The Importance of Data Sharing to Support Integration of Substance Use Treatment in California's Medi-Cal Program

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IN BRIEF

Effective coordination of health care services is critical to delivery system reform efforts taking place across the country — particularly in the context of mental health and substance use disorder (SUD) services. With passage of the Drug Medi-Cal Organized Delivery System waiver in 2015, California is on the cutting edge of efforts to ensure access to a full continuum of evidence-based and well-coordinated SUD services. The success of this demonstration rests in part on the ability of counties and their participating plans and providers to manage, share, and coordinate data on behalf of their patients and populations. Despite barriers to SUD treatment data management and sharing, several counties across California have made great strides in this area. This brief highlights two examples from San Francisco and Santa Clara counties in order to inform additional California-based efforts as well as initiatives in states across the country that are using data to better coordinate behavioral health care delivery.

Effective coordination of health care services is a cornerstone of most delivery system reform efforts taking place across the country — particularly in the context of behavioral health, including mental health and substance use services. Stakeholders in California — including policymakers, payers, providers, researchers, and advocates — are pursuing at least three approaches to address health care system and insurance coverage deficiencies in serving patients with behavioral health needs:

- **Stimulating a seamless, integrated system** of physical and behavioral health care delivery to improve the quality of care and ultimately the health and outcomes of this population.
- **Promoting financing** that accelerates clinical integration efforts.
- **Pursuing legislative changes** that require health insurers to provide adequate coverage of services for people with behavioral health disorders.
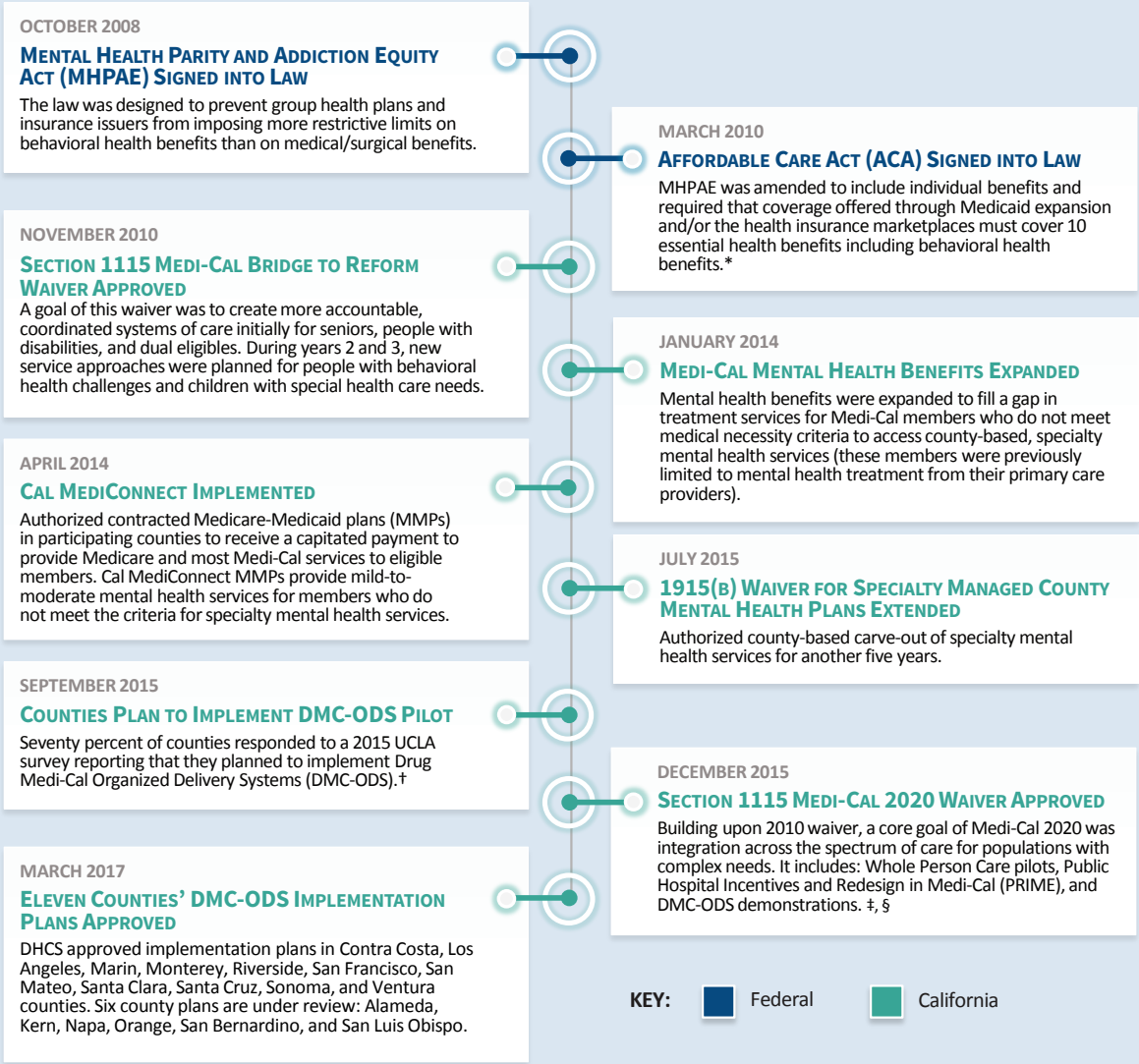
Coupled with state-based legislative changes, the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver represents the marriage of all three approaches, and is poised to dramatically change the landscape of substance use service delivery in California in the months and years ahead. With passage of the DMC-ODS waiver in 2015, California became the first state to receive approval from the Centers for Medicare & Medicaid Services (CMS) to use Medicaid funds for a continuum of additional treatment options based on American Society of Addiction Medicine (ASAM) placement criteria.[1] Given the ambitious scope of the proposed reforms under this waiver (as detailed in this brief), it will clearly take some time to implement. Nevertheless, local stakeholders are working in partnership to lay the groundwork needed to break down the bricks and mortar challenges as well as communication and cultural barriers that exist in provision of SUD services. A critical element to the

