EVALUATION SERVICES TO ENHANCE THE DATA MANAGEMENT SYSTEM IN CALIFORNIA (EnCAL)

FINAL REPORT 2010–2011

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Executive Summary

Organization of the Final Report

The work presented in this report addresses the objectives of UCLA's contract with ADP entitled Evaluation Services to Enhance the Data Management System in California (EnCAL) and reflects work completed in 2010–2011. This final report is divided into seven chapters including; Chapter 1: Data Systems Improvements: Data Analysis, Chapter 2: California's Forum on Data Privacy and Treatment of Substance Use Disorders, Chapter 3: Integration of Substance Use Disorder (SUD) and Healthcare Services, Chapter 4: Performance Measurement, Monitoring, and Management, Chapter 5: Developing and Financing Recovery Support Services and Linking them with Healthcare and Substance Use Disorder (SUD) Services, Chapter 6: Planning for Prevention and Chapter 7: Organizational Factors.

Chapter 1 Data Systems Improvements: Data Analysis

Unique participant identifiers. The accuracy of the participant identifier currently used by the California Outcomes Measurement System (CalOMS) to uniquely identify individual patients is critical for analyses of this database. However, inconsistent reporting on the following items appear to contribute to errors in the creation of the CalOMS identifier: birth name, birth state, birth county, and mother's name. Technical assistance can address some of the issues, but the best solution would include the use of probabilistic matching algorithms to identify the same person across treatment admissions despite data entry issues. In conjunction with the Department of Alcohol and Drug Programs (ADP), UCLA is working on methods to use such algorithms to improve the accuracy of the CalOMS identifier.

CalOMS Discharge Categories. UCLA worked with ADP and the County Alcohol and Drug Program Administrators' Association of California to improve and clarify CalOMS discharge status categories (e.g. defining treatment completion). The results of these efforts have been published separately as an ADP Bulletin (10-08), and ongoing discussions to monitor and refine categories are continuing.

Transfers. Counties that transfer a high percentage of patients from detoxification to treatment are thought to provide a better continuum of care than counties that do not. UCLA contacted counties that had the highest percentage of such transfers in an effort to identify promising practices. Administrators in these counties reported that detoxification and residential services were co-located in a way that allowed patients to become familiar with the residential program while still in detoxification. In other counties, data quality issues may result in under-reporting of transfers, however, particularly in cases in which patients receive detoxification and treatment from the same facility. In these cases, CalOMS data is not always submitted for each service delivered. To improve data quality, ADP might consider an abbreviated method of providing a CalOMS record when a patient transfers between modalities but stays within the same facility.

Case Mix Adjustment. County transfer rates from detoxification to treatment ranged from 3%-67%, with a median of 17%. However, stakeholders often express concern that their patients are different from those found in other locations, making between-county interpretation difficult. To address this concern, patient "case-mix adjustment" was used to statistically adjust measures for differences in the types of patients found in different counties. The case-mix model increased

the precision very little, however (from 9% to 12% of variance explained). It is possible that the model tested under-adjusted results due to limited data (e.g. lack of diagnostic information in CalOMS). Therefore, it may not be possible to substantially adjust county level performance measures using available CalOMS data. Organizational- and county-level predictors may provide more effective forms of case-mix adjustment.

Additional details and recommendations can be found in chapter 1.

Chapter 2 California's Forum on Data Privacy and Treatment of Substance Use Disorders

California's Forum on Data Privacy and Treatment of Substance Use Disorders brought together policy makers, administrators, treatment provider representatives and researchers to discuss how patient data can be shared to improve substance use disorder treatment quality while complying with federal privacy regulations. The forum specifically addressed key points surrounding how to adhere to the Health Insurance Portability and Accountability Act (HIPAA) and the Code of Federal Regulations, Title 42, Section 2 (42 CFR) when using electronic records to share SUD information. Main discussion points included determining which of the two sets of regulations to follow if they differed, how to establish secure electronic networks to exchange protected health information and how to obtain patient consent to share information for treatment purposes. Attendees also received a presentation on the meaningful use of electronic health records and the successes of and barriers to sharing health records in extant information exchanges.

Next steps for the field include development of standardized consent forms and development of methods to include and exchange consent information in electronic health records, first on a general basis and then applied to individual "bits" of data. Achieving these goals will require the field to engage with software vendors and the initiation of pilot projects to test such data-exchange methods among a limited number of organizations. Additional details and recommendations can be found in chapter 2.

Chapter 3 Integration of Substance Use Disorder (SUD) and Healthcare Services

As practice standards increasingly recommend that people suffering from substance use disorders (SUD) receive integrated treatment, more treatment providers are moving towards integrated services with primary care (PC) and mental health (MH). The SUD treatment field has traditionally been isolated from these systems due to separate funding streams, regulations, histories, and treatment philosophies. The passing of the Affordable Care Act (ACA) and recent guidelines are transforming the way that SUD treatment is delivered to provide more patient-centered, holistic care. One of ADP's priorities, therefore, is to facilitate the integration of SUD services with PC and MH. In an effort to assist counties with integration initiatives, ADP collaborated with UCLA on a number of investigative procedures to evaluate the current environment and promote movement toward integration.

With an initial review of the available literature on this topic, the administration of a statewide county survey on current integration activities and needs, case studies, site visits, and a Forum on Integration, UCLA obtained information to guide research and technical assistance. Collaborative processes to openly disseminate gathered knowledge and to attain information from other activities occurring in the field were initiated through the establishment of a public Integration Website and Integration Learning Collaborative.

Although this work is preliminary, it provides a valuable and unique preview of efforts to integrate specific SUD services into health care settings. There is solid evidence SUD/PC integration can increase access to SUD intervention and treatment, improve clinical outcomes for individuals with SUD service needs, prevent the development of SUDs, and as a result, lead to cost savings across the healthcare system. In spite of the commonalities between SUD and MH services, SUD treatment presents a distinct set of challenges that providers of integrated MH services do not face (such as detecting SUDs and managing some additional systemic and regulatory challenges). Commonly identified barriers for SUD/PC integration have involved financing, documentation, and partnering with PC providers.

Despite identified barriers, some providers have been able to effectively integrate SUD and PC services. Several themes emerged from these efforts. UCLA recommends that the State initiate training opportunities and implement provider competencies, partner with other systems and have a presence in other regulatory agencies, provide funding strategies for integrated care, and facilitate further research on best practices for SUD/MH health care integration. Recommendations more specific to county level leaders include more focused strategies for improving integration initiatives at the local level (e.g. developing adaptable models for integrating services, start small, identify core principles toward integrated care and conduct local outreach efforts, acknowledge the need for a cultural shift among the workforce, etc.). Additional details of these lessons and recommendations can be found in chapter 3.

Chapter 4 Performance Measurement, Monitoring, and Management

Use of Performance Reports in Other States. This chapter provides information on the wide variety of performance measures that are in use or in development in various states. Beyond the measures used, however, research indicates that several key elements are important for the actual implementation of performance measures: the investment of leadership and staff, adaptation and evolution of measures over time, collaboration with consultants and partners, reporting to providers and the public, and addressing data infrastructure needs. A clear lesson identified from those who have taken the lead in this area is that obtaining buy-in and feedback from stakeholders in the dashboard development process is a key aspect to successful implementation. In accord with this, ADP and UCLA plan to obtain feedback from county representatives through the CADPAAC data and outcomes committee, and following this, ADP and CADPAAC will need to discuss next steps in broader stakeholder dissemination.

Los Angeles County: The Los Angeles County Department of Public Health Substance Abuse Prevention and Control (SAPC) initiated work on patient outcome monitoring and program improvement by holding a number of meetings between treatment providers, SAPC, and UCLA. Outpatient counseling was the first program type to receive performance measures, benchmarks, and dashboards. Three performance measures were decided upon: 30-Day Engagement (minimum 80%), 90-Day Retention (minimum 65%), and completed exit interviews (minimum 50%). Reports are posted on a quarterly basis to the same system where providers enter data and view other reports. Providers who fall short of the benchmarks are offered technical assistance, training, and other help in order to improve their performance.

Development of Dashboard Templates for California. Based on information from the national- and local-level work on performance measurement and management, UCLA developed draft

dashboard templates for California's Department of Alcohol and Drug Programs (ADP) to consider for statewide implementation. Separate templates, for detoxification, residential treatment, outpatient treatment, methadone maintenance, and county systems, are included in this chapter. These templates are currently undergoing refinement and testing. Dashboards may help facilitate the integration of the SUD field into the larger healthcare field, where use of dashboards is already more common. UCLA recommends that the dashboard templates be finalized and pilot-tested and/or combined with existing ADP measures of performance.
Access to more detailed "encounter-level" data not currently included in CalOMS-Tx but included in other systems such as Electronic Health Records (EHRs) would enhance performance measurement, management, and contracting efforts. Given that it is easier to implement such performance capabilities in data systems during development than afterward, it will be important for ADP and the SUD field to remain abreast of ongoing changes and provide feedback to relevant organizations engaged in EHR development (e.g., vendors, EHR certifying organizations, SAMHSA) to ensure that future needs are considered. Additional details and recommendations can be found in chapter 4.

Chapter 5 Developing and Financing Recovery Support Services and Linking them with Healthcare and Substance Use Disorder (SUD) Services
The passage of the ACA and recent federal guidelines are transforming the way that SUD services are delivered to provide more patient-centered, holistic care. A number of governmental agencies at the federal level have redirected strategies and initiatives to incorporate Recovery Support Services (RSS) to reduce the impact of substance abuse and mental illness across the United States. UCLA conducted a literature review, key informant interviews, and a survey to conduct an environmental scan of RSS efforts in the state.

The literature supports the benefits of Recovery Support Services (RSS), and most county SUD leaders reported that RSS are crucial to an individual's recovery. Over two-thirds (68%) of counties offered RSS using a variety of workforce and funding strategies. Across counties, services also varied by type, by setting and by staffing model. There is evidence that RSS may reduce the need to rely on more expensive, higher levels of care, but more research is needed on the impact of specific types of RSSs on health outcomes and fiscal savings.

Counties often cited funding barriers to either implement or measure RSS. There is a need for guidance to ensure counties are aware of potential funding opportunities within the future. The workforce providing RSS are typically peers and certified addiction counselors. Training and technical assistance efforts to increase data collection efforts are necessary and may need to be specifically designed for paraprofessionals. Although there is current discussion regarding healthcare reform's impact on licensing and certification requirements, peers and certified addiction counselors may be best utilized in RSS settings. Therefore, if measurement of these services becomes a priority, it is crucial to train the workforce on the specific requirements to collect, enter, and interpret the relevant data elements. Additional details and information on this work can be found within chapter 5 of this report.

Chapter 6 Planning for Prevention
Prevention continues to be a priority to reduce the rates and severity of those with SUDs. The national imperative to expand and integrate prevention strategies as stated through provisions

within the ACA is shifting focus onto prevention services for SUDs. While the distinction between treatment and prevention still remains unclear under health care reform benefits, "Screening and Brief Intervention" (SBI) is being used as an effective integrative vehicle within the two spheres of service.

In an effort to assist local AOD prevention efforts with ADP's Prevention Services Branch and the CADPAAC prevention committee, UCLA conducted a number of investigative and technical assistance activities to ensure that more evidence-based SBI strategies become widely adopted and implemented. In line with their efforts, UCLA worked toward achieving a better understanding of the bridge between treatment and prevention and where and how provisions within the ACA would enhance prevention initiatives for the SUD system.

UCLA recommends that State and county-level prevention stakeholders work with treatment staff through a SBI System Integration Committee to identify similar and diverse areas of cross-system SBI efforts. Within this committee, definitions related to SBI concepts could be clarified (i.e., prevention, early intervention, brief intervention and brief treatment) to establish a clear distinction between what is the role of prevention versus treatment. This type of clarity and ongoing discussion can assist in identified SBI implementation challenges (i.e.: lack of time from professionals, insufficient training and motivation from professionals, and organizational limitations such as administrative opposition and competing concerns). UCLA also recommends that key linkages be identified between prevention stakeholders in various settings where SBI efforts can occur, including primary care/emergency rooms, nurse/home visitation programs, student/employee assistance programs, school-based programs, mental health settings, and juvenile detention programs. This will enable the development of cross-system linkages between State systems working to bridge SUD prevention. These kinds of cross system relationships can create opportunities to develop core SBI data elements to allow for tracking of SUD clients across these various settings. Additional details of these lessons and recommendations can be found in chapter 6.

Chapter 7 Organizational Factors

Systematically operationalizing and implementing the measurement of organizational adaptation as a performance measure has been challenging. In an effort to identify and explain organizational processes that contribute to successful delivery of alcohol and drug services to patients, UCLA conducted exploratory site visits in 2010 to gain insight into the experiences of managers and staff of seven AOD treatment programs in Los Angeles County.

Programs were selected on their levels of retention and engagement, modality type, and size. UCLA observed common themes that either increased effectiveness of treatment or deterred it. *High* retention/engagement organizations tended to have effective leadership that fostered collaboration and cohesion, emphasize client-staff relationships, and were accredited or licensed.

UCLA recommends providing treatment organizations with training and technical assistance to help organizations better understand CalOMS data definitions and procedures, and how to use this data for performance and quality improvement purposes. In addition, UCLA recommends further exploration into client-provider "rapport" measures, and examination of how to facilitate integration between substance use disorder and primary care organizations.

Chapter 1: Data Systems Improvements: Data Analysis

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Introduction

A top priority of the California Department of Alcohol and Drug Programs (ADP) is to improve the accountability of the alcohol and other drug (AOD) treatment system in California in terms of ensuring quality services and effective patient outcomes. In 2009, ADP's Office of Applied Research and Analysis (OARA) approved a UCLA work plan designed to help ADP address several objectives in line with this priority. One of these objectives was to examine California Outcomes Measurement System – Treatment (CalOMS-Tx) data to enhance AOD treatment services and patient outcomes in California. A number of data analysis research questions were addressed in the previous report (Urada, Fan, & Rawson, 2010). This chapter addresses the remaining four research questions on (1) unique identifiers, (2) discharge categories, (3) successful transfers, and (4) case-mix adjustment.

Section 1: Patient Unique Identifiers

***Research Goal*:** Which patient unique identifiers (CADDS UID and CalOMS UID – both in CalOMS) currently used by ADP are the most accurate method for identifying and tracking patients?

The accuracy of the participant identifier currently in use for CalOMS is critical for analysis of this database. It is used, for example, to determine if the same person was admitted to treatment for multiple service sets over time; this is important both to compute the number of unique patients in the treatment system as well as to track the patient through episodes of care comprising multiple admissions and discharges.

Unique identifiers (UIDs) can differ in the number of data elements used to create them. This raises two competing concerns.

1. The more pieces of information used to create the UID, the more opportunities there will be for an incorrect entry to result in incorrectly identifying two records as belonging to different patients (false differentiation).
2. The fewer pieces of information used to create a UID, the greater the probability that the UID will incorrectly identify two records from different people as belonging to the same patient (false matching) due to coincidental matches (e.g., two people with the same initials).

The degree to which these concerns would lead to actual errors if the UID were used in the CalOMS dataset was tested. A head-to-head comparison was undertaken to examine the accuracy of the CalOMS unique participant identifier (CalOMS UID) compared with its predecessor, the CADDS unique participant identifier (CADDS UID). The CalOMS UID is a system-generated identifier created from seven pieces of participant information (birth first name, birth last name, mother's first name, county of birth, state of birth, date of birth, and sex). The CADDS UID was generated from a shorter list of four pieces of information: the person's last initial, first initial, sex, and date of birth.

Methods

Nearly half a million CalOMS admissions (n=494,179) through April 2008 were used for the initial analysis to determine how often the CalOMS UID and CADDS UID agreed or disagreed on whether records belonged to the same person or not. Note that although we refer to the "CADDS" UID in reference to its origin as the type of identifier used in the CADDS data, all analyses and ratings discussed below were conducted using data from the CalOMS database. That is, for each record in CalOMS, the CalOMS UID was present and a CADDS UID was generated.

To compare the ability of the two identifiers to differentiate between patients, three subsets were created from the CalOMS dataset:

- Records for 50 patients randomly selected among patients with a CalOMS UID that was identical for multiple admission records but with a CADDS UID that differed for one or more of them. That is, the CalOMS UID suggested that these admissions all belonged to the same patient, whereas the CADDS UID suggested that one or more admissions belonged to a different patient.
- Records for 50 patients randomly selected among those patients with a CADDS UID that was identical for multiple admission records but with a CalOMS UID that differed for one or more of them. That is, the CADDS UID suggested that these admissions all belonged to the same patient, whereas the CalOMS UID suggested that one or more admissions belonged to a different patient.
- Records for 50 patients with multiple admissions that matched on social security number (SSN).

To determine whether the CalOMS or CADDS UID was correct in the above cases, a human rater (Dr. Urada) reviewed the cases in these datasets. The rater had the following 14 pieces of information available to make this determination (some data was missing for some patients):

- Date of Birth
- Current First Name
- Current Last Name
- Social Security Number
- Birth First Name
- Birth Last Name

- Driver's license number / State Identification Card Number
- Driver's license state
- Race
- Ethnicity
- Veteran status
- Sex
- Zip code of residence
- State of Birth

The dataset UCLA had in its possession did not have mother's first name or the person's county of birth in it. However, at UCLA's request, ADP staff examined these variables for the group of patients that had apparently erroneous multiple CalOMS UIDs.

Results

Where the CalOMS UID indicated that one patient participated in multiple admissions, the CADDS UID indicated that they were actually different people only 1,221 times in the database (0.2%). Where the CADDS UID indicated that one patient participated in multiple admissions, the CalOMS UID indicated that they were different people 35,440 times (7.2%).

In summary, the CalOMS and CADDS UIDs were in agreement on 92.6% of admissions, but disagreed in 36,661 cases.

Records in which CalOMS UIDs matched but CADDS UIDs did not (0.2% of admissions)

When the CalOMS UID indicated that multiple admissions belonged to the same patient, but the CADDS UID did not, the human rater found that the CalOMS UID was usually correct. Out of 50 cases examined, in 43 cases the CalOMS UID was judged to be clearly correct, in 5 cases there was not enough information available in the records to make a definitive judgment and in 2 cases the CADDS UID was judged to be correct.

Among the 43 cases in which CADDS UID was judged to be incorrect, the reasons were:

40%	Change in the person's name (often apparently due to marriage)
27%	Transposition of the person's first and last names
9%	Only initials entered rather than names, and initials conflicted
9%	Conflicting dates of birth
7%	Typographical errors in the person's name
5%	Use of a nickname (e.g., "Tony" rather than "Anthony")
2%	Conflicting or changed gender information[1]

Among the 2 cases where CalOMS UID was judged to be incorrect, the reason was:

100%	Birth name was entered as "UNKNOWN" or "DEFAULT" for multiple admissions, resulting in a false name match between patients.

[1] It is unclear why the CalOMS UID was accurate in this case, since it too relies on gender information.

Among the 5 cases in which a definitive judgment could not be made, the reason was:

100% Only initials had been entered rather than names.

A separate analysis showed that in the full CalOMS dataset, only one letter (presumably an initial) was entered for 6.5% of birth first names and 6.8% of birth last names. Because the CalOMS ID is generated using the first 3 letters of the birth first and last names, the use of initials for some admissions but not others would cause the CalOMS system to erroneously identify the records as belonging to different patients and would generate new UIDs in these cases.

In summary, although it was relatively rare for the CADDS UID to determine that records belonged to different patients when the CalOMS UID did not, the CalOMS use of the person's birth name made it more accurate than the CADDS UID in these cases.

Records in which CADDS UIDs matched but CalOMS UIDs did not (7.2% of admissions)

When the CADDS UID indicated that multiple admissions belonged to the same patient, but CalOMS UID did not, the human rater found that the CADDS UID was usually correct. Out of 50 cases examined, in 35 cases the CADDS UID was judged to be correct, in 9 cases the CalOMS UID was judged to be correct, and in 6 cases there was not enough information available in the records to make a definitive judgment. That is, the CalOMS UID was incorrect between 70% (35/50) and 82% ([35+6]/50) of the time in these cases.

Among all 9 cases where the CADDS UID was judged to be incorrect, the cause was:

100% Different people with the same initials

Among the 35 cases where the CalOMS UID was judged to be incorrect, contributing factors were:

29% Mother's first name mismatch
26% Mother's first name and birth county/state mismatch
20% Birth county mismatch
3% Birth state mismatch
9% Mismatched because initials were used for some admissions, full names for others
9% Different or misspelled birth names
3% "DEFAULT" was entered as a name
3% Unknown

Among the 6 cases in which there was too little information to make a judgment, insufficient name information was the responsible factor:

100% Only initials rather than names had been entered.

In summary, relative to the CADDS ID, the CALOMS UID tended to erroneously identify two records as belonging to different patients when, in fact, they belonged to the same patient. Mother's first name played a large role in these errors. It is possible that errors also occurred due to date of birth and sex, but that in these cases both the CADDS and CalOMS UIDs were wrong.

Accuracy of UIDs for records in which SSNs matched

This analysis shows how the CalOMS and CADDS UIDs performed for patients with an exact match on SSNs. Matches on the nine-digit SSN number provide the strongest evidence for a match among any single identifier collected. The following results were found from an examination of 50 cases with valid SSN values:

72%	Both CalOMS and CADDS UIDs were accurate (consistent with the SSN match)
22%	CalOMS UID only was incorrect
4%	Both CalOMS and CADDS UIDs were incorrect
2%	CADDS UID only was incorrect

Where the CalOMS UID was incorrect, the reasons were:

38%	Changes in birth name
23%	Changes in birth state
23%	Unknown (may be mother's name or county)
8%	Change in DOB (one digit mis-entry)

This provides an approximation of the prevalence of CalOMS UID problems in the database but is not a perfect test because patients that provided SSNs were not necessarily representative of everyone in the CalOMS database. Patients that provided SSNs tended to provide other information. For example, in all 50 cases examined, the patient's full names were always provided, whereas patients who did not provide SSNs were more likely to provide only initials.

Conclusions

The data above put us in a better position to evaluate the merit of the competing concerns introduced earlier:

1. The more pieces of information that are used to create the UID, the more opportunities there will be for an incorrect entry to result in incorrectly identifying two records as belonging to different patients (more likely with CalOMS UID, created from 7 variables).
2. The fewer pieces of information that are used to create a UID, the greater the probability will be that the UID will incorrectly identify two records from different people as belonging to the same patient due to coincidental matches, e.g. two people with the same initials (more likely with CADDS UID, created from 4 variables).

The key to evaluating these concerns are the errors where the CalOMS UID identified records as belonging to different patients (which could be erroneous due to incorrect data on one of the seven variables – Concern #1), whereas CADDS UID identified records as belonging to the same

patient (which could be erroneous due to coincidental matches – Concern #2). Concern #1 resulted in an error in 70% of these cases, whereas Concern #2 resulted in an error in 18% of the cases. This suggests that the CADDS UID performed better based on this sample.

This does not suggest that the CADDS UID is superior in all respects, however. Where CalOMS UID identified records as belonging to the same patient and CADDS UID identified records as belonging to different patients, the CalOMS UID was clearly more accurate. However, this accounted for only 0.25% of admissions.

Based on sheer volume, the issue of resolving why CalOMS sometimes identifies records as belonging to different patients even when they often belong to the same patient is a more important issue. Assuming the randomly selected sample analyzed here is representative of the larger database, roughly 10,000–11,000 admissions per year (70–80% of 7% of 200,000 admissions) may be erroneously assigned a new CalOMS UID, when they should be assigned an existing one.

While there are limitations to the analyses conducted, the following appear to be substantial contributors to errors in the CalOMS UID:

- birth name
- birth state
- birth county
- mother's name

Sex and date of birth did not appear to be strong contributors to errors.

Recommendations

- Birth name: The primary problem with birth names appears to stem from entry of the patient's current name as the birth name in some cases, whereas the real birth name is entered in others. For example, a (fictitious) patient born as Joan Smith gets married and changes her name to Joan Jones, and then is admitted to treatment where both her birth and current names are erroneously recorded as Joan Jones. A year later she relapses and is admitted again, but this time the treatment program correctly records her birth name as Joan Smith. This creates a mismatch in names and erroneously results in a new CalOMS UID being generated (resulting in one for Joan Smith and one for Joan Jones). It may be that interviewers are sometimes re-entering the current name as the birth name to save time. If so, this appears to be an issue that could be addressed through technical assistance.

- An additional problem with birth names is the practice of only entering the person's initial. This occurs in about 7% of admissions. Because CalOMS uses the first 3 letters of names, a "John Smith" will not match a "John S." Use of initials may be due in part to the fact that for CalOMS's predecessor CADDS, only initials were recorded, so some treatment personnel may have continued this practice. However, it is also possible that respondents and/or treatment providers may be resistant to submitting the full name due to privacy concerns. In either case, technical assistance to encourage entry of full names and allay

fears of confidentiality issues may be warranted. Alternatively, ADP might weigh the effect of reverting back to using initials. This should not be the first choice since use of initials makes it impossible to accurately match records in cases that are missing other identifying information, but as long as a range of other identifying variables is also diligently collected (e.g., SSN), use of initials might not have a large detrimental effect.

- Birth state/county: As with birth name, it appears that the current information is sometimes being entered as birth information. For example, the person's birth state is being entered in some cases, whereas in others, the birth state is being entered as "California." In all cases of state mismatches, it is because "California" was entered for one or more cases. Some interviewers may sometimes be entering "California" to save time. If so, this appears to be a technical assistance issue. Alternatively, this could be seen as partly an outgrowth of burdensome requirements, and to reduce the burden on data collectors, ADP might consider removing state of birth. As currently recorded, most admissions (72%) are for patients born in California and for another 14% the question results in a not-applicable 999xx code, most frequently because the patient was born outside the United States. Therefore for 86% of patients, this variable is not very useful for differentiation between patients and probably could be dropped.

- Mother's name: The question for mother's name is currently "What is the first name of your mother or the individual you consider to be your mother?" (California ADP, 2011). Because the individual a patient considers as a mother figure may change over time, the question as currently worded appears to be unsuitable as the basis for UID generation. ADP should consider either removing this variable or changing the definition to ask about the name of the person's birth mother, which should not change over time.

- Ultimately, data collection and data entry errors will always be present in the data regardless of the level of technical assistance or the number of variables used. Therefore, the best, most comprehensive solution would be to stop using exact deterministic matching and use probabilistic matching instead. In probabilistic matching, possible matches are given a score based on an algorithm that calculates their relative fit rather than requiring exact matches, and scores above a given threshold are considered to be matches. With probabilistic matching, common human errors such as data entry transpositions, misspellings, and even use of common nicknames (e.g., "Tony" rather than "Anthony") would not necessarily result in failure to match, making the process more tolerant of human errors compared to the current exact matching requirements. This could also allow other variables to be used. For example, the algorithm could be programmed to take into account social security numbers or drivers license numbers, when these are available. Probabilistic matching is commonly used in research, including the UC San Francisco's Family Health Outcomes Project (FHOP), which served as the basis for CalOMS UID generation methodology. However, whereas CalOMS has adopted FHOP's core data elements, CalOMS did not adopt the full methodology. FHOP used probabilistic matching rather than the exact matching used by CalOMS (see http://www.ncvhs.hhs.gov/app7-12.htm). This probabilistic matching ameliorates the problems caused by using the data elements in question, so if CalOMS adopts the FHOP data elements it makes sense to also adopt or adapt the rest of the FHOP methodology (these methods will work regardless of

whether the task is linking records across databases, as in FHOP, or within databases, as in CalOMS). Perhaps the best example of public domain software that performs this function is the Link King (http://www.the-link-king.com/), which was developed for the Substance Abuse and Mental Health Services Administration's Integrated Database Project. In conjunction with ADP, UCLA is currently working on methods to use the Link King software to improve CalOMS UID generation and accuracy. This, in turn, should improve ADP's ability to count and estimate the total number of unique patients over time, and use performance measures that require tracking of patients (e.g., transfers between services).

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Section 2: CalOMS Discharge Categories

Research Goal: Identify ways of dealing with categories for discharge that fit within Continuum of Services System Re-Engineering (COSSR) objectives, or discuss alternatives if discharge has lost relevance. In either case, the goal is to have mutually exclusive categories with clear definitions.

Over the course of the EnCal project, UCLA has regularly attended and contributed to efforts by the County Alcohol and Drug Program Administrators Association of California (CADPAAC) Data and Outcomes Committee (which also includes participants from ADP). These efforts contributed to the production of ADP Bulletin 10-04, "Criteria for Discharging Treatment Clients using the CalOMS-Tx Completion Discharge Statuses" (California ADP, 2010). UCLA is also working with the committee to revise ADP Bulletin 08-08, "Guidelines to Clarify Procedures for Collection of Admission and Discharge Data for the California Outcome Measurement System – Treatment (Caloms-Tx)" (California ADP, 2008). UCLA views these as steps in the right direction toward improving discharge categories to the extent possible.

Beyond the use of discharge categories, which are to some degree inherently oriented toward an acute model of treatment as opposed to a chronic one, UCLA is pursuing other measures that facilitate measurement beyond the single treatment service set to track patients through a continuum of care (transfers, see Sections 3 and 4). These issues will continue to be discussed as part of CADPAAC's data/outcomes committee meetings.

Recommendations

- Recommendations on CalOMS discharges are already reflected in ADP policy through ADP Bulletin 08-08 (which may soon be revised and superseded) and ADP Bulletin 10-04.
- ADP, CADPAAC, and UCLA should continue to address issues through the Data and Outcome Committee meetings, which has proven to be a useful and productive group.

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Section 3: Transfers

Research Question: Find out what those counties that have the highest transfer rates from detoxification into residential treatment are doing.

Based on CalOMS, UCLA calculated the percentage of patients who were transferred into treatment based on having a treatment admission within 14 days of discharge from detoxification (detox). See Table 1.

Table 1. County transfer rates from detoxification to treatment

Rank	14-Day Transfer Rate	County*
1	67.4%	Kings
2	51.2%	Santa Clara
3	45.3%	Monterey
4	30.9%	Contra Costa
5	26.1%	Riverside
6	24.9%	Tulare
7	24.7%	Sacramento
8	24.1%	San Bernardino
9	23.2%	Napa
10	22.6%	Shasta
11	19.8%	San Mateo
12	16.9%	Alameda
13	16.4%	Los Angeles
14	15.2%	Placer
15	15.0%	Humboldt
16	14.7%	Orange
17	13.9%	Tulare
18	13.2%	Solano
19	12.9%	San Diego
20	12.0%	Fresno
21	10.6%	San Francisco
22	10.5%	Sonoma
23	7.8%	Mendocino
24	4.8%	San Luis Obispo
25	4.6%	Santa Barbara
26	3.1%	Marin
27	0.0%	Butte

*Counties with at least 20 detox admissions in CalOMS in FY 2008-2009

UCLA also calculated percentages allowing 30 days rather than 14, and the rankings were nearly identical. The rankings of 25 out of 27 counties were the same or within 2 ranks regardless of which method was used, and no county differed by more than 5 ranks.

Among counties with at least 20 detoxification admissions, three counties had transfer rates that were clearly higher than the rest: Kings, Santa Clara, and Monterey. Monterey's rate was nearly one and one half times that of the fourth ranked county. UCLA sent an e-mail to the administrators in the top three counties to obtain their thoughts on what was responsible for their counties' superior rates and received the following responses:

Kings County

In a phone conversation with Kings County AOD Program Administrator Brenda Randle, UCLA determined that the detoxification and residential services were provided within the same facility. Typically patients received about 10 days of detoxification and then were moved to residential treatment, though about 10% transferred to outpatient treatment. Unfortunately, this facility closed due to budget cuts. Kings County hopes to resume these services using funds from realignment.

Monterey County

Robert Jackson, Program Manager with the Monterey Alcohol & Drug Program sent the following response:

"The principal provider of this service in Monterey County is Sun Street Centers (SSC), which has a long history of providing a variety of Alcohol and Drug Services to our county residents. SSC operates a social model men's residential treatment program (50 beds) located in Salinas. There are 4 social model detox beds. The site is co-located. The staff on site are quite adept at working with persons entering the detox beds and counseling them about the residential program. The consumers eat meals together, learn about the program and how it works. Monterey County Behavioral Health contracts for a total of 11,288 bed days and in 09/10, SSC had a year-end actual use of 16,176 bed days from all county funding sources. I believe that Sun Street has a good program, good reputation and works collaboratively with all county partners and consumers. In addition, due to the size of the residential program, there is bed capacity available for those persons desiring to make a lasting commitment to change and move from the detox bed to the residential treatment program."

Santa Clara County

The following two responses were received from Santa Clara County:

"When we became a managed system of care, we set a performance measure around clients in detox being transferred from detox to another level of care. We no longer have this performance measure because over time it became part of how we operate. We continue to stress with providers through our IP meeting and clinical supervisors meetings, etc., that we are a seamless continuum of care."

Cheryl Berman, Ph.D., Sr. Program Manager, Adult Treatment,
Department of Alcohol & Drug Services

"I would add that the handoff from residential detox to residential treatment is a "warm" handoff. In the men's facility, the detox and regular residential treatment are in the same facility and this enhances the odds of the client staying. But in general, our system is set up to view treatment as being comprehensive and flexible, based on client need, rather than program centric where the program is the beginning and end."

Bob Garner, Director
Dept. of Alcohol & Drug Services

Limitations

While Kings, Monterey, and Santa Clara had the best transfer rates according to CalOMS data, this may or may not reflect reality. Based on a small and non-representative survey of CADPAAC administrators, it is clear that not all transfers are detected by CalOMS, particularly in cases in which a patient moves from detox to treatment but stays within the same facility. In these cases, the treatment program often only provides a CalOMS record once, typically for the treatment program. This may stem from the burdensome process that would be required to submit a CalOMS admission record when the person enters detox, a CalOMS discharge record for detox, and then a (largely duplicative) CalOMS admission record to re-admit the patient for treatment. To facilitate accurate reporting, it would be reasonable to provide a more streamlined system in these cases.

Recommendations

- In all three of the counties that had the highest transfer rate from detox to treatment, detox and residential services were co-located in a way that allowed patients to become familiar with the residential program while still in detox. Adopting similar models using co-located residential or other services may contribute to higher transfer rates.

- To some extent, both Monterey and Santa Clara give credit to staff for "counseling clients about the residential program" and providing a "warm handoff." Development of staff skills in these areas may contribute to higher transfer rates to other services.

- Monterey noted that availability of residential bed capacity facilitated their rates. It is logical that availability of treatment would play an important role in transfer rates.

- Santa Clara has adopted a system-wide approach that facilitates transfers by including performance measurement, regular meetings, and infrastructure to stress the continuum of care.

- To improve data quality, ADP might consider the feasibility of easing reporting requirements when transfers occur. Specifically, if a patient transfers between modalities

within the same facility, an abbreviated method of providing a CalOMS record may be useful, if it can be achieved within federal reporting guidelines. To some extent, ADP has already partially eased the requirements by instructing that if an individual transfers within five calendar days from one modality to another, within the same provider, then the provider can use the discharge data from the first modality for the admission data in the next modality (California ADP, 2011). However, an admission and discharge record from the first service set is still required in this situation. In detoxification admissions, it may not be feasible to obtain full information at admission, and required outcome measures at discharge will probably not be informative because the 30-day period for most outcome measures (e.g., drug use in the last 30 days) will usually extend back into the time period before the person was admitted. Consistent with this, ADP allows a subset of data elements to be collected at discharge (see File Instructions, pp. 32–34) that excludes some of the 30-day questions, but despite this, in reality, almost all counties require a full set of detox discharge questions. Ideally, it would make sense from the standpoint of reducing the data collection burden to create or allow an even more abbreviated process whereby treatment programs could simply indicate that the patient was in detoxification without collecting and resubmitting CalOMS information for a discharge and re-admission. The reduction in data collection and reporting burden would need to be weighed against the costs of implementing such a change via the re-programming of state and/or county systems. Discussions of these issues has commenced within the CADPAAC data and outcomes committee and are ongoing at this writing.

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Section 4: Case Mix Adjustment

***Research Goal*:** Review the literature for models of case-mix adjustment, key variables. Discuss lessons learned from Los Angeles County, where relevant.

Introduction

Continuity of service for patients leaving detoxification is a major challenge for the substance abuse treatment system (Carrier et al., 2011; Dennis & Scott, 2007; Garnick, Lee, Horgan, Acevedo, & Washington Circle Public Sector Workgroup, 2009; McLellan, Weinstein, Shen, Kendig, & Levine, 2005).[2] In California, only 23% of detoxification (detox) patients transferred to further treatment, which is necessary to treat the behavioral and psychosocial aspects of addiction, within 30 days (Rawson, Gonzales, Brecht, Crèvecoeur-MacPhail, & Hemberg, 2008). Moreover, 11.3% of patients who receive detox recycle back into detox two or three times, a situation that indicates the chronic nature of addiction, but also inadequate care and inefficient use of public resources (McLellan et al., 2005). As such, the substance use disorder treatment community has begun to emphasize both the provision and measurement of continuity of service

In California, the Department of Alcohol and Drug Programs is beginning to reengineer its treatment services in an effort to move toward a chronic-care, continuum-of-services model. The Department of Alcohol and Drug Programs (ADP) has recently begun to develop performance measures as part of this effort. In particular, ADP is considering the application of a performance measure, recommended by the Washington Circle (Garnick, Lee, Horgan, & Acevedo, 2009) that tracks continuity of service after detox. The Washington Circle piloted the feasibility of using routinely collected administrative data to calculate continuity of service in substance abuse treatment. They defined continuity of service as the percentage of individuals who transferred to another service within 14 days of assessment or discharge from a previous service. Based on findings from pilot projects in five states, the authors concluded that using administrative datasets to extract performance measures, including measure of continuity of care, is indeed feasible and recommended further study to better understand and validate the measure (Garnick, Lee, Horgan, Acevedo, et al., 2009).

The Washington Circle performance measure for detox is the proportion of detox patients who are transferred to a treatment service within 14 days of discharge from detox (Garnick, Lee, Horgan, & Acevedo, 2009). While most studies examine performance of individual treatment providers (Harris, Humphreys, & Finney, 2007; Phibbs, Swindle, & Recine, 1997), California ADP is interested in measuring performance of treatment systems within counties that receive public funding for treatment services. To inform efforts to measure the performance of treatment systems at the county level, this chapter examines detox transfer rates among 25 counties in California and assesses the impact of patient case-mix adjustment on their relative performance.

The Role of Case-Mix Adjustment in Program Evaluation

[2] The term "continuity of service" is used here to reflect the receipt of services at different levels of care, which often are provided by different treatment facilities. By contrast, "continuity of care" in the healthcare literature implies ongoing care provided by the same provider or provider team.

Patient case-mix is a collection of socio-demographic and clinical characteristics of patients that are thought to impact treatment effectiveness, independent of clinical interventions and organizational factors. For example, patients with severe drug use disorders may be harder to treat in short-term treatment programs than patients with less severe conditions. Drug use severity, therefore, may moderate treatment effectiveness. In addition, some treatment programs may have more severe patients than other programs. For this reason, evaluation studies that compare treatment effectiveness across treatment programs must adjust for drug-use severity and other patient-level characteristics that vary across programs (Koenig et al., 2000; Phibbs et al., 1997). Applying case-mix adjustment tools in evaluation studies serves to "level the playing field" within treatment systems that comprise specialized services and unique patient populations.

Phibbs et al. (1997) applied case-mix adjustment in a study that predicted readmissions to inpatient substance abuse treatment programs in the Department of Veterans Affairs. The study sample included 116 VA medical centers. The authors compared observed readmission rates to the expected rates based on patient case-mix. Support for a case-mix model of readmission was found. Patient case-mix accounted for 36% of the observed facility-level variation in inpatient readmissions. After applying the case-mix model, the performance rankings of more than 20% of the medical centers changed appreciably. The study by Phibbs et al. (1997) served to document the utility of administrative data to fairly evaluate the performance of treatment programs.

Methods

Sample and Procedures

Transfer rates were examined using admissions data for all patients in 25 California counties who received detox services between July 1, 2008, and June 30, 2009 (n=18,943). Data are from the California Outcomes Measurement Data System (CalOMS), which includes all publicly funded treatment programs. The 25 counties were selected because they reported at least 20 admissions to detox services during the study period. Patients admitted to an initial detox service during the last two weeks of June 2009 were censored because a full 14-day window to observe transfers to treatment was required.

A transfer is defined as an admission to any treatment service, e.g., narcotic treatment programs, residential drug-free, and outpatient drug-free treatment, within 14 days of discharge from a detox service. Because patients can have multiple detox services within a year, the transfer variable was coded as "0" for no transfers to treatment within the year and "1" for one or more transfers within the year. Approximately 17% of patients received at least one transfer and the modal number of transfers was one.

Analysis

Transfer rates were aggregated to the county level. The 25 counties were ranked from best to worst on transfer rates (1–25, where 1 is best and 25 is worst). The study employed the case-mix approach for evaluating provider performance described by Koenig et al. (2000). The current study differs from the Koenig et al. study in that the unit of analysis is the county. To conduct the

case-mix adjusted rankings, binary logistic regression was used to estimate the probability of individual patients having at least one transfer, and examining these probabilities in relation to patient characteristics. Indicator variables were created for each county. Counties were identified by letters A–Y in the order of the unadjusted ranking. The median county (county M, rank 13) was used as the reference county and indicates "average" performance.

With the indicator variable approach to ranking counties, the focus is on comparing counties' positions above and below the average before and after the adjustment. Adjusted rankings were based on the regression estimates of transfer probabilities; positive estimates indicate above average performance and negative estimates indicate below average performance. The Wald chi-square test was used to assess whether the probability of transfers for each county was significantly different from the reference county.

All plausible demographic and clinical factors available in the dataset were tested for their association with transfers from detox to treatment services. Independent variables fell within the following dimensions: socio-demographic (age, gender, Hispanic, White, African American, high-school education, employed part/full time); drug use condition (alcohol primary drug, heroin primary drug, prior treatment (no prior treatment/1–2 prior episodes, 3 or more prior episodes), days of use in the past 30 days reported at admission to the index detox service); detox setting (residential vs. outpatient); criminal justice involvement at admission; co-morbid mental health condition (ever received a mental illness diagnosis, any emergency room visits due to mental health in the past 30 days); and health status (any health problems in the past 30 days). Lastly, county population size (#/1000 persons) was added to the model to adjust for differences in the size of treatment systems across counties. All analyses were conducted in SAS.

Results

The sample characteristics are as follows. Seventy percent are male. Mean age is 39.9. Almost three-quarters have a high-school education. Racial/ethnic breakdown is 56.1% White, 22.7% Hispanic, and 15.3% African American. A small fraction reports working part- or full-time (12%). In terms of primary drug use, 42% of the sample report alcohol as their primary drug. Opiate users comprise 25% of the sample. The opiate category includes heroin, OxyContin/OxyCodone, and non-prescription methadone. Lastly, more than one quarter of patients (27%) report ever having received a mental health diagnosis. See sample characteristics in Table 1.

Unadjusted transfer rates ranged from 67% for the top ranking county to 3% for the bottom ranking county. The median county had a transfer rate of 17%. The odds of being transferred to treatment compared with the reference county ranged from 10.5 in the top-ranking county to 0.17 for the lowest-ranking county (see Table 2). For example, being in county A, the top-ranking county, increases a patient's odds of transferring from detox to treatment more than tenfold in contrast to the reference county.

Table 1. Sample Characteristics, Detox Patients Receiving Treatment 2008-2009 (N=18,613)

Variable	% (mean)
Male	70.6
Age	39.9 (*SD*=11.6)
African American	15.3
White	22.7
Hispanic	56.1
High school education	73.4
Criminal justice involvement, past 30 days	29.8
Full- or part-time employed, past 30 days	12.2
Alcohol primary drug	41.5
Opiates primary drug	25.1
Ever had mental illness diagnosis	27.4
Any ER visit due to mental illness, past 30 days	5.2
Num days used primary drug, past 30 days	23.2 (*SD*=10.4)
1-2 prior treatment episodes in life	31.6
3 + prior treatment episodes in life	26.7
Inpatient detox received first detox	89.4
Any physical health problem, past 30 days	27.1

The results of the logistic regression show several statistically significant associations between the probability of transfers to treatment and the socio-demographic, drug use severity, and service type covariates. Lower odds of transferring from detox to treatment were found for patients who were male, older, and employed, and those who had entered treatment for alcohol or opiates, visited the ER for mental health issues, used drugs on more days in the 30 days prior to admission, experienced prior treatment episodes, and entered residential detox facilities as opposed to outpatient detox. Criminal justice involvement increased the odds of transitioning into treatment by 52%. The odds ratios for all covariates are listed in Table 3.

Population size was dropped from the logistic regression model because population size was a linear combination of the county indicator variables; therefore, population size did not add any new information to the model. The initial regression model with only the 24 county variables explained 9% of the variance in patient transfers to treatment. Including the covariates in a second logistic regression increased the amount of explained variance to 12%. Both models have good fit, but do not explain an appreciable amount of the variance across individual patients.

As a result of the case-mix adjustment, however, eight counties changed positions in the rankings (see Figure 1). County N went from being below average to above average after the adjustment (from 14th place to 12th place). County L switched places with County N, moving from an above average position to one spot below the average county (12th to 14th place). Only one county, County V, moved from the bottom 20% on the rankings to a higher position (from 22nd to 20th place). Counties in the top 20% of the rankings held their positions after the adjustment.

Table 2. Comparison of Unadjusted and Adjusted Odds of Transfers, Detox Patients Receiving Treatment 2008-2009 (N=18,943) †

	Odds Ratios	
County	**Unadjusted (N=18,943)**	**Adjusted (N=18,613)**
A	10.54*	6.33*
B	5.35*	4.21*
C	4.23*	3.58*
D	2.28*	1.91*
E	1.80*	1.39*
F	1.69*	1.39
G	1.66*	1.24*
H	1.62*	1.27
I	1.54*	1.25
J	1.49*	1.26
K	1.26*	1.06
L	1.04	.87
N	.91	.87
O	.90	.75
P	.88	.67*
Q	.82	.44
R	.78	.57*
S	.76*	.56*
T	.70*	.59*
U	.61*	.53*
V	.60*	.53*
W	.43*	.35*
X	.25*	.18*
Y	.17*	.14*

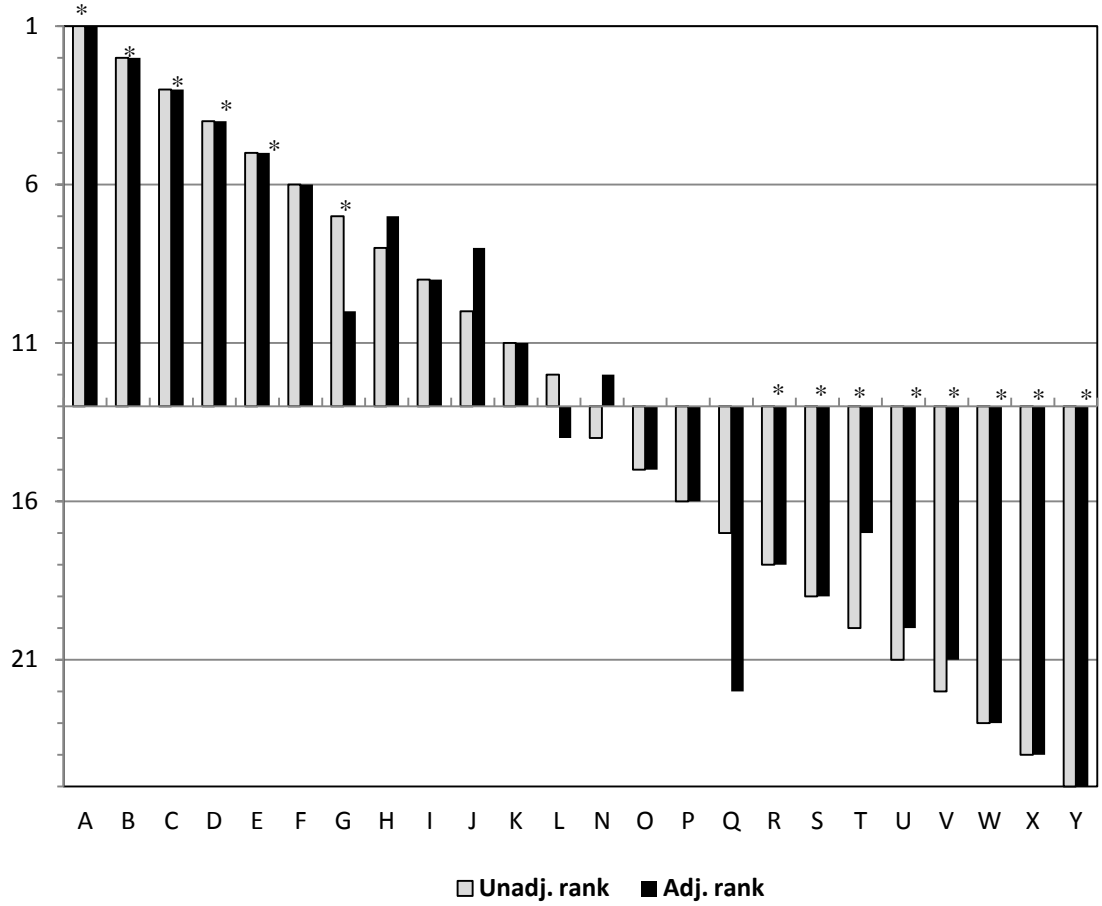
†330 cases were dropped because of missing data.
*Significantly different from the reference county at the .05 level.

Table 3. Adjusted Odds Ratios for Case-Mix Variables Predicting the Probability of Transfers from Detox to Treatment (N=18,943) †

Variable	Odds Ratio	95% CI
Male gender vs. female	.72*	.66 - .79
Hispanic vs. all others	1.08	.89 – 1.30
White vs. all others	1.01	.84 – 1.21
African American vs. all others	1.08	.88 – 1.32
Age at admission	.99*	.99 – 1.0
High school education vs. less than HS	1.07	.98 – 1.17
Criminal justice status vs. none	1.52*	1.39 – 1.66
Full- or part-time employment vs. none	.83*	.72 - .95
Alcohol primary drug vs. all other drugs	.84*	.76 - .93
Opiates primary drug vs. all other drugs	.74*	.66 - .83
Ever had mental illness diagnosis vs. none	1.08	.98 – 1.19
Any ER visit due to mental illness, past 30,	.74*	.61 - .90
Number of days used primary drug, past 30	.99*	.984 - .99
Prior treatment episodes in life vs. none	.91*	.86 - .96
Residential detox received first detox vs. outpatient	.96*	.92 - .99
Any physical health problem, past 30 days	1.01	.92 – 1.12
Likelihood Ratio X^2=1365.59, DF=45, p<.001; R-square=.12		

†330 cases were dropped because of missing data.
*Significantly different from the reference county at the .05 level.

