



Los Angeles County's Substance Use Disorder (SUD) System of Care Transformation

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Updates on California's DMC-ODS and Participating Counties

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Waiver 101

- The approval of the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS) by the federal Centers for Medicare and Medicaid Services (CMS) paves the way for statewide transformation of the administrative, business and clinical aspects of safety net SUD treatment.
- Counties will be able to set provider reimbursement rates and expand access to SUD treatment services for adolescents and adults who are Medi-Cal eligible.



Waiver 101

- Medicaid waivers provide for exemptions to federal regulation that permit states to implement managed care (under section 1915(b)) or demonstration projects (under section 1115).
- Demonstration waivers permit states to test and evaluate new approaches to systems operation, client care and/or financing.



Waiver 101

- The DMC-ODS is authorized as a demonstration waiver and DHCS is referring to the waiver overall as a pilot project.
- It is an amendment to the broader Medi-Cal 2020 health care services waiver.
- This waiver runs through 2020 and can be renewed at that time.



Waiver 101

- Under this waiver, Counties will be able to set provider reimbursement rates and increase access to SUD treatment services for adolescents and adults who are Medi-Cal eligible.
- In addition, Counties and providers will be subject to a new set of clinical, administrative and financing requirements based in federal regulation.



Phase I Update

- The Waiver is being implemented in phases:

Phase I – Bay Area

Phase II – Southern California

Phase III – Central Valley

Phase IV – Northern California

Phase V – Indian Tribes and Indian Health Service



Phase I Update

- At present 4 Counties have implementation plans submitted to DHCS
- Plans will be reviewed by DHCS and CMS
- Financial details are not yet clear; specifically
 - the Certified Public Expenditure (CPE) protocol
 - the State General Fund (SGF) contribution



Phase I Update

- Some information will be forthcoming shortly –
 - DHCS Fiscal Plan should be out in a couple of weeks
 - This will ask Counties for provider rates and documentation on how they were developed.
 - CPE Protocol approval is expected from CMS within a few weeks.
- However, the particulars on SGF funding may not be available until the Governor's Budget for Fiscal Year 16-17 is introduced in early January 2016.



DHCS Update

- Provider Enrollment Division (PED) staffed up to handle increased demand for certification.
 - <45% of outpatient providers are DMC certified
 - <1% of residential providers are DMC certified.
- 72 providers have ASAM levels assigned, with another 100+ in the pipeline.
- External Quality Review Organizations (EQRO) and Training and Technical Assistance contracts have been awarded.



EQRO Responsibilities

- EQRO responsibilities include:
 - Assessment of County DMC-ODS plans' access and health information system (HIS) capabilities.
 - Development and implementation of quality of care performance measures (PM).
 - Develop County DMC-ODS plans' performance improvement projects (PIP) guidelines.



More EQRO Responsibilities

- Include a diverse group of consumers and family members on the County review teams as part of the onsite review team
- Provide assurances that DMC-ODS quality requirements are being met.
- Examination of State and County consumer satisfaction surveys.



And Still More EQRO

- Examine Federal Data Integrity Requirements for Health Information Security (HIS), including:
 - Verifying the accuracy and timeliness of data reported to, and by County DMC-ODS plans;
 - Screening provider and County DMC-ODS data for completeness, logic, and consistency;
 - Collecting service information reported by providers and County DMC-ODS plans in standardized formats to the extent feasible and appropriate.



What will be happening around CA in 2016

- Selective Contracting Process
- Transition to DMC as primary funding for SUD treatment.
- Migration of SAPT funds to other purposes, e.g., recovery residences.
- Formation of regional provider networks
- Development/expansion of youth treatment services.
- Changes in business model related to DMC financing and utilization management.
- Change in clinical models relative to EBPs, MAT and greater integration with primary care and MH.



For More Information:



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Managing the SUD System Transformation and Key Priorities

John M. Connolly, Ph.D.

Deputy Director

Policy, Strategic Planning and Communications Branch

Substance Abuse Prevention and Control





SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT OF SUBSTANCE USE DISORDERS

This is the greatest opportunity in recent history to design, build and implement a substance use disorder (SUD) system of care that has the financial and clinical resources to more fully address the complex and varied needs of all our patients.

There will be challenges as the SUD network strives to develop the necessary clinical and business capacity, and new technology/infrastructure to implement this transformation.

SAPC is fully committed to engaging stakeholders throughout this process, and providing technical assistance and training.

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The SUD Organized Delivery System Waiver comes with significant opportunities to improve our system of care, but also comes with significant expectations of our providers.

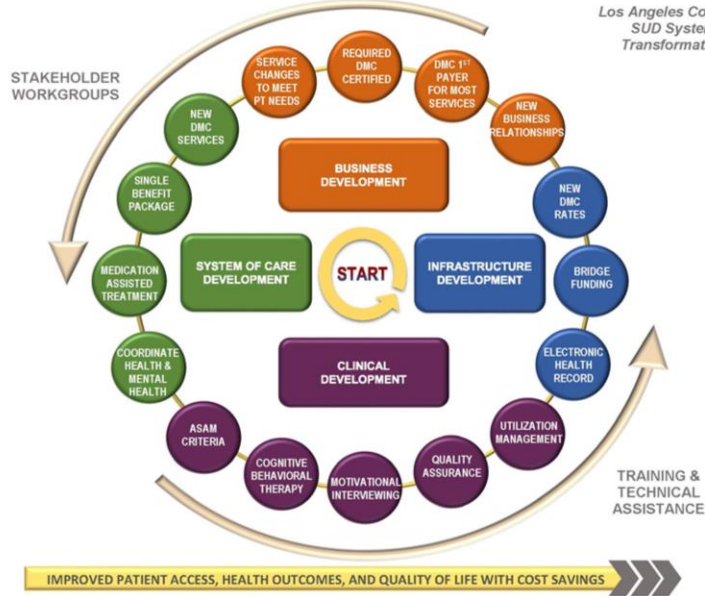
New opportunities to provide better care for our clients include: The provision of case management, care coordination both within the SUD system and with other systems such as health and mental health, recovery support services, physician consultation services for DMC physicians, and enhanced access to medication-assisted treatment.

The higher expectations of our providers include: Required use of evidence-based practices (EBP) such as Motivational Interviewing and Cognitive Behavioral Therapy, required use of the ASAM Criteria and DSM-5 diagnoses to determine medical necessity and the appropriate level of care, and enhanced documentation that is more detailed and frequent than previously provided.

The SUD Organized Delivery System Waiver is an unprecedented opportunity to truly transform and upgrade our system of care, and its success will depend heavily on SAPC and its providers to effectively work together to serve our patients.

SAPC is fully committed to do what it can to ensure providers have the tools in terms of training, finances, and support to accomplish the goals of the SUD Organized Delivery System Waiver, and will rely on its providers for their active participation in this process. SAPC will be holding various workgroups focused on several key aspects of the waiver in the coming months, and will rely on providers to attend and participate so they can help to shape and build our redesigned system of SUD care.

Los Angeles County's
SUD System
Transformation



Note: Not all key elements in the diagram will be expanded upon in this presentation.



KEY CHANGES: BUSINESS DEVELOPMENT

- **SERVICE CHANGES TO MEET PATIENT NEEDS:**
 - Patients will have more opportunities to decide which provider best meets their needs, and choose accordingly.
 - Services need to be patient-centered versus program-centered (e.g., no pre-defined number of sessions).
 - Agencies can expand field-based services, business hours, days of operation, and otherwise tailor the program to better match patient preferences.



