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

OCTOBER 2024 | Version 9.0

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 that will evolve 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-Cal 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 individuals enrolled or eligible for Medi-Cal, select County-funded programs, as well as safety net populations receiving care by the Los Angeles County (LAC) Department of Health Services (DHS).

Additionally, it offers 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 service, 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 to improve health and social outcomes.

The Los Angeles County Department of Public Health (DPH), Substance Abuse and Prevention Control Bureau's (SAPC) Substance Use Disorder Treatment Services Provider Manual, along with other Federal, State, and local regulations[1], govern the delivery of SUD treatment services in LA County. The Provider Manual is specifically designed for use by all administrative and direct service staff to ensure an understanding of the SUD system of care's core values. Additionally, it outlines the clinical and business expectations to ensure quality and outcome-based service delivery.

SUDs as a Chronic Disease

SUDs are often chronic, relapsing brain conditions that cause compulsive substance seeking and use, despite harmful consequences to individuals and their social network[2]. A chronic disease such as cancer, diabetes, and heart disease 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, throughout a lifetime. While some individuals may develop an SUD and achieve recovery after minimal intervention over a brief period, most will exhibit a more chronic and relapsing course.

[1] 42 CFR Part 2 - Confidentiality of SUD Patient Records; 42 CFR Part 438 - Managed Care; Health Insurance Portability and Accountability Act (HIPAA); Title 9 CCR Chapter 8 - Certification of Alcohol and Other Drug Counselors; Title 22 CCR § 51341.1 - DMC SUD Services; DMC-ODS Special Terms and Conditions (STCs); State-County Intergovernmental Agreement; DHCS Perinatal Practice Guidelines (v1.1, 2022) and Adolescent Substance Use Disorder Best Practices Guide (October 2020); START-ODS Implementation Plan and Finance and Rates Plan; and the DPH SAPC Contract including but not limited to the Specific Services to be Provided, Information Notices and Bulletins.

[2] American Psychiatric Association. (2022). Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787.

The chronic nature of SUDs frames the approach necessary to treat these conditions effectively. Chronic conditions need to be managed via a 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 that 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, in the right setting, for the right duration.

Wagner's "Chronic Care Model" identifies a healthcare system's essential elements that encourage high-quality chronic disease care. Effective care of chronic conditions, such as SUDs, is characterized by collaboration with engaged patients, their families and caregivers, and a skilled team of service providers, including counselors and other health professionals. Chronic care systems:

- Create a culture of and mechanisms for providing safe, high-quality care.
- Deliver effective, efficient clinical care and self-management support.
- Promote clinical care that is consistent with scientific evidence and patient preferences.
- Organize patient and population data to facilitate efficient and effective care.
- Empower and prepare patients to manage their health and healthcare.
- Mobilize community resources to meet the needs of patients.

Defining Patient-Centered Care

Treatment retention is crucial for success in SUD care, given that an individual cannot benefit from treatment if they do not participate in it. Furthermore, one critical component of engaging SUD patients in treatment is the ability to deliver patient-centered care that eliminates unneeded barriers to enrolling and retaining patients.

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

Patient-centered care requires flexibility from both the providers and the program delivering the services. By cultivating an environment in which patients' individualized needs are prioritized in all aspects of care delivery, SUD programs are better able to engage their patients and better positioned to deliver high-quality care.

Ensuring a Standard Quality of Service

The specialty SUD system is a core component of the more extensive healthcare system. As such, it needs to maintain minimum standards and expectations to ensure high-quality services for the patient population served. Similar to managing other chronic conditions, these minimum standards for SUDs ensure a reasonable degree of consistency across service providers, while allowing for sufficient flexibility to deliver services tailored to the patient's individualized needs. For example, an individual with diabetes may receive slightly different services depending on the provider (i.e., recommendations about dietary/lifestyle changes). Still, certain best practices and clinical standards guide the treatment and management approach.

Similarly, SUD services must be guided by best practices and clinical standards, including Evidence-Based Practices (EBPs) such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Standards-based care and individualized care are not mutually exclusive. Service providers can offer individualized, patient-centered care that meets certain minimum best practice(s) and clinical standards.

Integration and Coordination of Care

A key goal of the specialty SUD system is to better integrate SUD care into healthcare and social service systems and vice versa to better serve the comprehensive needs of its patient population. In addition, the specialty SUD system needs to be better organized and coordinated so that patients can effectively access the entire continuum of SUD services and the Level of Care (LOC) available to them.

Integrated care is the routine and systematic coordination of health services to address patients' various needs comprehensively and cohesively. An example of care integration is an SUD program with primary care and mental health providers housed in the SUD treatment facility to address patients with multiple healthcare needs in one location. Integrating social services such as housing assistance is also important. 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 the sharing of information among care providers to ensure 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 needs and preferences. It should also be based on clinical judgment, so the information being shared and the care being coordinated are in the patient's best interests. The primary goal of Care Coordination is to ensure that while multiple health and social service providers may be involved in an individual's care, the services (as listed in Table 1) are organized and coordinated to collectively provide timely, comprehensive, appropriate, and effective care to the patient.

Table 1

Examples of Care Coordination Activities

Assessing patient needs and goals
Creating a proactive care plan
Monitoring and follow-up, including responding to changes in patient needs
Helping with transitions of care
Supporting patient 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 patient and provider outcomes.

Section 2. PATIENT SERVICE STANDARDS

Substance Use Disorder Benefit Package

LA County's SUD benefit package includes:

- Outpatient (OP)
- Residential
- Withdrawal Management (WM)
- Addiction Medication Services (also known as Medications for Addiction Treatment [MAT] Services)
- Opioid Treatment Program (OTP) Services
- Recovery Bridge Housing (RBH)
- Early Intervention Services
- Recovery Services (RS)

Services are free of charge to fully covered members and eligible participants. This comprehensive continuum of care effectively addresses each unique individual's treatment and recovery needs. Further, Network Providers assist patients in transitioning between LOCs as medically necessary to provide care in the least restrictive environment.

Eligibility Determination and Establishing Benefits

Covered Members and Eligible Participants

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

- Residents of LA County; **and**
- Medi-Cal enrolled or in the process of enrollment due to presumed eligibility, including those transferring benefits from another County; **or**
- Uninsured patients assigned to DHS for primary care; **or**
- Participants in the Assembly Bill (AB) 109, Drug Court, General Relief (GR), California Work Opportunity and Responsibility to Kids (CalWORKs), Juvenile Justice Crime Prevention Act (JJCPA) program and/or California Department of Health Care Services (DHCS), Women 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.

Note: The My Health LA (MHLA) Program ended on January 31, 2024. On January 1, 2024, the State of California will expand Medi-Cal to all ages regardless of immigration status, and SAPC provider agencies should enroll all Medi-Cal eligible individuals in Medi-Cal to ensure their coverage for health services continues.

County of Responsibility

In accordance with State policy, the LA County specialty SUD benefit package follows a County of Residence model of service delivery. As such, individuals need to be a resident of LA County to receive services; this includes individuals residing here but transferring benefits from another County. Network Providers that render services to individuals whose County of Residence is not LA County will not be reimbursed. Only services rendered to individuals with LA County as their County of Residence and/or Responsibility are treated at a contracted site will be reimbursed. There are occasions when the patient has County of Responsibility listed as County 19 (LA County), but another county as County of Residence. The State will approve claims as long as

one or the other is identified as LA, as noted in BHIN 24-008. In 2021, changes to the Short-Doyle system resulted in allowances for counties to submit DMC-ODS claims based on either the County of Responsibility or the County of Residence, which allowed for greater flexibility in situations such as inter-county transfers (ICTs), and other specific exceptions, such as temporary moves.

If a new referral or current continuing patient does not reside in LA 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: 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 members reside to be reimbursed.

Out-Of-County Treatment Facilities

Network Providers that operate a DMC-certified site in neighboring or adjacent counties (e.g., Kern, Orange, San Bernardino, Ventura), may apply to add those location(s) to this Contract to deliver services to eligible members if there is a SAPC determined need. In most cases, locations in non-adjacent counties will not be approved, with limited exceptions to fill service gaps due to DMC-ODS only authorizing services to current 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 DHCS and the United States Drug Enforcement Administration (DEA) certifications.
- Inclusion of facility information (e.g., phone numbers, contract staff, hours of operations) in the contract.
- Site inspections are 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 SAPC Contract Program Auditor (CPA).

Opioid Treatment Programs Courtesy Dosing

SAPC reimburses courtesy dosing of methadone and buprenorphine for up to 30 days for Medi-Cal members who travel to LA County for business or leisure, and who do not qualify for, or are 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 the dose, duration, and any other special instructions, such as take-home doses. Compliance with the relevant California Code of Regulations (CCR) - Title 9 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 Client Index Number (CIN), County/State of residence, home clinic, dates of service, medication type, Healthcare Common 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 data collection is 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 emailed securely to SAPC's Finance Services Division (SAPC-FSD) at 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 LA County, but Medi-Cal benefits are assigned to another County, Network Providers will conduct the screening/assessment and admit the patient for medically necessary services while Medi-Cal benefits are being transferred through ICTs. **Patients cannot be delayed or denied admission for eligible (i.e., Medi-Cal, 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.

Note: The County of Residency/County of Responsibility rule does not apply to Narcotics Treatment Program (NTP) dosing, individual and group counseling services (H0004, H0005, H0020, S5000, and S5001) if these service codes are claimed with modifiers UA (ASAM OTP/NTP) and HG (OTP) (DMC-ODS-Billing-Manual-v-2-0.pdf (ca.gov).

Eligibility Determination Process

The SUD provider rendering services must verify eligibility for LA County's SUD benefit package, and include the considerations outlined in **Table 2**.

Table 2

Eligibility Requirements for Specialty SUD Services in LA County

	Eligibility Requirement	Source of Verification
Step 1	**Resident of LA 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 • Uninsured patients assigned to DHS for primary care; or • Participants in AB 109, Drug Court, CalWORKs, GR, WCRTS, and/or the JJCPA program who are commercially insured or otherwise ineligible for Medi-Cal.	• Providers must utilize the 270/271 real-time Medi-Cal Eligibility Verification (EV) process in Sage, to verify Medi-Cal status through the State system. This process automatically updates the Financial Eligibility status in Sage if the member is enrolled in Medi-Cal. • Medi-Cal application submitted or Medi-Cal verification via AEVS file or Medi-Cal Eligibility Data System Lite (MEDSLITE). • Once the member's Medi-Cal is active, providers must update the Financial Eligibility Form in Sage with the patient's Medi-Cal Eligibility Data System (MEDS) ID, Policy number, and Coverage Effective Date. • DHS patients can contact their assigned DHS primary care clinic or call the Patient Access Center at (844) 804-0055 to link to their primary care clinic. • 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).	• Services are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain (California Welfare and Institutions Code (WIC) § 14059.5(a)).

	Eligibility Requirement	Source of Verification
		• For OTPs, a history and physical exam conducted by a Licensed Practitioner of the Healing Arts (LPHA) at admission, pursuant to Federal and State regulations, qualify for the determination of medical necessity.
Step 4	**Meets medical necessity access criteria for specialty SUD services** (see *Determining Medical Necessity* section).	**ADULTS (AGE 21 AND OVER)** • Completed American Society of Addiction Medicine (ASAM) CONTINUUM assessment* for non-withdrawal management, non-recovery service LOCs within the specified time periods in **Table 3**; **and** • The clinical justification for withdrawal management must be documented (through the ASAM CONTINUUM assessment or through directly documenting the patient's withdrawal features) during the withdrawal management episode • Must meet criteria for at least one (1) 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 17 AND UNDER) AND YOUNG ADULTS (AGE 18-20)** • For Youth (age 17 and under) being admitted to treatment services, a completed SAPC Youth Assessment*is required; parental consent is required for services delivered to youth under the age of 12. • For Young Adults (age 18-20), a completed ASAM CONTINUUM Assessment* within the specified time period in **Table 3**; and Meet criteria for the DSM criteria specified for Adults (age 21 and over); 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 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. For additional information, see *Definition of Early Intervention Services for Youth and Young Adults* section.

*Admission to Withdrawal Management services does not require a full ASAM assessment. RS requires the completion of ASAM CO-Triage for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20).

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 Inquiry (270) Request Form in Sage allows a provider to request Medi-Cal eligibility directly from the DHCS in real-time. Providers will receive an immediate response via a 271 file to determine their current or previous eligibility status.

For instructions on interpreting the 271 eligibility results, visit the Sage - Other Training Resources webpage on SAPC's website.

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 – patient's treatment would be moved to the secondary funding source; this would apply to any 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 eligible members/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 Section (SAPC-UM) as this situation is very rare since the maximum duration is 14 days.
2. If the patient remains in treatment, modify the Financial Eligibility and California Outcomes Measurement System (CalOMS)/Los Angeles County Participant Reporting System (LACPRS) data to reflect the funding source change.

Establishing and Transferring Benefits

DMC-ODS services for Medi-Cal Members are reimbursable in keeping with DHCS Behavioral Health Information Notices (BHINs): BHIN 24-001 and BHIN 24-008.

In accordance with BHIN 24-008**:** The County listed in the County of Responsibility field in MEDS and/or MEDSLITE is responsible to provide authorizations for Medi-Cal Specialty Mental Health Services (SMHS), and/or SUD treatment services and to pay claims for services provided. The only exceptions to this policy are when an ICT is initiated because the member: provided notice of a change of residence; foster care children referred for treatment from out of county or a patient being released from a prison, jail, or a youth Correctional Facility (CF). In these cases, once the County of Residence field is updated in MEDS, and/or MEDSLITE, the county listed in the County of Residence field is responsible for payment of SMHS, and/or SUD treatment services claims.

When a SAPC provider agency is treating a Medi-Cal member who moved to LA County, the provider agency should initiate an ICT on admission by the process as demonstrated in **Figure 1**:

Figure 1

Key Inter-County Transfer Steps

Option 1: Contractor and Patient on BenefitsCal	First, assist the patient in creating a new account or signing into an existing account on the BenefitsCal website. Completing the MC382/383 form will allow the provider to become an authorized representative on behalf of the patient, helping to facilitate further updates. Once completed, upload it into the patient's BenefitsCal account and also the patient chart. Link the patient's case from the originating county to LA County. Medi-Cal benefits will show as pending in LA County. It will become active once the County of Responsibility has transferred. Next, report a change of address. After completing it, download or print a Change Report Summary (CRS) and upload it to the patient's chart. Utilization Management will refer to the Effective Date noted when Authorizing treatment for the patient.
Option 2: Contractor and Patient working with DPSS	Contact the local LA County DPSS office and report the change of residence. A Notice of Action (NOA) will be mailed to the patient. It will acknowledge the transfer of county with an Effective Date. Upload a screenshot into the patient's chart. Utilization Management will refer to the Effective Date noted when Authorizing treatment for the patient.
Contractor	Complete a Progress Note for Care Coordination in the patient's chart for all interventions used to assist the patient with the ICT. After 1-2 weeks, contact ncrosby@ph.lacounty.gov to confirm the transfer of residence or wait until Automated Eligibility Verification System (AEVS) provides confirmation that the County of Responsibility is LA County. Submit Service Authorization using the Effective Date on the NOA or CRS as the initial date of service. Select DMC as Guarantor and use the Effective Date found on the NOA or CRS and use the BIC Issue Date in the Financial Eligibility form Coverage Effective Date in order to help prevent claims from being denied. To access the AEVS, submit the following forms and register for the provider portal: • Form: Medi-Cal Eligibility Verification Enrollment Form (point frms) • Form: Medi-Cal Point of Service (POS) Network/Internet Agreement (point frm 1 net)

*For step-by-step instructions on updating Financial Eligibility in Sage for ICT process, visit Finance Related Forms and Documents on the SAPC website and select the Documenting Changes in Financial Eligibility Status document (Patients Who Obtain Benefits During Treatment section: Intercounty Transfers).

For individuals seeking care who are eligible for Medi-Cal but whose benefits are not active at the time of assessment and intake, SAPC providers should enroll eligible patients in Medi-Cal and/or applicable financial eligibility programs. **Eligible individuals may NOT be denied services pending the establishment of Medi-Cal participation. Sliding scale fees or flat fees are not allowable for Medi-Cal-eligible patients or those who qualify for applicable County-funded programs.**

Providers need to use the Care Coordination benefits to:

- Assist individuals to obtain Medi-Cal 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 LA County residents in transferring Medi-Cal benefits to LA 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 the first service or intake appointment occurs no later than ten (10) business days from the date of referral or screening for all LOCs except OTPs, which must occur no later than three (3) business days from the date of referral or screening.

Only one 30-day reimbursement is available per patient (regardless of agency or LOC) per Fiscal Year (FY) system-wide. This does not include patients who lose Medi-Cal during a treatment episode and submit a new application. 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 Medi-Cal and completed the Medi-Cal application submitted with a CIN assigned **but** whose application was not processed by the 30th day or was ultimately denied by the State.

If Medi-Cal benefits are established, SUD treatment services are reimbursable from the first date of the month the Medi-Cal benefit was approved. There are occasions when a patient's eligibility is established retroactively and can include several previous months. It is essential to initiate this process as close to the date of the first service as possible in order to establish the Medi-Cal benefit as quickly as possible. It is also critical that:

- Individuals may step up or step-down to another LOC whenever clinically appropriate with medical necessity documentation (e.g., from WM to OP) both to support improved and sustained recovery outcomes and to increase the time needed for patients to obtain health benefits; **and**
- In the case of a change of LOC, 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 contacting the Los Angeles County Department of Public Social Services (DPSS) or utilizing the patient's BenefitsCal account on the day the first DMC service delivered to link the case to Los Angeles County from the originating county. 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.

For DPSS Customer Service Center contact information, visit www.dpss.lacounty.gov/en/resources/contact.html.

For a portal where Californians can get and manage public benefits online, visit www.benefitscal.com.

For contact information on public social services agencies outside of LA County, visit www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Note: Only one 30-day reimbursement is available per patient while assisting the patient in submitting a new Medi-Cal application (regardless of agency or LOC) per FY system-wide.

Definitions of Eligible Plans

Medi-Cal Managed Care

Medi-Cal managed care plans in LA County include LA 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 member and has a member card from one of these health plans, they are entitled to the full SUD benefit package, which should be referred to an appropriate Network Provider. The treating provider is responsible for coordinating 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 full DMC benefit package, including any County-specific supplemental services such as RBH. 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. For additional information, see SAPC Bulletin 20-01.

Additionally, for all other LOCs, 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 the 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 members 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" clears 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. It is possible that a well-known commercial plan (e.g., Kaiser, Anthem) covers members who are also eligible or enrolled in Medi-Cal.

SAPC providers must serve all eligible or enrolled patients in Medi-Cal, including those enrolled in Medi-Cal through the health plans in LA County, including LA Care, Health Net, Kaiser, Anthem, Blue Shield, and Molina.

Non-Medi-Cal Eligible Participants

The specialty SUD system in LA County services individuals within the State and County safety net programs. Therefore, there may be times when individuals who are not eligible for 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: AB 109 (including Proposition 47 and Proposition 57), Drug Court, Family Dependency Court, Perinatal Service, Los Angeles County Probation Department (LAC-Probation), Juvenile in Custody Probation Camp, 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. This is only applicable when the CalOMS admission data reflects participation in the applicable program.

For patients with commercial insurance who are ineligible for Medi-Cal and who 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: Sliding scale fees or flat fees are not allowable for Medi-Cal or the select other County-funded program enrolled members or participants.

Access to Care

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

- Timely access barriers, such as 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 the lack of capabilities to engage with non-English monolinguals or those with Limited English Proficiency (LEP), hearing, or visually impaired people, or those who do not answer the phone lines during business hours as listed on the Service & Bed Availability Tool (SBAT).
- Privacy barriers, such as the lack of soundproofing in counseling offices and the lack of privacy in assessment rooms.
- Business operation-influenced barriers, such as attitudes expressed by counselors or other staff that denote biases or communicate stigma to patients, a lack of a diverse workforce, operational hours that restrict access to services, or a lack of opportunity for patient input into the treatment 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 Food and Drug Administration (FDA) approved medications for opioid use disorders (OUDs), cannot be denied for members meeting the criteria for DMC-ODS services, and it is prohibited to put members on waitlists.

Access begins with the point of first contact. There are four (4) main ways to enter LA 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:
        - **SBAT:** Web-based, filterable provider directory of specialty SUD services contracted through SAPC; visit https://sapccis.ph.lacounty.gov/sbat/.
        - **RecoverLA:** Mobile-friendly platform with information about SUD services available across the County, including a mobile-friendly version of the SBAT. Access www.RecoverLA.org using the mobile device's browser for optimal performance.

Note: Effective July 9, 2024, the Substance Abuse Service Helpline (SASH) and the Department of Mental Health (DMH) ACCESS Help Line became one (1) centralized call center. The new centralized call center is called "The Los Angeles County Help Line for Mental Health and Substance Use Services". Callers can access either mental health or substance use service assistance by dialing (800) 854-7771. For substance use services, after the language prompt, select option 2. To ensure uninterrupted access to substance use services, the dedicated SASH phone number – (844) 804-7500 – will continue to be active and automatically route to the centralized call center.

Maximizing access and minimizing time and barriers to care are fundamental priorities for the specialty SUD system. Every effort must be made to minimize the time between the initial EV, clinical need determination, referral, and the first clinical encounter.

Service Connection Portals

LA County operates three (3) service connection portals to facilitate efficient entry into the SUD system of care:

1. **SASH**: Qualified agents are available 24 hours a day, seven (7) days a week, and 365 days a year to determine an appropriate provisional LOC based on the ASAM Screener Youth (age 17 and under) and Young Adults (age 18-20), **or** the ASAM CO-Triage and facilitate a successful referral and linkage to treatment. Language assistance services are available and TeleType (TTY) services are available to callers at no cost to them.
2. **CENS:** SUD Counselors are co-located at various County facilities, Permanent Supportive Housing (PSH), and area office sites during varying hours. They perform the ASAM Screener Youth (age 17 and under) and Young Adults (age 18-20), **or** the ASAM CO-Triage, determine an appropriate provisional LOC, and facilitate a successful referral and linkage. Other available services include outreach and

engagement, eligibility determination and benefits enrollment, SUD educational sessions, service navigation, and other ancillary service referrals and linkages.

3. **CORE Centers:** SUD Counselors are co-located within DPH 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 (age 17 and under) and Young Adults (age 18-20), **or** the ASAM CO-Triage to determine an appropriate provisional LOC and facilitate a successful referral and linkage. For additional information on CORE Centers, visit www.publichealth.lacounty.gov/sapc/public/corecenter/?lang=en.

Each of these Service Connection Portals follows 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 Service Connection Portals Referral Process

Individuals may seek referrals by phone (SASH) or in-person (CENS/CORE). The following describes the key steps that occur during the service connection process:

1. Respond to the initial contact based on the 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 requests 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. Individuals can also initiate a call or in-person visit with the CENS and the process can also begin immediately.
2. Connect individuals to interpretation or translation services during the call/interview, and verify accommodations upon referral, including those with sensory impairment.
3. Call 911 when an individual is having a medical, psychiatric, or other emergency and remain on the line or with the individual until emergency personnel have assumed responsibility for the call or arrive at the location.
4. Conduct eligibility and income verification to determine Medi-Cal 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.
(see **Table 2**).
5. Conduct the ASAM CO-Triage Tool for Adults (age 21 and over) or the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20).
    a. If the screening results indicate a provisional LOC or that Youth (age 17 and under) and Young Adults (age 18-20) qualify for EPSDT, proceed to Step 6.
6. When an individual refuses referral, advise the prospective patient about risk reduction measures such as needle exchange, overdose prevention, and other harm reduction strategies that may reduce negative consequences.
    a. 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 that can initiate care and conduct an assessment during the engagement period prior to establishing medical necessity, as described in **Table 3**.

b. For individuals who decline referral to treatment, alternative options (e.g., prevention, CENS Adult At-Risk [AAR] Services) shall be provided in the community or offered by the Medi-Cal managed care plan, if applicable.
    i. The SASH may refer court-ordered individuals to the CENS, as applicable, for written verifications, follow-up, and/or coordination with the case worker from the referring entity.

7. Identify appropriate SUD Network Providers using the online Provider Directory, known as the SBAT, and determine available beds/intake appointments. For Youth (age 17 and under), refer the individual to the most appropriate OP Youth SUD Treatment Provider. Individuals reporting opioid use within the past 30 days are also offered referrals to OTP/Medication for Addiction Treatment (MAT) sites in addition to any other LOC.
8. Assist with scheduling an appointment and/or providing contact information, to comply with timely access standards (see **Table 3**) as follows:
    a. Identify up to three (3) other Network Providers based on individual preference or time and distance standards (see **Table 3**).
    b. Contact Network Providers with the individual on the phone or in-person to schedule the intake appointment date within ten (10) business days for all LOCs except for OTP, which is three (3) business days.
    c. If the recommended provisional LOC is unavailable after reasonable attempts have been made, a lower LOC may be used as needed in the interim.
    d. Individuals may also be offered an Out-of-Network (OON) provider if the identified LOC is unavailable within the network.
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 an ROI that includes each SUD Network Provider, not just the specific agency receiving the referral, for Care Coordination purposes, and obtain a signed release if agreed upon. Also, obtain an ROI with the referring and other applicable entities 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.
6. If ROI is signed and as directed by SAPC, report back to the referring entity through relevant data entry systems on the status of the individual's connection to services.

Network Provider Responsibilities for Service Connection Portals and Direct Referrals

Treatment agencies have the following responsibilities around referrals from SASH, CENS, CORE, and other provider referrals:

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. Contact your CPA to complete an SBAT survey when updates need to be made to:
    a. Days; **and/or**
    b. Hours of operation;
    c. Specialized expertise such as language capability or populations served; **and**
    d. New site locations. Submit the completed SBAT survey to your CPA within **five (5) business days** of these changes.
3. Respond timely to all service connection portals. Providers are required to ensure the phone number listed on the SBAT is answered **at all times during normal business hours** and times when intake appointments are conducted; see *Hours of Operation* section. This ensures that an appointment can be scheduled while the individual is on the line or at the screening interview, whenever possible.
    a. Voicemail and extensive prompt systems are not acceptable alternatives to an individual answering the phone.

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 (age 17 and under) and Young Adults (age 18-20), **or** ASAM CO-Triage screener to create a more patient-friendly experience, and support efforts to limit total call-time to ten (10) minutes or less.

For providers making referrals to other treatment agencies, the following outlines the requirements:

1. If there is no answer or the calls go straight to voicemail, staff can proceed to the next Network Provider site that meets the individual's needs and preferences.
2. Ensure the capability to assess and admit patients who require language assistance services, and/or have sensory (visual/hearing) limitations even if facility staff cannot perform this responsibility, and/or have mobility limitations, including the ability to accommodate service animals.
3. 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 (age 17 and under) and Young Adults (age 18-20), **or** ASAM CO-Triage screener to create a more patient-friendly experience, and support efforts to limit total call-time to ten (10) minutes or less.
4. Schedule intake/assessment appointments within three (3) calendar days of the call, and subsequent immediate admission if medical necessity is established.
5. Conduct a reminder call in advance of the appointment, and if it is missed, whenever the individual provides a contact phone number.
6. Schedule an appointment with another appropriate Network Provider after the in-person assessment if it indicates a different recommended LOC and:
    a. 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**

   b. A bed/slot is not geographically convenient to the individual or does not meet preference; **and**
   c. Using the SBAT tool, provide at least two (2) referral options whenever possible and contact the selected provider to schedule an appointment on behalf of the individual.
7. Use the Care Coordination benefit to assist enrolled patients to transition between treatment LOCs and successfully connect with the receiving Network Provider. Management of these transitions is the responsibility of the referring treatment agency.
8. All providers making referrals to another provider MUST complete the Referral Connection 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.

Member Support

SAPC's Member Support team is available during normal business hours to assist patients in understanding their benefits and rights, and submitting a grievance/appeal. Member Support works with providers to improve the patient experience at provider sites, such as by providing technical assistance in how to best use the patient orientation videos and the patient handbook. To contact Member Services, patients can dial (888) 742-7900 and press 7, Monday through Friday, 8:00 a.m. to 5:00 p.m., or email MemberServices@ph.lacounty.gov.

Client Engagement and Navigation Services

Since many youths, young adults, and adults are referred for SUD treatment by State, County, city, or other government entities, ensuring successful connections for these multi-systems involved individuals is important. Often, prospective clients may need more hands-on assistance to maximize treatment admission and retention, and the 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 who serve as liaisons between individuals, their case workers, and the specialty SUD system. CENS counselors provide services, in-person or via phone, to facilitate access to and completion of SUD treatment.

CENS provides various activities, including screening and referrals to SUD services, client education, Medi-Cal eligibility and enrollment assistance, and navigation services. In accordance with State guidance, BHIN 21-075 effective November 30, 2023, SAPC issued SAPC IN 23-13, directing the CENS providers to bill DMC for services provided to Medi-Cal beneficiaries via their applicable DMC-ODS contract with SAPC. To bill DMC for CENS activities, providers will deliver the Recovery Services benefit to individuals enrolled in Medi-Cal. The services must be provided at approved CENS community sites or at a CENS Area Office site that is DMC-certified for OP treatment services, and all CENS activities that are delivered to individuals not enrolled in Medi-Cal will continue to be billed under the CENS Staff Hour contract.1 Billing for DMC reimbursable activities will be submitted through Sage.

For additional information, see CENS Standards and Practices, which 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 and SAPC IN 23-13.

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 contact 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 are 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 eligibility and facilitate enrollment. CENS assists clients in entering data in the statewide BenefitsCal website for Medi-Cal enrollment. If the individual is eligible for Medi-Cal, CENS counselors initiate the necessary paperwork and refer the client to a qualified provider to continue the benefits enrollment process. This includes assisting with transferring 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 the other County-funded programs (specifically AB 109, Drug Court, JJCPA, CalWORKs, GR and/or WCRTS). CENS counselors may provide referrals to SUD providers that accept clients on a sliding scale basis. Moreover, if the client who is not eligible for Medi-Cal 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 an 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 Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) education and referrals for HIV testing and treatment.
- Discuss the availability of MAT for any Alcohol Use Disorders (AUDs) and OUDs.
- 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 a 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 in *Summary of Service Connection Portals Referral Process* section. A CENS counselor calls the individual to remind them of the upcoming appointment. They also call individuals if they fail to show up to their assessment appointment. CENS also contacts the Network Provider to determine the linked individual's admission and treatment status.

For justice-involved clients, the appropriate LOC and interventions should be determined by a qualified counselor or clinician, not by justice partners. SUD treatment must be individualized and based on medical necessity. For clients who are incarcerated, SUD screening should be based on the client's substance use status 30 days prior to incarceration.

Service Navigation, Ancillary Referrals, and Linkages

CENS serves as a liaison between referring State, County, city, and community partner entities and SUD treatment agencies. This helps ensure the referring entities are aware of their client's treatment status, including treatment location and anticipated completion date. For example, CENS counselors co-located at the LA Superior Courts serve 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 establishes and maintains 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 providers, physical health providers, HIV/AIDS and Sexually Transmitted Infection (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 the partnering agency's electronic data collection system, as appropriate (e.g., California State Automated Welfare System [CalSAWS]).

Depending on the Medi-Cal status, CENS staff will document services as described below:

- Client not eligible for Medi-Cal – CENS will document all services for this client in the Service Connections Log (SCL) and/or Monthly Activity Report (MAR). Time spent with this client will be billed to the CENS Staff Hour contract.
- Client with active Medi-Cal – CENS staff will provide Recovery Services to the client. All services will be documented in the SCL and/or MAR. In addition, CENS staff will complete a Financial Eligibility Form, Diagnosis Form, and Progress Note that must indicate the service start and end time to be used for billing to DMC.
- Client eligible for Medi-Cal but not active – Eligible but not enrolled clients will receive CENS non-DMC services. These will be documented in the SCL and/or MAR and billed to the CENS Staff Hour contract.

The Recovery Services benefit is medically necessary for individuals at risk of relapse and, therefore, a criterion that is met by all CENS clients. In addition, Recovery Services are authorized at the provider level, not the member level. For the short period of time that clients are seen at the CENS, it is most appropriate to utilize the Provider Authorization (PAUTH). The CENS contract also allows for staff hour billing. Staff hour billing will be utilized for any CENS activities that are not DMC reimbursable.

All Recovery Services billing will occur through the provider's DMC contract in Sage. All approved claims submitted by CENS providers via their DMC contract that utilize Recovery Services in Sage will be analyzed and allocated to funding sources by SAPC based on patient eligibility, service type, funding hierarchy, and in accordance with applicable Federal, State, local, and SAPC policies, guidelines, and restrictions. Staff hour billing for non-DMC billable services and for clients who are not enrolled in Medi-Cal will continue to use the procedures detailed in the CENS Standards and Practices. For all clients, irrespective of their Medi-Cal status, CENS will provide all appropriate services as outlined in the CENS Standards and Practices, including screening, referral to treatment, follow-up and coordination with the referring agency, and referral to ancillary services. For additional information, see SAPC IN 23-13.

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 State/County/city 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 Greater Avenues for Independence (GAIN) Regional – Los Angeles County Office of Education (LACOE) sites CalWORKs. Orientation services are designed to educate participants and DPSS staff (when possible) about assessment, treatment, and RS available through the CalWORKs Supportive Services program. Orientation sessions are to be conducted by individuals who have in-depth knowledge and expertise in Alcohol and Other Drugs (AODs), as well as knowledge of the alcohol and drug treatment and recovery system in LA County.

Adult At-Risk Services for Prevention and Early Intervention

The AAR Program is a no-cost opportunity for eligible individuals to learn about and be aware of SUD through interesting and interactive educational sessions. CENS provides early intervention services for Adults (age 21 and over):

- whose ASAM CO-Triage results do not meet the criteria for SUD treatment services,
- who 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.

Youth (age 17 and under) and Young Adults (age 18-20) are referred and provided Early Intervention Services at ASAM 0.5 OP SUD service locations.

AAR 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 AAR Program provides education sessions about the effects of SUD and its impact on a person's life. The sessions are designed to teach how to maintain a healthy and SUD-free lifestyle.

Adult At-Risk Services (available to Adults [age 21 and over]):

Enrollment

Complete enrollment in At-Risk services, including identifying the individual's needs or behaviors for a tailored intervention approach.

Intervention Guide

The intervention guide is a tool for CENS counselors to assess factors affecting an individual's risk for SUD. Participants will be able to identify suitable resources within SAPC's SUD Continuum of Care and receive verification of their progress, as documented by the CENS counselor. These resources may include:

- Substance Use, Intoxication/Withdrawal Potential (e.g., early initiation, Intravenous (IV) substance 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 support, lives with others who use substances)

Participation Documentation

AAR CENS Counselors can provide At-Risk sessions and the intervention guide can provide documentation on the participant's behalf based on progress. Counselors verify participants' consent to release information and provide documentation to other County departments such as DPSS, Los Angeles County Department of Children and Family Services (DCFS), and LAC-Probation with the participants' completion status. All releases shall adhere to all confidentiality laws, including 42 CFR Part 2 and HIPAA.

Training for CENS Counselors

SAPC's Clinical Standards and Training Section (SAPC-CST) offers the AAR trainings for CENS counselors aimed at providing intervention services to all adult clients who screen negative for SUD or positive for ASAM 0.5 Early Intervention LOC.

SAPC-CST also offers Training of Trainers (ToT) trainings, a series of trainings conducted by SAPC-CST instructors for CENS counselors in "cohorts." These trainings focus on information about SUD issues in the community, common substance use trends in the community, and exploring the differences between use, abuse, and disorder. They can be provided to groups, educational sessions, or client workshops.

Note: The CENS counselor cannot train other staff in the ToT.

To attend trainings offered by SAPC-CST, visit the SAPC Trainings and Events webpage on SAPC's website and refer to the training calendar to register for upcoming sessions.

Educational Sessions

Educational sessions are meant as a resource for participants, presented by certified CENS counselors, to utilize when working with adults who are considered at risk of SUDs. They are intended to be knowledge and skill-based for an individual session.

Important Note:

- CENS counselors who are only certified in the educational sessions may provide individual sessions, but NOT group sessions or trainings to interagency staff.
- Only CENS counselors certified through ToT may provide individual or group intervention sessions for clients and to interagency staff if required.

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 (SPAs). CENS are also co-located at various State, County, city, and community sites to facilitate client entry into and navigation through the specialty SUD system.

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

- DMH Psychiatric Emergency Services (PES) and Urgent Care Centers (UCCs)
- Driving Under the Influence (DUI) courts
- Family Solutions Centers
- Homeless Encampments
- Interim Housing and PSH sites
- Juvenile Halls
- LA Superior Courts (e.g., Community Collaborative Court and Proposition 47)

- Medical facilities, including Federally Qualified Health Centers (FQHCs) and selective private and public hospital medical emergency rooms (ERs)
- LAC-Probation (e.g., AB 109 HUBS and Adult Area Offices)
- Los Angeles County Sheriff's Department (LASD) (e.g., Community Re-entry and Resource Center (CRRC), Twin Towers)
- Other approved co-locations, as necessary

Target populations serviced at these co-located sites include individuals who are involved in the juvenile or criminal justice system, uninsured, underinsured, PEH, and individuals with co-occurring disorders (CODs), among other vulnerable conditions.

There is one (1) CENS lead agency per SPA that 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 *Appendix E*.

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

CENS Staffing

CENS provides 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.

CENS Hours of Operation

Hours of operation vary depending on CENS staffing patterns and client volume. Some CENS co-locations do not have full-time 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. Other responsibilities include:

- Supervision and Training
- Ensuring CENS staff have the appropriate experience, training, and current forms to provide and document CENS services.
- Ensuring CENS staff are kept informed of any changes or updates to CENS requirements, procedures, and forms.
- Sage Onboarding

- Ensuring CENS staff create and manage their Sage User accounts. For step-by-step instructions to create and manage Sage User accounts, see Sage User Onboarding/Offboarding and Privilege Management.
- Updating CENS Information
- Updating SAPC on 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.
- Ensure staff attendance at CENS Meetings and Trainings.
- Participating 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

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 relates to supporting healthy families. CORE Centers, which operate with the philosophy "*the opposite of addiction isn't sobriety, the opposite of addiction is connection*" (Johann Hari), operate with 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 PSH, 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. Being At Risk (for Substance Use Disorder)
2. Harm Reduction Strategies and Syringe Exchange Programs
3. Health Consequences of Substance Use
4. How to Talk to Your Loved Ones About Substance Use
5. Recognizing and Responding to an Overdose with Naloxone
6. Relapse Prevention and Healthy Coping
7. Stigma and Substance Use Disorders
8. Substance Use in Our Community
9. Teen and Substance Use

10. Teen and Vaping
11. Treatment and Healthcare for People with Substance Use Disorders
12. Understanding the Connection Between Substance Use and Mental Health
13. How to Talk About Substance Use with People You Care About (Youth-Facing)
14. Recognizing and Responding to an Overdose with Naloxone for Youth (Youth-Facing)
15. Vaping & You: What You Need to Know (Youth-Facing)
16. Understanding the Risks of Cannabis

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 judgment on the individual's readiness to change (e.g., pre-contemplation, contemplation, action, etc.). Services are available to the public, and particularly those who are Medi-Cal eligible or enrolled. Agreement to be referred to treatment (when indicated) is not a condition for receiving 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 therefore 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 and prior experiences by using the SBAT or the RecoverLA.org application on mobile devices for information about specialty SUD providers throughout the County.

Staffing

For minimum staffing requirements, see *Workforce* section.

Hours of Operation

For guidance on minimum hours of operation, see **Table 4**.

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. For additional information, see *Intake and Enrollment – Required Process – Assessment* section.

3. Treatment provider sites that do NOT offer the full SUD continuum of care: Administer either the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) or ASAM Triage Tool for Adults (age 21 and over) 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.
    a. 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 LOCs are not offered at that treatment provider site.
    b. If the provider site does not offer the LOC to meet the patient's 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 (age 17 and under), refer the individual to the most appropriate OP 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.
    c. Provide the individual with an appointment and/or contact information, and comply with timely access standards (see **Table 3** as follows):
        i. Identify and contact up to three (3) 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, and urgent services within 48 hours. If the recommended provisional LOC is unavailable after reasonable attempts have been made, a lower LOC may be used, as needed, in the interim.
        ii. Document all encounters where a referral contact was attempted and/or successfully made within the Referral Connection Form in the Sage system.
4. Assist the patient in successfully connecting 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 do not meet the individual's geographic and other preferences. Management of these transitions through Care Coordination is the responsibility of the last treatment provider.

Service & Bed Availability Tool and Provider Directory

SBAT is a web-based tool that provides a dashboard of available specialty County-contracted SUD services throughout LA County, including OP, Intensive Outpatient (IOP), various levels of Residential Treatment, and WM, OTP, RBH, and 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 needs 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 SBAT Survey and return their survey responses to their CPA. Once this is completed and the site is added to the SBAT, the number of intake appointments/slots and beds must be updated daily for all SAPC LOCs.

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 in the Provider Directory Survey. Information about beds/slots availability and intake appointments must be updated in the SBAT, as required, using the SBAT Provider Log-In Site: https://sapccis.ph.lacounty.gov/SBATProviderSite/Account/Login.aspx. Staff should complete the SBAT New User Form to obtain access to the SBAT Provider site: www.publichealth.lacounty.gov/sapc/NetworkProviders/Sbat/SBATUserRegistrationForm.pdf.

Intake slot and bed availability automatically revert 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 RBH 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 the SBAT reset
- When the SBAT resets to zero (0) bed availability
- One (1) hour post-reset, applicable only when an update has not yet been made
- Three (3) hours post-reset, applicable only when an update has not yet been made

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

The SBAT provider site has a slot calculator to assist in calculating intake availability. For detailed instructions about using the SBAT, see the SBAT User Manual.

Lastly, to effectively comply with the requirements of 42 CFR Part 438 to update the licensed practitioner information outlined in the SBAT, each month, this information will be updated through the monthly Network Adequacy Certification Application (NACA) submissions). For additional information, see *Network Adequacy Certification Submissions* section.

Timeliness and Access Standards

Ensuring timely access to services and engaging patients when they are ready to initiate treatment is essential to improving the specialty SUD system's outcomes. 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's 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** 15 miles from the patient's location of choice (see **Table 3**). If it is not feasible, every effort should be made to decrease the likelihood of the commute or transportation issues being 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 3

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: • 30 minutes of travel time by personal or public transportation; **or** • 15 miles from the patient's location of choice.
Screening for Provisional LOC[3]	Date of first contact (walk-ins only). Provide two (2) alternate referral agencies and connect the patient within 48 hours to the provider.
Urgent Appointment for WM	When a member is experiencing active withdrawal symptoms and their provisional or assessed LOC determination supports WM levels of 3.2, 3.7, and 4.0, it is imperative that the provider takes the following action within 48 hours: • Directly initiate the appropriate WM service (WM levels 3.2, 3.7, or 4.0); **or** • Ensure enrollment in the appropriate WM service at another provider site.
Intake Appointment – Scheduled	Immediately, but no longer than three (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 three (3) business days for OTP settings.
County Residency Eligibility Verification **Medi-Cal or DHS 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 seven (7) calendar days of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over); **or** • Within 14 calendar days of first service or first intake appointment for Youth (age 17 and under). **For patients in <u>non-residential</u> treatment settings:** • Within 30 calendar days of first service or first intake appointment for Adults (age 21 and over); **or** • Within 60 calendar days of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and all Adults (age 21 and over) who are documented as PEH[4]. For additional information, see *Initial Engagement Authorizations* section. ***If every attempt has been made to complete and finalize the ASAM Assessment and establish medical necessity during the above timeframes, the Provider must include a Progress Note detailing the reason(s) that the patient was unable to participate in an assessment within the above timeframes.***

[3] 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**).
[4] Documentation of homelessness status must be indicated in a Progress Note.

