

Community Clinic and Health Center Case Study Highlights: Integrating Substance Abuse and Primary Care Services in Community Clinics and Health Centers

"I love this place. My counselors are great. When I have a problem or an issue, I always just ask the physician assistant. She can go on the computer and find all my information so I don't have to keep explaining. If I need medication for my anxiety, I come here before group and she can give me a prescription before I leave. It is easier because everything is coordinated."

Substance Abuse Services Client, CommuniCare Health Centers

Case study health centers...

...rely on staff who are extremely knowledgeable about substance use disorder (SUD) issues and committed to doing anything in their power to support patients getting the help they need.

...screen their patients for alcohol or drug abuse using any number of available screening tools.

...make the warm handoff readily available to primary care providers who are not necessarily comfortable addressing a patient's SUD issues themselves.



...have created an infrastructure that encourages primary care and SUD departments to meet regularly, review challenging cases, and/or participate in joint trainings.

...constantly have to figure out how to cover staffing costs since they rely so heavily on grant funding, and Medi-Cal reimbursement is allowed for only some types of providers.

...are able to share patient health information between departments while complying with HIPAA. This benefits the patient who can trust that a provider knows their history and will treat them accordingly, for example by not prescribing narcotics.

Case Study Health Centers

CommuniCare Health Centers • Korean Community Services • San Diego American Indian Health Center

Sonoma County Indian Health Project • WellSpace Health

The Benefits of Integrated Services

As many as 22% of all patients who present in health care settings have a problem with substance abuse,¹ and many of these individuals will visit a primary care doctor for a health condition that is related directly or indirectly to their substance abuse problem.² Individuals who are addicted to drugs or alcohol are more likely to have physical health problems that lower their life expectancy such as lung disease, hepatitis, HIV/AIDS, cardiovascular disease, diabetes and cancer. They are also nine times more likely to get congestive heart failure, 12 times more likely to develop liver cirrhosis, and 12 times more likely to develop pneumonia.³

“We can’t pretend that when a patient is actively using something, it isn’t affecting their physical health. You can keep giving them anti-hypertensive medication, but when they are taking drugs that are increasing their blood pressure, we have to do something about that too if we want them to get healthy.”

William Johnson, Addiction Treatment Programs Manager, WellSpace Health

A primary care provider is in a position to identify a patient’s substance abuse issues through validated screening tools, even if that patient is not aware of it or reluctant to admit it. These screening tools include CAGE (an acronym of the four screening questions) for alcohol, CAGE Adapted to Include Drugs (CAGE-AID), the Addiction Severity Index (ASI), or screening, brief intervention, and referral to treatment (SBIRT) protocols, among many others.

Once identified, the primary care provider may offer a brief intervention themselves, such as motivational interviewing. He or she may also refer the client to their own agency’s behavioral health services department, or to a community specialty agency that treats substance use disorders (SUD). (See **Figure 1** for general information about substance abuse treatment services as well as the screening tools used by the health centers that participated in this study.)

Some of the advantages of obtaining substance abuse screening and treatment services within integrated community health settings are that these clinics:

- Improve whole person health since SUDs are addressed in addition to primary care or mental health issues.
- Have SUD staff available with the training and confidence to talk with and educate patients about substance use and how this impacts their overall health.
- Provide both SUD and mental health services in a more coordinated way for patients with co-occurring disorders.
- Allow patients to experience a seamless system of care between primary care and SUD programs.
- Reduce the stigma that some patients feel when receiving care in a freestanding drug or alcohol treatment clinic.
- Have improved collaboration and coordination between providers compared to services received at separate agencies.

- Know not to prescribe opioids (for pain) in primary care to a patient with addiction issues or being seen in an SUD program.
- Offer wraparound services such as child care, parent education classes, and assistance seeking housing.
- Link patients to other services in the community when needed.

