time period included in this data analysis (1Q 2014). While SPA approval allows payment retroactively to January 1, this meant providers needed to undertake some financial risk by providing services during this period, since if the SPA failed to be approved, they would not be reimbursed for costs already incurred. Residential services were also not included in the SPA due to challenges in overcoming federal Institutions for Mental Disease (IMD) policies prohibiting payment for such facilities with 16 beds or more.

Perhaps more important, the California Department of Health Care Services (DHCS)'s Provider Enrollment Division was also embarking on an ambitious plan to recertify treatment programs while also certifying new ones during this period. During the Integrated Learning Collaborative discussion in January, several counties reported that their programs were still awaiting certification or recertification, which meant that while the benefit was available, their providers could not bill DMC for them at the time and services were therefore only being provided under other traditional funding sources such as county Substance Abuse Prevention and Treatment block grant funds. In this light, it is perhaps not surprising that there was not a clear immediate spike in treatment across modalities. Outpatient treatment (non-NTP) programs were the first to undergo recertification.

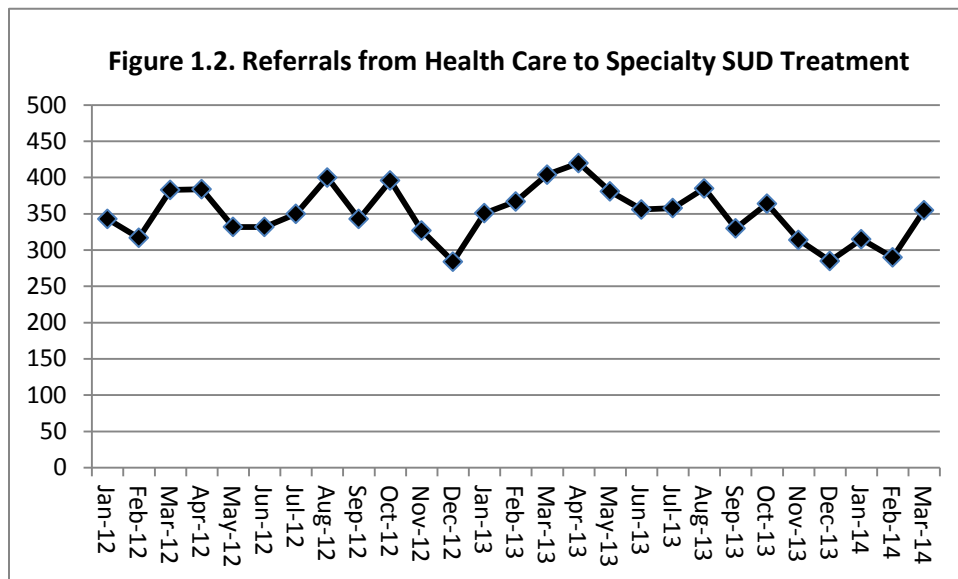
Aside from DMC-specific issues, at least one county mentioned that general Medi-Cal enrollment had gotten off to a slow start, which in turn affected eligibility for DMC services. In addition, the deadline for individuals to enroll in private health insurance via Covered California also did not occur until March 31, which was the end of the period for which we were able to analyze admission data. Once these initial challenges subside, the impact of the coverage expansions should become clearer.

Summary and Lessons Learned

While it appears that the ACA coverage expansion was associated with an increase in NTP maintenance, it did not appear to have a substantial impact on other modalities statewide. A number of factors, including delays in SPA approval, certification and recertification of programs, and Medi-Cal enrollment during the time period in question, may all have served to reduce use of the DMC benefits in the first quarter of 2014. However, as these initial implementation challenges are resolved and newer data becomes available, the longer-term effect of the ACA on specialty SUD care should become clearer.

Referrals from Health Care to Specialty SUD Treatment

On January 1, 2014, California mandated the use of screening, brief intervention, and referral to treatment (SBIRT) in primary care (DHCS, 2014a), becoming the first state in the nation to do so. SBIRT is being implemented in health care systems that do not report data to CalOMS-Tx, but the dataset does include information on where patients were referred from. It may therefore be possible to detect an uptick in referrals from the health care system as a result of SBIRT. Referrals from health care over time are shown in Figure 1.2.



Referrals from the broader health care system to SUD specialty care have remained within the historical range, meaning there is no evidence yet of large numbers of new referrals to treatment occurring during the first months of SBIRT implementation. The referral to care portion of SBIRT has always been challenging. In a six-state Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored study of SBIRT in medical settings (Madras et al., 2009), only 3.7% were recommended for referral to specialty treatment, with an unknown smaller number actually being admitted. Still, if SBIRT is implemented widely, then even this small percentage should eventually result in increased referrals to specialty care (for more information on the potential impact of SBIRT in California, see Urada, 2013).

On an absolute basis, a somewhat smaller number of treatment programs received at least one referral from health care in the first quarter (January–March) of 2014 (199) than did in the first quarter of 2013 (227). However, there were also fewer treatment programs in 2014 overall (886 vs. 992), possibly in part due to Drug Medi-Cal fraud investigations that led to the suspensions of a number of programs in 2013. On a relative basis, the percentage of programs that received at least one health care referred patient was virtually the same in the first quarter of 2014 (22.5%) as it was during the same period in 2013 (22.9%), suggesting that at an aggregate level, programs statewide do not appear to be getting any better (or worse) at receiving referrals from the health care system.

Most of the referrals that did come from health care that occurred in the first quarter of 2014 were for non-hospital detoxification (41.4%), followed by outpatient treatment (30.8%), and residential treatment (23.2%). This pattern was essentially unchanged from health care referrals in the first quarter of 2013 (41.9%, 31.1%, 21.9%, respectively).

Detoxification admissions continued to be highly concentrated in a few programs. One program, Baker Places, Inc., in San Francisco County accounted for nearly half (46.3%) of all non-hospital detoxification referrals from health care statewide. This mirrors a finding with 2012 data. For these results and further background on Baker Places, see Urada (2013).

Outpatient and residential admissions were also somewhat concentrated, but not to the same extent as detoxification. The outpatient program that received the most health care referrals accounted for 6.1% of outpatient referrals, and the two residential programs that accounted for the most referrals in this modality accounted for 8.0% of residential referrals each.

Early SBIRT Challenges

SBIRT will take time to implement. The benefit, officially announced in December 2013 (DHCS, 2014b), includes training requirements for practitioners and supervisors and represents a change in organizational practices. These represent challenges that will require time and effort for organizations to overcome, so it is perhaps not surprising that large changes were not evident in the first quarter of 2014.

Summary and Lessons Learned

Despite the availability of an SBIRT benefit on January 1, 2014, substantial changes in referrals from health care to specialty SUD treatment programs did not occur in the first quarter of 2014. It is likely that it will take organizations time to change their processes and train their workforce to implement SBIRT. Changes will likely occur on an organization-by-organization basis, with aggregate changes occurring gradually over time. Continued monitoring of referrals, as well as the monitoring of screenings and brief interventions in primary care (most likely through Medi-Cal claims data), are needed to track the implementation of SBIRT.

B. Building an Organized Delivery System under the Proposed Drug Medi-Cal Waiver

On July 16, 2014, DHCS released a draft of the Drug Medi-Cal Waiver Special Terms and Conditions (DHCS, 2014c). The goal of the waiver is to “demonstrate how organized substance use disorder care increases the success of DMC beneficiaries.” To this end, the waiver would, among other things, require that all patients be assessed using the American Society of Addiction Medicine (ASAM) Criteria to establish medical necessity for their level of care for both initial placement and for ongoing movement through the continuum of care.

A number of counties have been using ASAM criteria for some time, especially for special populations (e.g., AB 109). However, based on discussions with county representatives, county presentations, and communications with the editor of the ASAM criteria, the California county that appears to have advanced the furthest in implementing ASAM criteria on a systemwide basis for all patients, backed up by systems and processes to ensure quality improvement, appears to be Santa Clara County. We can therefore look at Santa Clara County to gather insights on what the state might potentially look like under the proposed Drug Medi-Cal Organized Delivery System.

The waiver draft also allows for a one-year transition period to “build system capacity, provide training, implement the required services . . . and create the necessary county systems.” Given the complexity of the task, counties may wish to examine existing models, such as that in Santa Clara, to learn from their experiences and adapt what has been learned to their counties’ needs and resources.

Figure 1.3 shows time in treatment for residential treatment statewide for fiscal year 2012/2013 (July 1, 2012–June 30, 2013). It is clear from this graph that treatment lengths of stays are currently strongly driven by fixed lengths, especially 90 days. Under ASAM criteria in an Organized Delivery System, length of stay would be dictated by individual patient needs rather than by standard program lengths.

Figure 1.4 shows time in treatment for residential programs in Santa Clara over the same time period. The distribution in Santa Clara more closely resembles a normal (bell-shaped) distribution that could be expected if discharges are based on individual patient needs rather than fixed lengths of stay.

Overall, patients stay in residential treatment for an average of 36.2 days in Santa Clara, which is substantially shorter than the average stay of 60.7 days statewide.

Figure 1.3. Statewide Time in Treatment among Residential Completers (FY 12/13 admissions)

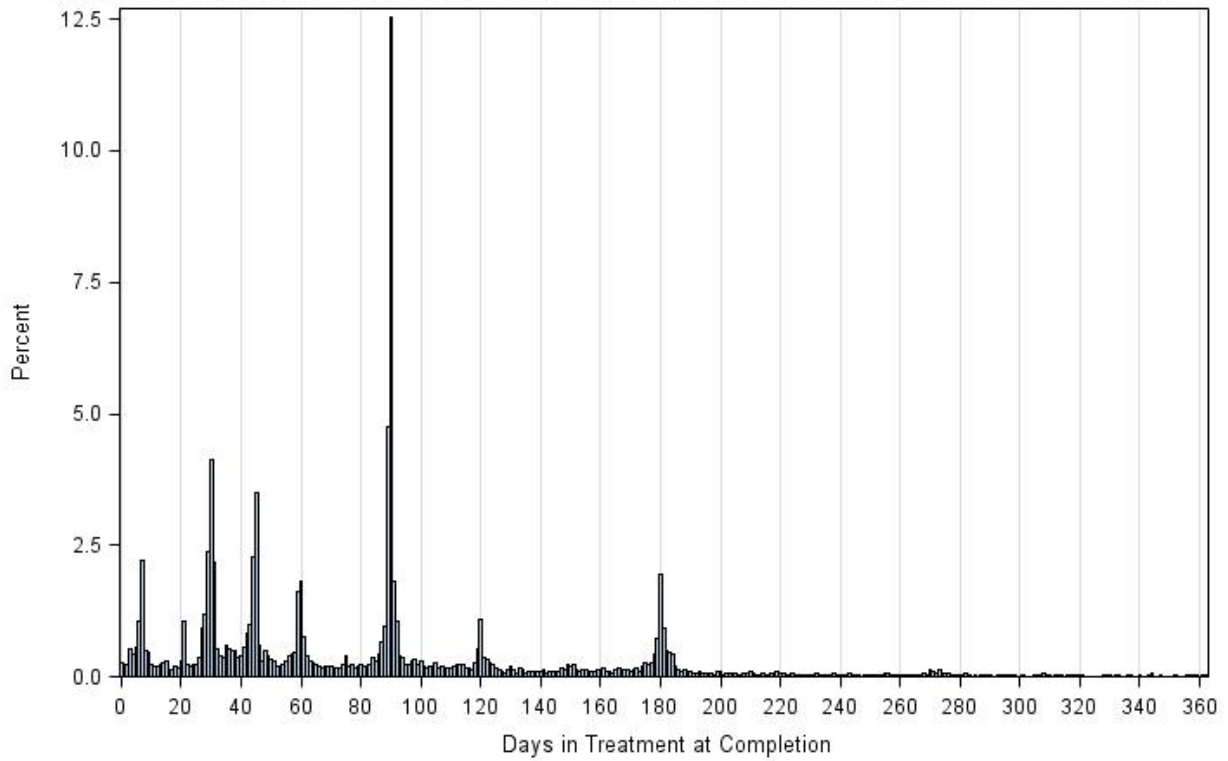
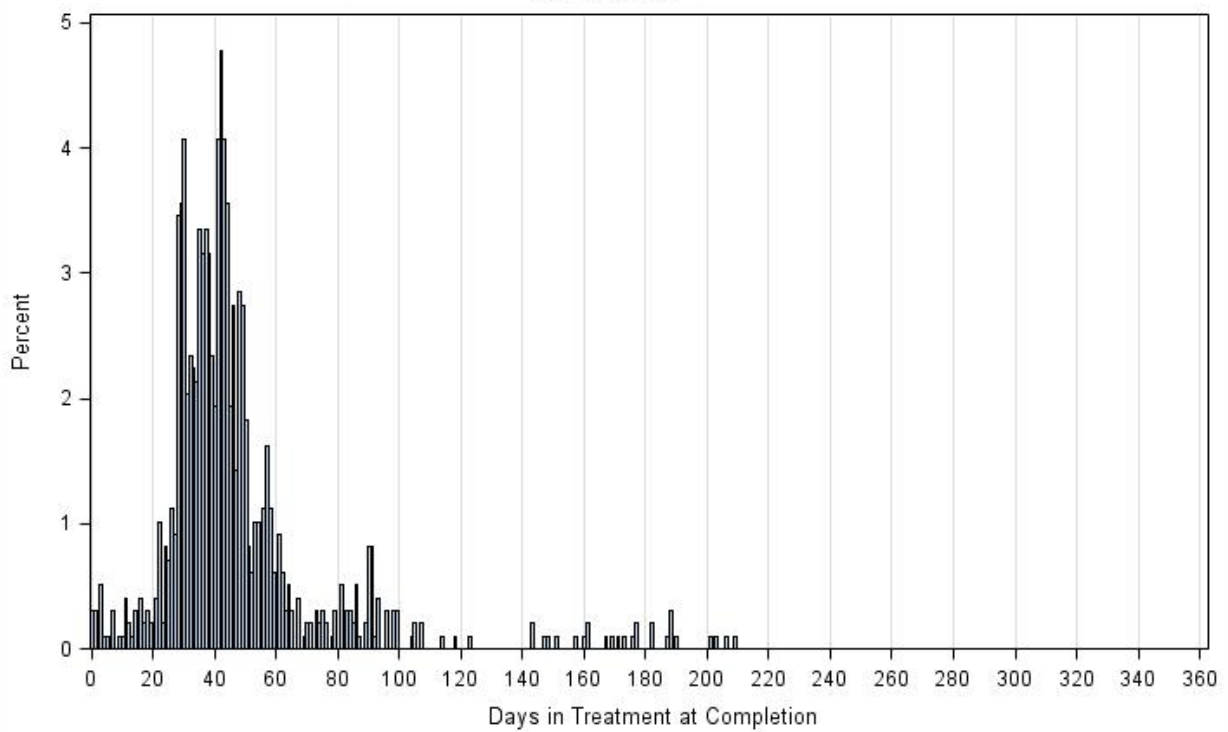


Figure 1.4. Santa Clara Time in Treatment among FY 12/13 Residential Completers (FY 12/13 admissions)



The shorter length of stay in residential treatment in Santa Clara County is only part of the story, however. In Santa Clara, the goal of residential treatment is to stabilize the patient, then move them into outpatient treatment. Consistent with this, 47.2% of patients in Santa Clara are admitted to outpatient treatment within 14 days of their residential discharge, while this only occurs in 6.1% of residential discharges in other counties. These patients spend an average of 84.8 days in outpatient treatment, while the few who step down to outpatient in other counties average 102.7 days.

If we combine the information above with the average costs of outpatient and residential treatment from SAMHSA (2004; in 2004 dollars), we can generate a very rudimentary estimate of the costs of the initial treatment episode:

Approximate Average Episode Cost in Santa Clara:

$(36 \text{ day avg stay in Residential} \times \$76 \text{ per day}) + (47\% \text{ transferred to Outpatient} \times 85 \text{ day avg stay in Outpatient after transfer} \times \$27 \text{ per day}) = \$3,815$

Approximate Average Episode Cost in other Counties:

$(61 \text{ day avg stay in Residential} \times \$76 \text{ per day}) + (6\% \text{ transferred to Outpatient} \times 103 \text{ day avg stay after transfer} \times \$27 \text{ per day}) = \$4,803$

Difference

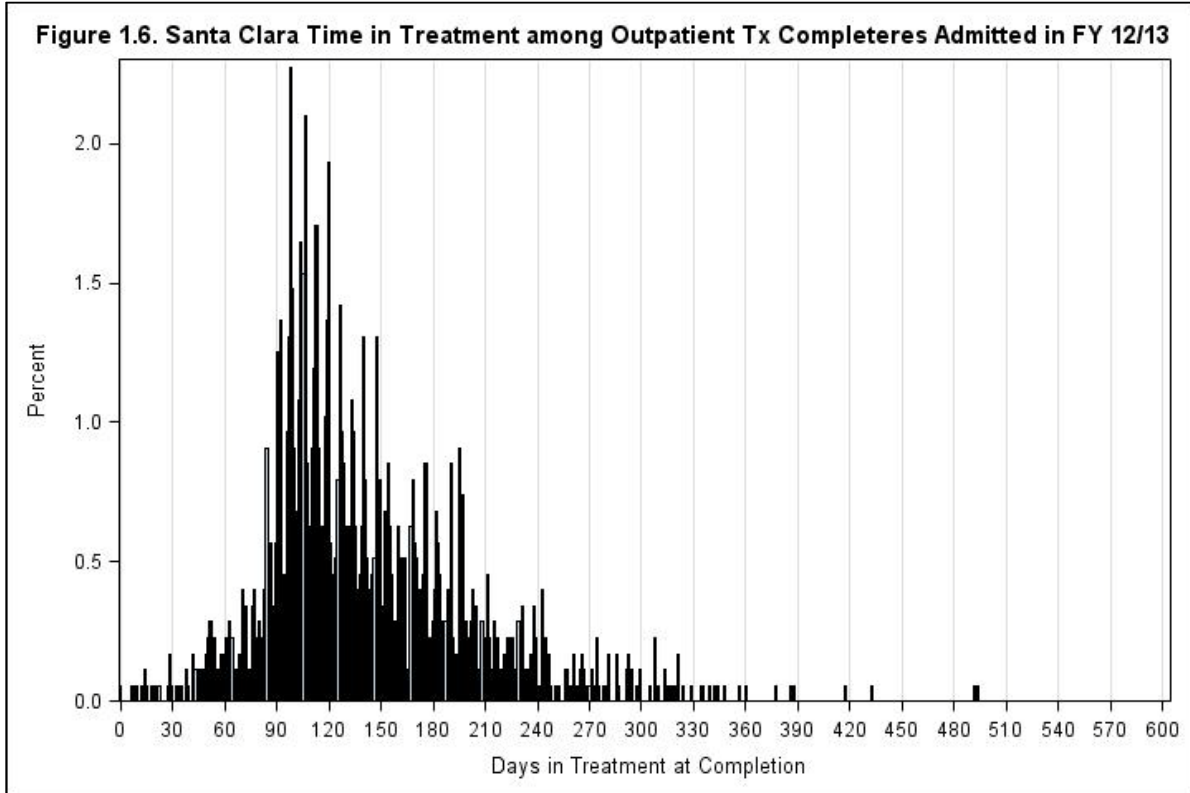
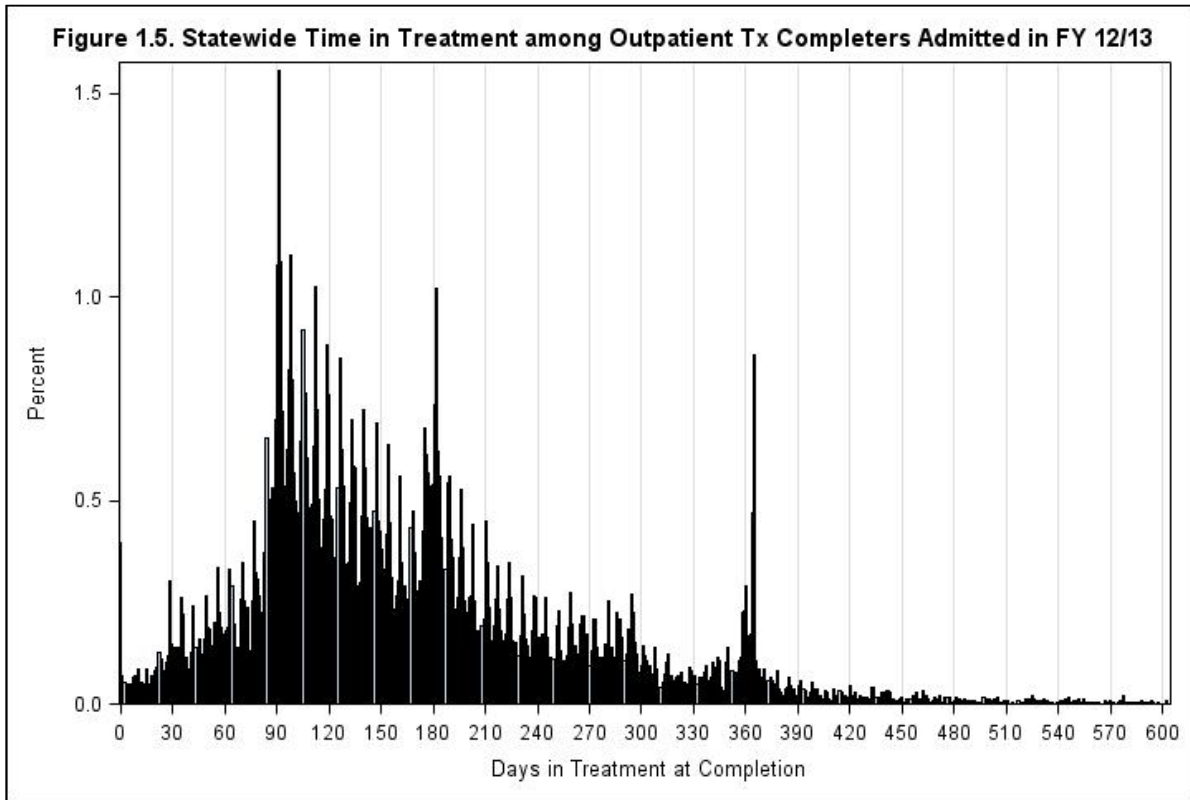
$\$4,803 \text{ (other counties)} - \$3,815 \text{ (Santa Clara)} = \988

These numbers do not take into account differences between Santa Clara's population and that of the rest of the state (e.g., higher meth use, lower heroin use), costs of modalities utilized other than residential or outpatient, or costs of additional care beyond the initial episode. This very basic calculation therefore may not represent a complete picture of either Santa Clara County costs or what costs would be incurred under the waiver in other counties. This calculation is only meant to provide a simple demonstration of the *potential* to achieve substantial savings on the initial episode of care.

Santa Clara began to transform their system in 1995 (Berman, 2009). In addition to the use of ASAM, a key element included setting a benchmark for patients' average length of stay (personal communication, Bruce Copley, 7/28/2014). This is a step that is not written into the current waiver special terms and conditions, and would be an additional step that counties could choose to take if they were to follow Santa Clara's model. Copley reported that initial resistance to this step was overcome with outcome measures that, "Demonstrated that as long as an individual was stepped-down to outpatient treatment upon discharge from residential the actual outcomes for the clients were the same as an extended stay in residential."

Other key elements of Santa Clara's system, according to Copley and Berman, include the use of ASAM criteria to base treatment on individual needs, a strong Quality Improvement team, and robust data on outcomes and process efficiency. These represent infrastructure and processes that would need to be quickly built in counties that opt into the waiver during the transition period, and that would need to continually evolve thereafter, as they have in Santa Clara County.

In other modalities, the difference between Santa Clara and the state as a whole is less stark, but still present. Figures 1.5 and 1.6 show outpatient treatment.



While the distributions are similar in these graphs, pronounced spikes in the statewide graph at 3, 6, and 9 months indicate that at least some programs are basing their length of stays on fixed targets rather than on individual patient needs.

Patients admitted to non-hospital detoxification in Santa Clara in FY 12/13 were also more likely to be admitted to treatment in the 14 days following their discharge. Over half made the transition to treatment (52.4%) in Santa Clara, whereas only 17.5% did so in other counties. This is another area in which better treatment and lower costs could in theory be achieved by reductions in “revolving door” use of detoxification. According to CalOMS-Tx data, one patient was admitted to detoxification an incredible 115 times from July 2011 through June 2014. While there is always a chance that this single case could have erroneous data, another 26 patients had 25 or more detoxification admissions during that same period. *UCLA ISAP is in the process of performing additional analyses to identify whether these results could result from errors in the dataset.*

Despite Santa Clara’s proficiency at moving patients from detoxification into treatment, overall, Santa Clara and other counties had similar rates of detoxification re-use. It is unclear why this is the case. Santa Clara does use continuous recovery monitoring to stay in touch with patients after completion of outpatient treatment, which may facilitate admission to detoxification if there is a need (Santa Clara, 2011).

Where patients had 10 or more admissions to detoxification, alcohol was reported as the individual’s primary drug on the 10th admission slightly more than half the time (51.2%), followed by cocaine/crack (23.1%) and methamphetamine (19.2%). Patients with this many detoxification admissions tended to be re-admitted rather quickly after discharge (within days or weeks). If the waiver introduces DMC coverage of depot naltrexone injections, which are effective for 30 days, this would provide a very useful tool to break the cycle of repeated detoxifications for patients who are willing to take it, and potentially provide an opportunity to stabilize and engage the patient in treatment.

Summary and Lessons Learned

The proposed Drug Medi-Cal waiver provides California with a tremendous opportunity to reshape the field and build an organized delivery system in each county or region. The experiences of Santa Clara County may be particularly useful for other counties to examine given the need to rapidly deploy a system that in many ways resembles what Santa Clara has built. Preliminary analyses begin to suggest that such systems have the potential to lead to better care as well as savings, but questions about costs and outcomes remain, and additional data and analyses are needed. Building a system similar to that found in Santa Clara will also be very complicated. Santa Clara’s system has been evolving for 19 years, but counties will have a one-year transition period to install theirs, and therefore would likely be well served to examine and adapt existing models.

Repeated use of detoxification is a problem statewide. If depot naltrexone is covered under the DMC waiver, care might be improved and the costs of repeated detoxification might be reduced by treating alcohol patients with this long-acting medication wherever possible.

C. AB 109 and SUD Treatment Update

As reported previously (Urada, 2013), accurate statewide analysis of data on AB 109 patients in SUD treatment continues to be a challenge due to the lack of an accurate AB 109 indicator in CalOMS-Tx data, and significant barriers to creating one (for details see Urada, 2013). The only way to accurately identify such individuals in the CalOMS-Tx may be to obtain a list of AB 109 participants from each of the 58 county probation departments, which would represent a tremendous logistical challenge.

Over the past year, the County Alcohol and Drug Program Administrators Association of California (CADPAAC) merged with the County Mental Health Directors Association (CMHDA) to form the County Behavioral Health Directors Association (CBHDA). An unfortunate outcome of this merger is that the previously productive CADPAAC data and outcomes committee that was attempting to deal with the AB 109 data issue has been disbanded.

As a result of these developments, UCLA ISAP accepted an invitation from the Bureau of State and Community Corrections (BSCC) to work with them on AB 109 issues. BSCC has a legislative mandate to analyze and report on outcomes among the AB 109 population, including measures such as treatment completion. Criminal justice organizations (e.g., County Probation Officers of California) are closely involved in this BSCC effort, and we are exploring whether we can serve as a bridge between BSCC and DHCS and help guide data efforts that may be useful for both.

D. Program Performance and Patient Outcome Measurement Update

Administrative Data

UCLA ISAP and DHCS worked together on a paper, *Justification for Integration of Substance Use Disorder (SUD) Data Systems into the Mental Health Data System Enhancement Efforts*, that proposed improving and exploring the combination of MH and SUD data systems that were previously housed separately at the Department of Mental Health and Department of Alcohol and Drug Programs before these became divisions within DHCS. This paper describes the overlap between patients with MH and SUD problems, and the potential benefits of using MH and SUD together. Current MH and SUD data systems now housed at DHCS that can potentially be used together for performance and outcome measurement purposes include:

Mental Health (DMH) data systems:

- Client and Service Information (CSI) – collects individual-level data on California’s mental health population.
- Data Collection and Reporting (DCR) – collects data on children, youth, and emotionally disturbed adults who receive mental health services through the Full Service Partnership program.

SUD data systems:

- Short-Doyle Drug Medi-Cal (SDMC) Claiming System and Remediation Technology (SMART) – the DMC billing and tracking system.
- California Outcomes Measurement System Treatment (CalOMS-Tx) – individual-level
- Drug and Alcohol Treatment Access Report (DATAR) – collects data on treatment capacity and waiting lists at the SUD treatment program level.

UCLA ISAP has used CalOMS-Tx and CSI together in the past for research purposes. UCLA ISAP is currently working with DHCS to obtain new mental health and Medi-Cal data and will continue to investigate ways to use this data together with SUD data for research, evaluation, and performance/outcome measurement purposes.

Field Data Collection: Overlap and Divergence in MH and SUD efforts

UCLA ISAP recently reviewed an evaluation of a large integration project being evaluated by another university that is using methods that are similar to UCLA ISAP’s efforts to evaluate a separate MHSA-funded project in Kern County (see Chapter 2). The overlap and divergence in measures and methods is striking, and suggests opportunities for future collaboration and communication that might be useful, particularly where MH/SUD integration measures overlap.

As one example, the evaluation reviewed employs an alcohol-screening question that reads: “During the last 6 months, how often did you have any kind of drink containing alcohol, such as beer, wine, or liquor?” This question contrasts with the new Staying Healthy Assessment alcohol “pre-screen” question that DHCS (2013) added in December 2013 to be used as a trigger for SBIRT, which reads:

In the past year, have you had:

(men) 5 or more alcohol drinks in one day?

(women) 4 or more alcohol drinks in one day?

Both questions trace their roots to National Institutes of Health research, and both have value, but if this divergence is not reconciled, there is a danger that some providers might inadvertently be required to ask patients two different alcohol questions.

The evaluation reviewed also includes instructions at the beginning of its SUD measures section that reads, “If you have not used any alcohol or illegal drugs in the past six months, please skip these questions and continue the assessment on the next page.” Unfortunately, as currently worded, this question would result in participants with prescription drug problems skipping the entire SUD section, since they are not using either alcohol or illegal drugs, and thereby the fast-emerging problem of prescription drug misuse would not be evaluated.

As a third example, UCLA ISAP has been using the Dual Diagnosis in Health Care Settings (DDCHCS) instrument on site visits to measure behavioral health integration in primary care. In Los Angeles County, the Integrated Treatment Tool (ITT) has been used for the same purpose. Both tools are products of SAMHSA-funding, with the DDCHCS developed by Dartmouth University, and the ITT developed by Case Western Reserve University. It is likely, therefore, that once again there is no “right” tool to use and that each has its strengths. That said, further

discussions of standardizing measures may be valuable if the state would like to be able to compare this type of data across projects.

These are examples from only one project that UCLA ISAP became aware of and had the opportunity to review. It is likely that such overlaps and divergences are occurring in many projects statewide. To the extent that these evaluation results are used for local improvement efforts, it may not be necessary or useful to standardize measures across all of them, but it would be worth opening lines of communication to look for opportunities to collaborate and share information and expertise across evaluators who have varying degrees of specialization and expertise in SUD or MH issues.

Summary and Lessons Learned

Just as practitioners and policymakers are emerging from their “silos” of SUD and MH treatment to work in behavioral health, the same will need to be true of those who collect and analyze data. Combining or using MH and SUD data and systems together and collaborating on measures will improve the usefulness of behavioral health data.

IV. Conclusion

E. Chapter Summary and Recommendations

The ACA coverage expansion was associated with an increase in NTP maintenance but did not appear to have a substantial impact on other modalities statewide. A number of factors, including federal delays in SPA approval, certification and recertification of programs, and local variations in Medi-Cal enrollment, during the time period in question may all have served to reduce use of the DMC benefits in the first quarter of 2014. However, as these initial implementation challenges are resolved and newer data becomes available, the longer-term effect of the ACA on specialty SUD care should become clearer.

Despite the availability of an SBIRT benefit on January 1, 2014, substantial changes in referrals from health care to specialty SUD treatment programs did not occur in the first quarter of 2014. It is likely that it will take organizations time to change their processes and train their workforce to implement SBIRT.

The proposed Drug Medi-Cal waiver provides California with a tremendous opportunity to reshape the field and build an organized delivery system in each county or region. The experiences of Santa Clara County may be particularly useful for other counties to examine given the need to rapidly deploy a system that in many ways resembles what Santa Clara has built. Preliminary analyses begin to suggest that such systems have the potential to lead to better care as well as savings, but questions about costs and outcomes remain, and additional data and analyses are needed. Building a system similar to that found in Santa Clara will also be very complicated. Santa Clara’s system has been evolving for 19 years, but counties will have a one-year transition period to install theirs, and therefore would likely be well served to examine and adapt existing models.

Repeated use of detoxification is a problem statewide. If depot naltrexone is covered under the DMC waiver, care might be improved and the costs of repeated detoxification might be reduced by treating alcohol patients with this long-acting medication wherever possible.

Progress has been made this past year, but there is more work to do, requiring ongoing training and technical assistance at all levels.

Just as practitioners and policymakers are emerging from their “silos” of SUD and MH treatment to work in behavioral health, the same will need to be true of those who collect and analyze data. Combining or using MH and SUD data and systems together and collaborating on measures will improve the usefulness of behavioral health data.

State Level Recommendations

1. Monitor referrals and quantify screenings and brief interventions in primary care (most likely through Medi-Cal claims data) to track the implementation of SBIRT. UCLA ISAP can assist DHCS with these efforts.
2. Cover and encourage use of depot naltrexone under the DMC waiver, to aid in the reduction of detoxification re-admissions. At this writing, coverage of this medication is ambiguous.
3. To the extent that it attracts evaluators and county participants in MH and SUD projects being evaluated, DHCS might consider using a session at the annual DHCS conference as a starting point to facilitate communication on MH and SUD measures across the state.

County and Provider Level Recommendations

1. Counties should examine Santa Clara’s model as one way to implement the proposed waiver provisions. Santa Clara County, DHCS, and UCLA ISAP should facilitate this through dissemination of Santa Clara practices through trainings and dissemination of information, as well as further analyses of Santa Clara outcomes to provide a picture of potential waiver outcomes.
2. Lessons may also be learned from other counties that have experience with policies that resemble those that would be implemented under the waiver. Under DHCS’s direction, UCLA ISAP could embark on efforts to systematically collect and disseminate this information.
3. Prescribe depot naltrexone (brand name Vivitrol) to reduce “detox churn” among frequent users of detoxification. This medication may be covered under DMC under the waiver (see State-level Recommendation 3 above).

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Chapter 2: Health Care Reform and the Integration of SUD Services with Mental Health and Primary Care

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Integration of SUD, MH, and physical health care has continued to progress throughout the past year. Challenges remain, however, especially in the areas of reimbursement for services, organization of services, health information technology, and developing an adequate and well-trained workforce to deliver culturally competent and comprehensive care.

Many lessons can be learned from county- and provider-level pilot projects, but long-term integration of health care service delivery can only occur when service delivery policies, regulations, and funding are aligned in the broader system. The state has recently taken a step in this direction with the recent release of the draft Drug Medi-Cal Waiver Special Terms and Conditions (Department of Health Care Services, 2014b), which contains language aimed at facilitating integration.

It is critical that the state continue its efforts to improve payment structures to facilitate integrated care. Data from accountable care organization (ACO) and coordinated care organization (CCO) demonstration pilots in other states suggest these models can be effective for financing integrated services, and may inform the future development of more integrated delivery models in California.

Health homes can provide enhanced care coordination for individuals with complex behavioral health needs, but changes in state regulations are needed to support the development of this promising model. The state should also pursue opportunities provided by Section 2703 that specifically address integrated behavioral health care within the health home.

Broader adoption of evidence-based practices has the potential to greatly improve SUD and MH care. Additional training and technical assistance is needed to support dissemination and implementation of effective practices.

Behavioral health providers face special challenges in adopting electronic health records and collecting and sharing patient information through health information exchanges. Increased funding (e.g., federal incentives) and provider technical assistance to support the development of behavioral health information technologies policies and infrastructure are necessary to further the progress.

Workforce development will continue to be critical. Further technical assistance and allocated funds are needed to develop the content for a behavioral health workforce curriculum to train the current SUD workforce in regard to current and future changes.

I. Introduction

Substance use disorders (SUDs) in the United States are prevalent and harmful (Hasin, Stinson, Ogburn, & Grant, 2007; Merikangas & McClair, 2012), yet the problem is not being effectively addressed by current systems of care. In every year for about the past decade, roughly 20 million individuals in the United States went without treatment for existing SUD problems (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013b). Additionally, mental illness comorbidities are common among individuals with SUDs (Bassuk, Buckner, Perloff, & Bassuk, 1998; Cuffel, 1996; Grant et al., 2004; Hasin et al., 2007; Olfson et al., 2000; Swendsen et al., 2010). Approximately 8.4 million adults had co-occurring SUDs and mental illness in 2012 (SAMHSA, 2013a). Co-occurring mental health (MH) and SUDs can exacerbate other diseases and conditions (Ornstein, Nietert, Jenkins, & Litvin, 2013; Rehm et al., 2009), leading to poorer outcomes and higher costs (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011). As states work to advance changes in their SUD, MH, and physical health care systems, it remains critical to address these issues in an integrated manner.

Along with other related health reform legislation, the Affordable Care Act (ACA) of 2010 helps to expand insurance and coverage of SUD benefits to a greater population and also supports numerous initiatives to improve care through integration and quality improvement (Beronio, Glied, & Frank, 2014; Buck, 2011; Humphreys & Frank, 2014; Humphreys & McLellan, 2010, 2011; McLellan & Woodworth, 2014). As a result, there are new opportunities to improve care for SUDs in a variety of settings. These settings include not only specialty treatment centers for SUDs and MH disorders but also other health care facilities and settings in the community. Until recently, co-occurring SUDs and MH disorders have not been addressed sufficiently by the multiple independent and fragmented “silos” of care (Lee, Morrissey, Thomas, Carter, & Ellis, 2006). Increased integration and care coordination through health reform and related initiatives shows promise for improving behavioral and physical health outcomes, reducing costs, and enhancing patient care.

II. Chapter Organization

Within this chapter we review and summarize the various components, obstacles, strategies, and other “hot topics” permeating the field as the integration of behavioral health services continues to evolve and emerge within the broader health care system. The findings in this chapter have been gathered by conducting multiple investigative methods and activities in an effort to obtain a wide scope of data and information on the broad and complex topic of integration. Methods and activities include: literature reviews, participating in national and statewide webinars, attending integration-focused conferences, consulting with key stakeholders and integration experts, conducting surveys and focus groups, facilitating the California Integration Learning Collaborative, and evaluating piloted integration initiatives with selected counties within California.

The findings are organized as follows, concluding with a chapter summary and recommendations:

A. Review of Emerging Integration Topics

- Objective and Methods
- Topic Discussion
 - i. Financing Integrated Care
 - ii. Service Organization and Delivery
 - iii. Health Information Technology
 - iv. Staffing and Workforce Development
- Summary and Lessons Learned

B. A Focus on California

- California Integration Learning Collaborative
 - i. Topic Summaries
 - ii. County Case-Study Summaries
 - Napa
 - Orange
 - San Bernardino
 - San Joaquin
 - Sonoma
- Pilot Evaluations
 - i. Counties:
 - Kern
 - Los Angeles
 - San Luis Obispo

C. Chapter Summary and Recommendations

III. Findings

A. Review of Emerging Integration Topics

Objective and Methods

The objective of this section is not to provide an in-depth review of the background and evidence for integration (see Rawson et al., 2011, 2012), but to describe new research and emerging trends in integration that have seen further development in the past year. UCLA Integrated Substance Abuse Programs (UCLA ISAP) has gathered information from a variety of sources, including peer-reviewed research literature; unpublished reports, briefs, fact sheets and other “grey” literature; and websites, newsletters, and blogs published by authoritative national sources, including the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS), National Council for Behavioral Health, and the Agency for Healthcare Research and Quality (AHRQ) Integration Academy. Information has also been gathered through webinars and conferences from around the country (see *Appendix 2.1*), and consultation with Dr. Mady Chalk (Treatment Research Institute, Inc.), who assists UCLA ISAP with national and federal perspectives.

As described in the *Preface* of this report, the term “integration” as used in this report refers to the coordination or integration of SUD prevention, treatment, and recovery support services with primary health care services and settings. Lessons learned from the coordination and integration of *mental health services* with primary care have also been applied when relevant, even though SUD integration often faces different challenges.

Some questions that this section will address are:

- What research has recently been published that sheds further light on what the next steps should be, or provides additional evidence to support integration?
- What legislation or regulation has been created in the past year that might affect integration strategies moving forward?
- What websites are “must-see” for supporting the integration of behavioral health (mental health and SUD) services into primary care?

UCLA ISAP anticipates that recent policy developments will result in numerous changes in the delivery of SUD services in the key areas of **financing, service organization and delivery, health information technology, and staffing/workforce development**. Thus, the discussion in this section has been organized under these four topics.

Topic Discussion

1. Financing Integrated Care

Increased federal emphasis on cost control has led payers to focus on reducing costs, which past research indicates can be promoted through addressing MH and SUD concerns in physical health care settings (Parthasarathy, Mertens, Moore, & Weisner, 2003; Wickizer, Krupski, Stark, Mancuso, & Campbell, 2006). A recent analysis of the potential value of behavioral health integration estimated that \$293 billion in savings could be gained across commercially insured,

Medicaid, and Medicare populations in the United States by targeting behavioral health interventions to individuals with certain high-risk conditions, including arthritis, hypertension, and kidney disease (Melek, Norris, & Paulus, 2014). Through new payment mechanisms that enhance access and encourage coordination of services, both the quality and cost of care can be improved.

In the past year, changes in financing have proceeded, and evaluation of new payment models has advanced. The following is a brief review of changes over the last year.

Expansion of Coverage and Benefits

According to McClellan and Woodworth (2014), the main effects of the ACA on SUD services are the expansion of covered populations, the delivery of services in additional settings and by new provider types, and the reimbursement of a broader array of services. Starting on January 1, 2014, the decision of many states to expand their Medicaid programs under the ACA gave a large number of previously uninsured individuals access to health coverage. The inclusion of mental health and SUD services as one of the law's essential covered benefits helps extend access to SUD services to individuals with new or existing coverage. In addition, the California Department of Health Care Services (DHCS) released an All Plan Letter (APL 14-004) adding a covered benefit under Medi-Cal for screening, brief intervention, and referral to treatment (SBIRT) for alcohol misuse, a service recommended by the U.S. Preventive Services Task Force (see DHCS, 2014a). Increasing use of SBIRT in primary care and other health care settings can help to reduce stigma among providers and patients, while also providing critical early intervention and access to treatment, which can reduce costs from hospital and emergency department visits (Fleming et al., 2000).

New Financing Models

New financing models have been developed that aim to reduce the costs of care while allowing for the provision of quality care and improving population health. These include capitation, bundled payments, and pay for performance, which are often contrasted with traditional fee-for-service mechanisms that tend to reward quantity over quality. Accountable care organizations (ACOs) in particular have started to incorporate many of these new payment mechanisms. They are a type of financing model that government and commercial payers have advanced as they seek new ways to control costs while improving quality and coordination of care for patients. As groups of formally coordinated organizations and providers, ACOs encourage population health management through varying levels of risk, responsibility, and capitation (Health Management Associates, 2014). Thus, they help to shift the incentive structure for health care away from being driven by volume of procedures to a more value-driven system.

As one of the first demonstrations of the ACO model, the Medicare Pioneer ACO program showed promising results in its first year. Together with the Medicare Shared Savings Program, ACOs participating in these two federal initiatives account for about 5.3 million beneficiaries (Bachrach, Pfister, Wallis, & Lipson, 2014). While many of the Pioneer ACOs did not achieve substantial cost savings initially, those that succeeded in this area attributed their success to targeting individuals with chronic illnesses. Accordingly, behavioral health service integration may be a worthwhile strategy for ACOs to pursue. Some examples of ACOs integrating behavioral health services include the Montefiore Care Management Organization in New York and the Franciscan Alliance ACO in Indiana (Bachrach et al., 2014). The Montefiore Care

Management Organization has pursued efforts to improve behavioral health integration by conducting screening and coordinating care for depression and substance use in primary care (Chung, 2014), while the Franciscan Health Alliance ACO includes depression screening as a quality measure and has partnered with behavioral health providers to coordinate care transitions and provide care to beneficiaries with behavioral health conditions (Franciscan Alliance, Inc., 2013). The incentives provided by the ACO financial structure can encourage rather than impede appropriate screening and coordination of care for individuals with behavioral health conditions.

In addition to federal demonstration programs, which are Medicare-based, states are experimenting with their own program innovations. One example of a promising model is the Coordinated Care Organization (CCO), currently being piloted in Oregon's Medicaid program (McConnell et al., 2014). This program allows for more flexible use of funds in delivering alcohol and other drug (AOD) and MH services, removing some of the barriers that currently exist in providing integrated care. Another example is Minnesota's Medicaid ACO program. The result of this initiative has been the formation of the state's safety-net ACO, the Federally Qualified Health Center Urban Health Network (FUHN), an arrangement of 10 FQHCs with, collectively, 40 different sites serving about 150,000 patients, 23,000 of which are Medicaid patients (Schoenherr et al., 2013). As low-income and either uninsured or under-insured populations have historically experienced higher rates of SUD, incentivizing safety net organizations that serve these groups to participate in ACOs has the potential to greatly improve care for these individuals (Shortell, Weinberger, Chayt, & Marciarille, 2012). FQHCs participating in the FUHN ACO have also engaged in efforts to redesign their primary care service delivery by becoming patient-centered medical homes (PCMHs), with four already having obtained PCMH certification as of 2013.

Despite their promise for improving care for vulnerable populations and reducing costs, safety-net ACOs may face particular challenges due to lack of financial resources and infrastructure, shortage of primary care physicians and lack of access to specialists, and, at times, poor integration with private or public community-based systems of care (Shortell et al., 2012). Continued evaluation will be needed to determine whether the ACO model can provide an effective structure for integrating SUD services for individuals with other high-risk conditions while achieving its goals of enhanced quality and lower costs, or if further changes are necessary to achieve these desired outcomes.

