SUD Agencies – 10 Things To Focus On In 2024 & Beyond

All Treatment Provider Meeting – 01/09/24

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1. **SAPC's Ongoing Evolution to Better Support the Specialty SUD System**
2. **The Next Phase of Payment Reform**
   - Strengthening Data at the Provider-Level to Prepare for Value-Based Reimbursement (VBR)
3. **4th Edition of the ASAM Criteria**
4. **Meaningful MAT Expansion**
5. **Meaningful Co-Occurring MH & SUD Service Delivery**
6. **Behavioral Health Administrative Integration**
7. **Planning for Implementation of Involuntary SUD Care (Senate Bill 43)**
8. **Understanding Your/Our Workforce**
9. **Reaching the 95% (R95) Initiative**
10. **Growing Our Solutions-Focused Advocacy & Legislative Voice**

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SAPC recognizes that its ability to support its provider network depends on its own development and organizational improvements

i. Added medical leadership to SAPC to support a biopsychosocial system of care
ii. Strengthened data infrastructure and data- and client-informed decision-making
iii. Enhanced fiscal strategy – moving from transactional to strategic approaches
iv. Enhanced focus and investment in the full continuum of SUD services (prevention, harm reduction, treatment & recovery)
i. Ongoing technology investments (SBAT, ASAM CONTINUUM, RecoverLA, LANES, HIDEX, etc)
ii. Transitioning to more quality-focused compliance activities
iii. Strengthening technical assistance for agencies
iv. Strengthened legislative and statewide regulatory and policy voice (i.e., AB 2473 was first bill SAPC has ever sponsored with the County and passed)

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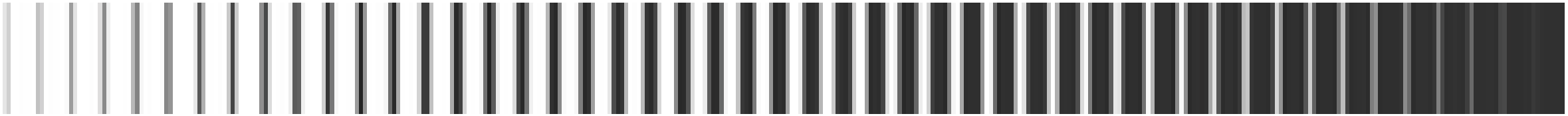
Being Successful with the Current Fee-for-Service (FFS) Reimbursement Environment

- Become experts in the costs required to operate your agency well & the revenue your services generate – these are two critical data points you will need to track closely to thrive in a FFS environment.
- Costs and revenue are also the variables that are most under your agency's control to modify to ensure financial sustainability.
  - Identify and address gaps/opportunities leading to financial leakage (insufficient clients, insufficient staff to see clients, high denial rates, etc.) to optimize revenue opportunities.
  - Analyze your costs to ensure they are necessary and appropriate. However, it is important to realize that cost-cutting that results in decreased revenue generation may not ultimately support financial sustainability.

Behavioral Health (BH) Payment Reform

Value-Based Reimbursement
(various arrangement types)

Cost-Based Reimbursement | Lesser of Costs or Charges | **Fee-For-Service** | Bundled Payments | Shared Savings | Shared Risk | Accountable Care Organizations | Global Capitation