Figure 1. Comparison of Unadjusted and Adjusted Ranking of Counties Based on Logistic Regression (1 is best, 25 is worst)



* Statistically different than the median-ranked county at the .05 significance level.

Discussion

This study represents a first step in exploring the utility of a case-mix adjustment model for monitoring county-wide performance on treatment engagement after detox. The results from this study show substantial variation between counties; the logistic regression model with county indicator variables alone explained 9% of the variance in patient transfers to treatment. The case-mix model used in this study, on the other hand, increased the precision of the model very little (from 9% to 12% of variance explained). Even weaker findings were found by Brecht (2011), who used a case-mix adjusted model to predict the average length of stay of patients in outpatient treatment programs in Los Angeles County, finding that it predicted less than 1% of the variance. The data used by Brecht were also administrative treatment episode data, which were very similar to the data used for the present study.

Results from the logistic regression suggest that the odds of transitioning to treatment are lower for patients who are men, older, employed, not involved with the criminal justice system, more frequent users, and users of alcohol and opiates. These findings are concerning given that 70% of

patients going into detox are male and have alcohol or opiate use disorders. Future analysis should consider comparing alcohol users with opiate users, as opposed to comparing alcohol and opiate users separately with other drug users. Stein, Kogan, and Sorbero (2009) found that Medicaid patients with opiate disorders were less likely to receive follow-up treatment after detox. Lastly, in contrast to the study by Stein et al., the current analysis did not find any relationship between race/ethnicity and transitions to treatment after detox.

Why do we find such meager results from the case-mix model? One possible explanation is that the measures of alcohol and drug use disorders, mental health disorders, and health conditions in CalOMS are weak; these administrative data do not include diagnostic information. The case-mix studies conducted with data from Veterans Affairs had diagnostic information based on ICD-9 codes (Phibbs et al., 1997) or Addiction Severity Index composite scores for medical, employment, legal, psychiatric, and family domains (Harris et al., 2007). It is possible that the case-mix model tested in the present study under-adjusted results due to limited clinical data. The failure of the analysis (Brecht, personal communication, 2011) to find large case mix effects tends to support this conclusion. Second, while case-mix adjustment has been found to be important for other types of measures, it may be that the measure of transfers analyzed in this study has a weaker association with patient characteristics than other measures. Third, it could be that using patient-level characteristics to adjust a county-level measure of transfers does not work well because within-county variations in demographics and transfer rates are lost to aggregation. Additional data on the counties themselves may have enhanced the case-mix model. County-level factors that may impact transfers to treatment after detox include geography, e.g., rural vs. urban, accessibility of treatment, e.g., ratio of the number of treatment facilities to population size, and per capita funding for treatment.

The literature suggests that case-mix adjusted models for treatment programs (as opposed to counties) are important because case-mix adjustment allows for fair comparisons across diverse programs. While treatment programs cannot control the nature of their patient populations, they can exert control over how treatment services are organized and delivered (Carroll, 2009). Case-mix models can help policy makers identify highly effective programs and, as a second step, identify the clinical interventions that improve patient outcomes.

From a policy perspective, it is appealing to compare counties on performance measures. However, as this preliminary examination shows, it may not be possible to substantially adjust county level performance measures using variables included in CalOMS. Research that includes organizational- and county-level predictors may provide more effective forms of case-mix adjustment.

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Chapter 2: California's Forum on Data Privacy and Treatment of Substance Use Disorders

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Executive Summary

California's Forum on Data Privacy and Treatment of Substance Use Disorders brought together policy makers, administrators, treatment provider representatives, and researchers to discuss how patient data can be shared to improve substance use disorder treatment quality while complying with federal privacy regulations. This document summarizes discussions that occurred during the forum.

Key points from the forum included:

- Electronic records can be used to share substance use disorder (SUD) data, but confidentiality laws apply, including the Health Insurance Portability and Accountability Act (HIPAA) and the Code of Federal Regulations, Title 42, Section 2 (42 CFR).

- HIPAA sets a "floor" for confidentiality, but 42 CFR provides stricter confidentiality rules that take precedence.

- It will be important to set up electronic health records (EHRs) to handle 42 CFR requirements from the beginning. Unfortunately, thus far, financial incentives provided for meaningful use of EHRs through the HITECH act have not been extended to apply to SUD treatment. The SUD field must advocate for inclusion in future incentive stages.

- Sharing of patient data across organizations can be achieved through use of patient consent forms and/or qualified service organization agreements.

- HIPAA is coming up for review and it is predicted that there will be a shift in focus regarding privacy policy to focus on patients' relationships to their own information, shifting more toward 42 CFR policies in areas such as consent requirements.

- In order to facilitate information sharing, electronic health records may in the future use a "Universal Exchange Language" that would include more refined control of privacy for different pieces of patient information.

Next steps include broad dissemination of Forum materials and stakeholder participation in future events (e.g., by SAMHSA) to continue discussions on implementation of electronic systems that will facilitate sharing of data in accordance with the regulations.

I. Introduction

On May 24, 2011, California's Forum on Data Privacy and Treatment of Substance Use Disorders brought together policy makers, administrators, treatment provider representatives and researchers to discuss how patient data can be shared to improve treatment quality while complying with federal privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA) and the Code of Federal Regulations, Title 42, Section 2 (42 CFR). This document simply summarizes notes taken during forum discussions and should not be regarded as legal advice. Due to the complexity of these issues, stakeholders are advised to obtain legal advice before implementing policies to address privacy regulations.

The forum was hosted by the California Department of Alcohol and Drug Programs (ADP) and UCLA Integrated Substance Abuse Programs (UCLA); Michael Cunningham, Acting Director of ADP, and Darren Urada of UCLA opened the forum. Paul Samuels, Director and President of the Legal Action Center (LAC), then addressed frequently asked questions on 42 CFR. Mady Chalk, Director of the Center for Policy Research and Analysis at the Treatment Research Institute (TRI), then discussed recent policy and technological developments. The following are summaries of their presentations, including responses to questions asked by forum participants.

Background and Welcome

Darren Urada, Ph.D.
Principal Investigator, UCLA Integrated Substance Abuse Programs

Michael Cunningham
Acting Director, California Department of Alcohol and Drug Programs

Dr. Urada opened with a brief background on how this forum came to be, why, under UCLA's contract with ADP, the topic has been highlighted for this type of event, and an introduction of the two expert speakers on the panel.

Healthcare reform at the federal level will dramatically shift the nature of addiction service delivery. As funding streams are restructured, costs for healthcare delivery are re-evaluated, and evidence-based practices are encouraged to improve overall health outcomes, particularly for the treatment of chronic care diseases, there has been a call for better integrated healthcare services among physical, substance use, and mental health disorders. In order to prepare for the implementation of healthcare reform, it is crucial for the State of California and county leaders to understand the implications of better integration of health services, specifically as it relates to regulations and policies on data privacy and data sharing. Two experts, Paul Samuels and Mady Chalk, were selected for this forum to provide current knowledge about information technology as it relates to health records and the treatment of substance use disorders as well as to discuss the developing federal guidelines around data privacy and sharing regulations. The goal of this forum was to open discussion with the panel to increase the understanding of these issues, to discuss how this will affect California, and whether/how California may help to shape these developments.

Mr. Cunningham introduced the forum topic and elaborated on the relevance and importance of discussing data privacy in the treatment of substance use disorders (SUDs).

Mr. Cunningham stated that there are many barriers to sharing data but they can be overcome. These barriers impede data sharing in all types of treatment, not just SUD. Mr. Cunningham shared his own experience of being asked the same questions by many different treatment providers within the same emergency department. While this case did not involve alcohol or drugs, in the case of admissions that do, the already inefficient state of data sharing in our medical system would be further complicated by legal issues as well as stigma.

Under healthcare reform, our goal is to effectively work within the bounds of privacy regulations to ensure that providers have access to the information they need to provide proper treatment while adhering to privacy regulations.

II. Applying Substance Use Disorder Confidentiality Regulations to Health Information Exchange

Paul Samuels, J.D.
Direct and President, Legal Action Center

Mr. Samuels' goal for the Data Privacy Forum was to make SUD privacy law as clear as possible to California County SUD administrators, and he encouraged questions, comments and discussion. Mr. Samuels used the Substance Abuse and Mental Health Services Administration's (SAMHSA) "Frequently Asked Questions" (FAQs) document, authored by his organization, Legal Action Center, to guide the forum (SAMHSA, 2010). The following FAQs and their corresponding answers are denoted by their reference numbers in SAMHSA's document.

Q1: Can electronic health records include SUD information?
A1: Yes, but federal confidentiality laws apply. SUD records must be integrated into primary care records in order to fully integrate healthcare.

EHR Discussion Points

- HIPAA confidentiality rules cover all healthcare records, including electronic health records (EHRs); 42 CFR Part 2 covers SUD records.

- 42 CFR Part 2 is similar to HIPAA but has stricter confidentiality rules.

- HIPAA sets a "floor" for confidentiality but does not take precedence over 42 CFR Part 2.

- HIPAA stipulates that when there is a stricter confidentiality rule, the stricter law must be followed, so 42 CFR Part 2 and individual states' laws must be considered when implementing electronic record keeping as these laws often "win out."

- Software companies must consider all differing privacy requirements when developing EHRs for healthcare reform. A number of organizations are working with SAMHSA to make it a federal requirement that software companies develop EHR systems that comply with 42 CFR Part 2 regulations. The Office of the National Coordinator (ONC) is very concerned about data privacy and supports this.

- It is important to set up EHRs correctly upon initial implementation. It will be far more difficult to fix afterwards.

- Unfortunately, resources to ensure that EHRs are properly implemented are lacking; SUD and mental health (MH) treatment providers were not included in the Meaningful Use incentives established by the HITECH act, even though Medicare and Medicaid facilities were given financial incentives to update existing EHRs or switch to EHRs. Another disbursement of Meaningful Use funds may be made, so the SUD field must fight to ensure eligibility.

Q2. What types of organizations must follow 42 CFR Part 2?
A2. There are two criteria that make an organization fall under 42 CFR Part 2 privacy law:

- The program (or individual provider) must be federally assisted (authorized, certified and/or funded by the federal government, even if funds do not pay for SUD services) and/or nonprofit.
- The program must also provide and promote SUD services (diagnosis, treatment and/or referral for treatment).

42 CFR Part 2 Coverage Discussion Points

- If a program provides SUD treatment in addition to other services (e.g., mental health (MH) services), 42 CFR Part 2 privacy law only applies to the records of those receiving SUD services (whether in conjunction with other services or not).

- Patients not receiving SUD treatment are not covered by 42 CFR Part 2.

- It does not matter how a program identifies itself (e.g., programs that provide SUD services but do not consider themselves SUD programs) but what services the program actually provides; if a program provides SUD services, the patients that receive those services are covered under 42 CFR Part 2.

- Even if a program is not certified to provide SUD services, if the program provides SUD services and is federally assisted, the patients receiving SUD treatment are covered under 42 CFR Part 2; certification is a state issue and does not dictate whether 42 CFR Part 2 (a federal law) must be followed.

- It is not clear whether 42 CFR Part 2 applies to preventative SUD treatment; the underlying statute itself says it does but there are no specifics in the regulations. For example, if an individual identifies himself in a self-help group or other public meeting as having an SUD problem, he is not covered by privacy law, but if there were formalized

prevention activities held in schools, clinics, or other private locations, 42 CFR Part 2 would apply.

- Patients receiving buprenorphine for opiate addiction are covered under 42 CFR Part 2. This is an issue SAMHSA and CSAT, as well as other government organizations, are looking at closely. In SAMHSA's FAQs, it is clarified that such patients are covered, but it is not clear if such patients are covered when buprenorphine maintenance management is only a small part of a physician's practice. 42 CFR Part 2 does not cover patients in generalized medical settings unless the patient receives services in a specialized unit or from a specialized practitioner. For example, if a patient presents to an emergency room with a broken leg and smells of alcohol but is treated only by general medical staff, that interaction is not covered under 42 CFR Part 2.

- Because treatment programs are now multifaceted with staff outside of the program doing work inside of the program or program staff going out to other programs for services, it is difficult to determine what constitutes a program and how that affects obtaining consent to release information. It should be noted that consent is not required for disclosures within a program for the purposes of providing care.

- In a medical emergency disclosure, rules are different—a medical worker may "break the glass" to access protected records but documentation must be made regarding who and for what purpose the records were accessed.

Q4. As far as 42 CFR Part 2 privacy law, does it matter how a Health Information Organization (HIO) is structured?
A4. No, regardless of the functions of the HIO (whether its merely an infrastructure to exchange patient information, a data repository, a locating service to match patients to their records, or a way for providers to review and respond to requests regarding patient records), 42 CFR Part 2 must be followed where it applies. SAMHSA is looking into how privacy laws factor in when there are changes among members in an already established HIO (such as if an agency within the HIO goes out of business or is taken over by another agency).

Health Information Organization (HIO) Discussion Points

- All of the above functions of an HIO involve the disclosure of information covered by 42 CFR Part 2; there are two ways to ensure that this disclosure satisfies privacy law:
    - Written patient consent to disclose health information
        - A consent form signed by the patient can authorize the initial disclosure of records to the HIO, *as well as re-disclosure* by the HIO to all other healthcare providers in the network.
        - This consent must be clear to the patient and must specifically state to whom the information can be disclosed (not just simply "everything can be released to everyone").
        - The consent ensures that only providers who need the protected information to provide healthcare will have access to it. For example, a patient who has not paid a bill for care provided 3 years ago is now

in SUD treatment with a program that shares the same HIO as the provider he saw for healthcare 3 years ago. The provider that has not received payment cannot access the patient's information for the purpose of settling the old bill.

- Qualified Service Organization Agreements (QSOAs)
  - A QSOA is an agreement between organizations that must follow 42 CFR Part 2 to enable information transfer among QSOAs.
  - Information transfer can only happen in two directions: from a treatment program into the HIO and from the HIO to a treatment program.
  - Express, written patient consent is needed In order to allow for other types of information exchange (e.g., between two programs directly).

- Any group of healthcare providers can set up a HIO, regardless of proximity. The providers simply need to have patient information that they need to share for healthcare purposes and maintain appropriate privacy.

- It is a federal requirement that all HIOs protect and back up electronic data including hard drives, stored discs, etc., and that all information is encrypted.

Consent Discussion Points

- HIPAA does not require consent to disclose information from one healthcare provider to another, nor to disclose information to "payers" (insurance companies, employers, etc.).

- Consents may become the norm for patient information exchange, since they satisfy the requirements of stricter confidentiality laws.

- 42 CFR Part 2 and HIPAA differ regarding consent expiration but both indicate a "common sense" approach. For example, the consent form can say that it will expire once the patient is no longer in the network of care or two years after the patient leaves care. As long as the expiration date makes logical sense and is not excessive (for example, that it is good forever), establishing an expiration date is up to the provider. It's good practice to base the expiration on the expected time it will take to complete the course of treatment, as opposed to an arbitrary date.

- A consent form is valid until it expires or it is revoked, so in the case of a patient leaving treatment before the consent expiration, the consent is still valid until the date of expiration on the consent. In the case of criminal justice mandated treatment, 42 CFR Part 2 allows for irrevocable consent, but HIPAA does not (one of the only instances in which HIPAA provides more protection than 42 CFR Part 2).

- A statement regarding the re-disclosure of information is not a requirement on the original consent form because it is a separate requirement altogether.

- HIPAA does not require consent for disclosures to law enforcement or for payment, but 42 CFR Part 2 does. 42 CFR Part 2 **prohibits** disclosure to law enforcement, even when provided with a subpoena. Disclosure to law enforcement is only allowed with a specific court document that requires special consideration on whether that disclosure is required. For example, before 42 CFR Part 2, police investigating a murder in New York subpoenaed all methadone maintenance programs in the city for records on African American males in treatment because a witness indicated that the killer was African American and may have been in a methadone maintenance program. Ultimately, the New York City methadone programs happened to have a federal grant at that time that required confidentiality, so that information was not released.

- A provider cannot deny treatment if a patient refuses to sign a consent form to release information to the provider's HIO. If a patient refuses to sign consent to release information, the HIO will simply have no knowledge there is an SUD record at all. An audience member proposed a case in which a patient is receiving methadone from an oncologist for pain but is also receiving methadone maintenance from an SUD treatment provider and has opted out of signing a consent form to release information. This question had not been raised to Mr. Samuels before, and he will take the question to SAMHSA.

- An original consent is not necessary as long as the consent is signed; a faxed or scanned copy of a consent form is fine. Someday soon, all signatures will be electronic, anyway.

- The consent form must state who can have the patient's protected information; it must list every healthcare provider in the HIO and state that the patient is authorizing the release of information to each provider (including to SUD treatment providers) for healthcare, specifically.

- All programs to which a patient's records may be released must be listed on the consent form, regardless of how many there are. A way to circumvent multiple consent form changes is to create a list that is separate from the consent form and note on the consent to "see the attached list." In this scenario, a new consent will have to be signed if new programs join the HIO, but changes will not have to made if programs drop out of the HIO.

- It **is** permissible to list multiple providers on a written consent form; the rules for electronic consent are the same as for paper forms.

- SAMHSA is working on whether patients can pick and choose which providers within a HIO can access their information.

- Patients may need to sign a new consent form when new providers join the HIO, but a federal decision on that has not yet been made.

- Consent scenario: A Federally Qualified Health Center (FQHC) that provides primary healthcare and SUD treatment; links need to be established between the primary care group and one or more substance use disorder treatment programs.
    - FQHC could sign a QSOA to allow for information sharing without consent
    - FQHC or SUD programs could ask for consent forms separately for treatment purposes

Additional Discussion Point: What are SAMHSA's and other government agencies' roles in interpreting and enforcing 42 CFR Part 2?

Under federal confidentiality law (passed in the early 70s) the Department of Health and Human Services (DHHS) has legal authority to issue interpretations and to regulate the interpretation of privacy regulations. DHHS has extended that authority to SAMHSA. Whatever SAMHSA interprets is sent to DHHS for review and final approval. The Justice Department has the power to criminally prosecute violators of 42 CFR Part 2. However, 42 CFR Part 2 has been in effect almost 40 years and no one has faced criminal prosecution for being in violation of it. There have been a few instances in which the Justice Department informed organizations to be more careful, but there have been no actual criminal prosecutions.

III. Health Information Technology and Substance Use Disorder Treatment

Mady Chalk, M.S.W., Ph.D.
Director, Center for Policy Research and Analysis
Treatment Research Institute (TRI)

Dr. Chalk opened her discussion of Health Information Technology (HIT) by defining "meaningful use" and describing the new direction that thoughts on information sharing are going federally. Dr. Chalk talked about the barriers to health information exchange and revealed to the group a new approach to HIT that may circumvent those barriers.

Meaningful Use

It is anticipated that the meaningful use of protected health information under healthcare reform will evolve in three stages:

1. widespread adoption of electronic health records and information
2. information exchange
3. improving health outcomes

Unfortunately, SUD and MH services were left out of funding opportunities in Stages 1 and 2 of healthcare reform, but there will be an opportunity for these fields to get involved during Stage 3, so it is very important that they are ready when the time comes.

HIPAA Up for Review

HIPAA privacy policy is coming up for review, and it is predicted that there will be a shift in focus regarding privacy policy to a focus on patients' relationships to their own information. The focus will be on patients' ability to access and understand their information and have some control over it, and it is believed that electronic health records (EHR) will facilitate that.

Problems with EHR

The White House Office of Science and Technology Policy (OSTP) is involved in the development of HIT with regard to what they've learned from other countries already successfully using EHR. Barriers to implementing EHR information sharing in the United States so far have been:

- that it is not functionally feasible for primary care physicians day-to-day
- all existing EHRs are not directly exchangeable
- EHR developers have little incentive to make them accessible
- EHRs are often viewed as merely internal resources
- EHRs are typically designed specifically for an individual site, making use outside of that site limited
- There is not a lot of funding available to improve EHR accessibility

Moving Forward: A Universal Information Exchange Language

In order to facilitate information sharing, EHR is moving toward developing a "Universal Exchange Language" (President's Council of Advisors on Science and Technology [PCAST] Report to the President, 2010).

- Every piece of information (patient name, diagnosis, medication, address, etc.) is a "bit" of information.
- Each "bit" can be extracted from a file or hidden.
- "Bits" allow for the sharing of specific information from a file rather than the sharing of an entire file.
- Sharing information "bits" will require a common infrastructure for locating and assembling data (records can stay where they originate; the issue is how the information is entered and accessed).
- "Bits" will not require universal patient identifiers or the creation of a federal database.
- "Bits" provide stronger privacy protections than what currently exists.
- "Bits" will facilitate public health and medical research by providing a secure way to de-identify data.

In closing, Dr. Chalk pointed out that data sharing should be a concern for everyone, as we are all consumers. When we can share data in healthcare, we can empower the patient with additional choices, different treatments, and better outcomes, to provide better care overall.

Conclusion and Next Steps

Concretely, follow-up steps from the Forum on Data Privacy include broad dissemination of Forum materials (including this report) via e-mail to participants and making it available for download via UCLA's website (http://www.uclaisap.org/Affordable-Care-Act/). UCLA and the Pacific Southwest Addiction Technology Transfer Center (PSATTC) are also developing a technical assistance workshop on data privacy based in part on the Data Privacy Forum, and will deliver the first session in July 2011 in Kern County. In addition, UCLA will also continue to participate in the CADPAAC data/outcomes committee and the ADP health information technology committee related to data and health information discussions on the implementation of electronic systems that will facilitate sharing of data within the boundaries of regulations.

More generally, next steps for the field include development of standardized consent forms and development of ways to include and exchange consent information in electronic health records, first on a general basis and then applied to individual "bits" of data. Achieving these goals will require the field to engage with software vendors, and initiation of pilot projects to test such data-exchange methods among a limited number of organizations may be useful as a first step.

References

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Executive Office of the President, President's Council of Advisors on Science and Technology. *Report to the President - Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward.* December 2010, accessed http://www.whitehouse.gov/sites/default/files/microsites/ostp/pcast-health-it-report.pdf.

Attendees

California County SUD Administrators and Other County Representatives

MINIMUM BASE ALLOCATION (MBA) COUNTIES

- Amador (Patricia Bartosiewicz, Sherry Parkey)
- Calaveras (David Sackman)
- Del Norte (Jill Fullington)
- Glenn (Thomas Waggoner, Erin Valdez)
- Inyo (Linda Benson)
- Lake (Linda Morris)
- Lassen (Anita Harsh, David Rothery)
- Mariposa (Linda Murdock)
- Modoc (Tara Shepherd)
- San Benito (Alan Yamamoto)
- Sierra (Rhonda Grandi)
- Siskiyou (Randy Davis)
- Tehama (Susan McVean)
- Trinity (Pete Smyth)

SMALL COUNTIES

- Butte (Marion Reeves, Dean True)
- Humboldt (Helene Barney)
- Kings (Brenda Randle)
- Madera (Sonja Bentley)
- Mendocino (Leslie Kirkpatrick)
- Merced (Kathleen Reyes, Natalie Vasquez)
- Napa (Connie Moreno-Peraza, Karen McElroy, Lisa Montanez)
- Yolo (Mark Bryan)

MEDIUM COUNTIES

- Kern (Lily Alvarez)
- Marin (DJ Pierce, Michael Hodges, Leigh Steffey)
- Placer (Cheyl Trenwith, Amy Ellis)
- San Joaquin (Vic Singh)
- Solano (Andrew Williamson)
- Stanislaus (Madelyn Schlaepfer)

LARGE COUNTIES

- Alameda (Tom Trabin)
- Contra Costa (David Cassell)
- Fresno (Dennis Koch)
- Orange County (Brett O'Brien, William Murray)
- Sacramento (Maria Morfin, Melinda Avey, Lisa Scott-Lee)
- San Bernardino (Vicki Baumbach)

- San Diego (Susan Bower, Angie DeVoss)
- San Francisco (Alice Gleghorn)
- San Mateo (Keith Clausen)
- Santa Clara (Robert Garner Michael Hutchinson, Francis Ita-as, Gelin Ordana, Nubia Torres)
- Ventura (Patrick Zarate)

Organization Participants

- ADPI (Victor Kogler)
- Aegis Medical Systems/COMP (Steve Maulhardt)
- CAADPE (Albert Senella)
- California Department of Public Health (Alessandra Ross)
- CADPAAC (Tom Renfree)
- California Department of Mental Health (Heide Lange)
- Rural Health Providers (Tom Avey)
- Risk Management Services (Linda Garrett)

ADP Participants

- Michael Borunda
- Cynthia Castillo
- Craig Chaffee
- Tina Chiginsky
- Debra Connick
- Michael Cunningham
- Jessica Delgado
- Darrien De Lu
- Mary Dodson
- Jonathan Graham
- Cynthia Guest
- Theresa Gulley-Reed
- Gayle Hirahara
- Sally Jew-Lochman
- Janine LaMar
- Marjorie McKisson
- Maurilio Mendez
- Dave Neilsen
- Katrina Parker
- Nanette Rufo
- Suzi Rupp
- Gigi Smith
- Denise Wallace Warrick
- Kevin Wortell

- Marcia Yamamoto
- Angela Zamora

UCLA Participants

- Desirée Crèvecoeur-MacPhail
- Elizabeth Nelson
- Valerie Pearce Antonini
- Deborah Podus
- Darren Urada

Chapter 3: Integration of Substance Use Disorder (SUD) and Healthcare Services

Valerie Pearce Antonini, MPH, Allison Ober, Ph.D., Stella Lee, B.A., Howard Padwa, Ph.D., and Richard A. Rawson, Ph.D.

I. Introduction

Through a combination of proposed healthcare reform changes and a federal commitment to improving healthcare in the United States, the public substance use disorder (SUD) service system faces monumental changes in the way services are delivered and funded. Consistent with promising evidence for the benefits of integrating SUD services into healthcare settings (Samet, Friedmann et al. 2001; Weisner, Mertens et al. 2001; Parthasarathy, Mertens et al. 2003) and the call to improve the quality of healthcare nationally, the United States is moving toward more coordinated, clinically integrated behavioral (mental health and SUD services) and physical healthcare (Institute of Medicine [IOM], 2006).

As stated in the 2006 Institute of Medicine (IOM, 2006) Quality Chasm report, "Healthcare for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body." In addition, healthcare reform—the Affordable Care Act (ACA) of 2010 and the Mental Health and Addiction Equity Act of 2008 (MHPAEA)—as well as the American Recovery and Reinvestment Act (ARRA) of 2009, emphasize prevention, accessibility of healthcare, as well as better coordination and integration of behavioral and physical healthcare (National Association of Community Health Centers, 2010). With greater emphasis on providing integrated services within healthcare settings (and potential financial benefits for doing so), with potentially more patients having insurance or Medicaid coverage for SUD services, and with more patients being referred to treatment if they are screened in primary care settings, the public SUD system will need to adjust the way services are delivered and billed.

With these changes on the horizon, the California Department of Alcohol and Drug Programs (ADP) and researchers from the University of California, Los Angeles (UCLA), began work under the EnCAL contract to understand the implications of SUD/healthcare integration as it relates to the ongoing work at the state level around providing a full continuum of services. The work delineated in Domain 2 of this contract, therefore, consisted of addressing specific objectives to prepare counties and providers for integrating SUD services with primary care (PC) and mental health (MH).

Objectives

Although a variety of integration models for integrating behavioral health services into PC exist, it is not clear which models produce optimal impacts. In fact, because integration of SUD treatment into PC and MH settings is in its infancy, the mechanisms by which to best define and measure the impact of integration efforts is unknown. Despite the lack of data and empirical evidence on this topic, implementation of service integration has begun in many California counties. UCLA and ADP identified the following objectives to begin work under this domain:

- To Assess Existing Integration Models and Local and National Integration Efforts;
- To Assist Integration Planning through One or More Learning Collaboratives; and
- To Evaluate the Integration Environment and Learning Collaborative Processes and Outcomes

Workplan

During fiscal year 2010–2011, UCLA embarked upon a number of preliminary investigative processes to address the above listed objectives. We conducted extensive literature searches and key informant interviews with national experts in the field and attended several conferences and webinars on integration and healthcare reform. UCLA conducted a statewide integration survey to acquire a snapshot of integration activities across counties, and we visited several Federally Qualified Health Centers (FQHCs) and community health centers to gain a more qualitative assessment of what integration models and activities are up and running in "real world" settings across California, as well as one facility in Arizona.

Following this preliminary research, UCLA facilitated the California Forum on Integration followed by an ongoing Learning Collaborative directed toward administrative personnel of county SUD services. Finally, UCLA initiated in-depth case studies at selected counties piloting integration initiatives in which the university provided training and technical assistance as well as process and outcome evaluation, when applicable.

During this pivotal time of service delivery evaluation, national and state policy review, and development of preparations for federal healthcare reform, UCLA established an information resource website to house "must see" literature, presentations, and reports from the national effort. In addition, this site houses the information collected from and disseminated to the Integration Forum and Learning Collaborative to assist counties plan for integration.

Chapter Organization

This chapter is organized into the following sections:

- Investigative/Preliminary Research
  - Literature review on evidence for and models of integrated behavioral healthcare;
  - California County Integration Survey;
  - Exploratory site visits of FQHCs in the field
- Statewide Activities
  - Descriptive case studies of county integration initiatives;
  - California's Forum on SUD/Primary Care Integration;
  - SUD/Healthcare Integration Learning Collaborative (ILC);
  - Website development
- Lessons Learned/Recommendations

II. Investigative/Preliminary Research

A. Literature Review

Background

Integrating substance use disorder (SUD) services (i.e., screening, intervention, and/or treatment) with healthcare services is feasible (Babor, McRee et al. 2007; Ernst, Miller et al. 2007; Madras, Compton et al. 2009), is associated with better patient outcomes and reduces overall healthcare utilization costs (Willenbring, Olson et al. 1995; Weisner, Mertens et al. 2001; Parthasarathy, Mertens et al. 2003; Mertens, Flisher et al. 2008; Madras, Compton et al. 2009), and is reportedly well underway in many community health centers and other medical settings throughout the United States (National Association of Community Health Centers, 2009; Treatment Research Institute Inc., 2010; Ober, Urada, Pearce et al., 2011; Ober, Urada, Pearce, Padwa et al., 2011), yet there is little documentation about the nature, scope, and practical implications of integrated services. Integration can mean providing SUD services in healthcare settings, providing healthcare services in SUD settings, or increasing collaboration, coordination, and linkage between the two. SUD services may include screening, intervention, referral to treatment, or treatment such as medication-assisted therapy and counseling. For example, 51% of Federally Qualified Health Centers (FQHCs) in the United States report that they provide SUD services (National Association of Community Health Centers, 2009), but few data are available (Lardiere, Jones et al., 2011) on what integration models (e.g., who delivers services, what services are being delivered) or what levels (e.g., coordinated, co-located, partly-integrated, fully integrated) (Doherty, McDaniel et al., 1996) are being implemented, how SUD services are coordinated, billed, and documented (Collins, Hewson et al., 2010), and whether some models work better than others for providers and for patients.

Although there is ample documentation of "behavioral health" integration, which by definition includes both SUD and mental health services, the majority of the documentation focuses primarily on the integration of mental health services into healthcare settings (Mauer, 2006; Butler, Kane et al., 2008; Collins, Hewson et al., 2010). With SUD integration into medical healthcare settings lagging behind mental health/medical healthcare integration by many years, there is a dearth of documentation on the practical implications of and best practices for SUD service integration into healthcare settings. Closer study and documentation of SUD/healthcare integration is needed to provide information about facilitators and barriers to integration that may be unique to SUD and to ensure quality and sustainability of integrated SUD services.

The Evidence for Integrated SUD Services

Although SUD services traditionally have been provided outside of medical practices (Treatment Research Institute Inc., 2010)—typically they are offered in separate facilities with little coordination between SUD and medical providers—there are a number of evidence-based arguments for integrating the two. These reasons fall roughly into three categories: increased access to SUD prevention and treatment, better clinical care and improved outcomes for patients with SUD, and cost-effectiveness.

Increased access to SUD prevention, intervention, and treatment

An estimated 20 million Americans who have problematic substance use currently do not receive treatment for their substance use (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007), about 22% of individuals who currently present for services in medical settings are affected by an SUD (SAMHSA, 2005), and more than 90 percent of patients who meet the criteria for an SUD do not recognize their need for treatment (SAMHSA, 2008). Moreover, individuals with SUD use about five times more healthcare services than do people without SUDs (SAMHSA. 2005). Offering SUD services in healthcare settings can increase the number of people screened for SUDs and offer greater linkage to intervention and treatment for those who need it. With an estimated 32 million more Americans expected to receive healthcare coverage under healthcare reform legislation, increased federal funding to community health centers to build more facilities and to expand behavioral health services, and parity legislation that promises equal reimbursement for health and behavioral health conditions by insurers who cover behavioral health, healthcare settings are well-situated to increase access to intervention and treatment by providing a number of SUD services.

Preventing the Development of SUDs

Beyond facilitating the treatment of SUDs, SUD/PC integration can also help prevent the onset of SUDs. There are approximately 68 million Americans who use psychoactive substances in an unhealthy or dangerous manner, but do not meet diagnostic criteria for substance abuse or dependence (Caetano & Cunradi, 2002; Whitlock, Polen et al., 2004; Humphreys & McLellan, 2010). Though these individuals do not need specialty SUD treatment, excessive drinking and drug use can cause significant and permanent alterations to the brain's reward circuitry—changes that can, in some individuals, lead to the development of SUDs (McLellan, Lewis et al., 2000). Consequently, though heavy substance use does not always lead to dependence, it is strongly correlated with SUDs (Caetano & Cunradi, 2002), and interventions designed to reduce the level and frequency of substance use can help prevent SUD onset.

Through the use of validated screening instruments, primary care providers can identify patients who are using substances in a risky manner, and through brief intervention techniques, can facilitate the reduction of substance use (Gentilello, Rivara et al., 1999; Fleming, Mundt et al., 2002; Babor & Kadden, 2005; Babor, McRee et al., 2007; Solberg, Maciosek et al., 2008; Humphreys & McLellan, 2010). In as little as one 15-minute session, providers can help patients reduce both the level and frequency of their substance use by educating them about the risks associated with drinking and drug use and utilizing motivational techniques (Whitlock, Polen et al., 2004; Babor, McRee et al., 2007; Humphreys & McLellan 2010). When implemented as part of a more comprehensive program designed to provide screening, brief interventions, and referral to treatment (SBIRT) when necessary, such interventions can be particularly effective. A recent federally funded initiative to institute SBIRT protocols in a variety of medical settings across six states led to 67.7% reductions in drug use and 38.6% reductions in heavy drinking (Madras, Compton et al., 2009). By facilitating such dramatic decreases in substance use, the integration of SBIRT services into primary care settings can help prevent the development of SUDs in a significant portion of the patient population.

Better Clinical Care and Improved Outcomes

In addition to increasing SUD identification, intervention, and treatment for those who need it, there is growing evidence that providing integrated and/or coordinated SUD and physical healthcare—either screening, brief intervention, and referral to treatment (SBIRT; Fleming, Barry et al., 1997; Babor, McRee et al., 2007) and/or full treatment (Weisner, Mertens et al., 2001; Mertens, Flisher et al., 2008)—can result in better SUD and primary health outcomes for patients. Adults receiving SUD treatment are significantly more likely to have medical problems such as an injury, lower back pain, hypertension, migraines, asthma, and arthritis than are people without SUDs (Mertens, Lu et al., 2003). Weisner et al. (2001) found that patients with SUD-related medical problems who received integrated SUD treatment and primary care were almost two times as likely to be abstinent from substance use at six months as patients who received the two services independently, and that the positive effects of SUD treatment lasted for five years (Weisner, Mertens et al., 2001).

Integrated care can also result in better outcomes by increasing usage of primary care by SUD patients. Umbricht-Schneiter et al. (1994) compared on-site medical care for methadone patients to referrals to primary care off-site and found that providing on-site care resulted in significantly higher use of primary care services (Umbricht-Schneiter, Ginn et al., 1994). Effectively linking patients from SUD treatment to primary care can even result in lower substance use and improved health outcomes (Samet, Larson et al., 2003). Not surprisingly, there is evidence that individuals who receive screening and brief interventions in emergency rooms and trauma centers also show significant reductions in substance use as well as in re-injury (Gentilello, Donovan et al., 1995; Gentilello, Rivara et al., 1999). Although further study of which models work best for which patients (who provides care to which patients in what setting) is needed (Butler, Kane et al., 2008), there is a growing body of evidence supporting, at the very least, greater coordination of SUD and primary care services and, at most, provision of coordinated screening, intervention, and/or treatment within healthcare settings, including primary care settings, emergency rooms, and trauma centers.

Cost-Effectiveness

Due to the multiple health problems associated with SUDs, people with SUDs tend to have higher medical costs than patients who do not use substances (Holder & Blose, 1991; Lennox, Scott-Lennox et al., 1992; Parthasarathy, Weisner et al., 2001). Higher medical costs incurred by people with SUDs are primarily attributable to costly emergency room and inpatient care (Parthasarathy, Mertens et al., 2003). In 2006, more than 1.7 million visits to hospital emergency departments were related to some form of substance misuse or dependency (SAMHSA Office of Applied Studies, 2008).

Research has long suggested that SUD treatment reduces medical costs (Holder & Blose, 1991; Holder, Lennox et al., 1992; Walter, Ackerson et al., 2005); integrated SUD treatment in primary care settings can result in even lower costs than independently delivered SUD and medical care (Parthasarathy, Weisner et al., 2001). Further, SBIRT in medical settings, including emergency rooms and trauma centers, is also associated with overall cost reductions (Quanbeck, Lang et al., 2010; Fleming, Mundt et al., 2000; Gentilello, Ebel et al., 2005; Babor, McRee et al., 2007). Parthasarathy et al. (2003) found that integrated care for patients with substance-abuse related medical conditions resulted in significant decreases in hospitalizations,

inpatient days, and emergency room use compared with patients who received independent SUD and medical care (Parthasarathy, Mertens et al., 2003). Research by Gentillelo et al. (2005) suggests that brief intervention in a trauma center can result in $3.81 in healthcare costs saved for every $1.00 spent on screening and intervention (Gentilello, Ebel et al., 2005). With growing evidence that integrating SUD and healthcare services can result in cost savings and benefits that extend across healthcare settings, there likely will be greater efforts to integrate the two. As this trend takes hold, providers and policy makers must take care to ensure that practical implications of SUD/healthcare integration are well-understood in order to ensure the quality and sustainability of services.

SUD/Healthcare Integration Defined

Compared to mental health service integration into healthcare settings, models and levels of SUD/healthcare integration are not yet well-defined, but we can use mental health integration as a roadmap for the study and implementation of SUD/healthcare integration. To create a framework for studying SUD integration, we draw primarily from three seminal reports on behavioral health integration (almost exclusively mental health) and one article on levels of care, as follows: (1) The Milbank Memorial Fund report by Collins, Hewson, et al. (2010) entitled *Evolving Models of Behavioral Health Integration in Primary Care*; (2) an Agency for Healthcare Research and Quality (AHRQ) systematic review of behavioral health integration models entitled *Integration of Mental Health/Substance Abuse and Primary Care* (Butler, Kane et al., 2008); (3) *The Treatment Research Institute Report from their Forum on Integration: A Collaborative for States* (Chalk, Dilonardo et al., 2010); and the article entitled *Five Levels of Primary Care/Behavioral Health Collaboration* (Doherty, McDaniel et al., 1996).

Integration

As originally offered by Butler et al. (2008), but adapted slightly for SUD/healthcare integration, we define SUD/healthcare integration as *the systematic linkage of SUD and healthcare services*. This definition encompasses all models and levels of integration, as described below, and applies to SUD integration into any healthcare setting and primary care integration into any SUD setting.

Models of Integration

The term "integration model" has been used loosely and varies greatly across the behavioral health integration literature. For the sake of clarity, we define "integration model" as the *processes* by which behavioral health services are delivered in conjunction with healthcare services, i.e., *what services are delivered to whom, by whom, under whose guidance or supervision, and how services are billed and documented*. Two examples of well-defined, evidence-based behavioral health integration models are the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model (Unutzer, Katon et al., 2002) and the Primary Care Behavioral Health Model (PCBH), both of which follow the overarching principles emphasized in Wagner's Chronic Care Model (CCM; Wagner, 2000; Wagner, Austin et al., 2001). In the CCM, or disease management model, which was designed to identify and support individuals at risk for chronic disease, a care manager located in the healthcare setting provides ongoing assessment, teaches patients self-management techniques, provides psychiatric consultation, and uses a patient registry to track care across disciplines (Wagner, Austin et al., 2001; Collins, Hewson et al., 2010). These processes can be applied to treat more specific chronic conditions

and adapted to fit in the environment and population being served. Models developed from the principles of the CCM and adapted in various PC settings for SUD/healthcare integration might involve a care manager or behavioral health specialist who provides SUD screening and brief interventions to individuals in a healthcare setting and then refers those who need further treatment to on-site or off-site specialty treatment.

In the IMPACT Model, a depression care manager, who is supervised by a psychiatrist and a primary care expert, offers education, care management, and depression management support to the physician, as well as brief psychotherapy to the patient for depression (Unutzer, Katon et al., 2002). In this model, a care manager works in a healthcare setting to provide psychosocial support and referral to patients and ongoing support to physicians and behavioral health clinicians. The IMPACT model adapted the Problem Solving Treatment manual for the Primary Care setting (PST-PC), which begins with a 1-hour first session and 30-minute follow-up sessions. Treatment is typically only 4–8 sessions within the primary care setting. Based on several studies PST-PC is an effective and feasible treatment for major depression, for more broadly defined emotional syndromes with a poor prognosis, and for dysthymia. PST-PC not only improves depressive symptoms but also improves daily function in a broader sense (e.g., work, family, and social functioning) (Catalan, Gath et al., 1991; Mynors-Wallis, Gath et al., 1995; Mynors-Wallis, Davies et al., 1997; Mynors-Wallis, Gath et al., 2000).

The Primary Care Behavioral Health (PCBH) model of integrated care has been on the forefront of the integrated care movement and has been employed as the model of integrated care by large healthcare systems like Kaiser Permanente, Veterans Affairs, Federally Qualified Health Centers, and the United States Air Force, Army, and Navy (Strosahl & Robinson, 2008). This model's emphasis is on population management and is designed to improve overall population health through comprehensive healthcare and by decreasing the BH load on the PC system. It involves the delivery of services by a new member on the PC team, the Behavioral Health Consultant (BHC), who operates as a member of the PC team to help primary care providers (PCPs) manage the psychosocial needs of their patients. Their role is designed to have the largest effect possible on the population and to provide maximal help to PC patients and providers. This model affords easy access to behavioral healthcare by providing service side by side with PCPs (co-located). The PCP is the BHC's principal customer, for whom the goal is to provide practical care recommendations. The BHC does not conduct ongoing care but rather teaches patients new skills that, it is hoped, will be discussed, reinforced, and perhaps even expanded upon during subsequent PCP visits.

According to the model, the BHC sees 10–15 patients a day with follow-up limited to 1–4 visits. The goal is to develop a well-rounded treatment plan for the PCP to follow. Feedback to the PCP regarding the plan occurs promptly and the PCP retains control of the patient's care and learns more about behavior change strategies. In order for the model to be implemented successfully, the PCP must identify a specific reason for consultation with the BHC, emphasize consultative relationship, and display confidence in the BHC.

The PCBH model can be adapted as needed and as such, differing ways in which to measure its effectiveness is available. To evaluate its productivity, the average number of daily encounters can be measured, but estimates need to reflect BHC consistency in effort and success in impact

on PCP knowledge, confidence, and practice patterns by whatever means, including creating pathways and group programs. Measureable practice parameters include adequate BHC-to-patient staffing ratios and balanced ratios on other practice indicators. A customer satisfaction assessment or some type of functional status measure at every contact, including individual, class, and group medical appointments can also be developed and utilized. Further research is needed to develop and test whether this and other existing models of mental health integration are effective for SUD and to identify new models that specifically address SUD.

Levels of Integration

We define "level of integration" separately from "integration model," and use it to describe the *degree* of collaboration between behavioral health services and medical providers. As originally described by Doherty et al. (1996) and adapted by Collins et al. (2010), degree of collaboration tends to fall into one of these five levels;

- Level One: Minimal collaboration. At this level, behavioral health and healthcare providers provide services in separate facilities, have totally separate systems and rarely communicate about cases (Doherty, McDaniel et al., 1996; Collins, Hewson et al., 2010). Historically, this has been the level of collaboration between SUD providers and healthcare providers. Services at this level are not considered to be integrated.
- Level Two: Basic collaboration at a distance. At this level of collaboration, primary care and behavioral health providers work within separate systems at separate sites, but engage in periodic communication about shared patients (Doherty, McDaniel et al., 1996; Collins, Hewson et al., 2010). This also can be described as "coordinated" care (Blount, 2003).
- Level Three: Basic collaboration on site. At this level, behavioral health and primary care professionals work separately in separate systems but share the same facility. Although being in the same facility may allow for more communication between providers, collaboration is minimal, with little case coordination and totally separate record-keeping (Doherty, McDaniel et al., 1996; Collins, Hewson et al., 2010). This can also be defined as "co-located" care (Blount, 2003) and could take place in a healthcare or an SUD setting. Healthcare services in an SUD setting might be described as "reverse co-located" care.
- Level Four: Close collaboration in a partly integrated system. At this level, behavioral health professionals and primary care providers share the same facility and have some systems in common, such as appointment scheduling and medical records. Close collaboration might also involve behavioral health and healthcare providers engaging in face-to-face consultation about shared patients (Doherty, McDaniel et al., 1996; Collins, Hewson et al., 2010). This falls between "co-located" and "integrated" care (Blount, 2003).
- Level Five: Close collaboration in a fully integrated system. At this level, the behavioral health provider and primary care provider are part of the same team, share records, and are in close communication. The patient experiences the behavioral health treatment as part of regular primary care, or vice versa, if the primary care provided is located in the SUD setting (Doherty, McDaniel et al., 1996; Collins, Hewson et al., 2010). This is "fully integrated" care (Blount, 2003).

Conclusion

Research on BH/PC integration has shown that mechanisms for facilitating integration can vary, ranging from informal partnerships or mutual agreements between separate PC and BH providers to more unified setups, where PC and BH staff work for the same agency and fully coordinate integrated care for their patients (Doherty, McDaniel et al., 1996; Blount, 2003; Mauer, 2006; Butler; Collins, Hewson et al., 2010). The optimal model for BH/PC integration largely depends on the service needs of the patient population, as the role of BH and PC providers in service delivery and treatment planning should vary, depending on the relative level of each patient's physical and behavioral healthcare needs (Mauer, 2006; Collins, Hewson et al., 2010).

As we move ahead in our study of existing models of SUD integration with healthcare, it is important to note that few clinical trials exist that provide support for any specific model or level of integrated SUD/healthcare. In fact, evidence for specific models is even still lacking with regard to mental health/healthcare integration. In a systematic review of 33 trials examining mental health service integration, outcomes were not associated with a particular model or level of integration, although they were generally supportive of integrated care (Butler, Kane et al., 2008). As such, the authors of this review point out that we still do not know which elements of integration are most important to producing better outcomes for patients and which patients are most likely to benefit from integrated care. Further, the authors note that it is still unclear how evidence-based integration models can retain fidelity and sustainability in real-world settings.

Special Considerations for SUD/PC Integration

In spite of the commonalities between SUD and MH services (Davidson & White, 2007), and the fact that 42.8% of the population with SUDs also has a co-occurring MH disorder (SAMHSA, 2010), it cannot always be assumed that models for MH/PC integration would work for SUD/PC integration. And while many programs that integrate MH into PC do offer some SUD services as well, they generally focus their BH services on mental health issues rather than on problems related to substance use; in many of these settings, in fact, SUD services are limited to screens and interventions focused on problematic alcohol use, but not the use of other psychoactive substances (Chalk, Dilonardo et al., 2010). Given that some 7 million Americans meet diagnostic criteria for dependence on substances other than alcohol (Humphreys & McLellan, 2010), a large patient population would continue to have its SUD treatment needs go unmet if the only SUD services offered in PC settings were those that rely solely on integrated MH/PC services.

In particular, models for MH integration do not facilitate the use of medications such as naltrexone (a drug that can help in the treatment of opiate and alcohol dependence), buprenorphine, or methadone (which are effective in the management of opiate dependence). While PC providers often prescribe psychotropic medications for the treatment of MH problems (Mark, Kassed et al., 2009), the use of medications to treat SUDs is much more rare (Mark, Kranzler et al., 2003; Lardiere, Jones et al., 2011). Many of the barriers that prevent the use of SUD medication are systemic, as the medications are more expensive and tightly controlled than the medicines used to treat mental illness, and insurers are reluctant to pay for them. Furthermore, Medicaid licensing requirements for SUD treatment reimbursement are also more restrictive, thus creating further disincentive for PC clinics to integrate SUD treatment into their array of services (Chalk, Dilonardo et al., 2010). At the clinic level, providers often lack the specialized

training to properly utilize these medications in treatment (Mark, Kranzler et al., 2003; Lardiere, Jones et al., 2011), and the resources and time to effectively provide SUD medication support services (Chalk, Dilonardo et al., 2010). At the patient level, individuals with SUDs and their families are often reluctant to start taking SUD medications, particularly if needed as part of a long-term or lifetime maintenance regimen (Mauer, 2010).