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success of this demonstration effort is the ability of counties and their participating plans and providers to manage, share, and coordinate data on behalf of their patients and populations. This brief explores how two county-based demonstrations in California are addressing data sharing to help inform behavioral health integration efforts across the country.

A Timeline of Federal and State Reforms that Improve Care for People with Behavioral Health Disorders

Stakeholders' efforts to improve care for people with behavioral health disorders — whether in terms of clinical or financial integration or benefit design — have paid off. Two pieces of federal legislation passed in the last decade put some real teeth into the move toward integration across the nation. California leveraged these federal reforms and secured Centers for Medicare & Medicaid Services (CMS) waivers important to reforming Medi-Cal and the systems of care upon which it relies.

OCTOBER 2008

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAE) SIGNED INTO LAW

The law was designed to prevent group health plans and insurance issuers from imposing more restrictive limits on behavioral health benefits than on medical/surgical benefits.

MARCH 2010

AFFORDABLE CARE ACT (ACA) SIGNED INTO LAW

MHPAE was amended to include individual benefits and required that coverage offered through Medicaid expansion and/or the health insurance marketplaces must cover 10 essential health benefits including behavioral health benefits.*

NOVEMBER 2010

SECTION 1115 MEDI-CAL BRIDGE TO REFORM WAIVER APPROVED

A goal of this waiver was to create more accountable, coordinated systems of care initially for seniors, people with disabilities, and dual eligibles. During years 2 and 3, new service approaches were planned for people with behavioral health challenges and children with special health care needs.

JANUARY 2014

MEDI-CAL MENTAL HEALTH BENEFITS EXPANDED

Mental health benefits were expanded to fill a gap in treatment services for Medi-Cal members who do not meet medical necessity criteria to access county-based, specialty mental health services (these members were previously limited to mental health treatment from their primary care providers).

APRIL 2014

CAL MEDICONNECT IMPLEMENTED

Authorized contracted Medicare-Medicaid plans (MMPs) in participating counties to receive a capitated payment to provide Medicare and most Medi-Cal services to eligible members. Cal MediConnect MMPs provide mild-to-moderate mental health services for members who do not meet the criteria for specialty mental health services.

JULY 2015

1915(B) WAIVER FOR SPECIALTY MANAGED COUNTY MENTAL HEALTH PLANS EXTENDED

Authorized county-based carve-out of specialty mental health services for another five years.

