"Working Together for a Healthier Tomorrow"

Drug Medi-Cal Organized Delivery System Implementation Plan

Prepared by:

Orange County Health Care Agency

Behavioral Health Services

Mission

"To prevent substance use and mental health disorders; when signs are present, to intervene early and appropriately; and when assessments indicate that treatment is required, to provide the right type of treatment, at the right place, by the right person/program to help individuals to achieve and maintain the highest quality of health and wellness."

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Drug Medi-Cal Organized Delivery System
(DMC-ODS) County Implementation Plan

PART I
PLAN QUESTIONS

This part is a series of questions that summarize the county's DMC-ODS plan.

1. Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.

   ☑ County Behavioral Health Agency
   ☑ County Substance Use Disorder Agency
   ☑ Providers of drug/alcohol treatment services in the community
   ☑ Representatives of drug/alcohol treatment associations in the community
   ☑ Physical Health Care Providers
   ☑ Medi-Cal Managed Care Plans
   ☐ Federally Qualified Health Centers (FQHCs)
   ☑ Clients/Client Advocate Groups
   ☑ County Executive Office
   ☑ County Public Health
   ☑ County Social Services
   ☑ Foster Care Agencies
   ☑ Law Enforcement
   ☑ Court
   ☑ Probation Department
   ☑ Education
   ☑ Recovery support service providers (including recovery residences)
   ☑ Health Information technology stakeholders
   ☑ Other (specify) FQHC approval pending

2. How was community input collected?

   ☑ Community meetings
   ☑ County advisory groups
   ☑ Focus groups
   ☑ Other methods(s) (explain briefly) individual stakeholder discussions

3. Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.

☑ Monthly
☐ Bi-Monthly
☑ Quarterly
☐ Other

***Review Note*: One box must be checked**

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4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?

☑ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.

☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.

☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.

☐ There were no regular meetings previously, but they will occur during implementation.

☐ There were no regular meetings previously, and none are anticipated.

5. What services will be available to DMC-ODS clients upon year one implementation under the county plan?

REQUIRED

☑ Withdrawal Management (minimum one level)
☑ Residential Services (minimum one level)
☑ Intensive Outpatient
☑ Outpatient
☑ Opioid (Narcotic) Treatment Programs
☑ Recovery Services
☑ Case Management
☑ Physician Consultation

How will these required services be provided?

☐ All County Operated
☑ Some County and some contracted
☐ All contracted

OPTIONAL

☑ Additional Medication Assisted Treatment
☐ Partial Hospitalization
☑ Recovery Residences
☐ Other (specify)_____

6. Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?

☑ Yes (required)
☐ No. Plan to establish by _____

***Review Note**: If the county is establishing a number, please note the date it will be established and operational.*

7. The county will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.

   ☑ Yes (required)
   ☐ No

8. The county will comply with all quarterly reporting requirements as contained in the STC.

   ☑ Yes (required)
   ☐ No

9. Each county's Quality Improvement will review the following data at a minimum on a quarterly basis external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into EQRO protocol:

   - Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after assessment
   - Existence of a 24/7 telephone access line with prevalent non-English language(s)
   - Access to DMC-ODS services with translation services in the prevalent non-English language(s)
   - Number, percentage of denied and time period of authorization requests approved or denied

   ☑ Yes (required)
   ☐ No

Part II Draft Plan Narrative

1. Collaborative Process. ***Describe the collaborative process used to plan DMC-ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.***

Review Note: Stakeholder engagement is required in development of the implementation plan.

In Orange County, collaborative relationships among county entities and community partners support an effective service delivery system to improve the health and quality of life for individuals, families, and communities. The Health Care Agency, Behavioral Health Services (HCA BHS) provides mental health (MH) and substance use disorder (SUD) services to those also served in other systems. In developing the Drug Medi-Cal Organized Delivery System (DMC-ODS) implementation plan, HCA BHS employed a collaborative process with its partner agencies, providers, beneficiaries, family and community members in the various systems of care.

HCA BHS established an internal Coordinating Committee to oversee the plan development. The committee includes the HCA BHS Director; the Director of Adult and Older Adult BHS; the Director of Children, Youth, and Prevention BHS; the Director of HCA BHS Authority and Quality Improvement; HCA Program Support Manager; Auditor Controller representative; Adult and Children HCA BHS Division Managers; HCA Contract Services Division Manager; HCA BHS IT Manager and supporting staff. Three subcommittees support the Coordinating Committee: Program, Fiscal and Administration and Operations. Subcommittees meet weekly to focus on their respective areas of the implementation plan. They address issues, develop methods to accomplish goals and work to resolve any barriers expressed in feedback from the HCA BHS DMC stakeholders. The subcommittees make recommendations to the Coordinating Committee regarding planning and implementation issues.

HCA BHS sought input from a broad spectrum of stakeholders to gather perspectives representative of Orange County's diverse population. Participation by interested stakeholders was achieved through various methods of community outreach including written materials, surveys, ongoing collaborative meetings, public forums, provider meetings, focus groups and presentations. At every opportunity, HCA BHS provided information regarding the DMC-ODS, and requested feedback on the current system of care, service gaps and recommendations for improving and/or expanding the SUD services delivery system.

- The DMC-ODS implementation planning process was presented to the community via:
    - A written informational notice from the HCA BHS Director to all Orange County partner agencies and related boards and commissions, as well as to behavioral health providers, community groups and the Managed Care Plan, CalOptima.
    - A website created to provide DMC-ODS information and receive feedback at ochealthinfo.com/bhs/mhi/dmcods
    - A phone survey conducted with the 360+ DHCS certified/licensed SUD programs/facilities in Orange County, to assess knowledge of DMC, educate them on the DMC-ODS, and to encourage participation.

- All contracted providers were surveyed to assess current capabilities and needs and quarterly provider meetings have been valuable avenues for direct feedback and approaches to resolving barriers to implementation. This has also been accomplished in monthly Alcohol and Drug Advisory Board (ADAB) meetings, monthly individual contract provider meetings and in HCA BHS staff meetings. Regular and ongoing collaborative meetings with County partners were used to provide information about DMC-ODS and gather input for effective implementation.

- Public forums were held in each of the five (5) Orange County supervisorial districts to enable interested stakeholders from all regions of the county to participate in the planning process. Community participation was also accomplished through conference presentations, participant focus groups, and conversations with interested stakeholders. The following list is representative of those from whom HCA BHS solicited and will continue to solicit input.

  - SUD Providers
  - SUD Beneficiaries
  - MH Providers
  - Alcohol and Drug Advisory Board
  - Social Services Agency
  - Probation
  - Sober Living Coalition
  - Families and Communities Together
  - Collaborative Courts Oversight Committee
  - Managed Care Plan (CalOptima)
  - Bright Futures
  - Orange County Department of Education
  - Solace Group
  - Mental Health Services Act Steering Committee
  - Children and Family Futures
  - Jamboree Housing/Homeless
  - Acute Care Hospitals (UCI, St Joseph's)
  - SUD Clinicians/Contract Monitors
  - HCA BHS Service Chiefs
  - Family Members
  - Orange County Reentry Program Committee
  - HCA BHS Community Quality Improvement Committee
  - Social Services Welfare Improvement Committee

The primary concerns discussed with stakeholders included: **timely access** to local treatment, **network capacity**-particularly residential treatment programs, **criminal justice** involvement, expanded **treatment for youth**, **co-occurring services** for those with mental health issues, allowable **lengths of stay**, **medication assisted therapies**, **housing, transportation, monitoring** and **reporting requirements**. These issues are addressed in the implementation plan.

During the DMC-ODS implementation the Coordinating Committee membership will be expanded to include provider representatives, County partner agencies, and a QI committee member. The subcommittees will continue to meet at least monthly until the plan is fully implemented and they will report to the Coordinating Committee for direction.