The PAST:
Transition from Pre- to Post-DMC-ODS

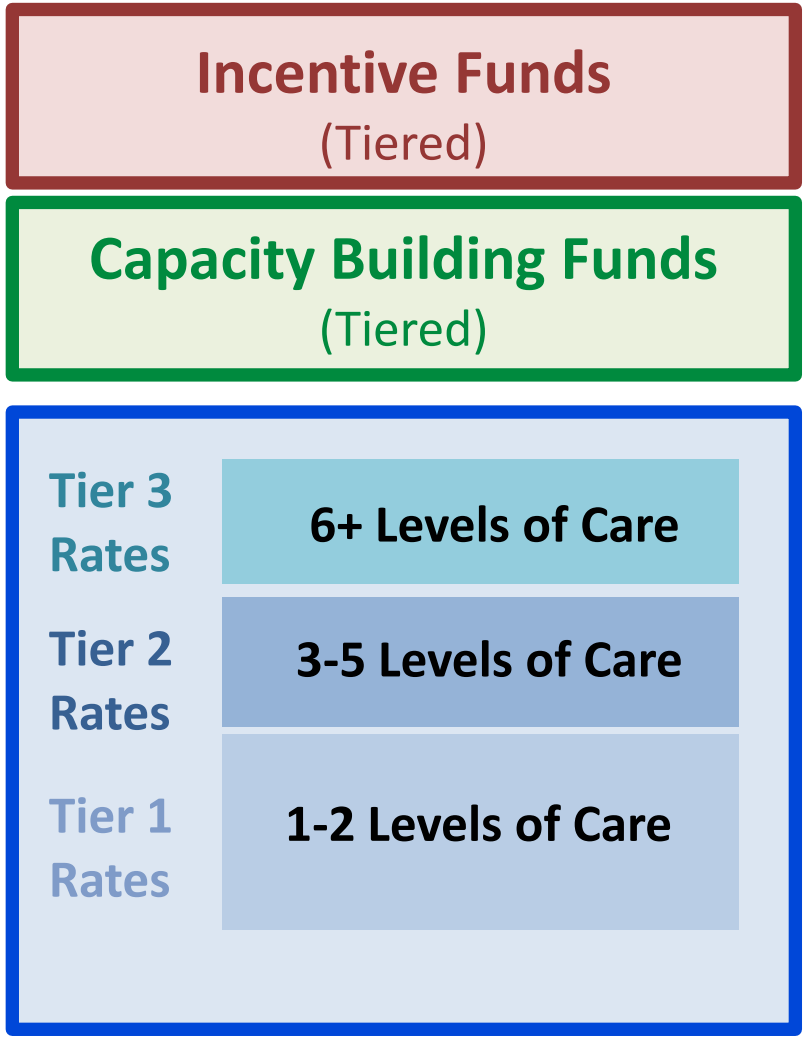
The PRESENT:
Transition from DMC-ODS to BH Payment Reform under CalAIM

The FUTURE:
Transition from FFS with incentive payments based on quality benchmarks, to some form of value-based reimbursement (likely capitation per DHCS)