Service	Due Date
	*Providers of Residential Treatment services, except Withdrawal Management services, ensure patients are admitted to the right LOC by completing ASAM CO-Triage for Adults (age 21 and over) or Youth (age 17 and under) and Young Adults (age 18-20) Screener within 72 hours of admission.
Data Submission (CalOMS/LACPRS) & AWOL Policy	**CalOMS/LACPRS Data Submission** • Admission Data: Within seven (7) calendar days of a patient's entry into treatment • Discharge Data: On the day of discharge. • Annual Updates: Must submit no later than 12 months from the patient's admission anniversary date. Can submit as early as 60 days prior to the individual's admission date anniversary. • Must report CalOMS data for all patients, irrespective of their funding source (e.g., private pay, commercial insurance) and for all LOCs. **Absence Without Leave (AWOL) Policy:** Patients frequently leave without notice, resulting in varying AWOL policies among providers. These discrepancies often lead to delays in the admission process, particularly in submitting CalOMS/LACPRS data for subsequent providers. To enhance the efficiency of patient transitions and admissions to CalOMS across network, the following unified policy is hereby established: **For Non-OTP LOC (ASAM 0.5, OP, IOP, WM, Residential, RS):** If a patient fails to appear for the scheduled appointment, the provider should make efforts to reengage the patient before discharging the patient from CalOMS and the treatment program **within 14 calendar days from the scheduled appointment date**. However, if another provider contacts the original provider with the intention of opening a CalOMS/LACPRS record for the patient who attended their program, the original provider should promptly discharge the patient from CalOMS/LACPRS. The discharge date should correspond to the date of the patient's last face-to-face or telehealth treatment session or MAT service. They shall document the actual date of discharge as the "Discharge Process Date" in the relevant CalOMS Discharge forms. **For OTP:** If a patient fails to appear for the scheduled appointment, the provider should make efforts to reengage the patient before discharging the patient from CalOMS and the treatment program **within 30 calendar days from the scheduled appointment date**. If a patient misses their scheduled appointment, the provider should endeavor to reengage the patient within 30 calendar days before initiating the discharge process from CalOMS and the treatment program. However, if another provider contacts the original provider with the intention of opening a CalOMS record for the patient who attended their program, the original provider should promptly discharge the patient from CalOMS. The discharge date should correspond to the date of the patient's last face-to-face or telehealth treatment session. They shall document the actual date of discharge as the "Discharge Process Date" in the relevant CalOMS Discharge forms. ***For questions regarding CalOMS data submission, visit SAPC's CalOMS Resource webpage or email hoda_caloms@ph.lacounty.gov.***
Initial Problem List (for non-OTP Services) **Initial Plan (for OTP Services)**	**For patients in OP and IOP treatment settings:** • Within **30 calendar days** of first service or first intake appointment for Adults (age 21 and over); **or** • Within **60 calendar days** of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and all Adults (age 21 and over) who are documented as PEH[3]. • Must be finalized/signed by an LPHA. **For patients in Residential treatment settings:**

Service	Due Date
	• Within **7 calendar days** of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over); **or** • Within **14 calendar days** of first service or first intake appointment for Youth (age 17 and under). • Must be finalized/signed by LPHA. Treatment Plans for patients receiving OTP services prior to the completion of the ASAM Continuum or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) should describe the plan for obtaining this assessment within the required 30- or 60-day timeframe described above. *In OTP settings, the Initial Treatment Plan must be completed and signed by the patient and LPHA within **28 calendar days** of admission. If every attempt has been made to complete and obtain signatures on the Treatment Plan but circumstances do not allow for full completion, then the provider must:* • Include a Progress Note with justification detailing what prevented completion within the timeframe; • The appropriate LPHA or Medical Director must then legibly sign the Treatment Plan within **15 calendar 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 and any potential barriers. 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 to address them. The plan may be a Quality Improvement Project (QIP) (see *Quality Improvement Expectations* section) 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 4

Hours of Operation by Benefit

Benefit	Applicable LOCs	Minimum Hours of Operation*
Early Intervention Services ***For Youth (age 17 and under) and Young Adults (age 18-20)***	• Early Intervention Services (ASAM 0.5)	• Must operate at least 8 hours per day, 5 days a week, including either: ○ One 8-hour day on Saturday or Sunday; **or** ○ One 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 LOC	• Outpatient (ASAM 1.0) • Intensive Outpatient (ASAM 2.1) • Ambulatory-Withdrawal Management (Outpatient) **without** extended on-site monitoring (ASAM 1-WM)	• Must operate at least 8 hours per day, 5 days a week, including either: ○ One 8-hour day on Saturday or Sunday; **or** ○ One 4-hour day on Saturday and 4-hour day on Sunday; **and**

Benefit	Applicable LOCs	Minimum Hours of Operation*
	• Ambulatory-Withdrawal Management (Outpatient) **with** extended on-site monitoring (ASAM 2-WM)	• At least 2 days must include evening hours (5:00 p.m. – 9:00 p.m., at a minimum).
Residential and Inpatient LOC	• 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 Inpatient-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 8 hours per day, 5 days a week (including either: ○ One 8-hour day on Saturday or Sunday; **or** ○ One 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.**		

Holiday Closure Pre-Approval

The minimum and maximum number of hours per week do not change for weeks that include a Federal, State, local, or religious holiday. Providers must obtain SAPC approval when an OP facility is scheduled to be closed to observe Federal, State, local, or religious holidays. This occurs by notifying SAPC in writing annually by July 1st of each FY (changes only). New providers must provide their current FY request for holiday closures no later than 60 days from the execution of their contract. Consistent with other health services, OP sites cannot be closed for days other than actual recognized holidays (local or religious). Agencies must submit the requested closure dates in the coming calendar year at the time of a new contract and/or contract renewal, and thereafter, on December 31, for SAPC review and approval. The closure may only be on the day of the recognized Federal, State, local, or religious holiday. Requests must be emailed to SAPC-CCD at SAPCMonitoring@ph.lacounty.gov.

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

Out-of-Network Policy

Individuals may be eligible to receive medically necessary DMC-ODS services from OON providers in certain circumstances. All OON providers must meet specified requirements, including but not limited to those required by the DHCS for Medicaid Managed Care Plans. Individuals may be eligible to receive OON services under the following circumstances:

1. **Indian Health Care Provider (IHCP):** American Indian and Alaska Native (AI/AN) individuals are entitled to receive DMC-ODS services from an IHCP for whom they are eligible, whether or not the IHCP chooses to become part of the DMC-ODS network, in accordance with BHIN 22-053, as well as other Federal and State regulations.
2. **Alternate Access Standards (i.e., services outside of time/distance access standards):** When an area of the County does not fall within time/distance access standards, individuals may be approved (depending on any alternative standard that may be approved by DHCS) to receive services from an OON provider closer to them.
3. **Transition in Care:** Under certain conditions (risk of serious health, hospitalization, or institutionalization), an individual who is transferring to LA County from another DMC-ODS or State Plan DMC County is permitted to retain their current provider for a period of time as an OON provider to ensure access to services.

When a service meets one (1) of the above requirements, then the primary service connection portal staff are responsible for informing the individual about the availability of OON providers. Entryway providers include:

1. SASH
2. CENS
3. CORE Centers

Service connection portal staff will refer OON requests to SAPC's Contracts and Compliance Division (SAPC-CCD) at (626) 299-4532 or e-mail SAPCMonitoring@ph.lacounty.gov. Requests for OON providers shall not be denied based on travel time or transportation costs.

Network Adequacy Certification Submissions

Overview

DHCS sets forth the requirements for counties' certification of network adequacy. SAPC's network capacity and timely access standards are reviewed regularly 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 regulations, including those outlined in 42 CFR § 438.68 and California WIC § 14197.

The Network Adequacy Certification Tool (NACT) and the newly required 274 Standard Process are completed by DMC-ODS Counties and used by DHCS to assess whether the County Plan:

- Offers an appropriate range of services for the anticipated number of members;
- 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 members.

Notifications and Provider NACT Coordinator

Effective May 2024, as required by DHCS and outlined in BHIN 23-042, DMC-ODS counties are required to submit provider network data on a monthly basis. NACT Coordinators will be responsible for ensuring that provider information in the SAPC Network Adequacy Certification Application (NACA) is updated by the last week of each month.

SAPC will notify providers of the timelines for that annual network adequacy certification and timelines for updating any additional information using the SAPC NACA. The timeline will include training, office hours, deadlines, and other pertinent information.

Providers must inform SAPC of any updates in their NACT coordinator assignments, including the name and contact information. The NACT coordinator is the agency representative who works with SAPC to coordinate efforts to ensure accurate and timely submission. Each agency is allowed a minimum of one (1) and a maximum of three (3) NACT coordinators are allowed per agency.

Network Adequacy Certification Application

NACA is SAPC's database used to obtain and verify NACT and 274 Standard Process data. The database allows providers to review, update, and validate the required information about their organization more easily. This information includes, but is not limited to, the following:

- Organization information such as:
  - Contract effective and expiration date
  - Name of Chief Executive Officer (CEO) and Chief Financial Officer (CFO)
  - Website URL of agency (if available)
  - Primary and Secondary NACT Coordinators
- Active service location information such as:
  - General site information, site address, and hours of operation.
  - Maximum and current number of Medi-Cal members by age group and modality
  - Additional LOCs for Residential
  - ADA compliance
  - TTY/TDD (Telecommunications Device for the Deaf) equipment
  - Language capacities
  - Age groups served
- Staff (practitioner) information such as:
  - Personal identifiable information, including gender, DOB, and email address
  - Provider Type, Licensing entity and number
  - Contact effective (hire) date and expiration date (if open-ended employment, indicate N/A)
  - Age groups served
  - Practitioners' current caseload and maximum number of patients practitioners will accept by age group and modality.
  - Language capacity
  - Telehealth capabilities
  - Cultural Competency training and the number of hours completed

To ensure SAPC meets the DHCS NACT and 274 Standard Process submission deadline, providers must have completed and validated all data in the NACA by the last week of every month, unless otherwise notified by SAPC.

Initial Engagement Authorizations

SAPC covers clinically appropriate non-residential treatment services for Adults (age 21 and over) and who are not experiencing homelessness for up to 30 days following the initial date of service, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current DSM is established, and for up to 60 days for Youth (age 17 and under) and Young Adults (age 18-20), or if a provider documents that the patient is experiencing homelessness and therefore requires additional time to complete the assessment. Providers who exercise these flexibilities to initiate care prior to completing an ASAM assessment and establishing an SUD diagnosis should submit initial engagement authorizations, as described below. **The initial engagement authorization precedes but does not replace medical necessity.**

- If the provider can complete all medical necessity documentation and member has valid financial eligibility coverage, providers may **skip** this type of authorization and submit a standard authorization for the requested LOC.
- Initial Engagement Authorizations are available for non-residential and non-WM LOCs.
- Providers can request for Initial Engagement Authorization(s) **prior** to the establishment of medical necessity.
- To receive an Initial Engagement Authorization, providers must submit a Service Authorization request with a provisional LOC (i.e., ASAM 0.5, 1.0, 2.1 or OTP).
- Providers must document the medical necessity justification Progress Note that the request is for Initial Engagement Authorization.
    - For Adults (age 21 and over), providers should indicate whether this is a person who is experiencing homelessness.
    - A 30-day Initial Engagement Authorization can be given for Adults (age 21 and over) who are not experiencing homelessness.
    - A 60-day Initial Engagement Authorization can be given to:
        - Adults (age 21 and over) experiencing homelessness; **or**
        - Youth (age 17 and under); **or**
        - Young Adults (age 18-20).
- Authorization will be limited to 30 days for those utilizing the applying for Medi-Cal benefit, regardless of member's age and/or homelessness status.
    - For members who are eligible for a 60-day Initial Engagement period, the provider could submit service authorization for the remaining 30 days if:
        - Member has secondary non-DMC funding.
        - Medi-Cal is approved for covered services within the requested timeframe.
- If there is no existing EV period, a new EV period will be established and will align with the start date of the Initial Engagement Authorization.
- In cases where the EV period does not cover the entire initial engagement authorization, a new EV will be established.
- A standard authorization should be submitted after initial engagement authorization for ongoing care, including documentation of medical necessity.

  - To receive continued services following the initial engagement period, a new standard authorization must be submitted by the provider that received the initial engagement authorization.
  - A completed and finalized ASAM by LPHA (within seven [7] days for Young Adults [age 18-20] and Adults [age 21 and over] or 14 days for Youth [age 17 and under] of medical necessity authorization start date), medical necessity justification note, and diagnosis all within established time frames. For additional information, see Checklist of Required Documentation.
  - Verify Medi-Cal &/or non-DMC funding.
  - If a member meets medical necessity, authorization will be approved for the remainder of the current eligibility period.
- The Initial Engagement process can restart if the member leaves treatment prior to the establishment of medical necessity.

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, RBH, etc.).

Medical necessity to initiate non-residential services means that services are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain (California WIC § 14059.5(a)). For OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to Federal and State regulations, qualify for medical necessity determination.

Medical necessity for most LOCs (except for Withdrawal Management, RS, and Early Intervention services for Youth [age 17 and under] and Young Adults [age 18-20]) can only be determined **after** a full ASAM CONTINUUM Assessment 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. RS requires the completion of ASAM CO-Triage for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20). The ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) may also be used to establish medical necessity for Early Intervention (0.5) services.

Definition of Medical Necessity

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

1. **Diagnostic and Statistical Manual of Mental Disorders – 5th Edition – Text Revision (DSM-5-TR) diagnosis**
   - Youth (age 17 and under) and Young Adults (age 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 EPSDT criteria to ameliorate or correct a substance misuse-related condition. For additional information, see *Definition of Early Intervention Services for Youth and Young Adults* section.
- Parental consent is required for services delivered to youth under the age of 12.

- Adults (age 21 and over)
  - 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 (California WIC § 14059.5(a)); **or**
    - For OTPs, a history and physical exam conducted by an LPHA at admission, pursuant to Federal and State regulations, qualifies for the determination of medical necessity.
  - To fully establish medical necessity:
    - Meet criteria for at least one (1) 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 (1) 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 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 considers the extent and biopsychosocial severity of the various dimensions within the required full ASAM CONTINUUM Assessment or SAPC Youth ASAM assessment. Medical necessity must not be restricted to acute care and/or narrow medical concerns (such as the 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 Youth and Young Adults

Youth (age 17 and under) and Young Adults (age 18-20) in the specialty SUD system are eligible for Early Intervention services under 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 Youth (age 17 and under) and Young Adults (age 18-20) without any caps or limitations. Early intervention services are covered DMC-ODS services for members 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 OP LOC as Early Intervention services. Parental consent is required for services delivered to youth under the age of 12.

Note: Federal EPSDT requirements supersede state Medi-Cal requirements, and DMC-ODS does not override.

Assessment

Assessments are patient evaluation, measurement, and documentation 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 a standardized structure to collect necessary clinical information to make appropriate SUD LOC determinations. Assessments need to be appropriately documented (see *Clinician Consultation Services - Licensed Clinician Consultation Process - Documentation* section), reviewed, and updated on a regular basis, including at every care transition, to promote engagement and meet the patient's needs and preferences.

If the provider determines that adequate progress toward treatment goals has been made while assessing the patient, 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, whose scope of practice includes behavioral health assessments and SUD counselors, must have the appropriate experience and training before conducting screening, assessment, and medical necessity determinations. LVNs, LPTs, and LOTs practitioners' scope of practice does not include determining medical necessity for SUD treatment. Training is available via SAPC-CST; visit the SAPC Trainings and Events webpage on SAPC's website and refer to the training calendar to register for upcoming sessions.

Process for Determining Medical Necessity

Verification of Medical Necessity

Medical necessity must be verified by an LPHA via an in-person review, telehealth, or telephone with the individual conducting the assessment (e.g., SUD counselor). At a minimum, the in-person or telehealth review must involve the LPHA verifying and signing off on medical necessity in an in-person, 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 Medical Necessity Justification Progress Note within 30 calendar days of each patient's treatment admission date. The basis for 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 was reviewed. The Medical Necessity Justification Progress Note must be signed/finalized by LPHA and dated, then submitted in the patient record in Sage.

Timeliness of Medical Necessity Determination

The LPHA must determine medical necessity as outlined below:

- For patients in residential treatment settings:
  - Within **seven (7) calendar days** of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over); **or**
  - Within **14 calendar days** of first service or first intake appointment for Youth (age 17 and under).
- For patients in non-residential (e.g., OP) treatment settings:
  - Within **30 calendar days** of first service or first intake appointment for Adults (age 21 and over); **or**
  - Within **60 calendar days** of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and for those Adults (age 21 and over) who are documented as a PEH. For additional information, see *Initial Engagement Authorizations section.*

Providers need to make every effort to complete the assessment as soon as is feasible for the patient. The initial assessment with the patient shall be performed in-person 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 within the 30- or 60-day initial assessment period timeline by documenting an appropriate diagnosis code outlined in *Reimbursement and Diagnosis Codes* section below.

Providers must include a Progress Note in the individual patient record, which details:

- If applicable, reason(s) that the patient was unable to participate in an assessment within the above timeframes; **and/or**
- Basis for the status of the diagnosis and establishment of medical necessity; **and/or**
- Homelessness status if seeking up to 60 days to complete the initial assessment for non-residential LOCs.

If a patient withdraws from treatment prior to establishing a DSM diagnosis for SUDs, and later returns, the 30- to 60-day time period starts over. Assessments shall be updated as clinically appropriate and based upon medical necessity when the patient's condition changes.

Reimbursement and Diagnosis Codes

Diagnoses shall be established and updated as clinically appropriate by an LPHA within their licensed scope of practice when a member's condition changes to accurately reflect the member's needs. 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. Diagnoses are documented using a Centers for Medicare & Medicaid Services-approved International Classification of Diseases, Tenth Revision (ICD-10) diagnosis code.

Providers may use the following ICD-10 diagnosis options during the assessment phase of a member's treatment when an SUD diagnosis has yet to be established:

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all practitioners during the assessment period prior to
- diagnosis and do not require certification as, or supervision of, an LPHA. For a list of applicable diagnosis codes that can be documented by any DMC-ODS practitioner, see *Appendix D*.
- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during a member's treatment assessment phase when a diagnosis has yet to be established.
- LPHAs may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

Services for covered services are reimbursable[5] even when:

- Services are provided prior to the determination of a diagnosis or prior to the determination of whether access criteria are met;
- The assessment determines that the member does not meet the DMC-ODS access criteria after the assessment;
- Prevention, screening, assessment, treatment, or RS 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**
- The member 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 patient's treatment admission date or from the last re-verification. The justification of medical necessity must be documented in a Medical Necessity Justification Progress 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. LPHA's recommendation for continued treatment
5. Patient progress toward treatment goals

The Medical Necessity Justification Progress Note must be signed and dated by the LPHA, and 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.

[5] California WIC § 14184.402(f)

Screening Tools

Screenings are abbreviated evaluations of individuals that allow for a provisional determination about whether 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; they are meant to provide a 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 determining medical necessity for Early Intervention (ASAM 0.5) Services (using the Youth ASAM screening), RS, and WM.

Allowable Screening Tools

- Youth (age 17 and under) and Young Adults (age 18-20)
  - Parent Screener for Youth developed by SAPC (paper-based)
  - Youth and Young Adult Screener (in PCNX) required to qualify for Early Intervention Services
  - ASAM Screener for Youth and Young Adults (paper-based, use only during Sage downtime)
- Adults (age 21 and over)
  - ASAM CO-Triage Tool
  - SAPC-approved paper-based brief ASAM triage assessment (use only during Sage downtime)

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.

Minus the exceptions listed above, 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 (age 17 and under) and Young Adults (age 18-20) or the ASAM CO-Triage tool for Adults (age 21 and over) in the CENS AAR Program. Full ASAM assessments determine if an individual meets the diagnostic criteria for an SUD from the current DSM. A full ASAM assessment does not need to be repeated unless the individual's condition changes.

Allowable Full ASAM Assessment Tools

- Youth (age 17 and under)
  - SAPC Youth ASAM assessment
- Young Adults (age 18-20) and Adults (age 21 and over)
  - ASAM CONTINUUM (validated electronic tool)
  - SAPC-approved paper-based full ASAM assessment

Intake and Enrollment

Establishing 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 is important. The sections below describe essential components of the intake process.

Required Forms

Patient Rights

Patient rights ensure that all patients preserve the basic rights of independence of expression, decision, and action, as well as concern for personal dignity and human relationships. 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 feedback and input from network providers, 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 (Version 3.0, November 2023) 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 in one of the following ways and at no charge to the patient:

1. Provide a printed copy in person or mailed 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 Provider 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.

Provider Responsibilities: Notice of Significant Change to the Patient Handbook

In accordance with BHIN 23-048, current patients must be notified of any significant change to the information contained in the patient handbook at least 30 days before the effective date of the change. Significant changes are typically due to regulatory or other changes. When changes are issued, SAPC will notify providers and provide a copy of the updated document and the "Patient Handbook Notification of Significant Change Letter". Providers must take the following steps:

1. Notify all current patients regarding changes to their Patient Handbook with the stated effective date.
2. Use one (1) or more of the following methods to notify members (this does not require documentation):

a. Provide a printed copy in person or mail a copy with the "Patient Handbook Notification of Significant Change Letter" to the patient's mailing address; **and/or**
b. Email an electronic copy with the "Patient Handbook Notification of Significant Change Letter" after obtaining the patient's agreement to communicate by email; **and/or**
c. Direct the patient to the handbook published on SAPC's website and give the member the "Patient Handbook Notification of Significant Change Letter" during regularly scheduled sessions.

The Patient Orientation Video provides patients with a user-friendly summary of the Provider Handbook and a 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 the 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 offers the patient a summary of the benefits and 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 Acknowledgment Form is available using the link above or within Sage. Providers are required to do the following:

- Obtain the patient's signature upon admission (or upon completion of the orientation video within the identified timeframes).
- Provide a copy of the signed document to the patient.
- Ensure the signed document is placed in the patient record or completed in Sage. stored in Sage by:
  - For primary Sage users who do not use the document in Sage, they must upload it using the following title "Patient Handbook Summary ##-##-##)" that includes the date signed (e.g., Patient Handbook Summary (04-01-24)).

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

Notice of Privacy Practices

LA County's Notice of Privacy Practices (available in English and Spanish) explains patient rights and the treatment agency's legal duties regarding patient health information. It must be made available to all new and continuing patients upon their first service appointment.

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., SAPC Release of Information [ROI] Forms, both within the SAPC SUD provider network and with external providers). All confidentiality and ROI forms must comply with 42 CFR Part 2, HIPAA, and other pertinent regulations, including regulations governing the collection of written signatures

As indicated on the SAPC ROI Form, patients can elect to consent to share information with:

- **Option 1:** the entire SUD network of providers, **or**
- **Option 2:** only to specific SUD providers

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 SAPC ROI Form for it to be finalized.

Importantly, after the patient elects either **Option 1** or **Option 2** on the SAPC ROI Form, providers must indicate the patient's consent option by going on the Internal Client Consent Form page within Sage and selecting the provider(s) the patient is authorizing releasing information to. This process translates the patient's desires with regard to consent to release information into Sage. Similar to SAPC, 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 Internal Client Consent within Sage is completed, providers must upload the signed SAPC ROI for Sage Primary Users.

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.

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 can access the latest versions to facilitate information exchange.

Note: 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.

Why Encourage Information Sharing?

The SUD system is moving into a new era that encourages appropriate 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.

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 recommended services to give patients the information necessary to make informed decisions regarding the care being proposed.

Additionally, the intake process must include consenting patient information for information-sharing purposes. Sharing information with other SUD and physical and mental healthcare providers is essential to providing coordinated care that is in patients' best interests. As such, patients must be provided with thorough information regarding confidentiality regulations (HIPAA and 42 CFR Part 2) to obtain informed consent that balances the need for information sharing and maintains necessary privacy that supports high-quality, coordinated care.

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.

Note: Parental consent is required for services delivered to youth under the age of 12.

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 the County (e.g., denial of a requested service). Patients need to be informed about their rights and the availability of due process to file complaints/grievances and appeals, both at the level of the treatment providers and when concerns 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. For additional information, see *Complaints/Grievances and Appeals Processes* section.

Required Processes

Admission

When individuals interact with treatment providers, they may need to be entered in Sage in order to access forms such as screenings or for eventual billing purposes. Historically, Sage admissions have been limited to one episode per patient, per agency for which they are never discharged. This resulted in difficulty identifying “active patients.” Effective July 1, 2024, SAPC is introducing a new required form, the Provider Site Admission form, that will help address this gap. This form is to be completed by all treatment providers within Sage when a patient is admitted or re-admitted to a particular contracting provider site for any LOC including RBH and Recovery Services – if provided as a standalone service.

When a patient is concurrently enrolled in services, the Provider Site Admission form should be completed for each LOC. For example, if a patient is enrolled in ASAM 1.0 and RBH at the same agency, there should be two Provider Site Admission forms.

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. For additional information, see *Access to Care – Assessment* section.

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 member's care create and maintain the Problem List.

The minimum timeframes for completing, reviewing, updating, and obtaining LPHA signatures on Problem Lists depend on the LOC in which treatment is delivered. Problem List updates must be completed by practitioners delivering services to the patient whenever a problem is added, modified, or removed from the Problem List and finalized by LPHAs within the timeframes outlined in **Table 16**.

The Problem List is a list of symptoms, conditions, diagnoses, social drivers, 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 member.

The Problem List shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice.
- Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
- Current ICD-CM codes.
- Problems identified by a provider acting within their scope of practice.
- Problems or illnesses identified by the member 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.

Note: Provider staff shall add to or remove problems from the Problem List when there is a relevant change to a member's condition.

Care Planning in non-OTP Settings

Standalone Treatment Plans are no longer required in non-OTP settings. However, providers are still required to engage in care planning and document these care plans in their clinical documentation. This change is to affirm that care planning is an ongoing, interactive component of service delivery rather than a one-time event. Non-OTP providers should engage in ongoing collaboration with patients to identify and prioritize problems, explore EBPs and care options, identify action steps to address problems, and review the effectiveness of action steps ***with a patient-centered and culturally sensitive approach is an integral part of substance use treatment. The Plan of Care should be clearly documented in all clinical documentation.***

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 outlined in **Table 17**. 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 the patient's and LHPA's signatures no later than 28 days after the first service/first intake appointment. The LPHA or Medical Director must sign and print their name on the Treatment Plan within 15 days of the patient signing. These are the maximum time frames, but it's best to complete and sign the Treatment Plan as quickly and close to the treatment admission date as possible.

The minimum timeframes for Treatment Plan reviews and updates are outlined in **Table 17.** Treatment Plan updates must be completed and signed by both the patient and the LPHA, as well as the 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 the 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 goal: 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 examinations 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 12 months on file. The Physician, Nurse Practitioner (NP), or Physician Assistant (PA) is responsible for reviewing documentation of the most recent **(within the last 12 months)** physical examination within 30 calendar days of the member's admission to treatment. In accordance with CCR Title 22, if the physician is unable to acquire or review a patient's physical exam that has been conducted in the last 12 months, the **provider (registered or certified counselor or LPHA)** must include a Progress Note detailing efforts made to obtain this documentation.

If a physical examination is not on file, it must occur within 30 calendar days of the patient's admission, or it will need to be incorporated into the documented clinical notes, which 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 collect and submit CalOMS)/LACPRS data and Drug Alcohol Treatment Activity Report (DATAR).

- **CalOMS/LACPRS:** CalOMS/LACPRS includes data elements that gather information on patient characteristics, social factors, physical and mental health, employment, and criminal justice information in addition to drug use and treatment. Importantly, CalOMS/LACPRS includes data elements that serve as SUD treatment and/or recovery outcome measures, which are obtained by measuring changes in patient responses at admission and discharge.
  - **CalOMS/LACPRS admission data is required for the following:**
    - New admissions, including RS, ASAM 0.5, and "OTP – Detoxification".
    - Any changes in services/LOC
    - Any changes in location
    - **If** the movement is within the **SAME** residential facility and within residential LOCs (3.1 to 3.3. to 3.5 or reverse order), a new CalOMS Admission is not required.
    - Facilities receiving DHCS funding for SUD treatment services must report CalOMS/LACPRS for **ALL patients** regardless of the sources of funding for a patient (e.g., private pay, commercial insurance).
    - No concurrent CalOMS/LACPRS are allowed for the same type of services/LOCs.
  - **CalOMS/LACPRS Submission Deadlines**
    - Admission Data: Full (100%) data must be submitted **within seven (7) calendar days** of a patient's entry into treatment
    - Discharge data: Full (100%) data must be submitted **on the day of discharge** from the treatment.
    - Annual Updates: Full (100%) data must be submitted **no later than 12 months** from the patient's admission anniversary date. However, it can be submitted as early as 60 days before the individual's admission date anniversary.
    - Provider No Activity (PNA): If a provider plans to be temporarily inactivity or will not be in operation for the next month and thus ***not expecting any CalOMS submissions***, providers must promptly email SAPC's Health Outcomes and Data Analytics Division (SAPC-HODA) CalOMS Team at hoda_caloms@ph.lacounty.gov.

For questions regarding CalOMS/LACPRS data submission, visit SAPC's CalOMS Resources webpage or email hoda_caloms@ph.lacounty.gov

- **DATAR:** DHCS system to collect data on SUD treatment capacity and waiting lists.
  - **DATAR Overview:** Providers submit monthly data on:
    - The program's capacity to provide different types of SUD treatment to patients and how much capacity was utilized that month.
    - Summary information about the people on the waiting list who cannot be admitted due to the facility's lack of capacity.

- The DATAR weblink is https://portal.dhcs.ca.gov/

- **Submission Deadlines**
  - DATAR monthly reports are **due on the 10th of the month** for the previous month's activities.
  - On the 11th of each month, SAPC-HODA will generate the state's monthly non-compliance report and cross-reference it with the state DATAR dashboard to identify providers who have not yet submitted their DATAR data. Subsequently, SAPC-HODA will send non-compliance emails to these providers, requesting that they submit their reports **within five (5) business days.**
- **DATAR Modalities:** DATAR displays only the types of services the facility is contracted to provide. If a modality listed on the report is not contracted with SAPC, email hoda_datar@ph.lacounty.gov. For abbreviations of the types of services displayed on the DATAR form that are cross-referenced with the ASAM LOC, see **Table 5**.
- **Access to the DATAR Online Application**
  - Submit a registration form to add, update, or delete individuals.
  - DATAR User Registration Form can be downloaded at www.publichealth.lacounty.gov/sapc/register/register.htm
  - Email the completed form to hoda_datar@ph.lacounty.gov
  - The person who registers is the "DATAR analyst" and is responsible for submitting monthly reports for assigned provider numbers/facilities. Most agencies register one or two individuals for each of the agency's provider numbers.

Table 5

ASAM Level of Care vs. DATAR Modalities

ASAM	DATAR	
	Abbreviation	Description
ASAM 1.0 (Outpatient)	ODF	Outpatient Drug-Free
ASAM 2.1 (Intensive Outpatient)	IOT/DCR	Intensive Outpatient Treatment/Daycare Rehab
ASAM 3.1	RES	Residential Drug-Free
ASAM 3.3		
ASAM 3.5		
ASAM 3.2 - WM	RES DTX-NH	Residential Detoxification – Non-Hospital
ASAM 3.7 - WM	Other	Other
ASAM 4.0 - WM	Other	Other
ASAM 1 - OTP	MAINT NTP/OTP	NTP/OPT MAINT
ASAM 1 - WM Ambulatory Withdrawal Management	ODF or IOT/DCR	Outpatient Drug-Free or Intensive Outpatient Treatment/Daycare Rehab
Recovery Services	Not Applicable	Not Applicable

Service Benefit and Levels of Care

Addiction treatment is delivered across a continuum of services that reflect the severity of the SUD and the intensity of services required. One of the county's key goals is to facilitate SUD service delivery for the right service, at the right time, in the right setting, for the right duration.

Referral to a specific LOC must be based on a complete assessment of each patient. The primary goal is to place the patient in the least restrictive setting that supports the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency. Initial referrals may be accomplished with a brief screening tool. Then a more comprehensive assessment can be completed at the treatment program to confirm placement. In LA County, LOC determinations are based on the ASAM Criteria. 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.

LOC determinations begin with the full ASAM assessment, which covers patient risks, needs, strengths, skills, and resources. The ASAM assigns a rating for each of these dimensions. These ratings will help you to decide the correct LOC. If the patient has physical or mental health conditions, the first priority is to stabilize them immediately. If they have more than one physical or mental health condition, the decision about how to stabilize them should be based on the most severe of these needs. That may mean they are placed within the SUD system of care (including OTPs), 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 OP, residential, and WM services; see Table 6.

Table 6

ASAM Criteria Continuum of Care for SUD Treatment

Benefits	ASAM LOC	Description
Early Intervention Services	0.5	For Youth (age 17 and under) and Young Adults (age 18-20) who do not meet DSM criteria for an SUD but would benefit from psychoeducation and other services to correct or improve a substance-related health condition as part of the EPSDT benefits.
Outpatient	1.0	For patients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.
Intensive Outpatient	2.1	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	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	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	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.

Benefits	ASAM LOC	Description
Opioid Treatment Program	1-OTP	For patients with OUDs that require methadone or other medications for addiction treatment.
Recovery Bridge Housing	N/A	For patients who are homeless or unstably housed; and are concurrently enrolled in an OP, IOP, OTP, or Ambulatory-Withdrawal Management LOCs.
Recovery Housing	N/A	For patients who are homeless or unstably housed; and are voluntarily seeking to live in recovery-oriented housing. Residents are encouraged but not required to be concurrently enrolled in treatment.
Recovery Services	N/A	For patients in care, including CENS, 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-Withdrawal Management (Outpatient) *without* extended on-site monitoring	1-WM	For patients with mild withdrawal who require either daily or less than daily supervision in an OP setting (e.g., physician's office or clinic).
Ambulatory-Withdrawal Management (Outpatient) *with* extended on-site monitoring	2-WM	For patients with moderate withdrawal who require daytime WM and support. Includes daily assessments with daytime WM and support and supervision in a non-residential setting (e.g., day hospital).
Clinically Managed Residential-Withdrawal Management	3.2-WM	For patients with moderate withdrawal who need 24-hour support to complete WM and increase the likelihood of continuing treatment or recovery.
Medically Monitored Inpatient-Withdrawal Management	3.7-WM	For patients with severe withdrawal that require 24-hour inpatient care and medical monitoring with nursing care and physician visits.
Medically Managed Intensive Inpatient-Withdrawal Management	4-WM	For patients with severe, unstable withdrawal that requires 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability.

Source: American Society of Addiction Medicine. (2013). The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions (3rd ed.).

OTPs (also known as 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. In addition to the various Federal and State requirements that govern OTPs, the quality and resource management standards and requirements set within the SAPC's Quality Improvement Section (SAPC-QI) and SAPC-UM also pertain to OTPs.

The ASAM Criteria also outlines a continuum of care for WM for Adults (age 21 and over). Since severe withdrawal is less common in adolescents than in adults, WM for adolescents is unique. When an adolescent is in withdrawal and does not require emergency care, every effort should be made to provide WM services in the setting in which adolescent patients are receiving their SUD care. **WM for adolescent populations will be approved by SAPC on a case-by-case basis as clinically warranted and based on medical necessity.**

In cases where the recommended LOC is unavailable, which can occur for various reasons (lack of availability, funding limitations, resource constraints, etc.), providers should arrange for patients to obtain needed services in a different program.

Effectiveness and safety should be the 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 reason 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. Includes, but not limited to: individual counseling, group counseling, family therapy, patient education, psychosocial interventions, MAT services, collateral services, Care Coordination, crisis intervention, care planning, Contingency Management (CM), RS, and discharge services.

As patients transition between LOC, progress in all six (6) ASAM 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 an LPHA. LOC transitions need to be based on clinical need as the patient's condition changes, and not by the type of health coverage the patient has or what is available or more convenient for the provider.

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 of different LOCs, both within the SUD system or care and between other healthcare systems. This streamlined system of care can be achieved through Care Coordination, role induction (preparing individuals for treatment by sharing the rationale of treatment, the treatment process, and their role in that process), warm hand-offs, and assertive outreach.

Providers must also familiarize themselves with other SUD treatment requirements. These include the CCR Title 22, CCR Title 9, BHIN 17-017, the provisions of LA County's implementation of DMC-ODS and CalAIM, including SAPC Bulletins, Information Notices (INs), and contracted Specific Services to be Provided and Definitions of Services.

A brief description of funded services and LOCs are outlined below. For a detailed description of ASAM LOCs, see *The ASAM Criteria* textbook.

Care Coordination

Care Coordination, formerly referred to as Case Management, links patients with appropriate health and social services to address specific needs and achieve treatment goals. Care Coordination is a patient-centered service intended to complement clinical services, such as individual and group counseling, and 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.

Care Coordination should:

- Be patient-centered, e.g., focused on meeting the varied needs of patients;
- Provide a point of contact between SUD care, mental health care, medical care, and social services;
- Provide advocacy by acting in the patient's best interests;

- Help the patient navigate and obtain community resources, and integrate into the community after discharge from inpatient or residential services;
- Be culturally sensitive;
- Be flexible; **and**
- Anticipatory with the understanding that SUDs may be chronic and relapsing.

Care Coordination is available to all patients who enter the SUD treatment system. This service is available throughout treatment and may be continued during RS. Care Coordination services may be provided in-person, by telephone, or by telehealth.

Overview of Care Coordination and Services

The primary goal of Care Coordination is to ensure patients in SUD treatment receive the support and services necessary to be successful in meeting treatment and recovery goals. A barrier to successfully completing treatment may be a lack of communication and established referral procedures between health and social systems. Care Coordination is effective at keeping individuals in treatment and moving toward recovery by addressing other life challenges along with substance use.[6] Care Coordination services are especially important for patients with chronic health problems, CODs, PEH, or who are involved with the criminal justice system.

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.

Care coordinators must have a working knowledge of the appropriate resources to successfully link patients to services and resources (e.g., financial, medical, or community services). Services provided through Care Coordination are tailored to facilitate and track continuity of care across all systems of care.

Providers should perform three (3) core Care Coordination functions to ensure successful treatment outcomes and recovery: **Connection**, **Coordination**, and **Communication**. Although not an exhaustive list, see **Table 7** or 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 to resources and services necessary to address the problems documented on the Problem List (for non-OTP settings) or in the Treatment Plan (OTP settings). High-quality referrals and linkages require the care coordinator to play an active role in reducing access barriers and ensuring patients have "actual" access to needed services. This means going beyond providing resource lists to patients to actively establishing relationships and protocols with external providers to ensure patients will be connected with agencies and services upon referral. ***Note: Care coordinators must assist patients with applying for and maintaining health and public benefits (e.g., Medi-Cal, Minor Consent Program, GR, and LA 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.***

[6] SAMHSA. (2000). Chapter 4 – Evaluation and Quality Assurance of Case Management Services. *Treatment Improvement Protocol (TIP) Series, No. 27.* www.ncbi.nlm.nih.gov/books/NBK64527/

- **Coordination**: Care coordinators act as a bridge between health and human service providers to ensure that information is appropriately exchanged, and patients are successfully linked to needed resources/services. Activities include helping patients set up medical appointments, ensuring SUD providers at the treating agency are aware of the patient's other services, following up with patients in service transition, and notable events. For example, care coordinators should follow up with patients within a few days of an ER visit, hospital discharge, or discharge from a residential facility. Care coordinators also 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 patient's needs. Care coordinators are expected to schedule appointments and track 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. It is the responsibility of care coordinators to be a line of communication between patients and their service providers. 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 unmet, care coordinators will educate patients about their rights and advocate for them 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 and maintain health and public benefits (e.g., Medi-Cal, GR, Perinatal, Housing, etc.). ○ Assisting PEH access the Coordinated Entry System (CES), and if needed, assist in completing any intake/assessment documents such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SDAT). ○ Transferring benefits for the previous county of residence to LA County for patients who have moved. • **Community Resources** ○ Coordinating with other service providers to provide individualized connection, referral, and linkages to community-based and governmental services and resources, including direct referrals to local food banks and/or community churches for groceries and meals, clothing assistance, educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

The 3 Cs of Care Coordination
2. COORDINATION: Acting as a liaison to aid transitions of care and arranging for health services and social services. • **Transitioning between SUD LOCs** ○ Facilitating necessary transitions in SUD LOCs (e.g., from Residential to IOP treatment, OP to RS, etc.), including initiating referrals to the next LOC, and coordinating with and forwarding necessary information to the accepting treatment agency. • **Mental and Physical Health Services** ○ Coordinating care with physical health providers (including managed care health plans such as L.A. Care and Health Net), community health clinic providers, and mental health care providers to ensure a coordinated approach to whole-person care by monitoring and supporting care for other health conditions. • **Social Services** ○ Coordinating with state and County entities (DPSS, DCFS, LAC-Probation, LA 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 LA 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, DMH workers, LA Superior Courts, LAC-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 Vulnerable Groups

People with special needs require more intensive Care Coordination activities. Moreover, some County agencies (DCFS, DPSS, Law Enforcement, LA Superior Courts, 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 or mental illness, PEH, PPW, youth, and justice-involved individuals. Each population will require coordination activities to help an individual effectively navigate, access, and participate in treatment, access health and mental health services, secure housing, and obtain other supportive services.

People Experiencing Homelessness

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. Care Coordination aims 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. Care coordinators need the right

skills and adequate community knowledge to succeed. Therefore, it is highly 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 EBPs of Trauma-Informed Care, Cultural Humility, Housing First, Harm Reduction, MI, and Critical Time Intervention.

The courses address how care coordinators can apply these practices to their work with the following subpopulations: chronically homeless; single adults; families; youth; young adults; women; Lesbian, Gay Bisexual, Transgender, Queer (LGBTQ+, "+" represents other identities such as non-binary, asexual, pansexual, two-spirit, and more) people; people with disabilities; domestic violence/intimate partner violence (DV/IPV) survivors; human trafficking survivors; the aging and the elderly; incarceration/re-entry; and Veterans.

Justice-Involved

The care coordinator should communicate with criminal justice staff (e.g., LAC-Probation, LASD, LA 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 the progress of SUD treatment.
- Arrange letters, phone calls, e-mails, and/or direct in-person meetings with law enforcement agencies (LAC-Probation, LASD, and Parole) and courts (LA Superior Courts) about patient enrollment and SUD treatment progress.
- Receive health records related to in-custody treatment for individuals being released from custody, including those released from facilities outside of LAC.

Children and Family Services

For patients who participate in County-funded programs for children and family services, one (1) 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. For additional information about these populations and requirements, see the following sections: *Pregnant and Parenting Women Population*, *Family Programs – DPSS Programs – CalWORKs*, and *Family Programs – DCFS Programs – Family Dependency Drug Court Program*.

Care Coordination: 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 match the DMC-ODS enrollment criteria.

Staffing Requirement

The care coordinator must be a registered/certified SUD counselor and/or LPHA.

Documentation

Planning and documentation are important to a structured and integrated Care Coordination model. Following the ASAM CONTINUUM or SAPC Youth ASAM assessment, a care coordinator must discuss the results and collaborate with the patient to develop a plan of action that includes the patient's Care Coordination needs. The plan should address the problems documented on the patient's Problem List and Progress Notes in non-OTP settings, or Treatment Plan and Progress Notes in OTP settings. For CENS RS, see CENS Standards and Practices.

The Care Coordination plan should include tracking key service components, including Care Coordination needs, Connection/Coordination/Communication activities, and advocacy efforts. Progress 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 that addresses the problems listed on the Problem List and follow action steps documented in the plan section of Progress Notes (non-OTP settings), or Treatment Plan (OTP settings), and monitor the patient's progress.

Care Coordination should be documented in the Progress Notes and should include a description of the patient's prioritized service needs. In non-OTP settings, action steps to address the patient's prioritized needs should be documented in Progress Notes. In OTP settings, the Treatment Plan should include a problem statement, long-term goals, short-term goals in SMART format, action steps, desired outcomes, and target completion dates. When appropriate, the Progress Notes (non-OTP settings) or the Treatment Plan (OTP settings) should describe barriers, ways to handle anticipated complications, or alternative plans to achieve stated objectives. Providers should obtain an ROI documented on SAPC-approved ROI forms whenever a Care Coordination activity requires releasing any patient information, including the patient's enrollment in an SUD program.

Treatment Plan

Evaluating Care Coordination needs can be documented under Assessment, and discussing the Care Coordination component of the Plan of Care can be documented under Individual Counseling. Updating Problem Lists (non-OTP) or Treatment Plans (OTP settings) is not a Care Coordination activity and should be billed under the Treatment Planning billing code. Billing under Care Coordination requires the Care Coordinator to engage in a Care Coordination activity. A Care Coordination activity includes coordination with a person, agency, and/or service to connect the patient to a service or resource not being provided to the patient by the agency that would support the patient in their SUD treatment and recovery goals.

Service Hour Requirements

For most LOCs, Care Coordination services can be billed separately from other services. The only exceptions are WM Levels 3.7, and 4.0, where the benefit is covered by the day 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 patient confidentiality as outlined in 42 CFR Part 2; 42 CFR Part 438; HIPAA; CCR Title 9, Chapter 8: Certification of Alcohol and Other Drug Counselors; and Title 22 CCR § 51341.1 - Drug Medi-Cal Substance Use Disorder Services, and appropriate ROI should be obtained for care coordination that accords with these regulations.

Medi-Cal Peer Support Specialist Certification Program

Since FY22-23, SAPC opted in to participate in the Medi-Cal Peer Support Specialist Certification Program, a statewide initiative designed to certify peer support specialists. In alignment with SB 803, DHCS launched this program to officially recognize Certified Medi-Cal Peer Support Specialists (CMPSS), also referred to as "Certified Peers," as a new provider type. The program also established Certified Medi-Cal Peer Support Services (commonly known as Peer Support Services or PSS) as a new Medi-Cal reimbursable benefit under the SMHS and DMC-ODS programs.

Additionally, DHCS established the standards for certifying peer support specialists across California and designated the California Mental Health Services Authority (CalMHSA) as the sole certifying entity. CalMHSA is responsible for implementing the Medi-Cal Peer Support Specialist Certification Program, which outlines the eligibility, training, and examination requirements for peer support specialists to become Certified Peers.

For additional information regarding the Medi-Cal Peer Support Specialist Certification Program, see BHIN 21-041 or visit CalMHSA's Medi-Cal Peer Support Specialist Certification Program website.

Certified Peers

Certified Peers provide non-clinical, recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, natural supports, and are trauma-aware. Certification under this policy is designed for individuals who are 18 years of age or older and self-identify as having lived experience with the process of recovering from mental illness, SUD, or both. This includes individuals who have either received these services themselves or are parents or family members of consumers. To be certified practitioners in California, Certified Peers must master the 17 Core Competencies and adhere to the Code of Ethics for Certified Medi-Cal Peer Support Specialists.

Certification Fees

To provide DMC-ODS reimbursable PSS, individuals must complete CalMHSA's Medi-Cal Peer Support Specialist Certification Program. CalMHSA sets all certification guidelines and associated fees. For additional information on certification fees, see CalMHSA's Fee Schedule webpage.