Providing SUD services in a primary care setting improves health outcomes while reducing costs to the healthcare system overall.⁴ Integrated substance abuse and primary care services are integral to decreasing emergency department utilization, hospitalization rates, and hospital inpatient days for patients who abuse drugs or alcohol. For individuals with medical problems associated with substance use, treating both types of issues together can cut monthly medical costs in half.⁵ Despite the clear benefits to patients and the health system overall, health centers face multiple challenges in delivering these types of services, not the least of which is the lack of stable and consistent funding. However some health centers have a long history of integrating SUD services into their operations, and some of their key success factors and challenges of doing so are described in the following pages.

Figure 1: Overview of Health Center Substance Abuse Services and Screening Tools

	CommuniCare Health Centers Yolo County	Korean Community Services Orange County	San Diego American Indian Health Center	Sonoma County Indian Health Project	WellSpace Health Sacramento County
Years providing substance abuse (SA) services	40 years	30 years	30 years	15 years	40 years
Number of sites providing SA services	2	3	1	1	4
Drug Medi-Cal Provider	Yes	Yes	No	Yes	Yes
# patients receiving SA services in the past year	Less than 1,000	1,000-2,000	Less than 1,000	Less than 1,000	2,000-5,000
Offer SBIRT ?	Yes	Yes	Yes	Yes	Yes
Which populations do you routinely screen for alcohol use ?	Pregnant women, adults	All patients	All patients	Patients with signs/symptoms	All patients
Which populations do you routinely screen for drug abuse ?	Adults, pregnant women, chronic pain patients	All patients	Pregnant women and other patients at risk	Patients with current signs/symptoms	All patients
What screening tools* do your providers use?	AUDIT, CAGE-AID, TCU Drug Screen II and MHSF III	SBIRT and ASI	CAGE, AUDIT, and ASI	CAGE and CAGE-AID	ASI

* Screening tools: **AUDIT** (Alcohol Use Disorders Identification Test); **SBIRT** (Screening, Brief Intervention and Referral to Treatment); **ASI** (Addiction Severity Index); **CAGE** (An acronym of the four screening questions for alcohol); **CAGE-AID** (CAGE Adapted to Include Drugs); **TCU Drug Screen II** (Texas Christian University Drug Screen); **MHSF III** (Mental Health Screening Form III for co-occurring disorders)

Essential Ingredients for Successful Integration

It is probably safe to say that no single health center has all of the ingredients for successful integration, but rather lie on different points along a continuum for each element. CEO buy-in is important, but if it is not as strong as it could be, then another champion might advance integration, such as a medical director or program director. Provider buy-in is challenging since a surprising number of physicians are not comfortable asking their patients about substance use, stigmatize patients abusing substances, or lack the confidence to address most issues that arise. The single most important element of integrated services is the warm handoff – being able to introduce a patient to an LCSW or other behavioral health clinician on the same day as their medical appointment. Without it, providers will be even less likely to ask their patients about drug or alcohol abuse. Doing a warm handoff requires physical proximity of substance abuse services in the health center – another essential ingredient for successful integration.

CEO and Primary Care Provider Buy-In

Health centers with strong substance abuse services programs have CEOs and physician leaders that have fully committed to the program. They recognize that addressing SUDs is as important as handling any other chronic health condition, since all components contribute to health and wellness.

While the CEO sets the tone for the entire organization, primary care providers also influence how well integrated behavioral health programs will work. They need to be willing to screen for or be aware of substance abuse issues, and refer patients to the behavioral health department. Some physicians are uncomfortable when it comes to confronting someone with their addiction (see **text box**). Others will not be persuaded it is a good idea to screen for alcohol or substance abuse, regardless of the amount of education and training that has taken place that supports the idea. Providers remain resistant for a number of reasons. They often:

- Don't understand addiction and recovery. They have not experienced it themselves or with loved ones.
- Lack confidence in providing the necessary treatment for people with SUDs because of their limited training and exposure to the population.
- Find that addicts are more complicated to treat than other patients, and that they are too time consuming. Their problems cannot be treated in the same way as other diseases physicians are more used to treating.
- View addiction as a lack of self-control or lack of willingness to live responsibly, and don't have compassion for addicts and the challenges they face.
- Fear being in an exam room with people who are dirty, high, disruptive, or potentially violent.
- Believe that some addicts are trying to take advantage of them to get them to prescribe opiates such as OxyContin or Vicodan to support their addiction.