2. Service Organization and Delivery

While financing and reimbursement can affect how patient care is organized, additional factors can also promote the development of effective service delivery. The increasing recognition of the importance of patient-centered and whole-health-oriented care has created a need for new collaborative and team-based care delivery models. Additionally, increased pressure for organizations to report and improve performance has led to greater emphasis on applying evidence-based practices (EBPs). In this section, both the integrated care models for delivering services and the evidence-based clinical practices will be discussed. Both can help to enable more effective and better coordinated care through changes in the types of services delivered, the settings they are provided in, and the methods used to organize delivery of care.

Patient-Centered Medical Homes (PCMHs) and Health Homes

Current models of delivering primary care and behavioral health care have become more patient-centered and less system-centric, with a focus on coordinating care for patients with multiple, complex, and chronic conditions. One important example is the patient-centered medical home (PCMH). Through care coordination within the medical home, PCMHs show the potential to reduce costs (Flottemesch, Anderson, Solberg, Fontaine, & Asche, 2012) and service utilization among complex patients, especially for inpatient care (Higgins, Chawla, Colombo, Snyder, & Nigam, 2014). Community health centers throughout the country are attaining recognition as PCMHs through bodies such as the National Committee for Quality Assurance (NCQA), as one of their key strategies in preparing for the ACA (Pourat & Hadler, 2014). Furthermore, the PCMH can also coexist with the ACO model, with each facilitating the goals of the other. A group of PCMHs can form the foundational component of an ACO, directly coordinating services through clinician teams, while ACOs contribute the infrastructure and incentives needed to promote cooperation between providers and organizations (Bao, Casalino, & Pincus, 2013; Meyers et al., 2010). PCMHs and other providers within an ACO receive additional payments or penalties based on meeting shared goals for quality and cost savings, while the size and scope of ACOs allows them to manage care transitions, promote connections with community resources, and better align resources with local population needs.

Although PCMHs lay the foundation for better coordinated, more patient-centered care, behavioral health services are not currently a required component, nor are they routinely incorporated into, the PCMH model (Bao et al., 2013). In response, several family medicine organizations have endorsed the integration of behavioral health into the PCMH as essential for meeting the core mission and values behind patient-centered primary care (Baird et al., 2014). In addition, Kathol, deGruy, and Rollman (2014) have proposed “Value-Based Financially Sustainable Behavioral Health Components,” meant to spur the adoption of value-based behavioral health services within the PCMH. The recommendations include, among others: using a single payment pool to finance behavioral health clinicians and services together with medical services and benefits; specifically targeting patients with behavioral health conditions who present a high risk for negative health outcomes; and using multidisciplinary teams and care coordinators that are trained to support integrated care. These suggestions are intended to provide the highest value for PCMHs implementing behavioral health services, while making effective use of limited resources.

Another model similar to the PCMH is the health home, an option that states can pursue under Section 2703 of the Affordable Care Act. While management of care within PCMHs is appropriate for individuals with lower-intensity BH needs, individuals with more complex BH needs can receive better coordination of care in a behavioral health home, which supports care for the whole person (SAMHSA-HRSA CIHS, 2012). In addition to the enhanced federal matching funds that states are eligible to receive for health home services, different states have considered various approaches to financing health homes (SAMHSA-HRSA CIHS, 2013). As of June 2014, 15 states had approved Medicaid State Plan Amendments to develop health homes, with many specifically including MH disorders and SUDs as eligible chronic conditions for health home services (see Centers for Medicare & Medicaid Services [CMS], n.d.).

Evidence-based Practices (EBPs)

To inform integration strategies for counties and the state, an understanding of evidence-based practices (EBPs) supported by current scientific knowledge is needed. In order to demonstrate outcomes and results, providers, payers, and stakeholders throughout the system are increasing their focus on EBP implementation. Successful implementation ensures that patients receive high-quality care that will lead to better outcomes.

A brief update is provided below on selected EBPs that are important for SUD and MH integration in primary care:

- *Screening, brief intervention, and referral to treatment (SBIRT)*. SBIRT is an effective method of early detection and intervention for SUDs (Babor et al., 2007; Madras et al., 2009). In 2014, the U.S. Preventive Services Task Force (USPSTF) issued a final recommendation that clinicians screen adults for risky alcohol use in primary care and provide brief behavioral counseling (Moyer & USPSTF, 2013), and DHCS released an SBIRT All-Plan Letter (APL) 14-004, adding coverage to Medi-Cal for SBIRT (DHCS, 2014a).
- *Motivational Interviewing/Brief Intervention*. Motivational interviewing is used in counseling and can be delivered as a brief intervention for SUDs. Evidence supports the effectiveness of motivational interviewing in reducing alcohol consumption (Satre, Delucchi, Lichtmacher, Sterling, & Weisner, 2013; Vasilaki, Hosier, & Cox, 2006). As SUD and MH services continue to be integrated into primary care, training providers in motivational interviewing and brief intervention techniques will help to engage more patients into treatment.
- *Medication-assisted treatment (MAT)*. MAT is an important but underutilized method for providing effective, evidence-based treatment to patients with SUDs (Fields et al., 2014; Wessell, Nemeth, Jenkins, Ornstein, & Miller, 2014). In particular, buprenorphine and naltrexone are two medication options that can be effectively prescribed and monitored in primary care. Increasing access to medications for SUDs is necessary for effectively integrating services into primary care, as well as helping to address prescription opioid overdoses (Volkow, Frieden, Hyde, & Cha, 2014).

To increase the use of EBPs in integrated care settings, more training and education are necessary to familiarize providers on how to implement these practices (Rawson et al., 2011; Squires, Gumbley, & Storti, 2008).

3. Health Information Technology

The development of health information technology (HIT) has demonstrated the potential to facilitate the coordination and integration of services among physical health care, SUD, and mental health delivery systems as well as foster greater communication between and access for providers and patients. As the rest of health care is working on adopting electronic health records (EHRs) and other forms of HIT, which can help increase the efficiency and effectiveness of care, behavioral health providers will also need to develop their HIT infrastructures and systems in order to integrate with primary care. However, special challenges arise when trying to integrate MH/SUD information with primary care and share information. Concerns arise about

confidentiality and privacy due to regulations such as HIPAA and 42 CFR Part 2. Meanwhile, another HIT opportunity for behavioral health lies in telehealth, which can enable greater access to MH/SUD services, especially in rural or underserved areas where there is insufficient behavioral health capacity. While both EHRs and telehealth can help facilitate integration, numerous barriers remain, particularly around resources and confidentiality concerns. Addressing these challenges will be necessary to facilitate integration.

Electronic Health Records (EHRs)

Electronic health records (EHRs) can be used for a variety of purposes, including collecting information and sharing it with other providers and with patients. Across the nation, the federal “meaningful use” incentive program has prompted the increasing adoption of EHRs in hospitals, physician offices, community health centers, and other health care settings (DesRoches et al., 2013; Hsiao et al., 2013; Robert Wood Johnson Foundation, 2013). In fact, the majority of community health centers in the United States currently qualify for payments based on their participation in “meaningful use” (Ryan, Doty, Abrams, & Riley, 2014).

Recognizing the benefits of capturing social and behavioral domains in EHRs, the Institute of Medicine (2014) formed the Committee on the Recommended Social and Behavioral Domains and Measures for Electronic Health Records. In its first phase, the committee recommended the inclusion of psychological factors such as stress, depression and anxiety, patient engagement and activation, and self efficacy, and behavioral factors such as nicotine use and alcohol use. With this information readily available through EHRs, providers will be able to identify patients with behavioral health needs and provide appropriate care to help improve patients’ health and well-being. However, incorporation of behavioral health providers and SUD/MH patient information into EHRs has been slower.

Health Information Exchange (HIE)

In addition to EHR capacity and implementation, many challenges exist in the area of health information exchange (HIE). While HIE is being developed as a way to share information so that the data always “follows” the patient and enables better coordination of care, barriers to including behavioral health providers’ participation in the HIEs continue to exist, due to tight restrictions on the sharing of behavioral health information. The SAMHSA-HRSA CIHS worked with five states in an initiative to increase the use of behavioral health information in HIE (Lardiere & O’Donnell, 2013). The initiative was moderately successful due to sustained training, technical assistance, and resources provided by grant funding. All five states achieved the ability to share mental health information, but none were able to share substance use information by the conclusion of the project, citing particular challenges related to 42 CFR Part 2. Meanwhile, HIEs in California are only in their early stages and are limited in their capabilities for storing and sharing behavioral health-related patient data, so time will tell if they can be effectively leveraged to improve care, particularly for individuals with SUDs and MH disorders.

Confidentiality (42 CFR Part 2)

Due to the numerous challenges to sharing behavioral health information to help coordinate care and services for patients, coupled with the continuing need to protect patients from any harm resulting from the unlawful disclosure of their SUD-related information, many providers support revising 42 CFR Part 2 to reflect the new realities of technology and health care coordination and

integration (Popovits, Lardiere, & Ashpole, 2014). SAMHSA proposed a public listening session on June 11, 2014, to gather feedback on 42 CFR Part 2 regulation surrounding confidentiality protections for AOD patient information (SAMHSA, 2014). The listening session is in response to stakeholder feedback that current regulations have created barriers obstructing the ability of ACOs, CCOs, health homes, and HIEs to include information related to SUDs. While any changes will require careful consideration and input from stakeholders, revising the current regulations to reduce barriers to sharing information may help improve care coordination while continuing to protect the privacy and integrity of patients' health information.

Telehealth

Recent evaluations describe how telehealth has been used to increase access to psychiatric and addiction medications in California (Denering, Crevecoeur-MacPhail, Dickerson, & Rawson, 2014) and Maryland (Fields et al., 2014), as well as other states. Rural areas in particular may lack access to medical providers and specialists, including physician prescribers of buprenorphine. Recent research continues to suggest that using telehealth will be an important way to deliver SUD services to patients in remote locations who may have difficulty finding regular transportation to visit their providers and receive care (Santa Ana, Stallings, Rounsaville, & Martino, 2013; Staton-Tindall et al., 2012); however, use of telehealth in California has also been limited by restrictions on Medi-Cal billing for unlicensed substance use staff.

4. Staffing and Workforce Development

Amid tremendous changes in the landscape for the delivery of health care and SUD treatment, prevention, and recovery services, issues related to the workforce remain challenges to be addressed. The need for a properly trained and billable workforce for undertaking work in integrated settings will only continue to grow. Mirroring the rest of health care, there are discussions about expanding the roles of existing SUD providers in order to keep up with demand for services. Not only do providers who are currently working in the field find that their roles are expanding or adapting with changes brought about by health care reform, but new types of workers are increasingly being used, including care managers and peer specialists. In order to implement team-based care and co-locate staff in integrated settings, there needs to be an adequate and well-trained supply of workers available who are permitted by regulation to practice within the full scope of their knowledge and competencies. A full discussion of the issues is presented in Chapter 3, but summarized below are selected topics that have surfaced in the literature and among webinars and conferences occurring in the past year.

Staffing and Designing Teams

One option for ensuring adequate staffing is to make use of the existing workforce by expanding their roles. The inability to bill for certain providers, such as SUD counselors in California, places constraints on the ability of some under-resourced and under-staffed programs to provide adequate services. Meanwhile, team-based care is emerging as an approach for addressing workforce shortages and improving communication and continuity of care. A report prepared for the SAMHSA-HRSA CIHS discusses the processes and development of integrated care teams in both primary care and behavioral health, illustrated with case examples from various providers (Lardiere, Lasky, & Raney, 2014). The SAMHSA-HRSA CIHS eSolutions newsletter for April 2014 discussed teams, providing strategies for effective communication (e.g., use of team

huddles, case conferences, and HIT) and defining key elements to ensure successful integrated teams (SAMHSA-HRSA CIHS, 2014).

Workforce Competencies and Training

The new workforce required to work in integrated settings will need to be knowledgeable in evidence-based practices and comfortable working in teams. The SAMHSA-HRSA CIHS in response has recently developed guidance on core competencies that can help frame activities for workforce education and training, staff recruitment, and performance evaluation as providers organize their workforce to deliver integrated care (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). The competencies comprised nine categories (interpersonal communication; collaboration and teamwork; screening and assessment; care planning and care coordination; intervention; cultural competence and adaptation; systems-oriented practice; and practice-based learning and quality improvement) and highlighted not only the need for “soft” skills such as flexibility and ability to create linkages, but also knowledge of specific primary care-based strategies and interventions for behavioral health.

Peer Specialists and Patient Self-management Support

Interest has grown in the area of peer specialists and patient self-management support as areas that could make use of paraprofessional workers supporting patients in the management of their own health conditions, which has been shown to improve outcomes for individuals with severe mental illness and SUDs (Chinman et al., 2014; Reif et al., 2014). Additional research is needed to support the use of peer specialists in helping improve patient outcomes, in order to demonstrate results and convince payers to support the practice (Chinman et al., 2013; Hamilton, Chinman, Cohen, Oberman, & Young, 2013).

Summary and Lessons Learned

In summary, integration in the fields of SUD, MH, and physical health care has continued to develop throughout the past year. State agencies, providers, and others interested in the integration of care for MH and SUDs face continued challenges related to financing and reimbursement for services, determining ways to organize services to support integrated care, building the HIT infrastructure necessary to exchange information for care coordination, and developing an adequate and well-trained workforce ready to deliver culturally competent and comprehensive care. Lessons learned from each of the four topic areas are listed below in an effort to help guide stakeholders throughout the state in developing an integrated system for SUD, MH, and physical health care.

Financing and reimbursement:

- To further facilitate integration and coordination of care among primary care, SUD, and MH providers, supportive financial reimbursement and structural incentives are required. Data from ACO and CCO demonstration pilots in other states suggest these models can be effective for funding integrated services, and may inform the future development of more integrated delivery models in California.
- Lack of financial reimbursement for SBIRT has historically limited the extent to which appropriate screening, intervention, and referral to treatment has been provided for individuals with SUDs and MH disorders in primary care. The recent addition of SBIRT

as a covered benefit under Medi-Cal has the potential to increase the number of individuals receiving needed care for behavioral health.

Service organization and delivery:

- While PCMHs demonstrate great potential in providing coordinated care for individuals with complex health needs, behavioral health is not a required component of the PCMH model. Value-based components have been proposed for integrating behavioral health into the PCMH, which can provide benefits even in resource-limited primary care settings.
- Health homes can provide enhanced care coordination for individuals with complex behavioral health needs, but changes in state regulation may be needed to support the development of this promising model.
- Broader adoption of EBPs has the potential to greatly improve care for SUDs and MH disorders. Additional training and technical assistance is needed to support dissemination and implementation of effective practices.

Health information technology:

- Behavioral health providers often face special challenges to adopting EHRs and collecting and sharing patient information through HIEs. Funding and technical assistance such as that provided by the SAMHSA-HRSA CIHS can make a difference in the success of behavioral health-specific and integrated HIT initiatives.
- 42 CFR Part 2 is meant to provide stricter confidentiality protections for patients' and clients' SUD-related information; however, many providers support revising the regulations to reflect new technological capabilities and the need to share information for care coordination. Considerations for respecting individual privacy will remain important.
- Access to services is an important issue in rural and underserved areas throughout the state. Given existing barriers, telehealth is a viable option to increase integration and expand access to counseling, consultation, and medications for SUDs and MH disorders.

Staffing and workforce development:

- Development and support of the workforce that will be delivering integrated care requires attention to (1) staffing and designing teams, (2) developing competencies for integrated care through training, and (3) engaging patients and peer support specialists to be involved in managing the process of care in a patient-centered manner.

B. A Focus on California

California Integration Learning Collaborative (ILC)

Goals and Objectives

The California Integration Learning Collaborative (ILC) is an interactive forum in which county administrators, SUD provider organization representatives, and other key stakeholders can collaborate on finding and developing sustainable approaches to the integration of SUD services within the broader health care setting. The ILC provides an ongoing discussion forum where participants learn how other counties and programs are implementing integration initiatives. The ILC participants also receive technical assistance and support from selected experts in the field on improving specific clinical and operational areas.

Topics have included: county integration initiatives; financing integrated services; SUD treatment programs engaged in successful partnerships with health care organizations; Affordable Care Act implementation; synthetic drugs (epidemiological update); best practices and effectiveness of residential treatment, outpatient treatment, and sober living; parity; data privacy; health homes; workforce considerations; health care reform in other large states; brief treatment; medication-assisted treatment (MAT); the prescription drug abuse problem (epidemiological update); integration survey results; county experiences with the Low-Income Health Plan (LIHP); and behavioral health screening instruments.

The objectives for the ILC are to enable county and provider participants to:

- Engage in active communication and share experiences, ideas, solutions, and lessons learned to facilitate integration.
- Gain technical and social support to improve specific clinical and operational areas.

Activities include:

- Monthly meetings discussing selected topics and issues around integrated care conducted both in person and via tele-conference/webinar.
- Dissemination of relevant reports, toolkits, and publications generated from carefully selected resources such as national and state-level forums, top-level research journals, other research, or University-based organizations, etc.
- Dissemination and posting of meeting summaries and materials made available on the ILC website:
<http://www.uclaisap.org/integration/html/learning-collaborative/index.html>
- Ongoing expansion of the ILC listserv to keep people informed of ILC activities and provide information dissemination (to subscribe to the mailing list, visit: <http://lists.ucla.edu/cgi-bin/mailman/listinfo/ilc>)

In order to make the ILC available to all 58 counties in California, the ILC is predominantly conducted via teleconference or webinar. When possible, the ILC also took the form of in-person presentations and discussions at the County Alcohol and Drug Program Administrators'

Association of California (CADPAAC) quarterly meetings (prior to the reorganization to California Behavioral Health Directors Association [CBHDA]).

Participants include county AOD program administrators and other key stakeholders, including the California Association of Alcohol and Drug Program Executives (CAADPE), California Opioid Maintenance Providers (COMP), California Therapeutic Communities (CTC), Mental Health Systems (MHSINC), California Association of Addiction Recovery Resources (CAARR), California Institute of Mental Health (CiMH), and Alcohol and Drug Policy Institute (ADPI), and more recently expanded the audience to providers registered within the PS-ATTC listserv. Meetings commenced in April 2011 and are ongoing. A total of 35 meetings have been held as of June 30, 2014, with 11 of those occurring within this report year (July 2013–June 2014).

ILC Methods and Activities

The content and agenda for each ILC session was determined through a variety of resources. Challenging areas faced by counties and administrators to facilitate integration of SUD and MH services were highlighted in the California Integration Survey conducted by UCLA ISAP in 2012. The survey also solicited interest from county administrators as to whether they would be willing to report on models and outcomes from their own integration initiatives. UCLA ISAP and DHCS also incorporated other priority topic areas as recommended by DHCS or other stakeholder groups. Below are summaries of all ILCs conducted over this fiscal year, organized by both topic discussions as well as by county initiatives. Detailed meeting summaries and materials are available on UCLA ISAP's ILC website:

<http://www.uclaisap.org/integration/html/learning-collaborative/index.html>

1. Topic Summaries

Topic: Financing Integrated Care (July 24, 2013)

Presenter: Patrick Gauthier (AHP)

Patrick Gauthier was invited to do a Question and Answer session within the ILC as a follow-up to the California Addiction Training and Education Series (CATES) and Webinar series that took place during the summer of 2013. CATES provided information on the changing health care environment and how to capitalize on those changes within the SUD field. During the ILC, Gauthier discussed strategies for financing integrated services, with a focus on partnering with ACOs, managed care contracts, billing, and parity. He emphasized the need to further incorporate behavioral health providers into health care systems. Highlights included:

- ACOs are any constellation of providers organized to participate and contract in the Medicare Shared Savings Program. They stimulate the consolidation/integration of providers into organized systems of care in order to improve the patient experience of care, improve population health, and control costs. Providers should do what they can now and find out how to do business with them as subcontractors before ACOs solidify

their provider networks. There are an estimated 32 ACOs in California today, and their contact information can be found online.

- Peer Recovery Support Services are very nonthreatening to payers. There is a lot of interest in adoption of these services.
- Crisis Stabilization Units are seen as a relatively short-term alternative to hospitalization. Beds are available for detox at rates much lower than those for a hospitalization. Once a patient is medically cleared to come to a unit that is staffed with nurses and a psychiatrist/MD, they can stay for 10–15 days for crisis stabilization. The reception to this business model has been very good (e.g., in Illinois, Iowa) because it is non-threatening. Basically, when a family wants one of its members in a safe setting and the hospital is not the right place, this is a good option.
- Medi-Cal Expansion and MH/SUD Services have come a long way, including expanding Medicare to low-income adults without children and setting a floor on benefits of the existing Medi-Cal benefit package. However, we can expect issues with Essential Health Benefits (what is covered and how it is managed). Under ACA, insurance companies must cover MH and SUD services, but we already know that parity and equality laws are not being complied with adequately. The State of California is free to define what the Essential Health Benefits are within MH/SUD. Under Medicaid Managed Care, whether SUDs are carved out or not, the state must comply with the parity and equality law. On the commercial side, there are three class action lawsuits against managed care companies in Vermont, Connecticut, and New York.

Topic: SUD Treatment Programs Engaged in Successful Partnerships with Health Care Organizations (HCO's) (August 28, 2013)

Presenters: Jim Sorg & Jose Salazar (Tarzana Treatment Center) and Marjeanne Stone (Empire Recovery Center)

Tarzana Treatment Center and Empire Recovery Center were invited to discuss their lessons learned and tips for success in building partnerships with health care organizations (HCOs).

Tarzana Treatment Center prioritizes getting referrals, and this message comes from the top. The CEO is vocal about the importance of increasing the number of referral sites every year. They have exhibit booths at conferences where they solicit their services to potential HCOs; they also hosts referral conferences twice a year inviting people who refer or might refer to them (including insurance companies and managed care companies). Tarzana also reaches out to hospitals, and tailors their services to the needs of that hospital. Specific hospitals have specific needs and patient populations that an outside organization will need to be able to address. “What can we bring to the table that the hospital can’t?” In most cases, Tarzana has had to address different patient population concerns for each HCO it partnered with. For instance, at the psychiatric ER, MDs wanted more behavioral health screening, assessment, and referral assistance from a person on-site. They have learned that the hospital pace does not match the pace experienced at community health centers, which causes issues with primary care staff who

are used to receiving updates on a more expedited basis. Also, hospital systems experience large workforce turnover, which creates the need for constant education of primary care staff.

Empire Recovery Center is a residential treatment program in Shasta County that has been officially partnered with Shasta Community Mental Health Center (FQHC) for the past two years. Shasta owns and operates a mobile health van that offers physical, mental, and social services designed to help the homeless and underserved. Empire saw the value in having a partnership because they would then be able to more easily refer patients to multiple levels of care. Empire uses a treatment team approach with the Hope Van and medical clinics that address the patient's problems in a holistic manner. The goal is to establish a continuum of care between Empire and Shasta, funded through contracts, grants and donations. They are preparing for the changes that ACA implementation will bring.

Topic: ACA Implementation: Medi-Cal Enrollment, Utilization Review, Primary Care Integration and SUD Workforce Issues (September 28, 2013)

Presenters: Alice Gleghorn (San Francisco), Bruce Copley (Santa Clara), Clara Boyden (San Mateo), Victor Kogler (ADPI), Darren Urada (UCLA ISAP), and Richard Rawson (UCLA ISAP)

Enrollment Efforts

Alice Gleghorn (San Francisco), Bruce Copley (Santa Clara), and Clara Boyden (San Mateo) gave an update on how enrollment efforts were going in their counties.

In San Francisco, on January 1, 2014, all Low Income Health Plan (LIHP) patients will become the Medi-Cal newly eligible population. San Francisco expanded LIHP eligibility criteria from 25% to 200% Federal Poverty Level (FPL). They have targeted 11,000 uninsured clients using MH/SUD services as well as 3,000 uninsured participants in the Department of Public Health program "Healthy San Francisco." They have employed several strategies to enroll patients. One involved training 40 new enrollment "assisters" who will be sent out to SUD program sites. They are also holding special events such as the Project Homeless Connect event to help enroll people in San Francisco PATH (Homeless Connect also helps people obtain IDs that are paid for by the county).

In Santa Cruz, the goal is to join with the county MH and hospital system to enroll 20,000 individuals by December 30, 2013. They determined client-population overlap in specialty MH/SUD care with primary and hospital-based care and used this as basis of the partnership. County-hired enrollers were sent out in the field to determine eligibility and help enroll individuals. About 30% of individuals required additional follow-up and outreach, but many of them were eventually reached to be enrolled. They established a criminal justice assessment center for individuals released from state or county jail, where eligibility workers provide help getting documentation and obtaining the county eligibility card.

The San Mateo enrollment strategy was to rebuild the provider network and have enrollment and eligibility assistance for clients. The program partners included many agencies such as the Health

Plan of San Mateo, Social Service Agency, county clinics, homeless programs, and county AOD-MH providers. The program success grew with time, training, and follow-ups. The lesson learned is to keep tight connections with clients. It is very important to create a welcoming “front end,” and it is just as important to create a system where “no wrong door” is a reality. Enrollment efforts will work if you keep advocating for your clients. They have also learned to earn and keep clients’ trust to achieve a “culture of coverage.”

Medical Necessity and Utilization Review (Victor Kogler)

By federal law, establishing medical necessity is the first step in accessing and billing for services. Medical necessity is defined as a physician’s determination that a specific course of treatment is essential for treating or preventing a disease. Utilization review and medical necessity are both part of a single continuum in the medical oversight of treatment; we must consider throughout the entire treatment process whether the current level of care is appropriate for the client’s needs.

SBIRT in Primary Care (Darren Urada)

Signs indicate that there are real barriers to achieving referrals through SBIRT on a wide scale. In addition to stigma and perceived lack of capacity, the main challenge for FQHCs lies in billing for services and the costly upfront investment required, including re-evaluating the PPS encounter rate, and limitations on the behavioral health workforce that can bill for services. Capitation is a potential long-term solution. CPCA is preparing to launch a pilot project on payment reform in 2014.

SUD Workforce Challenges (Richard Rawson)

One challenge (and opportunity) currently facing the field is how to work with primary care to help serve high-cost patients with complex or chronic conditions. Additional skills are needed beyond those currently possessed by the specialty workforce, including a basic understanding of common medical and psychiatric issues. A few training programs currently exist to equip workers with behavioral health skills and strategies for working in primary care (University of Massachusetts, University of Michigan, and Arizona State University).

Topic: Open Table Discussion: Are You Ready for January 1, 2014? (November 20, 2013)

Facilitated by UCLA ISAP

The purpose of this ILC was to “open the table” for discussion to address some of the common issues that existed as January 1, 2014, drew closer. Although several issues were identified around confidentiality, billing, and partnerships, the bulk of the discussion surrounded the processes for contracting with payers as well as workforce development training needs.

Contracting with payers is a complex and challenging process for many providers. Tarzana Treatment Center, which successfully contracts with many insurance companies, offered these important lessons from their experiences:

- Have the right infrastructure and processes in place: billing systems, credentialing, utilization review, and referral staff.
- Learn to communicate with insurance companies, understand what insurance companies expect from providers, and obtain contracts.

The training ideas and proposed ILC Topics included:

1. Training MH/SUD staff to understand (1) how co-occurring conditions impact long-term recovery and (2) how to interact with clients to address not only their SUD issues but also their MH (depression, anxiety) and medical issues.
2. Medical billing is a high priority.
3. Preparing an ACA “readiness timeline” so counties and providers can see where they need to be in regards to preparation, including why and how to start if they have not yet begun.
4. Third-party contracting.

Topic: ACA Implementation and Round Table Discussion (January 29, 2014)

Moderators: Darren Urada (UCLA ISAP) and Tom Freese (UCLA ISAP)

The 30th ILC was a roundtable discussion on counties’ experiences with ACA implementation now that January 1 had come and gone. General challenges were discussed, such as navigating private insurance (Covered California plans), requirements for managed care plans, reimbursement and parity, establishing memoranda of understanding (MOUs) with providers, the new SBIRT benefit coverage and requirements, and availability of centralized client assessment. Insurance restrictions (including medication restrictions and “fail first” guidelines), as well as the continuing issues surrounding DMC recertification were all discussed. Discussion among counties ensued with informal reporting of local experience with new enrollment issues, LIHP transfer enrollment status, and access-related issues.

Topic: Will they turn you into a Zombie? What Clinicians Need to Know about Synthetic Drugs (February 26, 2014)

Presenter: Beth Rutkowski (UCLA ISAP)

Despite widespread availability and use of synthetic drugs among certain populations, health care providers remain largely unfamiliar with synthetic drugs and the multiple variations of them that have appeared recently. This topic has relevance and practice implications for all types of providers, whether they are working in integrated primary care or in specialty MH and SUD treatment settings. The lack of information on the chemical content, dosage levels, and quality of the products is a major problem since users are taking drugs about which they know little, which

makes provision of health care for adverse events more difficult. Research is needed to better understand the side effects and long-term consequences associated with the use of synthetic cannabinoids and synthetic cathinones. More toxicological identification of these new drugs, more information on the sources of them, as well as their distribution and patterns of use is needed to curtail future increases in use. In addition, guidance on treatment approaches is greatly needed.

Topic: Best Practices & Effectiveness of Residential, Outpatient and Sober Living Services (March 26, 2014)

Presenter: Richard Rawson (UCLA ISAP)

Richard Rawson presented on the current research evidence available to guide treatment for individuals with SUDs within California's new SUD financing structure. The presentation covered specific evidence-based practices, which are essential to effective treatment regardless of treatment setting. Among these practices are behavioral approaches (including motivational interviewing, contingency management, and 12-Step facilitation) and use of medications (including methadone, buprenorphine, and naltrexone). Research on the effectiveness of various treatment modalities (e.g., sober living, inpatient, outpatient, and intensive outpatient) was also discussed.

- When determining what level of care to provide, the important question is: which level is more appropriate at a given time for each client? Using patient placement criteria to optimally match patient needs with level of care is key.
 - Length of stay should be based on degree of functional improvement and patient strengths/challenges.
 - Availability of a broad continuum of treatment options benefits the client.
-

Topic: Implementing and Monitoring Parity (May 21, 2014)

Presenter: Suzanne Gelber Rinaldo (Avisa Group)

During the final CADPAAC Quarterly Meeting, Suzanne Gelber Rinaldo presented an overview of the Mental Health Parity and Addiction Equality Act (MHPAEA), including requirements for covered plans and issues that will need continued monitoring and enforcement during implementation in order to ensure equal access to evidence-based care for MH disorders and SUDs. MHPAEA requires both the financial requirements and treatment limitations applicable to MH/SUD benefits be no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits in the plan.

- Financial requirements include: deductibles, copayments, coinsurance, out-of-pocket limits

- Treatment limitations include: frequency of treatment, number of visits, days of coverage, and other limits on scope or duration of treatment

MHPAEA does not mandate that a plan provide MH/SUD benefits. Covered plans include plans sponsored by private- and public-sector employers with more than 50 employees and to health insurers who sell plans to those employers. The final rule for Medicaid managed care plans has not yet been issued.

There are many issues that will need to be closely monitored, including enforcement (though there has been no federal money allocated to enforcement), costs (co-pays, etc.), non-quantitative treatment limits (NQTLs), and Behavioral Health Provider Networks. For instance, health plans must ensure that they contract with enough providers to ensure sufficient access and choice. Health plan information and documents must be made available so that compliance with parity can be examined by stakeholders. There will also need to be insurance report cards (are there any complaints?) and evaluation and research to measure the impact of parity.

2. County Case-Study Summaries

In addition to the ILC meetings, which focus on certain *topics* associated with integrating SUD services, other ILC meetings focus on the integration initiatives underway in certain *counties*. County administrators volunteer to present during the meetings, which helps everyone engage in integration efforts. Detailed meeting summaries and materials are available on the ILC website: <http://www.uclaisap.org/integration/html/learning-collaborative/index.html>

Below is a list of individual counties* that presented their integration work within the ILC:

- Napa
- Orange
- San Bernardino
- San Joaquin
- Sonoma

* See Pilot Evaluations section to review additional county-based descriptions of pilot projects and ongoing evaluation work in Kern, Los Angeles, and San Luis Obispo counties.

Each county's work has been organized to address:

- Background (*Who was involved? Where were the sites?*)
 - County (name, size, urban/rural population)
 - Program/site
 - Integration settings (FQHC or other)
- Objectives and methods (*What was the plan?*)
 - Project goals/description
 - Models used
 - Types of integration (MH and SUD together, MH and SUD into primary care [PC])
 - Integration partners (if known/appropriate)
- Implementation outcomes (*Did it work? What actually happened?*)
 - Key findings
 - Facilitators and barriers
- Lessons learned

NAPA COUNTY

Background

Napa County is located in Northern California. As of the 2010 census, the population was 136,484, and it occupies 788 square miles (www.countyofnapa.org).

Napa County has an integrated health and human services agency (HHS), meaning all of its services are located on the same “campus.” MH, AOD, public health, self-sufficiency, and child welfare services work collaboratively to provide referrals for patients. Clinic Ole has a satellite office on the county health and human services campus, so that services for MH disorders, SUDs, and primary care can be offered on the same location.

Objectives/Methods

Napa County’s SBIRT project began in fiscal year 2012–2013, in partnership with each of the stakeholders and with training and technical assistance provided by UCLA ISAP (funded by the county’s SAMHSA MH block grant funds). The county MH division, AOD services division, and the local FQHC (Clinic Ole) participated in a series of meetings to begin planning the SBIRT implementation process.

The goal of the project was to implement the SBIRT screener and assessments in each of the designated key access points on the county’s health and human services campus, which are:

- The mental health access point
- The AOD services intake center
- The Clinic Ole satellite office
- The “hub,” a multidisciplinary access point for all of the services offered at Napa County HHS (so far, the hub is not yet fully operational, but it will provide a central point to assess and refer individuals for MH, AOD, and primary care services as needed)

The screening process involved identifying the target population, which was all adults and transitional age youth (aged 16 years and older) getting services on the campus for their first intake appointment in either MH, SUD, or primary care. They chose to use the screener developed by Orange County, adapting it by adding primary health care, tobacco, and domestic violence questions to the pre-screener. The pre-screener is self-administered. Patients entering key access points on the campus receive a screener, which are scored by registration staff to determine whether they should be given full screeners; based on their answers on the full screeners, they are given a brief intervention and/or referral to treatment as appropriate. Full screens are then conducted with the AUDIT, DAST, PHQ-9, GAD-7 tools as appropriate, depending on patients’ scores on the pre-screener.

Additional questions were added to the pre-screener for data gathering purposes, including patient/client demographic data and specific information for staff to complete (e.g., how often staff are providing BIs, whether they made a warm hand-off or referral within the agency or to a community provider, or whether they provided general information to the patient/client).

Pre-screeners and screeners are in a format that can be readily scanned into a database by the quality management division, which provides data analysis for the project (no manual data entry required).

Implementation Outcomes

They have encountered several challenges, including finding funding and ensuring follow-up on referrals. The project initially began using SAMHSA grant funds; however, those funds are now being directed to other areas, so it will take a renewal of investment from the county's divisions to continue providing SBIRT and motivational interviewing (MI) training. While providers have successfully been screening patients, providing and following-up on referrals has been more difficult; they need to work on ensuring appropriate follow-up. Screeners have been implemented in the MH access point and the county campus Clinic Ole office as of November 2013, but they have not yet been implemented in the AOD division due to difficulties changing the current workflow. The data have indicated mismatches in the number of pre-screeners and full screeners that were completed, so they will be checking with staff to see how they perceive the forms and processes and whether they work.

Lessons Learned

- Importance of staff buy-in: It is important to get buy-in from the line staff who will be implementing the screeners, to better understand what their needs were.
- Maintaining communication and ongoing meetings.
 - Due to turnover and changes in key players involved in the project, priorities have been shifting. It has been important to bring new leaders up to speed and make sure that everyone understands the importance of SBIRT so that it remains a priority for each of the county divisions
- Revisiting processes to make sure they are working.

ORANGE COUNTY

Background

Orange County is the third most populous county in California, with 3 million residents. The county is located in Southern California and has three main cities: Santa Ana, Anaheim, and Irvine (<http://ocgov.com>).

In 2010, Orange County became interested in creating a screening, brief intervention, and referral to treatment (SBIRT) program in primary care. The SBIRT program would help to identify individuals at risk for SUDs or MH disorders and begin to integrate the county's behavioral health services into primary care.

From initial planning in 2010 through implementation in June 2013, the County Alcohol and Drug Abuse Services worked together with UC Irvine to develop an instrument with validated measures, create screening and documentation procedures, and hire two licensed therapists to conduct on-site SBIRT with clinic patients. Additionally, screening data indicated that a majority of patients who screened positive were successfully referred to community or county-provided services.

Objectives and Methods

Orange County began working with the health center to develop a screening instrument using previously validated tools. The instrument initially included 9 items and has since been expanded to 10 items covering anxiety, depression, alcohol and drug use, domestic violence, and trauma.

After developing the screening instrument, it was determined that the best way to conduct the screening was to have the two licensed therapists personally conduct and score the screenings rather than simply hand out the screening instrument for patients to complete. To fit the needs of clinic patients, who are predominantly monolingual Spanish-speaking, the therapists are both bilingual and are able to interpret and explain items on the screening instrument that may be unclear or confusing to patients. UCI Family Health Center created a field in their EHR to indicate whether each screening was positive or negative.

The screening process involved paying attention to the workflow of the clinic. The initial screen with the patient is done during the waiting time after patients have their vitals taken and before the physician enters the room. When the physician comes into the room, the staff member exits and returns again once the physician leaves. If a second-level screening (triggered by a positive result on the initial screen) or brief intervention is needed, that is usually conducted during the waiting time at the end of the appointment. Physicians are also able to indicate if a patient may need screening or additional follow-up by putting a label into a folder. Follow-up with patients is done by conducting the screening over the phone using the SBIRT tool.

Implementation Outcomes

Between July 1, 2013, and February 28, 2014, 99% of patients who visited the UCI Family Health Center were screened through the SBIRT program (a total of 4,300 patients). More than 500 patients on average were screened each month, and patients were re-screened if they visited the clinic more than once. More than 1 in 4 patients screened positive for mental health, substance use, or domestic violence issues; out of those patients, more than 8 out of 10 had mental health concerns. For half of all positive screens, the identified issues were previously untreated. Women were slightly more likely than men to screen positive using the SBIRT tool, and younger and middle-aged patients were more likely to screen positive than patients who were 50 or older.

The program has so far been able to screen for individuals who are at risk for MH/SUD and make linkages with treatment services and other assistance for those patients. Both the county and UCI have been very happy about the program's initial success and are working to expand it to other health care clinics.

Lessons Learned

Successful implementation strategies included:

- Building relationships with clinicians and staff at the health center (e.g., by regularly attending staff meetings, introducing yourself, explaining your role, and generally endearing yourself to the staff)
- Obtaining buy-in from the leadership (e.g., the medical director and other site administrators)
- Conducting trainings and other activities to familiarize physicians and clinic staff with the importance of SBIRT
- Maintaining up-to-date resources for patient referrals
- Networking with county-contracted and community services in order to provide warm hand-offs for patients

SAN BERNARDINO COUNTY

Background

San Bernardino County (located in Southern California) covers 20,105 square miles with just over 2 million residents as of the 2010 census (www.sbcounty.gov). San Bernardino County has experienced challenges integrating behavioral health and medical services due to the county's large geographic size and population demographics.

Objectives/Methods

The Behavioral Health (BH) Integration Initiative involves the co-location of behavioral health into primary care. Co-located BH services have been embedded into the primary care workflow at three FQHC sites: BH staff conduct screenings, provide short solution-focused therapies for patients, and provide consults to primary care (PC) practitioners and psychiatrists. Reverse co-location of medical services into BH has been more challenging. Many barriers exist; there is only one BH site, it is expensive to do, and most individuals in the county would not be able to access services due to the distance needed to travel.

BH is meeting every 2 weeks with Medi-Cal managed care plans to discuss how to communicate within and across systems in order to coordinate care for patients across systems and benefits.

This includes enrollee population characteristics, referral process and care coordination, medication reconciliation, technology and information sharing.

Implementation Outcomes

A Client Perspectives and Access to Services survey was conducted with beneficiaries in specialty MH to assess their access to and use of primary care services. The sample size was 2,500 individuals. The questions asked regarded what settings clients received health care services in (ER, hospital room, doctor's office), whether their primary health care provider was accessible and provided quality services, etc. The results showed that patients received very little care from the health care service system. MH clients interpreted their primary care provider to be their psychiatrist, not a health care provider as expected. According to claims data, less than 1% of this MH client sample was receiving care in primary care offices, although they were receiving many specialty services in hospitals and ERs.

They are currently working with Medi-Cal managed care partners to deal with issues of integrated health and Medicaid expansion. The focus has been on (1) setting up a more streamlined process for screening, referrals, and assessments, and (2) improving care coordination through greater communication between plans. The ultimate goal is to create a system of care that encompasses all of the beneficiaries' needs and that is easier for beneficiaries to navigate.

Lessons Learned

- Better coordination is needed to make bidirectional referrals more successful given the limited number of available facilities and large geographic distances
- Partnering with the county's Medi-Cal managed care plans is critical. They are currently developing better communication to coordinate care for patients across systems in light of the Medicaid expansion.
- Collaboration with partners required regular meetings and dedicated staff time, coordinating different systems and processes to work toward the ultimate goal of creating a system of care that gives beneficiaries better access and ease of navigation.

SAN JOAQUIN COUNTY

Background

San Joaquin County is located in Northern California (east of San Francisco) and as of the 2010 census, the population was 685,306. San Joaquin County includes seven cities (approximately 921,600 total acres), with the largest being Stockton.

During the ILC, several integration initiatives were discussed.

Objectives/Methods

The Consumer Health Empowerment Initiative (2011 to present) is a partnership between the Behavioral Health Department, Consumer Health Advisory Council, and the local NAMI chapter. The goal is to assist consumers with MH disorders/SUDs in reclaiming increased life expectancy and quality of life.

A Health Information Exchange, which is in the planning stage, is an initiative to share information electronically (with patient consent) between primary care providers (e.g., county general hospital, local Medi-Cal managed care health plans, FQHCs) and behavioral health in order to improve care. At this time it will involve mental health information only - due to additional restrictions on sharing SUD patient information.

San Joaquin County is developing its behavioral health integration through a task force to improve workforce capacity and training for co-occurring disorders. They identified core competencies and developed a training program based on the SAMHSA TIP 42. Trainings were provided for all MH and SUD line staff, each led jointly by both an MH staff specialist and an SUD staff specialist. A major training focus area was SBIRT.

This involved collaboration with a family medicine psychiatry clinic to provide behavioral health care within a primary care clinic and through its Transitional Care Behavioral Health Integration Project to target high-risk users of the health care system with case manager and behavioral health counselor home visits. This 3-year project provided a psychiatrist and social worker. The role of the social worker was to receive referrals from PC physicians, nurses, and residents, provide brief treatment within the clinic, and make referrals/linkages to resources for patients (including long-term care if needed). They also received a Blue Shield grant to hire a consultant who assisted with setting up collaboration meetings, provided a series of webinars to train BH staff on bidirectional healthcare concepts, and provided assistance with data collection.

Implementation Outcomes

Collaboration with partner agencies was challenging. A great deal of coordination was needed to address the challenges of bringing together different agencies with different systems such as electronic billing systems, registration processes, and the documentation and sharing of information. Many meetings were held to work out a common process, address issues, and define

roles. It was critical to commit time and staff resources toward holding implementation and planning meetings.

Patients were initially uncertain about the programs, but now see mostly positive benefits. Providers need to take the time to explain the purpose of various programs to patients and allow them to experience them for themselves.

Health reform and parity bring great opportunities to help clients get full access to services. The main goal is to work together with partners and within the BH system to manage the influx of new clients, and to ensure that existing clients are able to access benefits.

Lessons Learned

- Dedicated staff time for planning, implementation, and oversight is critical for success.
- Obtaining buy-in: provide education and training to prepare staff on the concept of BH integration into primary care.
- No agency can do it all by themselves. Go the extra mile to make connections—collaboration requires stepping outside your comfort zone.

SONOMA COUNTY

Background

Sonoma County is located in Northern California. As of the 2010 census, the population was 491,829; the county occupies 1,768 square miles. Its county seat and largest city is Santa Rosa (<http://sonomacounty.ca.gov/>).

Sonoma County's SBIRT project is in its early stages. The implementation and training project began with reaching out to multiple stakeholders within the county. They engaged in outreach and meetings with health center leadership, including executive and medical directors. They also partnered with the county-managed Medi-Cal plan and engaged with other health centers as well, including a junior college health center and Indian health project.

Sonoma gathered information on what the health centers' experience and training interests were in order to plan trainings in SBIRT and MI. They also opened trainings to other partners, including other AOD providers and all hospital emergency departments. They are planning a county-wide learning collaborative to provide technical assistance to each health center tailored to their specific billing processes, clinic flow, staff involved in implementation, and experience level with SBIRT. They are hoping to develop a toolkit to provide to each health center, other large medical providers, and hospital emergency departments with information to bring them on board to the project.

Objectives/Methods

One of the ultimate goals of the project was to have co-location at least once a week of a certified AOD provider, and eventually work to provide brief counseling for AOD, nutrition, obesity, and mental health; however, they have learned that this may take time.

If the project is successful, the county health plan may want to replicate SBIRT in other areas of the region.

Implementation Outcomes

To date, five SBIRT trainings have been conducted in the county. The trainings have gone well with high attendance rates.

Implementing SBIRT after the trainings is proving to be more difficult, and many sites need more help. Providers are screening but have more difficulty with the BI and RT parts of SBIRT. Sonoma is working on breaking down silos so that they can collaborate better on referrals. When they started, MH, AOD, and primary care were still somewhat siloed. Implementing the SBIRT project has created a common language that will help these different groups talk to each other.

Lessons Learned

- They have learned that it is important to continue to focus on outreach, engagement, and frequent encouragement. Staff and stakeholders may have different approaches and varying amounts of investment in the project. They may be on different timelines with regard to preparation for implementation—be prepared to offer your assistance based on each individual’s particular situation and needs.
 - It may be difficult at first, but investing in the electronic medical records (EMRs) is important for creating efficiency and for engaging providers. Not all providers were on the same EMR system, so we needed to figure out how to build templates for the same assessment tool, which includes specific follow-ups depending on the score.
 - Having a standard system can help with documentation and determining how to improve a process.
 - As SBIRT is implemented many questions have come up regarding billing, and therefore guidance from the state is needed.
-

Pilot Evaluations

UCLA ISAP is working with a small group of counties to facilitate integration, including counties that are in the “early integration” stages as well as counties that are more advanced. UCLA ISAP selected three counties (described below) to focus these pilot evaluation efforts. A plan was created for each county and approved by DHCS. The participating pilot counties include:

- Kern
- Los Angeles
- San Luis Obispo

The Los Angeles Telepsychiatry and Vivitrol pilot projects and parts of the Kern work were funded by these respective counties, but the results that are relevant to integration are informative for state efforts and are therefore presented here. In addition, San Luis Obispo County volunteered to collaborate with UCLA ISAP to evaluate the selected integration efforts specifically conducted to inform DHCS.

