CALIFORNIA HEALTH POLICY STRATEGIES

Policy Brief

Co-Occurring Mental Health and Substance Use Disorder Treatment Coordination Models

March 2019

Executive Summary

This policy brief focuses on the coordination of treatment of co-occurring mental health and substance use disorders (CODs) for individuals returning to the community following incarceration. The gold standard for integrated services is when clients experience treatment as seamless, with a consistent clinical approach, philosophy, and set of interventions and recommendations from a joint clinical team. When this happens, the need to negotiate with separate clinical teams, programs, or systems disappears.

With support by the Fresno and San Mateo Counties Divisions of Behavioral Health Services, California Health Policy Strategies (CalHPS) identified and observed models of integrated care. Each county identified a community-based program that has developed and succeeded in the co-location and coordination of co-occurring services. With county support, Turning Point of Central California, Inc in Fresno and Our Common Ground, Inc in San Mateo have each overcome many challenges and barriers in their efforts to meet client treatment needs for two or more co-occurring conditions.

Over the years, each county has maximized all funding to push the limits of the siloed allocations and incrementally achieve significant changes in service delivery. The redesign of California's alcohol and drug treatment delivery system with the significant infusion of funding through the implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) in the state's 1115 Medi-Cal Waiver demands a transformation of the historic social model system into a specialty managed care system that will function under the same Center for Medicare and Medicaid Services (CMS) rules as mental health services statewide. The equalization of the administrative regulations provides an opportunity for alignment and communication between the two specialties, and a chance to rethink the delivery of co-occurring services. This paper examines the steps taken by two counties and two programs, as well as the challenges ahead to meet the needs of our most complex consumers.

Introduction

Our policy brief, *Toward an Integrated Model of Care for Individuals with Co-Occurring Disorders*, discusses traditional sequential or parallel approaches to treatment for co-occurring disorders and the alternative integrated services for individuals served. The barriers to providing seamless, concurrent clinical services for mental health and substance use disorders are significant and begin with differing clinical philosophies and practices that are reinforced by administrative and financial silos. The two discreet funding streams initiate at the federal level; however, Fresno and San Mateo counties have incrementally implemented the principles of integration over the past 15 years.

The service delivery silos are defined in California by state law and regulations and solidified by the mental health and substance use disorder carve-outs under the Medicaid State Plan. These well-established, siloed clinical pathways are not robust, if they exist at all, and the workforce has been trained and developed in one of two systems. Many questions about the delivery of coordinated and/or integrated services by community-based programs in California remain unanswered. To explore these questions, CalHPS first identified a tool for evaluating the implementation of best practices in the delivery of services for co-occurring disorders.

How Did We Identify Integrated Best Practices?

The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Version 4.0 was chosen to evaluate each program's capability to provide integrated services (SAMHSA, 2011). The DDCAT is a field-tested tool to assess co-occurring disorder program capability developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2002. In the absence of national or state guidelines, the toolkit was developed in response to the need for standards defining the core elements of delivering integrated co-occurring disorder services. The tool remains widely accepted and was updated to Version 4.0 in 2011. The DDCAT is familiar to the alcohol and drug treatment field in California and has been used in the past by counties to assess programs and the local delivery system (Padwa, Larkins, Crevecoeur-MacPhail, & Grella, 2013).

The DDCAT measures the co-occurring (or dual diagnosis) capability of a substance use disorder treatment program using a 35-item rating tool organized into seven dimensions (see Table 1 in the appendix). Using these ratings, a program is identified along a continuum where a score of 1 means addiction-only services, 3 means the program is dual diagnosis–capable, and 5 means the program provides enhanced dual diagnosis services. Generally, Addiction Only Services (AOS) programs do not accommodate individuals with mental health disorders or may attempt to engage individuals with mild to moderate mental health disorders without specialized interventions. Dual Diagnosis Capable (DDC) SUD treatment programs accommodate and treat individuals with mental health disorders that are relatively stable, and the programs address CODs to some extent in policies, procedures, assessment, and programming. Dual Diagnosis

Enhanced (DDE) programs accommodate individuals with even acute and unstable mental health disorders. The Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) is the corresponding tool used to evaluate mental health programs capability serving individuals with substance use disorders.

Working with the California Behavioral Health Directors Association, we identified several *integrated* programs. Administrators in the Fresno and San Mateo County Behavioral Health Services Departments volunteered to participate in a deep dive into the structure of the integrated services and the funding design in two programs: (1) Turning Point of Central California, First Street Center Outpatient Services and (2) Our Common Ground Residential Services. These programs operate in unique contract configurations which have evolved over time.