HCA BHS will continue to collaborate with all interested stakeholders as implementation progresses. The DMC-ODS implementation will be an agenda item of the monthly Alcohol and Drug Advisory Board (ADAB) meeting, the CalOptima (MCP) collaborative meeting and the quarterly provider meeting. Updates will be provided at least quarterly at the established collaborative meetings with County agencies and committees. The contract monitoring and quality improvement processes will be used to evaluate the access to and the quality of services provided. The website will also be maintained and updated to provide information to the public.

2. ***Participant FLOW: Describe how participants move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, the professional qualifications of individuals who will conduct ASAM criteria interviews and assessments, how admissions to the recommended level of care will take place, how often participants will be re-assessed and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care and who is providing the case management services. Also describe if there will be timelines established for the movement between one level of care to another. Please describe how you plan to ensure successful care transitions for high-utilizers or individuals at risk of unsuccessful transitions.***

Review Note: A flow chart may be included.

Initial Screening and Referral:

Multiple portals of entry into treatment are available to ensure a beneficiary's timely access to care. The goal is to engage the beneficiary in the treatment process as quickly as possible, to reduce no-shows and improve treatment outcomes. The beneficiary's initial introduction to services may be through various sources, including the 24-hour access line, the medical community, the Managed Care Plan-Cal Optima (MCP), the County operated BHS navigation system, other community partners, or by the beneficiary's direct contact with a provider. An initial screening or Screening brief intervention and referral to treatment (SBIRT) is completed and includes:

1) a preliminary determination of needed services including substance use disorder (SUD), mental health and physical health care services and
2) whether there is an urgent or emergent need for treatment.

Screening resources include:

- The 24-hour access line: A contracted Administrative Services Organization (ASO) provides a 24 hour Access Line, screens for behavioral health disorders and verifies Medi-Cal eligibility. The request is logged as either routine, urgent or emergent. If the screening indicates the need for

SUD services, the caller will be referred to an HCA BHS outpatient clinic for a face to face assessment to determine level of care placement and referral to services.

- Cal Optima: The Orange County MCP is responsible for screening all of its members for mental health and substance use services, providing a 24-hour phone line and referring to HCA BHS for SUD services, if appropriate, based on the screening. SBIRT is conducted by the network primary care provider (PCP) at the medical home, if the Staying Healthy assessment or physical health issues indicate a substance use problem.
- OC Links: An HCA BHS operated information and referral phone and online chat service is available Monday through Friday 8 a.m. to 6 p.m. Licensed clinicians help the public navigate the BHS system, providing brief screening for level of impairment, history of mental health and substance use disorders, suicidality, etc. Based upon the screening, the clinician provides information and warm hand-offs or referrals to treatment providers. Between October 2013 and October 2015, staff provided 12,884 referrals/warm hand offs for SUD information, prevention and treatment. These comprised 59% of all requests for behavioral health services.
- Partner Agencies, Community Providers and Systems: Referral processes are in place with Social Services Agency, the Collaborative Courts, community health care clinics, Probation and the Sheriff's Department to serve special populations. These partners refer to HCA BHS for on-site screening by imbedded HCA BHS staff at the Courts, Probation and community health clinics, as well as to HCA BHS operated clinics. Community Program staff in the jails refer inmates for residential screening while in-custody. Partner organizations also directly refer to County operated clinics and contract programs.
- Direct phone contact or walk in: Beneficiaries may directly contact any County or contracted outpatient, residential detoxification (detox), Narcotic Treatment Program (NTP) or residential program for initial screening. There are four (4) County operated adult outpatient access sites, with staff trained in SBIRT available to perform screening for walk-ins as well as screening by appointment. The screening and referral for inpatient detox (ASAM 3.7) is done by HCA BHS at a centralized location. Initial screening for youth is done at seven (7) County sites.

Assessment and Placement:

When the initial screening/SBIRT indicates a beneficiary is appropriate for, and is referred to, SUD services, a complete psychosocial assessment will be completed. Admission to a program will occur only if determined appropriate by the diagnosis of an SUD, as defined in the current DSM (excluding tobacco use and non-substance related disorders), and by an assessment using all six (6) dimensions of the ASAM criteria conducted, or reviewed and approved in a face-to-face interaction by a trained Licensed Practitioner of the Healing Arts (LPHA), the Medical Director (MD), or a physician. In addition to the ASAM assessment, placement will take into account the geographic, language and cultural needs of the individual, his/her preferences and motivation to engage in a type and level of treatment. Placement may be in the same program that conducted the initial screening. Admission to a residential treatment program also requires prior authorization by a HCA BHS Residential Placement Coordinator (RPC)within 24 hours of the request submitted by the provider, which is one business day. ***Section 19. Residential Treatment Authorization*** fully describes the authorization process.

The appropriate level of care is normally identified in the initial screening. However, if it is determined during the ASAM criteria assessment that a different level or type of treatment is more appropriate to meet a beneficiary's needs, a warm hand-off (if possible) or referral will be made to an appropriate provider by the program in which the assessment was done. Information will be shared between programs in compliance with 42 CFR Part 2 requirements. If the assessment indicates there is no medical

necessity for any SUD treatment levels, a Notice of Action (NOA-A and NOA-Back) will be provided to the beneficiary at the conclusion of the assessment, or it will be mailed to the beneficiary through the US Postal Service no later than three (3) working days after the decision to deny SUD services has been made.

Authorization for Treatment:

HCA BHS prior authorization is required only for Residential Treatment. It is not required for admission to outpatient, withdrawal management, or NTP for those individuals determined appropriate for admission to those levels of care by an LPHA or MD. HCA BHS contract monitors regularly review charts to verify compliance with admission requirements for all programs, review treatment plans, documentation and the services delivered.

The provider will notify the HCA BHS Residential Placement Coordinator (RPC) prior to the full ASAM assessment and subsequent admission if the initial screening indicates residential treatment is appropriate. HCA BHS maintains a centralized referral list and a daily count of available beds. The RPC will ensure the beneficiary enters treatment as quickly as possible by designating placement at the program with an available bed (unless the beneficiary is requesting a specific program). The provider will submit a Treatment Request for Admission form (TRAF, Attachment III) to the RPC who will make a determination for admission within 24 hours of the request, excluding weekends and holidays. In those instances, authorization will be provided the following business day. If immediate admission is not available, due to a beneficiary's specific program requests, interim services are offered. The purposes of interim services are to engage the individual, reduce the adverse health effects of SUD, promote the health of the individual, and reduce the risk of transmission of disease. Interim services may include group orientation and education sessions, referrals to medical care, detoxification programs and outpatient or recovery services.

If the RPC denies admission to residential services, the beneficiary will be referred by the RPC, to an appropriate level of care to support the beneficiary's engagement in treatment.

HCA BHS also screens beneficiaries for admission to inpatient medical detoxification services and if the criteria are met, the beneficiary is linked to one of the contract provider's two Chemical Dependency Recovery Hospitals (CDRH). The HCA BHS contract monitor reviews admissions and length of stay on a monthly basis.