KEY CHANGES: BUSINESS DEVELOPMENT

- **REQUIRED DMC CERTIFICATION*:**
 - By January 31, 2016, all current SAPC residential contractors should submit DMC applications.
 - By July 1, 2016, all current SAPC non-residential contractors must submit DMC applications (e.g., outpatient, intensive outpatient).
 - By July 1, 2017, any treatment agency that contracts with SAPC must be DMC-certified for contracted levels of care.
 - By July 1, 2017, all current and new contractors must have a Master Agreement with SAPC based on the current RFSQ and WOS requirements.

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DMC Application Submission: The January and July 2016 deadlines were selected based on anticipated processing times by DHCS and to better ensure that applications are DHCS approved by the July 2017 County deadline. Agencies are strongly encouraged, however, to submit their application(s) before these dates to maximize their ability to provide new services. In addition, Phase 3 Counties will soon be allowed to submit new applications which could impact processing time.

Certification Deadline: If a current provider is not DMC certified for contracted levels of care by July 2017, they will no longer be able to contract with SAPC to provide SUD treatment services. This also applies to agencies who are seeking new contracts to provide SUD services.

Master Agreement: In addition to DMC certification, all agencies seeking to obtain or maintain a contract with SAPC must be on the Master Agreement List, and qualify under the current Request for Service Qualifications (RFSQ) and appropriate Work Order Solicitations (WOS). More information on the RFSQ/WOS process will be distributed soon.

* Treatment services only (does not apply for prevention services)



KEY CHANGES: BUSINESS DEVELOPMENT

- **DMC 1ST PAYER FOR MOST CLIENTS AND SERVICES:**
 - If an individual is Medi-Cal eligible, they must receive DMC reimbursable services at a DMC provider.
 - This includes outpatient, intensive outpatient, residential, and withdrawal management (formerly detox), case management, and recovery support.
 - This will be required once the new State-County contract is signed (expected late Summer 2016).

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DMC will be the primary funding source for our entire system of care moving forward. As a result, the Organized Delivery System Waiver pertains to changes that will impact every single SUD provider within our network.



KEY CHANGES: BUSINESS DEVELOPMENT

- **NEW BUSINESS RELATIONSHIPS:**
 - Regional networks will become more important as the new system transformation takes place over the next three years.
 - Developing formal business relationships with other providers may be helpful for particularly small- and medium-sized agencies to cover cost of new infrastructure requirements (e.g., medical directors, quality assurance programs).



KEY CHANGES: SYSTEM OF CARE DEVELOPMENT

- **MEDICATION-ASSISTED TREATMENT (MAT):**
 - MAT needs to be explored as a treatment option for patients with alcohol and/or opioid addictions.
- **COORDINATE HEALTH AND MENTAL HEALTH SERVICES:**
 - Care coordination and case-management will include ensuring necessary collaboration and connections (e.g., attended appointments) with physical and mental health services.



KEY CHANGES: INFRASTRUCTURE DEVELOPMENT

- **DMC RATES**

- New fee-for-service DMC rates will be negotiated with DHCS for an anticipated 2-year period and then transition to an alternate reimbursement structure (e.g., performance-based, capitation).

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A key SAPC priority is to determine and secure rates that will support the enhanced expectations of the SUD Organized Delivery System Waiver. SAPC is able to negotiate with the State on the DMC rates that will be the primary funding source of SUD services in LA County. These higher DMC rates would help to enhance our workforce and services, and also help to encourage new providers to become DMC certified so that we can grow our provider capacity and improve access to SUD services, particularly in medical detox and residential settings. *See presentation by Patrick Gautier for more information on the methodology.*



KEY CHANGES: CLINICAL DEVELOPMENT

- **ASAM CRITERIA**

- The American Society of Addiction Medicine (ASAM) Criteria and medical necessity will determine initial and ongoing patient placement.

- **EVIDENCE-BASED PRACTICES**

- All clinical/counselors staff must be capable of effectively implementing and consistently using **MOTIVATIONAL INTERVIEWING** and **COGNITIVE BEHAVIORAL THERAPY**

- **QUALITY ASSURANCE and UTILIZATION MANAGEMENT**

- QA and UM will be a central component to ensuring effective care, including appropriate placements and transitions in levels of care.

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CLINICAL DEVELOPMENT: To ensure positive health outcomes for patients the waiver requires implementation of new clinical standards and management practices. This includes requires use of the ASAM Criteria to determine placement at the appropriate level of care based on medical necessity, use of two DHCS selected EBPs (in Los Angeles County this is Motivational Interviewing and Cognitive Behavioral Therapy), and implementation of Quality Assurance and Utilization Management programs. *See presentation by Gary Tsai for more information on the methodology.*



Contribute to
the new service
design and clinical
expectations



Staff development,
train-the-trainer,
and agency-specific
assistance

Essential to the success of this system transformation will be the stakeholder workgroups, and on-going clinical and business capacity building to support providers in this significant transformation.



Engaging Stakeholders in the Plan Development Process and throughout Implementation

Michelle Gibson, M.P.H.
Strategic Planning Chief
Substance Abuse Prevention and Control





PREVIOUS STAKEHOLDER OPPORTUNITIES

KICK-OFF MEETING **AUGUST 13, 2015**

SUBSTANCE ABUSE PREVENTION AND CONTROL ALHAMBRA

REGIONAL MEETINGS **AUGUST 19 – SEPTEMBER 9, 2015**

MLK COMMUNITY ENGAGEMENT CENTER	WILMINGTON
DEPARTMENT OF HEALTH SERVICES	COMMERCE
HIGH DESERT MEDICAL CENTER	LANCASTER
BEHAVIORAL HEALTH SERVICES	GARDENA
PHOENIX HOUSES OF LOS ANGELES	LAKEVIEW TERRACE
ARCADIA PARK	ARCADIA
BURTON CHASE PARK	MARINA DEL REY
EAGLE ROCK LIBRARY	LOS ANGELES (EAGLE ROCK)

ONLINE SURVEY



COUNTY PARTNERS AND HEALTH PLANS MEETING

- Department of Mental Health
- Department of Health Services
- Department of Public Health (DHSP and CMS)
- Department of Public and Social Services
- Department of Children and Family Services
- Countywide Criminal Justice Coordination Committee
- Public Defender's Office
- Probation Department
- LA CARE
- Health Net
- UCLA Integrated Substance Abuse Programs
- California Community Foundation



THEMES: BENEFICIARY ACCESS LINE



The majority of comments received were on three topics: beneficiary access line, benefit package and residential authorizations. Key issues raised are highlighted in these figures – the larger the font, the more frequently an issue was raised.



THEMES: BENEFIT PACKAGE

American Society Of Addiction Medicine (ASAM) Criteria **Cultural competence**
Sufficient availability of levels of care **Residential and methadone** Transportation
Telehealth
Assessment guidelines **Court ordered requirements**
What will duration of services be **Coordinate with mental health**
Define recovery support Does medical director need to be on-site
Drug Medi-cal certification process **Medication assisted therapy and residential**
Case-management Hours of operation **Homeless and medical necessity** Staff training
Must be patient-centered **Can services be provided in the field**
Define LPHA ICD-10/DSM-5 **Face-to-face assessment** **Funding**



THEMES: RESIDENTIAL SERVICES


What are eligibility requirements for authorization Who makes final determination

Prior authorization requirement is a challenge

Who is qualified to make assessments How was length of stay determined


Duration of services **SAPC hours of operation** Transportation

Provisional placement Is maximum length automatically authorized



FOR MORE DETAILED INFORMATION

Summary Factsheet



SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT OF SUBSTANCE USE DISORDERS
DEPARTMENT OF PUBLIC HEALTH, SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC)
AND THE DRUG MEDICAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

SUMMARY OF STAKEHOLDER FEEDBACK

THE STAKEHOLDER FEEDBACK PROCESS

The California Department of Health Services (CHS) Drug Med-Cat Organized Delivery System (DMC-ODS) review plan proposes to expand substance use disorder (SUD) treatment services nationwide under the Drug Med-Cat program using dissemination of medical necessity, the American Society of Addiction Medicine (ASAM) placement criteria, and quality assurance and utilization management processes to improve outcomes for Med-Cat beneficiaries while also reducing overall health care costs. This is potentially the most extensive transformation of the SUD system in California and Los Angeles County since the establishment of the Federal Substance Abuse Prevention and Treatment Block Grant in the 1980's.