The changes associated with the Drug Medi-Cal Organized Delivery System promise to enhance the delivery of services significantly when implemented in both counties in 2019. In both cases, the counties have been committed to the integration of the delivery of services and have pushed the limits of the current funding and administrative silos in unique and innovative ways. The transformation of the alcohol and drug delivery system to an organized system of care, following Medi-Cal rules, provides an opportunity to rethink the coordination of behavioral health services.

The Landscape

In 2005, the SAMHSA Center for Substance Abuse Treatment (CSAT) released the *Substance Abuse Treatment for Persons with Co-Occurring Disorders, Treatment Improvement Protocol 42* which summarizes evidence-based practices for co-occurring disorders, including integrated psychiatric and addiction medication services, psychoeducation, counseling, and specialized peer recovery support for persons with co-occurring disorders (SAMHSA, 2005). Researchers, planners, and policymakers have consistently identified four basic findings related to the discussion of mental health and substance use disorders (Peters, et al., 2015; McGovern, 2014; Blanford & Osher, 2013; Chaple, et al., 2013; Torrey, 2010; Baillegeon, 2009; Steadman, et al., 2009; Drake, et al., 2001):

1. The co-occurrence of mental health and substance use disorders is common, ranging from mild to severe conditions.
2. Dual and multiple diagnoses are associated with a variety of very costly negative outcomes, including higher rates of relapse, hospitalization, incarceration, homelessness, violence, and serious infections such as HIV and hepatitis.
3. The parallel but separate mental health and substance abuse treatment systems deliver fragmented and ineffective care.
4. Treatments aimed at addressing both disorders at the same time are generally more effective than dealing with one disorder at a time.

The mentally ill reentry population with substance use disorders and other health conditions presents significant challenges for communities, counties, and treatment providers throughout the state, and consumes a tremendous amount public health and other community resources. However, traditional mental health and substance abuse treatment programs in California offer no specialized services for CODs and have limited capacity to address the complex needs of these offenders, including interventions to reduce criminal thinking. Furthermore, most seriously impaired clients are unable to navigate the separate systems or make sense of disparate messages about treatment and recovery. In some situations, individuals continue to be excluded from services in one system because of their comorbid disorder and are told to return when the other problem is under control.

Research from both the mental health and substance abuse fields has shown that treatments aimed at addressing both disorders simultaneously are generally more effective than dealing with one disorder at a time (Priester, et al., 2016). Integrated services represent the most promising approach to support recovery and successful community reentry among justice involved persons with CODs. Unfortunately, a lack of available co-occurring disorder treatment programs, combined with a shortage of appropriately trained clinicians, limits access to integrated treatment in both fields. The lack of specialized services results in high rates of dropout from treatment, rearrests and reincarceration, and rapid cycling among crisis centers, hospital emergency rooms, jails, and prisons. (KiDuek, et al., 2015)

While the information on knowledge and practice are widely available and growing, , the expansion of integrated services has not kept pace with the demand. There are traditional, community-based alcohol and drug treatment agencies primarily funded by the Substance Abuse Prevention and Treatment Block Grant and Public Safety Realignment funds (AB 109), maximizing the co-location and/or coordination of mental health services with substance use disorder treatment. Mental Health Services Act (MHSA) funding has also been utilized for the purpose of treating co-occurring disorders under local MHSA Plans. At present, the California Department of Health Care Services does not have a way of identifying the level of services available throughout the state.

One of the greatest barriers to the coordination of services with mental health and the health systems has been the underfunding and underdevelopment of the alcohol and drug service delivery system. Funded primarily by the SAPT Block Grant, the AOD system has not had the resources to develop network capacity, deliver evidenced-based practices, monitor quality, and manage utilization at the same level of competency or scale as the mental health service delivery system. The inclusion of the DMC-ODS 1115 Waiver in the Medi-Cal 2020 State Plan allows for the building of the needed capacity over time to meet the substance use disorder treatment needs of Medi-Cal beneficiaries at an unprecedented level (CMS, 2018).

The Case Studies - Overview

In a typical treatment program, even if services are co-located, a client with COD is screened and assessed by two or more staff members using two or more instruments. This information is

then housed in two separate records and fed into two separate state systems. Confidentiality regulations require a client to give permission for the sharing of information, which is usually done using multiple release of information documents that are not uniform. There is an enormous amount of duplicate information collected, and the process does not lend itself to the critical development of trust and the therapeutic alliance needed between client and practitioner. From this point on, the client typically receives individual mental health services and group alcohol and drug counseling. Integrated stage-wise practices are not widely used.

All of this leads to different philosophies and approaches, in addition to unnecessary time spent for compliance with guidelines and/or regulations. Integrated case conferencing and management is not routinely practiced, frequently resulting in competing treatment plans, as well as fragmented and incomplete continuing care plans.