Primary Care Provider Discomfort with Alcohol and Other Drug (AOD) Issues

“Unfortunately, primary care providers are not always comfortable supporting patients with AOD issues. This is a problem since this patient population is so susceptible to relapse and co-occurring disorders. One provider admitted to smelling alcohol on a patient’s breath, but didn’t say anything about it because he didn’t know how to treat the patient. He worried that if he did say something, he might make the patient angry, potentially even putting his own safety at risk. Having behavioral health staff on hand gives providers an option to call for assistance by someone who can link the patient with services or resources.”

Behavioral Health Provider

“Physicians don’t want to ask about substance abuse because there is fear of the unknown, there is stigma, and there is a sense of ‘if I can’t medicate something with a pill and fix it, then what do I do?’ So some providers simply avoid talking about it.”

SUD Program Leader

Despite this resistance on the part of some primary care providers, executives need to continue to set the expectation that primary care providers will screen their patients. Leadership can demonstrate their expectations of collaboration and mutual support in three concrete ways:

1. **Model a positive and inclusive attitude** toward the substance abuse department and its clients.
2. **Create an infrastructure** with joint meetings in which substance abuse, mental health and primary care providers meet to develop coordinated treatment plans or review challenging cases.
3. **Require training**, such as how to care for a patient with a chronic disease who also has depression and abuses substances.

As an example, **CommuniCare Health Centers** has implemented multiple strategies to enhance integrated behavioral health:

- Primary care and behavioral health providers have **monthly case consultations** in which they confer on difficult cases.
- The behavioral health director attends **monthly provider meetings** at each clinic site. She uses this forum to make announcements about new services, groups, or procedures.
- The psychiatrist offers mandated **quarterly provider trainings** on behavioral health and primary care topics.
- The behavioral health director trains primary care and behavioral health providers on **motivational interviewing**.
- Behavioral health clinicians participate in the **daily huddles** that take place twice per day.
- Primary care and behavioral health providers have received **SBIRT** training.

In order to be successful, the CEO and medical providers need to promote the idea that addressing substance use is an integral part of primary health care, and they need to establish an infrastructure that promotes communication and collaboration.

"The doctor knows I am in the substance abuse program at the clinic, so he understands my needs. He knows not to prescribe narcotics since it could trigger me. I don't have to explain it to him."

Substance Abuse Services Client, CommuniCare Health Centers

Warm Handoff

The single most critical component of integrated substance abuse services programs is using the warm handoff technique. While there are a few different ways of accomplishing the warm handoff, it is essentially comprised of a primary care provider who introduces a patient to a behavioral health services clinician (i.e. LCSW or MFT) or other provider. That person then briefly talks to the patient about their concern, whether they would be interested in counseling, and when they might be able to come back for a longer appointment. There are a few ways of designing the warm handoff process:

- **WellSpace Health** places a licensed marriage and family therapist (LMFT) and a program coordinator (Ph.D.) in the medical providers' room so mental health staff are easily accessible for the warm handoff. The clinician's time is primarily unscheduled so they can be available to medical providers for on-the-spot behavioral health consults or for 30-minute visits. If necessary the behavioral health provider will walk the patient over to the substance abuse services program to determine whether the person is eligible for Drug Medi-Cal, outpatient services or residential treatment. Integrated behavioral health staff then work with the patient to move them to the next step in the process.
- At **CommuniCare Health Centers**, a provider that identifies a patient needing AOD services will typically make a warm handoff to a behavioral health clinician or intern who is available for warm handoffs on that day. The clinician will then talk to the patient about the SUD treatment services that are available, and will explain how to get enrolled in the program.
- **Sonoma County Indian Health Project** places a behavioral health intern in the primary care department on one day per week. This placement helped to improve the relationship with primary care not only on the one day, but every day of the week. Now providers call the behavioral health department with questions and refer patients there on a regular basis.
- At **Korean Community Services Health Center**, all patients complete a 9-question screening tool for mental health and substance abuse concerns. If a patient answers yes to more than one question, the physician tells them about the Integrated Care Services (ICS) program and does a warm handoff to a behavioral health worker. This individual gives the patient more information about the benefit of the ICS program, which may include a referral to Drug Medi-Cal services. If the patient is not receptive to talking that day, the behavioral health staff will follow up by phone at a later date.