1. Counties

KERN COUNTY

Background

Kern County is very large (approximately 8,500 square miles), which requires that the service delivery system be organized to reach outlying areas. In Bakersfield, the primary industries are oil and agriculture, and the unemployment rate is 33% in one community. Kern County's population is also very diverse (the residents in one community are 80%–90% Hispanic, while in other communities they are 60%–70% White). Kern County's mental health system of care services and facilities include community mental health agencies, crisis intervention, family counseling, forensic mental health evaluation, inpatient mental health facilities, mental health evaluation, outpatient mental health facilities, psychiatric case management, psychiatric medication services, psychiatric rehabilitation, supported employment, and transitional mental health services. The county's substance abuse system of care consists of assessment for substance abuse, detoxification, substance abuse counseling, substance abuse education/prevention, methadone maintenance, perinatal substance abuse treatment, residential substance abuse treatment facilities, sober living homes, diversion programs, DUI offender programs, and dual diagnosis. There are two FQHCs in Kern County.

Kern County Mental Health (KCMH) is working with FQHC and health center partners to implement an SBIRT-type model in primary care settings (Project Care). Using MHSA funds, Project Care provides select MH and SUD screening and treatment services within the primary care facilities. Referrals to specialty care are made when appropriate. Project Care's funding facilitates "warm hand-offs" (i.e., the primary care provider directly introduces the client to the MH/SUD provider) by allowing providers to be reimbursed for providing two services in the same day (e.g., for a physical ailment and an SUD), unlike other primary care sites in California that rely on Medi-Cal (Medicaid) reimbursement.

Objectives/Methods

Project Care aims to promote integration through regular meetings of case managers, use of electronic registries, use of evidence-based practices, and required administrative meetings, practitioner networking, and trainings. The goals of Project Care are to provide universal screening of all adult clients coming to the health centers. Three screening instruments are used (PHQ9, GAD7, and AUDIT-C+). Brief interventions are delivered onsite and include SUD assessment and MH solution-centered treatment (using the Assist Model and Motivational Interviewing techniques) that take place over 6–10 visits. Integrated case conferencing with the physician, psychiatrist, and behavioral health staff are mandatory and Project Care uses data to monitor progress.

Implementation Outcomes

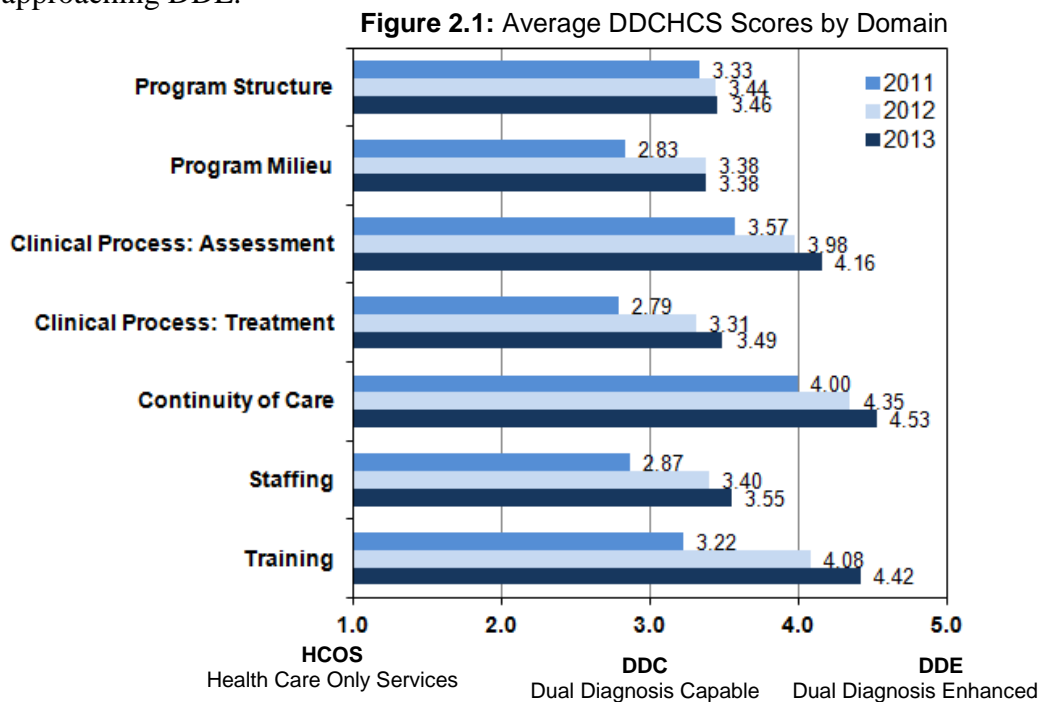
Project Care staff have expressed that creating a safe learning environment where people can discuss and share has been an important first step. Monthly provider meetings have also ensured the success of the project.

Dual Diagnosis Capability in Health Care Settings (DDCHCS)

The Dual Diagnosis Capability in Healthcare Settings (DDCHCS) tool¹ was designed to measure the degree of primary care, substance use disorder, and mental health integration within health care settings, and as such, was adopted as a key measure for the evaluation. DDCHCS administration requires an in-person site visit, inspection of the site and records, and interviews with multiple staff members. UCLA ISAP conducted DDCHCS visits with all Project Care sites in 2011, 2012, and 2013.

Overall, improvements in the average ratings were observed since the 2011 assessment visits across all of the DDCHCS dimensions and were maintained or surpassed at the visits in 2012 and 2013 (see Figure 2.1). The three dimensions with the lowest average ratings in 2011 (HCOS) were Clinical Process - Treatment, Program Milieu, and Staffing. The dimension with the highest average rating in 2011(DDC/DDE) was Continuity of Care. The largest improvements from 2011 to the 2013 visits occurred with regard to Training (an increase of 1.23 points), Clinical Process - Treatment (an increase of .7 points) and Staffing (an increase of .68 points). Average ratings for Program Structure increased slightly from 2011 to the 2013 assessments (an improvement of .13 points), maintaining a DDC rating.

The dimension that showed the most improvement between the 2012 and 2013 assessments was Training (an improvement of .34 points), whereas the average scores on all of the other dimensions increased slightly (between .02 to .18 points), except for Program Milieu, which remained the same as in 2012. During the 2013 visits, average ratings for all of the dimensions were at least DDC, with 3 dimensions - Clinical Process - Assessment, Continuity of Care, and Training - approaching DDE.



¹ McGovern, M. P., Matzkin, A. L., & Giard, J. L. (2007). Assessing the dual diagnosis capability of addiction treatment services: The Dual Diagnosis Capability in Addiction Treatment Services (DDCAT) Index. *Journal of Dual Diagnosis*, 3(2), 111-123.

Lessons Learned

The DDCHCS is a useful tool for evaluating the mental health and substance use disorder services integration in community health center settings, providing guidance for improvements in the key dimensions, and measuring changes over time. Overall, improvements in the average DDCHCS ratings since 2011 were maintained or surpassed at the 2012 and 2013 assessment visits.

Staff Satisfaction Surveys

From 2011 through 2013, UCLA ISAP conducted repeated yearly surveys of staff and clinicians at several primary health care clinic sites that were participating in behavioral health integration through Project Care. The purpose of the surveys was to explore staff perceptions and satisfaction with delivering integrated behavioral health services in primary care settings, including FQHC sites and one hospital outpatient clinic.

Methods

Surveys were originally adapted from the Integrated Behavioral Health Project (Tides Center, 2007), and forms corresponded to each of three staff types: (1) behavioral health providers, including psychologists, social workers, and therapists; (2) primary care providers, including physicians, nurses, and physician assistants; and (3) support staff, including medical and administrative assistants, clerks, front office staff, medical records staff, and other line staff. For greater detail on initial survey development and procedures, see Urada et al. (2012).

Survey items asked for staff ratings of their own and other providers' effectiveness and comfort with behavioral health, beliefs in the value of integration, and the quality and frequency of communication between staff types. Participants were also given the opportunity to provide written comments on the survey explaining their ratings. Responses were collected anonymously, with the number of valid responses received each year ranging from 59 to 69.

Findings

The most recent results from 2013 suggest that overall, integrated behavioral health services in primary care continue to be highly valued among staff. (Average ratings are reported, with options ranging from 1 to 5.) All staff types were satisfied with the ability of medical staff to address the needs of patients with behavioral health needs, with average ratings ranging from 4.05 to 4.47 among staff types. In addition, staff reported that additional training regarding the diagnosis and treatment of MH disorders, SUDs, and other psychosocial issues would be helpful to them, reflecting an interest in further education about behavioral health issues (average ratings ranging from 4.00 to 4.21 among staff types).

Clinicians and staff remain uniformly in agreement that behavioral health services are helpful for patients, with average ratings ranging from 4.64 to 4.87 among staff types. Staff also reported that integration increases access to behavioral health services, with average ratings ranging from 4.43 to 4.80 among staff types. Communication between medical and behavioral health staff was generally viewed as good, with primary care providers, support staff, and behavioral health providers on average rating their agreement with this item as 4.40 and above.

Conclusions

Primary care providers, other medical staff, and behavioral health providers who are taking part in primary care-behavioral health integration find that integrated behavioral health services are valuable and believe in the benefits that they provide for patients. Staff are also interested in training to learn more about behavioral health issues. While limitations and potential turnover may exist from year to year, additional analyses are planned in order to examine changes in staff views over time.

Patient Focus Groups

Three focus groups were conducted at two FQHCs to better understand patients' perspectives on and experiences with integrated behavioral health (BH) services and to solicit recommendations to improve the integration of such services in community health center settings. Participants were recruited via flyers. Focus groups were held on-site at the health centers and conducted by UCLA ISAP research staff (one in English, two in Spanish). Using a semi-structured interview guide, UCLA ISAP researchers asked participants open-ended questions about their perspectives on and experiences with the BH services (referred to as mental health and/or alcohol/drug use services in the focus groups) offered through the health center (e.g., services available, medication for anxiety, depression, alcohol and/or drug use, how they found out about the services, communication between providers, what they like most and least about getting BH services at the health center), and (2) recommendations for improving the services. Each focus group lasted approximately 1.55 hours. Participants were paid \$25 (gift card) for their participation. The focus groups were audio recorded, and later professionally transcribed. Qualitative data were content analyzed using Atlas.ti, a qualitative data analysis software.

A total of 18 patients participated in the focus groups. The majority of the participants were female (94%) and self-identified as Hispanic (77%). The average age was 45 years (range: 23 to 57 years) and the average length of time at the health center was about 5 years (range: 4 months to 15 years). All of the participants reported receiving mental health services for their primary behavioral health problems. Half (50%) had prior experience with behavioral health services. A little over one-third (39%) had been receiving mental health services at the health center for 4–6 months, almost one-third (28%) for 7–12 months, and one-third (33%) for more than 1 year.

Themes that emerged from the focus groups are presented below.

- Satisfaction with MH services. Overall, participants expressed their appreciation and satisfaction with the BH services offered. For example, one participant said, “There are times when we wake up sad or have our ups and downs; we need this program.”
- Awareness of MH services available. Although at one site, participants requested to see a psychologist and/or psychiatrist, at two other sites, participants found out about MH services from their primary care provider or a family member. As an illustration, one participant explained: “It was a coincidence that I found out. I came to see my doctor for my check-up and she asked if I was sick. I don’t know how I looked, but I started talking to her and she told me about these services.”

- Access to BH services. Participants at one site felt they did not have enough time with the psychologist and psychiatrist, which they attributed to insurance coverage restrictions (e.g., Medi-Cal), with one of them stating, “I don't feel like it's enough. I don't know how it is for other insurances, but the insurance that I have, it only allows 20 minutes [with the psychologist] and I don't feel like that's long enough, because right as you start opening up or you start getting comfortable, then all [of a] sudden the time is up.” Participants at the two other sites, many of whom did not have insurance coverage, described having “enough” time with the therapist, who they felt was readily available.
- Communication between providers. Participants at two of the sites described communication between the therapists and psychiatrists and between the therapists and primary care providers as “good.” For example, one participant commented: “When I went to see the psychiatrist, he knew everything. He said [the therapist] told him everything, but [he said], ‘I want you to tell me how you feel right now.’ So I told him and that’s how they gave me the medication. That’s why I say there is good communication between them.” However, according to participants at the third site, there was a “gap in communication” between health care providers, with one participant saying, “I'm like, ‘Well I mean, I talk to you [psychologist] when I don't see him [psychiatrist]...You guys supposed to be on the same level, then he will know what my problem is.’”
- Privacy/confidentiality issues associated with stigma. Although participants at two of the sites liked having one waiting area for medical and BH visits, some commented that they feel uncomfortable when other patients “see” that they are seeing the therapist. As an example, one participant explained, “I think it’s very hard to make the decision to get help for mental health. Like I said before, I didn’t want to come or didn’t want people to see me because they judge you. They ask, ‘Why are you going?’ Or, ‘She’s crazy’...They don’t understand mental health problems until it happens to them.”
- Patient recommendations to improve BH services. Focus group participants made the following recommendations to improve behavioral health services at the health centers.
 - Hire additional BH staff (psychologists, therapists, psychiatrists) to:
 - serve more patients (and adolescents)
 - be available at additional sites
 - support the current therapists
 - provide longer sessions with the psychologist and psychiatrist (e.g., at least 45 minutes)
 - take calls from patients with non-emergency/non-crisis situations
 - provide patients with a choice
 - Offer more information on mental health issues and resources in the community
 - Advertise mental health services (especially if they are free)
 - Offer group therapy and support groups on site
 - Make certain that patients’ utilization of mental health services is kept private/confidential
 - Ensure communication between providers (primary care and BH staff; psychologist and psychiatrist) about patients they have in common

Limitations

It is important to note several limitations when interpreting the findings from the focus groups. The findings were drawn from a small convenience sample (n=18), thus the perspectives and experiences of the participants may not be representative of all patients receiving behavioral health services at the sites who did not participate in the focus groups. In addition, as the focus groups were conducted at the health center where participants were receiving their health care, some may not have felt free to answer questions candidly. However, we assured participants that information that might identify individuals in manuscripts or reports would be kept confidential. Further, the findings provide perspectives from patients, in their own words, at one point in time that may be helpful in efforts to improve the quality and integration of behavioral health services in community health centers.

Discussion

Patient responses raise questions about BH services to be provided in 2014. Several insured patients expressed concerns about limitations on visits and time with their providers that they perceived as being imposed by their insurance. If patients who obtain Medi-Cal in 2014 as a result of the ACA face these same restrictions, this may mean that some patients now on Project Care may ironically have their services curtailed as a result of becoming insured, unless their services continue to be supplemented by Project Care or other funding.

Uninsured patients who are currently being seen for free (presumably through Project Care) are happy with the services they currently receive. However these services are not advertised (seemingly due to resource limitations) and feature visits that are often delivered by providers that cannot bill Medi-Cal.

Determining how to provide sustainable care similar to that provided through Project Care using Medi-Cal funds will be a significant challenge.

Lessons Learned

There is a great need and appreciation for behavioral health services among patients in community health center settings, many of whom may not otherwise have received such care. However, funding and regulations influence multiple aspects of behavioral health services provided in community health centers (e.g., whether, how, how much, by whom such services are provided). In addition, the stigma associated with mental health and substance use disorders is still a concern for many patients, which may affect their use of behavioral health services.

Plans for Year 3 Activities

Patient perspectives on their alcohol and/or drug use and experiences receiving behavioral health care in a community health center

In Year 3 of the ETTA project, UCLA ISAP is planning to conduct a pilot evaluation that involves individual phone interviews, including a 30-day follow-up interview, with a sample of

adult patients who have screened positive at intake for alcohol and/or drug use. Data will be collected on participants' alcohol and drug use and their perceptions of the behavioral health care they received at a selected health center in Kern County.

LOS ANGELES COUNTY

Los Angeles (LA) County is located in Southern California and has the largest population of any county in the nation. Approximately 27% of California's residents (10.4 million residents) live in LA County. Although each of the 88 cities in the county has its own city council, they all contract with the county to provide municipal services (e.g., public health protection, public social services, property assessment, and vital records). It is such a diverse county—with more than 140 cultures and as many as 224 languages—that sometimes providing services to its residents can be challenging. Nevertheless, LA County has many programs to protect, maintain, and improve the health and mental health of its residents. These include providing low-cost and no-cost care at public and private facilities, coordinating the emergency medical services system, working to prevent disease, and protecting against basic threats to public health (lacounty.info).

Several pilot projects have been implemented in Los Angeles County, including the Telepsychiatry Program at the Antelope Valley Rehabilitation Center, the Vivitrol Pilot Projects, and the Dual Diagnosis Capability in Health Care Settings evaluation of a federally qualified health center. Each description below highlights the integration efforts taking place within those programs.

Telepsychiatry at the Antelope Valley Rehabilitation Center (AVRC) in Acton, CA

Background

Since April 2011, UCLA ISAP has partnered with the County of Los Angeles Department of Public Health, Substance Abuse Prevention and Control (SAPC) office to provide telepsychiatry services for inpatient substance use disorder patients admitted to the county-operated Antelope Valley Rehabilitation Center (AVRC) in Acton, CA. Telemedicine is defined as “the practice of health care delivery, diagnosis, consultation, treatment and transfer of medical data and interactive tools using audio, video and/or data communication with a patient at a location remote from the provider” and has been in use for over 20 years. As technological advances rapidly develop, so too has the development and expansion of telemedicine, which encompasses a number of medical disciplines, including telepsychiatry.

Objectives/Methods

The AVRC is located in the high desert of Los Angeles County, where access to psychiatric services is limited due to the remoteness of the facility. Research suggests that 33%–50% of patients in substance use disorder (SUD) rehabilitation programs often have co-morbid psychiatric problems (Drake et al., 2007), yet very few rehabilitation programs (and even fewer rural programs) have onsite psychiatrists (Hilty, 2007). Through this project, UCLA psychiatrists provide services related to SUDs and mental health issues to AVRC patients one day a week using a secure Web-based, mobile telemedicine cart and accompanying software. This system allows the psychiatrist and patient to clearly see and hear each other. Once the psychiatrist meets with the patient, the psychiatrist makes notes that are stored with the patient’s UCLA patient record and copies are sent via a secure line to the medical personnel at the Acton facility for

placement in the patient's AVRC file. Prescriptions are written by the UCLA psychiatrist and filled at a local Acton pharmacy.

UCLA/AVRC Telepsychiatry Protocol

1. Patients are identified by the AVRC psychologist or LCSW, as appropriate, to receive telepsychiatry services.
2. Patients complete telemedicine information sheet, telemedicine consent form, and multi-consortium consent form. AVRC staff faxes via a secure line and mails hard copies to UCLA Neuropsychiatric Hospital.
3. Patient registration is processed and UCLA medical record numbers are issued.
4. Registration information is forwarded via secure line to UCLA psychiatrist.
5. AVRC mails copies of patients' clinical information directly to UCLA psychiatrist.
6. UCLA psychiatrist conducts the session and completes dictations, which are stored with the patients' UCLA patient record.
7. Copies are sent via a secure line to the medical personnel at the Acton facility for placement in the patient's AVRC file.
8. Prescriptions are written by the UCLA psychiatrist and filled at a local Acton pharmacy.

Implementation Outcomes

As of May 30, 2014, 313 telepsychiatry patients have been registered. Most patients have had a number of follow-ups and depending on their needs, some are seen on a weekly basis. Using a low-cost medication formulary, the psychiatrist prescribes psychotropic medications for a number of issues including depression and anxiety. As a result of the low-cost formulary and increased medication management, more patients are now able to incorporate psychotropic medications into their treatment.

This project has resulted in a number of positive outcomes, including a reduced barrier to psychiatric care for patients in remote areas and an increase in efficiency for the AVRC and UCLA systems. There was a 25.3% increase in diagnoses of mental illness. There was a 126.1% increase in the prescribing of medications for mental health issues (Denering, L.L, Crevecoeur-MacPhail, D.A et al. 2013). The increases in diagnoses and prescribed medications for non-Serious and Persistent Mental Illness (SPMI) patients are also noted as a benefit of the continuous care. Other benefits include opportunities for enhanced cultural competency (i.e., increased interaction with traditionally underserved ethnic groups) and inter-and intra-agency collaboration. A satisfaction survey was conducted that demonstrated that this project has been well-received by participants, and feedback from UCLA staff and AVRC staff has also been positive.

Lessons Learned

The telepsychiatry project increased access to mental health services and medications for patients in an underserved area. Patients and staff have reported positive feedback on the use of telepsychiatry. This innovative project demonstrates a successful collaboration between two Los

Angeles County agencies (Public Health and Health Services) and UCLA ISAP. It is testament to the benefits of integrated care, which has become increasingly important as the field of substance use disorder treatment continues to move toward a chronic care model.

Los Angeles County Vivitrol Pilot Projects (Phase I and II)

Background

Vivitrol is the injectable form of naltrexone, an opioid receptor antagonist that acts by blocking the mu-opioid receptors in the brain. These receptors are responsible for the “high” or “buzz” individuals feel when alcohol is consumed. When the receptors are blocked, the high or buzz is no longer achievable and cravings for alcohol are reduced significantly. The results from a pilot project in Los Angeles County to administer Vivitrol in three large, publicly funded treatment organizations in Los Angeles County will be discussed as well as a follow-up study.

Objectives/Methods

In 2010–2011, the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (SAPC), in collaboration with UCLA ISAP, conducted an outcome evaluation on the implementation of Vivitrol in three county-funded treatment centers (Vivitrol Phase I). The aims of the outcome evaluation were to determine changes in patient outcomes and counselor attitudes. To do so, three agencies were selected to administer Vivitrol. Data collected included the Urge to Drink Scale, the Medication Assisted Treatment Survey, a survey developed by UCLA ISAP to measure counselor attitudes, and the Los Angeles County Participant Reporting System (LACPRS) admission and discharge questions.

Implementation Outcomes

Results indicate that approximately 60% of patients were given a second injection. The outcome evaluation determined that the patients’ urges to drink and drinking behaviors were reduced, with limited side effects from the medication (Vivitrol Final Report, 2011). Specifically, urges to drink decreased from an average score of 19.3 to 6.6 (out of a total of 30). Vivitrol patients also demonstrated reduced use of their primary substance, better treatment engagement, and higher completion rates compared to the average county patient. In addition, results indicated that in-service trainings improved staff attitudes regarding the use of medication-assisted treatments. Conclusions from this initial pilot project suggest that counselor education and support appear to be important in the effort to help patients remain on Vivitrol for second and subsequent doses. The decreases in urges to drink may also have an impact on patient outcomes, in that patients who remain on the medication are also more likely to remain in treatment.

Vivitrol Phase II

Given the success of the first pilot project, SAPC, again in collaboration with UCLA ISAP, sought to examine how patients' cessation of Vivitrol impacts patient cravings and outcomes. In late February 2012, the Los Angeles County Evaluation System (LACES) began the Vivitrol Phase II project, a follow-up study of the original project. The Phase II follow-up period for Vivitrol patients was from February 2012 to February 2013. This brief follow-up study examined whether patients can maintain their sobriety once they are no longer receiving Vivitrol injections. Consistent with Phase I, the project collected data on medication-assisted treatment (to ascertain side effects, days used, etc.) and the urge to drink/use (to ascertain cravings). In addition, patient outcomes were also examined as that data became available.

Preliminary results suggest that patients who have taken at least one dose of Vivitrol report clinically significant decreases in the urge to drink alcohol or use opioids. Results appear to suggest that patients' urge to drink/use remain within a clinically safe range (scoring below 10; reflecting little danger of relapse) 30- and 60-days after their final injection of Vivitrol. The decrease in urge to drink/use may indicate a continued reduction in urge to drink/use, or at least a significant delay in a return of urges after the medication is no longer administered. Additionally, preliminary analysis suggests that Vivitrol may decrease the number of days using alcohol and/or opioids. Patients also seem to have reduced their days of use to intoxication, which is clinically significant. It also appears that the patients are able to maintain the reduction in days used or intoxicated after the medication is no longer administered. Future analysis will examine if these findings are statistically significant. Analyses of the follow-up group demonstrated that urges to drink/use did not increase significantly once the medication was ceased. Predictor analyses indicate that the use of the medication is a significant predictor of treatment engagement, retention, and completion. About a third of all patients experienced side effects (e.g., headache, nausea, fatigue) after receiving an injection. An overall trend appears to suggest that side effects lessen after the initial injection.

It must be noted that this study is an evaluation study and not a clinical trial. Random assignment was not used to determine whether a patient would receive the Vivitrol medication or a placebo. Thus, one of the shortcomings of the current pilot is that no causal conclusions can be made and it must be considered that the results could have occurred without the medication.

Lessons Learned

The Vivitrol Pilot Projects (Phase I and Phase II) have demonstrated the potential benefits of medication-assisted treatment (MAT). MAT, although a recognized evidenced-based practice, is still new to many SUD treatment providers. Many have limited knowledge of the new medications available that may be used to help patients better handle withdrawal and cravings, and help to reduce the likelihood of relapse. Counselors should be given opportunities to gain the education and skills they need to address their concerns as well as the concerns of their patients. This, in addition to other barriers to MAT, such as cost and availability of prescribing medical staff, must be addressed given the improvements to health care with HCR and parity.

Plans for Year 3 Activities

The above pilot projects will continue, funded by SAPC through UCLA ISAP's LACES contract. The ETTA project staff will continue to follow the progress and findings of these projects in order to obtain lessons learned, which will be disseminated to state and county administrators.

In Year 3 of the ETTA project, UCLA ISAP is planning to conduct a pilot evaluation to obtain adult patients' perspectives on the behavioral health care they have received in a primary care setting. UCLA ISAP will conduct one focus group (semi-structured group interview) with patient volunteers who have received behavioral health services at a selected community health center site in Los Angeles County that has initiated integration efforts. Patients' recommendations to improve the integration of behavioral health services will also be solicited.

SAN LUIS OBISPO COUNTY

Background

San Luis Obispo County is located along the Central Coast of California. Most of the county's 3,326 square miles are unincorporated. The majority of residents live along the coast or the corridor of Highway 101. The eastern region is sparsely populated, with vast areas of agricultural and government lands between small, unincorporated towns.

The Central Coast Behavioral Health Policy and Education Committee (CCBHPEC), which was formed in 2012 to work collaboratively to increase access to behavioral health services in San Luis Obispo (SLO) County in preparation for ACA provisions effective as of 2014, represents private, public, and non-profit professionals. The CCBHPEC requested technical assistance from UCLA ISAP to help it reach its goals.

The setting for the pilot evaluation comprised community providers, including North County Connection, Community Health Centers of the Central Coast, French Hospital Medical Center, CenCal Health, Department of Social Services, Independent Resource Center, and the San Luis Obispo County Drug and Alcohol Services.

The providers in the north county community appeared to be at the early stages of integration and development of a community-based system of care for behavioral health in SLO County. Thus, this pilot study could potentially serve as a model for other counties at a similar stage of integration that are seeking to achieve comparable goals.

Objectives/Methods

The goal of this project was to provide data and guidance to assist the SLO County CCBHPEC in developing its community-based behavioral health continuum of care in preparation for 2014. The specific project objectives developed in conjunction with the CCBHPEC were to:

- Conduct administrative data (e.g., Uniform Data System) analysis to assist the County in its efforts to: (1) identify gaps in data collection/tracking, (2) establish a baseline to monitor progress, (3) demonstrate areas of need for behavioral health services and obtain buy-in from stakeholders for addressing such needs, and (4) provide data that can be used in preparing grant proposals.
- Survey physical health care and behavioral health service providers (e.g., emergency room physicians, behavioral health specialists, community health center primary care providers) to obtain a "snapshot" of behavioral health services integration with physical health care.
- Measure the integration of mental health and substance use disorder services with primary care in three community health centers to provide a baseline to help identify areas in which integrated services could be improved.

- Provide trainings on motivational interviewing, screening, brief intervention and referral to treatment (SBIRT), and, potentially, other topics if needed.

Implementation Outcomes

Administrative data analysis

The potential administrative data sources that were identified included Dignity Health, Tenet, Department of Public Health, CenCal, Department of Health, California Outcomes Monitoring System (CalOMS), Office of Statewide Health Planning and Development (OSHPD), and Uniform Data System (UDS). UCLA ISAP prepared a data “wish-list” for requesting the data (see *Appendix 2.2*). Other than the CalOMS and UDS data that UCLA ISAP had access to, no other administrative data were available to be analyzed at the time of this report. Below are the results.

UDS Data

UDS data provides a snapshot of SUD diagnoses and treatment within SLO County’s community health centers (CHCs). This is a particularly important setting to identify SUDs because primary care reaches a large proportion of the population on an annual basis. As an example, data (only in aggregate form) were available for one of the large health care organizations in the county. The data below describes all 20 sites in the 2012 UDS database, 12 of which were located in SLO County. The other eight sites were located in neighboring Santa Barbara County.

In 2012, the CHCs saw patients with the following diagnoses:

Alcohol related disorders (visits)	1,192
Alcohol related disorders (patients)	590
Other substance related disorders excl. tobacco (visits)	2,099
Other substance related disorders excl. tobacco (patients)	1,000

It is worth noting that each of these patients averaged only about two visits each ($1,192/590 = 2.0$, $2,099/1,000 = 2.1$). Nationally, the average for these diagnoses is 3.5 visits per patient for alcohol and 5.0 visits per patient for other substances. This suggests that behavioral health resources and capacity to engage and treat patients with SUDs may be relatively limited within CHC.

California Outcomes Measurement System, Treatment (CalOMS-Tx) Data

Data was also available on patients that entered the publicly funded SUD specialty care system in SLO County. These are programs in the community (typically not part of health centers discussed above) specifically dedicated to the treatment of SUDs.

In fiscal year 2011–2012 (July 1, 2011–June 30, 2012), there were 1,492 admissions to specialty care.

Primary Drug (% of admissions)

Marijuana/hashish and methamphetamine were the most common primary drugs used at admission according to CalOMS categorization. However, if all opiate categories are combined, including heroin, oxycodone/oxycontin, other opiates and opiate synthetics, then opiates are the most common primary drug, accounting for nearly one third (32%) of admissions.

- 25% Marijuana/Hashish
- 24% Methamphetamine
- 20% Heroin
- 12% Other opiates/synthetics, including Oxycodone/Oxycontin
- 16% Alcohol
- 3% Other

Providers

Only five providers in the county in FY11/12 submitted CalOMS records. Most services (70%) were provided by County Drug and Alcohol Services. However, 19% were delivered by Aegis Medical Systems, and 12% were provided by the SLO County Office of Education.

- 33% San Luis Obispo County Drug and Alcohol Services, San Luis Obispo
- 19% Aegis Medical Systems, Inc., Atascadero
- 12% San Luis Obispo County Office of Education, Sober Community School
- 14% San Luis Obispo County Drug and Alcohol Services, Grover Beach
- 23% San Luis Obispo County Drug and Alcohol Services, Atascadero

Services

Most services were outpatient drug-free, followed by methadone maintenance and narcotic treatment program (methadone) detoxification. No inpatient/residential services were recorded.

- 71% Outpatient drug-free
- 14% Methadone maintenance
- 9% Narcotic treatment program detoxification
- 6% Intensive Outpatient

Referral Source

The most common source of referral resulting in treatment services was the criminal justice system. Individual referrals, including self-referrals, were next. Notably, less than 1% of referrals came from health care providers, suggesting a deep disconnect between the health and specialty SUD systems.

- 43% Court/criminal justice
- 40% Individual, including self referral (may be mis-coded in some cases)
- 9% Dependency court
- 2% Drug Court
- 2% School/Educational
- <1% Health Care Provider (8 people)
- 4% Other

Characteristics of clients who reached treatment as a result of an individual/self-referral might reflect the types of clients who may increasingly seek services in the future as a result of the Medi-Cal expansion and “enhanced” SUD benefits available under Drug Medi-Cal. Among these patients, the top drugs used were heroin (36%), other opiates (including synthetics, oxycontin, oxycodone) (18%), and marijuana/hashish (25%). They most commonly seek outpatient drug-free care (44%), methadone maintenance (32%), and narcotic treatment program detoxification (21%).

Stakeholder Survey – Behavioral Health Needs Assessment Survey

A web-based Behavioral Health Needs Assessment survey was developed by the UCLA ISAP-SLO County team to obtain a “snapshot” of behavioral health services integration with primary care and assess the need for behavioral health services in SLO County.

Methods

The survey was developed in collaboration with team members and administered by UCLA ISAP using SurveyMonkey, an online survey tool (see *Appendix 2.3*). The survey took approximately 15 minutes to complete and participants were given the opportunity to enter a drawing for a \$50 gift card after completing the survey.

Team members from SLO County identified relevant stakeholder groups providing care to adult patients (e.g., clinical psychologists, physicians, social workers, and marriage and family therapists). However, the only email addresses that were accessible during December 2013 and January 2014 were that of 82 psychologists on the Central Coast Psychological Association listserv, 10 occupational or physical therapists, and 1 MFT. Participants were initially given 2 weeks to complete the survey; however the date was extended and several follow-up email reminders were sent to potential participants. Twenty-three individuals (about 25%) responded to the survey.

Descriptive analyses were conducted to characterize the nature of the current delivery of behavioral health services, use of current behavioral health referral resources in the community, and community-based behavioral health service needs. The study findings are based on a convenience sample of 21 respondents. (As two of the participants served pediatric populations, their responses were not included in the analysis.)

Although the findings are not meant to be representative of all physical and behavioral health providers in SLO County, they provide the perspectives of a group of professionals who deliver such care to patients who have MH disorders and/or SUDs. Thus, their perspectives and recommendations may shed light on areas where behavioral health service needs exist in SLO County.

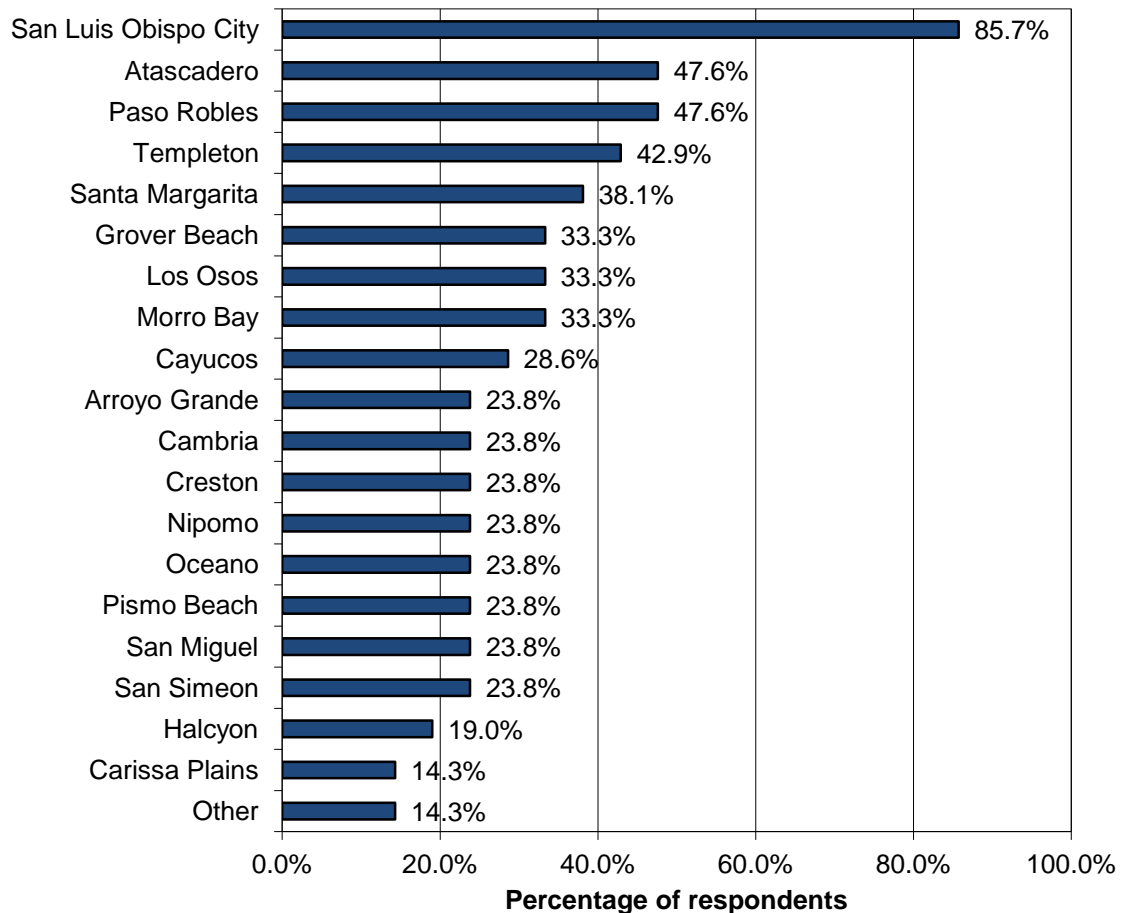
Survey Findings

Survey Participants

The majority (76.2%) of the sample (n=21) were licensed psychologists, followed by physical therapists/occupational therapists (14.3%), a marriage and family therapist (4.8%), and a psychological assistant (4.8%). The average number of years respondents reported working in their respective fields was 14.3 years (standard deviation=9.6 years; range: 3-30 years). More than half of respondents reported working in group or self practices (61.9%), with approximately one-third in government (38.1%), and one-third in private organizations (33.3%). The respondents served communities county-wide, with the majority serving San Luis Obispo City (85.7%), and almost half serving the Atascadero (47.6%) and Paso Robles (47.6%) areas (see Figure 2.2).

Survey respondents reported the average number of patients seen in a given month as 43.8 (standard deviation= 31.5; range: 1.5-105). On average, respondents recognized or suspected 18.1 of their patients as having co-occurring MH disorders and SUDs (standard deviation= 22.7; range: 0-65 based on 14 responses), 25.5 as having an MH problem/issue only (standard deviation=31.4; range: 0-100 based on 16 respondents), and 3.6 as having an SUD only (standard deviation=5.4; range: 0-20 based on 15 responses).

Figure 2.2: Geographic areas served. [Q4]



Screening

- *The majority of respondents' organizations routinely screen for mental health and substance use.*

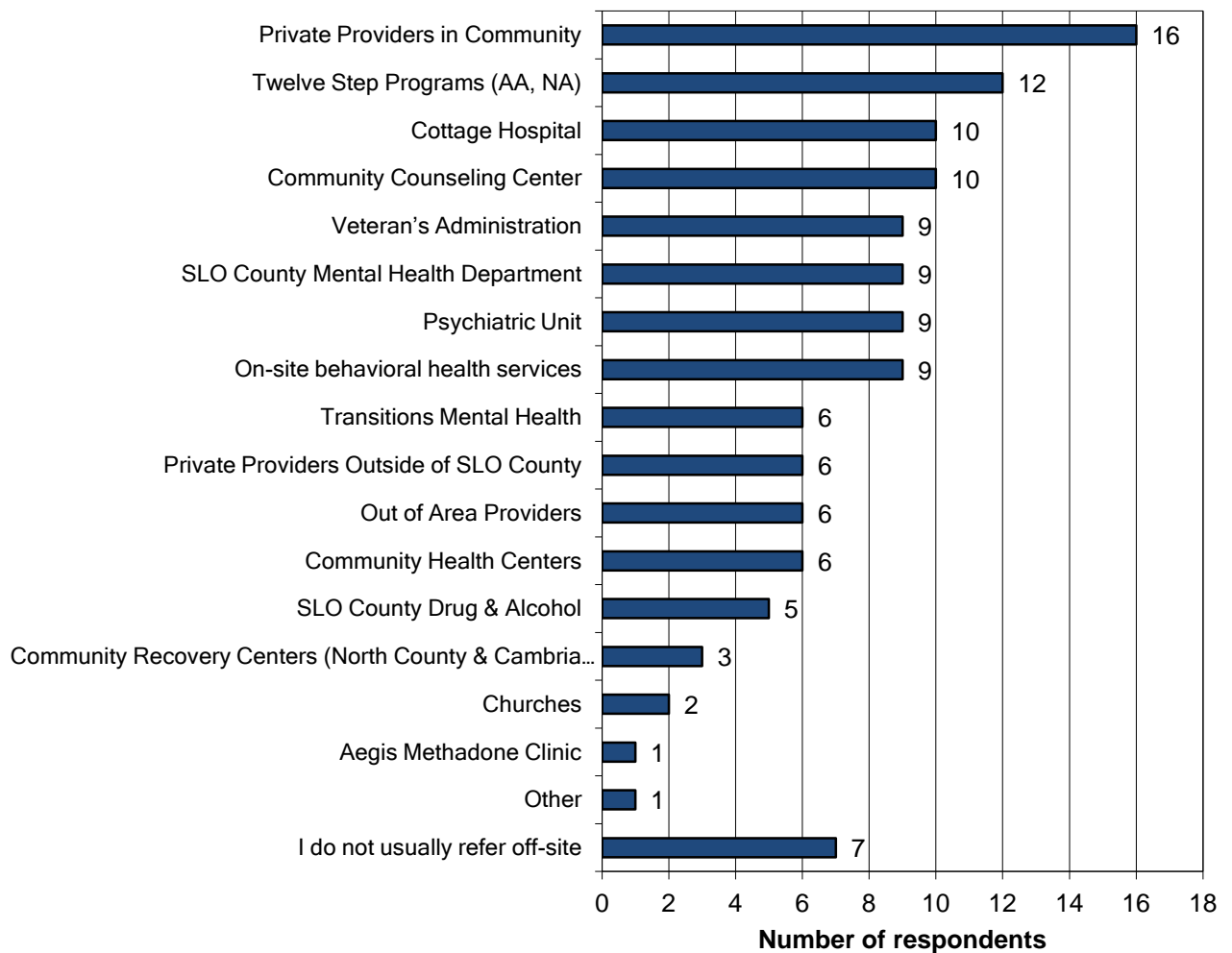
The majority of the participants' organizations routinely screen patients for MH disorders (61.1%) and substance use (55.6%), and most of them (72%) routinely ask patients verbally about their MH or substance use without using a formal screening instrument. Only one respondent reported that her/his organization did not routinely screen.

Referrals for Behavioral Health Services

- *Respondents typically refer their patients off-site to a wide variety of places for behavioral health services based on diagnosis.*

While survey respondents indicated that they refer their patients to a number of places for behavioral health services (see Figure 2.3), they referred patients most often (n=16) to private providers in the community, followed by twelve-step programs (n=12), mostly for SUDs.

Figure 2.3: Referrals for behavioral health services, type of program [Q8]



Few respondents reported referring patients to Aegis Methadone Clinic, churches or Community Recovery Centers. Five (5) respondents reported referring patients to SLO County Drug & Alcohol, mostly for SUDs and co-occurring MH disorders and SUDs, whereas 9 reported referring patients to the SLO County Mental Health Department, typically for MH and co-occurring disorders.

- ***Once patients are referred offsite for behavioral health services, respondents are generally unaware of how long it typically takes for patients/clients to receive services.***

The majority of the respondents who referred off-site to each of the agencies for behavioral health services, except private providers in the community and the psychiatric unit, reported being unaware of how long it typically takes for patients to receive services after being referred (see Figure 2.4). More than 50% indicated that when they refer patients off site to Aegis Methadone Clinic, the Veterans Administration, churches, the SLO County Mental Health Department, private providers outside of SLO County, out-of-area providers, community health centers, SLO County Drug & Alcohol Department, community counseling centers, Transitions Mental Health, Cottage Hospital, Twelve-Step Programs, or other programs. They did not know how long it typically takes for their patients to receive services; however, the average length of time reported was typically within 30 days for patients referred to on-site behavioral health services (73%), the psychiatric unit (58%), and private providers in the community (57%).

- ***There are multiple reasons why patients are not referred off-site for SUD services, such as not knowing where to refer them, whereas there appears to be adequate MH services on-site and thus less need to refer patients off-site.***

Figure 2.5 shows reasons that respondents reported for not typically referring patients off-site for either MH or SUD services.

When respondents who do not typically refer patients off-site for *SUD services* (n=11) were asked why they did not do so, their reasons included: they are not sure where to refer patients (n=3), they have adequate SUD services on-site (n=2), SUD services are not readily available in the community (n=2), patients cannot afford them (n=2), and patients are not interested in these services (n=1). Among the five that checked “other,” respondents specified: “clients are often resistant and in denial”; “I don’t have clients with these issues”; “forensic hospitalization or incarceration”; and “Oftentimes, it is not my role as the forensic evaluator to do a direct referral...”).

According to the respondents who indicated that they do not normally refer patients off-site for *MH services* (n=11), the reasons they do not do so included: they have adequate MH services on-site (n=7); patients cannot afford them (n=2); they are not sure where to refer patients (n=2); MH services are not readily available in the community (n=1); and patients are not interested in these services (n=1). Among the respondents who indicated “other” reasons (n=3), a few wrote in: “I typically refer to only other private practice providers or on occasion, the Community Counseling Center. Otherwise, even MH services are extremely limited and I do not necessarily trust the quality of the care”; and “forensic hospitalization or incarceration”.