Nonetheless, a handful of providers have begun to implement models of SUD/PC integration that circumvent some of these challenges. The National Council for Community Behavioral Healthcare has laid out a theoretical framework for designing integrated SUD/PC services (Mauer, 2010), and the Treatment Research Institute identified several models of SUD integration that are being put into practice (Chalk, Dilonardo et al., 2010). In its 2010 Issue Brief on SUD/PC integration, the Treatment Research Institute reported that some providers have integrated SUD services as part of their health homes within FQHCs, and that some states have used SAMHSA grants to implement SBIRT into a variety of PC and medical-care settings. Some providers have been narrower in the focus of their SUD/PC integration efforts, providing screening and early intervention services to target populations, such as pregnant women. Some states such as Wisconsin and Massachusetts, and local systems such as those in Baltimore and San Francisco, have initiated programs to facilitate office-based SUD treatment with buprenorphine. Furthermore, some FQHCs and county SUD treatment providers have formed partnerships to offer specialty SUD services co-located within regular medical clinics (Chalk, Dilonardo et al., 2010).

Though these models for SUD/PC integration have begun to emerge in some systems, they are still not being implemented on a wide scale. Thus, while providing valuable examples of what SUD/PC integration could look like, these models are not necessarily indicative of the SUD/PC integration efforts that are being initiated in most of the nation's health systems. In our study of integration in California, our intention is to describe models, levels, and barriers to integration in existing integration initiatives and programs in order to identify technical assistance and training needs in California counties, to inform ADP policy around integration, and to lay the foundation for further study of SUD/healthcare integration.

B. California County Integration Survey*

Purpose

To get a sense of the scope of the SUD-healthcare integration projects in California counties, the California Department of Alcohol and Drug Programs (ADP) and UCLA Integrated Substance Abuse Programs (ISAP) conducted a brief survey of county AOD administrators. The purpose of the survey was to assess the status of integration efforts in California counties among county-operated and county-contracted SUD providers and primary care providers (although this survey focused specifically on *primary care* providers, we have since expanded our focus to all healthcare settings, including emergency rooms and trauma centers), in order to determine what technical assistance, if any, is needed to facilitate integration plans. This effort was the first in a series of technical assistance and training activities to further integration of SUD and primary care services in California.

Methods

To conduct the survey, UCLA research staff, with input from ADP and several county administrators, constructed a brief electronic survey (using Survey Monkey) to get a snapshot of SUD/primary care integration activities across the state and to assess technical assistance needs. In October 2010, AOD administrators from every county (n=58) received an e-mail with a link to the survey. Administrators were given six weeks to complete the survey. Forty-four administrators responded to the survey. UCLA research staff conducted a descriptive analysis of the survey results. A report that provides a summary of these results, highlights key findings, and provides a take-away message for each key finding was written and disseminated.*

Summary of Findings

While the report goes into greater detail, survey analyses revealed several key findings. Many counties, as indicated by responses from the survey, are working on or planning initiatives to integrate SUD screening, intervention, referral to treatment with PC, either in SUD specialty settings or PC settings. Twenty-five counties (57%) reported that SUD/PC efforts are underway in their counties, and 18 counties reported (32%) planning SUD/PC integration within the coming year. To date, providers in California have primarily used four models or categories of SUD/PC integration.

SUD Services Delivered By SUD Specialists in PC Settings

Of the 25 California counties undertaking SUD/PC integration efforts, 10 of them are utilizing models that colocate SUD treatment specialists within PC settings. In most of these programs, SUD specialists conduct screenings for alcohol and drug misuse, while some also screen for nicotine use and substance use by pregnant women. In some programs, SUD specialists also carry out brief interventions for patients who are flagged for risky substance use, and they also provide psychosocial treatment services. In most of the counties using this model, SUD services

* Please see http://www.uclaisap.org/Affordable-Care-Act/assets/documents/CA%20Forum%20on%20Integration/CA%20County%20Integration%20Survey_Report_FINAL.pdf for the full Survey Summary Report

are partially integrated into PC clinics, with SUD specialists working onsite and collaborating with PC providers in treatment planning and care management, but maintaining their own documentation and billing systems. In three counties, SUD administrators reported that SUD specialists were "fully integrated" clinically, administratively, and financially.

SUD Services Delivered by MH Specialists in PC Settings

In the 25 California counties involved in SUD/PC integration, 23 of them reported that their efforts are coordinated with, or part of, broader efforts to integrate BH services with PC. We visited two FQHCs that, as part of their broader BH service integration initiatives, gave specialty MH providers the responsibility for screening patients for SUD and providing interventions. At both sites, we noted that screening processes were relatively informal, as they did not involve the use of validated SUD screening instruments and were only conducted on patients who providers suspected were using substances problematically. Clinicians we spoke to at these sites were aware of the limitations of this model, particularly since their screening processes were somewhat haphazard, and not evidence-based. These providers expressed a desire for further training so they could expand their SUD services to meet their patients' treatment needs.

PC Services Delivered by PC Specialists in SUD Settings

In 11 of the 25 California counties currently integrating SUD and PC services, models placing PC providers in specialty SUD treatment settings are being implemented. Beyond providing narcotic medication management services and conducting physical exams for new patients at intake into SUD treatment, PC providers screen for chronic diseases, provide lifestyle counseling, perform routine physical exams and follow-ups, and refer patients to outside providers for services when extra medical attention is needed. SUD providers using this model reported that offering medical services onsite is particularly helpful for their clientele, who are predominantly homeless or low-income, and have little access to medical care elsewhere.

Medication-Assisted SUD Treatment in Collaboration with Primary Care

Another promising model of SUD/PC integration involves the use of MATs — such as methadone or buprenorphine for the treatment of opiate dependence — in conjunction with other PC, MH, and SUD services. One FQHC we visited had distinct protocols to allow for patients who needed MAT to receive their medications in coordination with other PC, MH, and SUD services. For patients taking methadone (which is subject to particularly tight licensing and dispensation restrictions), an offsite pharmacy provides patients with their doses, but all other SUD services are given at the FQHC. For those receiving buprenorphine, regulations allow for greater flexibility, so patients receive their first dose from an offsite pharmacy, but FQHC medical staff give all subsequent doses onsite. All providers serving patients receiving MAT work in close collaboration.

Although this survey provided only a snapshot of SUD/primary care integration activities in California counties from the perspective of SUD administrators, the results suggest that integration is well underway. A variety of initiatives are taking place across the state, including co-location of primary care providers in SUD treatment settings, co-location of SUD specialists in primary care settings, and delivery of SUD screening and brief interventions in primary care settings by primary care providers. In many counties, integration of SUD services also involves integration with mental health services. In counties in which SUD services are provided in

primary care settings, most administrators believe that FQHCs are the main providers of integrated care. Models and funding sources for integrated care vary as much as the counties themselves.

Administrators perceive barriers to integrating SUD and primary care services. Almost all administrators believe that financing is a critical barrier to integrated care. Many also list documentation of integrated care (i.e., sharing information about patients across providers) and developing partnerships with primary care providers as additional barriers.

Conclusions

Findings from this brief survey offer the following "take-away" messages:

- SUD/primary care integration is well underway in California counties.
- Much work is needed to familiarize primary care providers with SUD specialty care services and to foster partnerships between SUD and primary care providers.
- There is great diversity in models and funding sources for primary care services provided in SUD settings, and services extend beyond medication management and a one-time physical exam.
- Although co-locating SUD specialists in primary care might be a good way to begin integration, and services provided by SUD specialists are diverse, few AOD specialists are currently providing services in primary care settings.
- Screening within primary care settings may result in the identification of individuals who are in need of specialty care; this is another reason SUD providers might consider building partnerships with primary care providers.
- SUD integration with primary care may be inevitably linked to mental health service integration; the days of fragmented care may be coming to an end.
- Technical assistance may be needed to assist counties to better understand barriers to integrated care and to determine how to work through them.

These findings provided insight on the current landscape of integration in California and allowed UCLA to identify FQHCs and community health centers as well as counties already implementing integration initiatives in their respective programs. By doing so, UCLA was able to further examine the procedural details of their programs through site visits and in-depth case studies (see sections IIC and IIIA within this chapter).

C. Exploratory Site Visits of FQHCs and Community Health Centers in the Field

Purpose

We learned through our survey and through national health center data that SUD services are already being delivered in a variety of healthcare settings, but few, if any, data exist on actual implementation and barriers to implementation. To better understand SUD integration models (i.e., what services are delivered to which patients in which settings), the differing levels of integration (i.e., to what degree services are integrated), and how services are billed and documented, we conducted five site visits to health centers and service organizations of varying types and characteristics across California, as well as one in Arizona.

Methods

In order to address whether FQHCs can be depended upon as a reliable service delivery setting for SUD patients, whether there is resistance to integration, and whether FQHCs will have the capacity to meet demand, we set out to learn more about the dynamics of these organizations by visiting various FQHCs, FQHC look-alikes, and clinics partnering with FQHCs. These visits allowed us to gather initial information about how they functioned and were organized. While brief and preliminary, we were able to attain an environmental scan of the conditions that could possibly affect whether SUD services were integrated and delivered. Due to the pilot nature of these site visits, they were exploratory and informal. Sites varied and operated under different stipulations and requirements. We selected the following five sites to visit:

1) La Clínica de la Raza, Vallejo and Oakland, CA
2) Tarzana Treatment Center, Tarzana, CA
3) Los Angeles Gay and Lesbian Center, Los Angeles, CA
4) Mountain Park Health Center, Phoenix, AZ
5) St. John's Well Child and Family Center, Los Angeles, CA

The above sites were selected because they were identified as implementing successful models of behavioral health integration within a primary care setting. Each site was interested in learning more about improving substance use service delivery and was willing to share their experience to date with service integration.

Site visits included a tour of each facility, including space designated for SUD services, and interviews with staff members including, whenever possible: chief operating officers, medical directors, behavioral health directors, physicians, behavioral health (mental health and SUD) clinicians, nurses, and other health and behavioral healthcare specialists.

Summary of Findings

1. La Clínica de La Raza, Vallejo and Oakland, CA

Background

La Clínica de La Raza, Inc. is a Federally Qualified Health Center (FQHC) aiming to serve the specific needs of the diverse communities in the San Francisco Bay Area. La Clínica started as a single "storefront" operation in Oakland, California, in 1971 and in the last 30 years has expanded to 27 locations in three Northern California counties (Alameda, Contra Costa, and Solano). La Clínica offers primary health, dental, optical, and community mental healthcare, in addition to health education and preventative medicine; five sites offer primary care with Integrated Behavioral Health Programs (IBHP). In 2009, La Clínica performed 304,000 visits, serving 62,000 unduplicated patients. In 2010, La Clínica performed 328,191 visits, serving 68,140 unduplicated patients.

In 2007, with funding from the John Muir-Mt. Diablo Community Health Fund, La Clínica initiated the Behavioral Health Integration Project (BHIP), in which two clinic sites integrated behavioral health services into primary care. Prior to the BHIP program, there had been one small pilot a few years before in which a county employee was placed at a La Clínica site to provide integrated services. Before these integration projects, La Clínica relied on medical social work and external specialty mental health services to address patient mental health needs. After a year of planning and a two-year pilot implementation, the evaluation spanning the three years found that the BHIP successfully improved access to mental health services for La Clínica patients with mild to moderate mental health symptoms and reduced symptom severity. Provider satisfaction with the program was high, including increased confidence in helping patients with their mental health symptoms. When it was determined that the project was a success, it became an important component of La Clínica Integrated Behavioral Health (IBH) services, with the goal being to spread the practice across the large primary care sites.

Project Description

Project Goals

Mission Statement: "The mission of La Clínica is to improve the quality of life of the diverse communities they serve by providing culturally appropriate, high quality and accessible healthcare for all. Guiding Principles: Commitment to provide affordable, quality health services in a manner that is culturally and linguistically accessible to the community; Commitment to serve patients with the ability to pay and to subsidize those patients who cannot pay; Commitment to recognize the total health needs of their patient population by considering its psychological, social, economic, and physical needs; Commitment to advocate for the short-term and long-term healthcare needs of their patients, as well as to advocate for a more humane and effective healthcare system; Commitment to respond to new market opportunities and service needs that are prompted by new technology, an evolving healthcare industry, the changing political environment, and the social, health, and economic demographics of the communities we serve."

Key Partners

- John Muir/Mt. Diablo Community Health Fund (CHF): The Community Health Fund is governed by an independent, 10-member board of directors, with five members appointed by the Mt. Diablo Health Care District and the other five appointed by the John Muir Association. The John Muir/Mt. Diablo Community Health Fund supports health initiatives that address current and emerging healthcare needs. To do so, they distribute grants to and partner with the leaders of these initiatives—community-based, nonprofit organizations that provide high quality, affordable primary, specialty, dental, and behavioral healthcare or innovative wellness and support programs that contribute to good health.

Partnership Development Process

Through a series of discussions, La Clínica worked with the CHF to explore a need for change, formulate a practical vision for making it happen, develop a written plan of action for achieving the health improvements envisioned, implement the plan of action for a defined period of time to achieve documented results, prove its value, and attract other sources of sustaining income. This process required identifying visionary leadership, strategies for health initiatives, and key players. Taking into consideration an array of readiness factors, the CHF and La Clínica tailored a timetable for discussions and actions that led to formulating and funding their new IBH program.

Integration Model

- Co-location: In the new IBH program, the behavioral health clinician, called a Behavioral Medicine Specialist (BMS), is an integral part of the primary care team, acting as a consultant to the medical care provider. Essentially, the primary medical healthcare provider maintains responsibility for the care of the patient even when the patient is utilizing BMS services. This type of relationship helps with "buy in" from both the medical care provider and the patient.
    - The medical provider can use the BMS as a helpful resource to ensure that the patients' needs are met holistically, without spending time outside of the typical 15-minute visit time allotment. Patients are receptive to service from the BMS because, as is well-documented, patients are fundamentally more trusting of their primary medical healthcare providers, and are more likely to engage in treatment from the BMS if the primary medical healthcare provider demonstrably partners with the BMS.
    - To ensure successful behavioral health referrals, or "warm handoffs," the BMS is physically present in the clinical setting. Although the BMS at La Clínica Vallejo does have a private desk space, she "floats" about the clinic, increasing her availability to medical care staff. Ideally, the BMS conducts the behavioral intervention visit in the same room directly after the medical staff completes that portion of the visit. Due to space issues, the BMS may collect the patient from the exam room and conduct the behavioral visit in another private location. Meeting the patient in the exam room, regardless of where the BH visit is ultimately conducted, facilitates both patient "buy in" and a successful handoff,

which in turn yields more effective behavioral treatment engagement and outcomes.
    - Co-location of behavioral and medical healthcare facilitates seamless patient flow between providers for the most efficient care of the patient's full spectrum of needs. Having the BMS co-located promotes rapid diagnosis and treatment with simple, solution-focused interventions compatible with the constraints of 15-minute healthcare visits. Based on pre/post scores from behavioral health assessments (anxiety, depression, and insomnia),patient self-report and clinician assessment, the severity of patient symptoms decreased in response to brief behavioral interventions with the BMS usually within one to three visits.

- Procedures: Upon checking in, a clerk/medical assistant provides patients with an age-appropriate annual behavioral health questionnaire to complete while waiting in the common area for their visits (which can be primarily either medical or behavioral in nature, but are typically medical).
    - La Clínica has developed its own broad, bilingual, culturally appropriate tool that is simple enough for patients to complete in a busy waiting area but robust enough to help staff quickly identify potential mental health and substance abuse issues. The adult survey, for example, is a 16-item form; 13 items screen for depression, anxiety, trauma, domestic violence, alcohol/drug abuse, sleep problems, and pain. Three additional questions address medical care utilization as well as impairment in activities of daily living. Patients complete the survey yearly. If a patient needs assistance filling out the survey, a medical assistant will help the patient in an exam room, for privacy. When the form is complete, a medical assistant reviews it and notes any responses that should be further reviewed by the primary care physician for consideration of whether a BH consultation would be appropriate. Upon discussion with the patient, whether a positive behavioral health screen indicated an area of need, or because of the physician's medical evaluation apart from the results of the behavioral health survey, the physician determines if the patient would benefit from a referral to behavioral health staff.

- Brief Behavioral Health Assessment and Intervention
    - The BMS conducts a brief assessment guided by the medical providers' referral. Clinical interventions include teaching patients how to recognize and address signs and symptoms of mental health conditions and giving patients tools that enable them to set achievable goals and return quickly to healthy levels of activity and functioning.
    - BMS methods include supportive counseling, psycho-education, motivational enhancement, behavior change strategies, and patient "homework" practice that focus on self-management skills.
    - Initial behavioral visits typically last about 30 minutes, although warm handoffs to schedule a later appointment may be briefer. Follow-up visits range from 15–30 minutes. When needed, follow-up visits are targeted toward a specific behavioral health issue and they are typically terminated after perceived improvement or resolution by the 3rd visit, with some patients needing additional visits.

- The BMS can also refer the patient to the in-house medical social workers to provide longer-term counseling (up to 10 sessions) or to connect the patient to specialty mental health and alcohol and other drug services outside La Clínica.

Outcomes

It is expected that regular data collection and analysis will contribute to the improvement of services and subsequent patient outcomes. Screen results from the year 2009 are as follows: two-thirds (67%) of screens were positive for one or more behavioral problems; the most prevalent single concern was pain (37.1%), the highest cluster (44.6%) was anxiety/depression (3 questions) and the the 2nd highest cluster (27%) was alcohol/drugs (3 questions). Among those screened, those who reported "use of drugs" ranged from 4.7% to 9.1%; those comsuming ≥ 4 drinks ranged from 18.5% to 27.7%; and those identified as "unable to stop drinking/using drugs" ranged from 6.7% to 11.4%; 43.1% of men screened positive for an alcohol and other drug (AOD) concern and 18.6% of women screened positive for an AOD concern. Respondents who speak English had a positive screen rate for an AOD concern more than 10% higher than that of Spanish speakers.

Barriers

- Workforce: As La Clínica implemented behavioral health integration, it became apparent that the model would not succeed without appropriate staffing. La Clínica had difficulty finding licensed, bilingual clinicians willing to work within the integrated healthcare model. It is important to note that within an FQHC, the only BH providers who are "eligible" for reimbursement are licensed psychologists (PhD/PsyD) and licensed clinical social workers (LCSW). It should be noted that La Clínica has no specialty SUD staff in house. La Clínica found that very few licensed mental health providers are trained in behavioral health integration, and many clinicians struggled with providing only brief, short-term interventions. However, there have been several areas of great success in this domain:
  - Provider enthusiasm and patient response improved in one site when La Clínica hired a bilingual, *bicultural* clinician.
  - Upon our site visit, the integral role of the medical assistant became apparent. The medical assistant maintains the efficient flow between primary care and behavioral health providers and keeps track of critical day-to-day integrated clinic activities, such as the completion of the yearly behavioral health survey. The medical assistant "sets the tone" of integrated care for the patients as their first and last contact at the clinic and his/her duties span every level of integration from maintaining the integrated medical files to facilitating "warm handoffs."
  - La Clínica dedicates a medical assistant to the Behavioral Medicine Specialist to ensure proper flow in the clinic. He/she assists in managing the increased demand created by universal screening, prepping patients for the BMS, applying evidence-based BH tools, and scheduling follow-up patient visits.

- Differences in Professional Culture: Due to differing backgrounds, PC and BH often conflict in customs, conduct, and standards of care.

- Upon interviewing one of the primary healthcare providers, we came to learn some of the unique features of provider psychology that facilitate integrated care delivery at La Clínica. This provider encourages PC physicians to become "lumpers" as opposed to "separators" when it comes to patient care. This provider hypothesizes that many physicians choose to view the spectrum of patient holistic health issues one at a time and as requiring separate interventions, when it would not only be more appropriate but more effective to view them the opposite way—that all of the patient's various ailments should be treated together.

- Billing: A major obstacle to successful behavioral healthcare integration into primary care at La Clínica is that California Medicare cannot be billed for two types of service provided in the same day.
  - In order to facilitate the completion of a warm handoff and subsequent behavioral treatment, generally the initial visit (via warm handoff) is a non-reimbursable visit. This is a particular challenge in that the majority of visits with the BMS are single-session, same-day visits; therefore, providers are typically, ultimately not reimbursed.
  - Another obstacle to providing integrated behavioral healthcare is that FQHCs can only get reimbursed for IBHP services provided by licensed PhD/PsyDs, clinical social workers (LCSWs) and medical doctors, who, as noted above, have been hard to recruit.

Plans for Sustainability

La Clínica is a nonprofit organization that had a $74 million annual budget in 2010. La Clínica was established as a free clinic and remains as such to serve the needs of its unique population; 68% of all La Clínica patients have incomes at or below the federal poverty line and 93% of La Clínica's patients are uninsured or have public health insurance.

As it stands, much of the IBHP funding comes from philanthropic or grant support. Since 1999, La Clínica began receiving funds from the John Muir-Mt. Diablo Community Health Fund. In 2004, two La Clínica sites (Contra Costa County) began receiving funding from the Mental Health Services Act (MHSA; Proposition 63) and in 2010, La Clínica received MHSA funding to provide services at two additional sites in Solano County. La Clínica receives no specified SUD treatment or prevention funding for the IBH program. With a commitment to providing its unique populations of patients with the best care possible, La Clínica understands that effective services require recognition and response to the diversity of experience and needs presented by their consumers. Through collaboration and coordination, La Clínica functions with intersecting systems to have the enhanced capacity to deliver the continuum of services that most if not all clients need to receive quality care and achieve the most favorable health outcomes.

2. Tarzana Treatment Center, Tarzana, CA

Background

Tarzana Treatment Centers, Inc. (TTC), was founded in 1972 with the vision of providing comprehensive care to a wide patient population. Throughout its 39-year history, TTC has expanded and developed its infrastructure to sustain an integrated behavioral healthcare system that provides patients with a range of services to fully manage their health and well-being. In addition to offering a continuum of substance use disorder (SUD) treatment, TTC provides care for co-occurring mental health disorders and for chronic medical diseases that frequently ail patients and compound their SUDs. Instead of ignoring these confounding conditions, TTC recognizes and treats them together to provide holistic care at every level.

TTC first began offering primary care services in 1995 at their main Tarzana location, and shortly thereafter opened a second primary care clinic in Lancaster, approximately 60 miles away in the Antelope Valley. The need for more space in 2007 resulted in moving the Tarzana outpatient clinic a few miles away to a new location in Northridge, California. In 2011, TTC has continued to grow and recently opened a second primary care site in Palmdale, California. Their integrated system of reverse colocation allows for smooth patient flow and optimal patient care. With 10 locations within the treatment system that offer a range of SUD, mental health, HIV/AIDS, housing, case management, and medical care, TTC has become one of the leaders in the field of behavioral health.

In 2010, TTC was awarded a four-year Primary-Behavioral Healthcare Integration (PBHCI) grant to provide integrated care to individuals with severe mental illness and one or more chronic medical conditions. This project is helping TTC develop the processes and the model to further integrate care among the various populations it serves.

In 2011, TTC began offering mental health services to some primary care clinic patients with mild to moderate mental health problems, as part of a contract with the Los Angeles County Department of Mental Health. These patients will be screened for depression (with the PHQ-9) and anxiety (with the GAD-7) and offered short-term counseling and psychotropic medication, as indicated.

Project Description

Project Goals

Tarzana Treatment Center's mission is to address a wide range of the community's healthcare and social service needs with responsive alcohol and other drug treatment; HIV/AIDS treatment, prevention, and education; mental health treatment and education; primary outpatient and medical care, and other areas of healthcare to meet community needs.

Key Partners (Off-Site Integration Efforts)

- Kaiser (Woodland Hills and Northridge): TTC has two intake / admission specialists (Community Assessment Services Centers, or "CASCs") who are co-located in the psychiatric unit (considered "urgent care") to assist with patients who utilize the

emergency department but would be better served if linked to primary care (PC). Often, frequent ER utilizers lack access to community resources. To reduce the cost of preventable readmissions, full time TTC case managers help intervene, screen, and link PC, MH, and substance abuse treatment. Care Coordinators/Case Managers utilize motivational interviewing and follow-up with the patient to ensure service-linkage beyond the initial hospital visit. To assess SUDs, the AUDIT is used and can be populated into the Kaiser system, should Kaiser seek to do so. In addition, TTC has a business agreement with the hospital to release patients to TTC. Previous data indicates that ER utilization was reduced by 50% post TTC intervention.

- Olive View: TTC has one intake / admission specialist who is co-located in a psychiatric unit (also considered "urgent care"). This full-time employee helps intervene, screen, and link MH and SUD treatment. The case manager utilizes the Addiction Severity Index (ASI), which is electronically entered into the TTC database but copied for Olive View.

Partnership Development Process

All facilities serviced through TTC are licensed and certified by the State of California, licensed by the County of Los Angeles, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). TTC is also active within the Community Clinic Association of Los Angeles County and the California Primary Care Association. Apparent through its involvement with community organizations and leadership, TTC understands the importance of communicating and developing partnerships with neighboring providers to arrange service agreements and protocols to expand and strengthen linkages. As a result, TTC has fostered the interface between different sectors to build upon their existing system of specialty services and create a networked team.

Integration Model

- Reverse Colocation: Within seven days of entry, each patient in residential treatment is required to have a full medical history, physical exam, and mental health assessment. All reported conditions that require attention are noted on their treatment plan and tracked to make sure that they are not left untreated. All services in the residential programs are coordinated through a nurse on-site and assessors in other programs coordinate each patient with appropriate services through referrals that are granted through their overseeing supervisor. With a multi-disciplinary team of professionals that are located either on- or off-site, warm handoffs or referrals are made for each patient and the entire team is held accountable to ensure that all patient needs are met.

- Record-Keeping: Assessments include the ASI, Self-Medical History Form, and Psychological Symptom Checklist (developed by TTC). In addition, electronic health records are integrated across treatment modalities (ASI, Progress Notes, Integrated Summary, and Treatment Plan, and details of each episode of treatment), while maintaining compliance with current privacy regulations.

- Access: TTC offers a range of services across their 10 operating sites to combine typical SUD treatment with interdisciplinary services. For those who do not have easy access to

transportation, TTC has a van for transporting patients between different clinics to receive the scope of services they need.

- Behavioral Health Counseling: In addition to individual counseling, TTC offers family counseling services and support groups to help patients become more aware of their need to recover. This effort began as a way to address the familial and secondary psychological factors that often lead to a lack of patient compliance but are not fully dealt with through individual counseling alone. Most of TTC's patient population does not normally have access to these types of health psychology services, and while TTC does not have funds allocated to hire full-time behavioral health counselors, the organization is able to provide these services through interns and students in training within their nationally accredited internship program.

Outcomes

Tarzana treatment Center is rated as one of the most integrated treatment centers in Los Angeles County and often used as a model for other programs to follow. Regular data collection occurs on a wide range of measures, and outcomes reflect positive results on varying scales. Due to the limited scope of the visit, these numbers are currently unavailable for reporting.

Barriers

- Funding Sources and their complexities: MediCare reimbursement restrictions; only a LCSW or psychologist can bill for services, and MediCare can only be billed for one service visit per day. Additionally, AOD dollars cannot be used to pay for mental health services and vise versa.
    - TTC's patient population does not meet the requirements for the organization to attain MediCare certification for reimbursements, and the Medicaid restriction that prohibits billing for more than one service in one day further frustrates appropriate remuneration for services.
    - TTC's largely uninsured population typically cannot provide any financial compensation for care.
    - However, while funding sources and their complexities prove to be a constant barrier for TTC to pay for and manage their system, external grants and partnerships have allowed TTC to sustain and expand their services. With the use of innovative funding models and payment methods that allow TTC to meet the expectation to appropriately compensate their providers, TTC has been able to outsource resources to support integrated care.

- Licensing/Regulations: While a California Alcohol and Drug Program (ADP) licensed residential facility cannot employ staff in a medical position, this regulation does not apply to outpatient services.
    - An outpatient program may be linked and contract with the residential program to utilize physician time. The residential program can also develop partnerships with nearby medical services to set up clinic times for their patients. Instead of utilizing physicians to conduct assessments, TTC employs other non-medical staff

to ask the appropriate questions and gather the information for linking each patient with the service he or she needs. After the assessment, TTC can then provide patients with physician attention and primary care services..
    - Although ADP regulations further restrict licensed residential facilities from dispensing medications, TTC does not ignore the importance of pharmacotherapy as an integral part of SUD treatment. Without the ability to prescribe and distribute medication, TTC makes sure that all patients are referred to receive medications and closely monitors compliance. If patients fail to take their prescribed medications, TTC sees this as a health risk and educates all of its patients on the repercussions this will have on their overall treatment plan.
    - As TTC has fully illustrated through its various partnerships and procedural mandates, the organization can overcome the notion that integration is not possible due to licensing rules and regulations.

- Education/Training: There is a need for Primary Care education on the sensitive nature of substance misuse (e.g. prescribing strategies).
    - TTC maintains the ongoing goal of developing a collaborative service approach and workforce to **e**ffectively manage the integrated system of care. While there is no one right approach for collaboration—as this will vary with differing needs, resources and infrastructure—TTC touts education and communication as imperative components of their integrated model.
    - In addition to developing partnerships with external sectors, TTC enhances their teamwork through the development of shared service protocols and pathways to treatment.

- Culture: With regard to the self-reported medical information, there is concern that primary care doctors may not always pay attention to the SUD-related questions. In addition, patients may refrain from divulging substance use. SBIRT may therefore only identify a small number of problematic users.
    - Through multiple trainings and joint meetings on SBIRT and other tools within the SUD, MH, and PC fields, TTC is committed to sharing information and retaining an integrated process for intake, assessment, referral, and/or case management. In this way, TTC is working on bridging cultural differences and improving the effectiveness of SBIRT on screening for at-risk and SUD patients.
    - Accountability further ensures that all providers remain engaged and held responsible for their scope of practice and participation in the shared system of care.

- Information Sharing: As noted, TTC has their medical and SUD records electronically integrated across all of their treatment modalities. While episodes of care are captured within primary care, tracking of charting procedures still remain manual.
    - TTC is in the process of setting up electronic health records to address these issues. All of TTCs partners have Memorandums of Understanding (MOUs) set up with additional business associate agreements to further their departmental relationships.

- While many programs view 42CFR as a barrier to data sharing, TTC has appropriate consent forms set up to cover data accessibility within all components of their system. Upon treatment admission, patients are provided with a consent form to allow disclosure of SUD treatment information to the various providers that will be managing their care.
- An already networked system that has all of the appropriate partnerships in place makes information sharing much more feasible within the confines of existing documentation regulations.

Plans for Sustainability

With a commitment to providing their patients with the best care possible, TTC understands that effective services require the recognition of and response to the diversity of experience and needs presented by their consumers. Through collaboration and coordination, TTC functions with intersecting systems to have the enhanced capacity to deliver the continuum of services that most, if not all, patients need to receive quality care and achieve the most favorable health outcomes. By effectively addressing barriers with innovative solutions, TTC is able to maintain funding, comply with regulations, and improve services to allow their programs to continue and develop.

3. Los Angeles Gay and Lesbian Center, Los Angeles, CA

Background

Founded in 1971, the Los Angeles Gay and Lesbian Center (LAGLC) offers a wide range of services and programs for the lesbian, gay, bisexual, and transgender community in Los Angeles. The center originally started as a sexually transmitted disease (STD) clinic for gay men but has expanded to serve a range of clientele and offer a wide array of services, including free HIV/AIDS care and medications, housing, food, clothing and support for homeless lesbian, gay, bisexual, and transgender (LGBT) youth, and support and advocacy services for LGBT seniors and LGBT-parented families. They also offer low-cost counseling and addiction-recovery services, legal services, health education and HIV prevention programs, transgender services, and much more. LAGLC was granted FQHC look-alike status in 2009 and is currently in the process of applying for full FQHC status.

Project Description

Project Goals

LAGLC's goals are based on their mission and values statement upon which their services were founded: Mission Statement—*Empower people to lead full and rewarding lives without limits based on sexual orientation and gender identity, by providing the highest quality educational, cultural, and wellness programs to residents of Los Angeles County; Heal the damage caused by discrimination based on sexual orientation and gender identity, by providing the highest quality health and social services to residents of Los Angeles County in need; Advocate full access and equality for all people regardless of sexual orientation or gender identity, by promoting our communities' needs at local, state, and national levels; and Lead through example, by living our values, sharing our expertise, and celebrating the full diversity of our lives, families, and communities. Values- Respect, Excellence, Inclusiveness, Innovation, and Integrity.*

Key Partners

- Community Clinic Association of LA County (CCLAC) - an association of about 8–9 clinics (consisting of FQHCs, look-alikes, and Public Private Partnerships [PPPs]) that meet with a medical team on a regular basis. The Community Clinic Association of Los Angeles County is an advocacy and support organization serving and representing the interest of Community Clinics and Health Centers in the greater Los Angeles area. As a membership-driven association, their clinics are non-profit healthcare providers committed to providing quality care and dedicated to serving uninsured /underinsured, working poor, high-risk and vulnerable populations; as well as serving the linguistic and cultural needs of Los Angeles diverse populations.

Integration Model

- Co-location: LAGLC houses a number of health, social, and behavioral services all within the same building to allow for on-site referral to services and warm handoffs.

- Case conferencing: With a staff that consists of doctors, HIV/AIDS specialists, social service case managers, nutritionists, pharmacists, counselors, and more, there is

professional and specialty expertise available to tend to the wide range of patient needs. Staff members consult with one another to link patients to necessary services and ensure that they receive appropriate care.

- LAGC provides services and programs in four buildings: The McDonald/Wright Building, The Village at Ed Gould Plaza, Jeff Griffith Youth Center, and The Spot. The McDonald/Wright Building houses most of their services and departments, including the Jeffrey Goodman Special Care Clinic and a pharmacy.

- SUD/MH Services: LAGLC focuses a lot of its SUD services on addressing crystal methamphetamine use, abuse, and dependence, as this drug affects a majority of the population they serve. The center offers a crystal meth support group, drop-in counseling (at the Spot and the Jeff Griffith Youth Center—their two satellite clinics), and an abstinence-based educational group. Additional SUD/MH counseling services, which include one-on-one counseling, group therapy, support programs, and treatment, are made available and tailored to each patient's needs and situation.
    - Most therapy is short term, usually 26 sessions, but group treatment may go on for longer periods of time.
    - Most common issues for which patients seek counseling and therapy include depression, anxiety, relationship issues, HIV, SUDs (particularly crystal meth), and domestic violence.

Outcomes

Available data through the LAGLC's annual report provides financial statements that indicate continuing services and programs. While patient-related data is collected, access to this information is currently unavailable for deducing any health-related outcomes.

Barriers

As an organization that specifically targets the lesbian, gay, bisexual, and transgender community, LAGLC's array of services and programs are developed to best serve this patient population. As such, learning how to best partner and communicate with other agencies less familiar with the needs of this patient population can be difficult. The history of stigma related to LGBT people can also hinder outside relationships and prevent partnerships with outside agencies that may have a negative perception of the LGBT population. By being a leader in advocating for equality regardless of sexual orientation or gender identity, LAGLC is working toward promoting equal rights and overcoming this barrier.

Plans for Sustainability

With funds from grants, private foundations, sustaining donors, contributions, fundraisers, and special events, LAGLC is a fully sustainable and expanding organization. In step with the board's strategic plan, the Center only continues to make plans to grow and increase its services. As LAGLC continues to receive more funding and awards, it is able to foster collaborative partnerships with more agencies. LAGLC is also in the process of becoming an FQHC, which

will also open more doors for grant opportunities. With growing dollars and support, LAGLC will continue to operate its scope of services and maintain its programs.

4. St. John's Well Child and Family Center, Los Angeles, CA

Background

In 1964, St. John's Clinic started as a small volunteer operation in a building behind St. John's Episcopal Church to provide access to healthcare to the poor communities in downtown and South Los Angeles. Since then, it has expanded to a large network of 11 Federally Qualified Health Centers (FQHC) and school-based clinics throughout downtown and south and northeast Los Angeles. Its clinics provide comprehensive medical services, dental services, mental health and case management, and family support services. In addition to operating these centers, St. John's is responsible for managing a number of community, health, social service, and school readiness programs.

Project Description

Project Goals

St. John's goals are based on their mission and vision statement upon which their services were founded: Mission Statement- *to eliminate health disparities and foster community well being by providing and promoting the highest quality care in South Los Angeles.* Vision- *St. John's Well Child and Family Center will be a leader, catalyst, and model for the best care, long-term community health improvement and sustainable, health-enhanced systems and structures in Los Angeles.*

St. John's is interested in expanding the behavioral health services provided in some of its clinics in order to meet community needs and function as a vibrant resource in the community as healthcare reform regulations evolve. They are willing to partner with UCLA and other entities to support the shift in how services are delivered.

Key Partners

St. John's operates with a number of partners to reach their patient population and have the ability to provide them with a comprehensive set of resources. A number of key services would not be possible without the support of outside agencies and organizations. These collaborating entities include:

- California Primary Care Association (CPCA) - California Primary Care Association is the statewide leader and recognized voice representing the interests of California community clinics and health centers and their patients. CPCA represents more than 600 not-for-profit community clinics and health centers (CCHCs) that provide comprehensive, quality healthcare services, particularly for low-income, uninsured and underserved Californians who might otherwise not have access to healthcare.

- The Community Clinic Association of Los Angeles County (CCALAC) – The Community Clinic Association of Los Angeles County is an advocacy and support organization serving and representing the interest of Community Clinics and Health Centers in the greater Los Angeles area. As a membership-driven association, their clinics are nonprofit healthcare providers committed to providing quality care and dedicated to serving the uninsured/underinsured, working poor, high-risk, and vulnerable

populations; as well as serving the linguistic and cultural needs of Los Angeles' diverse populations.

- Compton Unified School District – The mission of the Compton Unified School District is to empower leaders to lead, teachers to teach, and students to learn by fostering an environment that encourages leaders and teachers to be visionary, innovative, and accountable for the achievement of all students.

- The Department of Healthcare Services' (DHCS) – The Department of Healthcare Services' (DHCS) mission is to protect and promote the health status of Californians through the financing and delivery of individual healthcare services. The DHCS finances and administers a number of individual healthcare service delivery programs, including the California Medical Assistance Program (Medi-Cal).

- Esperanza Community Housing Corporation – Esperanza Community Housing Corporation (Esperanza) was founded in 1989 as a result of a four-year organizing effort by community residents. Based on the area in which those residents lived—the Figueroa Corridor—Esperanza's target neighborhood was established. Esperanza remains rooted in and focused on this area to this day.

- LA Health Action- LA Health Action's overarching goal is to improve the health of low-income Los Angeles County communities through policy advocacy and strategic alliances. A program office of The California Endowment, LA Health Action was created through a grant to Community Partners, a nonprofit organization that provides program management, coordination, and technical assistance to local and statewide initiatives.

- The Los Angeles Community Action Network (LA CAN) – LA CAN's mission is to help people dealing with poverty create and discover opportunities, while serving as a vehicle to ensure they have voice, power, and an opinion in the decisions that are directly affecting them.

- Los Angeles Unified School District (LAUSD) – The teachers, administrators, and staff of the Los Angeles Unified School District (LAUSD) believe in the equal worth and dignity of all students and are committed to educating all students to their maximum potential.

- National Association of Community Health Centers – To address the widespread lack of access to basic healthcare, Community Health Centers serve 18 million people at more than 7,000 sites located throughout all 50 states and U.S. territories. Health centers depend in large part on public financial help and need a unified voice and common source for research, information, training and advocacy.

- Physicians for Social Responsibility-Los Angeles (PSR-LA) – PSR-LA envisions a world in which the physicians' adage to "prevent what we cannot cure" is reflected in public policies that foresee and forestall damage to human health and the environment. PSR-LA

brings together health professionals and the diverse communities of Southern California to protect public health from threats related to nuclear weapons and environmental toxins.

- Strategic Actions for a Just Economy (SAJE) – SAJE is an economic justice, community development, and popular education center that has been building economic power for working class people in Los Angeles since 1996. Over the past 12 years, SAJE's winning combination of community organizing, coalition-building, and grassroots policy has gained significant benefits for the community.

- Southside Coalition of Community Health Centers (SCCHC) – SCCHC is a network of autonomous non-profit community clinics that have joined together to better sustain, coordinate and improve healthcare to the impoverished, vulnerable, publicly insured and under or uninsured people without access to care in the South Los Angeles area.

For more information about each of these collaborators please visit:
http://www.wellchild.org/collaborations.html

Integration Model

- St. John's operates a Behavioral Health Program in which behavioral health counselors work with medical providers to address patients' physical, psychological, and social problems.

- Services are co-located and bi-directional: All clinics have a behavioral health (BH) staff member on site, in addition to primary care physicians (PCPs) to address both BH and physical health problems at the same location. Some patients may be referred to specialty services located in other clinics or partnering sites.
    - Patients are referred to and accepted from specialty behavioral health and PC as needed.
    - While there is some in-house behavioral health services and referral, there is no formal procedure in place.

- Available behavioral health services include:
    - Crisis intervention counseling
    - Individual psychotherapy for children, adolescents, adults, and families
    - Adult, teenager, and women support groups at three of their sites
    - Care management

- FQHC clinics include: Magnolia Place, Dr. Louis C. Frayser, Center Compton W.M. Keck Foundation, Lincoln, Hyde Park, and S. Mark Taper Foundation Center

- School-based clinics include: Manual Arts High School Clinic, Dominguez High School, Cezar Chavez School Clinic, and Bunche Middle School

Outcomes

Available analyses indicate that St. John's patients have remarkably better health outcomes in comparison to the larger Los Angeles County and South Los Angeles populations. Measurable health outcomes include data on healthy births, reduction in childhood asthma, diabetes management, access to dental care, and lower adolescent STD rates.

Barriers

- All St. John's sites have a behavioral health team on staff but there is limited attention given to substance use disorder (SUDs).
    - Although they are called "behavioral health professionals," these individuals are mainly MH specialists who have more experience and knowledge on MH services and care than on SUDs.
    - Although providers are trained on motivational interviewing (MI) and CAGE screeners, they are not used routinely. Minor SUDs are primarily addressed by the MH clinicians on staff and as mentioned, behavioral health services largely focus on managing MH without specialty SUD services.

- The required intake assessment form that must be completed for all new patients has one question addressing SUDs.
    - While the answer to this question is regularly reviewed by the doctors, they find that the majority of patients do not indicate having a SUD problem. Without greater awareness of SUDs and outreach for providing SUD services, St. John's may be limiting the scope of services needed by its patients. If SUDs are not adequately addressed, other health and social problems can result.
    - The center may not attract the SUD population, but it could also be unaware of those patients with mild or moderate SUD problems that they do see. Due to the greater emphasis on MH, SUDs continue to remain inadequately addressed. Possible associated reasons for this could be due to stigma and lack of knowledge. The high level of child and adolescent patients may also promote a culture that keeps patients with SUDs from seeking care from St. Johns' clinics.

Plans for Sustainability

With funds from government contracts and support from private foundation grants, St. John's has and continues to sustain and expand its programs and services. Partnerships with varying organizations further allow St. John's to provide a wide range of comprehensive care. St. John's constantly strives to improve their services to lead to better health outcomes for their patient population. As new partnerships develop to increase the level of patient care they can offer and better serve their patients' needs, St. John's is able to maintain community support and have a beneficial impact on the overall health of their clientele.

Conclusions

During the process of conducting case studies across these county initiatives, we learned that Federally Qualified Health Centers (FQHCs) provide primary healthcare to about 19 million people per year and are expected to rapidly double their capacity with expected healthcare reform legislation. FQHCs not only provide services to populations at high risk due to their goal of serving economically disadvantaged individuals in medically underserved areas, but are expected to play a central role in the identification and treatment of SUD nationally after 2014.

The growing body of literature further suggests that patients receiving integrated primary care and SUD services have better outcomes and reduced costs relative to patients receiving non-integrated care. We found, however, that little is known about SUD service provision, the state of its integration with primary care, its coordination with other mental health services or HIV/AIDS services in FQHCs, or the organizational factors that serve as facilitators or barriers to provision and integration of SUD services. With minimal information about the FQHC organizational factors that serve as facilitators or barriers to provision and integration of SUD services, it was determined that the first step was to understand these issues in order to develop strategies to facilitate the integration of effective and sustainable SUD services. Identified activities to generate this understanding are described in the following section.

III. Statewide Activities

A. Descriptive case studies of county integration initiatives

Purpose

Through the Integration Survey and ad hoc preliminary investigative discussions, we learned of county integration initiatives that were further along in development and could be excellent sources for learning about the implementation processes, barriers, and solutions toward integrative services within California. We determined that gaining insight into program-level experiences would allow us to achieve the specific knowledge needed to identify technical assistance needs as well as gather information in order to assist in the information dissemination process. The following seven counties were selected for further study:

1) Kern County
2) Los Angeles County
3) Orange County
4) San Francisco County
5) San Bernardino County
6) Santa Clara County
7) Marin County

Methods

In addition to the data obtained from the Integration survey, UCLA conducted site visits to each of the selected counties. Information was gathered from county leaders and program leaders to gain a clear understanding of program goals, objectives, and processes. In addition, ongoing discussion of progress and obstacles occurred across the course of the year. UCLA provided technical assistance as needed and made suggestions toward solutions.

The following is a summary of findings from each of the above listed counties.

Summary of Findings

1. Kern County: Project Care

Background

In response to the Affordable Care Act (ACA) of 2010 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which highlight the integration of behavioral healthcare into the primary healthcare setting, the Kern County Department of Mental Health (KCMH) has implemented "Project Care" to mobilize and facilitate teams of clinicians from five selected Federally Qualified Health Centers and one hospital outpatient clinic in the early adoption of healthcare integration.

Project Description

Project Goals

The ultimate goal of Project Care is to build capacity to deliver brief behavioral interventions and treatments within primary care facilities before 2014. Specific goals include:

- Performing consistent patient behavioral health (mental health and substance use disorder) screening
- Providing onsite behavioral healthcare services
- Facilitating "warm handoffs" between primary care and behavioral health staff, allowing for two points of services in the same day
- Creating integrated teams of staff led by a primary care physician "champion" that include a consulting psychiatrist, therapists/counselors, social workers and case managers who meet regularly to discuss integrated patient care successes and barriers
- Using registries to manage patient care
- Using evidence-based practices to treat behavioral health problems
- Holding regular administrative meetings and training, and facilitating practitioner networking
- Referring patients to specialty care when appropriate

Key Partners

- KCMH has selected six primary care facilities [five FQHCs and one outpatient hospital clinic] in Kern County to be a part of Project Care: La Clinica Sierra Vista, Delano; Sagebrush Home and Family Services; and four National Health Services, Incorporated sites (Oildale, Shafter, Taft, and Wasco).

- Additionally, in an effort to facilitate the integration of behavioral and medical health records, KCMH has partnered with the software group Anasazi to create a health information exchange (HIE) that is compliant with both the Health Insurance Portability and Accountability Act (HIPAA) and the Code of Federal Regulations 42, Part 2 (42 CFR Part 2) for use across participating sites. The HIE will ensure that protected patient health information can be securely and appropriately exchanged.

- Finally, KCMH has contracted with UCLA Integrated Substance Abuse Programs (UCLA-ISAP) to conduct an evaluation of "Project Care"; that is, to assess the extent to which the selected FQHCs are providing integrated mental healthcare and substance abuse treatment as they prepare for healthcare reform and to study the processes, successes, and barriers to integration over time.

Partnership Development Process

KCMH has established ongoing meetings with the lead behavioral health administrators at each Project Care site to begin discussions about the current push toward BH integration and the benefits to this project. Buy-in and leadership from each administrator has been crucial in order to get things moving on the ground level.

KCMH has involved the evaluation team early in the process in order to establish relationships with each site as well as to begin data collection at the baseline level.

Integration Models

- KCMH intends for integrated behavioral and primary healthcare to be co-located, so that patients can receive concurrent care for co-occurring behavioral and physical health disorders.

- At each site location, screening tools for alcohol, drug, depression, and anxiety will be implemented for those in the primary care setting. Upon a positive screen, patients will be referred to the embedded behavioral healthcare staff (clinical psychologists and LCSWs) for assessment and brief intervention. The need for referral for treatment will be assessed and navigated with the patients as needed. Feedback from the BH team will be documented and shared back to the medical team and integrated into the patient's chart, while maintaining compliance with current privacy regulations.

Outcomes

Measuring the impact of this intervention is a key priority for KCMH. UCLA and KCMH have an agreement to evaluate the program by assessing the following factors:

- Environment (using the Dual Diagnosis Capability for Community Health Centers – DDCHCS)
- Provider satisfaction (using a modified survey from the Integrated Behavioral Health Project – IBHP)
- Process data
    - KCMH administrators are planning to use patient registries to measure the penetration of behavioral health screening and brief intervention into primary care at Kern County clinics. Many FQHCs in Kern County are currently using the "i2i" registry system (electronic patient registry), though discussion is underway to build inter-operability between electronic medical records used in FQHCs and specialty providers in the near future. Information captured in the patient registry would allow for the calculation of:
        - the percentage of patients who are screened for mental health and substance use disorders; the percentage of positively screened patients

who are referred for further evaluation; the percentage of those referred for further evaluation who are in fact assessed further
- the percentage of those given further assessments who were provided with brief interventions or treatment
- the percentage of patients who are referred out to specialty care for treatment

In addition to tracking BH treatment episodes resulting from the initial screening process, KCMH administrators intend for participating FQHCs to re-screen patients at least once between 6 and 12 months after the initial screen, and for FQHCs to use their patient registries to notify staff when it's time to rescreen each patient.

Barriers

While still in its initial development stages, "Project Care" has come across varying barriers regarding HIPAA & 42 CFR Part 2 regulations but work and progress in complying with standards while sharing patient information is underway, including extensive staff training and consulting with outside organizations. KCMH leadership has also put a lot of effort into identifying the appropriate IT infrastructure that will allow for a shared data system. Stakeholders needed to be taught how to differentiate between electronic health records (EHRs) and patient registry systems, research software compatibility issues, and to learn about what is being developed according to current systems and future needs. In addition, it has been vital to stay abreast on anticipated federal regulations and facilitate testing of various options. Throughout this process, KCMH has learned that training, frequent meetings and communication, and gaining administrative buy-in is critical in creating the infrastructure needed to establish successfully integrated care.

Change takes time: Not only is buy-in needed at the leadership level, but it is also required at the line staff level. Communication from the top down as well as taking feedback from the bottom up is imperative for successful implementation. Making decisions about the intervention and the selected procedures at each site must take into account the time and space burden on the primary care staff in order to take those baby steps toward integrated services.