Co-Location

The effectiveness of integration depends in part on the physical plant and the co-location of primary care and SUD services. The more services that are located under one roof or in contiguous offices, the more likely a patient is to get the services they need.

- **WellSpace Health** started as a substance abuse services clinic. When they added primary care, they initially created a separate line for check-in at the front desk. The health center recently changed this arrangement so now all receptionists can help all patients. They retained the use of one of their substance abuse counselors to check in patients so they would be close by in case a patient needed additional information or there was a sudden escalation in the waiting room. Training all staff to check in all patients, regardless of whether they have an appointment with primary care or behavioral health, allows the patients to experience a seamless system of care at the clinic.
- At **CommuniCare Health Centers' Salud Clinic** location, primary care and behavioral health services are in adjoining suites with connecting doors. They are also connected to County specialty mental health, as well as to Medi-Cal, SSI, and other services. This set-up is ideal for patients since such a variety of services are offered in one location.

“This location has everything, not only for me but for my kids – counselors, Medi-Cal, mental health. You walk in one time and you got a person that helps instead of sending you somewhere else. Nine out of 10 times if someone is sent away they're not going to make it to their destination because in between are too many distractions, like, ‘Hey, look, that's where I used to get drugs.’ It's better to get help in the same building.”

Substance Abuse Services Client, CommuniCare Health Centers

At **CommuniCare Health Centers**, 85-90% of their SUD clients are mandated by an outside entity (e.g., probation, family court, and/or child protective services) to attend their outpatient programs. The **Outpatient Substance Abuse and Recovery Program (OSARP)** is for basic addictions and uses individual and group treatment in a structured program that promotes recovery and provides relapse prevention and other information. The **Path to Recovery** program is an integrated program serving adults with mild to moderate mental health and substance abuse issues. These highly structured programs entail education, group therapy, and interpersonal support, and generally last for about six months. The health center also offers ancillary services such as family and fatherhood groups, detoxification, and referrals to community resources.

A **dedicated physician assistant** with an office adjacent to the behavioral health services department gets to know the clients in these programs while they are there, and she is able to respond efficiently to their primary care needs. She completes a physical examination of every person who is enrolled in the substance abuse services program in order to get more familiar with their medical conditions. She is at the health center twice per week during which time patients can see her before and after counseling sessions. The physician assistant is in regular touch with the substance abuse counselors, coordinating closely on patients with concerns that span both physical and behavioral health. Through the electronic

health record she has access to the patient's primary care information as well as their substance abuse counseling records.

Clients appreciate that the physician assistant knows what addicts are going through physically and emotionally. She understands addiction issues, has compassion for people in recovery, and looks creatively at how to link clients with the services they need, even if that support is outside the health center, as is the case with food or housing needs. Having a person in this role with this kind of commitment and experience has a tremendously positive impact on patients.

“Patients are making the connection between substance abuse and physical health. I see a lot of asthma, smoking, and dental needs in particular. Clients realize they haven't been taking care of themselves.

A patient I saw recently with Type 1 diabetes had just finished inpatient rehab and ate a lot of carbohydrates while he was there. He didn't have much money for fresh food once he left the facility. I linked him with a program in his community that offered free or low cost fruit and vegetables so he could get on track with his eating.”



