DMC-ODS Waiver:
Opportunity for Cultural Competency

Cultural Competency Conference
October 23, 2018

William W. Harris, MPS, CCPS, CADC-II
April M. Marier, LCSW, CATC-IV
Kristen D. Duffy, RADT-I
James W. Hill, CCPS, CADC-II
Outline

• Background and History of Waiver
• Previous System of Care
• Conceptual Elements of System Redesign
• Trauma Informed System of Care
• Opportunities for Peer Involvement
• Role of Family Advocates
• Next Steps
Background and History of Waiver
What is DMC-ODS?

- The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of healthcare services for Medicaid eligible individuals with a SUD. The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system healthcare costs.
Essential Elements of DMC-ODS

- Provision of a continuum of care based on ASAM Criteria
- Increased local control & accountability
- Greater administrative oversight
- Creates utilization controls to improve care and efficient use of resources.
- Utilization of EPB in SUD treatment
- Increased coordination with other systems of care
Waiver History

- First submitted to CMS on November 21, 2014
- California DHCS announced federal approval of the State’s Drug Medi-Cal Organized Delivery System (DMC-ODS) on August 14, 2015
- Counties have option to opt-in or opt-out of the DMC-ODS
- Riverside and San Mateo Counties were first counties in California to go live with their plans – February 1, 2017
Previous System of Care
Riverside County System of Care

- 10 County operated Substance Abuse clinics providing prevention, outpatient, and intensive outpatient services
- 16 Contracted Providers located at 50+ sites around the County that provide the balance of service
  - Outpatient/Intensive Outpatient
  - Residential
  - Withdrawal Management
  - NTP/OTP
Services covered previously under State Plan Amendment

• **Services reimbursable under DMC**
  – Outpatient Drug Free (ODF) – group counseling
  – Intensive Outpatient (IOT) – group counseling (perinatal only)
  – NTP (methadone only)
  – Perinatal Residential
  – Individual Counseling Sessions (ODF & IOT)
    – Crisis Intervention
    – Collateral services
    – Other Individual Counseling sessions were not covered
Services covered previously under State Plan Amendment

• Services not reimbursable under DMC and billed to SAPT Block Grant
  – Non-perinatal residential (adult and adolescent)
  – Non-perinatal Intensive Outpatient (IOT)
  – Medication Assisted Treatment (MAT)
  – Case Management
  – Individual Counseling Sessions (ODF and IOT) other than crisis intervention and collateral sessions
    • Family sessions
    • Weekly individual sessions
  – Withdrawal Management (Detox)
Other limitations with State Plan Amendment

- Wait time for county funded residential beds anywhere from 3 weeks to 6 months
- SAPT-BG limited the number of available county funded beds
- Unable to provide therapy with CT
- Aftercare not available
Conceptual Elements of System Redesign
New Elements Reimbursable Under DMC-ODS Waiver

- Multiple Levels of Residential Care based on ASAM
- Multiple Levels of Withdrawal Management based on ASAM
- Multiple Levels of Outpatient Care based on ASAM
- Case Management Services
- Recovery Services (Aftercare)
- Physician Consultations
- Medication Assisted Treatment
- OTP/NTP – expanded drug selection
  - Buprenorphine
  - Naloxone
  - Disulfiram
  - Methadone
# ASAM Levels of Care

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>1.0</td>
<td>Outpatient</td>
</tr>
<tr>
<td>2.1</td>
<td>Intensive Outpatient</td>
</tr>
<tr>
<td>2.5</td>
<td>Partial Hospitalization</td>
</tr>
<tr>
<td>3.1</td>
<td>Low Intensity Outpatient (Clinically Managed)</td>
</tr>
<tr>
<td>3.3</td>
<td>Med. Intensity Outpatient (Population Specific; Clinically Managed)</td>
</tr>
<tr>
<td>3.5</td>
<td>High Intensity Outpatient (Clinically Managed)</td>
</tr>
<tr>
<td>OTP</td>
<td>Opiate Treatment Program (formerly NTP)</td>
</tr>
</tbody>
</table>
## ASAM Levels of Care (cont)

