Safer in Treatment and Recovery

Mitigation Strategies for a Pandemic Related Influx of Californians in Need of Addiction Treatment

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At this time, the substance use disorder treatment system in California faces an extremely precarious future. Simultaneously, its capacity will soon be called upon to expand as rates of addiction are expected to skyrocket due to unemployment, environmental stressors, and despair that a worsening economy portends (Reference: *The Disease of Addiction Thrives on Isolation*, *A Report to Governor Gavin Newsom and the California Legislature on the Impact of COVID-19 on the State's Fragile Substance Use Disorder Treatment System*).

In response to the initial shortcomings the treatment system had prior to the COVID-19 pandemic, and to prepare for a forecast for a higher need for additional services, CCAPP has developed the following policy and budgetary recommendations to lessen the number of lives that will be lost if no action is taken to bolster California's substance use disorder treatment and recovery system.

Each policy/budget area is addressed by topic with regulatory, statutory, and budgetary needs included at the end of each section.

I. Physical Expansion

Residential and outpatient programs cannot expand physical space to accommodate an increase in new admissions and to meet distance requirements without additional physical space. They are also not in consideration for using hotel, temporary hospital, or dormitory space to augment shortages of physical space. There is simply no place to house people who need services. In order to conduct groups in person, providers must reduce group sizes to fit rooms to accommodate six-foot distance requirements. This greatly reduces the capacity for group counseling sessions.

Strategy Responses Regulatory:

1. Allow programs to use temporary space at approved offsite locations to expand space to meet distance requirements without paying for additional licenses.

2. Waive group counseling requirements for non-waiver county providers from 20 hours to five hours (requirement currently for waiver counties) to allow providers to run more groups of smaller size.

Strategy Responses Budgetary:

1. Provide start-up or reimbursement funding for expenses related to temporary or augmented space (rent, beds, furnishings, etc.).

2. Provide state grants to programs operating at less than 65% of capacity to retain treatment beds for expected influx (possibly earmark state opioid response funding for this purpose).

Strategy Response Statutory:

1. Waive statutory bed limit for local government ordinances requiring conditional or special use permits for 18 months to 8 beds for treatment programs with less than 2,000 square feet, 9 beds for homes of 2,000 but less than 3,000, 10 beds for homes with 3,000 but less than 4,000 square feet and 12 beds for 4,000 square feet or more. This waiver would only pertain to residential treatment where clients do not have cars.

II. Workforce Expansion

Programs are expressing urgent concern about depleted workforces due to illness, needing to care for family, etc. Facing an already distressed workforce, there is now a 20-50% decrease in the number of professionals working in many programs.

Mental health personnel will soon be urgently needed to respond to mental health case increases. This will impact programs' ability to staff required Licensed Professionals of the Healing Arts (LPHAs) who are required by regulation to sign treatment plans, progress notes, and discharge paperwork. Due to the previous administration's opposition to creating new boards, there is no license for substance use disorder counselors. Although these professionals are far more educated, trained, and competency tested for addiction treatment services than their mental health counterparts, valuable LPHA time is being wasted in "rubberstamp" oversight provisions.

There are an undetermined number of recently retired or alternate career path substance use disorder counselors who have left the profession but could be recruited to serve as extra capacity, except that regulations require that continuing education requirements must be met to re-certify, creating a significant barrier to re-entry.

There are also a number of registrants (interns) who are backlogged for testing to become certified due to test center closures, or who may be too involved with caring for children and working to complete requirements for certification.

Addressing possible recruitment and extension opportunities could raise capacity.

Strategy Responses Regulatory:

1. Waive expired continuing education (CE) requirements (40 for each two-year period not certified, not to exceed six years) for any previously certified counselor who wishes re-enter the workforce.

2. Allow certifying organizations to provisionally certify applicants who have met all requirements for certification except testing for 18 months (allow them to be counted in meeting the 30% certification staff requirement for programs).

3. Augment Executive Order N-55-20 (12) to waive five-year requirement to become certified to state that the requirement will be six years until 2022; Include hardship extensions in the order.

4. Waive regulation that excludes experienced substance use disorder counselors (five years' experience/passing score on a nationally recognized licensing exam) from acting as Licensed Professionals of the Healing Arts for post admission/placement functions (approval of charting, discharge summaries, etc.) within licensed and certified treatment programs for up to 18 months, or six months after the expiration of the emergency declaration.

Strategy Responses Budgetary:

1. Reimburse counties (100%) for programs that provide hazard pay (not more than 20% of customary) to retain workers.

2. Approve budget request for SUD workforce expansion (sponsored by Senator Umberg and Assemblymember Nazarian) to provide grants for test preparation, test fees, and certification fees; vocational education stipends; cross training for mental health professionals; and loan stipends for SUD treatment education.

III. Workforce and Client Safety

Supply chain issues are impacting programs. Unlike hospitals and clinics, addiction treatment programs purchase their food, paper products, and personal protective devices like any member of the public would. The inability to access protective devices, including gloves and masks, will make it impossible for them to comply with safety regulations for programs. This puts them at liability should a client become sick and die from the illness. This is an immediate crisis for many programs.