Lorraine Lunden, Physician Assistant, meets with every client receiving substance abuse treatment. (Courtesy photo)

Lorraine Lunden, Physician Assistant, CommuniCare Health Centers

Outreach, Prevention and Early Intervention

While this paper has described some of the essential ingredients for integrating SUD and primary care services, the optimal situation is to prevent the need for SUD services at all, or to intervene early before a serious problem develops. A young person whose parent abuses alcohol or drugs, for example, is more likely to develop a problem themselves. This is why it is so important for funders to invest in education, prevention, and early intervention programs.

Reaching community members and families early is a strategy used by the Indian health centers participating in this study. Outreach and family support services are also a way of building trust in the community, and of removing the stigma associated with seeking substance abuse or mental health services. By doing so, health centers are able to identify individuals or families that need help before a young person begins experimenting with drugs or becomes addicted.

- **Sonoma County Indian Health Project** has after-school tutoring and life skills training for youths. An added benefit of the program is that it draws in the parents and grandparents of the children. By becoming familiar with the health center, the adults are more likely to take advantage of other services,

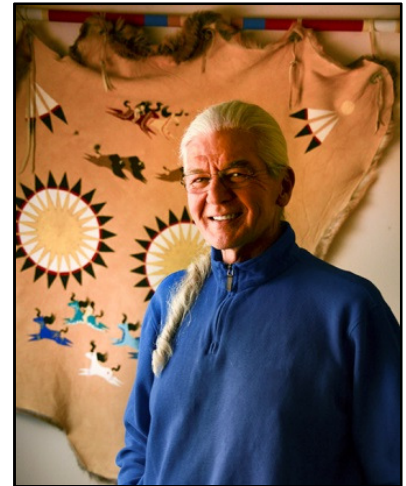
such as parent education, behavioral health, or primary care services. The health center offers community outreach through various events as well. All of these activities are geared toward **reducing the stigma** of going to the clinic and receiving services.

- **San Diego American Indian Health Center** has a youth center funded primarily with Mental Health Services Act prevention and early intervention dollars, and augmented with other grant funding. The center serves an average of 12-15 individuals ages 10-24 per day, with a focus on older adolescents and transition-aged youth. About 60% of their work focuses on substance abuse education and prevention, and they also emphasize academic enrichment, tutoring, healthy lifestyles and recreation. Although not many of the young people attending are using themselves, some are living in households where the parent is. Substance abuse education may happen informally during general conversation at the youth center, or in a weekly group that focuses on substance abuse prevention.

Youths needing weekly counseling services are referred to the behavioral health department to meet with a licensed professional who specializes in AOD issues. Some also obtain their medical care from a doctor at the health center, and the primary care department regularly refers families to the youth center. Many youths attending the center were referred by their doctor. Sometimes a parent will visit the health center for counseling and drop off the child at the youth center. The young person may enjoy it enough to return on a regular basis.

CommuniCare Health Centers has conducted extensive outreach in the community and today uses case managers to connect people with primary care or behavioral health services. The model was instituted after the health center was one of nine recipients nationally of a grant from SAMHSA for **Recovery Oriented Systems of Care**. With this funding, CommuniCare Health Centers set up a team to go into the field and provide primary care, mental health and substance abuse screenings of homeless people in Yolo County. Multiple staff supported the project, including a case manager and staff with SSI expertise. In the end, about half of the homeless people contacted (360 out of 766) were open to receiving services over the three-year period. Of those, 95% obtained substance abuse and/or mental health services, and 97% selected CommuniCare Health Centers as their medical home. The grant ended in 2013, and despite its outstanding outcomes, SAMHSA did not offer any additional funding to continue the program. Nevertheless, this program bolstered the health center staff's experience in outreach and linking individuals needing services with their health center.