SEPTEMBER 2015

COUNTIES PLAN TO IMPLEMENT DMC-ODS PILOT

Seventy percent of counties responded to a 2015 UCLA survey reporting that they planned to implement Drug Medi-Cal Organized Delivery Systems (DMC-ODS).†

DECEMBER 2015

SECTION 1115 MEDI-CAL 2020 WAIVER APPROVED

Building upon 2010 waiver, a core goal of Medi-Cal 2020 was integration across the spectrum of care for populations with complex needs. It includes: Whole Person Care pilots, Public Hospital Incentives and Redesign in Medi-Cal (PRIME), and DMC-ODS demonstrations. ‡, §

MARCH 2017

ELEVEN COUNTIES' DMC-ODS IMPLEMENTATION PLANS APPROVED

DHCS approved implementation plans in Contra Costa, Los Angeles, Marin, Monterey, Riverside, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, and Ventura counties. Six county plans are under review: Alameda, Kern, Napa, Orange, San Bernardino, and San Luis Obispo.

KEY: ■ Federal ■ California

*The potential for future ACA reforms create some uncertainty related to the longevity of the 10 essential health benefits.
†E. Tran, D. Urada, V. Antonini, C, Teruya, K. Lovinger, H. Padwa, J. Lim and R. Rawson. *California County Administrator Survey 2015, Preliminary Results*. Presented September 24, 2015 at CBHDA SAPT+ Committee Meeting.
‡DMC-ODS was originally passed as a separate waiver and eventually folded into the Medi-Cal 2020 waiver.
§In addition, California plans for its Health Home program to begin on July 1, 2018.

The Importance of Data Management Systems for Effective Implementation of DMC-ODS Pilots

Critical to the success of California's DMC-ODS demonstration effort is the ability of counties and their participating plans and providers to collect, manage, share, and coordinate data on behalf of their patients. Even though counties previously funded SUD services, there were few, if any, systems in place to monitor system utilization as a whole or to collect the data necessary for this purpose. In addition, the array of Medi-Cal covered benefits and the expansion in Medi-Cal eligibility have underscored the need to track and optimize service utilization to keep costs in check. Strong data management and sharing will be required to:

- Enable accurate billing and payment for services to providers;

- Enable the county or contracted plan to conduct utilization review in partnership with case managers;

- Support counties' newly enhanced quality control responsibilities. Each county needs to set quality control measures and benchmarks to monitor patient services and to track progress in meeting these benchmarks;

- Support providers' efforts to coordinate services across physical, mental health, and SUD domains. Similarly, counties, plans, and providers need to be able to track and follow up on patient referrals; and

- Enable the county or contracted plan to manage population health and conduct associated analytics. Counties have highlighted effective population health management as essential to successful implementation of the pilot.

Challenges Facing County-Level Data Management Systems and Implementation of DMC-ODS Waiver

As in other aspects of health care, the collection, management, and sharing of data will be a challenge for counties. Following are key barriers facing counties in advancing data strategies:

- **Low Electronic Health Record Take-up.** The general electronic record infrastructure is lacking among many substance use providers across California. Small counties in particular face very low use of electronic records by their local providers, and many counties in general lack a functional regional health information organization.[2] In a 2015 UCLA survey of county administrators, only 20 percent of responding counties reported that they tracked client referrals and movement within the SUD continuum of care through electronic databases like a system-wide electronic health record or health information exchange. Other methods included paper or phone calls. A full 10 percent responded that they had no method for tracking client referrals and movement.[3]

A Brief History of Medi-Cal SUD Services

Medi-Cal SUD Services Prior to DMC-ODS Pilots

Prior to approval of the DMC-ODS demonstration, SUD services for Medi-Cal beneficiaries were delivered as a limited set of services in each of the 58 counties. The services could be offered by the local county department or, if a county chose not to administer SUD services, by providers contracting with DHCS. Each county received an allocation of the State's Federal Substance Abuse Prevention and Treatment Block Grant, which was the primary source of funds for these services and generally not large enough to meet service demand or pay adequate provider rates. What resulted was a largely siloed system of care — where physical and mental health needs were not addressed in tandem with addiction services and coordination of services was largely nonexistent. And, the network of substance use treatment providers willing to accept state-paid rates was far too small to meet demand. The DMC-ODS waiver was designed to address extensive unmet need in a way that improves outcomes for the Medi-Cal population. The "organized delivery system" concept encourages a continuum of care for Medi-Cal beneficiaries who need substance use treatment services, with an end goal of better health outcomes for beneficiaries. Additionally, counties were limited to the types of services they could offer — outpatient drug-free services, narcotic treatment programs, intensive outpatient services — and many services were limited to specific populations. Intensive outpatient services, for example, were limited to pregnant/post-partum women and EPSDT-eligible youth.

