

Process Evaluation for the Integrated Substance Use Disorder Treatment (ISUDT) Program:

Creating a Rehabilitative Environment That Improves Public Safety for
CDCR/CCHCS Patients and Staff

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Executive Summary

In January 2020, the California Department of Corrections and Rehabilitation (CDCR) and the California Correctional Health Care Services (CCHCS) launched the Integrated Substance Use Disorder Treatment (ISUDT) Program in California prisons. The program seeks to provide timely and effective evidence-based treatment and transition to the community for incarcerated individuals with Substance Use Disorders (SUDs). ISUDT received funding under a Fiscal Year (FY) 2019-20 Budget Change Proposal (BCP) that provided background and funding for the first phase of a planned five-year rollout of the model across CDCR's 35 institutions.¹ The model is a fundamentally different approach in the way that SUD services are delivered to individuals in CDCR, with a comprehensive and integrated approach across multiple CDCR/CCHCS divisions in order to address SUDs under a clinical model with a particular focus on Opioid Use Disorders (OUDs).

This report presents the findings of a process evaluation of ISUDT conducted by the Center for Evidence-Based Corrections at the University of California, Irvine (UCI). A process evaluation is designed to assess whether program activities have been implemented as designed. It is distinct from an outcome evaluation, which measures the effects of a program. Six separate tasks were conducted over the period of April through December 2021, using data on ISUDT participants provided to the research team and documentation provided by CDCR/CCHCS, as well as interviews with key staff involved with the ISUDT Program. This document is written in a report format. The Executive Summary highlights key findings in the report. Individual chapters are devoted to the tasks. A final Conclusions chapter summarizes major findings. This document is written in the first person; "we" refers to the authors of the report.

Through interviews with ISUDT staff, analysis of program data, and review of documents, the process evaluation revealed the following:

- Hiring and training of staff for the model met (or exceeded) BCP expectations. Components of training and (to some extent) hiring were modified successfully to incorporate online formats in response to Coronavirus Disease 2019 (COVID-19).
- Over 63,000 individuals were screened or assessed from program inception in January 2020 through Spring 2021. Medication-Assisted Treatment (MAT) evaluation and assessment were provided to over 20,000 individuals and just under 16,000 individuals initiated on MAT during the process evaluation period. The Cognitive Behavioral Interventions (CBI) component was greatly affected by COVID-19, experiencing two major CBI program suspensions during the study period. Packet programming was instituted to help address CBI program suspensions, but CBI experienced long delays, on the order of six months from initial referral/placement on the waitlist for CBI until start in CBI. As a result, our estimate is that slightly over 300 individuals completed CBI during the study period, which was based on a 12-month CBI model.
- Supportive Housing is a recognized important part of the ISUDT model; however, program developers felt that it was important to focus early on MAT and CBI

¹ During the majority of the process evaluation, CDCR operated 35 prisons. Deuel Vocational Institution closed September 30, 2021.

components due to risk of overdose with the population. ISUDT is currently examining several options for Supportive Housing. At present, discussions are focused on the second option (rehabilitation and recovery housing for ISUDT participants plus those involved in other rehabilitative programs and services). ISUDT Program leadership are hopeful they can initiate Supportive Housing in summer 2022, contingent upon COVID-19 restrictions.

- Transition Services utilize a Whole Person Care (WPC) approach. Transition Services start in prison with Enhanced Pre-Release processes for individuals within 15-24 months of release. About seven months before release, charts for every individual leaving a CDCR facility are reviewed by the ISUDT Nursing Resource Team to provide a medical needs assessment as well as outreach to the community to assure that MAT and medical/mental health care continue. California Advancing and Innovating Medi-Cal (CalAIM) implementation should help with assuring a “warm handoff” to counties and collection of information on how participants fare once released. Data for Transition Services are not yet available on the Quality Management (QM) dashboard to examine the services received in this ISUDT component.
- The ISUDT model is supported by a QM dashboard that was developed and built, and is being maintained, within CCHCS. The dashboard extracts data from existing databases in the CDCR and CCHCS data warehouses and is updated between two and four times a day. The dashboard is used to directly monitor patient care as well as to manage workflows for both clinical and CBI programming as a “one-stop” interface, rather than users needing to access different databases within CDCR/CCHCS. Currently, the database contains metrics and information on MAT and preliminary CBI outcomes. The dashboard is evolving as the ISUDT model matures.
- A future outcome evaluation for the ISUDT model is planned to understand the impact of ISUDT on in-prison as well as community outcomes. Several considerations need to be addressed in the design and conduct of such a study, including an appropriate comparison group, outcomes, measurement of components for an economic analysis, and best research design. It is recommended that the outcome evaluation be conducted when a cohort of individuals has experienced the full ISUDT model, which may be fall of 2022.

In each chapter of the report, we provided more specific recommendations and next steps for each of the process evaluation tasks. In general, we see the following as key areas to attend to in the ongoing operation of the ISUDT model:

- Continued development of the ISUDT model with respect to Supportive Housing, Community Transition, QM metrics, and processes within ISUDT.
- Continued focus on data quality from source data systems as well as quality checks within the QM dashboard.
- Reexamination of services provided once the ISUDT model is operating at steady state.
- Outcome evaluation of ISUDT using a third-party evaluator working with a CCHCS research coordinator.
- Continued utilization of an ISUDT Project Management Team working to resolve cross-divisional barriers, and continued facilitation of coordination with external stakeholders.

This process evaluation comes less than two years after ISUDT began implementation—thus it represents the early experiences of ISUDT. As outlined in the BCP, full implementation will occur over a five-year timeline. However, ISUDT is fully operational with screenings, assessments, linkages to care (MAT and CBI), and Enhanced Pre-Release Services available at all prisons. In addition, it is important to note the implementation of the ISUDT Program occurred during the same time as COVID-19, and CDCR/CCHCS made significant progress in identifying, treating, and linking those with SUDs to care despite unprecedented challenges created by this global pandemic. Current data from the ISUDT public dashboard indicate continued progress in screening/assessing CDCR/CCHCS’ population, and ISUDT service provision (MAT and CBI).

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List of Acronyms

Acronym	Description
AMCT	Addiction Medicine Central Team
AOD	Alcohol and Other Drug
ARMS	Automated Reentry Management System
ASAM	American Society of Addiction Medicine
ASP	Avenal State Prison
BCP	Budget Change Proposal
CA DOJ	California Department of Justice
CAC	California City Correctional Facility
CAL	Calipatria State Prison
CalAIM	California Advancing and Innovating Medi-Cal
CB2	Integrated Substance Use Disorder Treatment Life Skills
CBI	Cognitive Behavioral Interventions
CBIAT	Cognitive Behavioral Interventions Attendance
CBITCODE	Cognitive Behavioral Interventions TCODE
CBT	Cognitive Behavioral Therapy
CCC	California Correctional Center
CCCMS	Correctional Clinical Case Management System
CCHCS	California Correctional Health Care Services
CCI	California Correctional Institution
CCJBH	Council on Criminal Justice and Behavioral Health
CCWF	Central California Women’s Facility
CDCR	California Department of Corrections and Rehabilitation
CDPH	California Department of Public Health
CEN	California State Prison, Centinela
CHCF	California Health Care Facility
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men’s Colony
CMF	California Medical Facility
CO	Correctional Officer
COR	California State Prison, Corcoran
COVID-19	Coronavirus Disease 2019
CRC	California Rehabilitation Center
CTF	Correctional Training Facility

Acronym	Description
CVSP	Chuckawalla Valley State Prison
DAI	Division of Adult Institutions
DAPO	Division of Adult Parole Operations
DHCS	Department of Health Care Services
DMH	Department of Mental Health
DMV	Department of Motor Vehicles
DNS	Division of Nursing Services
DRP	Division of Rehabilitative Programs
DVI	Deuel Vocational Institution
EHRS	Electronic Health Record System
EOP	Enhanced Outpatient Program
FEI	Focused Electronic-Health Innovation
FSP	Folsom State Prison
FY	Fiscal Year
HDSP	High Desert State Prison
ICF	Intermediate Care Facility
ISI	Integrated Substance Use Disorder Treatment Intensive Outpatient
ISO	Integrated Substance Use Disorder Treatment Outpatient
ISP	Ironwood State Prison
ISUDT	Integrated Substance Use Disorder Treatment
ISUDT Demographic	Integrated Substance Use Disorder Treatment Demographic
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
LCSW	Licensed Clinical Social Worker
LMS	Learning Management System
MAT	Medication-Assisted Treatment
MATAPP	Medication-Assisted Treatment Evaluation Appointment
MATTX	Medication-Assisted Treatment Appointment
MCSP	Mule Creek State Prison
MHCB	Mental Health Crisis Beds
MI	Motivational Interviewing
MOU	Memorandum of Understanding
NA	Not Applicable
NIC	National Institute of Corrections
NIDA	National Institute on Drug Abuse
NIDA MA	National Institute on Drug Abuse Modified Assist (NIDA Modified Assist)

Acronym	Description
NIDAQUICK	National Institute on Drug Abuse Quick Health Screen (NIDA Quick Screen)
NKSP	North Kern State Prison
OIG	Office of Inspector General
OMCP	Offender-Mentor Certification Program/Apprenticeship and Training
ODU	Opioid Use Disorder
PBSP	Pelican Bay State Prison
PCT	Primary Care Team
PVDTs	Parole Violation Disposition Tracking System
PVSP	Pleasant Valley State Prison
QM	Quality Management
RJD	Richard J. Donovan Correctional Facility
RN	Registered Nurse
SAC	California State Prison, Sacramento
SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation Center
SI	Substance Involvement
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SQ	San Quentin State Prison
SUD	Substance Use Disorder
SUDT	Substance Use Disorder Treatment
SVSP	Salinas Valley State Prison
T4C	Thinking for a Change
TCU	Texas Christian University
TRS	Transition Reentry Services
UC	University of California
UCI	University of California, Irvine
UCLA	University of California, Los Angeles
VSP	Valley State Prison
WPC	Whole Person Care
WSP	Wasco State Prison

Introduction

In January 2020, the California Department of Corrections and Rehabilitation (CDCR) and the California Correctional Health Care Services (CCHCS) launched the Integrated Substance Use Disorder Treatment (ISUDT) Program as a collaborative and comprehensive approach to treating Substance Use Disorders (SUDs) in California prisons. The program is to provide timely and effective evidence-based treatment and transition to the community for incarcerated individuals with SUD, with a particular focus on the provision of Medication-Assisted Treatment (MAT) to address Opioid Use Disorders (OUDs).

The mission of ISUDT, as stated in the Budget Change Proposal (BCP), is “to provide timely and effective, evidence-based treatment and transition services to incarcerated individuals with SUDs with the long-term goals of reducing SUD-related morbidity, and recidivism.”² The program requires a phased five-year approach to reach full implementation. The program is targeted to three participant populations at higher clinical risk for SUD-related harm, to accomplish the following goals:

1. Reduce both SUD-related morbidity and mortality.
2. Create a rehabilitative environment to improve safety for inmates and staff.
3. Reduce overall recidivism.
4. Reintegrate individuals successfully into their community at time of release.
5. Improve public safety and promote healthy families and communities.

ISUDT is designed for three major groups of patients: those entering prison already on MAT; those already in CDCR/CCHCS who have one or more events indicative of high-risk behavior (with SUD-related complication, self-referral, overdose) or clinical need, and those preparing to leave prison within the next 15 to 24 months. Individuals in each of the three groups flow through processes of screening and assessment; treatment; enhanced pre-release; and community transition. Estimates by CDCR/CCHCS were that over 26,000 individuals will be identified for SUD via the National Institute on Drug Abuse Quick Health Screening (NIDA Quick Screen). Approximately 40% of these individuals would be lower risk and provided with screening, brief intervention, and referral to treatment. The 60% identified as Moderate and High Risk by the National Institute on Drug Abuse Modified Assist (NIDA Modified Assist) would be assessed using American Society of Addiction Medicine (ASAM) criteria. Ninety percent of those almost 16,000 Moderate and High-Risk individuals would receive intensive outpatient services; 10% would receive outpatient services.

Under ISUDT, individuals are to receive services consistent with their level of care. These services include MAT, Cognitive Behavioral Interventions (CBI) specific to SUD as well as Life Skills, and expansion of the Offender-Mentor Certification Program/Apprenticeship and Training (OMCP) for the in-prison component of ISUDT. The Community Transition component includes services and care coordination with community resources through the Whole Person Care (WPC) model. Transition Services are wide

² Source: Budget Change Request FY1920 (Budget Change Proposal 5225-429-BCP-2019-MR).

ranging including medication continuity, housing, caregiver appointments prior to release, activation of benefits, and integrated case planning, among others. ISUDT treatment and services are designed to be provided within Supportive Housing at the institution. ISUDT brings together cross-unit collaboration using seven major business teams to plan and implement the ISUDT Program, with associated goals and aims in each effort.

This report presents the findings of a process evaluation of ISUDT conducted by the Center for Evidence-Based Corrections at the University of California, Irvine (UCI). A process evaluation is designed to assess whether program activities have been implemented as designed. It is distinct from an outcome evaluation, which measures the effects of a program. Six separate tasks were conducted over the period of April through December 2021, using data on ISUDT participants provided to the research team and documentation provided by CDCR/CCHCS, as well as interviews with key staff involved with the ISUDT Program. The evaluation tasks were designed to address the second goal for ISUDT: create a rehabilitative environment to improve safety for inmates and staff. The six tasks included:

- Task 1: Document Services to CDCR/CCHCS Patients (a pipeline analysis of the process from screening to treatment for ISUDT individuals)
- Task 2: Document Hiring and Training (BCP targets and numbers hired and trained)
- Task 3: Document Supportive Housing (housing planned and available for ISUDT participants)
- Task 4: Document Transition Process (planned and available services)
- Task 5: Data Management Utility (including a discussion of the data dashboard used for ISUDT management)
- Task 6: Determine Evaluability (discussion of how best to envision an outcome evaluation for ISUDT)

We present our findings for each task in a separate chapter, each of which contains information on methods and results as well as recommendations and observations for that task. The final Conclusions chapter summarizes findings and overall recommendations. This document is written in the first person; “we” refers to the authors of the report.

One major historical event has impacted the implementation of the ISUDT Program since early 2020—the Coronavirus Disease 2019 (COVID-19) pandemic. This pandemic has caused major disruptions in almost every aspect of daily life not only in California and the United States, but throughout the world. The ISUDT Program was no exception. We point out aspects of the implementation of the ISUDT Program that were impacted and those that were not, as well as changes made to deliver the program in the context of a virtual world that many of us had to adapt to over the past two years.

