City and County of San Francisco
Department of Public Health
BEHAVIORAL HEALTH SERVICE
SUBSTANCE USE DISORDER SERVICES

May 26, 2021

AVAILABILITY OF SUBSTANCE USE DISORDER TREATMENT IN SAN FRANCISCO

The Department of Public Health, Behavioral Health Service (SFDPH, BHS), funds, supports and oversees a network of 46 community-based substance use disorder (SUD) treatment programs. These programs provide residential, residential step-down, intensive outpatient, outpatient, case management and opioid treatment services. Additional substance use disorder treatment is available through programs and services in DPH's primary care and street-based medicine programs. The first part of this report focuses on BHS funded services; information about non-BHS funded programs is discussed in the sections following.

Funding for City SUD services derives from the City's general fund as well as, increasingly, federal Medicaid dollars. As of May 1, 2018, SFDPH began to bill Drug Medi-Cal (federal Medicaid) for residential treatment for the first time. As of July 1, 2019, the Department began to expand billing for Outpatient Treatment, Intensive Outpatient treatment, and Case Management. Physician phone consultation is available to other physicians with individuals with substance use disorders. We anticipate that with additional Drug Medi-Cal revenues related to a state initiative aiming to reform Medi-Cal program and payment called CalAIM, BHS will be able to fund additional outpatient treatment, case management and residential treatment beds, and thereby increase flow and access through our SUD treatment system.

The figure below shows the contracted residential substance use disorder treatment and withdrawal management (call detox in state statute) bed capacity and funding for fiscal years 19-20 and 20-21. Also shown are the projected unduplicated client counts (UDC) for SUD outpatient, day treatment and case management and opioid treatment programs (referred to in state statute as narcotic replacement therapy) and their funding for fiscal years 19-20 and 20-21.

Modality	FY19-20 Beds	FY20-21 Beds	Increase/ (Decrease)		FY19-20 Funding	FY20-21 Funding	Increase/ (Decrease)
Residential	391	390	(1)		$ 19,135,333	$ 19,021,595	$ (113,738)
Residential Detox	56	56	-		$ 6,228,154	$ 6,359,675	$ 131,521
Modality	FY19-20 UDC	FY20-21 UDC	Increase/ (Decrease)		FY19-20 Funding	FY20-21 Funding	Increase/ (Decrease)
Outpatient, Day Treatment & Case Mgmt	2,379	1,938	(441)		$ 10,865,762	$ 10,881,574	$ 15,812
Narcotic Replacement Therapy	4,079	4,072	(7)		$ 20,275,788	$ 20,326,229	$ 50,441

The utilization of available contracted SUD residential treatment beds is complex. Some bed types are "overstocked" or held exclusively for specific populations (e.g. perinatal SUD or clients at-risk for incarceration) or with particular needs (e.g. language and cultural preferences). In addition, the daily bed census fluctuates daily, monthly and seasonally. The daily bed capacity may also be impacted by staffing, building maintenance and other unplanned agency events. Monthly residential bed capacity is higher at the end of the month and varies seasonally by as much as 10-20% with higher client demand in the Spring quarter.

During the Covid-19 pandemic, all SUD treatment services were significantly impacted by the need to reduce capacity to maintain social distancing. Outpatient programs were limited to telecare. Residential SUD treatment and detox services were severely curtailed by the need for observational isolation upon admission and to retain clients in treatment as a result of the sheltering-in-place directive. Also SUD beds were set aside (held vacant) for on-site isolation and quarantine and temporarily taken off-line following Covid-19 exposures or confirmed outbreaks. During outbreaks, programs closed to new admissions for up to 6 weeks, which was further complicated by staff shortages.

The daily availability of substance use disorder withdrawal management, residential treatment and residential step-down beds is located online at https://findtreatmentsf.org/.

During the period July 1-December 31, 2020 (Q1/2 FY2020-21), for Residential Treatment: 95% of clients entering treatment entered within 10 days of request; for Outpatient Treatment: 70% of clients entering treatment entered within 10 days of request with a median time to first kept appointment of 5-6 days. For all SUD services, overall satisfaction with services was 92% (N=802 surveys sampled November 2020), with average rating of 4.4 (out of 5) for appointments offered at convenient location and 4.5 for convenient time.

The table below outlines the average time to access for SUD treatment services, the identified access target and the state and local reference standards guiding those timely access standards. Compliance with state-mandated Department of Health Care Service (DHCS) standards are monitored in twice annual state audits.