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.7</td>
<td>Intensive Inpatient Services (Medically Monitored)</td>
</tr>
<tr>
<td>4.0</td>
<td>Intensive Inpatient Services (Medically Managed)</td>
</tr>
<tr>
<td>1.0-WM</td>
<td>Ambulatory Withdrawal Management (w/o on-site monitoring)</td>
</tr>
<tr>
<td>2.0-WM</td>
<td>Ambulatory Withdrawal Management (with on-site monitoring)</td>
</tr>
<tr>
<td>3.2-WM</td>
<td>Clinically Managed Residential Withdrawal Management</td>
</tr>
<tr>
<td>3.7-WM</td>
<td>Medically Monitored Inpatient Withdrawal Management</td>
</tr>
<tr>
<td>4.0-WM</td>
<td>Medically Managed Inpatient Withdrawal Management</td>
</tr>
</tbody>
</table>
## Minimal Requirements for DMC-ODS Counties

<table>
<thead>
<tr>
<th>Service</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention</td>
<td>Level 0.5</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Level 1.0 and Level 2.1</td>
</tr>
<tr>
<td>Residential</td>
<td>At least one ASAM level of services initially (3.1, 3.3, or 3.5)</td>
</tr>
<tr>
<td>NTP</td>
<td>Required (includes 4 drug options)</td>
</tr>
<tr>
<td>Withdrawal Management</td>
<td>At least one level of service</td>
</tr>
<tr>
<td>Recovery Services</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
</tr>
<tr>
<td>Physician Consultation</td>
<td></td>
</tr>
</tbody>
</table>
Additional Conceptual Elements

- 24-hour access hotline (required by waiver)
- Level of Care determined by ASAM
- Residential Placements controlled by County instead of providers
- Creation of ASAM Screening Tools
- Countywide Care Coordination Team to provide case management for residential and high risk consumers
- Peer and Clinical Therapist Involvement
- Provider involvement throughout the design process
- Service delivery in schools (prevention & treatment)
- Family Advocate Services
Plan Development

- Behavioral Health Commission
- Interdisciplinary Care Team
- Youth Interagency Committee
- Contract Provider & Community Stakeholders
- Strategic Partner Committees (Residential, Outpatient, Adolescent Services, MAT/OTP)
- Internal Readiness Committee (Fiscal, Billing, EHR, Contracts, Program, QI, Compliance)
Substance Use Community Access Referral Evaluation & Support Line (SU CARES)

- 24 Hour informational line as required by Waiver
- This team is responsible for all residential withdrawal management and residential treatment placement in County
- Calls initially answered by clerical staff which gather demographic information about client and check for Medi-Cal Availability. Call then passed on to Counselor for ASAM Screening and placement
Care Coordination Teams

- Case management team assigned to consumers placed in residential withdrawal management and residential treatment. Case managers follow clients through entire residential episode.
- Originally had 3 CCT teams and 1 START team located in 3 distinct geographic regions of County.
Additional Preparations

• Development of ASAM screening tools (adult and adolescent)
• 4 levels of ASAM training offered to counseling staff: (A, B, C, Continuum of Care)
• Training on Evidence Based Practices for counseling staff: MI, CBT, Relapse Prevention
• EBP Curriculum training for counseling staff: Living in Balance, Matrix (Adult & Adolescent), CBT for PTSD, Coping with Stress: Teens and Trauma
Services Directly in Schools

• Idea was to be able to provide services for high risk youth directly at school sites
• Created MOU with SELPA – this allowed us to be active in any district serviced by SELPA
• Providing Indicated Prevention Services (funded through SAPT-BG) and Treatment Services (DMC-ODS) as a satellite service from closest county operated SAPT clinic; same counselor provides both services
• Currently active in 4 districts and 8 schools
New System Rollout

• System live at 7:00 am on February 1, 2017. Riverside and Santa Clara County were the first in California to roll-out waiver. New contracts started on that day; Riverside County rolled out all services on that day.

