**Treatment Coordinators Responses (21) to Request from TCLC Block Grant Requirements Committee**
**Treatment Capacity and Referral Management Systems**
**Compiled by NASADAD 1/11/2019**

**255. Request from TCLC Block Grant Requirements Committee, asked 12/5/2018:**

The TCLC Block Grant Requirements Committee is exploring what capacity management and treatment referral systems states are using to connect people to the appropriate level of care in a timely fashion. The goal is to **identify states who feel they are doing this well** who could then describe their methods on a future topic call, **so please include a description of a few sentences in all of your answers.**

*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*

**Summary of Responses**
A total of 21 states (AL, AK, AZ, CT, GA, IN, IA, ME, MA, NE, NH, NM, OH, OR, PA, RI, TX, UT, VT, WA, WI) responded to this request. Seventeen states provided information about how their treatment capacity and referral management systems, or those that they are in the process of developing, work for priority populations, monitor interim services, and share availability information with providers and the public.

**Individual Responses**

**Positive Responses**
**Alabama, Nicole Walden**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

While the state can look at this within our management information system, it is not reflected as part of our bed availability/waiting list, so it is difficult monitor.

2. *Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
It does not.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Yes, we publish a residential bed availability list weekly.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
Not particularly. There are concerns with the difficulty in determining priority populations and the use of the capacity management system in an efficient manner at the provider level.
We are in the process of changing our management information system which we believe will resolve many of the issues identified above. Our plan is to have the system in plan within the next 6 to 9 months.

**Alaska, Kathryn Chapman**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

Priority populations in our system are identified as people who inject drugs, pregnant women, pregnant women who inject drugs and families involved in the child protective services system. These individuals are prioritized by the agencies for program admission. Programs have established waitlists and monitor and track their own waitlists. Our Division uses an electronic database (AKAIMS) and requires our network of providers to enter the TEDS minimal data set in this platform. AKAIMS has a mechanism that providers can use for a waitlist where they can track and ensure priority populations are getting priority admission. This feature is not used at this time but we are exploring it as a possibility. We recently asked providers to report to us how they are tracking the priority admissions for these populations and based on the feedback received, it is evident that there are inconsistencies across the network in how waitlists are used, and how intake and admission processes are established.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
No, we recently asked SAMHSA for TA to help us with working with the network of providers to ensure they are providing interim services.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Yes. We have a treatment locator and availability portal on our State website. The public and providers have access to it. Providers submit updates on a daily basis to this portal describing their waitlist time and capacity. We are in process of establishing a contract with Open Beds to improve real time capacity and appointment availability.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*

We have not received feedback on this. Internally we are not satisfied, and we know that the public and providers are not satisfied, so we are in need of technical assistance and improved mechanisms to facilitate better access to treatment resources.

**Arizona, Dan Greenleaf**

*1.Please describe in a paragraph how your state's capacity management and treatment referral systems work for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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- *Non-priority populations, e.g. those with severe alcohol disorders*

In Arizona, we are updating our capacity management and monitoring practices based on the preliminary report received from SAMHSA based on the Core Review Site Visit that took place in May 2017. Below is the contract language added that is now in effect with the Regional Behavioral Health Authorities (RBHAs) who are responsible for operationalizing the use of the capacity management system for their respective Geographic Service Areas (GSAs).

*Substance Abuse Block Grant (SABG) recipient*: The Contractor shall submit a SABG/Prevention/MHBG Plan as specified in the RBHA Contract to the AHCCCS System of Care and Grants Unit as follows:

1. Identified methodology and data used to identify populations to be served for Prevention of Substance Use and treatment of Substance Use Disorders (SUD) including SAMHSA's identified priority populations and specific underserved populations, which must at a minimum include proactively identifying adolescents, transitional aged youth, and those who have SUD at risk of attempting suicide;
2. Outreach efforts to reach identified populations,
3. Strategy to fully expend funds as well as steps that will be taken throughout the course of the year to monitor expenditures and make adjustments in a timely manner to best meet the needs of the community,
4. Identified providers to serve the populations, including provider name, locations, contact information, programs/levels of care offered, specialty populations served, and capacity, to include caseload ratios that allow for adequate access to individualized services in a timely manner,
5. Identified services to meet the needs;,
6. Plan for coordinating with other Health Plans for Non-Title XIX/XXI funded state only services,
7. Plan for coordinating with other Health Plans for access to Non-Title XIX/XXI funding for members who lose their Title XIX/XXI eligibility, and
8. Additional information as directed by AHCCCS.