Plans for Sustainability

Billing for behavioral healthcare, especially BH visits/services performed on the same day as primary healthcare services has posed problems for the integration effort in Kern County, as well. It is anticipated that the problems will be remedied at the federal and state levels, as progress is made toward the 2014 goal for healthcare reform. In the meantime, KCMH is using MHSA Prevention and Early Intervention (PEI) funds to support this effort.

2. Los Angeles County: Primary Care, Mental Health, and Substance Abuse Treatment Services

Background

The Center for Community Health (CCH) is a state-of-the-art facility designed to provide primary care, mental health, and selected substance abuse treatment services to the population that occupies the Skid Row area of Los Angeles. CCH provides these services through partnerships with private agencies and county departments. Such integrated care has been shown to be beneficial to patients because they are not required to travel off site in order to have varying aspects of their care addressed.

Treating the substance use disorder needs of CCH patients is of particular concern to CCH staff and administrators and the Los Angeles County Department of Public Health Substance Abuse Prevention and Control (SAPC). Assessment and limited treatment services are provided on-site, but utilization of these services by CCH patients has been minimal.

During the 2009–2010 fiscal years, CCH reported treating the primary healthcare needs of approximately 9,000 patients. In addition, approximately 1,500 received mental health services and a similar number received HIV-related services; however, less than 100 individuals were assessed for substance use or abuse problems, and according to reports from treatment staff, few attended the group treatment sessions available on-site.

Project Description

To address these issues, SAPC and UCLA Integrated Substance Abuse Programs worked with the staff of CCH, Homeless Healthcare Los Angeles, and Volunteers of America to examine the agency processes and structure to ascertain ways to increase patient participation in assessment, referral, and on-site treatment. Several initial issues were determined to be potential barriers to getting patients to either the assessment or the group counseling session. A team of individuals that included staff from CCH, SAPC, Homeless Health Care, Volunteers of America, and UCLA met on a biweekly basis (or as needed) to discuss the barriers, ways to overcome them, and the success of the suggested organizational changes.

Project Goals

- Ensure that the medical doctors, mental health staff and substance abuse assessment and treatment staff were aware of the array of services available on-site.
- Modify patient charts to include a section on substance use to prompt doctors and other medical professionals to address this area with patients when they return for follow-up visits.
- Change the flyer announcing the availability of group counseling sessions to make clear the purpose of the group counseling session (substance and alcohol use), inform the reader of when and where the groups would be held, and that refreshments are offered.
- Use incentives (refreshments, raffle for a $5 gift card) to encourage patients to attend the group counseling sessions.

- Provide resources (pamphlets, booklets, etc.) to the substance use staff on addiction, medical problems, etc., that can then be provided to the patients as further "food for thought" to encourage participation in on-site group counseling or off-site treatment if required.
- Provide training on motivational interviewing for all staff (medical, mental health, and substance use treatment) in order to increase the number of tools providers have to treat patients who may be resistant to treatment.

Key Partners

- The Center for Community Health (CCH) is a Federally Qualified Health Center (FQHC) that serves the primary care, mental health, and substance abuse treatment needs of individuals who live in the Skid Row area of Los Angeles. Services at CCH include primary healthcare, mental health, HIV related services, and substance abuse assessment, treatment, and referral. The official boundaries of skid row are Third and Seventh Streets to the north and south and Alameda and Main Streets to the east and west, respectively; this is the area CCH covers.

- Homeless Healthcare Los Angeles provides a continuum of outreach, assessments for drug and alcohol treatment, mental health services, case management, and an array of social services for homeless persons with co-occurring mental health and substance use disorders.

- Volunteers of America provides substance abuse services including assessment, treatment, case management, and individual and group therapies.

- The Substance Abuse Prevention and Control (SAPC) program, a division of the Los Angeles County Department of Public Health, has the primary responsibility of administering the County's alcohol and drug programs. SAPC provides a wide array of alcohol and other drug prevention, treatment, and recovery programs and services for individuals through contracts with over 150 community-based organizations. The primary recipients of County-funded alcohol and drug treatment, recovery, and intervention services are Los Angeles County residents, particularly those who are uninsured and/or underinsured.

- UCLA Integrated Substance Abuse Programs (ISAP) coordinates substance abuse research and treatment within the Department of Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine at UCLA. As one of the largest substance abuse research groups in the United States, ISAP works to:
    - Develop and evaluate new approaches for the treatment of substance abuse disorders;
    - Move empirically supported treatments into mainstream application;
    - Advance the empirical understanding of substance abuse and support efforts to ameliorate related problems;
    - Investigate the epidemiology, neurobiology, consequences, treatment, and prevention of substance abuse.

Partnership Development Process

The group brainstormed ideas to:

- Increase the likelihood that doctors and other medical staff would refer patients for assessments,
- Increase the likelihood that assessments and referrals would be conducted,
- Increase the attendance at the on-site group counseling session.

As a result of the brainstorming session, all staff were informed of the availability of assessment, referral and on-site substance use treatment. In addition, motivational interviewing training was provided for all staff to give providers additional tools to help with patients who are resistant to treatment. The skills taught in the training could also be used to encourage follow-up with treatment if the first referral attempt was unsuccessful. It should be noted that the staff could use these same skills with any patient who is engaging in unhealthy behaviors such as excess sugar consumption for diabetics, poor dietary choices for over-weight patients, medication noncompliance, etc. As part of the motivational interviewing training, the nature of substance use disorders was discussed and the reasons why patients may relapse or fail to seek treatment when offered were presented. The notion that addiction is a chronic disease and that many patients may be ambivalent at best was discussed as well as ways to "meet the patient where he or she is" were presented.

To address ways to motivate patients to attend group counseling sessions Homeless Health Care became the provider for group counseling sessions (Volunteers of America withdrew from the project). Once Homeless Health Care was put in charge, they actively began informing patients of the availability of the counseling sessions by conducting outreach and increasing communication with patients in the waiting areas. Doctors were provided with raffle tickets to give to patients to encourage them to attend the group counseling sessions. In addition, attendees were also given raffle tickets at the door. Refreshments (coffee, water, snacks) were provided for those who attended the group counseling sessions.

To address the breakdown in feedback loop between the substance use disorder assessment and referral staff and doctors the decision was made to ensure that the staff completed a disposition form that noted what happened if and when the patient showed up for the assessment. When the patient presents for the assessment, the disposition form is completed with information regarding what the next steps are. For example, the patient may be referred to treatment or an assessment appointment may be made. This information is recorded on the disposition form by the substance abuse treatment staff and the form is then returned to the person who made the referral for follow-up at the patient's next appointment and for filing in the patient's chart.

In addition, UCLA provided the substance use treatment staff with several pamphlets that can be re-ordered from the source on ways to discuss substance use, substance use and health, prescription medication misuse, etc.

Integration Models

- The integration model at work at CCH is a co-located model, working toward full integration. Currently, the client has separate sections in the same file for medical record, mental health records, and substance use treatment records. However, because these services are provided by three different agencies (primary care by CCH; mental health care by the Department of Mental Health, and substance use treatment by SAPC-

contracted providers) each of these agencies must also keep their own files and submit separate billing statements. In addition, substance use treatment is a recent addition to the services CCH provides, so the culture of the program has had to adjust.

- In the next several months, CCH will implement a fully integrated electronic medical chart that will help to facilitate some of the paper-work issues discussed earlier (feedback loop between substance use treatment staff, medical staff, and mental health staff). This should help to increase the level of integration in the program.

Outcomes

Several improvements were noted based on the changes implemented. All who attend the meetings noted an improvement in the number and frequency of patients being referred and a general increase in communication. The feedback loop between substance use treatment providers and the medical and substance use treatment staff has been closed and the outcomes of referrals are now being noted in the charts. New and returning patients are being asked about any problematic substance use, which will increase the likelihood that patients will be offered the opportunity for assessment, referral, and treatment. All providers have been notified of the availability of other services offered on site.

Attendance at group counseling increased from zero attending to the maximum number of patients allowed in a group counseling session (15) over the course of a few weeks. In addition, assessments have steadily increased and the total for the 10 months reviewed is about 30% greater than the number of assessments completed last year. Referrals to more long-term, off-site treatment also increased.

Barriers

Barriers to further progress include the issue of duplicative assessments—patients with multiple problems are being assessed over and over and oftentimes the same questions are asked twice. In addition, there are diminishing substance use treatment referral sources for patients with co-occurring disorders or patients with no ability to pay for treatment. Finally, the culture change at CCH will need continual work to ensure that the CCH and mental health staff continue to refer patients in-house for substance use treatment.

Plans for Sustainability

The process-improvement work conducted at CCH over the course of about five months resulted in significant improvements in the utilization of the substance abuse treatment services available on-site. These improvements were accomplished primarily through communication, some changes to documents and procedures, and limited additional funds (used for incentives and refreshments). Continued communication, monitoring, and training will hopefully increase screenings, assessments, and referrals and seamless integrated services. In addition, UCLA will continue to work with SAPC to increase the number of patients receiving services on-site at CCH.

3. Orange County: Patient Registry, Bi-Directional Care, and SBIRT in Emergency Rooms

Background

Patient Registry (CalMEND): Through a collaborative effort between the Department of Mental Health (DMH) and Department of Health Care Servcies (DHCS), facilitated by the California Institute for Mental Health (CiMH) using MHSA funding, Orange County (OC) is one of six California counties participating in a 1½-year integration learning project to promote the California Mental Health Care Management Program's (CalMEND) identified core competencies for high performing behavioral health organizations. One of these competencies is to develop a robust electronic health record (EHR) that includes patient registries.

Bi-Directional Care: Through MHSA Innovation funds, OC will be funding primary care services that will be co-located with the county-operated mental health services and the alcohol and drug treatment services. The plan was approved by the Board of Supervisors on 6/28/11. Additionally, behavioral health staff will be co-located in two community clinics. One is an FQHC and the other is an FQHC look-alike. Services are planned to begin in the fall of 2011.

SBIRT in Emergency Rooms (ER): In an effort to prepare Orange County for Healthcare Reform (HCR), discussions to utilize Prevention and Early Intervention (PEI) funding for SBIRT arose. After initial research and meetings began, plans to place trained staff in ER settings to conduct SBIRT developed. This has changed somewhat. After facing much difficulty in gaining traction working with hospital ERs, OC began discussions to explore the possibility of providing SBIRT services in busy community clinic settings. In early June 2011, OC held a meeting with a FQHC community clinic to begin exploring this possibility. The FQHC was very interested and the next meeting is set to begin discussing logistics of how to actually integrate the SBIRT worker into the flow of patient care. An outcome of this meeting was that the possibility arose for doing SBIRT at a different ER than originally approached. Current plans are to work out logistics for SBIRT in these settings, train selected staff on doing SBIRT, and develop an MOU of some sort to move this project forward. The hope is to implement this before the end of the 2011 calendar year.

Project Description

Project Goals

Patient Registry (CalMEND): The goal of this project is to develop a patient registry, based on the chronic disease model, in which both behavioral health (BH) and primary care (PC) can enter and access laboratory type data (vitals, lab results, urine tests, etc.). In this way, it is hoped that all patient data related to medication, test results, and other measurements between MH, AOD, and PC can be shared in an effort to improve quality of care and reduce costs.

Bi-Directional Care: OC hopes to provide integrated care by placing a PC team in a behavioral health home for those who choose BH services to be their primary source of care (reverse co-location), and a BH team to provide BH services to those who choose to have PC as their main site for treatment (co-location).

SBIRT in Emergency Rooms (ER): The overall goal of this project is to place behavioral health specialists in ERs and/or busy community clinics to conduct SBIRT among clients who frequent these settings. This will create an opportunity for early intervention among selective and indicated populations.

Key Partners

- Patient Registry (CalMEND)
  - CalMEND: CalMEND is several inter-related things at once: it is a partnership initiative of the California Departments of Mental Health (DMH) and Health Care Services (DHCS) to improve quality and outcomes for publicly funded mental health services; an articulated vision and design of a transformed mental health service delivery system committed to person/family centered wellness, recovery and community integration; a community of individuals and organizations committed to the continuous improvement of the mental health services system; and a set of resources designed to help manage and improve the current mental health service delivery system. http://www.calmend.org/whatiscalmend.html

- Bi-Directional Care
  - CalOptima: CalOptima is the second largest health insurer in Orange County, providing coverage to one in eight residents and more than a quarter of the community's children. CalOptima provides healthcare coverage through three major programs: Medi-Cal, OneCare (HMO, SNP), and the Healthy Families Program. http://www.caloptima.org/

- SBIRT in Emergency Rooms (ER)
  - Key partners are CalOptima and a local FQHC community clinic. CalOptima was instrumental in setting up the contacts and meetings with the FQHC to discuss SBIRT. In addition, CalOptima is applying for grant funding that will provide support to this program.

Partnership Development Process

Patient Registry (CalMEND): By teaming within Orange County's Health Care Agency to facilitate a partnership with CalMEND, Orange County was able to access vital resources and funds to improve the quality of their health delivery system through the development of an enhanced patient registry. Although the county has been granted a minimal amount of funding for the project, which only covers transportation to and lodging at face to face meetings, relationship-building has been a key aspect to expansion. The first step to this process was developing the necessary relationships within the offices and departments in their healthcare agency to approach CalMEND as a team. The first joint collaborative processes inextricably led to the development of additional contacts to improve and support the progression of their project. OC indicated that this first collaboration of many to come has brought about a closer relationship between behavioral health and CalOptima. The Medical Services Initiative (MSI), a federal-, state- and county-funded healthcare program that provides medical care for Orange County's low-income citizens is also allowing for the inclusion of this patient population. Through joint efforts, Orange County is seeking out willing PCP partners while attending CalMEND trainings/workgroups to address any barriers and training needs.

Bi-Directional Care: With initial relations established through other joint projects such as CalMEND, the behavioral health teams have been able to establish a strong partnership with CalOptima and two community clinics to support services provided through this initiative.

SBIRT in Emergency Rooms (ER): A number of trainings were planned to introduce this effort and gain support for this initiative. However challenges were faced delaying this effort. Overall, OC AOD and MH hope to begin building a relationship with the hospitals, increase awareness of the benefit of AOD and MH screening, and measure outcomes once screening begins. OC shared this project with the California Mental Health Director's Association (CMHDA) to further bring attention to their plans for integration.

Integration Models

- Patient Registry (CalMEND)
    - The primary purpose of this project is to find clients/patients in common to CalOptima, OC Mental Health, OC Alcohol & Drug Abuse Services, Asian Health (FQHC look-alike) and the county's Coverage Initiative services. At the conclusion of the CalMEND project, a registry was not realized due to many factors, mainly, each entity in the project is at various phases of implementing an EHR.

- Bi-Directional Care
    - The concept of bi-directional integration is to assure not only that behavioral healthcare services should be available in the primary care site, but also that primary care should be available in the behavioral health specialty settings. To this end, the National Council for Community Behavioral Health (NCCBH) has developed "Person-Centered Healthcare Homes," planning models for pursuing bi-directional integration of primary care (PC) and behavioral health (BH) services (NCCBH, 2009) and PC–SUD care (NCCBH, 2010).
    - Six sites have been chosen (3 PC and 3 BH) for the placement of these teams.
    - Outcome measures (to be reported every 6 months) in addition to an evaluation tool are being developed. With MSI and CalOptima on board, the teams will be able to get reimbursed for all services at these sites.

- SBIRT in Emergency Rooms (ER)
    - SBIRT, or screening, brief intervention, and referral to treatment, is a comprehensive, integrated approach to identify people with or who are at risk for SUDs. SBIRT utilizes both screening and treatment to promote a system of early identification and intervention to provide a more comprehensive system of care. SBIRT is an evidenced-based practice that allows providers to effectively connect those with SUDs with appropriate care and actively reduce the chances of those at risk from developing an SUD. SBIRT can be implemented in a number of settings, by a variety of trained professionals, and practiced using a range of available screening tools.

Outcomes

Patient Registry (CalMEND): Due to several barriers around Health Information Technology (HIT), the registry has not been fully established to determine any outcome measures.

Bi-Directional Care: In order to begin the process of implementation, partnerships have been developed with willing PCPs, locations for integration have been determined, and experts to hire the necessary clinical staff have been identified. Once all staff are hired, the PC teams will be trained on motivational interviewing techniques, the Promotora model of engagement, SBIRT, and screening tools. The BH and PC teams will be trained on how to best collaborate and work together. Due to the early stages of this project, no measures have been collected to produce any identifiable outcomes.

SBIRT in Emergency Rooms (ER): Orange County has started the process of finding willing PCP partners and increasing awareness of the value of SBIRT. While presentations at hospital association meetings with willing administrators at hospitals have been made, more work is needed to access hospital administrators. No outcomes are yet available due to the preliminary/planning stages of this project.

Barriers

- Patient Registry (CalMEND)
    - While still in its initial development stages, this project has come across varying barriers regarding HIPAA & 42 CFR regulations, but work and progress in complying with standards while sharing patient information is underway. Solutions include the use of signed consents to release public health information and training across sectors to learn about varying confidentiality rules. Identifying the appropriate IT infrastructure that will allow for a shared data system is also being worked on. Stakeholders needed to be taught (a) how to differentiate between EHR and registries, (b) research software compatibility issues, and (c) what is being developed according to current systems and future needs. In addition, it has been vital to stay abreast on anticipated federal regulations and facilitate testing of various options. Throughout this process, OC has learned that training, frequent meetings, communication, and gaining administrative buy-in is critical in creating the infrastructure needed to establish the proposed system change.
    - The ultimate goal of this project is to share all patient data related to medication, test results, and other core measurements between MH, SUD, and PC in an effort to improve quality of care and reduce costs. Money, time, and perceptions of HIPAA regulations, however, have and continue to be major barriers to the development and use of this registry. Different interpretations of confidentiality, stigma, and staff time restrictions continue to delay buy-in and must continually be addressed. In addition, without ample research in the field, deciding which screening tools and measurement items to collect is difficult. There are still many

unanswered questions regarding the availability of a compatible and affordable registry.

- Bi-Directional Care
  - As clientele that frequent PC settings and BH settings differ, engaging these patients to see and trust a different team of professionals is a challenge. In addition to patient perceptions, staff that work in PC settings need to shift their often stigmatized attitudes toward MH/SUD. By doing so, staff can motivate patients to trust and actively seek help from the MH/SUD field. While engaging patients into integrated care is challenging, staff and administrative support can prove to be an even greater hurdle, as most are not easily receptive to changing their normal behavior.

- SBIRT in Emergency Rooms (ER)
  - One of the main barriers to implementing SBIRT is engaging hospital administrators and communicating the value of SBIRT to them. Due to differences in culture and perception, they are not easily receptive to adding additional screens and protocols upon their busy workload. By learning "how to" best approach and teach hospital staff the value and benefits of SBIRT, Orange County can begin to make SBIRT a part of the everyday routine. Practice, time, and training are essential to overcoming this barrier and eventually gaining the funds to support staff.

Plans for Sustainability

Patient Registry (CalMEND): As the project is in its final stage, Orange County continues to find shared clients/patients, be persistent with trainings/workgroups, and further define and establish a shared data and treatment plan. By doing so, it will set the stage for the future. Plans are to build a self-sustaining registry that is regularly managed and utilized by multiple partners in the treatment team.

Bi-Directional Care: While still in its formative stages, Orange County continues to gauge administrative support and buy-in from partners to shift assigned providers for integration. By utilizing trained patients as case managers for outreach and engagement, patients can be accustomed to seeing both PC and MH/SUD professionals. By increasing educational groups on healthy living and using trained patients as medical case managers, BH patients will learn to see the PC team. The staff and patient support system for bi-directional care will strengthen the infrastructure for sustainability. The establishment of early outcome measurements and the ability to demonstrate cost-effectiveness is crucial for Orange County to build their justification for maintenance and rationale for continued support.

SBIRT in Emergency Rooms (ER): As Orange County is still in the process of developing partnerships and commitment from hospital administrators, no set plans are in place for sustainability. By working with doctors to open the ER doors to SBIRT and to see the benefits and cost savings from SBIRT, it is hoped that hospitals will routinely fund and train staff to

conduct SBIRT. Once buy-in and agreements are established, a memorandum of agreement (MOA) will be developed for continuing oversight.

4. San Francisco County: Integration with Office-Based Opiate Treatment (OBOT)

Background

San Francisco County has been at the vanguard of integrated care with the integration of health and behavioral health services occurring at many levels within their public treatment system. At the administrative level, the public health, mental health, and SUD departments are all now within one department. In addition, the county health department offers a drop-in integrated assessment center where individuals are evaluated for mental health, SUD needs, and medical issues, with referral to the appropriate provider. This center also provides assistance with enrollment into San Francisco's universal healthcare program and Medi-Cal.

Through the adoption of the Comprehensive, Continuous, Integrated System of Care *(*CCISC*)* and the Primary Care Behavioral Health Model (PCBH), San Francisco has a strategy in place to guide them throughout the planning and implementation stages of their new integration initiatives. The county has a consortium of 12 county-operated FQHCs and a number of non-county operated FQHCs, many of which are providing some level of integrated behavioral healthcare. By having the structure to develop intersystem coordination and integration, the systems are much more prepared and responsive to the overall change process. San Francisco's newest integration project involves the placement of behaviorists and behaviorist assistants in their FQHCs. In line with the PCBH Model that stresses the importance of a primary care team approach, San Francisco is working with a team of consultants from Patty Robinson and Kirk Strosahl to make the BH specialist an integral part of the PC team. While this is still in its early stages of implementation, a key accomplishment and continuing project in San Francisco has been the integration of office-based opioid treatment (OBOT) into healthcare settings, which consists of either buprenorphine or methadone treatment.

With high rates of heroin use and without sufficient access to treatment for users, San Francisco was paying a large sum for opiate-related costs that could be reduced or eliminated. Despite evidence showing that investment in opiate treatment would lead to distinct savings for the county, the access gap still remained due to unavailable funds for indigent patients, restrictions to expanding existing methadone treatment facilities, and the still pervasive stigma associated with methadone treatment. After an NIH Consensus Statement was released affirming the need to reduce the harsh regulations tied to Opiate Agonist Treatment (OAT) and the need to provide all opiate dependent persons with access to treatment, the Board of Supervisors in San Francisco passed a resolution to expand prescription methadone in 1998. This decision directed the Department of Public Health to allow physicians to treat opiate addiction with prescription methadone through a waiver process. After an OBOT Working Group was formed that guided the development of the policy and procedural requirements for the integration of methadone and buprenorphine treatment for opiate addiction into physician office settings, program planning began and the OBOT program was officially launched in 2003.

Project Description

Project Goals

The guiding principles of San Francisco's OBOT program are to expand access to effective treatment, increase patient choice, integrate care, reduce stigma, and achieve regulatory parity for narcotic treatment programs (NTPs).

San Francisco's overarching goal for their additional integration initiatives is to provide their population with comprehensive, ongoing care that includes behavioral health services as a regular, integral part of treatment.

Key Partners

A number of key partners were involved in various stages of the planning and implementation phases of their OBOT pilot and continue to play an integral role as it expands and further progresses. These individuals include the NTP directors and staff, a number of PCPs, SUD counselors, pharmacists, various consumers of treatment services, and city and county officials. Representatives from state and federal regulatory agencies (ADP, DEA, and CSAT) also continue to ensure proper operations and compliance to regulations.

Partnership Development Process

After the Board of Supervisors' released the resolution to expand prescription methadone in 1998, San Francisco's DPH convened an interdisciplinary work group to produce a consensus statement. Three subcommittees were formed that provided provider, pharmacy, and counselor recommendations in 1999 to begin the development of a grant proposal for the OBOT program. The work and collaboration of these subcommittees allowed for the development of the partnerships needed for the OBOT workgroup. Joint efforts led to the submission of the application for the OBOT program, which was approved and initiated in 2003.

Integration Models

- OBOT Methadone:
    - As an ADP licensed Narcotic Treatment Program, OBOT Methadone is governed by state and federal regulations with four OBOT provider sites. While the counseling and medical components of the program occur at these sites, the methadone dosing occurs at the pharmacy that has an NTP designation from the DEA and an NTP license from ADP.
    - Enrollment into the OBOT program occurs through admission at San Francisco General Hospital. Upon meeting the criteria for OBOT, to receive care after about 3–6 months patients are transferred to the OBOT sites and pharmacy.
    - Data collection: OBOT methadone has its own EHR that shares data between the members of the treatment team (pharmacy, counselor, and MD). This EHR is not linked in any way with the main EHR used in the Primary Care-Lifetime Clinical Record (LCR). The OBOT database shares medication orders and dosing information between members of the treatment team, and special consents are signed by patients entering the program. Clinical alerts between team members can also be posted. The security of the system meets NTP standards.

- OBOT Buprenorphine - Integrated Buprenorphine Intervention Services (IBIS):
    - Most IBIS patients are referred from a clinic site to OBIC (Outpatient Buprenorphine Induction Clinic) to be evaluated and begin dosage right away. The pharmacy is located on site. Once patients are on a stable dose and ready for community care, they are referred back to their initial provider while continuing to pick up their medication from the pharmacy. That MD continues the prescription, and the nurse or SUD counselor at the provider site can provide counseling support.
    - There are also some drop-in groups available in various community sites for those interested.
    - Data Collection: IBIS for patients enrolled in primary care uses the LCR to record treatment and prescription information. This care is provided as part of patient's primary care treatment by their physician. In most cases, the physician notes the buprenorphine prescription into the LCR and faxes this directly to the pharmacy. The pharmacy does NOT record all their dosing information in the LCR (there is a pharmacy-specific data system that records their information in compliance with pharmacy standards) but they might add notes to the chart in the LCR, particularly if there is an issue such as persistent no shows or requests for dosage increase. When patients enter treatment in PC (for any service), consents that allow members of the treatment team to share information are signed so no IBIS-specific consent is needed.

Outcomes

Preliminary data from the OBOT Pilot revealed high compliance with treatment, very few missed doses, high program retention, little-to-no clinical deterioration, patient satisfaction, and positive patient reports.

Barriers

- Resistance to change: Staff and practitioners are resistant to change known practices and therefore not receptive to adding a new treatment program. Especially with the stigma and misinformation associated with methadone/Opiate Agonist Treatment, it is a continuing challenge to gain support and buy-in from providers and staff to develop the necessary workforce in new settings.
- Funding/Restrictions: With insufficient funding to establish new programs for indigent patients, garnering the funds and public support to provide OBOT is an ongoing challenge. In addition, MediCal requirements that restrict billing for two services in one day can impede full reimbursements for services. The OBOT program was recently certified as a Drug Medi-Cal reimbursable service.
- Community opposition: Without full community support to expand existing or site new opiate treatment facilities, public funding is harder to acquire. As a result, San Francisco continues to promote its wider acceptance through strong outcomes that can garner stronger community encouragement.

Plans for Sustainability

Staff training and support: The OBOT staff undergoes a full training course prior to participation that includes an 8-hour didactic training program, practicum experience, on-site general trainings, and other policy and clinic-specific trainings. Continuing staff support include monthly counselor trainings, weekly cross-site and on-site clinical review, ongoing supervision by a coordinator, weekly core meetings, monthly cross-site implementation meetings. In addition, database monitoring for clinical, state and federal guideline adherence requires a monthly report to be submitted by all providers. The development of a strong workforce prior to and throughout the progression of the program allows for a sustained set of people to maintain its principles and foster its growth.

As SBIRT and SUD training in medical settings and medical schools becomes more widespread, San Francisco expects the use of alternate treatment models to expand as well. Research is continuing to identify new medications and interventions, and it is hoped that healthcare reform will cover more services, more patients, and more settings. San Francisco is ready to respond as experts at all levels of care, for all age groups, and for all types of patients. With flexibility, open-mindedness, and patience, physicians, counselors, and others are integrating to create a collaborative, team-approach to care. The focus on the mechanics of maintenance treatment and raising consciousness on the nature of SUDs is allowing for a well-managed program that continues to improve and be refined. A documentation process further allows for outcomes reporting that garners support and future funding opportunities.

5. San Bernardino: Integrated Health Program: Mental Health and Substance Use Disorder Service Integration within Primary Care Settings

Background

Co-location of MH staff in a Primary Care Setting: In 2007, San Bernardino County started working on integration of services between behavioral health and primary care. The initial effort began with the ideal of embedding mental health services into primary care settings, with an emphasis on addressing low-level mental health issues that did not qualify for specialty mental health services. The initial site was chosen for its location as well as space availability to accommodate mental health clinicians.

Co-location of Specialty MH and AOD in a Primary Care Setting: In 2009, this integration effort was enhanced to provide a better linkage to a higher level of care. The Department of Behavioral Health relocated one of their specialty Mental Health Clinics to this same primary care site that was addressing lower-level MH needs. The clinic became dual certified and provides specialty mental health as well as alcohol and drug services.

Comprehensive Pain Management Services: In 2010, the Integrated Health Program expanded further by providing embedded services into a second Primary Care Clinic. Within this second site, a need surfaced around addressing prescription medication abuse while managing pain issues in the primary care setting. Both AOD and MH services are provided, with an added component of assessing for early emotional trauma co-morbidities.

Project Description

Project Goals

Co-location of MH staff in a Primary Care Setting: The goal of San Bernardino's project is to move toward better coordinated care and address low-level mental health issues among patients seen within the broader healthcare setting who did not qualify for specialty mental health services.

Co-location of Specialty MH and AOD in a Primary Care Setting: The goal for this enhancement to the Integrated Health Program is to improve the link between the broader healthcare system to the specialty care system (MH and AOD) for those individuals presenting a need for a higher level of care. Dual licensing was required and achieved at one site, Ontario.

Comprehensive Pain Management Services: The overall goal of this component to the project is to address the prescription drug use and trauma issues commonly related to pain management. This will create an opportunity for early intervention among selective and indicated populations. This program has great potential to serve as a source for providing integrated mental health and alcohol and drug services as each team member provides an expertise that is recognized as having value to the other team members.

Key Partners

To implement each initiative, partnerships were established with two clinics: Ontario Clinic and the McKee Family Health Center.

- The Ontario Clinic houses both the co-located MH staff as well as the specialty MH and AOD staff with the dual certification. The McKee Family Health Center also houses the co-located behavioral health staff and has the additional Comprehensive Pain Management program.

- Key partnerships within the county departments (Behavioral Health, Public Health) were also crucial to establish these initiatives. In addition, the county has also involved two managed care organizations (Inland Empire Health Plan (IEHP) and Molina) as part of a working committee with the county to navigate through regulatory and policy issues as these services evolve. Discussions continue on a biweekly basis through this committee as funding opportunities develop, particularly around the 1115 waiver and LIHP.

Integration Models

- Co-location of MH staff in a Primary Care Setting
    - The model selected was to co-locate mental health services for patients who were being seen in the primary care practice. The initial site was chosen for its location as well as space availability to accommodate mental health clinicians. The program is staffed with a Licensed Clinical Therapist and a Social Worker ll/Case Manager providing brief, solution-focused therapy and case management to patients who are experiencing low-level mental health issues that would not qualify for services in the Specialty Mental Health Clinics as they are not seriously and persistently mentally ill. In addition, both of the mental health staff members at this site have been trained in the Trauma Resiliency Model (TRM) and use it on a regular basis.
    - The selected site also housed a public health clinic as well as WiC setting. Based on needs, the program was expanded to address the MH needs of patients receiving services in those settings as well.

- Co-location of Specialty MH and AOD in a Primary Care Setting
    - Using the co-location strategy, a county specialty MH and AOD service site was relocated into the primary care clinic. The program continues to be staffed with a Licensed Clinical Therapist and a Social Worker II/Case Manager, but referrals to higher level of care are facilitated to the Specialty Clinic that is dual certified to provide both specialty MH and AOD services.

- Comprehensive Pain Management Services
    - A second primary care site was established through this expansion of the Integrated Health Program. Staffing under this model includes a Clinical Therapist and Alcohol and Drug Counselor. With the addition of the second site, both integrated healthcare teams work together to provide a mechanism to share the expertise of the Alcohol and Drug Counselor, Social Worker / Case Manager and Clinical Therapist.

- In April/May 2010, this program established a new service component within this effort to address behavioral health issues within pain management. One of the PCPs shared a concern that he had with the alcohol and drug counselor over patients that become addicted to prescribed pain medication. After much thought and discussion between the two, they discovered a common feature to the majority of these patients: they had experienced some form of unresolved emotional trauma in the past. At a later date, a physical injury such as a broken bone or injury requires the use of pain medication. Long after the physical injury has healed, the patient is still requesting pain medication. The alcohol and drug counselor suggested to the PCP that it was a possibility that the patient was medicating the emotional trauma. The alcohol and drug counselor recently attended TRM training and has added this component to the program to address the emotional trauma the patient experienced.

Outcomes

A database has been established that allows the county to keep track of patients and interventions as well as demographics for the population that we are serving across each initiative. There is a need for further development of outcome measures and quality assurance for all three integration efforts; this item is on future agendas to develop.

Barriers

- Co-location of MH staff in a Primary Care Setting
  - Practice differences in terms of the rapid turnover that is necessary in primary care as compared to the 50-minute sessions that are the norm in the MH setting.
  - Misconceptions regarding mental illness.
  - Difficulty of obtaining appointments to a higher level of care when necessary; the necessity of developing a network of contacts to facilitate the transition to a higher level of care quickly was the first issue that was addressed.

- Co-location of Specialty MH and AOD in a Primary Care Setting
  - No mechanism to accommodate referrals for a higher level of care quickly and also to transition stable patients to a lower level of care.
  - Communication of events between clinics that are co-located on-site was identified as a need and was addressed with a policy and procedure to provide guidelines.

- Comprehensive Pain Management Services
  - This program is new; barriers would be that the information regarding this service is slow to get out. Once the providers are aware of the service, it promises to be popular.

Plans for Sustainability

- Co-location of MH staff in a Primary Care Setting
  - MHSA funded for patients that do not meet medical necessity.
  - MAA billing is getting started (Medi-Cal Administrative Activities Program).
  - Further mechanisms for funding are being explored.

- Co-location of Specialty MH and AOD in a Primary Care Setting
  - Medi-Cal funding for patients that meet medical necessity.
  - A Low Income Health Plan, which is in the final stages of approval, will assist with funding patients who were previously being seen, with the cost of their care being taken care of by the Department.

- Comprehensive Pain Management Services
  - Funding is being explored.

6. Santa Clara: Department of Alcohol and Drug Services (DADS) Integrated Care Projects

Background

From a survey of primary ambulatory care physicians, there is a strong need and an even stronger interest in developing linkages for specialty care for patients with substance use disorders. The Santa Clara Department of Alcohol and Drug Services (DADS) Integrated Care Project seeks to enhance treatment service systems by changing how substance abuse is managed in primary care settings by identifying and intervening at a lower level of acuity before patients are diagnosed with a greater severity of substance use disorders. Two projects were initiated in 2010 that incorporated the core components of screening, brief intervention/treatment, and referral (SBIRT).

Moorpark Medical Home: In September 2010, substance use services were integrated into this medical home clinic to provide a more coordinated model of care in one setting. Moorpark has three clinics: two remain standard primary care clinics, while the third was designed as a medical home. All three clinics are housed in the same building. In September 2010, the medical home clinic was initiated to add specialty care, including MH and SUD services to provide a more coordinated and integrated model of care in one setting.

Alexian Integrated Care Project: In 2009, Alexian methadone clinic was closed due to budget cuts and it then became a primary medical clinic called the Valley Homeless Project. In 2010, the Santa Clara County Board of Supervisors voted to restore the Alexian methadone program, now called the Alexian Health Clinic. The county wishes to restore the methadone program in an integrated way with the Valley Health Homeless Project (VHHP), since they have many patients in common.

Back in 2002, the county conducted a pilot study with this type of integration model and was able to demonstrate a 40% reduction in hospitalizations, 78% reductions in Emergency Department visits, and an overall more efficient use of the medical system.

Project Description

Project Goals

As a result of both initiatives, DADS is hoping to see (1) greater improvements in medical and substance abuse problems when patients are treated in an integrated way; (2) improvement in patient compliance with their medical care plan and substance abuse treatment plan; (3) a decrease in over-utilization of limited medical services; and (4) cost offsets and savings through the health system.

Moorpark Medical Home: The goal of the Moorpark Medical Home is to develop a pilot project within one of three similar primary care settings that will demonstrate that when substance abuse services are integrated with primary medical care, both medical and substance use outcomes are improved, thus supporting future efforts to expand services integrating substance abuse in primary care settings.

Alexian Integrated Care Project: The goal of the Alexian Integrated Care project is to integrate its addiction medicine division with the Valley Health Homeless primary care setting. DADS is also planning to conduct pilot studies on an array of various addiction medicines in addition to those being used for opioid addiction. These would include naltrexone, acamprosate, ondansetron, topiramate, and disulfiram.

Key Partners

- Moorpark Medical Home: DADS' partnership with the Moorpark medical staff was crucial to begin the process.

- Alexian Integrated Care Project: DADS partnership with the Alexian Valley Health Homeless Project staff was crucial to begin the process.

Partnership Development Process

Moorpark Medical Home:

- Regular planning meetings were held in order to co-develop the logistics with medical clinical staff.
- Development began on a screener form that would be integrated into the medical system.
- Permanent office space was secured for the addiction specialist.
- A screening test was selected and substantial training occurred for the medical staff on the importance of routine screening for SUDs in all patients.
- 42 CFR issues that can impede integration were addressed.

Alexian Integrated Care Project:

- Regular planning meetings were held in order to co-develop the logistics with medical clinical staff.
- 42 CFR issues that can impede integration were addressed.
- Minor construction was needed to assist integrating both programs and an increase in patient capacity.

Integration Models

- Moorpark Medical Home
    - The Moorpark Medical Home will add specialty care including an LCSW who is dual diagnosis proficient – i.e., specializes in the treatment of substance use disorder and mental illness. This person will be located on site. Referrals to the LCSW will come from the medical staff whose patients have a positive SUD screen, using the CAGE-AID. The LCSW will then assess for severity of addiction and determine a disposition using the ASAM PPC 2-R. If indicated, the brief intervention will be provided on-site. If the severity of the addiction is beyond brief intervention, the patient will be referred out to the substance abuse treatment system of care. In this case, the LCSW will serve as case manager and will interface between the SUD treatment provider and the Moorpark medical staff.

- Medical staff screen and refer to the on-site addiction specialist for full assessment, brief intervention, and referral to treatment, if needed. In addition, MDs were trained in motivational interviewing.

- Alexian Integrated Care Project
  - Co-locating primary medical care and addiction medicine.
  - Addressing medical needs for those with SUD and physical health co-morbidities.
  - Cross training with addiction medicine medical staff and primary care

Outcomes

Moorpark Medical Home: DADS established a data dashboard to document outcomes compared to the non-medical home settings. Measures include: # of patients, % SUD screened, % assessed and diagnosed, % received patient education and brief intervention, % referred to DADS for treatment, % referred to the continuous recovery model posttreatment and the number active in posttreatment. Preventative care and patient satisfaction will also be measured.

- Outcome benchmarks include:
  - No substance use in 30 days prior to follow-up
  - No new substance abuse treatment
  - No substance abuse related hospitalizations
  - No substance abuse related emergency room visits
  - Improved medical/health condition (corroborated with PCP)
  - Improved psychiatric condition

Alexian Integrated Care Project: Based in part on the Primary Care Behavioral Health model, the Alexian Health Clinic is a fully integrated model where behavioral health is a routine part of the medical care. In this model, the patient is just as likely to see a behavioral health clinician as a nurse during a routine office visit. A hallmark of this model is its focus on an epidemiological, public health view of service delivery. In specialty care, the focus is on the individual. In population-based care, the entire primary care population is the target. This model uses a "wide-net" approach aimed at serving the entire primary care population, with emphasis on brief, focused interventions.

- Effective collaboration for the Alexian Health Clinic and the VHHP will improve the quality of care for patients of both programs and will include:
  - Increased accessibility to needed care through patient referrals (i.e., methadone patients needing primary medical care, VHHP Suboxone patients needing transition to methadone, etc.);
  - Consultations by Addiction Medicine staff with VHHP and vice versa to patients in common;
  - In-service trainings on addiction medicine including screening, MI, and addiction clinical practice;

- VHHP/AMT participation in regular case conference meetings (42 CFR federal confidentiality guidelines restrictions would apply);
- Patient education series on substance abuse, co-occurring medical conditions, preventive healthcare, and medical comorbidities provided;
- VHHP representative in weekly AMT clinic management team

Barriers

Moorpark Medical Home:

- Time and place to conduct screening and brief intervention is problematic.
  - MDs cannot do the full SBIRT, but they can do SRT (screening, referral to treatment). Therefore, it is essential to bring in support behavioral health staff to conduct the pieces in between.
  - To save some time, patients can complete the CAGE-AID on their own and the MD can review it with them during the exam.

- Selecting the data measures and collecting data remains challenging.
  - There are no data fields to capture patient information for SUDs in current medical databases. 42 CFR can be a barrier to accomplish this.
  - During the process of selecting or modifying electronic medical records, and/or modifying procedures to stay compliant with privacy regulations, it is important to manually collect data as soon as possible.
  - It is also crucial to establish benchmark indicators for project success early. How else will you know if this effort is working?

Alexian Integrated Care Project

- Selecting the data measures and collecting data remains challenging (same as for Moorpark)

Plans for Sustainability

Moorpark Medical Home and the Alexian Integrated Care Project plan to: (1) Test out a billing system using LCSW staff who can bill FQHC for Medi-Cal patients. This is a very high reimbursement rate that may support the full cost of the SUD staff. (2) If cost savings can be identified as a result of integrating and treating SUDs, such as reduction in hospitalizations or use of ED for medical care, this would help justify the investment in treatment of SUDs. (3) Integration, if successful, identifies that primary care settings are the appropriate place to identify and initiate treatment for SUDs, and this will shift responsibility to the primary care system, thus increasing the likelihood that the services will continue. If they see value, and recognize their responsibility, they may decide they own it. (4) As we get increased Medi-Cal reimbursement from the MCE waiver, and ultimately from healthcare reform in 2014, the SUD services may have their own reimbursement stream.

7. Marin County: SBIRT in Healthcare & Other Community Settings

Background

In the spring of 2009, The Marin County Department of Health and Human Services, Division of Alcohol, Drug and Tobacco Programs (ADTP) began a continuum-of-services strategic planning process that included a needs assessment, data-driven problem statements, evidence-based strategies to address the issues, and standards and practices to guide the delivery of high quality services. Priority areas and strategic goals for Fiscal Years 2010/11 – 2014/15 were established. These priorities and goals strive to establish a comprehensive, integrated, and recovery-oriented continuum of evidence-based services that are responsive to community needs, engage multiple systems and stakeholders, encourage community participation, promote system integration, and embrace a comprehensive approach to service delivery.

One of the priority areas identified was the improvement of system capacity and infrastructure for the Marin County community. With the goal of coordinating, communicating and collaborating across departments, HHS Divisions, and community partners, Marin County wanted to ensure that individuals with or at-risk of alcohol, tobacco, or other drug problems were identified early, screened, and referred for services as appropriate.

As a part of their program and infrastructure development, the Marin County Division of Alcohol, Drug and Tobacco Programs collaborated with agencies to give them the training and knowledge to perform screening, brief intervention and/or treatment for multiple and co-occurring conditions, including substance use and mental health.

Project Description

Project Goals

The goal of Marin County's SBIRT project is to implement SBIRT in healthcare and other community settings in order to provide early identification and intervention and prevent the progression of problems related to substance use. Additionally, Marin hopes to enhance and facilitate access to treatment and other ancillary services.

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

- Upon initial screening and brief intervention at each site, Marin County has employed a Centralized Assessment Center/Care Management Program to further the assessment and placement process as needed. The Centralized Assessment Center staff will function as the care coordinators between the non-AOD setting and the AOD specialty settings.

Key Partners

The Marin County Division of Alcohol, Drug and Tobacco Programs collaborated with a number of key partners and agencies in various stages of their SBIRT training, implementation, and technical assistance process. These partners included the healthcare and community service agencies that agreed to make SBIRT a reality in their settings. Potential partners included: FQHCs, hospitals, homeless resource centers, adult mental health programs, Public Health HIV/AIDS Services program, youth program, jails, and other criminal justice settings.

Partnership Development Process
As a result of the needs assessment, various settings were identified to improve access to SUD services. Several challenges surfaced as a result of competing efforts in the differing settings. Despite efforts to collaborate with jails and shelters initially, SBIRT implementation occurred first at the adult mental health settings.

After acquiring technical assistance resources on SBIRT, Marin had the ability to appropriately train the interested agencies with comprehensive material and guidance. An important part of the partnership development process was achieving "buy-in" so that these programs would understand the importance of SBIRT and the many benefits conducting SBIRT in their programs would have on their patients. Upon doing so, Marin conducted an assessment of each of the settings to determine training and capacity-building needs so that appropriate identification, hiring, and training of staff could take place.

Integration Models
Marin's project required interested partners to participate in SBIRT training provided by the Marin County Division of Alcohol, Drug and Tobacco Programs or a designee. This entailed one full-day of training, participation in periodic follow-up training/technical assistance calls or meetings, and collaboration with the Centralized Assessment/Care Management Program (operated by Bay Area Community Resources) to ensure the seamless referral of appropriate patients.

In order to adequately prepare programs, their staff were trained on how to adhere to objective criteria (based on screening scores) regarding when and how to refer appropriate patients. They were also required to determine a process of communicating a referral, including documentation. A system to maintain data on process and outcome measures using a database provided by the county was also essential. In addition, procedures that complied with 42 CFR and HIPAA regulations needed to be established to share pertinent information across service systems.

Outcomes

Marin County has established data elements in which to document the impact and outcomes of the SBIRT initiative. Consultation with UCLA on these elements occurred and processes were put in place to begin data collection.

Marin began screening all individuals accessing CMHS' Case Management services in early spring 2011. Marin is in the process of compiling year-end data and will provide that to UCLA as soon as possible. Marin ADT staff, CMHS staff, and RCC staff are meeting bimonthly to further operationalize a full range of co-occurring services (*A workplan and timeline is provided as Attachment A).*

Barriers

- Major financial challenges: Due to limited funds and other county-wide re-structuring projects, there were delays in the release of the Five-Year Strategic Plan. As a result, the

implementation of the SBIRT Project was postponed, and attention was deferred to other initiatives. This barrier required Marin to engage with a larger number of stakeholders and demonstrate SBIRT's effectiveness and efficiencies to a wider group of community programs. Upon doing so, Marin was able to get the community support and engagement it needed for their project to commence.

- Engaging, planning, and implementing SBIRT in 12 diverse settings: Due to the complexity and number of settings in which SBIRT would be implemented, Marin had to make sure that the screening instruments, protocols, training, and suggested data collection measures and tools, were adapted to fit the needs and requirements of each program. In order to have the capability to prepare each program on how to conduct SBIRT, Marin accessed expert technical assistance and compiled various resources so that each program could have customized guidance.
- Changing system-wide policies and practices, and building staff capacity, knowledge, and skills during difficult economic times has been challenging, especially for our community-based providers. Many CBOs are struggling to build and sustain expertise in evidenced-based practices, counselor certification, and implementing data systems and electronic health records while working with individuals and families with increasingly complex emotional, physical, social, and legal issues.

Plans for Sustainability

Marin has re-directed existing staff time and financial resources to support SBIRT implementation, and expansion of treatment and recovery services. In addition, the majority of services, including Primary & Secondary Prevention, Intensive Outpatient Services, Criminal Justice Services, Case/Care Management Services and Recovery Support Services, were all RFP'ed in FY 2010/11.

In the spring of 2010, Sutter awarded a Behavioral Health Grant, to be managed by the Marin Community Foundation, to the following three clinics:

- Marin Community Clinic (MCC - FQHC). MCC has participated in training and needs assessment activities, but has not yet engaged in any implementation activities. County Health & Human Services Staff worked with Marin Community Foundation and MCC staff in developing an implementation plan and timeline that is included in their FY 2011/12 contract. ADTP anticipated that SBIRT would be operational in their clinic by January 1, 2012.

- Coastal Health Alliance (CHA- FQHC). CHA, operating in West Marin, has been collaborating with Dr. Jason Satterfield, PhD, Director and Behavioral Medicine Professor of Clinical Medicine, UCSF; on the development of an implementation plan for the SBIRT Program. Both Dr. Gullion and Dr. Goetz, CHA psychologists, have completed the "SBIRT Train the Trainer" seminar offered by the Marin County Division of Alcohol, Drug & Tobacco Programs in December of 2010. CHA planned the implementation of SBIRT training for CHA providers and medical support staff and expected that SBIRT would be fully implemented by the end of 2011.

- Ritter Center (Health Clinic). Ritter Center developed protocols and implemented SBIRT; however, efforts were paused in mid-spring 2010 due to staffing changes. An integrated SBIRT/IMPACT implementation plan has been negotiated and included in their FY 2011/12 contract. A challenge for this organization is that patients accessing this service are generally homeless and most often have significant substance abuse, mental health, physical, and legal issues. Most patients screen very high for requiring treatment, but they resist referrals. The organization's professional and peer support staff attempt to use motivational interviewing, continuous engagement, and assistance with housing and other living skills, including food, showers, and basic healthcare, to help patients as they develop relationships with them. Marin is searching for promising/evidenced-based practices for use with this population.

- ZIA Partners: Building on work from last year, Marin County is continuing to work with ZIA Partners in designing a transformational quality-improvement partnership across the entire Marin County substance use and mental health systems. The purpose is to improve capacity to welcome, engage, and provide integrated services to individuals with co-occurring mental health (including trauma) and substance use conditions. All community-based providers working with the Divisions are invited to continue to participate in this process, building upon last year's work of selecting a Change Agent and a Quality Improvement Plan and expanding their co-occurring capability by using the COMPAS-EZ and the CODECAT-EZ.

2011-2012 Initiatives

Proposed ADT/CMHS-Adult Case Management Service Integration Pilot FY 2011/12
The goal of the one-year integration pilot for the Adult Case Management Program is to provide the training and technical consultation necessary to increase the existing staff's capacity to identify patients with co-occurring mental health and substance use issues, provide appropriate interventions, and/or refer them to specialty substance use treatment services, as indicated. The proposed project also includes the provision of on-site engagement and assessment services to enhance the coordination of patient care, increase communication and collaboration between substance use and mental health staff, and minimize barriers for patients to access treatment and ancillary and recovery support services. *(A Workscope of the Project's Activities, Timeline & Expected Outcomes is included below with specific goals including Enhancing Staff's Capacity & Skills and Enhance Service Delivery to individuals requiring both SUD and MH* services.)