Average Time to Access (Q3/Q4 FY19-20 & FY 20-21 estimate)

	Time to Access[1]	SUD Treatment Service	Reference standard	Target
1.	**Same Day**	Opioid Treatment Programs	SFDPH standard[2] DHCS standard[3]	<24hr <3days
		Perinatal Residential Treatment	SFDPH standard DHCS standard	<24hr <3days
2.	**24 to 48 hr**	Withdrawal Management (Detox) Residential	DHCS urgent care[4]	24-48H
		Withdrawal Management (Detox) Outpatient	DHCS urgent care	24-48H
3.	**1 to 8 days**	Residential Treatment	DHCS routine care[5]	<10day

[1] Average time to access based upon Q3/Q4 FY19-20 and partial year estimates of Q1/Q2 FY20-21.
[2] OTP: SFDPH follows an internal standard more stringent than required by DHCS.
[3] DHCS OTP: see DHCS MHSUDS INFORMATION NOTICE NO.: 18-011 February 13, 2018, accessible at https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-%20Network%20Adequacy/MHSUDS_IN_18-011_Network_Adequacy.pdf
[4] DHCS urgent care: see DHCS MHSUDS INFORMATION NOTICE NO.: 18-011 February 13, 2018, accessible at https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-%20Network%20Adequacy/MHSUDS_IN_18-011_Network_Adequacy.pdf

4.	**1 to 2 wks**	Residential Step-Down with outpatient care*	DMC-ODS	N/A
5.	**1 to 3 wks**	Outpatient Treatment*	DHCS routine care	<10day
		Intensive Outpatient Treatment	DHCS routine care	<10day

In addition to timely access, BHS monitors SUD network adequacy to determine if the department has an adequate quantity and types of contracted SUD treatment programs. Currently, we have adequate number of services at all levels of care, except outpatient treatment, residential step-down linked to outpatient treatment and residential treatment for Spanish speaking clients. The City also maintains residential capacity for pregnant or perinatal clients, and for persons discharged from or at-risk for incarceration. The City also contracts for capacity in opioid treatment programs to provide easy entry to this modality.

Lastly, the City offers a broad range of low-threshold on-demand services, including with buprenorphine. We find that individuals increasingly prefer outpatient treatment using medication assisted treatments in lieu of residential treatment. The City has also broadened the use of medications for the treatment of alcohol use disorders, including expanded the use of naltrexone in primary care. It also conducts or funds overdose education and makes the opioid overdose reversal medication, naloxone, available for use citywide through the City's harm reduction, medical care and first responder programs.

In general, delays in treatment access are mostly attributable to mandatory clinical and/or financial assessment required for admission. The California DHCS requires all Drug Medi-Cal clients to undergo clinical assessment to determine medical necessity prior to admission. Drug Medi-Cal (DMC) in particular requires completion of the American Society of Addiction Medicine Placement Criteria[6] assessment to substantiate the requested level of care prior to utilization review and authorization. In circumstances of high-need or clinical safety, SFDPH may bypass authorization requirements. For example, this might occur when a client meets medical necessity for treatment but awaits Medi-Cal enrollment or meets high-risk criteria such as injection drug use with recent overdose.

[5] DHCS routine or non-urgent care: see DHCS MHSUDS INFORMATION NOTICE NO.: 18-011 February 13, 2018, accessible at https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-%20Network%20Adequacy/MHSUDS_IN_18-011_Network_Adequacy.pdf

[6] David Mee-Lee, Gerald D Shulman, et al. American Society of Addiction Medicine Criteria, 2nd edition, American Soc. of Addiction Medicine, Chevy Chase, 2013

Covid-19 Impact on Substance Use Services

Covid-19 had significant impact on the delivery of substance use services throughout FY19-20 and FY20-21 fiscal years. All outpatient programs were substantially curtailed and some closed to admissions for significant durations. SUD residential treatment programs remained open, but all programs were strained by personnel shortages, required reductions in bed or service capacity and the impact of Covid-19 exposures and outbreaks.

Telehealth

To mitigate the impact of COVID-19 on in-person services, California's Department of Health Care Services (DHCS) created regulations allowing telehealth to be used in outpatient treatment as well as for the counseling components of opioid use disorder treatment and residential treatment. This allowed clients greater safety and the convenience of remote access. The majority of clients found telehealth advantageous. As a result, our programs made fundamental changes in equipment, procedures, and training that will be maintained into the future. The transformation to telehealth in such a short period was another major accomplishment.