The Contractor shall submit a SABG/Prevention/MHBG Block Grant Report as specified in the RBHA Contract to the AHCCCS System of Care and Grants Unit as follows:

1. The corresponding information from the preceding annual plan,
2. Identification of any barriers that occurred in accomplishing the plan as well as steps to address barriers moving forward,
3. Description of actions throughout the course of the year monitoring expenditures and making adjustments in a timely manner to best meet the needs of the community,
4. All required information for SAMHSA's annual reporting requirements,
5. All required information for the annual legislative reporting requirements, and
6. Additional information as directed by AHCCCS.

The Contractor shall submit documentation for annual SABG/Prevention/MHBG Operational Review and site visits as specified in the RBHA Contract to the AHCCCS System of Care and Grants Unit as follows:

1. Documentation of compliance with SABG treatment requirements,
2. Documentation of compliance with 45 CFR 96.132(b) stating that any facility for treatment services or prevention activities that is receiving amounts from a Block Grant, continuing education in such services or activities (or both, as the case may be) shall be made available to employees of the facility who provide the services or activities,
3. Documentation of strategies and monitoring of targeted interventions to improve health outcomes including, but not limited to Social Determinants of Health (SDOH) and National Outcome Measures (NOMS),
4. Documentation of strategies and monitoring of enhancing the Recovery Oriented System of Care (ROSC),
5. Documentation of the use of and expansion of Evidence Based Practices and Programs (EBPPs) to fidelity,
6. Documentation of compliance with SABG prevention requirements;
7. Documentation of compliance with SABG HIV requirements,
8. Documentation of service provision strategically fully expending SABG funding,
9. Additional information as directed by AHCCCS.

SABG funds are used to ensure access to treatment and long-term recovery support services for (in order of priority):

1. Pregnant women/teenagers who use drugs by injection,
2. Pregnant women/teenagers who use substances,
3. Other persons who use drugs by injection,
4. Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children, and
5. All other clients with a substance use disorder, regardless of age, gender, or route of use (as funding is available).

The Contractor shall ensure Capacity Management will:

1. In compliance with 45 CFR 96.132(a), create and monitor the process for referring individuals to treatment facilities that can provide to the individuals the treatment modality that is most appropriate for the individuals. Examples of how this may be accomplished include the development and implementation of a capacity management/waiting list management system; the utilization of a toll-free number for programs to report available capacity and waiting list data; and the utilization of standardized assessment procedures that facilitate the referral process.
2. Provide notification upon reaching 90% of its capacity to admit individuals to the program within seven days,
3. Ensure that each individual who requests, and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment not later than:
    a. 14 days after making the request for admission to such a program; or
    b. 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request.
4. Carry out activities to encourage individuals in need of such treatment to undergo such treatment. The Contractor shall require such entities to use outreach models that are scientifically sound, or if no such models are available which are applicable to the local situation, to use an approach which reasonably can be expected to be an effective outreach method.

5. The Model shall require that outreach efforts include the following:
    a. Selecting, training and supervising outreach workers,
    b. Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including [42 CFR part 2],
    c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV,
    d. Recommend steps that can be taken to ensure that HIV transmission does not occur, and
    e. Encouraging entry into treatment.

The Contractor shall develop effective strategies for monitoring programs compliance with this section. The Contractor shall submit a SABG Capacity Management Report under the requirements of [45 CFR 96.122(g)] on the specific strategies to be used to identify compliance problems and corrective actions to be taken to address those problems.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
Yes, through the Residential Waitlist System there is a place that lists the interim services including Risk Assessment completed, Education about HIV and Tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners & infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, Referral for HIV/TB treatment, Education of the effects of alcohol & drug use on a fetus, Referral for Prenatal Care, Referral for Medical Care, Referral for Pediatric Care, Additional Information and date/details regarding referrals provided. No, it does not include recovery support services.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Yes, through the RBHA's websites.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
The reviews have been mixed and at the time of the Core Review there was significant staff turnover, so the right people were not in the review due to being needed in other review sessions that were happening concurrently. Establishing case management ratios was a recommendation to address establishing a capacity limit for outpatient services.