Initial Certification

To become a Certified Peer, an individual must meet all of the following qualifications:

1. Be at least 18 years of age.
2. Possess a high school diploma or equivalent degree.
3. Be self-identified as having experience with the process of recovery from a mental illness or SUD, either as a consumer of these services or as the parent, caregiver, or family member of a consumer.
4. Be willing to share their experience.
5. Have a strong dedication to recovery.
6. Agree, in writing, to adhere to the Code of Ethics.
7. Successfully complete the required Medi-Cal Peer Support Specialist 80-hour training through a CalMHSA approved training entity.
8. Pass the certification examination administered by CalMHSA.

Application Process Overview

Candidates interested in becoming a Certified Peer must register to create an account and submit an application to CalMHSA. Candidates will need scanned copies of the following documents prior to beginning the application:

1. Government-issued ID/License/Passport that shows you are over 18 years of age (Note: First and last name on the application must match exactly as it appears on your uploaded government-issued ID)
2. High school diploma/equivalency or other advanced degree

CalMHSA will review the application, which may take up to 30 days. If any revisions are needed, CalMHSA will email instructions on how to update the application. Incomplete applications will be held for 90 days, and if still incomplete after that time, the application will be voided, fees will be forfeited, and will require submission of a new application, documentation, and new fees.

Once the application is approved, candidates must complete the Medi-Cal Peer Support Specialist 80-Hour Training from a CalMHSA approved training entity. After completion, candidates will upload their certificate. CalMHSA will then review the certificate and notify candidates of their application status within 14 days.

Once the training certificate is approved, eligible candidates will receive an email from CalMHSA, allowing them to schedule and take the Certification Exam within 14 days of paying the exam fee.

CalMHSA will send a notification email 7-14 days after the exam, providing the exam status and instructions on accessing the certification document. If a candidate does not pass the exam, they can initiate an exam retake request.

For additional information, visit CalMHSA's Initial Certification Requirements webpage and CalMHSA's How to Apply webpage.

80-Hour Training for Certification

See *Training for Peer Support Specialists* section.

Certification Exam

The Medi-Cal Peer Support Specialist Certification Exam is only offered by CalMHSA. The exam is a 2.5-hour, 120-item multiple-choice exam. It is available in English, Spanish, Chinese, Hindi, Japanese, Korean, Russian, and Vietnamese. It can be taken through live online proctoring or at in-person testing centers in California. The online exam is delivered via Pearson VUE's online delivery system called OnVUE. To aid in exam preparation, a test preparation guide and day of exam preparation tips are available on CalMHSA's website.

Candidates requiring exam accommodations should refer to CalMHSA's Exam Accommodations webpage. The items listed on the Exam Comfort Aid List do not require an Exam Accommodation Request. However, for requests not included in the list, candidates must complete the Exam Accommodations Form. This form must be submitted to CalMHSA prior to registering for the exam to ensure that accommodation needs are duly considered. CalMHSA will review all requests for accommodations and will provide a response within 30 days.

Certified Medi-Cal Peer candidates will receive an email notification regarding exam results within 7-14 days after completion. If a candidate does not pass the exam, CalMHSA will send information on how to retake the exam via email. Candidates can take the certification exam up to three (3) times during a 12-month period. Each retake requires a new retake request, and associated fees must be submitted to CalMHSA. For additional information, visit CalMHSA's Exam webpage.

Certification Registry

Once an individual successfully completes all the requirements outlined in the Medi-Cal Peer Support Specialist Certification Program, they will be awarded a certificate. Their certification number will be accessible to the public via the CalMHSA Medi-Cal Peer Support Specialist Certification Registry.

Certified Peers are required to maintain an active certification in order to provide DMC-ODS reimbursable PSS. Certifications are valid for two (2) years from the issue date.

Certification Renewal

See *Workforce – Certified Peers – Certification Renewal* section.

Supervision of Certified Peers

Supervision is a crucial component in delivering high-quality behavioral health services, professional development, and overall support. As outlined in BHIN 22-018, a supervisor must meet applicable California state requirements, including completing the Medi-Cal Peer Support Specialist Supervisor Training within 60 days of beginning supervision of Certified Peers.

As with all SUD services, PSS must be provided as a component of the individualized Plan of Care developed for each patient by an LPHA. While the LPHA directing services per an individualized Plan of Care assumes the overall responsibility for the PSS provided to each patient, the LPHA is not required to be present at the time of service delivery. The direct supervisors of Certified Peers do not need to be LPHAs. Using Certified Peers as supervisors is highly encouraged. Opportunities for career advancement are important as the Certified Peer workforce is established.

Certified Peers must provide services under the direction and supervision of an individual who meets at least one (1) of the below qualifications:

1. Have a Medi-Cal Peer Support Specialist Certification, two (2) years of experience working in the behavioral health system, and completed an approved supervisory training; **or**
2. Be a non-peer behavioral health professional (including registered and certified SUD counselor), two (2) years of experience working in the behavioral health system, and completed an approved supervisory training; **or**
3. Have a high school diploma or GED, four (4) years of behavioral health direct service experience that may include peer support services, and completed an approved supervisory training.

In accordance with the State of California licensure requirements and listed in the California Medicaid State Plan as a qualified DMC-ODS provider, LPHAs must be licensed, waivered, certified, or registered.

For additional guidance regarding Certified Peer Supervisor standards, see BHIN 21-041. For additional information on the Medi-Cal Peer Support Specialist Supervisor Training, see *Training for Supervisors* section below.

Peer Trainings

Training for Peer Support Specialists

The Medi-Cal Peer Support Specialist training is an 80-hour training that covers 17 Core Competencies and the Code of Ethics for Certified Medi-Cal Peer Support Specialists in California. The training is designed to give Certified Peer candidates the tools to support clients through their recovery process.

Training from an approved provider is mandatory for all Initial Certification applicants. Certificates for Medi-Cal Peer Support Specialist 80-Hour Training issued by a CalMHSA-approved provider are valid for two (2) years from the date of completion and certificate issuance. Training options include virtual, in-person, or hybrid. Training costs vary by approved vendors. For additional information, visit CalMHSA's Training for Medi-Cal Peer Support Specialists webpage.

Training Specializations

There are four (4) areas of specialization for certified Medi-Cal Peer Support Specialists. These specializations focus on additional training that builds on the knowledge, skills, and abilities of Medi-Cal Peer Support Specialists. The training hours and core competencies covered vary by specialization. The four (4) areas of specialization are:

- Parent, Caregiver, and Family Member Peer;
- Peer Services in Crisis Care;
- Peer Services for Unhoused; **and**
- Peer Services for Justice-Involved.

These areas of specialization are not required for certification as a Medi-Cal Peer Support Specialist. For additional information, visit CalMHSA's Training for Specializations webpage.

Training for Supervisors

CalMHSA offers the Medi-Cal Peer Support Specialist Supervisor Training at no cost. The one (1) hour training is based on SAMHSA's best practices for supervising peer support specialists. Objectives include identifying supervisor qualifications, understanding peer work principles and competencies, modeling recovery-oriented supervision, and accessing resources to improve supervisory skills. CalMHSA will accept the certificate of completion towards the Continuing Education (CE) requirements for Medi-Cal Peer Support Specialist Certification renewal process. For additional information, visit CalMHSA's Training for Supervisors webpage.

Scope of Practice for Certified Peers

Peer Support Services

PSS are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching designed to set and make progress toward recovery goals. These services aim to prevent relapse, empower individuals through strength-based coaching, provide support linkages to community resources, and educate members and their families about their conditions and recovery.

PSS may be provided to the individual or significant support person and may be provided in a clinical or non-clinical treatment setting, with or without the member present. They may be delivered in-person or via telephone, telehealth, or at approved FBS sites.

For PSS to be reimbursable, they must be provided by a Certified Peer. Per DHCS, Certified Peers' scope of practice is limited to the services outlined in the section below and based on a Plan of Care approved by an LPHA or a Certified Peer Supervisor. The Plan of Care must be submitted in accordance with the guidelines outlined in *Sage for Certified Peers – Documentation for PSS* section. In residential treatment settings, Peer Support Services would count toward weekly therapeutic hours. For additional guidance, visit SAPC's Manuals, Bulletins, and Forms webpage, under the Bulletins tab for the latest version of the Provider Staffing Guidelines.

In accordance with BHIN 22-026, Certified Peers can utilize the following codes to provide Medi-Cal reimbursable PSS:

- **H0025 Behavioral Health Prevention Education Services**
  - **Educational Skill Building Groups:** Providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills to help members achieve desired outcomes. These groups promote skill building for members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- **H0038 Self-Help/Peer Services**
  - **Engagement:** Activities and coaching led by Peer Support Specialists to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions between LOCs and supporting members in developing their own recovery goals and processes.

- **Therapeutic Activity:** A structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; distribution of naloxone or other overdose prevention supplies in accordance with established distribution policies; and collaboration with the members and others providing care or support to the member, family members, or significant support persons.

Contingency Management Pilot Program for Certified Peers

In accordance with BHIN 22-056, Certified Peers can also serve as a CM Coordinator at a participating DMC-ODS provider site and administer CM services. The CM Coordinator will be the main point of contact for those in the Recovery Incentives Pilot Program, which ends on December 31, 2026. Certified Peers can utilize the following code to provide Medi-Cal reimbursable CM:

- **H0050 HF Alcohol and/or drug services, brief intervention**
  - HF is the modifier used to identify when CM Services were provided.

Reimbursement Rates for Certified Peers

For additional information on billing processes and rates, see SAPC Bulletin 24-04: Fiscal Year 2024-2025 Rates and Payment Policy Updates.

Sage for Certified Peers

Certified Peer User Enrollment

Certified Peers will need access to Sage to document reimbursable services. For primary Sage users, SAPC has developed two (2) different access levels for Certified Peers, as indicated below. Secondary Sage users must use the Clinical Visible-Only access group indicated below.

Certified Peer Support Specialist – This access group allows Certified Peer staff to conduct non-clinical treatment services, including Educational Skill Building, Engagement Services, Therapeutic Activity, Plans of Care, and documentation of services.

1. **Financial + Certified Peer Support Specialist:** This access group is intended for Certified Peers who may also submit billing claims.
2. **Clinical Visible-Only:** This access group is intended for Secondary Sage users who do not need to enter data directly but need to be "visible" in Sage for billing purposes.

For additional information on accessing Sage, see Sage User Onboarding/Offboarding and Privilege Management.

Documentation for PSS

PSS must be based on an approved, individualized Plan of Care to be reimbursable. Certified Peers can develop a Plan of Care, but it must be reviewed and signed by an LPHA **or** a Certified Peer Supervisor.

The Plan of Care shall be documented:

- Using Plan of Care service type option on the Progress Note form in Sage for a primary Sage user; **or**
- Within a SAPC-approved EHR Progress Note form for a secondary Sage user.

And approved/signed by an LPHA **or** a Certified Peer Supervisor within the time frames listed below:

- For patients in non-residential treatment settings:
  - Within 30 calendar days of first service or first intake appointment for Adults (age 21 and over); **or**
  - Within 60 calendar days of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and all Adults (age 21 and over) who are documented as a PEH.
- For patients in residential treatment settings:
  - Within seven (7) calendar days of first service or first intake appointment in residential settings for Young Adults (age 18-20) and Adults (age 21 and over); **or**
  - Within 14 calendar days of first service or first intake appointment in residential settings for Youth (age 17 and under).

The Plan of Care must be reviewed and updated when clinically appropriate to reflect significant changes in the patient's treatment and signed by an LPHA **or** a Certified Peer Supervisor:

- No later than every 90 calendar days after the initial Plan of Care approval in OP settings, **or**
- No later than every 30 calendar days after the initial Plan of Care approval in residential settings.

Plan of Care Guidelines for PSS

The documented Plan of Care must be developed with patient involvement and include the patient's long- and short-term goals. The Progress Note needs to specify when there's an updated Plan of Care, or a review of the Plan of Care. Providers can adapt the guidelines below in accordance with their current documentation formatting. In addition, PSS must be documented in a Progress Note within three (3) business days. For documentation examples, see SAPC Peer Support Services Guide.

These guidelines are intended to be used within a Progress Note with "Peer Support Services – Plan of Care" Service Type. Below are the minimum requirements of what to include in a Plan of Care.

1. Indicate if this is a new Plan of Care, updated plan, or review of an existing Plan of Care
2. Long-term Goals
3. Short-term Goals (in SMART format)
4. Indicate that the patient participated in and agreed with the Plan of Care.
5. Signatures: Certified Peer and LPHA **or** Certified Peer Supervisor

Complaints, Appeals, and Actions for PSS

DHCS will conduct a review of a Medi-Cal Peer Support Specialist Certification Program upon receipt of a complaint regarding the violation of an applicable law or guidance. Complaints may only be submitted by those who have applied for Medi-Cal Peer Support Specialist Certification, their designated representative, a staff member from the Medi-Cal Peer Support Specialist Certification Program, or a county staff member.

Complaints regarding Medi-Cal Peer Support Specialist Certification Programs may be submitted to DHCS at peers@dhcs.ca.gov or submitted by mail to:

Department of Health Care Services
Behavioral Health MS 2710
P.O. Box 997413
Sacramento, CA 95899-7413.

CalMHSA will investigate all complaints made against Certified Peers and approved training entities. CalMHSA will also review:

- Appeals related to denials of application for certification,
- Suspension or revocation of a certification,
- Denials for certification renewal,
- Denials for training provider applications.

CalMHSA will complete the investigation of a complaint within 90 days upon receipt of a complaint. Information on how to file a complaint will become available on the CalMHSA Certification Registry. The registry will post updates regarding complaints about a Certified Peer within 72 hours of the change in certification status.

For additional information regarding CalMHSA's complaints, appeals, and actions, see CalMHSA Medi-Cal Peer Support Specialist Certification – Guidelines, Standards & Procedure Manual.

In addition to CalMHSA's process, complaints regarding agencies delivering PSS or a Certified Peer can be submitted directly to SAPC at SAPCMonitoring@ph.lacounty.gov.

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

Early Intervention services are covered DMC services under EPSDT (ASAM 0.5) for Youth (age 17 and under) and Young Adults (age 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 an SUD) and would benefit from psychoeducation (using the "*Healthy YOUth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth*" Curriculum) and any other services covered under the OP 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 an SUD condition. The Early Intervention services benefit also includes receipt of any DMC reimbursable service available in OP settings. For a description of service components available in Early Intervention and OP treatment settings, see *Early Intervention and Treatment Service Components* section.

Early Intervention services are provided in an OP modality and must be available as needed based on individual clinical needs, even if the member is not participating in the full array of OP treatment services. A full assessment utilizing the ASAM criteria is not required for a DMC member 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". For additional requirements, see Checklist of Required Documentation for Utilization Management.

While an 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." ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances," or ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out." If the member meets the diagnostic criteria for an SUD, a full ASAM assessment must be performed, and the member must receive a referral to the appropriate LOC indicated by the assessment.

In collaboration with Azusa Pacific University, SAPC developed the early intervention curriculum. It 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 well-being. The curriculum is the main psychoeducation component to be delivered under Early Intervention services. Youth and adult treatment providers must have completed the required training on 1) the early intervention curriculum entitled "*Healthy YOUth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth*" and 2) the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) by June 30, 2023, in order to submit claims for Early Intervention Services provided.

ASAM 0.5: Service Requirements

Treatment services at this LOC include screening, assessment/intake (if applicable), care planning, and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including the provision of, or referral to MAT for alcohol and opioid users, unless patient refusal is documented in Progress Notes), alcohol/drug testing, RS, 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 provided in an environment that facilitates recovery, directed toward 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.

ASAM 1.0: Service Requirements

Treatment services at this LOC include screening, assessment/intake care planning, completing the 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 those with AUD and/or OUD, unless patient refusal is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Services may be provided up to:

- Six (6) hours per week for Youth (age 17 and under)
- Nine (9) hours per week for Young Adults (age 18-20) and Adults (age 21 and over)

Services may exceed the maximum based on individual clinical needs. 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. For additional information, see *Service Delivery Options* section.

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

Intensive Outpatient Treatment (ASAM 2.1)

ASAM 2.1 treatment services are appropriate for patients with minimal risk regarding acute intoxication/withdrawal potential, biomedical conditions, and mental health conditions. They are also 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.

ASAM 2.1: Service Requirements

Treatment services at this LOC include screening assessment/intake, care 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 those with AUD and/or OUD, unless patient refusal is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Treatment services must be provided between:

- Six (6) and 19 hours per week for Youth (age 17 and under); 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 of 19 hours and are submitted under DMC claims.
- Nine (9) and 19 hours per week for Young Adults (age 18-20) and Adults (age 21 and over); 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 6-9 hours of service per week, they should be stepped down to a lower LOC (e.g., OP). Reviews occur to determine if patients are served in the appropriate LOC and if reimbursement needs to be modified (i.e., reduced to the OP rate) based on a consistently insufficient number of service hours. Services may be provided in-person or via telehealth for

individuals who consent to receive SUD services. Some services may be provided via telephone. For additional information, see *Service Delivery Options* section.

Providers are required to either offer MAT directly or have effective referral mechanisms in place for 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. For additional information, see *Service Delivery Options* section. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria.

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. 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 for the most clinically appropriate MAT services.

As outlined in CCR Title 9, Chapter 5 - Licensure of Residential Alcoholism or Drug Abuse Recovery or Treatment Facilities: Every resident shall be tested for tuberculosis (TB) under licensed medical supervision six (6) months prior to or 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 does not include general primary medical care or medical services required to be performed in a licensed health facility as defined by California HSC § 1200 or California HSC § 1250.

Low-Intensity Residential Services (ASAM 3.1)

ASAM 3.1 Residential services are 24-hour non-medical, short-term rehabilitation services for patients with an SUD diagnosis. It is appropriate for patients needing time and structure to practice and integrate their recovery and coping skills in a supportive residential environment. IMS may be approved by the State to allow for MAT, including WM, to be provided in residential settings. The facility must have a DHCS LOC Certification to deliver care under this designation.

ASAM 3.1: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care 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 users, unless patient refusal is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Patients enrolled in Medi-Cal cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS' policy on transferring GR and/or CalFresh benefits to a residential provider. While this policy is under review, SAPC residential providers may continue collecting GR/CalFresh benefits from residential patients. Those fees must be reported to SAPC in 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 (1) 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, Care planning, Discharge Services, and Care Coordination) or **four (4) to six (6) 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 two (2) hours weekly for both on-site and off-site services)**.

For a detailed list of approved services at Residential Treatment Programs, see SAPC Bulletin 18-13.

If the patient receives less than ten (10) hours or 40 units of services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the patient must be moved to a lower LOC, and no further reimbursement will be allowed.

When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress 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 pre-authorized by SAPC, and patients must meet medical necessity requirements. For additional information, see **Table 14**.

High-Intensity Residential Services: Population Specific (ASAM 3.3)

ASAM 3.3 Residential services are 24-hour non-medical short-term rehabilitation services for patients with an SUD diagnosis. They are appropriate for patients with functional limitations that are primarily cognitive, who require a slower pace of treatment, and who 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 DHCS LOC Certification to deliver care under this designation.

The state may approve IMS to allow the provision of MAT and IMS, including WM, in residential settings.

Level 3.3 services are available to Young Adults (age 18-20) and Adults (age 21 and over). ASAM Level 3.5 (High-Intensity Residential) is recommended for Youth (age 17 and under) requiring high-intensity clinical services in a manner that meets functional limitations.

ASAM 3.3: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care 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 those with AUD and/or OUD disorders, unless patient refusal is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Patients enrolled in Medi-Cal cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS' policy on transferring GR 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 collecting GR/CalFresh benefits from residential patients. Those fees must be reported to SAPC in 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 (1) 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, care planning, Discharge Services, and Care Coordination), or **four (4) to six (6) 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 two (2) hours weekly for both on-site and off-site services)**.

For a detailed list of approved services at Residential Treatment Programs, see SAPC Bulletin 18-13.

If the patient receives less than 12 hours or 48 units of services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the patient must be moved to a lower LOC, and no further reimbursement will be allowed.

When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress 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 pre-authorized by SAPC, and patients must meet medical necessity requirements. For additional information, see **Table 14**.

High-Intensity Residential Services: Non-Population Specific (ASAM 3.5)

ASAM 3.5 Residential services are 24-hour non-medical short-term rehabilitation services for patients with an 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 DHCS LOC Certification to deliver care under this designation.

The state may approve IMS to allow the provision of MAT, including WM, in residential settings.

ASAM 3.5: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care 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 those with AUD and/or OUD disorders, unless patient refusal is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Patients enrolled in Medi-Cal cannot be charged fees for room and board and/or treatment services. However, SAPC is reviewing DPSS's policy on transferring GR 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 collecting GR/CalFresh benefits from residential patients. Those fees must be reported to SAPC in 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 (1) 15-minute unit** of Clinical Services is required for individual-based services (intake and ASAM assessment, individual counseling, family therapy, collateral service, crisis intervention, care planning, discharge services, and Care Coordination), or **four (4) to six (6) 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 two (2) hours weekly for both on-site and off-site services)**.

For a detailed list of approved services at Residential Treatment Programs, see SAPC Bulletin 18-13.

If the patient receives less than 11 hours or 44 units of services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the patient must be moved to a lower LOC, and no further reimbursement will be allowed.

When services provided are less than the minimum, it must be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress 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 pre-authorized by SAPC, and patients must meet medical necessity requirements. For additional information, see **Table 14**.

Withdrawal Management

WM, also known as detoxification or detox, is a set of treatment interventions aimed at medical and clinical management of acute intoxication and withdrawal from alcohol and other substances. WM services provide the appropriate level of medical and clinical support to allow for patient safety during the withdrawal period, which then allows the patient and treatment team to work together to determine the best ongoing treatment strategy. WM services may be provided in an OP, residential, or inpatient setting. Members who receive WM in a residential setting must be residents of that facility. Inpatient treatment services will primarily be provided in-person. Telehealth and telephone services, when provided, shall supplement, not replace the in-person service. For additional information, see *Service Delivery Options* section

WM is an opportunity to initiate abstinence and begin substance use treatment. The primary goal is patient safety to minimize the health risks associated with withdrawal. All SUD patients, particularly those with

sedative, AUD, and OUDs, should be considered for WM and have access to these essential treatment services. Whether or not the patient's goal includes sustained abstinence from all substances, the WM services must be provided to patients with medical necessity, and patients' WM services should be offered referral for ongoing care.

The science of comprehensive and effective SUD treatment supports the use of medications for withdrawal and the use of medications that treat SUD during WM and in all other LOCs where patients with SUDs are treated. Research has consistently shown that the use of medications for withdrawal and MAT help to improve patient engagement and SUD outcomes, especially when combined with other evidence-based interventions. Providers are required to either offer MAT directly or have effective referral mechanisms to the most clinically appropriate MAT services in place. 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:

- **Intake:** The intake process should, at minimum, include a thorough evaluation, establishing the diagnosis of substance withdrawal syndrome, and formalizing an individual assessment; it may also include a physical exam and/or laboratory testing.
- **Observation:** At a minimum, a patient must be monitored during withdrawal as frequently as deemed appropriate based on the patient's unique presentation. This may include, but is not limited to, monitoring the patient's health status.
- **Medication Services:** Medications should be offered to all patients for whom there are medication options to help manage withdrawal and help stabilize SUD (e.g., MAT).
- **Documentation of 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).
- **Discharge Services:** 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 8

Withdrawal Management

Treatment/Service Type	ASAM LOC	Description
Ambulatory-Withdrawal Management (Outpatient) without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily OP supervision.
Ambulatory-Withdrawal Management (Outpatient) with extended on-site monitoring	2-WM	Moderate withdrawal with daytime OP WM, support, and supervision in a non-residential setting.
Clinically Managed Residential-Withdrawal Management	3.2-WM	Moderate withdrawal that is not manageable in OP settings and needs 24-hour support which can be managed by non-medical staff) to complete WM and increase likelihood of continuing treatment or recovery.

Treatment/Service Type	ASAM LOC	Description
Medically Managed Inpatient-Withdrawal Management	3.7-WM	Severe withdrawal in addition to medical or psychiatric co-morbidities; needs 24-hour nursing care and physician visits as needed; unlikely to complete WM without medical monitoring.
Medically Managed Intensive Inpatient-Withdrawal Management	4-WM	Severe, unstable withdrawal with documented risk for acute medical complications requiring 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability.

WM 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

WM: Assessment

- Substance withdrawal and the patient's related needs must be assessed 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 includes a determination of anticipated risks that will inform the need for WM, the intensity of services needed, and the most appropriate treatment setting.
- Best practice would include using an age-appropriate assessment tool (ASAM Continuum or SAPC Youth Full Assessment), which should result in a determination about whether WM services are necessary. If additional clinical assessment information is needed for Dimension 1 (withdrawal potential), additional withdrawal assessment tools such as the Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opioid Withdrawal Scale (COWS) may be used.
- If the assessment indicates WM is needed, qualified SUD treatment providers must determine the most appropriate LOC (ambulatory WM vs. residential WM vs. inpatient WM) and explain the WM options, including medication, available to the patient.
- Individuals recommended for ambulatory (OP) 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 situation of the individual, the severity of symptoms, history of previous withdrawal episodes, and patient preference.
- If the patient needs a LOC not provided at the current location, SUD treatment providers have two options:
  - Call the SASH to schedule an intake appointment with another agency; **or**
  - 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 rescheduled 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.

WM: Stabilization

Following a comprehensive assessment of WM needs, the stabilization period focuses on developing a Plan of Care to effectively manage the patient's withdrawal symptoms while also considering the potential general medical and psychiatric complications that may accompany withdrawal.

- The SUD treatment team 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.
- Stabilization should consist of a combination of psychosocial intervention and medications, when appropriate.
- If 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 important because it 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 medication, dose, and route of administration.
- Although not all individuals will be in a state of mind to engage in behavioral/talk therapy during WM, psychosocial interventions are an important component of the services that should be offered in the WM setting. MI, for example, can be skillfully used during WM to better understand patients' readiness to change and help them progress along the readiness continuum to encourage them to continue treatment after withdrawal symptoms are addressed.
- Throughout WM, qualified staff must continually evaluate the patient for changes in their condition and health status.
- The treatment agency must assign the patient a care coordinator to assist them with transitioning to an appropriate LOC.

WM: 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, the fact that WM is typically only the first component of treatment, and the Care Coordination priorities and activities outlined in *Eligibility Verification – Transitions in Care section.*

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

WM for Youth (age 17 and under)

WM is generally not indicated for youth because they typically have not consumed substances for sufficient duration, intensity, or frequency to cause significant withdrawal symptoms. However, instances, where WM for Youth (17 and under) is clinically indicated, will be authorized by SAPC on a case-by-case basis as clinically warranted, based on medical necessity, and consistent with EPSDT requirements. Parental consent is required for services delivered to youth under the age of 12.

Ambulatory-Withdrawal Management

Ambulatory-Withdrawal Management without extended on-site monitoring (ASAM 1-WM)

ASAM 1-WM ambulatory services are provided in OP settings for patients with mild alcohol, sedative, and/or opioid withdrawal symptoms. Patients treated in this setting should require daily or less than daily OP supervision and are generally likely to complete WM and continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an OP 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 (prior to services being provided) but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to an appropriate LOC, as clinically indicated.

ASAM 1-WM: Staffing

ASAM 1-WM services are staffed by interdisciplinary staff that are appropriately trained and credentialed to assess the patient and manage mild withdrawal. 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 managed in an OP setting.

ASAM 1-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, 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 those with AUD and/or OUD, unless patient refusal is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Ambulatory-Withdrawal Management with extended on-site monitoring (ASAM 2-WM)

ASAM 2-WM ambulatory services are provided in OP settings for patients with mild-moderate alcohol, sedative, and/or opioid withdrawal symptoms. Patients treated in this setting require daily OP supervision and serial medical assessments. They are likely to complete WM and to continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an OP setting. Patients should have access to psychological and psychiatric consultation when needed. Patients should be at lower risk for withdrawal complications and have a greater likelihood of successful WM than individuals recommended for WM 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.

ASAM 2-WM: Staffing

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

ASAM 2-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, 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 those with AUDs and/or OUDs unless patient refusal is documented in Progress Notes), alcohol/drug testing, RS, 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 alcohol, sedative, and/or opioid withdrawal who need 24-hour support to successfully complete WM. IMS may be approved by the State to allow for medication treatments and IMS, including WM, 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 (ASAM 1-WM and 2-WM), but less need for medical supervision and support than is provided in inpatient WM settings (ASAM 3.7-WM and 4.0-WM).

ASAM 3.2-WM: 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 from opioids, alcohol, or sedatives. Withdrawal from stimulants is not an indication of WM. Although it is not a requirement that a physician/prescriber is always on-site, medical evaluation and consultation are available 24 hours a day. In addition, the facility requires 24-hour care with trained personnel, including awake staff on the overnight shift to address patient needs. The additional training required for staff who monitor or supervise the provision of WM services includes: certification in cardiopulmonary resuscitation and first aid, training in the use of naloxone, six hours of orientation for providing, monitoring, and supervising WM services, repeated orientation training within 14 days for returning staff following a 180 continuous day break in employment, eight (8) hours of training annually that covers the needs of residents who receive WM services, training documentation must be maintained in personnel records. Personnel training shall be implemented and maintained by the licensee pursuant to Title 9 CCR § 10564(k). It is recommended that a licensed physician/prescriber with specific training in addiction be available for consultation as medically necessary (for example, a physician/prescriber prescribes medications, and a nurse on-site can coordinate providing the prescribed medications to patients without the physician/prescriber needing to be on-site). Individuals in 3.2-WM should receive both medications and psychosocial therapies. Necessary services must be coordinated or referred to other LOCs as needed, either through direct affiliation or an external referral process.

Note: To participate in 3.2-WM, providers are required to arrange for medications to be available on-site. Providers can coordinate medication services with off-site physicians or other licensed prescribing clinicians to arrange for medications medically necessary to treat withdrawal. ASAM 3.2-WM services do not require pre-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.

ASAM 3.2-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, 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 those with alcohol and/or OUDs unless patient refusal is documented in Progress Notes), transportation, alcohol/drug testing, RS, 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).

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

ASAM 3.7-WM services are short-term medically monitored settings for patients with severe alcohol, sedative, and/or opioid withdrawal or stimulant intoxication that offer 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 inpatient-level care with medical oversight and 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 LOC. Withdrawal from stimulants, cannabis, dissociatives, and/or hallucinogens alone does not require an inpatient level of medical intervention. In some instances, acute stimulant intoxication and/or withdrawal from multiple substances, including alcohol, opioids, and/or sedatives, may be considered for inpatient admission.

ASAM 3.7-WM: Admission Criteria

Criteria for admission to 3.7-WM must include one (1) or more of the following:

1. The diagnosis of delirium tremens (DTs), also known as alcohol withdrawal delirium (AWD), 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. A severe score on a validated withdrawal scale, including the Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar), Prediction of Alcohol Withdrawal Severity Scale (PAWSS), Clinical Assessment of Narcotic Assessment (CINA), and COWS.
3. A moderate score on a validated withdrawal scale, including the CIWA-Ar, PAWSS, CINA, COWS, and one or more of the following high-risk factors:
    a. A current serum ethanol level over 0.10mg%
    b. Serum chloride under 96mEg/L (if known)
    c. Use of multiple substances
    d. History of AWD
    e. Inability to receive necessary medical assessment, monitoring, and treatment at a lower LOC
    f. Medical co-morbidities that make detoxification lower LOC unsafe
    g. History of failed OP treatment
    h. Psychiatric co-morbidities
    i. Pregnancy
    j. History of seizure disorder or withdrawal seizures
4. Complications of alcohol, sedative, and/or opioid withdrawal that cannot be adequately managed in the OP setting due to:
    a. Presenting with persistent vomiting and diarrhea from withdrawal
    b. Dehydration and electrolyte imbalance that make managing withdrawal in a lower LOC unsafe
5. Stimulant intoxication complications that impair patient stability or significantly reduce the patient's ability to safely participate in treatment at a lower LOC.
6. Recent history of severe withdrawal symptoms

Substances with a higher risk of causing illness and death (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 WM 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. For additional information, see the respective Staffing sections in Level 3.7-WM and 4-WM.

ASAM 3.7-WM services do not require pre-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.

ASAM 3.7-WM: Staffing

All 3.7-WM programs are staffed by physicians/prescribers who are available by phone 24 hours per day. A physician/prescriber must assess the patient within 24 hours of admission (or earlier if needed) and is available on-site daily. The facility requires 24-hour care with trained personnel, including awake staff, on the overnight shift to address patient needs. A Registered Nurse (RN) or other licensed nurse is available to do a nursing assessment upon admission and is responsible for oversight of the 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.

ASAM 3.7-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake care planning, 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 the provision of MAT directly or by effective referral mechanisms to MAT unless patient refusal is documented in Progress Notes), transportation, alcohol/drug testing, RS, 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.

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

ASAM 4-WM services are short-term medically managed settings for patients with severe and unstable alcohol, sedative, and/or opioid withdrawal or stimulant intoxication that offer 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 inpatient-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. Withdrawal from stimulants, cannabis, dissociatives, and/or hallucinogens alone does not require an inpatient level of medical intervention. In some instances, acute stimulant intoxication and/or withdrawal from multiple substances, including alcohol, opioids, and/or sedatives, may be considered for inpatient admission.

ASAM 4-WM: Admission Criteria

Criteria for admission to 4-WM must include one (1) or more of the following:

1. The diagnosis of 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. A severe score on any one of the following scales CIWA-Ar, PAWSS, CINA, and COWS.
3. A moderate score on any one of the following withdrawal scales CIWA-Ar, PAWSS, CINA, COWS, and one or more of the following high-risk factors:
   a. A current serum ethanol level over 0.10mg%
   b. Serum chloride under 96mEg/L (if known)
   c. Use of multiple substances
   d. History of AWD
   e. Inability to receive necessary medical assessment, monitoring, and treatment at a lower LOC
   f. Medical co-morbidities that make detoxification a lower LOC unsafe
   g. History of failed OP treatment
   h. Psychiatric co-morbidities
4. Pregnancy
5. History of seizure disorder or withdrawal seizures
6. Complications of withdrawal that cannot be adequately managed in the OP setting due to:
   a. Presenting with persistent vomiting and diarrhea from withdrawal
   b. Dehydration and electrolyte imbalance that make detoxification in a lower LOC unsafe
7. Complications from stimulant intoxication that result in medical or psychiatric conditions that impair the patient's stability or drastically reduce the patient's ability to safely participate in treatment at a lower LOC.

Substances with a higher risk of causing illness and death (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 WM and offer similar services. The key differences are in the level and availability of medical staffing 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. For additional information, see the respective Staffing sections in Level 3.7-WM and 4-WM.

ASAM 4-WM services do not require pre-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.

ASAM 4-WM: 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 if needed) and provide daily visits. The facility requires 24-hour direct observation and nursing care.

ASAM 4-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake care 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 documented in Progress Notes), transportation, alcohol/drug testing. RS, 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 (OTP)

OTPs are treatment settings that provide MAT, including methadone, buprenorphine, naltrexone, naloxone (for opioid overdose prevention), and disulfiram for individuals with AUDs and/or OUDs. OTPs may also offer other types of MATs to address a co-occurring SUD in addition to an OUD. If the OTP is unable to directly administer or dispense medically necessary medications covered under DMC-ODS, they must prescribe the medication to a pharmacy or refer the member to a provider who can dispense it.

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 CCR Title 9, Chapter 4, Division 4, and 42 CFR Part 2. OTPs provide various services, including medical, prenatal, and psychosocial support.

An OTP is classified as an ASAM LOC. Medical necessity for OTP services must be established, including a DSM-5 diagnosis of an SUD and an appropriate LOC designation based on 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 must work together to ensure familiarity with and access to MAT in OTP and other SUD treatment settings.

OTP: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, 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, TB testing, RS, discharge services, medical psychotherapy, and Care Coordination.

Patients served in OTP settings must receive between 50 and 200 minutes of treatment services per calendar month. Counseling services provided in OTP can be 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 must comply with all Federal and State licensing requirements. If they cannot comply, they must assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. OTPs are regulated under CCR Title 9.

OTP: Documentation

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

Recovery Services

RS are support services designed to help individuals remain engaged in care, support their recovery, and reduce the likelihood of relapse.[7] RS 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. Beneficiaries may receive RS based on a self-assessment or provider assessment of relapse risk. Patients do not need to be in remission to access RS.

How to Ensure Patient Engagement in Recovery Services

- Ensure that patients connect with other individuals in recovery to establish a positive recovery support network.
- Emphasize the patient's central role in managing their health.
- Emphasize 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 needs are met, enabling them to navigate the health and social service system independently in the future.

RS can be provided prior to admission, concurrently with admission to any other LOC, and following discharge from another LOC. RS may be delivered as a standalone service or concurrently with other DMC-ODS services and LOCs as clinically appropriate. For patients admitted to RS concurrently or immediately following SUD treatment at a higher LOC where medical necessity had been established for that higher LOC, no additional screening is required for a patient enrolled in RS. If there is a lapse between treatment discharge and receipt of RS, or RS is discontinued, completion of ASAM CO-Triage for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) needs to occur to determine if RS is appropriate for the patient.

RS is available for Youth (age 17 and under), Young Adults (age 18-20), and Adults (age 21 and over) patients prior to enrollment in another LOC, who are currently participating in or discharging from any LOC, and immediately upon discharge from another LOC or upon release from incarceration based on pre-incarceration SUD history (and regardless of receipt of in-custody treatment services). Patients may receive RS based on self-assessment or provider assessment of relapse risk. Patients enrolled in RS treatment as a standalone service are required to have a new CalOMS/LACPRS admission and Financial Eligibility form completed.

[7] SAMHSA. (2024, March 26). Recovery and Recovery Support. www.samhsa.gov/find-help/recovery.

Continued RS participation is based on the patient's continued financial eligibility for DMC-ODS services. For CENS RS, see CENS Standards and Practices.

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

Participation in RS is voluntary for the patient. Therefore, treatment providers should make every effort to educate and engage patients in RS and facilitate their acceptance while ultimately honoring the patient's choices and preferences.

Accessing RS

RS CENS

See CENS Standards and Practices.

Prior to Admission to SUD Treatment

The RS benefit allows for pre-admission contact with patients prior to formal enrollment in treatment. Patients enrolled in treatment as a standalone treatment are required to complete a new CalOMS/LACPRS admission and Financial Eligibility form.

During SUD Treatment

Given the value of RS, the treatment provider should explain the benefits at the beginning, during, and at the end of treatment. Treatment providers should introduce the patient to any designated RS counselor/clinicians and ensure that a warm hand-off is completed. This is particularly important when the RS provider is different from the treatment provider. Patients can be enrolled in RS and another LOC at the same time.

Following SUD Treatment

Following discharge from treatment, an assigned RS 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 in the RS benefit prior to terminating follow-up efforts. If the patient does not consent 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 RS. The RS provider will document all follow-up contacts in the patient's EHR.

For the first 60 calendar days following a patient's discharge from treatment, the RS counselor/clinician will contact and engage the patient at a frequency according to clinical need if the patient consented to participate in RS. Patients who reconnect for RS more than six (6) months since their last DMC-ODS clinical service must be screened to determine if RS continues to be an appropriate service for the patient.

Service Requirements for RS

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

Individuals can continue to receive RS as long as they continue to meet financial eligibility requirements for DMC-ODS services. An LPHA at the RS provider site must document the justification for ongoing RS at least every six (6) months. Individuals may receive RS while enrolled in other DMC-ODS services and LOCs, as clinically appropriate.

Note: CalOMS/LACPRS discharge must be completed when a client is discharged from the RS program on the day of discharge. The discharge date should correspond to the date of the patient's last face-to-face or telehealth treatment session or MAT service. They shall document the actual date of discharge as the "Discharge Process Date" in the relevant CalOMS Discharge forms.

RS Counseling

The goal of individual or group counseling is to allow the patient to gain/develop personal autonomy (managing stress, free time, and 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 one-on-one or in group settings. Groups should consist of 2-12 individuals per group and these services must be delivered in-person or via telehealth. Patients who are enrolled in RS, OP (ASAM 1.0), and IOP (ASAM 2.1) can participate in the same group counseling if clinically appropriate. Patients who are enrolled in RS cannot participate in the same group counseling and patient education sessions as those in residential treatment services.

RS 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 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 in-person, by telephone, or by telehealth.

RS 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.

Note: Care Coordination can be delivered in-person, by telephone, or by telehealth.

RS 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, see respective sections on *Care Coordination*, *Group Counseling*, and *Individual Counseling*.

RS Required Documentation

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

RS provided in the community, by telephone, or by telehealth requires equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility.

Recovery Bridge Housing

Housing and residing in a safe and stable living environment are often critical to achieving and maintaining recovery from SUDs. Research shows that SUD treatment outcomes are better for PEH, particularly those who experience 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. RBH is a type of recovery-oriented, peer-supported housing that provides a safe interim housing environment for individuals who are homeless according to the United States Department of Housing and Urban Development (HUD) definition of unstably housed. Participants in RBH must also be concurrently enrolled in treatment, such as OP, IOP, 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 (age 18-20) and Adults (age 21 and over) who are:

- In need of a stable, safe living environment to best support their recovery from SUD; **and**
- 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), or a lapse in treatment/discharging Against Medical Advice (AMA). Beds held for this timeframe and for the reasons listed 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 populations will be prioritized for RBH, see **Table 9** (*RBH Requirements, Number 3*).

The RBH Requirements are based on the characteristics of Recovery Housing (RH) as defined by HUD and 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 to meet their clinical needs. While RBH is not officially an ASAM LOC, it serves as a bridge between the more intensive and restrictive residential treatment setting and OP/IOP/OTP/OP-WM treatment settings. Patients shall not be required to accept treatment with addiction medications as a condition for admission to RBH.

Table 9

RBH Requirements

Recovery Bridge Housing Requirements	
1	RBH beds are available to any eligible member, especially those in one of the prioritized groups for this benefit. RBH providers: • cannot restrict access to this benefit to their treatment patients, • 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.
2	SAPC-contracted beds must only be dedicated for SAPC members. Providers utilizing SAPC-contracted beds for non-SAPC members are out of compliance with SAPC contract requirements.
3	SUD treatment providers must prioritize the following high-risk populations for RBH according to the following ranking: • CARE program participants • PPW (pregnant to 60 days postpartum) • History of IV drug use • Patients with high utilization of treatment services (as defined by high utilizer criteria for high-tier care management[8]) • People experiencing chronic homelessness (according to HUD definition[9]) • People who are justice-involved without alternative options for RH • Young Adults (age 18-20) • People living with HIV/AIDS • PEH stepping down from residential treatment into RBH, also known as “residential step down” • LGBTQ+ populations ***Populations not on the prioritized list will be considered for RBH only if there is enough capacity to accommodate those on the prioritized list first.*** ***Note: Undocumented homeless adult members who meet the prioritization criteria listed above and are receiving concurrent SUD treatment through Medi-Cal or other applicable County program benefits (e.g., AB 109) are eligible for placement in 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] Patients 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.

Recovery Bridge Housing Requirements	
4	Eligible participants should be medically and psychiatrically stable enough to benefit from RBH.
5	Program participation is self-initiated, and member chooses abstinence-focused housing. Participants who receive RBH benefit are expected to be abstinent 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. RBH providers need to have policies and procedures to ensure a patient-centered process for RBH patients receiving MAT.
6	Program policies and operations are consistent with the National Standards for Cultural and Linguistically Appropriate Services (CLAS) and ensure individual rights of privacy, dignity, respect, and safety.
7	Program emphasizes the personal recovery goals of participants and long-term housing stability to minimize the likelihood of homelessness.
8	Program design establishes minimal barriers for entry into programs.
9	Programs are to meet or exceed National Alliance for Recovery Residences (NARR) standards of care, including ensuring that there is 50+ sq. ft. bed per sleeping room (NARR standard Core Principle E.14.d) and that there is a minimum of one sink, toilet and shower per six residents (NA NARR standard Core Principle E.14.e): www.narronline.org/wp-content/uploads/2018/11/NARR_Standard_V.3.0_release_11-2018.pdf.
10	Holistic services and peer-based supports are available to all program participants.
11	A relapse or lapse should not be an automatic cause for eviction from housing or termination from the program. Providers should work with the participants to refer them to a higher LOC or a more appropriate housing type if the client is no longer interested in stopping substance use or engaging in treatment.
12	Incorporate low-barrier policies as follows: • Whenever possible, separate beds (or housing) for individuals who lapse so they can sober up while still maintaining housing placement, but not being disruptive to other residents. • Establishing a "buddy support system" after a resident lapses to support individuals during this transition phase to maintain their recovery and recovery-oriented housing. • When a resident lapses, increase participation in self-help meetings, as applicable. • In instances where residents must be discharged, provide a warm hand-off to an appropriate level of care or other service, with an open-door policy for them to return, when ready. • Streamlining the intake process for RBH. • Implement contingency plans for intoxication and overdose that are clear to residents and staff, including having overdose medications readily available for use. • Host, at a minimum, monthly house meetings to ensure staff and residents are trained in administering overdose medications. • Allowing staff within an RBH setting to be part of the process of shaping low-barrier policies • Encourage social activities and team-building opportunities
13	Discharge from housing only occurs under two conditions. • A participant's behavior substantially disrupts or impacts the welfare of the recovery community. • 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.
14	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.
15	Throughout the duration of program participation, programs assist participants in transitioning into permanent housing to ensure a smooth transition once they are ready to leave RBH.

