California's Guide to Reshaping Addiction Treatment

C-CARA

THE CALIFORNIA COMPREHENSIVE ADDICTION RECOVERY ACT

January 2017

The California Comprehensive Addiction Recovery Act of 2017

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California's comprehensive blueprint for addiction treatment, prevention, and recovery services:

Reformulating resources, priorities, and vision to focus on addiction as a public health crisis

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California Urgently Needs a Comprehensive Plan to Improve Addiction Treatment Service Access for Californians

California lacks a coherent plan for expanding access and improving services for addiction treatment. Every day Californians who come forward and are determined to have a medical necessity for addiction treatment die waiting for it. Others lose hope and continue to use substances in a manner that results in billions of unnecessary expenditures at emergency rooms; for treatment of physical health disorders acerbated by abuse; and spending for the justice system and social welfare programming. The state has not integrated a coherent substance abuse treatment strategy into California's health care, foster care or corrections systems. Currently, treatment is often reserved for the most dependent and is not given to those in the earliest abuse stages, where it can be the most cost-effective.

With the passage of federal parity laws, the Affordable Care Act, and most recently, the Adult Use of Marijuana Act (AUMA), access to treatment for addiction is a statutory requirement. However, the treatment system in California lacks both physical and workforce capacity to deliver it. Consumers and their loved ones face barriers to access that would not be tolerated for similar life-threatening diagnoses.

The addiction treatment reimbursement structure dictates low pay for the treatment workforce, high staff turnover, and inexperienced and undereducated counselors. Workforce shortages and funding gaps across departments and between private and public payer systems result in long wait times that defy "timely access" statutes. The C-CARA focuses policy and funding to drive improvements in the system, creating greater capacity and access. It also places addiction treatment delivery under the same statutes that prohibit unscrupulous business practices, such as patient brokering and kickbacks, which are commonly prohibited in other health related industries. Increased funding, functional quality improvements, and efforts to reduce stigma are primary drivers of C-CARA policy and priorities.

C-CARA MISSION:

To create the nation's first, true, "on demand" addiction treatment system by guaranteeing universal access to treatment when the individual presents a need, and by eradicating waiting lists where Californians die while waiting for treatment.

C-CARA ACTION PLAN:

C-CARA'S mission will be accomplished through legislative action on a set of legislative bills to address each of four areas identified as cornerstones of a comprehensive "treatment on demand" system for California.

C-CARA PILLARS:

Pillar One: Physical Capacity

Issue 1: California Lacks Capacity to Provide Addiction Treatment; Prohibits Local Access to Treatment

- There are only 25 hospitals in California licensed to provide SUD services; of these only nine are chemical dependency recovery hospitals. The latter equals approximately 1,200 total beds for those who are chemically dependent needing hospitalization.
- Broken down that leaves only 97 CD beds for Alameda, Contra Costa and San Joaquin counties combined; 95 CD beds for San Diego County; 659 for Los Angeles County; with the rest peppered throughout the state.
- An estimated 23 million Americans needed treatment (7% of the population) for an alcohol or drug problem in 2012, but only about 11% of this population received treatment (SAMHSA); this would equate to approximately 260,000 Californians needing some level of assistance.
- It is estimated that hospitals across the state treat roughly one opioid overdose victim every forty-five minutes.
- Emergency room visits for nonmedical opioid use doubled from 2004 to 2008.
- Stigma based views lead to NIMBY issues at the local government level where anti-treatment and sober living ordinances are being launched throughout the state.
- Local ordinances make siting facilities nearly impossible thereby reducing local access to treatment and transitional housing.
- Waiting for treatment is associated with many negative outcomes from general health to public safety. It is estimated addiction cost Californians $3 billion in costs and lost productivity annually.

Pillar 1: California Comprehensive Addiction Recovery Act; Continuum of Care Physical Capacity Expansion

Goal: 50% increase in treatment beds and treatment availability

1. Capital construction loans/grants through DHCS
2. DHCS loan/grant program for financing of recovery residences
3. Incentives for future development with beds/housing units dedicated to treatment and recovery residences
4. Removal of per bed licensing fees; $500 grants per bed for additional capacity
5. Funding for medical detox units at hospitals to increase CD bed availability
6. Strengthening of State's facility siting laws for SUD programs
7. Local government technical assistance for local ordinance writing
8. Statewide anti-stigma campaign
9. Creation of small outpatient certification to create greater local access at small facilities

