



DISTRICT OF COLUMBIA

SUBSTANCE USE DISORDER COMMUNITY NEED AND SERVICE CAPACITY ASSESSMENT

**SUMMARY REPORT OF FINDINGS
AND RECOMMENDATIONS**

FINAL SUMMARY REPORT

FEBRUARY 2021



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The DHCF and DCPCA would like to acknowledge the tremendous efforts of all who supported and directly participated in the development of this assessment. Since October 2019 when this work began, more than 150 individuals participated in interviews, focus groups, and community meetings. These participants included representatives from health and social service organizations, DHCF, the DC Department of Behavioral Health (DBH), the DC Department of Health (DOH), advocacy and professional groups, and community businesses, as well as individuals from the community at-large. Special thanks to the community residents, many of whom are in SUD recovery, who boldly shared their experiences and provided critical feedback. Special thanks also go to the DC SUD service providers who participated in this work for their input and the important work they do for the District.

The information gathered through these efforts is critically important and DHCF and DCPCA would like to thank everyone who was involved for their time, effort, and expertise. While it was not possible for the assessment process to involve all of DC's relevant stakeholders, care was taken to ensure that a representative sample of key stakeholders was engaged through interviews, focus groups, and community meetings. Those involved showed a commitment to strengthening the District's SUD system of care, particularly for segments of the population that are most at risk. This assessment would not have been possible or as comprehensive without the support of all the individuals who were involved.

DHCF and DCPCA were supported in this work by JSI Research & Training Institute, Inc., an independent health care consulting firm dedicated to improving the health of individuals and communities, with expertise in behavioral health. DHCF and DCPCA appreciate the contributions that JSI has made in analyzing data, interviewing stakeholders, and conducting research throughout the assessment process.

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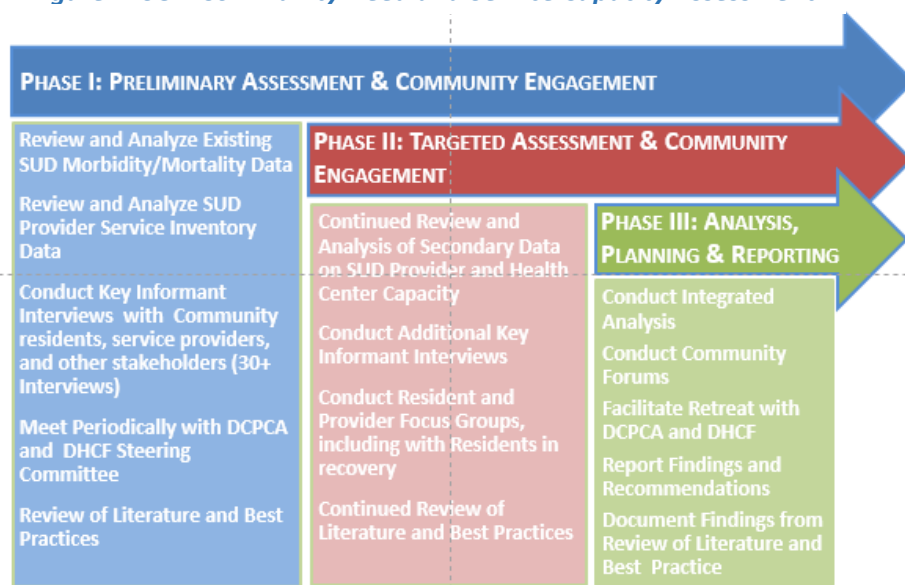
District of Columbia Substance Use Disorder Community Need and Service Capacity Assessment

Executive Summary

In the Fall of 2019, the District of Columbia Department of Health Care Finance (DHCF) was selected to receive federal funding from the Centers for Medicare and Medicaid Services (CMS) Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. To fulfill one of the grant's obligations, DHCF engaged the DC Primary Care Association (DCPCA) to oversee an assessment of substance use disorder (SUD) community need and service capacity. In turn, the DCPCA engaged JSI Research & Training, Inc., a public health and health care consulting firm, to assist with conducting the assessment. The ultimate goals of this work were to assess SUD provider capacity and need, and to develop recommendations to strengthen the SUD system in ways that would result in a whole-person, population-based, integrated Medicaid SUD system that is comprehensive, coordinated, high quality, culturally competent,¹ and equitable.²

This SUD Needs Assessment builds on and affirms many of the findings from the Live.Long.DC strategic plan³ and an assessment conducted by the Pew Charitable Trust for the Office of the Deputy Mayor for Health and Human Services.⁴ Both reports focused on improving services for District residents impacted by the opioid epidemic. This report also builds on other work performed by DHCF to support the development of DC's 1115 Behavioral Health Transformation Waiver. Key distinctions between prior reports and the SUD

Figure 1: SUD Community Need and Service Capacity Assessment



¹ Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations, according to the Centers for Disease Control and Prevention.

² Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities, according to the U.S. Department of Health and Human Services, Office of Minority Health.

³ <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan-%20March%20Revision.pdf>

⁴ <https://dmhhs.dc.gov/page/policy-recommendations-address-opioid-crisis-dc>

Community Need and Service Capacity Assessment is the focus of this report on the Districts' system of SUD care overall, rather than a more explicit focus on opioid use disorder (OUD), and that it includes a review of the entire service continuum for Medicaid beneficiaries, rather than a sole focus on behavioral health providers.

To conduct this work, JSI applied a three-phased, mixed-methods approach that gathered both quantitative and qualitative data. Figure 1 details the activities that were included in each phase of JSI's work.

Phase I and much of the Phase II work was completed by March 2020 at the time the COVID-19 public health emergency was declared. Simultaneously, social unrest in response to racial inequities, spurred by the killing of George Floyd on March 25, 2020, has highlighted the impact of racism and inequality. This increased awareness, along with the disproportionate impact of COVID-19 on racial and ethnic minorities, resulted in increased need for social and behavioral health support and services, and was compounded by numerous changes in practice, including a growing reliance upon virtual care or telehealth. Despite these changes, DCPCA and JSI are confident the core findings and recommendations articulated in this report are valid. If anything, the findings and recommendations may even have grown in importance as a result of the pandemic.

This report begins with a brief review of the burden of substance use on DC's residents and continues with a discussion of the project's key findings and summary recommendations.

BURDEN OF SUBSTANCE USE IN THE DISTRICT OF COLUMBIA

Over the past decade, substance use disorder prevalence rates in DC have consistently been among the highest in the nation. From 2017-2018, according to data gathered by the Substance Abuse Mental Health Services

Administration's (SAMHSA) Center for Behavioral Health Statistics and Quality, DC had the highest SUD prevalence rate in the United States – 13% among adults 18 years old or older.⁵ In FY 2019, 5,174 DC residents received adult

Figure 2: Prevalence of SUD among DC residents, 18 years old or older

Substance Use Disorder* in the Past Year – Percentages Amongst Those 18+ (2017-2018), Top 5 in the US	
TOTAL U.S.	7.7%
Washington, D.C.	13.0%
Colorado	11.9%
Vermont	10.5%
Oregon	9.9%
Alaska	9.8%

substance abuse rehabilitation services (ASARS) from DBH contracted providers.

The report also details the disproportionate impact that SUD has had on DC's African American/Black residents and highlights the underlying racial inequities that have been at the heart of these disparities.

⁵ SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2017 -2018

Between January 2016 and February 2020, 84% of fatal opioid overdoses in the District were among Black residents, despite the African American/Black population accounting for only 45.5% of DC's total population in 2018.

KEY FINDINGS AND RECOMMENDATIONS

The following is a summary of the assessment's key findings and recommendations, organized into two domains: 1) gaps and service delivery challenges across the SUD service continuum, and 2) system improvements and organizational capacity building. These findings are further elaborated in the full report, including additional details on provider capacity and the network of DBH certified ASARS providers. Quotes from those who participated in the assessment's interviews, focus groups, and community meetings are presented in the full report and are also detailed in the report's appendices. Many of the recommendations in this report align with best practice programs or strategies identified through the project's literature review. These best practices, along with other, supportive, peer reviewed literature, are described and cited in Appendix B of this report.

I. Gaps and Service Delivery Challenges across the Substance Use Disorder Continuum

At the outset of the project, DBH and DHCF worked together to compile client utilization and paid claims data for all DBH certified SUD service providers at the service location level. The dataset also provided information on the types of services for which the certified providers submitted claims. This allowed JSI to characterize DC's SUD service system and assess the breadth and capacity of the provider network, including a review of the distribution of services by ASAM level of care.

In December 2020, DC's SUD provider network included 32 DBH certified SUD providers, 21 of which were ASARS providers contracted by DBH to provide substance use services. In addition, the SUD provider network includes 155 Medication Assisted Treatment (MAT) waived providers who prescribe medication to SUD clients. The assessment showed that this provider network is strong and well-supported compared to SUD service networks in similar urban markets. Services are well-distributed throughout the District and provide a full breadth of services across the SUD service continuum. Figure 3 lists the number of DBH certified SUD service locations by ASAM level of care.

Figure 3: Number of DBH Certified SUD service sites by ASAM levels of care (FY 2019)

ASAM Levels of Care	# of DBH Certified Service Locations ^c
Level 0.5 – Early Intervention ^a	6
Level 1.0 – Outpatient Services ^b	20
Level 2.1 – Intensive Outpatient Services	4
Level 2.5 – Partial Hospitalization	1
Level 3.1 – Clinically Managed Low Intensity Residential Services	5
Level 3.3/3.5 – Clinically Managed High/Medium Intensity Residential Services	8
Level 3.7 – Medically Managed Intensive Outpatient Services	1
Level 4.0 – Withdrawal Management	1

a - Includes DBH certified providers, recently contracted to provide assessment and referral providers and the DC Assessment and Referral Center (ARC). Note ARC utilization is not included in the report's utilization/claims analyses as it is not a contracted DBH provider. ASTEP service providers are also included in the early intervention category.

b - Includes DBH certified providers delivering SUD outpatient and MAT services.

c - Total number of service locations exceeds number of certified provider organizations because some organizations provide multiple services at a given site.

In FY 2019, 5,174 DC residents received adult substance abuse rehabilitation services (ASARS) from DBH certified providers. Of those who received these services, 99% were adults 18 years old or older, 63% were male, and 87% identified as Black.

Relative to the types of services that these 5,174 residents received, 37% (1,920 clients) received residential services, 31% (1,598) received opioid treatment services, 28% (1,461) received outpatient services, 14% (702) received recovery services, 13% (692) received withdrawal management services, and the remaining 2% received adolescent treatment and assessment/referral services.^{6 7} Based on a review of the total value of paid claims to DBH certified ASARS providers, in FY 2019 54% of paid claims were for residential services, 20% were for methadone MAT services, 13% were for withdrawal management services, and 8% were for outpatient services. The remaining 5% of claims were paid for assessment and screening services, recovery services, and for Adolescent Substance Abuse Treatment Expansion Program (ASTEP) services.

Despite the breadth of the SUD network and the sizeable number of clients served by service type, the assessments showed that DC residents with SUD are not always able to access the services they need, when and where they want them.

The assessment identified several significant gaps across the ASAM levels of care that limit engagement in timely, person-centered care, hinder care coordination, and interfere with care transitions. Ultimately, these gaps reduce the effectiveness of the existing service network.

In addition to these service gaps, the assessment identified four themes reflecting an array of service delivery challenges that appear to limit the capacity of the service system overall.

The identified service gaps and other service delivery challenges must be addressed if DHCF and its partners are to maximize the capacity of the existing network and ensure DC residents have access to—and are engaged in—the assessment, referral, treatment, and recovery services they need. The following is a summary discussion of the identified gaps in services followed by a discussion of the other service delivery challenges.

⁶ The percentage of total clients receiving services by service type, along with the actual number of clients receiving particular services, reflect unduplicated counts by service type. The sum of the percentages exceed 100% and the sum of the number of clients received particular services exceed 5,174 because some clients received multiple types of services.

⁷ DBH Mental Health and Substance Use Report on Expenditures and Services, January 2020 (FY 2019)
<https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20for%20FY%2019.pdf>

A. Service gaps across the ASAM continuum

Over the course of the assessment's stakeholder interviews and focus groups, five primary gaps in the SUD service continuum were identified for Medicaid-eligible residents of DC. These include:

1) Outreach, assessment, and referral services (ASAM 0.5). Service providers overwhelmingly supported DBH's decentralized "no-wrong-door" approach to assessment and referral.⁸ In addition, providers believed outreach should be expanded further, and that program requirements should be refined to be more flexible and provider- and patient-centered.

2) Care transitions services (ASAM 1.0). Many stakeholders reported that there were shortages in the availability of care transition services and inconsistencies in the quality of existing services that support clients as they "stepped down" from one level of care to another. These shortages and inconsistencies in quality were reported despite the numerous policies and programs designed to encourage Medicaid providers in the District to furnish care transition services, including DC's My Health GPS⁹ and My DC Health Homes program,¹⁰ transition planning services, and other strategies implemented through the District's MCO contracts. Nearly all of the service providers and many of the SUD clients who participated in this assessment reported shortages of peer recovery coaches, recovery specialists, and specialized SUD case managers who provide vital, tailored supports that assist clients through the care transition process. These services are particularly important as clients' transition to a new provider organization and as coordination and case management needs increase.