Adoption of Global Appraisal of Individual Needs (GAIN) Short Screen and Gain Core
Marin County ADT has had a longstanding relationship with its criminal justice partners as well as joint programs including Proposition 36, Adult Juvenile Drug Court, STAR Court (for persons with mental health disorders¸ many with co-occurring substance abuse disorders). In June 2011, Marin County ADTP submitted an application to SAMHSA that would bring together the existing "collaborative justice" courts in the county into a network that will serve adult men and women in all stages of the criminal justice system who have any type of behavioral health problem, including: substance abuse or misuse, alcohol and/or drug addiction, serious psychological distress, and mental and substance use disorders. Building upon the Department's efforts to create system-wide screening, a single point-of-entry, and a "no wrong-door" approach

to its system of behavioral health services, *all partners agreed to select uniform, consistent and comprehensive assessment, referral, adjudication, case management and follow-up services to those with behavioral health-related criminal justice involvement.* Regardless of whether Marin receives funding, these same partners have agreed to implement the GAIN Short Screen by Chestnut. In addition, Marin's newly developed Recovery Resource Center, a developing single point of entry for individuals seeking SUD and co-occurring mental health disorders, is conducting the GAIN Core on all patients referred. In FY 2011/12, ADTP anticipates adoption of the GAIN Short Screen by the following county departments: Juvenile & Adult Probation, In-Custody Staff, GA, CalWorks, and the Division of Aging and Adult Services.

Proposed ADT/CMHS-Adult Case Management Service Integration Pilot
FY 2011/12

The goal of the one-year integration pilot for the Adult Case Management Program is to provide the training and technical consultation necessary to increase the existing staff's capacity to identify clients with co-occurring mental health and substance use issues, provide appropriate interventions, and/or refer to specialty substance use treatment services, as indicated. The proposed project also includes the provision of on-site engagement and assessment services to enhance the coordination of client care, increase communication and collaboration between substance use and mental health staff, and minimize barriers for clients to access treatment, ancillary and recovery support services.

Proposed Activity	Timeframe	Activities	Expected Outcomes
Preparation for Implementation			
Introduce Pilot Project: Meet staff and/or clients to gain greater understanding and introduce the concept/services, etc.	07/11 07/5/11 07/12/11 07/11 – 08/11 07/11 – 08/11	• Modify consent forms • Provide staff with an overview/ purpose of the project • Introduce/present to ACM team about the project. Note: Bring updated SBIRT referral form to ACM staff meeting • Obtain signatures from clients to consent to exchange info (ACM staff) • Request approximately 5 clients/cases for RCC to meet with (with ACM staff) to gain greater understanding of client culture/issues (AW/ACM)	• ADT staff/providers increase understanding of AMC client issues so services can be designed/provided appropriately • Engage ACM team to increase understanding/ skills related to AOD and to utilize AOD resources • Enable communication between CMHS/ADT/ RCC to effectively serve clients

Develop Protocols: Develop and execute written protocols and forms to ensure effective treatment planning and communication across AOD & CMHS-ACM services	07/11 – 09/11 09/11 – 10/11	• Draft protocols and related forms to ensure integrated client care/treatment planning/communication. Ensure forms are approved by the Compliance program • Review and finalize with ACM staff (ADT/ACM)	• Increase understanding and use of integrated treatment planning for clients with co-occurring conditions • Improved client outcomes as care is coordinated and services for AOD are accessed though ACM/RCC staff

Staff Capacity Building			
Alcohol, Drug and Tobacco (ADT) Consultation: Monthly AOD-focused staff meetings	07/11 – 06/12 09/11, 11/11, 1/12, 3/12, 5/12, 7/12	• Participate in monthly staff meetings, beginning in September and every 2nd Tuesday of the month thereafter • Periodically re-assess benefit and purpose of participating in staff meetings to ensure needs/outcomes are being met (All)	• AOD is embedded in the culture of the ACM program • ACM increases skills to address AOD issues, and increases knowledge of related integration efforts and resources
ADT Consultation: 10-minute "Quick Tip" at weekly staff meetings	07/11 08/11 – 6/12	• Draft quick tip concepts based on core competencies, best practices for SBIRT and integrated care, etc. and on ACM staff input/requests • Present weekly, beginning at the August 2nd staff meeting	• ACM staff increases skills to address AOD issues • ACM staff link clients with assessments
Identify AOD/MH Skill Set and Referral Criteria: Identify ideal and appropriate knowledge/skills/core competencies for designing and delivering intervention strategies, and establish/agree on criteria of when it is appropriate to refer for specialty AOD services	07/11 – 09/11 09/11 10/11	• Solicit technical assistance from ZIA Partners to: 1) identify core competencies for ADT and CMHS staff/providers to provide integrated care; and 2) identify criteria/thresholds for when to refer for specialty ADT and CMHS services • Circulate draft documents to CMHS/ADT managers group for endorsement • Review with ACM team (and distribute to ADT providers)	• ACM/ADT staff can more effectively serve clients with co-occurring AOD/MH issues and identify when a client should be referred to specialty services • Increase in ACM/ADT clients accessing CMHS/ADT specialty services, as appropriate

Targeted Training Series: Convene a training series targeted to enhancing identified skill sets	09/11 09/11 - 10/11 09/11 – 11/11 09/11 – 6/12	• Develop a list of training topics for ACM and ADT staff/providers that align with the core competencies, ACM input, etc. • Review/finalize list and share with CMHS/ADT management team • Seek trainers and schedule trainings • Coordinate CEU's and logistics	• ACM/ADT staff increase confidence and ability to serve clients with co-occurring conditions • Increase in ACM/ADT staff including AOD/MH measures in the client's treatment plan

Enhancing Service Delivery			
Implement SBIRT: Implement SBIRT for new ACM clients and all clients annually	Ongoing	*Implemented in February 2011* • Check-in with ACM at least quarterly at staff meetings to assess progress, answer questions, provide technical assistance, etc. • Generate quarterly SBIRT data reports	• Improve client outcomes by identifying and addressing alcohol and other drug issues, and enabling communication about client care, as appropriate
Assessments: Recovery Connections Center can provide on-site assessments	Ongoing	• Established fixed time slots available for assessments for ACM clients (and other CMHS clients if available) at the HHS Campus • ACM team to schedule client appointments during the weekly ACM staff meetings (or by telephone/fax in between)	• Increase in ACM clients being referred to and participating in specialty AOD treatment services
Engagement Groups: Convene an on-site engagement group for appropriate ACM clients (and other CMHS clients if space permits); (1 – 2 groups/week for 40 weeks)	07/11 07/11 08/11 – 6/12 08/11 – 6/12	• Determine room availability for a recurring weekly 90 minute group at the HHS Campus and communicate • Based on availability, confirm a weekly group time with staff and communicate to supervisor • Convene weekly engagement groups at the HHS Campus, beginning in August (RCC) • Arrange for refreshments for the weekly groups	• Increase in ACM clients accepting a referral for an assessment for specialty AOD treatment services
ADT Consultation: Make telephone/in-person consultation services on client issues, a weekly/monthly drop-in case conference session, and/or participate in a client visit available to ACM staff for 15 hours/month	07/11 – 06/12 09/11, 11/11, 1/12, 3/12, 5/12, 7/12	• Inform ACM staff of availability of ADT consultation at the introductory and ongoing staff meetings • Check-in bi-monthly to assess utilization and determine effectiveness of the model (ACM/RCC/ADT)	• Increase in integrated treatment planning for ACM clients • ACM staff increase confidence and ability to serve clients with co-occurring conditions

Monitoring and Evaluation				
Regular Check-In: Convene the planning team (ACM/ADT/RCC) at least quarterly to determine progress, assess fidelity with the design, identify course corrections, determine steps to ensure integration and sustainability, discuss broadening the pilot to other programs, etc.	All	Ongoing 09/11, 11/11, 1/12, 3/12, 5/12, 7/12 Ongoing	• Schedule bi-monthly meetings with ACM/ADT/RCC staff and outline agendas • Convene meetings with the planning team to monitor progress, identify course corrections, etc (All) • Communicate progress to the CMHS/ADT management group and IBH group	• Ensure pilot is designed and delivered in a manner to achieve intended outcomes
Data Reports: Collect and compile data to assess progress, identify successes and lessons learned, inform future integration efforts, and communicate to leadership	All	07/11 – 09/11 Ongoing Quarterly	• Determine the types of data to be tracked/collected (e.g. SBIRT data reports; number/percent of referred clients participating in groups, being assessed, referred to treatment; staff training evaluations; etc.) and present to the planning group for input and consideration • Collect data and submit to ADT quarterly to compile an evaluation report to be reviewed by the planning team (ACM/RCC/ADT) • Share the annual report (and quarterly reports as appropriate) with the ACM team and IBH group	• Ensure pilot is designed and delivered in a manner to achieve intended outcomes • Ensure results and recommendations are shared with HHS leadership

Acronym Key
ACM = Adult Case Management Team
ADT = HHS, Division of Alcohol, Drug and Tobacco Programs
AOD = Alcohol and Other Drug
CMHS = HHS, Division of Community Mental Health Services
HHS = Marin County Department of Health & Human Services
IBH = Integrated Behavioral Health group composed of Bobbe, Bruce, DJ, Larry and Margaret
RCC = Recovery Connections Center (Centralized Assessment/Care Management Program managed by Bay Area Community Resources)

A. California's Forum on SUD/Primary Care Integration[*]

The investigative and preliminary research on integration revealed important findings and lessons that could enhance and stimulate further integration efforts across California. In order to disseminate gathered knowledge and expand upon existing information, UCLA planned for a Forum on Integration that would bring together policy makers, program administrators, provider group representatives, and researchers from across California on this issue. With a better understanding of needs and areas in development, UCLA felt such a forum to be timely and appropriate to promote further movement on integration and address the barriers and limitations unearthed from initial research.

Purpose

California's Forum on Integration: Integrating Substance Use Disorder (SUD) Services and Primary Care brought together policy makers, program administrators, provider group representatives, and researchers from across California to:

1) Discuss the role of the public substance use disorder (SUD) treatment system in the integration of behavioral health and primary care services;

2) Learn about models of SUD/primary care integration currently being implemented throughout the United States; and

3) Set an agenda for moving California's Alcohol and Drug Programs Department (ADP) and California counties toward integration with medical health services.

Methods

On December 8–9, 2010, the California Department of Alcohol and Drug Programs (ADP), in conjunction with UCLA Integrated Substance Abuse Programs (ISAP), sponsored *California's Forum on Integration: Integrating Substance Use Disorder (SUD) Services and Primary Care*. County SUD administrators currently engaged in SUD/primary care integration efforts[*] along with provider group representatives convened with SUD integration experts from across the country to identify successful models and processes for SUD/primary care integration as well as common barriers and solutions. The purpose of the forum was to explore promising practices associated with the integration of SUD and care services in order to inform ADP's strategy for moving forward with SUD/primary care integration and to identify technical assistance needs and further action needed to assist counties and providers with integration efforts. This forum was intended as a starting point for more long-term and broadly disseminated statewide

[*] Please visit http://www.uclaisap.org/Affordable-Care-Act/assets/documents/CA%20Forum%20on%20Integration/CA%20Integration%20Forum%20Summary%20Report_FINAL.pdf for a full Forum Summary Report.

[*] An integration survey was sent to SUD administrators from all 58 counties. Administrators who (1) completed the survey; (2) indicated any current or planned integration initiatives; and (3) expressed interest in the Forum were invited to participate in the Forum.

integration activities. Forum participants included county administrators who are currently engaged in integration initiatives, provider group representatives, ADP staff members, and representatives from the California Department of Health and the California Department of Mental Health.

On Day 1 of the forum, individuals from across the country who have been involved with the implementation of sustainable SUD/primary care integration programs and with components of integration, such as financing and research, conducted presentations for participants. The expert presentations included individual presentations and three panel presentations: (1) Integrating SBIRT into primary care; (2) Health homes and fully integrated care; and (3) Integrated medication-assisted treatment. On Day 2, administrators from six counties each conducted a presentation on planned or current integration initiatives. County presentations included integration models, barriers, solutions, and technical assistance needs. Following the presentations, ADP, UCLA ISAP, and all participants engaged in a strategic planning session to identify themes from the meeting and to plan next steps for ADP and for counties.

In order to continue the momentum, UCLA compiled the information, recommendations, and lessons gathered from the forum into a summary report for distribution.* As summarized in the report, the findings and conclusions from the forum were as follows:

Summary of Findings

What the experts say about integration. Expert speakers, including Dr. Richard Rawson, noted professor and SUD researcher from UCLA; Dr. Mady Chalk, an expert on SUD policy from the Treatment Research Institute; Dr. Suzanne Gelber, a specialist in financing integrated care from The Avisa Group; Dr. Connie Weisner, a researcher from Kaiser Permanente; and Kenneth Stark, Director of Snohomish County Department of Health and Human Services in Washington State, each spoke about SUD/healthcare integration. These experts presented evidence-based arguments for the need for integrated SUD and healthcare; provided evidence that integrated care can be beneficial to patients and reduce costs; discussed potential challenges to integration such as financing and shared documentation, and provided helpful solutions to overcoming some of these barriers. In general, the experts agreed that although there may be challenges to integrated care, substantial evidence indicates that integrated care will increase access to SUD services for many more individuals and that patients' physical health and SUD problems will benefit from integrated care.

Panel I: SBIRT. Speakers on the SBIRT Panel were Elinore McCance-Katz, MD, PhD, Professor of Psychiatry and ADP Medical Director, University of California, San Francisco (UCSF); José Esquibel, Director, Interagency Prevention Systems, Colorado Department of Public Health and the Environment; and Cosette Taillac, Regional Director, Mental Health Outcomes/Best Practices, Kaiser Permanente Northern California. Although each panelist spoke about a different approach to SBIRT (Dr. McCantz-Katz spoke about UCSF efforts to add SBIRT to medical school curricula; Mr. Esquibel spoke about Colorado's efforts to make SBIRT a standard of care across the state; and Ms. Taillac presented an SBIRT program designed to decrease substance use in pregnant women) each conveyed that SBIRT is feasible, has been

accepted by medical staff in a variety of different settings, and results in positive outcomes for patients.

Panel II: Health Homes and Fully Integrated Care. This panel consisted of two speakers from large, federally qualified health centers (FQHCs) at opposite ends of the country: Dr. Trip Gardner, MD, Chief of Psychiatry, Penobscot Community Health Center, Co-Director, Summer Street Clinic, in Bangor, Maine, and Leslie Preston, Behavioral Health Director, La Clínica de La Raza, in Northern California. Dr. Gardner spoke about a fully-integrated health home model for providing SUD, mental health, and healthcare services, including medication-assisted treatment for addiction. The approach is patient-centered, with primary care as the focal point of services. Ms. Preston presented on a fully-integrated model of behavioral health services that centers around a behavioral health specialist who provides screening to all patients and brief interventions to those who need them. A medical social worker is also on-site to provide perinatal assessments and individual and group therapy. Fully integrated programs, including health homes, albeit challenging to establish, appear to result in positive outcomes for patients and to have financial benefits for providers.

Panel III: Medication-Assisted Treatment (MAT). On the MAT panel, Sheila Barbee, Vivitrol Program Manager, Florida Substance Abuse and Mental Health, spoke about increasing patient retention in substance abuse treatment through the use of Vivitrol for the treatment of alcoholism; Alice Gleghorn, PhD, County Alcohol and Drug Administrator, San Francisco Department of Public Health, Community Behavioral Health Services, spoke about San Francisco's integrated Office-Based Opioid Treatment (OBOT) program; and Colleen LaBelle, RN, CARN Program Director STATE OBOT B, Boston University Medical Center, MDPH Bureau of Substance Abuse Services, presented on Boston University's nurse model of OBOT. Although all three programs were very different, each with different settings and different medications, the message from these presentations was similar: Despite challenging infrastructure and development requirements, such as the need for special licensing and staff credentials to distribute the medications, intensive training, and time to obtain support from all involved stake-holders, MAT can be an effective component of SUD treatment and can be integrated into SUD treatment, primary care, and hospital settings.

Innovative SUD/Healthcare Initiatives in California Counties. In order to improve SUD care for patients and to prepare for potential changes that will take place through healthcare reform, a number of California counties have begun to pilot innovative programs that integrate primary care and SUD services. Kern County is working with three FQHCs to expand their SUD screening, brief intervention, and treatment services. Orange County is testing three different models: a shared county electronic health record that contains SUD, mental health, and primary care data; a bi-directional care model in which primary care physicians are being placed in a SUD/mental health setting and SUD counselors are being placed in primary care settings; and an SBIRT model in which a behavioral health specialists conduct SBIRT in an emergency room. San Francisco is creating a fully-integrated primary care team approach that includes behaviorists and behaviorist assistants in several FQHC settings to provide SUD and mental health screening, intervention, and referral. A Los Angeles program has already integrated primary care with specialty HIV/AIDS, mental health, and substance use disorder care. Santa Clara County is piloting two models. In one model, an addiction specialist is co-located within a

primary ambulatory care clinic. At this clinic, medical staff screen and refer patients to an on-site addiction specialist for full assessment, brief intervention, and referral to treatment if needed. In the second model, primary medical care is integrated within a methadone treatment clinic. Although each of these counties has experienced challenges in planning for and implementing integrated care, the county pilots provide a valuable foundation for further development of integration pilots and programs.

Conclusions

Conclusions and insights gained from the California Integration Forum are as follows:

- "One size does not fit all." Integration can take many forms along a continuum, from better coordination between primary care and specialty care to full integration where it is feasible and fundable.

- "Think big, start small, use data." Sustainable integration programs can begin as small pilots. Funding can come from a variety of sources, including federal and state government sources as well as local foundations. Whenever possible, data from pilots should be collected and disseminated to show funders that integration is good for patients and is cost-effective.

- "Workforce and training issues loom large." Training and technical assistance for SUD and primary care providers is needed in a variety of areas, including planning and funding integration pilot projects; protocols for integrating evidence-based screening, brief intervention, referral and treatment (SBIRT) models into primary care settings; setting up electronic health records; and cross-field training in which primary care personnel learn about SUD services and SUD providers learn about primary care systems.

- Barriers to SUD/primary care integration exist but can be overcome. Barriers to SUD integration include resistance (real or perceived) by primary care providers to integrate SUD services; financing barriers due to Medi-Cal billing restrictions (in California a behavioral health and physical health visit cannot be billed on the same day, and only licensed behavioral healthcare staff can be reimbursed); and limits to patient file sharing pursuant to the regulations in 42 CFR (the federal law that sets privacy protections for substance use information). However, there are many examples of SUD/primary care integration programs that have moved beyond these barriers. Training, technical assistance, and information dissemination are the first steps toward overcoming barriers.

The encouragement to begin integration initiatives elicited many questions and qualms that still needed to be answered. With the collaborative progress made during the forum, the impetus for an ongoing Integration Learning Collaborative (ILC) was established. All counties, provider group representatives, and state-level representatives were invited to participate in this discussion and information sharing about integration in the hopes of moving California toward a more integrated system of care. The ILC sustained the teamwork and alliance-building needed to further initiate and sustain the integration initiatives that emerged from the Integration Forum presentations and discussions.

B. California SUD/Healthcare Integration Learning Collaborative (ILC)

Purpose

Through the Integration Forum, the Integration Survey, and the case studies and site visits, it became clear that counties were in need of technical assistance and training on topics related to integration. Areas of needed information included: how to develop partnerships with primary care providers; which integration model works best in which settings; how to fund integration pilots; and how to adapt SUD services to fit healthcare settings. In order to meet the need for further assistance on integrating SUD services into healthcare settings, UCLA initiated the development of the California SUD/Healthcare Integration Learning Collaborative (ILC).

Objectives

The ILC aims to provide an interactive forum where county administrators, SUD provider organization representatives, and other key stakeholders can collaborate to identify successful models and processes for SUD/PC integration, as well as common barriers and solutions. The ILC serves as a portal for program leaders to develop and work together to find sustainable approaches to integrating SUD services within the broader healthcare setting, a significant issue brought about by health reform.

It is expected that participating members of this online Integration Learning Collaborative (ILC) will:

1) Learn from one another's integration activities/initiatives to gain resources, skills, knowledge, and ideas to support similar movement in their scope of service,
2) Gain technical and social support to improve specific clinical and operational areas in need of assistance and further development within various integration pursuits,
3) Engage in active communication and share experiences to gather ideas, solutions, and lessons for current and future work around integration.

Methods

In order to offer this assistance and learning collaborative to all 58 counties, the ILC is conducted via teleconference and web-based technology, and, when possible, in person at the CADPAAC quarterly meetings. The ILC meetings are held on a monthly basis and topics are determined collaboratively by UCLA, ADP, and the participating county administrators. Meetings commenced in April 2011 and will continue through the first half of fiscal year 2011–2012. Further discussions to continue the ILC will be determined by ADP and UCLA.

Summary of Findings

To date, the work of the ILC has produced identified technical assistance needs among the participating county administrators, and critical discussions on privacy and data sharing as well as on billing/funding of SUD services in healthcare settings. Expert speakers were invited to

each discussion to provide assistance to UCLA to facilitate discussions and address topic-specific issues.

Information dissemination is a key aspect of the ILC because all 58 county administrators are not present at each meeting. All meeting materials are posted on the Integration Learning Collaborative Website: http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html; in addition, regular e-mail correspondence occurs from UCLA to remind participants of next calls, provide any updates/changes, and distribute important and relevant resources/information. Summary reports are disseminated and posted after each call to review resources and information shared.[*] Ongoing communication and support via e-mail and on the website (listed above) disseminate resources, materials, and presentations generated through the collaborative meetings.

Conclusions

As the ILC continues, engaging in active communication and sharing experiences to gather ideas, solutions, and lessons for current and future work around integration is imperative. Through our work to date, key lessons and concepts have been identified that serve as a founding framework to conduct the ILC.

The "Big I" and "little i" in Integration

Integration is a widely used term that is becoming more and more undefined. While the general meaning of integration is understood, the specific conditions required to achieve integration are often overlooked. Especially when integration is applied to specific contexts and case scenarios, integration can involve a wide variety of situations and circumstances. As such, integration needs to be properly explained for it to hold any significance. In spite of these considerations, integration continues to be a more pervasive term appearing in webinars, the literature, policy statements, and recommendations as an end goal for providers to prepare for healthcare reform. While these resources push SUD providers to aim for integration, they are not always informed of what this should look like and how it can be fully achieved. One of the underlying causes behind this confusion is due to the great diversity in models for service integration that exist. Another reason, specifically in the case of SUD services, is the two fields of integrated care that take hold when applied to SUD care. These two levels of integration should be noted as two separate ideologies:

- Integration with a lower case "i."
  - Integrating substance use services with mental health
- Integration with a capital "I".
  - Integrating both substance use and mental health services into the larger health system.

The ILC successfully brought this distinction to light and emphasized the focus of the collaborative effort on integration with a capital "I." Although each are significant priorities, SUD and MH have had a much longer history of collaborative services due to the high rates of co-occurring disorders (CODs). SUD and MH have therefore made considerable strides in

[*] Please see http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html for full summary reports of all completed ILC meetings.

working together since operating in separate "silos" and continue to bridge services, specifically through the work within the Co-Occurring Joint Action Council (COJAC). The PC arena is an area that is less familiar to the SUD field and where a lot more work needs to be done to build partnerships and link services. As such, integration on the overarching need to improve services with the larger health system remains in the forefront of current and future ILC discussions.

Teamwork

As the ILC continues, each meeting or session brings forth varying examples and lessons from which participating members can learn from. In addition to insightful information, the collaborative provides an avenue for members to offer solutions and strategies to overcome obstacles and barriers along the integration process. Current progress is proving that the ILC is beneficial in enhancing county and provider efforts.[*] The success of the ILC is evidence for the importance of teamwork and partnerships in improving efforts toward developing and implementing a transformation plan to achieve integration.

Additional conclusions and lessons learned will be captured in the corresponding report for future fiscal years.

[*] Please see http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html for full summary reports of all completed ILC meetings.

C. Website Development and Information Dissemination

Purpose

Due to the nationwide initiative to prepare for the changes occurring and expected as a result of the Affordable Care Act and healthcare reform, a number of reports, webinars, policy statements, toolkits, and journal articles began to be heavily circulated in 2010–2011. These informative resources were made and continue to be made available through a wide variety of organizations, policy groups, stakeholders, and leaders in the field. While filled with important findings and recommendations for providers and county administrators preparing for integration and other changes in the organization and delivery of SUD prevention and treatment, the quantity and variation in the information available is extensive. Effective information dissemination methods, at this time, are critical for state leaders and county administrators to keep up with the fast paced changes on the horizon.

In order to ease the burden of having to sort through such a large amount of complex material, UCLA initiated the development of a website that houses the most recent and significant resources related to the Affordable Care Act. The resources are categorized by topic to allow for easy navigation for California state leadership, county administrators, and providers to retrieve timely and important information in a straightforward manner.

Methods

By keeping abreast on information related to federal healthcare reform and the SUD field, UCLA identifies the most useful resources that become available. The website, titled Affordable Care Act Resources, is accessible through the url: www.uclaisap.org/Affordable-Care-Act. Resources are categorized by the following topics: Health Care Reform, Primary Care/ Behavioral Health Integration, Health Information Technology, Funding Strategies, Workforce Development, and Performance Measurement/ Dashboards. These themes were identified after numerous discussions with state and county leaders, who expressed guidance on specific issues pertaining to these areas of focus.

UCLA joined a number of listservs to receive timely materials and updates on healthcare reform initiatives and changes. In addition, UCLA monitored a large variety of websites that continually post important resources and reports on expected changes and recommendations. UCLA also participated in numerous webinars and continues to constantly review updates and literature from national, state, and local research groups and organizations. In addition, through our subcontract with the Treatment Research Institute, UCLA is able to stay connected to federal leaders responsible for policy changes and new proposals. UCLA's full awareness and knowledge of the field allows the website to be maintained and updated on a timely basis with the most informative presentations, reports, and recommendations.

Summary of Findings

In addition to providing state leaders and county administrators and providers with a comprehensive portal to access resources, UCLA finds the website to be a useful tool for posting

additional information related to upcoming and past trainings, as well as the Integration Learning Collaborative. Users of the website report that it allows them to save time in accessing information and understanding how healthcare reform will shift the nature of SUD prevention and treatment service delivery.

Conclusions

In a time of rapid change and a number of demands, county administrators and providers are restricted in staff, time, and resources. Without the ability to stay abreast on timely issues and recommendations, they are in need of constant guidance and assistance from leaders in the field. The development of the Affordable Care Act Website is one of many initiatives UCLA has embarked upon to help them access relevant information and progress in their strategies for effective action. With years of experience, UCLA understands the challenges they face as well as the wide differences in county structure, organization, and capacity. UCLA's expertise and foundation of knowledge has allowed the website to be an effective avenue for disseminating information and encouraging integration. Counties are utilizing the website to discover strategies implemented in the field, what the challenges are, and how to best optimize their efforts to become better prepared for healthcare reform.

IV. Lessons Learned and Recommendations

A. Lessons Learned

Although our work is preliminary and based primarily on informal, qualitative study of a few providers and SUD administrators in California, it provides a valuable and unique preview of efforts to integrate specific SUD services into healthcare settings.

SUD/PC Integration can help improve outcomes for both individual patients and the entire healthcare system.
There is solid evidence that SUD/PC integration can increase access to SUD intervention and treatment, improve clinical outcomes for individuals with SUD service needs, prevent the development of SUDs, and, as a result, lead to cost savings across the healthcare system. There are still as many questions about SUD/PC integration as there are answers. Research is needed to identify what models for SUD/PC integration are most effective, and which are most appropriate for specific patient populations and treatment settings, in order to inform both policy and clinical practice.

BH/PC Integration and SUD/PC Integration are similar, but not the same.
To date, most research addressing SUD/PC integration fits into larger studies examining BH/PC integration, which focuses predominantly on MH/PC integration. While this literature can serve as a good guide for SUD/PC integration, there are differences between SUD treatment and MH treatment services that warrant consideration when integrating with PC.

In spite of the commonalities between SUD and MH services (Davidson & White, 2007) and the fact that 42.8% of the population with SUDs also has a co-occurring MH disorder (SAMHSA, 2010), SUD treatment presents a distinct set of challenges that providers of integrated MH services do not face:

1. Diagnostically, SUDs differ from other MH disorders because they are often more difficult to detect.
    - Though screening instruments that can be used to identify SUDs in primary care settings exist (Babor & Kadden, 2005; Davidson & White, 2007), they generally rely on self-report, which may be problematic in situations where patients are in denial of having an SUD, enjoy their substance use behaviors and do not want to reduce them, or believe that there could be negative consequences for reporting their substance use (Babor & Kadden, 2005; Babor, McRee et al., 2007). This is particularly the case when controlled or illicit substances are involved. Self-report can be even more problematic in cases of prescription medicine misuse or abuse; patients who procure their drugs through medical channels may hide their SUDs out of fear that doctors may report their drug-taking behaviors or refuse to refill their prescriptions.

2. There are systemic and regulatory challenges unique to SUD/PC integration that are not present in other BH/PC integration efforts.
    - Some of the medicines used in the treatment of SUDs (particularly methadone) are subject to tighter regulations and controls than those used to treat mental

illness. Significant roadblocks, particularly the need for providers to receive specialized training on how to utilize these medications, further inhibit their use outside of specialty SUD treatment settings. Medicaid licensing requirements for SUD treatment reimbursement are also more stringent, thus creating further disincentives for PC clinics to integrate SUD treatment into their array of services. Furthermore, privacy restrictions surrounding SUD treatment documentation are more restrictive than they are for MH records, creating an extra barrier that SUD and PC providers need to overcome when collaborating on treatment planning and service delivery.

To date, providers in California have primarily used four models for SUD/PC Integration.
Data from the California Integration Survey conducted in October 2010 revealed that the models most commonly used to begin integration efforts were as follows:

1. *SUD Services Delivered By SUD Specialists in PC Settings (N = 10 of 25 county respondents)*
   - In most of the counties using this model, SUD services are partially integrated into PC clinics, with SUD specialists working on-site (co-located) and collaborating with PC providers in treatment planning and care management, but maintaining their own documentation and billing systems.

2. *SUD Services Delivered by MH Specialists in PC Settings (N = 23 of 25 county respondents)*
   - In most of the counties using this model, it was reported that their efforts are coordinated with, or part of, broader efforts to integrate BH services with PC. At the ground level, it was more commonly found that specialty MH providers are given the responsibility for screening patients for SUD and providing interventions. It was noted that screening processes were relatively informal, did not involve the use of validated SUD screening instruments, and were only conducted on patients whom providers suspected were using substances problematically. Limitations of this model are known, particularly that their screening processes are somewhat haphazard and not evidence-based. Providers expressed a desire for further training so they could expand their SUD services to meet their patients' treatment needs.

3. *PC Services Delivered by PC Personnel in SUD Settings (N = 11 of 25 county respondents)*
   - In this model, PC providers are co-located in specialty SUD treatment settings. Beyond providing narcotic medication management services and conducting physical exams for new patients at intake into SUD treatment, PC providers screen for chronic diseases, provide lifestyle counseling, perform routine physical exams and follow-ups, and refer patients to outside providers for services when extra medical attention is needed. SUD providers using this model reported that offering medical services on-site is particularly helpful for their clientele, who are predominantly homeless or low-income, and have little access to medical care elsewhere.

4. *Medication-Assisted SUD Treatment in Collaboration with Primary Care*
    - Another promising model of SUD/PC integration involves the use of medications — such as methadone or buprenorphine for the treatment of opiate dependence — in conjunction with other PC, MH, and SUD services. For patients taking methadone (which is subject to particularly tight licensing and dispensation restrictions), an off-site pharmacy provides patients with their doses, but all other SUD services are given at the FQHC. For those receiving buprenorphine, regulations allow for greater flexibility, so patients receive their first dose from an off-site pharmacy, but FQHC medical staff give all subsequent doses on-site. It was found that the providers who do offer the use of medications as part of a comprehensive treatment plan work in close collaboration.

Beyond these models, participants in the integration survey and integration forum identified other initiatives that are now in the planning stages or just beginning implementation. These include the creation of unified patient registries to allow PC, MH, and SUD treatment providers to share clinical information, and the co-location of BH specialists to provide SBIRT services in primary care and emergency department settings.

There are a number of perceived barriers when initiating SUD/PC integration.
In spite of some successes, providers and administrators in California have also encountered roadblocks as they have planned and begun to implement SUD/PC integration initiatives. From our initial investigative research and survey results, the in-depth case studies, the Integration Forum and ILC, several of these barriers became clear, as did possible strategies to overcome them.

The most common barriers that administrators reported facing in their SUD/PC integration efforts have involved financing, documentation, and partnering with PC providers. Forum participants and interviewees also confirmed that PC physician resistance, licensing issues, and poor coordination of integration protocols can undermine SUD/PC integration initiatives.

1. *Financing*
    - The most commonly cited barrier to SUD/PC integration in California is inadequate funding. Twenty-three of the 25 county systems that have begun to integrate SUD and PC services reported that financing integrated care was a major barrier. Regulations at the state level are largely to blame for this, as California's Medicaid program does not allow FQHCs to bill for physical health and behavioral health services provided to one individual on the same day. Though a technicality at first glance, this serves as a significant impediment to integration, as it makes it virtually impossible to carry out "warm handoff" linkages between PC and SUD treatment providers and get reimbursed by Medicaid. Administrators also cited lack of reimbursement for collaborative care and case management related to SUD, for SBIRT, and for services provided by unlicensed clinicians who could otherwise conduct SUD interventions as barriers to integration. Though pending policy changes under the ACA and California's 1115 Medicaid Waiver may help overcome some of these barriers in the future, they still

represent serious obstacles for administrators and policy makers who are trying to integrate SUD and PC services today. Furthermore, even when policy changes that can facilitate integration (such as the activation of Medicaid codes for SBIRT) do occur, challenges in defining billing rates and implementing billing procedures can inhibit the actual delivery of newly reimbursable services.(Fussell, Rieckmann et al., 2011)

2. *Documentation*
   - Another set of major barriers to SUD/PC integration that SUD administrators reported involved documentation. In our integration survey, 63% of respondents indicated that documentation issues hindered integration activities. In particular, Federal Regulation 42 C.F.R. Part 2 was cited as a serious impediment. Under this regulation, records regarding SUD treatment in designated SUD treatment programs cannot be shared with other health providers or included in open electronic health records without written consent. Administrators and providers expressed confusion about whether or not SBIRT or treatment that takes place in PC settings is subject to the same restrictions. Moreover, they feared that if SUD and PC treatment providers could not freely and openly share documentation concerning patients' SUD treatment, efforts to realize the clinical benefits of integration could be severely hampered, if not completely undermined.

3. *Partnerships*
   - A third set of barriers that have emerged in the course of SUD/PC integration in California is related to the task of forming effective partnerships with PC providers; 63% of integration survey respondents reported this as a concern, and much of the discussion at the integration forum focused on these issues. PC providers, who are already balancing large caseloads and packed schedules, are often reluctant to implement new protocols (such as SUD screening) since they have little face-to-face time with most of their patients, and they prefer to focus on patients' more immediate medical concerns. Administrators also reported that some PC providers stigmatize individuals with SUDs, harbor misconceptions about methadone and buprenorphine, and are suspicious about working with specialists from other disciplines.

B. Recommendations

Despite identified barriers, some providers have been able to effectively integrate SUD and PC services. With information gathered from initial investigative research and survey results, the in-depth case studies, the Integration Forum and ILC, several themes emerged that give light to various steps that the state and counties can take to move forward with various integration initiatives. These recommendations have been compiled for the state as well as for providers in diverse stages to improve and enhance their work toward the common goal of integrating SUD services into PC and other healthcare settings.

State Level Recommendations

Further Research and Evaluation is Necessary to Identify Best Practices for SUD/Healthcare Integration in California.

While the research on BH integration has yet to identify best practices for BH/PC integration, SUD integration research is equally ambiguous, as different levels and models of SUD integration have rarely been compared (Babor & Kadden, 2005; Babor, McRee et al., 2007). In order to provide adequate training and information for providers on best practices, research is needed on effective models for the integration of SUD and healthcare services as well as models that incorporate mental health and SUD together into healthcare settings. Research is also needed to determine which models work best in which specific settings and for which patients. And finally, a definition of "successful" integration and additional research on organizational factors associated with "successful" integration are needed to provide further guidance to providers. The findings presented in this report mark a first step in this process, with a focus on the experience of providers working to integrate SUD and PC services in California.

Initiate Training Opportunities and Implement Provider Competencies

As research evolves, ongoing training and technical assistance is crucial for adequate implementation of SUD/Healthcare integration in California. Historically, SUD providers have worked in relative isolation from other disciplines, which has resulted in training and education that is disconnected from other fields. As a result, many SUD providers are unaware of new information and opportunities that arise from other arenas that can be beneficial to and improve their services. At a time when collaboration skills and multidisciplinary experience is key across providers that want to be equipped for the changes that are and will continue to occur with healthcare reform, the SUD field needs to have access to new information and training opportunities.

State leaders are critical in overseeing the SUD field and defining its scope of practice. The state, therefore, plays a key role in guiding the future direction of the SUD system and disseminating information to counties and providers. By being one of the central sources of information, the state must be continuously articulating a vision of integration across its system and providing guidance for the SUD field to pursue more collaborative functions with other fields. In order to be a positive agent of change, the state must not only convey the new skills and competencies the SUD workforce needs to obtain, but be prepared to offer the instruction and training to reach these aims.

By being in constant connection with national level stakeholders, other state leaders, and county leaders, the state can continue to be an influential resource that guides providers throughout the change process. We encourage the state to constantly disseminate what providers must learn so as to not let anyone (or more broadly, the unique services provided within the SUD field) be left behind in the ever-changing healthcare reform arena.

Partner with Other Systems and Have a Presence in Other Regulatory Agencies

In addition to having a leadership role among county and provider authorities, the state can take part in external governing bodies that have responsibilities for making key policy decisions and recommendations. Although ADP is an SUD department, its sphere of influence can extend far beyond the SUD field, given that appropriate partnerships are made and relationships developed. While collaboration with primary care is of value to the SUD system, the primary care system must also understand the value the SUD system has to the PC field and scope of practice. In order to initiate effective partnerships with other state-level agencies that have similar leadership potential to facilitate integration, the state must be responsible for fostering alliances that allow for networked discussions and cross-system solutions.

The state mental health department, public health agencies, drug courts, Medicaid agency, and human service departments are just a few examples of the many systems the state SUD department needs to form alliances with, if it has not done so already. As the state prepares for the foreseeable changes to come with healthcare reform, partnerships with other agencies will provide the SUD department with invaluable resources and information that would be unavailable to it if it remains isolated. By taking active positions in other systems, regulatory agencies that have broader decision-making power to influence the SUD system will be more inclined to initiate policy and regulations that work in favor of the SUD system.

Through the example set by the state, county and provider leaders will see the need for and benefits from external partnerships and be more inclined to develop relationships outside of the SUD system. Given the state's ability to influence financial and legal decisions, counties will gain additional resources in favor of moving toward a more integrated system of care. The state, therefore, should be committed to investing in the development of linkages to other healthcare systems early and continuously to reap the most benefits for the SUD field.

Provide Funding Strategies for Integrated Care

Healthcare funding structures have not been designed to facilitate collaboration, and compensation mechanisms for collaborative care are not easily accessible or available across fields. For any provider or organization seeking to initiate a new practice or model for integration, the lack of financing can be a huge barrier to implementation and sustainment. While the state can provide models and recommendations on how to begin integrating with the PC field, these proposals must come with the dollars that can support any such action. Tight budgets that do not leave much room to consult with and provide support to primary care providers further prevent the SUD field from being able to support activities such as joint planning and training that is needed for integration.

Due to unaligned payment systems, it is essential for the state to take leadership in sorting through the complexities of healthcare financing as tied to reimbursements and policy. By

working with external agencies such as Medicaid, the state can begin to align payment incentives and learn the processes involved in receiving reimbursement for SUD services in primary care. The state can then provide the necessary technical assistance related to adequate submission and receipt of claims for SUD services. Payment mechanisms need to incentivize all systems involved in collaborative care to motivate and sustain change.

The state needs to become immersed in other payment options, plans, purchasing mechanisms, and publicly funded managed care that will be tied to paying for treatment of SUDs under healthcare reform. This will involve high levels of involvement with external agencies and strategic planning to assure changes are in place to support billing and reimbursement.

County Level Recommendations

Strategies to integrate SUD services should be adaptable to match the varying settings in the healthcare field.

"When you've seen one FQHC, you've seen one FQHC." Each FQHC we examined through case studies and site visits varied and provided examples of different levels in which integration can be implemented. The wide variation and uniqueness of sites and the range of initiatives across the counties were indicative of the need to evaluate each organization on a case-by-case basis. Instead of one step-by-step guide that can inform organizations on how to initiate integration, we learned that each organization needs to proceed in a unique integration plan based on their specific resources, environment, and situation. Overarching approaches need to be adapted in varying ways to fit the needs of the organization and/or partners at hand for the transformation process to begin.

Funding: Start small

To circumvent financing barriers to integration, participants at the Integration Forum agreed that one solution is to initiate SUD/PC integration projects with smaller, but more accommodating, funding sources. Grants from governments, foundations, and nonprofit organizations can fund new integration programs free of concerns about federal reimbursement. Flexible forms of state and local funding can also help overcome some of the requirements and regulations that inhibit SUD/PC integration. Though usually not substantial enough to facilitate large-scale or system-wide integration, more modest funds can help administrators establish the infrastructure, protocols, and procedures for SUD/PC integration.

Leadership is crucial and champions must be identified within the team.

Due to the differences in history, culture, and attitudes across the SUD and PC sectors, collaboration requires appropriate leadership to direct the process for working together. Commitment is needed from leaders in both sectors to shepherd the change process and leverage support and respect. Collaboration must be modeled from the top to lay the foundation of a strong interface that will improve how systems work together and direct the delivery of services. These leaders will ensure that SUD and PC providers hold shared responsibility to provide the most appropriate and effective care for their patients.

When integrating SUD services into PC settings in particular, it is imperative to identify "champions" for integration. These "champions" should be well-respected providers who value and are willing to advocate for changes to organizational structure and clinical protocols.

Identify core principles before initiating an integration plan.
Prior to the development of a work plan and strategy, core principles need to be established to direct next steps and the plan for action. These core principles can serve as the starting point from which to initiate goals and the overall change process. The partnering organizations and stakeholders involved will be an integral part of establishing this foundation, from which those involved can work off of as a team. With a shared commitment to a set of core principles, the planning and development of collaborative service approaches can be initiated.

Involve consumers and the community
The SUD and PC fields must not only work in concert with each other but with the overall community at large. Patients should be an active participant in their own care to ensure their needs are fully addressed. In order to appropriately recognize and respond to the diversity of experience and needs presented by the community, SUD and PC providers must seek constant input and feedback from their consumers. By empowering the community to be active partners in the transformation process, their skills, knowledge, and experience can contribute to the integrated system of care. A bridge between professionals and people with lived experience will result in linkages to community resources and enhanced support for patient self-management. Buy-in from both leaders and community organizations will garner further support from additional sectors to create an even stronger and sustainable integration plan.

Conduct local advocacy and outreach efforts
In order to change attitudes and approaches to treating patients with SUDs, leaders must get involved in policy, education, and outreach to promote integrated SUD care. By educating and training other professionals and policy makers on the benefits of integrated treatment, the stigma associated with SUDs can be reduced, which will subsequently improve access and collaboration. The normalization of SUDs in PC settings must occur in conjunction with the overall community and national environment for sustained and enhanced outcomes. Without rules and regulations supporting the operations of an integrated system, providers will lack the tools and resources to change and maintain new practices. Leaders in both the SUD and PC fields must stay connected with stakeholders involved in policymaking and education to promote an integrated system of care across all fields.

Acknowledge the need for a cultural shift
Change needs to be enabled by initiating a shift in the environment's culture, that is PC providers need to become accustomed to serving as a point of contact for people with SUDs. The PC field needs to engage in their role in providing a connection to specialized SUD services. This cultural shift requires the SUD field to be active partners in fostering a framework of collaborative care that is supported by both systems.

Create new expectations and consider offering incentives
The responsibility to work collaboratively must be reflected in agreements between SUD and PC providers to ensure that both sectors see collaborative care as an essential part of their role. In

addition to understanding their roles, they must be motivated to fulfill them. With an already long list of expectations, PC providers must understand the benefits tied to providing integrated care in order to consistently fulfill their new responsibilities. This requires expectations to be tied to appropriate remunerations that will propel movement and further enhance results. These incentives do not necessarily have to be associated with additional funding but can be tied to improving patient outcomes and management of patient flow. Integrated care can actually reduce the burden on PC providers by allowing them to effectively refer patients to specialized treatment. If PC providers can see advantages directly linked to integrated care, they are more likely to accept their responsibilities in support of integration. A full cultural shift is inherently tied to the motive for providers to sustain and improve their newly defined collaborative tasks.

Workforce development

In order to successfully implement new practices that utilize varying skills and expertise for collaboration, the workforce needs to be appropriately trained and educated. Clinical competency, in addition to the development of attitudes and skills for integration, is required. Strategies to deliver the training and education needed from varying inter-disciplinary approaches are imperative to prepare providers in effectively delivering integrated care. The educational system represents the principle means for promoting the value of integration among PC providers. Training and knowledge must be delivered through accessible venues and be continuously improved and developed as new information becomes available to equip providers from all arenas for collaborative care.

Communication and coordination are key

Even when other barriers have been overcome, administrative challenges can undermine integration. At one FQHC we visited, for example, clinic staff was completely unaware of new SUD/PC integration procedures that had been put in place. As a result, though there was an SUD specialist working onsite, integration had almost no effect on actual service delivery because few patients were ever linked to specialty services. As the experience of this clinic shows, even if integration models are well designed, poor communication and coordination can thwart them.

If co-location models are used, it is critical to establish effective channels of communication between PC and SUD providers, so that they can identify and overcome differences in clinical and administrative culture and practice. To minimize resistance to integration and make it more palatable to clinical staff, forum participants recommended implementing integration initiatives gradually, starting with simple co-location models and then instituting measures to enhance administrative and clinical integration over time.

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Chapter 4: Performance Measurement, Monitoring, and Management

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I. Introduction

Efforts to measure performance and use data to improve substance use disorder (SUD) services continue to be a priority at the state and national levels (Institute of Medicine, 2006; McLellan, Chalk, & Bartlett, 2007). Significant efforts have been made across California to improve upon the use of performance measures[3]; however there continue to be significant barriers to progress as a result of the current fiscal climate as well as the shifting nature of the healthcare delivery system. Much of the pilot work established during Year 1 of this contract was put on hold at the county level as a result of the emerging emphasis around healthcare reform. In addition, the terms "dashboards" and "scorecards" became common nomenclature within the national and statewide discussions to refer to brief, easy-to-use reports on measures that can be used for performance monitoring and management purposes. Therefore, over this past year, UCLA's investigative work in performance focused on the following objectives:

- Examining the use of performance reports in other states;
- Exploring how to apply these trends using existing data from the California Outcomes Measurement System (CalOMS-Tx); and
- Developing dashboard templates identifying performance measures to be used to monitor and manage SUD services at the program and county levels

Organization of Chapter

Within this chapter, we have addressed each objective above and then follow with a section on Lessons Learned and Recommendations.

II. Use of Performance Reports in Other States

Within the UCLA 2009 Continuum of Services System Reengineering (COSSR) Final Report, UCLA provided an extensive summary of performance measures being used in other states. Information in Table 1 below has been taken from this review and updated based on information gathered through a 2010 SAMHSA-sponsored State Systems Development Program Conference (SSDP) in Baltimore, MD, contacts with state representatives, and literature reviews. For an in-depth discussion of the definitions and examples of each measure, see Chapter 8 of the UCLA 2009 COSSR Final Report. Please also note that Table 1 focuses on performance measures only, but some states also include patient outcomes (e.g., drug use) in their dashboards

[3] "Performance measures" refer to measures of functioning at the treatment program level or county level (e.g., average retention). This differentiates performance from "outcomes," which refer to measures of individual functioning at the patient level (e.g., substance use, employment, arrests).

or provider reports (including New York and Oklahoma, see Appendices A and B, respectively). The examples below are not meant to be an exhaustive list of efforts nationwide.[4]

Table 1. Common Performance Measures Utilized by States

State	Performance Measures
Arkansas	-Access -Retention -Continuity of care
Connecticut	-Access -Retention -Use of evidence-based practices -Continuity of care
Iowa	-Access -Engagement -Retention -Patient satisfaction with services (rate each type in terms of how beneficial it was) -Continuity of care
Maine	-Access -Retention -Continuity of care -Use of evidence-based practices
Maryland	-Retention -Continuity of care
Massachusetts	-Access -Engagement -Retention -Continuity of care
Missouri	-Engagement -Retention
New Jersey	-Retention -Continuity of care
New York (see Appendix A)	-Retention -Completion -Efficiency (counseling sessions/FTE)

[4] Results from another broad survey of state activities can be found in a report from the National Association of State Alcohol and Drug Abuse Directors (http://nasadad.org/resources/Final%20PMM%20Report-10%201%2006.doc). However, the reader is cautioned that in some cases, activities appear to be overstated.

State	Performance Measures
	- Program compliance
North Carolina (see: http://nctopps.ncdmh.net/dashboard/)	-Access (capacity/utilization) -Engagement -Retention -Continuity of care -Use of evidence-based practices -Patient perceptions of care
Ohio	-Access -Engagement -Retention -Continuity of care
Oklahoma (see Appendix B for partial report, or see website: http://www.odmhsas.org/eda/advancedquery/advancedquery.htm)	- Access (capacity/utilization) -Initiation -Engagement -Use of evidence-based practices -Patient perceptions of care -Continuity of care
Rhode Island	-Retention -Continuity of care
South Carolina	-Engagement (Services in first 30 days) -Retention
Texas	-Access -Retention -Continuity of care
Washington State	-Engagement -Retention -Continuity of care

Researchers have also published recent research on the implementation of performance measurement that can provide general lessons for California. Garnick et al.(2011) examined five states (Connecticut, Massachusetts, New York, North Carolina, and Oklahoma) and found a number of common themes required for adoption and sustainability. While Garnick's findings were focused on Washington Circle measures, they could easily be applied to other types of performance measures as well. These themes, adapted below for application to California, are:

- *Leadership and staff*: ADP leadership must be invested in developing, implementing, and using performance measures, as well as defending resources for performance management efforts in an atmosphere of competing demands on limited resources. This may also involve developing alliances with outside stakeholders including legislators, provider groups, and others. Performance measurement will not be sustainable unless linked closely to quality improvement (e.g., NIATx or similar process improvement

efforts, technical assistance). Linkage to larger trends, including use of performance incentives, will help to ensure that the measures remain a focus of stakeholder interest.

