# California Mental Health and Substance Use System Needs Assessment and Service Plan

**Volume 2: Service Plan**
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# 1. Introduction

Early in 2011, The California Department of Health Care Services (DHCS) contracted with the Technical Assistance Collaborative (TAC) and the Human Services Research Institute (HSRI) to conduct a *Mental Health and Substance Use System Needs Assessment* *(Needs Assessment)* as well as prepare a *Mental Health and Substance Use Service Plan* *(Service Plan)* for California's Medi-Cal program.[1] This needs assessment and plan for implementation was carried out under the Special Terms and Conditions of California's Bridge to Reform 1115 waiver, in anticipation of the expansion of Medicaid coverage for uninsured adults in 2014.

California has a decentralized public mental health and substance use disorders delivery system with most direct services provided through county systems. County Mental Health Plans (MHPs) have primary funding and programmatic responsibilities for the majority of Medi-Cal mental health programs, and Drug Medi-Cal (DMC) covers most Medi-Cal substance use service programs. Stakeholders have pointed out the bulk of funding at the county level for public SUD prevention and treatment services currently comes from the Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) , one of the largest in the nation and principally administered at the county level. County and state general revenues filtered through the counties also provide some substance use disorder (SUD) services funding in the counties. For mental health, counties administer Mental Health Services Act (MHSA) funding and the federal Mental Health Block Grant as well as the Medi-Cal Specialty Mental Health Program. Stakeholders have acknowledged that current funding proportions may shift as the state's 1115 waiver and full Affordable Care Act (ACA) implementation and expansion begin to cover more Medi-Cal eligible SUD beneficiaries. However, those proportions will depend on who enrolls in Medi-Cal expansion and who amongst these enrollees is assessed as needing mental health and/or substance use disorder services.

The primary purpose of the needs assessment was to review the statewide needs and service utilization patterns of current Medi-Cal recipients at a specific point in time in the current delivery system, and to identify the most prominent opportunities to prepare California's Medi-Cal programs for the expansion of enrollment and increased demand for mental health and substance use services resulting from health care reform and the implementation of the ACA. The needs assessment included analysis of the state's data including California Outcome Measurement Service and Treatment (CalOMS Tx[2] ) and Client and Service Information (CSI[3] ) data as well as Medi-Cal claims data. Interviews were conducted with over 140 key stakeholders, and over 100 documents related to California's mental health and substance use systems were reviewed.

This broad assessment and analysis of mental health and substance use participants, providers, stakeholders and systems was conducted with an awareness that the Medi-Cal program is interconnected with many other systems of services and funding sources in California (e.g., MHSA, federal Mental Health Block Grant, SAPT Block Grant, realignment

[1] This project received substantial support from the California Endowment.
[2] California Department of Alcohol and Drug Programs *Outcome Measurement System*
[3] California Department of Mental Health *Client and Services Information System*

funds etc.) and that Medi-Cal mental health and substance use service consumers interact with and rely upon resources in these other systems of care, as well as those to be added through the Medi-Cal expansion. This specific project focused on fulfilling the special terms and conditions of the Medi-Cal expansion waiver, and did not seek to quantify the total resources needed to meet California's total need for mental health and substance use disorder services. The focus of this effort was specifically to look at the portion of the delivery system that provides services reimbursed through Medi-Cal.

The needs assessment phase of this project, which was the first of two components (Volume 1), was completed with the March 1st, 2012 submission to CMS of the document formally titled ***California Mental Health and Substance Use System Needs Assessment***. The Executive Summary of the ***California Mental Health and Substance Use System Needs Assessment*** is included in Appendix B to this report. The *Needs Assessment* report summarized information from the quantitative data analyses and qualitative information collection activities noted above. The report also summarized national and California based state-of-the-art information related to topics of importance to the overall quality and effectiveness of mental health and substance use services in the context of health reform. These topics included:

1. Mental health and substance use prevalence;
2. Characteristics and size of the Medi-Cal expansion population;
3. Strategies for more effectively reaching and serving special populations;
4. Commentary on provider capacity and workforce analysis issues;
5. The importance of health integration; and
6. Mental health and substance use Information technology issues

Much of the information contained in the *Needs Assessment* is currently being used by both state and county policy makers to support broad scale system wide mental health and substance use services planning as part of the statewide reorganization and realignment of mental health and substance use services and responsibilities, as well as statewide and county specific efforts to prepare for ACA implementation.

TAC/HSRI were tasked with using the information from the *Needs Assessment* in concert with input from partners and stakeholders to develop a mental health and substance use *Service Plan* that would provide a high level overview focused specifically on the implementation of specialty mental health and substance use services for the Medi-Cal coverage expansion population starting in 2014.[4]

The *Service Plan*, which follows the *Needs Assessment* and is the second component (Volume 2), builds on the extensive analysis provided in the *California Mental Health and Substance Use Needs Assessment* that was provided as required to CMS as part of the STCs. For a more in depth analysis of many of the issues related to mental health and substance use disorder needs in California, the entire *Needs Assessment* Report and attachments are available at:

[4] Note: individuals may begin seeking coverage and selecting among coverage options through the California Health Benefit Marketplace in October 2013. More importantly, the LIHP coverage expansion in the Bridge to Reform waiver continues to be expanded, and uninsured adults may continue to be enrolled in LIHP prior to 2014. Over 500,000 previously uninsured individuals are already enrolled in these LIHP plans.

http://www.dhcs.ca.gov/provgovpart/Documents/1115%20Waiver%20Behavioral%20Health%20Services%20Needs%20Assessment%203%201%2012.pdf

The purpose of the *Service Plan* is to provide an overview and description of the key elements of the plan whereby DHCS for the State of California, counties and other entities in and outside state government, in partnership with the federal government, will ensure an effective and successful transition to enroll and serve the Medicaid expansion population in the Medi-Cal program.

As noted above, many of the details related to implementation and monitoring of the Medi-Cal services for these populations will be affected by discussions and decisions related to systems of care funded by sources other than Medi-Cal. The *Service Plan*, therefore, should be seen as simply one among many important sources of information that will help guide DHCS and other state and county units of jurisdiction as they coordinate multiple federal, state and county funding streams in order to meet the needs of California citizens for mental health and substance use services.

Specifically, this *Service Plan* report is intended to address the following six elements:

1. Mental health and substance use benefit design and delivery systems for the Medi-Cal expansion population
2. Utilization and costs of mental health and substance use services over multiple years for the Medi-Cal expansion population and the assumptions used to generate those estimates;
3. State and county engagement and enrollment strategies for expansion population members with mental health and substance use service needs;
4. Implications for provider network capacity and workforce development;
5. Strategies for integration of  health, mental health and substance use services
6. Performance measurement, quality enhancement and health information technology recommendations and strategies for Medi-Cal mental health and substance use services.

## Stakeholder input

The process leading up to the completion of this report has involved many iterative steps and interactions with state program leaders, county business partners, stakeholders, legislative staff, consultants and contractors participating in the broader planning for health reform and coverage expansion in California.  Extensive partner and stakeholder input has reinforced to DHCS the importance of such engagement and input on a regular basis.

One of the strengths of California's system has been stakeholder involvement and continued stakeholder participation at both the State and County levels remains vital.  However, DHCS recognizes that the current development and implementation efforts have put considerable stress on existing stakeholder engagement strategies and the Department is committed to improving this area of its responsibilities. The Department recognizes the importance of a robust stakeholder engagement process as the need to include stakeholders at all levels continues and evolves in the fast paced and often confusing environment of health care reform.

In reviewing the draft *Service Plan*, several organizations suggested the creation of different types of new Department advisory groups. One was the creation of a Technical Advisory Group on SUD services for DHCS. Another was the merging of the mental health and substance use disorder advisory groups into a state Behavioral Health Advisory Council. As it evaluates strategies for ongoing input and stakeholder engagement going forward, the Department believes these recommendations are worthy of more discussion and is assessing how best to develop and coordinate all the various stakeholder forums in the relatively recently reorganized and realigned environment.

Regardless of the forum, it is clear that mental health and substance use disorder staff within DHCS and the counties should continue strategies at both the state and county levels that engage people with mental health and substance use service needs and their providers and advocate organizations leading up to and following coverage expansion in 2014.[5]

The state, through DHCS, will be addressing stakeholder/partner communications and engagement, through a variety of ongoing forums, one of the newest under consideration being a DHCS-County Partnership forum. DHCS will be working in consultation with The California Institute for Mental Health (CiMH) and the Alcohol and Drug Policy Institute (ADPI) as well as their partners, the California Mental Health Director's Association (CMHDA), the County Alcohol and Drug Program Administrators Association of California (CADPAAC) and the California State Association of Counties (CSAC) to evaluate and prioritize a variety of fiscal, policy and service delivery recommendations that were identified in an extensive stakeholder process and published in a recent (June 2013) report: *Stakeholder Recommendations for Mental Health and Substance Use Disorder Services: Presented to the California Department of Health Care Services and Its County Partners - June 2013.* This report has become known as the '*business plan*".

The goal is that the DHCS work with county partners and stakeholders to develop effective and ongoing forums for facilitating stakeholder input on a regular basis. Ensuring clear points of contact (as well as re-evaluating periodically for effectiveness) will be an important strategy to assure stakeholder issues and recommendations receive effective attention.

## Analytic approach

Several possible approaches to provide mental health and substance use services to the Medi-Cal expansion population were considered and compared on the way to reach agreement between state and county leadership as to how California will move forward. These analyses are discussed in greater detail in Sections 2 and 3 of this report.

Decisions about the mental health and substance use benefit design and enrollment process were also made in the context of the development of the physical health benefit design and the implementation of other elements of ACA for Medi-Cal recipients.

These other contextual ACA issues include:

[5] Note: enrollment activities are planned to commence in October, 2013.

- Inclusion and definition of the ten categories of essential health benefits (EHBs)

- Selection of a qualifying reference plan (benchmark plan) to compare to the current Medi-Cal benefit design for the ten essential health benefits;

- Assessment of consistency with health benefit decisions and access models under the California Health Benefit Exchange (Covered California);

- Assessment of federal mental health and substance use parity requirements (MHPAEA) as they relate to California's carve out system for specialty mental health and Drug Medi-Cal services.

Because of the importance of integrating mental health and substance use service planning with the overall physical health and ACA implementation planning effort, TAC and HSRI have worked closely with DHCS and its general health consultants to analyze options and adopt approaches that are consistent across all elements of the coverage expansion under ACA. This report has benefitted from the input and guidance of DHCS and the other consultants.

## 2. Recommended Benefit Design and Delivery System

California has elected to provide for all of the Medi-Cal populations (current and expansion) the current Medi-Cal mental health and substance use disorder benefits with the addition of any benefits covered by Kaiser Small Group that are not currently provided by Medi-Cal. These covered benefits are for all eligible Medi-Cal populations and not just the newly eligible. Additional benefits based on the Kaiser benefit design are:

1. individual and group mental health evaluation and treatment (psychotherapy)
2. psychological testing when clinically indicated to evaluate a mental health condition
3. outpatient services for the purposes of monitoring drug therapy
4. outpatient laboratory drugs, supplies and supplements
5. psychiatric consultation to non-specialty benefits

These covered benefits also include the expansion of these three substance use benefits:

1. Intensive Outpatient Treatment (Day Care Rehabilitation) will be provided to the full population rather than the current pregnant/postpartum restrictions
2. Residential Substance Use Disorder Services will be provided to the full population rather than the current pregnant/postpartum restrictions
3. Elective Inpatient Detox will no longer be restricted to the current requirements and limitations

For the delivery of services to the Medi-Cal expansion population, California has decided to use its existing delivery systems, with specialty mental health and Drug Medi-Cal benefits primarily administered through the counties. DHCS recognizes the important role that primary care settings (especially the community clinics, health centers including FQHCs and Federally Qualified Health Center lookalikes) play in providing points of access for mental health and substance use disorder services and how the state, county, managed care plans and these primary care access points can collaborate to provide more effective and efficient care.

Non-specialty mental health services, which are not covered by county mental health plans under the specialty mental health services waiver, will be covered by the existing Medi-Cal managed care plans. The expanded substance use disorder (SUD) benefits will utilize the existing county-based delivery systems. The state General Fund will pay the nonfederal share of the expanded SUD benefits for all populations (current, mandatory expansion and optional expansion). DHCS will be working closely with county partners (CMHDA, CADPAAC, CSAC), providers and stakeholders to clarify the roles/responsibilities and other details related to these decisions and how they are implemented.

Some of the important and yet to be finalized implementation decisions include:

- Developing and conducting plan readiness assessments
- Developing contract amendments
- Developing regulations
- Developing and implementing IT systems changes/adjustments
- Considering the feasibility of a waiver for an organized delivery system for Drug Medi-Cal
- Defining precisely benefits, services, eligibility criteria, responsibilities, referral processes QA and UR plans and processes etc.
- Conducting ongoing stakeholder meetings
- Submitting and negotiating SPAs and possible waivers and waiver amendments with CMS
- Developing and vetting reimbursement rates
- Revisit and amend Memorandums of Understanding (MOUs) between county mental health plans and Medi-Cal managed care plans

The Department believes clear delineation of roles/responsibilities and clinical referral criteria between specialty and non-specialty systems and services are essential to ensure quality beneficiary referral and coordination experiences and minimize and avoid confusion and fragmentation.

It should also be noted (and was reinforced by stakeholder input in various forums), that the Duals project (*CalMediConnect*) may actually represent California's future direction. The emphasis on closer coordination between the MHPs and the managed care plans, support for bi-directional integration and co-location of staff; support for strengthening mental health and substance use disorder screening and assessment in the primary care arena; and better connections between prevention and early intervention programs was repeatedly emphasized by stakeholders.

To reach core benefit and delivery system decisions, California worked with TAC, HSRI and various consultant groups to assess various Medicaid benefit options as required by the Patient Protection and Affordable Care Act (ACA) for the newly eligible optional expansion in 2014.

The Administration and Legislature, in consultation with county partners and stakeholders, assessed coverage among Medicaid benefit options. DHCS developed cost estimates, all in the service of providing California decision makers information regarding the multiple Medicaid benefit options as well as supporting the dialogue with the Legislature, counties and stakeholders regarding what benefit and delivery systems California should choose.

## Overview of the Benefit Design to be Implemented

In determining the benefit recommendations, one of the key documents was the *Medicaid Alternative Benefit Plan (ABP) Options Analysis* prepared by Mercer for the California HealthCare Foundation (CHCF) and The California Endowment, with technical assistance from the Department of Health Care Services (DHCS). In carefully considering various options, this

document, sent to CMS on April 1st, 2013, was an essential work product and a key source of information for decision makers.

The Mercer options analysis document compared current Medi-Cal mental health and substance abuse benefits[6] to three selected reference plans:

- Anthem Choice
- Kaiser Traditional
- Blue Cross Blue Shield Standard

Mental health and substance use benefits in each of these reference plans were cross-walked with the current Medi-Cal plan,[1] this approach enabled California to estimate the service level and total annual costs for 2014 through 2020 strictly for comparison purposes and based on the maximum need assumptions listed in the Needs Assessment. Table I below summarizes the total cost projections for benefit levels in each reference plan using assumptions from the Needs Assessment of March, 2012. (The assumptions used and methodology for conducting the cost comparisons among the reference plans in Table I below are different (higher) from this report's Appendix A. Appendix A includes estimates that were agreed upon in the 2013 Budget Act and contains assumptions of utilization based on past observed Medi-Cal utilization among current populations, which is significantly lower.)

**Table I: Summary Analysis of Estimated Total Mental Health and Substance Use Services of the Reference Plans Compared to Current Medi-Cal benefits**

| Calendar Year | Current Medi-Cal Grand Total | Anthem Choice Grand Total | Kaiser Traditional Grand Total | BCBS Standard Grand Total |
|---|---|---|---|---|
| 2014 | $507,036,718 | $420,035,832 | $505,803,951 | $503,544,804 |
| 2015 | $542,334,274 | $449,276,788 | $541,015,688 | $538,899,049 |
| 2016 | $593,086,050 | $491,320,221 | $591,644,069 | $589,329,355 |
| 2017 | $628,636,731 | $520,770,869 | $627,108,316 | $624,654,853 |
| 2018 | $658,470,338 | $545,485,418 | $656,869,388 | $654,299,490 |
| 2019 | $685,760,276 | $568,092,759 | $684,092,975 | $681,416,569 |
| 2020 | $706,333,084 | $585,135,541 | $704,615,764 | $701,859,066 |

As a result of these comparisons and invaluable input from the Legislature, counties, providers, stakeholders and other key partners, California has decided that all full scope Medi-Cal beneficiaries including the expansion population will receive the same schedule of mental health and substance use disorder benefits.

The projected increase in services has raised concerns that the Medi-Cal expansion and the expansion of certain Medi-Cal benefits will increase demand beyond current capacity, which in turn could increase pressure on provider pay scales. Capacity limits could present significant access challenges in some regions of the state. This is a difficult factor to accurately predict, and the state will monitor this issue with county and managed care partners during the implementation.

[6] Referred to as the "Secretary's Approved Option" in the document
[1] Credit is due to Mercer for collecting information from the reference plans and creating the service crosswalk template and analysis.

### *MENTAL HEALTH BENEFITS: Medi-Cal Specialty Mental Health Services (SMHS)*

Today, under the provisions of our Title 42, Section 1915(b) "*freedom of choice"* waiver covering the mandatory enrollment of eligible Medi-Cal beneficiaries, these individuals receive specialty mental health and specified emergency and hospital services through the county Mental Health Plans (MHPs). California's county MHPs are considered prepaid inpatient health plans (PIHPs) because they are responsible for assuring 24 hour, seven day/week access to emergency, hospital and post-stabilization care for the covered psychiatric conditions for Medi-Cal beneficiaries.

In addition, California has two approved state plan amendments (SPA) that increase the scope of rehabilitative outpatient, crisis, residential and inpatient mental health coverage provided to Medi-Cal beneficiaries, when medically necessary, by the MHP. The first, which was updated and approved by CMS in December 2010, covers targeted case management for persons with mental illness. The second, which was updated and approved by CMS in October 2010, covers mental health services available under the Rehabilitation Option, broadening the range of personnel and locations that were available to provide services to eligible beneficiaries. MHPs are also subject to Title 42, Part 438 Managed Care requirements which specify additional access, beneficiary protection and quality management requirements that the MHP must conform to. Furthermore, both federal and state law specify that there is to be a contract between the state and the MHP specifying the conditions under which the managed care program will operate. The regulations and contract also specify requirements for the coordination of health and mental health treatment between the county and the state contracted health plans, including that a Memorandum of Understanding (MOU) be in place between the county and each health plan specifying the process for timely referral and treatment.

California will provide both specialty mental health and managed care mental health benefits to the expansion population through the current county-based delivery system and through the current managed care system.[7] In doing so, counties will continue to provide or arrange for the provision of specialty mental health services that meet medical necessity criteria under a waiver of federal Medicaid law.

The twelve key specialty mental health benefits are:

1) Psychiatric Hospital Inpatient Services: provided in an acute psychiatric hospital or the distinct acute psychiatric portion of a general hospital that is approved by the Department to provide psychiatric services.

2) Therapy and Other Service Activities: include assessments, plan development, individual or group therapies and interventions, and collateral services.[8]

[7] In certain parts of the state historically, where there was not Medi-Cal managed care, these services were available through the Medi-Cal fee for service program.

[8] It should be noted that to the extent "*behavioral health treatment*" services are considered mental health services pursuant to the EHBs, these services in California are only provided to individuals who receive services through federally approved waivers or state plan amendments which would both need to be pursuant to the Lanterman Developmental Disability Act.)

3) Medication Support Services: include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness.

4) Day Treatment Intensive Services: a structured program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the beneficiary in a community setting; half-day services must be for a minimum of three hours, and full-day services are for more than four hours per day.

5) Day Rehabilitation Services: a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning; half-day services must be for a minimum of three hours, and full-day services are for more than four hours per day.

6) Crisis Intervention Services: last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit; service activities include, but are not limited to, assessment, collateral and therapy.

7) Crisis Stabilization Services: last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit; service activities include but are not limited to assessment, collateral, and therapy.

8) Adult Residential Treatment Services: rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving these services.

9) Adult Crisis Residential Services: provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization.

10) Psychiatric Health Facility: provides acute inpatient psychiatric treatment and serves as an alternative to hospital care; beneficiaries do not have physical health needs (i.e. illness or injury) that could not ordinarily be treated in an outpatient setting.

11) Targeted Case Management: services that help a beneficiary access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

12) Therapeutic Behavioral Services: are intensive, individualized, short term, outpatient treatment intervention for beneficiaries up to age 21 with serious emotional disturbances (SED) and are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan.

### *MENTAL HEALTH BENEFITS: Medi-Cal Managed Care and Fee for Service*

California has now enhanced the managed care benefit and will now provide non-specialty mental health services through Medi-Cal managed care plans and the fee for service program in places where managed care is not available. In addition to mental health services determined to be within the scope of practice of the primary care physician, Medi-Cal managed care plans will also provide mental health benefits covered in the state plan but exclude benefits provided by

county mental health plans under the specialty mental health services waiver. Specifically, individual and group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; outpatient laboratory drugs, supplies and supplements and psychiatric consultation will be available for non-specialty mental health qualifying beneficiaries and psychology services will be more broadly available to qualifying beneficiaries. DHCS will also cover mental health pharmacy benefits for the expansion population as currently required by contracts between DHCS and the Medi-Cal managed care plans.

Many of the implementation details are in the process of being finalized. There are also many suggestions and recommendations about more effective reimbursement strategies under consideration. For example, some stakeholders have raised the idea that rehabilitative services should specifically delineate socialization and club house approaches (e.g., the use of clubhouse models that not only teach socialization skills, move toward employment and provide for a *'connecting glue*,' has implications for planning and benefits), or that reimbursement for behavioral health consultation (and a subset for psychiatric consultation) within the ED and inpatient hospital stay be considered. What can be agreed to, and then can be done immediately (versus longer term) and what will take further consideration, will need to be addressed carefully. In the coming months, DHCS will be working with CMHDA/CADPAAC/CSAC, the Department of Managed Health Care (which regulates managed care plans) and stakeholders to clarify the roles/responsibilities and details related to the implementation of these benefit and delivery system changes as there is no question that clear roles/responsibilities and workflow processes must be established along with a well-defined arbitration process to resolve inevitable disagreements between partners.

### *SUBSTANCE USE DISORDER BENEFITS: Drug Medi-Cal Services (DMC)*

Counties will continue providing Drug Medi-Cal services to the currently eligible Medi-Cal population, however this program will be enhanced for both expansion as well as existing Medi-Cal enrollees. The enhanced substance use disorder (SUD) services of Residential Substance Use Disorders Services and Intensive Outpatient Treatment (currently called Day Care Rehabilitation) will be delivered through county alcohol and drug programs as part of the Drug Medi-Cal program. Inpatient detoxification will be provided through Fee-for-Service (FFS) with county authorization and screening and brief intervention (SBI) will be covered by managed care or FFS in areas where managed care is not available. Thirteen counties do not currently have Drug Medi-Cal. In cases where counties have decided not to provide all or part of the benefit, DHCS will continue to contract directly with providers in the county. Any medication treatments for alcohol or drug dependence not provided through the Drug Medi-Cal formulary are provided through Medi-Cal fee-for-service.

In discussing the overall SUD benefits (more fully described below), some stakeholders recommended that Inpatient Detoxification and Intensive Outpatient Treatment SUD benefits be made available via Medi-Cal providers more generally, not just via DMC providers. It is currently planned that Inpatient Detoxification will be through Medi-Cal FFS providers. However, Intensive Outpatient is planned for delivery through the existing Drug Medi-Cal delivery system.

DHCS is in the midst of a thorough evaluation of Drug Medi-Cal services and the enrollment and monitoring of Drug Medi-Cal providers is currently underway. This recommendation, along with others, will be under consideration during implementation. Key to the decision will be issues of quality, safety and program integrity/accountability. As the benefits are implemented, the Department recognizes the importance of evaluating the current oversight and utilization review tools, especially related to services in the Drug Medi-Cal program. This includes the need to explore the feasibility of a possible waiver for an organized delivery system and approaches to provide stronger oversight and quality control. These program improvements will be developed by DHCS in concert with counties, substance use providers and other stakeholders to address requirements to assure that the substance use benefit for the expansion population as well as the Medi-Cal eligible population meet Federal and state requirements.

The current Drug Medi-Cal program now has the following benefits, eligibility for which will be expanded as described below:[9]

*1) Residential Substance Use Disorder Services (SUD)*

Drug Medi-Cal currently covers residential SUD services only for pregnant and postpartum women. In the new benefit plan this service will be available for all adults in both the current Medi-Cal and the expansion populations. This benefit includes the following services:

- *Intake:* the process of admitting a beneficiary into a SUD treatment program. It includes the evaluation of the beneficiary's current health status regarding the presence of an SUD, diagnosis of the SUD, and the assessment of treatment needs that can include physical exam and lab tests.

- *Individual Counseling:* face to face contacts between a beneficiary and a therapist or counselor.

- *Group Counseling:* face to face contacts in which one or more therapists or counselors treat two or more beneficiary at the same time.

- *Medication Services:* the prescription or administration of medication related to SUD services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services or order laboratory testing.

- *Collateral Services:* face to face sessions with the therapist or counselors and significant persons (not official or professional relationship) in the life of a beneficiary, focusing on the treatment needs of the patient to support the achievement of the beneficiary's treatment goals.

[9] Note: all Drug Medi-Cal services are provided at DMC-certified outpatient substance use disorder clinics under the medical direction of a physician by a qualified substance use disorder counselor. In addition, programs can use psychologists, clinical social workers, marriage and family therapists, or registered interns of the psychology board functioning within the scope of his or her practice.

- *Crisis Intervention:* face to face contact between a therapist or counselor and a beneficiary in crisis, with services focused on alleviating the crisis. Crisis is a relapse or an unforeseen event or circumstance that presents as an imminent threat of relapse. Services are limited to stabilization of the beneficiary's crisis situation.

- *Service Access*: provision of, or arrangement for transportation to and from medically necessary treatment.

- *Beneficiary Education* to reduce harmful effects of alcohol and drugs, and associated life style issues

- *Coordination of ancillary services:* assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent the beneficiary's relapse to substance use.

- *Treatment and Discharge Planning:* preparation of a written plan for treatment based on the information obtained from an individual's intake and assessment processes.

Residential services are provided at licensed alcoholism or drug abuse recovery, treatment, or detoxification facilities that provide 24-hour services in a non-medical residential setting as licensed and certified by DHCS. CDSS licenses children's group homes which may include alcohol and other drug (AOD) services. Services are provided by physicians, psychologists, clinical social workers, marriage and family therapist, a registered intern of the psychology board, or a qualified substance use disorder counselor functioning within the scope of his or her practice as defined in California regulations. If the severity of a client's SUD indicates a residential placement as the most appropriate setting to initiate treatment, this benefit provides the comprehensive set of SUD treatment services and supports within that same setting. This single point of service provision is particularly useful with persons lacking sufficient coping skills within the community and those lacking supportive community living situations that promote successful SUD interventions.

### *2). Outpatient Drug Free Services Program*

Outpatient Drug Free Treatment involves services to stabilize and rehabilitate beneficiaries who have a substance use disorder. Beneficiaries receive at least two group counseling sessions per month every 30 days. Reimbursable group sessions may last 90 minutes. Reimbursement for individual counseling is per session per day and equivalent to 50 minutes in length. Prior authorization is not required except in those cases where EPSDT beneficiaries require services beyond what is listed. DMC services are primarily delivered by the county AOD programs and their sub-contractors and are delivered thru the "*Clinic Service Option*", which requires treatments to be provided in a DMC certified facility. Current regulations for Outpatient Drug Free Services restrict individual counseling unless it is for assessment, treatment planning, crisis intervention or discharge. Many stakeholders were clear that they recommended the Department consider changing this as it was seen as inconsistent with best practice.

The Department also recognizes the phrase “Outpatient Drug Free” is a term that is seen as antiquated and some believe should be eliminated. The Department agrees that this term is outmoded and is open to considering alternatives as part of a number of potential statutory and/or regulatory changes in the areas of substance use disorder services and Drug Medi-Cal treatment.

### *3). Narcotic Treatment Program*

This outpatient program uses methadone (or levoalphacetylmethadol [LAAM] if available and prescribed) as a narcotic replacement drug-when ordered by a physician as medically necessary to alleviate the symptoms of withdrawal from opioids. Services delivered at a licensed NTP clinic include counseling services and medication services to achieve stabilization. A beneficiary must receive a minimum of fifty minutes of face-to-face, counseling sessions with a therapist or counselor per calendar month with a maximum of 200 minutes per month. Admission requires two failed attempts to stop opioid use. Prior authorization is not required and there is no limitation on length of service. Some stakeholders pointed out that this requirement is often waived, but at the expense of time and paperwork, and recent (not yet published) analyses from UCLA show that detoxification has no significant association with subsequent maintenance treatment retention. The recommendation has been made to drop the “*two failed attempts*” requirement. Since the referenced requirement may be waived, the Department believes any discussion about changing the Title 9 and Title 22 requirements should wait until the UCLA analysis is available for review. Stakeholders also continued to advocate for the elimination of state regulations that go beyond federal requirements as being overly burdensome and adding unnecessary costs to the delivery of services. DHCS is open to re-evaluating these and other regulations as it implements the new and expanded benefits.

### *4). Naltrexone for Opioid Dependence*

Naltrexone treatment includes medication administration and counseling services and a minimum of two face-to-face counseling sessions within each 30 day period and is recommended to be used with counseling and social support to help people who are substance free.

Reimbursement for individual counseling is limited to one counseling session per day equivalent to 50 minutes in length. Reimbursement for group counseling is one session per day and equivalent to 90 minutes in length. Naltrexone treatment services do not require a TAR (prior authorization is not required).

### *5). Intensive Outpatient Treatment (Currently called Day Care Rehabilitation)*

While currently limited to pregnant and postpartum women and children and youth under the age of 21, this service is will be opened up for the general adult population in the existing and expansion populations.

This benefit is appropriate as an initial treatment, a step-down or as a transitional treatment after the beneficiary has been detoxified. The provision of intensive therapeutic services, with multiple levels of services and supports is essential to the beneficiary developing a personal treatment plan that will guide the recovery process and help prevent relapse. Allowing for a minimum of three intensive services of substantial length (minimum of three hours) provides an

environment for close monitoring of a beneficiary's status and meets beneficiary needs by providing SUD services and/or other referrals to community based services. The supportive environments of these intensive treatment settings assist care managers in closely tracking the success of a beneficiary in managing community life and their substance use condition.

With Intensive Outpatient treatment, beneficiaries receive treatment services at least three times per week for a minimum of three hours per day. Services consist of:

- *Intake:* the process of admitting a beneficiary into a SUD treatment program. It includes the evaluation of the beneficiary's current health status regarding the presence of an SUD, diagnosis of the SUD, and the assessment of treatment needs including physical exam and lab tests.

- *Individual Counseling:* face to face contacts between a beneficiary and a therapist or counselor.

- *Group Counseling:* face to face contacts in which one or more therapists or counselors treat two or more patients at the same time.

- *Medication Services:* the prescription or administration of medication related to SUD services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services or order laboratory testing.

- *Collateral Services:* face to face sessions with the therapist or counselors and significant persons (not official or professional relationship) in the life of a beneficiary, focusing on the treatment needs of the patient to support the achievement of the beneficiary's treatment goals.

- *Crisis Intervention:* face to face contact between a therapist or counselor and a beneficiary in crisis, with services focused on alleviating the crisis. Crisis is a relapse or an unforeseen event or circumstance that presents as an imminent threat of relapse. Services are limited to stabilization of the beneficiary's crisis situation.

- *Treatment and Discharge Planning:* preparation of a written plan for treatment based on the information obtained from an individual's intake and assessment processes.

### *Substance Use Disorder Benefits: Medi-Cal Managed Care and Fee-for-Service System Improvements*

In addition, DHCS will be improving the continuum of substance use disorder services for beneficiaries in the Medi-Cal managed care and fee-for-service settings, as follows:

#### *1). Elective Inpatient Detoxification*

This service will be broadly available, without the current restriction of physical medical necessity, through Medi-Cal FFS with county authorization. This will make medically supervised

drug detoxification available in inpatient settings, whereas it is currently covered by FFS and managed care only as emergency alcohol detoxification in a hospital inpatient setting or detoxification when discovered as concurrent with the primary admitting medical diagnosis. Offering medically supervised detoxification services for drug withdrawal will increase beneficiary safety and allow more individuals to receive appropriate medical treatment.

DHCS recognizes that research demonstrates that detoxification alone is largely ineffective and should only be used as part of an extended plan of treatment. If not carefully managed with clear criteria for utilization review and management, the concern is this could be an expensive benefit with very little appropriate clinical application and research consistently recommends that detoxification should be paired with treatment. The Department will be giving careful consideration to this issue as part of proposed State Plan Amendment (SPA) 13-038.

### *2). Medication Assisted Treatment (SUD Medications Outside the Scope of DMC)*

There is also a need to improve the availability of Medication Assisted Treatment (e.g., Buprenorphine, Vivitrol) through the Medi-Cal FFS system. Currently, any United States Food and Drug Administration (FDA) approved medications not provided through the Drug Medi-Cal (DMC) formulary are available through the Medi-Cal FFS system as a pharmacy benefit or a medical benefit (physician administered drug) and via the Treatment Authorization Request (TAR) process. These are:

- Naltrexone/oral form for alcohol dependence (This is pharmacy benefit)
- Naltrexone/injectable extended release (Vivitrol®) for treatment of alcohol and opioid addiction (This is a medical benefit)
- Buprenorphine (Subutex® or Suboxone®) for treatment of opioid addiction (This is pharmacy benefit)
- Disulfiram (Antabuse®) for alcohol dependence (This is pharmacy benefit)
- Acamprosate Calcium (Campral®) for alcohol dependence (This is pharmacy benefit)

During stakeholder forums on this *Service Plan*, stakeholders raised the suggestion that DHCS explore options for increasing access to these and other medication assisted treatments, such as through making additions to the Drug Medi-Cal formulary. In Medi-Cal FFS, improvements to the availability of medication treatments for alcohol or drug dependence could also strengthen detoxification and maintenance treatments for individuals that are substance use dependent. At the present time, DHCS does not believe there is a need to add to the Drug Medi-Cal formulary as these medicated assisted treatments are already available in Medi-Cal. However, DHCS will continue to monitor the issue. The Department recognizes that some providers continue report cumbersome delays associated with the TAR and medical benefit processes, respectively, creating a deterrent to the use of Buprenorphine and Vivitrol. The Department takes the concerns related to TAR delays seriously and will evaluate and monitor this concern during implementation.

### *3). Screening and Brief Intervention (SBI)*

Screening and brief intervention (SBI) for alcohol misuse for adults will be provided in primary care settings with the goal of dissuading individuals from continuing their pattern of alcohol

misuse before they become dependent. The vast majority of those screened will not meet the criteria for further brief intervention. Those who are determined to need treatment will be referred by the primary care physician (PCP). This service complies with ACA essential benefit requirements related to United States Preventive Services Task Force (USPSTF) standards for screening and brief interventions for alcohol issues among adults.

Commenting on screening in the primary care setting, several stakeholders stressed that screening and brief intervention should not be limited to substance use issues but should include mental health conditions as well and that all providers of care for people with serious mental illness (SMI) should routinely screen for physical health conditions and assure coordination with primary care. The Department supports the importance of integrated care and while mental health screens currently occur, DHCS will be evaluating screening and assessment tools that address both mental health and substance use disorder conditions as research shows that 30-50% of people who have a substance use disorder also have a mental health disorder. The Department will be assessing current practice in addition to what's currently being required and done vis-a-vis screening as it works with the legislature and stakeholders to implement the benefits.

There are currently required tools to assess mental health issues (*required by CCR, Title 22, Sec. 538511(b)(1), 53902(m) and 53910.5(a)(1)* for Two Plan and for Geographic Managed Care (GMC) plans and by contract for County Organized Health Systems (COHS) to be used by the managed care plans *(Staying Healthy Assessment* [*SHA*]. As of March 2001, they were required for all managed care providers as part of the initial health assessment for English and Spanish speaking members and in 2005 the SHA was also required for Chinese, Hmong, Lao, Russian and Vietnamese speaking members.) Medi-Cal MCPs must complete an assessment within 120 days of beneficiaries' enrollment. The broad assessment is the first screening tool. There are follow-up questions in each area of the broad assessment where there are positive responses. Psychological testing is also now included in the Medi-Cal MCPs.

The state will assess the need to evaluate the current mental health and substance use disorder screening tools used by both the plans and the MHPs. DHCS intends to work with counties, health plans, providers and other stakeholders to encourage all Medi-Cal plans to screen for mental illness and co-occurring substance use/mental illness in addition to the required screening for alcohol issues as the managed care system moves forward with the SBI requirement. This will be an important priority for the Department as it works with partners and stakeholders on the details of implementation.