3) Recovery support services (ASAM 1.0). Many providers and SUD clients who participated in the assessment reported that there were gaps in the availability and variety of recovery support services. Stakeholders described a need for a broader range of SUD services for specific segments of the SUD client population (e.g., veterans, men-only, women-only, women with children); different service types (e.g., peer groups, community centers, housing first models, one-on-one mentorship or coaching programs); and services with different requirements and philosophies (e.g., sober and non-sober living, 12-step, SMART Recovery, faith-based or secular).

4) Intensive outpatient programs (ASAM 2.1). A number of stakeholders cited gaps in the availability of intensive outpatient programs. Stakeholders felt it was important that these services be well distributed geographically, with care taken to ensure they are available in the communities with the highest need. Stakeholders also identified a need for a range of services, similar to the variety listed above, for recovery support services geared to specific segments of the SUD client population with different service delivery policies and/or philosophies.

5) Transitional housing services (ASAM 3.1). Nearly all of the service providers and clients who participated in the assessment's interviews, focus groups, and community forums reported that there were substantial gaps in transitional housing services in the District, particularly for clients stepping down from withdrawal management and long-term residential treatment services. This gap too often means that clients transition from treatment to unsafe, unsupported housing situations. Participants also reflected on the need for a greater variety of safe, affordable, and supportive

⁸ <https://dds.dc.gov/page/no-wrong-door>

⁹ <https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps>

¹⁰ <https://dhcf.dc.gov/page/health-homes>

housing options more generally that are tailored to individuals with different needs and who are in various stages of SUD recovery.

These discrete service gaps can have immediate consequences on a person's care as they hinder timely engagement as they step up or down from one level of care to another. However, the gaps can have broader impacts and derail clients from their path to recovery. The strength of the SUD network depends largely on it being an unbroken continuum of services. According to ASAM's core principles, a client is not admitted to a particular program or level of care but rather to the continuum itself.¹¹ This focus on moving the client along the continuum prompts clinicians to look ahead and engage in long-term treatment planning.

B. Inconsistencies in the quality of care

Many of the providers and clients that were engaged in the assessment reflected on the need for DBH, DHCF, SUD service providers, and other partners to focus on improving the quality of care across the SUD service continuum. Specifically, participating service providers and clients reported that workforce shortages, low payment rates, ineffective communication systems, limited use of evidence-based protocols, and lack of quality improvement systems led to inconsistencies in the quality and capacity of care. Service providers believed that DHCF and its partners needed to address these quality-related issues to realize the full capacity of the system.

Furthermore, participating service providers said there was a need for more robust training and technical assistance services, which they believed was critical to addressing these inconsistencies. Participants said that these training and technical assistance services should be focused on:

- Developing and promoting the use of evidence-based, client-centered service guidelines, protocols, and standard operating procedures to guide and support more effective outreach, assessment, treatment, and recovery services.
- Facilitating the adoption and use of health information technology (HIT) and health information exchange (HIE) resources.
- Improving provider documentation.
- Promoting collaboration, communication, and partnership within and across organizations.
- Improving quality, performance improvement, and accountability efforts.

C. Shortages in housing, financial resources/supports, employment opportunities, job training, and transportation

Nearly all participating service providers and SUD clients referenced the need for additional services to address the social determinants of health. Stakeholders reported a need for greater investment in programs that promote safe and affordable housing, increase financial supports for those in recovery, create employment and job training opportunities, enhance on-demand transportation services, and reduce the impacts of institutional racism and trauma. Information gathered during the assessment

¹¹ Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2006. (Treatment Improvement Protocol (TIP) Series, No. 47.) Available from: <https://www.ncbi.nlm.nih.gov/books/NBK64093/>

suggested that, for many SUD clients, addressing underlying social factors is more important to recovery than improving the capacity or quality of SUD services.

D. Need to address structural racism and its impacts on individuals with SUD

Numerous SUD clients and other stakeholders who participated in the assessment discussed the impacts of racism, structural inequities, and the underlying trauma that can contribute to or even be at the root of SUD for many DC residents. It is also clear that these factors limit access to affordable housing, education, employment, and overall well-being, which can be underlying causes of SUD on their own. These participants believed that it was essential that DC continue to invest in efforts to reduce the impact of racism and address the breadth of related structural inequities.

E. Need for greater emphasis and investment in prevention and harm reduction services

Many of the service providers and SUD clients who participated in the assessment cited the need for increased investment in SUD prevention and harm reduction services. With respect to prevention services, participants appreciated the significant investments that the District has made, yet reported need for greater investments in evidenced-informed prevention programming in clinical, school-based, and community-based settings. Participants believed that these investments would serve to further increase awareness, decrease stigma, and support early intervention, which would ultimately reduce the demand for SUD services. With respect to harm reduction, participants believed that, in addition to addressing the gaps within the ASAM levels of care, the District should expand access to needle exchange programs, invest in sobering centers, and apply principles of harm reduction across the SUD service continuum. Participants believed that SUD services needed to be more person-centered and embrace the idea that, for many clients the path to recovery may not always be a straight-line, and sobriety may not be the immediate goal. These ideas are supported by best-practice literature and are described in Appendix B of this report.

II. System Improvements and Organizational Capacity Building

One of the most common themes throughout the assessment was the need for enhanced systems and targeted supports geared to strengthening the capacity of individual service providers and the SUD service network overall. There was nearly a consensus among the service providers that were involved in the assessment's interviews, focus groups, and community meetings that focusing on system improvements could increase the quality of care and facilitate outreach, care coordination, referrals, care transitions, and collaboration. Many of the participating service providers and SUD clients believed that addressing these system issues could be more important than addressing ASAM service gaps. Below is a summary of the identified needs and opportunities in this area.

A. Need for enhanced support from DBH

Numerous service providers reported that they needed additional or more enhanced support from DBH with respect to HIT/HIE, regulation, certification/licensure, and payment. These issues were said to hinder program operations, treatment documentation, care/discharge planning, and communication, as well as quality improvement and accountability efforts. Some participants felt that these issues prevented some SUD providers in the District from seeking DBH certification. More specifically:

- **DATA WITS.** Service providers expressed concerns with the District’s analytic and reporting systems (namely DATA WITS), which were described as awkward, ineffective, and time consuming to use. Participants reported that they believed these systems were developed primarily to manage billing and payment and greater efforts were needed to retool or replace these systems so that they more effectively supported documentation, care/discharge planning, care coordination, and communication.
- **Program Regulations.** A number of service providers felt that DBH’s regulatory and program requirements were too rigid and not entirely provider-centered. A number of participants also cited that these requirements were not always communicated in an effective or timely manner. A number of providers reported that these requirements sometimes required them to substantially alter their staffing, existing work flows, and systems, which led to duplicative systems, confusion and inefficiencies.
- **Licensure/Certification.** Some service providers described the District’s certification processes as unnecessarily cumbersome, time-consuming, and, at times, duplicative.
- **Payment rates.** A number of service providers reported that payment rates were too low, resulting in providers being “stretched thin.” As discussed above, some service providers said that the low rates affected their ability to hire experienced staff and to sustain quality services.

B. Need for greater adoption and use of HIT/HIE, particularly among SUD providers

As discussed above, many service providers expressed concerns with DBH’s analytic and reporting systems (namely DATA WITS). More generally, nearly all of the service providers who participated in the assessment reflected on the importance of strong HIT and HIE systems to support outreach, referral, care coordination, care transitions/step-down, and client treatment/recovery efforts. Service providers were appreciative of the tremendous strides that have been made with respect to supporting the adoption and use of HIT/HIE, developing client consent systems, and facilitating other HIT/HIE-related capacity building efforts. Nonetheless, service providers believed that continued efforts to support SUD providers to adopt and use HIT/HIE technology for outreach and identification, assessment and referral, documentation and treatment planning, care coordination, and communication, just to name a few, were essential to improving SUD outcomes and building system capacity.

C. Challenges related to collaboration across providers

Many of the service providers who participated in the assessment said that collaborating with other providers across the SUD spectrum was challenging. Some reported that there were limited systems, funding, and other supports to encourage communication, collaboration, and better integration of physical and behavioral health. Others reflected on the need for an automated and well-maintained resource inventory to promote referrals and facilitate care coordination. These ideas are supported by promising-practice literature and are described in Appendix B of this report.

D. Need for value-based payment models/policies

There was near consensus among participating service providers and stakeholders regarding the need and potential benefits of value-based payment models that allowed for involvement of the SUD provider network. There was an appreciation for the advancements that were underway, but stakeholders reported that continued efforts geared specifically to SUD service providers were needed to improve

quality, promote care coordination, and incentivize greater collaboration and partnership. These ideas are supported by best-practice literature and are described in Appendix B of this report.

E. Need for expanded and enhanced training and technical assistance (T/TA) resources

One of the clearest findings from the assessment—supported by findings from interviews, focus groups, and the literature review—is the need for comprehensive, robust training and technical assistance services aimed at building organizational capacity, improving the quality of services, promoting participation in value-based payment models, and enhancing clinical, administrative and management operations. The assessment made it clear that T/TA offerings needed to span a broad range of clinical, operational, and management/leadership domains and cover a range of subjects, such as evidence-based care, improving operational workflows, quality/performance improvement, trauma informed care, care transitions, and person-centered care. Participants also reported that T/TA resources should be available to all staff and provider types (e.g., clinicians, paraprofessionals, front desk staff, and administrators) and should be offered in multiple formats (e.g., coaching, webinars, communities of practice). These ideas are supported by best-practice literature and are described in Appendix B of this report.

Summary of Recommendations

The following recommendations were drawn from the findings above informed by a series of robust discussions with the project’s Steering Committee. These recommendations were also greatly informed by the project’s Literature and Best Practice Review, the details of which are summarized in Appendix B of this report.

GAPS AND SERVICE DELIVERY CHALLENGES ACROSS THE SUBSTANCE USE DISORDER CONTINUUM

A. Service gaps across the ASAM continuum

- Continue to invest in and enhance existing assessment and referral services, moving forward with DBH’s “no-wrong-door” approach
- Expand access to evidence-based outreach and crisis stabilization services geared specifically to those with SUD
- Continue investments in behavioral health integration programs in primary care, hospital, and other settings, including evidence-based SUD screening, assessment, treatment, and referral
- Expand access to care transitions services, including peer recovery coaches, recovery specialists, and case management in outpatient settings
- Ensure that the numerous policies and programs designed to encourage DC Medicaid providers in the District to furnish care transition services (e.g., My Health GPS, My DC Health Homes program, transition planning services) can be used by DBH certified SUD providers
- Expand access to recovery support services, including peer support groups and multi-service community centers

- Expand access to a range of person-centered intensive outpatient program services
- Expand access to a range of person-centered transitional and supportive housing service options
- Develop targeted approaches to improve care transitions for specific population groups
- Develop and maintain a web-based SUD resource inventory to support care transitions
- Develop targeted approaches to improve care transitions for specific population groups

B. Inconsistencies in the quality of care

- Offer a broad range of training and technical assistance services, in multiple formats, aimed at building organizational capacity, improving the quality of services, and enhancing clinical and administrative operations
- Develop evidence-based, SUD-specific, person-centered guidelines, protocols, and standard operating procedures across the service continuum (e.g., outreach, assessment, stabilization/treatment, referral/step-down, discharge planning, documentation, peer group facilitation)
- Continue to invest in and train organizations to implement robust quality, performance improvement, and accountability initiatives
- Increase provider payments, implement enhanced payment models, and explore compensation models that incentivize service providers and possibly individual practitioners to adhere to strict quality standards

C. Shortages in housing, financial resources/supports, employment opportunities, job training, and transportation

- Invest in programs that provide or connect individuals to recovery support services that address the social determinants of health

D. Need to address structural racism and its impacts on individuals with SUD

- Invest in efforts to reduce the impact of racism and address the breadth of related structural inequities.