• County SAPT program had 132 FTEs in April 2015 and 218 FTEs on February 1, 2017 (approximately 68 positions unfilled – 150 working).
Medical Necessity

• One of biggest challenges of rollout centered on the paradigm shift that treatment level of care should be based on medical necessity

• Lots of pushback from courts, probation, DPSS, etc. that had mandated clients receive a specific regiment of treatment

• Great effort launched to prepare and educate our community partners of this change, which made the transition much smoother
Other Challenges

• Keeping up with staffing - difficulty in increasing workforce and training workforce. SU Cares Line staffing estimates were inadequate
• CCT Team Restructuring in first few months
• 88 hours training every 6 month for the first 18 months that began 6 month before live date
• Staff mastery of the ASAM has been one of the more challenging components
• Also, trying to get staff to change their concept of treatment from a non-medical one to one based on an ASAM standpoint
Call Center Should Have Library of Local Resources

- Many of calls coming in to SU CARES line are for information.
- Having library of local resources makes it easy to connect consumers with services.
- Often, consumers going into residential treatment need to have certain issues addressed before treatment - local resource library helps with this.
- Also important to have contact information for SUD offices of other counties in area – especially important when consumers present with out-of-county Medi-Cal coverage.
Wait Times Reduced or Eliminated

• Once County took over bed placement for residential and withdrawal management services, providers committed to providing more beds and wait time for placement were reduced significantly or eliminated all together

• Residential beds for adolescents and beds for withdrawal management are scarce, so wait times can be around 2 weeks

• Many clients can be placed in residential bed on same day or next day
Trauma Informed Care
Trauma-Informed Approach

According to SAMHSA’s concept of a trauma-informed approach, “A program, organization, or system that is trauma-informed:

1. **Realizes** the widespread impact of trauma and understands potential paths for recovery;
2. **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively **resist re-traumatization.**

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.
## Trauma Examples

<table>
<thead>
<tr>
<th>Caused Naturally</th>
<th>Caused by People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tornado</td>
<td>Train derailment</td>
</tr>
<tr>
<td>Lightning strike</td>
<td>Roofing fall</td>
</tr>
<tr>
<td>Wildfire</td>
<td>Structural collapse</td>
</tr>
<tr>
<td>Avalanche</td>
<td>Mountaineering accident</td>
</tr>
<tr>
<td>Physical ailment or disease</td>
<td>Aircraft crash</td>
</tr>
<tr>
<td>Fallen tree</td>
<td>Car accident due to malfunction</td>
</tr>
<tr>
<td>Earthquake</td>
<td>Mine collapse or fire</td>
</tr>
<tr>
<td>Dust storm</td>
<td>Radiation leak</td>
</tr>
<tr>
<td>Volcanic eruption</td>
<td>Crane collapse</td>
</tr>
<tr>
<td>Blizzard</td>
<td>Gas explosion</td>
</tr>
<tr>
<td>Hurricane</td>
<td>Electrocution</td>
</tr>
<tr>
<td>Cyclone</td>
<td>Machinery-related accident</td>
</tr>
<tr>
<td>Typhoon</td>
<td>Oil spill</td>
</tr>
<tr>
<td>Meteorite</td>
<td>Maritime accident</td>
</tr>
<tr>
<td>Flood</td>
<td>Accidental gun shooting</td>
</tr>
<tr>
<td>Tsunami</td>
<td>Sports-related death</td>
</tr>
<tr>
<td>Epidemic</td>
<td>Arson</td>
</tr>
<tr>
<td>Famine</td>
<td>Terrorism</td>
</tr>
<tr>
<td>Landslide or fallen boulder</td>
<td>Sexual assault and abuse</td>
</tr>
<tr>
<td></td>
<td>Homicides or suicides</td>
</tr>
<tr>
<td></td>
<td>Mob violence or rioting</td>
</tr>
<tr>
<td></td>
<td>Physical abuse and neglect</td>
</tr>
<tr>
<td></td>
<td>Stabbing or shooting</td>
</tr>
<tr>
<td></td>
<td>Warfare</td>
</tr>
<tr>
<td></td>
<td>Domestic violence</td>
</tr>
<tr>
<td></td>
<td>Poisoned water supply</td>
</tr>
<tr>
<td></td>
<td>Human trafficking</td>
</tr>
<tr>
<td></td>
<td>School violence</td>
</tr>
<tr>
<td></td>
<td>Torture</td>
</tr>
<tr>
<td></td>
<td>Home invasion</td>
</tr>
<tr>
<td></td>
<td>Bank robbery</td>
</tr>
<tr>
<td></td>
<td>Genocide</td>
</tr>
<tr>
<td></td>
<td>Medical or food tampering</td>
</tr>
</tbody>
</table>