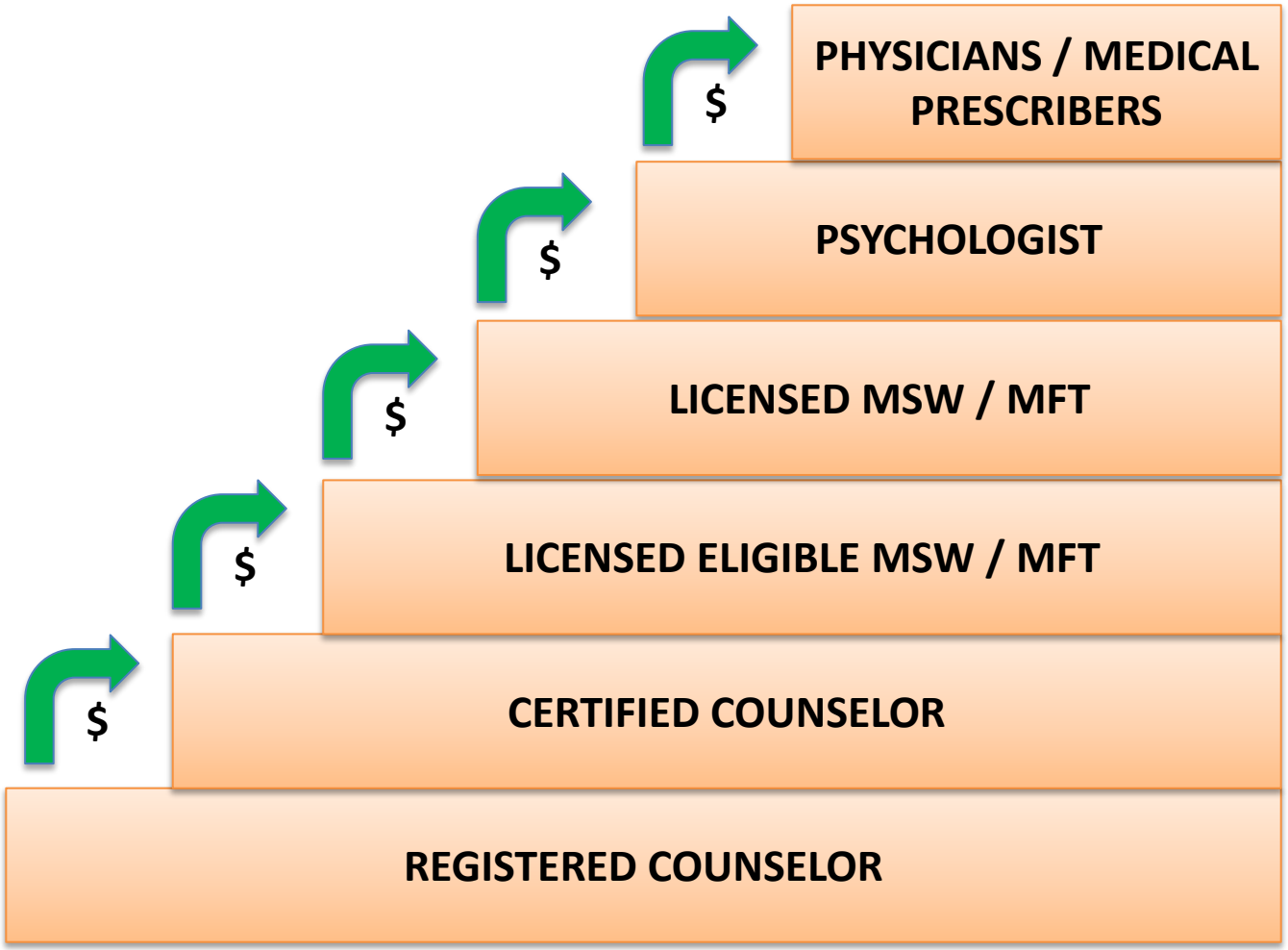
SAPC's Payment Reform Rate Structure

Tiered:

1. Base Rates
2. Capacity Building Funds
3. Incentive Funds



Practitioner Level Rates – Non-Residential Settings



Practitioner level rates will increase based on practitioner type

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Preparing for the future transition to value-based reimbursement

- Establish processes to optimize organizational alignment and execution – if there are incentive payments for quality metric "X" and provider leadership would like to draw down that incentive payment, what would need to happen in your organization to operationalize that desire?
