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

2015 Report

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Prepared for the Department of Health Care Services

California Health and Human Services Agency

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Table of Contents

Executive Summary

Chapter 1: Data Analysis: Understanding the Changing Field of Substance Use Disorder Treatment

As expected, the 2014 Medi-Cal expansion associated with the Affordable Care Act on its own does not appear to have resulted in substantial increases in admissions to substance use disorder (SUD) treatment in California yet. A number of challenges remain, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver may address many of them. Key improvements can be made to pave the way for successful implementation, including a more streamlined provider certification process and providers making an effort to integrate with primary care, possibly by following in the footsteps of the small number of providers that historically have been successful in receiving referrals from the health care system (e.g., Baker Place, Tarzana Treatment Centers, Empire Recovery Center).

In health centers, SUD treatment can be expanded in federally qualified health centers (FQHCs) by allowing marriage and family therapists (MFTs) to deliver and bill for services in the same way that licensed clinical social workers currently do.

As the DMC-ODS waiver approaches implementation, the UCLA Integrated Substance Abuse Programs (UCLA) and the California Department of Health Care Services (DHCS), with feedback from stakeholders, should continue to refine measures of patients' movement through the continuum of care and calculation of maximum utilization as a proxy for capacity. These measures will depend upon the quality of the California Outcomes Measurement System (CalOMS-Tx) data, however. To that end, DHCS should address whether reporting CalOMS-Tx records for patients that DHCS does not pay for directly violates 42 CFR Part 2 privacy rights. This, in addition to continued training and education on current data-reporting guidelines, will be necessary to improve the quality of data in CalOMS-Tx.

Further research into why Black/African American adolescent males and Black/African American young adult females are less likely to be referred to treatment by the criminal justice system, relative to other racial/ethnic groups, may be warranted to determine whether there may be missed opportunities to provide treatment to these groups through criminal justice diversion programs. Qualitative evaluation, perhaps involving interviews of criminal justice and treatment stakeholders as well as members of these groups, could help to determine the causes of these disparities and may suggest steps to address them.

The recent surge in treatment for heroin use also merits attention, as it suggests a rise in use. It is likely that this is linked to decreasing accessibility to pain medications, and if so, it may be best to focus efforts on health care settings where prescribing practices can be addressed, monitoring for patient misuse can be implemented, and treatment can ideally be provided on site, potentially with medications such as buprenorphine, without necessarily requiring a referral to specialty treatment, which typically does not work well due to stigma and logistical issues on the part of both the provider and patient.

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

The landscape of California's publicly funded SUD treatment is evolving as major policy changes, including the DMC-ODS waiver, present unprecedented opportunities to increase access to SUD services while integrating such services with mental health and primary care. The numerous efforts to integrate and coordinate care across health systems that are currently underway highlight the different approaches to integrating SUD, MH, and PC services in diverse settings. As part of an Integration Learning Collaborative (ILC), some of these efforts were presented to provide emerging information about promising integration models, challenges, keys to success, and lessons learned. These included:

- Program descriptions, outcomes, and lessons learned from three SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Program Grantees (San Francisco Department of Public Health, Tarzana Treatment Centers, and Alameda County Behavioral Health Care Services)
- Discussions with county administrators (Phase 1 of the DMC-ODS waiver) about current implementation plans and preparations, actual or anticipated challenges, and areas in which the counties seem to be well-positioned for the waiver
- A description of Santa Clara County's Adult Drug and Alcohol Treatment Services transformation to an organized system of care and lessons learned
- Presentations on SUD-related "hot topics", including: a brief treatment toolkit for primary care; making the case for integrated care - mental health and substance use services in primary care settings; medication-assisted treatment for SUD - extended release Naltrexone improves treatment outcomes; and characteristics of medical marijuana users - findings from a survey of dispensaries in Los Angeles County

Key lessons learned from the ILC and county integration initiatives/case studies in Los Angeles County (telepsychiatry, Vivitrol, AB109 process improvement), Kern County (patient interviews, waiting room health survey, staff satisfaction survey), and Santa Clara County (organized system of care) presented in this chapter could help inform future integration efforts.

Chapter 3: Technical Assistance – State and County level

In this past year, UCLA provided technical assistance to DHCS on the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver, American Society of Addiction Medicine (ASAM) Criteria, 2020 Medi-Cal waiver renewal, Substance Abuse Prevention and Treatment Bloc Grant, Statewide Needs Assessment and Planning, workforce development, a vision of the SUD continuum of care, and the DHCS Behavioral Health Forum. In addition, county-level technical assistance was delivered directly to counties and county organizations. Brief summaries and links to resources created during these efforts are included in this chapter.

Chapter 4: County/Provider Training Activities

UCLA also provided trainings to facilitate integration across the state. This included in-person trainings, webinars, and technical assistance to counties. Topics included: Integration Strategies, Screening, Brief Intervention, and Referral to Treatment (SBIRT), Medication-Assisted Treatment (MAT), Motivational Interviewing (MI), Ethics and Confidentiality, and Synthetic Drugs. This chapter briefly summarizes these activities and provides a link to training materials.

Chapter 5: Conclusions and Recommendations

Although 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. The upcoming Drug Medi-Cal Organized Delivery System waiver could potentially lead to a substantial improvement of California's SUD treatment system. To further facilitate system improvement, UCLA has provided 24 policy and practice recommendations drawn both from this year's report and the project's prior two annual reports.

Preface

Darren Urada, Ph.D.

On January 1, 2014, coverage for substance use disorder (SUD) and mental health (MH) treatment was expanded to millions of Californians through Medi-Cal and private plans offered on California's health insurance exchange, Covered California. This report, the third and final in a series of three, takes a first look at trends in SUD treatment before and after this date, discusses what we have learned from efforts around the state to improve and integrate SUD treatment with the rest of the health care system, and makes recommendations to overcome the wide array of implementation challenges that remain.

These efforts are supported through 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) and the California Department of Health Care Services (DHCS). The work plan consists of conducting qualitative and quantitative research/evaluation efforts as well as providing 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. Previous reports can be found at this link:
http://www.uclaisap.org/html/past-updates-reports.html

In addition, based on discussions with DHCS, UCLA shifted efforts as described in the original work plan to providing technical assistance to DHCS related to their preparations for the pending Drug Medi-Cal Organized Delivery System (ODS) waiver and to begin preparations for the evaluation of this waiver.

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 MH and primary care services. However, coordination of MH services with primary care often occurs in the same locations and typically involves the same behavioral health staff as coordination with SUD services, so challenges and lessons learned from one of those coordination 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 MH 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, referrals from the health care system, SUD services delivered in primary care settings, current patterns of patient movement through the specialty SUD treatment continuum of care, ways of measuring maximum utilization, and patterns of gender and ethnic treatment disparities.

- Chapter 2 reviews efforts to integrate SUD and MH services with the health care system across the state, and provides information and recommendations aimed at helping stakeholders prepare for the DMC-ODS waiver.

- Chapter 3 discusses the technical assistance activities provided by UCLA at the state and county levels, with an emphasis on strategic planning purposes. Technical assistance efforts on topics such as Drug Medi-Cal Waiver, 1115 Waiver Renewal, ASAM Criteria, Workforce Development, SNAP Report, and Behavioral Health Integration Strategies are discussed.

- Chapter 4 discusses the county/provider-level training activities UCLA has engaged in to help address county and provider service delivery 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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As expected, the Medi-Cal expansion associated with the Affordable Care Act (ACA) on its own does not appear to have resulted in substantial increases in admissions to substance use disorder treatment in California yet. A number of challenges remain, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver may address many of them. Key improvements can be made to pave the way for successful implementation, including a more streamlined provider certification process and providers making an effort to integrate with primary care, possibly by following in the footsteps of the small number of providers that historically have been successful in receiving referrals from the health care system (e.g., Baker Place, Tarzana Treatment Centers, Empire Recovery Center).

In health centers, data suggest there remains room for improvement in identifying patients with substance use disorders and delivering services to these patients. One reasonable way to expand treatment in these settings would be to expand the behavioral health workforce in federally qualified health centers (FQHCs) by allowing marriage and family therapists to deliver and bill for services.

As the Drug Medi-Cal Organized Delivery System waiver approaches implementation, UCLA and DHCS should continue to refine measures of utilization as a proxy for capacity. These measures will depend upon the quality of CalOMS-Tx data, however. To that end, DHCS should address and clarify whether reporting CalOMS-Tx records for patients that DHCS does not pay for directly violates 42 CFR Part 2 privacy rights. This, in addition to continued training and education on current data reporting guidelines, will be necessary improve the quality of data in CalOMS-Tx.

It will be important to investigate why Black/African American adolescent males and Black/African American young adult females are less likely to be referred to treatment by the criminal justice system relative to other racial/ethnic groups in order determine whether there may be missed opportunities to provide treatment to these groups through criminal justice diversion programs. Further qualitative analysis, e.g., interviews of criminal justice and treatment stakeholders as well as members of these groups, could help to determine the causes of these disparities and may suggest steps to address them.

It also will be important to examine and address the recent surge in treatment for heroin use. This may be related to the diminishing accessibility of prescription pain medications. If so, it may be best to focus efforts not on the specialty care system, but on health care settings, where prescribing practices can be addressed, monitoring for misuse can be implemented, and treatment can ideally be provided on site, potentially with medications such as buprenorphine, without invoking the stigma of specialty care, which may serve as a barrier to patient participation.

INTRODUCTION

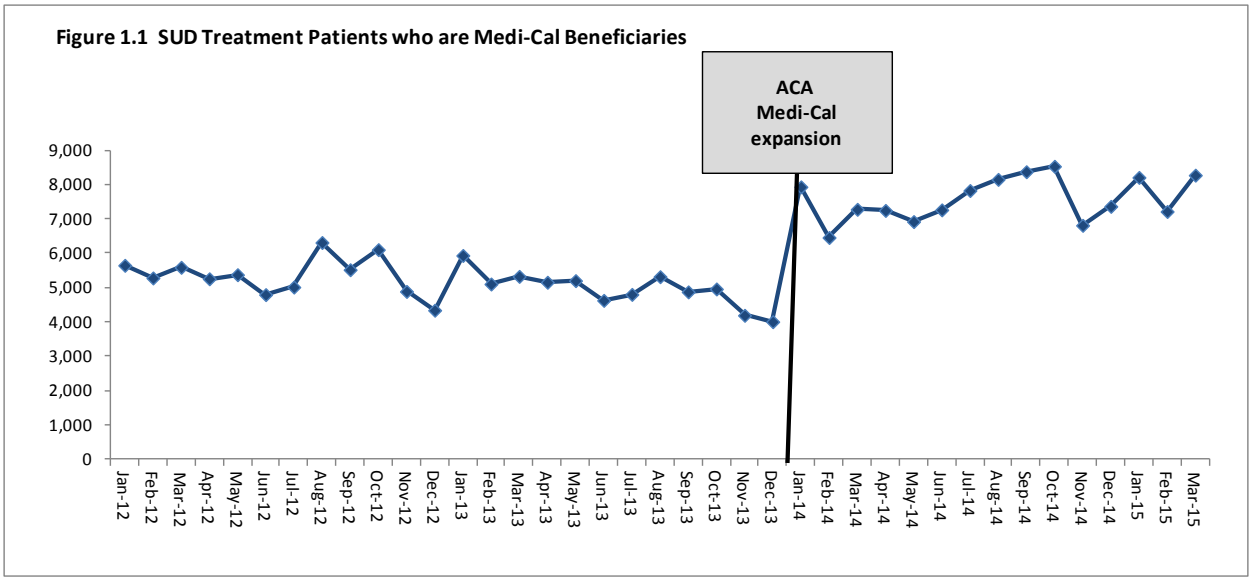
After the long awaited Medi-Cal expansion associated with the Affordable Care Act (ACA) arrived on January 1, 2014, along with expansions in the number of individuals covered by private health care insurance plans purchased through Covered California, it was anticipated that more individuals may access substance use disorder (SUD) treatment. In our previous report, analyses of counties that received expanded coverage early did not experience substantial increases in SUD treatment. In this year's report, additional data from before the key 2014 date are analyzed, enabling stronger conclusions.
Findings are organized as follows:

A. Admission Trends
    i. Medi-Cal Beneficiaries
    ii. Admissions by Month
    iii. Referrals
B. SUD Services in Federally Qualified Health Centers
    i. Alcohol
    ii. Other Substances
    iii. Screening, Brief Intervention, and Referral to Treatment
C. Organized Delivery System Baseline
    i. Service Delivery Following Non-NTP Detoxification
    ii. Service Delivery Following Residential Treatment
D. Capacity and maximum utilization
    i. Background
    ii. Alternative Measure: Maximum Utilization
    iii. Limitations
    iv. Maps
E. Disparities
    i. Adolescents
    ii. Young Adults
F. Chapter Summary and Lessons Learned

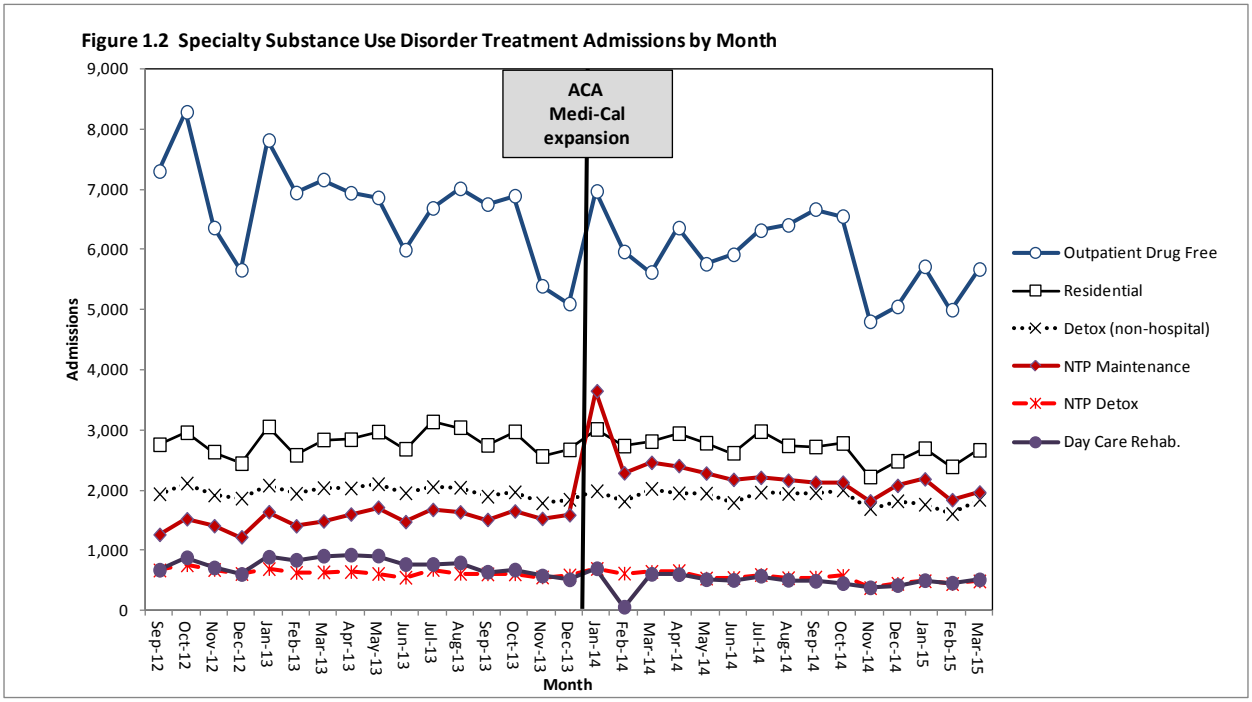
A. Admission Trends

Medi-Cal Beneficiaries

There was a large and sustained increase in SUD patients who were Medi-Cal beneficiaries after the Medi-Cal expansion was implemented on January 1, 2014 (see Figure 1.1). These were not necessarily all new patients, however, since patients may already have been in treatment without a CalOMS-Tx record (further discussion of this below) or would have still entered treatment using other funding sources (e.g., self-pay, Substance Abuse Prevention and Treatment [SAPT] block grant) in the absence of the Medi-Cal expansion.



Admissions by month



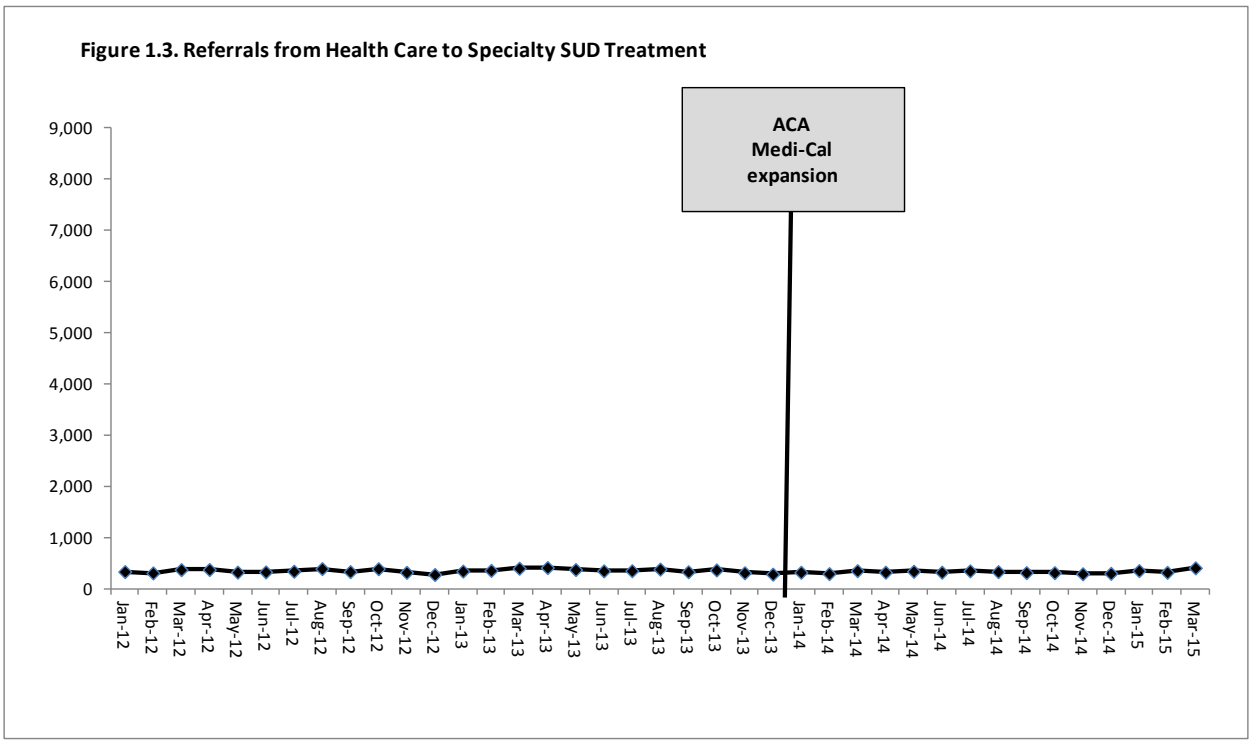
No sustained increases in admissions occurred in the wake of the expansion in any modality except methadone maintenance (Figure 1.2). Even within this modality, however, anecdotal evidence suggests that while the increase may be partially real, it may also be partially a data issue, with methadone clinics submitting CalOMS-Tx records now for previously unreported patients who were self-pay prior to January 1, 2014. Further study of how often this occurs may

be needed. Under CalOMS-Tx guidelines, clinics should have been submitting records even for self-pay patients, but discussions with stakeholders suggest that often this does not happen.

Potential increases in admissions were likely held back by the fact that many providers were unable to become Drug Medi-Cal certified quickly. Although DHCS's Provider Enrollment Division has been working with stakeholders to improve the certification process and improve communication, feedback from stakeholders at a CBHDA meeting as recently as June 2015 made it clear that significant frustrations remain. Examples of suggestions from stakeholders included requests to expedite certifications for sites that are already Short Doyle certified (already providing mental health [MH] services under Medi-Cal), and for new sites that belong to organizations that already have current Drug Medi-Cal certification. In both of these cases, DHCS has already approved the organization, so although some review of the new site may be necessary, it would be logical to assume that at least some of the review focused on the organization could be streamlined.

In general, the start up of new programs is very challenging. Providers need to find a location, hire staff, etc., creating substantial costs on the front end. If they serve primarily a Drug Medi-Cal population, then long delays in obtaining Drug Medi-Cal certification can present serious financial risks, undercutting the viability of such expansion efforts and providers' willingness to attempt them.

Referrals



There was no discernible change in the number of SUD treatment admissions that were referrals from health care associated with the January 1, 2014, expansion date (Figure 1.3). The number of

referrals from health care remains low. The percentage of treatment programs that received at least one patient from a health care referral did rise very slightly in the first quarter of 2015 (25.4%), compared to the same period in 2014 (23.2%).[1] Overall, however, there was not much change.

Most of the referrals that did come from health care that occurred in the first quarter of 2015 (the most recent quarter for which the data is relatively complete) were for non-hospital detoxification (37.8%), followed by outpatient treatment (26.7%), and residential treatment (26.3%). This pattern was essentially unchanged from health care referrals in the first quarter of 2014 (40.1%, 26.6%, 23.3%, 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 (45.1%) of all non-hospital detoxification referrals from health care statewide. This mirrors a finding from the 2012 data. For these results and further background on Baker Places, see Urada (2013).

Outpatient and residential admissions also were somewhat concentrated, but not to the same extent as detoxification. The outpatient program that received the most health care referrals accounted for 5.1% of outpatient referrals, and three residential programs account for the most referrals in this modality, accounting for approximately 8.2-8.6% of referrals each.

The DMC-ODS waiver contains language that requires coordination between county departments overseeing SUD treatment and managed health plans, including memoranda of understanding (MOUs) that cover bidirectional referrals. Therefore, although expanded Medi-Cal coverage by itself has not resulted in more referrals to SUD treatment from the rest of the health care system, the waiver has the potential to do so, depending on how well this coordination is implemented.

B. SUD Services in Federally Qualified Health Centers (FQHCs)

SUD and MH treatment, historically provided in separate "silos" of care, must become more closely integrated with each other as true behavioral health services, and ultimately merge with primary care (Grantham, 2010; McLellan, 2010). In particular, there is an "unprecedented" emphasis on federally qualified health centers (FQHCs) in this transformation (Office of National Drug Control Policy, 2010).

To track SUD services in FQHCs in the lead up to the ACA's Medicaid expansion in 2014, we analyzed data from the federal Uniform Data System (UDS) database. Unfortunately calendar 2014 data will not be available until fall of 2015, so we were unable to analyze the impact of the 2014 expansion in this year's report. In addition, patient and visit data in UDS prior to 2012 are

[1] This was an early analysis with preliminary data, but the increase might change slightly once 1Q2015 data is finalized. For example, in last year's report, the percentage of health care referrals in 1Q 2014 was 22.5%, but this increased to 23.2% using this year's more complete 2014 data. If the same trend holds this year, then the improvement from 2014 to 2015 may grow by a small amount.

not comparable to more recent data.[2] Together, these data limitations required us to restrict our analyses to calendar years 2012 and 2013.

All FQHCs are required to report to UDS the number of patients and visits for patients with different diagnoses, including alcohol related disorders and other substance abuse related disorders (excluding tobacco use disorders). They also report on the number of brief interventions provided as part of screening, brief intervention, and referral to treatment (SBIRT) efforts.

Within California during 2012 and 2013, there were 129 FQHCs. Of these, 73% (94) are located in urban settings. FQHCs provided services for 3,261,720 patients in 2012 and 3,412,961 patients in 2013.

Alcohol

Among patients diagnosed with alcohol related disorders, there was a median increase of 49 visits in rural FQHCs and 86.5 visits in urban FQHCs. The trend in visits was similar in regard to number of patients. Only about 0.9% of patients seen at FQHCs in 2012 and 1.0% in 2013 had an alcohol related disorder diagnosis. This is far fewer than the 2.9% of Californians age 12 and over who are conservatively estimated to have alcohol dependence or the 7.3% with abuse or dependence, according to the National Survey on Drug Use and Health,[3] suggesting there is still progress to be made in identifying and addressing the needs of patients with alcohol dependence.

Table 1.1. Alcohol related disorders diagnosed in California FQHCs by year.

Alcohol Related Disorders	**Median Visits per FQHC**		**Median Patients per FQHC**	
	Rural	Urban	Rural	Urban
2012	126	296.5	73	136.5
2013	175	383	96	163.5
Median Difference	+49	+86.5	+23	+27

Other Substance Abuse Related Disorders

Among patients diagnosed with other substance abuse disorders (excluding tobacco related disorders), there was again a greater median increase in urban areas compared to rural areas, both in visits and in number of patients. About 1.2% of those seen at FQHCs in 2012 and 1.3% in 2013 had other substance abuse disorder diagnoses in 2012. This is fewer than the approximately 1.8% of Californians age 12 and over who are conservatively estimated to have illicit drug

[2] Prior to 2012, FQHCs reported only patients and visits by primary diagnosis, which lowered the reported frequency of SUD. For example, prior to 2012, if a patient visited for an upper respiratory infection but also received a secondary diagnosis of SUD, the patient was not counted as a patient with SUD. Starting in 2012, UDS rules were changed to require that patients be counted for each diagnosis regardless of whether it was the primary diagnosis or not, so the patient in the prior example would be counted in the number of SUD patients.

[3] http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeCalifornia2013.pdf

dependence, or the 2.9% with abuse or dependence, suggesting there is still progress to be made in identifying and addressing the needs of patients with drug dependence.

Table 1.2. Other non-tobacco substance abuse related disorders diagnosed in California FQHCs by year.

Other Substance Abuse Related Disorders	**Median Visits per FQHC**		**Median Patients per FQHC**	
	Rural	Urban	Rural	Urban
2012	127	263.5	82	133
2013	209	376	96	197.5
Median Difference	+82	+112.5	+14	+64.5

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

There was a small increase in SBIRT services between 2012 and 2013. In 2012, 14.3% (467,685) of those seen at FQHCs received at least one SBIRT service. This increased slightly to 14.5% (493,380) in 2013. There were four FQHCs that did not report SBIRT for any patients in 2012, and only one FQHC that did not report such services in 2013. DHCS implemented a new SBIRT benefit that started January 1, 2014, and sponsored a large number of trainings around the state. The data in this section do not reflect these efforts, but provide a baseline measure for comparison, once 2014 data becomes available later this year.

Table 1.3. SBIRT brief interventions delivered in California FQHCs by year.

SBIRT (brief interventions)	**Median Visits per FQHC**		**Median Patients per FQHC**	
	Rural	Urban	Rural	Urban
2012	1,494	2,472	1,035	1,762
2013	1,677	3,198	1,138	2,536.5
Median Difference	+183	+726	+103	+774.5

As could be expected, there was a correlation between number of FQHC visits with SBIRT and the number of visits by patients with alcohol related disorders. There was a correlation of .30 in 2012 and .32 in 2013 ($p < .001$ for both). For other SUDs, the trend is also statistically significant, but somewhat weaker ($r = .19$ in 2012, $p = .02$, and $r = .19$ in 2013, $p = .03$).

C. Organized Delivery System – Baseline

The goal of the Organized Delivery System (ODS) waiver is to create a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria. These criteria envision patients being moved up and down to different levels of care in the continuum (e.g., from detoxification to residential to outpatient) depending on the assessed needs of each individual patient. It is therefore important to document the current baseline state of the system

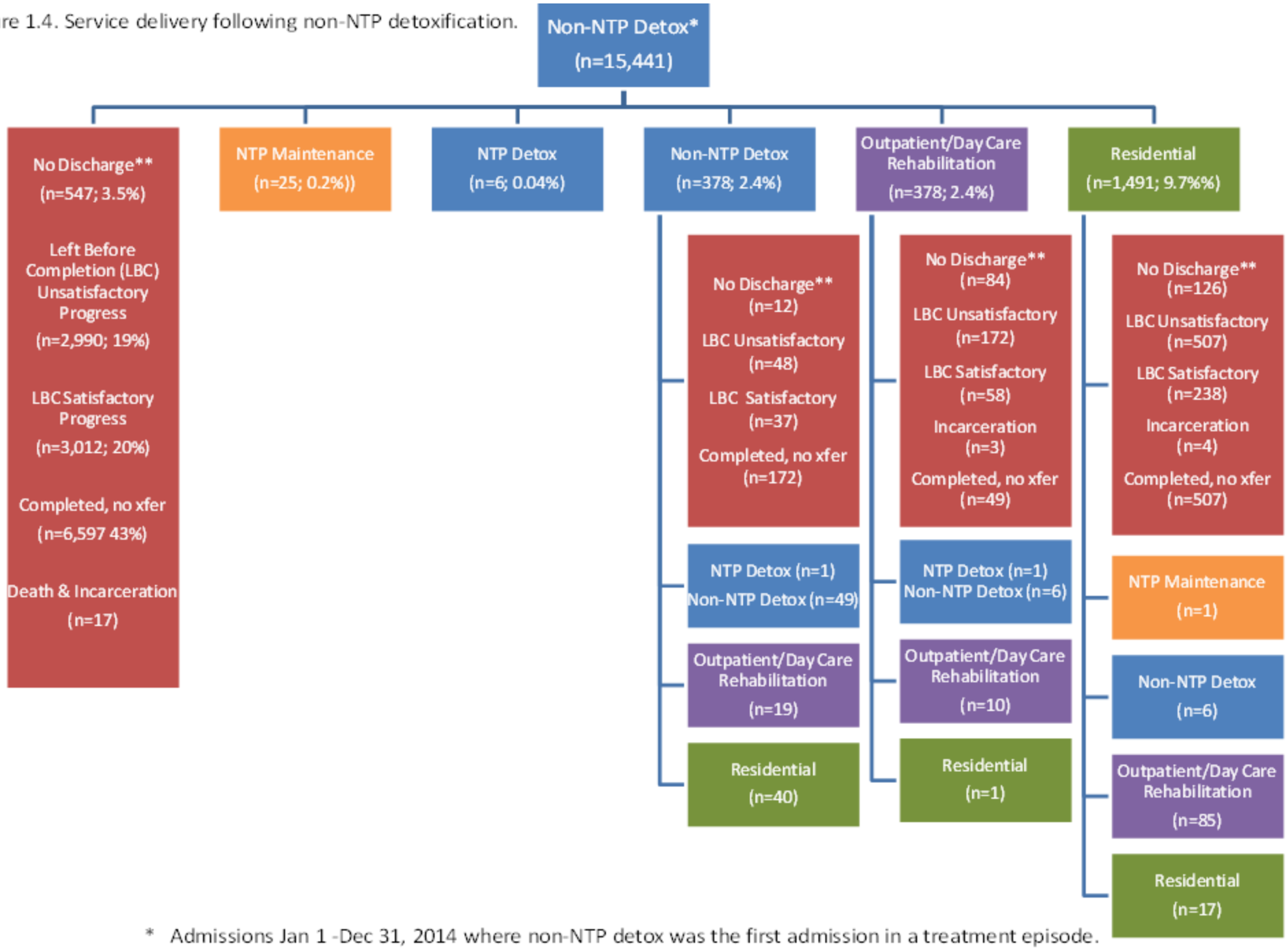
prior to waiver implementation. Based on the Washington Circle definition of the continuity of care performance measure,[4] the following charts show the proportion of patients that move from one modality to another within 14 days of discharge. In general, few patients enter a different level of care.