E. Need for greater emphasis and investment in prevention and harm reduction services

- Invest in programs that embrace and integrate principles of harm reduction (e.g., sobering centers, needle exchanges, wet shelters, etc.)
- Invest in primary/secondary prevention programs

SYSTEM IMPROVEMENTS AND ORGANIZATIONAL CAPACITY BUILDING

A. Need for enhanced support from DBH

- Refine or replace DATA (WITS) to increase functionality and make it more user friendly to improve information transfer, care coordination, reporting, and quality improvement efforts;
- Continue to invest in more streamlined and effective reporting, documentation, measurement, and accountability structures

- Explore how to simplify program requirements and regulations to increase flexibility while retaining some level of accountability
- Improve communication and enhance provider services capacity
- Simplify and reduce the burden of the DBH credentialing process
- Explore ways to increase payment rates and/or develop ways to enhance payments with value-based payment arrangements

B. Need for greater adoption and use of HIT/HIE, particularly among SUD providers

- Continue to invest in HIT/HIE adoption and use, including targeted training/technical assistance activities, and policies, programs, and contracting efforts
- Continue to refine and/or roll-out patient consent process within the HIE
- Continue to pilot and incent the use of programs that model evidence-based or proven practices with respect to the use of HIT/HIE in an array of high value circumstances (e.g., outreach and crisis stabilization, care coordination, care transitions/step down, and referrals)

C. Challenges related to collaboration and the siloed nature of DC's SUD system

- Take steps to ensure timely and effective communication with the SUD provider network
- Clarify, streamline, and improve assessment, discharge planning, and referral processes to enhance step down and promote greater collaboration and partnership
- Continue to develop a robust an on-line, interactive, well-maintained resource inventory to promote communication, facilitate referrals, and promote collaborative care
- Actively promote the development of SUD service organizations that provide multiple services along the ASAM continuum
- Explore the development of accountable care organizations (ACOs) and Behavioral Health Integrated Care Network(s)

D. Need for value-based payment models/policies

- Develop value-based payment arrangements for SUD providers
- Explore the development of accountable care organizations (ACOs) and Behavioral Health Integrated Care Network(s)
- Continue to develop and refine contractual relationships with MCO partners to incent them to meet or exceed quality and performance metrics related to care coordination, collaboration, and partnership

E. Need for expanded and enhanced training and technical assistance (T/TA) resources

- Continue to invest in comprehensive training and technical assistance services aimed at building organizational capacity, improving the quality of services, promoting participation in value-based payment models, and enhancing clinical and administrative operations

Next Steps and Contacts

DHCF and DBH are working together to develop a comprehensive approach to Medicaid Behavioral Health Transformation. On August 25, 2020, DBH and DHCF jointly published a Request for Information (RFI) to solicit information from interested parties regarding the pathway to integrate behavioral health services more fully into the benefits offered by District's Medicaid managed care program. DHCF and DBH envision a three-phase approach to Medicaid behavioral health transformation that will result in a whole-person, population-based, and integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.

The findings from this report, and recommendations proposed, will be used by DHCF to facilitate DC's SUPPORT Act Section 1003 activities, including the development of the act's forthcoming demonstration grant and other Medicaid redesign efforts.

For further information on this report and other SUPPORT Act Section 1003 activities in the District of Columbia, please contact healthinnovation@dc.gov.

District of Columbia Substance Use Disorder Community Need and Service Capacity Assessment

I. Introduction

In the spring of 2019, the District of Columbia (DC) Department of Health Care Finance (DHCF) applied for funding under the federal Centers for Medicare and Medicaid Services (CMS) Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. The SUPPORT Act was designed to assist states and other federal jurisdictions to increase the treatment capacity of Medicaid providers to deliver substance use disorder (SUD) treatment and recovery services. In the Fall of 2019, DHCF was notified that they were one of fifteen federal jurisdictions to receive an 18-month planning grant under the SUPPORT Act.

Specifically, these funds were granted to:

- Conduct and assess the SUD needs and service capacity in the District,
- Provide training and technical assistance services for DC's Medicaid providers that offer SUD assessment, treatment, or recovery services; and
- Improve reimbursement for and expand treatment capacity.

To fulfill one of the grant's obligations, DHCF engaged the DC Primary Care Association (DCPCA) to oversee an assessment of substance use disorder (SUD) treatment need and service capacity. In turn, the DCPCA engaged JSI Research & Training Institute, Inc., a public health and health care consulting firm, to assist with conducting the assessment. The ultimate goals of this work were to assess SUD provider capacity and need, and to develop recommendations to strengthen the SUD system in ways that would result in a whole-person, population-based, integrated Medicaid SUD system that is comprehensive, coordinated, high quality, culturally competent,¹² and equitable.¹³ This SUD Needs Assessment builds on and affirms many of the findings from the Live.Long.DC strategic plan¹⁴ and an assessment conducted by the Pew Charitable Trust for the Office of the Deputy Mayor for Health and Human Services,¹⁵ which focused on improving services for those impacted by the opioid epidemic. This report also builds on other work performed by DHCF to support the development of DC's 1115 Behavioral Health Transformation Waiver. Several of the findings reported, as well as the recommendations proposed, align with those of the prior reports. Key distinctions of the SUD Needs Assessment are focused on the Districts' system of SUD care overall, rather than a more explicit focus on

¹² Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations, according to the Centers for Disease Control and Prevention.

¹³ Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities, according to the U.S. Department of Health and Human Services, Office of Minority Health.

¹⁴ <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan-%20March%20Revision.pdf>

¹⁵ <https://dmhhs.dc.gov/page/policy-recommendations-address-opioid-crisis-dc>

opioid use disorder (OUD), and that it includes a review of the entire service continuum for Medicaid beneficiaries, rather than a sole focus on behavioral health providers.

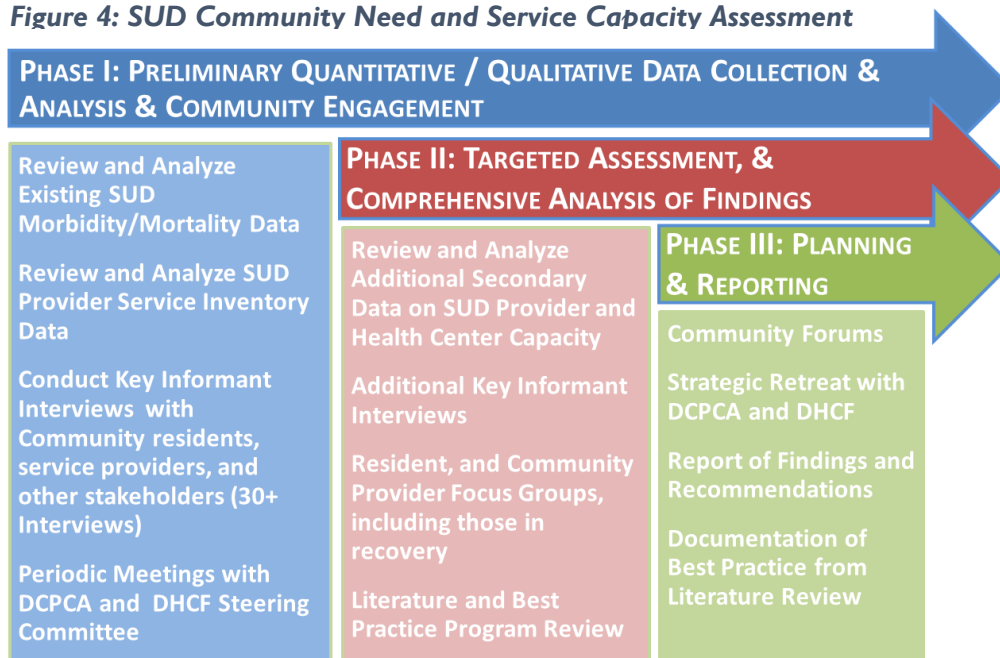
This report begins with a review of the three-phased, mixed-methods approach implemented by JSI to conduct this work and continues with a brief discussion of the burden of substance use disorder in the District. Following these sections is a detailed summary of the assessment's key findings and recommendations organized into two core domains: 1) gaps and service delivery challenges across the SUD service continuum, and 2) system improvements and organizational capacity building.

II. Project Approach and Methods

This assessment was conducted through a three-phased process designed to:

- Clarify the burden of SUD in DC and describe DC's SUD service system;
- Assess community need related to SUD, including service delivery assets and gaps, system strengths and weakness, barriers to access, and quality of care;
- Engage the full range of possible stakeholders, including staff across DC's public agencies, SUD-related service providers, and community residents, with special attention to ensure the inclusion of those who are most impacted by SUD;
- Conduct a robust, integrated analysis of the quantitative and qualitative information collected; and
- Develop recommendations to fill service gaps, build service capacity, enhance quality, and improve the systems and structures that support the SUD provider network.

Figure 4: SUD Community Need and Service Capacity Assessment



Phase I: Phase I involved a review of secondary quantitative data to clarify the burden of substance use and addiction on the District, and characterize DC's SUD service system. Appendix C provides a listing of the core data indicators and web links to the data references. In this effort, JSI relied on information gathered from existing datasets and reports, which were aggregated and analyzed using an interactive data analysis and visualization tool developed in Tableau (Appendix D). More specifically, the quantitative data, provided jointly by DHCF and DBH, combined data from DBH on the type of services provided by specific certified SUD provider organizations with data from DHCF on service volume (Medicaid and DC local claims data). DHCF also provided a breadth of information related to health information technology (HIT) adoption and health information exchange (HIE) connectivity. This data was instrumental in providing information on the distribution and volume of SUD services across the District by American Society of Addiction Medicine (ASAM) levels of care and HIT/HIE capacity. In Phase I, JSI staff interviewed more than 40 key stakeholders, including community residents, health and social service providers, DHCF/DBH/DOH staff, representatives from community and professional advocacy organizations, and other stakeholders (See Appendix A for a listing of those interviewed). The culmination of Phase I was a preliminary report of SUD needs and service capacity that was presented to the project Steering Committee, which informed findings and Phase II activities.

Phase II: Phase II involved a more targeted assessment of community need and broad community engagement activities, including additional key informant interviews, ten focus groups with community residents and SUD service providers, and two community meetings that engaged the community at-large (See Appendix A for a listing and brief descriptions of the focus groups and other community meetings). Throughout Phase II, efforts were made to engage SUD clinicians and professionals, individuals in recovery, and individuals who currently or formerly utilized the SUD service system. The culmination of Phase II was a slide deck, presented to staff at DCPCA and DHCF, which summarized the findings and preliminary recommendations from the assessment (Appendix E).

Phase III: Phase III involved a series of meetings with the project's Steering Committee to vet and prioritize assessment findings and explore recommendations. Phase III also involved a targeted review of literature and best practices to ensure that recommendations were evidence informed (See Appendix B for an annotated listing of the literature and best practices that were identified). The culmination of Phase III was a series of slide deck presentations and reports for various audiences summarizing the assessment findings and recommendations. One of the core slide deck presentations is included in Appendix E.

Phase I and much of the Phase II work was completed by March 2020 at the time the COVID-19 public health emergency was declared. Simultaneously, social unrest in response to racial inequities, spurred by the killing of George Floyd on March 25, 2020, has highlighted the impact of racism and inequality. This increased awareness, along with the disproportionate impact of COVID-19 on racial and ethnic minorities, resulted in increased need for social and behavioral health support and services, and was compounded by numerous changes in practice, including a growing reliance upon virtual care or telehealth. Despite these changes, DCPCA and JSI are confident the core findings and recommendations articulated in this report are valid. If anything, the findings and recommendations may even have grown in importance as a result of the pandemic.

III. Burden of Substance Use and Addiction in the District of Columbia

Substance use and addiction have had a devastating impact on individuals, families, and communities throughout DC for decades. While DC is not alone in this

regard, the impact of SUD on the District is considerable compared to the rest of the country; SUD prevalence rates in DC have consistently been among the highest in the nation. According to data gathered by the Substance Abuse Mental Health Services

Figure 5: Prevalence of SUD Among DC Residents, 18 Years Old or Older

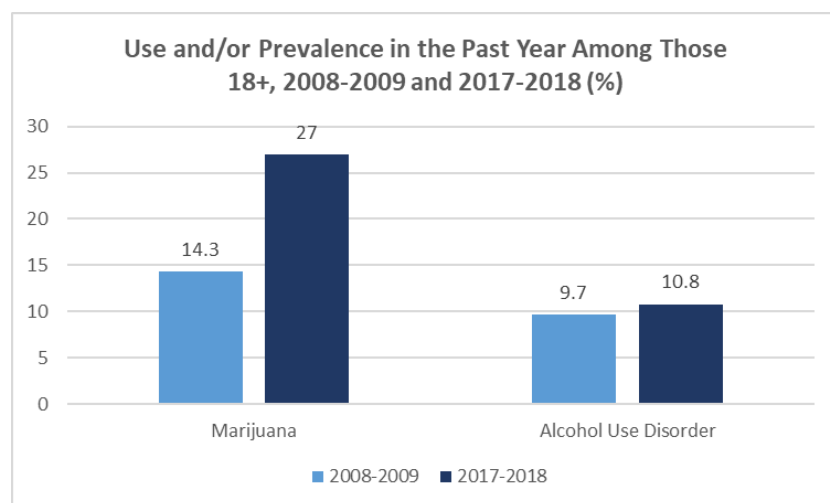
Substance Use Disorder* in the Past Year – Percentages Amongst Those 18+ (2017-2018), Top 5 in the US	
TOTAL U.S.	7.7%
Washington, D.C.	13.0%
Colorado	11.9%
Vermont	10.5%
Oregon	9.9%
Alaska	9.8%

SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2017-2018

Administration's (SAMHSA), Center for Behavioral Health Statistics and Quality, in 2017/18 DC had the highest SUD prevalence rate in the United States – 13.0% among adults 18 years old or older.¹⁶ This rate was nearly twice as high as the national average of 7.7%. Perhaps even more troubling is that over the past decade, SUD rates in the District have continued to increase. From 2014 to 2017, the District's

opioid-related fatal overdoses increased by 236%¹⁷ and between 2009 and 2018, the prevalence rates of alcohol use disorder and marijuana use also increased. Notably, starting in 2015, small amounts of marijuana are legal in the District of Columbia. In the case of alcohol, the prevalence rate nearly doubled during this time from 14.3% to 27.0%.