We intend to apply and participate in the DMC-ODS plan, the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (SAPC) program invited stakeholders to provide feedback on the draft DMC-ODS review application. As a key component of the application process, SAPC sought input on its proposed implementation plan from service providers, clients, community members and/or other stakeholders.

The stakeholder process began with a kick-off meeting held on August 13th, 2015. There were 88 attendees at this meeting, the majority being SUD treatment providers funded by SAPC.

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- Department of Mental Health
- Department of Health Services
- Department of Public Health (Division of HIV & STD Programs and Children's Medical Services)
- Department of Children and Family Services
- Department of Public and Social Services
- Public Defender's Office
- Countywide Criminal Justice Coordination Committee
- Probation Department
- LA CARE
- Health Net
- UCLA Integrated Substance Abuse Programs
- California Community Foundation

Full Listing of Comments



SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT OF SUBSTANCE USE DISORDERS
DEPARTMENT OF PUBLIC HEALTH, SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC)
AND THE DRUG MEDICAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

NOTICE FROM THE STAKEHOLDER FEEDBACK PROCESS
AUGUST 11, 2015 (ORIGINAL DATE: SEPTEMBER 1, 2015)

The following are questions and recommendations received during the regional stakeholder meetings and via telephone or other means. SAPC intends to bring these stakeholder comments to the implementation process. These comments and questions will be addressed in the implementation plan. Questions received from the County of Los Angeles Department of Public Health and the Department of Health Care Services (DHCS) in coordination with the implementation plan and the implementation staff. For this reason, revisions to questions may change in the future.

As a reminder, until the County's DMC-ODS application is approved and the new contract between the state and county is executed, the current DMC-ODS will apply and the new benefits will not be implemented.

Questions from the Regional Stakeholder Meetings

1. **How will accommodations be offered for services? How will professional treatment services be provided?**
After the initial intake assessment and determination of professional level of care (SUD) services the individual and his or her family/caregivers will be notified of the next steps. The individual will be notified via phone or in person. The individual will be notified via phone or in person. The individual will be notified via phone or in person.
2. **What are the qualifications for staff who answer the access line?**
The access line will be staffed by trained staff members. The staff members will be trained to provide information and support to individuals who are seeking services.
3. **How will calls be managed during holidays, weekends and after office hours?**
The access line will be staffed by trained staff members. The staff members will be trained to provide information and support to individuals who are seeking services.
4. **Why does the accommodation made for patients who speak other languages or are hard of hearing?**
The access line will be staffed by trained staff members. The staff members will be trained to provide information and support to individuals who are seeking services.
5. **How do we access line will operate 24 hours a day and 7 days a week, what does mean that the services will need to be available those times as well?**
The access line will be staffed by trained staff members. The staff members will be trained to provide information and support to individuals who are seeking services.

Available At: <http://publichealth.lacounty.gov/sapc/HealthCare/HealthCareReform.htm>

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The *Summary of Stakeholder Feedback* document provides summary feedback from the in-person meetings and the online survey. It also includes tables on the degree to which survey participants felt a topic was adequately addressed in the implementation plan.

The *Comments and Questions from the Stakeholder Feedback Process* document provides full detail of public comments received from the in-person meetings and the online survey, and initial responses to questions received.

Both documents are posted on SAPC's website at the link provided on the slide.



Key Changes to the Proposed Implementation Plan

- The access line will initially be operated by the CASC until a final determination is made. Staff will at minimum be certified counselors. A youth and adult version of the triage tool is being developed to determine provisional level of care. Reminders and follow-up is required. An automated appointment system will be developed.
- Efforts will be made to expand use of medication-assisted treatment (MAT).

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There were four key modifications to the August 10, 2015 version of the implementation plan. The plan will be reviewed and approved by DHCS and CMS so not all information in the plan will be accepted and additional modifications may be required. Most clinical and operational issues will be further defined after submission of the implementation plan to DHCS and CMS in early 2015.



Key Changes to the Proposed Implementation Plan

- **Initial Authorization:** Residential providers willing to take the financial risk may admit patients pending County authorization determination, and may retroactively bill to date of admission if approved.
- **Continuing Authorization:** Residential cases will be reviewed by UM staff to monitor progress and ensure continued appropriateness of this level of care.

Providers are expected to monitor progress throughout the patients' stay to ensure a transition to a lower level of care when clinically indicated, even if prior to completion of the approved authorization period.



PLANNED ADVISORY WORKGROUPS

- **SYSTEM OF CARE**
 - Adolescent Considerations
 - Adult Considerations
- **INTEGRATION OF CARE**
- **QUALITY ASSURANCE AND UTILIZATION MANAGEMENT**
- **SYSTEM OPERATIONS**
 - Financing
 - Contracts
 - Information Technology
- **SYSTEM INNOVATIONS AND NETWORK CAPACITY BUILDING**

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The implementation plan reviewed by stakeholders in August/September is the outline for Los Angeles County's SUD system transformation, and was drafted to meet the terms and conditions of the waiver. The detail of these changes will be determined during the implementation phase (beginning January 2016), and include collaboration with stakeholders through the advisory workgroup process. SAPC will prioritize advisory workgroup topics based on what needs to be achieved upon approval of SAPC's plan and execution of the new State/County contract by the Board of Supervisors (expected late Summer 2016) and what can be phased in during year one through three. To prepare for these workgroups, SAPC will conduct background research (e.g., review efforts in other jurisdictions/departments and best practices), develop the proposed model/plan, and obtain stakeholders feedback.

1. **SYSTEM OF CARE** will address how new services will be designed and expected clinical practices. Depending on the topic, adolescent and adult considerations may be discussed separately or jointly. The goal, however, is to develop one system of care for all individuals served.
2. **INTEGRATION OF CARE** will address how to ensure that the physical and mental health needs of patients are coordinated and addressed, including collaboration with the health plans and related County departments.
3. **QA/UM** will address development of SAPC plan (currently reviewed via LACES Advisory Group), and expectations of SUD network agencies.
4. **SYSTEMS OPERATIONS** will address how new expectations developed in

collaboration with the System of Care, Integration of Care and QA/UM Advisory Workgroups will be operationalized. SAPC intends to have finance, contracts and IT staff attend other relevant workgroups regularly to provide guidance on what is feasible early in the development process. Therefore, this group may not meet as frequently or as early in this process.

5. SYSTEMS INNOVATIONS AND NETWORK CAPACITY BUILDING will take a more global look and what is needed to transform the SUD system to a specialty health plan model, and what efforts are needed to fully support developing the necessary business and clinical capacity of the SUD provider network.