**Connecticut, Lauren Siembab**
1. *1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*
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- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

CT has a web based application that shows our residential capacity at any given time for detox beds, rehab beds, Recovery House beds and sober house beds. There is a specific section for our Women's beds, however, there is no specificity about other target populations or for outpatient capacity: www.ctaddictionservices.com

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.* No and no. We have no wait lists anywhere. People can get intake appointments quickly, although, at times there could be a brief wait for a physical. Nevertheless, I am putting a policy together for tracking interim services.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.* Yes and yes, web-based.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.* They liked the website but felt it was too limited. . They did not like that it didn't include outpatient and targeted pops like IVDU's. There were problems with incomplete policies and procedures and our provider contracts.

**Georgia, Yomi Makanjuola**

*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
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- *Non-priority populations, e.g. those with severe alcohol disorders*

The system for treatment referral for priority populations identified has not been updated within the past 5 years. However, DBHDD policy is in alignment with SAPT Block grant requirements, which requires that providers give women seeking substance use treatment priority in admissions. The priority allows for immediate access to treatment. If space is not available, the provider is required to communicate with DBHDD's Women's Treatment Coordinator and provide interim services within 48 hours of initial contact. This policy describes the priority for admissions as, working collaboratively with Medication Assisted Treatment (MAT) Programs, with the minimum expectation for delivery of interim services. Pregnant Women - include women who are actively engaged in MAT services, seeking treatment, must be giving priority for admission. The same also apply to female IV substance users. It is important to note that admission for pregnant women must occur within 48 hours of such request. For female IV substance users urgent access to treatment must occur within 14 days of such a request for admission OR within 120 days if the program does not have immediate capacity.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
Yes. Annual site reviews are initiated reviewing interim services policy and implementation of that policy and how it is documented with each provider. An interim services checklist was created and utilized that includes addiction recovery support centers, 12 step community, faith-based community and other recovery supports. Certified Addiction Recovery Empowerment Specialist, peer support professionals, are also utilized with many providers to provide recovery check-ins for additional interim services.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*

The Office of Addictive Disease has developed a comprehensive tool kit that includes all providers in Georgia's network and the level of care identified, available to providers and the public. Also, through the department ASO which include Beacon health, the Georgia Crisis and Access Line has a site mygcal.com where the public and providers can search for providers through region, city, or county, to find what is available in their area. Each program (women's treatment, adult services, medication assisted treatment, child and adolescent, STR/SOR grant, gambling, HIV/EIS, etc.) has a specific identified program officer that also serves as referral and community link. Outreach and marketing for each program is done through program officer and provider network to ensure public information and accessibility is shared.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
Our waitlist capacity management and treatment referral system meet federal block grant requirements and is functioning adequately. However, SAMHSA technical reviewers noted there is a need for improvement in some areas that can be of beneficial to our system, but not required, as Georgia meets expectation for defined areas from block grant regulations.

They were thinking along the area that maybe we can utilize a centralize web base for the management and treatment referral waiting list system. At the same time, they understand that the way out system is set up is working well for us and our providers.

**Indiana, Nicholas Svetlauskas**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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In the last year, we contracted with 211 and Open Beds to give real time bed availability for residential and inpatient SUD tx. Contractually, we expect our providers to refer to another provider that has the same level of care if they are unable to admit the person. If there is a referral that is not able to receive services, they are red flagged and take priority regarding looking into and assisting the person requesting services.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
No, our quality control team monitors interim services. Recovery supports are not required but suggested.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Yes, 211 can be accessed by anyone. They may not know personally what the availability is, but 211 has access to check and inform the caller.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
SAMHSA gave us TA around our referral and capacity management. Since our review, we have added 211 and strengthened our contract language.