Fewer than 13%[5] of non-narcotic treatment program (non-NTP) detoxification and fewer than 6% of residential patients proceed from those services into another level of care. An additional 2% from each are re-admitted to detoxification or residential, respectively. By contrast, in Santa Clara County, which may be the closest county in the state to having an ASAM-based system like that envisioned by the DMC-ODS waiver (see Appendix 1), 60% of detoxification discharges result in a treatment admission within 14 days, demonstrating what a difference such an organized system can make. Santa Clara has reported recently that they are continuing to look for ways to improve their system and are working on a "2.0" version, so even better results might be forthcoming.

[4] "Continuity of care refers to the percent of individuals who receive AOD services within 14 days after being discharged from a detox, residential, or inpatient stay, or after an assessment that results in a diagnosis of AOD disorders." http://www.washingtoncircle.org/pdfs/9a1.pdf

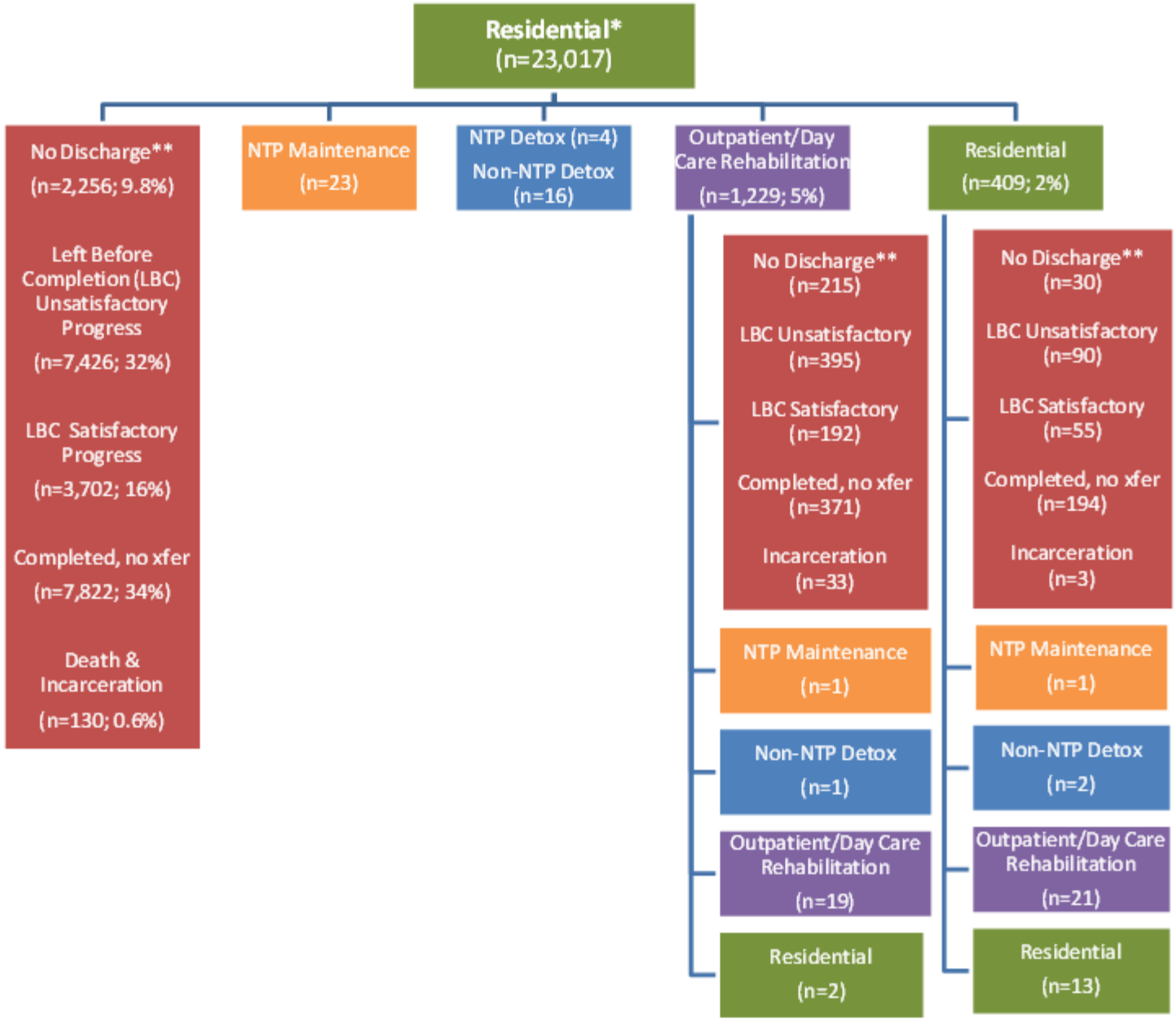
[5] For example, for Non-NTP detox, (25+6+378+1491)/15,441 = 12.3%

Figure 1.4. Service delivery following non-NTP detoxification.



* Admissions Jan 1 -Dec 31, 2014 where non-NTP detox was the first admission in a treatment episode.
** Patient was either still in treatment or a discharge record was not available as of June 3, 2015

Figure 1.5. Service delivery following residential treatment.



* Admissions Jan 1 -Dec 31, 2014 where residential was the first admission in a treatment episode.

** Patient was either still in treatment or a discharge record was not available as of June 3, 2015

D. Capacity and Maximum Utilization

Background: Why not DATAR?

DHCS has asked UCLA to explore ways to measure and map treatment capacity, which has been a challenge for the field for some time. Although California has a Drug and Alcohol Treatment Access Report (DATAR), the accuracy of data being received by this system is unclear at best, especially for outpatient modalities. The self-reported measure appears to be inherently difficult to answer for providers. For example, the DATAR manual defines total and public treatment capacity as follows:

"The total treatment capacity (or utilization) for an outpatient program (including Daycare Habilitative) should equal the number of unique clients that can be served in the month, based on public funding."[6]

Treatment providers have a wide variety of options to expand or reduce "capacity" easily. It is therefore difficult for providers to accurately answer what their total capacity is, especially in the context of outpatient treatment. In correspondence with UCLA, one provider explained it this way: "(We) simply need to add staff as the numbers go up. The issue with (outpatient) is really facility space and staffing; further, you can run multiple programs in the same space by staggering hours–morning track, afternoon track, evening track."

Alternative Measure: Maximum Utilization

An alternative method would be to measure maximum actual utilization by treatment programs using records submitted to CalOMS-Tx. This would measure how many patients a treatment provider has served at a given point in time (e.g. on a single day in the last year), counting previously admitted patients who have not been discharged into account in addition to any patients admitted that day. In theory, given the high demand for treatment and relatively low supply, this may serve as a proxy for capacity, with limitations (see below). UCLA tested such a measure using Los Angeles County as a first example. These methods can easily be expanded to other counties. These maps are meant to begin discussions with DHCS and stakeholders, not as final products.

Limitations:

First, in the absence of a better way to measure capacity, this is a measure of recent (2014) utilization, not absolute capacity. It is possible that some providers could take on more patients. During 2014, the Medi-Cal expansion had occurred for patients, but many providers were still trying to become Drug Medi-Cal certified. It is possible that their maximum utilization (and "capacity") may increase once they are certified.

Second, the accuracy of this measure is limited by the quality and quantity of data being reported to CalOMS-Tx. According to the CalOMS-Tx data collection guide,[7] all programs that receive public funding must report to CalOMS-Tx. The guide states:

[6] http://www.dhcs.ca.gov/provgovpart/Documents/DATARWeb_Manual_04-15-2014.pdf
[7] http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

"Data must be collected on all service recipients, by all providers that receive funding from DHCS, regardless of the source of funds used for the service recipient. For example, if a provider receives DHCS funding, but provides services to a person using only county funds, or provides services to a private-pay client, the provider must still collect and submit CalOMS Tx data for that individual."

Based on discussions with multiple providers, however, it appears this is not how data collection is always implemented. Specifically, many treatment programs have not been reporting CalOMS-Tx records for patients who are not paid for individually by DHCS through either Drug Medi-Cal or the SAPT block grant. This means there are an unknown number of patients whose records are missing from CalOMS-Tx if they pay for their own treatment, use private insurance, or have their treatment paid for by the criminal justice system or other funders. One treatment provider expressed strong concerns to UCLA on the part of his organization and others that reporting records to CalOMS-Tx for these patients would be a violation of these patients' 42 CFR Part 2 privacy rights. DHCS needs to address this lack of consistent data collection, and privacy rights concern if the guidelines are to be followed more widely.

Maps

The following Los Angeles County maps showing maximum utilization were generated using CalOMS-Tx data for the 2014 calendar year using GISTe software version 1.2.3. Maximum utilization is defined as the maximum number of patients seen on a single day at a single provider in a single modality throughout the calendar year by all providers reporting to CalOMS0Tx. The number of patients in treatment is determined by their admission and discharge dates, and patients must have been admitted in 2014 and have had a discharge by June 2015.[8] For outpatient services, it is not necessarily the case that all of the program's patients were physically present on the same day, but rather that this was the number of patients that were part of that program's caseload during that time.

The first set of maps (Figures 1.6-1.9) are zip code maps color-coded by maximum utilization. The darker the red coloration is in each zip code, the larger the maximum utilization was in that zip code. The pink through red colors are determined by the range of utilization (which is approximately divided into quartiles), whereas grey areas indicate zero treatment in the relevant modality reported to CalOMS-Tx in 2014. The dots represent the locations of treatment providers, based on data from DHCS's SMART6i dataset.

The advantage of the zip code map is that policy makers can look up a specific zip code of interest and quickly tell how much treatment has been utilized in that area. One disadvantage, however, is that zip codes differ widely in size. Although in Los Angeles County they are typically a good proxy for short distances, even in this county the large zip code 93536 at the northern end of the county has an outpatient provider on the eastern end of the zip code, but a resident at the western tip could reside approximately 30 miles from this provider, even though it

[8] We conducted a sensitivity analysis to determine whether including data from calendar year 2013 would change these maximum utilization numbers, but it did not.

is in the same zip code. This problem is likely to occur with greater frequency in counties with less dense populations and larger zip code areas.

To avoid this problem, another option is to use a "kernel density map" (see Figure 1.10), which maps utilization more specifically by the locations of the programs. The disadvantage is that the colors on the map are more difficult to interpret, since they do not represent specific, discrete maximum utilization ranges but rather relative differences that also change according to the distance from the provider.

UCLA is providing these maps to DHCS for discussion, and plans to continue to develop these maps according to the needs of the department.

Figure 1.6. Outpatient / intensive outpatient treatment maximum utilization by zip code, 2014.

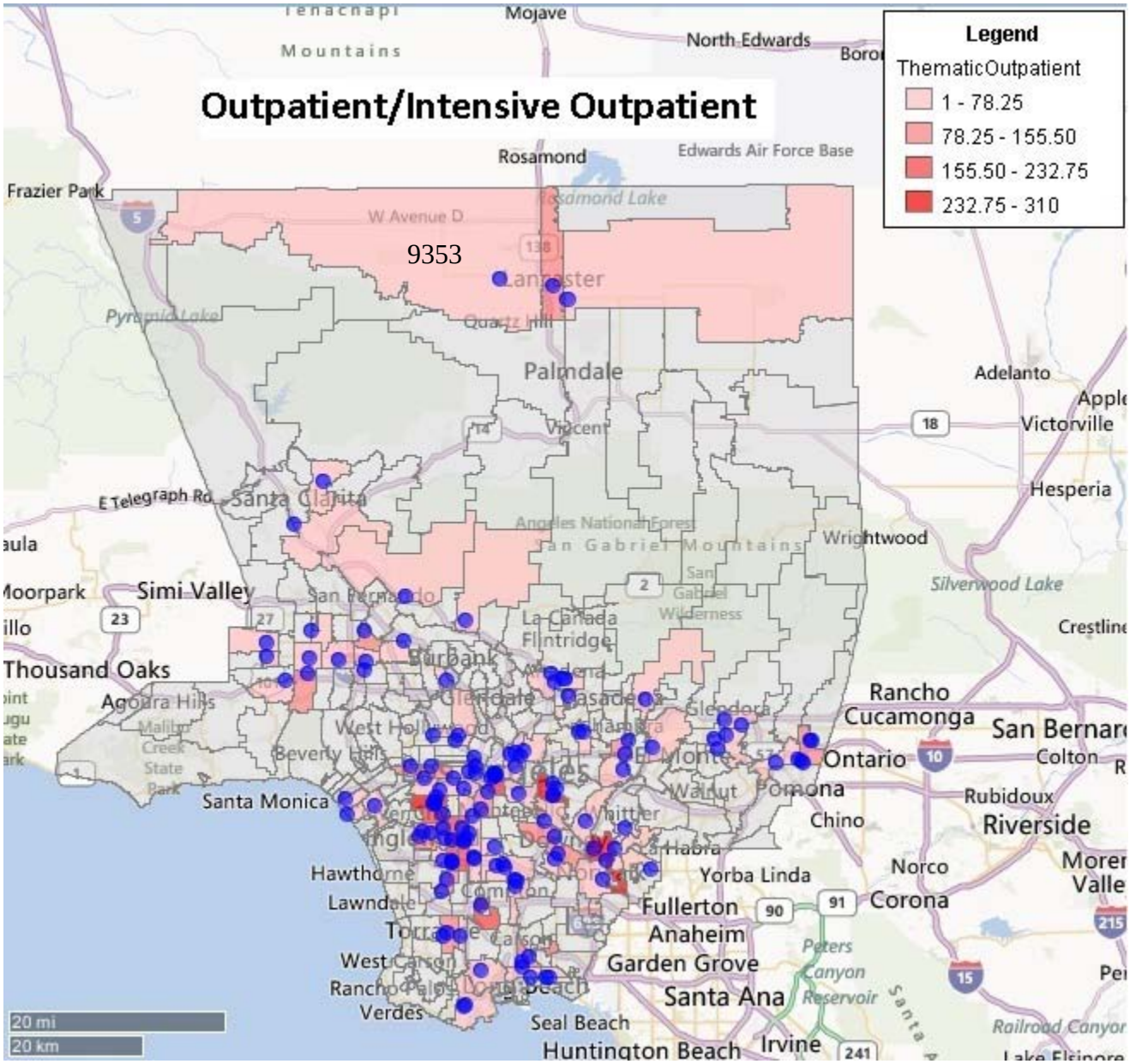


Figure 1.7. Residential treatment maximum utilization by zip code, 2014.

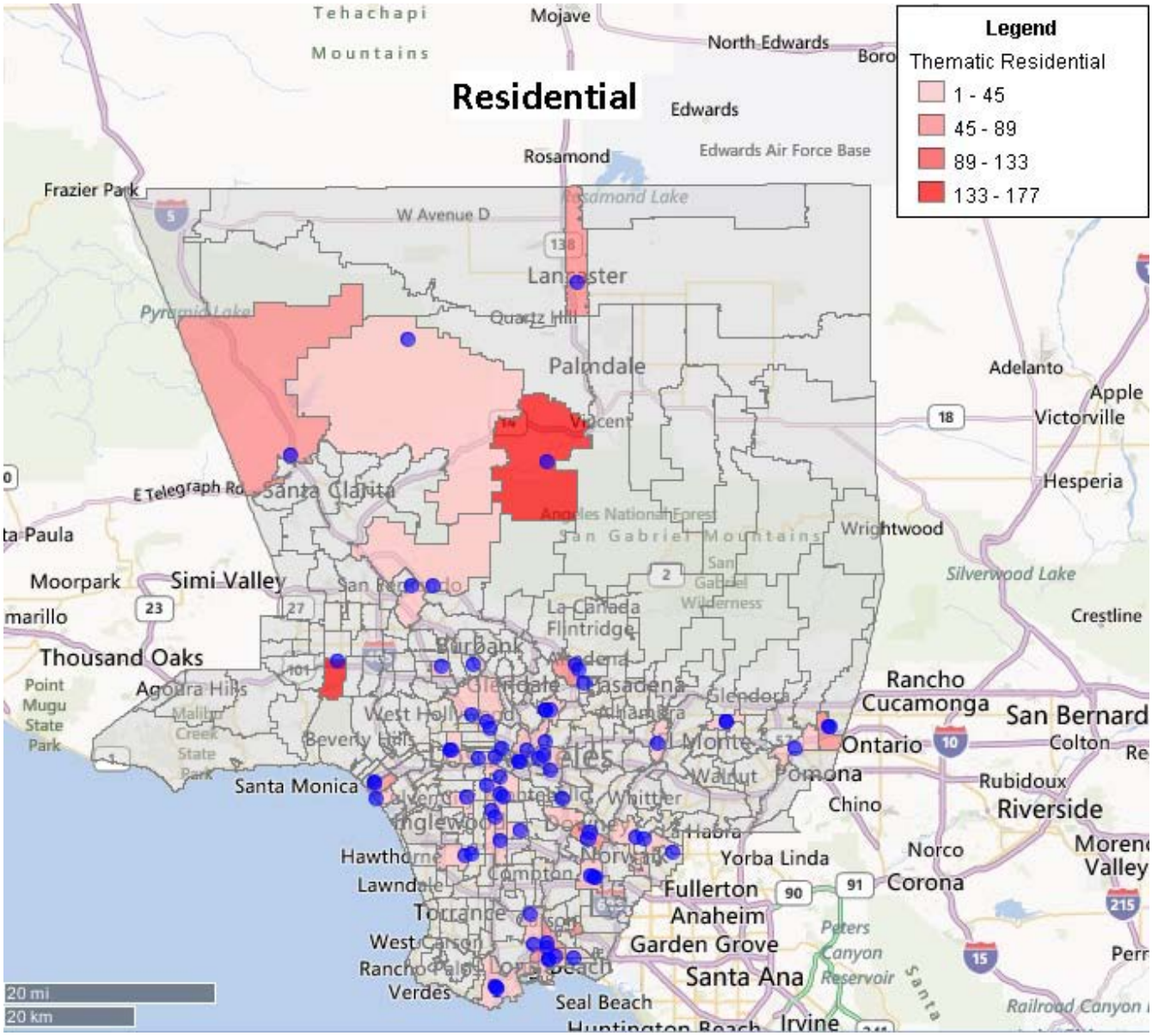


Figure 1.8. Non-NTP detoxification maximum utilization by zip code, 2014.

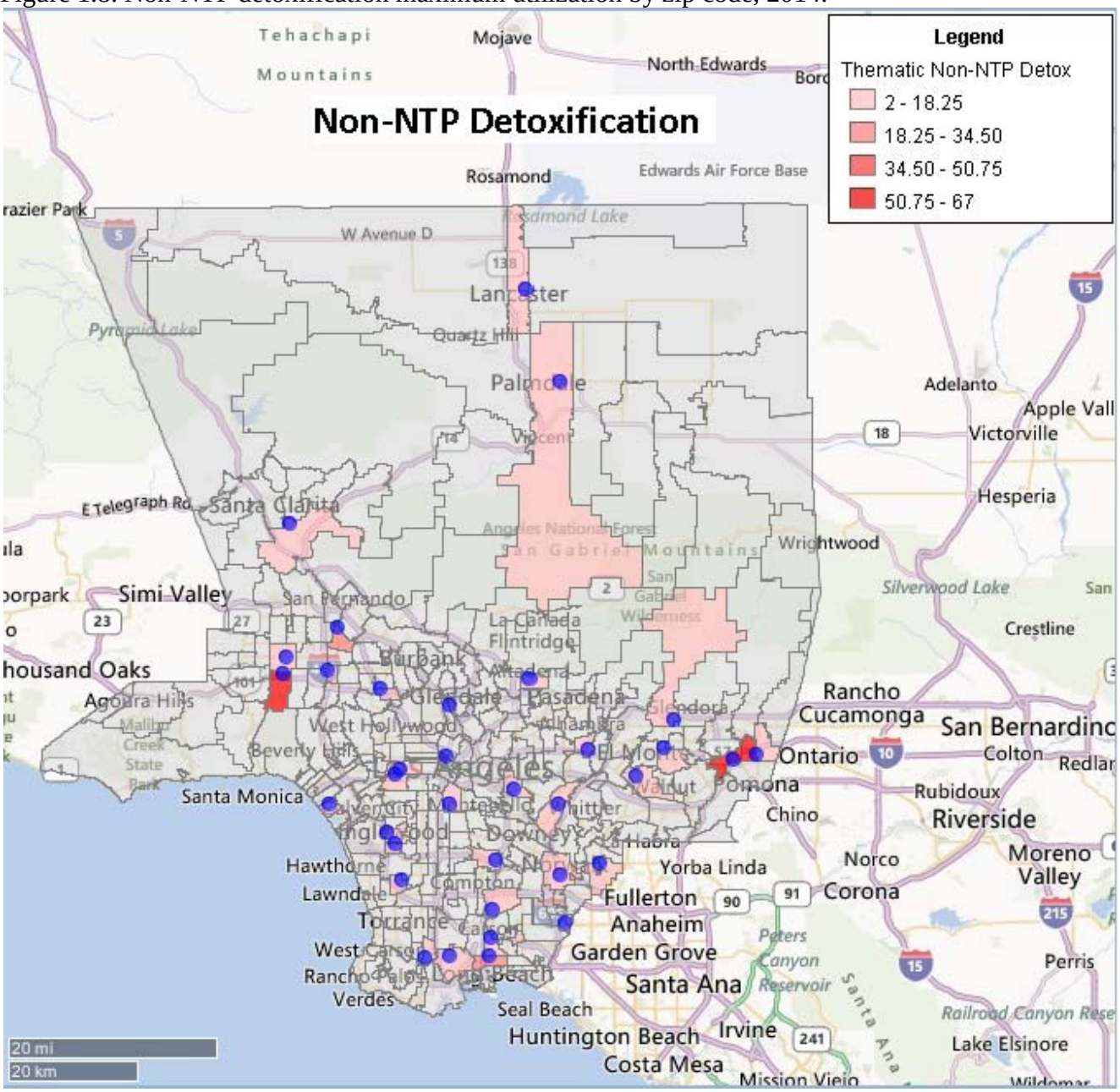


Figure 1.9. NTP maintenance maximum utilization by zip code, 2014.

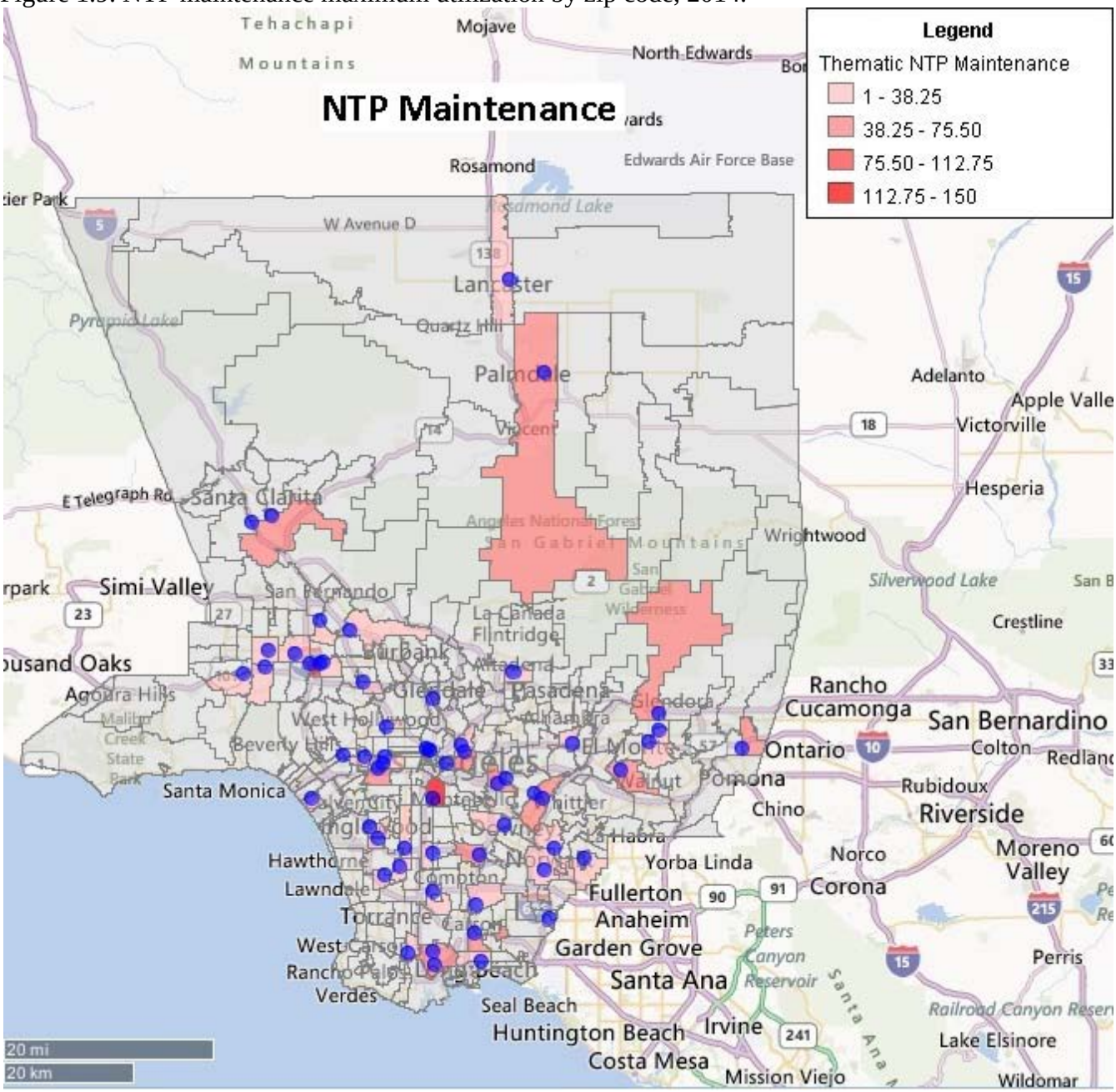
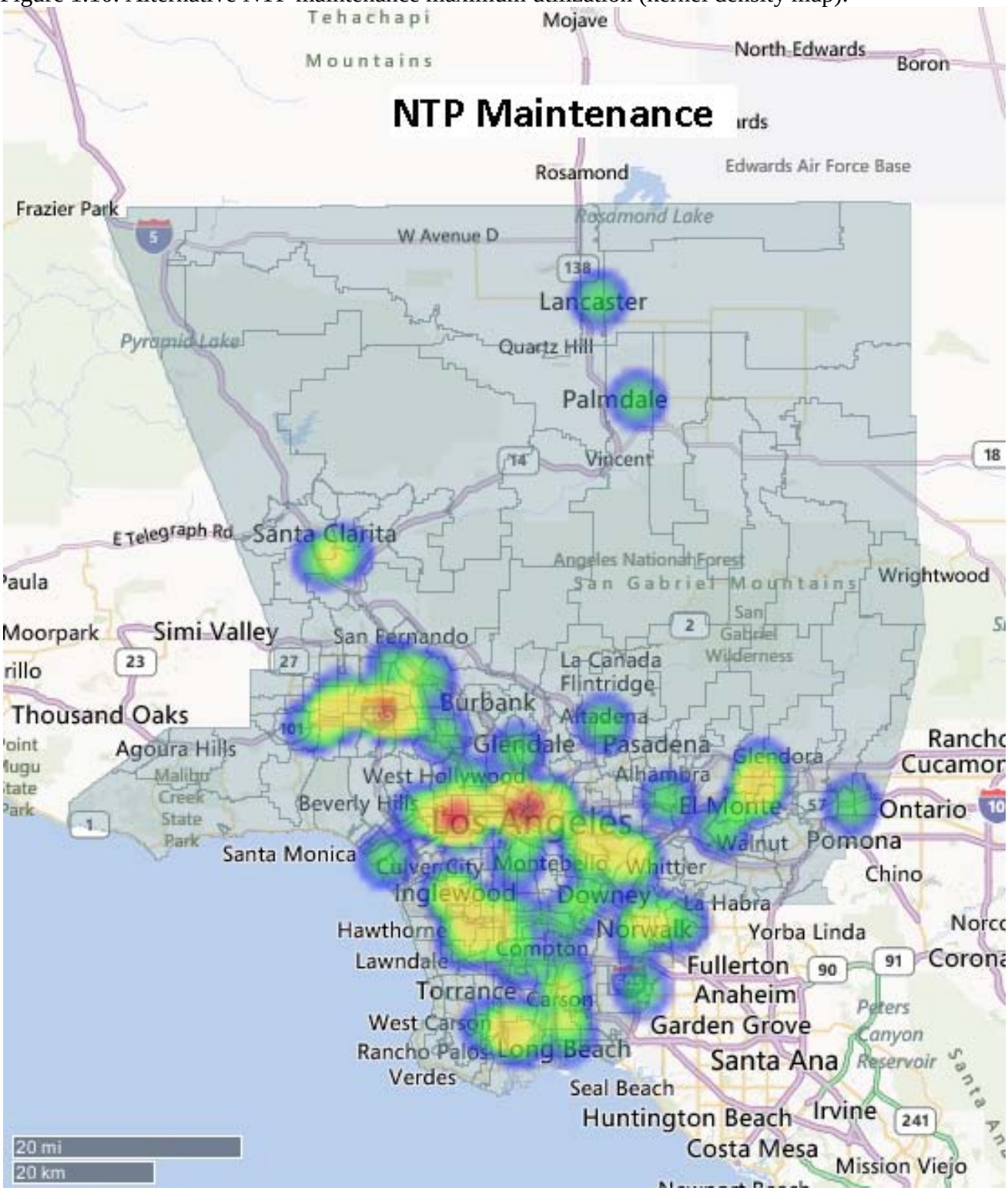


Figure 1.10. Alternative NTP maintenance maximum utilization (kernel density map).



E. Disparities

Although disparities are common across the treatment population, including among adults, this section will focus on adolescent and young adult populations.

The number of adolescents and young adults in treatment for SUDs decreased substantially between 2009 and 2014, but the percentage of males versus females in treatment remained consistent at about 67% to 33% for adolescents and 60% to 40% for young adults, respectively (see Table 1.4). Described below are trends for adolescents and young adults in treatment with regard to their primary drug of choice and the sources by which they get referred into treatment. The young adults are discussed by gender and then by race/ethnicity. When looking at the intersection of gender and race/ethnicity for adolescents, however, the longitudinal patterns were generally similar. Thus, the adolescents are mostly described by race/ethnicity.