WORKGROUP PROCESS

- **OUTREACH AND RECRUITMENT**

- Seeking experts and decision-makers on various topics
- Seeking representatives from small, medium, large agencies
- Seeking perspectives from physical and mental health, health plans
- Will outreach to help fill gaps (e.g., survey, form, calls)

- **EXPECTATIONS OF ADVISORY MEMBERS**

- All perspectives are important, so all contribute to discussion
- Thoroughly review documents in advance, and share comments
- Provide supplemental research/data where appropriate

To develop the best SUD network for our patients, we will need to develop appropriate operational and clinical practices. This requires considering feedback from all participating agencies and individuals equally. Therefore, SAPC will actively seek participation not only from experts on a particular topic (e.g., access line, telehealth) but also those from organizations with special expertise and of varying size. To achieve this, SAPC will develop a recruitment process (e.g., develop a survey to learn more about agency and individual expertise and willingness to participate on specific topics, nomination form to highlight expertise of one's self or another, phone calls based on SAPC staff knowledge of the provider network) to ensure a well-rounded and informed workgroup. Participation will also be open to any SUD provider with interest, expertise and decision-making ability.



FEEDBACK PROCESS AND DISTRIBUTION

- **WORKGROUP MEMBER PROCESS**
 - SAPC will develop background materials and the proposed plan for a topic (e.g., access line) and distribute to workgroup members.
 - Workgroup members will provide comments, and the document will be updated as needed.
- **NON-WORKGROUP MEMBER PROCESS**
 - You do not need to be a member of a workgroup to provide feedback or learn about what is being developed.
 - SAPC is developing an email listserv that will be used to distribute factsheets on key topics, updates on workgroup efforts and other relevant changes. This will also be posted on SAPC's website.

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The advisory workgroups will be highly interactive discussions to review proposed plans, discuss opportunities and challenges for implementation and make modifications to best meet the needs of patients and achieve the objectives of the waiver. We recognize that agencies want to be informed but may not be able to send representatives to all meetings. Therefore, we are developing a process to ensure all providers can stay informed on these changes and contribute where able. This will begin with developing an email listserv that will be open to all individuals, regardless of their position within an organization. We will also regularly post updates to our website, including details on workgroup efforts. An email will be sent shortly on how to join the listserv (the initial email will be sent to those who have attended any stakeholder workgroup or are on another SAPC email list).

We expect the System of Care workgroup to be the first to start first in January/February 2016 since many issues need to be decided in time for the launch of Los Angeles County's participation in the waiver (expected late Summer 2016).



The success of this transformation, and ultimately the success of our patients, will depend on our collective ability to design, build and implement this new SUD system of care.

SAPC looks forward to extensive and ongoing collaboration with the SUD provider network and other stakeholders to develop this enhanced system of care, and supporting capacity building and infrastructure development efforts of the agencies providing these services.



Key Clinical Elements, Estimated Utilization, and Capacity by Level of Care (ADULT)

Gary Tsai, M.D.
Medical Director and Science Officer
Substance Abuse Prevention and Control





Precision Addiction Medicine

- Overarching goal of an organized system of SUD care:
 - Right SERVICES
 - Right TIME
 - Right SETTING
 - Right DURATION



- Tailored treatment to individual need, as opposed to programmatic need

The new system of care will be driven by client preference, with the goal of providing the RIGHT SERVICE, at the RIGHT TIME, in the RIGHT SETTING, for the RIGHT DURATION. As much as possible and as clinically appropriate, services will be more patient-centered and less program-centered moving forward, meaning that the needs of the client rather than the needs of the program should drive care.



ASAM & DSM-5

- **ASAM (American Society of Addiction Medicine) Criteria**
 - Multidimensional assessment focused on: substance abuse and withdrawal, medical problems, MH problems, readiness to change, relapse potential, recovery/living environment
 - Organizes decision-making process of determining the most appropriate level of care
- **DSM-5 Criteria for SUDs → 11 diagnostic criteria**
 - Mild → 2 - 3 criteria
 - Moderate → 4 - 5 criteria
 - Severe → > 6 criteria

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The ASAM Criteria and DSM-5 will be the primary tool used to determine medical necessity and the appropriate level of SUD care moving forward.

While the ASAM Criteria will replace the Addiction Severity Index (ASI) as the primary SUD assessment tool in our system, there is significant overlap between the two and the ASAM Criteria should be familiar to most counselors and clinicians. All patients being treated in our system of care will need to have a DSM-5 diagnosis of at least one substance use disorder in order to establish medical necessity.



How to Determine Medical Necessity

DSM-5 diagnosis of a substance use disorder



Appropriate level of care as determined by the ASAM Criteria

= MEDICAL NECESSITY



Training

- **Priority 1 topics:**
 - ASAM Criteria / DSM-5 / Documentation
 - Motivational Interviewing
 - Cognitive Behavioral Therapy
- } Evidence-based practices
- **Priority 1.5 topics:**
 - Data Integrity
 - Cultural Competency
 - Co-Occurring Disorders, particularly Personality Disorders
 - Staff Burnout



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Upcoming trainings and other related resources are posted on SAPC's website:
<http://publichealth.lacounty.gov/sapc/Event/event.htm>

SAPC will continue to support providers with trainings, but providers will also need to ensure their staff are adequately trained and that knowledge gained from trainings is maintained through continued education and support.



Quality Assurance and Utilization Management (QA/UM) Program

- **Quality Assurance**

- Establish clinical standards of care, or expectations for quality SUD care
 - E.g., evidence-based practices (Motivational Interviewing, Cognitive Behavioral Therapy), use of the ASAM Criteria, case management, patient-centered care, etc.

- **Utilization Management**

- SAPC clinical staff will review cases to determine that clinical standards are being met
- Key focus → appropriate level of care placement & transitions between levels of care
 - ALL residential services will need to be authorized
 - Random review of a proportion of cases at all levels of care

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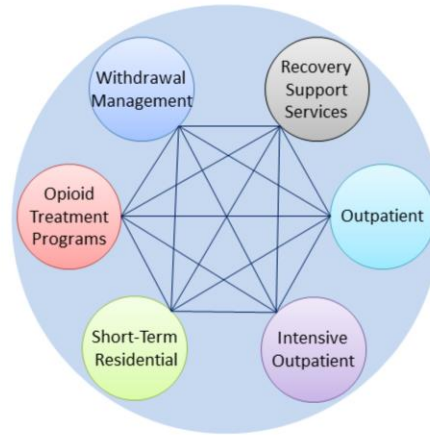
Ensuring that clients use a fuller continuum of care within our system and resource management will be key focuses of this system transformation and the waiver.

SAPC's Quality Assurance and Utilization Management team will be reviewing the care being provided by providers to ensure that it is consistent with recognized standards of practice, and will need to authorize all residential services. This will mean that some people will receive shorter lengths of stay in residential settings, but also that others will have more access to residential services if we can ensure an appropriate flow of clients through the various levels of care.