Task 1: Document Services to CDCR/CCHCS Patients

Overview

Task 1 was designed to conduct a “pipeline” analysis that tracks the flow of patients as they are identified, screened, assessed, referred, and placed into and leave MAT and behavioral treatment. This analysis requires obtaining information at an individual level on participants screened and assessed (and their scores), which programs and treatment individuals are placed in and for how long (including their status at program termination), reentry services received while in the institution, and when they are reintegrated into the community. Our pipeline analysis focused on individuals who had been screened and follows them through program MAT and CBI assignment and delivery. We did not have data on the reentry services or events that happened post-release from a CDCR institution.

The ISUDT Program serves three populations of individuals: the arriving population—already on MAT, the high-risk population (e.g., SUD-related complication, self-referral, and/or overdose), and the reentry population (releasing in 15-18 months).

Individuals identified positive with the NIDA Quick Screen by the Primary Care Team (PCT) nursing staff are referred next to WPC, represented by Licensed Clinical Social Workers (LCSWs) or the Resource Registered Nurse (RN), for further assessment with the NIDA Modified Assist questionnaire. The resultant Substance Involvement (SI) score is used to identify a patient’s clinical risk level. Patients with an SI score higher than 27 are considered high risk, patients with a 4-26 SI score have a moderate risk, while patients with a 0-3 SI score have a low risk. Individuals may also be referred for a NIDA Modified Assist through self-referral and/or if they have demonstrated a need for assessment through an SUD-related event, such as hospitalization for overdose. The results of the screening and assessment process determine the waitlist for enrollment into CBI, including ISUDT Intensive Outpatient (ISI), ISUDT Outpatient (ISO), and Life Skills (CB2). Individuals with a score of 4 or more on the NIDA Modified Assist or with an SUD diagnosis per the ASAM assessment are referred to the Division of Rehabilitative Programs (DRP) for enrollment in CBI. Individuals eligible for MAT are referred to the Addiction Medicine Central Team (AMCT) for a MAT evaluation to determine if MAT is clinically appropriate.

Key Findings

Over 63,000 individuals participated in the ISUDT Program. Approximately 16,000 individuals initiated MAT. Almost 7,000 individuals were enrolled in CBI, but only 300 individuals completed CBI during the study period; suspensions due to COVID-19 greatly affected the numbers who received CBI.

Data Provided to UCI for Analysis

UCI was provided with nine ISUDT datasets: ASAM, CBI, CBIAT, CBITCODE, ISUDT Demographic, MATAPP, MATTX, NIDAQUICK, and NIDA MA. The ASAM dataset contains data of the patients who received an SUD diagnosis based on the biopsychosocial ASAM assessment. The CBI dataset has data of the patients who were enrolled in CBI. The CBIAT (CBI Attendance) dataset contains data of the patients who took instructional classes as part of CBI, either in person or through paper packet. The data included in these analyses were from ISUDT implementation in January 2020 through the end of February 2021. The CBITCODE dataset has data on patients who received a CBI TCODE equivalent to T1-ISI, T2-ISO, or T3-CB2. The ISUDT Demographic dataset contains demographic data of the patient population in the ISUDT Program. The NIDAQUICK dataset contains data of the patients who received

the initial NIDA Quick Health Screening (NIDA Quick Screen) for the use of alcohol, tobacco, and drugs. The NIDA MA dataset contains data of the referral patients who received the pharmacologic assessment for the use of illicit or non-medical prescription drugs using the NIDA Modified Assist. The MATAPP (MAT Evaluation Appointment) dataset has data on the patients who were evaluated for MAT. The MATTX (MAT Appointment) dataset contains data of the patients who received medication-assisted treatment.

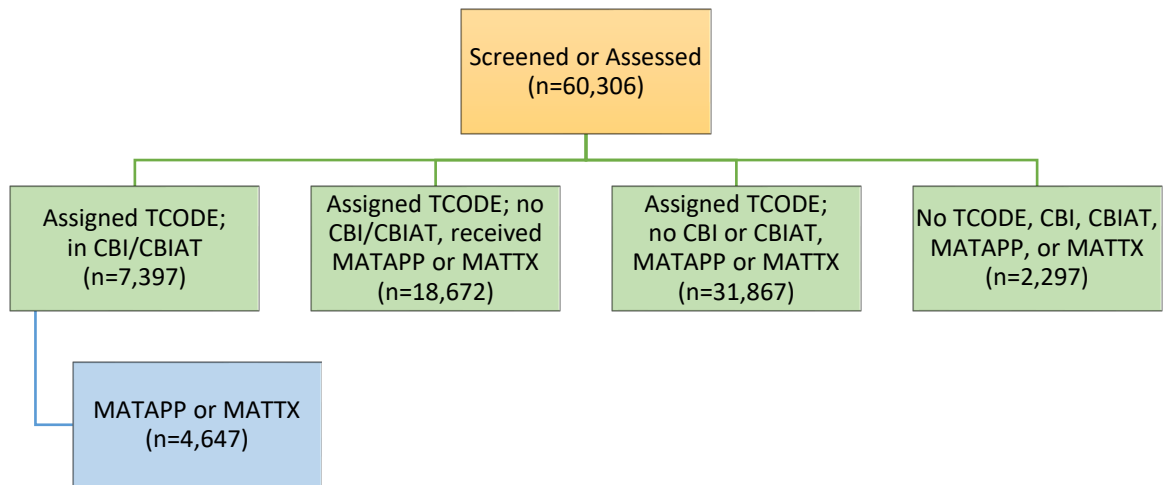
Table 1. Total Number of Records and Individuals in the ISUDT Datasets (from January 2020 through February 2021)

Dataset	Number of Records	Number of Distinct Individuals
ASAM	587	585
CBI	8,906	7,529
CBIAT	671,597	7,476
CBITCODE	82,651	58,770
ISUDT Demographic	149,709	149,709
MATAPP	161,705	24,986
MATTX	3,927,298	16,956
NIDAQUICK	49,043	43,123
NIDA MA	32,061	30,614

Sample Used for Analyses

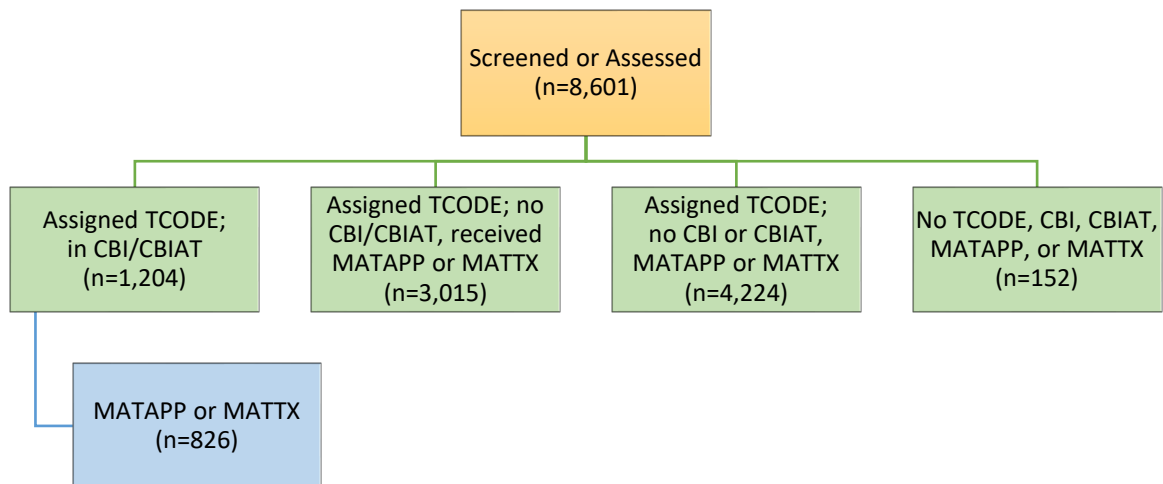
To establish the screened ISUDT dataset, we merged the nine datasets and kept only the observations for the patients who had any type of screening. We removed observations for 87,702 individuals present only in the demographic dataset and not present in the other datasets, and for the 1,701 individuals who were not in the ASAM, NIDAQUICK, and NIDA MA datasets. We examined the ISUDT full sample of 60,306 screened individuals, and respectively the ISUDT High-Risk sample of 8,601 screened individuals. The CBIAT dataset was updated twice during the evaluation process for the CBI attendance observations entered for the ISUDT Program participants.

Figure 1. All ISUDT Screened Participants³



As Figure 1 shows, 60,306 individuals were screened. Of those, 57,936 (96.2%) were to receive CBI; however, the vast majority did not receive CBI during the study period and remained on the waitlist. About 40% (23,309) were referred to MAT. Just under one-fifth (19.9%) of those who were referred to MAT participated in CBI. A total of 2,297 individuals did not get a CBI TCODE and did not receive CBI or MAT referral/treatment.

Figure 2. ISUDT High-Risk Screened Participants



³ Figures 1-4 blue and green boxes do not include: 335 participants who had no match in the demographics file (these 335 individuals had either MATTX treatment or MATAPP evaluation and were in CDCR for fewer than 30 days); 71 individuals with no TCODE, who had either MATAPP or MATTX; 2 inmates with no TCODE, who are in CBI or CBIAT; and 1,701 individuals who had no ASAM, NIDA Quick Screen, or NIDA Modified Assist.

As Figure 2 shows, 8,601 of the 60,306 participants were classified clinically as High Risk. Of these individuals, 8,443 (98.2%) were referred to CBI; however, as we saw with the total sample, the vast majority did not receive CBI. Over one-fifth of those with MAT referrals participated in CBI (826 of 3,841). Almost 4,000 of the High-Risk participants (44.7%) were referred to MAT. A total of 152 individuals were not referred to MAT or CBI.

Table 2 presents the background characteristics of the screened sample of 60,306 individuals as well as of the 8,601 High-Risk individuals.

Table 2. Background Characteristics for Screened Participants

Background Characteristic	ISUDT Screened (%) (60,306 individuals)	ISUDT Screened – High Risk (%) (8,601 individuals)
Gender		
Male	93.90	92.91
Female	6.10	7.09
Age		
18-25	9.81	1.87
26-35	34.87	12.46
36-45	27.21	19.51
46-55	15.71	21.56
55+	12.40	44.60
Mean age (years)*	39.41	52.04
Risk level**		
LOW	47.58	0
MEDIUM	38.16	0
HIGH1	5.37	37.64
HIGH2	8.89	62.36
Mental health		
ACUTE	1.11	2.92
CCCMS	76.71	63.78
DMH	0	0
EOP	18.63	25.03
EOPMod	0.53	1.14
ICF	2.60	6.08
MHCB	0.42	1.05
Institution		
ASP	3.67	0.37
CAC	3.10	0.17
CAL	3.05	0.41
CCC	3.41	0.29
CCI	3.53	1.40
CCWF	3.57	3.64
CEN	2.97	0.38
CHCF	1.93	8.03
CIM	2.68	8.02
CIW	1.99	3.53

Background Characteristic	ISUDT Screened (%) (60,306 individuals)	ISUDT Screened – High Risk (%) (8,601 individuals)
CMC	3.54	5.78
CMF	1.80	6.49
COR	3.51	2.55
CRC	3.91	1.53
CTF	4.02	3.35
CVSP	2.08	0.98
DVI	0.52	0.26
FSP	2.99	1.87
HDSP	2.97	1.00
ISP	2.85	0.58
KVSP	3.15	1.99
LAC	2.24	5.10
MCSP	3.79	11.22
NKSP	2.39	0.78
PBSP	1.61	0.51
PVSP	2.94	0.07
RJD	3.07	7.98
SAC	2.05	2.88
SATF	4.80	3.60
SCC	4.50	0.70
SOL	2.29	4.07
SQ	1.70	3.70
SVSP	2.30	2.81
VSP	2.87	3.12
WSP	2.23	0.84
Mean Classification Score*	47.29	56.78
Bed security level		
I	10.69	4.08
II	37.16	42.54
III	20.01	15.85
IV	17.45	15.13
NA	14.67	22.38
UNKNOWN	0.01	0.01

*Numerical value; **clinical risk

Most of the ISUDT screened and High-Risk screened individuals are males between 26-35 years for the full sample and 55+ for the High-Risk sample. The majority of the ISUDT sample (47.6%) are categorized as Low Risk. The most represented mental health level of care group is the Correctional Clinical Case Management System (CCCMS) category. More than three-quarters of ISUDT screened patients and 63.8% ISUDT screened High-Risk patients are classified as CCCMS.

Screening and Assessment

Participants were to receive screening and assessments depending upon the eligibility group. The data we received did not classify which eligibility group participants belonged to. As a result, we were unable to determine whether individuals flowed through the testing protocol as outlined in the BCP. We were, however, able to classify participants based on which screening and assessment tools they had.

Figure 3. All ISUDT Participants Who Received NIDA Quick Screen, NIDA Modified Assist, or ASAM

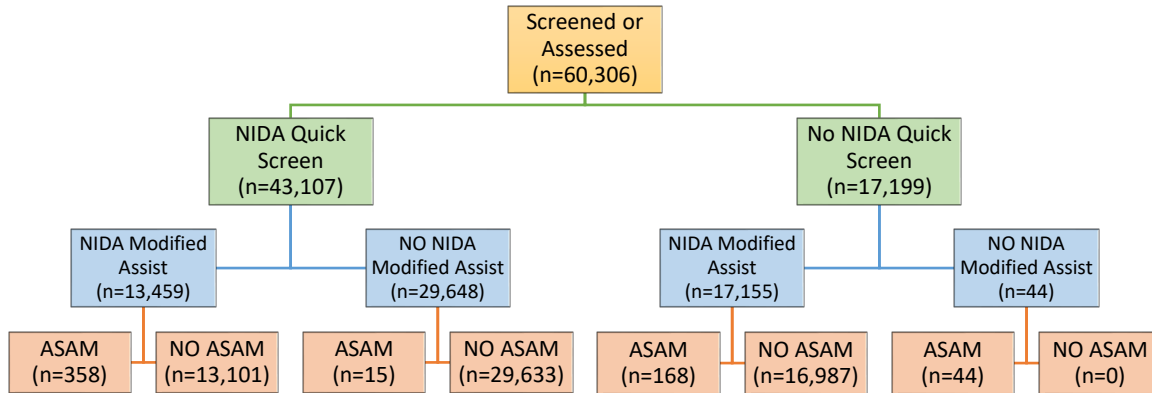


Figure 3 shows that out of the 43,107 ISUDT participants assessed with the NIDA Quick Screen, 13,459 patients received the NIDA Modified Assist. Out of this group, 358 patients received an ASAM assessment. Fifteen individuals received an ASAM assessment after being screened with NIDA Quick Screen and without NIDA Modified Assist. Out of 17,155 patients who received NIDA Modified Assist and not assessed with the NIDA Quick Screen, 168 individuals received the ASAM assessment; 44 individuals received the ASAM assessment without being screened with NIDA Quick Screen or NIDA Modified Assist.

