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Substance Use Disorder in California

A Focused Landscape Analysis

Written By
Charles Robbins, MBA
Marc Avery, MD
Serene Olin, PhD
Emma Clark, PhD
Rachel Johnson-Yates, MA, LMHC, LAC
Brittany Doughty, MPH
Brittany Thompson, MPH, CHES®

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EXECUTIVE SUMMARY

Health Management Associates, Inc. (HMA), found that the substance use disorder treatment system, which sits outside of specialty mental health and mild-to-moderate mental health services, results in an inconsistent and siloed system. The delivery of programs and services across the state vary because of differences in geography (rural, suburban, and urban densities) as well as county participation in the Drug Medi-Cal Organized Delivery System (DMC-ODS). This landscape analysis provides a deeper exploration into the challenges and opportunities specific to addressing substance use disorder.

Summary of Key Findings

HMA conducted a pre-interview survey of the key stakeholders interviewed for this landscape analysis. Stakeholders ranked “lack of access to needed housing and residential services for persons with substance use disorder (SUD)” as the top barrier to access. Inaccessible food, transportation, and other social drivers of health (SDOH) also topped the list. Stakeholders ranked “insufficient access to stable housing” as the predominant factor that leads to disparate clinical outcomes. “Insufficient coordination of care” also ranked high as contributors to negative clinical outcomes.

Survey data also indicated that three racial/ethnic populations are most likely to experience SUD service gaps: Latine/Hispanic, African American/Black, and Native American/Alaska Native people, in that order from greatest to least service gaps. Ranked by age, transition age youth (ages 19−25) topped the list, followed by adults (ages 26−65).

Many qualitative themes emerged from the interview responses to HMA’s query on restrictions to providing access to comprehensive SUD care. Dominant themes included those of social and provider stigma, SDOH barriers, lack of integrated care, lack of comprehensively trained clinical staff, and variations in payment models.

Respondents were eager to share their experiences with innovative treatment models in their communities. Specific models that were frequently referenced included harm reduction, implementation of contingency management, recovery residences and sobering centers, and collaborative models with community health centers.

In interviews regarding innovative workforce models, several notable themes emerged, which particularly emphasized the integral roles of peers, community health workers. robust workforce pipelines, and establishing high-quality trainings and certifications for staff. Interviewees frequently highlighted the success of workforce models that prioritize the integration of peer support specialists who bring invaluable lived experience.

Several themes to improve quality of SUD care emerged, including a desire to increase standards for licensing, certification, and training; building infrastructure to support payment reform; building capacity for a continuum of SUD services; and a need to define the quality and value of SUD services.

Interviewees indicated a need for cross-sector care coordinators who would be responsible for connecting and orchestrating care between the many providers who are often involved in supporting the multifaceted needs of people engaged in behavioral health treatment.

Overall, stakeholders interviewed across the board appreciate the vision and the potential for various The California Advancing and Innovating Medi-Cal (CalAIM) initiatives to support seamless care, the efforts to reorganize the SUD treatment system, and the forthcoming integration of mental health and substance use disorder services and other related initiatives; however, the implementation rollout remains a challenge.

HMA subject matter experts have provided input to the landscape of SUD in California. Key opportunities for reaching 95 percent of the people with SUD treatment needs but do not access care include developing strategies to improve access (e.g., extended hours, changing workflows) and reduce barriers to evidence-based care. Specific recommendations include expanding education about medications for opioid use and alcohol use disorders, ensuring all prescribers and behavioral health providers can bill for services, integrating systems to reduce navigational challenges, and improving opportunities to share information. Additionally, HMA developed a shared solutions framework for improvements in specialty mental health and SUD services, which can be found at the end of this document.

KEY DEFINITIONS

BEHAVIORAL HEALTH (BH) SERVICES, for purposes of this document, refer to both mental health and substance use treatment and support services.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM has been in place since 2015 and offers drug and alcohol treatment programs, including assessment and treatment in accordance with nationally recognized criteria and standards and based on each individual's needs.

EVIDENCE-BASED PRACTICE (EBP) is an approach to care that integrates the best available research evidence with clinical expertise and patient values.

NON-SPECIALTY MENTAL HEALTH SERVICES are provided to people who have been diagnosed with a mild to moderate mental health disorder who do not meet the eligibility criteria for specialty behavioral health and are administered by Medi-Cal managed care plans.[1,2]

RECOVERY MODEL: The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a working definition and set of principles for a recovery model approach, which defines recovery as, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The 10 guiding principles of recovery are: self-direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope.[3]

SUBSTANCE USE DISORDER (SUD) is the illicit use of drugs or meeting criteria for alcohol dependence or abuse, defined based on a person reporting a pattern of substance use leading to clinically significant impairment or distress.[4]

SPECIALTY MENTAL HEALTH SERVICES (SMHS) are services provided to beneficiaries of a county mental health plan. Enrollees typically meet criteria of an appropriate diagnosis, have a related functional impairment, and have a medical need for the proposed services. California's mental health plans have historically prioritized services, especially for adults with serious mental illness (SMI) and minors with serious emotional disturbance.

ACRONYMS

BH: Behavioral health

DHCS: (California) Department of Health Care Services

DMC-ODS: (California) Drug Medi-Cal Organized Delivery System

EBP: Evidence-based practice

MH: Mental health

MHSA: Mental Health Services Act

SUD: Substance use disorder

SMHS: Specialty mental health services

INTRODUCTION

Substance use disorder (SUD) is a common health concern facing our nation and state. Despite ongoing progress to address and treat this condition, many indicators suggest that SUD has become increasingly prevalent over the past few years, leading many state and national leaders to describe the situation as a crisis.[5,6,7,8] These circumstances and concerns are detailed in the following graphics.

SUDs are common both nationally and in California.

	
In the United States	**In California**
• In 2021, approximately 16.5% (1 in 6) people ages 12 and older met criteria for an SUD (roughly one-half with an alcohol use disorder, and the other half with a drug use disorder).[9]	• In 2022, approximately 9% of Californians ages 12 years and older met criteria for an SUD.[10]

Also concerning is the general trend toward an increased prevalence of SUD in our nation and state.

	
In the United States	**In California**
• The prevalence of SUD among individuals 12 years of age and older increased to 17.3% in 2022 from 16.5% in 2021.[11,12]	• The prevalence of SUD among individuals 12 years of age and older increased to 8.8% in 2022 from 8.1% in 2015.[13,14]

Individuals with an SUD are at a greater risk of morbidity and mortality both nationally and in California.

In the United States	In California
• More than 140,000 Americans ages 12 years and older died from the effects of alcohol from 2020 to 2021.[15] • The total annual number of alcohol-related deaths i**n** the nation increased by approximately 10% from 2020 to 2021.[16]	• More than 19,335 Californians ages 12 years and older died from the effects of alcohol from 2020 to 2021.[17] • The total annual number of alcohol-related deaths increased by approximately 18% in the state from 2020 and 2021.[18]

The number of non-fatal overdoses and fatal overdoses from opioids and psychostimulants also presents a significant health problem.

In the United States	In California
• In 2022, 181,806 people experienced non-fatal opioid overdoses.[19] • In 2021, 106,699 people in died from overdoses, a number mainly driven by synthetic opioids, such as fentanyl, representing a 14% increase from 2020.[20] • Psychostimulant-related overdose deaths in the increased by 37% from 2020 to 2021.[21,22]	• In 2022, 23,864 people were seen in the emergency department (ED) for non-fatal opioid-related overdoses.[23] • In 2022, 6,959 people died from overdoses related to opioids, with 88% of deaths related to fentanyl,[24] representing a 25% increase in opioid-related deaths from 2020.[25] • The rate of psychostimulant-related overdose deaths in California increased to 2022 (14.37 per 100,000 residents) from 2020 (10.65 per 100,000 residents).[26]

The number of ED visits related to SUD also increased.

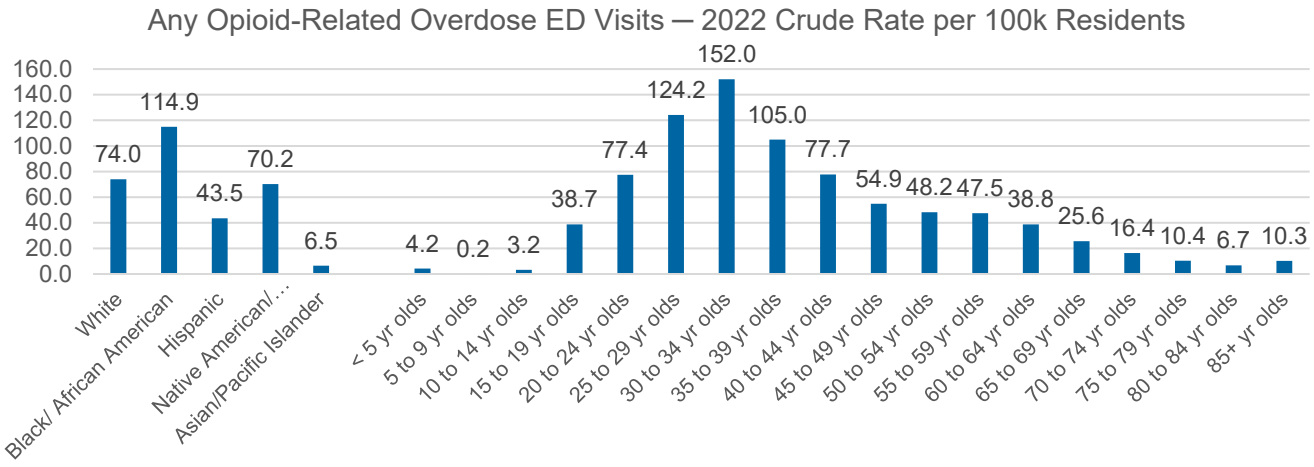
In the United States	In California
• The national rate of ED visits with a primary diagnosis of an SUD among adults ages 18 years and older increased to 103.8 in 2020–2021 from 74.4 per 10,000 population in 2018–2019.[27] • The rate of alcohol-related ED visits in 2022 was 970 per 100,000 individuals.[28] • The rate of opioid-related ED visits in 2022 was 274 per 100,000 individuals.[29] • The rate of methamphetamine-related ED visits in 2022 was 176 per 100,000 individuals.[30]	• In California, the number of alcohol-related ED visits increased 67 percent in 2008−2017,[31] and more than 630,000 alcohol-related ED visits occurred in 2021.[32] • The rate of opioid-related emergency department visits increased slightly between 2021 (53.82 per 100,000 residents) and 2022 (54.88 per 100,000 residents).[33] • The rate of amphetamine-related ED visits decreased slightly from 2021 (7.78 per 100,000 residents) to 2022 (6.33 per 100,000 residents).[34]

SUDs are key drivers of distress, disability, and morbidity. Furthermore, prenatal substance exposure can negatively affect infant morbidity and mortality (e.g., fetal alcohol syndrome).[35] Substance use disorders generally are associated with a 10 to 20 year decrease in life expectancy.[36] This reduction in life expectancy is primarily related to comorbidities, such as cardiovascular illness, diabetes, renal disease, and other chronic conditions—many of which are associated with higher risk behaviors and all of which contribute to increased health costs.

