

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

2013 Report

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Executive Summary

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

The increased coverage of substance use disorder (SUD) services as part of low-income health programs meant to prepare California for health care reform did not lead to increased coordination between health care and specialty care services in the form of referrals. By extension, it may be assumed that the 2014 Medi-Cal expansion and enhanced SUD benefit may not, on their own, result in better coordination. Rather, partnerships need to be actively pursued. Currently, a relatively small number of programs have established such partnerships.

Patients referred from health care to specialty SUD treatment tend to be White, male, and entering detoxification for alcohol use. Female and Hispanic patients are underrepresented.

Data on AB 109 clients (offenders who are being transferred from the state prison system to county systems) is sparse and of questionable accuracy, but their numbers appear to be rising rapidly. Identified AB 109 clients tend to be male, unemployed, and methamphetamine users. Very low enrollment of AB 109 clients in Medi-Cal is of particular concern. Benefits should be suspended during incarceration rather than terminated to avoid gaps in coverage, and Medi-Cal outreach and enrollment efforts should be targeted at soon-to-be released inmates.

Data Indicator Reports for outpatient and methadone-maintenance performance measurement have been deployed. Development of measures for residential treatment and detoxification are being considered in the future.

Drug Medi-Cal data and CalOMS-Tx treatment data can potentially be productively used to perform performance measurement, identification of SUD “hot spots,” cost analyses, and fraud detection.

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

In order to evaluate and assist with California’s efforts to integrate SUD, mental health (MH), and primary care services, information was collected through literature reviews, webinars, conferences, and consultations with stakeholders and integration experts. Within the state, UCLA conducted surveys, focus groups, and evaluations of integration pilot initiatives; facilitated monthly meetings of the California Integration Learning Collaborative; and attended other learning collaboratives in our efforts to gather and share the most current resources on integration.

From these activities, we have documented common barriers and facilitators, as well as key lessons learned from counties throughout the state. The field has made progress in developing tools and shared solutions for supporting integration. Current strategies for achieving integration include evidence-based practices (such as screening, brief intervention, and referral to treatment

[SBIRT] and medication-assisted treatment [MAT]), new organizational models, and via innovations with technology. Promising models and practices continue to emerge, but further research is needed to determine whether these approaches can improve quality and outcomes, while effectively reducing costs. Barriers persist with regard to health care reform implementation, specifically among patient/consumer confidentiality and data sharing practices, electronic health records (EHR) implementation, workforce development needs, financing integrated services. There is currently a tremendous opportunity at hand in which to re-evaluate current policies and regulations that could enhance and better facilitate an integrated health care system in California.

Among counties working on integration, practices and funding strategies varied. Lessons learned from counties are highlighted in this chapter. Cultivating relationships among integration partners, delivering strong leadership, and achieving staff buy-in were important factors in the success of several initiatives. There continues to be high interest in more training throughout the state.

A great deal of work remains ahead across the realms of policy, research, training, and technical assistance. Recommendations at the policy level to lessen the number of potential difficulties providers face include: Drug Medi-Cal certification expansion to include primary care providers (PCPs), lifting the restriction on same-day physical and behavioral Medi-Cal service billing, allowing certification of reasonably sized residential facilities for Medi-Cal reimbursement, and allowing PCPs to be placed in residential treatment programs. In addition to continued investment in research, training, and technical assistance, further recommendations include continuing involvement in collaborative efforts and pilot projects.

Chapter 3: Strategic Planning for Workforce Development: Preparing the Alcohol and Drug (AOD) Workforce for 2014 and Beyond

As SUD and MH integration efforts roll out in California, it is clear that the workforce will require a broad and diverse set of skills. As SUD integration under health care reform is still evolving, the workforce necessary to implement SUD services outside of the specialty system remains unclear. The goal is to prepare our current AOD workforce for the types of settings and practice changes that will occur in SUD treatment delivery, including changes in recovery and prevention services brought forth by health care reform. Recommendations include:

1. A concerted workforce planning effort should be initiated in which key stakeholders and workforce experts work in concert with the Department of Labor Workforce Investment Board (WIB).
2. A series of meetings should be convened to provide a forum for a review of the critical issues that will determine SUD workforce needs as well as discussions and plan development.
3. A transition plan should be created to establish a counselor certification infrastructure in which there is a single counselor certification/license administered by the State of California.
4. The SAMHSA career ladder for SUD counseling should be implemented in California.

5. The state should expand existing training and technical assistance services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment.

These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into Integrated Behavioral Health (IBH) providers in medical settings.

Chapter 4 - Training and Technical Assistance

Over the past year, UCLA provided trainings and technical assistance to facilitate integration across the state. This included in-person trainings, webinars, technical assistance to counties, and technical assistance for the California Institute for Mental Health's Care Integration Collaborative. Training and technical assistance needs related to integration persist throughout the state.

Conclusions

The lessons learned throughout this report support a common conclusion:

On their own, the much-anticipated enhanced SUD benefits and expanded insured population in 2014 will not ensure adequate SUD treatment capacity or integration.

If a number of barriers are not overcome, the enhanced SUD benefits will not be used to their potential. Both the CMSP/Path2Health and LIHP experiences suggested that many treatment programs currently lack the infrastructure and staff training needed to bill Medi-Cal and insurance. Furthermore, the CMSP/Path2Health experience demonstrated that if the claims process is perceived as too complicated or unreliable, benefits may not be used.

In smaller counties, such as those served by CMSP/Path2Health, the costs of building and maintaining a billing infrastructure may outweigh the payments that can be obtained by serving a relatively small number of individuals. UCLA's current CATES training series proposes one solution: the formation of provider networks to share the costs of billing infrastructure as well as, potentially, electronic health records, marketing, and other administrative expenses across many programs. In primary care, such organizations, known as Management Services Organizations (MSOs) or Independent Practice Associations (IPAs), are common.

Integration also holds the promise of making SUD treatment accessible to more patients through primary care. However, programs need to actively pursue partnerships with primary care. As described in Chapter 1, a very small number of treatment programs currently receive an outsized proportion of referrals from health care providers. These programs and their primary care partners are demonstrating that such partnerships can be successful, but the number of programs that have taken this step has, so far, been limited.

Beyond referral arrangements, SUD services can also be *integrated into* primary care. A number of integration initiatives have emerged around the state to attempt this (see Chapter 2). From

these diverse initiatives, a few closely related and recurring lessons have emerged, including the need to educate staff on the importance of integration and to clarify roles, the importance of having a “champion” physician to promote integration, and the need to obtain buy-in among the participants.

Even if education, a champion, and buy-in are present at the ground level, however, there are impediments to integration at the policy level. These barriers include Medi-Cal restrictions on same-day billing for two services (Chapter 2) and the lack of an adequately trained workforce whose services can be reimbursed in primary care settings (Chapters 2 and 3). Without addressing these problems, actions such as activating SBIRT billing codes will likely fail to have the desired effect.

To overcome these barriers, training and technical assistance will continue to play an important role in facilitating the field’s progress. To measure this progress and improve practices and policymaking, the collection and use of valid and reliable data will be critical.

In conclusion, California is continuing to make progress toward integration, but further preparations are still needed to prepare the state for 2014 and beyond.

Preface

Darren Urada, Ph.D.

Today less than 11% of individuals who need substance abuse treatment receive it from the current community-based specialty treatment system (Substance Abuse and Mental Health Services Administration, 2012). One goal of health care reform and related legislation,¹ is to change this by taking the treatment of substance use disorders (SUDs) out of its current “silo” and integrating it with the broader health care system, which reaches a much larger portion of the population. As a result, the SUD treatment field now faces the most significant and sweeping changes that it has experienced in decades (Halvorson, 2010).

Integration with primary care is feasible (Ernst, Miller, & Rollnick, 2007; Madras et al., 2009), and promises better outcomes for patients (Babor et al., 2007; Butler et al., 2008; Parthasarathy, Mertens, Moore, & Weisner, 2003; Saitz et al., 2003, 2010; Samet, Friedman, & Saitz, 2001; Saxon et al., 2006; Weisner et al., 2001; Willenbring & Olsen, 1995, 1999).

Such integration will also play a critically important role in “bending the cost curve” of medical expenses. Medicaid patients with SUD have nearly twice the medical costs of patients without SUD (Boyd et al., 2010), but integrated medical and SUD treatment has been shown to reduce costs by as much as 54% among patients with chronic medical conditions, while also improving care (Parthasarathy et al., 2001, 2003).

At the same time that these health care changes are occurring, another dramatic change is taking place in the form of criminal justice realignment, better known as AB 109,² which is moving lower-level offenders from the state to the 58 counties. This is changing the population that needs and seeks treatment at the county level.

Health care reform and AB 109 are not just two independent changes, but factors that will interact. Preliminary data suggests that SUDs are a primary driver of violations in the AB 109 population. While these individuals may be able to access SUD services more readily in 2014 due to the Medi-Cal expansion, this will only occur if sufficient treatment capacity is available and if these individuals do not lose their health care benefits as a result of incarceration.

This report, produced by the UCLA Integrated Substance Abuse Programs (referred to as “UCLA” in this report) as part of an interagency agreement with the Department of Health Care Services (formerly the Department of Alcohol and Drug Programs), seeks to explore these issues.

- Chapter 1 will explore the latest data on patients entering the specialty SUD treatment system from health care and AB 109 referrals. It also proposes next steps in terms of performance and outcome measurement, and use of data to inform policymaking.

¹ Patient Protection and Affordable Care Act of 2010 (ACA), the American Recovery and Reinvestment Act (ARRA) of 2009 and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

² AB 109 refers to Assembly Bill 109, which was passed by the legislature and signed by Gov. Brown in 2011. Realignment legislation comprised both AB 109 and AB 117, but the original name “AB 109” has remained in common use.

- Chapter 2 discusses current efforts to integrate SUDs within the health care system itself, both nationally and across the state.
- Chapter 3 discusses the critical role that workforce development will play in ensuring delivery of appropriate SUD services.
- Chapter 4 discusses the training and technical assistance activities UCLA has engaged in and plans to engage in to help address the state's needs.
- Chapter 5 summarizes key findings and recommendations from this report.

For further information, see <http://www.uclaisap.org/Affordable-Care-Act/> or contact:

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

Darren Urada, Ph.D.

The increased coverage of substance use disorders (SUD) services as part of low-income health programs meant to prepare California for health care reform did not lead to increased coordination between health care and specialty care services in the form of referrals. By extension, it may be assumed that the 2014 Medi-Cal expansion and enhanced SUD benefit may not on their own result in better coordination. Rather, partnerships need to be actively pursued. Currently, a relatively small number of programs have established such partnerships.

Patients referred from health care to specialty SUD treatment tend to be White, male, and entering detoxification for alcohol use. Female and Hispanic patients are underrepresented.

Data on AB 109 clients (lower-level offenders who are being transferred from state to county systems) is sparse and of questionable accuracy, but their numbers appear to be rising rapidly. Identified AB 109 clients tend to be male, unemployed, and methamphetamine users. Very low enrollment of AB 109 clients in Medi-Cal is of particular concern. Benefits should be suspended during incarceration rather than terminated to avoid gaps in coverage, and Medi-Cal outreach and enrollment efforts should be targeted at soon-to-be released inmates.

Data Indicator Reports for outpatient and methadone-maintenance performance measurement have been deployed. Development of measures for residential treatment and detoxification are being considered in the future.

Drug Medi-Cal data and CalOMS-Tx data can potentially be productively used to measure performance, identify SUD “hot spots,” analyze costs, and detect fraud, which may be useful to policymakers.

I. Introduction

Two major policy changes in California have the potential to dramatically change the number and type of individuals accessing SUD services in the near future. The first is health care reform. California has put into place “bridge to reform” policies in preparation for changes expected in 2014, but little is known about the effect these policies have had on SUD treatment. The second policy change underway is criminal justice realignment (AB 109)³ which is resulting in increased numbers of individuals with SUD being involved in the criminal justice system at the county level. There has been no statewide evaluation of the effect of AB 109 on the number and characteristics of individuals seeking SUD services, however. This chapter provides initial data on individuals referred to specialty care from health care or AB 109, as well as a discussion of what can be done to improve the accuracy of the data on these populations in the future.

³ AB 109 refers to Assembly Bill 109, which was passed by the legislature and signed by Gov. Brown in 2011. Realignment legislation included both AB 109 and AB 117, but the original name “AB 109” has remained in common use.

Currently the best source of data available to measure the number and characteristics of individuals accessing specialty SUD services statewide is the California Outcomes Measurement System, Treatment (CalOMS-Tx). CalOMS-Tx captures data at admission, discharge, and annual updates (where relevant), for all patients entering publicly funded treatment or detoxification facilities for SUDs and all licensed methadone programs in the state (Department of Alcohol and Drug Programs [ADP], 2012). CalOMS-Tx is the only statewide source of patient outcome data for SUD treatment. It therefore plays a central role in current efforts to implement treatment program performance and outcomes measures. We will provide an update on the status of these measures.

When Medi-Cal expands to cover a larger population in 2014, data systems used in the administration of Drug Medi-Cal can potentially become a second important source of information on SUD services. We therefore will discuss potential future uses of Medi-Cal data in tracking and improving SUD services, either alone or in conjunction with CalOMS-Tx data.

Finally, we will present an example of how CalOMS-Tx can be used to make specific policy recommendations. In this case, we focus on a state policy requiring patients to fail detoxification first before being admitted to methadone maintenance treatment.

We begin the chapter by identifying our objectives followed by describing the methods used to address each objective. We include detailed findings and lessons learned drawn from our investigations, and close the chapter with a summary and recommendations.

II. Objectives

This chapter addresses the Department of Health Care Services (DHCS) / UCLA contract Domain 1, entitled “Data Analysis”: Understanding the Changing Field. Below are the two objectives identified under this domain.

1. Examine how ongoing policy changes are affecting who receives SUD treatment and how access, services, costs, and quality of care are being affected. Make recommendations to improve policies, practices, and data quality.
2. Refine program performance and patient outcome measures.

III. Methods

The findings described in this chapter are based on analyses of data from CalOMS-Tx. UCLA obtained this data from ADP (now DHCS) on February 21, 2013.

The findings reported here are descriptive in nature. Inferential statistics (“significance”) are not reported because these statistics are appropriate for determining whether findings in a sample are likely to be found in the larger population, but CalOMS-Tx data essentially represents the population of admissions to publicly funded treatment programs, not a sample. Furthermore,

even if inferential statistics were to be applied, the very large number of cases in CalOMS-Tx would result in “statistical significance” even for differences that are very small and of little to no real-world significance. Therefore, findings include tables and graphs of measures of central tendency such as medians and means (averages), and frequencies (counts) that the reader can examine for differences, and we identify differences of potential real-world importance where relevant.

We examined patient numbers and characteristics for referrals from health care and from AB 109 in particular, and compared these to non-health care referrals and non-AB 109 referrals, respectively.

We also discuss the implementation of performance and outcome measures for treatment programs and counties based on CalOMS-Tx data, and discuss potential future uses of CalOMS-Tx data in association with Medi-Cal data.

IV. Findings

The findings are organized in the following order:

- A. Impact of Policy Changes and SUD Integration with Primary Care and Referrals from the Health Care System
- B. Impact of AB 109 on SUD Treatment
- C. Program Performance and Patient Outcome Measurement
 - 1. Performance and outcome reports based on CalOMS-Tx
 - 2. Proposed ways DHCS can use Drug Medi-Cal and CalOMS-Tx data for performance and outcome measurement and to inform policymaking
 - 3. Methadone detoxification policy example using CalOMS-Tx

A. Impact of Policy Changes and SUD Integration with Primary Care and Referrals from the Health Care System

Referrals from Health Care

SUD services coverage was not associated with changes in admissions to specialty SUD services in the five medium and large counties providing SUD coverage through the Low Income Health Program or the 35 smaller counties participating in the County Medical Services Plan.

Large/Medium Sized Low Income Health Program Counties

The Low Income Health Program (LIHP) was created through a Medicaid waiver often referred to as California’s “bridge to reform.” LIHP provided the opportunity for California counties to expand Medi-Cal in ways that resembled the Medi-Cal expansion expected to occur in 2014 due to the Affordable Care Act (ACA). However, only five counties (Kern, San Francisco, San Mateo, Santa Clara, and Santa Cruz) provided an SUD benefit as part of their LIHP program, and these were generally aimed at narrowly defined populations (for more on LIHP implementation, see Chapter 2). Still, it was plausible that when these counties expanded their

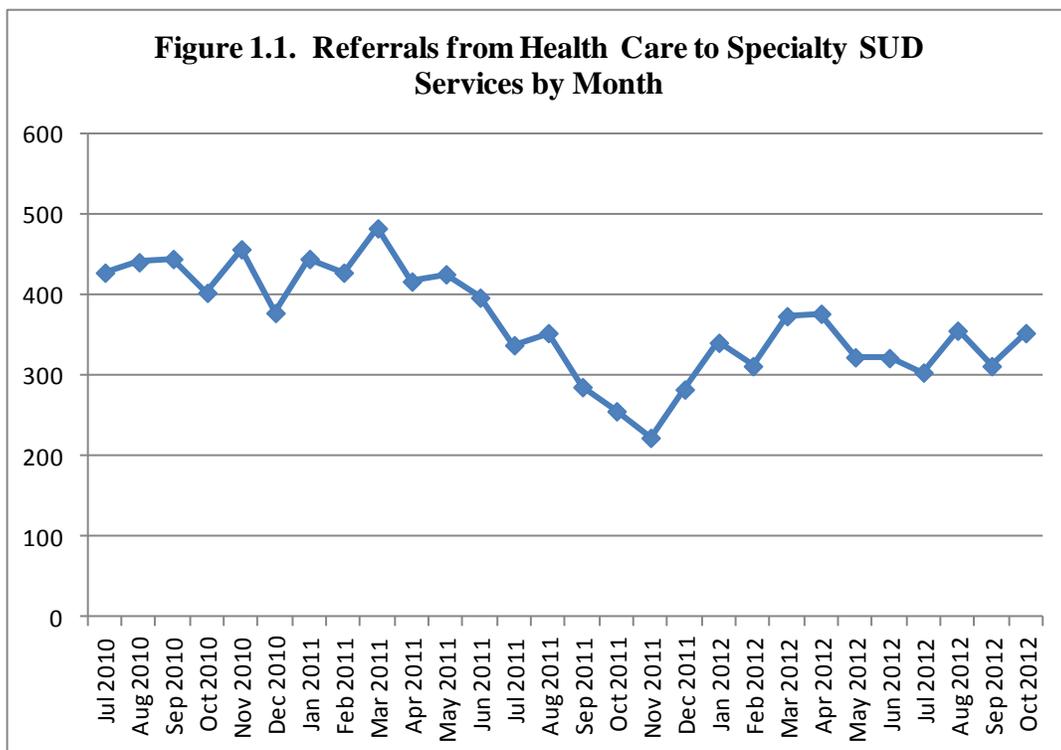
Medi-Cal populations and provided SUD coverage, primary care might provide limited services onsite and refer patients needing more intensive care to specialty providers in the community, leading to increasing numbers of patients referred from health care sources to specialty SUD care. However, in reality, referrals from health care rose only slightly in these five counties. In the year prior to LIHP implementation (July 1, 2010 – June 30, 2011) programs in these five counties averaged a total of 79.5 health care referrals per month. In the following year (July 1, 2011 – June 30, 2012) they averaged 83.2 per month. Over half of these referrals could be traced back to a single medical detoxification program in San Francisco County whose activities were supported by county general funds and had little to do with LIHP, according to the county administrator (Alice Gleghorn, personal communication, 7/16/2013). Excluding this program, the difference narrowed to 37.4 referrals per month in the year prior to LIHP and 39.7 in the year after.

CMSP/Path2Health Counties

A similar story emerged in County Medical Services Plan (CMSP) counties. On January 1, 2012, CMSP/Path2Health began limited coverage of SUD services, but this does not appear to have measurably increased referrals from health care providers to specialty SUD providers. In fact, the average number of admissions in the six months following the initiation of coverage actually fell from 46.8 to 42.0 in the comparable period in the prior year. This makes sense in light of the challenges counties reported in using this benefit. For further information about CMSP/Path2Health, see Chapter 2.

All Counties

Health care referrals to specialty care SUD services have not risen since the passage of the ACA or implementation of CMSP or other LIHP programs. The number of referrals has dropped slightly since 2010, but this closely follows a drop that occurs across all referral sources, suggesting that most variations over time may be unrelated to health care reform. See Figure 1.1.



Characteristics of Health Referral Patients

See Table 1.1 for detailed statistics. Compared to other clients, health care referrals are:

- More likely to be White (58.7% vs. 50.2%), consistent with the FQHC population, which is 58.6% White (HRSA, 2012)
- Less likely to be Hispanic (23.2% vs. 36.7%). This is lower than the FQHC population, which is 62.1% Hispanic (HRSA, 2012)
- As likely to be male (63.7% vs. 62.4%). However this is higher than the FQHC population, which is 41.0% male (HRSA, 2012).
- More likely to report alcohol as their primary drug (45.5% vs. 22.0%).
- Likely to use their primary drug more often (median 15 days out of the last 30 vs. 4 days).
- More likely to enter non-hospital residential detoxification (35.5% vs. 9.2%) or residential treatment (24.8% vs. 17.9%) and less likely to enter outpatient treatment (35.0% vs. 64.8%).
- Older (median age of 39 vs. 31)
- Less likely to be enrolled in school at admission (10.1% vs. 21.0%).
- More likely to report not being in the labor force at admission (69.8% vs. 58.0%)
- More likely to be homeless (32.0% vs. 17.9%)
- More likely to be a veteran (7.5% vs. 2.9%)
- As likely to be a Medi-Cal beneficiary (36.7% vs. 38.1%)
- More likely to report a disability (35.9% vs. 18.3%), particularly a mental one (24.0% vs. 10.4%)
- More likely to complete treatment (43.8% vs. 37.8%) and more likely to complete treatment and receive a referral for further services (34.8% vs. 23.3%). These are both likely due to the higher use of detoxification in the health care referred group.
- Likely to spend less time in the program (median 20 days vs. 62 days). This is also likely due to the relatively high use of short alcohol detoxification services among the health care referred group.

On the basis of admissions (as opposed to unique patients), nearly half are for non-hospital residential detoxification (49.4%). These referrals were highly concentrated. In the last six months of 2012, 46 residential non-hospital detoxification programs reported seeing patients. Of these, only two programs (4.3%) collected more than half of the health care referrals to these programs (57.8%). These two programs were Baker Places, Inc., in San Francisco County and Tarzana Treatment Center in Los Angeles County. UCLA attempted to learn more about why these programs were successful in attracting referrals from health care sources.

- According to the county administrator (Alice Gleghorn, personal communication, July 16, 2013), Baker Place was developed with the goal of developing a community-based alternative to expensive hospital-based medically managed detoxification. It has full medical staffing, and typically has 14–21 day stays, mostly for alcohol or opiate issues. There were difficulties getting the license renewed recently due to restrictions on medical services in residential settings (for more on this barrier to integration, see Common Barriers and Challenges, Chapter 2).

Table 1.1. Characteristics of patients referred from health care.

	Non-Health Care Referral	Health Care Referral
Unique Patients, Jul 2011-June 2012	134,026	3,536
Female	37.5%	36.2%
Race		
African American/Black	15.2%	15.0%
Asian/PI	2.9%	2.2%
White	50.2%	58.7%
Other	31.8%	24.1%
Ethnicity: Hispanic	36.7%	23.2%
Primary Drug Route of Administration		
Oral	28.8%	54.3%
Smoking	49.1%	29.9%
Inhalation	4.7%	4.1%
Injection	17.0%	11.1%
Service Modality		
Outpatient Intensive	4.7%	3.2%
Outpatient Detoxification	3.4%	1.6%
Outpatient Treatment/Recovery	64.8%	35.0%
Residential Detoxification (non-hospital)	9.2%	35.5%
Residential Treatment/Recovery	18.0%	24.8%
Enrolled in Job Training at Admission	2.3%	2.4%
Enrolled in School at Admission	21.0%	10.1%
Employment Status		
Employed Full Time	7.3%	6.1%
Employed Part Time	6.5%	4.2%
Unemployed, looking for work	28.2%	19.8%
Not in the labor force	58.0%	69.8%
Primary Drug		
Alcohol	22.0%	45.5%
Cocaine/Crack	5.8%	6.1%
Heroin	16.8%	10.4%
Marijuana/Hashish	22.6%	10.2%
Methamphetamine	25.4%	17.7%
Other	7.4%	10.2%
Discharge Status		
Completed	37.8%	43.8%
Left before completion / satisfactory	18.8%	20.3%
Left before completion / unsatisfactory	41.3%	35.4%
Death	0.2%	0.0%
Incarceration	2.0%	0.5%
Had HIV Test	69.9%	69.8%
Living Arrangement at Admission		
Homeless	17.9%	32.0%
Medi-Cal Beneficiary	38.1%	36.7%
SUD Medication Prescribed	16.4%	13.4%
Pregnant at Admission	1.8%	2.0%
Termination of parental rights	3.8%	3.1%
Veteran	2.9%	7.5%
Disability	18.3%	35.9%
Age*	31	39
Age at first use of primary drug*	16	16
Days primary drug use, last 30 days, Admission*	4	15
Days primary drug use, last 30 days, Discharge*	0	3
Days in treatment*	62	20
Number of prior admissions*	1	1
Days of social support, admission*	0	0
Days of social support, discharge*	5	7

* median

- Tarzana Treatment Center operates a primary care facility that refers patients to their SUD programs for detoxification and treatment. According to its chief operating officer, the program also works with several local emergency rooms and both public and private clinics (Al Senella, personal communication, July 17, 2013).

Non-detoxification referrals tended to be for outpatient drug-free (24.4%) and long-term residential treatment (22.2%). These referrals were somewhat concentrated as well. Excluding residential non-hospital detoxification programs, there were 959 programs that reported patients in the last six months of 2012. Of these, just two (0.2%) clinics (Tarzana Treatment Center in Tarzana and Empire Recovery Center in Redding) accounted for 14.4% of the health care referred admissions statewide.

- Empire Recovery Center (Shasta County) reported forming a partnership with a local Federally Qualified Health Center (Shasta Community Health Center). Empire requires that patients be on medication and stable before going there. Patients continue to receive medications from their prescribing physician while Empire provides social model treatment. Empire reports that the medications seem to help for individuals with long drug-use histories, and that the relationship with the health center has been great, because “each side believes in what the other does.”
- For more information on Tarzana Treatment Center, see the prior discussion of detoxification programs.

SBIRT

On February 1, 2013, the Centers for Medicare and Medicaid Services provided guidance to states on section 4106 of the Affordable Care Act, which describes incentives for preventative services, including screening, brief intervention, and referral to treatment (SBIRT). Support for SBIRT in medical settings may facilitate referrals to treatment. In a six-state SAMHSA-sponsored study of SBIRT in medical settings (Madras et al., 2009), 22.7% of patients screened positive for risky/problematic use, and 3.7% were recommended for referral to specialty treatment. If only 1/10th of California’s population of 38 million (i.e., 3.8 million) are screened each year and 3.7% of these (about 140,000) are referred for specialty care (as in the SAMHSA study), the resulting number of new referrals from medical settings would exceed the total number of unique clients per year seen by the current system (137,562 in FY 2011–12). In other words, if SBIRT is successfully promoted in California, the current specialty treatment system will need to undergo a dramatically substantial expansion. There are a number of California-specific barriers to successful SBIRT implementation, however, including:

1. Restrictions on same-day billing that will preclude primary care providers from getting paid for SBIRT in most cases, since they would typically see the patient for another service on the same day.
2. Shortages of behavioral health personnel to provide SBIRT in primary care settings. Providers are unlikely to screen for SUD if they do not have the personnel to provide services or support to medical staff when SUD is identified. Currently only psychiatrists, psychologists, and LCSWs can bill Medi-Cal in a Federally Qualified Health Center (FQHC) setting, and FQHCs report that they are unable to find enough professionals with these

degrees and other qualifications (e.g., bilingualism) to fill these positions. Allowing other staff types (e.g., LMFTs) to bill Medi-Cal in these settings would help to address the problem. For more on this issue, see Chapters 2 and 3.

Lessons Learned

In summary, increased coverage of SUD services in and of itself did not appear to lead to increased coordination between health care and specialty care services. By extension, it may be assumed that the 2014 Medi-Cal expansion and enhanced SUD benefit may not, on their own, result in better coordination. Instead, partnerships will have to be actively pursued.

The most common health care referrals are currently patients who are White, male, and entering detoxification for alcohol use. It will be important to monitor this as more individuals gain coverage through private insurance or Medi-Cal in 2014, and to examine why more minority and female patients are not being successfully referred for specialty SUD services. Current demographics are inconsistent with the fact that the vast majority of federally qualified health center patients in California are female (63.2% of patients 15–64) and are members of racial/ethnic minorities (77.7%; Health Resources and Services Administration, 2011). It may be that health centers are attempting to treat these patients onsite or that culturally and linguistically appropriate services are unavailable in the community.

A relatively small number of programs are regularly receiving referrals from health care. Where referrals are occurring, it has been due to concerted efforts by the receiving program to develop relationships with the referring local health care providers.

Finally, if SBIRT is successfully promoted in California, the current specialty treatment system will need to undergo a dramatically substantial expansion. However, there are a number of California-specific barriers that will need to be evaluated in order to facilitate a successful SBIRT implementation.

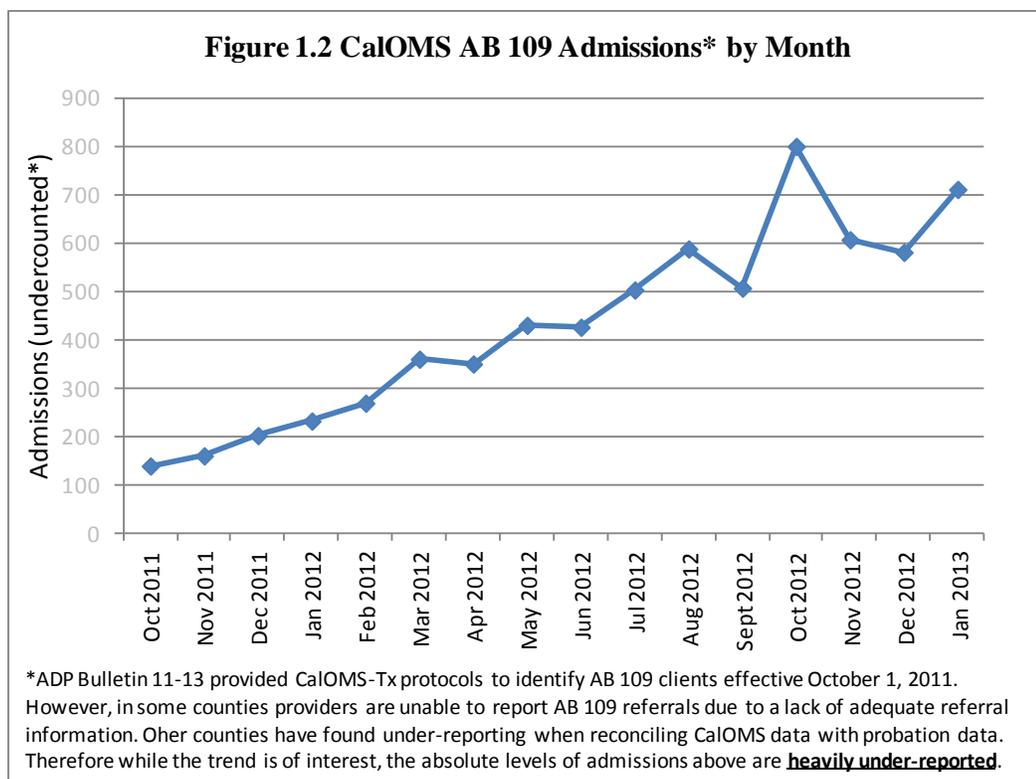
B. Impact of AB 109 on SUD Treatment

CalOMS-Tx Data Analyses

The true number of statewide AB 109 admissions is difficult to measure. ADP Bulletin 11-13 provided protocols to identify AB 109 clients effective October 1, 2011. However, anecdotal reports from county administrators suggest that in some counties this information is difficult to record in CalOMS-Tx due to the structure of the referral system. For example, if probation sends an AB 109 client to a centralized assessment center, that center often refers the person to a treatment program without notifying the program that it is an AB 109 client, and the clients themselves often do not know or think of themselves as an “AB 109” referral. Thus, when the program asks the client what their referral source was, the answer may be recorded as a self-referral or assigned to some other referral source. Participants in the CADPAAC data and outcomes committee who were able to view CalOMS-Tx reports of the number of AB 109 referrals and compare them to their local probation reports stated that the CalOM-Tx numbers

were too low. In summary, the overall number of AB 109 clients in the state is unknown, but is certainly higher than the numbers reported here.

Despite the fact that the absolute numbers are almost certainly inaccurate, month-to-month differences in reported admissions can still be informative. If some counties are unable to report admissions, for example, the statewide numbers will be low but the differences in the remaining counties over time may reflect real changes in the AB 109 population. The change in AB 109 admissions is shown in Figure 1.2. While some of the increase may reflect increasingly more accurate use of the CalOMS-Tx AB 109 reporting mechanism, the numbers suggest admissions are rising quickly and approximately linearly over time. Interestingly, this pattern is consistent with the increasing number of AB 109 active post-release community supervision offenders in the state (Chief Probation Officers of California, 2013).



We were also able to examine AB 109 client characteristics by focusing on unique clients that did have an AB 109 referral noted at admission, and compare them to clients that did not have this designation (see Table 1.2). Note that it is likely that the non-AB 109 data actually includes an unknown number of AB 109 clients for the reasons described above, which means the differences between the AB 109 and non-AB 109 populations may actually be slightly larger than those reported here.⁴

⁴ We do not believe the reverse occurs very often, however. One large county that compared their CalOMS data to a probation list reported that less than 2% of clients identified as AB 109 via CalOMS were not on the probation list.

Table 1.2. Characteristics of identified AB 109 clients.

	Non-AB 109	AB 109
Unique Patients, Nov 2011-Oct 2012	131,945	4,141
Female	37.9%	16.8%
Race		
African American/Black	15.3%	15.6%
Asian/PI	2.8%	4.0%
White	50.3%	48.3%
Other	31.7%	32.1%
Ethnicity: Hispanic	36.3%	37.6%
Primary Drug Route of Administration		
Oral	29.8%	15.8%
Smoking	48.4%	59.6%
Inhalation	4.7%	5.6%
Injection	16.9%	18.2%
Service Modality		
Outpatient Intensive	4.9%	1.6%
Outpatient Detoxification	3.6%	0.1%
Outpatient Treatment/Recovery	63.5%	54.0%
Residential Detoxification (non-hospital)	10.3%	3.0%
Residential Treatment/Recovery	17.8%	31.2%
Enrolled in Job Training at Admission	2.2%	2.2%
Enrolled in School at Admission	20.7%	3.5%
Employment Status		
Employed Full Time	7.4%	6.7%
Employed Part Time	6.4%	6.5%
Unemployed, looking for work	27.5%	43.2%
Not in the labor force	58.6%	43.6%
Primary Drug		
Alcohol	22.8%	13.8%
Cocaine/Crack	5.5%	8.2%
Heroin	16.9%	12.2%
Marijuana/Hashish	22.4%	12.9%
Methamphetamine	25.0%	50.5%
Other	7.4%	2.4%
Discharge Status		
Completed	35.8%	30.6%
Left before completion / satisfactory	19.2%	16.0%
Left before completion / unsatisfactory	42.9%	50.0%
Death	0.1%	0.0%
Incarceration	1.9%	3.4%
Had HIV Test	69.6%	83.2%
Living Arrangement at Admission		
Homeless	18.9%	25.1%
Medi-Cal Beneficiary	38.8%	8.8%
SUD Medication Prescribed	16.6%	1.0%
Pregnant at Admission	1.8%	0.6%
Termination of parental rights	3.7%	5.0%
Veteran	3.0%	3.6%
Disability	19.1%	14.4%
Age*	31	36
Age at first use of primary drug*	16	17
Days primary drug use, last 30 days, Admission*	5	0
Days primary drug use, last 30 days, Discharge*	0	0
Days in treatment*	44	42
Number of prior admissions*	1	1
Days of social support, admission*	0	0
Days of social support, discharge*	6	14

* median

Compared to other participants, identified AB 109 clients are:

- Similar in race and ethnicity
- More likely to be male (83.1% vs. 62.0%)
- Less likely to be admitted to detoxification (3.1% vs. 10.3%) and more likely to be in residential treatment (31.2% vs. 17.7%).
- Less likely to be enrolled in school (3.5% vs. 20.7%).
- More likely to be unemployed looking for work (43.2% vs. 27.5%).
- More likely to report methamphetamine as their primary drug (50.5% vs. 25.0%), less likely to report marijuana (12.9% vs. 22.4%) or alcohol (13.8% vs. 22.8%).
- Less likely to complete treatment (30.6% vs. 35.8%), somewhat more likely to be discharged due to incarceration (3.4% vs. 1.9%).
- More likely to have received an HIV test (83.2% vs. 69.6%).
- More likely to be homeless at admission (25.1% vs. 18.9%).
- Less likely to be a Medi-Cal beneficiary (8.8% vs. 38.8%)
- Less likely to receive medication as part of their treatment (1.0% vs. 16.6%).
- More likely to have had parental rights terminated (5.0% vs. 3.7%).
- Older (median age 36 vs. 31).
- Similar in regard to time spent in treatment (median 42 days vs. 44 days)

The AB 109 population looks similar to the previous Proposition 36 parolee population (Evans, Hunter & Urada, 2009) in terms of demographics and the high use of methamphetamine. Of particular concern is their low enrollment in Medi-Cal. This does not appear to be due to a lack of dependents, as AB 109 clients actually had slightly more children (average 1.05 vs. 0.92), and fewer children living with someone else (average 0.21 vs. 0.27). This suggests there may be an alternative explanation, such as losing Medi-Cal benefits as a result of their involvement with the criminal justice system.

Offenders often have their benefits terminated while incarcerated, which can cause problems when the inmate is released and seeks health care. In Massachusetts, this led to a 22% uninsured rate among SUD patients even as the general population enjoyed a less than 3% uninsured rate. Suspending rather than terminating Medicaid benefits for offenders and aiming Medicaid outreach and enrollment efforts at inmates are recommended solutions (Cuellar & Cheema, 2012). At this writing, AB 720 (Skinner), which would require measures along these lines, had passed the Assembly and has been referred to the Senate Appropriations Committee.

Other AB 109 data from around the state

Despite AB 109 being “the biggest penal experiment in modern history,” the state provided no funding to evaluate its overall effect (Petersilia & Snyder, 2013). Research on its relationship to SUD is therefore sparse. Here is data that UCLA was able to find:

- Fresno (Penner, Owen, Takahashi, Owen, & Hughes, 2012) reported that two of the top five offenses that led to participation in AB 109 were drug and controlled substance possession. They also reported that the most common reason for failure to comply with one or more conditions of supervision was substance abuse (38%).

- After analyzing AB 109 county plans, a team from Stanford (Abarbanel, McCray, Newhall, & Snyder, 2013) reported that most plans (83%) mentioned implementing community SUD treatment as part of their implementation of AB 109, but only 36% provided any details about the SUD treatment they would provide.
- The California Mental Health Planning Council (2013) reported the percentage of AB 109 funds counties spent on SUD services ranged from 0% to 9%. Mental Health services ranged from an additional 0% to 19%. County representatives expressed surprise at the level of substance use disorder needs among the AB 109 population. San Mateo County Probation reported a disparity between their regular probation population and the realigned population—with 90% of the latter reportedly having substance abuse problems.
- A 2012 CADPAAC survey of county alcohol and drug (AOD) program administrators found that the AOD administrator was involved in their county’s County Community Corrections Partnership, which discusses AB 109 implementation in 47 of the 51 counties. In 24 of these counties, agencies were providing SUD treatment outside of the system overseen by the AOD administrator, with this most frequently occurring through the county’s probation department.

Originally UCLA had proposed to analyze CalOMS-Tx data in conjunction with the CADPAAC survey or a new survey on AB 109 implementation. However, due to the challenges in identifying AB 109 clients using CalOMS-Tx, and particularly variations in CalOMS-Tx reporting by county, it would be premature to do so. Improving identification of AB 109 clients may be a more productive first step.

Lessons Learned

Available data suggest that AB 109 admissions to SUD treatment are rising, but the exact number of individuals is unknown. Aside from encouraging counties to provide accurate CalOMS-Tx data, which may not be possible in some cases, there are two other possible methods of obtaining more accurate data:

1. In theory, it would be possible for the 58 county probation departments to provide lists of current AB 109 offenders to DHCS or to UCLA. UCLA could then merge these lists with the CalOMS-Tx database to determine how many people on these lists are in SUD treatment. This would require cooperation from the probation departments, however (e.g., Chief Probation Officers of California).
2. A second option would be to encourage county AOD administrators to obtain this information at the local level, then compare it to their own treatment lists. Anecdotally, some of the larger counties already do this. UCLA could then collect the resulting offender counts via survey to produce a statewide number. Based on a similar effort that UCLA implemented for the Substance Abuse and Crime Prevention Act (SACPA, aka Prop. 36) evaluation, this is possible but is likely to produce inconsistent county responses that will require some estimation.

C. Program Performance and Patient Outcome Measurement

Performance and outcome reports based on CalOMS-Tx

Over the past year, UCLA continued to work with the Department of Alcohol and Drug Programs and the CADPAAC data and outcomes committee to refine performance and outcome measures. The Department has now rolled out “Data Indicator Reports” (DIRs) for outpatient programs and for narcotic treatment programs that were partly based on the previously proposed dashboards. Initial provider feedback has reportedly been positive.

Updated versions of the “dashboard” measures UCLA previously proposed for residential and detoxification modalities are included below. These have also been circulated to the data and outcome committee members, and discussions about potential revisions have begun. At the request of ADP, UCLA also produced a county-level dashboard that incorporates elements from the detoxification and residential versions (see below).

The numbers in the dashboards below are real, and based on statewide numbers. When deployed, these dashboards would actually contain program- or county- level data. The statewide 2011–2012 measures generated mixed results, with a number of measures falling from the prior year (red Xs in the middle column). For the most part, these changes were small.

County Level Dashboard Example

County: All

Reporting Period: 7/1/2011–6/30/2012

Performance Measure	SCORE (%)	Comparison with Previous Report		Comparison with State Benchmark	
		%	Improved?	%	Goal met?
Patients transferred from detox to treatment within 14 days of discharge	19.4%	20.7%	X	Over 20%	X
Patients transferred from residential to outpatient, intensive outpatient, or day-care rehabilitative within 14 days of discharge	8.8%	8.1%	✓	Over 8%	✓
Patients reporting primary drug abstinence* at discharge	57.7%	62.0%	X	Over 60%	X
Reliability of abstinence information (% of discharges with data)	52.7%	54.3%	X	Over 55%	X

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

Dashboard update: Reliability of abstinence information was added to provide context for the abstinence measure.

Program Level Dashboard for Detoxification Programs

Program Name: Detox Program X **County:** All
Program Sub-Category: All **Reporting Period:** 7/1/2011–6/30/2012
(Includes: Residential-Hospital and Non Hospital, Outpatient, NTP)
Number of Discharges: 28,152 (statewide data used for this example)

Performance Measure	SCORE (%)	Comparison with Previous Report		Comparison with State Benchmark	
		Prev %	Improved?	Target %	Goal met?
Patients transferred to treatment within 14 days of discharge	19.4%	20.7%	X	Over 20%	X
Patients who “completed” detox	48.8%	48.3%	✓	Over 50%	X
Patients NOT re-entering detox within 14 days of discharge	96.4%	96.3%	✓	Over 95%	✓

Dashboard update: The “immediate drop outs” measure was dropped because this measure was generating numbers that were too low to be informative.

Program Level Dashboard for Residential Treatment Programs

Program Name: All **County:** All
Number of Discharges: 28,360 **Reporting Period:** 7/1/2011–6/30/2012

Performance Measure	SCORE (%)	Comparison with Previous Report		Comparison with State Benchmark	
		Prev %	Improved?	Target %	Goal met?
Patients in treatment at least 30 days	62.0%	64.2%	X	Over 60%	✓
Patients transferred to outpatient, intensive outpatient, or day-care rehabilitative within 14 days of discharge	8.8%	8.1%	✓	Over 8%	✓
Patients reporting primary drug abstinence* at discharge	77.9%	80.9%	X	Over 80%	X
Reliability of abstinence information (% of discharges with data)	66.6%	72.6%	X	Over 70%	X

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

** Same-day admission and discharge

Note: The performance dashboard for short-term residential would be the same, but without the “patients in treatment at least 30 days” measure.

Dashboard update: The “immediate drop outs” measure was dropped because this measure was generating numbers that were too low to be informative.

Methadone detoxification policy example using CalOMS-Tx

Opioid detoxification treatment is proven to be ineffective in achieving long-term abstinence among opioid-dependent individuals (Dhalla et al., 2009). In addition to federal criteria for opioid maintenance treatment eligibility, State of California policies require two failed attempts at opioid detoxification.

CalOMS-Tx and its predecessor, the California Alcohol and Drug Data System (CADDs), can be used to determine whether the data support this policy or suggest a need to revisit it. We analyzed CADDs and CalOMS-Tx data covering the period January 1, 1991, to March 31, 2012, covering a sample of 237,709 unique individuals and 857,030 treatment episodes.

The main outcomes and measures used were:

- Successful completion of opioid detoxification treatment (methadone or buprenorphine)
- Duration of opioid maintenance treatment
- Duration of time to initiation of maintenance treatment following detoxification.

Results

A total of 112,211 individuals accessed only opioid-detoxification treatment (259,168 episodes), and 125,498 individuals accessed opioid-maintenance treatment. Among individuals never accessing maintenance treatment, the adjusted odds of successful opioid detoxification declined with each successive attempt (vs. first attempt: 2nd attempt, Adjusted Odds Ratio:0.66; 3rd attempt: 0.51; 4th attempt: 0.44; 5th attempt: 0.44; \geq 6th attempt: 0.36). Further, single or multiple prior attempts at detoxification had no significant association with subsequent maintenance treatment durations (vs. no prior detoxification attempts: 1–3 detoxification attempts: Adjusted Hazard Ratio: 0.98; \geq 4 prior detoxification attempts: 0.99).

Summary

Detoxification has no significant association with subsequent maintenance treatment retention. These findings suggest a need to revisit current State of California policies mandating two unsuccessful opioid detoxification attempts for maintenance treatment eligibility.

Lessons Learned

The statewide 2011–2012 measures generated mixed results, with a number of measures falling from the prior year (red Xs in the middle column). For the most part, these changes were small.

As next steps, we recommend a focus on the development of residential treatment and detoxification DIRs. The data and outcomes committee has a goal of completing a residential DIR by the end of September 2013 for deployment beginning in October.

Following this, DIRs will have been deployed for the major modalities included in CalOMS-Tx. If CalOMS-Tx could ever be expanded to cover new modalities, it would be advantageous to the field to have performance and outcome measures on continuing care, in particular, and sober living, if possible.