Figure 4. High-Risk ISUDT Participants Who Received NIDA Quick Screen, NIDA Modified Assist, or ASAM

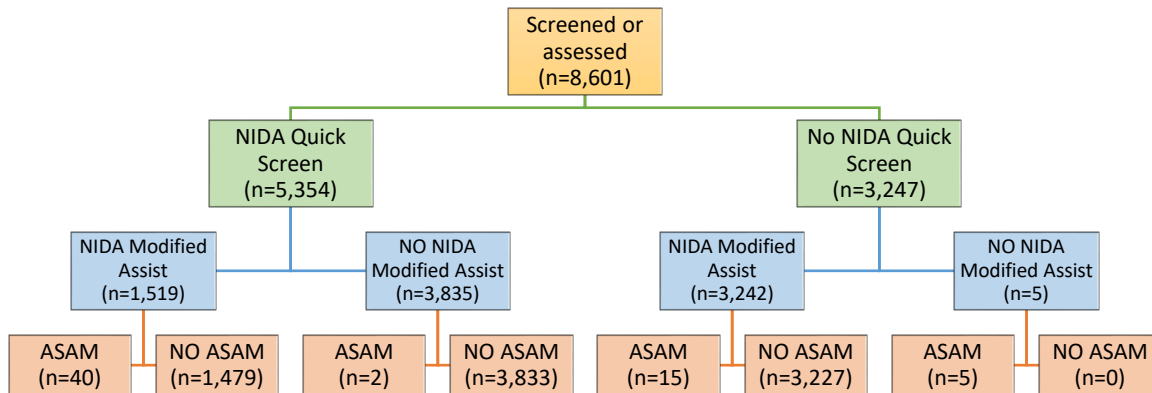


Figure 4 shows that out of 5,354 ISUDT High-Risk participants assessed with the NIDA Quick Screen, 1,519 patients received NIDA Modified Assist. Out of this group, 40 individuals received an ASAM assessment. Out of 3,242 High-Risk patients who received NIDA Modified Assist and not assessed with the NIDA Quick Screen, 15 individuals received the ASAM assessment.

The relatively low number of ASAM assessments performed was primarily attributable to COVID-19 and other accelerated releases. During the period of this evaluation, CDCR/CCHCS were focusing on the NIDA

Modified Assisted to refer to CBI, in part because the hiring of LCSWs (responsible for ASAM assessments) was impacted by COVID-19.

Figures 5 through 8 show the level of care and prior use of drugs for those individuals who received the NIDA Modified Assist. The vast majority were recommended for Intensive Outpatient, followed by Outpatient. Figures 6 through 8 display the type of drugs used by participants in the three levels of risk—High, Medium, and Low. Almost half (46.3%) of High-Risk participants showed use of street opioids, with almost a fifth (18.2%) using prescription opioids. Levels of opiate use were much lower for Moderate and Low-Risk participants.

Figure 5. Level of Care for Participants with NIDA Modified Assist

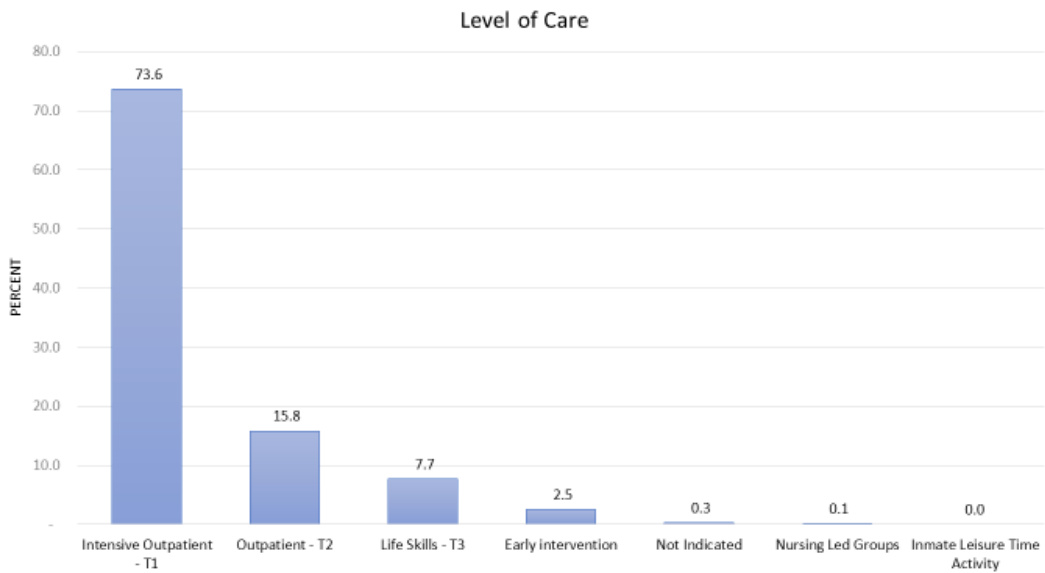


Figure 6. Substance Use for Participants with NIDA Modified Assist, High-Risk Group

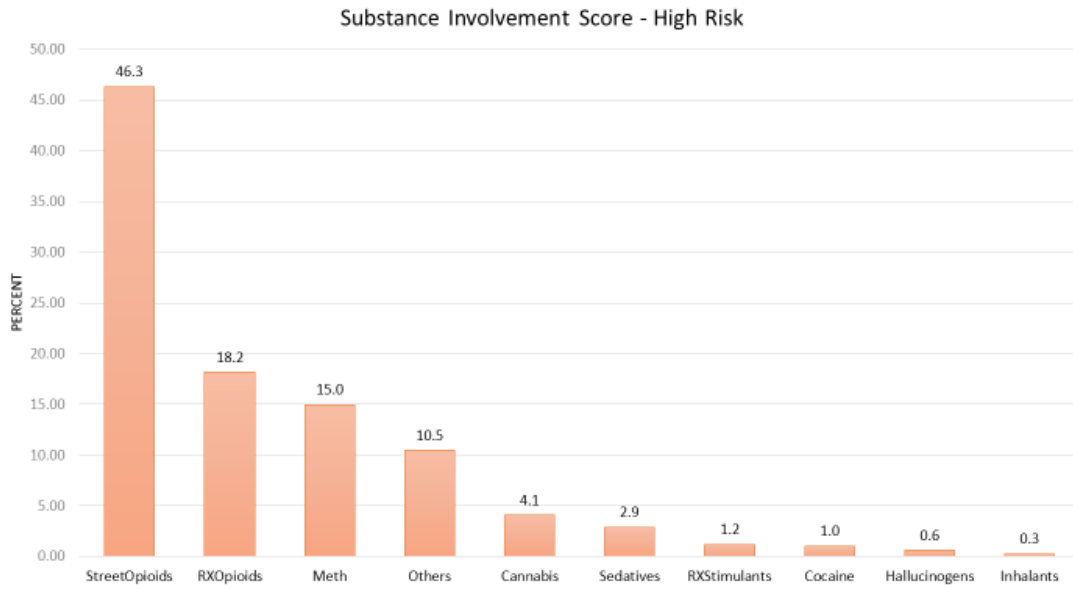


Figure 7. Substance Use for Participants with NIDA Modified Assist, Moderate-Risk Group

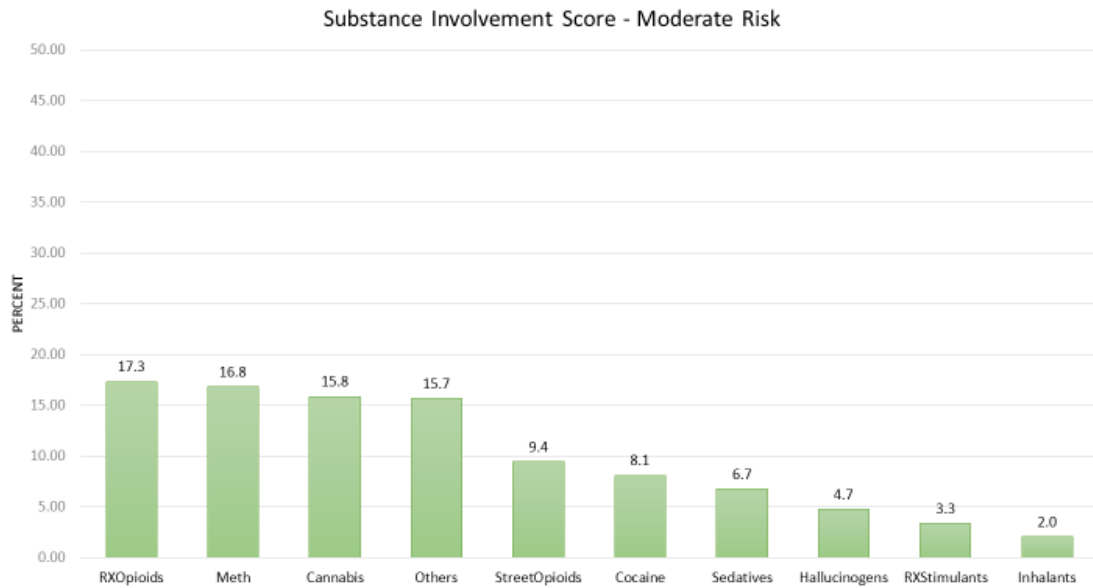
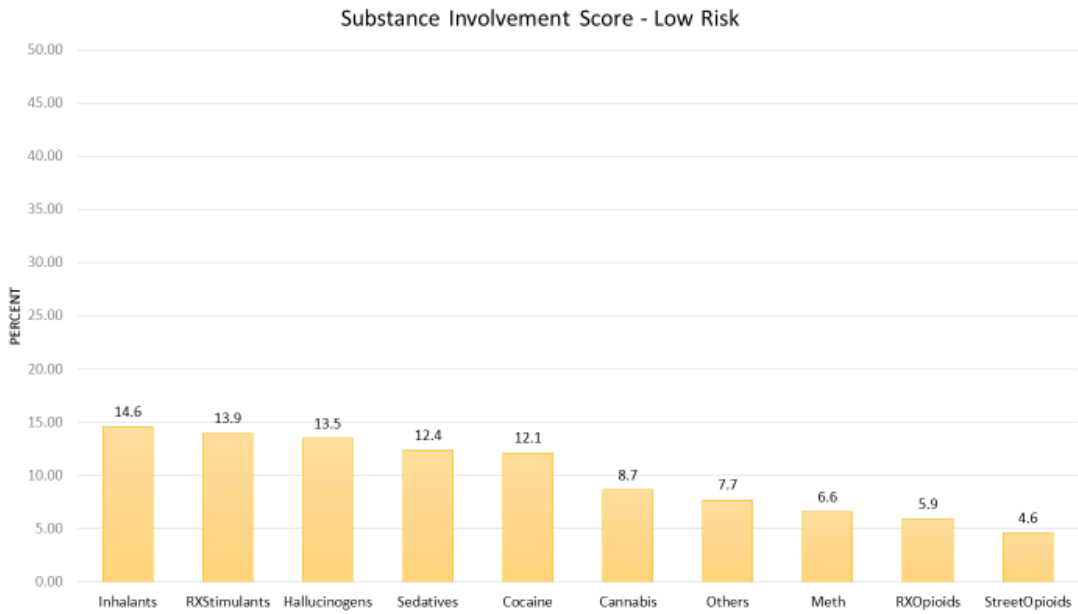


Figure 8. Substance Use for Participants with NIDA Modified Assist, Low-Risk Group



MAT Appointments and Treatment

We next turn to flowcharts that represent MAT referrals and treatment. Figures 9 and 10 show the flow of individuals who did not appear in either of the CBI files, but were either in the MAT appointment or MAT treatment files.

Figure 9. Evaluation and Treatment for MAT Sample, No CBI Participation

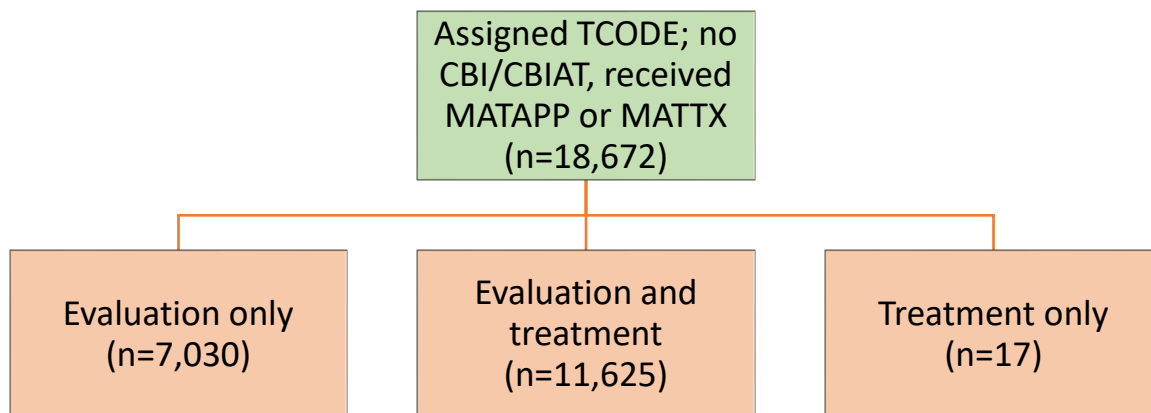


Figure 9 shows that out of 18,672 screened ISUDT participants who were not in CBI files, 7,030 patients were referred to MAT, while 11,625 patients were referred and treated for MAT, and 17 patients were in the MAT treatment file only.

Figure 10. Completed Evaluation and Treatment for MAT Sample, No CBI Participation

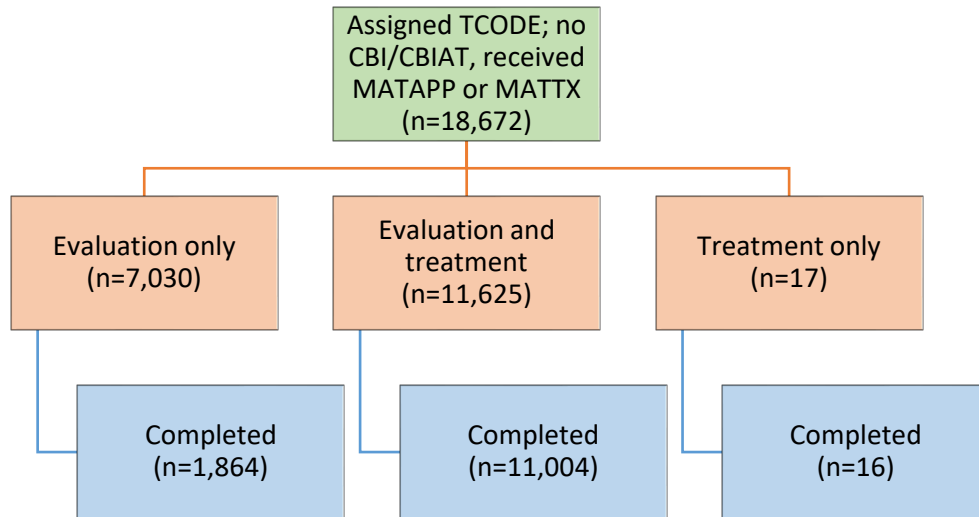


Figure 10 breaks down the sample further to show completed evaluations for those who were referred for MAT evaluation.⁴ As seen in Figure 10, 1,864 screened patients had a complete evaluation for MAT, while 11,004 patients completed both MAT evaluation and treatment, and 16 patients were treated for MAT only, without an evaluation.