Figure 2.4: Referrals for behavioral health services, length of wait time. [Q9]

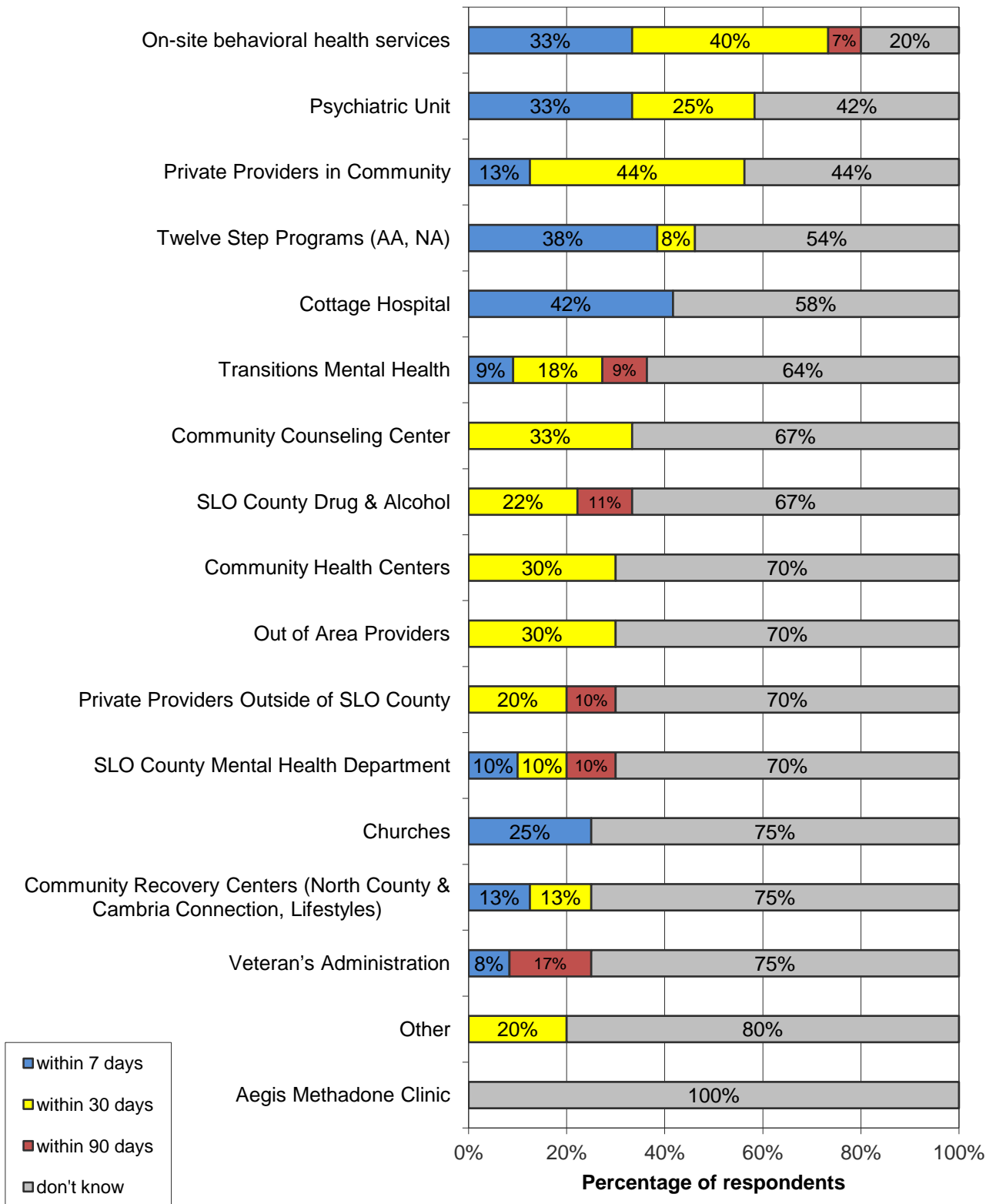
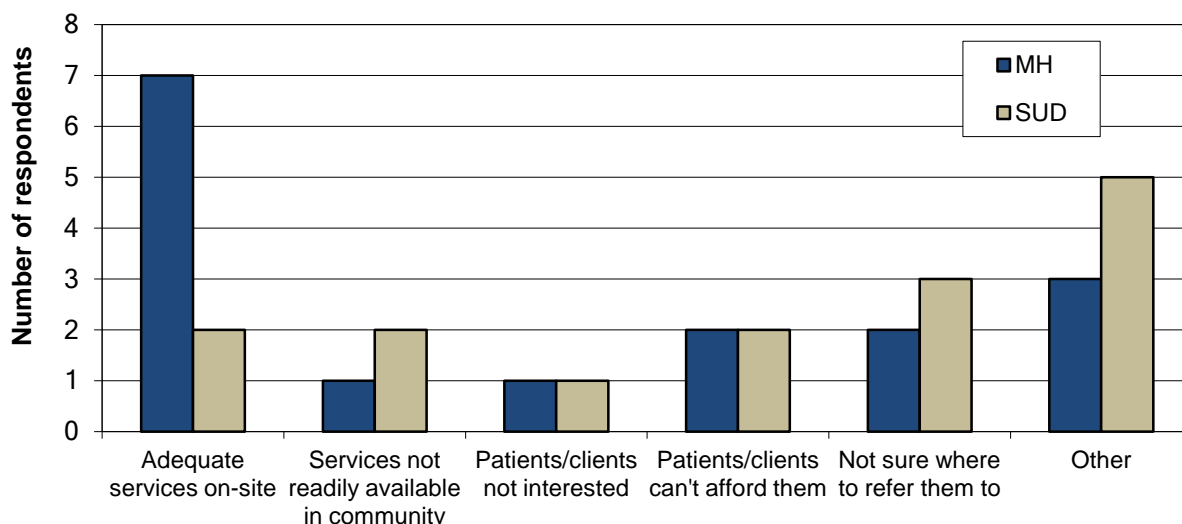


Figure 2.5: Reasons for not referring patients/clients for off-site MH or SUD services. [Q10 and Q12]



Behavioral Health Services

- *Survey respondents cited a need for inpatient/residential services and services that would be affordable for low income clients.*

When asked to recommend additional or expanded services to help address their patients/clients' MH and SUD needs, 11 respondents focused on: insurance and affordability issues; inpatient MH services; detoxification services; residential SUD and co-occurring MH and SUD services; hospital MH day treatment; sober living facilities; group therapy; and services to treat sex addiction. The two most common themes were:

1. Need for inpatient/residential/detox services (6 respondents).
2. Need for affordable/low income/low fee services (4 respondents).

Individual responses are provided below:

- “Insurance also needs to accept the reality of this situation (that many persons have dual diagnosis conditions) without being pejorative to the clients.”
- “More outpatient group treatments that are affordable or that accept insurance.”
- “More affordable options”
- “In-patient services for acutely mentally ill children”
- “Increased local inpatient options for MH, substance abuse, and co-occurring. Increased low fee options.”
- “Residential facilities for dual diagnosis clients (e.g., board and care), partial hospitalization or day.”

- “More on-site counseling for inpatient services”
- “Anything and everything, given the very limited services that are currently provided in this community. There is currently no inpatient or partial inpatient program for MH services in our county. There is also no detox services readily available or rehab facilities in our county despite the substance use that occurs within this county.”
- “Local Detox...not jail...for low income. Local Voluntary inpatient. Hospital Mental Health Day Treatment program for low income. Local residential program for 90 days for all income[s]. Local sober living facilities....the ones we have are full”
- “A group therapy for alcohol abuse and one for substance abuse that I could refer to on an on-going basis in addition to their current sessions.”
- “Sexual addiction groups and treatment”

Access to Behavioral Health Services

Respondents’ recommendations to improve access to behavioral health services for their patients were diverse (e.g., communication and collaboration among various entities, the referral process, stigma, community education, transportation services, “gateway” recovery services, affordable services).

When asked what they thought needs to be done to improve access to behavioral health services for their patients, nine participants responded with the following recommendations:

- “More open communication between MH services and private providers in the community”
- “Better communication among various local agencies.”
- “INTEGRATED CARE. Agencies here DO NOT work collaboratively.”
- “Knowledge of where and times such group therapies are available if they exist. Also, a list of all organizations serving such population as alcohol and substance abuse. These organizations need to add all psychologists, LMFCs, etc. to their email list.”
- “Easier referral process”
- “Community education and stigma reduction. Transportation services. One-stop shop services (i.e., mental health, substance use, psychiatric, general wellness such as exercise or yoga)”
- “Gateway treatment, intervention and groups to get people started in their recovery. Too many people are stigmatized by the shame of addiction to seek outside intervention.”
- “I believe that there needs to be a humanistic attitude to dual diagnosis clients and one that is client centered”
- “Services for low income and those that have high deductible insurance”

Training and Information Needs

- *There is a need for information on local behavioral health resources available in the County.*

Among the 9 respondents who answered the question regarding which topics they would like to receive more information about, the majority (78%) indicated they would like information on local resources available in the county, 44% on medication-assisted treatment, 44% on insurance parity and billing for behavioral health services, 22% on motivational interviewing, and 22% on screening, brief intervention and referral to treatment.

Survey Limitations

The data analyzed were from a small convenience sample of professionals who provide health and/or behavioral health care to adult patient populations in SLO County. The findings are not meant to be representative of all clinical psychologists, marriage and family therapists, and occupational and physical therapists or other professional groups that were not surveyed (e.g., physicians, licensed clinical social workers). However, the findings highlight areas that stakeholder groups in the county may want to explore further.

Summary

- There is a need for more behavioral health services in the community for referrals, especially inpatient MH, residential services for SUDs, and detoxification.
- There is a need for information about behavioral health services available in the community as well as the referral process.
- There is a need for better communication and collaboration among entities in the county around behavioral health services.
- More affordable service options for low-income patients and more services that accept insurance are needed.

Dual Diagnosis Capability in Healthcare Settings (DDCHCS)

UCLA ISAP conducted assessments using the Dual Diagnosis Capability in Health Care Settings (DDCHCS) Index (Version 3.0), a standardized integration tool, at three community health center (CHC) sites (Cambria, Lompoc, Nipomo) in one health care organization during August 20–22, 2013. The purpose of the site visits was to assist the organization in better understanding the extent to which it is providing integrated behavioral health (BH) services (MH care and SUD treatment) for its primary health care patient population.

Methods

The DDCHCS index is designed to assess the extent to which primary care, MH, and SUD services are integrated within health care settings and to help identify areas in which integration can be improved. Administration of the DDCHCS involves an in-person site visit, observation of the clinic milieu and physical setting, interviews with key staff members and patients, and document review (e.g., medical records, program manuals). The health center receives ratings on seven dimensions: program structure; program milieu; clinical process – assessment; clinical

process – treatment; continuity of care; staff; and training. Each dimension is assessed individually and given a score between: 1 (Healthcare Only Services; HCOS), 3 (Dual Diagnosis Capable; DDC), and 5 (Dual Diagnosis Enhanced; DDE); an overall score is also calculated. The higher the score, the more integrated are the primary care, MH and SUD services.

Summary of Findings

Figure 2.6: DDCHCS site summary scores, by dimension.

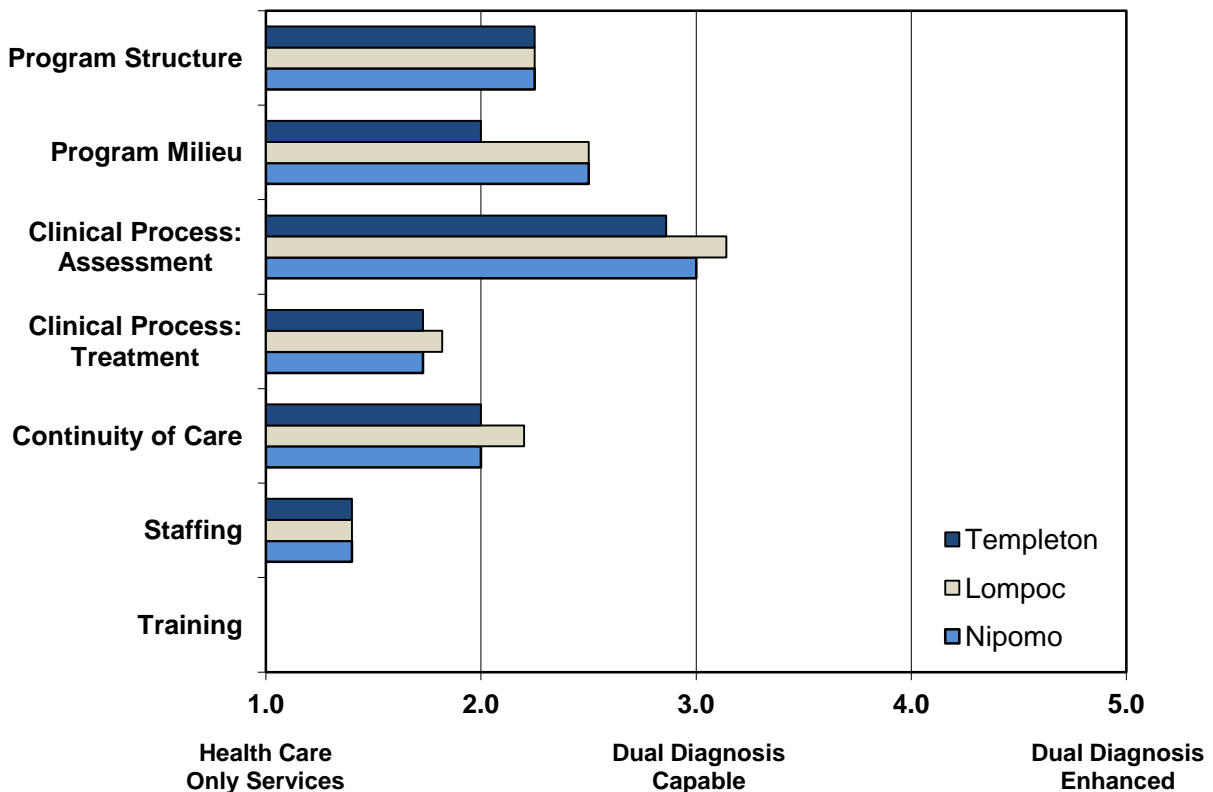


Figure 2.6 summarizes scores from the three CHC sites.

Health center staff members expect to encounter patients with SUDs, MH issues, and co-occurring disorders. Although some staff members expressed some hesitancy, they are amenable to providing services to these patients. The three sites’ overall DDCHCS score of 1.97 (Health Care Only Services) suggests that the organization currently provides services primarily for patients with physical health needs, but currently also provides MH services.

The Lompoc site received a higher DDCHCS score than the other two sites because of the slightly higher ratings in the Clinical Process–Assessment, and Clinical Process– Treatment domains. Although the Templeton and Nipomo sites have similar overall ratings, Nipomo scored a little higher in the Program Milieu and Clinical Process–Assessment domains. It might be important to note that both the Templeton and Nipomo sites are located in SLO County, while

the Lompoc site is in Santa Barbara County; and the Lompoc and Nipomo sites are currently working toward becoming patient-centered medical homes.

The domain in which all three sites scored the highest was Clinical Process–Assessment (DDC or nearly DDC), and the domains where improvements would help the health care organization move toward DDC were in Training and Staffing (both HCOS).

There is evidence that the health care organization is moving toward co-occurring capable services, and changes and improvements in certain areas detailed in the DDCHCS report, which was given to the Director of Mental Health and subsequently shared with the Assistant Medical Director, would significantly help to improve the overall integration of services at the CHC sites. It is important to acknowledge that true challenges exist to implementing full integration of BH services at these sites, including systemic issues beyond any one particular organization’s control, such as barriers in billing for MH and SUD treatment and workforce availability.

Training

As part of the technical assistance requested by SLO County, UCLA ISAP provided two full-day training sessions.

- Introduction to Motivational Interviewing (February 20, 2013, 71 participants)
- Screening, Brief Intervention, and Referral to Treatment (April 26, 2013, 38 participants)

Lessons Learned

Both the data analyses and survey responses suggest a need for residential / outpatient services. There also appears to be a need for affordable services. These findings indicate a need for an expansion of Drug Medi-Cal certified residential options. At this writing, DHCS is working with the Centers for Medicare and Medicaid services (CMS) to provide a Drug Medi-Cal benefit for these services. Given the typically long periods required to locate and certify these services, SLO County should initiate the Drug Medi-Cal certification process in advance. For persons who became newly eligible for Medi-Cal under the Affordable Care Act, the Federal Government will cover the match requirement for the first three years, and the state will cover it beyond that, making Drug Medi-Cal-covered residential treatment a low cost option (counties will still need to pay the matching requirement for the Medi-Cal population that existed before 2014).

Several members of the Central Coast Behavioral Health Policy and Education Committee (CCBHPEC) have expressed to UCLA ISAP that the overarching goal of the project, which was to raise awareness of behavioral health services in SLO County, was achieved. Leadership and communication and collaboration between entities in the county and with the state will be critical to increasing behavioral health services and access to such services to serve the needs of SLO County communities.

The pilot evaluation project in the north county community of SLO County assessed and documented behavioral health services that were currently being provided, the extent of the integration of such services in primary care settings, unmet needs for behavioral health services, and referrals for community-based behavioral health services. The model developed for SLO

County for a community-based continuum of care could potentially be implemented county-wide and perhaps in other counties across the state that are at the early stages of integration to effectively and efficiently streamline and accelerate the process. Another lesson learned is that buy-in and commitment from the top levels of the stakeholder organizations/agencies involved (e.g., Chief Medical Director, Chief Executive Officer, County administrators) are essential for a project of this nature, given competing priorities and the time and effort required for the collaboration necessary to develop a community-based behavioral health continuum of care. Engagement and commitment from stakeholders at the ground- and mid-levels are necessary, but may not be sufficient if integrated care is not deemed a priority at the organizational/agency levels.

IV. Conclusion

C. Chapter Summary and Recommendations

Integration in the fields of SUD, MH, and physical health care has continued to develop throughout the past year. State agencies, providers, and other stakeholders in the integration of care for MH disorders and SUDs face continued challenges related to financing and reimbursement for services, determining ways to organize services to support integrated care, building the HIT infrastructure necessary to exchange information for care coordination, and developing an adequate and well-trained workforce ready to deliver culturally competent and comprehensive care.

In addition, California continues to be at the forefront on many issues, yet has significant regulatory and reimbursement barriers to continue to navigate through. Integrating behavioral health services into the primary health care system is complex and requires solutions to issues at the state, county, and provider levels. Many lessons can be learned from county- and provider-level pilot projects, but long-term integration of health care service delivery can only occur when the system at large can facilitate cohesion between service delivery policies, regulations, and funding. The state has recently taken a step in this direction with the recent release of the draft Drug Medi-Cal Waiver Special Terms and Conditions (DHCS, 2014b), which contains language aimed at facilitating integration. Progress has been made this past year, but there is more work to do, requiring ongoing training and technical assistance at all levels. Based on the information garnered over the past year, below are recommendations to further the progress of creating an integrated service delivery system in California.

State Level Recommendations

1. Examine how models such as the Accountable Care Organization (ACO) and Coordinated Care Organization (CCOs) might inform future development of integrated delivery models in California.
 - To further facilitate integration and coordination of care among primary care, SUD, and MH providers, supportive financial reimbursement and structural incentives are required. Data from ACO and CCO demonstration pilots in other states suggest these models can be effective for financing integrated services, and may inform the future development of more integrated delivery models in California.
2. Evaluate how reimbursement for SBIRT is affecting access to services and treatment for individuals with SUDs and MH disorders.
 - Lack of financial reimbursement for SBIRT has historically limited the extent to which appropriate screening, intervention, and referral to treatment (SBIRT) has been provided for individuals with SUDs and MH disorders in primary care. The recent addition of SBIRT as a covered benefit under Medi-Cal has the potential to increase the number of individuals receiving needed care for behavioral health.

3. Explore practical and cost-effective methods for increasing behavioral health integration into the patient-centered medical home (PCMH) model, while emphasizing the importance of behavioral health to the mission and values of patient-centered care.
 - While PCMHs demonstrate great potential in providing coordinated care for individuals with complex health needs, behavioral health is not a required component of the PCMH model. Value-based components have been proposed for integrating behavioral health into the PCMH, which can provide benefits even in resource-limited primary care settings.
4. Investigate existing behavioral health home initiatives in other states and consider implementing the health-homes option provided through Section 2703 of the ACA.
 - Health homes can provide enhanced care coordination for individuals with complex behavioral health needs, but changes in state regulation are needed to support the development of this promising model. The state should capitalize on opportunities provided by Section 2703 that specifically address integrated behavioral health care within the health home.
5. Direct resources toward training and implementation of evidence-based practices (EBPs), while continuing to monitor fidelity and effectiveness among different settings and populations.
 - Broader adoption of EBPs has the potential to greatly improve care for SUDs and MH disorders. Additional training and technical assistance is needed to support dissemination and implementation of effective practices.
6. Continue efforts to build the California Behavioral Health workforce.
 - Workforce development will continue to be critical as ACA implementation continues. Training and technical assistance ideas include: (1) identifying the training needed to help SUD/MH staff become effective in primary care, (2) make distinctions between specialty care needs and MH/SUD generalist skills, and (3) identify SUD personnel who want to learn new skills to work in primary care and provide them with training.
7. Direct resources to further develop content areas for the future Behavioral Health workforce curriculum.
 - Recommended content areas include: (1) providing behavioral health care in a primary care setting: culture, needs and interdisciplinary collaboration, (2) screening, brief intervention, and referral for substance use, mental health and medical diseases, (3) understanding chronic medical diseases, basic physiology, terminology and treatment strategies, (4) understanding common mental health disorders—identification and intervention, (5) medical interventions for substance use, physiology of drugs of abuse and medication assisted treatment, and (6) care management of patients in a multi-service setting.

8. Provide funding and technical assistance to providers to support the development of telehealth infrastructure for behavioral health integration.
 - Access to services is an important issue in rural and underserved areas throughout the state. Given existing barriers, telehealth is a viable option to increase integration and expand access to counseling, consultation, and medications for SUDs and MH disorders.
9. Advocate for increased funding (e.g., through grants and/or greater inclusion of behavioral health in federal meaningful use incentives) and provide technical assistance to providers to support the development of behavioral-health-specific health information technologies (HIT) policies and infrastructure.
 - Behavioral health providers often face special challenges to adopting EHRs and collecting and sharing patient information through HIEs. Funding and technical assistance such as that provided by the SAMHSA-HRSA CIHS can make a difference in the success of behavioral health-specific and integrated HIT initiatives.
10. Examine barriers posed by 42 CFR Part 2 and provide input to SAMHSA to help guide revision of the regulations to better support integration while continuing to protect individual privacy and confidentiality.
 - 42 CFR Part 2 is meant to provide stricter confidentiality protections for patients' and clients' SUD-related information; however, many providers support revising the regulations to reflect new technological capabilities and the need to share information for care coordination. SAMHSA has been soliciting input on these issues.
11. Provide training and technical assistance to support the implementation of team-based care models and the development of staff competencies for integrated behavioral health. Explore options for certification and reimbursement of MH and SUD peer-support specialists.
 - Development and support of the workforce that will be delivering integrated care requires attention to (1) staffing and designing teams, (2) developing competencies for integrated care through training, and (3) engaging patients and peer support specialists to be involved in managing the process of care in a patient-centered manner.

County- and Provider-Level Recommendations

1. Obtain buy-in and commitment from organizational leadership to support integration.
 - Ensuring that the senior leadership of all participating organizations is actively engaged and supportive is critical for success. Leaders must establish integration as a priority, work to clear existing barriers, and create a culture that is conducive to integration.

2. Obtain buy-in from staff at all levels of the organization throughout the implementation process.
 - Staff are directly responsible for the day-to-day work of implementing integration; therefore, it is essential to understand their needs and solicit input on any new processes and procedures. Provide education and training to prepare staff and use frequent encouragement and outreach throughout the process.
3. Ensure continuing communication between providers and help them understand each other's respective roles.
 - Primary care and behavioral health providers should have ongoing meetings, both formal and informal, to consult and communicate about shared patients. Relationships must be built through regular contact and communication (e.g., electronic, face-to-face, or written).
4. Reach out to other local agencies and provider organizations to create partnerships and deliver better coordinated and integrated care at the local community level.
 - Collaboration and networking between local agencies and provider organizations is important to support successful bidirectional referrals and ensure that patients experience better access to services and ease of navigation throughout the system of care.
5. Partner with county Medi-Cal managed care plans and commercial insurance in order to coordinate care for patients across systems of care.
 - Behavioral health organizations must learn to communicate with insurance companies, understand what insurance companies expect from providers, and negotiate and obtain contracts.
6. Invest in building the right organizational infrastructure and processes for integration, such as through integrated EHR and billing systems, credentialing, utilization review, and referral staff.
 - Because providers often use different systems, it is necessary to work on creating shared templates and tools in order to exchange information. Designing standard processes and engaging providers is important for creating efficiency.
7. Seek input from patients on their perceptions of integrated services and barriers and challenges to accessing behavioral health services.
 - Patient feedback and engagement are important for gauging the true success of any integration project and can help guide further improvements to make care more accessible and patient-centered. Methods for soliciting patient input may include focus groups and interviews.
8. Continue efforts to reduce the stigma associated with mental and substance use disorders and create awareness of available behavioral health services through brochures and information.
 - Many patients who receive integrated behavioral health services appreciate them and find them helpful, but stigma remains a barrier to accessing services.

Providing information about available MH and SUD services in primary care and other health care settings can increase awareness and help individuals receive services that they need.

9. Engage in data collection and tracking in order to measure outcomes and performance and identify gaps in care.
 - Analysis of process- and outcome-data can help counties and providers identify where improvements can be made when planning or implementing an integration initiative. Collected data can also be used in applying for grant funding, sharing successes with other stakeholders, and other activities.

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Chapter 3: State/System-Level Technical Assistance: Strategic Planning Activities and Recommendations

Darren Urada, Ph.D., Valerie P. Antonini, M.P.H., Richard A. Rawson, Ph.D., Brandy T. Oeser, M.P.H.

With an emphasis on issues related to integrating and improving SUD services within the current and changing health care delivery service system, UCLA Integrated Substance Abuse Programs (ISAP) has worked to provide technical assistance to the Department of Health Care Services (DHCS) in its efforts to develop an integrated drug-treatment delivery system in California. In collaboration with DHCS, UCLA provided strategic planning recommendations in several areas this past year, including workforce development, SBIRT benefit analysis, Drug Medi-Cal Waiver and Evaluation planning, Drug Medi-Cal audit recommendations, participation in the DHCS Behavioral Health Forum and Subcommittees, and providing a visionary plan for Los Angeles County. Submitted reports and recommendations for each topic are enclosed within the Appendices (*end of report*). However, we intend to continue our investigations on these topics to inform the state with current and evidence-based information and recommendations.

I. Introduction

As the health care system is evolving and the management, auditing, funding, and delivery of behavioral health services expand outside of specialty care, system- and state-level technical assistance needs have increased and broadened. Drawing from both literature and key informants from state and federal level experts, UCLA Integrated Substance Abuse Programs (ISAP) has worked to provide recommendations and evidence-based support (as available) to inform the Department of Health Care Services (DHCS) on various areas as the State of California navigates through the obstacles and challenges brought forth by the changing health care system.

Below are brief summaries of the following topic areas addressed this past year:

- Workforce Development
- SBIRT: Benefit Analysis and Recommendations for Supervision
- Drug Medi-Cal Audit Recommendations
- DHCS Behavioral Health Forum and Subcommittee Actions
- DMC Waiver Workgroup and Evaluation Planning
- Vision 2020 – A Proposed Plan for Los Angeles County

Full reports are included within *Appendices 3.1 to 3.6*.

II. Summary of Work and Activities

A. Workforce Development

Objective: Provide the State with evidence-based data and informational support to further assist in the evolving discussion of Workforce Development for SUDs.

UCLA ISAP's investigative efforts to further support Workforce Development for SUDs and essentially all of behavioral health have continued throughout this fiscal year (2013–2014). As summarized in our findings and recommendations provided in the ETTA Report 2012–2013, it was clear that the workforce that is needed to operate in integrated care settings would require a broad and diverse set of skills that very few individuals in the current SUD or MH workforces possess. In addition to identifying and building training efforts, a parallel issue is billing and reimbursement policies. Due to unaligned payment systems, it was recommended that the state work with external agencies such as CMS (Centers for Medicare & Medicaid Services) to align payment incentives and facilitate reimbursement for SUD services in primary care.

White Paper and SARC

As part of DHCS's effort to develop a framework for a future workforce in California, DHCS asked UCLA ISAP to develop a White Paper on California Substance Use Disorder Treatment Workforce Development. Although the white paper was prepared under a different contract with the California Department of Health Care Services (10-00130, Thomas E. Freese, Ph.D., Principal Investigator), the UCLA ISAP ETTA staff were highly involved in the investigative process as well as drafting and finalizing the paper. This paper was drafted and presented for review and comment during the September 2013 Substance Abuse Research Consortium (SARC) research-to-policy meeting. The September 2013 SARC research-to-policy meeting focused on the theme "*Challenges and Opportunities for the Substance Use Disorder Treatment Workforce – 2013 and Beyond.*" A daylong meeting agenda was assembled that highlighted several major themes or topics related to the current SUD workforce, and the challenges and opportunities presented to this workforce with full implementation of the Affordable Care Act. All presentations delivered at SARC were grounded in science, and whenever possible, included a discussion of the policy implications of the latest empirical findings.

Following the meeting, a final draft of the white paper was submitted to DHCS, along with documentation of the meeting proceedings. Enclosed please find the final White Paper as well as the Meeting Proceedings from the SARC research-to-policy meeting (*Appendices 3.1 and 3.2*).

OSHPD Career Pathways Sub-Committee

UCLA ISAP also participated in the Office of Statewide Health Planning and Development (OSHPD) Career Pathways Sub-Committee to contribute to and stay apprised of workforce development issues. The OSHPD, in concert with the California Workforce Investment Board (State Board), re-convened this Sub-Committee to analyze and provide recommendations on career pathways focusing on Behavioral Health, Mental Health, and Substance Abuse occupations. Specifically, the Sub-Committee focused on developing career pathways for the following occupations:

- Psychiatrist
- Marriage and Family Therapist (MFT)
- Clinical Psychologist
- Psychiatric Mental Health Nurse Practitioner/Clinical Nurse Specialist
- School Psychologist
- Peer Support Specialist
- Licensed Professional Clinical Counselor
- Alcohol and other Drug Abuse Counselor

The subcommittee convened on four occasions: July 9, 2013, July 30, 2013, August 20, 2013, and September 17, 2013. UCLA ISAP contributed to all meetings, with an emphasis on the career pathway of Substance Use Counselors.

Background: In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA). The MHSA imposes a 1% tax on personal income in excess of \$1 million to support the public mental health system (PMHS) via prevention, early intervention, and services. Historically underfunded, California’s PMHS suffers from a critical shortage of qualified mental health personnel to meet the needs of the diverse population it serves, in addition to maldistribution, lack of diversity, and under-representation of practitioners with consumer and family member lived experience. To address the workforce issues, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. A total of \$444.5 million was made available for the WET component with the Department of Mental Health (DMH). In 2008, DMH developed the Five-Year Workforce Education and Training Development Plan (Five-Year Plan). The Plan provided a framework for the advancement of mental health workforce education and training programs at the county, regional, and state levels.

In July 2012, following the reorganization of DMH, the MHSA WET programs were transferred to OSHPD. OSHPD assumed responsibility for the administration of WET programs developed under the 2008–2013 Plan and the development of a new Five-Year Plan that will be in effect from April 2014 through April 2019.

A key component of the 2014–2019 WET planning process was development of career pathway recommendations for select public mental health occupations. OSHPD partnered with the California Workforce Investment Board (CWIB) to reconvene the Career Pathways Subcommittee. In 2011 and 2012, this committee developed recommendations for 12 key health professions. The 2013 committee’s charge was to develop career pathways and recommendations that will strengthen the supply, distribution, and diversity of the public mental health workforce in seven selected professions. The committee included public and private stakeholders representing multiple mental health professions employers, government agencies, K-12, higher education, and advocates. A team of consultants from University of California, Berkeley School of Public Health, facilitated the process.

The career pathways and recommendations developed by the committee are summarized in their final report, which can be accessed at <http://oshpd.ca.gov/HWDD/pdfs/wet/Mental-Health-Career-Pathway-Report-2013.pdf>. OSHPD and the WET Advisory Committee will review and incorporate recommendations into the 2014–2019 WET Plan. The Health Workforce Development Council of the California Workforce Investment Board will also review and integrate the pathways and relevant recommendations into its overall health workforce priorities and action plans.

B. SBIRT: Benefit Analysis and Recommendations for Supervision

Objective: Provide the state with evidence-based documentation for or against expanding the list of allowable SBIRT supervisors beyond the existing list of physicians, physician assistants, nurse practitioners, and psychologists.

Following DHCS’s release of the state’s All Plan Letter (APL 14-004) in February 2014 on the topic of screening, brief intervention, and referral to treatment (SBIRT) for misuse of alcohol, there was a flurry of concern raised from providers and county administrators statewide around the topic of billable providers and the supervision requirements. To summarize, the APL described new requirements regarding the provision of SBIRT services, covered as a new benefit by the Medi-Cal Program. Beginning January 1, 2014, managed care health plans (MCPs) became responsible to cover and pay for an expanded alcohol screening for members 18 years of age and older who answer “yes” to the alcohol question in the Staying Healthy Assessment (considered a “pre-screen” in this APL), or any member the primary care provider identifies as having a potential alcohol misuse problem. Also, MCPs are to cover and pay for brief intervention(s) for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder. Any member identified with possible alcohol use disorders should be referred to the alcohol and drug program in the county where the member resides for evaluation and treatment.

Within the requirements of the SBIRT provision were details of provider requirements. Non-licensed health care providers providing SBIRT must be under the supervision (with documentation) of a licensed health care provider. Licensed health care providers eligible to supervise staff are currently limited to Licensed Physicians, Physician Assistants, Nurse Practitioners, and Psychologists. Currently in clinical environments, the Licensed Clinical Social Workers (LCSWs) and Licensed Marriage and Family Therapists (LMFTs) are billable behavioral health providers for services to Medi-Cal (LCSWs) or have proposed ability to do so under State Plan Amendment 14-012 (LMFTs).

DHCS asked UCLA ISAP to provide advice on whether SBIRT is more or less effective based on the type of staff supervising the intervention. UCLA ISAP analyzed existing data from SBIRT efforts underway in one California county, examined current research and policy literature on SBIRT, and obtained guidance from experts across the United States. Expert consultation began with Mady Chalk, Ph.D. (national SUD policy expert and director at the

Treatment Research Institute and consultant to UCLA ISAP), who referred us to experts who in turn referred us to others, allowing us to reach out to and receive feedback from a broad network of experts in the field. Experts included Richard Brown, M.D., M.P.H. (Wisconsin SBI), Reed Forman, M.S.W. (CSAT), Eric Goplerud, Ph.D. (NORC, University of Chicago), Dane Libart, LCSW (Oklahoma SBIRT), Bertha Madras, Ph.D. (Harvard), Richard Saitz, M.D. (Boston University), Brie Reimann, M.P.A. (Colorado SBIRT), and Tom Stegbauer, M.B.A. (HHS).

Summary of Findings

There have been no published research studies that have specifically and directly addressed which providers should supervise the delivery of SBIRT services. However, there are four converging lines of evidence that appear to suggest the same answer.

- a. LCSWs and LMFTs currently supervise SBIRT activities in California in two FQHCS and one medical center in Kern County as a part of MHSA-funded Project Care. Although this project was not designed to generate outcome data by type of staff supervision, thousands of patients have been successfully screened at these sites. Preliminary data suggest positive patient outcomes, but this data is not conclusive, as very plausible alternative explanations for the results exist.
- b. Supervision aside, there is empirical evidence that SBIRT has been delivered effectively by LCSWs, LMFTs, RNs, and health educators. This tends to support the idea that such providers could also supervise SBIRT efforts.
- c. There appears to be consensus among top national SBIRT experts that expanding the list of authorized supervisors beyond the current providers would be a good idea. A recent SAMHSA-HRSA workforce report also made the general point that health care should be delivered by the least expensive staff qualified to ensure quality care, which, if extended to supervision, would support expansion to allow lower-cost but well qualified providers to serve as SBIRT supervisors.
- d. The scope of practice for both LMFTs and LCSWs includes substance use disorders, and training requirements for these titles appear to be at least as extensive as those for physicians, physician assistants, and nurse practitioners.

In summary, although there is not much data that specifically addresses the question of what type of providers should supervise SBIRT, the data that do exist, related research evidence, consensus among experts, and existing training requirements all tend to support the idea of expanding the list of providers that can supervise SBIRT, and to do so in particular for LCSWs and LMFTs. Based on experiences in implementing SBIRT in other states, experts suggested that implementation of SBIRT using only the currently approved providers would likely be slow due to existing demands on these providers. In California, if the discussion of SBIRT supervision is limited to licensed providers whose services can be billed to Medi-Cal (or may be able to do so shortly), then LCSWs and LMFTs appear to be well positioned to serve in this role. SUDs are within their training and scope of practice, and preliminary evidence suggests that these providers have been adept at supervising SBIRT in non-Medi-Cal funded efforts in the state. They can also potentially provide supervision at a lower cost than the currently approved supervisors. Enclosed please find the final report submitted to DHCS for their review and consideration (*Appendix 3.3*).

C. Drug Medi-Cal Audit Recommendations

Objective: Provide feedback to the state on the implementation plan for the DMC audit recommendations

On January 10, 2014, DHCS Behavioral Health Director Karen Baylor released an Implementation Plan to act on each of the recommendations of a November 2013 Drug Medi-Cal (DMC) Limited Scope Review by DHCS Audits and Investigations, which reviewed the DMC program. Karen Baylor asked UCLA ISAP to review and comment on this implementation plan. UCLA ISAP generally agreed with the proposed plan, and provided additional ideas on how it might potentially be augmented by bringing in stakeholders with SUD knowledge, using algorithms employed by other states to detect fraud through data mining, using a rolling recertification process, using Live Scan to perform regular checks of providers, and strengthening anti-fraud training among providers.

Enclosed please find the full list of recommendations submitted to DHCS (*Appendix 3.4*).

D. DHCS Behavioral Health Forum and Subcommittee Actions

Objective: Contribute to the activities and discussions within the Behavioral Health Forum and subcommittees to stay apprised of developments and assist with evidence-based feedback and recommendations as necessary.

As part of DHCS's strategic planning work addressing both the reorganization within the department as well as future planning of Behavioral Health services, DHCS initiated the Behavioral Health Forum in early 2014. The goal of the Behavioral Health Forum is to provide another resource to more effectively integrate, coordinate, deliver and monitor community-based MH/SUD services and care while ensuring meaningful stakeholder engagement.

This forum was developed to assure adequate and well-informed responses and planning addressing the current major changes under federal health care reform and the implementation of 2011 Realignment for Medi-Cal specialty mental health services, Drug Medi-Cal, and other alcohol and drug treatment programs. In addition, DHCS issued a business plan in June 2013 (in partnership with CiMH and ADPI), entitled, "Stakeholder Recommendations for Mental Health and Substance Use Disorder Services," which identified three goals for further investigation and discussion:

- Strengthen the overall delivery system for MH and SUD treatment services;
- Develop a coordinated and integrated system of care for MH, SUD treatment, and medical care; and

- Create a coordinated method for data collection and evaluation of outcomes that helps to ensure excellence in care and improved outcomes for individuals, children, families, and communities.

The Behavioral Health Forum established three subcommittees focused on addressing each of the above goals. Initial activities began on March 24, 2014, by way of a web-based meeting to discuss the goals of the BH Forum and each subcommittee. One of the first orders of business was to review and solicit feedback for the Stakeholder Issues Grid.

The Stakeholder Issues Grid is a compilation of the issues identified through the following sources: (1) CiMH-developed Business Plan, (2) the process to develop the “California Mental Health and Substance Use System Needs Assessment and Service Plan,” which was produced as part of the 1115 Waiver, (3) the SUD-Parking Lot, and (4) issues/recommendations that have been raised during a variety of forums related to the transition of DMH and ADP to DHCS, as well as at ACA implementation discussions regarding the new and/or expanded specialty and non-specialty MH/SUD benefits.

UCLA ISAP conducted a comprehensive review of the Stakeholder Issues Grid and submitted a response to DHCS on April 9, 2014. Enclosed please find the submitted document for DHCS consideration (*Appendix 3.5*).

Ongoing participation in the Behavioral Health Forum and subcommittee activities is a priority for UCLA ISAP, and we will continue to contribute in this stakeholder process.

E. DMC Waiver Workgroup and Evaluation Planning

Objective: Provide feedback to the state on the 1115 waiver and the associated evaluation.

The Department of Health Care Services (DHCS) is seeking an 1115 Demonstration Waiver for the Substance Use Disorder Drug Medi-Cal (DMC) Program. The intent is to demonstrate how California delivers DMC services to California’s beneficiaries through an organized delivery system. The Waiver will need to be consumer-focused, use evidence-based practices and improve program quality outcomes. DHCS is conducting a stakeholder involved and transparent process to gather input from all impacted parties, including other state departments, consumers, associations, counties, and providers.

UCLA ISAP has provided technical assistance as DHCS prepares to apply for a Drug Medi-Cal waiver. DHCS conducted three Waiver Advisory Group (WAG) meetings in April 2014 in an effort to plan accordingly and comprehensively for the submission. UCLA ISAP has participated in all Waiver Advisory Group meetings (April 2, 15, and 30) and has refocused substantial resources toward providing DHCS with information and feedback relevant to the development of the Waiver terms and conditions.

On April 2, 2014, UCLA ISAP provided a broad overview on the parameters that could be evaluated in the Waiver. Ideas for various approaches included differences in differences, comparison counties, or stages of implementation comparisons. Penetration rates, ASAM matching and placement, outcome measures, and cost savings to other systems were also presented as ways to measure the access, quality, and cost of the demonstration Waiver. On April 15, 2014, UCLA ISAP provided a presentation entitled “Best Practices & Effectiveness of Residential, Outpatient and Sober Living.” Minutes and materials from these meetings are located on the DHCS website (<http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-PreviousMeetings.aspx>).

These efforts are ongoing.

F. Vision 2020 – A Proposed Plan for Los Angeles County

Objective: Provide DHCS with UCLA ISAP’s proposed concept for Los Angeles County’s health care system for 2015–2020 as an example or framework for the state to consider when mapping out a direction for the future SUD service system as part of the larger health care system.

UCLA ISAP has been engaged with Los Angeles County Department of Public Health’s Substance Abuse Prevention and Control (SAPC) division and Department of Mental Health (DMH) for many years, providing evaluation services, training services, and recommendations for service delivery enhancement. In late 2013, UCLA ISAP began communications with LA county leaders at SAPC, DMH, and Public Health to propose a plan for what would be a “vision for 2020,” with emphasis on an SUD service system that is grounded in the concept that SUD services are health services that should be integrated throughout the health care system. Services would employ evidence-based practices and promote recovery, be delivered by a qualified workforce, be monitored with data to promote quality and prevent fraud, and address the diverse cultural, ethnic, geographic, and socioeconomic needs of the LA County population. Financing of these services would provide excellent care in the most efficient manner possible, maximizing the application of insurance, Medi-Cal, block grant, and other funding. Services would meet the needs of related LA County departments, including the social service system and criminal justice/public safety systems.

Following several discussions with LA County leadership, with additional consultation from Dr. Mady Chalk at Treatment Research Institute, a draft concept plan was submitted to LA County on February 19, 2014, for their consideration.

At the request of DHCS, we provided the proposed plan to Karen Baylor in an effort to inform long-term strategic planning efforts at the state level. Enclosed is a copy of the proposed concept plan (*Appendix 3.6*).

Chapter 4: County/Provider-level Training and Technical Assistance

Brandy Oeser, M.P.H., Darren Urada, Ph.D.

Over the past year, UCLA Integrated Substance Abuse Programs (UCLA ISAP) provided trainings and technical assistance to facilitate integration across the state. This included in-person trainings, webinars, technical assistance to counties, and technical assistance for the California Institute for Mental Health's Care Integration Collaborative. UCLA ISAP also participated in the BHbusiness Learning Network. Training and technical assistance needs persist throughout the state and will continue as health care reform is implemented.

I. Introduction

UCLA Integrated Substance Abuse Programs (ISAP) provided trainings and technical assistance at the county level across the state on strategies to prepare for health care reform and facilitate integration. This included in-person trainings, webinars, technical assistance to counties, and technical assistance for the California Institute for Mental Health's Care Integration Collaborative. UCLA ISAP also participated in the BHbusiness Learning Network.

II. Summary of Work and Activities

A. Training Topics and Events

Trainings were conducted throughout California from July 1, 2013–June 30, 2014, on topics relevant to integration. Below are descriptions and objectives for each major topic area followed by a list of training activities conducted. Event materials can be found on this website: <http://uclaisap.org/Integration/html/workforce-development.html>

Integration Strategies

In March 2010, President Obama signed into law historic health care reform legislation that will extend insurance to currently uninsured and under-insured Americans. The Patient Protection and Affordable Care Act (ACA) supports previous legislation requiring that SUD and mental illness benefits are on par with those for medical illnesses. This law went into effect on January 1, 2014. The new policies outlined in the ACA are likely to dramatically change how SUD treatment is funded and the types of services that are reimbursable. The SUD treatment and recovery workforce will need to learn additional skills to navigate a much broader primary health, SUD, and mental health care system. This training examined key components of the ACA and how SUD treatment practitioners can alter their practices to be most responsive to patient needs. Questions and concerns practitioners may have regarding health care reform were addressed, and several specific models and strategies for providing integrated behavioral health and primary services were presented.

California Addiction Training and Education Series (CATES) 2013: The Changing Behavioral Health Care Landscape: Integration, Innovation, and Financing Models for Success

Health care reform has initiated a tremendous change in the behavioral health care sector. With any transformative effort, there are many challenges but also a wealth of opportunities. This training provided participants with knowledge and information to overcome the challenges and capitalize on the growing market opportunities that exist in the new health care environment. Providers everywhere have the opportunity to design their future in the spirit of innovation and with an eye toward care coordination, new clinical pathways, and the emerging field of behavioral medicine. By leveraging what we know about Health Neighborhoods, Health Homes and Accountable Care Organizations (ACOs), and innovative financing, behavioral health providers can learn to identify unmet needs in their communities, conduct more comprehensive market research than ever before, and develop new programs and services that align the capabilities of new partners in mutually reinforcing business models. For some, the future will be about vertical integration, or an opportunity to expand into new markets. For others, the road ahead will lead to mergers and acquisitions. Still for others, the future will be about affiliation networks and consortia. In any event, these new business models require vision, planning, and execution. This training provided participants with the background, knowledge, and strategies to turn challenges into opportunities. A series of webinars were conducted following the CATES regional trainings that provided more technical assistance surrounding the topics of Contract Negotiations, Financing Strategies, Developing Payer Relations, Marketing, and Integrating Services with Primary Care.

Working in the Health Care System

Facilitating coordinated care between the primary-health and the substance-use and mental-health disorders treatment systems requires an understanding of the most common medical issues associated with misuse of substances. These trainings focused on identifying symptoms of medical conditions associated with and the medical consequences of alcohol and other drug use. The training helped behavioral health providers to develop strategies and language for communicating and coordinating care with medical providers to shift toward the provision of integrated care. Information was provided on primary care service delivery systems, including managed care systems and Federally Qualified Health Centers/community health centers.