Unfortunately, not everyone with an SUD receives necessary care given the high cost of treatment and general barriers to access.[37] In 2021, only 6 percent of Americans and 10 percent of Californians ages 12 and older with an SUD received treatment for their condition.[38, 39] Concerningly, 81 percent of adults in the United States who did receive care for substance use reported having trouble accessing the services they needed.[40]

Despite ongoing changes in the SUD delivery system, the data suggest a significant amount of unmet need remains for individuals with SUD. Thought leaders propose that the SUD delivery system be reformed to improve effectiveness.

Details on all of these findings are highlighted in the following figures.


Any Opioid-Related Overdose ED Visits — 2022 Crude Rate per 100k Residents
160.0
140.0
120.0
100.0
80.0
60.0
40.0
20.0
0.0
74.0
114.9
43.5
70.2
6.5
4.2
0.2
3.2
38.7
77.4
124.2
152.0
105.0
77.7
54.9
48.2
47.5
38.8
25.6
16.4
10.4
6.7
10.3
White
Black/ African American
Hispanic
Native American/…
Asian/Pacific Islander
< 5 yr olds
5 to 9 yr olds
10 to 14 yr olds
15 to 19 yr olds
20 to 24 yr olds
25 to 29 yr olds
30 to 34 yr olds
35 to 39 yr olds
40 to 44 yr olds
45 to 49 yr olds
50 to 54 yr olds
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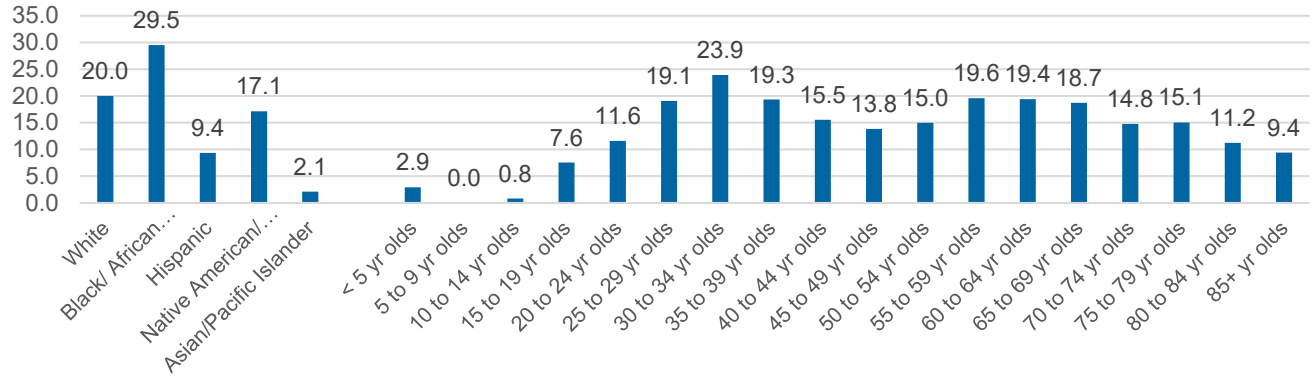
60 to 64 yr olds
65 to 69 yr olds
70 to 74 yr olds
75 to 79 yr olds
80 to 84 yr olds
85+ yr olds


Any Opioid-Related Overdose Hospitalizations — 2022 Crude Rate per 100k Residents
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
20.0
29.5
9.4
17.1
2.1
2.9
0.0
0.8
7.6
11.6
19.1
23.9
19.3
15.5
13.8
15.0
19.6
19.4
18.7
14.8
15.1
11.2
9.4
White
Black/ African…
Hispanic
Native American/…
Asian/Pacific Islander
< 5 yr olds
5 to 9 yr olds
10 to 14 yr olds
15 to 19 yr olds
20 to 24 yr olds
25 to 29 yr olds
30 to 34 yr olds
35 to 39 yr olds
40 to 44 yr olds
45 to 49 yr olds
50 to 54 yr olds
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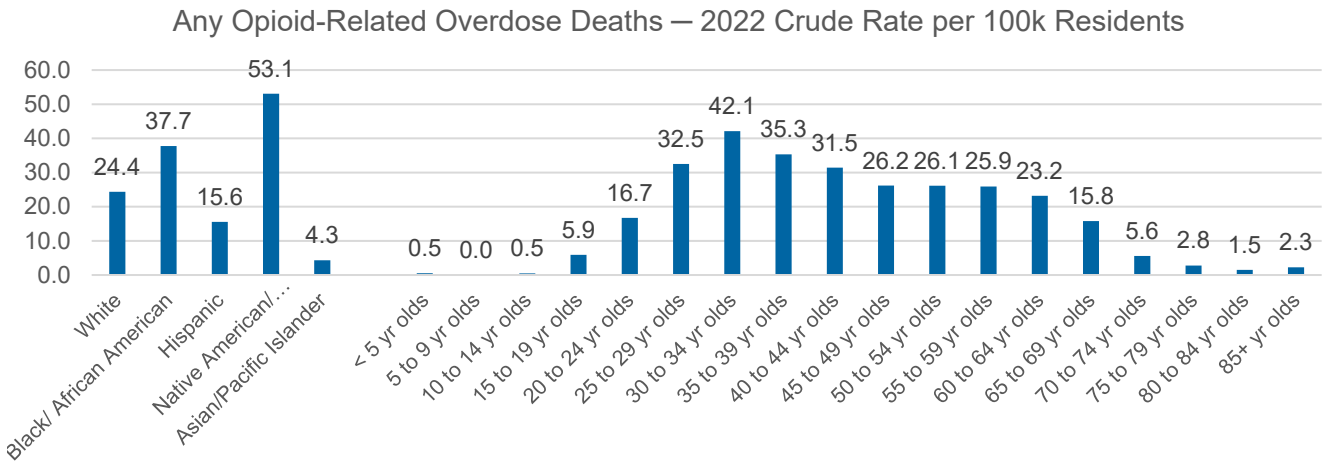
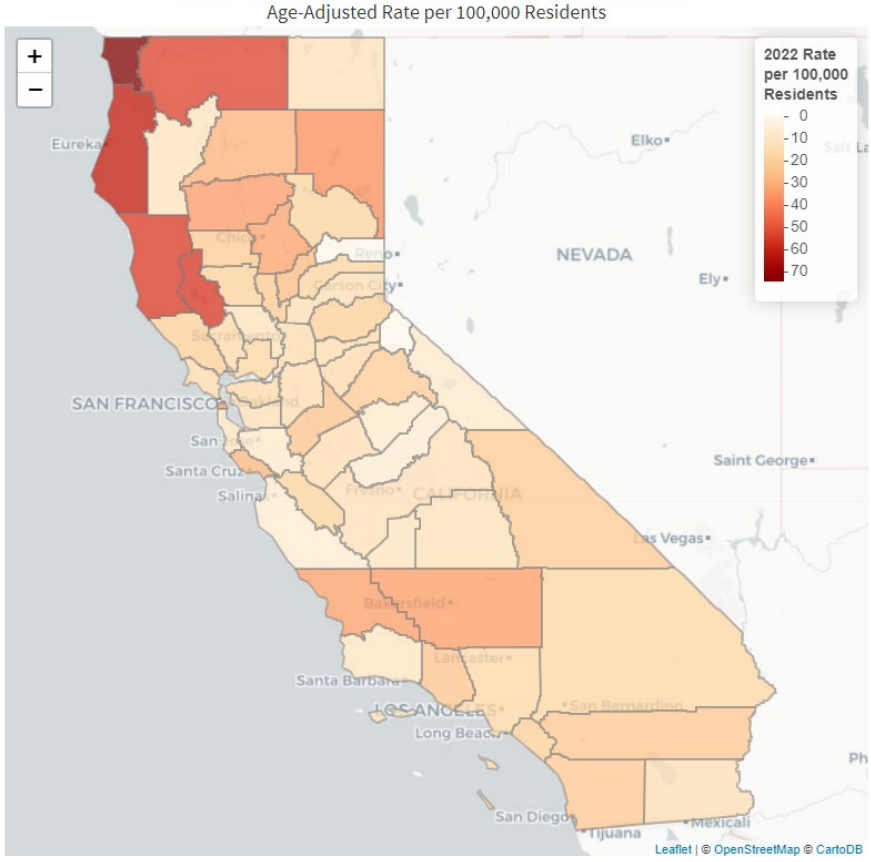
65 to 69 yr olds
70 to 74 yr olds
75 to 79 yr olds
80 to 84 yr olds
85+ yr olds

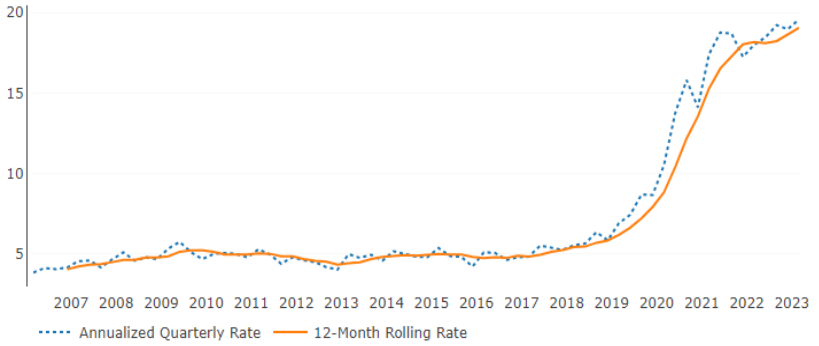

Any Opioid-Related Overdose Deaths — 2022 Crude Rate per 100k Residents
60.0
50.0
40.0
30.0
20.0
10.0
0.0
24.4
37.7
15.6
53.1
4.3
0.5
0.0
0.5
5.9
16.7
32.5
42.1
35.3
31.5
26.2
26.1
25.9
23.2
15.8
5.6
2.8
1.5
2.3
White
Black/ African American
Hispanic
Native American/…
Asian/Pacific Islander
< 5 yr olds
5 to 9 yr olds
10 to 14 yr olds
15 to 19 yr olds
20 to 24 yr olds
25 to 29 yr olds
30 to 34 yr olds
35 to 39 yr olds
40 to 44 yr olds
45 to 49 yr olds
50 to 54 yr olds
55 to 59 yr olds
60 to 64 yr olds
65 to 69 yr olds
70 to 74 yr olds
75 to 79 yr olds
80 to 84 yr olds
85+ yr olds