Continuum of Care

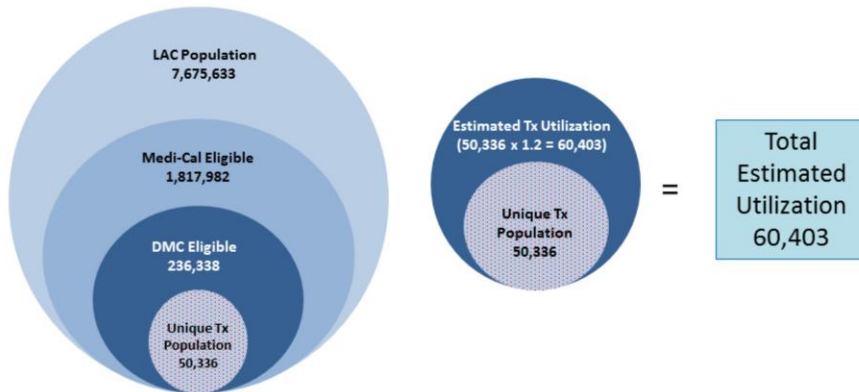
- Core elements of an effective SUD system of care
 - The use of the full continuum of care available to our patients
 - Fluid transitions between levels of care within that continuum



Done well, the end result will be services that are more tailored to individual need and more available to a greater number of people



DMC-ODS Utilization: **Low Estimation**

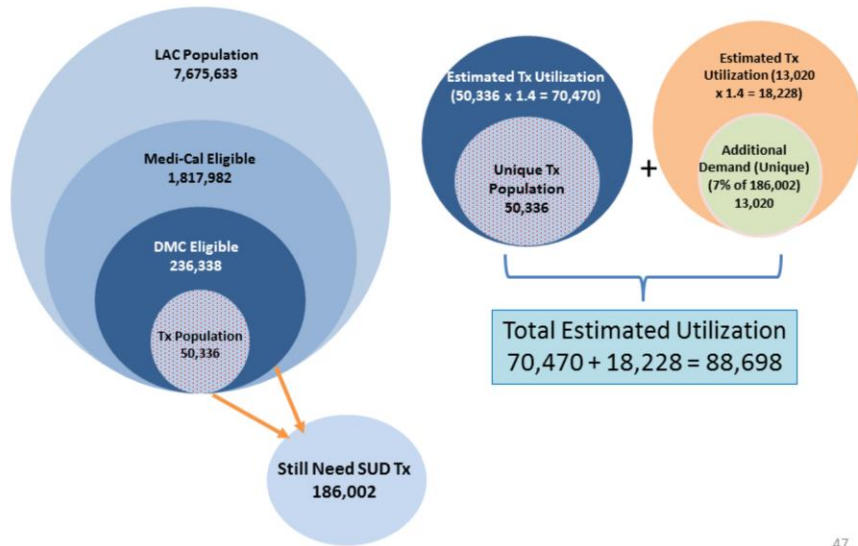


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Treatment population (50,336) = average unique clients within and across LOC (non-repeated clients) per year during last 10 years; Average treatment utilization was 1.2 times per person; $50,336 \times 1.2 = 60,403$ will be the estimated low utilization (this is essentially the status quo)



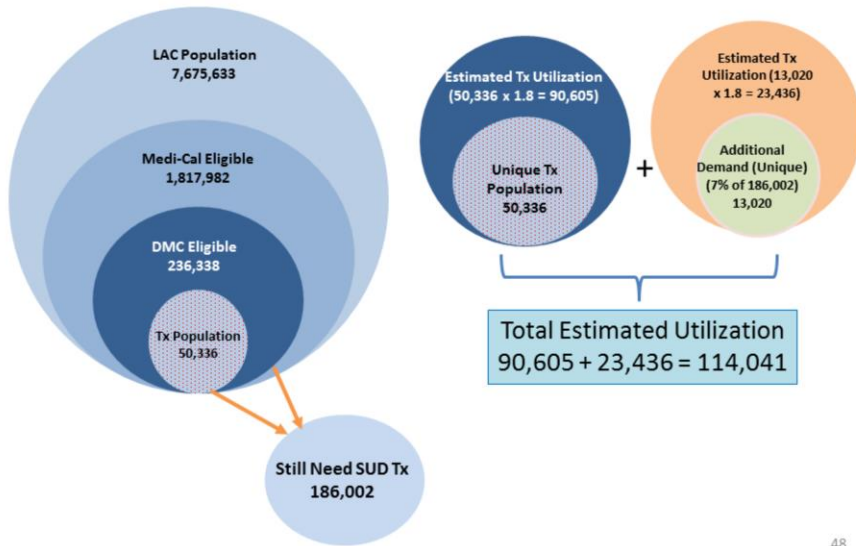
DMC-ODS Utilization: Medium Estimation



Treatment population (50,336) = average unique clients within and across LOC (non-repeated clients) per year during last 10 years;
Medium estimation: unique clients (50,336) x average estimated continuum of care utilization of 1.4 readmissions per client with use of some levels of the continuum (greater utilization of the continuum of care [residential detox, residential, and outpatient] than currently, but less so than the high estimate)



DMC-ODS Utilization: High Estimation

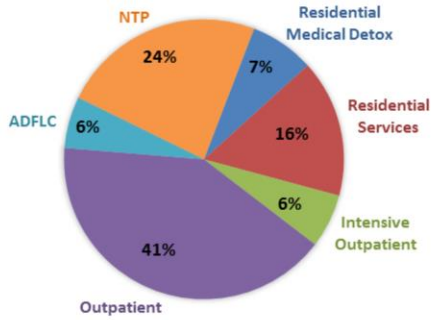


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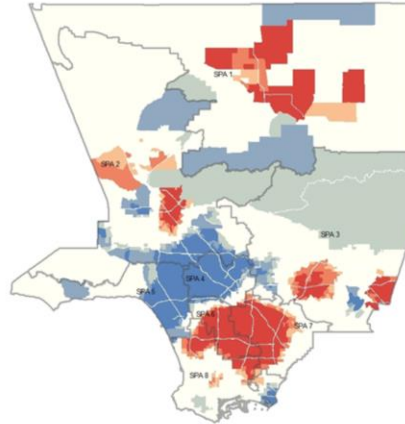
Treatment population (50,336) = average unique clients within and across LOC (non-repeated clients) per year during last 10 years;
Maximum estimation: unique clients (50,336) x average estimated continuum of care utilization of 1.8 readmissions per client (medical detox: 3 episodes, residential: 2 episodes, IOP: 2 episodes, OP: 1.5 episodes, and NTP: 1.8 episodes). This is a very optimistic/ideal estimation bc it is based on the assumption that most people will step down to the next level of care after completing the initial LOC, which would be a shift from the status quo.



Estimated LOC Utilization



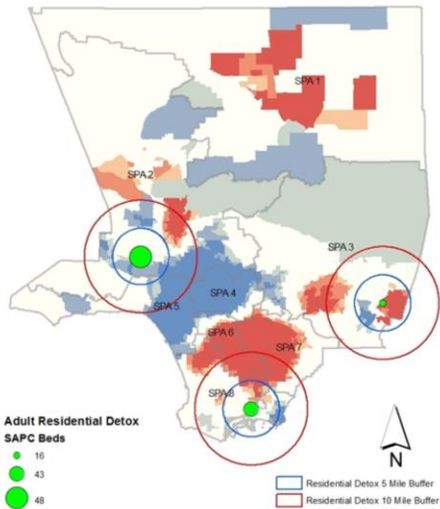
DMC Eligible Adult Hot Spots in LAC



Red areas indicate the highest concentration of DMC eligible people; Blue areas indicate the lowest concentration of DMC eligible people.

Applied this adjusted % breakdown to all three levels (low, medium, & high) of estimation.