- *Adaptation and evolution of measures over time*: Measures need to be adapted for existing data infrastructure, and they need to change as conditions change. In particular, as SUD treatment is linked with other healthcare services, the types of data recorded and available from electronic health records may change rapidly. For example, this may provide an opportunity in California to examine encounter-level data using additional measures, including Washington Circle measures of initiation and engagement.

- *Collaboration with consultants and partners*: Collaboration with others who are developing common measures can accelerate development.
    - To some extent, interstate collaboration has already been successfully initiated. At the SSDP conference in Baltimore, UCLA and ADP made contact with representatives from other states that were developing their own "dashboards" or "scorecards" and joined with other states to form the Interstate Performance Management Community of Practice (Interstate PM COP). California has been an active participant in this group, and UCLA took the lead in organizing one of the group's conference calls on data linkage. UCLA recommends continued participation in this group to stay up-to-date on other states' efforts and lessons learned.
    - Garnick et al. makes the case that inclusion of academic partners is important to increase credibility and bring a broader perspective about measurement alternatives, and they provide examples of how Massachusetts and Oklahoma have worked with academic partners to develop their performance measures. To date, UCLA has filled this role in California.

- *Reporting to providers and the public, and data infrastructure needs*: Reports on program performance and patient outcomes for the general public have become common for hospitals, nursing homes, and managed care plans. Expectations for such reports are likely to be extended to SUD treatment as it becomes more closely integrated into the larger medical system due to healthcare reform legislation. It will therefore be important to develop such reports for providers and, eventually, for the public. This will require adequate resources for technical staff as well as the hardware and software infrastructure required to meet this demand. Anecdotally (based on informal observations and discussions with stakeholders) it appears that, in particular, the CalOMS-Tx hardware infrastructure may need upgrades before it can provide real-time data reports in a widespread and timely fashion as intended, as the current infrastructure is overtaxed and often functions slowly, or sometimes not at all. Garnick et al. point out that federal funding for block grant reporting along with SAMHSA's technical assistance program can be used to support data infrastructure development and maintenance of data analysis staff. However, competition for funds between infrastructure and treatment needs is a reality.

III. Applying National Trends to California: An Examination in Los Angeles County

Background

Using work from other state initiatives, recommendations from national workgroup reports, as well as expert consultants, the County of Los Angeles Department of Public Health Substance Abuse Prevention and Control (SAPC) initiated work on patient outcome monitoring and program improvement as early as five years ago. As the science has developed and trends have evolved, SAPC has enhanced their measurement efforts accordingly and more specifically moved from providing patient outcome reports to including program performance benchmarking strategies and dashboard development.

Initially, the substance use treatment providers received reports that provided information on patient outcomes, but these reports did not provide any performance benchmarks or report on whether the program had met the benchmark. The next step was to implement performance measures, benchmarks, and dashboards in order to continue to improve substance use treatment in Los Angeles County.

Planning

The SAPC and UCLA met with a group of providers in order to discuss performance measures. The focus was primarily on program performance because LA county already had a report that looked at patient outcomes, and since patient outcomes are thought to be the result of program performance. In addition, providers were concerned about being held accountable, and patient outcomes are less closely related to program activities than are direct program performance measures. Several potential measures were suggested including:

- Reduce early dropouts to less than 25%;
- Use of drug tests for all patients in treatment;
- Use of medically assisted treatment (e.g., medications);
- Inclusion of continuing care in treatment planning for all patients; and
- Consistent use of evidence-based practices

The meetings involved, at times, intense discussions concerning the need to measure performance and hold providers accountable. There was some resistance to the process, and treatment providers expressed concerns about the administrative burden and how performance measures could somehow be used against them. Given the current economic downturn, providers reported increasing difficulty in obtaining sufficient funding to serve the needs of those who requested or required treatment in Los Angeles County. The response from SAPC was two-fold. First, the Department of Public Health argued that the timing may have felt inconvenient, but there was no real reason to wait. Second, SAPC indicated that no program would be penalized immediately. It also became clear that such a system could take months or more than a year to develop and the process had to begin immediately. Once the providers understood that the system was going to be developed, discussions concerning performance measures began.

After extensive dialogue, a few issues came to light. First, given the economy and the reductions in budgets, requiring treatment providers to provide services they are not reimbursed for, such as drug tests for all patients, was argued against as unreasonable. It was agreed that these would put a substantial burden on the providers. Second, it was decided the performance measures should be based on patient data already collected by SAPC. This would allow SAPC to review the data and use prior data to develop the benchmarks and would not add to the administrative burden at the provider level. Collecting new categories of data would have required changes to the current data system, which would have entailed additional time for programming, trouble-shooting, and training. Third, there was consensus that the performance measures may differ for each program type (i.e., residential treatment vs. outpatient), but in those instances when the performance measures did not differ, the benchmarks still could. There was also discussion about the possibility of selective admission of patients having an adverse effect on provider's data if that provider treated a more "difficult to treat" population. Therefore, before the benchmarks could be finalized, providers requested an examination of the data to determine if "case mix" adjustment[5] should be made to adjust for these differences. A statistician at UCLA analyzed the Los Angeles County Participant Reporting System (LACPRS) data[6] and found that the demographics captured in the system predicted less than one tenth of one percent of the variance in length of stay. This suggested that selective referral of patients is unlikely to affect the system. In some respects, every patient is disadvantaged (unemployed, mentally ill, homeless, high use, long history of use, etc.) in one form or another, and overall detectable disadvantages did not appear to be affecting performance between programs.

At the conclusion of the discussions, the determination was made to focus on outpatient counseling as the first program type to receive performance measures, benchmarks, and dashboards. This was in part due to the fact that outpatient counseling contracts were in development and the timing would allow the inclusion of the performance measures and benchmarks into the contract. Furthermore, three performance measures were decided upon, with a potential fourth under development: 30-Day Engagement, 90-Day Retention, and completed exit interviews.

Defining Measures and Developing Benchmarks

The 30-day engagement performance measure is an assessment of how many patients leave treatment before 30 days. Although engagement is typically defined as including at least four encounters in the first 30 days, the current data system does not track individual services outside of the billing data, which is collected and stored in a different system. Therefore, in this case, engagement is calculated by examining the date of admission and comparing it to the date of the last face-to-face encounter (discharge), with the rationale that at least four encounters in the first 30 days should be met under most circumstances (e.g., intake, assessment, and two group counseling sessions).

In addition to engagement, retention was also selected as a performance measure. It is calculated using the same formula as engagement, but rather than looking for 30 days in treatment,

[5] For further discussion of case-mix adjustment, see Chapter 1
[6] LACPRS is a county system that collects data for CalOMS in addition to county specific items.

retention assesses those who are in treatment in a given service for 90 days or more. As noted earlier in this chapter, engagement and retention in treatment are supported in the literature as being factors in how successful SUD treatment will be.

An alternative to the above measures would be to track retention over "episodes" comprising multiple services, but this was not pursued in the current project due to technical limitations and the desire to focus first only on outpatient services.

The final performance measure is more of an administrative measure in that it assesses how well programs collect discharge information from patients. When a patient is discharged, questions similar to those asked at admission are asked again (exit interview) in order to measure improvements or behavioral changes that occurred during treatment. However, there were a significant number of programs where these data are not collected for any number of reasons (e.g., patient leaves against program advice, patient leaves treatment and does not return, providers do not make the collection of discharge information a priority, etc.). Due to the importance of this measure to determine patient outcomes, it was decided that this too should be a performance measure.

Once the performance measures were finalized, the discussion on where to set the benchmarks began. Data on the three performance measures were examined over a 3-year period, including only those programs with at least 10 discharges in any given year. The averages[7] for each performance measure were then calculated. For the 30-Day Engagement performance measure, on average about 79% of the patients remain in treatment at least 30 days. For the 90-Day Retention measure, about 67% remained in treatment at least until the threshold. For the administrative measure, about half of the discharged patients completed an exit interview. Given that using the mean for each measure meant that about half of the providers would be above the benchmark and half below, this appeared to be a good starting point for the performance benchmarks, with the understanding that the benchmarks may be adjusted in the future. The numbers were rounded for simplicity, and the final benchmarks were as follows:

- At least 80% of the patients discharged must remain in treatment 30 days or more (Engagement benchmark)
- At least 65% of the patients discharged must remain in treatment 90 days or more (Retention benchmark)
- And at least 50% of the patients discharged must have completed exit interviews.

Once the performance measures and benchmarks were finalized, work began on designing the reports that would inform providers of the performance measures, benchmarks, and the performance of each provider.

[7] The means and medians were very similar (median was slightly higher). Since the measures were intended for use by non-researchers, it was felt that averages should be used because they would be easier for everyone to understand.

Implementation

Meetings were held to discuss the format and content of the reports, which were automated. Once the design of the reports (now referred to as "dashboards") was finalized, the dashboards were posted to the same system where providers enter data and view other reports. Dashboards are posted on a quarterly basis.

Providers who fell short of the benchmarks are offered technical assistance, training, and other help in order to improve their performance. Given previous success with process improvement, SAPC determined that similar work would be done with those providers that fell below the benchmarks.

Currently (Summer 2011), SAPC, UCLA and the providers are meeting to discuss performance measures, benchmarks, and dashboards for residential treatment and narcotic treatment programs. It is expected that performance measures for these programs will be implemented by the end of the calendar year.

IV. Development of Dashboard Templates for California

Introduction

Based on knowledge from the national- and local-level work on performance measurement and management discussed in the preceding sections, UCLA worked to develop draft dashboard templates for California's Department of Alcohol and Drug Programs (ADP) to consider for statewide implementation. The purpose for these dashboard templates was to create simple snapshots describing how counties and programs are performing with regard to the delivery of SUD services. These dashboards are intended to be used to drive decision-making processes to improve services and identify strong and weak performance at both the county and program levels.

Using data to improve services is a priority, and efforts in California have been advancing over the past 5 years; however, successful dissemination of data in general to the county and program levels has been challenging. Through the use of the CalOMS-Tx data system, county-level outcome data reports can be generated; however, anecdotal reports from county administrators indicate that access to these data reports can be slow and the reports themselves may be difficult to interpret. In addition, the reports can be filled with too much information that is not relevant to many at the program level. Quick and easy-to-read reports may be more functional and are more common within the broader healthcare field.

Template Development Process

Initial discussions regarding the development of these dashboards were based on identifying appropriate measures. Following recommendations at the national level, our focus was to start with indicators of identification, initiation, engagement, retention, and continuum of care. However, since CalOMS-Tx is the only statewide data system available to populate the dashboards and it does not contain service encounter level data, measures were necessarily restricted to only those that could be captured using admission and discharge data. Measures were ultimately determined through multiple discussions with ADP as well as through consultation with the Treatment Research Institute.

The next step was to determine how to convey the data output in a simple, easy-to-interpret form. A comprehensive review of dashboards used in various fields was conducted. It was determined that the use of percentages and proportions was most common and conducive for the purposes of these dashboards. As discussed in the prior section, setting benchmarks to provide context to the output is necessary as well. Consistent with practices in other states (see Section 1), Los Angeles County (see Section 2), and discussions with stakeholders, it was determined that program-level dashboards would be created for each treatment modality (detoxification, residential, outpatient, methadone maintenance), because performance can differ markedly depending on the type of services being delivered (e.g., time in treatment/retention should be longer for methadone maintenance than for detoxification). We also generated county-level dashboards to capture "system" measures that may involve more than one treatment program (e.g., a continuity-of-care measure that captures transfers between detoxification and treatment). Program-level dashboards could be utilized as a method to provide feedback regarding program-specific

performance between county administrators and their providers. The system-level dashboard was developed to gain a snapshot at the county level of provider connectedness by modality (transfer rates). UCLA recommended setting the benchmarks at the state mean average in order to maintain consistency across the counties. The alternative of using multiple, more detailed benchmarks would likely confuse users and undermine the goal of making dashboards easy to understand and simple to use.

Finally, determining the format and visual style in which to translate the data in a snapshot method became the next challenge. Several formats were identified utilizing various visual aids in a simple manner. These ranged from dials, meter bars, gauges, basic grids and charts, 5-star systems, thumbs up/down, red light/green lights, etc. Lessons from the Los Angeles County project led us to understand that computer technology across each county varies and would likely create restrictions on the complexity of the graphics, including the use of colors. Therefore, UCLA recommended using a black and white table with check marks "√"s and "X"s to indicate at-a-glance indicators as to whether the outcomes fall above or below the benchmark.

Program Level Dashboard Templates by Modality

Detoxification

Program Name: _____ County: _____

Program Sub-Category: _____ Reporting Period: _____ - _____
(Includes: Residential-Hospital and Non Hospital, Outpatient, NTP)

Performance Measure	N (Number Discharged)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts transferred to a different tx modality *(14 days post discharge)*					Over X%	
Pts who "completed detoxification"					Over X%	
Pts re-entering detox within 30 days of previous discharge					Under X%	
Number of admits/discharges in same day					Under X%	

(Note: include data only from patients who report a primary drug of choice of alcohol and/or methadone)

Residential

Program Name: _____ County: _____

Program Sub-Category: _____ Reporting Period: _____ - _____
(Includes: Short-term residential, Long-term residential)

Performance Measure	N (Number Discharged)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts in treatment at least 30 days*					Over X%	
Pts transferred to another tx modality (step down to outpatient)					Over X%	
Pts reporting primary drug abstinence** at discharge					Over X%	
Number of admits/discharges in same day					Under X%	

** exclude short term residential* data from the N
**abstinence is defined as 0 days used within the last 30 prior to discharge interview

Outpatient

Program Name: _____ County: _____

Program Sub-Category: _____ Reporting Period: _____ - _____
(Includes: Intensive outpatient, Day care rehabilitative)

Performance Measure	N (Number Discharged)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts in treatment at least 30 days					Over X%	
Pts in treatment over 90 days *(retention)*					Over X%	
Pts reporting primary drug abstinence** at discharge					Over X%	
Number of admits/discharges in same day					Under X%	

**abstinence is defined as 0 days used within the last 30 prior to discharge interview

Methadone Maintenance

Program Name: _____ County: _____

Reporting Period: _____ - _____

Performance Measure	N (Number Discharged)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts in treatment at least 30 days					Over X%	
Pts in treatment over 1 year						
Pts with Annual Updates					Over X%	
Number of admits/discharges in same day					Under X%	

System Level Dashboard by County

County: _____ Reporting Period: _____ - _____

Performance Measure	N (Number d/c's from program category)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts transferred from Detox to treatment modality (step down)					Over X%	
Pts transferred from Residential to other tx modality (step down)					Over X%	
Pts reporting primary drug abstinence** at discharge					Over X%	

(Note: exclude County under analysis from total N)

**abstinence is defined as 0 days used within the last 30 prior to discharge interview

Future Considerations for Dashboard Enhancement

In an effort to maintain progress on performance measurement and management, ongoing discussions have been pursued this past year at the state level on the next steps to enhance the CalOMS-Tx data system. Ideally, program-level encounter data, as well as program- and county-level measures to monitor for integration of services into the broader healthcare system would allow for the CalOMS-Tx data system to populate dashboards addressing measures more in line with current Washington Circle performance measure recommendations (identification, engagement, retention, etc.) as well as healthcare reform priorities.

However, under the current budget constraints, developing dashboards and data sources to incorporate these types of measures may not be feasible. They may become more feasible in the future if the use of electronic health records becomes widespread among SUD treatment providers. In the meantime, while it may not be possible to immediately implement them, for planning purposes it may be productive to discuss measures that would be useful in an "ideal" system. Each of the measures listed below require further discussion and additional progress in the field before they could be implemented as part of a performance dashboard. Key points for discussion around each are included. An overarching concern with all potential new measures is the need to minimize the reporting burden on providers by making CalOMS as short as possible. Therefore the advantages of each measure will need to be weighed carefully against this burden.

Program-level measures for consideration

- Proportion of patients screened for co-occurring disorders
    - *Key discussion point:* There are a number of short screening instruments for mental health issues such as anxiety and depression disorders that could be used to identify patients for further assessment. The addition of this type of measure could indicate a general cultural shift toward broader implementation of screening strategies and supportive means toward integrated SUD and MH services.

- Proportion of patients tested for HIV during treatment
    - *Key discussion point:* Currently CalOMS-Tx collects data on whether the patient was tested for HIV two times, at admission and discharge. If a patient answers "no" at admission but "yes" at discharge, it can be inferred that testing occurred during treatment. However, if the patient answers "yes" at admission, it is not possible to know if the patient was tested during treatment or not. For performance purposes, it may make sense to modify the discharge question to ask if testing occurred during treatment.

- Proportion of patients tested for hepatitis C, sexually transmitted diseases (STDs)
    - *Key discussion point:* Data on hepatitis C and STD diagnoses are only collected at admission. For performance purposes it may make sense to have a discharge question asking if testing occurred during treatment.

- Proportion of patients on (or offered) medication-assisted therapies (MAT) at the time of discharge
    - *Key discussion point:* MAT provokes mixed reactions across treatment providers, but leaders in the SUD field believe that offering MAT, or at least referral for MAT, should be required as an evidence-based practice. CalOMS-Tx does already record whether MAT is used, but determining an appropriate benchmark may be challenging, as "drug free" providers are likely to resist any benchmark above zero.

- Proportion of patients initiated into treatment
    - *Key discussion point:* Washington Circle defines this as two or more visits within the first 14 days for outpatient treatment, which would require encounter-level data that is currently unavailable.

- Proportion of patients engaged into treatment within the first 30 days
    - *Key discussion point:* Instituting this in accordance with the Washington Circle definition would require encounter-level data, which is currently unavailable. We have suggested a proxy measure that can be used based on current CalOMS-Tx data instead. The degree to which encounter-level data would add value beyond this proxy measure is unknown.

- Proportion of patients with social connectedness/social support
    - *Key discussion point:* While social support is important in recovery, feedback from stakeholder meetings (e.g., SAPC planning meetings described in Section 2 and CADPAAC Data and Outcome Committee meetings) suggest that the current definition is too imprecise for the measure to be used for performance purposes.

County-level measures for consideration

- Proportion of programs with memoranda of understanding (MOUs)/partnerships with other programs
    - *Key discussion point:* Although a good indicator of integration and continuum of services, this measure is not currently collected, would need to be well-defined, and may not be meaningful within MBA counties.

- Proportion of levels of care represented across the county
    - *Key discussion point:* Although a good indicator of continuum of services offered within the county, performance can be expected to differ sharply by county size.

- Proportion of programs that use data reports to make decisions
    - *Key discussion point:* This information is not currently collected and would need to be well defined, e.g., use of specific reports. Data reports would also need to be easily accessible; suggesting use of this measure should be revisited in the future but may be premature until dashboards are in use.

V. Lessons Learned and Recommendations

Through our work this past year, we have further developed methods of using CalOMS-Tx data to measure and potentially improve performance and outcomes. However there is much more to accomplish as we move toward integrating services under a chronic care model. Below are recommendations that UCLA has identified from our recent work in this area:

Continue to work closely with others to obtain input and buy-in for ongoing dashboard development

Performance measurement efforts have been identified in several states across the nation; however, relatively few have utilized a dashboard mechanism to disseminate this data to providers and/or stakeholders. Through our work within the Interstate Performance Management Community of Practice, we have learned more about models used by other states. In addition, we have gained ground-level experience at the county level through the innovative steps taken within Los Angeles County. A clear lesson identified from those who have taken the lead in this area is that obtaining buy-in and feedback from stakeholders in the dashboard development process is a key aspect to successful implementation. It would be productive for ADP to continue to work closely with county and provider groups to obtain input and buy-in for this dashboard development effort. In accord with this, ADP and UCLA plan to obtain feedback from county representatives through the CADPAAC data and outcomes committee, and following this, ADP and CADPAAC will need to discuss next steps in broader stakeholder dissemination.

Consider ongoing use of dashboards to improve performance measurement, management, and contracting efforts

Dashboards may help facilitate the integration of the SUD field into the larger healthcare field, where use of dashboards is already more common. It is recommended that the dashboard templates be finalized and pilot-tested and/or combined with existing ADP measures of performance.

Continue to enhance CalOMS-Tx data system to trends at the federal and state level

As the SUD field further integrates with mental health and primary care, it will become more important for the SUD field to adapt to the evolution of data systems within the broader field. For example, the capacity to collect encounter-level data is not present in CalOMS-Tx but may become accessible through electronic health record systems that are currently being developed and implemented. Access to such data would enhance performance measurement, management, and contracting efforts. Given that it is generally easier to implement such system capabilities during development and early implementation than afterward, it will be important for ADP and the SUD field to remain abreast of ongoing changes and provide feedback to relevant organizations engaged in EHR development (e.g., vendors, EHR certifying organizations, SAMHSA) to ensure that future needs are considered

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APPENDIX 4A
New York Scorecard
(From Phillips, 2010)

New York State Office of Alcoholism and Substance Abuse Services

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Program Scorecard

Service: Outpatient Clinic
Provider Name:
Program No:
Address:

Provider No:
Certificate No:

Avg Daily Enrollment:
Admissions:
Discharges:
Unique Clients Served:

Certified Capacity:
Transfers In:
Transfers Out:

Access [IPMES Data created Oct. 20, 2009]	Program		NYS Average	
	Score (%)	Rating	Score (%)	Rating
One Month Retention Rate	93	★★★★★	81	★★★

Quality [IPMES Data created Oct. 20, 2009]	Program		NYS Average	
	Score (%)	Rating	Score (%)	Rating
Three Month Retention Rate	84	★★★★★	74	★★★
Six Month Retention Rate	70	★★★★★	56	★★★
One Year Retention Rate	57	★★★★★	41	★★★
% Completing Program or Referred	50	★★★	45	★★★

Outcomes [IPMES Data created Oct. 20, 2009]	Program		NYS Average	
	Score (%)	Rating	Score (%)	Rating
% with Discontinued Use	74	★★★★	74	★★★★
% Maintaining Full Time / Improving Employment	63	★★★★	49	★★★
% Reduction in Six Month Arrests	66	★★★★	41	★★

Efficiency [IPMES Data created Oct. 20, 2009]	Program		NYS Average	
	Score (%)	Rating	Score (%)	Rating
Sessions / FTE Primary Counselor / Week	22	★★★★★	16	★★★★

Compliance	Program		NYS Average	
	Level	Rating	Level	Rating
Recertification Review - [Latest Review Jun. 29, 2007]	4	★★★★	4	★★★★
Facility Inspection - [Latest Review Jul. 21, 2009]	4	★★★★	4	★★★★
Fiscal Viability (1) - [Latest Review Jan. 09, 2007]	5	★★★★★	4	★★★★
Client Data Reporting [IPMES Data created Oct. 20, 2009]		★★★		★★★

Rating: 1-5 Stars. 5 Stars is Highest Performing

Footnotes:

(1) Fiscal Viability is a provider level score. It will be the same for all programs within a provider.

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APPENDIX 4B
Oklahoma Scorecard
(From Leeper, 2010)

Substance Abuse Provider Performance Management Report (PPMR)

Agency: (640) Twelve & Twelve
Contract Source: (02) Alcohol/Drug Contract
Age Group: Adults (18+)
Time Period: 07/01/2009 to 06/30/2010

Level of Care	Measure	Current Time Period (07/01/2009 to 06/30/2010) State Score	Agency Score	Agency Numerator	Agency Denominator	Agency vs State	Rank	Quartiles Bottom	Middle 2	Top	Previous Time Period (07/01/2008 to 06/30/2009) Agency Score	Agency Numerator	Agency Denominator	Current vs Previous
National Outcome Measures (NOMs) - http://www.nationaloutcomemeasures.samhsa.gov/														
Detox	Increased Level of Functioning (1 Point)	82.3	69.6	451	648	↓	4 of 4	●			74.3	420	565	↓
	Increased Level of Functioning (5 Points)	67.4	68.5	444	648	↑	2 of 4		●		72.2	408	565	↓
Residential	Increased Level of Functioning (1 Point)	77.7	81.1	356	439	↑	6 of 17		●		85.3	330	387	↓
	Increased Level of Functioning (5 Points)	65.3	75.4	331	439	↑	4 of 17			◎	76.2	295	387	↓
	Maintained Housing	99.3	99.0	383	387	↓	14 of 16	●			98.9	365	369	↑
	Maintainence of Employment	86.1	67.7	21	31	↓	11 of 14	●			69.7	23	33	↓
	Maintainence of Sobriety	96.9	100.0	22	22	↑	1 of 15			◎	97.1	34	35	↑
	Reduction in Homelessness	48.3	36.5	19	52	↓	5 of 6	●			55.6	10	18	↓
	Reduction in Number of Arrest	64.3	77.7	66	85	↑	8 of 13		●		74.6	44	59	↑
	Reduction in Substance Use	68.3	75.3	301	400	↑	11 of 17		●		76.4	262	343	↓
	Abstinence from Substance Use	61.4	67.4	273	405	↑	7 of 17		●		70.9	244	344	↓
	Reduction in Unemployment	3.9	1.9	7	375	↓	11 of 13	●			4.1	13	318	↓
	Increased Self Help Program Attendance	70.1	89.5	393	439	↑	4 of 13		●		87.8	337	384	↑
Halfway	Increased Level of Functioning (1 Point)	70.1	58.9	43	73	↓	7 of 7	●			77.2	71	92	↓
	Increased Level of Functioning (5 Points)	45.3	32.9	24	73	↓	7 of 7	●			50.0	46	92	↓
	Maintained Housing	97.7	94.4	67	71	↓	7 of 7	●			88.2	75	85	↑
	Maintainence of Employment	88.9	100.0	7	7	↑	1 of 1			◎	100.0	11	11	↑
	Maintainence of Sobriety	83.2	77.1	47	61	↓	6 of 6	●			81.9	68	83	↓
	Reduction in Substance Use	36.5	63.6	7	11	↑	1 of 3			◎	100.0	7	7	↓
	Abstinence from Substance Use	32.9	54.6	6	11	↑	1 of 3			◎	100.0	7	7	↓
	Reduction in Unemployment	36.7	41.0	25	61	↑	3 of 4		●		54.1	40	74	↓
	Increased Self Help Program Attendance	38.4	17.8	13	73	↓	6 of 7	●			15.0	12	80	↑
Outpatient	Increased Level of Functioning (1 Point)	57.0	45.3	58	128	↓	30 of 39	●			41.0	73	178	↑
	Increased Level of Functioning (5 Points)	40.2	33.6	43	128	↓	21 of 39		●		30.3	54	178	↑
	Maintained Housing	99.5	98.4	124	126	↓	34 of 39	●			98.3	172	175	↑
	Maintainence of Employment	91.8	89.6	43	48	↓	25 of 37		●		92.3	60	65	↓
	Maintainence of Sobriety	92.6	82.8	48	58	↓	30 of 37	●			90.8	69	76	↓
	Reduction in Number of Arrest	67.0	75.0	9	12	↑	6 of 17		●		72.7	8	11	↑
	Reduction in Substance Use	50.2	36.1	22	61	↓	30 of 39	●			34.0	33	97	↑

Questions? Please call Mark A. Reynolds at (405) 522-3824 or Shailendra Kumar at (405) 522-1328. Page 3 of 9

APPENDIX 4C

Substance Abuse Provider Performance Management Report (PPMR)

Agency: (640) Twelve & Twelve
Contract Source: (02) Alcohol/Drug Contract
Age Group: Adults (18+)
Time Period: 07/01/2009 to 06/30/2010

Level of Care	Measure	Current Time Period (07/01/2009 to 06/30/2010) State Score	Agency Score	Agency Numerator	Agency Denominator	Agency vs State	Rank	Quartiles	Previous Time Period (07/01/2008 to 06/30/2009) Agency Score	Agency Numerator	Agency Denominator	Current vs Previous
Outpatient	Abstinence from Substance Use	42.4	27.9	17	61	↓	29 of 38	Middle 2	22.4	22	98	👍
	Reduction in Unemployment	25.2	19.7	14	71	↓	23 of 36	Middle 2	18.2	18	99	👍
	Increased Self Help Program Attendance	17.6	8.1	10	123	↓	26 of 34	Middle 2	18.4	21	114	👎
Washington Circle Measures - http://www.washingtoncircle.org												
Detox	14-Day Follow Up	41.3	61.4	398	648	↑	2 of 4	Middle 2	49.7	281	565	👍
	14-Day Follow Up (Referred)	57.0	94.2	229	243	↑	2 of 4	Middle 2	94.3	182	193	👎
Residential	14-Day Follow Up	31.5	26.7	117	439	↓	11 of 17	Middle 2	33.7	130	386	👎
	14-Day Follow Up (Referred)	48.4	64.8	46	71	↑	3 of 11	Top	82.9	63	76	👎
Outpatient	Outpatient Initiation	74.1	79.7	102	128	↑	15 of 39	Middle 2	76.5	137	179	👍
	Outpatient Engagement	58.4	66.4	85	128	↑	12 of 39	Middle 2	66.5	119	179	👎
Oklahoma Performance Measures (OPMs)												
Detox	Community Tenure (30 Days)	96.5	96.5	625	648	↑	3 of 4	Middle 2	97.3	550	565	👎
	Community Tenure (90 Days)	93.0	92.9	602	648	↑	3 of 4	Middle 2	93.3	527	565	👎
	Planned Discharges	75.8	68.4	443	648	↓	4 of 4	Bottom	72.4	409	565	👎
Residential	Community Tenure (30 Days)	96.8	98.0	430	439	↑	8 of 17	Middle 2	99.0	382	386	👎
	Community Tenure (90 Days)	94.1	96.1	422	439	↑	6 of 17	Middle 2	97.2	375	386	👎
	Planned Discharges	65.9	69.3	304	439	↑	8 of 17	Middle 2	69.0	267	387	👍
Halfway	Planned Discharges	55.5	41.1	30	73	↓	7 of 7	Bottom	45.7	42	92	👎
Outpatient	Planned Discharges	38.9	33.6	43	128	↓	26 of 39	Middle 2	31.3	56	179	👍
Data Quality Measure (DQMs)												
All Levels	Non Transaction Type 92 Discharges	95.5	100.0	958	958	↑	1 of 50	Top	100.0	926	926	👍

Indicator Summary	Agency Compared to the State	Rank/Quartile	Agency Compared to Previous Period
	↓ = 23 ↑ = 24	Bottom = 16 Middle 2 = 24 Top = 7	👎 = 28 👍 = 19

Questions? Please call Mark A. Reynolds at (405) 522-3824 or Shailendra Kumar at (405) 522-1328. Page 4 of 9

Chapter 5: Developing and Financing Recovery Support Services and Linking them with Healthcare and SUD Services

Sarah Cousins, B.S, Valerie Pearce Antonini, M.P.H, and Richard A. Rawson, Ph.D.

I. Introduction

In order to reduce the impact of substance abuse and mental illness across the United States, a number of governmental agencies at the federal level have redirected strategies and initiatives to incorporate recovery support services (RSS) as a higher priority. The evidence base behind behavioral health recovery services continues to grow and promises better outcomes for people with and at risk for mental and substance use disorders. In addition, under federal healthcare reform, there is an impending shift in funding behavioral health services, and RSS may contribute an essential element to the provision of a high quality continuum of care for patients seeking care for behavioral health problems. However, all of this change is happening at a time when state budgets are shrinking and fiscal restraint is a top priority.

With these changes on the horizon, in fiscal year 2010–2011, California's Department of Alcohol and Drug Programs (ADP) and UCLA Integrated Substance Abuse Programs (UCLA) have continued efforts to further research the RSS offered throughout the state, as well as make progress in measuring these services to provide support strategies to fund these services.

Initial pilot studies conducted by UCLA revealed that, despite having little funding and lack of guidance, counties within the state have long used RSS to meet the needs of communities. However, little documentation is conducted around these services for multiple reasons: (1) most RSS are not required to report patient data to the current CalOMS-Tx data system, (2) collecting and using data within RSS appears to be challenging due to the organizational culture of anonymity, time consumption to collect data on less structured services, and limited training among the workforce typically delivering these services, and (3) there are no clear guidelines on RSS measurement and few standardized program performance and patient outcome measures to test the efficacy of these services.

Objectives

As referenced in the 2009–2010 EnCAL report, it was determined that a number of states have developed an extensive set of RSS and have a variety of models for these services (e.g., AZ, CT, PA, VT, and MA). The objectives for UCLA's continued work on RSS during the 2010–-2011 fiscal year were established to address the following:

1. Identify types of RSS utilized by California and other states.
2. Identify data collection procedures within the RSS environments that can effectively and efficiently document RSS.
3. Identify funding strategies of RSS utilized by California and other states.

Each of the items above was identified to assist the state in the process of preparing for federal healthcare reform and improving the documentation and measurement of RSS conducted within California.

Workplan and Methods

There is little systematic information collected statewide about the implementation, measurement, and perceived impact of recovery support services. Therefore, UCLA utilized both qualitative and quantitative methods to address the objectives identified by ADP across the course of 2010–2011:

- Literature review
- Key informant interviews with leading recovery researchers
- Statewide survey among CA county administrators
- Professional conference and meeting participation on the topic of RSS delivery

The focus of the literature review and key informant interviews across the course of the year included an emphasis on describing types of RSS, measurement strategies, as well as funding mechanisms utilized across the country. In-person and email communications were held with William White, Michael Flaherty, John de Miranda, and Alexandra Laudet.

The purpose of the statewide survey was to conduct an environmental scan of the specific types of RSS offered and delivered across the state, where these services are offered, and by whom. In addition, UCLA inquired about RSS measurement efforts, funding mechanisms, as well as needs around technical assistance and training as we move toward federal healthcare reform. With consultation from ADP and through pilot testing among a few county administrators, a short survey was developed. In November 2010, the survey was disseminated to all 58 county alcohol and other drug (AOD) treatment administrators via a web-based platform (Survey Monkey). Survey Monkey is a commonly used web-based platform that is used to collect survey data in a confidential manner via email. Administrators were given six weeks to complete the survey.

Statewide, 40 of 58 county administrators (an approximately 70% response rate) completed the survey (Please refer to Table 5.1.1). However, three counties did not complete the survey; therefore, the final analytical dataset consisted of 37 counties. Because some respondents reported that their county does not offer recovery support services, some sections of the survey were skipped. Thus, a total of 25 respondents completed the recovery support services, institution, and staffing section, whereas 37 respondents completed the funding and measurement section.

Table 5.1.1. County Respondents (N=40)	
Alameda	Placer
Amador	Riverside
Calaveras	Sacramento
Colusa	San Bernardino
Contra Costa	San Diego
Del Norte County	San Francisco
Fresno	San Joaquin
Glenn	San Mateo
Inyo	Santa Clara
Kings	Shasta
Lassen	Solano
Los Angeles	Sonoma
Mariposa	Stanislaus
Marin	Sutter-Yuba
Mendocino	Tehama
Merced	Trinity
Modoc	Tulare
Mono	Tuolumne
Napa	Ventura
Orange	Yolo

To stay informed of the current discussions, presentations, and strategies from leaders in the recovery field, UCLA staff also attended the following professional conferences and meetings:

- *11th Annual Arizona Summer Institute*. Presented by the Addiction Technology Transfer Center Network. July 20–23, 2010 in Sedona, Arizona;
- *A Day of Recovery and Wellness Workshops*. Presented by the Long Beach Mental Health Wellness Center Collaborative Work Group and Memorial Counseling Associates & Universal Care Itinerary. July 28, 2010, in Long Beach, CA.
- *The First Recovery Oriented Systems of Care Training of Facilitators (ROSC-ToF).* Presented by the Addiction Technology Transfer Center Network. August 2–4, 2010, in Tampa, Florida.
- *The Recovery Oriented Systems of Care*, an online six week course from July 14 – August 17, 2010. Presented by the South Coast ATTC. http://www.scattc.net/
- *Peer Addiction Recovery Support Services: An Overview* A talk by John de Miranda at CADPAAC on September 22, 2010.
- 2010 Southern California Recovery Summit held on November 6, 2010, at Loyola Marymount University in Los Angeles, California. This year's program featured David K. Mineta who spoke on ONDCP priorities within the White House recovery domain
- "Role of ROSC in Health Reform: The intersection of co-occurring substance use and mental health disorders with community health" a webinar hosted by the ATTC Great Lakes on December 16, 2010.

- UCLA conducted a site visit at Sober College, a recovery school located within a residential recovery center in Los Angeles County in February 2011.

Organization of Chapter

This chapter describes our findings followed by a summary of lessons learned and recommendations. As there are many components to the information gained from our work, the findings have been broken out into sections. The sections are as follows:

A. Types and Models of Recovery Support Services
B. Recovery Support Service Institutions
C. Measurement of RSS
D. Funding RSS, and
E. The Potential Impact of Healthcare Reform

II. Findings

A. Types and Models of Recovery Support Services

Literature Review

National Trends among Recovery Support Services

As described within the COSSR 2009 and EnCAL 2010 reports, the meaning of "recovery" is largely in flux within the substance abuse community. The Betty Ford Consensus Process Panel's definition that recovery "is a voluntarily maintained lifestyle comprised of sobriety, personal health and citizenship" may be the most encompassing definition of recovery and provides specific domains of RSS measurement (Betty Ford Consensus Process, 2007). Without a system-wide definition in place, states and counties have been given minimal guidance on the delivery and funding of these services, which has led to the unsystematic nature and variability of the types of services delivered at the program level.

Recovery supports and services have been defined by SAMHSA (Kaplan, 2008) and White (2008) as flexible nonclinical services that assist individuals and families to recover from alcohol or drug problems. These services are provided prior to, during, after, or in lieu of treatment and can be provided by professionals, volunteers, and/or peers. RSS incorporate a full range of social, legal, and other services that facilitate recovery and wellness, including social supports and linkage to and coordination among allied service providers and other services. Additionally, RSS seek to intervene earlier (pre-treatment) with individuals with substance use problems to improve their recovery outcomes and to support long-term recovery. RSS are delivered through a variety of recovery community organizations (RCOs) and treatment providers. Within this past fiscal year, there has been significant movement in the arena of addiction recovery. In 2010, The White House identified recovery services as a key priority of the Office of National Drug Control Policy (ONDCP) and appointed Peter Gaumond the Recovery Branch Chief to ensure RSS are considered across all branches of government (e.g., the departments of Education, Housing and Urban Development, Labor, and Health and Human Services). The ONDCP strategy seeks to foster the development of community-based RSS, programs, recovery schools, and the like (Mineta, 2010).

In April 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued their Strategic Initiatives, including its 2011–2014 Strategic Initiative #4: Recovery Support, which also placed a high priority on recovery support services. . The initiative's purpose is to promote individual, program-, and system-level approaches that foster health and reliance; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to recovery. With support from both of these national entities, it is clear that a shift has occurred in the ways in which recovery support services are viewed within the overall healthcare delivery system.

In addition to these national organizational strategies, regulations and policies have been passed in which to further assist in the reevaluation process of recovery support service delivery. The Affordable Care Act (ACA) of 2010 emphasizes prevention, access, quality, wellness, and better

coordination of care. The ACA, approved by the U.S. Senate on December 24, 2009, and the U.S. House of Representatives on March 21, 2010, includes a number of provisions aimed at improving coverage for and access to substance use disorder and prevention, treatment, and recovery services (The Patient Protection and Affordable Care Act, 2009).

For instance, the ACA has proposed a National Strategy for Prevention and Wellness (NSPW). This provision was created to "develop policy and program recommendations…on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion" (DHHS, 2010). In order to implement the NSPW, a National Prevention, Health Promotion and Public Health Council will be established to coordinate federal prevention, wellness, and public health activities. This council will be chaired by the Surgeon General and will create task forces on Preventive Services and Community Preventive Services. These task forces will develop evidence-based recommendations on the use of clinical and community prevention services, and then disseminate these recommendations (DHHS, 2010).

As the nation moves toward improving the quality, affordability, and accessibility of healthcare, it is important to increase access to treatment and recovery programs under the ACA as well as identify and encourage other funding streams to foster the development of other community-based RSS (Halvorson, 2010; McLellan, 2010; Mineta, 2010). In light of policy changes subsequent to the addiction field's movement toward a chronic disease model, researchers and policy makers are beginning to shift their attention toward understanding the role of RSS throughout the recovery process as well as developing program performance and patient outcome measures to monitor their efficacy (McKay, 2005; McLellan, 2010).

Supportive Studies

Although there are a number of studies that show the effectiveness of components of recovery support services (Kaplan, 2008), we found that there are several variables in the implementation of these services, such as differences in types of services, where services are provided, when they are provided, and the levels of the workforce offering these services.

As reported in Kaplan (2008), studies indicate that among people with low recovery capital (internal and external resources to support recovery) and high disease severity, social supports provided by sober living communities are critically important to long-term recovery (Groh, Jason, Davis, & Ferrari, 2007; Jason, Davis, Ferrari, & Bishop, 2001). Other studies on recovery support services involving family members and other allies found that the provision of social supports helps patients maintain recovery (Gruber & Fleetwood, 2004). In addition, research suggests that not only can a comprehensive selection of recovery support services assist individuals in recovery from substance use disorders, but strong social supports can also improve recovery outcomes (Humphreys, Moos, & Finney, 1995; Pringle, et. al, 2002)

Research on peer-recovery support provides evidence for the effectiveness of services in supporting recovery (Humphreys et al., 2004). In a study in which 150 individuals were randomly assigned to either an Oxford House (a democratically run, self-supporting, and drug-free home, i.e., "sober living") or usual-care condition after substance abuse treatment, it was revealed that at 24-month follow-up, those in the Oxford House condition had significantly lower

substance use, significantly higher monthly income, and significantly lower incarceration rates than did those in the usual-care condition (Jason, Olson, Ferrari, & Lo Sasso, 2006). Recovery coaches, mutual aid societies, and social and community supports are also beneficial in achieving long-term recovery (Laudet, Savage, & Mahmood, 2002; Scott, Dennis, & Foss, 2005). Recovery check-ups and active linkage to recovery supports following treatment are important in maintaining recovery (McKay, 2005). RSS can be low cost, such as telephone-based support and checkups, and still be effective.

A combination of long-term housing, treatment, and auxiliary services has been shown to improve residential stability and reduce substance use and psychiatric symptoms (Polcin & Henderson, 2008). Properly addressing behavioral health conditions is necessary because substance use disorders negatively impact a person's behavioral health and may lead to worse outcomes for co-occurring physical health problems. Good behavioral health is associated with better physical health outcomes, improved educational attainment, increased economic participation, and meaningful social relationships (Friedli & Parsonage, 2007).

Although RSS can be provided for those outside of the treatment system as well as before and after treatment episodes, RSS also have important implications during treatment. In 2009, NASADAD reported that over half (65%) of individuals in treatment were involved in support services (NASADAD, 2009). Those who participate in both treatment and recovery support groups may have better long-term recovery outcomes than people who used either service alone (Fiorentine & Hillhouse, 2000). A qualitative study found that individuals who dropped-out from substance abuse treatment reported that they might have stayed longer in treatment if they had received assistance with life functioning and better individualized services (Laudet, 2007).

California Survey Findings

Recovery Support Services offered throughout California

With the above evidence in mind, ADP and UCLA sought to determine what and how RSS services were offered throughout the state as well as the perceived importance of these services. In order to categorize types of services, UCLA used the current SAMHSA definitions of components of recovery support services (Kaplan, 2008):

- *Recovery monitoring* – recovery coaching, monitoring via telephone and the Internet
- *Substance abuse assistance* – Outreach, peer-to-peer services, relapse prevention, substance abuse education
- *Education and job skills* – Life skills, employment services and job training, education and G.E.D. services
- *Family support* – Childcare, parent education and child development support services, family/ marriage education
- *Support groups* – self-help and support, spiritual and faith-based support
- *Access to ancillary services* – housing assistance and services, transportation, case management, individual services coordination, providing linkages with other services, transportation.

Types of RSS

To gain a snapshot of the recovery support services offered in California, county administrators were asked to indicate which services they provide in their county, the locations in which the services were provided, as well as the type of staff providing these services.

Table 5.2.1. Top 10 Reported RSS in the State	
1	Substance Abuse Education (38%)
2	Relapse Prevention (37%)
3	Life Skills (nutrition, etc) (35%)
4	Mutual Self-Help (35%)
5	Case management (coordination of services) (33%)
6	Peer-to-peer services (32%)
7	Recovery Check-ups/ Monitoring (27%)
8	Recovery Coaching (27%)
9	Outreach (24%)
10	Housing assistance and services (24%)

Twenty-five of the 40 respondents completed this portion of the survey. Table 5.2.1 summarizes the top 10 most frequently utilized RSS across all treatment and community organization settings. The most endorsed (*yes*/*no*) RSS were substance abuse education (37.9%), relapse prevention (37.3%), life skills (35.4%) self-help and support groups (35.4%), case management (32.9%), peer-to-peer services (31.7%), recovery check-ups/monitoring (26.7%), recovery coaching (26.7%), outreach (24%), housing assistance and services (23.6%), and employment services and job training (20.5%). The least endorsed RSS across all settings were Internet-based recovery (4.4%), telephone continuing care (10.67%), education (G.E.D., etc.; 10.67%) and family education (14.3%).

RSS Across all Settings (Treatment and Community Organizations)

Recovery supports and services that were most frequently endorsed within outpatient settings included relapse prevention (100%), substance abuse education (100%), case management (87.0%), life skills (73.9%), parent education (73.9%), recovery check-ups (69.6%), childcare (65.2%), transportation (65.2%), recovery coaching (60.9%), outreach (60.9%), mutual support (56.5%), family and marriage education (52.2%), and peer services (52.2%). Outpatient settings were less likely to provide RSS such as Internet-based support groups (4.3%), faith-based counseling (8.7%), substance abuse education (100%), education (G.E.D., etc.; 21.7%)

Similar to outpatient settings, residential and inpatient services also offered abundant recovery supports and services. Life skills (60.9%), case management (52.2%), substance abuse education (47.8%), self-help support groups (47.8%), peer services (43.5%) and relapse prevention (43.5%) were the most likely services to be reported within residential and/or inpatient settings. The least likely RSS utilized in residential and/or inpatient centers were Internet-based support (4.3%) and spiritual and faith-based services (8.7%).

RSS Staffing Models Across all Settings (Treatment and Community Organizations)

To determine the staffing structures of the RSS offered throughout the state, county administrators were asked to indicate which type of staff provided the RSS in their counties.

It was not surprising to find that across all settings (treatment settings and recovery community organizations), certified addiction counselors were the most utilized staff to provide RSS. (Please refer to Table 5.2.2. and Appendix 5B) California certified addiction counselors (54.5%) were endorsed the most as the staff who provided RSS across all services and settings, followed by peers (31.1%), clinicians (26.8%), and volunteers (24.0%).

Table 5.2.2. Top 4 Utilized Staff to Provide RSS	
1	Certified Addiction Counselors *(54.5%)*
2	Peers (*31.1%)*
3	Professional/Clinician (*26.8%))*
4	Volunteers *(24.0%)*

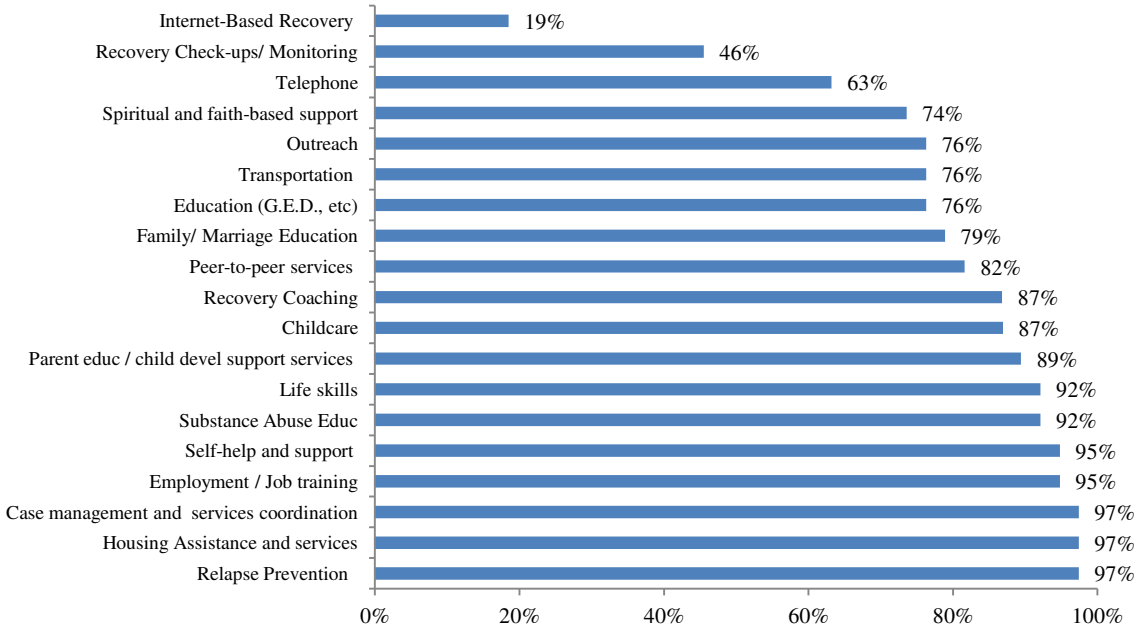
Conversely, the least frequently reported staff providing RSS across all services and settings were medical doctors (2.7%) and faith-based addiction counselors (16.7%). These findings are consistent with the notion that most recovery settings are not faith-based or medical institutions.

Reported Value of RSS by Service Type

Eight-nine percent of respondents reported that RSS were important in an individual's trajectory of overall improved sobriety, health, and wellness. However, with the variety of services offered, we further surveyed county administrators regarding their perceived value of specific types of RSS. Respondents were asked to rate the importance of 19 types of RSS to an individual's recovery on a 5-point scale ranging from "very important" to "unimportant."

