Los Angeles County

DMC-ODS

Drug Medi-Cal Organized Delivery System

Los Angeles County's Substance Use Disorder Organized Delivery System

Substance Use Disorder Treatment Services

PROVIDER MANUAL

SEPTEMBER 2022 | Version 7.0

SAPC | Substance Abuse Prevention and Control

County of Los Angeles Public Health

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NOTE: Given the continual evolution of the field of addiction treatment, the Provider Manual is a living document evolving with the availability of new information and research, changes in policy, regulatory mandates, and/or contractual agreements. As a result, this document is subject to ongoing review and revision at the discretion of the County.

Section 1. MODERNIZING SUBSTANCE USE DISORDER TREATMENT

Transforming the Treatment System of Care

California's Drug Medi-Ca; Organized Delivery System (DMC-ODS) transformation, coupled with further system advancements for physical health, mental health, and substance use disorder (SUD) services under California Advancing and Innovating Medi-Cal (CalAIM), provides for a more robust and effective system of care for youth and adults enrolled or eligible for Medi-Cal, with the same benefits package extended locally to individuals participating in My Health LA, select County funded programs, as well as safety net populations receiving care by the Los Angeles County Department of Health Services (DHS). It also presents an opportunity for the County to achieve the following:

- Integrating physical and mental health service needs with SUD services;
- Raising quality standards to improve health outcomes;
- Providing the right services, at the right time, in the right setting, for the right duration;
- Establishing a single benefit package for publicly funded SUD services regardless of referral source or insurance plan; and
- Solidifying SUD's status as a chronic health condition rather than as an acute condition.

These enhancements enable SUD patients to receive quality services that match their individualized needs and preferences, and to improve health and social outcomes.

This document, along with other federal, state, and local regulations[1] govern delivery of SUD treatment services in Los Angeles County. The Provider Manual is specifically designed for use by all administrative and direct service staff to ensure understanding of core values for the SUD system of care. It also provides clinical and business expectations meant to ensure delivery of quality and outcome-based services.

Substance Use Disorders as a Chronic Disease

Substance use disorders (SUDs) are often chronic, relapsing bran conditions that cause compulsive drug seeking and use, despite harmful consequences to individuals and their social network (National Institute on Drug Abuse).

A chronic disease is one that cannot be easily or simply cured, but instead must be treated, managed, and monitored over time. For example, while an ear infection is considered an acute or episodic condition that requires a fixed period of treatment to obtain a cure, SUDs generally require treatment and management over a much longer period, and at times over the course of a lifetime. Examples of other chronic health conditions are heart disease, diabetes, and asthma. While some individuals may develop a SUD and achieve recovery after minimal intervention over a brief period of time, most individuals will exhibit a more chronic and relapsing course.

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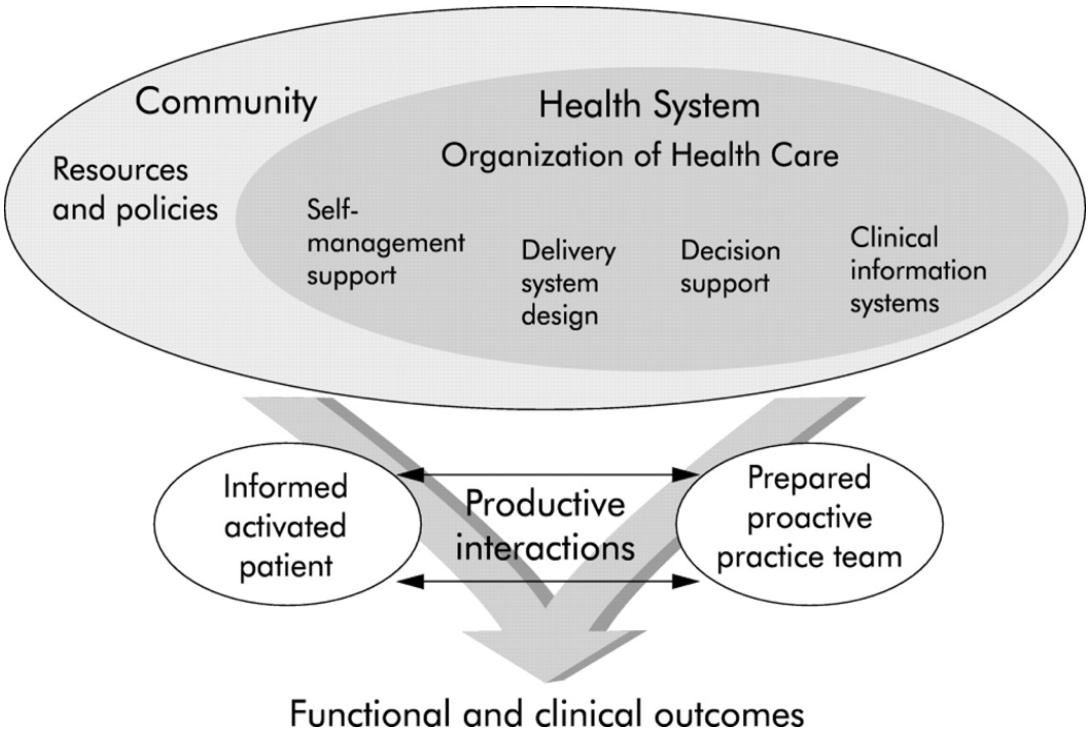
[1] *42 Code of Federal Regulations (C.F.R.) Part 2 Confidentiality of Substance Use Disorder Patient Records; 42 C.F.R. Part 438 Managed Care; Health Insurance Portability and Accountability Act (HIPAA); California Code of Regulations (CCR) Title 9 Chapter 8 Certification of Alcohol and Other Drug counselors; CCR Title 22, Section 51341.1 Drug Medi-Cal Substance Use Disorder; Drug Medi-Cal Organized Delivery System Special Terms and Conditions; State-County Intergovernmental Agreement; Department of Health Care Services Perinatal Practice Guidelines and Youth Treatment Guidelines; START-ODS Implementation Plan and Finance and Rates Plan; and the Department of Public Health, Substance Abuse Prevention and Control (SAPC) Contract including but not limited to the Specific Services to be Provided, Information Notices and Bulletins.*

The chronicity of SUDs frames the approach necessary to effectively treat these conditions. Chronic conditions need to be managed via a chronic model of care that offers a continuum of services tailored to an individual's needs at that point in time. As an individual advances along their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the patient's SUD. This approach highlights the importance of Care Coordination and access to a full continuum of care is best tailored to meet patient needs. As a result, a key goal of SUD treatment is to provide the right service, at the right time, for the right duration, in the setting.

Wagner's "Chronic Care Model" (CCM; see **Figure 1**) identifies the essential elements of a health care system that encourages high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. The components of the CCM are described in greater detail in **Table 1**.

Figure 1. Chronic Care Model (CCM)



Source: The MacColl Institute, © ACP-ASIM Journals and Books

Table 1.

Component of the Chronic Care Model
1. **Health Systems:** Create a culture, organizations and mechanisms that promote safe, high-quality care: • Visibility support improvement at all levels of the organization, beginning with the senior leader • Promote effective improvement strategies aimed at comprehensive system change • Encourage open and systematic handling of errors and quality problems to improve care • Provide incentives based on quality of care • Develop agreements that facilitate Care Coordination within and across organizations 2. **Delivery System Design:** Assure the delivery of effective, efficient clinical care and self-management support: • Define roles and distribute tasks among team members • Use planned interactions to support evidence-based care • Provide clinical Care Coordination services for complex patients • Ensure regular follow-up by the care team • Give care that patients understand and that fits with their cultural background 3. **Decision Support:** Promote clinical care that is consistent with scientific evidence and patient preferences: • Embed evidence-based guidelines into daily clinical practice • Share evidence-based guidelines and information with patients to encourage their participation • Use proven provider education methods • Integrate specialist expertise and primary care 4. **Clinical Information Systems:** Organize patient and population data to facilitate efficient and effective care: • Provide timely reminders for providers and patients • Identify relevant subpopulations for proactive care • Facilitate individual patient care planning • Share information with patients and providers to coordinate care • Monitor performance of practice team and care system 5. **Self-Management Support:** Empower and prepare patients to manage their health and healthcare: • Emphasize the patient's central role in managing their health • Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up • Organize internal and community resources to provide ongoing self-management support to patients 6. **The Community:** Mobilize community resources to meet needs of patients: • Encourage patients to participate in effective community programs • Form partnerships with community organizations to support and develop interventions that fill gaps in needed services • Advocate for policies to improve patient care **Source:** http://www.improvingchroniccare.org/

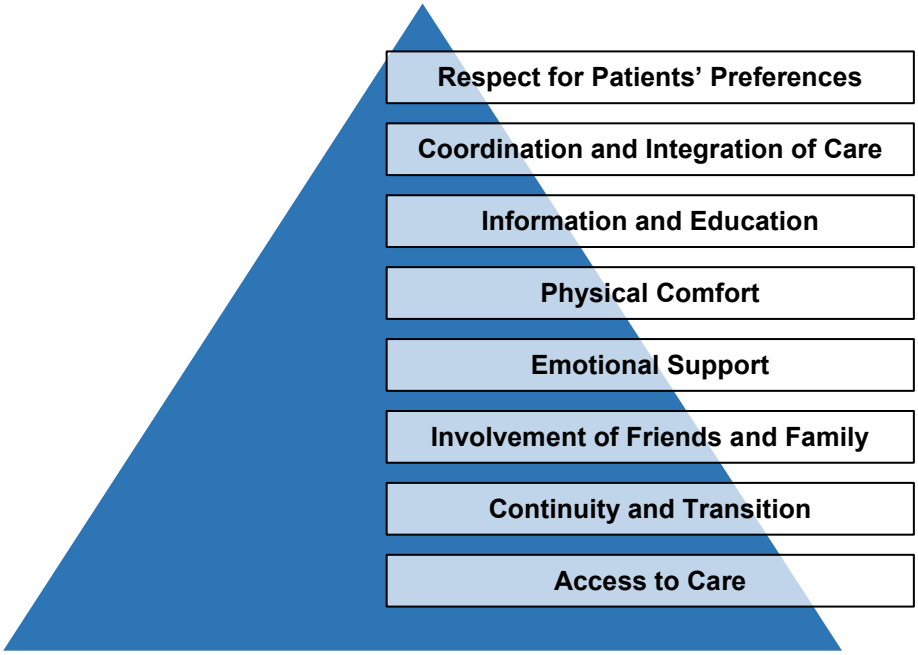
Effective care of chronic conditions, such as SUD, is characterized by productive interactions between engaged patients, as well as their family and caregivers, and a skilled team of service providers, including counselors and other health professionals.

Defining Patient-Centered Care

Treatment retention is one of the most important keys to the success of SUD care, given that an individual cannot benefit from treatment if they do not participate in it. Furthermore, one of the critical components of engaging and retaining SUD patients in treatment is the ability to deliver patient-centered care.

Patient-centered care is a collaborative approach to SUD service delivery that emphasizes respect for the patient and are that is responsive to an individual's preferences, needs, well-being, and values. Patient-centered care does not mean always doing exactly what the patient desires. There will be instances when clinical judgment is in the best interest of the patient yet does not align with patient desire. However, providers should consider patient preferences and values, and let them guide the decision-making process.

Figure 2. Picker Principles of Patient-Centered Care



Source: https://www.picker.org/about-us/picker-principles-of-person-centred-care/

Instead of the needs or policies of the clinic/facility guiding service delivery needs, patient-centered care requires flexibility by both the providers delivering the services and the program within which the services are being delivered. In doing so, SUD programs are better able to engage their patients, and better positioned to deliver high-quality care by cultivating an environment in which patients' individualized needs are prioritized in all aspects of care delivery.

Ensuring a Standard Quality of Service

The specialty SUD system is a core component of the larger healthcare system. As such, it needs to maintain minimum standards and expectations to ensure high quality services for the patient population served. Similar to the management of other chronic conditions, these minimum standards for SUDs ensure a reasonable degree of consistency across service providers, while also allowing for sufficient flexibility to deliver services that are tailored to the individualized needs of patients. For example, an individual with diabetes may receive slightly different services depending on the provider (e.g., recommendations about dietary/lifestyle changes), but the treatment and management approach is guided by certain best practice and clinical standards.

Making the Connection

Standards ensure consistent and quality care across provider organization but allow for enough flexibility to meet the specific needs of the target population or individual patient.

Similarly, SUD services need to be guided by best practice and clinical standards, which include the use of evidence-based practices such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) techniques.

It is important to note that standards-based care and individualized care are not mutually exclusive. Service providers can offer individualized and patient-centered care that also meets certain minimum best practice and clinical standards.

This Provider Manual described a framework of standards that involved patient services, clinical and business processes, and pertains to all providers within the SAPC network of care in outlining these minimum expectations, this Provider Manual established an infrastructure of quality for the specialty SUD treatment system throughout Los Angeles County.

Integration and Coordination of Care

To better serve the comprehensive needs of its patient population, a key goal of the specialty SUD system is to better integrate SUD care into healthcare and social service systems, and vice versa. In addition, there is also need for the specialty SUD system to be better organized and coordinated so that patients are effectively accessing the full continuum of SUD services and levels of care (LOCs) available to them.

Integrated care is the routine and systematic coordination of health services so that the varied needs of patients are addressed both comprehensively and cohesively. An example of care integration is a SUD program that has primary care and mental health providers stationed in the SUD treatment facility so that patients with multiple healthcare needs can have them addressed in one location. Integrating social services such as housing assistance is also important. Broadly speaking, integrated care should make it easier for patients to receive the care they need by positioning health services in ways that make them more accessible.

Care Coordination is the deliberate organization of patient care activities and sharing of information among care providers to ensure that the needs of patients are addressed comprehensively and across all their areas of need. Care Coordination needs to be patient-centered and driven by a combination of patient need and preference. It should also be based on clinical judgment, so that information being shared, and the care being coordinated is in the best interests of the patient.

The primary goal of Care Coordination is to ensure that while there may be multiple health and social service providers involved in an individual's care, the services being provided are all organized and coordinated to collectively provide timely, comprehensive, appropriate, and effective care to the patient.

Table 2. Examples of Care Coordination Activities

Examples of Specific Care Coordination Activities
Assessing patient needs and goals
Creating a proactive care plan
Monitoring and follow up, including responding to changes in patients' needs
Helping with transitions of care
Supporting patients' self-management goals
Linking to community resources
Working to align resources with patient and population needs
Communicating/sharing knowledge
Establishing accountability and agreeing on responsibility

In summary, both integrated and coordinated care can improve outcomes for patients and providers alike.

Section 2. PATIENT SERVICE STANDARDS

The Substance Use Disorder Benefit Package

Los Angeles County's SUD benefit package includes Outpatient, Residential, Withdrawal Management, Opioid Treatment and Medication for Addiction Treatment (MAT), Recovery Bridge Housing, Early Intervention, and Recovery Services (that are outlined in more detail herein). It is available free of charge to fully covered beneficiaries and eligible participants.

This comprehensive continuum of care is necessary to effectively address the treatment and recover needs of each unique individual. Further, Network Providers should assist individuals in transitioning between LOCs as medically necessary to provide care in the least restrictive environment as appropriate.

Eligibility Determination and Establishing Benefits

Covered Beneficiaries and Eligible Participants

The Los Angeles County specialty SUD system is available to the safety net population, and specifically individuals who are:

- Residents of Los Angeles County; and
- Medi-Cal enrolled or in the process of enrollment sue to presumed eligibility, including those transferring benefits from another County or State; or
- My Health LA enrolled or eligible; or
- Uninsured patients assigned to DHS for primary care; or
- Participants in the Assembly Bill (AB) 109, Drug Court, General Relief, CalWORKs, Juvenile Justice Crime Prevention Act (JJCPA) program and/or California Department of Health Care Services (DHCS) Women's and Children's Residential Treatment Services (WCRTS) (Pregnant and Parenting Women [PPW] Residential Service providers and patients only) and are commercially insured or otherwise ineligible for Medi-Cal or My Health LA.

County of Responsibility

In accordance with State policy, the Los Angeles County specialty SUD benefit package follows a County of Residence model of service delivery. As such, individuals need to be a resident of Los Angeles County to receive services; this includes individuals residing here but transferring benefits from another State or county. Network Providers that render services to individuals whose County of Residence is not Los Angeles will not be reimbursed. Only services rendered to individuals who have Los Angeles County as their County of Residence and are treated at a contracted site will be reimbursed.

If a new referral or current continuing patient does not reside in Los Angeles County and does not intend to move, they need to be referred to a provider in their county of residence. Providers should provide out-of-county patients with the county of residence phone number available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Network Providers who intend to deliver services to non-County residents must contract with the County where those beneficiaries reside to be reimbursed.

Out-Of-County Treatment Facilities

Network Providers that operate a DMC-certified site in neighboring counties (i.e., Kern, Orange, San Bernardino, Ventura), may apply to add those location(s) to this Contract to deliver services to eligible Los Angeles County beneficiaries if there is a SAPC determined need. In most cases, locations in non-adjacent counties will not be approved except to fill service gaps due to the requirement that DMC-ODS only permits service to current Los Angeles County residents. All local contract requirements still apply including but not limited to:

- Adherence to treatment requirements as outlined in this Provider Manual and other contract-related documents.
- County approval prior to reimbursement for treatment service delivery.
- Compliance with all certifications and/or licensing requirements, including certifications by the DHCS and the Federal Drug Enforcement Administration (DEA).
- Inclusion of facility information (e.g., phone numbers, contract staff, hours of operations) in the contract.
- Site inspections at the discretion of SAPC, where Network Providers may be required to reimburse the county for resources (e.g., travel and lodging) used to inspect out-of-county sites.

For additional information, contact your assigned Contract Program Auditor.

Opioid Treatment Programs (OTP) Courtesy Dosing

SAPC reimburses courtesy dosing of methadone and buprenorphine for up to 30 days for Medi-Cal beneficiaries who have travels to Los Angeles County for business or leisure, and who do not qualify for, or re unable to bring enough take-home doses for the trip duration. The SAPC Network Provider must receive a courtesy dosing order from the home OTP clinic that is signed by the medical director or program physician. The order form must outline dose, duration, and any other special instructions, such as take-home doses. Compliance with relevant Title 9 regulations is required.

For claims to be approved, Network Providers must submit the Courtesy Dosing Reimbursement Form to SAPC. Required information includes the name, date of birth, Social Security Number (SSN), Medi-Cal Patient Index Number (CIN), County/State of residence, home clinic, dates of service, medication type, health care procedure coding system (HCPCS), amount billed, and courtesy dosing reason Individuals receiving courtesy doses are not entered as new admissions into the electronic health record (EHR) Sage and date collection in not required. Claims must be submitted after the last dose is administered or distributed to the patient. The Courtesy Dosing and Reimbursement Form must be sent securely SAPC-Finance@ph.lacounty.gov or via fax at (626) 299-7225 (Attention: DMC Unit).

Inter-County Transfers

In situations where the individual resides in Los Angeles County, but Medi-Cal benefits are assigned to another County, Network Providers conduct the screening/assessment and admit the patient for medically necessary services while Medi-Cal benefits are being transferred. Patients cannot be delayed or denied admission for eligible (i.e., Medi-Cal, My Health LA, AB 109) SUD treatment services due to incomplete or pending application and/or if Medi-Cal benefits are assigned to another County. For additional information, see *Establishing and Transferring Benefits* section.

Eligibility Determination Process

Eligibility for Los Angeles County's specialty SUD benefit package must be verified by the SUD provider rendering services, and include the considerations outlined in **Table 3**.

Table 3. Eligibility Requirements for Specialty SUD Services in Los Angeles County

	Eligibility Requirement	Source of Verification
Step 1	**Resident of Los Angeles County**	Proof of residence (e.g., identification card, utility bill, etc.)
Step 2	• Medi-Cal enrolled or in the process of enrollment due to presumed eligibility, including those transferring benefits from another county or state OR • My Health LA Enrolled or Eligible OR • Uninsured patients assigned to DHS for primary care OR • Participants in AB 109, Drug Court, CalWORKs, General Relief, WCRTS and/or JJCPA program and commercially insured or otherwise ineligible for Medi-Cal or My Health LA	• Providers must utilize the 270/271 real-time Medi-Cal eligibility verification process in Sage, to verify Medi-Cal status through the State system. This process automatically updates the Financial Eligibility status in Sage if the beneficiary is enrolled in Medi-Cal. • Medi-Cal application submitted or Medi-Cal verification via AEVS file. • Once the beneficiary's Medi-Cal is active, providers must update the Financial Eligibility Form in Sage. • My Health LA application submitted or proof of participation in My Health LA program (e.g., identification card). To confirm the uninsured patient's My Health LA enrolled, email myhealthla@dhs.lacounty.gov or call My Health LA at (626) 525-5789. • DHS patients can contact their assigned DHS primary care clinic or call the Patient Access Center at (844) 804-0055 to linked to their primary care clinic. • Proof of participation in other qualified County funded programs/projects.
Step 3	**Meet medical necessity criteria to initiate specialty non-residential SUD services** (see *Determining Medical Necessity* section of Provider Manual for additional information).	• Services are reasonable and necessity to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (W&I Section 14059.5(a)). • For OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for the determination of medical necessity.

Step 4	**Meets medical necessity access criteria for specialty SUD services** (see *Determining Medical Necessity* section of Provider Manual for additional information).	**Adults (ages 21+)** • Completed ASAM CONTINUUM assessment within the specified time periods below; **AND** • Must meet criteria for at least one diagnosis from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders; **OR** • Meet criteria for at least one diagnosis from the current DSM for Substance-Related Disorders and Non-Substance-Related Disorders prior to being incarcerated or during incarceration as determined by substance use history. **Youth (age 12-17) and Young Adults (age 18-20)** • For youth being admitted to treatment services, a completed SAPC Youth Assessment (ages 12-17) • For young adults (ages 18-20), a full ASAM Assessment within the specified time period below; **AND** Meet criteria for the DSM criteria specified for adults; **OR** • For Youth and Young Adults being admitted to Early Intervention Services, meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria to ameliorate or correct a substance misuse related condition and submit a completed ASAM screener for Youth and Young Adults within the specified time period. Services need not be curative or completely restorative to ameliorate a substance use condition, including substance misuse and substance use disorder (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services, (see *Definition of Early Intervention EPSDT Services for Youth and Young Adults* section for additional details).

All providers must use the 270/271 process in order to determine a patient's Medi-Cal eligibility before admission or authorization for services. Failure to do so may impact the provider from receiving payment for claims submitted/services rendered to patients under the 30-day policy.

The Real-Time 270 Eligibility Request Form in Sage is the process where a provider requests Medi-Cal Eligibility directly from the DHCS in real-time. Providers will receive an immediate response via a 271 file to determine current or previous eligibility status.

Directions on how to complete this process within Sage can be found here: https://admin.publichealth.lacounty.gov/sapc/NetworkProviders/pm/012919/SageMediCalEligibilityVerificationRealTimeProcessUserGuide.pdf

If a patient loses Medi-Cal eligibility while in treatment, and the treatment duration extends beyond the end of the month in which the termination occurred (as services would continue to be reimbursable by DMC during this period), the following should occur:

1. Determine if the patient is eligible for AB 109, Drug Court, JJCPA, CalWORKs, GR and/or WCRTS:
    a. If yes – the patient's treatment would move to the secondary funding source; this would apply to any level of care (LOC) listed in the Rates and Standards Matrix.
    b. If no – continued SAPC payment will depend on the LOC:
        i. Residential (ASAM 3.1, 3.3, 3.5) – If the agency elects to continue providing services to the patient beyond the service authorization period, it must be on a sliding scale basis with no financial participation by SAPC.
        ii. Outpatient (ASAM 0.5 Early Intervention Services, 1.0, 2.1) – SAPC ceases payment for services. In instances where the agency elects to continue providing services to the patient, it must be on a sliding scale basis. As a reminder, Medi-Cal or My Health LA eligible beneficiaries/participants may NOT be charged sliding scale fees or flat fees.
        iii. Withdrawal Management (ASAM 1-WM, 2-WM, 3.2-WM, 3.7-WM, 4-WM) – Contact SAPC's Utilization Management Unit as this situation is very rare since the maximum duration is 14-days.
2. Modify the Financial Eligibility and the California Outcome Measurement System (CalOMS)/Los Angeles County Participant Reporting System (LACPRS) data to reflect the funding source change if the patient remains in treatment.

Establishing and Transferring Benefits

DMC-ODS services for Medi-Cal Beneficiaries are reimbursable in keeping with DHCS Behavioral Health Information Notices (BHIN):

In accordance with DHCS BHIN 21-075 and BHIN 21-032: *"If a beneficiary moves to a new county and initiates an inter-county transfer, the new county is immediately responsible for DMC-ODS treatment services and can claim reimbursement as of the date of the inter-county transfer initiation (i.e., change of address)."*

In accordance with BHIN 21-032: *"Counties and providers should use the County of Responsibility to determine which county is responsible to provide authorizations for SUD (whenever authorizations are needed to approve care) and to pay claims for medically necessary services for eligible beneficiaries."*

In addition, it is likely that many individuals seeking care may be "eligible" for Medi-Cal or My Health LA but whose benefits are not active at the time of assessment and intake. For these reasons, **eligible individuals may NOT be denied services pending establishment of Medi-Cal or My Health LA participation. Sliding scale fees or flat fees are not allowable for Medi-Cal, My Health LA eligible or the select other County-funded program enrolled beneficiaries or participants.**

Providers need to use the Care Coordination benefits to:

- Assist individuals obtain Medi-Cal or My Health LA if qualified but whose benefits are not active at the time of first contact. Providers should initiate the process on or before the date of the Treatment Service to better ensure reimbursement for delivered services.
- Assist Los Angeles County residents transfer Medi-Cal benefits to Los Angeles County if assigned to another County on or before the date of the first Treatment Service. Reimbursement is denied for service claims for non-County residents.

For those individuals, Network Providers must also meet access to care requirements which necessitates that the date of first service or intake appointment occurs no later than 10 business days from the date of referral or screening for all LOCs except OTPs which must occur no later than 3 business days from the date of referral or screening.

To facilitate access to care, Network Providers are **reimbursed** for delivered treatment services **for up to 30 calendar days** after admission, assessment, submission of the 270 Eligibility Form, authorization, and completion of CalOMS/LACPRS for:

- Patients who may be eligible for My Health LA and whose complete application is submitted **but** not processed by the 30th day or it was ultimately denied by the County.
- Patients who are undocumented and eligible for My Health LA but who refuse to participate in the program **if** a Miscellaneous Not was completed. The Miscellaneous Note must outline multiple efforts taken to encourage participation given advantages such as covered physical health services and detail the patient's refusal reasons. In general, this reason will be accepted provided the vast majority of eligible participants enroll.
- Patients who may be eligible for Medi-Cal and whose complete Medi-Cal application is submitted with a Patient Identification Number (CIN) assigned **but** whose application was not processed by the 30th day or it was ultimately denied by the State.
- Patients who need current Medi-Cal benefits re-assigned to Los Angeles County due to a permanent move and who submitted a transfer request to the County of residence **but** whose transfer was not processed by the 30th day of treatment.

If Medi-Cal benefits are ultimately established, SUD treatment services are reimbursable from the first date of the month the Medi-Cal application was submitted. Therefore, it is essential to initiate this process as close to the date of first service as possible. It is also critical that:

- Individuals step-up or step-down to another LOC whenever clinically appropriate (e.g., from Withdrawal Management to Outpatient) both to support improved and sustained recovery outcomes and to increase the time needed for patients to obtain health benefits; and
- The initial care coordinator communicates with the new care coordinator regarding the status of the patient's benefits application. The initial provider will rely on the subsequent provider to support the patient in completing the paperwork, so all are reimbursed once the application is approved.

Therefore, for patients whose Medi-Cal is assigned to another County, providers must assist patients with connecting with the Department of Public Social Services on the day of first DMC service delivered to initiate or confirm that a change of address has been processed. Treatment providers should utilize the Care Coordination benefit to assist patients with obtaining and maintaining Medi-Cal or other benefits throughout the

SUD treatment and recovery process, patients will need to provide their new physical and mailing addresses (for people experiencing homelessness this may include the DPSS District Office, provider address as permissible by agency policy, or other designated mailing address) and primary contract number.

Visit https://dpss.lacounty.gov/en/resources/contact.html for DPSS Customer Service Center contact information and http://benefitscal.com for a portal where Californians can get and manage public benefits online.

Visit https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx to find contact information for public social services agencies outside of Los Angeles County.

Only one 30-day reimbursement is available per patient (regardless of agency or LOC) per fiscal year system-wide.

Definitions of Eligible Plans

Medi-Cal Managed Care

Medi-Cal managed care plans in Los Angeles County include L.A. Care and its delegated partners Kaiser Foundation Health Plan, Anthem Blue Cross, Care 1st Health Plan, and Health Net and its delegated partner Molina Health Care. If the individual is a Medi-Cal beneficiary and has a member card from one of there health plans, they are entitled to the full SUD benefit package and this should be referred to an appropriate Network Provider. It is then the treating provider's responsibility to coordinate care as appropriate with the Health Plan and/or their primary care physician. It is important that provider staff are aware that some managed care plans such as Kaiser and Anthem Blue Cross offer both private commercial benefits as well as Medi-Cal benefits, so patients must not be turned away simply because their health plan is typically known as a private commercial health plan and their Medi-Cal eligibility must be checked.

Medi-Cal and Medicare: "Medi-Medi"

Dually eligible individuals, or those with Medi-Cal and Medicare, are entitled to the fill DMC benefit package, including any County-specific supplemental services such as Recovery Bridge Housing. Medicare does not cover most SUD services, and this does not need to be billed first. As of January 1, 2020, OTP providers must be enrolled in Medicare as Medicare will be the primary payor for OTP services (see *SAPC Bulletin 20-21*). Additionally, Medicare Part C (Medicare Advantage) must be billed as an Other Health Coverage (OHC) prior to billing Medi-Cal for all services. Any Medicare associated share-of-cost cannot be collected before delivery of services.

Medi-Cal and Private Insurance (OHC)

If the individual has private insurance (e.g., employer-sponsored, small group, or individual commercial insurance) and has Medi-Cal, the private insurance (OHC) coverage must be fully utilized before Medi-Cal coverage can be accessed.

Medi-Cal and Share-of-Cost

Some Medi-Cal beneficiaries are required to share in the cost of their treatment services. These individuals must pay out of pocket until the share-of-cost (deductible) is met. This "spend down" is a clearance of the patient's share-of-cost liability. The patient must pay an amount towards medical expenses prior to receiving Medi-Cal benefits for that month.

As a reminder, health plans often have commercial and Medi-Cal lines of business, so just because a health plan is well known as a commercial plan (e.g., Kaiser, Anthem) does not mean their beneficiary cannot also have Medi-Cal, and SAPC providers must serve all patients who are eligible or enrolled in Medi-Cal, including those enrolled in Medi-Cal through the health plans in Los Angeles County including L.A. Care, Health Net, Kaiser, Anthem, Blue Shield, and Molina.

Non-Medi-Cal Eligible Participants

The specialty SUD system in L.A. County service individuals within the State and County safety net programs. Therefore, there may be times when individuals who are not eligible for either the My Health LA program or Medi-Cal (due to income that is above the allowable Medi-Cal threshold), and/or who are not assigned to DHS for primary care, seek services in the specialty SUD system.

Admission is allowable if a patient participates in one of the following County-funded programs, even if ineligible for Medi-Cal or My Health LA: AB 109 (including Proposition 47 and 57), Drug Court, CalWORKs, GR, JJCPA and DHCS, WCRTS (PPW Residential Service providers and patients only). The full benefit package is available to these patients at no-cost.

For patients who have commercial insurance and are ineligible for My Health LA, Medi-Cal, and select other County-funded programs, SAPC is not responsible for reimbursement for services rendered to these patients. In these instances, SUD providers may serve these individuals and seek sliding scale reimbursement directly from the patient using the Patient Fee Determination Scale.

Note: Siding scale fees or flat fees are not allowable for Medi-Cal, My Health LA eligible or the select other County-funded program enrolled beneficiaries or participants.

Access to Care

Access to care refer to the psychosocial and physical access to the location where treatment services are rendered. There are many types of access barriers including:

- Timely access barriers such as unallowable delays in conducting the initial screening and assessment or placing prospective patients on unofficial waitlists instead of assisting with connections to another appropriate and available Network Provider.
- Physical barriers such as building design with steps but no ramp entrance for individuals with mobility limitations.
- Communication barriers such as lack of capabilities to engage in those who are non-English monolingual or limited English proficiency, hearing or visually impaired.
- Privacy barriers such as lack of soundproofing in counseling offices and lack of privacy in assessment rooms are also potential barriers.
- Business operation influenced barriers such as attitudes expressed by counselors or other staff that denote biases or communicate stigma to the patients, lack of a diverse workforce, operational hours that restrict access to services, or a lack of opportunity for patient input into the treatment that they receive or program operations.
- Geographical barriers such as program locations that are inaccessible by public transportation, far from areas where patients live, or where patients do not feel safe.

In all cases, Network Providers are expected to implement practices specifically designed to overcome the above types of barriers, or minimize in terms of geographic barriers, to improve patient access to care and comply with federal, state, and local regulatory requirements. Importantly, access to medically necessary services, including all FDA-approved medications for opioid use disorders (OUD), cannot be denied for beneficiaries meeting criteria for DMC-ODS services and it is prohibited to put beneficiaries on waitlists.

Access begins with the point of first contact. There are four main ways to enter Los Angeles County's specialty SUD system, with various resources to facilitate service access:

- **Toll-free Substance Abuse Service Helpline (SASH) at (844) 804-7500**
- **Connecting to Opportunities for Recovery and Engagement (CORE) Centers**
- **Client Engagement and Navigation Services (CENS)**
- **Direct-to-provider self-referrals**
    - Resources to support referrals into the specialty SUD system include:
        - **Service and Bed Availability Tool (SBAT):** Web-based, filterable provider directory of specialty SUD services contracted through SAPC (https://sapccis.ph.lacounty.gov/sbat/).
        - **www.RecoverLA.org**: Mobile-friendly platform with information about SUD services available across the County, including a mobile-friendly version of the SBAT. Access this website using a mobile device for optimal performance.

NO WRONG DOOR PATHWAYS TO ACCESS ALCOHOL/DRUG TREATMENT

In all instances, maximizing access and minimizing the time and barriers to care are fundamental priorities for the specialty SUD system. Every effort must be made to minimize the elapsed time between the initial verification of eligibility, clinical need determination, referral, and the first clinical encounter.

Service Connection Portals

Los Angeles County operate three service connection portals to facilitate efficient entry into the SUD system of care:

SASH: Qualified agents are available 24 hours a day, seven (7) days a week and 365 days a year to perform the ASAM Screener for Youth and Young Adults or the ASAM Co-Triage, determine an appropriate provisional level of care and facilitate a successful referral and linkage. Oral Interpretation and TTY services are available.

Substance Abuse Service Helpline Tollfree
(844) 804-7500

Agents are available 24/7/365 to perform the Youth Engagement Screener or the ASAM CO-Triage, determine an appropriate provisional level of care and facilitate a successful referral and linkage.

- **CENS:** SUD Counselors are co-located at various County facilities, permanent supportive housing (PSH), and area office sites during varying hours that are available to perform the ASAM Screener for Youth and Young Adults or the ASAM CO-Triage, determine an appropriate provisional level of care and facilitate a successful referral and linkage. Other available services include outreach and engagement, eligibility determination and benefits enrollment, educational sessions, service navigation, and ancillary referrals and linkages.
- **CORE Centers:** SUD Counselors are co-located within Department of Public Health Community Wellness Communities during varying hours (including evenings and weekends) to provide SUD prevention education and wellness support, including naloxone training and distribution, for individuals, youth, families, and those impacted by loved ones' use of alcohol and drugs. Additionally, they can perform the ASAM Screener for Youth and Young Adults or the ASAM CO-Triage to determine an appropriate provisional level of care and facilitate a successful referral and linkage. For more information on CORE Centers visit: http://publichealth.lacounty.gov/sapc/public/corecenter/?lang=en.

Each of these Service Connection Portals follow the same procedures for screening and referrals, with follow-up, for clients and agencies. Network Provider expectations are also the same regardless of referral entity.

Summary of SASH, CENS, and CORE Center Referral Process

Individuals may also seek referrals by the phone (SASH) or in-person (CENS/CORE). In the case of CENS, additional steps are required to communicate with the referring department/entity and prospective patient. The following is a summary of key steps in the service connection process:

1. Respond to the initial contact based on type of service connection portal:
    a. For SASH and CORE, individuals initiate the call or visit, therefore, the process can begin immediately.
    b. For CENS, an external department/entity often request the referral, therefore, an individual may be asked to report to the CENS location, or a phone/paper referral precedes the initial contact. The CENS staff make every attempt to contact the individual on the date of the referral. When this does not happen, staff notify the referring entity and provide the date of the screening and referral appointment.
2. Connect individuals to interpretation or translation services during the call/interview, and verify accommodations upon referral, including those with sensory impairment.
3. Connect to 911 when an individual is having a medical, psychiatric, or other emergency, and remain on the line or with the individual until emergency personnel has assumed responsibility for the call or arrives at the location.
4. Conduct eligibility and income verification to determine Medi-Cal or My Health LA eligibility and enrollment, or participation in the AB 109, Drug Court, JJCPA, CalWORKs, GR, or WCRTS (PPW Residential Service providers and patients only) if ineligible for Medi-Cal or My Health LA (see **Table 3**).
5. Conduct the ASAM CO-Triage Tool (ages 21 and over) or the ASAM Screener for Youth and Young Adults (ages 12 through 20).
    a. If the screening results indicate a provisional LOC, or the youth (ages 12-20) may qualify without a SUD diagnosis under Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines, proceed to Step 6.
    When an individual refuses referral, advise the prospective patient about risk reduction measures such as needle exchange, overdose prevention, and other steps that may reduce negative consequences.

b. If the screening results do not indicate a provisional LOC ("negative results"), but there is reasonable suspicion that an individual might meet medical necessity for treatment services, SASH, CENS, and CORE can refer to a non-residential LOC setting who can initiate care and conduct an assessment through the engagement period prior to the establishment of medical necessity as described in **Table 4**.
c. For individual who decline referral to treatment, individuals shall be provided alternative options (e.g., prevention, Adult At-Risk Services located at CENS Area Offices) available in the community or offered by the Medi-Cal managed care plan if applicable.
    i. The SASH refers court-ordered individuals to the CENS for follow-up. CENS coordinates with the case worker from the referring entity to close the case.

6. Identify appropriate SUD Network Providers using the online Provider Directory known as the SBAT and determine available beds/intake appointments. For Youth (ages 12-17) refer the individual to the most appropriate Outpatient Youth SUD Treatment Provider. Individuals reporting opioid use within the past 30-days are also offered referrals to OTP/MAT sites in addition to any other LOC.
7. Provide the individual with an appointment and/or contact information, and comply with timely access standards (see **Table 4**) as follows:
    a. Identify and contact up to three other Network Providers to schedule the intake appointment date within ten (10) business days for all LOCs except for OTP which is three (3) business days. If recommended provisional level of care is not available after reasonable attempts have been made, a lower LOC may be used as needed in the interim.
8. Inform the Network Provider, if needed, that the conducted screening complies with SAPC requirements and only limited additional questions are allowable, and that a signed release of information (ROI) is required to share the individual's responses to the screening.
9. Document all encounters within the Service Connection Log in the Sage system.

Additional Responsibilities of the CENS and/or CORE Centers Only

1. Educate the individual on the benefits of signing a ROI that includes each SUD Network Provider and not just the specific agency receiving the referral for Care Coordination purposes and obtain a signed release if agreed. Also obtain a ROI with the referring entity to allow communication for Care Coordination and reporting purposes, if necessary.
2. Provide ancillary service referrals for vocational rehabilitation, educational needs, housing, and other public social services when identified as a need.
3. Coordinate transportation as necessary to support the individual's ability to attend the appointment.
4. Conduct a reminder call in advance of the scheduled appointment and reschedule if requested by the individual.
5. Follow-up with the selected Network Provider to ensure documentation of whether the client did or did not attend the assessment appointment within the SUD Treatment Referral Tracking Form or once the Sage system is configured.
6. Report back to the referring entity through relevant data entry systems on the status of the individual's connection to services, as directed by SAPC.

Network Provider Responsibilities for SASH, CENS, CORE Center, and Direct Referrals

To receive referrals from the SASH, CENS, or CORE Centers the treatment agency must:

1. Update the SBAT on at least a daily basis to reflect the number of available beds and/or intake appointments and other required information.
2. Complete a revised SBAT survey within **five (5) business days** when the days and hours of operation, and any specialized expertise such as language capability or populations served changes.

3. Answer the phone number listed on the SBAT at all times during normal business hours and times when intake appointments are conducted (see *Hours of Operations* section) as agents need to schedule the appointment while the individual is on the line or at the screening interview, whenever possible.
    - Voicemail and extensive prompt systems are not acceptable alternatives to an individual answering the phone
4. If there is no answer or the calls goes straight to voicemail, staff proceed to the next Network Provider site that meets the individual's needs and preferences.
5. Ensure capability to assess and admit patients who require interpreter/translation services, and /or have sensory (visual/hearing) limitations even if facility staff cannot perform this responsibility, and/or have mobility limitations including ability to accommodate service animals.
6. Limit additional screening questions to only allowable programmatic restrictions (e.g., arson or registered sexual offender status, tobacco use), refrain from duplicating questions from the ASAM Screener for Youth and Young Adults or ASAM CO-Triage screener to create a more patient-friendly experience, and support efforts to limit total call-time to 10 minutes or less.
7. Schedule intake/assessment appointments within three (3) calendar days of the call, and subsequent immediate admission if medical necessity is established.
8. Conduct a reminder call in advance of the appointment, and is it is missed whenever the individual provided a contact phone number.
9. Schedule an appointment with another appropriate Network Provider after the in-person assessment if it indicates a different recommended LOC and:
    - A bed/slot is not available within five (5) business days at an assessing Network Provider site, or it does not offer that LOC; **or**
    - A bed/slot is not geographically convenient to the individual or does not meet preference; **and**
    - Provide at least two referral options whenever possible using the SBAT tool and contact the selected provider to schedule an appointment on behalf of the individual.
10. Use the Care Coordination benefit to assist enrolled patients transition between treatment LOCs and successfully connect with the receiving Network Provider. Management of these transitions is the responsibility of the referring treatment agency.
11. Complete the bottom section of the SUD Treatment referral Tracking Form documenting the client's appointment status, scheduled date, and time as applicable, full ASAM assessment status, admitted LOC if different from the provisional LOC, treatment admission details, and admission counselor's name.
12. Return the SUD Treatment Referral Tracking Form to the CENS agency within 30 calendar days or document within the Sage system once it is configured.

Client Engagement and Navigation Services Information

Given that many youth, young adults, and adults are referred for SUD treatment from State, County, city, or other government entities, it is important to ensure successful connections for these multi-systems involved individuals. Often, prospective clients may need more hands-on assistance to maximize treatment admission and retention, and likelihood of positive outcomes, including employment, income benefits, health benefits and housing; reuniting with children; and satisfying probation requirements or pre-plea/post-plea diversion from the court system. CENS counselors are, at a minimum, State-registered or certified SUD counselors that serve as liaisons between individuals, their case workers, and the specialty SUD system. CENS counselors provide face-to-face services to facilitate access to and completion of SUD treatment.

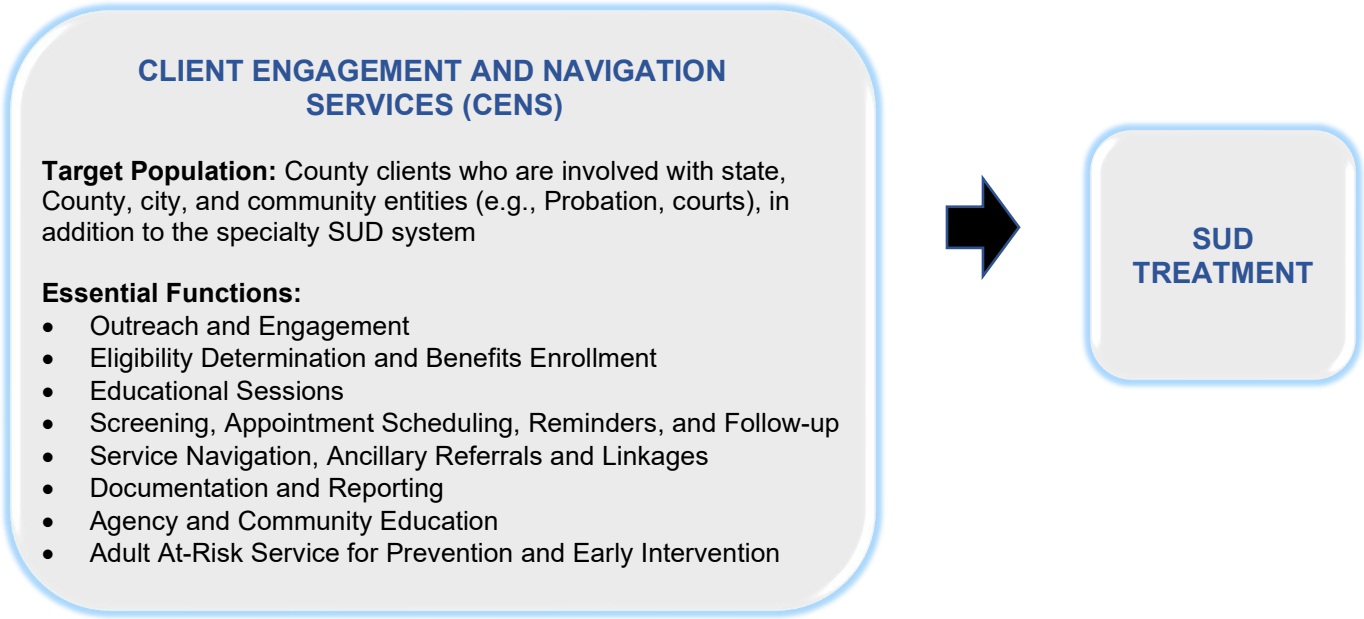
Essential functions of the CENS are highlighted in **Figure 3** and described in further detail below.

For more information, please refer to CENS Standards and Practices. The CENS Standards and Practices serves as a guide for CENS providers in meeting the necessary requirements to deliver high quality SUD services that align with all SAPC standards and practices.

Client Engagement and Navigation Services (CENS)

The CENS is staffed by at minimum State-registered or certified SUD counselors who serve as liaisons between individuals involved with state, County, city, and community partners (e.g., Probation, courts) and the specialty SUD system. The CENS provides face-to-face services to facilitate access to and completion of SUD treatment.

Figure 3. Client Engagement Navigation Services



Essential functions of CENS

Outreach and Engagement

Although most clients are referred to a co-located CENS site, some hard-to-reach individuals may be engaged by CENS in the field (e.g., streets, encampments, shelters, jails, etc.). Outreach and engagement may take frequent contacts over an extended period of time to develop a rapport and trusting relationship that eventually motivates the individual to engage in treatment. Clients who finally become ready to accept SUD treatment must be immediately linked to services. Client outreach and engagement is conducted based on need and at the direction and approval of SAPC.

Eligibility Determination and Benefits Enrollment

CENS counselors conduct eligibility determinations and income verification to determine Medi-Cal or My Health LA eligibility and/or DHS enrollment and facilitate enrollment. CENS assist clients in entering data in the

new statewide BenefitsCal website for Medi-Cal enrollment or contacting a My Health LA provider to schedule an enrollment appointment. If the individual is eligible for Medi-Ca; or My Health LA but coverage has lapsed, CENS counselors initiate the necessary paperwork and refers the client to a qualified provider to continue the benefits enrollment process. This includes assisting with the transfer of Medi-Cal benefits when a client moves from another state or county and has established residency in LA County.

If a client referred to CENS is not eligible for Medi-Cal or My Health LA, or the other County funded programs (Specifically AB 109, Drug Court, JJCPA, CalWORKs, GR and/or WCRTS), CENS counselors may provide referral to SUD providers that accept clients on a sliding scale basis. Moreover, if the client who is not eligible for Medi-Cal or My Health LA happens to be covered by a County-funded program (e.g., AB 109 or others mentioned above), CENS counselors will refer the client to SUD providers and remind such providers that SUD treatment services are available and free-of-charge for the client.

Educational Sessions

When necessary and beneficial, CENS counselors provide clients with a basic overview of SUDs and the treatment system to increase the likelihood of follow through with treatment initiation. Frequently, clients referred to CENS for a SUD screening may not understand the severity of their substance use problem. CENS counselors use MI and CBT techniques to engage and facilitate behavioral change in clients and encourage them to be more amendable to SUD treatment.

CENS counselors also:

- Discuss coping strategies with clients, including the steps to take in case of relapse
- Provide HIV/AIDS education and referrals for HIV testing and treatment
- Discuss the availability for MAT for their alcohol and opioid use disorders
- Discuss the availability of naloxone for overdose prevention

Screening, SUD Treatment Referral, Appointment Scheduling, Reminders and Follow-Up

CENS counselors screen clients using the appropriate screener to determine whether referral to treatment is necessary. If treatment is needed, CENS counselors schedule an assessment appointment at the agreed upon Network Provider per the guidelines outlined under *Summary of SASH, CENS, and CORE Center Referral Process*. CENS call the individual to remind them of the upcoming appointment and if they fail to show to their assessment appointment. CENS also contacts the Network Provider to determine the admission status and treatment status of the linked individual.

Service Navigation, Ancillary Referrals and Linkages

CENS serves as a liaison between referring State, County, city, and community partner entities and SUD treatment agencies, ensuring that the referring entities are aware of the treatment status of their clients, including treatment location and anticipated completion date. For example, CENS counselors co-located at the Los Angeles Superior Courts service as liaisons during regular court appearances or at the request of the bench officer and may provide client status reports on behalf of the treatment agency.

Navigation assistance and linkages to health and social service resources are important CENS functions, particularly when referring entities do not or cannot provide these needed connections. Navigation and linkage services must include assistance with:

- Eligibility determinations
- Completing paperwork
- Appointment reminders and rescheduling missed appointments
- Providing or arranging for transportation to appointments
- Accompanying clients to their appointments to ensure optimal attendance and treatment retention

To support these functions, CENS establish and maintain cooperative linkages with other providers (e.g., public, private, and other social, economic, health, legal, vocational, and mental health partners) to make appropriate referrals that address unmet client needs. CENS counselors maintain a working knowledge and up-to-date resource directory that includes, but is not limited to, all SUD providers (via the SBAT), mental health provides, physical health providers, HIV/AIDS/STI providers, and Medi-Cal managed care plans.

Documentation and Reporting

CENS counselors document their work in Sage, and capture client service utilization, progress, and outcome information for submission to SAPC and the referring State, County, city, and community entities. Staff also enter client and service activities in partnering agencies electronic data collection systems, as appropriate (e.g., Treatment, Court, Probation, eXchange (TCPX), and LEADER Replacement System (LRS)).

Agency and Community Education

CENS is responsible for the following agency and community education activities at the request and direction of SAPC:

- Conduct presentations for city/County/State entities on SUD prevention and treatment (including syringe exchange and overdose prevention), the SUD treatment benefit package, and other requested topics.
- Conduct trainings about SUD treatment and the referral process into the specialty SUD system.
- Conduct community outreach to promote public awareness about SUDs and inform the community about available SUD treatment options.
- Participate in health and job fairs, as well as other community events, hosted by providers, faith-based organizations, hospitals, cities, the County, and others.
- Conduct Orientation services at GAIN Regional – Los Angeles County Office of Education (LACOE) sites CalWORKs. Orientation services are designed to educate participants and when possible DPSS staff about assessment, treatment, and recovery services available through the CalWORKs Supportive Services program. Orientation sessions are to be conducted by individuals who have in-depth knowledge and expertise in the area of alcohol and other drugs, as well as a knowledge of the alcohol and drug treatment and recovery system in LA County.

Adult At-Risk Services for Prevention and Early Intervention

The Adult At-risk Program is a no-cost opportunity for eligible individuals to learn about and be aware of SUD through interesting and interactive educational sessions. CENS provide early intervention services for adults (ages 21 and older) whose ASAM CO-Triage results do not meet the criteria for SUD treatment services, engage in SUD high-risk behaviors or do not meet medical necessity for SUD treatment but may benefit from an intervention based on high-risk behaviors. Young adults (ages 18-20) are referred and provided Early Intervention Services at Outpatient SUD treatment.

Adult At-risk services address issues that are identified in an individualized intervention plan. While at-risk engagement is an essential activity of CENS, there may be program variations for CENS providers working specifically with at-risk youth, young adults, and adult populations. The Adult At-risk Program provides education sessions about the effects of SUD and its impact on a person's life. The sessions are designed to teach about ways to maintain a healthy and SUD free lifestyle. Individuals who complete the program may receive a certificate and/or relevant documentation from the CENS provider.

Adult At-risk services include (services are available to clients ages 21 and older):

Enrollment
Complete enrollment in At-risk services including identifying the client's needs or behaviors for a tailored intervention approach

Intervention Guide
The intervention guide is a plan to be utilized as a tool for CENS counselors to identify areas that can impact the client's SUD risk. Participants will be able to identify appropriate resources within the LA County SAPC SUD Continuum of Care and can receive verification of their progress as documented by the CENS counselor. These can include:

- Substance Use, Intoxication/Withdrawal Potential (e.g., early initiation, IV use, previous treatment, previous overdose)
- Biomedical Conditions/Complications (e.g., chronic pain, communicable health condition)
- Emotional, Cognitive, Behavioral Health Conditions/Complications
- Readiness to Change (e.g., substance use in hazardous situations)
- Relapse/Continued Use or Problem Potential (e.g., legal, work, family stressors)
- Recovery Environment/Living Situation (e.g., lack of social support, lives with others who use substances)

Participation Documentation
Adult At-risk Counselors are certified to provide At-risk sessions and intervention guide can provide documentation on the client's behalf based on the client's progress. They verify client's consent to release information and provide documentation to other county departments such as DPSS, DCFS, and Probation with the client's completion status. All releases shall adhere to all confidentiality laws, including 42 CFR Part 2 and HIPAA.

Training for CENS Counselors
SAPC launched the Adult At-risk trainings for CENS counselors aimed a providing intervention services to all adult clients who screen negative for SUD or positive for ASAM 0.5 Early Intervention LOC. There are currently 8 trainings or educational workshops that all CENS counselors must receive certification prior to providing these services. These trainings include:

- Substance Use Disorders (SUDs) – Signs and Symptoms
- Health Consequences of Substance Use & the Benefits of Sobriety
- Recognizing & Responding to an Overdose with Naloxone
- Being at Risk for SUDs: What it Means and What Can You Do About It
- Understanding the Connections Between Substance Use and Mental Health

- How to Stay Sober: Relapse Prevention & Healthy Coping
- Understanding the Risks of Cannabis
- Harm Reduction Strategies and Syringe Exchange Programs

Training of the Trainer (ToT)

The ToT trainings are a series of trainings conducted for CENS counselors in "cohorts" which will focus on information about SUD issues in the community, common substances of abuse, and exploring the differences between use, abuse, and disorder. These can be provided to groups, educational sessions, or workshops to clients. ***The CENS counselor cannot train other staff in the ToT***.

Educational Sessions

Educational sessions are meant as a resource for participants to be presented by certified CENS counselors to utilize when working with adults who are considered at-risk of SUDs and are mandated to seek SUD assistance by a program or court, such as DCFS, DPSS, AB 109, etc. These are intended knowledge and skill-based for an individual session.

Only CENS counselors who are certified through ToT can provide individual or group intervention sessions for clients and to interagency staff if required.

****CENS counselors who are certified in the educational sessions can provide individual sessions, but not group, and provide the trainings to interagency staff.***

Location, Staffing, and Responsibilities of CENS

CENS Locations

To improve access to SUD services, CENS has Area Offices located in each of the eight (8) Service Planning Areas (SPA). CENS are also co-located at various State, County, city, and community sites to facilitate client entry into and navigation though the specialty SUD system.

CENS are co-located at the following SAPC-approved sites:

- Department of Mental Health (DMH) Psychiatric Emergency Services (PES) and Urgent Care Centers (UCC)
- DUI courts
- Family Solutions Centers
- Homeless Encampments and PSH sites
- Juvenile Halls
- Los Angeles Superior Courts (e.g., Community Collaborative Court and Prop 47)
- Medical facilities, including Federally Qualified Health Centers and selective private and public hospital medical emergency rooms
- Probation Department (e.g., AB 109 HUBS and Adult Area Offices)
- Sheriff's Department (e.g., Community Re-entry and Resource Center, Twin Towers)
- Other approved co-locations, as necessary

Target populations serviced at these co-located sites include clients who are involved in the juvenile or criminal justice system, uninsured, underinsured, people experiencing homelessness, individuals with co-occurring disorders, among other vulnerable conditions.

There is one CENS lead agency per SPA who manages all locations within that region. Lead agencies may subcontract with other providers to ensure SPA-wide coverage, as approved by SAPC. New co-locations are either established by SAPC based on need and funding availability or requested by CENS agencies (see *CENS Co-locations Procedures* [**Appendix 5**]).

To support CENS objectives, all co-located sites must carry out activities in a uniform manner to establish measurable and successful linkages to SUD treatment and other necessary services.

CENS Staffing

CENS provide face-to-face services to facilitate access to and completion of SUD treatment. CENS are responsible for employing registered and/or certified SUD counselors who utilize a patient-centered and biopsychosocial approach to assist clients in accessing SUD treatment and other ancillary services. LPHAs may also be employed (see *Workforce* Section and *Staffing Grid* in the Network Provider section on the SAPC website for additional details).

Hours of Operation

Hours of operation vary depending on CENS staffing patterns and client volume. Some CENS co-locations do not have full-tine staff due to lower client volume, and scheduled days/times reflect this. However, for co-locations and CENS Area Offices with full-time CENS staff, service hours are minimally available Monday through Friday, from 8:00 a.m. to 5:00 p.m.

CENS Director Responsibilities

CENS Directors must ensure CENS staff have the most updated forms, training and resources needed to carry out CENS core activities and documentation. Responsibilities include ensuring CENS staff complete necessary training and Sage onboarding activities, informing SAPC of changes at each co-location, and attending CENS meetings.

1. **Supervision and Training**
   CENS Directors must ensure CENS staff have the appropriate experience, training, and current forms needed to provide and document CENS services. CENS Directors are responsible for ensuring CENS staff are kept informed of any changes or updates to CENS requirements, procedures, and forms.
2. **Sage Onboarding**
   Sage is designed to enable network providers to perform important patient care and administrative functions. CENS Directors are responsible for ensuring CENS staff create and manage their Sage User accounts. For step-by-step instructions to create and manage Sage User accounts, see http://publichealth.lacounty.gov/sapc/Sage/Provider/SageUserOnboarding.pdf
3. **Updating CENS Information**
   It is essential to keep SAPC updated regarding all changes occurring at area offices and each co-location. CENS Directors must ensure the following information is reported to SAPC at the time of, or prior to occurrence:
   - Contact information for new CENS staff and counselors
   - Staff changes (e.g., CENS staff no longer assigned to/or transferred to a different co-location)
   - Schedule changes or changes in staff coverage (e.g., days/hours) at a CENS site
   - Any major changes, or anything not functioning properly that may interrupt services and daily routine

4. **CENS Meetings and Trainings**
   CENS Directors and/or their designee are required to participate in monthly CENS Director meetings at SAPC to address CENS implementation and management, and any changes or updates to CENS requirements, procedures, and forms. In addition, CENS counselors are expected to attend periodic co-location meetings relevant to their sites (e.g., AB 109, GR, PSH, etc.), and other CENS-related meetings and trainings mandated by SAPC.

CORE Centers Information

The CORE Centers aim to increase opportunities for youth, adults, and family/friends throughout LA County to better understand the impact of substance use on individuals and communities, and collectively identify ways to broaden community action particularly as it related to supporting healthy families. The central philosophy of the Center is "The Opposite of Addiction is Not Sobriety. The Opposite of Addiction is Connection" (Johann Hari). The Core Centers operate with DPH Community Wellness Complexes (formally *Public Health Centers*) in Antelope Valley, Hollywood/Wilshire. Inglewood, South Los Angeles, Pomona, and Whittier.

The CORE Centers serve as a welcoming environment to address questions about substance use and services including risk reduction (e.g., fentanyl test strips), prevention (e.g., brief intervention, youth development), and treatment (e.g., MAT). Additional services include: conducting in-person screening and referral services (e.g., linkage to physical or mental health services); trainings on naloxone administration and distribution of supplies/prescriptions; conducting individual education and group discussions; making connections to support services (e.g., benefit acquisition, interim and permanent supportive housing, family reunification, etc.); and when feasible, serving as a venue for partner entities to conduct supplemental workshops.

Specific programming and workshops to support families and friends of loved ones at-risk or experimenting with alcohol/drugs, and/or struggling with addiction include:

1. Youth development and positive activities
2. Your teen and substance use
3. Your teen and vaping
4. Overdose prevention options
5. MAT options
6. No-cost prevention and treatment services
7. Reducing stigma of SUD
8. How to help your loved one and family support options
9. What families should know about the treatment process
10. Defining recover services and what is available to your family
11. Community driven strategies to address SUD are the local level

Central to the CORE model will be the ability of the assigned Substance Abuse Counselors (SACs) at each site to foster engagement and connection in an environment that educates equally on all service options (risk-reduction to abstinence) without judgement on the individual's readiness to change (e.g., precontemplation, contemplation, action, etc.). Services are available to the public, and particularly those who are Medi-Cal or My Health LA eligible or enrolled. Agreement to be referred to treatment (when indicated) is not a condition to receive other CORE Center referrals/services. Most services are delivered by the SACs, however, prevention

and treatment providers, and other community-based organizations (CBOs) may be engaged to conduct specialized workshops to support the needs of individuals and families seeking care.