In addition, UCLA has identified several possible strategies to improve performance and outcome measurement by utilizing both Drug Medi-Cal data and CalOMS-Tx data together. Drug Medi-Cal data and CalOMS-Tx data can potentially be used productively to measure performance, identify SUD “hot spots,” analyze costs, and detect fraud. If DHCS were to authorize⁵ analyses using CalOMS-Tx and Drug Medi-Cal (DMC) data, including the use of protected health information from both datasets, it is theoretically possible to produce a number of analyses that would benefit the Medi-Cal program.

It is important to note that UCLA did not have access to the DMC data at the time of this writing and was unable to verify certain facts about the data, so although the following ideas are theoretically possible, verification will be needed to ensure that practical issues such as data coverage, missing/unreported data, and data quality would not interfere with these plans.

Assuming adequate quality of DMC data, patient identifiers (name, date of birth, sex, mailing address) contained in CalOMS-Tx can be matched to the same “subscriber” variables contained in DMC data using deterministic algorithms or probabilistic matching software (e.g., Link King). Having achieved this link between CalOMS-Tx and DMC subscriber information, the matched data could then be linked to data from DMC “claim lines” drawn from DMC 837 P claims transactions by using the client index number contained in both the subscriber and claims data. The dataset could then be stripped of identifiers (de-identified) and the resulting DMC claims-CalOMS-Tx dataset could potentially be used for a number of analyses, examples of which are described below.

Performance Monitoring: The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care (National Committee for Quality Assurance (NCQA), 2013). Among the HEDIS measures are Initiation⁶ and Engagement⁷ of Alcohol and Other Drug Dependence Treatment. Measuring either Initiation or Engagement requires encounter-level data, which appears to be available in the DMC claims data. Medicaid HMOs reported 39.2% initiation and 11.9% engagement in 2011 (NCQA, 2012). Both represented declines from the prior year. Using DMC data would allow DHCS to monitor initiation and engagement among the population of DMC providers, including fee-for-service providers. Using DMC data in conjunction with CalOMS-Tx data would enable DHCS to monitor the initiation and engagement measures in conjunction with CalOMS-Tx patient outcomes data. Note that doing so would require use of both datasets to produce provider-level measures, but the two datasets would not necessarily need to be linked at the patient level.

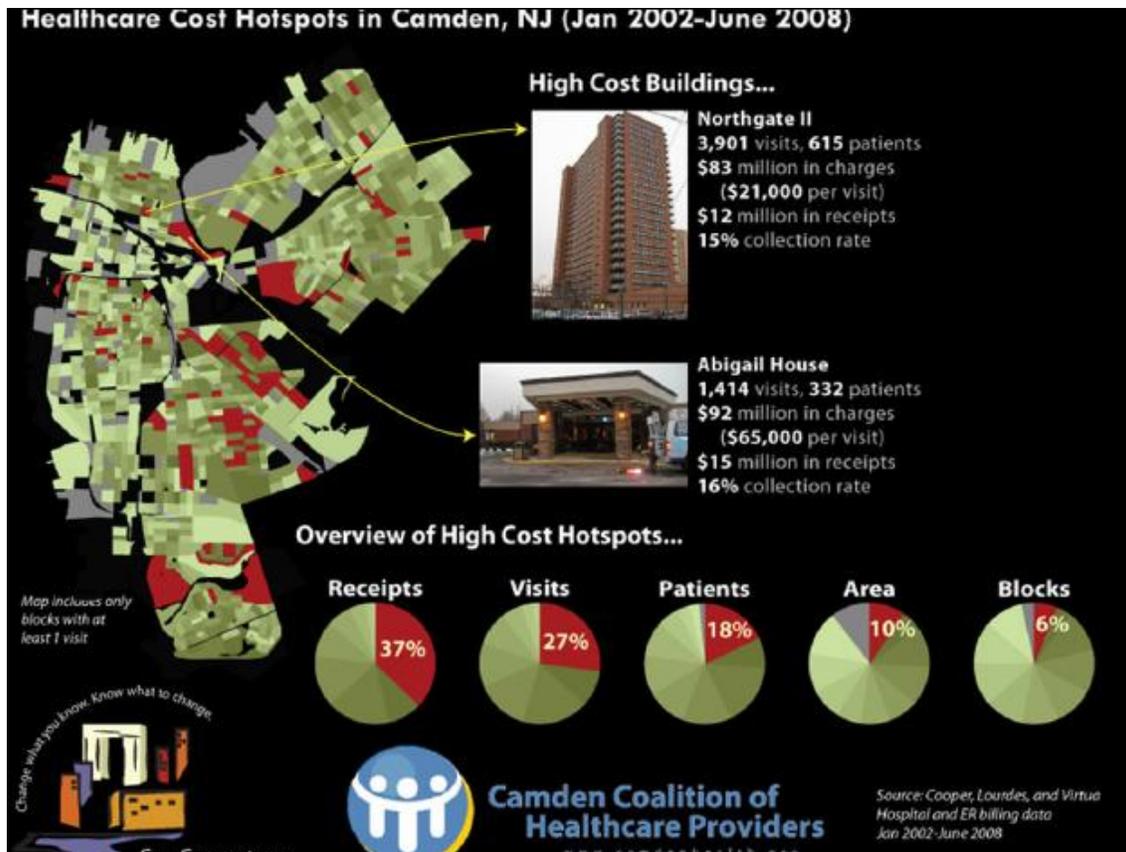
⁵ Section 1902 (a) of the federal Social Security Act (42 U.S.C. § 1396a (7)) restricts DHCS from disclosing protected information other than for purposes that are directly connected with the administration of the Medi-Cal Program.

⁶ *Initiation of AOD Treatment.* The percentage of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.

⁷ *Engagement of AOD Treatment.* The percentage of people with a diagnosis of AOD use or dependence who initiated treatment and had 2 or more additional services within 30 days of the initiation visit.

“Hot spotting” (Brenner, 2013): “Hot spotting” can be used to identify where patients are coming from (residential address) and to compare that to where the services are (facility address). This can be used to identify where help is needed most, including treatment, prevention, and outreach services. For example, Brenner generated the map of Camden, NJ, below, showing that patients from 6% of the city blocks (in red) accounted for 37% of healthcare costs, and two specific buildings had particularly high costs.

Figure 1.3 “Hot Spotting” Example



Source: <http://nationalcouncil.info/natcon2013/handouts/TLT3-Brenner-1.pdf>

Included with permission.

Brenner’s organization also conducted a similar study using Maine’s Medicaid data (Camden Coalition of Healthcare Providers, 2013), thereby establishing the feasibility of using state Medicaid data for hot-spotting analyses. If applied to DMC data, or (even better) Medi-Cal data more generally, we may find similarly concentrated patterns of service utilization and costs in California. Identifying these patient hot spots would provide information on where prevention and outreach efforts may have the greatest impact in intervening with individuals before they develop SUDs or to reach out to those who are in need of treatment. Identifying spots with high concentrations of residents that use SUD services (from DMC “subscriber” data), especially those who have poor outcomes (from CalOMS-Tx) and no treatment programs nearby (from DMC data or CalOMS-Tx+Master Provider file), can provide valuable information on where

new programs are needed. Patients are more likely to drop out of treatment if they are unable to access it conveniently, and dropouts have worse health and cost outcomes than treatment completers. Therefore, hot-spotting may be helpful in achieving the triple aim of better care, better health, and reduced costs.

Cost Analyses: With sufficient time and resources, it may be possible to compare costs per unit of outcome, adjusting for patient characteristics (e.g., demographics, drug use, primary drug) taken from CalOMS-Tx. For example, one could determine for a 33-year-old Hispanic female with daily meth drug use, 10 years of use, and two prior treatment episodes, which modality (e.g., outpatient, intensive outpatient, or residential treatment) produces the greatest reduction in drug use per dollar spent. If all Medi-Cal data (as opposed to DMC only) can be obtained, we could study the association between modalities or varying lengths of stay on overall medical costs. By using DMC and CalOMS-Tx data together, it is theoretically also possible to identify individual programs that provide the greatest “bang for the buck” in order to study them as model programs that may be able to provide promising practices for dissemination to other programs.

Fraud Detection

To protect the effectiveness of the methods discussed, details of the procedures proposed in this section have been moved to a separate report.

There are a number of things DHCS analysts or UCLA via contract could do to pursue fraud using DMC data analysis. Since all Drug Medi-Cal programs are currently being re-certified, this would be an ideal time to initiate a pilot analysis program that identifies a list of outlier programs that could be examined more closely during the recertification process. If this list proves helpful and successfully identifies fraudulent programs, efforts could be expanded. If these methods are successful, it is likely that programs will change their methods in response, and DHCS safeguards will therefore need to continually evolve to keep up as well.

V. Chapter Summary and Recommendations

Summary

A multitude of data analysis efforts were conducted to address the following objectives:

1. Examine how ongoing policy changes are affecting who receives SUD treatment and how access, services, costs, and quality of care are being affected. Make recommendations to improve policies, practices, and data quality.
2. Refine program performance and patient outcome measures.

Outcomes revealed overall that increased coverage of SUD services in and of itself did not appear to lead to increased coordination between health care and specialty care services. By extension, it may be assumed that the 2014 Medi-Cal expansion and enhanced SUD benefit may not, on their own, result in better coordination. Instead, partnerships will have to be actively

pursued. Currently, a relatively small number of programs are regularly receiving referrals from health care sources due to concerted efforts by these programs to develop relationships with local health care providers.

Patients referred from health care to specialty SUD treatment tended to be White, male, and entering detoxification for alcohol use. This may change as more individuals gain coverage through private insurance or Medi-Cal in 2014. Further research is needed to determine why female and Hispanic patients are underrepresented.

A review of SBIRT implementation in a six-state SAMHSA-sponsored study revealed data that could indicate a major impact to California's current SUD specialty treatment system, if SBIRT is successfully promoted in California. However it is likely that the current specialty system will need to undergo a dramatically substantial expansion. There are a number of California-specific barriers that will need to be addressed in order to facilitate a successful SBIRT implementation.

Data on AB 109 clients is sparse and currently of questionable accuracy, but suggest that the number of AB 109 clients entering treatment may be rising rapidly. Very low enrollment of AB 109 clients in Medi-Cal is of particular concern. Benefits should be suspended during incarceration rather than terminated, and Medi-Cal outreach and enrollment efforts targeted at soon-to-be released inmates are needed.

Data Indicator Reports for outpatient and methadone maintenance performance measurement have been deployed, and development of measures for residential treatment and detoxification are next. Initial provider feedback has reportedly been positive.

Drug Medi-Cal data and CalOMS-Tx data can potentially be productively used to measure performance, identify SUD "hot spots", analyze costs, and detect fraud, which may be useful to policymakers.

Recommendations

- Examining information from the Uniform Data System to determine whether the number of patients treated for SUD increased within health centers during these time periods. It is possible that SUD services actually did increase overall, but that this occurred in primary care settings that do not report to CalOMS-Tx. UCLA has requested this information from the Health Resources and Services Administration (HRSA), but at this writing, the data was not available yet.
- Continue efforts to train and provide technical assistance to improve data entry processes and data quality.
- Consider alternative methods of obtaining more accurate AB109 data:
 1. In theory, it would be possible for the 58 county probation departments to provide lists of current AB 109 offenders to DHCS or to UCLA. UCLA could then merge these lists with the CalOMS-Tx database to determine how many

people on these lists are in SUD treatment. This would require cooperation from the probation departments, however (e.g., Chief Probation Officers of California).

2. A second option would be to encourage county AOD administrators to obtain this information at the local level, then compare it to their own treatment lists. Anecdotally, some of the larger counties already do this. UCLA could then collect the resulting offender counts via survey to produce a statewide number. Based on a similar effort that UCLA implemented for the Substance Abuse and Crime Prevention Act (SACPA, aka Prop. 36) evaluation, this is possible but is likely to produce inconsistent county responses that will require some estimation.
- Whether or not AB 720 becomes law, UCLA recommends the practice of suspending rather than terminating benefits where possible. Aside from improving available data on AB 109 admissions to SUD treatment, it will be important to ensure that this population will actually be able to receive treatment by ensuring they do not lose Medi-Cal benefits, should they be incarcerated.
 - To improve referral practices between SUD and primary care providers, it is recommended that developing partnerships be encouraged at the system level. Currently, a relatively small number of programs are regularly receiving referrals from health care sources.
 - SBIRT implementation efforts could be significantly impacted if the following barriers were evaluated: Restrictions on same-day billing and eligible workforce.
 - Continue to develop and deploy performance dashboards. Efforts toward measurement of residential treatment and detoxification are underway. Detoxification has no significant association with subsequent maintenance treatment retention. These findings suggest a need to revisit current State of California policies mandating two unsuccessful opioid detoxification attempts for maintenance treatment eligibility.
 - Utilize both Drug Medi-Cal data and CalOMS-Tx data together to improve performance and outcome measurement. Drug Medi-Cal data and CalOMS-Tx data can potentially be used productively to measure performance, identify SUD “hot spots,” analyze costs, and detect fraud.

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

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In order to evaluate and assist with California's efforts to integrate SUD, MH, and primary care services, information was collected through literature reviews, webinars, conferences, and consultations with stakeholders and integration experts. Within the state, UCLA conducted surveys, focus groups, and evaluations of integration pilot initiatives; facilitated monthly meetings of the California Integration Learning Collaborative; and attended other learning collaboratives in our efforts to gather and share the most current resources on integration.

From these activities, we have documented common barriers and facilitators, as well as key lessons learned from throughout the state. The field has made progress in developing tools and shared solutions for supporting integration. Current strategies for achieving integration include evidence-based practices (such as screening, brief intervention, referral to treatment [SBIRT] and medication-assisted treatment [MAT]), new organizational models, and technology. Promising models and practices continue to emerge, but further research is needed to determine whether these approaches can improve quality and outcomes while effectively reducing costs. Barriers persist with regard to health care reform implementation, specifically among patient/consumer confidentiality and data sharing practices, electronic health records (EHR) implementation, workforce development needs, and financing integrated services.

Among counties working on integration, practices and funding strategies varied. Lessons learned from counties are highlighted in this chapter. Cultivating relationships among integration partners, delivering strong leadership, and achieving staff buy-in were important factors in the success of several initiatives. There continues to be high interest in more training throughout the state.

A great deal of work remains ahead across the realms of policy, research, training, and technical assistance. Recommendations at the policy level to lessen the number of potential difficulties providers face include: Drug Medi-Cal certification expansion to include primary care providers (PCPs), lifting the restriction on same-day physical and behavioral Medi-Cal service billing, allowing certification of reasonably-sized residential programs for Medi-Cal reimbursement, and allowing PCPs to be placed in residential treatment programs. In addition to continued investment in research, training and technical assistance, further recommendations include continuing involvement in collaborative efforts and pilot projects.

I. Introduction

Integrating substance use disorder (SUD) services (i.e., prevention, screening, intervention, and treatment) with health care services is feasible, is associated with better patient outcomes and reduced overall health care utilization costs, and is reportedly well underway in many community health centers and other medical settings throughout the United States. However, 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 on the integration of mental health services into health care settings, and there is little documentation on the nature of integrated SUD and health care services and best practices for SUD service integration with both mental health and physical health care services.

Based on feedback from stakeholders, particularly due to the current state of affairs nationally and statewide around the implementation of the Affordable Care Act and other health care reform related policies (described in the Preface), it is clear that counties are in need of technical assistance and training on topics related to SUD integration.

We begin the chapter by identifying our objectives followed by describing the methods used to address each objective. We include detailed findings and lessons learned drawn from our investigations, and close the chapter with a summary and recommendations.

II. Objectives

This chapter addresses the ADP/UCLA contract Domain 2, entitled “Health Care Reform and the Integration of SUD Services with Mental Health and Primary Care.” Below are three objectives* identified under this domain that are addressed within Chapter 2.

1. Collect and disseminate cutting edge information on the integration of SUD services with mental health and primary care services
2. Coordinate and facilitate an interactive forum (i.e., Learning Collaborative) with counties and other key stakeholders to discuss SUD integration barriers and practical models
3. Conduct case study/pilot evaluations

*Note: remaining objectives under contract Domain 2 are addressed in Chapters 3 and 4.

III. Methods

The findings in this chapter have been gathered by conducting multiple investigative methods and activities in an effort to obtain a wide scope of data and information on the broad and complex topic of integration. Activities included: literature reviews, participating in national and statewide webinars, attending integration-focused conferences, consulting with key stakeholders and integration experts, conducting surveys and focus groups, facilitating the California Integration Learning Collaborative, and evaluating piloted integration initiatives with selected counties within California.

IV. Findings

Due to the various investigative methods utilized within this chapter, the findings are organized in the follow way. The contract domain objectives are noted below in order to clearly identify where to find the specific outcomes:

A. Conceptual Review: Integration of SUD services with mental health and primary care services (Objective A)

- Why integrate care?
- Defining “integrated care”
 - A framework for integrated care: An update
 - Talking “integration”: Finding a common language
- How integration can be achieved
 - Evidence-based practices (EBPs)
 - Organizational models
 - Using technology to facilitate integration
- Promising practices/programs from the field
- Common barriers and challenges
 - HCR implementation
 - Confidentiality: HIPAA and 42 CFR
 - Health IT: EHRs, EMRs, interoperability
 - Financing, billing, and regulations for integrated care, including policy challenges
 - Workforce limitations in brief (full review in Chapter 3)

B. What is happening in California (Objectives B and C)

- 2012 Integration Survey: an update from 2010
- California Integration Learning Collaborative (ILC)
 - Goals and objectives
 - Methods
 - Topic summaries
 - County case study summaries
- Pilot evaluations
- Other statewide evaluations

A. Conceptual Review: Integration of SUD services with mental health and primary care services

Why integrate care?

Because individuals with SUD tend to have poorer health outcomes, often associated with co-occurring chronic conditions, developing better approaches to address their needs is necessary. Medicaid patients with SUD have nearly twice the medical costs of patients without SUD (Boyd et al., 2010), and Parthasarathy et al. (2003) found a 54% medical cost savings when patients with chronic medical conditions received integrated medical and SUD care. Additional research

has shown that fragmented or poorly coordinated care is often associated with negative outcomes and higher treatment costs among SUD patients (Croft & Parish, 2012).

In the final report submitted by UCLA for the Evaluation Services to Enhance the Data Management System in California project (EnCAL, FY 2011–2012), it was shown that:

- Substance use disorders (SUDs) are common and costly;
- SUDs are a major driver of health costs, especially for Medicaid;
- SUD treatment services can cut health care costs;
- Most Californians who need SUD services do not receive them;
- Screening and early interventions are one way to address substance misuse within the broader health care system; and
- In spite of potential benefits of SUD integration with primary care (PC), such integration is lagging behind the integration of mental health (MH) services with PC.

Consistent with the “triple aim” of health care reform proposed by Berwick, Nolan, and Whittington (2008), integrated care has the potential to improve patient care, enhance health outcomes, and reduce costs. The Affordable Care Act (ACA) and other recent legislation have created new opportunities for improving SUD treatment and prevention by lifting barriers to accessibility, creating new reimbursement and financing mechanisms, and helping to build the infrastructure for better care delivery. Parity and the inclusion of mental health, SUD, preventative, wellness, and chronic disease management services as part of the 10 categories of essential health benefits that health plans must cover provide further support to this goal. Additional opportunities have come in the form of an increased emphasis on wellness and recovery, care coordination, whole-person health, and person-centered health care. With the rapid approach of 2014 and the expansion of the Medicaid population, information is needed to determine the status of SUD/PC integration.

In the past year, there has been much activity in the development of integration-related toolkits, reports, and websites. Resource websites include the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS; <http://www.integration.samhsa.gov/>), which houses useful materials and hosts regular webinars on topics relating to integrated behavioral health, and the Agency for Healthcare Research and Quality (AHRQ) Integration Academy (<http://integrationacademy.ahrq.gov/>), which collects and compiles published and unpublished literature on the topic of integration. The State Refor(u)m website (<https://www.statereforum.org/>), provides a way for administrators, researchers and providers from different states to communicate with one another on health reform developments, including impacts on behavioral health and care coordination. The National Council for Community Behavioral Health (<http://www.thenationalcouncil.org/>) continues to host relevant and informative webinars on topics relevant to integration. Now more than ever, a wealth of national resources and support is available for those working on integration.

Sharing of solutions and lessons learned is also helping to pave the way for more integration projects to achieve success. The collective dissemination of procedures, workflows, checklists and forms will accelerate the process of integration so that each organization need not “reinvent

the wheel.” Standard templates and tools can be adapted and tailored to each organization’s unique needs.

Defining “Integrated Care”

An updated framework for integrated care

As the field continues to move forward in implementing SUD/MH and health care integration, detailed frameworks have been developed and refined in response to the profusion of different integration models that exist. The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS, 2013) released an issue brief describing a “Standard Framework for Levels of Integrated Healthcare,” which adapts a previous framework proposed by Doherty, McDaniel, and Baird (1996), incorporating work from Blount (2003) and Collins, Hewson, Munger, and Wade (2010). The new framework encompasses six levels of behavioral health and health care integration, under a continuum ranging from coordinated care to co-located care and finally integrated care. This framework reinforces the fact that individuals seeking primary care do not have isolated problems limited to only SUD or only mental illness, but often have issues that co-occur. Hence, the framework encompasses behavioral health and is meant to include both SUD and mental health service integration.

Previously, the framework comprised five levels (Doherty et al., 1996) ranging from minimal collaboration to close collaboration in a fully integrated system.

While the first three levels of the old framework are retained, the newer framework adds further refinement as practices approach higher levels of integration (SAMHSA-HRSA Center for Integrated Health Solutions [CIHS], 2013). In addition, there are clearer definitions of key elements that tie together levels at each integration stage. These six levels of collaboration/integration can be used by organizations to identify their current stage of integration. This information would then be helpful in forming goals for reaching the next stage, or allocating resources to improve quality at the current level of integration. Finally, it should be noted that each level comes with its own set of advantages and weaknesses, described in the SAMHSA-HRSA CIHS report. A standard framework will contribute a basis for integration for organizations, but this approach, by no means, should be considered “one size fits all.”

Summary descriptions of each level follow.

Coordinated Care

Level One: Minimal Collaboration. At this level, care is at its least integrated according to the framework. Communication between behavioral health providers and primary care providers is low and they operate in separate facilities with separate systems.

Level Two: Basic Collaboration at a Distance. Periodic communication between providers differentiates this level from the first, although physical and systems separation is maintained. Behavioral health and primary care providers may communicate occasionally about shared patients and view each other as resources in providing coordinated care.

Co-Located Care

Level Three: Basic Collaboration Onsite. Closer proximity due to co-location of behavioral health and primary care providers allows for more frequent communication between them. Providers may begin to feel like part of a larger team, and referrals are more likely to be successful due to reduced distance between providers in the same facility. However, behavioral health and primary care systems are still kept separate.

Level Four: Close Collaboration with Some System Integration. Behavioral health and primary care providers begin to share some systems, leading to greater integration. Increasing consultation and collaboration occurs between providers as they learn each other's roles and share information to help patients with multiple complex health issues.

Integrated Care

Level Five: Close Collaboration Approaching an Integrated Practice. By this level, behavioral and primary care providers communicate frequently and regularly and have started to function more as a team, actively seeking solutions to integrate care for more of their patients. Certain barriers still exist, but work is being done to create a more fully integrated system (such as through an integrated medical record).

Level Six: Full Collaboration in a Transformed/Merged Practice. “Practice change” defines this level; systems and people are blended together so that they operate as one single practice and are recognized as such by both providers and patients. The health system applies principles of “whole health” in treating their entire patient population.

Talking “*Integration*”: Finding a common language

In order to encompass the broad range of integration activities occurring in SUD, MH, and primary care settings, the working definition of “integration” used throughout this report includes any type of routine or standard SUD/MH screening, referral, intervention, or treatment conducted in a primary care setting; any primary care services conducted in a SUD/MH setting; bidirectional referrals; and/or the inclusion of SUD/MH primary prevention or recovery support services in primary care settings. To better describe specific examples of integration, other terms are frequently employed, but confusion still exists regarding common terms surrounding the concept of integration.

The general term “integration” often takes a wide variety of forms, and similar related terms can mean different things depending on the context and who is using the term. For instance, Butler et al. (2008a) describe the terms “integrated care” and “collaborative care” in interchangeable terms, both of which derived from early research conducted by Wayne Katon and colleagues, who brought together multiple facets of care to help treat depression (Katon et al., 1995). Using a distinction proposed by Strosahl (1998), the difference can be usefully conceptualized as

“behavioral health working *with* primary care” in collaborative care, contrasted with “behavioral health working *within* and as a part of primary care” in integrated care (Collins et al., 2010).

Because integration involves bringing together contributions from different fields and perspectives, consensus on basic terminology would aid these groups in working with one another. A consensus-based lexicon of terms relating to behavioral health and primary care integration published by the Agency for Healthcare Research and Quality (AHRQ) attempts to fill this need (Peek & National Integration Academy Council [NIAC], 2013). According to this lexicon, the key element of integrated care is the presence of onsite teams working together, with other important considerations being organizational integration and linkage to community resources. The publication also lists various “altitudes” of integration to consider, proposing that integration can apply to programs, systems, treatment and payment, all of which should ideally be aligned in order to serve patient needs most effectively.

Once a common consensus can be reached about the definitions of these terms, they can be used and better understood across disciplinary boundaries. The different “cultures” and language used by the different fields that are integrating are often cited as a barrier (see Common Barriers and Challenges).

How integration can be achieved **Evidence-based practices (EBPs)**

As providers continue working on integrating behavioral health and primary care, evidence-based practices (EBPs) can play an important role in the process by bringing research-supported interventions into clinical practice to help improve outcomes (Glasner-Edwards & Rawson, 2010). The selected examples of EBPs described in this section are commonly used in integration initiatives, as they are well suited for delivery in primary care and other settings outside of specialty care. The summaries provided here have been derived from recent reports and toolkits.

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

For many integration programs, screening, brief intervention, and referral to treatment (SBIRT) is a key practice component used to address problems with substance use and other health behavior issues. The process of SBIRT is designed to incorporate the following steps for integrated prevention and care: (1) assess individuals for SUD problems using standardized tools, (2) identify the level of needed treatment, (3) increase individual awareness and motivation for behavior change through brief conversation, and (4) provide a referral to specialty care if the level of treatment need is severe enough.

One of the advantages of SBIRT is that it can be provided in a variety of health care settings; SAMHSA’s SBIRT Initiative, spanning several states across the nation, has demonstrated the effective integration of SBIRT for SUD in settings such as FQHCs, HIV and STD clinics, senior centers, tribal clinics, and specialty health clinics, to name a few (Substance Abuse and Mental

Health Services Administration [SAMHSA], 2013). SAMHSA found that SBIRT led to significant reductions in both substance use and its associated harms, and that SBIRT can be economically viable and sustainable (SAMHSA, 2013). The U.S. Preventative Services Task Force recommends screening and brief counseling interventions for adults age 18 or older for alcohol misuse (USPSTF, 2013).

SBIRT provides the opportunity to identify and help patients with substance use problems in primary care settings that may otherwise go unaddressed. As a practical aid to these integration efforts, SAMHSA-HRSA Center for Integrated Health Solutions provides a wide compilation of resources for use in community health settings (<http://www.integration.samhsa.gov/clinical-practice/sbirt>).

Appropriate selection of instruments plays a role in the amount of time it takes to administer the screening process. Taking into consideration the measurement properties of the instruments as well as the time constraints of operating in a primary care environment, the AUDIT, AUDIT-C, and single-item screens were recommended for use in screening for the spectrum of alcohol misuse in primary care (AHRQ Comparative Effectiveness Review Number 64, July 2012). Other validated screening instruments that are commonly used are the CAGE and the ASSIST (SAMHSA, 2013).

Workforce and reimbursement for SBIRT can be another barrier to its mass implementation. For further discussion, see the Common Barriers and Challenges Section.

Motivational Interviewing (MI)

Motivational Interviewing (MI) is a counseling approach used to promote behavior change through exploring and resolving ambivalence. It can be used to help patients with MH, SUD, diabetes, and other chronic conditions by increasing their awareness and motivation to make positive behavioral changes regarding their health. The process is goal-driven and collaborative; it focuses on patients' own values, beliefs, and wishes rather than being dictated top-down by the provider (Rollnick & Miller, 1995). Brief MI interventions can be delivered through SBIRT in health care settings, and evidence supports the use of MI with patients who have behavioral health issues (Baker & Hambridge, 2002; Britt, Hudson & Blampied, 2004; Miller & Rollnick, 2002; Rollnick, Miller, & Butler, 2008). MI interventions have also been shown to reduce hazardous drinking among depressed adults in outpatient psychiatric settings (Satre, Delucchi, Lichtmacher, Sterling, & Weisner, 2013).

To further encourage the use of MI in health care settings, the effective training of providers in MI skills is important. Research on MI trainings has generally yielded positive outcomes and has focused on isolating different components of successful training and successful implementation of MI as part of routine clinical practice (Madson, Loignon, & Lane, 2009; Söderlund, Madson, Rubak, & Nilsen, 2011).

Medication-Assisted Treatment (MAT)

Use of medication-assisted treatment (MAT) for addiction shows great promise for the integration of addiction treatment services into primary care. The American Society for Addiction Medicine (ASAM) has recently published a compilation of reports on the current state of MAT for opioid dependence, including systematic reviews clearly demonstrating the effectiveness of methadone, buprenorphine, and naltrexone for opioid dependence (American Society of Addiction Medicine (ASAM), 2013). Of these drugs, naltrexone and buprenorphine are currently the focus of much interest relating to SUD and health care integration because unlike methadone, they can be prescribed by physicians in office settings. This provides a way for patients to receive SUD treatment in the same place they receive other medical care.

Despite the evidence in support of MAT, knowledge gaps about its benefits and appropriate use, issues with medication costs and reimbursement, and the need for greater workforce training all contribute to its under-utilization. In order to break through some of these barriers, continued efforts toward education and training are needed. In addition, greater MAT adoption can be facilitated by funding the policies and medical infrastructure to support it (Knudsen, Abraham, & Oser, 2011; Roman, Abraham, & Knudsen, 2011).

Organizational models

Under health care reform, new organizational models are emerging and gaining prominence as ways to transform care so that is better integrated, more comprehensive, and more responsive to the needs of patients. Examples of these models are health homes, patient-centered medical homes (PCMHs), and accountable care organizations (ACOs).

Health Homes and Patient-Centered Medical Homes

http://www.integration.samhsa.gov/integrated-care-models/Medicaid_HH_and_Patient_Centered_Medical_Homes.pdf

The primary care health home model was developed as a way to address the needs of patients with multiple complex conditions. A provision of the ACA created an option of establishing health homes, which provide enhanced Medicaid reimbursement for services to individuals with chronic conditions, including mental health or SUD. Care is organized to be holistic and team-based, with an explicit focus on the integration of behavioral health and primary care. Under ACA provisions, there is also an option to create behavioral health-based health homes for patients with serious mental illness or SUDs (SAMHSA-HRSA CIHS, May 2012). Behavioral health homes can be valuable in serving the needs of these patients because many may already receive the majority of their care in behavioral health settings rather than primary care. Regardless of their focus, health homes must ensure that the full array of services is available and coordinated, which may improve both outcomes and cost for health-home patient populations.

A similar concept, the patient-centered medical home (PCMH) is not exclusive to Medicaid and therefore can serve a broad population. According to the National Committee on Quality Assurance (<http://www.ncqa.org/>), which provides recognition to PCMHs that meet its published set of standards and criteria, a PCMH is defined as “a health care setting that facilitates

partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.” Health information technology (health IT), patient registries, and health information exchange play a role facilitating care in the PCMH, and all care delivered aims to be culturally and linguistically appropriate. In a PCMH, a primary care provider does not operate alone but works as part of a team coordinating care for the patient’s whole health needs.

The University of Minnesota has developed a “paradigm case” of the PCMH to help further clarify what features are important in defining what they are (Peek & Oftendahl, 2010):

- Patients/citizens identifying and accessing a primary care practitioner and team as first contact for a new health concern or ongoing health/illness needs
- Routinely acting from a patient-centered (hence whole-person) orientation
- Aiming for population health outcomes
- A practice team tailored to the needs of each patient and situation
- Carrying out practice-based care coordination / care management
- Coordinating with the “health care neighborhood” of other teams, practices, and community resources shaped around the needs of specific patients
- Patients actively participating in quality improvement (QI) and practice development functions—co-creating the practice and shaping its performance
- Demonstrating capacity for continuous learning and practice improvement
- Supported by a sustainable business model and administrative / leadership alignment
- Accountable to achieving a specific set of clinical, experience, and financial outcomes appropriate to the population under the care of the practice

Accountable Care Organizations (ACOs)

The concept of the accountable care organization (ACO) originated under Medicare in order to improve quality and reduce costs for the chronically ill through better care coordination (<http://innovation.cms.gov/Files/x/Pioneer-ACO-Model-Frequently-Asked-Questions-doc.pdf>). ACOs are large networks of health providers, doctors, and hospitals that contract together to provide coordinated care to their patient population. Through various shared savings arrangements, ACOs are able to “share” in any cost savings they generate with Medicare, although certain arrangements involve more risk and could entail financial losses to the ACO. In contrast with health homes and PCMHs, ACOs are still largely Medicare based, although the ACO concept is beginning to gain the interest of commercial health plans.

The three-year CMS Pioneer ACO demonstration project is designed to allow ACO Pioneers to test out new payment models to see whether they can reduce costs while improving quality of care. It provides incentives for payers and providers to support greater care coordination and reduce unnecessary spending, while allowing all parties who are accountable for the cost and quality outcomes to share in the possible savings that result. Thirty-two Pioneers signed up to participate in the program, but nine—including two in California—left the program for alternate arrangements after the first year, citing concerns about financial risk (<http://www.medscape.com/viewarticle/807919>).

ACOs remain a hot topic due to their promise of improving care while reducing costs. Because of their emphasis on integrating services, they provide a potential opportunity for behavioral health. A large body of evidence supporting their use has not yet been developed, but over time a set of best practices may emerge.

Using technology to facilitate integration

There are many ways that technology can be used to facilitate integration. New technologies and the mass deployment of existing technologies expands the ability of providers to not only share information with each other across disciplines, but also to monitor and track patients and communicate important developments with patients regarding their health. Opening the lines of communication through technology can help increase patient engagement as well as put patients in greater control of their health.

Telehealth: Telemedicine and Telepsychiatry

Telehealth has the potential to transform care by expanding the settings from and to which it can be delivered. Conducting telepsychiatry via video conferencing can be feasible and has a variety of benefits, including increased access to care and facilitation of specialty consultation (Hilty, Marks, Urness, Yellowlees, & Nesbitt, 2004). Because of these benefits, it is an attractive idea for organizations integrating SUD and PC services, particularly considering the opportunity to use telehealth for consultation with behavioral health specialists. Telehealth can facilitate provider discussion about shared patients in addition to its use in communicating with and educating patients from afar.

Research reviews show promise for the benefits of videoconferencing and telehealth, but important limitations must be acknowledged. Video conferencing can help increase access to psychiatric services for patients in rural areas, but only certain groups of patients benefit from telehealth, whereas the benefits are unclear for others. Before recommending telehealth for all patients, more research is needed to determine which groups would be most helped by telehealth and which would be better served through traditional face-to-face care (Norman, 2006). Furthermore, costs depend on the type of technology used and how much use is extracted from the initial investment in equipment; a “break-even” point should be anticipated in order to ensure financial feasibility (Hyler & Gangure, 2003; Norman, 2006).

Health Information Technology (HIT) and Electronic Health Records (EHRs)

Use of health information technology and EHRs is expanding (Adler-Milstein, Bates, & Jha, 2013; DesRoches et al., 2013; Hsiao et al., 2013), facilitated by funding from the federal Meaningful Use program, which offers incentives for providers to track and share clinical information, including some behavioral health elements introduced in Stage 2 (Tai et al., 2012). The process of implementing and integrating an EHR can be difficult (see Common Barriers and Challenges section). However, the fully functional integration of SUD and health care services is difficult if not impossible without integration of the medical record system. Health IT allows

better management and tracking of patient data, which can not only help improve immediate patient care, but also allows organizations to develop and adjust long-term quality improvement programs.

Promising Practices/Programs from the Field

Providers across the country have been pilot-testing promising practices to integrate mental health and SUD services with primary care. Despite barriers, some have been able to effectively integrate different services. Information on various integration initiatives has been obtained from conferences and webinars attended throughout the year, with the highlights presented here. For a full listing of these conferences and webinars, see Appendix 2A. This section provides summaries of programs that are examples at multiple different levels of integration, discusses what unique or key innovations are used by these programs, why they are shown to be promising, and initial outcomes that support their inclusion. In some cases, independent evaluations and replication of these models will be needed to better establish evidence for them.

University of Washington TEAMcare Model

<http://www.teamcarehealth.org/>

TEAMcare is an intervention developed by the University of Washington to provide coordinated care for patients with chronic disease. Patient-centered multidisciplinary team-based approaches can help overcome many barriers faced by individuals with multiple chronic health conditions, leading to more cost-efficient care and improved patient outcomes. For patients with depression, diabetes, and/or coronary heart disease, the TEAMcare integrated multi-condition collaborative care program, relying on coordinated care management between the patient, the primary care provider, and behavioral and medical healthcare specialists (Katon et al. 2010, Ciechanowski 2011, Von Korff et al., 2011, Davydow et al. 2013, Katon et al., 2012, McGregor et al. 2011, Lin et al. 2012), can lead to improved quality of life, reduced disability related to activities of daily living (Von Korff et al. 2011), and reductions in mean outpatient costs (Katon et al. 2012). Given that TEAMcare has demonstrated efficacy for comorbid general medical and behavioral health conditions in a community-based setting, this innovative model may be an effective approach to providing coordinated care for the treatment of co-occurring substance abuse and chronic medical conditions, which engender some of the most costly, chronically underserved, and challenging patients in the health care system. Further research is needed to determine whether this and other existing models of integrated care are effective for the treatment of SUD.

VA Model for Treating SUD and Comorbid Chronic Pain

<http://www.va.gov/painmanagement/>

Misuse of prescription opioids is a major public health problem resulting in substantial morbidity and mortality. The Veterans Affairs (VA) clinics in Philadelphia, PA (Wiedemer, 2007), and Albuquerque, NM (Pade, 2012), have taken steps to provide more patient-centered and integrated services to address the medical and psychiatric conditions that underlie prescription opioid misuse behaviors and complicate their treatment (Gallagher, 1999; Jewell, 2011). They have established specialized programs that have brought together medical, psychiatric, SUD, and pain

specialists to monitor and treat patients receiving chronic opioid therapies. These initiatives have shown promising results, including improved patient adherence to opioid treatment plans (Meghani 2009; Wiedemer 2007), success in getting opioid-dependent patients to begin and maintain buprenorphine treatment (Pade, 2012), reductions in patients' emergency room utilization, reductions in the number of unscheduled primary care visits, savings in pharmacy costs, improved primary care physician monitoring of patients receiving opioid therapies, and high provider satisfaction (Wiedemer, 2007).

SBIRT Initiative: Oregon Model

<http://www.sbirtoregon.org/>

As part of SAMHSA's nationwide SBIRT Initiative, which has led to the launch of several pilot SBIRT training programs across the country, SBIRT Oregon has developed a model to train resident physicians to use SBIRT for detecting and addressing problems with alcohol and substance misuse in primary care. By working closely with the state Medicaid program and Medicare intermediaries, Oregon Health and Science University (OHSU) was able to obtain reimbursement for SBIRT services (see Appendix 2A, Webinar 28). Another important component to the program's implementation design is meaningful integration of the SBIRT process into the EMR system for more streamlined documentation and billing (Muench, Jarvis, Boverman, Hardman, Hayes, & Winkle, 2012). OHSU has provided training to resident physicians in seven primary care residency clinics and is planning to train almost 400 future primary care physicians on the SBIRT approach. The goal of the initiative has been to develop useable curricula and spread the adoption of SBIRT training in residency programs (Pringle, Kowalchuk, Meyers, & Seale, 2012). As a result, SBIRT Oregon's curricula and materials, including screening forms, clinic workflows, clinic tools, a reimbursement model and demonstration videos, have all been made freely available on the program's website.

While a strong case has been made for the importance of incorporating SBIRT training into residency programs (Muench, Jarvis, Hayes, Vandersloot, & Winkle, 2013), future research and outcomes data are needed to judge the success of this technique. Issues to consider are whether the approach will remain sustainable without grant support, and whether the SBIRT training curricula developed through the initiative will be used to implement similar programs across the country (Pringle et al., 2012).

Tarzana Treatment Center

<http://www.tarzanatc.org/>

The Tarzana Treatment Center (TTC), based in Los Angeles County, California, provided a presentation on a webinar saying they aim to provide care that is patient-centered, team-based, and coordinated. As an SUD provider that has integrated comprehensive services, including MH and primary care, TTC reports providing one point of access for its patients' health care and behavioral health needs. Through federal, state, and foundation grants; Medicare and Medi-Cal fee-for-service and managed care; contracts with counties; and managed care contracts with all

major private insurance carriers, TTC reports being able to receive reimbursements for its many integrated activities (see Appendix 2A, Webinar 38).

Bay Area Addiction Research and Treatment (BAART)

<http://www.baartprograms.com/>

The Bay Area Addiction Research and Treatment (BAART) program is a comprehensive SUD service provider that has worked to provide MAT, primary care, and mental health services to patients through its 20 clinics located in 5 states. In the Southeast BAART clinic located in Los Angeles, patients are universally screened for their SUD/MH/PC needs. Primary care and SUD treatment is handled in-house, while patients are referred to a nearby mental health clinic for further evaluation and care through formal agreements. BAART reports being able to reduce the likelihood of patients “falling through the cracks” due to disjointed care and thereby reduce unnecessary emergency room use and hospitalizations by providing community-based coordinated care (see Appendix 2A, Webinar 23).

Missouri CMHC Health Home

<http://www.mocmhc.org/>

Beginning in 2012, Missouri began implementation of the Community Mental Health Center (CMHC) Health Home model. The objective of this systems-level change is to improve patient experiences and healthcare outcomes among Medicaid eligible patients with a MH condition or SUD and at least one other chronic medical condition (see Appendix 2A, Webinar 40). The Health Home model relies on a team of providers, including the Health Home director, nurse care managers, the PCP, and behavioral health specialists to provide comprehensive care management. Over the course of the first year of implementation, Missouri’s CMHC Health Homes reported reductions in numbers of hospitalizations, and cost savings in reduced ER admissions and Medicaid spending. According to the Director of Missouri’s Department of Mental Health, keys to the success of this program have included strong communicative networks, EMR implementation, and recognition of the amount of technical assistance and training required for the providers (Parks, Floyd, Graham 2013).

Salud Family Health Center

<http://www.saludclinic.org/>

The Salud Family Health Center in Colorado is an FQHC integrating behavioral health into primary care. As an NCQA-recognized patient-centered medical home, the Salud model includes such components as co-location, teams utilizing both PCPs and BHPs who accept shared responsibility for patients, and a shared medical record system between PCPs and BHPs, wherein both can access each other’s progress notes (Auxier, Farley, & Seifert, 2011; see Appendix 2A, Webinar 4). The behavioral health providers have strong generalist training backgrounds and are on call to provide services to physicians and patients. Its sources of funding include the Mental Health Expansion Grant from HRSA; partnership with a local health

district; partnership with local mental health centers; commitment of its general operating funds; grants from private foundations; allocation of per member, per month (PMPM) revenue; and training programs (post-docs, interns, students, etc. – as a way to provide care at lower cost while also increasing educational opportunities for workers).

Common Barriers and Challenges

As part of UCLA’s ongoing efforts, we are documenting key barriers to integration that have been expressed in webinars and discussions with stakeholders. Over the last year, health care reform implementation, confidentiality, health information technology, workforce issues, financing, and regulations have emerged as areas of particular concern.

HCR implementation

Traditionally, behavioral health practitioners have operated under fundamentally different service delivery processes compared to their primary care counterparts, often creating misconceptions of each party’s service delivery role and value to the patient. These traditional “silos” of care also contribute to common misconceptions about the nature of SUD itself by primary care staff. The SAMHSA-HRSA Center for Integrated Health Solutions has made online resources available for providers to educate themselves on effective strategies to combat cultural challenges (see <http://www.integration.samhsa.gov/workforce>).

In this past year, the field produced many webinars that dealt with cultural and communicative barriers inherent within historically separate health disciplines. From the distinct terminology used by each discipline to basic interpersonal communication that occurs on a daily basis, practitioners have expressed experiencing some “pushback” from their staff in response to the new personnel and new roles within the PC and/or MH and BH domains. From behavioral health providers, one common concern regarding integration is the truncation of time and accessibility to the patient. One BH provider notes, “I can’t just walk in on a patient; I like to spend more time with patients...I don’t like interruptions, this isn’t the way I was trained” (see Appendix 2A, Webinar 4: <http://www.integration.samhsa.gov/about-us/webinars>). Conversely, some PC providers view BH services in a PC setting as more of a convoluted form of health care services rather than a streamlined form of care. As one PCP notes, “I don’t like other people seeing my patients; the BHP slows me down; I’m really good with psych stuff and I don’t need help” (see Appendix 2A, Webinar 4: <http://www.integration.samhsa.gov/about-us/webinars>).

Providers who have experienced cultural pushback have advocated for leadership to instill in their staff the idea that “chronic physical illness is often comorbid with chronic mental health problems, which can affect the fidelity of the treatment of both issues if they are not treated in tandem” (see Appendix 2A, Webinar 32: <http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>). When the issue of health is framed in a holistic manner and is clearly stated by leadership as the organizational standard for service delivery, it is easier for staff to see themselves as part of a team whose duty is to mitigate patients’ range of illnesses rather than to continue to engage in a “siloed” model of care.

Confidentiality: Issues around 42 CFR

In addition to cultural differences, PC and MH/BH medical disciplines have also operated under different privacy and information-sharing criteria based upon the services they deliver and the type of personal health information (PHI) they handle. Every organization that handles some form of PHI is subject to federal privacy guidelines under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA provides a “floor” or minimum privacy standard for individuals’ PHI that all covered entities must comply with; however, 42 CFR Part 2 adds stricter confidentiality requirements when patients behavioral health information is included, specifically information relating to alcohol and drug treatment and anything that identifies a patient (directly or indirectly) as having a current or past drug or alcohol problem. 42 CFR Part 2 privacy restrictions apply to organizations, units, or individuals that are federally assisted and “hold themselves out” as providing, and actually providing, substance use disorder diagnoses, treatment, or referral to treatment. For a more complete overview of the Code of Federal Regulations, Title 42, Section 2 (42 CFR), please refer to the Legal Action Center’s website for relevant webinars and documents on 42 CFR at: <http://www.lac.org/>.

The most commonly cited issue that providers have expressed regarding 42 CFR is that it inhibits the sharing of health information that is critical to integrated or coordinated care. However, providers may receive written consent from patients to share SUD information (see Appendix 2A, Webinar 26: <https://jbsinternational.webex.com/jbsinternational/onstage/g.php?t=a&d=576164902>) and may use “Qualified Service Organization Agreements (QSOA) to allow for information sharing across organizations for some purposes. (http://www.lac.org/index.php/lac/webinar_archive).