Table 1.4. Number of Adolescents and Young Adults in SUD Treatment (2009-2014)

Year	Adolescents (ages 12-17) *			Young Adults (18-24)*		
	Total	Females	Males	Total	Females	Males
2009	26,938	33%	67%	31,163	40%	60%
2010	25,158	32%	68%	29,054	41%	59%
2011	26,503	33%	67%	27,279	42%	58%
2012	24,991	33%	67%	26,969	42%	58%
2013	20,431	33%	67%	26,452	41%	59%
2014	13,656	31%	69%	23,627	40%	60%

*Those who have valid responses to race/ethnicity questions

Adolescents (ages 12–17)

Primary Drug

From 2009–2014, the top primary drug of choice for adolescent males and females was marijuana. Although the number of adolescents in treatment overall has decreased steadily from 2009–2014, the percentage of teenagers in treatment with marijuana as their primary drug of choice is on the rise. As shown in Figure 1.11, a larger percentage of males than female adolescents in treatment indicated marijuana as their primary drug. Black/African American adolescents have a disproportionately higher rate of marijuana treatment than other racial/ethnic groups. For example, in 2014 about 78% of overall teens in treatment indicated marijuana as their primary drug, whereas over 85% of African American/Black teens reported the same (Figure 1.12).

Figure 1.11. Primary drug by gender: Adolescents(age 12-17) in treatment, 2009-2014

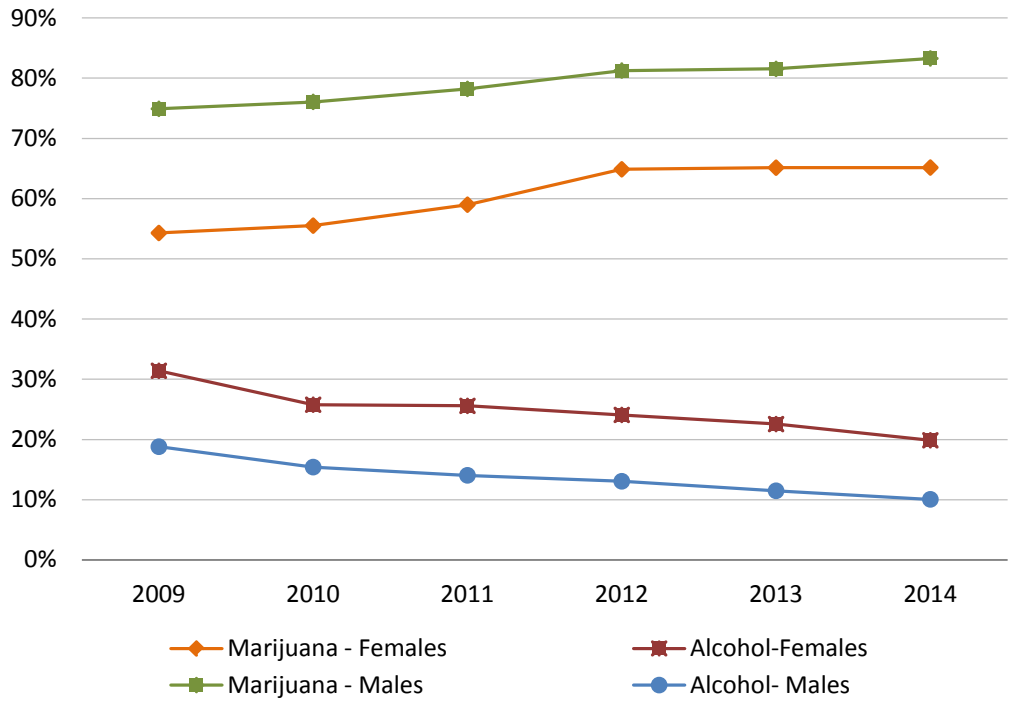
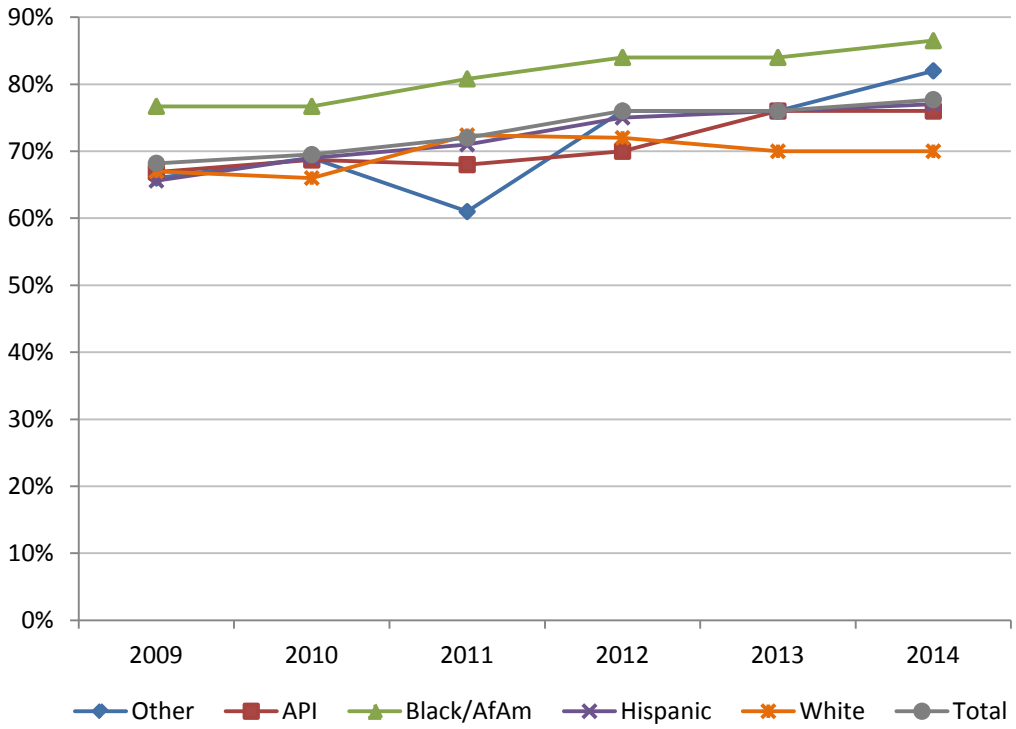


Figure 1.12. Marijuana Use by Race/Ethnicity Adolescents (age 12-17), 2009-2014



The second most common primary drug for adolescents is alcohol. The percentage of adolescents in treatment who indicate alcohol as their primary drug is decreasing. Of note, a larger percentage of females than males report it as their primary drug. Specifically, in 2009 about 19% of males and 31% of females indicated alcohol as their drug of choice, and this percentage decreased to about 10% and 20%, respectively, in 2014.

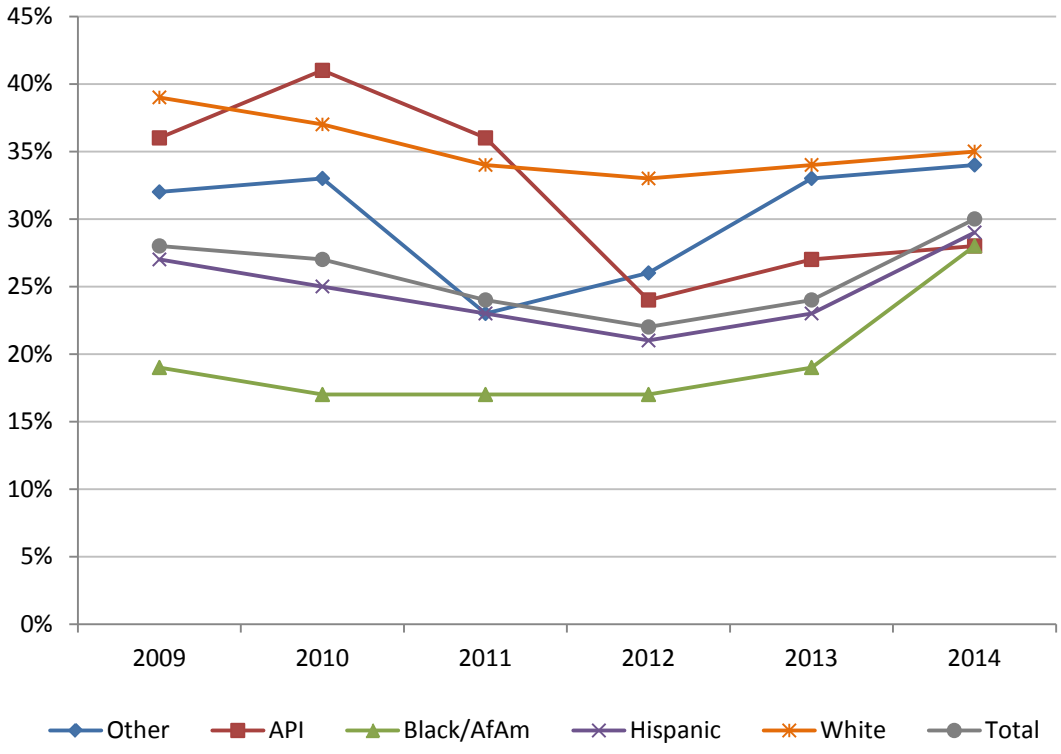
Disparities in Referral Sources

The two top referral sources into treatment for adolescents from 2009–2014 were the criminal justice system and schools. For females, schools were the top referral source, whereas for males the criminal justice system was generally the primary source.

The percentage of adolescents referred into treatment through the criminal justice system decreased, on average, from about 28% to 22% from 2009 to 2012, but has been on the rise and was back up to about 30% in 2014 (See Figure 1.13).

White, Asian American, and Alaska Native/American Indian teens were referred into treatment through the criminal justice system at higher rates than average, whereas Black/African American adolescents were referred into treatment at a lower rate than the average.

Figure 1.13.Criminal Justice System Referrals by Race/Ethnicity for Adolescents



Young adults (ages 18–24)

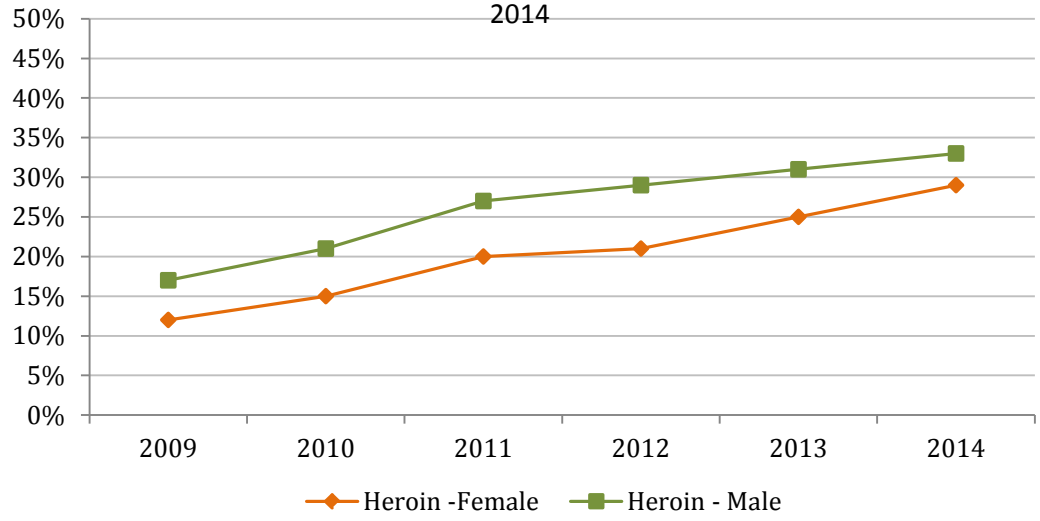
Primary Drug

The most common drug for young adult females in treatment from 2009–2015 was methamphetamine, at about 40% across the 5 years. The percentage of young adult males in treatment with methamphetamine as their primary drug is lower than for females, but has also remained steady at about 20%.

In 2009–2010, the predominant primary drug for young adult males in treatment was marijuana. Although marijuana was still the top primary drug in 2011, with 28% of young adult males reporting it, an additional 27% of young adult males reported heroin as their primary drug.

Since 2012, heroin has been the most common primary drug for young adult males, with more than 30% of them in treatment reporting it as such each year (see Figure 1.15). Over a quarter of young adult males continued reporting marijuana as their primary drug from 2012–2014, and it was the second top primary drug reported. However, starting in 2014, methamphetamine had rates similar to marijuana. The percentage of both males and females in treatment reporting heroin as a primary drug has more than doubled from 2009 to 2014 (see Figure 1.14).

Figure 1.14. Primary Drug: Heroin Among Young Adults (18-24) by Gender, 2009-2014



Among males and females, Hispanic/Latino and Asian American young adults in treatment reported methamphetamine as their primary drug at a higher rate than average. It is much lower among Black/African American males and females, although the rate has risen for both between 2012 and 2014. Conversely, a much larger percentage of Black/African American males and females indicated marijuana as their primary drug than other race/ethnicities; Hispanic/Latinos also indicate marijuana as their primary drug at somewhat higher rates than average. Although heroin as the drug of choice is on the rise across all races/ethnicities, it is highest among White young adults—both males and females. (See Figures 1.15–1.20)

Figure 1.15. Marijuana Primary Drug by Race/Ethnicity: Young Adult Males

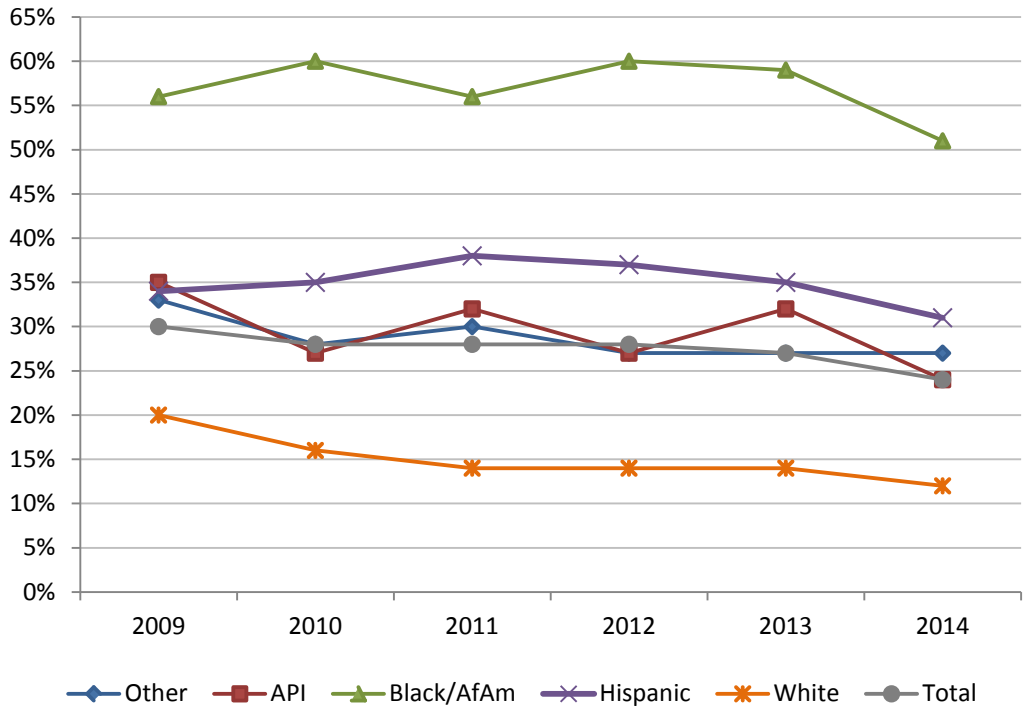


Figure 1.16. Marijuana Primary Drug by Race/Ethnicity: Young Adult Females

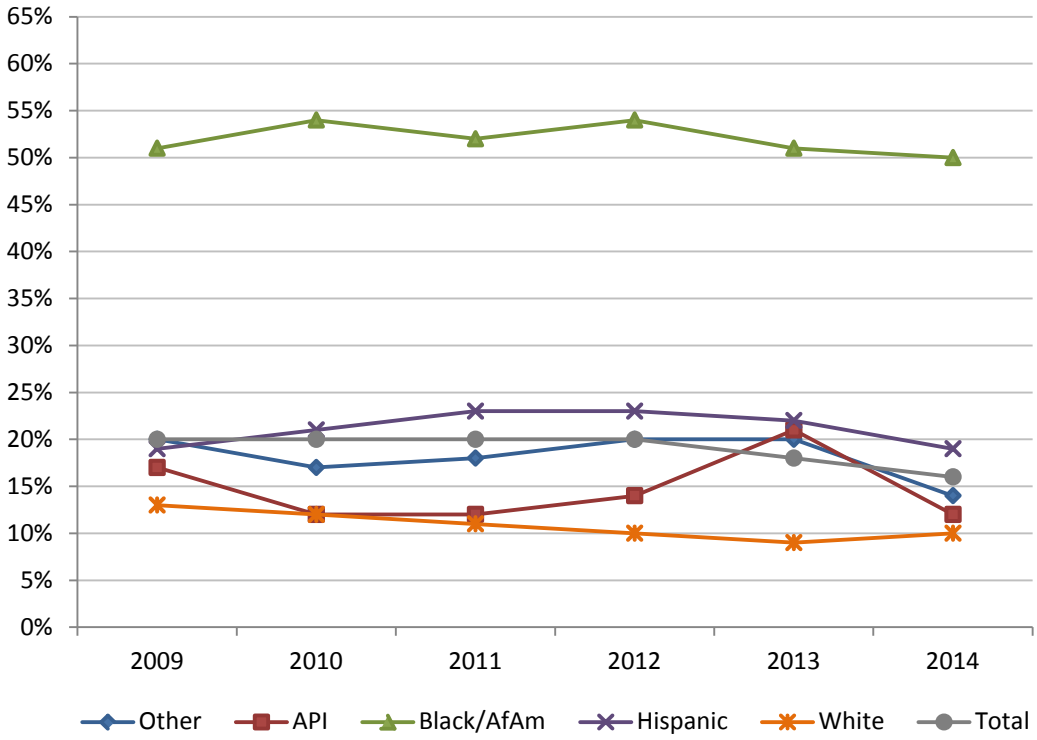


Figure 1.17. Methamphetamine Primary Drug by Race/Ethnicity: Young Adult Males

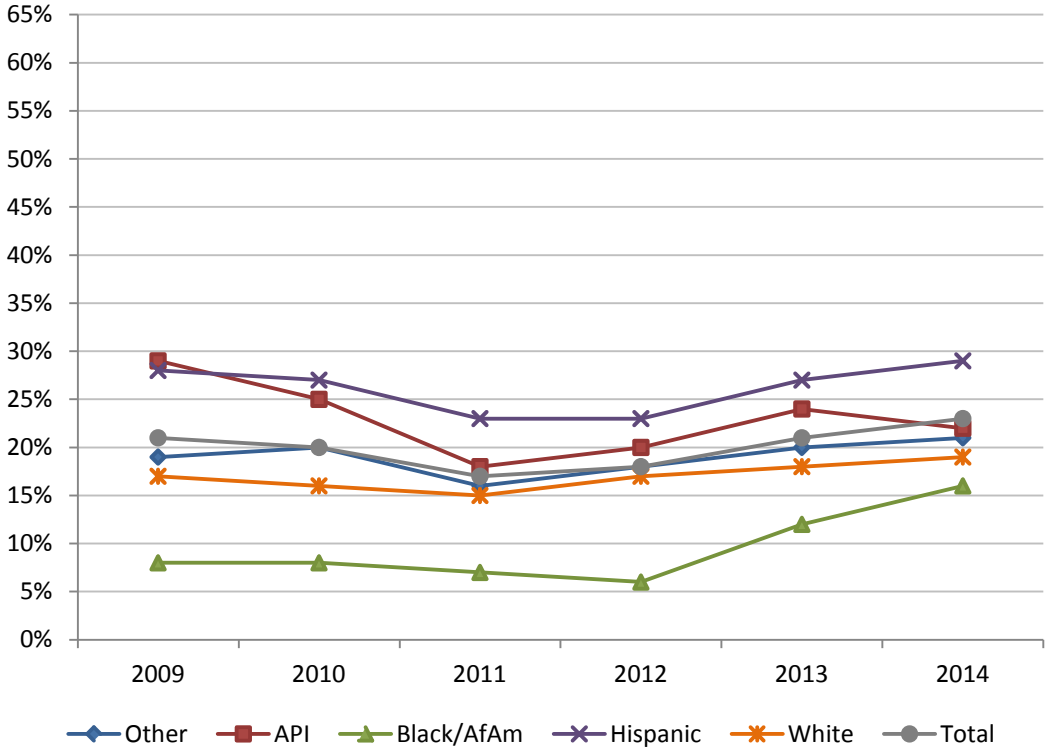


Figure 1.18. Methamphetamine Primary Drug by Race/Ethnicity: Young Adult Females

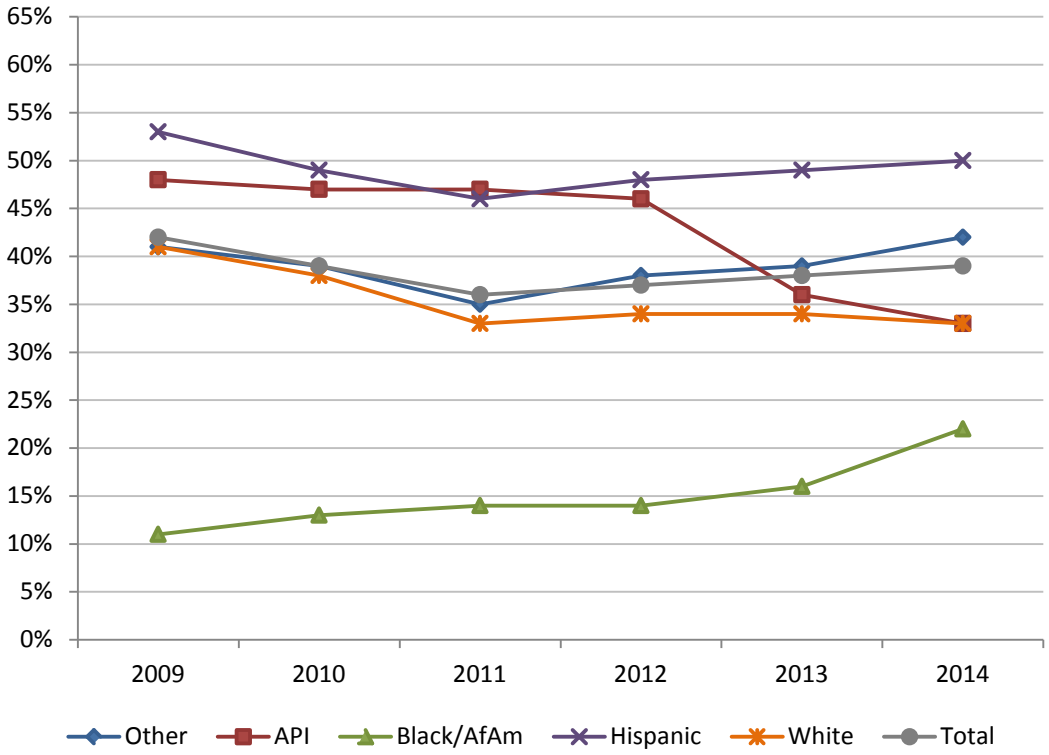
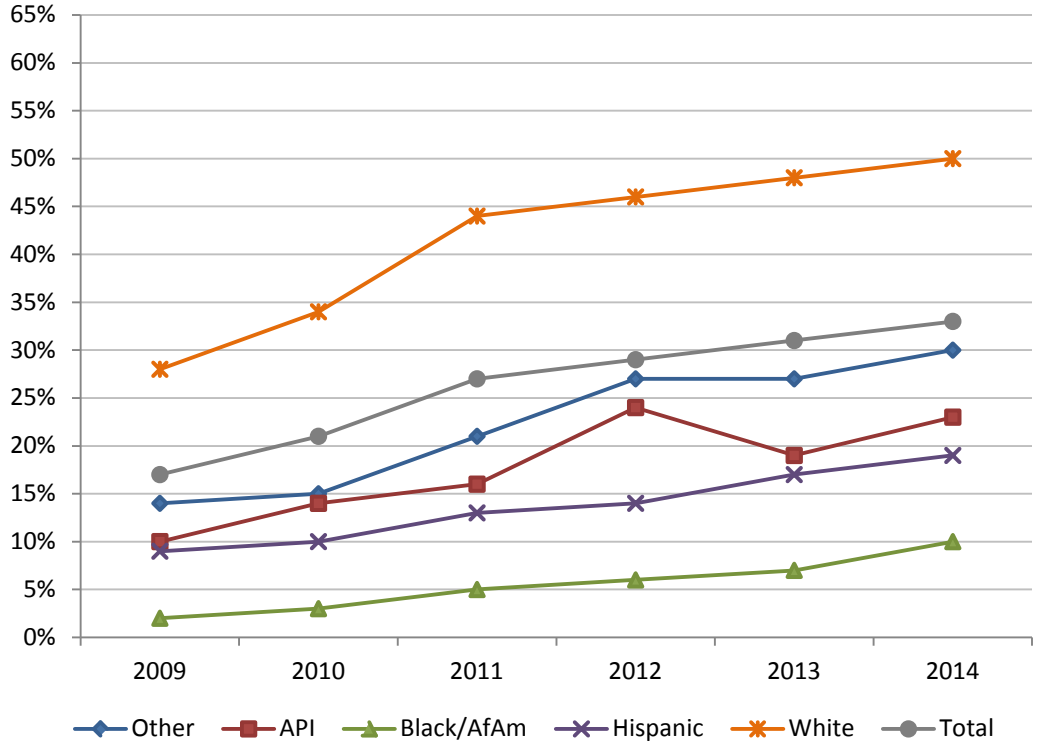
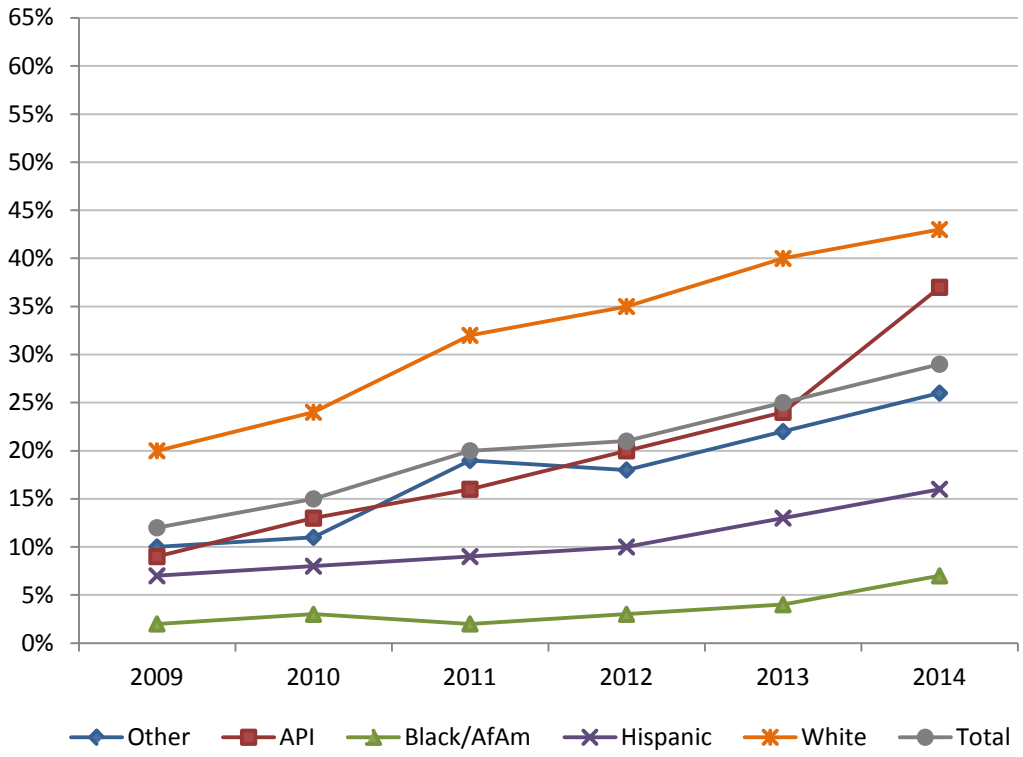


Figure 1.19. Heroin Primary Drug by Race/Ethnicity: Young Adult Males



Figue 1.20. Heroin Primary Drug by Race/Ethnicity: Young Adult Females



Disparities in Referral Sources

The top three sources of referrals into treatment for young adult males in 2009 to 2014 were: (1) criminal justice system, (2) individual/self, and (3) community. The top four referral sources into treatment for young adult females between 2009 and 2014 were: (1) individual/self, (2) criminal justice, (3) dependency system, and (4) community referrals. This report, however, focuses on racial/ethnic disparities in referrals to treatment through the criminal justice system and the dependency system (unique to female young adults). Among young adult males, overall, there was a decrease in the percentage of referrals into treatment from the criminal justice system between 2009 and 2012; however, these referrals began to increase thereafter for males across all races/ethnic groups. Asian American, Hispanic/Latino, and Black/African American young adult males were referred through the criminal justice system at higher rates than White males. The patterns differ for females: Asian American, White, and Alaska Native/American Indian/Other young adult females were referred by the criminal justice system at higher rates than the average, whereas Black/African American females were referred at much lower rates. Referral rates into treatment through the child dependency system have remained steady at about 15%. Hispanic/Latina young adults have been referred into treatment at higher rates than the average. This was the case for Asian American females from 2009 to 2012 as well, but their rate has since dropped.