Direct-to-Provider

Individuals seeking specialty SUD services can go directly to or contact an SUD treatment agency to initiate services, and therefor are not required to contact the SASH, CENS, or CORE to access specialty SUD services. Oftentimes, individuals identify providers based on word-of-mouth in the community, prior experiences, by using the SBAT or the Recoverla.org application on mobile devices for information about specialty SUD providers throughout the County.

Staffing

See minimum staffing requirements in the *Workforce* section.

Hours of Operation

See **Table 5** for guidance on minimum hours of operation.

SUD Treatment Agency Process and Responsibilities in Receiving Direct Self-Referrals

Treatment agencies MUST:

1. **Comply with the requirements outlined under Network Provider Responsibilities for SASH, CENS, CORE Center, and Direct Referrals**.
2. **Treatment provider sites that offer the full SUD continuum of care:**
   Triaging patients via the screening is less critical for SUD treatment sites that offer the full SUD continuum. No matter what LOC an individual may need, the treatment provider site would be able to offer that LOC and meet the identified needs. As such, when patients present to SUD treatment sites that offer the full SUD continuum of care, the full ASAM CONTINUUM or SAPC Youth ASAM assessment may be conducted (see *Assessment* section for additional details).
3. **Treatment provider sites that do NOT offer the full SUD continuum of care:**
   Administer either the ASAM Screener for Youth and Young Adults (ages 12-20) or ASAM Triage Tool (ages 21+) for patients who are not referred by the CENS, SASH, or CORE to prevent scenarios in which patients are taken through a full ASAM assessment only to realize that the assessing treatment site does not offer the LOC needed to meet the patient's needs.
   - Starting with a screening ensures a patient-centered approach to the intake process and reduces the likelihood that treatment provider sites will invest resources in a full ASAM CONTINUUM or SAPC Youth ASAM assessment if the level(s) of care are not offered at that treatment provider site.
   - If the provider site does not offer the LOC to meet the patient needs, the treatment provider site must identify and refer the patient to an appropriate SUD Network Provider using the SBAT and determine available beds/intake appointments. For Youth (ages 12 through 17), refer the individual to the most appropriate Outpatient Youth SUD Treatment Provider. Individuals reporting opioid use within the past 30-days must be offered referrals to OTP/MAT sites in addition to any other LOC.
   - Provide the individual with an appointment and/or contact information, and comply with timely access standards (see **Table 4**) as follows:

- Identify and contact up to three other Network Providers to schedule the intake appointment date within ten (10) business days for all LOCs except OTP which is within three (3) business days. If recommended provisional LOC is not available after reasonable attempted have been made, a lower LOC may be used, as needed, in the interim.
- Document all encounters within the Referral Connections Form in the Sage system.

4. Assist the patient successfully connect with the receiving treatment agency in instances in which transitions between LOCs or treatment and health providers are necessary, including instances in which the assessing provider sites does not meet the geographic and other preferences of the individual. Management of these transitions through Care Coordination is the responsibility of the last treatment provider.

Service and Bed Availability Tool and Provider Directory

The Service and Bed Availability Tool (SBAT) is a web-based tool that provides a dashboard of available specialty County-contracted SUD services throughout LA County, including Outpatient, Intensive Outpatient, various levels of Residential treatment and Withdrawal Management, OTPs, Recovery Bridge Housing (RBH), and Driving Under the Influence (DUI) programs.

The purpose of the SBAT is to help achieve the aim of a more organized SUD delivery system by simplifying the process of identifying appropriate SUD providers. By allowing users to filter their search based on the LOCs, languages spoken, and types of services delivered, users can tailor their search according to their need, and more quickly identify intake appointment times and available residential and RBH beds.

To add a DMC-certified agency-operated treatment site to the SBAT, agencies must first complete the *Provider Directory Survey*. Once this is completed and the site is added to the SBAT, the actual number of intake appointments/slots and beds need to be updated for all SAPC LOCs daily.

Since the SASH, CENS, CORE, and the public will use the SBAT to identify which treatment agency and location to contract for services, it is critical to update and verify the information provided in the survey. Information on beds/slots availability and intake appointments must be updated in the SBAT, as required.

Intake slot and bed availability automatically reverts to zero (0) 24-hours after the last provider update to the SBAT. Therefore, each day, providers MUST update information on intake availability AND bed capacity (residential, Residential Withdrawal Management, and Recovery Bridge Housing providers only) to ensure accurate and timely referrals. SBAT users will receive automatic e-mail notifications according to the following schedule:

- One (1) hour prior to SBAT reset
- When the SBAT resets to zero bed availability
- One (1) hour post reset, if applicable because an update has not yet been made
- Three (3) hours post-reset, if applicable because an update has not yet been made.

The SBAT intake slot availability allows providers to input information on the number of intake slots that are available on a given day for Outpatient Services (including Intensive Outpatient) and Residential Services (including all LOCs) for referral sources to schedule an intake appointment.

A slot calculator is available on the SBATs provider interface to assist in calculating intake availability. More detailed instructions about using the SBAT is available on the SAPC website (see SBAT User Guide).

Timeliness and Access Standards

Ensuring timely access to services is essential to accomplish the aim of improving outcomes of the specialty SUD system, as is engaging patients when they are ready to initiate treatment. All DMC-ODS services are to be delivered with reasonable promptness in accordance with federal Medicaid requirements and as specified in the contract and herein.

In addition to time, distance to access treatment has been linked to patient outcomes. Generally, the shorter the distance between a patient and their treatment site, the better the patient outcome. Unless otherwise requested by the patient, every effort must be made to refer the patient to a treatment program that is within 30 minutes of travel time by personal or public transportation, OR fifteen (15) miles from the patients' location of choice (see **Table 4**). If it is not feasible, every effort should be made to decrease the likelihood that the commute or transportation issues serve as a barrier to accessing treatment. If the patient prefers to have some aspect of treatment delivered in a different region than where they reside or work, this preference must be considered and documented in their clinical record.

Table 4. SAPC Access and Services Delivery Standards

SERVICE	DUE DATE
Distance Standards for Referrals	Every effort must be made to refer patients to a treatment program within: 1. 30 minutes of travel time by personal or public transportation; **OR** 2. 15 miles from the patients' location of choice
Screening for Provisional LOC[2]	Date of first contact (walk-ins only) Provide 2 alternate referral agencies and connect the patient within 48 hours to the provider
Urgent Appointment for Withdrawal Management	When provisional LOC determination supports that a medically monitored setting with 24-hour nursing care is needed to manage severe withdrawal, then the Network provider must, within 48 hours: 1. Directly initiate the indicated withdrawal management service; **OR** 2. Ensure enrollment in the indicated withdrawal management service at another provider site
Intake Appointment - Scheduled	Immediately, but no longer than 3 calendar days of screening/referral (NOTE: SASH may move to the next provider if there is no immediate response or available appointment)
Intake/Assessment Appointment – Conducted	Within 10 business days of screening/referral for non-OTP settings and 3 business days for OTP settings

[2] *If the agency does not offer the provisional LOC or a slot/bed will not be available within timeliness standards, referrals must be provided (**no waitlists allowed**)*

County Residency Eligibility Verification Medi-Cal, DHS, or MHLA Eligibility Verification Patient Handbook Provided/Patient Orientation Video	Date of first service intake/appointment
ASAM CONTINUUM or SAPC Youth ASAM Assessment and Medical Necessity Determination	**For patients in <u>Residential</u> treatment settings:** • Within 7 calendar days of first service or first intake appointment for adults (ages 18+); **<u>OR</u>** • Within 14 calendar days of first service or first intake appointment for youth (ages 12-17) **For patients in <u>non-residential</u> treatment settings:** • Within 30 calendar days of first service or first intake appointment for adults (ages 21+); **<u>OR</u>** • Within 60 calendar days of first service or first intake appointment for youth (ages 12-17) and youth adults (ages 18-20), and all adults (age 21+) who are documented as experiencing homelessness[3] *If every attempt has been made to complete and finalize the ASAM Assessment and establish medical necessity during the initial 30-day or 60-day authorization period, but was not possible, Provider must include a Miscellaneous Note detailing the reason why they were unable to meet the established timeline*
Data Submission (CalOMS/LACPRS)	• Within 7 calendar days of first service or first intake appointment for youth adults and adults (ages 18+); **<u>OR</u>** • Within 14 calendar days of first service or first intake appointment for youth (ages 12-17)

[3] *Documentation of homelessness status must be indicated in a Miscellaneous Note*

Initial Problem List (for non-OTP Services) Initial Treatment Plan (for OTP Services)	• Within 7 calendar days of first service or first intake appointment for young adults and adults (ages 18+), including the legible LPHA signature on the Problem List. Treatment Plans in OTP settings require both the legible patient's and LPHA's signature); **OR** • Within 14 calendar days of first service or first intake appointment for youth (ages 12-17) including the legible LPHA signature on the Problem List. Treatment Plans in OTP settings require both the legible patient's and LPHA's signature. Treatment plans for patients receiving OTP services prior to the completion of the ASAM Continuum or ASAM Screener for Youth and Young Adults should describe the plan for obtaining this assessment within the required 30 or 60 day timeframe described above. *In OTP settings, if every attempt has been made to complete and obtain signatures on the Treatment Plan within the 7 or 14 calendar day timeframe, but circumstances do not allow for full completion, then the provider must:* 1. Include a Miscellaneous Note with justification detailing what prevented completion within the timeframe; 2. Complete an initial Treatment Plan (required only for OTP settings) based on the information (and signatures) available at the 7 or 14 calendar day deadline; and 3. Within 28 day of first OTP service, complete a Treatment Plan based on the available clinical information that includes all Treatment Plan elements and is signed by the patient and the appropriate LPHA. The appropriate LPHA or Medical Director must then legibly sign the Treatment Plan within 15 days of the patient signing.

To optimize access to SUD services, SUD treatment agencies must implement an ongoing, systematic evaluation process for identifying physical and/or psychosocial access issues that may impede SUD treatment seeking behavior. The evaluation process should identify counselor/staff attitudes around substance use, patient transportation, or any other accessibility issues. Providers must also consider patient and stakeholder feedback during this process. Once barriers are identified, SUD treatment agencies should develop a plan detailing how they plan to address the identified barriers. The plan may be a Quality Improvement Project (see *Providers – Quality Improvement & Utilization Management Expectations* section for additional information) that specifies the barrier(s) and action(s) that will be taken to eliminate or reduce the impact of the barrier, and when these specific actions will be completed.

Hours of Operation by Benefit

Table 5. Hours of Operation by Benefit

Benefit	Applicable Levels of Care	Minimum Hours of Operation*

Early Intervention Services (for Youth and Young Adults)	• Early Intervention Services (ASAM 0.5)	• Must operate at least 5 days a week, including either:
		  ○ One 8-hour day on Saturday or Sunday **or**
		  ○ A 4-hour day on Saturday and 4-hour day on Sunday; **AND**
		• At least 2 days must include evening hours (5:00 p.m. – 9:00 p.m., at a minimum)

Outpatient Levels of Care	• Outpatient (ASAM 1.0)
	• Intensive Outpatient (ASAM 2.1)
	• Ambulatory (Outpatient) Withdrawal Management **without** Extended On-Site Monitoring (ASAM 1-WM)
	• Ambulatory (Outpatient) Withdrawal Management **with** Extended On-Site Monitoring (ASAM 2-WM)
		• Must operate at least 5 days a week, including either:
		  ○ One 8-hour day on Saturday or Sunday **or**
		  ○ A 4-hour day on Saturday and 4-hour day on Sunday; **AND**
		• At least 2 days must include evening hours (5:00 p.m. – 9:00 p.m., at a minimum)

Residential and Inpatient Levels of Care	• Clinically Managed Low-Intensity Residential Services (ASAM 3.1) • Clinically Managed Population-Specific High-Intensity Residential Services (ASAM 3.3) • Clinically Managed High-Intensity Residential Services (ASAM 3.5) • Clinically Managed Residential Withdrawal Management (ASAM 3.2-WM) • Medically Monitored Inpatient Withdrawal Management (3.7-WM) • Medically Managed Intensive Impatient Withdrawal Management (4-WM)	• Must operate 24 hours per day, 7 days a week; **AND** • Must accept intakes at least during regular weekday business hours (9:00 a.m. – 5:00 p.m., at a minimum)
Opioid Treatment Program	• Opioid Treatment Programs (1-OTP)	• Must operate at least 5 days a week (including either: ○ One 8-hour day on Saturday or Sunday; **or** ○ A 4-hour day on Saturday and 4-hour day on Sunday.
Recovery Bridge Housing	• Recovery Bridge Housing	• Must operate 24 hours per day, 7 days a week; **AND** • Must accept intakes at least during regular weekday business hours (9:00 a.m. – 5:00 p.m., at a minimum)
Hours of operation Standards do not apply to approved field-based services locations.		

The minimum and maximum number of hours per week do not change for weeks that include a federal, state, or local holiday. The County, however, will consider this during administrative reviews and during monitoring visits. In general, this would not be an audit exception provided the week prior and the week after the holiday meets minimum and maximum standards.

For Intensive Outpatient programs, the rate may be lowered to the outpatient rate for any claims associated with an individual who does not receive the minimum number of service hours/units in any week.

Network Adequacy Certification Tool

SAPC's timeliness and access standards are reviewed annually as outlined in DHCS BHIN 21-023: Federal Network Adequacy Standards for Mental Health Plans (MHPS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties to ensure that all required services covered under DMC-ODS are available and accessible to DMC-ODS enrollees in accordance with the applicable state and federal time and distance standards including those set forth in 42 CFR 438.68 and W&I Section 14197. This notice sets forth the requirements for annual certification of network adequacy.

The Network Adequacy Certification Tool. Or NACT, is completed by DMC-ODS Counties and used by DHCS to access compliance to network adequacy requirements. The NACT assesses whether the County Plan:

- Offers an appropriate range of services for the anticipated number of beneficiaries;
- Maintains a network of providers, operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries.

SAPC providers must review, update, and validate their organization, service location and staff on an annual basis, unless otherwise indicated by SAPC, using the tool provided, to ensure the County complies with this submission. This includes, but is not limited to:

1. **Organization information** such as:
    - Contract effective and expiration date
    - Name of CEP and CFO
    - Website URL of agency (if available)
2. **Service location information** such as:
    - Maximum and current number of Medi-Cal beneficiaries by age group and modality
    - ADA compliance
    - TTY (TeleType)/TDD (Telecommunications Device for the Deaf) equipment
    - Language capacities
    - Age groups served
3. **Staff (practitioner) information** such as:
    - Contact effective (hire) date and expiration date (if open ended employment, indicate N/A)
    - Age groups served
    - Maximum number of beneficiaries practitioner will accept, and the current number of beneficiaries assigned to the practitioner by age group and modality.
    - Language capacity
    - Telehealth capabilities
    - Cultural Competency training and the number of hours completed

DHCS requires that DMC-ODS Counties submit the NACT by June 1st of each year. To ensure this deadline is met, providers must submit the requested information by no later than **May 15th** of each year, unless otherwise noted by SAPC.

Determining Medical Necessity

Medical necessity is a standard applied to justify services as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.

Medical necessity must be consistently applied to ensure equitable access to services, must be established to demonstrate and maintain DMC eligibility, and must also be established for provided services (e.g., residential treatment, Recovery Bridge Housing, etc.).

Medical necessity to initiate non-residential services means that services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (W&I Section 14059.5(a)); and for OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for the determination of medical necessity.

To fully establish medical necessity for all LOCs except Early Intervention services for youth and young adults, Recovery Services, and Withdrawal management can only be determined **after** a full ASAM CONTINUUM or SAPC Youth ASAM assessment, which includes an SUD diagnosis from the current edition of the DSM, is finalized. Screenings do not generally include sufficient information to determine medical necessity for most LOCs because they do not include a DSM diagnosis determination or contain sufficient information regarding the six (6) ASAM dimensions to constitute a comprehensive biopsychosocial ASAM assessment. The ASAM Screener for Youth and Young Adults is used to establish medical necessity for Early Intervention services.

Definition of Medical Necessity

To meet medical necessity criteria, patients must meet the following two (2) criteria:

1. **Diagnostic and Statistical Manual or Mental Disorder (DSM) diagnosis**
    - Youth (ages 12-17) and Young Adults (ages 18-20)
        - Meet criteria for at least one diagnosis from the current DSM for Substance-related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

            OR
        - Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria to ameliorate or correct a substance misuse related condition (see *Definition of Early Intervention Services for Individuals up to Age 21* section for additional details).
    - Adults (ages 21+)
        - To begin services delivery prior to completion of the full assessment:
            - Services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (W&I Section 14059.5(a)).

                OR
            - For OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for the determination of medical necessity.
        - To fully establish medical necessity:
            - Meet criteria for at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-related Disorders.

- Meet criteria for at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-related Disorders prior to being incarcerated or during incarceration as determined by substance use history.

2. **American Society of Addiction Medicine (ASAM) treatment criteria for services**
   DMC-ODS providers must ensure that patients meet the ASAM treatment criteria for services after completion of the initial assessment period (30-60-days after first service depending on the population), including the ASAM adolescent treatment criteria, when applicable. Medical necessity encompasses all six (6) ASAM dimensions and takes into consideration the extent and biopsychosocial severity of the various dimensions within the required full ASAM CONTINUUM or SAPC Youth ASAM assessment. Medical necessity must not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1), acuity of physical health needs (as in Dimension 2), or Dimension 3 psychiatric issues (such as imminent suicidality).

Definition of Early Intervention Services for Individuals Under 21

Youth (ages 12-17) and Young Adults (ages 18-20) in the specialty SUD system are eligible for Early Intervention services under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Eligibility for EPSDT broadens the definition of medical necessity for youth and young adults to include individuals who need services to ameliorate or correct a substance misuse related condition and makes the full SUD benefit package available to all individuals ages 20 and under without any caps or limitations. Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21 who are screened and determined to be at risk of developing an SUD and thus may receive any service component covered under the outpatient level of care as Early Intervention services.

It is important to note that federal EPSDT requirements supersede state Medi-Cal requirements, and DMC-ODS does not override EPSDT.

Assessment

Assessments are the evaluation, measurement, and documentation of patients to determine diagnosis and service needs. In the treatment of persons with SUDs, assessments are an ongoing process and are essential to identify patient needs and help the provider focus their services to best meet those needs. Assessments are also important opportunities for patient engagement and developing a plan of care. Assessments are generally performed in the initial phases of treatment, though not necessarily during the initial visit.

A full assessment or initial provisional referral tool for preliminary LOC recommendations is not required to begin receiving DMC-ODS treatment services.

Comprehensive, validated, standardized assessment tools, and their corresponding documentation, form the foundation of high-quality SUD services. Assessments based on the required ASAM Criteria ensure that there is a standardized structure by which to collect necessary clinical information to make appropriate SUD LOC determinations. Assessments need to be appropriately documented (see *Documentation* section for additional information). Reviewed, and updates on a regular basis, including at every care transition, to promote engagement and meet the patient's needs and preferences.

If while assessing the patient the provider determines that adequate progress toward treatment goals has been made, plans to build upon these achievements need to be made, which may include transitions to other services and recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals need to be performed if progress toward agreed upon goals is not being made within a reasonable time.

LPHAs and SUD counselors must have the appropriate experience and training before conducting both screening, assessment, and medical necessity determinations.

Who is considered an LPHA?

- **Physician**
- **Nurse Practitioner**
- **Physician Assistant**
- **Registered Nurse**
- **Registered Pharmacist**
- **Licensed Clinical Psychologist**
- **Licensed Clinical Social Worker**
- **Licensed Professional Clinical Counselor**
- **Licensed Marriage and Family Therapist**
- **Licensed-Eligible LPHA: Working under the supervision of a licensed clinician**

Process for Determining Medical Necessity

Verification of Medical Necessity

Medical necessity must be verified by a Licensed Practitioner of the Healing Arts (LPHA) via a face-to-face review or by telehealth or by telephone with the individual conducting the assessment (e.g., SUD counselor). The face-to-face or telehealth review must at minimum involve the LPHA verifying and signing off on medical necessity in a face-to-face or telehealth or telephonic collaboration with the SUD counselor who conducted the assessment. The review may include the patient, although it is not required.

The LPHA is required to document separately from the Problem List (non-OTP settings) or the Treatment Plan (OTP Settings) the basis for the diagnosis in the form of a Miscellaneous Note within thirty (30) calendar days of each patient's treatment admission date. The basis for the documenting a diagnosis made by an LPHA should align with the scope of practice for making diagnoses as regulated by that LPHA's relevant licensing board. The basis for the diagnosis, or qualification under EPSDT, should include a statement that the patient's personal, medical, and substance use history were reviewed. The Miscellaneous Note must be signed and dated, then submitted in the patient record in Sage.

Timeliness of Medical Necessity Determination

The LPHA must determine medical necessity as outlines below:

- **For patients in residential treatment settings:**
  Within 7 calendar days of first service or first intake appointment for adults (age 18+)
  OR
  Within 14 calendar days of first service or first intake appointment for youth (ages 12-17)

- **For patients in non-residential (e.g., outpatient) treatment settings:**
  Within 30 calendar days of first service or first intake appointment for adults (ages 21+)
  OR

Within 60 calendar days of first service or first intake appointment for youth (ages 12-17) and young adults (ages 18-20), and for those adults (age 21+) who are documented as experiencing homelessness.

Providers need to make every effort to complete the assessment with the shortest duration possible. The initial assessment with the patient shall be performed vis face-to-face or by telehealth (where the patient is in the community or in the home) by an LPHA, licensed eligible LPHA, or registered/certified counselor, as this will ensure admission to the appropriate LOC. If the completed assessment findings indicate no qualifying SUD diagnosis (except under EPSDT as defined above) to establish medical necessity, services are reimbursable under DMC is within the 30- or 60-day initial assessment period timeline by using a qualifying International Classification of Diseases Tenth Revision (ICD-10) code such as "other specified", "unspecified", or "factors influencing health status and contact with health services" conditions.

Providers must include a Miscellaneous Note in the individual patient record detailing:

1. reason(s) for being unable to meet the 30- to 60- timeline;
2. basis for the status of the diagnosis and establishment of medical necessity; and/or
3. homelessness status if seeking up to 60-days to complete the initial assessment.

If a patient withdraws from treatment prior to establishing a DSM diagnosis for Substance-related and Addictive Disorders, and later returns, the 30- to 60-day time period starts over. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes.

Reimbursement and Diagnosis Codes

During the initial assessment period (between 30- to 60-days depending on the population), provisional diagnoses are used prior to the determination of a diagnosis or in cases where suspected SUD has not yet been diagnosed. An LPHA may document and categorize a suspected SUD under "Other Specified" and "Unspecified" disorder or "factors influencing health status and contact with health services" (*Z-codes*). Diagnoses shall be updated by an LPHA as clinically appropriate when beneficiary's condition changes to accurately reflect the beneficiary's needs.

Services for covered services are reimbursable[4] even when:

1. Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met;
2. The assessment determines that the beneficiary does not meet the DMC-ODS access criteria after the assessment;
3. Prevention, screening, assessment, treatment, or Recovery Services were not included in an individual treatment plan (in OTP settings) or lack of patient signature on the treatment plan in OTP settings; and/or
4. The beneficiary has a co-occurring mental health disorder.

Timeliness of Medical Necessity Re-verification

For each patient to receive ongoing SUD services, the LPHA must monitor each patient's response to SUD treatment to determine medical necessity for continued services no later than six (6) months after the

[4] *W&C Code 14184.402(f)*

beneficiary's treatment admission date or from the last justification. The justification of medical necessity must be documented in a Miscellaneous Note and include information on the following:

1. Description of the continued functional impairment in the domains of current use or risk for relapse, medical issues, cognitive-behavioral challenges, motivation for change and current barriers, social and environmental factors
2. Most recent physical exam
3. Progress Notes, Problem Lists (for non-OTP settings), and Treatment Plan goals (for OTP settings)
4. The LPHA's counselor's recommendation for continued treatment
5. Patient progress toward treatment goals

The Miscellaneous Note must be signed and dated by the LPHA, then submitted in the patient record in Sage. In addition, when Medical Necessity Re-verification is required, the provider agency must complete the re-verification process by the end of the treatment episode.

Screening Tools

Screenings are abbreviated evaluations of individuals that allows for a provisional determination about, if, and what types of additional SUD services are necessary and appropriate. These abbreviated assessments are less comprehensive than full assessments and thus do not replace full assessments but are meant to provide reasonable estimation of the type and intensity of SUD services that will be necessary to meet an individual's needs.

Screenings do not contain sufficient information to determine medical necessity because they do not include a DSM diagnosis determination and contain insufficient information regarding the six (6) ASAM dimensions to constitute a comprehensive biopsychosocial ASAM assessment. The only exceptions are in the determination of medical necessity for Early Intervention (ASAM 0.5) Services (using the youth ASAM screening), Recovery Services, and Withdrawal Management.

Allowable Screening Tools

- Youth (Ages 12-17) and Young Adults (ages 18-20)
  - Parent Screener for Youth developed by SAPC (paper-based)
  - ASAM Screener for Youth and Young Adults -- required to qualify for Early Intervention Services (currently paper-based)
- Adults (ages 21+)
  - ASAM CO-Triage Tool
  - SAPC-approved paper-based brief ASAM triage assessment

Assessment Tools

Full ASAM assessments include a comprehensive evaluation of the six (6) dimensions of the ASAM Criteria, in addition to other important clinical elements captured during the assessment interview.

Medical necessity must be determined by a full ASAM CONTINUUM or SAPC Youth ASAM assessment and not solely by a screening tool except for Early Intervention Services which can be determined using the ASAM screener for Youth and Young Adults (ages 12-20) or the ASAM Co-Triage tool for adults in the CENS Adult At Risk Program. Full ASAM assessments include a determination if an individual meets the diagnostic criteria for a SUD from the DSM-5. A full ASAM assessment does not need to be repeated unless the individual's condition changes.

Allowable Full ASAM Assessment Tools

- Youth (ages 12-17)
  - SAPC Youth ASAM assessment
- Young Adults (ages 18-20) and Adults (ages 21+)
  - ASAM CONTINUUM (validated electronic tool)
  - SAPC-approved paper-based full ASAM assessment

Service Benefit and Levels of Care

Addiction treatment is delivered across a continuum of services that reflect illness severity and the intensity of services required. One of the key goals of the County is to facilitate SUD service delivery that is the right service, at the right time, for the right duration, in the right setting. The LOCs need to be viewed as points along a continuum of treatment services, each of which may be provided in a variety of settings.

Referral to a specific LOC must be based on a comprehensive and individualized assessment of the patient, with the primary goal of placing the patient in the least restrictive setting, and consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency. Initial referrals may be accomplished through a brief screening tool with a more comprehensive assessment completed at the treatment program to confirm placement. In Los Angeles County, LOC determinations are based on the ASAM Criteria to organize the assessment and clinical formulation to provide more consistency in LOC determinations. In general, the preferable and most appropriate LOC is one that is the least intensive while still safely meeting the unique treatment objectives of the patient and treatment team.

Level of care determinations begin with the full ASAM multidimensional assessment, which explores patient risks, needs, strengths, skills, and resources. Dimension-specific risk ratings are generated from the assessment process and are used to help inform providers as to dimensional priorities, which are subsequently used for service planning and placement. When physical or mental health conditions are apparent, the need for immediate stabilization should be prioritized and the highest severity problem should determine the patient's entry point into the treatment continuum, whether it is within the SUD system or care (including Opioid Treatment Programs), or in the physical or mental health systems. Treatment is best conceptualized as a flexible continuum, marked by different ASAM LOCs, with graduations of service intensities for residential and Withdrawal Management services (see **Table 6**).

Table 6. SUD Continuum and Levels of Care (LOCs)

SUD CONTINUUM AND LEVELS OF CARE		
Benefits	**ASAM Level of Care**	**Description**
Early Intervention Services	0.5	Appropriate for youth (ages 12-17) and young adults (18-20) who do not meet DSM criteria for a SUD, but who would benefit from psychoeducation and other services to correct or ameliorate a substance related health condition as part of the EPSDT benefits.

Outpatient	1.0	Appropriate for patients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.
Intensive Outpatient	2.1	Appropriate for patients with minimal risk for acute intoxication/withdrawal potential, medical, and mental health conditions, but need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting.
Low Intensity Residential (Clinically Managed)	3.1	Appropriate for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential environment.
High Intensity Residential, Population Specific (Clinically Managed)	3.3	Appropriate for patients with functional limitations that are primarily cognitive, who require a slower pace to treatment, and are unable to fully participate in the social and therapeutic environment.
High Intensity Residential, Non-Population-Specific (Clinically Managed)	3.5	Appropriate for patients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances.
Opioid Treatment Program	1-OTP	Appropriate for patients with an opioid use disorder that require methadone or other medication-assisted treatment.
Recovery Bridge Housing	N/A	Appropriate for patients who are homeless or unstably housed; and are concurrently enrolled in an Outpatient, Intensive Outpatient, Opioid Treatment Program, or Ambulatory Withdrawal Management LOCs.
Recovery Services	N/A	Appropriate for patients in care, during transition in setting or intensity of care, or following discharge from a treatment episode who require additional support to organize internal and community resources for ongoing self-management.
Ambulatory (Outpatient) Withdrawal Management *without* extended on-site monitoring	1-WM	Appropriate for patient with mild withdrawal who require either daily or less than daily supervision in an outpatient setting (e.g., physician's office or clinic).
Ambulatory (Outpatient) Withdrawal Management with extended on-site monitoring	2-WM	Appropriate for patients with moderate withdrawal who require daytime withdrawal management and support. Includes daily assessments (including serial medical assessments documenting withdrawal) in an outpatient setting (e.g., day hospital).
Clinically Managed Residential Withdrawal Management	3.2-WM	Appropriate for patient with moderate withdrawal who need 24-hour support to complete withdrawal management and increase the likelihood of continuing treatment or recovery.

Medically Managed Inpatient Withdrawal Management	3.7-WM	Appropriate for patients with severe withdrawal that requires 24-hour inpatient care and medical monitoring with nursing care and physician visits.
Medically Managed Intensive Inpatient Withdrawal Management	4-WM	Appropriate for patients with severe, unstable withdrawal that requires 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.
Source: American Society of Addition Medicine		

Note: Currently the SAPC provider network does not provide Level 3.7 and 4.0 Intensive Inpatient Services; it only offers 3.7-WM and 4-WM. If the patient screens for level 3.7 or 4.0 Intensive Inpatient Services, then the provider may consider the following options as clinically appropriate:

- **Refer the patient to level 3.7 or 4.0 Withdrawal Management, as medically necessary.**
- **Refer the patient to a general acute hospital for medical treatment or an inpatient psychiatric hospital is the patient requires psychiatric treatment.**
- **Consider a referral to a residential setting, as clinically appropriate.**

Opioid Treatment programs (OTPs; aka Narcotic Treatment Programs) are an essential component of the continuum of care for SUDs. As with other levels of SUD care, ensuring a flow of appropriate referrals between OTPs and other SUD providers, and appropriate referrals into other health systems (if needed), are all critical to high quality OTP services. As such, in addition to the various State and Federal requirements that govern OTPs, the quality and resource management standards and requirements set within the Quality Improvement and Utilization Management (QI and UM) program also pertain to OTPs.

The ASAM Criteria also outlines a continuum of care for Withdrawal Management (also known as detoxification) for adults. Given that severe withdrawal is less common in adolescents than in adults, the approach to withdrawal management for adolescents is unique. When adolescent physiologic withdrawal is evident and when the clinical scenario does not require emergent care, a more integrated approach is ideal, and every effort should be made to provide withdrawal management services in the setting in which adolescent patients are receiving their SUD care. Withdrawal management for adolescent populations will be approved by SAPC on a case-by-case basis.

In cases in which the recommended LOC is not available, which can occur due to a variety of reasons (lack of availability, funding limitations, resource constraints, etc.), providers should arrange for patients to obtain needed services in a different placement.

Effectiveness and safety should be first priority in these circumstances, which may require that patients be placed in higher LOCs than the ASAM Criteria indicates. In these instances, it is the providers' responsibility to advocate for the patient and justify and explain the rationale for the alternative LOC or intervention, based on the available clinical documentation.

Services provided at the various LOCs should reflect the patient's clinical condition, including consideration for severity level and functional impairment. Interventions may include, but are not limited to:
Individual counseling, group counseling, family therapy, patient education, psychosocial interventions, medications for addiction treatment services, collateral services, Care Coordination, crisis intervention, treatment planning, Recovery Services, and discharge services.

As patients transition between levels of service, progress in all six (6) dimensions should be formally assessed at regular intervals to monitor for changes in the patient's condition, in accordance with the patient's severity level and functional impairment, as clinically indicated. These assessments help to ensure that patients are placed in appropriate LOC based on medical necessity, as reviewed and verified by a LPHA. LOC transitions need to be based on clinical need as the patient's condition changes, and not driven by funding source or provider preferences.

Continuity of care and longitudinal follow up are critical for SUD patients. Referrals and linkages to different services and LOCs within the SUD, physical, and mental health systems help to ensure that patient needs are appropriately addressed. High quality care is characterized by the seamless linking or different LOCs, both within the SUD system or care and between other systems of health care. This streamlined system of care can be achieved by Care Coordination, role induction (preparing individuals for treatment by sharing the rationale of treatment, treatment process, and their role in that process), warm hand-offs, and assertive outreach. Providers must also familiarize themselves with other requirements that govern SUD treatment. These include the California Code of Regulations Title 22, Title 9, Alcohol and/or Other Drug Program Certification Standards, DHCS Informational Notices, the provisions of LA County's implementation of DMC-ODS and CalAIM including SAPC Bulletins and Information Notices, and the Contract's Specific Services to be Provided and Definitions of Services.

A brief description of funded services and LOCs are outlined below, however, a detailed description of ASAM levels care is beyond the scope of this document. Providers need to refer to *The ASAM Criteria* textbook or other resources for additional information.

Care Coordination

Care Coordination, formally referred to as Case Management, is a collaborative and coordinated approach to the delivery of health and social services that links patients with appropriate services to address specific needs and achieve treatment goals. Care Coordination is a patient-centered service that is intended to complement clinical services, such as individual and group counseling, to address areas in an individual's life that may negatively impact treatment success and overall quality of life. Care Coordination offers support services to patients to increase self-efficacy, self-advocacy, basic life skills, coping strategies, self-management of biopsychosocial needs, benefits and resources, and reintegration into the community.

Guiding principles[5] for Care Coordination are the following:

- Patient-centered and should be primarily focused on meeting the varied needs of patients;
- Provides a point of contact between health and social services;
- Provides advocacy by acting in the patient's best interests;
- Helps patient navigate and obtain community resources, and integrate into the community after discharge from inpatient or residential services;
- Culturally sensitive;
- Flexible; and
- Anticipatory and understands that SUDs may be chronic and relapsing.

[5] *SAMHSA (US); 2000. (Treatment Improvement Protocol (TIP) Series, No. 27.) Chapter 2 – Applying Case Management to Substance Abuse Treatment.*

Care Coordination is available to all patients who enter the SUD treatment system. This service is available throughout the treatment episode and may be continued during Recovery Services. Care Coordination services may be provided face-to-face, by telephone or by telehealth, with the patient.

Description of Care Coordination and Services

Care Coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the patient with linkages to services and supports designed to restore the patient to their best possible functional level. The primary goal of Care Coordination is to ensure patients in SUD treatment receive the necessary support and services available to be successful in meeting treatment and recovery goals. Since patients in SUD treatment have an array of service needs and interact with multiple systems, one barrier to successfully completing treatment may be a lack of communication and established referrals procedures between health and social systems. Care Coordination is effective at keeping individuals engage in treatment and moving toward recovery by addressing other problems concurrently with substance use.[6] Care Coordination services are especially important for patients with chronic health problems, co-occurring disorders, those experiencing homelessness or who are involved with the criminal justice system.

To successfully link patients to services and resources (e.g., financial, medical, or community services), care coordinators must have a working knowledge of the appropriate resources, both at the system and the service levels, to refer patients to relevant networks of support. Services provided through Care Coordination are this tailored to facilitate continuity of care across all systems of care and provide extensive assessment and documentation of patient progress toward self-management and autonomy.

Although an important component of Care Coordination in SUD treatment is connecting patients to outside systems of care, such as physical and mental health systems, Care Coordination is equally important in transitioning patients through the SUD system of care. Comprehensive SUD treatment often requires that patients move to different LOCs within the SUD continuum, and care coordinators help to facilitate those transitions.

There are three (3) core Care Coordination functions that providers should perform to ensure successful treatment outcomes and recovery: **Connection**, **Coordination**, and **Communication**. Although not an exhaustive list, please see **Table 7** for a list of the three (3) functions and the respective activities that can be performed and billed under Care Coordination.

- **Connection**: Establishing connections through referrals that link patients to housing, educational, social, prevocational, vocational, rehabilitative, or other community services. This includes providing high-quality referrals and linkages for patients to necessary resources and services necessary to address the problems documented on the Problem List (for non-OTP settings) or in the Treatment Plan (OTP settings), which provides Care Coordination needs. High-quality referrals and linkages require the care coordinator to plan an active role in reducing access barriers and ensure patients have ‘actual’ access to needed services. This means going beyond the distribution or resource lists to patients and actively establishing relationships and protocols with external providers to ensure patients will be connected with agencies – and services upon referral.

[6] *SAMHSA (US); 2000. (Treatment Improvement Protocol (TIP) Series, No. 27.) Chapter 4 – Evaluation and Quality Assurance of Case Management Services.*

In addition, care coordinators must assist patients with applying for and maintaining health and public benefits (e.g., Medi-Cal, My Health LA, Minor Consent Program, General Relief and LA County (County) funded programs/projects). This includes helping patients who have moved and must transfer their Medi-Cal benefits from the previous county of residence to LA County.

- **Coordination**: Care Coordination is intended to address the fragmentation of care and help patients better navigate and access treatment across the different systems of care. Care coordinators perform Care Coordination by acting as a bridge between health and human service providers to ensure that information is appropriately exchanges, and patients are successfully linked to needed resources/services. Activities include helping patients set up medical appointments, providing that SUD providers at the treating agency are aware of services being conducted by other health providers and following up with patients in service transition or notable events. For example, care coordinators should follow up with patients within a few days of an emergency room visit, hospital discharge, or discharge from a residential facility. As SUD patients interact with multiple systems, it is the responsibility of care coordinators to help improve the accessibility of services for the patient by reducing barriers between care delivery settings.

  Additionally, care coordinators should coordinate successful transitions between SUD LOCs, including setting up an assessment appointment, transferring necessary documentation to the receiving treatment agency, and providing a warm hand-off for necessary services. If patients are transitioned to a higher or lower LOC at a different treatment agency, the care coordinator should use the SBAT to identify providers that meet the individualized needs of the patient. Care coordinators are expected to schedule appointments and monitor referrals until obtaining confirmation that patients have enrolled at the receiving treatment agency.

- **Communication: Communication is the primary way in which Care Coordination activities are successfully performed.** Patients in the SUD system of care receive services for various service providers, and it is the responsibility of care coordinators to be a line of communication between patients and others. Communication may include telephone, emails, letters, and progress notes and/or reports to the County, State, and other service providers on behalf of the patient. For example, a patient may need a letter sent to a judge verifying that they are participating in SUD treatment. At times, care coordinators must also advocate on behalf of patients. If patient service needs are not being met, care coordinators will educate patients in their rights and advocate for patients with their service providers.

Table 7. Core Functions of Care Coordination

The 3 Cs of Care Coordination
1. **CONNECTION: Referrals that link patients to housing, education, social, prevocational, vocational, rehabilitative, or other community services** • **Establishing and Maintaining Benefits** ○ Helping patients to apply for the maintain health and public benefits (e.g., Medi-Cal, My Health LA, Minor Consent Program, General Relief, Perinatal, Housing, etc.). ○ Conducting the Coordinated Entry System (CES) Survey Packet including: Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SDAT) for adults; or the Next Step Tool for youth. ○ Transferring benefits for the previous county of residence to LA County for patients who have moved. • **Community Resources** ○ Coordinating with ancillary services to provide individualized connection, referral and linkages to community-based and governmental services and supports that can maximize independence and support recovery goals, including referrals to local food banks and/or community churches for groceries and meals, clothing assistance, educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child care, child development, family/marriage education, cultural sources and mutual aid support groups.
2. **COORDINATION:** Acting as a liaison to aid transitions of care and arranging for health services and social services. • **Transitioning between SUD Levels of Care (LOCs)** ○ Facilitating necessary transitions in SUD LOCs (e.g., from Residential to Intensive Outpatient treatment, Outpatient to Recovery Services, etc.), including initiating referrals to the next level or care, and coordinating with and forwarding necessary documentation to the accepting treatment agency. • **Mental and Physical Health Services** ○ Coordinating care with physical health (including managed care health plans such as L.A. Care and Health Net), community health clinic and providers, mental health care providers to ensure a coordinated approach to whole person health service delivery by monitoring and supporting care of comorbid health conditions. • **Social Services** ○ Coordinating with state and County entities (Department of Public Social Services [DPSS], Department of Children and Family Services [DCFS], Probation, Superior Courts, Housing Providers, etc.) to ensure the social aspects of health and well-being are being coordinated with health services.

3. **COMMUNICATION: Correspondence, including emails, letters, and reporting documentation, by the care coordinator to the County, State, and other service providers on behalf of the patient.**
    - **Health Providers**
        - Communicating with physical health (including managed care health plans such as L.A. Care and Health Net), community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.
        - Monitoring and following up with other agencies regarding scheduled services and/or services received by patients.
    - **Service Partners**
        - Communicating with DPSS workers, DCFS social workers, Department of Mental Health (DMH) workers, LA Superior Court, Probation Officers, Housing Providers, etc., to align objectives and activities.
    - **Advocacy**
        - Advocating for patients with health/social service providers, County and community partners, and others (such as officials at schools, juvenile or adult court hearings and/or meetings with corrections staff, and Student Attendance Review Boards or other school-related hearings) in the best interests of patients (e.g., respectfully advocating for necessary services to be provided in a timely manner).

Care Coordination Considerations for People in Vulnerable Groups

People with special needs require more intensive Care Coordination activities. Moreover, some County agencies (DCFS, DPSS, Law Enforcement, LA Superior Court, etc.) may require providers to submit additional documentation and perform additional activities (e.g., attending court hearings or meeting with case workers to advocate on the patient's behalf).

These groups include people living with HIV/AIDS, mental illness, homelessness, are pregnant and parenting women, adolescents, and the criminal justice-involved. Each population will require coordination activities to help an individual effectively navigate, access, and participate in an appropriate SUD LOC, access health and mental health services, secure housing, and obtain other supportive services.

People Experiencing Homelessness

Care Coordination is a planned, collaborative approach to ensuring that people experiencing homelessness (PEH) get the services and supports that they need to move forward with their lives. A patient-centered Care Coordination approach ensures that PEH participate in identifying goals and service needs, and that there is a shared accountability with the care coordinator. The goal of Care Coordination is to empower people, draw on their strengths and capabilities, and promote an improved quality of life by facilitating timely access to the necessary supports to help them obtain and maintain housing. To be successful, care coordinators need the right skills and adequate community knowledge. Therefore, it is recommended that care coordinators take the Direct Service Training Curricula Courses provided by the Los Angeles Homeless Services Authority (LAHSA) Centralized Training Academy. These courses emphasize the application of, and adherence to, the evidence-based practices of Trauma-Informed Care, Cultural Humility, Housing First, Harm Reduction, Motivational Interviewing, and Critical Time Intervention.

The courses address how care coordinators of various skill levels can apply these practices to tailor services towards caring for members of the following subpopulations: chronically homeless, single adults, families,

Transitional Age Youth (TAY), TAY families, women, LGBTQA+ people with disabilities, domestic violence/intimate partner violence (DV/IPV) survivors, human trafficking survivors, the aging and the elderly, incarceration/re-entry, and Veterans.

Housing Assessment and Intervention Options

Housing Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. An individual's environment is oftentimes a critical component of the ability to achieve and maintain recovery from SUDs. Therefore, care coordinators should begin the process of identifying and securing permanent housing for PEH **immediately** upon treatment admission, but no later than three (3) calendar days after admission. This timeframe is intended to allow care coordinators enough time to work with patients to fine an appropriate housing placement. All care coordinators must be trained to problem-solve, screen, and assess patients using the Coordinated Entry System (CES) problem-solving practice and CES Triage Tools. Additionally, all care coordinators should have access to the Homeless Management Information System (HMIS).

Within three (3) calendar days if admission for patients identifying as homeless, care coordinators must initiate the following:

1. **Develop a Housing Plan:** The patient-focused housing plan documents all the steps both the patient and the care coordinator will take to support the patient to move towards stable housing. The housing plan serves as a road map of services that are needed and to be provided, actions that need to be taken by both the care coordinator and the patient, and referrals that need to be made that address the patient's housing barriers. The care coordinator must develop a housing plan for every patient who is identified as homeless or unstably housed. The care coordinator must engage with the patient and work together in identifying the housing barriers and challenges that prevent the patient from achieving housing stability. Once the barriers and challenges are identified, the care coordinator and patient will work to identify:

    1) Steps needed to mitigate those barriers to housing,
    2) The patient's strengths and the steps to build on those strengths,
    3) The services and resources available and the paths to access them.

    While the long-term objective is to achieve and maintain stable permanent housing, this may not always be possible within the timeframe the patient receives SUD services. Therefore, the care coordinator must propose interim housing options, including emergency housing so the patient does not return to homelessness upon discharge. The care coordinator should work with the patient's need since it requires continued SUD treatment and abstinence from drugs/alcohol. Therefore, an interim housing program with a harm reduction approach may be more appropriate.

    The housing plan should include both short-term and long-term goals and objectives with reasonable timeframes to achieve them. The purpose for this breakdown is to make the goals and objectives in the housing plan more manageable. The goals can address housing, income through benefits and/or employment, money management and budgeting, and improving physical, mental, and/or SUD health. The goals must be patient-led and flexible for adjustments as the patient's circumstances change with the care coordinators providing support, information of resources, assistance with linkage to services. The care coordinator must have an in-depth knowledge of available housing, social, and community services and programs.

A housing plan should include the following:

- A list of housing options. This should include interim housing and shelters, as well as permanent housing. Each housing option should list the requirements to be admitted within a feasible timeframe.
- A summary of three (3) achievable goals or objectives identified by the patient that will help them achieve and maintain stable housing. Expand on each goal or objective with practical and tangible action steps that can be completed in a reasonable timeframe and will allow them to be met. Clearly state is the patient or the care coordinator is responsible for each goal and action step.
- A list of available social and housing programs and/or services with a plan or information of requirements that will enable the patient to link with these resources.
- Any challenges that were encountered that may have delayed or prevented action steps to be completed, and what will be done to resolve the setbacks. Care coordinators should utilize Motivational Interviewing techniques to brainstorm solutions with the patient to address the setbacks.
- Upon the completion of a goal, a new one should be set with the appropriate action steps and necessary resources and services listed, as needed.

At a minimum, care coordinators must collaborate with the patient once a month to review any changes in status and make regular updates in the housing plan until the patient transitions to stable housing. The housing plan, relevant notes, and updates should be entered in Miscellaneous Notes in Sage.

2. **Engage in Problem-Solving:** Problem-Solving is a national short-term housing intervention approach that seeks to assist PEH to identify options to maintain their current housing or identify an immediate and safe housing alternative within their family, friends, and social support network. Care coordinators should attempt to divert patients that can self-resolve their housing instability away from CES. The Problem-Solving practice should be the first intervention with every patient who presents with a housing crisis before any formal, documented assessment occurs. Care coordinators and patients should engage in deliberate (and multiple) thoughtful and individualized conversation(s) that seek to uncover unique strengths, existing supports, and needs of the patient to resolve their housing crisis as quickly as possible. The individualized conversation is the first step in a phased assessment approach that should not be reliant on any checklist of form. Problem-Solving should be considered an ongoing intervention and may require multiple conversations that rely on the ability of care coordinators (through guided conversation and deep listening) to collaborate with patients, helping them to regain control over their situation and identify their own solutions without relying on the CES.

   Problem-Solving activities should include active listening, coaching, motivational interviewing, mediation and conflict resolution with families/friends and/or landlords, connection to mainstream resources, housing search assistance, housing stabilization planning, and family reunification. Problem-Solving may include financial assistance through the Problem-Solving Assistance Funds (PSAF), available through the CES Access Centers. Care coordinators must complete the free web-based Problem-Solving Training Series through LAHSA's Centralized Training Academy.

3. **Connect Patient to the Coordinated Entry System (CES) if Problem-Solving is not successful:** The Los Angeles CES works to connect the highest need, most vulnerable persons in the community to

available housing and supportive services equitably. All providers should ensure that care coordinators are familiar with CES and the CES Access Centers within each of the eight (8) SPAs.

If the patient is unable to self-resolve through Problem-Solving, then the treatment provider care coordinator must utilize the CES to connect the patient to housing. The CES prioritizes housing eligibility and homeless assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it. Prioritization is determined by the vulnerability acuity score that is generated from completing the CES Triage Tool. These Triage Tools are critical to assessing housing options. The CES Triage Tools assess PEH based on their physical and behavioral health needs to match them with appropriate housing intervention and services. The CES Triage Tools are based on the Vulnerability Index-Service Prioritization Decision Assistance Tool, or VI-SPDAT:

- The CES Survey Packet for adults
- The Next Step Tool for youth

Within LA County, HMIS is used in the coordinated entry process for homeless assistance providers to coordinate care, manage their operations, and better serve their patients. The HMIS is a secure online database that enables organization to collect patient-level, system wide information on the services they provide to PEH and those who are at risk at homelessness. The care coordinator will use HMIS to collect the most correct patient information to best match them to the services available in the CES.

The care coordinator must check if the patient has a profile in the HMIS system:

1. If there is no record of an existing profile, providers will initiate a patient record in HMIS and complete the appropriate and the most recent version of the CES Triage Tools.
2. If the PEH has a patient profile in HMIS, and a completed CES Triage Tool score in HMIS, and additional CES Survey Packet does not need to be administrated unless the care coordinator believes the result of the score does not accurately reflect their vulnerability, because:
    a) Their life circumstances have changed,
    b) Their triage tool result contains errors, or
    c) Because their condition limits their ability to respond to the questions on the triage tool.

    The care coordinator must use the CES Triage Tool Score Revision Worksheet to update the patient's assessment. This document can be found in LAHSA's Document Library at www.lahsa.org/documents
3. If a care coordinator is not trained to administer the CES Triage Tools and does not have access to HMIS, the care coordinator must refer and set-up an appointment to the adult or youth CES Access Centers within the same SPA and within three (3) calendar days of admission.
4. For patients who are homeless along with their families, the care coordinator will call 211 and refer them to the Family Solution Centers within each of the eight (8) SPAs countywide, within three (3) calendar days of admission.

4. **Enter or update the Point of Contact:** Care coordinators must enter and update patient's information and Point of Contact every 90 days in HMIS to ensure that the patient remains in the queue for a housing participant can be reached in the event of a potential match to a housing resource. Points of Contact work to:

    1) Connect patients to services and resources in support of a successful housing placement,

2) Provide document collection support, and
3) Provide a warm handoff to any services and resources made available.

The Point of Contact may change while on the path to permanent housing. The current Point of Contact should ensure that the patient has a new designated Point of Contact and that the patient profile is updated in HMIS. For example, a patient's transitioning from Residential to Outpatient treatment would necessitate a change in the Point of Contact. See **Table 8** for additional information about identifying a Point of Contact.

Table 8. Point of Contact

Designing or Updating a CES Patient's Point of Contact	
Designating a Point of Contact	The care coordinator will serve as the Point of Contact for patients on their caseload. To enter a Point of Contact, complete the following steps: 1. Open HMIS and go to Client Profile Page 2. Add Point of Contact fields (Date, Name, Phone, Email, Agency, Program)
Reviewing a Point of Contact Before 90 Days	The Point of Contact for CES patients must be confirmed when there is a change or updated at least 90 days to remain active in the Community Queue for resource matching. After 90 days without an update, the patient will become inactive in HMIS. Records can be made active again when the Point of Contact is updated. 1. Open HMIS and go to Patient Profile 2. Revise Date
Updating a Point of Contact After Loss of Communication	When the Point of Contact is no longer able to contact the CES patient and/or to perform the roles and responsibilities of a Point of Contact, the contact fields should be deleted. 1. Open HMIS and go to Patient Profile 2. Delete Point of Contact fields (Date, Name, Phone, Email, Agency, Program)
Updating a Point of Contact During an Extended Leave	When the Point of Contact plans an extended absence, he/she should work to ensure coverage for any of his/her CES patients by adding a secondary point of contact within their agency, when there is not already a second Point of Contact recorded. 1. Open HMIS and go to Patient Profile 2. Add Point of Contact fields for secondary Point of Contact (Date, Name, Phone, Email, Agency, Program) 3. Delete Point of Contact fields for original Point of Contact (Date, Name, Phone, Email, Agency, Program)
Updating Points of Contact When There are Two	• Open HMIS and go to Client Profile • If 2 Points of Contacts are already recorded, confirm that both contacts are still working with the patient. • Delete and Point of Contacts that are out of date. • If both are still active, delete the oldest record and replace it with the new Point of Contact's information (Date, Name, Phone, Email, Agency, Program)

- **Assist in Document Readiness:** While the patient waits to be matched to a housing subsidy, care coordinators should prepare the patient for housing by collecting housing readiness documents. The goal is to efficiently and effectively connect and coordinate people through CES; however, the timeframe and process for a patient to be matched and enrolled in permanent housing can be lengthy. Housing Readiness documents including the following:

    - Government-issued identification documents (e.g., social security card, identification card, driver's license, and birth certificate)
    - Proof of income and/or benefits (needs to be obtained monthly, it expires every 30 days)
    - Verification of homelessness and disability if any

    Once, the documents are obtained, they should be uploaded to HMIS. The verification of homelessness and disability forms can be found on the LAHSA website.

- **Assist in Matching:** Once there is a housing match, the care coordinator must connect and coordinate with the patient and CES Matcher to complete the housing application, accompany the patient to housing appointments and/or leasing appointments, and provide other support associated with the housing placement process. Activities that assist patients with accessing housing resources and securing stable housing are billable under the Care Coordination benefit.

Criminal Justice-Involved Patients

Care coordinator should communicate with criminal justice staff (e.g., Probation, Sheriff, Los Angeles Superior Courts, etc.) to ensure that Care Coordination activities meet the respective criminal justice supervision requirements of the referring agency. As needed, care coordinators may be asked to perform the following activities:

- Attend court hearings to report progress in treatment
- Arrange letters, phone calls, and/or direct face-to-face meetings with law enforcement agencies (probation Department, Sheriff's Department, and Parole) and courts (Superior Courts) about patients
- Enter data into non-Sage electronic systems (e.g., TCPX and Drug Court Management Information System (DCMIS), Probation Department web-based reporting system)

See *Los Angeles County Superior Court Referrals, Treatment Program Procedures for Probation Referrals,* and *Los Angeles County Sheriff's Department – Substance Treatment and Re-entry Transition (START-Community) Referrals* sections for more information.

Children and Family Services

For patients that participate in County funded programs for children and family services, one of the primary focuses for providers should be the family unit (e.g., helping patients meet requirements set forth in their family reunification plan). Therefore, Care Coordination activities should help patients gain access to services and resources that consider family needs. Care Coordination activities for this group may include linkage to parenting classes, childcare, food and clothing assistance, and family planning services.

When working with children, families, and perinatal women, the care coordinator should confer with the patient's DPSS worker, DCFS social worker, DMH worker, etc., at least once to ensure that the objectives and activities developed in Care Coordination are consistent and do not unintentionally overwhelm the patient.

See *Department of Public Social Services (DPSS) – California Work Opportunity and Responsibility to Kids (CalWORKs) Referral*, *Department of Children and Family Services – Family Dependency Drug Court (FDDC)*, and *Pregnant and Parenting Women* sections to learn more about these populations and requirements.

Service Requirements and Components

Eligibility Criteria for Care Coordination Services

Care Coordination services are available to all patients who are enrolled in all LOCs under the DMC-ODS. Reimbursement eligibility criteria for Care Coordination services are the same as DMC-ODS enrollment criteria.

Staffing Requirement

The care coordinator must be registered/certified SUD counselors and/or LPHAs.

Documentation

Planning and documentation are important to a structured and integrated Care Coordination model. Following the comprehensive and multidimensional ASAM CONTINUUM or SAPC Youth ASAM assessment, which should include a patient's Care Coordination needs, a care coordinator must discuss the results and collaborate with the patient to develop a plan that includes the patient's Care Coordination needs. The plan should address the problems documented on the patient's Problem List (non-OTP settings) or Treatment Plan (OTP settings).

The Care Coordination plan should include tracking key components of service, including Care Coordination needs, Connection/Coordination/Communication activities, and advocacy efforts. Regular Miscellaneous Notes clearly documenting Care Coordination activities are critical to demonstrating the rationale and details of the activities performed. Care coordinators are responsible for working with patients to implement a Care Coordination plan the addresses the problems listed on the Problem List (non-OTP settings) or Treatment Plan (OTP settings) and monitor the patient's progress.

Care Coordination should be documented within the clinical notes in the medical record and should include a description of the patient's relevant resources and prioritized service needs, a quantifiable statement of the patient's short-term and long-term goals, planned activities, desired outcomes, and target completion dates. When appropriate, the clinical notes should describe barriers, contingencies for anticipated complications, or alternative plans to achieve stated objectives on which the care coordinator should focus.

Although evaluating for Care Coordination needs, discussing the Care Coordination component of the plan of care, and carrying out Care Coordination activities can be billed under Care Coordination, Problem List (non-OTP settings) or Treatment Plan (OTP settings) development and updates are not a part of Care Coordination and should only be billed under the Treatment Plan billing code.

Service Hour Requirements

This standalone benefit applies to most LOCs, with the exception of Withdrawal Management Levels 3.7, and 4.0, where the benefit is incorporated into the date rate and is not a separate billable service. Care Coordination services may be delivered face-to-face, by telephone or through telehealth supportive services.

Care Coordination services shall be consistent with the confidentiality of patients as set forth in 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records; CFR 438 Managed Care; HIPAA; California Code of Regulations (CCR) Title 9 Counselor Certification; and CCR Title 22 Drug Medi-Cal, and appropriate releases of information should be obtained for care coordination that accords with these regulations.

Early Intervention Services for Youth and Young Adults (ASAM 0.5)

Early Intervention services are covered DMC services under EPSDT (ASAM 0.5) are appropriate for youth (ages 12-17) and young adults (ages 18-20) who have been screened and determined to be at risk of developing an SUD (i.e., but who do not meet DSM criteria for a SUD) and would benefit from psychoeducation (using the Healthy Youth Early Intervention Curriculum) and any other services covered under the outpatient LOC as early intervention services and in accordance with the EPSDT benefit to correct or ameliorate a substance use condition. This includes services that sustain, support, improve or make more tolerable an existing substance misuse or a SUD condition. The Early Intervention services benefit includes receipt of any DMC reimbursable service available in outpatient settings. (See *Treatment Service Components* section for a description of service components available in Early Intervention and outpatient treatment settings).

Early Intervention services are provided in an outpatient modality and must be available as needed based on individual clinical needs, even if the beneficiary is not participating in the full array of outpatient treatment services. A full assessment utilizing the ASAM criteria is not required for a DMC beneficiary to receive Early Intervention services. To establish medical necessity for Early Intervention services, providers must screen youth and/or young adults using the “ASAM Screener for Youth and Young Adults”.

While a SUD diagnosis is not required to provide Early Intervention services, claims for Early Intervention services must include a CMS approved ICD-10 diagnosis code. For example, these include codes for “Other specified” and “Unspecified” disorders, or “Factors influencing health status and contact with health services”. The youth rate modifier is only available to youth network providers for Early Intervention services. If the beneficiary meets diagnostic criteria for a SUD, a full ASAM assessment must be performed, and the beneficiary must receive a referral to the appropriate LOC indicated by the assessment.

In collaboration with Azusa Pacific University, SAPC developed the Healthy Youth Early Intervention Curriculum which is an evidence-based psychoeducational program designed to provide brief, developmentally appropriate interventions to help youth struggling with substance use behaviors improve their overall physical, mental, and social health and wellbeing. The curriculum is the main psychoeducation component to be delivered under Early Intervention services. All youth network treatment providers must complete the required training on the Early Intervention curriculum in order to submit claims for Early Intervention services. In addition, beginning July 1, 2022, adult treatment providers that provide Early Intervention services to young adults (ages 18-20) must also complete the required training on the Early Intervention curriculum by June 30, 2023 in order to submit claims for Early Intervention Services.

Service Hour Requirements

Treatment services at this LOC include screening, assessment/intake [if applicable], treatment planning, and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including provision of, or referral to MAT for alcohol and opioid abusers, unless patient refusal is documented in progress notes), alcohol/drug testing, Recovery Services, discharge services, and Care Coordination.

Early intervention services are delivered as medically necessary and appropriate to ameliorate or correct a substance use condition and may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone.

Outpatient Treatment (ASAM 1.0)

ASAM 1.0 treatment services are those alcohol and drug treatment services which are provided in an environment that facilitates recovery, directed towards alleviating and/or preventing alcohol and drug problems. ASAM 1.0 treatment services do not require residency at an agency's facility as part of the treatment and recovery process. Services are provided to individuals when medically necessary.

This LOC is appropriate for patients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.

Service Hour Requirements

Treatment services at this LOC include screening, assessment/intake treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including provision of, or referral to MAT for alcohol and opioid abusers, unless patient refusal is documented in progress notes), alcohol/drug testing, Recovery Services, discharge services, and Care Coordination.

At least two (2) hours of Treatment Services must be provided per month, and up to:

- Six (6) hours per week for youth (ages 12-17)
- Nine (9) hours per week for young adults (ages 18-20) and adults (ages 21+)

Services may exceed the maximum based on individual clinical need. Services may be provided in person, or via telehealth services for individuals who consent to receive SUD services. Some services may be provided via telephone. See *Service Delivery Options* for details.