Reassessments, Transitions and Case Management:

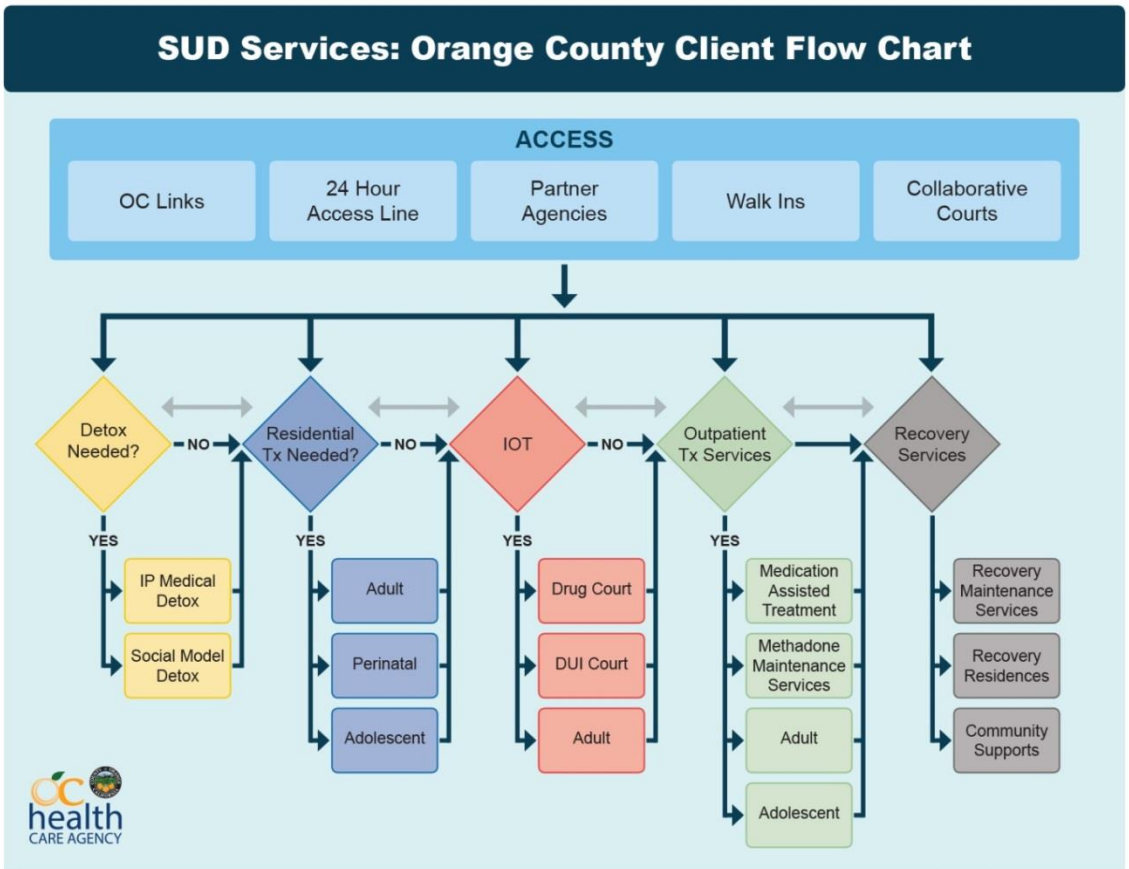
Beneficiaries in all treatment modalities are reassessed whenever necessary and not later than every 90 days. Discharge planning begins upon admission, and is included in the treatment planning process. Reassessments determine whether treatment is supporting the beneficiary in reaching established goals. This includes addressing barriers to meeting their goals; if continuing care or a transition to another level of care-lower or higher--is more appropriate, or requested, by the beneficiary. The continuation of residential services beyond 90 days for adults and 30 days for youth require BHS prior authorization and will be limited to 30 additional continuous days, and no more than two non-continuous treatment episodes with a maximum of 180 and 60 days respectively, in a 12-month period.

The providers are responsible for all case management services during treatment, which have historically been integrated into the treatment sessions. Under the DMC-ODS, however, case management will be a distinct service. The treating certified counselor or LPHA, as the plan coordinator, has a collaborative therapeutic relationship with the beneficiary. This ensures that the beneficiary

receives the advocacy and support services necessary to promptly meet the full range of needs, including medical, educational, vocational, legal and housing. It also ensures that transitions to different levels of care, if appropriate to beneficiary needs, are accomplished smoothly and appropriately through referrals, linkages and warm hand offs. The treating provider, as plan coordinator, provides case management services for the beneficiary during treatment, transition to other levels of care and follows up, to encourage the beneficiary to engage and participate in an appropriate level of care or Recovery Services after discharge. Case management becomes the responsibility of the treating provider after successful transition to a different level of care.

HCA BHS provides oversight of case management services. Clinical supervisors and contract monitors review chart notes and treatment plans regularly to evaluate compliance with case management contract requirements. This is also included in the formal annual review.

During the first year of implementation, providers will be responsible for providing care coordination services to beneficiaries who are having trouble engaging in treatment, maintaining sobriety and/or are high utilizers of SUD and other services. These services will commence at the initial screening and be provided until the beneficiary is successfully enrolled in a treatment program. Upon enrollment, the continuing case management services will be provided by the treating program.



3. Beneficiary Notification and Access Line. For the beneficiary toll free access number, what data will be collected (i.e.: measure the number of calls, waiting times and call abandonment)? How will individuals be able to locate the access number? The access line must be toll-free, functional 24/7, accessible in prevalent non-English languages, and ADA-compliant (TTY).

Review Note: Please note that all written information must be available in the prevalent non-English languages identified by the state in a particular service area. The plan must notify beneficiaries of free oral interpretation services and how to access those services.

HCA BHS contracts with an Administrative Services Organization (ASO) that staffs and operates a toll free Access Line twenty- four (24) hours per day/seven (7) days per week, which is a primary point of contact for individuals and their families for behavioral health services. The Access Line is staffed 24 hours per day by clinicians who speak the prevalent non-English (threshold) languages of the majority of callers in Orange County which are Spanish, Vietnamese, Korean, Farsi and Arabic. For callers who may require language translation services, the ASO 24/7 Access Line utilizes the Language Line or equivalent interpreter services. The California Relay Service, which is ADA compliant and provides the full range of relay services including use of TTY, is used for hearing-impaired callers. In addition, the hearing impaired may use video relay services.

The ASO Access Line staff conducts a brief screening to determine if the person seeking behavioral health services meets medical necessity and to verify Medi-Cal eligibility. While the ASO currently screens for all behavioral health issues, HCA BHS will negotiate a revised contract to include a brief screening based on ASAM criteria for the DMC-ODS. ASO staff will consult with designated HCA BHS staff for level of care appropriateness, as needed.

The Access Line will be listed on the http://ochealthinfo.com website under Behavioral Health Services, and advertised on the MCP's website. In addition, Medi-Cal informing materials will include this access information. Informing materials will be available in multiple formats, including written in all threshold languages and large print version; PDF of the written formats will be posted on line and will be available on audio disc in all threshold languages.

Multiple methods will be used to inform beneficiaries of free oral interpretation services and how to access them, including in the informing materials. The information will also be posted in all program locations, where visible to beneficiaries.

The ASO maintains an Access Log of all requests for services received by telephone, in writing or in person. The Access Log contains:

- Name of the caller
- Date of request
- Medi-Cal status of the caller
- Nature of the request for SUD or MH
- Call status (emergent, urgent, routine)
- Disposition of the request including:
    - Referrals to DMC-ODS approved facilities and
    - Referrals to other treatment services
- Verification of authorization provided

- Resources provided

The log can be sorted for reporting and data analysis needs and is made available to HCA BHS by the ASO within 24 hours for any time-period specified by HCA BHS. The ASO is required to track call volume, and evaluate timeliness of access and patient satisfaction. Measurements include:

- No more than 1% of total monthly calls will be abandoned, and
- 95% of the calls will be answered within 30 seconds.
- ASO surveys all beneficiaries who have requested HCA BHS services, to track satisfaction with the customer services provided on the access line. The required satisfaction rating is that NO LESS THAN 90% of the respondents will rate services as, at least, satisfactory.
    - Satisfaction is determined by responses to questions regarding the screening provided, such as courtesy of Access Line staff, timeliness of call answered, Access Line staff demonstrating concern with caller's well-being, services provided in caller's preferred language and sensitivity of Access Line staff to caller's cultural and/or ethnic background.