During the stakeholder forums, there were requests the Department consider exempting SBIRT (Screening, Brief Intervention, Referral and Treatment) and associated behavioral health services from California's same-day billing restriction. DHCS believes that since the billing systems for mainstream Medi-Cal and Short-Doyle are separate, this problem will not actually exist unless the practitioner attempts to bill Short-Doyle twice. Even so, providers can request a waiver from this limitation and gain the ability to bill for two different services on the same day. In addition, the same day billing issue should not pose a problem for FQHCs given their bundled rates. However, these are important concerns and will need monitoring during implementation.

The *Needs Assessment* report also did note concerns on the part of providers and stakeholders that a more complete analysis of the current DMC benefits as it pertained to federal guidance on benefit parity should be completed. The Department recognizes there is a heightened parity obligation for the new adult expansion group given the requirement they receive coverage under Sec. 1937, and that parity will apply regardless of the delivery system.

The DHCS did in fact evaluate the current DMC benefits as they pertained to parity and determined that it currently appears that while CMS encourages parity, given the fact the specialty mental health and DMC substance use disorder benefits remain carved out, that parity is not required in that delivery system. However, even with that determination, with the addition of the enhanced SUD benefits, California believes it would meet Federal Parity requirements if required and will work closely with CMS to resolve any questions or concerns. CMS has also indicated they plan to issue more specific policy guidance in the near future on the SPA assurances that states will be making. Regarding the non-specialty benefits, given the carve-in of non-specialty mental health, the Department expects parity will be applicable to both the new optional expansion group (because of the Sec. 1937) and the existing population to the extent the managed care plans will now be providing both the medical and mental health benefits.

During the stakeholder forums, questions were raised regarding the application of the Medicaid Institution for Mental Disease (IMD) exclusion as it pertains to substance use residential treatment programs under the newly expanded benefit design. DHCS is in process of conducting an analysis of: (a) actual current CMS definitions and guidance related to the IMD exclusion; (b) the current actual and potential impact of the IMD exclusion on substance use residential treatment providers in California; and (c) strategies being planned or employed by other states with regard to the IMD exclusion as it applies to substance use residential treatment.

Several in the SUD community of providers asserted that the IMD exclusion both creates barriers (limit on size) and should not apply to DMC services as the DMC services are not provided within an Institution. However that limitation and connection to Institutions is currently in the State Medicaid Plan and DHCS, while making no promises, has agreed to look to recent guidance from SAMHSA (e.g. SAMHSA Medicaid Handbook, Interface with Behavioral Health Guidelines) as well as CMS specifically related to non-medical residential programs as it considers and evaluates options.

The ACA provides authority for eligible states to participate in a three year Medicaid Emergency Psychiatric Demonstration which allows FFP reimbursement for certain emergency services provided to eligible Medi-Cal beneficiaries ages 21-64 in IMDs under specified conditions. Without an approved Demonstration application outside of this limited demonstration authority, the DHCS emphasized that all services for Medi-Cal beneficiaries are subject to the IMD exclusion and ineligible for FFP.

Regarding the demonstration, DHCS invited all counties with private IMDs to participate in the demonstration; Sacramento and Contra Costa counties volunteered and DHCS is currently working with Sacramento and Contra Costa counties to implement the Medicaid Emergency Psychiatric Demonstration Program.

The demonstration enrolled Medicaid beneficiaries between the ages of 21 and 64 who reside in Sacramento or Contra Costa County and are suicidal or homicidal or a threat to self or others. Contra Costa County will also enroll individuals who are eligible for Medicaid at the time of admission and subsequently enroll in Medicaid. Before the demonstration, the counties paid participating IMDs for providing inpatient care to this population but did not receive federal matching funds for services. Without an approved Demonstration application, all services for these beneficiaries are subject to the IMD exclusion and ineligible for FFP.

## Overview of the Delivery System to be Implemented

California has made a decision that all new enrollees resulting from the Medi-Cal coverage expansion will be placed in managed care plans. The state will use the existing Medi-Cal delivery system strategies and processes and will seek approval from the United States Secretary of Health and Human Services for this approach. With this decision, California is maintaining its current MHP and DMC service financing and delivery systems. Thus, when expansion population members are enrolled, they will follow the same path as current Medicaid recipients and will have access, consistent with medical necessity, to the same mental health and substance use benefits currently available to already-enrolled Medi-Cal beneficiaries. California made this decision because this approach promotes quality, familiarity, consistency and administrative efficiency. The state has also greatly benefited from the implementation of the Mental Health Services Act (MHSA) and MHSA values of recovery, resiliency, community collaboration, cultural competence, consumer driven care and integrated service experiences for clients and families. These are principles that will inform the expansion of Medi-Cal.

In spite of the clear advantage in using existing systems, DHCS appreciates how MHP systems differ greatly from county to county and how variability will be a challenge. The lessons being learned from *CalMediConnect* as well as the rural managed care expansion will be invaluable.

The Department also recognizes how important it is that the various delivery systems be in close and ongoing communications and will be working with county partners and stakeholders to monitor the delivery of services. Given there are multiple delivery systems, issues such as roles/responsibilities related to specific services (e.g. autism for example, as there were significant concerns from advocates about how mental health benefits are provided to individuals with autism spectrum disorders [ASD]) were also cited as examples of the importance of the need clarity for both providers and consumers alike.

The intent is that effective January 1, 2014, the alternative benefit package (ABP) for the expansion population shall provide the same schedule of benefits provided to full-scope Medi-Cal beneficiaries qualifying under the modified adjusted gross income (MAGI) standard pursuant to Section 1396a(e)(14) of Title 42 of the United States Code. California will also seek approval of any necessary state plan amendments or waivers to implement this section, recognizing that this effort will be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

The state will use a variety of communication tools including but not limited to all-county letters, plan letters, beneficiary booklets and communications, plan or provider bulletins, or similar instructions to communicate with legal entities until the time regulations are adopted.

Also, in order to ensure effective and responsive communication with the Legislature, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted

California has chosen the State administered approach, whereby physical health will be managed by physical health managed care plans for the coverage expansion population. Non-specialty mental health and substance use disorder services will be provided by the managed care plans, which will receive Per Member Per Month (PMPM) payments[10]. Specialty Mental Health services, and substance use services through the Drug Medi-Cal will continue to be provided or arranged for by County MHPs and county alcohol and other drug programs.

Medi-Cal expansion population participants needing specialty mental health services will be referred by their physical health plan to county based specialty Mental Health Plans (MHPs) or will self-refer for an initial assessment interview which may lead to screening and further assessment.

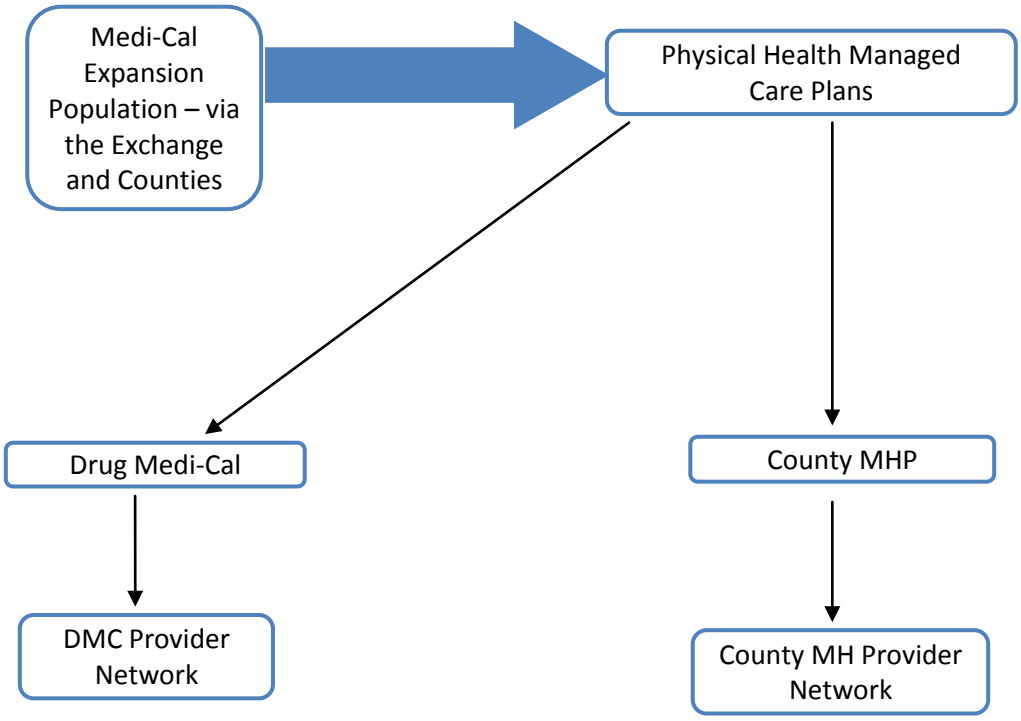
Medi-Cal expansion population participants needing substance use services will be referred by their managed care plan or will self-refer to: (a) County behavioral health departments where the mental health and substance use disorder services are administratively blended; (b) separate alcohol and other Drug departments in those counties where they are not blended; or (c) the Medi-Cal fee-for-service program. Medi-Cal payments for these carved out mental health and substance use services will remain outside the physical health PMPM payments. As described in the ACA, specific preventive screening services are included in the essential health benefit (EHB) design. This means that a significant number of the expansion population will be eligible to receive annual alcohol screening and brief counseling interventions under the aegis of the physical health managed care plans.

Figure I below portrays the general structure of enrollment and service access pathways for the Medi-Cal coverage expansion population for mental health and substance use services.

The diagram notes that Medi-Cal expansion participants in Drug Medi-Cal and MHPs will be referred for enrollment into physical health plans in the same manner as members of the expansion population. This referral/enrollment function will be facilitated at the county and provider levels through direct access to California's Health Benefit Insurance Exchange (*Covered California*.) The outreach and enrollment process is described in greater detail in Section IV below.

[10] Note: Fifteen of these plans have been selected to manage integrated care systems for people with dual eligibility for Medicare and Medicaid.

**Figure I: Structure of Enrollment and Benefit Access for the Medi-Cal Expansion population**




As was described earlier, the current county MHPs and Drug Medi-Cal structures will continue to be used as delivery systems for these specialty mental health and Drug Medi-Cal benefits and continue to provide the expansion population with the same access points, service benefits, and provider networks as current Medi-Cal beneficiaries receive.

This model for enrollment, service access and delivery will reduce the confusion, complexity and administrative burdens that could arise from administering a separate benefit plan for expansion population members with mental health and substance use service needs. Equally important, this model increases the potential for continuity of service and providers for expansion population members who have already received services through safety net providers that are intrinsic to the county MHP and DMC provider networks. This is particularly true for expansion population members who have already been enrolled in county Low Income Health Plans (LIHPs) under the Bridge to Reform Waiver. People currently enrolled in county-operated LIHP plans will be enrolled in physical health plans in the same manner as currently un-enrolled members of the Medi-Cal expansion population.

Using the existing delivery systems also reduces implementation issues, in that new specialty plans do not need to be procured and selected, and new benefits do not need to be designed and implemented.[11]

[11] However, some counties will need to expand provider networks to assure access on an equitable basis to MHP and DMC services for all enrollees.

To the extent the current Medi-Cal system reflects "good and modern"[12] practices for mental health and substance use services, these services will be protected and sustained. Two areas requiring further attention are the implementation and development of alcohol screening and brief intervention (SBI) capacities for the expansion populations and the implementation of utilization management strategies that ensure clinical and medical necessity for initiating and continuing treatment. The state, county MHPs and county alcohol and drug departments along with managed care plans will jointly need to discuss personnel, expertise and referral capacity issues as the state continues to support more routine use of evidence based screening tools by the managed care plans. There may be issues with developing sufficient personnel and expertise within primary care to conduct the required preventive screening and counseling activities that need to be monitored, especially as related to substance use disorder services for adults.

This arrangement of delivery systems builds on the strengths of the status quo. However, as noted in the *Needs Assessment* conducted under the first phase of this project, there are a number of issues and challenges, many in the substance use services area, still needing to be addressed to move the current system forward as it copes with an expansion of this size. Some key challenges are:

1. The existing and continued division of funding and benefit management among physical health plans, MHPs, and DMC, complicates the integration and coordination of physical health, mental health and substance use services. California has some various models of effective physical health and mental health integration, but more work could be done to strengthen effective integration of services and delivery systems statewide.[13] This includes but is not limited to further assessment of the DMC rates.

2. The expansion of Drug Medi-Cal benefits to a broader population, plus the including of additional benefits, will strengthen the current DMC program. However, it may create pressure on provider capacity, participant care management, and inter-service linkage mechanisms even more than had been anticipated in the *Needs Assessment* report.

3. The expansion of DMC benefits raises concerns about the adequacy of utilization review and other quality oversight and management tools.

4. County MHPs employ medical necessity criteria specified in California regulations (CCR 1820.205, CCR 1830.205, and CCR 1830.210) related to diagnosis and functional impairment. As a result of strengthening the managed care mental health and substance use disorder benefits, the Managed Care Plans will now work to develop access to mental health and substance use services that do not fit within the

[12] Substance Abuse and Mental Health Services Administration *Description of a Modern Addictions and Mental Health Service System* (2010)

[13] As discussed in greater detail in Section 6 of this report, California strongly supports physical; health and behavioral health integration, and encourages co-location and bi-directional approaches at the local level. DHCS encourages managed care plans to work closely with MHPs to determine the feasibility of co-locating respective staff in both physical and behavioral health environments whenever possible.

specialty plan criteria. Pursuant to CCR 1810.370, the MHP shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal Managed Care Plan that enrolls beneficiaries covered by the MHP. Counties and plans may need to revisit and amend existing MOUs as necessary and consistent with CCR 1810.370 in order to appropriately delineate responsibilities and specify access criteria. The state and MHPs will need to support these efforts by the plans.

5. There is a scarcity of mental health and substance use professionals and facilities in some parts of the state, including limitations in the number and capacity of culturally and linguistically competent providers in MHP, DMC and managed care provider networks.

6. Providers, particularly substance use service providers may be lacking in health information technology.

7. As indicated by the *Needs Assessment,* and acknowledged as difficult to accurately track, the utilization of evidence based mental health and substance use disorder services, beyond those reported, as required by SAMHSA, remains a concern on a state-wide basis. A lack of support services for families of people with serious mental illness was also noted.

8. There are disparities in enrollment and service access, particularly for Hispanic and Asian populations. These groups are also more likely to be uninsured, and thus may require tailored outreach and engagement strategies to encourage participation in the coverage expansion opportunities.

9. People involved with the criminal justice system will need special attention with regard to enrollment and retention post incarceration.

Addressing these challenges requires collaboration between the State and their county partners. The mental health and substance use disorder Medi-Cal benefits for the expansion population also needs to be seen in the larger context of discussions with counties and stakeholders regarding the Medi-Cal and non-Medi-Cal services, programs and funding sources. DHCS has been actively engaged in planning activities with CMHDA and CADPAAC (via CiMH and ADPI) to address partner and stakeholder recommendations on an ongoing basis. One tool that will help address these challenges is implementation of the June 2013 Stakeholder Recommendations report from CiMH/ADPI, historically referred to as the "*business plan.*"

In the *Stakeholder Recommendations* report, DHCS partnered with the California Institute for Mental Health (CiMH) and the Alcohol and Drug Policy Institute (ADPI) to obtain stakeholder input for identifying key mental health and substance use disorder services issues. CiMH and ADPI completed the process of engaging stakeholders and compiled the previously mentioned report, formally titled "*Stakeholder Recommendations for Mental Health and Substance Use Disorder Services."* The report identified seven key areas of focus. These are:

- Evaluation, outcomes, and accountability;
- Financing of mental health and substance use disorder services;
- Coordination and integration of primary care and mental health and substance use disorder treatment;
- Reducing administrative burden;
- State and county roles and responsibilities;
- Workforce skills and capacity; and
- Organizational capacity for substance use disorder service providers.

DHCS, CMHDA, and CADPAAC intend to focus on these issues going forward in a manner in which meaningful stakeholder engagement and stakeholder recommendations are not only considered but also implemented when feasible and appropriate. DHCS recognizes the importance of ongoing partner and stakeholder engagement and there will need to be discussions between all parties. Decisions will have to be made regarding priorities as well as what recommendations are feasible in the short versus long term. In addition, determinations will need to be made about what can be accomplished administratively and what may need legislation.

As with any widespread and sustainable system improvements, the necessary and desired changes will result from data-driven and consumer focused performance measurement (the importance of which was also stressed by several stakeholders who are prominent in research and higher education) and quality improvement activities involving both state and county programs as the counties take on even greater responsibility as a result of the 2011 realignment. This will require increased attention to contract management and monitoring by the state over both the managed care plans and county mental health plans. Specific short term actions steps to address these types of issues are addressed in sections 4 through 7 of this report.

# 3. Estimated Utilization and Costs of the Recommended Mental Health and Substance Use Service Benefit Design

As noted in Section II of this report, TAC/HSRI conducted detailed analyses to estimate the potential utilization and costs of mental health and substance use services for the Medi-Cal expansion population. The data used for the analyses were 2009 Medi-Cal claims data, the same data used for the *Needs Assessment* Report.

TAC/HSRI, DHCS and the other health consultants developed a set of concrete assumptions to be used to extrapolate the 2009 utilization data to the Medi-Cal expansion population for the period 2014 through 2020. These assumptions are summarized in Table II below. Some stakeholders raised the concern that estimates did not specifically involve the homeless and those involved with the criminal justice system or those estimated to use the new SUD inpatient detoxification benefit. TAC/HSRI recognized these challenges from the outset and attempted to adjust for this concern. In order to account for any possible undercounts for certain populations and anticipate capacity required. For example, we know that surveys used to determine prevalence often exclude the prison and jail population (e.g., NSDUH) and therefore may represent an undercounting of actual prevalence. The approach taken with developing projections of service use included two key decision points that impacted the anticipated users of services that allowed for the anticipation of higher prevalence rates for certain subpopulations. The two assumptions are:

- Of the anticipated number enrolling in the Medi-Cal Optional expansion, the 2013 Budget Act is based on enhanced take-up rate assumptions.

- Of the options available, these estimates assume prevalence rates consistent with the recently published SAMSHA substance use rates.

**Table II: Assumptions used for the utilization and costs estimates for mental health and substance use services for the Medi-Cal expansion population**

| Assumption Variable | Assumption Adopted |
|---|---|
| Overall Medi-Cal coverage Expansion Population size | The DHCS enrollment assumptions were adopted, with an estimated average monthly eligible population of approximately 575,000 in 2013-14, increasing to more than 945,097 in 2020-21. |
| Mental health and substance use services expansion population | TAC/HSRI prevalence estimates were used to project that 18.64% of the total expansion enrollee population would need mental health services.<br>SAMHSA prevalence estimates were used to project that 10.30% of the total expansion enrollee population would need substance use services. |
| Services included in the benefit | All current Medi-Cal mental health and substance use services benefits were included in the analyses. New services being added to the benefit were not included in the original service projections because there were no Medi-Cal or other claims data available on which to base projections of utilization and costs. |
| Expansion population take-up rates | DHCS Population estimates were used as noted above. The take-up rate for FY 2014-15 is estimated to be 53%, increasing to 65% in FY 2020-21.[14] See table III below for a year by year summary. |
| Users of services | Not all enrollees that need and qualify for mental health and substance use services will actually ask for and access these services. The estimate used for the base analysis assumes that current Medi-Cal participation rates will apply to the expansion population and this includes 25.1% of people needing mental health services will access such services, while 11.8% of people needing substance use services will access such services.[15] [16] |
| Distribution of service use | With the exception of inpatient psychiatric hospitalization, and for enhanced SUD benefits for residential, intensive outpatient and elective detoxification (which could not be estimated since there is no current utilization) the distribution of utilization of both mental health and substance use services in the current Medi-Cal program is assumed to accurately reflect utilization of various service types for the expansion population. Inpatient utilization in the current Medi-Cal system is heavily weighted towards people with serious mental illness receiving SSI, which is not projected to be true for the expansion population. Thus, LIHP plan utilization of inpatient utilization, which is assumed to more accurately reflect the expansion population, has been used to adjust hospitalization downward by 50% (from 8% to 4% of expected utilization of MH users.) |
| Adjustment for Medical Cost Inflation | The costs of mental health and substance use services are estimated to increase by 5% per year between 2014 and 2020 and current costs inflated by 3% to 2014. |
| Eligible but not enrolled | There are a number of people currently eligible for Medi-Cal that are not enrolled. The utilization and costs estimates in this analysis do not include this potential population. (Otherwise known as the Mandatory Expansion population) |
| County Administrative Costs | For the Medi-Cal Specialty Mental Health Services (SMHS) Waiver an administration cost of 13% was added to the total costs of these services to reflect the current administration costs of this program. |

[14] "*Take up*" refers to an estimate of how many of the overall expansion population eligibles will actually enroll. It does not predict how many of the eligibles who enroll will actually present for services.
[15] "*Users of services*" means how many eligible and enrolled are predicted to actually present to USE services. This does not sort for what types (e.g. intensity) of specific services; it just attempts to estimate how many will present themselves to use services.
[16] Effective substance use screening within primary care systems could increase the use rate for people with substance use services needs.

## Caveats related to the analyses

As with all projections, these estimates are subject to a certain degree of uncertainty. First, they do not account for supply effects. The estimates assume that demand is not greatly suppressed because of lack of supply.[17] The increase in users will be smaller if providers are unable or unwilling to increase capacity to fully meet demand. Second, the proportion of individuals with mental health or substance use service needs that will enroll in Medicaid is uncertain. In Massachusetts, for example, anecdotal information suggests that adults with substance use service needs are among the last to enroll in Medicaid. Third, data on users of mental health and substance use services come from surveys, and like all surveys the results have a margin of error. For example, stakeholders in California have noted that that estimates for ER services may be understated. DHCS recognizes these data challenges and looks to the implementation experience over the coming 36 months to provide more precise information. Fourth, the estimates assume that expansion population enrollees will have a similar probability of using services,[18] once they obtain Medicaid coverage, as the current Medi-Cal mental health and substance use service users. However, use rates may differ since the expansion population is known to be dissimilar from both existing Medicaid disabled population and Medicaid non-disabled populations.[19]

This report recognizes the difficulty in accurately estimating the impacts to the primary care system. The impacts to the specialty DMC system would be dependent upon primary care system's capacity to perform these functions. Widespread implementation of screening and brief treatment for alcohol is likely to affect the beneficiary mix arriving at specialty care, and potentially challenge provider capacity.

## Results of the Estimates

Appendix A contains the summary of estimated mental health and substance use service costs for the Secretary Approved Plan (current Medi-Cal mental health and substance use service benefit plan). It should be noted that by FY 2020-21, 90% of these costs will be borne by the federal government as part of the expansion initiative under ACA.[20] The remaining 10% will be the non-Federal share.

Table III shows that by 2020-21 there are projected to be approximately 945,097 average monthly eligible beneficiaries as a result of the newly enrolled Medi-Cal recipients who are members of the expansion population.[21] Just over 170,000 of these individuals are expected to access and use mental health services, and approximately 96,000 of these are expected to be access and use substance use services.[22] This represents a substantial increase in the average number of monthly Medi-Cal beneficiaries who may need mental health and substance use services between 2014 and 2020.

[17] This could become a larger issue if widespread screening for SUD results in increased referrals to already sparse substance use service resources in some parts of the state – see discussion in next paragraph.
[18] Not including inpatient hospitalization.
[19] See chapter VII of the Mental Health and Substance Use Services Needs Assessment.
[20] In 2014, 2015, and 2016 the federal share of costs will be 100%.
[21] Reminder – this does not include currently eligible but un-enrolled individuals that may also access Medi-Cal after 2014.
[22] These categories are not mutually exclusive, and thus cannot be added together. Some Medi-Cal expansion population members will access and use both mental health and substance use services.

## Table III: Estimated Mental Health and Substance Use Service Populations within the Medi-Cal Expansion Population

### Mental Health Services Population

| Fiscal Year | Estimated total Medi-Cal Expansion Population | Enrollment Take-Up Estimate | Total Medi-Cal Expansion Population Enrollment | Estimated Mental Health Prevalence | Medi-Cal Expansion Population Needing Mental Health Services |
|---|---|---|---|---|---|
| 13/14 | 1,420,000 | 40.5% | 575,184 | 18.64% | 107,214 |
| 14/15 | 1,420,000 | 53% | 757,405 | 18.64% | 141,180 |
| 15/16 | 1,430,000 | 57% | 821,422 | 18.64% | 153,113 |
| 16/17 | 1,440,000 | 60% | 869,930 | 18.64% | 162,155 |
| 17/18 | 1,450,000 | 62% | 900,491 | 18.64% | 167,852 |
| 18/19 | 1,460,000 | 63% | 920,317 | 18.64% | 171,547 |
| 19/20 | 1,460,000 | 64% | 934,724 | 18.64% | 174,233 |
| 20/21 | 1,460,000 | 64% | 934,724 | 18.64% | 174,233 |

### Substance Use Services Population

| Fiscal Year | Estimated total Medi-Cal Expansion Population | Enrollment Take-Up Estimate | Total Medi-Cal Expansion Population Enrollment | Estimated Substance Use Prevalence | Medi-Cal Expansion Population Needing Substance Use Services |
|---|---|---|---|---|---|
| 13/14 | 1,420,000 | 40.5% | 575,184 | 10.30% | 59,244 |
| 14/15 | 1,420,000 | 53% | 757,405 | 10.30% | 78,013 |
| 15/16 | 1,430,000 | 57% | 821,422 | 10.30% | 84,606 |
| 16/17 | 1,440,000 | 60% | 869,930 | 10.30% | 89,603 |
| 17/18 | 1,450,000 | 62% | 900,491 | 10.30% | 92,751 |
| 18/19 | 1,460,000 | 63% | 920,317 | 10.30% | 94,793 |
| 19/20 | 1,460,000 | 64% | 934,724 | 10.30% | 96,277 |
| 20/21 | 1,460,000 | 64% | 934,724 | 10.30% | 96,277 |

In the *Needs Assessment*, TAC/HSRI noted that ten counties will account for over 50% of the total enrollment increase. These counties are listed in the left hand column in Table IV. The right hand column lists the counties with the highest percentages of Latino people. The high degree of congruence between the two columns highlights the importance of special effort to enroll the Latino population within these counties.

It should be noted that seven of the ten counties identified are also part of the *Cal MediConnect* (Duals) demonstration and as a result are placing increased attention on what's needed for effective integration and collaboration of physical and behavioral health presented by these new beneficiaries. The lessons learned from these counties participating in the Continuing Care Initiative will have a significant positive impact on implementation and service for the expansion population.

**Table IV: Ten California Counties with the Highest Number of Potential Medi-Cal Expansion Enrollees (* indicates participating CCI county)**

| Rank | Rank Order of Counties in Number of Potential Medi-Cal Enrollments | Rank Order of Ten Counties with the Highest Percent Latino Population[23] |
|---|---|---|
| 1 | Los Angeles* | Los Angeles* |
| 2 | San Bernardino* | Orange* |
| 3 | Orange* | San Bernardino* |
| 4 | San Diego* | Riverside* |
| 5 | Riverside* | San Diego* |
| 6 | Sacramento | Santa Clara* |
| 7 | Fresno | Fresno |
| 8 | Santa Clara* | Kern |
| 9 | Alameda* | Alameda* |
| 10 | Kern | Ventura |

These ten counties will have the greatest impact in terms of overall enrollment of new Medi-Cal eligibles, increased mental health and substance use service demand, and increased pressures on current provider capacity. The high proportion of Latino people in these counties highlights the need for special outreach and engagement efforts as well as strategies to increase the cultural/linguistic competence of providers in their networks.[24]

The top ten community-based service categories by dollar amount for Medi-Cal mental health and substance use services historically are:[25]

1. Mental Health outpatient services (includes individual, group and family counseling services)
2. Medication support services
3. Case management
4. Narcotic replacement therapy
5. Mental health day rehabilitation
6. Outpatient drug-free treatment
7. Mental Health day treatment intensive
8. Crisis stabilization
9. Crisis intervention
10. Crisis stabilization – Emergency Room

This service array represents a relatively standard distribution of service utilization and costs for a Medicaid participant population with greater needs than non-disabled current Medi-Cal recipients, but lesser needs than the current Medi-Cal disabled population. As noted above, this benefit package represents the current Medi-Cal program as well as representing essential

[23] California Statewide Marketing, Outreach and Education Program June 26,
[24] Note: most of these counties also have relatively high numbers and proportions of Asian/Pacific Rim and Native American people. As noted in the needs assessment report, these people are also currently under-represented in Medi-Cal, and are expected to need special attention in the education and enrollment process.
[25] Pharmacy costs are managed and accounted for separately from mental health and substance use services, and thus are not included in this discussion.

components of mental health and substance use service systems.[26] It should be noted that best practice service approaches, such as CBT/DBT[27] can be implemented in the context of the above outpatient service categories within specialty mental health. Administrative adjustments to the DMC program regulations will be needed to allow for similar types of best practices to be implemented. In addition, better outcomes and costs effectiveness can be achieved by increasing utilization of certain services while decreasing reliance on less effective legacy service modalities.[28] Neither type of strategy de facto necessitates adding new service categories to the current Medi-Cal plan.[29]

[26] Prevention and screening services, which are priority services under the ACA, are likely to be included in the physical health benefit for Medi-Cal enrollees.
[27] Cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT), which are evidence based practices for people with mental illness or co-occurring mental illness and substance use conditions.
[28] See Chapters IV, V and VI of the Needs Assessment Report
[29] Increasing the use of peer supports, which is evidence based service, may require changes to current service definitions and staff credentialing requirements within the current Medi-Cal plan.

# 4. State and County Engagement & Enrollment Strategies for Expansion Population Members with Mental Health and Substance Use Service Needs

California has embarked on a large scale and assertive outreach and enrollment initiative for both Medi-Cal, California's Medicaid program and Covered California (California's Health Benefit Exchange).

Historically, there have been several pathways through which individuals and families qualify for Medi-Cal. These pathways differ among themselves according to three main components: (1) The groups they cover ("covered groups"), (2) their income and/or asset requirements, if any, and (3) the scope of benefits provided (full or restricted). Some coverage groups are mandatory while other coverage groups are optional. Under the ACA, obsolete eligibility categories have been eliminated and all others were collapsed into four primary categories: parents and other caretaker relatives; pregnant women; infants and children under age 19; and the new adult group. California has elected to cover the new adult group under the *"Optional Expansion"*.

California has elected to implement the ACA Optional Expansion, providing Medi-Cal coverage to adults with incomes up to 138 percent of the federal poverty level (FPL).

In order to effectively enroll newly eligible individuals, the state and counties will be implementing federally required simplification measures procedures to process new applications and re-determinations, developing training and curriculum materials, training county eligibility workers and providing general support for planning and implementation activities. Essentially, newly eligible beneficiaries will be able to go to the Covered California web-site, call centers or the counties to get enrolled.

The Affordable Care Act requires a "*no wrong door"* solution that supports application, eligibility determination, and enrollment by way of the Internet, phone, and mail, as well as in person. This approach will also simplify and streamline the eligibility criteria for Medi-Cal and new commercial insurance coverage options.

An important example of simplified and streamlined enrollment can be seen with how the LIHP program is progressing with transition planning. One of the most significant transition activities for newly eligibles thus far has been the effective planning for those already in LIHPs who will be transitioned to Medi-Cal on January 1st, 2014. It is noteworthy that no new application will be required. This important simplification will ensure that approximately 490,000 Californians are enrolled in a seamless fashion. Most counties in California have implemented LIHP plans, and thus are already engaged in local outreach and engagement activities for uninsured people. These counties will be able to build on the previous efforts. Some counties have been operating LIHP or LIHP-like coverage expansions plans for several years, and already have successfully engaged large numbers of un-enrolled people in coverage and service access. Some of the interviews and site visits conducted as part of the mental health and needs assessment focused on enrollment and service access strategies employed by counties with their LIHP plans. Based on anecdotal information, it seems that most counties have been successful in: (a) converting

qualifying but un-enrolled people who utilize county safety net services to enrolled Medi-Cal LIHP participants; and (b) identifying and enrolling people receiving county-funded mental health and substance use service into LIHP plans. The successes on the part of counties to enroll people with mental health and substance use service needs are important building blocks for the coverage expansion initiative. As noted above, representatives of these county initiatives should continue their effective collaboration with the state and remain be active participants in the implementation process for statewide education, marketing and assister/navigator strategies.

As noted above, the ACA requires integrated and simplified processes for eligibility determination and enrollment that provide a first-class consumer experience. Consumers must be able to apply for public programs and coverage in the Exchange (both subsidized and unsubsidized) online, by phone, by mail, or in person. DHCS and Covered California, in collaboration with the California Health and Human Services Agency (CHHS) and the Managed Risk Medical Insurance Board (MRMIB), are developing the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) to serve as a centralized tool for determining eligibility for and enrolling people in health insurance affordability programs; for comparing health plan benefits, cost sharing, and quality; and ultimately for enrolling in plans. To improve consumer understanding of new coverage programs prior to the release of CalHEERS, *Covered California* has launched www.coveredca.com, which offers fact sheets, a subsidy calculator, and a phone number for consumers with specific questions. What follows has borrowed and been informed significantly from that valuable and helpful website.

Medi-Cal eligibility determination and enrollment today are the responsibilities of the 58 counties, which use three different Statewide Automated Welfare Systems (SAWS). Most Medi-Cal applications are handled in person at county social services offices. Currently a phone-based application is available through a statewide contractor for Healthy Families and Medi-Cal for Children as well as an online application, Health-e-App Public Access. However, with the transition of the Healthy Families Program to Medi-Cal as of January 1,2013, and the discontinuance of the Healthy Families as of December 31, 2013, the Healthy Families Program has stopped accepting new applications. Online application is available for Medi-Cal on a limited basis via the county SAWS systems. Enrollment help is offered by Certified Application Assisters, typically located at community-based organizations, and many medical providers. Eligibility determination, program and plan enrollment, re-enrollment, and case management for Medi-Cal and Exchange programs will be supported by different platforms, making coordination among these systems of paramount importance.

The Covered California web-site emphasizes the importance of improving the consumer experience by ensuring smooth hand-offs among state and county customer service representatives in the eligibility and enrollment processes, a seamless experience for families whose members may qualify for different programs, easy transitions for those whose eligibility status changes, and consumer-friendly decision support for applicants.

Promoting and supporting enrollment is crucial to achieve the goals of the ACA. The June, 2012 Phase I and II report: ***Statewide Marketing, Outreach and Education Program: Final Design Options, Recommendations and Work Plan for the California Health Benefits Marketplace***

contains multiple strategies for educating the public about health coverage expansion, and for reaching target audiences that are considered to be more difficult to engage and enroll.

The *Covered California* website describes how California is establishing an Assisters Program to reach diverse populations and help them enroll in the Exchange and Medi-Cal and planning outreach and marketing activities to ensure that Californians are aware of newly available coverage programs. Specifically related to substance use disorder populations, stakeholders also encouraged counties to partner with local health departments, pharmacies, syringe services programs, safety net clinics, and other organizations with expertise in serving active substance users, including injection drug users, to enroll them in Medi-Cal and ensure that these individuals receive equal access to mental health, substance use, and primary care services.

The companion plan: ***Phase I and II Statewide Assisters Program Design Options, Recommendations and Final Work Plan*** provides a structure and starting point for designating Assisters and Navigators to facilitate enrollment in both Medi-Cal and Health Benefit Exchange insurance products.

The California marketing, outreach and education plan and the statewide Assisters plans address special populations and people who may be more difficult to engage in health coverage expansion. Both rely on existing networks of community agencies, advocacy organizations, and specialized information outlets to reach all the different components and special populations in the expansion population. In addition, the Assisters plan specifically references county eligibility workers and local provider agencies as sources of face-to-face assistance in enrollment for both Medi-Cal and health benefit exchange products. Although Navigators will not be paid to enroll people in Medi-Cal, they will be expected to assist people to complete the eligibility information input process. Over 21,000 eligibility workers, 23,000 certified application assistors, and hundreds of community organizations are expected to participate in California's outreach and enrollment initiative.

The Marketing and Assisters plans identified above do not have specific and detailed strategies targeted solely to uninsured, un-enrolled adults with mental illness or substance use service needs.[30] This does not imply that more generic strategies will not be effective, but it suggests that as the work plans are actually implemented, DHCS will need to stay in close communication with the counties (and in particular the ten with the highest potential enrollees), especially through CMHDA and CAADPAC, to assure that there is an effective county focus on outreach, engagement and enrollment for people with these conditions. For example, counties could choose to prioritize training County MHP intake staff as Assistors and/or Navigators. The same is true for the counties' departments of alcohol and drug services, along with their substance use service providers, including those that are DMC providers. County health programs, county clinics, and county hospitals are another natural source of outreach and engagement for un-enrolled safety net mental health and substance use service recipients. Counties could also focus their efforts on engaging and enrolling special populations such as people experiencing homelessness and people exiting jails and prisons, a high proportion of

[30] Note: The ACA, §2201 part F requires specific outreach to individuals with mental health and substance use service needs.

whom are likely to have substance use and mental health services needs and face unique barriers to care. In addition, it is noteworthy that many adults with mental health or substance use service needs have their first and/or only contacts with the system via hospital emergency departments.[31] Counties could also consider options for focusing their efforts on this population as well as evaluating the feasibility of the co-location of specially trained mental health and substance use Navigators/Assisters in emergency rooms as a potentially productive strategy.