Figure 6: Use and Prevalence in the Past Year



SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2008-2009 and 2017-2018

What is also clear from the assessment's quantitative and the qualitative findings is that SUD continues to have a gravely disproportionate impact on DC's

African American/Black communities. Between January 2016 and February 2020, 84% of fatal opioid

¹⁶ SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2017 -2018

¹⁷ Live.Long.DC: Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse and Related Deaths, Department of Behavioral Health, December 24, 2018, 4.

overdoses in the District were among Black residents, even though in 2018 the African American/Black population accounted for only 45.5% of DC's total population.¹⁸

The disproportionate impact of COVID-19 has magnified deep-seated inequities in health care that impact Black and Latinx communities. Present time exclusion and past injustices compound each other and put these communities at greater risk of chronic health conditions. This assessment and the recommendations provided are focused primarily on identifying SUD service and capacity gaps and identifying what DHCF and its public and private partners can do to address these issues; however, addressing the disparities in SUD outcomes and dismantling underlying causes of racial health disparities will require a long term, sustained commitment at all levels of government and health care. More immediately, targeted strategies are needed to address the social determinants of health, promote long-term engagement in care, and improve SUD outcomes for communities of color.

IV. Key Findings and Recommendations by Domain

In December 2020, DC's SUD provider network included 32 DBH certified SUD providers, 21 of which were ASARS providers contracted by DBH to provide substance use services. In addition, the SUD provider network includes 155 Medication Assisted Treatment (MAT) waived providers who prescribe medication to SUD clients. The assessment showed that this provider network is strong and well-supported compared to SUD service networks in similar urban markets. Services are well-distributed throughout the District and provide a full breadth of services across the SUD service continuum.

However, this does not mean that DC residents with SUD are always able to access the person-centered services they need, when and where they want them. The assessment identified several significant gaps across the ASAM levels of care and a range of service delivery challenges, discussed in detail below, that limit engagement in care, hinder care coordination, interfere with care transitions, and that ultimately reduce the effectiveness of the existing service network.

Assessment findings suggest that if DHCF and its public and private partners are to make a shift toward a fully integrated population management approach, then they will need to address the identified gaps and continue to invest in system strengthening, service delivery/payment reform, quality improvement, and robust training and technical assistance. Findings from the assessment interviews and focus groups suggest that addressing the service delivery challenges and system-related issues may have a greater impact on DC's ability to meet the SUD needs of District residents than addressing the service gaps.

The following is a detailed summary of the assessment's key findings and recommendations organized into two core domains: (1) gaps in the SUD service continuum, and (2) system improvements and SUD capacity building. Quotes from those who participated in the assessment's interviews, focus groups, and community meetings are incorporated into the findings. Many of the recommendations in this report align with best practice programs or strategies identified through the project's literature review. These best practices, along with other supportive, peer reviewed literature, are described and cited in Appendix B. Hyperlinks to the appropriate sections in Appendix B are included below in the findings when applicable.

¹⁸ District of Columbia Office of the Chief Medical Examiner, "Opioid-Related Fatal Overdoses: January 1, 2016 to February 29, 2020" (2020)

As noted earlier, it is important to acknowledge that much of the work conducted for this report was completed at the time the COVID-19 public health emergency was declared and it therefore does not reflect the most recent challenges faced by SUD providers in the District. For example, many ASARS providers have experienced a substantial reduction in service volume—and therefore revenue during the public health emergency. While some ASARS providers have increased their use of telehealth as mode for service delivery, uptake remains notably lower than that of DBH-certified mental health providers. To help ASARS providers offset some of their losses, DHCF has implemented a 20 percent increase in Medicaid reimbursement rates for most ASARS services through the duration of the public health emergency. Another important change is that as a result of modifications to Chapter 63, Assessment and Referral is now a core ASARS service that required of most providers, which has broadened access to this important service.

I. GAPS IN THE SUBSTANCE USE DISORDER SERVICE CONTINUUM

A. Service Gaps Across the ASAM Continuum

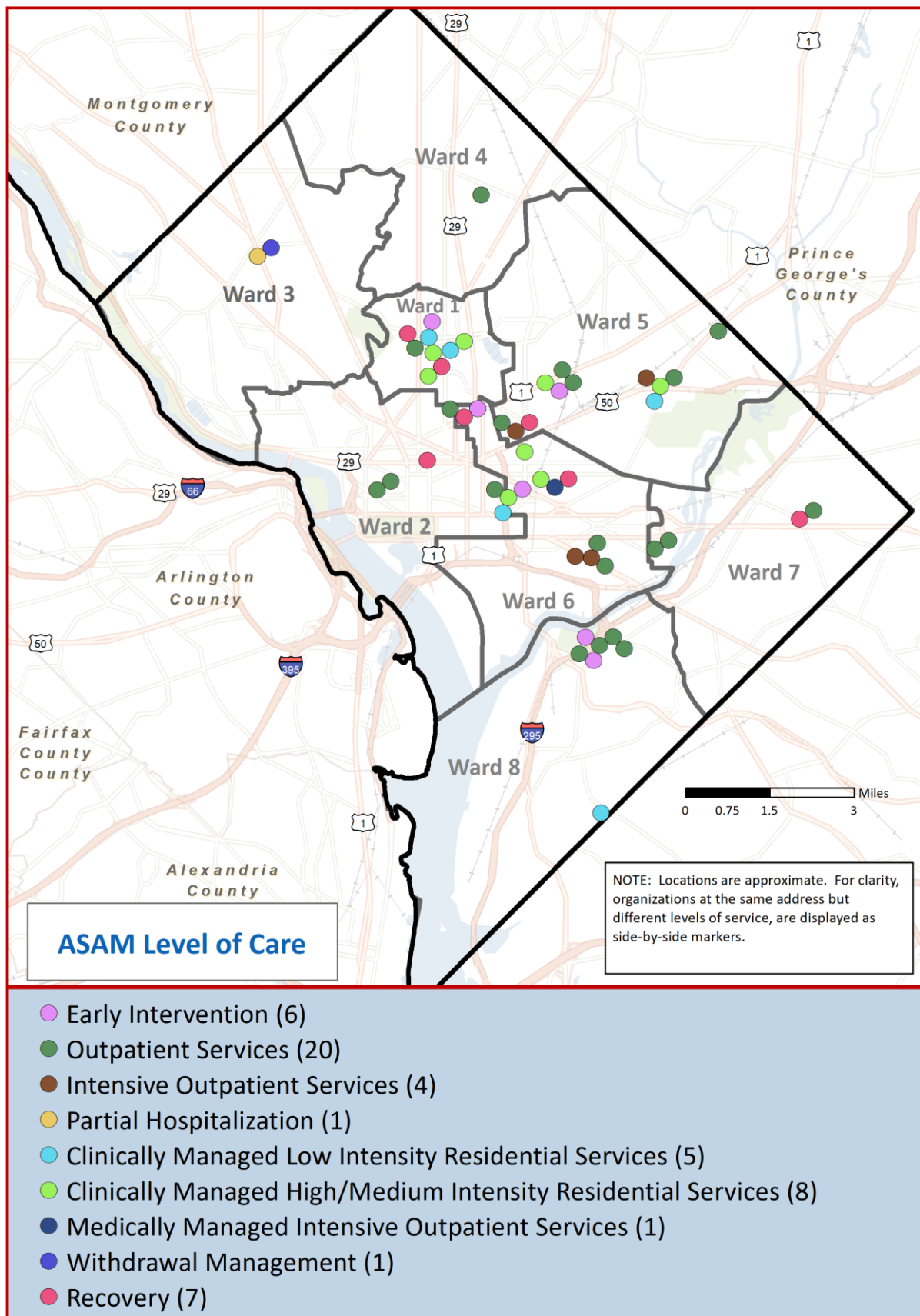
At the outset of the project, DBH and DHCF worked together to compile utilization and paid claims data from all DBH certified SUD service providers, which allowed JSI to characterize DC's SUD service system and assess the breadth and capacity of the provider network. These data were provided to JSI at the organization and service site level and included information on service site location, dollar volume of paid claims (Medicaid and local¹⁹) and unduplicated clients served by location. These data were entered into a Tableau²⁰ database and analyzed geospatially. These data also provided information on the types of services that the certified providers were submitting claims for at the service location level, which facilitated a review of the distribution of services by ASAM level of care.

Figure 7: Number of DBH Certified SUD service sites by ASAM levels of care (FY 2019)

ASAM Levels of Care	# of DBH Certified Service Locations ^c
Level 0.5 – Early Intervention ^a	6
Level 1.0 – Outpatient Services ^b	20
Level 2.1 – Intensive Outpatient Services	4
Level 2.5 – Partial Hospitalization	1
Level 3.1 – Clinically Managed Low Intensity Residential Services	5
Level 3.3/3.5 – Clinically Managed High/Medium Intensity Residential Services	8
Level 3.7 – Medically Managed Intensive Outpatient Services	1
Level 4.0 – Withdrawal Management	1
<p><i>a - Includes DBH certified providers, recently contracted to provide assessment and referral providers and the DC Assessment and Referral Center (ARC). Note ARC utilization is not included in the report's utilization/claims analyses as it is not a contracted DBH provider. ASTEP service providers are also included in the early intervention category.</i></p> <p><i>b - Includes DBH certified providers delivering SUD outpatient and MAT services.</i></p> <p><i>c – Total number of service locations exceeds number of certified provider organizations because some organizations provide multiple services at a given site.</i></p>	

¹⁹ Local claims are submitted to DBH by DBH certified providers and pay for services provided to eligible residents who are uninsured.

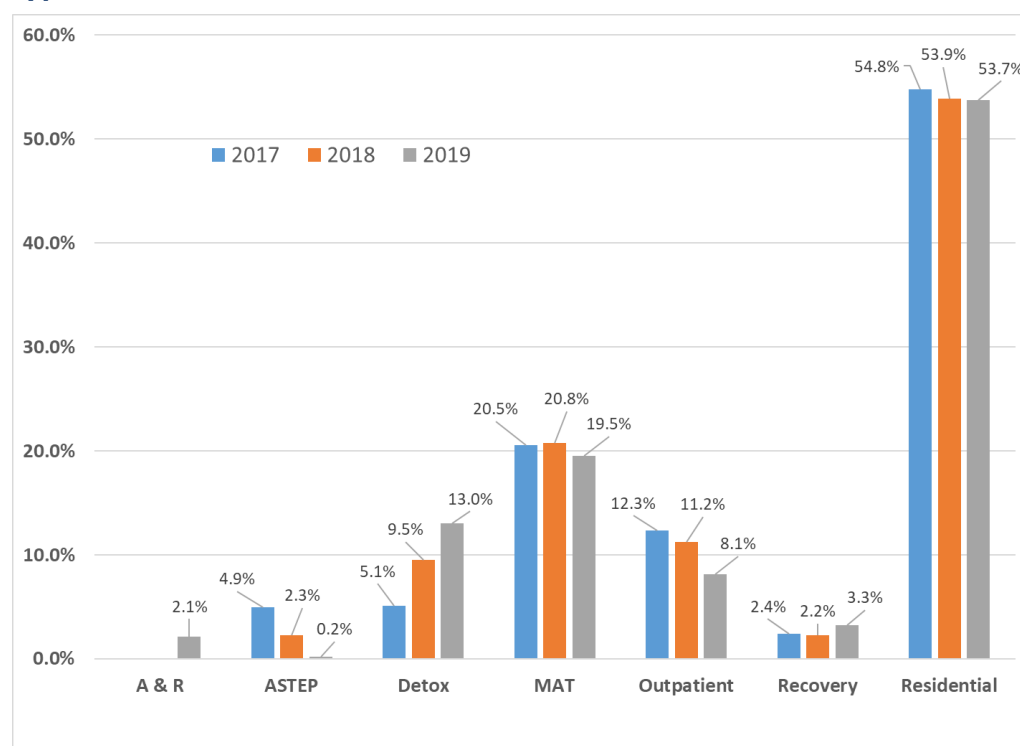
²⁰ Tableau is a visual analytics software platform that supports data management, analysis, and visualization.
<https://www.tableau.com/>

Figure 8: DBH Certified ASARS Providers by Service Location

In FY 2019, 5,174 DC residents received adult substance abuse rehabilitation services (ASARS) from DBH certified providers. Of those who received these services, 99% were adults 18 years old or older, 63% were male, and 87% identified as Black. Relative to the types of services that these 5,174 residents received, 37% (1,920 clients) received residential services, 31% (1,598) received opioid treatment services, 28% (1,461) received outpatient services, 14% (702) received recovery services, 13% (692) received withdrawal management services, and the remaining 2% received adolescent treatment and assessment/referral services.^{21 22}

Based on a review of the total value of paid claims to DBH certified ASARS providers, in FY 2019 54% of paid claims were for residential services, 20% were for methadone MAT services, 13% were for withdrawal management services, and 8% were for outpatient services. The remaining 5% of claims were paid for assessment and screening services, recovery services, and for Adolescent Substance Abuse Treatment Expansion Program (ASTEP) services. These data also showed that the percentage of paid

Figure 9: Percentage of Total Paid Claims to ASARS Providers by Type of Service, 2017-2019



claims by service type as a share of total paid claims remained relatively stable for residential, MAT, and recovery services between 2017 and 2019. Alternatively, the percentage of total paid claims increased

²¹ The percentage of total clients receiving services by service type, along with the actual number of clients receiving particular services, reflect unduplicated counts by service type. The sum of the percentages exceed 100% and the sum of the number of clients received particular services exceed 5,174 because some clients received multiple types of services.