Providers are required to either offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services.

Intensive Outpatient Treatment (ASAM 2.1)

ASAM 2.1 treatment services are appropriate for patients with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. It is appropriate for patients who need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting. Services are provided to individuals when medically necessary.

Service Hour Requirements

Treatment services at this LOC include screening assessment/intake, treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including provision of, or referral to MAT for alcohol and opioid abusers, unless patient refusal is documented in progress notes), alcohol/drug testing, Recovery Services, discharge services, and Care Coordination.

Treatment services must be provided between:

- Six (6) and 19 hours per week for youth (ages 12-17), more than 19 hours per week may be provided when determined to be medically necessary and when a higher LOC is not clinically appropriate, service hours can exceed the maximum 19-hours and are submitted under DMC claims.
- Nine (9) and 19 hours per week for young adults (ages 18-20) and adults (ages 21+), more than 19 hours per week may be provided when determined to be medically necessary.

If it is determined that the patient no longer consistently requires at least 6- to 9-hours of service per week, they should be stepped down to a lower LOC (e.g., outpatient). Reviews occur to determine if patients are served in the appropriate LOC and if reimbursement needs to be modified based (i.e., reduced to the outpatient rate) based on consistently insufficient number of service hours. Services may be provided in person, or by telehealth services for individuals who consent to receive SUD services. Some services may be provided via telephone. See *Service Delivery Options* for details.

Providers are required to either offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services.

Residential Services

All residential treatment services will primarily be provided in person. Telehealth and telephone services when provided, shall supplement, not replace the in-person service. See *Service Delivery Options* for details. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria.

Each patient shall live on the premises and be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

Providers are required to either offer MAT directly or have effective referral mechanisms in place to clinically appropriate MAT services.

As defined in Title 9, Division 4, Chapter 5: Every resident shall be tested for tuberculosis under licensed medical supervision with six (6) months prior to or thirty (30) days after admission.

> **Incidental Medical Services** (IMS) are services provided at a licensed residential facility by a health care practitioner, or staff under the supervision of a health care practitioner, to address medical issues associated with detoxification, treatment, or recovery services. IMS do not include general primary medical care or medical services required to be performed in a licensed health facility as defined by HSC Section 1200 or 1250.

Low Intensity Residential (ASAM 3.1)

ASAM 3.1 Residential services are 24-hour non-medical, short-term rehabilitation services for patients with a SUD diagnosis. It is appropriate for patients who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment. Importantly, Incidental Medical Services may be approved by the State to allow for MAT and incidental medical services, including Withdrawal Management, to be provided in residential settings. The facility must have a DCHS Level of Care Certification to deliver care under this designation.

Service Hour Requirements

Treatment services at this LOC include screening, assessment/intake, treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including provision of, or referral to MAT for alcohol and opioid abusers, unless patient refusal is documented in progress notes), transportation, alcohol/drug testing, Recovery Services, discharge services, Care Coordination, and room and board.

Patients enrolled in Medi-Cal or My Health LA cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS' policy on the transfer of General Relief (GR) and/or CalFresh benefits to a residential provider. While this policy is under review, SAPC residential providers may continue to collect GR/CalFresh benefits from residential patients and those fees must be reported to SAPC on the year-end cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one 15-minute unit** or Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, treatment planning, Discharge Services, and Care Coordination) or **four to six 15-minute units** for group-based services (Group Counseling and Patient Education) per patient per day. Treatment services must be provided **at least 20 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services must equal at least half of the weekly treatment hour standard (10 hours or 40 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services (**up to 2 hours weekly for both on-site and off-site services**). Please see the Residential Treatment Program bulletin for a more detailed list of approved services. If less than 10 hours or 40 units of services are provided per week, for more than two (ages 12-20) or three (ages 21+) weeks, the patient needs to be stepped down to a lower LOC and further reimbursement will be disallowed. When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in a Miscellaneous Note.

Providers may choose to hold a patient's bed if the patient is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held with only be reimbursed for room and board and will not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Residential services must be preauthorized by SAPC, and patients must meet medical necessity requirements. See **Table 15** for Residential Pre-authorization and Reauthorization Service Limits for more details.

High Intensity Residential – Population Specific (ASAM 3.3.)

ASAM 3.3 Residential services are 24-hour non-medical short-term rehabilitation services for patients with a SUD diagnosis. It is appropriate for patients with functional limitations that are primarily cognitive, who require a slower pace to treatment, and are unable to fully participate in the social and therapeutic environment. These functional limitations may be either temporary or permanent, and may result in problems in interpersonal relationships, emotional coping skills, or comprehension. The facility must have a DCHS Level of Care Certification to deliver care under this designation.

Importantly, Incidental Medical Services may be approved by the State to allow for MAT and incidental medical services, including Withdrawal Management, to be provided in residential settings.

Level 3.3 services are only available to youth on a case-by-case basis, per medical necessity.

Service Hour Requirements

Treatment services at this LOC including screening, assessment/intake, treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding mediations and medication services (including provision of, or referral to MAT for alcohol and opioid abusers, unless patient refusal is documented in progress notes), transportation, alcohol/drug testing, Recovery Services, discharge services, Care Coordination, and room and board.

Patients enrolled into Medi-Cal or My Health LA cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS' policy on the transfer of General Relief and/or CalFresh benefits to a residential provider and will make a final determination soon on whether to grant an exception. While this policy is under review, SAPC providers may continue to collect GR/CalFresh benefits from residential patients and those fees must be reported to SAPC on the yearend cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, treatment planning, Discharge Services, and Care Coordination), or **four to six 15-minute units** for group-based services (Group Counseling and Patient Education) per patient per day. Treatment services must be provided **at least 24 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services must equal at least half of the weekly treatment hour standard (12 hours or 48 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services (**up to 2 hours weekly for both on-site and off-site services**). Please see the Residential Treatment Program bulletin for a more detailed list of approved services. If less than 12 hours or 48 units of service are provided per week, for more than two (ages 12-20) or three (ages 21+) weeks, the patient needs to be stepped down to a lower LOC and further reimbursement will be disallowed. When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in a Miscellaneous Note.

Providers may choose to hold a patient's bed if the patient is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held will only be reimbursed for room and board and will not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Residential services must be preauthorized by SAPC, and patients must meet medical necessity requirements. See **Table 15** for Residential Pre-authorization and Reauthorization Service Limits for more details.

High Intensity Residential – Non-Population Specific (ASAM 3.5)

ASAM 3.5 Residential services are 24-hour non-medical short-term rehabilitation services for patients with a SUD diagnosis. It is appropriate for patients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances. The facility must have a DCHS Level of Care Certification to deliver care under this designation.

Importantly, Incidental Medical Services may be approved by the State to allow for MAT and incidental medical services, including Withdrawal Management, to be provided in residential settings.

Service Hour Requirements

Treatment services at this LOC include screening, assessment/intake, treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including provision of, or referral to MAT for alcohol and opioid abusers, unless patient refusal is documented in progress notes), transportation, alcohol/drug testing, Recovery Services, discharge services, Care Coordination, and room and board.

Patient enrolled in Medi-Cal or My Health LA cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS's policy on the transfer of General Relief and/or CalFresh benefits to a residential provider and will make a final determination soon on whether to grant an exception. While this policy is under review, SAPC providers may continue to collect GR/CalFresh benefits from residential patients and those fees must be reported to SAPC on the yearend cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one 15-minute unit** of Clinical Services is required for individual-based services (intake and ASAM assessment, individual counseling, family therapy, collateral service, crisis intervention, treatment planning, discharge services, and Care Coordination), or **four to six 15-minute units** for group-based services (Group Counseling and Patient Education) per patient per day. Treatment services must be provided **at least 22 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services must equal at least half of the weekly treatment hour standard (11 hours or 44 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services (**up to 2 hours weekly for both on-site and off-site services**). Please see the Residential Treatment Program bulletin for a more detailed list of approved services. If less than 11 hours or 44 units of service are provided per week, for more than two (ages 12-20) or three (ages 21+) weeks, the patient needs to be stepped down to a lower LOC and further reimbursement will be disallowed. When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in a Miscellaneous Note.

Providers may choose to hold a patient's bed if the patient is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held will only be reimbursed for room and board and will not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs.

Residential services must be preauthorized by SAPC, and patients must meet medical necessity requirements. See **Table 15** for Residential Pre-authorization and Reauthorization Service Limits for more details.

Withdrawal Management

Withdrawal Management (WM), also known as detoxification, is a set of treatment interventions aimed at medical and clinical management of acute intoxication and withdrawal from alcohol and other substances, The rationale for WM is to provide the appropriate level of medical and clinical support to allow for patient safety during the withdrawal period, which them allows the patient and treatment team to work together to determine the optimal ongoing treatment strategy. Withdrawal Management Services may be provided in an outpatient, residential, or inpatient setting. If beneficiary is receiving WM in a residential setting, each beneficiary shall reside in the facility. Inpatient treatment services will primarily be provided in-person. Telehealth and telephone services, when provided, shall supplement, not replace the in-person service. See *Service-Delivery Options* for details.

While WM may be an opportunity to initiate lasting abstinence from alcohol and/or other drugs, the primary goal is patient safety to minimize the health risks associated with withdrawal, not long-term abstinence. As such, WM should not be withheld from a patient die to provider uncertainty about their commitment to long-term abstinence.

WM is a critical point within the ASAM continuum of care. All SUD patients, particularly those with alcohol, sedative, and opioid use disorders, should be considered for WM and have access to these essential treatment services. However, in and of itself, WM does not constitute adequate treatment for addiction. Effective WM will increase the likelihood that a patient will complete withdrawal successful to transition to the next stage in the addiction treatment process. Patients who receive WM should be connected with ongoing treatment services.

The science of comprehensive and effective SUD treatment supports the use of medications for WM and the use of MAT during WM and in all other LOCs where patients with SUDs are treated. Research has consistently demonstrated that the use of medications, both in the form of WM and maintenance treatment with MAT, help to improve treatment engagement and SUD outcomes, particularly when combined with evidence-based psychosocial interventions. Providers are required to either offer MAT directly or have effective referral mechanisms to the most clinically appropriate MAT services in place. For this reason, the passive or active discouragement of the use of medications for WM and FDA-approved MAT is contrary to the science of addiction treatment, and WM and MAT must be discussed as a treatment option for all patients for whom it may be appropriate and helpful.

Required components of WM at any LOC include:

1. Intake: At a minimum, the intake process should include thorough evaluation, establishing the diagnosis of a substance withdrawal syndrome and formalizing an individual assessment; may also include physical exam and/or laboratory testing.
2. Observation: At a minimum, a patient must be monitored during the course of withdrawal as frequently as deemed appropriate based on the patient's unique presentation. This may include, but is not limited to, monitoring of the patient's health status.
3. Medication Services: Medications should be offered to all patients for whom there are medication options to help manage withdrawal and help stabilized SUD (e.g., MAT).

4. Documentation or medications prescribed, administered, and/or the assessment of side effects and the results of medication use is required. If medications are available but not utilized, documentation must be provided as to the reason medications were not used (e.g., patient refusal).
5. Discharge Services: As aforementioned, utilizing WM as the only treatment for addiction is clinically inappropriate. Patients should be referred to another LOC following WM, and/or connected to appropriate community treatment (e.g., mental health), housing, or other social service resources, as needed.

Table 9.

Level of Care	ASAM Level	Description
Ambulatory (Outpatient) Withdrawal Management without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.
Ambulatory (Outpatient) Withdrawal Management with Extended On-Site Monitoring	2-WM	Moderate withdrawal with daytime outpatient withdrawal management, support, and supervision in a non-residential setting.
Clinically Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal that is not manageable in outpatient settings and needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
Medically Managed Inpatient Withdrawal Management	3.7-WM	Severe withdrawal; needs 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring.
Medically Managed Intensive Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

Withdrawal Management should consist of three (3) essential features:

1. Assessment of needs
2. Stabilization
3. Facilitation of follow up, including readiness for and entry into SUD treatment

Assessment

1. Assessment of substance withdrawal and substance withdrawal potential needs must occur during every initial SUD assessment when a patient shows up for treatment. This assessment needs to be performed by appropriate personnel operating within their scope of practice and licensure and include a determination of anticipated risks confronting patients that will inform the need for WM, the intensity of services needed, and the most appropriate treatment setting.

2. Patients must be assessed using a full SAPC Youth ASAM assessment, which should result in a determination about if WM services are necessary. If additional clinical assessment information is needed for Dimension 1 (withdrawal potential), additional validated withdrawal assessment tools such as the Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opioid Withdrawal Scale (COWS) may be used to provide additional assessment information.
3. If assessment indicates WM is needed, qualified SUD treatment providers must make a clinical determination of the most appropriate LOC (ambulatory WM vs. residential WM vs. inpatient WM) and explain the WM options, including medication, available to the patient.
4. Individuals recommended for ambulatory (outpatient) WM (e.g., 1-WM or 2-WM) should be at lower risk for complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential or inpatient settings. Assessments need to also take into consideration the unique situations of the individual, the severity of the presenting symptoms, as well as patient preference.
5. In the event the patient is assessed as needing a LOC other than the one provided at the current location, SUD treatment providers have two options:
    1) Call the SASH to schedule an intake appointment with another agency, or
    2) Identify and call another agency directly by using the SBAT to set up an intake appointment.

   SUD treatment providers must make every effort to facilitate a warm hand-off with the receiving treatment agency. The new intake appointment must be re-scheduled within three (3) business days. If the agency does not use the County's EHR, Sage, the assessment results must be sent to the receiving treatment agency either electronically or via fax within 24 hours.

Stabilization

Following a comprehensive assessment of WM needs, the focus of the stabilization period is on developing a plan of care to effectively manage the withdrawal symptoms of the patient, while also considering the potential general medical and psychiatric complications that may accompany withdrawal.

1. The SUD counselor must work with the patient to develop a comprehensive plan of care that considers the biopsychosocial needs of an individual to effectively manage withdrawal symptoms, which may include the use of medications.
2. Stabilization should, when appropriate, consist of a combination of psychosocial intervention and medications.
3. Once it is determined that a patient would benefit from and is interested in MAT, a determination needs to be made about whether the most appropriate intervention is acute management of the withdrawal symptoms either with or without medications, or induction onto agonist (methadone), partial agonist (buprenorphine), or antagonist (naltrexone) maintenance therapy. Assessing this determination early is paramount given that is impacts the interventions used during an individual's care in WM settings. When WM medications are indicated, an evidence-supported approach should be used to select the pharmacological agent, dosage, and route of administration.
4. Although not all individuals will be in a state of mind to effectively engage in behavioral/talk therapy during WM, psychosocial interventions are in important component of the services that should be offered in the withdrawal management setting. Motivational Interviewing, for example, can be skillfully employed during WM to better understand patients' readiness to change and help them progress along the readiness continuum to encourage them to continue with treatment after their withdrawal symptoms are addressed.
5. Throughout WM, qualified staff must continually assess the patient for changes in their condition and health status.

6. The treatment agency must assign a care coordinator to the patient to assist them with the transition process to treatment.

Facilitation of Follow-Up

In and of itself, WM does not constitute adequate addiction treatment and thus patients who receive withdrawal services should be connected with ongoing SUD treatment.

1. As early during the withdrawal process as is feasible and appropriate, SUD providers must engage their patients in discussions about their readiness for change and begin preparing them for entry into ongoing SUD treatment at the next point along the continuum of SUD care. Care Coordination can and should support this LOC transition.
2. This preparation must include engaging the patient in discussion regarding comprehensive SUD treatment and the fact that WM is typically only the first component of treatment, and Care Coordination priorities and activities described in the section above titled *Coordination of Transitions in Care*.

The duration of WM services must be based on individual patient need as determined by qualified personnel operating within their scope of practice and licensure.

Withdrawal Management for Youth (ages 12-17)

Withdrawal Management is generally not indicated for youth because they typically have not consumed substances for sufficient duration, intensity, or frequency to elicit significant withdrawal symptoms. However, instances where WM for youth under age 18 is clinically indicated will be authorized by SAPC on a case-by-case basis.

Ambulatory Withdrawal Management

Ambulatory Withdrawal Management Without Extended Monitoring (ASAM 1-WM)

ASAM 1-WM ambulatory services are provided in outpatient settings for patients with mild withdrawal symptoms. Patients treated in this setting should require no more than a daily or less than daily outpatient supervision and are generally likely to complete Withdrawal Management and to continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an outpatient setting. Patients should be at a lower risk for withdrawal complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential (ASAM 3.2-WM) or inpatient (ASAM 3.7-WM and 4-WM) settings.

ASAM 1-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Staffing

ASAM 1-WM services are staffed by interdisciplinary staff that are appropriately trained and credentialed to assess the patient and manage mild withdrawal. It is important that physicians/prescribers and nurses are readily available to assess, evaluate, and confirm that patients are stable to be managed in an outpatient setting.

Service Requirements

Treatment services at this LOC include screening, assessment/intake, treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, ambulatory detoxification, medication services (including provision of or referral to MAT for alcohol and opioid abusers, unless patient refusal is documented in progress notes), alcohol/drug testing, Recovery Services, discharge services, and Care Coordination.

Ambulatory Withdrawal Management with Extended Monitoring (ASAM 2-WM)

ASAM 2-WM ambulatory services are provided in outpatient settings for patients with moderate withdrawal symptoms. Patients treated in this setting requires daily outpatient supervision and serial medical assessments. They are likely to complete withdrawal management and to continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an outpatient setting. Patients should have access to psychological and psychiatric consultation when needed. Patients should be at lower risk for withdrawal complications and have greater likelihood of successful WM than individuals recommended for withdrawal management in residential (ASAM 3.2-WM) or inpatient (ASAM 3.7-WM and 4-WM) settings.

ASAM 2-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Staffing

The care provided at level 2-WM is delivered by interdisciplinary staff that are appropriately trained and credentialed to assess the patient. As with all other WM LOCs, 2-WM services are medically- and clinically-focused. Although they need not be present at all times, physicians/prescribers and nurses should be readily available to assess, evaluate, and confirm that patients are stable to be safely managed in an outpatient setting.

Service Requirements

Treatment services at this LOC include screening, assessment, assessment/intake, treatment planning, Health Status Questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, ambulatory detoxification, medication services (including provision of or referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), alcohol/drug testing, Recovery Services, discharge services, and Care Coordination.

Residential Withdrawal Management (ASAM 3.2-WM)

ASAM 3.2-WM services are 24-hour short-term rehabilitation services provided in residential settings for patients with moderate withdrawal and who need 24-hour support to successfully complete withdrawal management. Importantly, Incidental Medical Services may be approved by the State to allow for MAT and incidental medical services, including withdrawal management, to be provided in residential settings.

Patients appropriately treated in residential WM settings typically exhibit, have a history of exhibiting, or are at risk for exhibiting moderate withdrawal symptoms with a greater need for support than can be provided in

ambulatory WM settings, but less need for medical supervision and support than is provided in inpatient WM settings.

Staffing

The care provided at level 3.2-WM is medically and clinically focused and is delivered by interdisciplinary staff that are appropriately trained and credentialed to assess the patient and manage moderate withdrawal. Although it is not a requirement that a physician/prescriber be on-site at all times, medical evaluation and consultation is available 24 hours a day. In addition, the facility requires 24-hou care with trained personnel, including awake staff on the overnight shift to address patient needs. It is recommended that a licensed physician/prescriber with specific training in addiction be available for consultation as medically necessary (for example, if a physician/prescriber prescribes and orders a WM taper, the nurse onsite can carry out the order, without the physician/prescriber needing to be onsite). Individuals in 3.2-WM should receive pharmacotherapy integrated with psychosocial therapies. There also must be coordination of necessary services and/or referral to other LOCs (as needed) through direct affiliation or external referral process.

Note: To participate in 3.2-WM, providers are not required to provide MAT services on site. Providers may partner and refer patients to off-site physicians/prescribers for MAT services. ASAM 3.2-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Service Requirements

Treatment services at this LOC include screening, assessment/intake, treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications, and medication services (including provision of or referral to MAT for alcohol and opioid abusers unless patient refusal is documented in progress notes), transportation, alcohol/drug testing, Recovery Services, discharge services, Care Coordination, and room and board (which cannot include financial participation by the patient in the form of payment/transfer of federal, state or local benefits such as Cal Fresh).

Inpatient Withdrawal Management – Medically Monitored (ASAM 3.7-WM)

ASAM 3.7-WM services are short-term medically monitored settings for patients with severe withdrawal that offers 24-hour nursing care and physician visits, as necessary. Patients treated in this setting have severe problems in Dimensions 1, 2, or 3 that require hospital-level care with medical oversight are unlikely to complete WM without medical monitoring. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care. Detoxification of cannabis, stimulants, and/or hallucinogens alone does not require an inpatient level of medical intervention; however, the abuse of multiple substances including alcohol, opioids, and/or sedatives may be considered for inpatient admission.

Criteria for admission to 3.7-WM must include one or more of the following:

1) The diagnosis of alcohol withdrawal delirium that also includes any combination of the following clinical manifestations resulting from cessation or reduced intake of alcohol and/or sedatives:
    a. Hallucinations
    b. Disorientation
    c. Tachycardia
    d. Hypertension
    e. Fever
    f. Agitation
    g. Diaphoresis

2) Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar) score >15
3) A Prediction of Alcohol Withdrawal Severity Scale (PAWSS) score of ≥4 along with a CIWA-Ar score >8
4) Alcohol/sedative withdrawal with CIWA-Ar score >8 and one or more of the following high-risk factors:
    a. A current serum ethanol level over 0.10mg% with an elevated CIWA-Ar >8 (if known)
    b. Serum chloride under 96mEg/L (if known)
    c. Use of multiple substances
    d. History of alcohol withdrawal delirium
    e. Inability to receive necessary medical assessment, monitoring, and treatment at a lower LOC
    f. Medical co-morbidities that make detoxification in an outpatient setting unsafe
    g. History of failed outpatient treatment
    h. Psychiatric co-morbidities
    i. Pregnancy
    j. History of seizure disorder or withdrawal seizures
5) Complications of withdrawal that cannot be adequately managed in the outpatient setting due to:
    a. Persistent vomiting and diarrhea from withdrawal
    b. Dehydration and electrolyte imbalance that cannot be managed in a setting with a lower LOC
6) Complications from withdrawal of stimulants that results in medical or psychiatric conditions that impair patient's stability or drastically reduce the patient's ability to safely participate in treatment.

Substances that confer higher risk of morbidity and mortality (e.g., alcohol, opioids, sedatives) are often more appropriate for inpatient WM than substances with lower risk that may be able to be managed at a lower LOC. Level 3.7-WM and 4-WM are both inpatient LOCs for withdrawal management and offer similar services, with the key difference being in the level and availability of medical staffing available in these settings. Level 4-WM requires greater availability of medical staffing and 24-hour direct observation and nursing care compared to level 3.7-WM. See respective Staffing sections in level 3.7-WM and 4-WM for more details.

ASAM 3.7-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Transitions to and from this LOC are critical and must be managed carefully, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated.

Within the specialty SUD system, ASAM level 3.7-WM includes Chemical Dependency Recovery Hospitals and Free-Standing Psychiatric Hospitals. ASAM level 3.7-WM may also be provided in general acute hospitals, in which case the services are funded through fee-for-service (FFS) Medi-Cal for physical health systems.

Staffing

All 3.7-WM programs are staffed by physicians/prescribers who are available by phone 24 hours per day. A physician/prescriber is needed to assess the patient within 24 hours of admission (or earlier if needed) and is available on-site on a daily basis. The facility requires 24-hor care with trained personnel, including awake staff on the overnight shift to address patient needs. A registered nurse or other licensed nurse in available to do a nursing assessment upon admission and is responsible for oversight of patient's progress and medication administration on an hourly basis (if needed). The level of nursing care is consistent with the severity of patient needs.

Service Requirements

Treatment services at this LOC include screening, assessment/intake treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including provision of MAT directly or by effective referral mechanisms to MAT unless patient refusal is documented in progress notes), transportation, alcohol/drug testing, Recovery Services discharge services, Care Coordination, and room and board (which cannot include financial participation by the patient in the form of payment/transfer of federal, state or local benefits such as Cal Fresh). These services are intended to be individualized to treat functional deficits identified in the ASAM criteria.

Inpatient Withdrawal Management – Medically Managed (ASAM 4-WM)

ASAM 4-WM services are short-term medically managed settings for patients with severe and unstable withdrawal that offers 24-hour nursing care and daily physician visits. Patients treated in this setting are unlikely to complete WM without medical management and have severe problems in Dimensions 1, 2, or 3 that require hospital-level care with medical oversight. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care. Detoxification of cannabis, stimulants, and/or hallucinogens alone does not require an inpatient level of medical intervention; however, the abuse of multiple substances including alcohol, opioids, and/or sedatives may be considered for inpatient admission.

Criteria for admission to 4-WM must include one or more of the following:

1) The diagnosis of alcohol withdrawal delirium (DT) that also includes any combination of the following clinical manifestations resulting from cessation or reduced intake of alcohol and/or sedatives:
    a. Hallucinations
    b. Disorientation
    c. Tachycardia
    d. Hypertension
    e. Fever
    f. Agitation
    g. Diaphoresis
2) Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar) score >15
3) A Prediction of Alcohol Withdrawal Severity Scale (PAWSS) score ≥4 along with a CIWA-Ar score >8
4) Alcohol/sedative withdrawal with CIWA-Ar score >8 and one or more of the following high-risk factors:
    a. A current serum ethanol level over 0.10 mg% with an elevated CIWA-Ar >8 (if known)
    b. Serum chloride under 96 mEg/L (if known)
    c. Use of multiple substances
    d. History of alcohol withdrawal delirium
    e. Inability to receive necessary medial assessment, monitoring, and treatment at a lower LOC
    f. Medical co-morbidities that make detoxification in an outpatient setting unsafe
    g. History of failed outpatient treatment
    h. Psychiatric co-morbidities
    i. Pregnancy
    j. History of seizure disorder or withdrawal seizures
5) Complications of withdrawal that cannot be adequately managed in the outpatient setting due to:
    a. Persistent vomiting and diarrhea from withdrawal
    b. Dehydration and electrolyte imbalance that cannot be managed in a setting with a lower LOC

6) Complications from withdrawal of stimulants that results in medical or psychiatric conditions that impair patient's stability or drastically reduce the patient's ability to safely participate in treatment.

Substances that confer higher risk of morbidity and mortality (e.g., alcohol, opioids, sedatives) are often more appropriate for inpatient WM than substances with lower risk that may be able to be managed at a lower LOC.

Level 3.7-WM and 4-WM are both inpatient LOCs for withdrawal management and offer similar services, with the key differences being in the level and availability of medical staffing available in these settings. Level 4-WM requires greater availability of medical staffing and 24-hour direct observation and nursing care compared to level 3.7-WM. See respective Staffing sections in level 3.7-WM and 4-WM for more details.

ASAM 4-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Transitions to and from this LOC are critical and must be managed carefully, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated.

Within the specialty SUD system, ASAM level 4-WM is provided in Chemical Dependency Recovery Hospitals and Freestanding Psychiatric Hospitals. ASAM level 4-WM may also be provided in general acute hospitals, in which care the services are funded through FFS Medi-Cal for physical health systems.

Staffing

All 4-WM programs are staffed by physicians/prescribers who are available 24 hours per day. A physician/prescriber is needed to assess the patient within 24 hours of admission (or earlier is needed) and the facility requires 24-hour direct observation and nursing care.

Service Requirements

Treatment services at this LOC include screening, assessment/intake treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including provisions of MAT directly or by referral mechanisms to MAT services unless patient refusal is documents in progress notes), transportation, alcohol/drug testing. Recovery Services, discharge services, Care Coordination, and room and board (which cannot include financial participation by the patient in the form of payment/transfer of federal, state, or local benefits such as CalFresh). These services are intended to be individualized to treat functional deficits identified in the ASAM criteria.

Opioid Treatment Programs (1-OTP)

Opioid Treatment Programs (OTPs) treatment settings that provide MAT, including methadone, buprenorphine, naltrexone, naloxone (for opioid overdose prevention), and disulfiram for individuals with opioid and alcohol use disorders. OTPs may also offer other types of MAT to address co-morbid SUD in addition to opioid use disorder. If the OTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the OTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication.

A distinguishing feature of OTPs compared to other SUD LOCs is that OTPs are the *only* setting that can legally provide methadone treatment for addiction. OTP services are provided in DHCS-licensed facilities pursuant to the California Code of Regulations, Title 9, Chapter 4, Division 4, and Title 42 of the CFR. OTPs also offer a broad range of the other services including medical, prenatal, and/or other psychosocial services.

An OTP is identified as an ASAM LOC and as such, medical necessity for OTP services must be established, including a DSM-5 diagnosis of a SUD and an appropriate LOC designation vis an ASAM assessment.

Clinicians, such as counselors and non-prescriber LPHAs play an important role in identifying who may benefit from MAT and treatment at an OTP. For example, non-prescriber SUD service providers should explain potential MAT benefits alongside other services and refer patients to appropriate health professionals for further assessment. SUD providers from across disciplines will need to work together to ensure familiarity with, and access to, MAT both in OTP and other SUD treatment settings.

Service Requirements

Treatment services at this LOC include screening. Assessment/intake, treatment planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including prescribing methadone, naltrexone, buprenorphine, and naloxone as needed), alcohol/drug testing, syphilis testing, tuberculosis testing, Recovery Services, discharge services, medical psychotherapy, and Care Coordination.

Patients served in OTP settings must receive between 50-200 minutes of treatment services per calendar month. Counseling services provided in the OTP modality can be provided in person, by telehealth, or by telephone. However, the medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) must be conducted in-person. Additional services may be provided based on medical necessity.

OTPs shall comply with all federal and state OTP licensing requirements. If the OTP cannot comply with all federal and state OTP requirements, then the OTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand/off to ensure engagement. Opioid Treatment Programs are regulated under California Code of Regulations Title 9: Rehabilitative and Developmental Services.

Documentation

All OTP providers must have a complete initial ASAM Assessment for all patients. Reimbursement for cases in which ASAM assessments were not completed within the required timeframes will be subject to recoupment.

Consistent with Title 9 requirements, OTP providers must re-verify DMC eligibility and perform justification every 12 months from treatment admission date, for patients who need ongoing OTP care. An annual ASAM assessment is not required. To re-establish medical necessity, a narrative justification of the ongoing need for OTP services is sufficient.

Recovery Services

Recovery Services, formally *Recovery Support Services (RSS),* are support services designed to help individuals remain engaged in care supportive of their recovery and reduce the likelihood of relapse.[7] Recovery Services emphasizes a patient's central role in managing their health and recovery and promotes the use of effective self-management and coping strategies, as well as interval and community resources to support ongoing self-management. Medical necessity is considered established for any individual receiving Recovery Services concurrently with or immediately following SUD treatment at a higher LOC where medical necessity had been established for that higher LOC. If there is a lapse between treatment discharge and receipt of Recovery Services, or Recovery Services is discontinued, a screening needs to occur to determine if Recovery Services are appropriate for patient.

Recovery Services is available for youth (ages 12-17), young adult (ages 18-20), and adult (ages 21+) patients participating in or discharging from any LOC, and immediately upon release from incarceration regardless of receipt of in-custody treatment services based on pre-incarceration SUD history. Recovery Services may be delivered as a standalone service or concurrently with other DMC-ODS services and LOCs as clinically appropriate. Patients may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Patients do not need to be diagnosed as being in remission to access Recovery Services.

To enroll a patient in Recovery Services, a new CalOMS/LACPRS admission and Financial Eligibility form are needed. Continued Recovery Services participation is based on the patient's continued financial eligibility for DMC-ODS services.

Recovery Services may be conducted face-to-face in a contracted DMC-certified treatment facility, at an approved field-based services location, and/or by telephone or by telehealth. Recovery Services can be delivered by either an experienced registered or certified SUD counselor, LPHA or licensed-eligible LPHA and will be offered when they are deemed medically necessary by an LPHA/licensed-eligible LPHA (e.g., during a treatment episode or after completion of a treatment episode).

How to Ensure Patient Engagement in Recovery Services

- **Ensure that patients are connected with other individuals in recovery to establish a positive recovery support network.**
- **Emphasize the patient's central role in managing their health**
- **Emphasize the use of effective self-management and coping strategies to deal with stress and setbacks**
- **Facilitate access to internal and community resources to provide ongoing self-management support to patients**
- **Facilitate autonomy by linking patients to necessary resources (e.g., vocation, education, housing, transportation) to ensure that their needs are met, and they are prepared to navigate the health and social service system independently in the future, as needed**

Participation in Recovery Services in voluntary for the patient. Therefore, treatment providers should make every effort to educate and engage patients in, and facilitate acceptance or, Recovery Services while ultimately deferring to the patient's choice and preferences.

[7] https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4454.pdf

Accessing Recovery Services

During SUD Treatment

Given the value of Recovery Services, the patient's treatment provider should explain the benefits of Recovery Services at the beginning of treatment, during treatment, and as treatment is concluding. Treatment providers should introduce the patient to any designated Recovery Services counselor/clinicians and ensure that a warm hand-off is completed. This is particularly important when the Recovery Services provider is different from the treatment provider where non-Recovery Services treatment services are, or were most recently, rendered. Patients can be concurrently enrolled in Recovery Services and another LOC.

Following SUD Treatment

Following discharge from treatment, an assigned Recovery Services counselor/clinician must contact the patient within two (2) business days from their last treatment service to ensure that the patient is receiving necessary support. Counselors are required to demonstrate efforts to engage a patient into the Recovery Services benefit prior to determining that they are lost to follow-up. If patient consents to services, at least three (3) documented attempts to engage patients on three (3) separate days are required. If the counselor has neither heard from nor contacted the patient for 60 calendar days after the last attempted contact, the patient should be discharged from Recovery Services. The Recovery Services provider will document all follow-up contacts in the County's EHR, Sage.

For the first 60 calendar days following a patient's discharge from treatment, the Recovery Services counselor/clinician will contact and engage the patient at a frequency according to clinical need if the patient consented to participate in Recovery services.

Patients lost to follow-up who reconnect for Recovery Services more than six (6) months since their last DMC-ODS clinical service must be screened to determine if Recovery Services continues to be an appropriate service for the patient.

Service Requirements and Components

Services at this LOC includes assessment, treatment planning, recovery monitoring, relapse prevention, group counseling, individual counseling, family therapy, Care Coordination, and discharge services.

An individual can continue to receive Recovery Services for so long as they continue to meet financial eligibility for DMC-ODS services. A LPHA at the Recovery Services provider site must document the justification for ongoing Recovery Services at intervals not less than six months. Individuals may receive Recovery Services while concurrently enrolled in other DMC-ODS services and LOCs, as clinically appropriate.

A CalOMS/LACPRS discharge needs to be completed when the Recovery Services provider anticipates a patient will not reengage in Recovery Services, but no later than 45 days after the date of last service.

Counseling

The goal of individual or group counseling is to allow the patient to gain/develop:

- Personal autonomy (managing stress, free time, activities of daily living)
- Personal care (grooming, managing finances), health, and wellness (exercise options, nutrition)

- Social Skills coping skills and learning adaptive behaviors (coping with cravings or triggers that could result in relapse)
- Individualized Recovery Plan

Counseling services may be provided 1:1 or in group settings. Groups should consist of two (2) to 12 individuals per group and these services must be delivered face-to-face. Patients who are enrolled in Recovery Services, Outpatient (ASAM 1.0), and Intensive Outpatient (ASAM 2.1) can participate in the same group counseling if clinically appropriate. Patients who are enrolled in Recovery Services cannot participate in the same group counseling and patient education sessions as those in residential treatment services.

Recovery Monitoring

This service provides patients with dedicated guidance and recovery management to help them learn practical strategies to prevent relapse and address real-world environmental and personal triggers for drug or alcohol misuse. Recovery Monitoring targets SUD behavior and associated symptoms of use/relapse (stress, mood, and self-efficacy). This service can be delivered face-to-face, by telephone or by telehealth.

Care Coordination

Individual service coordination, providing linkages with other services including:

- Support for education and job/life skills, employment services job services, job training, and legal and educational services
- Parenting support for childcare, parent education, child development support services, and family/marriage education
- Linkages to benefits, mental and physical health, self-help and support groups, spiritual and faith-based support, and peer-delivered support services and groups
- Ancillary services, such as housing assistance and transportation. Providers should identify service gaps and link the patient to ancillary supports to help address those gaps.

Care Coordination can be delivered face-to-face, by telephone or by telehealth.

Relapse Prevention

Relapse prevention focuses on identifying a patient's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs and cope with the potential for relapse.

For definitions of group counseling, individual counseling, and Care Coordination, see other sections.

Required Documentation

Recovery Services counselors/clinicians must document each patient encounter, capturing relevant recovery details such as a summary of status and progress, pertinent changes, relapse potential, etc.

Recovery Services provided in the community, by telephone, or by telehealth require equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility. Documentation guidelines and templates developed by SAPC must be used for Recovery Services progress notes. For more information on documentation requirements, see the *Documentation* section.

Recovery Bridge Housing

Housing, and residing in a safe and stable living environment, is often critical to achieve and maintain recovery from SUDs. Research shows that SUD treatment outcomes are better for PEH particularly chronic homelessness when they are stably housed. People with SUDs need access to safe, stable, and supportive living environments to help them initiate and sustain their recovery and reduce the risk of relapse. Recovery Bridge Housing (RBH) is a type of abstinence-focused, peer-supported housing that provides a safe interim housing environment for individuals who are homeless according to the U.S. Department of Housing and Urban Development (HUD) definition or unstably housed. Participants in RBH must be concurrently enrolled in treatment, such as Outpatient (OP), Intensive Outpatient (IOP), Opioid Treatment Program (OTP), or Outpatient (aka Ambulatory) Withdrawal Management (OP-WM) settings.

The goal of RBH is to provide safe interim housing that is supportive of recovery for patients who are receiving OP/IOP/OTP/OP-WM treatment for their SUD. RBH is available for young adults (ages 18-20) and adults (ages 21+) who are:

1. In need of a stable, safe living environment to best support their recovery from SUD; and
2. Concurrently enrolled in OP/IOP/OTP/OP-WM treatment settings

Participants who are discharged from treatment in OP/IOP/OTP/OP-WM settings will no longer be eligible to receive the RBH benefit. However, RBH providers may hold beds for up to seven (7) days for participants who need to leave the interim housing facility for reasons such as hospitalization, therapeutic pass (violation of post release-supervision) and return to treatment after discharging against medical advice. These held beds within the aforementioned timeframe, and reasons are billable through the provider's RBH contact.

Certain populations, such as PEH, are particularly at risk for relapse without access to housing and should be prioritized for this benefit. Other vulnerable population will be prioritized for RBH, as listed in **Table 10** (see *Principle, Number 2*). Populations other than the prioritized populations listed in **Table 10** will be authorized for RBH if sufficient capacity is available to accommodate prioritized populations.

The Foundational Principles of Recovery Bridge Housing (see **Table 10**) are based on characteristics of Recovery Housing as defined by the U.S. Department of Housing and Urban Development (HUD), as well as recommendations from DHCS around best practices. RBH aligns with the spirit of the ASAM Criteria in the sense that individuals should be appropriately placed in the least restrictive treatment environment necessary in order to meet their clinical needs. While RBH is not officially an ASAM LOC, it services as a bridge between the more intensive and restrictive residential treatment setting and OP/IOP/OTP/OP-WM treatment settings.

Table 10.

Recovery Bridge Housing Foundational Principles	
1	Agencies operating RBH cannot restrict access to this benefit to their treatment patients. Agencies are required to accept referrals to available RBH beds from other networked providers and need to refer their patients to other available RBH beds if they have met their capacity. RBH beds are available to any beneficiary that is eligible for this benefit within the SUD system of care, especially those belonging to one of the groups prioritized for this benefit.

2	SAPC-contracted beds must only be dedicated for SAPC beneficiaries. Providers utilizing SAPC-contracted beds for non-SAPC beneficiaries are out of compliance with SAPC contract requirements.
3	The following high-risk populations need to be prioritized for RBH at the SUD treatment provider level according to the following ranking (from higher priority to lower priority*): 1. Pregnant and parenting women (pregnant to 60 days postpartum) 2. Active intravenous drug users (injected drugs within the last 30 days) 3. High utilizer patients (as defined by high utilizer criteria for high tier care management[8]) 4. Chronically homeless (according to HUD definition[9]) 5. Certain non-AB 109 criminal justice-involved patients without alternative criminal justice finding for recovery housing 6. Young Adults (ages 18-21) 7. Persons living with HIV/AIDS 8. Residential step down (PEH stepping down from residential treatment into RBH) 9. Lesbian, gay, bisexual, transgender, queer (LGBTQ) populations *Populations outside of the prioritized list will be authorized for RBH if sufficient capacity is available to accommodate prioritized populations. Note: Undocumented homeless adult beneficiaries who meet the prioritization criteria listed above and are receiving concurrent SUD treatment through Medi-Cal, My Health LA, or other applicable County program benefits (e.g., AB 109) are eligible for placement in RBH.
4	Eligible participants should be medically and psychiatrically stable enough to benefit from RBH

[8] ***High tier care management inclusion criteria*** *– All individuals diagnosed with SUD who meet any of the following criteria:*
- *a) 3+ emergency department (ED) visits related to SUD within the past 12 months*
- *b) 3+ inpatient hospital admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD*
- *c) Homeless with SUD (as defined by HUD homelessness definition)*
- *d) 3+ residential SUD treatment admissions within the past 12 months*
- e) *5+ incarcerations with SUD in 12 months*

[9] *HUD definition of homelessness includes 4 categories:*
1) ***Literally Homeless:*** *Individuals or families who live in a place not meant for human habitation, in an emergency shelter, or in an emergency shelter, or in an institutional care facility where s/he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;*
2) ***Imminent Risk of Homelessness:*** *Individuals or families who will imminently lose their primary nighttime residence within 14 days, has no subsequent residence, and who lack the resources to obtain other permanent housing;*
3) ***Homeless Under Other Statuses:*** *includes unaccompanied youth under 25 or families with children and youth who are defined as homeless according to other federal statuses, have not been placed in permanent housing in the last 60 days, have experienced persistent instability and are expected to remain in such a status for an extended period due to special needs or barriers; and*
4) ***Fleeing/Attempting to Flee Domestic Violence:*** *An individual or family attempting to flee DV who has no other residence and lacks the resources or support networks to obtain other permanent housing.*

*HUD definition of **chronic homelessness** is *a person [having] a disability and have been living a place not meant for human habitation, in an emergency shelter, or a safe haven for the last 12 month continuously or on at least four occasions in the last three years where those occasions cumulatively total at least 12 months* (United States Department of Housing and Urban Development 2016).*
Patient in RBH meet the HUD chronic homelessness definition. For participants who are chronically homeless upon entering RBH, they maintain their chronic homeless status even by staying in RBH for 90 days or longer.

5	Program participation is self-initiated, and beneficiary chooses abstinence-focused housing. Participants who receive RBH benefit are expected to be abstinence from drugs and alcohol. However, abstinence is not defined as including abstinence from MAT. Patients placed in RBH must be allowed to continue receiving MAT, when clinically indicated and cannot be excluded from admission as a result of prescribed MAT. RBH providers need to have policies and procedures to ensure a patient-centered process for when patients placed in RBH are receiving MAT.
6	Program policies and operations are consistent with the National Standards for Cultural and Linguistically Appropriate Services (CLAS) and ensure individual rights or privacy, dignity, respect, and safety.
7	Program emphasize the personal recovery goals or participants and long-term housing stability to minimize the likelihood of homelessness.
8	Program design are to establish minimal barriers for entry into programs.
9	Programs are to meet or exceed National Alliance for Recovery Residences (NARR) standards of care.
10	Holistic services and peer-based supports are available to all program participants.
11	Relapse is not treated as an automatic cause for eviction from housing or termination from the program.
12	Discharge from housing only occurs under two conditions – first, when a participant's behavior substantially disrupts or impacts the welfare of the recovery community in which the participant resides; and second, if the participant is no longer able to benefit from RBH due to becoming medically or psychiatrically unstable. Participants may apply to reenter the program if they express a renewed commitment to living in an abstinence-focused housing setting.
13	Patients who determine they are no longer interested in living in abstinence-focused housing or who are discharged from the program are aided in accessing other housing and service options.
14	Throughout the duration of program participation, programs assist participants transition into permanent housing options to ensure a smooth transition once they are ready to leave RBH.

Recovery Bridge Housing Considerations

- RBH is voluntary, and patients being considered for RBH need to choose to be placed in an abstinence-focused interim housing environment to facilitate their recovery.
- RBH is appropriate for individuals who have minimal risk with regard to acute intoxication/withdrawal potential biomedical and mental health conditions.
- The activities provided in RBH vary and include peer support, group and housing meetings, self-help, and like skills development, among other recovery-oriented services. Life skills such as budgeting, bill paying, shopping, cooking, managing a household, and social skills are essential for promoting self-sufficiency and living independently.
- Participants in RBH cannot receive in-person SUD treatment services and Care Coordination at the RBH sites.

- SUD treatment services, including alcohol/drug testing or urinalysis, cannot be provided in RBH. The RBH provider may coordinated with the treatment provider, and request that the test be conducted for the participant. However, participant consent must be secured to release the test result to the RBH provider.
- Individuals appropriate for RBH may be stepping down from residential or may be entering the SUD treatment system directly into OP/IOP/OTP/OP-WM LOCs.
- Youth (under age 18) who require recovery housing may be eligible for placement in a group home that provides treatment and ancillary services in sites licensed by DPSS.
- Participants in RBH must be screened for tuberculosis (TB) or provide evidence of having been screened (e.g., for those stepping down from residential treatment) within six (6) months prior to or 30 days after admission into RBH.
- Whenever possible and as preferred by the patient, individuals should be placed in an RBH site that is located within 30 minutes or 15 miles of their treatment provider site.
- RBH sites should be in geographic areas that will not hinder recovery and should not be near alcohol outlets and/or high drug trafficking areas.

Recovery Bridge Housing Authorization Process

If RBH is determined to be appropriate, SUD treatment providers must refer the patient to the appropriate RBH provider. The SUD treatment and RBH provider must coordinate very closely to ensure the patient's safe and timely arrival at the RBH facility. The RBH provider must submit a Sage authorization request and supporting documentation to ensure the patient meets RBH eligibility criteria, and to receive reimbursement for RBH from SAPC. The RBH provider must collaborate with the treatment provider for the submission of needed documentation, ensuring the patient's concurrent enrollment in OP/IOP/OTP/OP-WM treatment. In instances in which the SUD treatment provider is a different agency than the RBH provider, there must be appropriate communication and policies and procedures in place between the referring and accepting providers to confirm that a bed is available and to ensure coordination between agencies. The policies and procedures between the referring and accepting providers must clearly describe the agree upon referral and acceptable procedure, necessary coordination processes, and a clear process by which disagreements are resolved.

Eligibility for Recovery Bridge Housing

RBH is available for *young adults* and *adults* who meet all the following criteria:

1. **In need of a stable, safe living environment to best support their recovery from a SUD; and**
2. **Concurrently enrolled in treatment in OP/IOP/OTP/OP-WM treatment settings.**

Utilization Management staff will review the Sage authorization request form and supporting documentation (e.g., full ASAM CONTINUUM assessment, Problem List (non-OTP settings) or Treatment Plan (OTP settings), progress notes, and discharge/transfer plan), and render a decision on authorization, which is required for an agency to receive reimbursement for RBH services. SAPC will reimburse up to seven (7) days of RBH services while the participant is enrolling in outpatient treatment. Referring treatment providers must document the need for RBH in patient's Problem List (non-OTP settings) or Treatment Plan (OTP settings). Both RBH and treatment providers must refer to the most recent Sage and Manual (non-Sage) versions of the SAPC Checklist or Required Documentation for Eligibility verification and Service Authorization Request, as posted on the SAPC website.

Duration of Recovery Bridge Housing

Young adult and adult participants may be authorized and reimbursed for 90 days, and reauthorized for an additional 90 days if needed, for a maximum stay of 180 days if they meet medical necessity for OP/IOP/OTP/OP-WM and the RBH eligibility criteria specified above. The 180 days are not required to be continuous and may be used throughout a 12-month period starting from the date of initial RBH admission.

Pregnant and parenting women are authorized for an initial 90 days. They may be reauthorized for another 90 days and every 30 days thereafter, up to 60 days postpartum, based on medical necessity for OP/IOP/OTP/OP-WM.

Discharging Patients from Recovery Bridge Housing

SUD treatment providers should begin discharge planning regarding the housing needs of PEH immediately upon treatment admission. Care coordinators should work with participants to create a housing plan to ensure a smooth transition to stable housing upon RBH discharge. Once the RBH participants complete their stay or stop receiving the benefit, the RBH provider must complete the RBH Discharge Form in Sage on the same day of discharge.

Eligible Recovery Bridge Housing Providers

At this time, RBH provides are limited to current SAPC-contracted providers that have experience providing RBH to individuals receiving treatment in OP/IOP/OTP/OP-WM settings. Also, RBH providers must be members of a recovery housing organization such as Sober Living Network (SLN), or California Consortium Addiction Programs and Professionals (CCAPP) that adheres to NARR standards and best practices. RBH providers must enter into a separate participant agreement with each participant placed in RBH. It is best practice for RBH providers to maintain a naloxone kit for overdose prevention onsite and ensure that RBH House Managers or other designated staff receive training in administering naloxone.

Service House of Operation

RBH must operate 24 hours per day, seven (7) days a week, and must accept intakes during regular weekday business hours (9:00 a.m. to 5:00 p.m., at a minimum).

Staffing for Recovery Bridge Housing

RBH providers are responsible for ensuring that onsite house managers oversee the day-to-day operations of the facility. This includes ensuring adherence to policies and procedures, rules and requirements, and the quality of the facility and the health and safety of residents. RBH house managers must receive appropriate onsite orientation and training prior to performing assigned duties have appropriate experience and necessary training at the time of hiring and should be familiar with confidentiality regulations under 42 Code of Federal Regulations (CFR) Part 2 governing the confidentiality of SUD patient records. Further, housing managers should be trained in and practicing, at a minimum, trauma-informed care, cultural competency, and implicit bias.

RBH staff must submit any reports requested by the County and/or County partners, including required information and supporting documentation, such as daily Participant sign-in/out logs. RBH staff are responsible for completing authorization applications and other required documentation in Sage and coordinating with the treatment provider if the participant is receiving treatment from another agency. Some examples of coordination include verifying with the treatment provider that the participant is still concurrently receiving OP/IOP/OTP/OP-WM treatment, informing the treatment provider is the participant leaves or has been discharged from RBH, reminding the treatment provider to conduct housing activities and/or refer patient to

interim or permanent housing resources, and sharing with treatment provider requested information to accurately complete the participant/s CalOMS/LACPRS records. The RBH staff must document these coordinate efforts with the treatment providers.

RBH providers authorized by the County to provide services for pregnant and/or parenting women shall ensure that all services being provided to the parent and child(ren) are in accordance with the latest version of the State's Perinatal Practice Guidelines.

Clinician Consultation Services

Given the shortage of medically trained addition specialists in the SUD workforce, the Clinician Consultation Service aims to build the capacity of clinicians through consultation and education. It is designed to help facilitate the exchange and dissemination of addiction expertise both *between* clinician providers and *within* the specialty SUD system of care for youth, young adults, and adults.

Clinician consultation consists of DMC-ODS LPHAs consulting with LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care. Clinician Consultation is not a direct service provided to DMC-ODS patients. Rather, Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or LOC considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS patients. DMC-ODS Counties may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services. These consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

Clinician Consultation Services available to physicians within the specialty SUD system in LA County are provided by the University of California, San Francisco (UCSF) Substance Use Warmline.

Licensed Clinician Consultation Process

Licensed clinicians within the specialty SUD system who seek consultation are responsible for initiating the consultation by calling the UCSF Substance Use Warmline at **(855) 300-3595** (more information available at: http://nccc.ucsf.edu/clinical-resources/substance-use-resources/).

Eligible Participants

Clinician Consultation requests are intended for **licensed clinicians only** and must not be initiated by non-licensed clinicians or patients.

Service hours

These services are available Monday through Friday (excluding holidays) between 6:00 a.m. and 5:00 p.m. Pacific Time. Voicemail is available 24-hours per day. Every effort is made to respond to consultation requests in a timely manner.

All consultation requests must include a clear explanation as to the reason for the consultation and include any relevant history and clinical details that help to inform and provide contact for the concern/question. Additional details related to consultation topics include:

- The content of the consultative advice offered through Clinician Consultation Services is limited to addiction expertise, and these consultations may involve, but are not limited to, management of complex cases and questions involving MAT.
- Consultation requests that are non-clinical in nature, administrative, or more appropriate for County staff are not appropriate for this line. For example, if a clinician has a question regarding DMC eligibility, service availability, or questions regarding policies/procedures related to substance abuse treatment, these questions should be directed to the County.
- The UCSF Substance Use Warmline provides general addiction expertise and will not be able to answer non-clinical or administrative questions specific to LA County.
- For the protection of patients and involved providers, Clinician Consultation Services are strictly limited to routine consultation requests. Emergent and urgent consultation needs should be directed to more appropriate resources (e.g., emergency department, psychiatric emergency services). If the Consultant Specialist determines that a consultation request is emergent or urgent, or that the consultation request is otherwise inappropriate (e.g., patient's condition not consistent with services provided by the consult service), the Referring Clinician will be notified of this determination and will be provided an explanation for this decision.
- The Consultant Specialist from UCSF will utilize the information provided by the Referring Clinician to provide recommendations focused on the question/concern, the question asked by the Referring Clinician may be posed to other addiction specialists within the UCSF Substance Use Warmline to elicit alternative clinical options and ideas.
- In conjunction with the consultant's expert opinion, the Referring Clinician will then utilize their own professional judgment and other considerations (e.g., patient preferences, family concerns, other comorbid health conditions and psychosocial factors) to provide comprehensive and patient-centered treatment that is informed by the consultation.

Documentation

Documentation expectations for services provided as a result of Clinician Consultation Services are the same as documentation requirements in other patient care scenarios. A Progress Note must be completed within seven (7) calendar days by a LPHA or MD, practicing within the scope of their practice. Progress notes must include:

- beneficiary's name;
- purpose of the service;
- the date; start and end times of each service; and
- identify is services were provided face-to-face or by telephone

If the Referring Clinician utilizes the Clinician Consultation Service, the Referring Clinician is also responsible for including thorough documentation of the patient encounter and the role of the Clinician Consultation Service in informing that encounter. All documentation should use language that is clear and comprehensible to non-physician LPHA and SUD counselors.

Billing

Clinician Consultation Services are provided as a free service for the specialty SUD system. The time clinicians in the specialty SUD system spend seeking clinician consultation from the Clinician Consultation Service is not a billable service.

All local, state, and federal confidentiality requirements involving HIPAA and 42 CFR Part 2 must be followed during the Clinician Consultation process.

Service Delivery Options

Field-Based Services

The SUD treatment field is evolving to allow for the delivery of services in a more flexible manner that is based on patient need and established treatment goals. Flexible treatment approaches such as field-based services (FBS) and the use of a patient-centered philosophy can increase patient motivation in treatment and lead to positive treatment outcomes.[10]

FBS are a method of mobile service delivery for OP services (ASAM 1.0), IOP services (ASAM 2.1), Care Coordination, and Recovery Services for patients with established medical necessity. FBS provide an opportunity for SUD network providers to address patient challenges to accessing traditional treatment settings, such as physical limitations, employment conflicts, transportation limitations, or restrictive housing requirements (e.g., registered sex offenders). FBS is intended to serve populations that have been historically difficult to serve (see Table 11). Utilization of FBS needs to be based on demonstrated patient need for services outside of a DMC-certified site.

FBS can only be delivered in designated, SAPC-approved sites, and in all instances, the provider delivering FBS must be linked to the contracted DMC-certified agency site that is billing for the FBS service. OTP providers wishing to provide group or individual counseling outside of their OTP program are required to obtain certification for the specific LOC. Once the required certification is obtained, providers should contact SAPC Contract Services Division.

[10] *U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (2002). Enhancing Motivation for Change in Substance Abuse Treatment. Tip 35. Rockville, MD*

Table 11. Allowable Non-Clinic Field-Based Service Sites

Allowable Non-Clinic Field-Based Service Site	
Youth	**Adults**
• Youth Homeless Shelters • Short-Term Residential Therapeutic Programs (STRTPs) • Community Facility Centers • Community Centers • Recreation Centers • Department of Children and Family Services Offices • Department of Probation Office sites/regional hubs • Los Angeles County Office of Education Alternative sites • SAPC approved school sites	• Adult Day Centers • Board and Care settings • Federally Qualified Health Centers • Drop-in Centers • Department of Mental Health clinic sites (including DMH legal entities) • Department of Health Services directly operated facilities • Department of Probation Area Offices • Department of Children and Family Services Offices • Department of Public Social Services Offices • Temporary or Permanent Supportive Housing Locations

Table 12. Field-Based Service Target Populations

Field-Based Service Target Population	
FBS is intended for those populations that have been historically difficult to serve which include, but are not limited to the following populations:	
• Arsonists • Registered Sex Offenders • Homeless • Individuals with Co-occurring Conditions • Medically Fragile • Residents of Rural Areas • Juvenile Justice-Involved • Foster Care System Involved	• Youth residing in STRTPs • Pregnant and Postpartum Women • Gang-Involved • Older Adults • Women with Children • Veterans • School-Based Youth, including Alternative School Placements

Site Limitations/Exclusions

DMC Site Certification

FBS cannot be used in lieu of obtaining California Department of Health Care Services (DHCS) DMC site certification for providers' directly operated sites (e.g., rented, leased, owned sites) where delivery of SUD or mental health treatment services are the primary business and where services are delivered by individuals employed by the agency managing the service site.

DHCS DMC site certification is not required for facilities whose primary business is the provision of services *other than SUD and mental health* and where services are delivered by individuals *not employed by the agency managing the service site*. If services are provided on a regular basis, specifically permanent, full-time co-locations, the SAPC-contracted SUD service provider must add the site location to their SAPC contract to receive DMC reimbursement for those services.

A limit of five (5) field-based service sites are allowed per each DMC-certified location. Additional sites will be considered by SAPC on a case-by-case basis.

Seeking Approval for Field-Based Service Sites

To obtain approval to provide FBS at a desired site, providers must submit a FBS work plan proposal request to SAPC with the rationale for a community-based service co-location. Proposals need to include data about the following:

- Proposed FBS site and target population (see **Table 12** for recommended target populations and **Table 11** for allowable FBS sites)
- Special needs of individuals who will be served in each proposed FBS site
- Volume of individuals expected to be served in the site
- LOCs or services to be delivered (ASAM 1.0, ASAM 2.1, Care Coordination, or Recovery Services)
- Frequency and hours of operation on the site
- A MOU from the host agency or organization
- Explanation of how the FBS will comply with required patient confidentiality requirements (42 CFR Part 2 and HIPAA) when they are delivered in the proposed settings

In-Custody Services

In-custody services are not permissible as a FBS delivery site and are not reimbursable through the DMC program.

Field-Based Service Procedures

1. If during the intake process a SUD counselor/clinician determines that a patient is a member of at least one of the target populations highlighted in **Table 12**, the counselor/clinician needs to assess if FBS as a delivery option is necessary and appropriate for the patient
2. If it is determined that the patient would be better services by FBS as compared to a more traditional service delivery method, the counselor/clinician must submit documentation
3. The SUD counselor/clinician must work with the patient to develop a plan of care that includes goals specific to FBS
    - The problems to be addressed by FBS must be explicitly included in the Problem List (non OTP settings) or Treatment Plan (OTP settings) in order to be billable
    - Clinical notes documenting the plan of care for FBS must include the anticipated number of FBS sessions to be provided and the FBS site location that was approved

4. Minimum FBS service expectations include:
    - Providing culturally, linguistically, and developmentally competent services
    - Utilizing a biopsychosocial approach, including education regarding medication-assisted treatment, when applicable and necessary
    - Using evidence-based practices such as Motivational Interviewing and Cognitive Behavioral Therapy
    - Using Care Coordination to facilitate access to necessary health and social services
    - Compliance with applicable legal and regulatory obligations, including confidentiality requirements (e.g., HIPAA and 42 CFR Part 2)
5. The same treatment and discharge procedures for OP (ASAM 1.0), IOP (ASAM 2.1), Care Coordination, and Recovery Services apply to patients receiving FBS.
6. Documentation expectations for FBS are identical to that of other services delivered throughout the specialty SUD system. It is critical that SUD counselors/clinicians clearly document all FBS rendered to patients, including but not limited to: specifying the type of FBS service delivered; duration; and location of service delivery.

Components of Field-Based Services

1. Assessment and Patient Outreach
    - Agencies may opt to utilize FBS to conduct ASAM CONTINUUM or SAPC Youth ASAM assessments and outreach. However, only services rendered to individuals who meet medical necessity will be reimbursable. Thus, agencies that opt to utilize FBS to conduct the ASAM CONTINUUM or SAPC Youth ASAM assessments and outreach should acknowledge that time spent conducting assessments for individuals that do not ultimately meet medical necessity are not reimbursable. Additionally, work plans submitted for assessments will not be approved for sites and co-located CENS.
2. Direct SUD Treatment Services
    - FBS outpatient, IOP services and Care Coordination may be provided on an individual or group basis. Groups should have at least two (2) and can be no more than twelve (12) individuals per group. Individuals must meet medical necessity based upon the ASAM Criteria in order to access the following service components:
      FBS Components (refer to OP Treatment section for full description of services)
        - Individual Counseling
        - Group Counseling
        - Care Coordination
        - Patient Education
        - Family Therapy
        - Collateral Services
        - Recovery Services

Field-Based Service Site Approvals

Prior to initiating FBS, contractors must submit a completed work plan summary and narrative (see *Work Plan Summary* on the SAPC website under Field-Based Services) to SAPC for review and approval. The purpose of the work plan is to:

- Identify the proposed non-clinic settings and target populations to be served (see **Table 12** for recommended target populations and **Table 11** for allowable FBS sites);

- Demonstrates that FBS will comply with required patient confidentiality and security for records requirements (42 CFR part 2 and the HIPAA) when they are delivered in the proposed settings; and
- Describe the frequency and duration of service provision in field-based locations

SAPC will require a written agreement such as MOU, Service Delivery Agreement (SDA), etc. between the contractor and the agencies/organizations that will host the provider of FBS including school-based sites. SAPC reserves the right to deny approval or work plans at its sole discretion at any time.