RBH Considerations

- RBH is voluntary, and patients being considered for RBH need to choose to be placed in an interim housing environment that facilitates their recovery.
- RBH is appropriate for individuals who have minimal risk regarding acute intoxication/withdrawal potential biomedical and mental health conditions.
- Activities in RBH include peer support, group and housing meetings, self-help, and development of life skills, among other recovery-oriented services. Life skills such as budgeting, bill paying, shopping, cooking, household management, and social skills are essential for promoting self-sufficiency and independent living.
- RBH Participants cannot receive in-person SUD treatment services and Care Coordination at RBH sites.
- SUD treatment services cannot be provided in RBH.
- The RBH provider may conduct alcohol/drug testing or urinalysis or coordinate with the treatment provider to request that the test be conducted for the participant. However, participant consent must be secured before the test result can be released to the RBH provider. Additionally, a positive test result should not be a cause for automatic removal from the program. The provider should work with the client to refer to a more appropriate LOC or housing type.
- 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 (age 17 and under) who require recovery-oriented housing may be eligible for placement in a group home that provides treatment and ancillary services in sites licensed by DPSS.
- RBH Participants must be screened for TB or provide evidence of being 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.

RBH Authorization Process

If RBH is determined to be appropriate, SUD treatment providers must refer the patient to the appropriate RBH provider within one (1) business day of determination. 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 receives reimbursement for RBH from SAPC. The RBH provider must collaborate with the treatment provider to submit the needed documentation, ensuring the patient's concurrent enrollment in OP/IOP/OTP/OP-WM treatment. In instances where the SUD treatment provider is a different agency than the RBH provider, there must be appropriate communication, policies, and procedures between the referring and accepting providers to confirm that a bed is available and ensure coordination between agencies. The policies and procedures between the referring and accepting providers must clearly describe the agreed upon referral and admission procedure, necessary coordination processes, and a clear process by which disagreements are resolved. If a bed is not available within 24 hours of the determination of RBH need, then the SUD treatment

provider must make efforts to connect the patient to appropriate interim housing[10].

SAPC-UM 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 enrolls in OP treatment. Referring treatment providers must document the need for RBH in the patient's Problem List (non-OTP settings) or Treatment Plan (OTP settings). Both RBH and treatment providers should refer to the most recent version of the Checklist of Required Documentation for Utilization Management and Eligibility Verification and Member Authorizations on SAPC's Clinical Forms and Documents - Treatment Services Related webpage.

Duration of RBH

Services for young adult and adult participants may be authorized and reimbursed for 90 days. The initial 90 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.

RBH Reauthorizations

A provider may request a maximum of three (3) reauthorizations that extend the time RBH participants continue to reside in RBH for longer than 90 days if they meet medical necessity and as long as the client continues to meet the RBH eligibility criteria specified above, including concurrent enrollment in OP/IOP/OTP/OP-WM. Reauthorizations past the initial 90 days will be granted if the provider has documentation showing active progress/steps taken to secure housing (i.e. actively working with a Housing Navigator, Coordinated Entry System, Housing Authority, etc.). Providers must submit their extension requests not less than 14 calendar days in advance of the end date of the current authorization to ensure a decision is reached prior to the expiration of their current authorization.

RBH participants can receive a maximum of 360 days in a 12-month period. Once an individual has resided in RBH for a total of 360 calendar days within the past 12 months or has met the 12-month period since the first day of RBH admission (e.g., June 1st – May 31st), whichever occurs first, the benefit period ends and cannot restart until 30 days after the most recent discharge date.

SAPC-UM will review the authorization requests and issue a response to the RBH provider in accordance with established UM response timelines for authorization requests for RBH authorization.

[10] SAPC. (2024, January). Recovery-Oriented Housing Assessment and Intervention Workflow. http://publichealth.lacounty.gov/sapc/docs/providers/trainings/Recovery-Oriented-Housing-Assessment-Intervention-Workflow.pdf.

Discharging Patients from RBH

SUD treatment providers should begin discharge planning for PEH's housing needs upon treatment admission. Care coordinators must work with participants to create a housing plan to ensure a smooth transition to stable housing upon RBH discharge. Once RBH participants finish their stay or no longer receive the benefit, the RBH provider must fill out the RBH Discharge Form in Sage on the same day of discharge.

Eligible RBH Providers

RBH providers are currently limited to SAPC-contracted providers with experience providing RBH to individuals receiving treatment in OP/IOP/OTP/OP-WM settings. Also, RBH providers must be members of an RH 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 on-site and ensure that RBH House Managers or other designated staff and residents receive training in administering naloxone.

RBH Hours 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).

RBH Staffing

RBH providers must ensure that on-site house managers oversee the facility's day-to-day operations. This includes ensuring adherence to policies and procedures, rules, and requirements, the facility's quality, and residents' health and safety. RBH house managers must receive appropriate on-site orientation and training prior to performing assigned duties, have appropriate experience and necessary training at the time of hiring, and should be familiar with SUD patient record confidentiality regulations under 42 CFR Part 2. Further, housing managers should be trained in and practicing, at a minimum, trauma-informed and culturally humility care and implicit bias awareness.

RBH staff must submit reports requested by the County and/or County partners, including required information and supporting documentation (e.g., 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 receives treatment elsewhere. Coordination examples include verifying with the treatment provider that the participant is still concurrently receiving OP/IOP/OTP/OP-WM treatment, informing the treatment provider if the participant leaves or has been discharged from RBH, reminding the treatment provider to conduct housing activities and/or refer the patient to interim or permanent housing resources, and sharing requested information with the treatment provider to accurately complete the participant's CalOMS/LACPRS records. The RBH staff must document coordination 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 Perinatal Practice Guidelines (v1.1, 2022).

Clinician Consultation Services

Clinician Consultation Services are available to SAPC network LPHAs. Clinician Consultation Services consist of DMC-ODS LPHAs consulting with LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists. It 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 to provide consultation services. These consultations can occur in-person, by telehealth, by telephone, or by asynchronous (not in real-time) telecommunication systems such as e-mail.

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.

Note: Clinician Consultation is not a direct service provided to DMC-ODS patients.

Licensed Clinician Consultation Process

Licensed clinicians within the specialty SUD system who seek consultation are responsible for initiating the consultation with specialists outside of their agency for expert clinical consultation. One option for expert clinician consultation is through the **UCSF Substance Use Warmline** at **(855) 300-3595**. For additional information, visit www.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 of the reason for the consultation and any relevant history and clinical details that help inform and provide context 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, the 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 SUD treatment, these questions

should be directed to the applicable SAPC Division. 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 providers, Clinician Consultation Services are strictly limited to routine consultation requests. Emergency and urgent consultation needs should be directed to more appropriate resources (e.g., ED, PES). 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 is 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 health conditions, and psychosocial factors) to provide comprehensive and patient-centered treatment.

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 three (3) business days by an LPHA or MD, practicing within the scope of their practice. Progress Notes must include:

- Patient's name;
- Purpose of the service;
- Date of consultation;
- Start and end times of each service; and
- Identify if services were provided in-person, via telehealth, or by telephone.

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

Billing

Clinician Consultation Services are provided free of charge for the specialty SUD system. The time clinicians spend seeking consultation from the Clinician Consultation Service is not billable.

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

Early Intervention and Treatment Service Components

Below is a description of various Treatment Services that are available to patients. For additional services, see the following sections: *Allowable Screening Tools* for Screening, **Table 2** for Assessment, *Care Coordination*, and *Recovery Services*.

For additional information on how these services are billed and any service minimums or maximums, visit SAPC's Manuals, Bulletins, and Forms webpage, under the Bulletins tab for the latest version of the Provider Staffing Guidelines and SAPC Bulletin 24-04: Fiscal Year 2024-2025 Rates and Payment Policy Updates.

Group Counseling

Group Counseling sessions are designed to support discussion among patients, with guidance from the facilitator to support understanding and encourage participation in 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 techniques such as MI and CBT. 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, including the topic, location, date, time, and facilitator.

Group Counseling sessions are available at all LOCs and are defined as in-person or telehealth contact between up to two (2) registered or certified SUD counselors or LPHAs and 2-12 patients at the same time. This includes family members and non-Medi-Cal participants. Only services to eligible patients (Medi-Cal participants, or individuals 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 the signatures and printed names of all participants (including participants not reimbursed by SAPC and family members) and group facilitators, as well as the 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: Youth (age 17 and under) and Young Adults (age 18-20) are only allowed to participate in the same Group Counseling sessions in school-based settings.

Patient Education

Patient Education sessions aim to teach participants and encourage discussion on research-based educational topics such as SUDs, SUD treatment including MAT, recovery, and associated health consequences. The goal of these sessions is to minimize the harms of SUDs, lower the risk of overdose, and reduce the severity of 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 EBPs that incorporate youth or adult learning styles and support information retention.

A SAPC-approved early intervention curriculum entitled "*Healthy YOUth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth*" is available for Youth (age 17 and under) and Young Adults (age 18-20) enrolled in Early Intervention services. All youth and young adult network treatment providers must complete the required Early Intervention Curriculum training before delivering the early intervention patient education sessions.

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, including the topic, location, date, time, and facilitator name.

Patient Education sessions are available at all LOCs and are defined as in-person, by telephone or by telehealth contact between up to two (2) registered or certified SUD counselors or LPHAs, and

- 2-12 patients at the same time in non-residential settings, **or**
- 2-30 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 HER 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 staff and patients 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). They need to incorporate techniques such as MI and CBT.

Individual Counseling sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) registered counselor, certified counselor, or LPHA, and one (1) patient.

A trainee may observe for training purposes with patient consent. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. Individual Counseling sessions of 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 justify the 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:

- 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**
- An unforeseen event or circumstance occurs that results in or presents an imminent threat of serious relapse.

These sessions are immediate and short-term encounters that focus on:

- Stabilization and immediate management of the crisis, often by strengthening coping mechanisms; **and**
- Alleviating a patient's biopsychosocial functioning and well-being after a crisis.

Note: Crisis Intervention sessions must incorporate techniques such as MI and CBT.

A component of this service includes linkages to ensure ongoing care following 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 ER) 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 in-person, by telephone, or by telehealth contact between one (1) registered/certified counselor or LPHA and one (1) patient. 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 according to after-hours crisis procedures.

Family Therapy

Family Therapy is a form of psychotherapy that involves both patients and their family members and uses specific techniques and EBPs (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 techniques such as MI and CBT.

Family Therapy sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) therapist-level LPHA, one (1) patient, and their family member(s). 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 patient's life (i.e., personal, not official, or professional relationship with the patient) and SUD counselors or LPHAs. CalAIM has changed the format and billing for collateral services. Collateral services are only available as part of other services to the patient, including assessment, individual counseling, and peer support services. Per DHCS, collateral may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. As such, collateral services must be documented and billed as part of the primary service being delivered to the patient and is not a standalone service.

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 examines 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. Use of accurate language such as negative or positive to report the results of drug testing is encouraged.

Drug testing is best when administered randomly instead of scheduled, and the method of drug testing (e.g., urine, saliva) should ideally vary as well. When body fluid testing is performed, practitioners should balance the need to protect against the falsification and/or contamination of any urine sample with patient privacy. Reasonable steps should be taken to ensure specimens are not switched, substituted, or adulterated before analysis. Direct observation specimen collection is not routinely necessary unless clinically indicated, such as when there is a discrepancy between a patient's clinical examination and prior toxicology results.

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

- Chronic nature of addiction.
- Relapse is a part of the condition for which people are seeking SUD treatment.
- 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 HER or Sage.

Medication for Addiction Treatment

MAT service components include Assessment, Care Coordination, Individual Counseling, Group Counseling, Family Therapy, Medication Services, Patient Education, RS, Crisis Intervention, and WM services. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as part of all LOCs. For a list of FDA-approved addiction medications that SAPC requires providers to offer patients, see Table 10.

Table 10

Required Addiction Medications

Opioid Use Disorder (OUD)	Alcohol Use Disorder (AUD)	Tobacco Use Disorder (TUD)[11]
Methadone *(oral methadone for the indication of OUD is only available via OTPs)*	**Naltrexone** Oral and long-acting injectable formulations are effective for AUD	**Varenicline** Oral formulation
Buprenorphine Sublingual or injectable extended-release buprenorphine formulations for the indication of OUD	**Disulfiram** Oral formulation	**Bupropion** Oral formulation
Naltrexone Long-acting injectable formulation is preferred to oral for OUD	**Acamprosate** Oral formulation	**Nicotine Replacement Therapy** Transdermal patch, transmucosal gum/lozenge, inhaler, nasal spray formulations
Medications FDA-Approved to Reverse Opioid Overdose[12] Injectable or Intranasal Formulations that Reverse Opioid Overdose		

[11] TUD cannot be a primary diagnosis for 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 SUD.
[12] Medications FDA-Approved to Reverse Opioid Overdose should be prescribed to patients who received treatment within the SAPC network. 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 Medications FDA-Approved to Reverse Opioid Overdose to people (such as those who are not enrolled as patients).

MAT as a Core Component of SUD Treatment

Just as medications are commonly accepted for the treatment of other chronic conditions, the evidence shows that MAT can help decrease alcohol- and opioid-related cravings and ease withdrawal symptoms.

While interventions such as counseling are critical for recovery, the use of medications for the treatment of addiction is also important and necessary in many cases. **MAT is a best practice** and a **core component of SUD treatment** for individuals for whom it is clinically appropriate because it facilitates recovery; and improves outcomes.

Medi-Cal covers the use of medications that can be used outside of their FDA-approved indications (off-label) to treat SUD, including off-label medications effective at treating methamphetamine, cocaine, and cannabis use disorders through the Medication Services benefit. Treatment providers should make clinically effective off-label medications that treat SUD available to patients in their care. Provider agencies should refer to the latest SAPC IN 24-01 and the SAPC Trainings and Events webpage for additional information and resources about clinically effective medications that can be used outside of their FDA-labeled indication to treat SUD.

MAT Services for Youth (age 17 and under)

Research and clinical experience have not identified any age-specific safety concerns for addiction medications, and all treatment options should be considered for patients of all ages. Providers treating Youth (age 17 and under) with addiction medications should obtain parental/guardian consent when required to provide medication services. A minor 16 years of age or older may consent to OUD treatment that uses buprenorphine outside of an OTP setting, whether or not the minor also has the consent of their parent or guardian.[13]

MAT Services Requirements

Treatment agencies are required to create and update, as necessary, active policies and procedures related to the provision of addiction medications either directly to their patients or via linkage with other providers (e.g., FQHCs, primary care providers [PCPs]) that offer addiction medication services. SAPC encourages formal arrangements such as a Memorandum of Understanding (MOU) between agencies in order to optimize referral relationships and processes. California Health and Safety Code (HSC) § 11831, California HSC § 11834.28, and BHIN 23-054 require active policies and procedures related to the provision of addiction medications either directly to their patients or via linkage with external agencies that offer addiction medications.

Treatment agency practitioners shall provide patients and any adult collateral contacts (including but not limited to adult family members) with information about addiction medications at intake, during treatment, and at discharge in accordance with the patient's Plan of Care. The information provided must be specific to each type of addiction medication that is clinically effective for treating that patient's specific SUD(s) to support informed patient consent. Patients who are not actively being treated with addiction medications should continue to be offered addiction medications, as clinically appropriate, in accordance with the patient's Plan of Care.

[13] California FAM § 6929.1, amended by Assembly Bill 816, effective January 1, 2024.

Treatment agencies shall provide patients with information using SAPC-approved materials about addiction medications that clearly explain the benefits of addiction medications and the risks of not accepting addiction medications; see SAPC IN 24-01, Attachment A. SAPC providers shall document specifically which addiction medications information was provided to patients, the patient's response upon receiving this information, and all medication services offered to the patient, including a description of the patient's clinical history and prior use of addiction medications when applicable.

Every patient admitted to a treatment agency's care shall have access to all required addiction medications, either directly or through referral to external partners. For a list of required addiction medications, see SAPC IN 24-01, Attachment B.

Direct Provision of MAT Services to Patients On-Site

Each treatment agency shall have available to its staff and keep an updated list of addiction medications available directly via practitioners providing on-site services, including when these medications are prescribed through fee-for-service (FFS) Medi-Cal and picked up at an off-site pharmacy. Each patient with a documented SUD meets the criteria to receive a medical evaluation, which shall include the patient being offered all addiction medications clinically appropriate to treat the patient's particular SUD(s). Each treatment agency shall ensure that initial and follow-up addiction medication service appointments are arranged in accordance with the patient's individualized Plan of Care. Treatment agencies who offer on-site medication services shall maintain sufficient medical LPHA staffing operating within the scope of practice of their license (licensed prescribing clinician) to meet patient demand for MAT services, which may include employment of, or contracts with, prescribing clinicians and arranging coordination of telehealth medication services if applicable.

Documentation of MAT Services Provided to Patients On-Site

Medication services billed to SAPC require documentation of the eligible (non-tobacco) SUD diagnosis. The documentation must also describe the medication services provided to address each applicable SUD. Agencies shall offer TUD treatment, including medications appropriate for the patient when TUD is present alongside a non-tobacco SUD. For TUD treatment services offered on-site alongside treatment of non-tobacco SUD(s), the applicable (non-tobacco) SUD(s) should serve as the diagnosis listed on the claim. Other problems treated by the licensed prescribing clinician (for example, psychiatric care and general medical care) can also be included alongside addiction medication services if the eligible (non-tobacco) SUD was documented as a focus of the visit (it does not need to be the only focus of the visit). Medication services associated with documentation where there is no mention of an eligible (non-tobacco) SUD and no mention of treating the SUD are not billable to SAPC.

Referral for MAT Services through External Partners

Each treatment agency that does not directly offer each required addiction medication via practitioners operating on-site shall coordinate care to ensure patient access to each remaining addiction medication through one or more external partners. Treatment agencies shall:

- Maintain a list of referral locations that include (at minimum) the name, address, phone number, website (when available), and distance to the external partner.

- Ensure that at least one (1) external partner that offers each remaining required addiction medication is identified.
- Maintain procedures for client transportation to/from these external partners.

Patient Eligibility for MAT

Treatment agencies shall obtain a history of the patient's substance use during intake and provide the patient with information about addiction medications in accordance with SAPC-approved materials addressing addiction medications. For additional information, see SAPC IN 24-01.

For patients who indicate a history of substance use (outlined in SAPC IN 24-01), each treatment agency shall perform a diagnostic assessment confirmed by an LPHA within the first 24 hours of the initial date of service to determine whether the patient meets the current version of the DSM criteria for one or more substance-related and addictive disorders.

All patients who meet the current version of the DSM criteria for one or more substance-related and addictive disorders (outlined in SAPC IN 24-01) should be offered an evaluation by a licensed prescribing clinician. This evaluation with a licensed prescribing clinician shall be arranged within the first 48 hours of the initial date of service. The licensed prescribing clinician shall determine which addiction medications, if any, are appropriate for the patient and shall either prescribe the addiction medication(s) directly and/or initiate a referral for addiction medication services to one or more external partners as described above. The addiction medications must be provided to the patient in alignment with the treatment agency's approved policies and procedures.

Administration, Storage, and Disposal of Addiction Medications

Each treatment agency shall create and keep updated a policy that describes the appropriate administration, storage, and/or disposal of each addiction medication (outlined in SAPC IN 24-01), as is aligned with the agency's LOC and in accordance with which addiction medications are available on-site and/or through referral to external partners. This policy shall describe the medication self-administration requirements, the documentation requirements for self-administered medication, the medication storage requirements, (including location, accessibility, inventory, handling, and documentation), and the medication disposal procedures, (including how often medications are disposed of, the methods of destruction, and documentation). This policy shall be aligned with the latest version of the SAPC Bulletin addressing addiction medications, see SAPC IN 24-01.

MAT Staff Training Requirements

Each treatment agency shall ensure that all staff interacting with patients are provided with SAPC-approved training (outlined in SAPC IN 24-01) about the benefits and risks of addiction medications and the agency's addiction medication policy. This training must occur within 90 days of hire and not less frequently than annually thereafter. Treatment agencies shall document their staff's training in each staff member's personnel file.

Procedures for Patient Use of Addiction Medications

Each treatment agency's Medical Director or their licensed prescribing clinician designee, with appropriate input from the patient, determines when a current medication treatment, including treatment with controlled medications, is clinically beneficial. When the patient is being treated with clinically beneficial medication(s), the treatment agency shall, at a minimum, do all of the following: Ensure access to the facility is not denied because a patient is being treated with addiction medication(s). Assure the patient that the full range of medically necessary treatment services are available and not contingent upon the patient changing their addiction medication(s).

- Support the patient's continued receipt of addiction medication(s).
- Confirm that a patient will not be compelled to taper, discontinue, decrease the dosage, or abstain from addiction medications as a condition of entering or remaining in treatment.
- Assure the patient that they will not be denied access to addiction medications if they do not participate in all services offered by a facility.
- Assure the patient that they will not be denied access to addiction medication services if they use non-prescribed intoxicants.

Patients diagnosed with OUD shall receive information about the medications available for OUD, including through treatment agencies and external partners (outlined in SAPC IN 24-01). Medications for OUD are available through both OTP and non-OTP sites of care.

Procedures for Care Coordination for OTP Services

Treatment agencies without on-site OTP services shall arrange timely referrals within 24 hours for patients who request an evaluation for addiction medication services through an OTP. Medications dispensed from OTPs shall be stored in accordance with SAPC IN 24-01, Attachment D for applicable LOCs. Treatment agency sites without on-site OTP services shall create and keep updated a plan to submit requests to the treating OTP for exceptions to take-home limits when additional take-home doses are clinically appropriate in accordance with the patient's individualized Plan of Care.

Treatment agencies shall coordinate the continuation of clinically beneficial OTP-dispensed addiction medications(s) at intake, throughout admission, and at discharge. This shall include coordinating OTP services arranged prior to discharge to ensure that sufficient medication is available until the next scheduled follow-up appointment.

Procedures for Treatment with Buprenorphine

Licensed prescribing clinicians appropriately registered with the DEA can treat patients with buprenorphine at treatment agency sites of care. Residential facilities with practitioners who offer on-site addiction medication services, including treatment with buprenorphine, should be certified to provide IMS; see SAPC IN 24-01, Attachment G. Patients with OUD shall be informed about the scientific evidence base, effectiveness, associated risks and benefits, and clinical considerations for treatment with buprenorphine; see SAPC IN 24-01, Attachment A. All patients with OUD being treated in sites without buprenorphine medication services available on-site should be offered a referral and care coordination for addiction medication services through

external partners where treatment with buprenorphine is available. Treatment agencies shall coordinate continuing clinically beneficial treatment with buprenorphine on intake, throughout the admission, and at discharge. This shall include arranging follow-up appointments scheduled prior to discharge with coordination of access to addiction medication services arranged to ensure that sufficient buprenorphine is available until the next scheduled follow-up appointment.

Note: Treatment agencies shall provide a copy of their current addiction medication policy to their assigned SAPC CPA and the assigned DHCS licensing analyst.

Medications FDA-Approved to Reverse Opioid Overdose

SAPC provider agencies shall establish protocols for both prescribing medications FDA-approved to reverse an opioid overdose and to distribute naloxone, obtained outside of pharmacy-dispensing and OTP-dispensing sources, to all patients within the SAPC treatment network. Naloxone at no cost to SAPC providers is available for distribution through the DHCS Naloxone Distribution Project (NDP), which can be accessed via the NDP online application form.

SAPC providers shall:

- Maintain, at all times, at least two (2) unexpired doses of naloxone or any other FDA-approved opioid antagonist medication for the treatment of an opioid overdose on their premises.
- Have at least one (1) staff member, at all times, on the premises who knows the specific location of the naloxone or other FDA-approved opioid antagonist medication **and** who has been trained in its administration. Training includes a review of educational resources provided by SAPC to respond effectively to an opioid-associated overdose emergency.
- Staff are required to certify that they have reviewed and undergone training in opioid overdose prevention and treatment. Document proof of completion of the training in the staff member's individual personnel file.

Naloxone should be readily available and not stored in locked cabinets or offices. Providers should develop written policies and procedures for labeled naloxone, whether prescribed or received through community distribution, to be kept on the person or at the bedside while in DHCS-licensed treatment facilities, similar to how a person may keep an inhaler on their person to treat asthma.

SAPC providers can provide **or** arrange for naloxone to be prescribed and provided to each patient by leveraging Medi-Cal. For example, SAPC provider practitioners whose scope of practice includes prescribing medication can prescribe naloxone to each patient who is under their care and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of the members. Additionally, providers can coordinate delivery of the naloxone from a pharmacy to the patient's location.

Medical Directors and prescribing clinicians are also able to establish a Standardized Protocol that authorizes designated staff working in a DMC-ODS provider agency (using a standardized procedure and standing order specific to prescribing medications FDA-approved to reverse opioid overdose) to issue prescriptions on behalf of the Medical Directors or prescribing clinicians to a local pharmacy for medications FDA-approved to reverse opioid overdose. The pharmacy bills these prescriptions for medications FDA-approved to reverse opioid

overdose through Medi-Cal. The staff may bring this dispensed medication back to the DMC-ODS provider site, or the pharmacy may arrange delivery to furnish these medications directly to patients. This method enables DMC-ODS providers to better facilitate on-site access to medications FDA-approved to reverse opioid overdose reimbursement through Medi-Cal. DMC-ODS providers may also refer patients to pharmacies that will dispense medications FDA-approved to reverse opioid overdose directly to the patient.

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 reimburses for MAT services even when provided by DMC-ODS providers in non-clinical settings and as a standalone service. These are billed under Medication Services (MAT).

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

Safeguarding of medications in accordance with regulations is required in residential and WM settings, and may be performed by qualified staff (e.g., LVN or Medical Assistants [MA]). For a complete list of staff who may assist with medication services, visit SAPC's Manuals, Bulletins, and Forms webpage, under the Bulletins tab for the latest version of the Provider Staffing Guidelines.

Medication Services are available at all LOCs and are defined as in-person, telephone, or telehealth contact between patients and medical staff (e.g., physicians, NPs, or PAs) regarding the use of FDA-approved MAT or other medications medically necessary to treat SUDs. Medication Services are reported in 15-minute increments, with sessions ranging from 15 to 30 minutes in length. A separate Progress Note must document the encounter with each patient.

Note: Medication Services provided in residential settings require IMS approval from the State for the specified residential site. Despite this allowance from the state, there is no current billing mechanism. As a result, Medication Services provided in residential settings are not DMC reimbursable.

Transportation Services

Providers must make every effort 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 (LA Care, Health Net, or Kaiser). Transportation services may require pre-authorization from the health plan, and the patient's care coordinator is responsible for arranging 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 members receiving behavioral health services as outlined at these links and below. For additional information see APL 22-008 FAQs.

There are two (2) types of transportation on the Medi-Cal program:

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

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

- Transportation to medical, dental, or behavioral health appointments for all Medi-Cal services (available to patients receiving outpatient, inpatient, or residential services).
- Transportation for transfer from general acute care hospitals or EDs to psychiatric facilities, including psychiatric hospitals, skilled nursing facilities, and mental health rehabilitation centers.
- 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 additional information about Medi-Cal covered transportation services, visit 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. For additional information, see SAPC Bulletin 24-04: Fiscal Year 2024-2025 Rates and Payment Policy Updates.

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

Also, select costs can be added to 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.

Transportation costs must be reported under the "Transportation" line item under "Services and Supplies" category and be clearly tracked and managed. Since transportation costs are included in the day-rate for residential treatment, transportation is not billable as a separate service in residential treatment. However, for Non-Emergency Transportation services to count towards the Residential weekly treatment hour standard, providers must document how transportation contributes to patient care and recovery in a Progress Note. 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 to 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 RS or the next step in their recovery journey. It also helps to convey that recovery is an ongoing life process, not a unit of service. Transition to RS needs to be included in 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 in-person, by telephone, or by telehealth contact between one (1) registered counselor, certified counselor, or LPHA and one (1) patient. If permitted by the patient, a trainee may observe for training purposes. 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 must be completed on the day of the last in-person treatment/telephonic contact or dispensed or administered medication (OTP) for all LOCs unless the patient's discharge is unplanned. If a patient's discharge is unplanned, the Discharge Form must be completed within 30 calendar days of the last day that services were provided. For RBH, the Discharge Summary Form must be completed for each patient and submitted into Sage at the time of discharge from RBH.

Culturally and Linguistically Appropriate Services

focuses on addressing patients' cultural and linguistic needs by promoting understanding and respect for the diverse ways language and culture (inclusive of race, faith, ethnicity, abilities, gender identity, class, sexual orientation, housing, and education) shape individual experiences and interactions. This approach is essential for providing high-quality SUD services. Treatment agencies must ensure that their policies, practices, and procedures support culturally, developmentally, linguistically, and population-appropriate services. These principles should be integrated into both organizational and daily operations.

Research shows that inadequate diversity, inclusivity, and cultural relevance in service design and delivery can lead to poor outcomes in access, engagement, treatment receptivity, help-seeking behaviors, treatment goals, and family response. Essential practices for cultural competence and humility include:

- Developing patient-centered attitudes, beliefs, values, and skills among providers
- Implementing policies and procedures that outline care quality and consistency requirements (e.g., Notice of Non-Discrimination, language taglines)
- Ensuring administrative structures and procedures are ready and available to support these commitments (e.g., leadership and staff that reflect the primary populations, staff training)

SAPC is dedicated to fostering a service delivery system that respects individuals' language, culture, ethnicity, gender identity, age, sexual orientation, development stage, and any physical, psychiatric, or cognitive disabilities.

Services for Persons with Disabilities

Providers must comply with all elements of the Americans with Disabilities Act of 1990 (ADA). This includes access to alternate access technologies (e.g., TTY/TVR, magnification, audio, etc.) and policies for allowing service animals. Providers must accommodate the communication needs of all qualified individuals and be prepared to facilitate alternative format requests for braille, audio format, large print, and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services, as appropriate.

SAPC's website provides resources and additional information about implementing culturally competent services. In addition, providers can use the DHCS Alternative Format website (https://afs.dhcs.ca.gov/) to identify alternative format selections by beneficiaries.

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.) at no cost for members who are monolingual, non-English speakers, or LEP.

A qualified interpreter is an individual who:

- Adheres to generally accepted interpreter ethics principles, including client confidentiality; **and**
- Can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.

When a member requests services in a non-English language, network providers shall (as outlined in SAPC IN 24-02):

- Input member self-reported preferred language for treatment services into the EHR-Sage and the relevant data fields in CalOMS.
- Offer language assistance services for treatment in their preferred language.
- Use the Care Coordination benefit to refer members for treatment in their preferred language, when requested by the member.
- If a patient refuses interpreter services, document in the patient's chart that free interpreter services were offered and declined.
- Do not use family members, friends, etc., as interpreters unless specifically requested by the member. In such cases, the interpretation shall be restricted to intake and screening/assessment activities only. A minor child may not be used as an interpreter except when an emergency involves an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is unavailable.

Language assistance services shall be available during all hours the provider is open for business. Effective July 1, 2024, SAPC Bulletin 24-04: Fiscal Year 2024-2025 Rates and Payment Policy Updates includes a language assistance add-on that may be applied when using a third-party interpreter during DMC ODS eligible services. In very limited circumstances, SAPC may assist network provider agencies with the identification of interpretation services. For assistance with these services, email eapu@ph.lacounty.gov.

Service Delivery Options

Field-Based Services

FBS provides SUD services to patients in nontraditional settings such as schools, community locations, county departments, and where patients reside (e.g., encampments, shelters, residential care facilities, interim or permanent housing). FBS aims to increase access to treatment services, promote patient motivation and engagement, and better serve hard-to-reach populations.

The DMC-ODS benefit allows for the provision of FBS as a method of service delivery for OP-type services as classified by ASAM. Network providers must apply to provide FBS at SAPC-approved sites, referred to as Community FBS (e.g., community centers, schools, homeless services facilities, government offices) and/or at locations/settings where a patient lives, referred to as In-Home FBS.

Allowable FBS Settings and Types

The following outlines SAPC-recommended settings for FBS:

- Community / Drop-In / Day Centers
- In-Home (e.g., encampments, shelters, interim or permanent housing settings)
- LACOE Alternative sites
- Recreation Centers
- Schools
- Harm Reduction Sites
- Board and Care / Group Home
- FQHCs
- Homeless Shelters
- Permanent or Interim Housing Sites
- County of Los Angeles locations: DCFS, DHS facilities**,** DMH clinic sites (including DMH legal entities), LAC-Probation Area Offices, DPSS Offices

FBS cannot be utilized in lieu of obtaining a DHCS DMC Site Certification for providers' directly-operated sites (e.g., rented, leased, and 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 providing services other than SUD and mental health and where individuals not employed by the agency manage the services delivered on-site.

In-custody/carceral services (e.g., jails, prisons) provided for youth or adults are not permissible as an FBS delivery site nor reimbursable through the DMC-ODS program.

Allowable FBS

FBS is a method of mobile service delivery for Early Intervention (ASAM 0.5), OP services (ASAM 1.0), IOP services (ASAM 2.1), Care Coordination, and RS. Based on the ASAM Criteria, the following service components are allowable:

- Screening
- Assessment/Intake
- Individual Counseling
- Group Counseling
- Care Coordination
- Problem List/Treatment Planning
- Discharge Planning
- Crisis Intervention
- Patient Education
- Family Therapy
- Collateral Services
- MAT services
- Behavioral Health Prevention Education Services (Peer Support Services)
- Help/Peer Services (Peer Support Services)

FBS Expectations

- **Culturally Competent Services**: Network providers must provide culturally competent services. Network providers must ensure that their policies, procedures, and practices are consistent with the principles outlined in CLAS and are embedded in the organizational structure.
- **Age and Developmentally-Appropriate Services**: Network providers must deliver services that align with the patient's age and developmental level to ensure engagement in the treatment process.
- **MAT Services**: Network providers must maintain procedures for linkage/integration to MAT services. Patients receiving MAT must not be discriminated against and must have equal access to services. The prescribing of MAT should follow established prescribing standards from the ASAM and the Substance Abuse and Mental Health Services Administration (SAMHSA). Provider staff will regularly communicate with prescribers of MAT to ensure coordination of care, assuming the patient has signed a 42 CFR Part 2 compliant ROI for this purpose.
- **Reaching the 95% (R95) Population:** Supporting access to the 95% of people who need treatment but who do not want or access it, oftentimes because of lack of current treatment or abstinence goals.
- **Naloxone Training and Availability:** FBS providers must carry naloxone, or other FDA-approved opioid antagonist medication, at all times and be trained and ready to administer this medication in response to overdose, with exceptions only for the rare circumstances where carrying and administering naloxone is expressly prohibited by site-specific local regulation. To access naloxone resources, visit: http://publichealth.lacounty.gov/sapc/public/harm-reduction/?tm#access-naloxone.
- **Evidenced-Based Practices (EBP)**: Network providers must implement, at minimum, the following two EBPs: MI and CBT. Providers are encouraged to implement additional EBPs, including relapse prevention, trauma-informed treatment, and psychoeducation.

- **Care Coordination**: Network providers must deliver a variety of care coordination services, including transitioning patients from one LOC to another, navigating mental health, physical health, and social service delivery systems, including housing referrals, as appropriate.
- **Confidentiality Regulations**: Network providers must adhere to all applicable confidentiality laws, including but not limited to, 42 CFR § 2.35(a); HIPAA Privacy Regulations; 45 CFR § 164.508(b)(2) and 45 CFR § 164.501; and the California Civil Code (CIV) § 56.11, when providing FBS.
- **Employee Safety Regulations:** Network providers shall update their Injury and Illness Prevention Plan as required by CALOSHA (Title 8 CCR § 3203) to account for FBS. Updates to the plan shall include assignment of the responsibility, assessment of hazards, investigation of occupational accidents, injuries, and illnesses, correction of hazards, communication plan, training, systems for ensuring employee compliance with safety procedures, and recordkeeping and documentation.
- **Employee Safety Regulations:** Network providers must update their Injury and Illness Prevention Plan as required by CALOSHA (Title 8 CCR § 3203) to account for FBS. Updates to the plan shall include assignment of the responsibility, assessment of hazards, investigation of occupational accidents, injuries, and illnesses, correction of hazards, communication plan, training, systems for ensuring employee compliance with safety procedures, and recordkeeping and documentation.
- **Minor Consent:** For in-home delivered to Youth (age 17 and under) at home, the provider must obtain consent from the parent or guardian allowing the youth to receive in-home services. Additional consent must be obtained if in-home services need to be provided while a parent or guardian is not home. The provider must obtain signed consent from the youth patient to communicate with a parent or guardian. Emancipated youth and/or youth who meet conditions of California Family Code (FAM) § 6922 may consent to in-home services; providers must verify eligibility and document it.

For additional information on FBS, see SAPC Bulletin 23-14.

Mobile Outreach Services

Travel to the FBS site is reimbursable. FBS staff's personal vehicle mileage reimbursement rate is $0.67 cents per mile. Each FBS staff must have a permanent headquarters, namely the office in which they spend most of their office work time or receive their supervision. Mobile Outreach Services It is not intended to reimburse a workforce member for traveling to and from the basic work location, temporary or otherwise. Providers may bill up to 500 miles per month, per FBS site, when agencies are not also leveraging transportation services funded by other programs.

FBS Staff Experience Requirements

FBS may be delivered by:

- Registered SUD counselors with 1 year (12 months) of relevant experience working to provide SUD prevention, harm reduction, treatment, or RS (close supervision of the registered SUD counselor is required);
- Certified SUD counselors;
- LPHAs;

- Certified Peers: Peer Support Services can only be delivered by Certified Peers with close supervision. Certified Peers are limited to providing Behavioral Health Prevention Education Services and Self-Help/Peer Services, as outlined in SAPC IN 23-04.

Staff providing FBS to youth patients must either have at least two (2) years of experience providing behavioral health services to youth OR at least one (1) year of experience providing behavioral health services to youth AND have completed 11 hours of SAPC-required youth-specific trainings prior to delivering FBS (a list of required trainings can be found in Field-Based Services: Standards and Practices Version 3.0.

FBS Procedures

New FBS Site Application

Providers must get approval from SAPC to provide FBS. To apply for FBS, SAPC network providers need to email a complete application package with the subject line "Field-Based Services Application" to SAPCMonitoring@ph.lacounty.gov and SAPC_ASOC@ph.lacounty.gov. Please review the FBS Application Instructions for additional information. A complete FBS application includes the following documents:

- Field-Based Services Application Form (SAPC Bulletin 23-14, Attachment III)
- Signed cover letter stating intention to provide FBS
- Narrative Overview

Additional documents for community site applications (e.g., FBS at schools, CBO):

- MOU, Service Delivery Agreement, or a Partnership Agreement with the site operator

Additional documents for in-home applications:

- Safety Plan (SAPC Bulletin 23-14, Attachment IV for template)
- Confidentiality Protocol

FBS Site Renewal

FBS providers must submit a renewal annually by **May 31st**. To renew, the following must be emailed to SAPCMonitoring@ph.lacounty.gov:

- Renewal Form (SAPC Bulletin 23-14, Attachment V)
- Cover letter
- Narrative documenting all changes (if applicable), including:
  - Any changes to services outlined in the initial application and/or to remove Community FBS sites that are no longer operational and/or if in-home services will be continued.
  - Any staffing change.
  - Any sites that are not renewed via this process will be removed from the Contract, and subsequent services will be denied.

Your CPA will conduct compliance reviews as a part of the standard monitoring process for any sites maintained in the contract for subsequent years.

FBS Site Modification

In the event that the network provider and/or SAPC note that a particular site shall not be used for FBS, or if notable changes to FBS operations are made, a request to modify a currently approved FBS application must be submitted along with all relevant supplemental documents. A memo documenting all changes must be submitted to SAPC within 30 days of implementation of operational changes by emailing SAPCMonitoring@ph.lacounty.gov and SAPC_ASOC@ph.lacounty.gov with the subject line "FBS Modification."

FBS Documentation

All FBS services must be documented according to the latest version of the Provider Manual. Claims may be subject to recoupment if documentation is missing, incomplete, or incorrect.

A Progress Note must be written for each session and documented in Sage or other approved EHRs. For Primary Sage users, when services are delivered via FBS, the Method of Service Delivery for "Field-Based Services" must be selected within the Progress Note and documented with the location in which services were provided. Secondary Sage users must document within their EHR Progress Notes that services were delivered via Field-Based Services and where the services were delivered.

Documenting FBS services within the claim requires the use of the appropriate Place of Service Code. For a list of Place of Service codes and their respective locations when billing for FBS, see **Table 11**. Only allowable Place of Service Codes corresponding to the allowable billing may be used. The location of the Place of Service Code used for billing shall match the code used for the Progress Note.

Table 11

Place of Service Codes for Field-Based Services

Location Name	Description	Place of Service Code
School	A facility whose primary purpose is education.	3
Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).	4
Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.	12
Assisted Living Facility	Congregate residential facility with self-contained units providing assessment of each resident's needs and offering on-site services, including some health care.	13
Group Home	A residence with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial services, and minimal services (e.g., medication administration).	14
Mobile Unit	A facility/unit that moves from place to place and equipped to provide preventive screening, diagnostic, and/or treatment services.	15
Temporary Lodging	A short-term accommodation including hotels, campgrounds, or hostels where the patient receives care.	16

Location Name	Description	Place of Service Code
Urgent Care Facility	A location, distinct from a hospital ER, an office or a clinic, with a purpose to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	20
Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	23
Outreach Site/Street	A non-permanent location on the street or found environment, including encampments where services are provided to for PEH.	27
Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons; or, on a regular basis, health-related care services above the level of custodial care to residents other than individuals with intellectual disabilities.	32
Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.	33
Federally Qualified Health Center (FQHC)	A facility located in a medically underserved area that provides Medicare members with preventive primary medical care under the general direction of a physician.	50
Community Mental Health Center (CMHC)	A facility that provides mental health services, including DMH provider agencies and other mental health services organizations.	53
Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.	71
Other Place of Service	Other place of service includes community centers, parks, faith-based organizations, CBOs, and non-profit organizations. *	99

If your FBS location does not correspond with the location types listed in Table 11, email SAPC_ASOC@ph.lacounty.gov for instructions on which code to use. Place of Service Code 99 should not be used for locations outside of the locations described or similar.

Agencies shall notify SAPC if they need to use the Place of Service Codes in **Table 11** for services other than FBS. Agencies shall use the appropriate Place of Service Code when providing non-FBS services (e.g., 55-Residential Substance Abuse Treatment Facility, 57- Non-residential Substance Abuse Treatment Facility) at their DMC-certified facility.

Telehealth and Telephone

In accordance with BHIN 23-018: If a service is provided through telehealth (synchronous audio or video) or telephone, the provider staff must inform the patient prior to initiating applicable health care services (e.g., SUD) and obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering health care services. Providers are required to share additional information regarding:

- Right to in-person services;
- Voluntary and 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;

- Availability of Medi-Cal coverages for transportation services to in-person services when other available resources have been reasonably exhausted;
- Potential limitations or risks related to receiving services through telehealth compared to an in-person visit, if applicable; **and**
- Availability of translation services.

Note: Telehealth and telephone services are meant to supplement, not replace, in-person services. Providers must also offer in-person services or have a documented process to link patients to in-person care within a reasonable time if the services are unavailable from the provider.

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

Consent requirements may be found in California Business and Professions Code (BPC) § 2290.5(b) and California WIC § 14132.725(d).

Telehealth

Telehealth is a way to deliver healthcare services remotely. Telehealth allows SUD services to be delivered between a Certified Peer, registered or certified SUD counselor, or LPHA and a patient via audio and video communications, even when they are not able 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 the eligibility requirements for SUD services and consent to receive these services remotely. The following LOCs are permitted to be conducted via telehealth:

- Outpatient services (ASAM 1.0 & 0.5 LOC)
- 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
- Group Counseling[14]

[14] **Group counseling sessions** may be conducted via telehealth if the provider obtains consent from all the participants and takes the necessary security precautions in compliance with HIPAA and 42 CFR Part 2.

- Initial Clinical Assessment
- Medication Services (MAT)
- Positive Youth Development
- Care Planning
- Relapse Prevention
- Recovery Monitoring

In-person appointments need to occur whenever patient signatures are required. This would include signing initial consents, 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, the reason must be clearly documented in the patient's chart.

Agency Requirements and Responsibilities for Telehealth

Each registered or certified SUD counselor/LPHA delivering Telehealth Drug Medi-Cal (DMC) covered services must meet requirements of California BPC § 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 WIC § 5328.

Telehealth Platforms

SAPC does not impose requirements on which live video platforms can be used to provide services via Telehealth, provided they are 42 CFR Part 2 and HIPAA-compliant (rules for telehealth technology) and conform to DHCS expectations and regulations. Telehealth platforms must meet security safeguards to Protected Health Information (PHI) confidentiality. Additional information about Telehealth platforms is available through The California Telehealth Resource Center (CTRC) at www.caltrc.org.

For additional claiming requirements or clarification, see SAPC Bulletin 24-04: Fiscal Year 2024-2025 Rates and Payment Policy Updates and the 837P Companion Guide.

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

Section 3. PATIENT SERVICE STANDARDS: SPECIAL POPULATIONS

Special Programs Defined

Special programs aim to address high-need, high-risk populations that are challenging to reach or engage in treatment services. 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.