How DMC-ODS Pilots Expand Treatment Services and Change Treatment Paradigms

The DMC-ODS expands addiction treatment services available to Medi-Cal beneficiaries and — at the same time — disrupts how the services are administered to improve coordination of care. The table below outlines pre- and post-DMC-ODS allowable services.

Medi-Cal Substance Use Service Benefits Before and After DMC-ODS (for counties implementing the waiver) [4]

DMC services before DMC-ODS	DMC-ODS services after DMC-ODS	
✔ Outpatient drug-free programs ✔ Intensive outpatient (limited to pregnant/post-partum women and EPSDT-eligible youth) ✔ Narcotic treatment programs	✔ Early intervention ✔ Outpatient ✔ Intensive outpatient ✔ Short-term residential ✔ Opioid/narcotic treatment ✔ Withdrawal management ✔ Recovery programs ✔ Case management ✔ Physician consultation	**Optional:** ✔ Partial hospitalization ✔ Additional medication assisted treatment ✔ Recovery residences

These expanded addiction services are beneficial for California's substance use treatment delivery system and for the people who need these services. Some of the other DMC-ODS requirements will continue to push the system toward higher quality of care and better patient outcomes. Under DMC-ODS, addiction recovery services must be delivered in accordance with American Society of Addiction Medicine criteria, which support outcome-oriented treatment.[5] In addition, expanded benefits allow for broader use of medication-assisted therapy. DMC-ODS also opens the door for case management, recovery services, and residential treatment and detox with an outcome-oriented and results-based lens. Finally, telehealth and expansion of regional networks of providers are wrapped into DMC-ODS demonstrations. Knitting all of these expanded services together, however, are the DMC-ODS demonstration's administrative requirements that should result in seamlessness and coordination of care for Medi-Cal beneficiaries who struggle with addiction, including the criminal justice population.

- **Limited Financial Resources for Data Innovations.** Many counties lack the financial resources to implement an electronic health record system or health information exchange. Fortunately, federal and other funding sources have become available over the years, including funds from the Health Information Technology for Economic and Clinical Health (HITECH) Act, which are now supporting efforts to better connect SUD treatment providers and incorporate drug and alcohol treatment information into health information exchanges.

- **Strict Privacy Guidelines.** Federal privacy regulations (42 CFR Part 2)[6] governing the exchange of individual–level substance use data in federally funded treatment programs are very restrictive. Participating providers and plans may find it useful to establish a standardized uniform written consent form to enable sharing of protected health information (PHI) among patient-identified physicians and other treatment professionals. Where a health information exchange exists, mechanisms must be in place to ensure that only those clinicians identified in the consent form are allowed access to protected information and only within the expiration date timeline. Written patient consent is also required for further redisclosure of information, and patients can revoke their consent at any time.[7] In early 2017, SAMHSA released updated rules under 42 CFR Part 2. The original ruling was written in the 1970s, well before widespread use of electronic health records and data management systems. Though the new language attempts to streamline how PHI is shared for patients with SUD, critics suggest that the new language does not go far enough.[8]

Counties as Specialty Managed Care SUD Plans

For counties that have decided to implement the DMC-ODS waiver — the requirements represent a seismic shift in how they will administer SUD benefits going forward. Counties are moving from administering or contracting administration of a block grant to becoming specialty managed care plans.

Going forward, DMC-ODS counties will be responsible for quality control, compliance with federal regulations such as 42 CFR Part 2, billing and reimbursement, data management, contracting directly with providers, and memorandums of understanding (MOU) with managed care plans. CMS and DHCS require each county to have an MOU with its local Medi-Cal plan(s) that articulate: (1) the process for SUD screening and referral; (2) shared care plans and collaborative treatment; (3) care management responsibilities; (4) clinical consultation between providers; (5) referral tracking; and (6) dispute resolution.[9]

Promising Practices for Improving Data Management and Sharing Under DMC-ODS

Despite the barriers to SUD treatment data management and sharing, several counties across California have made great strides in this area. Highlighted below are examples from San Francisco and Santa Clara counties. These county efforts have been underway for many years and provide important foundations for implementing the DMC-ODS pilots. While these examples represent

sophisticated, long-term data management and sharing efforts, they offer practical guidance that can help inform other county-based or state efforts in this area.