Health IT: EHR Implementation and Privacy

A recent national survey of primary care providers and specialty care providers’ utilization of electronic health record (EHR) systems found that basic adoption of EHR systems had risen to 34% by March 2012 (DesRoches, Audet, Painter, et al., 2013). One of the driving factors behind the increased usage of EHRs in PC settings is the financial incentive put into place through the Health Information Technology for Economic and Clinical Health (HITECH) Act, which provides federal subsidies for incentive payments to support the meaningful use of health information technology (HIT). However, one of the major issues hindering EHR adoption is that the HITECH Act did not qualify behavioral health organizations to receive facility incentive payments that would have allowed BH organizations to fund EHR implementation initiatives (Young, 2012). Michael Lardiere, the National Council’s Vice President of HIT and Strategic Development, has stated that “Without these federal incentive payments, behavioral health organizations are unfairly restricted from achieving the Triple Aim of improving the patient experience of care, improving the health of the populations, and reducing the per capita cost of healthcare” (Young, 2012).

Another area of concern cited by BH providers as a barrier to integrated care is the sharing of 42 CFR covered electronic PHI among different types of staff. While having access to an EHR system can streamline and facilitate coordinated care, it is important to know who is allowed

access to certain information and who is not. SAMHSA pilot projects are currently testing the use of “metadata” tagging that prompts clinicians to seek patient consent before disclosing specific data elements to another healthcare provider (“HHS, VA demonstrate,” 2012). SAMHSA and the VA have reported safely and securely transmitted a mock patient’s substance abuse treatment records tagged with privacy metadata from one EHR to a different EHR system, but the full results from the pilot project have yet to be released. While this technology may eventually allow more nuanced privacy controls for individual pieces of patient data, in the meantime providers can implement blanket data-sharing solutions using 42 CFR compliant consent forms (see prior section).

Workforce limitations

Shortages of staff that are adequately trained to handle SUDs in an integrated setting persist. This is made worse by the fact that the only BH staff FQHCs can bill Medi-Cal for are psychiatrists, psychologists, and LCSWs, and they report a shortage of workers in these professions. Allowing other types of providers to bill in these settings, including LMFTs, would alleviate this situation. See Section B and Chapter 3 for more on workforce issues.

Financing, billing, regulations for integrated services, including policy challenges

In 2014, SUD coverage through insurance plans, enhanced Medi-Cal benefits for SUD services, and the Medi-Cal expansion will combine to create unprecedented new opportunities to expand SUD services in the state. A number of challenges and barriers remain, however, including:

The Medi-Cal carve-out: Primary Care facilities typically do not have Drug Medi-Cal certification, which is obtained through a different process (and until recently, a different department). Primary care’s inability to bill for SUD services interferes with efforts to integrate such services within primary care facilities.

Medi-Cal same-day service billing restrictions: In California, primary care providers cannot bill Medi-Cal for more than one service on the same day. Therefore, even if Medi-Cal billing codes for screening, brief intervention, and referral to treatment (SBIRT) were to be activated, primary care providers seeing a patient for a medical visit would not be able to also bill for SBIRT or other behavioral health services. Furthermore, primary care providers will likely be reluctant to provide SBIRT without having adequate behavioral health staff available to handle patients identified as needing behavioral health services (workforce issues are discussed in Chapters 2 and 3).

Certification of Drug Medi-Cal SUD treatment programs: Given resource restraints, it may be challenging for DHCS to newly certify enough Drug Medi-Cal programs in time for 2014. The counties have expressed interest in working with DHCS to assume this function. Given realignment, they have an interest in determining which programs receive certification and contracts in their counties.

Institutions for Mental Disease (IMD) exclusion: Residential facilities with more than 16 beds cannot be reimbursed through Medi-Cal. The purpose of the policy is, in part, to avoid “warehousing” patients in large state hospitals (NAMI, 2013). However, the restriction will disqualify a number of SUD residential providers, which in turn will have a negative impact on system capacity. Anecdotally, some programs circumvent these rules by licensing multiple small units separately, even if they are located on a shared campus, but this undoubtedly creates a greater burden on both the state and programs during the certification process. A solution that allows certification of reasonably sized existing programs without resulting in “warehousing” is needed.

Loss of Medicaid coverage due to incarceration: Medicaid benefits are often terminated for incarcerated offenders, which can cause problems when the inmate is released. Suspending rather than terminating Medicaid benefits for offenders and aiming Medicaid outreach and enrollment efforts at inmates are recommended solutions (Cuellar & Cheema, 2012). At this writing, AB 720 (Skinner), which would require measures along these lines, had passed the Assembly and has been referred to the Senate Appropriations Committee. See Chapter 1 for more on this topic.

Inability to place physicians in residential treatment programs: Having physicians on staff at residential programs would facilitate integration and coordination with primary care, but this is currently not allowed. As of this writing, AB 395 (Fox) would allow residential SUD treatment programs licensed by DHCS to include physicians on staff as part of a multidisciplinary team.

Lessons Learned

In the past year, the field has made progress in defining language and developing resources to support integration. Current strategies for achieving integration include EBPs, organizational models, and technology, and promising models testing new practices continue to emerge. However, further research is needed to determine whether these approaches can improve quality and outcomes while effectively reducing costs.

Significant barriers to integration continue to persist within the field. Over the last year, discussions have continued around the development and challenges related to health care reform implementation and cultural issues across the health care field, confidentiality, health information technology, workforce development, financing integrated services, and regulation requirements and policy barriers within the current system. These issues require ongoing discussion and state-level leadership to assist and facilitate counties and providers to navigate through the complexities of delivering integrated care. This is a prime time for review and evaluation of current policy around substance use and behavioral health service delivery.

B. What is happening in California

California County Integration Survey 2012

As a follow-up to the 2010 SUD/PC integration survey reported in UCLA's 2010–2011 EnCAL report, this 2012 survey of county alcohol and other drugs (AOD) administrators assessed the status of integration efforts in California counties among county-operated or contracted SUD, mental health, and primary care providers in order to determine progress and technical assistance needs to prepare for health care reform.

Results suggest that from 2010 to 2012, there has been an increase in the number of counties working on or planning initiatives to integrate SUD screening, intervention, and referral to treatment within mental health or PC settings. Many counties have reported progress in their integration initiatives, despite the many existing barriers still intact from 2010 (i.e., financing integrated services in various settings and addressing regulations and certifications to facilitate integrating services).

Technical assistance continues to be needed to assist counties in overcoming barriers to integrated care. More work is also needed to familiarize primary care providers with SUD specialty care services and to foster partnerships between the two.

Purpose

The purpose of this survey was to follow-up a 2010 examination of the scope of SUD and health care integration initiatives in California counties. The 2012 survey of county alcohol and other drugs (AOD) administrators, conducted by UCLA, assessed the status of integration efforts in California counties among county-operated or contracted SUD, mental health (MH), and primary care (PC) providers in order to determine progress as well as the extent of technical assistance needed to facilitate changes in service delivery resulting from health care reform. With feedback from ADP and the California Institute for Mental Health (CiMH), the original 2010 survey was revised to incorporate an increased orientation toward integration efforts among behavioral health providers. This survey was part of a continuing effort to provide evaluation services, technical assistance, and training activities to further the integration of SUD, MH, and PC services in California (See Appendix 2B for full survey).

Note: within the survey items, the terms “AOD” and “SUD” were used when appropriate to allow for alcohol and drug prevention, treatment, and recovery services to be included in the responses.

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/PC integration activities across the state and to assess technical assistance needs. In October 2012, AOD administrators from every county (N=57) received an e-mail with a link to the survey. Administrators were given six weeks to complete the survey. Fifty-three

administrators (93%) responded to the 2012 survey, while the 2010 survey saw a 77% response rate (n=44). UCLA research staff conducted a descriptive analysis of the survey results. A discussion of the results, highlighting key findings and summary statements, was conducted during the Integration Learning Collaborative meeting #19. A summary of this discussion was posted online on the ILC website (<http://uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>), and is also detailed in this chapter in the section title: *CA Integration Learning Collaborative, Topic summaries*.

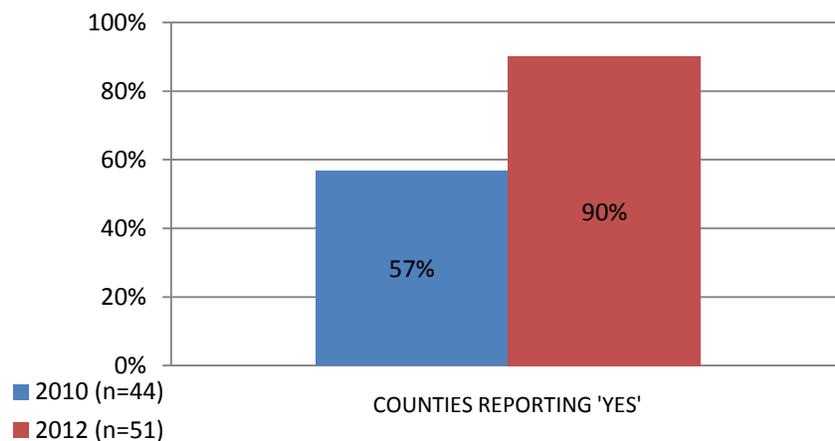
Summary of Findings:

General Ratings of Integration

From 2010 to 2012, there was an increase in the number of counties working on or planning initiatives to integrate SUD services within MH or PC settings.

Forty-six counties (90%) reported that SUD/PC integration efforts were underway, up from 57% of counties surveyed in 2010 (see Figure 2.1). Of the 7 counties (10%) not currently engaged in integration work, 43% reported planning SUD/PC integration within the coming year. This figure represents an increase compared to the 2010 survey results, in which only 32% of those counties not currently engaged in integration activities had SUD/PC integration plans in the future.

Figure 2.1: Integration efforts underway (2010 vs. 2012)



Models of Integration

Integration of AOD/SUD services into PC (45%) was reported more frequently than integration of PC services into SUD programs (31%) by 2012 survey respondents. Overall, ratings of AOD/PC integration activity increased in 2012 compared to 2010 results.

AOD/SUD services in PC settings

County administrators were asked whether AOD/SUD services, including SBIRT, primary prevention, and recovery support services, were being provided in primary care settings. The percentage of respondents agreeing increased from 23% in 2010 to 45% in 2012 (see Figure 2.2). Of those who offered AOD/SUD services in PC settings in their counties, 31% reported that SUD treatment was provided, while 18% reported that primary prevention was offered and 14% offered recovery support services (see Figure 2.3). The percentage of counties reporting *no* integration of AOD services in primary care settings was lower in 2012 than in 2010, and a higher percentage of counties reported that AOD services were provided in more than 25% of primary care settings in their counties (see Figure 2.4).

Figure 2.2: Respondents agreeing that AOD/SUD services are provided in one or more PC clinics

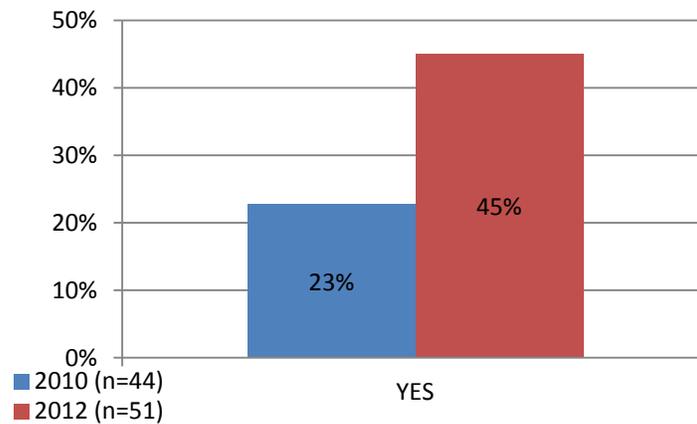


Figure 2.3: Breakdown of AOD/SUD services provided in PC settings (n=51)

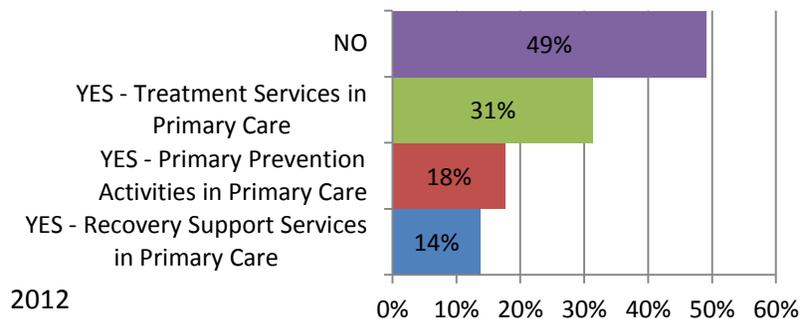
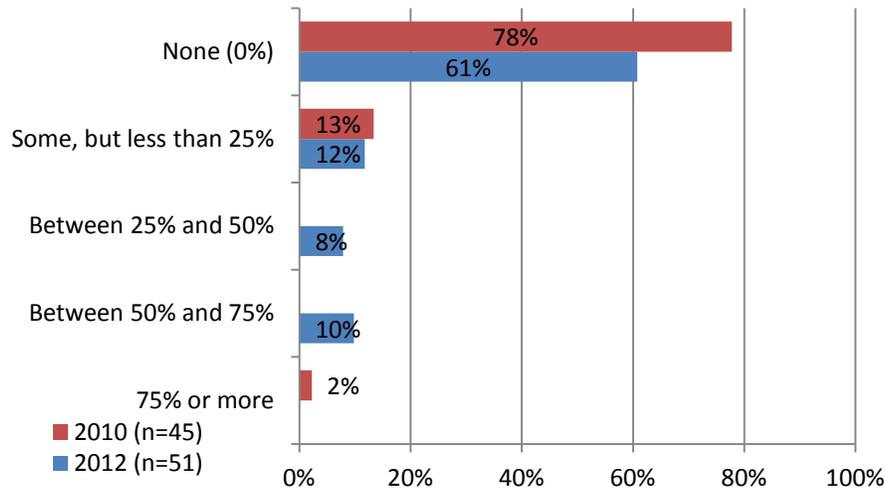


Figure 2.4: Percentage of PC settings providing AOD/SUD services (2010 vs. 2012)



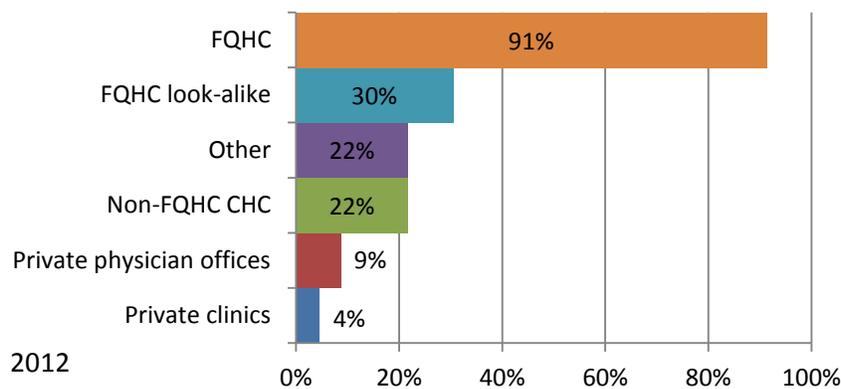
PC services in SUD programs

In 2012, 31% of respondents noted that PC services were being integrated into AOD specialty treatment programs, comprised of SUD treatment providers *other than narcotic treatment programs* licensed to have an onsite medical professional providing primary care services such as physical exams to patients. These results demonstrated a small but noteworthy increase over those of the 2010 survey, in which only 25% of respondents noted that PC was being integrated into SUD programs.

FQHCs and community health care settings

Ninety-one percent of respondents noted that their county’s FQHCs provided AOD services, and 30% noted that their FQHC look-alikes provided AOD services (see Figure 2.5). Some non-FQHC community health centers were reported as providing AOD services (22%) and a small percentage of private physician offices (9%) and private clinics (4%) were reported as offering AOD services.

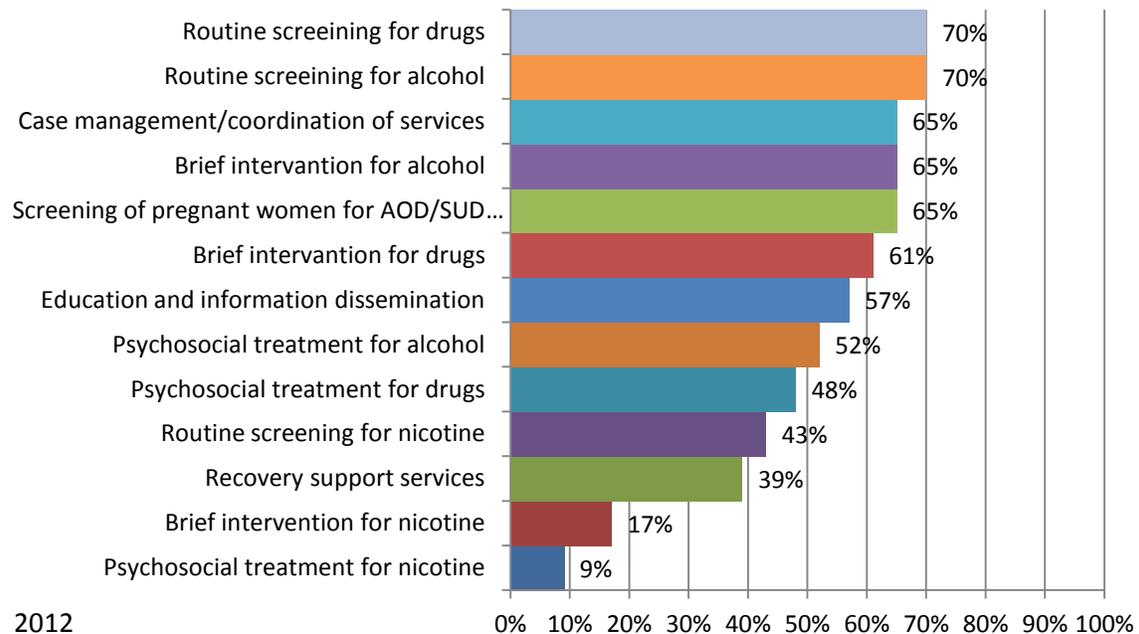
Figure 2.5: Types of primary care settings with AOD services (n=23)



AOD Services

The most common AOD services provided in the primary care clinics were routine screenings and brief interventions for drugs and alcohol, and case management (see Figure 2.6).

Figure 2.6: Types of AOD services offered in PC (n=23)



Funding

Mental Health Service Act (Proposition 63) funds were the most commonly reported source of funding for integrated AOD services in PC settings, whereas Medi-Cal and self-pay were the most common sources of funding for primary care services in SUD treatment.

In 2012, half of survey respondents reported that 25% or less (or none) of their county's SUD treatment providers were currently billing private insurance for AOD services.

Service Delivery Models

Where SUD services were present in PC settings, they tended to be better-integrated than when medical services were provided in SUD treatment settings.

Medical services provided in SUD treatment settings tended to follow a co-located model rather than full integration.

Administratively, the majority of counties in 2012 had behavioral health services (MH and SUD) under one department/agency and health services in a separate department/agency (similar to

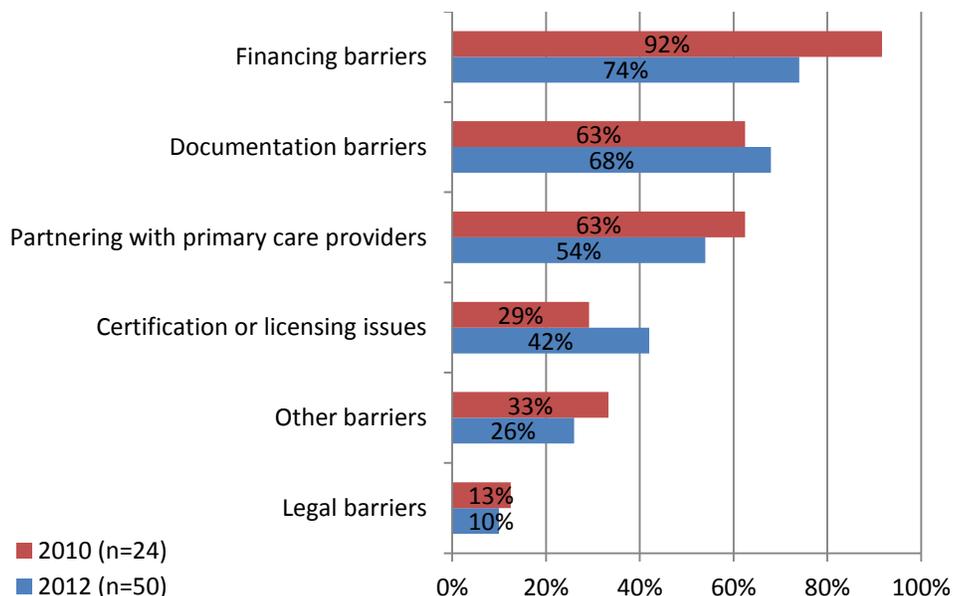
2010). In roughly one-quarter of counties responding, all three services were served by a single department/agency.

Barriers to Integration

Factors identified as barriers in 2010 persisted in 2012.

Almost all administrators (92%) believed that financing was a critical barrier to integrated care (see Figure 2.7). Many also listed documentation of integrated care (i.e., sharing information about patients across providers; 63%) and developing partnerships with primary care providers (63%) as additional barriers. Although financing is still considered the primary barrier to integration, the percent of administrators who perceive it as such (74%) has decreased since 2010. Documentation and certification or licensing issues are understood to be greater barriers than they were in 2010. Sixty-eight percent of respondents found documentation to be a barrier, up from 63%, and 42% found licensing to be an obstacle, up from 29% in 2010.

Figure 2.7: Perceived barriers to integrated care (2010 vs. 2012)



Training

Respondents were specifically very interested in trainings on the topic of integration with health care

Respondents were specifically interested in: integration strategies, chronic diseases associated with SUD or MH, and working in the health care system. The survey responses will be used to help guide the Pacific Southwest Addiction Technology Transfer Center (PSATTC) in

developing the training curricula. A majority of respondents were interested in participating in further discussions through the monthly ADP/UCLA learning collaborative (ILC), which further validates the need for this ongoing forum. Many respondents volunteered to present their own experiences in future ILCs.

Survey Limitations

A few factors limit the scope of these conclusions. The survey asked administrators to provide their best guesses regarding integration activities occurring in their counties. However, structures for services vary by county and can restrict the amount of knowledge or communication an administrator may have with their providers. Additionally, at the time of the survey, little consistency existed in use of the terms relating to integration. UCLA used more inclusive language in order to capture the full spectrum of integration activities, but future surveys making use of standardized categories may provide useful information on county integration activities.

Summary/Lessons Learned

- While a few counties have not yet begun the process of integrating AOD services with mental health and primary care, many others have reported progress.
- Despite many barriers remaining intact between 2010 and 2012, integration initiatives have expanded among California counties.
- Although an increased number of primary care settings were providing AOD services in 2012, more work is needed.
- There remains great diversity in models and funding sources for primary care services provided in SUD settings, and the services provided extend beyond medication management and a one-time physical exam.
- SUD services tended to be better integrated into PC settings than medical services were into SUD settings.
- Technical assistance will continue to be needed in order to assist counties in understanding barriers to integrated care and to determine how to work through them.

California Integration Learning Collaborative (ILC)

Goals and Objectives

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

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

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

To this end, activities have included:

- Monthly meetings or calls. Topics have included: County Integration Initiatives, Data Privacy, Health Homes, Billing/Funding, Workforce Considerations, HCR in other Large States, Brief Treatment, Medication-Assisted Treatment (MAT), and the Prescription Drug Abuse Problem (epidemiological update), Integration Survey Results, County Experiences with the LIHP, and Behavioral Health screening instruments.
- Detailed meeting summaries and materials are available on the website: <http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>
- A listserv was created; to subscribe to the mailing list visit: <http://lists.ucla.edu/cgi-bin/mailman/listinfo/ilc>

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

Invitations to participate are sent to county AOD program administrators and other key stakeholders, including the Association of Alcohol and Drug Program Executives (CAADPE), California Opioid Maintenance Providers (COMP), California Therapeutic Communities (CTC), Mental Health Systems (MHSINC), California Association of Addiction Recovery Resources (CAARR), California Institute of Mental Health (CiMH), and Alcohol and Drug Policy Institute (ADPI). The ILC meetings are held on a monthly basis, with topics determined collaboratively by UCLA, ADP, and the participating members. Meetings commenced in April 2011 and are ongoing.

ILC Methods and Activities

From August 2012 to June 2013, the ILC held five teleconference sessions and five in-person discussions. On average, teleconference attendance was approximately 26 participants, whereas the in-person meeting attendance was as high as 100. All meeting materials and summaries are posted on the Integration Learning Collaborative website. Ongoing communication and support are provided via e-mail.

Many of the topics described below were determined by drawing on information gathered from the California Integration Survey. The survey requested topics of interest and identified county representatives who were willing to report on models and outcomes from their own integration pilot activities. UCLA and ADP came to a consensus on all topics in advance of each ILC session.

Topic Summaries

Topic: Latest Findings: Integration of Substance Use Disorder (SUD) Services with Primary Care (September 26, 2012)

Presenter: Darren Urada, PhD

This presentation covered three main topic areas: the impact of SUD on health and health care costs, the impact of integration on health and health care costs, and how we can use tools and data to strengthen the case for providing integrated care.

SUDs contribute to over 70 conditions that require medical care (NCASA, 2012). SUDs increase the risk for chronic diseases including cardiovascular, pulmonary, and liver diseases (Stein, 1999), mental health disorders (CSAT, 2007), communicable diseases such as HIV and hepatitis (Clark, 2010), and serious injuries (Vinson, 2003).

People with SUDs incur over double the total medical costs of people without SUDs (Parthasarathy, 2003; Thomas, 2005). SUDs roughly double the cost of care for Medicaid enrollees who have co-occurring medical conditions (Boyd, 2010). It is anticipated that 147,000–195,000 new Medi-Cal enrollees in 2014 and beyond will need SUD services (TAC & HSRI, 2012). Cost studies have demonstrated the benefits of providing SUD treatment. Brief physician advice on SUDs leads to \$4.30 in savings for every dollar invested (Fleming et al., 2002). SBIRT in emergency departments may result in \$3.81 in health care cost savings for every dollar spent (Gentilello et al., 2005). Compared to drug-free treatment for opioid dependence, buprenorphine reduces costs by 30% (Baser et al., 2011). Compared to oral naltrexone, Vivitrol reduces the cost of inpatient services by 31–38% (Baser et al., 2011, 2011b). These studies do not take into account other non-medical savings, such as treatment in lieu of incarceration. For example, for every treatment completer, Prop. 36 saved California \$4 for every \$1 spent.

Measuring Integration: The Dual Diagnosis Capability in Health Care Settings (DDCHCS) tool can be used to score how integrated a primary care organization is. Other potential measures of integration may include patient pipelines, and surveys to measure staff perceptions and attitudes.

A detailed meeting summary and materials are available on the ILC website:
<http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>

Topic: Open Table Discussion: Hot Topics from an AOD/SUD Integration Survey (November 28, 2012)

As a result of the Integration Survey distributed by UCLA ISAP in October 2012, this ILC discussed hot topics identified from the survey (information collected during this ILC is also described in the preceding section *Common Barriers and Challenges*). The discussion began with a conversation regarding forming partnerships with primary care providers and organizations as well as the challenges related to working in a primary care setting. Forming effective partnerships between SUD and PCPs can be very challenging. ILC participants shared how they achieved such partnerships and provided tips on engaging primary care physicians and how to work with the different “culture” of primary care and behavioral health. The group also discussed the challenges associated with implementing screening protocols and the need for the field to develop a standard form that can be used in the primary care setting.

Documentation also continues to be a barrier to integration, with many counties reporting that they are having trouble working with confidentiality regulations around SUD and MH patient records (especially among care coordination clients). Discussion ensued regarding the challenges surrounding information exchange and 42 CFR (including obtaining appropriate consent from patients). Another barrier mentioned concerns finding an EHR and a patient registry that works well and adequately meets the needs of the field. The discussion ended with a brief remark that the most commonly cited barrier to SUD/PC integration in California continues to be inadequate funding.

A detailed meeting summary and materials are available on the ILC website:
<http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>

Topic: ADP-UCLA 2012 Integration Survey Results (January 23, 2013)

Presenter: Darren Urada, PhD

This ILC Meeting covered the results from UCLA/ADP’s 2012 Integration Survey, as a follow-up to the 2010 Integration Survey (please see Section B for a detailed description of the survey methods and results).

Conclusion: While a few counties have not yet begun the process of integrating AOD services with mental health and primary care, significant progress has been made in county integration initiation and implementation from 2010 to 2012. The state was not ready for 2014 yet, but was moving in the right direction. DHCS and UCLA plan to continue offering training and technical assistance to aid counties every step along the way.

A detailed meeting summary and materials are available on the ILC website:
<http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>

Topic: Challenges for the SUD Workforce: 2013 and Beyond (March 27, 2013)
Presenters: Richard Rawson, PhD, and Thomas Freese, PhD (UCLA ISAP)

This ILC presentation focused on how to prepare the current AOD workforce for the types of setting and practice changes in SUD treatment delivery, recovery, and prevention brought forth by health care reform (see Chapter 3 for a detailed discussion). Over the next 10 years, there will be a large effort to develop policies, infrastructure, educational curriculum at schools, and training centers to prepare the workforce to meet the needs of providing services in the broader health care system, which will require California certification/licensing reform as well. While there will continue to be a need for SUD counselors in the specialty care system, there will be a far bigger need for behavioral health clinicians in the broader health care system. In the meantime, short-term plans are required to prepare for 2014. Proposed ideas included: (1) Identify training needs so that SUD/MH services can become an effective part of primary care, (2) Identify specialty care needs versus MH/SUD generalist skills, and (3) Identify SUD personnel who want to learn new skills to work in primary care and provide them with training. Workforce development will continue to be a hot topic as ACA implementation draws closer. UCLA and DHCS will convene a meeting of state and national experts in September 2013 to discuss next steps.

A detailed meeting summary and materials are available on the ILC website:
<http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>

Topic: Low Income Health Program (LIHP) in Los Angeles and San Mateo (April 24, 2013)
Presenters: John Viernes (Los Angeles) and Clara Boyden (San Mateo)

John Viernes described Los Angeles County's efforts in establishing a LIHP program with SUD services. Ultimately, the county decided not to pursue the LIHP program in order to focus on Medi-Cal expansion.

Clara Boyden described San Mateo's current Medicaid Coverage Expansion for SUD Services. The covered SUD services include: Assessment, Behavioral Health Integration, Case Management, Collateral Services, Day Care Rehabilitation, Detoxification, Group Counseling, Individual Counseling, Medication Assisted Treatment, Narcotic Replacement Therapy (Methadone), Outpatient Treatment, Residential Acute Stabilization, Residential Perinatal Treatment, Residential Treatment Including Detoxification, and Screening and Intervention. The challenges that they have faced include: the transitory nature of the population, picture identification requirements, failure to disclose all income (unemployment), individuals with benefits in neighboring counties, delayed notification of coverage to providers, the changing face of partners and referral sources (from criminal justice to primary care), and credentialing of staff

(State ADP requirements vs. health insurance requirements/licensing and the ability to diagnose). A lot of time was spent educating the providers on documentation of medical necessity and services, knowledge of billing codes and establishing relationships with private insurers and primary care providers. San Mateo plans to continue to learn how to navigate the primary care system and develop relationships. They also plan to further establish referral and communications protocols (bi-directional), provide outreach materials to primary care providers, and expand medication-assisted treatment. The ultimate goal is to improve the physical and mental health of SUD patients through greater coordination of care.

A detailed meeting summary and materials are available on the ILC website:

<http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>

Topic: Integration Updates from the Field (May 29, 2013)

Presenter: Darren Urada, PhD

As we approach January 1, 2014, the field is changing on a daily basis. This presentation sought to provide updates collected from various recent conferences that highlight national and international trends.

Issues with financing and the workforce continue to be widely discussed. Some believe that non-billable behavioral health (BH) staff under an accountable care organizations (ACO) model are all moving toward becoming “billable” as long as they are credentialed. The rules are still in progress and will vary from state to state. Forming partnerships between a federally qualified health center (FQHC) and BH will become increasingly important, and innovative examples were given. FQHCs get paid based on patient encounters, with a national average rate of \$143 per encounter. In one instance, a BH center that was seeing a lot of medication-only patients and getting paid very little due to their time-based billing moved these patients to a partner FQHC center, which could bring in much more money due to their encounter rate. This allowed the FQHC to then pay the BH center for other behavioral health services. The “sell” to primary care is that the doctor really wants to hand off “the crying patient” to the BH center. This allows the doctor to move on to the next patient and increase revenue while still providing the patients with quality care. It is exclusive to California that counselors cannot get paid in FQHCs. In other states such as Nebraska, all licensed mental health practitioners (e.g., social workers, MFTs, and counselors) can bill at FQHCs.

Chronic pain and prescription drug abuse continues to be a growing problem. In dealing with these patients, daily functioning and happiness are the primary goals. Complete pain relief is unrealistic. It is important not to use the term “addiction” in dealing with chronic pain treatment. Doing so will often impede the practitioner’s ability to reach patients who—presumably because of denial—will not want to be referred to a specialty clinic.

This emphasizes the need for integrated care so that patients struggling with addiction can receive quality care without having to cope with the negative stigma surrounding the disease.

England's National Treatment Agency (<http://www.nta.nhs.uk/>) has a focus on patient-centered care and performance measurement. All National Health Services in Britain use a performance measurement called the net promoter score (NPS). The NPS is calculated by asking each patient, "How likely are you to recommend the services that you received today to a friend or family member, from 0 to 10"? If scores go down, a regulator will come in. If scores are good, then the organization is left alone. Businesses with a high net promoter score (around 7.5) are likely to grow very fast, and those that do poorly often go out of business.

The term "Hot Spotting" was also discussed. Jeffrey Brenner, M.D., identified high-cost users and mapped where they lived over the course of five years. There are healthcare cost hotspots—which are very concentrated numbers of high cost users in small geographic areas. If we could incorporate these data into our approach, it could help with prevention and treatment outreach. For more on hot-spotting, see Chapter 1.

A detailed meeting summary and materials are available on the ILC website:
<http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>

Topic: Behavioral Health Screening Instruments (June 26, 2013)

Behavioral Health screening instruments, including AOD screens, MH screens, two-stage screens, and combo screens were a topic requested by the ILC members. Screening is when a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any health care setting.

According to one 2010 survey of FQHCs, approximately 53% of FQHCs routinely screen all of their patients for depression (Lardiere, Jones & Perez, 2011). When the same survey was conducted for substance abuse, that number dropped to approximately 39%, indicating that fewer FQHCs screen for substance abuse than depression. The survey had a low response rate, and the actual percentages may be lower. The most commonly used screening tool used for substance abuse was the CAGE (44.5%), followed by "other" tools (36.1%) and the AUDIT (12%).

Participants shared their experiences with instruments, including the UNCOPE (Alameda, Kern), ASI-MV (San Francisco), CRAFFT (Sacramento), and brief combination screens (Orange).

Two-Stage Approach

As community-based screening for health risk behaviors, including substance use, are being implemented, utilizing a two-stage approach to screening is being encouraged by agencies such as the PSATTC. This approach involves using the ultra-brief screens in the first stage and includes: a single question for alcohol, single question drug use, the GAD-2, and the PHQ-2. Ultra-brief screeners help identify the potential for a problem but do not give enough information to define levels of risk that can guide intervention strategies. This is true for the AUDIT-C+, the 2 one-item screeners and the PHQ-2 and GAD-2. If the short screener is positive, then a second, longer instrument is used for those patients (e.g., full AUDIT, DAST, GAD-7, PHQ-9).

Many organizations have created their own combination screener to fit the needs of their patients. Combined screening instruments are incredibly important due to the high frequency of comorbidity among patients with SUD.

Tracking Patients' Improvement Over Time

The challenges of tracking patient improvement over time was also discussed. The UNCOPE and the Treatment Effectiveness Assessment (TEA) were discussed as possible solutions.

A detailed meeting summary and materials are available on the ILC website:

<http://www.uclaisap.org/Affordable-Care-Act/html/learning-collaborative/index.html>

County Case-Study Summaries

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

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

- Riverside
- Merced
- Lassen
- Imperial
- Trinity

* Los Angeles and Kern counties also presented their integration work within an ILC, but their summaries are included in the Pilot evaluations section within this chapter.

Each county's work has been organized to address:

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

- Key findings
 - Facilitators and barriers
- Lessons learned

RIVERSIDE COUNTY

Background

Riverside County has a population of 2.24 million and covers 7,208 square miles in Southern California. The unemployment rate in Riverside County is 10.5% (as of March 2013).

Three integration programs in Riverside County were discussed during the Integration Learning Collaborative on August 22, 2012:

- 1) The Rubidoux Public Health Clinic (which is an FQHC-Look Alike),
- 2) The Blaine Street Mental Health Clinic, and
- 3) The Suboxone Treatment Program with a Primary Care Physician.

Rubidoux Public Health Clinic

This clinic is a FQHC-Look Alike with mental health services integrated within a public health clinic. The clinic began seeing patients in August 2012 and is a grant-funded project through the Riverside Health Foundation.

Objectives/Methods

The program was created to address the needs of their patients—co-occurring disorders (COD) patients are dying at an average age of 48 years. The program goal is to identify and link mental health patients to physical health care, and to link physical health patients to mental health care. The mental health clinic identified those mental health patients in the public health catchment area who had two or more physical health problems, who were not engaged with a primary care provider, and who needed integrated management of health problems. The program staff includes two bilingual MFTs and a psychiatrist three days/week (20 hours total). Most of the patients served within the Mental Health Clinic are eligible for Medi-Cal. The MH clinician sees patients in an exam room within the public health clinic. Mental health clinicians were trained in administering the CRAFFT, which is used to screen patients for substance use. Patients receiving a certain score are referred to substance abuse treatment services. Nurses from other doctors bring patients to the MH clinician if the doctor is prescribing a psychotropic drug. If there is an acute crisis, the clinician and/or psychiatrist will see someone immediately (if they're available).

The program is tracking all services provided during the grant period so they can figure out how to bill under available funding in the future. The grant from Riverside Health Foundation covers: psychiatrist time, nurse practitioner time at Blaine St. Clinic, and limited amount of physical health set-up costs. The charts are fully integrated at this site.

Implementation Outcomes

Program barriers included finding the appropriate staff, patient concerns, and merging different work cultures. Licensed staff were needed for the program, but they could not find LCSWs to fill the position. It was clear during the planning process that the doctors did not understand what mental health (MH) providers do. The medical model at the Public Health clinic is very different from the mental health model. They have two different work styles and languages. This has required patience, tolerance, and openness in order to merge the two cultures. Dysfunction existed in each system. “We know we have it – we just don’t talk about it. We

don't know all the hidden rules in the other the system," said one program administrator. Some mental health patients did not want to move to a Public Health Clinic for services.

Blaine Street Mental Health Clinic

This clinic is an integrated adult outpatient clinic. The program serves adults ages 18–59 who have a serious mental illness. The program provides initial assessments including crisis and urgent care services. A multidisciplinary team provides mental health treatment, case management, and linkage to community services. Treatment ranges from psychiatric services and short-term therapy to ongoing support, housing, and benefits assistance. The program also provides vocational services to adults currently receiving services through the Department of Mental Health.

Objectives/Methods

The grant from the Riverside Health Foundation allowed for the placement of a nurse practitioner (NP) who was bilingual and experienced in public health to work in the mental health clinic. The program focus was on basic physical health care prevention and education services including birth control, STD education and testing, and women's reproductive health care (for women age 40 and older). The program was initiated because the mental health patients have high rates of obesity, cancer, high blood pressure, and diabetes. The patients need onsite medical services. To facilitate these services they set up a primary health care exam room, which cost \$35K for equipment and supplies (which was more than expected). The clinic also needed to have a lab room for supplies and specimen collection. This required specialized equipment including a phlebotomy chair, more refrigerators, urine test cart, microscopes, slides, ear scopes, etc. The clinic is keeping the charts separate (one for mental health and one for physical health), but the two are kept together so they can both be pulled when the clinician or doctor sees the patient. Both charts are used at the same time.

Implementation Outcomes

In the first two weeks of the added emphasis on physical health care, there were two medical crises identified that the employees had not been aware of that required referral to the emergency room. Hiring the right person for the job was also very important. The NP has a good way of talking to the patients; she provides education and advocacy, which is necessary to provide coordinated care. The NP had to get to know the MH patients and they needed to get to know her. It was critical to establish that relationship.

Initially MH staff tended to screen out too many patients. The NP also needed to get the MH nurses more comfortable with physical health issues. The NP's first approach was to teach the MH nurses about phlebotomy and how to approach patients to increase their comfort level. The patients did not want to switch to the new service initially. Clinicians found introducing the patient to the NP in the hall very helpful. Once the patient met the NP, they were very likely to keep the next appointment.

Suboxone Treatment with Primary Care Physician

This program followed the drug manufacturer's protocol, which requires three months of Suboxone, on a step-down basis, plus 3 months of simultaneous substance abuse counseling, followed by one month of Naltrexone, if needed. The county requires a 4-month outpatient substance abuse treatment program.

The protocol that was put into place involves the doctor, pharmacist, and treatment center all working together. The doctor identifies Drug Medi-Cal eligible patients in his private practice, and writes a prescription that the patient takes to a specific pharmacy. The pharmacist calls the doctor prior to filling the prescription for verification from the doctor that the patient is obtaining SUD treatment. The doctor's nurse checks with the SUD clinic weekly to see if the patient is keeping appointments. Sometimes, if there are problems, the nurse visits patients at the treatment site. The pharmacist calls the doctor to approve refills of prescriptions for each additional 30 days.

Implementation Outcomes

As of September 2011, the program has treated 8 patients and 3 have completed the program. There were no dropouts. The reported drugs of choice among the treated patients were Oxycontin and Norcos. One graduate completed their Perinatal program and is now a Peer Support Specialist. She has cleared all past legal issues and plans to become a volunteer for our department.

Lessons Learned

Lessons learned during implementation of integrated services in Riverside County included the following:

- Doctors needed education regarding the roles and responsibilities of the MH staff.
- Patience, tolerance, and openness were required from both physical and mental health care providers in order to merge the two cultures.
- Filling the NP role with a person who had a strong ability to establish relationships with patients was crucial.
- Warm handoffs between physical and mental health providers in the clinic hall were critical in establishing patient-provider relationships.

MERCED COUNTY

Background

Merced County is located in the heart of the Central Valley of California. As of the 2010 U.S. Census, the population was 255,793 and the total area of the county is approximated 1,980 square miles (<http://www.co.merced.ca.us/index.aspx?nid=1874>). The county serves about 256,000 patients. Integration programs in Merced County were discussed during the ILC on August 22, 2012. The county is beginning to co-locate services within primary care settings (two FQHCs). Merced County has staff co-located on site at the primary care facility to work with physicians, nurses, and their patients to conduct screening and referral for SUD services.

Objectives/Methods

After receiving support from their psychiatrists and more buy-in, they began with an SUD counselor at the clinic for 20 hours per week. The program is using a Behavioral Health Screening Tool, and they have trained the physicians on how to use it. A considerable amount of time has been spent training the physicians on the signs/symptoms of SUDs and how to use the screening tool. The process is as follows: front desk staff give out the screening tool to all patients seen in primary care; the physician reviews it; patients that need follow-up are flagged; the SUD counselor is paged and the physician provides a warm handoff. Sometimes the patient speaks with the SUD counselor in the exam room or they are taken into the counselor's office. Patients provide consent to release information. The goal is to provide small groups at the clinic (group therapy and psych-education groups) in the future.

The Community Outreach Program Engagement and Education (COPE) program seeks to reach the underserved and disparate racial populations throughout Merced County. COPE has further enhanced services by collaboration with agency partners, law enforcement, and other departments. COPE clinicians partner with primary health clinics.

The county also has probation co-located with the children and adult SUD judicial team. This provides a one-stop shop for clients to see their probation officers before or after their treatment appointments. MH and SUD staff are co-located at juvenile hall to provide SUD and MH services and facilitate a warm handoff when clients are released to the community.

Implementation Outcomes

It has been a long process to get the staff on board in Merced. The clinic staff were used to referring-out for SUD services. A considerable amount of time has been spent training the physicians on the signs/symptoms of substance use and how to use the screening tool. One of the benefits of co-locating staff is that it facilitates warm handoffs.

Lessons Learned

Lessons learned during implementation of integrated services in Merced County included the following:

- It was important to get the staff on board with integration efforts early. This was achieved successfully through education and training efforts.
- Co-locating services was found to facilitate warm handoffs between MH and SUD service providers, thus providing simple “one-stop shopping” for patients.

LASSEN COUNTY

Background

Lassen County is located in rural Northeastern California and is the 8th largest (by area) county in California. Lassen has about 34,000 county residents. Lassen is rated as one of the three worst counties in California for economic well-being. The unemployment rate holds steady at around 17.1%. Out of all employed workers, 60% are employed by some type of government agency. About 41.4% of residents live below the 200% federal poverty limit. Integration efforts in Lassen were described during the ILC on February 27, 2013.

The Alcohol and Other Drug (AOD) and Mental Health (MH) departments began merging on July 1, 2012, to become the Department of Behavioral Health (BH). At the time of the presentation, MH and AOD services were reported to be co-located but not fully integrated, with separate intakes for MH or AOD, and services that were not well-coordinated. The screening process involved assessing for either AOD or MH by doing a brief assessment; if an issue was detected, patients were then referred to the other side for a separate intake. The BH department is trying to become more holistic and patient-centered, a process that will likely take several years.

Objectives and Methods

The county is beginning to use a team-based approach to provide integrated care. All of the systems are organized around teams. In each team, there are case managers, psychotherapists, psychiatrists, and nurses all working together. Lassen plans to implement the SAMHSA-HRSA Behavioral Health Home model in its 5 BH locations in order to provide better coordination of MH, AOD, and primary care services. They also plan to add primary care services, such as bringing in nurses to take patient histories, and setting up regular onsite screenings to check for potential health problems. Most patients have SUD, MH issues, and physical conditions that are sometimes co-occurring.

Implementation Outcomes

Some of the barriers and challenges to implementing the integrated model in Lassen include:

- **Bureaucracy.** Working within a larger bureaucracy (with unions, personnel, advisory boards) can slow down the process of change, although Lassen BH has been working on combining both their advisory boards and creating new bylaws.
- **Limited or unstable local resources.** As in many rural areas, Lassen has limited resources with limited stability.
- **Organizational instability/uncertainty.** Because their FQHC has recently discharged the CEO, there is instability and uncertainty about what the future of integrating with primary care will look like.
- **Different sets of rules, regulations.** AOD and MH have different sets of rules and regulations, and different ways of doing things. The county is waiting for more guidance from the state to see how it will be possible to combine to become one unit, with one way of thinking and doing things.
- **Cultural and linguistic differences (developing a common language).** AOD and MH speak different languages and need to find the middle ground and learn each other's language.