Any Opioid-Related Overdose Deaths

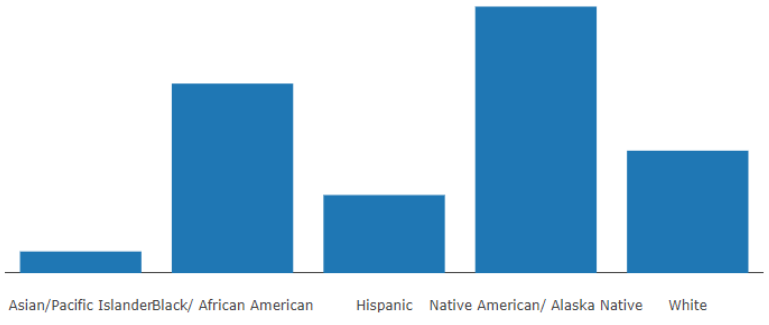
Any Opioid-Related Overdose Deaths - Total Population, 2022
Age-Adjusted Rate per 100,000 Residents



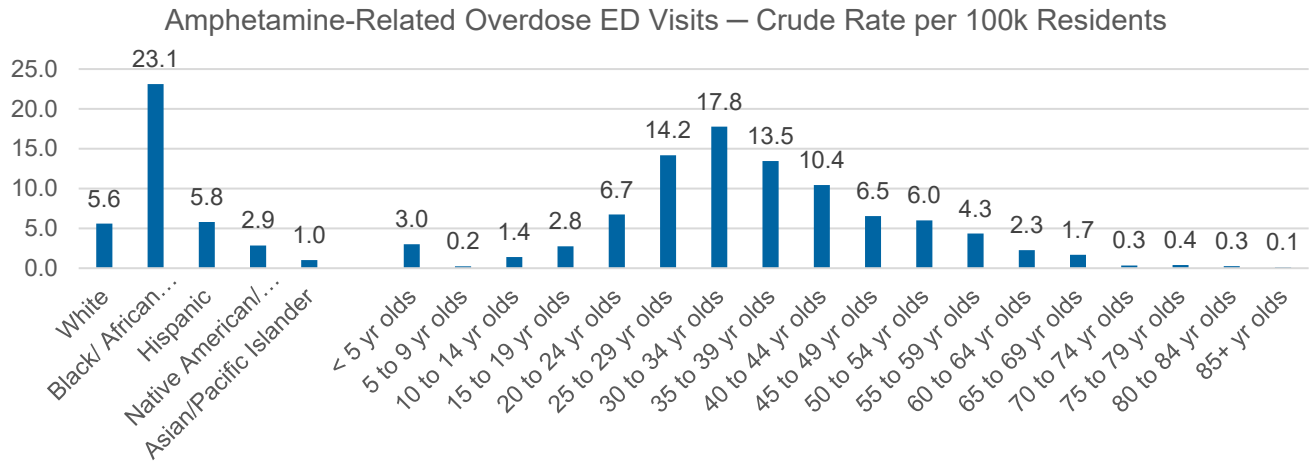
Any Opioid-Related Overdose Deaths - Total Population
Age-Adjusted Rate per 100,000 Residents **- 2023 data are preliminary**

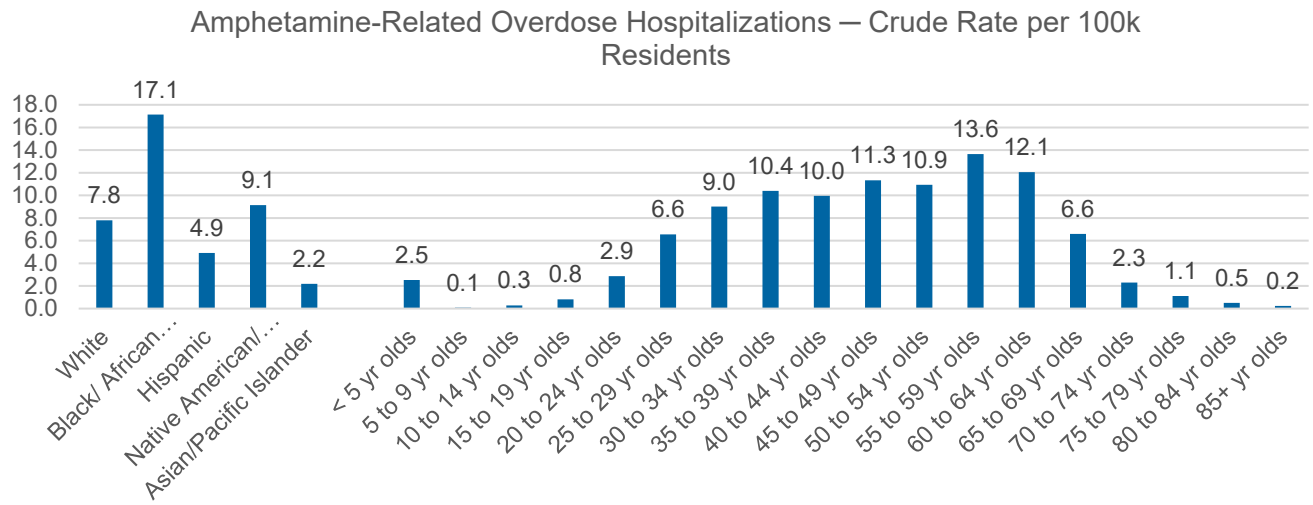


Any Opioid-Related Overdose Deaths by Race/Ethnicity , 2022
Crude Rate per 100,000 Residents



Source: California Overdose Surveillance Dashboard. Prepared by California Department of Public Health, Substance and Addiction Prevention Branch (CDPH-SAPB). Available at: https://skylab.cdph.ca.gov/ODdash/.


Amphetamine-Related Overdose ED Visits — Crude Rate per 100k Residents
25.0
20.0
15.0
10.0
5.0
0.0
5.6
23.1
5.8
2.9
1.0
3.0
0.2
1.4
2.8
6.7
14.2
17.8
13.5
10.4
6.5
6.0
4.3
2.3
1.7
0.3
0.4
0.3
0.1
White
Black/ African…
Hispanic
Native American/…
Asian/Pacific Islander
< 5 yr olds
5 to 9 yr olds
10 to 14 yr olds
15 to 19 yr olds
20 to 24 yr olds
25 to 29 yr olds
30 to 34 yr olds
35 to 39 yr olds
40 to 44 yr olds
45 to 49 yr olds
50 to 54 yr olds
55 to 59 yr olds
60 to 64 yr olds
65 to 69 yr olds
70 to 74 yr olds
75 to 79 yr olds
80 to 84 yr olds
85+ yr olds


Amphetamine-Related Overdose Hospitalizations — Crude Rate per 100k Residents
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
7.8
17.1
4.9
9.1
2.2
2.5
0.1
0.3
0.8
2.9
6.6
9.0
10.4
10.0
11.3
10.9
13.6
12.1
6.6
2.3
1.1
0.5
0.2
White
Black/ African…
Hispanic
Native American/…
Asian/Pacific Islander
< 5 yr olds
5 to 9 yr olds
10 to 14 yr olds
15 to 19 yr olds
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25 to 29 yr olds
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35 to 39 yr olds
40 to 44 yr olds
45 to 49 yr olds
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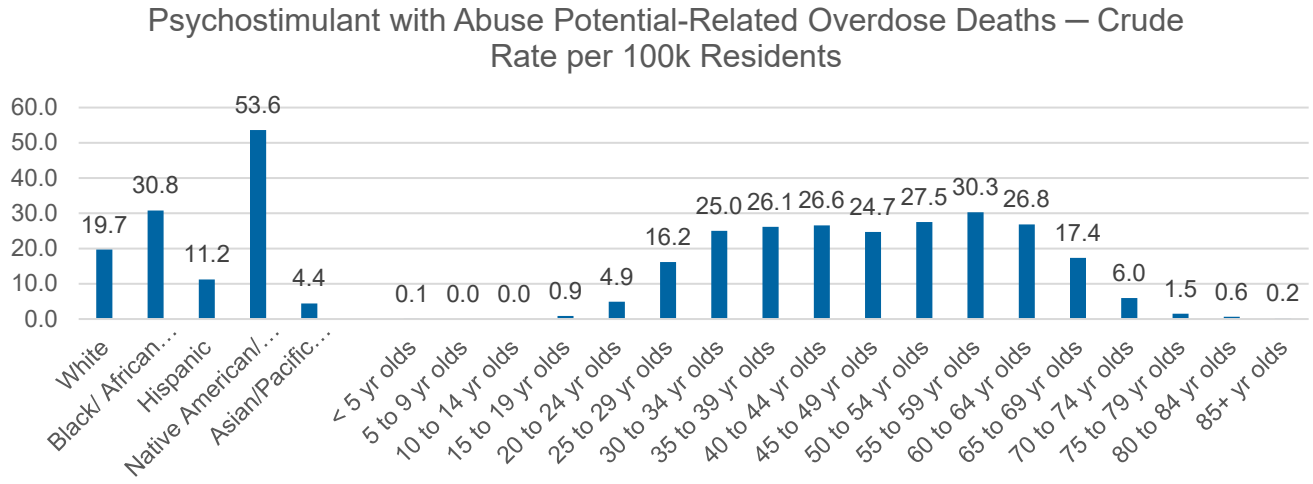
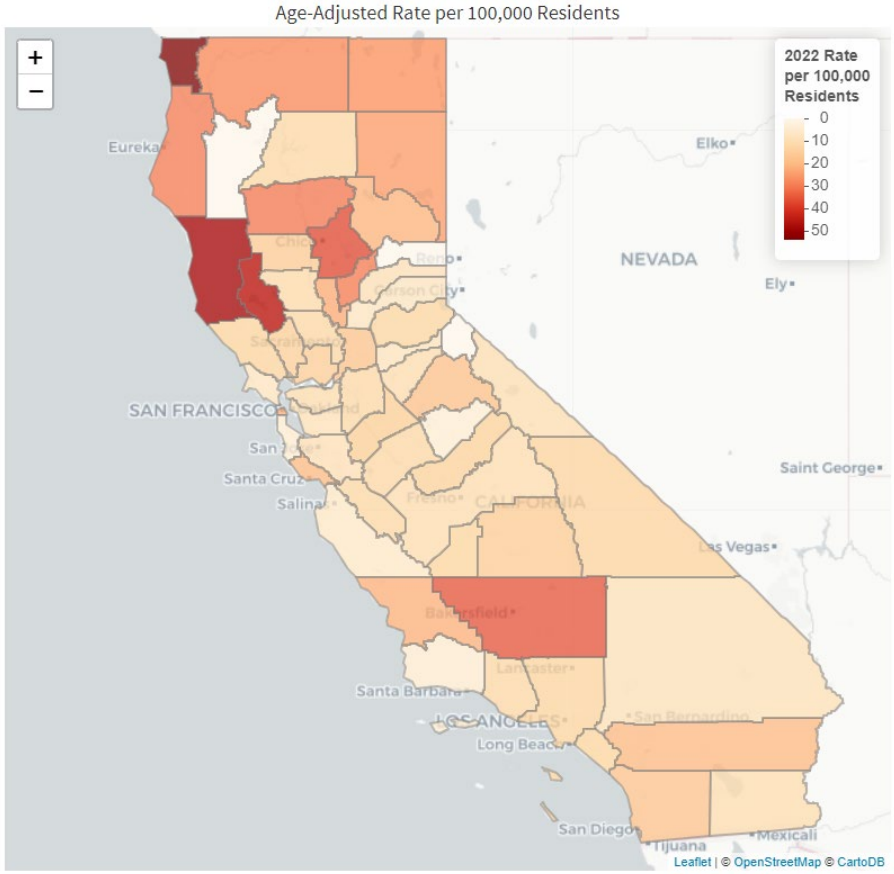
75 to 79 yr olds
80 to 84 yr olds
85+ yr olds