A similar training tailored to physicians, nurses, and other medical providers included information on how substance use disorders may be an aggravating or underlying cause of common medical problems, and how physicians might think about encouraging their patients to address their substance use issues in those cases. In addition, the training helped physicians, nurses, and other medical providers to develop strategies and language for effectively communicating and coordinating care with behavioral health providers to shift toward the provision of integrated care. The training provided an overview of strategies medical providers can use to connect at-risk patients with necessary behavioral health services.

Synthetic Drugs

Unlike major illicit drugs of abuse, such as heroin, cocaine, methamphetamine, or marijuana, synthetic drugs have only appeared on the street in the last few years. Because they are constantly changing, our knowledge of synthetic drugs is not as comprehensive as we would like.

Whereas other drugs have been subjected to years of toxicological and pharmaceutical testing and numerous clinical trials and research on the effects on users' brains and bodies, our knowledge of synthetic drugs is often based on newspaper stories, pro-drug websites, and "street" information from users or individuals who really do not know the facts. The purpose of this training was to provide multi-disciplinary SUD-treatment practitioners with a detailed overview of synthetic drugs, most notably substances known on the street as "K2," "spice," and "bath salts." The presentation defined key terms, described the major classes of commonly available synthetic drugs, presented available data on the extent of use, discussed the acute and chronic effects of synthetic drug use, and provided information on how to identify and assess synthetic drug users. The training concluded with a brief discussion of the clinical implications of synthetic drug use. At the end of the training, participants were able to: (1) Identify the key characteristics and acute and chronic effects of synthetic drugs, most notably synthetic cannabinoids (spice) and synthetic cathinones (bath salts); (2) Describe the current information on the availability and patterns of synthetic drug use in the United States; and (3) explain strategies for communicating the dangers involved with synthetic drug use.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders and those at risk of developing these disorders. SBIRT is effective in a variety of settings. Its effectiveness has been proven particularly in hospital emergency departments and trauma centers treating individuals with alcohol-related injuries. SBIRT has also been shown to be effective in primary care settings, where it is incorporated into other routine medical assessments such as measuring blood pressure. A major focus of the daylong training was a detailed review of key motivational interviewing concepts and principles that are tied to effective use of the FLO (Feedback; Listen and Understand; Options Explored) brief intervention. Core clinical components that are covered include: (1) brief intervention to raise awareness of risk and motivate change; (2) brief treatment for patients seeking help; and (3) referral to treatment for patients with more serious substance-use related problems.

SBIRT 4-hour trainings were also conducted and were approved by the California Department of Health Care Services as meeting the policy requirements of SBIRT coverage as a new Medi-Cal Program benefit. The trainings provided a brief overview of the prevalence of substance use, criteria for risky use, and the effects of substance use on health and mental health functioning. The two approved screening tools (AUDIT and AUDIT-C) were reviewed, and providers were taught how to conduct a three-step Brief Intervention utilizing motivational interviewing techniques focused on motivating people toward positive behavioral change. For individuals identified to be at high risk for an alcohol use disorder, we taught providers how to motivate patients to accept a referral to specialty substance abuse treatment services. At the conclusion of the training, participants were able to: (1) describe the background and rationale for conducting SBIRT with patients in primary care settings; (2) utilize the AUDIT or AUDIT-C to screen and identify patients engaged in moderate or high-risk alcohol consumption; and (3) demonstrate, through role-play and group discussion, the effective use of brief intervention strategies and techniques to motivate patients to change their at-risk substance use behavior and/or seek treatment.

Medication-Assisted Treatment (MAT)

The purpose of this half-day training was to provide participants with a detailed overview of medications that have been shown to be effective as a component of the treatment of alcohol and opioid addiction. Topics included: the context for medication-assisted treatment (positive and negative perceptions), the epidemiology of alcohol and opioid dependence, an overview of each medication, its indication, to whom it is administered, and how it works, and treatment settings for medication-assisted treatment. Medications discussed included: naltrexone, acamprosate, disulfiram, methadone, and buprenorphine. Time was provided for discussion and questions.

Motivational Interviewing (MI)

Motivational interviewing, a treatment approach developed by William Miller, has been well established as an effective way to promote change in individuals. This evidence- and consensus-based technique has been shown to elicit change in behavior and attitudes by helping patients explore and resolve ambivalence. This training workshop provided participants with a fundamental understanding of motivational interviewing and specific techniques for promoting behavior change.

Prescription Drug Abuse Problem

This training provided a detailed overview of the epidemiology of prescription drug abuse and its impact, including the extent of the problem and demographics of those affected. Three major categories of prescription drugs (e.g., opioids, stimulants, and sedatives/tranquilizers) were compared and contrasted to help participants understand why people use each class of drugs and how the effects of these drugs differ. The session concluded with a comprehensive review of various prevention approaches and evidence-based treatments, including behavioral therapies and medication-assisted treatment.

Ethics and Confidentiality

This training introduced participants to the confidentiality and ethical issues associated with the provision of treatment for substance use disorders, as well as strategies that can be used to best deal with patient crises and difficult patients.

**List of Trainings Conducted
July 1, 2013 – June 30, 2014**

Name of Training	Location/Date of Training	Trainer(s)	Number of Participants	Back-up Documents	Funding Source*
Integration Strategies					
CATES Follow-up Webinar: Contract Negotiations	Webinar July 2, 2013	Bill Tenhoor	12	PPT slides; Webinar recording	1
CATES Follow-up Webinar: Financing Strategies	Webinar July 10, 2013	Bill Tenhoor	10	PPT slides; Webinar recording	1
CATES: The Changing Behavioral Health Landscape – Integration, Innovation, and Financing Models for Success	Hanford, CA (Kings Co) July 12, 2013	Charles Ray, MEd	47	Agenda/program and PPT slides	1
CATES Follow-up Webinar: Developing Payer Relations	Webinar July 17, 2013	Bill Tenhoor	9	PPT slides; Webinar recording	1
CATES Follow-up Webinar: Marketing	Webinar July 18, 2013	Angi Halvorson	11	PPT slides; Webinar recording	1
CATES Follow-up Webinar: Integrating Services with Primary Care	Webinar July 23, 2013	Bill Tenhoor	16	PPT slides; Webinar recording	1
ILC Call with Patrick Gauthier	Conference Call July 24, 2013	Patrick Gauthier	20	PPT slides	1
CATES Follow-up Webinar: Contract Negotiations	Webinar July 31, 2013	Bill Tenhoor	12	PPT slides; Webinar recording	1
CATES Follow-up Webinar: Financing Strategies	Webinar August 7, 2013	Bill Tenhoor	10	PPT slides; Webinar recording	1
Clinical Supervision Foundations Workshop	Los Angeles, CA (Los Angeles Co) August 13-14, 2013	Steven Gallon, Ph.D.	14	Flyer, agenda, and PPT slides	4
CATES Follow-up Webinar: Developing Payer Relations	Webinar August 14, 2013	Bill Tenhoor	8	PPT slides; Webinar recording	1
(CATES: The Changing Behavioral Health Landscape – Integration, Innovation, and Financing Models for Success	Oakland, CA (Alameda Co) August 16, 2013	Charles Ray, MEd	122	Agenda, and PPT slides	1
Tenth Annual Training and Educational Symposium (Health Reform Update) – COMP	Los Angeles, CA (Los Angeles, CA) September 18, 2013	H. Westley Clark, MD, JD, MPH, CAS, FASAM	130	Flyer, agenda, and PPT slides	4

CATES: The Changing Behavioral Health Landscape – Integration, Innovation, and Financing Models for Success	Redding, CA (Shasta Co) September 20, 2013	Charles Ray, MEd	27	Agenda/program and PPT slides	1
ACA Implementation on the U.S./Mexico Border Webinar	Webinar October 8, 2013 (morning and afternoon session)	Multiple	124 / 99	PPT slides; Webinar recording	4
Tenth Statewide Conference: Integrating Substance Use, Mental Health, and Primary Care Services	Universal City, CA (Los Angeles Co) October 23-24, 2013	Multiple	759	Agenda/program and PPT slides	3
Integration Strategies (AM Session)	Rialto, CA (San Bernardino Co) January 23, 2014	Thomas E. Freese, Ph.D.	34	Agenda and PPT slides	2
Integration Strategies (PM Session)	Rialto, CA (San Bernardino Co) January 23, 2014	Thomas E. Freese, Ph.D.	31	Agenda and PPT slides	2
Substance Use, Mental Health, and Health – Integrated Interventions (LA County DMH INN)	Los Angeles, CA (Los Angeles Co) May 19, 2014	Sherry Larkins, Ph.D.	47	Agenda and PPT slides	3
Working in the Health Care System					
Culture of Integrated Services Webinar	Webinar July 24, 2013	Thomas E. Freese, Ph.D., and Sherry Larkins, Ph.D.	75	PPT slides; Webinar recording	3
Culture of Integrated Services Webinar	Webinar July 30, 2013	Thomas E. Freese, Ph.D., and Sherry Larkins, Ph.D.	104	PPT slides; Webinar recording	3
Will They Turn You into a Zombie: What Behavioral Health Clinicians Need to Know about Synthetic Drugs	Bakersfield, CA (Kern Co) October 25, 2013	Beth Rutkowski, M.P.H.	115	Agenda and PPT slides	1
Working in the Health Care System (AM Session)	Rialto, CA (San Bernardino Co) October 29, 2013	Thomas E. Freese, Ph.D.	19	Agenda and PPT slides	2
Working in the Health Care System (PM Session)	Rialto, CA (San Bernardino Co) October 29, 2013	Thomas E. Freese, Ph.D.	15	Agenda and PPT slides	2

Los Angeles County Annual Drug Court Conference – New Opportunities for Coordinated Physical Health and Behavioral Health Care for Drug Court Participants (Plenary)	Los Angeles, CA (Los Angeles Co) June 12, 2014	Clayton Chau, M.D., Ph.D., Roderick Shaner, M.D., and Holly McCravey, M.A.	200	Agenda and PPT slides	3
Screening, Brief Intervention, and Referral to Treatment (SBIRT)					
SBIRT Grand Rounds at Mee Memorial Hospital	Salinas, CA (Monterey Co) July 25, 2013	Thomas E. Freese, Ph.D.	8	PPT slides	3
SBIRT Training for Residents – Natividad Hospital	Salinas, CA (Monterey Co) July 25, 2013	Thomas E. Freese, Ph.D.	40	Agenda and PPT slides	3
SBIRT Grand Rounds at Community Hospital of Monterey Peninsula	Monterey, CA (Monterey Co) July 25, 2013	Thomas E. Freese, Ph.D.	25	Agenda and PPT slides	3
SBIRT Training (Training #1)	Napa, CA (Napa Co) August 1, 2013	Joy Chudzynski, Psy.D.	12	Flyer, agenda, and PPT slides	3
SBIRT Training	Riverside, CA (Riverside Co) August 6, 2013	Thomas E. Freese, Ph.D.	45	Flyer, agenda, and PPT slides	3
SBIRT Training (Training #2)	Napa, CA (Napa Co) August 6, 2013	Joy Chudzynski, Psy.D.	14	Flyer, agenda, and PPT slides	3
SBIRT Training (Training #3)	Napa, CA (Napa Co) August 21, 2013	Sherry Larkins, Ph.D.	24	Flyer, agenda, and PPT slides	3
SBIRT Training (Training #4)	Napa, CA (Napa Co) August 23, 2013	Sherry Larkins, Ph.D.	27	Flyer, agenda, and PPT slides	3
SBIRT Training (Training #5)	Napa, CA (Napa Co) August 27, 2013	Thomas E. Freese, Ph.D.	45	Flyer, agenda, and PPT slides	3
Napa County HHS SBIRT TA Meeting	Napa, CA (Napa Co) September 17, 2013	Beth Rutkowski, M.P.H.	10	SBIRT Resource Materials (screeners, data dashboards, SBIRT implementation plan)	3
Napa County HHS SBIRT TA Meeting	Napa, CA (Napa Co) September 27, 2013	Sherry Larkins, Ph.D.	8	SBIRT Resource Materials (screeners, data dashboards, SBIRT implementation plan)	3
SBIRT Training Series for LA County DMH Adult Systems of Care Providers (19 sessions in total)	Various locations across Los Angeles Co September 9- November 21, 2013	Sherry Larkins, Ph.D., and Alina Bond, L.C.S.W.	629	Flyer, agenda, and PPT slides	3

SAPC Quarterly Lecture: Maximizing the Use of SBIRT in an Era of Health Reform, Integrated Care Delivery, and Added Value	Alhambra, CA (Los Angeles Co) December 6, 2013	Sherry Larkins, Ph.D.	107	Flyer, agenda, and PPT slides	3
SBIRT Webinar for DHCS Medical Directors	Webinar December 19, 2013	Thomas E. Freese, Ph.D., and Sherry Larkins, Ph.D.	74	PPT slides	3
SBIRT Training (Santa Barbara County)	Santa Barbara, CA (Santa Barbara Co) January 24, 2014	Beth Rutkowski, M.P.H.	18	Agenda and PPT slides	2
SBIRT Training (LA County DMH OASAC)	Los Angeles, CA (Los Angeles Co) February 18, 2014	Sherry Larkins, Ph.D.	86	Flyer, agenda, and PPT slides	3
SBIRT Training (LA County DMH INNOVATIONS)	Los Angeles, CA (Los Angeles Co) February 20, 2014	Sherry Larkins, Ph.D.	36	Flyer, agenda, and PPT slides	3
SBIRT Training (Council of Community Clinics – San Diego)	San Diego, CA (San Diego Co) February 20, 2014	Thomas E. Freese, Ph.D.	31	Agenda and PPT slides	3
SBIRT Training (Council of Community Clinics – San Marcos)	San Marcos, CA (San Diego Co) February 21, 2014	Thomas E. Freese, Ph.D.	24	Agenda and PPT slides	3
DHCS SBIRT Webinar for Primary Care Providers	Webinar February 28, 2014	Thomas E. Freese, Ph.D., and Sherry Larkins, Ph.D.	152	PPT slides	3
DHCS SBIRT Webinar for Non-Primary Care Providers	Webinar March 10, 2014	Thomas E. Freese, Ph.D., and Sherry Larkins, Ph.D.	188	PPT slides	3
DHCS SBIRT Webinar for Primary Care Providers	Webinar March 24, 2014	Thomas E. Freese, Ph.D., and Sherry Larkins, Ph.D.	160	PPT slides	3
DHCS SBIRT Webinar for Non-Primary Care Providers	Webinar April 3, 2014	Thomas E. Freese, Ph.D., and Sherry Larkins, Ph.D.	134	PPT slides	3
SBIRT Training (LA Co SAPC)	Los Angeles, CA (Los Angeles Co) March 25, 2014	Joy Chudzynski, Psy.D.	27	Agenda and PPT slides	2
SBIRT Training (ACBHCS)	San Leandro, CA (Alameda Co) March 28, 2014	Thomas E. Freese, Ph.D.	41	Agenda and PPT slides	3
SBIRT Training (Kern Health Systems)	Bakersfield, CA (Kern Co) April 22, 2014	Joy Chudzynski, Psy.D.	15	Agenda and PPT slides	3

SBIRT Training (CCLAC)	Los Angeles, CA (Los Angeles Co) May 19, 2014	James Peck, Psy.D.	39	Agenda and PPT slides	3
SBIRT Training (NCADD)	Covina, CA (Los Angeles Co) May 21, 2014	James Peck, Psy.D.	31	Agenda and PPT slides	3
SBIRT Training (Tarzana Treatment Center)	Tarzana, CA (Los Angeles Co) June 2, 2014	Joy Chudzynski, Psy.D.	41	Agenda and PPT slides	3
SBIRT Training (Santa Rosa Junior College Health Center/SRCHC)	Santa Rosa, CA (Sonoma Co) June 10, 2014	James Peck, Psy.D.	19	Agenda and PPT slides	3
SBIRT Training (Alliance Med Ctr/Alexander Valley Healthcare)	Healdsburg, CA (Sonoma Co) June 17, 2014	Thomas E. Freese, Ph.D.	12	Agenda and PPT slides	3
SBIRT Training (CenCal)	Santa Barbara, CA (Santa Barbara Co) June 17, 2014	James Peck, Psy.D.	20	Agenda and PPT slides	3
SBIRT Training (Sonoma Valley CHC)	Sonoma, CA (Sonoma Co) June 24, 2014	James Peck, Psy.D.	31	Agenda and PPT slides	3
SBIRT Training (SCIHP)	Santa Rosa, CA (Sonoma Co) June 18 and 25, 2014	Thomas E. Freese, Ph.D., and James Peck, Psy.D.	7	Agenda and PPT slides	3
SBIRT Training (Petaluma Health Center)	Petaluma, CA (Sonoma Co) June 18 and 25, 2014	Thomas E. Freese, Ph.D., and James Peck, Psy.D.	18	Agenda and PPT slides	3
Medication-Assisted Treatment (MAT)					
Tenth Annual Training and Educational Symposium (Key Medical Issues with Methadone; Pain and Addiction) – COMP	Los Angeles, CA (Los Angeles, CA) September 18, 2013	Jack McCarthy, MD; Walter Ling, MD	130	Flyer, agenda, and PPT slides	4
Pharmacology of Addiction Treatment	San Mateo, CA (San Mateo Co) October 16, 2013	Thomas E. Freese, Ph.D.	56	Flyer, agenda, and PPT slides	2
Medication-Assisted Treatments for Alcohol and Opioid Addicted Individuals	Rialto, CA (San Bernardino Co) March 31, 2014	Thomas E. Freese, Ph.D.	31	Agenda and PPT slides	2
Pharmacology of Addiction Treatment (CLARE Foundation Staff Development Training Series)	Santa Monica, CA (Los Angeles Co) April 23, 2014	Joy Chudzynski, Psy.D.	37	Flyer, agenda, and PPT slides	3
MAT Session for LA County DMH Psychologist Working Group	Los Angeles, CA (Los Angeles Co) May 21, 2014	Sherry Larkins, Ph.D.	11	PPT slides	3

An Overview of Medication-Assisted Treatment Approaches for Treating Opioid Addicted Individuals	Webinar May 28, 2014	Beth Rutkowski, M.P.H.	50	PPT slides	3
Los Angeles County Annual Drug Court Conference – Medication-Assisted Treatment (2 workshops)	Los Angeles, CA (Los Angeles Co) June 12, 2014	Larissa Mooney, M.D.	75	Agenda and PPT slides	3
Motivational Interviewing					
Treatment for Drug Offenders: Does it Work? How to Make it Work	Los Angeles, CA (Los Angeles Co) July 23, 2013	Igor Koutsenok, M.D.	141	Flyer, agenda, and PPT slides	4
Effecting Change through the Use of Motivational Interviewing	Rialto, CA (San Bernardino Co) July 25, 2013	Joy Chudzynski, Psy.D.	97	Agenda and PPT slides	2
Effecting Change through the Use of Motivational Interviewing (MI Training #1)	Napa, CA (Napa Co) July 31, 2013	Joy Chudzynski, Psy.D.	15	Agenda and PPT slides	3
Effecting Change through the Use of Motivational Interviewing (MI Training #2)	Napa, CA (Napa Co) August 5, 2013	Joy Chudzynski, Psy.D.	13	Agenda and PPT slides	3
Effecting Change through the Use of Motivational Interviewing (MI Training #3)	Napa, CA (Napa Co) August 20, 2013	Sherry Larkins, Ph.D.	26	Agenda and PPT slides	3
Treatment for Drug Offenders: Does it Work? How to Make it Work	Sacramento, CA (Sacramento Co) August 21, 2013	Igor Koutsenok, M.D.	106	Flyer, agenda, and PPT slides	4
Effecting Change through the Use of Motivational Interviewing (MI Training #4)	Napa, CA (Napa Co) August 22, 2013	Sherry Larkins, Ph.D.	36	Agenda and PPT slides	3
Effecting Change through the Use of Motivational Interviewing (MI Training #5)	Napa, CA (Napa Co) August 25, 2013	Thomas E. Freese, Ph.D.	45	Agenda and PPT slides	3
Using Motivational Interviewing Skills in Counseling Groups (Nor Cal)	Oakland, CA (Alameda Co) September 4-5, 2013	Steven Gallon, Ph.D.	20	Flyer, agenda, and PPT slides	4

Using Motivational Interviewing Skills in Counseling Groups (So Cal)	Los Angeles, CA (Los Angeles Co) September 10-11, 2013	Steven Gallon, Ph.D.	15	Flyer, agenda, and PPT slides	4
Motivational Interviewing and Brief Intervention Techniques for Adolescent and Older Adult Providers (OC HCA)	Santa Ana, CA (Orange Co) October 28, 2013	Sherry Larkins, Ph.D.	87	Flyer, agenda, and PPT slides	3
Motivational Interviewing Training of Trainers (Penny Lane Centers)	Burbank, CA (Los Angeles Co) October 29-30, 2013	Thomas E. Freese, Ph.D., and Joy Chudzynski, Psy.D.	9	Agenda and PPT slides	3
Motivational Interviewing and Brief Intervention Techniques for Adolescent and Older Adult Providers (OC HCA)	Santa Ana, CA (Orange Co) November 4, 2013	Sherry Larkins, Ph.D.	77	Flyer, agenda, and PPT slides	3
Effecting Change through the Use of Motivational Interviewing (LA Co DMH)	Los Angeles, CA (Los Angeles Co) November 12, 2013	Sherry Larkins, Ph.D.	82	Flyer, agenda, and PPT slides	3
MI Training (2nd Cohort) – Penny Lane Centers	Lancaster, CA (Los Angeles Co) December 16, 2013	Sherry Larkins, Ph.D., and Grant Hovik, M.A.	14	Agenda and PPT slides	3
MI Training, Part 1 and 2 (CLARE Foundation Staff Development Training Series)	Santa Monica, CA (Los Angeles Co) February 5, 2014 and February 12, 2014	Sherry Larkins, Ph.D.	50 / 50	PPT slides	3
MI Training (2nd Cohort) – Penny Lane Centers	North Hills, CA (Los Angeles Co) February 10, 2014	Sherry Larkins, Ph.D., and Grant Hovik, M.A.	25	Agenda and PPT slides	3
Effecting Change through the Use of Motivational Interviewing (OC HCA)	Santa Ana, CA (Orange Co) March 12, 2014	Sherry Larkins, Ph.D.	36	Agenda and PPT slides	3
Effecting Change through the Use of Motivational Interviewing (AltaMed)	Los Angeles, CA (Los Angeles Co) May 6, 2014	Joy Chudzynski, Psy.D.	10	Agenda and PPT slides	3

Introduction to Motivational Interviewing (Child and Family Guidance Center)	Northridge, CA (Los Angeles Co) May 28, 2014	Joy Chudzynski, Psy.D.	48	Agenda and PPT slides	3
Motivational Interviewing, Part 2 (Child and Family Guidance Center)	Northridge, CA (Los Angeles Co) June 25, 2014	Joy Chudzynski, Psy.D.	50	Agenda and PPT slides	3
Prescription Drug Abuse Problem					
Prescription Opioid Addiction Treatment Study (POATS) Webinar	Webinar September 24, 2013	Beth Rutkowski, M.P.H.	26	PPT slides; Webinar recording	4
Prescription Opioid Addiction Treatment Study (POATS) Webinar	Webinar September 30, 2013	Beth Rutkowski, M.P.H.	17	PPT slides; Webinar recording	4
Prescription Opioid Addiction Treatment Study (POATS) Webinar	Webinar April 22, 2014	Beth Rutkowski, M.P.H.	20	PPT slides; Webinar recording	4
Ethics and Confidentiality					
Tenth Annual Training and Educational Symposium (Ethics and Confidentiality Session) – COMP	Los Angeles, CA (Los Angeles, CA) September 18, 2013	Sherry Larkins, Ph.D.	130	Flyer, agenda, and PPT slides	4
Ethics and Boundaries (CLARE Foundation Staff Development Training Series)	Santa Monica, CA (Los Angeles Co) November 20, 2013	Thomas E. Freese, Ph.D.	65	PPT slides	3
Law, Ethics, and Confidentiality Issues in Substance Use Disorder Treatment (LA County SAPC)	Alhambra, CA (Los Angeles Co) December 12, 2013	Sherry Larkins, Ph.D.	22	Agenda and PPT slides	2
Confidentiality/HIPAA Issues (CLARE Foundation Staff Development Training Series)	Santa Monica, CA (Los Angeles Co) January 7, 2014	Sherry Larkins, Ph.D.	70	PPT slides	3
Law, Ethics, and Confidentiality Issues in SUD Treatment (Lake County DBH)	Lakeport, CA (Lake Co) January 13, 2014	Sherry Larkins, Ph.D.	58	Agenda and PPT slides	2
Law, Ethics, and Confidentiality Issues in Substance Use Disorder Treatment	Los Angeles, CA (Los Angeles Co) April 25, 2014	Sherry Larkins, Ph.D.	47	Agenda and PPT slides	2
Ethical and Confidentiality Issues in Substance Use Disorder Treatment	Concord, CA (Contra Costa Co) May 5, 2014	Thomas E. Freese, Ph.D., and James Peck, Psy.D.	57	Agenda and PPT slides	2

Faith-Based Training and Education Series Training #1 – Ethics and Confidentiality	Los Angeles, CA (Los Angeles Co) May 10, 2014	Cheryl Branch	12	PPT slides	2
Ethical and Confidentiality Issues in Substance Use Disorder Treatment – AM Session	Fresno, CA (Fresno Co) May 13, 2014	Thomas Litwicki	88	Agenda and PPT slides	2
Ethical and Confidentiality Issues in Substance Use Disorder Treatment	Fresno, CA (Fresno Co) May 13, 2014	Thomas Litwicki	74	Agenda and PPT slides	2

*Funding Source Key:

Code	Funding Source
1	ETTA Contract
2	UCLA ISAP’s agreement with ADPI (for a separate TA contract funded by CA DHCS)
3	Separate county-/agency-based training contract
4	Separate funding from NIDA or SAMHSA

B. Technical Assistance

The level of preparation for health care reform varies dramatically across California’s counties. UCLA ISAP provides technical assistance to counties by request as resources and expertise allow. Counties requested assistance on many topics including billing/financing integration, preparing providers and contractors for health care reform, electronic health records, and models of collaboration. Technical assistance is provided via e-mail or telephone. In addition, UCLA ISAP organized a number of Integration Learning Collaborative calls that featured non-UCLA ISAP speakers (see Chapter 2 for further information). UCLA ISAP also worked with the California Institute for Behavioral Health Solutions (CiBHS, formerly CiMH) to support their own collaborative by providing SUD-specific expertise.

CiBHS Care Coordination Collaborative

The CiBHS Care Coordination Collaborative (CCC) was organized to improve the health outcomes of individuals with complex needs through care coordination. UCLA ISAP joined the CCC core team to bring SUD expertise to the collaborative in August 2013; the collaborative is scheduled to conclude in March 2015.

Ten teams from around the state are participating in CCC from nine counties: Fresno, Inyo, Lake, Madera, Mendocino, Modoc, two teams from Orange County (College Community Services, Project Renew), Solano, and Tuolumne. Each team includes representatives from mental health, SUD, primary care, and local health plans. These teams are participating in regular phone calls and six in-person meetings to obtain training, discuss and plan

implementation, and obtain training and technical assistance with plan-do-study-act change cycles and use of registries. Each team is also engaging in a pilot project along with their Medi-Cal managed health plans to track costs and outcomes among 10 patients with complex needs.

UCLA ISAP has been leading or co-leading sessions on SUDs or behavioral health integration more generally at each of the learning sessions that have occurred to date, as well as on calls with the teams. Topics discussed have included 42 CFR part 2, care coordination, recent developments in SUD policies, and challenges faced by the teams in coordinating care with their SUD providers. With input from UCLA ISAP, CiBHS will produce a summary document at the conclusion of the collaborative. Conclusions from this document will be included in the next ETTA report if this CCC report is released before the ETTA project concludes in July 2015.

BHbusiness Learning Network

SAMHSA convened the BHbusiness Learning Network, which solicited provider organizations in California to participate in a course to learn more about strategic business planning. The course included online discussions, webinars, and conference calls as well as one in-person meeting. UCLA ISAP participated in the learning network and provided technical assistance and administrative support.

During the six-month course, participants learned about various business principles, including information on how to identify organizational strengths and weaknesses within the context of local healthcare markets and how to identify gaps in market services. Participants also learned how to seek out new customers or clients, increase organizational value in the local healthcare market, and how to overhaul the revenue structure of the organization. The course culminated in a final presentation by each organization that illustrated what they learned from participating, project outcomes, and best practices.

Chapter 5: Report Conclusions and Recommendations

Darren Urada, Ph.D., Valerie Antonini, M.P.H.

Final Report Conclusions

The date January 1, 2014, marked a major milestone in the treatment of substance use disorders and mental health services across the nation. In California, coverage for SUD and MH treatment was expanded to millions of Californians through Medi-Cal and private plans offered through Covered California. Still, while this coverage is critically important, coverage was only a step in expanding access to high quality substance use disorder treatment. As emphasized in our 2013 report, “On their own, the much-anticipated enhanced SUD benefits and expanded insured population in 2014 will not ensure adequate SUD treatment capacity or integration.” Early analyses seem to have confirmed this statement so far.

Expansions of SUD treatment and integration/coordination with primary care face a variety of implementation barriers ranging from federal regulations and approvals down to individual patient perceptions. SPA approval, the IMD exclusion, challenges in certifying and recertifying programs, local variations in Medi-Cal enrollment, the need for workforce development, challenges in financing behavioral health in primary care settings, and health information technology challenges may all have played a role in slowing expansions in service delivery.

Going forward, strategic planning to harmonize efforts at the state, county, and provider levels to create organized delivery systems seems to hold promise for overcoming these challenges. The proposed Drug Medi-Cal waiver provides California with a tremendous opportunity to advance in this direction. While many details still need to be worked out, as currently written the proposed waiver and associated efforts attempt to address numerous barriers described in this report (e.g., appropriate movement through a continuum of care, use of evidence-based practices, coordination with primary care, training and technical assistance, telehealth, IMD exclusion). In addition, early stakeholder responses appear to be positive, which bodes well for buy-in, commitment, and partnerships, all of which are key to the success of integration efforts (see Chapter 2).

If approved, counties will need to submit a plan for their waiver implementation. The system in place in Santa Clara County may be particularly useful for other counties to examine as part of this process, given the need to rapidly deploy a system that in many ways resembles what Santa Clara has already built. Preliminary analyses suggest that such systems have the potential to lead to better care as well as savings, but questions about costs and outcomes remain, and additional data and analyses are needed. Counties need not necessarily try to duplicate Santa Clara’s system, but can learn from it. Santa Clara’s system is complex and has been evolving for 19 years, while under the waiver, counties will have a one-year transition period to build and transform their system. It would therefore make sense to examine and adapt established models, whether from Santa Clara County or elsewhere.

Measuring actual progress toward service expansion and integration will require advances in the use of data systems and measures as well. Accurately measuring the success of SBIRT, for

example, will require both Medi-Cal data from primary care and CalOMS-Tx or Drug Medi-Cal data from the “SUD side.” Just as practitioners and policymakers are being required to emerge from their “silos” of care, the same will need to be true of those who collect and analyze data or maintain the existing data systems.

As expected, California’s system did not leap out of the gate as a result of the 2014 coverage expansion. Still, there is reason for optimism as initial challenges are beginning to resolve and the state is working on a Drug Medi-Cal waiver, which could potentially lead to a substantial transformation of California’s SUD treatment system.

In support of this transformation and the more general continuing evolution of behavioral health’s integration with primary care, the following is a review of all of the recommendations contained in this report.

Review of Recommendations

State Level Recommendations

Integration of Behavioral Health Services

1. ***Monitor referrals and quantify screenings and brief interventions in primary care to track the implementation of SBIRT and its impact on the SUD treatment system.***
 - SBIRT has great potential to link primary care and SUD treatment while driving referrals to specialty care, but data on SBIRT implementation is not yet available. This would most likely be best achieved through Medi-Cal claims data. UCLA ISAP can assist DHCS with these efforts if needed.
2. ***Cover and use depot naltrexone under the DMC waiver to aid in the reduction of detoxification re-admissions.***
 - At this writing, waiver coverage of this medication is ambiguous, but if it is included as a DMC pharmacy benefit, the medication will be easier to access than it is in its current designation as a Medi-Cal medical benefit.
3. ***Use a session at the annual DHCS conference as a starting point to facilitate communication on MH and SUD measures across the state.***
 - To the extent that this conference attracts evaluators and county participants in MH and SUD projects being evaluated, including such a session on the agenda in 2015 could serve as a useful starting point to start a discussion of the appropriateness and practicality of standardization of integration-related measures being used by separate projects across the state.
4. ***Examine how models such as the Accountable Care Organization (ACO) and Coordinated Care Organization (CCOs) might inform future development of integrated delivery models in California.***

- Data from ACO and CCO demonstration pilots in other states suggest these models can be effective for financing integrated services, and may inform the future development of more integrated delivery models in California.
5. ***Investigate existing behavioral health home initiatives in other states and consider implementing the health homes option provided through Section 2703 of the ACA.***
 - Health homes can provide enhanced care coordination for individuals with complex behavioral health needs, but changes in state regulation are needed to support the development of this promising model. The state should pursue opportunities provided by Section 2703 that specifically address integrated behavioral health care within the health home.
 6. ***Explore methods of increasing behavioral health integration into the patient-centered medical home (PCMH) model, while emphasizing the importance of behavioral health to the mission and values of patient-centered care.***
 - While PCMHs demonstrate great potential in providing coordinated care for individuals with complex health needs, behavioral health is not a required component of the PCMH model. Value-based components have been proposed for integrating behavioral health into the PCMH, which can provide benefits even in resource-limited primary care settings.
 7. ***Direct resources towards training and implementation of evidence-based practices (EBPs), while continuing to monitor fidelity and effectiveness among different settings and populations.***
 - Broader adoption of EBPs has the potential to greatly improve care for SUDs and MH disorders. Additional training and technical assistance is needed to support dissemination and implementation of effective practices.
 8. ***Continue efforts to build the California behavioral health workforce.***
 - Workforce development will continue to be critical as ACA implementation continues. Training and technical assistance ideas include: (1) identifying the training needed to help SUD/MH staff become effective in primary care, (2) making distinctions between specialty care needs and MH/SUD generalist skills, (3) identifying SUD personnel who want to learn new skills to work in primary care and provide them with training.
 9. ***Further develop content areas for the future behavioral health workforce curriculum.***
 - Currently recommended content areas include: (1) providing behavioral health care in a primary care setting: culture, needs and interdisciplinary collaboration, (2) screening brief intervention and referral for substance use, mental health and medical diseases, (3) understanding chronic medical diseases, basic physiology, terminology and treatment strategies, (4) understanding common mental health disorders—identification and intervention, (5) medical interventions for substance use, physiology of drugs of abuse and medication assisted treatment, and (6) care management of patients in a multi-service setting.

10. *Provide funding and technical assistance to providers to support the development of telehealth infrastructure for behavioral health integration.*

- Access to services is an important issue in rural and underserved areas throughout the state. Given existing barriers, telehealth is a viable option to increase integration and expand access to counseling, consultation, and medications for SUD and MH.

11. *Advocate for increased funding (e.g., through grants and/or greater inclusion of behavioral health in federal meaningful use incentives) and provide technical assistance to providers to support the development of behavioral health-specific health information technologies policies and infrastructure.*

- Behavioral health providers often face special challenges to adopting EHRs and collecting and sharing patient information through HIEs. Funding and technical assistance such as that provided by the SAMHSA-HRSA CIHS can make a difference in the success of behavioral health-specific and integrated HIT initiatives.

12. *Examine barriers posed by 42 CFR Part 2 and provide input to SAMHSA.*

- 42 CFR Part 2 is meant to provide stricter confidentiality protections for patients' and clients' SUD-related information; however, many providers support revising the regulations to reflect new technological capabilities and the need to share information for care coordination. SAMHSA has been soliciting input on these issues.

13. *Provide training and technical assistance to support the implementation of team-based care models and the development of staff competencies for integrated behavioral health. Explore options for certification and reimbursement of MH and SUD peer support specialists.*

- Development and support of the workforce that will be delivering integrated care requires attention to (1) staffing and designing teams, (2) developing competencies for integrated care through training, and (3) engaging patients and peer supporters to be involved in managing the process of care in a patient-centered manner.

County- and Provider-Level Recommendations

Integration of Behavioral Health Services

14. *Obtain buy-in and commitment from organizational leadership to support integration.*

- Ensuring that the senior leadership of all participating organizations is actively engaged and supportive is critical for success. Leaders must establish integration as a priority, work to clear existing barriers, and create a culture that is conducive to integration.

15. Obtain buy-in from staff at all levels of the organization throughout the implementation process.

- Staff are directly responsible for the day-to-day work of implementing integration; therefore, it is essential to understand their needs and solicit input on any new processes and procedures. Provide education and training to prepare staff and use frequent encouragement and outreach throughout the process.

16. Ensure continuing communication between providers and help them understand each other's respective roles.

- Primary care and behavioral health providers should have ongoing meetings, both formal and informal, to consult and communicate about shared patients. Relationships must be built through regular contact and communication (e.g., electronic, face-to-face, or written).

17. Reach out to other local agencies and provider organizations to create partnerships and deliver better coordinated and integrated care at the local community level.

- Collaboration and networking between local agencies and provider organizations is important to support successful bidirectional referrals and ensure that patients experience better access to services and ease of navigation throughout the system of care.

18. Partner with county Medi-Cal managed care plans and commercial insurance in order to coordinate care for patients across systems of care.

- Behavioral health organizations must learn to communicate with insurance companies, understand what insurance companies expect from providers, and negotiate and obtain contracts.

19. Invest in building the right organizational infrastructure and processes for integration, such as through integrated EHR and billing systems, credentialing, utilization review, and referral staff.

- Because providers often use different systems, it is necessary to work on creating shared templates and tools in order to exchange information. Designing standard processes and engaging providers is important for creating efficiency.

20. Seek input from patients on their perceptions of integrated services, and barriers and challenges to accessing behavioral health services.

- Patient feedback and engagement are important for gauging the true success of any integration project and can help guide further improvements to make care more accessible and patient-centered. Methods for soliciting patient input may include focus groups and interviews.

21. Continue efforts to reduce the stigma associated with mental and substance use disorders and create awareness of available behavioral health services through brochures and information.

- Stigma remains a barrier to accessing behavioral health services. Providing information about available MH and SUD services in primary care and other health care settings can increase awareness and help individuals receive services that they need while reducing stigma by presenting it as a normal part of health care.

22. Engage in data collection and tracking in order to measure outcomes and performance and identify gaps in care.

- Analysis of process and outcome data can help counties and providers identify where improvements can be made when planning or implementing an integration initiative. Collected data can also be used in applying for grant funding, sharing successes with other stakeholders, and other activities.

23. Examine Santa Clara and other counties to aid in development of waiver implementation plans.

- Santa Clara County, DHCS, and UCLA ISAP could facilitate dissemination of information about the Santa Clara model through trainings and dissemination of information. Further UCLA ISAP analyses of Santa Clara outcomes may also help counties form projections about potential waiver outcomes.
- Lessons may also be learned from other counties that have experience with policies that resemble those to be implemented under the waiver. Under DHCS's direction, UCLA ISAP could embark on efforts to systematically collect and disseminate this information.

24. Prescribe depot naltrexone (brand name Vivitrol) to reduce “revolving door” admissions among alcohol and opiate users.

- This may be particularly useful for very frequent users of detoxification. This medication may be covered by DMC under the waiver.

Appendices

CONFERENCES ATTENDED

Listed below are selected conferences and meetings at which ETTA staff have attended, presented, and/or provided assistance through FY 2013-2014.

July 2013

- **California Addiction Training and Education Series (CATES)** on the topic of “The Changing Behavioral Health Care Landscape: Integration, Innovation, and Financing Models” – May 17 in Rialto, CA; July 12 in Hanford, CA; August 16 in San Leandro, CA; and September 20 in Redding, CA.
- **Office of Statewide Health Planning and Development (OSPHD) Mental Health Services Act (MHSA) Workforce Education and Training (WET) Program Career Pathways Sub-Committee (Mental Health Focus) Meeting** – July 9, July 30, and August 20, and September 17 in Sacramento, CA. Brandy Oeser participated on the sub-committee as a Substance Abuse Representative.

August 2013

- **California Addiction Training and Education Series (CATES)** on “The Changing Behavioral Health Care Landscape: Integration, Innovation, and Financing Models” – May 17 in Rialto, CA; July 12 in Hanford, CA; August 16 in San Leandro, CA; and September 20 in Redding, CA.
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September 2013

- **California Addiction Training and Education Series (CATES)** on the topic of “The Changing Behavioral Health Care Landscape: Integration, Innovation, and Financing Models” – May 17 in Rialto, CA; July 12 in Hanford, CA; August 16 in San Leandro, CA; and September 20 in Redding, CA.
- **Office of Statewide Health Planning and Development (OSPHD) Mental Health Services Act (MHSA) Workforce Education and Training (WET) Program Career Pathways Sub-Committee (Mental Health Focus) Meeting** – July 9, July 30, and August 20, and September 17 in Sacramento, CA. Brandy Oeser participated on the sub-committee as a Substance Abuse Representative.
- **2013 Substance Abuse Research Consortium (SARC) Meeting** on the topic of “Challenges and Opportunities for the Substance Use Disorder Treatment Workforce - 2013 and Beyond” and a follow-up workgroup meeting on “Starting a Workforce Conversation in California” – September 11-12 in Sacramento, CA.
- **California Primary Care Association (CPCA) Behavioral Health Network Meeting** – September 12 in Sacramento, CA.

- **County Alcohol and Drug Program Administrators Association of California (CADPAAC)** Quarterly Meeting – September 25-26 in Sacramento, CA. Drs. Darren Urada and Richard Rawson co-moderated a discussion with Dr. Mark Stanford and Victor Kogler on the topics of SUD workforce issues; Medi-Cal enrollment; utilization review procedures and medical necessity; and inpatient detoxification services.

October 2013

- **California Primary Care Association (CPCA)** Annual Conference on the topic of “Community Clinics and Health Centers: Leading the Way” – October 3-4 in Sacramento, CA.
- **10th Statewide Conference on Integrated Care** on the topic of “Integrated Substance Use, Mental Health, and Primary Care Services” – October 23-24 in Universal City, CA.
- **2013 Addiction Health Services Research (AHSR)** Conference – October 23-25 in Portland, OR. Elise Tran and Dr. Cheryl Teruya presented on integration-related work at the conference.

November 2013

- None reported.

December 2013

- None reported.

January 2014

- **Insure the Uninsured Project (ITUP)** Issue Workgroup on the Healthcare Workforce – January 17 in Los Angeles, CA.
- **Governor’s Prevention Advisory Council (GPAC)** Quarterly Meeting – January 23 in Sacramento, CA. Dr. Rawson delivered a brief presentation on screening, brief intervention and referral to treatment (SBIRT) at the meeting.
- **County Alcohol and Drug Program Administrators Association of California (CADPAAC)** Quarterly Meeting – January 29-30 in Sacramento, CA. Drs. Urada and Tom Freese moderated a roundtable discussion on Affordable Care Act (ACA) implementation and SBIRT.

February 2014

- **Insure the Uninsured Project (ITUP)** 18th Annual Statewide Conference – February 11 in Sacramento, CA.

March 2014

- **Arizona State University (ASU) Integrated Behavioral Healthcare Conference** – March 13-14 in Long Beach, CA. Dr. Urada presented on the topic of “Do Substance Use Disorder and Mental Health Services Reduce Medical Costs: What Does the Research Say?”
- **BHbusiness Strategic Business Planning Deep Dive Meeting** – March 14 in Los Angeles, CA.
- **DHCS Behavioral Health Forum Kick Off Meeting, Part 1** – March 24 in Sacramento, CA.

- **Board of State and Community Corrections (BSCC) Data and Research Committee Meeting** – March 25 in Sacramento, CA.
- **County Alcohol and Drug Program Administrators Association of California (CADPAAC) Quarterly Meeting** – March 26 in Sacramento, CA. Dr. Rawson presented on the topic of “Best Practices & Effectiveness of Residential, Outpatient and Sober Living Services.”

April 2014

- **DHCS Waiver Advisory Group Meeting, Parts 1, 2, and 3** – April 2, April 15, and April 30 in Sacramento, CA. Dr. Urada presented at the April 15 meeting on the research evidence supporting various SUD treatment modalities.
- **California Institute for Mental Health (CiMH) Evidence Based Practices Symposium** on the topic of “Early Identification Approaches and Treatment for Underserved Populations” – April 9 in Sacramento, CA. Dr. Freese presented on “Evidence Based Practices and Current Innovations in the Treatment of Substance Use Disorders.”
- **UCLA Addiction 2014 Seminar in Addiction Psychiatry** on the topic of “The Affordable Care Act and the Future of Addiction Medicine in Primary Care” presented by Keith Heinzerling, MD, MPH – April 22 in Los Angeles, CA.
- **California Institute for Mental Health (CiMH) Behavioral Health Information Management Conference** – April 23-24 in San Diego, CA. Dr. Urada presented on the topic of “Building the Business Infrastructure to Thrive in the Era of Health Care Reform: Will Some Be Left Behind?”

May 2014

- **DHCS Behavioral Health Forum Kick Off Meeting, Part 2** – May 6 in Sacramento, CA.
- **National Council for Behavioral Health Annual Conference** – May 5-7 in Washington, D.C.
- **County Alcohol and Drug Program Administrators Association of California (CADPAAC) Quarterly Meeting** – May 20-23 in Sacramento, CA.

June 2014

- None reported.

WEBINARS ATTENDED

Listed below by topic are selected webinars that ETTA staff have attended through FY 2013-2014.

ACA Enrollment and Implementation

Changes in Medicaid and Other Coverage: Learn How the CMS Rule Impacts Behavioral Health

National Council for Behavioral Health

July 24, 2013

10:00-11:00am Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

Update on Implementation of the ACA: Is California Ready?