The County maintains full discretion to approve and deny FBS work plan proposals at any time. Agencies conducting FBS at sites not listed on the approved work plan will be disallowed and may have their approved FBS work plan revoked. A current executed MOU, SDA, etc. must be in place at all times or services cannot be delivered.

Telehealth and Telephone

Pursuant to BHIN 22-019: If a service is provided through telehealth (synchronous audio or video) or telephone, the provider staff is required to confirm consent for telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services (e.g., SUD) via telehealth to Medi-Cal and non-Medi-Cal patients, including:

- An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit;
- An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time without affecting their ability to access covered Medi-Cal or other SUD services in the future;
- An explanation of the availability of Medi-Cal coverages for transportation services to in-person visits when other available resources have been reasonably exhausted; and
- Potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

The provider staff must document provision of this information and the patient's verbal or written acknowledgement that the information was received in the patient's record.

***NOTE: There are various flexibilities related to the COVID-19 public health emergency that relate to telephone and telehealth services. These flexibilities are described in the COVID-19 Information Notices released by SAPC, please refer there for the time-limited flexibilities related to the pandemic period as opposed to the Provider Manual given that the fluidity of the pandemic has required that Information Notices be the primary mechanism for SAPC to outline policies related to rapidly evolving and time-limited policies, including those related to telephone and telehealth.**

Telehealth and telephone services shall supplement, not replace in-person services when they are provided.

Telehealth

Telehealth is defined as a SUD service that can be delivered between a registered or certified SUD counselor, and/or a LPHA and a patient via audio and video communications where the SUD counselor/LPHA and patient are not required to be at the same location. Telehealth services will be available to all populations and allow eligible DMC services to be provided where physical access is a barrier for patients. The type of settings patients can be located at while receiving telehealth services include but are not limited to, hospitals, medical

offices, community clinics, or the patient's home Licensed providers and non-licensed staff may provide services via telehealth, as long as the service is within their scope of practice.

Available Telehealth Services

Telehealth services are available to all individuals who meet eligibility requirements for SUD services and who consent to receive SUD services via telehealth. The following are allowable LOCs that can be conducted via Telehealth:

- Outpatient services (ASAM 1.0 & 1.0-AR)
- Intensive Outpatient services (ASAM 2.1)
- Ambulatory Withdrawal Management (ASAM 1-WM & ASAM 2-WM)
- Recovery Services

Allowable Services within LOCs:

- Care Coordination
- Crisis Intervention
- Collateral Services
- Determination of Medical Necessity
- Individual Counseling
- Initial Clinical Assessment
- Medication Services (MAT)
- Positive Youth Development
- Treatment Planning
- Relapse Prevention
- Recovery Monitoring

In-person appointments need to occur whenever patient signatures are required, this would include signing of initial consents and Treatment Plans and Treatment Plan Updates in OTP settings. Patient signatures are not required on Problem Lists documented in non-OTP settings. If the patient is unable to sign, it must be clearly documented with the patient's chart as to why.

Agency Requirements and Responsibilities

Each registered or certified SUD counselor/LPHA delivering Telehealth Drug Medi-Cal covered services must meet requirements of Business and Professions Code (BPC) Section 2290.5(a)(3), or equivalent requirements under California law. For example, SUD counselors are certified as outlined in the CCR Title 9 Chapter 8 Certification of Alcohol and Other Drug counselors.

Provider agencies that elect to provide Telehealth services are required to ensure the staff delivering these services have the necessary knowledge, skills, and training to deliver high quality Telehealth services. Provider agencies must establish Telehealth policies and procedures that outline how agency staff will abide by the requirements outlined by SAPC in order to deliver Telehealth services.

Agencies that provide Telehealth services must ensure proper technical specifications, system maintenance, security, confidentiality, support, and functioning of associated technologies in accordance with applicable federal, State, and local policies and regulations.

Services provided via Telehealth are subject to the same privacy and security laws and regulations as services provided by in-person services, and providers must ensure that they comply with HIPAA, the California Medical Information Act, and, if applicable, 42 CFR Part 2 or California Welfare & Institutions Code section 5328.

Telehealth Platforms

SAPC does not impose requirements of which live video platform can be used to provide services via Telehealth, provided it is 42 CFR part 2 and HIPAA-compliant and it conforms to DHCS expectations and regulations. Telehealth platforms must meet security safeguards to protect confidentiality of personal health information (PHI). Additional information about Telehealth platforms is available through The California Telehealth Resource Center (CTRC) at http://www.caltrc.org/.

For additional claiming requirements or clarification, review the *SUD Treatment Services Rates and Standards Matrix* and the *837P Companion Guide* for more information.

Telephone

SAPC reimburses for eligible telephone services. Telephone services must be documented in the patient's file. Eligible telephone services include:

- Screening
- Crisis intervention
- Individual Counseling
- Collateral Services
- Care Coordination
- Recovery Services

Intake and Enrollment

It is important to establish a comprehensive and standardized intake and enrollment process that balances the need for information with the need to create a streamlined and patient-centered experience for the patient. The sections below describe essential components of the intake process.

Required Forms

Patient Rights

Patient rights assure that the basic rights of independence of expression, decision and action, concern for personal dignity, and human relationships are preserved for all patients. As a cornerstone of a patient-centered and effective treatment system, specialty SUD providers must share an individual's patient rights with them in writing, either collectively or individually.

Based on network provider feedback and input, SAPC developed a patient rights and responsibilities poster that can be used and posted in visible areas throughout facilities.

Patient Handbook and Patient Orientation Video

The County's Substance Use Services Patient Handbook outlines the benefit package for Medi-Cal. It also includes information on eligibility, accessing network providers that meet patient needs and preferences, patient rights and responsibilities and the grievances/appeals process. The Patient Handbook is available in all threshold languages and must be provided to the patient upon admission by one of the following ways and at no-charge to the patient:

1. Provide a printed copy or mail it to the patient's mailing address, or
2. Email a copy after obtaining the patient's agreement to communicate by email, or
3. Direct the patient to the County's website for viewing

If at any time, the patient requests a printed copy of the Patient Handbook after being directed to the County website or sent via e-mail, the Network Provide must provide it at no-charge to the patient within five (5) days of the request. Providers are responsible for informing current patients whenever a new version of the patient handbook is available. SAPC will notify providers whenever there is a change in the patient handbook.
The Patient Orientation Video is to be used to provide patients with a user-friendly summary of the Provider Handbook and description of key benefits under the DMC-ODS. Network Providers are required to demonstrate that new and existing patients have viewed the video in its entirety within a specified number of days from first service. The Patient Orientation Video is available on SAPC's website with subtitles in all threshold languages.

The Patient Handbook and Orientation Video Acknowledgment Form acknowledges that the patient has viewed the patient orientation video and/or has been provided with the Patient Handbook. The Patient Handbook and Orientation Video Acknowledgement Form offers the patient a summary of the benefits and Summary and Orientation Video Acknowledgement Form offers the patient a summary of the benefits and must be:

1. Signed by the patient upon admission (or upon completion or orientation video within the identified timeframes)
2. Provide a copy of the signed document to the patient
3. Store the completed document within your EHR system for all new admission. For primary Sage users, please use the following title "Patient Handbook Summary ##-##-##)" that includes the date signed (e.g., Patient Handbook Summary (04-01-18)).

The form is available in English and in other threshold languages.

Notice of Privacy Practices

Los Angeles County's Notice of Privacy Practices explains patient rights and the treatment agency's legal duties with respect to patient health information. It must be made available to all new and continuing patients upon first service appointment.

The *Notice of Privacy Practices* is available in English and Spanish on SAPC's website.

Confidentiality/Release of Information

SUD treatment providers within the specialty SUD system must thoroughly explain confidentiality options to patients and have them sign the necessary confidentiality forms (e.g., DPH-SAPC Release of Information (ROI) Form, both within the SAPC SUD provider network and with external providers). All confidentiality and ROI forms must comply with 42 C.F.R. Part 2, HIPAA, and other pertinent regulations.

As indicated on the DPH-SAPC ROI Form, patients can elect to consent to share information with the entire SUD network of providers **(Option 1)** or consent only to specific SUD providers (**Option 2).** The benefits, risks, and alternatives to these options, must be discussed with patients to allow them to make informed decisions about their care. Patients must sign the DPH-SAPC ROI Form for it to be finalized.

Importantly, after the patient elects either **Option 1** or **Option 2** on the DPH-SAPC ROI Form providers, in Sage, must indicate the patient's consent option by going on the Consent Form page within Sage and selecting the providers the patient is interested in releasing information to. This process translates the patient's desires with regard to consent to release information into Sage. Similar to the DPH-SAPC ROI Form, there is also the option within Sage to select all providers and consent to share information with all SUD network providers, or to select only specific providers within the SUD network to share information. Once the Consent Form page within Sage is completed, providers must upload the signed DPH-SAPC ROI Form into Sage.

If the patient is transferring from a new location, providers must ensure that consent forms are signed and appropriately utilized to ensure information exchange while maintaining compliance with applicable confidentiality regulations.

Why Encourage Information Sharing?

The SUD system is moving into a new era that encourages information sharing with physical and mental health systems to improve care coordination and health outcomes.

It is important to support appropriate information sharing as SUD patients often have other health conditions that complicate care and can prevent long-term achievement of recovery goals if un/under treated.

SUD treatment providers within the specialty SUD system must update the ROI and consent forms that patients sign. Providers must also upload the latest documents to Sage so that other network providers have access to the latest versions of these documents to facilitate information exchange.

If patients revoke consent to disclose information to a specific SUD provider within the network, SUD treatment providers must notify involved entities of this update.

Patient Informing-Consent for Treatment and Information Sharing

The foundational principle of consent for treatment is that individuals must give permission before they receive any type of health treatment, test, or examination.

Informed consent generally includes:

- The nature of the decision, treatment, and/or procedure
- Reasonable alternatives to the proposed intervention
- The relevant risks, benefits, and uncertainties related to each alternative
- Assessment of patient understanding
- The acceptance of the intervention by the patient

It is critical that SUD providers thoroughly describe and explain the services that are recommended to give patients the information necessary to make informed decisions regarding the care that is being proposed.

Additionally, the intake process needs to include consenting patients for information sharing purposes. Sharing information with other SUD and physical/mental health providers is essential to provide coordinated care that is in the best interests of patients. As such, thorough information regarding confidentiality (HIPAA and 42 CFR Part 2) needs to be provided to patients in order to obtain informed consent for information sharing purposes that balances the need to maintain necessary privacy and the need to share information to provide high-quality and coordinated care.
In order to be valid, the consent process must be free of coercion, voluntary, and the patient giving consent must have decision-making capacity and be deemed competent to make the decision at hand.

Patient Informing – Complaint/Grievance and Appeals Process

All patients served within the specialty SUD system in LA County have access to a complaint/grievance and appeals process to, respectively, either express dissatisfaction or request reconsideration for an action taken by either the provider or County (e.g., denial of a requested service).

Patients need to be informed about their rights and the availability of a due process to file complaints/grievances and appeals, both at the level of the treatment providers and when there are concerns that are more appropriately addressed to the County. Patients should be given a form to sign indicating they have been informed of their rights. This signed form should be maintained in the patient file. These complaints/grievances and appeals may either be filed by the patient, provider, or another designated entity.

See *Complaints/Grievances and Appeals Processes* section for additional details.

Required Processes

Assessment

Part of the intake process involves assessing the patient by using a full ASAM CONTINUUM assessment to determine medical necessity and confirm LOC placement. See the *Assessment* section for further information on assessment.

Problem List Development and Updates in Non-OTP Settings

Non-OTP SUD treatment providers must prepare individualized Problem Lists in coordination with the patient and based on information obtained during the intake and assessment process and updated on an ongoing basis based upon the patient's progress within treatment. The provider staff(s) responsible for the beneficiary's care create and maintain the problem list.

The minimum timeframes for completing, reviewing, updating, and for obtaining LPHA signatures on Problem Lists depend on the LOC in which treatment is delivered (see **Table 17**). Problem list updates must be completed and signed by practitioners delivering services to the patient whenever a problem is added, modified, or removed from the problem list.

The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric and other diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the documenting practitioner (within their scope of practice) during that service encounter, and subsequently added to the problem list. The problem list shall be updated on an ongoing basis to reflect the current presentation of the patient beneficiary.
The problem list shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any.
- Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the beneficiary and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Provider staff shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.

Treatment Plan Development and Updates in OTP Settings

OTP providers must prepare individualized written Treatment Plans in coordination with the patient and based on information obtained during the intake and assessment process.

The treatment Plan must be completed upon intake and submitted within the timeframes specified in Table 18. Every attempt must be made to complete and obtain patient and LPHA/Medical Director signatures within the stated timeframe. However, given that it may take time for the patient to sign and print their name on the Treatment Plan, the provider must obtain both patient and LHPA signature no later than 28 days of the first service/first intake appointment. The LPHA or Medical Director must then sign and print their name on the Treatment Plan within 15 days of the patient signing. These are maximum time frames, and the ideal scenario is to complete and sign the Treatment Plan as expeditiously and close to the treatment admission date as possible.

The minimum timeframes for Treatment Plan reviews and updates are specified in **Table 18.**). Treatment Plan updates must be completed and signed by both the patient and the LPHA, and counselor, if applicable.

Treatment Plans must include:

- A statement of problems to be addressed that are consistent with the qualifying diagnosis
- Goals to be reached which address each problem
- Action steps to be taken by the provider and/or patient to accomplish identified goals
- Target dates for accomplishment of action steps and goals
- A description of services including the type of counseling to be provided and the frequency thereof as well as steps taken to complete the physical exam
- The proposed type(s) of interventions/modalities that includes frequency and duration of intervention(s)
- Specific quantifiable goals and treatment objectives (e.g., SMART goals that are Specific, Measurable, Attainable, Realistic, and Time-bound) related to the patient's SUD diagnosis and multidimensional assessment
- A DSM diagnosis for OUD and any other SUDs.
- The assignment of a primary therapist or counselor
- Physical exam goal or documentation

Physical Examination

Physical exams are required to ensure that patients are medically stable and receiving the physical health services they need to facilitate biopsychosocial well-being.

Patients are required to have a physical examination within the last twelve (12) months on file. The physician/nurse practitioner/physician assistant is responsible for reviewing documentation of the most recent (**within the last twelve (12) months)** physical examination within thirty (30) calendar days of the beneficiary's admission to treatment. In accordance with Title 22, if the physician is unable to acquire or review a patient's physical exam which has been conducted in the last twelve (12) months, the provider (**registered or certified counselor or LPHA**) must include a Miscellaneous Note detailing efforts made to obtain this documentation. If a physical examination is not on file, a physical examination must occur within thirty (30) calendar days of the patient's admission, or the physical exam will need to be incorporated into the documented clinical notes that include the goal of obtaining a physical examination with a specified date of completion.

Data Reporting

Treatment providers within the specialty SUD system in LA County are required to report data into the County's electronic data collection system formerly known as the Los Angeles County Participant Reporting System (LACPRS). CalOMS/LACPRS is now integrated into Sage and includes performance and outcome measures designed to inform and shape policy and practice.

These metrics help to ensure an evaluation system for the specialty SUD system that allows for continuous improvement and high-quality clinical care at the system, provider, and patient level. As such, ensuring data integrity is of the utmost importance and to the benefit of both the County and its providers. For this reason, CalOMS/LACPRS admission data must be completed within seven (7) calendar days of first service or first intake appointment for both youth (ages 12-17) and adults (ages 18+) and discharge data on the day of last treatment service.

Providers are required to develop internal processes to support data integrity efforts.
The County recognizes the importance of sharing performance and outcome data with its provider network and encourages providers to leverage available data analytic tools within Sage and their EHRs to allow for the detailed analysis of their provider- and patient-level data.

Additionally, since DHCS requires submission of CalOMS/LACPRS data for all individuals who are served within county systems, CalOMS/LACPRS data must be entered.

Early Intervention and Treatment Service Components

Below is a description of various Treatment Services that are available to patients served within the specialty SUD system. These services are available to patients receiving Early Intervention, Outpatient, Intensive Outpatient, Residential, Withdrawal Management and Opioid Treatment Programs. See the sections above on additional services including screening, assessment, Care Coordination, and Recovery Services. For more information on how these services are billed and any service minimums or maximums, see the *SUD Treatment Services Rates* and *Standards Matrix* and the *Staffing Grid.*

Group Counseling

Group Counseling sessions are designed to support discussion among patients, with guidance from the facilitator to support understanding and encourage participation, on psychosocial issues related to substance use.

This does not include recreational activities, skill building sessions (e.g., employment, education, tutoring), or time spent viewing videos/DVDs (although discussion time is generally allowable). Group Counseling sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques. To ensure that patients are aware of upcoming Group Counseling and Patient Education sessions, a monthly calendar must be posted in areas accessible to patients which includes the topic, location, date, time, and facilitator name of upcoming sessions.
Group Counseling sessions are available at all LOCs and are defined as face-to-face contact between up to two (2) registered or certified SUD counselors or LPHAs, and between two (2) to twelve (12) patients at the same time. This includes family members, non-My Health LA (MHLA), and non-Medicaid (Medi-Cal) participants. Only eligible patients (Medi-Cal or MHLA participants, or individual participating in a County funded program such as AB 109 receiving treatment) can be claimed to SAPC.

Services are reported in 1-minute (1 unit) increments with sessions ranging from 60 to 90 minutes in length. A separate Progress Note must be written for each participant and documented in the EHR or Sage. Group sign-in sheets must include signatures and printed names of all participants (including participants not reimbursed by SAPC and family members) and group facilitators, date, start/end times, location, and group topic.

The frequency of Group Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Note: Only in school-based settings are youth (12-17) and young adults (18-20) allowed to be in the same Group Counseling sessions.

Patient Education

Patient Education sessions are designed to enable the facilitator to teach participants and encourage discussion among patients on research-based educational topics such as addiction, treatment, recovery, and associated health consequences, with the goal of minimizing the harms of SUDs, lowering the risk of overdose and dependence, and minimizing adverse consequences related to substance use. This does not include recreational activities, skill building sessions (e.g., employment, education, tutoring), or time viewing videos/DVDs (although discussion time is generally allowable). Patient Education sessions need to include evidence-based practices that incorporate youth or adult learning styles and support information retention.

A SAPC-approved early intervention curriculum entitled “Health Youth: Early Intervention Services for Youth At Risk of Substance Use Behaviors” is available for youth and young adults who are enrolled in in Early Intervention services. All youth network treatment providers must complete the required Early Intervention Curriculum training before delivering the early intervention patient education sessions. Beginning July 1, 2022, adult treatment providers that provide Early Intervention services to young adults (ages 18-20) must also complete the required training on the Early Intervention curriculum by June 30, 2023.

To ensure that patients are aware of upcoming Group Counseling and Patient Education sessions, a monthly calendar must be posted in areas accessible to patients which includes the topic, location, date, time, and facilitator name of upcoming sessions.

Patient Education sessions are available at all LOCs and are defined as face-to-face contact between up to two (2) registered or certified SUD counselors or LPHAs, and between two (2) to twelve (12) patients at the

same time in non-residential settings and between two (2) to thirty (30) patients at the same time in residential settings. Patient Education sessions may include family members and legal guardians. Services are reported in 15-minute increments with sessions ranging from 60 to 90 minutes in length. A separate Progress Note documenting the Patient Education session must be written for each participant and documented in the EHR or Sage. Group sign-in sheets must include signatures and printed names of participants and group facilitators, date, start/end times, location, and group topic.

The frequency of Patient Education sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Individual Counseling

Individual Counseling sessions are designed to support direct communication and dialogue between the staff and patient and focus on psychosocial issues related to substance use outlined in the patient's individualized Problem List (non-OTP settings) or Treatment Plan (OTP settings). Individual Counseling sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

Individual Counseling sessions are available at all LOCs and are defined as face-to-face, by telephone or by telehealth contact between one (1) registered counselor, certified counselors or LPHA, and one (1) patient at the same time. A trainee may observe for training purposes if permitted by the patient. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. Individual Counseling sessions less than 15 minutes cannot be billed as they are less than the minimum requirement. If Individual Counseling sessions exceed 60 minutes, the Progress Note for that encounter must substantiate exceeded time. If the counseling session is split into different services (e.g., Care Coordination, Crisis Intervention, etc.), a Progress Note must be written for each session and documented in the EHR or Sage.

The frequency of Individual Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Crisis Intervention

Crisis Intervention sessions include direct communication and dialogue between the staff and patient and are conducted when:

1. A threat to the physical and/or emotional health and well-being of the patient arises that is perceived as intolerable and beyond the patient's immediately available resources and coping mechanisms; or
2. An unforeseen event of circumstance occurs that results in or presents an imminent threat of serious relapse.

These sessions are immediate and short-term encounters that focus on (1) stabilization and immediate management of the crisis, often by strengthening coping mechanisms, and (2) alleviating a patient's biopsychosocial functioning and well-being after a crisis. Crisis Intervention sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

A component of this service includes linkages to ensure ongoing care following the alleviation of the crisis. Crises that are not responsive to intervention need to be escalated to urgent (e.g., urgent care clinic) or emergent (e.g., medical or psychiatric emergency room) care. Crisis situations should not be confused with emergency situations, which require immediate emergency intervention, such as calling 911.

Crisis Intervention sessions are available at all LOCs and are defined as face-to-face, by telephone or by telehealth contact between one (1) registered/certified counselor or LPHA, and one (1) patient at the same time. Services may, however, involve a team of care professionals. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the EHR or Sage. Crisis Intervention sessions are not scheduled but need to be available to the patient as needed during the agency's normal operating hours or in alignment with afterhours crisis procedures.

Family Therapy

Family Therapy is a form of psychotherapy that involves both patients and their family members and uses specific techniques and evidence-based approaches (e.g., family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit. Sessions also need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

Family Therapy sessions are available at all LOCs and are defined as face-to-face contact between one (1) therapist level LPHA, one (1) patient and their family members. Services are billed in 15-minute increments with sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the EHR or Sage.

The frequency of Family Therapy sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Collateral Services

Collateral Services are sessions between significant persons in the life of the patient (i.e., personal, not official or professional relationship with patient) and SUD counselors or LPHAs used to obtained useful information regarding the patient to support the patient's recovery. The focus of Collateral Services is on better addressing the treatment needs of the patient.

Collateral Services sessions are available at all LOCs and are defined as face-to-face, by telephone or by telehealth contact between one (1) SUD counselor or LPHA, one (1) patient - unless clinically inappropriate for the patient to be present - and significant persons in the patient's life. If patient is not present, reasoning must be provided in documentation of Collateral Services. Services are billed in 15-minute increments with sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the EHR or Sage.

The frequency of Collateral Services sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized patient needs rather than a prescribed program required for all participants.

Alcohol and Drug Testing

Alcohol and drug testing is the examination of biological specimens (e.g., urine, blood, hair) to detect the presence of specific substances and determine prior substance use. While there is not a widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment effectiveness and progress to inform treatment decisions. The frequency of alcohol and drug testing should be based on the patient's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued alcohol and/or drug use has been identified to be more common. In general, alcohol and drug testing should not exceed more than twice (2x) a week. OTP requires monthly testing at a minimum.

Drug Testing as a Therapeutic Tool

Drug testing should be viewed and used as a therapeutic tool. A punitive approach to drug testing generally does not facilitate a productive relationship with patients and should be avoided. Consequences to drug testing should also be communicated in a therapeutic manner.

Drug testing is best when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) should ideally vary as well. If body fluids testing (urinalysis) is performed, the patient's emission of the urine must be collected and observed by an employee with the same gender to protect against the falsification and/or contamination of the urine sample. The treatment agency should take care to be respectful of the patient and patient privacy during the specimen collection process of drug testing.

Decisions about appropriate responses to positive drug tests and relapses should consider:

- The chronic nature of addiction
- That relapse is a manifestation of the condition for which people are seeking SUD treatment
- That medications or other factors may at times lead to false or appropriately positive drug test results

Alcohol and Drug Testing is allowable at all LOCs. Testing is NOT allowable for RBH. While it is not a reimbursable service, a Progress Note must be written for each test and the service reported in the EHR or Sage.

Medications for Addiction Treatment Within All Levels of Care

Medications for Addiction Treatment (MAT) service components include assessment, care coordination, individual and group counseling, family therapy, medication services, patient education, recovery services, SUD crisis intervention services, and withdrawal management services. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of all LOCs.

Service Requirements

SAPC contracted treatment providers are required to establish and maintain active policies and procedures facilitating the provision of MAT either directly to their patients or via linkage with other providers (e.g., community health centers such as federally qualified health centers [FQHCs], or primary care providers who provide care within the patients' financial eligibility) that offer MAT services.

Contracted treatment providers that do not offer MAT directly must establish referral relationships with both Opioid Treatment Programs (OTP) and non-OTP clinics with MAT prescribing clinicians for their patients. SAPC encourages formal arrangements such as via memorandums of understanding (MOU) between agencies in order to optimize referral relationships and processes. Simply providing the patient contact information for a treatment program that offers MAT is insufficient. An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not that provider seeks reimbursement through DMC-ODS. SAPC monitors the referral process or provision of MAT services to ensure that patients appropriately connect to care and receive information about all available treatment options.

SAPC contracted providers, including CENS staff, are required to discuss and inform patients about MAT as a treatment option for all patients being treated for an alcohol, opioid, and/or tobacco use disorder[1] so that they understand that MAT is an evidence-based treatment option for their condition. MAT is required to be offered as a concurrent treatment option for patients with these conditions at all levels of care and settings across the specialty SUD system. The passive or active discouragement of the use of MAT is contrary to both SAPC policy and to the science of effective SUD treatment.

MAT should be discussed and offered as a treatment option for all individuals with an SUD diagnosis for which there are FDA-approved medications and biological products to treat any SUD including opioid use disorder (OUD) and alcohol use disorder (AUD. Acceptance or refusal of MAT must be documented in clinical record. MAT is available to Medi-Cal beneficiaries through the Medi-Cal pharmacy benefit without prior authorization and can be delivered to provider offices by pharmacies. Patients needing or utilizing MAT must be served by SAPC providers and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in treatment. SAPC providers offering MAT shall not deny access to medication or administratively discharge a patient who declines counseling services.

For patients who lack connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as utilizing different evidence-based practices, different staff and/or different services. If the Provider is unable to capably continue treating the beneficiary, they must assist the patient in choosing another MAT provider, ensuring continuity of care and facilitating a warm hand-off.

MAT as a Core Component of SUD Treatment

While psychosocial interventions such as counseling are critical to achieving recovery, the use of medications for the treatment of addiction are also oftentimes essential for recovery.

Just as medications are commonly accepted and can help with the treatment of other chronic conditions, MAT can help to alleviate alcohol- and opioid-related cravings, and ease withdrawal symptoms. As such, MAT is an evidence-based tool to facilitate recovery and improve outcomes and is best practice and a core component of SUD treatment for individuals for whom it is clinically appropriate.

There are currently several FDA-approved medications for the treatment of various types of addiction in adults, as indicated in **Table 13**. For more information on Naloxone Administration and Availability, please see *SAPC Bulletin Number 19-04*.

Table 13. Medications for Addiction Treatment Options

Opioid Use Disorder (OUD)	Alcohol Use Disorder (AUD)	Tobacco Use Disorder (TUD)[11]
Methadone ***(oral methadone is only available via OTPs for the indication of OUD)***	Naltrexone Oral and long-acting injectable formulations effective for AUD	Varenicline
Buprenorphine **Sublingual or injectable buprenorphine formulations for the indication of OUD**	Disulfiram Oral formulation	Bupropion
Naltrexone **Long-acting injectable formulation is preferred to oral for OUD**	Acamprosate	Nicotine Replacement Therapy
Naloxone[12] **Injectable or Intranasal Formulations that Reverse Opioid Overdose**		

MAT includes obtaining informed consent, ordering, prescribing, administering, and monitoring of all medications for SUDs. When MAT is provided to patients, licensed prescribers operating within their scope of practice should assist the patient to collaborate in clinical decision-making, assuring that the patient is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT, taking into consideration the benefits, side effects, alternatives, cost, availability, and potential for diversion, among other factors.

Accessing MAT as a Medi-Cal Enrolled Beneficiary (including individuals whose Medi-Cal benefits are active and being transferred from another county)

- SAPC non-OTP prescribing clinician writes a prescription for MAT. Patient either goes to a community pharmacy that bills Medi-Cal to dispense the prescription or the provider arranges that the pharmacy deliver the medication to the provider site. SAPC recommends that the provider contact the community pharmacy to confirm that it has the prescribed MAT in stock.
- SAPC providers who do not have an available prescribing clinician should consider these alternative pathways to establish MAT access for Medi-Cal beneficiaries:

    1. SAPC non-OTP provider refers the patient to another clinic or service that prescribes MAT. LA County community clinics that prescribe MAT are listed here: http://LosAngelesMAT.org

[11] Tobacco use disorder (TUD) cannot be a primary diagnosis for Drug Medi-Cal Organized Delivery System (DMC-ODS) services, but SAPC programs should treat TUD as a component of other DMC-ODS services as long as a non-tobacco SUD is the primary diagnosis for DMC-ODS services. Given the high co-occurrence of TUD and other SUDs, tobacco use can be a topic for patient education groups, included as part of risk reduction groups and individual counseling services, and as part of a patient's overall treatment for the primary substance use disorder.
[12] Naloxone should be prescribed to patients with opioid, stimulant, sedative and other use disorders where patients are at risk for opioid overdose. Naloxone does not require a prescription to be distributed, and should be distributed to patients, their family members, and the community when it is impractical to prescribe to individuals at risk of opioid overdose.

OR

2. SAPC non-OTP provider refers the patient with an OUD to enroll in a SAPC- contracted OTP. SAPC-contracted OTPs are listed on the SBAT as listed here: http://sapccis.ph.lacounty.gov/sbat

Accessing MAT as a MHLA Enrollee

Uninsured patients who do not qualify for public insurance such as full-scope Medi-Cal can access MAT through the LA County DHS MHLA program. They must first be enrolled in MHLA and then can receive medications through MHLA-contracted pharmacies.

1. MHLA enrollees can be prescribed MAT by a SAPC providers' prescribing clinician even if the SAPC provider and clinician are not directly contracted with MHLA.
    1. Confirm that the MHLA's formulary covers the specific MAT prescription on the MHLA Drug Formulary available here: http://dhs.lacounty.gov/my-health-la/pharmacy. MHLA covers naloxone as well as most type of MAT including: buprenorphine-naloxone, oral naltrexone, and bupropion
    2. SAPC non-OTP providers' prescribing clinician writes MAT prescription for a MHLA enrollee.
    3. SAPC non-OTP provider refers the patient to a MHLA-contracted pharmacy which bills MHLA to dispense the prescription or arranges with the MHLA-contracted pharmacy for delivery of the medication to the provider site.
    Find a MHLA-contracted pharmacy here: http://www.ventegra.com/MHLA
    SAPC recommends that the provider contact the community pharmacy to confirm that it has the prescribed MAT in stock
2. SAPC providers who do not have an available prescribing clinician should consider these alternative pathways to establish MAT access for MHLA enrollees:
    1. SAPC provider refers the patient to a MHLA community clinic or service that prescribes MAT. MHLA clinics that prescribe MAT are listed here: http://LosAngelesMAT.org
    OR
    2. SAPC non-OTP provider refers the patient with an OUD to enroll in a SAPC- contracted OTP. SAPC-contracted OTPs are listed on the SBAT: http://sapccis.ph.lacounty.gov/sbat

Accessing MAT as a Los Angeles County Department of Health Services Primary Care Patient Without Medi-Cal

Uninsured patients without Medi-Cal or MHLA who are already receiving DHS primary care should be referred to a DHS-operated hospital or clinic to receive a prescription for MAT that will also need to be filled via a DHS-operated pharmacy.

For more information about DHS and to locate a DHS-operated hospital or clinic, visit: http://dhs.lacounty.gov/our-services or the patient can call the DHS Access Center via (844) 804-0055.

3. SAPC non-OTP provider refers the patient to a DHS clinic or hospital that prescribes MAT. DHS primary care clinics that prescribe MAT are listed here: http://LosAngelesMAT.org
OR
4. SAPC non-OTP provider refers the patient with a prescription for MAT from a DHS prescribing clinician to a DHS-operated pharmacy which dispenses MAT. Find a DHS- operated pharmacy here: http://dhs.lacounty.gov/our-services/pharmacy

OR

5. SAPC non-OTP provider refers the patient with an OUD to enroll in a SAPC- contracted OTP. SAPC-contracted OTPs are listed on the SBAT: http://sapccis.ph.lacounty.gov/sbat

***Important**:*
For injectable naltrexone (Vivitrol®), the SAPC provider must assist the patient with enrollment in the manufacturer's co-pay program (available via http://od.vivitrol.com/co-pay-savings-program for patients with OUD and http://www.vivitrol.com/alcohol-dependence/co-pay-savings-program for patients with AUD). If co-pay program application is denied, refer patient to their MHLA community clinic for follow up and provide the co-pay application denial letter/notice. The patient's assigned MHLA clinic will then need to complete and submit a MHLA Naltrexone (Vivitrol®) Prior Authorization (PA) Form, available via http://dhs.lacounty.gov/my-health-la/pharmacy (Prior Authorization Forms), to DHS Pharmacy Affairs (by email: priorauth@dhs.lacounty.gov or by fax: (310) 669- 5609) for coverage consideration.

All MAT must be prescribed in accordance with generally accepted standards of medical practice and best practice guidelines for the condition being treated.

Medication Services and Safeguarding Medications

Medication Services include the prescription, administration, or supervised self-administration (in residential settings) of medication related to SUD treatment services or other necessary medications that are not already reimbursed under an OTP for MAT. Medication Services may also include assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure. SAPC does not cover the drug product costs for MAT outside of the pharmacy or OTP/NTP benefit. SAPC does reimburse for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a standalone service. These are billed under Medication Services (MAT).

Safeguarding of medications in accordance with regulations is required in residential and withdrawal management settings, and may be performed by qualified staff (e.g., Licensed Vocational Nurses [LVN] or Medical Assistants [MA]). However, LVNs/MAs are not billable providers for treatment services as they do not fall under the LPHA, licensed-eligible LPHA, or certified counselor categories. Therefore, services rendered by LVNs/MAs will not be reimbursed by SAPC other than in the instance of LVNs/MAs performing activities of Safeguarding Medications.

Refer to the *Provider Staffing Grid* on SAPC's website for a complete list of staff that may assist with Medication Services.

Medication Services are available at all LOCs and are defined as face-to-face contact between patients and medical staff (e.g., physicians, nurse practitioners, or physician assistants), as related to the use of FDA-approved MAT, or other necessary medications. Medication Services are reported in 15-minute increments with sessions ranging from 15 to 30 minutes in length. A separate Miscellaneous Note or Progress Note must document the encounter for each participant.

Importantly, Medication Services provided in residential settings require Incidental Medical Services approval from the State for the specified residential site. Despite this allowance from the state, there is not a current

mechanism in place for billing. As a result, Medication Services provided in residential settings are not DMC reimbursable.

Transportation Services

Providers need to make every effort possible to provide transportation or make arrangements for transportation to and from medically necessary, but non-emergent, treatment, transportation services may be covered by the patient's Medi-Cal managed care health plan (L.A. Care and Health Net). Transportation services may require a pre-authorization from the health plan, and it is the patient's care coordinators responsibility to arrange for services ahead of time. The time spent coordinating transportation services is billable under Care Coordination, but not the transportation services.

In accordance with BHIN 22-031 and All Plan Letter (APL) 22-008, transportation services are available for beneficiaries receiving behavioral health as outlined at these links and below. For additional information see APL 22-008 FAQs.

There are two types of transportation on the Medi-Cal program:

- Non-medical transportation (NMT) for beneficiaries who do not need medical assistance during transit.
- Non-emergency medical transportation (NEMT) for when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated.

NMT and NEMT services may be covered by the patient's Medi-Cal managed care plan for the following situations:

1. Transportation to medical, dental or behavioral health appointments for all Medi-Cal services (available to patients receiving outpatient, inpatient, or residential services).
2. Transportation for transfer from general acute care hospitals or emergency departments to psychiatric facilities, including psychiatric hospitals, skilled nursing facilities and mental health rehabilitation centers.
3. Transportation after discharge.

Patients in need of NEMT will require the treating physician to submit an approved physician certification statement form from the patient's MCP authorizing the NEMT. For more information about Medi-Cal covered transportation services, see DHCS Transportation Webpage

Exceptions include when providing treatment services at SAPC approved FBS location, the performing provider will be able to add travel time to and from the approved location, up to 30 minutes each way. See *SUD Treatment Services Rates* and *Standards Matrix* for more information.

For each network provider with a DMC Perinatal Contract and site certification with DPH-SAPC, non-emergency transportation is billable under Perinatal Transportation (up to 80 miles per month) at every LOC. See *Pregnant and Parenting Women* section for more information.

Also, select costs can be added in the budget which includes but is not limited to transporting the patient to and from medical appointments, mileage for staff vehicle (a log for odometer readings before and after trip must be properly maintained) or provider vehicle costs (e.g., gas, maintenance, depreciation). Bus and metro tokens can also be included in the budget, provided a log of total purchases and distribution to each patient is

maintained and available to auditors upon request. Rideshare services (e.g., taxi, Uber, Lyft) cannot be included in the budget, with the exception of patients enrolled in the Youth Enhancement Services (YES) Project.

Transportation costs must be reported under the "Transportation" line item under "Services and Supplies" category and be clearly tracked and managed. While transportation costs are included in the day-rate for residential treatment, transportation is not billable as separate service in residential. However, for Non-Emergency Transportation services to count towards the Residential weekly treatment hour standard, providers must document in a Miscellaneous Note how transportation is contributing to patient care and recovery. Start and end times per trip must be captured in the note.

Discharge Planning

Discharge planning is the process of preparing the patient for referral into another LOC, post-treatment return, or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. The discharge planning process should be initiated at the onset of treatment services to ensure sufficient time to plan for the patient's transition to subsequent treatment or recovery services. It also helps to convey that recovery is an ongoing life process not a unit of service. Transition to Recovery Services needs to be included as part of this process. Discharge planning should identify a description of the patient's triggers, a plan to avoid relapse for each of these triggers and an overall support plan.

Discharge Planning sessions are available at all LOCs and are defined as face-to-face, by telephone or by telehealth contact between one (1) registered counselor, certified counselors or LPHA, and one (1) patient at the same time. A trainee may observe for training purposes if permitted by the patient. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the EHR or Sage.

The Discharge Form is required to be completed on the day of the last face-to-face treatment/ telephonic contact, or oral medication (OTP) for all LOCs, unless the patient's discharge is unplanned. If a patient's discharge is unplanned, the Discharge Form is required to be completed within 30 calendar days of the last day that services were provided. For Recovery Bridge Housing, the RBH Discharge Summary Form is required to be completed for each patient and submitted into Sage at the time of discharge from RBH.

Culturally, Linguistically, and Population-Appropriate Services

Cultural competence and humility include building knowledge of and respect for the multidimensional and complex ways language and culture (inclusive of race, faith, ethnicity, abilities, gender identity, class, sexual orientation, housing and education) is experienced individually and impacts personal interactions. It is a critical component of high-quality SUD services.

Treatment agencies are expected to ensure that their policies, practices, and procedures facilitate the provision of culturally, developmentally, linguistically and population appropriate services. These principles should be embedded in the organizational and day-to-day operations. Research indicates that a lack of cultural competency in the design and delivery of services can result in poor outcomes in access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response. Core practices that address cultural competence and humility include:

- Developing patient-centered attitudes, beliefs, values, and skills at the provider level
- Policies and procedures that clearly state and outline the requirements for the quality and consistency of care (e.g., Notice of Non-Discrimination, language taglines)
- Readiness and availability of administrative structures and procedures to support such commitments (e.g., leadership and staff that reflect the primary populations, staff training)

Providers are Required to Deliver Culturally, Developmentally, and Linguistically Appropriate Services

Providers need to ensure that their policies, procedures, and practices are consistent with this requirement, and that these principles are embedded in both the organizational structure and day-to-day operations of their agency (e.g., Personnel recruitment/retention, equal access to services, assessment of accessibility, linguistic and cultural needs, etc.).

This also includes provisions for:

1. Services provided in Los Angeles County's threshold languages or in the individual's preferred language (if not one of the threshold languages)
2. Written material provided in threshold languages of populations served
3. Culturally relevant and competent services (i.e., demonstrate a respect for the diverse cultural, ethnic, and linguistic needs of the primary population served)

SAPC is committed to promoting a service delivery system that treats individuals within the context of their language, culture, ethnicity, gender identity, age, sexual orientation, development stage, and any physical, psychiatric, or cognitive disabilities.

Services for Persons with Disabilities

Providers must be compliant with all elements of the Americans with Disabilities Act, this includes access to alternate access technologies (e.g., TTY/TVR, magnification, audio, etc.) and policies for allowing service animals. The SAPC website provides resources and addition information about how to implement culturally competent services.

Language Assistance Services

SAPC and its contracted providers shall ensure compliance with all requirements for ensuring access to language assistance services (e.g., oral interpretation, sign language, written translation, etc.) for beneficiaries who are monolingual non- English speaking or limited English proficiency (LEP) at no cost, this may include linguistically proficient staff and/or interpreter services.

When a beneficiary requests services in a non-English language, network providers shall (as outlined in *SAPC Bulletin 18-03*):

- Input beneficiary self-reported preferred language for treatment services into the EHR-Sage and the relevant data fields in CalOMS
- Use the Care Coordination benefit to refer beneficiaries for treatment in their preferred language if treatment services are not available by linguistically proficient staff

- If a beneficiary refuses interpreter services, document in the chart that free interpreter services were offered and declined
- Family members, friends, etc. are not used as interpreters, unless specifically requested by the beneficiary, and when restricted to intake and screening/assessment activities. Under no circumstances is a minor child used as an interpreter

Interpretation services shall be available during all hours the provider is open for business. In some limited circumstances, SAPC may provide assistance to its network provider agencies with identification of oral and sign language interpretation services, contact eapu@ph.lacounty.gov.

Special Populations

Co-Occurring Disorder Population

For the purposes of this document, co-occurring disorders (COD) are defined as when an individual has a combination of any SUD or any mental health condition, though individuals with COD can have physical health conditions as well. The COD must meet the diagnostic criteria independently from the other condition and cannot simply be a cluster of symptoms resulting from a single disorder. The significant co-morbidity of SUDs and mental illness (typically reported as 40 percent to 80 percent depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse Treatment for Persons with Co-Occurring Disorders[13] consensus panel members recommend the following guiding principles in the treatment of patients with CODs:

- **Employ a recovery approach** - The recovery perspective essentially acknowledges that recovery is a long-term process of internal change that requires continuity of care over time and recognizes that these internal changes proceed through various stages, and that treatment approaches need to be specific to the goals and challenges of each stage of the COD recovery process
- **Adopt a multi-problem viewpoint** - Treatment comprehensively addresses the immediate and long-term needs of the multidimensional problems typically presented by patients with COD (e.g., housing, work, health care, a supportive network)
- **Develop a phased approach to treatment** - Treatment phases generally include engagement, stabilization, treatment, and continuing care, which are consistent with, and parallel to, the various stages of recovery. Treatment through these phases allows providers to develop and use effective, stage-appropriate treatment interventions

[13] Substance Abuse and Mental Health Services Administration. Substance Use Disorder Treatment for People With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series, No. 42. SAMHSA Publication No. PEP20-02-01-004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

- **Address specific real-life problems early in treatment** - Given that CODs often arise in the context of social and personal problems, addressing such problems is often an important first step toward achieving patient engagement in continuing treatment
- **Plan for the patient's cognitive and functional impairments** - Patients with a COD often display cognitive and functional impairments that affect their ability to comprehend information or complete tasks. As a result, services need to be tailored to and compatible with the need and functional level of COD patients
- **Use support systems to maintain and extend treatment effectiveness** - Given that many patients with a COD have strained support systems, and the central importance of supportive people and environments in the recovery process, a vital element of effective treatment of the COD population is ensuring that patients are aware of available support systems and motivated to use them effectively

An important component of being able to develop a therapeutic alliance with the patient with a COD is the counselor or clinician's own comfort level in working with the patient. Some SUD counselors/clinicians may find some patients with significant mental health conditions threatening or unsettling, and likewise, some mental health clinicians may feel uncomfortable or intimidated by patients with SUDs. As a result, it is critical for the counselor/clinician to recognize these feelings so that they can develop strategies to avoid allowing them to interfere with the treatment of the patient with a COD. Oftentimes, these reactions can eventually be overcome with further experience, training, supervision and consultation with a supervisor or peer, and mentoring.

Optimal Treatment of Co-Occurring Disorder Population

Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the SUD and mental health condition separately and in a silo of separate treatment approaches. When providers have staff that possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided in-house. However, if providers are unable to provide necessary services to this population, patients with CODs should receive appropriate referrals to providers who are able to deliver these necessary services.

While SUD counselors and staff are not expected to diagnose mental health disorders, it is important that they familiarize themselves with the terminology, criteria, and how to identify if there may be mental health concerns that may benefit from referral to other health providers. In order to meet the needs of this population, SUD counselors and clinicians need to receive training designed to help them better understand the signs and symptoms of mental disorders and how and when to access medical or mental health support.

Importantly, agencies should not be screening out patients with COD based on a mental health diagnosis or prior psychiatric hospitalization history. Simply because a patient has a prior diagnosis of schizophrenia or bipolar disorder does not mean that he/she is inappropriate for the SUD system, as people can be stable and have a mental health diagnosis or may have also been incorrectly diagnosed previously as a result of symptoms resulting from their SUD. Similarly, a prior psychiatric hospitalization history indicates prior acute psychiatric needs but does not necessarily mean that someone has acute psychiatric needs presently. The key determination for appropriateness of admission to SUD treatment for COD populations should be if an individual is psychiatrically stable enough to benefit from SUD treatment in his/her present state, and not be based on a prior history of specific diagnoses or prior psychiatric hospitalization history.

Appropriate staffing is another key element of effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to implement integrated care programs successfully and to maintain a motivated and effective staff. Ideally, enhanced staffing for patients with a COD at SUD treatment sites would include mental health professionals, and vice versa at mental health treatment sites. Alternatively, establishing appropriate referral relationships and referral processes and protocols can also help to ensure comprehensive and necessary care for individuals with a COD.

Psychosocial interventions that have been demonstrated to be effective for the COD population include motivational enhancement, contingency management, relapse prevention, and cognitive–behavioral techniques. These strategies need to be tailored to the patient's unique stage of recovery and can be helpful even for patients whose mental disorder is severe. For patients with functional and cognitive deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Additionally, 12-Step and other dual recovery mutual self-help groups may be valuable as a means of supporting individuals with COD, and counselors and clinicians often play an important role in facilitating participation in such groups. The use of appropriate psychotropic medications and medications for addiction treatment is an essential component of the treatment of individuals with a COD. Oftentimes the appropriate use of medications can help patients with a COD stabilize and control their symptoms so that they can better focus on their recovery for either their SUD or mental health condition. Research has clearly demonstrated that medications used in conjunction with psychosocial interventions for both SUDs and mental illness is preferable and leads to better outcomes than either intervention alone. An important component of the treatment of patients with a COD is thus ensuring a recovery environment that is supportive of the various and individualized paths to recovery that many patients with CODs take. This includes ensuring that staff are prepared to facilitate the patient's treatment with medications for both SUDs and mental health conditions when determined to be necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, the treatment of patients with a COD requires a comprehensive and flexible treatment approach, in addition to coordination with other systems of care.

Pregnant and Parenting Women Population

Substance use while pregnant can result in significant maternal, fetal, and neonatal morbidity. SUD providers offering services funded by DMC shall address specific treatment and recovery needs of pregnant and parenting women of up to 60 calendar days postpartum[14]. Research indicates that targeted interventions to pregnant women with SUDs increases the incidence of prenatal visits, improves birth outcomes, and lowers overall health care costs for both mother and baby. The unique needs of pregnant and parenting women must be considered in the provision of services for this special population.

Motivational therapies are critical to the engagement and recovery process. While there is overlap between treatment approaches for the general population and pregnant and parenting women, ideal therapies for this special population incorporate treatment elements that are unique to this group. These include promoting bonding with the expected child, reproductive health planning, and Care Coordination to address the material and physical/mental health needs that accompany pregnancy. The initial assessment, Problem List (non-OTP settings) or Treatment Plan (OTP settings), and reassessments of progress need to consider the varied needs related to the health and well-being of both woman and fetus/infant.

[14] *California Department of Health Care Services (DHCS), Perinatale Practice Guidleines (PPG) FY 2018-2019*

Federal priority guidelines for SUD treatment admission give preference to pregnant substance use users, pregnant injecting drug users, and any parenting female substance and injection drug users. However, a specific LOC is not prescribed and thus the appropriate setting and LOC for this population needs to be consistent with the ASAM criteria, with consideration of the ability to accommodate the physical stresses of pregnancy (e.g., climbing stairs, performing chores, bed rest when medically required, etc.) and the need for safety and support during this period. LOC determinations need to be based on individualized and multidimensional ASAM assessments and may lead to placement recommendations in the residential or outpatient setting, depending on clinical need.

Staff working in settings that provide services for pregnant and parenting women need to be trained in proper procedures for accessing medical services related to prenatal care, labor and delivery, and therapeutic responses to the varied positive and negative outcomes of pregnancy. Services need to be provided in a non-judgmental, supportive, and open environment.

The use of MAT during pregnancy needs to include careful and individualized consideration of the potential impact of both treatment and lack of treatment on mother and baby. Though there is some risk in using medications during pregnancy, there is also known risk in the inadequate treatment of addiction during pregnancy, and this needs to be considered and discussed with patients. For pregnant women with opioid use disorders, MAT such as methadone and buprenorphine are the standard of care. In these instances, informed consent needs to be obtained, including discussions regarding Neonatal Abstinence Syndrome and what to expect at delivery. Opioid detoxification should also be reserved for selected women because of the high risk and potential consequences of relapse on both mother and baby. The risks and benefits of breastfeeding while patients are receiving medication-assisted treatments need to be weighed on an individual basis. Methadone and buprenorphine maintenance therapy are not contraindications to breastfeeding.

Given that women may be at increased risk of resuming substance use following delivery, treatment should not end with delivery. Post-delivery treatment services include, but are not limited to:

- Support for parenting a newborn
- Education about breast feeding
- Integration with other children and family members
- Care Coordination for practical needs such as legal assistance
- Equipment and clothing
- Coordination of physical and mental health services as needed
- Coping with the physical and psychosocial changes of the postpartum period
- Reproductive health planning
- Encouragement of the continued pursuit of recovery goals

Perinatal services must also be in accordance with the most recent version of the Perinatal Practice Guidelines released by DHCS.

Adolescent Patients

Adolescence represents an opportunity to influence risk factors related to substance use earlier on in an individual's development as compared with adult patients. Adolescent SUD treatment needs to be approached

differently than adults because of differences in their stages of psychological, emotional, cognitive, physical, social, and moral development. Examples of these developmental issues include their newly formed independent living skills, the powerful influence of interactions between adolescent and family/peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

These unique characteristics of the adolescent population are reflected in both clinical practices as well as in the ASAM criteria, as adolescents tend to require more intensive LOCs than their adult counterparts. As a result, the patient-to-counselor ratio for adolescent cases is ideally less than the ratio for adult cases to accommodate for this increased treatment intensity.

Due to the rapid progression of adolescent substance use, particular attention must be paid to streamlining the treatment admission process so that adolescent SUD needs are identified and addressed as soon as possible. Strategies to engage adolescents, hold their attention, channel their energy, and retain them in treatment are especially critical. Adolescent treatment needs to also address their increased rates of co-occurring disorders, highlighting the need to coordinate care with the mental health system, as clinically indicated.

Treatment planning needs to begin with a comprehensive assessment based on the ASAM criteria or, for youth (ages 12-17) receiving Early Intervention services, with a ASAM Screener for Youth and Young Adults. The assessment includes all the dimensions and biopsychosocial components of the complete adult assessment, the nuances of the adolescent experience, and their unique needs and developmental issues. Strengths and weaknesses need to be identified and adolescents need to be involved in setting their treatment objectives. Comprehensive adolescent assessments include information obtained from family, and when the appropriate releases are obtained, members of the community who are important to the adolescent patient, such as school counselors, peers, and mentors. The support of family members is important for an adolescent's recovery and research has shown improved outcomes for interventions that seek to strengthen family relationships by improving communication and improving family members' ability to support abstinence from drugs.

Optimal Treatment of the Adolescent Population

Generally, optimal treatment of the adolescent population requires greater amounts of external assistance and support compared to adults, and more intensive treatment and/or higher levels of care for a given degree of severity or functional impairment, when compared with adults.

Although most adolescents do not develop classic physical dependence, physical deterioration, or well-defined withdrawal symptoms as is common for adults who have longer durations of substance use, adolescents may be more susceptible to the functional impact of SUDs. For youth, casual substance use can quickly escalate to highly problematic abuse. Subsequently, adolescents often exhibit higher rates of co-occurring disorders, such as anxiety and depression, because of the negative impact that substance use has on normal adolescent social and psychological development.

During treatment of the adolescent population, every effort needs to be made to support the adolescent's larger life needs in order to maximize the likelihood of treatment success, for example by having flexible weekend and evening hours to accommodate continued engagement with school and appropriate social activities. These larger life issues may be related to medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or

behavioral issues. Failing to address such needs simultaneously could sabotage the adolescent's treatment success.

Behavioral therapies, delivered by trained counselors and clinicians practicing within their scope of practice, need to be employed to help adolescent patients strengthen their motivation to change. Effective psychosocial interventions may provide incentives for abstinence, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

The use of MAT for adolescents is promising, but the current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. With the exception of methadone and buprenorphine, which can be prescribed in youth ages 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, there are currently no FDA-approved medications for the treatment of addictions in adolescents. As a result, the use of MAT for adolescents should be considered and used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. While most adolescents do not develop classic physical dependence or well-defined withdrawal symptoms as a result of shorter durations of substance use compared with adults, youth opioid addiction is an exception that at times may require MAT when clinically indicated, particularly for severe withdrawal symptoms.

The ASAM LOC criteria for adolescents are distinct from that of adults and are tailored to the particular needs of this population. In general, the ASAM criteria tends to place adolescents in more intensive LOCs than their adult counterparts.

Treatment services for adolescents occur in a setting that is clinically appropriate and comfortable for this population. The adolescent treatment environment should be physically separate from that of adult patients. Staff also need to be familiar and appropriately trained to address the developmental nuances of caring for this unique population.

Similar to other groups, treatment of the adolescent population is regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue into adulthood, with a gradual transition to adult SUD services.

Adolescent patients should be referred to a qualified adolescent/youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate LOC, as necessary. If the individual initially presents at a SUD treatment provider that does not offer the appropriate provisional LOC, that agency will identify alternate referral options and assist the individual in connecting with the selected agency, or the individual may elect to remain with the initial provider if clinically appropriate. All Medi-Cal eligible beneficiaries will be referred to, and/or served by, a DMC-certified agency for DMC-reimbursable services.

Young Adults

In this document, the term "young adult" refers to individuals between the ages of 18 – 20 and represents young people transitioning into adulthood, some of whom may have received services from the adolescent service system and may need continued services and supports from the adult system. Clinically, age range definitions should be viewed flexibly given the variable nature of chronological age and developmental maturity. This population presents unique service challenges because they are often too old for youth services but may not be ready for adult services. Young adults are simultaneously emerging into independence while

Optimal Treatment of the Young Adult Population

In general, the treatment needs of young adults will be more intensive than the typical adult, but less than the typical adolescent. This will require a blending of programs that currently exist for adolescents and adults, and ideally would occur within programs with specific expertise in treating this population. The approach toward caring for young adults needs to include a flexible mixture of treatment techniques depending on prior contacts with the treatment system and the unique needs of each clinical case.

For young adults who have previously been served in the youth system of care for their substance use and other health needs, every effort needs to be made to coordinate care with their prior providers to determine the best treatment approach. Prior response to interventions should inform and guide future interventions, with the understanding that the approach toward treatment would be dynamic as young adults transition into adulthood.

still relying on the support of parents and caregivers. The mixture of adolescent and adult characteristics in the young adult population often requires a specialized approach due to issues of confidentiality, financial support, and shared living environments, among others.

Multidimensional assessments include determinations of the developmental stage of young adult populations to help inform treatment approaches and whether care modeled after adolescent approaches or adult approaches may be more appropriate. Strengths and goals need to be identified and young adults need to be involved in treatment planning. When the appropriate authorizations are obtained, family should be involved in the information gathering and treatment process, when family involvement is clinically appropriate and determined to be beneficial. Treatment planning begins with the ASAM full assessment or, for young adults receiving Early Intervention Services, the ASAM Screener for Youth and Young Adults.

Similar to youth, young adults typically have various life needs beyond their substance use treatment, and every effort need to be made to support these needs to increase the likelihood of positive outcomes. These larger life issues may be related to medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues.

Behavioral therapies and MAT, delivered by trained counselors and clinicians practicing within their scope of practice, should be employed depending on clinical need. As discussed in the Medication-Assisted Treatment section of this document, there are various medications used for addictions that have been FDA-approved for individuals over the age of 18 (and some over the age of 16) and need to be a treatment option available to young adults in conjunction with psychosocial interventions and as a component of a multifaceted treatment approach. Effective psychosocial interventions may provide incentives for abstinence, enhance motivation for change and recovery, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

Ideally, staff working with the young adult population would be familiar with and interested in working with the unique needs of this population. They should have experience in treating both the adolescent and adult populations in order to best blend necessary treatment approaches.

While the ASAM criteria does not specifically explore the specialized considerations of young adults, the ASAM criteria does note that an intermediate stage between adolescence and adulthood may become standard in the

future, with accompanying treatment approaches that are individualized to address the unique assets, vulnerabilities, and needs of this group.

Older Adults

Given the chronic nature of substance use disorders and the expanding population of older adults, it is increasingly important to modify treatment approaches to the unique needs of this population. In general, older adults include individuals over the age of 65, but this definition should be individualized based on clinical need. For example, some individuals younger than age 65 may have cognitive deficits, medical conditions, or social situations that necessitate the utilization of treatment approaches that are more typical for individuals of more advanced age.

Key differences between older and younger populations necessitate different approaches toward treatment. Due to altered metabolism and brain function, and the medical conditions that often accompany advanced age, the quantity and frequency of substance use in older adults may underestimate the functional impact in this population and create diagnostic challenges. In addition to the fact that many older adults are retired, limiting the sensitivity of using work or social impairment as a diagnostic indicator, a smaller amount of alcohol or substances may impact older adults more severely than younger counterparts. Health care providers also sometimes overlook substance use in this population, mistaking symptoms and indications of substance use for dementia, depression, or other problems common to older adults.

Optimal Treatment of the Older Adult Population

In general, panelists from SAMHSA recommend the following treatment approaches for the older adult population:

- Treat older people in age-specific settings, where feasible, ensuring appropriate pace and content of treatment.
  - Create a culture of respect for older patients. Follow treatment approaches that are supportive, non-confrontational, and aim to build self-esteem.
  - Take a broad, flexible, holistic approach to treatment that emphasizes age- and gender-specific psychological, social, and health problems. These approaches need to include building social support networks and coping skills dealing with depression, loneliness, and loss.
  - Staff working with older adults need to be interested and experienced in working with this population.

Social isolation, lack of transportation, and heightened levels of shame and guilt in this group may make accessing services for the older adult population more difficult than other age groups. As a result, older adults may be more likely to attempt to hide their substance use and less likely to seek professional help. Older adults are also more likely to be primary caregivers for a spouse who has greater needs than their own, which may limit their willingness to enter into treatment due to their caregiving responsibilities.

Research has demonstrated that age-specific assessment and treatment is associated with improved outcomes when compared with mixed-aged treatment. Assessments need to be age-specific and multidimensional, given the various physical and mental health needs, as well as social needs, of the older adult population. The treatment of older adults needs to be paced to the individual's physical and cognitive capabilities and limitations. The schedule of programs and expectations, and the overall timeframe for clinical

progression and change is typically slower for older adults than other age groups. As such, treatment programs should be realistically designed to accommodate these anticipated differences.

Studies have generally indicated that cognitive-behavioral techniques are effective for older populations, particularly those that address negative emotional states that pose significant risk for relapse (e.g., self-management approaches for overcoming depression, grief, or loneliness). In general, confrontational therapy should be avoided. Educational treatment approaches should be geared toward the specific needs of older adults (e.g., coping strategies for dealing with loneliness, general problem-solving). Older adults may absorb presented information better if they are given a clear statement of the goal and purpose of the session and an outline of the content to be covered. Repetition of educational information may also be helpful (e.g., simultaneous visual and audio).

Given that social isolation is a common problem in this population, group therapies and skill building around establishing social support networks are often beneficial, in addition to family therapy. According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse among Older Adults[15] consensus panel members recommend limiting involvement of family members or close associates to one or two members to avoid overwhelming or confusing older adults. Panel members also suggest that the involvement of grandchildren may lead to obstacles for open communication, as older adults may at times resent their problems being aired in the presence of younger relatives.