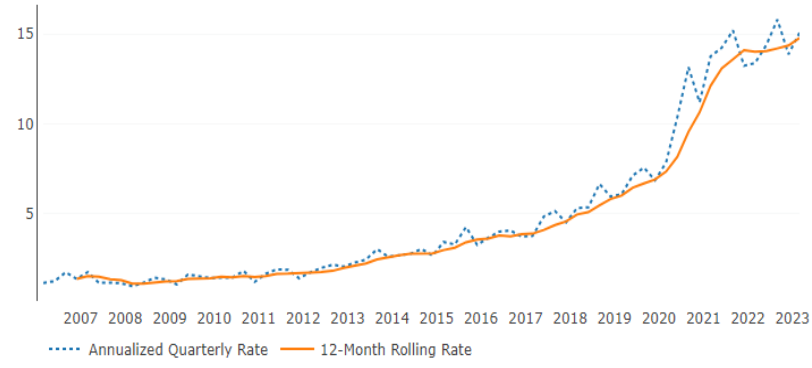

Psychostimulant with Abuse Potential-Related Overdose Deaths — Crude Rate per 100k Residents
60.0
50.0
40.0
30.0
20.0
10.0
0.0
19.7
30.8
11.2
53.6
4.4
0.1
0.0
0.0
0.9
4.9
16.2
25.0
26.1
26.6
24.7
27.5
30.3
26.8
17.4
6.0
1.5
0.6
0.2
White
Black/ African…
Hispanic
Native American/…
Asian/Pacific…
< 5 yr olds
5 to 9 yr olds
10 to 14 yr olds
15 to 19 yr olds
20 to 24 yr olds
25 to 29 yr olds
30 to 34 yr olds
35 to 39 yr olds
40 to 44 yr olds
45 to 49 yr olds
50 to 54 yr olds
55 to 59 yr olds
60 to 64 yr olds
65 to 69 yr olds
70 to 74 yr olds
75 to 79 yr olds
80 to 84 yr olds
85+ yr olds

Psychostimulant-Related Overdose Deaths

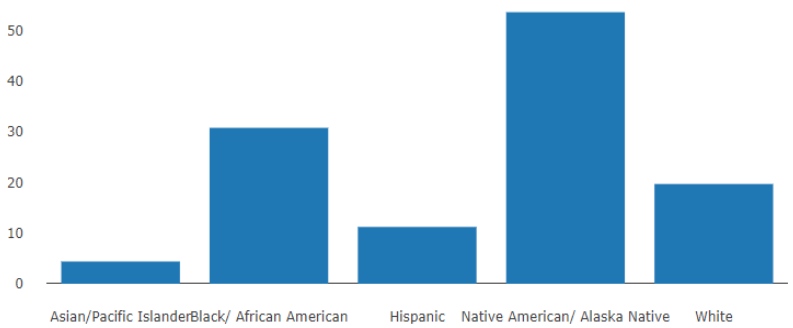
Psychostimulant with Abuse Potential-Related Overdose Deaths - Total Population, 2022
Age-Adjusted Rate per 100,000 Residents



Psychostimulant with Abuse Potential-Related Overdose Deaths - Total Population
Age-Adjusted Rate per 100,000 Residents **- 2023 data are preliminary**



Psychostimulant with Abuse Potential-Related Overdose Deaths by Race/Ethnicity , 2022
Crude Rate per 100,000 Residents



Source: California Overdose Surveillance Dashboard. Prepared by CDPH-SAPB. Available at: https://skylab.cdph.ca.gov/ODdash/.

California's SUD Landscape

California's specialty behavioral health (BH) programs are administered by county plans, each of which has memorandums of understanding (MOUs) with the Department of Health Care Services (DHCS). These MOUs are separate from the state arrangements for providing physical healthcare services. This separate BH arrangement is often referred to as a carve-out benefit. County BH plans are required to provide a range of services, including prevention and early intervention activities, child and family mental health and SUD services, individual and group counseling, psychological testing, psychiatric recovery and rehabilitation services, case management, psychiatric consultation and medication management, residential care, acute psychiatric inpatient, and crisis services. Because BH control is delegated to the counties, BH programs vary significantly across the state, with key variations in access procedures, quality monitoring, services, and programming.[41]

The implementation of the mild-to-moderate (non-specialty) mental health (MH) benefit in 2014, administered by Medicaid managed care plans rather than county BH plans, has resulted in an overall system design that is often referred to as a "bifurcated system" between mild-to-moderate and serious mental illness (SMI) care. This dichotomy also has resulted in numerous challenges for the delivery system—especially in terms of coordinating prevention efforts, as well as managing transitions and information sharing between the two arms of the system. Further complicating the BH system is the positioning of SUD treatment programs in another silo, resulting in fragmented care for people who have co-occurring disorders.

Medicaid services are reimbursed using a hybrid fee-for-service arrangement with end of year cost adjustments. County BH entities also may have other sources of revenue, including Medicare, federal, and other grant funding. Payment reform efforts are under way for California Advancing and Innovating Medi-Cal (CalAIM), however, which would likely discontinue the cost-settlement process in favor of a predetermined payment rate.[42]

Over the years, DHCS has sought to reduce the variation and fragmentation across programs with only partial effectiveness. Similarly, the state has sought to shift in the direction of value-based care with standardized outcomes-based measurement and reimbursement, but this vision has yet to be realized.

To address the variances in SUD treatment in California, in August 2015 the state received approval of a Medicaid 1115 waiver from the Centers for Medicare & Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS)—the nation's first SUD treatment demonstration program.[43,44] By July 2020, the DMC-ODS initiative had been implemented across 37 counties, which comprised most of California's population (95.9%); 21 small and rural counties did not participate.

The University of California, Los Angeles, evaluated the DMC-ODS waiver and in February of 2022 reported that the program had improved access to treatment, quality of care, and coordination of care in the participating counties when compared with counties having Drug Medi-Cal only.[45] Additional studies have suggested that the DMC-ODS waiver was associated with an increase in unique patient admissions to SUD outpatient treatment and residential SUD treatment.[46] Although this initial demonstration waiver ended December 31, 2021, DMC-ODS was reauthorized in December of that year, which shifted managed care authority to the consolidated CalAIM 1915(b) waiver and used the Medicaid State Plan to authorize most DMC-ODS benefits.[47] The 1915b waivers took effect January 1, 2022, and will continue through December 31, 2026.[48] Although these changes in the DMC-ODS waiver are intended to improve quality of care, they also may present new challenges to SUD treatment.

METHODS

HMA used both qualitative and quantitative methods to collect data for this report.

Qualitative

HMA coordinated and conducted 60-minute interviews with key stakeholders from a cross-section of SUD thought leaders, including state and county behavioral health payors and SUD providers, representing a diversity of geographies and services. In each interview, one HMA team member facilitated the conversation while a second took notes. These notes were then reviewed to extract common themes for reporting, without attribution to individual participants.

HMA developed a comprehensive interview guide with standard introductory language and questions for each interview. The guide covered a range of topics, including system gaps and barriers, innovations in workforce, value-based payment, cross-sector collaborations, and state requirements.

HMA completed 20 interviews (see Table).

Table 1. Stakeholder Interview Participants

Completed Interviews	
Name	**Organization**
Tony Vartan	Stanislaus County
Tabitha Sprague	Stanislaus County
Kevin Panyanouvong	Stanislaus County
Elise Jones	Lake County
Luke Bergmann	San Diego County Behavioral Health
Gary Tsai	LA County SAPC
Rhyan Miller	Riverside County
Victoria Mansfield	Imperial County
Ivan Bhardwaj	DHCS
Jose Salazar	Tarzana Treatment Center
Jonathan Porteus	WellSpace Health (Federally Qualified Health Centers [FQHCs] & Certified community behavioral health clinics [CCBHCs])
Christie Gonzales	WellSpace Health (FQHCs & CCBHCs)
Sage Smiley	Santa Cruz County – Encompass
Laura Guzman	Harm Reduction Coalition
Jamina Hackett	Harm Reduction Coalition
Kyle Temple	SFAF – Harm Reduction, SUD Counseling
Stephanie Macwhorter	Janus
Glen Hayes	Humboldt County
Michael Brodsky	LA Care
Joe Hallet	Glenn

In addition, HMA conducted a 60-minute focus group with three HMA subject matter experts:

- Helen DuPlessis, MD, MPH, Physician Principal
- Bren Manaugh, MSW, LCSW, Principal
- Shannon Robinson, MD, Principal

Quantitative

To facilitate efficient regarding specific improvement needs and ideas with limited time, HMA asked participants to complete a pre-interview questionnaire, which identified more high-level impressions of systems barriers, gaps, and inequities. A total of 14 individuals completed a survey over an eight-week period to inform this report.

SUDs can be prevented, treated, and managed.

Prevention education, harm reduction, sobering centers, residential treatment, behavioral therapy, medications for addiction treatment, contingency management, sober living, peer supports, and 12-step and recovery programs play an important role in addressing SUD.