In our review of the delivery of services at Turning Point of Central California, Inc. and Our Common Ground. Inc. as Dual Diagnosis Capable programs, the following observations emerged:

- A seamless continuum of mental health and substance use disorder services are delivered under a single contract, using multiple funding sources to support both specialties.
- Assessments and treatment plans are more effective when they reflect both specialties and are jointly utilized and developed with joint ownership of client outcomes.
- Medication for the treatment of both addiction and mental health conditions are provided, as needed, to clients, and continue across multiple levels of care without interruption.
- The clinical leadership is knowledgeable and competent in both specialties.
- Practice regimes are adopted that focus on client engagement and continuing services are driven by meeting the clients' goals.

Case Study #1: Turning Point of Central California, in Partnership with Fresno County Behavioral Health Services Department

The leadership of the Fresno County Behavioral Health Department has aspired to embrace an integrated approach to mental health and substance use disorder service delivery since creating its Integrated Care Charter in 2007. The current county website recognizes that clients with co-occurring mental health and substance abuse disorders may be the most common group seeking behavioral health services, and that inadequate access to integrated services results in over-utilization of criminal justice, health care, child protective, and homeless shelter services (Fresno County, 2019a). All too frequently, individuals are not provided integrated services.

Over the years, efforts to commit funding, improve care coordination, increase co-location, and deliver integrated clinical practices have developed in a systematic and focused fashion in

Fresno—as demonstrated by multiple collaborations across public systems, using all available funding streams. These innovative collaborations and resulting contracts have maximized the available funding sources with the goal of providing whole person care. The ongoing integration of substance use disorders services with mental health service delivery, a longstanding element of the County's Annual Mental Health Services Act Plan. Over time, Fresno County's MHSA funded program's well-documented outcome results have demonstrated significant success in reduction of hospitalizations, use of emergency services, and incarceration (Fresno County, 2019b). The same annual reports demonstrate that access to stable housing and employment remain the most challenging needs.

With the passage of the Public Safety Realignment Act of 2011, the county built upon its model of integration and coordinated access and engaged its criminal justice partners in the alignment of treatment services and probation supervision. One of the most innovative outcomes was the partnership with Turning Point of Central California (TPCC), resulting in the creation of the First Street Center - Outpatient Program. At about the same time, the county's leadership recognized the complexity of access and reentry transitions and accordingly, the Sheriff's and Probation Departments created the in-custody Community Transition Program, which focuses on pre-release engagement and delivery of services while incarcerated. TPPC was chosen as the treatment partner and provides pre-release assessment, referrals, and assists with navigation to services.

TPCC has provided an array of alcohol and drug prevention and treatment services to the incarcerated and re-entry populations since the 1970s. Its history demonstrates an organization dedicated to meeting the needs of the persons served and expanding services through a patchwork of grants and funding sources. Eventually, mental health services were co-located with substance use disorder treatment services wherever possible in the TPCC network of programs, along with housing and employment services.

The program reviewed for this brief, First Street Center - Outpatient Program (FSC-OP) is certified by California's Department of Health Care Services (DHCS) to provide alcohol and drug outpatient services. It is also certified as a Drug Medi-Cal (DMC) outpatient clinic. Short-Doyle Medi-Cal certified mental health services are co-located with the AOD program in order to meet the jointly held program and client outcomes, as defined in the county agreement. The program provides outpatient mental health and substance use disorder services specifically tailored to the needs of the probation population identified in AB 109. The county agreement stipulates clearly that the outpatient program will deliver broad and cohesive substance use disorder, mental health, and co-occurring treatment interventions for all clients. It also sets the expectation of the coordination of care with the AB 109 Full Service Partnership Program operated on the same site as FSC-OP. Most importantly, the agreement mandates that when a client presents with a substance use disorder and a mental health disorder, each disorder will be considered *primary* and staff will coordinate to develop an integrated plan of care for individualized treatment.

A significant innovation is that all services are provided at FSC-OP under one contract agreement with the County of Fresno. In one administrative document, the contract includes all possible funding sources that can be used by the provider to eligible individuals, including AB 109, Short Doyle Medi-Cal, Drug Medi-Cal, MHSA, Substance Abuse Treatment and Prevention Block Grants (SATPBG), and County general funds. It is left to TPCC to manage the appropriate utilization of these funds based on the cost allocation of services delivered. Due to the service continuum allowed under this agreement, the coordination for high intensity FSP services, and the referral partnerships with the local Narcotic Treatment Programs, TPCC provides a full and flexible continuum of mental health and substance use disorder services. The implementation of the DMC-ODS in January 2019 creates even more flexibility, increases billable coordination of services, and enhances billable case management and recovery services for those clients with mild to moderate mental illness under the auspices of the FSC-OP. The unique nature of this agreement is the all-inclusive funding structure that allows TPCC to provide, coordinate, and subcontract for all services for which a client may be eligible without needing to transfer and break an established clinical and program alliance.