The ASO is required to submit monthly and quarterly reports related to access and caller satisfaction with services. The contract monitor reviews the reports and the arranges quarterly test calls to evaluate 24 hour accessibility, capacity to provide services in Orange County's threshold languages and to test responses to inquiries related to access, beneficiary problem resolution and the treatment of an urgent behavioral health condition. Findings are reviewed by the Community Quality Improvement Committee (CQIC).

4. Treatment Services. Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

> ***Review Note: Include in each description the corresponding American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date. This list will be used for billing purposes for the Short Doyle 2 system.***

Orange County HCA BHS provides at least one level of care in all modalities of the required continuum, either directly in DHCS certified County operated clinics or through certified/licensed contracted providers. The majority of the providers are not yet DMC certified, but are in varying stages of the application process. Services are provided to adults and youth with a substance use disorder, and youth at risk of SUD, who are DMC eligible, uninsured and those with limited ability to pay for treatment. The Social Services Agency (SSA) has out-stationed staff at HCA BHS outpatient clinics to enroll Medi-Cal beneficiaries. HCA BHS has collaborative relationships with the MCP and other County and community partners to ensure that those in other systems, such as Probation, Sheriff's Department, SSA and the Courts receive the SUD services needed to successfully return to, or remain in, the community. Evidence Based Practices (EBP) are required in all treatment modalities. In addition, case management services are integrated into every level of care to provide the advocacy, support and linkage to ancillary services

that support engagement and participation in treatment. Table 1. is a chart of the services to be provided by HCA BHS in the DMC-ODS.

TABLE 1: SERVICES TO BE PROVIDED : POPULATIONS SERVED				
ASAM Level	Service Modality	Populations to be Served: Adults/Youth/Both		
		Within Year One	Within Year Two	Within Year Three
REQUIRED SERVICES				
0.05	*FFS: Early Intervention: Screening, Brief Intervention, & Referral to Treatment (SBIRT)/Not DMC*	*Both*		
1	Outpatient Treatment Services	Both		
2.1	Intensive Outpatient Treatment	Adult		Youth
3.1	Residential Treatment Services	Both		
3.3	Residential Treatment Services			Adult *
3.5	Residential Treatment	Both		
3.7/4.0	*Medically Monitored/Medically Managed Intensive Inpatient-Non DMC*	Adult**		
3.2 WM	Social Model Residential Detox	Adult		
3.7 WM	Inpatient Medical Detox-Chemical Dependency Hospital	Adult		
4.0 WM	*Inpatient Medical Detox-Acute Care Hospital FFS /Non DMC*	*Adult*		
1 - OTP	Opioid/Narcotic Treatment Services	Adult		
-------	Recovery Services	Both		
-------	Case Management	Both		
-------	Physician Consultation	Both		
OPTIONAL SERVICES				
1 - OTP	Additional Medication Assisted Treatment	Adult		
-------	*Recovery Residences/Non DMC*	Adult		

*currently there are no ASAM Level 3.3 designated programs in Orange County. If there are still no designated facilities by year three, HCA BHS will seek contracts in surrounding counties.

***Refer and Coordinate with contracted Chemical Dependency Hospital, and with the MCP.**

Service Descriptions:

Early Intervention/SBIRT: ASAM Level 0.5

Screening, brief intervention and referral to treatment (SBIRT) services are available to individuals who are experiencing substance use problems. These services are preliminary to any formal services and are not DMC-ODS reimbursed. SBIRT is available through the MCP network providers, community health clinics and other community prevention and health providers. It is also provided at HCA BHS County operated adult outpatient clinics, whereas youth clinics have historically made use of the CRAFFT. If screening indicates treatment services are needed, referrals are made to appropriate providers. Referral procedures between the MCP and HCA BHS are included in the MOU.

HCA BHS also offers substance abuse prevention/early intervention services in elementary, middle and high schools with an identified need. Evidenced based curriculum teaches students the harmful effects of alcohol and drug use, develops their refusal skills, and enhances their ability to make healthy decisions. Teacher and parent education workshops are provided in addition to the student curriculum so students can be further supported at school and in the home.

Outpatient Services: ASAM Level 1

Outpatient Drug Free services (ODF) are provided to adults and youth experiencing SUD who meet medical necessity for this level of care, determined by an LPHA or MD's diagnosis and ASAM criteria. Youth may be diagnosed and assessed as at risk for substance abuse. Services are provided up to nine (9) hours per week for adults and up to six (6) hours per week for youth. Under the DMC-ODS demonstration project, services may be provided anywhere in the community, by telephone or by telehealth (when available).

All ODF SUD providers are competent in the following treatment components, as defined in the Special Terms and Conditions (STC):

- Intake and Assessment; Individual and Group Counseling; Family Therapy; Patient Education; Crisis Intervention; Medication Services; Collateral Services; Treatment Planning and Discharge Planning.

Adult ODF services are currently provided by the County and contract operated programs at a total of 17 sites. All providers have received training in, and use at least two (2), EBPs including Motivational Interviewing and Cognitive Behavioral Therapy.

Within the adult SUD system of care there are also six (6) specialized programs, which are coordinated with partner entities including Probation, the Collaborative Courts, and SSA, and include:

- Perinatal
- Drug Court
- DUI Court
- AB 109
- CalWORKs
- Deaf and Hard of Hearing

Adolescent ODF services are currently provided at five (5) locations in accordance with the current DHCS *Youth Treatment Guidelines*. Historically the majority of the beneficiaries for youth services have been referred by Probation. Providers are trained in, and incorporate a minimum of two (2), EBP including Motivational Interviewing and Seeking Safety, in treatment.

A Request for Proposals (RFP) is currently in development for adult and youth outpatient services. HCA BHS is seeking DMC certified providers with the ability to provide additional treatment opportunities to meet the anticipated need. Services are expected to commence in July 2017.

Intensive Outpatient Services (IOT): ASAM Level 2.0

One current DMC certified adult contract provider is certified to provide both ODF and IOT (ASAM levels 1 and 2.0), but provides only ODF under the current contract. Services that meet the criteria of IOT certification are currently provided in Adult Drug Court for the small number of beneficiaries in a caseload (average five) who meet criteria based upon the six dimensions of ASAM. The clinic providing services is not DHCS certified for IOT at this time, although services include all IOT components. Services are available up to five (5) days a week for a minimum of nine (9) hours per week and no more than 19 hours per week for a minimum of eight (8) weeks.

IOT service components include:

- Intake and Assessment, Individual and Group Counseling, Family Therapy, Patient Education, Crisis Intervention, Medication Services, Collateral Services, Treatment Planning, and Discharge Planning.

The HCA BHS County operated drug court clinic location currently providing IOT level services and the DUI court program will obtain DHCS IOT certification in the first year of implementation. Also, the RFP to be released for outpatient services includes a requirement that IOT services must be made available. Increased availability of IOT is expected to reduce the current and continuing burden on residential treatment.

Residential Treatment: ASAM Level 3.1

Residential treatment services ASAM level 3.1 are available for adults and youth with prior authorization from an HCA BHS RPC. See ***Section 19. Residential Authorization*** for a complete description of the authorization process.

All contracted residential providers are competent in the following components of residential services as required in the STC:

- Intake and Assessment, Individual and Group Counseling, Family Therapy, Patient Education, Crisis Intervention, Medication Services (including safeguarding meds), Collateral Services, Transportation, Treatment Planning and Discharge Planning.