Residential Services

For residential services, managing Covid-19 was a major challenge. In most programs, space was redesigned to keep clients six or more feet apart. By the time of the third surge, most treatment groups were discontinued and converted to on-site telecare. Social outings were discontinued. New intakes were reduced to accommodate observational isolation and Covid-19 admission testing. Finally, the most significant impact on SUD residential treatment access was the need to retain clients for longer periods of time, including in withdrawal management, residential treatment and residential step-down programs, to comply with the shelter-in-place directive and avoid discharge to the street due to closure of congregate shelters and the Navigation Centers.

Outbreak Management

DPH's Behavioral Health Services developed its own physician-lead outbreak management team. The team investigated the cause of the outbreaks so that safety procedures could be developed, implemented and reinforced. Sick and exposed clients were separated and cohorted or referred to isolation and quarantine hotels if clinically indicated. Treatment capacity decreased most rapidly during the third through six months of the pandemic and leveled off during the third surge, mainly because individuals in need of housing were either already placed in community-based sheltering sites or sheltering on-site in residential treatment. The greatest placement growth was for people being discharged from hospitals or released from jail; these became prioritized target populations. Globally, the department-maintained flow by assertively managing the remaining bed supply, although at times this required modifications in usual treatment protocols, such as completing withdrawal management in the hospital setting.

New Substance Use Disorder Services

In addition to operating its comprehensive system of care for substance use disorders, DPH operates numerous low-threshold on-demand services for persons who are primarily experiencing homelessness and/or uninterested in receiving care in the licensed SUD treatment system. In FY20-21 DPH rolled out its first low-threshold virtual buprenorphine treatment, using telemedicine (tele-buprenorphine) pilots at three sites in order to engage people with opioid use disorder for whom traditional treatment posed too many barriers. In FY21-22 we plan to expand beyond the original three pilot sites to include other venues where opioid users can be reached. Venues may include shelters, single room occupancy (SRO) hotels, and community-based organizations. The tele-buprenorphine project provides on-demand access to buprenorphine via on-call prescribers who can be accessed through iPads and smartphones. The client is then able to pick up the buprenorphine prescription at the pharmacy.

DPH also brought addiction services to the shelter-in-place (SIP) hotels, including buprenorphine, medication assisted therapy, withdrawal management and a newly initiated demonstration project to provide medically monitored alcohol administration for clients who were unwilling or unable to discontinue the use of alcohol. In these monitored alcohol programs (MAP), medical providers assessed clients based upon their average alcohol use and wrote a prescription for medically supervised access to alcohol. This program proved extremely effective and continuation of this service is under consideration.

Expansion Plans

In FY21-22, DPH intends to establish a new Drug Sobering Facility, using the model of the existing Alcohol Sobering Facility. A Drug Sobering site will provide easy, low-threshold access to harm reduction, medical care and drug treatment for individuals who are intoxicated from drugs, particularly methamphetamine and/or opioids.

DPH has also developed proposals to expand low threshold services for clients experiencing homelessness, including expansion of tele-buprenorphine services, contingency management, substance abuse navigators embedded into the hospital consult service, mobile site embedded substance counseling, substance use counseling supporting people of color (POC) communities, additional ASAM level 1.0 SUD outpatient treatment openings, and sexual health services embedded substance counseling. These services follow the recommendations of the Methamphetamine Task Force, treatment on demand planning efforts, the Safe Injection Services Task Force, and substance use work group recommendations from the Community HIV Planning Group (HCPC). Expansion of programs is contingent on availability of new funding.

Summary:

In FY 20-21, BHS expects to meet or exceed all state and city timely access targets for SUD opioid treatment, perinatal treatment and withdrawal management and residential treatment. Timely access to outpatient treatment was lower than preferred due to restrictions imposed by Covid-19. Gaps in SUD residential care also affected access for Spanish speaking clients and BHS is working to address this gap in care. Lastly, delays in care due to clinical, financial and Drug Medi-Cal authorization are mitigated by at-risk funding, utilizing general funds when appropriate, and maintaining capacity for the treatment of perinatal, in-custody and opioid use disorders.

Counter-balancing these delays and service gaps are expansion of new low threshold on-demand services such as tele-buprenorphine; treatment in SROs, shelters, shelter-in-place hotels and other locations servicing people who are experiencing homeless; and enhanced outpatient treatment, hospital linkages and a new drug sobering center that serves as an entry into treatment for clients who traditionally do not enter the healthcare system.

Access is a complex process affected by client acuity, comorbidities, targeted risks, language, financial status, legal status and housing needs, and most recently, the impact of Covid-19. BHS strives to continue working on every access challenge and to expand the availability of lower barrier and more flexible services.