Most importantly, clinical protocols and workflows have been developed to meet the needs of clients with mental health and substance use disorders. Full screening, assessments, and documented history of both substance use disorders and mental health disorders are completed, albeit in discrete records using discrete formats and forms. The AOD primary diagnosis and treatment uses specific forms and a paper record, other than county billing submissions. The mental health primary diagnosis and treatment is recorded in a county electronic health record via Avatar. The clinical leadership is led by licensed senior clinicians who are experienced in the screening, assessment, and treatment of a full range of mild, moderate, to serious substance use disorders and mental health disorders. Clinical supervision is available to licensed professionals of the healing arts (LPHA).

There are formal protocols and contract structures that support transitions within the program, such as warm hand-offs, step-ups for when more complex care is needed, and/or step-downs as the client progresses. This includes the ability to subcontract for residential and/or sober living and wraparound funds to support clients. There is established coordination with the TPCC Full Service Partnership Program. Multiple staff are available to provide 5150 assessments and placements. The program maintains mental health services and medication management within the agency post discharge from SUD services, until step-down and transition to the next level of care is achieved. TPCC accepts clients currently enrolled in Methadone Maintenance Programs.

The agreement's stipulated "integrated plan of care" has not been achieved due to the current use of two discrete documentation systems. The county does have plans to activate the SUD records in its well-developed mental health electronic record. The separate record keeping produces significant duplication, inefficiency, and ineffective use of clinical staff time. Again, the DMC-ODS will provide resources that will allow for case management. However, each

system requires discrete documentation of all clinical treatment functions, resulting in duplication that may undermine the therapeutic alliance with clients. Until a singular screening, assessment, and care planning process is developed—which would be useable across systems, while meeting confidentiality rules—the segregation of processes and data will continue.

The initiation of DMC-ODS in January 2019 allows for promising improvements in same day billing and increased access to medication assisted treatment, case management, long term recovery support services, and care coordination. Perhaps the most significant change under the DMC-ODS is the increase in rates for SUD services and the mandate to embed licensed professionals of the healing arts (LPHA) in SUD treatment services. These resources alone will increase the capability for the provision of integrated services if appropriate workflows are created.

To this end, a significant strength of the TPCC program is the access to telepsychiatry services for evaluation and medication services, as well as services when clients require more than psychotherapeutic interventions alone. The established telepsychiatry protocols present the opportunity to include waivered physicians to provided medication assisted treatment.

The First Street Center - Outpatient Program met or exceeded 80% of the DDCAT standards for the Co-Occurring Capable level of care. 22% of the standards were met for fully integrated or Co-Occurring Enhanced services. This is a significant achievement, given the hard stops in regulations and the prohibitive costs of duplication. As mentioned, administrative challenges continue as the funding streams are discrete and the necessary structures have yet to be built. The organization tackles program and clinical challenges systematically through a management team dedicated to continuous quality improvement and improved outcomes.

It is clear that TPCC has been able to achieve its level of capability in integrated service delivery with the innovative partnership and contract structure provided by the Fresno County Department of Behavioral Health Services. The joint goal of integrated services has provided significant alignment of claims and cost accounting. Discrete funding stream expenditure regulations and rules are met through defined units of service, cost allocation, and staffing distribution records reported and paid in arrears monthly. The county managers articulated the critical importance of maintaining appropriate cost accounting linked to discrete services; however, it was noted that there are different definitions of service, units, delivery methods, and coding that could be aligned between the two systems. It was recommended by the county managers that the next step, within the purview of the DHCS, would be the development, alignment, and standardization of claim submissions to the DHCS. A huge opportunity to reduce duplication and complexity would be the development of a single year-end cost report and single audit process. Another opportunity for change that directly impacts Medi-Cal beneficiaries would be the alignment of the rules for out of network service and the transfer of benefits from one county to another. This is necessary not only for the mental health and substance use disorder county-based plans, but also for managed health care plans.

In summary, the delivery of co-occurring services by TPCC has been in part due to their dedication to meeting the needs of the persons served and helping them achieve wellness and recovery for over 50 years. For all the challenges of organizational, cultural, and funding changes, integration of services for TPCC is simply a better way of meeting the complex needs of the persons served. While TPCC advances its mission, it has been able to achieve this within the supportive contract and funding structure provided by Fresno County.

Case Study #2: Our Common Ground, in partnership with the San Mateo County Behavioral Health and Recovery Division

San Mateo County Behavioral Health and Recovery Services (BHRS) is the mental health and substance use managed care plan for Medi-Cal beneficiaries residing in San Mateo County. The BHRS provides a broad spectrum of services for the prevention, early intervention, and treatment of mental illness and/or substance use conditions. Since the adoption of its 2006 Charter to improve service delivery to persons with complex conditions, the county has continued to work on the transformation of services on the system, program, and individual level. The BHRS has endeavored to provide integrated services by mental health clinicians, psychiatrists, alcohol and drug counselors, peers, family partners, and other professionals through county clinics, community agencies, and a private provider network—maximizing and blending funding opportunities for innovations as they arose.