HCA BHS contracts with eight (8) adult residential treatment providers at nine (9) sites in Orange County. Among the contract providers, there are currently 295 beds available to serve HCA BHS adults. HCA also has a letter agreement with another residential provider to serve deaf and hard of hearing. Beneficiaries receive at least 14 hours of therapeutic activities, including five (5) hours of individual and/or group counseling per week. The length of stay in adult non-perinatal residential treatment services will not exceed 90 days with one possible 30-day extension approved by the RPC, with the exception of the criminal justice population which may have extended stays funded by other sources. No one will be allowed to participate in DMC-ODS non-perinatal residential services for more than two non-consecutive instances of up to 90 days in a 12-month period. The length of stay for beneficiaries in perinatal residential is in accordance with the *Perinatal Services Network Guidelines.*

Residential programs are offered that are gender specific as well as culturally and linguistically appropriate. The residential providers are capable of meeting the needs of special populations, such as those with co-occurring mental health disorders, criminal justice involvement, opiate users, HIV and veterans. Also, there is one specialized perinatal program with two sites for pregnant and parenting women and the specialized residential program available at a negotiated rate in Los Angeles County for deaf and hard of hearing beneficiaries.

Residential treatment services for youth are available at a 22-bed Community Care Licensed contracted program. Services are provided in accordance with the current DHCS *Youth Treatment Guidelines* and mental health treatment services are provided to those with co-occurring disorders. The length of stay in DMC-ODS adolescent residential services may not exceed 30 days with one possible 30-day extension approved by the RPC. No one will be allowed to participate in adolescent residential programs more than two non-consecutive instances of up to 30 days in a 12-month period.

In an effort to expand residential services, HCA BHS increased the number of contracted ASAM level 3.1 adult beds in fiscal year 2016-17, but further expansion is needed to meet increasing demand. Due to current funding limitations, HCA BHS contracts for up to 295 beds of the total available bed capacity of 322 beds at contracted facilities. The DMC funding will enable an increase in the contracted bed capacity in the contracts for at least eight (8) additional beds. However, providers have indicated that they may maintain some dedicated beds for other populations, so increases for DMC beds will be negotiated, and a solicitation will be released as necessary to meet demand for services. HCA BHS will also seek to expand the availability of MAT at residential facilities to assist beneficiaries to maintain sobriety. In addition, the outpatient/IOT RFP will increase capacity for those services and the additional IOT is anticipated to reduce placements in residential services.

Residential ASAM Level 3.5

HCA BHS contracts with one adult (1) residential provider in Orange County that has DHCS ASAM designations for level 3.1 and 3.5. There is a contract in place with the provider for level 3.1 residential services and available services under the contract will be expanded to include level 3.5 criteria, which will be co-located with the designated 3.1 services. This will become effective within the first year of services in the DMC-ODS. In addition, the youth residential treatment provider is seeking 3.5 designation, to provide co-located 3.1 and 3.5 services within the first year of implementation. If necessary, an RFP will be developed to meet additional demand.

Medically Monitored (ASAM 3.7)/Medically Managed (ASAM Level 4.0) Intensive Inpatient Services

HCA BHS does not currently offer medically monitored or medically managed intensive inpatient services. However, HCA BHS currently contracts with a non-profit provider operating two Chemical Dependency Recovery Hospitals (CDRH) in Los Angeles County that are licensed by the Department of Public Health for inpatient withdrawal management services. For those needing medically monitored inpatient treatment (ASAM Level 3.7), HCA BHS will refer to and coordinate care with these CDRH. Medically managed intensive inpatient services at acute care hospitals will be coordinated with the Orange County MCP as a FFS benefit.

Withdrawal Management Social Model Residential Detox: ASAM Level WM 3.2

HCA BHS currently contracts with two (2) residential non-institutional, non-medical withdrawal management programs, providing co-ed social model detox not to exceed seven (7) days. Among the providers, there are currently 22 contracted beds available to serve adults, which are sufficient to enable timely access to treatment. The programs serve adults who have used substances within the last 48 hours, and meet medical necessity and ASAM criteria for this level of care.

The contracted residential detoxification providers are competent in the components of withdrawal management services as defined in the STC:

- Intake, Observation, medication services, and discharge services

One of the two contracted programs allows and manages medications brought in and self-administered by the beneficiary to assist in reducing the discomfort or withdrawal side effects. These include anticonvulsant medications and Suboxone.

Staff begins discharge planning upon admission, including transition to continuing care at a lower level. Detox staff works with the HCA BHS RPC for beneficiary admission to a residential treatment program upon discharge. HCA BHS has designated residential treatment beds for persons discharging from detox to provide a seamless transition between levels of care.

During the first year of the demonstration project, HCA BHS will negotiate an increase in the number of contracted beds within the total capacity of the current providers (30 beds) and will solicit additional residential detox providers, if indicated by utilization.

Withdrawal Management Inpatient Detox: ASAM Level 3.7

BHS currently contracts for inpatient medical detox, on a negotiated rate basis, with a non-profit provider operating two Chemical Dependency Recovery Hospitals (CDRH) in Los Angeles County that are licensed by the Department of Public Health. The CDRHs have a combined total of 70 medical detox beds to serve adults. HCA BHS refers adults who have received a psychosocial assessment at a County operated clinic and are in need of inpatient detoxification to complete withdrawal management. Services are provided in accordance with all federal and state statutory requirements and regulations for inpatient medical detox and include:

- Intake, Observation, Medication Services, and Discharge Services

HCA BHS has designated residential treatment beds for persons discharging from both residential and inpatient detox to provide a seamless transition between levels of care.

The ability to provide these services locally, until now, has been precluded by funding limitations. During the first year of the demonstration project, HCA BHS will develop a solicitation for medical inpatient detox services at free standing CDRHs located in Orange County.

Medical Inpatient Withdrawal Management ASAM 4.0 (FFS-non DMC-ODS)

Beneficiaries may receive voluntary inpatient medical detoxification services at acute care hospitals. This is a Medi-Cal fee-for-service benefit and the MCP coordinates referrals and care with the hospitals. The MCP responsibilities for inpatient SUD services are delineated in the MOU.

Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP): ASAM OTP 1

Narcotic replacement therapy is currently available to adults ages 18 and over, by one (1) provider at two (2) contracted licensed NTP facilities providing methadone 21-day detox (a non-DMC benefit) and ongoing maintenance services to adults.

NTP/OTP Maintenance Services are provided in accordance with Title 9, Division 4, Chapter 4 of the California Code of Regulations and the Department of Health Care Services regulations.

The combined capacity of the two facilities is 950 individuals and services are provided regardless of a beneficiary's county of residence. The NTP provider is competent in all the components of NTP services, as defined in the STC that include:

- Intake, Individual and Group counseling, Patient Education, Medication Services, Collateral Services, Crisis Intervention, Treatment Planning, Medical Psychotherapy, and Discharge Planning.

The provider orders, prescribes, administers and monitors methadone as a substitute narcotic analgesic drug for beneficiaries who meet medical necessity for dependence on heroin or other morphine-like opioids. Under the DMC-ODS demonstration project, NTP programs will also prescribe, monitor and administer naloxone, buprenorphine and disulfiram, as required in the DMC-ODS.

The beneficiaries receive a minimum of 50 minutes of counseling with a therapist or counselor up to 200 minutes per month and face-to-face medical psychotherapy conducted by the Medical Director or physician on a one-to-one basis, as appropriate. NTP case management services are provided linking beneficiaries to needed ancillary services and have recently been expanded by the provider to include in-home case management to beneficiaries who are also in Shelter + Care housing. This supports the beneficiaries' ability to sustain independent living.