Behavioral Health
Other Types of Trauma

- **Group Trauma**
  - Military, first-responders (police, firefighters, emergency personnel, etc.), gang members

- **Historical Trauma**
  - Japanese internment camps, First People’s genocide, African American slavery

- **Mass Trauma**
  - Hurricane Katrina, Flint water supply, Porter Ranch Aliso Canyon, Refugees, War survivors

- **Interpersonal Trauma**
  - Intimate partner violence, child molest and abuse

- **Systems Induced Trauma**
  - Usually involves re-victimization

*Kathleen West, DrPH, USC Dept of Preventive Medicine*
Trauma, Violence, & Substance Abuse

- Children & youth are at highest risk for being victims of violence (3x adult rate)
- Substance abuse, aggression, & trauma exposure are highly correlated
- Trauma exposure also correlates with:
  - substance use with high risk behaviors
  - substance use associated with both perpetration of violence – and victimization
  - substance use related to severe accidental injury, personal loss, and ensuing trauma

Courts with High Risk High Need Population, Have Clients with Trauma

Kathleen West, DrPH, USC Dept of Preventive Medicine

Riverside University HEALTH SYSTEM Behavioral Health
What we know about Trauma and Substance Use Disorders
Adverse Childhood Experiences (ACE) Study Findings & SUDs

ACE: a study of 8,613 adults interviewed re: original ACE 8 categories: Childhood Abuse (3 items: emotional, physical, sexual), Household Dysfunction (5 items: substance abuse, mental illness/depression/suicidal, battered mother, incarcerated family member, at least 1 biologic parent died before subject 18 yrs)

Each ACE increased the likelihood for early initiation of drug use 2 to 4 times. Individuals with 5 or more ACEs were 7 to 10 times more likely to have Substance Use Disorders (SUDs).

Effects of ACEs outweigh increased drug access, attitudes towards drugs, and public education campaigns to prevent drug abuse for 4 successive cohorts back to 1900.

Kathleen West, DrPH, USC Dept of Preventive Medicine
10 ACES Survey Questions

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often… **Swear at you, insult you, put you down, or humiliate you?** or **Act in a way that made you afraid that you might be physically hurt?**  
   Yes / No  
   If yes enter 1

2. Did a parent or other adult in the household often or very often… **Push, grab, slap, or throw something at you?** or **Ever hit you so hard that you had marks or were injured?**  
   Yes / No  
   If yes enter 1

3. Did an adult or person at least 5 years older than you ever… **Touch or fondle you or have you touch their body in a sexual way?** or **Attempt or actually have oral, anal, or vaginal intercourse with you?**  
   Yes / No  
   If yes enter 1

4. Did you often or very often feel that … **No one in your family loved you or thought you were important or special?** or **Your family didn’t look out for each other, feel close to each other, or support each other?**  
   Yes / No  
   If yes enter 1
5. Did you often or very often feel that … **You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?** or **Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?**  Yes/No If yes enter 1