UCLA Fielding School of Public Health: Continuing the Conversation

October 2, 2013

12:00-1:00pm Pacific

<http://ph.ucla.edu/news/multimedia/continuing-conversation>

The ABCs of Open Enrollment for Behavioral Health Providers

National Council for Behavioral Health

October 31, 2013

10:00-11:30am Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/>

Got Insurance? California's Progress Toward Universal Coverage

UCLA Fielding School of Public Health: Continuing the Conversation

January 15, 2014

12:00-1:00pm Pacific

<http://ph.ucla.edu/news/multimedia/continuing-conversation>

ACA and Addiction Treatment: Implications, Policy and Practice Issues

National Council for Behavioral Health

January 29, 2014

10:30am-12:00pm Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/>

The Affordable Care Act in California: Briefing and Panel Discussion

Kaiser Family Foundation

February 19, 2014

<http://kff.org/health-reform/event/a-briefing-in-washington-d-c-on-the-aca-in-california/>

Primary Care-Behavioral Health Integration

Developing an Integrated Care Management Program (Certificate Program in Integrated Care Management for the Patient Centered Medical Home)

UMass Medical School Center for Integrated Primary Care

July 11, 2013

12:00-12:45pm Pacific

<http://www.umassmed.edu/uploadedFiles/fmch/CIPC/Training/CMN/CM%20Free%20intro%20webinar.pdf>

Introduction to Primary Care Behavioral Health and Integrated Behavioral Care

UMass Medical School Center for Integrated Primary Care

July 15, 2013

11:00-11:45am Pacific

Integration Innovations: A Discussion with Federal Agencies, Part 1

SAMHSA-HRSA Center for Integrated Health Solutions, co-sponsored by AHRQ

July 31, 2013

<http://www.integration.samhsa.gov/about-us/webinars>

Integrating Addiction and Mental Healthcare

National Council for Behavioral Health

August 22, 2013

11:00am-12:00pm Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

Integrating Behavioral Health in Primary Care: Lessons from Health Centers

SAMHSA-HRSA Center for Integrated Health Solutions

September 19, 2013

10:30-11:30am Pacific

<http://www.integration.samhsa.gov/about-us/webinars>

Successful Partnerships: What Primary Care Needs from Behavioral Health

National Council for Behavioral Health

March 3, 2014

10:00-11:00am Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/>

A Review of Successful but Stressful Integration of Behavioral and Primary Care

Institute for Behavioral Healthcare Improvement (IBHI)

June 17, 2014

9:00am-10:00am Pacific

<http://www.ibhi.net/webinar-june-17-a-review-of-successful-but-stressful-integration-of-behavioral-and-primary-care/>

Workforce Development and Training

Peer Support in Behavioral Health and Its Emerging Practice Standards

SAMHSA Recovery to Practice (RTP)

August 1, 2013

<http://www.dsgonline.com/RTP/webinars/8.1.2013.html>

New Roles for Case Managers in Integrated Health Systems, Part 1

National Council for Behavioral Health

October 10, 2013

11:30am-1:00pm Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/>

New Roles for Case Managers in Integrated Health Systems, Part 2

National Council for Behavioral Health

October 30, 2013

11:00am-12:30pm Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/>

Training Behavioral Health Professionals to Succeed in Primary Care

UMass Medical School Center for Integrated Primary Care

December 11, 2013

10:00-11:00am Pacific

<http://www.umassmed.edu/cipc/index.aspx>

Resources for the New Integrated Healthcare Workforce

SAMHSA-HRSA Center for Integrated Health Solutions

March 6, 2014

11:00am Pacific

<http://www.integration.samhsa.gov/about-us/webinars>

Role of Peer Providers in Integrated Health

SAMHSA-HRSA Center for Integrated Health Solutions

March 25, 2014

11:00am-12:30pm Pacific

<http://www.integration.samhsa.gov/about-us/webinars>

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Screening, Brief Intervention and Referral to Treatment: Educational Webinar

CA Department of Health Care Services and UCLA ISAP

December 19, 2013

11:30am-12:30pm Pacific

SBIRT: Part of Project Care – Integrated Behavioral Health Care Services in Kern County, CA

Institute for Research, Education, and Training in Addictions (IRETA)

June 25, 2014

9:30-11:00am Pacific

http://ireta.org/6_25_14webinar

Medication Assisted Treatment (MAT)

What's New with Addiction Treatment Medications: Exploring the Implications for the Addiction Workforce

MAT Health Network Learning Collaborative

January 9, 2014

10:00-11:30am Pacific

<http://naadac.org/default.aspx?p=110588&evtid=152683&date=1/9/2014>

Prescription Drug Abuse Prevention and Treatment

Innovative Approaches to Reducing Opioid Misuse and Caring for Chronic Pain

National Council for Behavioral Health

October 16, 2013

11:00am-12:30pm Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/>

**SAMHSA's Opioid Overdose Prevention Toolkit & Prescription Drug Abuse
Prescription Drug Abuse & Misuse: Neurobiology, Epidemiology, & EBPs**

ATTC Network Third Thursday iTraining

January 16, 2014

<http://www.attcnetwork.org/learn/education/webinarseries.asp>

Health Information Technology

Care Coordination in Action: Sharing Behavioral Health Patient Information

National Council for Behavioral Health

November 20, 2013

11:00am-12:30pm Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/>

Adopting Innovative Technology to Support Recovery: Lessons from Payers

NIATx

June 17, 2014

10:00-11:00am Pacific

<http://www.niatx.net/Content/ContentPage.aspx?NID=163>

Mental Health and Addiction Parity

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Stakeholder Briefing

U.S. Department of Health and Human Services, Department of Labor, Department of the Treasury

May 22, 2014

9:00-10:00am Pacific

Privacy and Confidentiality

SAMHSA 42 CFR PART 2 Listening Session

Substance Abuse and Mental Health Services Administration (SAMHSA)

June 11, 2014

<http://www.samhsa.gov/healthprivacy/>

Other Topics

Improving Quality and Access to Integrated Care for Racially Diverse and Limited English Proficiency Communities

SAMHSA-HRSA Center for Integrated Health Solutions

July 16, 2013

11:00am-12:30pm Pacific

<http://www.integration.samhsa.gov/about-us/webinars>

DSM-5 Changes: Clinical Overview & Business Implications

National Council for Behavioral Health

July 31, 2013

11:00am-12:30pm Pacific

<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

Drug Trends: Old Drugs and New Problems - New Drugs and New Problems

Providers' Clinical Support System for Opioid Therapies (PCSS-O) and the American Psychiatric Association

September 6, 2013

11:30am-12:30pm Pacific

<http://www.pcoss-o.org/archived-webinar-61>

An Intense Discussion About Measuring Outcomes in Behavioral Health Care

Institute for Behavioral Healthcare Improvement

October 10, 2013

9:00-10:00am Pacific

<http://www.ibhi.net/ibhi-webinar-october-10-measuring-and-utilizing-outcomes-of-treatment/>

Patient-Centered Care: Meaning, Evidence and Future

UCLA Fielding School of Public Health: Health Policy Seminar

January 22, 2014

12:00-1:00pm Pacific

<http://healthpolicy.ucla.edu/newsroom/press-releases/pages/details.aspx?NewsID=132>

Medical Record Number	First name	Last name	Date of birth	Sex	Race	Ethnicity: Hispanic?	Date of Service	Type of Service	Substance Use Score	Depression score	Anxiety score	Patient Satisfaction score
1	John	Doe	1/1/1970	M	White	N	1/1/2013	Assess and POC	7	17	4	50
1	John	Doe	1/1/1970	M	White	N	1/2/2013	Psychotherapy				
1	John	Doe	1/1/1970	M	White	N	1/15/2013	Psychotherapy				
1	John	Doe	1/1/1970	M	White	N	2/1/2013	Psychotherapy	5	8	4	70

Names, dob are only necessary if we want to link across organizations, e.g. if someone was referred from one organization to another, this would allow us to see what the outcome of that referral was.	Demographics are mostly for descriptive purposes for now, but if enough data accumulates we can look for patterns, e.g. are some groups more or less likely to get treatment? If so, strategies can be developed to address this. In addition to its role as an identifier, birth date will be used to generate age.	Dates and types of services provide information on treatment initiation, engagement, and retention. We can also look at their association with changes in outcome measures (screening, costs, etc)	If screening/monitoring is in place, scores can be tracked over time to evaluate whether patients are getting better, and to provide clues to where greater staff attention or staff training and technical assistance might be beneficial. We can work with organizations regarding measures and procedures if there is an interest in screening but it is not currently in place.
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Diagnosis 1, ICD9	Diagnosis 1 desc	Diagnosis 2, ICD9	Diagnosis 2 desc	Diagnosis 3, ICD9	Diagnosis 3 desc	Diagnosis 4, ICD9	Diagnosis 4 desc	Diagnosis 5, ICD9	Diagnosis 5 desc	Paid for by	Cost	Notes
493.9	Asthma, un	296.3	Depressio	303.9	Alcohol Dependence					Medi-Cal	\$X	
										Medi-Cal	\$X	
										Medi-Cal	\$X	
										Medi-Cal	\$X	
<p>Diagnoses provide an alternative measure of how common MH/SUD problems are. This is particularly useful if screening is not in place. If medical diagnoses are available, we can also give you feedback on what medical problems are most common and which are most commonly associated with MH/SUD problems. In some cases this can yield surprising results. For example, one hospital had a large number of sickle cell anemia diagnoses. It turned out that patients seeking pain medications had learned they could get pain meds if they reported having this.</p> <p>Costs can be collected if the organization wants to examine whether MH/SUD services reduce total medical costs. This might be a moot point if there are few such services today, however, so this could be put off for now.</p> <p>Explanations, e.g. was the patient referred elsewhere?</p>												

San Luis Obispo County Behavioral Health Needs Assessment

Introduction

Thank you for participating in the San Luis Obispo County Behavioral Health Needs Assessment Survey. This county-wide survey is being conducted by the Central Coast Behavioral Health Policy Group with technical assistance from the UCLA Integrated Substance Abuse Programs.

Your input regarding the delivery of adult behavioral health services in the San Luis Obispo County community is important and will help assess the county's need for community-based services.

The survey should take approximately 15-20 minutes to complete, and your responses will be kept anonymous.

As a token of appreciation for completing this survey, you will be given the opportunity to enter a drawing for a \$50 gift card.

You may contact Dr. Cheryl Teruya (cteruya@ucla.edu) if you have any questions regarding the survey.

Background

1. What is your professional degree?

- MD
- RN
- NP
- PA
- MFT
- LCSW
- Licensed Psychologist
- Other (please specify):

2. How many years have you worked in your current field of expertise?

San Luis Obispo County Behavioral Health Needs Assessment

3. What type of organization do you work for? (Check all that apply.)

- Government
- Group or Self Practice
- Private
- Not for Profit

4. What geographic areas of the county does your organization/practice serve? (Check all that apply.)

- Arroyo Grande
- Atascadero
- Cambria
- Carissa Plains
- Cayucos
- Creston
- Grover Beach
- Halcyon
- Los Osos
- Morro Bay
- Nipomo
- Oceano
- Paso Robles
- Pismo Beach
- San Luis Obispo City
- San Miguel
- San Simeon
- Santa Margarita
- Templeton
- Other (please specify):

Patient/Client Screening and Referral

San Luis Obispo County Behavioral Health Needs Assessment

5. On average, how many patients/clients do you see in a given month (total)?

6. On average by month (estimates OK), about how many of your patients/clients do you recognize or suspect as having:

Both mental health and substance use disorders (co-occurring)?

A mental health problem/issue only (e.g., depression, anxiety, bipolar)?

A substance use disorder only (e.g., alcohol dependence, prescription opioid misuse/dependence, illicit drug use)?

7. Does your organization routinely screen patients/clients for mental health or substance use disorders by asking them standardized questions on these topics? (Check all that apply.)

- Yes, for mental health
- Yes, for substance use
- We routinely ask patients verbally, but not by using formal screening instruments
- No, no routine screening

Patient/Client Screening and Referral

San Luis Obispo County Behavioral Health Needs Assessment

8. Please check all places that you refer your patients/clients for behavioral health services based on diagnosis:

	Mental Health Diagnosis	Substance Use Disorders	Both - Co- Occurring Disorders
I do not usually refer off-site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On-site behavioral health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twelve Step Programs (AA, NA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aegis Methadone Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Churches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Counseling Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Health Centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Recovery Centers (North County & Cambria Connection, Lifestyles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cottage Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out of Area Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Providers in Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Providers Outside of SLO County	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SLO County Drug & Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SLO County Mental Health Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transitions Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "Other", please specify:

San Luis Obispo County Behavioral Health Needs Assessment

9. What is the average length of time from referral to when patients/clients receive their service (by listed agency):

	within 7 days	within 30 days	within 90 days	after 90 days	don't know
On-site behavioral health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Twelve Step Programs (AA, NA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aegis Methadone Clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Churches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Counseling Center	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Health Centers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Recovery Centers (North County & Cambria Connection, Lifestyles)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cottage Hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Out of Area Providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Private Providers in Community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Private Providers Outside of SLO County	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatric Unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SLO County Drug & Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SLO County Mental Health Department	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transitions Mental Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Veteran's Administration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If "Other", please specify:

Patient/Client Screening and Referral

San Luis Obispo County Behavioral Health Needs Assessment

10. If you do not normally refer patients/clients for off-site substance use disorder services, why not? (Check all that apply.)

- We have adequate substance use disorder services on-site
- Substance use disorder services are not readily available in the community
- Patients/clients are not interested
- Patients/clients can't afford them
- I'm not sure where to refer them to
- Other (please specify):

11. If the obstacles above were overcome, about how many more patients/clients do you think you would refer monthly for substance use disorder services?

12. If you do not normally refer patients/clients for off-site mental health services, why not? (Check all that apply.)

- We have adequate mental health services on-site
- Mental health services are not readily available in the community
- Patients/clients are not interested
- Patients/clients can't afford them
- I'm not sure where to refer them to
- Other (please specify):

13. If the obstacles above were overcome, about how many more patients/clients do you think you would refer monthly for mental health services?

With serious mental illness (SMI)

Non-SMI

Looking Ahead

San Luis Obispo County Behavioral Health Needs Assessment

14. What services need to be added or expanded to help address your patients'/clients' mental health and substance use disorder needs?

15. What do you think needs to be done to improve access to behavioral health services for your patients'/clients?

16. Which of the following topics would you like to receive more information about (through training, brochures, etc.)?

- Motivational Interviewing
- Screening, Brief Intervention & Referral to Treatment (SBIRT)
- Medication-Assisted Treatment
- Insurance Parity / Billing for Behavioral Health Services
- Local Resources Available in the County
- Other (please specify):

White Paper on California Substance Use Disorder Treatment Workforce Development

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**WHITE PAPER ON CALIFORNIA SUBSTANCE USE DISORDER TREATMENT
WORKFORCE DEVELOPMENT**

EXECUTIVE SUMMARY

Traditionally, substance use disorder (SUD) services have been delivered in isolation from the rest of health care, with a paraprofessional treatment staff, different treatment philosophies, different sources of funding, and different expectations for treatment than the rest of the healthcare system. In the past two decades, this has begun to change, as increasing numbers of formally trained clinicians have entered the SUD workforce and begun providing more evidence-based treatments. With the enactment of legislation mandating parity in insurance coverage for SUD with the treatment of other medical conditions and the growth of the insured population under the Affordable Care Act, trends toward the professionalization of the SUD treatment field will accelerate in the next few years.

As SUD services are increasingly integrated into primary care settings in the coming years, providers will need to evolve from being SUD providers (who deliver services only to address SUD) into *behavioral health specialists*—providers who deliver services to address SUD, mental health, and the management of associated medical conditions. Thus, in the future, California’s SUD workforce will be bifurcated into two distinct *workforces*—one that treats acute SUD in the specialty care system and another that provides integrated behavioral health services in general medical settings.

It is important to note that this White Paper is focused on the workforce development needs for the *treatment* of substance use disorder. It does not address the needs of the

primary prevention workforce, which will be equally as important as the implementation of ACA and its focus on primary prevention.

Key Issues in developing the workforce for the future.

- It is difficult to precisely measure the quantity or quality of California's current SUD workforce. Two challenges inhibit a thorough assessment of the California SUD workforce's capacity: (1) the lack of any comprehensive data concerning the California SUD workforce's size and composition, and (2) the lack of any comprehensive assessments measuring the California SUD workforce's professional capacity. Nonetheless, various data sources do give some insight into the size, composition, and professional capacities of the state's SUD workforce. Available data indicate that the SUD workforce in California is undersized and undereducated and needs additional training in critical skills for implementing evidence-based SUD services in specialty care and for providing behavioral health services in primary care settings.
- The specialty SUD workforce of the future will need to have an adequate understanding of: (1) a basic minimum of professional knowledge, skills, and attitudes needed to provide SUD treatment; (2) recently developed evidence-based practices for SUD treatment; and (3) how to provide appropriate recovery support services. In order to achieve these ends, the California Department of Health Care Services (DHCS) needs to take steps to improve the recruitment and retention of qualified and skilled providers in the SUD workforce.

- To survive and thrive in the integrated behavioral health workforce of the future, SUD providers will need to adapt to working in new clinical roles and develop a new set of clinical and professional competencies. These individuals will need considerable knowledge and skills about working within medical settings and working as part of a comprehensive healthcare team, and they will need a solid foundation in addressing a wide range of mental health and other behavioral conditions.
- Negative attitudes and knowledge gaps concerning substance use conditions among medical and mental health providers working in primary care settings need to be addressed in order to ensure that patients receive appropriate services for substance use conditions.

Recommendations

1. DHCS should conduct a thorough and comprehensive assessment of the California SUD workforce's size, composition, and professional capacity in order to guide future workforce development planning and activities.
2. The State should expand existing training and technical assistance services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment. These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into integrated behavioral health (IBH) providers in medical settings. While

- expanding the workforce, it is also critical that DHCS ensures that SUD and IBH providers are reimbursable.
3. The State should develop strategies to increase compensation for the SUD treatment workforce.
 4. The Substance Abuse and Mental Health Service Administration (SAMHSA) career ladder for SUD counseling should be implemented in California.
 5. Replace the multiple counselor certification organizations with a single, state-level certification organization.
 6. DHCS should collaborate with institutions of higher education to increase recruitment and properly train the SUD workforce.
 7. DHCS and providers of SUD services across California should make a concerted effort to recruit young individuals, males, and racial/ethnic minorities into the SUD workforce. Fewer members of these groups are involved, and generally it is preferable for clients to receive treatment from individuals who are of similar age, gender, and racial/ethnic background.
 8. DHCS should train medical and mental health professionals working in integrated care settings on the basics of substance use and SUD, and their impact on health.

I. Background and Context: The Professionalization and Bifurcation of the SUD Treatment Workforce

Overview

Traditionally, substance use disorder (SUD) services have been delivered in isolation from the rest of health care, with different treatment staff, different treatment philosophies, different sources of funding, and different expectations for treatment. In the past two decades, this has begun to change, as increasing numbers of formally trained clinicians have entered the SUD workforce and begun providing more evidence-based services. With the enactment of legislation mandating parity in insurance coverage for SUD with the treatment of other medical conditions, as well as the growth of the insured population under the Affordable Care Act, trends may encourage a more professional workforce for SUD specialty services.

Furthermore, as SUD services are increasingly integrated into primary care settings in the coming years, providers will need to evolve from being SUD providers (who deliver services only to address SUD) into *behavioral health specialists*—providers who deliver services to address SUD, mental health, and the management of associated medical conditions. Thus in the future, California’s SUD workforce will need to become two distinct *workforces*—one that treats acute SUD in the specialty care system and another that provides integrated behavioral health services in general medical settings.

The Ongoing Professionalization of California's Substance Use Disorder (SUD) Treatment Workforce

Historically, most SUD services in California have been delivered in standalone nonprofit or government-run treatment agencies that were isolated from the rest of the healthcare system.¹ Physicians and other health professionals received minimal to no addiction education or training and generally had not been involved in the care of SUD patients. SUD services operated outside of the medical field. Staff employed in SUD treatment settings were usually addiction counselors who made key decisions related to SUD treatment admission, planning, and discharge without input from physicians or other formally trained medical professionals.² Most addiction counselors organized their programs around self-help, mutual aid, and 12-step principles.³ Often, counseling consisted of encouraging clients to engage with 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous; little was done to treat SUD with psychological, psychiatric, or medical interventions.⁴ SUD providers and the medical field generally did not accept that relapse is part of the natural course of chronic conditions such as substance dependence, or that disease management strategies are necessary to ensure sustainable SUD treatment outcomes.⁵

The SUD workforce has begun to evolve over the past 25 years, becoming increasingly formally trained in using evidence-based strategies and methods adapted from other health disciplines. In the 1990s, an increasing number of academically trained

¹ Jeffrey A. Buck, "The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable Care Act." *Health Affairs (Millwood)* 2011;30(8):1402-1410.; David R. Pating, Michael M. Miller, Eric Gopelrud, Judith Martin, Douglas M. Ziedonis, "New Systems of Care for Substance Use Disorders: Treatment, Finance, and Technology Under Health Care Reform" *Psychiatric Clinics of North America* 2012;35:327-356.

² A. Kennison Roy III & Michael M. Miller, "The Medicalization of Addiction Treatment Professionals" *Journal of Psychoactive Drugs* 2012;44(2):107-118; National Center on Addiction and Substance Abuse, *Addiction Medicine: Closing the Gap Between Science and Practice*. New York: The Author, 2012: Buck, "The Looming Expansion."

³ Buck, "The Looming Expansion"; Roy & Miller, "The Medicalization of Addiction Treatment Professionals."

⁴ Ibid.

⁵ Ibid.

master's-level addiction therapists began entering the SUD workforce. These providers, who had a strong background in developmental psychology and mental health treatment, began utilizing more sophisticated interventions that were tailored to individual client needs.⁶ In particular, SUD clinicians with backgrounds in behavioral psychology created therapeutic modalities (e.g., motivational interviewing, cognitive behavioral therapy, contingency management) that utilized proven psychological and counseling techniques to achieve and maintain positive SUD treatment outcomes. The subsequent development of new SUD medications (e.g., naltrexone, buprenorphine) also helped facilitate an increased presence of physicians in the provision of SUD services in recent decades.⁷

These trends have been buttressed by concerted efforts at the federal and state levels to bring the quality of SUD services up to that expected in the rest of health care. Since 1993, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) has sponsored a network of Addiction Technology Transfer Centers (ATTCs) to enhance professional development among the SUD workforce.⁸ In California, the California Department of Alcohol and Drug Programs has disseminated knowledge of best practices in SUD treatment and facilitated their implementation in clinical settings across the State.

Increased Demand for SUD Treatment as Part of Medical Care

Recent changes in healthcare policy will accelerate the integration of the SUD treatment field with the rest of the medical system in California, while expanding service

⁶ Ibid.

⁷ Joan DiLonardo, *Workforce Issues Related To: Physical and Behavioral Health care Integration, Specifically Substance Use Disorders: A Framework*. Paper developed for joint ONDCP/SAMHSA/HRSA meeting, Washington D.C. August, 2011.

⁸ Center for Substance Abuse Treatment, *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*. Technical Assistance Publication (TAP) Series 21. HHS Publication No. (SMA) 08-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration. 2006.

access and utilization. These trends will hopefully compel SUD service providers to enhance their professional competency in order to operate as members of the healthcare workforce.

Several recent pieces of legislation will facilitate the incorporation of SUD treatment services into the rest of the healthcare system. The 2008 Medicare Improvements for Patients and Providers Act (MIPPA), the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), and the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) have brought insurance coverage for substance use conditions in line with that offered for other chronic conditions by reducing co-payments and increasing benefits for SUD treatment. The 2010 Affordable Care Act (ACA) will expand Medicaid coverage to between 149,000 and 195,000 previously uninsured Californians who need access to health care (including SUD treatment),⁹ and provide them with access to SUD services as mandated by the MIPPA, MHPAEA, and CHIPRA. It is hoped that a significant number of Californians will be gaining access to SUD services in the near future, and that the treatment they receive will be funded by health insurance rather than block grants or other siloed SUD treatment funds. Overall, it is anticipated that these shifts will require the SUD treatment workforce in California to grow by between 2,100 and 2,828 FTEs by 2019.¹⁰

The shift in funding for SUD treatment promises to revolutionize the way that SUD services in California are structured and delivered. Whereas in the past most SUD services have been provided by undertrained, uncertified individuals with little training in

⁹ Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment: Final Report*. Report prepared for California Department of Health Care Services. Boston: Authors, 2012.

¹⁰ Dale Jarvis & John Freeman, *Briefing Paper 4: Workforce Issues Today and in the Future: Workforce Implications of Increased Demand for Mental Health and Substance Use Service*. Paper prepared for California Institute of Mental Health. Seattle, WA: Dale Jarvis and Associates, LLC: 2012.

evidence-based practices, insurers may exert pressure for providers to be properly educated, certified, and able to deliver evidence-based services.¹¹

Integration and the Bifurcation of the SUD Treatment Workforce

The ACA will also facilitate the integration of SUD services with other physical and mental health care services in California. The ACA provides incentives for primary care providers to become Patient Centered Medical Homes for patients with chronic health conditions, including SUD. Though there will be some initiatives to co-locate medical providers in specialty SUD treatment settings, the main focus of integration under the ACA will be the integration of SUD service providers into general medical settings. Though individuals with acute and poorly controlled SUD will continue being treated in the specialty SUD treatment system, many believe that patients with mild to moderate substance use conditions or SUD that is well managed will receive services within integrated primary care and other general medical settings.¹²

The providers who deliver SUD services in integrated care settings will need to expand the scope of their work beyond the diagnosis, treatment, and management of substance use conditions. In almost all of California, the integration of SUD services into primary care settings is occurring as part of a broader effort to integrate *behavioral health* treatment—a broad array of services that includes mental health services, SUD services, and services for co-occurring mental health disorders and SUD—into primary

¹¹ David R. Pating, Michael M. Miller, Eric Goplerud, Judith Martin, & Douglas M. Ziedonis. "New Systems of Care for Substance Use Disorders: Treatment, Finance, and Technology under Health Care Reform." Pating et al., "New Systems of Care." *Psychiatr Clin North Am* 2012 Jun; 35(2):327-56.

¹² Barbara J. Mauer, *Substance Use Disorders and the Person-Centered Healthcare Home*. Report prepared for the National Council for Behavioral Healthcare. Rockville, MD: National Council for Behavioral Healthcare, 2010.

care settings.¹³ Thus providers who deliver SUD services in integrated primary care settings will need to operate as *integrated behavioral health* (IBH) providers, professionals who have a different treatment focus and a broader skill set than is needed in specialty SUD treatment settings.

Consequently, California’s SUD workforce will become bifurcated in the future, with one group of providers working in specialty SUD settings that serve clients with acute SUD, and an IBH workforce that serves clients in integrated primary care settings, serving clients with a broad array of needs related not only to substance use, but also to mental and physical health. The major differences between the work of specialty SUD treatment providers and IBH providers are illustrated in Table 1:

TABLE 1. Comparison of Specialty SUD Services and Integrated Behavioral Health		
Area	Specialty SUD Providers	IBH Providers
Environment and Pace of Work	Planned and scheduled over several months	Spontaneous and hectic, with interventions lasting 3-5 sessions
Treatment Population	Acute SUD	Behavioral health problems (both mental health and SUD) at varying levels of severity
Treatment Focus	SUD	Interrelated medical and behavioral health problems
Who Provides Services	Individual SUD Provider	Integrated Care Team (including IBH provider)
Billing/Administrative Responsibilities	Only SUD system	Complex interrelationship across diverse policies and billing structures

- Treatment Environment/Pace of Work: Traditional SUD treatment tends to occur in relatively small treatment settings with low staff-to-client ratios, and with

¹³ Howard Padwa, Darren Urada, Valerie P. Antonini, Allison Ober, Desiree A. Crevecoeur-MacPhail, & Richard Rawson. "Integrating Substance Use Disorder Services with Primary Care: The Experience in California" *Journal of Psychoactive Drugs* 2012; 44(4):299-306.

intensive treatment services being delivered in the 50-minute hour. By contrast, primary care and integrated medical environments where IBH providers work are characterized by a fast pace of brief interactions with patients, a high patient volume, constant interruptions, and a persistent need to balance immediate needs and priorities.¹⁴

- *Treatment Populations*: The specialty SUD treatment workforce focuses on serving only individuals with acute substance use conditions who meet moderate and severe diagnostic criteria. IBH providers serve clients with more varied levels of severity (moderate to mild).
- *Expanded Focus of Treatment*: Specialty SUD providers generally provide services that address just one type of disorder (SUD) and at one level of severity (acute). IBH providers, on the other hand, need to be able to work with clients with several types of disorders (SUD and mental health disorders) and varying levels of severity. Compared to SUD providers, IBH providers need to deliver care that is more person-centered and focused on an individual's overall health than it is disease-specific.
- *Team Approach*: In specialty SUD treatment, individual providers play a central role in the planning, organization, and delivery of care. In integrated care settings, by contrast, teams of providers from a variety of medical and behavioral health disciplines deliver services and closely collaborate on treatment planning and service delivery activities. IBH providers need to have the communication skills required to work on teams, as well as a willingness to collaborate with others on patient care that is often not necessary in specialty SUD treatment settings. In addition, they will often be working on teams led by primary care

¹⁴ DiLonardo, *Workforce Issues*.

physicians or other medical staff. In particular, medical staff will likely take the lead in organizing and delivering care for patients who have high levels of physical health need or low-level behavioral health conditions. For IBH providers with experience in the SUD system, where they made unilateral decisions about treatment and service delivery without input from collaborators, the adjustment to working as an ancillary team member may be particularly difficult.

- *Billing and Administrative Responsibilities:* With the exception of Drug Medi-Cal services, most SUD services in California have been funded through various block grant, State, and local funds. The majority of behavioral health services delivered in integrated care settings, however, will need to be billed through the same health insurance systems that are used to bill all other medical and behavioral health services. Consequently, IBH providers who shift from specialty SUD settings to integrated care settings will need to become proficient in medical billing and associated policies and administrative responsibilities.

As California plans its SUD workforce development activities in the future, it will need to take the aforementioned differences between specialty SUD care and integrated behavioral health services into account.

Summary

The professionalization and bifurcation of the SUD treatment landscape will have significant implications for the present and future of California's SUD workforce. The specialty workforce will need to rapidly enhance its training, certification, and capacity to provide high-quality, evidence-based services in the specialty SUD treatment sector. Simultaneously, a significant proportion of the SUD workforce may need to develop skills and competencies needed to work as IBH providers, in order to serve new treatment

populations in new treatment settings. The needs of the future specialty SUD workforce and the needs of the future IBH workforce are significantly different; this will be discussed in detail Sections III and IV, respectively.

II. The California SUD Treatment Workforce Today

Overview

It is difficult to precisely measure the quantity or quality of California's current SUD workforce. Two challenges inhibit a thorough assessment of the California SUD workforce's capacity: (1) the absence of any comprehensive data concerning the California SUD workforce's size and composition, and (2) the absence of comprehensive assessments measuring the California SUD workforce's professional capacity.

Nonetheless, various data sources do give some insight into the size, composition, and professional capacities of the State's SUD workforce. The available data indicate that despite progress, California's SUD workforce faces many challenges that are similar to those faced by the SUD workforce across the nation.

Size

It is challenging to precisely measure the size or composition of California's SUD treatment workforce today.¹⁵ A heterogeneous mix of SUD counselors, social workers, nurses, psychologists, and psychiatrists currently provide services to address SUD in a variety of treatment settings, making it difficult to quantify their numbers or precisely define their scopes of practice. As the authors of a 2012 report prepared for the California Office of Statewide Health Planning and Development's Workforce Investment Board (OSHPD/WIB) concluded, the State's SUD treatment workforce remains

¹⁵ University of California, Berkeley, Department of Public Health, *Health Workforce Development Council Career Pathway Sub-Committee: Updated Report*. Report prepared for Office of Statewide Health Planning and Development, California Workforce Investment Board, 2012.

“undefined, lacks clear parameters, and cuts across multiple licensed, certified and unclassified professions”¹⁶ that have not been systematically tracked or analyzed.

Though it is not currently possible to precisely measure the size or composition of the State’s SUD workforce, data from several disparate sources can be merged to create a rough estimate of how many individuals are providing SUD services in California, as well as some of their basic characteristics.

According to OSHPD/WIB, there were fewer than 20,000 persons registered as alcohol or drug abuse counselors with the California Department of Alcohol & Drug Programs as of late 2012.¹⁷ Data from the U.S. Bureau of Labor Statistics shows that in 2008, there were approximately 13,400 mental health and substance use social workers in California and 9,500 substance use and behavioral disorder counselors.¹⁸ However, since these categories include both SUD service providers and individuals who do not provide SUD services, it is difficult to use these data to gauge how many SUD social workers or counselors are working in California.

Nonetheless, it is clear that California’s SUD workforce is not as large as it should be. According to the 2012 OSHPD/WIB report, California had just 2.01 SUD counselors per 100,000 total population, approximately 8.6% lower than the national average.¹⁹ Furthermore, the State’s 2012 Mental Health and Substance Use Needs Assessment reported that there are “very few” board certified addiction psychiatrists practicing in California, and there is a dearth of SUD providers of any sort serving the State’s rural populations.²⁰ Consequently, California’s SUD workforce needs to grow and

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*.

¹⁹ University of California, Berkeley, School of Public Health, *Career Pathway Sub-Committee Updated Report*.

²⁰ Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*.

develop greater disciplinary and geographic diversity in order to better meet the SUD service needs of the State's population.

It is particularly critical to increase the size of California's SUD treatment workforce because demand for SUD services will grow dramatically in the coming years. According to estimates from the California Employment Development Department, demand for all categories of mental health and SUD service providers will have increased at least as fast as average compared to other occupations between 2008 and 2018. Demand for many behavioral health professionals—particularly those who work in fields related to the delivery of SUD services—will have accelerated at a significantly more rapid rate than demand for other occupations; demand for mental health and substance use counselors will have increased by 15.7%, demand for substance use and behavioral disorder counselors will have increased by 14.7%, demand for mental health counselors will have increased by 16%, and demand for rehabilitation counselors will have increased by 9.1%.²¹

In all likelihood, these projections underestimate the actual growth in demand for SUD services, as they were made before recent developments that will likely lead to significant spikes in SUD treatment demand. California's 2011 Public Safety Realignment Act (Assembly Bill 109) will increase the number of criminal justice offenders under community supervision, and between 60% and 90% of the offenders being sent back to local communities have SUD treatment needs.²² Furthermore, the Affordable Care Act will give between 149,000 and 195,000 previously uninsured

²¹ Ibid.

²² California Mental Health Planning Council, *AB 109 Implementation, The First Year: How Four California Counties Met the Challenges of the 2011 Public Safety Realignment in Their Communities*. Sacramento, CA: The Author, 2011.

Californians who need SUD services access to health care (including SUD treatment), thus further driving demand for a larger SUD workforce.²³

Composition

Though it is difficult to develop a detailed picture of the California SUD workforce, two statewide surveys—one conducted by the County Alcohol and Drug Programs Administrators' Association of California (CADPAAC) in 2007²⁴, the other conducted by the Pacific Southwest Addiction Technology Transfer Center (PSATTC) in 2011–2012²⁵—provide some insight into the California SUD workforce's demographics, makeup, training, and job roles. Both of these surveys have limitations: the CADPAAC survey is over five years old and had a very low response rate; the PSATTC survey did not include detailed information concerning the workforce's job duties or capacities and includes data from Arizona as well as from California. Nonetheless, the data from the two surveys can be triangulated to get a rough picture of the State's SUD workforce (Table 2).

California's SUD workforce is predominantly female, White, and in their 40s and 50s. A significant proportion of the workforce—between 39% and 57%—is personally in recovery from SUD. The workforce is not highly educated, with approximately 40% of SUD workers reporting that they did not earn a college degree, and approximately 10%–20% reporting that they only finished high school or less. Slightly more than one-fifth of California's SUD workforce has graduate degrees, and only 2%–3% of the workforce has a doctoral or medical degree. Approximately half of the workforce has current

²³ Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*

²⁴ Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*. Survey Analysis and Summary Report prepared for County Alcohol and Drug Programs Administrators' Association of California. Sacramento, CA: Authors, 2009.

²⁵ Margaret Camarena, *Pacific Southwest ATTC 2012 Regional Workforce Report*. Report prepared for Pacific Southwest Addiction Technology Transfer Center, 2012.

certification or licensure, and around one-quarter of them have certification or licensure pending. Though the PSATTC data do not provide detailed information on job roles, the CADPAAC survey indicates that the bulk of SUD providers in California are addiction counselors (72.7% of the workforce). Social workers account for 14% of California’s SUD providers, psychologists account for approximately 12%, and nurses and medical staff make up just 3%. Thus, in spite of the aforementioned trends that have facilitated an increased role for formally trained mental health and medical professionals in SUD treatment settings, a significant portion of the SUD workforce remains poorly educated, has no advanced training, and lacks appropriate certification.

TABLE 2. CHARACTERISTICS OF THE CALIFORNIA SUD WORKFORCE		
	CADPAAC Survey (2007)	PSATTC Survey (2012)
Gender	61.6% Female	67% Female
Race	50.4% White 20.8% Hispanic/Latino 14.7% Black/African American 3.1% Asian/Pacific Islander	77% White 4% Hispanic/Latino 6% Black/African American 4% Asian/Pacific Islander
Age	54.1% in Age Range 41–59	53% in Age Range 35–55
In Recovery from SUD	56.5%	39%
Education	High School or Less: 9.4% Some College: 29% Associates Degree: 14.9% Bachelor’s Degree: 17.5% Master’s Degree: 18.9% Doctoral Degree: 3.2%	High School or Less: 21% Some College: 19.5% Associates Degree: 13% Bachelor’s Degree: 17% Master’s Degree: 22% Doctoral Degree/MD: 2%
Certification/Licensing	Never/Not Current: 20.8% Pending: 28.1% Current: 49.4%	Never/Not Current: 9% Pursuing: 23% Pending: 5% Current: 54%
Job Role	Addictions Counseling: 72.7% Social Work/Human Service: 14.0% Psychology: 11.9% Nursing: 2.5% Medicine: 0.5%	N/A

Judging by these indicators, together with findings from other major reports such as the State's 1115 Waiver Mental Health and Substance Use Needs Assessment,²⁶ OSHPD/WIB's Health Workforce Development Council Career Pathway Sub-Committee,²⁷ and the 2008 Little Hoover Commission on California's SUD treatment system,²⁸ it is clear that California's SUD workforce is understaffed, undereducated, and underqualified.

Training and Technical Assistance Needs

Data concerning the California SUD workforce's professional capacity to deliver evidence-based care across the continuum of SUD services are sparse. However, the little information available supports the finding that the State's SUD workforce is underqualified and undertrained in several key areas. The closest available proxies for determining professional capacities are the sections of the 2007 CADPAAC survey where respondents self-reported on their training and technical assistance needs (Table 3).²⁹

²⁶ Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*.

²⁷ University of California, Berkeley, School of Public Health, *Career Pathway Sub-Committee Updated Report*.

²⁸ Little Hoover Commission, *Addressing Addiction: Improving & Integrating California's Substance Abuse Treatment System*. Sacramento, CA: Authors, 2008.

²⁹ Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*.

TABLE 3. CALIFORNIA SUD STAFF TRAINING AND TECHNICAL ASSISTANCE NEEDS	
TRAINING/TECHNICAL ASSISTANCE NEED	PERCENT REPORTING NEED
Providing trauma informed/trauma sensitive services	47.6%
Treating co-occurring SUD and mental health disorders	46.8%
Providing clients with integrated treatment services for co-occurring SUD and mental health disorders	43.0%
Improving client problem solving skills	39.5%
Improving behavioral management of clients	39.2%
Improving client thinking skills	38.6%
Improving cognitive focus of clients during group counseling	38.3%
Using pharmacological interventions with clients	36.7%
Using computerized client assessments	35.2%
Providing culturally competent services	34.2%
Working with staff on other units/agencies	29.1%
Monitoring client progress	21.7%
Assessing client problems and needs	21.1%
Improving rapport with clients	17.6%

Respondents to the CADPAAC survey revealed a high level of need in areas that are essential to the delivery of comprehensive SUD care. In domains related to the assessment of clients entering treatment, over one-fifth of respondents reported needing assistance on assessing client problems and needs, and over 35% reported needing assistance using computerized assessment tools. Significant numbers of providers reported needing assistance improving clients’ problem-solving skills (39.5%) and thinking skills (38.6%), and 39.2% reported needing assistance with the behavioral management of clients. Most important, over 35% of respondents reported needing training and technical assistance with the delivery of critical evidence-based services: 36.7% reported needing training and technical assistance on how to utilize pharmacological interventions, and 45%–50% reported needing training and technical

assistance on how to provide services for co-occurring SUD and mental health disorders and trauma-informed care.

Notably, 96.5% of staff report knowledge of the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment's Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs).³⁰ These manuals are free, easy-to-use guides designed to advise and train clinicians on evidence-based practices and treatments, and can help develop the workforce's professional competence and service delivery capacity. However, even though staff report being aware of the existence of these publications, none report ever actually using them.³¹ Thus, effective training and technical assistance services are needed to help translate the knowledge in the TIPs and TAPs into practice. Yet, according to the CADPAAC survey, SUD agency administrators have difficulty providing these services; over half of them report challenges in accessing effective training programs and resources for their staff.³² Furthermore, over 46% report that they do not even know which treatment interventions or strategies should be the foci of staff training and technical assistance activities.³³

It is clear that California's SUD workforce needs further training and technical assistance to improve its professional capacity, but the breadth and depth of need is so great that it is difficult to pinpoint the exact areas where further training and technical assistance efforts should be targeted.

³⁰ Ibid.

³¹ Ibid.

³² Ibid.

³³ Ibid.

Barriers to Growth and Improving Professional Capacity

The low size and professional capacity of California's SUD workforce reflects serious challenges in the recruitment and maintenance of qualified direct care staff. SUD providers in California report significant difficulty recruiting and maintaining qualified direct care staff. Over 45% of respondents to the 2007 CADPAAC survey and nearly one-third of respondents to the 2012 PSATTC survey reported difficulties filling staff vacancies.³⁴ As in other parts of the country, the major challenges facing SUD programs trying to recruit staff is the lack of qualified applicants; most do not have the education, experience in SUD treatment, and/or certification needed to work in most SUD service settings.³⁵

The low salaries offered to SUD treatment staff amplify these recruitment challenges.³⁶ SUD workers receive particularly low salaries because SUD services are grossly undervalued by third-party payers, and SUD treatment agencies often fail to factor necessary administrative and benefit costs into their fees. Since SUD treatment agencies' revenues are artificially low, so are the salaries they pay their staff.³⁷ In California, nearly half of SUD treatment staff earn less than \$35,000 per year, and over one-fifth earn less than \$25,000 per year.³⁸ These salaries are not commensurate with the high levels of stress associated with SUD services or the skills required to deliver them well (a direct care worker in a 24-hour residential treatment facility earns less than an assistant manager at a Burger King).³⁹ Compared to their counterparts elsewhere in

³⁴ Ibid; Camarena, *Pacific Southwest ATTC 2012 Regional Workforce Report*.

³⁵ Ibid; Steven L. Gallon, Roy M. Gabriel, & Jeffrey R.W. Knudsen, "The Toughest Job You'll Ever Love: A Pacific Northwest Treatment Workforce Survey" *Journal of Substance Abuse Treatment* 2003; 24:183-196.

³⁶ Ibid.

³⁷ Debra Langer, *Taking Action to Build a Stronger Addictions Workforce: An Update of Accomplishments*. Report prepared for the Northeast Addiction Technology Transfer Center. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, 2006.

³⁸ Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*.

³⁹ Office of National Drug Control Policy and U.S. Department of Health and Human Services (Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration)

the health care system, SUD service providers are particularly poorly paid; a social worker with a master's degree working in a SUD treatment agency earns less money each year than a peer provider working in a general health care agency.⁴⁰ Furthermore, nearly half of individuals in California's SUD treatment workforce do not receive employer-sponsored insurance.⁴¹ Because of the combination of poor pay and inadequate benefits, many members of the SUD workforce live in near poverty, and some even qualify for food stamps.⁴²

Compensation issues are further exacerbated by the lack of professional respect accorded to SUD treatment professionals. The stigma against SUD often extends to the profession of SUD treatment as well, and widely held skepticism about the efficacy of SUD treatment further undermines attempts to make SUD treatment seem like a desirable career choice for qualified applicants.⁴³ Furthermore, once individuals enter the field, there are numerous obstacles to keeping them in the SUD workforce: the certification and licensing process is cumbersome, confusing, and expensive; the cost of classes needed to professionally advance can be prohibitively high; many workplace environments are unsafe; and the actual job of SUD service provision is difficult and often frustrating.⁴⁴

Given these conditions, it is hardly surprising that the relatively small pool of qualified potential SUD workers often opts for a career other than SUD treatment.⁴⁵ Recently, an online employment site ranked SUD counselor the third most "high

Workforce Issues: Integrating Substance Use Services into Primary Care. Summit Proceedings, August 2011.

⁴⁰ Ibid.

⁴¹ Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey.*

⁴² Substance Abuse and Mental Health Services Administration [SAMHSA], *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*, January 2013.

⁴³ Ibid.

⁴⁴ University of California, Berkeley, School of Public Health, *Career Pathway Sub-Committee Updated Report.*

⁴⁵ Little Hoover Commission, *Addressing Addiction.*

stress/low pay” job in the United States.⁴⁶ In fact, a significant portion of the SUD workforce actually did not originally plan to enter the field of SUD treatment at the outset of their careers; in California, 34% of SUD workers report that SUD treatment is a second career for them, not their original career plan.⁴⁷ Furthermore, once individuals enter the SUD treatment workforce, rates of turnover are exceedingly high, between 20% and 50% annually.⁴⁸

Summary

In 2008, the Little Hoover Commission studying California’s treatment system observed that there is an inherent tension between the need for quantity (having an adequately sized workforce) and quality (having an adequately trained/competent workforce) in the SUD system. According to the commission, “Absent a focus on results, government agencies that fund treatment and the providers who administer treatment, largely have opted to treat as many people as possible, regardless of outcomes. This approach is built on a cost structure that results in low pay for the treatment workforce, high staff turnover, and inexperienced and undereducated counselors.”⁴⁹ Though data on the State’s SUD treatment workforce are limited, it is apparent that five years after the Little Hoover findings, the SUD workforce in California is insufficient in numbers and requires additional education and training to meet the State population’s SUD treatment needs.

⁴⁶ SAMHSA, *Report to Congress*.

⁴⁷ Pacific Southwest Addiction Technology Transfer Center, *CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey*.

⁴⁸ Lillian T. Eby, Hannah Burk, Charleen P. Maher. “How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover.” *Journal of Substance Abuse Treatment* 2010;39:264-271.

⁴⁹ Little Hoover Commission, *Addressing Addiction*.