HCA BHS will be extending a contract opportunity to the only other DMC certified NTP provider in Orange County. The provider's current capacity is 650 and the additional contract will enable HCA BHS to immediately increase the number of NTP beneficiaries funded by DMC.

Recovery Services:

Recovery Services address ASAM Criteria Dimension 6: the recovery environment and its impact on sustained recovery, and are currently available to adults ages 18 and over who require a support system and assistance maintaining their recovery. Recovery Maintenance Services are currently

provided by a DMC certified outpatient provider staffed with certified counselors. Referrals are accepted from all treatment providers and over 80% of the beneficiaries are, or have been, involved with the criminal justice system. Services are made available via telephone, on-site, or in the community to over 600 unduplicated individuals per year. Each beneficiary has a recovery plan and the goal is for beneficiaries to develop skills to self-manage their health and recovery.

Services available to beneficiaries address all required components as defined in the STC and include:

- Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
- Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
- Education and Job Skills: Linkages to life skills, employment services, job training and education services;
- Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;
- Support Groups: Linkages to self-help and support, spiritual and faith-based support;
- Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

HCA BHS is currently developing a solicitation for RMS services and intends to expand RMS capacity. All outpatient and residential providers will be required to offer Recovery Services, within the first year of implementation.

Case Management:

Beneficiaries often enter treatment with multiple issues impinging upon their ability to engage and actively participate in treatment. Case Management is a vital component of SUD care and is available to beneficiaries in every HCA BHS County operated and contracted adult and youth SUD program. Case

management services are provided by an LPHA or certified counselor, as the plan coordinator, and integrated into treatment sessions to help beneficiaries access needed medical, educational, pre-vocational and vocational, social, rehabilitative and other community support services. While not all beneficiaries require this support, HCA BHS has found that the majority require at least some case management services during treatment which can be effectively provided within the therapeutic relationship between the beneficiary and the provider. Case management services are provided in compliance with 42 CFR Part 2 confidentiality regulations.

SUD Case Management activities are designed to support the beneficiaries in recovery through:

- Assessment and periodic reassessment of the beneficiary's need for continued case management services, and revision of the treatment plan, as indicated.
- Assistance to successfully transition to lower or higher levels of care, as determined by review of the treatment plans.
- Monitoring the service delivery to ensure beneficiary access in the service delivery system, as well as monitoring beneficiary's progress.
- Referral and linkage to ancillary services needed, such as educational, pre-vocational and vocational assistance, benefits, primary medical care, housing, and transportation.
- Coordination of care and advocacy with other systems, including criminal justice, social services, mental health and physical health providers.

Case Management is currently documented in the chart, but not as a distinct service. Providers have been advised that this will be an allowable same day service under DMC-ODS and can be provided anywhere in the community, in person or by telephone.

HCA BHS provides oversight and coordinates SUD case management activities. Services are regularly reviewed by the contract monitor, supervisor or manager through chart reviews and in the annual review. During the first year of implementation, HCA BHS will have coordinated care management services for high utilizers and those who are having difficulty engaging in treatment. High utilizers are defined as individuals with two or more admissions to treatment in the past two years and who have a high risk of relapsing during or upon completion of treatment.

Plan coordinators will assist beneficiaries, prior to admission into a treatment program, to ensure that barriers to treatment engagement are reduced. Care coordination services will be provided until a beneficiary is admitted to a treatment program, which will then be responsible for ongoing case management services. Plan coordinators will not be assigned to youth outpatient clinics due to the smaller population and the historical need which has been effectively met by the treating LPHA.

The delineation of SUD and physical health care case management services between BHS and the MCP is set forth in the MOU.

Physician Consultation:

HCA BHS has psychiatrists on staff in adult and youth programs who are available to consult with HCA BHS and contract provider staff on issues related to co-occurring MH and SUD. In order to ensure the availability of expert advice related to complex medication requirements of some beneficiaries, the psychiatrists may provide consultation to the DMC provider MDs regarding SUD medication assisted therapies, dosing levels, side effects, drug interactions and level of care considerations. In addition, a full time pharmacist is on staff supporting Authority Quality Improvement Services (AQIS), as well as Adult,

Older Adult BHS and is available to provide consultation services. Also, HCA BHS is actively recruiting for an Addiction Specialist(s).

Optional Services to be provided:

Additional Medication Assisted Treatment: ASAM Level OTP1

Medication Assisted Treatment (MAT) of Vivitrol is available at two (2) DHCS certified contract outpatient providers to AB109 participants with or without Medi-Cal and to probationers and parolees who are on Medi-Cal. Beneficiaries must be dependent on opiates and/or alcohol, are committed to recovery, and are actively participating in outpatient or residential SUD treatment programs. Beneficiaries may start Vivitrol while in custody and will receive their injection about a week before scheduled release. Vivitrol is prescribed monthly by the provider's physician, in accordance with the protocols established by the Food and Drug Administration, and with the drug manufacturer's instructions. Beneficiaries are required to be randomly drug and alcohol tested at least once each month. AB 109 beneficiaries are assigned a plan coordinator who coordinates the care with the contracted providers and maintains close follow-up with beneficiaries referred/receiving Vivitrol. Individuals may remain on Vivitrol as long as the prescribing physician determines that it is clinically necessary to maintain the beneficiary's sobriety.

During the first year of implementation, HCA BHS intends to expand MAT to non-criminal justice involved adult beneficiaries. Additional medications for opiate and/or alcohol withdrawal and dependence will be available including: Suboxone, Campral, Naltrexone and Disulfiram. Beneficiaries will be referred to physicians, who may or may not be in the DMC-ODS, who will evaluate beneficiary needs and help identify the appropriate medications to be used that will support the SUD treatment goals. HCA BHS is also evaluating the benefits of MAT for adolescents. ***Section 18. Additional Medication Assisted Treatment*** provides a complete description of MAT.

Recovery Residences: (Non Drug Medi-Cal)

Adult recovery residences offer sober living environments for persons whose living situation negatively impacts the individual's ability to maintain sobriety. HCA BHS currently contracts with six (6) Recovery Residences.

Five (5) residences are Sober Living Homes providing approximately 50 beds for AB 109 beneficiaries who are actively participating in outpatient treatment or the Orange County Probation Department's (OCPD) Day Reporting Center (DRC) program. The Sober Living Homes meet the certification guidelines established by the Orange County Sheriff's Department, ensuring a supervised drug and alcohol free environment that is also a non-smoking facility. The length of stay is up to four (4) months, unless HCA BHS approves an extension.

A seven (7) bed Recovery Residence provides transitional housing for up to six (6) months, specifically for persons with co-existing HIV and SUD. In addition to meeting basic living needs, the residents receive linkage to medical case management for HIV, outpatient substance abuse counseling, self-help recovery groups, vocational assistance and medical and dental assistance.

During the first two years of the DMC ODS, BHS will explore expanding availability to other criminal justice populations, as well as the general population. Additional recovery residences may help address housing which is a primary need identified by most beneficiaries and providers. However, any expansion of services will be dependent upon the availability of allowable funding in the County.