FINDINGS

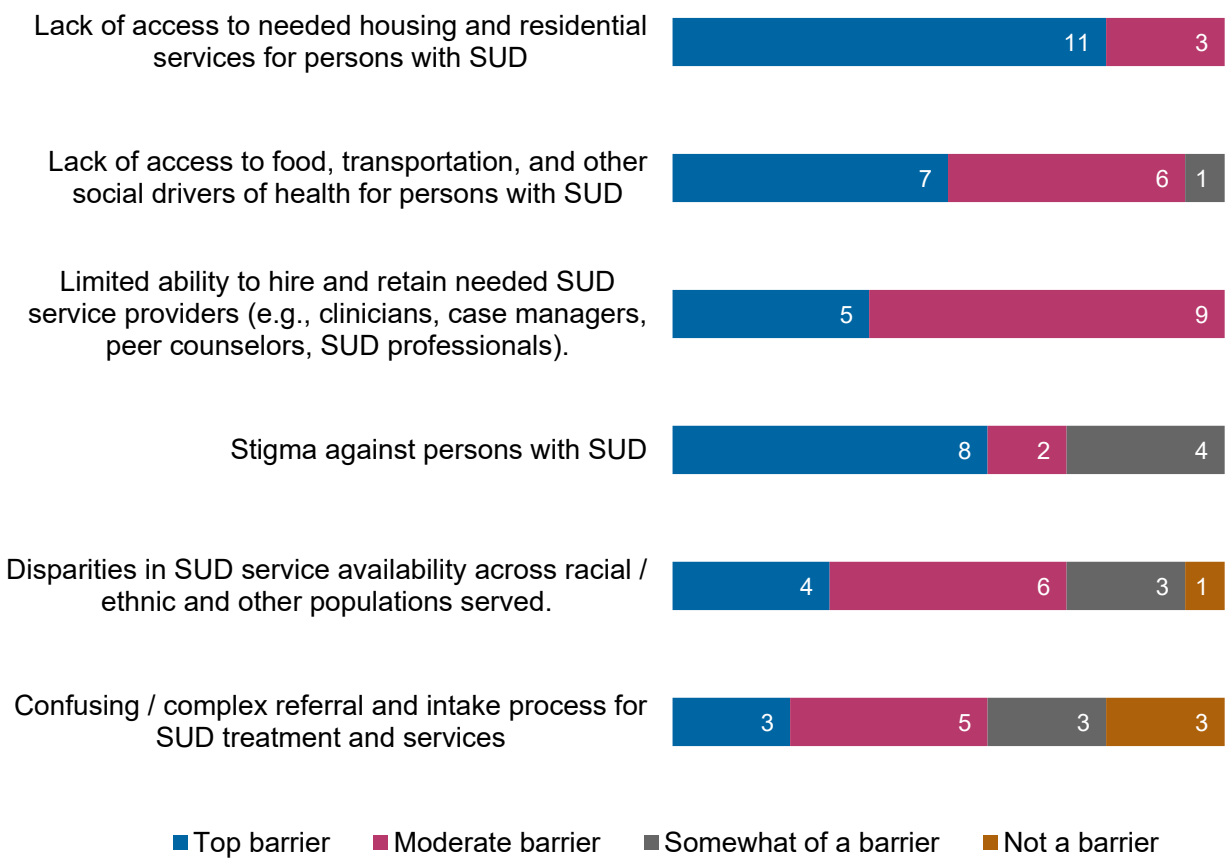
Pre-Interview Survey

Interview participants were invited to complete a pre-interview questionnaire to provide quantitative data and more general feedback; 14 of the 20 interview candidates completed the survey. The questionnaire was developed by HMA and programmed into an online tool (Qualtrics) for data collection and preliminary analysis.

1. **What are the top barriers to SERVICE in the SUD System?** (Ranked from a selected list of six.)

   "**Lack of access to needed housing and residential services for persons with SUD**," is the primary barrier, according to 11 respondents; three people identified it as moderate impediment. The barrier ranked as having the least impact on service was a "confusing / complex referral and intake process for SUD treatment and services." Only three people ranked it as a top barrier, and three people ranked it as not presenting a barrier at all.

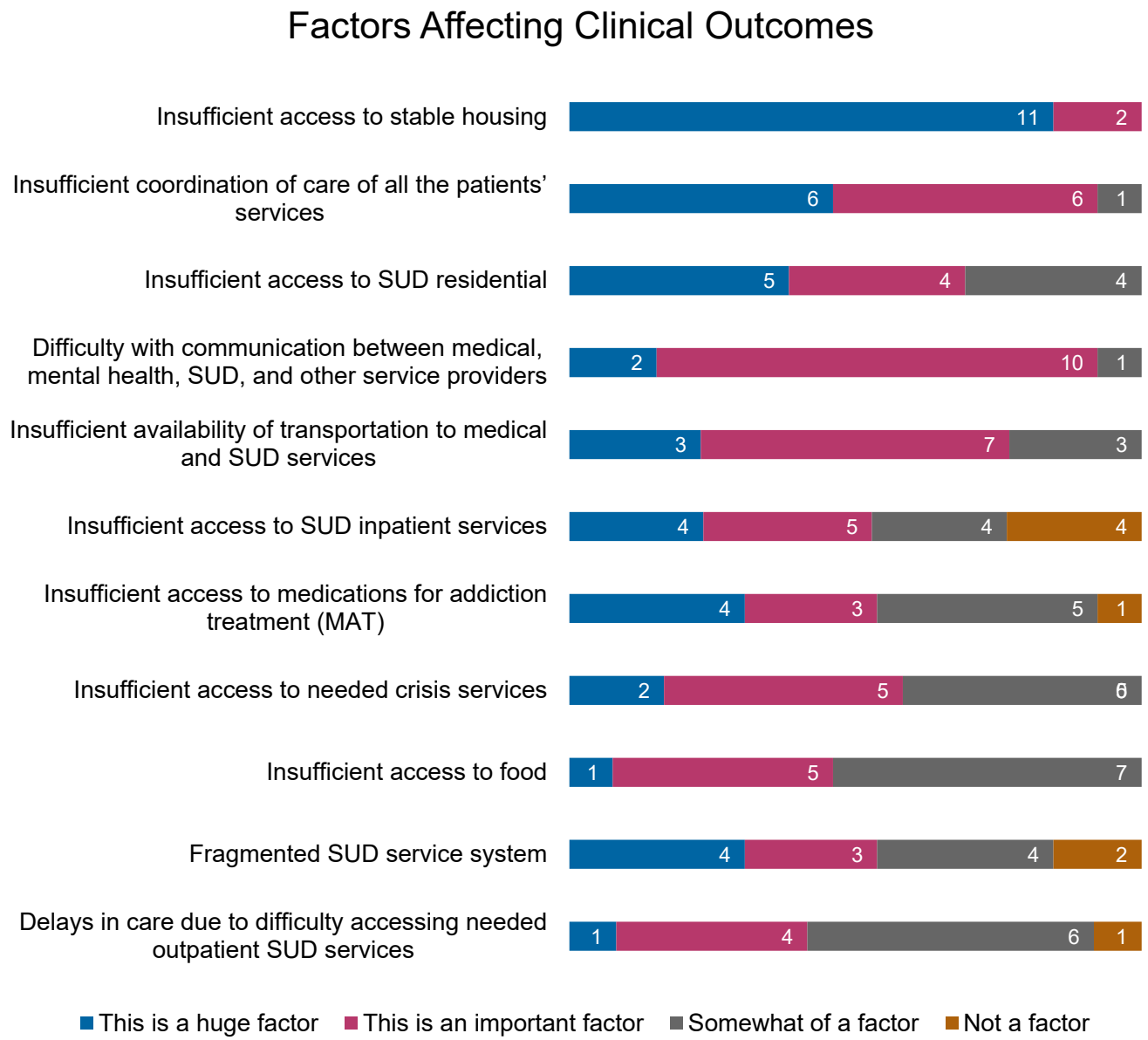
Figure 1. SUD System Access Barriers, Ranked from a List of Six



2. **What are the top factors that lead to reduced OUTCOMES in the SUD system?** (Ranked from a selected list of 11.)

The top factor leading to lesser outcomes in the SUD system is **"insufficient access to stable housing**," according to 11 respondents who said it was a "huge factor," and two people described it as an important factor. The factor ranked as least significant was "delays in care due to difficulty accessing needed outpatient SUD services," and only one person ranked it as a huge factor and one person as not a factor at all.

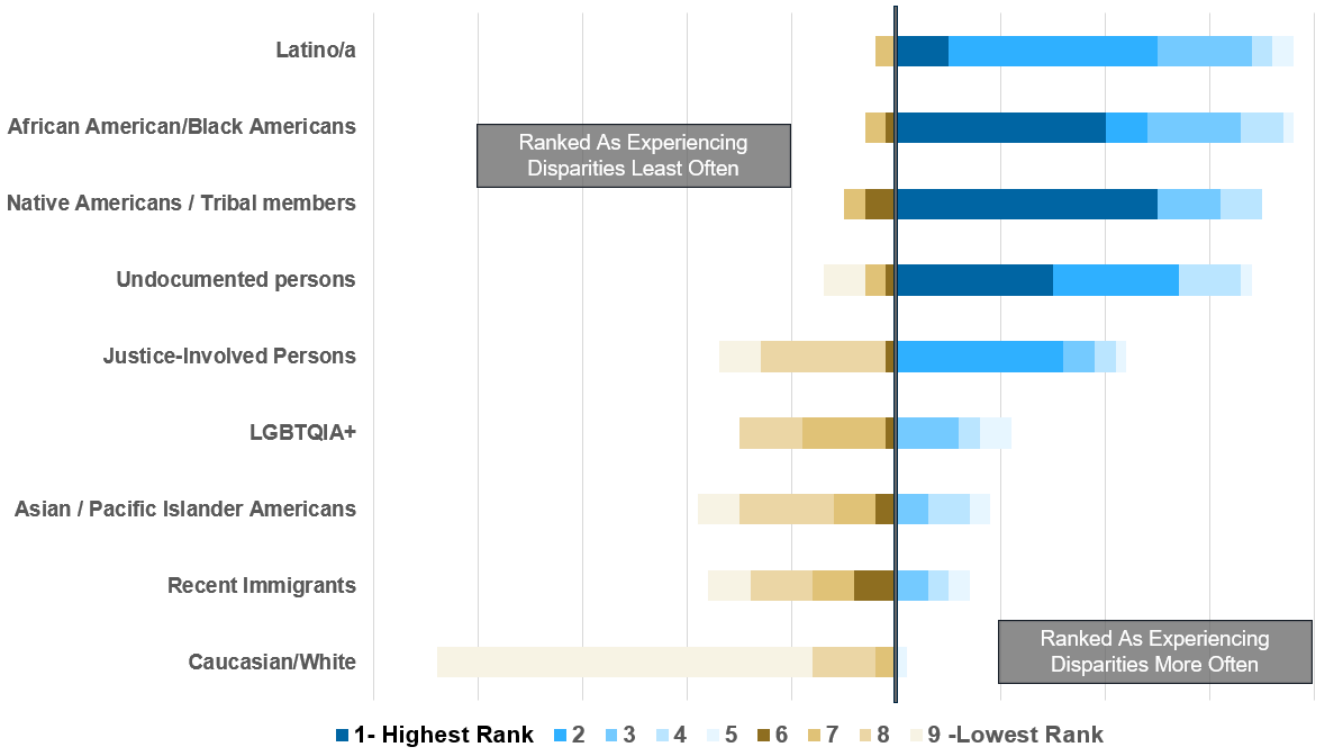
Figure 2. Factors Leading to Reduced Outcomes, Ranked from a List of 11



3. **How would you rank the top service GAPS by population?** (Ranked from a selected list of nine.)

   From a list of various population groups (Latine, African American/Black, Native American/Alaska Native, undocumented persons, justice-involved people, LGBTQIA+, Asian/Pacific Islander, recent immigrants/New Americans, White), participants ranked the following as the populations that experience the greatest service disparities: **Latine/Hispanic** and **African American/Black**. The White population ranked as having the least service disparities.