- **Staff turnover.** Many staff members have retired. The influx of new personnel at different stages of the learning curve has created uneasiness for existing staff, who are also dealing with new expectations and a new model they must learn to work with.
- **Staff competencies.** Some staff, especially older staff, have not taken tests in a long time and may be uncomfortable or resistant to new performance requirements and trainings.
- **Building staff morale.** Prior to integrating with AOD, MH staff had teams that didn't work as well together. Morning coffee hours were held to give MH staff an opportunity to voice their thoughts and concerns and bond together.
- **Balancing competing demands.** There is a need to balance a focus on integration with other concerns. The AOD and MH systems in Lassen already faced challenges before integrating, and beginning the process without a strong foundation and clear structure made work more difficult.

Lessons Learned

The following lessons were learned, as reported by Lassen County:

- Developing knowledge and trust among staff developed teamwork and communication.
- Creating staff competencies greatly increased the quality of patient care.
- It was important to hold staff accountable, but also provide assistance in reaching expected levels of integration.

IMPERIAL COUNTY

Background

Imperial is a rural county located in Southern California. The County population is about 180,000 residents. Because of its dependence on agriculture, Imperial County resembles the Central Valley more than it does other Southern California counties. Integration efforts in Imperial were described during the ILC on February 27, 2013.

Imperial's systems are organized around teams. In each team, there are case managers, psychotherapists, psychiatrists, and nurses working together. SUD is now being co-located into the MH clinics and offered to adolescents and adults. Everyone is assessed for both SUD and MH and then referred as appropriate. Imperial has partnered with one FQHC and co-located BH staff there. BH staff conduct intakes and are eventually going to be at all the different locations. Imperial BH is organized around 3 main parts of the population: children, young adults, and adults. For each group, Imperial has implemented EBPs for their unique issues.

Objectives/Methods

The children's system (ages 0–14 years) concentrates on services to schools and the foster care system. A lot of time and effort has been placed into trauma-focused cognitive behavioral therapy (CBT), multidimensional treatment for foster care, developing a model for ADHD processes, and nurturing parenting. For youth and young adults (14–25), they have implemented functional family therapy, trauma-focused CBT, SMART recovery, nurturing parenting, and CBT.

The adult system (25 and older) is organized around the idea of having recovery centers at different clinics. We implement EBPs for, and train staff to deal with, specific disorders (for example, anxiety disorders, schizophrenia, bipolar disorder, etc.). The recovery center provides programs in medication education, family education, SMART recovery (for SUD, AOD, and smoking cessation), physical fitness, CBT, occupational services and academic services. The centers are designed to help people learn the skills to manage their illness. Once they gain skills to manage their illness and physical health, they also get help learning a trade or going to college.

Implementation Outcomes

Imperial BH is organized around 3 main parts of the population: children, young adults, and adults. For each group, Imperial has implemented EBPs for their unique issues. Imperial has one FQHC with co-located BH staff. BH staff have been there for a couple of years. They do intakes and are eventually going to be at all the different locations: 3 main clinics and 5 satellite clinics. Hopefully, this will lead to better healthcare for MH patients, and help physical health patients get access to MH healthcare.

Lessons Learned

Lessons learned, as reported by Imperial County, included the following:

- Addressing the needs of specific patient populations is key to providing services that treat the whole patient.

- It is critical to foster a shared vision and goals across all clinics through regular staff meetings and strong communication among organization leadership.

TRINITY COUNTY

Background

Trinity County is located in Northwest California, and is bordered by Humboldt, Shasta, Siskiyou, Mendocino, and Tehama counties. The county size is about 3,000 square miles and the population consists of about 13,000 residents. An estimated 17% live below the poverty line. The rural poor are the main group that BH works to serve. The Trinity BH Department is small and serves patients with both MH and AOD concerns. There are an estimated 57 AOD patients. Integration efforts in Lassen were described during the ILC on February 27, 2013.

Objectives/Methods

There are separate assessments and treatment plans for MH and AOD, although the diagnosis form is shared. Patients can be screened and referred from one department to the other. Releasing information is a challenge, so all MH and AOD patients sign a release to use their information in the shared Kingsview EHR, which has been in use for 4 years, and they are comfortable with it.

MH patients with AOD issues are often put in the dual diagnosis group at first if the issues are not severe. The group focuses more on harm reduction and assesses if referral to AOD is appropriate. The AOD program itself is abstinence based. There are separate team meetings for each program, but MH and AOD also meet jointly each week to discuss patients of concern and dealing with crises. MH and AOD have joint advisory boards as well.

With regard to primary care, Trinity has participated in the Small County Care Integration (SCCI) learning collaborative through CiMH. Trinity is planning to do the same for AOD patients in the future. Under the SCCI project, Trinity BH has also done a smoking cessation program that is going well. BH is working on building relationships with the hospitals and hospital staff.

Implementation Outcomes

Trinity is trying to become more patient-centered. They have MH drop-in centers in both Weaverville and Hayfork that are open to people with both MH and AOD issues. AOD and MH are working together with their MHSA program. Both the AOD director and the MH director are involved at the state level to prepare for health care reform.

Lessons Learned

Lessons learned, as reported by Trinity County, included the following:

- Educating and training staff about integration helped to encourage provider buy-in.
- Developing knowledge and trust among staff supported teamwork.
- Eliminating silos and hierarchical thinking by encouraging open communication and feedback among staff and leadership was critical to successful implementation.
- It was important to acknowledge that change is difficult.

Pilot Evaluations

UCLA is working with a small group of counties to facilitate integration, including counties that are in the “early integration” stages as well as counties that are more advanced. UCLA selected several counties (described below) to focus these pilot evaluation efforts. A plan was created for each county and was approved by ADP. The Los Angeles Telepsychiatry and Vivitrol pilot projects and parts of the Kern work were funded by these respective counties, but the results relevant to integration are informative for state efforts and are therefore presented here.

LOS ANGELES COUNTY

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

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

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

Background

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

Objectives/Methods

The AVRC is located in the high desert of Los Angeles County, where access to psychiatric services is limited due to the remoteness of the facility. Research suggests that 33%–50% of patients in substance use disorder (SUD) rehabilitation programs often have co-morbid psychiatric problems (Drake et al., 2007), yet very few rehabilitation programs (and even fewer

rural programs) have onsite psychiatrists (Hilty, 2007). Through this project, UCLA ISAP psychiatrists provide services related to SUD and other mental health issues to AVRC patients one day a week using a secure Web-based, mobile telemedicine cart and accompanying software. This system allows the psychiatrist and patient to clearly see and hear each other. Once the psychiatrist meets with the patient, they make notes that are stored with their UCLA patient record and copies are sent via a secure line to the medical personnel at the Acton facility for placement in the patient's AVRC file. Prescriptions are written by the UCLA psychiatrist and filled at a local Acton pharmacy.

UCLA/AVRC Telepsychiatry Protocol

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

Implementation Outcomes

As of June 3, 2013, 171 telepsychiatry patients have been discharged. Most patients have had a number of follow-ups and depending on their needs, some are seen on a weekly basis. Using a low-cost medication formulary, psychiatrists prescribe psychotropic medications for a number of issues including depression and anxiety. As a result of the low-cost formulary and increased medication management, more patients are now able to incorporate psychotropic medications into their treatment.

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

Lessons Learned

The Telepsychiatry project increased access to mental health services and medications for patients in an underserved area. Patients and staff have reported positive feedback on the use of telepsychiatry. This innovative project demonstrates a successful collaboration between two Los Angeles County agencies (Public Health and Health Services) and UCLA ISAP. It is testament to the benefits of integrated care, which has become increasingly important as the field of substance use disorder treatment continues to move toward a chronic care model.

Los Angeles County Vivitrol Pilot Projects

Background

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

Objectives/Methods

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

Implementation Outcomes

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

Vivitrol Phase II

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

Preliminary results suggest that patients who have taken at least one dose of Vivitrol report clinically significant decreases in the urge to drink alcohol or use opioids. Results appear to suggest that patients' urge to drink/use remain within a clinically safe range (scoring below 10; reflecting little danger of relapse) 30- and 60-days after their final injection of Vivitrol. The decrease in urge to drink/use may indicate a continued reduction in urge to drink/use, or at least a significant delay in a return of urges after the medication is no longer administered. Additionally, preliminary analysis suggests that Vivitrol may decrease the number of days using alcohol and/or opioids. Patients also seem to have reduced their days of use to intoxication, which is clinically significant. It also appears that the patients are able to maintain the reduction in days used or intoxicated after the medication is no longer administered. Future analysis will examine if these findings are statistically significant. About a third of all patients experienced side effects (e.g., headache, nausea, fatigue) after receiving an injection. An overall trend appears to suggest that side effects lessen after the initial injection.

It must be noted that this study is an evaluation study and not a clinical trial. Random assignment was not used to determine whether a patient would receive the Vivitrol medication or a placebo. Thus, one of the shortcomings of the current pilot is that no causal conclusions can be made and it must be considered that the results could have occurred without the medication. Future analyses will explore treatment outcomes among those receiving Vivitrol compared to similar patients who are not receiving Vivitrol.

Lessons Learned

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

Dual Diagnosis Capability in Health Care Settings (DDCHCS)

Background

As part of a two-day training conducted by Mark McGovern, Ph.D., for UCLA staff on the Dual Diagnosis Capability in Health Care Settings (DDCHCS) tool, a site visit was conducted at a federally qualified health center located in an urban area in Los Angeles County. A brief description of the DDCHCS and summary of the findings are presented below.

Objectives and Methods

The DDCHCS tool was designed to assess the extent to which primary care, mental health, and SUD services are integrated within health care settings and to help identify areas in which integration can be improved. Administration of the DDCHCS involves an in-person site visit, observation of the clinic milieu and physical setting, interviews with key staff members and patients, and document review (e.g., medical records, program manuals). The health center receives ratings on seven dimensions: program structure; program milieu; clinical process – assessment; clinical process - treatment; continuity of care; staff; and training. Each dimension is assessed individually and given a score between 1 (*Healthcare Only Services*) and 5 (*Dual Diagnosis Enhanced*); an overall score is also calculated. The higher the score, the more integrated the primary care, mental health, and substance use disorder services.

Implementation Outcomes

The health center's overall DDCHCS score was 2.82, which indicates that it is nearly Dual Diagnosis Capable. The health center's program structure and program milieu were both rated 4.0, midway between Dual Diagnosis Capable and Dual Diagnosis Enhanced, whereas the range of scores for the other five dimensions (clinical process – assessment, clinical process – treatment, continuity of care, staffing, and training) was between 2.0 and 2.8, which indicates a lower level of integration—between Healthcare Only Services and Dual Diagnosis Capable.

Lesson Learned

Overall, while some elements required for integration are present at this health center (e.g., program focus on both MH and SUD services), they are necessary but not sufficient. Oversight and coordination of the MH and SUD services by a single supervisor with an interest and/or experience in both disciplines would help improve integration efforts. For more DDCHCS outcomes, see the Kern pilot below.

Plans for Year 2 Activities

Patient perspectives on the integration of behavioral health and primary care in community health centers

In Year 2 of the ETTA project, UCLA is planning to conduct a pilot evaluation to obtain adult patients' perspectives on the behavioral health care they have received in primary care settings. UCLA will conduct one focus group (semi-structured group interview) with patient volunteers (n=6) who have received behavioral health services at a selected community health center site in Los Angeles County that has initiated integration efforts. Patients' recommendations to improve the integration of behavioral health services will also be solicited.

Objective: To obtain patient perspectives of what is working well, what is not working as well, and how behavioral health care could be better integrated in primary care settings.

Significance: Patient-level information may differ substantially from the staff perceptions collected previously, and understanding such information is critical for patient-centered care. Data collection is currently underway.

KERN COUNTY

Background

Kern County is very large (approximately 8,500 square miles), which requires that the service delivery system be organized to reach outlying areas. In Bakersfield, the primary industries are oil and agriculture, and the unemployment rate is 32% in one community. Kern County's population is also very diverse (one community is 80%–90% Hispanic while other communities are 60%–70% White residents). The mental health system of care consists of crisis and residential services (five clinics, 31 physicians, eight contracted providers). The SUD system of care consists of traditional outpatient care in regional areas, with inpatient care handled in Bakersfield (14 clinics, including inpatient and methadone). There are 27 FQHCs in Kern County.

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

Objectives/Methods

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

Implementation Outcomes

Kern County works with UCLA to provide program evaluation services of Project Care. The evaluation component consists of administrative data analysis, measures of the level of integration at each clinic using the Dual Diagnosis Capability in Health Care Settings (DDCHCS) tool, staff satisfaction surveys, and patient interviews.

Administrative Data

UCLA has been working with the three primary care organizations to obtain administrative data (data now collected by each of the participating organizations as a part of their routine care) on the number of people screened, their scores, and the number assessed, treated, and referred. When fully implemented, this data will be generated by each organization using i2i registry software. This i2i software will aggregate individual patient-level data from their NextGen electronic health record (EHR) system to regularly produce automated and customized aggregate reports that NextGen itself does not have the capacity to create. However, all three of the

organizations are in various stages of transition to the new EHR system, which has delayed installation of i2i. When i2i is functional, the organizations will be able to produce their own reports on a regular basis, but in the meantime, UCLA is obtaining raw data in spreadsheet format and analyzing it using SAS software.

Figure 2.8 shows the increasing number of screens at these clinics over the last few years.

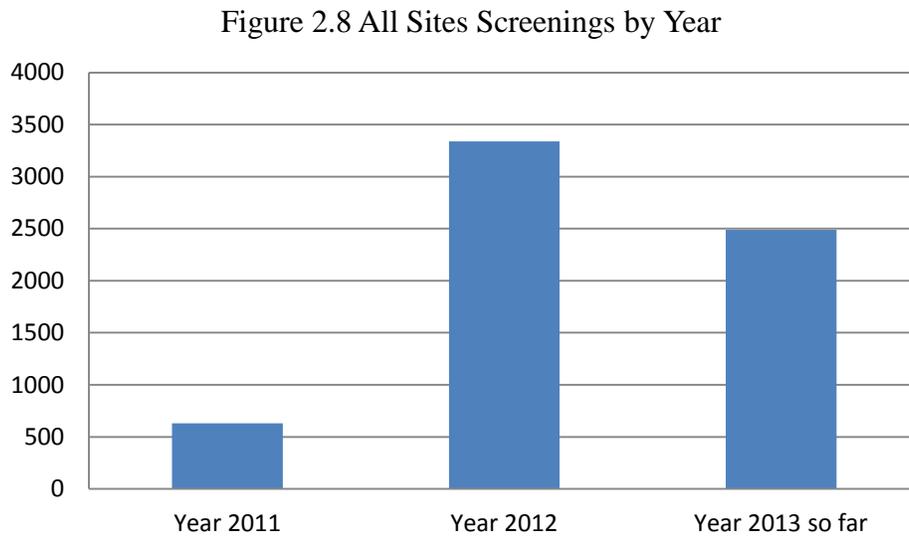
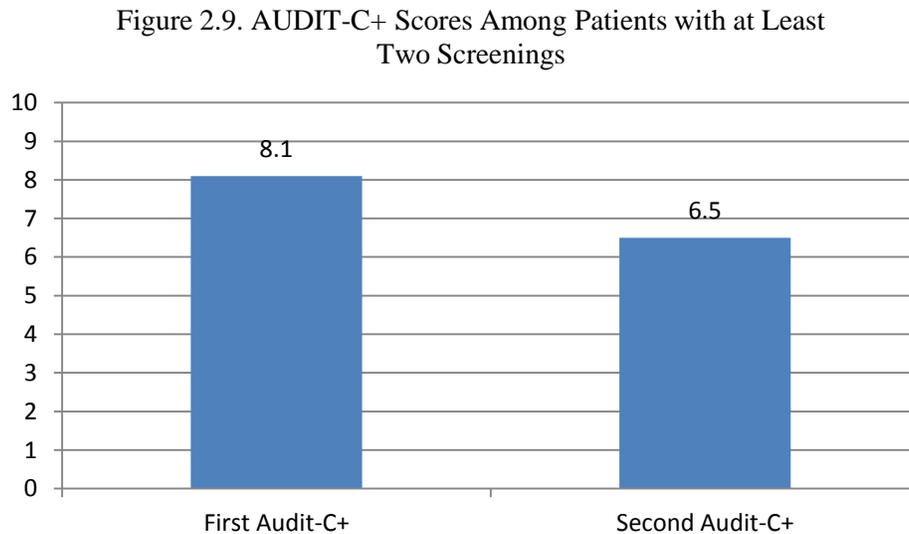


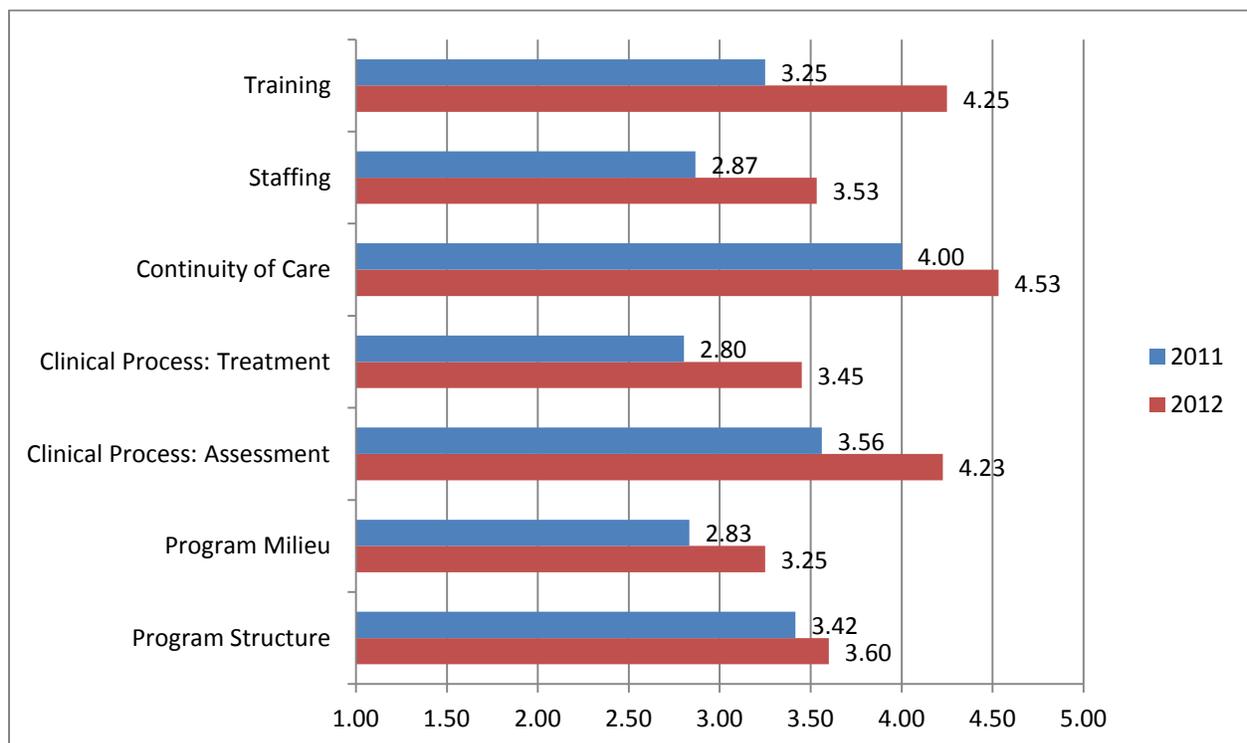
Figure 2.9 provides a preliminary example of one site's substance use disorder scores before and after treatment.



Dual Diagnosis Capability in Health Care Settings (DDCHCS)

The Dual Diagnosis Capability in Healthcare Settings (DDCHCS) tool was designed to measure the degree of primary care, SUD, and mental health integration within health care settings, and as such, was adopted as a key measure for the evaluation. DDCHCS administration requires an in-person site visit, inspection of the site and records, and interviews with multiple staff members. UCLA conducted DDCHCS visits with all Project Care sites in 2011 and follow-up visits in 2012. Ratings on aspects of integration measured by the DDCHCS assessment (Figure 2.10) have increased on average for the organizations assessed. The largest improvement occurred with regard to training, which increased by 1.04 points. Average scores on staffing, clinical assessment and treatment all increased by at least .65 points.

Figure 2.10. Dual Diagnosis Capability in Health Care Settings (DDCHCS) Average Ratings

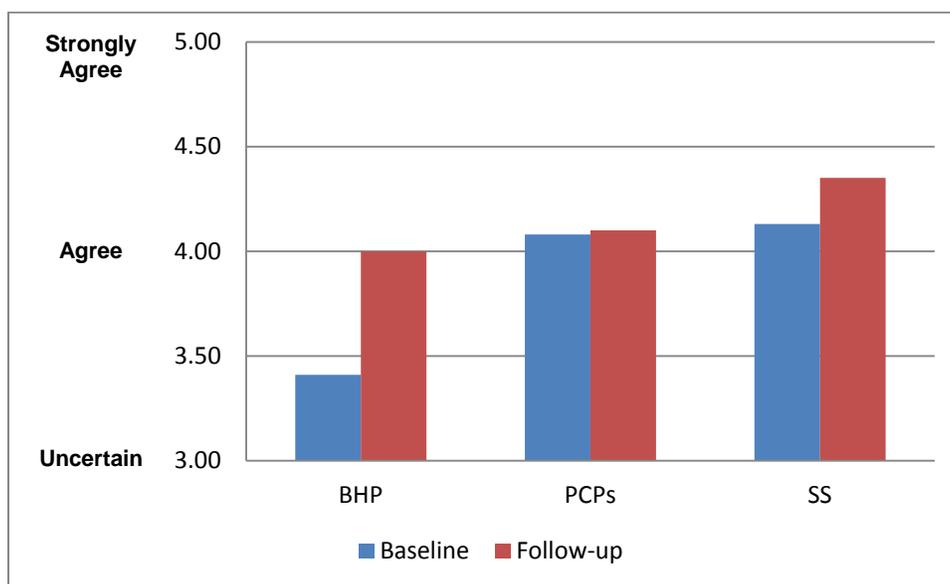


Staff Satisfaction Surveys

Staff satisfaction surveys were administered to mental health/substance use disorder staff, support staff, and primary care providers from all three organizations. The survey used was adapted from surveys developed by the Integrated Behavioral Health Project (<http://www.ibhp.org>). Survey results suggested that integration and MH/SUD services were highly valued at the Project Care sites that were studied, and that staff were uniformly interested in further MH/SUD training. However, there were significant differences in the way staff

perceive current processes, particularly communication. A second round of surveys, which were collected in June and July 2012, determined how staff perceptions have changed over time. During the 2011 survey, behavioral health staff were less confident in the abilities of medical staff to handle behavioral health patients than the primary care providers (PCPs) and support staff (SS) were. About one year after baseline assessment, this gap had been largely erased (see Figure 2.11).

Figure 2.11. Staff Perceptions: Satisfaction with the ability of the medical staff to address the needs of patients with behavioral health issues.



Lessons Learned

During an ILC presentation on October 24, 2012, the primary care providers (PCPs) in Kern County discussed the challenges and successes experienced thus far.

Top 10 key lessons included:

- 1) Initially, PCPs believed BH screenings would make people uncomfortable and there was also a fear that integrated BH services would lead to undesirable change in the patient population. The solution was to educate PCPs on SUD and SBIRT.
- 2) Having BH Practitioners available when needed by the PC staff was challenging. They learned that rotating BHPs through multiple clinics on designated days (Mobile Brief Services) didn't work. It created a hit-or-miss referral system. The solution was to teach SBIRT to staff, and they introduced 15–20 minute brief interventions.
- 3) The “right staff” for the BH job must be identified. Therapists must be chosen wisely. The person must be flexible, proactive, able to handle ambiguity, and able to form strong relationships.
- 4) Stakeholders must be willing to modify initial plans as needed. Even good plans need “tweaking” when put into practice.

- 5) Buy-in must be obtained from all levels of clinic staff, and feedback must be welcomed. Communication is key and continuing staff education is important, as it makes them feel valued and an important part of the process.
- 6) Screening forms must be managed thoroughly. Screening forms were not always given to patients to complete, patients did not fill them out, or they were misplaced. Some solutions included reducing the length to a single page and adding color to make the form more visible within patient packets. They also created a box for screens to be deposited into when the therapist isn't immediately available.
- 7) "Champion physicians" who attend all trainings and then share the lessons with the rest of the PC staff are very important.
- 8) There are many challenges surrounding the implementation of a new EHR system, such as problems with glitches and data transfers. The data tracking system must be kept simple at the outset.
- 9) Patients are benefiting from the integration of services. Patients feel understood and supported with in-person warm handoffs. This builds trust, which allows patients to feel they are put in good hands.
- 10) Having behavioral health providers down the hall from PCPs creates an open, accessible environment.

Plans for Year 2 Activities

Kern county Low Income Health Program Data Analysis

Kern county is one of the few LIHP counties that included an SUD benefit. Patients are enrolled in the LIHP program at the Kern Medical Center emergency room. Reportedly, implementation occurred without delays on July 1, 2011. However, nobody has looked at the county's data specifically in relation to SUD services. UCLA plans to work with Kern to look at services and medical costs before and after this LIHP implementation date to try to answer questions such as:

- Did SUD services get more frequent?
- What kinds of services were used?
- Were SUD services associated with a reduction in costs among those getting them?

We believe lessons from this data may help inform the state on what results might be expected when SUD coverage expands in 2014 through the Medi-Cal expansion and insurance exchange plans.

We are currently in the process of acquiring records from Kern County Medical Center's NextGen Records. This data will be extracted by Kern county staff and sent to UCLA. Data will include number of visits, hospitalizations, medical visits, medical costs, and ICD9 codes. UCLA and Kern County are currently reviewing business associate agreements to allow the transfer of data.

Patient perspectives on the integration of behavioral health and primary care in community health centers

In Year 2 of the ETTA project, UCLA is planning to conduct a pilot evaluation to obtain adult patients' perspectives on the behavioral health care they have received at selected health center

sites as well as information on their alcohol and drug use. UCLA will conduct focus groups (semi-structured group interviews) with patient volunteers who have received behavioral health services at five community health center sites with moderate to high levels of integration in Kern county. In addition, UCLA will conduct individual phone interviews, including a 30-day follow-up interview, with a sample of adult patients who have received behavioral health care at one selected health center site in the county.

ORANGE COUNTY

Background

Orange County is the third most populous county in California, with 3 million residents. The county is located in Southern California and has three main cities: Santa Ana, Anaheim, and Irvine. The city of Santa Ana serves as the governmental center of the county, Anaheim as its main tourist destination, and Irvine as its major business and financial hub. Orange County has a thriving business economy and a well-educated workforce. In addition, it is a regional service provider and planning agency whose core businesses include public safety, public health, environmental protection, regional planning, public assistance, social services, and aviation. As such, it offers numerous intervention and prevention services for mental health disorders and many accessible behavioral health treatment facilities (<http://ocgov.com>).

Objectives/Methods

Orange County is working on a bi-directional care project. Funded through MHSA, the program is a unique public/private partnership between a community clinic, substance abuse treatment provider, and mental health provider. They have four sites: two FQHC and two FQHC look-alikes. The Behavioral Health (BH) Team consists of two peer counselors, a psychiatrist, and a BH therapist at each site. The peer counselors provide home visits, outreach, nutrition education, smoking cessation, and medication compliance. The BH team and primary care team meet one time per week for case coordination of services. The integrated health care model used in the program aims to address the unmet needs of patients by providing a coordinated team of SUD, MH, and PC professionals under one roof.

Implementation Outcomes

They have encountered many challenges, including: (1) Registry: the development of a patient registry is costly. They need one that suits their needs and allows for information sharing across agencies, and (2) Confidentiality: 42CFR and HIPAA regulations have been a hurdle. Currently, information can be shared between different agencies.

Orange County is also working with UCLA to train and "coach" at nine FQHCs and/or mental health agencies funded to provide fully integrated health care and behavioral health. Several motivational interviewing (MI) and SBIRT trainings have been conducted for providers working on these projects. For physicians, training is provided at their monthly resident luncheon. Ongoing coaching services (on-site 2–3 days per week) will be provided to the behavioral health staff to ensure they are effectively creating integrated teams (one part-time LCSW was hired as the coach). A screening tool was established with nine questions addressing anxiety, depression, alcohol, drug, and domestic violence (trainings were provided on how to complete this tool). Forty-two coaching sessions were provided to sites during the contracted period of time and over 100 staff were trained. The final evaluation surveys showed that staff felt confident in completing a brief intervention and in using the Orange County Screening tool.

The program implementation phase is currently underway. Patients are being screened using the Orange County Screening tool. Depending on the screening results, a brief intervention would be done using motivational interviewing skills. Findings from this program will be available in the near future and will be discussed in a future Integration Learning Collaborative meeting.

Lessons Learned

The integrated health care model used in the program aims to address the unmet needs of patients by providing a coordinated team of SUD, MH, and PC professionals under one roof. Though challenges have been encountered, the benefits of integrated care are appreciated by staff. SBIRT and MI trainings were well received. The staff felt more confident in completing a brief intervention and in using the Orange County Screening tool.

Plans for Year 2 Activities

Patient perspectives on the integration of behavioral health and primary care in community health centers

In Year 2 of the ETTA project, UCLA is planning to conduct a pilot evaluation to obtain adult patients' perspectives on the behavioral health care they have received in primary care settings. UCLA will conduct one focus group (semi-structured group interview) with patient volunteers who have received behavioral health services at a selected community health center site in Orange County that has initiated integration efforts. Patients' recommendations to improve the integration of behavioral health services will also be solicited.

SAN FRANCISCO COUNTY

Background

The City and County of San Francisco has a population of 825,863 in a 46.9 square-mile land area, making it the most densely populated area in the state. According to census estimates, San Francisco's population is 54% White, 34% Asian, 6% African American, and 4% mixed. Overlaid on these ethnic categories, 15% report being of Hispanic ethnicity.

(<http://quickfacts.census.gov/qfd/states/06/06075.html>).

Objectives/Methods

We identified one FQHC in San Francisco as doing integration work several months ago when we conducted our survey of FQHCs (see section Federally Qualified Health Center Integration Survey and Interviews for more on this survey). We visited the site and found that they were integrated in their HIV/AIDS clinic in particular, where they had brought in an SUD counselor to work with medical staff and patients. They reported that this has made a big difference, but they hadn't had time to look at their data to prove that. This FQHC is also able to link to the county's data to acquire data on emergency room visits, hospital utilization, etc., putting it in a good position to track patient outcomes. UCLA will work with this FQHC to examine whether adding the SUD counselor in 2011 made any noticeable difference in cost and utilization.

The HIV/AIDS clinic is interesting in that they have Ryan White funds, so they are able to pay for SUD services. This FQHC may therefore be able to provide lessons for others that may acquire coverage for SUD under ACA provisions in 2014. This organization is also unusual in that most FQHCs are considering using LCSWs and other FQHC-billable staff that don't necessarily have a great deal of SUD training, while this organization is using a CADAAC certified Alcohol and Other Drug counselor.

Data Analysis

De-identified data was sent to UCLA extracted from their local electronic health record and data tracking registry (NextGen/Lifetime Clinical Record using i2i Tracks software) covering initial visit dates from October 1, 2010, through October 1, 2012. Current data includes medical visits, CD4, viral load, hospitalizations, medical visits, medical costs, and ICD9 codes. The patients are mostly male (90%), with a mean age of 46 (range of from 22–71 years), and with an average of seven substance abuse counseling visits, four medically acute visits, and three medically routine visits (average of 15 visits total). Half of them are Spanish speakers and a third have an unstable living situation. We are in the process of analyzing records from San Francisco to measure the impact of their SUD counselor on patient measures.

SAN LUIS OBISPO COUNTY

Background

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

The Central Coast Behavioral Health Policy and Education Committee (CCBHPEC), which represents private, public, and non-profit professionals, is working collaboratively to increase access to behavioral health services in San Luis Obispo (SLO) County in preparation for ACA provisions effective as of 2014. The Committee was formed subsequent to the "The Integration of Behavioral Health into Primary Care" training by Thomas Freese, Ph.D., that was held in San Luis Obispo County on May 15, 2012. The CCBHPEC has requested technical assistance from UCLA to help it reach its goals:

- Define the unmet needs of SLO County residents for affordable and accessible behavioral health care services;
- Create a model for a community-based continuum of care for behavioral health needs for E.R., FQHC, and primary care physician referrals; and
- Educate the physicians and community about the referral resources.

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

The providers in the north county community appear to be at the early stages of integration and in developing a community-based system of care for behavioral health in SLO County.

Objectives/Methods

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

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

- Measure the integration of mental health and substance use disorder services with primary care in three community health centers to provide a baseline to help identify areas in which integrated services can be improved. Administer follow-up assessment if requested.
- Provide trainings on motivational interviewing, SBIRT, and, potentially, other topics if needed.
- Introduce medication-assisted treatment in primary care settings, if possible and where interest exists.

Administrative data analysis

UCLA plans to analyze administrative data that are available (e.g., Community Health Centers of the Central Coast, CenCal, Tennant, CalOMS-Tx, billing data if available). We will discuss with Committee members the possibility of obtaining data on dates and type of behavioral health services received, behavioral health screening and assessment scores, diagnoses, billing, and cost. We will conduct further analyses as additional relevant data sets are identified and received.

Stakeholder survey

In collaboration with Committee members, UCLA will develop and administer a web-based or paper survey questionnaire to collect data on primary care and behavioral health service providers' perspectives on and experiences with the integration of behavioral health services within primary care settings. This will require e-mail addresses of staff and buy-in among Community Health Center and other organization leaders.

Dual Diagnosis Capability in Healthcare Settings (DDCHCS)

UCLA will utilize the Dual Diagnosis Capability in Health Care Settings (DDCHCS) tool to collect information on current levels of primary care-behavioral health integration and to provide recommendations at 3 Community Health Centers of the Central Coast sites (Templeton, Lompoc, Nipomo). This will require in-person site visits, observation of clinic operations, records review, and interviews with key staff members from all disciplines. Reports from these visits will be prepared.

Medication-Assisted Treatment (MAT)

If there is interest and it is possible, UCLA will provide physicians and relevant staff in primary care settings (e.g., care coordinators, physician assistants, behavioral health staff) with information and guidance on MAT for addiction (e.g., buprenorphine, Vivitrol, naltrexone), including obtaining waivers for physicians to prescribe buprenorphine, and billing.

Implementation Outcomes

To date, several UCLA-SLO County meetings have been held via conference call to discuss: data variables of interest and potential data sources for the administrative data analyses; stakeholder survey purpose, development (e.g., questions), and distribution list; and visits to three community health centers to administer the DDCHCS assessment.

Future plans involve continuing with our regularly scheduled biweekly UCLA-SLO meetings to ensure progress is made in implementing the activities outlined above. The pilot evaluation project in the north county community is expected to assess and document behavioral health services currently being provided, the extent of the integration of such services in primary care settings, unmet needs for behavioral health services, and referrals for community-based behavioral health services. UCLA hopes to learn from SLO County's development of a model for a community-based continuum of care that could potentially be implemented county-wide and perhaps in other counties in the state. The model that is developed could potentially be used with other counties at the early stages of integration to effectively and efficiently streamline and accelerate the process.

Other Statewide Evaluations

California County Medical Services Program (CMSP)/ Path2Health Survey 2012

Path2Health, a 2-year program sponsored by the County Medical Services Program (CMSP) Governing Board and authorized under California's 1115 Medicaid Waiver, expanded no-cost medical coverage in 35 rural counties to uninsured, low-income adults. UCLA conducted a brief 15-minute electronic survey to collect information on counties' experiences with the CMSP/Path2health program (response rate 76%).

Our findings show that the expanded benefit (particularly with the SUD coverage) is predominantly underutilized. Only six respondents reported that their county had attempted to process claims for SUD services using this benefit, and these respondents reported that (1) there were many questions at the beginning, (2) payment was not enough to compensate for the staff time required to process claims, and receiving payment was problematic, (3) there were not enough services authorized upfront, and (4) the amount of services covered under the benefit did not fit the needs of the typical SUD client. Satisfaction was low among these respondents. These respondents rated their satisfaction as only 1.8 on a 5-point scale.

Respondents who were not utilizing the expanded SUD benefit (n=20) reported reasons such as: (1) not having the infrastructure in place to bill to this benefit or any other health insurance (including Drug Medi-Cal), (2) not having enough CMSP-eligible clients to bother with the paperwork and frequent re-authorizations requirements, (3) belief that it did not seem to generate enough money to the county to compensate for the time to process claims, and (4) due to negative experiences and anecdotal reports from fellow administrators of the disorganization, slow response time, and inconsistent information at Anthem Blue Cross, respondents did not want to engage in the program.

Although there were a few positive remarks about the program, overall results suggested that the CMSP/Path2Health expanded SUD benefit went largely underutilized and therefore had minimal impact. Although some have accessed the covered services and receive reimbursement, it comes with a high administrative cost that many counties are not able to afford. Responses suggested that claims processing and payment needs to be simplified and streamlined if SUD benefits are to be used effectively when they become more widely available in 2014. Providers will also need to have the infrastructure and adequately trained staff to submit claims.

Introduction

The County Medical Services Program (CMSP) was established in January 1983, when California law transferred responsibility for providing health care services to indigent adults from the State of California to California counties. This law recognized that many smaller, rural counties were not in the position to assume this new responsibility. As a result, the law also provided counties with a population of 300,000 or fewer with the option of contracting back with the California Department of Health Care Services (DHCS) to provide health care services (medical, dental, vision and prescription benefits) to indigent adults. DHCS utilized the

administrative infrastructure of Medi-Cal's fee-for-service program to establish and administer the CMSP program. Since 1983, financing of CMSP services has varied, but today, CMSP is funded exclusively by Realignment revenue (motor vehicle license fees and sales tax) and county general revenue.

Beginning October 1, 2005, Anthem Blue Cross Life & Health Insurance Company assumed administrative responsibility for CMSP. CMSP offers health coverage for low-income adults who are age 21–64, have limited income and assets, do not qualify for Medi-Cal, and live in one of the mainly rural counties that participate in the program. Anthem Blue Cross Life & Health Insurance Company (BC Life & Health) administers this program for the CMSP Governing Board. CMSP members receive health care services from participating doctors, hospitals, and clinics in the BC Life & Health/CMSP provider network. Healthcare providers contract with Anthem Blue Cross to participate in the Anthem Blue Cross/CMSP Provider Network. Only providers participating in the Network may receive payment for non-emergency health care services provided to CMSP members. (www.cmspcounties.org/)

On January 1, 2012, the Path2Health program was initiated to offer early implementation of coverage, similar to that expected in 2014 under the Affordable Care Act. Path2Health is a Low Income Health Program (LIHP) sponsored by the County Medical Services Program (CMSP) Governing Board and authorized under California's 1115 Medicaid Waiver. Path2Health has federal funding for two years under a 1115 Medicaid Waiver the State of California received. The program ends December 31, 2013. Federal health reform (Affordable Care Act) will provide Medi-Cal coverage to this population beginning January 1, 2014. (www.mypath2health.org/)

On a two-year pilot project basis, Path2Health is expanding no-cost medical coverage in 35 rural counties to uninsured, low-income adults with incomes up to 100% of the federal poverty level (about \$10,890 for a single person annually), and eligibility is expanded to those between the ages of 19 and 64. Additionally, with Path2Health, enrollees will not have to pay a share of cost unless they have more than \$900 of income per month. Finally, in response to favorable results from a CMSP Behavioral Health Pilot Project conducted from 2008 to 2011, the benefit package within Path2Health was expanded to include mental health and substance abuse counseling.

Thirty-five counties participate in the CMSP/Path2Health Program. These counties cover



nearly 90,000 square miles of territory and have a general population of approximately 3 million people. On a monthly basis, approximately 40,000 indigent adults residing in these counties rely upon CMSP benefit coverage.

Eligibility for CMSP/Path2Health is determined by the county social services departments in the 35 participating CMSP counties in accordance with eligibility rules set by the Governing Board. All treatment authorization requests for medical, dental, vision, and behavioral health services are processed by Anthem Blue Cross or its dental and vision service subcontractors.

Payment for medical, dental, vision, and behavioral health services is processed by Anthem Blue Cross and its dental and vision services subcontractors in accordance with current HIPAA standards. Both paper and electronic billings are processed. CMSP/Path2Health provides payment for emergency health care services provided to CMSP members by Network providers and all other providers of emergency services in California.

Services covered include: acute inpatient hospital care; adult day health care services; audiology services; blood and blood derivatives; chronic hemodialysis services; dental services; durable medical equipment; emergency air and ground ambulance services; hearing aids; home health agency services; hospital outpatient services; laboratory and radiology services; limited mental health and substance abuse counseling services; medical supplies; non-emergency medical transportation; occupational therapy services; optometry services, including eye examination an allowance of \$80 for materials (lenses and frames); outpatient clinic services; outpatient heroin detoxification services; prescription drug services provided by network pharmacies; physical therapy services; physician services; podiatry services; prosthetic and orthotic appliances; speech therapy services; emergency and post-stabilization services in all 50 U.S. states or all U.S. territories.

The limited substance abuse counseling services include:

- One assessment;
- Individual SUD counseling sessions (up to two) based on medical necessity (authorization is required),
- SUD group counseling sessions* (up to 20 group sessions)
- Allowed provider types: licensed psychologist, licensed clinical social workers, licensed marriage/family therapists, and licensed professional clinical counselors, certified substance abuse counselors.

**clinics (such as FQHCs, RHCs) were not eligible to bill for substance abuse group counseling sessions.*

Purpose

UCLA and ADP agreed that gathering information on counties' experiences with the CMSP/Path2Health benefit Behavioral Health (BH) Treatment Services that went into effect on January 1, 2012, would be of benefit to stakeholders. We had two primary goals:

- (1) to document the utilization of and experiences with the CMSP/Path2Health Behavioral health benefit, with an emphasis on substance use disorder (SUD) services (i.e., what is working well, what is not working well, recommendations for improvement); and

- (2) to gather lessons learned from the utilization of this benefit to help guide other counties and the state as they prepare for Medicaid expansion (including SUD services) in 2014.

Methods

UCLA conducted a brief 15-minute electronic survey using Survey Monkey to collect information on counties' experiences with the CMSP/Path2health program based on the objectives listed above. Targeted questioning focused on the following areas:

- Eligibility and Enrollment
- Authorization and Approval
- Benefit Design
- Payment and Claims

To assure language clarity, relevant questioning, and feedback on survey structure/design, UCLA consulted with key informants such as CADPAAC's executive director, Tom Renfree, as well as one of the CMPS county representatives, Anne Lagorio, for input and final review. UCLA also consulted with CMSP's Local Health Connections Pilot Project manager on survey design and inquired about implementation of the benefit, but received minimal feedback.

The county alcohol and other drugs (AOD) administrators from the 35 counties who are eligible to participate in the CMSP benefit were sent an e-mail in April 2013 with a link to the survey (n=34, since Sutter and Yuba are administratively combined). Administrators (or a delegate) were given five weeks to complete the 15-minute survey. Twenty-six counties responded (76.5% response rate). Over half of the respondents reported that they were not participating in the expanded SUD benefit. UCLA research staff conducted a descriptive analysis of the survey responses, which included comments and explanations as to why some counties opted out of the participating in the SUD benefit offered as part of the CMSP program. The survey is included in Appendix 2C.

Findings

Of the 26 county respondents, only six counties reported attempting to process claims, six reported some experience/contact with CMSP/Path2Health, nine counties explicitly reported opting not to use the benefit, and five counties reported no data, but returned the survey.

Respondents who were not utilizing the expanded SUD benefit (n=20) reported reasons such as:

- Not having the infrastructure in place to bill to this benefit or any other health insurance (including Drug Medi-Cal),
- Not having enough CMSP-eligible clients to bother with the paperwork and frequent re-authorizations requirements,
- A perception that it would not generate enough money to the county to compensate for the time to process claims, and
- Negative experiences or anecdotal reports from fellow administrators of disorganization, slow response times, and inconsistent information from Anthem Blue Cross.

Respondents whose counties did attempt to process claims (n=6) rated their satisfaction as only 1.8 on a 5-point scale ranging from 1 (*not at all satisfied*) to 5 (*very satisfied*). Five of the six

respondents complained about timeliness or non-payment of claims, and/or recommended simplification of the claim process.

Additional selected comments and recommendations from counties that provided data are included in the findings listed below (n=21), grouped by themes.

Eligibility and Enrollment

General comments

- The form is tedious to fill out and time consuming. Because this form is to be filled out at intake, questions regarding primary care physician cooperation, treatment plan goals and progress are inappropriate. They should be removed if the form is to be filled out at this time.
- The front end...getting people eligible is easy and useful...

Respondent recommendations for improvement

- Set up an online step-by-step training for direct line staff who support counselors in starting the eligibility/enrollment process.
- A separate brochure outlining BH benefits would be helpful upon enrollment.
- More clarity for enrollees as to when they need to reapply.
- Increased communication and partnership between enrolling agencies and service providers would be helpful.

Authorization and Approval

General comments

- Our experience has been good; we have started utilizing this process with line staff
- Excellent response to faxed requests.
- The process only allows for a very limited number of services to be authorized at one time causing the process to have to be revisited numerous times to access the full benefit for the client.
- We don't have an in-house process to attain authorizations because the process is cumbersome and time consuming.
- The services that were approved were sent to the benefactor rather than the service provider. The benefactor did not know what they were and did not bring them to us.
- It was difficult to keep track of the large number of people and when their authorizations would run out, to ask for more.
- Pre-authorization process is too cumbersome to be fiscally effective for BH benefits as well as SUD.

Respondent recommendations for improvement

- One form to authorize the intake assessment and ongoing treatment (if recommended by staff).
- Most, if not all, of our SUD clients utilize the total benefit amount of 20 sessions. This would work much better if all 20 were authorized up front to prevent duplicating paperwork and time.

- We would like to see more groups authorized at once because our clients may be scheduled 1–3 times per week
- More visibility from regional reps from Anthem would be helpful in that onsite visits could help identify process improvements in the eligibility and approval process as well as coverage gaps based on local level need.
- Authorize more visits at one time (at least 10).
- The provider should approve the number of approved sessions.

Benefit Design

General comments

- Coverage such as this benefits our clients and provides something for those who are in the middle of various income guidelines.
- It's been a great benefit for those that haven't had access to SUD services previously or at least helps those financially who have had to do it all out of pocket.
- The CMSP benefit design is clear and resources were provided; however, for primary staff who have to navigate the system/design it appears troublesome. Anthem administration does have good local level support. The Anthem Blue Cross rep (R. Morales) for CMSP/Path2Health has been very instrumental. Having direct contact with him helps our county in trying to find solutions to issues we may have.

Respondent recommendations for improvement

- A benefit that matches current standard for treatment, e.g., 3 sessions a week for 2 months, 2 sessions a week for 2 months, 2 sessions a week for 2 months, and 1 session biweekly for 2 months.
- Clients typically attend 2–3 groups per week for approximately 6 months for SUD treatment. A 20-group benefit only meets part of the treatment need.
- Allow interns to provide services. Counties are training grounds for interns and rural counties have fewer licensed therapists.
- Expand benefit to include case management or rehab services
- Outreach to the eligible population about the overall CMSP benefit, as well as the specifics on the SUD benefit.