Medications used in older populations, including MAT, should be used with caution due to the physiological changes that occur with advanced age. Dosages of medications may need to be lowered, particularly if co-morbid medical conditions are involved. In cases where medications are used for withdrawal management, dosages for older populations should often be one-third to one-half the usual adult dosage. Concerns or questions regarding the safe use of medications in the older adult populations need to be directed toward appropriately trained medical professionals.

Staff working with older adults should ideally have training in aging and geriatric issues. Staff should also have an interest in working with this population and the skills required to provide age-specific services for individuals of more advanced age. The best results are typically achieved when staff is experienced in dealing with the physical, psychological, social, and spiritual issues unique to older adults. Staff who interacts with older patients need to receive regular trainings on empirically demonstrated principles and techniques effective for older populations.

Criminal Justice Involved Patients

The criminal justice system includes Justice involved patients and those at-risk, accused, or adjudicated who require various SUD services. Parole and probation status is not a barrier to SUD treatment services, provided that the people on probation or parole meet the DMC eligibility verification and medical necessity criteria.

For many people in need of alcohol and drug treatment, contact with the criminal justice system is their first opportunity for treatment. Services are provided through diversion programs, courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction and respective requirements of the

[15] Substance Abuse and Mental Health Services Administration. Treating Substance Use Disorder in Older Adults. Treatment Improvement Protocol (TIP) Series No. 26, SAMHSA Publication No. PEP20-02-01-011. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020

referring agency. Legal incentives to enter SUD treatment, at times, motivate individuals to pursue recovery. Staff working with criminal justice involved individuals need to be specifically trained in working with criminogenic risk, need, and responsivity (RNR), as well as SUDs and CODs. Staff also need to be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with agencies offering diversion programs, probation and parole officers, judges, the court, and other legal entities involved in the patient's care.

The first step in providing SUD treatment to people under criminal justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to criminal justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.
In general, clinical approaches and the use of MAT need to be consistent with those utilized for individuals who are not involved with the criminal justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements.

Treatment interventions need to be based on a multi-dimensional assessment and individualized needs. However, working with the criminal justice involved individuals does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

Optimal Treatment of the Criminal Justice Population

Effective clinical strategies for working with criminal justice patients may include interventions to address criminal thinking and provide basic problem- solving skills. Providers need to be capable of using evidence-based practices designed to address SUDs, mental health, and criminogenic needs. For example, motivational interviewing, cognitive behavioral therapy that focuses on both substance use and antisocial behaviors that lead to criminal recidivism, trauma-informed care, and contingency management therapies.

Similar to other groups, treatment of offenders needs to be regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue even after the legal issues for criminal justice patients are resolved.

For example, offenders from cultural minority groups may have unique cultural needs, women offenders are more likely to have been traumatized by physical and sexual abuse and to have concerns about their children, and many offenders have co-occurring substance use and mental health conditions that can complicate treatment. Strategies to engage offender populations are especially critical. Criminal justice involved individuals often have problems dealing with anger and hostility, and experience the stigma of being criminals, along with accompanying guilt and shame. Other groups with specific needs include older adults, violent offenders, people with disabilities, and sex offenders.

Due to court mandates, classification policies and procedures, various security issues, and differences in available programming, one of the challenges of working with the criminal justice involved individuals is

determining when the ASAM Criteria can be meaningfully applied. The ideal scenario is for the LOC setting to match the severity of illness and functional impairment, similar to the general population. However, there are instances in working with offenders that necessitate close collaboration with correctional staff to provide services that are clinically appropriate and that also align with correctional and supervision case planning and/or release conditions. When skillfully applied, the ASAM criteria can be used to access the full continuum of care in a clinically appropriate manner for the criminal justice involved population.

Homeless Population

Homelessness is an issue that impacts many individuals with SUDs as a result of the socioeconomic decline that oftentimes accompanies addictions. Conservative estimates of the prevalence of substance use among homeless individuals are approximately 20-35 percent. Although homeless patients typically require more intense treatment and have greater and more varied needs than housed individuals, patients experiencing homelessness face a myriad of structural, interpersonal, and biopsychosocial barriers they face in accessing care. Some of these obstacles include social isolation, distrust of authorities, lack of mobility and/or transportation, and multiplicity of needs.

Stable housing is often critical to attaining treatment goals and is an important component of necessary services. Services that link patients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of Care Coordination in order to meet the varied needs of homeless patients.

Optimal Treatment of Homeless Populations

Research supports the notion that effective programs for homeless patients address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/older adult populations); and provide longer-term, continuous interventions. As such, substance use in the homeless population cannot be treated apart from addressing the needs of the whole person in the context of their environment.

A continuum of comprehensive services is needed to address the various safety, health, social and material needs of homeless patients. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and mental health care, dental care, job training, and employment services. These services may be provided within the SUD program itself or through linkages with existing community resources. Proactive outreach, addressing needs in a non-judgmental and non-threatening environment, and addressing the various identified needs early in treatment may help to better engage this population.

Psychosocial interventions and MAT for homeless patients need to mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. As a whole, the homeless population tends to be less responsive to confrontational approaches to treatment. Counselors and clinicians also need to be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many homeless individuals. Medications should be used when clinically indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that medications

that require refrigeration are not prescribed when the patient has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

Successful counselors and clinicians who work with homeless patients tend to have a particular interest and comfort level in working with this challenging and rewarding population. Staff need to be experienced with the various aspects of care involved in working with homeless patients and need to be familiar with the resources available in the community so that appropriate referrals and linkages can be made in order to best address the varied needs of patients. Ideally, care teams work collaboratively and include interdisciplinary staff comprised of medical, mental health, substance use, and social service providers.

In general, treatment for homeless patients with SUDs is challenging, but successful outcomes can be achieved by prioritizing access to appropriate housing and providing comprehensive, well-integrated, patient-centered services with uniquely qualified staff.

Lesbian, Gay, Bisexual, Transgender, Questioning Population

Lesbian, gay, bisexual, transgender, questioning (LGBTQ) populations tend to experience higher rates of substance use than the general population. The stigma and discrimination of being a member of a marginalized community causes some LGBTQ individuals to cope with these additional stressors by using substances. Furthermore, research has also shown that once LGBTQ patients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ population faces in seeking treatment, and unique needs LGBTQ patients have that may not be addressed by SUD programs.

Although there are various protections in place that are intended to shield recovering substance abusers from many forms of discrimination, LGBTQ individuals are oftentimes not afforded the same protections. As a result of homophobia, heterosexism, and/or transphobia, some may find it difficult or uncomfortable to access treatment services and be afraid to speak openly about their sexual orientation or gender identity. Many LGBTQ patients may also internalize the effects of society's negative attitudes, which can result in feelings of sadness, doubt, confusion, and fear.

Important Considerations in the Treatment of the LGBTQ Population

There are some unique aspects of treating LGBTQ patients that providers need to be aware of. While group therapies should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ patients. Staff members need to ensure that LGBTQ patients are treated in a therapeutic manner and group rules should support an inclusive and welcoming culture within the group.

The LGBTQ patient is solely responsible for deciding whether to discuss issues relating to their sexual orientation and/or gender identity in mixed groups and not the other group members. Although providing individual services decreases the likelihood that heterosexism/homophobia/transphobia will become an issue in the group setting, there is also an opportunity for powerful healing experiences in the group setting when LGBTQ patients experience acceptance and support from non-LGBTQ peers.

Problems in traditional health care systems may lead to distrust of health care professionals, requiring extra sensitivity from SUD providers.

In many ways, psychosocial and pharmacologic interventions (e.g., MAT) geared toward LGBTQ patients are similar to those for other groups. An integrated biopsychosocial approach considers the various individualized needs of the patient, including the societal effects on the patient and their substance use. Unless SUD providers carefully explore each patient's individual situation and experiences, they may miss important aspects of the patient's life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences being discriminated against, a history of antigay violence and hate crimes such as verbal and physical attacks, etc.).

As with any patient, substance use providers need to screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ patients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in the counseling competency model apply to all populations, particularly in working with LGBTQ patients. In this model, a counselor:

1. Respects the patient's frame of reference;
2. Recognizes the importance of cooperation and collaboration with the patient;
3. Maintains professional objectivity;
4. Recognizes the need for flexibility and being willing to adjust strategies in accordance with patient characteristics;
5. Appreciates the role and power of a counselor as a group facilitator;
6. Appreciates the appropriate use of content and processes therapeutic interventions; and
7. Is non-judgmental and respectfully accepting of the patient's cultural, behavioral, and value differences

Family dynamics are also important in working with LGBTQ individuals and SUD providers need to be aware that family therapy may be difficult because of alienation owing to the patient's sexual/gender identity. However, inclusion of family in the treatment process may also result in more positive outcomes. Given common concerns regarding living environments (in terms of recovery and safety), social isolation, employment and finances, and ongoing issues related to homophobia and transphobia, particular attention needs to be paid to discharge planning.

Elements of treatment that promote successful treatment experiences for the LGBTQ patient include cultural sensitivity, an awareness of the impact of cultural victimization, and addressing issues of internalized shame and negative self-acceptance. Cognitive-behavioral therapies challenge internalized negative beliefs and promote emotional regulation, which can be helpful for relapse prevention. Motivational enhancement techniques may also encourage treatment engagement in this population.

Because each patient brings their unique history and background into treatment, furthering our understanding of individuals different from ourselves helps to ensure that patients are treated with respect and improve the likelihood of positive outcomes. At times, SUD treatment staff may be uninformed or insensitive to LGBTQ issues, may have preconceived biases toward LGBTQ patients, or may falsely believe that sexual

identity/gender identity causes substance abuse or can be changed by therapy. In these cases, providers need to be aware of these beliefs in order to prevent them from becoming barriers to effective treatment of the LGBTQ patient. A substance abuse treatment program's commitment to promote sensitive care for LGBTQ patients can be included in its mission statement and administrative policies and procedures. Providing staff training and education are oftentimes valuable and include sexual orientation sensitivity training to promote better understanding of LGBTQ issues, trainings that assist staff in better understanding the needs of transgender individuals and the role that acknowledging gender identity plays in culturally competent treatment services, and other educational areas to ensure that quality care is provided. Providers who understand and are sensitive to the issues surrounding LGBTQ issues such as culture, homophobia, heterosexism, and sexual and gender identity can help LGBTQ patients feel comfortable and safe while they start their recovery journey.

Veterans

According to U.S. Census estimates, there are over 330,000 veterans who live in LA County. Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular, gender may also influence veteran experiences, as reports of women veterans who have experienced sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUDs and present to treatment with a unique set of needs and circumstances that must be addressed.

Under certain circumstances, veterans may be ineligible for Veteran's Administration (VA) benefits due to a dishonorable discharge or discharge "under other than honorable conditions," among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

Important Considerations in Treating the Veteran Population

Given the higher likelihood of trauma, physical and behavioral health complications of the veteran population, SUD providers are encouraged to perform thorough assessments that encompass the full range of complications that may be present. For example, assessments may include questions concerning trauma, combat or war experiences, or injuries that may impact the patient's participation in SUD treatment. If the patient reports (or it is determined that) injuries exist that may impact treatment, the SUD treatment provider is encouraged to work with other providers (e.g., medical, mental health) to coordinate care, which is often particularly critical in this population.

Stigma is often an additional complicating issue. Although stigma exists around substance use, within the military stigma often also exists for seeking help for any health condition. Anger or personality disorders may also be present, further making treatment engagement difficult. In these instances, effectively engaging veterans and utilizing evidence-based techniques, such as motivational interviewing, will be critical to treatment success.

While substances vary, veterans may use sedating substances such as prescription drugs in efforts to address untreated/under-treated anxiety or other mental health conditions. Additionally, co-occurring physical health conditions and injury may increase rates of prescription drug and opioid use, including the use of heroin, and thus certain veterans may be at higher risk for fatal overdoses and may be appropriate candidates for MAT.

In summary, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.

Population-Based Services by Funding Source – Adult

Special Programs Defined

Special programs are those that have dedicated referral pathways and data tracking responsibilities from County partners that require additional documentation or procedures. These programs are typically comprised of special populations that warrant special attention during evaluation and treatment due to certain life circumstances or comorbid medical or psychosocial conditions.

Individuals must meet the conditions of the referral entity in addition to meeting medical necessity to access SUD treatment services under DMC-ODS. Contracted SUD treatment agencies providing services to these populations should utilize evidenced-based practices to assist individuals in developing awareness of the correlation between addiction and their involvement with the referring entity.
The SBAT will allow individuals, County partners, and other referral entities (e.g., SASH, CENS and CORE) to search for contracted SUD treatment agencies based on special parameters including those that serve the Criminal Justice, Perinatal, and Families with Children populations.

Los Angeles County Superior Court Referrals

In 1993, the Los Angeles County Drug Court Program was developed to divert drug offenders into SUD treatment services in lieu of incarceration. The model was founded on the notion that Representatives from the District Attorney, Public Defender, Probation, Judge, and contracted SUD treatment provider function as a multidisciplinary team. Each entity advocates for the public interest, patients' legal rights, responsible treatment progress, etc., to help develop, support, and continually motivate the patients' engagement in taking responsibility for their own treatment and continued recovery from their SUD[16]. The model has grown to include dedicated Superior Court programs for women, individuals with co-occurring mental health, and those who have high risk to reoffend. Historically, SAPC funding and capacity have limited SUD drug court diversion to nine (9) dedicated courtrooms countywide.

The Substance Abuse and Crime Prevention Act of 2000, passed in November 2000 and implemented on July 1, 2001, amended drug sentencing laws where criminal defendants who were convicted of drug possession, use, transportation of drugs for personal use, or under the influence of controlled substance be placed in drug treatment as a condition of probation in lieu of incarceration. Patients who successfully completed drug treatment would be eligible to have their drug-related charges dropped. Funding for the Proposition 36 (now called Penal Code 1210) drug treatment program, which required defendants to pay out of

[16] Adult Drug Court Best Practice Standards, Volume II, National Association of Drug Court Professionals

pocket, ceased in September 2011. However, Proposition 36/Penal Code 1210 patients can now pay for drug treatment under Medi-Cal, My Health LA, or other County funding (e.g., AB 109). In these instances where Proposition 36/Penal Code 1210 patients are not eligible for any County funding assistance, SUD providers may serve these individuals and seek sliding scale reimbursement directly from the patient using the Client Fee Determination, as determined by the SUD provider.

In 2015, SAPC implemented screening services at the Community Collaborative Courts, developed by the Superior Court, to assist with its continued need to divert and link clients to SUD treatment. CENS staff co-located at participating Superior Courthouses conducted these screenings.

Court Populations

Services are available to adults (ages 18+) who were arrested in and are residents of LA County and are referred from one of the following Superior Court programs:

1) **Client Engagement and Navigation Services Court Co-location for Proposition 47 Drug Cases (formerly known as Misdemeanor Diversion Treatment Track Project (MDTT)** - The primary goals of this project are to increase the percentage of defendants who engage in treatment following a plea to a Proposition 47 drug case and to retain those defendants in treatment for a minimum of twelve weeks in order to earn dismissal and facilitate lasting behavioral change. Individuals' referrals are made to the co-located CENS at the respective courthouses where Prop 47 cases are heard.

2) **Los Angeles County Drug Courts** - Based on a national model, participating courts, law enforcement, Probation, and contracted SUD treatment providers work together to motivate and engage court-vetted, high risk/high needs defendants in long- term, court supervised treatment and recovery to become productive and law-abiding citizens in LA County. The Superior Court holds the discretion to dismiss all criminal charges upon successful completion of the SUD treatment and court supervision requirements.

   In 1993, the LA County Drug Court Program was developed to divert drug offenders into SUD treatment services in lieu of incarceration. The model was founded on the notion that Representatives from the District Attorney, Public Defender, Probation, Judge, and contracted SUD treatment provider function as a multidisciplinary team. Each entity advocates for the public interest, patients' legal rights, responsible treatment progress, etc., to help develop, support, and continually motivate the patients' engagement in taking responsibility for their own treatment and continued recovery from their SUD[17]. The model has grown to include dedicated Superior Court programs for women, individuals with co-occurring mental health, and those who have high risk to reoffend.

3) **Sentence Offender Drug Court** - The Sentenced Offenders Drug Court program was established in 1998 as an intensive SUD treatment approach. This program includes a mandatory in-custody treatment approach for 90-days in county jail followed by community based, court supervised SUD residential and/or outpatient treatment services for convicted, non-violent felony offenders who are at high risk for return to incarceration.

4) **Community Collaborative Courts** – The Community Collaborative Courts are multi-disciplinary and resource intensive responses to addressing the needs of veterans, the chronically homeless, the mentally ill, victims of sex trafficking, transitional at-risk youth, and individuals with an SUD.

[17] *Adult Drug Court Best Practice Standards, Volume II, National Association of Drug Court Professionals*

5) **Los Angeles County Second Chance Women's Reentry Court** - The Second Chance Women's Reentry Court Program is a drug court-modeled program which provides women on parole or probation who have re-offended and have chosen to participate in court-supervised, integrated SUD treatment (e.g., intensive residential treatment, outpatient treatment, and then recovery-support services) as an alternative to returning to incarceration.

6) **Co- Occurring Disorder Court (CODC)** – The CODC is a specialty referral court delivering collaborative services to court referred individuals with a co-occurring mental health and SUD. The CODC court program is founded on the drug court model of the court, Probation, mental health, and contracted SUD treatment providers, and law enforcement working as a multidisciplinary team to closely supervise and engage individuals in their treatment and well-being.

Screening and Referral Process

Should an arraignment court sentence a defendant to drug treatment through Penal Code 1210, pre- or post-plea diversion, or other City Attorney drug diversion program, the court will order the defendant to the court co-located CENS staff for an SUD screening (before leaving the courthouse).

Prior to doing so, the Judge will have explained that compliance with the treatment process is legally binding, and the consequences of failing to complete treatment (e.g., issuing of a bench warrant for their arrest and/or incarceration). If the CENS staff is not available, the individual will be referred to the SASH for screening and referral to treatment services or directly to a SAPC contracted SUD treatment provider for screening and treatment services.

CENS staff will administer a screening with the ASAM CO-Triage for Young Adults (ages 18-20) and Adults (age 21+) and will explain the results with the defendant and the court, so that the defendant and court can make an informed decision on the client's diversion into SUD treatment services. If all parties agree on the defendant's participation in treatment, the CENS staff will perform the following procedures unique to the Superior Court:

1. CENS staff will provide referral, linkage, and placement services to a SAPC contracted SUD treatment provider with expertise in serving the criminal justice involved population.
2. CENS staff will:
    - Schedule an intake appointment with the agency within 48 hours of the screening, and
    - Provide written instructions including contact information, treatment facility address, and date and time of the appointment to the defendant. This information will also be shared with the court.
3. CENS staff will verify treatment slot availability via the SBAT and contact the SAPC contracted SUD treatment provider about appointment availability via telephone.
4. CENS staff will follow-up with the SAPC contracted SUD treatment provider and confirm that the referred individual attended the agreed upon appointment. If they did not attend the appointment, CENS staff will conduct follow-up actions to determine why the individual did not attend the treatment placement appointment. When appropriate, CENS staff will inform the court of the individual's failure-to-show. The court may take action, accordingly, including issuing a bench warrant for the individual's arrest.

Treatment Requirements and Care Coordination

Court supervision remains at the discretion of the judge, however SUD treatment must be individualized and based on medical necessity. SUD treatment services for clients referred by the Superior Court may be a combination of various treatment service modalities, as described in the *Treatment Services* section.

Contracted SUD treatment providers delivering services to patients referred by the courts will be expected to inform the court of the patients' treatment progress (with informed consent), which may include the following:

- **Pre- court staff meetings**
  - Team members consistently attend pre-court staff meetings to review participant progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court
- **Status hearings**
  - Team members attend status hearings, with their patient(s) on a regular basis, as determined by the court team
  - During the status hearings, team members contribute relevant information or recommendations when requested by the judge and/or court as necessary to improve outcomes or protect participants' legal interests
- **Drug Court Management Information System**
  - The Drug Court Management Information System (DCMIS) is a web-based database application which selectively permits access to the data by a variety of system users, including Drug Court judges, court officers, project coordinators, treatment staff, and program managers
  - To guarantee confidentiality, all DCMIS users are registered and assigned specific data access privileges

Treatment Program Procedures for Probation Referrals

In October 2011, DPH-SAPC and the LA County Probation Department partnered to implement an assessment process and client flow in response to the Public Safety Realignment Act or more commonly referred to as Assembly Bill (AB) 109. AB 109 called for the release of low-level felons from state prison to County Probation supervision, known as Post-release Supervised Persons (PSPs), and allowed new County offenders charged with offenses that are considered Non-violent, Non-serious, and Non-sexual (N3) to serve time in County jail versus state prison with condition of probation supervision upon release (known as N3 Splits). The passage of California Legislature Proposition 47 and Proposition 57 have also affected the number of County residents under Probation supervision.

SAPC contracted SUD treatment providers accepting referrals from the Probation Department are required to utilize the **Treatment, Court, Probation eXchange (TCPX) System**[18], which is a web-based data system application designed to support the operational and administrative requirements of Probation Supervision.

Given that accurate records must be maintained to permit patient access to needed services, all treatment providers are required to accurately enter all patients' data into the TCPX system daily.

Probation Populations

All individuals who are court ordered to report to the Probation Department for probation supervision will report to the area office ordered for SUD screening.

[18] *TCPX provides a "real-time" connectivity between contracted SUD treatment agencies, CENS, Probation, and the County*

Probation will orient the individual regarding the requirements of supervision, explain the court ordered conditions of supervision, and make referrals to the appropriate linkages if services are recommended by the court. Under Probation, specialized caseloads are maintained to ensure compliance for certain populations including but not limited to:

1) **Assembly Bill (AB) 109:** Adult AB 109 male and female clients classified as PSPs, N3s, and N3 splits and have a history of criminal activity with the majority of them at high risk for recidivism

2) **Co-Occurring Integrated Care Network (COIN):** The COIN program was designed to address the needs of adult AB 109 PSPs who have a co-occurring chronic SUD and severe and persistent mental illness. COIN provides integrated SUD and mental health treatment and follows the traditional Drug Court model. Treatment is for patients who are at high risk for relapse and are referred through the AB 109 Revocation Court

3) **Proposition 47:** Also known as the Safe Neighborhoods and Schools Act was a referendum passed by voters in the State of California on November 4, 2014. It recategorized many nonviolent offenses, such as drug and property offenses, from misdemeanors, rather than felonies, as they had previously been categorized. These offenses include shoplifting, writing bad checks, and drug possession

4) **Proposition 57:** Proposition 57 was a California ballot proposition, passed by voters on November 8, 2016. It allows the Parole Board to release nonviolent prisoners once they have served the full sentence for their primary criminal offense. Previously, prisoners were often required to serve extra time by a sentence enhancement, such as those for repeated offenders. In addition, Proposition 57 requires the Department of Corrections to develop uniform parole credits, which reward prisoners' good behavior with reduced sentences. Certain Proposition 57 clients may be required to be supervised by Probation under AB 109

5) **Registered Sex Offenders:** Probationers assigned to this level of supervision are required to register with local law enforcement pursuant to Penal Code Section 290, regardless of whether the current offense is a sex offense or not. The client must report to the area office once a month for a face-to face meeting with their probation officer. This population must participate in State mandated sex offender counseling while under supervision and as arranged by Probation. In accordance with State law, all high-risk sex offenders are placed on Global Positioning Satellite (GPS) monitoring for the duration of their felony probation supervision[19]

6) **Gang Affiliations:** Clients assigned to this Probation caseload are determined to be active gang members or associates, may have specific orders from the court regarding participating in gang activity, or have a requirement to register with local law enforcement as a gang offender. These clients are seen once a month, face-to-face in the office and may be contacted in the field by members of the Probation Department Mobile Gang Unit[20]

Referral Process

The probationer referral process begins when they arrive at their assigned Probation area office:

[19] http://probation.lacounty.gov
[20] http://probation.lacounty.gov

1. The probationer will meet with the Deputy Probation Officer (DPO) for screening and assessment and to receive specific instructions of probation supervision requirements. The DPO will screen the probationer using the Level of Services/Care Coordination Inventory, which measures the risk factors and needs of the client
2. The DPO will refer the probationer to the CENS co-located at designated Probation Area Offices for an SUD screening if it is determined that the probationer has a history of a SUD and has frequent SUD-related contact with the criminal justice system
3. The DPO will provide a TCPX referral form to the probationer with instructions to contact the designated CENS site within five (5) business days to schedule an appointment for an SUD screening
4. The DPO will enter the probationer data and referral information into the TCPX system for tracking purposes

Screening Process

The CENS shall perform the following procedures unique to Probation referrals during screening and referral process:

1. Obtain from the client a copy of the Probation referral form when they arrive for the CENS screening
2. Administer a screening with the ASAM Co-Triage for Young Adults (ages 18-20) and Adults (age 21+) and initiate referral to a SAPC contracted SUD treatment provider, indicating the provisional level of treatment services needed
3. The CENS will verify treatment slot availability via the SBAT and by contacting SUD treatment providers via telephone
4. In the event that a client fails to show for the scheduled appointment, the CENS staff are responsible for contacting the client to facilitate the rescheduling of the assessment screening appointment. After rescheduling, the CENS should notify the client that if they miss the second appointment then the DPO will be notified
5. Clients with revoked probation supervision will be screened by the co-located CENS at the Central Arraignment Revocation Court. The co-located Revocation Court CENS will conduct the clinical screening within two (2) days of notification from Probation or during court hours of operation
6. CENS will update the TCPX system with the client's screening results, referral, and treatment information within 24 hours of the client's appointment
7. CENS will provide the DPO with proof of screening (confirmation) or non-compliance (failure-to-show) via TCPX within 24 hours of scheduled appointment
8. If the client has a residency restriction due to their criminal charge (e.g., sex-offender, arsonist, etc.) or requires special arrangements (e.g., wheelchair-bound, hearing impaired), the CENS should refer the client to an agency that is able to accommodate the client
9. The CENS is responsible for following-up with the agency within 30 days of referral to ensure that special needs of the client are met

Treatment Requirements and Care Coordination

Treatment agencies may not process an admission for a patient without proper documentation from the CENS. All documentation must be processed from the TCPX system. Only referrals printed from TCPX shall be accepted. The treatment provider will provide the patient and CENS with proof-of-enrollment or failure-to-show and update TCPX within 24 hours of enrollment.

Treatment services are administered based on medical necessity. SUD treatment services for patients referred by Probation may be a combination of various treatment service modalities as described in the *Treatment Services* section.

Status Reports

Each treatment agency is responsible for providing timely reports at the request of Probation. All treatment status/discharge reports will be prepared and maintained in TCPX. Probation is responsible for assessing the information in the report and determining if the patient is compliant with their conditions of Probation. Status/Progress Reports are due as follows:

- Confirmation of enrollment within 14 days of admission, completed in TCPX
- Progress reporting, completed in TCPX at 30-day intervals for a treatment progress report, beginning from the date of admission, and/or as needed by the DPO
- If the assigned DPO makes a request, then a hardcopy of the status report may be delivered in a sealed envelope by the patient to the assigned DPO

Compliance with Conditions of Probation

Los Angeles County law enforcement entities may conduct compliance checks to ensure the patient is adhering to conditions of probation. Treatment agencies shall obtain the proper consent to release information form from the patient to allow law enforcement entities to conduct compliance checks. Compliance checks are limited to verification of enrollment and physical confirmation of the patient in treatment. Contracted SUD treatment agencies shall retain a copy of the form in the patient's file.

The DPO will work closely with the patient to encourage program compliance, support the patient in adhering to the Treatment Plan, and monitor, track, and supervise the patient to ensure public safety. Non-compliance with the case plan and/or individualized Treatment Plan could result in intermediate sanctions (e.g., house arrest, flash incarceration, or revocation process initiation).

Los Angeles County Sheriff's - Referrals Substance Treatment and Re-entry Transition - Community (START-Community) Referrals

The Los Angeles County Sheriff's Department (LASD) utilizes Alternatives to Custody (ATC) to allow inmates to serve the remainder of their jail sentence in the community at a residential facility. All individuals must receive clearance from the LASD Community-Based Alternatives to Custody Division for electronic monitoring in a therapeutic SUD residential treatment community in lieu of incarceration. ATC provides individuals with a foundation to promote successful re-entry post incarceration, and under DMC-ODS individuals will have access to additional services to assist with successful reintegration.

Patients participating in the START-Community program will remain under the supervision of LASD using a GPS ankle monitor worn for the duration of their 90 days residential treatment episode. Although patients must initially meet medical necessity to participate in the program, they may remain in residential treatment for days 61-90 even if medical necessity is not met to prevent their return to custody. Treatment providers are expected to work with the justice system to transition patients to more appropriate LOCs (e.g., residential to outpatient with RBH) when an agreement can be met without jail time. Upon completion of their sentence, other treatment modalities are available to the patient on a voluntary basis if patient meets medical necessity.

Population

Eligibility for the START-Community program shall be limited to those N3 individuals referred through LASD and meet the following general criteria:

1. History of drug and/or alcohol usage and/or drug related charges for eligibility
2. N3 classification
3. No past violent, sexual, or arson charges
4. 18 years or older
5. No medical or psychiatric conditions that require medications prior to release
6. Have a minimum of 90 to 120 days left on their sentence and no pending court dates. Individuals that have less than 90 days may be considered for admission on a case-by-case basis

Referral Process

Eligible inmates are identified and assessed by LASD using the Correctional Client Management Profiling for Alternative Sanctions and review overall criminal history and other determinants to make appropriate recommendation for placement in the START-Community program. LASD will provide a referral list of potential inmates to the designated CENS staff. CENS staff will coordinate with LASD to conduct the SUD screening and make the appropriate referral into a community-based residential treatment facility.

SAPC contracted SUD treatment providers accepting referrals from LASD are also required to utilize the TCPX System, which is a web-based data system application designed to support the operational and administrative requirements of AB 109.

TCPX provides a "real-time" connectivity between contracted SUD treatment agencies, CENS, and the County. Given that accurate records must be maintained to permit patient access to needed services, all SAPC contracted SUD providers are required to accurately enter all patients' data into the TCPX system daily.

Community Re-entry and Resources Center (CRRC)

The CRRC is a hub station that operates as a one-stop shop for male inmates transitioning back to the community. The CENS provides the on-site SUD screening to clients being released from the county jail or for Probation to refer AB 109 clients with potential need of SUD treatment.

The referral process for the CRRC begins when the client arrives at the kiosk located in the Inmate Reception Center Release Lobby. An LASD officer at the kiosk will conduct a preliminary screening and direct the inmate to the appropriate window. If the client is identified as a PSP or N3/N3 Spilt, the officer will direct them to the Probation window. If appropriate, the on-site Probation Officer will initiate the referral for CENS SUD screening at the CRRC. If the client is a traditional-sentenced person and is seeking SUD services, the LASD officer will refer the client directly to the co-located CENS at the CRRC.

Screening and Referral Process

LASD will notify CENS staff co-located at the Los Angeles County Jail and/or CRRC of potential clients for screening. The CENS will:

1. Provide on-site screening
2. Coordinate referrals to treatment
3. Coordinate support service referrals
4. Refer clients to designated contracted SUD treatment providers with expertise in providing services to clients under electronic monitoring

Note: Screening or assessing of post-release custody should be based on client's status 30 days prior to incarceration.

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. SUD treatment services for patients referred by LASD may be a combination of various treatment service modalities as described in the *Treatment Services* section.

Treatment agencies may not process an admission for a patient without proper documentation from the CENS. Documentation must be processed and printed from the TCPX system. The treatment provider will provide the patient and CENS with proof-of-enrollment or failure-to-show and update TCPX within 24 hours of enrollment.

Care Coordinators may perform additional Care Coordination activities for the criminal justice-involved patients as described in the *Care Coordination* section.

Electronic Monitoring Requirements

Patients participating in the program are required by LASD to wear GPS equipment at all times. Failure to adhere to this requirement will result in immediate return to custody. LASD contracts with a dedicated service provider for 24/7 technical support for GPS equipment. Should contracted SUD treatment agencies encounter any concerns with GPS equipment, they must contact the assigned Representative to report these concerns. Most common concerns reported include, but are not limited to:

- Battery life diminishing
- Patient wandering out of bounds
- Notification of patient being transported to off-site appointments

Compliance Check Procedures

LASD will conduct periodic compliance checks for all patients that are receiving SUD treatment services and under electronic monitoring. Compliance checks and investigations are conducted at random and may occur in person or via telephone and require a status report on the patient's progress in treatment and/or verification of physical presence at treatment program.

For contracted SUD treatment agencies serving START-Community patients to remain in compliance with LASD supervision requirements, agency staff must supervise patients at all times. Any scheduled recreation activities, or off-site appointments need to be cleared with LASD one (1) week in advanced by contacting **(213) 893-5345** (during business hours) for approval on a case-by-case basis. LASD will arrange GPS clearance for **approved** off-site activities. Patients are to be escorted by staff at all times while off-site.

START-Community patients remain in-custody while participating in residential treatment therefore should a patient abscond from the residential treatment facility, contracted SUD treatment providers **MUST**:

- Immediately contact the Sheriff's Department at **(213) 453-4528** (24-hour line) and LASD Community-Based Alternative to Custody at **(213) 893-5345** (during business hours) to report that the patient has absconded;
- Allow LASD designated personnel limited access into the relevant treatment facility and/or room to verify patient location and/or locate GPS monitoring device, and to gather relevant information from the Supervisor and/or designated staff on duty for LASD investigative report on the patient; and
- Complete the required CalOMS/LACPRS and TCPX admission and discharge reports within 24 hours of the patient's admission and discharge

Treatment Discharge Procedures for Criminal Justice Referrals – Successful or Unsuccessful

All discharge reports shall be prepared and developed in collaboration with supervising entity and should address discharge planning processes as described in the Treatment Services section.

Early Termination

Termination of any criminal justice involved referred patient can occur if the patient violates any facility rules, engages in violent behavior, utilizes alcohol and/or drugs, or makes threats to another participant. Contracted SUD treatment agencies shall notify LASD and DPH-SAPC within 24 hours and document in the appropriate data tracking system (e.g., CalOMS/LACPRS and TCPX) the termination reason.

In addition, treatment agencies shall complete Incident Report Form (See START-Community Program, Incident Report [Appendix 5]) describing the incident being reported and maintain a copy of the form in the patient's file. Completed forms should be submitted within 24-hours to DPH-SAPC at SAPC_ASOC@ph.lacounty.gov.

Termination can occur for the following reasons:

- One (1) or more positive drug tests
- Absconding, or willful violations of program requirements
- Participant poses a safety risk for self or others
- Participant opts out of project

Note: Termination of START-Community will require the patient to be returned to jail to complete the remainder of their sentence.

Division of Adult Parole Operations (DAPO)

The adult parole population is supervised by the Division of Adult Parole Operations (DAPO), which consist of 110 parole units located throughout the State (information based on California Department of Corrections and Rehabilitation (CDCR) website as of March 24, 2021). DAPO's Division headquarters provides statewide oversight, while the Regional Administrators are responsible for the day-to-day operations related to the supervision of adult parolees. The field parole units supervise the adult offenders subject to State supervised parole, as well as those currently serving their sentences in an alternative custody program, and adult offenders released on medical parole.

The parole population can access the County's DMC-ODS SUD treatment system of care through the SASH or direct-to-provider. In addition, SAPC contracted treatment providers are encouraged to participate in Parole and Community Team (PACT) resource fairs for parolees. Resource fairs offer the parole population information for various community resources (e.g., housing, legal counsel, etc.). At these PACT Meetings, SAPC contracted providers can educate and inform the parole population about their respective SUD treatment services and the services offered under County's DMC-ODS SUD treatment system of care.

In-Custody to Community Referral Program

The In-Custody to Community Referral Program (ICRP) is a substance use disorder (SUD) collaborative designed to link individuals transitioning from incarceration to SUD services in the community upon release from custody. ICRP links individuals that are screened and meet clinical criteria for SUD with Care

Coordination services and a warm handoff to a designated community treatment program within DPH-SAPC's SUD treatment service provider network.

The ICRP is a collaborative partnership among the DPH-SAPC, SUD contracted treatment providers contracted by DPH-SAPC, Department of Health Services-Integrated Correctional Health Services (DHS-ICHS) and Whole Person Care (WPC). ICRP DHS-ICHS counselors are co-located at Twin Towers Correctional Facility, Men's Central Jail, Pitches Detention Center, and Century Regional Detention Center.

Referral Process

Referrals for ICRP must be initiated by DHS-CHS.

1. Obtain client consent to release information before screening
2. ICRP in-custody SUD counselors screen clients using the ASAM Co-Triage and complete the Reentry SUD Treatment Pre-Intake form. The pre-intake screener provides the SUD treatment providers with information on the clients' physical and mental health status
3. SUD counselors also screen clients using the ASAM Co-Triage to determine and recommend the provisional LOC
4. SUD counselors contact SUD treatment providers to ensure a treatment slot will be available upon the client's release from custody
5. SUD counselors confirm release date and email pre-intake form (using secure email) to the SUD treatment provider
6. WPC provides transportation of client and a harm handoff to the appropriate SUD treatment provider

Assessment Process

SUD counselors initiate the referral to the SUD treatment provider. Providers receive client's pre-intake form and the provisional LOC needed based on the clinical screening. Treatment providers are responsible for following assessment procedures:

1. SUD treatment providers who agree to assess clients, reserve a treatment slot, and coordinate care for individuals transitioning out of custody within 2 weeks
2. If a client fails to show for the scheduled appointment, the SUD treatment provider is responsible for contacting the client to facilitate the rescheduling of the assessment appointment
3. The SUD treatment providers must obtain client consent to release information before conducting the assessment
4. Conducts the ASAM to confirm the level of care
5. The client is placed in the appropriate level of care and begins treatment
6. SUD treatment provider must use Sage and TCPX (for AB 109 patients) systems to enter the patient's screening results, and treatment information within 24 hours of the patient's appointment and daily thereafter, and
7. If the patient has a residency restriction due to their criminal charge (e.g., sex-offender, arsonist, etc.) or requires special arrangements (e.g., wheelchair-bound, hearing impaired), the treatment provider must refer the patient to an agency that can accommodate them

Other CENS Co-Locations

Community Re-Entry and Resource Center (CRRC) (Twin Towers CTU) - The CRRC is a hub station that operates as a one-stop shop for male inmates transitioning back to the community.

The CENS provides the on-site SUD screening to clients being released from the county jail or for Probation to refer AB 109 clients with potential need of SUD treatment. The referral process for the CRRC begins when the client arrives at the kiosk located in the Inmate Reception Center Release Lobby. An LASD officer at the kiosk will conduct a preliminary screening and direct the inmate to the appropriate window. If the client is identified as a PSP or N3/N3 Spilt, the officer will direct them to the Probation window. If appropriate, the on-site Probation Officer will initiate the referral for CENS SUD screening at the CRRC. If the client is a traditional-sentenced person and is seeking SUD services, the LASD officer will refer the client directly to the co-located CENS at the CRRC.

Developing Opportunities Offering Reentry Solutions (DOORS) - The DOORS center is an initiative of Probation's Adult Services Division and the Department of Health Services, Office of Diversion and Reentry (ODR). The DOORS center is designed to be a one-stop-center for those on adult felony probation supervision, their families, and the community, providing or arranging linkage(s) to a range of rehabilitative services that assist with SUD, mental health care, employment, education, housing, legal issues, family reunification, and social support. The goal of the DOORS center is to provide a welcoming environment where adults on probation can receive services that will assist them in successfully reentering the community, thereby reducing recidivism; and family members and other community members can receive supportive services from Probation and County Partners (ODR, DMH, DPH-SAPC, Workforce Development Aging and Community Services (WDACS), Arts and Culture, and DPSS).

CENS Diversion Partnership Programs - In addition to serving justice involved individuals coming from Probation and the Courts, CENS ensures SUD screening and referral to treatment are provided in the following programs:

- **The Department of Health Services, Office of Diversion and Reentry** partners with CENS at the East Los Angeles Law Enforcement Assisted Diversion (LEAD). The program intervenes at the earliest point of contact with law enforcement to reduce the number of individuals who enter the jail system and to stem further justice involvement. LEAD is a pre-arrest community-based diversion model that diverts individuals with repeated low-level drug related offenses at the earliest contact with law enforcement to harm reduction-based Care Coordination and social services as an alternative to jail and prosecution. LEAD operational partners, including prosecutors, care coordinators, and law enforcement, meet bi-weekly to coordinate care, engagement, and advocacy efforts for program participants.

- **The Department of Mental Health (DMH) Rapid Diversion Program (RDP)** is a partnership with CENS: The Alternatives to Incarceration (ATI) Rapid Diversion is the desire for a true diversion (no conviction/probation) to treatment. The ATI RDP is based on the California Penal Code 1001.36 which allows some people with mental disorders to receive treatment when they are charged with a crime. If the defendant successfully completes treatment, the criminal charges will be dismissed. Pretrial diversion allows a willing defendant to postpone further action in his/her case to participate in a treatment program. It can be requested at any point in a criminal case before a defendant is sentenced. This partnership with DMH allows clients to receive both MH and SUD treatment, since it is common for many individuals to suffer from both.

Department of Public Social Services (DPSS) Programs - California Work Opportunity and Responsibility to Kids (CalWORKs) Referrals

CalWORKs Referral Process

CalWORKs Welfare to Work (WtW) participants are screened by their GAIN Services Worker (GSW) during their GAIN Orientation and Vocational Assessment. Participants who screen positive for SUD, and those who self-declare a need for substance use services, will be referred for clinical assessment one of three ways:

1. Referral to the CENS area office nearest to the participant where the CENS will:
    - Schedule the screening appointment within three (3) business days after receiving the GSW GN 6006A referral
    - Screen participant using the ASAM Co-Triage
    - Secure intake appointment with an SUD treatment agency selected from the SBAT to review the SAPC Provider Network, within three (3) business days of screening, and
    - Forward a copy of the GN 6006A to the selected treatment provider
2. Referral directly to a contracted SUD treatment agency
3. Referral to the SASH. The GSW will provide the client with the SASH number for screening and referral to treatment

NOTE: Treatment agencies may also admit existing patients, who identify as having CalWORKs, without a formal GSW referral. This is called a "Reverse Referral". When this occurs, the treatment agency must initiate notice to DPSS via a PA1923 form (see *SAPC website*), which states that the patient is in treatment and requests that their case be expedited to GAIN. The PA1923 form must be faxed or emailed via encrypted email, to the DPSS Centralized Unit (CU) for processing within ten (10) business days of completion of the PA1923 form.

Intake

Once the contracted SUD treatment agency receives the referral either directly from the GSW or the CENS, they are to:

- Schedule the assessment appointment within three (3) business days after receiving either the GN 6006A or GN 6006B referral
- Conduct the full ASAM CONTINUUM or SAPC Youth ASAM assessment
- Complete page two (2), section B, of the GN 6006B, and
- Submit the GN 6006B to the GSW within five (5) business days of assessment to indicate if participant enrolled into treatment or if they failed to keep the appointment. If agency receives GN 6006A from CENS, agency is to file form in participant's records as CENS already submitted a copy to the DPSS GSW.

The patient shall be admitted to treatment according to appropriate LOC and/or patient's preferences. If the patient has to transfer to a different agency, a copy of the GN 6006B will be faxed to the GSW to notify them of the patient's new treatment location. A copy of the GN 6006B must also be forwarded to the new treatment agency.

Treatment Requirements and Care Coordination

Treatment services are administered based on the medical necessity. Services may be a combination of various treatment service modalities as described in the Treatment Services section.

SUD treatment services for CalWORKs participants include: Outpatient, Residential, Withdrawal Management (WM), also known as detoxification, Recovery Bridge Housing, and Recovery Services.

Status Reports

Contracted SUD treatment agencies are required to communicate the status of the patient's progress and treatment/services to DPSS using the appropriate forms noted below:

- Complete GN 6006B, page two (2) within five (5) business days of service enrollment, to report date services began, (or failure to appear for services), expected duration of hours per week and, if less than 32-35 hours per week, whether the number of hours is considered full-time by the service provider
- Complete GN 6008, Service Provider Progress Report, every 90 days, or as required, to indicate whether the participant is complying with program requirements and maintaining satisfactory progress, has successfully completed treatment, or has dropped out of treatment
- After treatment for 90 days, complete the CW 61, Authorization to Release Medical Information (see the SAPC website). This form is used to evaluate a participant's ability to participate in a work/training program. The clinician completing the form will determine the length of time the person should be exempt from work requirement. At the end of that timeframe, the GSW will contact the participant to determine if they are able to participate in a work-related activity
- Complete GN 6007B, Enrollment Termination Notice, within three (3) business days of termination to report if the participant has successfully completed treatment services, or treatment services were terminated and the reason for termination
- Complete GN 6007A, Notification of Change from Service Provider, within five (5) business days of a service change. This will include changes in levels of care, start date, treatment hours, and other service information
- Contracted SUD treatment agencies must retain copies of all documentation and communications with DPSS, in the patient's chart, including: the PA 1923, GN 6006A, GN 6006B, GN 6007, GN 6008, confirmation of faxing, and any letters/ correspondence to and from DPSS regarding the patient. This includes any written notice of eligibility/acceptance provided by the Centralized PA 1923 unit. Agencies must obtain and keep on file a Provider Notification Letter for patients entering treatment through the PA 1923

DPSS CalWORKs (CW) Asian Pacific Islander Targeted Outreach Program (API)

The purpose of outreach to the Asian Pacific Islander (API) targeted population is to provide SUD information and education for CalWORKs participants as well as those who may be eligible for CalWORKs who may have a SUD and/or co-occurring mental health and substance use disorder in API communities. The outreach seeks to identify SUD needs and connect persons with culturally and linguistically appropriate levels of staff and treatment services, where possible. Persons to be served include participants in the API communities in LA County including homeless individuals.

The program also provides intensive, family-centered pre-treatment outreach, education, and supportive services to affected Korean, Cambodian, and Samoan families in Los Angeles County, both to encourage participants with SUDs and family members to enter treatment, and to ensure that a supportive family network is in place to support those individuals who choose to enter treatment.

There are three dedicated DPH-SAPC Treatment agencies who administer the API Targeted Outreach Program: Cambodian Association of America (CAA), Asian American Drug Abuse Program, Inc. (AADAP), and Special Services of Groups (SSG). The duties of the API Outreach Worker include:

- Assist participants to self-explore the consequences of alcoholism and other drug dependence
- Educate on how self-hep (i.e., Alcoholics Anonymous, Al-Anon, and Narcotics Anonymous) compliment alcoholism/drug addiction or dependency counseling and the unique role of each in the recovery process
- Connect participants with culturally and linguistically appropriate treatment agencies

DPSS CalWORKs Additional Programs

CalWORKs funding also covers two additional programs: Job Club and the CalWORKs Adult At-Risk Program. Both programs are provided by Treatment Agencies who are contracted to operate as a CENS Area Office. Each CENS office has two dedicated CalWORKs counselors: one is assigned to provide Job Club services and the other (.25 FTE) is dedicated to work as the CalWORKs Adult At-Risk counselor.

CalWORKs Adult At-Risk Program Overview

The CalWORKs Adult At-Risk Program is designed to provide individuals receiving DPSS CalWORKs benefits an opportunity to learn about and be aware of substance use disorders (SUD) through interactive educational sessions. This initiative provides education courses about the effects of substances and their impact on an individual's life. These courses are designed for individuals whose screening results determined they might be at-risk of developing a SUD based on reports of experimental or early-phase substance use. The sessions are designed to teach ways to prevent adults from developing SUDs and maintain a healthy and SUD free lifestyle.

Target Population for CalWORKs Adult At-Risk Program

The target population is any DPSS CalWORKs participant who has been referred by the DPSS GAIN Services Worker (GSW) to the CENS due to suspected substance use and:

- Has screened by the CENS for ASAM 0.5 Early Intervention, or does not meet medical necessity for SUD treatment, and would benefit from Early Intervention services
- Has engaged in or is engaging in SUD high-risk behaviors

CalWORKs Adult At-Risk Program Referral Process

DPSS refers the CalWORKs recipient deemed at-risk for SUD to CENS Area Office for screening. The designated CalWORKs CENS counselor screens using ASAM Co-Triage. If the screening result indicates 0.5 Early Intervention LOC, CENS offers referral to the Adult At-Risk Program, which is voluntary. The dedicated CalWORKs CENS Counselor refers client to and arranges appointment with the CENS At-Risk Counselor for enrollment and services. Client enrolls and completes the program or refuses to enroll. If client consents, CalWORKs At-Risk Counselor informs DPSS worker via email.

Job Club Orientation Overview

A partnership between DPSS and LACOE, Job Club is an educational program for DPSS CalWORKs GAIN and GROW participants. Services include Job Readiness and Career Planning as well as assisting participants in overcoming employment barriers, such as SUD and Mental Health, through goal setting, building self-esteem, SUD education, and providing job search and placement activities which enable participants to obtain gainful employment.

CENS Area Office – CalWORKs Dedicated CENS Responsibilities

The Contracted CENS Area Office has a dedicated CENS Counselor who will schedule and conduct Job Club presentations on the topic of SUD 101 using the specified PowerPoint presentation created by DPH-SAPC. The schedule is submitted to CENS Area Office on a quarterly basis. Upon receipt:

- CENS staff/manager will schedule the time they can conduct their presentation and return the schedule back to their SAPC Job Club liaison
- SAPC liaison will forward the schedule back to DPSS
- CENS counselor will conduct presentations at the scheduled time they selected and document the number of CW recipient who participated in Job Club

Department of Public Social Services – General Relief Referrals

General Relief Referral Process

All adult General Relief (GR) applicants, as a condition of eligibility, are required to undergo a pre-screening interview for a SUD by their DPSS Eligibility Worker (EW). If there is a reasonable suspicion of a SUD, the GR applicants must be referred to the DPSS Mandatory Substance Use Disorder Recovery Program (MSUDRP). GR applicants with a positive SUD pre-screen are referred to:

1. The CENS area office nearest to the participant;
2. Directly to a contracted SUD treatment agency; or
3. SASH for a clinical screening and/or assessment

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. Services may be a combination of various treatment service modalities as described in the *Treatment Services* section.

The Treatment Progress Report (Form ABP 132) is generated by LRS and mailed directly to receiving contracted SUD treatment agency every 60 days for completion, and returned to DPSS, who monitors the individual's participation. LRS resets this date to generate a new Treatment Provider Progress Report form.

Contracted SUD treatment agencies are required to notify DPSS of all changes in participant's status within five (5) days of the actual change including:

- Transfers to other sites or treatment modalities
- Dropouts
- Completions

Contracted SUD treatment agencies are required to notify DPSS within three (3) days of changes in the number of hours participants are in treatment using the Report of Changes form. These changes should correspond to changes in the participant's Problem List (non-OTP settings) or Treatment Plan (OTP settings). Treatment Extensions are initiated when agencies determine the patients' need for treatment proceeds beyond the initial six (6) months, based on medical necessity.

If a treatment extension is needed, the contracted SUD treatment will submit a reauthorization request to the SAPC Utilization Management (UM) Unit that evaluates and approves/denies the request.

The contracted SUD treatment agency will forward the form to DPSS for final approval/denial who then updates LRS. It is up to DPSS to notify and send copy of extension status back to the contracted SUD treatment.

In addition, contracted SUD treatment agencies are to contact the CENS Area office and notify their dedicated GR CENS of any GR client changes as the CENS must update client data in LRS via the California Statewide Automated Welfare System (CalSAWS) website.

Department of Children and Family Services (DCFS) Programs

Substance Use Disorder – Trauma-Informed Parent Support Program

The Substance Use Disorder - Trauma-Informed Parent Support (SUD-TIPS) program provides access to SUD screening and referrals into treatment to parents/guardians with open DCFS referrals and cases. Designated CENS counselors work with the DCFS Regional office aligned to their SPA to receive SUD-TIPS referrals from the DCFS social worker via email or by the DCFS parent walking into the CENS Area office.

The designated SUD-TIPS CENS counselors apply MI techniques to provide:

- Outreach and engagement of the target population
- Onsite or virtual evidence-based SUD screenings to parents with alcohol and substance-use challenges using the ASAM Co-Triage
- Medi-Cal and My Health LA eligibility and enrollment
- Referral to SUD treatment services
- Client Education
- Referrals to early-intervention SUD or mental health services, as appropriate
- Navigate linkages and provide a warm hand-off to the appropriate community SUD treatment resources

SUD-TIPS Referral Process

Referrals into the SUD-TIPS program:

1. Made by any DCFS staff member using the SUD-TIPS referral form sent via email to their aligned CENS Area office or given to the parent
2. Upon receipt, CENS staff will contact the DCFS Child Social Worker (CSW) for any missing or questions regarding contacting the parent
3. The CENS staff will contact the parent to schedule the screening appointment within 24 hours of receipt of the referral
4. If the parent does not show up to the screening appointment, the CENS staff will attempt to make contact to re-schedule an appointment for a total of three attempts. After two attempts, the CENS staff will update the DCFS Staff by email or phone
5. If the parent refuses to be screened, does not show for a scheduled screening appointment, or is not reached for an appointment after a third attempt, the CENS staff will note the Screening as either: "*not completed", "no show", "refusal or unable to reach"* by completing **Section D** of the SUD-TIPS Referral Form. CENS will then forward the Referral Form, via secure email, to the referring DCFS staff
6. Refer screened participants to the appropriate SAPC DMC contracted treatment providers based on participant's proximity, type, and level of service/(s) needed

7. Request participant's consent to release information to share their treatment planning and progress information with, DCFS, and the State. Such releases shall adhere to all confidentially laws including 42 CFR Part 2 and HIPAA
8. By the 10th of each month, CENS staff will submit copies of the prior month's referral forms, either by using the SUBMIT button at the bottom of the referral form, or by scanning and transmitting encrypted email to: SAPC_FamilyServices@ph.lacounty.gov

DCFS – Family Dependency Drug Court Referrals Program

Referral Process

In order for adult male/female parents, age 18 and older, to be eligible for treatment services under the Family Dependency Drug Court (FDDC) program, parents must have active cases with DCFS and the Juvenile Dependency Court. While efforts are being made to foster family reunification, parents enter the program on a voluntary basis and are under court supervision for the duration of treatment.

Candidates for the program are identified either by the DCFS office located nearest the parent, dependency attorneys for parents and children, County Counsel and/or judicial officers. Referrals into the FDDC program are initiated by the assigned DCFS FDDC CSW.

Once eligibility is verified, the DCFS CSW or Program Manager will refer their participants for a clinical assessment, using the DCFS 6006A, in the following way:

- Direct to a contracted SUD treatment agency nearest to the patient
- The treatment agency will:

    1. Schedule an ASAM assessment appointment within three (3) business days of receipt of the DCFS 6006A from the TLFR Manager
    2. Make best efforts to complete the ASAM CONTINUUM assessment within five (5) business days of appointment
    3. Complete page two (2), sections B and C of the DCFS 6006B and faxes form to the DCFS CSW within 24 hours of completing assessment
    4. Notify CSW of any appointments the parent missed within 48 hours of the patient's missed appointment date

The contracted SUD treatment agency will follow up on DCFS participants who fail to keep their initial assessment appointment and reschedule a missed appointment once. PSSF-TLFR participants who fail to keep the second appointment must contact their CSW.

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. Services may be a combination of various treatment service modalities as described in the *Treatment Services* section.

Contracted SUD treatment agencies are advised that in serving these patients, family counseling sessions should be an integral part of the treatment planning and services.

Once accepted into the FDDC program, the CSW:

- Contacts the contracted SUD treatment agency that completed the initial screening/assessment and schedules an intake appointment for the patient
- Completes sections A and B of the FDDC referral form and faxes it to the selected contracted SUD treatment provider

Status Reports

Contracted FDDC SUD treatment agencies serving FDDC patients are required to:

- Complete section C of the FDDC referral form, ensuring patient has completed section D, and return it via fax to the FDDC CSW within five (5) business days of the intake appointment.
- Submit an initial report to the DCFS CSW within five (5) business days of the treatment admission
- Submit a progress report to the DCFS CSW within five (5) business days prior to the participant's scheduled Court appearance
- Submit a progress report to the DCFS CSW immediately upon discharge (expected or unplanned)
- Submit progress reports for each court hearing that reflects patient progress since the last court hearing, pertaining only to SUD treatment services. ***Recommendations and/or comments on visitation rights are <u>not</u> permitted.***

Treatment Completion/Reunification

1. Contracted SUD treatment agencies must work closely with the DCFS CSW on family reunifications. Discharge planning should begin shortly after the patient enters treatment and should focus on aftercare preparation.
2. Within five (5) workings days of program completion, the treatment provider shall enter the information on a progress report to confirm completion and notify DCFS and/or court of patient discharge. A copy of the completion report will be delivered in a sealed envelope by the patient to the CSW and the court.
3. When patients are terminated from treatment due to non-compliance, the contracted SUD treatment provider shall forward a termination report to the CSW and the court within five (5) business days of program termination.
4. Graduations are conducted to acknowledge the completion of the FDDC program and may take place at a later date designated by the contracted SUD treatment provider and/or court. Graduation marks the end of SUD treatment episode.

Pregnant and Parenting Women (PPW)

Referral Process

Perinatal clients who self-identify or are identified by a County department (e.g., DCFS) are referred to the appropriate LOC by the CENS, SASH, or may present directly at a SUD agency. Clients should be directed to a PPW Service provider to ensure that clients are receiving all services to which they are entitled. Only designated PPW agencies are allowed to bill for perinatal services.

Perinatal Target Populations

The Perinatal Practice Guidelines (PPG) provides guidance on perinatal requirements in accordance with Drug Medi-Cal (DMC), and the Substance Abuse Prevention and Treatment Block Grant (SABG) Perinatal Set-Aside from the Substance Abuse and Mental Health Services Administration (SAMHSA).

The SABG requires specified funds to be used for perinatal patients and are governed by 45 CFR, Part 96, Subpart L; DMC funds are governed by Title 22 of the California Code of Regulations.

Per the PPG, those eligible for PPW services includes:

- Pregnant women
- Women with dependent children
- Women attempting to regain custody of their children
- Postpartum women and their children
- Women with substance exposed infants

PPG Admission Priority

SUD agencies serving PPW shall provide preference to pregnant women following this priority admission order:

- Pregnant injection drug users
- Pregnant substance users
- Injection drug users
- All others

In accordance with the SABG requirements, all PPW Service Providers must treat the family as a unit and admit both women and their children into treatment services, if appropriate. PPW Treatment Providers must service the following individuals with a SUD: pregnant women, women with dependent children, women attempting to regain custody of their children, postpartum women and their children, or women with substance exposed infants. PPW Service Providers shall address specific treatment and recovery needs of pregnant and parenting women of up-to 60 days postpartum.

PPW Service Providers, who are contracted to provide Residential or RBH will be able to be reimbursed for the cost of room and board, and/or for the bed day rate for Residential and RBH for children (0-16) who accompany or have overnight visits with the parent in these settings while in treatment. Services will be covered using SAPT-BG Perinatal Set-Aside funds as applicable or other non-DMC funds as needed, to account for PPG required services.

Treatment Requirements and Care Coordination for Perinatal Populations

Per the PPG, treatment agencies that serve PPW are to provide or make arrangements for the following treatments services:

- **Primary Medical Care** – Including a referral for prenatal care to PPW receiving SUD treatment services (**NOTE: Childcare services must be provided during this specific treatment**)
- **Primary Pediatric Care** – Including immunization for the children while the PPW are receiving SUD treatment
- **Gender-Specific Services** – Including relationships, sexual and physical abuse, and parenting
- **Therapeutic Interventions for Children** – Treatment services for the children of the women receiving SUD treatment services should address the child's developmental needs, sexual abuse, physical abuse, and neglect

- **Care Coordination** – Includes the arrangement, coordination and monitoring of services: primary medical care, gender-specific treatment, and therapeutic interventions for adults
- **Child Care Coordination** –Includes the arrangement, coordination, and monitoring of services: primary pediatric care, gender-specific treatment, and therapeutic interventions for children
- **Perinatal Transportation** – Must provide/arrange transportation for PPW for primary medical care, primary pediatric care, gender specific treatment, and therapeutic services for children
- **Childcare** – Childcare must meet applicable standards of State and local law for licensed and/or licensed-exempt childcare, as defined in Title 22, Division 12, Chapter 1. SAPC will reimburse for the following types of childcare for children ages 0-14 years:
    - **Cooperative (Co-op) Child Care** – Licensed-exempt cooperative childcare is delivered while the mother receives SUD treatment services. Co-op childcare involves one woman watching the children of her fellow group members while they participate in treatment. The patient/caregiver watching the children should rotate so that each woman gets the opportunity to participate in treatment.
        - Staff to caregiver to child ratios are one (1) staff and one (1) caregiver to 12 children
    - **Licensed-Like Child Care**
        - Staff to caregiver to child ratios are as follows:
            - Infants (0 to 18 mo.): one (1) staff to three (3) children
            - Toddlers (18 to 36 mo.): one (1) staff to four (4) children
            - Preschool Age (36 to 60 mo.): one (1) staff to eight (8) children
            - School Age (5 to 14 years): one (1) staff to fourteen (14) children

Expanded PPW Services

In accordance with the Department of Health Care Services' Perinatal Practice Guidelines, SAPC expanded SUD treatment services for PPW to include their dependent children (age 0-16). Dependent children can receive the following support services while the mother is enrolled in treatment:

- **Residential**: Room and board for up to five (5) children per parent, (age 0-16), accompanying parent in residential treatment services. Contingent on participation in Residential Treatment services by pregnant or parenting woman.
- **Recovery Bridge Housing**: Bed for up to five (5) children per parent, (age 0-16), accompanying parent in Recovery Bridge Housing (RBH). Contingent on participation in RBH by perinatal or parenting woman.
- **Child Care Coordination**: Arrangement, coordination and monitoring of services for children: primary medical care, primary pediatric care, gender-specific treatment, and therapeutic interventions.
- **Transportation**: Transportation (using an agency owned or leased vehicle) for the mother and child(ren) 0-16 years of age. May be used only to ensure access to the following services: primary medical care, primary pediatric care, gender-specific treatment, therapeutic services for children. ***Not available to residential providers as this benefit is built into the residential rate.***

For more information, on expanded services for PPW, please see the *SAPC Perinatal Services Bulletin Number (Information Notice 18-11)*.