⁴ Evaluations were considered completed for the following codes for "Order Status": Consult to Addiction Medicine Central Team 45; Consult to Addiction Medicine Central Team 60; Consult to Addiction Medicine Champion 45; Consult to Addiction Services Champion; and Consult to Addiction Services Provider.

Figure 11. Evaluation and Treatment for High-Risk MAT Sample, No CBI Participation

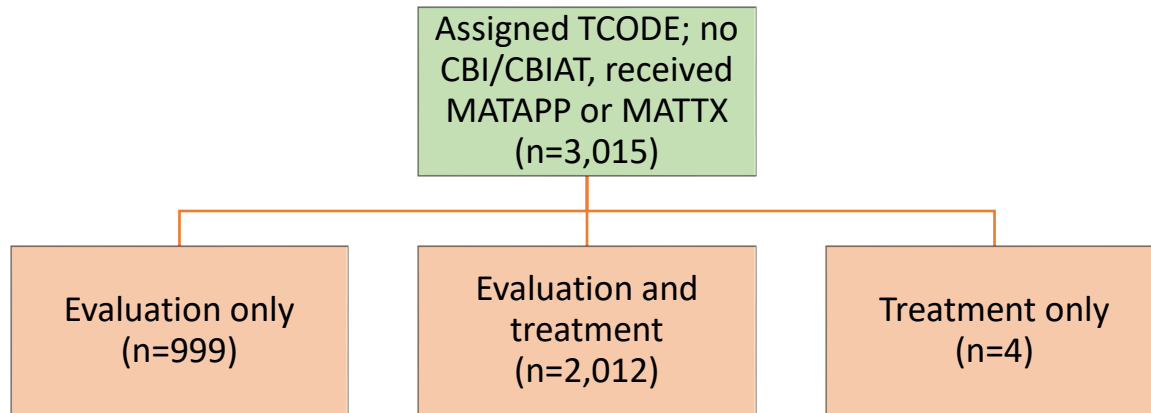


Figure 11 shows the same analysis for High-Risk patients. Out of 3,015 screened ISUDT High-Risk participants, 999 patients were referred for MAT. An additional 2,012 patients were both evaluated and treated for MAT, and 4 patients received MAT treatment only.

Figure 12. Completed Evaluation and Treatment for High-Risk MAT Sample, No CBI Participation

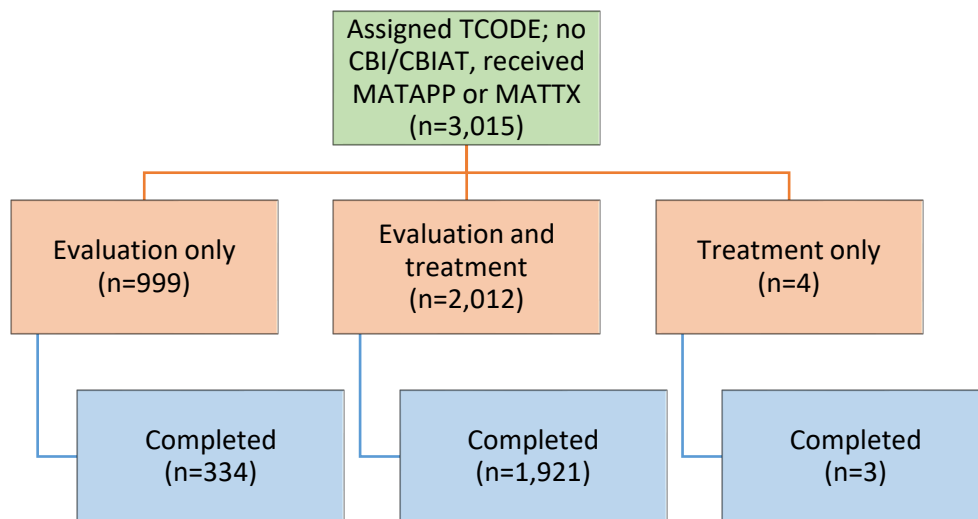


Figure 12 displays completed evaluations for those who were referred for evaluation.⁵

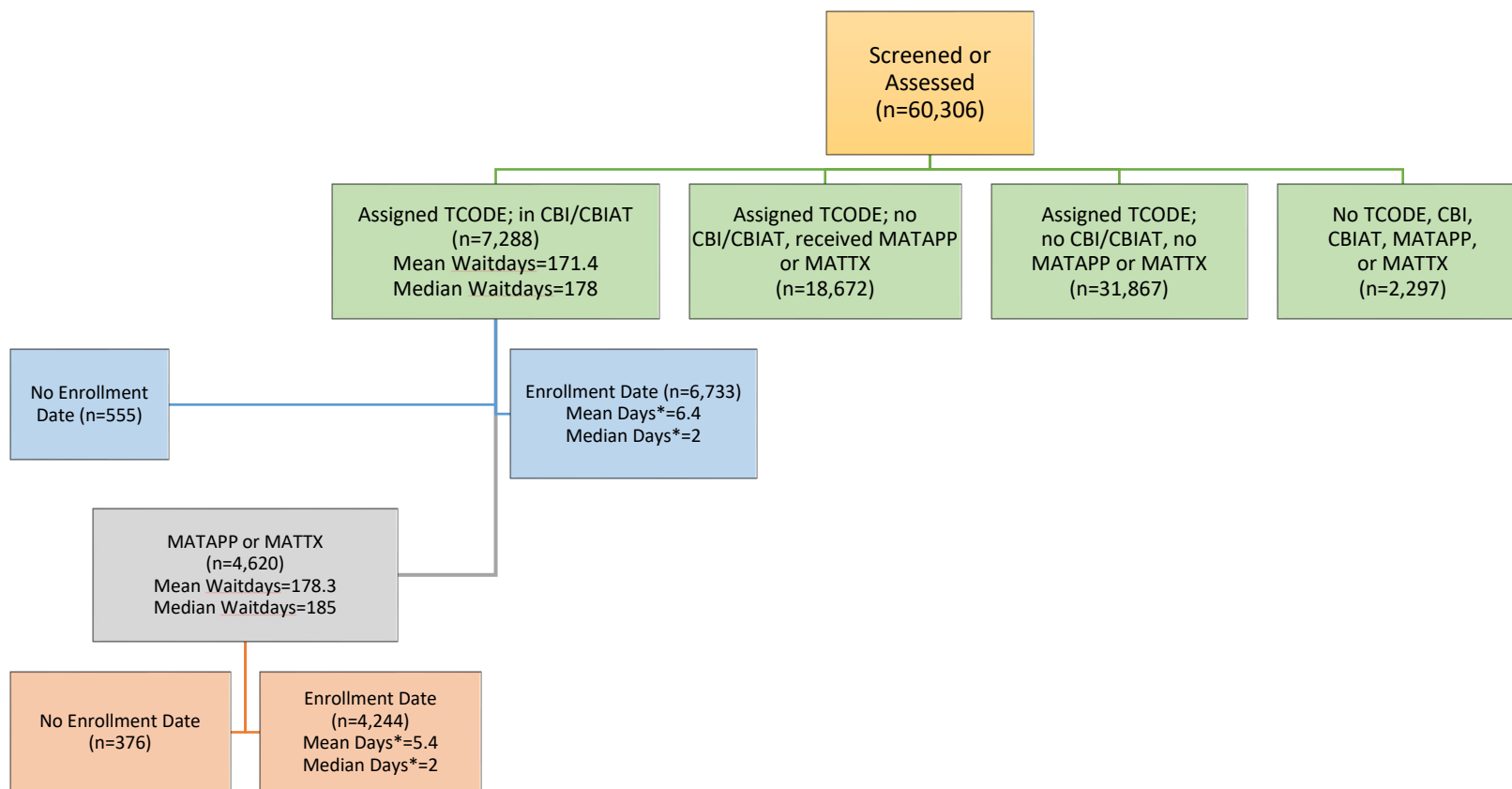
⁵ Evaluations were considered completed for the following codes for “Order Status”: Consult to Addiction Medicine Central Team 45; Consult to Addiction Medicine Central Team 60; Consult to Addiction Medicine Champion 45; Consult to Addiction Services Champion; and Consult to Addiction Services Provider.

As seen in Figure 12, 334 screened High-Risk patients had a complete evaluation for MAT, while 1,921 screened High-Risk patients completed both MAT evaluation and treatment, and 3 High-Risk patients were treated for MAT, without an evaluation.

CBI Programming

Figures 13 and 14 examine the flow of patients into CBI. Participants are assigned a TCODE for programming; however, during COVID-19, CBI programming was greatly affected, with no programming taking place for several months in early 2020. CBI programs were revamped from in-person to “packet” formats quickly to ensure that some level of programming could take place. However, analysis of the available data showed substantial wait times, on the order of six months between initial assignment and start program assignment date. In Figures 13 and 14, this time is displayed as “Waitdays.” Waitdays is defined as the number of days between first start date in the CBITCODE file and first program assignment start date in CBI file. Once an individual received a program start date, however, they were enrolled within about a week. “Mean Days” represented the number of days from first program assignment date to first enrollment date in the CBI file.

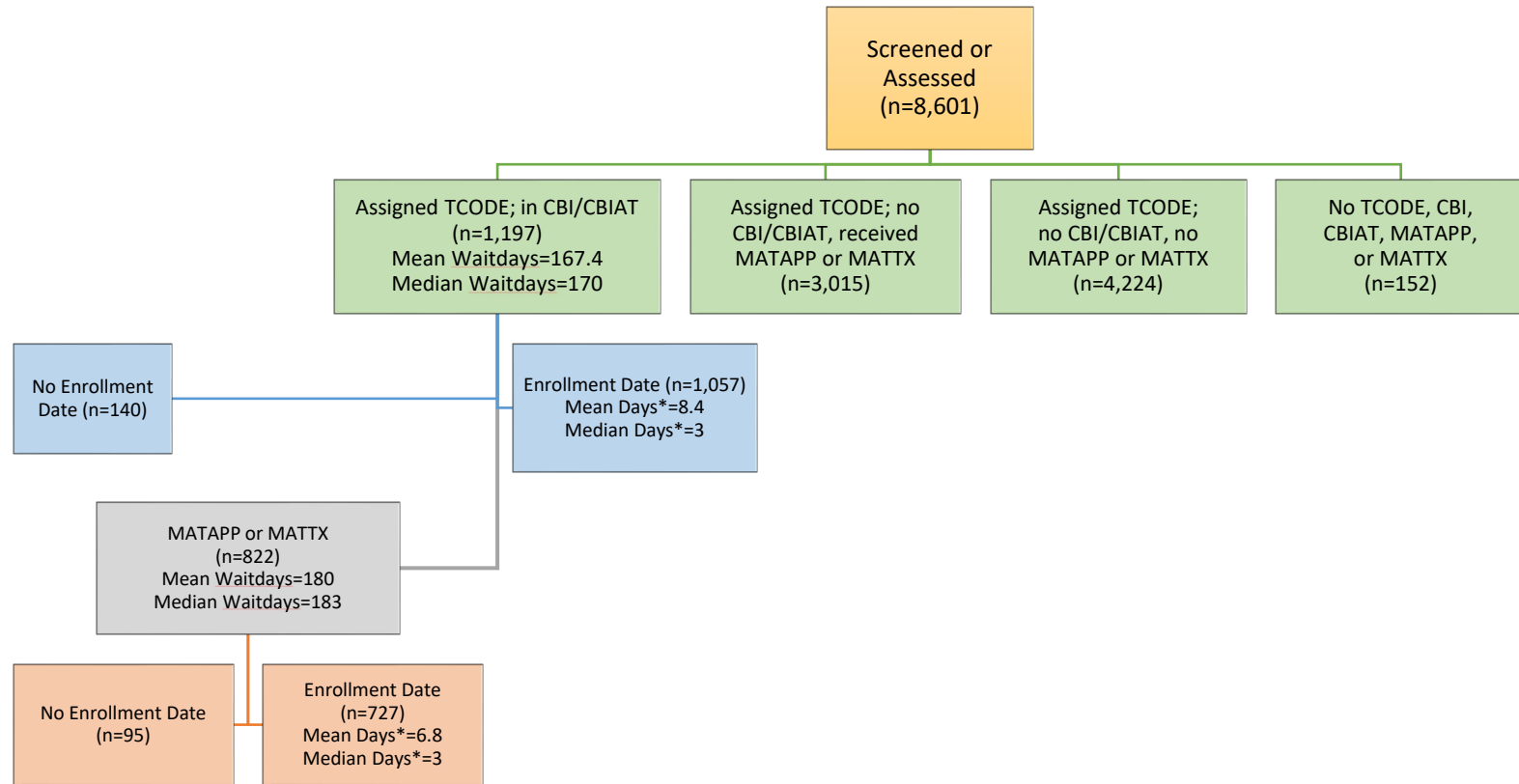
Figure 13. Wait Times for CBI for All Screened ISUDT Participants⁶



*=days between assignment and enrollment dates

⁶ Figures 13 and 14 do not include: 335 participants who had no match in the demographics file (these 335 individuals had either MATTX treatment or MATAPP evaluation and were in CDCR for less than 30 days); 71 individuals with no TCODE, who had either MATAPP or MATTX; 2 inmates with no TCODE, who are in CBI or CBIAT; and 1,701 individuals who had no ASAM, NIDA Quick Screen, or NIDA Modified Assist. Data with negative values for “Waitdays” and “Median Days” were dropped.

Figure 14. Wait Times for CBI for High-Risk Screened ISUDT Participants



*=days between assignment and enrollment dates

Our original plans for CBI analyses included whether individuals completed CBI successfully, whether participants completed all assigned components of the curriculum, and the length of time to complete the program. Our analyses on program completion used variables that captured a participant's program assignment status and program assignment status reason. Data entry appeared to be inconsistent with these two fields. For example, a number of cases were coded as completed while their assignment was "unassigned" or "reassigned." Over 20 percent of program status reasons were recorded as "other" and responses entered into a comment field. We did not have access to the comment field to examine what was entered; nor was analyses at this level planned as part of this evaluation. However, such a large percentage of "other" codes in data entry is problematic for accurate analyses of an individual's program status. Despite these difficulties, data available suggested that a small number of individuals completed CBI during the time frame of the data we were provided. Our estimate is that slightly over 300 individuals completed CBI. Almost 7,000 were enrolled in CBI during the study period; an additional 555 were assigned, but had not yet enrolled.