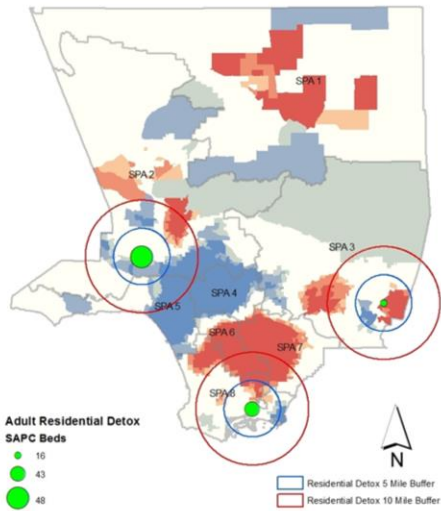
Low: Residential Medical Detox Bed Capacity



Residential Medical Detox Bed Utilization and Capacity	Number
Total estimated utilization	60,403
Estimated residential medical detox utilization	4,228 (7%)
Clients per bed per year	40*
Total beds needed	106
SAPC bed capacity	107
Additional beds needed	0
Unfunded beds	0
Additional beds needed after using unfunded beds	0
Number of Residential Medical Detox Facilities	3

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 7 days (70%), 14 days (30%); that concluded roughly 40 clients per slot per year

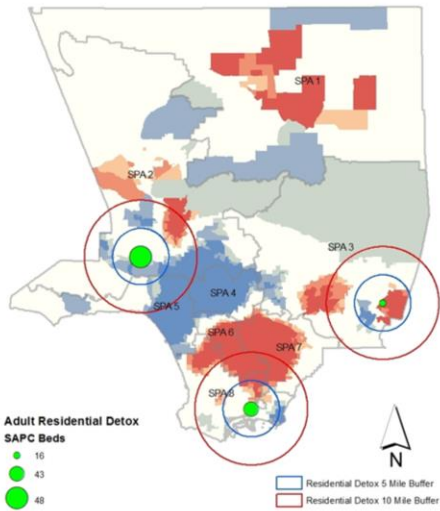
Medium: Residential Medical Detox Bed Capacity



Residential Medical Detox Bed Utilization and Capacity	Number
Total estimated utilization	88,698
Estimated residential medical detox utilization	6,209 (7%)
Clients per bed per year	40*
Total beds needed	155
SAPC bed capacity	107
Additional beds needed	48
Unfunded beds	0
Additional beds needed after using unfunded beds	48
Number of Residential Medical Detox Facilities	3

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 7 days (70%), 14 days (30%); that concluded roughly 40 clients per slot per year

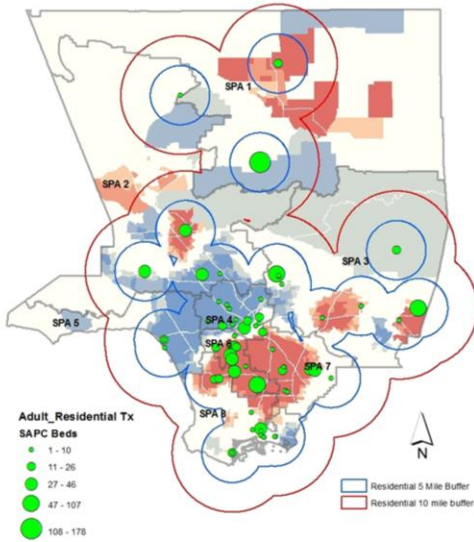
High: Residential Medical Detox Bed Capacity



Residential Medical Detox Bed Utilization and Capacity	Number
Total estimated utilization	114,041
Estimated residential medical detox utilization	7,983 (7%)
Clients per bed per year	40*
Total beds needed	200
SAPC bed capacity	107
Additional beds needed	93
Unfunded beds	0
Additional beds needed after using unfunded beds	93
Number of Residential Medical Detox Facilities	3

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 7 days (70%), 14 days (30%); that concluded roughly 40 clients per slot per year

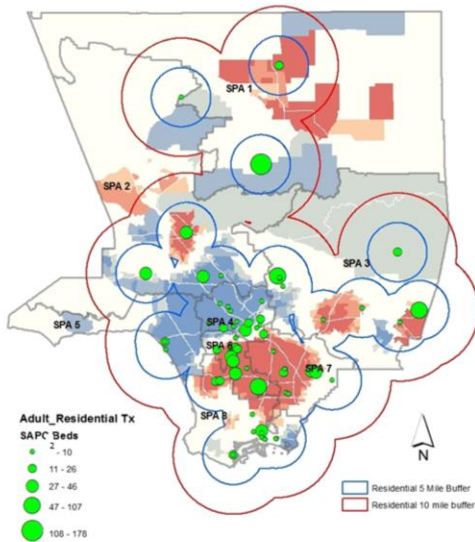
Low: Residential Bed Capacity



Residential Bed Utilization and Capacity	Number
Total estimated utilization	60,403
Estimated residential utilization	9,664 (16%)
Clients per bed per year	6*
Total beds needed	1,611
SAPC bed capacity	1,220
Additional Beds needed	391
Unfunded beds	697
Additional beds needed after using unfunded beds	0
Number of Residential Facilities	75

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 30days (30%), 60 days (40%), 90 days (20%), 120 days (10%) that concluded roughly 6 clients per slot per year (5.8)

Medium: Residential Bed Capacity

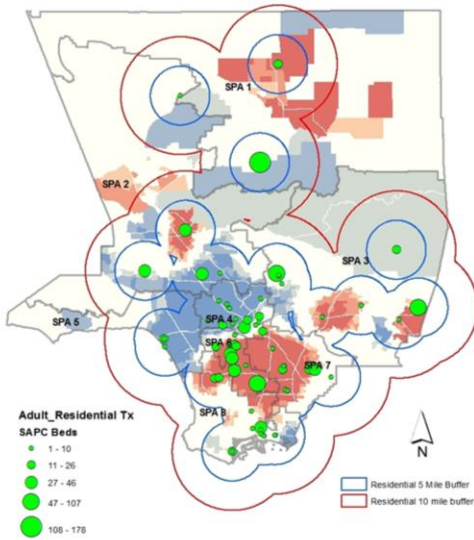


Residential Bed Utilization and Capacity	Number
Total estimated utilization	88,698
Estimated residential utilization	14,192 (16%)
Clients per bed per year	6*
Total beds needed	2,365
SAPC bed capacity	1,220
Additional Beds needed	1,145
Unfunded beds	697
Additional beds needed after using unfunded beds	448
Number of Residential Facilities	75

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 30days (30%), 60 days (40%), 90 days (20%), 120 days (10%) that concluded roughly 6 clients per slot per year (5.8)



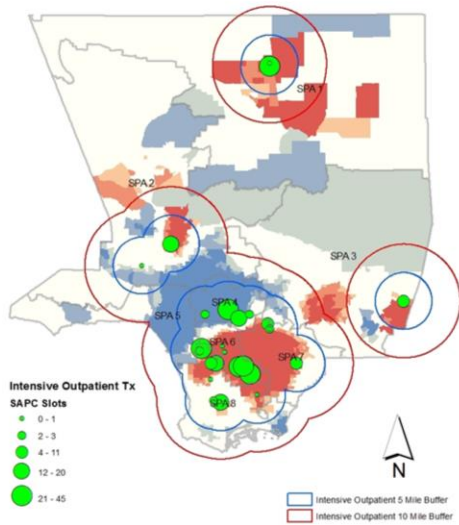
High: Residential Bed Capacity



Residential Bed Utilization and Capacity	Number
Total estimated utilization	114,041
Estimated residential utilization	18,247 (16%)
Clients per bed per year	6*
Total beds needed	3,041
SACP bed capacity	1,220
Additional Beds needed	1,821
Unfunded beds	697
Additional beds needed after using unfunded beds	1,124
Number of Residential Facilities	75

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 30days (30%), 60 days (40%), 90 days (20%), 120 days (10%) that concluded roughly 6 clients per slot per year (5.8)