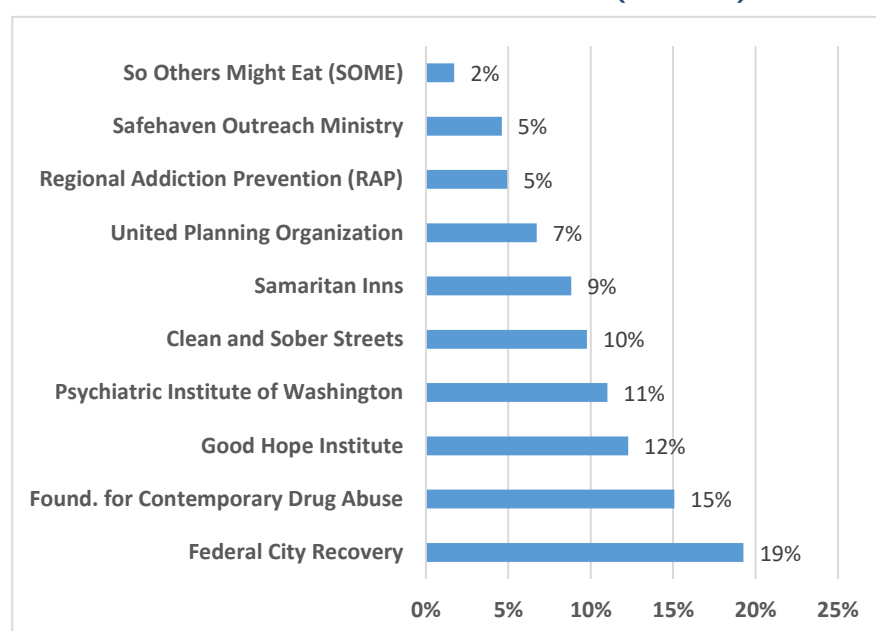
²² DBH Mental Health and Substance Use Report on Expenditures and Services January 2020 (FY 2019) <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20for%20FY%202019.pdf>

substantially over this period for withdrawal management services and decreased for outpatient and ASTEP services.

While more research is required, these findings seem to corroborate the qualitative findings from a number of service providers that SUD clients are often referred to residential services, rather than outpatient services that might have been more appropriate, because the clients lacked safe, affordable housing.

The quantitative data also showed that in FY 2019, 70% of all claims were paid to the top five DBH certified ASARS providers, and 86% of claims were submitted by the top eight ASARS providers. The remaining 14% of total claims were submitted by 16 other service providers.

Figure 10: Percent of Paid Claims for the Top 10 DBH Certified ASARS Providers as a Percent of Total Paid Claims (FY 2019)



The qualitative information gathered from community residents, service providers, and other stakeholders through the assessment's interviews, focus groups, and community meetings corroborated many of the assessment's quantitative findings, including the DC SUD provider network is robust, well-supported, and well-distributed geographically. However, nearly everyone believed that there were significant gaps across ASAM levels of care that worked together to limit engagement in timely, person-centered care, hinder care coordination, interfere with effectiveness of care transitions, and ultimately reduce the impact of the existing service network. Specifically, stakeholders identified gaps in the following five ASAM levels of care:

- Outreach, assessment, and referral services (ASAM 0.5)
- Care transitions services (ASAM 1.0)
- Recovery support services (ASAM 1.0)
- Intensive outpatient programs (ASAM 2.1)

- Transitional/supportive housing (ASAM 3.1)

The following are specific findings regarding each of these identified shortages and reflects findings that were cited broadly from many of the participating stakeholders and are thus classified as key findings.

1) Outreach, assessment, and referral services (ASAM 0.5)

Many of those who participated in the interviews, focus groups and community meetings expressed that there were gaps with respect to the capacity and geographic distribution of assessment and referral services across the District. Participants believed that these gaps hindered engagement and prevented clients from receiving the person-centered services they needed to support their recovery. Service providers overwhelmingly supported DBH's decentralized "no-wrong-door"²³ approach to assessment and referral, but believed it should be expanded even further and that program requirements should be refined and made more flexible so that they were more provider- and patient-centered. More specifically, stakeholders:

- Voiced concerns regarding the lack of evidence-based outreach and crisis stabilization services, specifically tailored for those with SUD.
- Believed that the assessment process did not always lead to the most appropriate, person-centered referrals and voiced that DBH needed to refine the assessment processes to ensure greater adherence to the ASAM guidelines.
- Voiced that the current requirements for community-based assessment and referral sites were at times cumbersome and inflexible. They believed they needed to be changed to reduce provider burden, promote sustainability, and to maximize the intent and capacity of the "No-Wrong-Door" approach.
- Spoke about the importance of, but general lack of attention provided to the assessment and referral process. This was considered an issue when clients were being discharged and transitioning between levels of care, after the initial referral. Stakeholders believed that DBH and DHCF needed to develop and disseminate best practice protocols, policies, and procedures to guide the assessment, referral, and care transitions process between levels of care following discharge.

"When a client comes in, there is a feeling that we need to get them into treatment as soon as they walk through the door. We're not getting accurate information from them and that affects their assessment and placement. Then you have the unhoused population, who want to find a safe place, and will say certain things to be in a residential program, when they could be in a Level 2 program. Or, you have people who come in, and the criminal justice system pulls them out of that level of care and puts them where they want them. All of this disrupts the process." – Provider, Focus Group Participant

²³ <https://dds.dc.gov/page/no-wrong-door>

2) Care transitions services (ASAM 1.0)

Many stakeholders reported that there were shortages with respect to the availability of care transition services and inconsistencies in the quality of existing services that support clients as they “stepped down” from one level of care to another. These shortages and inconsistencies in quality were reported despite the numerous policies and programs designed to encourage Medicaid providers in the District to furnish care transition services, including DC’s My Health GPS²⁴ and My DC Health Homes program,²⁵ transition planning services, and other strategies implemented through the District’s MCO contracts. Nearly all of the service providers and many of the SUD clients that participated in this assessment reported shortages of peer recovery coaches, recovery specialists, and specialized SUD case managers who provide vital, tailored supports that assist clients through the care transition process. These services are particularly important as clients’ transition to a new provider organization and as coordination and case management needs increase. More specifically stakeholders:

- Spoke of how important it was that specialized providers (e.g., peer recovery coaches, recovery specialists, and/or specialized SUD case managers) be available to support consumers as soon as they engage the system during the initial assessment and referral process and/or during subsequent referral and care transitions processes, as they move from one level of care to another. If those with SUD are going to be successful, they must be able to access SUD services, including the supportive care transitions services, at least as quickly as they can access the substances that they are trying to refrain from using.
- Shared that not enough attention was placed on the care transition process and that the services provided in this regard were not always of the highest quality. There is a need for more specialized training provided to the therapists, case managers, care planners, etc. during the discharge process. Technical assistance needs to be provided at the organization-level to ensure that service providers were designing effective internal workflows, operations, and systems to support effective care transitions.
- Voiced that the care transition process is hindered by barriers in communicating and sharing information between providers that prevented smooth, well-coordinated care transitions.
- Reflected that too often clients are discharged into unsafe settings in ways that derail the recovery process.
- Believed that health care providers across the spectrum should have access to an on-line SUD resource inventory so that providers across the spectrum would know where and how access these services for their clients/patients

²⁴ <https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps>

²⁵ <https://dhcf.dc.gov/page/health-homes>

Information drawn from the project's literature and best practice review (Appendix B), suggests that programs that provide care transitions assistance that is carefully tailored to specific population segments are often able to promote longer-term engagement and smooth care transitions during the recovery process. The literature further suggests that DBH, DHCF, MCOs, and other partners should explore developing tailored programs geared to specific population segments, such as homeless/unstably housed, formerly incarcerated, women with children, and individuals with co-occurring mental health diagnoses.

“There are many organizations in the District who provide SUD services - but that doesn't mean that they all provide high quality services, are good with follow up, and support their clients after they finish their treatment. It's not hard for clients to get their first appointment. What is hard is getting good follow up care from a qualified and invested provider or case manager so that you can move on in your recovery.” – Stakeholder Interview

“When I moved into my apartment [after treatment], my transition was so bad. It was so stressful. It was like an Olympic event. I had to get multiple case managers – I had four of them. Each one was working on something different.” – Individual in recovery, focus group participant.”

3) Recovery support services (ASAM 1.0)

Many providers and SUD clients who participated in the assessment reported that there were gaps in the availability and variety of recovery support services. These stakeholders believed that clients were not always able to access the tailored, person-centered services they needed to promote long-term engagement in care as they transitioned or stepped-down from one level of care to another. Service providers and clients reflected on the need for more peer groups as well as the need for more recovery specialist or case managers who could provide direct, hands-on support. Providers spoke particularly about transitions from withdrawal management (ASAM 4.0) and residential services (ASAM 3.3, 3.5, 3.7), as well as direct supports for clients receiving medicated assisted treatment (MAT) to help with medication adherence. Furthermore, service providers discussed the need for increased payment rates or specialized service delivery/payment models that would allow them to augment the services they already provide.

These stakeholders also described a need for a broader range of SUD services for specific segments of the SUD client population (e.g., veterans, men-only, women-only, mothers with children); different service types (e.g., peer groups, community centers, housing first models, one-on-one or coaching programs); and services with different requirements and philosophies (e.g., sober and non-sober living, 12-step, SMART Recovery, faith-based or secular).

More specifically, stakeholders:

- Believed that DHCF and partners should take steps to expand access to multi-service organizations or “centers” that offered a range of SUD and non-SUD services that would work together to support long-term engagement in care and recovery. For example, multi-service centers geared specifically to those with SUD that offer peer recovery groups, specialized case management, housing and employment supports, as well as opportunities to stay active and engaged with their social networks. This idea is supported by the best-practice literature and are described in Appendix B of this report.

- Reflected that many MAT providers struggle to link their patients to the resources they need to adhere to challenging medication regimens and/or sustain their engagement in recovery. This was true particularly for MAT providers who practice independently in small or solo medical practices. These providers often lack the support of providers who operate in SUD provider settings or in multi-service clinics with co-located behavioral health services. These types of recovery services are available in the District, but there are shortages and barriers that hinder MAT providers' ability to easily link their patients to these resources.

These shortages and barriers can work to prevent primary care providers from becoming waived MAT providers or limit them from developing robust SUD screening services that would allow them to use their privileges and fully support their patients.

- Indicated the need to increase the capacity, variety, and quality of peer recovery groups. Stakeholders described how successful and important these peer groups were to those in recovery but shared that those operating the groups were often not well-supported and that the groups were inconsistently administered. There is a need for more robust training and technical assistance provided to the individuals facilitating the groups as well as the organizations who are responsible for organizing the groups. There is also a need for best practice manuals or operating procedures to help ensure the quality and effectiveness of these groups.
- Believed that health care providers across the spectrum should have access to an on-line SUD resource inventory so that providers across the spectrum would know where and how access these services for their clients/patients.

“Providers don’t get much support in addressing disparities and recovery capital – what people bring to recovery and how this can help the recovery process. Experienced clinicians know how to do that but our system does a bad job at looking at recovery as a separate phase. We say ‘here is your treatment, we wish you well.’” – Consumer, Focus Group

4) Intensive outpatient programs (ASAM 2.1)

Many stakeholders cited that there were gaps in the availability, variety, and quality of intensive outpatient programs (IOPs). Stakeholders felt it was important that these services be geographically well distributed and that there be a variety of services geared to specific segments of the SUD client population (e.g., veterans, men/women, men and women, mothers with children, etc.) with different service delivery policies and/or philosophies (e.g., sober and non-sober living, faith-based or secular, etc.) Some stakeholders also shared that existing services were not always of the highest quality and that there needs to be more specialized training provided to the SUD organizations providing these services to encourage more effective application and/or development of these resources.

5) Transitional housing (ASAM 3.1)

Nearly all of the service providers and clients who participated in the assessment’s interviews, focus groups, and community forums reported that there were substantial gaps in transitional housing services in the District, particularly for clients stepping down from withdrawal management and long-term residential services. This gap too often means that clients transition

to unsafe, unsupported housing situations. Participants also reflected on the need for a greater variety of safe, affordable, and supportive housing options more generally that are tailored to individuals with different needs and who are in various stages of SUD recovery.

These discrete service gaps can have immediate consequences on a person's care as they hinder timely engagement as they step up or down from one level of care to another. However, the gaps can have broader impacts and derail clients from their path to recovery. The strength of the SUD network depends largely on it being an unbroken continuum of services. According to ASAM's core principles, a client is not admitted to a particular program or level of care but rather to the continuum itself. This focus on moving the client along the continuum prompts clinicians to look ahead and engage in long-term treatment planning.