Pillar Two: Workforce Capacity

Issue 2: Workforce Roadblocks Cripple Addiction Treatment Providers

- There are an estimated 3.5 million persons with diagnosable substance use disorders in California, there are less than 20,000 alcoholism and drug abuse counselors of an unknown competency level currently certified by private credentialing bodies in California.
- California employs fewer SUD counselors per population than the national average.
- California addiction treatment providers list inability to recruit and retain counselors in top three issues impacting capacity expansion.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) redefined its services as "behavioral health" and included BOTH mental health and substance use disorder clinicians as participants in workforce development funding, yet California currently funds ONLY licensed mental health practitioners.
- SAMHSA has produced a career ladder model as a means for attracting and encouraging addiction counselors to increase education and experience levels, yet California has not agreed to a uniform career ladder.
- Counselor salaries in the public sector are defined by historic (previous years) levels which institutionalizes low pay.

Pillar 2: California Comprehensive Addiction Recovery Act; Workforce Expansion

Goal: increase addiction workforce by 50%

1. 20% increase in reimbursement for direct treatment staff expenses at publicly funded programs
2. Information campaign to draw interest in the profession
3. Student loan repayment for those willing to intern at programs serving publicly funded programs
4. Certification and testing fee waivers
5. No cost tuition for college and BPPE schools who offer courses in addiction counseling
6. Creation of a uniform career ladder for the addiction profession

Pillar Three: Workforce Professionalization

Issue 3: Addiction Profession Lacks Licensure for Private Practice

- Roughly one of every four substance-abuse clinicians chooses to leave the job in the United States every year.
- 38 states have enacted licensure of addiction counselors thereby providing a career path that encourages entry into the profession and retention.
- Bureau of Labor Statistics reports that addiction counselors earn an average of about $40,000 a year; coupled with stressful workloads in a field that treats client pain, leads to tremendous turn over.
- "Interventionists," who are not required to be licensed or sign codes of ethics, are selling patients, in the form of kickbacks, for as much as $10,000 each.
- "Peer Support Specialists" and "Recovery coaches" are underutilized, poorly trained and unregulated.

Pillar 3: California Comprehensive Addiction Recovery Act; Workforce Professionalization

Goal: increase addiction workforce by 50%

1. State licensure for private practitioners
2. Authority for DHCS to approve certifying organizations to create certification for interventionists, peer support professionals and recovery coaches.

Pillar Four: Payment Reform and Stigma Reduction

Issue 4: Payment Systems for Addiction Treatment Lack Accountability & Stigma Prevents Support for Treatment and Recovery

- Insurers are sending addicts who receive out of network treatment reimbursement checks, sometimes as high as $50,000, which are then used to purchase drugs leading to overdose deaths.
- "Interventionists," who are not required to be licensed or sign codes of ethics, are selling patients, in the form of kickbacks, for as much as $10,000 each.
- Outpatient programs are not required to be certified; they can be reimbursed with no standards, adherence to ethical practices; or acceptable treatment plans.
- Recovery residences are unregulated, creating issues in communities and wasting valuable treatment resources.
- The Medi-Cal expansion patient group receives inadequate, inaccessible, and untimely access to care causing death and devastation to individuals, families, and communities.
- Many people who struggle with addictive disorders fail to seek treatment, in part because of their concern that they will be labeled an "addict."
- In 2014 alone, nearly forty-four hundred California residents lost their lives to opioid overdoses; many of these persons were afraid to seek help for addiction.
- Deaths from opioid overdoses have quadrupled in since 1999.
- Despite passage of Federal Mental Health Parity legislation, mental health and substance use disorders continue to be treated differently—and often poorly—compared to "medical" illnesses.
- Stigma contributes to relapse by creating unsupportive environments for those in recovery.

Pillar 4: California Comprehensive Addiction Recovery Act; Payment System Reform and Stigma Reduction

Goal: End waste and improve allocation to quality programs in reimbursement systems; Reduce overall stigma and increase understanding of addiction as a public health issue

1. Remove direct pay to clients
2. Prohibit patient kickbacks in addiction treatment
3. Review public and private benefits and access via an addiction treatment coverage task force
4. Require Recovery Residences to be certified to receive state, county, or private insurance reimbursement
5. Require drug and alcohol outpatient treatment centers to be certified
6. Include relapse prevention (recovery) in the prevention budget
7. State education campaign about recovery
8. Opioid specific prevention campaign for all ages
9. Opioid specific early intervention training for communities