- Identify ways to optimize outcomes now, before value-based reimbursement is implemented, to best prepare for this goal in the future (leveraging MAT, case management, addressing housing and other social determinants of health, etc.).

KEY GOAL OF THIS FFS PERIOD OF PAYMENT REFORM: Collecting and learning how to use your fiscal and operational/clinical data to inform your agency's decisions on practice and process

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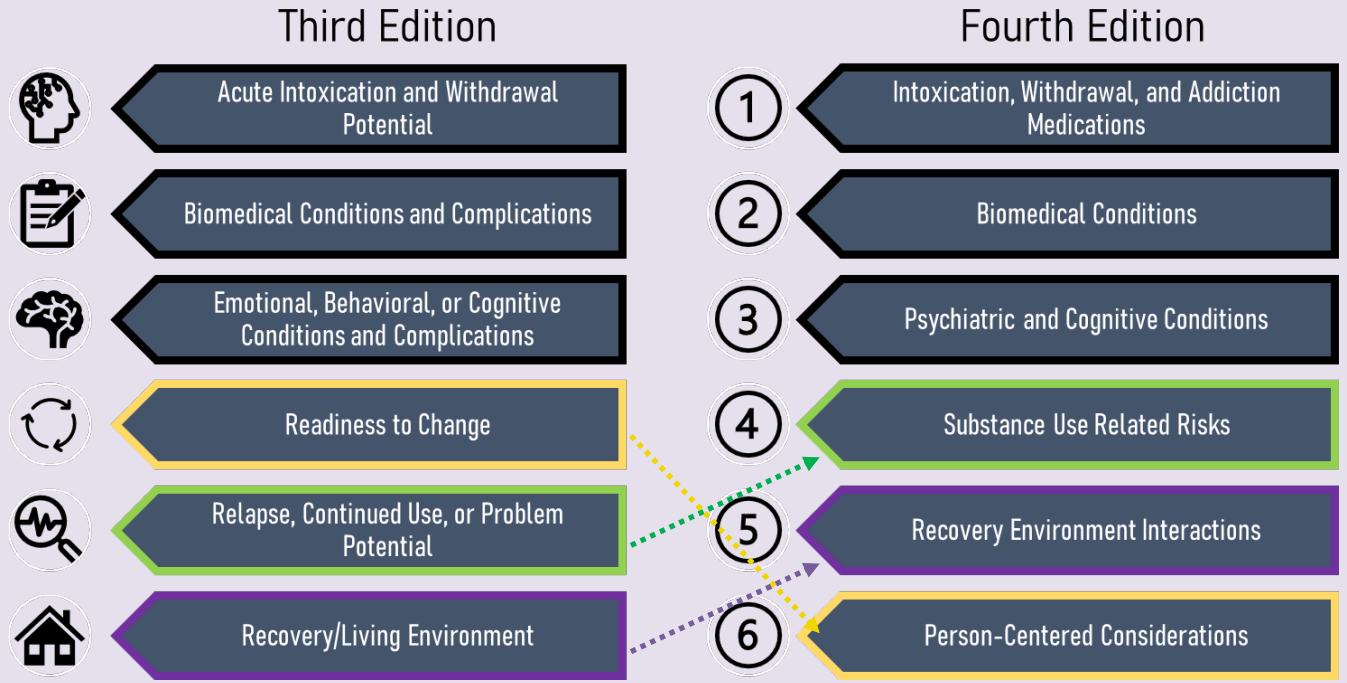
Reordering of the 6 Dimensions of the 4th Edition of ASAM Criteria