III. Developing the Specialty SUD Treatment Workforce

Overview

As discussed in Section I above, the California SUD workforce of the future will be divided into two distinct workforces—one that operates in the specialty SUD treatment sector as it does today, and another that evolves into part of a broader, more interdisciplinary integrated behavioral health workforce. This section delineates areas where the Department of Health Care Services can focus efforts to improve the capacity of the specialty SUD treatment workforce of the future. The specialty SUD workforce of the future will need to have an adequate understanding of: (1) a basic minimum of professional knowledge, skills, and attitudes needed to provide SUD treatment; (2) recent advances in the field of SUD treatment; and (3) how to provide appropriate recovery support services. In order to achieve these ends, DHCS needs to take steps to improve the recruitment and retention of highly qualified and skilled providers in the SUD workforce.

Baseline Knowledge, Skills, and Attitudes

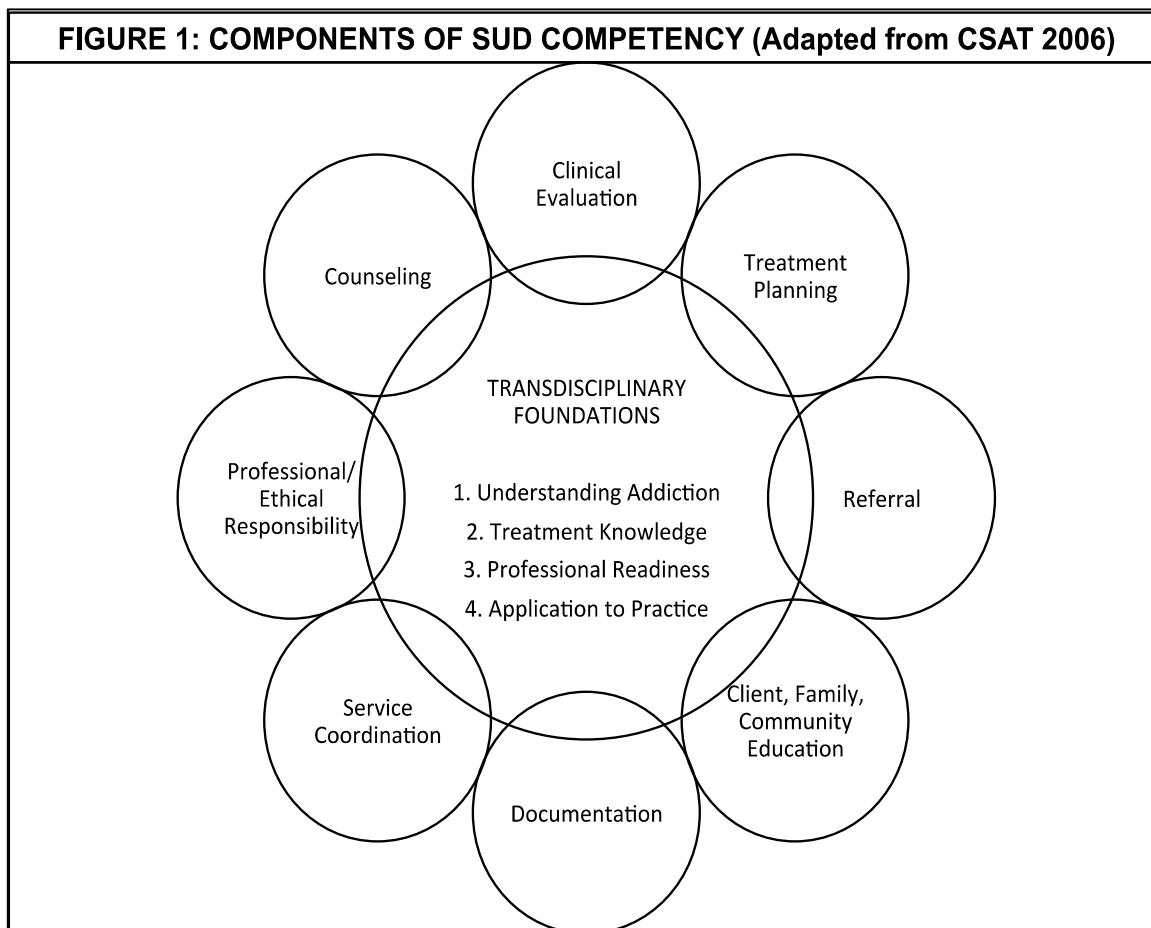
The basic knowledge, skills, and attitudes the specialty SUD treatment workforce should have are laid out in the Center for Substance Abuse Treatment's Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (The Competencies)*.⁵⁰

TAP 21 delineates two sets of core competencies for SUD counseling—four transdisciplinary foundations of SUD treatment and eight practice dimensions. The transdisciplinary foundations—understanding addiction, treatment knowledge, application to practice, and professional readiness—are knowledge, skills, and attitudes

⁵⁰ Center for Substance Abuse Treatment, *Addiction Counseling Competencies*.

that are needed to provide high quality SUD services regardless of discipline, scope of practice, treatment setting, or service orientation. Medical providers, social workers, counselors, case workers, peer recovery support staff, and others who work with individuals in treatment should have mastery of these four fundamental competencies in order to deliver effective SUD services.

SUD counselors should be able to build upon their knowledge of the four transdisciplinary foundations with competency in some or all of the eight practice dimensions—clinical evaluation, treatment planning, referral, service coordination, counseling, client/family/community education, documentation, and professional/ethical responsibility (See Figure 1). The eight practice domains span the full continuum of SUD care, ranging from screening and assessment to referral, service delivery, and recovery supports and services. A strong grounding in each of the four transdisciplinary foundations can equip the entire SUD workforce to deliver high quality, client-centered, and evidence-based services as they carry out daily functions, as delineated in the eight practice dimensions.



Recent Advances in the Field of SUD Treatment

Specialty SUD service providers should also have more specific knowledge of the recent advances in evidence-based practices in the areas of SUD management and treatment. These areas include:

- *Treating Individuals with Co-Occurring Mental Health Disorders*: Over half of clients who present for services in specialty SUD treatment settings have co-occurring mental health disorders. In order to improve treatment retention and outcomes, it is critical for SUD service providers to be well-versed in methods of identifying clients with mental health disorders, how to adjust treatment modalities and interventions to meet their treatment needs, and approaches

that should be taken to the treatment and management of co-occurring disorders that are distinct from those generally used in specialty SUD treatment.⁵¹

- *Medication-Assisted Treatment*: Researchers have developed safe, effective, and evidence-based medications such as acamprosate (for the management of alcohol dependence),⁵² naltrexone (for the management of opioid and alcohol dependence),⁵³ and buprenorphine (for the management of opioid dependence).⁵⁴ Many providers in specialty SUD treatment settings, however, remain reluctant to utilize these medications in treatment, particularly because they believe their use may compromise 12-step oriented recovery. In order to provide state-of-the art SUD treatment, it is critical for all providers to be educated about the use of SUD medications and the role that such pharmacotherapies can play in facilitating and sustaining recovery.
- *Motivational Interviewing*: Motivational Interviewing is a tool that SUD providers can use to understand the motives clients have in order to address their substance use problems, gather clinical and administrative information needed to plan care, and build and strengthen client readiness to change. It is essential for all providers of SUD services to understand and be prepared

⁵¹ Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons with Co-Occurring Disorders*. Treatment Improvement Protocol (TIP) Series, No. 42. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

⁵² Center for Substance Abuse Treatment, *Incorporating Alcohol Pharmacotherapies Into Practice*. Treatment Improvement Protocol (TIP) Series, No. 49. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

⁵³ Ibid; Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series, No. 43. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.

⁵⁴ Ibid.

to utilize motivational interviewing techniques throughout the SUD assessment, treatment, and recovery processes.⁵⁵

- Cognitive Behavioral Therapy: Cognitive Behavioral Therapy (CBT) is a treatment approach that focuses on the connections between thoughts, cognitive schema, beliefs, attitudes, and behavior. CBT has been proven effective in the behavioral treatment and management of SUD involving various substances and at varying levels of severity. All providers of SUD services should be well-versed in CBT techniques, have a strong understanding of situations where it can be effectively used, and be prepared to deliver services that incorporate CBT.⁵⁶
- SUD Treatment for Women: Recent research has highlighted that gender differences can have a significant impact both on the development of SUD and on SUD treatment. By taking a biopsychosocial approach to treatment that addresses women's specific needs, providers can improve treatment engagement, and outcomes. Providers delivering specialty SUD treatment services should be aware of these factors and familiar with specific strategies and approaches that are effective in helping women achieve and sustain recovery.⁵⁷
- Treating Stimulant Use Disorders: In the past few decades, a flurry of research has led to tremendous advances in knowledge of stimulant use disorders and their treatment with behavioral interventions. Providers of

⁵⁵ Steve Martino, et al. *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency*. Salem, OR: Northwest Addiction Technology Transfer Center and Oregon Health and Science University, 2006.

⁵⁶ Center for Substance Abuse Treatment, *Brief Interventions and Brief Therapies for Substance Abuse*. Treatment Improvement Protocol (TIP) Series, No. 49. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

⁵⁷ Center for Substance Abuse Treatment, *Substance Abuse Treatment: Addressing the Specific Needs of Women*. Treatment Improvement Protocol (TIP) Series, No.51. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

specialty SUD treatment should be well-versed in evidence-based engagement and treatment strategies and techniques for treating individuals with stimulant use disorders.⁵⁸

- ***Chronic Pain:*** Chronic pain is common among individuals with SUD, is often interrelated with many of the physical and psychological challenges associated with SUD, and often underlies substance use conditions. Pain management is often essential for the successful treatment of SUD, and clinicians need to be well-versed in the causes of chronic pain, pharmacological and behavioral strategies to manage it, and the best ways to achieve and sustain recovery from SUD for clients experiencing chronic pain. Providers of SUD services should be able to assess clients for chronic pain conditions; develop treatment plans that address pain along with associated functional impairments and psychological symptoms; and monitor clients for pain-related issues that can lead to relapse. Even optimal pain treatment is unlikely to completely eliminate it, so providers need to be able to collaborate with clients to devise effective strategies to manage it. The most effective treatment of chronic pain often involves collaboration with other health professionals (e.g., medical doctors, psychologists), as well as clients themselves playing an active role in pain monitoring and management. SUD providers need to be able to balance the variety of tasks associated with the

⁵⁸ Center for Substance Abuse Treatment, *Treatment for Stimulant Use Disorders*. Treatment Improvement Protocol (TIP) Series, No. 33. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

management of chronic pain among SUD patients in order to increase clients' chances of achieving and sustaining recovery.⁵⁹

- HIV: Individuals who use psychoactive substances are at increased risk for contracting HIV, particularly if they are injection drug users. It is critical, therefore, for providers to be cognizant of HIV screening and assessment techniques, the treatment of behavioral health problems for SUD clients with HIV, case management for clients with HIV, the treatment and management of HIV, ethical and legal issues associated with the condition, and prevention strategies to help clients avoid spreading it.⁶⁰
- Hepatitis: Individuals who use psychoactive substances are at increased risk of contracting viral hepatitis, particularly if they are injection drug users. However, many SUD treatment providers are poorly informed about how to identify, manage, or treat hepatitis. In order to safeguard clients' health and reduce the risk that hepatitis poses to their well-being, SUD providers should be able to educate clients about hepatitis, teach them the importance of managing the condition, and advise them on ways to avoid spreading it.⁶¹

Recovery Support Services (RSS)

Given that SUD is a chronic condition, clients who achieve recovery in specialty SUD service settings often need continuing support in order to sustain the gains they made in treatment. Recovery Support Services (RSS) are psychosocial and community-

⁵⁹ Center for Substance Abuse Treatment, *Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders*. Treatment Improvement Protocol (TIP) Series, No. 54. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

⁶⁰ Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons with HIV/AIDS*. Treatment Improvement Protocol (TIP) Series, No. 37. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.

⁶¹ Center for Substance Abuse Treatment: *Addressing Viral Hepatitis in People With Substance Use Disorders*. Treatment Improvement Protocol (TIP) Series, No. 53: Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

based services delivered in sober living homes, recovery centers, and faith-based recovery ministries to assist clients with self-management of SUD, facilitate their connection with community-based resources, and help them address the myriad physical health, mental health, social, economic, and housing challenges they may face once they have completed treatment.⁶² Formally trained professionals generally deliver RSS for clients immediately after specialty treatment, utilizing telephone-based continuing care models and recovery management checkups to monitor client status, minimize risk for relapse, and provide linkages to services in the event of relapse.⁶³

Peers who have experienced SUD also play a key role in the delivery of RSS by providing nonclinical assistance to aid clients in initiating and maintaining recovery in the community and helping them enhance their quality of life.⁶⁴ For the specialty SUD treatment system to offer comprehensive and effective RSS services, it needs to have a RSS workforce that has strong skills in client engagement, motivational enhancement, communication, conflict resolution, crisis intervention, recovery enhancement, community liaison, and advocacy.

Professional Development for the Specialty SUD Treatment Workforce

SUD service providers need to be competent in a large number of complex areas—and do a job that can be physically and emotionally taxing. To develop a workforce that is up to the challenge of providing evidence-based SUD care, California needs to have a SUD treatment workforce that is highly qualified and motivated. Yet today, the vast majority of the State’s SUD workforce is inadequately trained, faced with

⁶² Sarah J. Cousins, Valerie P. Antonini & Richard A. Rawson, “Utilization, Measurement, and Funding of Recovery Supports and Services,” *Journal of Psychoactive Drugs* 2012; 44(4):325-333. Office of National Drug Control Policy, et al. *Workforce Issues*: Alexandre B. Laudet & Keith Humphreys. “Promoting Recovery in an Evolving Policy Context: What Do We Know and What Do We Need to Know about Recovery Support Services?” *Journal of Substance Abuse Treatment* 2013; 45:126-133.

⁶³ Ibid.

⁶⁴ Ibid.

limited opportunities for career advancement, and subject to extraordinarily high rates of turnover.

The establishment of a career ladder that defines SUD job roles and lays out a career trajectory for individuals in the SUD workforce can help address all of these issues. The clear delineation of a career trajectory can encourage qualified individuals to enter the SUD treatment field and motivate those already in the SUD workforce to pursue further training and education so they can advance. Furthermore, the promise of merit- and skill-based advancement can incentivize performance and encourage providers to seek out opportunities for ongoing career development.

In 2011, SAMHSA published “Scopes of Practice & Career Ladder for Substance Use Disorder Counseling,” which provides a model that states and other providers of SUD services can follow.⁶⁵ The SAMHSA ladder defines five levels of SUD counseling, as illustrated in Table 4. Each step on the ladder requires increasing levels of education and work experience, and increasing professional responsibility. By laying out a clear career path, with increases in pay and responsibility commensurate with each step, a career ladder can help establish professional standards for the field of specialty SUD treatment. As a result, it can also ensure that an adequately skilled, trained, and educated pool of providers enters and remains in the field, and that the SUD services it delivers are provided by staff that have appropriate levels of education and experience.

In California, approximately 40 community colleges offer accredited programs in addiction studies. Many four-year institutions also provide continuing education courses through their Extension programs, including Sacramento State, San Diego State, UCLA, Loyola Marymount, and Dominguez Hills. However, Extension programs are generally not accredited and course credits are not transferable to colleges or

⁶⁵ Substance Abuse and Mental Health Services Administration, *Scopes of Practice & Career Ladder for Substance Use Disorder Counselors*. Rockville, MD: Author, 2011.

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universities (Dominguez Hills is one exception where Extension class credits can be applied toward a bachelor’s degree at the same university). California State University, Fullerton, is currently the only school with a full bachelor’s program—a BS in Human Services with emphasis in Substance Abuse Treatment and Prevention.

TABLE 4. MODEL CAREER LADDER FOR SUD COUNSELING			
TITLE	EDUCATION/TRAINING	SUPERVISED WORK EXPERIENCE	PROFESSIONAL RESPONSIBILITIES
Independent Clinical SUD Counselor/Supervisor (Level 4)	Master’s Degree in SUD counseling or allied mental health profession with at least 300 hours SUD-related training	4,000 hours post-master’s supervised work experience, 2,000 direct client hours	Clinical evaluation, treatment planning, referral, education, documentation, service coordination and case management, therapy, psychoeducation, services for co-occurring mental health disorders and SUD
Clinical SUD Counselor (Level 3)	Master’s Degree in SUD counseling or allied mental health profession with at least 300 hours SUD-related training	3,000 hours post-master’s supervised work experience, 2,000 direct client hours	Clinical evaluation, treatment planning, referral, education, documentation, service coordination and case management, therapy, psychoeducation, services for co-occurring mental health disorders and SUD
SUD Counselor (Level 2)	Bachelor’s Degree in SUD counseling or allied mental health profession with at least 200 hours SUD-related training	2,000 hours supervised work experience, 600 hours direct client work	Screening, brief intervention, referrals, treatment planning, education, documentation, service coordination, case management, psychoeducation, therapy
Associate SUD Counselor (Level 1)	Associate’s Degree, with at least 100 hours SUD-related training	2,000 hours supervised work experience, 600 hours direct client work	Screening, brief intervention, referrals, treatment plan monitoring, education, service coordination, case management, psycho-education
SUD Technician (Entry Level)	High School/GED 150 hours SUD training	1,500 hours supervised work experience	Screening, psychoeducation, participate in documentation and treatment planning

Summary

In spite of the California SUD workforce's current shortcomings, there are concrete steps the Department of Health Care Services can take to improve both the quality and quantity of the State's SUD workforce. By ensuring that the workforce is competent in the basic knowledge, skills, and attitudes needed to provide SUD treatment, capable of delivering evidence-based services, and prepared to provide recovery support services, DHCS can ensure that the workforce is prepared to meet the needs of the California population that needs specialty SUD services. By adopting the Scopes of Practice & Career Ladder model, it can create a workforce infrastructure that will help recruit individuals with the education, skills, and experience needed to provide high-quality SUD treatment into the workforce, and keep them there by providing ample opportunities for advancement. By taking these steps, the Department can ensure that California's future specialty SUD treatment workforce will be of sufficient quality and quantity to provide evidence-based SUD services for all Californians.

IV. Needs of the Integrated Behavioral Health Workforce of the Future

Overview

As discussed in Section I above, the California SUD workforce of the future will be divided into two distinct workforces—one that operates in the specialty SUD treatment sector as it does today and another that evolves into part of a broader, more interdisciplinary integrated behavioral health (IBH) workforce. This section delineates areas where the Department of Health Care Services can focus efforts to improve the capacity of the IBH workforce of the future. To survive and thrive in the IBH workforce of the future, SUD providers will need to adapt to working in new clinical roles and develop

a new set of clinical and professional competencies. Furthermore, as SUD services become integrated into primary care settings, it will be critical to ensure that clinicians from all disciplines—not just IBH providers—have at least a basic understanding of SUD and how services to address substance use conditions need to be integrated into medical care.

IBH Roles

To date, when IBH staff have worked in integrated health care settings, they have generally filled one of three roles—health educator, primary care behavioral health specialist, and expanded care manager. In order to facilitate the integration of current SUD workers into the integrated care workforce, efforts should be made to prepare them to fill the following roles:

- ***Health Educator:*** Health educators are members of healthcare teams who teach patients about behaviors that promote wellness, and they develop programs that encourage patients to make healthy decisions.⁶⁶ In integrated care settings, health educators who specialize in behavioral health screen patients for risk in a number of behavioral health domains—including depression, alcohol use, nicotine use, and the use of psychoactive substances—using standardized instruments.⁶⁷ If indicated, based on screening results, they then provide feedback or brief intervention services. In addition, health educators can be trained to provide motivational interviewing or case management services for

⁶⁶ Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Health Educators <http://www.bls.gov/ooh/community-and-social-service/health-educators.htm>.

⁶⁷ DiLonardo, *Workforce Issues*.

clients with and without SUD, and provide monitoring and support for patients receiving MAT for SUD within primary care settings.⁶⁸

Health educators need to have strong knowledge of physical and behavioral health treatment, the social skills needed to engage clients, and the communication skills needed to identify patient needs and impart relevant information both to patients and their colleagues. In addition, health educators need to be able to manage time efficiently and to work effectively in collaboration with other health professionals.⁶⁹

Generally, health educators have a bachelor's degree at the entry level, and some employers require that entrants to the field have a Certified Health Education Specialist (CHES) credential from the National Commission for Health Education Credentialing.⁷⁰ Individuals who lack these credentials can qualify if they have provided similar services as a Community Health Worker.⁷¹ In California, Health Educators earn approximately \$47,600 per year, which is significantly more than most in the SUD workforce currently earns. It is anticipated that demand for Health Educators will grow rapidly in the near future, particularly as more primary care clinics begin providing integrated services. In California, demand for Health Educators is expected to have risen 30% between 2010 and 2020, with the State workforce adding approximately 400 new Health Educators per year.⁷²

⁶⁸ Ibid.

⁶⁹ O*Net Online (2012). SummaryReport for Health Educators. <http://www.onetonline.org/link/summary/21-1091.00>.

⁷⁰ Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Health Educators <http://www.bls.gov/ooh/community-and-social-service/health-educators.htm>.

⁷¹ <http://www.onetonline.org/link/summary/21-1091.00>.

⁷² United States Department of Labor, Employment, and Training Administration. (2013). *Occupation Profile: Health Educator, California*.

- *Behavioral Health Specialist (BHS)*: Behavioral Health Specialists (also referred to as “Primary Care Behavioral Health Specialists”) work as members of primary care teams and focus on identifying, triaging, and managing patients with behavioral health problems and other medical conditions.⁷³ BHS staff assist primary health care staff in recognizing and treating mental health disorders, SUD, and other psychosocial problems, and also assess the behavioral/psychosocial status of patients referred by other members of the primary care team for behavioral health evaluations. In addition, they assist in the detection of patients who are at risk for more serious behavioral or physical health problems, and help develop plans to develop action plans to manage these patients’ chronic health conditions. For patients with chronic conditions that are prone to relapse (such as SUD), BHS providers also provide monitoring and relapse prevention services.⁷⁴

BHS providers need to have a strong understanding of chronic disease and self-care, be competent in assessment, and be able to provide treatment with brief cognitive behavioral, psychoeducational, and motivational interviewing techniques. The focus of BHS treatment services needs to be more oriented toward behavior modification than deep psychological probing or analysis, and their services will need to be more action-oriented and focused on identifying solutions to client problems rather than concentrated on going through thorough therapeutic processes. However, it is likely that in many primary care settings,

http://www.careerinfonet.org/occ_rep.asp?optstatus=011000000&soccode=211091&id=1&nodeid=2&stfips=06&search=Go

⁷³ DiLonardo, *Workforce Issues*; Society for Human Resource Management (2013). *Job Descriptions: Behavioral Health Specialist*.

http://www.shrm.org/TemplatesTools/Samples/JobDescriptions/Pages/CMS_010205.aspx

⁷⁴ Ibid.

administrators would want to hire BHS workers who could also be used to provide more in-depth, individualized care for patients who need more intense one-on-one counseling services. Given this reality, BHS workers should have a flexible enough skill set that they could also provide more in-depth treatment, using psychotherapeutic techniques, when necessary.⁷⁵

BHS providers generally have a master's degree or higher and licensure or certification as a clinical social worker, professional counselor, or clinical psychologist. There are no data on typical compensation or projected job growth for BHP professionals, though it is anticipated that they will play a key role in providing integrated services in many treatment settings in the near future.

- *Expanded Care Manager*. Care managers are members of integrated primary care teams who assist patients and their support systems in managing medical conditions and related psychological problems more effectively. Many patients do not need care management services, but care managers' services are highly valued in the treatment of patients with multiple chronic conditions and patients with conditions that require a significant amount of high intensity or high cost care. Given the chronicity of SUD and the potentially high costs of SUD treatment, patients with substance use conditions are among those who could benefit from expanded care management services. For example, care managers can provide monitoring and support for physicians who are treating opioid-dependent patients with buprenorphine but do not have the time or resources to personally provide the appropriate medication monitoring or support services.

⁷⁵ Di Lonardo, *Workforce Issues*.

Care managers may have a range of functions for a specific population of patients, including patient management care coordination, increasing self-efficacy in patients, tracking patients on registries, linking patients with needed resources, and consultation with other health professionals or specialists as needed.

Though there are no available data concerning salary or projected job growth for expanded care managers, it is anticipated that they will play a key role in the provision of integrated services, particularly for individuals with SUD.⁷⁶

Skills and Competencies of the IBH Workforce

As models of behavioral health / primary care integration continue to develop, it is likely that current SUD providers will fill niches other than the three mentioned above (health educator, behavioral health specialist, expanded care manager) as members of the IBH workforce. Regardless of their precise role, however, it is anticipated that IBH service providers will need a number of core attributes, competencies, and skills in order to contribute as members of the integrated care service teams:

- ***Efficiency***: Compared to specialty SUD treatment settings, primary care clinics are busy and hectic work environments: patients with a variety of medical and behavioral conditions with varying levels of severity and chronicity present for services; assessments, consultations, and interventions are often done quickly and spontaneously; and sessions are often interrupted or cut short.

Consequently, providers working in integrated primary care settings need to be

⁷⁶ Ibid.

- flexible and efficient. IBH providers need to be able to make clinical assessments quickly and accurately, and deliver services in a targeted, time-efficient manner.
- *Interpersonal communication skills*: Regardless of their precise role or title, strong interpersonal communication skills will be essential for all IBH providers. In their work with patients, behavioral health providers will need to be able to efficiently and thoroughly identify patient service needs. This will require them to make patients feel at ease and communicate sensitive, personal issues concerning mental health and substance use in a brief amount of time. It will also require strong listening, comprehension, and analytic skills to identify and clearly synthesize information gleaned from patients during brief screenings/interactions and then document it in patient charts. In addition, IBH providers will need strong interpersonal communication skills to effectively work with other members of their treatment teams, including being able to communicate information gathered during interactions with patients back to colleagues. Conversely, they will need to be able to understand information concerning clients' physical health that other treatment team members tell them, so they can incorporate it into service provision and treatment planning.
 - *Collaboration and Teamwork*: In traditional SUD treatment, individual providers play a central role in the planning, organization, and delivery of care. In integrated care settings, by contrast, teams of providers from a variety of medical and behavioral health disciplines deliver services and closely collaborate on treatment planning and service delivery activities. IBH providers will need to be willing to collaborate with others on patient care, a collaboration that is often not necessary in specialty SUD treatment settings.

- *Consultation and Liaison Skills*: One of the major roles behavioral health specialists will play in integrated primary care practices will be as consultants for medical providers who are serving patients with behavioral health conditions. To serve as an effective consultant in integrated care environments, behavioral health providers will need a strong understanding of the impact that mental health and substance use conditions have on physical health, and how they may present in medical patients. They should also have a strong understanding of treatment modalities appropriate for medically ill patients who present with common conditions or co-morbidities. As liaisons, behavioral health service providers should have the capacity to coordinate communication between medical providers and other staff who are involved in the management of patients' psychosocial needs.
- *Screening and Assessment*: One of the major responsibilities of IBH providers will be the identification of patients who need behavioral health services. Whereas all clients in specialty SUD treatment settings clearly need services, a major task in primary care is the determination of which patients need mental health or SUD services, what the duration of these services should be, and how intense they need to be. Doctors and other medical professionals often lack the time and training to identify patients' behavioral health needs, so it will be incumbent upon IBH providers to identify patients who need either brief interventions or more intensive treatment services. Consequently, they will need to be well-versed in validated screening and assessment tools (e.g., PHQ-9, AUDIT-C) that are used to identify patients who are at risk for mental health disorders and SUD in primary care settings.

- *Brief Interventions for Mental Health and Substance Use:* The majority of patients with behavioral health service needs do not have conditions that are as chronic or acute as those usually found in specialty treatment settings. When working with clients who have mild to moderate behavioral health conditions, IBH providers will not have nearly as much time to establish rapport or deliver therapeutic services as they usually do in specialty treatment settings. Primary-care based interventions for individuals with mild to moderate behavioral health conditions tend to be brief and time-limited, generally three to five sessions that are 15 minutes or less. The provision of these services will require IBH to adapt a new clinical approach and a new clinical tool set geared toward achieving rapid behavior change and problem solving rather than personality-centered or insight-oriented therapy.
- *Harm Reduction:* Many SUD providers have traditionally provided care that is abstinence-oriented and focused on making sobriety the ultimate goal of services. In integrated care settings, services need to be more holistic and tailored to making clients' overall health the top priority. When IBH providers work in primary care environments, they will need to adjust their approach to treatment in order to ensure that it is more oriented to harm reduction than to abstinence.
- *Care Planning and Care Coordination:* IBH providers will need to be proficient in planning and coordinating various aspects of patient care. They will need to be able to collaborate with other providers to determine the role that behavioral health services will play in patients' overall treatment plan. Furthermore, as providers who will likely provide support services to assist patients with complex and multifaceted treatment needs, behavioral health providers will need to be well-versed in how to interpret and adjust care plans, how to coordinate the

organization and delivery of services, and how to make outside linkages and referrals when necessary.

- *Cultural Competence and Adaptation:* IBH providers will serve a diverse population with many specific cultural and linguistic characteristics that need to be taken into consideration when providing care. Though it will be difficult for IBH providers to have a deep knowledge of the culture/language of all clients, they will need to have a solid understanding of the way that culture and language impact the way that clients from diverse backgrounds interpret and use information related to physical and mental health. They should also be familiar with strategies that can be used to adapt communication styles and interventions to be culturally and linguistically appropriate for the patients they serve.

The existence of disparities is well documented and understood in relation to physical health but not as clearly understood as related to substance use. While there are certain health conditions (hypertension, certain cancers, etc.) that are more prevalent in persons from certain racial/ethnic groups, the same is not true for substance use when controlling for environmental factors. Although substance use is an equal opportunity condition, we do know that certain racial/ethnic groups are disproportionately impacted. This view is critical in assembling the necessary local planning partners to comprehensively address the many factors involved in the occurrence of alcohol and other drug disparities.
- *Understanding of Medical Disorders and their Treatment:* To provide truly patient-centered and holistic care, IBH providers will need to understand how mental health and substance use behaviors impact, and are impacted by, physical health conditions. In addition, they will also need to have a strong grasp on how treatment for physical conditions may affect patients' mental health or substance

use behaviors, and vice versa. A strong grasp of medical conditions and treatment will be needed to inform treatment planning and care coordination activities, and also to determine health behaviors (e.g., diet, exercise) that should be targeted in behavioral interventions and disease management activities. Furthermore, a solid understanding of basic physiology, psychopharmacology, and medical terminology will facilitate improved communication with team members who are in charge of providing physical health services and enhance the overall coordination and integration of care.

- Understanding of Stepped-Care Models: Services in integrated primary care settings are often organized on principles of stepped care. Stepped care is structured to ensure that services cause the least disruption necessary in patients' lives, and that they are the least extensive, intensive, and expensive needed to achieve positive results.⁷⁷ In practice, this means that if a patient's functioning does not improve with the usual course of practice, they receive progressively more intense and specialized services, until ultimately being referred to specialty care, if conditions prove too intense or acute. Once patients are stabilized and their functioning improves, stepped care models call for their care to be "stepped down" to the least disruptive, extensive, intensive, and expensive level that is needed. IBH providers need to be familiar and comfortable with stepped care models, so that they can tailor service provision and treatment planning according to stepped-care principles.

It is currently unknown if individuals in the current SUD workforce possess the training or skills needed to serve as health educators, behavioral health specialists, expanded care managers, or other roles as members of the IBH

⁷⁷ Chris Collins, Denise Levis Hewson, Richard Munger & Torlen Wade. *Evolving Models of Behavioral Health Integration in Primary Care*. New York: Milbank Memorial Fund, 2010.

workforce. Given the glaring needs of the current SUD workforce in areas simply related to the provision of specialty SUD services, it is likely that they lack the expanded set of knowledge, skills, and attitudes they will need to work in integrated care settings. However, the SUD workforce's experience in working with individuals with SUD should be a valuable asset for primary care providers, many of whom are unfamiliar with or uncomfortable with managing and treating substance use conditions. Furthermore, adequately trained and competent specialty SUD providers should have many of the skills needed to evolve into IBH providers—screening, assessment, monitoring, care management, referral, motivational interviewing, cognitive behavioral therapy techniques, and other skills that are essential competencies for specialty SUD treatment providers will also be highly valued in integrated care environments. Unfortunately, many in the SUD workforce currently lack these competencies. However, if DHCS invests in rapidly and thoroughly improving the quality of the current SUD workforce (see Recommendations below), it can help adequately prepare current SUD providers for their future roles as IBH providers.

SUD Competency beyond the Current SUD Workforce

In integrated care environments, a broad array of providers—IBH providers with little background in SUD, physicians, nurse practitioners, and other health professionals—will become directly involved in the delivery of services for clients with substance use conditions.⁷⁸ They will need to be able to assess the effect that substance use has on clients' health and well-being; detect clients who have health problems related to substance use; provide services that help engage clients in

⁷⁸ Buck, "The Looming Expansion"; Roy & Miller, "The Medicalization of Addiction Treatment Professionals."

appropriate treatment for substance use conditions; and monitor the course of treatment for and recovery from SUD in collaboration with other members of their health care teams.

Unfortunately, available data indicate that the current medical and mental health workforces are poorly prepared to work with clients who have substance use conditions. Some health professionals may have negative attitudes about patients with SUD, harboring beliefs that they are violent, manipulative, and not motivated to make positive change. Consequently, compared to the care that they provide other patients, healthcare providers tend to be less personally engaged, less empathic, and less likely to provide full effort when treating individuals with SUD.⁷⁹ Furthermore, general healthcare providers receive relatively little training about SUD when compared to the training they receive about other chronic health conditions: only 56% of residency programs require training in SUD, and when required, the median number of hours of training is just 3–12.⁸⁰ Evidence suggests that mental health clinicians also have negative attitudes toward individuals with substance use conditions and are poorly trained on how to treat and manage SUD.

These attitudes and knowledge gaps must be addressed as the healthcare system prepares to serve increasing numbers of individuals with SUD in primary care settings.

Summary

SUD providers who transition into the IBH workforce will need to develop a new approach to service delivery and a new skill set, and they need to become capable of

⁷⁹ Leonieke C. van Boekel, Evelien P.M. Brouwers, Jap van Weeghel & Henk F.L. Garretsen, "Stigma Among Health Professionals Towards Patients with Substance Use Disorders and its Consequences for Helathcare Delivery: Systematic Review" *Drug and Alcohol Dependence* 2013:131:23-35.

⁸⁰ Di Lonardo, *Workforce Needs*.

working with patients who traditionally have not been treated in the specialty SUD treatment system. Furthermore, the boundaries of what the “SUD treatment workforce” is will become increasingly blurred; providers who previously specialized in the treatment of SUD will need to develop the capacity to also address mental health disorders and physical health conditions related to substance use, and medical and mental health staff will become increasingly involved in the treatment and management of patients with SUD. Consequently, significant work will need to be done to prepare the SUD treatment workforce to deliver new services in their future roles as IBH providers. At the same time, the SUD treatment workforce will need to expand to include a broader range of providers from various health disciplines.

V. Recommendations

- 1. The California Department of Health Care Services should conduct a thorough and comprehensive assessment of the California SUD workforce’s size, composition, and professional capacity in order to guide future workforce development planning and activities.**

A number of published reports and peer-reviewed research articles from across the nation assert that the current SUD workforce is too small, underpaid, underqualified, and unstable to meet the population’s needs.⁸¹ Though available data give the impression that California’s SUD treatment workforce faces similar challenges, the scope and scale of the workforce’s shortcomings remain unclear. Employment surveys and labor statistics that are used to draw broad conclusions about the workforce’s size

⁸¹ Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*; University of California, Berkeley, School of Public Health, *Career Pathway Sub-Committee Updated Report*; Little Hoover Commission, *Addressing Addiction: Improving & Integrating California’s Substance Abuse Treatment System*. Sacramento, CA: Authors, 2008.

and makeup often do not distinguish SUD workers from other behavioral health workers; State data only capture counselors who are certified; and data from recent workforce surveys are of limited utility because they either ask only superficial questions or have very low response rates.

Consequently, we suggest that the Department of Health Care Services (DHCS) undertake a thorough and comprehensive SUD workforce-needs assessment that is more thorough and specific than existing data sources. The workforce-needs assessment should differentiate between the needs of the specialty SUD workforce and the SUD workforce that will be integrated into medical settings as behavioral health staff. This undertaking would provide DHCS with a more comprehensive and nuanced picture of the current SUD workforce than is currently available, and would enable the Department to prioritize workforce development activities based on current needs.

2. The State should expand existing training and technical assistance services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment. These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into Integrated Behavioral Health (IBH) providers in medical settings.

Though it is difficult to identify the California SUD workforce's most pressing needs, it is nonetheless clear that it needs significant training and technical assistance in areas critical to the provision of comprehensive and evidence-based SUD services. Agencies and individual providers report that they prefer to receive training and technical assistance at offsite meetings in which one or two staff members are trained and then

disseminate the knowledge they've gained through trainings they provide at their clinics.⁸²

The California Department of Alcohol and Drug Programs supported many training and technical assistance opportunities for SUD providers throughout the State in the past. It is strongly recommended that DHCS continue to do so, and expand them if possible, in order to ensure that as many members of the SUD workforce as possible develop the knowledge and skill set needed to provide state-of-the-art SUD treatment on a regular and consistent basis.

Training and technical assistance activities should be designed to reflect the future bifurcation of the SUD treatment workforce. One training and technical assistance track should emphasize the skills and competencies needed to deliver specialty SUD services, as described in Section III. A second training and technical assistance track should be designed to prepare the current SUD workers to become IBH providers, as described in Section IV. While expanding the workforce it is also critical that DHCS ensures that IBH providers are reimbursable.

3. The State should develop strategies to increase compensation for the SUD treatment workforce.

The SUD treatment field will not be able to attract significant numbers of adequately trained and qualified candidates if it does not begin paying its employees decently. DHCS needs to collaborate with California Workforce Investment Bureau (WIB), Health Workforce Development Council, Office of Statewide Planning and Development (OSHPD), and provider organizations to devise strategies to increase employee compensation and benefits, in order to make them competitive with those

⁸² Pacific Southwest Addiction Technology Transfer Center, *Workforce Survey*.

offered in other health care sectors. A variety of strategies should be considered: tuition assistance, loan forgiveness, performance-based or merit-based salary increases, and restructuring fee and payment schemes for agencies so that they can pay their workforce competitive wages.⁸³ Though not all of these strategies may be feasible, it is urgent for DHCS to devise strategies to increase salaries, so it can attract and maintain an adequately trained and skilled SUD workforce.

4. The SAMHSA career ladder for SUD counselors should be implemented in California.

Many states have already adopted career ladders for SUD counselors, similar to that recommended by SAMHSA, but California has not. The adoption of a career ladder would require the input of and collaboration with the six agencies that certify SUD counselors in California. The certifying organizations would need to agree on definitions of each step on the ladder, as well as the professional responsibilities, salaries, and benefits that should be linked to each title. Though this would be a significant undertaking, the adoption of a career ladder or similar scheme would help address the significant challenges to workforce recruitment and retention that currently affect California's SUD workforce. We concur with the recommendations of the 2008 Little Hoover Commission on Addictions and stakeholders interviewed for the Statewide Mental Health and Substance Use Treatment Needs Assessment in 2012, by strongly suggesting that DHCS create and implement a scheme—such as a career ladder—to create clear standards and career trajectories for individuals in California's SUD workforce.

⁸³ Michael A. Hoge, John A. Morris, Allen S. Daniels, Gail W. Stuart, Leighton Y. Huey & Neil Adams. *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion*. Report prepared for the Substance Use and Mental Health Services Administration. Cincinnati, OH: Annapolis Coalition on the Behavioral Health Workforce, 2007.

5. Replace the multiple counselor certification organizations with a single, state-level certification organization.

Multiple certification bodies with complex and inconsistent requirements make career planning difficult. Low cost alternatives that are incapable of creating competent counselors attract many students because they are “easy” and inexpensive. Combining multiple certification bodies into one state-sanctioned, credentialing organization would standardize definitions and facilitate more streamlined communication about the strengths and services of the SUD counselor profession and move towards a clearer, unified career path.

6. DHCS should collaborate with institutions of higher education to increase recruitment and properly train the SUD workforce.

Many community colleges, 4-year institutions, and graduate schools have programs that provide SUD education and training for prospective members of the SUD workforce. Though these institutions offer appropriate preparation for a career in SUD treatment, they are not producing enough graduates to satisfy the treatment system’s workforce demands.⁸⁴ Thus, we suggest that DHCS initiate collaboration with institutions of higher education across the state to teach students about the SUD treatment field and the professional opportunities it offers. There is also a need for more SUD-specific degree programs at the bachelor’s and master’s levels. It is worth noting that this process will be much more effective once a career ladder (Recommendation 4) is established, and students can see that there is potential for decent compensation, growth, and career advancement within the SUD treatment field.⁸⁵ Once a career ladder is established, it can also be used to help institutions of higher learning design their

⁸⁴ Ibid.

⁸⁵ Ibid.

curricula and training programs, so that graduates will complete their education prepared to enter the SUD treatment workforce.

7. DHCS and providers of SUD services across California should make a concerted effort to recruit young individuals, males, and racial/ethnic minorities into the SUD workforce.

The majority of the SUD treatment workforce is White, female, and in their 40s or 50s, making them highly mismatched for the clients they serve. According to ADP data, 63% of Californians receiving SUD treatment are male, and 57% of them are non-White (34% are Hispanic, 16% are Black).⁸⁶ Furthermore, almost 60% of individuals who need SUD services are under the age of 35.⁸⁷ Though efforts to inculcate cultural competency and encourage the delivery of culturally appropriate services can help improve the quality of treatment delivered to these populations, it is still preferable for clients to receive treatment from individuals who are of a similar age, gender, and racial/ethnic background.⁸⁸ Thus, DHCS should focus workforce recruitment and expansion efforts on adding more men, racial/ethnic minorities (particularly Hispanics and Blacks), and young individuals to California's SUD workforce.

⁸⁶ Technical Assistance Collaborative & Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment*.

⁸⁷ Ibid.

⁸⁸ Susan G. Pfefferle & Tyronda S. Gibson, *Minority Recruitment for the 21st Century: An Environmental Scan*. Report prepared for the Substance Abuse and Mental Health Services Administration. Cambridge, MA: Abt Associates, 2010.

8. DHCS should train medical and mental health professionals working in integrated care settings on the basics of substance use and SUD and their impact on health.

Many of the physicians, mental health professionals, and allied medical providers who will serve individuals with SUD in integrated primary care settings continue to harbor negative attitudes about individuals with substance use conditions, and have received minimal training on how they should be treated. To address this issue, DHCS should make a concerted effort to provide training for doctors, nurses, and other physical health staff working in primary care settings on the nature of SUD, its etiology, and its treatment.

**Starting a Workforce Conversation in California:
Workforce Development Workgroup Meeting
Thursday, September 12, 2013
Hilton Sacramento Arden West Hotel
Sacramento, California
Meeting Proceedings
Submitted to DHCS in November 2013**

Meeting Background

On September 12, 2013, a daylong working group meeting was held in conjunction with the 47th semi-annual *Substance Abuse Research Consortium* Meeting in Sacramento, California. It was sponsored by the California Department of Health Care Services, UCLA Integrated Substance Abuse Programs, and the Pacific Southwest Addiction Technology Transfer Center. A total of 39 individuals participated in the meeting; a list of the 25 working group meeting participants who provided consent to have their name included in this document is detailed in Attachment 1.

The purpose of the meeting was to bring together national and state substance use disorder (SUD) treatment stakeholders and workforce development experts to begin the conversation that will eventually result in the development of a set of recommendations for the California Department of Health Care Services relating to workforce development needs and priorities of a SUD treatment workforce operating in an era of health reform and integrated care delivery.

The majority of the workforce experts who presented at the September 11th SARC meeting attended the working group meeting to add their perspectives and provide guidance.

The following proceedings document will hopefully serve as the foundation for future discussions of workforce development needs and priorities for the state of California.

Working Group Recommendations that Achieved Consensus among the Majority of Meeting Participants

These nine (9) recommendations were developed by comparing and consolidating the records of three separate note takers who participated in the meeting. Only those items that were noted as reaching broad consensus by all three note takers are included in these recommendations. A draft proceedings document was distributed by e-mail to all meeting participants prior to completing this final draft of the recommendations. A single response was received from meeting participants. Richard DeCuir from CAADAC and Susan Blacksher from CAARR sent a joint letter to Dr. Freese [dated November 18, 2013] disputing that consensus was reached on several of the recommendations. Their specific disputes are noted in italics following the corresponding recommendation. Many of the items presented in their letter are, in fact, included in the Section on “Additional Items of Discussion that did not Achieve Broad Consensus” (see pages 10-16). They were not included in the recommendations because our note takers did not demonstrate broad consensus across the group in their documentation.

While consensus was not universal across all of these recommendations, we are confident from our documentation of the meeting that these recommendations accurately reflect the consensus of the majority of the group. We specifically note the objections that were raised in the CAADAC/CAAR letter to ensure a complete picture of both the discussion that ensued at the meeting, and this response to the draft proceedings. To further avoid

miscommunication, the complete CAADAC/CAARR is included as Attachment 2 at the end of this document for review and consideration by DHCS staff.

1. Establish an ongoing SUD Treatment Workforce Advisory Committee.

Specific tasks include:

- Convene a workforce development advisory committee that brings together providers, consumers, medical providers (CSAM/chemical dependency, hospitals/primary care), FQHCs, mental health practitioners, insurers/payers, and stakeholders from other states.
- Determine budget, timeframe, and facilitator for future workforce development advisory committee meetings.

2. Design and conduct a comprehensive workforce survey/concerted data collection effort that includes the counselor certification organizations.

The assessment of the size, composition, and professional capacity of the California SUD workforce is needed in order to guide future workforce development planning and activities.

Employment surveys and labor statistics that are used to draw broad conclusions about the workforce's size and makeup often do not distinguish SUD workers from other behavioral health workers; State data only capture counselors who are certified; and data from recent workforce surveys are of limited utility because they either ask only superficial questions or have very low response rates.

Consequently, the workgroup suggests that a comprehensive SUD workforce needs assessment should be conducted that is more thorough and specific than existing data sources. The workforce needs assessment should differentiate between the needs of the specialty SUD

workforce and the SUD workforce that will be integrated into medical settings as behavioral health staff. This undertaking would provide a more comprehensive and nuanced picture of the current SUD workforce than is currently available, and would enable the prioritization of workforce development activities based on current needs. *(In a November 18, 2013 letter to Dr. Freese, the CAADAC and CAARR representatives present at the meeting state that they disagree with this paragraph).*

Specific tasks include:

- Create and disseminate survey(s) to get a clearer picture of:
 - The demographics of the current SUD counselor workforce
 - DMC-certified provider facilities (who plans to get certified)
 - Existing billing/data collection systems (EHRs)
 - Activities of counties and providers to prepare for health care reform
 - Review the minimum dataset that is currently being piloted for a national database (IC&RC and NAADAC with SAMHSA and HRSA funding).
 - Look into national workforce surveys that already exist for MH.
- 3. Expand existing training and technical assistance services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment. These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into Integrated Behavioral Health (IBH) providers in medical settings.**

Though it is difficult to identify the California SUD workforce's most pressing needs, it is nonetheless clear that it needs significant training and technical assistance in areas critical to the provision of comprehensive and evidence-based SUD services. Agencies and individual providers report that they prefer to receive training and technical assistance at off-site meetings in which one or two staff members are trained and are then responsible for disseminating the knowledge they've gained through in-service trainings they provide to their colleagues once they return to their work site.