In addition to meeting medical necessity to access SUD treatment services under DMC-ODS, individuals must also meet the conditions of the referral entity to participate in these special programs. 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 categories, including those that serve the Criminal Justice, Perinatal, Youth, and Families with Children populations.

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 PPW's specific treatment and recovery needs up to 365 calendar days postpartum. Research indicates that targeted interventions for pregnant women with SUDs increase the incidence of prenatal visits, improve birth outcomes, and lower overall healthcare costs for both mother and baby. The unique needs of PPW must be considered in providing 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 PPW, 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.

Federal priority guidelines for SUD treatment admission give preference to people who are pregnant and inject substances, people who are pregnant and use substances or have an SUD, people who inject substances, and then all others.[15] However, a specific LOC is not prescribed, and thus, the appropriate setting and LOC for this population need 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. Depending on clinical need, LOC determinations need to be based on individualized and multidimensional ASAM assessments and may lead to placement recommendations in the residential or OP setting.

[15] DHCS. (2022, June 3). Perinatal Practice Guidelines (Version 1.1). https://www.dhcs.ca.gov/Documents/CSD_KS/CSD%20Perinatal%20Services/Perinatal-Practice-Guidelines.pdf.

Staff working in settings that provide services for PPW 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 a known risk in the inadequate treatment of addiction during pregnancy, and this needs to be considered and discussed with patients. For pregnant women with OUD, MATs, 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 MAT 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 breastfeeding
- 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 latest version of the Perinatal Practice Guidelines (v1.1, 2022) released by DHCS. The Perinatal Practice Guidelines provides guidance on perinatal requirements in accordance with DMC; and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG or SUPTRS BG; *formerly known as Substance Abuse Prevention and Treatment Block Grant or SABG*) Perinatal Set-Aside from SAMHSA.

The SUBG requires specified funds to be used for perinatal patients and are governed by 45 CFR § 96, Subpart L; DMC funds are governed by CCR Title 22.

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 an SUD agency. Clients should be directed to a PPW Service provider to ensure that they are receiving all services to which they are entitled. Only designated PPW agencies approved by DHCS are allowed to bill for perinatal services.

PPW Target Populations

Per the Perinatal Practice Guidelines (v1.1, 2022), those eligible for PPW services include:

- Pregnant women
- Women with dependent children
- Women attempting to regain custody of their children
- Postpartum women and their children
- Women with substance-exposed infants

PPW Treatment Requirements and Care Coordination

Per the Perinatal Practice Guidelines (v1.1, 2022), treatment agencies that serve PPW are to provide or make arrangements for the following treatment services:

- **Primary Medical Care:** This includes a referral for prenatal care to PPWs 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:** This includes relationships, sexual and physical abuse, DV/IPV, and parenting.
- **Therapeutic Interventions for Children:** Treatment services for the children of PPW receiving SUD treatment services should address the child's developmental needs, sexual abuse, physical abuse, and neglect.
- **Care Coordination:** This includes arranging, coordinating, and monitoring services such as primary medical care, gender-specific treatment, and therapeutic interventions for adults.
- **Childcare Coordination:** This includes arranging, coordinating, and monitoring services such as 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 CCR Title 22, Division 1, Chapter 1. SAPC will reimburse for the following types of childcare for children ages 0-14 years:
  - **Cooperative (Co-op) Childcare**: Licensed-exempt cooperative childcare is delivered while PPW receives SUD treatment services. Co-op childcare is when one woman watches 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 Childcare**
    - Staff-to-child ratios are as follows:
      - Infants (0 to 18 months): one (1) staff to three (3) children
      - Toddlers (18 to 36 months): one (1) staff to four (4) children
      - Preschool Age (36 to 60 months [or 5 years]): 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 Perinatal Practice Guidelines (v1.1, 2022), SAPC expanded SUD treatment services for PPW to include their dependent children up to age 16. Dependent children (age 0-16) 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, accompanying parent in residential treatment services. Contingent on participation in Residential Treatment services by pregnant or parenting women.
- **RBH:** Bed for up to five (5) children per parent, accompanying parent in RBH. Contingent on participation in RBH by perinatal or parenting woman.
- **Childcare 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 dependent children. This benefit may only be used to ensure access to the following services: primary medical care, primary pediatric care, gender-specific treatment, and therapeutic services for children. It is not available to residential providers as this benefit is built into the residential rate.

For additional information on expanded services for PPW, see SAPC Bulletin 18-11.

Drug Medi-Cal Perinatal Eligibility

- The LPHA shall determine whether SUD services are medically necessary and document approval of the diagnosis performed by the therapist, PA, or NP by signing and dating the Problem List (non-OTP settings) or Treatment Plan (OTP settings).
- Medical documentation to substantiate pregnancy and the last day of pregnancy must be in the patient record.
- Pregnant and up to 365 days postpartum. Eligibility (based on pregnancy) ends on the last day of the month in which the 365th day occurs.[16]

Mother/Child Habilitative

Per CCR Title 22, DMC Perinatal programs are to provide mother/child habilitative services. These services focus on the development of parenting skills and training in child development, and coordinating ancillary services. Services include:

- Education to reduce the harmful effects of SUD 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).

[16] 22 CCR § 51303 - General Provisions; 22 CCR § 5026 - Answer to Petition.

For additional information regarding services that are required to be provided to the PPW population, see Perinatal Practice Guidelines (v1.1, 2022).

Women and Children's Residential Treatment Services Program

WCRTS is a funding source used to support Residential Services that are not covered under DMC for PPW patients receiving services in these settings. Covered non-DMC costs include residential room and board and the full cost of treatment services for women ineligible for or unenrolled in Medi-Cal who are receiving services in a PPW residential program.

PPW residential providers may use SAPC WCRTS funds if they meet the conditions outlined in California HSC § 11757.65. Pursuant to California HSC § 11757.65, providers participating in the WCRTS programs must pursue four (4) primary goals and achieve four (4) outcomes for PPW in residential SUD treatment settings.

The **four (4) primary goals** of the WCRTS Program include:

1. Demonstrate that AOD use 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 6- or 12-month stays in a comprehensive residential treatment program.
3. Develop effective, comprehensive service delivery models 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 (4) outcomes** include:

1. Preserving family unity
2. Promoting healthy pregnancies
3. Enabling children to thrive
4. Freeing women and their families from substance use

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 go with pregnancy.
- Support for newborn parenting, education about breastfeeding, 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 needing services can access treatment.
- Promote – Promote awareness among women using injection drugs about the relationship between injection drug use and communicable diseases, such as HIV, Hepatitis B, Hepatitis C, and TB, and offer referrals to appropriate service providers for appropriate screenings.
- Perinatal programs must notify SAPC and DHCS within seven (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 Perinatal Practice Guidelines (v1.1, 2022), providers must report this information on the DATAR system.

Sexual and Reproductive Health Services

SAPC has partnered with DHS to implement programming services geared at identifying and screening women of reproductive age (age 18-50) to facilitate conversations regarding each woman's pregnancy intention. DHS health educators offer health education classes at several PPW provider sites, aiming to expand these services across all sites that serve the PPW population. These programs integrate sexual and reproductive health 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 delivering Reproductive Health Training to offer these services.

The goals of this collaboration are to better identify and support women of reproductive age, help improve access to reproductive healthcare through direct linkages, expand participants' sexual and reproductive health knowledge, improve pregnancy and birth outcomes, manage chronic diseases and STIs, 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 needs with patients. PPW treatment providers who receive Reproductive Health Training will utilize the standardized Reproductive Health Screening (RHS) tool to screen and determine the reproductive needs and services of the individual. This training will guide the PPW treatment providers on how to discuss pregnancy intentionality with their participants and provide them with an overview of the RHS tool. The PPW Treatment Providers will:

- Access the RHS form in Sage to screen individuals during intake or later in treatment to identify what, if any, reproductive health needs the individual may have based on their reproductive preferences.
- Follow the prompts on the RH form to connect the individual with the most appropriate service. This could include their PCP, local clinic, or the nearest DHS clinic or hospital.

For individuals who are currently pregnant, seeking to become pregnant, wanting to prevent pregnancy, or opting to achieve their preferred birth spacing, PPW treatment providers are to facilitate appointment scheduling and referrals for appropriate services (based on their reproductive preferences), such as contraception, pre/inter-conception care, prenatal and postpartum care, and pregnancy options counseling and other services.

DHS-MAMA's Neighborhood Project (PPW-CENS)

The PPW-CENS Project utilizes dedicated CENS counselors to identify pregnant or parenting women to assess for SUD services and, if appropriate, health services pertaining to their pregnancy or reproductive needs. Upon their consent, women would be screened and offered a referral to treatment, other health-related services, or early intervention services. If SUD services are recommended, the CENS Counselor:

- Refers individuals to the appropriate SAPC SUD treatment providers based on the individual's location, type of services needed, and LOC;
- For pregnant individuals who encounter CENS during the screening, CENS are trained to also refer to DHS-MAMA's Neighborhood or other clinics/hospitals for prenatal care and/or options counseling.

Youth Population

In this document, the term "Youth" refers to individuals under the age of 17. Adolescence presents a critical period for influencing risk factors related to substance use, offering an opportunity to address these issues earlier than with adult patients. Youth SUD treatment must be approached differently from adult treatment due to differences in 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 youth and family/peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

These developmental differences are reflected in clinical practices and the ASAM criteria, which often necessitate more intensive LOCs for youth compared to adults. Consequently, the patient-to-counselor ratio for youth cases should be lower than for adults to manage this increased treatment intensity effectively.

Given the rapid progression of substance use among youth, it is crucial to streamline the treatment admission process to promptly identify and address their needs. Engaging youth effectively, maintaining their attention, and retaining them in treatment are essential. Youth treatment should also address their higher rates of CODs, emphasizing the need for coordinated care with mental health services as clinically indicated.

Optimal Treatment of the Youth Population

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

Although most youth 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, youth may be more susceptible to the functional impact of SUDs. For youth, casual substance use can quickly escalate to highly problematic use. Subsequently, youth often exhibit higher rates of CODs, such as anxiety and depression, because of the negative impact that substance use has on normal youth social and psychological development.

Care planning needs to begin with a comprehensive assessment based on the ASAM criteria or, for youth receiving Early Intervention services, with an 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 youth experience, and their unique needs and developmental issues. Strengths and weaknesses need to be identified and youth need to be involved in setting their treatment objectives. Comprehensive youth assessments include information obtained from family, and when the appropriate releases are obtained, members of the community who are important to the youth patient, such as school counselors, peers, and mentors. The support of family members is important for youth‘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.

During treatment, it is important to address the youth’s broader life needs, such as 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. Flexibility in treatment schedules, such as offering weekend and evening hours, helps accommodate ongoing school and social activities, thereby supporting treatment success.

Behavioral therapies, delivered by trained counselors and clinicians practicing within their scope of practice, must be employed to help youth 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 cravings, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

MAT for youth should be considered and used when deemed clinically appropriate by a licensed prescribing clinician. Research and clinical experience have not identified any age-specific safety concerns for MAT, and all treatment options should be considered for patients of all ages.

The ASAM LOC criteria for youth differ from those for adults, as they are specifically designed to address the unique needs of younger individuals. Generally, the ASAM criteria often assign youth to more intensive LOC compared to adults.

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

Similar to other groups, treatment of the youth 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.

Youth patients should be referred to a qualified youth OP treatment agency where they will receive a full assessment and referral to an appropriate LOC, as necessary. If the individual initially presents at an 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 members will be referred to and/or served by a DMC-certified agency for DMC-reimbursable services.

Young Adult Population

In this document, the term "Young Adult" refers to individuals between the ages of 18 and 20 and represents young people transitioning into adulthood, some of whom may have received services from the youth service system and may need continued services and support 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 still relying on the support of parents and caregivers. The mixture of youth 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.

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 youth. This will require a blending of programs that currently exist for youth and adults, and ideally would occur within programs with specific expertise in treating this population. The approach toward caring for young adults must include a flexible mixture of treatment techniques depending on prior contact 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. Initial 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.

Multidimensional assessments include determinations of the developmental stage of Young Adult populations to help inform treatment approaches and whether care modeled after youth approaches or adult approaches may be more appropriate. Strengths and goals need to be identified, and young adults must be involved in care planning. When the appropriate authorizations are obtained, the family should be involved in the information-gathering and treatment process when family involvement is clinically appropriate and determined to be beneficial. Care 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 needs 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 outlined in the *Medication for Addiction Treatment* section, 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 cravings, 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 meeting their unique needs. They should have experience treating Youth (age 17 and under) and Adults (age 21 and over) populations to best blend necessary treatment approaches.

While the ASAM criteria do not specifically explore the specialized considerations of young adults, they do 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.

SAPC Justice-Involved Population

SUD often directly or indirectly results in interaction with law enforcement and the criminal legal system. As a result, most incarcerated people have an active SUD, and overdose is a leading cause of death in the two (2) weeks after release. SUD treatment can help break this cycle by supporting alternatives to incarceration, a safer pathway to community reentry, and ultimately by treating the SUD and its root causes.

Optimal Treatment of the Justice-Involved Population

Effective clinical strategies for working with justice-involved patients should include interventions that address criminal thinking and develop basic problem-solving skills. Providers need to utilize EBPs tailored to managing SUDs, mental health issues, and criminogenic needs. For example, approaches like MI and CBT target both substance use and antisocial behaviors that contribute to criminal recidivism. Additionally, trauma-informed care and CM therapies play a crucial role.

As with other populations, the treatment of justice-involved clients should be viewed as a dynamic, longitudinal process aligned with the chronic disease model of addiction. Consequently, effective treatment should persist even after the legal issues of justice-involved clients are resolved.

CalAIM Justice-Involved Reentry Initiative

Effective October 1, 2024, new requirements for reentry care for individuals released from incarceration under the CalAIM Justice-Involved Reentry Initiative, see BHIN 23-059. Under CalAIM, DMC-ODS providers must engage in Behavioral Health Linkages (BH Link), a type of clinical handoff between pre- and post-release providers, for eligible individuals being released from any state or county CF within California. CFs will need to provide a BH Link for individuals who require MAT or have ever met the diagnostic criteria for an SUD. BH Links aims to streamline data sharing, ensure individuals are released with necessary behavioral health

appointments, and facilitate connections between care managers and post-release treatment providers. Providers should anticipate being contacted by in-custody care managers and are required to coordinate with them to receive in-custody health records, set intake appointments, and facilitate smooth transitions to post-release SUD services. In addition, individuals will have a care coordinator assigned as part of Enhanced Care Management (ECM). The ECM is assigned by the individual's Medi-Cal Managed Care Plan (e.g. LA Care) and will designate a lead care manager for each individual. Providers will need to work closely with the ECM Care Manager to coordinate care and assist the individual with receiving support from their Medi-Cal plan.

Note: SAPC anticipates releasing a SAPC IN in September 2024 with more details regarding the CalAIM Justice-Involved Reentry Initiative.

Adult Justice-Involved Population

While justice-involved clients may have similar clinical needs to other clients in SUD treatment, they often require that treatment providers communicate with justice partners, such as court and probation professionals, to support the client's legal obligations and keep them in the community and recovery.

"Justice-Involved" is an expansive term that includes pre-law enforcement interactions. However, treatment providers interact with justice-involved clients and their justice partners either through:

- Court-Based Diversion Programs,
- Jail-Release/Community-Reentry Programs, **and**
- Community-Supervision Programs through probation or parole.

This section of the Provider Manual reviews each of these three (3) entryways, focusing on LAC-based programs and procedures so that treatment providers are familiar with the local landscape and can continue to support justice-involved clients at this important opportunity for treatment.

Court-Based Diversion Programs

Courts have an important opportunity to recognize alleged criminal activity due to underlying problems, such as SUD, and offer treatment as an alternative to incarceration or further legal action. Court-based diversion is often the earliest opportunity to refer justice-impacted clients to treatment and can prevent the consequences of being charged or extended jail time. Court-based diversion is often conditional on the client being enrolled and engaged in treatment, and judges expect regular updates to assure them that the client is continuing to receive care. For this reason, timely communication with court partners is critical to support clients in continuing treatment and avoiding legal consequences.

Expected communication includes:

1. Being responsive to requests for progress reports, **and**
2. Notifying court partners if the client leaves AMA or is at risk of administrative discharge.

Jail-Release/Community-Reentry Programs

People re-entering the community after incarceration have significant physical and behavioral health needs and are at high risk of injury and death, especially immediately after release. Compared to the general population, people who have been released from jail within the past two (2) weeks are 12 times more likely to die, and the risk of overdose is 129 times that of the general population.[17]

California has prioritized incarcerated individuals with certain qualifying conditions – including substance use disorder – as part of Medi-Cal's CalAIM project. This work involves universal Medi-Cal screening and enrollment, delivery of services 90 days prior to release, and a warm hand-off between in-custody and community-based providers.

For additional information on CalAIM, see DHCS's Justice-Involved Initiative. This policy is anticipated to increase referrals of clients being released from jail to community-based SUD treatment with ongoing case management to ensure that clients who want to receive treatment are successfully enrolled and that services initiated in jail, such as MAT, continue after release.

Community-Supervision Programs: Probation & Parole

Most justice-involved individuals are on probation or parole, roughly twice (2x) as many as those who are incarcerated. This "community-supervision" allows people to remain in the community, maintaining their relationships and employment instead of incarceration. However, people under community supervision need to satisfy any number of conditions – including SUD treatment – to maintain good standing and avoid legal consequences and possible incarceration. **For this reason, timely communication with LAC-Probation partners is critical to support clients remaining in the community and avoid legal consequences.** Expected communication includes:

- Being responsive to requests for progress reports,
- Notifying LAC-Probation partners if the client leaves against medical or is at risk of administrative discharge, **and**
- Discharge date and final report.

The community supervision model in California today is the result of several pieces of legislation enacted over the past two decades. In 2000, Proposition 36 (now known as California Penal Code (PEN) § 1210) mandated that certain non-violent drug offenders be sentenced to probation and receive SUD treatment rather than be incarcerated. In 2011, AB 109 redirected certain Non-violent, Non-serious, and Non-sexual (N3) offenses away from state prisons and towards country jails or community supervision. In 2014, Proposition 47 further reclassified certain non-violent offenses from felonies to misdemeanors. In 2016, Proposition 57 created new parole considerations for non-violent offenses. Taken all together, many offenders who would previously be incarcerated now serve their sentence in the community and often in partnership with SUD treatment providers. **Importantly, Proposition 36/PEN 1210, Proposition 47, and Proposition 57 clients can have SUD treatment services supported by AB 109 funds**. SUD treatment providers should identify "AB109" as a secondary guarantor in Sage to cover expenses not covered by Medi-Cal.

[17] California Health Care Foundation. (2023). CalAIM Explained: Caring for Californians Leaving Incarceration. https://www.chcf.org/publication/calaim-explained-caring-californians-leaving-incarceration/.

Communication with Justice Partners

Justice-involved clients – whether referred from LA Superior Courts, LAC-Probation, or other justice partners – rely on treatment providers communicating with justice partners when necessary to stay in good standing and remain in treatment. While the specifics of what needs to be communicated and when it needs to be shared can vary, overall, there are general expectations that treatment providers should keep in mind.

- **Initial Confirmation of Treatment:** Some partners may request simple confirmation that the client was successfully admitted and is currently in treatment.
- **Progress Reports:** For clients who are receiving treatment as part of a court-diversion or community-supervision-based program, regular progress reports inform justice partners that the client is engaged in treatment as expected. Partners who require this information will typically reach out around every 30 days. However, this may vary depending on scheduled court dates, etc.
- **Discharge/Exiting Treatment:** For clients who are receiving treatment as part of a court-diversion or community-supervision based program, justice partners should be notified when the client exits treatment, whether it be a self-discharge, administrative discharge, or planned discharge. This allows justice partners to help plan and work to bring the client into compliance with their program and, ideally, avoid unnecessary legal consequences.

Treatment Requirements and Care Coordination

The appropriate LOC and interventions should be determined by a qualified counselor or clinician and are not to be determined by justice partners. SUD treatment must be individualized and based on medical necessity. For clients who are incarcerated, SUD screening should be based on the client's substance use status 30 days prior to incarceration.

Contracted SUD treatment providers delivering services to patients referred by the courts will be expected to inform the court of the patient's treatment progress (with informed consent), including other care coordination activities as outlined in the *Overview of Care Coordination and Services* and *Justice-Involved Patients* sections.

Specialty Programs

Substance Treatment and Re-entry Transition - Community (START-Community)

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 ATC 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 Global Positioning Satellite (GPS) ankle monitor worn for the duration of their 90-day 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 OP 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 the patient meets medical necessity.

START-Community Target Population

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

- History of drug and/or alcohol usage and/or drug-related charges for eligibility
- N3 classification
- No past violent, sexual, or arson charges
- Age 18 or older
- No medical or psychiatric conditions that require medications prior to release
- Have a maximum of 90 days left on their sentence and no pending court dates. Individuals who have more than 90 days may be considered for admission on a case-by-case basis as determined by SAPC

Screening and Referral Process

Eligible inmates are identified and assessed by LASD using the Correctional Client Management Profiling for Alternative Sanctions. Then, the overall criminal history and other determinants are reviewed to make an 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 to a community-based residential treatment facility.

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. SUD treatment services for patients referred by LASD may consist of a combination of various treatment service modalities, as outlined in the *Service Benefit and LOC* section.

Care Coordinators may perform additional Care Coordination activities for justice-involved patients as outlined in the *Overview of Care Coordination and Services* and *Justice-Involved Patients* sections.

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 an 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. The most common concerns reported include, but are not limited to:

- Battery life diminishing,
- Patient wandering out of bounds, **and/or**
- Notification of patient being transported to off-site appointments.

Compliance Check Procedures

LASD will conduct periodic compliance checks for all patients receiving SUD treatment services and who are under electronic monitoring. Compliance checks and investigations are conducted randomly and may occur in person or via telephone. They require a status report on the patient's progress in treatment and/or verification of physical presence at the 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 advance 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 must 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 LASD 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 admission and discharge reports within 24 hours of the patient's admission and discharge.

Early Termination

Termination of any 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 SAPC within 24 hours and document the termination reason in the appropriate data tracking system (e.g., CalOMS/LACPRS).

In addition, treatment agencies shall complete the Program Incident Form (see Appendix G) 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 SAPC's Treatment Systems of Care Division (SAPC-SOC) at SAPC_ASOC@ph.lacounty.gov.

Termination can occur for the following reasons:

- Absconding or willful violations of program requirements,
- Participant poses a safety risk for self or others, **or**
- Participant opts out of the project.

Note: Termination of START-Community will require the patient to be returned to jail to complete the remainder of their sentence.

In-Custody to Community Referral Program

The In-Custody to Community Referral Program (ICRP) is an SUD collaborative designed to provide a warm handoff for individuals transitioning from incarceration to SUD services in the community upon release from custody. The ICRP is a partnership among SAPC, its contracted treatment providers, and the Los Angeles County Department of Health Services, Correctional Health Services (DHS-CHS).

Rapid Diversion Program

The Rapid Diversion Program (RDP) is a pre-plea diversion program targeting individuals with a mental health diagnosis or SUD. Individuals participate in programming, receive housing resources, and are case-managed for a period of time recommended by the service provider and approved by the court. Cases are dismissed for individuals who successfully complete the program. RDP is run through the Justice Care and Opportunities Department, and case managers are contracted through Project 180 and Exodus.

Los Angeles Law Enforcement Assisted Diversion

Los Angeles Law Enforcement Assisted Diversion (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 is run through the Los Angeles County Department of Health Services, Office of Diversion and Reentry (DHS-ODR), with case management contracted through Alma Family Services and the LA Community Health Project.

Community Re-Entry and Resource Center

The CRRC is a hub station that operates as a one-stop shop for male inmates transitioning back to the community. CENS provides on-site SUD screening to clients being released from the county jail or for LAC-Probation to refer AB 109 clients with potential need of SUD treatment.

Developing Opportunities Offering Reentry Solution

The Developing Opportunities Offering Reentry Solutions (DOORS) center is an initiative of LAC-Probation's Adult Services Division and DHS-ODR. It 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.

Co-Occurring Integrated Care Network

The Co-Occurring Integrated Care Network (COIN) program addresses the needs of adult AB 109 clients who have co-occurring chronic SUD and severe and persistent mental illness. COIN provides integrated SUD and mental health treatment. Treatment is for patients who are at high risk for relapse and are referred through the AB 109 Revocation Court.

Division of Adult Parole Operations

The California Department of Correction and Rehabilitation, Division of Adult Parole Operations (DAPO) supervises the adult parole population. DAPO's 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 CENS, 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 the County's DMC-ODS SUD treatment system of care.

Juvenile Justice-Involved Population

The County's juvenile justice system governs the legal (i.e., LA Superior Courts) oversight and LAC-Probation detention (i.e., juvenile halls/camps) of youth and young adults pre- and post-adjudication. The system's objectives – in addition to maintaining public safety – are skill development, habilitation, rehabilitation, addressing treatment needs, and successful reintegration of youth and young adults into the community. The County is currently expanding diversion efforts to deter in-custody placements; however, patients dispositioned to the County's juvenile justice system may be placed in-custody for short periods of time and should be prepared for rapid re-entry transition. Additionally, youth and young adults serving sentences in State juvenile justice facilities have been transferred to the County, which will result in longer periods of custody at County facilities.

Given the nature of in-custody settings, delivery of services must consider security protocols and limited access to youth throughout the day-to-day settings. SAPC and its providers will work with LAC-Probation to understand security protocols and advocate for appropriate youth SUD services.

Juvenile Justice Crime Prevention Act

The JJCPA funds collaborative projects between SAPC and LAC-Probation. The goals of this collaboration are to:

- Provide youth with skills to resist continued substance use and the associated negative behaviors.
- Demonstrate reductions in subsequent arrests, incarceration, and probation violations.
- Increase completion of probation, restitution, and community service requirements.

JJCPA Target Population

JJCPA services are for at-risk youth and probation-involved youth either in-custody or under community LAC-Probation supervision.

Referral Process for In-Custody Juvenile Population

- In-custody, pre-adjudicated youth are typically referred when probation case workers have identified an individual in need of SUD screening, intervention, and treatment linkage in preparation for release from custody. However, any entity providing in-custody services to the youth may refer to CENS (i.e., DMH, DHS, LACOE Courts) for the appropriate screening and services. JJCPA funds co-located CENS services at the Los Padrinos Juvenile Hall.
- All referrals for JJCPA CENS services must be submitted utilizing the *Juvenile Justice SUD Screening Referral Form for CENS (see Appendix I)*. For additional details on CENS services for this population, see CENS Standards and Practices.

Referral Process for Juvenile Population in the Community

- LAC-Probation's Prospective Authorization and Utilization Review Unit (PAUR) makes/approves all JJCPA referrals to youth providers, including those from school-based and other LAC-Probation Officers.
- Within five (5) business days of receiving a referral, the youth provider must notify PAUR of family contact via email and the CBO tracking system. Request an extension via email to PAUR if needed.
- After the first in-person (intake) session, return the referral form with the "Agency Response" section completed (including the start date) to PAUR. 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 Deputy Probation Officer (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 incomplete, return the referral form to PAUR with the Did Not Complete (DNC), date, and reason.
- Upon discharge and service completion, return the referral form to PAUR with the completion date.

Reporting Requirements and Procedures

- **Reporting to LAC-Probation (Community)**: A CBO Note must be entered into LAC-Probation's web-based reporting system (www.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 LAC-Probation's web-based reporting system must be completed monthly and updated as necessary.
- **Reporting to LAC-Probation (In-Custody)**: Upon completion of appropriate ROI, the completed screening results form shall be returned to the LAC-Probation case worker for inclusion reporting back to the court. For patients accessing ongoing intervention services, monthly progress reports shall be reported to the case worker.
- **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 LAC-Probation 's web-based system.

Staffing and Fingerprint Clearance

SAPC and LAC-Probation shall ensure ongoing compliance with background and security investigations applicable to each department's contracts and contract employees.

Secure Youth Treatment Facilities

Senate Bill (SB) 823, the Juvenile Justice Realignment Bill, resulted in the closure of the State of California Division of Juvenile Justice (DJJ), effective June 20, 2023, and the transfer of individuals aged 15-25 who were convicted of crimes as juveniles back to the County. The Board of Supervisors has identified three (3) site locations as Secure Youth Treatment Facilities (SYTF) to house these high-risk detainees. SAPC has received SB 823 funding via a Direct Service Order with LAC-Probation to implement SUD services for this population.

SYTF Target Population

The target population includes Youth (age 17 and under) and Young Adults (age 18-20) referred for JJ-SUD and housed at one of three (3) sites identified as SYTF by the Board of Supervisors to house high-risk detainees diverted from DJJ to the County in response to SB 823. The three (3) current SYTF sites are:

1. Barry J. Nidorf Juvenile Hall,
2. Camp Vernon Kilpatrick, **and**
3. Dorothy Kirby Center.

Contracted SUD treatment providers co-located at these SYTF sites offer Early Intervention/AAR and OP Services for suitable clients (see more information about these services below). SYTF Probation case workers can refer potential clients for these SUD services by completing the *Juvenile Justice SUD Screening Referral Form for SYTFs (see Appendix J)*. In addition, post-adjudicated clients sentenced to SYTF sites from Los Padrinos Juvenile Hall (LPJH) and screened by the co-located CENS at LPJH to be suitable for SUD services can also receive Early Intervention/AAR or OP services.

SYTF Provided Services

Early Intervention and Adult At-Risk Services

are available for clients whose screenings show no need for SUD treatment but who would benefit from intervention due to high-risk behaviors, including those leading to incarceration. These services, which use evidence-based and County-approved materials (e.g., "*Healthy Youth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth*" for Youth [age 17 and under] and Young Adults [age 18-20], and AAR materials developed by SAPC-CST), can be delivered individually or in groups and focus on:

- Understanding SUD signs, risks, and associated consequences
- Minimizing harm related to SUD
- Preventing overdose, dependence, and relapse
- Promoting sobriety
- Delivering curriculum within a timeframe appropriate for individual comprehension

SUD Treatment Services (ASAM 1.0)

OP treatment services are available to individuals who meet the medical necessity criteria for this LOC. Providers receive referrals from on-site LAC-Probation staff and may also get information from other providers when individuals are transitioning from other probation facilities. Barry J. Nidorf offers an SUD housing unit for a small group, but placement in this unit is not required to receive SUD treatment services.

If individuals are transitioning to another probation facility or would benefit from ongoing community-based care upon release, the provider will facilitate a warm handoff.

People Experiencing Homelessness Population

Homelessness significantly affects many individuals with SUDs, often due to the socioeconomic decline associated with addiction. Estimates suggest that 20-35 percent of PEH have substance use issues. PEH generally require more intensive treatment and face greater and more diverse needs compared to those with stable housing. They encounter numerous barriers to accessing care, including social isolation, distrust of authorities, lack of transportation, and multiple needs.

Stable housing is crucial for achieving treatment goals and is a key component of effective services. Early linkage to secure housing in treatment often leads to better outcomes, highlighting the importance of Care Coordination to address the diverse needs of PEH.

Optimal Treatment of PEH Populations

Research indicates that effective programs for PEH should address both their substance use and practical needs, such as housing, employment, food, clothing, and finances. These programs should be flexible, non-demanding, and tailored to the specific needs of different subpopulations, such as by gender, age, or COD. They should also offer long-term, continuous interventions. Therefore, substance use treatment for PEH must integrate a holistic approach that considers the individual's overall needs and environment.

A comprehensive range of services is required to meet the safety, health, social, and material needs of PEH. Common services include food and clothing assistance, shelter/housing, identification papers, financial aid, legal support, medical and mental health care, dental care, job training, and employment services. These services can be provided directly within the SUD program or through connections with community resources. Proactive outreach in a non-judgmental and supportive manner, and addressing identified needs early in treatment, can enhance engagement with this population.

Psychosocial interventions and MAT for PEH should adapt successful strategies used with other populations to address their unique needs. Mobile outreach services and motivational enhancement interventions are particularly effective in encouraging ongoing treatment engagement, as PEH generally respond better to supportive rather than confrontational approaches.

Counselors and clinicians must address the physical and mental health needs of PEH, considering their high rates of co-morbidity. Medications should be used when clinically indicated, with prescribing practices that

consider the environment in which medications will be used and stored (e.g., 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 PEH tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

Effective counselors and clinicians often have a particular interest and comfort level in working with this challenging and rewarding population. Staff should be skilled in managing the diverse needs of PEH and knowledgeable about community resources to make appropriate referrals and linkages. Ideally, care teams are interdisciplinary, including medical, mental health, substance use, and social service professionals, working collaboratively.

While treating PEH with SUDs is challenging, successful outcomes are achievable by focusing on access to suitable housing and providing comprehensive, patient-centered services with skilled staff.

Services for PEH

PEH 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.

PEH Target Population

All single adults, youth, and families who meet the homeless or chronic homeless definition set by the HUD, LA County agencies, and other local housing organizations.

Determination of Appropriate LOC and Linkage to Treatment

- **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 OP, IOP, OP-WM, or OTP 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.
- **Patient is Enrolled in Treatment:**
  - If the patient is enrolled in treatment, the provider must complete the steps noted in PEH under Care Coordination Considerations for People in Vulnerable Groups.

Assessment for PEH

Trained SUD care coordinators with access to the Homeless Management Information System (HMIS) will:

- Obtain patient's consent to share information in HMIS to coordinate housing resources. Administer the CES Survey Packet, including the VI-SPDAT for homeless adults, families, and the Next Step Tool for Youth (age 17 and under) and Young Adults (age 18-20);
- Enter or update the homeless patients' information into HMIS; **and**
- Coordinate with the CES agency for the patients' housing within 14 calendar days of the first treatment service or intake appointment; see CES Access Point Directory.

Treatment providers who have not been trained on the CES adult and youth tools and have not received access to HMIS:

- Will need to refer PEH directly to the CES agency within the same SPA within 14 calendar days of the first service or intake appointment.
- To get access to HMIS, email SAPC-SOC at SAPC_ASOC@ph.lacounty.gov.

For PEH 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, and PPW may be offered SAPC's RBH benefit if they prefer a temporary recovery-focused environment prior to securing more permanent housing.

Care Coordination for PEH

The SUD counselor or care coordinator will work with the CES Housing Navigator to ensure all required documents and forms are uploaded into HMIS and that the patient is Match Ready (i.e., all necessary documentation is collected and entered into HMIS). They will also assist the patient in completing the required application forms and ensure eligibility for permanent housing vacancies listed in the CES.

Housing Assessment and Intervention Options[18]

Within three (3) calendar days of admission for patients identifying as homeless, SUD counselors/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 SUD counselor/care coordinator will take to support the patient in moving toward stable housing. The housing plan serves as a road map of needed services, actions that need to be taken by both the SUD counselor/care coordinator and the patient, and referrals that need to be made to address the patient's housing barriers. The SUD counselor/care coordinator must develop a housing plan for every patient identified as homeless or unstably housed and work together to identify 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:

[18] SAPC. (2024, January). Recovery-Oriented Housing Assessment and Intervention Workflow. http://publichealth.lacounty.gov/sapc/docs/providers/trainings/Recovery-Oriented-Housing-Assessment-Intervention-Workflow.pdf.

a. Steps needed to mitigate those barriers to housing,
b. The patient's strengths and the steps to build on those strengths,
c. 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 SUD counselor/care coordinator must propose interim housing options, including emergency housing, so the patient does not return to homelessness upon discharge.

The housing plan should include both short-term and long-term goals and objectives with reasonable timeframes to achieve them. The goals can address housing, income through benefits and/or employment, money management and budgeting, and improving physical, mental, and/or SUD health.

At a minimum, the SUD counselor/care coordinator must collaborate with the patient every 15 days to review any changes in status and regularly update the housing plan until the patient transitions to stable housing. The housing plan, relevant notes, and updates should be entered in Progress Notes in Sage.

2. **Connect Patient to the CES:** LA 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.

   In LA County, HMIS is used in the coordinated entry process by homeless assistance providers to coordinate care, manage operations, and enhance service delivery. This secure online database allows organizations to gather and manage patient-level and system-wide information on services for PEH and those at risk. SUD treatment providers will utilize HMIS to collect accurate patient information, facilitating the best match to available services in the CES. The care coordinator must check if the patient has a profile in the HMIS system:
   a. If there is no record of an existing profile, providers will initiate a patient record in HMIS and complete the appropriate and most recent version of the CES Triage Tools.
   b. If the PEH has a patient profile in HMIS, a completed CES Triage Tool score in HMIS, and an 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:
      i. Their life circumstances have changed,
      ii. Their triage tool result contains errors, **or**
      iii. Because their condition limits their ability to respond to the questions on the triage tool.
   c. The SUD treatment provider 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.
   d. If the SUD treatment provider staff 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 with the adult or youth CES Access Centers within the same SPA and within three (3) calendar days of admission.
   e. Homeless families should contact 211 and be referred to the Family Solution Centers within each of the eight (8) SPAs countywide within three (3) calendar days of admission.

3. **Enter or update the Point of Contact:** SUD counselors/Care coordinators must enter and update the patient's information and Point of Contact every 90 days in HMIS to ensure that the patient remains in the queue so the housing participant can be reached in the event of a potential match to a housing resource. Points of Contact work to:
    a. Connect patients to services and resources in support of a successful housing placement,
    b. Provide document collection support, and
    c. Provide a warm handoff to any services and resources made available.

The Point of Contact may change while the patient is 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 transition from Residential to OP treatment would necessitate a change in the Point of Contact. For additional information about identifying a Point of Contact, see Table 12.

Table 12

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: • Open HMIS and go to the Client Profile Page • 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. • Open HMIS and go to Patient Profile • Revise Date
Updating a Point of Contact After Loss of Communication	When the Point of Contact can no longer contact the CES patient and/or perform the roles and responsibilities of a Point of Contact, the contact fields should be deleted. • Open HMIS and go to Patient Profile • 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. • Open HMIS and go to Patient Profile • Add Point of Contact fields for secondary Point of Contact (Date, Name, Phone, Email, Agency, Program) • Delete Point of Contact fields for original Point of Contact (Date, Name, Phone, Email, Agency, Program)
Updating Points of Contact When There are Two (2)	• Open HMIS and go to Client Profile • If two (2) Points of Contact are already recorded, confirm that both contacts are still working with the patient. • Delete any Points of Contact 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)

Discharge for PEH

When the CES Housing Navigator notifies the SUD counselor/care coordinator when a housing resource has been identified, the SUD counselor/ care coordinator will coordinate the appointments between the Housing Provider and the patient, verifying eligibility information and assisting the patient with the housing application process. The SUD counselor/care coordinator will link the patient to the appropriate supportive services for securing and maintaining appropriate housing, including income/benefits/employment and transportation.

SAPC aims to prevent situations where patients are discharged into unsheltered homelessness. Requests for continued residential admission for PEH without stable housing will be considered if:

- The patient's homelessness status is documented in CalOMS, a current finalized Problem List/Care Plan (updated every 30 days), or the patient's EHR.
- The patient agrees to ongoing residential admission and treatment.
- The provider has documented efforts to develop a post-discharge housing plan.
- These details are included in a Progress Note submitted with the request for residential LOC reauthorization.

Interim Housing Outreach Program

The Interim Housing Outreach Program (IHOP) addresses current gaps in behavioral and physical health services in interim housing settings to support stability, facilitate transitions to permanent housing, and prevent homelessness recurrence. CENS counselors join Interim Housing Multi-Disciplinary Teams (MDTs) across LA County, collaborating with staff from DMH and DHS-Housing for Health (HFH) to meet clients' comprehensive behavioral and physical health needs.

CENS counselors will deliver on-site substance use outreach, engagement, educational sessions (both individual and group), screening, and referrals to SUD services. This includes connecting clients with SAPC treatment providers offering MAT at interim housing sites.

Additionally, CENS counselors will implement harm reduction strategies, coordinate referrals to harm reduction services like syringe programs, and provide overdose prevention training and kits to residents and staff. For residents needing traditional SUD treatment but unable or unwilling to attend a treatment facility, OP services can be offered on-site through SAPC's network of FBS treatment providers.

Measure H

As part of LA County's agenda to combat homelessness and effectively serve PEH, special funding through the Measure H quarter-cent sales tax is allocated to support RBH for PEH who are exiting from institutions such as jails, prisons, other correctional facilities, hospitals, UCCs, SUD residential treatment centers, mental health treatment facilities, and foster care and probations camps for young adults aging out of these settings. For full benefit details, see *Recovery Bridge Housing* section. Measure H also supports SUD screening and referral services at PSH sites throughout the county. For full benefit details, see *Client Engagement and Navigation Services* section.

Recovery Housing

RH is recovery-oriented housing provided for Young Adults (age 18-20) and Adults (age 21 and over) who have minimal risk of acute intoxication/withdrawal potential, and biomedical and mental health conditions. Certain populations, such as PEH, are particularly at risk for relapse without access to housing and should be prioritized for this benefit. Participants in RH must be interested in living in recovery-oriented housing and be interested in following RH requirements. However, they do not need to be concurrently enrolled in treatment.

RH Program Eligibility

- In need of a stable, safe, and abstinence-based living environment to best support their Substance use recovery.
- Engaged in SUD treatment and/or RBH in the last 90 days in a SAPC-SOC or DPH-contracted agency.
- Able to conduct activities of daily living independently.

RH Participant Prioritization

The following high-risk populations must be prioritized for RH according to the following ranking:

1. CARE program participants
2. PPW (pregnant to 60 days postpartum)
3. History of IV drug use
4. Patients with high utilization of treatment services
5. People experiencing chronic homelessness
6. People who are justice-involved without alternative options for RH
7. Young Adults (age 18-20)
8. People living with HIV/AIDS
9. PEH stepping down from residential treatment into RBH, also known as “residential step down”
10. LGBTQ+ populations

Note: Populations not on the prioritized list will be considered for RBH only if there is enough capacity to accommodate those on the prioritized list first.

RH Program Length

Young adults and adult participants may be authorized and reimbursed for up to 12 months cumulatively (not necessarily consecutive) within the past two (2) years, provided they meet the specified eligibility criteria. SAPC aims to prevent planned transitions from RH to unsheltered homelessness and will consider one (1) extension of up to three (3) months under specific conditions.

To request an extension, providers must submit a written request to SAPC detailing the circumstances. The final decision will be made by SAPC-SOC. Extensions may be granted in cases such as:

- Preventing a client from leaving RH into unsheltered homelessness, **or**
- There is a housing plan with a housing date but no interim housing option.

RH Referral Process

Referrals for RH should be made directly to SAPC. The referral can be made by the following:

- By a service provider;
- By a Housing Navigator;
  - By one (1) of the SAPC entryways: LGBTQ+ Populations.
  - CORE, 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 the unique needs that may not be addressed by SUD programs.
  - SASH, or
  - CENS.
- Self-referral.

Conditions of referral process:

- Agencies operating RH cannot restrict access to this benefit to only their own agency's treatment patients.
- Agencies are required to accept referrals to available beds from other networked providers and need to refer their patients to other available RH beds if they have met their capacity.

RH Discharge Procedure

Complete and submit the discharge form to SAPC.

RH Participant Discharge

- Relapse is not treated as an automatic cause for eviction from housing or termination from the program.
- Discharge from housing only occurs under the following conditions:
  - Participant is no longer interested in residing in RH and voluntarily leaves on their own accord;
  - Participant's behavior substantially disrupts or impacts the welfare of the recovery community in which the participant resides; **or**
  - Participant is no longer able to benefit from RH 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.
- 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.

Housing Navigation

Housing Navigation (HN) is an integral part of the process of assisting people in identifying housing options, resources, and services. Housing navigators help individuals prepare, find, move into, and retain affordable and permanent housing opportunities. Providing HN services to clients residing in RBH and RH will ensure that clients can actively work towards securing a permanent housing plan, thus mitigating the risk of homelessness and relapse with SUD.

HN Program Eligibility

- PEH and are enrolled in SAPC-SOC.
- Individuals enrolled in RBH or RH must enroll in HN services.
- Clients have the option to opt out of these services if:
  - Have already established a housing plan when they complete RBH and/or RH, **or**
  - Are already engaged in HN services through another agency/provider.

HN Program Length

Clients will have access to HN services prior to and during their enrollment in RBH (up to 180 days) or RH (up to 12 months), and for up to 30 days after leaving either housing program.

HN Referral Process

Housing Navigators are limited to providing services to individuals seeking or enrolled in SAPC-SOC. Housing navigators will notify the RBH/RH agencies within their respective SPA locations about any individuals who would benefit from a linkage. RBH/RH agencies will be required to connect individuals in either housing setting to HN services, unless the individuals are connected to another HN Service, as reported by the client. Agencies will be expected to document when a client declines participation in the participant file.

HN Documentation

- The housing navigator develops an Individualized Housing Plan for each client and documents progress on the plan.
- Complete the HMIS Intake and Referral Form.
- Housing Navigator must document participants as directed by SAPC and maintain a file documenting all occurrences and services provided as part of HN services.
- Billing must be submitted with all the required documentation as directed by SAPC.

HN Participant Assistance Funds

As funds are available, HN includes distributing Participant Assistance Funds of up to $500 to enrolled PEH to remove barriers and mitigate stress that may contribute to behavioral health conditions while assisting in meeting their immediate housing needs (e.g., assistance obtaining identification and related vital documents, transportation, food, and hygiene products). Funds may also be used to support individuals in completing housing applications, or for costs associated with credit reports, security deposits, utility hookups, and moderate furnishings.