- Readiness should be considered across all dimensions and does not independently contribute to initial treatment recommendations.
- New Dimension 6 focuses on patient preferences, barriers to care, and need for motivational enhancement.

Source: ASAM

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6 Dimensions of the 4th Edition of ASAM Criteria

Dimension 1: Intoxication, Withdrawal, and Addiction Medications

- Intoxication and Associated Risks
- Withdrawal and Associated Risks
- Addiction Medication Needs

Dimension 2: Biomedical Conditions

- Physical Health Concerns
- Pregnancy-Related Concerns
- Sleep Problems

Dimension 3: Psychiatric and Cognitive Conditions

- Active Psychiatric Symptoms
- Persistent Disability
- Cognitive Functioning
- Trauma-Related Needs
- Psychiatric and Cognitive History

Dimension 4: Substance Use-Related Risks

- Likelihood of Engaging in Risky Substance Use[1]
- Likelihood of Engaging in Risky SUD-Related Behaviors[2]

Dimension 5: Recovery Environment Interactions

- Ability to Function Effectively in Current Environment
- Safety in Current Environment
- Support in Current Environment
- Cultural Perceptions of Substance Use and Addiction

Dimension 6: Person-Centered Considerations

- Barriers to Care
- Patient Preferences
- Need for Motivational Enhancement

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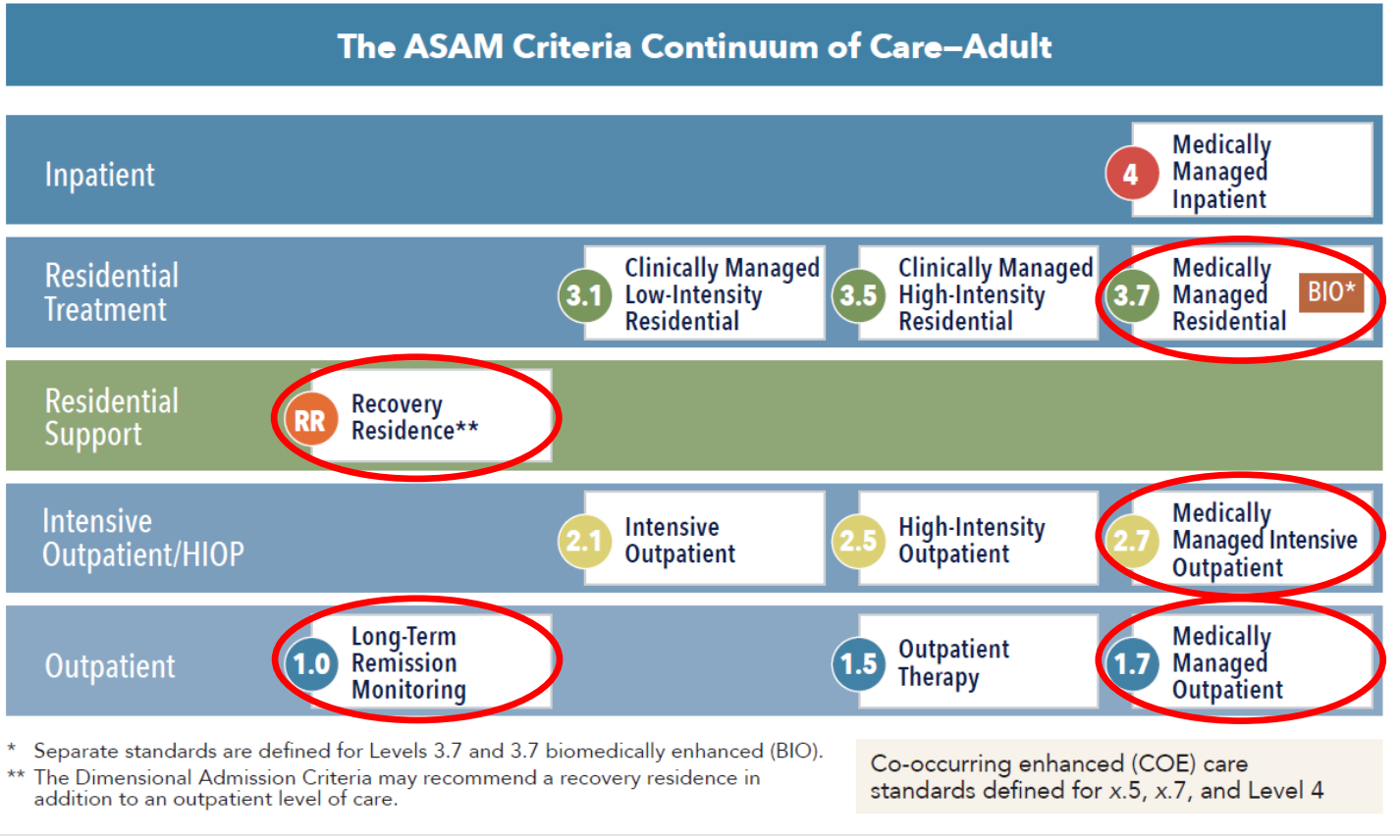
Levels of Care of the 4th Edition of ASAM Criteria



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- **All <u>medically</u> managed levels of care** can initiate all FDA-approved medications
- **All <u>clinically</u> managed levels of care** can support continuation of any FDA-approved medication
- **All settings should be co-occurring capable**, at a minimum

Highlights of Level of Care Changes

- **Level 1.0 – Long-Term Remission Monitoring**
  - Recovery management checkups and rapid re-engagement in care, when needed
- **Level 1.5 – Outpatient Treatment**
  - Less than 9 hours per week of psychosocial services
- **Level 1.7 – Medically Managed Outpatient Treatment**
  - Encompasses Level 1-WM from 3rd edition
  - Incorporates low threshold medication initiation
  - Able to provide psychosocial services equivalent to Level 1.5
- **The ".7" levels of care → Integrating withdrawal management and biomedical care in the continuum of care**
  - Level 1.7: Medically Managed Outpatient Treatment
  - Level 2.7: Medically Managed Intensive Outpatient Treatment
  - Level 3.7: Medically Managed Residential
    - Level 3.7 BIO has advanced biomedical capabilities including intravenous (IV) fluids and medications, as well as advanced wound care
  - Level 4: Medically Managed Inpatient

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Integrating Co-Occurring Capability

- **All settings should be co-occurring capable, at minimum, and:**
  - Be designed with expectation that most patients have co-occurring conditions
  - Have the ability to manage mild to moderate MH acuity and/or functional impairment
  - Have at least one staff member qualified to assess and triage MH conditions
  - Have Problem Lists or Treatment Plans that are integrated that address multi-dimensional and individualized needs of clients
  - Coordinate with external mental health providers, as needed
  - Include program content that addresses co-occurring conditions

Source: ASAM

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Best practice for modern SUD care is biopsychosocial treatment

- Bio = medical care (MAT, etc)
- Psycho = psychological and behavioral health care (counseling, therapy, etc)
- Social = addressing social determinants of health (housing, etc)

While SUD agencies have traditionally been strong in the area of psychosocial SUD treatment, medical aspects of care have been a needed area of improvement.