Payment and Claims

General comments

- When the nurse is contacted, the process is fairly easy. Without a contact, it feels like the claims are just lost and not adjudicated.
- “Our initial experience has been a nightmare.” Lengthy turnaround times (3 months at a time) with issues of payments and other paperwork lost in the mail, etc.
- We have only received 2 payments
- We have received no payments for SUD consumer.
- Claims are denied stating “no authorization,” when pre-authorization was received. Substance use services have been denied as the services were provided by staff other than those listed on the authorization. Our facility is a group with any of our certified staff being able to provide services. We have 55 unresolved disputes . . .

- Requires an inordinate amount of time to process a claim for little to no reimbursement. System is not the least bit provider friendly.
- The Anthem Blue Cross rep (R. Morales) for CMSP/Path2Health has been very helpful to process payments.

Respondent recommendations for improvement

- Better reimbursement rates

Summary/Lessons Learned

Generally, of the respondents whose counties attempted to process claims (n=6), most reported that (1) there were many questions at the beginning, (2) payment was not enough to compensate for the staff time required to process claims, and receiving payment was problematic, (3) there were not enough services authorized upfront, and (4) the amount of services covered under the benefit did not fit the needs of the typical SUD patient. Satisfaction was low among these respondents.

Although there were a few positive remarks about the program, overall results suggested that the CMSP/Path2Health expanded SUD benefit went largely underutilized and therefore had minimal impact. In addition, data analysis reported in Chapter 1 revealed that the CMSP counties do not appear to have measurably increased referrals from health care providers to specialty SUD providers (see Chapter 1, Figure 1.2). Although some have accessed the covered services and receive reimbursement, it comes with a high administrative cost that many counties are not able to afford. Responses suggested that claims processing and payment needs to be simplified and streamlined if SUD benefits are to be better used when they become more widely available in 2014. Providers will also need to have the infrastructure and adequately trained staff to submit claims.

Low Income Health Program (LIHP)/Medicaid Coverage Expansion for Substance Use Disorder Services Survey

Findings from a survey conducted with administrators from the five California counties that include SUD services as part of their Low Income Health Program (LIHP) highlight some promising practices and recommendations that may be helpful to other counties and the state in preparation for the Affordable Care Act provisions taking effect in 2014.

Administrators reported using a variety of strategies to facilitate enrollment of eligible individuals into LIHP (e.g., assertive outreach, training staff at treatment programs and other venues to help eligible clients apply for insurance coverage, accommodating walk-in enrollment at medically indigent adult programs, and a streamlined application process).

Once eligible individuals are enrolled, they need to be kept engaged to utilize the services for which they are eligible.

Implementation of LIHP SUD services appears to be underway in the five counties offering such services (e.g., use of electronic health records for monitoring SUD screening, coordination between county mental health and physical health systems, hospital-based screening, a centralized medication initiation unit).

The infrastructure for billing Medi-Cal and Drug Medi-Cal and payments may need to be developed and providers may need training and technical assistance (e.g., Medicaid requirements) as their experience in these areas appear to be limited.

Integration of SUD services in primary care settings involves organizational culture change; as such, implementation requires management oversight and time as well as staff accountability for changes to occur.

Introduction

As part of California's Bridge to Reform Demonstration, a waiver granted by the federal government to Section 1115 of the Social Security Act, the state began expanding Medi-Cal coverage to eligible low-income adults through the Low Income Health Program (LIHP) in preparation for national health care reform in 2014. The program consists of two parts, Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI), which will both end December 31, 2013, when the majority of enrollees are expected to become Medi-Cal eligible; the remaining enrollees will become eligible for the California Health Benefit Exchange.

LIHP is an optional local program that varies by county in terms of whether it offers both the MCE and the HCCI parts, the upper-income limit in either part, additional add-on services to the core benefits for each part, and level of enrollee cost share (ranging from zero to the maximum allowable). In addition, eligibility, enrollment and other implementation processes may differ across counties. While eight counties had planned to offer add-on substance use disorder (SUD) services in their LIHP (Manov, 2011), only five counties participating in LIHP have included

approved SUD services in addition to the core MCE and HCCI benefits as part of their Department of Health Care Services contracts: Kern, San Francisco, San Mateo, Santa Clara, and Santa Cruz. (Only San Francisco offers the SUD services covered for the MCE population to its HCCI population.)

The efforts and experiences of the counties participating in LIHP, particularly as they relate to SUD services, may help inform other counties and the state in preparing for and implementing provisions of the Affordable Care Act in 2014. (Also see the summary of Clara Boyden's presentation on San Mateo County's LIHP during the ILC session held on April 24, 2013.) The purpose of the pilot project was to collect data on the status of the implementation of add-on SUD services in the five LIHP counties offering such services, and describe "promising practices" and lessons learned that have emerged in the enrollment and provision of SUD services to patients under LIHP.

Methods

UCLA conducted a brief electronic survey using Survey Monkey to collect information on counties' experiences with (1) expanding Medi-Cal coverage to eligible low-income adults through LIHP, and (2) implementing the covered SUD services. (A draft of the survey was reviewed by Victor Kogler, Executive Director, Alcohol and Policy Institute, and Chair of the LIHP Counties meeting held during the CADPAAC/ADP quarterly meetings, and his input was incorporated.) In April 2013, county alcohol and other drugs (AOD) administrators from the five counties with LIHP add-on SUD services were sent an e-mail that included a link to the survey, and asked to complete the survey within two weeks. (See Appendix 2D for the survey.) Descriptive statistics were calculated from the quantitative data. Qualitative data from the open-ended survey questions were compiled and content analyzed. The sample size was small, but all five of the administrators responded to the survey.

Findings

Target populations and settings for LIHP SUD Services

The target populations and settings for LIHP SUD services varied among the five counties. One county reported that its target population included primary care patients at four safety-net medical care clinics. Another county targeted all of its SUD patients, while a different county focused its LIHP SUD services on residents between 19 and 24 years of age, under 134% of the Federal Poverty Level (FPL) who qualify for the Medicaid expansion benefit, with primary emphasis on homeless adults, the criminal-justice involved (including AB109), parents with children, those with co-occurring mental health disorders, and any others for whom treatment is indicated. While one county's LIHP SUD services were directed toward individuals below 25% of the FPL due to the large numbers of Ryan White patients who entered LIHP, another county's LIHP SUD services were aimed at medical inpatients and psychiatric emergency center patients.

LIHP SUD services were offered in residential, residential detoxification (with and without medical support), perinatal residential, outpatient, MAT, and methadone maintenance settings by one county and at any provider site within the County AOD Treatment Provider network offering a covered service by another county. A third county reported that outpatient and residential services were available for a segment of the LIHP population (hospitalizations or psychiatric

emergencies) and SUD services were included as part of screening and brief interventions in primary care settings (federally qualified health centers).

LIHP SUD services implementation status

Under their LIHP contracts, counties had the option of adding 17 approved SUD services. The average number of LIHP SUD services among the 5 counties was 13, ranging between 6 and 16 services. All five of the counties surveyed offered and had implemented assessment, case management, group counseling, individual counseling, and outpatient services. Four of the counties offered and had implemented collateral services, detoxification, residential acute stabilization, residential perinatal treatment, residential treatment (includes detoxification), and treatment placement. Only three of the counties offered and had implemented narcotic replacement therapy (methadone), screening and intervention, and behavioral health integration services. One county reported that it had not yet implemented screening and intervention or behavioral health integration services (e.g., BH with primary or SUD integration with MH) due to staffing issues and pending determination of medical necessity, respectively. Further, two counties reported offering and having implemented sober living environment and medication-assisted treatment (buprenorphine) services, although one of the counties indicated that it had not yet implemented medication-assisted treatment as it is taking into consideration what is in the formulary and how to encourage medical doctors to provide it as part of outpatient treatment. Day care rehabilitation was available in only one county.

Eligibility and Enrollment

Challenges

The survey respondents described experiencing a variety of challenges regarding LIHP eligibility and enrollment at the county level. Two counties reported re-enrollment difficulties after enrollees' eligibility period had expired (e.g., six months, one year) and one administrator indicated that the photo identification requirement proved challenging. Several respondents noted the transitory nature of homeless and SUD populations (e.g., frequent address changes, difficulty contacting them), and another administrator indicated that the county's projected pharmacy budget was "stretched" due to the federal determination that Ryan White patients must be covered under LIHP and the county's large number of eligible low-income HIV-positive enrollees.

Promising Practices/Strategies

The survey respondents were also asked to briefly describe eligibility and enrollment strategies that were working well in their counties. Examples of promising practices included assertive outreach to enroll eligible patients (e.g., travelling to residential and outpatient programs, locating eligibility staff at a central behavioral health access program), walk-in enrollments at medically indigent adult programs, a streamlined application process, and having onsite SUD provider staff trained to help potential enrollees complete applications to obtain benefits for which they are eligible. In addition, one administrator indicated that the SUD screening is embedded into the electronic medical record at the hospital and onsite screening is administered to any hospitalized patient to initiate treatment options.

Implementation of LIHP SUD Services

Challenges

All but one of the county AOD administrators reported some challenges in implementing LIHP SUD services, which varied by county. Implementation challenges included: getting primary care clinics (front office medical assistants and medical providers) to implement the agreed-upon screening, brief intervention, and referral to treatment (SBIRT) protocols, and difficulties related to insurance billing and payments, some of which were due to the lack of infrastructure for and experience with Medi-Cal billing and in meeting Medicaid requirements. In addition, one county administrator commented that since LIHP enrollees must go through the same process as anyone else seeking SUD services, the challenges are similar to the total system in that some high demand services (residential, methadone maintenance) may have longer access waits.

Promising Practices/Strategies

Respondents offered examples of strategies and practices that they have found effective in implementing LIHP SUD services in their counties, including: close monitoring of the implementation of SUD screening using the clinics' electronic health records, which has been useful in providing accountability for implementation of the screening protocol; coordination with mental and primary health systems in the county; having a centralized medication initiation unit for medication-assisted treatment (MAT), which also serves as a safety net for patients struggling in primary care to be re-stabilized; and hospital-based screening.

Managed Care Concepts/Tools for Medicaid Expansion Enrollees

Three of the five counties that offer SUD services under LIHP are using treatment authorization, and the same number are using utilization review (UR) concepts/tools. Two counties are employing both tools. One of the county administrators commented, "We are doing this in a less formal way than we ultimately should. As our tools for tracking placement and outcomes improve, we will hopefully be more efficient in these functions." Another county reported not using either of the tools, commenting, "Our first priority is to get primary care to fully utilize available SUD assessment and treatment resources. We are not yet concerned about managing SUD treatment costs, especially since the SUD benefit is so limited (basically, only outpatient counseling)." Further, a respondent from a county that is using treatment authorization, but not utilization review wrote, "UR is still being developed. We do site visits to review charts, but have not used it to deny payment at this point," whereas an administrator from a county that is using utilization review, but not treatment authorization, commented, "After 20 outpatient visits, review of medical necessity is initiated."

Recommendations for Policy Makers

County AOD administrators were asked, "Based on your experiences, what should policy makers know about implementing SUD services for the Medicaid Expansion Population?" Their responses offer insights that may be helpful in preparation for the ACA provisions taking effect as of 2014.

- Engaging enrollees to utilize primary health services is key.
- A full continuum of services is needed, including group/individual counseling, day treatment, residential, narcotic replacement therapy (NRT), case management, and rehabilitative services.

- Avoid replication of DMC program, which has many problems, including "population based limitations" (e.g., adults - perinatal only for day care rehabilitative, residential) or individual session limitations.
- Ensure that AOD certified counselors can provide services (under the ADP certification requirements) with oversight by a licensed clinician to meet medical necessity.
- Develop equivalent formularies and covered medications across all plan types so patients do not have to undergo clinically harmful changes if their plan changes.
- While a crisis provides a window of opportunity to engage individuals, particularly those who have little or no recognition that they are addicted, there is a need to create reimbursable case management services to outreach to patients when they discharge.
- Have the SUD benefits under LIHP available to a broader segment of the population (e.g., individuals screened at hospitals).
- Implementation of SUD/primary care integration efforts involve organizational culture change, and as such require management time and oversight to navigate and negotiate the changes. As one respondent put it, "It is not a case of 'build it and they will come.'"

Conclusions

The findings from this small study offer a range of examples and insights from five counties that have implemented SUD services as part of their LIHP. Their experiences shed light on what other counties and the state may encounter in 2014 when provisions of the Affordable Care Act take effect, and provide strategies that have shown promising results in the respective counties. Some "take away" messages drawn from the findings include:

- Implementation of SUD services appears to be underway in the five counties that chose to offer such services as part of their LIHP programs, and has involved use of electronic health records for monitoring SUD screening, coordination between county mental health and physical health systems, hospital-based screening, and a centralized medication initiation unit.
- A variety of strategies have been reported to facilitate enrollment of eligible individuals in LIHP, including assertive outreach, training staff at treatment programs and other venues to help eligible patients apply for insurance coverage, accommodating walk-in enrollment at medically indigent adult programs, and a streamlined application process.
- Once eligible individuals are enrolled, they need to be kept engaged to utilize the services for which they are eligible.
- The infrastructure for billing Medi-Cal and Drug Medi-Cal and payments may need to be developed and providers may need training and technical assistance (e.g., Medicaid requirements) as their experience in these areas appears to be limited.
- Integration of SUD services in primary care settings involves organizational culture change; as such, implementation requires management oversight and time, as well as staff accountability, for changes to occur.

Federally Qualified Health Center (FQHC) Integration Survey and Interviews

Findings from the FQHC integration survey and interviews include:

- Some screening for SUD has occurred in FQHCs, but practices vary widely.
- Most FQHCs reported availability of individual SUD counseling, but less group counseling.
- There is moderate use of common behavioral-health evidence-based treatment practices.
- SUD services are generally not as well integrated with primary care as MH services are, are rated as less effective, and are separated from primary care services physically and temporally. The difference in effectiveness appears to be due to provider training, not in attitudes toward SUD patients. SUD services were more integrated with MH services than with primary care services.
- There is great interest in SUD training, and work to be done on integration of SUD into electronic health records.

Policy recommendations include: expanding the SUD workforce that can bill Medi-Cal (particularly marriage and family therapists) to enable FQHCs to recruit needed staff; allowing same-day billing of two services; including medicine that has been shown to be effective in treating opioid addiction (e.g., Suboxone, Vivitrol) in the formulary; developing the workforce to effectively provide care to individuals who present with SUDs in primary care settings; and increase capacity in the community for specialized SUD and support services, especially residential treatment and detoxification.

Purpose

Research suggests that providing substance use disorder (SUD) services in health care settings is feasible, can reach many more individuals than reliance on community-based specialty SUD treatment alone, promises better outcomes for patients, and can result in reduced overall health care utilization costs. Furthermore, as a result of the Affordable Care Act, mental health and SUD treatment are expected to become more closely integrated with each other and with primary care. However, little data on the current state of integration currently exists. UCLA conducted a small study during 2012 targeting federally qualified health centers (FQHCs) to assess SUD integration with primary care, mental health, and HIV/AIDS services in California primary care settings. The study (Urada, Principal Investigator) was supported in part by the California Program on Access to Care (CPAC) and the California Department of Alcohol and Drug Programs (ADP).

Methods

This study consisted of both quantitative and qualitative research methods. In the first phase of the two-phase study, FQHCs (n=18) in five California counties (Butte, Kern, San Francisco, Santa Clara, Sonoma) were targeted for an online survey about specific SUD-related practices and integration of these practices with primary care, as well as with other MH and HIV/AIDS services. (See the survey in Appendix 2E.) The quantitative survey data (78% response rate) were analyzed in conjunction with administrative data on FQHC patient characteristics, staffing patterns and characteristics, services provided, and program/services financing using data from the Health Resources and Services Administration's (HRSA) Uniform Data Set (UDS) and from

California's Office of Statewide Health Planning and Development (OSHPD) Primary Care and Specialty Clinics Annual Utilization Database (Annual Survey of Clinics). In the second phase of the study, qualitative interviews and focus groups were conducted with 18 participants (e.g., management, staff, patient representatives) from three FQHCs, one in each of the selected counties (San Francisco, Santa Clara, Sonoma) to gain a deeper understanding of SUD-related practices and barriers to and facilitators of integrating SUD services in primary care settings. The qualitative data were analyzed using Atlas.ti, a qualitative data analysis software, and the constant comparative method (Glaser & Strauss, 1967).

Summary of Findings

The study findings are not meant to be representative of the state's FQHCs since they represent a sample of organizations that were expected to be more advanced than other FQHCs in California in integrating SUD services due to the integration efforts that were underway in the counties at the time of the survey. However, these results could be interpreted as describing a likely "upper limit" with regard to integration results that would be obtained if the study were conducted statewide.

Survey Findings

- **Some screening for SUD occurs, but practices vary widely.**
Eight of the 15 responding organizations (53%) reported screening all patients for SUD; three (20%) reported screening a targeted group of patients; and four (27%) did not screen for SUD.
- **There is work to be done on integration of SUD into electronic health records.**
Five of the 14 participants that responded to this question (36%) reported that they did not yet have an electronic health record system that integrates both physical health and behavioral health information, while nine (64%) reported that they do.
- **Most FQHCs reported availability of individual SUD counseling, but less group counseling.**
Twelve (86%) of 14 respondents reported having individual SUD counseling available onsite, and four (27%) reported having group counseling onsite.
- **Moderate use of common evidence-based treatment practices was reported.**
The most common behavioral health practices included motivational interviewing, cognitive behavioral therapy, and social skills building, all reported to be in routine use by seven of the 14 survey respondents (50%). SUD services were most commonly provided by an SUD counselor (35%), LCSW (57%), or psychologist (43%). Use of SUD medication-assisted treatment onsite is infrequent. Only three (21%) reported prescribing buprenorphine (brand names: Subutex, Suboxone) "sometimes"; none do it routinely. Three (21%) report never prescribing it, but being interested in adding it. Only one (7%) reported prescribing intramuscular naltrexone (brand name: Vivitrol).
- **SUD services are generally not as well integrated with primary care as MH services are, are rated as less effective, and are separated from primary care services physically and**

temporally. The difference in effectiveness appears to be due to provider training, not in attitudes toward SUD patients.

Even though we targeted “high integration” counties for the surveys, seven (50%) of organizations described their SUD services as having minimal or only “basic at a distance” collaboration with primary care, while the other seven (50%) described it as “Close Collaboration, Partly Integrated” (i.e., 4 on a 5-point scale), but none described their SUD services as fully integrated. By comparison, for mental health and primary care integration, 11 (79%) reported close or full integration. Statistically, the difference in SUD and MH integration levels was marginally significant ($t(13)=-1.79, p<.10$). Respondents also rated their organization’s effectiveness in treating SUD problems on a 5-point scale ranging from *not at all effective* to *extremely effective* and had significantly lower ratings for effectiveness in treating SUD (mean=2.9) than MH disorders (mean=3.6) ($t(13)= -2.35, p<.05$). The lower effectiveness for SUD treatment did not appear to be due to differences in attitudes toward treating these problems, however. Participants were asked to rate their agreement with the statements “it is possible to treat substance use disorders effectively” and “it is possible to treat mental health disorders effectively” and provided essentially the same ratings for both (4.2 and 4.1 respectively, $t(13)=.37, ns$). Instead the difference in SUD and MH treatment effectiveness appeared to reflect staff training. Participants indicated significantly lower knowledge of evidence-based SUD treatment practices than MH treatment practices (3.3 vs 3.9, $t(13)=-2.22, p<.05$).

A marginally significant correlation between level of SUD integration and perceived SUD treatment effectiveness ($r=.46, p<.10$) was also identified, with greater effectiveness tending to occur with greater integration.

In only two cases (13%) were primary care and SUD services located in the same building. No FQHCs reported providing SUD services on the same day as a primary care referral. Five (36%) said it happened within seven days. The other 10 (64%) reported providing SUD services after more than seven days.

- **SUD services were more integrated with MH services than with primary care services.** SUD services were generally better integrated with mental health, with six (43%) respondents reporting close collaboration between the two, likely because the same behavioral health staff generally addressed both MH and SUD problems. Still, more than half (eight, 57%) reported that MH and SUD service integration was only minimal or basic.
- **Integration between SUD services and HIV/AIDS services is driven by funding.** Across all organizations, SUD and HIV/AIDS services were found to be even less well integrated than SUD and other primary care services. Five respondents reported close collaboration (36%), while the other eight (64%) reported only minimal or basic integration. All of the organizations reporting close collaboration either billed SUD services as part of their prospective payment system (4 out of the 5) or through grants (2 out of 5), suggesting that integration was strong only where the organizations had found a way to finance such services.

- **Reimbursement for SUD services varied.**

Nine of the FQHCs (64%) included SUDs in their FQHC prospective payment system rate. Other revenue sources reported included billing to other county health sources (4, 29%), paying for services through grant funding (5, 36%), and services provided without any billing (3, 21%). Six out of the seven organizations that reported close collaboration also reported that they found ways (sometimes indirect) to fund their SUD services through use of the prospective payment system rate, suggesting the importance of reimbursement for integration efforts.

- **There is great interest in SUD training.**

Twelve of the 14 respondents (86%) agreed that additional SUD-related training would be helpful for their clinic staff.

Qualitative Interview Findings: Barriers & Challenges to Integration

The main themes that emerged from the qualitative data on barriers and challenges to SUD service provision and integration are presented below. Quotations are provided to illustrate the themes.

- **Workforce training is an issue.**

According to several participants at two of the sites, sometimes it is challenging to find behavioral health providers who have an interest in and the skill set (e.g., flexibility, bilingual Spanish and English) to work in community health care settings. For example, such specialists may be more comfortable with a traditional approach that is focused on long-term counseling and where patients are seen by appointment for a particular period of time (50 minutes) rather than a crisis intervention or short-term approach that addresses the immediate needs of patients. A few providers explained:

“The way therapists are trained is not conducive to what’s needed in a community health center. It doesn’t work. The 50-minute hour is useless in a community health center, I think, but that’s [how] therapists are trained...The people I see, they don’t stick to a schedule. They don’t wanna talk for 50 minutes, a lot of them. When they need it, they need it now. Then when they don’t need it, they’re not gonna come to an appointment. To me, there’s a new breed of therapists that we need that I’ve only met one or two that fit that role over the years.”

“We have very good therapists...It’s just so much of what we see are people with head injuries or people on big levels of opiates and benzos. I mean, insight therapy is not really gonna be what helps them, but they sure need some mental health kind of holding and case management and helpin’. Most therapists, that’s not really what they’re perspective is. That’s my take on it.”

“Usually, [behavioral health] counselors don’t like to deal with people with substance use issues.”

“If you can get a mental health therapist who specializes in substance abuse therapy and they can do the whole panel, it could work. At least in my observation, we’re talking

about very different needs. I would say the caseload for mental health, depression, personality disorders, some psychosis, but that's pretty limited, we usually refer out for that, anxiety—that's a pretty different set of issues than people who are abusing meth or cocaine or heroin. Dealing with those clients requires a very different skill set.”

“It was hard to find someone qualified [for both SUD counseling and psychiatry]. Of course, we have that extra layer of preferring to have someone who is bilingual and bicultural, because that helps them to get a lot farther with our client population. That was an extra qualification that was probably added to the difficulty. Still, it was hard to find someone to fill the position.”

In addition, some of participants interviewed said that patients with chronic pain and/or SUD can be challenging for providers to deal with. Providers vary widely in their comfort and skill levels in working with these patients, as the following comments exemplify.

“The chronic pain stuff and substance abuse...A lot of docs come into it with biases that are not particularly helpful. Some of them aren't all that amenable to change.”

“It's a hard population and they push you to do things you don't feel comfortable with and you have to get comfortable with settin' limits and sayin' okay to this and not to that. It's a different strategy than accommodating...everybody all the way along. We try to talk about that and there's differing degrees of interest.”

“The area where providers I think do get frustrated is around patients who have a chronic pain condition, where narcotic seeking behavior, or other prescription drug abuse is a big part of their substance use disorder – that feels very frustrating and often you feel like you're in a position where you can't trust your patient. Often there's manipulation, where they try and use different team members to sort of split us, or come to the nurse and say, ‘Oh, I need my early refill, the doctor told me it was okay.’ ... I think we all get a little frustrated ...even knowing it's part of a different condition that needs treatment. It just gets tiring.”

- **Same-day SUD services are not billable.**

Providers are not reimbursed through Medi-Cal for physical and mental health services delivered on the same day. This policy has a negative impact on both patients and providers according to many of the providers interviewed. Patients must return on another day or providers either are not paid for services they actually provide or must develop “workarounds” to deliver the needed behavioral health services. As providers in community health care settings are increasingly utilizing multidisciplinary care teams, embracing a patient-centered approach to care, and trying to increase access to care, they explained that this policy undercuts integration efforts:

“We can't bill for a primary care and a mental health visit on the same day...It's crazy. That's a huge barrier for patients because it means that...I have to develop all these workaround things...They have to come back...So you have to do 'em on a different day, and it's very complicated for us because we have some of our mental health providers in different offices, and so we have to make sure that they don't make an appointment to see

a mental health provider at a different office on the same day as their primary care because we wouldn't get paid for both visits."

"A huge issue that we've struggled with along with everybody else is that you can't bill for more than one provider on a single day. So here we have these group medical visits where the psychiatrists, the primary care physician, the psychologist and a clinical social worker are all seeing the patient on the same day. So basically we've had to eat that cost largely."

"This is a walk-in clinic. Our folks have a hard time getting to places. When they show up here they often see three or four providers the same day, and we're all doing completely different things with the patient. We can't bill for it. That being said, we have the highest productivity rates in the county and the highest customer satisfaction rates. I think it's because when people come here they feel like they've gotten a really good bang for the buck, and really good like use of their time. You know they have to wait around for hours to be seen, but they see three or four people, and they get a lot out of it."

- **Services provided by certain providers are not billable.**

Another billing issue raised across the sites visited is that SUD services provided or that could be provided by marriage and family therapists (MFTs) and certified SUD counselors currently cannot be billed to Medi-Cal.

"That's the number one [barrier]. I mean, we would have substance abuse counselors on staff if you could bill for it, but you can't bill for it...The FQHCs, that's basically how they run, is on billable services."

"From the FQHCs point of view, Medi-Cal is our primary funding source...so if Medi-Cal pays for substance abuse services, great. We'll provide 'em till the cows come home. If they don't provide 'em, forget it. They're not gonna get it."

"If we could bill for a substance abuse counselor, we'd have somebody busy all the time."

- **Some of the SUD medications are not on the formulary.**

The process for obtaining prior approval for non-formulary medication to treat opioid addiction (e.g., Suboxone, Vivitrol) can be complicated. According to several participants at one of the programs with multiple providers licensed to prescribe Suboxone, although a provider can submit a treatment authorization request (TAR) and receive approval for the medication, the paperwork can be complicated and there may be delays in receiving such approval, which may negatively impact patients (e.g., dosing, dose adjustments) and providers trying to deliver care (e.g., time and effort to submit and follow-up with paperwork).

"A lot of our patients at some point end up getting on either Medi-Cal or Medicare...Things become a lot more complicated at that point, where there's this constant fight with the insurance company requesting approval for this non-formulary

medicine, to the extent that...it puts the treatment of our patients at risk, 'cause they are not able to get the medicine."

"It also ties our hands with dosage changes, because the TAR is saying, 'They're gonna be at 16 milligrams for a month.' Well, if in that month we decide we need to bump up their dose, we can't. We have to do a whole new TAR, which takes a week or two to get approved, so we can't have an immediate medical change to their treatment.'

"It takes time for the process, but it also requires just a huge energy, just from the staff of the clinic. Our nurses are dealing with it. Our MAs are dealing with it. All of our providers are dealing with it...We're all just constantly spending this extra time, which we don't have, to fight with the insurance companies to get this approval.'

- **SUD resources/services in the community for patient referrals are limited.**

Participants interviewed in all three of the selected counties commented that there are very limited or no community resources/services for SUD, particularly residential treatment and detoxification. The following quotations from providers exemplify this theme.

"When we wanna get somebody into inpatient rehab, it's almost impossible if they have Medi-Cal or [the county version of Medi-Cal] ...If they go through the criminal system, then there's plenty of beds."

"I think waiting lists and the amount of paper work that they request from us... I was trying to get a client into a residential, and they wouldn't admit it unless he would go to detox first. I couldn't get into detox because they didn't have a space. What do I do here?"

"Outpatient is something, but it's really not addressing the level of need that my patients have. It's like putting someone with an active GI bleed in-I don't know-an observation bed or something. These are ICU-level addicts, and...we're offering them outpatient at best. A lot of the times, we don't even offer 'em that. Because they try to call for inpatient for three weeks. They get nowhere. They just end up leaving and giving up. ...We need beds."

"Someone is willing to go into a treatment program. It's very hard to get a spot if they want a residential program...They have to go through the detox...Then it just seems like there is a very limited supply of that resource."

Qualitative Interview Findings: Facilitators of Integration

Additional qualitative data were collected on facilitators of SUD service provision and integration. The main themes that emerged are presented below.

- **Easy access to resources onsite or within the organization to address SUD issues**

Participants in all three organizations visited expressed that primary care providers feel more comfortable, willing, and able to deal with SUD issues when there are behavioral health specialists and other providers (e.g., a physician licensed to prescribe Suboxone, a case

manager), particularly on the care team responsible for the patient or within the organization, to provide SUD consultation and services. According to providers interviewed, multi-disciplinary teams are able to more effectively address patients' many and diverse needs, and may also decrease the burden on any one provider. The following quotations from participants exemplify this theme.

“As far as the providers being uncomfortable with substance abuse, that's not our experience. They really value having [the SUD counselor onsite] there. They [primary care providers] can talk about substance abuse issues, but to have someone to do the kind of follow-up...A lot of people who are not on antiretrovirals are not on them because of substance use issues. The doctors love to have someone who can specifically address that so that they can get them to a place where they can prescribe.”

“The other thing is with the Suboxone...it can be overwhelming for one provider to see people, and then try to address at least some of their needs so that they can maintain their sobriety...I mean the Suboxone helps. It's great. It can get rid of their cravings. But then what? There's all this other stuff that comes along with addiction that also has to be treated or else they're gonna relapse.”

“When you have these really complex, complicated, intertwining issues and problems, then you can't just count on a certain, one set of skills, and a person who's an expert in the physical issues to be able to address that...So having a psychiatrist on our staff, having mental health professionals on our staff has been really helpful.”

- **Providers with the right “fit” for working in community health care settings**

Participants across the three sites visited similarly commented about the importance of having the right people (e.g., skills, personality, training, flexibility, interest in and comfort level with addiction) in the appropriate roles when trying to integrate SUD services into primary care. Many of the patients in FQHCs need care in multiple areas, including the harmful use of alcohol and drugs.

“We have a new provider [physician]She's right there. She takes people coming in, 'Just get 'em in. Just get 'em in. I want to see 'em.' ...She has the most hours... She really has the substance users...She's...no judgment... 'How can we help'?”

“You really need a staff who actually are okay working with drug users. You know, who don't think that they're weak, bad people, don't think that they shouldn't be wasting their time on them anyway.”

“This clinic selects for people who have an interest in addiction medicine.”

- **Organizational culture and leadership that supports innovation**

According to participants interviewed, an organizational culture (e.g., patient-centered, team based) and leadership (e.g., Director, “champion”) that encourage and support new ideas to increase patient access to needed services, including SUD services, are important in the integration of SUD services into primary care. The quotations below from providers illustrate this thematic finding.

“I think we have a progressive administration who’s interested in trying to figure out how to get this stuff in here ‘cause they recognize the need. [The substance abuse treatment program is] a great resource. They’re a very good community resource...so it’s making these collaborations. We don’t have to reinvent the wheel. We just have to figure out how to bring the people that know how to do this in on site.”

“The principles of patient-centered medical home I think are more in line with supporting the integration of these services, both because they see the need for multidisciplinary care, but also the type of infrastructure that’s being created, it’s more open access scheduling. You’re not scheduling visits four months out or you want to see a substance abuse...The emphasis is on you provide care when the client is ready to receive care.”

In talking about how the idea for the multi-disciplinary team visit for the Suboxone groups came about, one of the participants commented, “One of the great things about here, too—you come up with an idea, we’ll figure out how to make it work.”

Administrative Data Analyses

No statistically significant relationships were found between reported level of integration and organizational or patient characteristics from UDS and OSHPD data.

Provider/Organizational-level Promising Practices

The following practices that facilitated integration of SUD services were drawn from the qualitative interviews with primary care staff.

- Use of multidisciplinary care teams (e.g., psychologist, psychiatrist, physician, case manager) helps to address patients’ multiple needs and reduces the burden on any one provider.
- Suboxone groups are useful in providing patients with peer support and helpful to providers in monitoring patients who are receiving the medication.
- Development of linkages/partnerships/collaboration with community resources facilitates patients’ access to services (e.g., provide SUD counseling services onsite or through referrals).
- Having case management services available is key for patients with multiple needs (e.g., medical, psychological, drug use treatment, housing).

Policy-related Recommendations

Participants who completed the online survey and those who participated in the qualitative interviews were asked for policy recommendations to facilitate integration of SUD or MH services or remove barriers to integration. The main themes are presented below.

- Expand SUD workforce who can bill Medi-Cal to enable FQHCs to recruit needed staff. In particular, FQHCs want to add marriage and family therapists to the list of staff that are eligible to bill Medi-Cal. Currently licensed clinical social workers and psychologists are the only behavioral health providers that can do so.

- Allow same-day billing of two services. This is consistent with best practices regarding “warm handoffs” between primary care and behavioral health. If a patient must make an appointment to return another day to receive these services, they will often become “no shows” and an opportunity to address their problems will be lost. Nationally, 28 states currently allow same-day billing, but California does not.
- Include medicine that has been shown to be effective in treating opioid addiction (e.g., Suboxone, Vivitrol) in the formulary. Although providers may submit a treatment authorization request for Suboxone, providers and support staff sometimes find the process to be time consuming, labor intensive, and frustrating, which can negatively impact providers’ willingness or ability to provide medications that are effective in treating opioid addiction.
- Develop the workforce to effectively provide care to individuals who present with SUDs in primary care settings. SUD and recovery should be covered in the curriculum for medical and nursing students, social workers, psychologists, and other direct-care providers so they are comfortable and effective in addressing SUD.
- Increase capacity in the community for specialized SUD and support services, especially residential treatment and detoxification. Patients who are referred from primary care to specialty SUD services in the community find it extremely difficult to access needed services due to lack of availability.

Study Limitations

There are several limitations that should be considered when interpreting the study findings. Qualitative findings were drawn from a convenience sample of FQHC staff and board members who were willing to participate in the interviews and who were available when the site visits were conducted. Thus, their perspectives may not represent the perceptions and experiences of staff and Board members at the selected organizations who were not interviewed. Our sample size of 18 participants is small. However, the interviews were conducted with participants in diverse disciplines and across three different organizations/programs to explore a range of perspectives. The perspectives of staff who provide direct services to patients and patient representatives are essential in gaining a more in-depth understanding of SUD services provided at the ground level in primary care settings, while the survey questionnaire provides important breadth of information about integration in real-world.

Due to the dearth of current information on SUD integration and the relatively small size of this study, our aims were primarily descriptive. The lack of significant relationships between some variables (e.g., administrative data) is likely largely due to the small size of the study and accompanying low statistical power, and should not be interpreted as evidence for the absence of such relationships.

V. Chapter Summary and Recommendations

Summary

UCLA sought to address the following objectives in this domain:

1. Collect and disseminate cutting edge information on the integration of SUD services with mental health and primary care services
2. Coordinate and facilitate an interactive forum (i.e., Learning Collaborative) with counties and other key stakeholders to discuss SUD integration barriers and practical models
3. Conduct case study/pilot evaluations

As the field continues to move forward in implementing SUD/MH and health care integration, detailed frameworks have been developed and refined in response to the profusion of different integration models that exist. A refined iteration of the “Standard Framework for Levels of Integrated Healthcare,” was released by SAMHSA-HRSA Center for Integrated Health Solutions (CIHS, 2013). The new framework encompasses six levels of behavioral health and health care integration, under a continuum ranging from coordinated care to co-located care and finally integrated care. This framework reinforces the fact that individuals seeking primary care do not have isolated problems limited to only SUD or only mental illness, but often have issues that co-occur. Hence, the framework encompasses behavioral health and is meant to include both SUD and mental health service integration.

The general term “integration” often takes a wide variety of forms, and similar related terms can mean different things depending on the context and who is using the term. Because integration involves bringing together contributions from different fields and perspectives, consensus on basic terminology would aid these groups in working with one another. Once a common consensus can be reached about the definitions of these terms, they can be used and better understood across disciplinary boundaries.

As providers continue working on integrating behavioral health and primary care, evidence-based practices (EBPs) can play an important role in the process by bringing research-supported interventions into clinical practice to help improve outcomes. Commonly used EBPs used to facilitate integrated services include: SBIRT, the use of motivational interviewing (MI), and medication assisted therapies (MAT). However each contains barriers to successful implementation such as workforce development requirements, billing and reimbursement challenges, as well as policy obstacles.

Under health care reform, new organizational models are emerging and gaining prominence as ways to transform care so that is better integrated, more comprehensive, and more responsive to the needs of patients. Examples of these models are health homes, patient-centered medical homes (PCMHs), and accountable care organizations (ACOs). Because of their emphasis on integrating services, they provide a potential opportunity for behavioral health. A large body of evidence supporting their use has not yet been developed, but over time a set of best practices may emerge.

There are many ways that technology can be used to facilitate integration (e.g: Telehealth and Health Information Technology and Electronic Health Records). New technologies and the mass deployment of existing technologies expands the ability of providers to not only share information with each other across disciplines, but also to monitor and track patients and communicate important developments with patients regarding their health. However, implementation is costly and is imbedded with barriers around confidentiality and data/information sharing regulations.

Providers across the country have been pilot-testing promising practices to integrate mental health and SUD services with primary care. Despite barriers, some have been able to effectively integrate different services. This chapter describes a selection of successful integration models highlighted across the state over the past year. Although many have found positive impacts from their piloted activities, further research is needed to determine whether these approaches can sustainably improve quality and outcomes while effectively reducing costs. Common keys to success include grant or foundation funding, strong communicative networks, EMR implementation, and recognition of the amount of technical assistance and training required for the providers.

Common barriers that continue to persist include: cultural differences and pushback among the SUD, MH and PC disciplines, common misconceptions about the nature and value of behavioral health (particularly with SUD) assessment and treatment, confidentiality and issues around 42 CFR, Health IT and Electronic Medical Record implementation, workforce limitations and training needs, and financing/billing for integrated services, including policy implications and challenges built within current regulations.

Within California, the UCLA Integration Survey revealed that while a few counties have not yet begun the process of integrating AOD services with mental health and primary care, many others have reported progress. Despite many barriers remaining intact between 2010 and 2012, integration initiatives have expanded among California counties.

The California Integration Learning Collaborative continues to function as a useful mechanism to share information and discuss successes and challenges across county administrators and executive level providers/administrators. It serves as a monthly mechanism for the state to provide technical assistance and training opportunities at the county level though the facilitation at UCLA.

Through case studies and pilot projects, UCLA has been able to identify several lessons learned from the many integration activities occurring across the state.

- Developing partnerships at the leadership level across the health care disciplines and silos was an initial place to begin integration efforts.
- Educating and training staff (at all levels) is critical to 1) clarify roles and responsibilities across the various collaborating disciplines, 2) to obtain buy-in at the provider and administrative staff level, 3) to foster a shared vision, 4) improve utilization of evidence-based practices, and 5) instill value among the workforce.

- Identifying a strong leadership team guided by a shared vision that meets regularly helps to create successful implementation.
- Creating an open forum for staff feedback to the leadership level was crucial to maintain buy-in, instill accountability, and allow for staff to be a part of the process.
- Establishing “champion physicians” and incorporating them into the leadership team was a successful mechanism to implement new services and practices.
- Selecting the “right staff” to conduct integrated behavioral health in primary care settings is critical. These staff must be flexible, proactive, able to handle ambiguity, and able to form strong relationships.
- Stakeholders must be willing to modify initial plans as need.
- Communication is key and continuing staff education is important.
- Patience, tolerance, and openness were required from both the physical health and behavioral health providers in order to merge the two cultures.
- It is important to acknowledge that change is difficult.
- There are many challenges surrounding the implementation of a new EHR system, such as problems with glitches and data transfers. The data tracking system must be kept simple at the outset.
- Follow latest SAMHSA developments to assure 42 CFR compliance when sharing data; review consent and admission form accordingly.
- Patients/consumers are benefiting from the integration of services. Anecdotally, patients feel understood and supported with in-person warm handoffs. This builds trust, which allows patients to feel they are in good hands.
- Integrating services requires funding and/or an identified staff to navigate through the complex billing mechanisms.

Additional surveys of selected FQHCs in California revealed that:

- SUD services are generally not as well integrated with primary care as MH services are, are rated as less effective, and are separated from primary care services physically and temporally.
- The difference in effectiveness appears to be due to provider training, not in attitudes toward SUD patients.
- SUD services were more integrated with MH services than with primary care services.
- There is great interest in SUD training, and work to be done on integration of SUD into electronic health records.

Surveying SUD/BH administrators who participated in LIHP or CMSP programs revealed that although some have accessed the covered services and receive reimbursement, it comes with a high administrative cost that many counties are not able to afford. Responses suggested that claims processing and payment needs to be simplified and streamlined if SUD benefits are to be better used when they become more widely available in 2014. The infrastructure for billing Medi-Cal and Drug Medi-Cal and payments may need to be developed and providers may need training and technical assistance (e.g., Medicaid requirements) as their experience in these areas appear to be limited.

Recommendations

- Support research to identify best practices of coordinated care and evaluate long term impacts on quality of care and patient outcomes.
- Continue to educate providers and their workforce on the importance and effectiveness of coordinated care and the value of behavioral health for the overall improvement of quality of patient care and outcomes.
- Continue to advocate for the inclusion of behavioral health organizations in meaningful-use subsidy programs.
- Continue efforts to foster partnerships between SUD and primary care providers.
- Continue efforts to support pilot projects at the county and provider level as a mechanism to test and evaluate successful implementation strategies.
- Technical assistance is needed to assist counties in overcoming barriers to integrated care, specifically around financing integrated services and addressing regulations that present challenges.

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Chapter 3: Strategic Planning for Workforce Development: Preparing the AOD Workforce for 2014 and Beyond

Brandy T. Oeser, M.P.H., Richard A. Rawson, Ph.D., and Jessica Haddad, B.S.

As SUD and MH integration efforts roll out in California, it is clear that the workforce will require a broad and diverse set of skills. As SUD integration under health care reform is still evolving, the workforce necessary to implement SUD services outside of the specialty system remains unclear. The goal is to prepare our current AOD workforce for the types of setting and practice changes in SUD treatment delivery, including recovery and prevention, brought forth by health care reform. Recommendations include: A concerted **workforce planning effort** should be initiated in which key stakeholders and workforce experts work in concert with the Department of Labor Workforce Investment Board (WIB). A series of meetings should be convened to provide a forum for a review of the critical issues that will **determine the SUD workforce needs** as well as discussions and plan development. A transition plan should be created to establish a counselor **certification infrastructure** in which there is a single counselor certification/license administered by the State of California. The SAMHSA career ladder for SUD counseling should be implemented in California. The state should expand existing **training and technical assistance** services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment. These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into Integrated Behavioral Health (IBH) providers in medical settings.

I. Introduction

As the SUD service delivery system is shifting, strategic plans at the state level require re-evaluation. Under direction and with guidance from ADP, UCLA has worked to identify strategic planning principles and recommendations, with an emphasis on workforce development, in an effort to assist ADP prepare for the changes ahead and guide the future development of an integrated drug-treatment delivery system in California over the next 5 years. A full investigative review, including literature reviews, stakeholder consultations, and evaluations of California and other states' strategic plan developments, has been conducted and was submitted December 7, 2012 (Appendix to EnCAL Report 2011–2012). Since that time, investigative work has continued on this evolving topic and will be summarized within this chapter.

II. Objectives

This chapter addresses the ADP/UCLA contract Domain 2, entitled “Health Care Reform and the Integration of SUD Services with Mental Health and Primary Care.”

1. Provide recommendations for strategic planning principles to guide the future development of an integrated drug treatment delivery system in California under health care reform.

III. Methods

During fiscal year 2012–2013, UCLA continued to address the objective to develop strategic planning principles to guide the future development of an integrated drug treatment delivery system in California under health care reform. As SUD integration under health care reform is still evolving, the workforce necessary to implement SUD services outside of the specialty system remains unclear.

The goal is to prepare our current AOD workforce for the types of setting and practice changes in SUD treatment delivery, including recovery and prevention, brought forth by health care reform. In order to get a picture of the long-term goals and short-term plans for developing our workforce of SUD counselors, UCLA undertook several tasks. Specifically, UCLA consulted with national experts from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of National Drug Control Policy (ONDCP), Health and Human Services (HHS), California’s Workforce Investment Board (WIB), Annapolis Coalition, and other leaders in the field of substance abuse, mental health, health policy, service billing/financing, and workforce development. Discussions were held with Sarah Wattenberg (HHS/Office of the Assistant Secretary for Health), Linda Kaplan (SAMHSA), Donna Doolin (SAMHSA), Mady Chalk (Treatment Research Institute), Patrick Gauthier (AHP Healthcare Solutions), and representatives of NASADAD (National Association of State Alcohol and Drug Abuse Directors) to gather guidance and insight from workforce development leaders at the national level. In addition, UCLA consulted frequently with leaders at the California Department of Alcohol and Drug Programs (Michael Cunningham, Dave Neilson, Marcia Yamamoto) to further understand current priorities and issues at the state level. UCLA also utilized the knowledge gained across the course of the last 2 years (2010–2012) through the EnCAL contract, as well as from the UCLA ISAP Training Department and the Pacific Southwest Addiction Technology Transfer Center (PSATTC), to compile recommendations of county- and provider-level workforce needs. UCLA reviewed documents produced by the Annapolis Coalition, Joan Dilonardo’s report, documents produced by the California WIB, and other reports; investigated programs at colleges and universities for workforce training programs and models being developed in the area of SUD treatment in primary care; and had conversations with stakeholders at the county level and with FQHCs on the direction that health care reform would take the field.

IV. Findings

Due to the various investigative methods utilized within this chapter, the findings are organized around the following activities:

- A. Background
- B. Workforce Conference Call with ADP and Stakeholders (*December 17, 2012*)
- C. CADPAAC Presentation on March 27, 2013 (*Rawson, Freese*)
- D. Involvement with other Workforce Groups (WIB, HWDC, OSHPD)
- E. Investigative Work (Financing/Billing – Medicaid Codes)

A chapter summary and set of recommendations conclude the chapter.

A. Background

Recent changes in health care policy will accelerate the integration of the SUD treatment field with the rest of the medical system in California while rapidly expanding the population that needs SUD services and has access to treatment. These trends will compel SUD service providers to enhance their professional competency in order to operate as members of the medical workforce.