Respondents were provided definitions of the 19 types of RSS and were also given the option to add additional recovery support services not listed (Please see Recovery Survey Question #8 in Appendix 5C). As Table 5.2.3 displays, relapse prevention, housing assistance, case management (all at 97%), followed by employment/job training and self-help support (both at 95%) were indicated as the most important types of RSS to an individual's recovery. Interestingly, innovative types of RSS, such as Internet-based recovery (19%), recovery-check-ups (46%), and telephone RSS (63%) were considered the least important types of RSS.

Table 5.2.3: Importance of Specific Recovery Support Service



Conclusions

In summary, findings from the brief RSS survey and literature review offer the following "take-away" messages:

- An overwhelming majority of respondents believe that RSS are important to an individual's recovery and wellness.
- Despite the evidence of efficacy in controlled clinical trials, innovative forms of recovery support services, such as recovery monitoring and telephone RSS were the least important forms of RSS services. However, considering that three of SAMHSA's four strategic initiative goals are health, housing, and purpose (employment), it is promising that RSS providers rank housing, service coordination, and employment as among the top five important services.
- Given recent innovations in recovery support services to induce long-term recovery, further investigation is needed to determine AOD familiarity with Recovery Check-Ups/Monitoring and Telephone RSS. For the purposes of this survey, respondents did not survey providers. As a result, it is not clear if county administrators were uncertain whether these mechanisms were utilized or if providers are not aware of these innovative RSS strategies. There may be a greater need to provide technical assistance on these evidence-based innovative RSS strategies to counties and providers. This technical assistance also needs to include what the specific strategies are, if professional training/qualifications are needed by staff providing these RSS services, and for how long after the treatment services are completed.
- Given that recovery settings appear to utilize peers, volunteers, and addiction certified counselors, there is some evidence that future workforce training and credentialing may

need to target these groups. Based on site visits from the 2009–2010 work, it appears that these staffing models may face significant barriers in data collection efforts as well.

B. Recovery Community Organizations

Literature Review

Through key informant interviews, Internet searches, and RSS reports, we found that recovery support services can be delivered in a number of settings, including freestanding recovery community organizations, as part of treatment agencies, and as services offered by faith-based organizations. Recovery support services are also delivered by organizations affiliated with other systems, such as criminal justice, HIV/AIDS services, and child welfare. A number of Recovery Community Service Program (RCSP) grantees are housed—and have peers providing services for recently released offenders—in jails, HIV/AIDS programs, and child welfare agencies. There is a wide variety of recovery support institutions, settings, and staffing models. These can include: recovery community centers, recovery homes, recovery colonies, recovery schools, recovery industries, recovery ministries/churches, recovery cafes, recovery-based sports teams, recovery book clubs, recovery-themed radio and television programming, and recovery-themed art (White, 2008).

It is important to note that many of these entities are grassroots organizations with annual budgets of less than $500,000. According to key informant interviews with leading recovery centers across the nation, some organizations operate with an annual budget of as low as $100,000 (Ames, 2010). However, these organizations have highly organized recovery support service volunteer staff and mobilize donations and provide technical assistance on RSS.

Based on our Year 1 findings and the literature (White, 2008), states and counties appear to fund recovery supports and services to community residents at no cost to the recipient. Also, there are typically four categories of recovery community organizations (RCOs): recovery centers, schools, recovery/sober living homes, and faith-based/recovery ministries. These RCOs are occasionally attached and/or linked to treatment settings such as residential, inpatient, or outpatient treatment centers. From this research, we have found that there are typically four categories of recovery support service institutions/organizations:

- *Recovery Centers*: Recovery centers are "… often referred to as recovery community centers, are a 'recovery hub' gathering place, and are a peer-based service center for people seeking or in recovery and for their family members. These centers serve a clubhouse function in terms of recovery fellowship, but offer a much wider spectrum of recovery support services than would be available in a typical AA clubhouse" (White, 2008). There is limited literature on the efficacy of recovery centers.

- *Recovery School* programs vary in their design, but generally combine special RSS, with an emphasis on academic excellence. The former may include special faculty guidance, recovery dorms, recovery support meetings, recovery drop-in centers, sober social

activities, and peer mentoring. The latter is achieved through academic guidance, study centers, and peer-tutoring programs.

- *Recovery Homes/Sober Living*: May include sober living homes, transitional living, etc. (not to be confused with medical homes). Some examples are Oxford House, Clean and Sober Transitional Living, etc.

- *Faith-Based/Recovery Ministries:* Some recovery mutual-aid societies use religious ideas or rituals and a faith community to initiate or sustain recovery and enhance the quality of life. Some examples are Celebrate Recovery, Victorious Ladies, etc. Like other RSS, faith-based/recovery ministries may be utilized prior, during, after, or in lieu of substance abuse treatment.

RCO Staffing Models

Although there is a limited literature on RSS staffing models, we have learned that staffing models vary across RSS organizations. RSS staffing continues to evolve as the field evolves and workforce standards within these settings are under evaluation. New roles are developing as will traditional roles will find their place within the system. For example, the role of the recovery coach is a fairly recent component to RSS for SUD and is evident in both public and private mental health and addiction treatment organizations. Yet, peer-based service models continue to grow rapidly in the mental health service arena, particularly for patients with co-occurring psychiatric and substance use disorders (Davidson, Harding & Spaniol, 2005; Mowbray, Moxley, Jasper & Howell, 1997).

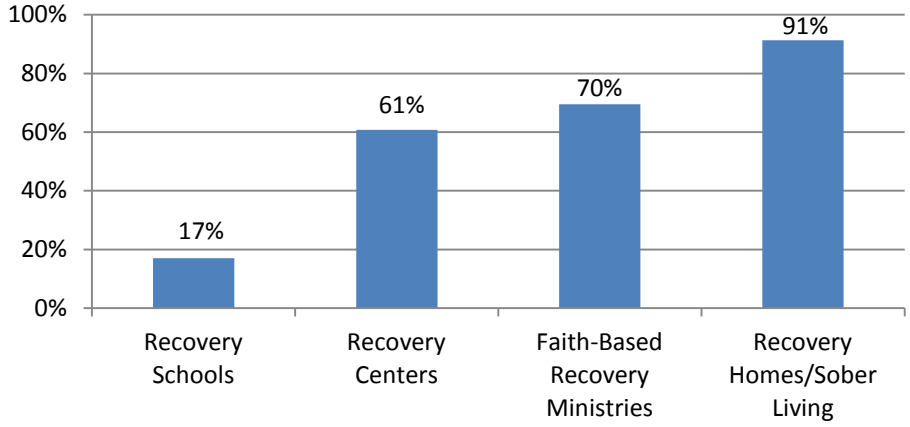
UCLA and ADP sought a better understanding of these institutions and how they operate within California. More knowledge in this arena can provide guidance on workforce development, measurement models, and funding strategies. Therefore, surveys for California were developed, and data were collected and analyzed.

California Survey Findings

The Prevalence of RCOs

County administrators were surveyed to determine the prevalence of RCOs in their respective county and how they operate. As Table 5.2.4 shows, the most commonly identified RCO within the counties is "Recovery Homes/Sober Living" (91%), followed by "Faith-Based Recovery Ministries" (70%) and "Recovery Centers" (61%). Respondents were least likely to identify "Recovery Schools" (17%) as the recovery support services institution within their counties. This finding is to be expected given that recovery schools are often private institutions.

Table 5.2.4 Proportion of RSS Counties Reporting RCOs by Type (*n* = 23)



Respondents were also asked to approximate the number of RCOs in operation within their respective counties. Although approximations were acceptable, Table 5.2.5 depicts that Recovery Homes/Sober Living Homes were the most abundant (n = 379) within the 21 counties, representing an average of 18 recovery homes/sober livings per reporting county. Recovery Centers were also abundant (n = 37) among the 17 counties that reported recovery centers within their county, averaging about 3 centers per county.

Table 5.2.5: Prevalence of Recovery Community Organizations (RCOs)

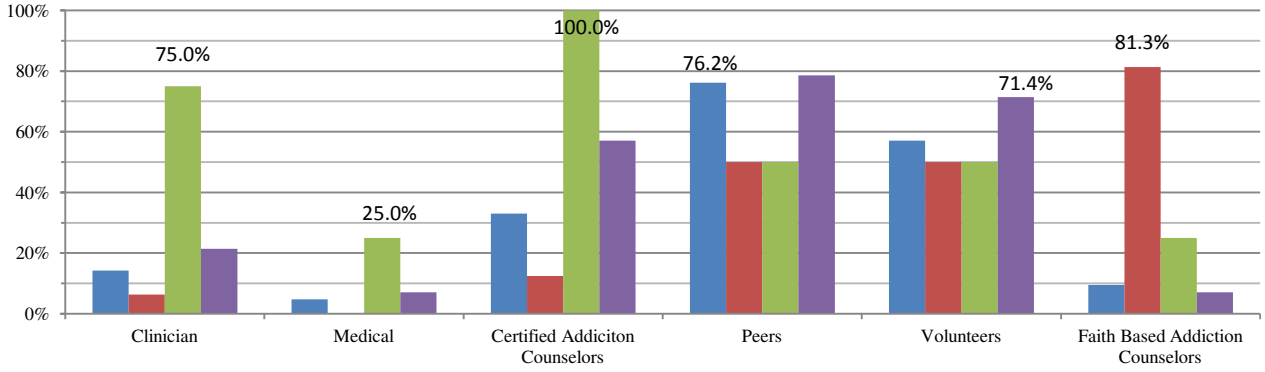
	Recovery Schools (*n* = 4)	**Recovery Center (*n* = 14)**	**Faith-Based Recovery Ministries (*n* = 16)**	**Recovery Homes/ Sober Living (*n* = 21)**
Total	14	37	34	379
Range	1 to 10	1 to 6	1 to 10	1 to 100
Mean *(Average number within county)*	3.5	2.6	2.1	18.0

Staffing within RSS Institutions

As Table 5.2.6 shows, among recovery-community organizations (RCOs) specifically, the most utilized staff endorsed across all RCOs were peers (39.1%), volunteers (34.8%) and certified addiction counselors (22.8%), followed by faith-based ministers (18.5%), clinicians (10.9%), and medical staff (3.2%). As Figure 3 depicts, among counties reporting recovery homes/sober living (n = 21), staffing most likely included peers (76.2%), followed by volunteers (57.1%) and certified addiction counselors (33.3%). Recovery centers (n = 14) utilized peers (78.6%), followed by volunteers (71.4%) and addiction counselors (57.1%). Faith-based/recovery ministries (n = 16) utilized faith-based addiction counselors (81.3%), followed by volunteers

(50%). Recovery schools (n = 4) utilized certified addiction counselors (100%), followed by clinicians (75%), peers (50%), and volunteers (50%).

Table 5.2.6: Staffing within RCOs (n=23)



Recovery Support Services Offered within RCOs

Among recovery-community organizations (RCOs) specifically, the most utilized staff endorsed across all RCOs were peers (39.1%), volunteers (34.8%) and certified addiction counselors (22.8%), followed by faith-based ministers (18.5%), clinicians (10.9%), and medical staff (3.2%). As Figure 3 depicts, among counties reporting recovery homes/sober living (n = 21), staffing most likely included peers (76.2%), followed by volunteers (57.1%) and certified addiction counselors (33.3%). Recovery centers (n = 14) utilized peers (78.6%), followed by volunteers (71.4%) and addiction counselors (57.1%). Faith-based/recovery ministries (n = 16) utilized faith-based addiction counselors (81.3%), followed by volunteers (50%). Recovery schools (n = 4) utilized certified addiction counselors (100%), followed by clinicians (75%), peers (50%), and volunteers (50%).

Conclusions

In summary, findings from the brief RSS survey and literature review offer the following "take-away" messages:

- Recovery homes/sober living homes are the most prevalent RSS institutions within counties.
- More than half (58%) of the responding counties indicated having recovery centers. Recovery centers appear to be the second most prevalent recovery institution among counties reporting recovery centers.
- These findings indicate that a majority of counties may seek funding strategies for recovery homes/sober livings and recovery centers with the roll-out of healthcare reform.
- Given that recovery institutions appear to utilize peers, volunteers, and addiction certified counselors, there is some evidence that future workforce training and credentialing may need to target these groups. Given the prevalence of faith-based/recovery ministries, there is evidence that future workforce training may need to target this group as well.

C. Measuring Recovery Support Services across the State

Literature Review

From our 2009–2010 work, it was determined that there were no clear guidelines on RSS measurement and there were few standardized performance/outcome measures to test the efficacy of RSS. With the passage of the Affordable Care Act of 2010 (ACA), the ability to measure program quality and performance, and client/patient outcomes, has become a high priority and essential in order to ensure accountability and high quality care (The Patient Protection and Affordable Care Act, 2009).

Given that the ACA may provide unique opportunities to fund RSS, it is critical to identify RSS performance/outcome measures to capture the efficacy of recovery services. There are several states that have begun to utilize self-made surveys to measure RSS performance/outcomes. These surveys typically include the domains of recovery status, legal, housing, and employment status. For states and providers who receive Access to Recovery (ATR) grants, they are mandated to collect Government Performance and Results Act (GPRA) patient data and report this data to SAMHSA . The GPRA data is collected by asking a series of questions using a lengthy assessment instrument called "the GPRA interview tool." This GPRA tool collects patient demographic and outcome measures data at baseline, discharge, and 6-month follow-up. GPRA requires very detailed information on individuals' drug use, health, education, employment, legal, housing and employment status, and social connectedness. Reportedly, the GPRA interview takes approximately 45 minutes to complete by a trained professional.

Additionally, recovery centers may track volunteer hours to ensure efficiency of operations and fiscal restraint. However, from our key informant interviews with Dr. Alexandra Laudet, we have learned that SAMHSA is working to develop a monograph which will include a set of measures to help assess a person's recovery. Reportedly there will be an emphasis on developing indicators that assess quality of life and may have recommended resources such as *Recovery Assessments of the Self, Organization, Family Member, Director, and Line Staff (RSA).* The Recovery Self-Assessment (RSA) is a 36-item measure designed by Yale University to gauge the degree to which programs implement recovery-oriented practices (Davidson, Tondora, Davidson et al., 2007; See Appendix 5D). It is a self-reflective tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care. The RSA contains concrete, operational items to assist program staff, persons in recovery, and significant others to identify practices in their mental health and addiction agency that facilitate or impede recovery.

The National Quality Forum (NQF) has also weighed in on measurement strategies for recovery support services to enhance continuing care. Because there is little information available on RSS effects on patient outcomes over time, the Forum concluded that it is imperative to determine long-term morbidity and mortality outcomes, the impact of interventions on a continuum of outcome goals ranging from improvement in function and reduction of harm/hazard to complete abstinence at the individual and community level (NQF, 2007). The NQF report and the RSS monograph on RSS measurement agree that Quality of Life (QOL) measures, such as the SF-12

and Recovery assessments, especially when used together, may provide opportunity for consistent measurement to furnish meaningful outcome assessments across the state.

California Survey Findings

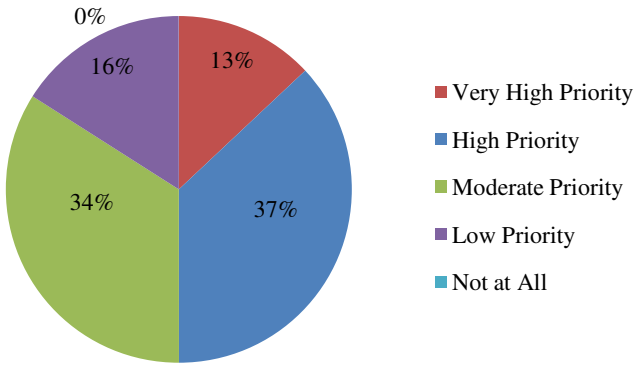
In order to assist California counties in developing data measurement guidelines, it is first important to understand attitudes and perceived barriers to measurement. This will assist in the process to establish measures and test feasibility of standardizing data collection efforts in RSS institutions. County administrators were asked to rate the priority of measuring RSS in their county, what data is collected, if any, and how much of need there is for technical assistance to measure RSSs.

Despite the fact that a majority of counties do not collect data on RSS, many respondents indicated that measuring RSS is a priority. Perceived barriers to RSS data collection include the lack of an assessment tool, a data collection system, and funding. There is a need for technical assistance on how to measure RSS.

RSS Types

Over half (63%) of county administrators indicated that their county does not currently collect data on RSS. Yet, interestingly half (50%) of county administrators indicated that measuring and documenting recovery support services was a very/high priority (See Chart 5.2.7.). Out of the 38 respondents, none of the county administrators felt that measuring RSS was not a priority.

Chart 5.2.7 Priority of Measuring RSS (n = 38)



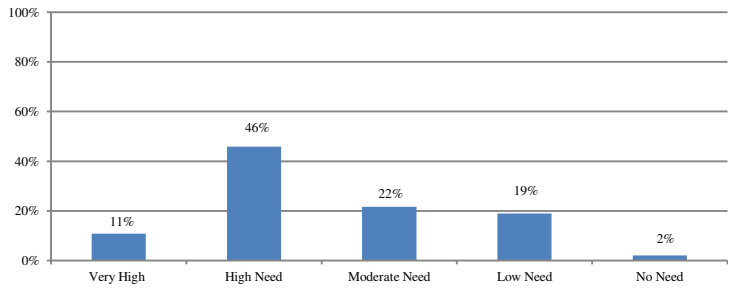
A little over one-third (37%) of county administrators collected data on RSS in their county. Of those counties, the most common type of data collected was service utilization (e.g., 12-step, parent groups) and patient satisfaction. In addition, outcomes pertaining to substance use (i.e., "sober births"), health outcomes (criminal justice involvement, mental and physical health status) and housing and employment status were also indicated as measurement domains. However, standardized measurement tools were not indicated; thus, the results of this survey may be difficult to interpret. In order to better understand why counties did not measure recovery support services among those with such services, UCLA assessed the barriers reported for not measuring RSS.

As shown in Table 5.2.8, the most commonly reported barriers to the measurement of RSS were the lack of: (1) measurement tools / data collection Information Technology system (38 responses), (2) funding (21 responses), (3) qualified or identified staff to conduct this effort (19 responses), and (4) time (9 responses). SUD providers also noted lack of collaboration between RSS providers and other systems, as well as the lack of political will and lack of mandates. Of those who did not collect data in their county (63%), demographics, encounter data linked to outcomes service utilization, outcomes, patients' perception of the usefulness of RSS, and outcomes by modality were selected as a "wish list" of data measures.

Table 5.2.8. Top 5 Barriers to Collecting RSS Data
1. Lack of Measurement Tools / Data Collection System (electronic)
2. Funding
3. Staff
4. Time
5. Other

Finally, more than half (57%) of county administrators indicated a need for technical assistance on strategies to fund RSS (See Table 5.2.9.).

Table 5.2.9 Need for Technical Assistance to Measure RSS



Conclusions

In summary, findings from the brief RSS survey and a relevant literature review offer the following "take-away" messages for this theme:

- 2009–2010 pilot counties' data collection efforts were commendable and are very useful to the respective counties; however, findings from the statewide survey replicate earlier work that suggested that data collection methods either do not exist or are not standardized.
- Given the RSS workforce, training efforts to increase data collection efforts may need to be specifically designed for paraprofessionals (peers and certified addiction counselors).

D. Funding of Recovery Support Services across California

Literature Review

Investing in prevention, treatment, and recovery support services benefits society by reducing the social and economic burdens of substance use. As reported by Halvorson & Whitter (2009), it may be possible to decrease the nation's substance misuse costs, which exceed half a trillion dollars, as well as costs related to mental health problems, which amount to approximately $79 billion, annually.

Under healthcare reform, it is conceived that substance use treatment may move toward a Medicaid and SAMHSA Block grant funding system, and RSS may contribute an essential element to the provision of a high quality continuum of care for AOD patients. In addition to improving care, RSS may reduce costs by offsetting treatment costs with community supports (Humphreys & Moos, 2007). RSS aimed at facilitating engagement in substance abuse treatment and aftercare appears to foster modest savings in Medicaid costs for working-age disabled patients. One study found that the Access to Recovery grant (ATR)—a program which expanded substance abuse recovery services through the use of vouchers for specialized recovery support services, such as childcare, housing, transportation, and items that might help them employment—was associated with reductions in per member per month (PMPM) Medicaid costs of $66 ($p = .11$) to $136 ($p= .05$) depending upon months of Medicaid eligibility (Wickizer, Mancuso, Campbell & Lucenko, 2009).

As there is a variety of public and private funding and reimbursement streams for recovery support services (as shown in Table 5.2.10), the ACA may expand funding for prevention, treatment, and recovery support services as Medicaid reimbursement expands (Halvorson, 2010). In addition, the door may open to third-party payer reimbursements (Halvorson, 2010). However, it is evident that actively promoting RSS and social support involvement may be a useful clinical practice for helping addicted patients recover, especially in a time of constrained fiscal resources (Humphreys & Moos, 2007).

Given the uncertainty of future RSS funding, UCLA investigated current strategies to fund RSS. According to SAMHSA's *Funding Recovery Support Services* (March 2010), states currently use funding mechanisms such as SAPT grants, federal and state grants, appropriations, private pay, and Medicaid reimbursement. A summary of RSS funding mechanisms is provided below:

Table 5.2.10: Summary of Funding Streams and Provision of RSS

Funding Streams	Description	Provision of RSS
Medicaid	The Medicaid program operates as a partnership between the federal government and state governments to provide health coverage to certain low-income individuals and families. Each state operates its own Medicaid program, with unique eligibility guidelines and benefits packages approved by the federal government. While treatment for substance use conditions is not a mandatory benefit under Medicaid, the majority of states have amended their Medicaid state plans to cover treatment and some RSS.	Medicaid allows the provision of RSS through the waiver processes described below and by state plan amendment.
Medicaid Rehab Option	Under the rehab option, states can cover "other diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other institution) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."	States are required to identify what specific services will be offered as a part of the program and obtain CMS approval for these services. There is flexibility in that services can be delivered in a variety of locations by a wide range of professionals. The current exclusions are room and board, transportation, and vocational/educational training.
Medicaid Managed Care/ Freedom of Choice Waivers	A Medicaid section 1915(b) or "freedom of choice" waiver allows states to implement managed care systems for Medicaid beneficiaries. These waivers are used by states to operate programs that affect the delivery system for some or all of the individuals eligible for Medicaid in a state.	There are no specific instructions on what services can be included. There are two limitations listed: (1) they cannot negatively impact beneficiaries' access to care, and (2) offering the services cannot cost more than the program would have cost without the waiver. This guidance still provides states with flexibility in determining what services should be offered to best meet the needs of individuals.
Medicaid Deficit Reduction Act	The DRA allows states greater flexibility to furnish community-based services, including RSS, through Medicaid. States have the ability to provide home-based and community-based services to elderly individuals and people with disabilities without requiring a waiver or demonstrating cost-neutrality. States can provide any of the services now covered under Home and Community Based Services (HCBS) waivers. DRA also expands services to populations not previously eligible for HCBS waivers and allows states to tailor HCBS to the needs of a particular population.	States can offer a range of support services, including financial management, personal development, advocacy, crisis management support, skills training, coordination/ linkages with other resources, and peer support services. These services can be provided one-on-one, in groups, in community institutions, or in the individual's natural institution/home.
SAPT Block Grant	The SAPT Block Grant provides foundational support to states for prevention and treatment services and activities. SAPT Block Grant recipients are given considerable flexibility to determine how to spend funds on "treatment activities," which is broadly defined and could include RSS. In addition, the importance of services that constitute RSS is emphasized both in the SAPT Block Grant section of the law and in regulation.	The SAPT Block Grant requires the provision of RSS to an identified population: pregnant women and women with dependent children. Block Grant language specifically states that agencies providing treatment services must also offer prenatal care and child care to women with dependent children. SAPT Block Grant funds may also be used to help establish group homes for recovering individuals with substance use conditions. Section. 300x28(c) requires the coordination of additional services to aid individuals in the areas of health, social, vocational, educational, criminal justice, and employment, although there is no specific guidance. Designated States are required to provide HIV pretest and posttest counseling.

ATR	ATR is a discretionary grant program funded by SAMHSA/CSAT that provides individuals with vouchers to purchase treatment for substance use conditions and RSS at the provider of their choice. The three goals of the program are to expand consumer choice, to track and improve outcomes and, to increase capacity. ATR also aims to include more faith-based and community-based providers in service delivery. RSS are delivered by staff, peers, and volunteers in the community to promote a drug-free lifestyle.	Allowable services include family services (marriage education, parenting, and child development services), child care, individual services coordination, transportation, employment services and job training, HIV/AIDS education and services, supportive transitional drug-free housing services, other case management services, continuing care, relapse prevention, recovery coaching, self-help and support groups, spiritual support, other aftercare service, substance abuse education, and peer coaching and mentoring.
RCSP	RCSP is a program designed specifically to deliver peer support services. These services are not related to treatment and are not provided by professionals at treatment agencies unless these professionals identify themselves as peers and function only in that capacity. RCSP promotes the healthy community by helping the individual achieve and maintain a drug-free lifestyle. The program builds on the premise that individuals in recovery are a valuable resource.	Allowable services include peer-led recovery support groups and meetings, recovery coaching or mentoring, peer case management, recovery education, life skills training, health and wellness training, education and career planning, leadership skills development, and alcohol- and drug-free social and recreational activities.
State and Local	States are funding RSS within their overall service continuum to promote health and wellness. By demonstrating need and benefit to legislators, state agencies have been appropriated funds to expand RSS. States have begun to offer additional supports to individuals before, during, and after treatment. Additionally, states are extending the length and the range of RSS options as a way to promote ongoing recovery.	The types of services provided, target populations, services requirements, and availability of funding vary from state to state.
TANF	The TANF program is a Federal block grant administered by the Office of Family Assistance within the U.S. Department of Health and Human Services, which funds states to provide temporary assistance to aid individuals in gaining employment and achieving self-sufficiency. The TANF Final Rule indicates that states may offer "pro-family" expenditures to individuals in order to meet the overarching TANF goals of reducing out-of wedlock births and increasing the number of two-parent families. The "pro-family" expenditures can be provided regardless of family income and composition.	"Pro-family" activities are consistent with RSS offered through other funding streams (e.g., child care, transportation, family counseling, peer supports).
Drug Courts **State and Local Funding**	State drug courts often combine resources from federal, state, and local revenue streams to fund the program. This approach allows greater flexibility in designing the services to be included in the program. State drug courts recognize the importance of including RSS in programs to better assist individuals in achieving and maintaining recovery.	States often have flexibility in designing the components of their drug court program to include RSS when using local resources.
Drug Courts **SAMHSA Funding**	SAMHSA partnered with the Federal Department of Justice (DOJ) /Bureau of Justice Assistance to fund drug courts. The purpose of this program is to expand and/or enhance treatment for substance use conditions services in "problem solving" courts, which promote treatment for substance use conditions and RSS to aid individuals in accessing treatment services.	The program allows states to fund wraparound services/RSS to participants to aid them in accessing treatment and remaining in treatment. The wraparound services/RSS may include child care, transportation, vocational training, educational training, etc.

Drug Courts **DOJ Funding**	The Drug Court Discretionary Grant Program, administered by DOJ, awards grants to state, local, and tribal governments up to $200,000 to establish or enhance their drug court programs. The Bureau of Justice Assistance within DOJ developed a drug court resource guide outlining key components of a drug court program to aid states in developing these services. This guide outlines the effectiveness of providing treatment for substance use conditions to nonviolent offenders involved in the drug court system. Key Component #4 in the guide also outlines the need for additional supports to aid the individual and reduce recidivism: "Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services."	Allowable services include housing; educational and vocational training; legal, money management, and other social service needs; cognitive-behavioral therapy to address criminal thinking patterns; anger management; transitional housing; social and athletic activities; and meditation or other techniques to promote relaxation and self-control.
Private Funding	Some state and local agencies use private donations and foundation grants to help fund RSS.	States may have the flexibility to design which RSS are offered depending on the funding source and the requirements associated with the funding

Source: Substance Abuse and Mental Health Service Administration (March 2010) *Financing Recovery Support Services.* Retrieved from http://pfr.samhsa.gov/docs/RSS_financing_report.pdf

California Survey Findings

In order to make progress and/or promote new mechanisms to fund recovery support services, it is important to understand how services are currently funded as well as what technical assistance is needed to inform counties as to how to use available funds for these types of services. County administrators were also asked to rate the priority of funding RSS in their county.

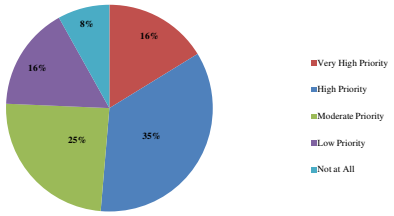
Survey findings revealed that the majority of county administrators funded their RSS using county discretionary funds, matching funding, and private contracts with RSS providers. The SAPT Block Grant accounted for the second largest contribution of RSS funding. Also referenced, but less utilized included MHSA funds, grants (i.e., state and/or SAMHSA grants), and through treatment providers (See Table 5.2.11).

Table 5.2.11. Top 5 Mechanisms to Fund RSS

1. County Funds (Matching, Discretionary Funds, etc)
2. SAPT Block Grant
3. MHSA Funds
4. Grants (State and/or Federal)
5. Treatment and/or RSS Providers

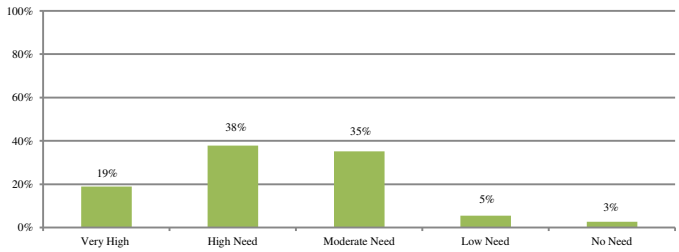
As Chart 5.2.12 displays, county administrators indicated funding for recovery support services was a very/high priority (60%). Only three county administrators (8%) indicated that funding RSS was not a priority.

Chart 5.2.12 Rated Priority of Funding RSS (n = 38)



More than half (57%) of county administrators indicated a need for technical assistance on strategies to fund RSS (See Chart 5.2.13).

Chart 5.2.13 Rated Priority of Funding RSS (n = 38)



Conclusions

In summary, findings from the brief RSS survey and relevant literature review offer the following "take-away" messages:

- Funding RSS is a priority, but there is a need for technical assistance on how to fund RSS. The top three funding mechanisms include local funding, SAPT Grant, and MHSA funding.
- Many counties have begun to use funding mechanisms such as the SAPT Block Grant; however, most funding mechanisms are at the local level.
- It is apparent that barriers at the federal and state level limit counties' ability to utilize funding mechanisms such as Medicaid.

- Given healthcare reform, it is plausible that counties may have more opportunities to utilize Medicaid if RSS states identify what specific RSS services will be offered as a part of the Medicaid program and obtain CMS approval for these services.
- In February 2011, NASADAD released a healthcare reform policy recommendation to alter the SAMHSA Substance Abuse Prevention and Treatment (SAPT) Block Grant to explicitly authorize the purchase of recovery support services for substance use disorders. NASADAD also recommended regulatory action flow from this change that would help systematically shape definitions to help ensure effectiveness and accountability (NASADAD, 2011).

E. The Impact of Healthcare Reform on RSS

Literature Review

The Affordable Care Act recognizes that an individual's health and behavioral healthcare are interwoven and that both must be appropriately addressed to achieve successful health outcomes (The Patient Protection and Affordable Care Act, 2009). Several provisions of the Affordable Care Act support an integrated approach to care, and several agencies are working to ensure that the integrated approach supports recovery from substance use disorders. The challenge in achieving the promise of integrated physical and behavioral healthcare is that it requires structural, policy, practice, cultural, and financial changes to our healthcare systems as well as to our social service systems. Currently, SAMHSA is engaging stakeholders and partners within and outside of the behavioral health field to understand and embrace recovery and all of its dimensions and determine the appropriate course to follow. In fact, over the past year, SAMHSA has established a Recovery Initiative in which they developed a working definition of recovery with guiding principles as well as integrated these guiding principles into the revised Block Grant applications for both mental health services and substance abuse prevention and treatment (SAMHSA, 2011).

California Survey Findings

Given the competing interests and priorities set forth under the ACA, UCLA surveyed county administrators on their perceptions of the impact of healthcare reform on Recovery Support Services as well as what concerns they had as regulations and practices evolve.

Eighty-three percent (83%) of AOD administrators felt that RSS were important under healthcare reform, whreas only 7% felt that RSS were "moderately" important under healthcare reform. The biggest concerns about RSS under healthcare reform included whether RSS would be supported with public funds, given the potential changes to the funding mechanisms.

Conclusions

In summary, findings from the brief RSS survey and relevant literature review offer the following "take-away" messages:

- Actively promoting RSS may be a useful clinical practice for helping addicted patients recover, especially in a time of constrained fiscal resources (Humphreys & Moos, 2007).
- Uncertainty around the funding and role of RSS under healthcare reform is prominent, and counties are seeking guidance on strategies to fund these important services.

III. Lessons Learned and Recommendations

Not only is there growing evidence in the literature to support the benefits of recovery support services (RSS), most SUD county leaders are reporting that RSS are crucial to an individual's recovery. However minimal measurement efforts of RSS occur statewide, nor are there substantial public funding resources available for RSS due to systematic barriers and the need for technical assistance and guidance. As support for RSS increases at the federal level, it is important for state and county level leadership to consider the following recommendations:

More research is needed on consensus definitions and the impact of specific types of recovery support service on health outcomes. This evidence is needed to provide guidance and incentives at the county and provider level to offer RSS that achieve the highest outcomes at the least cost.

It is evident that there is a variety of RSS offered across the state; however, county by county, these services varied by type, by setting, and by staffing model. The selection of services offered seems to be selected by availability of staff and time, rather than by data supporting their efficacy. In fact, it is not clear which models of RSS produce enhanced outcomes with optimal fiscal savings. There is evidence, however, that community supports may reduce the need to rely on more expensive, higher levels of care (Humphreys & Moos, 2007). Therefore, it is recommended that evidence-based practices are utilized within these settings and incentives to provide these practices are provided.

One component under the Affordable Care Act (ACA) is to create Accountable Care Organizations. This may provide a unique opportunity for RSS integration and funding.

Accountable Care Organizations (ACO)s address the problem of fragmentation of care, current financial incentives that encourage wasteful use of tests and services, unnecessary care, poorly coordinated care, use of higher-cost providers where lower-cost ones are effective, and the lack of timely and consistent care (McClellan et al., 2011 NCL Brief for State Legislators, May 2010). The goal of ACOs is to shift Medicare away from paying for *quantity* of services to rewarding a better *quality* of service and healthier outcomes. It is likely that RSS may be utilized by providers in ACOs to ensure that the following three ACO aims are met: (1) better care for individuals; (2) better health for populations; and (3) lower growth in expenditures" (DHHS, April 2011). ACOs provide a unique opportunity to utilize RSS to reduce unnecessary preventable re-admission, reduce duplication of services, and prevent medical errors (CMS, April 2011). The approach of ACOs is novel to the Medicare Fee for Service program, under which providers have little incentive to coordinate care or limit wasteful and unnecessary tests (CMS, April 2011). Additionally, if an ACO is not able to save money, it may incur the costs of investments made to improve care, such as adding new nurse care managers to ensure a coordinated system of care or patient management. The law also gives regulators the ability to devise other payment methods, which would likely ask ACOs to bear more risk (DHHS, 2011). If ACOs are successful, they will be expanded for other payment models by the Secretary (DHHS, April 2011). As providers seek to increase their shared savings benefits, RSS may use RSS to provide a link to coordinate care and manage health needs of patients in recovery.

It is apparent that some counties make use of the SAPT block grant and may make better use of the revised block grant. Revisions within the federal block grant (as of June 17, 2011), may provide counties with more opportunities to fund RSS through the use of the federal block grant.

In an effort to streamline the application and reporting procedures for the Mental Health Services and Substance Abuse, Prevention and Treatment block grant programs, SAMHSA has drafted a new uniform block grant application. Among the changes to the block grant application is a greater focus on services in support of recovery from mental health and substance use problems. States will use the substance abuse block grant for prevention, treatment, recovery supports, and other services that will supplement services covered by Medicaid, Medicare, and private insurance.

Given that the goal of healthcare reform is to increase access, contain costs, and create incentives for quality and not quantity, several health systems are being revised in order to be in alignment with reform. Therefore, it is critical to standardize measurement strategies used throughout the state.

There are several states that have begun to utilize self-made surveys to measure RSS outcomes. However, from our key informant interviews, we learned that SAMHSA is working to develop a set of measures to help assess a person's recovery with an emphasis on developing indicators that assess quality of life (the document had not yet been released). UCLA learned that some resources that might be recommended within the monograph include *Recovery Assessments of the Self, Organization, Family Member, Director, and Line Staff*. In addition, quality of life (QOL) measures, such as the SF-12, may provide important evidence of patient outcome measure.

Training and technical assistance efforts to increase data collection efforts are necessary and may need to be specifically designed for paraprofessionals.

As shown from our survey results, the workforce providing RSS are typically peers and certified addiction counselors. Although there is current discussion regarding licensure and certification requirements, these staff are best utilized in these RSS settings. Therefore, if measurement of these services becomes a priority, it is crucial to train the workforce on the specific requirements involved in collecting, entering, and interpreting the relevant data elements.

UCLA learned that the Pennsylvania Drug and Alcohol Coalition (2010) recommended the following funding strategies for RSS, which may also be of use to California:

- State departments and administrators will need to be resourceful and innovative in providing funding within a system that is already strained in delivering the current regimen of services. Emphasis should be placed on collaboration among alternative funding streams from state, regional, and local agencies that provide additional services to patients with alcohol and other drug addiction (e.g., criminal justice system, child welfare, education, juvenile justice, etc.).

- Reinvestment dollars - Utilize reinvestment dollars through the Health Choices system to support recovery support services (e.g., Recovery Housing, Recovery Checkups, and CRSs).
- External, federal and other grants – Pursue funds to reframe existing funding allocations and services, including Medicaid reimbursement for CRSs.
- Funding partnerships – Establish partnerships with criminal justice, child welfare, mental health and related fields, private non-profits, academic communities, and others in order to develop new funding options for individuals in need of services.
- As new funding opportunities arise, we should remain open-minded and receptive to working in collaboration with others to secure funding needed for systems transformation. A strategic plan should be implemented for statewide system transformation, even if new dollars for this process have not been identified.
- Given that there is much anxiety in the field on how healthcare reform will impact current funding as well as operations, there is a greater need for technical assistance to communicate current strategies to counties.

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APPENDIX 5A

Recovery Support Service Locations by Type (N=23)

% Counties Reporting "Yes" and Number of Counties Reporting "Yes"

	Not Applicable	Residential or Inpatient Treatment	Outpatient Treatment	Recovery Home / Sober Living	Recovery Center	Recovery School	Faith-Based Ministry	Mobile Unit
Telephone Continuing Care (*f*=17)	**60.9% (14)**	13.0% (3)	34.8% (8)	17.4% (4)	4.3% (1)	0.0% (0)	4.3% (1)	0.0% (0)
Internet-Based Recovery (*f*=7)	**87.0% (20)**	4.3% (1)	4.3% (1)	4.3% (1)	**8.7% (2)**	4.3% (1)	4.3% (1)	0.0% (0)
Recovery Check-ups/ Monitoring (*f*=43)	17.4% (4)	34.8% (8)	**69.6% (16)**	26.1% (6)	**34.8% (8)**	8.7% (2)	13.0% (3)	0.0% (0)
Recovery Coaching (*f*=43)	**39.1% (9)**	**34.8% (8)**	**60.9% (14)**	**34.8% (8)**	21.7% (5)	8.7% (2)	26.1% (6)	0.0% (0)
Relapse Prevention (*f*=60)	0.0% (0)	**43.5% (10)**	**100.0% (23)**	**39.1% (9)**	34.8% (8)	13.0% (3)	26.1% (6)	4.3% (1)
Substance Abuse Education (*f*=17)	0.0% (0)	**47.8% (11)**	**100.0% (23)**	30.4% (7)	**39.1% (9)**	4.3% (1)	34.8% (8)	8.7% (2)
Education (G.E.D., etc) (*f*=17)	**60.9% (14)**	**17.4% (4)**	**21.7% (5)**	8.7% (2)	13.0% (3)	8.7% (2)	4.3% (1)	0.0% (0)
Parent education and child development support services (*f*=32)	8.7% (2)	**34.8% (8)**	**73.9% (17)**	8.7% (2)	4.3% (1)	**13.0% (3)**	4.3% (1)	0.0% (0)
Family/ Marriage Education (*f*=23)	**43.5% (10)**	21.7% (5)	**52.2% (12)**	**8.7% (2)**	4.3% (1)	4.3% (1)	**8.7% (2)**	0.0% (0)
Employment Services and Job training (*f*=33)	21.7% (5)	**34.8% (8)**	**52.2% (12)**	17.4% (4)	**21.7% (5)**	0.0% (0)	17.4% (4)	0.0% (0)
Housing Assistance and services (*f*=38)	17.4% (4)	**39.1% (9)**	**56.5% (13)**	17.4% (4)	**30.4% (7)**	0.0% (0)	21.7% (5)	0.0% (0)
Life skills (*f*=57)	8.7% (2)	**60.9% (14)**	**73.9% (17)**	30.4% (7)	**43.5% (10)**	8.7% (2)	26.1% (6)	4.3% (1)
Case management and individual services coordination, providing linkages with other services (*f*=53)	4.3% (1)	**52.2% (12)**	**87.0% (20)**	21.7% (5)	**34.8% (8)**	13.0% (3)	17.4% (4)	4.3% (1)
Transportation (*f*=31)	17.4% (4)	**39.1% (9)**	**65.2% (15)**	**17.4% (4)**	13.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)
Childcare (*f*=29)	8.7% (2)	**34.8% (8)**	**65.2% (15)**	4.3% (1)	**13.0% (3)**	0.0% (0)	8.7% (2)	0.0% (0)
Outreach (*f*=39)	8.7% (2)	**21.7% (5)**	**69.6% (16)**	4.3% (1)	**34.8% (8)**	8.7% (2)	30.4% (7)	0.0% (0)
Peer-to-peer services (*f*=51)	8.7% (2)	**43.5% (10)**	**52.2% (12)**	**47.8% (11)**	39.1% (9)	4.3% (1)	30.4% (7)	4.3% (1)
Self-help and support (*f*=57)	13.0% (3)	**47.8% (11)**	**56.5% (13)**	**47.8% (11)**	**47.8% (11)**	4.3% (1)	39.1% (9)	4.3% (1)
Spiritual and faith-based support(*f*=26)	**13.0% (3)**	8.7% (2)	8.7% (2)	**13.0% (3)**	8.7% (2)	4.3% (1)	**60.9% (14)**	8.7% (2)

APPENDIX 5B

Recovery Support Services by Staff Type (N=23)

% Counties Reporting "Yes" and Number of Counties Reporting "Yes"

	Not Applicable (*f*=97)	Medical (*f*=12)	Professional / Clinician (*f*=116)	Certified Addiction Counselors (*f*=238)	Peers (*f*=130)	Volunteers (*f*=105)	Faith-Based Addiction Counselors (*f*=60)	Other (*f*=48)
Telephone Continuing Care	**60.9% (14)**	4.3% (1)	17.4% (4)	**39.1% (9)**	17.4% (4)	13.0% (3)	4.3% (1)	0.0% (0)
Internet-Based Recovery	**91.3% (21)**	4.3% (1)	4.3% (1)	4.3% (1)	4.3% (1)	4.3% (1)	0.0% (0)	4.3% (1)
Recovery Check-ups/ Monitoring	8.7% (2)	13.0% (3)	39.1% (9)	**78.3% (18)**	**52.2% (12)**	30.4% (7)	21.7% (5)	4.3% (1)
Recovery Coaching	30.4% (7)	4.3% (1)	30.4% (7)	**56.5% (13)**	**52.2% (12)**	21.7% (5)	13.0% (3)	4.3% (1)
Relapse Prevention	0.0% (0)	13.0% (3)	**52.2% (12)**	**95.7% (22)**	39.1% (9)	21.7% (5)	21.7% (5)	4.3% (1)
Substance Abuse Education	0.0% (0)	8.7% (2)	**47.8% (11)**	**95.7% (22)**	26.1% (6)	26.1% (6)	21.7% (5)	0.0% (0)
Education (G.E.D., etc)	**56.5% (13)**	0.0% (0)	4.3% (1)	13.0% (3)	4.3% (1)	8.7% (2)	0.0% (0)	**26.1% (6)**
Parent education and child development support services;	13.0% (3)	0.0% (0)	**47.8% (11)**	**60.9% (14)**	13.0% (3)	17.4% (4)	8.7% (2)	8.7% (2)
Family/ Marriage Education	30.4% (7)	0.0% (0)	**56.5% (13)**	**43.5% (10)**	8.7% (2)	8.7% (2)	8.7% (2)	0.0% (0)
Employment Services and Job training	**30.4% (7)**	0.0% (0)	8.7% (2)	**43.5% (10)**	21.7% (5)	26.1% (6)	8.7% (2)	**30.4% (7)**
Housing Assistance and services	17.4% (4)	0.0% (0)	17.4% (4)	**65.2% (15)**	**34.8% (8)**	30.4% (7)	13.0% (3)	26.1% (6)
Life skills	8.7% (2)	0.0% (0)	**47.8% (11)**	**91.3% (21)**	30.4% (7)	17.4% (4)	17.4% (4)	4.3% (1)
Case management and individual services coordination, providing linkages with other services	4.3% (1)	0.0% (0)	**47.8% (11)**	**91.3% (21)**	26.1% (6)	21.7% (5)	21.7% (5)	8.7% (2)
Transportation	13.0% (3)	0.0% (0)	17.4% (4)	**65.2% (15)**	17.4% (4)	**30.4% (7)**	8.7% (2)	17.4% (4)
Childcare	8.7% (2)	0.0% (0)	13.0% (3)	**43.5% (10)**	**52.2% (12)**	39.1% (9)	8.7% (2)	30.4% (7)
Outreach	4.3% (1)	4.3% (1)	30.4% (7)	**78.3% (18)**	30.4% (7)	26.1% (6)	26.1% (6)	4.3% (1)
Peer-to-peer services	8.7% (2)	0.0% (0)	13.0% (3)	26.1% (6)	**65.2% (15)**	**52.2% (12)**	17.4% (4)	8.7% (2)
Self-help and support	13.0% (3)	0.0% (0)	8.7% (2)	34.8% (8)	**60.9% (14)**	**47.8% (11)**	26.1% (6)	3.0% (3)
Spiritual and faith-based support	**21.7% (5)**	0.0% (0)	0.0% (0)	8.7% (2)	8.7% (2)	**13.0% (3)**	**13.0% (3)**	8.7% (2)

APPENDIX 5C

California Recovery Support Service Survey

COVER PAGE

Purpose of Survey:

We would like your help to assess the Recovery Support Services (RSS) currently offered within the 58 counties across California. As most, if not all, of these services fall outside of the CalOMS-Tx data system, there is little systematic information about the implementation, measurement, and perceived impact of these services across the counties. The purpose of this survey is to catalog for the state the following information about RSS offered by county:

1) Types of recovery support services (RSS) currently offered;
2) Staffing models for these services;
3) Measurement efforts of RSS; and
4) Funding mechanisms for RSS.

Findings from this study may have important policy implications. The results of this survey will be disseminated across all counties to learn from one another about California's models, measurement and funding of RSS.

Background:

Recovery is commonly viewed as a *voluntarily maintained lifestyle comprised of sobriety, personal health and citizenship*. ***Typically, RSS are <u>not</u> treatment services, but rather services to assist individuals in recovery to maintain lifelong sobriety and fully reintegrating with the community***. RSS complement the focus of treatment, outreach, engagement and other strategies and interventions to assist people in recovery in gaining the skills and resources needed to initiate and maintain recovery. The availability of RSS within a community may help reduce preventable treatment readmission rates, deter criminal activity and offer a safe and drug free alternative. RSS may also increase the likelihood of sustained recovery which allows an individual to contribute positively to family, community and economic well-being.

The survey should take about 20 minutes to complete. Please answer questions to the best of your knowledge; there is no need to survey your providers.

Everyone who returns a survey will be eligible to win a free UCLA training for your providers on the topic of your choice. Thank you for agreeing to participate in this survey!

DEFINITIONS

Treatment: Comprises structured interventions with specific pharmacological and/or psychosocial techniques aimed at reducing or abstaining from the use of illegal drugs.

Recovery: A voluntarily maintained lifestyle comprised of sobriety, personal health and citizenship (Betty Ford Institute, 2007)

Recovery Support Services (RSS): are nonclinical services that assist individuals and families to recover from alcohol or drug problems. These services can be flexibly staged and may be provided prior to, during, and after treatment. According to CSAT (2010) RSS:

- Assist individuals & families working toward recovery.
- Incorporate a full range of social, legal, and other services that facilitate recovery and wellness.
- Include social supports, linkage to and coordination among allied service providers, and other services that improve quality of life for people seeking recovery.
- May be provided before, during, or after formal clinical treatment or to those individuals who are not in treatment but need and seek support services.
- Are provided by professionals, volunteers, and/or peers
- Are delivered through a variety of community and faith-based groups, treatment providers, and other RSS providers**.**

Goals of RSS:

- To intervene earlier (pre-treatment) with individuals with substance use problems;
- To improve treatment outcomes; and
- To support long-term recovery for those with substance use disorders.

DEMOGRAPHICS

A. County: _____

B. Department: _____

C. Are RSS for substance use disorders (SUD) funded within your County?

CLICK ONE

☐ YES
☐ NO
☐ Don't know

D. Does your county currently provide recovery support services inside and/or outside of SUD treatment? *Some examples of RSS may include Sober Living Homes, Recovery Coaches, Continuing Care, Ongoing Recovery Monitoring, Mutual Help Groups, etc.*

CLICK ONE

☐ YES
☐ NO **(If C <u>and</u> D are no, SKIP to Question 14)**

E. Of your county-operated or county-contracted clinics, how many provide recovery support services for substance use disorders? _____ *(best estimate is acceptable)*

In this section, we will be asking you about recovery support service SETTINGS.