UCI was unable to conduct analyses on curriculum received by individuals because we were not provided with the data from the Automated Reentry Management System (ARMS) that could allow us to correctly interpret the attendance and curriculum data provided to us. According to CDCR, ARMS fields are being modified to remove "other" as an option to ensure curriculum-level data are entered and can be analyzed in the future.

CBI In-Person and Packet Programming

As COVID-19 began spreading rapidly, CBI programming had to be suspended. Class instruction was suspended on March 23, 2020 via a statewide memo. On September 25, 2020 a memo to introduce packet programming was sent out, with a drop-down option to enter "In-Person" or "Paper Packet," along with process and didactic groups. A second COVID-19 Mandate was issued on December 4, 2020 for a lockdown, suspending all programming including paper packets. By February 2021, in-class participation began to roll out statewide; however, the start and stop dates of program assignment were not consistently entered across institutions, groups, or even individuals. Although UCI was provided data on paper or packet programming, analyses proved problematic as data showed both packet and in-person programming during "program suspension" times, which may reflect incomplete data provided to us which did not allow us to parse the packet/in-person variable accurately.

Recommendations and Next Steps

Based on information from data provided, documentation, and interviews with ISUDT staff, we make the following suggestions:

- **Enhance data entry and cleaning efforts with source data for ISUDT analyses.**
As we noted in this chapter, we discovered instances in which data entry for variable fields appeared to be inconsistent, as well as the use of comment fields, allowing text data entry that would have to be manually recoded for analyses. Efforts to improve data entry and cleaning efforts may entail additional training of individuals who enter information into the various systems.
- **Ensure curriculum-level data for individual participants are entered daily to ensure progress through CBI can be appropriately tracked and credit-earning opportunities are not impacted.**

The practice of entering data weekly may lead to inaccuracies and makes it difficult to correct errors. Entering information for each individual daily may help increase data accuracy.

- **Ensure monitoring processes to assure data errors are identified early and corrected in a timely manner.**

Related to the first bullet, we recommend that systematic processes be incorporated to help assure accurate information by flagging potential errors. This may include creation of reports run by the Quality Management (QM) dashboard team, as this platform pulls from various CDCR/CCHCS databases.

- **Ensure all ISUDT participants have screening and assessment performed/documented.**

We identified over 1,700 individuals who appeared to be in ISUDT, but who did not have any one of the three screening/assessment tools entered into the data. An additional 2,000 individuals did not show a treatment assignment. These may reflect the fact that they were not assessed or data entry problems. We did not have the information to determine the cause.

- **Reduce wait times for CBI programming—either in-person or packet programming.**

Wait times may be reduced by shortening program length to accommodate more individuals. As we point out in Task 2, there is a large shortage of contracted staff in DRP who deliver CBI—with approximately 450 of the 726 Alcohol and Other Drug (AOD) counselor positions filled.

- **Conduct more complete pipeline analyses of CBI to document the numbers completing, time to completion, percentage who complete all programming, and status at completion (successful/unsuccessful).**

We were unable to document many of the CBI processes. This was due in part to data issues. However, during COVID-19, CBI was shut down twice during the study time period (January 2020 through March 2021). Thus, we were unable to examine CBI processes as a fully implemented ISUDT component. Once the CBI program delivery is stabilized, we recommend conducting analyses that were originally planned for the current process evaluation.

- **Conduct pipeline analysis of Transition Services once performance measures are incorporated into the QM dashboard.**

As we note in this task, we did not have data to analyze on the Community Transition component of ISUDT. We recommend that this be completed once data on transitions are integrated into the QM dashboard.

Task 2: Document Hiring and Training

Overview

The Fiscal Year (FY) 2019-20 ISUDT BCP outlined a recruitment and hiring plan as well as training goals for clinical and contracted behavioral program staff across a variety of classifications, including AOD counselors funded through DRP contracts, and nursing, medical, and custody staff. The BCP planned for health care staff to complete motivational interviewing training, training on the ASAM assessments, X-waiver training, and a University of California (UC) addiction medicine training course. AOD counselors were to be trained on CBI curricula. Task 2 documents the hiring and training for ISUDT from inception through spring 2021.

Methods

For this task, a semi-structured interview protocol was developed for group interviews related to the hiring and training of ISUDT staff. Separate interviews were held with staff responsible for hiring and training. When individuals were not available for interviews, staff provided UCI with written documentation on hiring and training for ISUDT. In addition, we received the monthly hiring and training plan reports. A copy of the interview protocol is contained in the Appendix.

Key Findings

Despite COVID-19–related impacts, CDCR/CCHCS overall had great success in recruiting and hiring positions funded under ISUDT and met or exceeded ISUDT training goals identified in the BCP. A large part of the training accomplishment was due to successfully leveraging virtual and hybrid modes of training to replace originally planned in-person training.

ISUDT Hiring

The ISUDT BCP outlined hiring goals of 99 medical staff, 201 nursing staff, 126 correctional officers, and 5 positions in DRP in FY 2019-20 and 2020-21. As of October 12, 2021, the vast majority of positions had been filled. According to the ISUDT Position Tracking Dashboard, 87% of the overall positions had been filled, and 89% of the CCHCS positions had been filled.⁷ Some of the positions were filled completely; others remain vacant due to the nature of the position and geographical locations. For example, positions for administrative support and telemedicine were much easier to fill and filled in accordance with stated timelines. With clinical positions, health care providers, and LCSWs, hiring dates were impacted due to national shortages in general for LCSWs and AOD counselors, which are exacerbated by COVID-19. Positions in urban areas were more likely to be hired on schedule than in rural locations. Positions in regional offices were easier to fill than those in the institution.

The advertising and hiring process for ISUDT health care positions used existing hiring practices within the Department. However, interviews were held remotely due to COVID-19, due in part to candidates not wanting to conduct in-person interviews. A result of remote interviewing was that the pipeline for hiring opened up with a larger and wider pool of candidates. To date, retention does not seem to be an issue. Correctional Officers (COs) were drawn from existing workforce through a post and bid process. As of early October 2021, Division of Adult Institutions (DAI) gained approval to establish 80 of the 126 CO positions funded under ISUDT. According to DAI, this process would take three to four months;

⁷ The dashboard lists 393 overall positions and 282 CCHCS positions.

however, the Department currently fills these posts through redirection and/or overtime. As included in the BCP, 5 staff were hired by DRP for ISUDT and all remained filled.

The CBI component of the ISUDT Program is delivered under DRP contracts whereby staff are hired through a competitive request for bid process to serve as AOD counselors. Funding for these contracts were included in the BCP. AOD counselors who deliver the CBI component are contracted from the outside via three organizations, as there is no civil service job classification for these individuals. Currently, there is a large shortage of contracted staff in DRP—with approximately 450 of the 726 AOD counselor positions filled. About 30 new contracted staff are being hired per month to make up the deficit that resulted from COVID-19.

ISUDT Training

ISUDT training involved a number of types of training for different ISUDT classifications. The BCP outlines in detail the trainings and the number of individuals for which it is to be delivered. Overall, training was successful in reaching and exceeding training goals, although modifications had to be made in the format (i.e., in-person to online) because of COVID-19.

Motivational interviewing was to be delivered to approximately 500 medical and nursing staff statewide. This training was done pre-COVID-19 in a centralized mode in Elk Grove, requiring long travel for some participants. Training was done by the University of California, Los Angeles (UCLA), which was able to deliver the training through a funding source outside of the initially planned ISUDT funding.

X-waiver training was required for the entire CCHCS provider workforce (400 providers). The ASAM online buprenorphine course provides the required 8 hours needed to obtain the waiver to prescribe buprenorphine in office-based treatment of OUD. The X-waiver training for ISUDT was a hybrid of online and in-person modules. By July 2020, 90% of the workforce had been trained; approximately 40 completed the course in a self-paced format because they had missed the hybrid format.

CDCR/CCHCS contracted with Focused Electronic-Health Innovation (FEI) Systems (the developers of the computerized algorithm behind the ASAM assessment) for ASAM training. A two-day training was offered regionally to over 200 ISUDT staff, including LCSWs, which contained an overview of how to conduct ASAM assessments and clinically interpret results. The program was delivered to about 250 staff; however, the target group for training was different from that initially conceived. AOD counselors were not included due to recommendations by ASAM that only those who conduct or use the actual assessment be trained. Earlier training sessions (about half) were conducted in person. The second half of trainings were delivered virtually due to COVID-19. Both versions were two-day training.

The BCP planned for an Addiction Services Orientation, designed to provide a program overview and train staff on workflows, assessment, referral and care coordination, and reentry processes. This training has been delivered to approximately 250 individuals to date. Originally conceived as an in-person training, the orientation was revamped as part of the Department's onboarding process on its Learning Management System (LMS). The one-hour session provides an overview of the new ISUDT model, SUD as a brain disease, MAT, and the neuroscience of addiction. Custodial staff receive the one-hour orientation as part of the Academy.

CBI curriculum training was to be delivered as a train-the-trainer model to approximately 200 ISUDT clinical staff and approximately 150 DRP-contracted AOD supervising counselors. These training targets were exceeded. UCLA delivered the Helping Men Help Women program and covered the Texas Christian University (TCU) curriculum as outlined in the BCP. In addition, the training was expanded to include a training on transgender individuals and separate versions for Helping Men and Helping Women Recover. The 14 institutions with women and nonbinary individuals received both versions. Because of COVID-19, the training had to move from in person to online.

The Parenting Inside Out curriculum delivered by Pathfinder was originally designed to be in person. The contract was not fully executed until June 2020, necessitating an online version due to COVID-19 impacts.

Thinking for a Change (T4C) was to be delivered to approximately 356 staff. The targets were met for the AOD counselors, but health care staff were not part of this effort because it was determined the training was not needed for their work. Due to COVID-19 and the federal government shutdowns, the National Institute of Corrections (NIC) model was not delivered by NIC staff, but with a contract with Evidence-Based Systems. Facilitator training with contract staff was done in spring 2020, with an additional group trained in early 2021. A train-the-trainer training was also delivered. Approximately 185 completed the facilitator training and 88 of those completed the train-the-trainer model. Because of the labor-intensive components of the training, it took about three weeks to do the train-the-trainer model, rather than the one week in person. Some participants did not complete the training due to COVID-19 stress at the time; however, the standardization required for the online format raised the bar for participant competency.

The plan for onsite Town Hall Meetings was that, in partnership with DRP and custody, all institutions would be introduced to the ISUDT Program and given an opportunity to answer questions. Due to COVID-19, the Town Halls were placed on hold and are expected to resume in 2022. The ISUDT Program has worked on outreach efforts that include an ISUDT Ambassadors Program with activities that include hosting a one-on-one meeting with each institution's Ambassador Team and ISUDT headquarters since June 2021.

Recommendations and Next Steps

Based on information from documentation and interviews with ISUDT staff responsible for hiring and staff training, we make the following suggestions:

- **Determine if positions can remain remote as workforce might be more varied/qualified.**
Remote positions may help address some of the challenges in hiring in rural locations as well as other difficult-to-fill positions, although we recognize that certain positions have been historically more difficult to fill than others (e.g., institutional and more senior clinical positions). Anecdotally, experience with hiring virtually provided a more geographically diverse candidate pool and was a more efficient process, which may ultimately assist in building the workforce. Administrative and telehealth positions were conducted remotely and may have more potential to remain remote.
- **Determine how to hire for hard-to-fill positions, although we recognize this is a longstanding issue that existed before ISUDT and COVID-19.**

As indicated above, some positions are harder to fill than others. CCHCS had established networks, advertising in major organizations, media campaigns, and external marketing programs they use for open positions, which were used for ISUDT staffing. Leadership positions were highly competitive and could be filled in-house for ISUDT, whereas many of the clinical hires did not have correctional experience, a qualification that is highly desired for positions in ISUDT. AOD counselor numbers remain substantially fewer than desired (although targets were not set in the BCP). Efforts should continue to be made to fill these positions.

- **Determine how to deliver ongoing Motivational Interviewing (MI) training and support.**
MI training for ISUDT was delivered pre-COVID-19 in a centralized location. Given the success of other components of ISUDT in providing virtual and hybrid training, ongoing MI training and support may be delivered virtually or in hybrid formats.
- **Continue to incorporate training in onboarding process.**
One of the adaptations made during COVID-19 was to incorporate components of training when new staff were hired during the onboarding process. This approach to the Addiction Services Orientation proved successful and might be used as a model for other staff training components.
- **Find an easier way for contracted staff to access materials on LMS.**
Training materials were incorporated on the LMS that CDCR uses. Gaining access to materials through this system proved difficult for contracted staff, because they did not have the same access rights as CDCR employees. Future efforts should focus on making access easier for contracted staff to access training and other materials relevant to their work positions.
- **Fine-tune who requires training—some staff may not need certain types of training (e.g., nursing staff do not deliver CBI).**
The rollout of ISUDT provided valuable experience in terms of which ISUDT positions required which trainings in order to perform job duties. Although the ISUDT model relies on interdependent teams, not all roles need the same level of training.
- **Revisit refresher courses for CBI—not necessarily full training periodically.**
Refresher courses are a common approach to making sure that workforce members keep current on training and policies of organizations. Given the changing nature of CBI under the ISUDT model, in particular, refresher courses may be needed.

Task 3: Document Supportive Housing

Overview

ISUDT is designed to develop recovery communities, which has been shown to be effective for those with severe SUD, within each institution. One of the ISUDT Program goals is that each of CDCR's institutions provides Supportive Housing unit(s). The process to provide Supportive Housing units included a space survey and identification of ISUDT/CBI space for treatment slots, as well as processes for consolidating/clustering individuals into Supportive Housing to treat and house 250 individuals by March 2020 and 500 by December 2020.

Although Supportive Housing was identified in the initial ISUDT BCP, it was not discussed in detail, in the same way other program components were. Supportive Housing was recognized as important to support programming; however, CDCR/CCHCS leadership felt that it was important for the MAT and CBI components to roll out first, given the high risk of overdose among CDCR/CCHCS' population, while the Department worked to finalize the housing component.

Task 3 was designed to document the Supportive Housing portion of the ISUDT model. However, given that this component is the least developed to date, our analysis is limited.