The behavioral health department continues outreach into the community today to identify people needing substance abuse or other services. The department established a referral protocol so that any of the case managers who identify a need in the field can link the person with services. New patients are referred to a client benefits advocate who either meets with them in the community or asks them to go to the clinic to get enrolled and make an appointment. If a current patient is hospitalized and found to be under the influence of a substance, a field-based case manager visits the patient in the hospital and with the patient's permission schedules an appointment with substance abuse services. These various methods of outreach are a way of linking people with services as soon as possible rather than waiting for them to initiate an appointment.



Leon Wakefield, Ph.D., Director, Behavioral Health Department, **Sonoma County Indian Health Project**, feels it is important to reach out to young people early to build trust and connect them with services as soon as possible. (Photo Credit: Alaina Dall)

Challenges to Integration

The challenges to integrating substance abuse and primary care services have to do with stigmatizing patients who abuse alcohol or drugs, the lack of familiarity between service areas, inadequate funding, and technical challenges that make it difficult to share pertinent patient information. These challenges are described further below.

- **Stigma toward people abusing substances:** Some clinic physicians and staff have negative opinions about people who abuse drugs or alcohol. They feel that abusing substances is a personal weakness, and that those who do so could also be criminals willing to do anything for their next fix. Some providers don't want to be in an exam room alone with an addict, especially if that person seems unpredictable or has poor personal hygiene. Stigma will have to be eliminated or minimized before integration will be successful.
- **Lack of provider training or interest:** Some primary care providers don't have the knowledge or experience needed to communicate with patients about alcohol or drug abuse. These physicians worry that the conversation would get out of hand and overly personal if they started asking a patient questions about substance abuse, and that ultimately they would not be able to help the person. While some providers may be open to training, others are simply not interested in dealing with substance abuse issues and would prefer to avoid it all together.
- **Lack of staff reimbursement:** Medi-Cal reimburses health centers for behavioral health services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and licensed clinical social workers. The program does not reimburse services given by LMFTs or AOD providers (regardless of type of certification), even though they too are qualified and sometimes even more capable of providing the necessary services based on their experience, training or personal background. Limiting the type of staff eligible for reimbursement creates staffing shortages and instability since grant funding has to be pieced together to cover the additional staffing costs.
- **Inadequate program funding:** Health centers that do not have contracts to treat individuals from the criminal justice system or who are not certified Drug Medi-Cal providers rely primarily on grant funding for their substance abuse programs. Funding for pilot programs by definition is usually discontinued once the program ends. Program funding is inconsistent and unreliable. Furthermore, Medi-Cal will not reimburse a health center for a **same-day visit** for a medical and behavioral health (substance abuse services) visit, so health centers using a warm handoff for same-day visits do so without Medi-Cal reimbursement.
- **Electronic health record limitations:** Primary care, mental health and AOD providers are generally not yet able to enter and/or view each other's notes in the electronic health record. While substance abuse providers may be able to view primary care notes, the reverse is not usually true. In addition, the E.H.R. visit templates are geared toward medical entries. If an AOD provider wants to enter a note, for example, he or she has to bypass fields related to vital signs and current medications.



Michelle Tene, Mental Health Case Worker, shows interviewer Jennifer Brya the medical chart for the Integrated Care Services program at KCS Health Center as Ellen Ahn, CEO, (center) looks on.

The E.H.R. needs to be modified so that a behavioral health provider can enter notes in a template reflective of the visit type.

- **Misperceptions about sharing health information.** Even within the confines of HIPAA and 42 CFR Part II, information can be shared between behavioral health agencies and primary care providers when done correctly and with patient consent.⁶ Extensive resources are available to clarify when data sharing is allowed between organizations.⁷ Sharing information between departments in a single organization is easier. To facilitate the process, health centers should create routine consent forms that include the necessary organizations and providers, and should explain to patients why it is important. Staff should also inform patients that they can expect communication, shared treatment plans and joint decision-making from their providers.⁸ It is important to consult with legal counsel before implementing policies to be sure the organization is in compliance with all confidentiality requirements.⁹

Conclusion

Despite the challenges, integrated substance abuse and primary care treatment is actually on a precipice of significant promise because of two major policy changes. First, the **Affordable Care Act (ACA)** requires health plans to offer substance abuse and mental health services in addition to a full range of medical inpatient and outpatient services. In the past, substance abuse treatment was separated from physical health care, in part because these services were “carved out” from mainstream medical care. The ACA provides an opportunity to better integrate those services from a programmatic and fiscal point of view, resulting in better continuity of care.