Several recent pieces of legislation will facilitate the incorporation of SUD treatment services into the rest of the medical system. The 2008 Medicare Improvements for Patients and Providers Act (MIPPA), the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), and the 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) have brought insurance coverage for substance use conditions in line with that offered for other chronic conditions by reducing co-payments and increasing benefits for SUD treatment. The 2010 Affordable Care Act (ACA) will expand Medicaid coverage to between 149,000 and 195,000 previously uninsured Californians who need access to SUD services within health care (including SUD treatment), and provide them with SUD services as mandated by the MIPPA, MHPAEA, and CHIPRA (Needs Assessment Report, 2012). Thus, a significant number of Californians will be gaining access to SUD services in the near future, and the treatment they receive will be funded by health insurance rather than block grants or other siloed SUD treatment funds. Overall, it is anticipated that these shifts will require the SUD treatment workforce in California to grow by between 2,100 and 2,828 FTEs by 2019 (Needs Assessment Report, 2012).

The Affordable Care Act has emphasized the need to improve the quality, availability, and affordability of health care for all Americans through integration and collaborative processes. A central principle in this system change is the need to move toward a collaborative and patient-centered approach to health care through the integration and coordination of health services. The substance use disorder (SUD) and mental health (MH) fields will be part of the transition toward integrated care; it will be essential for SUD care and MH care to become more coordinated and integrated with physical health care (Institute of Medicine, 2006).

The current substance abuse treatment workforce is not sufficient in number and does not have all of the skills necessary to function in an integrated environment. Fewer counselor licensure/certification requirements are required for substance abuse counselors in comparison to mental health counselors. Requirements for substance abuse counselor certification varies substantially across California’s nine certifying organizations and does not include preparation related to physical health conditions or working in settings other than those providing substance abuse specialty treatment. The majority of members of the core disciplines (physicians, nurses,

social workers, psychologists, physician's assistants, and others) are also likely to have insufficient training in addiction. Physicians report barriers to the use of medication-assisted treatment and screening and brief intervention, including not feeling comfortable in managing all components of either type of intervention. It is essential that the availability of peer support be maintained as treatment for substance use conditions is integrated into primary and other medical care settings (Dilonardo, 2011).

The chronic illness approach to substance use disorders requires a continuum-of-services system model that shifts the emphasis away from acute symptom stabilization (episodic treatment) toward a continuum including prevention, intervention, treatment, and long-term recovery support (Flaherty, 2006; Kipnis & Killar, n.d.). This shift toward managing substance use problems as chronic health problems and taking on a public health approach is a national priority. The creation of a continuum of care that promotes treatment of SUDs has substantial regulatory, financing, and workforce implications.

Implementation of the ACA will result in substantial developments in the workforce. Consequently, ADP began a discussion with UCLA about designing a workforce development strategy for the State of California's SUD services. This collaboration hopes to prepare our current AOD workforce for the types of setting and practice changes in SUD treatment delivery, including recovery and prevention, brought forth by health care reform. In order to get a picture of the long-term goals and short-term plans for developing our workforce of SUD counselors, UCLA undertook several tasks. UCLA had conversations with stakeholders at the county level and with FQHCs on the direction that health care reform would take the field.

B. Workforce Conference Call with ADP and Other Stakeholders (December 17, 2012)

UCLA organized a meeting (in conjunction with ADP) on Dec 17, 2012. The purpose was to collect input on workforce needs in the area of "Drug and Alcohol Counselors" and to provide feedback to the California Workforce Investment Bureau's (WIB) Health Workforce Development Council (HWDC). A meeting summary is provided below.

UCLA was asked to assist ADP with the creation of a strategic plan for workforce development in California. The plan should include both short-term and long-term actions to take in the coming years in order to ensure that our current workforce has the necessary training, knowledge, and credentials to meet the demands of both our current population and the newly expanded population in 2014. The Dilonardo paper is a working framework/model that should be used to guide policies and questions that need to be addressed, such as the short-term and long-term outcome goals for our particular system of care; how to effectively position state, county, and local providers to be ready for HCR; and how to provide resources/incentives to achieve the desired outcomes.

At the current state of affairs, there are two different obstacles to the above stated goals: counselor certification and ACA related workforce issues. The current California counselor certification process is inherently confusing by having nine different certifying bodies, each with their own standards and requirements, which makes uniformity within the discipline exceptionally difficult. The ACA, conversely, brought about with its fundamental changes to the

industry itself, will require significant shifts in the workforce, the most impactful being the decreased reliance on specialty care; moving toward the integration of mental health (MH) and alcohol and other drugs (AOD) services into primary care; and increasing the emphasis on team-based care rather than individual providers giving counseling.

Some of the other types of workers that are being considered to counteract the anticipated shortage in the workforce include community health workers, recovery support workers, and expanded use of social workers. These “new workers” must understand both MH and SUD in order to effectively work in the PC/FQHC setting. Given these potential streams of personnel, however, program administrators are still extremely concerned about billing eligibility for the workforce. Cited concerns include questions about the services (including SBIRT) these workers would provide, the services they would be able to bill for, and the fate of the current ~30,000 workforce and whether or not they will be left behind (or out altogether).

The California Workforce Investment Board (WIB) has been identified as a potential bridge connecting policy and workforce efforts. Three arenas where the WIB can be utilized to improve the workforce situation include training entry-level workers, PCP education, and community college educational program development. The WIB could be used now to feed the specialty system with entry-level workers, which would prepare it for the incoming stream of newly insured patients being referred from the primary care system. Another possible immediate action the WIB could take would be to educate primary care providers on the new wave of workers that will be needed and how to incorporate these people into their primary care practice. Lastly, the WIB can work with community colleges to develop a pipeline for workers with the skill set needed for primary care-based MH/AOD service delivery in the future.

Other aspects of training will need to be further investigated to better inform best practices models. These include ascertaining what skill sets will be needed for behavioral health and for primary care and then seeing how we can use and develop our existing workforce. Also, individuals with broader expertise in behavioral health, not only MH or AOD specifically, will be increasingly important. We need to help the current counselor workforce prepare for changes (skills, training for the future). For the long term, we need to develop a pathway or set of skills for people working to provide behavioral health services in primary care in the future. Next Steps include reaching out to federal agencies for national guidance and a stakeholder meeting.

Meeting Attendees:

Michael Cunningham (ADP)

Marcia Yamamoto (ADP)

dave neilsen (ADP)

Marjorie McKisson (CA DHCS)

Mady Chalk (TRI)

Sarah Wattenberg (HHS/OASH)

Alicia Richmond (HHS/OASH)

Tom Renfree (CADPAAC)

Dennis Koch (CADPAAC)

Jim Sorg (standing in for Albert Senella - CADA & CAADPE)

Victor Kogler (ADPI)

Steve Maulhardt (COMP)
Richard Rawson (UCLA)
Thomas Freese (UCLA)
Darren Urada (UCLA)
Traci Rieckmann (UCLA)
Elise Tran (UCLA)
Valerie Pearce (UCLA)
Brandy Oeser (UCLA)
Beth Rutkowski (UCLA)

C. Integration Learning Collaborative: Challenges for the SUD Workforce: 2013 and Beyond (March 27, 2013)

Presenters: Richard Rawson, PhD, and Thomas Freese, PhD (UCLA ISAP)

Workforce discussions continued during the ILC presentation on March 27, 2013. It is evident that ongoing workforce development is imperative when we take a look at the current substance abuse treatment workforce. As the authors of a 2012 report prepared for the California Office of Statewide Health Planning and Development's Workforce Investment Board (OSHPD/WIB) concluded, the state's SUD treatment workforce remains "undefined, lacks clear parameters, and cuts across multiple licensed, certified and unclassified professions" that have not been systematically tracked or analyzed (Buck, 2012). ADP estimates that less than 35,000 persons are registered or certified as alcoholism and drug abuse counselors (Daley, 2011). Of these counselors, the mean annual income is \$37,400, with a range from \$23,784 to \$51,512 (Bureau of Labor Statistics, 2012). These numbers are low compared to other states such as Michigan, Alaska, New Jersey, Connecticut, and Wisconsin, all of which seem to prioritize SUD counselors and their work. These results warrant more research on the workforce in order to determine what particularly needs reform.

A PSATTC workforce survey conducted in 2011–2012 with clinical supervisors in California and Arizona provided descriptive information about two segments of the substance abuse treatment workforce: (1) line staff, the clinicians who interact directly with substance abuse treatment patients, and (2) clinical supervisors, the individuals supervising and ensuring the clinical integrity of the treatment services that are being provided. Clinical supervisors served as the respondents to this survey to offer a better understanding of the characteristics and workforce needs of these two critical functions in the delivery of substance abuse treatment. Based on the study, referring to the clinical supervisors only, the average age is 52 years, 80% are White/Non-Hispanic, 63% are female, 36% were in recovery, 90% work full time, 61% are licensed or certified in the field of SUD counseling, 41% have earned a master's degree, and the average number of years spent in SUD treatment is 15. The same survey also asked clinical supervisors to provide estimates for their direct care staff. Based on their estimations, 77% are White/Non-Hispanic, 67% are female, 73% work full time, 39% were in recovery, 54% were currently certified/licensed, 53% were mid-career (age range: 35–55 years), 39% had less than a bachelor's degree, and 22% had obtained a master's degree.

The current competencies for specialty care generally fall into three categories: understanding addiction, treatment knowledge, and application to practice. To understand addiction, professionals must be able to understand and recognize models and theories of addiction/SUD; the social, cultural, economic and political contexts of addiction; the behavioral, psychological, physical health, and social effects of substances on the person using and significant others; and the potential of SUDs to mimic or co-occur with other medical and mental health conditions. Indeed, 37% of people who are dependent upon or abuse alcohol and 53% of people who are dependent upon or abuse street drugs also have at least one serious mental illness (NAMI, 2010).

To be knowledgeable about treatment, professionals must be familiar with EBPs for treatment; recovery, relapse prevention, and continuing care for addiction/SUD; the importance of family and community in the treatment and recovery process; the importance of research and outcome data and their application in clinical practice; and the value of an interdisciplinary approach to addiction treatment. When applying these skills and insights to practice, professionals must be able to use established criteria to diagnose SUD and place it within the continuum of care; tailor helping strategies and treatment modalities to a patient's stage of dependence, change, or recovery; provide culturally and linguistically appropriate services; adapt practice to treatment settings and modalities; and be familiar with pharmacological treatments for SUD (Center for Substance Abuse Treatment, 2008).

To prepare for expected changes in the health care workforce due to health care reform, SAMHSA convened a meeting of representatives from higher education, the National Association of State Alcohol/Drug Abuse Directors (NASADAD), the State Association of Addiction Services (SAAS), the International Certification and Reciprocity Consortium (IC&RC), the National Association of Alcoholism and Drug Abuse Counselors (NADAAC), and the Addiction Technology Transfer Center (ATTC) network. The purpose of this meeting was to develop a "Model Scope of Practice and Career Ladder" for substance abuse treatment workers (SAMHSA, 2011) that states, jurisdictions, and credentialing bodies could adopt and/or adapt as a means of developing defined career paths, credentialing criteria, and educational opportunities for professionals entering or seeking to advance their current standing in the substance use disorder treatment field as it becomes more integrated into primary care as a result of health care reform.

Based on the SAMHSA-based Center for Substance Abuse Treatment's (CSAT's) Technical Assistance Publication 21 (TAP 21), entitled *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, the Model Scope of Practice and Career Ladder defines the following activities as falling within the scope of substance abuse disorder counseling:

- Clinical Evaluation;
- Treatment Planning;
- Referral;
- Service Coordination;
- Counseling;
- Patient, Family, and Community Education;
- Documentation;
- Professional and Ethical Responsibilities.

There are multiple organizations in California that certify counselors, and different organizations have varying educational requirements and competency standards. However, based on the Career Ladder defined by SAMHSA in September of 2011, all of these counselors fall into four categories of professional development: (1) Substance Use Disorder Technician (entry level) or Associate Substance Use Disorder Counselor; (2) Substance Use Disorder Counselor; (3) Clinical Substance Use Disorder Counselor; (4) Independent Clinical Substance Use Disorder Counselor/Supervisor. Within each category, roles and activities are defined.

Regardless of ACA implementation, the SUD workforce requires significant reform to provide quality care to prospective patients. The employment of EBPs (e.g., MAT, MI, SBI, brief treatments), the use of data to modify treatment, and a seamless integration with MH services will all be critical in these efforts. It is also essential that the SUD workforce become knowledgeable about the prescription drug abuse epidemic, harm reduction approaches, and chronic pain treatment. Addiction is a chronic disease and must be viewed as such to ensure efficient treatment, recovery, and sustained stability.

There are myriad implications that the ACA has on SUD treatment. Perhaps the most important condition is that all plans must include substance use disorder treatment. The SUD treatment field will be held to the same standards and requirements as the primary health field. Therefore, the SUD treatment profession needs to be ready to document and codify its services and service delivery systems. This can be accomplished through increased recognition of issues related to non-communicable diseases (including co-occurring MH/SA disorders), increased use of disease management for chronic health disorders, and development of EBPs for SUD to be implemented in primary care.

In primary care settings, people delivering behavioral health services (including SUD) will need a very diverse set of knowledge and skills (Dilonardo, 2011). Thus, SUD staff members need to prepare to have work driven by data, to work in integrated environments, to build team skills, and to have a solid understanding of SUD, MH disorders, common health conditions, and different environmental cultures. Furthermore, they need to establish several competencies, including:

- Understanding and application of EBPs
- Addressing all behavior change issues,
- Acquiring a harm reduction mentality,
- Developing interpersonal skills (e.g., communication, conflict resolution, teamwork)
- Developing quality improvement skills (e.g., use of data to drive change and technology competence).

Training and continuing education is needed to overcome barriers to the adoption of evidence-based practices for the treatment of substance use conditions and for all staff to work in an integrated environment. The following list includes the knowledge, practices/skills, and competencies needed within the field:

Universal Screening (Screening, Brief Intervention, and Referral to Treatment [SBIRT])

Screening, brief intervention, and referral to treatment (SBIRT) is effective in a variety of settings. Its effectiveness has been proven particularly in hospital emergency departments and

trauma centers treating individuals with alcohol-related injuries. SBIRT has also been shown to be effective in primary care settings, where it is incorporated into other routine medical assessments such as measuring blood pressure. Core clinical components include: (1) brief intervention to raise awareness of risk and motivate change; (2) brief treatment for patients seeking help; and (3) referral to treatment for patients with more serious problems related to substance use.

Behavioral Therapies

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

Cognitive behavioral therapy (CBT) is a type of psychotherapeutic treatment that helps patients understand the thoughts and feelings that influence their behaviors. CBT is commonly used to treat a wide range of disorders, including phobias, addiction, depression, and anxiety. Cognitive behavioral therapy is generally short-term and focused on helping patients deal with a very specific problem. During the course of treatment, people learn how to identify and change destructive or disturbing thought patterns that have negative influences on behavior.

Contingency management (CM; also known as “motivational incentives”) is a behavioral strategy that has been shown to be very effective in promoting behavior change. CM is the application of positive reinforcement principles to reduce behaviors associated with drug use and increase behaviors associated with abstinence/recovery. In SUD treatment, CM has been shown to be extremely effective at increasing treatment retention and reducing stimulant use.

Medication-Assisted Therapies (MAT)

The U.S. Food and Drug Administration has approved six medications indicated to treat substance use disorders. Oral naltrexone, disulfiram (Antabuse), and methadone also have long been available for the treatment of alcohol and opioid addictions. Over the past decade, the FDA approved three additional medications: buprenorphine to treat opioid addictions in 2002, acamprosate to treat alcohol addiction in 2004, and extended-release naltrexone (Vivitrol) to treat opioid addictions in 2006 and alcohol addiction in 2010. Two of the newer medications—buprenorphine and Vivitrol—are referred to as “office-based” medications because they can be prescribed and administered in a physician’s office rather than in a specialty treatment or opiate treatment program. While the testing pipeline contains promising pharmacological therapies to treat methamphetamine or cocaine addictions, no medications are currently available.

Despite their proven effectiveness, national data shows discouragingly low MAT usage rates in community treatment settings. Many reasons contribute to low rates of adoption, including lack of staff understanding of the medications, organizational philosophy/staff beliefs about the use of medications, cost of medications, and lack of appropriate staffing. Offering a full range of effective treatment options, including medications, to patients maximizes consumer choice and encourages improved outcomes. Educating the field on MAT will be very important.

ACA implementation will also result in new roles in integrated care. There are three types of roles being developed. The first is the Health Educator, whose responsibilities will include screening and behavioral intervention and collaborating with peers and community health workers. The second is the Behavioral Health Clinician, who will be responsible for working with all aspects of BH change (including MH/SU). The third and final new role is the Expanded Care Manager. In addition to the three roles described above, a proposed new role is the Primary Care Behaviorist (Feldman & Feldman, 2013). The PCB will be a primary care physician with advanced training and certification in diagnosis and treatment of mental and behavioral problems. The goal of executing this role is to integrate expertise in behavioral disorders in a single practitioner.

Several programs have already been working on integrating behavioral health services into their medical service provision:

- **Mountain Park Health Center (Arizona):** The Mountain Park Health Center in Arizona has a program that employs behavioral health consultants (BHC) who work with patient's behavioral health issues. Patients are referred by their physician or nurse practitioner to a consultant who then must: (1) Identify, triage, target treatment, and manage primary care patients with mental or behavioral health issues that complicate medical problems, and (2) Collaborate with the medical staff to promote their behavioral health skills. These two distinct functions focus on resolving problems within the primary care service context. BHC visits are brief (15 to 30 minutes), limited in number (1–4, with an average of between 2–3 visits), are provided in the primary care office, and are structured in a manner so that the patient views meeting with the behavioral health consultant as a routine primary care service. The BHC is trained in providing behavioral health interventions for medical diagnoses. A patient with hypertension may learn relaxation skills, diaphragmatic breathing, and problem-solving techniques. A patient with diabetes may learn self-management, goal identification and attainment, mood enhancement and stability, and stress reduction. A patient with asthma may learn trigger identification, trigger removal or management, daily monitoring techniques, and action planning. These examples are three of many medical conditions that BHCs are specialized in treating.
- **University of Massachusetts:** The University of Massachusetts has a certificate program in PC/BH that trains MH and SUD professionals to become behavioral health professionals in primary care. Hence, the program is designed to give social workers, psychologists, counselors, nurses, psychiatrists, or primary care physicians the rigorous introduction they need to succeed as primary care behavioral health clinicians (BHCs). There are two program options, both of which consist of 36 hours of didactic and interactive training and delivered in 6 full-day workshops (one Friday per month for six months). The first option prepares professionals to be generalist Behavioral Health Clinicians and Care Managers in primary care settings and the second prepares professionals to work in primary care SPMI.
- **University of Michigan:** The University of Michigan provides a web-based “Certificate in Integrated Behavioral Health and Primary Care,” designed for working professionals

interested in gaining skills that are critical for effective integration of behavioral health and primary care. Each course includes cutting-edge information that forms the foundation of effective practice. Participants learn through a range of interactive teaching methods including case studies, team sessions, and applied activities. Overall, the certification program teaches up-to-date, evidence-informed knowledge and skills that are critical to effective integrated behavioral health and primary care practice settings and health home service delivery models.

Over the next 10 years there will be an effort to develop policy, infrastructure, educational curriculum at schools, certification/licensing, and training centers. While there will be a need for SUD counselors in the specialty care system, there will be a far bigger need for behavioral health clinicians in the broader health care system.

From the Annapolis Coalition Integration Report (2012), these are the core competencies for providing integrated care:

- Interpersonal communication
- Collaboration and teamwork
- Screening and assessment
- Care planning and care coordination
- Intervention
- Cultural competence and adaptation
- Systems-oriented practice
- Practice-based learning and quality improvement, and
- Informatics.

The following are the core competencies for behavioral health clinicians (BHCs):

- Proficiency in the identification and treatment of diverse disorders;
- Ability to think in terms of population management, with a large clientele in highly efficient ways;
- Knowledge of evidence-based behavioral assessments and interventions relevant to medical conditions, e.g., disease management, treatment adherence, and lifestyle change;
- Ability to make quick and accurate clinical assessments;
- Care-management skills and knowledge of local resources for outside referrals;
- Skill in targeted, brief psychotherapy and groups;
- Knowledge of basic physiology, psychopharmacology, and medical terminology;
- Familiarity with the stepped care model (patients move along different levels of intervention depending on past responses);
- Ability to document services in a way that is useful both to the primary care provider and to management for quality-improvement services;
- Consultation liaison skills;
- Recognizes essential importance of harm reduction.

Behavioral health counselors must be able to function in the fast-paced primary care environment. To be effective, they should: be flexible enough to deal with noise, frequent interruptions, and constant changes in scheduling; be able to offer brief, targeted interventions

usually lasting less than 30 minutes; be comfortable with short-term counseling, often lasting less than 4–6 visits; function well in a team-approach, accepting the fact that they are not in charge of the patient’s care; be behaviorally, rather than personality, focused; be able to provide behavioral interventions addressing chronic substance, mental health, and medical diseases; be able to perform consultations and give provider feedback “on the fly”; be able to effectively communicate and interact with primary care providers; and perform a motivational interviewing approach to behavior change.

When comparing SUD counselors and BH clinicians, we can make several distinctions:

1. Focus: SUD counselors focus on longer courses of interventions in specialty settings, whereas BH clinicians focus on complex problems and integrating medical, MH, and SUD interventions.
2. Treatment time: SUD counselors have ongoing treatments that are delivered over months, whereas BH clinicians complete interventions in four sessions or fewer.
3. Service coordination: SUD counselors focus on recovery support, whereas BH clinicians provide coordination across multidisciplinary services.
4. Service delivery: SUD counselors plan/schedule service deliveries, whereas BH clinicians provide services on demand, or unscheduled.
5. Ethics: SUD counselors follow the SUD system (e.g., 42CFR, Part 2) in regard to billing and ethics, whereas BH clinicians develop a complex interrelationship across diverse policies and billing structures.

Workforce development will continue to be a hot topic as ACA implementation draws closer. In the meantime, short-term plans are required to prepare for 2014. So far, proposed ideas include:

- Identify the training needed to help SUD/MH staff become effective in primary care.
- Make distinctions between specialty care needs and MH/SUD generalist skills.
- Identify SUD personnel who want to learn new skills to work in primary care and provide them with training.
- Develop content areas to begin to build the California Behavioral Health workforce.

UCLA is currently developing content for all of the following training curriculum:

- Providing Behavioral Health Care in a Primary Care Setting: Culture, Needs and Interdisciplinary Collaboration;
- Screening Brief Intervention and Referral for Substance Use, Mental Health and Medical Diseases;
- Understanding Chronic Medical Diseases, Basic Physiology, Terminology and Treatment Strategies;
- Understanding Common Mental Health Disorders—Identification and Intervention;
- Medical Interventions for Substance Use, Physiology of Drugs of Abuse and Medication Assisted Treatment;
- Care Management of Patients in a Multi-Service Setting.

D. Other Workforce Groups (WIB, HWDC, OSHPD)

UCLA has stayed apprised of the efforts of several workforce groups in California; this includes attending meetings and participation in advisory boards.

The California Workforce Investment Board was established by Executive Order in response to the mandate of the federal Workforce Investment Act (WIA) of 1998 (Public Law 105-220). The board assists the governor in setting and guiding policy in the area of workforce development.

The [California Workforce Investment Board](#) (CWIB) is responsible for assisting the Governor in performing the duties and responsibilities required by the federal Workforce Investment Act of 1998. All members of the CWIB are appointed by the governor and represent the many facets of workforce development: business, labor, public education, higher education, economic development, youth activities, employment and training, as well as the Legislature. The Board meets on a regular basis and the public is encouraged to attend the meetings. Decisions are reached through a collaborative process. The CWIB [Strategic Plan](#) directs its work in providing guidance to the statewide workforce investment system.

The Health Workforce Development Council aims to help alleviate workforce shortages in California's health sector. The California WIB established the Health Workforce Development Council (HWDC) in August 2010. The HWDC will be a broad partnership consisting of industry representatives, education, economic development, elected officials, the public workforce system, philanthropic organizations, community-based organizations, health professional and advocacy organizations and organized labor. Its mission is to help expand California's health workforce in order to provide access to quality healthcare for all Californians. This includes the objective of expanding California's full-time primary care workforce by 10% to 25% over 10 years.

The HWDC is tasked with understanding the current and future health workforce needs of California and with developing a comprehensive strategy to meet those needs. Health workforce development issues will be addressed by the HWDC through strategic actions at the state, regional, and local levels by understanding, assessing, and acting on the training and education, skill development, and capacity and expansion needs of the Health Sector. The HWDC functions as a special committee of the CWIB and staff support for the HWDC will be provided by the CWIB and the [Office of Statewide Health Planning and Development \(OSHPD\)](#). HWDC meetings will be open to the public along with agendas, presentations, and other materials presented.

E. Investigative Work (Financing/Billing - Medicaid Codes)

Historically, the funding for SUD services in California has primarily come from federal block grants, with Medi-Cal (a specialty benefit referred to as "Drug Medi-Cal), CalWorks, and county funds serving as other sources of funding. Plans for the implementation of the Affordable Care Act include an expectation that Medi-Cal will play a much larger role in the funding of SUD care in California and that use of block grant funds will need to be restructured to fund nonmedical services ineligible for Medi-Cal reimbursement. This paradigm shift raises many issues that need

consideration: What will the basic federal benefit for SUD services under Medicaid be? Will “Drug Medi-Cal” continue to exist as a specialty program? How will plans for managed care interface with these benefits? Will California consider a rehab option for its SUD benefit? How will the funding of non-medical services using block grant funds be done and how will the interface between block grant and Medi-Cal funds be structured and monitored? Many of these questions remain unanswered at this time.

UCLA began to investigate how other states fund integrated healthcare. While Medicare billing processes and procedures are consistent nationwide, Medicaid benefits, coding, and payment requirements vary across states, territories, and the District of Columbia. To effectively bill for Medicaid reimbursable services, organizations must submit a claim form that contains specific CPT (Current Procedural Terminology) codes that link to relevant billable diagnostic codes and are provided by appropriately licensed professionals. CPT and diagnostic codes are consistent across the country; however, state Medicaid programs determine the types of services, codes, and individuals credentialed to provide services, resulting in unique billing rules and regulations in each state.

CIHS has developed customized [Interim Billing and Financial Worksheets for each state](#) that identify existing billing opportunities for services provided in integrated settings. UCLA compiled all of the state data into one spreadsheet (Appendix 3A; updated October 2012). The services provided as part of bidirectional integration are often more easily billable in partnerships between Federally Qualified Health Centers (FQHCs) and community behavioral health organizations. These Billing and Financial Worksheets identify the core set of CPT codes used to bill for specific bidirectional health and wellness services provided by FQHCs and/or community behavioral health organizations. The Worksheets link CPT codes with the state-specific diagnostic codes and associated professional credentials needed to submit a successful, payable claim.

See Figure 1 below for the CPT codes in California as well as the setting in which they are valid and who may bill for them.

FQHC			FQHC		
HBAI	Codes	Credential	SUD	Codes	Credential
Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	Y	01. 90805, 90807, 90809, 90811, 90813, 90815 MD, PA, NP only. Exclude 90857	MD, PA, NP, Clinical Psychologist, Clinical Social Worker
CMHC			CMHC		
HBAI	Codes	Credential	SUD	Codes	Credential
N			Y	90804 - 90815. 90805, 90807, 90809, 90811, 90813, 90815 Psychiatrist only. 90853.	Psychiatrist, Psychologist

V. Chapter Summary and Recommendations

As SUD and MH integration efforts roll out in California, it is clear that the workforce will require a broad and diverse set of skills, which very few individuals in the current SUD or MH workforces possess. Primary care settings are very busy environments that value personnel who have a wide range of flexible skills to address multiple problems (Linzer, 2005, 2009). Primary care settings are not conducive to personnel who “only do one thing.” In fact, according to experts in behavioral health integration, one of the most common contributors to failed behavioral health integration efforts is the employment of individuals who do not have a broad range of MH and SUD skills (Todd, 2002). They emphatically contend that moving the “specialty silos” of SUD services and MH services into primary care settings is a sure formula for poor acceptance of these services by primary care staff and suboptimal care for patients and their families (Grella, 2003, 2004). For the future success of integrating SUD and MH services into primary care, the traditional segregation of these services using personnel with a single set of specialty skills (i.e., SUD or MH) will impair integration efforts (Mangrum, 2008).

Due to unaligned payment systems, it is essential for the state to take leadership in sorting through the complexities of health care financing as tied to reimbursements and policy. By working with external agencies such as CMS (Centers for Medicare & Medicaid Services), 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 health care 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. The expansion of Medicaid coverage and funding for FQHCs through health care reform—the American Recovery and Reinvestment Act (ARRA) of 2009 and the Patient Protection and Affordable Care Act (PPACA) of 2010—are expected to result in: (1) construction of new FQHCs, (2) expanded behavioral health services (Hoadly, 2004; LoSassa, 2010; Wells et al, 2010), (3) increased use of electronic health records that may facilitate service integration (CIMH IPI Report), and (4) a dramatic increase in the number of newly insured Medicaid patients who receive services from FQHCs (Ku et al., 2009).

At the present time, it is unclear what the best course of action is for California to develop a framework for a future workforce. In order to create such a framework, it is recommended that:

- A concerted **workforce planning effort** be initiated in which key stakeholders and workforce experts work in concert with the Department of Labor Workforce Investment Board (WIB).
- A series of meetings should be convened to provide a forum for a review of the critical issues that will **determine the SUD workforce needs** as well as discussions and plan development.

- A transition plan should be created to establish a counselor **certification infrastructure** in which there is a single counselor certification/license administered by the State of California.
- The SAMHSA career ladder for SUD counseling should be implemented in California.
- The state should expand existing training and technical assistance services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment. These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into Integrated Behavioral Health (IBH) providers in medical settings.

Future Plans

The September 2013 SARC research-to-policy meeting focused on the theme “*Challenges and Opportunities for the Substance Use Disorder Treatment Workforce – 2013 and Beyond.*” A daylong meeting agenda was assembled that highlighted several major themes or topics related to the current SUD workforce, and the challenges and opportunities presented to this workforce with full implementation of the Affordable Care Act. All presentations delivered at SARC are grounded in science, and whenever possible, include a discussion of the policy implications of the latest empirical findings. We believe this meeting brought the field together to continue to form unified plans to address the needs of the SUD workforce.

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Chapter 4: Training and Technical Assistance Activities

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Over the past year, UCLA provided trainings and technical assistance to facilitate integration across the state. This included in-person trainings, webinars, technical assistance to counties, and technical assistance for the California Institute for Mental Health's Care Integration Collaborative. Training and technical assistance needs related to integration persist throughout the state.

This chapter addresses the ADP/UCLA contract Domain 2, entitled "Health Care Reform and the Integration of SUD Services with Mental Health and Primary Care," with the objective to provide training at the county level on strategies to prepare for health care reform.

Trainings and technical assistance were conducted throughout California from July 1, 2012, to June 30, 2013, on topics relevant to integration. Below are descriptions and objectives for each topic followed by a list of activities conducted. Event materials can be found on the website provided in Appendix 4A.

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

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

Integration Strategies

In March 2010, President Obama signed into law historic health care reform legislation that will extend insurance to currently uninsured and under-insured Americans. The Patient Protection

and Affordable Care Act (ACA) supports previous legislation requiring that SUD and mental illness benefits are on par with those for medical illnesses. The new policies outlined in the ACA are likely to dramatically change how SUD treatment is funded and the types of services that are reimbursable. The SUD treatment and recovery workforce will need to learn additional skills to navigate a much broader primary health, SUD, and mental health care system. This training examined key components of the ACA and how SUD treatment practitioners can alter their practices to be most responsive to patient needs. Questions and concerns practitioners may have regarding health care reform were addressed, and several specific models and strategies for providing integrated behavioral health and primary services were presented.

Working in the Health Care System

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

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

Screening, Brief Intervention and Referral to Treatment (SBIRT)

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

Medication-Assisted Treatment (MAT)

The purpose of this half-day training is to provide participants with a detailed overview of medications that have been shown to be effective as a component of the treatment of alcohol and opioid addiction. Topics will include: the context for medication-assisted treatment (positive and negative perceptions), the epidemiology of alcohol and opioid dependence, an overview of each

medication, its indication, to whom it is administered, and how it works, and treatment settings for medication-assisted treatment. Medications discussed will include: naltrexone, acamprosate, disulfiram, methadone, and buprenorphine. Time is provided for discussion and questions.

Motivational Interviewing (MI)

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

Prescription Drug Abuse Problem

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

Ethics and Confidentiality

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

Training List
July 1, 2012 – June 30, 2013

Name of Training	Location/Date of Training	Trainer(s)	Number of Participants	Back-up Documents
Integration Strategies				
CALDAR Summer Institute – Health Care Reform and SUD Services in California (Plenary)	Westwood, CA (Los Angeles, CA) August 13, 2012	Richard A. Rawson, Ph.D.	97	PPT slides
CALDAR Summer Institute – Integrating Alcohol and Drug Treatment with Primary Care: A Medical Home Model (Plenary)	Westwood, CA (Los Angeles, CA) August 13, 2012	Constance Weisner, Dr. P.H., L.C.S.W.	97	PPT slides
Integration of SUD services with Primary Care. California Alcohol and Drug Programs	Sacramento, CA September 26, 2012	Darren Urada, Ph.D.	75	PPT slides
Ninth Statewide Conference: Integrating Substance Use, Mental Health, and Primary Care Services – A Bridge to Health Reform	Universal City, CA (Los Angeles Co) November 7-8, 2012	Multiple	611	Agenda/program and PPT slides
Integrating Treatment for Co-Occurring Disorders	Hollister, CA (San Benito Co) December 13, 2012	Sherry Larkins, Ph.D.	34 (Conducted for a specific agency, not a county dept.)	Agenda and PPT slides
Medicaid Transformation – Behavioral Health	Sacramento, CA, February 5, 2013	Darren Urada, Ph.D.	60	PPT slides

Integrating Treatment for Co-Occurring Disorders	Concord, CA (Contra Costa Co) April 3, 2013	Joy Chudzynski, Psy.D.	137	Flyer, agenda, and PPT slides
Los Angeles County Annual Drug Court Conference – The Impact of Health Reform (Plenary)	Los Angeles, CA (Los Angeles Co) May 16, 2013	Wayne Sugita, M.P.A.	200	Agenda and PPT slides
California Addiction Training and Education Series (CATES): The Changing Behavioral Health Landscape – Integration, Innovation, and Financing Models for Success	Rialto, CA (San Bernardino Co) May 17, 2013	Patrick Gauthier, B.S.	58	Agenda/program and PPT slides
CATES Follow-up Webinar: Integrating Services with Primary Care	Webinar June 19, 2013	Patrick Gauthier, B.S.	3	PPT slides
CATES Follow-up Webinar: Marketing Strategies	Webinar June 26, 2013	Angela Halvorson, M.P.A.	4	PPT slides
Integration of Substance Use Disorder Treatment with Primary Care in Preparation for Health Care Reform	San Diego, CA June 17, 2013	Cheryl Teruya, Ph.D.	150	PPT slides

Working in the Health Care System				
Culture of Integrated Treatment Webinar	Webinar March 7, 2013	Thomas E. Freese, Ph.D.	32	PPT slides
Challenges for the SUD Workforce 2013 and Beyond	March 27, 2013	Richard Rawson, Ph.D.	75	PPT slides
Culture of Integrated Treatment Webinar	Webinar April 2, 2013	Thomas E. Freese, Ph.D.	9	PPT slides
Culture of Integrated Services Webinar	Webinar June 27, 2013	Thomas E. Freese, Ph.D.	44	PPT slides
Screening, Brief Intervention, and Referral to Treatment				
SBIRT and COD Training	Alhambra, CA (Los Angeles Co) July 17, 2012	Alina Bond, L.C.S.W.	19	Agenda and PPT slides
SBIRT/ASSIST Training	Alhambra, CA (Los Angeles Co) July 19, 2012	Joy Chudzynski, Psy.D.	38	Agenda and PPT slides
SBIRT Training	Santa Ana, CA (Orange Co) August 6, 2012	Alina Bond, L.C.S.W.	38	Agenda and PPT slides
SBIRT Training	Santa Ana, CA (Orange Co) August 8, 2012	Alina Bond, L.C.S.W.	61	Agenda and PPT slides
SBIRT Advanced Skills Training (AM Session)	Culver City, CA (Los Angeles Co) August 15, 2012	Sherry Larkins, Ph.D.	5	Flyer, agenda, and PPT slides
SBIRT Advanced Skills Training (PM Session)	Culver City, CA (Los Angeles Co) August 15, 2012	Sherry Larkins, Ph.D.	15	Flyer, agenda, and PPT slides
SBIRT Advanced Skills Training	Los Angeles, CA (Los Angeles Co) August 30, 2012	Sherry Larkins, Ph.D., and Alina Bond, L.C.S.W.	22	Flyer, agenda, and PPT slides

SBIRT Advanced Skills Training	Long Beach, CA (Los Angeles Co) September 6, 2012	Sherry Larkins, Ph.D., and Joy Chudzynski, Psy.D.	14	Flyer, agenda, and PPT slides
SBIRT Training	Sacramento, CA (Sacramento Co) December 7, 2012	Beth Rutkowski, M.P.H.	27 (Conducted for a specific agency, not a county dept.)	Flyer, agenda, and PPT slides
SBIRT Training (UNCOPE Plus)	Oakland, CA (Alameda Co) March 29, 2013	Thomas E. Freese, Ph.D.	25	Agenda and PPT slides
SBIRT Training	Alhambra, CA (Los Angeles Co) April 25, 2013	Joy Chudzynski, Psy.D.	33	Flyer, agenda, and PPT slides
SBIRT Training	San Luis Obispo, CA (SLO Co) April 26, 2013	Thomas E. Freese, Ph.D.	38	Flyer, agenda, and PPT slides
SBIRT Training	Santa Ana, CA (Orange Co) May 29, 2013	Alina Bond, L.C.S.W.	50	Agenda and PPT slides
SBIRT Training for Medical Providers Working with Adolescents (CRAFFT)	Oakland, CA (Alameda Co) May 29, 2013	Beth Rutkowski, M.P.H.	32 (Conducted for a specific agency, not a county dept.)	Agenda and PPT slides
SBIRT and MI Training	Granite Bay, CA (Placer Co) May 30, 2013	Thomas E. Freese, Ph.D., and Beth Rutkowski, M.P.H.	55	Flyer, agenda, and PPT slides
SBIRT and MI Training	Truckee, CA (Placer Co) May 31, 2013	Thomas E. Freese, Ph.D., and Beth Rutkowski, M.P.H.	35	Flyer, agenda, and PPT slides
SBIRT and MI Training	Grass Valley, CA (Nevada Co) June 1, 2013	Thomas E. Freese, Ph.D., and Beth Rutkowski, M.P.H.	29	Flyer, agenda, and PPT slides

Using Brief Interventions to Promote Behavioral Change in Primary Care Settings	Bakersfield, CA (Kern Co) June 25, 2013	Thomas E. Freese, Ph.D.	34	Flyer, agenda, and PPT slides
Screening Instruments	Webinar June 26, 2013	Darren Urada, Ph.D.	20	PPT slides
Medication-Assisted Treatment (MAT)				
Detoxification and Pain Management Training (Afternoon Session)	Bakersfield, CA (Kern Co) July 25, 2012	Suzette Glasner-Edwards, Ph.D., and Larissa Mooney, M.D.	95	Flyer, agenda, and PPT slides
Opioid Dependence and Chronic Pain Training (Evening MD Session)	Bakersfield, CA (Kern Co) July 25, 2012	Larissa Mooney, M.D., and Suzette Glasner-Edwards, Ph.D.	49	Flyer, agenda, and PPT slides
Ninth Annual Training and Educational Symposium (COMP) – two of four plenary presentations focused on MAT	Los Angeles, CA (Los Angeles Co) September 6, 2012	John McCarthy, M.D., and Mark Stanford, Ph.D.	90	Agenda and PPT slides
Alcoholism: Overview of Disease Progression, Pharmacology, and Treatment Approaches (Afternoon Session)	Bakersfield, CA (Kern Co) January 29, 2013	Thomas E. Freese, Ph.D., and Larissa Mooney, M.D.	179	Flyer, agenda, and PPT slides

Alcoholism: Overview of Disease Progression, Pharmacology, and Treatment Approaches (Evening MD Session)	Bakersfield, CA (Kern Co) January 29, 2013	Larissa Mooney, M.D., and Thomas E. Freese, Ph.D.	41	Flyer, agenda, and PPT slides
NIDA CTN Pacific Region Node Regional Dissemination Conference (3 of the 8 presentations focused on MAT)	Los Angeles, CA (Los Angeles Co) February 28, 2013	Walter Ling, M.D., Larissa Mooney, M.D., and Thomas E. Freese, Ph.D.	96	Flyer, agenda/program, and PPT slides
Los Angeles County Annual Drug Court Conference – Medication-Assisted Treatment Strategies (Plenary)	Los Angeles, CA (Los Angeles Co) May 16, 2013	Walter Ling, M.D.	200	Agenda and PPT slides
Foundations of Medication-Assisted Treatment for Substance Use Disorders (Opening Webinar)	Webinar May 20, 2013	Thomas E. Freese, Ph.D.	29	PPT slides
Foundations of Medication-Assisted Treatment for Substance Use Disorders (Closing Webinar)	Webinar June 10, 2013	Beth Rutkowski, M.P.H.	15	PPT slides
Motivational Interviewing				
Motivational Interviewing Academy	Los Angeles, CA (Los Angeles Co) July 11-12, 2012	Robert Rhodes, Ph.D.	39	Flyer, agenda, and PPT slides

Effecting Change through the Use of Motivational Interviewing	Santa Ana, CA (Orange Co) July 31, 2012	Alina Bond, L.C.S.W.	51	Agenda and PPT slides
Effecting Change through the Use of Motivational Interviewing	Santa Ana, CA (Orange Co) August 2, 2012	Alina Bond, L.C.S.W.	59	Agenda and PPT slides
Motivational Interviewing Basics Training	Sacramento, CA (Sacramento Co) August 8, 2012	Robert Rhodes, Ph.D.	7	Flyer, agenda, and PPT slides
Motivational Interviewing Academy	Encino, CA (Los Angeles Co) September 18-19, 2012	Robert Rhodes, Ph.D.	31	Flyer, agenda, and PPT slides
Effecting Change through the Use of Motivational Interviewing	Acton, CA (Los Angeles Co) January 24, 2013	Joy Chudzynski, Psy.D.	61	Agenda and PPT slides
Effecting Change through the Use of Motivational Interviewing	El Monte, CA (Los Angeles Co) February 7, 2013	Joy Chudzynski, Psy.D.	33 (Conducted for a specific agency, not a county dept.)	Agenda and PPT slides
Introduction to Motivational Interviewing (AM Session)	San Luis Obispo, CA (SLO Co) February 20, 2013	Thomas E. Freese, Ph.D.	71	Flyer, agenda, and PPT slides
Advanced Topics in Motivational Interviewing (PM Session)	San Luis Obispo, CA (SLO Co) February 20, 2013	Thomas E. Freese, Ph.D.	54	Flyer, agenda, and PPT slides
Effecting Change through the Use of Motivational Interviewing	El Monte, CA (Los Angeles Co) February 25, 2013	Joy Chudzynski, Psy.D.	19	Flyer, agenda, and PPT slides
Motivational Interviewing Academy	Los Angeles, CA (Los Angeles Co) March 27-28, 2013	Robert Rhodes, Ph.D.	35	Flyer, agenda, and PPT slides
Effecting Change through the Use of Motivational Interviewing	Gardena, CA (Los Angeles Co) April 29, 2013	Alina Bond, L.C.S.W.	9	Flyer, agenda, and PPT slides

Advanced Motivational Interviewing Training	El Monte, CA (Los Angeles Co) May 20, 2013	Joy Chudzynski, Psy.D.	25	Flyer, agenda, and PPT slides
Effecting Change through the Use of Motivational Interviewing	Santa Ana, CA (Orange Co) May 21, 2013	Alina Bond, L.C.S.W.	50	Agenda and PPT slides
Motivational Interviewing Academy	Los Angeles, CA (Los Angeles Co) May 22-23, 2013	Robert Rhodes, Ph.D.	23	Flyer, agenda, and PPT slides
Motivational Interviewing Academy	Los Angeles, CA (Los Angeles Co) June 5-6, 2013	Adrienne Belitsos, M.A., D.B.H.	29	Flyer, agenda, and PPT slides
Prescription Drug Abuse Problem				
Prescription Drug Abuse	Lakeport, CA (Lake Co) December 5, 2012	Beth Rutkowski, M.P.H.	82	Agenda and PPT slides
Prescription Drug Abuse	Rialto, CA (San Bernardino Co) May 23, 2013	Joy Chudzynski, Psy.D.	98	Agenda and PPT slides
Ethics and Confidentiality				
Ethical and Confidentiality Issues and Client Crises in Substance Abuse Treatment	Rialto, CA (San Bernardino Co) October 25, 2012	Sherry Larkins, Ph.D.	104	Flyer, agenda, and PPT slides
Ethical and Confidentiality Issues and Client Crises in Substance Abuse Treatment	Fresno, CA (Fresno Co) February 13, 2013	Joy Chudzynski, Psy.D.	202	Flyer, agenda, and PPT slides

****KEY**

Highlight Color	Funding Source
White	ETTA Contract
Yellow	UCLA ISAP's agreement with ADPI (for a separate TA contract funded by CA ADP)
Green	Separate county-based training contract
Blue	Separate funding from NIDA or SAMHSA-HRSA Center for Integrated Health Solutions

Technical Assistance

The level of preparation for health care reform varies dramatically across the counties. UCLA provides technical assistance to counties by request as resources and expertise allow. During the reporting period, 26 formal technical assistance requests were made to UCLA on topics related to integration and preparing for health care reform. Counties requested assistance on many topics including billing/financing integration, AOD certification process, preparing providers and contractors for health care reform, electronic health records, and models of collaboration. Technical assistance is provided via e-mail or telephone. In addition, UCLA organized a number of Integration Learning Collaborative calls that featured non-UCLA speakers (see Chapter 2 for further information). UCLA also worked with the California Institute for Mental Health (CiMH) to support their own collaborative by providing SUD-specific expertise.

CiMH Care Integration Collaborative

The CiMH Care Integration Collaborative (CIC) was organized to improve the health outcomes of individuals with complex needs through care coordination (CC) and related practices. The CIC was conducted over a 12-month period (February 2012 – January 2013) with support from DHCS. As part of our ETTA work, UCLA was an active participant in the CIC planning group and provided SUD-oriented technical assistance to CiMH over the course of the collaborative.

The participants in the CIC were five county teams with representatives from mental health, SUD, primary care, and local health plans. These teams participated in face-to-face and virtual collaborative meetings, regular web-conferences, and maintained contact with each other and with CIC faculty via e-mail and a secure website.