1. Recovery Centers are locations for people seeking to obtain or maintain recovery. *Examples of recovery centers are "recovery hubs" or "recovery resource centers, recovery community organizations.* Recovery programming offered may include social, emotional, and/or educational support to help prevent relapse or promote recovery. Recovery Center services are usually open to anyone within the community (regardless of treatment status) and may function as a clubhouse in terms of recovery fellowship and offer a wide spectrum of RSS.

Does your county have **Recovery Centers**?

- ☐ Yes
  - If Yes approximately how many (regardless of funding source): _____
- ☐ No (If no, skip to Question 2)
- ☐ Don't Know

Comments: _____
_____

2. Recovery School programs vary in their design, but generally combine special RSS, with an emphasis on academic excellence. The former may include special faculty guidance, recovery dorms, recovery support meetings, recovery drop-in centers, sober social activities, and peer mentoring. The latter is achieved through academic guidance, study centers, and peer-tutoring programs.

Does your county have **Recovery Schools**?

- ☐ Yes
  - If Yes approximately how many (regardless of funding source): _____
- ☐ No (If no, skip to Question 3)
- ☐ Don't Know

Comments: _____
_____

3. Faith-Based/Recovery Ministries: Some recovery mutual-aid societies use religious ideas or rituals, and a faith community to initiate or sustain recovery and enhance the quality of life. *Some examples are Celebrate Recovery, Victorious Ladies, etc.*

Does your county have **Faith-Based/Recovery Ministries**?

- ☐ Yes
  - If Yes approximately how many how many (regardless of funding source): ____
- ☐ No (If no, skip to Question 4)
- ☐ Don't Know

Comments: _____
_____

4. Recovery Homes/Sober Living: May include sober living homes, transitional living, etc (not to be confused with medical homes). *Some examples are Oxford House, Clean and Sober Transitional Living, etc.*

Does your county have **Recovery Homes/Sober Living**?

- ☐ Yes
  - If Yes approximately how many how many (regardless of funding source): ____
- ☐ No (If no, skip to Question 4)
- ☐ Don't Know

Comments: _____

In following sections, we would like to ask you about RSS staffing and RSS services offered within recovery support settings.

5. What staff are located at the following recovery support SETTINGS (Check All That Apply):

	Not Applicable	Professional / Clinician (MSW, PhD, PsyD, MFT, etc)	Medical (MD, DO, etc)	Certified Addiction Counselors	Peer	Volunteer	Ministers / Faith Based Addiction Counselors	Other
Recovery Centers	☐	☐	☐	☐	☐	☐	☐	☐
Recovery Schools	☐	☐	☐	☐	☐	☐	☐	☐
Faith-Based/Recovery Ministries	☐	☐	☐	☐	☐	☐	☐	☐
Recovery Homes/Sober Living	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐

Comments:_____
_____

6. WHERE are the following recovery support SERVICES provided? (Check ALL that apply):

	N/A	Residential or Inpatient Treatment	Outpatient Treatment	Recovery Home / Sober Living	Recovery Center	Recovery School	Faith-Based Ministry	Mobile Unit	Other
Telephone Continuing Care	☐	☐	☐	☐	☐	☐	☐	☐	☐
Internet-Based Recovery (Ex: Recovery Blogs, Recovery Social Networks, online recovery coaching, monitoring or assessment, internet based continuing care, telepsychiatry, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recovery Check-ups or Ongoing Recovery Monitoring	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recovery Coaching	☐	☐	☐	☐	☐	☐	☐	☐	☐
Relapse Prevention	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse Education	☐	☐	☐	☐	☐	☐	☐	☐	☐
Education (G.E.D., etc)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parent education and child development support services;	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family/ Marriage Education	☐	☐	☐	☐	☐	☐	☐	☐	☐
Employment Services and Job training	☐	☐	☐	☐	☐	☐	☐	☐	☐
Housing Assistance and services	☐	☐	☐	☐	☐	☐	☐	☐	☐

	N/A	Residential or Inpatient Treatment	Outpatient Treatment	Recovery Home / Sober Living	Recovery Center	Recovery School	Faith-Based Ministry	Mobile Unit	Other
Life skills;	☐	☐	☐	☐	☐	☐	☐	☐	☐
Case management and individual services coordination, providing linkages with other services (e.g., legal services, Temporary Assistance for Needy Families, social services, food stamps);	☐	☐	☐	☐	☐	☐	☐	☐	☐
Transportation to and from treatment, recovery support activities, employment, etc.;	☐	☐	☐	☐	☐	☐	☐	☐	☐
Childcare	☐	☐	☐	☐	☐	☐	☐	☐	☐
Outreach	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peer-to-peer services and mentoring	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self-help and support groups (e.g., 12-step groups, SMART Recovery, Women for Sobriety);	☐	☐	☐	☐	☐	☐	☐	☐	☐
Spiritual and faith-based support;	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:_____
_____

7. What STAFF provide or organize recovery support services (Check ALL that apply):

	Not Applicable	Clinician (MSW, PhD, PsyD, MFT, etc)	Medical Professional (MD, DO, etc)	Certified Addiction Counselors	Peer	Volunteer	Ministers / Faith Based Addiction Counselors	Other
Telephone Continuing Care	☐	☐	☐	☐	☐	☐	☐	☐
Internet-Based Recovery (Ex: Recovery Blogs, Recovery Social Networks, online recovery coaching, monitoring or assessment, internet based continuing care, telepsychiatry, etc.)	☐	☐	☐	☐	☐	☐	☐	☐
Recovery Check-ups or Ongoing Recovery Monitoring	☐	☐	☐	☐	☐	☐	☐	☐
Recovery Coaching	☐	☐	☐	☐	☐	☐	☐	☐
Relapse Prevention	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse Education	☐	☐	☐	☐	☐	☐	☐	☐
Education (G.E.D., etc)	☐	☐	☐	☐	☐	☐	☐	☐
Parent education and child development support services;	☐	☐	☐	☐	☐	☐	☐	☐
Family/ Marriage Education	☐	☐	☐	☐	☐	☐	☐	☐
Employment Services and Job training	☐	☐	☐	☐	☐	☐	☐	☐

	Not Applicable	Clinician (MSW, PhD, PsyD, MFT, etc)	Medical Professional (MD, DO, etc)	Certified Addiction Counselors	Peer	Volunteer	Ministers / Faith Based Addiction Counselors	Other
Housing Assistance and services	☐	☐	☐	☐	☐	☐	☐	☐
Life skills	☐	☐	☐	☐	☐	☐	☐	☐
Case management and individual services coordination, providing linkages with other services (e.g., legal services, Temporary Assistance for Needy Families, social services, food stamps);	☐	☐	☐	☐	☐	☐	☐	☐
Transportation to and from treatment, recovery support activities, employment, etc.;	☐	☐	☐	☐	☐	☐	☐	☐
Childcare	☐	☐	☐	☐	☐	☐	☐	☐
Outreach	☐	☐	☐	☐	☐	☐	☐	☐
Peer-to-peer services and mentoring	☐	☐	☐	☐	☐	☐	☐	☐
Self-help and support groups (e.g., 12-step groups, SMART Recovery, Women for Sobriety);	☐	☐	☐	☐	☐	☐	☐	☐
Spiritual and faith-based support;	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐

Comments:_____

8. Please rate the IMPORTANCE of the following recovery support services to an individuals' recovery (Check One for each RSS):

	Very Important	Important	Moderately Important	Of Little Importance	Unimportant
Telephone Continuing Care	☐	☐	☐	☐	☐
Internet-Based Recovery (Ex: Recovery Blogs, Recovery Social Networks, online recovery coaching, monitoring or assessment, internet based continuing care, telepsychiatry, etc.)	☐	☐	☐	☐	☐
Recovery Check-ups or Ongoing Recovery Monitoring	☐	☐	☐	☐	☐
Recovery Coaching	☐	☐	☐	☐	☐
Relapse Prevention	☐	☐	☐	☐	☐
Substance Abuse Education	☐	☐	☐	☐	☐
Education (G.E.D., etc)	☐	☐	☐	☐	☐
Parent education and child development support services;	☐	☐	☐	☐	☐
Family/ Marriage Education	☐	☐	☐	☐	☐
Employment Services and Job training	☐	☐	☐	☐	☐
Housing Assistance and services	☐	☐	☐	☐	☐

	Very Important	Important	Moderately Important	Of Little Importance	Unimportant
Life skills	☐	☐	☐	☐	☐
Case management and individual services coordination, providing linkages with other services (e.g., legal services, Temporary Assistance for Needy Families, social services, food stamps);	☐	☐	☐	☐	☐
Transportation to and from treatment, recovery support activities, employment, etc.;	☐	☐	☐	☐	☐
Childcare	☐	☐	☐	☐	☐
Outreach	☐	☐	☐	☐	☐
Peer-to-peer services and mentoring	☐	☐	☐	☐	☐
Self-help and support groups (e.g., 12-step groups, SMART Recovery, Women for Sobriety);	☐	☐	☐	☐	☐
Spiritual and faith-based support;	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

Comments:_____
_____

MEASUREMENT OF RSS

The next set of questions will ask you about the MEASUREMENT of RSS.

9. Please rate the priority of *measuring* RSS in your county?

- ☐ Very High Priority
- ☐ High Priority
- ☐ Moderate Priority
- ☐ Low Priority
- ☐ Not at All

Required Comments – Why?:
_____
_____

10. Does your county *currently collect* any data on RSS that are provided within your county?

- ☐ No
- ☐ Yes: If yes, what kind of data? (Examples might include: client's perception of care, service utilization data, health outcomes)_____

11. How much need is there for Technical Assistance on the *measurement* of *RSS* in your County?

- ☐ Very High Need
- ☐ High Need
- ☐ Moderate Need
- ☐ Low Need
- ☐ No Need

Required Comments:
_____
_____

12. Please list three barriers to measuring RSS in your county:

1. _____
2. _____
3. _____

FUNDING OF RSS

The next set of questions will ask you about the FUNDING of RSS.

13. What funding sources does your county use to contribute to RSS in your County?

_____
_____

14. Please rate the priority of *funding* RSS in your county?

- ☐ Very High Priority
- ☐ High Priority
- ☐ Moderate Priority
- ☐ Low Priority
- ☐ Not at All

Additional Comments:
_____
_____

15. How much need is there for Technical Assistance on *funding* for RSS?

- ☐ Very High Need
- ☐ High Need
- ☐ Moderate Need
- ☐ Low Need
- ☐ No Need

Additional Comments:
_____
_____

RSS AND HEALTH CARE REFORM

The final set of questions will ask you about your perceptions of RSS and how it relates to the passage of the H.R.3590 - Patient Protection and Affordable Care Act, or more popularly known as the Healthcare Reform bill (HCR).

16. How important are RSS in a persons trajectory of overall improved sobriety, health, and wellness?

- ☐ Very Important
- ☐ Important
- ☐ Moderately Important
- ☐ Of Little Importance
- ☐ Unimportant

Comment:_____
_____

17. In your own words, what is the value of RSS?

Required
Comment:_____
_____

18. How important are RSS under health care reform?

- ☐ Very Important
- ☐ Important
- ☐ Moderately Important
- ☐ Of Little Importance
- ☐ Unimportant

We Strongly Encourage Your
Elaboration:_____
_____
_____
_____

19. Do you have any *concerns* about RSS under healthcare reform?

Required Comment:_____
_____

CLOSING QUESTIONS

20. Is your county conducting any pilot testing on the implementation of RSS, measurement of RSS, or funding of RSS?

- ☐ Yes
- ☐ No

If Yes, Required
Comment:_____
_____

21. May we contact you if we have follow-up questions regarding your responses to this survey?

- ☐ Yes
- ☐ No

Comment:
_____
_____

Best Contact Telephone Number: _____

Best Contact E-Mail: _____

Thank you for your Participation!

APPENDIX 5D

Recovery Self Assessments

Copies of these surveys by O'Connell, Tondora, Kidd, Stayner, Hawkins, and Davidson (2007) may be obtained at: http://www.yale.edu/PRCH/tools/rec_selfassessment.html.

Chapter 6: Planning for Prevention

Rachel Gonzales, Ph.D., Valerie Pearce Antonini, M.P.H., and Stella Lee, B.A.

I. Introduction

Prevention encompasses any service designed to reduce the probability of developing and or increasing the severity of a substance use disorder (American Society of Addiction Medicine, 2001). According to the substance use disorder (SUD) continuum-of-services model, there are three classifications of prevention strategies aimed at targeting risk and protective factors associated with "the probability of developing or increasing the severity of a substance use disorder": primary, secondary, and tertiary.

Primary prevention focuses on reducing the probability that a SUD develops; secondary prevention focuses on minimizing the severity of a substance use problem if it occurs, through screening tests and brief interventions; and tertiary prevention seeks to minimize the disability caused by SUDs and is important in the treatment and recovery support service components of the continuum.

Objectives

Aligned with the California Alcohol and Drug Program (ADP) office's effort in developing capacity for building and mobilizing a "comprehensive, integrated, continuum of AOD services" model within the state (UCLA Integrated Substance Abuse Programs, 2008), primary prevention is a priority area. In collaboration with the UCLA Integrated Substance Abuse Programs' (ISAP) larger EnCal evaluation contract, prevention-related objectives consisted of addressing the following areas:

- **Understanding AOD Prevention Initiatives under Healthcare Reform**
  Conduct formative research with key prevention stakeholders to document efforts addressing AOD prevention initiatives under healthcare reform.

- **Identifying State AOD Vision and Prevention Priorities**
  Under the direction of ADP, we will consult with both internal ADP prevention staff and external Technical Assistance/Training consultants of ADP who have prevention expertise to identify key prevention priority areas deemed necessary for study.

- **Assisting Local Level AOD Prevention Efforts**
  Participate and document the stakeholder discussions at the state, county, or program level within California around strategic planning and activities focused on AOD prevention efforts.

Organization of Chapter

This chapter provides an overview of the above mentioned prevention related objectives and ends with lessons learned and recommendations.

II. Understanding AOD Prevention under Healthcare Reform

Healthcare Reform has impacted the nature by which substance use disorders (SUD) services are conceptualized. As a result, it is imperative to understand how prevention, treatment, and recovery service delivery are being considered at the federal level as healthcare reform is underway.

The national agenda for primary AOD prevention has been a focal point of AOD state departments in terms of understanding "what will be the fate of the prevention delivery system under healthcare reform?"

With key prevention provisions stated in the federal Patient Protection and Affordable Care Act (ACA), prevention for substance use disorders (SUD) remains a high priority under healthcare reform. Just as treatment agencies face significant changes in the way services will be delivered and funded, prevention programs are expected to undergo a similar if not greater degree of change to prepare for reform. While much is still unknown of what the prevention system will look like in the new environment, state and local governments are responsible for much of the stated requirements for the prevention of SUDs. With SUDs included in the classification of chronic disease, SUD prevention services will be eligible for chronic disease prevention dollars and grants that will become available and included in ACA initiatives. This includes coverage of evidence-based preventive health services recommended by the United States Preventive Health Services Task Force (USPSTF), which comprise screening and brief intervention for alcohol misuse and tobacco cessation. This requirement applies to Medicaid plans for the newly eligible population, certain plans in the state health insurance exchanges, Medicare, and new individual and small group plans. In addition to coverage of these recommended alcohol and tobacco prevention services, a new Prevention and Public Health Fund will be created to maximize and sustain the prevention of chronic disease. Initial investment will start at $500 million in fiscal year 2010 and increase to $2 billion per year in fiscal year 2015. This initiative within the ACA is intended to promote the early prevention, detection, and management of disease to improve the overall health and healthcare quality of Americans. Additional dollars will be distributed through the Centers for Disease Control and Prevention to maximize effective and evidence-based prevention programming. These grants will be awarded to state and local government agencies and community-based organizations for evidence-based, community preventive initiatives to reduce chronic disease and the severity of related problems.

An in-depth interview conducted with former Dr. Tom McLellan, former Deputy Director of the Office of National Drug Control Policy (ONDCP), provides insight into this question. Dr. McLellan indicated that an important question to consider for any state entity is the extent to which the "funding mechanisms for AOD prevention will be changed as a result of healthcare reform" — will primary prevention funds continue to be supported through the federal Substance Abuse Prevention and Treatment Block Grant or will this be changed as a result of healthcare reform prevention initiatives? According to Dr. McLellan, due to healthcare reform and the resulting AOD service changes that will occur within the next four years, the current funding objectives of the block grant (including both treatment and prevention) are being re-evaluated. There are discussions to use the block grant funds to support recovery-oriented systems of care

that provide essential services to support wellness and recovery, such as housing, transportation, vocational training, and other recovery support.

In response to an inquiry about prevention efforts, Dr. McLellan reported that the Obama Administration recognizes that the most effective way to keep America's youth drug-free is to prevent them from getting involved with drugs in the first place. Hence, a major focus of the Office of National Drug Control Policy is on identifying effective ways to address prevention. One such initiative that was on the federal agenda was the idea of "prevention prepared communities." However, according to the legislative update from CADCA Aug 4, 2010, the Prevention Prepared Communities did not receive funding by the Senate Appropriations Committee. The Senate Appropriations Committee stated that funding the PPC would be "*redundant given the work of the Partnerships for Success*." Dr. McLellan expressed frustration with this decision and indicated that the PPC initiative still has high importance and priority at the federal level. A point stressed was to ensure that prevention-based strategies were a focal point of AOD state agendas, especially in light of healthcare reform's goal of identifying and using evidence-based prevention models that demonstrate "cost effectiveness." Per Dr. McLellan, much of the work under healthcare reform entails defining what the "service benefit" will look like for AOD-related prevention and treatment. Because there is no clear distinction between treatment and prevention benefit services under healthcare reform at this point, Dr. McLellan stressed the importance of identifying evidence-based services that can be "labeled" as prevention under healthcare reform, such as assessment, screening and brief intervention, and referrals to treatment.

III. Identifying State AOD Vision and Prevention Priorities

The fragmented system of service delivery and the questionable quality of prevention services delivered for substance use is a national priority issue to address. For the California State Department of Alcohol and Drug Programs (ADP), a major focus is directed at developing a Continuum of Care AOD System Model. The new provisions of the ACA will undoubtedly expand the scope of the SUD prevention field and maintain the importance of the adoption and implementation of activities to support SUD prevention among state and county leaders. With this intention in mind, the ADP tasked its Prevention Services to plan and prepare for upcoming changes.

One area of focus under healthcare reform is to identify areas where primary AOD prevention, treatment, and recovery services can be "integrated."

Given that there has been increasing attention given to "early detection and prevention of SUDs" under healthcare reform, a major priority within ADP's move towards this prevention-treatment-recovery integration model, is to focus on how "screening and brief intervention" can be used as an effective integrative vehicle for primary prevention as it meets healthcare reforms' goal of "identifying and using evidence based prevention models that demonstrate cost effectiveness" [as indicated by Dr. McLellan].

AOD Screening and Brief Intervention: A promising and highly recommended practice to improve care, lower costs, and reduce the burden of those needing specialized treatment in a number of settings (Babor, McRee et al. 2007).

In response, the UCLA EnCal team agenda over the past year consisted of many investigative procedures to understand AOD screening and brief intervention, with much activity concerning the assessment of the current state of screening and brief intervention activities in California and the identification of promising practices for further expansion and development under a prevention umbrella. Following, we highlight some exemplar state initiatives:

- *State Dissemination of Screening and Brief Intervention Models.* The UCLA EnCal team developed a *SBIRT White Paper* that comprehensively describes past, current, and future screening and brief intervention related initiatives within the State (Davoudi and Rawson, 2010).

In addition to this paper, the UCLA EnCal team conducted an extensive literature review on screening and brief interventions in diverse settings, including: mental health, healthcare (primary care, emergency room), and criminal justice system. The following briefly summarizes the literature review done by UCLA.

The Need for Increased Access to Drug & Alcohol Interventions

The identification of individuals who are using alcohol and drugs at harmful levels and the delivery of effective and efficient interventions to these people with the goal of reducing their harmful substance use is a priority within the U.S. healthcare system. Despite the availability of evidence-based interventions for substance abuse prevention and treatment, millions of individuals who have or are at risk for substance use disorders are not receiving the care they need (SAMHSA, 2010). The United States has fallen short of several Healthy People 2010 objectives for substance abuse. For example, the 2010 target for past 30-day illicit drug use among adults was 3.2% (National Center for Health Statistics, 2008). As of 2009, the prevalence of past 30-day illicit drug use among adults was 13.8%. The 2010 target for binge drinking (5+ drinks on the same occasion) among adults was 13.4%; however, in 2009, 24.1% of adults reported binge drinking. Additionally, the 2010 target for the provision of addiction treatment for individuals ages 12 and over with either alcohol or drug use dependence was 16%. As of 2009, only 11.2% of individuals in need of treatment received treatment (SAMHSA, 2010). In sum, multiple channels for reaching individuals with or at risk for substance use disorders are needed to increase access to helpful interventions.

Screening, Brief Intervention, and Referral to Treatment (SBIRT): An Evidence-based Program for Addressing Substance Use in Healthcare Settings

The development of substance use prevention strategies for community settings is a priority included in the National Prevention and Health Promotion Strategy, a set of guidelines developed by the U.S. Surgeon General and the National Prevention, Health Promotion and Public Health Council (National Center for Health Statistics, 2008). The National Prevention and Health Promotion Strategy identified substance use screening and brief intervention as one of its high value preventive care practices. The health promotion approach "Screening, Brief Intervention, and Referral to Treatment" (SBIRT) has received considerable attention among researchers, clinicians, and policy makers over the past decade. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with

substance use disorders, as well as those who are at risk of developing these disorders (Madras, Compton et al., 2009). The SBIRT model derives from a long line of research on screening and brief intervention for heavy drinkers. Randomized, clinical trials of brief alcohol interventions found favorable results among heavy drinkers intercepted in primary care (WHO Brief Intervention Study Group, 1996; Fleming, Barry et al., 1997; Saitz, Horton et al., 2003), trauma centers (Gentilello, Rivara et al., 1999), and emergency departments (D'Onofrio & Degutis, 2002; Academic ED SBIRT Research Collaborative, 2007). Project TREAT (Trial of Early Alcohol Treatment) was a large-scale randomized clinical trial of brief interventions to reduce heavy drinking and improve health status among primary care patients. This study demonstrated 40–50% reductions in alcohol use as well as reductions in emergency department visits, motor vehicle accidents, and legal events (Fleming, Barry et al., 1997).

Other research by Saitz (Co-Investigator) enrolled 341 subjects in a randomized trial that had 90% follow-up over 3- and 12-month time points. This study tested a manualized brief alcohol intervention for medical inpatients in which 65% of eligible participants enrolled in the study. The intervention increased linkage with alcohol treatment for women and younger men but did not affect consumption or consequences, likely in part because the majority identified suffered from dependence (Saitz, Palfai et al., 2007).

Compared with alcohol, less is known about the efficacy of brief interventions in general medical settings for reducing illicit drug use. A randomized, controlled trial of a brief intervention for cocaine and heroin use conducted in outpatient clinics in Boston reported that cocaine and heroin users in the brief intervention condition had higher odds of abstinence at the 6-month follow-up compared with users in the control condition (Bernstein, Bernstein et al., 2005). An intervention study with illicit drug users was conducted by the World Health Organization (WHO) in partnership with an international team of researchers including one of our Co-Investigators (Ling). Using the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the accompanying single-session brief intervention, Humeniuk et al. found reduced cannabis and stimulant use and lower risk levels among patients who received the brief intervention compared with patients in the wait list control group (Humeniuk, Dennington et al., 2008). Patients in the WHO ASSIST study were recruited from primary care settings in the United States, Australia, Brazil, and India. Country-specific analyses revealed that in the United States, participants reduced their cannabis and stimulant use comparably across the ASSIST-only and ASSIST-plus-brief-intervention conditions. This finding suggested that the ASSIST itself may have therapeutic value and that in the United States, SBIRT research studies are advised to include a control group that excludes the ASSIST.

A recently completed study conducted by ISAP principal investigator (Rawson) evaluated SBIRT in a criminal justice population (Integrated Substance Abuse Programs, 2010). The study delivered the ASSIST and its accompanying brief intervention to a sample of 951 participants upon their release from jail. At the 6-month follow-up, participants' drug and alcohol use decreased substantially. Participants reported drinking less and using all other drugs on fewer days. The number of participants in outpatient treatment also increased. Additionally, subsequent criminal justice involvement decreased dramatically. Participants also reported being arrested fewer times, spending fewer nights in jail, and committing fewer crimes.

The Importance of Mental Health Treatment Settings in Substance Use Prevention and Intervention

A particularly vulnerable population in need of substance use prevention and treatment are individuals who have co-occurring substance use and mental health disorders. The relationship between substance use disorders and mental health disorders is well-established in the United States (Grant, Stinson et al., 2004; Harris & Edlund, 2005; Clark, Power et al., 2008). The 2009 National Survey on Drug Use and Health (N = 68,700) found that heavy drinking and illicit drug use were higher among individuals who reported a serious mental illness in the past year (SAMHSA, 2010). For example, past-year illicit drug use was reported by 31.3% of individuals with a serious mental illness, as compared with 11.6% for individuals without a mental illness. Moreover, the proportion of individuals with a serious mental illness who reported binge drinking in the past month was 29.4%, as contrasted with 24.1% for individuals without a mental illness (SAMHSA, 2010). Substance use has repeatedly been observed in mental health treatment populations (Kedote, Brousselle et al., 2008; Satre, Wolfe et al., 2008; Weaver, Conover et al., 2008). In an alcohol and drug use screening program in an outpatient psychiatric clinic in Northern California, Satre et al. found that among patients aged 18–91, heavy (binge) drinking in the past month was reported by 41% of men and 23% of women. Past-month cannabis use was reported by 13% of men and 11% of women (Satre, Wolfe et al., 2008).

Rehabilitation programs for substance use disorders have limited reach because the consumer demand for specialty care is limited. Few people with substance use disorders seek treatment on their own. Grant et al. found that only 5.8% of people with a 12-month alcohol use disorder and 13.1% of people with a drug use disorder sought treatment for these disorders (Grant, Stinson et al., 2004). On the other hand, a higher proportion of people with mental health disorders seek treatment. Among individuals with at least one 12-month mood disorder, 25.8% sought treatment in the past 12 months. Similarly, among individuals with co-occurring substance use and mental health disorders, a higher proportion receive mental healthcare compared to treatment for substance use disorders. Data from the 2009 National Survey on Drug Use and Health show that among adults with co-occurring mental health and substance use disorders, approximately 44% received substance abuse or mental health treatment in the past year (SAMHSA, 2010). Among the 44% who received treatment in the past year, 33% received only mental health treatment, 4% received only substance abuse treatment, and 7% received mental health and substance abuse treatment (SAMHSA, 2010). Higher rates of mental health service utilization among individuals with co-occurring disorders have also been found (Hatzenbuehler, Keyes et al., 2008; Weaver, Conover et al., 2008).

Expanding Substance Use Interventions through SBIRT in Mental Health Settings

The implementation of SBIRT approaches in mental health treatment settings may prove to be an important means of significantly expanding the delivery of empirically supported interventions for substance use. Underlying the low rates of addiction treatment in the United States is the fact that a majority of individuals with substance use disorders do not perceive a need for treatment (SAMHSA, 2010). Pro-active and multi-pronged strategies are needed to better identify potential substance use disorders and engage individuals in treatment when necessary. If health and human services systems in the United States manage to engage 45% of individuals with co-

occurring disorders in mental health therapy, substantial opportunity clearly exists in mental health settings for early identification of substance use disorders and linkage with addiction treatment. SAMHSA suggests that diverse health services can play a role in linking patients with substance use disorders to specialty care. For example, SAMHSA recommends that all individuals presenting for treatment for a mental disorder be screened routinely for any substance use disorder (Clark, Power et al., 2008). The SBIRT approach is very consistent with this recommendation.

A study conducted by the ISAP principal investigator (Rawson) and co-investigator (Spear) implemented SBIRT in a large university mental health counseling center via funding from SAMHSA (Spear, Tillman et al., 2009). The counseling center incorporated a pre-screen into routine care for all intake visits. The ASSIST was then administered to those who screened positive for risky alcohol use. From 2006–2009, over 8,000 students were screened. Staff clinicians subsequently administered the ASSIST with 1,534 students. Among students who reported binge drinking and who received the brief intervention, 57.1% reported fewer binge drinking days at the 6-month follow-up. Among students who reported marijuana use at baseline and who received a brief intervention, 61.5% reported fewer days of use at follow-up. A significant proportion of students who received the brief intervention reported no binge drinking or marijuana use at follow-up. Among students who reported binge drinking at baseline, 18.9% reported no binge drinking days at follow-up (29.5% for women vs. 8.7% for men). Likewise, among those students who reported marijuana use at baseline, 31.7% reported no marijuana use at follow-up (43% for women vs. 21.3% for men). This study suggested that SBIRT could be successfully implemented for this very specific mental health patient population in this specialized mental health setting.

Beyond this initial study by members of the research team, research on SBIRT in mental health settings is scant. What is known to date is that patients with problem drinking and possible dependence do seek care in mental health settings and that routine screening is needed in these settings. A study by Weisner and Matzger found that 33% of problem drinkers in a general population sample reported having a mental health visit in the past year (Weisner & Matzger, 2003). Among these patients who sought mental healthcare, over one-third did not have their drinking addressed during their visit. Moreover, women had lower odds of having their drinking addressed compared with men. In sum, the literature suggests that there is an unmet need for screening and intervention for substance use in mental health settings and that the mental health visit provides a critical opportunity as an entry point for intervention and referral to specialty care since persons are far more likely to seek help for mental health disorders than substance abuse disorders.

IV. Assisting Local Level AOD Prevention Efforts

Given the importance of "prevention" and the federal goal of "preparing local communities," the UCLA EnCAL team engaged in discussions with primary prevention AOD representatives throughout the state, including ADP's Prevention Services Branch and the CADPAAC prevention committee.

Local efforts around the state have been directed at "understanding the impact healthcare reform will have on the primary AOD prevention delivery system."

An important goal of these entities representing prevention throughout the state was "to better understand and/or improve the bridge between Prevention and Treatment as it related to healthcare reform." Like the state priority, the topic of interest at the local level was how screening and brief intervention can or will be utilized as a prevention strategy/service for the indicated population and current progress already underway in this area.

Collaboratively with ADP's Prevention Services Branch, the UCLA EnCAL team engaged in various efforts with the CADPAAC prevention committee to obtain regular updates on AOD prevention efforts happening throughout the state, with an emphasis on healthcare reform prevention-treatment-recovery integration models. Following are highlights of some exemplar local initiatives:

- *Screening and Brief Intervention as Evidence-Based Prevention Project*. The UCLA EnCAL team worked with the Napa County staff to implement the Screening and Brief Interventions as an evidence-based prevention practice at the local level. A series of conference calls were conducted with local level AOD prevention representatives (of Napa County and the Carey Group) to discuss strategic planning around this effort.

- *Technical Assistance*. ADP's Prevention Branch inquired with UCLA EnCAL team for our Integration Forum survey questions sent to local stakeholders for their planning purposes. See Appendix 6A for the questions ADP's Prevention Branch sent to counties regarding health reform and prevention.

V. Lessons Learned and Recommendations

The provision of AOD prevention services in California are expected to be impacted substantially under federal healthcare reform. The following are challenges and recommendations for preparing for these changes:

Close the gap for AOD Screening and Brief Intervention Reimbursement

The Challenge

Beginning in January 2007, new Medicaid codes were approved by the Center for Medicaid Services (CMS), which provided the opportunity to bill for SBIRT activities. In California, however, the current state of this SBI billing initiative is not active (i.e., "turned on"). This creates challenges for counties to bill for SBI-related activities and receive proper reimbursement for prevention-related SBI services.

Recommendations

It is recommended that the California ADP Prevention Branch begin to identify key linkages between prevention stakeholders in various settings where SBI efforts can occur, including primary care/emergency rooms, nurse/home visitation programs, student/employee assistance programs, school-based programs, mental health settings, and juvenile detention programs. This will enable the development of cross-system linkages between state systems working to bridge SUD prevention.

It is recommended that the state ADP Prevention Branch work with key stakeholders in these various settings (i.e., primary care/emergency rooms, nurse/home visitation programs, student/employee assistance programs, school-based programs, mental health settings, and juvenile detention programs) to begin to identify core SBI data elements that would allow for the tracking of SUD patients using SBI-related data across these various settings.

It is recommended that the state ADP Prevention Branch work with local level (county) prevention representatives to begin to create plans for developing and implementing a unified SBI prevention data system in order to track who is receiving SBI services, the costs of those services, and associated outcomes.

Consider SBI Implementation Challenges in the context of Prevention

The Challenge

Based on our extensive literature review, there are some implementation challenges for SBI that need to be addressed. Specifically, there are challenges when attempting to integrate prevention services (i.e., screening and brief interventions) when using diverse, multiple channels attempting to reach individuals with or at risk for substance use disorders including primary healthcare settings, mental health systems, educational settings, workplace settings, and criminal justice based settings, such as (1) lack of time from professionals, (2) insufficient training for and

motivation from professionals, and (3) organizational limitations such as administrative opposition and competing concerns.

Recommendations

It is recommended that the state ADP develop a series of SBI case studies or pilot programs at the local level within various diverse settings to understand these implementation challenges and identify solutions to address them.

It is recommended that through these SBI case studies, the state ADP develop the needed tools, resources, and methods to overcome such implementation barriers (i.e., referral plans and models for SUD patients within diverse settings).

Enhance the Collaboration between SUD Treatment and Prevention Systems on SBI Integration Efforts

The Challenge

Currently there are ongoing duplicative efforts addressing SBI integration work within the two SUD systems (i.e., surveys and partnering models).

Recommendations

It is recommended that the state ADP promote cross-system workforce collaboration between prevention and treatment branches around SBI System Integration efforts.

It is recommended that state and county-level prevention stakeholders work with state and local level (county) treatment staff through a SBI System Integration Committee to identify similar and diverse areas of cross-system SBI efforts.

It is recommended that this cross-system SBI committee should clarify definitions related to SBI concepts (i.e., prevention, early intervention, brief intervention and brief treatment) to establish a clear distinction between the role of prevention and the role of treatment. This lack of clarity brings challenges for identifying funding streams, staff roles, and implementation settings.

Appendix 6A: Questions to Counties Regarding Health Reform and Prevention

This short survey will provide helpful information to the Department of Alcohol and Drug Programs to determine ways we can better assist you in future health reform related efforts. Thank you for taking your time to provide this valuable information.

#1 Is your county AOD office <u>currently</u> partnering with other agencies/organizations to prepare for health reform?

- ☐ Yes
- ☐ No

If yes, with whom is the county collaborating and what is the purpose?

#2 Is your county AOD office <u>planning</u> on partnering with other agencies/organizations to prepare for health reform?

- ☐ Yes
- ☐ No

If yes, with whom is the county planning on collaborating and what will the purpose be?

#3 What type of clinic or health center does your county AOD office work with or plan to work with to provide prevention services?

- ☐ Federally Qualified Health Centers
- ☐ Community Based Health Clinics
- ☐ School Based Health Centers
- ☐ None

Other (please specify)

#4 Based on your previous answer, are the prevention services provided:

- ☐ AOD Screenings
- ☐ Brief Interventions
- ☐ Community Based Services
- ☐ None

Other

#5 (Optional) Please provide a brief description of the services you have selected?

#6 What funds is your county currently using or planning to use to support prevention related health reform efforts?

- ☐ Substance Abuse Prevention Treatment Block Grant - Primary Prevention
- ☐ Substance Abuse Prevention Treatment Block Grant - Discretionary
- ☐ Mental Health Services Act - Prevention Early Intervention

Other (please specify)

#7 Are other efforts currently underway through your county AOD office to prepare for health reform related to prevention services?

- ○ Yes
- ○ No

#8 Please provide a brief description of your efforts.

#9 Is your county interested in learning about and/or preparing for health reform as related to prevention services?

- ○ Yes
- ○ No

#10 Would you or your county designee be interested in learning about partnering with healthcare providers?

- ○ Yes
- ○ No

#11 What would be the best method(s) to provide information to your county?

- ☐ Conference calls
- ☐ Email

Other (please specify)

#12 What other interests does your county have regarding health reform and prevention services?

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Chapter 7: Organizational Factors

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Introduction

Organizational adaptation to improve program and patient outcomes is an area of performance monitoring and measurement that has been challenging to systematically operationalize and implement. Given the complexity and uniqueness of each treatment program, identifying and isolating key constructs in the form of specific organizational treatment factors and processes that lead to successful organizational adaptation continues to elude researchers, program managers, and other stakeholders.

In an effort to move closer to unlocking this "black box" and to identify and explain some of the organizational processes that contribute to successful delivery of alcohol and drug services to patients, UCLA conducted exploratory site visits from May 2010–October 2010. These visits provided us with invaluable insight into the experiences of clinical managers and staff of seven AOD treatment programs in Los Angeles County. Through these visits, we now have a richer understanding of the variability among treatment providers in their readiness to use program and patient data to assess their performance, and a greater awareness of how some programs are using these data to make strategic plans and improvements within their organizations. A preliminary analysis of our findings was included in the EnCal 2009–2010 Report. The current 2010–2011 report provides further analysis of findings and seeks to explain the importance of organizational adaptation in light of the fluctuating economic and healthcare policy environment in which California's AOD programs are now operating.

Since substance use disorder treatment organizations vary widely, the first step in preparation for organizational adaptation requires each program to clearly understand its organizational system, climate, and culture. The second step is to identify existing resources to strengthen organizational cohesion and enhance service delivery, and lastly, each organization must utilize its existing resources to strategically carry out its primary organizational goal or aim.

In the current fiscal environment, characterized by diminished state/county funding availability and increased requirements and regulations from funding and regulatory agencies, programs must become increasingly creative in their acquisition and allocation of resources. One way that programs can work to enhance their resources is through potential funding and collaborative opportunities that may be facilitated by new healthcare reform policies.

Process and Findings

Literature Review

Previous work has been done to survey treatment providers' perspectives on the effectiveness of empirically supported treatment interventions, finding that while providers tend to view psychosocial interventions—including Motivational Enhancement Therapy, Solution-Focused

Therapy, Community Reinforcement Approach, Supportive Expressive Psychotherapy, and the Matrix model—as effective forms of treatment, there is substantial variability in their use of these empirically based interventions (Herbeck et al., 2008). Benishek and colleagues (2010) also found a gap between providers' perceptions of the effectiveness of empirically supported treatments and their routine use. Use of these interventions was positively correlated with training resources and providers' perceptions of their effectiveness (Herbeck et al., 2008). Commonly reported barriers to their use include a lack of administrative support and staff time, funding/resource limitations, cost concerns, the need for expert consultation, and a lack of skills needed to implement the intervention (Benishek et al., 2010).

In addition to these barriers, providers who make clinical decisions primarily based on their own clinical and management experience have expressed skepticism or uncertainty about empirically supported interventions (Herbeck, in press). This skepticism can partly be attributed to program managers' belief that over-emphasis on performance measures and their relationship to patient outcomes ignores other important factors that influence patient outcomes, including program differences in patient characteristics, needs, and severity. A study surveying a random sample of outpatient program managers in Pennsylvania found that a substantial number (40%) believed that clinical experience carried more weight than research findings in guiding clinical practice, and nearly the same percentage "believed that empirically-supported treatments could be implemented without specific training (Benishek et al., 2010)."

While management and clinical experience are perceived as vital traits needed to improve program quality and performance, little research has been conducted on "the business of addiction treatment" (McConnell et al., 2009), or how providers actually make clinical and program decisions. Within the field of substance use disorder treatment, McConnell and colleagues (2009) sought to operationalize management practices among substance use disorder programs and found that the following traditional business practices have a significant positive relationship with reducing days to treatment: (1) attention/effort given to patient intake, (2) structure of quality improvement, (3) types of data collected, (4) feedback within the agency, (5) range of goals set for the program, and (6) clarity of goals set for the program.

Along with incorporating these management strategies and principles, drawing on and validating the prior experiences of program managers, may facilitate process improvement efforts. The examination of "expertise-based intuition" within organizations is a new area of study in the management field that may help explain the process of decision-making among treatment program leadership (Salas et al., 2010). This type of "educated intuition" may enhance program managers' ability to learn and adapt by drawing on prior experience to make critical decisions. It may also help managers quickly identify smaller adjustments to organizational functioning that can result in significant improvements to program operations and performance outcomes.
Differences in the quality of service delivery and patient outcomes can be attributed to a treatment program's ability to identify and manage its unique organizational social context (OSC; Glisson, 2010). A program's organizational social context influences the attitudes and behavior of program management and staff. According to Glisson (2010), effective organizations have OSCs that support their treatment and practice technologies. These OSCs can be developed through specific interventions and strategies based on organizational culture and climate. In addition to understanding the roles of organizational culture and climate in

organizational adaptation, it may be useful to explore organizational systems theory and the process of collaboration in reaching short- and long-term organizational goals and obtaining positive outcomes (Deming, 1994).

Methods for Exploratory Site Visits

Programs were selected as potential site visit locations by modality—Narcotic Treatment Program (NTP), Residential, Outpatient Drug Free (ODF), by size—over 60 patients admitted in the first and second fiscal quarters of 2009, and by their relatively high or low levels of engagement and/or retention (Source: Los Angeles County Participant Reporting System October – December 2009 Site Reports).

Programs with *relatively low engagement* were defined as having less than 45% of their patients remain in the program 30 or more days. Programs with *relatively high engagement* retained at least 80% of their patients 30 or more days. Programs with *relatively low retention* retained fewer than 30% of their patients at least 90 days, or had reported exit interviews for fewer than 30% of their patients. Programs with *relatively high retention* reported keeping at least 80% of their patients 90 or more days, or reported exit interviews for at least 80% of their patients.

Two to three programs in each modality and engagement/retention category were identified as potential sites to visit. A research assistant called, and if email addresses were available, emailed the program directors to schedule the visits.

A flexible semi-structured site visit protocol was developed to guide each visit with the program manager/director. The protocol included seven components:

1. Tour of the program's facilities
2. The program's "yardstick" for measuring its success
3. How the program deals with big changes
4. The program's current experience with performance measurement
5. The program's current experience with performance management
6. Specific training desires
7. A brief visit with counselors and other program staff.

In the 2010–2011 fiscal year, one of the program clinical directors of a site we visited requested "tools" to help him find out more about and implement performance measures to track program and patient progress. As a result, UCLA put together a binder of materials including a 2004 RAND report titled *Getting to Outcomes*. This report provides practical materials for treatment providers to implement performance monitoring and measurement. As a way to build rapport, we provided all four programs visited in the 2010–11 fiscal year with a binder that included the *Getting to Outcomes* report.

From May – October 2010, UCLA visited seven substance use disorder treatment organizations. Table 1 below describes the type of program visited by modality and engagement/retention category.

Table 1. Programs Visited by Engagement/Retention & Modality Type

Modality	***Relatively Low*** **Engagement/Retention**	***Relatively High*** **Engagement/Rentention**	**# of Visits per Modality**
Outpatient Drug Free (ODF)	X X	X	**3**
Residential (Res)	X	X X	**3**
Narcotic Treatment Program (NTP)	--	X	**1**
# Visits by Engagement/Retention Category	**3 ("*Low*")**	**4 ("*High*")**	**N=7**

Findings – Summary of Themes from Seven Site Visits

Effective leadership fostering collaboration and cohesion

Leadership is the overarching element that influences all aspects of treatment program organization and operations, including the utilization of patient and program data to improve organizational functioning. Effective leadership fosters collaboration at all levels of the organization and seeks to unite staff in their work toward helping patients adhere to their treatment plans and achieve success.

High engagement/retention programs generally exhibited work environments that fostered collaboration and cohesion. During one site visit, the program manager praised a relatively new staff member as "computer-savvy." He enlisted her help in accessing data summaries from their sophisticated database. Likewise, two other *High* programs felt cohesive. In other words, the staff and management appeared to get along well. At the remaining *High* program, tensions between staff and management were observed. Very little interaction between staff and management was observed in the *Low* programs.

Given our limited observations of each program during our seven site visits, it is difficult to tease out specific constructs or proxies for effective leadership. However, literature on toxic/destructive leadership may provide insight into how to measure leadership effectiveness. Pelletier (2010) provides a useful list of leader behavior scale items to assess the degree of leadership effectiveness within organizations.

Patient-staff relationship

The emphasis on the quality of the patient-staff relationship was a key element in programs with *relatively high engagement and retention (High).* As mentioned in the EnCal 2009–2010 Organizational Treatment Factors Report, having an "open-door" policy with patients promoted

positive relationships between patients and the clinical director. Development of a personal one-on-one relationship with patients was specifically mentioned by program leadership. One program manager pointed out that his patients have sought to maintain contact through social networking sites like Facebook. Off-site informal get-togethers were also mentioned. During another site visit, patients freely "popped-in" to talk to the clinical director and discuss their current situation and their plans for the future.

Accreditation, licensing, and building staff capacity

Two of the programs visited were accredited by the Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO). One program regarded the Joint Commission as key in keeping the program continually improving. This program undergoes a recertification process every three years. Another Joint Commission-accredited program had undergone a county audit shortly before the UCLA site visit. One *High* Residential program provided UCLA research staff with a copy of the program's accreditation document. Local and national oversight agencies were mentioned as impetuses providing program leadership with the motivation to maintain high standards of quality and patient care.

One *Low* program was eager to receive training, but also mentioned that the training would have to have an immediate feedback component to guarantee successful implementation.

Primary sources of funding

Programs with *relatively high engagement and retention* tended to have funding sources that were not exclusively public, while those with *relatively low engagement and retention* tended to rely heavily on public funding sources. The leadership within *High* programs sought alternative sources of funding and utilized networking skills. Or, if funding was not immediately available, they limited public "beds" in favor of self-pay or insurance patients. *Low* programs typically relied heavily on Drug Medi-Cal, or county contracts.

Familiarity with and use of performance measures or organizational "yardsticks" for measuring success

High Programs typically used established (created either in-house or by a third party) data systems that tracked patient progress. Two of these programs had sophisticated databases that enabled them to quickly access patient demographics and treatment plans. Another two *High* programs did not have sophisticated patient data collection and tracking systems; however, one of these programs expressed an interest in learning about new ways of measuring program performance and patient outcomes.

Ability to tailor the program to specific patient needs

We found that those programs that used creativity in adapting to the needs of their patients were among those in the *High* group. One *High* group program with low-income patients provides a shuttle service to group sessions. Another *High* program provides a meditation room/sanctuary for their patients. *High* programs also tended to provide auxiliary services to promote general

health. For example, one program provides their patients with passes to a fitness center. Life skills trainings, including vocational counseling, money management, and resume workshops, were also provided by a *High* program.

Among the programs visited, most expressed a desire to make organizational changes to run their programs more effectively and better serve their patients. For example, one *Low* program director wanted training and was open to accepting assistance in data collection procedures to track program performance. And a *High* program was interested in studying the tools from *Getting to Outcomes* (RAND, 2004).

Transparency

Interestingly, all four of the *High* programs provided a tangible paper document—either copies of instruments/forms, data summaries, data domains/definitions, or credentials. On the other hand, only one of the *Low* programs provided documentation. These examples of transparency, demonstrated through the sharing of information, could be constructs indicating preparation for organizational adaptation or readiness to change.

Summary and Recommendations

Since our EnCal 2009–2010 Report, we have continued to visit sites and identify elements of effective organizational functioning across programs according to their self-reported levels of engagement and retention. While engagement and retention are concrete performance measures that appear to be straightforward to collect, we suspect that some treatment providers may have limited experience in collecting these data and may need additional technical assistance to accurately collect and report patient admissions and discharges from which engagement and retention are computed.

Provide regularly scheduled standardized training to define terms and procedures

While we observed that treatment programs differ in their degree of organizational functioning, one commonly expressed need was standardized definitions of commonly used data terms and collection and reporting procedures. The dissemination of the "How to do CalOMS" webinar may be helping to address this need.

Provide technical assistance to providers on how to use data to improve organizational functioning by making process improvements

Once providers are trained on how to accurately acquire patient data, they are ready to learn how to use these data to improve their organizational functioning and to make tailored plans to track performance. We recommend developing a technical assistance module (which includes a feedback mechanism) to teach providers how to use and interpret engagement and retention data.

Make data relevant to program managers and their staff and patients

When program managers and staff feel that a system-wide data collection system tracking their patients continuum of care is relevant to them, they will begin to feel an interest in using patient data to monitor and improve organizational functioning. Timely and appropriate feedback after technical assistance sessions will help providers feel more invested in using data to track patient engagement, retention, and encounters. We recommend developing a mechanism for regular communication with and input from providers that would involve them in the process of identifying ways to use clinical data to improve organizational functioning.

Explore a patient-provider "rapport" measure

While it is beneficial for providers to know how to collect, report, and use data such admission and discharge data and the engagement and retention levels computed from admission and discharge data to make strategic decisions for their programs, other "interpersonal" measures, such as "developing rapport" or having an "open-door" policy that measure patient-provider engagement, while less researched and potentially more challenging to operationalize, are just as important in influencing engagement and retention.

Learn from the past: Integration of substance use disorder and primary healthcare systems

As we consider the integration of the substance use disorder treatment and primary healthcare systems, it may be useful to take the lessons learned from the integration of the substance use disorder and mental health treatment systems. Grella et al. (2004), provide a summary of literature on problems encountered by patients with co-occurring substance use disorder and mental health disorders when seeking treatment in a bifurcated substance use disorder and mental health system. Over the past 25 years, these two distinct systems have not yet been fully integrated.

However, patient treatment outcomes appear to improve when there are system-level changes establishing "formal structures for inter-program collaboration at the administrative level, in concert with integrated clinical protocols" (Grella et al., 2004). In addition, medical costs appear to diminish after those with substance use disorder-related medical conditions receive treatment in an integrated medical care system (Parthasarathy, et al., 2003). Lemak and Alexander (2001) examined the extent to which managed care was associated with treatment intensity in outpatient facilities. They found that selection of high quality organizations for managed-care participation could improve the overall treatment system. Lower-quality programs would likely be driven out of the system. Specialty Narcotic Treatment Programs may not fare well in such a system, resulting in a lack of access for needed treatment services.

We recommend that ADP take these lessons from the past and use the principles gleaned from previous research findings to prepare treatment organizations to work collaboratively within a system aimed at successful service delivery for patients and optimal program functioning. While this will require creativity and coordination among many entities and individuals, focusing on concrete principles and system aims will result in improved organizational functioning and performance.

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