In 2006, the county initiated the Comprehensive Continuous Integrated System of Care (CCISC) program, which focuses on the improvement of the delivery of co-occurring services throughout the county. With the revision of the original Charter in 2010, a steering committee was created to plan and implement CCICS values and goals. The new steering committee included not only representatives from stakeholders, but also the collaborating county systems of care, including the San Mateo Medical Center, Probation, Child Welfare, and Homeless Services. All divisions under the auspices of the Health System intensified shared integration goals; decision-making; alignment of resources, data and information collection; and measurement of program and system outcomes.

San Mateo County was one of the earlier adopters of an integrated model of health and behavioral health administration under one healthcare agency. As with all counties, the major obstacle to the development and implementation of best practices and access to mental health and substance use disorder services has historically been the funding carve-outs and the under-development and limited funding of the AOD system.

The passage of the Mental Health Services Act (MHSA) in November 2004 provided the first major opportunity to transform and support county mental health programs based on a local stakeholder planning process. Importantly, San Mateo County was one of the few California counties that overmatched the federal SAPTBG through local funding, strengthening its network of alcohol and drug services.

As noted above, the AOD system has not received Medi-Cal resources comparable to the mental health system until the approval of the DMC-ODS 1115 Waiver in 2015. San Mateo was one of the first counties in the state to activate the DMC-ODS in 2017. The Waiver has been a game changer and, for the first time, made it possible for increased funding, personnel, and other resources to support county substance use disorder treatment in all counties, throughout the state.

Operating within an organized and coordinated behavioral health system of care, San Mateo County maximized efforts to integrate service delivery through its MHSA stakeholder process under the allowed System of Care Enhancements and Supports. The county has maintained a consistent commitment to develop a full continuum of proven practices and supports promoting recovery from mental illness, alcohol and drug addiction, and co-occurring disorders. Central to the county's county efforts has been the improvement of coordination of care among providers, including matching the level of care provided with the varying levels of care and intensity of services that clients need.

Our Common Ground (OCG) has been a contractor with San Mateo County since the early 1990s. The organization committed to the provision of co-occurring services when it recognized that a significant number of the individuals it served presented with serious co-morbidities—not only substance use and mental health, but also serious physical health issues. Over the years, OCG has embedded licensed professionals of the healing arts (LPHA) into its Therapeutic Community to provide assessment, treatment planning, and mental health interventions at significant cost to the agency, with support from foundations and private donations.

OCG is currently licensed and certified as Residential Treatment Program for ASAM level 3.1 and 3.5 by the Department of Health Care Services. OCG also holds certification for Outpatient Alcohol and Other Drug services for an Intensive Outpatient Program with Recovery Residence. All levels of care offered hold DMC Certifications. In addition to having complex health, mental health, and substance use disorder treatment needs, the clients are typically homeless and involved with criminal justice system. This population has not historically been able to be supported in SUD residential treatment without specific clinical interventions. On October 31, 2017, the County Board of Supervisors approved an amendment to the Our Common Ground (OCG) agreement to add a specialized wellness component to treat seriously mental ill (SMI) adults with a co-occurring substance use disorder in addition to a rate that covered the actual costs of service to all clients.

Program modifications, staffing enhancements, and the use of trauma-informed, evidence-based practices has created a residential community environment that supports the needs of those with mild to moderate, as well as serious mental health disorders. OCG maintains a continuum of services for its clients, with step-down to recovery residences and outpatient services, along with case management, medication assisted treatment, and recovery support

services. With the introduction of DMC-ODS, all the clients at OCG Residential are linked to primary health care services and specialty mental health if needed.

The American Academy of Addiction Medicine (ASAM) assessment is enhanced by a full mental health assessment for all applicants/referrals to the program and is completed at admission by an LPHA—either the program psychologist, a LCSW, or a LMFT. The Program Operations manual reflects the delivery of co-occurring services with two tracks–-one for those with mild to moderate mental health disorders and one for those with a "secondary" diagnosis of serious mental health disorders. All services are delivered by licensed therapists for the enhanced track. Senior clinical managers and supervisors are licensed and are experienced in the screening, assessment, diagnosis, and treatment of a full range of mild, moderate, to serious substance use and mental health disorders. Clinical supervision is available to LPHAs. Weekly case reviews, led by a senior clinician, are held with all staff in attendance. The clinical and administrative management is integrated and maximizes the delivery of co-occurring services within the funding, documentation, and delivery constraints of each specialty.