6. **Were your parents ever separated or divorced?** Yes/ No If yes enter 1

7. **Was your mother or stepmother:** **Often or very often pushed, grabbed, slapped, or had something thrown at her?** or **Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?** or **Ever repeatedly hit at least a few minutes or threatened with a gun or knife?** Yes/ No If yes enter 1

8. **Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?** Yes/ No If yes enter 1

9. **Was a household member depressed or mentally ill, or did a household member attempt suicide?** Yes /No If yes enter 1

10. **Did a household member go to prison?** Yes No If yes enter 1

Now add up your “Yes” answers: ________ This is your ACE Score
PTSD and Addiction

• Prevalence, Correlates, Course
  ▪ Approximately 3.6% of U.S. population have current PTSD
  ▪ Among persons with PTSD and substance use disorders, rates range from 25 to 42% for addiction treatment program patients
  ▪ Persons with PTSD have poorer outcomes in routine addiction treatment.
Changes to Our System of Care
Trauma Services in our System of Care Prior the Waiver Implementation

1. Consumers were identified to have trauma exposure

2. Counselors were limited to the amount of services they could provide addressing trauma
   - Scope of practice
   - Reimbursable services (individual services were limited to crisis intervention as defined to relapse potential)

3. Counselors had to refer out to other agencies for trauma work, however resources were scarce
Considerations and trainings implemented to provide Trauma Informed Care

• Evaluation of Staffing Needs:
  – Provide Appropriate Trauma Services
  – Maintain Scope of Practice
  – Maintain Scope of Competence

• Partnership with Hazelton for EBP Training and Curriculum:
  – Provide training for all staff
  – Train the Trainers (for continued trainings 2x annually)
The Implementation of Licensed Practitioners of the Healing Arts (LPHA) Into our Service of Care

• After ASAM screening, SUD Counselors refer consumers to a LPHA for assessment and treatment of trauma related exposure
• LPHA establishes medical necessity for the appropriate Level of Care, according to the ASAM and DSM V criteria
• LPHA identifies consumers with trauma exposure and offers trauma related services
  – Provide individual therapy for consumers and/or their family
  – Provide therapeutic EBP group services (ex. CBT for PTSD, Dialectical Behavioral Therapy (DBT), and Coping with Stress – Teens and Trauma)
Menu of Services

(Outside of their assigned SUD Groups – Voluntary Groups)

1. Orientation Groups  (Explains services offered)
2. Individual Therapy Sessions
3. CBT for PTSD
4. Dialectical Behavioral Therapy (DBT)
5. Anger Management
6. Triple P Parenting Groups
7. Family Groups
No Wrong Door

Since implementation of the Waiver, we have learned that our consumers may become aware of the impact trauma has played on their life, at different stages of their recovery.

They can decide at any time to address this issue. We do not require them to participate in trauma services when they enroll.

There is NO WRONG DOOR to participate in the offered treatment. We support their self-determination.
Peer Involvement
Recovery Services

• Wellness-Oriented. Recovery services are important to beneficiaries in the recovery and wellness process. The treatment community becomes a therapeutic agent through which consumers are empowered and prepared to manage their health and health care.

• Treatment Goals. Treatment is designed to:
  – Emphasize the beneficiary’s central role in managing their health.
  – Promote the use of effective self-management support strategies.
  – Provide internal and community resources to support ongoing self-management.