Figure 1.21. Criminal Justice System Referrals by Race/Ethnicity: Young Adult Males

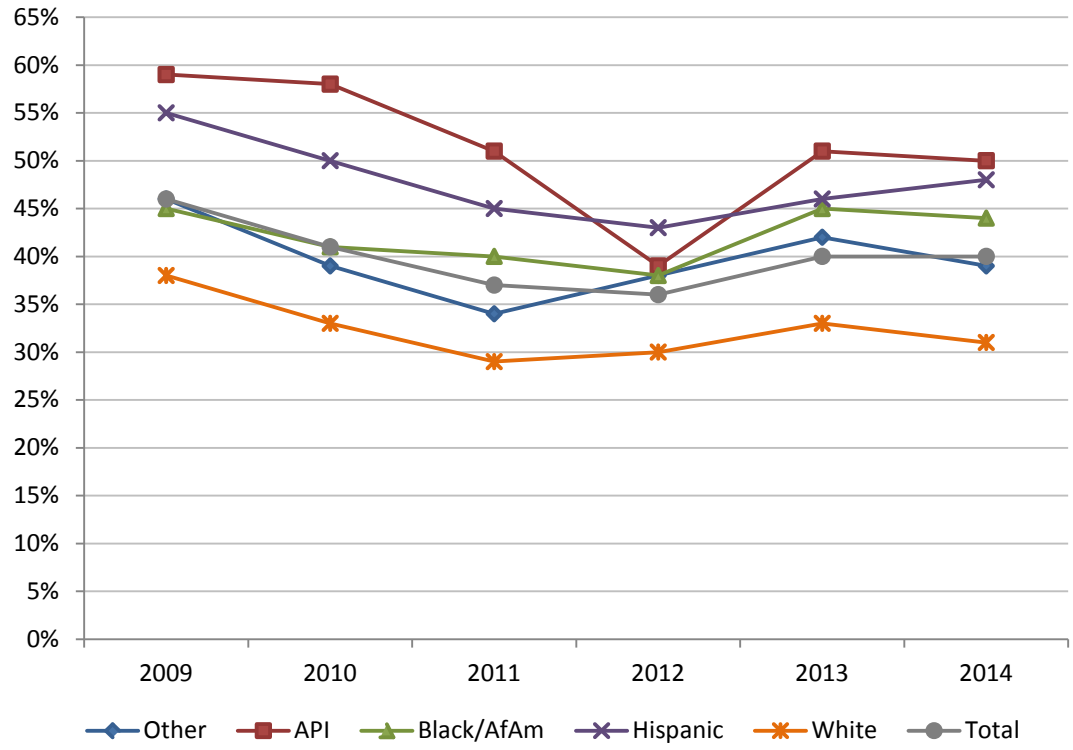


Figure 1.22. Criminal Justice System Referrals by Race/Ethnicity: Young Adult Females

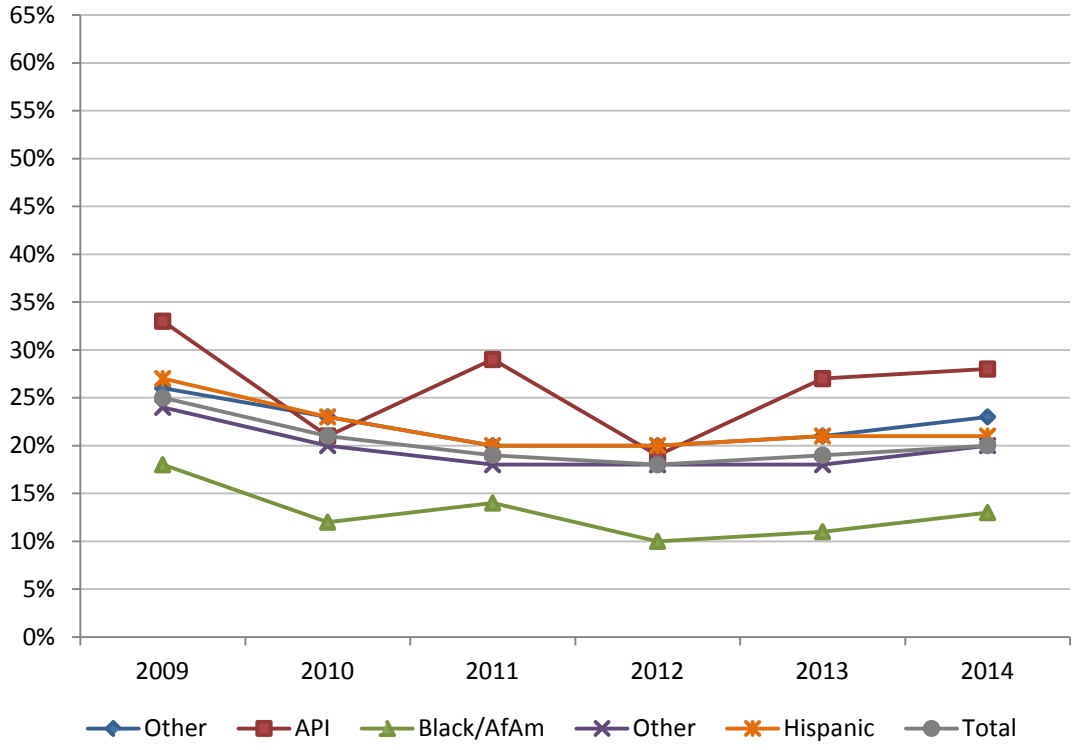
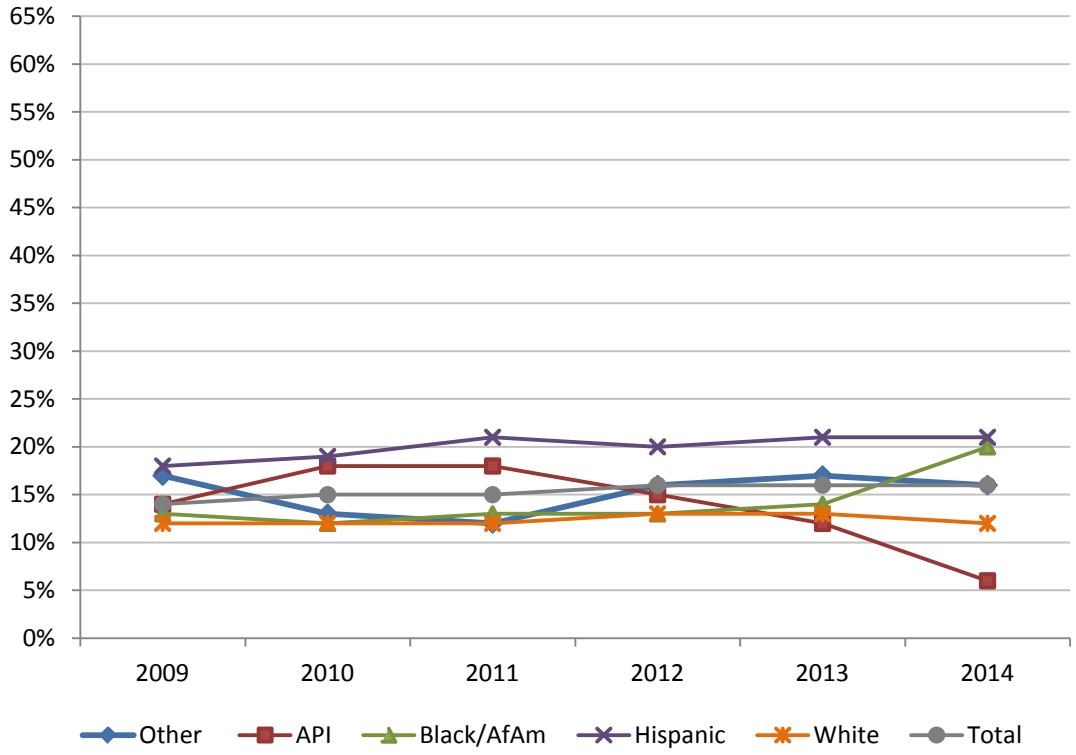


Figure 1.23. Dependency System Referrals by Race/Ethnicity: Young Adult Females



In summary, adolescents and young adults are less likely to get into specialty SUD treatment in general, compared to previous years. Analyses of data from the treatment that does occur suggest large differences in the ways in which different groups access care, and what drugs they are there for. Blacks/African American adolescents (12–17) are less likely to be referred to treatment by the criminal justice system. This trend does not continue into young adulthood for males, but a similar disparity does occur among female young adults. This raises questions about whether there may be missed opportunities to provide treatment early to adolescent Black/African American males and young adult Black/African American females through criminal justice diversion programs. Another issue is the surge in treatment for heroin use, particularly among Whites. This may be linked to their diminishing access to pain medications.

F. Chapter Summary and Lessons Learned

- **DHCS Provider Enrollment Division (PED) should explore all reasonable methods of facilitating provider certification.** Suggestions brought up by stakeholders that PED may wish to consider include the following:
    - Expedite certifications for organizations that are already certified under Short-Doyle Medi-Cal.
    - Expedite certification of new addresses for organizations that are already Drug Medi-Cal certified.
    - Once items in any detailed deficiency letter are satisfied, PED should refrain from raising new unrelated items.
    - Follow a standardized approach for site visits that (a) is consistent regardless of which local office of DHCS is conducting the site visit and (b) that does not include asking for materials that have already been submitted to PED.

- **Providers should try to adopt the practices of programs that have had success in securing referrals from the broader health care system, including Baker Place, Tarzana Treatment Centers, and Empire Recovery Center.** The Medi-Cal expansion also has not, on its own, resulted in more referrals from the broader health care system. Still, a handful of providers have demonstrated that it is possible to increase such referrals. In a previous report, we described the efforts of programs that are high in health care referrals (Urada, 2013, p. 13-15)[9], including the three listed above. The DMC-ODS waiver is intended to provide an additional push by requiring counties to establish MOUs with Medi-Cal managed health plans, but it will still be up to

[9] Urada, D. (2013). Data Analysis: Understanding the Changing Field of SUD Services. In: Evaluation, Treatment, and Technical Assistance for Substance Use Disorder Services Integration 2013 Report, p. 9-23. Prepared for the Department of Health Care Services, California Health and Human Services Agency. Los Angeles: UCLA Integrated Substance Abuse Programs.
http://www.uclaisap.org/assets/documents/California-ADP-DHCS-Evals/2012-2013_ETTA%20Report.pdf

stakeholders to successfully implement coordination at the ground level. Stakeholders can begin by looking at these successful models as a starting point.

- **Expand the behavioral health workforce in FQHCs by allowing marriage and family therapists (MFTs) to deliver and bill for services.** Integration with primary care also will be important. According to pre-2014 data from FQHCs, there was room for improvement in terms of screening for SUD and delivering brief interventions or treatment. Ensuring the availability of a behavioral health workforce that can bill Medi-Cal in FQHCs can be a challenge, particularly in rural settings. As discussed in our previous report, there is evidence that MFTs could successfully help fill this role in California (Urada, Antonini, Rawson, & Oeser, 2014).[10]
- **Develop measures of utilization**. As the DMC-ODS waiver begins implementation, it will be very important to have a measure of capacity, or, as an alternative, maximum utilization. Such tools are dependent on the quality of the underlying data, however.
- **Address whether reporting CalOMS-Tx records for patients that DHCS does not pay for directly violates 42 CFR Part 2 privacy rights.** DHCS clarification on this point, in addition to continued training and education on current data reporting guidelines, will be necessary to improve the quality of data in CalOMS-Tx, which in turn is critical to accurately measure performance and outcomes in the treatment system.
- **Examine why Black/African American adolescent males and Black/African American young adult females are less likely to be referred to treatment by the criminal justice system relative to other racial/ethnic groups.** It will be important to determine whether there may be missed opportunities to provide treatment to these groups through criminal justice diversion programs. Further qualitative analysis, e.g., interviews of criminal justice and treatment stakeholders as well as of members of these groups, could help to determine the causes of these disparities and may suggest steps to address them.
- **Examine and address the recent surge in treatment for heroin use.** It is likely that this is linked to diminished access to pain medications. If so, it may be best to focus efforts not on the specialty care system, but on health care settings, where prescribing practices can be addressed, monitoring for misuse can be implemented, and treatment can ideally be provided on site, potentially with medications such as buprenorphine, without invoking the stigma of specialty care, which may serve as a barrier to patient participation.

[10] Urada, D., Antonini, V.P., Rawson, R., & Oeser, B.T. (2014). SBIRT Benefit Analysis and Recommendations for Supervision. In: Evaluation, Treatment, and Technical Assistance for Substance Use Disorder Services Integration 2014 Report. p. 223-230. Prepared for the Department of Health Care Services, California Health and Human Services Agency. Los Angeles: UCLA Integrated Substance Abuse Programs. http://www.uclaisap.org/Integration/assets/documents/2014%20ETTA%20Annual%20Report%20FINAL%20corrected.pdf

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

Valerie P. Antonini, M.P.H., Cheryl Teruya, Ph.D., Elise Tran, B.A., Darren Urada, Ph.D., Howard Padwa, Ph.D., and Kate Lovinger, M.S.

The landscape of California's publicly funded SUD treatment is evolving as major policy changes, including the DMC-ODS waiver, present unprecedented opportunities to increase access to SUD services while integrating such services with mental health and primary care. The numerous efforts to integrate and coordinate care across health systems that are currently underway at both the county and provider levels highlight the different approaches to integrating SUD, MH, and PC services in diverse settings. UCLA featured and examined some of these efforts to provide emerging information about promising integration models, challenges, keys to success, and lessons learned.

California SUD/Health Care Integration Learning Collaborative (ILC) webinars included:

- Program descriptions, outcomes, and lessons learned from three SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Program Grantees (San Francisco Department of Public Health, Tarzana Treatment Centers, and Alameda County Behavioral Health Care Services)
- Discussions with county administrators (Phase 1 of the DMC-ODS waiver) about current implementation plans and preparations, actual or anticipated challenges, and areas in which the counties seem to be well-positioned for the waiver
- A description of Santa Clara County's Adult Drug and Alcohol Treatment Services transformation to an organized system of care and lessons learned
- Presentations on SUD-related "hot topics", including: a brief treatment toolkit for primary care; making the case for integrated care - mental health and substance use services in primary care settings; medication-assisted treatment for SUD - extended release Naltrexone improves treatment outcomes; and characteristics of medical marijuana users - findings from a survey of dispensaries in Los Angeles County

Key learnings from the ILC and county integration initiatives/case studies in Los Angeles County (telepsychiatry, Vivitrol, AB109 process improvement), Kern County (patient interviews, waiting room health survey, staff satisfaction survey), and Santa Clara County (organized system of care) presented in this chapter could help inform future integration efforts.

INTRODUCTION

The Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA) have the potential to facilitate a historic transformation of publicly funded substance use disorder (SUD) services. The MHPAEA requires that mental health (MH) and SUD services must be covered in parity with other medical benefits, and the ACA specifies SUD services as one of 10 essential health benefits for all health plans, including Medicaid. As a result, demand for publicly funded SUD services has the potential to grow dramatically. In California, these

services will increasingly be funded through the Medicaid specialty "carve out" program, Drug Medi-Cal. To adapt to these changes, county SUD systems will need to begin functioning as managed specialty health plans, requiring new procedures that will be unfamiliar to many providers and county staff.

Additionally, SUDs are major contributors to health care costs, especially among patients with comorbid chronic medical conditions, and substance use interventions and treatment are central to delivering "whole person" care and thereby bending the health care cost curve. Consequently, there is an urgent need for the SUD treatment system, which has traditionally been isolated from the rest of health care, to become more integrated with medical and MH services.

California's Department of Health Care Services (DHCS) is seeking an 1115 Demonstration waiver for the Drug Medi-Cal (DMC) Program. The overall purpose of the waiver is to create a model that will provide an organized delivery system for SUD services. This Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver will be an amendment to California's existing section 1115 "Bridge to Reform" waiver. Following a strategic planning process involving input from stakeholders, this amendment was submitted to the Centers for Medicare and Medicaid Services (CMS) in November 2014. At the time of this report, the amendment is still under review at CMS, even as preparation for implementation has begun to take place around the state.

In this chapter, we review recent efforts to integrate behavioral health with the broader health care system around the state, as well as other "hot topics" affecting the SUD field. Our methods and activities included conducting surveys and interviews; facilitating the California SUD/Health Care Integration Learning Collaborative (ILC); evaluating integration initiatives and conducting a case study of an SUD system of care within selected California counties; reviewing the literature; participating in webinars; attending integration-focused conferences; and consulting with key stakeholders and integration experts.

The findings are organized as follows:

A. California Integration Learning Collaborative
    i. PBHCI Grantees
    ii. DMC-ODS Waiver Activities
    iii. Other Substance-Use Related Hot Topics
B. County Integration Initiatives/Case Study
    i. Kern
    ii. Los Angeles
    iii. Santa Clara
C. Chapter Summary and Lessons Learned

A. California SUD/Health Care Integration Learning Collaborative (ILC)

The ILC, which was initiated in April 2011, is an ongoing forum for county administrators, provider organization representatives, and other key stakeholders to discuss current issues related

to the integration of SUD services and primary care, as well as the coordination of services within SUD service delivery systems. It has served as an avenue for UCLA to provide technical assistance on a monthly basis and incorporates speakers with expertise in topics of particular interest to ILC participants, as needed. As of June 30, 2015, 44 meetings had been convened.

During fiscal year 2014–2015, the ILC conducted nine meetings (#36-44) and transitioned from conference call–only capability to a webinar format, which allowed for improved participant access, connectivity, and information sharing, while also providing the capacity to archive recordings of meetings that occurred after August 2014. Participation at each webinar varied by topic, but averaged 45 attendees. UCLA tracked registration and attendance at each webinar to estimate interest in each webinar topic.

At the time of this report, the ILC mailing list had 271 subscriptions, consisting of county administrators, providers, and other stakeholders. Through the fiscal year, the ILC website and Vimeo channel received 43 website views and video plays on average per month.

All ILC Slides and other materials are available online:
http://www.uclaisap.org/integration/html/learning-collaborative/

Archived webinars are available for viewing at the ILC Vimeo channel:
https://vimeo.com/channels/ilcintegration

Below are brief summaries of ILC meetings conducted in FY 2014–15. Topics were selected collaboratively with DHCS based on ILC participants' requests, DHCS priorities, and UCLA expertise/resources. This past year, there was significant interest in outcomes and lessons learned from the Substance Abuse and Mental Health Services Administration (SAMHSA) Primary and Behavioral Health Care Integration (PBHCI) Program as well as state level preparations and expectations for the DMC-ODS waiver activities. The meeting summaries are grouped as follows: PBHCI Grantees, DMC-ODS Waiver Activities, and Other Substance-Use Related Hot Topics.

i. SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Program Grantees

The SAMHSA PBHCI program's purpose is to increase access to health care for individuals with serious mental illness (SMI) and improve their overall health status through better coordination of care. The PBHCI program provides grants to promote the integration of primary care services for adults with SMI in community-based behavioral health settings. As part of their participation in the program, grantees focus on developing (1) processes for screening and referral for physical health care services, (2) a tracking system for their clients' physical health needs and outcomes, (3) care management services, and (4) prevention and wellness services.

Read more about the PBHCI Program here: http://www.integration.samhsa.gov/about-us/pbhci

The first grants were awarded in 2009 with Cohort I; the initiative is currently active with Cohort VII (awarded in 2014). In California, 13 programs have participated across cohorts I-VII of the

PBHCI program, including: Alameda County Behavioral Health Care Services (II); Asian Community Mental Health Services (III); Catholic Charities of Santa Clara County (IV); County of Sonoma (VII); Didi Hirsch Community Mental Health Center (V); Glenn County Health Services Agency (III); Kedren Community Mental Health Center (VII); Mental Health Systems, Inc (I); Monterey County Health Department (V); Native American Health Center, Inc. (V); San Francisco Department of Public Health (IV); San Mateo County Health System (III); and Tarzana Treatment Centers, Inc. (III), (VII).

Three SAMHSA grantees volunteered to discuss their PBHCI program experience as part of the ILC.

- San Francisco Department of Public Health (Meeting 38)
- Tarzana Treatment Centers (Meeting 39)
- Alameda County Behavioral Health Care Services (Meeting 41)

The three programs have been pursuing the following goals:

- Increase access to primary care for individuals with SMI
- Improve the overall health of people with SMI
- Decrease health care costs
- Develop novel strategies to overcome institutional and cultural barriers to integration
- Track data in order to objectively measure what does and does not work
- Emphasize evidence-based practices of care, such as wellness groups, care coordination, and peer development

In addition, findings from the PBHCI national evaluation (conducted by RAND) are discussed.

Grantee Programs

San Francisco Department of Public Health

Meeting 38:
SAMHSA Primary and Behavioral Health Care Integration Program Grantees, Part 1
San Francisco Department of Public Health
Ryan Shackelford, M.D., & Tom Bleecker, Ph.D.
San Francisco Department of Public Health
October 29, 2014
https://vimeo.com/111857633

In San Francisco's PBHCI program, South of Market Mental Health Services has partnered with the Tom Waddell Urban Health Clinic, the city's largest clinic for indigent populations, to develop a memorandum of understanding (MOU) for co-locating primary care services within South of Market Mental Health Services. Prior to the grant, only one clinic session per week was staffed by nurse practitioners from the Tom Waddell Urban Health Clinic. Obtaining the PBHCI grant has allowed an increase in staffing at the integrated clinic, which has permitted the expansion of the types of services as well as more frequent sessions. At the time of the webinar presentation, five primary care clinic sessions per week were available on site at South of Market, with up to 8 clients scheduled per session.

One of the important strengths of the program is its strong focus on data. The use of the process and outcomes dashboard to examine referrals to the primary care clinic to target non-connected clients and improve engagement has led to many successful initiatives, including a publicity campaign to increase referrals to the primary care clinic; introducing double-booking and having designated drop-in hours to manage no-shows; and completing warm handoffs to help further engagement of clients with primary care services. In addition, morning primary care clinics have been moved to afternoons due to the preferences of their patient population. Program leadership has focused on engagement, not just referrals. Rather than the traditional primary care model of passively waiting for patients to come in, the PBHCI primary care clinic has tried different strategies to actively connect individuals with SMI to primary health care. Having a primary care partner with the necessary infrastructure (electronic health records [EHRs], primary care workflows, registration and eligibility processes) also has been important to the success of the project.

Continuing challenges facing the project include the separation of EHRs for behavioral health and primary care, the relatively large resource expenditure required to sustain services relative to the modest size of the clinic, and difficulties reaching their initial engagement and outcome goals. However, the project has had a robust evaluation program with monthly staff feedback and activities focused on quality improvement. Regular integrated team meetings and clinic-wide meetings have been held with primary care and MH services staff, though clinicians also rely on frequent informal communications. Flexibility has been an important factor, including among the staff, between partner sites, and at the integrated clinic in its relationship with the larger health care system it is operating in.

A key lesson learned from the project is that demonstrating outcomes takes time. The problems addressed by primary care often result from chronic and ingrained lifestyle patterns influenced by cultural and systemic barriers; therefore, positive results do not occur overnight and time is needed for these efforts to demonstrate efficacy. In addition, it is important to focus the limited resources on areas of highest yield, which for the San Francisco program has included wellness, care coordination, and peer development programs. It was recommended that other programs experiment while recording trials and learning to develop standards through practice. Guidelines and standards of care for the PBHCI program, a new and innovative model, should be created in order to inform others and to communicate information to healthcare insurers and policy makers in order to keep integration alive.

Tarzana Treatment Centers
Meeting 39:
SAMHSA Primary and Behavioral Health Care Integration Program Grantees, Part 2
Tarzana Treatment Centers (TTC)
Jim Sorg, Ph.D., & Ken Bachrach, Ph.D.
Tarzana Treatment Centers
November 19, 2014
https://vimeo.com/112427458

Prior to being awarded its PBHCI grants, Tarzana Treatment Centers (TTC) already provided many integrated services. Its specialty behavioral health care services included SUD treatment; MH disorder treatment; HIV/medical care and related services; housing services, assessment and referral services in their own facilities and hospital emergency departments; and in-home services. Through the use of PBHCI funds, TTC has continued to further integrate primary care with MH/SUD services for patients with comorbid chronic physical health conditions and a serious mental illness, both within the TTC as well as within the Los Angeles County Department of Mental Health center, with an emphasis on care coordination and the enhancement of services with health information technology. This presentation focused on the first PBHCI grant that TTC received, which has been used to strengthen integration of primary care with TTC's existing behavioral health services.

TTC offers a wide array of services within which their PBHCI program has been implemented. Six primary care clinics have been integrated with other services staffed by eight different providers (including physicians, nurse practitioners, and physician assistants). At TTC, all primary care patients are assigned to a care team, which may include a physician, nurse practitioner (NP) or physician assistant (PA) as a lead, and a nurse, behavioral health clinician, case manager, medical assistant, psychiatrist, and/or pharmacist, as is appropriate. The needs of patients with severe MH or SUDs are managed by the behavioral health home with linkages to primary care, because these patients may feel more comfortable with their care being coordinated and integrated in the behavioral health setting. Care teams in behavioral health include a licensed behavioral health clinician or supervisor as a lead and a psychiatrist, addiction counselor, case manager, nurse, NP, or PA, as needed. Both physical and behavioral health conditions are included in a single problem list (including medical, MH, and SUD problems), in the Integrated Summary (a brief document summarizing major problems identified in the assessment, which is used to develop the treatment plan), and in the patient's treatment plan to be addressed by all staff. Conditions are addressed with motivational interviewing to improve compliance with monitoring, treatment interventions, and lifestyle changes.

Four main challenges that have been experienced by the project are: (1) staff training, to educate behavioral health providers about medical conditions and what their role is in helping to manage them; (2) developing the EHR in order to integrate the treatment plan and provide more communication; (3) setting up the care teams and finding the funding for care coordination, which is not currently funded by Medi-Cal; and (4) being able to focus on population health to identify cohorts of patients with certain conditions, high utilizers, and individuals with the most costly conditions, in order to better manage their care.

The program has attributed its success to a strong health IT infrastructure, including an integrated EHR, which is one of the essential tools helping staff to provide integrated care. TTC has adopted a primary care EHR that integrates directly with their behavioral health EHR. The organization uses Avatar for behavioral health and maintains a patient registry, integrated records and problem lists, and integrated medical and MH/SUD diagnoses. An iPad-based interface used for the Avatar primary care EHR is able to display DSM diagnoses and behavioral health progress notes, which are viewable by primary care providers on the iPad. Meanwhile, in the Avatar behavioral health EHR, primary care information is visible to behavioral health staff (such as a problem list with all conditions listed, an integrated treatment plan, and the patient

registries). To address confidentiality issues relating to an integrated record, providers obtain a signed consent at admission for every episode of care and explain HIPAA and 42 CFR Part 2 regulations to patients.

Alameda County Behavioral Health Care Services
Meeting 41:
SAMHSA Primary and Behavioral Health Care Integration Program Grantees, Part 3
Alameda County Behavioral Health Care Services
Freddie Smith, M.P.H. (Alameda County Behavioral Health Care Services)
& Faith Elizabeth Fuller, M.B.A. (Project Evaluator)
February 25, 2015
https://vimeo.com/124630856

Alameda County has used its PBHCI program funds to support the development of collaborative partnerships with two community-based federally qualified health centers (FQHCs) for the provision of satellite primary care services in two outpatient MH centers. The result of this collaboration has been to make the MH service site the "Medical Home" for the SMI clients to receive both comprehensive physical and MH services at one location. These co-located clinics (LifeLong Medical Care in Oakland and Tri-City Health Center in Fremont) are referred to as the Promoting Access To Health (PATH) clinics.

Through Alameda's PBHCI program, primary care providers (physicians or NPs), a medical assistant, a full-time clinical coordinator, and a full-time care assistant from the FQHCs have been co-located at the PATH clinic. The MH center staff involved with the PATH clinics includes Alameda County Behavioral Health Care Services psychiatrists who provide consultation to primary care providers as needed, a nurse care coordinator, a peer support counselor, and case managers who assist getting clients to appointments and referrals to specialty care. In contrast to a typical brief FQHC primary care clinic visit, the average PATH visit with a primary care provider lasts about 30 minutes, after an initial relationship is established. A staff care assistant makes reminder calls and covers no-shows with walk-ins. Peer support individuals help clients get to their appointments, provide interpretation (working with the physician and medical assistants to ensure that clients understand the procedures and next steps), and help in planning wellness activities. A nurse coordinates referrals and follow-ups, medication refills, blood draws, and triage.

Organizational challenges faced by the project have included dealing with bureaucratic processes and delays; hiring, purchasing, setting up MOUs, and billing for behavioral health; working to meet primary care productivity targets; barriers to data sharing; and finding time and resources to conduct the mandatory reassessment interviews of clients. Factors that consumers have found to be challenges are disruptive staff changes; consumer substance use affecting compliance and engagement with primary care treatment plans; lack of transportation and limited access to healthy food; and a preference for one-on-one sessions as opposed to the group activities conducted under the PBHCI program.

On a regular basis, the clinic team at the Alameda County program has convened "lunch and learns;" worked to orient patients on how to effectively navigate the primary care visit and be

effective patients; and involved peers early on to help design service delivery, communication, and provide educational materials that made sense to consumers. For data collection, it has been important to work with the evaluator and clinical team to plan what data to collect, as well as to determine when, how, and why to collect data. Tracking performance measures and making charts and graphs for a "data wall" has helped with staff engagement and disseminated successes more widely.

Additional practices recommended by the Alameda County program include meeting at the end of each half-day clinic for a 30-minute debrief session. During these sessions, the behavioral health staff, primary care team, and nurse care coordinator discuss the next steps for each client. The nurse care coordinator follows up on those actions to make sure everyone is working on their tasks, and works with the case manager to make sure assigned tasks are accomplished. Annual "Visioning Retreats" help collect feedback from stakeholders (including consumers, PATH staff, and family members) about what is working, what is not working, and how the project can be improved. Suggested strategies for improvement received from stakeholders have been related to health education and wellness activities; recruitment, enrollment, and outreach; clinic operations and communication; and information sharing and data utilization.

PBHCI Evaluation and Data

RAND National PBHCI Program Evaluation

The RAND Corporation conducted an evaluation of the PBHCI grants program, which included a small effectiveness study of patients served at PBHCI clinics compared to those served at matched control clinics. PBHCI program successes included enabling multi-disciplinary teams to offer an array of integrated primary, behavioral health, and wellness services, as well as showing improvements over the control clinics in health indicators such as blood pressure, fasting blood glucose, and cholesterol levels. However, challenges comprised lower than expected rates of consumer enrollment, difficulties with financial sustainability, intra-team communication, creating a truly integrated clinic culture, and lack of improvement in certain other health indicators (e.g., smoking and obesity).

The RAND evaluation found that increased patient access to integrated services was associated with program features, including the number of days a primary care clinic was open per week, degree of service integration, and regularly scheduled team meetings to review clinical cases. The evidence for integration resulting in physical health improvements was more limited, potentially due to issues such as small sample size; heterogeneity of integration at grant sites; the early stages of implementation of integration; and limited implementation of evidence-based programs on obesity and smoking, the two major causes of increased morbidity and mortality among the population with SMI. This also points to the challenges of poverty, lack of access to healthy food, and other societal issues that present obstacles to healthy behaviors and health improvement.

Recommendations that followed from the evaluation include:

- Maximize data-driven quality improvement processes

- Ensure fidelity to evidence-based wellness programs
- Develop strategies that improve consumer access
- Create consensus around program performance expectations and establishment of national quality indicators for integrated care accountability and core performance monitoring requirements

The full RAND evaluation final report is available online:
http://www.rand.org/pubs/research_reports/RR546.html

ii. California's Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver

Waiver Background and Description
UCLA conducted two ILC meetings aimed at helping counties prepare for the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. ILC meeting #42 invited Santa Clara County staff to provide their experience on the development of their organized system of care at the local level. ILC meeting #44 facilitated discussions among the Phase 1 counties as they prepare for the implementation activities expected under the DMC-ODS waiver.

ILC topics relevant to the DMC-ODS waiver are:
- Santa Clara County: Transforming County Drug & Alcohol Treatment Services into a System of Care (Meeting 42)
- California's Drug Medi-Cal Organized Delivery System Waiver: Phase 1 Counties Panel Presentation (Meeting 44)

Meeting 42:
Santa Clara County: Transforming County Drug & Alcohol Treatment Services into a System of Care
Cheryl Berman, Ph.D., L.M.F.T.
Santa Clara County Adult Drug and Alcohol Treatment Services
March 25, 2015
https://vimeo.com/123651356

Description
Dr. Cheryl Berman presented on Santa Clara County's successful efforts in developing a managed system of care for alcohol and other drug (AOD) treatment services. The system offers a centralized point of entry and continuum of services to clients, and includes standardized systemic and clinical expectations.