At this time, OCG is not linked to the county electronic health record, except for enrollment, assessments, and billing claims. Frequently, when electronic information systems are developed and used, cross-system data--such as diagnosis, medications, treatment plan goals for secondary problems, and needs--are not included in the electronic health record. At OCG today, the treatment plan and progress notes are in paper format, allowing for the robust documentation of secondary mental health diagnosis and interventions within a single paper record.

As an earlier adopter of the DMC-ODS, BHRS worked diligently with providers in 2016 to identify the actual costs of meeting the requirements of the Waiver's Special Terms and Conditions, with the intent of maximizing system transformation for the integration of services. During the transition to DMC-ODS implementation in April 2017, the county reimbursed providers for appropriate expenditures that supported the ramp-up. The current county provider agreement provides a funding structure based on actual program costs, maximizing all funding streams for which a client is eligible. These funds include MHSA, Drug Medi-Cal, SAPT Block Grant, 2011 Realignment Funds, Public Safety Realignment funds, and county general funds. DMC-ODS payments are based on accurate documentation and submission of billing claims. The county recognized the learning curve for new processes, both in service documentation and billing for providers, during the first year of implementation. A unique innovation supporting the transition of providers to managed care was the creation of a shared risk pool among all implementing contractors based on the availability of funds. BHRS guaranteed payment of DMC billing submitted by a contractor using a phased approach with very clear conditions of performance. Contractors are paid monthly in arrears based on the projected monthly contract targets, while required to submit all codes, actual service detail, expenditures, and staff hours. The county administers the detailed collection, allocation, analysis, and reconciliation to appropriate funding streams. This structure efficiently pulls the

administration and adjudication of claims and the allocation of costs into the specialty managed care plan, as done in other health managed care models, thus standardizing financial management processes across its network.

The Our Common Ground contract with San Mateo County Department of Behavioral Health and Recovery Services provides for cost reimbursement of a program design that integrates mental health and substance use disorder professionals in one program. The contract structure allows OCG to provide a continuum of services, with step down and warm hand off to its own Outpatient and Recovery Residences, that is uninterrupted and maintains therapeutic alliances. The matching of client and services rendered to appropriate funding is controlled and monitored closely by the county. Programs' detailed costs and services are reported monthly to the county.

The Our Common Ground Residential Program achieved an overall score of 3.4, with 80 % of the standards for Co-Occurring Capable met or exceeded. Furthermore, 23% of the standards were met for fully integrated or Co-Occurring Enhanced. It is worth noting that the highest scores were achieved the areas of Assessment, Treatment, and Continuity of Care. It was clear that OCG has been able to achieve a continuum of service within the innovative contract and funding structure provided by San Mateo County Behavioral Health and Recovery Services.

Summary and Recommendations

The approval of the Medicaid Final Rules in 2017 by the CMS, with regulations governing access to mental health and substance use benefits for those eligible for Medi-Cal, initiated a county-by-county examination of the provider network adequacy and performance outcomes, in both the public mental health and substance use disorder treatment systems. While counties have attempted to provide access to co-occurring services incrementally over the past 15 to 20 years, counties are now actively engaged in expanding and building service capacity and capability to meet federal rules. However, there has not been a systematic statewide focus on the opportunity to expand mental health and/or substance use disorder treatment capacity for both disorders across the two systems using an integrated program design.

The DHCS currently maintains discrete practice parameters and administrative structures for the mental health and substance use disorder treatment systems. For co-occurring services, the necessary interfaces, or bridges, between the substance use and mental health service delivery and data mechanisms have yet to be developed. Additionally, many counties are operating two different electronic platforms for each specialty, which link to discrete state platforms. Many smaller community-based providers have not used electronic record systems. Larger providers have developed electronic health records independent of counties. Generally, provider, county, and state electronic information systems are not interoperable. It is standard practice that providers must use multiple discrete systems, dictated by county and state

agencies, which creates huge inefficiencies and costs. Ideally, the Whole Person Care Projects are examining the infrastructure communication issues and exploring coordinated solutions. The WPC innovations could be transferred to other projects or service delivery with investment and support. Additionally, specific modifications to Drug Medi-Cal and Short-Doyle Medi-Cal rules, such as common delivery codes, billing, and county of residency rules would reduce the duplicative administrative burden not only to community-based organizations but also to the county agencies responsible for these funds.

It is evident that Fresno and San Mateo counties have exercised all options within the current state structures to maximize the delivery of services within a single contract that includes all available funding sources. In both programs, clinical practice is improved by supporting shared case management, warm hand-offs, and strong therapeutic alliances that support engagement and retention in treatment. The DMC-ODS now makes the expansion of alcohol and drug services more feasible, committing appropriate levels of resources to a network of services in participating counties, which can result in an increase in coordination of services.