Actions needed for specialty SUD providers to more meaningfully provide more MAT and biopsychosocial SUD treatment:

- Ensuring medical leadership are involved in decision-making at the agency- and programmatic-level.
- Seeking to not just offer MAT via referral but building the capacity to directly offer it.
- Hiring sufficient medical practitioners to deliver biomedical services (MAT, etc).
- Ensuring SUD counselors and other staff are trained on and familiar with MAT, its indications, and how to talk to clients about it.

SAPC's aim is to eventually have all of its sites directly offering MAT as well as counseling, the same way how all diabetes clinics offer medications for diabetes as well as behavioral therapy.

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The integrated behavioral health goal of CalAIM requires specialty SUD systems to better serve people with mild to moderate MH conditions (and specialty MH systems to better serve people with SUD), which means:

- Eliminating policies that deny SUD treatment based on MH diagnoses (given that diagnoses are different than level of acuity).
- All SUD settings should be staffed with sufficient clinicians capable of providing co-occurring services for people with co-occurring mild to moderate MH conditions.
- Often, treating MH diagnoses will also benefit someone's SUD condition – documenting how this is the case is how reimbursable integrated behavioral health services can be provided within our current Medi-Cal specialty systems.

The 4th Edition of the ASAM Criteria will require co-occurring capability in all settings

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LA County is the only county in the State where its SUD system is under a different Department than the specialty MH system

- This can either be a strength or a weakness, as client-level BH care integration (which should be the key goal of BH Admin Integration) does not require that services be delivered under a single Department.

CalAIM already allows specialty MH and SUD services to be reimbursable across the BH system in CA, whether it be the specialty MH or SUD system.

- **BHIN 21-073**: Clarified that while a diagnosis is needed (e.g., "unspecified," "other specified," or Z codes), a SUD diagnosis is not a prerequisite for access to covered DMC-ODS services and a MH diagnosis is not a prerequisite for access to covered specialty MH services.
- **BHIN 22-011**: Clarified that clinically appropriate and covered DMC-ODS services delivered by DMC-ODS providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring MH condition. The same is true for specialty MH services.
- **BHIN 22-019**: Clarified that services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether specialty SUD or MH access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for specialty SUD s are covered Medi-Cal services whether or not the beneficiary has a co-occurring or MH services.
  - **As long as there is documentation to support how treating a MH diagnoses will also benefit someone's SUD condition, DMC-ODS providers can deliver MH services and be reimbursed through DMC-ODS. Similarly, specialty MH providers could deliver SUD services and be reimbursed through the specialty MH system provided documentation that those SUD services benefit someone's specialty MH condition. This is an example of how reimbursable integrated behavioral health services can be provided within our current Medi-Cal specialty systems.**

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SAPC is working closely with DMH to implement Los Angeles County's approach to BH Admin Integration.

- Initial focuses:
  - Call center integration
  - Quality Improvement Plan integration
  - Cultural Competency Plan integration
  - Data sharing

Key principles of SAPC's approach to BH Admin Integration

1. On-the-ground, client-level BH care integration must be the driving force behind implementation of BH Admin Integration
2. We cannot achieve a robust BH system without a robust SUD system → prioritizing the ongoing growth and support of the specialty SUD system

SAPC's role with SUD leadership, both locally and at the State and national levels, is also an important consideration

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- **Senate Bill (SB) 43 – Expands the definition of grave disability to include when a person, as result of a mental health disorder, severe substance use disorder, or a co-occurring mental health disorder and severe substance use disorder, is unable to provide for their basic needs of food, clothing, shelter, personal safety, or necessary medical care.**
  - Most significant reform to the Lanterman-Petris-Short (LPS) Act since it was enacted in 1967.
  - Most significantly for the specialty SUD system, this expands involuntary care to include people with "severe" SUD and means that people can be placed on 5150's and other involuntary holds based on their "severe" SUD, currently defined as per the most current version of the DSM.
  - There are positive and potentially very negative implications of this, ranging from insufficient capacity and sub-optimal SUD care to patient rights violations that may deter people from disclosing their substance use and expanding treatment gaps.