Second, the **Drug Medi-Cal Organized Delivery System Waiver** was submitted by the **Department of Health Care Services** to the **Centers for Medicare and Medicaid Services** in November 2014. If approved, it will expand Drug Medi-Cal services dramatically and enhance integration.¹⁰ The standard terms and conditions for this waiver create the opportunity for counties, if they opt in, to receive expanded benefits based on a continuum of services put forth by the **American Society for Addiction Medicine** ranging from outpatient services to medically managed intensive inpatient services and opioid treatment. Expanded substance use disorder services would include:

- Intensive outpatient treatment for all beneficiaries instead of a limited few (pregnant/post-partum women and early and periodic screening, diagnosis, and treatment -eligible youth);
- Residential SUD treatment for all beneficiaries; and

- A new elective inpatient detoxification benefit.

It would also remove the 16-bed limit on residential facilities.

To support integration, the waiver will include case management as a billable service. Case managers would monitor the client’s response to treatment and connect that

client to physical and mental health care providers as needed. In addition, counties will be required to develop an MOU with local Medi-Cal managed care plans to coordinate SUD services with primary care. The MOU will identify procedures for referrals, clinical consultations, care management, and information sharing.¹¹ DHCS has requested that

CMS approve their request by April 1, 2015.

These actual and proposed policy changes support the notion that in order to improve whole person health, people with substance use disorders need not only to have their addiction treated, but also to have their care coordinated with physical and mental health services. An integrated treatment approach will improve health outcomes and reduce costs by eliminating unnecessary hospital stays and emergency room visits.

The health centers participating in this study, and many others like them, are on the forefront of integrated SUD and primary care, and lessons learned from their experiences will help to inform other community clinics interested in responding to their patients’ physical and AOD service needs.



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- ⁷ SAMHSA-HRSA Center for Integrated Health Solutions. Confidentiality. Retrieved from <http://www.integration.samhsa.gov/operations-administration/confidentiality>
- ⁸ These recommendations were provided by CIHS Health Information Technology Director Mike Lardiere in "Quick tips: Educating patients on information sharing," cited in Reynolds C, 2011.
- ⁹ As an additional resource, refer to the SAMHSA FAQs about confidentiality regulations, which can be found at <http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs>
- ¹⁰ November 21, 2014 letter from California Department of Health Care Services to M Hossain, A Garner and HS Lee regarding the California Bridge to Reform Demonstration (No. 11-W-00193/9) Amendment for Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. Retrieved from http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver_Amendment_Request.pdf
- ¹¹ Connolly J. (2014, January). Drug Medi-Cal organized delivery system waiver amendment draft Special Terms and Conditions: A summary and comments. Insure the Uninsured Project.

About the Case Studies: The purpose of this project was to better understand the range of substance abuse services offered by experienced community clinics and health centers. Because more patients have health coverage under the Affordable Care Act, and because more substance use disorder treatment is covered, some health centers may be interested in adding or expanding services. At the time of this study, however, not much information was available about model clinic programs. In order to gather the information, the **CaIMHSA Integrated Behavioral Health Project** worked in partnership with **AGD Consulting** in a two-part process. First they used statewide data to identify the highest volume substance use disorder treatment health centers, and in February 2014 asked their substance abuse services directors to complete an online survey. Thirteen out of 18 clinics responded to the survey. Secondly, the study team conducted site visits at five of those health centers in order to gather more in-depth information. A series of "**Case Study Highlights**" were developed for key topics: **Funding, Integrated Services, Staffing and Stigma, and Treatment**. The papers are available at www.ibhp.org. (March 2015)