Drug Medi-Cal Perinatal Eligibility

- The LPHA shall determine whether SUD services are medically necessary and document approval of diagnosis that is performed by therapist, physician assistant, or nurse practitioner by signing and dating the Problem List (non OTP settings) or Treatment Plan (OTP settings).
- Medical documentation to substantiate pregnancy and last day of pregnancy must be in the patient record.
- Pregnant and up to 60 days postpartum. Eligibility (based on pregnancy) ends on the last day of the month in which the 60th day occurs (sources: Title 22, Section 51303; 22 CCR § 5026).

Mother/Child Habilitative

Per Title 22, Drug Medi-Cal Perinatal programs are to provide mother/child habilitative services. These services focus on the development of parenting skills and training in child development, and the coordination of ancillary services. Services include:

- Education to reduce the harmful effects of alcohol and other drugs on the mother and fetus, or the mother and infant
- Therapeutic interventions addressing issues such as relationships, sexual and physical abuse, and parenting

Discharge

It is important for providers to begin discharge planning shortly after the patient enters treatment services. This planning should include family planning and encouragement of the continued pursuit of recovery goals, education planning, and reunification planning (if applicable).

For more information on the services that are required to be provided to the PPW population, see the *Perinatal Practice Guidelines*.

Women and Children's Residential Treatment Services (WCRTS) Program

Women and Children's Residential Treatment Services (WCRTS) is a funding source provided to a number of counties to be used for support services that are not covered under DMC for PPW patients receiving services in residential settings. Covered non-DMC costs include residential room and board, as well as the full cost of treatment services for women ineligible for or unenrolled in Medi-Cal who are receiving services in a PPW residential program.

DPH-SAPC sought authorization from the State to enable all contracted PPW residential treatment providers to receive WCRTS funding to support non-DMC funded services. In May 2020, DHCS notified DPH-SAPC that WCRTS funds may be used by PPW residential providers as long as the conditions specified in Health and Safety Code § 11757.65 are met. Pursuant to HSC §11757.65, providers participating in the WCRTS programs must pursue four primary goals and achieve four outcomes for pregnant and parenting women in residential SUD treatment settings.

The **four primary goals** of the WCRTS Program include:

1. Demonstrate that alcohol and other drug abuse treatment services delivered in a residential setting and coupled with primary health, mental health, and social services for women and children can improve overall treatment outcomes for women, children, and the family unit
2. Demonstrate the effectiveness of six-month or 12-month stays in a comprehensive residential treatment program
3. Develop models of effective comprehensive service delivery for women and their children that can be replicated in similar communities.
4. Provide services to promote safe and healthy pregnancies and perinatal outcomes.

The **four outcomes** include:

1. Preserving family unity
2. Promoting healthy pregnancies
3. Enabling children to thrive
4. Freeing women and their families from substance abuse

Additional Perinatal Services

In addition to providing the expected services, treatment agencies providing PPW services must incorporate the following into PPW treatment services:

- Promote bonding with the expected child
- Reproductive counseling
- Care Coordination to address the material and physical/mental health needs that accompany pregnancy
- Support for parenting a newborn, education about breast feeding, and integration with other children and family members
- Care Coordination for practical needs such as legal assistance, equipment and clothing, coordination of physical and mental health services as needed, coping with the physical and psychosocial changes of the postpartum period, family planning, and encouragement of the continued pursuit of recovery goals
- Outreach – Providers must develop and implement outreach activities to ensure pregnant and/or parenting women in need of services can access treatment
- Promote - Promote awareness among women using injection drugs about the relationship between injection drug use and communicable diseases, such as Human Immunodeficiency Virus (HIV), Hepatitis B, Hepatitis C, and TB, and offer referrals to appropriate services providers for appropriate screenings
- Perinatal programs must notify SAPC and DHCS within 7 days once their program reaches 90% capacity. Providers must submit this notification by sending a notice to sapcmonitoring@ph.lacounty.gov and DHCSperinatal@dhcs.ca.gov. In accordance with the most current *Perinatal Practice Guidelines*, providers must report this information on the DATAR system

Sexual Reproductive Health Services

SAPC has partnered with the DHS to implement programming geared at identifying and screening women of reproductive age (ages 18-50) to facilitate conversations regarding each woman's pregnancy intention, including DHS health educators offering health education classes at a number of PPW provider sites, with the

goal of expanding these services across all sites that offer services to the PPW population. These programs integrate sexual and reproductive counseling and education into the participant's treatment goals. Participants are offered referrals to health clinics that address their reproductive health needs, including MAMA's Neighborhood, which is operated by DHS and provides prenatal and comprehensive healthcare services to women. Contract perinatal treatment providers are provided reproductive health training to provide these services.

The goals of this collaboration are to better identify and support women of reproductive age, help improve access to reproductive health care through direct linkages, expand their sexual and reproductive health knowledge, facilitate improved pregnancy and birth outcomes, chronic disease and sexually transmitted infection and HIV management, and improve recovery management and outcomes.

Process for Accessing Reproductive Health Services

Staff at most PPW treatment provider agencies have been trained in discussing sexual and reproductive health issues with patients. PPW treatment providers who received Reproductive Health Trainings will utilize a standardized reproductive health-screening tools, approved by DPH-SAPC, to screen and determine the reproductive needs and services of the individual. The PPW Treatment Providers will:

- Screen their female population (during intake or after intake) to identify the most appropriate service based on their reproductive preferences
- Connect participant with their primary care provider (PCP), local clinic, or the nearest DHS MAMAs Neighborhood clinic
- Submit the completed reproductive health-screening tool back to DPH-SAPC on a weekly basis

For those individuals who are currently pregnant, or who are seeking to become pregnant, prevent pregnancy, or achieve their preferred birth spacing, contracted perinatal treatment providers are to facilitate appointment scheduling for appropriate services (based on their reproductive preferences), such as contraception, pre/inter-conception care, prenatal and postpartum care, and pregnancy options counseling and services.

Pregnant and Parenting Women - CENS MAMA's Outreach Project (PPW-CENS MAMA's Outreach)

In addition to the Sexual and Reproductive Health screening services, the PPW-CENS Outreach Project utilizes dedicated CENS counselors who directly work with DHS MAMA's clinics to assess their clients who may need SUD services. Upon consent, women are referred to the CENS Area office aligned with the MAMAs Neighborhood clinic for SUD screening, referral to treatment or early intervention services. If SUD services are recommended, CENS refer participants to the appropriate DPH-SAPC network of DMC contracted treatment providers based on the woman's proximity, type, and level of services needed.

DPH-SAPC's CENS counselors participating in this program are trained by DHS MAMA's staff on pregnancy and reproductive health matters and work directly with a dedicated DHS staff for information and status of the women that are referred to the CENS.

Process for Accessing PPW-CENS Outreach Services:

- DHS MAMA's Staff contacts the CENS Area office aligned with their clinic by 3-way phone call with client or via email with client consent to:

  - Share the MAMA's site info, name, contact information, and current pregnancy status/date of next perinatal appointment of the woman they are referring to the CENS office
  - If the participant does not consent or to participate in the call, DHS shares only client contact information and any other key information to the CENS counselor
- CENS counselor reaches out to participant to schedule SUD screening (three attempts). If successful:
  - Screens the participant for SUD treatment and refers to PPW Treatment agency. If possible, obtains external ROI from participant for info to be shared with DHS and treatment agency

Homeless Services

Homeless patients have greater and more varied needs than housed individuals, and therefore typically require more intense treatment that addresses the needs of the whole person in the context of their environment. A full continuum of comprehensive services is necessary to treat the whole patient and fully address their needs.

As part of LA County's agenda to combat homelessness and effectively serve the homeless, special funding through the Measure H quarter-cent sales tax is allocated to support Recovery Bridge Housing for homeless patients who are exiting from institutions such as jails, prisons, other correctional facilities, hospitals, urgent care centers, SUD residential treatment centers, mental health treatment facilities, and foster care and probations camps for young adults aging out of these settings (See *Recovery Bridge Housing* section for full benefit details). Measure H also supports SUD screening and referral services at PSH sites throughout the county (See *Client Engagement and Navigation Services* section for full benefit details). Through general Drug Medi-Cal funding, Care Coordination plays a critical role in addressing the homeless patients' unique needs (See *Care Coordination* section for full benefit details). The following services may be provided within the SUD program itself or through linkages with existing community resources.

Target Population

All single adults, youth, and families who meet the homeless or chronic homeless definition set by HUD, LA County agencies, and other local housing organizations.

Identification of 5% Utilizers

On February 9, 2016, the Board of Supervisors approved the "5% Process" for the most expensive 5% among homeless single adults known to LA County when they approved the Los Angeles County Homeless Initiative. In November 2016, the Chief Executive Office (CEO) released the 5% Process for the identification and prioritization of high-acuity homeless single adults for housing and supportive services.

SUD treatment providers are required to determine whether patients being entered in Sage have been identified as part of the 5% process as follows:

- Enter a provider and CalOMS admission episode in Sage, then click the "Alerts" tab and check the "High Utilizer" box to confirm the patient's high utilizer status
- If the patient is a high utilizer, a "High Utilizer Alert" notification will appear on the screen
- If the patient is not a high utilizer, a "No alert found" message will appear on the screen
- Once the patient's high utilizer status is confirmed, the provider must continue the following steps

Determination of Appropriate Level of Care and Linkage to Treatment

A. Patient is not Enrolled in Treatment:

- If the client is not enrolled in treatment services, the provider must conduct the full ASAM CONTINUUM assessment to determine the appropriate LOC needed
- If the patient requires residential treatment, the provider must place the patient in residential treatment the same day, if available
- If the provider does not have an available residential treatment bed or does not offer residential treatment, the provider must contact the residential provider with available beds to schedule an appointment on behalf of the patient on the same day
- If the LOC for the patient is Outpatient, Intensive Outpatient, Outpatient Withdrawal Management, or Opioid Treatment Program services, then the provider must connect the patient to RBH as follows:
    - Contact an RBH provider with available beds for the patient's placement on the same day
    - If there are no available RBH beds, the provider will contact shelters and other interim housing providers with available beds and arrange for the patient's housing placement on the same day

B. Patient is Enrolled in Treatment:
- If the patient is enrolled in treatment, the provider must complete the steps noted in Patients Experiencing Homelessness under Care Coordination Considerations for People in Vulnerable Groups

Intake Process

A who identifies as homeless during the ASAM CONTINUUM or SAPC Youth ASAM assessment should be referred to the SUD counselor to determine the patient's housing and service needs.

Assessment

The trained SUD care coordinators from a provider with access to the HMIS will:

- Administer the CES Survey Packet including the VI-SPDAT for homeless adults, and the Next Step Tool for youth and young adults;
- Enter or update the homeless patients' information into HMIS; and
- Start coordinating with the CES agency for the patients' housing within fourteen (14) calendar days of first treatment service or intake appointment.

Treatment providers that have not been trained on the CES adult and youth tools and have not received access to HMIS will need to refer the homeless patients directly to the CES agency within the same SPA likewise within fourteen (14) calendar days of first service or intake appointment.

For patients who are homeless with their families, the SUD care coordinator will call "211" or refer them to any of the CES for Families agencies countywide to schedule a housing screening appointment. Depending on the availability of resources, adult and young adult patients may be offered DPH-SAPC's Recovery Bridge Housing benefit if they prefer a temporary abstinence-focused environment prior to securing more permanent housing.

Care Coordination

For providers that are trained and have the capacity to deliver housing services, the SUD care coordinator will coordinate with the CES Housing Navigator to ensure that all necessary documents and forms have been uploaded into HMIS and that the patient is Match Ready (e.g., necessary documentation is collected and

entered into HMIS), and eligible for permanent housing vacancies listed in the CES. The SUD care coordinator will also assist the patient in completing the necessary application forms.

Discharge

The CES Housing Navigator will notify the SUD care coordinator when a housing resource has been identified, and the corresponding Housing Provider has been notified of a match. The SUD care coordinators will coordinate the appointments between the Housing Provider and the patient, verifying eligibility information, and assisting the patient with the housing application process. The CES Housing Navigator will assist the SUD care coordinators with move-in resources (e.g., security deposits, furnishings, etc.) for the patient. The SUD care coordinator will link the patient to the appropriate supportive services for securing and maintaining appropriate housing, including income/benefits/employment and transportation.

Population-Based Services by Funding Source – Youth

Programs described below require the active participation of the Youth SUD treatment provider and the referral source. Activities may include Care Coordination services (e.g., providing status reports on patient's progress to judge, probation officer, or social worker), participating in case conferences, and developing and implementing a plan of care in collaboration with the referring staff.

Juvenile Justice Crime Prevention Act Program

The Juvenile Justice Crime Prevention Act (JJCPA) Program is a collaborative project between SAPC and Probation. The goals of the treatment program are:

1. Provide youth with skills to resist continued substance use and the associated negative behaviors
2. Demonstrate reductions in subsequent arrests, incarceration, and probation violations
3. Increase completion of probation, restitution, and community service requirements

Target Population

JJCPA services are for at-risk youth and probation involved youth.

Referral Process

- Youth are typically referred when conditions of probation require SUD treatment and/or prior to exiting Juvenile Probation Camps (for youth with a history of SUD).
- The Probation Department's Prospective Authorization and Utilization Review (PAUR) Unit makes and/or approves all JJCPA referrals to Youth SUD providers. This includes referrals by school-based and other Probation Officers.
- Within five (5) business days of receiving a referral, Youth SUD Treatment Provider must notify the PAUR unit of contact made with family via email and Community Based Organization (CBO) tracking system. Please contact the PAUR Unit by email to request for an extension if additional time is required.
- After the first face-to-face (intake) session, return the referral form with the "Agency Response" section completed (including the start date) to the PAUR Unit. If an intake appointment is rescheduled, hold the referral until the intake is complete. If reasonable attempts to schedule an intake are made, including contacting the referring DPO, and the family is unresponsive, please note in the JJCPA tracking system within one (1) working day of missed or rescheduled appointment.

- If the service is not complete, please return the referral form to the PAUR unit noting the Did Not Complete (DNC), date, and reason.
- Upon discharge once the service is completed, return the referral form to the PAUR unit noting the completion date.

Reporting Requirements and Procedures

- **Reporting to Probation**: A CBO Note must be entered into Probation's web-based reporting system (https://probjjcpa.lacounty.gov/cbo/) for each JJCPA referral, regardless of admission status, and at least once every 30 days for youth admitted into treatment. For all admissions, the "Enter Service Data" screen in Probation's web-based reporting system must be completed monthly and updated as necessary.
- **Reporting to SAPC**: The contracted SUD treatment provider must electronically submit a Program Participant Report that lists all new referrals, youth in treatment, and closed cases, to SAPC by the tenth (10th) of the month following the reporting month. All JJCPA admissions must also be entered in CalOMS/LACPRS.

Data reported on the Program Participant Report must be consistent with information reported in LACPRS and the Probation Department's web-based system.

Staffing and Fingerprint Clearance

DPH-SAPC and Probation shall be responsible for ensuring ongoing compliance of background and security investigations applicable to each department's contracts and contract employees.

Youth Enhancement Services (YES)

To increase engagement and retention of youth in treatment, the Youth Enhancement Services (YES) project supports the youth DMC beneficiary package by reimbursing DPH-SAPC youth-contracted SUD treatment providers for services that are not covered nor reimbursable under DMC, but are in alignment with DHCS' Adolescent Substance Use Disorder Best Practices Guide. The goal of the YES project is:

1. Encourage and link youth to treatment services;
2. Increase youth motivation and program retention rates in treatment;
3. Increase access to practical, community-based supports and develop life skills;
4. Enhance care-coordination and reduce geographical barriers to treatment services; and
5. Prevent youth involvement in the juvenile justice system and reduce recidivism.

The following service enhancements are available to youth ages 12-17 within all LOCs available in the youth system as part of the YES project.

Outreach and Engagement Services

Outreach and Engagement services support pre-treatment activities which aim at identifying and linking youth who meet the criteria for a SUD or are at risk of developing SUD to treatment services. Outreach and engagement services include community outreach, SUD screening/assessment, SUD treatment referral and linkages, brief intervention, patient education, and care coordination. Services must be documented in 15-minute increments and are limited to two units per youth, per day for up to five (5) days, per fiscal year, per youth.

Positive Youth Development (PYD) Programs

PYD are on-going, strengths-based, person-centered programs that include activities and experiences which assist in the development of social, ethical, emotional, physical, and cognitive competencies in SUD treatment settings, and help keep youth engaged in treatment. Programming includes instructor-led topic-driven groups, workforce development skills, academic support, alternative therapeutic activities (e.g., art therapy, journal writing, and self-help groups), diversionary recreation (e.g., sports, games, and supervised outings), and other pro-social activities. PYD services include support for programming supplies, non-cash incentives to encourage active participation, and Triple-P, an evidence-based positive parenting curriculum. PYD programs must be accessible to all youth in treatment services and provided to at least two (2) patients per session (not to exceed 12 patients per session). Claims of up to two (2) hours of PYD programming are allowed daily, totaling not more than 25 hours per month.

Requests from agencies to purchase special supplies (e.g., art supplies, journals, etc.) to support PYD activities may be submitted to SAPC for approval on a case-by-case basis in advance of the activity being provided. Providers are required to complete a Positive Youth Development Program Description and Attendance Form which must include printed names of participants as well as printed names and signatures of group facilitators and co-facilitators, if applicable, date, start/end times, location, description of activities, and program supplies (if applicable).

Transportation

Transportation Services assist youth enrolled in Early Intervention services and outpatient LOCs (e.g., Outpatient [ASAM 1.0], Intensive Outpatient [ASAM 2.1]), as well as Recovery Services with getting to and from the following services: Early Intervention services, SUD treatment, primary medical care, behavioral health services and other SUD treatment-related services.

There are three transportation options for youth:

1. Use of ride share services (such as Uber, Lyft, and other transportation network companies) where providers will be reimbursed up to $10.00 per round trip per youth
2. Use of an agency owned vehicle with reimbursement at a rate of $0.586 per mile when agencies are not also leveraging transportation services funded by other programs in which the youth is eligible
3. Public transportation (e.g., TAP cards).

Youth may be offered a mix of transportation options while they are actively enrolled in a treatment program or receiving Recovery Services up to a maximum of $70 per youth per month.

The use of rideshare services (such as Uber and Lyft) provided by Transportation Network Companies are prohibited for youth under 18 years of age unless they are accompanied by an adult who must be at least 18 years of age. The transportation benefit is not available to residential providers as transportation costs are built into the treatment rate.

Eligibility

YES project is available to providers in good standing with active SUD contracts to serve youth and are contracted to provide YES.

Documentation
Once individuals are enrolled in Early Intervention or treatment services, services provided under the YES project must be documented in a Miscellaneous Note (Type: Miscellaneous) in Sage or in the Contractor's own EHR system, accessible for review by SAPC upon request.

Reimbursement
Claims for YES services must be submitted manually to SAPC by the 10th of each month. Required reports and documents for each reporting period include:

- Cost/Line-Item Reimbursement form for all youth that participated in the program
- Participant and Service Log for each youth that participates in the program and services provided under the YES program
- Submit a Positive Youth Development Program Description and Attendance form for each PYD activity that took place during the month that includes the name, date and time, and description of PYD Activity, the participant's name and Sage/Patient number, PYD cost, and signatures of group facilitators and co-facilitators (if applicable).

Juvenile Delinquency Drug Court

The Juvenile Delinquency Drug Court (JDDC) program involves the collaborative efforts of the Drug Court Judge, District Attorney, Public Defender, DPO, Court Officer, and the Youth SUD treatment provider on developing and implementing a comprehensive program for diverting nonviolent minors from further involvement in the criminal justice system and SUD behavior.

Target Population
This program is for youth charged by the Juvenile Drug Court for nonviolent, SUD-related offenses.

Eligibility
To qualify for this program, a youth must be both eligible and suitable for treatment and meet medical necessity. Eligibility requirements include:

- Ages 14 – 17
- Moderate to heavy substance abuse
- Able to attend court hearings and treatment

Youth eligible for the program will subsequently be assessed to determine suitability for SUD treatment.

Consideration Phase
- To be formally accepted to this program, youth must plead to all open, non-drug related counts. The Prosecutor may dismiss some counts.
- Before the youth is accepted into the program, the DPO completes all court reports including pre-plea, progress, and violation.
- Prior to final admission to this program, youth are in a "consideration" phase during which they attend meetings and participates in counseling and treatment.
- The "consideration phase" is approximately 60 days.

- After youth is accepted into the program, the Drug Court DPO completes the court report if there are any new arrests or violations that may result in termination from the program.
- Youth's file is immediately transferred back to DPO of Record once the Drug Court DPO completes the supplement or pre-plea report even if disposition is pending.

Program Structure

- Rules:
    1. Youth and family must attend all ordered treatment sessions.
    2. Youth must maintain regular school attendance and/or possess a job.
    3. Youth must not engage in inappropriate or violent behavior toward any program participants or staff.
    4. Youth must not dress in gang attire, shave their head, or obtain new gang tattoos.
    5. Youth must follow all treatment rules, which includes drug testing.
- The Court applies incentives and sanctions to motivate the youth to comply with the program rules.
- Completion of the program is expected within twelve (12) to eighteen (18) months depending on medical necessity for treatment and on fulfilling other court requirements.

Section 3. CLINICAL PROCESS STANDARDS

Utilization Management Components

The Utilization Management (UM) program analyzes how the SAPC provider network is delivering services and how it is utilizing resources for eligible patients. The various responsibilities of the UM program include:

- Ensuring adherence to established DMC eligibility verification and medical necessity criteria
- Ensuring that clinical care and ASAM level of care guidelines are followed
- Monitoring both under- and over-utilization of services
- Assessing the quality and appropriateness of care furnished to enrollees with special health care needs
- Conducting clinical case reviews (prospective/concurrent/retrospective) of requests for select services
- Authorization of select services
- Random and retrospective monitoring of a portion of provider caseloads
- Ongoing monitoring and analysis of provider network service utilization trends

In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum
- To assure fair and consistent UM decision-making
- To focus resources on a timely resolution of identified problems
- To assist in the promotion and maintenance of optimally achievable quality of care
- To educate health care professionals on appropriate and cost-effective use of health care resources

SAPC follows federal and state decision and notification timeframes for all UM determinations. SAPC will make every effort to complete UM determinations expeditiously in order to facilitate timely treatment for the patients served in the specialty SUD system in LA County, and to assure compliance with all requirements. In support of prompt review of member authorizations, providers are required to submit member authorization requests along with related clinical documentation within thirty (30) calendar days of admitting a patient into a treatment or SUD-related benefit program or within thirty (30) calendar days of initiating continued services.

Eligibility Verification

Initial DMC eligibility verification should occur at the point of first contact between a patient and the specialty SUD system and include considerations outlined in **Table 3**. Medical necessity determinations will occur at the provider site. The initial DMC eligibility verification may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a LPHA (see *Workforce* section) and must be established regardless of the patient's insurance and funding status. Providers are required to confirm DMC eligibility monthly to ensure patients are actively enrolled in the DMC program.

Specialty SUD benefits are available to all patients who meet the requirements of the DMC eligibility verification and medical necessity criteria listed above. Legal status (e.g., parole, probation) is not a barrier to access substance use services, provided that the prospective patient meets the specified DMC eligibility verification and medical necessity requirement.

All patients eligible for specialty SUD services (e.g., My Health LA, or participant in qualified county funded programs/projects) will have access to the same benefit package as DMC beneficiaries and will be required to follow the same eligibility and medical necessity verification processes.

Re-verification period for DMC eligibility

- Non-OTP settings: At least every six (6) months
- OTP settings: At least every twelve (12) months

During the re-verification process for DMC eligibility, the LPHA at the provider agency will be required to justify ongoing eligibility for services by verifying DMC eligibility, submitting applicable request forms (e.g., Financial Eligibility Form; Discharge Transfer Form, etc.), and submitting clinical documentation including current Problem List (non OTP settings) or Treatment Plan (OTP settings), full ASAM CONTINUUM or SAPC Youth ASAM assessment, progress notes, pertinent miscellaneous notes, and laboratory test results (if available).

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible family member, patient record, substance use providers, physical/mental health providers, etc. UM staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the system of care, to render a decision about the provision of SUD services, as needed.

If UM staff determines that DMC eligibility verification and medical necessity criteria have been met, and the proposed or provided services are deemed clinically appropriate, service authorizations will be approved and the applying treatment provider will be notified in accordance with the notification timeframes listed in **Table 14**.

Adverse DMC eligibility and medical necessity determinations result in denial of reimbursement for services rendered. Denial notifications contain information including, but not limited to:

- Reason(s) including specific plan provisions, clinical judgment used
- Any additional information needed to improve or complete the authorization
- Descriptions of the appeal or grievance process

Patients, or providers acting on behalf of the patient, as state law permits by authorizing on the appeal form to including the patient signature, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of DMC eligibility, coverage of services, or denial of payment for services (see *Complaints/Grievances and Appeals* section).

Table 14. Utilization Management Notification Timeframes

Review Type	Decision Notification after Receipt of Completed Request	Written Decision Notification
INITIAL AUTHORIZATIONS and VERIFICATIONS		
Initial Pre-Authorization: Residential Services (ASAM 3.1, 3.3, 3.5) (for both adults and youth)	Within 24 hours of receipt of request	Approvals: Within five (5) business days of receipt of authorization request. Other Decisions: See timeframes outlined in the *Complaint*, *Grievance*, and *Appeal Notification Timeframes* section below.
Initial Verification: Non-Residential Services (ASAM 0.5, 1.0, 2.1, 2.5 and OTP) (for both adults and youth)	Within five (5) business days of receipt of request	Approvals: Within seven (7) calendar days of receipt of request. Other Decisions: See timeframes outlined in the *Complaint*, *Grievance*, and *Appeal Notification Timeframes* section below.
Initial Authorization: Recovery Bridge Housing (only for adults ages 18 and over)	Within five (5) business days of receipt of request	Within seven (7) calendar days of receipt of request
Initial Authorization: Medication for Addiction Treatment for Youth ages 17 and under *Must submit authorization requests for these services within seven (7) calendar days (ages 18+) or 14 calendar days (ages 12-17) after patient's admission to the treatment program.*	Within five (5) business days of receipt of authorization request	Within seven (7) calendar days of receipt of authorization request

RE-AUTHORIZATIONS and VERIFICATIONS		
• **Residential and Non-Residential Services (ASAM 0.5, 1.0, 2.1, 2.5, 3.1, 3.3, 3.5, and OTP)** Perinatal patients receiving residential services at PPW sites are authorized for an initial 60 days; and may be reauthorized for another 60 days and every 30 days thereafter, up to 60 days postpartum, based on medical necessity. • **Recovery Bridge Housing (RBH)** Young adult and adult patients may be authorized for 90 days of RBH and reauthorized for an additional 90 days of RBH if needed, for a potential maximum stay of 180 days per calendar year, based on medical necessity of outpatient services. *Must submit residential and RBH re-authorization request at least seven (7) calendar days in advance of end date of current authorization*	Within five (5) business days of receipt of re-authorization/verification request	Within seven (7) calendar days of receipt of re-authorization/verification request
Medications for Addiction Treatment for Youth under age 18 *Must submit reauthorizations at least 14 calendar days in advance of end date of current authorization or verification*	Within 14 calendar days of receipt of re-authorization for non-residential services and/or verification of ongoing medical necessity	Within 21 calendar days of receipt of re-authorization request for non-residential services and/or verification of ongoing medical necessity
Verification of Ongoing Medical Necessity *Must submit ongoing verification requests at least 21 calendar days but no sooner than 30 days in advance of end date of current authorization or verification*	Within 14 calendar days of receipt of re-authorization for non-residential services and/or re-verification for DMC eligibility request	Approvals: Within 21 calendar days of receipt of re-authorization request for non-residential services and/or DMC eligibility verification. Other Decisions: See timeframes outlined in the *Complaint*, *Grievance*, and *Appeal Notification Timeframes* section below.

Note:

- **These timeframes are only applicable after sufficient information is obtained by UM staff to make a determination. In other words, the clock for these timeframes will not start until UM staff receive sufficient information to make an authorization or verification decision.**

  - **These timeframes may be extended by up to an additional 14 calendar days if:**
    - **The patient or the provider, requests extension.**
    - **SAPC justifies a need for additional information and how the extension is in the patient's interest.**
- **Providers must submit requests for preauthorized residential services prior to initiation of services, unless providers elect to provide the service prior to receiving pre-authorization and accept financial loss if the pre-authorization is ultimately denied.**
- **Any request for Authorization may be denied due to untimely submission (e.g., not submitted in accordance with the timeframes specified above.**
- **If a patient enters treatment for a preauthorized or authorized service but leaves Against Medical Advice (AMA) before the Financial Eligibility Form is approved, the provider will still need SAPC preauthorization/authorization in order to receive compensation for services provided during the days in which the patient was in treatment. SAPC will deny services if information is missing upon review or medical necessity was not established prior to the patient leaving AMA.**

Utilization Management Case Review Considerations

- **Patient/family/guardian identified goals and preferences**
- **Care/service is necessary and clinically appropriate in terms of level of care, intervention, frequency, timing, and duration, and considered effective to promote recovery**
- **Care/service is consistent with generally accepted standards of clinical practice based on:**
  - **Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by independent clinical experts at the time the services are provided**
  - **Up-to-date diagnostic criteria from the most current DSM and ASAM criteria**
  - **Case discussions with treating providers, when appropriate**
  - **Any other relevant factors**
- **Care Coordination to ensure that care/service is coordinated both across the continuum of SUD care and across relevant physical and mental health systems, as clinically indicate**
- **Regular patient assessments ensure that care/service is provided in the least restrictive, most cost-effective environment that is consistent with clinical standards of care**
- **Care/service is not provided solely for the convenience of the provider, recipient, recipient's family, or custodian (e.g., placing patients in a residential level of care primarily for housing purposes)**
- **Care/service is not experimental, investigational, and/or unproven**
- **Care/service is deemed necessary and furnished by or under the and in accordance with all applicable rules, regulations, and other applicable federal, state, and local directives**

UM staff will review clinical cases from special SUD treatment providers, including adults, young adults, and youth. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the SUD service continuum. In some instances, these reviews are related to reimbursement of services and in others, the reviews are important and necessary to ensure the quality and appropriateness of services provided.

Specialty SUD treatment providers are required to cooperate with all case reviews conducted by the UM program. These reviews are independent from, but complementary with, SAPC contract monitoring activities.

The following methods of review are utilized by UM staff:

- **Prospective Review** - A prospective review occurs prior to the delivery of the services and applies to an initial request or for services that require authorization. The prospective review is performed by UM staff, who apply pre-established medical necessity/appropriateness criteria and render a decision on approval or denial of authorization and/or reimbursement.
    - Prospective reviews allow for the opportunity to assure the efficient and appropriate provision of care and utilization of resources, and to continually assess and improve access and quality of care.
    - Example of prospective review:
        - Pre-authorization of residential services.
- **Concurrent Review** - A concurrent review examines ongoing care to evaluate medical necessity, and the quality and appropriateness of care. This review is conducted by UM staff, in accordance with pre-established criteria, as previously mentioned.
    - The main objectives of the concurrent review process are to ensure that care is appropriate and in accordance with generally accepted standards of practice, to continually monitor patient progress, and to anticipate treatment needs and transitions that promote recovery.
    - Examples of concurrent review:
        - Authorization of MAT and withdrawal management for patients under age 18
        - Authorization of Recovery Bridge Housing
        - Initial authorization of residential services that was not received prior to admission
        - Reauthorization of ongoing MAT for patients under age 18
        - Reauthorization of ongoing residential services
- **Retrospective Review** - Retrospective reviews examine various aspects of previously provided services. These reviews yield information about the quality of verification of DMC eligibility and service authorization decisions, and other aspects associated with the services provided to patients. This information is used to evaluate the quality and appropriateness of the services the provider is contracted to deliver. Open and closed cases may be identified for retrospective review through numerous mechanisms.
    - Retrospective reviews allow for the opportunity to identify under- and over-utilization of services, to identify utilization patterns and trends, to continually evaluate the consistency of the UM review and decision-making process, and to continually identify areas of improvement.
    - Example of retrospective review:
        - Random, focused chart review of services that have already been rendered to ensure fidelity to verification of DMC eligibility and medical necessity criteria, as well as quality of care.

The UM program utilizes a variety of methods of review when performing case reviews to monitor care quality and appropriateness, and to inform decisions regarding verification of DMC eligibility, coverage of services, and authorizing reimbursements. The timely submission of Sage authorization requests by providers is helpful in minimizing the potential complications and financial impact of retrospective review denials and is therefore beneficial to the submitting provider.

Timeliness of Authorization Submissions

- Member authorizations and reauthorizations must be submitted to the SAPC Quality Improvement and Utilization Management Unit within thirty (30) calendar days of admission or within thirty (30) calendar days of the first date of service.
- Three exceptions to the 30 days rule – authorization submissions should be held pending the establishment of financial eligibility in the following circumstances:
    1. An individual who applied for Medi-Cal but has not established DMC benefits yet
    2. Awaiting receipt of an Other Health Coverage denial
    3. Pending resolution of SAGE technical issue that prevented authorization submission (providers must document SAGE Help Desk Ticket Number related to the technical issue)

  All service authorization requests, including those delayed due to establishment of financial eligibility, must adhere to and meet Medi-Cal standards and requirements for timelines of clinical assessment.

Transitions in Care

When a patient is stepping up or down in LOC completion of discharge/transfer form in Sage must be completed.

To verify eligibility for specialty SUD services, every six (6) months in non-OTP settings and every 12 months in OTP settings, providers treating patients in non-residential LOCs must either document that there has been no change in the patient's SUD and any associated medical or mental health conditions or complete the documentation for reverification of medical necessity for the LOC the patient is receiving.

Required documentation for reverification of medical necessity may be found in the Checklist of Required Documentation for Utilization Management document on the SAPC webpage. For more information about when a new ASAM is required, refer to the ASAM Assessment Requirements for Level of Care Transitions on the SAPC website.

Pre-authorized Services

Services requiring pre-authorization are services for which the treating provider must request approval before initiating treatment. In these instances, UM staff will perform prospective reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, as needed. The only pre-authorized services within the specialty SUD system in LA County is residential treatment.

SUD treatment providers must notify UM staff of the recommended services electronically via Sage in order to begin the pre-authorization review process. Notifications from providers must, at a minimum, include a completed Sage authorization request and initial intake documentation, completed Financial Eligibility form, Level of Care Miscellaneous Note justification and clinical contact information including assessment information. Providers must submit pre-authorization requests for residential services prior to initiation of services unless providers elect to provide the service prior to receiving pre-authorization and accept financial loss if the pre-authorization is ultimately denied. Requests for continuation of services that require pre-authorization must be submitted at least seven (7) calendar days in advance of the end date of current authorization. Required documentation includes, at a minimum, a completed Sage authorization request, current Problem List, assessment information, progress notes, pertinent miscellaneous notes, and laboratory test results (if available).

UM staff will perform clinical reviews of the case being referred for pre-authorization, based on the case review considerations listed above. Approval for initial Sage pre-authorization requests is based on medical necessity and ASAM level of care guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment.
If a decision determination cannot be made due to insufficient documentation, UM staff will return the Sage authorization request and notify the provider that additional information is needed to process the request.

Table 15. Residential Pre-authorization and Reauthorization Service Limits

<table>
<tr><th>Age Group</th><th>Initial Residential Pre-authorizations</th><th>Residential Reauthorizations</th><th>Drug Medi-Cal Service</th></tr>
<tr><td>Youth ages 12 – 17</td><td>Initial authorization of 30 calendar days</td><td rowspan="5">Reauthorizations required every 30 calendar days, based on medical necessity</td><td rowspan="2">N/A</td></tr>
<tr><td>Young Adults ages 18 – 20</td><td rowspan="4">Initial authorization of 60 calendar days</td></tr>
<tr><td>Adults ages 21+</td><td>Drug Medi-Cal service limits shall be determined by a LPHA, based on medical necessity. Limits on the residential length of stay have been removed. DHCS has moved to a statewide goal for the average length of stay for residential treatment services to 30 days or less.</td></tr>
<tr><td>Perinatal Adults</td><td>DMC reimbursable residential length of stay after the postpartum period is based on medical necessity for perinatal patients receiving services at PPW sites.</td></tr>
<tr><td>Criminal Justice Involved Adults</td><td>DMC reimbursable residential length of stay is based on medical necessity. Extensions may be granted based on the patients' continued medical necessity for residential services.</td></tr>
</table>

Residential Treatment

Residential services require pre-authorization before services will be reimbursed. This pre-authorization is required for ALL patients needing residential treatment, with the following considerations:

- SUD treatment providers must submit a pre-authorization request to the UM Program, which will conduct a prospective review, and then respond with an approval, denial, or urgent request for additional documentation within 24 hours of receiving the completed request.
    - Authorization will only be reviewed when all required elements are received.

- UM requests for missing or incomplete information will result in resetting of time for authorization review and may result in denial due to insufficient information if these requested materials are not provided in a timely manner.
- If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving residential pre-authorization, with the understanding that pre-authorization denials will result in financial loss if services are deemed not meeting medical necessity, whereas pre-authorization approvals will be retroactively reimbursed to the date of admission. For example, a residential treatment provider may choose to accept the financial risk of admitting residential cases during the weekend, with the understanding that the SAPC UM Program will render an authorization decision on the first business day and within 24 hours of receiving the completed request.
- Requests for continuation of residential services must be submitted at least seven (7) calendar days in advance of the end date of current authorization.
- Residential pre-authorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients, but excluding residential withdrawal management, which are non-authorized services.
- **Residential pre-authorizations are required when initiating residential care, transitioning from a lower to a higher level of residential care (e.g., ASAM LOC 3.1 to 3.5), transitioning from non-residential to residential levels of care, or transitioning from one residential location to another.**
- Residential lengths of stay (see **Table 15** for additional details)
    - **Youth (as defined by EPSDT)**
        - In general, youth patients typically require shorter lengths of residential stay than adult patients and should be stabilized and then moved down to a less intensive LOC. However, care should be individualized to the needs of the patient. While youth typically require shorter lengths of stay in residential settings than adults, it also true that they require more external assistance and support and at times more intensive treatment and/or higher levels of care. Higher intensity of service and longer duration of services are not necessarily correlated.

        - **Youth under age 18**
            - Initial residential pre-authorizations for youth will authorize no more than 30 calendar days at the outset of residential services.
            - For youth under age 18, residential reauthorizations beyond the initial 30 calendar day authorization will occur every 30 calendar days until the patient turns age 18, with extensions granted based on medical necessity. Upon turning age 18, residential authorization processes for young adults ages 18 – 20 will apply (*see below*). Once patients turn age 21, residential authorization processes for adults ages 21 and over will apply (*see below*).
        - **Young Adults ages 18 – 20**
            - Initial residential pre-authorizations for young adults ages 18 - 20 will authorize no more than 60 calendar days at the outset of residential services. In other words, residential services for young adults ages 18 to 20 require reauthorization after 60 calendar days to assess for appropriate LOC utilization, if determined to require longer lengths of residential care.
            -

- For young adults ages 18 to 20, residential reauthorizations beyond the initial 60 calendar day residential authorization will occur every 30 calendar days, with extensions granted based on medical necessity until the patient turns age 21. Upon turning age 21, residential authorization processes for adults ages 21 and over will apply (*see below*).

  - **Adults age 21+**
    - Initial residential pre-authorizations for adults ages 21 and over will authorize no more than 60 calendar days at the outset of residential services, with the exception of patients who are enrolled in the START program who may be eligible for an initial pre-authorization of 90 days (See *Criminal Justice-Involved Patients* section below). In other words, residential services for all adult populations ages 21 and over require reauthorization after 60 calendar days to assess for appropriate LOC utilization if adult patients are determined to require longer lengths of residential care.
  - **Criminal Justice Involved Patients**
    - Patients with in-custody status, participating in the START – Community program, can serve the final 90 days of their in-custody sentence in a community residential SUD treatment facility while wearing a GPS ankle monitor. START– Community patients may be authorized for 90 calendar days of residential SUD treatment (ASAM 3.1, 3.3, or 3.5), if providers include documentation from the LASD that identifies patient as a START – Community participant.
  - **Homeless Patients**
    - In order to meet the ‘‘chronically homeless’’ definition, an individual must be living in a place not meant for human habitation for at least 12 months continuously, or on at least 4 (four) separate occasions in the last three (3) years totaling 12 months of homelessness. If an individual resides in an institutional care facility, such as an SUD residential treatment facility, for more than 90 days, they will no longer meet the designation for chronically homeless even if they were homeless prior to entering the facility. This is important to keep in mind when applying for residential treatment re-authorizations and identifying available and appropriate housing placements during discharge planning as certain permanent supportive housing resources require the chronically homeless status.

- **Required documentation for Sage re-authorization requests for residential services for all populations must, at a minimum, include:**
  - Completed Sage reauthorization request
  - Current Problem List updated within the last 30 days and signed by an LPHA.
- Given the fluid nature of clinical progression, the expectation will be that the Problem List and the clinical progress notes / miscellaneous notes document progress on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower LOC as soon as clinically indicated. Required Problem List updates every 30 calendar days in the residential setting will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate. Please see *Documentation* section for additional details on Problem List requirements.
- If upon clinical review, either during a focused or random retrospective review, a residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for

residential services and recommend transition to an appropriate lower LOC. In these instances, reimbursement for residential services that have been previously approved will be maintained, but future reimbursement for the identified episode will be denied.
- SUD treatment providers will be responsible for ensuring successful Care Coordination during all LOC transitions.
- Providers will be required to notify UM staff of residential discharges and to submit a completed discharge form within 24 hours.

Authorized Services

Authorized services are services that require approval from SAPC, but do not require authorization prior to the provision of services. In these instances, UM staff will perform concurrent reviews of care and extensions of previous authorizations, when pertinent.

The provider will be required to notify UM staff of the recommended services within thirty (30) calendar days in order to begin the authorization review process. Any request for authorization may be denied due to untimely submission (e.g., if not submitted in accordance with the timeframes specified above).

Refer to the Checklist of Required Documentation for Utilization Management posted on SAPC's website for a list of required documents to be included with Member Authorization requests.

UM staff will perform clinical reviews of the case being referred for authorization, based on the case review considerations listed above. Approval for initial Sage authorization requests is based on medical necessity and ASAM LOC guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment. For services that require authorization, notifications will occur within the review timeframes specified in **Table 14**.

Campus-Like Setting Facilities

Providers who have been identified as operating campus-like settings should request member authorizations for the patient in the usual and customary manner. These authorizations will also be reviewed and processed by SAPC Utilization Management in the usual and customary manner.

Once these authorizations are approved by SAPC Utilization Management, ***the specific location will be automatically removed from the approved authorization***, which will enable any of the campus programs to submit claims under those authorizations. Any pending or denied authorizations will still show a location.

IMPORTANT: only campus programs that are licensed and contracted to provide services at the approved LOC will have those claims approved. If a program submits a service that they are not licensed or contracted to provide, ***the claim will be denied with a reason code of "Procedure not on fee schedule***".

Medications for Addiction Treatment (MAT) for Youth

Authorization for MAT is only required for youth under age 18, with the following considerations:

- Individuals under the age of 18 who initiate MAT require authorization. Providers must obtain written parental consent for treatment with MAT.
    - OTPs may seek an exemption to this on a case-by-case basis by submitting a temporary exception (Form SMA-168) request to DHCS.
- **Refer to the Checklist of Required Documentation for Utilization Management posted on SAPC's website for a list of required documents to be included with Member Authorization requests.**
    - Refer to the Checklist of Required Documentation for Utilization Management posted on SAPC's website for a list of required documents to be included with Member Authorization requests.
- Re-authorization for MAT for youth is required every 30 calendar days, until age 18, if the clinical determination is that patients under age 18 require ongoing MAT.
- **Refer to the Checklist of Required Documentation for Utilization Management posted on SAPC's website for a list of required documents to be included with Member Re-Authorization requests.**

Withdrawal Management for Youth

For youth (under age 18), WM is not an ASAM LOC and is therefore not included in the specialty SUD youth benefit package. However, WM may be approved for youth on a case-by-case basis via an authorization process if determined to be medically necessary and may be integrated with services in other settings.

Withdrawal Management for **youth under age 18 requires authorization**, with the following considerations:

- SUD treatment providers must submit a Sage authorization request for youth WM to the UM Program, which will conduct a concurrent review, and then approve or deny the request within three (3) business days of receiving the request.
- SUD treatment providers may admit youth prior to receiving WM authorization, with the understanding that authorization denials will result in financial loss, whereas authorization approvals will be retroactively reimbursed to the date of admission.
- **Authorization for youth WM is required in all WM LOCS for youth, including ambulatory (outpatient), residential, and inpatient.**
- Withdrawal management for youth in residential settings is considered a separate ASAM LOC than youth residential services. As such, only authorization for the youth residential WM services is required and an additional residential authorization is unnecessary unless patients are transitioned to residential services following their episode of WM services.
- Youth WM is authorized for the full duration of the episode of WM service. As a result, reauthorizations, and requests for continuation of youth WM services are not applicable.
- The typical duration of WM services ranges from several days to approximately two (2) weeks. Youth WM in ASAM 3.7-WM and 4-WM setting is restricted to a maximum of 14 calendar days, if continued service is medically necessary a new authorization is required. There is no predetermined length of stay restrictions for youth WM in other settings. Episodes of WM for youth will be monitored.
- Youth receiving WM services must be observed and monitored regularly to assess their progress. The expectation is that youth receiving WM services will be transitioned to a lower LOC as soon as clinically indicated.

- If during a focused or random retrospective review, a youth WM case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to deny ongoing reimbursement for youth WM services and recommend transition to an appropriate lower LOC. In these instances, reimbursement for youth WM services that have already been previously approved will be maintained, but future reimbursement for the identified episode will be denied.
- Treatment for SUDs should occur along a continuum of care and WM is a critical point within the ASAM continuum of care. However, in and of itself, WM does not constitute adequate treatment for addiction. As such, patients who receive WM should be connected with ongoing treatment services for their addiction. Youth WM providers will be responsible for ensuring successful Care Coordination during all LOC transitions.
- Providers will be required to notify UM staff of youth WM discharges and to submit a completed discharge plan within three (3) business days of ending the service.
- When WM for youth involves MAT, MAT for youth under age 18 requires authorization (*see above*).

Recovery Bridge Housing

- If RBH is determined to be appropriate, RBH providers must submit a Sage authorization request Refer to the Checklist of Required Documentation for Utilization Management document posted on SAPC website for a list of required documents to be included with Authorization requests.
- Staff from the UM Program will review the Sage authorization request form and supporting documentation and render a decision on authorization of the RBH. Referring treatment providers must document the need for RBH in the patient's Problem List (non-OTP settings) or Treatment Plan (OPT settings).
- Adults ages 18 years of age and above are eligible for RBH services if following criteria is met: they are homeless and meet medical necessity for concurrent outpatient care (e.g., ASAM 1.0, ASAM 2.1, OTP). Initial authorization is approved for 90 days and reauthorization is limited to 90 days. Patients do not need to use these days continuously. SAPC will not reimburse providers for RBH if criteria are not met and/or patient is no longer concurrently enrolled in outpatient services. Enrollment in Recovery Services will make patient ineligible for RBH. Perinatal patients are authorized for an initial 90 days; and may be reauthorized for another 90 days and every 30 days thereafter, up to 60 days postpartum, based on medical necessity, if the patient is receiving services at a PPW site.

A summary of services that require pre-authorization and authorization is included in **Table 16**.

Table 16. Pre-authorized and Authorized Service Request Timeframes

Service Type	Initial Service Request Timeframe	Ongoing Service Request Timeframe	Notification Timeframe	Reauthorization Timeframe
PREAUTHORIZED SERVICES				
Residential Services *for adults, young adults, and youth*	Pre-authorization must be submitted prior to service delivery, unless providers elect to provide the service prior to receiving pre-	Sage re-authorization request must be submitted at least seven (7) calendar days in advance of	See **Table 14**	**Youth under age 18** Re-authorization required after 30 calendar days, with re-authorizations every 30 calendar days based on medical necessity

	authorization and accept potential financial loss if the pre-authorization is ultimately denied.	end date of current authorization		**Young Adults ages 18 to 20** Re-authorization required after 60 calendar days for initial residential authorization, with re-authorizations every 30 calendar days based on medical necessity **Adults ages 21 and over** Re-authorization required after 60 calendar days of initial residential authorization, with re-authorizations every 30 calendar days based on medical necessity. An exception exists for specific adult populations, as clinically indicated (see above for details on residential lengths for stay for perinatal and criminal justice populations)
AUTHORIZED SERVICES				
Recovery Bridge Housing (RBH) *for adults and young adults only*	Sage authorization request must be submitted within seven (7) calendar days of first service/first intake appointment for young adults and adults (ages 18+)	Sage re-authorization request must be submitted at least seven (7) calendar days in advance of end date of current authorization.	See **Table 14**	**<u>Perinatal</u> Patients:** One 90-day reauthorization is allowable, followed by reauthorization requests every 30 calendar days until 60 days after the last day of the pregnancy for patients receiving services at PPW sites, based on medical necessity. **<u>Non-Perinatal</u> Patients:** Sage reauthorization request is required after the initial 90-day stay, for an extension of another 90 days. One 90-day Sage reauthorization is allowable for a potential maximum RBH stay of 180 days per calendar year for patients who meet medical necessity and the eligibility

				criteria specified in the RBH section of this manual.
Withdrawal Management for youth under age 18	Authorization must be submitted within fourteen (14) calendar days of initiation of service	**Note**: Youth WM services are authorized for up to 30 days	See **Table 14**	Re-authorization for youth WM for longer than 30 calendar days is required
MAT for youth under age 18	Authorization must be submitted within 14 calendar days of initiation of service	Sage re-authorization request for youth MAT must be submitted at least seven (7) calendar days in advance of end date of current authorization	See **Table 14**	Re-authorization for youth MAT required every 30 calendar days until age 18, or as clinically indicated

If after careful consideration of all case information UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the QI and UM programs, services and reimbursement will be authorized and the applying provider will be notified in accordance with the notification timeframes listed in **Table 14**. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

Denials of authorization will result in denial of reimbursement for services and the applying treatment provider will be notified of the denial decision within the timeframes listed in **Table 14.** Denial notifications will include information including, but not limited to:

- The action SAPC has taken or intends to take
- The reasons for the action
- The patient's or the provider's right to file an appeal or grievance
- The patient's right of a State fair hearing
- The procedures for exercising the patient's rights
- The circumstances under which expedited resolution is available and how to request it
- The patient's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the patient may be required to pay the costs of the services

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of service, coverage of services, or denial of payment for services (see *Complaints/Grievances and Appeals Process*).

Workforce

Increasingly, health systems are moving toward a chronic disease and public health model of SUD care that requires a diverse, skilled, and highly trained workforce.

SAPC recognizes and values the contributions of contract providers of all sizes and capacities, and also realizes that the composition of a successful SUD system of care must reflect the diversity of needs of the population it serves. While the specialty SUD system has traditionally been staffed primarily by SUD counselors, there is a recognized need to diversify the workforce to include various disciplines and more LPHA staff, including social workers, psychologists, nurses, and physicians. This is particularly important given the requirement for LPHAs to verify medical necessity and eligibility for DMC services and to sign Problem Lists (non-OTP settings or Treatment Plans (OTP settings).

In addition to ensuring the appropriate types and certifications of providers, a robust workforce must also have sufficient training to ensure that staff have the skillset necessary to meet the needs of its diverse population. As such, trainings and continuing education must be an integral component of professional development, which should include the ASAM criteria and required evidence-based practices (see *Evidence-Based Practices* for more information) for clinical staff.

In summary, it is critical that SUD treatment providers establish a business plan with a hiring and training strategy to ensure that they have the workforce with the background and training necessary to provide high quality SUD services for their patient population.

Recommended Responsibilities of Medical Directors and Physicians

- **Provide Medications for Addiction Treatment**
- **Provide withdrawal management**
- **Provide clinical supervision for staff**
- **Refer/treat co-occurring physical and mental health conditions**
- **Assist other professional staff with challenging cases**
- **Lead Quality Improvement functions/projects**
- **Conduct clinical trainings on issues relevant to professional staff**
- **Provide physical exams, when necessary**

Medical Director

Each SUD treatment site must have a DMC Medical Director that has been approved by DHCS by submitting Form 6010.

Additionally, per the State contract, each SUD treatment site must have an agreement with their Medical Director outlining the following:

- Ensure that medical care provided meets the appropriate standard of care and not influenced by fiscal considerations;
- Duties and responsibilities and state these duties may not be delegated to non-physician staff;
- Develop and implement medical policies and standards;
- Lines of supervision; and
- Education, training, work experience, and other qualifications for the position

An agreement and code of conduct for the Medical Director must be clearly documented and signed and dated by a provider representative and the physician.

The Medical Director, or their physician designee, must be on site for **at least two (2) hours per month.** If a physician is unable to meet this requirement for any reason, the agency would need to develop a plan and/or identify an on-call physician to meet this contractual requirement. It is up to each agency to determine what

approach best meets this requirement while also meeting their agency needs (for example, agencies could enter into agreements with other SUD providers to fill gaps when they occur).

It is advantageous to utilize staff at the highest level of their license and capability as a result of their education and training. Whenever possible, Medical Directors at SUD provider agencies should perform functions that others (e.g., other types of LPHAs) within the agency are unable to optimally perform.

Minimum expectations of Medical Directors of treatment sites within the specialty SUD system:

- Comply with clinical standards of best practice, licensing, accreditation standards and other local, state, and federal regulatory and reporting requirements. Interpret and support standards and requirements to others.
- Research and maintain knowledge of evidenced-based practices, as well as updates regarding treatment of SUDs and recovery-based services.
- Participate in SAPC-related meetings (e.g., Medical Director meetings, Provider meetings)

Recommended Responsibilities of Medical Directors

The following are some recommended responsibilities of Medical Directors and physicians to maximize their benefit and role within the DMC-ODS system of care. This is not an exhaustive list but is meant to provide guidance on ways Medical Directors and physicians can be fully utilized.

- Provide MAT, when clinically necessary
- Provide withdrawal management, when clinically necessary
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other professional staff with challenging cases (e.g., refractory SUD, co-occurring conditions, certain special populations)
- Lead Quality Improvement functions/projects (e.g., Quality Improvement Projects, leading clinical team meetings, etc.)
- Conduct clinical trainings on issues relevant to professional staff (e.g., documentation, ASAM Criteria, DSM-5, MAT, co-occurring mental health conditions)
- Provide physical exams, when necessary and appropriate at their facility

Licensed Practitioners of the Healing Arts

A Licensed Practitioner of the Healing Arts (LPHA) is defined as one of the following professional categories:

- Physician* (MD or DO)
- Nurse Practitioner* (NP)
- Physician Assistant* (PA)
- Registered Nurse (RN)
- Registered Pharmacist (RP)
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed-Eligible LPHA working under the supervision of licensed clinicians

Licensed-eligible LPHAs are persons who have already earned their advanced degree (e.g., MS, MA, MSW, PhD, PsyD, etc.), who are properly registered with their respective state board (e.g., CA Board of Behavioral Sciences [BBS], CA Board of Psychology, etc.) and are authorized to practice under the license of a fully licensed practitioner with proper supervision as required by the state board with which they are registered. Providers will need to be able to demonstrate compliance with this required supervision and oversight. Within the specialty SUD system, Licensed-Eligible LPHAs can fulfill the functions of independently licensed LPHAs (e.g., Finalize ASAM assessments, make Diagnoses (aligned with the scope of practice for making diagnoses as regulated the relevant licensing board.), sign Problem Lists (non-OTP settings) or Treatment Plans (OTP settings).

All LPHAs and Licenses eligible LPHAs must be approved by the California Department of Health Care Services (DHCS) by submitting Form 6010.

Students, interns or trainees are students who are enrolled in a graduate education program who are working at SUD provider agencies to accrue clinical experience for graduation. They have not yet received their advanced degree in their respective field, do not have registration with the appropriate state board, and are not considered LPHAs. For this reason,

A. these individuals cannot perform the duties of an LPHA (e.g., sign-off on a Problem List (non-OTP settings) or Treatment Plan (OTP settings) or ASAM assessment), and
B. network providers cannot submit claims for treatment services delivered by these individuals.

However, students, interns, or trainees can provide billable services under DMC-ODS if they register with a State-recognized SUD counselor certifying agency, which includes CCAPP (California Consortium of Addiction Programs and Professionals), CAADE (California Association for Alcohol and Drug Educators), and CADTP (California Association of DUI Treatment Programs). Even though registered counselors are able to provide many services without an LPHA's co-signature, because student/interns/trainees are working to earn graduate credit, these providers are required to have co-signatures on all of their clinical documentation and receive weekly supervision. At a minimum, this supervision requirement consists of one (1) hour of individual supervision or two (2) hours of group supervision for every ten (10) hours of direct clinical service provided by the student, intern or trainee.

All potential licensed prescribers* (MDs, DOs, NPs, PAs) in DPH-SAPC's network of care are urged to practice at the top of their licensed capability and to receive sufficient training with MAT to be able to prescribe these medications for addiction on either a routine or case-by-case basis in order to increase patient access to this core component of SUD treatment. MDs, DOs, NPs, and PAs with required training and specific DEA X-waivers are permitted to prescribe buprenorphine for addiction.

Minimum Staffing Requirements

Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their respective scope of practice laws.

Registered and Certified SUD counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8 and must be registered with or certified by one of the National Commission for Certifying Agencies (NCCA) accredited organizations recognized by DHCS: Addiction Counselor Certification Board of California (affiliated with California Association of DUI Treatment Programs (CADTP); California

Association for Alcohol and Drug Educators (CAADE); and California Consortium of Addiction Programs and Professionals (CCAPP).

To be able to conduct services under START-ODS, registered SUD counselors must:

1. Complete the State-required ASAM A and ASAM B trainings prior to delivering reimbursable treatment services; **AND**
2. Complete training on CBT, MI, clinical documentation, and treatment planning either through a qualified Continuing Education Unit (CEU) agency such as UCLA-ISAP and CIBHS, or a qualified trainer funded by a Network Treatment Provider; **AND**
3. Complete one (1) classroom courses equaling a minimum of 45 hours of formal instruction in a CAADE, CCAPP or CADTP approved SUD education program on relevant SUD related topics within 12 months of the counselor's first day of employment and annually thereafter until certified. Typically, one academic course is equal to three (3) hours of classroom instruction per week for one academic semester; **AND**
4. Complete the Certification process within five (5) years, unless qualified for a hardship extension which can extend registered status for an additional one (1) year.

Proof of completion must be documented in staff files and shared with SAPC staff upon request. Proof of completion may include letters from school administrators, certificates, and school transcripts. ***If required education/trainings are not completed within required timeframes, services will not be paid by SAPC and will be eligible for recoupment.***

Note: Registered counselors that have completed all necessary education hours for certification but have not taken the examination to become certified must complete 45 hours of SUD education OR approved continuing education units (CEU) of training on an annual basis until certified. Additionally, it is important to note that registered counselors are required to become certified within five (5) years of registration, unless qualified for a hardship extension which can extend registered status for an additional one (1) year, after which time they will no longer be eligible for registered counselor status.

Requirements for students/interns/trainees: For students/interns/trainees actively enrolled in graduate treating programs (and thereby not generally eligible to be registered with their state boards) can provide billable services if registered with a SUD counselor certifying agency recognized by DHCS. Students/interns/trainees who retain active enrollment and attendance in their graduate training program are exempt from training requirements #1, #2, and #3. If a student/intern/trainee is no longer actively enrolled or attending their graduate training program and has not matriculated to License-Eligible LPHA or LPHA status with five (5) years of registration, they will immediately be subject to the training requirements for all other Registered Counselors as outlined above.

Services in the WM setting may be provided by registered or certified SUD counselors or LPHA's, depending on the nature of the service with respect to their scope of practice. Where noted, physician involvement in evaluation and assessment of severity of WM is required.

All counselors and clinicians (including LPHAs and Licensed-eligible LPHAs), whether full-time, part-time, or on-call, have the same training requirements. The training requirements include:

1. All providers must be trained in the ASAM Criteria prior to providing services and

2. Staff conducting ASAM assessments must complete the two (2) e-Training modules entitled “ASAM Multidimensional Assessment" and “From Assessment to Service Planning and Level of care.”

In addition, LPHAs (including Medical Director) shall receive a minimum of five (5) hours of continuing education related to addiction every year and registered and certified SUD counselors shall adhere to all requirements in Title 9, Chapter 8.

It is the providing agency's responsibility to ensure their staff are competent, capable, and appropriately credentialed to provide SUD services, including the ASAM Criteria. Similarly, staff who are unfamiliar with MI and/or CBT are unlikely to be able to effectively utilize one of these required evidence-based approaches. As such, it is highly recommended that provider agencies ensure their staff is adequately prepared prior to providing treatment.

Provider agencies can and should provide workforce development training to their specialty SUD workforce within their agency. SAPC does not maintain a list of authorized trainers. Therefore, in addition to the requirements for initial trainings, provider agencies retain responsibility for all further training and development of their staff.

Provider agencies are responsible for ensuring that their staff are appropriately trained on Sage. Staff who are not trained on Sage will not be able to access the system. SAPC has worked with Netsmart to make trainings on Sage available to provider agencies for a nominal fee.

Provider agencies are also responsible for ensuring that their staff are appropriately trained on CalAIM requirements including documentation requirements, initiating treatment during the assessment period, and the treatment of patients with co-occurring disorders. SAPC requires providers send not less than one (1) representative per contracted agency to all designated trainings.