Effective enrollment of beneficiaries is a critical priority of the Administration and the Legislature. Additional highlights of the enacted 2013-14 budget include funding for efforts to enroll individuals with mental health and substance use needs into Medi-Cal as a part of the Medi-Cal expansion. The recently enacted budget:

- Leverages $26.5 million approved by The California Endowment to draw federal funds to provide a total of $53 million for management and funding of Medi-Cal outreach and enrollment plans and in-person assisters. Of this total amount, $25 million will be specifically focused on outreach and marketing to people who have special needs as specified, to enroll in coverage and begin to obtain needed mental health and substance use services. The remaining $28 million will be available to provide in-person enrollment assistance to Medi-Cal applicants.

- Increases funding for the Transitional Case Management Program for additional workers to increase Medi-Cal enrollment of inmates prior to release from prison,

Senate Bill X1 1 also authorizes the following simplified enrollment strategies:

- *"The department shall seek any federal waivers necessary to use the eligibility information of individuals who have been determined eligible for the CalFresh program under Chapter 10 (commencing with Section 18900) of Part 6, and who are under 65 years of age and are not disabled, to determine their Medi-Cal eligibility.*

- *The department shall seek any federal waivers necessary to automatically enroll parents in the Medi-Cal program who apply for Medi-Cal benefits and have one or more children who are eligible for Medi-Cal benefits based upon a determined income level that is at or below the applicable income standard for eligibility under Section 14005.60.*

- *The department may seek any federal waivers or state plan amendments necessary to use the eligibility information of individuals determined eligible for other state-only funded health care programs and county general assistance programs to determine an applicant's Medi-Cal eligibility to the extent that there is no General Fund impact."*

Additional attention by state and county agencies of jurisdiction should also be spent including key agencies and organizations that have routine contact with people with mental health and substance use service needs who might be eligible to enroll in Medi-Cal. These include homeless Continuums of Care and homeless service providers; Projects for Assistance in

[31] California has the option under the ACA of certifying hospitals as site to determine presumptive eligibility for Medi-Cal.

Transition from Homelessness (PATH); Federally Qualified Health Centers (FQHCs); Lesbian, gay, bi-sexual, transgender and questioning (LGBTQ) advocacy groups; and peer and consumer self help groups.

It will be important that outreach, education and marketing efforts as well as the activities of the assisters/navigators pay special attention to reaching out to and communicating with special populations that have particular language and cultural barriers to accessing health care. These barriers are likely to particularly affect people with mental health and substance use needs. Thus, during implementation, it will be important to assure and support media and education strategies at the county level and to train of assisters and navigators to address cultural attitudes about mental illness and substance use. For example, Native Americans, certain Asian/Pacific Islanders, and certain Latino sub-groups have values and perceptions related to mental illness and substance use that are different from the dominant culture and also different from each other.

The statewide Assisters program report notes that: "*Assistance delivered through trusted and known channels will be critical to building a culture of coverage.…"* Trusted and known channels for many of the defined special populations typically do not include traditional mental health and substance use service providers and organizations. County leadership should continue to recognize and encourage participation of neighborhood and community religious and cultural organizations, since these organizations are more likely to be able to communicate with their constituents about the potential for Medi-Cal enrollment and the benefits of seeking assistance for mental health and substance use issues.

Counties are also addressing re-entry and service access for people involved in the juvenile and adult criminal justice systems and need to continue this focus. Over the past ten years, the criminal justice system has been the most significant referral source for person with substance use disorder problems. To serve the needs of the persons from the criminal justice system, Parole and Probation officers may need to have access to Assisters. Counties are also likely to be engaged in planning for transition from foster care or related child welfare services. County agencies involved in these processes are in the best position to assure that re-entry and aging out populations are linked to appropriate insurance coverage, including Medi-Cal expansion. Thus, while already engaged, DHCS and the counties should ensure these entities are fully included in education, outreach, and engagement functions and activities.

## Monitoring of outreach, education and enrollment strategies on a statewide basis

Section 7 of this report addresses quality management and performance improvement for the Medi-Cal mental health and substance use services. While the state retains the lead role in relation to the federal government, it will be important for both the state and counties respectively to work closely to monitor the enrollment rates and the degree to which newly enrolled participants actually receive mental health and substance use services. Table V summarizes some examples of output measures that the state and counties might consider using with the managed care plans to assess the degree to which the Medi-Cal expansion population is actually being enrolled, and if enrolled, that they are actually accessing mental

health and substance use services. These can be added to, modified and adjusted via partner and stakeholder input and discussion during implementation.

### Table V: Suggested Indicators of Performance for the Medi-Cal Expansion Population Enrollment and Engagement Process

| Indicator | Question to be addressed |
|---|---|
| 1. Total number of actual new Medi-Cal enrollees compared to predicted enrollees per year | Is the pace of Medi-Cal enrollment matching the take-up assumptions in the estimates?<br><br>If take-up is lower than expected, then county-by-county and sub-population enrollment rates should be explored to see if corrections are needed for the outreach, education, marketing and assisters/navigators plans. |
| 2. Total number of new Medi-Cal expansion population enrollees that access a mental health service compared to the estimates. | Are new Medi-Cal enrollees actually accessing mental health services at the rate predicted in the estimates?<br><br>If mental health participation is lower than expected, quality improvement analyses should be conducted of cross-plan referral completion rates. |
| 3. Total number of new Medi-Cal expansion population enrollees that access a substance use service compared to the estimates | Are new Medi-Cal enrollees actually accessing substance use services at the rate predicted in the estimates?<br><br>If substance use service participation is lower than expected, quality improvement analyses should be conducted of cross-plan referral completion rates. |
| 4. Total number of expansion population that receives alcohol screening | What proportion of expansion population enrollees receives alcohol screening? |
| 5. Average annual service costs per enrollee for mental health services compared to the estimates. | Is the level of service access and costs for mental health services higher or lower than predicted?<br><br>If the costs are significantly higher, adverse selection may be occurring; if the costs are lower, either the expansion population is not being effectively engaged in services after initial contact or the expected participation rates by service type were too conservative. |
| 6. Average annual service costs per enrollee for substance use services compared to the estimates, within both managed care medical homes and specialty DMC. | Is the level of service access and costs for substance use services higher or lower than predicted?<br><br>If the costs are significantly higher, adverse selection may be occurring; if the costs are lower, either the expansion population is not being effectively engaged in services after initial contact or the expected participation rates by service type were too conservative. |

| Indicator | Question to be addressed |
| --- | --- |
| 7. Annual psychiatric inpatient hospital costs for new Medi-Cal enrollees compared to baseline measures. | Are expansion population members using higher than expected psychiatric inpatient hospitalization admissions and days and therefore costs?<br><br>Higher than expected psychiatric inpatient utilization could be an indicator of ineffective or incomplete referrals to outpatient mental health and substance use services. |
| 8. Utilization and costs of crisis services (e.g., crisis intervention, stabilization-ER, stabilization, etc.) compared between community and hospital emergency room settings, compared to baseline measures. | Are crisis services being delivered in community settings, thereby reducing pressure on hospital emergency rooms and perhaps reducing time spent in emergency rooms waiting for beds? |

# 5. Implications for Provider Network Capacity and Workforce Development

At the state level, the majority of the efforts to address provider network capacity and workforce development are being led by the Office of Statewide Health Planning and Development (OSHPD). At the county level, individual counties dedicate efforts to address their unique circumstances and needs, and at both the state and county levels, CiMH, ADPI, UCLA and others continue to play important roles.

Per WIC Section 5820, the Office of Statewide Health Planning and Development (OSHPD) is accountable for the development of the next Five-Year Plan that will be in effect (Appendix C), and OSHPD recognizes the fact that California currently has health workforce shortages in numerous health personnel categories. Recognizing that the ACA will bring a substantial proportion of uninsured persons into the state's health delivery system, OSHPD continues to engage in activities that aim to increase California's health workforce and ultimately increase health access for all Californians.

In 2010, OSHPD partnered with the California Workforce Investment Board (CWIB) to aid in the development of a comprehensive strategy for workforce development in California.

OSHPD and CWIB's work was focused on the health professions education, training, and workforce development provisions in Title V of ACA and included the establishment of the Health Workforce Development Council (Council) to guide the preparation of a comprehensive strategy that can be implemented statewide and regionally. OSHPD has now transitioned to the role of Council member and has begun the implementation of the Council's recommendations within the Healthcare Workforce Development Division. OSHPD's primary activities regarding health care reform include: Stakeholder engagement; program development and evaluation; resource development; research and analysis; and policy analysis. To view OSHPD's HCR work plan activities, go to the California OSHPD web-site and click on OSHPD HCR Work Plan.

In the area of mental health, OSHPD also manages the state MHSA Workforce Education and Training (WET) funds and this program targets workforce development programs to better address the shortage of qualified individuals to provide services to address severe mental illnesses. It should also be noted, given the estimated percentages of individuals with co-occurring mental health and substance use disorders (estimates ranging between 20%-40%), that any efforts led by OSHPD will also have significant a impact on both the mental health and substance use disorder workforce issues. OSHPD is preparing a Five-Year Workforce and Education Training Plan by April 1, 2014. This plan will inform the spending of remaining MHSA (WET) funds.

In addition to OSHPD's efforts, the enacted 2013-14 state budget included $2 million in MHSA State Administration funds for OSHPD to provide training in the areas of crisis management, suicide prevention, recovery planning, and targeted case management and to facilitate employment of Peer Support classifications.

Also, SB 82, the *Investment in Mental Health Wellness Act* of 2013, enacted as part of the 2013014 state budget, will increase capacity within the community mental health system. Specifically, it funds infrastructure grants that will strengthen capacity, target special needs populations and address workforce development issues for the community mental health system in California. Specifically, this legislation intends to:

- Add at least 25 Mobile Crisis Support Teams and at least 2,000 Crisis Stabilization and Crisis Residential Treatment beds over the next two years to expand community-based resources. These resources would bolster capacity at the local level to address short-term crisis, acute needs, and the longer-term ongoing treatment and rehabilitation opportunities of individuals with mental health care disorders.

- Add at least 600 triage personnel over the next two years to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, and clinics.

In addition, the enacted 2013-14 budget included focused resources for individuals leaving prison to receive mental health services:

- Increased funding for the Integrated Services for Mentally Ill Offenders Program to increase the programs capacity to serve mentally ill parolees, prioritizing those that are at-risk of homelessness (from 300 up to 1,000).

The *Needs Assessment* identified a number of issues related to provider and practitioner capacity for the system as a whole and for the Medi-Cal expansion population. This information has been up-dated and expanded by the CiMH in its June, 2012 Briefing Papers.[32]

The CiMH workforce paper includes a number of detailed strategies for (a) expanding the mental health and substance use service workforce; and (b) making better use of the current workforce and provider capacity. The recommendations address cultural and linguistic competence, adoption of best practices, and physical health integration as important components of overall provider and practitioner capacity enhancements. The TAC/HSRI needs assessment report and the CIMH report both identify important strategies to address the network capacity and workforce development issues.[33]

Table VI below provides estimates of new service participants and new service units for certain key service modalities to be delivered once Medi-Cal coverage expansion reaches "*steady state*" in 2020. Note that these estimates are over and above participants and services in the current system, and thus add to any current provider and workforce capacity shortfalls that have been previously identified.

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[32] California Institute for Mental Health Briefing ***Papers: Health Benefits Exchange – A series of Five Policy Papers on the California Health Benefit Exchange*** June, 2012. See specifically the policy paper entitled "*Workforce Issues Today and in the Future*"
[33] See Chapter IX of the ***Needs Assessment***

**Table VI: Estimates of New Participants and Service Units for Key Medi-Cal Services Effective 2020**

| Service Type | 2020 New Service Participants | 2020 New Service Units* |
|---|---|---|
| ***MHP Services*** | | |
| Crisis intervention | 10,194 | 20,388 |
| Crisis stabilization | 5,349 | 5,349 |
| Day Rehabilitation | 2,168 | 101,906 |
| Medication support - MH | 49,078 | 392,622 |
| Outpatient MH services | 53,095 | 902,619 |
| Targeted case management | 47,142 | 329,994 |
| ***DMC services*** | | |
| Outpatient drug free treatment | 14,683 | 337,703 |
| Narcotic replacement therapy | 6,920 | 2,525,805 |
| Day Care Habilitative | 1,284 | 1,284 |
| ***Other BH Services*** | | |
| Crisis stabilization - ER | 12,749 | 25,499 |

*Service units will vary by service type

These figures can be used (albeit with caution) to project workforce needs/provider capacity for mental health and substance use services for the Medi-Cal expansion population.

As noted in the CiMH report, it is difficult to predict provider and practitioner willingness to come into the Medi-Cal and commercial insurance provider networks. It is also difficult to know the degree to which there will be competition between commercial insurance networks, the managed care plans, the MHPs and the DMC provider networks for scarce provider and practitioner staff.

The baseline service participant population for all of the noted services is not static. There is considerable fungibility (meaning the ability to replace or exchange) between and among service types, meaning that if capacity for one type of service is limited, demand may be met with varying degrees of success with other service options (e.g. if there is insufficient community based crisis capacity, then inpatient and other residential utilization will increase).[34]

In addition, implementation of service delivery efficiencies and service enhancements can influence overall workforce demand. As the CiMH report points out, capacity improvements can be attained through better service delivery practices and more efficient service processes. For example, an increase in productivity from 50% to 70% can increase clinician caseload capacity by almost 400 encounters per year. Another example is the expansion of recovery-oriented evidence based services, which are known to produce less reliance on residential and inpatient treatment settings.

The needs of the SUD workforce are also critically important. Stakeholders were especially sensitive to this issue during stakeholder forums, emphasizing that the greatest capacity shortage may well be with SUD programs and services, and even

[34] The combination of Federal Block Grant requirements and service limitations within DMC limit flexibility among service categories compared to MHP services.

more so with those serving homeless and non-English speaking populations. Stakeholders also raised the concern that some current SUD statutes and regulations unintentionally serve as barriers to best practices and they encouraged DHCS to review and consider revising.

A recent draft report, ***Workforce Development Needs in the Field of Substance Use Disorders: June 2013 Draft***" (Appendix D) from the former Department of Alcohol and Drug Programs, offers valuable observations and key findings regarding the workforce needs. It also provides an excellent overview for future considerations.

As a result of the re-organization of this department and the complete transfer of its substance use programs to DHCS July 1, 2013, DHCS will now look specifically to its SUD Division for input and evaluating the feasibility and timing of these and other recommendations as it works with county partners and stakeholders. The draft report (pp. 31-36) also lists five chronic and longstanding issues with goals and objectives for consideration in addressing the problems.

While these problem statements all reflect longstanding challenges, there is hope that the transfer of the substance use programs of the former ADP into DHCS will provide new and stronger support for effectively addressing them. Specifically considering these and other key issues will also help focus attention as the state and counties determine what is feasible and in what order of priority.

1. ***Problem Statement 1:*** *The transition of ADP to DHCS may cause the implementation of these recommendations to stall. Progress on the implementation of the SUD workforce development task force recommendations must continue beyond June 30, 2013.*

2. ***Problem Statement 2****: There will be an immediate increased need for SUD services and no corresponding increase in the number of SUD workforce to address the need.*

3. ***Problem Statement 3****: There is not a sufficient number of SUD treatment workforce to address a sustained increased demand for service. Integration of healthcare creates a need to use resources in the most efficient manner possible.*

4. ***Problem Statement 4:*** *The SUD workforce is losing members due to a lack of employment opportunity, having a low pay scale, and other restrictions on various career ladders.*

5. ***Problem Statement 5:*** *Sufficient training does not exist to prepare and allow all healthcare disciplines to deliver SUD services*.

## TAC/HSRI Recommendations on Work Force Development

Considering the scope and size of these mental health and substance use disorder workforce and provider capacity issues, and the current unpredictability of the demand side in the marketplace, TAC/HSRI suggested in their analysis that it is logical to identify some specific, short term and measurable capacity enhancements that could serve as building blocks for future improvements in the system.

Below are five key provider capacity initiatives the Department, county partners and stakeholders consider worthy of immediate consideration as the state and its county partners work together with stakeholders:

1. ***State and Counties should explore feasibility and timing of collaborating on how best to assure maximum efficiency in access to and delivery of services***. As noted above, relatively small increases in productivity can substantially increase the capacity of providers to accept and serve new customers. In addition, rapid and facilitated entry into treatment is known to contribute to engagement and sustaining participation in services. This is especially true with the engagement of adults who have been screened and shown to have problematic alcohol use. Delayed access to services is frequently a concern of consumers and families, and the increase in service demand attending the Medi-Cal coverage expansion is likely to exacerbate current access issues.

   There have been many initiatives in California to increase the efficiency of service delivery. Because of the availability of MHSA funds, these initiatives have most frequently involved the mental health provider community, although the significance of co-occurring issues means these MHSA funds have impacted the substance use disorder community as well. DHCS and the counties should encourage expansion of these types of activities (e.g., participation in ***NIATx***[35] and SAMHSA ***BH Business***[36] - both of which support business and process improvements to increase productivity) for mental health and substance use providers, and should begin a process of measuring and benchmarking indicators of efficiency in the system. These types of indicators that the state and counties could consider and track could include, but not be limited to:[37]

   a. Elapsed time from initial assessment to first service;
   b. Elapsed time between service encounters;
   c. Percent of initial assessments/evaluations that result in on-going service provision;
   d. Percent of outpatient service participants receiving more than three encounters per episode of care; and
   e. Percent of participants dropping out of services before the forth encounter.

2. ***State and Counties should explore the feasibility of collaborating on how best to increase cultural/linguistic competence in provider networks***. As noted in Section

[35] See niatx.net
[36] See BHBusiness.org
[37] These indicators are available in California from existing datasets. However, additional analytic capacity will be needed to take advantage of the available data to assess implementation progress and performance.

IV of this report, the Medi-Cal coverage expansion population includes many Latino, Asian/Pacific Island, Native American and other special population groups that are disproportionately uninsured as well as disproportionately underserved in the mental health and substance use services systems. In addition, TAC/HSRI identified significant gaps in the availability of culturally/linguistically competent providers and practitioners in the current mental health and substance use service fields. Aggressive marketing of the coverage expansion for both Medi-Cal and Covered California is planned, but effective engagement of cultural/ linguistic minorities in services will require substantive changes in the current provider community. DHCS believes it is important to assess how best to utilize and supervise staff with lived experience as well as the use of peer supports as a strategy to address the issue of an insufficient number of credentialed professionals to meet expected needs. DHCS and counties should consider exploring the feasibility of the following steps to create a viable learning community:

a. Using state and county expertise and provider self-identification to identify a cadre of culturally/linguistically competent provider agencies in California (of which there are many, albeit not present in all communities). Engage these providers in developing strategies for other providers to: (a) effectively recruit bi-lingual, bi-cultural staff; and (b) participate effectively in community/neighborhood efforts to engage special population group members in treatment.

b. With technical assistance from the state involving OSHPD, CiMH and other resources in the University and Community College systems, counties should consider engaging these culturally/linguistically competent providers in developing training materials and case studies that can be used by other providers to increase their cultural competence and relevance to the community.

c. DHCS continue the existing training programs and technical assistance offered by the former Department of Alcohol and Drug Programs (now DHCS) to SUD providers, and consider feasibility of providing additional direct technical assistance to culturally/linguistically competent provider agencies to assure they qualify to participate in Medi-Cal provider networks and to bill Medi-Cal for services.

d. The state should explore feasibility of working with counties to develop and institute the process of measuring and benchmarking indicators of increases in Medi-Cal service participation on the part of defined cultural/linguistic and other special population groups. These indicators could include but not be limited to:

    i. Penetration rates in service compared with presence in the general population and the enrollee population;

    ii. Retention rates in services compared to other service sub-populations

iii. Analyses of other indicators of performance (see section VII of this report) by special population groups to see if there are disparities in access, service utilization, and proxy measures of performance.

3. ***State and Counties should explore the feasibility of collaborating on how best to expand and enhance the competencies of the substance use and mental health services workforce.*** One cross-cutting issue for both the mental health and substance use systems is workforce capacity and retention. In anticipation of individuals who will have access to services through the Medi-Cal expansion or Covered California, TAC/HSRI, ADPI, OSPHD and CiMH have identified substantial challenges including not only workforce shortages but also recruitment and retention, training, scope of practice and peer specialist issues in both the mental health and the substance use service arena. Stakeholders also suggested that a more aggressive approach to ensure a diverse and sufficient workforce (complementing the OSHPD WET 5-Year planning process) needs to occur. They suggested that one solution is to increase the number of peer specialists who offer a unique and powerful perspective as well as effective supports for clients. However, participants realized that Medi-Cal billing constraints for the services that peers can provide are a factor and some stakeholders recommended they be removed to encourage increased hiring and use of peers in the larger health eco-system.

   Additional workforce enhancement strategies under consideration involve exploring if and to what extent scope of practice of some health professionals should be expanded (e.g., the ability of nurse practitioners and other physician extender professionals, such as, but not limited to, Physician's Assistants, pharmacists and optometrists) to help treat beneficiaries.[38]

   Stakeholders emphasized the importance of increasing the use of telemedicine, specifically with professionals other than physicians, and that the list of individuals that can bill for services should include LMFTs and counselors. In addition, stakeholders recommended that these individuals should be able to bill Medi-Cal for behavioral health services in Federally Qualified Health Centers (FQHCs). The Department thinks these suggestions are worthy of further consideration.

   More closely evaluating scope of practice issues and allowing nurse practitioners and other physician extenders to offer more direct service that would make better use of their skills was seen as important, and this could also prove especially helpful in rural areas, where primary care physicians are particularly scarce, and in urban neighborhoods with a high percentage of Medi-Cal patients. In addition, TAC/HSRI identified substantial issues related to the training and certification of substance use counselors. Stakeholders identified the need for a regulatory standard for SUD providers that meet national certification standards, citing the current California

[38] The Institutes of Medicine, the health arm of the National Academy of Sciences, has recommended for years that nurses should play a larger role in diagnosing and treating beneficiaries and in helping to manage chronic diseases which would include chronic mental health and substance use disorders and their often concurrent medical issues.

standards as being the lowest in the nation. Stakeholders also recommended consideration of a single state certifying body for SUD providers/practitioners. The Medi-Cal expansion population is expected to include adults with substance use service needs who have never received treatment, or have received intermittent treatment through county safety net services. These individuals are known to incur system costs in a variety of sectors beyond substance use services, including hospital emergency departments, jails, homeless shelters, etc. Thus, it should be deemed a system wide priority to assure that when these individuals are enrolled in Medi-Cal they have access to substance use treatment. Increases in numbers of persons trained to conduct both the required alcohol use screenings and brief interventions within primary care settings, along with additional outpatient substance free treatment and intensive outpatient treatment practitioners are likely to be very important to this effort. LIHP plans have increased the access of people with substance use service needs to physical health care, but in most counties there has not been an increase in substance use treatment for LIHP enrollees. Thus, there may be pent up demand for substance use services that may not be observed in other service categories. DHCS should work with the counties to assess the feasibility of:

a. Establishing a measurable objective to add 300 new certified substance use outpatient counselors[39] by 2016 (Note that several stakeholders considered this number too low). That would provide sufficient staff to meet about 90% of the projected need for outpatient drug free treatment by 2020.

b. Consolidating and streamlining the substance use service staff certification process to assure consistency of substance use counselor competencies.

c. Earmarking a portion of SAPT Block Grant funds, or other available federal and state training dollars, between 2014 and 2016 to recruit, train and certify substance use counselors with cultural/linguistic competencies as well as best practice substance use service competencies;

d. Facilitating access to and participation in ***NIATx*** and SAMHSA ***BH Business*** training activities designed to assure that all key substance use service providers are qualified and have the capacity to bill Medi-Cal for services and to increase the overall efficiency and effectiveness of outpatient substance use provider systems.

4. ***State and Counties should explore the feasibility of collaborating on how best to increase effective working partnerships between mental health and substance use providers and FQHCs, health centers and other community***

[39] This estimate is derived by calculating that a FTE SUD counselor has about 1440 work hours in a year (2082 hours minus vacation, holidays and sick time). At 70 % productivity, which is an accepted industry standard, a counselor with 1440 work hours could deliver about 1,000 units of service per year. This, divided into the estimated 300,000 units of service (90% of the 377,703 new units of SUD outpatient service for the expansion population), results in a need for 300 new staff to meet the estimated service demand,

***based health service providers***. Strategies for increasing overall integration between and among mental health, substance use and physical health provider and service systems are addressed at length in the TAC/HSRI ***Mental Health and Substance Use Services System Needs Assessment***, and are summarized in Section VI below.[40] With regard to provider capacity, it is important to identify and forge linkages with community providers that can extend and enhance the ability of mental health and substance use providers to meet the needs of their participants. FQHCs, county health centers, rural health clinics and Native American health centers are examples of provider agencies that share service participants and have common missions. Other examples include homeless service providers, veteran's service entities, and public housing agencies. Effective linkages among these community partners at the point of service level can increase service access and appropriateness and can enhance service participant outcomes. DHCS should continue to work with state and county public health, mental health and substance use systems, and with statewide provider associations, to identify current best practices and to develop models that can be implemented on a statewide basis. Products of this activity could include but not be limited to:

a. Model interagency agreements defining mutual roles, responsibilities and referral mechanisms; (Nb. The current *CalMediConnect* effort is an example of this)

b. Model clinical protocols governing referral criteria, joint service planning, and service continuity mechanisms;[41] (Note: The current *CalMediConnect* effort is an example of this)

c. Model cross agency and cross clinical staff training materials to increase shared competencies; and

d. Strategies to expand the number of registered physicians who can provide specific medication assisted interventions within the primary/physical health care settings.

It is clear the ACA California's choice to adopt the Optional Expansion will likely increase workload for the current mental health and substance use disorder provider networks and workforce. California is addressing these workforce challenges. In addition, the state, working closely with county partners and stakeholders, will actively explore the feasibility, timing (short vs. long term) and approach to the key issues and recommendations so as to better meet the opportunities, needs and challenges created by health care reform.

[40] See Chapter X of the ***Mental Health and Substance Use Services Needs Assessment***
[41] For example, see: ***Clinically Informed Consensus Guidelines for Improved Integration of Primary Care and Mental Health Services in California*** published by CIMH.

# 6. Health, Mental Health and Substance Use Service Integration Opportunities and Strategies

The *Needs Assessment* report identified numerous initiatives related to the integration of mental health and substance use services with physical health services in California.[42] [43] In addition, the report notes that three major initiatives under the 1115 Bridge to Reform waiver have been providing real time experience with the opportunities and challenges of physical and mental health and substance use services integration. These are:

a. The enrollment of Seniors and People with Disabilities (SPDs) Medi-Cal enrollees into managed care plans.
b. The enrollment of 490,000[44] uninsured adults into Low Income Health Plans (LIHPs).[45]
c. A three year demonstration of integrated services for people dually eligible for Medicare and Medicaid (Duals - now called *CalMediConnect*).

In each of these three cases, the enrollee populations are likely to have high mental health and substance use service needs as well as physical health needs. Many of the participants in these demonstrations have also participated in mental health and substance use services through MHPs or DMC or through other county based safety net services. Based on these three initiatives, efforts are underway in virtually every county to strengthen interagency approaches to coordinating care among physical health managed care plans, MHPs, and DMC.

The DHCS requirements for mental health plans (MHPs)[46] and managed care plans require establishing memoranda of understanding (MOU) between MHPs and managed care plans. These requirements are relatively standard for this type of interagency MOU in the field. However, there are questions of whether these agreements are uniformly and effectively implemented. Moreover, the agreements do not pertain to substance use services. DHCS should work with both the managed care plans and the MHPs to strengthen and more closely monitor the MOUs as an important tool in implementing and tracking effective integration and collaboration.

By 2020, when the Medi-Cal coverage expansion population is fully enrolled into physical health plans, there will be a theoretical need to coordinate physical health and mental health for about 174,000 enrollees with mental health as well as physical health needs. Almost 96,000 enrollees are estimated to need substance use services as well as physical health services. Thus, it will be a major challenge for the physical health managed care plans to forge linkages and effective working agreements with the MHPs and DMC providers. Physical health managed care plans will need to be assured that when they refer a member to mental health or substance use

[42] Chapter X of the ***Mental Health and Substance Use Services Needs Assessment***
[43] For more information on integrated models, visit the SAMHSA, Center for Integrated Health Solutions website (http://www.integration.samhsa.gov/integrated-care-models) and also http://healthcaresubstanceuse.org/vision-2/models-2/."

[44] Current estimate
[45] California has also implemented the Delivery System Reform Incentives Payment (DSRIP) program, which also serves many individuals with co-occurring mental health, substance use and physical health service needs.
[46] 9 CCR § 1810.370

services that the referral, when appropriate, will be accepted in a timely manner. From the perspective of mental health and substance use systems, there is likely to be a large influx of new referrals from the physical health plans, and it will be important for those referrals to be clinically appropriate for the specific Medi-Cal services available through those systems. The CiMH report on clinically informed guidelines for mental health and physical health integration noted above provides a good start in defining how MOUs should actually produce results for participants, clinicians and providers, and are a basis for additional technical assistance and training to the field. However, these guidelines put more emphasis on mental health services and additional work is necessary to develop similar guidance related to effective integration of physical health and substance use services.

Integration of physical health and mental health and substance use care is critically important, but integration, communication and coordination between mental health and substance use systems and providers must be emphasized as well. These systems currently have separate plans, reimbursement streams, and provider networks. Anecdotal information from the needs assessment report suggests that integration, communication and coordination among these systems vary among the Counties. Now that both the publically community mental health and substance use services are re-organized and integrated within DHCS, there are new opportunities to increase joint planning and implementation of effective linkages between these systems at the provider and point of service levels.

# 7. TAC/HSRI Recommendations on Health, Mental Health and Substance Use Service Integration Opportunities and Strategies

In their analysis, TAC/HSRI suggested a number of concrete steps can be taken now to increase the degree to which integrated care becomes the standard for physical health, mental health and substance use services. Below are six key provider capacity initiatives suggested by TAC/HSRI that the state intends to consider in collaboration with our county partners and stakeholders. These include:

1. Attention to (and refinement if necessary) of existing regulations and contract terms to require all Medi-Cal plans (managed care and MHP), including DMC, have effective MOUs defining mutual referral practices, clinical protocols, information sharing protocols where appropriate, and joint planning for improved care coordination at the county/community level. In the discussion of MOUs, several stakeholders made the case for the importance of making the providers in the various systems more aware of and conversant with the warning signs and symptoms associated with elder abuse as well as child and domestic abuse.

2. Stronger monitoring and oversight by DHCS regarding implementation and operations of the MOUs.

3. Under the aegis DHCS, documentation and dissemination of best practices information from the many integration projects underway in California, with an emphasis on scalable integration practices emanating from SPD enrollment, LIHP implementation, and the Duals Demonstration. This could include best practice guidance related to screening for mental illness and co-occurring substance use and mental illness within all DMC, specialty mental health and physical health plans.

4. DHCS internal initiatives to increase joint planning, program implementation and program coordination within the mental health and substance use systems as well as other areas of the DHCS. This can be an integral part of DHCS's program implementation efforts as the newly acquired mental health and substance use systems are integrated with the rest of the Department, providing even stronger collaboration and integration.

5. Continued exploration of the feasibility of integrated health initiatives and special payment programs designed to increase physical health, mental health and substance use service coordination and integration. These include the continued active assessment by DHCS of the ACA Health Home option at some scale, and designation of Accountable Care Organizations (ACOs). Many people with serious mental illness, lacking access to decent primary health care, use emergency departments. The work of the Robert Wood Johnson Foundation has demonstrated that the Emergency Department (ED) overutilization and the subsequent cost

escalation found in certain zip codes was often due to people without access to quality primary care situating themselves where they knew they could get seen -- i.e. near EDs.

6. Implementation of indicators and benchmarks for health integration, including but not limited to the following output measures:

    - The percentage of Medi-Cal physical health plan members that access mental health and substance use services on an annual basis;
    - The percentage of MHP and DMC participants that also have physical health encounters on a annual basis; and
    - The number of emergency department presentations by MHP and DMC participants on an annual basis.

# 8. Performance Measurement, Quality Improvement, and Health Information Technology for Medi-Cal Mental Health and Substance Use Services

As noted throughout this paper and throughout *Needs Assessment*, the California health care system is complex, multi-layered and multi-faceted. Most Medi-Cal physical health care is organized through managed care plans at the county level, while specialty mental health is organized through county MHPs and substance use services are organized through the DMC program, primarily administered by county alcohol and drug administrators. Most counties in California[47] have a direct role in overseeing both the mental health and the DMC program, although in some situations the state contracts directly with providers in some counties for some services.

Many counties also operate LIHP plans for expansion population enrollment in Medi-Cal under the 1115 Bridge to Reform waiver. These LIHP plans have limited mental health benefits, (although some have voluntarily implemented more robust mental health benefits), and a smaller number of LIHPs have varying degrees of substance use service benefits.

Individual Medi-Cal enrollees can and do receive services from two or more plans at the same time (e.g., physical health from one plan, mental health and/or substance use disorder services from a county MHP or DMC provider). In addition, individual service participants could be receiving both Medi-Cal reimbursed services and state/county reimbursed services at the same time.

Given all the different ways in which individual consumers can be "*touched*" by the various plans, providers and funding streams, it is critical for DHCS to continue its current efforts to enhance its capacity to bring information together from a variety of sources to track both compliance and performance within the system. With regard to the Medi-Cal expansion population, for whom facilitated service access and increased health/mental health and substance use services integration are policy priorities, DHCS will be evaluating the feasibility of developing a set of key indicators (i.e., dashboard) that addresses specific performance and compliance policy objectives to track desired results of the Medi-Cal coverage expansion initiative. These measures will include behavioral health indicators. DHCS recognizes there is variability in type, quality, quantity and timeliness of data collection. With leadership from the DHCS Managed Care Division and the Mental Health and Substance Use Disorders area at DHCS, the department will work collaboratively with partners and stakeholders to work toward more effective collection and use of data. Stakeholders also cautioned the department that, in analyzing data that it was important not to lose the unique county variations. DHCS was clear that the Medi-Cal Managed Care Plan data dashboard is looking at Plan specific as well as state level data. In addition, the development of a data dashboard will be informed by various areas at DHCS as well as by the work of affiliated organizations such as the California Mental

[47] Fifty-two counties in California have combined mental and substance use administrative structures.

Health Planning Council, The Department of Managed Care, the Mental Health Oversight and Accountability Commission and other key state agencies and organizations.

The current and growing partnership between DHCS's newest area, Mental Health and Substance Use Disorder Services, with the Department's two long established Medi-Cal Managed Care and Benefits Divisions, are significant collaborations that need to continue to grow. While the discussion below is focused on mental health and substance use services, it must be viewed in the context of overall health reform and physical health, as well as mental health and substance use services interventions. The mental health and substance use systems cannot attain results for consumers unless all parts of the health care system under Medi-Cal are working in tandem. Also, while some indicators are focused on the coverage expansion population, quality and performance improvements should be viewed as benefitting all Medi-Cal mental health and substance use service participants, not solely members of the expansion population.

# 9. TAC/HSRI Recommendations on Performance Measurement, Quality Improvement, and Health Information Technology for Medi-Cal Health, Mental Health and Substance Use Services

TAC/HSRI suggested the following policy questions. DHCS agrees that, along with county partners and stakeholders, the Department should take the lead in jointly considering the feasibility and timing of the following policy questions, recognizing that more recommendations will emerge through implementation activities as well as the ongoing stakeholder engagement process.

Decisions will have to be made as to priorities, as well as which recommendations are feasible in the short versus long term and what can be accomplished administratively as opposed to what may need legislation. Key policy questions suggested by TAC/HSRI include but are not limited to the following:

1. To what degree are uninsured un-enrolled individuals being effectively enrolled in Medi-Cal and engaged, as needed, in mental health and substance use services?

    a. Are special populations being enrolled at an adequate rate to compensate for higher rates on un-insurance?

    b. Are all counties performing equally well in meeting enrollment expectations?[48]

2. Once enrolled, to what degree are these individuals receiving mental health and substance use services at predicted rates?

    a. Are health disparities being addressed in terms of the degree to which special populations are accessing and utilizing mental health and substance use services?

3. What is the mix of mental health and substance use services received by the expansion population as compared to the Medi-Cal existing population?

4. What are the per service and per year costs, for primary care and specialty care, of providing mental health and substance use services to the Medi-Cal expansion population, how do these differ from predicted costs, and how do they differ from the existing Medi-Cal population?