Summary
When Santa Clara County began to develop their Adult System of Care in 1995, treatment providers operated independently with no standardization and minimal oversight and accountability. Access was decentralized, resulting in clients having difficulty getting to treatment. Treatment was unique to each program and driven by program needs and goals rather than tailored to clients' individual needs.

In contrast, the treatment system today has undergone many changes. Services are now organized into a continuum of care with the ASAM Criteria used for placement, assessment, and development of the treatment plan. Clients can access services through a centralized toll-free number. Evidence-based practices are utilized, including motivational interviewing, cognitive-behavioral therapy, trauma-informed care, relapse prevention, and psychoeducation groups.

Key elements of the system transformation included use of innovative partnership meetings, quality improvement strategies and use of "hot groups" (part of the Network for the Improvement of Addiction Treatment [NIATx] process improvement model), implementing a gateway for services, organizing a continuum of care, tracking and reporting performance measures, creating a learning institute, and using clinical standards. These factors, combined with strong leadership, motivated staff, training, time, communication, collaboration, and perseverance have helped Santa Clara develop its AOD services into the organized system of care it has today.

NOTE: A full summary of Santa Clara County's organized adult system of care for AOD services is provided in Appendix 1, including a history of how the system was developed, a description of the system processes, and recommendations from Santa Clara County administrators for other stakeholders.

Meeting 44:
California's Drug Medi-Cal Organized Delivery System Waiver: Phase 1 Counties Panel Presentation
May 27, 2015
Notes from the panel session are available on the ILC website:
http://www.uclaisap.org/integration/html/learning-collaborative/

Description
UCLA asked administrators of counties identified in Phase 1 of the proposed DMC-ODS waiver (Northern and Bay Area region) to join a panel presentation to discuss challenges facing their counties as they prepare their county AOD systems to deliver the continuum of services enabled by the DMC-ODS waiver. Administrators participating in the panel represented San Francisco, Santa Clara, Alameda, Marin, San Mateo, Solano, and Contra Costa counties.

Summary

Phase 1 county panel participants discussed the following questions:

- ***What is your county currently doing to plan and prepare for the implementation of the DMC-ODS waiver?***

  Each of the Phase 1 counties are engaging in numerous efforts to prepare for implementation of the waiver. County administrators noted that their counties are assisting providers in transitioning from relying on Substance Abuse Prevention and

Treatment (SAPT) block grant funding to billing Drug Medi-Cal for services. As participation in the waiver will require improved protocols and systems for capturing and using data for utilization management, care coordination, and quality improvement, administrators also discussed efforts to strengthen their data systems. They are also examining data to assess client needs and network adequacy and to determine costs and financial models that potentially could be feasible to implement.

In addition, administrators are holding meetings to educate providers about changes due to the waiver, gather feedback from stakeholders, and align leadership with efforts in preparation for the waiver (for example, by getting buy-in from the county board of supervisors). They have provided trainings and direct technical assistance to providers on the ASAM Criteria, Drug Medi-Cal, and documentation requirements.

- ***What do you see as the biggest challenge for your county to prepare for the waiver? What challenges or questions do you feel you still need help with?***

  Counties reported facing multiple challenges in preparing for the waiver, including:
  - the need to quickly develop a robust data infrastructure;
  - the need to understand complex new regulations relating to the waiver;
  - uncertainty and delay relating to many aspects of the waiver implementation process (e.g., provider certification, prediction of future costs, adequacy of reimbursement rates);
  - managing the administrative burden of waiver preparation at the county level;
  - adjusting providers to a managed care culture with different expectations than what they are accustomed to (e.g., treating a different population with different payment sources, more stringent documentation standards);
  - engaging non-traditional providers in the treatment network;
  - network adequacy in certain geographic areas;
  - developing new services to meet requirements under the waiver due to upfront costs; and
  - overall resource constraints.

  In addition, county administrators suggested that DHCS provide guidance to counties on metrics or standards for measuring quality.

- ***In what areas do you feel your county is well prepared for the waiver (especially ones that other counties might be able to draw lessons from)?***

  County administrators reported areas in which their counties are particularly well-positioned in preparing for the waiver. Several counties have been able to pay for treatment services from county general funds. Another county's aggressive participation in the previous Bridge to Reform waiver has built a foundation for the waiver implementation. In addition, county administrators mentioned that working with and building a relationship with DHCS through the process of preparing for waiver implementation has been helpful. Strong partnerships and frequent communication

between and within county departments, and with health plans and hospitals, has also supported counties in preparing for the waiver.

iii. Other Substance Use Related Hot Topics

Description
Several meetings focused on topics of particular interest to ILC participants, including promising practices/tools for integrating SUD services in primary care settings, implementation of a medication-assisted treatment in an SUD treatment system, and findings from research on medical marijuana users.

Topics:

- Brief Treatment Toolkit for Primary Care (Meeting 36)
- Making the Case for Integrated Care: Mental Health and Substance Use Services in Primary Care Settings (Meeting 43)
- Medication Assisted Treatment for SUD: Extended Release Naltrexone Improves Treatment Outcomes (Meeting 37)
- Characteristics of Medical Marijuana Users: Findings from a Survey of Dispensaries in Los Angeles County (Meeting 40)

Meeting 36:
Brief Treatment Toolkit for Primary Care
Adam Brooks, Ph.D. (Research Scientist, Treatment Research Institute)
July 23, 2014
Slides from the webinar are available on the ILC website:
http://www.uclaisap.org/integration/html/learning-collaborative/

Description
Adam Brooks, Ph.D., presented on a brief treatment toolkit currently being developed and tested by the Treatment Research Institute (TRI) for addressing SUDs in primary care. He also shared information on a patient health education support tool that can be used in conjunction with the toolkit. Furthermore, he discussed initial implementation results and patient engagement rates from a study using the brief treatment toolkit.

Summary
In a study conducted at three Philadelphia FQHC clinics, researchers tested the use of screening, brief intervention, and referral to treatment (SBIRT) for drug use problems, comparing "classic" single-session SBIRT with SBIRT+, a more intensive on-site treatment approach. SBIRT+ consisted of 2–6 sessions, with the number of sessions varying based on a client's specific needs. It is based on motivational enhancement therapy techniques, with the addition of other evidence-based strategies as needed, including relapse prevention/cognitive behavioral therapy and 12-step facilitation. To facilitate implementation, researchers developed a toolkit to assist with patient communication.

- *The SBIRT+ Toolkit* consists of 35 brief tools in the form of client take-away cards and Quick Guides to help clinicians understand how to use each of the cards. Options are provided for 15-minute interventions and 5-minute interventions, depending on the amount of time available to clinicians. Activities are printed on the cards allowing patients to interact with the provided information.
- *The Activity Book (Keep it Moving™: A Guide to Breaking Habits)* served as a health education tool to provide to patients who may not come back for additional sessions or who are already motivated to change and simply need information on how to do so. The book is guided by theory: exercises are integrated into the storyline, which serves as a workbook that is engaging and culturally sensitive. The format is low-cost, revisable, scalable, and available in text or digital form.

Across sites, 10,456 patients received the initial screener, 3,237 were flagged for drug/alcohol use, and 563 were ultimately enrolled in the study and randomized into either of the two intervention groups. Results showed that overall, participants were satisfied with the SBIRT+ intervention. The intervention had high engagement, with the majority of participants attending at least the first three brief treatment sessions. However, referrals were more challenging. About 60% of participants reported receiving a referral for specialty services, but of those, 60% reported that they did not receive any services. About 20% of participants reported entering treatment.

Meeting 43:
Making the Case for Integrated Care: Mental Health and Substance Use Services in Primary Care Settings
Karen Larsen, M.F.T. (Mental Health Director and Alcohol and Drug Administrator, Yolo County Department of Health Services)
April 22, 2015
https://vimeo.com/125736040

Description
In this presentation, Karen Larsen, M.F.T., covered the case for integrated care and how to make the case to others such as administrators, payers, and potential partners. Additionally, she described types of integration and key features of successful models to consider for providers who are interested in integration.

Summary
Behavioral health is a key issue for many health care providers due to the prevalence of MH- and SUD-related problems among low-income populations and associated health care costs. For some patients, primary care may be their sole source of access to MH treatment. Additionally, depressed patients are more likely than non-depressed patients to be non-compliant with treatment recommendations. Behavioral health conditions, like SUDs, are chronic rather than acute in nature. For these and many other reasons, behavioral health and physical health care integration is vital.

With the integration of behavioral health and physical health care, all providers involved in an individual's care are committed to collaboration and coordination with each other, either through physical co-location or through shared EHRs. Common care plans are developed by a team of behavioral and physical health providers and include patient input to address both physical and behavioral health care needs. While the financing of integration remains challenging, improved enforcement of the MHPAEA may help address access and reimbursement issues.

To advance integration in the Medi-Cal managed care transition, recommendations include:

- Identify partners;
- Determine relationships and each other's respective roles in services for complex populations;
- Consider needs for staff recruitment and training as well as workforce credentials;
- Create critical mass to establish capacity;
- Measure outcomes for quality improvement; and
- Invest in health information technology to support clinical integration and service provision, including data sharing and outcome tracking.

Meeting 37:
Medication-Assisted Treatment for SUD: Extended Release Naltrexone Improves Treatment Outcomes
Desiree Crevecoeur-MacPhail, Ph.D. (UCLA Integrated Substance Abuse Programs)
September 24, 2014
https://vimeo.com/111857632

Description
Desiree Crevecoeur-MacPhail, Ph.D., presented on the implementation of extended-release injectable naltrexone (brand name Vivitrol®) in the Los Angeles County SUD treatment system and discussed the medication's effect on treatment outcomes for opioid and alcohol users.

Summary
The Los Angeles County Substance Abuse Prevention and Control Division (SAPC) implemented a program to provide extended-release injectable naltrexone to interested and eligible clients. Because staffing varies at the estimated 300–350 sites belonging to the approximately 200 agencies with which the county contracts, three medication hubs that had the necessary staffing and infrastructure and a long-standing history of providing quality SUD treatment to a broad range of clients were chosen to administer the medication.

Treatment providers referred their clients to one of the three hubs for medical tests and, if approved, the extended-release injectable naltrexone. The patients then returned to their original treatment programs to continue their psychosocial counseling. The county paid for the medication and provided an additional stipend to the medication hubs to cover the cost of medical screenings and other services related to the administration of the medication.

Findings included the following:

- On average, patients received about 2–3 doses of extended-release injectable naltrexone, regardless of substance used (alcohol or opioids), a positive sign indicating that patients

are not averse to taking multiple doses of injectable naltrexone. In contrast, the pill form of the drug has been shown to have very low refill rates.

- Though no causal conclusions can be made, extended-release injectable naltrexone was associated with positive outcomes, including improved treatment engagement, improved treatment retention, positive compliance in treatment, and reductions in substance use.
- Before the study, only one SUD treatment program in Los Angeles County had patients taking extended-release injectable naltrexone; after the study, the number of programs with patients taking the medication had expanded to 32.

Meeting 40:
Characteristics of Medical Marijuana Users: Findings from a Survey of Dispensaries in Los Angeles County
Christine E. Grella, Ph.D. (UCLA Integrated Substance Abuse Programs)
January 28, 2015
https://vimeo.com/124630855

Description
Christine E. Grella, Ph.D., presented findings from a focus group study and survey of individuals who use medical marijuana dispensaries in Los Angeles County. Areas examined included socio-demographics, reasons for use, and health status.

Summary
In a two-phase study supported by Los Angeles County Substance Abuse Prevention and Control, UCLA conducted a total of five focus groups with 30 medical marijuana consumers, and a larger survey of medical marijuana users using a cluster-based sample of dispensaries.

- In findings from the focus groups, nearly all participants had a history of marijuana use prior to receiving their medical marijuana recommendation, usually initiating use in adolescence and often with family. Most reported sleep problems, anxiety, depression, or chronic pain as their primary reason for using marijuana, although some had serious chronic health problems related to a serious accident, illness, or mental disorder. Participants felt that dispensaries counteract the highly stigmatized image of marijuana users that is pervasive in society, stemming from years of fear-based prevention messages. They appreciated being treated with respect and compassion and they identified as "patients."
- According to the survey responses, there was no indication that individuals initiated marijuana use by obtaining it from the dispensaries. Many obtained marijuana from other sources in addition to the dispensaries. Most were affiliated with others who also use medical marijuana, and patterns of use among younger adults were more socially embedded. Finally, location and convenience was most often cited as the reason for selecting a given dispensary, although individuals typically went to more than two dispensaries per month.
- The implications for providers are that many or most medical marijuana users have a long history of use and view marijuana as helpful in alleviating pain, insomnia, or other chronic problems, but they also acknowledge using it socially. The distinction between "medical" and "recreational" use is blurry. In addition, risky alcohol and tobacco use are

prevalent, and about one fifth of survey respondents report recent use of illicit drugs. Findings were similar to data from a statewide general population survey, in which about 5% of adults in California had used medical marijuana.

B. County Integration Initiatives/Case Study

During FY 2014–15, UCLA focused on three counties—Los Angeles, Kern, and Santa Clara—that have been doing innovative work around integration of behavioral and physical health care or creating an organized system of care for individuals with SUDs. Descriptions and findings from an examination of the integration models and SUD-related activities in these three counties are included in this report. The lessons learned may be helpful to the state and other counties in informing decisions regarding the integration and coordination of SUD, MH, and physical health services.

NOTE: Evaluation of integration initiatives for Los Angeles and Kern counties have been conducted for several years under separate county contracts.

i. Los Angeles County Integration Pilot Projects

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 AB 109 Process Improvement Project. 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 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 SUD 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 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 MH 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 Licensed Clinical Social Worker (LCSW), as appropriate, to receive telepsychiatry services.
2. Patients complete the 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 a secure line to the UCLA psychiatrist.
5. AVRC mails copies of patients' clinical information directly to the UCLA psychiatrist.
6. The UCLA psychiatrist conducts the session and completes dictations, which are stored with the patient's 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, 2015, 380 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 MH issues (Denering, Crevecoeur-MacPhail, 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 also has been positive.

Lessons Learned

The telepsychiatry project increased access to MH 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. It is testament to the benefits of integrated care, which has become increasingly important as the field of SUD treatment continues to move toward a chronic care model.

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

Background

As noted above, 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 (phase I) and the follow-up study (phase II) are described below.

Objectives/Methods

In 2010–2011, the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (SAPC), in collaboration with UCLA, 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 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, Vivitrol Phase II report, 2013, Drug Court Final Report, 2015). Vivitrol patients also demonstrated reductions in use of their primary substance, better treatment engagement, and higher completion rates compared to the average county patient. In addition, in-service trainings improved staff attitudes regarding the use of medication-assisted treatments. Conclusions from these pilot projects 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, sought to examine how participants' cessation of Vivitrol impacts cravings and treatment 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 participants was from February 2012 to December 2013. This brief follow-up study examined whether 249 enrolled participants (of which 49 were drug court participants) would maintain their sobriety once they were no longer receiving Vivitrol injections. Consistent with Phase I, the project collected data on side effects, days used, questions about the medication, and the urge to drink/use (to ascertain cravings). In addition, participant treatment outcomes were examined as that data became available.

Results suggest that participants who had taken at least one dose of Vivitrol reported clinically significant decreases in the urge to drink alcohol or use opioids. Participants' urge to drink/use remained within a clinically safe range (scoring below 10; reflecting little danger of relapse) 30 and 60 days after their final injection of Vivitrol (results were statistically significant for alcohol and opioids). These findings may indicate a continued reduction in urge to drink/use, or at least a significant delay in a return of urges once administration of the medication ceased. Vivitrol participants decreased the number of days using alcohol and/or opioids from baseline to the last follow-up. Participants also seem to have reduced their days of use to intoxication, which is clinically significant. It appeared that the participants were able to maintain the reduction in days used or intoxicated after the medication was no longer administered; however, these findings were only significant for participants with alcohol use disorder. Analyses of the follow-up group demonstrated that urges to drink/use did not increase significantly once the medication was ceased. Vivitrol participants were engaged in, retained, and completed treatment. About a third of all participants 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.

Vivitrol for Drug Court Patients

In late February 2012, LACES began an evaluation of the use of Vivitrol as part of a supplemental SAMHSA Enhancement Grant. This evaluation mirrored the Vivitrol Phase II project mentioned above and was conducted from February 2012 to March 2015. This brief follow-up study examined whether 81 enrolled drug court participants maintained their sobriety once they were no longer receiving Vivitrol injections. The project collected data similar to that for Phase II (side effects, days used, etc.) and the urge to drink/use (to ascertain cravings) as well as treatment outcomes.

A total of 81 drug court patients received Vivitrol in Los Angeles County. Vivitrol Drug Court recipients were primarily Latino (58%) and male (75.3%), had a mean age of 35.2 years (SD = 9.7), were enrolled in outpatient treatment (91.4%), and were seeking Vivitrol for alcohol problems (64.2%). Most (60.9%) of these participants took more than two doses of Vivitrol.

Vivitrol participants reported statistically significant reductions in days using alcohol or opioids. In addition, compared to admission, Vivitrol participants reported a decreased number of days incarcerated at discharge. Compared to other Los Angeles County drug court participants in psychosocial treatment (referred to herein as treatment-as-usual [TAU] participants), Vivitrol participants were less likely to leave treatment with negative compliance; that is, they were less likely to leave prior to treatment completion and with unsatisfactory progress (7.8% compared to 26.3%, respectively). Further, among those enrolled in outpatient treatment, Vivitrol participants were more likely than TAU participants to be retained for at least 3 months (84.4% compared to 65.4%, respectively). Finally, Vivitrol and drug court TAU patients had relatively similar days of incarceration at admission; however, Vivitrol patients had fewer days of incarceration at discharge compared to TAU patients.

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, Phase II and Drug Court) have demonstrated the potential benefits of medication-assisted treatment (MAT), specifically Vivitrol. Although the use of various medications is an evidenced-based practice, many SUD treatment providers still make little to no use of them. Many have limited knowledge of the new medications, as well as limited ability to prescribe or provide them. This must be addressed to facilitate improvements to health care as well as to achieve parity with the larger health care system with regard to patient access to FDA-approved medications.

AB 109 Process Improvement Project

Background

California Assembly Bill 109 (and 117) realigned some aspects of the criminal justice system. Generally speaking, the bills provided the opportunity for nonviolent, non-serious, non-sexual offenders convicted of a drug crime to be released from prison (as well as those who would have normally served a prison sentence) to take part in SUD treatment instead of completing a prison sentence.

Of those who were assessed to need SUD treatment, only 60% presented to treatment. The AB 109 Process Improvement Project was designed to examine the system of assessment and treatment admission to determine where there may be opportunities for improvement in the show rates to treatment.

Objectives/Methods

Methods included chart reviews (n = 109), telephone interviews with clients who failed to show for treatment (n = 13), focus groups with staff (2 intake staff members, 2 counselors, 1 Community Assessment Service Center [CASC] staff member) and three focus groups with clients who had completed the treatment process (or were near completion) and were participating in alumni groups (n = 20). Topics discussed as part of the staff focus groups included (1) experiences and perceptions working in substance abuse treatment and/or assessment centers; (2) experiences and perceptions of the assessment process for AB 109 clients; and (3) plans for assessment process improvement. Topics discussed as part of the client focus groups included: (1) perception of the assessment, intake, and treatment process, (2) how they felt about participating in SUD treatment, and (3) barriers to treatment participation and/or treatment completion.

Implementation Outcomes

SAPC is still collecting and analyzing information from the client alumni groups, client interviews, and staff focus groups. However preliminary results indicate that there are significant barriers to treatment access, such as transportation, limited resources, wait times, and competing priorities (e.g., the need to find a job). In addition, CASC and treatment personnel noted that some clients were referred inappropriately, that there were long wait lists to enter treatment due to funding limitations, and there was a complicated or multi-step process to access treatment; in addition, staff pointed to the need for additional staff training.

Lessons Learned

Treatment completers (e.g., alumni group participants) noted that gaining client trust and their engagement in treatment and assisting in their transitioning back into society (e.g., helping them obtain a drivers license or identification card, supporting career planning for employment, and providing life skills) could go a long way in increasing treatment compliance.

Plans for Future Activities

The above Vivitrol pilot project is complete; however the Telemedicine project will continue, funded by SAPC through UCLA's LACES contract. In addition, LACES will conduct a needs assessment of the undocumented population as part of the contracted activities for the next fiscal year.

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ii. Kern County Integration Initiative – Project Care

Kern County Mental Health has been working with FQHC and health center partners to implement integrated behavioral health in primary care settings since 2011 (Project Care). Project Care aims to promote integration through financial support for same-day services and an expanded behavioral health workforce, regular meetings of physical and behavioral health providers, use of evidence-based practices, required administrative meetings, practitioner networking, trainings, and SBIRT.

Objectives/Methods

The goals of Project Care are to provide universal screening of all adult patients coming to the health centers. Three screening instruments are used to screen for depression, anxiety, and substance use (PHQ-9, GAD-7, and AUDIT-C+, respectively). Behavioral health assessments and brief interventions are delivered onsite including Cognitive Behavioral Therapy, Motivational Interviewing, and Solution-Focused Brief Therapy. Integrated case conferencing with the Project Care physician, psychiatrist, and behavioral health staff are mandatory, and the program uses data to monitor progress. Referrals to specialty MH and SUD care are made when appropriate. Project Care's funding (from Mental Health Services Act [MHSA] funds) facilitates "warm handoffs" (i.e., the primary care provider directly introduces the patient to the behavioral health specialist) by allowing providers to be reimbursed for providing two services in the same day (e.g., for a physical ailment and behavioral health intervention), unlike other primary care sites in California that rely on Medi-Cal (Medicaid) reimbursement.

Kern County contracted with UCLA to conduct the evaluation of this project, and provide additional training and technical assistance as needed.

Implementation Outcomes

Over the course of four years, Project Care has demonstrated that it is feasible to integrate behavioral health services with physical health care in primary care settings. Several small studies were conducted to measure organizational factors and staff perceptions, as well as collect patients' perspectives of the integrated behavioral health services being provided in selected Project Care sites. In this past year (FY 2014-15), efforts were focused on gleaning patient-level perspectives using patient interviews and a waiting-room survey, and an analysis of the three years of staff perception survey data. Descriptions of each are highlighted below.

Patient Interviews

UCLA researchers conducted short (15–20 minute) telephone interviews (baseline and 30-day follow-up) with patients of one of the participating Project Care health clinics to explore participants' perspectives on their alcohol/drug use and the behavioral health care they received. In total, five participants completed the baseline interviews and four completed the follow-up

interviews. (One of the participants could not be reached for the follow-up interview.) Three of the participants were female and two were male. Participants' ages ranged from 19 to 64 years old.

Lessons Learned

There are several preliminary lessons that can be drawn from the pilot study. Four of the five participants' comments about answering the alcohol/drug use related questions on the screener reflected concerns about the process (e.g., it seemed "odd" to be asked so many questions, questions were too "personal," and they felt anxious). Where possible, it is suggested that doctors review the screeners with patients and provide warm handoffs to the behavioral health provider, when appropriate. Due to the stigma associated with substance use, programs should consider having providers use more neutral terms, such as "behavioral health specialist," with patients rather than "drug counselor," which might help patients be more open to talking with a behavioral health provider. Additional conversations with patients could shed light on whether changes to the screening process are needed, and if so, what those might be. While the participants' answers to the alcohol/drug use screener may not have warranted an appointment with the behavioral health provider to talk further, clinic staff might want to consider connecting patients to a self-help group, peer specialist (if available), or treatment, if patients express an interest in getting help.

Waiting Room Health Survey

UCLA researchers conducted an anonymous self-administered health survey (paper/pencil) available in both English and Spanish as part of Project Care among adult patients present for a health care visit who were in the waiting room of one community health center on February 24, 2015. The purpose of the survey was to better understand patients' perspectives of their health behaviors (including AOD use), behavioral health services received at the health center, outcomes as a result of receiving behavioral health services, and suggestions for improving such services.

Lessons Learned

The results of this pilot study (n = 58) suggested that while some patients have been receiving MH services at the community health center, there may be additional opportunities, especially among patients who prefer communicating in Spanish, for identifying the need for and providing behavioral health services to patients. Some patients may benefit from receiving information about the potential risks of taking prescription medications not prescribed to them or of taking pain medications in a manner not prescribed by their doctor. The findings also highlight the stigma that continues to be associated with seeking help for alcohol/drug use issues. In addition, it is important to consider the role that culture/ethnicity might play in terms of how patients are screened and how care is provided. Finally, the pilot study also provided evidence that it is

possible to use waiting room survey methods to collect data on substance use in busy community health centers without disrupting the patient flow.

Staff Satisfaction Survey

UCLA conducted repeated annual surveys of staff at community health center sites participating in Project Care from 2011 through 2013. The purpose of the surveys was to explore staff perceptions of and satisfaction with delivering integrated behavioral health services in primary care settings, focusing on the themes of (1) perceptions of effectiveness and comfort with the MH/SUD needs of patients; (2) beliefs in the value of integration; (3) and perceptions of communication between providers. The aim of the current analysis was to measure differences in staff views over time and examine interactions between time and staff type (behavioral health providers, medical, and support staff) or organization. The final sample consisted of 226 completed surveys received across the three years.

Lessons Learned

Overall, results from this analysis indicate that staff at Project Care sites had a positive view of behavioral health integration, which generally improved over time. The support and interaction facilitated by Project Care (e.g., co-located behavioral health staff and warm handoffs, regular meetings with training and networking opportunities for providers) appeared to help foster greater confidence among providers in dealing with patients' behavioral health in primary care. For example, behavioral health providers, who were initially uncertain of the medical staff's ability to address patients' behavioral health needs, increased their ratings to moderate agreement over time. Primary care providers were increasingly viewed to be comfortable being the "first line response" for patients with behavioral health needs over time. The survey results suggest that the availability of co-located behavioral health staff encouraged more frequent collaboration and consultation than the off-site referral model of coordinating with behavioral health. Future training may be beneficial to continue staff learning, and staff have indicated that they would be receptive to additional trainings on behavioral health topics and issues.

Plans for Future Activities

UCLA's contract with Kern County has been renewed for a fifth year (through June 30, 2016). Ongoing training, technical assistance, and evaluation are planned. Additional activities to further measure the impact of integrating behavioral health services in the primary care setting at the patient level are in discussion.

iii. Santa Clara County – Case Study: Creating an Organized System of Care

Traditionally, publicly funded SUD programs in California have operated independently of one another, without ensuring that services are coordinated or that client flow between levels of care is clinically appropriate. Consequently, SUD services in most counties have not constituted an actual *system*, but rather a patchwork of independent programs and treatment modalities. As mentioned above, one exception is Santa Clara County, which began developing an organized system of SUD over 20 years ago. UCLA collected information about Santa Clara's processes and procedures in an effort to disseminate information that might help other counties prepare for DMC-ODS waiver implementation.

Objective/Methods

In March and April 2015, leaders from the Santa Clara County Department of Alcohol and Drug Services (DADS) and Santa Clara County service providers shared their experience constructing an organized system of SUD care with researchers from UCLA, policy makers from the DHCS, and SUD administrators and program leaders from across California in a webinar and a day-long meeting. Through interviews, observations, a site visit, and follow-up correspondence, UCLA documented the findings and lessons learned in a report, included as Appendix 1. Below are a brief review of the findings and lessons learned.

Findings

Administrators from DADS began the process of system transformation in 1995 by establishing an "Innovative Partnership"—an open collaboration between DADS and providers—to facilitate the process of transforming Santa Clara's SUD service system. As challenges related to system design and client flow emerged, the Innovative Partnership created "Hot Groups"—subcommittees that included both county and provider staff—to plan and design action steps. Hot Groups brainstormed, tried ideas, and reported findings back to the Innovative Partnership in order to inform the development of DADS' system of care. Hot Group activities helped create and refine screening tools, referral processes, assessment protocols, and policies that facilitated client movement along the DADS continuum of SUD care.

The DADS continuum of care consists of outpatient counseling; residential treatment; transitional housing; withdrawal management; and perinatal, youth, and narcotic treatment services. Though these services do not make up the full spectrum of treatment modalities or levels of care recommended by ASAM, DADS uses ASAM principles to structure its system of care and procedures related to client placement and flow. In particular, DADS utilizes the six ASAM dimensions (acute intoxication and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral, or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; recovery/living environment) to evaluate client needs, place clients in the appropriate level of care, and design treatment plans.

Most clients enter the DADS system through the Gateway, a toll-free number operated by DADS that conducts brief screening and links clients to the appropriate level of care. Gateway operators conduct an initial assessment that gathers information on clients' clinical needs and information

that is used to determine what funding sources can be utilized to support client care. DADS developed decision trees informed by ASAM that Gateway staff use to make referrals based on information gathered during intake. The average intake through Gateway takes approximately 5–6 minutes to complete. To facilitate referrals for clients involved with the correctional system, DADS has collaborated with the county jail to set up a dedicated line that individuals in custody can use to call the DADS Gateway line.

DADS' Quality Improvement (QI) team monitors the effectiveness of its screening and referral procedures, authorizes client movement into and through the system of care, and assists in care coordination services. In particular, DADS authorizes client utilization of residential and transitional housing services in order to assure that the most costly and scarce services offered in the DADS continuum of care are utilized efficiently. QI staff has access to real-time data on the capacity and utilization of all levels of care every day, and they use these data to maintain and facilitate client flow. In addition, QI staff provide ongoing technical assistance to support providers operating as part of the DADS system of care.

Lessons Learned

- ***Strong central leadership is important:*** Engaging providers who are accustomed to operating as their own entities in a coordinated and broader system of care requires significant leadership from county administrators

- ***Providers are critical partners for transformation:*** Creating a system of care requires providers to significantly alter their administrative and clinical operations. Including providers in system redesign and implementation processes can facilitate transformation by incorporating provider input and maximizing buy-in.

- ***Counties need to use data to make systems of care function:*** For a system of care to truly function as a system, its operations need to be consistently informed by real-time data. Utilization, performance, and cost data are the lynchpins of system design in Santa Clara, and information systems and data-gathering protocols that facilitate real-time access to information are critical to ensuring that services operate as a cohesive whole.

- ***Ongoing training is key:*** By providing ongoing training to providers, counties can assure that they are proficient in all clinical and administrative matters.

- ***Continuous quality improvement is critical:*** It is critical for counties and stakeholders to continuously monitor the progress of their system and make modifications when necessary. In Santa Clara, policy makers and providers noted that "it is not QA (quality assurance), it's *QI* (quality *improvement*)" and continuously engaged in data monitoring and quality improvement efforts by using process improvement strategies (e.g., those used by the Network for the Improvement of Addiction Treatment, NIATx) to identify and address problems.