Low: Intensive Outpatient (IOT) Slot Capacity

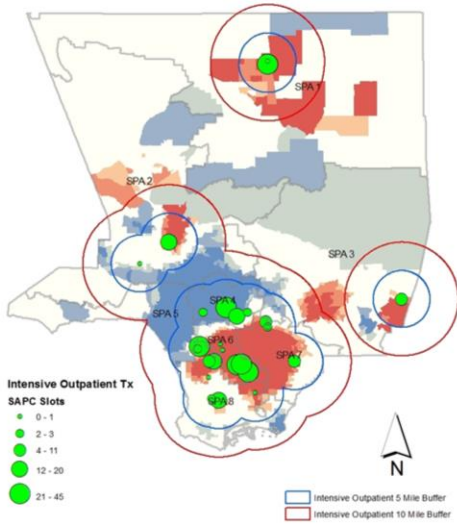


IOP Slot Utilization and Capacity	Number
Total estimated utilization	60,403
Estimated IOP utilization	3,624 (6%)
Clients per slot per year	5*
Total slots needed	725
SAPC slot capacity	375
Additional slots needed	350
Number of IOP Facilities	26

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay—60 days (55%), 100 days (20%), 130 days (25%), Days of services per week (up to 9-19 hours)—5 days (50%) 3 days (50%); roughly came out 5 clients per slot per year (5.3)



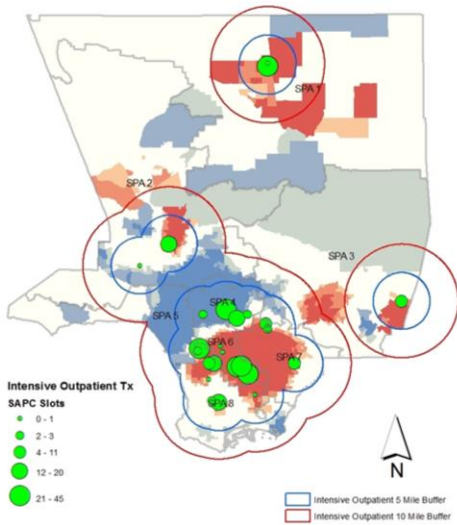
Medium: Intensive Outpatient (IOT) Slot Capacity



IOP Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Estimated IOP utilization	5,322 (6%)
Clients per slot per year	5*
Total slots needed	1064
SAPC slot capacity	375
Additional slots needed	689
Number of IOP Facilities	26

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay—60 days (55%), 100 days (20%), 130 days (25%), Days of services per week (up to 9-19 hours)—5 days (50%) 3 days (50%); roughly came out 5 clients per slot per year (5.3)

High: Intensive Outpatient (IOT) Slot Capacity

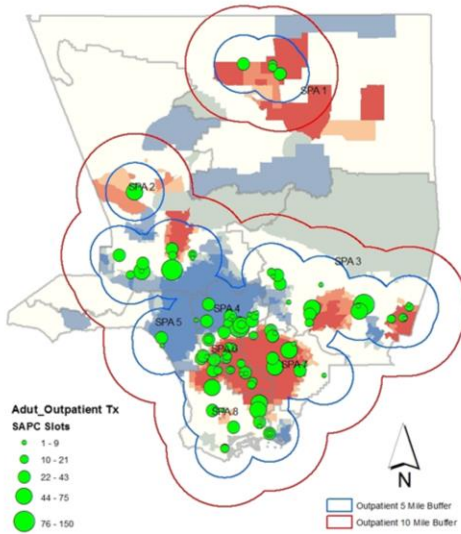


IOP Slot Utilization and Capacity	Number
Total estimated utilization	114,041
Estimated IOP utilization	6,842 (6%)
Clients per slot per year	5*
Total slots needed	1,368
SAPC slot capacity	375
Additional slots needed	993
Number of IOP Facilities	26

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay—60 days (55%), 100 days (20%), 130 days (25%); Days of services per week (up to 9-19 hours)—5 days (50%) 3 days (50%); roughly came out 5 clients per slot per year (5.3)



Low: Outpatient (OP) Slot Capacity

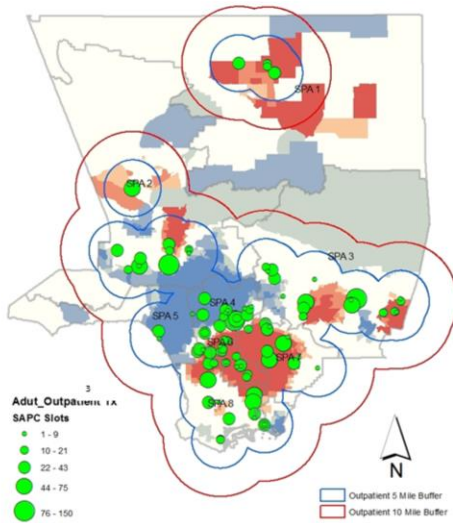


OP Slot Utilization and Capacity	Number
Total estimated utilization	60,403
Estimated OP utilization	24,765 (41%)
Clients per slot per year	7*
Total slots needed	3,538
SAPC slot capacity	2,402
Additional slots needed	1,136
Number of OP Facilities	98

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay of 60days (60%), 90 days (15%), 120 days (25%); Days of services per week (up to 9 hours)—5 days (30%), 3 days (50%), 1 day (20%); roughly came out 7 clients per slot per year (7.2)



Medium: Outpatient (OP) Slot Capacity

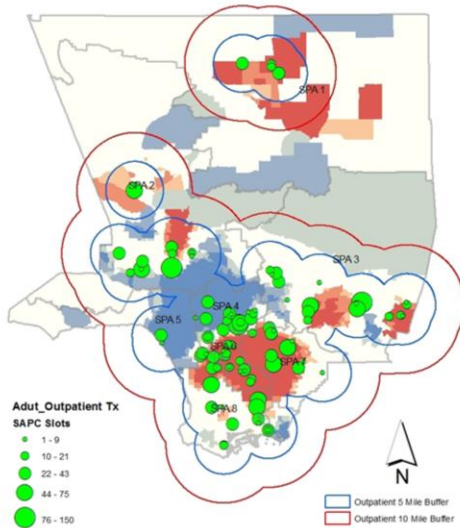


OP Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Estimated OP utilization	36,366 (41%)
Clients per slot per year	7*
Total slots needed	5,195
SAPC slot capacity	2,402
Additional slots needed	2,793
Number of OP Facilities	98

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay of 60 days (60%), 90 days (15%), 120 days (25%); Days of services per week (up to 9 hours)—5 days (30%), 3 days (50%), 1 day (20%); roughly came out 7 clients per slot per year (7.2)



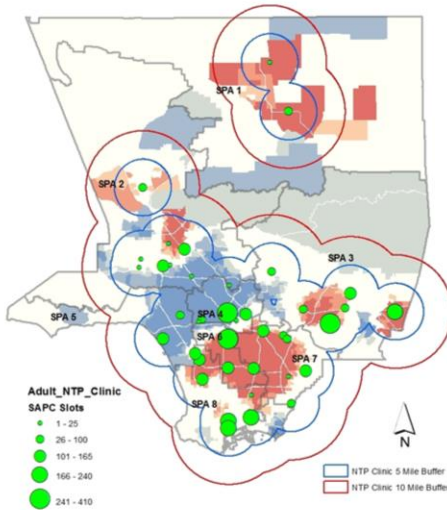
High: Outpatient (OP) Slot Capacity



OP Slot Utilization and Capacity	Number
Total estimated utilization	114,041
Estimated OP utilization	46,757 (41%)
Clients per slot per year	7*
Total slots needed	6,680
SAPC slot capacity	2,402
Additional slots needed	4,278
Number of OP Facilities	98

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay of 60days (60%), 90 days (15%), 120 days (25%); Days of services per week (up to 9 hours)—5 days (30%), 3 days (50%), 1 day (20%); roughly came out 7 clients per slot per year (7.2)