5. To what extent do Medi-Cal participants receive mental health and substance use screening and brief treatment under the aegis of their physical health managed care

[48] Counties are not solely accountable for meeting enrollment expectations, but the enrollment progress should be tracked on a county basis, and new strategies should be employed if county level enrollments are particularly low.

plans?[49]

6. What proportion of specialty mental health and DMC substance use service participants receive physical health services on an annual basis? This may also include assessing:
    a. What effect has Medi-Cal expansion had on drug-related death rates in California?" *(Data Source for tracking drug-related deaths in California: CDPH, Center for Chronic Disease Prevention, Division of Chronic Disease and Injury Control, Safe and Active Communities Branch.)*

    b. What proportion of substance use treatment facilities offered screening for hepatitis C?" *(Data Source for tracking the proportion of substance use treatment facilities offering hepatitis C screening: National Survey of Substance Abuse Treatment Services.)*

7. If it can be tracked in the primary care setting, what proportion of mental health and substance use service participants receive both mental health and substance use services on an annual basis?

8. What proportion of mental health and substance use participants are high cost users of health care services, and thus require care coordination or other similar interventions?

9. What proportion of mental health and substance use service participants receive a service encounter following screening.

10. Determine the feasibility of measuring to what degree mental health and substance abuse participants within Medi-Cal move back and forth between uninsured statuses or into commercial insurance on an annual basis?[50] Does the rate of movement between coverage statuses differ for people with mental health and substance use diagnoses as compared to physical health-only participants?

11. To what degree to Health Care Effectiveness Data and Information Set (HEDIS) measures indicate improving quality and performance in the system?

    a. Time from hospital discharge to follow-up outpatient encounter

    b. Hospital and emergency department readmissions within 30 days

12. What is the elapsed time between key service events (i.e., evaluation to first service, etc.) for mental health and substance use services?

13. What proportion of mental health and substance use service participants are accessing evidence based best practices and defined promising practices, and what proportion of

[49] Tracking this will require an ability to distinguish mental health and substance use screening and brief treatment encounters distinctly from other forms of health screening under physical health managed care plans.
[50] This is colloquially known as "churning."

overall Medi-Cal mental health and substance use service costs are attributable to such services?[51] (Some stakeholders expressed concern that the "*evidence based practice*" measure was "*ill defined and difficult to measure.")*

As can be seen from the above questions, the basic concerns of performance measurement and quality improvement focus on improving areas such as:

a. People getting enrolled in Medi-Cal, and as a result, accessing needed mental health and substance use services;
b. Enrollment and service access for underserved or other priority special populations;
c. Integration between physical health, mental health and substance use.
d. Continuity of enrollment in coverage;
e. Proxy measures of quality and effectiveness in the system; and
f. Evolution towards evidence based and promising practices in the system.

Stakeholders appreciated that the development of performance measures will be an ongoing project, with some taking more time to develop and needing to be phased in gradually. However, there was support for the implementation of effective outcome measures and cost/benefit measures and analysis, especially from representatives of higher education.

DHCS recognizes it must be concerned with compliance with CMS requirements, as well as the terms of contracts between DHCS and the managed care plans, counties and providers in the system. That is an on-going monitoring responsibility that underlies and is in addition to performance and quality improvement.

Recommendations for performance measurement and quality improvement have been listed because DHCS views the data to be collected and analyzed as indicators on the need for quality assessments and strategies, not necessarily as indicators of compliance. For example, it does not help consumers for the inpatient hospitalization rate to go down, if consumers with legitimate clinical needs for hospitalization cannot get admitted or wait in emergency rooms for extended periods for a bed. Nor is simple engagement in services by itself an indicator of success, unless other outcomes, such as reduced readmissions, are also attained. Compliance indicators typically focus on processes such as certification of staff, preparation of service plans, and documentation of service encounters. These are important underpinnings of quality and results for participants, but they are not specifically participant focused. Effective performance measurement and quality improvement must include participant outcome measures.

The focus on quality improvement has another important dimension: a quality- driven mindset about how to respond to the indicators of performance once they are measured. Quality management and quality improvement mean taking affirmative action to make the system and services actually work better for people. In the context of quality improvement, when an issue is identified through data analysis, a process of understanding the exact nature of the issue begins, and the state, the managed care plans and the counties must consider these questions both alone and in partnership with each other:

[51] Note: collecting this type of information will require changes to Medi-Cal claims codes/extenders.

- Is the result being shown in the data positive for service participants, or not positive for participants?

- What interventions might prove successful in remedying the identified problem and improving the experience and results for participants?

- How important is this issue to participants as compared to other identified issues in the system?

- What are the possible causes of the issue?

- How would desired improvements on the system be measured?

When compliance issues are identified, the usual intervention is a plan of correction addressing very specific items of non-compliance with specific time frames for correction. DHCS believes quality improvement interventions need to focus on broader scale and longer term initiatives that frequently include consumers, families and other stakeholders in the improvement process.

As noted above, DHCS understands the importance of establishing a central point for collection and analysis of Medi-Cal mental health and substance use service performance measurement and quality improvement issues. One function of this centralized function would be to collect data from all the disparate sources (including counties);[52] analyze and interpret the data; make it available on a regular basis to DHCS management and county management for system tracking and decision support; and publish summary information for use by the field and its stakeholders. Another function would be to translate findings from the data analyses into annual quality improvement initiatives to be carried out on a statewide or local basis in concert with physical health plans, MHPs, and DMC. A third function would be to collect and disseminate information on evidence based and promising practices to plans and providers in the field. The final function would be to assist county level entities to adopt their own quality improvement plans to address specific county level system and provider issues.

While there are significant evaluation efforts currently underway throughout the state, DHCS intends to work with the counties and other stakeholders to ensure more effective coordination. Many counties have developed their own approaches for local evaluation and quality improvement. DHCS recognizes that these efforts need to become part of a cohesive, coordinated evaluation strategy and the Department is committed to working toward the goal of a more comprehensive statewide picture of system performance that better captures and measures the effectiveness of services. System partners at the state and county levels must work together to adopt a continuous quality improvement framework as the foundation for this work, to identify strategies to improve data systems, and to support MHPs and health plans in their efforts to address gaps and improve outcomes for enrolled consumers.

[52] This should include CalOMS Tx and CSI data, but could also incorporate information on employment, criminal justice, homelessness and other issues pertinent to the mental health and substance use fields.

The overall goal is to use data to better track, monitor and improve the care delivered to Medi-Cal participants, including the coverage expansion population, by the various delivery systems.

DHCS currently has and is developing several mental health and substance use focused stakeholder forums and other input mechanisms, The Department recognizes stakeholder communication and input is a key area and it plans to evaluate existing and planned forums to ensure stakeholders across the continuum are better informed about evolving policies, programs and implementation issues---as well as ensure the Department has an adequate and accurate understanding of the issues from the various points along that stakeholder continuum. A systematic re-thinking of the various stakeholder processes that will be manageable by DHCS needs to occur, so these groups can continue to provide ~~a~~ valuable input to performance measurement and quality improvement, both for interpreting the data reports, and for adopting quality improvement plans and interventions.

Chapter XI of the *Needs Assessment* describes many initiatives, issues and recommendations related to modern health information technology for the mental health and substance use service systems

As noted in that report, there have been a number of successful initiatives, funded in part with Mental Health Services Act (MHSA) resources. In addition, the California Institute for Mental Health has been a leader in providing information and technical expertise to the mental health field to improve technology.

However, as also noted in the *Needs Assessment* report, there has not been an equivalent set of resources or technical expertise to assist the substance use services community to up-grade its technological capacities. Based on anecdotal information from the needs assessment report, some substance use service provider are not fully capable of documenting and billing claims for Medi-Cal reimbursement, which means they will not be able to contribute their capacities to meet increased demands for substance use services on the part of the coverage expansion population.

Effective health integration depends on effective health information technology, including the use of electronic health records (EHRs) and the ability to transmit and share information within California's Health Information Exchange (HIE). For example, participation by mental health and substance use service providers in Health Homes and Accountable Care Organizations will be dependent on their EHR/HIE capabilities.

In addition, effective implementation of and participation in performance monitoring and quality improvement strategies will be critical to the overall success of the Medi-Cal expansion initiative. Information originating at the provider agency level is the foundation for all performance measurement and quality improvement activities. Thus, providers in MHP and DMC networks will need capacity to collect and report data in a timely, accurate and consistent manner.

For all the above reasons, DHCS recognizes the importance of enhancing the information collection, reporting, sharing, and analysis capabilities of the mental health and substance use fields. Stakeholders repeatedly emphasized the need for additional resources for these improvements.

# 10. Conclusion

This *Service Plan* describes how DHCS intends to provide mental health and substance use services for the Medi-Cal coverage expansion population. To the extent possible, it is important that the recommendations offered for consideration in this plan are evaluated in the context of broader system wide initiatives related to *Covered California* (the Health Benefit Exchange), enrollment of the expansion population into physical health managed care plans, overall health reform activities driven in part by the Affordable Care Act, and the interface of the Medi-Cal system with other key systems and funding sources used to meet the needs of Californians needing mental health and substance use disorder services. This *Service Plan* recommends a set of enrollment and service access action steps and quality improvement activities for consideration that are intended to assist in the effective implementation of Medi-Cal expansion for people with mental health and substance use needs under several optional scenarios.

It is also recognized that regardless of the value of a particular suggestion or recommendation, there are significant state and county system resource capacity and timing issues that must be concurrently evaluated, considered and prioritized.

DHCS will enroll the Medi-Cal expansion population into managed care plans, and build upon California's county-based delivery systems for Medi-Cal Specialty Mental Health and Drug Medi-Cal. The goal is to facilitate seamless implementation of the expansion, which California will be well positioned to do, since these delivery systems are largely already in place.

This approach effectively builds on and expands the strengths and administrative efficiency of the current delivery systems while navigating the very complex implementation environment and imperatives of Medicaid expansion.

The expansion of Medi-Cal coverage in California will be the single largest coverage expansion initiative in the United States of America for adults under 138% of the poverty level. In addition to the scope of this expansion, California has considerable variety among its state and county based systems and diversity among its service population, all of which makes it a more complex undertaking. California intends to measure performance and use the findings to implement quality improvement to better guide and shepherd the implementation process. People in different geographic parts of the state may access mental health and substance use services through different types of entities. The plan's emphasis on data analysis, quality improvement and ongoing stakeholder engagement is designed to support as much as possible that enrollment and access for people in the mental health and substance use systems are consistent statewide.

As was discussed at the outset, this *Service Plan* provides a high level overview of how California will implement mental health and substance use disorder services in the expansion of Medi-Cal coverage. The Plan builds on the strengths of the current systems, recognizes the challenges, and seeks to serve as a guide for both the state and the counties as they implement these critical aspects of health care reform.

# Appendix A

# Analysis of Mental Health and Substance Use Benefits for the Medi-Cal Coverage Expansion Population

### Table 1: Medi-Cal Expansion Population Service Configuration Estimates for Adults

| | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|---|---|---|
| **Specialty Mental Health (SMH)** | | | | | | | | |
| Budget Act Total | $65,156,824 | $180,177,622 | $205,176,812 | $228,157,733 | $247,981,674 | $266,113,597 | $283,793,569 | $301,290,075 |
| **Drug Medi-Cal (DMC)** | | | | | | | | |
| Budget Act Total | $9,283,467 | $25,671,494 | $29,233,349 | $32,507,643 | $35,332,135 | $37,915,550 | $40,434,571 | $42,927,452 |
| **Enhanced Substance Use Disorder Services (SUDS)** | | | | | | | | |
| Budget Act Total | $10,483,474 | $28,989,860 | $33,012,132 | $36,709,700 | $39,899,295 | $42,816,640 | $45,661,253 | $48,401,609 |
| **Managed Care Mental Health (MH)** | | | | | | | | |
| Budget Act Total | $15,495,452 | $42,849,445 | $48,794,697 | $54,259,969 | $58,974,455 | $63,286,549 | $67,491,161 | $71,652,142 |
| **Mental Health Pharmacy** | | | | | | | | |
| Budget Act Total | $31,888,192 | $88,180,150 | $100,414,923 | $ 111,661,942 | $ 121,363,912 | $ 130,237,798 | $ 138,890,497 | $ 147,453,405 |
| **Assumptions** | | | | | | | | |
| Caseload | 575,184 | 757,405 | 821,422 | 869,930 | 900,491 | 920,317 | 934,724 | 945,097 |
| Mental Health Prevalence Rate | 18.64 | 18.64 | 18.64 | 18.64 | 18.64 | 18.64 | 18.64 | 18.64 |
| Substance Use Disorder Prevalence Rate | 10.30 | 10.30 | 10.30 | 10.30 | 10.30 | 10.30 | 10.30 | 10.30 |

## Appendix B: *Needs Assessment* Executive Summary

# California Mental Health and Substance Use Service Needs Assessment Executive Summary

# *Needs Assessment* Executive Summary

The California Department of Health Care Services (DHCS) contracted with the Technical Assistance Collaborative (TAC) and Human Services Research Institute (HSRI) (referenced throughout the report as TAC/HSRI), to conduct a Mental Health and Substance Use System Needs Assessment (referenced throughout the report as the Needs Assessment) and to develop a Mental Health and Substance Use Service System Plan. The Needs Assessment was carried out to satisfy the Special Terms and Conditions required by the Centers for Medicare and Medicaid Services (CMS) as part of California's Section 1115 Bridge to Reform waiver approval.

The primary purpose of the Needs Assessment was to review the needs and service utilization of current Medicaid recipients and identify opportunities to ready Medi-Cal, California's Medicaid program, for the expansion of enrollees and the increased demand for services resulting from health reform. While the report is focused primarily on the Medi-Cal mental health and substance use systems, our review also included analysis of data from the State's Department of Alcohol and Drug Programs' California Outcomes Measurement System Treatment (CalOMS Tx) database, and the Department of Mental Health's Client and Services Information (CSI) data set. This was done to provide a full picture of the mental health and substance use services system in California.

In addition to analysis of the three major datasets listed above, site visits, focus groups and interviews with over 140 key informants were an important element of the information collection process. TAC/HSRI also collected and reviewed over 100 documents related to California's mental health and substance use service systems. These activities resulted in a comprehensive report focusing on the following areas:

- Estimation of the prevalence of mental illness and substance use disorders (SUDs) among the population of California; (Chapter III)
- Analysis of service utilization, expenditures, and service penetration rates for the Medi-Cal, Department of Alcohol and Drug Programs (DADP), and Department of Mental Health (DMH) programs; (Chapters IV, V, VI)
- Projected numbers for and characteristics of the 2014 Medi-Cal expansion population; (Chapter VII)
- Identification of issues related to certain special populations enrolled in the Medi-Cal program; (Chapter VIII)
- Analysis of provider capacity and mental health and substance use workforce issues; (Chapter IX)
- Analysis of the state of health integration in California; (Chapter X) and

- Review of issues related to health information technology for mental health and substance use providers; (Chapter XI)

The following is an overview of the focus and major findings from the report.

## Prevalence of Mental Health and Substance Use Service Needs in California[53]

The chapter on prevalence of mental illness and SUDs addresses several important questions:

1. What is the estimated prevalence of mental illness among the population of California at both the state and county levels?
    a. What is the prevalence of serious emotional disturbance (SED) among youth?
    b. What is the prevalence of serious mental illness (SMI) among adults?
2. What is the estimated prevalence of substance use among the population of California at both the state and county levels?
3. How does the prevalence of mental illness and SUDs among Californians compare to that of other states?

Results of the analyses show statewide estimated prevalence as follows:

| Age & Diagnostic Group | Estimated Prevalence |
|---|---|
| Youth (0 – 17) with SED | 7.56% |
| Adults: SMI | 4.28% |
| Adults: broad definition of mental health need | 15.85% |
| Youth (0 – 17) with substance use needs | 8.15% |
| Adults with substance use needs | 8.83% |

Prevalence of mental illness and SUDs vary by gender, age, race, ethnicity, and county of residence. Results of these analyses included:

- Hispanic youth with SED were found to have a slightly higher estimated prevalence rate of 8.03% as compared with 6.85% for white (non-Hispanic) youth. African American and Native American youth also have a slightly higher prevalence rate of 7.99% and 7.91%, respectively.
- Prevalence of SED varies with income level with higher levels among youth from the lower income categories.
- Prevalence among adults with SMI increases with age between the ages of 18-20 and 35-44, ranging from 1.98% of the population for individuals ages 18-20 to 6.23% of the population among individuals ages 35-44.

[53] See methodological notes in forward and prevalence chapter based on stakeholder feedback

- Rates of SMI are higher among females (4.94% for females vs. 3.62% for males), Native Americans (7.02%), and individuals who are separated, widowed or divorced (6.93%). Prevalence tends to decrease as education level increases and as income increases.

Nationwide, state prevalence rates for youth with SED range from a low of 6.91% in New Hampshire to a high of 7.93% in Mississippi. California, with a prevalence rate of 7.44% for children with SED ages 0-17, falls approximately in the middle of the distribution with a rank of 28. State prevalence rates for adults with SMI range from a low of 3.26% in Hawaii to a high of 5.79% in Mississippi. Unlike with the children's estimate, California (4.28%) falls close to the lower end of the distribution for adults with SMI, coming in with the ninth lowest rate in the country. Similar state-by-state comparison data is not available for the substance use population.

County-level prevalence estimates of both mental health and substance use provide officials with useful information about the potential service demand in their locality to assist them in their own planning efforts. These data can also help clarify particular population subsets where need is greatest and can be used to help determine how best to tailor strategies and interventions to meet the needs of individuals with mental health and SUDs.

## Analysis of Medi-Cal Data for Mental Health and Substance Use Services

Chapter IV includes a comprehensive analysis of Medi-Cal mental health and substance use claims and encounter data for the years 2007–2009. These data were analyzed to answer the following questions:

1. What are the enrollment and penetration rates in mental health and substance use services for Medi-Cal participants?
2. What mental health and substance use services do Medi-Cal participants access and utilize? What are the overall expenditures for mental health and substance use services in Medi-Cal?
3. How are the expenditures distributed across key domains of service like inpatient, emergency, outpatient and rehabilitation? Who are the high utilizers of Medi-Cal mental health and substance use services, and what are the associated expenditures?
4. What is the current performance of the system as measured by HEDIS indicators (time from hospital discharge to follow-up outpatient appointment, and hospital and ED readmission rates)?
5. In what ways do the above variables vary by age, ethnicity, eligibility category, diagnostic category and participation in Drug Medi-Cal/Specialty Mental Health Services (DMC/SMHS) versus fee-for-service (FFS)?

Major findings of these analyses included:

### *Penetration rates*

TAC/HSRI used the prevalence estimates described in Chapter III as the basis for calculating penetration rates for Medi-Cal and also for the Department of Alcohol and Drug Program (DADP) and Department of Mental Health (DMH) datasets. The prevalence estimates are based on the total population of individuals needing mental health or substance use services, not just individuals who are or will be eligible for Medi-Cal. Also, the estimates do not reflect the number of people who will ask or present for services, but rather estimate the number of people in each category who theoretically need services. Finally, there are some people in the prevalence estimates already receiving mental health or substance use services through commercial insurance, private pay, or safety net service provision under county DADP and DMH programs. Thus, the prevalence estimates do not reflect unmet need or demand for services in an absolute sense. Nonetheless, use of the prevalence estimates support an accurate assessment of the degree to which the Medi-Cal, DADP and DMH systems are meeting the need for mental health and substance use services in California.

For example, the populations for DMC services and for SMHS under the 1915(b) waiver are adults with SMI and youth with SED. Thus, the most relevant calculation of penetration rates is to compare the number of individuals within these population groups actually served versus the estimated number of these types of individuals in California. At the same time, the broader definition of mental health need is used to calculate penetration rates for people accessing Medi-Cal services through FFS or physical health plans, since these individuals would be referred to the mental health plans (MHPs) if they met the clinical definition of the narrow prevalence estimates.

1. Penetration rates[54] for SMI and SED in the Medi-Cal program were 22% and 14% respectively.[55]

2. Penetration rates for substance use were 4% for the Medi-Cal program.

3. Penetration rates for adult other behavior health in the Medi-Cal program is 2%.

4. Asian and Hispanic populations have the lowest penetration rates across diagnostic cohorts.

### *Utilization, expenditures and performance - DHCS*

1. Total dollars spent on mental health and substance use services grew from just under $3.2 billion to a little over $3.8 billion during the years 2007 to 2009.

2. Substance use service expenditures averaged 11% of total mental health and substance use expenditures across the three years.

[54] Defined as number of people who receive a service within a demographic category divided by the number that need the service in the state according to prevalence estimates.
[55] Note that the penetration rate is based on the prevalence of SMI, SED, and SUD among the population of California and is not limited to current Medi-Cal beneficiaries.

3. The number of individuals receiving Medi-Cal funded services grew over the three year period – 3% from 2007 to 2008 and 4% from 2008 to 2009. The number of unique users of the system increased from 523,072 to 564,480 in 2009.

4. Expenditures increased 17% over the three-year period, but overall average costs per service participant increased by just over 10%. This occurred despite a positive shift of resources away from inpatient services and towards outpatient services between 2007 and 2009.

5. The largest eligibility category is SSI/SSP under age 65, at 42% in 2009.

6. The data showed a large number of people receiving a small number of service encounters (three or fewer).

7. High cost service users represent a large percentage of total expenditures – in 2009, the top 20% used 82% of total expenditures, and the top 5% used 55% of total expenditures.

8. The data indicates improving performance (e.g. increasing proportion of participants receiving an outpatient follow-up visit after an inpatient stay).

9. While available data from DHCS related to mental health and substance use ED utilization did not show an increase, use of claims data to draw a definitive conclusion is limited; there is no other available statewide data source that can provide such information. Further, many mental health and substance use services provided at EDs are not reported, since no formal billing, contractual or notification system exists.

## Analysis of the DADP California Outcomes Measurement System Treatment (CalOMS Tx) Data

The questions addressed in Chapter V include:

1. What are the characteristics of people accessing DADP services in California?

2. Are there differences in substance use service utilization based on these characteristics?

3. What patterns can be described relative to single episodes of care versus multiple (continuous and recurring) episodes of care in substance use services?

4. What are the average lengths of stay in services for different service modalities?

5. What proportion of service participants complete treatment?

6. What are the average wait times for accessing substance use services?

7. What patterns can be discerned related to resource utilization within the ADP system?

8. How do California's DADP service access and utilization patterns compare with national averages?

TAC/HSRI received CalOMS-Tx data for the time period 2007 through 2010. Data were analyzed according to: a) time (fiscal year); b) demographic characteristics (gender, age, race and ethnicity, etc.); c) treatment service type or modality (outpatient, detox, long-term residential, etc.); and d) proxy best practice indicators (days waited to enter treatment, length of stay, discharge status, and recurrent and continuous users of the treatment system). The project team examined these dimensions in relation to the following types of variables: Medi-Cal beneficiary status, referral source (individual, criminal justice, etc.), substance use conditions (primary substance use, poly drug use, needle use), other health-related services conditions (physical health, mental health, etc.), and social conditions (living with someone who uses substances, serious conflict with family members).

The following are some key findings from the DADP data analysis:

- The overall penetration rate within DADP is 6%.[56]
- The DADP system currently accomplishes over 180,000 service admissions per year, and the non-Medi-Cal budget for county-level substance use services is over $550 million.
- Access and utilization of DADP services is similar to national patterns.
- Compared to national estimates the system is producing better than average treatment completion rates for detox and residential services and slightly lower treatment completion rates for outpatient services.
- Unlike national trends, DADP short-term residential (1%) is much lower than long-term residential (16%).
- Positive measures include short time to treatment[57] (e.g. 72% of all admissions within one day and 89% within a week) and a good balance of outpatient, residential and detoxification services relative to national norms.

## Analysis of the DMH's Client and Services Information (CSI) Data

CSI data supplied by DMH permitted analysis of a number of key questions related to non Medi-Cal funded mental health services in California. Questions addressed in Chapter VI include:

1. What are the characteristics of people accessing services from California's MHPs?
2. What are the types and amounts of services delivered?

[56] As previously described, this is calculated by dividing the current DADP service population (unique individuals served within a year) by the estimated prevalence for that group.

3. To what extent are evidence-based practices (EBPs) and best practice service strategies being utilized across the state?

4. What is the functional level of people served by the system?

5. Are there differences in the type and amount of services received by functional status level?

6. Are there differences in how people transition into and out of the system by functional level and services utilized?

The CSI dataset includes some variables not included in the Medi-Cal claims data, such as level of functioning (GAF score) and use of EBP service models. This allowed analysis of the relationship between levels of functioning and the receipt of certain service modalities. However, this dataset does not include specific claims-based information on service encounters or costs. Nor does it identify which providers delivered services. . Given limitations in identifying information, it was not possible to compare unique individuals between CSI and Medi-Cal datasets.

Key results of the CSI data analysis include:

1. Penetration rates were 35% for SMI and 32% for SED.[58]

2. There is low utilization of EBPs reported in this dataset (approx. 1% to 2% across the years).

3. EBPs seemed to be on the rise until 2010. This is a valuable data set to keep tracking as most states are not maintaining data systems on EBPs and service strategies.

4. Adults who received an EBP seemed to be more likely to be retained and engaged by the system.

5. Lower functioning youths who received an EBP were more likely to improve, and higher functioning youth were more likely to exit the system (potentially an indicator they no longer needed services).

## Medi-Cal Expansion Population

The specific questions addressed in the expansion population chapter include:

1. What is the estimated size of the overall Medi-Cal expansion population that will begin enrollment in 2014?

2. What is the predicted composition of the Medi-Cal expansion population?

3. What is the health/mental health and substance use status of the expansion population?

[58] As with Medi-Cal and DADP, these penetration rates are calculated by dividing the total unduplicated number of individuals in each group served by the estimated prevalence for these groups. As noted previously, some people do not request services, and some people receive services from other systems with other payment sources. Thus, the difference between the penetration rates and 100% is not an indicator of unmet need.

4. What will be the county-by-county distribution of the expansion population?

5. What proportion of the overall expansion population can be expected to want and need mental health and substance use treatment services?

6. Will there be differential effects in mental health and substance use needs across the counties?

TAC/HSRI used data analysis and a combination of national and California based literature to prepare estimates of characteristics of the expansion population. Key findings include:

### *Expansion population size and demographics*

1. The total Medi-Cal expansion population beyond 2014 is estimated to be in the range of 1.5 to 2 million additional enrollees.

2. The following demographic characteristics are projected: 26% age 18-26 years (this could be significant given that this period coincides with typical onset of mental health and substance use issues and seeking of treatment); 40% age 27-44 years; 18% age 45-54 years.

3. 70% of the overall expansion population is expected to be non-Caucasian, with 23% non-English speaking.

### *Health status and mental health and substance use services need*

1. Between 279,000 and 373,200 individuals within the expansion population are estimated to need (but not necessarily ask for) mental health services.

2. Between 147,000 and 195,000 of the overall expansion population are expected to need substance use services.[59]

3. Individuals with the most serious health and mental health and substance use service needs are likely to have already enrolled in Medicaid and are not likely to be heavily represented in the expansion population.

4. The rates of mental health and substance use disorders among the total estimated mental health and substance use expansion populations are not likely to be substantially different from expected prevalence in the general population, but early enrollment of people with higher mental health and substance use needs is expected based on the experiences of other states.

5. Ten counties (Los Angeles, San Bernardino, Orange, San Diego, Riverside, Sacramento, Fresno, Santa Clara, Alameda, Kern) are expected to account for 50% of the increase in Medi-Cal enrollments after 2014.

[59] There is likely to be duplication between the substance use and mental health expansion populations, so the estimates cannot be added together.

### *Preparing for adverse selection*

1. Many childless adults have been categorically ineligible for Medicaid. Medicaid expansion presents a first opportunity for these individuals to obtain health coverage.

2. Public health and mental health and substance use service systems have been using extremely limited non-Medicaid public resources to serve people currently ineligible for Medicaid. When these individuals become eligible, there will be a powerful incentive for public systems and providers to assure these individuals are enrolled in Medicaid.

3. Although it is likely the expansion population will be enrolled in managed care plans, there is likely to be a need for facilitated access to both DMC and the MHPs for some portion of the expansion population. Not all members of the expansion population will have mental health and substance use service needs that can be met solely through the benchmark plan benefit design.

4. Due to predicted higher co-morbidity of physical health and mental health and substance use issues for the early enrollees in the expansion population, the degree of need for multi-system approaches and integrated care coordination models is likely to be higher among the expansion population than for the current non-disabled Medi-Cal population.

## Medicaid Strategies for Special Populations

The special populations discussed in Chapter VIII are:

- People experiencing homelessness;
- People with SUDs;
- Adults exiting the criminal justice system;
- Youth involved with the child welfare or juvenile justice systems; and
- Racial, ethnic, and cultural groups.

Key questions of interest include:

1. What are the current barriers to Medicaid enrollment for these populations, and what opportunities are available for targeting outreach and enrollment strategies?

2. What mental health and substance use benefit design and service array are effective in addressing the special mental health and substance use needs of these populations and what gaps exist in the current benefit design?

3. What range and type of providers (including special skills and competencies) are required to address the unique needs of these populations?

4. What can penetration rate data tell us about how well the current Medi-Cal mental health and service system is performing related to access and quality for particular special populations?

TAC/HSRI accessed a variety of qualitative and quantitative information for the analysis of special population issues. These include:

- Reviews of published reports on best practices occurring nationwide and in California related to enrollment, outreach, services, provider qualification and networks, and quality monitoring and improvement for these special populations.
- Key informant interviews about needs and gaps related to services, enrollment mechanisms, providers, and other issues impacting the effectiveness of the system to adequately address the mental health and substance use needs.
- Analysis of penetration rates, service utilization, and prevalence of mental health and substance use disorders for certain special populations.

Key findings of the analysis of special population issues include:

- California already has in place several provisions that support treatment access for special populations (e.g., 12 months continuous Medi-Cal enrollment for children; coverage of foster care involved children until age 21 (in place prior to new health reform requirements).
- Asian and Hispanic people have the lowest overall mental health and substance use service participation rates within the Medi-Cal, DMH and DADP datasets. These population groups are also estimated to be highly represented in the currently uninsured Medi-Cal expansion population. Special outreach and engagement efforts directed at these population subgroups are recommended within the system plan. It should be noted that all population groups, not just special populations, experience low participation rates, particularly in Medi-Cal.
- Given the vulnerability of special populations, continued efforts to monitor gaps, engage a diverse provider network, and include services in the benefit package that impacts these populations are critical.
- Many of the special populations discussed in this chapter, such as persons experiencing homelessness, persons with SUDs, and persons exiting the corrections systems will comprise a significant portion of the expansion population. Without specific attention to the needs of these populations in the design of outreach and enrollment strategies, services, provider qualifications and networks, as well as quality monitoring and improvement activities, these populations could continue to experience barriers to service access, poor treatment outcomes, and high utilization of costly services such as EDs and inpatient care.

## Provider Capacity and Workforce Analysis

Chapter IX highlights some of the critical workforce issues facing California, details provider and workforce capacity information and key trends, and discusses results of the various key informant interviews. Several key questions drove both the quantitative and qualitative aspects of this provider capacity and workforce analysis. These questions included:

1. Who are the enrolled providers of DMC, Medi-Cal MHPs, and other Medi-Cal reimbursable mental health and substance services, and what is their geographic distribution?

2. Given that Medi-Cal enrolled providers may also deliver services to persons covered by other insurers, two important questions arise: What is the functional capacity of the current Medi-Cal mental health and substance use service provider system for Medi-Cal beneficiaries? What number of unique Medi-Cal participants is served by Medi-Cal enrolled providers?

3. What is the inpatient capacity designated for acute psychiatric inpatient and/or substance use detoxification and treatment, and what is the geographic distribution?

4. What types of providers and mental health and substance use workers are in demand?

5. To what extent are persons with lived experience being utilized in the provision of mental health and substance use services?

6. What are the characteristics of the mental health and substance use workforce, including racial/ethnic composition and linguistic capacity?

7. What are the workforce skills and competencies considered necessary to meet the needs of Medi-Cal beneficiaries?

Several quantitative and qualitative data sources were used for this analysis. These include:

- Published reports related to national and California specific workforce issues and trends;

- State and County-level reports about provider and workforce, including selected Workforce Education and Training (WET) plans and needs assessments, and county MHP External Quality Review Organization reports;

- Interviews with key informants about issues, including perceived needs and gaps, facing the mental health and substance use workforce;

- Data about human resource capacity and labor statistics both nationwide and in California;

- Data from licensing and certification boards for various mental health and substance use service practitioners; and
- Medi-Cal claims and provider identification data.

In combination, these sources of information illuminate a number of key findings, as summarized below:

- California has invested significant effort in expanding and supporting the behavioral workforce.
- Determining provider capacity is incredibly challenging. Much of the data that is available to assess capacity are proxy measures (e.g. bed capacity) are only "moment-in-time" snapshots, and do not capture capacity dedicated solely to Medi-Cal beneficiaries (given that providers serve multiple payers).
- Analysis of inpatient psychiatric and detoxification beds suggests an inadequate supply as well as mal-distribution of these beds in the state. Availability of alternatives to inpatient hospitalization such as crisis residential services is also limited, with very few providers of crisis residential services existing across the state. Increasing the availability of services intended to divert people from inpatient care, such as crisis residential, ASAM levels 3.5 and 3.7 residential care, and peer support services, may lessen the impact of the shortage of inpatient and detoxification beds in the state.
- Specific issues include: a) shortages of psychiatrists/nurse prescribers, b) rural access issues, c) a need to further leverage FQHC capacity; and d) untapped workforce of consumers/persons with lived experience who could serve as Medi-Cal providers.
- There is a need to address SUD certification variation and alignment with best practice in SUD treatment; improve ability to treat co-occurring mental health and substance use issues; and challenges with readiness for broader implementation of EBPs.
- There is variability among the counties in the use and training of staff in state-of-the art and evidence-based and recovery-oriented treatments such as integrated treatment for co-occurring disorders, Assertive Community Treatment (ACT), Screening, Brief Intervention, and Referral to Treatment (SBIRT), Multisystemic Therapy (MST), or medication assisted therapies;
- There is a need for more culturally responsive and competent provider practices to engage underserved populations;
- There is variability among the counties in collaboration with FQHCs, pointing to a need for more consistent collaboration and stronger partnerships between FQHCs and county mental health and substance use departments statewide.

## Health Integration

The chapter on health integration (physical health, mental health and substance use) focuses on the following issues:

1. What structural, financing, practice, and/or regulatory issues promote care integration or conversely make integration of care challenging?

2. What best practice models exist for integration of care across physical health, mental health and substance use, and what lessons learned can be applied as California considers various options available under health reform to promote better integration of care?

The following activities were conducted as part of this health integration analysis:

- Published reports related to national and California specific health integration activities were reviewed and analyzed for key themes. The review included selected county MHP External Quality Review Organization reports.

- Key informant interviews about the lessons learned from various health integration projects in California. Key informant interviews also focused on understanding the various structural, financial, and regulatory issues that impede or promote integration.

Key findings of the analysis of health integration strategies include:

- There are numerous examples of exemplary practices occurring within several counties; however, most Medi-Cal participants in California do not have access to state of the art integrated treatment to address physical, mental and substance use treatment needs.

- As with other states, there is a need to turn pilots into scalable approaches.

- The unique configuration and diversity of county-level physical health plans and MHPs and the separateness of the substance use benefit in Medi-Cal from those health plans necessitates creative planning and problem-solving within each county as well as at the state level.

- There is a need to address a variety of different but interrelated integration strategies for the mental health and substance use service populations. These include customized approaches for children and youth, and coordination and access strategies for non-health services such as housing, employment and education.

- Current consideration of implementing Health Homes for certain Medi-Cal populations may lead to effective multi-system physical/mental health and substance use service integration models.

- There is a need to address better preparation of physical health providers to engage and treat persons with substance use and mental health needs.

- The state-level reorganization of the Departments of Mental Health and Alcohol and Drug Programs, including integration of these agencies' Medi-Cal functions into DHCS, promises to increase the uniformity and integration of policy and financing across these programs.

## Mental Health and Substance Use Service Information Technology

TAC/HSRI addressed the following questions in the chapter on Health Information Technology (HIT):

1. What is the current status of California's mental health and substance use HIT and exchange infrastructure?
2. What has occurred in the development and use of health electronic health records (EHRs) and the interoperability of different systems, the use of telemedicine and e-prescribing to support care delivery?
3. What are the implications for the health care delivery system including integration of care and delivery of high quality and cost effective care; and implications specific to the mental health and substance use system including workforce, privacy/confidentiality laws, vulnerable populations, and support of recovery-oriented care?

The analyses of HIT included:

- Review of published reports related to best practices occurring nationwide and in California related to HIT, Health Information Exchange, EHRs, and use of technology to support care delivery (i.e. tele-health).
- Interviews with key informants about the current status of HIT implementation in the physical health field and the mental health and substance use field; as well as the implications of confidentiality rules and laws for mental health and substance use that impact implementation of HIT.

Key findings of this analysis include:

- California has several specific efforts to address HIT (e.g. American Recovery and Reinvestment Act [ARRA] and Mental Health Services Act [MHSA] funding).
- There remains a dearth of fully integrated health/mental health and substance use service systems and sites within which EHR and health information exchange would be most natural.
- A disparity exists between mental health and substance use service providers and physical health providers in the use of and access to HIT. For substance use providers, in comparison to mental health providers, the gap is even wider. This gap will only grow given that ARRA funding is limited to physical health providers.