Barriers to Treatment:

In Orange County the barriers to providing services include the following:

- Limited capacity in residential treatment to meet estimated need. Most non-contracted residential providers in Orange County have not expressed interest in participating in DMC due to funding and reporting requirements. Due to the lack of DMC startup funds, it is difficult to pursue additional facilities and it is also very difficult to site residential services in Orange County, due to "NIMBYism." Under the DMC ODS, capacity at the DMC certified contracted facilities will be utilized to the extent each provider will accept and a solicitation will be developed for additional providers, as necessary.
- The majority of the outpatient services are currently provided at County operated clinics. The current contract providers do not have the capacity to serve all the beneficiaries in the County operated programs, nor have they worked with the collaborative courts. An RFP is in process for outpatient services and HCA BHS outpatient clinics may be submitting Medi- Cal applications to ensure services are delivered at the current or expanded levels.
- There are no residential facilities DHCS designated at ASAM Level 3.3 located in Orange County, which precludes providing this level of care within the next three years, unless we contract outside the County. Contract providers are finding the DMC certification process difficult and that is causing delays in application submissions. They are all in various stages of the application process. If submissions are made promptly, it is anticipated they will be certified by the implementation date if the DHCS DMC certification approval process is not delayed.
- Geographic accessibility is a barrier for some beneficiaries primarily due to poor public transportation in the more suburban southern areas of the County. HCA BHS provides bus vouchers but it may take well over an hour to get to the closest clinic on public transportation, affecting beneficiaries' ability to engage in treatment. This will be mitigated somewhat by the ability to provide services in the field under the DMC ODS.
- Ongoing workforce issues are anticipated. The need for appropriately licensed, certified staff will continue to increase, as will the need for program monitors and administrative staff. Setting rates that will provide appropriate compensation may reduce some hiring issues.
- Integrating different funding streams to provide the range of services needed by DMC beneficiaries may be difficult.

Coordination of Services with Opt-Out Counties:

In California's southern region, all counties have indicated they are opting into the DMC ODS. However, the current contracted NTP provider has indicated services are now provided to residents of surrounding counties who work in Orange County, while the most recent DHCS list indicates there are no inbound or outbound Orange County DMC services being provided. HCA BHS has collaborative relationships with surrounding counties and will meet all *County of Residence/Responsibility* requirements, as necessary.

5. *Coordination with Mental Health. How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?*

BHS is a major service area within the Health Care Agency (HCA), comprising both Mental Health (MH) and Substance Use Disorder (SUD) Services. It was re-organized in 2014 eliminating separate divisions for SUD and MH and is currently structured with three primary areas of responsibility: Adult and Older Adult BHS (AOABH); Children, Youth and Prevention BHS (CYPBH) and Authority and Quality Improvement Services (AQIS). This organizational structure supports collaboration and coordination of care for those with co-occurring disorders. AOABH and CYPBH and AQIS each have responsibility for both providing and monitoring BHS services and for providing quality assurance activities. AQIS provides training and documentation review to ensure consistency with DMC documentation requirements which are essential to claiming of services.

The 24/7 Access Line will screen callers for both MH and SUD and provide appropriate linkages to SUD and/or MH services based on the screening. Plan coordinators at the HCA BHS County operated adult and youth clinics screen for both disorders and beneficiaries are referred and placed into treatment, based upon medical necessity. OC Links, the HCA BHS navigation service, also inquires about caller needs and links to the appropriate services based on that screening. Contracted adult MH clinics also provide services for those with co-occurring SUD.

SUD providers will be contractually required to screen for MH issues and to provide or refer the beneficiary to needed services. Based upon the screening, referrals may be to HCA BHS for those with serious and persistent mental illness or to MCP network providers for those with mild to moderate

impairment of functioning due to mental illness. Each update of the treatment plan will include assessment of need for coordinated case management services, referrals and linkage to mental health services. Communications and coordinated care for both mental health and physical health will be provided in compliance with the 42 CFR Part 2 and HIPAA confidentiality requirements.

Examples of HCA BHS integrated care include:

- Fully integrated SUD and MH services are currently provided at the contracted residential program for youth. In addition to residential SUD services, outpatient mental health counseling is provided (funded by MHSA, EPSDT) to the adolescent residents with co-occurring emotional disorders.

- An RFP for an adult residential program for those with co-occurring SUD and severe mental illness is anticipated to be released within the next 12 months. MHSA funding will be used to support mental health services.

SUD contracts will include a requirement that each contracted provider have a person assigned to address quality of services, including coordination with mental health and physical health, when appropriate.

HCA BHS contract monitors review and monitor services at all contract providers. Monitoring addresses and ensures that beneficiaries are receiving all required services. This is accomplished by oversight of the contracted provider's assigned quality assurance process and direct review of charts, including assessments, treatment plans and service notes. Additionally, contract monitors visit the sites for a variety of reviews in addition to monthly management meetings and statistical analysis. Information collected in all these areas helps contract monitors and managers ensure that the quality, level and type of services provided meet the standards of care expected by HCA BHS. The same functions will be carried out in the County operated clinics with the responsibility being assigned to the supervisors and oversight assigned to the manager.

In addition, HCA BHS will require a periodic (at least annual) standardized client satisfaction survey to address satisfaction with meeting of service needs. The results of the survey will be reviewed by program administration, discussed with the contractors and County operated clinic staff and reviewed in the Community Quality Improvement Committee.

6. *Coordination with Physical Health. Describe how the counties will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?*

Medi-Cal beneficiaries in Orange County have access to physical health care services through the Managed Care Plan, Cal Optima (MCP). HCA BHS will have a Memorandum of Understanding (MOU) with the MCP to facilitate integrated care, ranging from care coordination to full integration to the extent possible given the County beneficiaries' medical home locations and consistent with all laws and regulations related to healthcare privacy. The MCP and HCA BHS multidisciplinary teams meet monthly to develop strategies to better coordinate and integrate the delivery system as well as the services provided to individual members.

SBIRT will be a required preventative service by the network primary care physician (medical home). If SUD care is needed, the medical home provider will facilitate referrals and linkages and will obtain authorizations to disclose information to the SUD provider from the beneficiary. Once linked, the SUD

provider will obtain the medical records and record the beneficiary's medical information in the chart, including all applicable authorizations to disclose information, primary care physician name and location, medical history (including the latest physical examination), medications and significant conditions.

When the beneficiary initially enters the system of care at the SUD provider (or outside of a medical home referral), the SUD provider will provide a health screening and obtain the medical home contact information and authorization to disclose in order to request all relevant medical records, including medical history (including the latest physical examination), medications and significant conditions. If the beneficiary has not had a physical examination in the past 12 months, the SUD provider will make a referral and include it as a goal in the treatment plan. While verifying Medi-Cal eligibility, staff will also obtain the beneficiary's medical home location from the MCP to discuss care coordination with the beneficiary. If the beneficiary provides an alternative medical home location, other than what is recorded with the MCP, the SUD provider will also obtain an authorization to disclose to/from that provider.

If the beneficiary refuses to sign an authorization to disclose, the SUD care provider will have ongoing discussions with the beneficiary regarding the benefits of coordinated/integrated care and this will be reflected in the treatment plan, as well as documented in the chart notes. SUD providers will notify (with proper authorization) the medical home provider immediately upon intake of the beneficiary's treatment and will request medical records within one (1) week. The SUD provider's Medical Director (or designee) will review the medical records and consult with the primary care provider at the medical home to ensure proper coordination within 30 days. Consultation with the primary care provider will be initiated any time there is a change in treatment plan, such as medication changes or whenever a new medical condition becomes evident. If medication is prescribed, SUD clinical staff will notify the medical home provider within one (1) week.

If the beneficiary does not have a medical home, the SUD provider will discuss the benefits of coordinated/integrated care with the beneficiary and identifying a medical home will be a goal that will

be reflected in the care plan. All progress towards and attempts to link beneficiaries to a medical home will be documented in the chart.

Adherence to these minimum integration requirements will be monitored by supervisors at the provider locations. HCA BHS contract monitors will verify the requirements are met by contract providers. All coordination activities will be documented in the chart. The SUD providers will contact the medical home at least bi-annually if there are no changes in SUD treatment to coordinate physical health care and more often if medically necessary or if changes in SUD treatment are made.