- ***Quality improvement needs to be clinical, not just administrative:*** Throughout the process of transforming into an organized system of care, DADS administrators made

sure that the processes of change and quality improvement focused on matters of clinical care as well as administrative functions and system design. To ensure that clinical matters were continuously being monitored and addressed, DADS created a position for a "Clinical Standards Coordinator" to help spark innovation and disseminate clinical knowledge. As one DADS administrator reported, this process was critical in "keeping the Innovative Partnership innovative," and maintaining focus on the long-term goal of improving service delivery and client care.

C. Chapter Summary and Lessons Learned

Summary

UCLA's activities addressed the following objectives in the domain of Health Care Reform and the Integration of SUD Services with Mental Health and Primary Care in FY 2014–15:

- Collect and disseminate cutting-edge information on the integration of SUD services with MH and primary care services;
- Coordinate and facilitate an interactive forum (ILC) with county administrators and other key stakeholders to discuss SUD integration; and
- Conduct case study/pilot evaluations.

The ILC continued to be well attended and has served as a useful mechanism for (1) sharing information on "hot topics," (2) discussing integration-related challenges, successes, and models, and (3) providing technical assistance opportunities at the county level through its contract with UCLA. Meanwhile, the identified initiatives have provided lessons learned from county efforts to integrate and improve SUD care.

Overall, these efforts demonstrate how the California health care system is continuing to evolve toward a more coordinated system of care, and suggests that the next few years can potentially be transformative under the DMC-ODS waiver, depending on how implementation unfolds.

The following lessons learned are drawn from UCLA's work related to health care reform and the integration of SUD services with MH and primary care during FY 2014–15. Many of these have been raised in previous reports and in the literature but are important to highlight as they continue to be necessary key ingredients for successful integrated care. We have compiled these lessons with an emphasis on issues that present where “the rubber hits the road” as counties and providers embark on the implementation of a coordinated, integrated, comprehensive, and organized system of care.

Recommendations and Lessons Learned

- SET A CLEAR ORGANIZATIONAL VISION:
    - Strong **leadership** and communication of a **vision** of what the organization/department is striving to achieve are critical for any change effort that involves transforming the organizational culture to one in which integrated and coordinated patient care is the norm.
- DEVELOP A STRATEGIC PLAN WITH REALISTIC TIMELINES:
    - Efforts to integrate behavioral health services and primary care and to develop organized systems of care are occurring and should be included as part of the organization's/agency's strategic plan. It is important to remember that major changes **take time** and **resources** to develop the requisite **infrastructures** (e.g.,

staffing, data, communication across disciplines, care coordination, training and technical assistance) and organizational culture.

- ESTABLISH MULTIPLE PARTNERSHIPS:
    - Identification and formation of **multiple partnerships** with key stakeholders (e.g., county departments, providers of different SUD treatment modalities, specialty MH providers, health plans, recovery support services, and primary care providers) is essential for seamless coordination of patient care.
- SCHEDULE ROUTINE MEETINGS
    - Ongoing regular and frequent face-to-face **communication** among stakeholders (e.g., multi-disciplinary team meetings to discuss shared patients, county and treatment provider partnership meetings) is a key element in integration as well as SUD system of care improvement efforts.
- PROVIDE BOTH CLINICAL AND ADMINISTRATIVE TRAINING AND TECHNICAL ASSISTANCE
    - **Training** and support must be provided on an **ongoing** basis to ensure that staff can be effective in an evolving health care environment. Both clinical (e.g., evidence-based screening and assessment tools, treatments, and practices) and administrative/operational (e.g., Medi-Cal billing requirements and procedures, patient data entry protocols, report generation, patient referral protocols) topics should be included in the county's/organization's training plan.
- CONSIDER NON-TRADITIONAL FUNDING SOURCES/RESOURCES:
    - Multiple **funding** sources and resources, including non-traditional ones (e.g., foundation grants, master's-level interns providing patient care under the supervision of a licensed clinician), are needed to make health care organizations and SUD systems of care function optimally.
- ENGAGE KEY STAKEHOLDERS, INCLUDING PATIENTS AND STAFF
    - **Engaging stakeholders**, including patients and staff, in planning, implementing and evaluating progress (e.g., integration of behavioral health and primary care, SUD system of care transformation) of integration/coordination and/or quality improvement efforts is important for success.
    - Providers must regularly **solicit patients' concerns** about the care provided and their suggestions for improvement, particularly those that may affect patients' willingness to seek and access behavioral health care (e.g., stigma associated with alcohol and drug use, cultural sensitivity, privacy and confidentiality issues), and use such input to improve the quality of care.
- IMPLEMENT AN ELECTRONIC HEALTH RECORD SYSTEM
    - Development of **interoperable electronic health record systems** is a key area of focus for integration, care coordination, and SUD systems of care. This includes:
        - electronically capturing patient health/treatment-related and other pertinent information in a standardized format

- examining that information to identify gaps in services and areas for improvement
- tracking and monitoring critical patient care information (e.g., key clinical conditions, movement along the SUD continuum of care, patient outcomes)
- communicating key information for care coordination processes
- initiating the reporting of clinical quality measures, program performance, public health information
- using information to engage patients and their families in their care
- allocating resources to acquire and retain staff (e.g., information technology, quality improvement) with expertise to support the system, ensure the privacy and security of patient health information, and analyze data in real-time to help inform decision-making and improve the quality of care.

Chapter 3: Technical Assistance – State and County level

Valerie P. Antonini, M.P.H., Darren Urada, Ph.D., Howard Padwa, Ph.D., and Richard A. Rawson, Ph.D.

UCLA has provided technical assistance to DHCS in its efforts to develop an integrated drug-treatment delivery system in California. This work has included providing strategic planning recommendations in several areas this past year, including the Drug Medi-Cal Organized Delivery System Waiver, ASAM Criteria, 2020 Medi-Cal waiver renewal, Statewide Needs Assessment and Planning, workforce development, developing a vision of the SUD continuum of care, and participation in the DHCS Behavioral Health Forum. In addition, county-level technical assistance was delivered directly to counties, as well as by working with county organizations.

Introduction

As California's 1115 Medicaid waiver (Bridge to Reform) draws to a close, the pending waiver amendment (DMC-ODS waiver) as well as the waiver renewal (Medi-Cal 2020), has the potential to put California at the vanguard of state efforts to build an organized delivery system for the treatment of substance use disorders (SUDs). UCLA, under contract with DHCS, has worked to assist the state and its counties during this process by providing recommendations, evidence-based support, and evaluation services as needed.

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

A. State Level – Strategic Planning efforts
    1. CA DMC-ODS Workgroup and Evaluation Planning
        i. Evaluation Planning
        ii. Survey and Interview Development
        iii. Advisory Group
        iv. County Implementation Plan
        v. 1115 Demonstration Waiver Special Terms and Conditions (STCs)
        vi. ASAM Criteria Technical Assistance
        vii. Santa Clara Case Study
        viii. Training to DHCS staff
    2. 1115 Waiver Renewal Activities
        i. MH/SUDS Integration Task Force
        ii. SBIRT Benefit Technical Assistance
        iii. Workforce Development
    3. Behavioral Health Forum
    4. Statewide Needs Assessment and Planning (SNAP)
    5. Designing a Complete SUD Continuum of Care
    6. Workforce Development

B. County Level –Technical Assistance Activities
    1. California Institute for Behavioral Health Solutions (CIBHS) Consultation

i. ILC Activities
ii. SUD Academy

2. County Behavioral Health Directors Association of California (CBHDA) Consultation

A. State Level – Strategic Planning Efforts

1. DMC-ODS Waiver Preparations and Evaluation Planning

Objective: Provide feedback and technical assistance to the state on the 1115 waiver amendment planning and the associated evaluation.

While DHCS prepared its application for the DMC-ODS waiver, UCLA provided technical assistance to aid DHCS with this task as well as to begin planning for a proposed evaluation of the state's future delivery system among counties, whether they opt in or out of the proposed waiver. In February 2015, UCLA began holding weekly internal meetings to discuss evaluation planning, develop surveys, and discuss responses to the requested technical-assistance activities.

Technical assistance included reviewing draft materials and performing literature searches. In addition, UCLA attended and made presentations at DHCS Drug Medi-Cal Organized Delivery System Waiver Advisory Group (WAG) meetings, as well as the DHCS Behavioral Health Forum. Minutes and presentations from these meetings are posted on the DHCS website (http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-PreviousMeetings.aspx).

Evaluation Planning
In addition to the activities conducted during the WAG meetings, further discussions were held with DHCS to specifically discuss evaluation measures and waiver plans on November 21 and December 9, 2014. UCLA presented the preliminary evaluation design to the WAG in January 2015 for discussion and consideration. Following stakeholder and other expert feedback received between January to March 2015 (WAG, CMS, CBHDA SAPT+ committee, CIBHS, and UCLA), UCLA refined the list of potential performance and outcome measures to be used in the upcoming evaluation of the organized delivery system. UCLA submitted a preliminary evaluation design draft with a timeline and proposed data sources to DHCS on March 20, 2015. If the waiver is approved, the plan will require further adjustments that take into account many unknown factors including, but not limited to which counties opt in and when, identification of control counties, and data availability.

Survey and interview development
In an effort to prepare for implementation of the waiver, if approved, UCLA began developing surveys as part of the DMC-ODS waiver evaluation. Throughout the implementation of the waiver, survey data collection will be a critical component in measuring the waiver's impact on three core components: (1) access to care, (2) quality of care, and (3) coordination/integration of care.

Surveys and key informant interviews will be targeted at the county administrator level as well as the provider level (organization level and site level/service delivery unit). Drafts will be circulated to DHCS for review and approval prior to implementation.

Advisory Group

In addition to being grateful to those who participated in the larger WAG meetings, UCLA is thankful for a number of individuals who have volunteered to serve as an informal advisory evaluation advisory group. This group of California behavioral health county administrators and provider organization representatives has been formed to provide feedback and guidance as needed in the evaluation. Volunteer advisory board members include: Clara Boyden (San Mateo), Wesley Ford (Los Angeles), Victor Kogler (CBHDA), Judith Martin (Sacramento), Steve Maulhardt (COMP), D. J. Pierce (Marin), Albert Senella (CAADPE), Tara Shepherd (Modoc), and Tom Trabin (Alameda). An additional member from a tribal organization is in the process of being identified.

County Implementation Plan

The County Implementation Plan, developed by DHCS, is a document to help DHCS assess a county's readiness to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver and for the counties to determine capacity, access, and network adequacy. The tool draws upon the Special Terms and Conditions and the appropriate CFR 438 requirements. DHCS intends to utilize this document to review and render an approval or denial of a county's participation in the waiver. UCLA reviewed and provided feedback to DHCS on the document, which included guidelines for counties regarding submission of their County Implementation Plan. UCLA submitted feedback to DHCS (M. Perez) on the draft Implementation Plan on January 16, 2015.

1115 Demonstration Waiver Special Terms and Conditions (STCs)

In June 2015, UCLA provided feedback to DHCS (M. Perez) in response to CMS' comments and recommendations following their review of the DMC-ODS waiver amendment package. UCLA feedback was focused primarily on measures identified for the evaluation, and on addressing questions CMS had about the plans for the evaluation.

ASAM Criteria Technical Assistance

The use of American Society of Addiction Medicine (ASAM) Criteria is currently being incorporated into the DMC-ODS waiver activities to improve standardization and efficient SUD treatment assessment, placement, and planning for all Drug Medi-Cal beneficiaries. In January and February 2015, UCLA, with consultant Mady Chalk from Treatment Research Institute (TRI), worked with David Gastfriend, who led in the creation of ASAM software, to organize and deliver a demonstration of the software for DHCS and CBHDA. The video is available here: https://vimeo.com/121265227

In addition, DHCS is exploring options for developing a California ASAM quality audit protocol with Mady Chalk and David Gastfriend. Currently, discussions include an audit protocol to verify whether residential treatment programs for SUDs have the services and staffing necessary to carry out treatment in those settings. A self-assessment checklist is in development to evaluate programs offering treatment service levels 3.1, 3.3, and 3.5.

While the checklist can provide a brief programmatic self-assessment review, the proposed Certification Program, a one-day auditing procedure that validates level of care and assesses quality, must be carried out to ensure that the intensity and nature of clinical and environment support services match the ASAM designated level of care.

TRI recommended that the checklist be used only as an initial step in a larger audit process that is being developed by TRI. The TRI Certification Program for ASAM level(s) of care will: (a) allow payers to assure that their enrollees are receiving the level of care that has been approved for coverage; (b) allow providers to match patient need with available programs and a documented and validated program profile; (c) contribute to the development of a standardized resource for patients and families to review and select programs; and (d) provide a framework and roadmap for all treatment programs to improve the quality of care they deliver. Future plans for ongoing discussion (September 2015 meeting) are pending between TRI and DHCS.

Santa Clara Case Study
Santa Clara County has a system that closely represents the Organized Delivery System envisioned in the waiver. Therefore, UCLA conducted a case study on the Santa Clara County Department of Alcohol and Drugs Services, Adult System of Care, in order to document how Santa Clara implemented their system and what lessons can be learned from their system that other counties may be able to use in their own preparations for the waiver. UCLA visited the county and spoke with a wide array of stakeholders and administrators, produced a summary report, and disseminated that report to DHCS and all counties via the County Behavioral Health Directors Association of California (CBHDA). This report is included in Appendix 1.

Training to DHCS staff
UCLA provided trainings (conducted by Richard A. Rawson) in Sacramento, CA, for the DHCS Prevention, Treatment and Recovery Services and Compliance Divisions on March 20 and June 19, 2015. The purpose of these trainings was to give the staff a scientific foundation to understand SUDs and their treatment.

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2. California's Medicaid Section 1115 Waiver Demonstration Renewal Activities: Medi-Cal 2020

Objective: Provide the state with evidence-based documentation requested for the 1115 waiver renewal and the development of the Medi-Cal 2020 key concepts

With the current 1115 waiver scheduled to expire in October 2015, the state submitted a waiver renewal application to CMS on March 20, 2015, seeking ongoing support of California's efforts to realize the full potential of the Affordable Care Act (ACA). Under this successor 1115 waiver (also referred to as Medi-Cal 2020), the state intends to build on successes from the Bridge to Reform waiver through delivery system and payment transformation, while also focusing efforts

on other critical components of health care reform, such as expanding access, improving quality and outcomes, and controlling costs of care. Below are summaries of how UCLA contributed to the state's process as requested.

MH/SUDS Integration Task Force
UCLA (Darren Urada and Traci Rieckmann) actively participated in the Mental Health/Substance Use Disorder (MH/SUD) Integration Task Force established to inform DHCS on strategies to develop and advance the behavioral health system in California. These efforts culminated in a meeting on November 10, 2014, to discuss and refine proposals on how the 2020 waiver could best facilitate integration of behavioral health with primary care.

UCLA (Urada) was a member of the MH/SUD task force, providing research on promising practices on coordination of care. In addition, UCLA participated in the DHCS briefing activities following the November meeting and contributed to the meeting Summary Report.

SBIRT implementation and benefit technical assistance
UCLA provided technical assistance to DHCS in several areas related to screening, brief intervention, and referral to treatment (SBIRT) implementation and benefit recommendations. UCLA gathered the most recent evidence on the following topics: SBIRT for adolescents (September 2014), SBIRT among medical specialists (emergency departments, prenatal care; February 2015), as well as current literature identified to inform the payment reform revisions of the 1115 waiver (October 2014 and April 2015).

Workforce Development
UCLA provided technical assistance to DHCS for discussion in the 1115 waiver workgroup on workforce development. The latest literature on peer providers, care coordinators, psychiatry and primary care consultation (bi-directional in multiple settings), and cross training were identified and submitted for discussion (December 2014).

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3. Behavioral Health Forum

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. The following subcommittees were established:

- Strengthen Specialty Mental Health and Drug Medi-Cal County Programs and Delivery Systems (Strengthening) Forum
- Coordinated and Integrated Systems of Care for MHSUDS and Medical Care (Integration) Forum
- Coordinated and Useful Data Collection, Utilization, and Evaluation of Outcomes (Data) Forum
- Cost-Effective and Simplified Fiscal Models (Fiscal) Forum

UCLA engaged in all forum subcommittee meetings remotely and presented at two forum meetings discussing SBIRT (October 2014, on Integration) and the next era of behavioral health data (October 2014, on Data). In addition, UCLA contributed to the MH/SUD Task Force summary presentation (January 2015, on Integration).

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4. Statewide Needs Assessment and Planning (SNAP)

Objective: Assist the state in the process of drafting the 2015 SNAP report.

As part of the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant application, DHCS is required to submit a Statewide Needs Assessment and Planning (SNAP) report[11] that addresses the state's current needs with regard to SUD prevention and treatment. Following an in-person meeting and multiple teleconference calls in December 2014 and January 2015, UCLA began collecting information and analyzing data.

UCLA used state and national data from the National Survey of Drug Use and Health (NSDUH) to summarize statewide prevalence and incidence rates, where available, and to provide a further breakdown of prevalence rates by age group for alcohol, tobacco, marijuana and other illicit drugs.

UCLA also provided examples of spotlight counties that are leading the way in the state on integration between health, social support, and prevention systems. UCLA wrote pieces on two counties, Kern and Santa Clara, which are providing innovative models for effective SUD treatment. When available, UCLA anticipates providing further technical assistance with the written report and recommendations.

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[11] http://www.dhcs.ca.gov/provgovpart/Pages/SAPTBLOCKGRANT.aspx

5. Designing a complete SUD Continuum of Care

Objective: Investigate the components that make up a comprehensive organized system of care

As California prepares to develop organized delivery systems for SUDs under the upcoming DMC-ODS waiver, it will be critical for policy makers and administrators to understand the clinical and organizational principles underlying the design and function of organized systems of SUD care. To help guide leaders across the state as they redesign their SUD treatment systems, researchers from UCLA are creating a document outlining the clinical and organizational principles underlying organized systems of SUD treatment and the continuum of specialty SUD services. The document will incorporate findings from the most recent peer-reviewed literature on SUDs and SUD treatment systems, principles gathered from the ASAM Criteria, and information gleaned from detailed discussions with consultants and policy makers who have overseen the development of SUD systems of care in municipalities across the United States.

See Appendix 2 for a working draft of the document that outlines the structure, clinical services, and functioning of an organized system of specialty SUD care.

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6. Workforce Development

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

UCLA continued to investigate issues facing the SUD workforce and recommend strategies to strengthen it. Dr. Richard Rawson presented this update to CIBHS and other stakeholders on March 18, 2015. In summary, the ACA and upcoming DMC-ODS waiver will have a major impact on SUD service delivery in California. The SUD workforce will evolve into two distinct workforces: (1) Integrated Behavioral Health, and (2) Specialty SUD Continuum of Care. In both systems, the SUD workforce will need to shift toward providing evidence-based care. Care in both systems will be part of a bigger system of care: (1) Integrated Behavioral Health, which will be part of the overall medical system, and (2) Specialty SUD Care, which will be an organized system of SUD care.

The future SUD workforce will need to appreciate that they are part of a larger service delivery system; they will no longer be able to provide services in isolation. The current and future SUD workforce will need to be trained to develop core competencies with new knowledge, skills, and attitudes that coincide with the understanding of their role in the future health care system. Critical new skills include: use of ASAM Criteria to conduct patient placement, use of utilization management procedures, use of a meaningful quality assurance process, creation of true community program linkages with all elements of the specialty care continuum (including outpatient methadone programs), and development of more effective intra- and inter-program communication.

An extensive training effort will be required to prepare the workforce for SUD service integration and for creating a functional organized system of SUD care. Without a comprehensive program of training conducted over the next 2–3 years, SUD services will not be successfully integrated with primary care and SUD services will not successfully function as an organized system of care.

Slides from this presentation can be found here:
http://uclaisap.org/slides/presentations-rawson.html

B. County Level – Technical Assistance Activities

The level of preparation for and implementation of behavioral health integration varies dramatically across California's counties. Counties requested assistance on many topics, including SUD evidence-based practices, models of collaboration, co-occurring disorders, performance and outcome measurement, and adolescent treatment strategies. UCLA provided technical assistance (TA) to counties when requested and as resources and expertise allowed. Depending on the request, technical assistance was conducted via phone, email, or by scheduling a training event. Other mechanisms in which TA was provided included through the California SUD/Health Care Integration Learning Collaborative (ILC; see Chapter 2 for further information) and by consultation to the California Institute for Behavioral Health Solutions (CIBHS) and County Behavioral Health Directors Association of California (CBHDA). In this section, UCLA reports on additional county-level technical assistance provided to the CIBHS and CBHDA, as well as direct responses to county requests.

1. CIBHS Consultation

The CIBHS Care Coordination Collaborative (CCC) was organized to improve the health outcomes of individuals with complex needs through care coordination. UCLA joined the CCC core team to bring SUD expertise to the collaborative in August 2013. Participation consisted of attending and contributing to routine in-person meetings as well as weekly tele-conference calls (e.g.: core team, team lead, and planning group meetings). UCLA provided the collaborative with technical assistance on SUD and behavioral health integration issues, with an emphasis on SBIRT, outcome measurement, and the upcoming DMC-ODS waiver. The last collaborative meeting convened in March 2015 and a summary report of the year's activities is in development at CIBHS (http://www.cibhs.org/care-coordination-collaborative-ccc).

In addition, UCLA experts presented as key speakers during the CIBHS SUD Academy to educate and inform CIBHS on current SUD issues, practices, and strategies for development. UCLA speakers included Richard A. Rawson, Thomas Freese, Darren Urada, and Jim Peck. Topics included motivational interviewing, SBIRT, evidence-based practices and other promising practices, medical marijuana, the prescription opiate problem, harm reduction

principles and practices, person-centered care and SUD services in primary care, SUD data issues, and criminal justice issues.

2. CBHDA Consultation

On July 1, 2014, the California Mental Health Directors Association (CMHDA) and the County Alcohol and Drug Program Administrators Association of California (CADPAAC) became the County Behavioral Directors Association of California (CBHDA). Building on previous work for CADPAAC, UCLA contributed to discussions and provided technical assistance as requested to the CBHDA SAPT+ committee meetings (December 2014, March 2015, and June 2015). UCLA's contributions have focused significantly on topics related to the DMC-ODS waiver preparations and evaluation-planning strategies. Most recently, UCLA facilitated discussion among the DMC-ODS waiver Phase 1 counties addressing the issues, challenges, and expectations at the county level for the upcoming waiver activities. (See Chapter 2, ILC meeting #44).

3. Other County-Level Technical Assistance

In addition to conducting training events, hosting the ILC, and evaluating select county evolutions (as resources allowed), UCLA also provided direct support to county- and/or provider-level leadership via email or phone communications. These include:

- Kern County: UCLA provided a brief research review on costs and outcomes associated with SBIRT and integrated care for SUDs to Kern County providers (October 23, 2014).
- Yolo County: Darren Urada provided information on performance and outcome measures in order to support Yolo County's efforts to develop such measures. Darren Urada sent materials/documents/reports and a summary. He also provided ideas for other measures and how those measures could be used for various modalities (April 22, 2015).
- San Diego: Darren Urada provided technical assistance to San Diego County Behavioral Health Services regarding performance measures for the AB 109 population to help define outcomes for that population that are meaningful to the public and policymakers (April 8, 2015).
- Madera: UCLA sent resources on evidence-based practices for the delivery of co-occurring disorder treatment (May 8, 2015).
- Merced: UCLA sent resources on evidence-based practices for the delivery of co-occurring disorder treatment (May 8, 2015).
- Riverside: UCLA sent resources on evidence-based practices for the delivery of co-occurring disorder treatment (May 21, 2015).

Chapter 4: County/Provider-level Training Activities

Valerie P. Antonini, M.P.H.

Over the past year, UCLA Integrated Substance Abuse Programs (UCLA) provided trainings and technical assistance to facilitate integration across the state. This included in-person trainings, webinars, and technical assistance to counties. Training and technical assistance needs persist throughout the state and will continue to persist as health care reform is implemented.

A. Training Topics and Events

Trainings were conducted throughout California from July 1, 2014–June 30, 2015, on topics relevant to integration. Below are descriptions and objectives for each major topic area, followed by a complete listing of training activities. 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 extended health insurance to many 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 (MH) care system. Trainings in this category 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 that practitioners had regarding health care reform were addressed, and several specific models and strategies for providing integrated behavioral health and primary care/general health services were presented.

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 synthetic drugs are constantly changing, our knowledge of them 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 their 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 their use, discussed the acute and chronic effects of synthetic drug use, and provided information on how to identify and assess synthetic drug users. The presentation concluded with a brief discussion of the clinical implications of synthetic drug use. At the end of the presentation, 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 (SUDs) 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 in the treatment of individuals with alcohol-related injuries. SBIRT also has 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 the effective use of the FLO (Feedback; Listen and Understand; Options Explored) brief intervention. Core clinical components that were 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 DHCS 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 MH 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. Regarding individuals identified to be at high risk for an alcohol use disorder, we taught providers how to motivate such 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 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 (indications for its use, 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.

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

List of Trainings Conducted
July 1, 2014 – June 30, 2015

Name of Training	Location/Date of Training	Trainer(s)	Number of Participants	Back-up Documents	Funding Source*
Integration Strategies					
SAPC Quarterly Lecture Series: Process Improvement, SBIRT, and Other Innovative Tools for Integrated Care Delivery	Alhambra, CA (Los Angeles Co) September 12, 2014	Beth Rutkowski, M.P.H.	61	Flyer and PPT slides	4
11th Statewide Conference: Integrating Substance Use, Mental Health, and Primary Care Services in Our Communities	Universal City, CA (Los Angeles Co) October 22-23, 2014	Multiple	911	Agenda/program and PPT slides	3
SAPC Quarterly Lecture Series: Integrated Health Services and Medication-Assisted Treatment	Alhambra, CA (Los Angeles Co) March 13, 2015	Thomas E. Freese, Ph.D., and Gary Tsai, M.D.	91	Flyer, agenda, and PPT slides	4
Coping with Hope 2015: Coping with Change	Los Angeles, CA (Los Angeles Co) May 13, 2015	Multiple	150	PPT slides	4
Co-Occurring Substance Use and Mental Health Disorders across the Lifespan	Sonora, CA (Tuolumne Co) June 26, 2015	Andrew Kurtz, M.A., M.F.T.	36	Flyer and PPT slides	1

Synthetic Drugs					
Will They Turn You into a Zombie: What Behavioral Health Clinicians Need to Know about Synthetic Drugs	Webinar (ATTC iTraining Series) November 20, 2014	Beth Rutkowski, M.P.H.	209	PPT slides	4
Screening, Brief Intervention, and Referral to Treatment (SBIRT)					
CATES 2014: Screening, Brief Intervention, and Referral to Treatment	Fairfield, CA (Solano Co) July 9, 2014	James Peck, Psy.D.	33	PPT slides	3
SBIRT Training	Rialto, CA (San Bernardino Co) July 10, 2014	Sherry Larkins, Ph.D., and Grant Hovik, M.A.	32	Agenda and PPT slides	3
SBIRT Training	Los Angeles, CA (Los Angeles Co) July 15, 2014	James Peck, Psy.D.	20	Agenda and PPT slides	3
CATES 2014: Screening, Brief Intervention, and Referral to Treatment	Santa Ana, CA (Orange Co) July 21, 2014	James Peck, Psy.D., and Grant Hovik, M.A.	132	PPT slides	3
CATES 2014: Screening, Brief Intervention, and Referral to Treatment	Merced, CA (Merced Co) August 4, 2014	James Peck, Psy.D.	33	PPT slides	3
CATES 2014: Screening, Brief Intervention, and Referral to Treatment	Quincy, CA (Plumas Co) August 20, 2014	James Peck, Psy.D., and Grant Hovik, M.A.	35	PPT slides	3
SBIRT Training	Santa Barbara, CA (Santa Barbara Co) August 26, 2014	Joy Chudzynski, Psy.D.	31	Flyer and PPT slides	3
SBIRT Training	Santa Rosa, CA (Sonoma Co) August 26, 2014	Beth Rutkowski, M.P.H.	44	Flyer and PPT slides	3
SARC 2014: Screening, Brief Intervention, and Referral to Treatment	Sacramento, CA (Sacramento Co) September 9, 2014	Thomas E. Freese, Ph.D., and Beth Rutkowski, M.P.H.	45	Flyer and PPT slides	3
SARC 2014: Screening, Brief Intervention, and Referral to Treatment	Sacramento, CA (Sacramento Co) September 10, 2014	Thomas E. Freese, Ph.D., and Beth Rutkowski, M.P.H.	27	Flyer and PPT slides	3
SBIRT Training	San Francisco, CA (San Francisco Co) September 10, 2014	James Peck, Psy.D.	20	PPT slides	3
SARC 2014: Screening, Brief Intervention, and Referral to Treatment	Los Angeles, CA (Los Angeles Co) September 16, 2014	James Peck, Psy.D., and Joy Chudzynski, Psy.D.	44	Flyer and PPT slides	3

SBIRT Training	San Francisco, CA (San Francisco, Co) September 17, 2014	Sherry Larkins, Ph.D.	20	Flyer and PPT slides	2
SARC 2014: Screening, Brief Intervention, and Referral to Treatment	Los Angeles, CA (Los Angeles Co) September 17, 2014	James Peck, Psy.D.	48	Flyer and PPT slides	3
SBIRT Training	Santa Monica, CA (Los Angeles Co) September 17 and September 24, 2014	Joy Chudzynski, Psy.D.	17	PPT slides	3
SBIRT Training	San Francisco, CA (San Francisco, Co) September 18, 2014	Sherry Larkins, Ph.D.	17	Flyer and PPT slides	2
SBIRT Training	Riverside, CA (Riverside Co) September 19, 2014	Sherry Larkins, Ph.D.	58	Flyer and PPT slides	3
SBIRT Training	Fresno, CA (Fresno Co) September 25, 2014	Joy Chudzynski, Psy.D.	91	Flyer and PPT slides	3
SBIRT Training	Napa, CA (Napa Co) September 26, 2014	Sherry Larkins, Ph.D.	51	Flyer and PPT slides	3
SBIRT/MI Training	Grass Valley, CA (Nevada Co) September 29, 2014	James Peck, Psy.D.	60	Flyer and PPT slides	2
DHCS Integration Forum – SBIRT Panel	Webinar October 2, 2014	Beth Rutkowski, M.P.H.	50+	PPT	3
SBIRT Training	Universal City, CA (Los Angeles Co) October 23, 2014	Joy Chudzynski, Psy.D.	95	Flyer and PPT slides	3
SBIRT Training	El Centro, CA (Imperial Co) November 17, 2014	Beth Rutkowski, M.P.H.	40	Flyer and PPT slides	3
SBIRT Training	Oakland, CA (Alameda Co) November 18, 2014	James Peck, Psy.D.	36	Flyer and PPT slides	3
SBIRT Training	Whittier, CA (Los Angeles Co) November 18, 2014	Joy Chudzynski, Psy.D.	49	Flyer and PPT slides	3
SBIRT Training	San Marcos, CA (San Diego Co) November 18, 2014	Beth Rutkowski, M.P.H.	13	Flyer and PPT slides	3
SBIRT Training	Scotts Valley, CA (Santa Cruz Co) November 19, 2014	James Peck, Psy.D.	14	Flyer and PPT slides	3
SBIRT Training	Orange, CA (Orange Co) December 2, 2014	James Peck, Psy.D.	66	Flyer and PPT slides	3
SBIRT Training	Los Angeles, CA (Los Angeles Co) December 10, 2014	James Peck, Psy.D.	47	Flyer and PPT slides	3