San Francisco County's Approach to Building an Integrated Data System

The San Francisco Department of Public Health (SFDPH) has developed its own care management platform — the Coordinated Care Management System (CCMS).[10] SFDPH developed this platform in 2003 to address the high number of vulnerable patients with comorbidities and high use of emergency services across multiple safety net systems (medical, mental health, and substance use), based on the premise that these patients could be better served elsewhere in the system at lower cost. The CCMS gathers disparate sources of information including medical, mental health, substance use, and social conditions — including homelessness and criminal justice — and integrates this information into a single record for each patient. The dataset includes information about more than 450,000 vulnerable adults, most of whom are Medi-Cal clients. SFDPH stratifies patients based on their emergency service utilization — the top five percent account for about half of emergency department use and spending. Dedicated care teams use CCMS to identify, outreach, and engage these patients to address their needs from a holistic perspective. CCMS also adheres to all federal regulatory requirements with respect to protected information, including 42 CFR Part 2 — substance use program information is therefore not visible at the individual patient level, but is aggregated to analyze population-level needs. All non-42 CFR Part 2 CCMS information is also visible to all members of the treatment team, including users of Avatar — the electronic health record system used by San Francisco Community Behavioral Health Services — enabling these providers access to a more complete health picture for their patients.

Building an integrated data system is not easy, but possible with the right ingredients. As guidance to other interested counties, SFDPH shared a number of the elements that are important to developing an integrated care system like CCMS:

Buy-in and planning

- Senior leadership support, as development will take time and resources. SFDPH had the long-term support of its director of health for this effort;

- Clear vision for the deliverable. At SFDPH, information had to improve care at the "moment of truth" (during service delivery) <u>and</u> help SFDPH better understand its vulnerable populations. One could not be sacrificed over another — both had to be true;

- Shared belief among leadership, privacy officers, and city attorneys that information sharing on patients who are served by different parts of the system is key to improving care and outcomes;

- Commitment to use information to support delivery system transformation; and

- Advisory groups of clinicians, management, and epidemiologists who could inform system design and implementation.

Implementation and roll-out

- Training and expertise in rules and regulations governing PHI;

- Memoranda of understanding (MOUs) between county departments that establish clear guidelines and expectations related to sharing PHI between the county and other care providers;

- Commitment among participating entities to not alter any source database;

- IT department willing to devote staff resources. At SFDPH, the IT department allocated one to three part-time staff members to manage development of the CCMS (in addition to many competing priorities); and

- Promotion and training to broaden the user group, including providers, researchers, and care managers.

Challenges remain to sharing SUD data due to confidentiality requirements. Individual patient records from CCMS are only shared for treatment purposes (as allowable under HIPAA), therefore no consent is required with the exception of SUD information because of 42 CFR Part 2 regulations. SFDPH did not have the technological capacity to include the multiple levels of access permissions and monitoring abilities necessary to enable sharing of SUD data while meeting regulatory requirements. Therefore, all 42 CFR Part 2-covered information is suppressed from end users.

Still, there are many benefits to having an integrated data system. Opportunities exist to improve SUD quality of care, based on CCMS' aggregate information. SFDPH can use aggregate-level CCMS data to analyze population data related to substance use. And, though SFDPH cannot share patient-level substance use program data with its major Medi-Cal plan, San Francisco Health Plan, given that SUD services are carved-out of managed care, it can share de-identified data in the aggregate with the plan to assist plan-specific population health efforts.