A more nuanced understanding of the needed modifications to many of the siloed administrative practices of the two systems of care emerged from these two case studies. Best practices have been known and well-documented for many years, and in some cases incorporated into county plans and efforts. With new funding for personnel and other resources, the next step is for contracting and oversight agencies to further align the administrative and financial practices of two historically carved-out systems of care. Doing so can remove unnecessary duplication cost and incrementally support the delivery of services at one time, to one client.

We all can agree that the government, commitment, and accounting for funds devoted to meet community needs will remain discrete for the foreseeable future. The future holds the promise of efficiency and cost savings, not only in improved outcomes and reduction of costs to other systems, but also in the cost of service delivery itself. Given the nature of discrete funding, moving the dial of integrated services further will require dedicated analysis and discussion between partners.

Recommendations:

1. Using the newly mandated Network Adequacy Data Collection Process, create a format to determine the extent and method of the delivery of co-occurring services statewide for both mental health and substance use disorders, including identifying licensed and certified providers.

2. Fund an evaluation of a sample of community-based agencies that identify as delivering both SUD and SMI services statewide, using the DDCAT and/or DDCMHT.

3. Convene a Learning Collaborative of agencies meeting DDC standards to provide support and lessons learned in the delivery of service and changes needed in administrative, program, and financing of services.

4. Support the development a Workforce Academy for the purpose of advancing co-occurring services.

5. The DHCS, in collaboration with County representatives, should create administrative changes that would streamline and align benefit and billing rules for Medi-Cal SUD and SMI billing.

6. The DHCS should create screening and assessment billing codes that would incentivize and allow a single LPHA to evaluate, diagnose, and triage individual beneficiaries to appropriate available level of care.

7. Examine lessons learned from Whole Person Care that can be used to accelerate interoperability.

Citations

Baillargeon, J. (2009). *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door.* American Journal of Psychiatry, Vol. 166, No. 1: 103-109.

Blandford, A. & Osher, F. (2013). *Guidelines for the Successful Transition of Individuals with Behavioral Health Disorders from Jail and Prison.* SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Delmar, NY.

California's Mental Health Services Oversight and Accountability Committee (2017). *Reducing Criminal Justice Involvement for People with Mental Illness Final Report: Findings and Recommendations.* Sacramento, CA.

Centers for Medicare & Medicaid Services (CMS) (2018). California Medi-Cal 2020 Demonstration: Special Terms and Conditions, 11-W-00193/9. Retrieved from: https://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCsAmended060718.pdf

Chaple, M., Sacks, S., Melnick, G., McKendrick, K., & Brandau, S. (2013). The Predictive Validity of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index. *Journal of Dual Diagnosis*, 9(2), 171-178.

Council of State Governments Justice Center (2012*). Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction System.* The Council of State Governments Justice Center. New York, NY.

County of San Mateo (2019). Behavioral Health & Recovery Services Dashboards: Medi-Cal Specialty Mental Health Services Performance Dashboard. San Mateo County Health. Retrieved from: https://www.smchealth.org/post/behavioral-health-recovery-services-dashboards

Ditton, PM. (1999). Mental Health and Treatment of Inmates and Probationers, NCJ 174463. Office of Justice Programs, Bureau of Justice Assistance, Department of Justice. Washington, DC.

Dixon, L. B., Holoshitz, Y., & Nossel, I. (2016). *Treatment Engagement of Individuals Experiencing Mental Illness: Review and Update.* World Psychiatry, 15(1), 13-20.

Drake, R., Essock, S., Shaner, A., Carey K., Minkoff, K., Kola, L, Lynde, D., Osher, F. Clark, R., & Rickards, L. (2001). *Implementing Dual Diagnosis Services for Clients with Severe Mental Illness*. Journal of Psychiatric Services, Vol.52, No. 4

Fresno County (2019a). Mental Health Services Act: Improving Services for People with Co-Occurring Disorders. Behavioral Health Department. Retrieved from: https://www.co.fresno.ca.us/departments/behavioral-health/mental-health-services-act/co-occurring-information

Fresno County (2019b). Mental Health Services Act: MHSA Outcomes. Behavioral Health Department. Retrieved from: https://www.co.fresno.ca.us/departments/behavioral-health/mental-health-services-act/mhsa-outcomes

Karberg, J., and James, D. (2005) *Substance Dependence, Abuse, and Treatment of Jail Inmates*. Office of Justice Programs, Bureau of Justice Assistance, Washington, DC.

KiDeuk, K., Becker-Cohen, M., and Serakos, M. (2015). The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System. Washington, DC: Urban Institute.

McGovern, M. P., Lambert-Harris, C., Gotham, H. J., Claus, R. E., and Xie, H. (2014). *Dual diagnosis capability in mental health and addiction treatment services: an assessment of programs across multiple state systems.* Administration and Policy in Mental Health and Mental Health Services Research, 41(2), 205-214.

McKee, S. A., Harris, G. T., & Cormier, C. A. (2013). Implementing residential integrated treatment for co-occurring disorders*. Journal of Dual Diagnosis*, 9(3), 249-259.