• Required Benefit. Recovery services are required in all counties that elect to participate in the DMC-ODS pilot program.
Components of Recovery Services

- Outpatient Counseling: In the form of individual or group counseling to stabilize the beneficiary, then reassess if further care is needed.
- Recovery Monitoring: Including recovery coaching and monitoring via telephone/telehealth.
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
- Support for Education and Job Skills: Including linkages to life skills, employment services, job training, and education services.
- Family Support: Including linkages to childcare, parent education, child development support services, and family/marriage education.
- Support Groups: Including linkages to self-help and faith-based support.
- Ancillary Services: Including linkages to housing assistance, transportation, case management, and individual services coordination.
Access to Recovery Services

- **Post-Treatment.** Recovery Services are made available to eligible beneficiaries after they complete their course of treatment.
- **Relapse Prevention and / or Early Intervention.** Services are available to beneficiaries whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.
- **Client Plan.** Services should be provided in the context of an individualized client plan that includes specific goals. This may include the plan for ongoing recovery and relapse prevention that was developed during discharge planning when treatment was completed.
Treatment Settings

• Service Delivery. Recovery Services can be provided in the following ways:
  – Face-to-face
  – By telephone
  – By telehealth
  – In the community
• DMC Certification. Sites offering recovering services must be certified as an DMC provider.
  – This does not mean that services must be provided at the certified site. Services may be provided in the community.
  – Services provided in the community must be linked with a physical site / facility that is DMC certified.
Who Can Provide Recovery Services

• Broad Range of Providers. Recovery services may be provided by the following types of providers:
  – Licensed Practitioner of the Healing Arts (LPHA)
  – Certified Counselor
  – Peer Support Specialists
Peer Support Services

- Substance Abuse Assistance. Peer-to-peer services are eligible for reimbursement under the DMC-ODS pilot when provided as substance abuse assistance services, as a component of recovery services.
- Training Plan Required. For counties that offer peer support services through the DMC-ODS, the county must first submit a SUD Peer Support Training Plan to DHCS for approval prior to providing billable peer support services.
- Provider Eligibility Verification. Counties are also responsible for ensuring that covered services are provided by peers that are eligible for participation in the Medi-Cal program. Review the OIG excluded list & the Medi-Cal suspended or ineligible list:
Peer Services RUHS- SAPT Provides:

- Build mutual, empowering relationships with consumers, sharing personal recovery story, to build hope, encouragement, and rapport.
- Assist consumers with community linkage to 12 step groups (i.e. take to a 12 step group).
- Support and Assist/Model and Mentor consumers in life skill building to avoid relapse, including exploring new hobbies, obtaining new relationships among their peers/support groups, gambling education etc. (i.e life skills of grocery shopping, housing, computer skills, GED/College enrollment, money management, impulse control, other solutions to Drugs/Alcohol use & Criminal behavior) explore barriers to recovery, family reunification, and other goals the individual wants to work on in their recovery.
Peer Services RUHS- SAPT Provides:

- Promote socialization, recovery, self-sufficiency, self-advocacy, development & maintenance of skills learned in support services.
- Support and assist members in getting to needed appointments, (i.e. Physician, lab work, CPS, DPSS, Probation, Court) including mentorship, role modeling and moral support.
- Reduce stigma of Behavioral Health challenges by providing education to consumers and families.
- Support and assist members to an inpatient setting, if a higher level or lower level of care is agreed upon.
- Provide individualized support, coaching, facilitation and education to the people we serve.
- Follow up with consumers after completion to capture outcomes (30/60/90 days and 6/9/12 months)
- Facilitate Facing Up to Whole Health, WRAP Group, Substance Abuse Education, and other Groups pertaining to the individual’s treatment with Behavioral Health.
Peers in SAPT Services

- Intensive Out Patient Programs – Mom’s Program
- Court Mandated Programs-Drug Court, Family Preservation, Juvenile Drug Court.
- Out Patient Programs
- Recovery Services (Aftercare)
- Specialty Programs – START Primary diagnosis is Behavioral Health Challenge, secondary is SA and CCT Team
Family Advocate Services
What is Family Advocacy?

- Department within Behavioral Health
- Voice of the Family
- Provide Family Perspective
- Provide Continuity of Care
- Provide Support, Education and Resources
- Important Part of Treatment Planning
- Conduit between the Family & Behavioral Health
- Empowering Families to Advocate for Themselves
Where Does BH Use Family Advocates?