B. Inconsistencies in the quality of care

Many of the providers and clients that were engaged in the assessment reflected on the need for DBH, DHCF, SUD service providers, and other partners to focus on improving the quality of care across the SUD service continuum. Specifically, participating service providers and clients reported that workforce shortages, low payment rates, ineffective communication systems, limited use of evidence-based protocols, and lack of quality improvement systems led to inconsistencies in the quality and capacity of care. Service providers believed that DHCF and its partners needed to address these quality-related issues to realize the full capacity of the system.

Furthermore, participating service providers said there was a need for more robust training and technical assistance services, which they believed was critical to addressing these inconsistencies. Participants said that these training and technical assistance services should be focused on:

- Developing and promoting the use of evidence-based, client-centered service guidelines, protocols, and standard operating procedures to guide and support more effective outreach, assessment, treatment, and recovery services.
- Facilitating the adoption and use of health information technology (HIT) and health information exchange (HIE) resources.
- Improving provider documentation.
- Promoting collaboration, communication, and partnership within and across organizations.
- Improving quality, performance improvement, and accountability efforts.

The following are more specific details about the quality issues identified:

- **Care transition and discharge planning processes.** One of the leading findings from the assessment was the challenges that organizations and clients faced with respect to discharge planning and care transitions or step down. Those participating in the assessment said that often not enough attention is paid to performing the assessment, referral, and discharge planning process as clients are transitioning from one level of care to another. Organizations need training and technical assistance on the discharge and care transitions process and clients need to be more effectively supported during this process.
- **Provider collaboration and partnership.** Another leading finding from this assessment and most assessments conducted in DC over many years is the siloed nature of DC's health system

and the need for greater collaboration and partnership. Efforts need to be made to promote information sharing, communication, collaboration and partnership.

- **Evidence-based services and collaborative care practices.** Many service providers do not consistently apply evidence-based protocols, guidelines, or procedures with respect to screening, assessment, treatment, care transitions, and recovery support. Providers also need to put more attention on team-based care practices to promote information sharing and improve care transitions.
- **Assessment and referral processes.** Stakeholders stated the importance of refining how clients were assessed to determine the appropriate level and amount of care at the outset of a client's engagement in treatment as well as during a client's course of treatment during the discharge and care transitions process. As alluded to above during the review of the assessment's quantitative claims data, service providers participating in assessment's interviews reflected that DBH may need to explore how they can enhance the assessment and referral process to ensure that clients were being referred to the most appropriate level of care on the continuum. Some providers suggested that clients might be advocating for residential services due to their need for safe, affordable housing, rather than relying on the assessment to determine the most appropriate level of care based on an evaluation of their SUD issues and service needs.
- **Quality/performance improvement (Q/PI).** SUD service providers and the SUD system overall (DHCF, DBH, MCO's, etc.) need to focus more resources on quality and performance improvement. There is substantial variability across SUD providers in the expertise and resources committed to Q/PI. DHCF, DBH, MCOs and other partners should develop and promote the use of standardized measures that would allow all involved to gauge the quality and impact of services and various initiatives at a provider- and system-level. Additionally, there is a need for more training and technical assistance at the service provider-level in the area of Q/PI.
- **Health Information Technology / Health Information Exchange (HIT/HIE) systems.** One of the more consistent findings during the assessment were reflections on the need for DBH to refine its DATA (WITS) system and for DC's providers to adopt and more effectively use data to communicate, coordinate care, and make referrals. Many providers reflected on the challenges related to using DATA (WITS). Increasing numbers of SUD service providers have electronic medical records and are using the available HIE systems, but SUD providers are still substantially behind other service providers across the system. Overall DC's health system has made great progress, but more investment is needed.

C. Shortages in housing, financial resources/supports, employment opportunities, job training, and transportation

Nearly all participating service providers and SUD clients referenced the need for additional services to address the social determinants of health. More specifically, stakeholders reported a need for greater investment in programs that promote safe and affordable housing, increase financial supports for those in recovery, create employment and job training opportunities, enhance transportation (on-demand services), and reduce the impacts of institutional racism and trauma. Many service providers and SUD

clients spoke passionately about the idea that for many SUD clients addressing underlying social factors is more important to recovery than improving the capacity or quality of SUD services.

“Need mentoring, education, and job training programs that start as early in treatment as possible. Get people basic education (getting GED) as soon as you get them into treatment so they have a little hope. Then once they achieve that you can start talking about skills and job training. Then you can talk about career counseling. Work with people as they work through recovery.” – Focus Group Participant

“Once I got housing, I got stable. I had time to look in the mirror and see myself. Housing is the key.” – Focus Group Participant

D. Need to address structural racism and its impacts on individuals with SUD

Numerous SUD clients and other stakeholders who participated in the assessment discussed the impacts of racism, structural inequities, and the underlying trauma that can contribute to or even be at the root of SUD for many DC residents. It is also clear that these factors limit access to affordable housing, education, employment, and overall well-being, which can be underlying causes of SUD on their own. These participants believed that it was essential that DC continue to invest in efforts to reduce the impact of racism and address the breadth of related structural inequities.

E. Need for greater emphasis and investment in prevention and harm reduction

Many of the service providers and SUD clients who participated in the assessment cited the need for increased investment in SUD prevention and harm reduction services. With respect to prevention services, participants appreciated the significant investments that the District has made but reported need for greater investments in evidenced-informed prevention programming in clinical, school-based, and community-based settings. Participants believed that these investments would serve to further increase awareness, decrease stigma, and support early intervention, which would ultimately reduce the demand for SUD services.

With respect to harm reduction, participants believed that, in addition to addressing the gaps within the ASAM levels of care, the District should expand access to needle exchange programs, invest in sobering centers, and apply principles of harm reduction across the SUD service continuum. Participants believed that SUD services needed to be more person-centered and embrace the idea that, for many clients the path to recovery may not always be a straight line, and sobriety may not be the immediate goal. More specifically, stakeholders:

- Believed that public and private agencies across the health care system needed to invest resources in SUD primary, secondary, and tertiary prevention programs. These investments should be focused broadly on the District overall as well as in a more focused way by prioritizing certain high-risk segments, conditions, or settings.
- Believed that there needs to be a heightened focus on harm reduction and how it can be applied in evidence-based ways to reduce the impact of SUDs on individuals, families and communities and promote longer-term engagement in care. Service providers need to provide more person-centered care and not assume that abstinence or sobriety was the best path for all clients.

- Reflected on the importance of DBH, DHCF and other partners making investments or enhancements to existing programs, such as sobering centers, needle exchange programs, and/or residential and outpatient programs, specifically tailored to those whose goals were not sobriety at that moment.

Summary Recommendations to Address Gaps in the Substance Use Disorder Service Continuum

The following recommendations were drawn from the findings above informed by a series of robust discussions with the project's Steering Committee. These recommendations were also greatly informed by the project's Literature and Best Practice Review, the details of which are summarized in Appendix B of this report.

A. Service gaps across the ASAM continuum

- Continue to invest in and enhance existing assessment and referral services, moving forward with DBH's "no-wrong-door" approach
- Expand access to evidence-based outreach and crisis stabilization services geared specifically to those with SUD
- Continue investments in behavioral health integration programs in primary care, hospital, and other settings, including evidence-based SUD screening, assessment, treatment and referral
- Expand access to recovery support services
 - Continue to increase the capacity and quality of peer support groups
 - Develop multi-service community centers that provide targeted services across the SUD outpatient treatment and recovery spectrum
- Expand access to a range of person-centered intensive outpatient program services
- Expand access to a range of person-centered transitional and supportive housing service options
- Expand access to care transitions services, including peer recovery coaches, recovery specialists, and case management in outpatient settings
 - Develop targeted approaches to improve care transitions for specific population groups
 - Develop and maintain a web-based SUD resource inventory to support care transitions
 - Develop targeted approaches to improve care transitions for specific population groups

B. Inconsistencies in the quality of care

- Offer a broad range of training and technical assistance services, in multiple formats, aimed at building organizational capacity, improving the quality of services, and enhancing clinical and administrative operations
- Develop evidence-based, SUD-specific, client-centered guidelines, service protocols, and/or standard operating procedures across a broad range of service-related areas (e.g., outreach,

assessment, stabilization/treatment, referral/step-down, discharge planning, documentation, peer group facilitation)

- Continue to invest in and train organizations to implement robust quality, performance improvement, and accountability initiatives
- Increase provider payments, implement enhanced payment models, and explore compensation models that incentivize organizations and individual service providers to adhere to strict quality standards

C. Shortages in housing, financial resources/supports, employment opportunities, job training, and transportation

- Invest in programs that provide or connect individuals to recovery support services that address the social determinants of health focused particularly on housing, financial resources/supports, employment opportunities, job training, and transportation

D. Need to address structural racism and its impacts on individuals with SUD substance use disorder

- Continue to invest in efforts to reduce the impact of racism and address the breadth of related structural inequities

E. Need for greater emphasis and investment in prevention and harm reduction

- Invest in primary/secondary prevention programs in clinical, school-based, and community-based settings
- Invest in programs that embrace and integrate principles of harm reduction (e.g., sobering centers, needle exchanges, wet shelters, etc.)

II. SYSTEM IMPROVEMENTS AND ORGANIZATIONAL CAPACITY BUILDING

One of the most common themes throughout the assessment was the need for enhanced systems and more targeted supports geared to strengthening the capacity of individual service providers as well as the SUD service network overall. Participants in the assessment believed that focusing on improving systems would increase the quality care and facilitate outreach, care coordination, referrals, care transitions, and collaboration. Many of the participating service providers and SUD clients reflected that addressing these system issues could be more important than addressing the ASAM service gaps discussed above. Below is a summary of the identified needs and opportunities in this area.

A. Need for enhanced support from DBH

Numerous service providers reported that they needed additional or more enhanced support from DBH with respect to HIT/HIE, regulation, certification/licensure, and payment. These issues were said to hinder program operations, treatment documentation, care/discharge planning, and communication, as well as quality improvement and accountability efforts. Some participants felt that these issues prevented some SUD providers in the District from seeking DBH certification. More specifically:

- **DATA WITS.** Service providers expressed concerns with the District’s analytic and reporting systems (namely DATA WITS), which were described as awkward, ineffective, and time consuming to use. Participants reported that they believed these systems were developed primarily to manage billing and payment and greater efforts were needed to retool or replace these systems so that they more effectively supported documentation, care/discharge planning, care coordination, and communication.
- **Program Regulations.** A number of service providers felt that DBH’s regulatory and program requirements were too rigid and not entirely provider-centered. A number of participants also cited that these requirements were not always communicated in an effective or timely manner. A number of providers reported that these requirements sometimes required them to substantially alter their staffing, existing work flows, and systems, which led to duplicative systems, confusion and inefficiencies.
- **Licensure/Certification.** Some service providers described the District’s certification processes as unnecessarily cumbersome, time-consuming, and, at times, duplicative.
- **Payment rates.** A number of service providers reported that payment rates were too low, resulting in providers being “stretched thin.” Participants said that the low payment rates sometimes lead to challenges with respect to: a) Recruitment and retention of providers, b) Compliance with reporting and billing requirements, c) Conducting robust quality/performance improvement, and d) Ensuring strong care transitions and step-down.

B. Need for greater adoption and use of HIT/HIE, particularly among SUD providers

As discussed above, many service providers expressed concerns with DBH’s analytic and reporting systems (namely DATA WITS). More generally, nearly all the service providers that participated in the assessment reflected on the importance of strong HIT and HIE systems to support outreach, referral, care coordination, care transitions/step-down, and client treatment/recovery efforts. Service providers were appreciative of the tremendous strides that have been made with respect to supporting the adoption and use of HIT/HIE, developing client consent systems, and facilitating other HIT/HIE-related capacity building efforts. Nonetheless, service providers believed that continued efforts to support SUD providers to adopt and use HIT/HIE technology were essential to improving SUD outcomes and building system capacity. Participants believed that these HIT/HIE efforts would ultimately support outreach, identification and crisis stabilization, assessment and referral, documentation and treatment planning, care coordination, and communication, just to name a few.

C. Challenges related to collaboration across providers

Many of the service providers who participated in the assessment said that collaborating with other providers across the SUD spectrum was challenging. Some reported that there were limited systems, funding, and other supports to encourage communication, collaboration, and better integration of physical and behavioral health. Others reflected on the need for an automated and well-maintained resource inventory to promote referrals and facilitate care coordination. These ideas are supported by promising-practice literature and are described in Appendix B of this report. Specifically, these stakeholders believed that there was need for:

- Evidence-based service delivery and payment models that promote collaboration, partnership, and care coordination

- Enhanced communication and more robust systems (e.g., HIT/HIE, behavioral health coalitions, communities of practice, etc.) that promote more collaborative care, person-centered referrals, and better care transitions
- Need for an interactive, maintained resource inventory to promote communication, facilitate referrals, and promote collaborative care

D. Need for value-based payment models/policies.

There was near consensus among participating service providers and stakeholders regarding the need and potential benefits of value-based payment models that allowed for involvement of the SUD provider network. There was an appreciation for the advancements that were underway, but stakeholders reported that continued efforts geared specifically to SUD service providers were needed to improve quality, promote care coordination, and incent greater collaboration and partnership. These ideas are supported by best-practice literature and are described in Appendix B of this report.