**Iowa, Deann Decker**
*Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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In Iowa, the Department of Public Health is the Single State Authority for the Substance Abuse Block Grant and holds authority for IDPH-funded substance use disorder treatment services. Iowa currently contracts with, and utilizes, a Managed Care Organization (MCO) as their intermediary for contracting with providers who receive the SABG funding, and to assist IDPH in meeting the SABG requirements. In meeting the state's capacity management and treatment referral system, IDPH-funded providers work through the MCO, and in partnership with IDPH staff, monitor and assist contracted providers in meeting the capacity and wait list system; mainly through data reporting, narrative reporting, telephonic and electronic communication. The MCO staff, and IDPH staff, monitor reporting and communications by providers, on a regular and consistent basis. The MCO submits monthly reports to IDPH necessary to support the Substance Abuse Prevention and Treatment Block Grant reporting requirements which includes: (1) IDPH Monthly Treatment Covered Services Summary, (2) IDPH Pregnant Women-Wait time, and (3) IDPH IV Drug User-Wait. The MCO coordinates with IDPH on results of findings and any corrective action plans as needed.
Effective January 1, 2019, IDPH, through a new RFP process, will be conducting many of the activities that the prior MCO completed on behalf of IDPH.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*

The MCO, through their contract with IDPH, is contracted to ensure that IDPH-funded contractors provide and manage interim services on behalf of IDPH. This is reported to IDPH in data and monthly narrative reporting. This currently does not include Recovery Support Services. Beginning in January/2019, IDPH will monitor and track Interim Services and will also begin reimbursement for selected Recovery Support Services, such as transportation and Peer Coaching.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Currently monitored through the MCO. Not easily accessible to providers and public. Beginning in January 2019, IDPH is working to make this information available to providers and public.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
SAMHSA TA reviews (most recent September 2017), has been satisfied with the capacity management and referral system as managed by the MCO, in partnership with IDPH.

**Maine, Victor Dumais**

*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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Capacity management system for all above populations involves monthly electronic reporting by providers. System is operated by state HHS staff, utilizing contracted web-based system (WITS). WITS has been updated within the past five years, and may be replaced within the next 12 months. Electronic sharing is only option, which has been challenging for providers.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*

No.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*

This is an area identified as in need of improvement, and a system that would provide this function has been considered to supplement or supplant the current system. Provider participation is a significant barrier to success of system.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*

No comment.

**Massachusetts, Julia Reddy**

*Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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Massachusetts contracts with a private vendor (Health Resources in Action, or HRiA) to operate our substance use treatment Helpline, helplinema.org. This service includes monitored hotline and web-search technologies to connect individuals and referring providers with treatment resources in our state. While the Helpline does not offer direct admission to treatment programs, they do assist by encouraging callers, connecting them to potentially appropriate levels of care through preliminary screening, and providing interim services (resources and education) to priority callers who cannot be immediately admitted into treatment. The Helpline also has trained clinicians on staff with a majority of the call-takers being bi-lingual. Interpreter services are available on-demand in 140 languages.

In 2018, the Helpline was enhanced further by the creation of a Waitlist Management Tool. This technology enables treatment programs to maintain a secure and confidential waitlist on the Helpline

system. The Helpline operators cannot see any private health information, but they can see the total numerical length of the waitlist at any given program. This enables the call-takers to make informed recommendations to treatment-seekers, guiding them toward programs with potentially shorter wait times.

The waitlist technology also indicates whether someone waiting for admission belongs to a priority population, encouraging programs to prioritize those admissions and reminding providers to offer interim services to those who inject drugs or are pregnant/parenting if they cannot be immediately admitted. Still, one does not need to be part of a priority population in order to receive full services, including motivational conversations and meaningful referrals to treatment resources, from the Helpline. Other providers and concerned family and friends can also call and be assisted by Helpline operators.

For pregnant and parenting clients, Massachusetts contracts with a different agency, the Institute for Health and Recovery (IHR) to provide specialized counseling and treatment referrals. This agency does provide direct admission to all eight of the Family Residential Programs in Massachusetts, including one program for fathers who would like to enter treatment with their children and parenting partner, should they have one. This Priority Access line also provides referrals to perinatal resources, pregnancy enhanced residential treatment programs, and other important services for perinatal women and families affected by substance use. The operators of this access line are specially trained in the provision of interim services.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
Currently, our Helpline operators keep logs of their conversations with callers and indicate whether or not Interim Services were provided. Similarly, our Priority Access Line indicates the number of callers each month who receive Interim Services. We would like, in the future, to add functionality to our waitlist system so that treatment providers can indicate their provision of Interim Services to direct callers.
In July 2017, the Helpline began offering to select callers the option (upon consent) to receive a "call back" from a Helpline Clinician to provide additional support on the path to recovery. This service allows follow up, assess barriers, and provide additional information and referrals to those who are looking for services through the Helpline. A new Oracle database and interface allows the Helpline call takers to schedule and conduct call backs, and ensure the security of information that is gathered to enable call back.