CiMH reported that integrating SUD services was perhaps the most challenging aspect of the CIC partnership approach. SUD organizations participated in each CIC partnership, but the dramatic gap between need and capacity of specialty SUD services impacted all providers' ability to better coordinate care and support for their patients with substance use disorders.

In the end, the teams made substantial progress in identifying individuals with SUD, obtaining consent to share information in compliance with 42 CFR part 2, deploying people with MH/SUD lived experience to support wellness and self-management, improving communication between providers, coordinating care for shared patients, and performing regular mediation reconciliations. For full details about the CIC and these results, see *The Care Integration Collaborative Final Report* (expected to be on the CiMH website later this summer).

The overall recommendations from this report are included below.

Key Recommendations for Care Coordination and Integration

Engaged and Effective Leadership

- Committed senior leader champions are essential to improvement—especially in complex change processes that involve multiple partners.

- Senior leaders must actively build and sustain accountability and the “will” for improvement within their organization and across partnering systems.
- Health plans are essential partners in designing and ultimately incentivizing CC processes that will result in better outcomes and lower costs.

Develop Clear and Accountable Roles for Individual CC Providers and Teams

- Mapping CC workflows and processes from the patient (and provider) perspective is useful to clarify resources, gaps, and roles of participating specialty MH/SUD and primary care organizations.
- CC across specialty and primary care organizations requires clear aim/purpose, goals and structure.
- Clearly define the role of care coordinator as well as related team roles and work processes.

Key Care Coordination and Care Integration Processes

- Provide support for development of effective provider communications, Shared Problem Lists/Care Plans and routine medication reconciliation as essential CC functions.
- Specialty SUD treatment providers must be integral partners in planning and creating new systems for care coordination.
- Actively educate and engage patients in CC and develop processes to obtain patients’ consent (ROI) to share clinical information among providers involved in their care.
- Adopt and use a clinical information sharing tool (preferably electronic) to effectively coordinate care among partnering organizations.

The Care Model (CCM) Provides a Useful Systems Framework for Care Coordination

- The “Care Model” (Ed Wagner, MD, McColl Institute) offers a framework for systems changes required to coordinate and integrate care for persons with SMI/SUD and co-occurring medical risk/conditions.

Measurement of Patient Outcomes and System’s Processes is very Challenging Across Multiple Provider Organizations Engaged in a CC Partnership

- Organizations need capacity to measure internal organizational improvement and to share integrated CC results across partnering organizations, providers and health plans.

In addition, details on the SUD-specific recommendations and conclusions included the following:

- *Substance Use Disorders Must Be Identified and Addressed By All Providers:* CIC promoted screening, referral and treatment of substance use disorders as essential in CC/integrated care for persons with complex conditions. However, not all teams included SUD providers and lack of access to specialty SUD treatment capacity was experienced as a significant barrier. CIC team strategies included co-locating or ensuring close proximity of SUD staff to other services, testing effective screening and referral processes and providing MH/PC access to SUD partners including regular and ad hoc consultation capacity. A training session was provided by UCLA on “Medication Assisted Treatment” (MAT) as an emerging evidence-based practice where PC or MH physicians prescribe medication to manage opiate or alcohol withdrawal while SUD providers provide ongoing

treatment and relapse prevention support. It was noted that very few physicians are trained or offer MAT.

- In California, the gap between need and availability of publicly funded SUD specialty care slots for intensive outpatient or residential treatment is well-documented; however, parity requirements and access to an SUD insurance benefit under the ACA may foster expanded capacity within the next few years. Future CC initiatives should increase their focus on involving SUD providers, promoting best practices in SUD treatment and relapse prevention. PC and MH organizations should be encouraged to train their behavioral health providers to routinely offer SUD screening and brief treatment when specialty SUD treatment is not required. Specialized training programs are becoming available for PC based SUD services—including some that are offered online.
- *Specialty SUD treatment providers must be integral partners in planning and creating new systems for care coordination.* Given the current lack of adequate public sector funding and capacity to provide needed specialty SUD treatment, CC programs and partnerships must continue to emphasize SUD as the responsibility of all providers. Efforts should include improving SUD screening, brief interventions, treatment, and recovery support capacity. Where access to specialty care is available, improving referral processes to include warm handoffs is also important.

In addition to the conclusions and recommendations listed above, the CIC demonstrated the feasibility of the learning collaborative model itself. As a result, CiMH plans to launch a new Care Coordination Learning Collaborative in the fall of 2013. UCLA has been invited to participate in this collaborative and will continue to provide SUD-related technical assistance.

Chapter 5: Report Conclusions and Recommendations

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

Domain 1. Data Analysis: Understanding the Changing Field of SUD Services

Data analyses were conducted to address the following objectives:

1. Examine how ongoing policy changes are affecting who receives SUD treatment and how access, services, costs, and quality of care are being affected. Make recommendations to improve policies, practices, and data quality.
2. Refine program performance and patient outcome measures.

Overall, increased coverage of SUD services in and of itself did not appear to lead to increased coordination between health care and specialty care services. By extension, it may be assumed that the 2014 Medi-Cal expansion and enhanced SUD benefit may not, on their own, result in better coordination. Instead, partnerships will have to be actively pursued. Currently, a relatively small number of programs are regularly receiving referrals from health care sources due to concerted efforts by these programs to develop relationships with local health care providers.

Patients referred from health care to specialty SUD treatment tended to be White, male, and entering detoxification for alcohol use. This may change as more individuals gain coverage through private insurance or Medi-Cal in 2014. Further research is needed to determine why female and Hispanic patients are underrepresented.

A review of SBIRT implementation in a six-state SAMHSA-sponsored study revealed data that could indicate a major impact to California's current SUD specialty treatment system if SBIRT is successfully implemented in California. In this event the current specialty system may need to undergo a substantial expansion. There are, however, a number of California-specific barriers that will need to be addressed in order to facilitate a successful SBIRT implementation.

Data on AB 109 clients is sparse and currently of questionable accuracy, but suggest that the number of AB 109 clients entering treatment may be rising rapidly. Very low enrollment of AB 109 clients in Medi-Cal is of particular concern. Benefits should be suspended during incarceration rather than terminated, and Medi-Cal outreach and enrollment efforts targeted at soon-to-be released inmates are needed.

Data Indicator Reports for outpatient and methadone maintenance performance measurement have been deployed, and development of measures for residential treatment and detoxification are next. Initial provider feedback has reportedly been positive.

Drug Medi-Cal data and CalOMS-Tx data can potentially be productively used to measure performance, identify SUD "hot spots", analyze costs, and detect fraud, which may be useful to policymakers.

Recommendations:

1. Monitor information from the Uniform Data System to determine the number of patients treated for SUD in California health centers to get a better picture of treatment as integration occurs. Primary care providers do not report to CalOMS-Tx. UCLA has requested this information from the Health Resources and Services Administration (HRSA).
2. Continue efforts to train and provide technical assistance to improve data entry processes and data quality.
3. Consider alternative methods of obtaining more accurate AB109 data.
4. Suspend rather than terminate Medi-Cal benefits from criminal justice patients during periods of incarceration where possible.
5. Encourage the development of partnerships between SUD and primary care providers. Currently, only a relatively small number of programs are regularly receiving referrals from health care sources.
6. Revisit restrictions on same-day billing and eligible workforce in order to facilitate the implementation of SBIRT.
7. Continue to develop and deploy performance dashboards.
8. Revisit current State of California policies mandating two unsuccessful opioid detoxification attempts for maintenance treatment eligibility.
9. Use Drug Medi-Cal and CalOMS-Tx data together to improve performance, outcome measurement, and fraud detection.

Domain 2. Health Care Reform and the Integration of SUD Services with Mental Health and Primary Care

UCLA had the following objectives in this domain:

- Collect and disseminate cutting edge information on the integration of SUD services with mental health and primary care services
- Coordinate and facilitate an interactive forum (i.e., Learning Collaborative) with counties and other key stakeholders to discuss SUD integration barriers and practical models
- Conduct case study/pilot evaluations

Key developments in the field

A refined iteration of the “Standard Framework for Levels of Integrated Healthcare,” was released by SAMHSA-HRSA Center for Integrated Health Solutions (CIHS, 2013). The new

framework encompasses six levels of integration under a continuum ranging from coordinated care to integrated care.

Commonly used evidence based practices used to facilitate integrated services include SBIRT, motivational interviewing, and medication assisted therapies. However each contains barriers to successful implementation such as workforce development requirements, billing and reimbursement challenges, as well as policy obstacles.

New organizational models are emerging to transform care to be better integrated, more comprehensive, and more responsive to the needs of patients. Examples include health homes, patient-centered medical homes, and accountable care organizations. Because of their emphasis on integrating services, they provide a potential opportunity for behavioral health.

New technologies and the mass deployment of existing technologies (e.g: Telehealth and Health Information Technology and Electronic Health Records) expands the ability of providers to not only share information with each other across disciplines, but also to monitor and track patients and communicate important developments with patients regarding their health . However, implementation is costly and is imbedded with barriers around confidentiality and data/information sharing regulations.

The California Integration Learning Collaborative continues to function as a useful mechanism to share information and discuss successes and challenges across county administrators and executive level providers/administrators. It serves as a monthly mechanism for the state to provide technical assistance and training opportunities at the county level though the facilitation at UCLA.

New data

Within California, the UCLA Integration Survey revealed that while a few counties have not yet begun the process of integrating AOD services with mental health and primary care, many others have reported progress. Despite many barriers remaining intact between 2010 and 2012, integration initiatives have expanded among California counties.

Through case studies and pilot projects, UCLA has been able to identify several lessons learned from the many integration activities occurring across the state.

- Educating and training staff (at all levels) is critical to 1) clarify roles and responsibilities across the various collaborating disciplines, 2) to obtain buy-in at the provider and administrative staff level, 3) to foster a shared vision, 4) improve utilization of evidence-based practices, and 5) instill value among the workforce.
- Identifying a strong leadership team guided by a shared vision that meets regularly helps to create successful implementation.
- Creating an open forum for staff feedback to the leadership level was crucial to maintain buy-in, instill accountability, and allow for staff to be a part of the process.

- Establishing “champion physicians” and incorporating them into the leadership team was a successful mechanism to implement new services and practices.
- Selecting the “right staff” to conduct integrated behavioral health in primary care settings is critical. These staff must be flexible, proactive, able to handle ambiguity, and able to form strong relationships.
- Stakeholders must be willing to modify initial plans as need.
- Communication is key and continuing staff education is important.
- Patience, tolerance, and openness were required from both the physical health and behavioral health providers in order to merge the two cultures.
- It is important to acknowledge that change is difficult.
- There are many challenges surrounding the implementation of a new EHR system, such as problems with glitches and data transfers. The data tracking system must be kept simple at the outset.
- Follow latest SAMHSA developments to assure 42 CFR compliance when sharing data; review consent and admission form accordingly.
- Patients/consumers are benefiting from the integration of services. Anecdotally, patients feel understood and supported with in-person warm handoffs. This builds trust, which allows patients to feel they are in good hands.
- Integrating services requires funding and/or an identified staff to navigate through the complex billing mechanisms.

Surveys of selected FQHCs in California revealed that:

- SUD services are generally not as well integrated with primary care as MH services are, are rated as less effective, and are separated from primary care services physically and temporally.
- The difference in effectiveness appears to be due to provider training, not in attitudes toward SUD patients.
- SUD services were more integrated with MH services than with primary care services.
- There is great interest in SUD training, and work to be done on integration of SUD into electronic health records

A survey of SUD/BH administrators who participated in LIHP or CMSP programs revealed that:

- Some have accessed the covered services and receive reimbursement, but it comes with a high administrative cost that many counties are not able to afford.
- The CMSP process of claims processing and payment needs to be simplified and streamlined if SUD benefits are to be better used when they become more widely available in 2014.
- The infrastructure for billing Medi-Cal and Drug Medi-Cal and payments may need to be developed and providers may need training and technical assistance (e.g., Medicaid requirements) as their experience in these areas appear to be limited.

Recommendations

10. Expand SUD workforce who can bill Medi-Cal to enable FQHCs to recruit needed staff. In particular, FQHCs want to add marriage and family therapists to the list of staff that are eligible to bill Medi-Cal. Currently licensed clinical social workers and psychologists are the only behavioral health providers that can do so.
11. Allow same-day billing of two services. This is consistent with best practices regarding “warm handoffs” between primary care and behavioral health. If a patient must make an appointment to return another day to receive these services, they will often become “no shows” and an opportunity to address their problems will be lost. Nationally, 28 states currently allow same-day billing, but California does not.
12. Include medicine that has been shown to be effective in treating opioid addiction (e.g., Suboxone, Vivitrol) in the formulary. Although providers may submit a treatment authorization request for Suboxone, providers and support staff sometimes find the process to be time consuming, labor intensive, and frustrating, which can negatively impact providers’ willingness or ability to provide medications that are effective in treating opioid addiction.
13. Develop the workforce to effectively provide care to individuals who present with SUDs in primary care settings. SUD and recovery should be covered in the curriculum for medical and nursing students, social workers, psychologists, and other direct-care providers so they are comfortable and effective in addressing SUD.
14. Increase capacity in the community for specialized SUD and support services, especially residential treatment and detoxification. Patients who are referred from primary care to specialty SUD services in the community find it extremely difficult to access needed services due to lack of availability.
15. Continue to educate providers and their workforce on the importance and effectiveness of coordinated care and the value of behavioral health for the overall improvement of quality of patient care and outcomes.
16. Continue to advocate for the inclusion of behavioral health organizations in meaningful-use subsidy programs.
17. Continue efforts to foster partnerships between SUD and primary care providers.
18. Continue efforts to support pilot projects at the county and provider level as a mechanism to test and evaluate successful implementation strategies.

Strategic Planning for Workforce Development: Preparing the AOD Workforce for 2014 and Beyond

During fiscal year 2012–2013, UCLA continued to address the objective to develop strategic planning principles to guide the future development of an integrated drug treatment delivery

system in California under health care reform. As SUD integration under health care reform is still evolving, the workforce necessary to implement SUD services outside of the specialty system remains unclear.

As integration efforts roll out in California, it is clear that the workforce will require a broad and diverse set of skills, which very few individuals in the current SUD or MH workforces possess. Primary care settings are very busy environments that value personnel who have a wide range of flexible skills to address multiple problems (Linzer, 2005, 2009). Primary care settings are not conducive to personnel who “only do one thing.” In fact, according to experts in behavioral health integration, one of the most common contributors to failed behavioral health integration efforts is the employment of individuals who do not have a broad range of MH and SUD skills (Todd, 2002). They emphatically contend that moving the “specialty silos” of SUD services and MH services into primary care settings is a sure formula for poor acceptance of these services by primary care staff and suboptimal care for patients and their families (Grella, 2003, 2004). For the future success of integrating SUD and MH services into primary care, the traditional segregation of these services using personnel with a single set of specialty skills (i.e., SUD or MH) will impair integration efforts (Mangrum, 2008).

Due to unaligned payment systems, it is essential for the state to take leadership in sorting through the complexities of health care financing as tied to reimbursements and policy. By working with external agencies such as CMS (Centers for Medicare & Medicaid Services), 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 health care 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. The expansion of Medicaid coverage and funding for FQHCs through health care reform—the American Recovery and Reinvestment Act (ARRA) of 2009 and the Patient Protection and Affordable Care Act (PPACA) of 2010—are expected to result in: (1) construction of new FQHCs, (2) expanded behavioral health services, (3) increased use of electronic health records that may facilitate service integration (CIMH IPI Report), and (4) a dramatic increase in the number of newly insured Medicaid patients who receive services from FQHCs.

Given that it is not clear what the best course of action is for California to develop a framework for a framework for a future workforce, we have listed the following recommendations in order to create such a framework.

Recommendations

19. A concerted **workforce planning effort** be initiated in which key stakeholders and workforce experts work in concert with the Department of Labor Workforce Investment Board (WIB).

20. A series of meetings should be convened to provide a forum for a review of the critical issues that will **determine the SUD workforce needs** as well as discussions and plan development.
21. A transition plan should be created to establish a counselor **certification infrastructure** in which there is a single counselor certification/license administered by the State of California.
22. The SAMHSA career ladder for SUD counseling should be implemented in California.
23. The state should expand existing training and technical assistance services to ensure that the SUD workforce develops capacity in areas that are critical to providing comprehensive and evidence-based SUD treatment. These activities should be designed to prepare two distinct workforces—one that will continue to work as SUD providers in specialty treatment settings and another that will evolve into Integrated Behavioral Health (IBH) providers in medical settings.

Future Plans

The September 2013 SARC research-to-policy meeting focused on the theme “*Challenges and Opportunities for the Substance Use Disorder Treatment Workforce – 2013 and Beyond.*” A daylong meeting agenda was assembled that highlighted several major themes or topics related to the current SUD workforce, and the challenges and opportunities presented to this workforce with full implementation of the Affordable Care Act. All presentations delivered at SARC are grounded in science, and whenever possible, include a discussion of the policy implications of the latest empirical findings. We believe this meeting brought the field together to continue to form unified plans to address the needs of the SUD workforce.

Final Report Conclusions

The lessons learned throughout this report support a common conclusion:

On their own, the much-anticipated enhanced SUD benefits and expanded insured population in 2014 will not ensure adequate SUD treatment capacity or integration.

If a number of barriers are not overcome, the benefit will not be used to its potential. Both the CMSP/Path2Health and LIHP experiences suggested that many treatment programs currently lack the infrastructure and staff training needed to bill Medi-Cal and insurance. Furthermore, the CMSP/Path2Health experience demonstrated that if the claims process is perceived as too complicated or unreliable, benefits may go unused.

Particularly in smaller counties like those served by CMSP/Path2Health, the costs of maintaining a billing infrastructure may outweigh the payments that can be obtained by serving a relatively small number of individuals. One solution discussed in UCLA's current CATES training series is provider formation of networks to share the costs of billing infrastructure, as well as potentially other expenses such as electronic health records, marketing, and other administrative expenses. In primary care, such organizations, known as Management Services Organizations (MSOs) or Independent Practice Associations (IPAs), are common.

Integration also holds the promise of making SUD treatment accessible to more patients through primary care. However, programs need to actively pursue partnerships with primary care. As described in Chapter 1, a very small number of treatment programs currently receive an outsized proportion of referrals from health care providers. These programs and their primary care partners are demonstrating that such partnerships can be successful, but the number of programs that have taken this step has so far been limited.

Beyond referral arrangements, SUD services can also be fully integrated *into* primary care. A number of integration initiatives have emerged around the state to attempt this (see Chapter 2). From these diverse initiatives, a few closely related and recurring lessons have emerged, including the need to educate staff on the importance of integration and to clarify roles, the importance of having a "champion" physician to promote integration, and the need to obtain buy-in among the participants.

Even if education, a champion, and buy-in are present at the ground level, however, there are impediments to integration at the policy level. These barriers include Medi-Cal restrictions on same-day billing for two services (Chapter 2), the lack of an adequately trained workforce whose services can be reimbursed in primary care settings (Chapters 2 and 3). Without addressing these problems, actions such as activating SBIRT billing codes may not have the desired effect.

To overcome these barriers, training and technical assistance will continue to play an important role in facilitating the field's progress. To measure this progress and improve practices and policymaking, the collection and use of valid and reliable data will be critical.

In conclusion, California is continuing to make progress toward integration, but further preparations are still needed to prepare the state for 2014 and beyond.

Appendices

Appendix 2A: ETTA Webinars and Conferences
ETTA Webinars
(FY 2012-2013)

July 2012

(1) Comparative Effectiveness Review of Screening, Behavioral Counseling, and Referral in Primary Care to Reduce Alcohol Misuse

July 31, 2012

AHRQ Effective Health Care Program

<http://ce.effectivehealthcare.ahrq.gov/continuing-education/CER40/Comparative-Effectiveness-Review-of-Screening,-Behavioral-Counseling,-and-Referral-in-Primary-Care-to-Reduce-Alcohol-Misuse>

August 2012

(2) Same Day Access and Open Meds: A Revolution in Behavioral Health

August 9, 2012

National Council for Community Behavioral Healthcare

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

(3) Motivational Interviewing Series: Engaging People in Discussions about Health-related Changes

August 15, 2012

11:00-12:30 pm Pacific

SAMHSA-HRSA Center for Integrated Health Solutions

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

(4) Integrating Behavioral Health in Community and Migrant Health Centers: Motivation, Readiness, & Cultural Challenges

August 23, 2012

SAMHSA-HRSA Center for Integrated Health Solutions

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

September 2012

(5) Enhancing Strategies to Promote Individual Change in Primary Healthcare Settings

September 5, 2012

SAMHSA-HRSA Center for Integrated Health Solutions

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

(6) The Power of Policy Webinar 5 - Health in All Policies: Lessons Learned from California

September 6, 2012

11:00 am - 12:00 pm Pacific

American Public Health Association Policy Capacity Building Assistance
<http://www.apha.org/programs/cba/webinars/>

(7) Meaningful Use Stage 2: The New Mandate for Behavioral Health
September 13, 2012
2:00-3:30 pm Eastern
National Council for Community Behavioral Healthcare
<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

(8) Doing Business Despite Disaster: HIT to the Rescue
September 25, 2012
National Council for Community Behavioral Healthcare
<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

October 2012

(9) How to do the Managed Care Dance – What You Need to Know to Participate in Networks
October 16, 2012
10:00-11:30 pm Pacific
SAMHSA-HRSA Center for Integrated Health Solutions
<http://www.integration.samhsa.gov/about-us/webinars>

(10) How Consumers Can Drive Better Personalized Outcomes: Learning From Successful Organizations
October 22, 2012
1:00-2:30 pm Pacific
National Council for Community Behavioral Healthcare
<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

(11) MAT: A Psychiatric and Primary Care Perspective
October 25, 2012
10:00-11:00 am Pacific
MAT Health Network Learning Collaborative
<https://www2.gotomeeting.com/register/982372162>

November 2012

(12) Integrated Care within the Patient Centered Medical Home: The Health Center Perspective
November 8, 2012
9:00-10:30 am Pacific
SAMHSA-HRSA Center for Integrated Health Solutions
<http://www.integration.samhsa.gov/about-us/webinars>

(13) Medicaid Expansion Basics

November 13, 2012
12:00-1:30 pm Pacific
Coalition for Whole Health
<http://www.coalitionforwholehealth.org/resources-for-local-advocates/webinarsupcoming-opportunities/>

(14) Medicaid Expansion Advocacy Strategies
November 27, 2012
12:00-1:30 pm Pacific
Coalition for Whole Health
<http://www.coalitionforwholehealth.org/resources-for-local-advocates/webinarsupcoming-opportunities/>

(15) HIT Strategic Planning and Implementation: Guided Tours, Part 1 of 3
November 27, 2012
11:00-12:30 pm Pacific
National Council for Community Behavioral Healthcare
<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

December 2012

(16) HIT Strategic Planning and Implementation: Guided Tours, Part 2 of 3
December 11, 2012
11:00 am - 12:30 pm Pacific
National Council for Community Behavioral Healthcare
<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

(17) Prescription Opioid Overdose and the Public Health Response
December 12, 2012
10:00-11:00 am Pacific American Medical Association
<http://eo2.commpartners.com/users/ama/session.php?id=9902>

January 2013

(18) WHAM: Eight Weeks to Whole Health through Peer Support Groups
January 15, 2013
National Council for Community Behavioral Healthcare
<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

(19) A (Health) Home Run: Operationalizing Behavioral Health Homes
January 18, 2013
National Council for Community Behavioral Healthcare
<http://www.thenationalcouncil.org/events-and-training/webinars/webinar-archive/>

(20) Engagement of Staff in the Use of MAT

January 31, 2013

MAT Health Network

<https://careacttarget.org/library/webinar-engagement-staff-use-mat>

February 2013

(21) HIT for Behavioral Health: What's in it for me?

February 6, 2013

Great Lakes ATTC

<http://archive.constantcontact.com/fs191/1110586445975/archive/1112143820554.html>

(22) Enrollment and Beyond: ACA Efforts and Implications in California

February 13, 2013

AcademyHealth

<http://www.academyhealth.org/Training/ResourceDetail.cfm?ItemNumber=10397>

(23) Substance Use Disorder, Primary Care and Emergency Room Services: Establishing Collaborative Partnerships through Chronic Disease

February 27, 2013

10:00-11:30 am Pacific

Los Angeles County Substance Abuse Prevention and Control and ADPI

<http://www.aodpolicy.org/HCR/HCR.htm>

(24) Enhancing Behavioral Health Care Using Health IT

February 27, 2013

11:00 am Pacific

Agency for Healthcare Research and Quality (AHRQ)

<http://healthit.ahrq.gov/events/national-web-conference-enhancing-behavioral-health-care-using-health-it>

(25) Use of MAT in Health Centers

February 28, 2013

10:00-11:00 am Pacific MAT Health Network

<https://www2.gotomeeting.com/register/476418162>

(26) Patient Privacy and Confidentiality in the Changing Health Care Environment: HIPAA, 42CFR Part 2 and Health Care Reform

February 28, 2013

10:00-11:30 am Pacific SAMHSA/Legal Action Center

<https://jbsinternational.webex.com/jbsinternational/onstage/g.php?t=a&d=576164902>

March 2013

(27) Integrating Treatment for Co-occurring Mental and Substance Use Disorders

March 12, 2013

11:00 am-12:30 pm Pacific

National Council for Community Behavioral Healthcare

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

(28) Reimbursement and Coding for Screening and Brief Interventions for Clinics/Health Systems/Hospitals

March 20, 2013

10:00 am-1:00 pm Pacific

National SBIRT ATTC

<http://ireta.org/webinarlibrary>

(29) Health IT for Primary and Behavioral Healthcare Integration

March 25, 2013

11:00-12:30 pm Pacific

National Council for Community Behavioral Healthcare

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

April 2013

(30) Managed Care – How Can I Do It? Succeeding in the New World of Managed Health Care Services, Part Two

April 18, 2013

10:00-11:30 am Pacific

Los Angeles County Substance Abuse Prevention and Control (SAPC)

<http://publichealth.lacounty.gov/sapc/HeathCare/HealthCareReform.htm>

<http://www.aodpolicy.org/HCR/HCR.htm>

(31) Telehealth: It's Not About Technology, It's About Expanding Access and Enhancing Care

April 18, 2013

11:00-12:30 pm Pacific

National Frontier & Rural ATTC

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

May 2013

(32) Integrating Psychiatry into Primary Care

May 8, 2013

11:00am-12:30pm Pacific

National Council for Community Behavioral Healthcare

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

(33) A Close Look at Care Coordination Within Patient-Centered Medical Homes: West Virginia's Experience

May 9, 2013

10:00-11:00am Pacific

Agency for Healthcare Research and Quality

<http://www.innovations.ahrq.gov/webevents/index.aspx?id=52>

(34) The Affordable Care Act and Implications for Recovery-Oriented Practice

May 9, 2013

12:00-1:30 pm Pacific SAMHSA Recovery to Practice

<http://www.samhsa.gov/recoverytopractice/RTPResources.aspx>

(35) Reducing Hospital Readmissions for Clients with Addictions

May 22, 2013

11:00am-12:30pm Pacific

National Council for Community Behavioral Healthcare

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

<https://www2.gotomeeting.com/register/198288386>

June 2013

(36) Building Health Information Exchanges to Support Accountable Care Organizations and Medical Homes: Delaware's Experience

June 5, 2013

10:00-11:00am Pacific

Agency for Healthcare Research and Quality

<http://www.innovations.ahrq.gov/webevents/index.aspx?id=53>

(37) Bridging Criminal Justice Systems and Community Healthcare: Integration's Role in Reentry

June 18, 2013

11:00am-12:30pm Pacific

SAMHSA-HRSA Center for Integrated Health Solutions

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

(38) Treatment Innovations: Perspectives from Addiction Providers Integrating Primary Care

June 24, 2013

9:00-10:30am Pacific

SAMHSA-HRSA Center for Integrated Health Solutions

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

(39) Affordable Care Act implementation one year post-decision: Medicaid expansion,

preventive services and public health implications

June 26, 2013

10:00-11:00am Pacific

American Public Health Association (APHA) Power of Policy

<http://www.apha.org/advocacy/reports/webinars/default.htm>

(40) Medicaid Health Home Implementation in Missouri: A Year Later

June 27, 2013

11:00am-12:30pm Pacific

SAMHSA-HRSA Center for Integrated Health Solutions

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

ETTA Conferences (FY 2012-2013)

July 2012

None reported.

August 2012

UCLA attended the Center for Advancing Longitudinal Drug Abuse Research (CALDAR) Meeting in Marina Del Rey, California on August 13, 2012. Dr. Rawson gave a plenary discussion on: Health Care Reform and Substance Use Disorder Services in California.

UCLA attended the California Department of Alcohol and Drug Programs (ADP) Conference on August 21-23, 2012. UCLA was involved with several workshops and when not presenting staff were sent to take notes on other workshops.

September 2012

UCLA attended the Agency for Healthcare Research and Quality (AHRQ) Annual Conference on September 9-10, 2012 in Bethesda, Maryland.

UCLA attended the California Institute for Mental Health (CIMH) Policy Forum on September 12-14, 2012 in Sonoma, California.

UCLA attended the County Alcohol and Drug Program Administrators Association of California (CADPAAC) Quarterly Meeting on September 26-27, 2012 in Sacramento, California.

October 2012

UCLA attended and presented at the Inter-state Community of Practice (CoP) teleconference on October 23, 2012 (Topic: Performance Management).

UCLA attended the Addiction Health Services Research (AHSR) Conference on October 17-19, 2012 in New York, New York.

UCLA attended the Insure the Uninsured Project (IUUP) Mental Health Issues Workgroup on October 18, 2012 in Los Angeles, California.

November 2012

UCLA attended the 9th Statewide Conference on Co-Occurring Disorders (COD) on November 7-8, 2012 in Universal City, California.

UCLA attended the Health Forum at UCLA (Fielding School of Public Health) on "The Impact of the 2010 Election on Health Care Reform" on November 28, 2012

December 2012

UCLA attended meeting on Creating a Strategic Plan for Workforce Development in California (tele-conference) on December 17, 2012.

January 2013

UCLA attended the UCLA David Geffen School of Medicine 17th Annual UCLA Health Care Symposium: "Bright Ideas: Innovations in Health Care Delivery" held on Saturday, January 12, 2013, 8:00AM to 12:30PM, at Covel Commons on the campus of UCLA.

UCLA attended meeting on Strategic Principles for the Integration of SUD/MH Services in California (Workforce Development) (tele-conference) with ADP on January 17, 2013.

UCLA attended the CADPAAC Quarterly Meeting on January 23-24, 2013 in Sacramento.

UCLA attended the Health Forum at UCLA (Fielding School of Public Health) on "How Will the

Mental Health System Change Under the Affordable Care Act?” on January 30, 2013.

February 2013

UCLA attended the ITUP 17th Annual Conference: “ACA: The Final Countdown” – Feb. 5, 2013 in Sacramento. DU participated as a panelist and also took notes. Good conference! We should

keep in touch with the ITUP group.

UCLA attended the CiMH Mental Health & Substance Use Policy Forum – Feb. 13-15, 2013 in Sacramento.

March 2013

UCLA attended the CADPAAC Quarterly Meeting on March 27-28, 2013 in Sacramento. Dr. Rawson and Dr. Freese presented a report on Workforce Development.

April 2013

UCLA attended the National Council for Behavioral Health Conference on April 7-10, 2013 in Las Vegas, NV. Darren Urada presented on SUD integration activities at the Preconference Institute on Sunday, April 7.

UCLA attended the CADA Public Policy Conference on April 10, 2013 in Sacramento, CA.

UCLA attended the Telehealth Summit: Moving California Forward (CA Telehealth Resource Center) on April 15-16 in Napa, California.

May 2013

UCLA attended the Mental Health Workforce Education and Training (WET) Five-Year Plan Community Forum on May 15 in Los Angeles, CA. This event was held by the California Office of Statewide Health Planning and Development (OSHPD).

UCLA attended the California Addictions Training and Education Series (CATES) training event held on May 17 in Rialto, CA, in San Bernardino County: “The Changing Behavioral Health Care Landscape: Integration, Innovation and Financing Models for Success”. Expert speaker Patrick Gauthier presented an update on health care reform with an emphasis on financing and billing models for integrating SUD and mental health (MH) services with primary care and other medical services.

UCLA attended the CiMH California Innovations Summit: “The Triple Aim as a Framework for Improving the Health of Individuals with Complex Mental Health, Substance Use, and Physical Health Conditions” on May 22-23, 2013 in Sacramento, CA. Conference attendees included mental health and SUD providers, administrators, and researchers, as well as representatives of various California health plans.

UCLA attended the CADPAAC Quarterly Meeting on May 28-29, 2013, in Sacramento.

June 2013

UCLA attended the College on Problems of Drug Dependence 75th Annual Scientific Meeting from June 15-20, 2013 in San Diego, CA.

UCLA attended the Joint California Health Workforce Alliance (CHWA) and California Health Professions Consortium (CHPC) Quarterly Meeting on June 24, 2013 in Universal City, CA.

California County Integration Survey 2012

Introduction

Purpose of Survey

We would like your help in assessing the status of AOD/SUD service integration efforts in California counties and to determine what technical assistance, if any, would be helpful to you in order to facilitate changes in service delivery resulting from health care reform.

The survey should take about 15 minutes to complete. Please answer questions to the best of your knowledge; there is no need to survey your providers.

Definitions

AOD - Alcohol and other drugs.

SUD - Substance use disorder(s). Refers to problems with AOD use that have been diagnosed and require treatment.

Primary Care Services - Routine health care focusing on the prevention and early detection of health problems through regular physicals, blood pressure tests, mammograms, and similar procedures. Services may occur in a physician's office, health center, or other locations. Primary care is the first (primary) point of medical consultation for patients, but may result in referrals to specialty care.

Primary Prevention - Programs aimed at educating and counseling individuals on AOD use and providing for activities to reduce the associated risks. Primary prevention includes wellness activities, and does not include early intervention activities or services directed at individuals already diagnosed with SUD.

Recovery Support Services - Nonclinical services that assist individuals and families in recovering from chronic illness. Here, we refer specifically to recovery from SUD.

Integration - Any type of routine or standard AOD/SUD screening, referral, intervention or treatment conducted in a primary care setting, any primary care services conducted in an AOD/SUD setting, or bidirectional referrals. May also refer to the inclusion of AOD/SUD primary prevention or recovery support services in primary care settings.

Behavioral Health Provider - Refers to a county-operated OR contract provider within the county system of care. May provide mental health services, and/or AOD/SUD primary prevention, treatment, or recovery support services.

FQHC - Community-based health centers that receive grant support through the Health Resources and Services Administration (HRSA) and can receive enhanced Medicaid rates.

FQHC Look-Alike - Community-based health centers that meet all of the requirements of an FQHC and can receive enhanced Medicaid rates but do not receive grant support through HRSA.

County

*** 1. County:**

California County Integration Survey 2012

Current Integration Status

*Remember that "**providers**" throughout this survey refers to county-operated OR contract providers, who may be providing mental health and/or AOD/SUD primary prevention, treatment, or recovery support services.

***2. Are behavioral health providers* in your county currently doing any work to integrate AOD/SUD screening, intervention, referral or treatment with primary care or mental health?**

- NO
- YES - with Primary Care
- YES - with Mental Health in Primary Care Settings
- YES - with Primary Care AND Mental Health
- Don't Know

If you need to clarify your answer, please do so here.

Plans for Future Integration

***3. Are behavioral health providers in your county planning to do any AOD/SUD integration work in the next year?**

- NO
- YES - with Primary Care
- YES - with Mental Health in Primary Care Settings
- YES - with Primary Care AND Mental Health
- Don't Know

If you need to clarify your answer, please do so here.

Primary Care in SUD Treatment Settings

California County Integration Survey 2012

***4. Other than narcotic treatment programs (NTPs), are any SUD treatment providers in your county licensed to have an on-site medical professional who provides primary care services (e.g., physical exams) to patients?**

- NO
- YES
- Don't Know

If you need to clarify your answer, please do so here.

Primary Care in SUD Treatment Settings

5. Other than NTPs, approximately what percentage of SUD treatment providers in your county have an on-site medical professional who provides primary care services? (Please give your best estimate; there is no need to survey your providers.)

- 75% or more
- At least 50% but less than 75%
- At least 25% but less than 50%
- Some, but less than 25%
- None (0%)
- Don't Know

6. Approximately how many of the SUD treatment providers that provide primary care services are Federally Qualified Health Centers (FQHCs) or FQHC look-alikes? (Please give your best estimate; there is no need to survey your providers.)

- Don't Know
- Approximate Number:

California County Integration Survey 2012

7. Other than NTPs, how are primary care services provided by SUD treatment providers funded? (Check all that apply)

- Medi-Cal
- Drug Medi-Cal
- Medicare
- Private Insurance
- Federal Block Grant Funds
- Self-Pay
- Don't Know
- Other (please describe)

8. How would you best describe the service delivery model for SUD treatment providers that provide primary care services in your county? (Check all that apply)

- Co-located – the primary care provider works at the SUD clinic but keeps separate documentation, bills for services separately from SUD services, and does not participate regularly in treatment planning or care management
- Partly integrated – the primary care provider works at the SUD clinic, keeps separate documentation, bills for services separately from SUD services, but collaborates with SUD providers in treatment planning and care management
- Fully integrated – the primary care provider works in the SUD clinic and documentation, billing, treatment planning, and care management are fully integrated
- Don't Know
- Other (please describe)

AOD/SUD Services in Primary Care

California County Integration Survey 2012

***9. Are there any primary care settings that provide AOD/SUD primary prevention, treatment, or recovery support services? (Check all that apply)**

- NO
- YES - Primary Prevention Activities in Primary Care
- YES - Treatment Services in Primary Care
- YES - Recovery Support Services in Primary Care
- Don't Know

If you need to clarify your answer, please do so here.

AOD/SUD Services in Primary Care

10. Approximately what percentage of county-operated or county-contracted primary care clinics have a behavioral health provider who provides AOD/SUD services to primary care clinic patients? (Please give your best estimate; there is no need to survey your providers.)

- 75% or more
- At least 50% but less than 75%
- At least 25% but less than 50%
- Some, but less than 25%
- None (0%)
- Don't Know

11. Which types of primary care setting(s), if any, provide any AOD/SUD services (by a behavioral health provider or medical professional)? (Check all that apply)

- Federally Qualified Health Center (FQHC)
- FQHC "look-alike"
- Non-FQHC community health center
- Private clinics
- Private physician offices
- Don't Know
- Other (please describe)

California County Integration Survey 2012

12. The behavioral health provider provides the following AOD/SUD services in primary care clinics: (Check all that apply)

- Education and information dissemination
- Screening of pregnant women for AOD/SUD (e.g., 4 P's)
- Routine screening for nicotine
- Routine screening for alcohol
- Routine screening for drugs
- Brief intervention for nicotine
- Brief intervention for alcohol
- Brief intervention for drugs
- Psychosocial treatment for nicotine
- Psychosocial treatment for alcohol
- Psychosocial treatment for drugs
- Case management/coordination of services
- Recovery support services
- Don't Know

13. How are AOD/SUD services provided by the behavioral health provider in the primary care setting funded? (Check all that apply)

- Drug Medi-Cal
- Enhanced Medi-Cal (FQHC rate / PPS)
- Federal Block Grant Funds
- Other Grants
- Medi-Cal
- Medicare
- Mental Health Services Act (MHSA / Prop 63)
- Private Insurance
- Self Pay
- Don't Know
- Other (please describe)

California County Integration Survey 2012

14. How would you best describe the service delivery model in primary care clinics that have a behavioral health provider providing AOD/SUD services? (Check all that apply)

- Co-located – the behavioral health provider works at the primary care clinic but keeps separate documentation, bills for services separately from primary care services, and does not participate regularly in treatment planning or care management with primary care providers
- Partly integrated – the behavioral health provider works at the primary care clinic, keeps separate documentation, bills for services separately from primary care services, but collaborates with primary care providers in treatment planning and care management
- Fully integrated – the behavioral health provider works in the primary care clinic and documentation, billing, treatment planning, and care management are fully integrated with primary care
- Don't Know
- Other (please describe)

15. If you would like to clarify any of your answers about integration of behavioral health providers and AOD/SUD services into primary care settings, please do so here.

Barriers to Integration

16. What barriers do you anticipate or have you already experienced in integrating AOD/SUD services and primary care? (Check all that apply)

- Financing barriers
- Documentation barriers (i.e., confidentiality, electronic health record)
- Partnering with primary care providers
- Legal barriers
- Provider certification or licensing issues
- Facility certification or licensing issues
- Other barriers (please describe)

California County Integration Survey 2012

17. What barriers do you anticipate or have you already experienced in integrating AOD/SUD services and mental health services within primary care settings? (Check all that apply)

- Financing barriers
- Documentation barriers (i.e., confidentiality, electronic health record)
- Partnering with primary care providers
- Legal barriers
- Provider certification or licensing issues
- Facility certification or licensing issues
- Other barriers (please describe)

Training/TA Needs

18. We are trying to assess training and technical assistance needs around the state. Please review the list of topics below and select the top three that would be most helpful in your county.

Choice 1

Choice 2

Choice 3

If you selected "Other", please specify:

Stages of Integration

*Remember, **AOD/SUD services** include primary prevention activities, treatment and recovery support services.

California County Integration Survey 2012

19. On a scale from 0 to 4, rate your county's level of AOD/SUD service* and primary care integration:

- (0) Not engaged in any activity related to integration
- (1) Learning about integration
- (2) Starting to communicate with primary care providers
- (3) Planning integration initiatives with primary care providers
- (4) Engaged in integration initiatives

If engaged in integration initiatives, please indicate how many:

20. On a scale from 0 to 4, rate your county's level of AOD/SUD service and mental health service integration within primary care settings:

- (0) Not engaged in any activity related to integration
- (1) Learning about integration
- (2) Starting to communicate with primary care providers
- (3) Planning integration initiatives with primary care providers
- (4) Engaged in integration initiatives

If engaged in integration initiatives, please indicate how many:

Billing

21. Approximately what percentage of SUD treatment providers in your county currently bill private insurance (non-Medi-Cal) for AOD/SUD services? (Please give your best estimate; there is no need to survey your providers.)

- 75% or more
- At least 50% but less than 75%
- At least 25% but less than 50%
- Some, but less than 25%
- None (0%)
- Don't Know

If you would like to clarify any of your answers about billing private insurance for AOD/SUD services, please do so here.

California County Integration Survey 2012

22. Is your county currently working with insurance providers to provide AOD/SUD services to low-income, indigent populations in preparation for 2014? (For example, have you been involved in planning for local initiatives like LIHP, CMSP, Dual Eligibles coordinated care demonstration project, etc.?)

- NO
- YES
- Don't Know

If yes, please describe briefly:

Structure of Services

23. Please select the option that best describes the structure of behavioral health and health services in your county:

- Mental health, AOD/SUD, and physical health services administration are provided by a single county department or agency
- Mental health, AOD/SUD, and physical health services administration are provided by three separate county departments or agencies
- Behavioral health services (mental health and AOD/SUD) are under one county department or agency; physical health services are under a separate county department or agency
- Some other structure (please describe):

Learning Collaborative - Invitation

The **ADP/UCLA California Integration Learning Collaborative (ILC)** meets monthly, typically via teleconference, and involves discussion on integration of AOD/SUD services into mental health and primary care settings.

***24. Would you or someone from your county be interested in participating (or continuing to participate) in the ADP/UCLA California Integration Learning Collaborative (ILC)?**

	Yes	No
I'd like to participate or continue my participation in the ILC.	<input type="radio"/>	<input type="radio"/>
I'd be willing to present my county's integration work in the ILC.	<input type="radio"/>	<input type="radio"/>
I'd like to discuss with UCLA the potential to pilot new integration activities within my county. (<i>This may involve data collection and/or technical assistance tailored to the county's efforts.</i>)	<input type="radio"/>	<input type="radio"/>

If you are interested in piloting new integration activities, please describe your initial ideas, if any:

California County Integration Survey 2012

25. What topics would be of interest to you for discussion within the ADP/UCLA California Integration Learning Collaborative?

Additional Thoughts

26. If you have any other thoughts you would like to share about integrating AOD/SUD services with primary care that have not been covered by this survey, please provide them below.

CMSP Behavioral Health Benefit Survey

SURVEY OF AOD/BH COUNTY ADMINSTRATORS

"COUNTY EXPERIENCES WITH THE PATH2HEALTH/COUNTY MEDICAL SERVICES PROGRAM (CMSP) WITH AN EMPHASIS ON THE ADDED OUTPATIENT BEHAVIORAL HEALTH BENEFIT"

As part of UCLA's Evaluation, Training and Technical Assistance for Substance Use Disorder Services Integration (ETTA) project under contract with ADP, we are gathering information on counties' experiences with the Path2Health/CMSP benefit, specifically with regard to the recently expanded coverage for Behavioral Health (BH) Treatment Services that went into effect on January 1, 2012. Although the benefit covers both outpatient mental health and substance use disorder services, our focus for this survey is on the utilization of and experience with this expanded benefit with those seeking substance use disorder treatment.

Objective 1: To document and understand the utilization of and experiences with the CMSP Behavioral health benefit, with an emphasis on substance use disorder (SUD) services (*i.e.: what is working well, what is not working well, recommendations for improvement*).

Objective 2: To gather lessons learned from the utilization of this benefit to help guide other counties and the State as they prepare for national health care reform, as it pertains to Medicaid expansion, health care coverage, and the provision of SUD services.

Expected Time: The survey should take approximately 15 minutes to complete.

Requested Return date: Please complete and return the survey no later than May 3, or let us know if you would like more time.

Note: Some questions may ask you for numbers and/or percentages. If you do not have these figures at your fingertips, please provide your best estimate. This survey is not meant for you to do too much digging in your files for exact numbers, but rather assess your perceptions from your experience.

1. Name:

2. Title:

3. County:

Eligibility and Enrollment

CMSP Behavioral Health Benefit Survey

4. Please describe your experience* with patient eligibility and/or enrollment into the expanded SUD benefit.

*Detailed anecdotes are encouraged. Please clarify whether your comment is directly related to Anthem administrative processes or to the CMSP benefit design.

5. Please provide at least ONE (1) recommendation you believe could improve the eligibility/enrollment process.

Utilization of the Benefit

For questions 6, 7, and 8, please complete the blanks* for the following SUD services covered under benefit.

*Remember, this survey is not meant for you to do too much digging in your files, so if you don't have exact numbers, please provide your best estimate based on your experience.

Please provide your estimates for the time period between **January 1, 2012** and **December 31, 2012**.

6. SUD assessment (code 90801/H0001)

Number of **authorization requests submitted** to Anthem:

(Include requests made per individual; not number of sessions requested.)

Number (or %) of **authorization requests approved** by Anthem:

(Do not count those that are currently in process.)

Number (or %) of **claims processed** for reimbursement:

(Do not count those that are currently in process.)

7. SUD individual counseling (code 90804, 90806, H0004 - up to 2 sessions)

Number of **authorization requests submitted** to Anthem:

(Include requests made per individual; not number of sessions requested.)

Number (or %) of **authorization requests approved** by Anthem:

(Do not count those that are currently in process.)