- Develop SUD-specific enhanced or bundled payment arrangements to promote quality and reward providers for applying best practices;
- Include behavioral health services in ACO payment models, either as a comprehensive ACO or a separate carved-out, behavioral health ACO;
- Ensure that MCO contracts promote whole-person care, care coordination, and integrated approaches to service delivery;
- Develop a DC Behavioral Health Integrated Care Network to incent collaboration, promote care coordination, better integrate services, and braid funding streams
- Consider piloting efforts with selected providers who are supported through Communities of Practice or learning collaboratives that bring together service providers with similar needs for improvement and promote the sharing and adoption of lessons learned

E. Need for expanded and enhanced training and technical assistance (T/TA) resources

One of the clearest findings from the assessment - supported by findings from interviews, focus groups, and the literature review - is the need for comprehensive, robust training and technical assistance services aimed at building organizational capacity, improving the quality of services, promoting participation in value-based payment models, and enhancing clinical, administrative and management operations. The assessment made it clear that T/TA offerings needed to span a broad range of clinical, operational, and management/leadership domains and cover a range of subjects, such as evidence-based care, improving operational workflows, quality/performance improvement, trauma informed care, care transitions, and person-centered care. Participants also reported that T/TA resources should be available to all staff and provider types (e.g., clinicians, paraprofessionals, front desk staff, and administrators) and should be offered in multiple formats (e.g., coaching, webinars, communities of practice).

Summary Recommendations for System Improvements and Organizational Capacity Building

As above, the following recommendations were drawn from the assessment's findings as well as from a series of discussions with the project's Steering Committee. These recommendations were also greatly

informed by the project's Literature and Best Practice Review, the details of which are summarized in Appendix B of this report.

A. Need for enhanced support from DBH

- Refine or replace DATA (WITS) to increase functionality and make it more user friendly so as to improve information transfer, care coordination, reporting, and quality improvement efforts;
- Continue to invest in more streamlined and effective reporting, documentation, measurement, and accountability structures
- Explore how to simplify program requirements and regulations to increase flexibility while retaining some level of accountability
- Improve communication and enhance provider services capacity
- Simplify and reduce the burden of the DBH credentialing process
- Explore ways to increase payment rates and/or develop ways to enhance payments with value-based payment arrangements

B. Need for greater adoption and use of HIT/HIE, particularly among SUD providers

- Continue to invest in HIT/HIE adoption and use, including targeted training/technical assistance activities, and policies, programs, and contracting efforts
- Continue to refine and/or roll-out patient consent process to promote the use of HIE
- Continue to pilot and incentivize the use of programs that model evidence-based or proven practices with respect to the use of HIT/HIE in an array of high value circumstances (e.g., outreach and crisis stabilization, care coordination, care transitions/step down, and referral management)

C. Challenges related to collaboration and the siloed nature of DC's SUD system

- Take steps to ensure timely and effective communication with the SUD provider network
- Clarify, streamline, and improve assessment, discharge planning, and referral processes to enhance step down and promote greater collaboration and partnership
- Continue to develop a robust an on-line, interactive, well-maintained resource inventory to promote communication, facilitate referrals, and promote collaborative care
- Actively promote the development of SUD service organizations that provide multiple services along the ASAM continuum
- Explore the development of accountable care organizations (ACOs) and Behavioral Health Integrated Care Network(s)

D. Need for value-based payment models/policies

- Develop value-based payment arrangements for SUD providers

- Explore the development of accountable care organizations (ACOs) and Behavioral Health Integrated Care Network(s)
- Continue to develop and refine contractual relationships with MCO partners to incent them to meet or exceed quality and performance metrics related to care coordination, collaboration, and partnership

E. Need for expanded and enhanced training and technical assistance (T/TA) resources

- Continue to invest in comprehensive training and technical assistance services aimed at building organizational capacity, improving the quality of services, promoting participation in value-based payment models, and enhancing clinical and administrative operations

Appendices

APPENDIX A:	COMMUNITY ENGAGEMENT SUMMARY
APPENDIX B:	TARGETED LITERATURE AND BEST PRACTICE REVIEW
APPENDIX C:	SECONDARY QUANTITATIVE DATA REFERENCES
APPENDIX D:	DC SUD SERVICE SYSTEM DATA (TABLEAU DATABASE TOOL)
APPENDIX E:	SUMMARY POWERPOINT PRESENTATION

Appendix A: Community Engagement Summary

Methods	Summary Description
Key Informant Interviews	37 interviews with SUD providers, advocates, thought leaders, and other stakeholders
Focus Groups	9 focus groups with SUD providers and consumers of SUD services
Community Meetings	2 community meeting to discuss assessment findings and preliminary solutions/recommendations
In total the assessment engaged more than 150 stakeholders representing the community at-large, with special emphasis on residents recovering from SUD, as well as service providers, policy makers, public agency officials from DBH, DHCF, and DOH, behavioral health advocates, professional organizations, and other key informants.	

KEY INFORMANT INTERVIEWS

Name	Title	Affiliation	Date
Gayle Hurt	Asst. VP of Patient Safety & Quality	DC Hospital Association	12/6/19
Michael Kharfen	Senior Deputy Director	HAHSTA	12/19/19
Dennis Hobb	CEO	McClendon Center	12/18/19
Robert Hay	Executive Vice President	Medical Society of the District of Columbia	1/15/20
Raymond Tu	Chairman of Radiology	United Medical Center	1/25/20
Mark LeVota	Executive Director Association	District of Columbia Behavioral Health Association	12/19/19
Andrew Robie	Family physician and CMIO	Unity Health Care, Inc.	12/18/19
April Grady	Associate Director, Division of Analytics and Policy Research	DHCF	12/19/19
Laura Heaven	Director of Data and Performance Management	DBH	12/19/19

Dr. Andrey Ostrovsky	CMO and SVP	Solera Health	2/13/20
Dr. Bernard Arons	CEO	Amerigroup	1/15/20
Dr. Yavar Moghimi	CEO	Amerihealth	1/15/20
Avery Gollinge	Director	W1/W2 Prevention Council	5/7/20
John Mathewson	COO	America's Health Insurance Plans (AHIP)	3/13/20
Luigi Leblanc	VP of Technology	Zane Networks	2/20/20
Audrey Whetsell	Co-Founder	Resource Partners	
Dr. Lisa Fitzpatrick	Founder and CEO	Grapevine Health	1/23/20
Calvin Smith	Director of Government and Community Relations	Bridgepoint	1/24/20
John Friedel	Executive Director	Baltimore Station	2/11/20
Denise Capaci	Director of Adult & Children Clinical Services	Catholic Charities	1/27/20
Dr. Eric Marshall	Family Medicine Specialist	Gerald Family Care	1/22/20
Michael Pickering	Executive Director	Regional Addiction Prevention	1/15/20
Jason Ginevan	Senior Director of Behavioral Health and Residential Services	So Others Might Eat	3/23/20
Michael Giordano	Provider	Private Practice	1/24/20
Sharon Hunt	Director, Specialty Care Division	DBH	4/21/20
Johnny Allem	President	Aquila Recovery Clinic	4/24/20
Corey Odol	Director of Business Development and Government Affairs	PIW	2/10/20
Jean Harris	President and Executive Director	NAMI DC	4/9/20
Lindsay Curtin	Policy Advisor	ICH	5/4/20
Dr. Howard Hoffman	President and Medical Director	PIDARC	5/8/20

Brian Crissman	Program Director	PIDARC	5/8/20
Jo Houston	Clinical Supervisor	PIDARC	5/8/20
Alison Rein	Vice President, Health & Human Services	Quantified Ventures	5/28/20
Jennifer Loken	Manager of Substance Use Treatment Services	Whitman Walker Health	5/28/20
Flora Hamilton	CEO	Family Medical Counseling Services	2/10/20
Marsha Lillie Blanton	Senior Policy Advisor,	G.W. School of Public Health, DBH Consultant	2/11/20
Dr. Edwin Chapman	Addiction Medicine Specialist	Founder of large private, outpatient practice serving Medicaid insured patients; Black Mental Health Alliance	6/10/20

FOCUS GROUPS

Name of Group	Population/Sector Represented	Date	# of Attendees
Family Medical Counseling Services (FMCS)	Consumers actively engaged in mental health and SUD services from FMCS. Some also have experience within the criminal justice system	2/25/20	18
Family Medical Counseling Services (FMCS)	Consumers with HIV who are actively engaged in mental health and SUD services	2/25/20	15
Recovery Coach/Peer Specialists	Representative group of peer recovery coaches, peer specialists, recovery coaches, substance abuse counselors, house managers, and prevention coordinators	2/25/20	12
RAP - Women's Group	Female SUD/mental health/CJ/homeless consumers	2/26/20	9
RAP - Men's Group	Male SUD consumers	2/26/20	10
Returning Citizens	Hope Foundation Re-Entry Network	2/29/20	6

DCPCA FQHC Integrated Behavioral Health Peer Group	Representative group of health center clinicians (MH, SUD, and PCP) and other staff	4/10/20	15
Case Management Operating Committee (CMOC)	Representative group of case managers from Operating Committee	5/4/20	8
HAHSTA Social Workers	Representative group of social workers from DC Health, HAHSTA	5/28/20	7
SUD Service Providers	SUD Provider Groups organized by the DC Behavioral Health Association, including representatives from Latin American Youth Center, Intercity Family Services, Volunteers of America (SUD program), DBHA (Mark LeVota), Elizabeth Garrison	6/1/20	5

COMMUNITY MEETINGS

Name of Group	Population/Sector Represented	Date	# of Attendees
Round Table #1	<p>Group of service providers and other stakeholders convened to provide feedback on summary findings and recommendations.</p> <p>Attendees: Regina Baker, Ann Emmanuel, Elizabeth, Emma Ansara, Hunts, Janet Bolomope, "jhouston", Jose Segura, Susan Koehne, Krysten A, Melissa Mayer, R. "whren", Toni McGuire, Trina Dutta, call-in, Elizabeth Garrison, Katara Coates</p>	6/4/20	17
Round Table #2	<p>Group of service providers and other stakeholders convened to provide feedback on summary findings and recommendations.</p> <p>Attendees: Toni McGuire, Mary Wozniak, Michael Pickering, Philippa Stuart, Ayana, Angele Moss-Baker, Gayle Hurt</p>	6/5/20	7

Appendix B: Targeted Literature and Best Practice Review

The following document is the result of a targeted, informal literature and best practice review that compiled peer reviewed and "grey"(1) literature from a broad range of academic, professional, and service health services research sources. The search conducted by JSI project team members with the support of JSI's in-house librarian compiled an extensive array of literature and best practice citations, based on agreed upon search parameters, for a series of topics drawn directly for JSI's list of key findings. The purpose of the literature and best practice review is to facilitate the sharing of best practice and lessons learned. This review includes citations or links to summary program descriptions from researchers, policy makers, program administrators, and other practitioners on a range of high-value topic areas or strategies related to this report's recommendations. The hope is that DHCF and its partners can use the review to inform this report's recommendations and future efforts to implement the ideas that have come from this project.

This review is organized into four (4) sections and provides brief descriptions of each source, program model, article or grey literature.

*(1) The term **grey literature** is used to describe a wide range of different information that is produced outside of traditional publishing and distribution channels, and which is often not well represented in indexing databases*

BURDEN OF SUBSTANCE USE IN THE DISTRICT OF COLUMBIA

1. [SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2017 & 2018](#)
 2. [District of Columbia Office of the Chief Medical Examiner, "Opioid-Related Fatal Overdoses: January 1, 2016 to February 29, 2020" \(2020\)](#)
 3. [SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2008-2009 and 2017-2018](#)
 4. [District of Columbia Department of Behavioral Health, Mental Health and Substance Use Report on Expenditures and Services \(MHEASURES\) January 2020 \(Fiscal Year 2019\)](#)
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GAPS IN SUD SERVICE CONTINUUM

Assessment and Referral Services

1. [Administration for Community Living \(ACL\)](#) This article explains that "...in 'No Wrong Door' systems, multiple states and community agencies coordinate to ensure that regardless of which agency people contact for help, they can access information and one-on-one counseling about the options available across all the agencies and in their communities."
2. [NWD System, Key Elements](#) This resource describes key elements of a No Wrong Door System of access to long-term services and supports (LTSS).

Evidence-based Outreach and Crisis Stabilization Services

3. [Project Recover \(Referral, Engagement, Coaching, and Overdose prevention Education in Recovery\)](#) This project's mission is to provide and evaluate a promising new model of recovery support using Peer Recovery Coaches (PRCs) for people with Opioid Use Disorder (OUD) coming out of detox from Boston Treatment Center and Dimock.

Behavioral Health Integration Programs

4. [Linking Individuals with Substance Use Disorders \(SUD\) in Primary Care to SUD Treatment: The Recovery Management Checkups-Primary Care \(RMC-PC\) Pilot Study.](#) This article describes the research conducted in FQHCs utilizing Recovery Management Checkups (RMC) model which is based on the public health theory that long-term monitoring through regular checkups and early (re)intervention will facilitate early detection of relapse, reduce the time to treatment re-entry, and, consequently, improve long-term outcomes.