- The continued separation among the Medi-Cal physical health plans, MHPs, and DMC at the state and county levels exacerbates the difficulties of forging effective health information exchange strategies and technologies.
- There are multiple statutory and regulatory barriers to exchanging personally identified health information among substance use, mental health and physical health providers.
- Proprietary health plans and systems may have disincentives or limitations in the amount they can exchange health information.
- Clinical information sharing remains difficult because health care organizations do not use data definitions and structures that can be easily cross-walked. This is true even when mental health and primary care services are located within the same organization and when both systems have EHRs.
- EHRs are not sufficient by themselves to facilitate sharing and full use of critical information across providers and payers. A patient registry is a key building block to integration, and most local systems are not yet developing integrated patient registries.
- The variation in vendor systems across California's counties and their health plans impedes cross-county operability and integration between primary care and mental health and substance use service systems.
- There is a proliferation of local county-specific databases designed for programs such as Criminal Offenders with Mental Illness, Drug-Courts, Computer Resource Allocation Inventories and others that are not compatible in many different and idiosyncratic ways.
- No statewide data system captures services that occur at an ED as these services are provided outside of billing/contractual or notification systems.
- Each county has to engage in specific efforts to establish data sharing agreements and navigate different systems.
- In order to implement EHR systems, mental health and substance use staff must be trained to function within an EHR environment and to adapt to HIT. This is a whole different dimension to workforce development and retention over and above training in best practices, cultural competence, etc.

It is recognized that neither the physical nor the mental health and substance use service system will have sufficient resources to significantly increase HIT/EHR and health information exchange on its own over the next few years. However, some health integration and improvement opportunities under the Patient Protection and Affordable Care Act (ACA) cannot be implemented without further progress with HIT/EHR, particularly in the mental health and substance use services realms. Improved use of technology and expanded exchange of health information must continue to be a priority for the field, even in the face of restricted resources.

## Report Conclusion

This report has described the California mental health and substance use service systems from a variety of perspectives. As noted in the introduction, the central focus of the report is Medi-Cal. However, Medi-Cal does not exist in a vacuum, and thus the report includes quantitative and qualitative information about mental health and substance use service consumers, services, providers, workforce, integration strategies and information technology for the larger system. All of these factors affect the quality and performance of Medi-Cal mental health and substance use services going forward.

In the course of conducting this comprehensive review, TAC/HSRI identified a number of strengths and challenges inherent in the various public systems that now finance, oversee, and deliver services to people with mental health and substance use service needs. These are summarized in the conclusion chapter, and are accompanied by a number of global recommendations for the mental health and substance use services plan that will result from this analysis. Highlights of this discussion are presented below.

### *Strengths*

In the course of collecting qualitative information and analyzing quantitative data, TAC/HSRI identified a number of key strengths in the current system. Major strengths in the system are summarized below.

*Implementation of the Bridge to Reform Waiver*

- Enrollment of Seniors and People with Disabilities (SPDs) into managed care is likely to increase participation of these individuals in mental health, substance use, and physical health primary care and preventive interventions.

- The enrollment of uninsured single adults in the Low Income Health Plans (LIHP) will increase access to mental health (not substance use in most cases) services. While substance use provisions are not required in LIHP as they are with mental health, certain counties have reported some increase for substance use services.[60] And, as with the SPD managed care initiatives, enrollment in LIHP is expected to increase both the potential and the incentives for LIHP counties to coordinate care across the physical health plans and MHPs.

- The Delivery System Reform Incentive Pool (DSRIP) initiative includes numerous opportunities for public hospitals to improve quality of care for individuals with mental health and substance use disorders.

*The Potential for Health Home implementation*

Section 2703 of the ACA, Health Homes for Individuals with Chronic Conditions, holds great promise for improving care for individuals with mental health and substance use disorders. It offers the opportunity to overcome barriers to information sharing and care coordination between the physical health plans and MHPs. It also has the potential to generate substantially

[60] Mental health services are included in the "core set of health care services" that must be covered under the LIHP. Substance use services are considered an optional "add-on" benefit.

increased integration of care at the point of service for people with multiple disabilities. Health homes provide both a framework and incentives for mental health and substance use service providers to forge partnerships related to both integrated care delivery models and HIT. As California considers which opportunities to pursue as part of national health reform, Health Homes offer the chance to reduce fragmentation in the care received by people with mental health and substance use disorders.

### *Proposition 63: The Mental Health Services Act (MHSA)*

California has been able to add substantial resources to the mental health system for adults and youth through the MHSA. MHSA funds have also supported beneficial planning and infrastructure development within county based mental health systems. Investments have been made in the implementation of EBPs and in the development of partnerships to coordinate care at the point of service for consumers with complex, multi-system needs. MHSA funds now also constitute a portion of the certified public expenditures that comprise the match for Medicaid FFP for DMC/SMHS services. This has expanded the utility of MHSA funds, but has also limited the flexibility with which the funds can be used.

In addition, MHSA funds have supported initiatives to improve and expand the mental health workforce, particularly with regard to addressing health access disparities based on cultural and linguistic barriers. Finally, MHSA funds have been used to foster improved HIT and the implementation of EHRs. These initiatives are limited at this point, but they could provide useful implementation experience to other counties and providers as they seek to implement HIT and EHR capacities.

### *Philanthropic and educational commitment*

California's Medi-Cal and related mental health and substance use service systems have benefitted from long-term and continuous support from both philanthropic organizations and educational institutions. Both the California Endowment and the California HealthCare Foundation (CHCF) have invested substantial funds in research and demonstration projects of benefit to Medi-Cal and the public mental health and substance use service system. The California Institute for Mental Health (CiMH) has spent many years fostering best practices within the public mental health system, particularly on working to implement EBPs and the integration of behavioral and physical healthcare. For substance use services, the Integrated Substance Abuse Programs at UCLA has provided similar expertise and technical assistance, and has supported numerous initiatives.

### *Evidence-based practices*

California has demonstrated some progress in the implementation of EBPs as defined by SAMHSA. Notable efforts to expand the availability of mental health EBPs, particularly for children and families has occurred due in large part to MHSA funding and support from CiMH. It is notable that DMH's Client and Services Information (CSI) database has the capability to track and report the numbers of individuals in that system receiving EBPs. Increasing participation in evidence-based services, particularly if these services maintain fidelity to their models, should assist to reduce inpatient and ED utilization in MHPs over time. Efforts to expand use of SUD EBP's have led to increased use of EBP's. In addition, data from DADP indicates that 54% of

counties provide MAT services with the following break-down by county size: 92% of large counties, 78% of medium counties, 36% of small counties, and 29% of MBA counties providing MAT services.

### *Needs and Gaps in the Current System*

As has been described throughout this report, there are a number of gaps and issues with regard to the system that need addressing. These include:

#### *Disparate administration and financing of major components of the system*

Until recently there has been trifurcated administration of mental health and substance use service administration, policy, financing and operations in California. This administrative separation: a) has exacerbated the inherent differences and boundaries between the physical health plans and MHPs; b) has diffused accountability for the overall performance of these various systems and funding streams; and c) has perhaps created unintended incentives for cost or care-shifting between the various plans and funding sources.

The administrative separation of these functions and program areas is further complicated by the devolution of the programs to the county level. There are 58 counties, each of which administers or contracts for physical health plans, mental health plans, and with the exception of 18 non-participating counties, the DMC program. The new phase of realignment, which places most sources of mental health and substance use funding at the county level, could potentially increase the already wide discretion at the county level with regard to managing these programs.

The consolidation of mental health and substance use service Medi-Cal functions and other community service funding streams within DHCS presents an opportunity to integrate management and policy across these systems. It also presents an opportunity to consider data collection on previously unavailable information such as mental health and substance use services at EDs. However, at the county and provider levels the DADP, DMH and DHCS systems are still quite separate; a variety of strategies will have to be used to forge greater coordination and integration within those local systems.

#### *Gaps in benefit design and coverage*

California's DMC program and covered services is limited and incomplete. For example, broader use of Medication Assisted Therapies and substance use residential services such as ASAM levels 3.5 and 3.7 are not currently covered under the DMC program, yet these services are an important part of the continuum of substance use services for people with addictions.

Consistent with the administrative separation of substance use, mental health and physical health services, differences in benefit design and coverage have also emerged. Perhaps the biggest gap is between the physical health benefit (both FFS and health plans) and services available through the MHPs and DMC. People have to meet high diagnostic, clinical and functional guidelines to access services from either DMC or the MHPs. This leaves a wide gap in coverage for people with serious needs for substance use or mental health services that

either do not meet the medical necessity criteria for the MHPs or DMC services or have a need for a service that is not available.

Another major gap in coverage is the lack of specific benefits for people with co-occurring mental illness and SUDs. Neither DMC nor the MHPs have specific benefits for integrated dual diagnosis treatment. Nor could we identify any formal mechanisms or financial provisions for effectuating referrals and coordinating treatment between the MHPs and DMC. The overall Medi-Cal claims data show very few participants receiving both mental health and substance use service encounters. Plus, only 10% of providers in the Medi-Cal claims data submitted claims for both substance use and mental health service encounters.

*Care is not integrated or coordinated*

While there is a requirement for MHPs and physical health plans to have memoranda of agreement governing mutual referrals and coordinating care for people served by both types of health plans, key informants stated that these agreements do not result in routine and effective integration or coordination of care. There are also no specific reimbursement mechanisms within Medi-Cal that support team service delivery, joint plan of care development, psychiatric consultation to primary care, or many other mechanisms of care coordination and integration. If DHCS implements a health home program, it is likely much of this issue will be addressed for those enrolled health home members. Nonetheless, there are many Medi-Cal participants, including potentially the expansion population, who are not eligible to participate in health homes. In addition, there are barriers to information sharing and accessing HIT/EHR technology that will not automatically be corrected in a health home initiative.

Cross-system and cross-plan integration and coordination are areas that could be improved through performance measurement and financial incentives as well as through traditional collaborative and co-location approaches. Enhanced performance measurement and incentives could be incorporated into a uniform purchasing plan that would integrate DHCS's prudent purchasing objectives across the multiple plans and jurisdictions.

*There are cultural/linguistic and regional variations in access to services*

California is similar to many other states in that: a) it does a good job tracking and reporting access to Medi-Cal services for each ethnic group; b) the proportion of people within each ethnic group service by Medi-Cal, at least in the MHPs and DMC, is not very far off from the proportion of each group in the general population; and c) despite these efforts and successes, there is still disproportionate access to mental health and substance use services on the part of certain ethnic populations. For example, when compared to overall estimated SMI needs (prevalence), White and African American groups are served in higher proportions (17% and 31% respectively) than are Asian, Native American, or Hispanic populations (6%, 13% and 8% respectively). This issue is compounded by the relative lack of cultural/linguistic capacity among providers and practitioners in California.[61]

[61] As noted earlier in this summary, the prevalence calculation is based on comparisons of the estimated prevalence for each sub-group with the actual number of individuals within these sub-groups being served.

County-level variations in access to Medi-Cal mental health and substance use services have also been identified in the data. When analyzing penetration rates for the expanded definition of mental health prevalence (the definition most likely to reflect the Medi-Cal expansion population), there is a range in penetration rates of 18% (Yuba County) to 3% (Sutter, Alpine and Sierra Counties). Within the large county category, there is a range of 10% (San Francisco) to 4% (Orange, Riverside and San Mateo Counties).

For substance use prevalence, the ethnic and geographic variations are similar. For example, penetration rates as a function of estimated prevalence for Hispanic people is 2% and Asians is 0%, whereas the rates are for African Americans (8%), Native Americans (3%) and Whites (3%).

### *Gaps in evidence based practices and integrated care*

Between the years 2006 and 2010, only 1% of individuals received an EBP or identified service strategy consistent with best practice, as categorized by SAMHSA. The fact that the reported employment rate for consumers in the DMH database is only 2% (compared to a national average of over 20%) is evidence that recovery-focused EBPs are not having a widespread effect on adults with SMI.

This does not mean that there are not additional EBPs being implemented within the state, particularly for youth with SED. In fact, the CiMH has done extensive work on implementing EBPs throughout the state including Aggression Replacement Therapy (100 sites in 38 counties), Incredible Years (30 sites in 13 counties), and Trauma-Focused Cognitive-Behavioral Therapy (105 sites in 18 counties and 81 sites in LA County). The low numbers of EBPs in the DMH database and the key informant responses indicating much more EBPs being delivered than the data shows is an opportunity for data improvement. There is a good infrastructure for tracking EBPs, and key service strategies and efforts should be made to report accurate data to understand the services and strategies individuals are receiving and how they can be related to consumer outcomes.

With regard to substance use services, the system does use ASAM criteria and levels of care in some counties to determine level of care and to triage for needed services, which are considered to be good practice. As indicated, there have been increases in the use of SUD EBP's across counties as available in the DADP reporting system. However, when examining specific EBP's, a high degree of variation across counties is evident. EBPs such as medication assisted treatment are not implemented statewide in the current SUD system. There is opportunity to expand the use of Motivational Interviewing, CBT, IDDT and other practices that are known to be beneficial. For example, as indicated in DADP reports, currently only 28 counties report use of Motivational Interviewing. This does not mean that there are not additional EBPs being implemented within the state for substance use; but rather that reported data indicates the need for greater consistency across the state in the availability and use of EBP's.

## Target Areas for Planning

### *Prudent purchasing plan*

TAC/HSRI recommends development of a comprehensive and uniform purchasing plan for DHCS, DMH and DADP. DHCS, DADP and DMH have separate approaches to scorecards, performance measures and quality indicators that could be incorporated into a comprehensive approach. This purchasing plan would addresses critical system functions:

- Intended results and outcomes for beneficiaries
- Equity of access to services
- Best practice array of services and clinical modalities for people at each level of care
- Protocols and mechanisms for integrated treatment
- Responsibilities of the counties, the plans, and their provider networks
- Sufficient cultural/linguistic competency, use of HIT, staff certified in evidence based practices
- Leveraging financial risk for over spending or under spending
- Incentives for performance

### *Strengthened local oversight*

TAC/HSRI recommends that DHCS and its state partners assert a strong and coordinated role with regard to how money is spent for mental health and substance use services, who is served, what services they receive, and how performance of the system is assessed and rewarded. We have recommended that this approach extend to the physical health plans as well, since care must be coordinated across the boundaries of the physical and MHPs, and with the DMC benefit. We believe this centralized role as the prudent purchaser of services is both necessary and appropriate for the state-level managing agencies.

We also recommend that the county role in managing the mental health and substance use systems in the context of the purchasing plan be strengthened and clarified. A comprehensive purchasing plan with uniform standards and measures of performance, and an equivalent benefit design across physical health, DMC, and the MHPs will support counties to innovate with local customized approaches to attain statewide programmatic goals.

### *Integration of mental health and substance use service systems*

DHCS and the counties need to continue to address effective integration of mental health and substance use services. This needs to occur before integration of mental health and substance use services and physical health can be fully implemented.

### *Benefit design for the expansion population*

TAC/HSRI recommend that the essential benefit mental health and substance use services benefit design and service definitions be consistent between the Medi-Cal benchmark plan and the benchmark benefit for the exchange plans. We also recommend that DHCS assure that there is not a substantive gap between the benefit design for the benchmark plans and that of DMC and the MHPs.

## Next steps

1. Public release of the needs assessment for review and comment: January 30, 2012
2. Completion of the public review and comment period: February 15, 2012
3. Submission of the needs assessment report to CMS: March 1, 2012

# Appendix C

## WET Five Year Plan

## Mental Health Workforce Education and Training (WET) Five-Year Plan

**WET Five-Year Plan: 2008-2013**

Pursuant to WIC Section 5820, in 2008, DMH, in concert with stakeholders, developed the Five-Year Workforce Education and Training Development Plan (Five-Year Plan), which provided a framework for the advancement and development of mental health workforce education and training programs at the County, Regional, and State levels. Specifically, the Five-Year Plan provides the vision, values, mission, measureable goals and objectives, proposed actions and strategies, funding principles, and performance indicators for the use of MHSA WET funds. The Five-Year Plan developed by DMH was approved by the California Mental Health Planning Council in 2008 and covers the period from April 2008 to April 2013 (http://www.oshpd.ca.gov/HPEF/Text_pdf_files/WET/MHSA_FiveYearPlan_5-06-08.pdf).

State level WET programs that were included in the 2008-2013 WET Five-Year Plan include:

• *Stipend Programs*

Stipend Programs are administered through contracts with ten higher educational entities, for graduate students who plan to work in the Public Mental Health System PMHS. The goals of the stipend programs are to increase the number of licensed mental health professionals in public mental health, and to incorporate the MHSA principles into graduate level curriculum. The graduate degrees funded in the WET stipend programs include: Masters of Social Work; Marriage and Family Therapist; Clinical Psychologist; and Psychiatric Mental Health Nurse Practitioner. A total of $100 million was authorized for Stipend Programs over 10 years.

• *Mental Health Loan Assumption Program (MHLAP)*

MHLAP offers loan assumption to mental health providers in hard-to-fill and/or hard-to-retain positions in the PMHS in exchange for a 12-month service obligation. A total of $75 million was authorized for MHLAP over 10 years.

• *Song-Brown Residency Program for Physician Assistants in Mental Health*

Adds a mental health track to the Song-Brown Residency Program for Physician Assistants (PA) as a strategy to address the shortage of PAs who can sign mental health treatment plans and administer psychotropic medications. PA programs that train second-year residents to specialize in mental health are eligible to apply for augmented funding. A total of $5 million was authorized for Song-Brown over 10 years.

• *Psychiatric Residency Programs*

The Psychiatric Residency Program ensures that psychiatric residents receive training in the County public mental health system, working with the populations prioritized by that community. Further, psychiatric residents are encouraged to continue working in the California PMHS after their rotations end. A total of $13.5 million was authorized for Psychiatric Residency Programs over 10 years.

• *Client and Family Member Statewide Technical Assistance Center*

The Client and Family Member Statewide Technical Assistance Center promotes the employment of mental health consumers and family members in the mental health system. A total of $8 million was authorized for the Technical Assistance Center over 10 years.

• *Regional Partnerships*

Five Regional Partnerships (RPs) have formed across the state to promote building and improving local workforce, education and training resources. The RP collaboratives represent Bay Area counties; Central Valley counties; Southern counties; Los Angeles County; and Superior Region counties. RPs include representation from mental health, community agencies, educational/training entities, consumers, family members, and other partners to plan and implement programs that build and improve local workforce education and training resources. Each RP focuses on projects and goals specific to their regional need. A total of $27 million was authorized for Regional Partnerships over 10 years.

- *Shortage Designation:*

Reviews and recommends Mental Health Professional Shortage Area (HPSA) and Medically Underserved Area/Medically Underserved Population (MUA/MUP) applications to HRSA's Shortage Designation Branch.

**MHSA WET Five-Year Plan: 2014-2019**

Per WIC Section 5820, the Office of Statewide Health Planning and Development (OSHPD) is accountable for the development of the next Five-Year Plan that will be in effect from April 2014 to April 2019. To ensure the development of a comprehensive plan, OSHPD is employing a robust stakeholder engagement process to engage diverse stakeholder groups through different strategies including the WET Advisory Committee and WET Five-Year Plan Advisory Sub-Committee, community forums/focus groups, key-informant interviews, webinars and surveys.

The WET Five-Year Plan will provide a framework on strategies state, local government, community partners, and other stakeholders can enact to further public mental health workforce, education, and training efforts. Specifically, the WET Five-Year Plan will provide the vision, values, mission, measureable goals and objectives, proposed actions and strategies, funding principles, and performance indicators for the use of MHSA WET funds for the period from April 2014 to April 2019.

# Appendix D

## Workforce Development Needs in the Field of Substance Use Disorders

# Workforce Development Needs in the Field of Substance Use Disorders

## A Report from Department of Alcohol and Drug Programs

**June 26, 2013**
**Version 1.1**

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Special thanks are extended to Jon T. Perez, Ph.D., Regional Administrator, Region IX, Substance Abuse and Mental Health Services Administration (SAMHSA) for his participation in task force meetings.

The Workforce Development Task Force first met on January 8, 2013. The executive sponsors were Michael Cunningham, Acting Director; Millicent Tidwell, Deputy Director; and dave neilsen, Deputy Director. A project charter was created and a report due date of June 28th was established.

At project initiation, the task force members represented the licensing, treatment, prevention, recovery support, cultural competency, performance monitoring, and executive perspectives of ADP. Resulting from the transfer of ADP programs and functions to Department of Health Care Services, some of the original task force members have since assumed new job responsibilities.

Contact Margie Hieter for a copy of the Workforce Development Task Force report.
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# Welcome Message

With the implementation of health reform on a national level, changes are required of programs, policies, and the workforce, to successfully and effectively meet these additional requirements and the resulting increased demand for services. Adding complexity to the difficult job of building the capacity to meet the demands for high quality SUD services is the lack of consistent and standard workforce credentials, a lack of a recognized career ladder, a decreasing number of individuals entering the field, and an increasing number of individuals leaving the field.

Even with these changes, I remain optimistic! Health reform creates the urgency and need to make changes long recognized as desired and necessary. It creates a challenge of meeting the requirements for service, but more importantly for the SUD workforce, it offers the opportunity to create standard and consistent credentials, a career ladder, and in general, make changes that recognize changes that solidify the recognition that the SUD workforce is a valid and vital part of our healthcare delivery system. Historically, the SUD workforce has consisted of highly motivated and passionate individuals who care strongly about their profession and those they serve. I expect this attitude will remain.

Until now, the SUD workforce has consisted of a fairly narrow range of practitioners in the prevention, treatment and recovery support fields. Moving forward, the functions and roles of individuals addressing SUD will likely change to meet the increased demand for services in new settings. The workforce will expand to include practitioners in managed care settings - outside the current realm of the SUD workforce.

Alcohol and Drug Program's (ADP'S) Workforce Development Task Force completed work resulting in this report: a summary of health reform related changes, an assessment of the current workforce, and recommendations for preparing the workforce to meet the changes required of health reform. This report is not an implementation plan, although it does contain an implementation strategy. This report recognizes that the development of an implementation plan as the next step requires the representation of all stakeholders as partners in creating workforce solutions.

As ADP transfers its programs and functions to Department of Health Care Services (DHCS), and as I transition to another role in life, I will enthusiastically watch from afar and continue to be a strong advocate for the SUD workforce. As each of you meets the challenge of change, I applaud the work you have accomplished, the dedication you have shown and your courage to expand your knowledge.

MICHAEL S. CUNNINGHAM
Acting Director
Department of Alcohol and Drug Programs

# Introduction: Health Reform Brings Change and Opportunity

Change is coming to California's healthcare field. For the first time, federal law requires every American to have health insurance by January 1, 2014. Health reform is the global term for the health care-related changes that came about as the result of the federal Affordable Care Act (ACA). Some of the health reforms originated at the federal level and others are mandated at the state level.

Health reform raises questions and creates complex issues because it touches or changes the very core of our healthcare system. In turn, these changes impact every segment of the Substance Use Disorders (SUD) workforce – administrators, treatment providers, prevention specialists, and recovery support specialists. To create efficiency and effectiveness, emerging directions from the federal government indicate that integration of services and collaboration between providers is critical. The federal government also places emphasis on using evidence-based practices, expanding the administrative support structure, and learning new skills such as Electronic Health Records and Electronic Billing.

The SUD field has long recognized the need to create a standardized credentialing system, grow the workforce in number, create an upward career path, and offer incentives to keep the workforce engaged, motivated, and committed to remain in the field. Even though the need for change has been recognized there has not been an urgency to make changes. A benefit of health reform is it has created the impetus for change, not only for the SUD workforce, but for the entire healthcare workforce, some of which have already recognized the need to make adjustments. For example, the mental health workforce identified core competencies that will allow them to fit into a primary care environment, and primary care has recognized the importance of adopting the use of Electronic Health Records and other uses of technology. It is now crucial for the SUD workforce to adjust and address the emerging requirements in health reform which creates a tremendous opportunity to make long-needed changes to the workforce scopes of practice, credentialing system and career ladder allowing the SUD workforce to remain competitive in the changing healthcare environment.

This report identifies the impact of health reform on the SUD workforce. It provides an overview of health reform; identifies the direction that substance abuse reduction efforts are taking; assesses the composition of the existing SUD workforce; and looks at the knowledge, skills and credentials needed to deliver services that comply with these new mandates. Regardless of the current position held or the location where services are delivered, the entire workforce needs to be informed and aware of the impending changes, and equipped with the proper tools and training to meet the service delivery requirements resulting from health reform. Expanding and enhancing one's skill set is not to be viewed as correcting a deficiency or defect, but rather as a way of keeping pace with changing times.

At the conclusion of this report are suggestions and recommendations regarding standards, training, policy and practices. Implementation of the recommendations will prepare the workforce to function efficiently in the emerging world that is recovery-oriented, uses prevention strategies at the community level, and provides individual choices for treatment. While some information remains unknown and decisions are still being made, the task force made assumptions in order to

make reasonable recommendations. The process of implementing the recommendations will be a multi-year process. To reflect this, the recommendations are presented as either short-, mid- or long-range.

In summary, health reform presents both a challenge and an opportunity to the State of California. The challenge comes in assessing the capacity of our workforce, identifying the skills required to deliver services in the changing environment, and developing the necessary infrastructure to support health reform. Several opportunities exist to strengthen the role of the SUD workforce by creating a standardized credentialing system, addressing the known shortfalls in the workforce career path, and providing training to broaden the workforce skill set. In the process, the workforce may become eligible for new employment opportunities, experience less employee turnover and greater job satisfaction. Acknowledging and addressing these issues now is critical to ensuring that our SUD workforce remains on a level playing field with the rest of the healthcare field.

A short report, such as this one, does not assume to address every possible scenario that may impact the workforce. It also does not delve into the intricacies of legislative authority and regulatory oversight. Issues such as pay scales and background checks are deemed important; however, they are not included in this report. This report has a fairly narrow scope and focuses on recommendations for tools and strategies that will allow the workforce to continue its dedicated and passionate work in the field of SUD treatment, prevention and recovery support.

The intended audience of this report includes the SUD workforce, primary care providers, county personnel, public and private agencies, and other stakeholders. As the SUD functions and programs of the Department of Alcohol and Drug Programs transfer to the Department of Health Care Services (DHCS), there is a desire to provide DHCS with specific SUD workforce related information and assistance.

Information in this report has been extracted from a large number of publicly available documents listed at the end of the report.

# Chapter 1 - Emerging Directions Resulting from Health Reform

## Summary of Health Reform

Healthcare in California changed in 2010 when Congress passed the Affordable Care Act (ACA) creating a minimum level of healthcare for citizens and residents using standardized programs and systems. The ACA ends the barrier of treating pre-existing conditions, expands Medicaid eligibility to those earning less than 139% of the Federal Poverty Level, establishes subsidies for individuals and small businesses needing health insurance, and requires most residents to obtain either private or public health insurance.

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA), Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues (January 24, 2013) an estimated 38 million more Americans will have an opportunity to be covered by health insurance due to changes under the ACA. Between 20 and 30 percent of these people (as many as 11 million) may have a serious mental illness or serious psychological distress, and/or a substance use disorder. Among the currently uninsured, aged 22 to 64, with a family income of less than 150 percent of the federal poverty level, 36.8 percent had illicit drug or alcohol dependence/abuse or mental illness. The lack of coverage and cost of services was cited as a significant barrier in seeking SUD services.

Based on this information and using round numbers, approximately one-third of the population who are newly eligible for health insurance will have a mental or substance use disorder. This increased need for services requires the existing workforce to expand, to become more efficient, and to broaden their skill set. The composition of the workforce will be reshaped by the ACA as we move toward a more integrated primary and behavioral health care system. Brief interventions and brief treatment will likely be delivered by staff in primary care settings as screening for depression, alcohol and substance abuse becomes a standard part of care. Staff will include health educators, nurse practitioners, care managers and physicians, as well as counselors, social workers, psychologists and addiction specialists.

Primary care settings differ from the specialty sector. As integration of primary and behavioral health services becomes the standard, a greater emphasis will be placed on evidence-based practices and outcomes, a team approach to patient care, and a focus on improving quality of care as well as administrative and clinical processes.

People with more severe and persistent mental and substance use disorders will receive longer term and more intensive treatment, either within a primary care setting or specialty setting. The use of peers to promote long-term recovery is also expanding across the country. These peer specialists, who in some states are now being certified, play a key role in the recovery process serving as role models, navigators, recovery coaches, as well as providing hope - a critical part of the recovery process. These peer specialists are an important component of the workforce and can help meet the increased need for services. The support they provide is that of a trained person who is certified but not licensed as a traditional health or behavioral health care practitioner. New or expanded roles and types of workers are also likely to be needed to facilitate integration, including health educators, behavioral health specialists, and care managers.

The following sections detail the areas affected by health reform that must be addressed in the assessment of workforce development needs.

## Types of Service Needed

The ACA established ten categories of Essential Health Benefits that new insurance plans must provide.

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- **Mental health and substance use disorder services, including behavioral health treatment**
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Each state determines the details of the services that will be included in each of the ten categories. Health plans will have to cover at least 60% of the costs for these services with the remaining 40% being paid by enrollees as copays and deductibles. California selected a benchmark plan that includes drug counseling and screening for alcohol use. In 2014, these will become mandatory benefits for all Medicaid participants and will create an increased demand for SUD services.

California's independent public entity responsible for creating standardized health plans, California's Health Insurance Exchange, has not finalized all of the details pertaining to SUD coverage. Covered services will likely include the types of services already generally provided for SUD treatment, plus alcohol screening and brief interventions. We do know there are specific locations where insurance-billable services can be delivered, and there is a staff scope of practice authorized to deliver the service. Both seem to be limited to primary care settings. This limitation of providers authorized to deliver insurance-billable services can negatively impact access to services for the newly eligible and expanded coverage populations.

## Increased Demand for Service

As more individuals from a variety of socio-economic groups and population segments become eligible for coverage under the new eligibility criteria, the demand for services is expected to increase. In addition to those who are newly eligible, individuals who are currently insured will be entitled to receive expanded benefits. Also included are the underserved populations who may be located in areas not currently well staffed with AOD professionals. Other segments of the population identified as having an increased need for service include veterans, older adults, newly released prison inmates, youth, and all cultural and ethnic groups.

Since mental health and SUD services are both included in the essential benefits package—and there is evidence that the two often are dual diagnosed—we can expect that this, too, will result in more people seeking SUD services.

Reports from SAMHSA, UCLA and others estimate that 300,000 – 700,000 Californians will become eligible for mental health, behavioral health and SUD related services. For the Medicaid Expansion population, the National Survey on Drug Use and Health (NSDUH) identifies the most common characteristics of those with a SUD as male, 18-34 years old, non-Hispanic White or Hispanic, and having less than a high school education.

Some of the expansion population may not have previously had the benefit of healthcare; therefore, it is not known if their needs will be significantly greater or different than the current population.

## Service Delivery Facilities/Locations

Depending on the individual's entry point and/or the intensity of services needed, SUD treatment may currently be provided through the criminal justice system, community organizations, outpatient programs, non-medical residential facilities, opioid treatment programs, medical residential/inpatient facilities, emergency room visits, and primary care facilities. As progress continues toward integration of care, primary care facilities, hospitals, nonmedical residential or social model programs, and mental health facilities will be expected to work together to find the best way to treat the individual.

The services provided in primary care and hospitals may be limited to a screening, brief intervention or counseling; however the current workforce providing services in these settings are not well trained in screening for, or recognizing, SUD. Likewise, the SUD workforce certified to provide services in residential nonmedical facilities licensed by ADP, and outpatient facilities certified by ADP are not well trained or prepared to screen for, or recognize, physical, or mental disorders.

In rural or underserved communities, the primary care facilities, hospitals, and mental health facilities may bear the sole responsibility for recognizing the need for and providing SUD intervention or treatment. Cross training staff in these locations becomes a priority because of the limited number of healthcare staff.

SUD often carries a stigma with it, whether it is a patient being treated for SUD or someone who works in the SUD field. As integration of care progresses and SUD services are made available in primary care, a potential benefit is that patients may have options for treatment in settings that do not inherently have an SUD treatment stigma.

## Linking Mental, Physical & Pharmacologic Treatment to AOD

Health reform extends the provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) to include treatment of mental health and substance abuse disorders. Currently, the SUD workforce is segmented among mental health, substance abuse, and physical healthcare settings. Generally, one segment does not have the skill set necessary to address all three service delivery domains. Primary healthcare workers typically are not well trained to screen for or provide treatment for substance use disorders. Likewise, SUD personnel and mental health practitioners usually are not medically trained to address the full range of physical wellness.

The prevalence of co-occurring mental health and substance use disorders is documented in the 2010 National Survey of Drug Use and Health (NSDUH) which indicates that approximately 9.2 million adults with SUD have a co-occurring mental illness. And approximately 20 percent of adults with a mental illness have a co-occurring SUD. This underscores the need for the development and

promotion of behavioral health competencies among both the addictions and mental health workforce. As the use of medication-assisted treatment increases and treating Co-Occurring Disorders (COD) becomes more frequent, more physicians will be needed in mental health settings. Physicians in primary care are also more likely to be treating and prescribing medications for addictions.

In California, estimates vary as to the number of people suffering from both SUD and mental health problems (not necessarily at a level considered to be "Seriously Mentally Ill" – SMI). The number of Californians with COD is presumed to be above the national average for several reasons. California has a higher-than-average veterans' population, among whom Post Traumatic Stress Disorder is prevalent and often a factor in COD. California also has a disproportionate number of homeless individuals, who have a higher rate of COD than the general population.

In raw numbers, based on SAMHSA figures nationwide (and projecting from those, based on California's percent of the national population), California could have, at least 800,000 to 1,000,000 individuals with both SUD and mental illnesses of some kind. More specifically to California's SUD population, the rate of CODs among California's SUD population is likely to range from 40 to 70 percent. Consequently, the core competencies for SUD providers should include those for COD treatment.

## Evidence-Based Practices

Evidence-Based Practices (EBP) are programs or strategies that are recognized to improve client outcomes in more than one randomized clinical trial. They can be pharmacological (i.e., methadone) or psychosocial (i.e., cognitive-behavioral therapy, motivational interviewing, contingency management, and 12-step facilitation).

Screening and brief intervention, motivational interviewing, and medication-assisted treatment are all EBPs for the treatment and prevention of substance use disorders. Additionally and specifically related to the prevention of underage drinking, environmental prevention strategies are EBPs.

The United States Preventive Services Task Force (USPSTF) ranked screening and brief intervention for alcohol use as a high priority and cost effective intervention. Medications are available to assist patients to reduce drinking, avoid relapse and support abstinence. Similarly, medications are available to treat opiate addictions. Their use in primary care is feasible and cost effective.

The best methods for training the workforce in using EBPs involve a multi-dimensional training approach or blending of strategies. Distance learning appears to develop knowledge, workshops may serve as the platform for establishing basic skills, and clinical supervision that includes observation, feedback and coaching can serve to develop proficiency with real patients.

## Screening and Brief Intervention

Screening and Brief Intervention (SBI) for alcohol misuse are now part of the Affordable Care Act's essential health benefits, and as noted above, the USPSTF has recognized its effectiveness in addressing alcohol misuse. SBI is an evidence-based approach that focuses upon early identification and intervention of potentially problematic substance use patterns. When correctly implemented, SBI

reduces the time and resources needed to treat conditions caused or worsened by substance use, improving the health status of patients and making our health systems more cost effective. Depending on the setting, the approach may include Screening and Brief Intervention; Screening and Referral to Counseling; or Screening, Brief Intervention and Referral to Treatment (SBIRT). As health reform is implemented, screening and brief intervention will be a new service within primary care settings.

In SAMHSA's recent Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues (January 24, 2013), SBIRT is part of routine and ongoing prevention activities. More people will receive the screenings, brief interventions or brief treatment, often conducted by health educators, recovery specialists or other staff in the primary care system. Those needing more intensive treatment services will be referred to specialty treatment providers.

SAMHSA defines a comprehensive SBIRT model to include the following components:

- Universal screening of all patients regardless of an identified disorder
- One or more specific behaviors related to risky alcohol and drug use are targeted
- Brief (e.g., typically 5-10 minutes for brief interventions; 5 to 12 sessions for brief treatments)
- Services occur in a public health non-substance abuse treatment setting
- Comprehensive Services (comprised of screening, brief intervention/treatment, and referral to treatment)

No specific SBIRT definition has been articulated by the USPSTF or other authoritative/coordinating bodies. The SAMHSA definition of SBIRT is based on methodology that was developed during the implementation of a comprehensive SBIRT grant program comprised of all the integral components, and supported by research by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

Universal screening as part of primary care accomplishes critical health objectives: it establishes a baseline of patient behaviors, and helps identify the appropriate level of services needed based on the patient's current risk level. Patients who indicate little or no risky behavior and have a low screening score will not need an intervention. Those who have moderate risky behaviors and/or reach a moderate threshold on the screening instrument may receive a brief intervention. Patients who score high may need a brief treatment or further diagnostic assessment and more intensive, longer-term specialty treatment.