Methods

This task relied primarily on an interview with ISUDT staff knowledgeable about this component of the ISUDT Program, as well as documents provided that described possible models for integrating Supportive Housing. The Appendix contains the interview questions.

Key Findings

Although beds for Supportive Housing were identified at each institution pre-COVID-19, initiation was impacted by COVID-19, and CDCR/CCHCS will need to move forward with Supportive Housing once safe and feasible.

Identification of Supportive Housing Beds

A survey was conducted pre-COVID-19 at each institution to identify 250 beds for Supportive Housing. Survey results included each institution's determination of whether its beds could be considered for Supportive Housing or not. Although beds were identified at each institution, initiation was halted, however, with the onset of COVID-19. Individuals could no longer be moved or transferred around the institutions due to concerns about the spread of the virus.

Supportive Housing Status

There are many considerations in developing Supportive Housing for ISUDT. Effective models, with co-located housing and programming space, will be challenging in CDCR. Current physical space is not conducive to a true therapeutic community, which is the foundation for Supportive Housing, and space is at a premium, especially for programming. At this point, efforts need to be focused on re-identifying space. This will require working with stakeholders to see which housing arrangements are reasonable. The Department may want to initiate Supportive Housing on a smaller scale, with some institutions, to get started. With successes on a small scale, this will help to gain incremental buy-in. ISUDT will need to balance a modified therapeutic community with current space limitations.

Reviews of Supportive Housing prepared by CCHCS staff note the positive effects of Supportive Housing on reducing substance use and recidivism.⁸ ISUDT is considering several different options for Supportive Housing, including a model with separate housing units for ISUDT participants with relatively small numbers of individuals (approximately 70) to comport with national standards; Supportive Housing for a broader set of the Department's population engaged in rehabilitation and recovery programs who volunteer to be housed together; and ISUDT participants co-located with non-ISUDT participants to ensure housing units are filled. At present, discussions are focused on the second option (rehabilitation and recovery housing for ISUDT participants plus those involved in other rehabilitative programs and services). ISUDT Program leadership are hopeful they can initiate Supportive Housing in summer 2022, contingent upon COVID-19 restrictions.

Recommendations and Next Steps

Based on information from documentation (including the space survey) and interviews with ISUDT staff, UCI makes the following recommendations:

- **Keep Supportive Housing as a priority for ISUDT per best practices for effective program models, including working to house together those involved in rehabilitation and recovery programming.** As noted in this chapter, the housing component of the ISUDT model was to be finalized after MAT and CBI programming were established. The housing component should remain a priority, given that best practices show its importance for rehabilitation programming.

- **Clarify importance of Supportive Housing with clinical, DRP, and custody staff, including department-wide messaging and cross-divisional training for staff working within Supportive Housing.**

As the ISUDT model contains many interdependent components, it will be important to inform and train staff from different areas on how a newly implemented Supportive Housing component will operate. This is particularly important for custody staff, as they are major stakeholders in making sure housing units function smoothly and safely.

- **Work with stakeholders to develop best options for Supportive Housing, including providing programming on housing units when possible.**

Currently, the department is considering three different models for Supportive Housing for ISUDT. Consideration of models will require working with stakeholders to determine which option is optimal.

- **Conduct focus groups with ISUDT and OMCP participants (expansion of OMCP is identified in the ISUDT model) and others involved in rehabilitative programming to gain insight into support and interest in Supportive Housing, barriers, and benefits.**

As part of the BCP, the OMCP program was expanded in order to increase the numbers of individuals who can support the delivery of SUD services in the ISUDT. How these individuals fit into the Supportive Housing component is yet to be determined. Focus groups are a way to engage the OMCP mentors in the development of this component to gauge their interest and insights into OMCP involvement in Supportive Housing units.

- **Re-survey institutions to determine how many beds are available and start small (build capacity over time).**

⁸ Allen, Denise. (2021). ISUDT Supportive Housing Options: Implementation Considerations & Next Steps. Internal CCHCS memo.

Findings from the original survey are now out-of-date and reflect pre–COVID-19 housing. In order to determine possible housing locations, a new survey should be fielded. However, given the complexities that surround housing, it may be best to pilot Supportive Housing in one or two locations. In this way, challenges can be identified and addressed before full-scale implementation in all institutions.

- **Determine if individual placement in Supportive Housing can occur early on in a participant’s incarceration period.**

As part of the development of the Supportive Housing component of ISUDT, stakeholders will need to determine when an individual should be placed in Supportive Housing. Placement may be dependent upon the path by which the individual enters ISUDT. For those who are on MAT at reception center, it may be easier to identify and place them in Supportive Housing early on in their sentence. Given that the ISUDT model targets a large group 15-24 months before release, it may be difficult to identify and place them in Supportive Housing early in their incarceration period.

- **Ensure linkage to community aftercare, and recovery and rehabilitative services for those releasing from Supportive Housing.**

Pre-release planning and post-release components are important components of the ISUDT model. As the Supportive Housing component is developed, it will be important to make sure those leaving Supportive Housing and returning to the community have linkages to these other services.

- **Engage with an independent third-party evaluator to reexamine Supportive Housing once it is initiated and to assess outcomes.**

Given that the Supportive Housing component was not in place during the time of the current project, it will be important to assess its implementation, as well as assure this component is part of a future outcome evaluation. The QM proposed measures for program monitoring and improvement contain a measure for Supportive Housing, extracted from the Strategic Offender Management System (SOMS) data source. This information should prove helpful for assessing implementation success of the Supportive Housing component in ISUDT.

- **Designate a Supportive Housing project coordinator/manager under the ISUDT Program to work across divisions to support initiation, resolve cross-divisional barriers, set goals, and coordinate evaluation efforts.**

Given the complexities of integrating Supportive Housing, we would suggest designating a point person who can liaison with the different stakeholders and lead the Supportive Housing effort.

Task 4: Document Transition Process

Overview

The ISUDT model not only provides services and programming while in prison, but it is also designed to prepare individuals for release into the community and to ensure medical and other program services are received after release. ISUDT Community Transition uses a WPC approach, which recognizes that multiple services—including medical, mental health, employment, and social services—should be provided in a coordinated manner. The Division of Nursing Services (DNS) within CCHCS is responsible for providing care coordination from the time an individual enters a CDCR reception center, through incarceration to release.

Task 4 was designed to document the ISUDT Community Transition Process, which begins while an individual is nearing the end of their term and continues as they transition into the community.

Methods

This task relied primarily on an interview with ISUDT staff knowledgeable about the transition component of ISUDT. The Appendix contains the interview questions.

Key Findings

Programs and services within the institution are developed; challenges exist with assuring a “warm handoff” with counties and with obtaining information about the extent of aftercare services. The new California Advancing and Innovating Medi-Cal (CalAIM) program should help address some of these challenges.

Community Transition Activities

Within the last 15-18 months of incarceration, individuals in ISUDT receive 5 weeks of Transition Reentry Services (TRS) provided by the DRP. This is considered the first phase of ISUDT Community Transition. TRS was in place before ISUDT and includes modules focused on workforce readiness, employability, and financial literacy. Before release from prison, individuals apply for Medi-Cal, Social Security benefits, CalFresh, and identification cards from the Department of Motor Vehicles (DMV).

Under ISUDT Enhanced Pre-Release and Transition Services, at about 210 days before release, the ISUDT Nursing Resource Team reviews medical charts for everyone who is leaving the institution. Enhanced pre-release is provided for individuals who are High and Moderate medical risk and/or on MAT. These individuals receive a medical needs assessment. For those individuals, the Nursing Transition Resource Teams conduct Pre-Release Weekly Huddles with Parole Service Associates, Transitional Case Management Program Benefit Workers, Mental Health Pre-Release Coordinators, and other partners as needed, to identify housing gaps and other needs. Nursing and Mental Health staff will reach out to the community where the individual is releasing to make sure that MAT and medical/mental health care continue. The staff meet with individuals between 7 and 21 days before release to discuss the discharge plan and conduct any last-minute follow-up. Upon release, individuals receive medication, discharge resources (a catalog for medical and MAT services), two doses of Narcan, and the name of the provider and date of their first appointment in the community. Individuals are provided with a printout of their plans.

Community Transition Status

According to data provided to UCI, 5,116 MAT patients were released between January 20, 2020 and December 31, 2021; 3,868 (76%) were provided MAT on the same day as release. Twenty-four hundred (47% of MAT patients released) had an external appointment established before release. COVID-19 and other accelerated releases impacted the Department's ability to provide Community Transition services. A QM COVID-19 tracker was created to capture who is releasing to manage expedited releases and linkage to care, with linkage to care data now reflecting that 84% of MAT patients have an external appointment established before release.

Other challenges exist with establishing relationships with counties for data sharing. Data sharing agreements need to be completed for each county separately. Currently, CDCR patients sign a release of information to the county, so community providers can see CDCR information. However, without county agreements, it is difficult for CDCR to determine whether ISUDT participants have, at a minimum, made it to their first appointment in the community. The QM team is working on a longer-term solution to getting information from the counties. About 14 data sharing agreements have been developed to date.

Benefits upon release have been a challenge for participants in ISUDT. Each county is different and benefits may not be approved in a particular county. This challenge is expected to ease when the Department of Health Care Services' (DHCS) statewide program, CalAIM, comes online in early 2022. This program will use a WPC approach to leverage Medicaid to vulnerable populations (including justice involved) to help provide health and social services to individuals. CalAIM is intended to reduce health care disparities and improve outcomes. CDCR/CCHCS have a particular interest in the Enhanced Care Management that will be provided to the highest-need Medi-Cal enrollees under CalAIM, which will include many of those releasing from state prison. In addition, DHCS has put forth requested waiver changes for federal review including a request for Medi-Cal benefit eligibility and activation prior to release from prison. If approved, this will further strengthen transitions of care, and help to reduce challenges in post-release linkage to care that occur due to delays in post-release Medi-Cal activation. Single points of contact for Community Transition have been established with four counties: Butte, Kern, Riverside, and Sacramento.

Recommendations and Next Steps

Based on information from documentation and interviews with ISUDT staff, we make the following suggestions:

- **Engage all relevant parties, including Division of Adult Parole Operations (DAPO) and DRP, as well as counties, DHCS, and the Council on Criminal Justice and Behavioral Health (CCJBH) in Community Transition future development as well as in recommendations below.**

The reentry component requires coordination not only with CDCR/CCHCS divisions, but also with agencies and stakeholders on the "outside"—in local corrections, health care services, and other social services. For this reason, it is important to continue to engage these agencies in the continued development of the Community Transition process.

- **Continue to work with counties to create data sharing agreements for information on key measures of outcomes for ISUDT community success.**

Data sharing is often difficult, given data privacy as well as security concerns. However, key outcomes proposed by the QM team require information that can only be obtained from agencies and stakeholders when the individual has returned to the community. To date, a number of data sharing agreements have been completed, but they take time and effort to complete.

- **Work within CDCR to help identify individuals who are releasing before the ISUDT staff can complete the transition programming and services.**

During COVID-19, some individuals received expedited release, which cut short their transition programming. Resentencing also creates short turnarounds for programming to be delivered. As indicated earlier, the QM team is developing a tracker that is designed to make sure that individuals do not release without ISUDT services.

- **Coordinate “warm handoff” for eligible participants with counties when CalAIM is implemented.**

CalAIM represents a transformation of the Medi-Cal delivery system to prioritize prevention and WPC approaches in the identification and management of individual needs. The program aligns the elements of Medi-Cal into a simplified and standardized system. Justice-involved adults and youth are one of the high-priority groups for the initiative, given that a large percentage (estimated at 80% by DHCS) are eligible for the program. Close alliance with this program should assist both in the warm handoff for services, but could potentially assist and streamline gathering ISUDT outcome information.

- **Integrate the proposed Post-Release Transition and Program Outcomes: Post-Release into the QM dashboard.**

The QM dashboard does not currently include proposed measures for release to the community that are needed to determine the longer-term success of ISUDT.

- **Continue to utilize the ISUDT Project Management Team to coordinate cross-divisional and cross-agency work related to transition services.**

As components of pre-release and Community Transition continue to be honed, it is important to keep management teams engaged in coordinating activities within CDCR/CCHCS as well as outside agencies to assure its success.

Task 5: Data Management Utility

Overview

The ISUDT model is supported by a QM dashboard that was developed and built, and is being maintained, within CCHCS. The dashboard extracts data from existing databases in the CDCR and CCHCS data warehouses and is updated between two and four times a day. The dashboard is used to directly monitor patient care as well as to manage workflows for both clinical as well as CBI programming as a “one-stop” interface, rather than users needing to access different databases in CDCR/CCHCS. Individual users can create their own queries and reports, customized to information they need. The dashboard has a public-facing version that can be used by external agencies and individuals to view aggregate case flow and outcomes. The public-facing version does not contain individual-level information on participants.

Methods

This task relied primarily on interviews with ISUDT staff knowledgeable about the QM and outcomes components of ISUDT. These included individuals who worked with the medical and operational data, as well as QM staff. We were also provided with screenshots of the dashboard and reviewed the publicly available dashboard at: <https://cchcs.ca.gov/isudt/dashboard/>. The Appendix contains the interview questions.

Key Findings

A QM dashboard has been designed, developed, and maintained for ISUDT, which brings together clinical and management information in a “one-stop” dashboard. Key metrics for MAT have been developed, with CBI in development. An extensive set of additional outcome measures is being developed by the QM team for future implementation.

Dashboard Use for Clinical and Management Purposes

Medical and Treatment Information

Clinicians are able to review data relevant to the medical and treatment needs of their patients; they can see backlogs and appointments that are due and have action tabs that remind care providers of what is required. The dashboard allows drill downs from a department-wide view to views at each institutional level to identify areas of concern and performance improvement. Management and executives use the tool for data-driven management and policy decisions in real time. The dashboard represents an evolution in culture of using data for performance with the ultimate goal of effective patient care. Although CDCR/CCHCS have dashboards in other areas, the ISUDT dashboard is unique in that it hosts protected health information for individuals (available to clinical staff only) and has separate views for non-clinical staff, as well as management information on services provided.