HN agencies are tasked with distributing Participant Assistance Funds as part of HN services and should follow the steps described below to document distribution. Agencies will submit an invoice for reimbursement as directed by SAPC.

Length for Use of Funds

Clients will receive Participant Assistance Funds while enrolled in HN services. Clients are eligible for HN while they are enrolled in RBH (180 days) or RH (12 months) and up to 30 days after leaving the program.

Documentation

Records of all Participant Assistance Funds distributed should be documented and logged in accordance with the County's accounting manual and should include:

- Name and contact information of clients who received them
- Date the funds were received
- What the funds were used for
- Agency staff, and client signature that funds were received

Lesbian, Gay, Bisexual, Transgender, Queer Population

LGBTQ+ individuals often experience higher rates of substance use compared to the general population. The stigma and discrimination associated with being part of a marginalized community can lead some LGBTQ+ people to use substances as a coping mechanism. 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 the unique needs that may not be addressed by SUD programs.

Despite protections intended to shield people in recovery from discrimination, LGBTQ+ individuals frequently face inadequate safeguards. Homophobia, heterosexism, and transphobia can make it challenging for them to access treatment and discuss their sexual orientation or gender identity openly. Internalized negative societal attitudes can lead to feelings of sadness, doubt, and fear, further complicating their trust in healthcare systems.

Important Considerations in the Treatment of the LGBTQ+ Population

Providers need to be aware of some unique aspects of treating LGBTQ+ patients. While group therapies should be as inclusive as possible and encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ+ patients. It is crucial for staff to ensure that LGBTQ+ patients are treated with respect, and group rules should foster an inclusive and welcoming environment.

LGBTQ+ patients should have control over whether they discuss their sexual orientation or gender identity in mixed groups, and this decision should not be influenced by other group members. While individual services can reduce the risk of heterosexism, homophobia, or transphobia in group settings, group therapy also offers valuable healing opportunities when LGBTQ+ patients receive acceptance and support from non-LGBTQ+ peers.

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 physical and mental health care.

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:

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

Family dynamics play a crucial role in treating LGBTQ+ individuals, and SUD providers should recognize that family therapy may be challenging due to potential alienation related to the patient's sexual or gender identity. Nonetheless, involving family in the treatment process can lead to more positive outcomes. Attention should be given to discharge planning, considering factors such as living environments (for recovery and safety), social isolation, employment, finances, and ongoing issues related to homophobia and transphobia.

Successful treatment for LGBTQ+ patients involves cultural sensitivity, understanding the effects of cultural victimization, and addressing internalized shame and negative self-acceptance. CBTs can help challenge negative beliefs and enhance emotional regulation, which aids in relapse prevention. Motivational enhancement techniques can also boost treatment engagement among LGBTQ+ individuals.

Understanding each patient's unique history and background enhances respectful treatment and increases the chances of positive outcomes. SUD treatment staff may sometimes be unaware or insensitive to LGBTQ+ issues, harbor biases, or mistakenly believe that sexual or gender identity causes substance use or can be altered through therapy. In these cases, providers need to be aware of these beliefs in order to prevent them from becoming barriers to the effective treatment of LGBTQ+ patients. A Substance Abuse Treatment Facility's commitment to promoting sensitive care for LGBTQ+ patients can be included in its mission statement, administrative policies, and procedures. Providing staff training and education are oftentimes valuable and include sexual orientation sensitivity training to promote a 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.

Co-Occurring Disorder Population

In this document, CODs 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 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 ensuring that COD treatment interventions are combined within a primary treatment relationship or service setting.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "TIP 42: Substance Use Treatment for Persons With Co-Occurring Disorders" 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.
- **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 needs and functional level of COD patients.
- **Use support systems to maintain and extend treatment effectiveness:** Given that many patients with COD have strained support systems and the central importance of supportive people and environments in the recovery process, ensuring that patients are aware of available support systems and motivated to use them effectively is a vital element of effective treatment of the COD population.

Optimal Treatment of COD Population

Research generally supports addressing through integrated care, rather than treating SUDs and mental health conditions separately. When staff are trained and skilled in managing CODs, integrated care should be provided in-house. If a provider cannot offer the necessary services, patients with CODs should be referred to appropriate external providers who can deliver the required care.

Developing a therapeutic alliance with patients who have CODs relies heavily on the counselor or clinician's comfort level in working with this population. Some SUD counselors or mental health clinicians might find patients with significant mental health conditions or substance use disorders intimidating. It's crucial for professionals to recognize these feelings and employ strategies to prevent them from impacting patient care. Often, these challenges can be addressed through further experience, training, supervision, and consultation.

While SUD counselors are not expected to diagnose mental health disorders, they should be familiar with relevant terminology and criteria to identify potential mental health concerns that may require referral. Training that enhances understanding of mental disorders and guidance on accessing appropriate medical or mental health support is essential.

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 in effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to successfully implement integrated care programs and 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, CM, 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 MAT is an essential component of the treatment of individuals with CODs. 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 are preferable and lead to better outcomes than either intervention alone. An important component of the treatment of patients with CODs 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 SUDs and mental health conditions when necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, treating patients with COD requires a comprehensive and flexible approach and coordination with other systems of care.

Veterans

According to the 2018-2022 United States Census, LA County is home to 230,028 veterans. While veterans share some common experiences, their backgrounds and needs are highly diverse. Some may have seen 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. Gender also plays a role, with increasing reports of female veterans experiencing sexual harassment and trauma.

These varied experiences can lead to SUDs and present unique challenges in treatment. Some veterans might not qualify 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. SUD treatment providers must ensure that their services are tailored to meet the diverse and specific needs of veterans and their families.

Important Considerations in Treating the Veteran Population

Given the high prevalence of trauma and complex physical and behavioral health issues among Veterans, SUD providers should conduct comprehensive assessments that address all potential complications. This includes exploring trauma, combat or war experiences, and injuries that might affect the patient's participation in SUD treatment. When such issues are identified, it is crucial for SUD providers to collaborate with other healthcare professionals, such as medical and mental health providers, to ensure coordinated care.

Stigma presents an additional challenge. While stigma around substance use is common, veterans may also face stigma regarding seeking help for any health condition. Anger and personality disorders can further complicate engagement in treatment. To overcome these barriers, EBPs such as MI can be essential for effective treatment.

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.

Older Adults Population

As the population of older adults grows and the chronic nature of SUDs becomes more evident, it's crucial to adapt treatment approaches to meet their specific needs. While "older adults" generally refers to those over 65, clinical needs may extend this definition. For example, individuals under 65 who experience significant cognitive deficits, medical issues, or social challenges might require treatment strategies typically reserved for older age groups.

Treating older adults requires specialized approaches due to several unique factors. Altered metabolism, changes in brain function, and common age-related health conditions can result in an underestimation of the impact of substance use in this population, creating diagnostic challenges. Many older adults are retired, which diminishes the significance of work-related or social impairment as an indicator of substance use. Even small amounts of alcohol or substances can have a more pronounced effect on older adults than on younger individuals. Additionally, healthcare providers may sometimes overlook substance use in older adults, mistakenly attributing symptoms to dementia, depression, or other age-related issues.

Social isolation, limited access to transportation, and heightened feelings of shame and guilt can make it more difficult for older adults to access services compared to other age groups. These challenges may cause older adults to hide their substance use and be less likely to seek professional help. Many older adults also serve as primary caregivers for spouses with significant needs, which can further limit their ability to enter treatment due to their caregiving responsibilities.

Optimal Treatment of the Older Adult Population

SAMHSA panelists suggest the following best practices for treating older adults:

- 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 in dealing with depression, loneliness, and loss.
- Staff working with older adults must be interested and experienced in working with this population.

Research has demonstrated that age-specific assessment and treatment are 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 are 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 a 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 and 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 TIP series titled "TIP 26: Treating Substance Use Disorder in Older Adults" consensus panel members recommend limiting the 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 cautiously 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 WM, 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 population 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 a more advanced age. The best results are typically achieved when the staff is experienced in dealing with the physical, psychological, social, and spiritual issues unique to older adults. Staff who interact with older patients need to receive regular trainings on empirically demonstrated principles and techniques effective for older populations.

Adult Programs

DPSS – General Relief

GR Referral Process

As a condition of eligibility, all adult GR applicants must undergo a pre-screening interview for an SUD by their DPSS Eligibility Worker (EW). If there is a reasonable suspicion of an 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:

- The CENS area office nearest to the participant;
- Directly to a contracted SUD treatment agency; **or**
- 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 outlined in the *Early Intervention and Treatment Service Components* section.

The Treatment Progress Report (Form ABP 132) is generated by the LEADER Replacement System (LRS) and mailed directly to the receiving contracted SUD treatment agency every 60 days for completion. It is then returned to DPSS, which 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 patient's 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 SAPC-UM, which will evaluate and approve/deny the request. The contracted SUD treatment agency will forward the form to DPSS for final approval/denial, which then updates LRS. DPSS is responsible for notifying and sending a copy of the extension status back to the contracted SUD treatment agency.

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, accessed according to login instructions given by DPSS.

Family Programs

DPSS Programs

CalWORKs

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 (3) ways:

1. Referral to the CENS area office nearest to the participant where the CENS will:
   a. Schedule the screening appointment within three (3) business days after receiving the GSW GN 6006A referral;
   b. Screen the participant using the ASAM CO-Triage;
   c. 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**
   d. 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 CalWorks Treatment/Services Verification Form (PA1923 Form), 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 Los Angeles County Department of Public Social Services, Centralized Unit (DPSS-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 forms;
- 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 whether the participant has enrolled in treatment or missed the appointment. If the agency receives GN 6006A from CENS, it should be filed in the participant's records, as CENS has already sent a copy to the DPSS GSW.

Note: The patient shall be admitted to treatment according to the appropriate LOC and/or patient's preferences. If the patient must transfer to a different agency, a copy of the GN 6006B form will be faxed to the GSW to notify them of their new treatment location. A copy of the GN 6006B form must also be forwarded to the new treatment agency.

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. Services may be a combination of various treatment service modalities as outlined in the *Early Intervention and Treatment Service Components* section. SUD treatment services for CalWORKs participants include: OP, Residential, WM, RBH, and RS.

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 the GN 6006B form, page two (2) within five (5) business days of service enrollment, to report the 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 CDSS 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 requirements. 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 and include changes in LOC, 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 by the Centralized PA 1923 unit. Agencies must obtain and keep on file a Provider Notification Letter for patients entering treatment through PA 1923.

CalWORKs Asian Pacific Islander Targeted Outreach Program

The purpose of outreach to the Asian Pacific Islander (API) targeted population is to provide SUD information and education for CalWORKs participants who may have an SUD and/or co-occurring mental health issues in the API communities. The outreach seeks to identify SUD needs and connect persons with culturally and linguistically appropriate staff and treatment services levels. Persons to be served include participants in the API communities in LA County, including PEH.

The program also provides intensive, family-centered pre-treatment outreach, education, and supportive services to affected Korean, Cambodian, and Samoan families in LA County. This is 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 (3) dedicated SAPC Treatment agencies that 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-help (i.e., Alcoholics Anonymous, Al-Anon, and Narcotics Anonymous) complements 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.

CalWORKs Adult At-Risk Program Overview

The CalWORKs AAR Program is designed to provide individuals receiving DPSS CalWORKs benefits an opportunity to learn about and be aware of SUD through interactive educational sessions. This initiative provides educational 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 an 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.

CalWORKs Adult At-Risk Program: Target Population

The target population is any DPSS CalWORKs participant who has been referred by DPSS' 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 the 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 a referral to the AAR Program, which is voluntary. The dedicated CalWORKs CENS Counselor refers a client to and arranges an appointment for enrollment and services with the CENS At-Risk Counselor. The client enrolls and completes the program or refuses to enroll. If the client consents, the CalWORKs At-Risk Counselor informs the DPSS worker via email and will send a secure email to SAPC with both the referral form and Intervention Plan on a monthly basis.

CalWORKs Additional Programs

CalWORKs funding also covers two additional programs: Job Club and the CalWORKs AAR Program. Both programs are provided by Treatment Agencies that are contracted to operate as CENS Area Offices. Each CENS office has two (2) dedicated CalWORKs counselors: one (1) is assigned to provide Job Club services, and the other (.25 FTE) is dedicated to working as the CalWORKs AAR counselor.

Job Club Orientation Overview

A partnership between DPSS and LACOE, Job Club is an educational program for DPSS CalWORKs GAIN 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 that 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 SAPC. The schedule is submitted to the CENS Area Office on a quarterly basis. Upon receipt:

- CENS staff/managers will schedule a time for their presentation and return the schedule to their SAPC Job Club liaison within 5 business days.
- 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 recipients who participated in Job Club.

DPSS – General Relief

GR Referral Process

As a condition of eligibility, all adult GR applicants must undergo a pre-screening interview for an SUD by their DPSS EW. If there is a reasonable suspicion of an SUD, the GR applicants must be referred to the DPSS MSUDRP. GR applicants with a positive SUD pre-screen are referred to:

- The CENS area office nearest to the participant;
- Directly to a contracted SUD treatment agency; **or**
- 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 outlined in the *Early Intervention and Treatment Service Components* section.

The Treatment Progress Report (Form ABP 132) is generated by LRS and mailed directly to the receiving contracted SUD treatment agency every 60 days for completion. It is then returned to DPSS, which 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 must notify DPSS of any changes in participants' treatment hours within three (3) days using the Report of Changes form. These updates should align with modifications in the participant's Problem List (for non-OTP settings) or Treatment Plan (for OTP settings). Treatment Extensions are requested when it is determined that a patient requires continued treatment beyond the initial six (6) months due to medical necessity.

If an extension is required, the contracted SUD treatment agency will submit a reauthorization request to SAPC-UM for evaluation and approval or denial. Once the request is evaluated, the SUD treatment agency must forward the form to DPSS for final approval or denial, which will then update the LRS. DPSS is responsible for notifying the contracted SUD treatment agency of the extension status and providing a copy of this status.

Additionally, contracted SUD treatment agencies must inform the CENS Area office and their dedicated GR CENS of any changes in GR client status. The CENS is responsible for updating client information in LRS through the CalSAWS website, using the login instructions provided by DPSS.

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
- On-site or virtual evidence-based SUD screenings to parents with alcohol and substance-use challenges using the ASAM CO-Triage
- Medi-Cal 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 Children's 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 contact the parent to reschedule an appointment for a total of three (3) attempts. After two (2) attempts, the CENS staff will update the DCFS Staff by email or phone.
5. If the parent refuses to be screened, does not show up 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 the participant's proximity, type, and level of service(s) needed.
7. Request the participant's consent to release information to share their care planning and progress information with DCFS and the State. Such releases shall adhere to all confidentiality 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 an encrypted email to SAPC_FamilyServices@ph.lacounty.gov.

Family Dependency Drug Court Program

FDDC Referral Process

Adult parents aged 18 and older must have active cases with DCFS and the Juvenile Dependency Court to qualify for treatment services under the Family Dependency Drug Court (FDDC) program. Although the program aims to support family reunification, participation is voluntary, and parents are supervised by the court throughout their treatment.

Candidates for the FDDC program are identified by the nearest DCFS office, dependency attorneys for parents and children, County Counsel, or judicial officers. Referrals to the FDDC program are initiated by the assigned DCFS FDDC CSW, not by the treatment agency's staff. Once eligibility is verified, the DCFS CSW or Program Manager will refer their participants for a clinical assessment, using the DCFS FDDC Referral Form, in the following way:

- Direct to a contracted SUD treatment agency nearest to the patient
- The treatment agency will:
  - Schedule an ASAM assessment appointment within three (3) business days of receipt of the DCFS FDDC referral form. 6006A from the TLFR Manager.
  - Make best efforts to complete the ASAM CONTINUUM assessment within five (5) business days of appointment and, with the patient's signed consent, send an update to the DCFS CSW citing that the patient was screened along with the screening results.
  - With patient consent, notify the DCFS CSW by completing page two (2), sections B and C of the DCFS 6006B, and fax to the DCFS CSW within 24 hours of completing the assessment.
  - 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 with DCFS participants who fail to keep their initial assessment appointment and reschedule a missed appointment once.

FDDC Treatment Requirements and Care Coordination

Treatment services are provided based on medical necessity and may include a combination of various modalities as specified in the *Early Intervention and Treatment Service Components* section.

Contracted SUD treatment agencies are advised that family counseling sessions should be an integral part of the care planning and services for these patients.

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.

FDDC 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 reflect patient progress since the last court hearing, pertaining only to SUD treatment services. ***Recommendations and/or comments on visitation rights are not permitted.***

FDDC Treatment Completion/Reunification

- 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.
- Within five (5) working days of program completion, the treatment provider shall enter the information on a progress report to confirm completion and notify DCFS and/or the court of patient discharge. The patient will deliver a copy of the completion report to the CSW and the court in a sealed envelope.
- 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.
- 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 the SUD treatment episode.

Section 4. CLINICAL PROCESS STANDARDS

Utilization Management Components

The Utilization Management (UM) program analyzes how the SAPC provider network delivers services and utilizes resources for eligible patients. The various responsibilities of the UM program include:

- Ensuring adherence to established DMC EV and medical necessity criteria.
- Ensuring that clinical care and ASAM LOC 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 ensure fair and consistent UM decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in promoting and maintaining the optimally achievable quality of care.
- To educate healthcare professionals on appropriate and cost-effective use of healthcare resources.

SAPC follows Federal and State decisions and notification timeframes for all UM determinations. SAPC will make every effort to complete UM determinations expeditiously to facilitate timely treatment for the patients served in the specialty SUD system in LA County, and to assure compliance with all requirements. To support the prompt review of member authorizations, providers are required to submit member authorization requests along with relevant clinical documentation within 30 calendar days of admitting a patient into a treatment or SUD-related benefit program or within 30 calendar days of initiating continued services.

Member authorizations and reauthorizations submitted 30 calendar days after the admission date or reassessment date may result in partial approval based on delayed establishment of medical necessity. In this scenario, only those services provided after medical necessity is established will be authorized for reimbursement. Providers who submit member authorizations outside of the 30-calendar day requirement will be subject to partial approval for the service dates based on the authorization submission date.

Eligibility Verification

Initial DMC EV occurs at the point of first contact between a patient and the specialty SUD system and includes considerations outlined in **Table 2**. Medical necessity determinations will occur at the provider site. The initial DMC EV may be performed by trained support staff and/or registered or certified SUD counselors.

However, medical necessity determinations must be performed by an 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 EV and medical necessity. Legal status (e.g., parole, probation) is not a barrier to accessing substance use services.

All patients eligible for specialty SUD services (e.g., participants in qualified County-funded programs/projects) will have access to the same benefit package as DMC members and will be required to follow the same eligibility and medical necessity verification processes. For additional information, see Eligibility Verification and Member Authorizations on SAPC's website.

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 and 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 (if patient's condition has changed), Progress Notes, Medical Necessity Justification Progress Note, and laboratory test results (if available).

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, patient needs, recommendations from providers, and characteristics of the system of care, to decide whether SUD services are provided, as needed.

If UM staff determines that DMC EV 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 13**.

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 and 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 can 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. For additional information, see *Complaints/Grievances and Appeals Processes* section.

Table 13

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)	Within 24 hours of receipt of request	**Approvals:** Within five (5) business days of receipt of authorization request. **Other Decisions:** See timeframes outlined in *Complaints/Grievances and Appeals Processes* section.
Initial Verification: Non-Residential Services (ASAM 0.5, 1.0, 2.1, 2.5, OTP, and the Recovery Incentive Program)	Within ten (10) business days of receipt of request	**Approvals:** Within ten (10) business days of receipt of request. **Other Decisions:** See timeframes outlined in *Complaints/Grievances and Appeals Processes* section.
Initial Verification: Withdrawal Management (ASAM 1.0WM, 3.2WM, 3.7WM and 4.0WM)	Within seven (7) business days of receipt of request	**Approvals:** Within seven (7) days of receipt of request. **Other Decisions:** See timeframes outlined in *Complaints/Grievances and Appeals Processes* section.
Initial Authorization: RBH *Only for Young Adults (age 18-20) and Adults (age 21 and over)*	Within ten (10) business days of receipt of request	Within ten (10) business days of receipt of request
Re-Authorizations and Re-Verifications		
Re-Authorization for ongoing Residential Services (ASAM 3.1, 3.3, 3.5)	Within seven (7) business days of receipt of request	**Approvals:** Within seven (7) business days of receipt of request. **Other Decisions:** See timeframes outlined in *Complaints/Grievances and Appeals Processes* section.
Re-Verification for Non- Residential Services (ASAM 0.5, 1.0, 2.1, 2.5, OTP, and the Recovery Incentive Program) *Must submit ongoing verification requests at least 21 calendar days but no earlier than 30 days in advance of the end date of current authorization or verification.*	Within 14 calendar days of receipt of re-authorization	Within 21 calendar days of receipt of re-authorization request.
Recovery Bridge Housing *Young Adults (age 18-20) and Adults (age 21 and over) may be authorized for 90 days of RBH and reauthorized for additional 90-day*	Within ten (10) business days of receipt of request	Within ten (10) business days of receipt of request

Review Type	Decision Notification after Receipt of Completed Request	Written Decision Notification
durations of RBH if needed, for a potential maximum stay of 360 days per calendar year, based on concurrent enrollment in non-residential treatment services. *Must submit residential and RBH re-authorization requests no earlier than seven (7) calendar days in advance of the end date of current authorization*		

Note:

- ***These timeframes start when UM staff receive sufficient information to make an authorization or verification decision.***
- ***If providers elect to provide the service prior to receiving pre-authorization, then providers accept financial loss if the pre-authorization is ultimately denied.***
- ***A request for authorization may be denied if it is not received within 30 days of the initial date of service or when the patient's financial eligibility to receive SAPC services has been established (whichever comes later).***
- ***If a patient enters treatment for a pre-authorized or authorized service but leaves AMA, the provider will still need SAPC pre-authorization/authorization to receive compensation for services provided during the days in which the patient was in treatment and receiving services. SAPC will deny services if financial eligibility is not verified, information is missing upon review, or if medical necessity was not established according to timeframes on Table 3 prior to the patient leaving AMA.***

UM staff will review clinical cases from SUD treatment providers. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care and appropriate utilization of services across the SUD service continuum. In some instances, these reviews are related to service reimbursement, and in others, they are to ensure the quality and appropriateness of services provided.

SUD treatment providers are required to cooperate with all case reviews conducted by the UM program. These reviews are independent of but complementary to, 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. UM staff perform the prospective review, applying pre-established medical necessity/appropriateness criteria and rendering a decision of 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. As previously mentioned, this review is conducted by UM staff in accordance with pre-established criteria.
  - 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 RBH
    - Initial authorization of residential services received following admission
    - Re-authorization 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, service authorization decisions, and other aspects associated with patient services. 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 service under- and overutilization, utilization patterns and trends, the consistency of the UM review and decision-making process, and 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, medical necessity criteria, and quality of care.

The UM program utilizes a variety of review methods when performing case reviews to monitor care quality and appropriateness and inform decisions regarding verification of DMC eligibility, coverage of services, and authorizing reimbursements. The timely submission of Sage authorization requests by providers is essential 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-QI and SAPC-UM within 30 calendar days of admission or within 30 calendar days of the first date of service.
- Five (5) 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 OHC 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).
  4. Pending ICT of Medi-Cal benefit.
  5. Authorizations for Recovery Incentives-Contingency Management (RI-CM)
- All service authorization requests, including those delayed due to the 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 steps up or down in LOC, the discharge/transfer form in Sage must be completed.

To verify eligibility for SUD services, 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 every six (6) months in non-OTP settings and every 12 months in OTP settings or complete the documentation for verification of medical necessity for the LOC the patient is receiving.

Required documentation for re-verification of medical necessity may be found in the Checklist of Required Documentation for Utilization Management on SAPC's website. For information about when a new ASAM assessment is required, see ASAM Assessment Requirements for Level of Care Transitions on SAPC's 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 have yet to be provided and concurrent reviews of extensions of previous authorizations, as needed. The only pre-authorized service 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 to begin the pre-authorization review process. Notifications from providers must, at a minimum, include a completed Sage authorization request and initial intake documentation, a completed Financial Eligibility Form, a Medical Necessity Justification Note, 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 (non-OTP providers) or Care Plan (OTP providers), assessment information, Progress Notes, Medical Necessity Justification Progress Note, 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 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.

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 14

Residential Pre-Authorization and Re-Authorization Service Limits

Age Group	Initial Residential Pre-Authorizations	Residential Re-Authorizations	DMC Service
Youth (age 17 and under)	Initial authorization of 30 calendar days	Re-Authorizations required every 30 calendar days, based on medical necessity	N/A
Young Adults (age 18-20)	Initial authorization of 60 calendar days		
Adults (age 21 and over)			DMC service limits shall be determined by an 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.
Perinatal Adults			DMC reimbursable residential length of stay after the postpartum period is based on medical necessity for perinatal patients receiving services at PPW sites.
Justice-Involved Adults			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.

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 as 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-WM, 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 LOCs, or transitioning from one residential location to another.
- Residential lengths of stay (for additional information, see **Table 14**)
    - 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 is also true that they require more external assistance and support and, at times, more intensive treatment and/or higher LOCs. Higher intensity of service and longer duration of services are not necessarily correlated.
    - Youth (age 17 and under)
        - Initial residential pre-authorizations for youth will authorize no more than 30 calendar days at the outset of residential services.
        - For Youth (age 17 and under), residential reauthorizations beyond the initial 30 calendar day authorization will occur every 30 calendar days until the patient turns 18, with extensions granted based on medical necessity. Upon turning age 18, residential authorization processes for Young Adults (age 18-20) will apply (*see below*).
        - Parental/guardian consent is required for services delivered to youth under the age of 12.
- For Young Adults (age 18-20), residential reauthorizations beyond the initial 60 calendar days will occur every 30 calendar days, with extensions granted based on medical necessity until the patient turns 21. Upon turning 21, residential authorization processes for Adults (age 21 and over) will apply (*see below*).
    - Young Adults (age 18- 20)
        - Initial residential pre-authorizations for Young Adults (age 18-20) will authorize no more than 60 calendar days at the outset of residential services. In other words, residential services for Young Adults (age 18-20) require reauthorization after 60 calendar days to assess for the appropriate LOC utilization if longer lengths of residential care are determined.
    - Adults (age 21 and over)
        - Initial residential pre-authorizations for Adults (age 21 and over) will authorize no more than 60 calendar days at the outset of residential services, except for patients who are enrolled in the START-Community program who may be eligible for an initial pre-authorization of 90 days (see next bullet point on *Justice-Involved Patients*). In other words, residential services for Adults (age 21 and over) require reauthorization after 60 days to assess for appropriate LOC utilization if adult patients are determined to require longer lengths of residential care.
    - 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 the patient as a START – Community participant.
    - PEH
        - PEH at the time of admission to residential treatment are at increased risk of returning to

problem substance use if they do not have a place to stay following discharge. Providers should establish a housing plan for PEH during their residential admission so that patients are discharged with a place to stay after discharge. SAPC recognizes that successful housing plans are more feasible for patients who complete residential treatment than for patients who leave AMA.

  - SAPC criteria for approval of authorization requests for continued residential admissions for PEH who do not have a place to stay include the following:
    - The patient's homelessness status is appropriately documented in CalOMS, on a current Problem List finalized/signed by an LPHA (required every 30 days) and documented within the clinical record.
    - The patient agrees to ongoing residential admission and treatment.
    - The provider has documented their efforts to establish a post-discharge housing plan for the patient.
    - The above is documented within a Progress Note that is submitted alongside the request for residential LOC reauthorization.

- 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 four (4) 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 PSH resources require the chronically homeless status.
- For a list of required documents to be included with member authorization requests, see the Checklist of Required Documentation for Utilization Management on SAPC's website.
- Given the fluid nature of clinical progression, the expectation will be that the Problem List and the Progress Notes will 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. For Problem List requirements, see *Clinician Consultation Services - Licensed Clinician Consultation Process - Documentation* section.
- If a residential treatment case is determined to be unnecessary based on the aforementioned considerations upon clinical review, either during a focused or random retrospective review, UM staff will have the authority to terminate/modify the current authorization, deny ongoing reimbursement for residential services, and recommend a 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 require approval from SAPC but do not require authorization prior to being provided. 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 30 calendar days to begin the authorization review process. Any authorization request may be denied due to untimely submission.

Refer to the Checklist of Required Documentation for Utilization Management 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 13**.

Campus-Like Setting Facilities

Providers 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-UM in the usual and customary manner.

Once these authorizations are approved by SAPC UM, **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".

RBH Authorizations

- 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 on SAPC's 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 OP treatment providers must document the need for RBH in the patient's Problem List (non-OTP settings) or Treatment Plan (OTP settings).
- Young Adults (age 18-20) and Adults (age 21 and over) are eligible for RBH services if the following criteria are met: they are homeless and meet medical necessity for concurrent OP 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.
- Perinatal patients are authorized for an initial 90 days; with the first reauthorization for another 90 days and subsequent reauthorizations every 30 days thereafter. Perinatal patients are eligible for continued

reauthorization up to 60 days postpartum, based on medical necessity, if the patient is receiving services at a PPW site.

- SAPC will not reimburse providers for RBH if criteria are not met and/or patient is no longer concurrently enrolled in OP services. Enrollment in RS will make patient ineligible for RBH.

For a summary of services that require pre-authorization and authorization, see **Table 15**.

Table 15

Pre-Authorized and Authorized Service Request Timeframes

Service Type	Initial Service Request Timeframe	Ongoing Service Request Timeframe	Notification Timeframe	Reauthorization Timeframe
Pre-Authorized Services				
Residential Services *for Youth (age 17 and under), Young Adults (age 18-20), and Adults (age 21 and over)*	Pre-authorization must be submitted prior to service delivery unless providers elect to provide the service prior to receiving pre-authorization and accept potential financial loss if the pre-authorization is ultimately denied.	Sage re-authorization request must be submitted no earlier than seven (7) calendar days in advance of end date of current authorization.	See Table 13	**Youth (age 17 and under)** Re-authorization is required after 30 calendar days, with re-authorizations every 30 calendar days based on medical necessity. **Young Adults (age 18-20)** Re-authorization is required after 60 calendar days for initial residential authorization, with re-authorizations every 30 calendar days based on medical necessity. **Adults (age 21 and over)** Re-authorization is 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 justice populations).
Authorized Services				
RBH	Sage authorization	Sage re-authorization	See Table 13	**Perinatal Patients:**

Service Type	Initial Service Request Timeframe	Ongoing Service Request Timeframe	Notification Timeframe	Reauthorization Timeframe
ONLY for Young Adults (age 18-20) and Adults (age 21 and over)	request must be submitted within seven (7) calendar days of first service/first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over)	request must be submitted no earlier than seven (7) calendar days in advance of end date of current authorization.		One 90-day reauthorization is allowable, subsequent reauthorizations every 30 days thereafter. Perinatal patients are eligible for continued reauthorization up to 60 days postpartum, based on medical necessity, if the patient is receiving services at a PPW site. **Non-Perinatal 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 of365 days based on first date of admission for patients who meet medical necessity and the eligibility criteria outlined in *Recovery Bridge Housing* section.

If UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the clinical service standard of this Provider Manual, the authorization will be approved. Reimbursements for services will be retroactive to the start date of the authorization if all required documentation and authorization submissions are complete and timely.

Denials of authorization will result in denial of reimbursement for services, and the applying treatment provider will be notified of the decision of denial within the timeframes listed in **Table 13.** Denial notifications will include, but will not be limited to, the following information:

- 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 to 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 benefits be continued, and circumstances under which the patient may be required to pay the costs of the services.

Patients or providers acting on behalf of the patient can 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. For additional information, see *Complaints/Grievances and Appeals Processes* section.

Sage Outage Procedure

Though every effort will be made to conduct maintenance procedures during low activity periods, unforeseen circumstances may require the system to be unavailable. Effective communication, planning, and training for these events through written processes and staff preparations can mitigate the impact on the organization, staff, patients, and their ability to provide or receive treatment.

In the event of a planned outage, providers will receive a notice from SAPC-CCD.

If you are experiencing technical issues and are unable to chart in real-time, contact Netsmart Helpdesk and document the Helpdesk ticket in Progress Note.

To prepare for such events, SUD treatment providers must maintain the following documents in hard copies or other formats that would not be impacted by their inability to access Sage:

- Current Patient Roster
- American Society of Addiction Medicine Assessment Tool (ASAM) or ASAM Screener for Youth and Young Adults
- Service Request Form Template
- Care Plan Template
- Problem List Template
- Progress Note Template
- Discharge and Transfer Form Template (for all LOCs)
- Recovery Bridge Housing Authorization Request Form
- Recovery Bridge Housing Discharge Form
- Billing related documents
- All required consents
- Admission/Discharge Forms
- Any other documents required by the County or the organization

Approved forms are available on SAPC's Manual, Bulletins, and Forms webpage, under the Clinical tab: http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm#clinical.

Once the Sage outage is resolved, the above forms should be uploaded as attachments in Sage. Documents should be labeled according to the naming convention.

Workforce

Health systems are increasingly adopting a chronic disease and public health approach to SUD care, necessitating a diverse, skilled, and well-trained workforce.

SAPC values the contributions of contract providers across all sizes and capacities, recognizing that a successful SUD system must reflect the varied needs of the population it serves. Traditionally staffed primarily by SUD counselors, the specialty SUD system now requires a broader range of disciplines. Increasing the

inclusion of LPHAs, such as social workers, psychologists, nurses, and physicians, is crucial. This diversification is particularly important for meeting the requirements of LPHAs to verify medical necessity and eligibility for DMC services, as well as sign Problem Lists (non-OTP settings or Treatment Plans (OTP settings).

Recommended Responsibilities for Medical Directors and Physicians

- Provide MAT
- Provide WM
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other professional staff with challenging cases
- Lead QI functions/projects
- Conduct clinical trainings on issues relevant to professional staff
- Provide physical exams, when necessary

A robust workforce in SUD treatment requires not only proper provider credentials but also comprehensive training to meet the needs of a diverse population. Professional development should include mandatory trainings and continuing education on ASAM criteria and EBPs for clinical staff. For additional information, see *Evidence-Based Practices* section.

Providers should develop a business plan with a clear hiring and training strategy to ensure their staff has the necessary background and skills to deliver high-quality SUD services. Additionally, DHCS has specified the types of providers qualified to deliver each DMC-ODS service under the CalAIM 1115 Demonstration & 1915(b) Waiver, California State Plan, and SPA 23-0026".

Clinicians in SAPC's network who prescribe medications (MDs, DOs, APRNs, PAs, RNs) should practice at the highest level of their license and receive adequate training in MAT to enhance patient access to this essential SUD treatment component.

Medical Director

Each SUD treatment site must have a DMC Medical Director who has been approved by DHCS by submitting Form 6010. The State contract requires an agreement with the Medical Director that includes:

- Ensure that medical care provided meets the appropriate standard of care and is 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, signed, and dated by a provider representative and the physician.

The Medical Director, or their designated physician, must be present on-site for **a minimum of two (2) hours per month.** If a physician cannot fulfill this requirement, the agency must develop a plan or identify an on-call physician to comply with this contractual obligation. Agencies should determine the most effective approach to meet this requirement while addressing their specific needs. For instance, agencies might establish agreements with other SUD providers to cover gaps when necessary.

Given their advanced education and training, it is beneficial to employ staff at the highest level of their licensure and expertise. Medical Directors at SUD provider agencies should ideally undertake responsibilities that cannot be performed as effectively by other staff members (e.g., different types of LPHAs) within the agency.

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 Federal/State/local regulatory and reporting requirements. Interpret and support the agency's standards of care by leading the development of the agency's treatment workflows that incorporate best practices.
- Research and maintain knowledge of EBPs and updates regarding the 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 recommended responsibilities of medical directors and physicians to maximize their roles within the DMC-ODS system of care. This list offers guidance for optimizing their contributions but is not exhaustive.

- Provide MAT, when clinically necessary
- Provide WM, when clinically necessary
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other staff with challenging cases (e.g., refractory SUD, CODs, certain special populations)
- Lead QI functions/projects (e.g., QIPs, leading clinical team meetings, etc.)
- Conduct clinical trainings on issues relevant to professional staff (e.g., documentation, ASAM Criteria, DSM5-TR, MAT, co-occurring mental health conditions)
- Provide physical exams, when necessary and appropriate, at their facility

Licensed Practitioners of the Healing Arts

LPHA is defined as one (1) of the following professional categories:

- Physician (MD or DO)
- Advanced Practice Nurse (APRN)
- 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 Vocational Nurse (LVN)
- Licensed Psychiatric Technician (LPT)
- Licensed Occupational Therapist (LOT)
- Licensed-Eligible LPHA working under the supervision of licensed clinicians

Licensed-eligible LPHAs are persons who have already earned their advanced degree (e.g., Master of Science [M.S.], Master of Arts [M.A.], Master of Social Work [MSW], Doctor of Philosophy [PhD], Doctor of Psychology [PsyD], etc.), who are properly registered with their respective state board (e.g., California Board of Behavioral Sciences [BBS], California 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[19] (aligned with the scope of practice for making diagnoses as regulated by the relevant licensing board), and sign Problem Lists (non-OTP settings) or Treatment Plans (OTP settings).

Note: All LPHAs and License-eligible LPHAs must be approved by DHCS by submitting Form 6010.

Clinical Trainees (Formally Students, interns, or trainees)

Previously referred to as students, interns, or trainees, Clinical Trainees are now credentialed under state plan amendment SPA 23-0026 to provide billable services under DMC-ODS. Additionally, AB 1860 and BHIN 23-008 exempt graduate student trainees from registration or certification requirements as SUD counselors for reimbursable services. According to AB 1860:

- A graduate student providing counseling services in an AOD program shall:
  - Be enrolled as a university graduate student in psychology, social work, marriage and family therapy, or counseling.
  - Be completing their supervised practicum hours to meet graduate school requirements; **and**
  - Provide proof of enrollment as a graduate student to the AOD program on an annual basis.
- A graduate student who is no longer enrolled in a university program identified above shall notify the AOD program in writing of their withdrawal within one working day. An AOD program shall immediately remove the former graduate student from providing counseling services.

A Clinical Trainee is an unlicensed individual currently enrolled in a post-secondary educational program in California that is required to obtain licensure as a Licensed Mental Health Professional or LPHA. This person is involved in a practicum, clerkship, or internship approved by their educational program and meets all relevant program and licensing board requirements to participate in these activities. Clinical Trainees provide rehabilitative mental health or substance use disorder treatment services, including fulfilling coursework and supervised practice requirements. However, they are not authorized to perform administrative duties reserved for LPHAs, such as signing off on Problem Lists (non-OTP settings), Treatment Plans (OTP settings), or finalizing ASAM assessments. They are, however, permitted to deliver clinical services within the scope

[19] Per DHCS, although RNs and RPs are classified as LPHAs, they are not allowed to diagnose.

outlined in SAPC Bulletin 24-04: Fiscal Year 2024-2025 Rates and Payment Policy Updates **and** BHIN 24-023 Standards for Specific Behavioral Health Provider Types and Services; Amends Relevant Sections Within Title 9 and Title 22 of the California CCR.

Clinical Trainees, as determined by DHCS, include the following:

- Psychologist Clinical Trainee
- Clinical Social Worker Clinical Trainee
- Marriage and Family Therapist Clinical Trainee
- Professional Clinical Counselor Clinical Trainee
- Psychiatric Technician Clinical Trainee
- Registered Nurse Clinical Trainee
- Vocational Nurse Clinical Trainee
- Occupational Therapist Clinical Trainee
- Clinical Nurse Specialist Clinical Trainee
- Pharmacist Clinical Trainee
- Physician Assistant Clinical Trainee
- Medical Student in Clerkship (Physician Clinical Trainee)

Retroactive to July 1, 2023, Clinical Trainees can now submit claims for services provided on or after this date. Claims for Clinical Trainee services will be reimbursed at the same rate as the licensed supervisor's discipline rate. Providers must notify the Sage Helpdesk of the primary supervisor's name, National Provider Identification Number (NPI), and credentials to configure the information in Sage. The supervisor's NPI must be active as it will be validated against the National Plan and Provider Enumeration System (NPPES) and must be included on the claim to DMC.

Students, interns, or trainees are students who are enrolled in graduate education programs and 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:

- 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**
- Network providers can submit claims for treatment services delivered by student providers for all disciplines, so long as these students are:
  - Enrolled and in good standing in their training program;
  - Credentialed within the Sage system;
  - Have an NPI;
  - Their credentialing also identifies their primary supervisor and the supervisor's NPI
  - Claims include the taxonomy code for their discipline and the appropriate provider type modifier.
- The sponsoring provider agency provides adequate clinical supervision and oversight of the trainees' clinical activities. These trainee 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 clinical students, interns, or trainees.

Certified Peers

Training Requirements

In addition to completing their state certification, all Certified Peers must also complete the training module entitled “ASAM Multidimensional Assessment" (ASAM A). This module provides an overview of the ASAM LOCs that the Certified Peers will assist clients in navigating. Given that this is not a standardized part of the Peer Support Specialist certification training, this singularly required training has been deemed critical for Certified Peers to assist patients within the specialty SUD system.

Certification Renewal

To maintain certification, Certified Peers must renew their certification every two (2) years. If a certification is not renewed by its expiration date, it is considered expired. State standards mandate that applicants fulfill renewal requirements, which include completing 20 hours of CE. This education must include six (6) hours of law and ethics training. For a comprehensive list of the renewal certification requirements, see CalMHSA’s Guidelines, Standards, and Procedures Manual.

Once these requirements are met, applicants can submit a renewal application and pay associated fees. It is important to note that applications for renewal can only be submitted up to 90 days prior to the expiration date. Any applications submitted after the certification has expired will incur additional fees and may cause delays in the renewal process. For additional information, visit CalMHSA’s Certification Renewal and Continuing Education webpage.

If an individual’s certification lapses within four (4) years of when the certification renewal was due, the individual must meet all Certified Peer Requirements, complete 40 hours of training, and pass the certification exam to reinstate certification. Applicants with a lapsed certification greater than four (4) years from the date the renewal was due do not qualify for recertification. If these applicants are interested in recertification, they must reapply for initial certification.

Resources to Support the Integration of Certified Peers in SUD Treatment

As Certified Peers enter the workforce, it is important to understand how these services can enrich substance use treatment. SAPC-CST developed the “Enriching Substance Use Treatment with Certified Medi-Cal Peer Support Specialist Services” training to support provider agencies in achieving a greater understanding of Certified Peer roles. For available trainings, visit the SAPC Trainings and Events webpage on SAPC’s website and refer to the training calendar to register for upcoming sessions.

CalMHSA provides Best Practice Guidelines for Employing Certified Medi-Cal Peer Support Specialists. These guidelines offer valuable insights and recommendations to help organizations optimize their integration of Certified Peers and enhance the quality of care they provide.

Additional information and resources can also be found on SAPC's Certified Peer Support Specialist webpage. If you have any questions or need additional support, email SAPC-SOC at SAPC_ASOC@ph.lacounty.gov.

Minimum Staffing Requirements

Professional staff must be licensed, registered, certified, or recognized under the 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 CCR Title 9, Division 4, 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 (ACCBC) – which is affiliated with California Association of DUI Treatment Programs (CADTP); California Association for Alcohol and Drug Educators (CAADE); and CCAPP.

To be able to conduct SAPC-contracted treatment services, registered SUD counselors must:

1. Complete the State-required ASAM A and ASAM B trainings prior to delivering DMC-reimbursable treatment services. The only exception to this requirement is Certified Peers, who are only required to complete their certification as PSS providers and complete ASAM A; **and**
2. Complete training on CBT, MI, clinical documentation, and Treatment Planning either through a qualified Continuing Education Unit (CEU) agency such as SAPC-CST, UCLA-ISAP, and CIBHS, or a qualified trainer funded by a Network Treatment Provider or through their training program; **and**
3. Complete one (1) classroom course 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/training is not completed within the required timeframes, SAPC will not pay for the services and will be eligible for recoupment.**

Note: Registered counselors who 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 CEUs 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.

Services in the WM setting may be provided by registered or certified SUD counselors or LPHAs, depending on the nature of the service and its scope of practice. Where noted, physician involvement in evaluating and assessing the 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 are:

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) training modules entitled “ASAM Multidimensional Assessment" (ASAM A) and “From Assessment to Service Planning and Level of Care” (ASAM B).

In addition, LPHAs (including the Medical Director) shall receive a minimum of five (5) hours of CE related to addiction every year, and registered and certified SUD counselors shall adhere to all requirements in CCR Title 9, Division 4, Chapter 8.

The providing agency's responsible for ensuring 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 utilize one of these required evidence-based approaches effectively. 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 be unable 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 treating patients with CODs. SAPC requires providers to send at least one (1) representative per contracted agency to all designated trainings.

For available SAPC trainings, including applicable CalAIM trainings, visit the SAPC Trainings and Events webpage on SAPC’s website and refer to the training calendar to register for upcoming sessions.

Non-professional staff, including clerical, billing, and facility management support, shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff must be supervised by professional and/or administrative leadership. Both professional and non-professional staff are required to have appropriate experience and the necessary training at the time of hiring.

For a complete list of services that can be provided by each provider type, providers should consult the current version of the SAPC Rates and Standards Matrix on the SAPC’s Manuals, Bulletins, and Forms webpage, under the Bulletins tab. Codes with rates associated with them reflect services that can be provided by that provider type under DMC-ODS.