As primary care begins to implement universal screening, it becomes important to understand how screening will be accomplished and by whom. Options may include having multiple access points to gather the information. For example, an online assessment could be used for those who have internet capabilities, patients could fill out a short survey as part of their intake process or, a trained and credentialed workforce member within the health care facility could conduct the screening and make the appropriate recommendation or referral for intervention or treatment. Training the existing primary care work force in these new requirements, or successfully co-locating substance use counselors with specialty training in brief interventions will be challenge in the years ahead.

## Essential Health Benefits and Federal Parity

Essential health benefits and federal parity are two federal frameworks that oversee mental health and substance use benefits. Both require inpatient, outpatient, emergency and prescription drug benefits that cannot have annual or lifetime limits, copays and deductibles, and treatment limitations that are more restrictive than medical/surgical benefits. The parity treatment issue is important because it prohibits states from instituting more rigorous management methods in behavioral health than exists in physical health.

A summary of the four categories of groups receiving benefits and their associated level of benefit is shown below.

| **Group** | **2014 Behavioral Health Benefits** |
|---|---|
| Individuals and small businesses | Essential health benefits at federal parity |
| Medi-Cal expansion and basic health | Benchmark benefits package at federal parity |
| Traditional Medi-Cal, moderate to severe disorders | No change in existing mental health benefits<br>Upgraded substance use benefits at federal parity |
| Traditional Medi-Cal, lower need | Upgraded mental health and substance use benefits at federal parity |

The Traditional Medi-Cal enrollees with moderate to severe disorders have access to a very limited mental health benefit that includes two visits per month to mental health care provided by a physical health practitioner, to medications and to emergency care. This category of benefit may be upgraded to the same mental health benefit as that offered to the Medi-Cal expansion population at federal parity.

## Insurance Billable Services

Billable services are defined differently, depending on the provider, the insurance plan, the setting in which the service is delivered, and the scope of practice authorized to deliver the service. The SUD field needs a translation of the various billable services definitions in a format that aligns with the available workforce credentials and scopes of practice.

As an example, the Kaiser Small Group HMO includes mental health and substance use benefits and is shown in Appendix F. This example demonstrates the use of terminology not consistent with that used by the SUD workforce resulting in confusion and questions about the types of services covered.

## Assumptions for Future Direction

The future direction of California's SUD workforce continues to evolve as federal directions and regulations change, and as the State determines the most effective methods to incorporate the existing workforce into the developing model. More than ever, the workforce is relying on the State to determine a future direction for the field. Regardless of the uncertainties that exist at the federal and state levels, there are assumptions that can be made. These assumptions are consistent with the findings identified in several reports and include: reports commissioned by SAMHSA, written by the University of California Los Angeles (UCLA), the County Alcohol and Drug Program Administrators' Association of California (CADPAAC), the National Association of Alcoholism and Drug Abuse Counselors

(NAADAC), the International Certification and Reciprocity Consortium (IC&RC), and others. These assumptions are the building blocks for the recommendations made in this report:

- In the next five years, more SUD treatment professionals will be needed who are able to care for individuals with SUDs in a variety of managed healthcare settings, recognize co-occurring disorders, and be culturally competent.
- Applicants for open positions in SUD treatment facilities need to be well qualified. The workplace will be competitive.
- The workforce needs to be diversified and able to work in integrated settings and collaborate between providers regarding a patient's care plan.
- Health reform offers California an opportunity to address the SUD workforce concerns and make forward progress for recognizing the SUD field as a standard component of healthcare.
- SUD treatment facilities must adopt and implement EHR systems to remain a part of the changing healthcare environment. The workforce must learn and adopt EHR systems and other technology that creates efficiencies.
- Now is the time to commit to an SUD professional Scopes of Practice and credentialing system.
- Specific steps must be taken to grow and sustain the workforce.
- The existing workforce must be provided tools to prepare for the future.

## Required Knowledge, Skills and Credentials

The workforce needs to expand and enhance its knowledge base to meet the increased demand for SUD services; to acknowledge that SUD services will be delivered in a variety of healthcare settings and that integration into primary care will occur; to recognize that the workforce must have the appropriate education and credentials to work in multiple health care settings; and to provide tools to keep pace with emerging federal directions and guidelines for SUD services.

As the workforce prepares to provide services in the varied settings of SUD treatment, any credentials they currently have may not be recognized as sufficient for a primary care setting. The existing credentials offered by California's seven certifying organizations are valid in a setting or program certified by ADP. Although the major healthcare providers such as Kaiser Permanente and other hospitals may choose to hire the individuals certified by the seven organizations, there are no requirements to do so.

The following list serves as a starting point for identifying the areas in which the workforce can develop. Since SUD services will be delivered in multiple healthcare settings, the primary care and mental health workforces should expand and enhance their knowledge base about alcohol and other drugs.

## Findings

- To prepare for integration of services into primary care, cross train between the SUD, primary care, and mental health workforces to understand the basics of substance abuse, mental health issues, and physical ailments that mimic AOD. (Goal 15)
- All practitioners of the healing arts, including doctors, nurses, physicians assistants, LCSW's, MFT's, and others, must expand their skill set to recognize AOD and COD. (Goal 3)
- COD affect a large portion of those seeking treatment. Core competency standards and training should address this. (Goal 7)

- Sharing information among providers will be a key element to creating one problem list, one drug list, and one care plan. This collaboration between providers can be aided by the use of Electronic Health Records, Electronic Billing, care management, and the concept of individual wellness. (Goal 9)
- The workforce must be trained in the use of, and adopt evidence-based practices. (Goal 11)
- Acknowledge that some areas of the state may have very limited access to SUD workforce. (Goal 5)
- Address the influx of underserved populations. (Goal 5)
- Identify how cultural competency will be addressed. (Goal 15)
- All services delivered are not considered insurance billable services. Build a business case for reimbursement and provide input to SAMHSA. (Goal 4)
- Universal screening could pave the way for a newly designated category of SUD credential. (Goal 6)
- Ensure the workforce is trained and prepared to deliver all SUD related services identified for the expansion population and the Health Insurance Exchange. (Goal 15)
- The private healthcare workforce will also expand and enhance its skillset to stay competitive and able to meet the increased demand for service. In an effort to augment the private workforce, county level workforce may be enticed to the private healthcare market by better wages, benefits, and educational opportunities. This will further add to the public sector workforce shortage. (Goal 5)

# Chapter 2 - Environmental Assessment – Overview of Existing Workforce

As it exists today, the workforce spans the realms of prevention, treatment and recovery support. Services are delivered in a wide range of SUD treatment facilities and include residential non-medical, community-based organizations, opioid treatment programs, hospital and primary care settings, mental health facilities, adolescent social service environments, prevention, and the criminal justice system. The education, licenses and skills of practitioners range from a high school education with no specialized licenses or certifications to a post graduate education with full accreditation. In addition, the workforce includes those who are in direct service plus those who have the combined responsibility of managerial and supervisory duties.

Each segment of the workforce is unique and plays a vital role in combating substance abuse. Those specializing in treatment provide services in a variety of programs and have a focus on individual outcomes. Most of the recovery support workforce consists of former substance users who provide mentoring to individuals and small groups. The prevention worker is both individual-based and community-based and has a focus of population-based change. Each segment of the workforce has a place in the emerging world of health reform. Their scope of practice may become more refined, and their knowledge base and skill set may be expanded to address new practices and technology.

The following information is a summary of the national workforce demographics taken from the report, *Vital Signs: Taking the Pulse of the Addiction Treatment Profession* (September 28, 2012). The report was written by the Addiction Technology Transfer Network and was funded by SAMHSA.

## National Workforce Demographics

- Clinical directors are predominantly white, middle-aged women with no military affiliation. These clinical directors are educated professionals who began their career in the SUD treatment field and have, an average of 17 years of experience in the field. About one-third identify as being in recovery from an SUD.
- Direct care staff members supervised by the clinical director respondents are also mostly white women with no military affiliation. Direct care staff members tend to be younger, on average, than clinical directors and have less years of experience at their current places of employment. Direct care staff members are also educated professionals. The highest degree status of direct care staff that was most commonly reported was a Master's degree. Furthermore, the majority of direct care staff is currently licensed/certified or is seeking licensure/certification. Slightly less than one-third of direct care staff are in recovery from SUDs as estimated by their clinical directors.
- Almost one-third of clinical directors are only somewhat proficient in web-based technologies, and almost half of SUD facilities do not have an electronic health record system in place.

## Common Strategies and Methodologies of Recruitment and Retention

- SUD treatment facilities most commonly offer professional development for staff through new employee orientation, ongoing training, and direct supervision. When facilities do not provide

for staff training and continuing education, the most commonly reported reason was a lack of funds.

- Recruitment continues to be a significant issue for many SUD treatment facilities. According to survey respondents, facilities primarily use web-based classified advertisements to recruit new staff and almost half of facilities have difficulty filling open positions, mostly due to an insufficient number of applicants who meet minimum qualifications. Through interviews, clinical directors emphasized the positive effects that developing relationships with colleges and universities can have on recruiting qualified professionals.
- Retention continues to be an ongoing challenge for SUD treatment facilities. According to survey respondents, the average staff turnover rate is 18.5 percent. Some of the most successful retention strategies employed by treatment facilities include the provision of healthcare benefits, a supportive culture, and access to ongoing training.

A CADPAAC Alcohol and Other Drug Abuse Treatment Workforce Survey released in 2009 reports similar workforce demographics for California. Two interesting responses are shown below and support the belief that the workforce is prepared to make changes.

- Twenty percent (20%) of respondents indicated that it was very likely (highly probable/definite) that they will be changing their place of employment within the next two years, and 13% indicated that it was very likely that they would leave the substance abuse treatment field altogether. The most frequently indicated reasons for changing place of employment (but staying in the field) include: greater pay and/or benefits (260 responses; 15%), greater responsibility/authority (137 responses; 8%), and better management/administration (124 total responses; 7%). And the most frequently indicated reasons for changing place of employment (and leaving the field) include: greater pay and/or benefits (136 responses; 8%), better management/administration (65 responses; 4%), and greater responsibility/authority.
- The top five personal training and technical assistance needs indicated by respondents include: providing trauma informed or trauma sensitive services (48%); providing services for co-occurring disorders (47%); providing clients with integrated treatment services of addiction and mental health disorders (43%); improving client problem solving skills (40%); improving behavioral management of clients OR improving client thinking skills (tied at 39%); and improving cognitive focus of clients during group counseling (38%).

## Education Levels and Credentials

The majority of clinical directors are well educated, with a large number holding graduate degrees (master's, 57%; doctoral or equivalent, 8%; medical degree, 1%). Of those who do not have graduate degrees, 15% have a bachelor's degree, 7% have an associate's degree, and 7% have some college but no degree. Clinical directors reported that of the direct care staff they supervise, 24% have bachelor's degrees and 36% have master's degrees.

More than three-quarters (84%) of clinical directors are licensed/certified in substance abuse counseling, and over half are licensed/certified as clinical supervisors (55%). Of those licensed/certified as clinical supervisors, most hold licensure/certification at the state level (77%). For direct care staff, most are already licensed/certified (54%) or are currently pursuing licensure/certification (18%).

Clinical directors discussed how financial and structural resources needed for recruitment in the SUD treatment field can often act as a barrier to attracting the best job candidates. Financial barriers do not

allow treatment facilities to offer competitive salaries, one of the key elements in successful recruitment. Additionally, structural barriers such as the amount of paperwork and documentation expected of clinicians affect successful recruitment.

Clinical directors also suggested that stigma and misunderstanding of SUD treatment play a role in recruitment challenges. They noted that SUDs are often not considered a legitimate healthcare issue and have not been traditionally integrated into mainstream healthcare.

## Areas of Concern

In February 2012, the Technical Assistance Collaborative (TAC) and the Human Services Research Institute (HSRI) released a major report, *California Mental Health and Substance Use System Needs Assessment.* The report applauds efforts to expand and support the behavioral health workforce and identified ten areas of concern:

1. A shortage of psychiatrists and psychiatric nurse prescribers, especially those specializing in serving children and elders.
2. Shortages of behavioral health workers in many rural areas.
3. A workforce that is predominately Caucasian, English-only speaking in a state where 38% of the population is of Hispanic/Latino origin, 36% of residents are foreign born, and 57% speak a language other than English.
4. A lack of formal integration and coordination of mental health and substance use treatment and primary care and a shortage of providers skilled in co-occurring disorder treatment.
5. An absence of state certifications for peer counselors and family support specialists, as well as a lack of positions in the public mental health system for peers/family members.
6. A need for more culturally responsive and competent providers' practices to engage underserved populations.
7. Variability among the counties in the use and training of staff in state-of-the art, evidence-based, and recovery-oriented treatments.
8. A workforce with limited training in providing care that is family-centered or recovery-oriented as well as limited training opportunities in those areas.
9. An inadequate supply and mal-distribution of inpatient psychiatric beds, detoxification beds, and inpatient alternatives such as crisis residential services.
10. Variability among the counties in collaboration with Federally Qualified Health Centers and a need for more consistent collaboration and stronger partnerships with these health centers.

The report notes that several California communities have addressed some of these issues.

Another report, *Evaluation Services To Enhance The Data Management System In California (EnCAL), Final Report 2011–2012*, by University of California, Los Angeles, Integrated Substance Abuse Programs, identifies a critical need to adopt EBPs and the barriers for doing so.

Providing quality care to identify and reduce risky substance use and diagnosing, treating, and managing addiction requires a critical shift to science-based interventions and treatment by health care professionals. Significant barriers stand in the way of making this critical shift, including: (a) an addiction treatment workforce starved of resources, operating outside the medical profession, and lacking capacity to provide the full range of evidence-based practices including necessary medical care; (b) a

health profession that should be responsible for providing evidence-based addiction screening, interventions, treatment, and management; and (c) inadequate oversight and quality assurance.

## Treatment

A person entering the treatment workforce has an abundance of credentials from which to choose. Confusion exists as to which credential is the most valuable—there are no standards or consistency. The lack of standards creates confusion for job applicants, hiring managers, and the patients themselves. Individuals who function as supervisors or managers typically do not receive special training to operate within that role and frequently are expected to carry a treatment workload and maintain their technical expertise.

Currently there is no state agency that issues certifications or licenses for a specific "SUD workforce." Individuals licensed as LCSW, MFT and physicians all may provide AOD counseling in any SUD treatment setting. ADP has the authority to determine the skills, knowledge and abilities of the workforce providing AOD counseling in ADP licensed and certified facilities. ADP has authorized seven certifying organizations to certify to the determined skills, knowledge and abilities regulated by ADP for individuals not otherwise licensed. These individuals are only certified to provide services in ADP licensed and/or certified facilities, not any of the other settings available for individual SUD treatment (hospitals, primary care) unless that hospital or primary care setting is also AOD certified by ADP.

## Prevention

SUD prevention strategies such as screening and brief intervention, classroom education, and youth development are individual-based. Other strategies such as community outreach, strategic planning, and public policy development are population-based. The manner in which the population-based activities are conducted is based on the needs of the specific community environment. The prevention workforce needs to be knowledgeable and skilled in these strategies for SUD prevention to be effective.

Credentialing or standards are needed within the prevention field. Currently, counties each have their own minimum competencies for prevention staff, resulting in a workforce with varying levels of knowledge, skills and abilities.

At the county level, the county Alcohol and Drug Program Administrator frequently has conflicting priorities between treatment and prevention. Recently, the prevention workforce has felt the brunt of California's economic turmoil. Prevention specialists have lost jobs due to budget cuts and responsibilities are then transferred to those who have little or no prevention background or experience.

The role of prevention within communities is similar to the role of health screenings in detecting early warning signs of cancer, diabetes and other medical conditions. Data suggests that early warning signs exist as risk factors. If ignored, the risk factors tend to lead to behaviors such as underage drinking, binge and excessive drinking, illicit drug use, and prescription drug abuse.

## Recovery Support

Recovery support plays a critical role for an individual with SUD. Many recovery support specialists, peer mentors and counselors come from the perspective of "been there, done that" and are able to build rapport with an individual and provide hope for recovery – a necessary element that extends beyond

medical care. Recovery support staff represent all walks of life, all socio-economic levels, and all racial and ethnic groups. This diversity makes them particularly effective at relating to others.

Recovery support is not always viewed as medically necessary, so it may not be considered an essential part of a primary care setting. There is no standard credential or certification for a recovery support person.

## Administration and Managerial

Individuals in administrative and managerial roles spend the majority of their day doing these types of tasks, leaving minimal time to practice their skills as counselors. The expectations for administrative and managerial staff are not standardized and little training exists to help prepare a person for these roles. There is no state recognized certification or license required to provide the administration and management function in a facility licensed or certified by the state.

## Findings

- Staff need specific training to become supervisors and managers. (Goal 16)
- Licensure and certification requirements are less for substance abuse counselors in comparison to mental health counselors. A standardized certification and scopes of practice may potentially allow SUD paraprofessionals to work within primary care settings. This not only adds credibility to their credentials, but also expands their job marketability. The certification and scopes of practice should include treatment, prevention, recovery support, and supervisory positions. (Goal 11)
- There is great diversity in the demographics of the workforce and in the patient population. Therefore, the workforce must acknowledge the influence of their own pre-conceived opinions and biases on the services they provide to specific segments of the population. There is a need for more culturally responsive and competent providers to engage underserved populations. (Goal 15)
- Grow, maintain and sustain the workforce by creating a career path - recognizing the current shortfalls within the career field, actively recruiting, and creating incentives to stay in the field. Youth and young professionals need to be encouraged to enter the workforce to help offset the natural attrition that will occur as the aging workforce retires or leaves the field. (Goal 13)
- To retain staff, incentives such as increased compensation, incentives for continuing education, healthcare and other benefits, and implementation of a supportive culture are needed. (Goal 14)
- Implementation of Electronic Health Records is needed, along with the training to effectively use the system. (Goal 15)
- Formal integration and coordination of mental health and substance use treatment, prevention and recovery support into primary care is needed, along with an increase in the number of providers skilled in treating co-occurring disorders. (Goal 8)
- Create consistency among the counties in the training of staff and use of state-of-the art and evidence-based and recovery-oriented treatments. (Goal 15)
- The workforce has limited training opportunities in providing care that is family-centered or recovery-oriented. (Goal 15)

# Chapter 3 - Potential Workforce Competencies, Certifications & Standards to Deliver Service in Health Reform

To meet the requirements of health reform and the emerging federal directions, all members of the workforce need to expand their knowledge, skills and abilities. In the process, it is expected that two of our State Needs Assessment and Planning (SNAP) goals will be achieved.

- Health Reform Readiness, Goal 3: Develop the AOD workforce to conform to health reform requirements for service provisions including early intervention and reimbursement strategies for health reform related activities, and
- Prevention Strategies, Goal 2: Build workforce capacity based on core competencies for Prevention practitioners.

The following sections provide examples of the types of services, certifications, and standards that are needed by the workforce.

## SAMHSA's Strategic Directions

SAMHSA provides the strategic direction for substance abuse and mental health. Therefore, it is logical for the workforce to prepare to meet the eight strategic initiatives that SAMHSA has embedded in its strategic plan document, *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014*. Examples of workforce objectives in each of the Strategic Initiatives include:

1. Prevention of Substance Abuse and Mental Illness: Educate the behavioral health field about successful interventions, such as screening, brief intervention, and referral to treatment (SBIRT); develop and implement training around suicide prevention and prescription drug abuse.
2. Trauma and Justice: Provide technical assistance and training strategies to develop practitioners skilled in trauma and trauma-related work and systems that have capacity to prevent, identify, intervene and effectively treat people in a trauma-informed approach.
3. Military Families: Develop a public health-informed model of psychological health service systems, staffed by a full range of behavioral health practitioners who are well trained in the culture of the military and the military family and the special risks and needs that impact this population, such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). The role of peer counselors within this model will also be important to its success.
4. Recovery Support: Build an understanding of recovery-oriented practices, including incorporating peers into the current workforce to support peer-run services. Emphasize collaborative relationships with children, youth, and families that involve shared decision-making service options.
5. Health Reform: Work with partners and stakeholders to develop a new generation of providers, promote innovation of service delivery through primary care and behavioral health care integration, and increase quality and reduce health care costs through health insurance exchanges and the essential and benchmark benefit plans.
6. Health Information Technology: Promote the adoption of electronic health records (EHRs) and the use of health information technology (HIT) through SAMHSA's discretionary program and Block Grant technical assistance efforts.

7. Data, Outcomes and Quality: Target quality improvement through workshops, intensive training and resources that promote the adoption of evidence-based practices, and activities to advance the delivery of clinical supervision to foster competency development and staff retention.
8. Public Awareness and Support: Ensure that the behavioral health workforce has access to information needed to provide successful prevention, treatment, and recovery services.

## Scope of Practice, Certifications, Career Ladder

Within the SUD field, agreement exists that a scope of practice and a career ladder are needed to address the full range of responsibility from entry level to clinical supervision, and include the roles of prevention, treatment and recovery support staff. However, there is not yet agreement about the specific details to include on a scope of practice, or the positions that should be on a career ladder.

As defined by the Federation of State Medical Boards (FSMB) a Scope of Practice is the "definition of rules, regulations and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability." The benefits of having a Scope of Practice include the following.

- Protect the public by setting standards
- Put practice in line with higher education
- Allow practitioners to be reimbursed for services (to collect 3rd party payment)
- Raise awareness of the profession
- Inform workforce development activities

Regarding credentials, according to the International Certification and Reciprocity Consortium (IC & RC), the credentialing of professionals enhances services in at least three important ways:

1. Ensuring Public Safety: The most compelling reason to certify substance abuse professionals is to ensure public safety. It is reasonable for consumers of substance abuse services to expect protection from other abuses, such as misappropriation of funds, misrepresentation of credentials, conflicts of interest, and discrimination.

2. Enhancing Public Funds Accountability: Ethical practice demands accountability for public expenditures, and accountability dictates that states and their programs utilize staff who demonstrate proficiency with competency-based standards.

3. Providing Professional Benefits: Professionals gain significant benefits by achieving and maintaining a practice credential. Not only are they able to demonstrate practice competencies in their daily work, but they become part of an international cadre of advocates for quality service delivery.

Career ladders are occupational structures designed to encourage and reward competent employee performance within a field or a particular organization. Employees move up the rungs – or in the case of a career lattice, across -- by demonstrating successful performance and/or obtaining education and

training that prepares them for the next level. Career ladders help employees plan for upward mobility in their careers, even if they start in an entry-level job.

Some benefits include the following.

- Employee retention—Career ladders illustrate potential for advancement, which serves as an incentive for employees to stay with organizations or within a field. Employers save on costly turnover, recruitment, and training expenses.
- Performance incentive—Opportunity for advancement motivates employees to produce and perform well on the job and to acquire new knowledge and skills.
- Career development programs—The graphic representation of career ladders provides an easily understood tool to assist career counselors and individuals in career planning and decision-making.

Used together, the scopes of practice and the career ladder create the standards for the roles and responsibilities within the field of substance use disorders. As these professional roles are more clearly articulated and these documents incorporated into the workplace culture, the SUD profession will be better able to position itself in a specialized field.

## Treatment

Creating a standard scope of practice and set of credentials for the entire SUD workforce, not just counselors providing services in ADP licensed and certified facilities, is a topic that has been reviewed and endorsed by multiple entities. The State recognizes that creation of these standards, having a universal code of conduct, and training all workforce members to understand prevention based services and cultural competency are needed.

Currently, treatment can be provided in multiple settings, both licensed and not licensed by ADP. The facility licensing aspect of treatment serves to confuse the already complex individual certification choices. Individuals may seek treatment for SUD issues from service providers; however, not all service providers are regulated by the state. ADP is the single state agency to monitor the funds from the SAPT Block grant, but ADP is not the single state provider of services for SUD issues.

Facility Licensing – Certain facilities must be licensed by the state to provide specific services to individuals. The facility license dictates the services which may be provided in the facility.

- Emergency medical services for individuals suffering from SUD issues are provided in a hospital. After the medical services are delivered, the individual will either be released or admitted for an extended period of time.
- Residential medical services for individuals with SUD can be provided only in a facility licensed to provide medical services to individuals overcoming alcohol and/or other drug issues. These services may be provided in either a hospital setting or in a chemical dependency recovery hospital licensed by Department of Public Health (DPH).
- Residential non-medical services for individuals with SUD can be provided only in a facility licensed by ADP to provide residential non-medical treatment or recovery services to adults for the treatment of alcohol and other drug issues.
- Outpatient SUD services may be provided in any outpatient facility. These facilities may provide medical services and need oversight from DPH to provide medical services. They may be

provided in a facility that provides no medical care. There is no requirement for this type of facility to be licensed by any state agency. There is no license available for this type of facility.

- Narcotic treatment programs (NTP) provide replacement narcotic therapy to individuals overcoming opioid dependency. These facilities must be licensed by ADP.
- Driving under the influence (DUI) programs provide court mandated educational sessions to individuals convicted of driving under the influence.

Program Certification – any program providing SUD treatment or recovery services may seek to have their program certified by ADP to provide AOD services. By state law, this AOD certification is voluntary. ADP certifies AOD programs providing AOD treatment or recovery services in residential medical facilities licensed by DPH; residential non-medical facilities licensed by ADP; and residential non-medical facilities licensed by DSS and DHS.

Drug Medi-Cal Certification – any qualifying program that seeks reimbursement for services through the state Medi-Cal system must be certified by DHCS (previously ADP) to provide drug Medi-Cal services. Facilities eligible to apply for a drug Medi-Cal certification include perinatal, residential non-medical, NTP's and outpatient providers.

For the SUD workforce, there is currently no state issued AOD/or SUD counselor registration, certification or license in California. ADP has been given the authority to determine the appropriate skills, qualifications, education, and training of personnel working in ADP licensed or certified recovery or treatment programs. Registration and certification of individuals providing AOD counseling in ADP licensed or certified facilities recognizes program compliance with established standards. Regulations require that to provide AOD counseling in any ADP licensed or certified program, individuals must be registered or certified with an approved certifying organization at the appropriate level of certification, or be otherwise licensed as defined as a physician, marriage family therapist, clinical social worker, or an intern registered with the Board of Behavioral Sciences. Six entities have been recognized as California's certifying organizations, each of which have established standards that meet the minimum standards identified in regulations and which vary significantly from one certification body to another.

While the examples shown in this report are from a federal perspective, the standards used within the State should reflect state-level needs. The state will need legislation to gain oversight of all individuals providing SUD counseling in California to include prevention, recovery or treatment services.

Much work has been done to define a scope of practice for the SUD treatment field. For an example, refer to Appendix F: Example - Scopes of Practice & Career Ladder for Substance Use Disorder Counseling, SAMHSA, September 2011.

## Prevention

SAMHSA has a strategic initiative to develop Prevention Prepared Communities. The Institute of Medicine's (IOM's) 2009 report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, describes evidence-based services and interventions that build emotional health by addressing risk factors and supporting protective factors and resilience to prevent many mental and substance use disorders in children and young adults. The report documents that behavior and symptoms signaling the likelihood of future disorders—such as substance abuse, adolescent depression, and conduct disorders—often manifest 2 to 4 years before a disorder is actually present. If communities and families can intervene earlier—before mental and

substance use disorders are typically diagnosed, future disorders could be prevented or the symptoms mitigated. Doing so requires multiple and consistent interventions by all systems touching these children and youth (e.g., schools, health systems, faith-based organizations, families, and community programs). Most adult mental and substance use disorders manifest before age 25, and many of the same risk and protective factors affect physical health. The focus on preventing mental health and substance use disorders and related problems among children, adolescents, and young adults is critical to the nation's health now and in the future.

Mental, emotional, and behavioral health contribute to the overall psychological well-being of individuals. SAMHSA plans to promote health by placing a national priority on healthy mental, emotional, and behavioral development, especially in children, youth, and young adults.

At the State level and in a collaborative effort, ADP and CADPAAC are developing components of curricula for the prevention workforce and include training in the areas of collaboration, community organization and outreach, youth development, screening and brief intervention, and the Strategic Prevention Framework (SPF).

At the international level, the United Nations Office of Drugs and Crime (UNODC) recently released a report, *International Standards On Drug Use Prevention*. The report contains a summary of the interventions and policies that have been found to yield positive results in preventing substance abuse. An excerpt from the report is shown in Appendix H: International Standards On Drug Use Prevention.

## Recovery Support

Although non-traditional, and unrecognized currently in California, the recovery support workforce needs to be a part of data collection efforts, including those in recovery from mental and substance use conditions, community health workers, patient navigators, and health educators. Recovery support workers play a key role in the mentoring of individuals and need to be included in the career ladder, in the credentialing system, and integrated into primary care.

One of SAMHSA's strategic initiatives is to build a recovery-oriented support structure which relies upon a strong peer recovery support network.

## Administrative and Managerial

As the use of electronic health records, electronic billing and other health information technology gains momentum, the workforce needs to be educated on the importance of using these systems, the value they bring to patient care, and trained in using the systems.

The changes in credentialing, scopes of practice, and available training require the creation and administration of a system to track and monitor activities such as, the level of credential held by each practitioner, credential renewal information, the training they have received, and the training they need, to name a few.

Workforce who desire to advance to managerial positions require training to understand and meet the demands of reporting, staff recruiting and retention, and create a plan to ensure their workforce is trained to meet credentialing and treatment standards.

## Coordination of Care

Integration into primary care will incorporate the concept of total individual wellness. This includes physical and mental health and requires coordination of care between multiple primary care and specialty treatment providers. Managing patient care from the perspective of one problem list, one medication list and one care plan requires a category of workforce having a focus on effective coordination of care. This role is not currently defined, and is not recognized as a credentialed position or included in a career ladder. Defining the role and identifying the training and credentials for it will help to establish it as a needed and viable part of the workforce.

## Summary

In combination, the federal government, IC&RC, UCLA and CADPAAC have many goals, objectives, and initiatives that point in the direction our workforce should go for credentials and types of services. Health reform creates an immediate need for increased treatment capacity. Federal directions point toward increasing the future role of prevention by creating Prevention Prepared Communities resulting in decreasing the future workload on the treatment workforce. Likewise, family-centered and recovery-oriented objectives could reduce treatment workload burden by shifting it to the recovery support staff.

The creation of a standardized SUD credentialing system that expands the workforce core set of competencies to allow work within a primary care setting will benefit the workforce. It will create consistency within the field and will make each individual more marketable. Each member of the workforce can choose a credential that is the best fit for them, and then take the appropriate steps to achieve that specific level of credential. The credentialing system, in combination with training, recruitment, and incentives, will help stabilize the SUD field and make it an integral part of the healthcare system.

Regardless of health reform and its impact on the SUD workforce, these recommendations should be implemented as quickly as possible. Health reform plays the role of providing the impetus and the urgency to start the process now.

As summarized in a report prepared by the Annapolis Coalition *The Action Plan on Behavioral Health Workforce Development: Executive Summary*, the following items identify the current state of the SUD workforce.

- A workforce and treatment capacity insufficient to meet demand.
- A changing profile of the people in need of services, which includes increased co-occurring mental illnesses and substance use disorders, medical comorbidity, rapidly evolving patterns of licit and illicit drug use, and involvement in the criminal justice system.
- A shift to increased public financing of treatment, accompanied by declining private coverage, budgetary constraints in publicly funded systems, managed care policies and practices, and the large number of undocumented and uninsured individuals.
- Major paradigm shifts within the field, including the movement toward a recovery management (and resilience-oriented) model of care.

- A continual escalation of demands on workers to change their practices, including the adoption of best practices and evidence-based interventions.
- An increase in the use of medications in treatment, with the resultant demand that the workforce be knowledgeable and skilled in managing medications.
- A challenge to provide services more frequently in non-behavioral health settings.
- An expansion of requirements to implement performance measures and to demonstrate patient outcomes through data.
- A climate of ongoing discrimination or stigma related to people who receive and provide care.

Trends such as illness self-management, peer-support approaches, and increased access to information via the Internet are remodeling the relationships among practitioners, patients, and their families, thus posing new challenges for the workforce as well as new opportunities for genuine partnerships between consumer and provider in the decision-making process.

The recommendations that follow are categorized as related to one of the five following areas:

- Ensure the work of the task force continues beyond the time when the SUD functions and programs of ADP transfer to DHCS
- Increase the short term capacity of the workforce to meet the increased demand for SUD services
- Increase the long term capacity of the workforce by effectively using all segments of the workforce
- Develop a long term strategy to attract and retain people to the workforce
- Provide easily accessible, affordable training that will allow the workforce to increase their skill set.

The implementation timeframes are either short-, mid-, or long-range.

- Short-Range Implementation Timeframe = by December 31, 2014
- Mid-Range Implementation Timeframe = by December 31, 2016
- Long-Range Implementation Timeframe = by December 31, 2019

## Findings

- Educate the SUD workforce about successful interventions, such as screening, brief intervention, and referral (SBIR); and develop and implement training around suicide prevention and prescription drug abuse. (Goal 10)
- Provide technical assistance and training strategies to develop practitioners skilled in trauma and trauma-related work and systems that have capacity to prevent, identify, intervene and effectively treat people in a trauma-informed approach. (Goal 15)
- Develop a public health-informed model of psychological health service systems, staffed by a full range of health practitioners who are well trained in the culture of the military and the military family and the special risks and needs that impact this population, such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). (Goal 15)
- Build an understanding of recovery-oriented practices, including incorporating peers into the current workforce to support peer-run services. Emphasize collaborative relationships with children, youth, and families that involve shared decision-making service options. (Goal 10)

- Ensure that the workforce has access to information needed to provide successful prevention, treatment, and recovery services. (Goal 10)
- Train health care personnel to deliver patient centered care as members of an interdisciplinary team and emphasizing evidence-based practices. (Goal 10)
- Develop a career ladder for the workforce that includes prevention, treatment, recovery support, administrative and managerial, and care management staff. (Goal 14)
- Develop a standardized credentialing system that includes prevention, treatment, recovery support, administrative and managerial, and care management staff. (Goal 3)
- Continue to support the clarification of needed competencies for peers and family members; encourage creation of a peer professional career ladder, including training and supervision of peers by peers. (Goal 10)
- Collect and disseminate information on state-specific descriptions of peer services for Medicaid programs and other insurers, including: identification of peer services that are reimbursed; descriptions of coverage limitations or specific supervision or training requirements; payment mechanisms and rates; and how to encourage the greater inclusion of peers in integrated health care teams. (Goal 10)
- Encourage funding of innovations and services that include peers in accountable care and other alternative payment programs, as well as in block grant and competitive grant programs where possible. (Goal 13)
- Build bridges between peer counselors, health educators, and community health workers in primary care settings; encourage their participation in prevention and wellness issues as well as programs or activities that help people maintain their recovery. (Goal 10)
- Include peers as navigators and enrollment/eligibility assistants in state and federally facilitated health insurance marketplaces and in Medicaid expansion programs. (Goal 11)
- Work with community colleges to develop curriculum and supports for peer and other alternative practitioners to assist licensed mental health and SUD practitioners. (Goal 13)
- Develop an administration system to track and monitor credential and training information. (Goal 12)
- Moving forward, ensure the recommendations in this report transition to DHCS. (Goal 1)

# Chapter 4 – Recommendations

## Logic Model - Workforce Development Task Force Recommendations

**Problem Statement 1: The transition of ADP to DHCS may cause the implementation of these recommendations to stall. Progress on the implementation of the SUD Workforce Development Task Force recommendations must continue beyond June 30, 2013.**

To ensure the Workforce Development Task Force recommendations continue to make progress toward implementation after the June 30, 2013 transfer of the SUD functions and programs of ADP to DHCS, create a Workforce Plan Development Work Group with responsibility and authority to ensure implementation of these recommendations, to monitor the progress of the implementation, to determine the data sources used to evaluate the effectiveness of the changes, and to continually work to create relationships among and between the many disciplines of the healthcare workforce at the county, state and federal levels. The Workforce Plan Development Work Group should consist of representation from the SUD, mental health, and primary care workforces; representation from the education, judicial, and public policy systems; stakeholders representing county and federal interests; and stakeholders such as insurance carriers and other groups impacted by SUD and health reform.

**Goal 1:** Increase the ability to monitor progress of the recommendation implementation.

**Objective:** Create a Workforce Plan Development Work Group that has the responsibility of implementing, monitoring, and evaluating implementation progress.
**Objective:** Determine the data sources to be used for evaluation purposes and to monitor the changes from pre- to post-implementation.
**Objective:** Ensure continuity by maintaining participation from the workforce development task force.
**Objective:** Ensure a broad representation of viewpoints by requesting participation from multiple disciplines.
**Objective:** Build communication bridges to multiple disciplines.

**Goal 2:** Increase the timeliness of integration of SUD into primary care and other health settings.

**Objective:** Seek representation on the Workforce Plan Development Work Group from the California Office of Statewide Health Planning and Development (OSHPD).
**Objective:** Seek representation of the Workforce Plan Development Work Group into OSHPD groups.
**Objective:** Incorporate the use of OSHPD pilot program options into the implementation of scopes of practice.
**Objective:** Seek representation of a Workforce Plan Development Work Group member on a National level advisory group/board to provide input and guidance.
**Objective:** Recognize the input from the field and create a Single State Authority for credentialing.