Care Transition and Support Services

5. [Peers Supporting Recovery From SUD-SAMHSA](#) These are brochures from SAMHSA describing what peer recovery support services and what peer recovery coaches do and the effectiveness of peer recovery coaching.
6. [Peer Recovery Coaching in Massachusetts](#) This is a presentation from 2019 from the Massachusetts Department of Health Bureau of Substance Addiction Services explaining the landscape of peer recovery coaches in the state and resources for training and funding.
7. [Boston Medical Center Leads Study on Peer Recovery Coaches for Opioid Use Disorder \(April 27, 2018\)](#) This press release describes a study on the impact of peer recovery coaches on patients with SUD.
8. [Benefits of peer support groups in the treatment of addiction, Tracy and Wallace, 2016.](#) This article reports the findings from a literature review showing that peer support groups included in addiction treatment show much promise, however more limited data relevant to this topic is needed.
9. [Baltimore Station.](#) The Baltimore Station turns lives around. We are an innovative therapeutic residential and outpatient treatment program supporting veterans who are overcoming obstacles to regain self-sufficiency.

Person-centered Intensive Outpatient Programs (IOP)

10. [Southern New Hampshire Health: intensive outpatient program](#) This is a program model for an intensive outpatient program (IOP) in the state of New Hampshire. This IOP is designed for individuals struggling with substance misuse issues. It allows patients to attend sessions and receive treatment while living in the comfort of their own home and continuing to work in the community.
11. [McLean Hospital: Alcohol and Drug Abuse Partial Hospital Program](#) This is a program model that provides treatment for individuals with SUD. This is a partial hospital (day) program for patients who do not require 24-hours care yet need more structure than is available in outpatient treatment.

Person-centered Transitional and Supportive Housing Services

12. [Supportive Housing and Surveillance](#). This article articulates the importance for supportive housing programs to not lean towards forms of social control that can hinder the development of social supports and independence.
13. [Health in the Tenderloin: A resident-guided study of substance use, treatment, and housing](#). This article describes a study conducted in the Tenderloin district of San Francisco and focused on women with children. Its findings show that any type of housing support needs to also be involved in upstream work and understanding the roots of substance use and homelessness. The programming available needs to also be contextualized to the environment.
14. [Feasibility and Acceptability of a Pilot Housing Transition Program for Homeless Adults with Mental Illness and Substance Use](#). This article describes a study conducted in the Metro-Boston area and its findings show that being housed is not a singular solution to homelessness and residents continue to experience need for life skill services within the domain of occupational therapy.
15. [Housing for Health Model](#) This program model focuses on individuals experiencing homelessness in Los Angeles County with the goal to reduce the inappropriate use of costly health care resources and improve outcomes for people experiencing homelessness and other vulnerable populations.
16. [Housing versus treatment first for supportive housing participants with substance use disorders: A comparison of housing and public service use outcomes](#). This article explains how low-demand supportive housing with no prerequisites for treatment or sobriety has been shown to improve housing stability and decrease public service use for chronically homeless persons with serious mental illness (SMI) and chronic medical conditions.

Targeted Approaches to Improve Care Transitions

17. [Multi-service prevention programs for pregnant and parenting women with substance use and multiple vulnerabilities: Program structure and clients' perspectives on wraparound programming](#). This article evaluates several community-based, multi-service programs aimed at reaching vulnerable pregnant or parenting women with substance use and complex issues.

SUD RESOURCE INVENTORY

18. [Health Resource Inventory](#): SUD resource inventory to support care transitions.

PROGRAMS THAT CONNECT INDIVIDUALS TO RECOVERY SUPPORT SERVICES

19. [Optimizing a Community-Engaged Multi-Level Group Intervention to Reduce Substance Use: An Application of the Multiphase Optimization Strategy \(2018\)](#) Community Wise is an innovative multi-level behavioral-health intervention created in partnership with service providers and residents of distressed communities with histories of SUD and incarceration, to reduce health inequalities related to AIDU.

SYSTEM IMPROVEMENTS AND ORGANIZATIONAL CAPACITY BUILDING

Robust systems that promote communication, collaboration, and partnership:

1. [King County Integrated Managed Care \(IMC\) and Integrated Care Network \(KCICN\) Overview](#)
This presentation provides information on the importance and value of integrated managed care and provides an overview of the funding structure along with the King County Integrated Care Network.
2. [Design and Impact of Bundled Payment for Detox and Follow-up Care](#) This article describes a study that designed a bundled payment for detox and follow-up care and to estimate its impact on provider revenues.
3. [State Approaches for Integrating Behavioral Health into Medicaid Accountable Care Organizations](#) This technical assistance tool examines the eight Medicaid accountable care organizations programs that have integrated behavioral health into their Medicaid ACO models. These states have used the following four methods to achieve this goal.
4. [Ready for Reform: Behavioral Health Care in Massachusetts](#) This report documents and describes the current behavioral health (inclusive of mental health and SUD) care system for children, adolescents, and adults in Massachusetts, including its strengths and weakness; describe a vision for behavioral health care in the Commonwealth; and develop recommendation for moving from the current state to the vision.
5. [Medicaid Accountable Care Organizations Version 2.0 Underway in Minnesota and Colorado](#)
This article by Center for Health Care Strategies, Inc. describes Minnesota and Colorado building on their initial successes as ACOs.

Promote value-based payment arrangements

6. [Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care](#) This brief, written by Technical Assistance Collaborative and Center for Health Care Strategies, examines how states and health plans are exploring value-based payment to promote SUD treatment in primary care, and offers considerations for implementing these models.
7. [State Strategies to Promote Value-Based Payment Through Medicaid Managed Care: Final Report](#) This report reviews findings from the interviews conducted by Bailit Health with state officials, managed care organizations (MCOs), and other stakeholders in five states that reflect a range of approaches to implementing value-based payment through managed care.
8. [Toolkit: State Strategies to Develop Value-Based Payment Methodologies for Federally Qualified Health Centers](#) This toolkit, developed by the National Academy for State Health Policy, can help state policymakers implement Medicaid value-based payment methodologies for FQHCs. The toolkit provides background information, key considerations, and state strategies.
9. [Value-Based Care in America: State-by-State](#) This study by Change Healthcare provides a state-by-state update of subsequent progress made in the past 18 months.
10. [Oregon's Roadmap to Value-Based Payment](#) This model describes Oregon's roadmap to value-based payment along with a toolkit for coordinate care organizations.

11. [Medicaid Value-Based Purchasing](#) This document describes the Missouri Department of Social Services beginning a ‘Medicaid Transformation’ with an overarching objective to ‘build a best-in-class program that address the needs of Missouri’s most vulnerable population in a way that is financially sustainable.’

TRAINING AND TECHNICAL ASSISTANCE

T/TA assistance activities aimed at improving care, operations, and management at the organizational level

Federal T/TA Providers

1. [Central East ATTC](#)-- Delaware, DC, Maryland, Pennsylvania, Virginia, and West Virginia; managed by the Danya Center
2. [Mid-America ATTC](#)-- Iowa, Kansas, Missouri and Nebraska and is based at the University of Missouri-Kansas City School of Nursing & Health Studies.
3. [Mountain Plains ATTC](#)-- Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming and is co-located at the University of North Dakota and the University of Nevada, Reno
4. [New England ATTC](#)-- New England region (CT, ME, MA, NH, RI, VT) and is based at Brown University
5. [Northeast & Caribbean ATTC](#)-- New York, New Jersey, Puerto Rico and the U.S. Virgin Islands and is based at the New York State Psychiatric Institute, Division of Substance Use Disorders at Columbia University
6. [Northwest ATTC](#)-- Alaska, Idaho, Oregon, and Washington and is based at the University of Washington’s Alcohol & Drug Abuse Institute
7. [Pacific Southwest ATTC](#)-- Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and Republic of Palau and is based at the University of California, Los Angeles, Integrated Substance Abuse Programs
 - a. [Innovative Ways to Provide T/TA to California SUD Treatment and Recovery Workforce](#)
8. [South Southwest ATTC](#)-- Arkansas, Louisiana, New Mexico, Oklahoma, Texas and American Indian Tribes and Communities. It is based at the University of Texas - Steve Hicks School of Social Work

SAMHSA training and technical assistance resources

9. [SAMHSA Training and Technical Assistance Resources](#) Brochure of SAMHSA-funded T/TA centers across the nation with respect to behavioral health.

T/TA centers that have focus on whole-person, population-based, culturally competent, and equitable service delivery

10. [C4 Innovations](#) Training, technical assistance, and consulting with expertise in: Best practices for person-centered and trauma-informed care; Recovery from substance use and mental health conditions; Roles and supports for peers and people with lived experience

11. [HRIA](#) Provide TTA to partner organizations to build capacity, refine systems, and coordinate processes, so that they can provide quality services to ACO members and improve overall population health outcomes. Services focus on care coordination and integration, community-based care and social determinants of health, consumer engagement, and performance improvement.
12. [SNI](#) Supports the implementation of Whole Person Care (WPC) by providing tailored technical assistance to the 25 pilot sites. Activities include webinars and in-person convenings, where pilots share lessons learned and tackle implementation challenges together.

T/TA assistance promoting evidence-based, better operational workflow, QI, trauma-informed care, care transitions, person-centered care

13. [CLAS \(Culturally and Linguistically Appropriate Services\)](#) This website features resources, education opportunities, and more for health and health care professionals to learn about culturally and linguistically appropriate services.
14. [Building Health Equity and Inclusion \(CLAS Resource Inventory\)](#) A compilation of resources developed by the ATTC (Addiction Technology Transfer Center Network) to support implementation of CLAS. Topics include, but are not limited to, cultural humility & cultural considerations; African American populations; Latinx/Hispanic Populations; Native American; American Indian, & Alaska Native populations; Women; and LGBTQIA.
15. NNEDshare ([resource library](#) and [innovative interventions](#)) NNEDshare is a collaborative space to share resources and intervention efforts to improve the delivery of behavioral health care interventions in diverse populations, learn about resources and innovative community efforts across the county, and connect with others to learn from you and support your efforts.
16. [Telehealth Strategies and Resources for Serving Patients with Limited English Proficiency](#) This resource offers information around third-party services to provide real time interpretation in telehealth visits, telehealth options beyond audio/visual, and other useful information for clinics serving LEP patients via telehealth.
17. [SAMHSA EBP Resource Center](#) The Evidence-Based Practices Resource Center provides communities, clinicians, policymakers and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings. The Resource Center contains a collection of scientifically based resources for a broad range of audiences, including Treatment Improvement Protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources.
18. [Trauma-Informed Care Implementation Center](#) Website developed by the Center for Health Care Strategies with support from the Robert Wood Johnson Foundation to provide a robust and growing inventory of resources from trauma-informed care leaders across the country. On the website you will find foundational knowledge regarding the impact of trauma on health and trauma informed care; testimonials from providers who have adopted trauma-informed principles within their own practices; in-the-field examples illustrating how trauma-informed care can be integrated into healthcare settings; and practical strategies and tools for implementing trauma-informed approaches to care.
19. [Care Coordination Strategies for Patients Can Improve Substance Use Disorder Outcomes](#) This document outlines key components of various models that use care coordination to improve outcomes for patients with SUD and discusses two examples—the nurse care manager model and the Medicaid health homes model—in detail.

20. [Oregon Behavioral health integration resource library](#) Tools, articles, webinars, expert interviews, virtual clinic visits

T/TA that are accessible in a broad range of modalities

ECHO (Extension for Community Healthcare Outcomes)

21. [Using ECHO Clinics to Promote Capacity Building in Clinical Supervision \(2018\)](#) ECHO virtual clinics are becoming more routinely utilized to enhance workforce implementation of evidence-based and promising practices for the treatment of SUDs. In this study, clinical supervision was chosen as a topic of workforce development given its importance to the delivery of high-quality SUD treatment. Results from this pilot study suggest that ECHO virtual clinics are feasible to implement for capacity building, are well liked by participants who completed the follow-up interview, and can enhance clinical supervision self-efficacy.
22. [Project ECHO \(Extension for Community Healthcare Outcomes\): A new model for educating primary care providers about treatment of substance use disorders \(2016\)](#) Example: [The ECHO model was developed by The University of New Mexico where it is now utilized by 40 states including Massachusetts, Illinois, and Ohio, to address managing substance use disorder.](#)

CoP (Communities of Practice)

23. [The Use of Virtual Communities of Practice to Improve Interprofessional Collaboration and Education: Findings From an Integrated Review \(2018\)](#) Example: The HRSA Center of Excellence for Behavioral Health Technical Assistance offers grantees structured virtual learning sessions to engage participants in organizational process improvement with their team, other participating organizations, and subject matter experts: <https://bhcta.hrsa.gov/>

Learning Collaboratives

24. [Using a Learning Collaborative Strategy With Office-based Practices to Increase Access and Improve Quality of Care for Patients with Opioid Use Disorders](#) Example: This study found that the learning collaborative approach improved the provision of buprenorphine in the state of Vermont due to decreases in practice variation across quality improvement measures.

Appendix C: Secondary Quantitative Data References

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4. District of Columbia Behavioral Risk Factor Surveillance System (BRFSS) survey, 2017, Center for Policy, Planning and Evaluation (CPPE),
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5. University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2019,
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6. National Survey on Drug Use and Health: Comparison of 2008-2009 and 2016-2017 Population Percentages (50 States and the District of Columbia),
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