Many training and technical assistance opportunities for SUD providers throughout the State have been supported in the past, and it is strongly recommended that future efforts should be supported and expanded, if possible, to ensure that as many members of the SUD workforce as possible develop the knowledge and skill set needed to provide state-of-the-art SUD treatment on a regular and consistent basis.

Training and technical assistance activities should be designed to reflect the future bifurcation of the SUD treatment workforce. One training and technical assistance track should emphasize the skills and competencies needed to deliver specialty SUD services. A second training and technical assistance track should be designed to prepare the current SUD workers to become IBH providers. While expanding the workforce it is also critical that IBH providers are reimbursable.

Specific tasks include:

- Expand the offering of pre-service education to individuals who are not yet certified (involves working with community colleges throughout California to infuse SUD-specific information into existing curricula).

- Provide training and technical assistance to SUD counselors, administrators, and clinical supervisors.
- Utilize existing TA/training providers (PSATTC, ADPI, etc.)
- [DHCS] Provide focused direction regarding the types of continuing education programs that need to be developed to minimize delay in developing a common language.

Suggested training/TA topics include:

- Working in the health care system (medical terms, team approach)
- Certification standards
- Documentation (billing, codes)
- Program administration
- Clinical supervision
- Other evidence-based practices

(In a November 18, 2013 letter sent to Dr. Freese, CAADAC and CAARR representatives present at the meeting state that they disagree with this recommendation).

4. Develop strategies to increase compensation for the SUD treatment workforce.

The SUD treatment field will not be able to attract significant numbers of adequately trained and qualified candidates if it does not begin paying its employees a more competitive salary. Collaboration with the California Workforce Investment Bureau (WIB), Health Workforce Development Council, Office of Statewide Planning and Development (OSHPD), and provider organizations can help to devise strategies to increase employee compensation and benefits, in order to make them competitive with those offered in other health care sectors. A variety of

strategies should be considered including tuition assistance, loan forgiveness, performance-based or merit-based salary increases, and restructuring fee and payment schemes for agencies so that they can pay their workforce competitive wages. Though not all of these strategies may be feasible, it is imperative that a comprehensive set of strategies be devised to increase salaries, so an adequately trained and skilled SUD workforce can be attracted.

5. Replace the multiple counselor certification organizations with a single, state-level certification organization.

(In a November 18, 2013 letter sent to Dr. Freese, CAADAC and CAARR representatives present at the meeting state that while they agree with this recommendation, it does not go far enough to convey their intent. They noted in their letter that they argued that a licensed category of professional be instituted and that the State of California “needs to take ownership of coordinating the workforce”).

6. Develop required competencies/unified scope of practice for SUD counselors (implement the SAMHSA career ladder for SUD counselors in California).

Many states have already adopted career ladders for SUD counselors, similar to that recommended by SAMHSA, but California has not. The adoption of a career ladder would require the input of and collaboration with the multiple organizations that currently certify SUD counselors in California. The certification organizations would need to agree on definitions of each step on the ladder, as well as the professional responsibilities, salaries, and benefits that should be linked to each title.

Specific tasks include:

- Identify a continuum of payable services, from prevention to aftercare/recovery.

- DHCS is interested in working with the certification organizations to develop this content
 - Link the career path and scope of practice to these service levels.
- Develop a list of skills SUD counselors need to possess to work effectively in primary care/integrated settings.
 - Define the role of an SUD counselor in working in a primary care team
 - Provide internships in primary care
- Develop a scope of practice highlighting the unique experience and knowledge of SUD counselors with regard to other professions (e.g., social workers and marriage and family therapists) and make it standard across the different certification organizations.

(In a November 18, 2013 letter sent to Dr. Freese, CAADAC and CAARR representatives present at the meeting state that they disagree with this recommendation, stating that they oppose the SAMHSA career ladder in favor of one specifically developed for CA providers).

7. Collaborate with institutions of higher education to increase recruitment and properly train the SUD workforce.

Many community colleges, 4-year Universities/Colleges, and graduate schools have programs that provide SUD education and training for prospective members of the SUD workforce. Though these institutions offer appropriate preparation for a career in SUD treatment, they are not producing enough graduates to satisfy the treatment system's workforce demands. Thus, we suggest increased collaboration with institutions of higher education across the state to teach students about the SUD treatment field and the

professional opportunities it offers. A need also exists for more SUD-specific degree programs at the bachelor's and master's levels. It is worth noting that this process will be much more effective once a career ladder (Recommendation 6) is established, and students can see that there is potential for competitive compensation and career advancement within the SUD treatment field. Once a career ladder is established, it can also be used to help institutions of higher learning design their curricula and training programs, so that graduates will complete their education prepared to enter the SUD treatment workforce.

(In a November 18, 2013 letter sent to Dr. Freese, CAADAC and CAARR representatives present at the meeting state that they agree that a career ladder needs to be developed; however, they disagree with specific actions recommended).

8. Make a concerted effort to recruit young individuals, males, and racial/ethnic minorities into the SUD workforce.

The majority of the SUD treatment workforce is White, female, and in their 40s or 50s, making them highly mismatched for the clients they serve. According to CA ADP/DHCS data, 63% of Californians receiving SUD treatment are male, and 57% of them are non-White (34% are Hispanic, 16% are Black). Furthermore, almost 60% of individuals who need SUD services are under the age of 35. Though efforts to inculcate cultural competency and encourage the delivery of culturally appropriate services can help improve the quality of treatment delivered to these populations, it is still preferable for clients to receive treatment from individuals who are of a similar age, gender, and racial/ethnic background. Thus, workforce recruitment and expansion efforts should be focused on adding more men, racial/ethnic minorities (particularly Hispanics and Blacks), and young individuals to California's SUD workforce.

9. Train medical and mental health professionals working in integrated care settings on the basics of substance use and SUD and their impact on health.

Many of the physicians, mental health professionals, and allied medical providers who will serve individuals with SUD in integrated primary care settings continue to possess negative attitudes about individuals with substance use conditions, and have received minimal training on how they should be treated. To address this issue, a concerted effort should be made to provide training for doctors, nurses, and other physical health staff working in primary care settings on the nature of SUD, its etiology, and its treatment.

Additional Items of Discussion that did not Achieve Broad Consensus

Marketing

- The SUD system needs to engage and align with the health care system:
 - Rebranding; all marketing messages should be positive in nature (internal controls must exist to reinforce the positive nature of the SUD specialty system).
 - Talk to primary care; find out how we can help them.
 - Formalize and professionalize the SUD field to be responsive to health care needs; educate SUD staff about primary care.
 - Embed SUD counselors in primary care to educate primary care providers about the benefits of SUD treatment.
 - Develop SUD counselors' "generalist" strategies for getting a foot in the door.
 - "Field" vs. "Profession."

- Define the continuum of services that need to be further developed and can be tied to funding/reimbursement.
- The SUD profession needs to agree on unified language/messaging that paints the field in a positive light (a “Rosetta stone”).
- Who will conduct this survey? Could the counselor certification organizations work collaboratively to survey their members?
- Look at successful models and see what strategies can be adapted; for example, ACOs are flexible with hiring, so SUD should go to the table with ACOs and offer them SUD expertise. Kaiser is a good model.

Stronger State Leadership

- Leadership is needed at the state level at the Department of Health Care Services:
 - The State needs to require ongoing clinical supervision.
 - The multiple certification organizations should be replaced by a single state body for certification.
 - Licensure is needed.
- Certification organizations often are not in agreement and do not have a unified direction for future efforts. Greater state oversight is needed to guide the organizations to consensus.

Documentation

- Document the benefits and key outcomes of integrated care delivery.

- Compile and disseminate a list of “measures” that primary care and managed care organizations would be responsible for (regarding SUD representatives).
- Compile baseline data or benchmarks around what is occurring where and how (SUD treatment).
- Demonstrate the cost savings of good integrated care by more consistent documentation of services. (“The bean counter will be counting”).
- What are our outcomes?

Short- and Long-Term Needs

- **Billing** (context – SUD providers need to be reimbursed for the services they provide)
 - Reform reimbursement practices:
 - Medi-Cal reimbursements (rates and practices).
 - State regulation currently prevents putting an on-site SUD counselor in primary care without a separate facility licensure to bill.
 - Talk to health benefits exchange people and learn what is needed to work with them. Talk to payers in order to get SUD counselor workforce reimbursed.
 - Need to align incentives, make use of funds in primary care to pay for SUD.
- **Parity**
 - Follow continuing litigation/legislation.
 - Americans in Recovery Act (ARA).
 - SB 1x1.
 - State should get a legal opinion (from CMS/HHS) on why parity doesn’t apply to DMC because it is a carve-out.

Other Comments and Concerns

- General consensus was reached regarding the need for SUD providers to be able to operate both inside and outside of the health care system.
- Ultimately, we need to remain focused on what is best for the consumer.
- A need exists to create and maintain a sustainable system – not all SUD counselors should necessarily leave the SUD specialty system for primary health care, and not all health care systems can afford high-level educated SUD workers – at the heart of this issue is need to further discuss whether we are talking about a single integrated system or the reification of a bifurcated system.
- What are the expected changes in health care? What are the expected changes for the specialty SUD profession?
- Are we equipped to manage the spectrum of SUD (including individuals with mild issues that might not be in the diagnosable stage)? Alternately, what are the implications of a sicker patient population (newly eligible for insurance through Medicaid expansion or the insurance exchanges) and the skill set that will be required of the SUD workforce?
- The specialty system will still be necessary for individuals with greater treatment needs, and linkages should be facilitated between health care and SUD specialty.
- Recovery system development.
- Prevention concerns.
- 42 CFR Part 2 remains a concern for SUD.
 - Potentially there is open source software being developed for data segmentation.

- The specialty system and payers are still looking at SUD treatment as acute (despite our emphasis on chronic care). Need to examine the services provided and the patient populations that will be served.
- How do you engage new patients by using SBIRT? Can the model be expanded to address the spectrum of early identification to aftercare?
- A very high number of patients are receiving buprenorphine from physicians and they are not counted in our data systems and may not even be receiving essential psychosocial counseling.

Licensure Discussion

- It is estimated that 32 states have SUD counselor licensure or a state-level certification that equals state licensure.
- Staffing difficulties exist because of billing regulations and requirements – currently need a licensed professional to sign off on SUD counselors. However, counselors are valuable because of their particular expertise and shouldn't be replaced by other staff types just because they're billable and counselors aren't.
- Workforce should have a clear entry and licensure.
- Comment: Why educate other BH professionals to do what SUD counselors do, rather than build up current SUD counselors in the field who already have the training and experience?
 - Are there equivalences with licenses? (Such as LVN/RN/NP) – What models exist in the SUD specialty field? Would that be desirable in California?

- The State does not want to spend money to develop a separate SUD board.
 - States that require licensure raise the bar on the educational requirements. But they also have the option to grandfather in certified people who might not have the necessary education, but have practical clinical experience.
 - Certification, like licensure, looks very different from state to state. Typically, with licensure, it's a masters-level person. Many things to think about because people can be grandfathered in but not everybody – meaning some will fall between the cracks and be lost.
 - Is there an option for levels of licensure that can be tailored specifically to the CA SUD workforce?
- A complicating issue is that there are many counselor certification organizations (currently 6). Efforts have been made to come together and standardize requirements. For example, in CA, there is a uniform code of conduct across certification organizations, but resistance remains because a uniform scope of practice has yet to be established.
 - The SUD system has a communication and image problem. The certification organizations need to talk to each other and agree on a scope of practice and a unified pathway to licensure. With this, other certified and licensed professionals will be more supportive once they see the unique position of SUD counselors.

- We should bring in people from other states to talk about their experiences. Nevada has a system where you have a 10 year period for licensure/certification. Counselors enter as interns without a BA and can take up to 10 years to earn their bachelor's degree.
 - What happened in Nevada is that people come in to the field to work for 10 years, and then leave after that period.
 - Grandfathering has also caused some issues.
 - Nevada has a certain number of hours needed, weighed on a certificate from an accredited college.
- For DUI programs: there needs to be a tiered system. The public and clients can't afford to pay for fully licensed staff for DUI programs. It's against the law for DUI programs to receive funding: they need to be 100% paid for by clients, who often can't pay.

On behalf of UCLA Integrated Substance Abuse Programs and the Pacific Southwest Addiction Technology Transfer Center, we thank the workgroup participants for taking time out of their busy schedules to provide their honest and direct feedback on the needs of the SUD treatment workforce. This is just the beginning of the conversation, but we are hopeful that this document will provide the foundation for future discussions.

Attachment 1

Workforce Development Workgroup Participants

NOTE: A total of 39 people participated in the meeting. The list below reflects the names and affiliations of those individuals who provided consent to have their name included.

First Name	Last Name	Agency/Affiliation	County
Charlotte	Bullen	UCLA Integrated Substance Abuse Programs	Los Angeles County
Jeff	Capobianco	The National Council for Community Behavioral Healthcare	Out of State (Washington, DC)
Maria	Castro	UCLA Integrated Substance Abuse Programs	Los Angeles County
Mady	Chalk	Treatment Research Institute/U Penn	Out of State (Philadelphia, PA)
Laura	Colson	Department of Health Care Services, SUD Prevention, Treatment & Recovery Services Division, Policy & Prevention Services Branch	Sacramento County
John	de Miranda	Door to Hope / NAADD	San Mateo County
Jessica	Delgado	California Department of Health Care Services	Sacramento County
Thomas E.	Freese	UCLA Integrated Substance Abuse Programs	Los Angeles County
Larry	Hearn	CADDTP/Safety Center, Inc.	Sacramento County
Linda	Kaplan	Workforce Consultant (Retired)	Out of State (Chevy Chase, MD)
Victor	Kogler	Alcohol and Other Drug Policy Institute	Sacramento County
Mary Jo	Mather	IC & RC	Out of State (Harrisburg, PA)
dave	neilsen	California Department of Health Care Services	Sacramento County
Ronald	O'Donnell	ASU Doctor of Behavioral Health Program	Out of State (Phoenix, AZ)

First Name	Last Name	Agency/Affiliation	County
Brandy	Oeser	UCLA Integrated Substance Abuse Programs	Los Angeles County
Katrina	Parker	California Department of Health Care Services	Sacramento County
Jon	Perez	Substance Abuse & Mental Health Services Administration	San Mateo County
David	Peters	CAARR	Sacramento County
Traci	Rieckmann	UCLA Integrated Substance Abuse Programs	Out of State (Portland, OR)
Nancy	Roget	UNR CASAT/NFAR ATTC	Out of State (Reno, NV)
Beth	Rutkowski	UCLA Integrated Substance Abuse Programs	Los Angeles County
Jeanna	Spanning	University of Massachusetts, Department of Family Medicine and Community Health, Hahnemann Family Health Center	Out of State (Worcester, MA)
Elise	Tran	UCLA Integrated Substance Abuse Programs	Los Angeles County
Rachelle	Weiss	California Department of Health Care Services	Sacramento County
Brenda	Wiewel	CAADPE/LA CADA	Los Angeles County
<i>Anonymous</i>	<i>14 individuals did not provide consent to have their names included in this list.</i>		

Attachment 2

Letter from CAADAC and CAARR dated November 18, 2013



November 18, 2013

Tom Freese
Principal Investigator and Co-Director
Pacific Southwest Addiction Technology Transfer Center
UCLA Integrated Substance Abuse Programs
11075 Santa Monica Blvd, Suite 100
Los Angeles, CA 90025

Dear Mr. Freese,

Thank you for sharing your draft document concerning workforce recommendations for the substance use disorder profession in California. We appreciate your organization's efforts to bring attention to the challenges we face in the area of counselor shortages, preparedness for health care reform, and long term capacity building. As you know, several CAADAC and CAARR representatives attended the meeting on September 12, in Sacramento. Please indicate in your report that our organization participated. However, our participation should not be listed as supporting the recommendations contained in the draft.

The draft presents a list of recommendations titled, "Working Group Recommendations that Achieved Consensus." CAADAC and CAARR strenuously object to this characterization for these items. There was discussion and a variety of opinions expressed about each topic, but consensus was reached on only a few of them, and none of them to the level of specificity indicated in the draft. It appears as though the input provided from the participants was excluded because it contradicted the recommendations originally crafted by UCLA. The draft document is not representative of the discussion that took place on September 12.

As per each recommendation, CAADAC and CAARR representatives have the following observations from the meeting:

Recommendation 1: CAADAC and CAARR representatives present at the meeting agree that consensus was reached upon the need to convene an ongoing advisory group.

Recommendation 2: CAADAC and CAARR representatives present at the meeting agree that consensus was reached that a California specific workforce survey should be conducted to more accurately document shortages. Meeting participants did NOT reach consensus that the SUD workforce is "under qualified, and unstable." In addition, there was no semblance of consensus that the workforce should be divided into two categories as suggested in the survey for recommendation 2, "The workforce needs assessment should differentiate between the needs of the specialty SUD workforce and the SUD workforce that will be integrated into medical settings as behavioral health staff." The majority of participants objected to the recommendation that the workforce be bifurcated in this way. This input is not reflected in the draft.

The recommendation to integrate SUD counselors into medical/clinical settings is unwarranted because it is already occurring on a wide scale. Many certified and licensed counselors either work within a medical setting or directly engage with primary care providers and/or clinics on a regular basis. In addition, there are more than a dozen state wide "chemical dependency recovery hospitals" operating exclusively under medical settings.

Recommendation 3: Again, the issue of preparing two workforces is presented as a consensus item when the input from the workgroup was rigorous opposition to this recommendation. This is inaccurately represented in the draft and should be deleted. The draft states that, "Training and technical assistance activities should be designed to reflect the future bifurcation of the SUD treatment workforce." This is factually untruthful. The participants did not support this recommendation. The draft goes on to suggest specific tasks to accomplish this recommendation. These tasks were NOT discussed at this meeting, so support or opposition to them cannot be reflected in this document. Participants opposed utilizing current or future resources for creating Integrated Behavioral Health (IBH) workers. They strenuously voiced a preference for using funding and training programs to increase the capacity of SUD specialists. This is not reflected in the draft.

Recommendation 4: CAADAC and CAARR representatives present at the meeting agree that consensus was reached on the need to incentivize entry and retention in the SUD workforce.

Recommendation 5: CAADAC and CAARR representatives present at the meeting agree that consensus was reached that a strategy for unifying the certification process is an important goal for the state. Participants also voiced strong support for the creation of a licensed level category for the profession. This is not reflected in this recommendation.

Participants iterated multiple times that the state, in some fashion, needs to take ownership of coordinating the workforce and that by partnering with the remaining certifying organizations concerning issues of safety, quality, and workforce issues such as recruitment and retention, California would see vast improvements in both the quality and quantity of the workforce.

Recommendation 6: CAADAC and CAARR representatives present at the meeting do NOT agree that consensus was reached regarding the implementation of the SAMSHA career ladder. The certifying organizations in California are actively discussing a unified career ladder. Only one of these organizations supports the SAMSHA career ladder, the other four (representing the vast majority of counselors in California) support career ladders which are reflective of the present workforce in California. Comments opposing the use of the SAMSHA career ladder were in the majority at the meeting.

The statement in the draft that, "Many states have already adopted career ladders for SUD counselors, similar to that recommended by SAMHSA, but California has not," is factually incorrect. Not a single state has adopted the SAMSHA career ladder. SAMSHA consultant, Linda Kaplan, has publicly stated that very few states have actually used the SAMSHA career path and that it has laid dormant for a number of years. States have a diverse offering of career ladders with varying education, experience and testing requirements.

Recommendation 7: CAADAC and CAARR representatives present at the meeting agree that consensus was reached that a complete career ladder, with accompanying levels of education, needs to be developed. At the meeting, participants explained that, without licensure for SUD counselors, students will not choose SUD counseling as a major because other professions are licensed and reimbursed at a higher level. This is not reflected in this recommendation.

Meeting participants suggested that the California Coalition of Certifying Organizations work group would be the appropriate designation for developing a simplified career path which could be used by OSHPD and other state departments to support the workforce with entry and sustainability.

Recommendation 8: CAADAC and CAARR representatives present at the meeting agree that consensus was reached on the issue of recruiting a more diverse workforce.

Recommendation 8: CAADAC and CAARR representatives present at the meeting agree that consensus was reached on the need to educate primary care providers about SUDs.

CAADAC and CAARR representatives at the meeting strongly urge project leaders to revise the draft so that it is more representative of what occurred at the meeting. Some consensus on broad issues was reached, but there was much debate concerning others.

Sincerely,



Richard DeCuir
Executive Director
CAADAC



Susan Blacksher
Executive Director
CAARR

CC: Department of Health Care Services, including: Karen Baylor, Marliese Perez, Janelle Ito-Orille

**Potential Expansion of SBIRT Supervision
Review of Existing Evidence and Feedback from National Experts**

**Darren Urada, Ph.D.
Elise Tran, B.A.
Brandy Oeser, M.P.H.
Valerie Antonini, M.P.H.
Cheryl Teruya, Ph.D.**

UCLA Integrated Substance Abuse Programs

Executive Summary

There have been no published research studies that have specifically and directly addressed which providers should supervise the delivery of SBIRT services. However, there are four converging lines of evidence that appear to suggest the same answer.

1. LCSWs and LMFTs currently supervise SBIRT activities in California in two FQHCS and one medical center in Kern County as a part of MHSa-funded Project Care. Although this project was not designed to generate outcome data by type staff supervision, thousands of patients have been successfully screened at these sites. Preliminary data suggest positive patient outcomes, but this data is not conclusive, as very plausible alternative explanations for the results exist.
2. Supervision aside, there is empirical evidence that that SBIRT has been *delivered* effectively by LCSWs, LMFTs, RNs, and health educators. This tends to support the idea that such providers could also supervise SBIRT efforts.
3. There appears to be consensus among top national SBIRT experts that expanding the list of authorized supervisors beyond the current providers would be a good idea. A recent SAMHSA-HRSA workforce report also made the general point that health care should be delivered by the least expensive staff qualified to ensure quality care, which, if extended to supervision, would support expansion to allow lower-cost but well qualified providers to serve as SBIRT supervisors.
4. The scope of practice for both LMFTs and LCSWs includes substance use disorders, and training requirements for these titles appear to be at least as extensive as those for physicians, physician assistants, and nurse practitioners.

In summary, although there is not much data that specifically addresses the question of what type of providers should supervise SBIRT, the data that do exist, related research evidence, consensus among experts, and existing training requirements all tend to support the idea of expanding the list of providers that can supervise SBIRT, and to do so in particular for LCSWs and LMFTs. Based on experiences in implementing SBIRT in other states, experts suggested that implementation of SBIRT using only the currently approved providers would likely be slow due to existing demands on these providers. In California, if the discussion of SBIRT supervision is limited to licensed providers whose services can be billed to Medi-Cal (or may be able to do so shortly), then LCSWs and LMFTs appear to be well positioned to serve in this role. SUD is within their training and scope of practice, and preliminary evidence suggests that these providers have been adept at supervising SBIRT in non-Medi-Cal funded efforts in the state. They can also potentially provide supervision at a lower cost than the currently approved supervisors.

Introduction

The goal of this paper is to summarize evidence for or against the expanding the list of allowable SBIRT supervisors beyond the existing list of physicians, physician assistants, nurse practitioners, and psychologists. While expansion could occur for a number of provider types, we focus in particular on Licensed Clinical Social Workers (LCSWs) and Licensed Marriage and Family Therapists (LMFTs) as potential supervisors due to their current ability to bill services to Medi-Cal (LCSWs) or proposed ability to do so under State Plan Amendment 14-012 (LMFTs), and the match between SBIRT and their scope of practice.

Methods

UCLA analyzed existing data from SBIRT efforts underway in one California county, examined current research and policy literature on SBIRT, and obtained guidance from experts across the US. Expert consultation began with Mady Chalk, Ph.D. (national SUD policy expert and director at TRI and consultant to UCLA ISAP) who referred us to experts who in turn referred us to others, allowing us to reach out to and receive feedback from a broad network of experts in the field. Experts included Richard Brown, M.D., M.P.H. (Wisconsin SBI), Reed Forman, M.S.W. (CSAT), Eric Goplerud, Ph.D. (NORC, University of Chicago), Dane Libart, LCSW (Oklahoma SBIRT), Bertha Madras, Ph.D. (Harvard), Richard Saitz, M.D. (Boston University), Brie Reimann, M.P.A. (Colorado SBIRT), and Tom Stegbauer, M.B.A. (HHS).

Findings

Outside of Medi-Cal, LMFTs and LCSWs are supervising SBIRT in California.

UCLA ISAP provides evaluation services for Project Care, a Mental Health Services Act (MHSA)-funded project in which LCSWs and MFTs supervise SBIRT services. To date, 6,354 patients have been screened for alcohol and other drug problems using the AUDIT C+¹ in 10 sites associated with two FQHCs and a large medical center in Kern county. In one organization, SBIRT is supervised entirely by LMFTs and LCSWs. In another, SBIRT is delivered and supervised by an LMFT and an SUD counselor. In a third organization, supervision is split between a clinical psychologist and an LCSW.

Preliminary data from the first two organizations described above (5 sites) suggests that patients who have a positive AUDIT C+ score at their initial screening on average have improved scores at follow-up. In the site with the most patients screened, 3,330 patients were screened and 1,057 had a positive score (31.7%). Of these, 408 had a follow-up screening (38.6%). Among these patients, their average initial AUDIT C+ score was 7.9, and their scores improved (decreased) to an average of 6.4 at their second screening, and to 6.2 at their last screening on record. The improvement from first to second screening was statistically significant ($t=7.10$, $p<.0001$) and the effect size ($d=.37$) is within the range of those reported in published SBIRT studies on alcohol (0.18 to 0.43) or illicit drugs (0.13 to 0.84) (Prendergast &

¹ The AUDIT C+ is identical to the AUDIT C, but adds two additional questions to detect illicit drug use and prescription drug misuse.

Cartier, 2013). In other words, there was no evidence that SBIRT using MFTs and LCSWs as supervisors performed any better or worse than published SBIRT studies in general, which mostly involve delivery by medical providers.

Limitations: This data cannot prove that it was the SBIRT supervised by MFTs and LCSWs that caused the reduction in scores. Plausible alternative explanations exist, including 1) Self-selection, which would occur if there was a greater tendency for patients who had reduced their substance use to return for a second screen, 2) Regression to the mean, which would occur if the positive scores tend to detect patients at the height of their substance use, and these scores then return to normal (lower) levels regardless of services received, and 3) Social desirability, which could occur for example if respondents receive a brief intervention after an initial positive screen and are subsequently more embarrassed to report that they are still using heavily during a second follow-up screen.

On the other hand, there were also factors working against detecting improvements in this analysis, including the fact that the AUDIT C+ asks about past year use, which would make it difficult to immediately detect improvements in use.

In summary, while not conclusive, data suggest that LCSWs and LMFTs are proficient at supervising screening and brief interventions, and the data weakly suggest that improved patient outcomes may be associated with SBIRT delivered under this supervision arrangement.

Published research suggests that a variety of providers are capable of delivering SBIRT effectively, which suggests they could supervise it.

The following three articles support the use of other types of providers than PCPs, including LCSWs, LMFTs, RNs, and health educators:

- Madras et al. (2009) - This was a large, multi-site SAMHSA-sponsored study of SBIRT. The study reported positive outcomes using a wide variety of staff types, including, among others, "Licensed Behavioral Health Counselors" (p.283).
- A meta-analytic review by Sullivan et al. (2011) concluded that "nonphysician brief interventions are modestly effective at reducing drinking in primary care patients with unhealthy alcohol use." The methods of many of those studies were limited so the best conclusion could be was that no differences were detected between physicians and non-physicians. The majority of "non-physician providers" were NPs, PAs, or RNs, but three studies included health educators, and one used therapists.
- Bernstein 2005 (peer outreach workers). Bernstein used BI delivered by peer outreach workers, which reduced cocaine and heroin use.

More generally, a 2011 SAMHSA-HRSA workforce paper by Dilonardo (2011) suggests that SBIRT should be delivered by the least expensive provider that is qualified to ensure quality care, stating: "The fact that reimbursement is allowable only when certain types of clinicians deliver the screening and brief intervention should be addressed. While it is no doubt important that knowledgeable workers provide these services, efficient health care can only be delivered by ensuring that the level of person

performing the function is not more qualified (and expensive) than what is needed to ensure quality care.” This argument could easily be extended to supervision.

Similarly, survey and interview data collected by UCLA from primary care sites suggests that enabling staff like LMFTs to provide Medi-Cal services in primary care settings will be important to address California behavioral workforce needs (including SBIRT) in primary care settings (Urada, Teruya, Gelberg, & Rawson, 2014).

SBIRT is within LMFT and LCSW training and scope of practice

SBIRT is designed to be simple enough to be delivered by providers without extensive training in SUD. Still, additional training and familiarity with SUD may be helpful in the supervision of these services.

Scope of Service for MFTs and LCSWs²

- The scope of practice for both MFTs and Social Workers includes substance use disorders. The California Code of Regulations requires “not less than 15 hours” of training in alcoholism and chemical substance dependency.³
 - The LCSW scope of practice as defined by B&P 4996.9 includes "the use, application, and integration of the coursework and experience required by Sections 4996.2 and 4996.23."
 - Section 4996.2 requires that a social worker "(e) Has completed adequate instruction and training in the subject of alcoholism and other chemical substance dependency."
 - In 2013 NASW published standards for social work practice with clients with substance use disorders.⁴
 - The MFT scope of practice as defined by BPC 4980.02 includes "the use, application, and integration of the coursework and training required by Sections 4980.36, 4980.37, and 4980.41, as applicable." BPC 4980.63 describes training in “Substance use disorders, co-occurring disorders, and addiction.”
- While 15 hours is not high, this minimum training in substance use disorders required for MFTs and LCSWs appears to set a higher minimum than exists for some current SBIRT supervisors (physicians, nurses, or physician assistants), though it is also lower than the minimum set for psychologists.
 - For physicians, there are “there are no formal requirements for addiction medicine training” according to Rasyidi, Wilkins, and Danivich (2012).

² Thanks to Associate Professor Benjamin Caldwell, MFT (Alliant University) for assistance in identifying the MFT and LCSW scope of service.

³ <http://www.bbs.ca.gov/pdf/publications/lawsregs.pdf>

⁴ <http://www.socialworkers.org/practice/standards/naswatodstatndards.pdf>

- Training for Nurses⁵ and Physician Assistants⁶ must “include” training in the detection and treatment of alcohol and chemical substance dependency, but no minimum number of hours is specified.
- Psychologists are required to complete a graduate level course on Alcoholism/Chemical Dependency detection and treatment that “shall not be less than a semester or a quarter term in length.”⁷

CMS Recognizes LCSWs as eligible SBIRT providers for Medicare

- CMS identifies LCSWs as being eligible for SBIRT⁸ providers for Medicare. While this is not Medicaid, it seems to suggest CMS recognizes LCSWs as being up to the task.

National experts seem to view expanding the list of authorized SBIRT supervisors favorably.

National SBIRT experts that have been involved in SBIRT implementation or research appear to be in agreement that expanding the list of authorized supervisors would be a practical accommodation to the field.

Richard Brown, M.D., M.P.H. (Wisconsin SBI)

In Wisconsin, unlicensed providers “Provide the screening and intervention services under the supervision of a licensed health care professional.”⁹ However, no physicians have participated in the required training, which suggests that other licensed professionals are needed to supervise. “The doctors, PAs, and NPs are too busy.” On the other hand, there is a 60 hr training requirement for unlicensed individuals delivering SBIRT (training must all be on SBIRT). Dr. Brown reports that over 20,000 SBIRTs have been performed, and that the unlicensed staff have never had to call on the physician for help. The practical reality, he says, is that the unlicensed professionals will know about this than the doctor. This suggests that the title and training of the supervisor is actually less important than that of the provider.

Richard Saitz, M.D., M.P.H. (Boston University)

In a similar vein, in Dr. Saitz’s opinion, although most studies only look at PCPs, and in an ideal world the patient’s PCP would deliver SBIRT, “I don’t think (no evidence) that this is about licensing or the letters after one’s name. Instead it is about the perceived role (by the patient), and how well they are trained to do this specifically, and the context (hospital ER etc) and whether they actually do it well and have time to do it well. There is already some mounting evidence that documented BI in the VA is not

⁵ <http://www.rn.ca.gov/regulations/bpc.shtml#2736.1>

⁶ <http://www.arc-pa.org/documents/Standards4theditionwithclarifyingchanges9.2013%20FNL.pdf>

⁷ <http://www.psychboard.ca.gov/licensee/instructions.shtml>

⁸ http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf

⁹ <https://www.forwardhealth.wi.gov/kw/pdf/2009-96.pdf>

associated with less drinking. Probably because documented BI by a physician is not the same as a patient actually receiving a well done BI. By the way, it isn't clear that nurses or doctors should be better at the actual counseling than other professionals, and certainly those with counseling skills as part of their profession ought to be able to have the skills, though they may need reorientation as to the goals and context which are very different from specialty settings."

Eric Goplerud, Ph.D., NORC (University of Chicago)

On the question of supervision, Dr. Goplerud replied "I doubt that there is a research literature on your question, but the assembled folks who are on the email should be able to provide you with the information." This was in reference to many of the other experts mentioned or quoted here, ie. Saitz, Stegbauer, Madras, Libart, Reimann, and Brown.

Dr. Goplerud also continued, "I led the group that applied to AMA and CMS for the CPS and HCPCS level 2 codes for screening and brief intervention. We worked hard to have licensed health professionals operating within their scope of practice as being eligible to provide the SBI services . . . AMA and CMS agreed. Their decision would suggest that "incident to" billing would cover a wide range of health professionals who could supervise health workers to directly provide the SBI services." (note: for more on scope of practice, see the previous section)

Mady Chalk, Ph.D., Director, Center for Policy Research and Analysis at Treatment Research Institute

"Yes, of course, CA should certify that SWs can supervise. They do in other states and probably in most states it is not a requirement---what seems important is that to get SBI implemented by very junior staff--counselors without a degree, health educators with HS degrees they need training and clinical supervision. If CA does not want to use SEs [sp] it will pay a price in terms of implementation...once CA learns the costliness of that lesson it will change its behavior. Physicians won't do it and there are not enough nurses so SBI simply won't happen"

Tom Stegbauer, M.B.A., Health & Human Services

"The issue many systems face is the fact that physicians don't have the time to administer a "four course dinner of SBIRT" (screening, brief intervention, referral to treatment, follow-up). The alternative to adding to the already overburdened physician is not the only pathway. Electronic screening is developing, but other providers have skills to appropriately aid patients and improve outcomes."

Brie Reimann, M.P.A. (led SBIRT Colorado's work to get Medicaid coverage of SBI)

"We felt it necessary to include a variety of professionals who could provide SBI because we currently employ health educators and are very focused on nurse-delivered SBI. Our biggest challenge since activating the codes is getting providers to bill for these services."

Dane Libart, LCSW (Oklahoma)

In Oklahoma's expansion of Medicaid coverage for SBI, Libart reported that they explicitly permit trained addictions counselors to provide the service, but they are supervised by primary care providers.

Joseph Hurley (Oregon)

“. . . most states include RN and LCSW. Clinical data shows FQHC and RHC centers have been effective services rendered with those types. We are striving to include LVN and Licensed Addiction Counselors. I have seen no clinical data to include Midwives, LMFT, or LPCC.”

Other experts consulted included:

Reed Forman, M.S.W. (CSAT)
Bertha Madras, Ph.D. (Harvard)

Summary:

In summary, although there is not much data that specifically addresses the question of what type of providers should supervise SBIRT, the data that do exist, related research evidence, consensus among experts, and existing training requirements all tend to support the idea of expanding the list of providers that can supervise SBIRT, and to do so in particular for LCSWs and LMFTs. Based on experiences in implementing SBIRT in other states, experts suggested that implementation of SBIRT using only physicians, nurse practitioners, and physician assistants would likely be slow due to the existing demands on these providers. However, research suggests that other providers are capable of delivering SBIRT, and experts suggested that the title of the provider is less important than their training and available time. Therefore, in California, if the discussion of supervisors is limited to licensed providers whose services can be billed to Medi-Cal (or may be able to do so shortly), then LCSWs and LMFTs appear to be well positioned to serve in this role. SUD is within their training and scope of practice, and preliminary evidence suggests that these providers have been adept at supervising SBIRT in non-Medi-Cal funded efforts in the state. They can also potentially provide supervision at a lower cost than the currently approved supervisors.

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Integrated Substance Abuse Programs (ISAP)

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January 28, 2014

Dear Karen,

Thank you for the opportunity to provide feedback on your *Implementation Plan for Drug Medi-Cal Program Limited Scope Review*. Overall we felt the action plans described in this document were very reasonable responses to A&I's recommendations. We have generated the following additional suggestions that you might consider to enhance the current plans. We hope you will find these helpful.

Fraud detection

1. Data Mining

- a. We were pleased to hear about the elite strike force described in Recommendation 1, Action step 1.2. We have previously forwarded a short report about techniques that the strike force could consider. We believe it will be critical that this team have access to knowledge from SUD providers and experts to enable them to optimally tailor their algorithms for these providers. Training DHCS staff in SUD-specific patterns of fraud would be an enhancement to the action steps for recommendations 1, 12, and 17.
- b. On a related note, you might consider expanding the action steps by using former counselors to advise the A&I strike team about the techniques used, much in the way that former hackers are often used to provide IT security consulting. See also recommendation 3a below, which is aimed at encouraging counselors to report fraud when it occurs. Both of these recommendations are based on anecdotal but reliable information that counselors are often the best source of information about DMC fraud.
- c. If it has not already been done by A&I, the strike force could consider tapping into other states' existing algorithms. For example, Florida's Bureau of Medicaid Program Integrity (MPI) Data Detection Unit has developed detection algorithms for Medicaid fraud that they are willing to share with other states.¹

2. Certification

- a. Recommendation 3: Consider a rolling recertification process. One way to do this may be to require earlier recertification for higher risk programs based on the risk assessment under development (mentioned in response to Recommendations 9, 17, 20, and 26). This would serve dual purposes of providing extra scrutiny for these programs while also avoiding the burden and problems associated with having a wave of simultaneous recertifications occurring at the same time every 5 years as a result of DHCS's current statewide recertification efforts.
- b. Recommendation 7: Monthly checks against the Medicare Exclusion Database (MED) is a good step and is consistent with practices used in other states. However, there are reasons to be concerned about the reliability of the OIG list, and whether it might allow ineligible persons to slip through the net.² If DHCS has the resources to implement additional safeguards, criminal background checks of all individuals holding key

positions within a DMC provider's operations via Live Scan would be a reasonable and effective addition to the action plan. DHCS can look to Alaska, Florida, Illinois, and New Mexico for models of using fingerprinting to reduce Medicaid fraud.¹

3. Training

- a. Recommendations 28 and 29: We recommend enhancing the action plan by extending training beyond DHCS's walls to the people in the best position to recognize and report fraud in the field, i.e. counselors. Counselors are often unaware of the rules concerning DMC, so requiring training for them to understand their ethical responsibility to avoid engaging in DMC fraud is important. This would include training to recognize the problems with paying patients, recruiting people en masse from group homes, indefinite billing of services, billing for non-existent sessions, and mass billing of patients for special services. The trainings should also emphasize counselors' *responsibility to call the DHCS fraud hotline to report fraudulent practices*, and to inform them of the whistleblower protections that apply to them should they do so. Requiring counselors to pass a test of their understanding of these issues would also be very useful. This may require DHCS to take over certifying responsibilities from the current multitude of non-state certifying bodies, which would be a positive step in itself.
- b. On a related note, providers should also receive training in treatment plans that are based on evidence-based practices to ensure that non-fraudulent and clinically appropriate treatment is being delivered. To facilitate use of these practices in SUD programs, DHCS could also consider changes to reduce barriers to implementing them (e.g. placing addiction medications on the Drug Medi-Cal formulary so they may be prescribed more easily in DMC programs, etc.).

UCLA ISAP is ready and able to help with any of these efforts, and would be happy to do so. Please let us know if we can be of any assistance.

Sincerely,

Richard Rawson, Ph.D.

Darren Urada, Ph.D.

Desiree Crevecoeur-MacPhail, Ph.D.

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Feedback on the DHCS Behavioral Health Forum Issue Grid

Thank you for the opportunity to comment on the DHCS Behavioral Health Forum Issue Grid. We have reviewed the grid and found it to be remarkably comprehensive, so our list of content suggestions is relatively short.

Some of our comments are related to formatting and redundancy within the list itself. Since the grid appears to reflect suggestions gathered from many different sources, DHCS is likely aware of the issue and may already be in the process of streamlining it, but we hope these comments might help with this process. We believe streamlining the list will greatly facilitate the ability of the workgroups to address the issues.

Streamlining & formatting suggestions

- Consider consolidating Blue issues into systems development (1, 4, 6, 7, 8, 14, 15), specific research questions (9, 10, 11, 12, 13).
- Consider moving Blue 2 and 16 out of the data workgroup, possibly sending to Red or Green.
- Blue 5 might be too vague to do much with. Consider deleting it unless it can be elaborated upon.
- Consider eliminating duplicative issues. Here are some examples (there may be others):
 - Delete Green 9, which is covered by Green 15.
 - Delete Green 13, which is identical to Green 18.
 - Consider consolidating Green 21, 25, 28, and the MOU portions of 29 and 30 into a single MOU issue.
 - Green 8 and 10 both call for peer certification. Consider consolidating the wording in 10 into the list in Green 8.
 - Move the portions of Green 8, Red 2, and all of Red 18 into Purple 22, which can serve as the single home for the state certification issue.
 - Delete Red 33, which is covered in Red 17 (joint MH-SUD certification).
- The use of an abbreviated sub-committee name in the left column, as occurs for purple section ("SUD-PL", though we're not sure what PL stands for!) is useful, and saves readers from having to refer to the legend at the bottom. Consider replacing "Blue" with "Data", Green with "Coord / Integ", red with "Delivery Systems."

Content Suggestions

- Blue 1: To clarify, add to the third bullet "e.g. NQF and HEDIS measures."
- Blue 3: While only clarification of MEDS access is mentioned here, the same could be said of many other important data systems including CalOMS, CSI, etc. We recommend expanding this

issue to include DHCS data systems relevant to performance and outcome monitoring more generally.

- Blue 13: Add HIV screening to the bullet point on Hep-C screening. The data source would be the same (NSSATS covers both).
- Green 8: Consider adding a bullet that calls for a more thorough assessment of the SUD workforce size, composition, and professional capacity.
- Red 17: Consider adding sober living, other recovery services.
- Purple 24: To clarify this further, consider adding “Consider eliminating the DMC carve-out to facilitate integration of SUD services into settings other than specialty care.”

Other feedback

- We had difficulties with the webinar during the first BH Forum call, so we had audio access only. Hopefully the technology will be more cooperative for future calls!

Thank you once again for the opportunity to comment on this grid. We are looking forward to participating in the forum workgroups to help address the many important issues listed.

Darren Urada, Ph.D.

Valerie Antonini, M.P.H.

Brandy Oeser, M.P.H.

UCLA Integrated Substance Abuse Programs (UCLA ISAP)

**Vision 2020: Bringing Substance Use Disorder Services into the Mainstream of the Los Angeles County
Healthcare System---A Planning Process to Optimize the Impact and Modernize SUD Care.
UCLA Integrated Substance Abuse Programs**

With the implementation of the Affordable Care Act, the health care system in Los Angeles County is undergoing fundamental transformation. ACOs, Health Homes and Health Neighborhoods are becoming realities. A theme that pervades all of these developments is the better integration and coordination of services to improve patient care, population health, and reduce health care costs.

Currently in Los Angeles County there are significant numbers of individuals with alcohol, prescription drug, and illicit drug use problems. Individuals with substance use disorders (SUDs) enter the health care system through every door, including ERs, hospitals, and mental health facilities. Unfortunately, at present the service delivery system for SUDs is “siloed” into specialty care facilities that have very little connection to the rest of the health care system. Fewer than 2% of admissions into these SUD facilities are the result of referrals from other health professionals. As a result, LA County patients fail to receive the well-documented benefits of SUD treatments and the County fails to achieve the cost savings that accrue when SUD services are effectively integrated or coordinated with other health care settings.

Small steps toward integration and coordination are underway in LA County in the form of pilot projects and screening, brief intervention, and referrals to treatment. However, thoughtful restructuring of the way that SUD services are configured within LA County is needed to bring about system-wide change by answering questions such as: How can a better, 21st century health system be designed that integrates SUD services? How should these services coordinate and integrate with the primary care, mental health, and public health systems? What kind of data and data systems are needed? What are the workforce implications? How can performance measures, recovery principles, peer staff, and culturally appropriate care be included in this vision? What role will SUD services play in Health Homes and ACOs? What regulatory changes are needed?

Proposed Plan of Action

In order to create a vision of how these services can be better incorporated into the rest of the health care system in Los Angeles County, it will take the input and buy-in from the leaders of all of the major components of the Los Angeles County health system. A forum will be required to create the vision and develop a set of action steps toward the realization of that vision.

Specifically we are proposing a series of four half-day meetings comprised of the Directors of the Los Angeles County Departments of Health Services, Public Health (including Substance Abuse Prevention and Control), and Mental Health. It will also be essential to have in attendance senior representatives of the major health plans in LA County and the California Department of Health Care Services, as well as outside content experts, including John O’Brien from CMS and Mady Chalk, Ph.D. and A. Thomas McLellan, Ph.D. from Treatment Research Institute, plus two other experts (to be named). In addition, representatives from UCLA would provide expertise, and the UCLA Integrated Substance Abuse Programs would coordinate the meetings. We propose that these meetings occur every two months, beginning in May and ending in November, 2014.

The output from this process would be a vision statement for how SUD services could be configured in LA County to improve patient care, population health, and reduce health care costs. More importantly, an action plan would be created to implement this vision in concrete steps from 2015-2020.