**Problem Statement 2: There will be an immediate increased need for SUD services and no corresponding increase in the number of SUD workforce to address the need.**

Increase the short term capacity of the workforce to meet the increased demand for SUD services by expanding the number and types of workforce skilled and trained in delivering SUD services, expanding

the number and types of services eligible for insurance reimbursement, and expanding the number and types of facilities authorized to deliver SUD services.

**Goal 3:** Change the licensing and credentialing structure to allow the workforce to meet the increased demand for services.

**Objective:** Coordinate and develop a scope of practice for SUD providers to clarify which positions are able to deliver services.

**Strategy:** Create a standard and uniform scope of practice for the SUD workforce.

**Strategy:** Establish the minimum or baseline level of credential needed to provide SUD services.

**Strategy:** Identify the primary care providers who have SUD diagnosis and treatment ability in their scope of practice.

**Strategy:** Determine the types of training necessary to allow primary care practitioners to feel comfortable working within their SUD scope of practice.

**Strategy:** Identify potential "new" positions that may emerge from health reform, i.e., health educator, care coordinator, universal health screener, etc.

**Strategy:** Identify the likely types of services to be delivered.

**Strategy:** Identify the minimum level of credential required to deliver SUD services, for all positions, new and existing.

**Strategy:** Identify the policy changes needed to implement a scope of practice.

**Objective:** Reduce the confusion regarding the multiple and varied SUD credentials available.

**Objective:** Increase or change the SUD workforce skills and competencies to work in multiple healthcare settings.

**Objective**: Increase or change the credentials needed to provide SUD services.

**Objective:** Increase the insurance reimbursement rate for providing SUD care resulting in an expansion of workforce employment opportunities which will ultimately lead to an increased salary range to help build a sustainable workforce.

**Objective:** Increase the types of facilities eligible for insurance reimbursement.

**Goal 4:** Increase the number of counties who are certified DMC providers.

**Problem Statement 3: There is not a sufficient number of SUD treatment workforce to address a sustained increased demand for service. Integration of healthcare creates a need to use resources in the most efficient manner possible.**

Expand the capacity of the workforce by effectively using all members of the workforce. Create methods to correctly identify and treat SUD problems, as well as share information between providers. Increase the long term capacity of the workforce by expanding the role of prevention and recovery support. Effective use of prevention addresses community-level risk factors and reduces the need for specialty SUD care through the use of early diagnosis of community problems, implementation of evidence-based practices, and high visibility messaging. Increased use of recovery support emphasizes a recovery-oriented approach and building collaborative relationships with family members who share decision making for treatment options.

**Goal 5:** Increase the ability of primary care providers to recognize and treat SUD.

**Objective:** Incorporate SUD diagnosis information into training sessions targeting primary care providers.
**Objective:** Incorporate best practices and evidence-based practices for SUD treatment into primary care facilities.
**Objective:** Identify the regions within the state having limited access to care.
**Objective:** Identify the needs associated with the influx of the underserved populations.

**Goal 6:** Increase the use of universal screening to be used in multiple healthcare settings and facilities.

**Objective:** Identify the types of conditions for which universal screenings are best suited.
**Objective:** Determine the locations where universal screenings can be used, i.e., hospitals, emergency departments, clinics, schools, etc.
**Objective:** Develop creative methods of conducting the screenings, i.e., online assessments, paper assessments, in office, telephone, etc.

**Goal 7:** Increase the ability of the integrated workforce to recognize co-occurring disorders.

**Goal 8:** Develop a list of core competencies that cross between primary care, mental health and SUD.

**Goal 9:** Develop a universal consent form to allow for sharing of information between providers.

**Goal 10:** Reduce the demand on the SUD treatment workforce while continuing to provide needed services.

**Objective:** Increase the role of the prevention and recovery support workforce.
**Strategy:** Build and sustain prevention prepared communities.
**Strategy:** Build and sustain a recovery oriented workforce using peer counselors, input from family members, and emphasizes collaborative relationships with families who share decision making service options.
**Strategy:** Emphasize the use of evidence-based practices.
**Objective:** Increase the roles and actions that can be taken by the primary care and mental health workforces to address SUD.

**Goal 11:** Increase the ability of the SUD workforce to provide services in an integrated healthcare environment.

**Objective:** Standardize SUD treatment protocols by creating best practices and implementing evidence-based practices.

**Problem Statement 4: The SUD workforce is losing members due to a lack of employment opportunity, having a low pay scale, and no career ladder.**

Develop a long term strategy to attract and retain members to the SUD workforce, provide them with a standard set of credentials, the tools to attain and maintain their credentials, and a system for monitoring and controlling the credentialing system.

**Goal 12:** Increase the definition and role of the administration aspects of monitoring and controlling changes.

**Objective:** Identify the method in which the workforce will be notified of changes.

**Objective:** Create a method to monitor and control the issuance of new credentials.

**Objective:** Create a method to monitor the workforce for staying current with their credentials.

**Objective:** Create a method to monitor and control the training requirements for the new credentials.

**Strategy:** Identify the method of determining training needs.

**Strategy:** Identify the method of evaluating if the training meets the needs of the workforce.

**Strategy:** Determine multiple methods of providing training.

**Strategy:** Determine a method to track how training was delivered and where it was received.

**Objective:** Determine whether existing credentials will be grandfathered into the new structure.

**Strategy:** Identify the difference between existing credentials and the new credentials.

**Strategy:** Determine the allowable time frame to enhance existing credentials to bring up to the level of the new credentials.

**Strategy:** Determine the training and or experience requirements to bring existing credentials up to the standard of the new credentials.

**Goal 13:** Increase the size and capacity of the SUD workforce.

**Objective:** Identify funding opportunities to expand the workforce.

**Objective:** Identify and develop partnerships to expand and sustain the workforce.

**Goal 14:** Increase the perceived value of the SUD workforce.

**Objective:** Develop incentives to keep the workforce, i.e., increased compensation, continuing education opportunities, having a career ladder, providing healthcare and other benefits.

**Objective:** Decrease the stigma associated with SUD treatment and the workforce that delivers it.

**Problem Statement 5: Sufficient training does not exist to prepare and allow all healthcare disciplines to deliver SUD services.**

Develop curricula and training for all healthcare workforce members who deliver SUD services. Make the training easy to access, affordable, and broad enough to address all elements of delivering SUD services in a wide variety of healthcare settings.

**Goal 15:** Increase the number and types of training available to all healthcare providers who deliver SUD services.

**Objective:** Increase the access points for training, i.e., web-based, distance learning, on-site, intern programs, self-study exams, etc.

**Objective:** Create curricula to address all core competencies and credentials.

**Objective:** Develop training programs for universal screenings, i.e., what screening tools are available, how to administer, how to interpret results, etc.

**Objective:** Develop training programs for evidence-based practices, i.e., what they are, how they are used, how to administer, etc.

**Objective:** Develop training programs designed to address cultural competency.

**Strategy:** Identify the population groups to recognize, i.e., veterans, aging population, prison population, underage drinking, Medicaid expansion, and health insurance exchange, etc.

**Strategy:** Train the practitioner to recognize their own preconceived ideas and the impact to service delivery.

**Objective:** Develop training programs to address AOD and its relationship to COD and physical health.

**Objective:** Develop programs designed to inform the SUD, mental health and primary care workforce about each other.

**Objective:** Develop training for the use of Electronic Health Records, Electronic Billing, and other health information technology.

**Objective:** Develop training in the use of the concept, "One problem list, one drug list, and one care plan".

**Objective:** Develop training for community organizing, youth development, strategic planning and public policy development needed for creating prevention prepared communities.

**Objective:** Develop standard training curricula that can be used statewide.

**Objective:** Develop training strategies to develop practitioners for trauma-related work.

**Goal 16:** Increase the number and types of training specifically for the Clinical and Managerial staff.

**Objective:** Improve the counseling skills and effectiveness of the clinical supervision staff.

**Objective:** Emphasize the conformity with the administrative and procedural aspects of the agency's work.

**Strategy:** Address the high turnover rate within the workforce.

**Strategy:** Find ways to retain staff.

**Strategy:** Reduce the paperwork burden for the workforce.

**Strategy:** Provide leadership training.

**Strategy:** Build relationships between specialty SUD facilities and primary care.

The charts on the following pages show a summary of the problem statements, goals, recommended implementation time frame, groups responsible for implementation, and the link/connection to the chapter findings.

| Problem Statement 1: The transition of ADP to DHCS may cause the implementation of these recommendations to stall. Progress on the implementation of the SD workforce development task force recommendations must continue beyond June 30, 2013. | | | |
|---|---|---|---|
| **Goal** | **Implementation Timeframe** | **Responsible Group** | **Link to Findings** |
| Goal 1: Increase the ability to monitor progress of the recommendation implementation. | Short Range | State | Chapter 3 - Moving forward, ensure the recommendations in this report transition to DHCS. |
| Goal 2: Increase the timeliness of integration of SUD into primary care and other health settings. | Short Range | State | All findings relate to this goal. |
| | | | |
| **Problem Statement 2: There will be an immediate increased need for SUD services and no corresponding increase in the number of SUD workforce** | | | |
| Goal 3: Change the licensing and credentialing structure to allow the workforce to meet the increased demand for services. | Short Range | State, County, Certifying Organizations | Chapter 1 - All practitioners of the healing arts, to include doctors, nurses, physician's assistants, LCSW's, MFT's, and others, must expand their skill set to recognize AOD and COD.<br>- All services delivered are not considered insurance billable services.<br>Chapter 3 - Develop a standardized credentialing system that includes prevention, treatment, recovery support, administrative and managerial, and care management staff. |
| Goal 4: Increase the number of counties who are certified DMC providers. | Short Range | County | Chapter 1 - All services delivered are not considered insurance billable services. |

| **Problem Statement 3: There is not a sufficient number of SUD treatment workforce to address a sustained increased demand for service. Integration of healthcare creates a need to use resources in the most efficient manner possible.** | | | |
|---|---|---|---|
| Goal 5: Increase the ability of primary care providers to recognize and treat SUD. | Short Range | Providers | Chapter 1 - Acknowledge that some areas of the state may have very limited access to AOD workforce.<br>- Address the influx of underserved populations.<br>- The private healthcare workforce will also expand and enhance its skill set to stay competitive and able to meet the increased demand for service. |
| Goal 6: Increase the use of universal screening to be used in multiple healthcare settings and facilities. | Short Range | Providers | Chapter 1 - Universal screening could pave the way for a newly designated category of SUD credential. |
| Goal 7: Increase the ability of the integrated workforce to recognize co-occurring disorders. | Short Range | Providers | Chapter 1 - COD affect a large portion of those seeking treatment. Staff core competency standards and training should address this. |
| Goal 8: Develop a list of core competencies that cross between primary care, mental health and SUD. | Short Range | State, County, Providers | Chapter 2 - Formal integration and coordination of mental health and substance use treatment, prevention and recovery support into primary care is needed, along with an increase in the number of providers skilled in treating co-occurring disorders. |
| Goal 9: Develop a universal consent form to allow for sharing of information between providers. | Short Range | State, County, Providers | Chapter 1 - Sharing of information between providers will be a key element to achieving success in creating one problem list, one drug list, and one care plan. This collaboration between providers can be aided by the use of Electronic Health Records, Electronic Billing, care management, and the concept of individual wellness. |
| Goal 10: Reduce the demand on the SUD treatment workforce while continuing to provide needed services. | Mid Range | State, County | Chapter 3 - Educate the SUD workforce about successful interventions, such as screening, brief intervention, and referral (SBIR); and develop and implement training around suicide prevention and prescription drug abuse.<br>- Build an understanding of recovery-oriented practices, including incorporating peers into the current workforce to support peer-run services. Emphasize collaborative relationships with children, youth, and families that involve shared decision-making service options.<br>- Ensure that the workforce has access to information needed to provide successful prevention, treatment, and recovery services.<br>- Train health care personnel to deliver patient centered care as members of an interdisciplinary team and emphasizing evidence-based practices.<br>Chapter 3 - Continue to support the clarification of needed competencies for peers and family members; encourage creation of a peer professional career ladder, including training and supervision of peers by peers.<br>- Collect and disseminate information on state-specific descriptions of peer services for Medicaid programs and other insurers, including: identification of peer services that are reimbursed; descriptions of coverage limitations or specific supervision or training requirements; payment mechanisms and rates; and how to encourage the greater inclusion of peers in integrated health care teams.<br>- Build bridges between peer counselors, health educators, and community health workers in primary care settings; encourage their participation in prevention and wellness issues as well as programs or activities that help people maintain their recovery. |
| Goal 11: Increase the ability of the SUD workforce to provide services in an integrated healthcare environment. | Mid Range | State, County | Chapter 1 - Using evidence-based practices is the wave of the future. The workforce must be trained in the use of, and adopt evidence-based practices.<br>Chapter 2 - A standardized certification and scopes of practice may potentially allow SUD paraprofessionals to work within primary care settings.<br>Chapter 3 - Include peers as navigators and enrollment/eligibility assistants in state and federally facilitated health insurance |

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| **Problem Statement 4: The SUD workforce is losing members due to a lack of employment opportunity, having a low pay scale, and no career ladder.** | | | |
| Goal 12: Increase the definition and role of the adminstration aspects of monitoring and controlling. | Short Range | State, County, Providers | Chapter 3 - Develop an administration system to track and monitor credential and training information. |
| Goal 13: Increase the size and capacity of the SUD workforce. | Long Range | State, County, Providers | Chapter 2 - Grow, maintain and sustain the workforce by creating a career path, recognizing the current shortfalls within the career field, actively recruiting, and creating incentives to stay in the field.<br>- Youth and young professionals need to be encouraged to enter the workforce to help offset the natural attrition that will occur as the aging workforce retires or leaves the field.<br>Chapter 3 - Encourage funding of innovations and services that include peers in accountable care and other alternative payment programs, as well as in block grant and competitive grant programs where possible.<br>- Work with community colleges to develop curriculum and supports for peer and other alternative practitioners to assist licensed mental health and SUD practitioners. |
| Goal 14: Increase the perceived value of the SUD workforce. | Long Range | State, County, Providers | Chapter 2 - To retain staff, incentives such as increased compensation, and incentives for continuing education, providing healthcare and other benefits, and implementation of a supportive culture are needed.<br>Chapter 3 - Develop a career ladder for the workforce that includes prevention, treatment, recovery support, administrative and managerial, and care management staff. |
| | | | |
| **Problem Statement 5: Sufficient training does not exist to prepare and allow all healthcare disciplines to deliver SUD services.** | | | |
| Goal 15: Increase the number and types of training available to all healthcare providers who deliver SUD services. | Short Range | State, County, Providers | Chapter 1 - To prepare for integration of services into primary care, cross train between the SUD, primary care, mental health and behavioral health workforces to understand the basics of substance use, mental health issues, behavioral health issues, and those physical ailments that mimic AOD.<br>- Identify how cultural competency will be addressed.<br>- Ensure the workforce is trained and prepared to deliver all SUD related services identified for the expansion population and the Health Insurance Exchange.<br>Chapter 2 - There is great diversity in the demographics of the workforce and in the patient population.<br>- Implementation of Electronic Health Records is needed, along with the training to effectively use the system.<br>- There is a need for more culturally responsive and competent providers to engage underserved populations.<br>- Create consistency among the counties in the training of staff and use of state-of-the art and evidence-based and recovery-oriented treatments.<br>- The workforce has limited training opportunities in providing care that is family-centered or recovery-oriented.<br>Chapter 3 - Provide technical assistance and training strategies to develop practitioners skilled in trauma and trauma-related work and systems that have capacity to prevent, identify, intervene and effectively treat people in a trauma-informed approach.<br>- Develop a public health-informed model of psychological health service systems, staffed by a full range of health practitioners who are well trained in the culture of the military and the military family and the special risks and needs that impact this population, such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). |
| Goal 16: Increase the number and types of training specifically for the Clinical and Managerial staff. | Short Range | State, County, Providers | Chapter 2 - Staff need specific training to become supervisors and managers. |
| | | | |

## Stakeholder Review and Comments

As it began to take form and direction, the task force chose to solicit input from the field, recognizing the value of the opinions and experience of those who currently are a part of the SUD workforce. Input and feedback was solicited and received from County Alcohol and Drug Program Administrators Association of California (CADPAAC), California Association of Addiction Recovery Resources (CAARR), California Association of Alcoholism and Drug Addiction Counselors (CAADAC), University of California Los Angeles – Integrated Substance Abuse Programs, California Association of Alcohol & Drug Education (CAADE), and California Association of Alcohol and Drug Program Executives (CAADPE).

Overall, the feedback received was encouraging. There was a stated desire to provide more specific and forceful recommendations especially regarding the creation of a Single State Agency for credentialing/certification. A summary of the comments is shown below.

- Address the need for a single state certifying agency/body for certifications and the credentialing system.
- A certifying body/system should be placed in the Department of Consumer Affairs.
- How will this report and project continue after the transition to DHCS?
- Include options and choices for a career ladder.
- Add detail about EBP for community support programs and peer supported programs.
- More clearly define who comprises the workforce.
- Focus on the skills needed to address patients with COD and the skills needed to work in medical and mental health settings.
- MAT training needs to include the knowledge of what the medications do, the kinds of services needed to promote retention and optimal treatment response, and how to work with/communicate with the medical staff (MDs and nurses) who manage the medications.
- Other training should include integration with mental health, harm reduction approaches, addiction and pain, addiction as a chronic disease, use of data to modify services.
- These content areas are important for training.
    - 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 Clients in a Multi-Service Setting
    - Integrated Care Competency Categories (From Annapolis Coalition Integration Report 12/12)
    - Interpersonal Communication
    - Collaboration & Teamwork

    - Screening & Assessment
    - Care Planning & Care Coordination
    - Intervention
    - Cultural Competence & Adaptation
    - Systems Oriented Practice
    - Practice Based Learning & Quality Improvement
    - Informatics
- CAADE has developed the curriculum for Goal 13 – Increase the size and capacity of the SUD workforce.
- CAADE has developed a career ladder.
- Eliminate all references to IC&RC and the 12 core functions. Reference should be SAMHSA's TAP 21.

## Implementation Strategy

Successful implementation of these report recommendations requires input from external stakeholders, their support as we move forward, and their participation in the planning and implementation phases.

The recommended implementation strategy is to immediately move forward to the next step – create a Workforce Plan Development Work Group. The Workforce Plan Development Work Group will recognize that time is of the essence and immediately develop the plan to address the recommendations outlined in this report. As a first step, the Workforce Plan Development Work Group should develop the implementation plan to address the creation of a Single State Authority/Agency for credentialing and certifications. This should occur by December 18, 2013, as shown in the Implementation Plan Time Line on page 45.

Another first step of the work group is to engage with Office of Statewide Health Planning and Development (OSHPD) to discuss possible methods and strategies to create an SUD career ladder.

The need is great to coordinate and collaborate on SUD workforce issues, therefore all functional areas within Department of Health Care Services should be approached for the purpose of coordinating and collaborating on SUD workforce issues. For example, working with groups such as the Managed Care Division can provide needed input regarding the types of skills required to deliver services within managed care facilities.

The current task force recognizes the challenge of creating forward momentum and progress given the current statewide need to work with minimal resources. To make the necessary changes, all stakeholders must participate in the process of developing and implementing solutions.

## Next Steps - Timeline for Implementation of Workforce Development Recommendations

| Date | Activity |
|---|---|
| July 31, 2013 | Create the Workforce Plan Development Work Group. Determine all stakeholders. |
| August 15, 2013 | Meeting #1 |
| August 23, 2013 | Develop the objectives, indicators of progress, and method used for tracking and monitoring progress. |
| August 23, 2013 | Determine the data sources to be used to track and monitor progress. |
| August 29, 2013 | Meeting #2 |
| September 13, 2013 | Develop a plan to address Problem Statement #1. |
| September 20, 2013 | Develop a plan to address Problem Statements #2, #3, and #5. |
| September 20, 2013 | Identify a strategy to achieve quick implementation of a screening and brief intervention pilot project by targeting counties with the highest need. |
| September 20, 2013 | Identify regions within the state with potential misalignment of the SUD workforce and develop a strategy to provide services. |
| Mid October, 2013 | Develop a plan to address Problem Statement #4. |
| Oct. – Dec. 2013 | Status check meeting 2 times per month. Report on progress, obstacles, risks, and successes. |
| December 18, 2013 | Quarterly status report and progress update. |
| December 18, 2013 | Complete the implementation plan to create a Single State Agency for certifications and credentials. |
| March 18, 2014 | Quarterly status report and progress update. |
| March 18, 2014 | Complete the plan to create an SUD workforce career ladder. |
| June 17, 2014 | Quarterly status report and progress update. |
| September 16, 2014 | Quarterly status report and progress update |
| December 16, 2014 | Quarterly status report and progress update. |

| | |
|---|---|
| December 31, 2014 | Completion of short-range implementation tasks. |
| January 2015 through December 2019 | Continue to meet on a quarterly basis. |
| December 31, 2016 | Completion of mid-range implementation tasks. |
| December 31, 2019 | Completion of long-range implementation tasks. |

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The Institute of Medicine's (IOM's) 2009 report Preventing Mental, Emotional, and
Behavioral Disorders Among Young People: Progress and Possibilities

An Action Plan for Behavioral Health Workforce Development. A Framework for Discussion. A report prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by The Annapolis Coalition on the Behavioral Health Workforce

United Nations Office of Drug Control, International Standards on Drug Use Prevention

# Appendix A: Overview of Federal and State AOD Healthcare Priorities

## Background

When evaluating options, strategies and potential programs to meet the increased demand for AOD/SUD services within California and resulting from health reform, there must first be an understanding of the federal and state guidelines, goals, objectives and strategies for reducing alcohol and drug use, and for providing AOD/SUD treatment. Understanding the federal and state direction will provide insight for the types of services that must be developed, which in turn determines the skill set required to deliver the necessary services. The service delivery model can quickly become complex when recognizing prevention, intervention and counseling, treatment, recovery, primary care, mental health, behavioral health, SUD settings, multi disciplines and multiple domains (individual, community, family, school) where services will be delivered.

Several federal agencies have similar goals and objectives. This document presents the information in a summarized and simplistic format and includes only those goals and objectives that relate to prevention, SBIRT, treatment and recovery of AOD/SUD. In the sections which describe specific health priorities, the information was taken directly from the public documents released by the named agency or organization.

## Summary of Federal Healthcare Priorities

- Prevention
- Alcohol and Other Drugs
- Underage Drinking
- Delay onset of drinking
- Reduce fatalities due to alcohol impaired driving
- Use Evidence Based Practices
- Maintain a skilled and cross trained prevention workforce
- Foster a nationwide community based prevention system
- Health Information Exchange (health information technology and Electronic Health Records)
- Enhance linkages between drug prevention, substance abuse, mental health, and juvenile and criminal justice systems
- SBIRT
- Incorporate cultural competence
- Implement prescription drug monitoring programs
- Heighten attention to driving under the influence of illicit and prescription drugs
- Healthcare Integration

## Federal Overview

When looking at the national picture, there are several key players who come from both the federal and non-federal perspectives. Some of the non-federal contributors receive federal funding and/or administrative support.

These agencies, departments and organizations establish the national priorities addressing alcohol and drug use within the United States.

- Office of the President of the United States of America
    - Office of the National Drug Control Policy
        - National Drug Control Strategy
    - National Prevention Council
        - National Prevention Council Strategy
        - National Prevention Council Action Plan
    - Office of the Surgeon General – a staff office within the Office of the Assistant Secretary for Health. The Assistant Secretary is the principal advisor to the Secretary on public health and scientific issues.
        - Surgeon General's Call to Action to Reduce Underage Drinking – 2007
    - Health and Human Services
        - Substance Abuse and Mental Health Services Administration (SAMHSA) – A part of the Department of Health and Human Services
            - Leading Change: A Plan for SAMHSA's Roles & Actions, 2011-2014
        - Healthy People 2020 – Supports the National Drug Control Strategy and the National Prevention Council Strategy. HP2020 identifies the initiatives and SAMHSA provides an avenue for funding.
- Institute of Medicine (IOM) – non governmental agency although receives federal funding
- The Community Preventive Services Task Force (The Community Guide) – non federal, unpaid, independent body, appointed by the Director of the Centers for Disease Control and Prevention (CDC). Established in 1996 by the Department of Health and Human Services
- United States Preventive Services Task Force (USPSTF) – independent group of national experts in prevention and evidence based medicine. Established in 1994. AHRQ provides support. AHRQ is a part of the Department of Health and Human Services.
- Cochran Reviews – an independent international, not-for-profit organization

## National Drug Control Strategy

- Goals to be attained by 2015
- Goal 1: Curtail illicit drug consumption in America
    - Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent
    - Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15 percent
    - Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10 percent
    - Reduce the number of chronic drug users by 15 percent
- Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse
    - Reduce drug-induced deaths by 15 percent
    - Reduce drug-related morbidity by 15 percent
    - Reduce the prevalence of drugged driving by 10 percent

Early intervention is essential to reducing drug use and its costs to society. Screening, Brief Intervention, and Referral to Treatment (SBIRT) provides an evidence-based approach to early intervention, addressing chronic diseases in medical settings. Research shows that in some instances a brief motivational intervention appears to facilitate abstinence from heroin and cocaine use at a 6-month follow up interview, even in the absence of specialty addiction treatment. SBIRT also reduces the time and resources

needed to treat conditions caused or worsened by substance use, making our health systems more cost-effective.

Expand and evaluate screening for substance use in all healthcare settings.

Increase adoption and reimbursement of SBIRT codes. To insure for SBIRT services, and to further implementation of SBIRT, efforts have been made to encourage states to adopt SBIRT as a reimbursable service with an available set of codes. HRSA has included SBIRT in the Uniform Data Systems to track activity in Federally Qualified Health Center grantees related to substance use disorder screening. SAMHSA has partnered with the Centers for Medicare and Medicaid Services to develop and disseminate the codes available for billing SBIRT services to Medicaid (if adopted by the state) and Medicare to all health care providers in the states. This will help promote the provision of these important screening services.

Integrate treatment for substance use disorders into healthcare and expand support for recovery. Integrating substance use disorder treatment into broader health care systems is a high priority for the Administration. Practitioners in mainstream health care systems historically have not screened for substance use disorders and often have limited knowledge of them. As a result, significant resources are spent treating conditions caused or worsened by undiagnosed substance use problems while the quality and cost-effectiveness of substance use disorder treatment is undermined by a failure to identify and address co-occurring medical and mental health conditions. Nonetheless, research has documented that substance use disorder treatment is a sound public investment. For example, a 2006 study found a 7:1 cost offset, meaning that every dollar spent on treatment yielded an average of seven dollars in costs savings. The majority of these savings came from reduced criminal justice system involvement and increased employment earnings.

Addiction treatment must be an integrated, accessible part of mainstream healthcare.

## National Prevention Strategy

- The National Prevention Strategy vision is**:** Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.
- The National Prevention Strategy overarching goal is: Increase the number of Americans who are healthy at every stage of life.
- 4 strategic directions
    - Healthy and Safe Community Environments**:** Create, sustain, and recognize communities that promote health and wellness through prevention.
    - Clinical and Community Preventive Services**:** Ensure that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing.
    - Empowered People**:** Support people in making healthy choices.
    - Elimination of Health Disparities**:** Eliminate disparities, improving the quality of life for all Americans.
- 7 priorities
    - Tobacco Free Living
    - Preventing Drug Abuse and Excessive Alcohol Use
    - Healthy Eating

    - Active Living
    - Injury and Violence Free Living
    - Reproductive and Sexual Health
    - Mental and Emotional Well-Being
- 5 categories of strategies
    - Policy
    - Systems change
    - Environment
    - Communications and media
    - Program and service delivery
- State, Tribal, Local, and Territorial Governments can:
    - Maintain and enforce the age 21 minimum legal drinking age (e.g., increasing the frequency of retailer compliance checks), limit alcohol outlet density, and prohibit the sale of alcohol to intoxicated persons.
    - Require installation of ignition interlocks in the vehicles of those convicted of alcohol impaired driving.
    - Implement or strengthen prescription drug monitoring programs.
    - Facilitate controlled drug disposal programs, including policies allowing pharmacies to accept unwanted drugs.
    - Implement strategies to prevent transmission of HIV, hepatitis and other infectious diseases associated with drug use.

## Key Facts

- Excessive alcohol use is a leading cause of preventable death in the United States among all adult age groups, contributing to more than 79,000 deaths per year. The alcohol-related death rate for American Indians and Alaska Natives is six times the national average.
- Over half of the alcohol consumed by adults and 90 percent of the alcohol consumed by youth occurs while binge drinking. Most Americans who binge drink are not dependent on alcohol.
- The relative low cost and easily availability of alcohol and the fact that binge drinking is frequently not addressed in clinical settings contribute to the acceptability of excessive alcohol use.
- Every day, almost 30 people in the United States die in motor vehicle crashes that involve an alcohol impaired driver – one death every 48 minutes.
- Prescription drug abuse is our nation's fastest growing drug problem. In a typical month, approximately 5.3 million Americans use a prescription pain reliever for nonmedical reasons. Emergency department visits involving the misuse or abuse of pharmaceutical drugs have doubled over the past five years.
- Chronic drug use, crime and incarceration are inextricably connected. At least half of both state and Federal inmates were active drug users at the time of their offense. Further, nearly 1/3 of state prisoners and a 1/4 of Federal prisoners committed their crimes while under the influence of drugs.
- Six million children (9 percent) live with at least one parent who abuses alcohol or other drugs. Children of parents with substance use disorders are more likely to experience abuse (physical, sexual, or emotional) or neglect and are more likely to be placed in foster care.
- Drugs other than alcohol (i.e., illicit, prescription, or over-the-counter drugs) are detected in about 18 percent of motor vehicle driver deaths.

- Injection drug use accounts for approximately 16 percent of new HIV infections in the U.S. In addition, injection and non-injection drug use is associated with sexual transmission of HIV and other STIs.
- Rates of marijuana use by youth and young adults are on the rise and fewer youth perceive great risk from smoking marijuana once or twice a week.

## Surgeon General's Call to Action to Prevent and Reduce Underage Drinking

- GOAL 1: Foster changes in American society that facilitate healthy adolescent development and that help prevent and reduce underage drinking.
- GOAL 2: Engage parents, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves, in a coordinated national effort to prevent and reduce drinking and its consequences.
- GOAL 3: Promote an understanding of underage alcohol consumption in the context of human development and maturation that takes into account individual adolescent characteristics as well as environmental, ethnic, cultural, and gender differences.
- GOAL 4: Conduct additional research on adolescent alcohol use and its relationship to development.
- GOAL 5: Work to improve public health surveillance on underage drinking and on population-based risk factors for this behavior.
- GOAL 6: Work to ensure that policies at all levels are consistent with the national goal of preventing and reducing underage alcohol consumption.

## Institute of Medicine (IOM)

Several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional, and behavioral (MEB) disorders are greatest by focusing on young people and that early interventions can be effective in delaying or preventing the onset of such disorders. National priorities that build on this evidence base should include (1) assurance that individuals who are at risk receive the best available evidence-based interventions prior to the onset of a disorder and (2) the promotion of positive MEB development for all children, youth, and young adults.

Interventions classified as:

- Universal
- Selective
- Indicated

## Key Areas of Progress Since 1994

- Evidence that MEB disorders are common and begin early in life.
- Evidence that the greatest prevention opportunity is among young people.
- Evidence of multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- Evidence that the incidence of depression among pregnant women and adolescents can be reduced.

- Evidence that school-based violence prevention can reduce the base rate of aggressive problems in an average school by one-quarter to one-third.
- Promising evidence regarding potential indicated preventive interventions targeting schizophrenia.
- Evidence that improving family functioning and positive parenting serves as a mediator of positive outcomes and can moderate poverty-related risk.
- Emerging evidence that school-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Evidence that interventions that target families dealing with such adversities as parental depression and divorce demonstrate efficacy in reducing risk for depression among children and increasing effective parenting.
- Evidence from some preventive interventions that benefits exceed costs, with the available evidence strongest for early childhood interventions.
- Evidence of interactions between modifiable environmental factors and the expression of genes linked to behavior.
- Greater understanding of the biological processes that underlie both normal brain function and the patho-physiology of MEB disorders.
- Emerging opportunities for the integration of genetics and neuroscience research with prevention research.
- Advances in implementation science, including recognition of implementation complexity and the importance of relevance to the community.
- Determinants of mental illnesses are on the horizon. It is now recognized that most disorders are not caused by a small number of genes and that this area of research is highly complex. An emerging area of research involves the influence of the environment on the expression of a specific gene or set of genes, the importance of epigenetic modification of gene expression by experience, and direct injury to neural systems that give rise to illness.

## Healthy People 2020 (HP)

HP2020 provides science-based, 10-year national objectives for promoting health and preventing disease. Since 1979, Healthy People has set and monitored national health objectives to meet a broad range of health needs, encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of our prevention activity. The development process strives to maximize transparency, public input, and stakeholder dialogue to ensure that Healthy People 2020 is relevant to diverse public health needs and seizes opportunities to achieve its goals. Since its inception, Healthy People has become a broad-based, public engagement initiative with thousands of citizens helping to shape it at every step along the way. Drawing on the expertise of a Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, public input and a Federal Interagency Workgroup, Healthy People provides a framework to address risk factors and determinants of health and the diseases and disorders that affect our communities.

The following are identified problem areas.

**Topic Area: Educational and Community-Based Programs**

> **ECBP–2:** Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas:

unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.
**ECBP-7:** Increase the proportion of college and university students who receive information from their institution on each of the priority health risk behavior areas (all priority areas; unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity).
**ECBP–10:** Increase the number of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services.

**Topic Area: Maternal, Infant, and Child Health**

**MICH–11:** Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.
**MICH–16:** Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors.
**MICH–16.4** Did not drink alcohol prior to pregnancy.

**Topic Area: Mental Health and Mental Disorders**

**MHMD–10:** Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

**Topic Area: Substance Abuse - Policy and Prevention**

**SA–1:** Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.
**SA–2:** Increase the proportion of adolescents never using substances.
**SA–3:** Increase the proportion of adolescents who disapprove of substance abuse.
**SA–4:** Increase the proportion of adolescents who perceive great risk associated with substance abuse.

**Topic Area: Screening and Treatment**

**SA–7:** Increase the number of admissions to substance abuse treatment for injection drug use.
**SA–8:** Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year.
**SA–9:** (Developmental) Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department.
Potential data source: National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
**SA–10:** Increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol Screening and Brief Intervention (SBI).

**Topic Area: Epidemiology and Surveillance**

**SA–11:** Reduce cirrhosis deaths.
**SA–12:** Reduce drug-induced deaths.
**SA–13:** Reduce past-month use of illicit substances.
**SA–14:** Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
**SA–15:** Reduce the proportion of adults who drank excessively in the previous 30 days.
**SA–16:** Reduce average annual alcohol consumption.
**SA–18:** Reduce steroid use among adolescents.
**SA–19:** Reduce the past-year nonmedical use of prescription drugs.
**SA–20:** Decrease the number of deaths attributable to alcohol.
**SA–21:** Reduce the proportion of adolescents who use inhalants.

## Substance Abuse and Mental Health Services Administration (SAMHSA)

The following eight Initiatives will guide SAMHSA's work from 2011 through 2014:

1. **Prevention of Substance Abuse and Mental Illness**—Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.
2. **Trauma and Justice**—Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.
3. **Military Families**—Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.
4. **Recovery Support**—Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.
5. **Health Reform**—Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.
6. **Health Information Technology**—Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).
7. **Data, Outcomes, and Quality**—Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.
8. **Public Awareness and Support**—Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help

people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

The impact on America's children, adults, and communities is enormous:

- The annual total estimated societal cost of substance abuse in the United States is $510.8 billion.
- By 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide.
- In 2008, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness. Two million youth aged 12 to 17 had a major depressive episode during the past year.
- In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use.
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.

In 2011 and beyond, SAMHSA will work to improve understanding about mental and substance use disorders, promote emotional health and the prevention of substance abuse and mental illness, increase access to effective treatment, and support recovery.

SAMHSA's Strategic Initiatives will address trauma; support military families; improve access to culturally competent, high-quality care; develop community, peer, and family support; build information systems; and promote important messages about behavioral health while adjusting to changing conditions. By working across health, justice, social services, education, and other systems and with State, Territorial, Tribal, and other partners, SAMHSA will lead the way to improving the Nation's behavioral health.

## Key Facts

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.
- Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.
- Annually, tobacco use results in more deaths (443,000 per year) than AIDS, unintentional injuries, suicide, homicide, and alcohol and drug abuse combined. Almost half of these deaths occur among people with mental and substance use disorders.
- In 2008, an estimated 2.9 million persons aged 12 and older used an illicit drug for the first time within the past 12 months, an average of 8,000 initiates per day.
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.
- Adults who began drinking alcohol before age 21 are more likely to be later classified with alcohol dependence or abuse than those who had their first drink at or after age 21.
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.
- One estimate puts the total economic costs of mental, emotional, and behavioral disorders among youth in the United States at approximately $247 billion.
- The annual total estimated societal cost of substance abuse in the Unites States is $510.8 billion.