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- **LPS services need to be provided in facilities specially designated for LPS populations**
  - **LPS facilities**
    - **Facility type**
      - General acute or inpatient psych hospitals
      - Psychiatric urgent care center or crisis stabilization units
      - Skilled nursing facilities
      - Jail inpatient units
    - **Substantially different staffing requirements than what DMC-ODS requires currently (particularly for mental health and medical staff presence).**
- **Implementation of SB 43 will stress currently LPS capacity in MH systems and SAPC will be exploring the feasibility of growing LPS capacity within the specialty SUD system.**

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- **SAPC's Specialty SUD System Workforce Survey – NON-OTPs**

Non-OTP Staff Classification	Total (Agencies = 62)			
	Average+	Range (Min-Max)	Total	% of Total
Licensed Clinician	**8**	**(1 - 67)**	**459**	**24.2%**
Medical Clinicians	3	(0 - 38)	165	8.7%
1. Physician (MD/DO)	1	(0 - 5)	83	4.4%
2. Nurse Practitioner (NP)**	<1	(0 - 4)	13	0.7%
3. Physician Assistant (PA)			0	0.0%
4. Registered Pharmacist (RP)	<1	(0 - 1)	1	0.1%
5. Registered Nurse (RN)**	<1	(0 - 11)	24	1.3%
6. Licensed Vocational Nurse (LVN)**	1	(0 - 23)	44	2.3%
Non-Medical Clinicians	2	(0 - 9)	141	7.4%
7. Licensed Clinical Psychologist	<1	(0 - 2)	9	0.5%
8. Licensed Clinical Social Worker (LCSW)	1	(0 - 6)	54	2.9%
9. Licensed Marriage and Family Therapist (LMFT)	1	(0 - 6)	68	3.6%
10. Licensed Professional Clinical Counselor (LPCC)	<1	(0 - 4)	10	0.5%
License-Eligible Non-Medical Clinicians	2	(0 - 38)	153	8.1%
11. Psychological Associate	<1	(0 - 1)	1	0.1%
12. Associate Clinical Social Worker	1	(0 - 22)	70	3.7%
13. Associate Marriage and Family Therapist	1	(0 - 10)	65	3.4%
14. Associate Professional Clinical Counselor	<1	(0 - 6)	17	0.9%
Certified Counselors**	11	(0 - 94)	682	36.0%
Registered Counselors	11	(0 - 100)	711	37.5%
Peer Support Specialists	1	(0 - 15)	42	2.2%
Overall across non-OTP Network	31	(2 - 199)	1,894	100.0%

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- **SAPC's Specialty SUD System Workforce Survey – OTPs**

OTP Staff Classification	Total (Agencies = 9)			
	Average+	Range (Min-Max)	Total	% of Total
Licensed Clinician	22	(2 - 52)	194	35.1%
Medical Clinicians	19	(2 - 43)	173	31.3%
1. Physician (MD/DO)	3	(0 - 8)	24	4.3%
2. Nurse Practitioner (NP)**	1	(0 - 5)	12	2.2%
3. Physician Assistant (PA)	1	(0 - 5)	13	2.4%
4. Registered Pharmacist (RP)			0	0.0%
5. Registered Nurse (RN)**	2	(0 - 19)	21	3.8%
6. Licensed Vocational Nurse (LVN)**	11	(1 - 26)	103	18.7%
Non-Medical Clinicians	2	(0 - 9)	14	2.5%
7. Licensed Clinical Psychologist	<1	(0 - 1)	2	0.4%
8. Licensed Clinical Social Worker (LCSW)	1	(0 - 8)	9	1.6%
9. Licensed Marriage and Family Therapist (LMFT)	<1	(0 - 2)	3	0.5%
10. Licensed Professional Clinical Counselor (LPCC)			0	0.0%
License-Eligible Non-Medical Clinicians	1	(0 - 3)	7	1.3%
11. Psychological Associate	<1	(0 - 1)	1	0.2%
12. Associate Clinical Social Worker	<1	(0 - 1)	2	0.4%
13. Associate Marriage and Family Therapist	<1	(0 - 3)	4	0.7%
14. Associate Professional Clinical Counselor			0	0.0%
Certified Counselors**	17	(1 - 53)	153	27.7%
Registered Counselors	10	(1 - 23)	93	16.8%
Peer Support Specialists	12	(0 - 112)	112	20.3%
Overall across OTP Network	61	(5 - 228)	552	100.0%