Reducing Polypharmacy and Contra-Indicated Medications in San Francisco County

One example of the type of quality management possible through an integrated mental health and substance use data system relates to avoiding polypharmacy and contra-indications associated with use of benzodiazepines. Benzodiazepines are a class of sedative-hypnotic prescriptions used for treatment of anxiety and insomnia, among other conditions; however, there are also serious hazards when used in combination with certain other drugs such as methadone. San Francisco Community Behavioral Health Services (CBHS) quality management staff members have access to the data warehouse for Avatar, which means they can see sedative hypnotic prescriptions by mental health providers (other prescriptions from outside mental health are not visible). They can also see co-enrolled mental health/methadone maintenance clients. Their observations enable them to work toward reducing benzodiazepine prescriptions by mental health prescribers to patients in methadone maintenance — a potentially deadly combination — but only when a patient discloses, or when service records indicate, methadone maintenance.

Santa Clara County's Approach to Improve Data Management and Sharing among Providers

Santa Clara County has been operating a managed system of substance use treatment for nearly 20 years. The county has historically allocated a substantial amount of general and AB 109[11] funds to the Department of Alcohol and Drug Services to develop its network of care, and the existing system of services for people with SUD offers a strong foundation for the DMC-ODS pilot.

Santa Clara County has established a few promising practices to facilitate data management and sharing. Santa Clara County's community primary care providers will use Epic software for their electronic health records, which is not compatible with Profiler, Santa Clara County's behavioral health information system. To address this incompatibility, Santa Clara County created a common patient number to use in all systems so they can more easily track behavioral health clients as they move across the health care system. A common patient identifier is a helpful starting point for all counties because it allows them to look at how many clients are seen in primary care as well as how many clients are referred for substance use treatment from any part of the health care system.[12]

Another promising practice from Santa Clara County is the Gateway call center, which is the point of entrance for many substance use clients.[13,14] Gateway staff members conduct brief substance use and risk screenings and determine an initial level of care (LOC) placement. The county receives 35,000 calls from the community per year, and 24,000 from justice-involved residents. Of that total, about 80 percent of callers are referred to substance use treatment service. Gateway is the starting point for data collection in Santa Clara County, and the place where the common patient identifier is established. For individuals that have not gone through the Gateway call center, Santa Clara County has a post-authorization process that allows certain programs to complete the screening and make an initial determination of treatment modality. This information is then conveyed to Gateway and entered into the tracking system. Having a centralized point of entry like Gateway enables a county to analyze who is calling, how well the county is placing clients, and whether clients are engaging with the system or not. If a county is positioned well to gather this information, it can use it to get at least a general understanding of its system quality and capacity and begin to conduct some population health analytics for improvement.

Santa Clara County is able to track network adequacy by producing a bi-monthly report of the available direct service hours of every behavioral health provider. The report includes:

1. Hours worked;
2. Number of individual and group services provided;
3. Clients seen during the reporting period;
4. Active outpatient case load, which helps to determine if all clients were seen within the previous two weeks;
5. Amount of time elapsed from the treatment episode to data entry (into the electronic health record). The county currently requires that all services must be logged within 72 hours; this requirement will decrease to 48 hours under the DMC-ODS pilot; and
6. Bed status of residential providers on a nightly basis to help the county track bed availability and ensure there are enough beds to place clients within the time frames set.

An important lesson from Santa Clara County relates to handling of client confidentiality. The Department of Alcohol and Drug Services worked closely with county counsel to determine how best to ensure client confidentiality without losing the ability to better integrate their care. To address the issue, county counsel issued a notice that all health professionals in the county, both in primary care and behavioral health, had to become 42 CFR Part 2 competent. A mandatory training is now required of all nurses, physicians, and other related providers in the county — this requirement is made clear via MOU. The training ensures that all providers who work with clients going through substance use treatment understand the requirements associated with obtaining releases to share information with collaborating providers.

Better data management and sharing will benefit patients' quality of care. Clients are screened using a universal screening tool during their initial Gateway call. The screening tool is based on ASAM criteria, which helps determine the level of care to assign each caller. Providers are also required to work with one of the county's quality improvement coordinators to approve a change in a client's intensity of care, and then document any changes in Profiler, the county's behavioral health information system. The county's quality improvement coordinators use these data to ensure the intensity of care makes sense. In a system that is functioning well, there should be a broad distribution of clients receiving treatment across various levels of care. This variation indicates that the system provides flexibility to allow clients to step up or down in level of care, as needed, depending on an individualized recovery process. In Santa Clara County, the behavioral health delivery system is adequate to place all adults within 14 days, and to move clients from that initial placement to higher or lower levels of care as needed.