Number (or %) of **claims processed** for reimbursement:

(Do not count those that are currently in process.)

CMSP Behavioral Health Benefit Survey

8. SUD group counseling sessions (code 90853, 90857, H0005 - up to 20 group sessions)

Number of **authorization requests submitted** to Anthem:

(Include requests made per individual; not number of sessions requested.)

Number (or %) of **authorization requests approved** by Anthem:

(Do not count those that are currently in process.)

Number (or %) of **claims processed** for reimbursement:

(Do not count those that are currently in process.)

Utilization of the Benefit, ctd.

Remember to clarify whether your comment is directly related to Anthem administrative processes or to the CMSP benefit design.

9. Please provide a **brief statement** of your experience with the **authorization/approval process**. Include details on what **IS** working and what is **NOT** working with this aspect of the benefit.

10. Please **describe** how this expanded benefit coverage has impacted **access to SUD services** in your county.

11. Please provide at least **ONE (1) recommendation** you believe may increase utilization of the **BH benefit** (particularly coverage for SUD services).

Benefit Design

Remember to clarify whether your comment is directly related to Anthem administrative processes or to the CMSP benefit design.

CMSP Behavioral Health Benefit Survey

12. Please rate how satisfied you are with how the benefit meets the needs of the SUD treatment seeking population in your county.

- 1 - Not at all satisfied
- 2 - Slightly satisfied
- 3 - Moderately satisfied
- 4 - Very satisfied
- 5 - Extremely satisfied

13. Please explain your answer. What works? What does NOT work?

14. Does this benefit allow you to address treatment seekers with co-occurring mental health and substance use disorders? Please explain.

- Yes
- No
- Don't know

Explanation:

15. Please provide at least ONE (1) recommendation you believe may improve the design of the BH benefit.

Payment and Claims

Remember to clarify whether your comment is directly related to Anthem administrative processes or to the CMSP benefit design.

CMSP Behavioral Health Benefit Survey

16. Please describe your experience with the payment and claims process for SUD covered services.

17. Please provide at least ONE (1) recommendation you believe may improve the Payment/Claims process under the current benefit.

County LIHP SUD Services Survey

Introduction

LOW INCOME HEALTH PROGRAM / MEDICAID COVERAGE EXPANSION

FOR SUBSTANCE USE DISORDER SERVICES SURVEY

As part of UCLA's Evaluation, Training and Technical Assistance for Substance Use Disorder Services Integration (ETTA) project under contract with ADP, we are gathering information on counties' experiences with (1) expanding Medi-Cal coverage to eligible low income adults through the Low Income Health Program (LIHP) and (2) implementing the covered substance use disorder (SUD) services.

The important information you provide will help guide other counties and the State as they prepare for national health care reform, particularly as it pertains to Medicaid expansion, health care coverage, and the provision of SUD services for the expansion populations.

The survey should take about 15 minutes to complete. Thank you in advance for your time- we appreciate and value your input!

Please complete this by May 3, or let us know if you would like more time.

Background

1. Name:

2. County:

3. Briefly describe the target population(s) and setting(s) for LIHP SUD services in your county (e.g., all SUD clients who may be eligible for LIHP; all medical inpatients and psychiatric emergency center patients).

SUD Implementation Status

County LIHP SUD Services Survey

4. Please indicate the implementation status of your county's covered LIHP SUD services for Medicaid Coverage Expansion (MCE) enrollees.

(You may refer to your county's [LIHP contract](#), Exhibit A, Attachment 15- Additional MCE Services and HCCI.)

	Implemented	Not implemented*	Not offered under the county's LIHP contract
Assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Behavioral Health Integration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Case Management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Collateral Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Day Care Rehabilitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Detoxification	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Group Counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Individual Counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication Assisted Treatment (MAT)**	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Narcotic Replacement Therapy (methadone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Outpatient	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Residential Acute Stabilization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Residential Perinatal Treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Residential Treatment Including Detoxification	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Screening and Intervention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sober Living Environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treatment Placement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

***If the SUD service is covered under the county's LIHP, but has not yet been implemented, please explain:**

5. **Specify which MAT services, if any:

Eligibility and Enrollment

County LIHP SUD Services Survey

6. Please describe the biggest challenge your county has experienced with regard to LIHP eligibility/enrollment and how it has been or is being addressed.

7. Please describe at least 1 promising practice or strategy that has worked especially well in your county with regard to LIHP eligibility/enrollment.

(Include enough details so others who might be interested could implement this practice/strategy in their counties.)

Implementing SUD Services

8. Please describe the biggest challenge your county has experienced in implementing LIHP SUD services and how it has been or is being addressed.

9. Please describe at least 1 promising practice or strategy that has worked especially well in your county in implementing LIHP SUD services.

(Include enough details so others who might be interested could implement this practice/strategy in their counties.)

County LIHP SUD Services Survey

10. Based on your experiences, what should policy makers know about implementing SUD services for the MCE population?

Additional Questions

11. Is your county utilizing managed care concepts/tools for MCE enrollees?

	Yes	No
Treatment Authorization	<input type="radio"/>	<input type="radio"/>
Utilization Review	<input type="radio"/>	<input type="radio"/>

Comments, if any:

12. Please indicate below whether you can provide additional information that will help UCLA gain a better understanding of your county's LIHP.

	Yes	No
Does your county have <u>claims and/or cost data</u> related to LIHP SUD services?	<input type="radio"/>	<input type="radio"/>
Does your county have <u>reports</u> that include LIHP SUD services information/data that could be shared with UCLA?	<input type="radio"/>	<input type="radio"/>
May we contact you for follow-up questions, if needed?	<input type="radio"/>	<input type="radio"/>

13. Additional comments (optional):

CPAC FQHC survey

Consent to Participate in Research

INTEGRATION OF SUBSTANCE USE DISORDER TREATMENT WITH PRIMARY CARE IN PREPARATION FOR HEALTH CARE REFORM

Survey

You are being asked to take part in a research study by ____, Ph.D., from the Integrated ____. You were selected as a possible participant in this study because you are the lead contact for your organization in the Health Resources and Services Administration's Uniform Data System, a designee of the contact person, or were identified as an appropriate participant by stakeholders in your area. Your participation is voluntary, and you may withdraw at any time.

PURPOSE OF THE STUDY

The purpose of this study is to better understand the current level of integration of substance use disorder (SUD) treatment with primary care and the barriers and facilitators to such integration. Please note that **EVEN IF YOUR ORGANIZATION DOES NOT CURRENTLY PROVIDE SUBSTANCE USE DISORDER SERVICES, YOUR PARTICIPATION IS VERY IMPORTANT.**

PAYMENT FOR PARTICIPATION

You will be provided with a \$100 gift card for participation. If you start but do not complete the survey, or if you skip any questions, you will still receive the \$100 gift card.

PROCEDURES

You are being asked to participate in a web-based survey lasting from 8 up to 22 minutes (depending on responses) to collect data on types of SUD treatment, use of evidence based SUD treatment practices, integration between SUD and primary care, mental health, and HIV/AIDS services, organizational characteristics, and the degree to which policies (e.g. Medi-Cal reimbursement rules) affect delivery of services.

POTENTIAL RISKS AND DISCOMFORTS

You may not wish to answer some questions. You may refuse to answer any question that you do not wish to answer, or stop the survey at any time.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

This study will not provide any direct benefits to participants. However, this study will give you an opportunity to voice your opinions and share your experiences regarding SUD service integration, and your input will be an important source of information that will be disseminated to policymakers interested in this topic. This may potentially lead to improvements in policies and practices that affect your organization and others like it.

CONFIDENTIALITY

All of your responses will be encrypted and accessible only to the researchers. All of the information you provide will be identified by a code number and will be used for research purposes only. All data collected will be kept in locked files at the researchers' office. No information that identifies you will be shared with other research programs, or with other agencies, or be released without your separate consent. All data reported in publications or reports will be in aggregate form, meaning that no individual will be identified. When the results of this study are published, your name will not be used.

PARTICIPATION AND WITHDRAWAL

Your participation in this survey is voluntary. If you do decide to participate, you are free to withdraw your consent and stop the survey at any time. You may also refuse to answer specific questions you do not want to answer and still remain part of the study.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research study, please feel free to contact ____, Ph.D., the Principal Investigator at ____. He can also be called at ____ or by writing to ____.

CPAC FQHC survey

RIGHTS OF RESEARCH SUBJECTS

You are not waiving any legal claims, rights or remedies because of your participation in this study. If you wish to ask questions about your rights as a research participant or if you wish to voice any problems or concerns you may have about the study to someone other than the researchers, please call the Office of the Human Research Protection Program at (310) 825-7122 or write to Office of the Human Research Protection Program, UCLA, 11000 Kinross Avenue, Suite 211, Box 951694, Los Angeles, CA 90095-1694

SIGNATURE OF STUDY PARTICIPANT

I have read (or someone has read to me) the information provided above. I have been given an opportunity to ask questions by contacting the researchers and all of my questions (if any) have been answered to my satisfaction.

*1. Click on the button below if you agree.

I AGREE

*2. Do you wish to receive a \$100 Visa gift card for your participation? Note only the invited participant or their designee is eligible (one per organization). If an invitation to participate was forwarded to you via e-mail and you are not sure of your eligibility, please contact ____.

Decline

Accept (enter name and mailing address below)

3. Which organization/health center do you work for?

4. What is your position within your organization/health center?

5. If you would be interested in receiving a report that includes the aggregated responses of survey participants organizations at the conclusion of this study, please indicate the e-mail address the report should be sent to below.

We hope to understand your organization's practices generally, but understand that individual sites can vary greatly in practices. If it is NOT possible to generalize, please answer according to practices at the largest primary care site in your organization (most patients/year).

Screening

"Screening" refers to a brief measure (usually only one or a small number of questions) to identify patients that may have alcohol or other substance use disorders. This may be administered in the waiting room as part of the patient's intake paperwork, or as part of a separate process. Examples of common screening tools include the AUDIT, AUDIT C/C+, ASSIST, and the CAGE. Some sites may also use one or more questions developed for their own use.

6. Are patients screened for substance use at your organization?

- Yes, all patients are screened for substance use
- No, patients are not normally screened for substance use
- Yes, a select or targeted group of patients is screened for substance use

7. What groups are targeted for screening (check all that apply)?

- Patients treated for behavioral health
- Patients with a history of substance use
- Patients with current symptoms or signs
- Pregnant women
- Patients with HIV/AIDS
- Patients with chronic pain
- Patients who are homeless
- Adolescents
- Other (please specify)

8. What substance use screening tools are used? (check all that apply)

- A screening tool created by my health center
- Alcohol Use Disorders Identification Test (AUDIT / AUDIT C /AUDIT C+)
- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- CAGE / CAGE-AID
- CRAFFT
- Drug Abuse Screening Test (DAST)
- Global Appraisal of Individual Needs Short Screener (GAIN-SS)
- Michigan Alcohol Screening Test (MAST)
- Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
- Substance Abuse Subtle Screening Inventory (SASSI)
- Other (please specify)

9. When are patients screened for substance use? (check all that apply)

- a. New patient's initial visit only
- b. New patient's initial visit plus additional screens as indicated below
- c. Every visit
- d. Every 3 months
- e. Every 6 months
- f. Annually
- Other / varies by patient (please specify)

10. Who typically administers the screening (who fills out the forms)?

- Self-administered by patient (for example, forms completed as part of paperwork during intake)
- Front desk staff
- Medical Assistant
- Nurse
- Physician's Assistant
- Physician
- Behavioral Health Specialist (e.g. licensed clinical social worker, counselor, psychologist, psychiatrist, etc.)
- Other (please specify)

11. Who scores the screening instrument?

- Not applicable, screen is simple yes/no.
- Front desk staff
- Medical Assistant
- Nurse
- Physician's Assistant
- Physician
- Behavioral Health Specialist
- Other (please specify)

12. If a screen is positive, what happens next? (check all that apply)

- Screening information is made available to physician
- Patient is given a brief intervention* by the physician
- Patient is given a brief intervention* by someone other than the physician
- Patient is referred for further assessment
- Patient is provided with informational / educational materials
- Other (please specify)

* Brief interventions are short, one-on-one counseling sessions generally aimed at moderating a person's alcohol/drug use. Brief interventions can be given in a matter of minutes and may include approaches such as motivational interviewing that are designed to persuade people who are resistant to moderating their alcohol/drug intake or who do not believe they are using these substances in a harmful or hazardous way.

13. You indicated that patients are given a brief intervention by someone other than the physician. Who performs this task?

- Front desk staff
- Medical Assistant
- Nurse
- Physician's Assistant
- Physician
- Behavioral Health Specialist (e.g. licensed clinical social worker, counselor, psychologist, psychiatrist)
- Other (please specify)

Assessment

Assessments are evaluations of patient substance use disorder problems that are more in-depth than screenings. Examples of common assessment instruments include the Addiction Severity Index (ASI) and American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). Whereas screening aims to simply identify patients with problems, assessment instruments seek to quantify problems faced by these patients to aid in the development of a treatment plan.

14. Are patients given assessments (as defined above) for substance use disorders?

- Yes
- No

15. Which patients are typically targeted for assessments? (check all that apply)

- Patients who had a positive screen
- Patients otherwise identified as being at risk (without a screening instrument) by staff
- Patients otherwise identified as being at risk by a physician
- Patients treated for behavioral health
- Patients with a history of substance use
- Patients with current symptoms or signs
- Pregnant women
- Patients with HIV/AIDS
- Patients with chronic pain
- Patients who are homeless
- Adolescents
- Other (please specify)

16. What instrument(s) are used (check all that apply)?

- Addiction Severity Index (ASI, ASI-lite)
- American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC)
- Structured Clinical Interview (SCID)
- Other (please specify)

17. Who administers the assessment (who fills out the forms)?

- Self-administered by patient
- Front desk staff
- Medical Assistant
- Nurse
- Physician's Assistant
- Physician
- Behavioral Health Specialist
- Other (please specify)

18. Who scores the assessment?

- Front desk staff
- Medical Assistant
- Nurse
- Physician's Assistant
- Physician
- Behavioral Health Specialist
- Other (please specify)

19. If an assessment indicates that a patient needs treatment, what happens next? (check all that apply)

- Brief intervention* delivered immediately
- Treatment on site
- Referred to an outside organization for treatment
- Other (please specify)

* Brief interventions are short, one-on-one counseling sessions generally aimed at moderating a person's alcohol/drug use. Brief interventions can be given in a matter of minutes and may include approaches such as motivational interviewing that are designed to persuade people who are resistant to moderating their alcohol/drug intake or who do not believe they are using these substances in a harmful or hazardous way.

Integration, Interventions, and Treatment

20. What is the status of electronic medical record integration in your organization?

- Electronic medical records for physical health only
- Separate electronic medical record systems for physical health and mental health/substance use disorders
- Electronic medical record system that integrates both physical health and mental health/substance use disorder records
- No electronic medical record system in place
- Other (please specify)

21. Does your organization provide treatment or interventions for substance use disorders, either onsite or by referral to an outside organization?

- Yes
- No

22. What substance use disorder services are provided on-site or by formal referral arrangements? (check all that apply)

	On-site	Off-site (referral)	Not available
Individual counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications (e.g. Buprenorphine/Subutex/Suboxone, Naltrexone/Vivitrol, Methadone, Acamprosate/Campral, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Medications, please specify which. If Other, please describe.

23. Which of the following specific substance use disorder practices are in use?

	Never	Never but interested in adding	Sometimes	Routine
Medication assisted treatment: Buprenorphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication assisted treatment: Vivitrol/Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication assisted treatment: Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Motivational interviewing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Motivational enhancement therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Screening, Brief Intervention & Referral to Treatment (SBIRT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cognitive behavioral therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Contingency management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12-step facilitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social skills building	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Telemedicine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Computerized Cognitive Behavioral Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

24. Who delivers the substance use disorder services? (check all that apply)

- Nurse
- Physician's Assistant
- Physician
- Substance Use Disorders Counselor
- Licensed Clinical Social Worker
- Psychologist
- Psychiatrist
- Other Behavioral Health Specialist
- Other (please specify)

25. How are substance use disorder services funded? (check all that apply)

- Billed as a service, included in the FQHC per-visit prospective payment system rate
- Not billed to an external funder, not included in the per-visit payment rate (costs are subsidized by other services at the FQHC)
- County alcohol and drug funding
- Mental Health Services Act (MHSA) funding
- Grant funding
- Varies/Other (please specify)

Integration

26. Which of the following best describes the level of integration between your Substance Use Disorder (SUD) and PRIMARY CARE services?

- Minimal Collaboration: SUD providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically
- Basic at a Distance Collaboration: Primary care and SUD providers have separate systems at separate sites, but engage in periodic communication about shared patients
- Basic On-Site Collaboration: SUD and primary care providers have separate systems but share the same facility
- Close Collaboration, Partly Integrated: SUD providers and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among SUD and primary care providers.
- Close Collaboration, Fully Integrated: The SUD provider and primary care provider are part of the same team. The patient experiences the SUD treatment as part of his or her regular primary care.

27. Which of the following best describes the level of integration between your Substance Use Disorder (SUD) and MENTAL HEALTH services?

- Minimal Collaboration: SUD providers and other mental health providers work in separate facilities, have separate systems, and communicate sporadically
- Basic at a Distance Collaboration: Mental Health and SUD providers have separate systems at separate sites, but engage in periodic communication about shared patients
- Basic On-Site Collaboration: SUD and Mental Health providers have separate systems but share the same facility
- Close Collaboration, Partly Integrated: SUD providers and Mental Health providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among SUD and Mental Health providers.
- Close Collaboration, Fully Integrated: The SUD provider and Mental Health provider are part of the same team. The patient experiences the SUD treatment as part of his or her regular Mental Health care.

28. Which of the following best describes the level of integration between your Substance Use Disorder (SUD) and HIV/AIDS services (e.g. prevention, education, treatment)?

- Minimal Collaboration: SUD providers and staff providing HIV services work in separate facilities, have separate systems, and communicate sporadically
- Basic at a Distance Collaboration: staff providing HIV services and SUD providers have separate systems at separate sites, but engage in periodic communication about shared patients
- Basic On-Site Collaboration: SUD and staff providing HIV services have separate systems but share the same facility
- Close Collaboration, Partly Integrated: SUD providers and staff providing HIV services share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among SUD and staff providing HIV services.
- Close Collaboration, Fully Integrated: The SUD provider and staff providing HIV services are part of the same team. The patient experiences the SUD and HIV services as part of his or her regular care.

29. (Note: This question is on Mental Health). Which of the following best describes the level of integration between your MENTAL HEALTH (MH) and PRIMARY CARE services?

- Minimal Collaboration: MH providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically
- Basic at a Distance Collaboration: Primary care and MH providers have separate systems at separate sites, but engage in periodic communication about shared patients
- Basic On-Site Collaboration: MH and primary care providers have separate systems but share the same facility
- Close Collaboration, Partly Integrated: MH providers and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among MH and primary care providers.
- Close Collaboration, Fully Integrated: The MH provider and primary care provider are part of the same team. The patient experiences the MH treatment as part of his or her regular primary care.

30. Please indicate which best describes the extent to which the primary care (PC) staff and substance use disorder (SUD) treatment staff communicate in providing SUD care (include e-mail or a shared electronic medical record as a form of communication if used).

- Very Low** - PC and SUD clinical staff very rarely communicate beyond the initial referral about a patient's SUD diagnosis, or communicate in deciding upon SUD treatment. There is little feedback or sharing of information about SUD treatment progress, changes or outcomes after referral, and there is almost no communication about missed SUD appointments.
- Low** - PC and SUD staff may communicate about a patient's SUD diagnosis on occasion, only in rare selected cases. Providing feedback or sharing information about SUD treatment progress or changes is only done infrequently, with discussion of outcomes limited to selected cases. The SUD staff communicates with PC staff about missed SUD appointments but only in special circumstances.
- Moderate** - PC and SUD clinical staff sometimes communicate about a patient's SUD diagnosis, and there is occasional communication in deciding upon SUD treatment, but not in most cases. There is some feedback and sharing of information about SUD treatment progress, changes, or outcomes. The MH/SUD staff communicates with the PC staff about missed SUD appointments in many cases.
- High** - PC and SUD clinical staff often communicate about a patient's SUD diagnosis, and there is usually communication in deciding upon SUD treatment. There is often feedback and sharing of information about SUD treatment progress, changes, or outcomes. The SUD staff communicates with the PC staff about missed SUD appointments in most cases.
- Very High** - PC and the SUD clinical staff almost always communicate about a patient's SUD diagnosis, and there is communication in deciding upon SUD treatment in most if not all cases. There is constant feedback and sharing of information about SUD treatment progress, changes, or outcomes. The SUD staff communicates with PC staff about missed SUD appointments in almost all cases.

31. Please indicate which best describes the physical proximity between the primary care (PC) and the setting where substance use disorder (SUD) services are delivered.

- Very Low** - PC and SUD services are separated by a distance greater than four blocks.
- Low** - PC and SUD services are located within four blocks but not within the same medical complex or campus.
- Moderate** - PC and SUD services are in different buildings but within the same campus, or medical complex.
- High** - PC and SUD services are in the same building but in different practice areas.
- Very High** - PC services are co-located with SUD services, in the same practice area.

32. Please indicate which best describes the separation in time between the referral from Primary Care (PC) and initial scheduled Substance Use Disorder (SUD) visit.

- Very Low** - PC referral and initial SUD visit/services are scheduled at distinctly different times, separated on average by more than 21 days.
- Low** - PC referral and initial SUD visit/services are provided at different times, separated by an average of 15 to 21 days.
- Moderate** - PC referral and initial SUD visit/services are usually provided within an average of 8 to 14 days of each other.
- High** - PC referral and initial SUD visit/services are each provided within a short time of the other, within seven days, but not on the same day.
- Very High** - PC referral and the initial SUD visit/services are provided during the same visit, on the same day.

33. Please indicate which best describes the array of Substance Use Disorder (SUD) services and expertise available within the primary care (PC) setting.

- Very Low** – No specialty SUD expertise is available on site; patients with anything more than minor SUD problems are always referred to off-site specialty SUD care (if available) for the expertise or services needed.
- Low** – Very limited specialty SUD expertise is available on site; patients with modestly complex SUD problems are almost always referred to off-site specialty SUD care for the expertise or services needed.
- Moderate** – Some limited specialty SUD expertise is available on site, with an expert available for consultation by phone; some short-term counseling for routine SUD problems are provided on site; patients with moderately complex problems are usually referred to off-site specialty SUD care for the expertise or services needed.
- High** – Basic SUD expertise is available with a trained SUD expert on site for consultation and/or treatment; all pharmacological and many counseling services for SUD problems are available on site; only patients with complex problems or treatment resistance are usually referred to specialty SUD care.
- Very High** – A wide range of specialty SUD expertise is available on site; almost all basic types of SUD services are provided on site by fully qualified SUD clinicians; patients with all kinds of SUD problems can be treated on-site with minimal need to use outside specialty SUD expertise or services.

34. Please indicate which best describes the extent to which primary care (PC) services and substance use disorder (SUD) services are integrated with respect to the elimination of stigma.

- Very Low** - The SUD program is known by name and signage, and is referred to by the PC staff as a separate designated setting for those requiring SUD or other Mental Health (MH) assistance (i.e. the "Psych team", "SUD Counselor" "MH Clinic"). PC and SUD staff treat it as a separate program.
- Low** - The SUD office or program may have a name and signage only indirectly related to SUD treatment ("Behavioral services", "Health Counseling", "EAP Program"), but PC and SUD staff make little attempt to avoid referring to it or treating it as a separate program.
- Moderate** - The SUD office or program has a distinct separate name and signage but it is not directly related to SUD treatment (e.g. "Integrated Care Office"). PC and SUD staff do make some attempts to avoid referring to it or treating it as a separate program.
- High** - Minimal distinction is made, in terms of signage, clinic names, or in the PC staff's references, between the PC setting and the SUD setting. PC and SUD staff make real attempts to avoid referring to it or treating it as a separate program.
- Very High** - No distinction is made, in terms of signage, clinic names, or in the PC staff's references, between the PC and the SUD setting, and PC and SUD staff always avoid referring to it or treating it as a separate program.

35. In general, how effective is your organization in addressing the needs of patients with substance use disorders?

- Not at all effective
- Slightly effective
- Somewhat effective
- Pretty effective
- Extremely effective

36. Communication between primary care and substance use disorder staff at my clinic is good.

- Agree Strongly
- Agree
- Uncertain
- Disagree
- Disagree Strongly
- Not Applicable

37. Additional training regarding diagnosing and treatment of substance use disorders would be helpful for my clinic's staff.

- Agree Strongly Agree Uncertain Disagree Disagree Strongly

38. My clinic's staff is very knowledgeable about the evidence based practices used to treat substance use disorders.

- Agree Strongly Agree Uncertain Disagree Disagree Strongly

39. It is possible to treat substance use disorders effectively.

- Agree Strongly Agree Uncertain Disagree Disagree Strongly

40. In general, how effective is your organization in addressing the needs of patients with mental health disorders?

- Not at all effective Slightly effective Somewhat effective Pretty effective Extremely effective

41. Communication between primary care and mental health staff at my clinic is good.

- Agree Strongly Agree Uncertain Disagree Disagree Strongly
- Not Applicable

42. Additional training regarding diagnosing and treatment of mental health disorders would be helpful for my clinic's staff.

- Agree Strongly Agree Uncertain Disagree Disagree Strongly

43. My clinic's staff is very knowledgeable about the evidence based practices used to treat mental health disorders.

- Agree Strongly Agree Uncertain Disagree Disagree Strongly

44. It is possible to treat mental health disorders effectively.

- Agree Strongly Agree Uncertain Disagree Disagree Strongly

Legislation / Policy / Regulations

45. Has your clinic's delivery of substance use disorder services been affected by recent policy changes? (e.g. changes in the Low Income Health Program, or coverage by County Medical Services Program ["Path2Health"], if applicable in your county)

- Yes
- No

If Yes, please describe:

46. If you had a chance to tell legislators or other policymakers what you would like them to do to facilitate integration of substance use or mental health services or remove barriers to integration, what would you tell them? (your anonymous responses will be passed on to policymakers)

47. (optional) So we may get a better understanding of your organization, we would appreciate estimates of Full Time Equivalents (FTEs) at your organization for the following staff types (approximations are ok)

Physicians	<input type="text"/>
Physician Assistants	<input type="text"/>
Family Nurse Practitioners	<input type="text"/>
Psychiatrists	<input type="text"/>
Clinical Psychologists	<input type="text"/>
Licensed Clinical Social Workers	<input type="text"/>
Others	<input type="text"/>

CPAC FQHC survey

48. (optional) Please estimate the percentage of encounters that are paid for from the following sources (approximations are ok)

Medicare	<input type="text"/>
Medicare - Managed Care	<input type="text"/>
Medi-Cal	<input type="text"/>
Medi-Cal - Managed Care	<input type="text"/>
County Indigent / CMSP / MISIP	<input type="text"/>
Healthy Families	<input type="text"/>
Private Insurance	<input type="text"/>
Self-Pay / Sliding Fee	<input type="text"/>
Free	<input type="text"/>

49. Thank you for your participation. Were there any questions on this survey that were difficult to answer that you would like to comment on, or do you have any additional comments?

50. Would it be ok for the researchers to contact you if they have follow-up questions regarding your responses on this survey?

- Yes
- No

51. When you filled out this survey, which of the following did you follow?

- Answered according to general practices in my organization across sites.
- Answered with the largest primary care site in mind.
- Other (please specify)

Thank you!

Billing Codes (FQHCs)

State		FQHC			FQHC		
		HBAI	Codes	Credential	SUD	Codes	Credential
AL	Alabama	N			N		
AK	Alaska	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	Psychologist, Licensed Clinical Social Worker LCSW	Y	90804-90815 (90805, 90807, 90809, 90811, 90813, 90815 MD, PA, ANP only). 90847,90853, 90857	MD, PA, ANP, Psychologist, Licensed Clinical Social Worker
AZ	Arizona	Y	See Arizona billing sheet.	?	Y	90804, 90806, 90808 only. 90853 no telemedicine; 90857 no telemedicine	MD, Psych, PA, ANP, D.O., LCSW (if Medicare paid), Marriage Family Therapist, LPC
AR	Arkansas	N			Y	T1015. Psychologist & Social Worker 90804, 90806, 90808, 90810, 90812, 90814 only.	MD, PA, ANP, Clinical Psychologist, Clinical Social Worker
CA	California	Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	Y	01. 90805, 90807, 90809, 90811, 90813, 90815 MD, PA, NP only. Exclude 90857	MD, PA, NP, Clinical Psychologist, Clinical Social Worker
CO	Colorado	N			Y	AOD Assess (99408, 99409) - SBIRT program.	MD, PA, ANP, Clinical Psychologist, Clinical Social Worker
CT	Connecticut	N			Y	90804 - 90815 (90805, 90807, 90809, 90811, 90813, 90815 MD, APRN only)	MD, APRN, Psychologist, IPBHP (includes LCSW, LMFT, LPC, and Licensed Alcohol and Drug Counselor LADC)
DE	Delaware	Y	96150, 96151, 96152, 96153, 96154, 96155. T1015	Clinical Psychologist, Clinical Social Worker	Y	90804 - 90815, 90847, 90853, 90857. Clinical Psychologist, Clinical Social Worker 90804, 90806, 90808, 90810, 90812, 90814 only.	MD, PA, NP, Clinical Psychologist, Clinical Social Worker

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FL	Florida	N			Y	90804 - 90815, 90847, 90853, 90857, H0004	MD, PA, APNP with Psychiatric Specialty, Licensed Clinical Psychologist, Licensed Clinical Social Worker
GA	Georgia	Y	90801, 90802, 90804 - 90814, 90846, 90853	Psychologist or LCSW	N		
HI	Hawaii	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, PA, APRN, Clinical Psychologist, Clinical Social Worker	Y	90804 - 90815 (Exclude 90808, 90809, 90812 & 90815. 90805, 90807, 90809, 90811 MD only.)	MD, PA, APRN, Clinical Psychologist, Clinical Social Worker
ID	Idaho	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	N		
IL	Illinois	N			Y	90804 - 90815, 90847, 90853, 90857	MD, PA, NP, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Clinical Professional Counselor (LCP, LCSW, LCPC)
IN	Indiana	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, PA, NP, Ph.D., LCSW	Y	MD, PA, NP, Ph.D., LCSW	90804 - 90815, 90847, 90853, 90857. Ph.D & LCSW 90804, 90806, 90808. 90810, 90812, 90814 only.
IA	Iowa	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, PA, NP	Y	90804 - 90815, 90847, 90853. Clinical Psychologist, Clinical Social Worker 90804, 90806, 90808, 90810, 90812, 90814 only	MD, PA, NP, Clinical Psychologist, Clinical Social Worker
KS	Kansas	Y	96150 Assessment	MD, PA, ARNP, Clinical Psychologist, Clinical Social Worker	N		

KY	Kentucky	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int.	MD, ARNP, Licensed Clinical Psychologist, Licensed Clinical Social Worker	N		
LA	Louisiana	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, PA, CNP, Psychologist, LCSW	Y	90804 - 90815, 90847, 90853, 90857	MD, PA, CNP, Psychologist, LCSW
ME	Maine	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient	MD, PA, APRN, Clinical Psychologist, Clinical Social Worker, Licensed Clinical Professional Counselor	N		
MD	Maryland	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int.	MD	Y	90804 - 90815, 90847, 90853, 90857, AOD Group, IOP Services	Certified Addictions Counselor (CAC)
MA	Massachusetts	N			Y	90804, 90806, 90847, 90849 & 90853	Psychiatrist, Psychiatric Nurse, Counselor, Psychologist, LICSW, LCSW, LSWA, LMHC, Licensed Alcohol and Drug Abuse Counselor LADAC I&II
MI	Michigan	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, BH Screening, BH Counseling, AOD Group, IOP Services	?
MN	Minnesota	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient	Physician, APN, CNS-MH, LICSW, LLP, LPCC, LP	N		
MS	Mississippi	N			N		
MO	Missouri	N			Y	90804 - 90815, 90847, 90853, 90857	Qualified Substance Abuse Professional (QSAP). See Missouri billing sheet for details.

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MD, PA, NP

MT	Montana	Y	96150 Assessment	MD, PA, NP	Y	AOD Assess (99408, 99409)	MD, PA, NP, Licensed Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC)
NE	Nebraska	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess [90804, 90805, 90807, 90808, 90809, 90847HF 90853 only, H0001, H0001 52]	MD, PA/APRN, Psych, Prov. Psych, LIMHP, LMHP, PLMHLP, RN, LADC (Licensed Alcohol and Drug Counselor), PLADC (Provisional Licensed Alcohol and Drug Counselor)
NV	Nevada	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient	MD, PA, ANP, Clinical Psychologist, Clinical Social Worker	Y	90804 - 90815, 90847, 90853, 90857	MD, PA, ANP, Clinical Psychologist, Clinical Social Worker
NH	New Hampshire	N			N		
NJ	New Jersey	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	Physician, Psychologist, LCSW	N		
NM	New Mexico	Y	96150 Assessment, 96151 Reassessment	Licensed Clinical Psychologist	Y	90804 - 90815, 90847, 90853, 90857	Psychiatrist, Psychologist, Licensed Psychiatric Nurse Psychiatrist, Psychologist, Licensed Psychiatric Nurse, Licensed Independent Social Worker, Licensed Professional Mental Health Counselor, Licensed Marriage and Family Therapist
NY	New York	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	Non-physician mental health practitioners	Y	90804 - 90815, 90847, 90853, 90857	MD, APN, PA, LCSW

NC	North Carolina	Y	96150 Assessment, 96151 Reassessment	MD, APN	Y	90804 - 90815, 90847, 90853, 90857	MD, APN, APPCNS, Licensed Psychologists, LCSW
ND	North Dakota	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, PA, NP, Clinical Psychologist	Y	90804 - 90815, 90847, 90853, 90857	MD, PA, NP, Clinical Psychologist
OH	Ohio	N			Y	90804 - 90815, 90847, 90853, 90857	MD, PA, APN, licensed Psych, licensed CSW
OK	Oklahoma	N			Y	90804 - 90815, 90847, 90853, 90857	LPHP, CADC Certified Alcohol and Drug Counselor
OR	Oregon	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int.	MD, NP	Y	90804 - 90815, 90847, 90853, 90857. Also 90849	MD, licensed providers. See Oregon billing sheet for more info.
PA	Pennsylvania	N			Y	90804 - 90815, 90847, 90853, 90857	MD, PA, CRNP, LCSW
RI	Rhode Island	N			N		
SC	South Carolina	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient	MD, PA, ANP, Clinical Psychologist, Clinical Social Worker	N		
SD	South Dakota	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient	MD, PA, ANP, Clinical Psychologist, Clinical Social Worker	N		
TN*	Tennessee*						
TX	Texas	N			?	?	?
UT	Utah	N			N		

VT	Vermont	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient	MD, PA, NP, Clinical Psychologist	N		
VA	Virginia	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	Y	90804 - 90815, 90847, 90853, 90857, AOD Assess	MD, PA, NP, Clinical Psychologist, Clinical Social Worker
WA	Washington	N			Y	90804 - 90815, 90847, 90853, 90857	MD, Psychologist, Clinical Social Worker
WV	West Virginia	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	Licensed Clinical Psychologist, Licensed Clinical Social Worker	N		
WI	Wisconsin	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	UA, UB HP, HO. See Wisconsin billing sheet for more info.	Y	90804 - 90815, 90847, 90853, 90857	UA, HP, HO. See Wisconsin billing sheet for more info.
WY	Wyoming		96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	Y	90804 - 90815, 90847, 90853, 90857, AOD Assess	MD, PA, APNP, Clinical Psychologist, Clinical Social Worker

Billing Codes (CMHCs)

State		CMHC			CMHC		
		HBAI	Codes	Credential	SUD	Codes	Credential
AL	Alabama	N			Y	90804 only (All Substance Abuse Codes must use "HF" modifier.) 90847, 90853 (Exclude 90857)	Physician MD or DO, Physician Assistant PA, Licensed Psychologist Ph.D., Licensed Certified Social Worker LCSW, Licensed Professional Counselor LPC, Licensed Marriage & Family Therapist LMFT, Certified Registered Nurse Practitioner CRNP, Psychiatric Registered Nurse PRN, Master's Level Therapist MA, Certified Substance Abuse Professional CSAP
AK	Alaska	N			Y	See Alaska billing sheet. CMHC must be separately approved by the Alaska Division of Behavioral Health to provide Substance Abuse Rehabilitation services.	Physician, Psychologist, MHPC. Licensed Substance Abuse Counselor.
AZ	Arizona	N			Y	90804-09, 90804, 90806, 90808 (90804, 90806, 90808 only if Medicare paid). AOD Assess, BH Screening, BH Counseling, AOD Group, IOP Services.	MD, Psych, PA, ANP, DO, LCSW, LMFT, LPC (MH); Licensed Independent Substance Abuse Counselor (LISAC-for some codes)

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AR	Arkansas	N			Y	H2019, H0005, T1006, H0001, H0047	Certified Division of Behavioral Health Services (DBHS) professional Substance Abuse Treatment Services (SATS) provider, including credentials: MD, DO, APN, PhD, PsyD, EdD, LADAC (Licensed Alcoholism and Drug Abuse Counselor), ACADC (Advanced Certified Alcoholism and Drug Abuse Counselor), CCDP-D (Certified Co-Occurring Disorder Professional - Diplomate Level), LCSW, LMSW, LPC, LMFT, LAC, LPE-I, LPE
CA	California	N			Y	90804 - 90815. 90805, 90807, 90809, 90811, 90813, 90815 Psychiatrist only. 90853.	Psychiatrist, Psychologist
CO	Colorado	N			Y	H0001, H0004, H0005	MD, NP, LAC, LCSW, LMFT, LPC, Licensed Psychologist, Certified Addictions Counselor (CAC I, CAC II, CAC III)
CT	Connecticut	N			Y	90804 – 90815, 90847, 90853, 90857, IOP Services, H0020 (AOD Services)	MD, APRN, Psychologist, IPBHP (includes LCSW, LMFT, LPC, and Licensed Alcohol and Drug Counselor LADC)
DE	Delaware	N			Y	90806, 90847, 90853, 90857	MD, PA, NP, Mental Health Clinician, Counselor I, Counselor II. See Delaware billing sheet for more information.
FL	Florida	Y	96150, 96151, H0031 HO, H0031 TS	Master's Level Practitioner. See Florida billing sheet for more information.	Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, BH Screening, BH Counseling, AOD Group	MD, All Qualified Practitioners (Master's/Bachelor's). See Florida billing sheet for more information.

GA	Georgia	Y	96150, 96151, 96152, 96153, 96154, 96155	Practitioner Levels 2, 3, 4 designated as U2, U3, U4. See Georgia billing sheet for more information.	Y	90853, AOD Assess, BH Screening, BH Counseling, AOD Group, IOP Services, AOD Services, Ambulatory Detox, Group BH Counseling and Therapy, Family Skills Training and Development, Crisis Intervention Service, Psychological Testing, Service Plan Development	Practitioner Levels 1-5. See Georgia billing sheet for more information.
HI	Hawaii	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	Qualified Mental Health Professional (QMHP), Mental Health Professional (MHP). See Hawaii billing sheet for more information.	Y	90804 - 90815. 90805, 90807, 90809, 90811, 90813, 90815 MD only. 90847, 90853, 90857, IOP Services.	Qualified Mental Health Professional (QMHP), Mental Health Professional (MHP). See Hawaii billing sheet for more information.
ID	Idaho	N			Y	90804 - 90815, 90847 only, AOD Assess, AOD Group	Qualified Substance Abuse Treatment Professional (QSATP). See Idaho billing sheet for more information. Includes Alcohol and drug counselor certified by the Idaho Board of Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC)
IL	Illinois	N			N		
IN	Indiana	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int.	Physicians (MD), Advanced Practice Psychiatric Nurse (APPN), Licensed Psychologist (Ph.D.), Licensed Clinical Social Worker (LCSW), Licensed Marriage & Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC), MA level therapist.	Y	90804 - 90815, 90847, 90853, 90857, BH Screening, BH Counseling, AOD Group, IOP Services, 90801 - 90819, 90821 - 90824, 90826 - 90829, 90845, 90847, 90853, 90857, 90865, 96101, 90862, Crisis Services (limitations apply)	MD, APPN, Ph.D, LCSW, LMFT, LMHC, MA, LP (Licensed Professional), QBHP (Qualified Behavioral Health Professional), OBHP (Other Behavioral Health Professional). See Indiana billing sheet for more information.
IA	Iowa	N			N		

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KS	Kansas	N			Y	AOD Assess, BH Counseling, AOD Group, IOP Services	LMHP
KY	Kentucky	N			N		
LA	Louisiana	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, BH Counseling, AOD Group	Requires face to face by Psychiatrist, Licensed Mental Health Professional (LMHP) can do assessment; APRN, CNS, or NP can do initial assessment but must obtain psychiatrist's signature. MHP under LMHP supervision.
ME	Maine	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, IOP Services	MD, APRN, LADC (Licensed Alcohol and Drug Counselor), CADC (Certified Alcohol and Drug Counselor), LCSW, LCPC, LMFT
MD	Maryland	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int.	MD	N		
MA	Massachusetts	N			N		
MI	Michigan	N			Y	90804 - 90815, 90847, 90853, 90857	?
MN	Minnesota	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	Physician, APN, CNS-MH, LICSW, LLP, LPCC, LP	N		
MS	Mississippi	N			N		

MO	Missouri	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, AOD Group	Qualified Substance Abuse Professional (QSAP). See Missouri billing sheet for details.
MT	Montana	Y	96150 Assessment	MD, PA, NP	Y	AOD Assess (99408, 99409)	MD, PA, NP, Licensed Psychologist, LCSW, LPC
NE	Nebraska	N			Y	90804, 90806, 90808, 90847, 90853, AOD Assess, AOD Group, IOP Services (Facility setting only)	MD, PA, APRN, Psych, Prov. Psych, LIMHP, LMHP, PLMHP, RN, LADC
NV	Nevada	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient	QMHP. See Nevada billing sheet for more information.	Y	90804 - 90815, 90847, 90853, 90857, BH Screening, BH Counseling, IOP Services	QMHP, QMHA. See Nevada billing sheet for more information.
NH	New Hampshire	N			N		
NJ	New Jersey	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	Physicians, Psychologists and state licensed Master's level clinicians	Y	90804 - 90815, 90847, 90853, 90857, AOD Group	Physicians, Psychologists and state licensed Master's level clinicians
NM	New Mexico	N			Y	90804 - 90815, 90847, 90853, 90857	Psychiatrist, Psychologist, Licensed Clinical Nurse Specialist, Licensed Independent Social Worker, Licensed Professional Mental Health Counselor, Licensed Marriage and Family Therapist. Some codes can also be provided by Licensed Master Level Social Worker, Licensed Psychologist Associate, Licensed Alcohol and Drug Abuse Counselor and other Licensed Master's Level Counselor.

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NY	New York	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, BH Counseling. Also 90846 and 90849	Licensed Creative Arts Therapist, Licensed; MD/NPP, Psych, LMSW, LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalyst; Psychiatrist/NPP or PA with specialized training approved by OMH
NC	North Carolina	Y	96150 Assessment, 96151 Reassessment	MD, APN	Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, BH Screening, BH Counseling, AOD Group	MD, CNP, Licensed Psych., LPA, LCSW, LPC, LMFC, CNP, CCNS, LCAS (Licensed Clinical Addictions Specialist), CCS (Certified Clinical Supervisor)
ND	North Dakota	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	MD, Psychiatrist, Psychiatric Nurse, Clinical Psychologist	Y	90804 - 90815, 90847, 90853, 90857	MD, Psychiatrist, Psychiatric Nurse, Clinical Psychologist, Licensed Addiction Counselor, Licensed Clinical Social Worker
OH	Ohio	N			Y	90804 - 90815, AOD Assess, BH Counseling, AOD Group, IOP Services, Laboratory Urinalysis, Medical/Somatic, Methadone Administration, Ambulatory Detoxification, Crisis Intervention	Qualified practitioner practicing in ODADAS certified Treatment Program. See Ohio billing sheet for more info.
OK	Oklahoma	N				90804 - 90815, 90847, 90853, 90857, AOD Assess, BH Screening, BH Counseling, AOD Group	LPHP, CADC Certified Alcohol and Drug Counselor
OR	Oregon	N			Y	90847, 90853, 90857, AOD Assess, BH Screening, BH Counseling, AOD Group	Physicians, Licensed Providers (CADAC). See Oregon billing sheet for more info.

PA	Pennsylvania	Y	96151 Reassessment	?	?	?	?
RI	Rhode Island	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, BH Counseling, AOD Group, IOP Services	Physician, Psychiatric RN, Licensed Psychologist, Licensed Independent Social Worker, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, Licensed Chemical Dependency Counselor, Certified Co-Occurring Disorder Professional
SC	South Carolina	N			N		
SD	South Dakota	N			N		
TN*	Tennessee*						
TX	Texas	N			?	?	?
UT	Utah	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, BH Counseling	LMHT, Licensed Substance Abuse Counselor, Certified Substance Abuse Counselor, Certified Substance Abuse Counselor intern. Licensed Social Service Worker, Licensed, Registered Nurse, Licensed Practical Nurse, Licensed Substance Abuse Counselor, Certified Substance Abuse Counselor, Certified Substance Abuse Counselor intern.
VT	Vermont	N			N		
VA	Virginia	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, IOP Services	LMHP, Qualified Substance Abuse Professional (QSAP), Licensed Substance Abuse Treatment Practitioner

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WA	Washington	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess	MD, PA, ARNP, CDP, MHC, MFT, MSW, Psychologist
WV	West Virginia	N			Y	90804 - 90815, 90847, 90853, 90857, BH Screening, BH Counseling, AOD Group	Professionally Trained & Licensed Staff (PTLS), Non-Professional Staff (NPS). See West Virginia billing sheet for more info.
WI	Wisconsin	Y	96150 Assessment, 96151 Reassessment, 96152 Individual Int., 96153 Group Int., 96154 Family+Patient, 96155 Family w/o Pt	UA, UB HP, HO. See Wisconsin billing sheet for more info.	Y	90804 - 90815, 90847, 90853, 90857, AOD Group	UA,HP,HO+HN. See Wisconsin billing sheet for more info.
WY	Wyoming	N			Y	90804 - 90815, 90847, 90853, 90857, AOD Assess, AOD Group	Psychiatrist, NP, Advanced Practice Psychiatric Nurse (APPN) Psychologist, Licensed Professional Counselor (LPC), Provisional Professional Counselor (PPC), Certified Addictions Practitioner (CAP), Licensed Addictions Therapist (LAT), Provisionally Licensed Addictions Therapist (PLAT), Licensed Clinical Social Worker (LCSW), Certified Social Worker (CSW), Marriage & Family Therapist (MFT), Provisionally Licensed Marriage & Family Therapist (PMFT)

*Contact the State Medicaid Office (Tennessee)

Training Materials

Please visit this website for training materials:

<http://uclaisap.org/Affordable-Care-Act/html/workforce-development.html>