Available SAPC trainings, including applicable CalAIM trainings, are posted on the SAPC Calendar Training & Events page available via the SAPC website http://publichealth.lacounty.gov/sapc

Non-professional staff including clerical, billing, and facility management support shall receive appropriate onsite orientation and training prior to performing assigned duties. Non-professional staff must be supervised by professional and/or administrative leadership. Professional and non-professional staff are required to have appropriate experience and necessary training at the time of hiring.

For more information on what duties each staff can perform, see the *Staffing Grid* on the SAPC website.

Personnel File Requirements

All contracted providers must maintain a personnel file on a staff funded under their SAPC service contract. All personnel files must include, but are not limited to, the following documents:

1. Signed employment confirmation statement/duty statement
2. Job description
3. Performance evaluations
4. Health records/status as required by the provider, AOD Certification or CCR Title 9
5. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)

6. Training documentation relative to substance use disorders and treatment, including staff participation in training delivered or contracted through SAPC
7. Current registration, certification, intern status, or licensure
8. Proof of continuing education required by licensing or certifying agency and program
9. Provider's Code of Conduct

Quality Assurance – Regulations

In health care, quality assurance refers to activities and programs intended to achieve improvement and maintain quality of care. Oftentimes, these activities involve ensuring compliance with regulations established by governmental and/or administrative entities. In all cases, key components of quality assurance involve:

- Assessing or evaluating quality
- Identifying problems or issues with care delivery and designing quality improvement activities to overcome them
- Follow-up monitoring to make sure activities achieve their intended aims

In addition to the requirements outlined in this manual, all SUD treatment programs must operate in accordance with Federal and state laws and regulations including those identified below, as well as those outlined in the DHCS Behavioral Health Information Notices (BHIN) and relevant SAPC All Providers Letters, Information Notices and Bulletins.

Confidentiality

Maintaining appropriate confidentiality is of paramount importance. All SAPC contracted providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with 42 CFR Part 2, HIPAA standards, and California State law regarding confidentiality for information disclosure of substance use disorder (formerly termed alcohol and drug use), and other medical records.

42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records

Covers all records relating to the identity, diagnosis, and/or treatment of any patient in a SUD program that is conducted, regulated, and/or assisted in any way by any federal agency.

- For a summary of 42 CFR Part 2, please see: https://www.samhsa.gov/newsroom/press-announcements/202007131330
- Subpart A includes an introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc.).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, and minor patients, etc.).
- Subpart C covers disclosures allowed with the patients' consent (e.g., prohibition on re-disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs, etc.).
- Subpart D covers disclosures that do not require patient consent (e.g., medical emergencies, research, evaluation and audit activities).
- And Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc.).

HIPAA – Health Insurance Portability and Accountability Act
Provides data privacy and security provisions for safeguarding medical information.

- A summary of the HIPAA privacy rule can be found here: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html.
- For more general information on HIPAA, please see: http://www.hhs.gov/ocr/privacy/index.html.
- For more specific information concerning covered entities, consumer information and health information technology, please see http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

These laws and regulations must not be used as barriers to provide coordinated and integrated care. Provided that the appropriate patient releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care, and also across systems of care (physical and mental health, etc.).

Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the specialty SUD system must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

42 CFR Part 438 – Managed Care

As a participant in LA County's DMC-ODS Waiver, the administrative entity that is SAPC becomes a specialty managed care plan responsible for overseeing the specialty SUD system. As a component of becoming a managed care entity, SAPC and its specialty SUD network must abide by the 42 CFR Part 438 managed care requirements.

In general, one of the primary aim of 42 CFR Part 438 is to achieve delivery system and payment reforms by focusing on the following priorities:

- Network adequacy and access to care standards (e.g., timeliness of services, distance standards)
- Patient/consumer protections
- Quality of care

California Code of Regulations (CCR) Title 22 Drug Medi-Cal

CCR Title 9, section titled Counselor Certification provides minimum requirements on the level of credentials counseling staff secure prior to conducting services. The minimum standards are designed to ensure a baseline quality of treatment services and effectiveness. The County has built on these requirements and established minimum staffing standards specific to LA County.

For additional information, please see the *Staffing Grid* in the Network Provider section on the SAPC website.

Evidence-Based Practices

Evidence-based practices (EBPs) are interventions that have been shown to be effective and are supported by evidence. In LA County, although other psychosocial approaches may be used (e.g., relapse prevention,

trauma informed treatment, and psychoeducation), SUD treatment agencies must at a minimum implement MI and CBT, and ensure their staff are appropriately trained to deliver both MI and CBT.

Providers are also expected to present and support the use of MAT as an evidence-based intervention, when clinically appropriate.

Motivational Interviewing

A patient-centered and empathic counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on patients' past successes. According to the Motivational Interviewing Network of Trainers, MI "is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

Cognitive Behavioral Therapy

According to the National Institute of Drug Abuse's *Principles of Drug Addiction Treatment: A Research-Based Guide*[21], "Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them more explicitly identify the relationship between their thoughts, feelings and behaviors and develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use and developing strategies for coping with cravings and avoiding those high-risk situations." The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.

Other Contractor Selected Practices

Relapse Prevention

According to SAMHSA's National Registry of Evidence-Based Programs and Practices, relapse prevention is "a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide patients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a patient's overall coping capacity."

Trauma-Informed Treatment

According to SAMHSA's concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in patients, families, staff, and others involved with the system;

[21] NIDA. 2020, September 18. Principles of Effective Treatment. Retrieved from https://nida.nih.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment on 2021, July 12

responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Seeking Safety is an example of an evidence-based trauma-informed practice.

Psychoeducation

Psychoeducational interventions educate patients about substance abuse and related behaviors and consequences. The information provided may be broad but are intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to patients' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist patients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Documentation

Clinical documentation refers to anything in the patients' health record that describes the care provided to that patient, and its rationale. It is observational and narrative in content and is written by counselors and clinicians to analyze the process and contents of patient encounters.

Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

1. **Ensure comprehensive and quality care –** The process of writing initial assessments and proper progress notes requires thought and reflection. Preparing proper clinical documentation serves an important role of helping assure quality patient care by giving practitioners an opportunity to think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work, and weigh alternative approaches to the care. Good clinical documentation helps one organize clinical details into a case formulation that can then be used for treatment planning and is an essential element of professional practice and of the provision of quality clinical services. It also helps to assure appropriate utilization of team members from multiple disciplines in order to leverage interdisciplinary competencies and maximize the quality of services provided.
2. **Ensure an efficient way to organize and communicate with other providers –** The documentation of clinical care helps to provide structure and efficiency to clinical communications with other providers who may be involved in the care of shared patients. This assures coordinated rather than fragmented treatment/service delivery.
3. **Protect against risk and minimize liability –** Accurate and comprehensive clinical documentation is not only important in terms of quality care but is also essential in risk management. Detailing and justifying the thought processes that contributed to the clinical decision-making process helps to support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan, and demonstrates the application of professional skills and knowledge toward the provision of professional services.
4. **Comply with legal, regulatory and institutional requirements –** Good clinical documentation practices help to assure compliance with recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations, and rules. It also helps to ensure that documentation meets the standards set by specific accreditation programs (e.g., CARF, Joint Commission), when applicable, and by health care institutions, facilities and agencies.

5. **Facilitate quality improvement and application of utilization management –** Clinical documentation provides an opportunity to explain the process and substance of assessments, treatment and service planning, clinical decision-making, medical necessity, and the effectiveness of treatments and other services provided. As a result, it is essential for the utilization review process because clinical documentation helps to substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services. From a quality perspective, clinical documentation facilitates supervision, consultation, and staff/professional development, and helps to improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be taken. Appropriate recordkeeping also provides data for use in planning educational and professional development activities, policy development, program planning and research in agency settings.
6. **Clinical documentation must be credible and complete and is protected via HIPAA and 42 CFR Part 2.** It encompasses every aspect of clinical care, including initial assessments, progress notes, and relevant encounters that occur outside of established appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment and reflects a comprehensive biopsychosocial approach. Progress notes are written during/after follow-up appointments in order to gauge clinical progress and assess to determine if patient needs have changed and if modifications to the treatment approach/plan are required. The style of documentation is expected to be consistent and standardized throughout the agency/institution (e.g., everyone uses the same progress note format).

In general, clinical documentation includes the following characteristics:

- Assessment, progress notes, and miscellaneous notes include the typed or legibly printed name, signature of the service provider and date of signature
- Patient name and identifier are included on each page of the clinical record
- Patient's race, ethnicity, and primary language spoken
- Referral information
- Sources of information are clearly documented
- The type(s) of service(s) being offered as described within the clinical record
- Duration of the service(s) being provided, including travel and documentation time
- The date that the service was provided to the patient
- Documentation of changes in patient status are documented (e.g., change in level of care provided or discharge status)
- Description of how services provided reduced impairment, restored functioning, and/or prevented significant deterioration.
- For patients with limited English proficiency, documentation if interpreter services were offered and provided, and an indication of the patient's response

Documentation, including forms and assessments within Sage, must be completed and signed on the date indicated on the documentation. Providers may NOT back- or forward-date documentation so that it appears to have been completed and signed on a different date than was actually the case.

Assessment

An ASAM Criteria assessment is required. The assessment includes the LPHA's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below support the medical necessity of each service provided.

Problem Lists for Non-OTP Settings and Treatment Plans for OTP Settings

Patient-centered care is critical and requires that patients be provided the opportunity to actively shape their treatment.

As patients advance through treatment, the corresponding Problem List (non-OTP) settings or Treatment Plan (OTP settings) are reviewed and updated on an ongoing basis to reflect the current presentation of the patient, including stability and the likelihood of rapid changes in patient condition. Problem Lists (non-OTP settings) or Treatment Plans (OTP settings) are updated more frequently if an individual is unstable or if there is a notable event that requires a change in plan of care. See **Tables 17 and 18** for additional detail regarding minimum requirements for Problem Lists (non-OTP settings) and Treatment Plan (OTP settings) Reviews and Updates**.**

It is important to note that these are maximum timeframes, and the ideal scenario is to complete and sign the Problem List (non-OTP settings) or Treatment Plan (OTP settings) as expeditiously and close to the treatment admission date as possible.

Table 17. Problem List Minimum Requirements for non-OTP Settings

Problem List Activity	Level of Care	Minimum Requirement*
Initial Problem List NOTE: Initial problem lists must be performed as instructed by SAPC on standardized SAGE templates on Sage or on Problem List or Treatment Plan forms approved by SAPC.	All Withdrawal Management LOCs	Must be completed upon intake and signed by an LPHA within the treatment episode
	Outpatient Intensive Outpatient	Must be completed 30 calendar days of first service or first intake appointment for adults (21+), including signature by LPHA OR Within 60 calendar days of first service or first intake appointment for youth (ages 12-17) and young adults (ages 18-20), and for adults (age 21+) who are documented as experiencing homelessness* including signature by LPHA. **Documentation of homelessness status must be indicated in a Miscellaneous Note.*

	Residential	Must be completed upon intake within seven (7) calendar days of first service or first intake appointment for adults (18+), including signature by LPHA OR Within 14 calendars days of first service or first intake appointment for youth (ages 12-17) including signature by LPHA.
Problem List Review NOTE: If the review of the Problem List results in a determination that changes to the Problem List are not necessary, a Miscellaneous Note or Progress Note stating that a Problem List Review was completed must be included in the patient's record. When Problem Lists require modification, an updated Problem List should be documented.	Outpatient Intensive Outpatient	Every 30 calendar days, at minimum
	Residential	Every 15 calendar days, at minimum
Problem List Update NOTE: Problem List updates involve a review, documenting any updates, and the LPHA signing the updated Problem List at the required intervals. of a Treatment Plan. Problem List updates must be completed as instructed by SAPC on LPHA, certified or registered counselor standardized SAGE templates on Sage or on Problem List or Treatment Plan forms approved by SAPC.	Outpatient Intensive Outpatient	No later than 90 calendar days after the signing of the initial treatment plan, and no later than 90 calendar days thereafter, or when there is a change in treatment modality or a significant event, whichever occurs first
	Residential	No later than 30 calendar days after the signing of the initial treatment plan, and no later than 30 calendar days thereafter, or when there is significant event, whichever occurs first
**** DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added, however, DHCS requires that providers update the problem list within a reasonable time and in accordance with generally accepted standards of practice, which for Los Angeles County are those outlined in Table above.***		

If a patient's condition does not show improvement at a given level of care or with a particular intervention, then a review, abbreviated assessment, and Problem List update should be made in order to improve therapeutic outcomes. Changing the level of care or intervention should be based on a reassessment and modification of the plan of care in order to achieve an improved therapeutic response.

The practitioners responsible for the patient's care create and maintain the problem list. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, diagnostic evaluation, other types of service encounters. A problem identified during a service encounter may be addressed by the documenting practitioner (within their scope of practice) during that service encounter, and subsequently added to the problem list. The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.

The problem list shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any.
- Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the beneficiary and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed
- Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.

Table 18. Treatment Plan Minimum Requirements for OTPs

Treatment Plan Activity	Minimum Requirement
Initial Treatment Plan NOTE: Initial Treatment Plans must be performed on standardized Treatment Plan templates on Sage or approved by SAPC.	**Must be completed and signed by patient and LPHA within 28 calendar days of admission**
Treatment Plan Review NOTE: Treatment Plan Reviews involve a review of a Treatment Plan. If the Treatment Plan Review results in a determination that changes to the Treatment Plan are not necessary, a Miscellaneous Note or Progress Note stating that a Treatment Plan Review was completed must be included in the patient's record. If Treatment Plans require modification, a Treatment Plan Update should be performed.	**Not less frequently than every 30 calendar days following completion of the initial treatment plan**
Treatment Plan Update NOTE: Treatment Plan Updates involve a review of a Treatment Plan. If the Treatment Plan Review results in a determination that changes to the Treatment Plan are needed. Treatment Plan Updates must be performed on standardized templates on Sage or approved by SAPC.	**Whenever necessary, and not less than every three months from the day of admission**

If a patient's condition does not show improvement at a given level of care or with a particular intervention, then a review, abbreviated assessment, and Treatment Plan Update should be made in order to improve therapeutic outcomes. Changing the level of care or intervention should be based on a reassessment and modification of the Treatment Plan in order to achieve an improved therapeutic response.

Treatment Plans must meet the requirements specified in the Title 9, CCR, Section 10305, as specified in Title 22, CCR, Section 51341.1(h)(2)(B).

At a minimum, Treatment Plans should include:

- Thorough documentation of case details, including a diagnosis and statement of problems to be addressed
- Goals that are mutually established between patient and provider for each identified problem
- Action steps to be taken by the provider and/or patient in order to achieve the identified goals
- Target dates for the achievement of identified action steps and goals
- Description of the type(s) and frequency of services to be provided. If the frequency changes, then a Treatment Plan update needs to be completed to prevent disallowances
- Required documentation, as specified in Titles 9 and 22, including documentation of physical examinations
- The patient shall review, approve, type or legibly print their name, sign and date the initial Treatment Plan and Treatment Plan Update, indicating whether they participated in preparation of the plan, within 7 (ages 18+) or 14 (ages 12-17) calendar days of the first service or first intake appointment. If the patient refuses to sign the Treatment Plan, the provider shall document the reason for refusal and the provider's strategy to engage the patient to participate in treatment. **See Table 4. SAPC Access and Services Delivery Standards for more information.**
- If the LPHA determines the services in the Treatment Plan Update are medically necessary, the LPHA shall type or legibly print their name and, sign and date the Treatment Plan Update within 15 calendar days of signature by the SUD counselor.
- LPHAs who sign off on Treatment Plans in OTP settings must be licensed prescribers.

Progress Notes

SAPC contracted providers shall create progress notes that describe the care provided to patients with SUDs. Each progress note shall provide sufficient detail to support the services being billing (as indicated by service code descriptions) during each treatment episode.

Progress notes shall include:

- The type of service rendered.
- A narrative describing the service, including how the service addressed the patient's SUD and/or mental health need (e.g., symptom, condition, diagnosis, and/or risk factors) in accordance with the ASAM Criteria.
- The date that the service was provided to the patient.
- Duration of the service, including travel and documentation time.
- Location of the patient at the time of receiving the service.
- Justification of discrepancy if the level of care suggested by ASAM criteria is not recommended by counselor/clinician (if applicable).

- Justification of discrepancy if the discussed LOC is not agreeable to patient (if applicable)
- Justification of discrepancy if the LOC the patient was referred to does not match the LOC suggested by the ASAM criteria (if applicable).
- A typed or legibly printed name, signature of the service provider and date of signature.
- An appropriate ICD-10 and HCPCS/CPT code(s) must appear in the clinical record, associated with each encounter and consistent with the description in the progress note as this is a requirement for Medi-Cal claims to be valid.
- Next steps including, but not limited to, planned action steps by the provider or by the patient, collaboration with the patient, collaboration with other provider(s) and any update to the Problem List (non-OTP settings) or Treatment Plan (OTP settings) as appropriate.

Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential treatment services.

When a group service is rendered, a list of participants is required to be documented and maintained by the provider. Should more than one practitioner render a group service, one progress note may be completed for a group session and signed by one practitioner. While one progress note with one practitioner signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each practitioner during the group activity, including documentation time. All other progress note requirements listed above shall also be met for group service progress notes.

Providers shall document the appropriate diagnostic ICD-10 codes in the Diagnosis Section of SAGE and bill for services using the applicable Healthcare Common Procedure Coding System (HCPCS) code as described in the subsequent Finance Management section of this provider manual to ensure that claims associated with progress notes include required diagnostic and procedure code elements required under DMC-ODS.

Progress notes or miscellaneous notes (under document titled “Miscellaneous Note Option”) must be documented for all patient encounters and services in all settings. Documentation is necessary for providers to demonstrate that services have been delivered in accordance with both the service hour requirements associated with the level of care the patient is receiving and in accordance with the patient’s clinical needs. Miscellaneous notes offer a free text and less extensive documentation option compared to progress notes.

Standardized documentation by SUD counselors and clinicians assists with increasing treatment consistency and quality of care and reducing reimbursement disallowances. As such, SAPC requires that the multidimensional components of the ASAM criteria be incorporated into initial documentation of the first full assessment, and that progress notes for both individual and group sessions follow one of four formats: SOAP, GIRP, SIRP, or BIRP.

SOAP (Subjective, Objective, Assessment and Plan) is an acronym that describes the structure of a specific style of progress note documentation. The SOAP format is widely used and improves the quality and continuity of patient services by providing a consistent and organized framework of clinical documentation to enhance communication among health care professionals and better recall the details of each patient’s case. This format allows providers to identify, prioritize and track patient problems so they can attend to them in a timely

and systematic manner. It also provides an ongoing assessment of both the patient's progress and the treatment interventions. While a full review of the SOAP note format is beyond the scope of this document, **Table 19** outlines a summary of its components and providers should refer to additional resources for more information.

Table 19. SOAP

SOAP Progress Note Format	
S	**Subjective –** Patient statements that capture the theme of the session. Brief statements as quoted by the patient may be used, as well as paraphrased summaries.
O	**Objective –** Observable data or information supporting the subjective statement. This may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
A	**Assessment –** The counselor's or clinician's assessment of the situation, the session, and the patient's condition, prognosis, response to intervention, and progress in achieving clinical goals/objectives. This should also include the list of problems documented on the Problem List (non-OTP settings) or Treatment Plan (OTP settings) that include a diagnosis and/or a list of symptoms and information around a differential diagnosis.
P	**Plan –** The plan of care, based on the assessment and clinical information acquired.

The ***GIRP***, ***SIRP***, and ***BIRP*** progress note formats are also used to record similar clinical information in a structured format. The information included in these progresses note formats includes patient goals/situation/ behavior, staff interventions used during the session, patient response to the session, and the plan for future sessions or progress made toward resolving the problems documented in the Problem List (non-OTP settings) or the Treatment Plan (OTP settings). Similar to the SOAP note format, GIRP, SIRP, and BIRP notes provide a standardized structure for documentation that better ensures a comprehensive and consistent quality of care. **Table 20, 21, and 22** summarize the key components of GIRP, SIRP, and BIRP progress notes, although a full review of these standardized formats is beyond the scope of this document. Providers should refer to additional resources for more detailed information.

For patients with multiple health problems, the problems can be numerically prioritized according to severity and treatment need in the plan section for the respective progress note format.

Table 20. GIRP

GIRP Progress Note Format	
G	**Goal –** Patient's current focus and/or short-term goal, based on the assessment and Problem List (non-OTP settings) or Treatment Plan (OTP settings).
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Plan** – The plan or care moving forward, based on the clinical information acquired and the assessment.

Table 21. SIRP

SIRP Progress Note Format	
S	**Situation –** Patient's presenting situation at the beginning of intervention. May include counselor/clinician observations, patient's subjective report and the intervention setting.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Progress** – The progress made toward treatment goals and objectives, as well as the plan for future interventions as determined by the clinical picture.

Table 22. BIRP

BIRP Progress Note Format	
B	**Behavior –** Patient statements that capture the theme of the session and provider observations of the patient. Brief statements as quoted by the patient may be used, as well as paraphrased summaries that closely adhere to patient statements. Provider observations may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished, etc.), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Plan** – The plan of care moving forward, based on the clinical information acquired and the assessment.

Residential Progress Notes

Residential progress notes can be completed by encounter or as daily summaries. Documentation by encounter involves documenting every service and/or activity that a patient is involved in within a residential setting, as it occurs. Daily documentation involves summarizing all the services and/or activities that a patient participates in within a given day in the residential setting.

Whether documenting by encounter or on a daily basis, residential progress notes describe the service and/or activity and how it facilitates patient progress towards the goals of care, those in attendance, the start and end time of the service and/or activity, the start and end time of the documentation time, as well as other pertinent information related to the patient's participation and response to the service and/or activity, the progress note must include the printed or typed and signed name of LPHA or counselor, whichever is applicable based on services provided and who conducted those services. Counselor and LPHAs signatures should be next to each other when both are required.

SAPC recommends documenting by encounter because it can be difficult to incorporate all services and/or activities that a patient engages in within a given day, particularly if different staff are engaging with the patient.

Daily documentation generally requires more extensive tracking and for this reason, writing residential progress notes by encounter may be easier or more efficient than writing daily summaries. However, the minimum requirement is that Residential progress notes be documented on at least a daily basis in residential settings. Importantly, if providers are already writing notes for every encounter in residential settings, the daily summary is NOT necessary.

Miscellaneous Notes

Miscellaneous notes offer a free text and less extensive documentation option compared to progress notes. Documentation of patient encounters and services that do not fit into the progress note format can be documented on the Miscellaneous Note Option. Miscellaneous notes do not replace the need for progress notes or other documentation but should supplement other available documentation formats and be used when using other formats are not appropriate.

Examples of Service Documentation Appropriate for Miscellaneous Notes

- **Care Coordination services**
- **Collateral information gathered from patient family members**
- **Level of Care justification**
- **Any other pertinent information related to a case that the provider wants to be acknowledged as having been performed, but which does not fit the format of other available documentation options such as progress notes, Problem Lists, Treatment Plans, discharge and transfer documents, etc.**

Discharge Summary and Transfer

Treatment providers within the specialty SUD system must submit discharge/transfer summaries to SAPC when their patients discharge or transition care. This information is intended to document a summary of the treatment episode, discharge reason, overall prognosis, follow-up plans, and other pertinent information that is necessary to ensure sufficient Care Coordination, as well as high quality and effective SUD service delivery.

In Sage, the Discharge/Transfer Form will need to be submitted when:

1) A patient is stepping up or stepping down between residential levels of care OR between outpatient LOC (e.g., ASAM level 2.1 to level 1.0);
   OR
2) A patient is being discharged from any LOC (e.g., they are not stepping up or down to other levels of care).

The Sage RBH Discharge form is required to be completed on the same day of discharge from their recovery bridge housing stay.

Complaints/Grievances and Appeals Processes

The complaint/grievance and appeals process is available for patients, their authorized representative, or providers acting on behalf of the patient ("involved parties"). A complaint is the same as a grievance.

An "appeal" refers to a request for review of an "action," which may include:

- Denial or limited authorization of a requested service such as the type or level of service
- Denial, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service

A "grievance" or complaint refers to an expression of dissatisfaction about any matter other than an "action," as defined above. Possible subjects for complaints/grievances include but are not limited to:

- The quality of care of services provided
- The timeliness of service provision, aspects of the interpersonal relationships such as rudeness of a provider or employee and
- Failure to respect the patient's rights

Involved parties may contact the Contracts Unit in these instances to discuss their concerns. In many cases, a responsible and reasonable resolution can be achieved through an informal and professional discussion. However, additional action in the form of a complaint/grievance or appeal may be required in some instances. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. The QI and UM programs, Finance Unit, or the Contract Unit is responsible for processing these complaints/grievances and appeals, depending on the circumstances, nature of the situation, and the responsibilities of the respective unit.

SAPC will provide patients reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

At the level of the SUD treatment agency, providers must have policies and procedures in place for collecting, reviewing, and acting on complaints/grievances/appeals that are filed by their patients. This process should be clear and transparent to all patients and providers and should be integrated into the quality improvement processes of the provider agency. Providers must post signage alerting patients of their right to file a grievance with SAPC, DHCS Office of Civil Rights and the U.S. Health and Human Services Office of Civil Rights.

Similarly, patients, their authorized representative, or providers acting on behalf of the patient and with the patient's written consent have the opportunity to file a complaint/grievance and/or appeal. Involved parties may review and respond to the evidence and rationale provided by QI and UM staff in instances of denials of authorization and may challenge denials of DMC eligibility verification or service authorizations for levels of care.

Complaint/Grievance Process

Providers may initiate complaints/grievances verbally or in writing **at any time**. Patients can file a complaint with SAPC by phone or in writing via web application or mail by submitting a Patient Complaint Form. If patients do not submit a written Patient Complaint Form, SAPC staff will complete the Patient Complaint Form based on the information provided by the patient. A patient may also authorize, in writing, another person as an ("authorized representative") to act on the patient's behalf.

- Upon receipt, complaints/grievances will be logged by SAPC Contracts staff. Clinically related complaints/grievances will be forwarded to the SAPC QI and UM staff for review.
- The staff making decisions on complaints/grievances will not have been involved in any previous level of review or decision making and are health care professionals with appropriate clinical expertise.
- Patients and/or providers are entitled to a full and fair review conducted by QI and UM staff that possess the appropriate clinical expertise.
- All clinical complaints/grievances will be reviewed by supervisorial staff within the QI and UM Programs, who will work with QI and UM staff and the involved party/parties filing the complaint/grievance to research all facts associated with these inquiries and conduct additional research, such as contacting the treating provider, if necessary. Every attempt will be made to achieve a satisfactory resolution, if applicable.
- A written acknowledgement of receipt and a written decision notification regarding the grievance will be rendered within the timeframes listed in **Table 23**, though many complaints/grievances will be addressed sooner. If the clinical complaint/grievance cannot be resolved within the respective timeframe, an extension of 14 calendar days may be requested by either the beneficiary or the County. Extensions may only be initiated by the county when there are delays due to the need for additional information AND it is in the best interest of the patient.
- Written decision notifications or Notice of Grievance Resolution (NGR) will include, but not be limited to:
    - The date and result of the grievance
    - Reasons and rationale for decision (if decision result in denial)
    - Contact information for the reviewer
    - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the State Fair Hearing is pending
- Clinical complaints/grievances will be addressed as a component of the quality improvement activities within the QI and UM Programs and depending on the nature of the complaint/grievance, may trigger more targeted follow up at the provider level.
- Concerns that arise during the complaint/grievance process will be discussed with SUD treatment providers and are viewed as a learning opportunity for both QI and UM staff and providers, with the shared goal of improving our system of SUD care.
- Complaints/ grievances may be presented to the Quality Improvement & Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.

Table 23. Grievance Timeline Table

<table>
<tr><td colspan="6">GRIEVANCE
Any complaint or expression of dissatisfaction about any matter (other than Adverse Benefit Determination)
• Quality of care or services provided
• Aspects of interpersonal relationships (i.e., rudeness of a provider or employee)
• Failure to respect beneficiaries right to dispute an extension of time proposed by County to make an authorization decision</td></tr>
<tr><th rowspan="2">Time of Filing</th><th rowspan="2">Written Acknowledgement of Receipt</th><th rowspan="2">Resolution:
Written Decision Notification</th><th colspan="2">Extensions
(not to exceed 14 calendar days)</th><th rowspan="2">“APPEAL”
No appeal for grievances only additional actions</th></tr>
<tr><th>Initiated by</th><th>Written Notice</th></tr>
<tr><td rowspan="2">Beneficiary/ provider/ authorized representative may file verbally or in writing at any time.</td><td rowspan="2">Within five (5) calendar days of receipt of grievance includes:
1. Date received <u>AND</u>
2. Contact Info of County staff patient may contact (Date received/ Name/ Phone/ Address</td><td rowspan="2">May not exceed 90 days from date of grievance. A decision may not exceed 30 calendar days when grievances is related to disputes of the County’s decision to extend the timeframe for making an authorization decision.
• Notice of Grievance Resolution (NGR) w/clear concise explanation of decision

One Exemption
Written Notification <u>not required</u> if:
1. Complaint received by phone/ in person <u>AND</u>
2. Resolved within (to beneficiary satisfaction) by close of next business day.</td><td>Beneficiary</td><td>N/A</td><td rowspan="2">1. If patient is dissatisfied with the results of grievance, they may file another grievance

<u>OR</u>

2. Submit grievance to the State Medi-Cal Managed Care Ombudsman office</td></tr>
<tr><td>County

ONLY when delays due to need for additional information AND is in best interest of patient</td><td>Requires:
1. Prompt verbal notice of delay <u>AND</u>
2. NOABD Grievance/ Appeal Delay Resolution template sent within 2 calendar days of decision to extend

• Resolution may <u>not exceed</u> 14 days

• Exemptions <u>do not apply</u> when a dispute is related to an Adverse Benefit Determination that is resolved by next business day. It <u>must</u> be in writing and logged.</td></tr>
</table>

Notice of Adverse Benefit Determinations

Notice of Adverse Benefit Determinations (NOABD) are letters sent to a patient when a specific action is taken by the Plan and, in some cases, the Network Provider on behalf of the Plan. Federal and State regulations govern the type and format for these letters. The following are types of NOABDs:

1. Denial or limited authorization of a requested service
2. Reduction, suspension or termination of a previously authorized service (when beneficiary disagrees)
3. Modification or limit of a provider's request for a service and approval of alternative services
4. Denial, in whole or in part, of payment for a service
5. Failure to provide services in a timely manner
6. Failure to process authorization decision in a timely manner
7. Failure to act within the required timeframes for grievance and appeals resolutions
8. Denial of a beneficiaries' request to dispute financial liability

NOTE: Notice of Adverse Benefit Determinations (NOABD) ONLY applies to Medi-Cal beneficiaries.

The purpose of the notice is to support patient protection by advising them about their appeal rights and other rights under the Medi-Cal program, in writing.

DHCS has provided uniform NOABD templates which **must not be modified, revised, or otherwise changed.**

Several SAPC units make decisions regarding NOABD. These decision makers are not incentivized or rewarded to issue adverse decisions. The goal is to ensure appropriate utilization of SUD resources, NOT intended to screen out patients for needed services or create unnecessary burden for providers.

Network Providers have the following responsibilities around the NOABDs, these include:

- Assisting patients who receive NOABDs in understanding their rights and who to contact
- Ensuring the following two types of NOABDs are provided to patients, where indicated):
    - Termination of a previously authorized service
    - Failure to provide services in a timely manner
- Completing the required information in the NOABD/Appeal/Grievance Log and submitting to SAPC on a quarterly basis
- Including the following three required attachments with provider initiated NOABDs
    - NOABDs Your Rights Attachment
    - Beneficiary Non-Discrimination Notice
    - Language Assistance Taglines

The timelines and processes for NOABDs are outlined below in **Table 24**. They can also be found, along with the approved NOABD templates, on the SAPC Network Provider webpage NOABDs in other languages are also available.

Appeals Process

Appeals offer an opportunity for additional review of adverse benefit determinations rendered by SAPC staff or by providers. These adverse determinations may include denials of DMC benefit verification, LOC decisions, or payment for services.

Patients, their authorized representative, or providers acting with the patient's written consent may request reconsideration of adverse decisions made by the Plan by filing a formal appeal.

Patients and providers are entitled to a full and fair review. Appeal reviewers will consist of supervisorial and/or managerial staff. The timelines and processes appeals are outlined in **Table 24**.

Appeals can be submitted in writing by forwarding a completed Appeal request that includes the patient's signature to SAPC, either electronically or via fax within 60 calendar days from the date of the NOABD. *See below for contact information*. The patient, authorized representative or SUD treatment provider may file an appeal orally or in writing. When appeals are filed orally (to establish the earliest possible filing date), it must be followed by a written and signed appeal, unless they request expedited resolution. Appeals filed without the patient's involvement, including appeal forms filed without the patient's written consent, must include a description for why the patient was unable to be involved with filing the appeal. Appeals filed without the patient's involvement will be processed as complaints/grievances in accordance with the previously described complaint/grievance process.

- Upon receipt, appeals will be logged by SAPC Contracts staff and receipt notification will be sent to the requesting party within the timeframes outlined in **Table 24**.
- Staff reviewing the appeal request will research the facts associated with the initial denial and conduct additional research, such as contacting the treating provider, if necessary. Reviewers will also consult the ASAM criteria and/or other appropriate clinical resources.
- The patient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. SAPC will inform the patient of the limited time available for this in the case of expedited resolution.
- After careful consideration of all case information, a decision will be rendered, and the rationale and outcome will be conveyed to the appealing patient and/or provider, in accordance with the timeframes outlined in **Table 24**. If the appeal cannot be resolved within the respective timeframe, an extension of 14 calendar days may be requested by either the beneficiary or the County. Extensions may only be initiated by the County when there are delays due to the need for additional information AND it is in the best interest of the patient.
    - Notice of Appeal Resolution (NAR) shall include, but are not limited to:
        - The date and result of the appeal
        - Reasons and rationale for decision (if decision result in denial), including criteria/clinical guidelines or policies
        - Contact information for the reviewer
        - Information regarding the State Fair Hearing process and the patient's right to continue to receive benefits while the fair hearing is pending
    - In instances in which appeals are denied and not wholly resolved in favor of the patient, patients must be notified of:
        - The right to request a State Fair Hearing and how to do so

    - The right to request to receive benefits while the hearing is pending, and how to make the request
    - The possibility the patient may be held liable for the cost of those benefits if the State fair hearing decision upholds the original denial decision
- Appeals for initial Residential authorizations, and WM and MAT for youth will follow the expedited appeal timeframe as outlined in **Table 24**, whereas residential reauthorizations will follow the standard appeal timeframe.
- Oral appeals (excluding expedited appeals) shall be followed by written appeal signed by beneficiary. SAPC will request written follow up. SAPC shall assist in completion of forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the beneficiary of the location of the form on the Plan's website or providing the forms upon request. SAPC will also advise and assist in requesting continuation of benefits during an appeal of the adverse benefit determination. SAPC will not dismiss nor delay resolution of appeal even if written confirmation is not received.
- The expedited resolution of appeals begins when SAPC determines (in response to a request from the patient or patient representative) or the provider indicates (in making the request on the patient's behalf) that taking the time for a standard resolution could seriously jeopardize the patient's life, health, or functional status. The SUD treatment provider will be notified within the timeframe listed in **Table 24**.
- The patient and their representative should have an opportunity, before and during the appeals process, to examine the patient's case file, including medical records, and any other documents and records considered during the appeals process.
- Concerns that arise during the appeals process will be discussed with SUD treatment providers, may result in corrective actions, and are viewed as a learning opportunity for both SAPC staff and providers, with the shared goal of improving our system of SUD care.
- Appeals will be presented to the Quality Improvement and Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.
- During the appeal process, the patient continues to receive their benefits if all of the following are met:
    - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
    - The services were ordered by an authorized provider
    - The patient or the patient's representative requests extension of benefits
- If, at the patient's or patient's representative's request, SAPC continues or reinstates the patient's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
    - The patient withdraws the appeal
    - A State fair hearing office issues an unfavorable hearing decision to the patient (e.g., denial)
    - The time period or service limits of a previously authorized service has been met
- Patient responsibility for services furnished while the appeal is pending
    - If the final resolution of the appeal is unfavorable to the patient (e.g., denial) and upholds SAPC's action, SAPC may recover the cost of the services furnished to the patient while the appeal is pending, to the extent they were furnished solely because of the appeal.
    - If SAPC or the State fair hearing office reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, SAPC must authorize and provide the disputed services promptly
    - If SAPC or the State fair hearing office reverses a decision to deny authorization of services, and the patient received the disputed services while the appeal was pending, SAPC must pay for those services

Contact Information:

County of Los Angeles, Department of Public Health
Substance Abuse Prevention and Control
Office of the Medical Director and Science Officer
1000 South Fremont Avenue; Building A-9 East, 3rd Floor
Alhambra, California 91803
(626) 293-2846

In all cases, patients who have exhausted the Complaint/Grievance and/or Appeals process may request a State Fair Hearing process with the California Department of Health Care Services.

Table 24. Notice of Adverse Benefit Determination (NOABD) and Appeals Process Timeline Table

TYPE OF ACTION	NOTIFICATION REQUIREMENTS	RESPONSIBLE PARTY FOR NOTIFICATION	APPEALS Beneficiary/provider/authorized representative MUST file within 60 days of NOABD[22]				STATE HEARING Beneficiaries must exhaust the appeal process prior to requesting
			Written Acknowledgement of Receipt	**Appeal Resolution** (Standard)	**Appeal Resolution** (Expedited)	**Extension** (max. 14 calendar days)	
Termination Suspension or Reduction of previously authorized service	**PATIENT** in writing at least 10 days before action **using NOABD[23] Template & attachments** (exceptions 42 CFR 431.213 and 431.214)	**NETWOK PROVIDERS**	Postmarked within 5 calendar days of appeal receipts. • Date received • Contact info of County staff patient may contact (Date received/ Name/ Phone/ Address)	May not exceed 30 calendar days from receipt of appeal. **Notice of Appeal Resolution & attachments** (**NAR) template** 1. Upheld NAR OR 2. Overturned NAR**	Resolved as expeditiously as health condition requires, but no longer than 72 hours after request 1. **Request Denied** • Prompt Oral notice • Written Notice within 2 calendar days of decision. Applicable NOABD; reverts to standard resolution time (30 days) 2. **Request Approved Resolve** within 72 hours or request 14-day extension. • Upheld NAR[24] • Overturned NAR** - If resolved wholly in favor of beneficiary	1. Initiated by Beneficiary 2. Initiated by County ONLY due to need for more information AND in best interest of patient. County must provide: • **Prompt Oral Notice** • **NOABD Grievance /Appeal Delay Resolution template & attachments** Sent in 2 calendar days of decision to extend.	Beneficiary must request w/in 120 days of NAR or County failure to adhere to requirements **Standard Hearing:** County notify beneficiaries that the State must reach its decision within 90 calendar days of date or request for hearing. **Expedited Hearing:** County must notify beneficiary that the State must reach its decision within 3 days of the request.
Failure to Provide Services in Timely Manner	**PROVIDER** via fax/phone within 24 hours of decision.	**SAPC and NETWORK PROVIDERS**					

[22] Oral appeals (excluding expedited appeals) shall be followed by written appeal signed by beneficiary. County must request written follow up. County shall assist in completion of forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the beneficiary of the location of the form on the Plan's website or providing the forms upon request. County must also advise and assist in requesting continuation of benefits during an appeal of the adverse benefit determination. The County may not dismiss nor delay resolution of appeal even if written confirmation is not received.

[23] NOABD must include 1) adverse benefit determination the County has made/plans to make; 2) A clear explanation of the reasons (if due to medical necessity criteria, then include clinical reasons) state why beneficiary condition does not meet criteria; 3) Description of criteria used; 4) beneficiary's right upon request and free of charge to access to and copies of all documents/records related to Adverse Benefit Determination

[24] NAR shall include: Date completed and reasons including criteria/clinical guidelines or policies); right to request a State hearing; For appeals not resolved wholly in favor of the beneficiary, the right to request/receive benefits while hearing is pending & how to request; and notification that the patient may be held liable for the costs of those benefits if the hearing decision upholds the County adverse benefit determination.

	PATIENT in writing within 2 business days of the decision **NOABD Template & attachments**						**Overturned Hearings**: County shall authorized/ provide disputed services as expeditiously as health condition requires, but no later than 3 working days.
• Denial of authorization (residential) • Denial of Payment • Failure to resolve grievance/ appeals • Denial of request to dispute financial liability		**SAPC**					

Note:

**** Plans must authorize/provide services (not furnished during appeal process) no later than 72 hours from date it reverses the determination.**

Risk Management and Reportable Incidents

Risk management refers to strategies that minimize the possibility of an adverse outcome or a loss and maximize the realization of opportunities. Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome and resulting liability to the health care provider. Standards of care, quality improvement, and the systematic gathering, analysis, and utilization of data are the foundations of risk management.

Risk Management Committee at the Provider Level

There is a growing need for and importance of risk management strategies in an evolving health care landscape, including in the specialty SUD system. As a result, each treatment provider agency providing services within the specialty SUD system is responsible for having a Risk Management Committee.

The functions and responsibilities of providers' Risk Management Committees must be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency.

The goals and activities of the provider Risk Management Committees should include:

- To assure implementation of an agency-wide risk management strategy that includes development of policies and procedures, and subsequent staff trainings, relating to quality improvement, fire safety, disaster preparedness, hazard reporting, etc.

- To assure a review, tracking, and documentation system for all reportable incidents, including follow up and implementation of any corrective action until follow up is no longer indicated
- To provide thorough investigation on all reportable incidents, which must be reported to SAPC
- To investigate adverse events, as necessary and appropriate
- To review safety and incident related data and to identify trends and patterns associated with risks or to identify problem areas
- To establish processes to maintain service/billing integrity and quality care, including implementation of peer review processes and Quality Improvement Projects
- To promote quality improvement activity through identifying opportunities towards maximizing safety of physical and therapeutic environment and reducing agency, staff, and patient risks
- To develop procedures aimed at detecting and preventing fraud, waste and abuse

Adverse Events

Adverse events are defined as incidents that have a direct or indirect impact on the community, patients, staff, and/or the SUD treatment provider agency as a whole and are required to be investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues.

Reportable Incidents

Reportable incidents are patient safety events that result in death, permanent harm, and/or severe temporary harm, and/or intervention required to sustain life.
Contracted providers are required to report provider-preventable conditions in accordance with MHSUDS 17-046 and the Reporting Form.

Reportable incidents must be investigated by the provider's Risk Management Committee and must be reported to the SAPC Quality Improvement & Risk Management Committee immediately. These incidents may result in corrective actions and are viewed as learning opportunities to improve care and risk management processes.

While reportable incidents must be reported to the SAPC Quality Improvement & Risk Management Committee, adverse events and other risk management and quality-related issues may be reported to SAPC at the discretion of the leadership of the SUD treatment provider agency.

Section 4. PROVIDER QUALITY IMPROVEMENT EXPECTATIONS

Providers – Quality Improvement Expectations

Treatment providers within the specialty SUD system must establish a culture and infrastructure to support continuous quality improvement to best serve its vulnerable patient population. This focus on quality necessitates internal processes that support assessment, evaluation, identification of opportunities for improvement, and follow up or action. The following is a description of required quality improvement processes that will facilitate this desired quality-focused culture and infrastructure at the provider agency level.

Peer Reviews

Provider agencies within the specialty SUD system must incorporate peer reviews into their continuous quality improvement activities and establish a formal process for regularly identifying processes or variations in care/services that may lead to undesirable or unanticipated events affecting patients or clinical care. The goal of the peer review process is to establish an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services.

As a component of the peer review process, SUD counselors/clinicians of various disciplines review their colleagues' patient charts and provide feedback on the care that is recommended and provided, in a professional and non-adversarial manner. Reviews should be performed by practitioners within their appropriate scope of practice, and when possible, supervisors should review and follow up with counselors/clinicians in order to provide feedback based on the peer review process. Analyses of clinical decisions and practices should be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and national standards.

The focus of these reviews may vary depending on needs determined by the provider agency and may highlight an individual event or aggregate data and information on clinical practices. However, at a minimum, peer reviews must include:

- Review of diagnosis/diagnoses and assessment(s)
- Review of documentation clarity and organization
- Ensure Problem Lists (non-OTP settings) or Treatment Plans (OTP settings) are documented and updated accordingly
- Ensure documentation is signed by appropriate individuals

The quantity and frequency of reviews may also vary depending on needs determined by the provider agency for each site, but no less than three (3) patient charts for each counselor/clinician must be reviewed twice annually.

All records and information obtained during peer review functions should remain confidential and be used only for the purpose of reviewing the quality and appropriateness of care for improved practices.

Quality Improvement Projects

A quality improvement project (QIP) is a concentrated effort on an identified problem in one area of a provider agency. It involves systematically gathering information to identify and clarify issues or problems and intervening for improvements. The purpose of a QIP is to examine and improve care or services in high-priority areas that the agency identifies as needing attention, which will vary depending on variables including, but not limited to, the population served, workforce, and unique scope and capabilities of services provided. The QIP is not meant to replace other quality improvement projects that organizations may already be using, which may be used or adapted to qualify as their QIP. Each provider is expected to be involved in a minimum of one (1) QIP at all times. SAPC staff will review treatment agency QIPs on an annual basis.

All QIPs should follow the Continuous Quality Improvement model and target improvement in relevant areas of clinical care, either directly or indirectly. Areas of focus may include improving access to and availability of services, improving continuity and coordination of care, improving the quality of specific interventions, enhancing service provider effectiveness, etc. Generally, a clinical issue selected for study should impact a significant portion of the patient population served and have a potentially significant impact on health, functional status or satisfaction. Over time, areas selected for improvement focus should address a broad spectrum of care and services.

Each provider agency must be involved in at least one Quality Improvement Project (QIP) at all times.

These QIPs will be reviewed on an annual basis by SAPC staff.

Performance and Outcome Measures

Healthcare providers, including SUD providers, share the common goal of providing high quality care. Measuring performance and outcomes helps organizations and providers understand how well they are accomplishing this goal and allows for an analysis of where and what changes need to be made in the process of striving for continual improvement.

Metrics allow providers to understand what is working well so that others can learn from their success, and also what is not working well so the necessary steps can be taken to seek improvement. The Performance Management System outlined in **Figure 4** provides a framework for how data from performance and outcome measures can be used for process improvement.

Performance and outcome measurement differ as follows:

- **Outcome measures** are used at the patient level to examine changes in substance use behaviors and psychosocial functioning. They are used to understand the effectiveness of treatment services in improving substance use and related functioning of *individuals* who have received treatment.
- **Performance measures** are used at the program level to evaluate how well a program is doing in achieving standards of quality. Performance measures can help identify where service problems exist, which programs are meeting or exceeding expectations of treatment quality, and what, if any, changes should be made to improve service delivery. They inform quality improvement strategies aimed at changing *clinical practices* and *organizational cost management*.

Figure 4. Performance Management System

Source: Public health Foundation
http://www.phf.org/focusareas/performancemanagement/toolkit/Pages/PM_Toolkit_About_the_Performance_Management_Framework.aspx

Although performance and outcome measurement in the field of addiction are challenging due to the nuances of care that are not always easy to capture in metrics, performance and outcome metrics play a crucial role in moving the field ahead.

As a result, treatment providers operating within the specialty SUD system in LA County are required to input data into CalOMS/LACPRS, the electronic data collection system that resides within the Sage. **SUD providers are also required to have ongoing mechanisms for quality assessment and performance improvement.** These metrics help to ensure that LA County has an evaluation system for its specialty SUD system that allows for continuous improvement and high-quality clinical care at the system, provider, and patient level. As such ensuring data integrity is of the utmost importance and to the benefit of providers and patients, and providers are required to develop internal processes to support data integrity efforts.

SAPC recognizes the importance of sharing performance and outcome data with its provider network and encourages providers to leverage available data analytic tools within Sage and their EHRs to allow for the detailed analysis of their provider- and patient-level data. SAPC will also make every effort to provide metrics to assist providers in their CQI efforts.

Section 5. BUSINESS PROCESS STANDARDS

Contract Management

The Contracts and Compliance Section (CCS) works with all contracted service providers to ensure full and accurate understanding and efficient management of their contract. This includes:

- Updating Provider's Contract
- Ongoing Compliance Monitoring
- DHCS Auditing and Corrective Action Plan Support
- Contractual and Regulatory Technical Assistance

Additionally, CCS is responsible for maintaining an avenue for new and existing DMC-certified providers to join the DMC-ODS provider network or add new services to their contract, to achieve this, CCS develops and maintains a solicitation process that is fair, open and reflective of the County's need while setting a minimum standard of qualifications to ensure the highest level of treatment services for SUD patients.

How to Join SAPC's Provider Network or Add Services

Whether looking to join SAPC's provider network or adding services, the first step requires that treatment providers have all the mandated certification or licenses. Because DMC is the primary funder of the SUD system all treatment levels of care, except for RBH, SAPC requires DMC Certification for all treatment providers. The County selects the DMC certified providers with whom to contract to establish the LA County provider network, with the exception of Indian Health Care Providers (IHCP), and DMC-certified providers that do not receive a DMC-ODS County contract cannot receive a direct contract with the State to provide services to residents within LA County. The County has established a set of minimum requirements to ensure that the specialty SUD provider network is diverse and qualified.

Interested in becoming a SAPC Contracted Provider

The information available at http://publichealth.lacounty.gov/sapc/interest.htm instructs treatment providers how to register as a Vendor with LA County. Not only will this allow treatment providers the opportunity to apply to become a contracted provider it will also notify treatment providers of any other funding opportunity with the County.

DMC-ODS Provider Qualifications

DMC-ODS services are provided to beneficiaries by DMC-certified providers. DMC certified providers providing DMC-ODS services must: 1) be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations; 2) abide by the definitions, rules and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and 3) sign a provider agreement with the DMC-ODS county(ies) in which DMC-ODS services will be rendered.

DMC Contract Application

Treatment providers interested in joining the network must successfully complete the DMC Contract application process. This includes meeting all the certifications, licenses, staffing, and financial requirements. The application is found at the above link and provides detail requirement information.
To access, visit:
http://publichealth.lacounty.gov/sapc/NetworkProviders/ContractForms/ApplicationDrugMediCalContracts.pdf

DHCS DMC Certification Application

This includes new providers to the network or current providers who wish to provide additional services under their existing contract. The link provides information and DMC certification application. Providers should note the following:

- The State of California's Department of Health Care Services is solely responsible for administering and processing the DMC certification process.
- Certification is site specific. Providers should identify any and all sites where treatment is offered and ensure the DMC certification application reflects this information.
- Accuracy is key. Providers should make every effort to review their application for accuracy and completeness. The DMC certification process can be timely, a provider's careful attention may increase the likelihood of approval.
- All providers delivering Residential Treatment services Levels 3.1, 3.3. and 3.5 billed to DMC-ODS must have either a DHCS LOC Certification and/or an ASAM LOC Designation.
- DMC-ODS residential treatment providers are subject to County verification of licensing by a state agency other than DHCS and must also obtain an ASAM LOC Designation.

To access, visit: https://www.dhcs.ca.gov/provgovpart/Pages/DMCApplicationInformation.aspx

Inpatient Withdrawal Management (Levels 3.7 and 4.0)

A valid license from the California Department of Public Health (CDPH) is acceptable for DMC Certification of Chemical Dependency Recovery Hospitals (CDRHs) or Freestanding Psychiatric Hospitals (FAPHs). For more information, visit: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx

DHCS ASAM Designation

In addition to the DMC certification, all network treatment providers must have the appropriate ASAM designation on their Alcohol and Other Drug (AOD) license. Much like the DMC Certification application process, this is a State-run process and providers should be mindful to submit accurate and complete information to increase the likelihood their application is approved in a timely manner. For more information, visit: http://www.dhcs.ca.gov/provgovpart/Pages/ASAM-Designation.aspx

Updating Service Provider's Contract

Contracts may be updated to reflect changes at the local, State and Federal levels. Contracts may also be updated at the request of the service providers wishing to update their organization's information or wishing to add or remove services. For additional information refer to SAPC Information Notice 22-03.

SAPC Updates

Contracts may be periodically amended to reflect changes at the local, State and Federal levels that impact the delivery of SUD treatment. These amendments may come in the form of a new contract or via SAPC Bulletin. Providers will be notified of all pending changes in a timely manner and be mandated to attend trainings or meeting on the new changes.

Service Provider Changes

Service Providers may wish to update, add, or remove services to their contract to reflect changes in the organization. Below is a table to help providers better navigate the contract amendment process.

Table 25. Process for Contract Amendments

Contract Action	When do I do this?	How do I do this?	How long does this take?
Funding Augmentation	Providers should monitor their funding utilization and requests any increases or decreases as needed. Funding augmentations are approved based on utilization, (providers must have utilized at least 70% of their contracted allocation), performance, and community needs.	Submit a letter to SAPC Director and include the requested amount and a clear justification. The justification should include any information and supporting data that provides insight into expansion or increase of services that have resulted in the need for additional funding.	3 to 4 months
Add/Remove Services or locations	Providers may request to add or remove services based on new certification or as a result of organizational changes. SAPC reserves the right to approve or deny any request for additional sites and/or services based on the provider's performance or in the interest of the County.	Providers wishing to add services should submit a request to add services to the SAPC Director and include: • Licenses and/or Certifications. • Purchase contract, rental/lease agreements • Zoning or City Permits • Days/Hours of Operation • Contact information including address, phone, fax and email • Any other relevant information The request should include justification of the needed additional services or site.	2 to 3 months
Update Staff Names	As part of the contract, providers are required to notify SAPC of any program leadership changes. Staff may be subject to be credentialing requirements.	Notify SAPC in writing of the new staff and describe his/her role and title. If staff are required to be credentialed, the provider should also include required documents.	1 month
Other Changes	Much of the service provider's information is entered into a database. Any organizational changes should be reported to SAPC to ensure the most current and accurate information.	Notify SAPC in writing of any organizational changes.	Varies

Required Information

Providers are required to justify all requests with relevant data that support the need for additional services and/or sites. Below are required items that must be included as part of the request:

- Needs assessments showing how requested service/capacity increases better address community needs
- Supporting evidence demonstrating that the existing network capacity does not meet community needs
- Documentation and history of serving high risk and/or special populations, if this is a component of justification for the request
- Any other important information relevant to or in support of the requested change to the contract/agreement

Ongoing Compliance Monitoring

As the steward of both taxpayer funds and SUD treatment in LA County, SAPC is mandated to ensure treatment is delivered in an appropriate and effective way and in accordance with contractual, state and federal requirements. To ensure this, all service providers will undergo various types of monitoring, including:

SAPC Compliance Monitoring

Contracts and Compliance Section (CCS) conducts ongoing compliance visits with providers to ensure full and appropriate understanding and application of contractual, local, State and Federal requirements. Each organization is assigned a Contract Program Auditor (CPA) which serves as the service provider's main point of contact for most non-clinical issues. The relationship between the service provider and the CPA is one of collaboration and partnership. The CPA conducts compliance checks and works with the service provider to correct any identified non-compliance issues. The CCS also works with SAPC's Quality Improvement Unit to conduct a clinical review of documentation. Major compliance activities include:

- Personnel Review: A collection and review of the provider staff records, including those documents related to credentialing
- Administrative Review: A collection and review of the provider's policies and procedures, protocols, licenses and certifications or any other administrative documents
- Documentation Review: A review of mandated patient chart files including authorization documentation, assessment notes, progress notes including whether MAT was offered as a component of treatment, Problem Lists (non-OTP settings) and Treatment Plans (OTP settings), release of information authorization forms, acknowledgments and other mandated documentations.
- Patient Interview/Activity Observations: Compliance staff will contact patients and/or observe treatment activities to assess and confirm the delivery of treatment services
- Compliance with Training Requirements: Compliance staff will monitor SAPC providers' participation in required SAPC provided or contracted trainings, including trainings related to CalAIM changes.
- Grievance/Compliant Review: Compliance staff will investigate any submissions to SAPC to reach a determination and work with the provider to resolve any identified issues
- Other compliance activities: SAPC will implement ongoing monitoring activities to assess quality, determine compliance and confirm delivery of services. These activities include, but are not limited to, review of data, key staff interviews, and facility inspections.

The CPA will work with the service provider to develop and implement a Corrective Action Plan that address and resolve all the deficiencies encountered during the monitoring visit.

In accordance with governing regulations around the use of tax-payer funds, some deficiencies may result in a repayment of funds to the County. The CPA can provide guidance to ensure a repayment plan is implemented, if needed.

State Monitoring

In accordance with AOD licensing and DMC Certification standards, the State of California's DHCS also conducts audits/reviews of treatment providers. These include Fiscal Reviews and Post Services/Post Payment reviews. CCS will work with the treatment provider to resolve any issues identified in the audit by collaborating on the Corrective Action Plan and ensuring its successful implementation. In addition to State audits, providers are also required to submit Single Audit report to the State if they receive $750,000 in Federal awards per year.

County Fiscal Monitoring

Fiscal monitoring is a review of the service provider's financial records to verify the compliance with the financial aspects of the contract and generally accepted accounting principles. The fiscal monitoring follows the same cycle as contract monitoring. However fiscal monitoring focuses on the following areas:

- Accounting Records: to obtain an overview of the contractor's operations
- Cash Position: to determine if the contractor is fiscally viable
- Financial Condition: ensures if contractor maintains positive working capital
- Billing/Expenses: service units and operating expenses are verified for accuracy
- Payroll: verify if appropriate staff are hired and payroll taxes are not delinquent

Contracted Provider and Staff Credentialing

CCS will work with all treatment providers on credentialing and recredentialing all providers and their staff. In accordance with MHSUDS 18-019, providers must submit an attestation as part of the contracting process, as mandated by the notice, are submitted and varied on an ongoing basis. The provider must submit a statement attesting the following information includes, but is not limited, to:

- Appropriate licenses, registrations, certifications
- A history of loss of license or felony conviction
- Evidence of completed required education and training, including medical residency and ongoing education, if applicable
- Work history
- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation
- Hospital and clinic privileges in good standing
- History of any suspension or curtailment of hospital and clinic privileges
- A history of loss or limitation of privileges or disciplinary activity
- Current Drug Enforcement Administration identification number
- National Provider Identifier number
- Current malpractice insurance in an adequate amount, as required for the particular provider type
- History of liability claims against the provider

- Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards
- A lack of present illegal drug use
- The application's accuracy and completeness.

Staff Vaccination Requirements

SAPC providers should adhere to the latest SAPC Bulletins describing COVID-19 testing and vaccination requirements.

Contractual and Regulatory Technical Assistance

Understanding all the regulations that govern services is critical to implementing a successful program. Contracts and Compliance Section staff works with providers to ensure understanding and appropriate implementation of all contractual and regulatory requirements. Service providers should contact their Contract Program Auditor with any questions or to request technical assistance.

Regulations to be familiar with:

- Contract/Agreement
- This Provider Manual
- Title 22 & 9
- DHCS BHINs
- Certification Standards (DMC and AOD)
- Current State and County Youth Treatment Guidelines
- HIPAA & Title 42 CFR part 2
- Title 42 CFR, part 438
- Federal Register
- Special Terms and Conditions (STCs) of the DMC-ODS waiver
- Los Angeles County Auditor-Controller's Contract Accounting and Administration Handbook
- Perinatal Practice Guidelines (Contracted Perinatal Programs)

SAPC Provider Policy Requirements

In accordance with the County's State contract, providers are mandated to develop and implement policies to ensure adherence to laws and guidelines that regulate substance use disorder treatment. In addition to those mentioned throughout this manual, below is a partial list of policies that providers are required to have:

- Record Retention: Ensure both clinical, administrative and financial records

- Program Integrity: Develop a committee comprised of high-level staff to implement policies aimed at detecting and preventing fraud, waste and abuse, see *SAPC Bulletin No. 20-14*
- Organizational Changes: Develop a procedure to ensure SAPC of any organizational changes including change in services, locations or high-level staff
- Training: Ensure that staff are properly training on aspects of the DMC-ODS including annually, ASAM
- Hepatitis Program: Ensure that policies and procedures are developed to prevent and/or reduce the risk of Hepatitis A, B, and C transmission to staff and patients, and make HAV/HBV/HCV resources readily available for patients to access. See *SAPC Bulletin No. 19-01*.

Providers should work with their CPA to identify all the required policies and procedures.

Finance Management

How Network Providers are reimbursed for services has changed, and will continue to do so, with LA County participating in the DMC-ODS Waiver and the resulting SUD system transformation. Therefore, key business management practices need to be in place and monitored regularly (e.g., monthly) to ensure that persons served, and units of services claimed align with costs incurred. Any excess funds resulting from rates that exceed actual costs should be reinvested on allowable business and clinical capacity building efforts well in advance of the end of the fiscal year. Long-term viability and sustainability will depend on the agency's ability to grow and retract costs/expenditures-based staff productivity as a result of delivering medically necessary treatment services at the right LOC.

Rates and Standards

The *SUD Rates and Standards Matrix* details allowable Healthcare Common Procedure Coding System (HCPCS) codes and the associated service description, rate, unit of service, and treatment standard for each LOC. The minimum number of hours required does not change for weeks that include a Federal, State, or local holiday.

Outpatient LOCs (ASAM 0.5 Early Intervention, 1.0, 2.1, 1-WM, 1-OTP, Recovery Services) report by HCPCS codes and get reimbursed by HCPCS codes at the associated rate. Residential/Inpatient LOCs (ASAM 3.1, 3.3, 3.5, 3.2-WM, 3.7-WM, 4-WM) report by HCPCS codes and get reimbursed by day rate, and room and board rate.

Gathering this information for all levels of care is needed both to:

- Understand the average and per person service mix and service frequency by provider and LOC and
- Inform the real cost of delivering medically necessary treatment services for use in the rates development process for the next fiscal year.