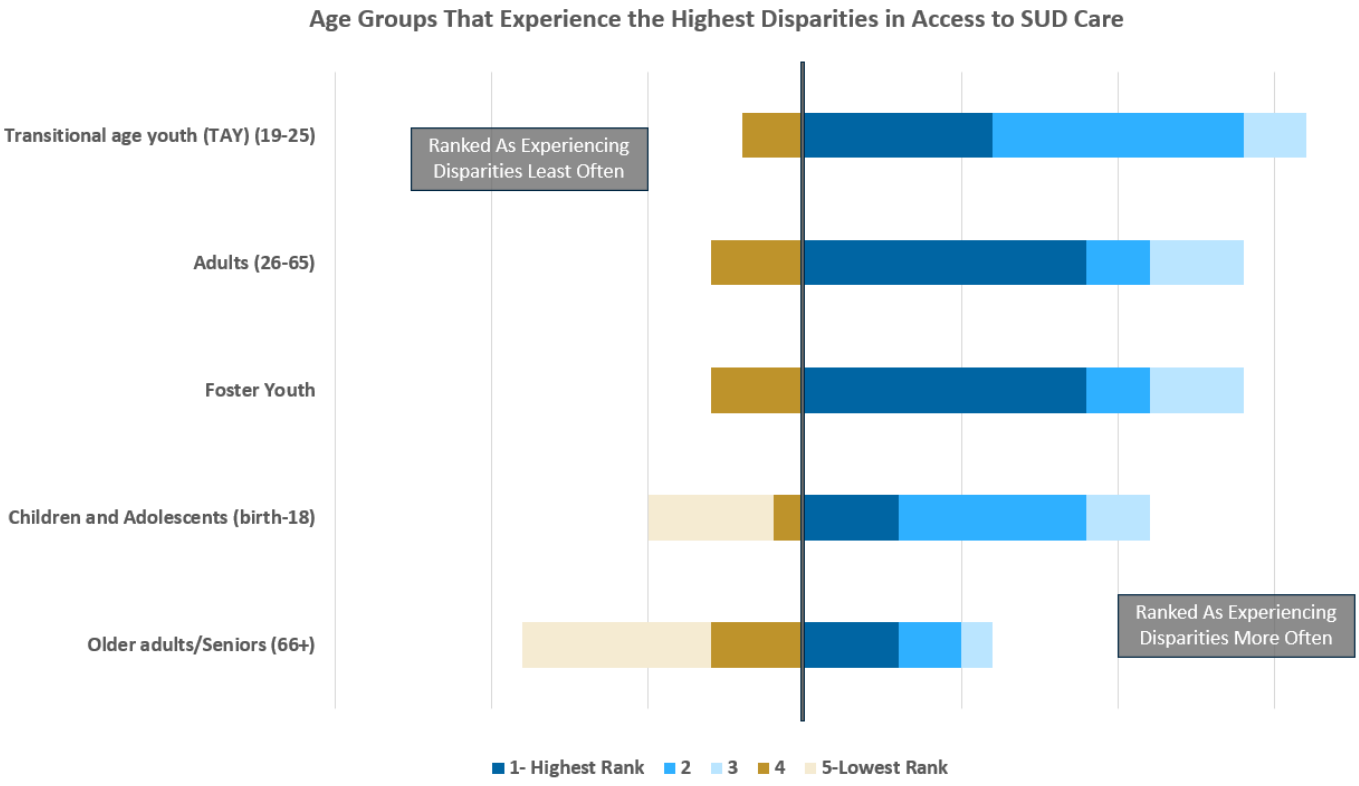
Figure 3. People Experiencing the Highest Disparities in Access to SUD Care, Ranked from a List of Nine



4. **How would you rank top service GAPS by age groups?** (Ranked from a selected list of five)

   From a list of five population groups (children, transitional youth ages 18−25, foster youth, adults, and older adults) participants ranked **transitional age youth** as having the highest service gaps. Older adults/seniors were ranked as having the lowest service gaps.

Figure 4. Populations with the Highest Service Gaps by Age Group



HMA Subject Matter Expert Focus Group

HMA coordinated a 60-minute focus group with three HMA subject matter experts (SMEs) in SUD. Specifically, we solicited their input on innovations in SUD care, including specific opportunities under California's BH transformation to highlight innovations in care integration and movement toward evidence-based models of care, harm reduction, and enhancing treatment services.

According to our SMEs, key opportunities for reaching 95 percent of the individuals with SUD needs include strategies to improve access (e.g., extended service hours, changing workflows), reduce barriers to evidence-based care, education about medications for opioid use disorder (OUD) and alcohol use disorder, ensure all prescribers and BH providers can bill for services, integrated systems to minimize navigational challenges, and information sharing. They pointed to Illinois's Medication-Assisted Recovery model, MAR NOW,[49] as an example of mechanism for increasing 24/7 treatment access and harm reduction for people with OUD. It includes immediate connections to treatment via telephonic prescription and home induction on buprenorphine or same-day appointments for methadone, buprenorphine, or naltrexone. MAR NOW also connects clients to withdrawal management and residential treatment and assists with insurance enrollment and connection to other BH supports as needed.

In addition to MAR NOW, our SUD experts highlighted the need to codify effective programs and support their expansion and/or sustainability, including several California programs, such as California Bridge, contingency management for stimulant use disorder, peer services for outreach to justice-involved people, community reinforcement approach, and evidence-based psychotherapy for mental illness, such as cognitive behavioral therapy. They noted that different evidence-based practices (EBPs) work best for different populations and the need to financially incentivize different levels of care to promote continuity of care. A clearinghouse for evidence-based practices (EBPs), with incentives for providers to use them and demonstrate outcomes, can support investments to build workforce competency. Variations in SUD care are noted, with Federally Qualified Health Centers (FQHCs) across the state viewed as doing a "pretty good job across the state" (e.g., San Diego, Santa Clara, Santa Cruz Counties).

Blue Shield of California's efforts related to intimate partner violence was cited as an example of innovation in grantmaking, with a focus on strengthening economic security and mobility, preventing and promoting healing from childhood exposure to domestic violence, and increasing alignment between systems and community priorities.

HMA's SMEs suggested that state, county, and local efforts target:

- Building knowledge:
    - Use education to illuminate the role of cannabis in fueling mental health challenges
    - Address stigma and rebrand child protection services to address maternal SUD
    - Educate people about the impact of SUD and educate them about the availability of treatments, especially in Tribal, Black/Brown, and LGBTQAI+ communities
    - Highlight where generational SUD, poverty, and racism intersect to inform policies and interventions for low-barrier care to combat discrimination, stigma, and access challenges
- Address regulations that interfere with providing quality care; work with policymakers to address these issues

- Enhance data transparency:
    - Improve data transparency (including data outside of DMC-ODS) to monitor and enforce the delivery of evidence-based medications among SUD providers, many of whom continue to practice an abstinence-only model despite state mandate to include lifesaving medications
    - Using data to determine reimbursement to incentivize innovation and improved outcomes
- Improve workforce competency and expansion:
    - Establish a clearinghouse of EBPs for SUD and other populations with BH needs
    - Support EBP training and incentivizing its use
    - Build and expand the network of care navigators (e.g., peers, community health workers) who can support treatment initiation and recovery
    - Provide funds to support incentives and mentorship to attract diverse staff from underserved communities
- Build the infrastructure:
    - Develop and support the external infrastructure to support provider agencies with neither the time nor the capacity to build internal workforce infrastructure, even if funded
    - Target funds to address gaps in SUD services (with a focus on care transitions and building out levels of SUD care, expanding scope of services), including ways to leverage existing initiatives, payment reform and incentives to tie quality care with payment and outcomes.

Key Stakeholder Interviews

HMA interviewed key stakeholders to gain a deeper understanding of the SUD landscape in California. Table 2 below outlines the key themes from these interviews.

Table 2. Key Themes Identified in Key Stakeholder Interviews

Question	Themes
1. What restricts comprehensive care for people with a SUD?	• Prospective clients experience stigma from society (i.e., fear of reprisal and loss of social and economic status for admitting they have a problem and entering treatment) as well as providers (i.e., many providers do not want to provide medication for opioid use disorder). • Social drivers of health (SDOH) barriers, including limited transportation (rural populations and lack of providers in rural areas), housing, technology (no cell phone, lack of computer/internet access for telehealth). • Siloed treatment system—historical, regulatory, and payment barriers between primary care and MH treatment systems (lack of communication between systems). • Payment structures with continued low levels of reimbursement for SUD disorder treatment (not funded as other health providers), limited state funding, lack of payment from commercial insurers. • Insufficient number of highly trained providers/residential beds.

Question	Themes
2. What are the innovative models of care you are aware of in your community or elsewhere?	• Incorporation of harm reduction principles into all levels of treatment and as a treatment engagement strategy. • Use of contingency management within treatment services. • Collaboration with diverse communities (e.g., Tribal, Latine communities). • Use of community health workers (CHWs) and peers to provide low-barrier care. • Collaboration with Sheriff's departments. • Creation of sobering centers.
3. Where do you see innovative workforce models in your community or elsewhere?	• The inclusion and integration of peer support service models has been beneficial. • Community health worker model is helpful in all different levels of care. • Building a workforce pipeline through colleges and universities can help improve workforce challenges. • Expanding the availability of high-quality trainings for staff can improve quality of care (e.g., harm reduction, peer supports, SUD counselors, cultural competency, stigma training).
4. I'd now like to get your observations around the move toward paying for value rather than volume. This means that payment needs to be conditioned on quality performance.	• Standards for SUD organization certification, licensing and training for SUD providers are needed. • Supports are needed to bridge the gap between payment reform and implementation of SUD care continuum. • Levers for building SUD continuum: Opportunity to leverage payment reform through incentives and capacity building, including electronic health records, patient tracking mechanisms, and data exchange infrastructure to promote integrated, coordinated, and seamless care. • Accountability for SUD care quality is needed, including defining and reporting meaningful metrics of the value of SUD care, beyond changes in substance use.
5. Where are the gaps/opportunities to develop the full continuum of care in your community from prevention and harm reduction to treatment and aftercare? In particular, can you speak to opportunities to improve care transition services (thinking about stimulants and opioids)?	• Enhance capacity building. • Address SDOH, especially lack of affordable housing in the community. • Provide greater investments in harm reduction, early intervention, and prevention. • Improve and connect the transitions of care/ strengthen connections between primary care, MH, and SUD care (e.g., warm handoffs, successful discharge plans, streamlined referrals)

Question	Themes

6. Where do you see effective cross-sector collaborations in your community?	• Effective cross-sector collaborations varied significantly across interviews with no cross-sector collaboration consistently being reported as effective. Most often, the following cross-sector collaborations were reported as being strong:
	  ○ Collaboration with justice programs
	  ○ SUD and MH providers (though integrated delivery of treatment for co-occurring SUD was not mentioned)
	• The following areas had varying cross-sector strength depending on the interview:
	  ○ Behavioral health agency and school partnerships
	  ○ Behavioral health agency and child welfare
	  ○ Physical health providers
	• Interviewees largely indicated significant systemic fragmentation with a significant need for cross-sector collaboration:
	  ○ Behavioral health agency collaboration with county nonprofit providers
	  ○ Behavioral health agency collaboration with physical healthcare providers, including hospitals/EDs
	  ○ Harm reduction
	  ○ Integrated, whole-person care
	  ○ SDOH

7. From your perspective, what is/has been the impact of state requirements and initiatives? (e.g., DMC-ODS, administrative integration of MH/SUD, various CalAIM initiatives, etc.).	• State initiatives are broadly viewed as a positive direction toward building a behavioral health continuum of care.
	• Implementation challenges associated with:
	  ○ State rollout of initiatives and need for more infrastructure and support to optimize rollout
	  ○ Payment reform and adequate funds to support infrastructure associated with greater requirements of initiatives (e.g., DMC-ODS, harm reduction efforts, etc.)
	  ○ Workforce availability, readiness, and competency, especially among the SUD counselor workforce
	  ○ Role of commercial and public insurance in paying for SUD care
	  ○ Attention to underserved populations, which vary by community

DISCUSSION OF FINDINGS

Comprehensive Care

Many themes emerged from the interview responses to the query on restrictions to providing access to comprehensive SUD care. Dominant themes included those of social and provider stigma, SDOH barriers, lack of integrated care, lack of comprehensively trained clinical staff, and limited payment models.