Interim Services, as defined in statute, includes motivational encouragement, education about substance risk, particularly pertaining to needle use and pregnancy, and referrals to immediately available resources. These resources include providers such as emergency medical providers, rape crisis or violence intervention services, perinatal services, needle exchanges, and – yes – recovery support services. The recovery support services to which our operators most often refer callers include Peer Recovery Centers, providers who offer Recovery Coaching, and grant-funded programs, such as Moms Do Care for perinatal women, that include recovery coaching.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Currently, providers can only see their own waitlist. However, the total waitlist count is available to any Helpline user on the website. Example: if you search on Helplinema.org using the "For Providers" tab under "search for Treatment," you can draw up a list of applicable programs and under the contact information for each program is their most recent Waitlist Count. While this does not explain how many beds are available in the program, it gives users some idea of how many people may be waiting for admission into any given program.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
The Helpline reached the goal of over 80% of BSAS licensed and funded residential program utilizing the Waitlist Management exceeding the goal provided to SAMHSA.
Massachusetts had a SAMHSA site visit in Summer 2018. We have not yet received the final report from that visit (it is due Spring 2019), so we do not know specifically if SAMHSA has feedback relevant to this waitlist technology. They did not express significant concerns during their visit.

**Nebraska, Linda Witmuss**
*1. Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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In the past two years, Nebraska implemented a new centralized data system (CDS), operated by the Division of Behavioral Health, that permits data entry and access to data reporting at a provider, intermediary network contractor and Division level. Service capacities (available and contracted) and utilization/available capacity is entered into the system and reviewed at varying frequencies by parties. Waitlist information for priority populations is another feature that captures priority, referral sources, and outcome. This is also reviewable at all levels.

Providers do not share PHI information electronically through this system. We have experienced continued challenges to asking for PHI in capturing waitlist information. The desired outcome is capturing waitlist for services for all populations but a few more specific data points are captured for the priority populations. The Division requires all agencies receiving funds from the Division to maintain a waitlist using the CDS and all persons waiting for designated levels of care are to be included on the agency/location waitlist regardless of anticipated payer source.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please Describe.*
Yes – specific data requirements are required by contract to be entered into the data system. Interim services includes but is not limited to support services, counseling and education. For priority populations, interim services delivered and date of service delivery are required from which monitoring and auditing occur.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Information is presently limited to service capacity funded through the Division. That information is accessible at the provider and administrative levels. Reports have been provided to the public but treatment capacity, i.e. like a bed availability with real time capacity availability is not available.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
Yes. During last on-site, staff were introduced to the new CDS.

**New Mexico, Mika Tari**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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- *Non-priority populations, e.g. those with severe alcohol disorders*

New Mexico Human Services Department Behavioral Health Services Division (BHSD)does not have centralized capacity monument system for the above populations. However, BHSD includes in the provider scope of work the treatment and referral requirements as outlined in 42 CFR Part 96. Each provider [individually] keeps an Excel based tracking system based on the outlined requirements.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
The tracking system does include monitoring of interim treatment services, and tracking the client until they are able to obtain service within their facility. The report does not include recovery services.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
New Mexico is currently working on a project with Open Beds to expand treatment bed availability options for substance abuse treatment providers and plans to expand to mental health treatment bed options in the future. BHSD also utilizes a public web based system called Network of Care as a tool to find treatment options within New Mexico.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
The 2016 review did not reveal any red flags of the way the system operates at present time.