- In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use.
- Among persons aged 12 and older who used prescription pain relievers nonmedically in the past 12 months, 55.9 percent got them from a friend or relative for free.
- In 2009, the percentage of female youth aged 12 to 17 (14.3 percent) who were current drinkers was similar to the rate for male youth aged 12 to 17 (15.1 percent).
- In 2009, transition age youth aged 18 to 25 had the highest rates of binge drinking (41.7 percent) and heavy alcohol use (13.7 percent) of any age group.
- Trauma is strongly associated with mental and substance use disorders.
- Adverse childhood experiences (e.g., physical, emotional, and sexual abuse; and family dysfunction) are associated with mental illness, suicidality, and substance abuse.
- More than half of all prison and jail inmates (people in State and Federal prisons and local jails) meet criteria for having mental health problems, 6 in 10 meet criteria for a substance use problem, and more than a third meet criteria for having both a substance abuse and mental health problem.
- The use of seclusion and restraint on persons with mental and substance use disorders has resulted in deaths and serious physical injury and psychological trauma. In 1998, the Harvard Center for Risk Analysis estimated deaths due to such practices at 150 per year across the Nation.
- In 2007, 8 percent of soldiers in Afghanistan reported using alcohol during deployment, and 1.4 percent reported using illegal drugs/substances.
- Between 2004 and 2006, 7.1 percent of U.S. veterans met the criteria for a substance use disorder.
- Mental and substance use disorders caused more hospitalizations among U.S. troops in 2009 than any other cause.

Mental and substance use disorders have a powerful effect on the health of individuals and on the Nation's social, economic, and health-related problems. Mental and substance use disorders are among the top conditions for disability, burden of disease, and cost to families, employers, and publicly funded health systems. Excessive alcohol use and illicit drug use are linked directly to increased burden from chronic disease, diabetes, and cardiovascular problems.

Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people receiving treatment for mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

## Summary of California Healthcare Priorities

Similar to the national healthcare priorities, California's healthcare priorities cover a lot of ground and include areas such as electronic health records, improvements in oral health, reductions in violence, improvements in environmental health and other areas. Only the AOD priorities and those that contain an element of AOD are listed below.

- Engage patients and families as partners in care.
- Reduce firearm-related deaths and injuries.
- Reduce homicides especially in those 25 years old and younger.
- Reduce pedestrian and bicyclist injuries and deaths.
- Reduce nonfatal motor vehicle crash-related injuries.
- Reduce motor vehicle crash-related deaths.
- Placeholder – positive youth development/resilience objective.
- Reduce violence by current or former intimate partners.
- Reduce sexual violence.
- Reduce child maltreatment.
- Reduce child maltreatment (physical and psychological) deaths.
- Reduce older adult falls.
- Add an alcohol indicator linked to injury and violence.
- Increase the age and proportion of adolescents who remain alcohol and drug free.
- Reduce per capita consumption of alcohol.
- Increase the proportion of children with mental health problems who receive treatment.
- Increase the proportion of adults with mental disorders who receive treatment.
- Reduce the suicide rate.
- Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.
- Decrease the annual prevalence of Major Depressive Disorders (MDO).
- Increase the diversity of the health workforce.

## California's No Wrong Door

The "No Wrong Door" element of the federally mandated Affordable Care Act is the driving force behind California's implementation for its "No Wrong Door" strategy. This ensures that at whatever point an individual enters the realm of health care, they will be routed to the appropriate entity for treatment. For example, if a person enters the system seeking health insurance, they will be provided with health care options based on their personal information and status. If a person enters the system for substance abuse and is found to have a mental disorder, they will be routed appropriately.

## California's Costs of Substance Abuse

Substance abuse is costing California billions of dollars. A recent report by Dr. Ted Miller, estimates costs to California to be $52.6 billion dollars. Using 2010 data, the tangible costs associated with this estimate includes medical care, public services, property damage and other costs. After recognizing the intangible quality of life costs such as lost wages, loss of life, and the contribution of substance abuse to violent crimes and car crashes, California's annual cost of substance abuse and misuse skyrockets to $172.6 billion dollars.

# Appendix B: Spreadsheet of California's Certifying Organizations

The certifications shown on the following pages are the approved certifications available from the six certifying organizations approved by ADP. Other certifying organizations that are not approved by ADP offer additional certificates/credentials in California, but only individuals with the certifications provided by the approved organizations, and identified in the spreadsheet, may provide services in ADP licensed or certified AOD programs.

| | | | | |
|---|---|---|---|---|
| Addiction Counselor Certification Board of California<br>**Affiliated with the California Association for Alcohol/Drug Educators (CAADE)** | | | | |
| | Title 9 requirements for certification/Certification must meet or exceed | | | Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved |
| | **Formal Classroom (155)** | **Supervised Training (160)** | **Additional Work Experience (2080)** | |
| CATC Certified Addictions Treatment Counselor | 550-660 hours Alcohol/Drug Studies | 2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility) | | YES |
| CATC II | Associates Degree and completed an alcohol and drug studies program or equivalent | 2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility) | | YES |
| CATC III | Bachelor's degree in AOD studies or a related field, has completed at least 15 units of CAADE-approved addiction studies or equivalent (including a | 2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility) | | YES |

| | | | |
|---|---|---|---|
| | minimum of two internship courses) | | |
| CATC IV | Master's degree in AOD studies or a related field , has completed at least 15 units of CAADE-approved addiction studies or equivalent (including a minimum of two internship courses) | 2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility) | YES |
| CATC V | Doctorate in a related field (psychology, counseling, social work, human services, addiction studies, has completed at least 15 units of CAADE-approved addiction studies or equivalent (including a minimum of two internship courses)) | 2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility) | YES |
| CATC N (I, II, III, IV, V)<br><br>The individual will have the CATC tier that correlates with their degree level, followed by the letter N. | Has a nursing degree in a related field, has completed at least 15 units of CAADE-approved addiction studies or equivalent (including a minimum of two internship courses) | 2240 supervised clinical hours at a State Licensed AOD facility (which include the hours completed in your field experience/practicum/fieldwork class at college and any supervised/verifiable work at a State Licensed AOD facility) | YES |

| American Academy of Health Care Providers in the Addictive Disorders (AAHCPAD) | | | | |
|---|---|---|---|---|
| | Title 9 requirements for certification/Certification must meet or exceed | | | Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved |
| | **Formal Classroom (155)** | **Supervised Training (160)** | **Additional Work Experience (2080)** | |
| Certified Addictions Specialist With Master's Degree or Doctorate in Mental Health | 270 hours of education | 6,000 hours or 3 years supervised experience providing direct health care services to those identified with an addictive disorder. | | |
| Certified Addictions Specialist With any other degree or without a degree | 270 hours of education | 10,000 hours or 5 years of full-time supervised experience providing direct health care services to those identified with an addictive disorder | | |

| Board for Certification of Addiction Specialists<br>**Affiliated with the California Association of Addiction Recovery Resources (CAARR)** | | | | |
|---|---|---|---|---|
| | Title 9 requirements for certification/Certification must meet or exceed | | | Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved |
| | **Formal Classroom (155)** | **Supervised Training (160)** | **Additional Work Experience (2080)** | |
| CAS<br>Certified Alcohol and Other Drug Addiction Recovery Specialist | 155 hours | 160 hours | 2,080 hours work experience within three years in an alcohol and or other drug recovery program | Yes |
| CAS II<br>Certified Alcohol and Other Drug Addiction Recovery Specialist II | 270 hours | 160 hours | 6,240 work hours in substance abuse services in an alcohol and or other drug recovery program | Yes |
| CAS III<br>Certified Alcohol and<br>Other Drug Addiction Recovery Specialist III | 1800 hours | 160 | 8,360 hours work experience in substance abuse services in an alcohol and or other drug recovery program | Yes |

| **Breining** | | | | |
|---|---|---|---|---|
| | Title 9 requirements for certification/Certification must meet or exceed | | | Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved |
| | **Formal Classroom (155)** | **Supervised Training (160)** | **Additional Work Experience (2080)** | |
| RAS<br>Registered Addiction Specialist | 155 hours | 160 hours | 2080 hours | YES |
| RAS II<br>Advanced Level Registered Addiction Specialist | 450 hours<br>295 additional to the 155 required for RAS | 10,000 hours (about 5 years) clinical experience (includes 160 hours supervised training in AOD counseling)<br><br>7920 Additional to the 2080 required for RAS | | YES |
| M-RAS<br>Masters Level RAS Credential<br>- Option 1 | Associate or Bachelors Degree* **and** 450 hours formal education in AOD abuse studies | 10,000 hours (about 5 years) clinical experience (includes 160 hours supervised training in AOD counseling)<br><br>7920 Additional to the 2080 required for RAS | | YES |
| M-RAS<br>Masters Level RAS Credential<br>- Option 2 | Masters degree or Doctorate degree and 450 hours education in AOD abuse studies | 6,000 hours (about 3 years) clinical experience (includes 160 hours supervised training in AOD counseling)<br><br>3920 additional to the 2080 required for RAS | | YES |

| California Association of Drinking Driver Treatment Programs (CADDTP) | | | | |
|---|---|---|---|---|
| | Title 9 requirements for certification/Certification must meet or exceed | | | Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved |
| | **Formal Classroom (155)** | **Supervised Training (160)** | **Additional Work Experience (2080)** | |
| CAODC Certified Alcohol and Other Drug Counselor | 155 hours | 160 hours | 2,080 hours work experience | |
| CAODC-A Certified Alcohol and Other Drug Counselor Advanced | 320 hours | 5 years or 10,000 hours of work experience | | |

| California Certification Board of Alcohol and Drug Counselors<br>**Affiliated with the California Association of Alcoholism and Drug Abuse Counselors (CAADAC)** | | | | |
|---|---|---|---|---|
| | Title 9 requirements for certification/Certification must meet or exceed | | | Education from WASC, or regional accrediting agency by US Dept of Education or BPPE approved |
| | **Formal Classroom (155)** | **Supervised Training (160)** | **Additional Work Experience (2080)** | |
| CADCA<br>Certified Alcohol and Drug Counselor Associate | 315 hours | 255 hours | (was approved if individual has 2080 of experience.) | Most Schools are WASC or BPPE, not all of the schools. Some schools have waivers |
| CADC I<br>Certified Alcohol and Drug Counselor | 315 hours<br><br>or no additional if have CADCA | 255 hours<br><br>or no additional if have CADCA | 4000 hours full time supervised work experience | Most Schools are WASC or BPPE, not all of the schools. Some schools have waivers |
| CADC II<br>Certified Alcohol and Drug Counselor | 315 hours<br><br>or no additional if have CADCA or CADCA I | 255 hours<br><br>or no additional if have CADCA or CADC I | 6000 hours full time supervised work experience or 2000 additional hours if have CADCA I | Most Schools are WASC or BPPE, not all of the schools. Some schools have waivers |

# Appendix C: IC&RC Core Competencies

## IC & RC Credentials

IC&RC provides the minimum standards for each reciprocal credential, but Member Boards may set higher standards for their credentials.

TAP 21 Competencies & the 12 Core Functions are contained within the domains.

IC&RC Credentials Offered

- Alcohol and Drug Counselor (ADC)
- Advanced Alcohol and Drug Counselor (AADC)
- Clinical Supervisor (CS)
- Prevention Specialist (PS)
- Certified Criminal Justice Addictions Professional (CCJP)
- Certified Co-occurring Disorders Professional (CCDP)

To receive the credential, applicants must pass an IC&RC examination and sign a code of ethics or affirmation statement.

Recertification must occur every two years.

IC&RC is currently developing a Peer Mentor (PM) credential.

Translating the IC&RC credentials to the CAADAC equivalents:

- ADC Acronym for CAADAC credential CADC II
- AADC Acronym for CAADAC credential CAADC
- CS Acronym for CAADAC credential CCS
- PS Acronym for CAADAC credential CCPS
- CCJP Acronym for CAADAC credential CCJP

The following table summarizes the qualifications for each IC&RC credential.

| | ADC | AADC | CS | PS | CCJP | CCDP | PM |
|---|---|---|---|---|---|---|---|
| Experience - hours | 6000 | 2000 | 10,000 | 2000 | 6000 | 6000 | 500 |
| Education – hours or degree | 270 | MS + 180 | MS + 30 | 100 | Varies based on degree | BA/BS + 200 | HS + 46 |
| Supervision – hours | 300 | 300 | | 120 | 200 | 200 | 25 |
| Must hold current credentials | | | x | | | | |
| Domains | | | | | | | |
| Clinical Evaluation | x | x | | | | | |
| Treatment Planning | x | x | | | x | x | |
| Referral | x | x | | | | | |
| Service Coordination | x | x | | | | | |
| Counseling | x | x | | | x | x | |
| Client, Family & Comm. Ed. | x | x | | | | | |
| Documentation | x | x | | | x | | |
| Prof. & Ethical Resp. | x | x | x | | | x | |
| Research Design, Analysis & Utilization | | x | | | | | |
| Clinical Supervision | | x | x | | | | |
| Counselor Development | | | x | | | | |
| Program Development & QA | | | x | | | | |
| Performance Evaluation | | | x | | | | |
| Administration | | | x | | | | |
| Treatment Knowledge | | | x | | | | |
| Planning & Evaluation | | | | x | | | |
| Education & Skill Development | | | | x | | | |
| Community Organizing | | | | x | | | |
| Public Policy & Env. Change | | | | x | | | |
| Prof. Growth & Responsibility | | | | x | | | |
| Dynamics of Addiction & Criminal Behavior | | | | | x | | |
| Legal, Ethical & Prof. Responsibility | | | | | x | | |
| Criminal Justice System & Processes | | | | | x | | |
| Clinical Eval: Screening & Assessment | | | | | x | x | |
| Case Mgmt, Monitoring & Participant Supervision | | | | | x | | |
| Crisis Prevention & Mgmt | | | | | | x | |
| Recovery Planning | | | | | | x | |
| Mgmt. & Coord. Of Care | | | | | | x | |
| Education of Person, Their Support System & the Community | | | | | | x | |
| Advocacy | | | | | | | x |
| Mentoring/Education | | | | | | | x |
| Recovery/Wellness Support | | | | | | | x |
| Ethical Responsibility | | | | | | | x |

# Appendix D: Example of Scopes of Practice for Substance Use Disorder Counseling, SAMHSA, September 2011

## DEVELOPING MODEL SCOPES OF PRACTICE FOR SUBSTANCE USE DISORDER COUNSELING

### Background

With the advent of parity legislation and health care reform, the need to develop a template or model Scopes of Practice and career ladder for the substance use disorders field increased in urgency. The other professions working in the behavioral health care field are all licensed and already have scopes of practice for their respective disciplines. For those who are specializing in the area of substance use disorders consistent set of scopes of practice are needed to level the playing field.

Realizing that this was a pressing concern, the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) convened a 15 member Expert Panel to craft model Scopes of Practice and a Career Ladder in March 2010. The intent of the meeting was to develop a model or template which could be used by the appropriate entities and which would provide some consistency across the field, while at the same time allowing for state/local variability. The group included representatives from the following organizations or categories of organizations (see Attachment 1 for specific individuals):

- Single State Authorities
- National Association of State Alcohol & Drug Abuse Directors
- State Director of Workforce Development & Fiscal Evaluation
- State Certification Board
- Association of Social Work Board
- International Certification & Reciprocity Consortium
- Higher Education
- State Association of Addiction Services
- NAADAC, The Association for Addiction Professionals
- The Applied Technology Transfer Network

The group worked together to draft elements of the Scopes of Practice and Career Ladder, and then provided comments after reviewing two drafts.

### Scopes of Practice

Unlike other behavioral health disciplines, Scopes of Practice for substance use disorder (SUD) counseling have not been fully articulated. Until now, stakeholders had not agreed upon the levels of practice to be included or the requirements for each level. The Expert Panel was charged with developing scopes of practice that included a full range of responsibility and practice, from entry level to clinical supervision and beyond.

The Expert Panel based much of their discussion on the definition of Scope of Practice developed by the Federation of State Medical Boards (FSMB); it defines a Scope of Practice as the “definition of rules, regulations and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability.” The Expert Panel attempted to develop Scopes of Practice that would allow the profession to regulate itself and to assure the public of appropriate self-regulation.

This model Scopes of Practice is based on CSAT's Technical Assistance Publication, Addiction Counseling Competencies: The knowledge, skills, and attitudes of professional practice, known in the field as "TAP 21".[1] The TAP 21 has been crossed-walked with the domains and functions required by the major certification and credentialing organizations and has been endorsed by these groups.

***How the Scopes of Practice can be used***

The Expert Panel identified the ways in which a model Scope of Practice could be used by States and their constituencies, including the Single State Authorities (SSAs), current leaders in the field, providers, professional associations, credentialing bodies, State consumer groups and institutions of higher education. Panelists noted that these constituencies might use a model Scope of Practice to:

- Protect the public by setting standards;
- Put practice in line with higher education;
- Allow practitioners to be reimbursed for services (to collect 3rd party payment);
- Raise awareness of the profession; and
- Inform workforce development activities.

Many States already have a Scope(s) of Practice for SUD counselors, along with licensing and credentialing requirements, while others do not. For those States without a Scope of Practice, this may provide a model upon which to build or adapt a particular State's needs for policy and regulation. For those States with an existing Scope of Practice, it may be a useful framework to assess whether the current Scope is in keeping with the most up-to-date thinking in the field of SUD counseling.

**Career Ladders**

Career ladders are occupational structures designed to encourage and reward competent employee performance within a field or a particular organization. Employees move up the rungs – or in the case of a career lattice, across – by demonstrating successful

[1] Center for Substance Abuse Treatment. Technical Assistance Publication (TAP) Series 21, Addiction Counseling Competencies: The knowledge, skills, and attitudes of professional practice. Rockville, MD: Substance Abuse and Mental Health Services Administration (DHHS Publication No. SMA 064171), 2006.

performance and/or obtaining education and training that prepares them for the next level. Career ladders help employees plan for upward mobility in their careers, even if they start in an entry-level job. A career lattice recognizes that opportunities include career paths that move a job seeker or employee laterally or upward between industries or positions. A career lattice path requires varied amounts of continuing education and/or training in order to transfer into a related job in a different type of setting in the same or related industry or in another industry.

The attached career ladder for counselors treating substance use disorders (SUDs) provides a framework for understanding the education, training, and supervised work experience necessary to enter and move up in the field to positions of increased responsibility. Some staff without degrees may start in an entry-level category and decide to pursue additional education and training to increase their level of responsibility, while others may decide to remain in such a position because it continues to be fulfilling and meaningful to them.

Individuals, employers, and industries can use this career ladder. Some benefits are:

- **Employee retention**—Career ladders illustrate potential for advancement, which serves as an incentive for employees to stay with organizations or within a field. Employers save on costly turnover, recruitment, and training expenses. Using this career ladder as an example, an organization hiring a peer support specialist in an entry-level position could encourage employee professional development by encouraging additional education and training to move into a position requiring a degree.

- **Performance incentive**—The opportunity for advancement motivates employees to produce and perform well on the job and to acquire new knowledge and skills. Using this career ladder as an example, an organization hiring someone with a Bachelor's degree could encourage employee professional development to obtain a Master's degree and supervised work experience to move into a clinical supervision position.

- **Career development programs**—The graphic representation of career ladders (such as the attached chart) provides an easily understood tool to assist career counselors and individuals in career planning and decision-making. Individual programs may add additional positions to the chart, such as program manager.

These two documents together, the Scopes of Practice and the Career Ladder, serve to support States, organizations, individuals and the greater public in setting the standards for the roles and responsibilities within the field of Substance Use Disorders. As these professional roles are more clearly articulated and these documents incorporated into the workplace culture profession will be better able to articulate its' standing as a specialized field.

Substance Use Disorder (SUD) professionals work in a broad variety of disciplines but share an understanding of the addiction process that goes beyond the narrow confines of any specialty. Professional counseling of people with SUDs consists of the application of general counseling theories and treatment methods adopted with the express purpose of treating alcohol and drug problems. Effective treatment can lead to a life of recovery and enhanced social, psychosocial or bio-psychosocial functioning of individuals, couples, families, groups, organizations, and communities. The activities of a counselor within this field are based on the practice dimensions outlined in TAP 21 and include the following:

1. Clinical Evaluation
2. Treatment Planning
3. Referral
4. Service Coordination
5. Counseling
6. Client, Family, and Community Education
7. Documentation
8. Professional and Ethical Responsibilities

## CATEGORY 3: CLINICAL SUBSTANCE USE DISORDER COUNSELOR

**Practice of Clinical Substance Use Disorder Counselor** – The scope of practice for a Clinical Substance Use Disorder Treatment Counselor can include:

1. Clinical evaluation, including screening, assessment, and diagnosis of Substance Use Disorders and Co-Occurring Disorders (CODs)

2. Treatment Planning for SUDs and CODs, including initial, ongoing, continuity of care, discharge, and planning for relapse prevention.

3. Referral

4. Service Coordination case management in the areas of SUDs and CODs

5. Counseling -Therapy and psycho-education with individuals, families, and groups in the areas of SUDs and CODs

6. Client, Family, and Community Education

7. Documentation

8. Professional and Ethical Responsibilities

9. Clinical supervisory responsibilities for all categories of SUD Counselors

The Clinical Substance Use Disorder Counselor can practice under the auspice of a licensed facility or as an independent private practitioner. It is the responsibility of the Clinical Substance Use Disorder Counselor to seek out clinical supervision and peer support.

## CATEGORY 2: SUBSTANCE USE DISORDER COUNSELOR

**Practice of Substance Use Disorder Counselor** – The Scope of Practice for the category of those with a Bachelor's degree includes the following activities with clinical supervision of a Clinical Substance Use Disorder Counselor or other state approved supervisor:

1. Clinical evaluation including, diagnostic impression, screening and assessment of SUD

2. Treatment Planning for SUDs and CODs, including initial, ongoing, continuity of care, discharge, and planning for relapse prevention.

3. Referral

4. Service Coordination case management for SUDs and CODs

5. Counseling -Therapy and psycho-education with individuals, families, and groups Client, Family, and Community Education

6. Documentation

7. Professional and Ethical Responsibilities

8. Clinical supervisory responsibilities for all categories of SUD Counselors

The Substance Use Disorder Counselor 2 can only practice under the auspice of a licensed facility and under the clinical supervision of Clinical Substance Use Disorder Counselor.

### CATEGORY 1: ASSOCIATE SUBSTANCE USE DISORDER COUNSELOR

**Practice of Associate Substance Use Disorder Counselor** – The Scope of Practice for the category of those with an Associate's degree include the following activities with clinical supervision from a Clinical Substance Abuse Counselor or state approved supervisor and/or the administrative supervision of a Substance Abuse Counselor:

1. Diagnostic impression, screening of SUD

2. Monitor treatment plan/compliance

3. Referral

4. Service Coordination, case management for SUD

5. Psycho-educational counseling of individuals and groups
6. Client, Family, and Community Education

7. Documentation

8. Professional and Ethical Responsibilities

The Associate Substance Use Disorder Treatment Counselor can only practice under the auspice of a licensed facility and under the clinical and or administrative supervision of Clinical Substance Use Disorder Counselor or the administrative oversight of the Substance Use Disorder Counselor.

# Appendix E: Example Career Ladder for Substance Use Disorder Counseling

Example: SAMHSA Career Ladder

| CAREER LADDER FOR THE FIELD OF SUBSTANCE USE DISORDERS (SUDs)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | What may be required to be licensed or credentialed in this category, which varies by state* | | | | | Possible job responsibilities, which varies by state and employer* | | |
| | Title | Education | Licensure & Credentialing | Training & Advanced Course Word | Supervised Work Experience | Activities | Setting | Supervisory responsibilities |
| CATEGORY 3 | Clinical Substance Use Disorder Counselor | Master's degree in SUD counseling or other allied mental health professional (e.g. MA in social work, mental health counseling, marriage & family counseling, etc.) including at least 300 hours of SUD related topics – if not received with degree can be obtained as advanced coursework outside the school setting. | Most states require some kind of license and/or credential at this level. Licensing is separate from credentialing in some states while some states link licensing to credentials. Appropriate license and/or credential & written exam from a nationally-recognized credentialing body based on state regulators. | Assumed that foundational & advanced courses have been taken on substance use disorders & counseling, as well as supervised practicum and/or internships if not at least 300 hours of specific SUD training must be obtained. OFTEN NEEDED FOR THIS LEVEL: Additional course work on clinical supervision. | Prior to taking the exam for this particular credential must complete 4,000 hours of POST Master's level supervised work experience in SUDs consistent with the laws & regulations of each state, with a minimum of 2,000 hours of direct client hours. | 1. Clinical evaluation, including screening, assessment & diagnosis of Substance Use Disorders & Co-Occurring Disorders (CODs)<br>2. Treatment Planning for SUDs & CODs, including initial, ongoing, continuity of care, discharge, & planning for relapse prevention,<br>3. Referral<br>4. Client, Family and Community Education<br>5. Documentation<br>6. Service Coordination, case management in the areas of SUDs & CODs<br>7. Therapy & psycho-education with individuals, families & groups in the areas of SUDs & CODs<br>8. Professional & Ethical Responsibilities | All confidential setting including private independent practice | Clinical supervisory responsibilities for all categories of SUD Counselors |

| | Title | Education | Licensure & Credentialing | Training & Advanced Course Word | Supervised Work Experience | Activities | Setting | Supervisory responsibilities |
|---|---|---|---|---|---|---|---|---|
| CATEGORY 2 | Substance Use Disorder Counselor | Bachelor's degree in SUD counseling or other allied mental health professional (social work, mental health counseling) including at least 200 hours of SUD related topics – if not received with degree can be obtained as advanced coursework outside the school setting. | Most states require some kind of license at this level. Licensing is separate from credentialing in some states while some states link licensing to credentials. Appropriate license and/or credential & written exam from a nationally-recognized credentialing body based on state regulations. | Assumed that foundational & higher level undergraduate courses have been taken on substance use disorders & counseling, as well as supervised practicum and/or internships if not at least 200 hours of specific SUD training must be obtained. | Prior to taking the exam for this particular credential must complete a minimum of 2,000 hours of Bachelor's level supervised work experience in SUDs consistent with the laws & regulations of each state, with a minimum of 600 hours of direct client work. | 1. Clinical evaluation including, diagnostic impression, screening & assessment of SUD<br>2. Treatment planning for SUDs including initial, ongoing, continuity of care, discharge & planning for relapse prevention.<br>3. Referrals<br>4. Client, Family, & Community Education<br>5. Documentation<br>6. Service Coordination, case management for SUD & COD<br>7. Psycho-educational counseling of individuals, families, & groups, therapy with individuals & groups.<br>8. Professional & Ethical Responsibilities<br><br>The Substance Use Disorder Treatment Counselor can only practice under the auspice of a licensed facility & under the clinical supervision of Category 4 Clinical or Category 3 Master's Substance Use Disorder Counselor. | All confidential settings, except private practice, with supervision provided | Provide administrative supervision of Category 1 Substance Use Counselor, Entry Level & Peer Recovery Staff |

| | Title | Education | Licensure & Credentialing | Training & Advanced Course Word | Supervised Work Experience | Activities | Setting | Supervisory responsibilities |
|---|---|---|---|---|---|---|---|---|
| CATEGORY 1 | Associate Substance Use Disorder Counselor | Associate's degree in a behavioral science field with a clinical application including at least 100 hours of SUD related topics – if not received with degree can be obtained as advanced coursework outside the school setting. | Most states require some kind of license and/or credential at this level. Licensing is separate from credentialing in some states while some states link licensing to credentials. Appropriate license and/or credential & written exam from a nationally-recognized credentialing body based on state regulations. | Assumed that foundational courses have been taken on substance use disorders & counseling, as well as supervised practicum and/or internships. Advanced course work & training are usually not required at this level unless SUD specific training was not obtained through course work, 100 hours of specific SUD course work is then required. | Prior to taking the exam for this particular credential must complete a minimum of 2,000 hours of Associate level supervised work experience in SUDs consistent with the laws & regulations of each state, with a minimum of 600 hours of direct client work. | 1. Diagnostic impression, screening of SUD<br>2. Monitor treatment plan/compliance<br>3. Referrals<br>4. Client, Family, & Community Education<br>5. Documentation<br>6. Service Coordination, case management for SUD<br>7. Psycho-educational counseling of individuals & groups<br>8. Professional & Ethical Responsibilities.<br>The Associate Substance Use Disorder Treatment Counselor can only practice under the auspice of a licensed facility & under the clinical and/or administrative supervision of Category 4 Independent, Clinical or Category 3 Master's or the administrative oversight of the Substance Use Disorder Counselor. | All confidential settings, except private practice, with supervision provided | Cannot provide clinical or administrative supervision of staff but can supervise community and social activities |
| ENTRY LEVEL | Substance Use Disorder Technician | GED/High School Diploma | Many states require some kind of license and/or credential for entry level staff. Licensing is separate from credentialing in some state while some state link licensing to credentials. Appropriate license and/or credential & written exam from a nationally-recognized credentialing body based on state regulations. | 150 clock hours from a jurisdiction approved education provider (related to KSA's or TAP 21) & minimum of 6 clock hours of ethics training. This must be completed before beginning supervised experience. | Prior to taking the exam for this particular credential must complete a minimum of 1,500 hours of Entry level supervised work experience in SUDs consistent with the laws & regulations of each state. | Often able to implement independently:<br>Screening of SUD & COD<br>Monitor Tx Plan Compliance<br>Under Supervision:<br>Psycho-educational counseling independently & with groups for clients & families<br>Tx Planning<br>Documentation<br>The Substance Use Disorder technician can only practice under the auspice of a licensed facility & under the clinical and/or administrative supervision of Category 3 Master's or the administrative oversight of the Substance Use Disorder Counselor. | All confidential settings, except private practice, with supervision provided. | Cannot provide clinical or administrative supervision of staff but can supervise community & social activities. |

* *Those who are interested in entering or advancing in the field of Substance Use Disorder counseling are encouraged to review the specific titles, education, training and licensing and credentialing requirement of their State. This Career Ladder is intended to show how employees might enter and advance in the field and what general job duties and requirements might be. Education and training requirements vary from State to State.*

# Appendix F: Insurance Billable Services – Example: Kaiser Small Group HMO

**Kaiser Small Group**

*Chemical Dependency Services*

- Inpatient detoxification
  - Hospitalization in a plan hospital for medical management of withdrawal symptoms
  - Room and board
  - Plan physician services
  - Drugs
  - Dependency recovery services
  - Education
  - Counseling
- Outpatient chemical dependency care
  - Day-treatment programs
  - Intensive outpatient programs
  - Individual and group chemical dependency counseling
  - Medical treatment for withdrawal symptoms
  - Methadone maintenance treatment for pregnant members during pregnancy and for two months after delivery at a licensed treatment center approved by the medical group. Methadone maintenance treatment is not covered under any other circumstances.
- Transitional residential recovery services
  - Chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the medical group. These settings provide counseling and support services in a structured environment.
- Exclusion
  - Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Chemical dependency services" section.

# Appendix G: CMS List of Authorized Credentials and Service Locations

Medicare defines SBIRT as alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention. SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. Medicare will pay for SBIRT services when they are medically reasonable and necessary, and when they are delivered in a physicians' office or outpatient hospital. In order to bill for these services, the mental health professional must be working within their State Scope of Practice Act, and licensed (or certified) to perform mental health services by the state in which the services are performed.

The following list of professionals is recognized by Medicare to deliver these services.

- Physician
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)

Two Healthcare Common Procedure Coding System (HCPCS) G codes exist for the structured assessment and brief intervention. One code covers an intervention lasting from 15-30 minutes. The second code covers an intervention lasting greater than 30 minutes.

SBIRT services must be reasonable and meet the requirements of diagnosis or treatment of illness or injury. Documentation of the intervention must be included in the patient's medical record.

Medicare covers an annual alcohol misuse screening, and for those who screen positive, up to four brief face-to-face behavioral counseling interventions in a 12-month period. In primary care, this screening covered by Medicare, is a stand-alone billable service and is separate from the Initial Preventive Physical Examination (IPPE) and the Annual Wellness Visit (AWV).

The definition for screening is shown below.

- Those who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet the criteria for alcohol dependence. Alcohol dependence is defined as having as least three of the following:
    - Tolerance
    - Withdrawal symptoms
    - Impaired control
    - Preoccupations with acquisition and/or use
    - Persistent desire or unsuccessful efforts to quit
    - Sustains social, occupational, or recreational disability
    - Use continues despite adverse consequences, and
- Are competent and alert at the time that counseling is provided, and
- Whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

Primary care settings are defined as one in which there is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The following are not considered as primary care settings:

- Ambulatory surgical centers
- Emergency departments
- Hospices
- Independent diagnostic testing facilities
- Inpatient hospital settings
- Inpatient rehabilitation facilities, and
- Skilled nursing facilities.

Medicare covers screening and behavioral counseling interventions provided in the following types of primary care settings.

- An independent clinic
- An outpatient hospital
- A physician's office
- A state or local public health clinic

A primary care physician is one who has a primary specialty designation of:

- Family practice
- General practice
- Geriatric medicine
- Internal medicine
- OG/GYN
- Pediatric medicine

A qualified non-physician practitioner is a:

- Certified clinical nurse specialist
- Certified nurse-midwife
- Nurse practitioner
- Physician assistant

# Appendix H: International Standards on Drug Use Prevention

**International Standards on Drug Use Prevention**

| | **Prenatal & Infancy** | **Early Childhood** | **Middle Childhood** | **Early Adolescence** | **Adolescence** | **Adulthood** |
|---|---|---|---|---|---|---|
| **Family** | Selective<br>Prenatal & infancy visitation<br>**<br><br>Selective<br>Interventions targeting pregnant women with substance abuse disorders<br>* | | Universal & Selective<br>Parenting Skills<br>**** | | | |
| **School** | | Selective<br>Early childhood education<br>**** | Universal<br>Personal & social skills<br>***<br><br>Universal<br>Classroom Management<br>***<br><br>Selective<br>Policies to keep children in school<br>** | Universal & Selective<br>Prevention education based on personal & social skills & social influences<br>*** | | |
| | | | | Universal<br>School policies & culture<br>** | | |
| | | | Indicated<br>Addressing individual vulnerabilities<br>** | | | |

The table is continued on the next page.

<table>
<tr><th></th><th>Prenatal & Infancy</th><th>Early Childhood</th><th>Middle Childhood</th><th>Early Adolescence</th><th>Adolescence</th><th>Adulthood</th></tr>
<tr><td>Community</td><td></td><td></td><td></td><td colspan="3">Universal<br>Alcohol & tobacco policies<br>*****<br><br>Universal & Selective<br>Media campaigns<br>*</td></tr>
<tr><td></td><td colspan="6">Universal & Selective<br>Community-based multi-component initiatives<br>***</td></tr>
<tr><td></td><td></td><td></td><td></td><td colspan="2">Selective<br>Mentoring<br>*</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td colspan="2">Universal<br>Entertainment venues<br>**</td></tr>
<tr><td>Workplace</td><td></td><td></td><td></td><td></td><td colspan="2">Universal, Selective & Indicated<br>Workplace prevention<br>***</td></tr>
<tr><td>Health Sector</td><td></td><td></td><td></td><td colspan="3">Indicated<br>Brief intervention<br>****</td></tr>
</table>

Notes: Strategy with an indication of (* limited/ ** adequate/ *** good/ **** very good/ ***** excellent) efficacy.

Universal = strategy appropriate for the population at large
Selective = strategy appropriate for groups that are particularly at risk
Indicated = strategy appropriate for individuals that are particularly at risk

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***Assumptions for Future Direction***

*The future direction of California's SUD workforce continues to evolve as federal directions and regulations change, and as the State determines the most effective methods to incorporate the existing workforce into the developing model. More than ever, the workforce is relying on the State to determine a future direction for the field. Regardless of the uncertainties that exist at the federal and state levels, there are assumptions that can be made. These assumptions are consistent with the findings identified in several reports commissioned by SAMHSA, University of California Los Angeles (UCLA), the County Alcohol and Drug Program Administrators' Association of California (CADPAAC), National Association of Alcoholism and Drug Abuse Counselors (NAADAC), the International Certification and Reciprocity Consortium (IC&RC), and others. These assumptions are the building blocks for the recommendations made in this report:*

- *In the next five years, more SUD treatment professionals will be needed who are able to care for individuals with SUDs in a variety of managed healthcare settings, recognize co-occurring disorders, and be culturally competent.*

- *Applicants for open positions in SUD treatment facilities need to be well qualified. The workplace will be competitive.*

- *The workforce needs to be diversified and able to work in integrated settings and collaborate between providers regarding a patient's care plan.*

- *Health reform offers California an opportunity to address the SUD workforce concerns and make forward progress for recognizing the SUD field as a standard component of healthcare.*

- *SUD treatment facilities must adopt and implement EHR systems to remain a part of the changing healthcare environment. The workforce must learn and adopt EHR systems and other technology that creates efficiencies.*

- *Now is the time to commit to an SUD professional Scopes of Practice and credentialing system.*

- *Specific steps must be taken to grow and sustain the workforce.*

- *The existing workforce must be provided tools to prepare for the future*