Adult Outpatient Clinics
Mature Adult Services
TAY Drop-in Centers
Prevention & Early Intervention
Crisis Outreach Teams – CREST/REACH
Navigation Center
Substance Abuse Clinics & Community
Family Room Clinics
CSU/CRT
Mental Health Courts
Law Enforcement Training

*Most Family Advocates are Bilingual*
Statistics - What we know.
How much of a role do you play in the care of your loved one? Does your loved one live with you? Please circle one.

Loved One Lives With Caregiver

- Yes 64%
- No 33%
- No Answer 3%

We know that 64% of our families in Riverside live at home, then how important is it to Educate, Support and provide Resources to these families!
Do you schedule the appointments and/or provide transportation to these appointments for your loved one? Please circle one.

Schedule Appointments and/or Provide Transportation

- Make Appointments 5%
- Provide Transportation 21%
- BOTH 43%
- No Answer 31%

We know 43% of our families are setting up appointments AND transporting their loved ones to these appointments. How important is it to include families in the client’s care plan?
How important is it to you to receive training and education in support of your loved one? Please circle one.

Importance of Training and Education

- Not Important: 0%
- No Answer: 6%
- Moderately Important: 5%
- Very Important: 89%

We know 100% of our families feel training and education is important and 89% of them find it to be VERY IMPORTANT. Do we not have an obligation to keep our families informed through training and education?
Better outcomes in family psychoeducation

• Over 20 controlled clinical trials, compared to standard outpatient treatment have shown:
  – Much lower relapse rates and re-hospitalization
    • Up to 75% of reduction in rates; minimally 50%
  – Increased employment
    • At least twice the number of consumers employed, and up to four times greater--over 50% employed after two years--when combined with supported employment
  – Improved family relationships and well-being
  – Reduced friction and family burden
  – Reduced medical illnesses in family members
    • Doctor visits for family members decreased by over 50% in one year

Dixon et al 2003
What is a Family Advocate?

- Under direction, they provide information, support, education, assistance and advocacy for families/caregivers.
- Family member/caregiver who live in Family Recovery.
- Family member/caregiver who directly assists families/caregivers in the utilization of appropriate community resources.
- Family member/caregiver who assists the families/caregivers in coping with immediate situations and crisis situations.
- Family member/caregiver who provides the family/caregiver perspective in the development of programs and services and in the formulation of treatment strategies.
Family Advocate’s Role in Clinics

- Communicates, represents and promotes the families'/caregivers' perspective within the behavioral health system.
- Facilitate Family Support Groups.
- Provide Billable Services.
- Develops activities, programs and resources which supports families/caregivers in achieving their goals.
- Facilitate Educational Programs.
- Attends and participates in special events, conferences, workshops, and trainings within the behavioral health system and in the community.
- Informs, trains, supports and empowers families/caregivers who directly or indirectly receive behavioral health services.
How Do We Utilize Family Advocates?

- Family One-on-One Support
- Family Support Groups
- Treatment Planning
- Navigation of Behavioral Health System
- Skill-Building Classes
  - Family WRAP (English/Spanish)
  - DBT (English/Spanish)
  - From Crisis to Stabilization (English/Spanish)
  - Recovery Management (English/Spanish)
  - Family Psychoeducation
- Community Outreach
- Family Perspective in Staff Meetings
- Liaison between Substance Abuse, Family and BH.
What Family Advocates Can NOT Do?