**Ohio, Joyce Starr**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

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Because Ohio is a home rule state….Each Board area handles their own providers who are contracted and manages referrals as needed. The Boards do provide a monthly report to the state of numbers entering into the system, days lapsing (if any) from assessment to admission and numbers served. Since many of our programs treat all populations, they are not necessarily separated out unless there is specific funding. Since we are a Medicaid Elevated state….all go through the same procedure.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
Most of Ohio providers provide interim services. These services would be counted from the start as an admission. If they change levels then it is documented and reported.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
A monthly report is provided to the Boards from each provider in their area. The Boards then upload one document to the state. All these are available on our Website

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
Ohio has not had a Technical Review since prior consolidation in 2014

**Oregon, Nicole Corbin**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

The Oregon Health Authority is in the process of establishing a contract with a non-profit vendor to establish a searchable inventory database for OUD treatment providers in the state. Providers will be able to use the database to update and track their own capacity on a regular basis. In addition, the vendor will employ their Peer run call center to connect individuals to the next nearest available provider if the provider initially chosen by them indicates no capacity at the time of contact with the individual. The call center will also follow up with individuals referred through the call-canter to ensure treatment received or reasons for not receiving treatment post referral. This will help OHA identify specific geographical regions with low treatment delivery and social determinants of low treatment delivery.

Individuals who are IVDUs and/or Pregnant/parenting women will be flagged within the capacity management database as they seek treatment and/or enter interim services.

Stakeholder engagement and training will be a critical component of this database since the quality of data available to OHA and to the public will be dependent on data input and update by providers in the database network, to a large extent.

Something that might be of interest to NASADAD is that we are using the TA fund (the previously known CAOT fund) that SAMHSA is directly giving o states now, to sustainably fund this capacity management database and related training.

The database is rolling out initially for OUD providers, and then will expand to all SUD providers.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
All providers receiving public funds are contractually required to provide interim services to individuals who get added to the waitlist. This will be tracked via the Capacity management database as well. OHA will review a quarterly generated report for the individuals who go on waitlist and whether they received timely interim services. Yes, recovery support services such as peer delivered services are included in interim services.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Will be available to both providers and public once the new capacity management system is up and running. Currently this information is not available from one single source across the state.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
A centralized database has been a necessity. Providers have expressed administrative burden and low confidence in reported capacity and waitlist data under the current system of manual submission. The new database is to address those concerns.

**Rhode Island, Linda Mahoney**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
- *Pregnant and parenting women*
- *<u>Non</u>-priority populations, e.g. those with severe alcohol disorders*

Rhode Island monitors a wait list for residential placement and receives daily capacity numbers separated out by ASAM Levels of care and gender specificity electronically..

The wait list is separated out by priority group:
Pregnant injecting women
Pregnant substance abusers
Injecting drug users
Persons with HIV
Persons with TB
All others

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
Yes interim services are monitored and peer supports are a recommendation often utilized.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
Not yet but we are hoping to soon. Our Department is just in process of getting a new data system

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*

How we monitored interim services was subject to improvement. We were relying on agency reports and bi-annual audits. They suggested more.

**Texas, Tina Hosaka**

*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

In Texas, funded block grant contactors input their daily capacity reports on slots they have available for their contracted services. If contractors are at 100% of their capacity individuals are placed on their waitlist. The waitlist document identifies the type of service, priority population (if applicable), and if interim services are needed.

Per contract, contractors are required to adhere to federal and state priority populations regarding admission to treatment services and maintain weekly contact so that person remains motivated while on a waitlist.

The State manages and provides oversight to contractor's waitlist to ensure individuals on a waitlist are provided interim services, and admitted based on federal and state guidelines. For those individuals that do not meet the federal and state priority population, the state requires contractor's to provide interim services and ensure that community support services are available while they wait for admission to substance use treatment.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*

In Texas, funded contractors document information into the State's web based clinical record. Contractors enter information into a "waitlist" document which holds a field to confirm if interim services were provided. In addition, the waitlist document allows the contractor to document the type of interim services provided, which includes offering recovery services. Several treatment contractors also hold a recovery support contract which allows them to streamline and coordinate services while on a waitlist.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*

On a local/regional level those systems/contractors are required to have developed mutual agreements to streamline access to services. Contractors can use the web-based clinical record to determine if and when an open slot is available. When a contractor is unable to place a person within region based on need, priority population status, or on the request of the individual they request assistance from the State. The State will coordinate with the contractor to ensure the person is admitted, or placed on a waitlist out of region.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*

No response

**Utah, Shanel Long**

*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

Utah currently allows each Local Authority to maintain their own capacity management and referral system. We are currently looking at implementing a statewide platform such as OpenBeds or other solutions to manage this capacity. The platform will be statewide for all behavioral health services (MH, SUD, State Hospital psych beds, etc). It will also highlight and flag priority populations.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*

This is not something we currently monitor and have not thought about including in the new platform monitoring system

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*

Each Local Authority can provide this information. The new platform will be easy accessible by public and private.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*

We have not had an SUD SAMHSA technical review but have discussed the new platform with our Grant Officers.