For this reason, it is critical that network providers report all delivered services even when the service is not currently reimbursable (e.g., alcohol/drug tests, screening) or when there are no minimum number of service hours required per day (e.g., ASAM 3.2-WM, 3.7-WM, 4-WM). For residential services (ASAM 3.1, 3.3, 3.5), however, it will be critical to document the total hours of services delivered each week to demonstrate meeting the per person standard (20, 24, and 22 hours respectively) and substantiate that, patients are receiving services at the appropriate LOC.

Example: How to Calculate Group Counseling Sessions

The Department of Health Care Services' (DHCS) group services billing formula has changed and is now based on the duration of the group session and no longer fluctuates based on the number of participants. Additionally, SAPC has updated the *Rates and Standards Matrix* to allow providers to submit claims for documentation time for group counseling sessions, provided it does not exceed the following standards and represents actual time documenting notes tailored to each participant:

a. 2-4 participants one 15-minute unit;
b. 5-8 participants up to two 15-minute units; and
c. 9-12 participants up to three 15-minute units.

The number of minutes would be added to the total time submitted for the group session, but it must be clear what amount of time relates to the time spent conducting the group versus the time spent documenting individualized group session notes.
Note: OTP group rates are billed in 10-minute units.

The Sage system will also automatically calculate the group counseling and patient education claims per person based on the established formula and ensure compliance with the group size (2-12 persons regardless of payer) and duration (60-90 minutes) limits. It will also have the capability to determine whether the following requirements are met:

1. **Enrollment in Multiple Programs:** An individual cannot be concurrently enrolled in two or more LOC (except Opioid Treatment Programs, Recovery Services, and RBH) or be enrolled by more than one contractor at a time (except Opioid Treatment Programs Recovery Services, and RBH).
2. **Recovery Bridge Housing Reimbursement with Treatment:** RBH participants must be concurrently enrolled in OP (ASAM 1.0), IOP (ASAM 2.1) OTP (ASAM 1-OTP), or Ambulatory Withdrawal Management (ASAM 1-WM, 2-WM) services for providers to receive RBH reimbursement.
3. **Lack of Services:** If services are not provided for 30 days an alert will be sent via Sage to notify the contractor to discharge the individual. If after 45 days no services have been provided, an administrative discharge will automatically be completed, and the County monitors will discuss the deficiency at the next site visit.

Review the *SUD Rates and Standards Matrix* included in the Network Provider section on the SAPC website for more information on allowable services and standards by LOC.

Cost Reconciliation Not Cost Reimbursement

SAPC contracts are now reimbursed at the lesser of costs or charges. This means at the end of the fiscal year final payment will be based on cost reconciliation, not cost reimbursement.

Cost Reconciliation: Settle up to, but not to exceed, the rate for services delivered to patients where allowable costs align with SAPC requirements including business and clinical capacity efforts outlined in the DHCS approved Fiscal and Rates Plan. This means if fee-for-service claims for patients served are below incurred costs, SAPC does not pay the difference (e.g., a loss).

Cost Reimbursement: Settle up to, the substantiated costs of delivering services to patients which may exceed the established rates. This meant if fee-for-service claims for patients served was below incurred costs, SAPC paid the difference. This process ended for all SAPC contract agencies as of June 30, 2017.

To avoid recoupment of previously paid service claims, all submitted costs must be allowable and within any specified amount or range. If the total amount paid by SAPC exceeds reported and substantiated costs, the contractor will be required to repay the County within the specified timeframe and in accordance with the repayment terms.

However, the foundation of the new treatment system of care is the delivery of medically necessary services. Therefore, this means patients cannot be served at a higher or lower LOC than is clinically appropriate and cannot receive more services than is minimally necessary to achieve positive health and recovery outcomes.

The California Institute for Behavioral Health Solutions (CIBHS) developed a spreadsheet titled *Projecting Service Capacity and Revenue* that enables providers to enter information from each budget line-item and experiment with utilization using either a 15-minute increment (e.g., outpatient) or a day rate (e.g., residential) to determine service targets. Agencies are encouraged to enter claims data from the previous fiscal year and budget line-item amounts for the current fiscal year to determine whether there will likely be overspending (not enough patients to cover costs) or underspending (not enough costs to support payment) if no business changes are made. If overspending occurs, agencies should meet with clinical staff to determine whether outreach needs to occur to bring in new patients and/or if productivity needs to improve to reduce the amount of time dedicated to non-billable activities. If underspending occurs, agencies should assess what business and clinical investments (e.g., computers, technology, training, staff, salaries) should be made to support improved patient care and outcomes. This tool can also be used to determine how many more people need to be served to support new staff positions, new sites, livable wages for staff, and so on. The Network Providers, Capacity Building, and Training Resources tab on SAPC's website includes the outpatient and residential version of this tool and a recorded webinar to help agencies get started with this process.

Requests to increase funding allocations are based on performance, utilization, and need. Providers seeking additional funding should send a request to the SAPC Director and Contract Services Division. Requests must include a justification that addresses these three (3) criteria:

1. Performance,
2. Utilization, and
3. Need

Based on this information and funding availability, SAPC may approve, deny, or modify the amount requested. Requests made solely on projected need will not be approved.

Capacity Building to Support a Modern SUD System

When designing the new reimbursement structure under the DMC-ODS Waiver, SAPC included various allowable capacity building costs in the *Finance and Rates Plan* approved by DHCS to enable Network Providers to make clinical and business improvements to better achieve long-term outcomes for patients. Network Providers are expected to evaluate clinical and business practices to determine whether the current efforts align with best practice and support an efficient and effective system of care, and to make investments when gaps or medications are needed. Depending on the organization's cash flow, some agencies may be able to make investments right away whereas others may need to do so later in, but prior to the end of the fiscal year, to allow time to accumulate funds since the rate received may exceed current operating costs. To know when to invest, organizations must understand the budget in relation to the cost reconciliation reimbursement model as well as projected and actual service utilization (e.g., patients served, units of service).

For the entire SUD system of care to transition to a modern healthcare delivery system, it is necessary for all Network Providers to see the value in making investments that directly or indirectly impact clinical care and the service environment, take steps to determine what is needed, and then enacting change. The following capacity building efforts are strongly encouraged and can be included if the budget provided expenditures do not exceed any limits (and comply with any federal, state or local regulations/requirements (see **Table 26**). Making some of these and other allowable investments will also enable Network Providers to implement and comply with requirements outlined in other sections of this Provider Manual.

Table 26. Allowable Clinical and Business Investments

ALLOWABLE & ENCOURAGED CLINICAL AND BUSINESS INVESTMENTS	
Need	**Considerations**
Benefits Acquisition: No eligible for Medi-Cal or My Health LA individual can be turned away because the application has not been submitted or is in-process, or the renewal is incomplete. Care Coordination needs to be used to help patients acquire benefits while concurrently receiving treatment.	• How many billable services are lost when Medi-Cal or My Health LA eligible beneficiaries are turned away for lack of current benefits? • Who is assigned to help patients acquire benefits? • Are there processes in place to track and confirm eligibility monthly? • Is training required? • Is equipment required?
EHR or Sage: Use of an approved EHR is required. Sage will be available soon and free of charge for agencies who do not wish to purchase their own EHR.	• Is it better to use Sage? • Does your computer system meet expectation in SAPC Bulletin 17-02? • Do you have enough computers for counselor and clinical staff?
Facility Environment and Access: Each outpatient site (except OTP) must provide services two evenings (5:00 p.m. – 9:00 p.m.) per week and 8	• Do you comply with new service day and hour standards? • Would expanding days and hours of operation increase services?

hours per weekend. Having a welcoming facility may also contribute to patient satisfaction and retention.	• Would minor facility improvements (e.g., paint, furniture) impact patient care?
Field-Based Services: FBS are allowable at select non-agency operated sites provided the location has been pre-approved by SAPC.	• Are there costs associated with any of these sites? • Are there any transportation (e.g. mileage) costs? • Do you have equipment (e.g., computers, cell phones) that can protect patient confidentiality if lost/stolen?
Medications for Addiction Treatment: Clinical and counselor staff need to be able to educate, refer and link all patients with opioid and alcohol use disorders on this available treatment option.	• Are staff trained? • Do policies and procedures reflect this requirement? • Are referral mechanisms in place?
Qualified Staff: LPHAs can perform some functions previously performed by the Medical Director. There are also new staffing requirements that begin July 1, 2018.	• Will improved salaries or benefits for direct service staff increase retention and reduce turnover? • Would hiring LPHAs in addition to counselors improve patient care? • Are new managers needed to monitor quality assurance and utilization/claims?
Trainings for Clinical and Counselor Staff: • ASAM Criterial and Medical Necessity • Cognitive Behavioral Therapy • Motivational Interviewing • Culturally and Linguistically Appropriate Services (CLAS)	• How many staff need training? • How often are trainings? • Who will conduct the trainings? • Will SAPC trainings be enough?
SBAT and SASH: The SASH will schedule appointments in real time whenever possible and the SBAT must be updated daily.	• Is a receptionist or other staff always available during regular business hours? • What are the potential losses in referrals if nobody is available to receive SASH calls? • How will the SBAT be updated?

Previously, some of these decisions may have been determined by program or clinical administration staff, with or without sufficient funding allocated in the budget. However, with new service standards, patient choice, and the need to meet utilization projections, it is critical for fiscal staff to make sure budgets address service needs. Ultimately, the more skilled the organization is with engaging and retaining patients in medically appropriate services that address individualized needs and preferences, the more likely the organization will be able to make further investments that contribute to business growth. Understanding the relationship between clinical and business operations are critical under this new managed care model, and these clinical and business investments should assist in the transition at the organizational level. Communication with agency staff as well as research and analysis will be key to determining what investments are right for an agency's organization and patients.

Budget Development Process

Now that the County and its Network Providers is operating under a managed care model, it is even more critical that the budget and expenditures clearly align with both the business and clinical needs of the organization. Therefore, when agencies build the annual budget for all agency-operated locations, it is critical to fully articulate the essential expenditures that will support compliance with federal, state, and local regulations, expectations outlined in this Provider Manual and other contract-related documents, and substantively contribute to positive patient outcomes.

One budget template called the *Budget Summary Template and Budget Narrative* will be used by all Network Providers. CFR Chapter 2 Office of Management and Budget Guidance, part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR part 200) governs reimbursement related to Federal funds. Each Network Provider will submit one budget that complies with 2 CFR part 200 and include detail by agency-operated site address; any costs associated with FBS need to be estimated and detailed under the associated agency-operated site. Costs can either be direct or indirect:

1. **Direct Costs**: Typical direct costs include, but are not limited to, compensation for employees who provide treatment, their related fringe benefits costs, the costs of materials and other items of expense incurred for treatment. These costs can be specifically identified with a particular final cost objective (2 CFR, § 200.413).

   Note: Meal costs are only allowable in residential and inpatient programs (ASAM 3.1, 3.3, 3.5, 3.2-WM, 3.7-WM, 4-WM); snack costs are only allowable when provided to minors (ASAM 0.5, 1.0, 2.1). Non-SAPC funds must be used for all other food purchases. Food costs must be reported under the "Food and Snacks" line item under "Services and Supplies" category and be clearly tracked and managed.

2. **Indirect Costs:** Typical indirect costs include, but are not limited to, depreciation, cost of operating and maintaining facilities, general administration and general expenses, such as the salaries and expenses of executive officers, personnel administration, accounting and utilities. These costs are incurred for common or joint objectives and cannot be readily identified with a particular final cost objective (2 CFR, § 200.414).

The budget summary template is divided into two parts:

A. **Budgeted Direct Costs:**
   - Salaries, Wages and Employee Benefits
   - Facility Rent or Lease
   - Equipment and/or Other Asset Leases
   - Services and Supplies

B. **Budgeted Indirect Costs:**
   - Salaries, Wages and Employee Benefits
   - Facility Rent or Lease
   - Equipment and/or Other Asset Leases
   - Services and Supplies

While the major budget line-items (a-d) are the same, the included information will either be specifically tied to a service site address (Direct Costs) or will be associated with more than one service site and/or administration site (Indirect Costs).

Claims Submission and Reimbursement Process

Providers will submit claims through the electronic billing system (e.g., Sage) by the 10th of each month. SAPC staff retrieves the Providers' billing invoices by contract number and by reporting period. SAPC staff then verifies the payment amount information calculated by the system that is due for the reporting period. Adjustments for Accounts Receivables are also applied due to Audit findings, Cost Report Settlements, and refunds.

Claims Submission Process: Medi-Cal Eligible or My Health LA Eligible but Not Enrolled

Network Providers will be reimbursed for delivered treatment services for up to 30 days after admission, assessment, submission of the 270 Eligibility Form, authorization, and completion of CalOMS/LACPRS for:

- Medi-Cal eligible patients whose complete Medi-Cal application is submitted but not processed by the 30th day or ultimately denied
- My Health LA eligible patients whose completed My Health LA application is submitted but not processed by the 30th day or ultimately denied
- Medi-Cal patients whose benefits need to be re-assigned to Los Angeles County due to a permanent move

If a patient has not been granted Medi-Cal or had benefits transferred to Los Angeles County after 30 days, an agency can continue to provide services, but services are not reimbursed by SAPC.

SAPC's reasonable timeline to process payments is 15 calendar days after receipt of an invoice, which is the 25th of each month. The County Auditor Controller's Office issues the checks and mails them to the agencies, unless a direct deposit is on file.

Table 27. Claims Submission Process for Medi-Cal Eligible/My Health LA Eligible but Not Enrolled

Claims Submission Process for Medi-Cal Eligible or Enrolled and My Health LA (MHLA) Eligible or Enrolled				
Status	**Financial Eligibility Form**	**Authorization Form**	**Claims Process**	**Status**
Medi-Cal Eligible or Enrolled (i.e., transferring Medi-Cal benefits to LA County):	When applying for Medi-Cal (i.e., Medi-Cal is pending)	Select: 1) **"Applying for Medi-Cal"** as primary guarantor and 2) **"LA County - Non-DMC"** as secondary guarantor	Authorizations will be granted for no more than 30 days	Submit claims for services provided up to the 30th day of treatment
	Once approved for Medi-Cal or benefits are successfully transferred to LA County	1) Update **"Applying for Medi-Cal"** to **"California Department of Alcohol and Drug"** for the primary guarantor 2) Make sure **"LA County - Non-DMC"** is selected as secondary guarantor	Once a patient is approved for Medi-Cal, the provider should submit a new Authorization with a start date of the 31st day of treatment through the end of the regular authorization period for the type of service being requested.	Once Medi-Cal has been approved and the Financial Eligibility Form has been updated, submit claims following the usual process *Note: For days 31+, any unpaid reimbursable services will be retroactively paid by SAPC*
	If a patient has been denied for Medi-Cal, but is eligible for other County funding: • AB 109, • CalWORKs, • GR or • JJCPA	1) Delete **"Applying for Medi-Cal"** as the primary guarantor 2) Update the primary guarantor to **"LA County - Non-DMC"** *Be sure to ensure that all payor sources a patient qualifies for is identified and updated on their CalOMS.*	Authorizations will be granted for the full period of time for the type of service being requested within the eligibility period	Once Medi-Cal has been denied, and the Financial Eligibility Form has been updated, submit claims following the usual process. *Note: For days 31+, any unpaid reimbursable services will be retroactively paid by SAPC.*
My Health LA Eligible or Enrolled:	When applying for MHLA	Select **"LA County - Non-DMC"** as the primary guarantor	MHLA Eligible document patient's application submission to MHLA. Authorizations will be granted for no more than 30 days. If the patient is enrolled in MHLA Authorizations will be granted for the full period of time for the type of service being requested within the eligibility period.	Submit claims for services provided up to the 30th day of treatment.
	Once approved for MHLA		Once a patient is approved for MHLA, the provider should submit a new Authorization with a start date of the 31st day of treatment through the end of the regular authorization period for the type of service being requested.	Submit claims following the usual process.

Note: Effective August 7, 2017, same day billing is allowed for certain SUD services and a multiple billing code form is no longer required for allowable services. For a list of allowable services, see the *DMC-ODS Same Day Billing Matrix* on DHCS' website.

Cost Reporting

It is required by law (HSC 11852.5 and WIC 14124.24) that cost reports are to be submitted to the State to determine how State/Federal funds are spent. **Cost reports are due no later than 60 days after the close of the fiscal year (August 30).**

Overview of Cost Report Settlement Process

DHCS releases cost report forms, instructions, and supporting documents to counties. Counties distribute appropriate forms and instructions to their contracted providers (DHCS does not have prescribed data collection forms for non-DMC providers, so counties may use other forms or processes to collect cost report data from those contracted providers). Providers collect and report cost data on the county (Non-DMC) or DHCS-required forms and submit them to the county. The county enters cost report data into the SUDCRS and submits it to DHCS.

County Cost Report Responsibilities

Distribute Forms and Instructions to Contracted Provider

It is the county's responsibility to distribute applicable cost report materials to its contracted providers.

As soon as DHCS releases the annual forms and instructions for the prior fiscal year's cost report, the County must distribute the DMC Cost Report (Excel) Workbook to their contracted DMC providers. DHCS also provides an informational reconciliation report that reflects all approved and denied services by providers. If a provider's name appeared on this report, the provider is required to submit cost report. DHCS typically gives counties three (3) to four (4) months to complete and submit their cost reports, so it is critical that counties give their providers a due date that allows the county sufficient time to review provider data, return to the provider for corrections if needed, and enter the data into the SUDCRS. Any manipulation to the cost report template format and/or formulas will deem the cost report null and void.

Collect and Review Data from contracted Providers

Counties that provide DMC services must collect cost data from their contracted DMC providers via the DHCS-prescribed DMC cost report workbook. DMC providers are responsible for completing the DMC cost report workbook and submitting it to the county. A workbook must be completed for each location that has a unique DMC number. The provider must certify that the cost report information is true, correct, and in compliance with federal law.

DMC Cost Settlement Methodology

The rate at which a provider bills for DMC services is an interim rate until the cost report is settled. SAPC will settle to the lower of cost or charges.

DMC Provider Cost Report Workbook

Cost Allocation Considerations

The provider must have a cost allocation plan that identifies, accumulates, and distributes allowable direct and indirect costs and identifies the allocation method(s) used for distribution of indirect costs. The provider must determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy.

A. Direct Cost Allocation
   - The direct cost allocation methodology adopted by the provider must assign costs to a particular cost objective based on benefit received by that cost objective
   - Any method of distribution can be used that will produce an equitable distribution of cost
   - In selecting one method over another, consideration should be given to the additional effort required to achieve a greater degree of accuracy

B. Indirect Cost Allocation
   - For consistency, efficiency, and compliance with Federal laws and regulations, the DMC workbook allocates indirect costs using a standard methodology. The workbook identifies the direct cost categories for each modality and uses the percentage of total direct costs to allocate indirect costs.
   - DHCS recognizes that there are other allocation bases (such as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an allocation basis other than the standard methodology established in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used.

Cost Report Records and Supporting Documentation

The provider must maintain a formal set of financial records that includes a general ledger, as well as books of original entry (cash receipts journal/register, cash disbursements journal/register, and a general journal). Entries in the books of original entry must be traceable to source documentation. Evidence of expenditure must be sufficient to substantiate that the expenditure was incurred, and that the expenditure was necessary for the provision of service. This evidence includes paid invoices, cancelled checks, contracts, purchase orders, and receiving reports.

The provider must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained until the later of:

1. A financial audit is conducted or
2. A period of ten (10) years following the date of the interim cost settlement.

All records of funds expended, and costs reported are subject to review and audit by DHCS and/or the Federal government pursuant to the Welfare and Institutions Code Section 14124.24(g) (2) and 14170.

Cost Report Training and Preparation

County provides cost report training to all providers every year during the month of August. If you do not receive invitation from us, please contact Christina Ruiz or Vella Louie at SAPC-Finance@ph.lacounty.gov.

To prepare a cost report, the following documents will be needed:

1. County contract
2. General ledger for each site
3. Units billed for the fiscal year
4. Download cost report forms and instructions from SAPC's website

Forms are available on SAPC's website at www.publichealth.lacounty.gov/sapc.

Cost Report Submission

Submit the complete set of cost report via email SAPC-Finance@ph.lacounty.gov and mail with original signature to:

County of Los Angeles
Department of Public Health
Substance Abuse Prevention and Control
Cost Reporting Unit
1000 S. Fremont Avenue., Building A-9 East
3rd Floor, North Wing, Unit # 34
Alhambra, California 91803

Cost Report Delinquent

SAPC may impose sanction for non-receipt of the cost report. Under contract Section 6.G: "If the Annual Cost Report is not delivered by Contractor to County within the specified time, Director may withhold all payments to Contractor under all service contracts between County and Contractor until such report is delivered to County and/or, at the Director's sole discretion, a final determination of amounts due to/from Contractor is determined on the basis of the last monthly billing received. Failure to provide the annual cost report may constitute a material breach of the Contract, at the sole discretion of the County, upon which the County may suspend or terminate this Contract."

Cost Reconciliation Process, Required Report, and Settlement

Preliminary Cost Report Settlement

The Preliminary report is the cost report settlement between County and providers that is submitted to the State for review.

SAPC receives the Units of Service Reconciliation Report from the State and sends it to each provider respectively. Providers then reconcile their billing record with the State's report. Providers submit their cost report to SAPC using the State's DMC Cost Report Form. The method of Lower of Cost (Program cost) or Charges (Total Units * Rate) will be calculated. SAPC then submits the cost report to the State. SAPC will determine the lower of cost or charges and process a settlement invoice and letter to provider. Participant/Patient Fees and 3rd Party Revenue collected will be offset from allowable cost.

Interim Cost Report Settlement

The Interim report is the cost report settlement that has been approved by the State.

Note: The State may have made adjustments to reflect the final approved and denied unit of services for the fiscal year.

The County receives the Interim Cost Report Settlement from the State 18 months after the preliminary cost report was submitted. This report reflects additional approved/ denied units as well as the State Final Approved Allowable Cost. SAPC uses this report to process the interim cost report settlement with providers using the same method, Lower of Cost (Program Cost) or Charges (State Final Approved Allowable Cost). SAPC then sends the Interim Cost Report Settlement invoice and letter to providers.

Note: The charges used at the Interim Cost Report Settlement is the State Final Approved Allowable Cost.

Information Technology Management

As the specialty SUD system better integrates into mainstream health care, there is a need to transition from a largely paper-based SUD system to an electronic, technology-based system to support integration and enhance service delivery. As such, it is important for SUD provider agencies to incorporate information technology (IT) considerations (e.g., staff, hardware, software, infrastructure) into their business planning to ensure a foundation of technological success, both from a business and clinical perspective.

Sage and Electronic Health Record Requirements

Collecting and sharing knowledge about patients through a centralized platform results in more confident decision-making when planning, delivering, monitoring, and billing for SUD services that are offered. As a result, EHR systems are the backbone of strong organizations and health systems.

EHRs are patient records that can be created and managed by authorized providers in a digital format capable of being shared with other providers. This interoperability between EHRs facilitates Care Coordination and information exchange, and ultimately improved patient care. Additionally, EHR systems often contain information beyond patient records, including assessment tools, processes to support utilization management, data reporting, and billing, among other functionalities.

As the SUD system becomes a specialty health system operating in a managed care environment, providers need EHR systems to document, organize, bill, and communicate their service delivery with other providers within the SUD continuum of care, as well as with providers outside of the specialty SUD system.

As a result, SUD provider sites are required to possess a certified EHR to ensure the delivery of high-quality specialty SUD services in a managed care environment.

Sage

Sage is a certified, web-based SUD EHR that consists of clinical, administrative, and data reporting modules that satisfy mandatory government reporting and interoperability requirements and provides the necessary framework for overseeing and delivering SUD services in a managed care environment. It is 42 CFR Part 2 and HIPAA compliant. **Figure 5** outlines the various functionalities of Sage, which includes all the capability a specialty SUD provider would need to operate within the SAPC network.

To help facilitate the transition from a paper-based specialty SUD system to an electronic system, SAPC is funding the development, implementation, ongoing maintenance and support, and initial trainings for Sage. Ongoing trainings will be the responsibility of SUD provider agencies.

Additional information on Sage is available on the SAPC website at http://publichealth.lacounty.gov/sapc/Sage/Sageinfo.htm, including details on trainings, User Access Groups, billing, and ASAM CONTINUUM assessment trainings.

Providers Eligible for Sage

The EHR system that specialty SUD providers use is an individualized business decision. While Sage is NOT required for all SAPC providers, all SAPC providers are required to possess a certified EHR that is approved by SAPC.
Sage is available to both SUD providers that do not currently have an EHR or that have an EHR already but choose to switch systems. Providers who elect to continue using their SAPC-approved EHR system may continue to do so, so long as they work with SAPC IT to ensure necessary data exchange.

For providers who elect to utilize Sage, it will be used for all treatment service providers within the specialty SUD system. In OTP settings, a portal for Sage will be used to access ASAM assessments, the Utilization Management module, billing, and data reporting. Otherwise, the clinical functions of OTPs will remain on their current EHR systems.

Prevention and DUI services will not be utilizing Sage at this time.

Sage Access Group Management

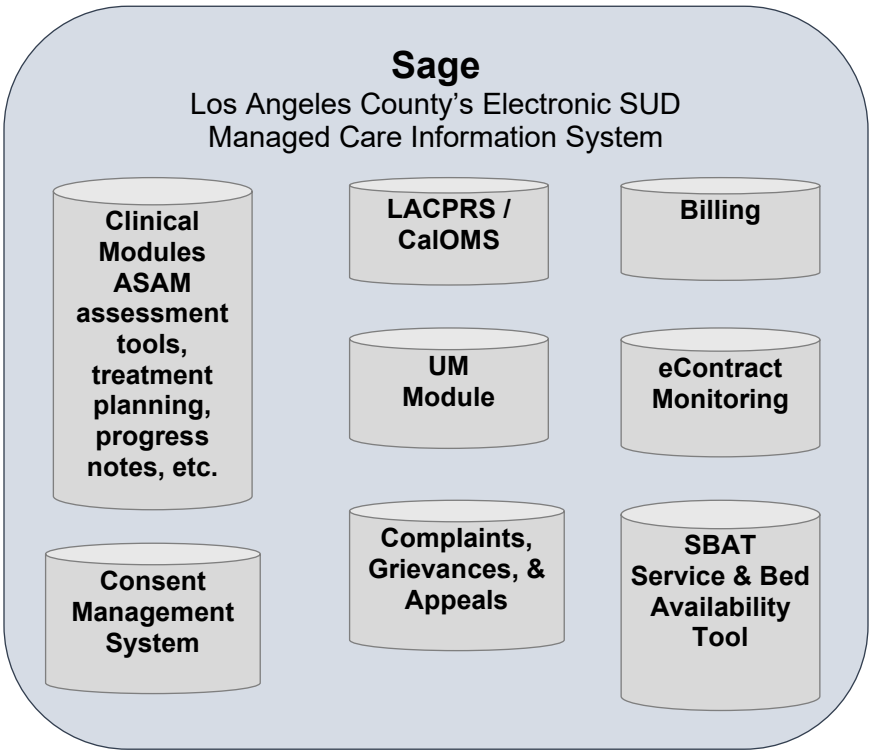
To fully utilize all the benefits that Sage has to offer, SUD providers should manage the access groups that they grant their staff. Sage is designed to capture most SUD provider staff roles to allow for most provider functions, these include:

- Varying Clinical Levels in LPHA, Counselors, and Licensed-Eligible LPHA, and those who also conduct financial tasks
- Financial Staff
- Student/Intern
- Audit User
- Operations
- Clerical

SUD Providers should visit the following link for more information on Sage, including managing access groups for staff: http://publichealth.lacounty.gov/sapc/Sage/SageInfo.htm

Note: SAPC will review all access groups to ensure that roles are appropriately assigned.

Figure 5. Sage: Los Angeles County's Electronic Information System



Provider Responsibilities

With regard to their EHR systems, SUD providers are expected to:

- Recognize the critical importance of EHR systems to the delivery of high-quality SUD care
- Include IT planning into their business plans to ensure sufficient hardware specifications, up-to-date anti-virus protection, latest windows security patches, and IT staff to support their EHR
- Ensure staff are appropriately trained on their EHR to use it proficiently
- Notify SAPC of issues so collaborative solutions can be identified
- Develop downtime procedures to ensure treatment and other services are not interrupted by planned or unplanned outage events
    - To prepare for such events, SUD treatment providers must maintain the following documents in hard copies or other formats not impacted by Sage: current patient roster, ASAM Assessment tool, Service Request Form template, Problem List (non-OTP settings) or Treatment Plan (OTP settings) template, Progress Note template, Miscellaneous Note template, Discharge and Transform template (for all LOCs), RBH Authorization Request form and Discharge form, billing required documents, all required consent, Admission/Discharge forms, and any other documents required by the County.

Sage Trainings

For provider agencies that elect to utilize Sage, while SAPC will support the start-up training for Sage, SUD providers are responsible for ensuring their staff receive sufficient training on Sage to ensure proficiency and for planning ahead to accommodate staff turnover by developing and leveraging internal super-user expertise. All staff that will be accessing Sage are required to undergo appropriate training. To ensure that these required Sage trainings are available and accessible, SAPC has worked with Netsmart to develop and produce web-based trainings for most major Sage Access Groups for providers to acquire the necessary knowledge and skills to use Sage effectively and to ensure quality and consistency of training across the network. To ensure access, these web-based trainings are available 24 hours/day 7 days a week and are module based to allow for completion in multiple sessions if provider does not have sufficient time to complete in one session. Provider who will be utilizing Sage will need to purchase these SAPC-approved trainings through Netsmart. These trainings are online and are allowable costs for provider budgets. Prior to being given access to Sage, users will be required to demonstrate proficiency by successfully completing these required trainings and passing the written competency exam that is part of this training.

All providers for whom a provider agency intends to bill for services need to be credentialed in the Sage system. Failure to have staff credentialed, even if they will not be directly using the Sage system will result in denial of services provided by those providers. For providers who have their own EHRs but have staff they will be billing SAPC for services rendered, this credentialing process will involve following the regular onboarding process (e.g., request for LA County C number) and completion of a Sage User Creation Form. This form should include the provider staff persons credentials (e.g., license number) and select Access Group #13 “Clinical Visible Only—No Login”. This will need to be done for staff providing all billable services, including medication distribution in OTP settings.

Section 6. APPENDICES

Definitions

Glossary of Terms	
ASAM CO-Triage Tool	This is a short screener based on ASAM criteria used to determine if adults and young adults need SUD treatment and the provisional level of care, they would most likely benefit from.
Assessment	The process for defining the nature of an issue, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis. Assessment are ASAM based which examines six dimensions: 1. Acute intoxication and/or withdrawal potential 2. Biomedical conditions and complications 3. Emotional, behavioral, or cognitive conditions and complications 4. Readiness to change 5. Relapse, continued use, or continued problem potential 6. Recovery/living environment At a minimum, comprehensive assessments include the following elements: • History of the present episode • Substance use and addictive behavior history • Developmental history (as appropriate) • Family history • Medical history • Psychiatric history • Social history • Spiritual history • Physical and mental status examinations, as needed • Comprehensive assessment of the diagnose(s) and pertinent details of the case • Survey of assets, vulnerabilities, and supports • Treatment recommendations • Financial status/history • Educational history • Employment history • Criminal history/Legal status
Beneficiary	Recipient of Medi-Cal
BenefitsCal	BenefitsCal is a portal where Californians can get and manage benefits online. This includes food assistance (CalFresh) formerly food stamps, cash aid (CalWORKs, General Assistance, Cash Assistance Program for Immigrants), and affordable health insurance (Medi-Cal). Review the BenefitsCal How-to Videos for additional information regarding BenefitsCal.
Care Coordination	A service to assist patients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. It is a collaborative process of assessment, planning, facilitation, Care Coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available

	resources to promote quality, cost-effective outcomes. In order to link patients with services and resources (e.g., financial, medical, or community services), care coordinators must have a working knowledge of the appropriate services needed for the patient to optimize care through effective, relevant networks of support.
Chronic Homelessness	Having a disability and living in a place not meant for human habitation, in an emergency shelter, or a safe haven for the last 12 months continuously or on at least four occasions in the last three years **where those occasions cumulatively total at least 12 months** (United States Department of Housing and Urban Development 2016).
Cognitive Behavioral Therapy	A short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Cognitive behavioral therapy (CBT) focuses on exploring relationships between a person's thoughts, feelings and behaviors. During CBT, a therapist will actively work with the patient to uncover unhealthy patterns of thought and how they may be causing self-destructive behaviors and beliefs. By addressing these patterns, the patient and therapist can work together to develop constructive ways of thinking that will produce healthier behaviors and beliefs.
Collateral Services	Collateral Services sessions are available at all levels of care and are defined as face-to-face, by telephone or by telehealth contact between one (1) SUD counselor or LPHA, one (1) patient—unless clinically inappropriate for the patient to be present —and significant persons in the patient's life.
Co-Occurring Disorder	A concurrent substance use and mental or medical disorder.
Crisis Intervention Services	Contact between a certified SUD counselor or LPHA and a patient in crisis. The service priority should be to alleviate crisis problems and may need to involve a team approach. "Crisis" is defined as a threat to physical and/or mental health and well-being of the patient or a known party. Depending on the circumstance, it may also mean a serious relapse or an unforeseen event or circumstance that presents as an imminent threat of serious relapse. Crisis intervention services shall be limited to the stabilization of the patient's emergency situation and should include linkages to appropriate services to ensure ongoing care following the crisis situation.
Culturally Competent Services	Providers are required to ensure that treatment services are delivered in such a way that interactions with people representing culturally, linguistically, and developmentally diverse groups are effective, address their individualized needs and optimize treatment engagement. Organizational policies, procedures, and practices must be consistent with the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care and embedded into the organizational day-to-day operations.
Discharge/Transfer Form	The document that details of the patient's planned discharge. The Discharge/Transfer Form shall include, but not be limited to, the following: • A description of each of the beneficiary's relapse triggers • A plan to assist the beneficiary to avoid relapse • A support plan

Discharge Planning	The process of preparing the patient for referral into another level of care, post-treatment returns or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. The discharge planning process should be initiated from the onset of treatment services. This serves to ensure sufficient time to plan for the patient's transition to subsequent treatment or recovery services and, from a clinical standpoint, to convey that recovery is an ongoing life process not a unit of service.
Documentation	DPH-SAPC will require that providers generate initial documentation based on the ASAM Criteria. The documentation must provide justification for the care provided, including the demonstration of medical necessity. Documentation templates developed by DPH-SAPC shall be used for Problem Lists (non-OTP settings) or Treatment Plans (OTP settings), progress notes, and other documentation developed by the Quality Improvement/Utilization Management (QI/UM) Unit. Services provided in the community, by telephone, or by telehealth require equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility.
Drug Testing	While there is currently no widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. The frequency of drug testing should be based on the patient's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common. Additionally, drug testing is best when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) would ideally vary as well.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	A benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. It is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, substance use, and developmental, and specialty services.
Evidence-based Practice(s)	Practices that have been implemented and are supported by evidence. Providers will be expected to implement, at a minimum, the two EBPs of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Other EBPs include relapse prevention, trauma informed treatment, family therapy and psychoeducation.
Face-to-Face	Occurring in person at a certified facility. Telephone contacts, telehealth, home visits, and hospital visits are not considered face-to face.
Family Services	Sessions involving patients and their family members in multi-family group sessions. These services can be provided by a certified SUD counselor or and LPHA. Sessions can be education or counseling focused.
Family Therapy	Psychotherapy, involving both the patient and their family members, that uses specific techniques and evidence-based practices (e.g., family systems theory, structural therapy, etc.). The effects of addiction are far-reaching and patients' family members and loved ones also are affected by the disorder. By including family members in the treatment process, clinicians provide education about factors that are important to the patient's recovery as well as their own recovery. Family members can provide social support to the patient, help motivate the

	patient's loved ones to provide social support to the patient, help motivate the patient to remain in treatment, and receive help and support for their own family recovery as well. These services must be provided by an LPHA-level therapist (see below for qualifying professions).
Field-based Services	Services that are provided at a location other than a brick-and-mortar treatment agency. Services may be provided to adults and youth, as well as parents or guardians, as needed. Service locations include, but are not limited to, patient's residence, recreational centers, sober living facilities, homeless encampments, and co-locations in emergency departments, primary care, mental health, court, jail re-entry (not in-custody), probation, and child protective services settings. Field-Based Services for MAT should be provided by staff that are specifically trained to recognize and respond to the unique biopsychosocial needs of their patients. Field-Based Services are responsive and appropriate to the cultural, linguistic, and developmental needs of patients, and are supported by evidence-based practices.
Group Counseling	Face-to-face contact between one or more certified or registered SUD counselors or LPHA, and two or more patients at the same time (with a maximum of 12 patients in the group). Psychosocial issues related to substance use are addressed utilizing relevant best practice clinical interventions and a focus on peer support. Note: Group sign-in sheets must include signatures and printed names of **all** participants (**including participants not reimbursed by SAPC and family members**) and group facilitators, date, start/end times, location, and group topic.
Homelessness as defined by HUD	HUD definition of **homelessness** includes four categories: 1. **Literally Homeless**: individual or family who lives in a place not meant for human habitation or in an emergency shelter or is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; 2. **Imminent Risk of Homelessness**: Individual or family who will imminently lose their primary nighttime residence within 14 days and who lacks the resources to obtain other permanent housing; 3. **Homeless Under Other Statutes**: includes unaccompanied youth under 25 or families with children and youth who have experienced persistent instability (see terms and definitions for more information); and 4. **Fleeing/Attempting to Flee Domestic Violence**: An individual or family attempting to flee DV who has no other residence and lacks the resources or support networks to obtain other permanent housing.
High Utilizer	A high utilizer is a person who is diagnosed with a SUD who meets any of the following criteria: • 3+ ED visits related to SUD within the past 12 months • 3+ inpatient admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD • Homelessness with SUD (as defined by HUD homelessness definition) • 3+ residential SUD treatment admissions within the past 12 months • 5 + incarcerations with SUD in 12 months

Imminent Danger	Imminent danger has the following three components: 1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications) 2. The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated) 3. The likelihood that such adverse events will occur in the very near future In order to constitute "imminent danger" ALL THREE ELEMENTS must be present.
Individual Counseling	Clinical contact between a LPHA or counselor and a patient that addresses psychosocial issues related to substance use disorders. DPH-SAPC's required evidence-based techniques include Motivational Interviewing and Cognitive Behavioral Therapy. Services may be provided in-person, by telephone, or by telehealth.
Intake	The process of determining that a patient meets the medical necessity criteria for care, and then admitting a patient into a SUD treatment program. Intake includes the assessment or analysis to determine whether or not an individual meets the current DSM-5 criteria for an SUD diagnosis or is at-risk for SUD. It also involves using the ASAM Criteria to determine if treatment is medically necessary as well as identifying the appropriate level of care. Intake for a pharmacological intervention includes a physical examination and laboratory testing necessary for determining and providing appropriate SUD treatment.
Lapse	A brief return to substance use following a sustained period of abstinence, despite the patient remaining committed to recover and demonstrating a willingness to re-engage with the recovery journey.
Licensed Practitioner of the Healing Arts (LPHA)	A LPHA possesses a valid clinical licensure or certification in one of the following professional categories: • Physician (MD or DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Registered Nurse (RN) • Registered Pharmacist (RP) • Licensed Clinical Psychologist (LCP) • Licensed Clinical Social Worker (LCSW) • Licensed Professional Clinical Counselor (LPCC) • Licensed Marriage and Family Therapist (LMFT) • Licensed-Eligible LPHAs working under the supervision of licensed clinicians
Medical Necessity	Medical necessity for all substance use disorder treatment provided under a DPH-SAPC contract is defined as: (Adults over the age of 21) • To begin service delivery prior to completion of the full assessment: ○ Services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (W&I Section 14059.5(a)).

	OR ○ For OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for the determination of medical necessity. • To fully establish medical necessity: ○ At least one diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). ○ Appropriate placement in a substance use disorder level of care that is consistent with recommended services and medical necessity based on the current edition of the American Society of Addiction Medicine (ASAM) Criteria. (Youth and Young Adults aged 12-20) • At least one diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); OR • Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria to ameliorate or correct a substance misuse related condition. • Any qualified provider operating within the scope of their practice, as defined by state law, can provide a screening service to trigger EPSDT coverage and medically necessary SUD treatment for youth up to age 21. Appropriate placement in a substance use disorder level of care that is consistent with recommended services and medical necessity based on the current edition of the American Society of Addiction Medicine (ASAM) Criteria.
Medical Psychotherapy	Medically oriented psychotherapy consists of a one-on-one face-to-face session with the patient and either the Medical Director, or their designated OTP licensed prescriber(s). The goal is to explain medication treatment, which can be complex, and enable the patient to provide informed consent. The meeting focuses on medication options (risks and benefits of proposed intervention, alternatives, risks and benefits of foregoing any intervention, potential side effects, etc.), and other components of person-focused care that are necessary in order to provide a comprehensive range of medical and rehabilitative services. See Section 10345 of Title 9, CCR
Medication Services	Medication Services including MAT, will be discussed and offered as a concurrent treatment option for individuals with an alcohol- and/or opioid-related SUD condition. The prescription or administration of MAT, and the assessment of side effects and/or impact of these medications, should be conducted by staff lawfully authorized to provide such services within their scope of practice and licensure. Youth under age 18 are eligible for MAT on a case-by-case basis with parental consent and DPH-SAPC authorization.
Methadone	An opiate agonist medication that has treats opioid use disorder.
Motivational Interviewing	Motivational Interviewing focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The

	method differs from more “coercive” or externally driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values, beliefs or wishes); but rather supports change in a manner congruent with the person's own values and concerns.
Patient Education	The presentation of research-based education on addiction, treatment, recovery and associated health risks with the goal of minimizing the use of addictive substances, lowering the risk of dependence, and minimizing adverse consequences of substance use. Patient Education sessions are defined as face-to-face contact between up to two (2) registered or certified SUD counselors or LPHAs, and between two (2) to twelve (12) patients at the same time in non-residential settings and between two (2) to thirty (30) patients at the same time in residential settings.
Peer Support	Peer support services must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the beneficiary’s clinical record and approved by any treating provider who can render reimbursable Medi-Cal services. Peers give and receive nonprofessional, nonclinical assistance to achieve long-term recovery for beneficiaries. The support is provided by individuals who have experiential knowledge. Peers provide assistance to promote a sense of belonging within the community. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.
Physical Examination	Appropriate medical evaluation must be performed prior to initiating treatment services, including physical examinations when deemed necessary.
Provisional Level of Care	The initial level of care that is determined by the ASAM triage tool. It will be replaced with the actual level of care once the patient has received a full ASAM CONTINUUM or SAPC Youth ASAM assessment at the treatment agency. The purpose of the provisional level of care is to increase the likelihood that the patient is directed to the appropriate treatment agency for them the first time.
Recovery Bridge Housing	Recovery Bridge Housing (RBH) is defined by DPH-SAPC as a type of abstinence-focused, peer-supported housing that combines a payment for recovery residences with concurrent treatment in Outpatient, Intensive Outpatient, Opioid Treatment Program, or Outpatient Withdrawal Management settings. RBH is often appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. If there is risk potential, these concerns are to be managed by the treating provider.
Recovery Services	Recovery Services will address all needs identified in Dimension 6 of the ASAM Criteria (See Recovery Environment of the ASAM Criteria below) and services will be provided face-to-face, by phone or via a telehealth modality. Recovery Services will include monitoring all six ASAM dimensions. Relapse education and warning sign monitoring will occur throughout the duration of Recovery Services. Adults and youth will both be linked to services that will address their psychosocial issues, help them develop self-management skills, and reinforce skills gained during treatment.
Relapse	A prolonged episode of substance use during which the patient is not interested or open to a therapeutic intervention.

Telehealth Services	Telehealth is defined as SUD service that can be delivered between a registered or certified SUD counselor, and/or a LPHA and a patient via audio and video communications which is 42 CFR part 2 and HIPAA-compliant and where the SUD counselor/LPHA and patient are not required to be at the same location.
Transportation Services	Providing transportation or making arrangement for transportation for beneficiaries receiving behavioral health residential, inpatient, or emergency department services. There are two types of transportation in the Medi-Cal program: • Non-medical transportation (NMT) for beneficiaries who do not need medical assistance during transit. • Non-emergency medical transportation (NEMT) for when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated.
Treatment Planning	The provider (certified SUD counselor or LPHA) shall prepare an individualized plan of care that is reflected in the clinical notes documenting the patient's care and aligned with the Problem List (non-OTP settings) or Treatment Plan (OTP settings). The requirements for this Problem List and Treatment Plan documentation is described in Table 17 and Table 18, respectively.
Warm Handoff	When a treatment agency, care coordinators, counselor, etc. refers a patient for additional services related to their treatment. This is not a simple referral but entails going the extra step to ensure that the patient feels supported and is not left to their own devices. An example is when a counselor calls another counselor, introduces the patient to the counselor, and then sets up a meeting between the patient and new counselor. The patient will go into the meeting having already been introduced to the new counselor.

Acronyms

Acronym Glossary	
AB	Assembly Bill
ASAM	American Society of Addiction Medicine
ATT	ASAM Triage Tool
ATC	Alternatives to Custody
AEVS	Automated Eligibility Verification System
CalWORKs	California Work Opportunity and Responsibility to Kids
CAP	Corrective Action Plan
CBO	Community-Based Organization
CBT	Cognitive Behavioral Therapy
CCR	California Code of Regulations
COD	Co-Occurring Disorders
CODC	Co-Occurring Drug Court
CORE	Connecting to Opportunities for Recovery and Engagement
CENS	Client Engagement and Navigation Services
CES	Coordinated Entry System
CFR	Code of Federal Regulations
CFT	Child Family Team
CIBHS	California Institute for Behavioral Health Solutions
CIN	Client Identification Number
CLAS	Culturally and Linguistically Appropriate Services
CPA	Contract Program Auditor
CPT	Central Processing Team
CQI	Continuous Quality Improvement
CRDF	Century Regional and Detention Facility
CRRC	Community Re-entry and Resources Center
CSR	Clinical Services and Research
CSW	Children's Social Worker
DCFS	Los Angeles County Department of Children and Family Services
DCMIS	Drug Court Management Information System
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMH	Los Angeles County Department of Mental Health
DPSS	Los Angeles County Department of Public Social Services
DO	Doctor of Osteopathic Medicine
DOJ	California Department of Justice
DPH	Los Angeles County Department of Public Health
DPO	Deputy Probation Officer

Acronym Glossary	
DSM	Diagnostic and Statistical Manual
EBP	Evidence-based Practices
EHR	Electronic health record
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FBS	Field-based services
FDA	Food and Drug Administration
FDDC	Family Dependency Drug Court
FFS	Fee-for-service
GAIN	Greater Avenues for Independence
GPS	Global Positioning Satellite
GR	General Relief
GSW	GAIN Services Worker
HCPCS	Healthcare Common Procedure Coding Systems
HIPAA	Health Insurance Portability and Accountability Act
HUD	U.S. Department of Housing and Urban Development
ICRP	In-Custody to Community Referral Program
IOP	Intensive Outpatient
JDDC	Juvenile Delinquency Drug Court
JJCPA	Juvenile Justice Crime Prevention Act
LACPRS	Los Angeles County Participant Reporting System
LASD	Los Angeles County Sheriff's Department
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
LPHA	Licensed Practitioner of the Healing Arts
LRS	LEADER Replacement System
MAT	Medications for Addiction Treatment
MD	Doctor of Medicine
MDT	Multi-Disciplinary Team
MDTT	Misdemeanor Diversion Treatment Track Project
MEDS	Medi-Cal Eligibility Data System
MI	Motivational Interviewing
N3	Non-violent, Non-serious, and Non-sexual
N3 Split	Non-violent, Non-serious, and Non-sexual (N3) with a condition of probation supervision upon release
NARR	National Alliance for Recovery Residences
NOABD	Notice of Adverse Benefit Determination
NP	Nurse Practitioner
OMDSO	Office of the Medical Director and Science Officer
OP	Outpatient
OTP	Opioid Treatment Program
PA	Physician Assistant

Acronym Glossary	
PAUR	Prospective Authorization and Utilization Review Unit
PC	Penal Code
PES	Psychiatric Emergency Services
PIP	Performance Improvement Project
PPG	Perinatal Practice Guidelines
PSP	Post-release Supervised Person
PSPC	Policy/Strategic Planning/Communications
PSSF-TLFR	Promoting Safe and Stable Families Time Limited Family Reunification
QI	Quality Improvement
QIP	Quality Improvement Project
RBH	Recovery Bridge Housing
RNR	Risk, Needs, Responsivity
RECOVERY SERVICES	Recovery Services *formerly Recovery Support Services (RSS)*
SAMHSA	Substance Abuse and Mental Health Services Agency
SAPC	Substance Abuse Prevention and Control
SASH	Substance Abuse Services Helpline
SBAT	Service and Bed Availability Tool
SMART	Specific, Measurable, Attainable, Realistic, and Time-bound
SPA	Service Planning Area
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TAY	Transition Age Youth
TBI	Traumatic Brain Injury
TCPX	Treatment, Court, Probation, eXchange System
UCC	Urgent Care Center
UCLA-ISAP	University of California Los Angeles – Integrated Substance Abuse Programs
UM	Utilization Management
VA	Veteran's Administration
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WM	Withdrawal Management
WCRTS	Women and Children's Residential Treatment Services
YES	Youth Enhancement Services

Care Coordination References

Care Coordination Scenarios		
***Note**: Although not an exhaustive list, these scenarios are meant to help providers distinguish between the types of services that are and are **NOT** billable under Care Coordination. The non-billable scenarios listed include activities that **should be conducted**, when appropriate, but **cannot be billed** under Care Coordination*		
	Billable	**Non-Billable**
Connection	• Actively helping patients apply for Medi-Cal • Completing the Coordinated Entry System Survey Packet including the Vulnerability Index - Service Prioritization Decision Assistance Tool for adults, or the Next Step Tool for youth; and linking patients to housing resources. • Transferring Medi-Cal benefits for patients who have moved, from the previous county of residence to Los Angeles County. • Linking patients to community resources such as food and clothing assistance.	• Providing transportation for patients to scheduled appointments. **Providers should arrange transportation for patients to and from appointments and attend scheduled appointments if patient consent is given. However, the time spent traveling to and from appointments is non-billable (except for patients in Residential Treatment, which is covered in the day rate and Perinatal patients in the Perinatal Practice Guidelines).**
Coordination	• Identifying a referral agency by using the Service and Bed Availability Tool (SBAT) and scheduling an appointment for a level of care transition (e.g., from Intensive Outpatient or ASAM 2.1 to Low Intensity Residential or ASAM 3.1, etc.). • Coordinating action plans with mental health providers to ensure patients are provided complementary services.	• Documenting Care Coordination activities in Miscellaneous Notes, including information regarding recent primary care and specialist visits, emergency room visits, auxiliary treatment services (e.g., dialysis), and any community resources received.
Communication	• Entering and updating data into the Treatment Court Probation eXChange (TCPX), Drug Court Management Information System (DCMIS), and Clarity Homeless Management Information System (HMIS). • Data entry into Probation Department's web-based reporting system for JJCPA referrals • Time spent communicating with service providers, county workers, judges, etc., either face-to-face or by phone (e.g., meeting with patient and doctor during a primary care visit). • Following up with other agencies regarding scheduled services and/or services received by patients. • Providing written or verbal status reports to health and mental health providers, and county partners (e.g., Department of Children and Family Services, Probation Department).	• Entering data into Sage (pre-authorizations, authorizations, progress notes, etc.). • Attempting, but not successfully contacting service providers either by phone or face-to-face. **Providers should only bill for Care Coordination if they are successful in communicating with other service providers on the patients' behalf.**

Care Coordination Checklist			
***Note**: This checklist is a reference tool for use during Care Coordination sessions to ensure that core functions of Care Coordination, and their respective activities, are being performed. This is not meant to be an exhaustive list of Care Coordination activities. This table is intended to offer examples of activities that should be covered in sessions, when applicable, and can be billed as Care Coordination.*			
Topics		**Potential Activities**	**Performed in session? (Y/N)**
Connection	**Establishing & Maintaining Benefit**	Actively help patients to apply for and maintain health and public benefits (e.g., Medi-Cal, My Health LA, Minor Consent Program, General Relief, Perinatal, Housing, etc.).	
		Transfer Medi-Cal benefits from the previous county of residence to Los Angeles County for patients who have moved.	
	Community Resources	Link patients to community resources and services (e.g., transportation, food and clothing assistance, family planning services, legal assistance, educational services, vocational services, housing, etc.)	
Coordination	**Transitions in SUD LOC's**	Facilitate necessary transitions in substance use disorder levels of care (e.g., initiating referrals to the next level of care, coordinating with and forwarding necessary documentation to the accepting treatment agency, etc.).	
	Health Services	Coordinate care with physical health, community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.	
	Social Services	Coordinate activities with state, County and community (e.g., DPSS, DCFS, Probation, Superior Courts, Housing Providers, etc.) entities.	
Communication	**Other Health Providers**	Communicate face-to-face or by phone with physical health, community health clinics and providers, and mental health providers	
	Service Partners	Communicate face-to-face or by phone with Department of Public Social Services (DPSS) workers, Department of Children and Family Services (DCFS) social workers, Department of Mental Health (DMH) workers, Probation Officers, Housing Providers, etc.	
	Advocacy	Advocate for patients with health/social service providers, County and community partners, and others in the best interests of patients.	

CENS: Procedure for Additional Co-Location Sites

All negotiations with any entity regarding the possible co-location of CENS staff will be at the direction of DPH-SAPC. CENS are to refer all interested parties to DPH-SAPC if contacted about the possibility of co-locating at a new site, continuing to co-locate at a site, or returning to a site that has been vacated.

CENS providers interested in co-locating at a state, County, city or community facility must follow the steps below:

1. Complete, sign and send the Request for CENS Co-Location Site form to SAPC, along with a brief narrative justifying the request to co-locate. The narrative should include the following information:

    - Name and address of agency/organization requesting a CENS to be co-located at their site (e.g., Probation, Court, etc.)
    - The justification for the co-location (e.g., incarcerated clients unable to go to the CENS Area Office for a screening)
    - Number and level of staff needed and hours of operation (i.e., the number of full-time equivalents (FTE) and days and hours at the co-located site)
    - Expected number of clients to be seen at the site (e.g., per day, per week, per month, etc.)

2. Unless otherwise directed by DPH-SAPC, execute a Memorandum of Understanding (MOU) or Letter of Agreement with the proposed entity that includes the following information:

    - The host organization contact information, including name, title, phone number and email address
    - Agreed upon days and times that CENS will be co-located
    - Detailed description of the roles and responsibilities of the involved entities
    - Steps taken to assure adherence to confidentiality rules and regulations, including 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, and HIPAA

3. SAPC reserves the right to approve or deny submitted Requests for CENS Co-Location form at its sole discretion based on the information provided in the narrative and the MOU. SAPC will disallow any services that CENS provides at sites not approved by SAPC.

4. Upon approval of the Request for CENS Co-Location Site form and a facility site walk-through by DPH-SAPC, the CENS will be notified of the date when services can begin. CENS co-locations will be reviewed as part of the agency's annual DPH-SAPC program audit.

5. Should DPH – SAPC or CENS determine that a site is no longer viable, notification must be submitted to the other party at least thirty (30) calendar days in advance of the proposed vacancy date.

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH

SUBSTANCE ABUSE PREVENTION AND CONTROL
CLIENT ENGAGEMENT AND NAVIGATION SERVICES (CENS)

Confidential Client Information

SUD Referral and Tracking Form

Section 1: Completed by Individual Requesting SUD Screening				
Requestor's Name:			Requestor's E-mail:	
Department/Agency:			Office Phone:	Fax:
Location Name and Address:				
Date of Referral:	Name of Client:			Client's Date of Birth:
Client's Gender: ☐ Male ☐ Female ☐ Transgender (F to M) ☐ Transgender (M to F) ☐ Unknown		Is the Client Pregnant: ☐ Yes ☐ No		Client's phone number:
Client's email:			Case/Program Identifying #:	
Select Program(s) or Population(s) that best fits with the client:	☐ AB 109 ☐ DCFS ☐ Juvenile Probation ☐ General Relief	☐ Mental Health ☐ Family Solutions Center ☐ MAMA's Neighborhood ☐ CalWORKs	☐ Mainstream Services Interim Housing ☐ Project Roomkey ☐ Homeless Outreach / Encampments ☐ Permanent Supportive Housing	☐ Other, specify: _____

Refer the client directly to the CENS counselor at assigned co-location if information is known. Otherwise you may refer the client to one of the CENS Area Office listed below.

CENS Providers and Sites

☐ SPA 1: Tarzana Treatment Centers
(661) 726-2630 (Phone)
(661) 723-3211 (FAX)
☐ Co-Located Site
Specify Facility name and Address:
_____

☐ SPA 3: Prototypes
(626) 444-0705 (Phone)
(626) 444-0710 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 5: Didi Hirsch Mental Health Services
(310) 895-2300 (Phone)
(310) 895-2353 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 7: Los Angeles Centers for Alcohol and Drug Abuse
(562) 273-0462 (Phone)
(562-273)-0013 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 2: San Fernando Valley Community Mental Health Center
(818) 285-1900 (Phone)
(818) 285-1906 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 4: Homeless Health Care Los Angeles
(213) 744-0724 (Phone)
(213) 748-2432 (FAX)
☐ Co-Located Site
Specify Facility name and Address:
_____

☐ SPA 6: Special Service for Groups
(323) 948-0444 (Phone)
(323) 948-0443 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 8: Behavioral Health Services
(310) 973-2272 (Phone)
(310) 973-7813 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

I agree to schedule an appointment at one of CENS site and show up to the referred treatment site for SUD assessment and treatment services determined by the CENS counselor.

Signed: _____ Date: _____
Client

Signed: _____ Date: _____
Referral Requestor

Section 2: Completed by CENS counselor

Client has Medi-Cal or My Health LA:	☐ If yes, Medi-Cal or My Health LA #: _____	☐ If no, Application #: _____ Submitted on: _____	Client's Sage Member ID Number: _____ Sage Referral ID Number *(auto generated in Sage)* _____

SUD Screening Completed by CENS Counselor:

Date of Screening:		Screened by:		Phone:	
CENS Agency:			Email:		

For CENS Counselors only - SUD Screening Results

Based on the American Society of Addiction Medicine (ASAM) Triage Tool the CENS Counselor recommends the following Provisional Level of Care (LOC):

SCREENED NEGATIVE OR EARLY INTERVENTION FOR TREATMENT
☐ SUD Treatment Not Recommended ☐ ASAM Level 0.5: Early Intervention

➥**WAS AT RISK EDUCATION WORKSHOPS PROVIDED?**
☐ Yes ☐ No

SCREENED POSITIVE FOR OUTPATIENT TREATMENT
- ☐ ASAM Level 0.5: Early Intervention Services only for the 12-20 population that is eligible for EPSDT
- ☐ ASAM Level 1.0: Outpatient Services
- ☐ ASAM Level 2.1: Intensive Outpatient Services
- ☐ ASAM Level 1-OTP: Opioid (Narcotic) Treatment Program
- ☐ ASAM Level 1-WM: Ambulatory WM without Extended On-Site Monitoring

SCREENED POSITIVE FOR RESIDENTIAL TREATMENT
- ☐ ASAM Level 3.1: Low-Intensity Residential Services
- ☐ ASAM Level 3.3: High-Intensity Residential Services, Population-Specific
- ☐ ASAM Level 3.5: High-Intensity Residential Services, Non-Population Specific
- ☐ ASAM Level 3.2-WM: Clinically Managed Residential WM

SCREENED POSITIVE FOR INPATIENT TREATMENT
- ☐ ASAM Level 3.7-WM: Medically Monitored Inpatient WM
- ☐ ASAM Level 4-WM: Medically Managed Intensive Inpatient WM

REFERRED TO OTHER SUPPORT SERVICES
- ☐ Recovery Services
- ☐ Recovery Bridge Housing (requires concurrent enrollment in ASAM 1.0, 2.1, 1-OTP, or 1-WM)
- ☐ Other (Specify): _____

Client Referred to SUD Treatment: ☐ Yes ☐ No ☐ Refused

If Yes, complete the following information:

Name of Treatment Agency:			
Address:		Phone:	
Contact Person:		Email:	
Appointment Date:		Time:	

If client is referred to SUD treatment, please complete Release of Information (ROI) form
ROI – In Network Provider; ROI – Out of Network
The Release of Information (ROI) form has been signed. ☐ Yes ☐ No

Section 3: Treatment Provider Must Complete this Section and Return to CENS

Client showed up to appointment: ☐ Yes ☐ No		If no, rescheduled to: _____ Date _____ Time	
If admitted LOC is different than the ASAM Co-Triage LOC, specify below: _____ (Specify LOC)	If admitted:	Admission Date:	Expected Completion Date:
		Weekly Treatment Hours:	Admission Counselor's Name:

Please return this form to the CENS via [Secure] FAX or email upon Admission, No Show, or Rescheduled Appointment.

Comments:

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

SUBSTANCE ABUSE PREVENTION AND CONTROL
Substance Treatment and re-entry transition – Community (START-Community)

Program Incident Report

START PROGRAM FACILITY	ACTIVITY SITE / LOCATION	DATE	TIME

TYPE OF ACTIVITY

Client Name: _____ Admit Date:_____ Discharge Date: _____

Participant progress to date (program phase, satisfactory progress to date, unsatisfactory progress to date):

What happened (objective brief description of incident):

When did it happen (time and date)?

Who was involved (client, staff name and title, and actual witnesses): Staff Members:

How did it happen (if applicable briefly describe cause of incident)?

Actions taken (briefly describe steps taken during incident and if applicable steps required to prevent future incidents):

Notified: County Program Offices ___ LASD____ SAPC___

Follow up (if applicable briefly describe plans for follow up):

Actions Taken:

NAME/TITLE/SIGNATURE OF REPORTING STAFF	DATE