Outcome Measures

In the planning of the ISUDT model, proposed performance measures were compiled by the QM Section in four major areas: Program Access Measures (13), Substance Abuse Measures (17), Release to Community Measures (19), and measures of the population outcomes and other trends (24). Program Access Measures include screening and assessment, referral and enrollment rates, and timely visits with medical staff and providers. Substance Abuse Measures include active MAT enrollment; medication

continuity for new patients, and ongoing treatment and upon transfer; MAT lab monitoring; access to addiction specialists; and CBI enrollment, initial visit, dosage, fidelity, continuity, and completion. Release to Community Measures include Medi-Cal application and enrollment; Social Security enrollment; DMV ID; CalFresh enrollment; stable housing enrollment; job placement or interview; whether MAT or naloxone is provided; MAT within 14 days of release; Medi-Cal plan, DMV, CalFresh, stable housing, community primary care provider visit, Substance Use Disorder Treatment (SUDT), and employment within 30 days. Population outcomes and other trends include SUD-related outcomes in prison as well as post-release program outcomes of arrest within 90 days, any new conviction within three years, return to CDCR within three years, and overdose and all deaths within one year.⁹

The information for these measures was designed to be extracted from CDCR/CCHCS databases such as the Electronic Health Record System (EHRS), SOMS, ARMS, and Parole Violation Disposition Tracking System (PVDTS), as well as external systems such as the California Department of Justice (CA DOJ; for recidivism measures) and the California Department of Public Health (CDPH; for deaths overall and due to overdose).

QM and Program Metrics Status

The dashboard is established and process improvements are being made as the ISUDT model matures. Currently, performance metrics for MAT include the number screened for SUDs, assessed for SUDT needs, and evaluated for MAT. It also contains the number of individuals who have received MAT, SUDT, and CBI. Goals for these measures are provided and internal CDCR/CCHCS users are able to see how well institutions and CDCR/CCHCS are meeting the goals in these areas, with the percentage of individuals for whom the goals were met by month (this is not available on the public-facing view). The dashboard also currently lists hospitalizations due to overdoses.

The dashboard allows users to see the numbers of individuals who are on waitlists for assessment and treatment for those individuals releasing within 15 to 24 months to prioritize workload. In collaboration with Medical Services, the dashboard team developed a MAT alert page with information on expiring medications, new institutional arrivals, and movement alerts, as well as whether MAT follow-up evaluation, diagnostic, and toxicology tests are needed.

Dashboard efforts on CBI performance metrics are under development. Currently, the number of individuals enrolled and who have attended a CBI class are on the dashboard. Efforts are underway to develop rules for CBI treatment priority, attendance, and curriculum completion. In addition, efforts are underway for pre-release measures. In the future, the community measures will be added. As the model matures, the performance measures developed during early 2020 may be updated based on ISUDT experience.

Ad hoc reports are routinely extracted from the dashboard to help with management decisions; standardized reporting is very early in development. A current focus is on the quality of the data in the system, with ongoing collaboration between the QM team and end users to assure that data appear

⁹ The complete list of proposed measures is contained in CCHCS Quality Management, Informatics and Improvement. (2020), CCHCS & CDCR Integrated Substance Use Disorder (ISUDT) Proposed Measures for Program Monitoring and Improvement. Internal Memo.

accurate, the QM team is apprised of any changes in forms used in the field, and users on the ground are trained on the dashboard for accurate data entry.

Recommendations and Next Steps

Based on information from documentation, analysis of data for the delivery of services, and interviews with ISUDT staff, we make the following suggestions:

- **Continue to work on incorporating performance measures in the dashboard and build out the dashboard for CBI and other outcomes, such as supportive housing, pre-release, post-release transition, and other population outcomes and trends.**
Although the QM team has proposed 73 outcomes in four major areas, a fraction of those proposed are currently hosted on the dashboard.
- **Attend to data quality issues with the ARMS database on CBI-related measurement and outcomes to improve dashboard reporting capacity.**
Our analyses revealed a number of inconsistencies related to source data for CBI outcomes. We were unable to determine the source of the inconsistencies in the short time frame of the current project; however, a combination of enhanced training and data quality checks may be helpful.
- **ISUDT Project Management Team should continue to coordinate collaborations between end users and the QM team to assure accurate data entry, and continuous process improvements are made that have department-wide implications.**
Programs and processes can change in any system—in ISUDT, changes can be made in forms and source data that are abstracted for the QM dashboard. It is important the changes on the ground are relayed to the QM team. QM can also assist end users by developing processes to check on quality and consistency of data from multiple sources in the department.
- **Consider creating standardized reports as ISUDT evolves to steady state.**
Our interviews with QM stakeholders revealed that the dashboard is a powerful tool to use for management purposes. At present, ad hoc reports are prepared for users. Standardized reports can help address questions and issues that are frequently raised.
- **Assure resources for QM activities, as maintaining the dashboard is a resource-intensive effort with changing demands as the ISUDT Program model evolves and matures.**
Conversations with key stakeholders mentioned that the QM dashboard requires a lot of staff time to maintain. Given the importance of this tool in both clinical and management activities, it is important to make sure resources are provided to ensure accuracy and to liaison with end users and data sources, as well as to build out planned outcome measures and prepare reports.
- **Consider adding a field to identify the source of ISUDT entrance—patients entering reception on MAT, those who are High Risk, and those with an expected release date within 15-24 months.**
Incorporation of the source of individuals in ISUDT will help assure that data can be examined and monitored by which of the three groups ISUDT is targeting.

Task 6: Determine Evaluability

Overview

The purpose of this task is to discuss the major outcome questions and outcomes that should be included in a future outcome evaluation. This task considered whether data are available to measure desired outcomes, recommendations for methods of analysis (cohorts to be examined), and types of analyses that would be most appropriate for outcome questions.

Key Findings

An outcome evaluation is needed to determine the impacts of the ISUDT Program on participants' outcomes while in prison and when participants return to the community. An outcome research design will need to incorporate a quasi-experimental design, using a third-party evaluator, working in conjunction with a CDCR/CCHCS coordinator.

Outcome Measures and Data Availability

Generally, outcome measures should capture the goals that a program is trying to accomplish. With ISUDT, there are multiple goals that the program is trying to impact—both within the institutions and after participants have left the institutions and rejoined their communities. The QM team has already created a number of proposed measures for program monitoring that reflect outcomes—both within the institutions and when participants leave—that appear to be appropriate outcomes. Proposed measures under “Post-Release Transition” include outcomes related to MAT, Medi-Cal enrollment, DMV ID acquisition, CalFresh, housing, visits with primary care providers, and placement in appropriate ASAM levels of care and employment—these reflect the emphasis of the program components of the ISUDT model. Within prison, measures include positive drug screens, naloxone administrations, rules violation reports, SUD-related community hospitalizations or emergency department encounters, and deaths. Post-release outcomes include SUD-related community hospitalizations or emergency department encounters, deaths, and linkage to care (Medi-Cal utilization), plus information about recidivism (arrests, convictions, and return to CDCR custody).

Although the QM team has proposed measures that seem appropriate as outcomes for the ISUDT model, the dashboard does not currently have these measures populated; however, the proposed source of the data for the measures has been delineated. Most are other data systems housed in the CDCR/CCHCS data warehouses. One exception is the CA DOJ criminal history records. ISUDT staff are currently in discussion with the Office of Research to establish mechanisms to extract this information. It is important that the dashboard data that is used for any outcome analyses be cleaned and validated. Our previous analyses of services data, particularly for CBI implementation, revealed data inconsistencies and use of text fields that make analyses difficult.

Economic Analysis

In addition to an outcome analysis, an econometric analysis is desired. This type of analysis will monetize estimated reductions in recidivism, health care (Medi-Cal) costs, court costs, direct costs of incarceration in jails and prison, community supervision costs, and less tangible societal costs such as avoided victimization. This type of analysis requires, at a basic level, a detailed accounting of the services received by each participant, the costs of each service, measurement of outcomes, and the costs associated with each outcome. The QM dashboard is gathering the detailed services for each program

participant; the BCP has detailed costs of different ISUDT components. Proposed outcome measurements should be able to indicate the number of arrests, and rates of encounters with SUD-related send-outs. The economic analyses for justice system outcomes will be able to leverage and update the methodology developed by CDCR as a participant in the Pew-MacArthur Results First Initiative for the calculations of program and criminal justice services and costs, including costs of victimizations. Costs and utilization of health care services in the community is a larger task and will require gathering details on usage of the wide range of health care services each individual participates in, as well as costs per unit of service. It is important to point out that outcomes requested for an economic analysis go far beyond those collected within the QM dashboard and will require additional data collection by the outcome study team as well as internal and external coordination.

Additional Data Considerations

Although one thinks primarily of outcome measures for an outcome evaluation, it is important that the outcome evaluation also consider the characteristics of the study population, as well as the services. Outcomes may be dependent upon background characteristics (e.g., risk of participants) as well as the delivery of different program services. For this reason, an outcome analysis will also require that complete measures of offender characteristics and services be included. Services data should be available from the QM dashboard when it is built out; key demographic data are available from SOMS.

Types of Possible Research Designs and Analyses

The most conclusive research design for program evaluation is a randomized experiment. With this research design, individuals who are eligible for a new program or model are randomly assigned to receive the new model (or treatment) or participate in what is known as “business as usual” (control condition). In this way, one can attribute any observed differences in outcomes to the program model and not to any preexisting differences between the groups of individuals who participate in the program or control services. This is not possible for the ISUDT outcome evaluation, which is a system-wide change to the way that SUD services are delivered in all institutions.¹⁰

For this reason, the outcome evaluation of ISUDT will need to incorporate a quasi-experimental design in which researchers try and establish treatment and control groups as comparable as possible. The treatment group would consist of ISUDT participants. We recommend that the outcome evaluation be conducted with a cohort of ISUDT participants who receive the full ISUDT model (possibly late fall 2022). The challenging part of the outcome evaluation will be the creation of the control group. The outcome evaluation will need to define the parameters of a group that looks as similar as possible to the ISUDT participants, but who did not receive the services. The researchers who conduct the outcome evaluation will need to determine, working with CDCR/CCHCS, which group might be the best. For example, if there were a number of eligible participants who were on waitlists and did not receive ISUDT services (through no fault of their own), this group might serve as a control. Propensity score matching analyses is appropriate to use with a quasi-experimental design to control for differences between the

¹⁰ At the time this evaluation was conducted, CDCR had 35 prisons. On September 30, 2021, Deuel Vocational Institution closed.

two groups. Outcome measures can be created that reflect categorical outcomes (e.g., arrest/no arrest), or that can be rates (deaths per 1,000) or numbers of individuals. Survival analyses can be used to determine whether events occur later for ISUDT participants (e.g., time to first arrest).

A regression-discontinuity design might be used to study those participants at the lower risk level who just “missed” placement into ISUDT. By comparing those who just missed the threshold for placement with those who had assessment scores that just made them eligible, one can determine whether participation in ISUDT is associated with more positive outcomes.

Recommendations and Next Steps

Based on information from documentation and interviews with ISUDT staff for all the process tasks conducted by UCI, we outline the following for a future outcome analysis:

- **Establish relationship with third-party evaluator to develop evaluation plan.**
The current evaluation was an implementation analysis. Once the ISUDT Program has incorporated planned components, it is important to determine what the impact of ISUDT has been on individual progress with SUD, recidivism, and successful return to the community. A third-party evaluator provides an independent assessment of the impact of ISUDT.
- **Develop logic model/workflows for ISUDT inputs, services, and intermediate and long-term outcomes in order to make sure outcomes align with program goals.**
As part of an outcome evaluation, it is important to document the logic model/workflows for the ISUDT Program components so that the evaluator and program stakeholders have a shared understanding of how the ISUDT components fit together and whether the short- and long-term outcomes identified are consistent with original program goals of ISUDT (e.g., reducing recidivism, and SUD-related morbidity and mortality). Developing the logic model will also assist the evaluator in determining which inputs and resources are expected to affect which outcomes. Structural equation modelling can measure whether expected inputs and resources predict short- and long-term outcome success.
- **Determine whether QM dashboard outcomes align with logic model outcomes.**
Once an agreed logic model/workflow is developed, it would be most efficient to leverage the QM dashboard to provide needed data. It is possible that QM program monitoring and improvement measures might be revised if the logic model metrics do not align with the dashboard. It may also be possible that logic model outcomes may need to be gathered from other source data, but this might be more time consuming and potentially less accurate than using dashboard data.
- **Define the costs and services for economic analysis with expert econometric team leveraging internal research expertise.**
Economic analyses are important to assess whether programs are, in a sense, “worth it.” Such analyses require detailed information on services and outcomes, both in terms of what was delivered, but also the costs. Generally, researchers with specialized backgrounds are needed to perform economic analyses. We recommend economists with research experience in the health and justice fields be part of the outside evaluation team for estimating costs associated with health care and social services once ISUDT participants return to the community. Fortunately, background work estimating criminal justice costs has already been done internally at CDCR that can be leveraged.

- **Determine when an outcome evaluation should begin—preferably once the full ISUDT model has been experienced by a cohort of participants—which may be the latter part of 2022.**
Outcome evaluations are best conducted when a program is fully operational in order to assess full model impact. The ISUDT model has key elements that are operational; however, CBI, housing, and community transition components are being developed and/or finalized. Discussions with ISUDT stakeholders suggest this may not happen for a number of months, perhaps towards the end of 2022.
- **Determine the most appropriate control group.**
One of the most difficult components of an evaluation design can be the selection of an appropriate control group. We generally understand how effective a program is by comparing it to another program or treatment. As we note above this will be a challenge for ISUDT. Evaluators might want to incorporate several control groups in an attempt to triangulate results. The critical aspect of selecting a control group is to assure, as best as possible, that the ISUDT and control group participants are as similar to each other as possible, with the only difference being participation in ISUDT. In this way, we can be confident that it is the program, and not systematic differences in the characteristics of the ISUDT and control groups that were responsible for observed differences in outcomes.
- **Identify CCHCS Research Coordinator/Project Manager to work with the external evaluator(s) chosen for the outcome evaluation.**
Given the complexities of the ISUDT Program model, data sources, and stakeholders, we recommend that a point person be identified within CCHCS to work with the external evaluator.

Conclusions

ISUDT received funding under a FY 2019-20 BCP, which provided funding for the first phase of a planned five-year rollout of the model across all CDCR institutions. The model is a fundamentally different approach in the way that SUD services were delivered to individuals in CDCR, with a comprehensive and integrated approach across multiple CDCR/CCHCS divisions in order to address SUDs and, in particular, OUDs.

This project was designed as a process evaluation of the ISUDT Program. Six different tasks were conducted to address one of the key goals of ISUDT—create a rehabilitative environment to improve safety for participants and staff.