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 SUDs and treatment, including staff participation in training delivered or contracted through SAPC
7. Current registration, certification, intern status, or licensure
8. Proof of CE required by licensing or certifying agency and program
9. Provider's Code of Conduct

Quality Assurance – Regulations

In healthcare, 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 quality.
- Identifying problems with care delivery and designing QI 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 BHINs and relevant SAPC All Providers Letters, INs, and Bulletins.

Confidentiality

Maintaining appropriate confidentiality is of paramount importance. All SAPC-contracted providers are required by contract to establish confidentiality policies and procedures and must comply with 42 CFR Part 2, HIPAA, and California State law regarding confidentiality for information disclosure of SUD, and other medical records.

Health Insurance Portability and Accountability Act

HIPAA provides data privacy and security provisions for safeguarding medical information.

- Summary of the HIPAA privacy rule: www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.
- General information on HIPAA: www.hhs.gov/ocr/privacy/index.html.

- Specific information concerning covered entities, consumer information, and health information technology: www.hhs.gov/hipaa/index.html.

These laws and regulations must not be used as barriers to providing 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 systems of care (physical and mental health, etc.).

Under 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 to improve the effectiveness, integration, and quality of health services.

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 an SUD program that is conducted, regulated, and/or assisted in any way by any Federal agency.

- For a summary of 42 CFR Part 2, visit: www.samhsa.gov/newsroom/press-announcements/20240208/hhs-finalizes-new-provisions-enhance-intergrated-care-confidentiality-patients-substance-use-conditions.
- Subpart A covers introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc.).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, minor patients, etc.).
- Subpart C covers disclosures allowed with the patient's 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).
- Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc.).

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 requirements.

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

Title 9 – Certification of Alcohol and Other Drug Counselors

CCR Title 9, a section titled Certification of Alcohol and Other Drug Counselors, provides minimum requirements on the level of credentials counseling staff must secure prior to conducting services. The minimum standards are designed to ensure baseline quality and effectiveness of treatment services. The County has built on these requirements and established minimum staffing standards specific to LA County.

For additional information, visit SAPC's Manuals, Bulletins, and Forms webpage, under the Bulletins tab for the latest version of the Provider Staffing Guidelines.

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

MI is 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 *Motivational Interviewing: Helping People Change and Grow, 4th Edition* (Miller & Rollnick, 2023), 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

CBT is among the most extensively studied psychotherapy treatments for substance use. The CBT model of relapse prevention focuses on cognitive, affective, and situational triggers for substance use and provides skills training specific to coping alternatives. CBT treatment often includes the following strategies: (1) identifying intrapersonal and interpersonal triggers for relapse, (2) coping-skills training, (3) drug-refusal skills training, (4) functional analysis of substance use, and (5) increasing nonuse-related activities.[20] 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.[21]

[20] Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. Journal of Studies on Alcohol and Drugs, 70(4), 516–527. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696292.

[21] SAMHSA. (2023, October). Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders: Counselor's Treatment Manual. http://store.samhsa.gov/product/matrix-intensive-outpatient-treatment-people-stimulant-use-disorders-counselors-treatment.

Other Contractor Selected Practices

Relapse Prevention

According to SAMHSA's National Registry of Evidence-Based Programs and Practices[22], 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[23], "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; 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 evidence-based trauma-informed practice.[24]

Psychoeducation

Psychoeducational interventions educate patients about substance use, SUDs, and related behaviors and consequences. The information provided may be broad but is intended to lead to specific objectives. Psychoeducation about substance use and SUD 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 act on their own behalf.

Documentation

Clinical documentation refers to anything in the patient's 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, clinicians, and Certified Peers 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 is important in helping ensure quality patient care by allowing practitioners to think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work, and weigh

[22] SAMHSA. (n.d.). Evidence-Based Practices Resource Center. https://www.samhsa.gov/resource-search/ebp.
[23] SAMHSA. (2014, October). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884.
[24] SAMHSA. (2023, August 23). Seeking Safety. http://www.samhsa.gov/resource/dbhis/seeking-safety.

alternative approaches to care. Good clinical documentation helps one organize clinical details into a case formulation that can then be used for care planning and is an essential element of professional practice and the provision of quality clinical services. It also helps to ensure the appropriate utilization of team members from multiple disciplines to leverage interdisciplinary competencies and maximize the quality of services provided.

2. **Ensure an efficient way to organize and communicate with other providers:** Documenting clinical care helps to structure and streamline clinical communications with other providers who may be involved in the care of shared patients. This ensures coordinated rather than fragmented treatment/service delivery.
3. **Protect against risk and minimize liability:** Accurate and comprehensive clinical documentation is vital in quality care and 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 providing 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., Commission on Accreditation of Rehabilitation Facilities [CARF], The Joint Commission), when applicable, and by healthcare institutions, facilities, and agencies.
5. **Facilitate QI 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. It helps to improve the quality of services by identifying problems with service delivery and 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, complete, and protected via HIPAA and 42 CFR Part 2:** It encompasses every aspect of clinical care, including initial assessments, Progress Notes, and relevant encounters outside 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 to gauge clinical progress and assess to determine if patient needs have changed and if modifications to the treatment approach/plan are required. The documentation style must be consistent and standardized throughout the agency/institution.

In general, clinical documentation includes the following characteristics:

- Assessment and Progress Notes include the typed or legibly printed name, signature of the service provider, and date of signature (requirement is met via Sage electronic signature)
- Patient name and identifier are included

- Patient's race, ethnicity, and primary language spoken as captured on admission and patient demographic forms.
- 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 LOC provided or discharge status)
- Description of how services provided reduced impairment, restored functioning, and prevented significant deterioration.
- For patients with LEP, 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 the case.

Assessment

An ASAM Criteria assessment is required. The assessment includes the LPHA's determination of medical necessity and service recommendation. The Problem List and Progress Note requirements identified below support the medical necessity of each service provided.

Problem Lists and Care Plans for Non-OTP and 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 with a care plan for non-OTP and OTP settings is reviewed and updated on an ongoing basis to reflect the patient's current presentation, including stability and the likelihood of rapid changes in patient condition. Problem Lists and care plans are updated more frequently if an individual is unstable or a notable event requires a change in the Plan of Care. For additional details regarding minimum requirements for Problem Lists (non-OTP settings) and Treatment Plan (OTP settings) reviews and updates, see **Table 16 and Table 17.**

It is important to note that these are maximum timeframes. 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 16

Problem List Minimum Requirements for non-OTP Settings

Problem List Activity	LOC	Minimum Requirement*
Initial Problem List *Note: Initial Problem Lists must be performed as instructed by SAPC on standardized Sage templates in Sage or Problem List or Treatment Plan forms approved by SAPC.*	All WM LOCs	• Must be completed upon intake and signed by an LPHA within the treatment episode.
	• Outpatient • Intensive Outpatient • Recovery Services	• Must be completed 30 calendar days of the first service or first intake appointment for Adults (age 21 and over), including signature by LPHA; **or** • Within 60 calendar days of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and for Adults (age 21 and over) who are documented as a PEH* including signature by LPHA. • *Documentation of homelessness status must be indicated in a Medical Necessity Justification Note.
	• Residential	• Must be completed upon intake within seven (7) calendar days of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over), including signature by LPHA; **or** • Within 14 calendar days of first service or first intake appointment for Youth (age 17 and under) 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 Progress.* *Note: (with Problem List-Treatment Plan Development Review Service Type) 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 • Recovery Services	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. Problem List updates must be completed as instructed by SAPC on LPHA, certified or registered counselor standardized SAGE templates on Sage or Problem List or Care Plan forms approved by SAPC.*	• Outpatient • Intensive Outpatient • Recovery Services	No later than 90 calendar days after the signing of the initial care 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 care plan, and no later than 30 calendar days thereafter, or when there is a 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 it 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 LA County are those outlined in the Table above.

If a patient's condition does not show improvement at a given LOC or with a particular intervention, a review,

abbreviated assessment, and update of the Problem List should be conducted to enhance therapeutic outcomes. Any change in LOC or intervention should be guided by a reassessment and adjustment of the Plan of Care to achieve better results.

The Problem List, maintained by the practitioners responsible for the patient's care, includes symptoms, conditions, diagnoses, and risk factors identified through assessments, diagnostic evaluations, and other service interactions. If a new problem is identified during a service encounter, it may be addressed by the documenting practitioner (within their scope of practice) and added to the Problem List. This list should be updated regularly to accurately reflect the patient's current condition.

The Problem List shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice.
- 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 member and 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 member's condition.

Table 17

Treatment Plan Minimum Requirements for OTPs

Treatment Plan Activity	Minimum Requirement
Initial Treatment Plan *Note: Initial Treatment Plans must be performed using standardized Treatment Plan templates on Sage or approved by SAPC.*	Must be completed and signed by the patient and LPHA within 28 calendar days of admission.
Treatment Plan Review *Note: If the Treatment Plan Review results in a determination that changes to the Treatment Plan are unnecessary, a 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 reviewing a Treatment Plan. If the review results in a determination, 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.

Suppose a patient's condition does not show improvement at a given LOC or with a particular intervention. In that case, a review, abbreviated assessment, and Treatment Plan Update should be made to improve therapeutic outcomes. Changing the LOC or intervention should be based on a reassessment and modification of the Treatment Plan to achieve an improved therapeutic response.

Treatment Plans must meet the requirements specified in Title 9 CCR § 10305 and Title 22 CCR § 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 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, a Treatment Plan update must be completed to prevent disallowances.
- Required documentation, as specified in Title 9 and Title 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 the preparation of the plan, within seven (7) calendar days for Young Adults (age 18-20) and Adults (age 21 and over) **or** 14 calendar days for Youth (age 17 and under) of the first service or first intake appointment. Suppose the patient refuses to sign the Treatment Plan. In that case, the provider shall document the reason for refusal and the provider's strategy to engage the patient to participate in treatment (see **Table 3**).
- If the LPHA determines the services in the Treatment Plan Update are medically necessary, the LPHA shall type or legibly print their name, 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 document the care provided to patients with SUDs in Progress Notes. Each Progress Note shall provide sufficient detail to support the services being billed (as indicated by service code descriptions) during each treatment episode. All Progress Note documentation would be entered directly into the Progress Note form within Sage.

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 LOC suggested by ASAM criteria is not recommended by the counselor/clinician (if applicable).
- Justification of discrepancy if the discussed LOC is not agreeable to the 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, service provider signature, and signature date.
- 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. This requirement is managed in Sage by linking the various items during the claiming process.
- Next steps including, but are not limited to, planned action steps by the provider or by the patient, collaboration with the patient, collaboration with another provider (s), and any update to the Problem List (non-OTP settings) or Treatment Plan (OTP settings) as appropriate.

Providers must complete Progress Notes within three (3) business days (excluding weekends and LA County holidays) of providing a service, except for crisis services, which must be completed within 24 hours. The day the service is provided counts as day 0.

For services billed daily, such as residential treatment, a daily Progress Note is required.

When documenting group services, providers must keep a list of participants. If multiple practitioners are involved in a group session, one Progress Note may be used, signed by one practitioner. This note must detail the involvement and time of each practitioner during the session, including documentation time. All other Progress Note requirements listed above shall also be met for group service Progress Notes.

Providers should document the appropriate ICD-10 codes in the Diagnosis form in Sage and use the applicable HCPCS code for billing, as outlined in the *Finance Management* section. This ensures that claims associated with Progress Notes include the necessary diagnostic and procedure code elements for DMC-ODS.

Progress Notes 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 the service hour requirements associated with the LOC the patient is receiving and with the patient's clinical needs.

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 the initial documentation of the first complete assessment. Progress Notes for both individual and group sessions do not require a specific format under CalAIM; however, SAPC recognizes that providers with other accreditations, such as CARF, may still need to use one of four (4) 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 healthcare 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 promptly and systematically. 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 18** outlines a summary of its components, and providers should refer to additional resources for additional information.

Table 18

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 patient's physical appearance (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, and 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), including a diagnosis and/or a list of symptoms and information around a differential diagnosis.
P	**Plan –** The Plan of Care is based on the assessment and clinical information acquired.

The ***GIRP***, ***SIRP***, and ***BIRP*** Progress Note formats also record similar clinical information in a structured format. The information included in these Progress 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). Like 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 19, Table 20, and Table 21** 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 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 19

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 toward individual plan goals and objectives.
P	**Plan –** The Plan of Care moving forward, based on clinical information acquired and assessment.

Table 20

SIRP

SIRP Progress Note Format	
S	**Situation –** Patient's presenting situation at the beginning of the intervention. It may include counselor/clinician observations, the 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 toward individual plan goals and objectives.
P	**Progress –** The progress made toward treatment goals and objectives and the plan for future interventions as determined by the clinical picture.

Table 21

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 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 toward individual plan goals and objectives.
P	**Plan –** The Plan of Care moving forward, based on clinical information acquired and assessment.

Residential Progress Notes

Residential Progress Notes can be documented either by individual encounter or as daily summaries. Documenting by encounter involves recording each service or activity a patient participates in as it occurs within the residential setting. Alternatively, daily documentation entails summarizing all services and activities the patient engages in over the course of a day.

Regardless of the method used, Residential Progress Notes must include details about the service or activity, how it supports the patient's progress toward care goals, attendees, the start and end times of both the service/activity and the documentation, and any relevant information about the patient's response. Progress Notes must be signed or initialed by the LPHA or counselor responsible for the service, with signatures placed adjacent to each other when both are required.

SAPC recommends documenting by encounter due to the difficulty of capturing all services and activities within a day, especially with multiple staff members involved. Encounter-based documentation can be more efficient than daily summaries, which often require extensive tracking. However, the minimum requirement is daily documentation of Residential Progress Notes in residential settings. If notes are written for each encounter, a daily summary is not necessary.

A Medical Necessity Justification Progress Note is essential for documenting medical necessity. This note should concisely explain how the patient meets the criteria for the requested LOC, including details about the patient's SUD history, current clinical condition, and treatment progress. Progress Notes must be finalized by an LPHA or LPHA-eligible staff.

Discharge Summary and Transfer

Specialty SUD treatment providers must submit discharge or transfer summaries to SAPC when patients are discharged or transition care. These summaries document the treatment episode, discharge reason, overall prognosis, follow-up plans, and other essential details for effective Care Coordination and high-quality SUD service delivery. In Sage, the Discharge and Transfer Form must be submitted by all treatment providers when:

- A patient is stepping up or stepping down between residential LOC **or** between OP LOC (e.g., ASAM level 2.1 to level 1.0); **or**
- A patient is being discharged from any LOC (e.g., they are not stepping up or down to other LOCs).

The Sage RBH Discharge form is required to be completed in Sage by all providers on the same day of discharge from the patient's RBH stay.

Complaints/Grievances and Appeals Processes

The complaint/grievance and appeals processes are 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 to review an "action," which may include:

- Denial or limited authorization of a requested service, such as the type or level of services;
- Denial, suspension, or termination of a previously authorized service; **or**
- Denial, in whole or in part, of payment for a service.

A "grievance" or complaint involves expressing dissatisfaction with any matter other than an action described above. It may also include situations where the patient's participation in filing a formal appeal is not feasible. Common grievance subjects include, but are not limited to:

- Quality of care or services provided;
- Timeliness of service provision or interpersonal issues, such as provider rudeness; **or**
- Failure to respect patient rights.

Involved parties can contact SAPC-CCD to discuss their concerns, often resolving issues through informal discussions. If informal resolution is insufficient, a formal complaint, grievance, or appeal may be necessary. Oral inquiries about appeals are treated as formal appeals to establish an early filing date but must be confirmed in writing unless expedited resolution is requested. Complaints, grievances, and appeals are processed by SAPC-QI, SAPC-UM, SAPC-FSD, or SAPC-CCD, depending on the nature of the issue and the responsible unit. SAPC will assist patients in completing forms and navigating procedural steps, including providing interpreter services and toll-free numbers with TTY/TTD and interpreter capabilities.

At the SUD treatment agency level, providers must have clear and transparent policies and procedures for managing complaints, grievances, and appeals. These processes should be integrated into the agency's QI efforts and include signage informing patients of their rights to file grievances with SAPC, DHCS Office of Civil Rights, and the United States Health and Human Services Office of Civil Rights.

Patients, their authorized representatives, or providers with the patient's written consent can file complaints, grievances, and appeals. Involved parties may review and respond to evidence provided by QI and UM staff, and challenge denials of DMC EV or service authorizations for LOCs.

Complaint/Grievance Process

Providers may initiate complaints/grievances verbally or in writing **at any time**. Patients can file a complaint with SAPC by phone, email, fax, or mail by submitting a Patient Complaint Form. If a patient does not submit a written form, SAPC staff will complete it based on the patient's provided information. Additionally, patients can authorize another person, in writing, to act on their behalf as an "authorized representative."

- Upon receipt, complaints/grievances will be logged by SAPC-CCD staff. Clinically related complaints/grievances will be forwarded to SAPC-QI and SAPC-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 licensed clinical staff within the SAPC-QI and SAPC-UM sections, 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 acknowledgment of receipt and a written decision notification regarding the grievance will be rendered within the timeframes listed in **Table 22**, though many complaints/grievances will be addressed sooner. If the clinical complaint/grievance cannot be resolved within the respective timeframe, either the member or the county may request an extension of 14 calendar days. Extensions may only be initiated by the county when there are delays due to the need for additional information **and** it is in the patient's best interest.
- Written decision notifications referred to as a 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 the decision results in denial).
  - Contact information for the reviewer.
  - Information regarding the state fair hearing process for Medi-Cal members and the member'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 QI activities within the SAPC-QI and SAPC-UM sections. Depending on the nature of the complaint/grievance, this may trigger more targeted follow-up at the provider level.

- Concerns arising 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 and Risk Management Committee during its meetings every other month to identify trends, areas needing process or performance improvement, and determine necessary action steps.

Table 22

Grievance Timeline Table

<table>
<tr><td colspan="4">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 members' right to dispute an extension of time proposed by the County to make an authorization decision.</td></tr>
<tr><td colspan="2">Time of Filing</td><td colspan="2">Member/provider/authorized representative may file verbally or in writing at any time.</td></tr>
<tr><td colspan="2">Written Acknowledgment of Receipt</td><td colspan="2">Within five (5) calendar days of receipt of the grievance includes:
• Date received; and
• Contact Info of County staff patient may contact (Date received/ Name/ Phone/ Address</td></tr>
<tr><td colspan="2">Resolution:
Written Decision Notification</td><td colspan="2">May not exceed 90 days from the date of grievance. A decision may not exceed 30 calendar days when the grievance is related to disputes of the County's decision to extend the timeframe for making an authorization decision.
• NGR with a clear, concise explanation of the decision.

One Exemption
Written Notification is <u>not required</u> if:
• Complaint received by phone/in-person; and
• Resolved (to member satisfaction) by close of next business day.</td></tr>
<tr><td rowspan="2">Extensions
(not to exceed 14 calendar days)</td><td>Initiated by</td><td>Member</td><td>County
ONLY when delays due to the need for additional information AND is in the patient's best interest.</td></tr>
<tr><td>Written Notice</td><td>N/A</td><td>Requires:
• Prompt verbal notice of delay; and
• 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 the next business day. It <u>must</u> be in writing and logged.</td></tr>
<tr><td colspan="2">"APPEAL"
No appeal for grievances only additional actions</td><td colspan="2">• If the patient is dissatisfied with the results of the grievance, they may file another grievance; or
• Submit grievance to the State Medi-Cal Managed Care Ombudsman office.</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 of these letters. The following are types of NOABDs:

- Denial or limited authorization of a requested service
- Reduction, suspension, or termination of a previously authorized service (when member disagrees)
- Modification or limit of a provider's request for a service and approval of alternative services
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure to process authorization decision in a timely manner
- Failure to act within the required timeframes for grievance and appeals resolutions
- Denial of a member's request to dispute financial liability

Note: NOABD ONLY applies to Medi-Cal members.

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 that must not be modified, revised, or otherwise changed (except where specific SAPC or DHCS policy is permitted **to provide additional detail)**.

Several SAPC units make decisions regarding NOABD. These decision-makers are not incentivized or rewarded to issue adverse decisions. The goal is to ensure the appropriate utilization of SUD resources, which are not intended to screen out patients for needed services or create unnecessary burdens for providers.

Network Providers have the following responsibilities around the NOABDs:

- Assisting patients who receive NOABDs in understanding their rights and who to contact.
- Ensuring the following two (2) 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 it to SAPC on a quarterly basis.
- Including the following three (3) required attachments with provider-initiated NOABDs:
  - NOABDs Your Rights Attachment.
  - Member Non-Discrimination Notice.
  - Language Assistance Taglines.

Table 23 provides NOABD timelines and processes. The approved NOABD templates can also be found on SAPC's Manual, Bulletins, and Forms webpage, under the Clinical tab: http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm#clinical.

Appeals Process

The appeals process provides a mechanism for reviewing adverse benefit determinations made by SAPC staff or providers. These determinations may involve denials of DMC benefit verification, LOC decisions, or payment for services.

Patients, their authorized representatives, or providers, with the patient's written consent, can request reconsideration of adverse decisions by filing a formal appeal. A full and fair review will be conducted by licensed clinical staff. Appeals can be submitted in writing by sending a completed Appeal Request form with the patient's signature to SAPC, either electronically or via fax, within 60 calendar days from the date of the NOABD. Appeals can also be filed orally, but must be followed by a written and signed appeal unless an expedited resolution is requested.

If an appeal is filed without the patient's involvement, including when the patient's written consent is not included, the appeal must explain why the patient could not participate. Appeals lacking patient involvement will be treated as complaints or grievances according to the complaint/grievance process.

- Upon receipt, SAPC-CCD staff will log the appeal and send a receipt notification to the requesting party within the timeframes specified in **Table 23**.
- Staff reviewing the appeal will investigate the initial denial, including additional research if needed, such as contacting the treating provider. They will also consult the ASAM criteria and other relevant clinical resources.
- The patient will be given a reasonable opportunity to present evidence and arguments, both in-person and in writing. SAPC will inform the patient of the time constraints for expedited resolutions.
- After reviewing all case information, a decision will be made. The rationale and outcome will be communicated to the appealing patient and/or provider according to the timeframes in **Table 23**. If the appeal cannot be resolved within the specified timeframe, an extension of up to 14 calendar days may be requested by the County if additional information is needed and it is in the patient's best interest
- 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 the decision results in denial), including criteria/clinical guidelines or policies;
  - Contact information for the reviewer; **and**
  - Information regarding the State Fair Hearing process and the patient's right to continue to receive benefits while the fair hearing is pending.
- If the appeal is denied or not fully resolved in the patient's favor, the patient will be informed of:
  - Right to request a State Fair Hearing and how to do so;
  - Right to request continued benefits while the hearing is pending, and how to make such a request;
  - Possibility of being held liable for the cost of benefits if the State Fair Hearing upholds the original denial.
- Appeals for initial Residential authorizations and WM will follow the expedited appeal timeframe as outlined in **Table 23**, whereas residential reauthorizations will follow the standard appeal timeframe.
- Oral appeals (excluding expedited appeals) shall be followed by a written appeal signed by the member. SAPC will request a written follow-up. SAPC shall assist in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the member of the form's location

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 or delay the appeal resolution 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 23**.
- 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 to identify trends and areas needing improvement and determine necessary action steps.
- During the appeal process, the patient continues to receive their benefits if all 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 an 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 (1) of the following occurs:
  - The patient withdraws the appeal.
  - A State Fair Hearing office issues an unfavorable hearing decision to the patient (e.g., denial).
  - A previously authorized service's time or service limits have been met.
- Patient responsibility for services furnished while the appeal is pending:
  - If the appeal results in an unfavorable decision for the patient (e.g., denial) and upholds SAPC's original action, SAPC may seek to recover the cost of services provided during the appeal period, provided these services were given solely due to the pending appeal.
  - If SAPC or the State Fair Hearing overturns a decision to deny, limit, or delay services not provided during the appeal, SAPC must authorize and promptly provide those services.
  - If SAPC or the State Fair Hearing office overturns a decision denying authorization of services, and the patient received these services during the appeal, SAPC must cover the cost of those services.

Contact Information:

County of Los Angeles, Department of Public Health
Substance Abuse Prevention and Control Bureau
Office of the Medical Director and Science Officer (OMDSO)
1000 South Fremont Avenue; Building A-9 East, 3rd Floor
Alhambra, California 91803
(626) 293-2846

Note: In all cases, patients who have exhausted the Complaint/Grievance and/or Appeals process may request a State Fair Hearing process with the DHCS.

Table 23

Notice of Adverse Benefit Determination (NOABD) and Appeals Process Timeline Table

Type of Action	Notification Requirements	Responsible Party for Notification	Appeals *Member/provider/authorized representative MUST file within 60 days of NOABD[25]*				State Fair Hearing *Members must exhaust the appeal process prior to requesting*
			Written Acknowledgment 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[26] Template & attachments** (Exceptions 42 CFR 431.213 and 431.214)	**NETWORK 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. **NAR & attachments 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[27] • Overturned NAR** - If resolved wholly in favor of member	1. Initiated by Member 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.	Member must request w/in 120 days of NAR or County failure to adhere to requirements. **Standard Hearing:** County notify members that the State must reach its decision within 90 calendar days of date or request for hearing. **Expedited Hearing:** County must notify member that the State must reach its decision within 3 days of the request. **Overturned Hearings**: County shall authorized/ provide disputed services as expeditiously as health condition requires, but no later than 3 working days.

[25] Oral Appeals – see oral appeals bullet point in *Appeals Process* section.
[26] NOABD must include: 1) adverse benefit determination the County has made/plans to make; 2) clear explanation of the reasons for the determination, including clinical reasons if it involves medical necessity criteria, specifying why the member's condition does not meet the criteria; 3) description of criteria used; 4) member's right upon request and free of charge to access to and copies of all documents/records related to Adverse Benefit Determination.
[27] NAR – see *Appeals Process* section to see what must be included.

Type of Action	Notification Requirements	Responsible Party for Notification	Appeals *Member/provider/authorized representative MUST file within 60 days of NOABD*[25]				State Fair Hearing *Members must exhaust the appeal process prior to requesting*
			Written Acknowledgment of Receipt	Appeal Resolution (Standard)	Appeal Resolution (Expedited)	Extension (max. 14 calendar days)	
Failure to Provide Services in Timely Manner	**PROVIDER** via fax/phone within 24 hours of decision. **PATIENT** in writing within 2 business days of the decision **NOABD Template & attachments**	**SAPC & NETWORK PROVIDERS**					
• **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 the appeal process) no later than 72 hours from the date it reverses the determination.

Risk Management and Reportable Incidents

Risk management refers to strategies that minimize the possibility of an adverse outcome or loss and maximize the realization of opportunities. Good risk management techniques improve the quality of patient care, reduce the probability of an adverse outcome, and reduce the health care provider's liability. Standards of care, QI, and the systematic gathering, analysis, and utilization of data are the foundations of risk management.

Risk Management Committee at the Provider Level

Risk management strategies are becoming increasingly important in an evolving healthcare landscape, including 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:

- Assure the implementation of an agency-wide risk management strategy that includes developing policies and procedures and subsequent staff training on QI, fire safety, disaster preparedness, hazard reporting, etc.
- 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.
- Provide thorough investigation on all reportable incidents, which must be reported to SAPC.
- Investigate adverse events, as necessary and appropriate.
- Review safety and incident-related data and identify trends and patterns associated with risks or identify problem areas.
- Establish processes to maintain service/billing integrity and quality care, including implementation of peer review processes and QIPs.
- Promote QI activity by identifying opportunities to maximize the safety of the physical and therapeutic environment and reduce agency, staff, and patient risks.
- Develop procedures to detect and prevent fraud, waste, and abuse.

Adverse Events

Adverse events are defined as incidents that directly or indirectly impact 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 and Risk Management Committee immediately. These incidents may result in corrective actions and are viewed as learning opportunities to improve care and risk management processes.

Note: While reportable incidents must be reported to the SAPC Quality Improvement and 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 5. PROVIDER QUALITY IMPROVEMENT EXPECTATIONS

Quality Improvement Expectations

Treatment providers within the specialty SUD system must establish a culture and infrastructure to support Continuous Quality Improvement (CQI) to best serve their 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 describes the required QI 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 CQI 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 identify 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 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 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 (2x) annually.

All records and information obtained during peer review functions should remain confidential and be used only to review the quality and appropriateness of care for improved practices.

Quality Improvement Projects

A 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. A QIP aims 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 QIPs 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 CQI 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 potentially significantly impact 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 a minimum of one (1) QIP at all times.

QIPs will be reviewed on an annual basis by SAPC staff.

Performance Improvement Projects

Healthcare providers, including SUD providers, share the common goal of providing high-quality care. Performance Improvement Projects (PIPs) measure performance and outcomes. This helps organizations and providers understand how well they're meeting their quality care goal. It also 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 what is not working well so that the necessary steps can be taken to seek improvement. The Performance Management System outlined in **Figure 2** 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 substance use behaviors and psychosocial functioning changes. 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 QI strategies aimed at changing *clinical practices* and *organizational cost management*.

Figure 2

Public Health Performance Management System

Source: Public Health Foundation. (n.d.). About the Performance Management System Framework. 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 is 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 levels. 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 6. BUSINESS PROCESS STANDARDS

Contract Management

SAPC-CCD 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 (CAP) Support
- Contractual and Regulatory Technical Assistance

Additionally, SAPC-CCD 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, SAPC-CCD develops and maintains a solicitation process that is fair, open, and reflective of the County's needs while setting a minimum standard of qualifications to ensure the highest level of treatment services for SUD patients.

Certification and Licensure Requirements

All contracted DMC-ODS LOCs and sites must maintain the mandated certifications and licenses in accordance with State and County requirements; this includes when a network provider seeks to add or expand services.

DMC-ODS Provider Qualifications

DMC-ODS services are provided to members 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 Federal and State laws and regulations;
2. Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by DHCS; **and**
3. Sign a provider agreement with the DMC-ODS county(ies) in which DMC-ODS services will be rendered.

DHCS DMC Certification Application

DMC Certification is required for all treatment LOCs except RBH and RH. New providers to the network or current providers who wish to provide additional services under their existing contract must apply for DMC certification. The link below provides information on the DMC certification application. Providers should note the following:

- DHCS 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 DMC Application Information webpage.

Inpatient-Withdrawal Management (ASAM 3.7-WM and ASAM 4-WM)

A valid license from the California Department of Public Health (CDPH) is acceptable for DMC Certification of Chemical Dependency Recovery Hospitals (CDRHs) or freestanding Acute Psychiatric Hospitals (APHs). For additional information, visit CDPH's Licensing and Certification Program webpage.

DHCS AOD Certification

In accordance with BHIN 23-058, effective January 1, 2025, DHCS AOD certification is required for all OP services, except DUI and OTP. DHCS AOD certification is and will continue to be required for residential LOCs.

DHCS ASAM Designation

In addition to the DMC certification, all network treatment providers must have the appropriate ASAM designation on their 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 additional information, visit DHCS's Level of Care Designation webpage.

Updating Service Provider's Contract

Contracts may be updated to reflect changes at the Federal, State, and local levels that impact the delivery of SUD treatment. Contracts may be amended at the request of service providers who wish to update their organization's information or to update/add/remove services. For additional information, see SAPC IN 22-14 or the most recently published IN regarding Amendments.

SAPC Updates

These amendments may be implemented as a new contract or sent via SAPC Bulletin or IN. Providers will be notified of all pending changes in a timely manner and mandated to attend training or meetings on the new changes.

Service Provider Changes

Service Providers may wish to update, add, or remove services from their contracts to reflect organizational changes. For additional information on navigating the contract amendment process, see **Table 24**.

Table 24

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 request any increases or decreases as needed. Funding augmentations are approved based on utilization, (providers must have utilized at least 50% of their contracted allocation), performance, and community needs.	Providers must justify all requests with relevant data and supporting documentation and submit the request using the "Contract Amendment Form" in SAPC IN 22-14 or the most recently published IN regarding Amendments. All required and applicable fields of the Contract Amendment Form must be completed, and appropriate justification, documentation, and attachments must be provided that support the need for additional services and/or sites. Agencies are advised to provide a budget summary and narrative if they submit a funding augmentation request.	3 to 4 months
Add/Remove Services or locations	Providers may request to add or remove services (including adding beds) 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.	The same information is listed above.	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 credentialing requirements.	Notify SAPC in writing of the new staff and describe their role and title. If staff are required to be credentialed, the provider should also include the required documents. Requests can be sent to SAPCMonitoring@ph.lacounty.gov and your assigned CPA.	1 month
Other Changes	Much of the service provider's information is entered into a database. To ensure the most current and accurate information, any organizational changes should be reported to SAPC.	Notify SAPC in writing of any organizational changes. Requests can be sent to SAPCMonitoring@ph.lacounty.gov and your assigned CPA.	Varies

Required Information

Providers must justify all requests with relevant data supporting the need for additional services or sites. The request must include:

- 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 relevant to the request).
- Any other pertinent information supporting the requested change to the contract or agreement.

Ongoing Compliance Monitoring

As the steward of taxpayer funds and SUD treatment in LA County, SAPC is mandated to ensure treatment is delivered appropriately, effectively, and in accordance with contractual, Federal, and State requirements. To ensure this, all service providers will undergo various types of monitoring, including:

SAPC Compliance Monitoring

SAPC-CCD conducts ongoing compliance visits with providers to ensure full and appropriate understanding and application of contractual, Federal/State/local requirements. Each organization is assigned a 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 involves collaboration and partnership. The CPA conducts compliance checks and works with the service provider to correct any identified non-compliance issues. SAPC-CCD also works with SAPC-QI 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 Nots, including whether MAT was offered as a component of treatment, Problem Lists (non-OTP settings) and Treatment Plans (OTP settings), ROI authorization forms, acknowledgments, and other mandated documentation.
- **Patient Interview/Activity Observations**: SAPC-CCD staff will contact patients and/or observe treatment activities to assess and confirm the delivery of treatment services.
- **Compliance with Training Requirements:** SAPC-CCD staff will monitor SAPC providers' participation in required SAPC-provided or contracted training, including training related to CalAIM changes.
- **Grievance/Complaint Review:** SAPC-CCD 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 the delivery of services as contractually required. These activities include, but are not limited to, data review, key staff interviews, and facility inspections.

The CPA will work with the service provider to develop and implement a CAP that addresses and resolves all the deficiencies encountered during the monitoring visit.

In accordance with governing regulations around the use of taxpayer 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. SAPC will disallow or recoup any services when fraud, waste, or abuse or the intent of committing fraud, waste, or abuse is identified. SAPC-CCD will report any suspected fraud, waste, or abuse to DHCS as required by the state.

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. SAPC-CCD will work with the treatment provider to resolve any issues identified in the audit by collaborating on the CAP and ensuring its successful implementation. In addition to State audits, providers are also required to submit a Single Audit report to the State if they receive $750,000 in Federal awards per year.

County Fiscal Monitoring

SAPC has partnered with the County Auditor-Controller to conduct mandated fiscal monitoring. Fiscal monitoring is a review of the service provider's financial records to verify compliance with the financial aspects of the contract and generally accepted accounting principles. 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

SAPC-CCD will work with all treatment providers on credentialing and re-credentialing all providers and their staff. In accordance with MHSUDS 18-019 providers must submit an attestation as part of the contracting process. For additional information, see the latest version of the Prospective DMC Contract Application published on SAPC's website.

- 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 DEA 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 webpage, when applicable.

- 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 webpage, may not participate in the Plan's provider network.
- 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 or INs describing COVID-19 testing and vaccination requirements.

Protected Health Information Requirements

All contracted provider staff who access or assist with the disclosure of PHI must undergo a background check, complete annual information and security training, and sign an annual confidentiality statement before gaining access to PHI or Personally Identifiable Information (PII).

- **Background Checks**
  - Network treatment providers are responsible for developing an agency-level protocol to ensure staff background checks are conducted on staff prior to employment.
  - This background check (screening) must be retained for a period of three (3) years by the provider agency.
- **Training**
  - Each provider agency is required to develop a protocol to ensure all staff comply with this training requirement and establish an annual training schedule.
  - Agency shall retain records of completed training for monitoring purposes.
- **Signed Confidentiality Statement**
  - Each provider agency is required to develop a protocol to ensure all staff comply with this confidentiality statement requirements on an annual basis.
  - The signed confidentiality statements shall be retained for a period of six (6) years following termination or expiration of a treatment provider contract.

Contractual, Programmatic, Fiscal, and Regulatory Technical Assistance

Understanding all the regulations that govern services is critical to implementing a successful program. SAPC-CCD staff works with providers to ensure understanding and appropriate implementation of all contractual and regulatory requirements. Additionally, SAPC-CCD and SAPC-QI teams monitor agencies' programmatic compliance with agency contracts and the most recent version of the Provider Manual. Service providers should contact their CPA with any questions or request technical assistance.

Regulations to be familiar with:

- Contract/Agreement with SAPC
- Substance Use Disorder Treatment Services Provider Manual (this manual)
- CCR Title 22 & CCR Title 9
- DHCS BHINs
- Certification Standards (DMC and AOD)
- DHCS Adolescent Substance Use Disorder Best Practices Guide (October 2020)
- HIPAA & 42 CFR Part 2
- 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
- Los Angeles County Auditor-Controller's County Fiscal Manual
- Perinatal Practice Guidelines (v1.1, 2022) (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 SUD 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 22-10.
- **Organizational Changes:** Develop a procedure to ensure SAPC is informed of any organizational changes, including changes in services, locations, or high-level staff.
- **Training:** Ensure that staff are properly trained on aspects of the DMC-ODS, including ASAM,
- **Hepatitis Program:** Develop policies and procedures 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 19-01.

Providers should work with their CPA to identify all the required policies and procedures.

Finance Management

Network providers' reimbursement methods continue to adapt due to LA County's participation in the DMC-ODS Waiver and CalAIM. Therefore, key business management practices need to be in place and monitored regularly (e.g., monthly) to ensure that the people served, and units of services claimed align with costs incurred. Any excess funds resulting from rates exceeding actual costs should be reinvested in allowable business and clinical capacity-building efforts well before the end of the FY. 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 Rates Standards Matrix in SAPC Bulletin 24-04: Fiscal Year 2024-2025 Rates and Payment Policy Updates details allowable HCPCS and Current Procedural Terminology (CPT) codes and the associated service description, rate, unit of service, and treatment standard for each ASAM LOC. The minimum number of service hours required for each ASAM LOC does not change for weeks, including a Federal, State, or local holiday.

OP LOCs (ASAM 0.5 Early Intervention, 1.0, 2.1, 1-WM, 1-OTP, RS) report by HCPCS/CPT codes and get reimbursed by codes at the associated rate. Residential LOCs (ASAM 3.1, 3.3, 3.5, 3.2-WM) report by HCPCS/CPT codes and get reimbursed by day rate, and room and board rate. Inpatient LOCs (ASAM 3.7-WM, 4.0-WM) report by revenue codes and get reimbursed by day rate.

Gathering this information for all LOCs 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 FY.

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 is 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), it is crucial to document the total hours of services delivered each week to demonstrate meeting the per person standard (20, 24, and 22 hours respectively) and confirm that patients are receiving appropriate LOC.

Example: How to Calculate Group Counseling Sessions

DHCS group services billing formula has changed. DHCS divides the rate by 4.5 which is the average number of participants in a group statewide. This rate has been configured in Sage for group services post CalAIM per unit of service. Providers should submit claims separately for each member receiving group counseling and will no longer indicate the number of patients in the group or group documentation time. Claims for groups will be similar to individual services for billing purposes.

Number of minutes for the group counseling session/15-minute increments = Total Units to submit using code H0005 per patient.

For example: 90 minutes/15 minutes = 6 Units which is equivalent to 6 units of code H0005

For pre-CalAIM claims, providers should review the training materials and billing guides for claiming group services pre- and post-CalAIM published on SAPC's Sage Trainings – Sage-PCNX webpage.

Sage will also have the capability to determine whether the following requirements are met:

- **Enrollment in Multiple Programs:** An individual cannot concurrently enroll in two or more LOCs (except OTPs, RS, CM, and RBH) or be enrolled by more than one contractor at a time (except OTPs, RS, CM, and RBH).
- **RBH Reimbursement with Treatment:** For providers to receive RBH reimbursement, RBH participants must be concurrently enrolled in OP (ASAM 1.0), IOP (ASAM 2.1), OTP (ASAM 1-OTP), or Ambulatory-WM (ASAM 1-WM, 2-WM) services.

For additional information, see
SAPC Bulletin 24-04: Fiscal Year 2024-2025 Rates and Payment Policy Updates.

Investments to Support a Modern SUD System

Moving from a cost reimbursement model to FFS, and ultimately value-based payments, requires planning and clinical investments now! If providers do not consider how revenue (the gap between costs and reimbursement) can be appropriately reinvested in program services (e.g., clinical trainings, competitive salaries, technology) it presents not only a lost opportunity to better support those that are served but also potential lost revenue downstream when provider compensation is not only FFS but tied to patient outcomes. Network Providers are expected to evaluate clinical and business practices to determine whether the current efforts align with best practices, support an efficient and effective system of care, and 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 FY, to allow time to accumulate funds since the rate received may exceed current operating costs. Provider Contract Budgets have been revised to include a Program Investment Fund allowing providers to identify a specific amount for program investments. However, providers must consider real-time investments such as increasing staff, specifically counselor salaries, to support staff retention. To know when to invest, organizations must understand the budget in relation to FFS revenue 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 enact change. The following investments are strongly encouraged and comply with any Federal, State, or local regulations/requirements, see **Table 25**. Making some of these and other allowable investments will also enable Network Providers to implement and comply with the requirements of this Provider Manual.

Table 25

Allowable Clinical and Business Investments

Need	Considerations
Benefits Acquisition: Not eligible for Medi-Cal 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 eligible members 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 is 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 expectations in SAPC IN 23-02? • Do you have enough computers for counselors and clinical staff?
Facility Environment and Access: Each outpatient site (except OTP) must provide services two (2) evenings (5:00 p.m. – 9:00 p.m.) per week and eight (8) hours per weekend. Having a welcoming facility may also contribute to patient satisfaction and retention.	• Do you comply with new service day and hour standards? • Would expanding days and hours of operation increase services? • Would minor facility improvements (e.g., paint, furniture) impact patient care?
FBS: 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?
MAT: Clinical and counselor staff need to be able to educate, refer and link all patients with AUDs and/or OUDs on this available treatment option.	• Are staff trained? • Do policies and procedures reflect this requirement? • Are referral mechanisms in place?
Qualified Staff: Outpatient LOCs are now reimbursed based on the practitioner level.	• Would some services be more appropriately provided by other practitioner levels? • Will improved salaries or benefits for direct service staff increase retention and reduce turnover? • Would hiring LPHAs in addition to counselors improve patient care?
Expanded Access: Reaching the 95% of people who need treatment but don't want it or don't access it	• How can you expand business practices to reach more people and draw down more revenue? • What training and support does your clinical and counselor team need to expand care?
Trainings for Clinical and Counselor Staff: ASAM Criteria and Medical Necessity, CBT, MI, and 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 in 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 is 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 and 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 are operating under a managed care model, it is even more critical that the budget and expenditures clearly align with the organization's business and clinical needs. 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/local regulations, expectations outlined in this Provider Manual and other contract-related documents, and substantively contribute to positive patient outcomes.

The *Budget Summary* and *Budget Narrative* Templates 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 details 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:

- **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 expenses 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.

- **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:

1. Budgeted Direct Costs:
   a. Salaries, Wages and Employee Benefits
   b. Facility Rent or Lease
   c. Equipment and/or Other Asset Leases
   d. Services and Supplies
2. Budgeted Indirect Costs:
   a. Salaries, Wages, and Employee Benefits
   b. Facility Rent or Lease
   c. Equipment and/or Other Asset Leases
   d. 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 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

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.
- Medi-Cal patients whose benefits need to be re-assigned to LA County due to a permanent move.

If a patient has not been granted Medi-Cal or had benefits transferred to LA 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 payments to providers via direct deposit.

Table 26

Claims Submission Process for Medi-Cal Eligible

Status	Financial Eligibility	Financial Eligibility Form	Claims Process	Status
Medi-Cal Eligible or Enrolled:	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	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 a 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 requested service type.	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"**. *Ensure that all payor sources a patient qualifies for are 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.***

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 latest version of the DMC-ODS Billing Manual on DHCS's website.

Fiscal Reporting

Effective FY23-24, SAPC will implement a streamlined Fiscal Reporting process for all service agreements, including treatment contracts. This revised process adheres to CalAIM's goals of reducing administrative burdens while meeting local funding requirements. For FY22-23 and prior, contracts will continue to adhere to DHCS' Cost Reporting process and forms as required by law (California HSC § 11852.5 and California WIC § 14124.24) that cost reports are to be submitted to the State to determine how Federal and State funds are spent.

Providers should establish separate and unique cost centers for each contracted ASAM LOC and other services provided under a SAPC contract (e.g., RBH services) and non-treatment services (e.g., prevention programs). Establishing cost centers to reflect all contracted treatment and non-treatment services will allow for the efficient and accurate tracking of associated costs and revenue by each service. This information is essential to ensure fiscal viable services and to identify resources to reinvest in the program.

Overview of Fiscal Report Process

SAPC-FSD will issue the fiscal reporting tools for the prior FY at the start of the FY. The tool is designed to collect cost information at the agency level and should be completed in a reasonably short period of time (approximately two [2] weeks). SAPC-FSD will review and finalize the report and issue a final report letter by the end of the calendar.