When discussing the role of **stigma** in reducing access to comprehensive care, respondents reflected on prospective patients' fear of ostracism from employers and their community. Many of these respondents described how clients who are unable to achieve abstinence, or do not want it as a goal, feel unwelcome in treatment environments. In addition, respondents indicated that many providers in the behavioral health workforce are reluctant to treat individuals with SUDs and are unenthusiastic about engaging them in treatment.

> "Most psychiatrists and doctors do not want anything to do with medications for addiction treatment (MAT)." – Stakeholder interviewee

The SDOH barriers most mentioned included **transportation**, particularly in rural areas, and **unstable housing**. Respondents reflected on how difficult it is for clients to engage in care when they are unhoused, as well as the lack of well-resourced recovery support housing to ensure ongoing recovery.

The continued **siloing of the medical, mental health, and SUD treatment systems** was consistently mentioned as a significant barrier to comprehensive care. Respondents discussed how clients have difficulty accessing care that addresses all their treatment needs, which often leads to certain areas of their health being neglected. Many individuals who could be screened for SUD in primary care settings are not, thereby creating a missed opportunity to provide low-barrier care.

Another barrier, according to interviewees, is the **lack of an adequately trained co-occurring disorder workforce**. "[The workforce] is not adequately trained to do what we need them to do," said one stakeholder. Respondents reflected on how the cost of living outpaces salaries in many communities and how the behavioral health system is competing for qualitied entrants into the field.

A final barrier mentioned centered on the **payment and reimbursement structures for the SUD system**. A recurrent theme was the disparity in reimbursement between medical and behavioral health. "The level of reimbursement is still not at the level of physical care. That is a barrier, and the counties cannot meet the level of care," one stakeholder said. The current payment model of funding limited residential stays also was mentioned.

Innovative Models of Care

Respondents were eager to share their experiences with innovative treatment models in their communities. Specific models that were frequently referenced include harm reduction, implementation of contingency management, recovery residences and sobering centers, and collaborative models with community health centers.

Stakeholders were in favor of innovative **harm reduction strategies,** and respondents discussed advocating for safe consumption sites, distribution of fentanyl test strips, and community vending machines with Narcan. Harm reduction encompasses a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use.

Many individuals also discussed positive examples of **contingency management strategies**, which provide incentives for people in recovery to stay with the program. Contingency management refers to a type of behavioral therapy in which individuals are "reinforced," or rewarded, for evidence of positive behavioral change. "The outcomes we achieved—we have over 1,000 medical members—it is showing positive outcomes and few dropouts. Some of the stories that we are hearing is folks are saving up their money to buy furniture or gifts for family," one stakeholder said. Respondents often strongly advocated for increased funding and regulatory reform to allow for continued innovation and use of contingency management models.

Other respondents discussed innovative collaborations with Sheriff's departments to open sobering centers.

Innovative Workforce Models

In interviews concerning innovative workforce models, several notable themes emerged, which particularly emphasized the integral roles of peers, CHWs, robust workforce pipelines, and establishing high-quality training and certification programs for staff. Interviewees frequently highlighted the success of workforce models that prioritize the integration of **peer support specialists** who bring invaluable lived experience.

Another recurring theme involved the effective use of **CHWs** to bridge gaps between healthcare systems and local communities. Moreover, interviewees frequently emphasized the importance of investing in **workforce pipeline development** initiatives that focus on training and supporting individuals who are interested in pursuing careers in behavioral health and SUD treatment by providing educational opportunities (e.g., internship programs in colleges and universities) mentorship, and career advancement pathways. Finally, stakeholders emphasized the importance of **quality, comprehensive training programs and certifications** for individuals working in the behavioral health and SUD treatment field to ensure that professionals are equipped with the necessary knowledge, skills, and competencies to provide effective care and support to people in treatment and recovery.

> "You must have a workforce that is invested in the community and understands the community."
>
> – Key stakeholder

Improving Quality of SUD Care

Standards for licensing, certification and training: DHCS defines SUD recovery or treatment facilities as entities that provide non-clinical care,[50] which creates perception among SUD providers that they are not healthcare providers. This creates challenges with a biopsychosocial model of care (e.g., do not offer MAT).

Certified community behavioral health clinics (CCBHC) that were developed with guidance from the Substance Abuse and Mental Health Services Administration receive federally funded grants to address the growing and unmet need for delivering and paying for BH care across the country. Though CCBHC clinics in California must meet certification standards, these requirements are not linked to payment incentives, creating a perceived missed opportunity for accreditation of BH providers focused on care quality. The lack of sustainable payment models (e.g., reliance on grant mechanisms like state opioid response funding) creates barriers to providing BH at the levels necessary to meet MH and SUD needs in California.

Infrastructure supports to implement payment reform: Payment reform in California was implemented to pave the way to value-based care. The state has developed payment rates for services to promote sustainability and expand the array of SUD services. Several county BH administrators see payment reform as paramount to moving toward value-based care. Nonetheless, most of these individuals perceive a chasm between mandated requirements associated with payment reform and SUD providers' capacity to meet them. To be responsive to legislation, a foundational infrastructure for building capacity to provide expanded SUD-related services (e.g., perinatal care, youth services, etc.) is considered critical to avoid larger caseloads and overworked staff, which negatively affect care quality. Many stakeholders said focusing on workforce competency was key for improved care quality, with several individuals suggesting a need to measure workforce competency, including a state role to set more robust standards for certification.

Levers for building continuum of SUD services: To date, only one county has leveraged payment reform to incentivize and build capacity among SUD providers. American Society of Addition Medicine (ASAM) criteria are viewed as helpful to drive the development of an SUD service continuum and standardize care levels; however, stakeholders expressed a need for provider training to support effective and evidence-based management of people with complex co-occurring SUD, MH, and medical needs within these levels of care.

> "We need counselors to be more open and trained on it. California has the lowest training requirements. Currently it is 9 hours, and none of it is clinical. It's all law and ethics to become a SUD counselor. They are not adequately trained to do what we need them to do. If it touches anything outside of their scope such as mental health or behavioral health issues, they consider it outside of their scope."
>
> –Key Stakeholder

Data infrastructure and an electronic health record to track care provision are seen as essential to achieving quality metrics, but many BH providers need both financial and IT support to develop effective data tracking systems. California lacks a statewide electronic health record (EHR) exchange system, though a semi-statewide option is being implemented in 25 counties. The path for including SUD data still needs to be developed to promote integrated SUD and MH care. To increase flexibility and reduce administrative burden, DHCS is requiring administrative integration of specialty mental health and SUD treatment services into a single integrated specialty behavioral health program by 2027, with a phased implementation that aligns with other CalAIM BH initiatives.[51] As one stakeholder noted, "The state needs to get serious about integrating SUD and MH."

Stakeholders shared different perceptions about the availability of data on SUD services. Though many of them see challenges to data access, a couple of individuals noted opportunities to track care quality. For example, Medi-Cal managed care plans and FQHCs collect and report SUD-related data (e.g., provision of MAT), providing a mechanism to link data across systems. At the federal level, 42CFR Part 2 continues to be a challenge for effective care coordination and integration that needs to be addressed. State guidance to support such effective information exchange is desired.

Accountability: Defining quality and value of SUD care. Most stakeholders concur on the need to focus on the quality of SUD care and value-based care, but also note the need to "better quantify what value is" and to go beyond changes related to substance use and account for engagement in recovery services. Current quality metrics on the medical side center on OUD and do not translate well to specialty BH care. County BH administrators and providers noted that BH provider agencies need training on how to succeed under a value-based structure, including aligning operations. Several stakeholders noted that the state uses the California Outcomes Measurement System (CalOMS)[52] to collect and report data on SUD treatment services, but this information has yet to be used for accountability purposes. Limited incentives are available for reporting, which leads to "checking off boxes and showing numbers" with little incentive to uncover the value in doing so.

Several county behavioral health directors noted the value of investing in the creation of regional networks or partnerships, especially among small counties, such as HealthForce, for joint accountability and coordination to support common goals. Another idea proposed is creation of a sub-state waiver lookalike that would enable regional capitated work in SUD care delivery.

Developing a Comprehensive Continuum of Care

In exploring the gaps and opportunities to develop a comprehensive continuum of care within the community, multiple themes emerged. Interviewees consistently highlighted the need to **enhance capacity building.** Further, the need for more **seamless transitions of care** across the continuum, emphasizing the importance of facilitating connections between different levels of care and service providers and ensuring individuals smoothly move between prevention, treatment, and aftercare services to avoid interruptions in care efforts was another common theme, as was the need to recognize and address **SDOH**, especially the **lack of safe, stable housing** to support individuals in their care journey. Lastly, interviewees stressed the importance of investing in **harm reduction strategies, early intervention programs, and prevention efforts**.

Cross-Sector Collaboration

In exploring the landscape of cross-sector collaboration within the community, a diverse range of perspectives emerged from interviews. Though no consistent pattern of cross-sector collaboration emerged, certain areas stood out for their effectiveness more often than others. The areas that most commonly were noted as having strong collaboration include:

- Behavioral health and justice programs
- SUD and MH treatment providers

Of note, none of the participants mentioned strong integrated care or service delivery for people with co-occurring SUD and MH needs because as treatment systems continue to be siloed.

Interviews revealed mixed responses regarding the following partnerships:

- Behavioral health and schools
- Behavioral health and child welfare
- Behavioral health and primary care

Overarching themes of systemic fragmentation and the pressing need for enhanced collaboration were prevalent throughout the interviews. The following were identified as areas where improved collaboration was needed:

- Behavioral health collaboration with county nonprofit providers
- Behavioral health collaboration with healthcare providers, including hospitals/EDs
- Harm reduction service delivery
- Integrated, whole-person care collaboration with healthcare providers
- Programs to address SDOH

Interviewees indicated a need for cross-sector care coordinators who would be responsible for connecting and orchestrating care between the many providers often involved in supporting the multifaceted needs of people engaged in BH treatment. Care coordination is necessary to improve the overall treatment experience and outcomes of the individual; however, agencies typically have difficulty retaining people in care coordination positions.

Potential pathways for funding care coordination include having agencies become recognized as enhanced care management (ECM) providers. ECM is a CalAIM initiative to support populations with the highest vulnerabilities. The reimbursable benefit is managed through the managed care plans and is described as follows:[53]

> "ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch and person-centered. DHCS' vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems."