A large percentage of clients have underlying health concerns that put them at risk for complications from COVID-19. Persons who have ingested dangerous substances including alcohol, tobacco and other drugs, for months or decades are at risk for respiratory disease. Ability to provide MAT in these environments, buprenorphine and nicotine replacement therapy, would optimize care of tobacco and opiate addiction. It would also decrease risk of first and second hand smoke aggravating respiratory conditions and mitigate risk of fires. Populations moving form homeless or unstable living environments where hygiene is compromised are more likely to contract the disease

Strategy Responses Regulatory:

1. Designate a portion of the hotel space acquired for Project Room Key to be dedicated for addiction treatment beds and to place quarantined clients for isolation period.

2. Allow programs to designate one common location for multiple programs, and multiple licensees if applicable, for COVID positive clients to recover, receive supervision, and begin treatment (if physically able to do so).

3. Include treatment programs and recovery residences in the priority cue for staff and client facility-wide testing for congregate living facilities.

Strategy Responses Budgetary:

1. Purchase and maintain a supply of PPE supplies for programs and recovery residences at a location in Southern California and a location in Northern California (storage and distribution to be provided by CCAPP, audited during DHCS review of certification operations).

IV. Fiscal Integrity

When smaller programs are short staffed, they will not be reimbursed for services which will lead to closure of programs who are not able to continue to operate with 50-75% less clients (reimbursement). These programs operate on very low margins. Thus, small business loans are not a solution.

Strategy Responses Statutory

1. Include substance use disorder treatment program owners in any waivers for other congregate living and care providers that create immunity for treatment providers who admit or continue to treat COVID positive clients.

Strategy Responses Budgetary

1. Continue to reimburse non-profit programs at 100% of past six-month average so that programs do not close.

V. Housing Availability

People in early recovery are chronically at risk for homelessness and relapse. For many in early recovery, work histories do not warrant unemployment benefits. To keep these individuals from homelessness, vouchers for six to nine months of bed fees need to be provided.

Local government restrictions and labor disputes are constricting the availability of recovery residence services. Although local ordinances and labor claims are contrary

to state and federal statute and regulation, time consuming and costly lawsuits continue to inhibit growth in these essential housing programs.

Project Room Key participants have agreed to move off of the streets. They will need screening and placement for substance use disorder, or transition to recovery residence housing if warranted.

Strategy Response Statutory:

1. Enjoin all local ordinances that are contrary to fair housing and Americans with Disability Act laws (list to be provided).

2. Create a moratorium on any current or new suits seeking to enforce discriminatory ordinances against recovery residences and treatment programs.

3. Create a moratorium on any current or new labor cases claiming back wages for recovery residence participants who pursue recovery goals or perform household chores.

Strategy Responses Statutory:

1. Pass urgency legislation that defines household chores and recovery journey activities as not compensable as employment.

Strategy Responses Budgetary:

1. Provide bed fee vouchers for recovery residence participants who are unemployed and cannot obtain unemployment benefits.

2. Provide recovery residence bed fee vouchers to Room Key participants who wish to transition to recovery residences.

3. Provide reimbursement for assessments and screening at Room Key locations.

VI. Insurance Coverage

As workers transition from workplaces where they have access to insurance benefits that may have covered a significant portion of the cost of treatment, to gain coverage they may access Medi-Cal or Covered California. This has tremendous implications for the publicly funded treatment system. Delaying treatment due to financial barriers will have costly long term effects on homelessness, disease progression, co-morbid health conditions, and adverse childhood experiences. These costs will exceed the costs of waiving co-pays for an 18-month period.

Strategy Responses Statutory:

1. Pass urgency legislation to remove co-pays and deductibles for addiction treatment services provided by certified providers who are reimbursed by both private and public insurance products.

Strategy Responses Budgetary:

1. Reimburse entities who waive deductibles and co-pays.

VII. Stigma Reduction

Persons facing mental health and substance use disorder crises may delay seeking help until the progression of their disease(s) is more difficult and expensive to treat. A concerted effort needs to be made to encourage people to seek the services they need in an appropriate timeframe. This can be accomplished with public health messaging and the use of peer professionals (people with lived experience).

Strategy Responses Statutory:

1. Pass urgency legislation to allow already approved certifying organizations to immediately certify peers for substance use disorder and mental health peer support services which can be reimbursed with federal funds.

Strategy Responses Budgetary:

1. Fund a statewide advertising campaign to inform Californians about mental health and substance use disorder treatment availability.

VIII. Adverse Childhood Experiences

According to the most recent California Department of Public Health data reporting from the Behavioral Risk Factor Surveillance System (BRFSS, 2017), 63.5 percent of Californians have experienced at least one of the ACEs, and 17.6 percent of Californians have experienced four or more. Nationally, the prevalence rate is similar. Additionally, research shows that individuals who experienced ACEs are at greater risk of numerous ACE-Associated Health Conditions, including nine of the 10 leading causes of death in the United States, and that early detection, evidence-based intervention, and trauma-informed care can improve outcomes. The COVID-19 pandemic is exacerbating ACEs while separating children from traditional sources of referral for services.

Strategy Responses Regulatory:

1. Allow treatment programs to staff weekly drop-in services at local school lunch pick up programs to meet with parents or loved ones experiencing substance use disorder symptoms.

Strategy Responses Budgetary:

1. Reimburse school districts for providing notifications within lunch distribution packaging to announce the availability of screening and assessment services throughout the summer months.
2. Create a central hub in California for “Celebrating Families” to address adverse effects of the pandemic.