A more specific example of the benefits of improved data management is the county's ability to track evidence-based measures related to how well clients are engaging in their treatment. Santa Clara County bases its measures for this area on evidence that supports motivational interviewing and client engagement.[15] The county is tracking the percent of clients with four services provided in the first 30 days of admission (e.g., treatment planning and counseling); number and type of treatment services; and customer satisfaction. This set of measures aims to change the existing treatment paradigm from asking clients to comply with a specific set of rules and standards imposed by a provider to one in which the client is helping to develop a treatment plan and individualized goals as part of his or her recovery process. The measures also align with ASAM's principles that are very patient-centric and require flexibility in terms of services offered to better engage the patient in his or her recovery. The challenge for the quality improvement aspect of an organized delivery system will be to ensure that the system is responsive, flexible, and adequately staffed in order to meet individualized patient needs — all within a managed care system environment that emphasizes population health management.

Five Things All Counties Should Consider for Behavioral Health Data Management and Sharing Efforts

1. Use call centers to establish "no wrong door" and access to services for potential clients. Call centers also enable collection of critical data points for clients entering the county substance use system — these data can support quality management efforts.

2. Set up data management to track clients' pathways through the system. For example, establish a common patient identifier that can be used across different data management systems. County data should enable population health and utilization management to determine if the system is responding well to clients' needs and helping clients to stabilize.

3. Develop measurable benchmarks that align with ASAM criteria and can highlight areas of strength and areas of opportunity in the system.

4. Collaborate with county counsel to establish best practices around privacy regulations and data sharing across the county system.

5. Institute provider training around privacy regulations, including how to share data.

Looking Ahead

The promise and potential of an organized delivery system for substance use disorder services is substantial — DMC-ODS pilots coupled with expanded insurance coverage and benefits stand to be a game changer in the quality of life for people with SUD. Under the DMC-ODS pilot, providers can offer a much broader menu of service options to facilitate clients' individual recovery processes. About three-quarters of California counties are working on implementing a pilot, which is a testament to the demand for improvements in care offered through the DMC-ODS waiver. A handful of counties are on the forefront of implementation efforts both in terms of developing and receiving approval of their proposals as well as having fairly well developed administrative and data management capacity already in place. In other counties, health plans, counties, and service providers are collaborating to develop this capacity at a rapid pace. Replication of the best practices identified above will pay off in the long run by leading to better integration of behavioral and primary care at the county level.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

ENDNOTES

[1] For more information about the new opportunities for states to use Medicaid funds to improve SUD treatment services, see July 27, 2015 State Medicaid Director Letter.

[2] Merced Community Health Information Exchange Plan. March 2016.

[3] E. Tran, D. Urada, V. Antonini, C. Teruya, K. Lovinger, H. Padwa, J. Lim, and R. Rawson. *California County Administrator Survey 2015, Preliminary Results*. Presented September 24, 2015 at CBHDA SAPT+ Committee Meeting.

[4] For more information, visit: http://www.dhcs.ca.gov/provgovpart/Documents/DMC_ODS_Pilot_FAQ_7.13.16.pdf.

[5] For more information, visit: http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about.

[6] 42 CFR Part 2 provides strict protections for patient information in any substance use program that receives federal support.

[7] For more information, visit: https://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs.

[8] For more information, visit: http://www.healthcare-informatics.com/article/samhsa-releases-part-2-final-rule-substance-use-data-sharing.

[9] For more information about DMC-ODS: http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx.

[10] For more information about CCMS, see: http://caph.org/wp-content/uploads/2014/12/Whole-Person-Care_Target-Population_Martinez_PPT-and-Handout.pdf.

[11] AB 109 established a dedicated and permanent revenue stream to counties for public safety realignment efforts.

[12] Interview with Bruce Copley, Director, Santa Clara County Department of Alcohol and Drug Services. November 29, 2016.

[13] Another point of entry is through the quality improvement system when the case involves coordination with physical health and mental health providers in the system.

[14] For more information about Gateway, visit: http://santaclara.networkofcare.org/mh/services/agency.aspx?pid=SantaClaraCountyDepartmentofMentalHealthDepartmentofAlcoholDrugServicesDADSGatewayProgram_356_2_0.

[15] W. R. Miller and S. Rollnick. *Motivational interviewing: Preparing people for change*. New York: Guilford Press, 1991.