To offer ECM services, an agency must be a CalAIM provider with experience serving the populations of focus. Approval of the request may be dependent on the managed care plan's determination of need in the area the agency proposes to serve. In addition, some providers report a continuing need to increase reimbursement for these services to financially sustain the associated positions.

Participants also noted that workforce concerns contribute to gaps in cross-sector collaboration. When leadership changes occur, established relationships may weaken or stop until the position is filled and the replacement is oriented to the role. Similarly, workforce shortages continue among direct service professionals who often serve in agency and care coordination roles.

Though pockets of effective cross-sector collaboration were identified, the interviewees underscored a broader call for greater cohesion and cooperation among various sectors to reduce silos and address the complex needs of the community more comprehensively. Interviewees noted that having funding for dedicated collaboration and coordination positions would bridge many of the gaps in the system.

Impact of State Initiatives and Requirements

Overall, stakeholders interviewed across the board appreciate the vision and the potential for various CalAIM initiatives to support seamless care, efforts to reorganize the substance use delivery system through DMC-ODS, the forthcoming integration of MH/SUD services,[54] and other SUD-related initiatives, with a focus on:

- Infrastructure investments to expand BH capacity across the continuum, including efforts to reorganize and build the SUD treatment system
- A focus on historically underserved populations and disparity reduction efforts (e.g., via populations of focus under ECM services)
- Payment reform to support the transition to value-based care
- Expand Medi-Cal benefits for SDOH to support medically necessary services that optimize SUD outcomes (e.g., sobering centers, street medicine, etc.)
- Efforts to require coordination between managed care plans and county MH plans to support whole-person care and dismantle traditional silos (e.g., "no wrong door")

They also noted critical challenges with implementation rollout that need to be addressed to realize the benefits of these state initiatives, including:

- State efforts to optimize success:
    - Planning and staging the rollout of numerous BH transformation components to allow systems and counties to prepare, build infrastructure, and develop partnerships (e.g., with law enforcement, courts, others) to avoid eroding community trust
    - Shifting the focus to developing structures and guidelines that support effective implementation of new initiatives with attention to SUD (rather than a focus on timelines and due dates)
    - Supporting counties and SUD providers with limited contracting experience to understand and meet requirements for access to federal and state dollars

    - Engaging with county BH to design legislation and models of care that promotes joint accountability for behavioral health (not just county accountability)
    - Providing expert guidance to support the integration of SUD and MH, particularly with the expected integration of SUD/MH administration
    - Addressing legislative, operational, and clinical barriers to integrating SUD, MH, and physical healthcare
- Payment reform that supports:
    - Adequate funding for DMC-ODS, which has more requirements than DMC
    - Funding for stimulant use disorders (focus on opioids and fentanyl is a mismatch for addressing county SUD needs)
- Workforce competency: Training providers to select and deliver evidence-based SUD care (targeted to population/community need), and capacity to treat co-occurring conditions, especially among the SUD counselor workforce
- Attention to the role of commercial insurance for funding SUD service delivery
- Underserved populations: SUD data on underserved populations that may be community specific, including unhoused populations, to guide service delivery efforts

Key Opportunities to Support Improvements in SUD Care

To enhance the delivery of SUD care in the state, several key opportunities have emerged through discussions with interviewees. These opportunities span various domains, reflecting both the challenges facing the care delivery system and the potential avenues for impactful innovation.

Investment in the workforce was discussed most frequently during interviews. Addressing the shortage of licensed clinicians and SUD counselors, as well as integrating peers into the care continuum, stands as a pivotal opportunity to increase access to care. One interviewee described the impact of the workforce shortage stating, “We are positioned to…meet the service demand in the community, but we don’t have the workforce to do that. [And] we don’t have the appropriately trained workforce to do that.”

Initiatives focused on incentivizing professionals, fostering skill development, and recruiting staff and clinicians reflective of California's diverse population were deemed essential. Interviewees also suggested development of initiatives that would engage youth early in BH careers to build a workforce pipeline and prevent future workforce shortages.

Respondents cited a significant **need for more residential treatment services and housing** options for people with SUD, especially for transition age youth. Further investments could include subsidizing the first month of rental assistance for individuals who need sober living after completing treatment.

The need for increased access and training around harm reduction was another frequently mentioned need. Interviewees described a system in which stigma regarding harm reduction has decreased, but where training and access to harm reduction remains a barrier. Providers want to have support for initiatives such as contingency management, liberating methadone, establishing safe consumption sites, and expanding MAT to include alcohol use disorder. Respondents also highlighted a need to increase Narcan distribution and improve access to MAT in EDs and via street kiosks.

Respondents indicated a need to better integrate MH and SUD treatment to develop a system truly capable of delivering care for co-occurring disorders. California continues to have a bifurcated MH and SUD treatment system, which leads to duplicative efforts that can be retraumatizing to the person served and causes misuse of staff time.

National models of best practice, including the ASAM guidelines, clearly define effective care for co-occurring MH and SUD concerns as being offered concurrently by the same treatment providers to minimize duplication. As one interviewee stated, “A lot of the providers are co-occurring capable, but we need co-occurring enhanced.”

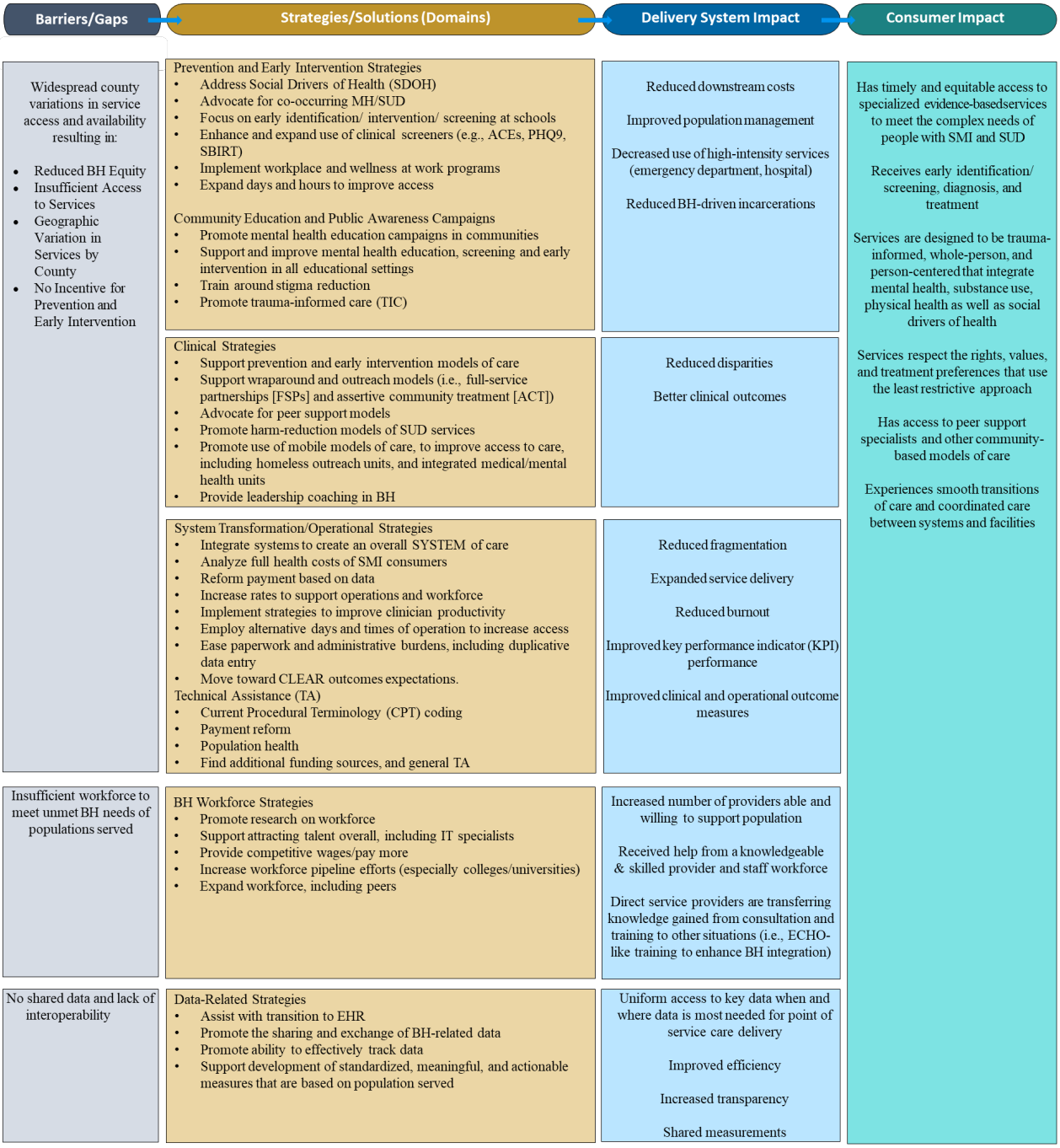
People served were described as needing better integration and coordination of care overall. Interviewees suggested options such as providing funding for formal care coordination positions. Federally funded programming across the country supports this best practice, including the nationwide BH transition toward the CCBHC model that many states are adopting. Care coordination is a primary focus of the CCBHC model, including coordination with hospitals and EDs; however, at this time, CCBHC presence in California is limited.

Interviewees indicated that the workforce would benefit from improved training in EBPs. Interviewees identified several promising approaches that could positively affect the state, such as: contingency management, dialectical behavior therapy, interpersonal psychotherapy, and specialized treatment for youth with SUD. Interviewees noted that several standard EBPs have been found to be less effective for non-White populations, so respondents were interested in receiving training in culturally responsive screening and interventions.

Respondents also indicated a need for improved data literacy. Interviewees indicated that their BH organizations needed support and technical assistance regarding how to track and use data to support continuous quality improvement. This area of practice often receives limited support through standard program finances but is critical to understanding program performance and ongoing agency and community needs.

SHARED SOLUTIONS FRAMEWORK

A Shared Solutions Framework for Improvements in Specialty Mental Health and Substance Use Disorder



ABOUT HEALTH MANAGEMENT ASSOCIATES

Founded in 1985, Health Management Associates, Inc. (HMA), is a leading independent, national research and consulting firm with office locations in 30 states/US territories and more than 700 consulting colleagues across all HMA companies. HMA consultants bring expertise that spans the health and human services environment. We support our clients through technical assistance and training, facilitation and strategic planning, research and evaluation, policy development and recommendations, technical report writing, and analytical services with a focus on improving the administration and delivery of public health, healthcare, and social services programs. Dedicated to serving populations who use publicly funded services, we assist federal, state, and county human services agencies, policymakers, providers, health plans, foundations, community-based organizations, and communities in navigating the ever-changing healthcare and human services environment.

ENDNOTES

[1] California Health Care Foundation. The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions. *Issue Brief*. August 2016. Available at: https://www.chcf.org/wp-content/uploads/2016/08/CircleMediCalMentalHealth.pdf.

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