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Summary of SAPC's Specialty SUD System Workforce Data

Non-OTPs

- Are ~75% SUD counselors (which are nearly 50/50 in terms of certified vs. registered)
- Have very little medical LPHA's
- Lean fairly heavily on license-eligible LPHA's; this is where most license-eligible LPHA's are in our system

OTPs

- Are primarily a medical workforce, but mainly medical staff with narrower scopes of practice (LVN's)
- Have very little non-medical LPHA's (social workers, MFTs, psychologists, etc)
- Are relatively lean on SUD counselors

Wages & Benefits

- Wages for registered SUD counselors are barely higher than Peer Support Specialists.
- Pay for all LPHA's is too low as well and will need to go up to compete with MH systems for the same workforce.
- There is more uniformity around SUD counselor pay than LPHA's, which have more variability.
- We need to raise pay across the board, in particularly for AMFT's and ACSW's, as well as their licensed counterparts.
- **Improving salaries and benefits will be essential moving forward, including SAPC's role in supporting these reinvestments in the SUD workforce.**

Looking Forward to 2024 & Beyond – 10 Things To Focus On

1. SAPC's Ongoing Evolution to Better Support the Specialty SUD System
2. The Next Phase of Payment Reform
   - Strengthening Data at the Provider-Level to Prepare for Value-Based Reimbursement (VBR)
3. 4th Edition of the ASAM Criteria
4. Meaningful MAT Expansion
5. Meaningful Co-Occurring MH & SUD Service Delivery
6. Behavioral Health Administrative Integration
7. Planning for Implementation of Involuntary SUD Care (Senate Bill 43)
8. Understanding Your/Our Workforce
9. **Reaching the 95% (R95) Initiative**
10. Growing Our Advocacy & Legislative Voice

"Recovery is about the journey and not the destination" – yet the SUD field has traditionally required people to demonstrate their commitment to treatment and abstinence before accepting them into treatment (essentially requiring someone seeking recovery to be in recovery before they can enter treatment).

- This bar is too high, especially when most people with SUD are not interested in traditional SUD treatment anyways.
- The R95 Initiative seeks to redefine what the SUD field defines as readiness for treatment so that our clients determine their interest and readiness for treatment, as opposed to SUD programs determining their readiness (this is patient-centered care).

While abstinence is absolutely a goal of SUD recovery, it shouldn't be an admission requirement, for the same reasons why primary care physicians don't require someone with diabetes to have their blood sugar under control before accepting them into care.

Low barrier SUD treatment means establishing as few pre-conditions as possible so that the bar for what clients need to do in order to be admitted into or stay in treatment is as minimal as possible.

- Most areas of health care are already low barrier in the sense that there are few medical conditions that require someone to meet pre-conditions to receive treatment.

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Operationalizing low barrier SUD treatment is a core priority for SAPC

- Accepting people into treatment wherever they are on their recovery journey, whether or not they are ready for abstinence
- Demonstrating to people who use drugs – through words, policies, and actions – that we care about them, do not judge them, and will do everything we can to support them wherever they are along their recovery journey
- Ensuring organizational alignment on this commitment to low barrier SUD treatment throughout SAPC's agencies from leadership to frontline staff → requires organizational coordination and dedicated efforts in agencies to establish forums and ways to establish and maintain this alignment
- Figuring out what we can be doing differently to better engage youth (leveraging early intervention, technology, etc.)?

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10. **Growing Our Advocacy & Legislative Voice**

SAPC has grown its advocacy and legislative voice and influence and will continue to advance SUD causes.

- Funding
- SUD workforce
- Obstacles to low barrier care

SUD legislative priorities are unlikely to be advanced by entities other than the SUD system itself

- Legislative success is often unavoidably tied to:
  - The need to identify priorities and be strategic in selecting focus areas
  - Compromise
  - Unified voices (e.g., clients, providers, counties, associations)

“The opposite of addiction is NOT sobriety; the opposite of addiction is connection.”

- Johann Hari, British-Swiss Writer