Through interviews with ISUDT staff, analysis of program data, and review of documents, the process evaluation revealed the following:

- Hiring and training of staff for the model met (or exceeded) BCP expectations. Components of training and (to some extent) hiring were modified successfully to incorporate online formats.
- CDCR/CCHCS made tremendous progress in identifying those with SUD, with over 63,000 individuals screened or assessed from program inception in January 2020 through Spring 2021.
- The provision of MAT was substantially expanded under ISUDT, with MAT evaluation and assessment provided to over 20,000 individuals, and just under 16,000 individuals initiated on MAT during the process evaluation period.
- The CBI component was greatly affected by COVID-19, experiencing two major suspensions during the study time period. Packet programming was instituted to help address suspensions, but CBI experienced long delays, on the order of six months from initial classification for CBI until start in CBI. As a result, our estimate is that slightly under 7,400 individuals were served with CBI, but only 300 individuals completed CBI during the study period. Notably this was under the old 12-month model that is being shortened to a 9-month model in an effort to deliver services to more individuals.
- Supportive Housing is a recognized important part of the ISUDT model; however, program developers felt that it was important to focus early on MAT and CBI components due to risk of overdose with the population. ISUDT is currently examining several options for Supportive Housing.
- Transition Services utilize a WPC approach. Transition Services start in prison with TRS for individuals within 15-18 months of release. About 7 months before release, charts for every individual leaving a CDCR facility are reviewed by the ISUDT Nursing Resource Team to provide a medical needs assessment as well as outreach to the community to assure that MAT and medical/mental health care continue. CalAIM implementation should help with assuring a “warm handoff” to counties and collection of information on how participants fare once released. Data for the transition services are not yet available on the QM dashboard to examine the services received in this ISUDT component.

- The ISUDT model is supported by a QM dashboard that was developed and built, and is being maintained, within CCHCS. The dashboard extracts data from existing databases in the CDCR and CCHCS data warehouses and is updated between two and four times a day. The dashboard is used to directly monitor patient care as well as to manage workflows for both clinical as well as CBI programming as a “one-stop” interface, rather than users needing to access different databases in CDCR/CCHCS. Currently, the database contains metrics and information on MAT and preliminary CBI outcomes. The status of the dashboard is evolving as the ISUDT model matures.
- A future outcome evaluation for the ISUDT model is planned to understand the impact of ISUDT on in-prison as well as community outcomes. Several considerations need to be taken into account for the design and conduct of such a study, including an appropriate comparison group, outcomes, measurement of components for an economic analysis, and best research design. It is recommended that the outcome evaluation be conducted when a cohort of individuals has experienced the full ISUDT model, which may be well into the fall of 2022.

In each chapter of the report, we provided more specific recommendations and next steps for each of the process evaluation tasks. In general, we see the following as key areas to attend to in the development of the ISUDT model:

- Continued development of the ISUDT model with respect to Supportive Housing, Community Transition, QM metrics, and processes within ISUDT.
- Continued focus on data quality from source data systems as well as quality checks within the QM dashboard.
- Reexamination of services provided once the ISUDT model is operating at steady state.
- Outcome evaluation of ISUDT using a third-party evaluator working with a CCHCS research coordinator.
- Continued utilization of an ISUDT Project Management Team working to resolve cross-divisional barriers, and continued facilitation of coordination with external stakeholders.

This process evaluation comes less than two years after ISUDT started—thus it represents the early experiences of ISUDT. As outlined in the BCP, it is expected that process improvement will occur over a five-year timeline. However, ISUDT is fully operational with screenings, assessments, linkages to care (MAT and CBI), and Enhanced Pre-Release Services available at all prisons. In addition, it is important to note the implementation of the ISUDT Program occurred during the same time as COVID-19, and CDCR/CCHCS made significant progress in identifying, treating, and linking those with SUDs to care despite unprecedented challenges created by this global pandemic. Current data from the ISUDT public dashboard indicate continued progress in screening/assessing CDCR/CCHCS’ population, and ISUDT service provision (MAT and CBI).

Appendix

Questions for Staffing

These questions will either be asked of individuals or small focus groups. The hiring plan for the Integrated Substance Use Disorder Treatment (ISUDT) Program was to hire 99.0 positions for the Medical Services, 201.0 positions for the Division of Nursing (DNS), 5.0 positions for the Division of Rehabilitative Programs (DRP), and 126.0 for the Division of Adult Institutions (DAI). The questions below ask whether the Department was able to hire the targeted numbers, how positions were advertised and filled, staff retention, challenges in hiring and retention, and the direct impact of Coronavirus Disease 2019 (COVID-19) on hiring for ISUDT.

Numbers Hired

Q1. Were the targeted numbers of hires made as planned? Yes or No

If No, how many staff were hired in:

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions

If No, why not?

Q2. What percentage of hired staff were internal to the California Department of Corrections and Rehabilitation (CDCR) or new hires to the Department?

Division of Medical Services: internal % external %

Division of Nursing Services: internal % external %

Division of Rehabilitative Programs: internal % external %

Division of Adult Institutions: internal % external %

Advertising and Recruitment

Q3. What were the advertising and recruitment strategies used for hiring:

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q4. What were you looking for in staff to fill the positions?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q5. Please explain any challenges for recruitment in:

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

How were challenges addressed?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q6. What modifications to original recruitment plans were made; why?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q7. How did COVID-19 (explicitly) impact recruitment?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q8. What were lessons learned about recruitment?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Hiring

Q9. Please explain any challenges for hiring in:

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

How were challenges addressed?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q10. What modifications to original hiring plans were made; why?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q11. How did COVID-19 (explicitly) impact hiring?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q12. What were lessons learned about hiring?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Retention

Q13. Please explain any challenges for retention in:

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

How were challenges addressed?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q14. What modifications to original retention plans were made; why?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q15. How did COVID-19 (explicitly) impact retention?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q16. What were lessons learned about retention?

Division of Medical Services:

Division of Nursing Services:

Division of Rehabilitative Programs:

Division of Adult Institutions:

Q17. Are there any additional areas or overall comments that you would like to make with respect to recruitment, hiring, and retention for ISUDT?

Questions for Training

Motivational Interviewing (MI)

Training for MI was to be delivered to nearly 500 Medical and Nursing staff statewide in two-day regionalized sessions. California Correctional Health Care Services (CCHCS) intended to establish a contract with the University of California (UC) to develop and implement the training.

Q1. Was MI training delivered to nearly 500 staff as planned? Yes or No

If No, to how many staff was MI delivered? (Both for 8-hour orientation and 2-day train the trainer):

Medical staff:

Nursing staff:

If No, why not?

Q2. Was a contract established with UC to develop and implement the training? Yes or No

If No,

Why was a contract not established?

Was a contract established with another agency; why?

Q3. Please explain any challenges for MI training.

How were challenges addressed?

Q4. What modifications to original rollout were made; why?

Q5. How did COVID-19 (explicitly) impact MI training?

Q6. What were lessons learned about MI trainings for the future?

X-waiver Training

The training for X-waiver was for the entire provider workforce (400 providers) to take the American Society of Addiction Medicine (ASAM) online buprenorphine course that provides the required 8 hours

needed to obtain the waiver to prescribe buprenorphine in office-based treatment of Opioid Use Disorder (OUD).

Q7. Was X-waiver training delivered to the entire workforce as planned? Yes or No

If No, to how many staff (and which staff positions) was X-waiver training delivered?

If No, why not?

Q8. Please explain any challenges to meeting the goals for X-waiver training.

How were challenges addressed?

Q9. What modifications to original rollout were made; why?

Q10. How did COVID-19 (explicitly) impact X-waiver training?

Q11. What were lessons learned about X-waiver trainings for the future?

Addiction Services Orientation

The training for Addiction Services Orientation was that it would be developed and conducted by Addiction Services' executive leadership, and provided regionally to approximately 200 Addiction Services clinical staff (Medical and Nursing) and 150 DRP-contracted Alcohol and Other Drug (AOD) supervising counselors and staff statewide. This training was intended to provide a program overview and train staff on workflows, assessment, referral and care coordination, and reentry planning processes. Additional Services Chiefs, Nurse Consultant Program Review, and AOD supervising counselors were expected to orient new program staff in the future.

Q12. Was Addiction Services Orientation provided to 200 clinical staff and DRP/AOD staff as planned? Yes or No

If No, to how many staff and which positions was Addiction Services Orientation provided?

If No, why not?

Q13. Were new program staff oriented by Services Chiefs, Nurse Consultant Program Review, and AOD supervising counselors? Yes or No

If No, to how many staff and which positions was Addiction Services Orientation provided?

If No, why not?

Q14. Please explain any challenges to meeting the goals for Addiction Services Orientation training.

How were challenges addressed?

Q15. What modifications to original rollout were made; why?

Q16. How did COVID-19 (explicitly) impact Addiction Services Orientation training?

Q17. What were lessons learned about Addiction Services Orientation trainings for the future?

Cognitive Behavioral Therapy (CBT)/Substance Use Disorder Treatment (SUDT)

The plan for CBT/SUDT training was to train approximately 200 Addiction Services clinical staff (Medical and Nursing), and approximately 150 DRP-contracted AOD supervising counselors in addition to existing staff statewide. This training was to be developed and delivered under a UC Regents contract in 1-week regionalized training sessions. The curriculum to be included are: Helping Men and Women Recovery (the core SUDT Program), and the Texas Christian University (TCU) CBTs. A train-the-trainer model was used to ensure program sustainability.

Q18. Was CBT/SUDT training delivered to approximately 350 staff as planned? Yes or No

If No, to how many staff was CBT/SUDT delivered? (Both for 8-hour orientation and 2-day train the trainer):

Medical staff:

Nursing staff:

Supervising counselors:

Others: (specify)

If No, why not?

Q19. Was a contract established with UC to develop and implement the training? Yes or No

If No,

Why was a contract not established?

Was a contract established with another agency; why?

Q20. Were the planned curricula used (Helping Men and Women Recovery and TCU CBTs)? Yes or No

If No, why not?

Q21. Was the train-the-trainer model utilized? Yes or No

If No, why not? What was used in its place and why?

Q22. Please explain any challenges for CBT/SUDT training.

How were challenges addressed?

Q23. What modifications to original rollout were made; why?

Q24. How did COVID-19 (explicitly) impact CBT/SUDT training?

Q25. What were lessons learned about CBT/SUDT trainings for the future?

Thinking for a Change (T4C)

The plan for T4C training was to have the National Institute of Corrections (NIC) conduct 1-week regionalized train-the-trainer sessions for 206 Addiction Services clinical staff and 150 DRP-contracted AOD supervising counselors and staff statewide.

Q26. Was T4C training delivered to approximately 356 staff as planned? Yes or No

If No, to how many staff was CBT/SUDT delivered?

Medical staff:

Nursing staff:

Supervising counselors:

Others: (specify)

If No, why not?

Q27. Was a contract established with NIC to provide the training? Yes or No

If No,

Why was a contract not established?

Was a contract established with another agency; why?

Q28. Was the train-the trainer model utilized? Yes or No

If No, why not? What was used in its place and why?

Q29. Please explain any challenges for T4C training.

How were challenges addressed?

Q30. What modifications to original rollout were made; why?

Q31. How did COVID-19 (explicitly) impact T4C training?

Q32. What were lessons learned about T4C trainings for the future?

ASAM Training

The plan for ASAM was to contract with Focused Electronic-Health Innovation (FEI) Systems for ASAM training. A 2-day training would be offered regionally to 206 Addiction Services staff statewide, and would include an overview of how to conduct ASAM assessments and clinically interpret results.

Q33. Was ASAM training delivered to approximately 206 staff as planned? Yes or No

If No, to how many staff was ASAM/SUDT delivered?

Medical staff:

Nursing staff:

Supervising counselors:

Others: (specify)

Q34. Was the planned curriculum used (overview and clinical interpretation)? Yes or No

If No, why not?

Q35. Please explain any challenges for ASAM training.

How were challenges addressed?

Q36. What modifications to original rollout were made; why?

Q37. How did COVID-19 (explicitly) impact ASAM training?

Q38. What were lessons learned about ASAM trainings for the future?

Onsite Town Hall Meetings

The plan for onsite Town Hall Meetings was that, in partnership with DRP and custody, all 35 institutions would be introduced to the Integrated SUDT Program and given an opportunity to answer questions.

Q39. Were Town Hall Meetings delivered at each of the 35 institutions? Yes or No

If No, in how many institutions were Town Halls held?

Q40. Please explain any challenges for Town Hall Meetings.

How were challenges addressed?

Q41. What modifications to original rollout were made; why?

Q42. How did COVID-19 (explicitly) impact Town Hall Meetings?

Q43. What were lessons learned about Town Hall Meetings for the future?

Any Other Trainings Offered for ISUDT?

Please indicate any other training sessions that were offered and attended. For each training, please specify the following:

- Name and type of program
- Target numbers for training
- Type of staff/institutions to be trained
- Challenges and how they were addressed
- Modifications during rollout

- Direct impact of COVID-19
- Lessons learned

Q44. Are there any additional areas or overall comments that you would like to make with respect to training for ISUDT?

Questions for Housing

- Q1. What role was supportive housing to play in the ISUDT model?
- Q2. How were initial supportive housing beds identified?
- Q3. How did COVID-19 impact the use of supportive housing beds?
- Q4. What is the current status of the use of supportive housing beds?
- Q5. What are the challenges with the use of supportive housing beds for a program like ISUDT? How can they be overcome?

Questions for Transition Process

- Q1. How were standards and policies revised to enhance patient transitions into the community?
- Q2. How were transition needs (including medication continuity, housing, benefits, health care, case plans, and network database) addressed?
- Q3. How were systems created to support information sharing of individual data for health care and county systems?
 - Are these currently operational? When did they start?
 - Is the Quality Management (QM) dashboard used for information sharing? Other systems?
- Q4. How was patient education addressed for MAT, naloxone, life skills, health care, and other resources?
 - Was this during the Transition Reentry Services (TRS) component or done another way?
- Q5. What kinds of relationships and Memoranda of Understanding (MOUs) were required with counties for service delivery and data sharing?

Questions for QM and Dashboard

Clinical Teams

- Q1. Describe (BP) front-end development of clinical decision-support tools to ensure providers have effective, patient-centered tools to support communication, timeliness, and efficiency in the delivery of care.
- Q2. Who has access to the database?
- Q3. How is the QM dashboard used to manage workflow?

Q4. How is the QM dashboard used for patient management?

- Describe (BP) the clinical informatics tools to organize, interpret, and present data used for day-to-day clinical management of complex patients.

Project Management

Q5. How is the QM dashboard most often used and by whom? Most frequent reports?

Q6. How is the database used by executives in decision-making processes?

Q7. What are measures used for ISUDT Program performance?

External Communication

Q8. How is the database used for external requests by the Office of Inspector General (OIG), legislature, or other agencies?

Q9. Is the database able to answer external questions in an accurate and timely manner?

Public Facing

Q10. Why was the public website created?

Q11. What were expectations about types/extent of analyses that could be conducted?

Q12. What is not available on the public-facing website?

Q13. How often is it used?

Research Support

Q14. How can the database be used for estimating cost and effectiveness of ISUDT Program delivery?

Q15. What research projects have been conducted to date (internally) using the database?

Database

Q16. What are the strengths of the database?

Q17. What are the challenges and how might they be addressed?

Q18. How does QM (BP) ensure data quality, integrity, and accuracy?