**Vermont, Megan Mitchell**

*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

Vermont posted an RFP for a centralized intake and resource system and has identified an apparently successful bidder and is in the contracting process at this time. This system, which will include a call center, bed/board functionality and website will provide the capacity management and treatment referral system for the populations above. This system will centralize the currently decentralized, manual system where individual providers report waitlist and capacity information to the State and referrals are done, again manually, by the providers and partners.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*

Vermont does have Recovery Support Services available statewide and these are available both to individuals in treatment and those waiting. Monitoring and provision of interim services will be a part of the system we are working to procure.

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
The system Vermont is looking to procure will have a public-facing website to publicize the availability of treatment. Currently, Vermont does post some waitlist information on our website in a static manner that is publicly available.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.* The most recent technical review findings, in part, led to the development and posting of the RFP for the new system.

**Washington, Tom Fuchs**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
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- *Non-priority populations, e.g. those with severe alcohol disorders*

In all Washington State Managed Care contracts, language has been included stating: Providers will be expected to fulfill requirements related to Network Adequacy (90%) for 14-120 day admission, interim services, and outreach activities. Each Managed Care entity is required to ensure substance use disorder treatment assessment and services shall be provided to Individuals who inject drugs and pregnant and parenting women no later than 14 days after the service has been requested by the individual. If the individual cannot be placed in treatment within 14 days interim services must be made available to the individual.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
A team of behavioral health administrators conduct block grant contract reviews which includes capacity management and date of first contact.

Managed Care entities are encouraged to include recovery support services as part of capacity management

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
The Recovery Help Line (RHL) has been available to the people in Washington State for over 30 years. Professionals and providers within the community know us very well and utilize our services daily (we received 21,043 calls in 2018) via telephone, email, and chat (soon to implement text). We are also accessible online through our website, www.warecoveryhelpline.org.

- Most people who contact us are friends and family of those who are struggling, followed by those struggling themselves. About 25-30% of the calls are from professionals looking for services for their clients/patients.

• The Recovery Helpline has current listing of treatment resources and recovery supports that are updated annually and can be found online (through the Statewide 211 system) as well as calling the RHL directly.
• Utilizing State funding, RHL is launching a MAT locator (Web-based and Mobile phone capable) that will provide information about MAT prescribers, how to connect, and who is accepting new clients/patients at this time. http://www.warecoveryhelpline.org/mat-locator/
• The goal is to expand the MAT locator services (location, availability, open slots, etc) to include other treatment services such as outpatient and residential.

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
During the Technical Review is 2015, the State of Washington was transitioning to a managed integrated care model. Prior to the transition, Capacity Management reporting was provided utilizing an information system (TARGET2000). Upon completion of the transformation, TARGET2000 became a legacy system and data stored was not migrated to the new data management system. Washington State is now in the process of developing a new information system which will include all data elements to meet reporting requirements for the block grant.

**Negative Responses**
**New Hampshire, Jaime Powers**
*1.Please describe in a paragraph how your state's capacity management and treatment referral system works for the following populations, describing who operates it, if it has it been updated within the past five years, and whether providers can share information electronically:*

- *People who inject drugs*
- *Pregnant and parenting women*
- *Non-priority populations, e.g. those with severe alcohol disorders*

While we have such a system built in to WITS, there have been significant challenges with/provider resistance to implementation so it is not currently in use. We are looking at how to accomplish this utilizing the Hub and Spoke model we are developing with SOR funding.

*2. Does your capacity management and treatment referral system include the monitoring of interim services? Do those interim services also include recovery support services? Please describe.*
See above

*3. Is information on your state's treatment availability easily accessible to your providers? To the public? Please describe.*
No

*4. In your SAMHSA technical reviews, have reviewers been generally satisfied with your capacity management and treatment referral system or have areas needing improvement been identified? Please describe.*
No

**Pennsylvania, Jeff Geibel**
Pennsylvania is in the process of implementing a new data system and we have only had preliminary discussions around capacity management.

**Wisconsin, Scott Stokes**
Wisconsin could use some help in this area. There is room for improvement.