SBIRT Training	Los Angeles, CA (Los Angeles Co) January 13, 2015	Sherry Larkins, Ph.D.	73	Flyer and PPT slides	3
SBIRT Training	Chico, CA (Butte Co) January 14, 2015	James Peck, Psy.D.	13	Flyer and PPT slides	3
SBIRT Training	Rialto, CA (San Bernardino Co) January 27, 2015	Sherry Larkins, Ph.D.	52	Flyer and PPT slides	3
SBIRT Training	Bakersfield, CA (Kern Co) January 29, 2015	Thomas E. Freese, Ph.D.	74	Flyer and PPT slides	1
SBIRT Training	Long Beach, CA (Los Angeles Co) February 4, 2015	James Peck, Psy.D.	55	Flyer and PPT slides	3
SBIRT Training	San Jose, CA (Santa Clara Co) February 10, 2015	James Peck, Psy.D.	49	Flyer and PPT slides	3
SBIRT Training	Martinez, CA (Contra Costa Co) February 11, 2015	James Peck, Psy.D.	47	Flyer and PPT slides	3
SBIRT Training	Alhambra, CA (Los Angeles Co) February 18, 2015	James Peck, Psy.D.	26	Flyer and PPT slides	3
SBIRT Training	Orange, CA (Orange Co) February 19, 2015	Sherry Larkins, Ph.D.	76	Flyer and PPT slides	3
SBIRT Training	San Jose, CA (Santa Clara Co) February 23, 2015	James Peck, Psy.D.	42	Flyer and PPT slides	3
SBIRT Training	Bakersfield, CA (Kern Co) February 24, 2015	Joy Chudzynski, Psy.D.	46	Flyer and PPT slides	3
SBIRT Presentation for CHLA Social Workers	Hollywood, CA (Los Angeles Co) March 5, 2015	Thomas E. Freese, Ph.D.	17	PPT slides	4
SBIRT Training	Los Angeles, CA (Los Angeles Co) March 17, 2015	James Peck, Psy.D.	90	Flyer and PPT slides	3
SBIRT Training	West Sacramento, CA (Sacramento Co) March 24, 2015	James Peck, Psy.D., and Andrew Kurtz, M.A., M.F.T.	69	Flyer and PPT slides	3
SBIRT Training	Modesto, CA (Modesto Co) March 25, 2015	James Peck, Psy.D.	42	Flyer and PPT slides	3
SBIRT Training	San Francisco, CA (San Francisco Co) March 25, 2015	Andrew Kurtz, M.A., M.F.T.	39	Flyer and PPT slides	3
SBIRT Training	Los Angeles, CA (Los Angeles Co) March 31, 2015	Andrew Kurtz, M.A., M.F.T.	30	Flyer and PPT slides	3
SBIRT Training	Sylmar, CA (Los Angeles Co) April 9, 2015	Andrew Kurtz, M.A., M.F.T.	52	Flyer and PPT slides	3

SBIRT Training	Redding, CA (Shasta Co) April 15, 2015	James Peck, Psy.D.	31	Flyer and PPT slides	3
SBIRT Training	Oakland, CA (Alameda Co) April 23, 2015	Andrew Kurtz, M.A., M.F.T.	68	Flyer and PPT slides	3
SBIRT Training	San Diego, CA (San Diego Co) April 28, 2015	Andrew Kurtz, M.A., M.F.T.	62	Flyer and PPT slides	3
Los Angeles County Annual Drug Court Conference (SBIRT Plenary Session)	Los Angeles, CA (Los Angeles Co) May 14, 2015	Sherry Larkins, Ph.D.	220	Agenda and PPT slides	3
SBIRT Training	Rialto, CA (San Bernardino Co) May 14, 2015	Andrew Kurtz, M.A., M.F.T.	68	Agenda and PPT slides	3
SBIRT Training	Merced, CA (Merced Co) June 2, 2015	James Peck, Psy.D.	22	Agenda and PPT slides	3
SBIRT/UNCOPE Plus Training	San Leandro, CA (Alameda Co) June 10, 2015	Thomas E. Freese, Ph.D., and Andrew Kurtz, M.A., M.F.T.	45	PPT slides	3
Medication-Assisted Treatment (MAT)					
Demystifying Opioid Addiction (Buprenorphine Update)	Webinar October 29, 2014	Beth Rutkowski, M.P.H., and Todd Korthuis, M.D.	131	PPT slides and webinar recording	4
11th Annual Training and Educational Symposium (COMP)	Los Angeles, CA (Los Angeles Co) November 13, 2014	Multiple	153	Flyer, Agenda, and PPT slides	4
Medication-Assisted Treatments Approaches for Opioid Addiction	Placerville, CA (El Dorado Co) January 27, 2015	Thomas E. Freese, Ph.D.	38	Flyer and PPT slides	3
CDCR Staff Development Training Series: Co-Occurring Disorders and Medication-Assisted Treatment Approaches	Sacramento, CA (Sacramento Co) February 20, 2015	Thomas E. Freese, Ph.D.	43	PPT slides	3
SAPC Quarterly Lecture Series: Integrated Health Services and Medication-Assisted Treatment	Alhambra, CA (Los Angeles Co) March 13, 2015	Thomas E. Freese, Ph.D., and Gary Tsai, M.D.	98	Flyer, agenda, and PPT slides	4
Motivational Interviewing					
Effecting Change through the Use of Motivational Interviewing	Hollywood, CA (Los Angeles Co) July 8, 2014	Joy Chudzynski, Psy.D.	15	Flyer, agenda, and PPT slides	3

Effecting Change through the Use of Motivational Interviewing	Rialto, CA (San Bernardino Co) July 15, 2014	Joy Chudzynski, Psy.D.	155	Agenda and PPT slides	2
Effecting Change through the Use of Motivational Interviewing	Napa, CA (Napa Co) September 25, 2014	Sherry Larkins, Ph.D.	60	PPT slides	3
SBIRT/MI Training	Grass Valley, CA (Nevada Co) September 29, 2014	James Peck, Psy.D.	60	Flyer and PPT slides	2
CDCR Staff Development Training: Motivational Interviewing and Cognitive Behavioral Therapy	Sacramento, CA (Sacramento Co) October 13, 2014	Thomas E. Freese, Ph.D.	45	PPT slides	3
Motivational Interviewing Training of Trainers	Pomona, CA (Los Angeles Co) December 15-16, 2014	Thomas E. Freese, Ph.D., James Peck, Psy.D., and Andrew Kurtz, M.A., M.F.T.	17	PPT slides	3
Effecting Change through the Use of Motivational Interviewing	Costa Mesa, CA (Orange Co) January 21, 2015	Thomas E. Freese, Ph.D.	22	PPT slides	3
Effecting Change through the Use of Motivational Interviewing	Pomona, CA (Los Angeles Co) January 27, 2015	James Peck, Psy.D., and Andrew Kurtz, M.A., M.F.T.	17	PPT slides	3
Effecting Change through the Use of Motivational Interviewing	Orange, CA (Orange Co) February 24, and March 2, 2015	James Peck, Psy.D., and Andrew Kurtz, M.A., M.F.T.	18	PPT slides	3
Integrated Interventions: Using Motivational Interviewing when Working with Youth with Co-Occurring Disorders	Westwood, CA (Los Angeles Co) March 6, 2015	Thomas E. Freese, Ph.D., and Andrew Kurtz, M.A., M.F.T.	10	PPT slides	4
Effecting Change through the Use of Motivational Interviewing	Riverside, CA (Riverside Co) March 9, 2015	James Peck, Psy.D.	51	Flyer and PPT slides	1
CDCR Staff Development Training: Effecting Change through the Use of Motivational Interviewing	Sacramento, CA (Sacramento Co) April 27, 2015	James Peck, Psy.D.	24	PPT slides	3

Effecting Change through the Use of Motivational Interviewing	Commerce, CA (Los Angeles Co) June 15, 2015	Thomas E. Freese, Ph.D., Andrew Kurtz, M.A., M.F.T., and Grant Hovik, M.A.	98	Flyer and PPT slides	1
Effecting Change through the Use of Motivational Interviewing	Stockton, CA (San Joaquin Co) June 25, 2015	Andrew Kurtz, M.A., M.F.T.	83	Flyer and PPT slides	1
Ethics and Confidentiality					
Law, Ethics, and Confidentiality Issues in Substance Use Disorder Treatment	San Mateo, CA (San Mateo Co) October 7, 2014	James Peck, Psy.D.	55	Agenda and PPT slides	2
Ethical and Confidentiality Issues in Substance Use Disorder Treatment	Fresno, CA (Fresno Co) May 4, 2015	James Peck, Psy.D.	108	Flyer, agenda, and PPT slides	2
Confidentiality Issues and Boundaries in Substance Use Disorder Treatment Settings	Pleasant Hill, CA (Contra Costa Co) June 3, 2015	James Peck, Psy.D.	57	Flyer, agenda, and PPT slides	2
CDCR Staff Development Training Series, Training #5: Ethics, Dealing with Difficult Clients, and Process Improvement Strategies	Sacramento, CA (Sacramento Co) June 22, 2015	James Peck, Psy.D.	16	PPT slides	3

*Funding Source Key:

Code	Funding Source
1	ETTA Contract
2	UCLA's agreement with ADPI/CIBHS (for a separate TA contract funded by CA DHCS)
3	Separate state-, county-, or agency-based training contract (e.g., SARC, DHCS SBIRT, CDCR, etc.)
4	Separate funding from NIDA or SAMHSA

Chapter 5: Report Conclusions and Recommendations

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Final Report Conclusions

In 2014, health care coverage for substance use disorder (SUD) and mental health (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, it was only a step. 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." Aside from some increases in narcotic treatment program (NTP) treatment, analyses seem to have confirmed that the Medi-Cal expansion has not resulted in substantial increases in specialty SUD treatment admissions in California yet, due, in part, to challenges in certifying or recertifying treatment programs so that they can participate in Drug Medi-Cal, the need for workforce development, and restrictions on the use of Drug Medi-Cal for residential treatment.

There is reason for optimism, however. The Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver proposed by the California Department of Health Care Services (DHCS) provides the state with a tremendous opportunity to address and potentially overcome challenges previously discussed in our reports, including appropriate patient movement through a continuum of care, use of evidence-based practices, coordination with primary care, training and technical assistance, telehealth, and overcoming the Institute for Mental Disease exclusion caps on the number of beds in residential facilities.

Also, there are useful models around the state for success at both the county level (e.g., Santa Clara County) and at the provider level (e.g., Baker Place, Tarzana Treatment Centers, and Empire Recovery Center). Our reports have reviewed these.

Delivery of behavioral health in primary care settings outside of specialty care is also extremely important in order to reach a broader population and treat patients who do not wish to participate in specialty care due to the stigma or logistical hurdles involved. Challenges to delivering integrated SUD treatment included financing behavioral health in primary care settings, workforce shortages, and health information technology challenges. Current legislative efforts are seeking to address some of these challenges.

Measuring actual progress toward service expansion and integration will require advances in existing and new data systems and measures to assess treatment access, quality, cost, and integration.

In support of the ongoing efforts to reconfigure and improve California's delivery of SUD services, the following is a review of the recommendations contained in this report, in addition to recommendations from our previous two reports that are still relevant and necessary.

Recommendations

STATE-LEVEL RECOMMENDATIONS

TRAINING AND WORKFORCE DEVELOPMENT

1. ***Build and support the development of the workforce that provides SUD-related services in both specialty care and integrated care settings.***

    a. For the workforce that delivers services in specialty SUD treatment settings:

        i. Provide training and technical assistance on the anticipated Organized Delivery System-Drug Medi-Cal waiver in counties that participate in the waiver. In particular, these activities should focus on familiarizing providers with the ASAM Criteria and how they can be utilized to inform treatment placement and treatment planning.

        ii. Further develop curricula and trainings in content areas relevant for staff delivering services in specialty SUD treatment settings. Topics for curricula and trainings should include: (1) Motivational Interviewing, (2) Cognitive Behavioral Therapy, (3) Relapse Prevention, (4) Trauma-Informed Treatment, (5) Psycho-education, (6) Medication-Assisted Treatment, (7) Cultural Competence, (8) Chronic Pain and Substance Use, (9) Detection and Management of Infectious Diseases Associated with SUDs, Such as HIV and Hepatitis C, and (10) The ASAM Criteria and How They Can Be Utilized to Inform Treatment Placement and Treatment Planning.

    b. For the workforce that delivers SUD services in integrated care settings as mental health/SUD generalists:

        i. Provide training and technical assistance on team-based care models.

        ii. Further develop curricula and trainings in content areas relevant to the behavioral health workforce that will be delivering MH- and SUD-related services in medical settings. Topics for curricula and trainings should include: (1) Providing Behavioral Health Care in a Primary Care Setting: Culture, Needs, and Interdisciplinary Collaboration, (2) Understanding Chronic Medical Diseases: Basic Physiology, Terminology and Treatment Strategies, (3) Understanding Common Mental Health Disorders – Identification and Intervention, (4) Medical Interventions for Substance Use, Physiology of Drug of Abuse, and Medication-Assisted Treatment, (5) Care Management of Patients in a Multi-Service Setting. (7) Cultural Competence, (8) Understanding the Interaction Between Mental Health, Substance Use, and Common Medical Conditions, and (9) Chronic Pain and Substance Use.

    c. For the workforce that delivers non-behavioral health services in medical settings:

        i. Provide training and technical assistance on team-based care models.

ii. Further develop curricula and trainings in content areas related to behavioral health that are relevant to the non-behavioral health workforce working in medical settings. Topics for curricula and trainings should include: (1) Understanding Mental Health and Substance Use Disorders, (2) Understanding the Interaction Between Mental Health, Substance Use, and Common Medical Conditions, and 3) Chronic Pain and Substance Use.

2. ***Identify steps that can be taken to maintain, build, and strengthen the workforce that treats SUDs, both in specialty care and integrated care settings, and promote these changes when possible though training, technical assistance, and advocacy (for policy improvements):***

    a. Support the inclusion of Marriage and Family Therapists (MFTs) as Medi-Cal billable staff in Federally Qualified Health Centers (FQHCs) in order to begin addressing the shortage of behavioral health staff in integrated care settings. In the current California legislative session, Assembly Bill 858 would make this change.

    b. Consider options to define the role of, certify, and reimburse MH and SUD peer support specialists. For example, examine Senate Bill 614 Medi-Cal (link: Mental Health Services: Peer, Parent, Transition-Age, and Family Support Specialist Certification), which establishes a peer and family support specialist certification program administered by DHCS.

3. ***Direct resources toward training and implementation of evidence-based practices (EBPs), while continuing to monitor fidelity and effectiveness among different settings and populations.***

    a. 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.

FUNDING FOR IMPROVED Health Information Technology

4. ***Advocate for expansion of the Federal Meaningful Use program for behavioral health providers, in order to promote electronic health record (EHR) use among behavioral health providers in California.***

    a. Consider supporting federal legislation that expands the meaningful use incentive program for EHRs to behavioral health. Language found in the "Helping Families in Mental Health Crisis Act" (H.R. 2646 - Murphy), would expand eligibility for Medicaid and Medicare meaningful-use incentive funding to include mental health treatment facilities, psychiatric hospitals, and substance abuse treatment facilities. (Note: H.R. 2646 would make a number of other sweeping changes affecting SUD treatment. This recommendation only pertains to the meaningful-use expansion, not necessarily to the other content of the bill.)

SUD/MH DATA, MEASURES, AND METRICS

5. ***Make pre-formatted CalOMS-Tx reports more easily available to SUD providers on a regular basis (CalOMS-Tx and DATAR) so that they can improve, analyze, and make use of their data to assess their own systems of care.***
    a. Consider sending quarterly reports via e-mail or allow UCLA to generate these and work with counties and providers for data quality assurance and improvement.
6. ***Coordinate efforts between the DMC-ODS waiver evaluation and External Quality Review (EQR) practices to develop quality measures for both youth and adult SUD service delivery systems.***
    a. Counties are seeking guidance in aligning their systems with state-level quality metrics and goals.
7. ***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.***
    a. 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 can assist DHCS with these efforts, if needed.
8. ***Refine measures of utilization***.
    a. As the DMC-ODS waiver begins implementation, it will be very important to have a measure of capacity or, as an alternative, maximum utilization. UCLA is willing to continue to assist on this.
9. ***Address and clarify whether reporting CalOMS-Tx records for patients that DHCS does not pay for directly violates 42 CFR, part 2, privacy rights.***
    a. This, in addition to continued training and education on current data reporting guidelines, will be necessary to improve the quality of data in CalOMS-Tx.
10. ***Further investigate key emerging trends in the data.***
    a. Determine why Black/African American adolescent males and Black/African American young adult females are less likely to be referred to treatment by the criminal justice system relative to other racial/ethnic groups, and whether this represents missed opportunities to provide treatment to either of these groups through criminal justice diversion programs. Interviews of criminal justice and treatment stakeholders, as well as patients, could help to determine the causes of these disparities and may suggest steps to address them.
    b. Examine and address the recent surge in treatment for heroin use. It is likely that this is linked to diminishing access to pain medications. If so, it may be best to focus efforts on addressing this in health care settings, where prescribing practices can be addressed, monitoring for misuse can be implemented, and treatment can ideally be provided on site, potentially with medications such as buprenorphine,

without invoking the stigma of specialty care that may otherwise serve as a barrier to patient participation.

PROVIDER CERTIFICATION AND REIMBURSEMENT

11. Streamline the Drug Medi-Cal Certification process.

a. Counties have expressed concern that delays in the Drug Medi-Cal Certification process have left providers unable to bill Drug Medi-Cal for services and has halted their participation in the continuum of services that are needed for the county's organized delivery systems.

b. We recommend that the DHCS Provider Enrollment Division (PED) explores all reasonable methods of facilitating provider certification. Suggestions brought up by stakeholders that PED may wish to consider include the following:
   i. Expedite certifications for organizations that are already certified under Short-Doyle Medi-Cal.
   ii. Expedite certification of new addresses for organizations that are already Drug Medi-Cal certified.
   iii. Once items in any detailed deficiency letter are satisfied, PED should refrain from raising new unrelated items.
   iv. Follow a standardized approach for site visits that (a) is consistent, regardless of which local office of DHCS is conducting the site visit, and (b) does not include asking for materials that have already been submitted to PED.

12. Increase Drug Medi-Cal reimbursement rates.

a. *Medi-Cal 2020*, the concept paper for renewal of California's Medicaid section 1115 waiver, proposes providing incentives to encourage existing Medi-Cal providers to accept additional Medi-Cal members. Similarly, DHCS should consider increasing Drug Medi-Cal reimbursement rates in order to ensure adequate provider capacity and resources to provide services to meet the needs of the client population.

13. Facilitate billing for two services in the same day in FQHCs (primary care and behavioral health).

a. Reimbursement for same-day medical and behavioral health visits is essential to facilitate "warm handoffs" between the two, but this is an issue that is more complicated than it may, at first, seem. If behavioral health staff are already included in the calculation of the FQHC's Prospective Payment System (PPS) rate, then providing a service on the same day is already accounted for within that rate. However, if they are not included, then adding behavioral health will likely reduce the FQHC's PPS rate. Although the increased number of encounters would mathematically cause FQHC bottom lines to remain the same in this case, anecdotally, it appears FQHCs do not see it this way, and as a result, this is

serving as a perverse incentive that may encourage FQHCs to NOT add behavioral health services. One possible solution to this problem would be to require re-computation of PPS rates at regular intervals (e.g., every few years) so that they accurately reflect the services and costs of the FQHC and FQHCs will no longer be either stuck with a rate that is too low for the services provided or one that is too high and serves as a barrier to adding behavioral health to their scope of services.

STAKEHOLDER ENGAGEMENT

14. Continue to engage stakeholders (e.g., counties and providers) as critical partners to inform the SUD system of care transformation through ongoing and special topic meetings (e.g., Behavioral Health Forum, DMC-ODS waiver advisory group) and to facilitate vital bi-directional communication.

a. Multiple stakeholders, for example, those participating in Phase 1 of the DMC-ODS waiver, have indicated that having a strong relationship and communication with DHCS has been encouraging in their efforts. Stakeholders appreciate the ability to negotiate requirements based on what is realistic and practical for local-level implementation (at the same time, they need more guidance and information to mitigate the amount of uncertainty that exists within the evolving system of care; for example, in regard to the pending DMC-ODS waiver).

COUNTY- AND PROVIDER-LEVEL RECOMMENDATIONS

ORGANIZATIONAL INFRASTRUCTURE

15. Set a clear organizational vision.

a. Strong leadership and communication of a vision of what the organization/department is striving to achieve are critical for any change effort that involves transforming the organizational culture to one in which integrated and coordinated patient care is the norm.

16. Develop a strategic plan with realistic timelines.

a. Efforts to integrate behavioral health services and primary care and to develop organized systems of care are occurring and should be included as part of the organization's/agency's strategic plan. It is important to remember that major changes take time and resources to develop the requisite infrastructures (e.g., staffing, data, communication across disciplines, care coordination, training and technical assistance) and organizational culture.

17. Establish multiple partnerships.

a. Forming multiple partnerships with key stakeholders (e.g., with county departments, providers of various SUD treatment modalities, specialty mental health providers, health plans, recovery support services, and primary care providers) is essential for seamless coordination of patient care.

18. Schedule routine meetings.

a. Ongoing regular and frequent face-to-face communication among stakeholders (e.g., multi-disciplinary team meetings to discuss shared patients, county and treatment provider partnership meetings) is a key element in integration efforts as well as SUD system-of-care improvement efforts.

19. ***Establish a quality improvement plan.***

- A quality improvement process is critical at both the county and provider levels to assure the effectiveness and efficiency of SUD treatment service delivery. This process should include the development of a team that meets regularly, discusses and reviews data (e.g., utilization, capacity, care coordination, quality, cost), and identifies practices that are working and not working, to inform ongoing training and technical assistance activities.
- Designate a coordinator or person to monitor for quality control for both clinical standards and system operation. For example a "Clinical Standards Coordinator" could hold monthly meetings with clinical supervisors or staff to share information (e.g.: performance data, system-wide data) and teach them about new clinical practices, gather information on areas where providers need assistance, and provide case consultation services.

20. ***Try to adopt practices of programs that have been successful in securing referrals from the broader health care system, including Baker Place, Tarzana Treatment Centers, and Empire Recovery Center.***

- The Medi-Cal expansion has not, on its own, resulted in more referrals from the broader health care system. Still, a handful of providers have demonstrated that it is possible to increase those referrals. In a previous report, we described the efforts of programs that have a high number of health care referrals (Urada, 2013, p. 13-15)[12], including the three listed above.

LOCAL-LEVEL TRAINING AND TECHNICAL ASSISTANCE

21. Provide both clinical and administrative training and technical assistance on an ongoing basis.

[12] Urada, D. (2013). Data Analysis: Understanding the Changing Field of SUD Services. In: Evaluation, Treatment, and Technical Assistance for Substance Use Disorder Services Integration 2013 Report, p. 9-23. Prepared for the Department of Health Care Services, California Health and Human Services Agency. Los Angeles: UCLA Integrated Substance Abuse Programs.
http://www.uclaisap.org/assets/documents/California-ADP-DHCS-Evals/2012-2013_ETTA%20Report.pdf

a. Ongoing training and support must be provided on both clinical best practices and administrative/system operations to ensure that staff can be effective in an evolving health care environment.

   i. Clinical best practices could include: evidence-based screening and assessment tools; behavioral interventions and medication-assisted therapies; and care coordination practices

   ii. Administrative/operational trainings could include: Medi-Cal billing requirements and procedures; patient data entry protocols; data report generation and interpretation; patient referral protocols; and privacy policies regarding the exchange of patient information for care coordination.

FUNDING AND OTHER RESOURCES

22. Identify multiple funding sources and other resources, including non-traditional ones, to supplement Medi-Cal and SAPT Block Grant funds to provide services to support the optimal functioning of health care organizations and the SUD system of care.

- For example, partner with universities to hire behavioral health interns. Master's-level interns can provide reimbursable patient care under the supervision of a licensed clinician.
- In addition, partner with other agencies (e.g.: universities, other behavioral health providers, community-based organizations, FQHCs, etc.) to seek grants. Below is a partial list of potential funding opportunities.

   i. Substance Abuse and Mental Health Services Administration (SAMHSA) Funding opportunities (CSAT, CSAP, CMHS) http://www.samhsa.gov/grants

   ii. Patient‐Centered Outcomes Research Institute (PCORI) http://www.pcori.org/funding-opportunities

   iii. California Endowment http://www.calendow.org/grants-and-pris/

   iv. National Institutes of Health (NIH) funding opportunities http://www.drugabuse.gov/funding

   v. Robert Wood Johnson http://www.rwjf.org/en/how-we-work/grants/funding-opportunities.html

   vi. California Wellness Foundation http://www.calwellness.org/about_us/mission_goals_philosophy.php

   vii. Blue Shield Foundation http://www.blueshieldcafoundation.org/grants

HEALTH INFORMATION TECHNOLOGY

23. Implement an electronic health record system.

a. Development of interoperable electronic health records systems is a key area of focus for integration, care coordination, and SUD systems of care. This includes:

i. electronically capturing patient health/treatment-related and other pertinent information in a standardized format

ii. examining that information to identify gaps in services and areas for improvement

iii. tracking and monitoring critical patient care information (e.g., key clinical conditions, movement along the SUD continuum of care, patient outcomes)

iv. communicating key information for care-coordination processes

v. initiating the reporting of clinical quality measures, program performance, public health information

vi. using information to engage patients and their families in their care

vii. allocating resources to acquire and retain staff (e.g., information technology, quality improvement) with expertise to support the system, ensure the privacy and security of patient health information, and analyze data in real time to help inform decision-making and improve the quality of care

STAKEHOLDER ENGAGEMENT

24. Engage key stakeholders, including patients and staff.

a. Engaging stakeholders, including patients and staff, in planning, implementing and evaluating progress (e.g., integration of behavioral health and primary care, SUD system of care transformation) of integration/coordination and/or quality improvement efforts is important for success.

    i. Providers must regularly solicit patients' concerns about the care provided and their suggestions for improvement, particularly those that may affect patients' willingness to seek and access behavioral health care (e.g., stigma associated with alcohol and drug use, cultural sensitivity, privacy and confidentiality issues), and use such input to improve the quality of care.

Appendices

Appendix 1: Creating an Organized Adult System of Care for Substance Use Disorder (SUD) Services: The Experience in Santa Clara County

Summary prepared by Howard Padwa, Ph.D. and Darren Urada, Ph.D.

May, 2015

UCLA Integrated Substance Abuse Programs

Prepared for the Department of Health Care Services

California Health and Human Services Agency

University of California, Los Angeles, Integrated Substance Abuse Programs

Acknowledgments
The authors wish to thank Cheryl Berman, Michael Hutchinson, Bruce Copley, and the staff of the Santa Clara County Department of Alcohol Drug Services, as well as the Santa Clara County providers and other individuals who took the time to share their experience creating an organized system of care.

The opinions, findings, and conclusions stated in this summary are those of the authors, and not necessarily those of the California Department of Health Care Services or the University of California, Los Angeles.

NOTE: Attachments A-G referenced in this report are located online at:
http://www.uclaisap.org/integration/html/learning-collaborative/

Introduction

The implementation of the 1115 Drug Medi-Cal Organized Delivery System Waiver promises to revolutionize the way that publicly-funded substance use disorder (SUD) treatment is structured and delivered across California. Counties that participate in the Waiver will need to organize their Drug Medi-Cal services into a system that provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for SUD services. For most California counties, this will be a daunting task. Traditionally, publicly-funded SUD programs in California have operated independently of one another, without ensuring that services are coordinated or that client flow between levels of care is clinically appropriate. Consequently, SUD services in most counties have not constituted an actual *system*, but rather a patchwork of independent programs and treatment modalities.

One exception can be found in Santa Clara County, which began developing an organized system of SUD care over twenty years ago. In March and April 2015, leaders from the Santa Clara County Department of Alcohol and Drug Services (DADS) and Santa Clara County service providers shared their experience constructing an organized system of SUD care with researchers from UCLA's Integrated Substance Abuse Programs, policymakers from the California Department of Health Care Services, and SUD administrators and program leaders from across California in a webinar and a day-long meeting.

This document outlines the steps that Santa Clara County took to create its system of SUD care, delineates its various components, and lays out considerations for other California counties as they develop their own organized SUD delivery systems tailored to their community's needs.

Development of Santa Clara County's SUD System of Care

In 1994, publicly-funded SUD services in Santa Clara County were not systematically organized or coordinated. The County's SUD services were provided by a mix of directly-operated and contract providers who functioned independently of each other, with no standardization of services, little oversight, and minimal accountability. Access to SUD services was decentralized, with clients often being left on their own to find a treatment program that could meet their needs. Often, judges would mandate individuals to a specific program or level of care, but without appropriate assessment of clients' clinical needs. Furthermore, most treatment programs provided services that were based on their own clinical philosophies and approaches, and utilized a "one size fits all" approach to SUD service delivery. Consequently, many clients fell through the cracks, either because they were unable to access SUD treatment, or because the services they received were incongruent with their clinical needs and personal preferences.

In 1995, administrators from DADS collaborated with treatment providers from both directly-operated and contract agencies to develop a blueprint for a model SUD system and how it would function. They set out to create a roadmap to transform Santa Clara's seemingly "random" array of SUD services into a system of care that offered a continuum of services that clients could utilize for a period of four-to-six months. At the

end of this process, DADS and its collaborators established several principles that would guide the creation of an organized system of SUD care:

- There needed to be a call center to assist clients and place them in the appropriate level of care.
- Residential care needed to simultaneously serve stabilization and program placement functions; in addition to stabilizing clients, residential services would facilitate client discharge to an appropriate outpatient program upon completion.
- Transitional housing was an essential service for many clients.
- If clients needed to access a higher level of care (e.g. move from outpatient to residential), procedures would be in place so that they could make this transition without needing to exit and then re-enter the system of care.

Using these principles as starting points, the County established an "Innovative Partnership"—an open collaboration between DADS and providers—to facilitate the process of transforming Santa Clara's SUD service system. As challenges related to system design and client flow emerged, the Innovative Partnership created "Hot Groups"—subcommittees that included both county and provider staff—to plan and design action steps. Hot Groups brainstormed, tried ideas, and reported findings back to the Innovative Partnership in order to inform the development of DADS' system of care. Hot Group activities helped create and refine screening tools, intake procedures, referral processes, assessment protocols, and policies that facilitated client movement along the DADS continuum of SUD care. According to both DADS administrators and contract providers, collaboration between the County and providers in Innovative Partnerships and Hot Groups was central to assuring the success of transformation; meaningful provider participation ensured provider buy-in into the changes being made to the DADS system, and it also helped improve providers' understanding of the County's expectations as it made major changes to the service delivery system.