Note: For FY22-23 and prior, DHCS will continue to manage its reporting in accordance with its internal timelines. Once released, SAPC-FSD will issue those reports and supporting documentation in accordance with DHCS's instructions. Any manipulation to the cost report template format and/or formulas will deem the cost report null and void.

DMC Cost Reconciliation Methodology

For FY22-23 and prior, the rate at which a provider bills for DMC services is an interim rate until the cost report is settled. SAPC will settle for the lower cost or charges.

Fiscal Report Records and Supporting Documentation

The provider must maintain a formal set of financial records, including a general ledger and books of original entries (e.g., 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, canceled checks, contracts, purchase orders, and receiving reports.

The provider must maintain fiscal and statistical records for the period covered by the cost report that is 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 California WIC § 14124.24(g)(2) and California WIC § 14170.

Fiscal Report Training and Preparation

The county provides cost report training to all providers every year during the month of August. If you do not receive an invitation from us, email SAPC-FSD at SAPC-Finance@ph.lacounty.gov.

To prepare a cost report, the following documents will be needed:

- County contract
- General ledger for each site
- Units billed for the FY
- Download cost report forms and instructions from SAPC's website; visit http://www.publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#finance.

Fiscal Report Submission

Submit the complete set of cost report via email to SAPC-Finance@ph.lacounty.gov and mail with the original signature to:

County of Los Angeles
Department of Public Health
Substance Abuse Prevention and Control
Fiscal Reporting Unit
1000 S. Fremont Avenue., Building A-9 East
3rd Floor, North Wing, Unit # 34
Alhambra, California 91803

Fiscal Report Delinquent

SAPC may impose sanctions for non-receipt of the fiscal 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."

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

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 and providers outside of the specialty SUD system.

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 improves 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.

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.

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

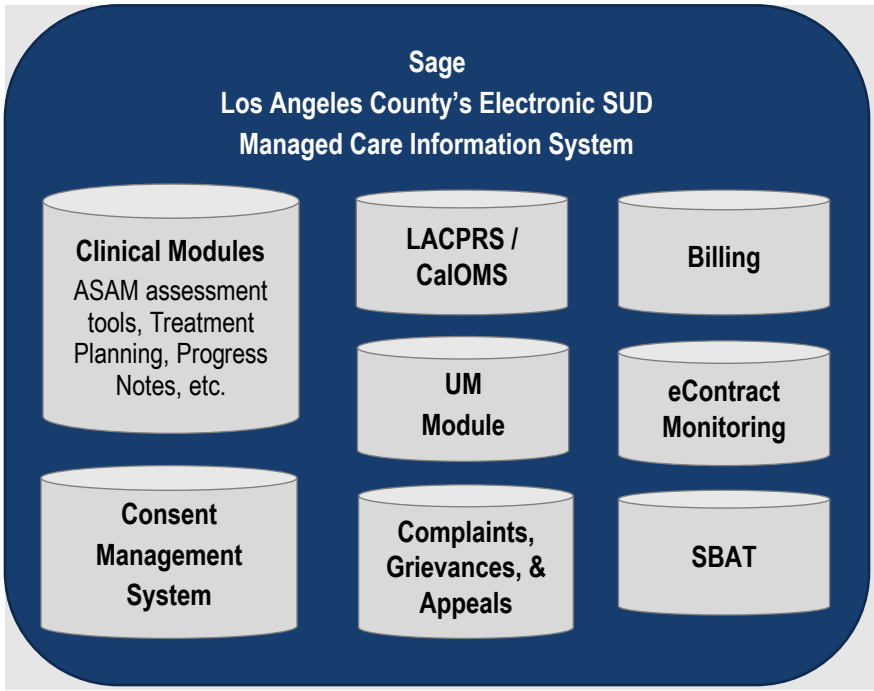
Sage is a certified, web-based SUD EHR that consists of clinical, administrative, and data reporting modules that satisfy mandatory government reporting and interoperability requirements and provide the necessary framework for overseeing and delivering SUD services in a managed care environment. It is 42 CFR Part 2 and HIPAA compliant. **Figure 3** outlines Sage's various functionalities, including all the capabilities 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 for Sage. SUD provider agencies will be responsible for ongoing training.

For additional information on Sage, including training details, User Access Groups, billing, and ASAM CONTINUUM assessment trainings, visit www.publichealth.lacounty.gov/sapc/Sage/Sageinfo.htm.

Figure 3

Sage: LA County's Electronic SUD Managed Care Information System



Providers Eligible for Sage

Selecting an EHR system is a personalized business decision for specialty SUD providers. While providers are not required to use Sage as their agency's EHR system, all SAPC providers must have a certified EHR that is approved by SAPC. Additionally, some functions must be completed by all providers, regardless of whether they have their own EHR system.

Sage is available to SUD providers who do not currently have an EHR or who already have one but choose to switch systems. Providers who elect to continue using their SAPC-approved EHR system may do so as long as they work with SAPC IT to ensure necessary data exchange. Please note that once a provider elects to use their own EHR system, they can no longer elect to use Sage as their EHR system in the future.

Due to functional requirements, OTP providers are not eligible to use Sage as their primary EHR. OTPs in the SAPC treatment network must have their own EHR system.

For non-OTP providers who elect to utilize Sage, it will be used for all treatment services within the specialty SUD system. In OTP settings, Sage will be used to document admissions, access ASAM assessments, access the UM module, and report data. Otherwise, OTPs' clinical and billing functions will remain on their current EHR systems.

Note: Prevention and DUI services do not utilize Sage at this time.

Sage User Roles

To fully utilize the benefits of Sage, SUD providers should manage the user roles they grant their staff. Sage captures most SUD provider staff roles, allowing for a wide range of provider functions, which 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
- Peer Support Specialist
- LVN & MA

For additional information on Sage, including managing access groups for staff, see the Sage User Enrollment webpage on SAPC's website.

Note: SAPC will review all user roles to ensure that roles are appropriately assigned.

Provider Responsibilities

With regard to their EHR systems, SUD providers are expected to:

- Recognize the critical importance of EHR systems to delivering high-quality SUD care.
- Include IT planning in their business plans to ensure sufficient hardware specifications, up-to-date anti-virus protection, and the latest Windows security patches, as well as 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, 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.
- Follow SAPC policies and procedures for reporting potential data breaches or data integrity issues immediately.

Sage Trainings

For provider agencies that elect to utilize Sage, while SAPC will support the initial credentialing training for Sage, SUD providers are responsible for ensuring their staff receive sufficient ongoing training on Sage to ensure proficiency, training in new functionality, 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 created and published web-based recordings of trainings and user guides for most major Sage User Roles 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 on the SAPC Sage website and are module-based to allow for completion in multiple sessions if the provider does not have sufficient time to complete in one session. Prior to being given access to Sage, users will be required to demonstrate proficiency by successfully completing these required trainings, reviewing the user guides, and passing the competency exam that is part of this training.

All practitioners 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 are not directly using the Sage system, will result in the denial of services provided by those providers. Providers with their own EHRs but have staff 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 submitting a Sage Help Desk ticket for SAPC Sage User Creation Form. This includes the practitioner's credentials (e.g., license number) and select Access Group #13 "Clinical Visible Only—No Login". This must be completed for staff providing all billable services, including medication distribution in OTP settings.

Section 7. APPENDICES

Appendix A. Glossary

TERM	DEFINITION
ASAM CO-Triage Tool	This is a short screener based on ASAM criteria used to determine whether adults and young adults need SUD treatment and the provisional LOC, which would most likely benefit them.
Assessment	The process for defining the nature of an issue, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis. ASAM-based assessments examine six (6) 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 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 diagnosis 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
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 on YouTube for additional information regarding BenefitsCal.
Campus-Like Provider	Sites that received DMC certification (and license for Residential and OTP providers) under an address with multiple street numbers &/or street names are considered campus-like providers (e.g., 100 – 108 Main St.; 1234 Main St. & 2223 Green St.). The campus address will correspond to one provider number.
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, 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.
Care Planning *(also known as 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 are described in Table 16 and Table 17, respectively.
Certified Medi-Cal Peer Support Services *(also known as Peer Support Services or PSS)*	PSS may be delivered in various settings; however, if a Certified Peer does not provide services, then they may not be reimbursable by Med-Cal. PSS must be based on an approved Plan of Care. The Plan of Care shall be documented within the Progress Notes in the member's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services. Certified Peers give and receive nonprofessional, nonclinical assistance to achieve long-term recovery for members. The support is provided by individuals who have experiential knowledge. Certified Peers provide assistance to promote a sense of belonging within the community. Another critical component that Certified Peers provide is the development of self-efficacy through role modeling and assisting their peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.
Certified Medi-Cal Peer Support Specialists (CMPSS) *(also known as Certified Peers)*	CMPSS or Certified Peers are peer support specialists who have completed the specific certification requirements set by the DHCS and CalMHSA. To get certified, individuals must apply, complete 80 hours of training, and pass a certification exam. Certified Peers are qualified to deliver PSS, which are reimbursable by Medi-Cal.

Chronic Homelessness *defined by HUD*	• A homeless individual with a disability as defined in section 401(9) of the McKinney-Vento Assistance Act (42 U.S.C. 11360(9)), who:
	  ○ Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and
	  ○ Has been homeless and living as described for at least 12 months* or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described.
	• An individual who has been residing in an institutional care facility for less, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria of this definition before entering that facility**; or
	• A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria of this definition, including a family whose composition has fluctuated while the head of household has been homeless.
	
	A "break" in homeless is considered to be 7 or more nights.
	****An individual residing in an institutional care facility does not constitute a break in homelessness.***

Co-Occurring Disorder (COD)	A concurrent substance use and mental or medical disorder.
Cognitive Behavioral Therapy (CBT)	A short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. 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 LOCs and are defined as in-person, telephone, or 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.
Crisis Intervention Services	A crisis for DMC-ODS services means an actual relapse or an unforeseen event or circumstance that presents to the beneficiary an imminent threat of relapse. Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to stabilizing the beneficiary's immediate situation, and be provided at the least intensive LOC that is medically necessary to treat the condition.
Culturally Competent Services	Providers are required to ensure that treatment services are delivered in a way that effectively interacts with people representing culturally, linguistically, and developmentally diverse groups, addresses their individualized needs, and optimizes treatment engagement. Organizational policies, procedures, and practices must be consistent with the principles outlined in the National Standards for CLAS in Health and Health Care and embedded into the organizational day-to-day operations.
Discharge and Transfer Form	The document that details the patient's planned discharge. The Discharge/Transfer Form shall include, but not be limited to, the following: • A description of each of the member's relapse triggers • A plan to assist the member to avoid relapse • A support plan
Discharge Planning	The process of preparing the patient for referral into another LOC, 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 RS and, from a clinical standpoint, to convey that recovery is an ongoing life process not a unit of service.
Documentation	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 SAPC are used for Problem Lists (non-OTP settings) or Treatment Plans (OTP settings), Progress Notes, and other documentation developed by the SAPC-QI and SAPC-UM sections. 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, developmental, and specialty services.
Evidence-Based Practice (EBP)	Practices that have been implemented and are supported by evidence. Providers will be

	expected to implement, at a minimum, the two (2) EBPs of MI and 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	Services are provided to patients and their family members to strengthen, enhance, and preserve the family unit. These services may include but are not limited to care coordination, childcare, crisis counseling, transportation, family therapy, or counseling.
Family Therapy	Psychotherapy involves the patient and their family members, using specific techniques and EBPs (e.g., family systems theory, structural therapy, etc.). The effects of addiction are far-reaching, and patients' family members and loved ones are also 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.
Field-Based Services (FBS)	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 EDs, primary care, mental health, court, jail re-entry (not in-custody), probation, and child protective services settings. FBS for MAT should be provided by staff who are specifically trained to recognize and respond to the unique biopsychosocial needs of their patients. FBS are responsive and appropriate to patients' cultural, linguistic, and developmental needs, and are supported by EBPs.
Group Counseling	In-person or telehealth contact between one (1) or more certified or registered SUD counselors or LPHA, and two (2) 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.
Homeless ***defined by HUD***	**HUD's Four (4) Categories of the Homeless Definition:** 1. **Literally Homeless:** Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: **(a)** has a primary nighttime residence that is a public or private place not meant for human habitation; or **(b)** is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State and local government programs); **or (c)** 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:** An individual or family who will imminently lose their primary nighttime residence, provided that: **(a)** residence will be lost within 14 days of the date of application for homeless assistance; **(b)** no subsequent residence has been identified; **and (c)** the individual or family lacks the resources or support networks needed to obtain other permanent housing. *(Note: Includes individuals and families who are within 14 days of losing their housing, including housing they own, rent, are sharing with others, or are living in without paying rent.)* 3. **Homeless Under Other Federal Statutes:** Unaccompanied youth under 25 years of age, or families with Category 3 children and youth, who do not otherwise qualify as

	homeless under this definition, but who: **(a)** are defined as homeless under the other listed Federal statutes; **(b)** have not had a lease, ownership interest in permanent housing during the 60 days prior to the homeless assistance application; **(c)** have experienced persistent instability as measured by two moves or more during in the preceding 60 days; **and (d)** can be expected to continue in such status for an extended period of time due to special needs or barriers. 4. **Fleeing/Attempting to Flee DV:** Any individual or family who: **(a)** is fleeing, or is attempting to flee, DV; **(b)** has no other residence; **and (c)** lacks the resources or support networks to obtain other permanent housing.
High Utilizer	A high utilizer is a person who is diagnosed with an SUD and 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 (3) 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 ***Note: In order to constitute "imminent danger," ALL THREE (3) ELEMENTS must be present.***
Individual Counseling	Clinical contact between an LPHA or counselor and a patient that addresses psychosocial issues related to SUDs. SAPC's required EBPs include MI and CBT. Services may be provided in person, by telephone, or by telehealth.
Intake	Intake is the process of determining that a patient meets the medical necessity criteria for care and then admitting a patient into an SUD treatment program. It includes the assessment or analysis to determine whether an individual meets the current DSM-5TR 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 and identifying the appropriate LOC. 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 recovery and demonstrating a willingness to re-engage with the recovery journey.
Licensed Practitioner of the Healing Arts (LPHA)	An 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 Vocational Nurses (LVNs) • Licensed Psychiatric Technicians (LPTs) • Licensed Occupational Therapists (LOTs) • Licensed-eligible LPHAs working under the supervision of licensed clinicians All LPHAs must operate under their established scope of practice. This does not include rendering diagnoses for RNs, LVNs, LPTs, and LOTs. As such, these specific LPHAs also cannot finalize ASAM Continuum assessments.

Medical Necessity	Medical necessity for all SUD treatment provided under a SAPC contract is defined as:
	
	Adults (age 21 and over)
	• 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 (California WIC § 14059.5(a)); **or**
	  ○ For OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to Federal and State regulations, qualify for medical necessity determination.
	• 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 DSM-5-TR.
	  ○ Appropriate placement in an SUD LOC that is consistent with recommended services and medical necessity based on the current edition of the ASAM Criteria.
	
	Youth (age 17 and under) and Young Adults (age 18-20)
	• At least one diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the DSM-5-TR; **or**
	• Meet 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 (age 17 and under) and Young Adults (age 18-20).
	
	Appropriate placement in an SUD LOC that is consistent with recommended services and medical necessity based on the current edition of the ASAM Criteria.

Medical Psychotherapy	"Medical Psychotherapy" is a counseling service to treat SUDs other than OUD is conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the patient. See Title 9 CCR § 10345.
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. Staff lawfully authorized to provide such services within their scope of practice and licensure should prescribe or administer MAT and assess the side effects and/or impact of these medications. Youth (age 17 and under) are eligible for MAT on a case-by-case basis with parental consent and SAPC authorization.

Member	Recipient of Medi-Cal.
Methadone	An opiate agonist medication used to treat OUD.
Motivational Interviewing (MI)	MI 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 values, beliefs, or wishes) but rather supports change in a manner congruent with the person's 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 in-person, by telephone, or by telehealth contact between up to two (2) registered or certified SUD counselors or LPHAs, and between 2-12 patients at the same time in non-residential settings and between 2-30 patients at the same time in residential settings.
Physical Examination	Appropriate medical evaluation must be performed prior to initiating treatment services, including physical examinations when deemed necessary.
Provisional LOC	The initial LOC that is determined by the ASAM CO-Triage tool. It will be replaced with the actual LOC once the patient has received a full ASAM CONTINUUM or SAPC Youth ASAM assessment at the treatment agency. The purpose of the provisional LOC is to increase the likelihood that the patient is directed to the appropriate treatment agency for them the first time.
Recovery Bridge Housing (RBH)	RBH is defined by SAPC as a type of abstinence-focused, peer-supported housing that combines a payment for recovery residences with concurrent treatment in OP, IOP, OTP, or OP-WM 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	RS will address all needs identified in Dimension 6 of the ASAM Criteria (See Recovery Environment of the ASAM Criteria), and services will be provided in-person, by phone, or via a telehealth modality. RS will include monitoring all six (6) ASAM dimensions. Relapse education and warning sign monitoring will occur throughout the duration of RS. 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 Certified Peer Support Specialist, a registered or certified SUD counselor, and/or an 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 arrangements for transportation for members receiving behavioral health residential, inpatient, or ED services. There are two types of transportation in the Medi-Cal program: • NMT for members who do not need medical assistance during transit. • NEMT for when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated.
Treatment Planning	See ***Care Planning***.
Warm Handoff	When a treatment agency, care coordinator, 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 the new counselor. The patient will go into the meeting having already been introduced to the new counselor.

Appendix B. Acronyms Glossary

ACRONYM	TERM
AADAP	Asian American Drug Abuse Program, Inc.
AAR	Adult At-Risk
AB	Assembly Bill
ACCBC	Addiction Counselor Certification Board of California
ADA	Americans with Disabilities Act of 1990
AMA	Against Medical Advice
AEVS	Automated Eligibility Verification System
AI/AN	American Indian and Alaska Native
AIDS	Acquired Immunodeficiency Syndrome
ALP	All Plan Letter
AOD	Alcohol and Other Drugs
APH	Acute Psychiatric Hospital
API	Asian Pacific Islander
APRN	Advanced Practice Nurse
ASAM	American Society of Addiction Medicine
ATC	Alternatives to Custody
AUD	Alcohol Use Disorder
AWD	Alcohol Withdrawal Delirium
AWOL	Absence Without Leave
BBS	California Board of Behavioral Sciences
BH Link	Behavioral Health Linkages
BHIN	Behavioral Health Information Notice (DHCS)
BPC	Business and Professions Code (California)
CAA	Cambodian Association of America
CAADE	California Association for Alcohol and Drug Educators
CADTP	California Association of DUI Treatment Programs
CalAIM	California Advancing and Innovating Medi-Cal
CalMHSA	California Mental Health Authority
CalOMS	California Outcomes Measurement System
CalSAWS	California State Automated Welfare System
CalWORKs	California Work Opportunity and Responsibility to Kids
CAP	Corrective Action Plan

CARF	Commission on Accreditation of Rehabilitation Facilities
CBO	Community-Based Organization
CBT	Cognitive Behavioral Therapy
CCAPP	California Consortium of Addiction Programs and Professionals
CCR	California Code of Regulations
CDPH	California Department of Public Health
CDRH	Chemical Dependency Recovery Hospital
CE	Continuing Education
CENS	Client Engagement and Navigation Services
CEO	Chief Executive Officer
CES	Coordinated Entry System
CEU	Continuing Education Unit
CF	Correctional Facility
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIBHS	California Institute for Behavioral Health Solutions
CIN	Client Index Number
CINA	Clinical Assessment of Narcotic Assessment
CIV	Civil Code (California)
CIWA	Clinical Institute Withdrawal Assessment
CIWA-Ar	Clinical Institute Withdrawal Assessment for Alcohol
CLAS	Culturally and Linguistically Appropriate Services
CM	Contingency Management
CMPSS	Certified Medi-Cal Peer Support Specialists (or Certified Peers)
COD	Co-Occurring Disorder
COIN	Co-Occurring Integrated Care Network
CORE	Connecting to Opportunities for Recovery and Engagement
COWS	Clinical Opioid Withdrawal Scale
CPA	Contract Program Auditor
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRRC	Community Re-entry and Resource Center
CRS	Change Report Summary
CSW	Children's Social Worker
DATAR	Drug Alcohol Treatment Activity Report

DAPO	California Department of Correction and Rehabilitation, Division of Adult Parole Operations
DCFS	Los Angeles County Department of Children and Family Services
DEA	United States Drug Enforcement Administration
DHCS	California Department of Health Care Services
DHS	Los Angeles County Department of Health Services
DHS-CHS	Los Angeles County Department of Health Services, Correctional Health Services
DHS-HFH	Los Angeles County Department of Health Services, Housing for Health
DHS-ODR	Los Angeles County Department of Health Services, Office of Diversion and Reentry
DJJ	State of California Division of Juvenile Justice
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DMH	Los Angeles County Department of Mental Health
DNC	Did Not Complete
DPSS	Los Angeles County Department of Public Social Services
DPSS-CU	Los Angeles County Department of Public Social Services, Centralized Unit
DO	Doctor of Osteopathic Medicine
DOJ	California Department of Justice
DOORS	Developing Opportunities Offering Reentry Solutions
DPH	Los Angeles County Department of Public Health
DPO	Deputy Probation Officer
DSM	Diagnostic and Statistical Manual of Mental Disorders
DT	Delirium tremen
DUI	Driving Under the Influence
DV	Domestic Violence
EBP	Evidence-Based Practices
ECD	Enhanced Care Management
ED	Emergency department
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency room
EV	Eligibility Verification
EW	Eligibility Worker
FAM	Family Code (California)
FBS	Field-Based Services
FDA	Food and Drug Administration

FDDC	Family Dependency Drug Court
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAIN	Greater Avenues for Independence
GPS	Global Positioning Satellite
GR	General Relief
GSW	GAIN Services Worker
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMIS	Homeless Management Information System
HN	Housing Navigation
HSC	Health and Safety Code (California)
HUD	United States Department of Housing and Urban Development
ICD-10	International Classification of Diseases, Tenth Revision
ICRP	In-Custody to Community Referral Program
ICT	Inter-County Transfers
IHCP	Indian Health Care Provider
IHOP	Interim Housing Outreach Program
IMS	Incidental Medical Services
IN	Information Notice (SAPC)
IOP	Intensive Outpatient
IPV	Intimate Partner Violence
IT	Information Technology
IV	Intravenous
JJCPA	Juvenile Justice Crime Prevention Act
LA	Los Angeles
LAC	Los Angeles County
LAC-Probation	Los Angeles County Probation Department
LACOE	Los Angeles County Office of Education
LACPRS	Los Angeles County Participant Reporting System
LAHSA	Los Angeles Homeless Services Authority
LASD	Los Angeles County Sheriff's Department
LCP	Licensed Clinical Psychologist

LCSW	Licensed Clinical Social Worker
LEAD	Los Angeles Law Enforcement Assisted Diversion
LEP	Limited English Proficiency
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer ("+" represents other identities such as non-binary, asexual, pansexual, two-spirit, and more)
LMFT	Licensed Marriage and Family Therapist
LOC, LOCs	Level of Care, Levels of Care
LOT	Licensed Occupational Therapist
LPCC	Licensed Professional Clinical Counselor
LPHA	Licensed Practitioner of the Healing Arts
LPJH	Los Padrinos Juvenile Hall
LPT	Licensed Psychiatric Technician
LRS	LEADER Replacement System
LVN	Licensed Vocational Nurse
M.A.	Master of Science
M.S.	Master of Arts
MA	Medical Assistant
MAR	Monthly Activity Report
MAT	Medication for Addiction Treatment *(also known as Medication Assisted Treatment)*
MD	Doctor of Medicine
MDT	Multi-Disciplinary Team
MEDS	Medi-Cal Eligibility Data System
MEDSLITE	Medi-Cal Eligibility Data System Lite
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSUDRP	Mandatory Substance Use Disorder Recovery Program
MSW	Master of Social Work
N3	Non-violent, Non-serious, and Non-sexual
NACT	Network Adequacy Certification Tool
NAR	Notice of Appeal Resolution
NARR	National Alliance for Recovery Residences
NCCA	National Commission for Certifying Agencies
NDP	DHCS Naloxone Distribution Project
NEMT	Non-emergency medical transportation
NGR	Notice of Grievance Resolution

NMT	Non-medical transportation
NOA	Notice of Action
NOABD	Notice of Adverse Benefit Determination
NP	Nurse Practitioner
MPPES	National Plan and Provider Enumeration System
NPI	National Provider Identification Number
NTP	Narcotics Treatment Program
OHC	Other Health Coverage
OMDSO	Office of the Medical Director and Science Officer
OON	Out-of-Network
OP	Outpatient
OP-WM	Outpatient-Withdrawal Management
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PA	Physician Assistant
PACT	Parole and Community Team
PAUR	Los Angeles County Probation Department, Prospective Authorization and Utilization Review Unit
PAUTH	Provider Authorization
PAWWS	Prediction of Alcohol Withdrawal Severity Scale
PCP	Primary Care Provider
PES	Psychiatric Emergency Services
PEH	People Experiencing Homelessness
PEN	Penal Code (California)
PES	Psychiatric Emergency Services
PhD	Doctor of Philosophy
PHI	Protected Health Information
PII	Personally Identifiable Information
PIP	Performance Improvement Project
PNA	Provider No Activity
PPW	Pregnant and Parenting Women
PSH	Permanent Supportive Housing
PSS	Peer Support Services (also known as Certified Medi-Cal Peer Support Services)
PsyD	Doctor of Psychology
QI	Quality Improvement
QIP	Quality Improvement Project

RBH	Recovery Bridge Housing
RDP	Rapid Diversion Program
RH	Recovery Housing
RHS	Reproductive Health Screening
RI-CM	Recovery Incentives-Contingency Management
RN	Registered Nurse
ROI	Release of Information
RP	Registered Pharmacist
RS	Recovery Services (*formerly Recovery Support Services or RSS)*
SAC	Substance Abuse Counselor
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPC	Substance Abuse Prevention and Control Bureau
SAPC-CCD	SAPC's Contracts and Compliance Division
SAPC-CST	SAPC's Clinical Standards and Training Section
SAPC-FSD	SAPC's Finance Services Division
SAPC-HODA	SAPC's Health Outcomes and Data Analytics Division
SAPC-SOC	SAPC's Treatment Systems of Care Division
SAPC-QI	SAPC's Quality Improvement Section
SAPC-UM	SAPC's Utilization Management Section
SASH	Substance Abuse Service Helpline
SB	Senate Bill
SBAT	Service & Bed Availability Tool
SCL	Service Connections Log
SLN	Sober Living Network
SMART	Specific, Measurable, Attainable, Realistic, and Time-bound
SMHS	Specialty Mental Health Services
SPA	Service Planning Area
SSG	Special Services of Groups
SSN	Social Security Number
STC	Special Terms and Conditions
STI	Sexually Transmitted Infection
SUBG or SUPTRS BG	Substance Use Prevention, Treatment, and Recovery Services Block Grant *(formerly known as Substance Abuse Prevention and Treatment Block Grant or SABG*)
SUD	Substance Use Disorder
SUD-TIPS	Substance Use Disorder Trauma-Informed Parent Support

SYTF	Secure Youth Treatment Facilities
TB	Tuberculosis
TBI	Traumatic Brain Injury
TDD	Telecommunications Device for the Deaf
TIP	Treatment Improvement Protocol
ToT	Training of Trainer
TTY	TeleType
TUD	Tobacco Use Disorder
UCC	Urgent Care Center
UCLA-ISAP	University of California, Los Angeles – Integrated Substance Abuse Programs
UCSF	University of California, San Francisco
UM	Utilization Management
VA	Veteran's Administration
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WIC	Welfare and Institutions Code (California)
WM	Withdrawal Management
WCRTS	Women and Children's Residential Treatment Services
WtW	Welfare to Work

Appendix C. 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	With the patient present and participating, • Actively helping patients apply for Medi-Cal. • Completing the CES Survey Packet, including the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) 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 their previous county of residence to LAC. • Linking patients to community resources such as food and clothing assistance.	• Time spent waiting with the patient to be seen by a provider (e.g., sitting with a patient in the ER waiting room). • 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 (v1.1, 2022).**
Coordination	With the patient present and participating, • Identifying a referral agency by using the Service & Bed Availability Tool (SBAT) **and** scheduling an appointment for a Level of Care (LOC) 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 Progress Notes, including information regarding recent primary care and specialist visits, ER visits, auxiliary treatment services (e.g., dialysis), and any community resources received.
Communication	With the patient present and participating, • Corresponding with justice system partners (ex. Courts, Probation, Jail, etc.) to provide progress report updates as necessary. • Time spent communicating with service providers, county workers, judges, etc., either in-person, by telephone, or by telehealth (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., DCFS, LAC-Probation).	• Entering data into Sage (pre-authorizations, authorizations, Progress Notes, etc.). • Time spent waiting on hold without the patient present to arrange the patient's connection to a resource (e.g. DPSS) • Attempting, but not successfully contacting service providers either by phone, email, telehealth, or in-person. **Providers should only bill for Care Coordination when they successfully communicate with other service providers on the patient's 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, Minor Consent Program, GR, Perinatal, Housing, etc.).	
		Transfer Medi-Cal benefits from the previous county of residence to LA 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 LOCs**	Facilitate necessary transitions in SUD LOCs (e.g., initiating referrals to the next LOC, 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, LAC-Probation, LA Superior Courts, Housing Providers, etc.) entities.	
Communication	**Other Health Providers**	Communicate in-person, by telephone or by audio-visual contact with physical health, community health clinics and providers, and mental health providers.	
	Service Partners	Communicate in-person, by telephone or by audio-visual contact with DPSS workers, DCFS social workers, DMH workers, LAC-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.	

Appendix D. ICD-10 Clinical Modification Codes Z55-Z65

Persons with Potential Health Hazards Related to Socioeconomic and Psychosocial Circumstances

Category	Code	Description
Problems related to education & literacy (8)	Z55.0	Illiteracy and low-level literacy
	Z55.1	Schooling unavailable and unattainable
	Z55.2	Failed school examinations
	Z55.3	Underachievement in school
	Z55.4	Educational maladjustment and discord with teachers and classmates
	Z55.5	Less than a high school diploma
	Z55.8	Other problems related to education and literacy
	Z55.9	Problems related to education and literacy, unspecified
Problems related to employment and unemployment (11)	Z56.0	Unemployment, unspecified
	Z56.1	Change of job
	Z56.2	Threat of job loss
	Z56.3	Stressful work schedule
	Z56.4	Discord with boss and workmates
	Z56.5	Uncongenial work environment
	Z56.6	Other physical and mental strain related to work
	Z56.81	Sexual harassment on the job
	Z56.82	Military deployment status
	Z56.89	Other problems related to employment
	Z56.9	Unspecified problems related to employment
Occupational exposure to risk factors (11)	Z57.0	Occupational exposure to noise
	Z57.1	Occupational exposure to radiation
	Z57.2	Occupational exposure to dust
	Z57.31	Occupational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
	Z57.4	Occupational exposure to toxic agents in agriculture
	Z57.5	Occupational exposure to toxic agents in other industries
	Z57.6	Occupational exposure to extreme temperature
	Z57.7	Occupational exposure to vibration
	Z57.8	Occupational exposure to other risk factors
	Z57.9	Occupational exposure to unspecified risk factor
Problems related to housing and economic	Z58.6	Inadequate drinking-water supply
	Z59.00	Homelessness unspecified

Category	Code	Description
circumstances (17)	Z59.01	Sheltered homelessness
	Z59.02	Unsheltered homelessness
	Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
	Z59.2	Discord with neighbors, lodgers and landlord
	Z59.3	Problems related to living in residential institution
	Z59.41	Food insecurity
	Z59.48	Other specified lack of adequate food
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.811	Housing instability, housed, with risk of homelessness
	Z59.812	Housing instability, housed, homelessness in past 12 months
	Z59.819	Housing instability, housed unspecified
	Z59.89	Other problems related to housing and economic circumstances
	Z59.9	Problem related to housing and economic circumstances, unspecified
Problems related to social environment (7)	Z60.0	Problems of adjustment to life transitions (life phase, retirement)
	Z60.2	Problems related to living alone
	Z60.3	Acculturation difficulty (migration, social transplantation)
	Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
	Z60.5	Target of (perceived) adverse discrimination and persecution
	Z60.8	Other problems related to social environment
	Z60.9	Problem related to social environment, unspecified
Problems related to upbringing (19)	Z62.0	Inadequate parental supervision and control
	Z62.1	Parental overprotection
	Z62.21	Child in welfare custody (non-parental family member, foster care)
	Z62.22	Institutional upbringing (orphanage or group home)
	Z62.29	Other upbringing away from parents
	Z62.3	Hostility towards and scapegoating of child
	Z62.6	Inappropriate (excessive) parental pressure
	Z62.810	Personal history of physical and sexual abuse in childhood
	Z62.811	Personal history of psychological abuse in childhood
	Z62.812	Personal history of neglect in childhood
	Z62.813	Personal history of forced labor or sexual exploitation in childhood
	Z62.819	Personal history of unspecified abuse in childhood
	Z62.820	Parent-biological child conflict

Category	Code	Description
	Z62.821	Parent-adopted child conflict
	Z62.822	Parent-foster child conflict
	Z62.890	Parent-child estrangement NEC
	Z62.891	Sibling rivalry
	Z62.898	Other specified problems related to upbringing
	Z62.9	Problem related to upbringing, unspecified
Other problems related to primary support group, including family circumstances (12)	Z63.0	Problems in relationship with spouse or partner
	Z63.1	Problems in relationship with in-laws
	Z63.31	Absence of family member due to military deployment
	Z63.32	Other absence of family member
	Z63.4	Disappearance/death of family member (assumed death, bereavement)
	Z63.5	Disruption of family by separation and divorce (marital estrangement)
	Z63.6	Dependent relative needing care at home
	Z63.71	Stress on family due to return of family from military deployment
	Z63.72	Alcoholism and drug addiction in family
	Z63.79	Other stressful events affecting family/household (ill/disturbed member)
	Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
	Z63.9	Problems related to primary support group, unspecified
Problems related to psychosocial circumstances (3)	Z64.0	Problems related to unwanted pregnancy
	Z64.1	Problems related to multiparity
	Z64.4	Discord with counselors
Problems related to other psychosocial circumstances (8)	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
	Z65.4	Victim of crime and terrorism
	Z65.5	Exposure to disaster, war and other hostilities
	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration

Appendix E. 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 SAPC. CENS are to refer all interested parties to SAPC 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:

3. 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.)

4. Unless otherwise directed by 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 and HIPAA.

5. 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.

6. Upon approval of the Request for CENS Co-Location Site form and a facility site walk-through by 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 SAPC audit.

7. Should SAPC or CENS determine that a site is no longer viable, notification must be submitted to the other party at least 30 calendar days in advance of the proposed vacancy date.

Appendix F. SUD Referral and Tracking Form

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
CLIENT ENGAGEMENT AND NAVIGATION SERVICES (CENS)

Confidential Client Information

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 ☐ ☐ 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:	☐ If yes, Medi-Cal: _____	☐ 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 (Only eligible for Youth and Young Adults)

➥**WAS AT RISK EDUCATION WORKSHOPS PROVIDED?**

☐ Yes ☐ No

SCREENED POSITIVE FOR OUTPATIENT TREATMENT	SCREENED POSITIVE FOR INPATIENT TREATMENT
☐ ASAM Level 0.5: Early Intervention Services only for the 0-18 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	☐ 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:

Appendix G: Program Incident Form

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
Substance Treatment and Re-entry Transition – Community (START-Community)

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

Appendix H. Reportable Incident Reporting Form

SUBSTANCE ABUSE PREVENTION AND CONTROL

Reportable Incident Reporting Form

A reportable event is any unanticipated event resulting in death or serious physical or psychological injury to a patient or patients.

PATIENT INFORMATION			
1. Name (Last, First, and Middle):		2. Date of Birth (mm/dd/yyyy):	3. Medi-Cal or MHLA Number:
4. Address:			5. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No
6. Gender:	7. Preferred Language	8. Race/Ethnicity	
PROVIDER AGENCY WHERE INCIDENT OCCURRED			
9. Provider Agency Name:		10. Contact Person:	11. Phone Number:
12. Address:			13. Email Address:
14. Date of Incident (mm/dd/yyyy):			15. Time of Incident:

16. Reportable Incident Type:

☐ Death – Medical Condition	☐ Patient Injured another Patient, Staff, or Visitor
☐ Death – Suspected Suicide	☐ Medication Error/Medication Event
☐ Death – Other	☐ Alleged Abuse by Staff
☐ Suicide Attempt	☐ Other
☐ Patient Injured Self (Not Suicide Attempt)	

DESCRIPTION OF THE INCIDENT
17. Please describe the nature of the incident. Include any important information about the incident, such as the date, person(s) involved, witnesses, etc. Attach any additional information, as necessary. 18. List any pre-disposing factor(s) or root cause(s) relevant to this incident:
RESPONSE AND FOLLOW UP ACTION
19. Please describe the staff response to the incident. Include a description of intervention(s) applied when dealing with the incident. Attach any additional information, as necessary. 20. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.

21. Reporting Staff Name:	22. Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to APPLICABLE Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2.

Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider.*

Comments:

Assigned Staff: Reviewed by: _____ Signature: _____ Date:

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: Reviewed by: _____ Signature: _____ Date:

Revised: 6/21/2017

Clinical Incident Form Instructions

PATIENT INFORMATION

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient date of birth.
3. Enter the patient Medi-Cal number. If the number is not known, leave the space blank.
4. Enter the patient address.
5. Enter the patient phone number. Check box to indicate if it is okay to leave a message at this phone number.
6. Enter the patient gender.
7. Enter the patient preferred language.
8. Enter the patient race/ethnicity

PROVIDER AGENCY WHERE INCIDENT OCCURRED

9. Enter the provider agency name.
10. Enter the name of the provider agency contact person.
11. Enter the contact person phone number.
12. Enter the provider agency address.
13. Enter the provider agency or the contact person email address.
14. Enter the date of incident.
15. Enter the time of incident.
16. Please describe the incident.
17. List any pre-disposing factor(s) or root cause(s) relevant to this incident.

INCIDENT RESPONSE AND FOLLOW UP ACTION

18. Please describe the staff response to the incident. Include description of intervention(s) applied to when dealing with the incident.
19. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.
20. Enter the name of the reporting staff.
21. Enter the date

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provide.

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

SUBMIT THE FORM TO:

Fax: (323) 725-2045 Phone: (626) 299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE

http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm

Revised: 6/21/2017

Appendix I. Juvenile Justice SUD Screening Referral Form (For CENS)

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
CLIENT ENGAGEMENT AND NAVIGATION SERVICES (CENS)

Los Padrinos Juvenile Hall
Juvenile Justice Substance Use Disorder (SUD) Screening Referral Form

Email form to: falesana@lacada.com

If referral is from outside Department of Probation (Probation), please include contact information of person submitting the referral for tracking purposes. Referral outcomes will only be disclosed if the client signs a Release of Information (ROI).

THIS SECTION TO BE COMPLETED BY REFERRAL SOURCE		
Referral Initiated by: ☐PROBATION ☐DMH ☐DHS ☐DYD ☐LACOE ☐COURT ☐Client/Self-Referral ☐Other: _____ **Name/Email:** _____		
Client Name: _____	**Client Date of Birth:** ____/____/____	**Client PDJ Number:** _____
Assigned DPO Name and Email: _____ **Assigned DMH Clinician and Email:** _____	**Client Housing Unit:** _____	**Client Date of Referral:** ____/____/____
Date Referral Form Submitted to Onsite DPH-SAPC CENS Counselor: ____/____/____	**Next Court Date** (if applicable): ____/____/____	**Release Date** (if applicable): ____/____/____

THIS SECTION TO BE COMPLETED BY ONSITE DPH-SAPC CENS COUNSELOR	
ROI Completed? ☐ Yes ☐ No **Client Completed Screening?** ☐ Yes ☐ No	**Date of Screening:** ____/____/____
In-custody SUD Screening Results and Services	
Based on the *American Society of Addiction Medicine (ASAM) Screener for Youth and Young Adults* (youth = age 17 and under and young adults = ages 18-20) or *ASAM CO-Triage Tool* (age 21 and over), the onsite DPH-SAPC CENS Counselor recommends the following service(s):	
SCREENED NEGATIVE ☐ No further SUD needs at this time	**SCREENED POSITIVE** ☐ Recommend Onsite Early Intervention Services Client Accepted? ☐ Yes ☐ No ☐ Recommend Referral to Community SUD Treatment Provider Client Accepted? ☐ Yes ☐ No
Onsite DPH-SAPC CENS Counselor/Screener (Name): _____ **Agency:** _____ **Phone No.:** _____ **Email:** _____ **Returned form to DPO (Name):** _____ **Date form returned to DPO: / /**	

Post-release/Community SUD Services Follow-up
Date of Initial Contact to SUD Treatment Agency: ____/____/____
Provisional Level of Care (*ASAM CO-Triage Tool* only): _____
Name of SUD Treatment Agency: _____
Address: _____
Contact Person: _____ Phone: _____ Email: _____
Appointment Date: ____/____/____ Time: _____
Client Referred to Other Support Services:
☐ Recovery Services ☐ Recovery Bridge Housing ☐ Other (Specify): _____
Attended post release appointment? ☐ Yes ☐ No

ADDITIONAL INFORMATION

PROBATION REFERRER

1) Positive Urinalysis (UA) Result	☐	Yes	☐	No	If yes, date(s):
2) Found with Substance(s) (Contraband)	☐	Yes	☐	No	If yes, date(s):
3) Substance Overdose	☐	Yes	☐	No	If yes, date(s):

Additional Notes/Comments:

NON-PROBATION REFERRER

Additional Notes/Comments:

DPH-SAPC CENS COUNSELOR

Additional Notes/Comments:

Revised: 5/30/2024

Appendix J. Juvenile Justice SUD Screening Referral Form (For SYTF)

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
EARLY INTERVENTION AND SUD TREATMENT SERVICES

Secure Youth Treatment Facilities (SYTF)
Juvenile Justice Substance Use Disorder (SUD) Screening Referral Form

Please email completed form as follows:
Camp Kilpatrick/Dorothy Kirby Center: LVTOutpatientReferral@phoenixhouseca.org
Barry J. Nidorf Juvenile Hall: vcardona@tarzanatc.org and dneal@tarzanatc.org

If referral is from outside Department of Probation (Probation), please include contact information of person submitting the referral for tracking purposes. Referral outcomes will only be disclosed if the client signs a Release of Information (ROI).

*THIS SECTION TO BE COMPLETED BY PROBATION CASE WORKER		
Referral on Behalf of: ☐PROBATION ☐DMH ☐DHS ☐DYD ☐LACOE ☐Client/Self-Referral ☐Other: _____ **Name/Email:** _____		
Client Name: _____	**Client Date of Birth:** ____/____/____	**Client PDJ Number:** _____
Location: Housing Module/Unit/Cottage ☐ **Barry J. Nidorf** _____ ☐ **Camp Kilpatrick** _____ ☐ **Dorothy Kirby Center** _____	**Assigned DPO Name and Email:** _____ **Assigned DMH Clinician Name and Email:** _____	**Client Date of Referral:** ____/____/____
Date Referral Form Submitted to Onsite DPH-SAPC SUD Service Counselor: ____/____/____	**Next Court Date** (if applicable): ____/____/____	**Release Date** (if applicable): ____/____/____

THIS SECTION TO BE COMPLETED BY ONSITE DPH-SAPC SUD SERVICE COUNSELOR	
ROI Completed? ☐ Yes ☐ No **Client Completed Screening?** ☐ Yes ☐ No	**Date of Screening:** ____/____/____

In-custody SUD Screening Results and Services

Based on the *American Society of Addiction Medicine (ASAM) Screener for Youth and Young Adults* (youth = age 17 and under and young adults = ages 18-20) or *ASAM CO-Triage Tool* (age 21 and over), the onsite DPH-SAPC SUD Service Counselor recommends the following service(s):

SCREENED NEGATIVE	SCREENED POSITIVE
☐ No further SUD-related needs at this time	☐ Recommend Onsite Early Intervention or SUD Treatment Services Client Accepted? ☐ Yes ☐ No ☐ Recommend Referral to Community SUD Treatment Provider Client Accepted? ☐ Yes ☐ No

Onsite DPH-SAPC SUD Service Counselor/Screener (Name): _____
Agency: _____
Phone No.: _____ **Email:** _____
Returned form to DPO (Name): _____ **Date form returned to DPO:** ____/____/____

Post-release/Community SUD Services Follow-up
Date of Initial Contact to Community SUD Service Agency: ____/____/____ Provisional Level of Care (*ASAM CO-Triage Tool* only): _____ Name of Community SUD Service Agency: _____ Address: _____ Contact Person: _____ Phone: _____ Email: _____ Appointment Date: ____/____/____ Time: _____
Client Referred to Other Support Services: ☐ Recovery Services ☐ Recovery Bridge Housing ☐ Other (Specify): _____
Attended post release appointment? ☐ Yes ☐ No

ADDITIONAL INFORMATION

PROBATION REFERRER

1) Positive Urinalysis (UA) Result	☐	Yes	☐	No	If yes, date(s):
2) Found with Substance(s) (Contraband)	☐	Yes	☐	No	If yes, date(s):
3) Substance Overdose	☐	Yes	☐	No	If yes, date(s):

Additional Notes/Comments:

DPH-SAPC CENS COUNSELOR

Additional Notes/Comments:

Revised: 5/30/2024