• Assume responsibility for a more appropriate service provider.
• Speak on behalf of the family.
• Force the ill family member to do something against his/her will.
• Divulge confidential information to family members without his/her written consent (ROI).
• Obtain preferential treatment/services for family members or their ill loved one.
Story Telling with Data
SU CARES Line Monthly Call Volume

January 2017 – June 2018

[Chart showing call volume for each month from January 2017 to June 2018, with bars indicating incomplete and completed calls.]
Residential Active Clients by Month

![Graph showing Residential Active Clients by Month with data points from February 2017 to June 2018. The number of clients ranges from 367 to 620.](image-url)
WM Active Clients by Month

Detox


86 117 119 128 120 136 116 148 148 164 184 208 205 190 143 155 158
RS Active Clients by Month

Recovery Services

[Graph showing the number of active clients by month, with a significant increase from November 2017 onwards.]
OT and OTP Active Clients

Outpatient and OTP Active Clients by Month

<table>
<thead>
<tr>
<th>Month</th>
<th>Outpatient</th>
<th>NTP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-17</td>
<td>1029</td>
<td>1136</td>
</tr>
<tr>
<td>Mar-17</td>
<td>1128</td>
<td>1149</td>
</tr>
<tr>
<td>Apr-17</td>
<td>1135</td>
<td>1207</td>
</tr>
<tr>
<td>May-17</td>
<td>1101</td>
<td>1208</td>
</tr>
<tr>
<td>Jun-17</td>
<td>1057</td>
<td>1274</td>
</tr>
<tr>
<td>Jul-17</td>
<td>1020</td>
<td>1189</td>
</tr>
<tr>
<td>Aug-17</td>
<td>1097</td>
<td>1193</td>
</tr>
<tr>
<td>Sep-17</td>
<td>1040</td>
<td>1217</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1023</td>
<td>1254</td>
</tr>
<tr>
<td>Nov-17</td>
<td>986</td>
<td>1260</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1031</td>
<td>1241</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1038</td>
<td>1264</td>
</tr>
<tr>
<td>Feb-18</td>
<td>991</td>
<td>1313</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1033</td>
<td>1320</td>
</tr>
<tr>
<td>Apr-18</td>
<td>1003</td>
<td>1307</td>
</tr>
<tr>
<td>May-18</td>
<td>1073</td>
<td>1309</td>
</tr>
<tr>
<td>Jun-18</td>
<td>1048</td>
<td></td>
</tr>
</tbody>
</table>
Results from Year 1

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Goal</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of clients that successfully transitioned from 3.2WM to either outpatient or residential LOC within 14 days of discharge</td>
<td>43%</td>
<td>17% increase</td>
<td>Q4 FY16/17 = 66.9% (55% increase) Q2 FY17/18 = 64.9% (51% increase)</td>
</tr>
<tr>
<td>% of clients transitioning from Residential to an outpatient level of care within 14 days of discharge from Residential</td>
<td>20.9%</td>
<td>19.1% increase</td>
<td>Q4 FY16/17 = 15.4% (26% decrease) Q2 FY17/18 = 20.0% (4.3% decrease)</td>
</tr>
<tr>
<td>Number of residential discharges with a re-admission within 16-90 days and within 16-180- days</td>
<td>90 day = 4.63% 180 day = 7.6%</td>
<td>Decrease to 3%</td>
<td>Q2 FY 17/18 90 day = 3.21% (1.42% decrease) 180 day = 4.86% (2.74% decrease)</td>
</tr>
</tbody>
</table>
Next Steps
Service Expansion

- Plans to release new RFP for Service Providers before end of year 2018 for services to begin for FY 19/20
- Looking to potentially expand services to include the following additional levels of care
  - Level 2.5 – Partial Hospitalization
  - Levels 1.0-WM and 2.0-WM
  - Levels 3.7-WM and 4.0-WM
Additional Steps

• Analyze outcomes
• Analyze Referral Sources and trends
• Analyze PIP’s and Data to make system changes
Questions???
Contact Information

William W. Harris  WWharris@rcmhd.org
April M. Marier  AMMarier@rcmhd.org
Kristen D. Duffy  KDDuffy@rcmhd.org
James W. Hill  JWHill@rcmhd.org

Riverside University Health System – Behavioral Health
Substance Abuse Prevention & Treatment
3525 Presley Ave.
Riverside, CA  92507
(951) 782-2410