Low: Opioid Treatment Program (OTP) Slot Capacity

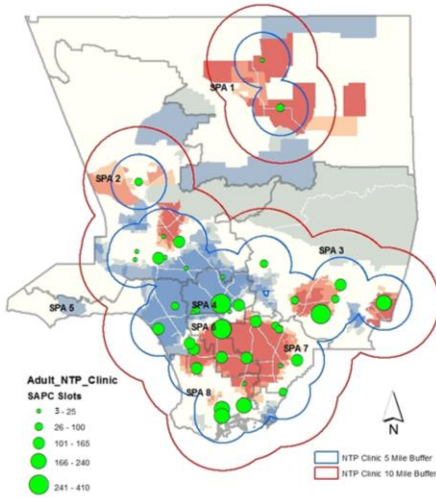


NTP Slot Utilization and Capacity	Number
Total estimated utilization	60,403
Estimated NTP utilization	14,497 (24%)
Clients per slot per year	3*
Total slots needed	4,832
SAPC slot capacity	5,373
Additional slots needed	0
No of NTP Clinics	39

* Clients per slot per year was estimated based on the current length of stay utilization pattern: 90days (30%), 120 days (20%), 150 days (30%), 180 days (20%) that concluded roughly 3 clients per slot per year



Medium: Opioid Treatment Program (OTP) Slot Capacity

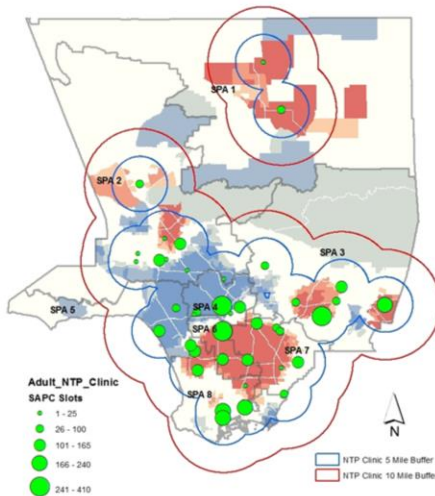


NTP Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Estimated NTP utilization	21,288 (24%)
Clients per slot per year	3*
Total slots needed	7,096
SAPC slot capacity	5,373
Additional slots needed	1,723
No of NTP Clinics	39

* Clients per slot per year was estimated based on the current length of stay utilization pattern: 90days (30%), 120 days (20%), 150 days (30%), 180 days (20%) that concluded roughly 3 clients per slot per year



High: Opioid Treatment Program (OTP) Slot Capacity



NTP Slot Utilization and Capacity	Number
Total estimated utilization	114,041
Estimated NTP utilization	27,370 (24%)
Clients per slot per year	3*
Total slots needed	9,123
SAPC slot capacity	5,373
Additional slots needed	3,750
No of NTP Clinics	39

* Clients per slot per year was estimated based on the current length of stay utilization pattern: 90days (30%), 120 days (20%), 150 days (30%), 180 days (20%) that concluded roughly 3 clients per slot per year

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Overall, SAPC anticipates more people coming into our system of care as a result of numerous influences, and this will require us to expand our network capacity in order to accommodate these increased numbers while ensuring access to necessary SUD services.

- Improved SUD services that are more client-centered
- Streamlined access to services
- Greater outreach and messaging to the general public
- Greater recognition of the importance of addressing SUD in the health and mental health community, which should result in more referrals
- Treatment of SUD in the criminal justice setting, which should result in community referrals once they are released



Financing the DMC-ODS and Reimbursement

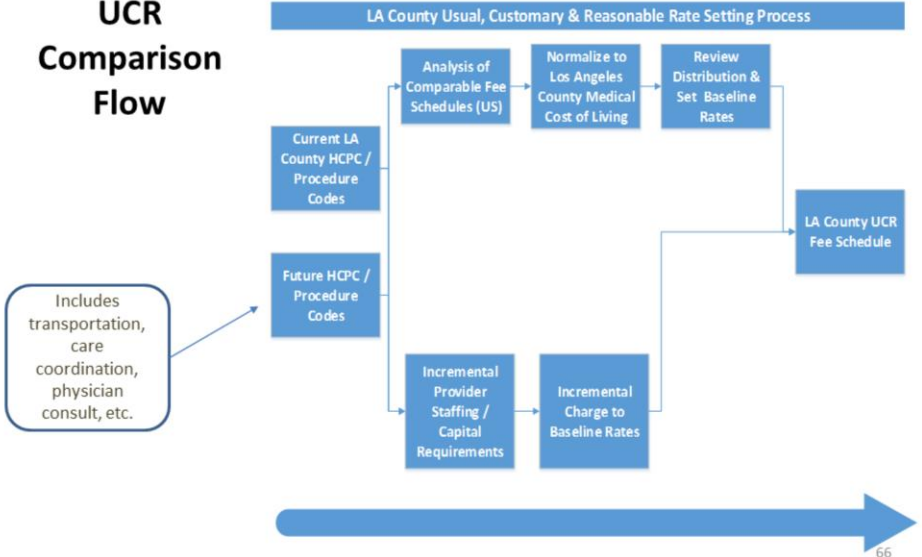
Patrick Gauthier

Director

Advocates for Human Potential (AHP) Healthcare Solutions



UCR Comparison Flow





UCR Comparison Chart

Usual, Customary & Reasonable Rate Setting Process Example		99204	H0004	H0005	H0015
HCPC / Procedure Code					
SAPC Rate	100				
CA Medi-Cal Rate	100				
Minnesota Rate	96				
Maryland Rate	81				
Kentucky Rate	86				
OR Rate	98				
SC Rate	94				
Average					

- Rate Comparison Example



UCR Comparison Chart

- Rate Comparison Example
- Maryland Rate for H0004 is \$20
- LA cost of living adjustment moves Maryland rate to \$24.69
- Analytic support to raise SAPC rate to \$23 - \$24

Usual, Customary & Reasonable Rate Setting Process Example					
HCPC / Procedure Code		99204	H0004	H0005	H0015
SAPC Rate	100	174.33	19.00	4.75	83.39
CA Medi-Cal Rate	100	68.90			
Minesota Rate	96			30.75	
Maryland Rate	81	200.16	24.69	16.05	154.32
Kentucky Rate	86			15.70	67.74
OR Rate	98	111.00	24.35	35.85	80.94
SC Rate	94	116.89	21.07		139.96
Average		124.24	23.37	24.59	110.74



Considering Shared Services and Administrative Functions in the new Organized Delivery System



Questions and Answers

Moderator: Victor Kogler

Participants: Wayne Sugita

Gary Tsai

John Connolly

Raymond Low





Opportunities, Challenges and Next Steps in the SUD System Transformation

Wayne K. Sugita, M.P.A.

Interim Director

Substance Abuse Prevention and Control





RELEVANT LINKS AND RESOURCES

DHCS DMC General Information

<http://www.dhcs.ca.gov/services/adp/Pages/default.aspx>

DHCS DMC Certification Documents

<http://www.dhcs.ca.gov/provgovpart/Pages/DMC-Forms.aspx>

DHCS DMC Residential Certification Documents

<http://www.dhcs.ca.gov/provgovpart/Pages/FacilityLicensing.aspx>

SAPC SUD Master Agreement RFSQ (#2012-004)

<http://publichealth.lacounty.gov/cg/index.htm>

SAPC Clinical Trainings

<http://publichealth.lacounty.gov/sapc/Event/event.htm>

SAPC SUD System Transformation/Waiver Documents

<http://publichealth.lacounty.gov/sapc/HeathCare/HealthCareReform.htm>