In 1995-1996, DADS established a Quality Improvement (QI) team to monitor the effectiveness of its screening and referral procedures, authorize client movement into and through the system of care, and assist in care coordination services that helped clients remain engaged in and flowing through the treatment system. In addition, QI staff provides ongoing technical assistance to support providers' operating as part of the DADS system of care. As explained below, QI continues to play a critical function in maintaining the efficiency and effectiveness of the DADS continuum of SUD services.

Services Offered in the DADS Continuum of Care

Outpatient Counseling is the primary modality offered by DADS, and clients' average length of stay in outpatient services is between three and six months. All outpatient service providers are Drug Medi-Cal certified, though the County also uses other funding streams to support the delivery of outpatient treatment.

Residential Services (RS) are available for clients who need more intensive treatment or supervision. In the DADS continuum, RS serve a dual function, as they a) stabilize clients, and b) provide discharge and linkage services to assure that clients are linked to other services they will need to continue on their road to recovery. The average length of stay in RS is 35 days, though with approval from the County's QI Department, client

stays can be extended. All staff in RS facilities are licensed or certified, and all RS facilities have staff on-call to immediately respond to inquiries, complaints, extension requests, and emergency situations. All RS providers are required to accept and support patients who are receiving medication-assisted treatment.

Transitional Housing Units (THUs) are available for clients who require housing assistance in order to support their safety, health, and recovery. THUs do not provide any formal treatment, and the general expectation is that THU residents will also be actively participating in outpatient treatment during their stay. Clients who successfully complete outpatient treatment may remain in THUs up to a maximum allowable stay determined by the County. Each THU has a resident house manager living on site and provides clients with basic staples, linens, and personal hygiene and household supplies for the duration of their stay. In addition, THUs provide food and beverages, or the ingredients needed to prepare three meals a day, for clients and their families for the first 30 days of clients' stays or until clients find gainful employment. Once employed, clients pay 35% of their net income for THU services. Some of the funds clients receive from food stamps or general relief also help defray the costs of THU services. Clients who are unemployed and/or unable to work because of mental or physical conditions are expected to participate in other productive activities, such as school, training, or volunteer work, during their stays at THUs. Overall, DADS has 300 THU slots.

In addition, DADS offers ***detoxification services*** for clients who are actively using and/or need assistance and supervision in reducing substance use, ***perinatal services*** for pregnant women and mothers of newborn children, school-based and clinic-based ***youth services***, and ***narcotic treatment services*** for clients who are found to have an interest in/need for treatment with methadone, Suboxone®, or Vivitrol®.

System Organization and Flow

Using ASAM to Organize the System of Care: In 2000, DADS began consulting with Dr. David Mee-Lee, the Chief Editor of the ASAM Criteria, to get in-depth, long-term technical assistance on how to structure its system of care. For approximately six months, Dr. Mee-Lee trained both county staff and providers on the ASAM Criteria and its applications on an almost weekly basis. After the initial training period, Dr. Mee-Lee continued providing ongoing trainings every month. According to providers, the regular trainings on ASAM were critical: they conveyed important information; they helped minimize resistance to change since they gave providers support they needed to successfully use ASAM; and they communicated the County's willingness to invest in the process of transforming its service delivery system.

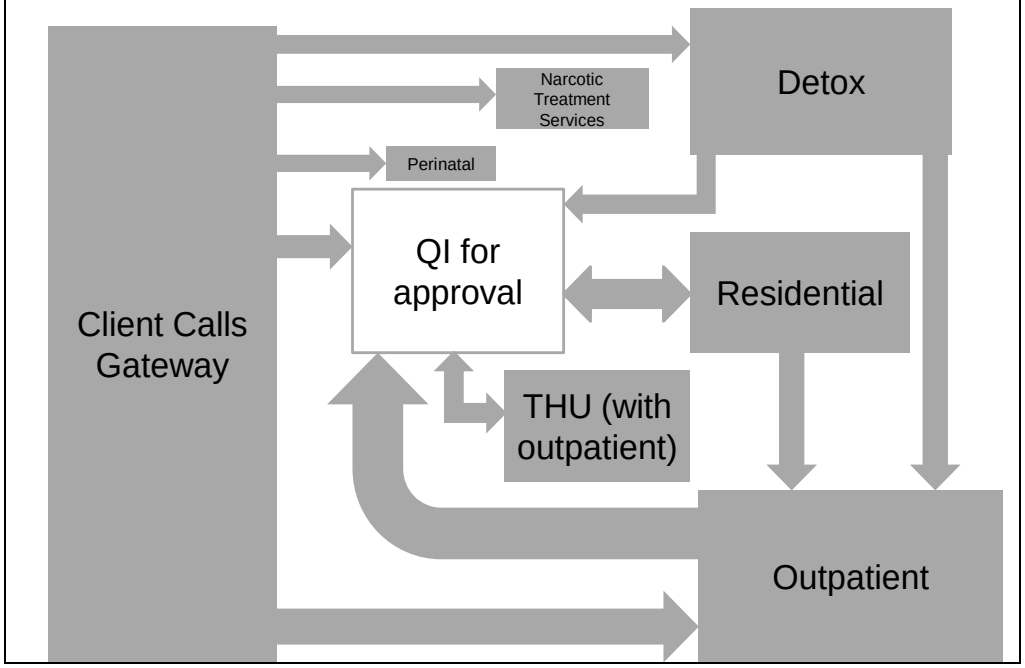
Though DADS does not offer every treatment modality or level of care recommended in the ASAM Criteria, it uses ASAM principles to structure its system of care and procedures related to client placement and flow. In particular, DADS utilizes the six ASAM dimensions to evaluate client needs, place clients in the appropriate level of care, and design treatment plans:

- Dimension One: Acute Intoxication and/or Withdrawal Potential

- Dimension Two: Biomedical Conditions and Complications
- Dimension Three: Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension Four: Readiness to Change
- Dimension Five: Relapse, Continued Use, or Continued Problem Potential
- Dimension Six: Recovery/Living Environment

The flow of clients through the DADS system is illustrated in Figure 1, and explained below.

FIGURE 1
Client Flow through Adult DADS System of Care



Gateway Screening and Placement: Clients enter the DADS system through the Gateway, a toll-free number operated by DADS that conducts brief screening and links clients to the appropriate level of care. The Gateway receives approximately 60,000 calls per year. At the beginning of each call, Gateway operators assure that clients are registered in Unicare (the County's registration/documentation/billing system for mental health and SUD services), and if they are not registered, operators register clients in the system. Operators then conduct an initial assessment over the phone utilizing a "DADS Referral for Services" form (Attachment A) that has four main components: Client Demographic Information, Screening Questions, In Custody/Detox Questions, and Referral. This assessment gathers information on clients' clinical needs and also information that is used to determine what funding sources can be utilized to support client care. Operators are able to refer clients to a crisis hotline or a counselor if the assessment indicates that clients need immediate or emergency services. In consultation with Dr. Mee-Lee, DADS developed decision trees that Gateway staff uses to make referrals based on information gathered during intake (Attachments B-E). According to internal data gathered by DADS, the decision trees are highly accurate, as they lead to correct treatment recommendations 96% of the time based on rates of agreement with full ASAM assessments performed at the provider level. The average intake through Gateway takes approximately 5-6 minutes to complete.

Referral procedures for clients who are not in the correctional system at the time they call Gateway are outlined in Attachments B and C. If clients are referred to outpatient treatment, Gateway staff make intake appointments for clients using an Outlook calendar that has access to the appointment schedules of all outpatient programs that operate as part of the DADS continuum of care. If screenings indicate that clients need

RS or THU services, Gateway operators begin the process of initiating RS/THU services through the Quality Improvement department (see below). In the event a client needs detoxification/withdrawal services, Gateway staff send Detox providers a DADS referral form, and the client calls the provider to check for availability.

A parallel set of procedures is in place for clients who call the Gateway while in custody of the correctional system (see Attachments D-E). To facilitate referrals for these clients, DADS collaborated with the County Jail to set up a dedicated line that individuals in custody could use to call the DADS Gateway line.

When the Gateway system was initiated, it was open 24 hours a day, 7 days a week, and it was staffed by clinicians and counselors. However, the County found that the Gateway did not receive many calls outside of regular business hours, so it decided to limit the Gateway line's hours to 8 AM-5 PM, Monday through Friday. DADS administrators also found that when clinicians and counselors answered the Gateway line, they often wanted to counsel clients directly over the phone instead of quickly and efficiently completing the screening process. Consequently, DADS decided to switch responsibility for answering Gateway calls to clerical staff members, who are appropriately empathic but do not engage clients in long or detailed conversations. Moreover, given the monotony of answering calls all day and the emotional intensity involved in doing intakes, DADS found that it was difficult for any one individual to be answering Gateway calls all day every day, and that burnout was a problem for Gateway staff. To address this problem, DADS altered its staffing strategy for the Gateway line, and has clerical staff and interns answering Gateway calls only part-time.

For clients with special needs or circumstances or who are in specific programs (e.g. Drug Courts, Medical Homes, Re-entry from incarceration), alternative screening services are available in addition to the Gateway line.

Using Quality Improvement to Manage Residential and THU Service Utilization: DADS Quality Improvement (QI) staff—which consists of a mix of clinicians and SUD counselors—play a critical role in managing the DADS system of care. QI staff access real-time data on the capacity and utilization of all levels of care every day, and they use these data to maintain and facilitate client flow through the DADS continuum of care. In addition to monitoring the effectiveness of DADS screening and referral procedures, DADS QI authorizes client utilization of RS and THUs; they review all referrals for RS and THU services from Gateway, Detox providers, and outpatient providers, and they also review requests for RS and THU service extensions. By reviewing all cases, QI assures that the most costly and scarce services offered in the DADS continuum of care (RS and THU) are utilized efficiently.

By tracking RS and THU utilization, QI is able to coordinate care for clients as they transition out of RS into outpatient treatment. Experience taught DADS administrators that most clients needed THU services upon discharge from RS and that waits to get in to THU housing posed a significant challenge for RS clients as they transitioned to outpatient care. To address this issue, QI staff tries to coordinate RS and THU utilization, so that whenever clients leave RS, there is a THU slot available for them to transition to immediately upon discharge. In addition, DADS administrators work to assure that clients are able to get into outpatient treatment at the same time they move

in to THU programs. DADS staff report that this process poses one of the more significant challenges for their system, as wait times for both RS and THU services sometimes persist. In particular, DADS staff report that it is often difficult to contact clients who are waiting for RS and THU services, and that often, they are unable to notify clients that a RS or THU bed has opened up for them. As a result, between 17% and 28% of DADS RS slots are vacant at any given time. However, by systematically tracking and managing utilization of these services, DADS facilitates client flow through its system of care as much as possible, and it currently has Hot Groups working to address barriers that prevent clients from accessing RS slots in a timely manner.

Assessment and Treatment Planning: After being referred through the call center or QI, clients complete a formal intake at their first appointment with their treatment providers. Regardless of treatment modality (outpatient, residential, detox), providers complete formal intakes using the Treatment Assessment form (Attachment F). Assessment forms are explicitly modeled on the ASAM Criteria, requiring providers to evaluate clients' level of severity on each of the six ASAM domains. As part of his work consulting with DADS, Dr. Mee-Lee provided county staff and providers extensive training on how to evaluate clients' severity in each domain. In the event clients face minimal challenges or have problems that are significant but being well-managed in a domain, providers rate clients' severity as "low." In domains where clients are assessed as having "medium" or "high" severity, treatment plans are required to explicitly address client challenges in those areas. Providers reported that it took approximately 6 months for staff to learn how to do assessments appropriately. Currently, assessments take approximately 45-60 minutes and are completed by counselors, who then submit them to supervisors for review before clients begin receiving services. In the event that assessments reveal clients have been referred to the wrong level of care, providers either transfer clients to a different level of care or refer cases to QI for review if RS or THU services are needed.

Keys to Making the System Function

Financing: Since the creation of the continuum of care, DADS administrators have utilized flexible forms of funding to finance services that are not covered by Drug Medi-Cal or inadequately reimbursed by it. Block Grant, AB 109, grants, and County General Funds have been used to support many functions of the system of care and ensure that providers are given appropriate compensation for the services they provide. In particular, the County uses alternative forms of funding to subsidize Drug Medi-Cal reimbursement rates in order to make it financially feasible for providers to operate as part of the DADS system of care.

DADS pools all funding that is distributed to providers and tracks which providers are receiving funding from which funding source; as a result, service providers do not have to take responsibility for tracking funding sources or determining which types of clients are covered for various types of service. Though some grant programs do require providers to enter specific eligibility data, the DADS QI and Finance staff assist providers with most data and reporting requirements; QI and Finance staff are on call during business hours to assist providers with questions about beneficiary coverage, and they offer ongoing technical assistance and supervision for providers if needed. Each provider within the DADS system has a direct contact with a designated QI staff

person who ensures that their questions and concerns about billing and financial issues are addressed in a timely manner. Consequently, providers can focus more on providing client care and less on devoting energy and resources to issues related to eligibility requirements and funding streams.

Contracting: In its contracts, DADS stipulates that providers need to follow countywide rules and procedures that are related to the continuum of care in order to receive county funding. In Requests for Proposals (RFPs) to provide DADS-funded services, DADS lays out minimum requirements for all providers and each level of service, and it stipulates that all contractors must gather data related to DADS performance measures and meet performance standards. In addition, as of January 2016, all providers will be required to utilize electronic health record systems that are capable of electronic data exchange that directly communicates client ASAM and utilization-related data to the County. Until these systems are in place, providers will continue directly inputting data into the county system. RFPs also define performance measures, the scope of services for each level of care, and specific expectations related to ASAM levels of care that providers are expected to meet (see Attachment G). In their proposals, providers are responsible for determining their capacity to provide these services and the funding they will need to meet county standards. Program selection is then based on provider costs for service, client data, and geographic need. To bill, providers are required to enter services into the County's electronic system within five days.

Though providers contracting with DADS need to give up a certain degree of autonomy and adhere to highly specific standards, they also get a significant benefit from contracting with DADS. In contracts, DADS commits to purchase a designated number of program slots, meaning that providers do not have to worry about getting clients or keeping their programs full. In addition, DADS handles issues related to identifying funding sources to support each client's care. Both DADS and providers report that this arrangement is a "fair trade off" and that providers are happy to alter their operations to meet DADS requirements in exchange for the security and administrative assistance that contracting with DADS offers their programs.

Ongoing Training: In addition to providing training on ASAM, DADS has continued offering training in order to ensure that all service providers remain updated on service standards and are trained in the same manner by the same people. Over the years, the County has brought in experts to provide trainings on cognitive behavioral therapy, motivational enhancement, SUD privacy regulations, and other issues and best practices related to SUD treatment. The County began requiring internal certification to assure that everyone working within the system was proficient in key areas. At the end of each training, the County gave brief tests on key concepts, and it issued trainees certificates after they completed all required trainings and tests. Recently, DADS has moved away from this model since state-level certification requirements have changed, but it still offers workshops for new employees.

Considerations for other Counties

For California counties preparing to develop their SUD continuum of care under the 1115 Drug Medi-Cal Organized Delivery System Waiver, there are many lessons learned from the experience in Santa Clara County that can be instructive.

Strong central leadership is important. Engaging providers who are accustomed to operating as their own entities in a coordinated and broader system of care requires significant leadership from county administrators. Santa Clara County led its system-wide transformation by putting concrete cooperative requirements in their RFPs and contracts that covered referrals, data sharing, and meetings, and by establishing a strong centralized QI team to monitor utilization and performance on an ongoing basis.

Providers are critical partners for transformation. Creating a system of care requires providers to significantly alter their administrative and clinical operations. Including providers in system redesign and implementation processes can facilitate transformation by incorporating provider input and maximizing buy-in. Both providers and administrators in Santa Clara County highlighted that having regular meetings between providers and the County can help facilitate and maintain bidirectional communication.

Counties need to use data to make systems of care function. For a system of care to truly function as a system, its operations need to be consistently informed by real-time data. Utilization, performance, and cost data are the lynchpins of system design in Santa Clara County, and information systems and data gathering protocols that facilitate real-time access to information are key to ensuring that county SUD services operate as a cohesive whole. DADS staff regularly engage in data quality checking and training activities in order to assure that the data being used to inform system-wide decisions are as timely and accurate as possible. DADS administrators recommend that for counties beginning to organize their SUD services into a system of care, efforts should be made to establish a data infrastructure that can be used to support system design at the outset. Counties should think about what data will need to be collected and where in order to make their SUD systems function, and they should establish protocols to ensure that all data they need are reportable and usable for administrative functions.

Ongoing training is key. By providing ongoing training to providers, counties can assure that they are proficient in all clinical and administrative matters that are critical to the functioning of the system of SUD care. Furthermore, county investment in training can help keep lines of communication between county administrators and providers open, and reinforces the message that counties are invested in assuring that providers have the knowledge and skills they need to contribute to the SUD system of care.

Funding sources other than Medi-Cal must be braided to make the system function optimally. In Santa Clara County, administrators used flexible funding sources to provide services that were not covered by Medi-Cal or to supplement Medi-Cal reimbursement rates. Though the 1115 Drug Medi-Cal Organized Delivery System Waiver will expand the range of SUD services covered by Medi-Cal, counties may still need to utilize other types of funding to supplement Medi-Cal dollars in order assure the financial viability of their systems of care.

A vision is needed to guide transformation. In Santa Clara, county staff collaborated with stakeholders to envision the key principles to guide the development of the new system of care, and they used these principles to inform system redesign from the outset. Developing a vision statement and/or a set of key principles that are central to

the task of system redesign is an important first step in assuring conceptual clarity for all stakeholders. Vision statements and/or key principles can guide the development of steps counties will take to reform their SUD treatment systems.

Continuous Quality Improvement is critical. Though developing a strong vision for system transformation is important at the outset, it is also critical for counties and stakeholders to continuously monitor progress and make modifications when necessary. In Santa Clara, county policymakers and providers noted that "it is not QA (quality assurance), it's *QI* (quality *improvement*)" and continuously engaged in data monitoring and quality improvement efforts by using process improvement strategies (e.g. those used by the Network for the Improvement of Addiction Treatment, NIATx) to identify and address problems. Throughout the process of designing and implementing an organized SUD system, counties should utilize continuous quality improvement strategies to make adjustments to policies and procedures as needed. In addition, DADS administrators recommended that all quality improvement activities be well-documented, so that lessons learned in the past can be used to inform the development of future policies and procedures.

Quality Improvement needs to be clinical, not just administrative. Throughout the process of transforming into an organized system of care, DADS administrators made sure that the processes of change and quality improvement focused on matters of clinical care as well as administrative functions and system design. To ensure that clinical matters were continuously being monitored and addressed, DADS created a position for a "Clinical Standards Coordinator" to help spark innovation and disseminate clinical practices. The Clinical Standards Coordinator held monthly meetings with clinical supervisors from every provider agency in the County to share systemwide data, teach them about new clinical practices, gather information on areas where providers needed assistance, and provide case consultation services. As one DADS administrator reported, this process was critical in "keeping the Innovative Partnership innovative," and maintaining focus on the long-term goal of improving service delivery and client care. As other counties begin the process of creating organized systems of SUD care, similar steps to assure that structural change is continually guided by ongoing clinical innovation and improvement can help assure both the quality and sustainability of efforts to improve SUD services in the age of health care reform.

Appendix 2: Designing a Complete SUD Continuum of Care

Historically, publicly funded substance use disorder (SUD) treatment systems have treated (SUDs) as acute conditions that can be fully "cured" by completion of one program or treatment modality. Decades of experience and research have shown that this approach is misguided; SUDs are chronic conditions that need to be monitored and managed for a lifetime, and SUD treatment is most effective when it utilizes a stepped care approach that facilitates patient flow to and from higher and lower levels of care as needed. To ensure that clients remain engaged in treatment and successfully transfer between levels of SUD care, it is critical for providers to provide hands-on referral and linkage services. Furthermore, SUD outcomes improve dramatically when services empower clients by giving them effective self-monitoring and self-management strategies that enable them to live full and healthy lives with minimal support. A comprehensive continuum of care for SUD would take all of these factors into account, and maximize both the clinical efficacy and cost effectiveness of SUD services.

A comprehensive continuum of care would be modeled on the principles articulated in the American Society of Addiction Medicine (ASAM) Criteria, which are guidelines for SUD assessment, treatment placement, and service planning. The ASAM Criteria utilize an individualized and holistic assessment that evaluates clients' clinical and psychosocial needs across six dimensions:

1. Acute intoxication/withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, and cognitive conditions/complications
4. Client readiness to change
5. Relapse, continued use, and continued problem potential
6. Recovery/living environment

After assessment, ASAM recommends that clients should be placed in one of five ASAM levels of care: 1) early intervention; 2) outpatient; 3) intensive outpatient/partial hospitalization; 4) residential/inpatient; or 5) medically managed inpatient. Each ASAM level of care has several sub-levels for specific populations with particular treatment needs. Due to the intricacy of ASAM's client placement criteria, a publicly funded SUD service system would probably not be able to offer every level and sub-level of care that ASAM advises. However, it is feasible to design a continuum of specialty SUD care modeled on the same assessment and treatment principles that ASAM recommends, delivering eight services across five levels of care.

Services Offered in an Organized System of Specialty SUD Care

1. *Intake and Treatment Planning:* Intake services are designed to determine if individuals require specialty SUD treatment services and facilitate initiation of an appropriate treatment modality. Information gathered during assessments is also used to inform the development of a treatment plan, which includes: a statement of problems to be addressed in treatment; goals to be reached in order to

address each problem; action steps that providers and patients can take to accomplish treatment goals; target dates for the completion of action steps and goals; and a detailed description of services that will facilitate the achievement of treatment goals. All treatment plans have specific quantifiable goals and treatment objectives that are directly related to SUD diagnoses and other needs identified during the assessment process, and should be updated at least every 90 days.

2. *Withdrawal Management:* For individuals with SUD who are alcohol and/or drug dependent, ambulatory, residential, or medically monitored withdrawal management services assist patients in managing withdrawal symptoms and associated medical and psychiatric complications.

3. *Case Management and Linkage:* Case management services assist patients in accessing medical, educational, social, prevocational, vocational, rehabilitative, and other services within the community. Linkage services prepare patients to transfer to other levels of SUD care, and ensure successful connection of patients to community-based treatment, housing, and human services as needed.

4. *Peer Support:* Peer support services involve having individuals in recovery utilize their lived experience with SUD to provide patients emotional support, knowledge, assistance, and community connections throughout the recovery process.

5. *SUD Counseling*: In SUD counseling, individuals in treatment learn about SUD, identify behaviors and problems related to their substance use, discuss how to cope with substance-related problems, and learn strategies they can use to achieve and maintain recovery from SUD.

6. *Crisis Intervention:* Crisis intervention services make clinicians or SUD counselors available to provide services for patients who have relapsed or experienced an unforeseen even or circumstance that presents imminent threat of relapse.

7. *Collateral Services:* When providing collateral services, SUD counselors and clinicians have face-to-face sessions with significant persons in patients' lives (family members, friends), and collaborate with them to identify ways that they can support patients in achieving treatment goals.

8. *Medication Assisted Treatment (MAT):* MAT services include the ordering, prescription, administration, and monitoring of medications used to treat and manage SUD, and assisting patients in managing SUD medication side effects

Organizing a Continuum of Publicly-Funded SUD Care

Within an organized publicly-funded system of SUD care, the eight service components would be delivered as part of a continuum that includes that provides services tailored

to patients' SUD acuity, their level of medical and psychiatric risk, and their stage in the recovery process. There would be five basic levels of care within the continuum in publicly-funded SUD treatment systems:

1. *Withdrawal Management*: For individuals who require detoxification, withdrawal management services include assessment, medical observation to monitor patients during withdrawal and make adjustments to withdrawal regimens as necessary, and discharge/linkage services. Since withdrawal is a critical first step toward recovery for many patients, a comprehensive continuum of care should include five types of withdrawal services, as recommended by ASAM: 1) Ambulatory withdrawal management; 2) Ambulatory withdrawal management with onsite monitoring; 3) Clinically managed residential withdrawal management; 4) Medically monitored inpatient withdrawal, and; 5) Medically-managed intensive inpatient withdrawal services for individuals with severe and unstable withdrawal symptoms.

2. *Residential Treatment*: Residential services are 24-hour non-institutional, non-medical services are designed to assure that patients are engaged in treatment and prepare them to transition to outpatient treatment. Residential services include the intake and treatment planning, case management, peer support, counseling, crisis intervention, collateral, and, medication assisted treatment SUD service components.

3. *Intensive Outpatient Services*: For patients who have high levels of risk and/or clinical need, intensive outpatient services are provided for nine hours per week or more. Intensive outpatient services include the intake and treatment planning, case management, peer support, counseling, crisis intervention, collateral, and, medication assisted treatment SUD service components.

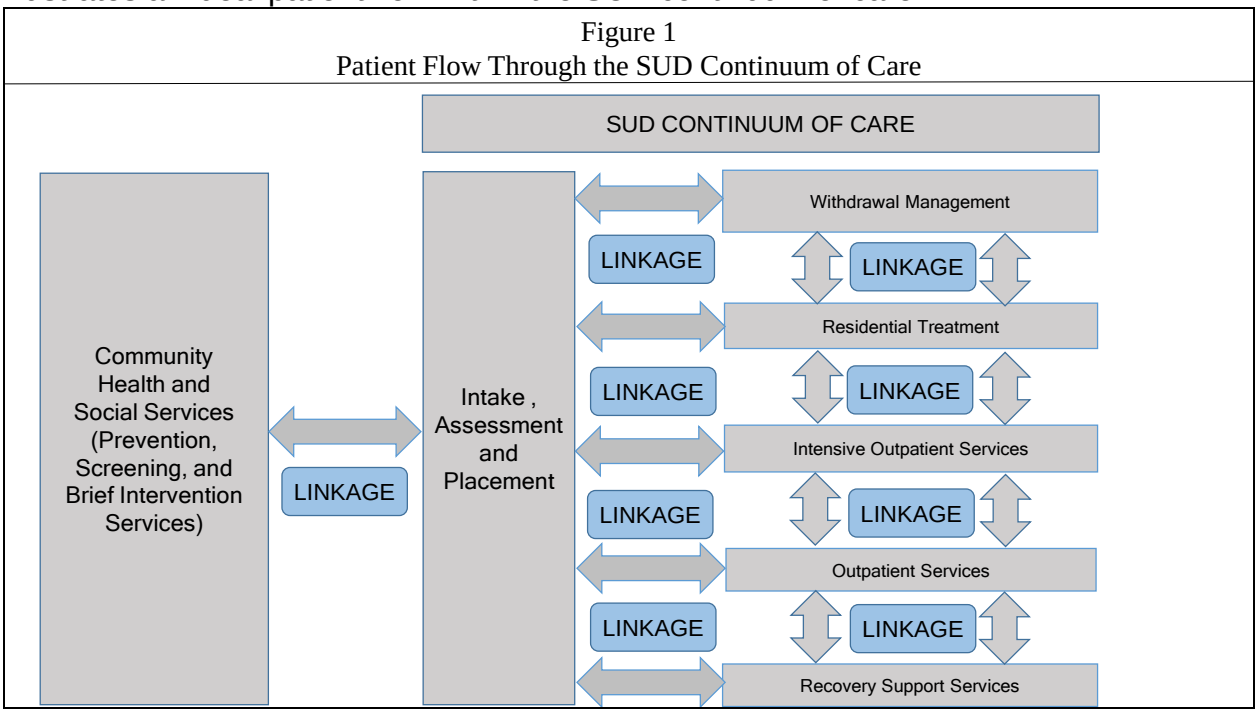
4. *Outpatient Services*: Patients with lower levels of risk or clinical need that do not require intensive outpatient treatment receive outpatient services, which are the same as intensive outpatient programs, but given for less than nine hours per week.

5. *Recovery Support Services*: Patients who have completed all medically necessary treatment modalities and achieved their treatment goals would receive recovery support services to help them maintain their sobriety, health, and other achievements accomplished during treatment. Recovery services focus on empowering clients and preparing them to manage their substance use, health, and well-being independently; they inculcate and reinforce patients' self-responsibility, and equip them with the self-management strategies and community resources needed to thrive without specialty care. Recovery support services include recovery coaching and monitoring, peer support, education and job skills training, family support services, linkages to community-based self-help and support groups, and ancillary services to provide assistance with issues related to housing, transportation, and case management.

How an Organized System of SUD Care Would Function

Services in a SUD continuum of care should facilitate flow to and from higher or lower levels of service based on patients' needs and responses to treatment. Figure 1 illustrates an ideal patient flow within the SUD continuum of care.

Figure 1
Patient Flow Through the SUD Continuum of Care



Patients would receive intake, assessment, and placement services upon entry into the SUD service continuum. Upon completion of the assessment, they would be either placed at an appropriate level of SUD services if they meet diagnostic criteria for SUD, or linked to health or social services for brief intervention services if they do not meet diagnostic criteria for SUD.

Once patients enter the SUD continuum of care, they would flow between levels based on their treatment responses and evolving service needs. For each transition between levels of care, and for their transition into and out of the SUD continuum of care, patients would receive linkage services from a social worker, counselor, case manager, health coach, or peer provider. To ensure that linkages are successful and that patients engage in the next step of their treatment, all linkages would involve a "warm handoff"—a process where staff, the patient, and staff at the next level of care would meet face-to-face and address any concerns the patient has about his or her next step in treatment. When patients are ready to flow out of the SUD continuum, warm handoffs would occur to assure that they are successfully linked to and engaged with whatever health and social services they need to sustain their recovery.

Ideally, patients would flow from more intensive levels of care (withdrawal management, residential treatment) to lower levels of care (outpatient, recovery support), until they can manage their substance use conditions without specialty treatment. However, SUDs are chronic conditions, relapse is common, and it is clinically unrealistic to expect

all individuals to make linear progress toward recovery. Consequently, the SUD continuum of care needs to allow for bidirectional patient flow, to and from levels of care depending on their treatment response and evolving needs.

A SUD continuum of care would be structured to allow for service flexibility as patients progress. Upon completion of each level, patients would be re-assessed to determine the best next step in their treatment. If an assessment determines that a patient is ready to proceed directly to a much lower level of care (e.g. from withdrawal management to outpatient) or that they need to enter a higher level of care (e.g. move from outpatient to residential) patients would have the option to proceed to the level of care best suits their needs. In the event that an assessment determines a patient no longer needs specialty SUD services, patients would be linked to whatever health and social services they need to maintain their recovery without specialty care. Once patients complete this "graduation" from the SUD continuum, they would still be able to re-enter specialty care in the event of a relapse or unforeseen circumstances that put them at risk for relapse.