Padwa, H., Larkins, S., Crevecoeur-MacPhail, D. A., & Grella, C. E. (2013). Dual diagnosis capability in mental health and substance use disorder treatment programs. *Journal of Dual Diagnosis*, 9(2), 179-186.

Peters, R., Wexler, H., & Lurigio, A. (2015). Co-Occurring Substance Use and Mental Disorders in the Criminal Justice System. *Psychiatric Rehabilitation Journal*, Vol.38. No. 1, 1-6.

Plotkin, Martha R., Blandford, Alex M. (2017). *Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need*. Council of State Governments Justice Center. New York, NY.

Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: an integrative literature review. *Journal of Substance Abuse Treatment*, Vol. 61, 47-59.

Steadman, H. J., Osher, F. C., Clark Robbins, P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6), 761-765.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2011). Dual Diagnosis Capability in Addiction Treatment Toolkit Version 4.0. HHS Publication No. SMA-XX-XXXX. Substance Abuse and Mental Health Services Administration. Rockville, MD. Retrieved from: https://www.centerforebp.case.edu/client-files/pdf/ddcattoolkit.pdf

SAMHSA (2005). Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series, No. 42. HHS Publication No. (SMA) 13-3992. Substance Abuse and Mental Health Services Administration. Rockville, MD. Retrieved from: https://store.samhsa.gov/system/files/sma13-3992.pdf

Torrens, M., Rossi, PC., Martinez-Riera, R., Martinez-Sanvisens, D., Bulbena, A. (2012). Psychiatric Co-Morbidity and Substance Use Disorders: Treatment in Parallel Systems or in One Integrated System? *Substance Use & Misuse*, 47:8-9, 1005-1014.

Torrey, E. Fuller (2010). *More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States.* Treatment Advocacy Center. Arlington, VA.

Wrenn, G., McGregor, B., Munetz, M. (2017). *Improving Outcomes for People with Serious Mental Illness and Co-Occurring Substance Use Disorders in Contact with the Criminal Justice System.* Thomas Scattergood Behavioral Health Foundation. Philadelphia, PA.

TABLE I: DDCAT VERSION 4.0 STANDARDS

Program Structure
1 A. Primary focus stated in mission statement
1 B. Licensure & Certification
1 C. Coordination and collaboration with mental health services
1 D. Financial Structure & Incentives

Program Milieu
2 A. Routine expectation & welcome to treatment for both disorders
2 B. Display & distribution of literature & educational materials

Clinical Process: Assessment
3 A. Routine screening methods for mental health symptoms
3 B. Routine assessment if positive screen for mental health symptoms
3 C. Mental health & substance use disorder diagnoses are made & documented
3 D. Mental health history reflected in the client record
3 E. Admission based on acuity: low, medium, high (stability at time of admission)
3.F Admission based on persistence of mental health disability: low, medium, high
3 G. Stage-wise assessment

Clinical Process Treatment
4 A. Treatment Plans
4 B. Assess and monitor interactive courses of both disorders
4 C. Procedures for mental health emergency & crisis management designed to maintain Individual in program
4 D. Stage-wise treatment
4 E. Medication management polices & procedures & monitoring of adherence
4 F. Specialize interventions with mental health content
4 G. Patient education about mental health disorders, treatment, & SUD interaction
4 H. Family education and support
4 I. Specialized interventions to facilitate use of peer support groups
4 J. Availability of peer recovery supports for patients with co-occurring disorders

Continuity of Care
5 A. Co-occurring disorders addressed in discharge planning
5 B. Capacity to maintain treatment continuity
5 C. Focus on ongoing recovery issues for both disorders
5 D. Specialized interventions to facilitate use of peer support groups during discharge planning
5 E. Sufficient supply & compliance plan for medications is documented

Staffing
6 A. Psychiatrist or other prescriber of psychotropic medications
6 B. On site clinical staff members with mental health licensure & competency
6 C. Access to mental health clinical supervision
6 D. Case review, staffing or utilization review procedures emphasize & support co-occurring disorder
6 E. Peer/Alumni supports are available for input with co-occurring disorders

Training
7 A. All staff members have basic training in attitudes, prevalence, common signs & symptoms, detection and triage for co-occurring disorders

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About the Reentry Health Policy Project

- This brief is part of the Reentry Health Policy Project, which seeks to identify state and county level policies and practices that impede the delivery of effective health and behavioral health care services for formerly incarcerated individuals who are medically fragile (MF) and living with serious mental illness (SMI), as they return to the community. The report also offers specific recommendations and best practices for addressing these barriers. The Reentry Health Policy Project was managed by California Health Policy Strategies LLC with support provided by the California Health Care Foundation.

About California Health Policy Strategies (CalHPS), LLC.

- CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com.