HCA BHS has an ongoing initiative to further strengthen relationships with community health care providers and to build and modify existing interactions to better meet beneficiaries' needs moving forward. Examples of relationships currently in place with community providers include:

- HCA BHS has established relationships with community health care providers to co-locate staff to provide Integrated Community Services. HCA BHS staff provides and coordinates care at three (3) community health care clinics for those clinic patients with chronic co-occurring physical and behavioral health issues. These community care clinics provide physicians and/or nurse practitioners to three (3) HCA BHS clinics in the north, central and west regions of the County to provide medical consultation support for beneficiaries who have a mental illness and may also have a co-occurring SUD.
- HCA BHS has two (2) LPHAs stationed at two (2) FQHCs providing SBIRT for substance use disorders, depression, anxiety, intimate partner violence and /or trauma that may be impacting the overall general health of the patient. Adult patients are provided with brief interventions using Motivational Interviewing to engage patients into services and provide appropriate referrals, as indicated by the positive screens. SBIRT services include follow up phone calls to encourage engagement and/or address barriers that affect successful linkage to ancillary services.

Additionally, HCA BHS will keep informed of the progress of the design and implementation of the integration plan as described by DHCS in the May, 2016 Behavioral Health Integration Plan and will participate in the planning process as appropriate in order to make revisions to the BHS physical health integration approach, as needed, to align the BHS practices with the highest levels of integration possible.

7. Coordination Assistance. The following coordination elements are listed in the STC. Based on discussions with your health plan and providers; do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.

- Comprehensive substance use, physical and mental health screening;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Care coordination and effective communication among providers;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems.

Coordination assistance from DHCS may be needed in the following areas:

- ***Comprehensive substance use, physical, and mental health screening;***

The MCP has indicated that it is facing challenges getting its network providers to consistently conduct SBIRT, as required. The issue is currently being evaluated to determine the need for additional training or other approaches to ensure compliance.

A continuing challenge for HCA BHS is to monitor and evaluate brief screening and assessments to determine if placement recommendations are consistent among the providers, based upon the screening instruments used.

- ***Collaboration, Coordination, Communication, and Navigation***

HCA BHS SUD programs currently have a limited Electronic Health Record (EHR) which captures registration, charge services, billing, and CalOMS. HCA BHS is in the process of rolling out a full EHR for County operated BHS programs including SUD. Contracted SUD providers maintain their own EHR or paper records. There is no plan to merge contracted SUD or MCP EHRs, though information is shared for individual beneficiaries with proper releases. The major challenge in all these areas is appropriately

navigating 42 CFR Part 2 and HIPAA requirements to effectively communicate and coordinate services with the various systems and providers serving the SUD population. The requirements make the collaborative process cumbersome. It is a current and continuing challenge, particularly between the MCP and HCA BHS for those with co-occurring physical health issues.

8. Availability of Services. Pursuant to 42 CFR 438.206, the pilot County must ensure availability and accessibility of adequate number and types of providers of medically necessary services. At minimum, the County must maintain and monitor a network of providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, describe how the County will consider the following:

- ***The anticipated number of Medi-Cal clients*.**

The DHCS Medi-Cal Certified Eligibles Recent Trends August 2016 report identified 908,622 eligible Orange County residents in April 2016. HCA BHS anticipates approximately 7,556 Medi-Cal beneficiaries, comprising 1,242 adolescents and 6,314 adults will seek SUD services in the first year of implementation. This is based on available DHCS and SAMHSA National Survey of Drug Use and Health (NSDUH) data and studies.

- Prevalence data: *Behavioral Health Trends in the United States, September 2015, page 22,* identified need for treatment for those ages 12+ as 8.1%. Table 20 of the *NSDUH Comparison of 2010-2012 and 2012-2014 Population P*ercentages (Substate Regions) reports Orange County having an 8.44% dependence rate in 2012-14. (Page 269). The *DHCS Behavioral Health Needs Assessment, 2013,* Table III, (page 32) estimates prevalence for SUD as 10.3% of the California population.

- Penetration data: DHCS 2013 Behavioral Health Needs Assessment Appendix A (page 20) reported that Orange County's penetration rate for all SUD is 4%, which is too low to consider

based upon the expanded DMC services. SAMHSA NSDUH 2010-13 reports 10.8% of those needing treatment will seek it.

For the Orange County estimates, the higher percentages for both prevalence and penetration were used, as reflected in Table 2.

TABLE 2. ANTICIPATED MEDI-CAL BENEFICIARIES			
OC Medi-Cal Eligible Population*	**Total**	**Need SUD Txt.**	**Seek SUD Txt.**
Total Medi Cal	**908,622**	**10.3%**	**10.8%**
Adolescents Ages 12-17	111,653	11,500	1242
Adults Ages 18+	567,596	58,462	6314
Medi-Cal Eligibles Ages 12+	**679,249**	**69,963**	**7556**

* April 2016, recorded in DHCS MEDS Recent Trends Report, August 2016

- ***The expected utilization of services by service type.***

Utilization for the first year of implementation is based upon historical service utilization data by service modality and takes into account additional DMC services. SUD services were provided to 5,673 unduplicated participants in Fiscal Year 2014-15, who received 7,304 episodes of care, or approximately 1.3 admissions per participant.

The majority of SUD services/providers in HCA BHS have not been in the Drug Medi-Cal system. Of those receiving SUD services in 2014-15, approximately 35% self-identified as Medi-Cal eligible. However, based on a MEDS data to IT records match for the period of April 2015 to May 2016, of 5,351 unduplicated clients, approximately 68% were Medi-Cal beneficiaries. This percentage is not incorporated in the utilization estimates, because it is anticipated that more beneficiaries will be participating in the DMC-ODS.

As evidenced by current DHCS MEDS and Orange County enrollee data, the number of Medi-Cal enrollees is no longer increasing significantly and has been remaining relatively consistent over the past 6 months.

Table 3. Provides the number and percentage of 2014-15 treatment episodes for 5,673 unduplicated clients, and uses those percentages, as well as known increases in DMC service modalities to estimate utilization of the anticipated Medi-Cal eligible beneficiaries in Table 4.

TABLE 3. 2014-15 Utilization		
Modality	**2014-15 Episodes**	**% Served**
Outpatient	3211	44%
MAT	24	0%
Intensive Outpatient	0	0%
WM- Medical Inpatient Detox	91	1%
WM- Social Model Residential Detox	1164	16%
Residential	1991	27%
NTP	223	3%
Recovery Services	600	8%
***TOTAL Txt. Episodes**	**7304**	100%

*5,673 Unduplicated Clients had 7,304 episodes of care.

Factors impacting estimates for the first year of implementation include:

1) MAT participation is expected to triple in the first year as treatment providers link those meeting medical necessity to MAT services and the NTP providers offer expanded MAT services.
2) Currently HCA BHS contracts only for non Medi-Cal eligible NTP beneficiaries. In the first year of implementation, NTP capacity will increase to include those on Medi-Cal and also to include a second provider in Orange County. This will increase utilization from 3 % to 15%.
3) Within one to two years of implementation, increased utilization of IOT is expected to reduce the number of beneficiaries currently projected to need residential treatment.

TABLE 4. YEAR ONE DMC BENEFICIARY ESTIMATE		
Modality	Beneficiaries	% Served
Outpatient	2947	39%
MAT	72	1%
Intensive Outpatient	64	1%
WM- Medical Inpatient Detox	76	1%
WM- Social Model Residential Detox	1209	16%
Residential	2067	27%
NTP	1138	15%
TOTAL Beneficiaries	7556	100%

HCA BHS has not closely monitored case management services or physician consultation so it is difficult to estimate the need. Based on recent surveys, it is estimated that at least 75% of beneficiaries will need some level of case management. Physician consultation during the first year is expected to be very limited and difficult to project. Contracted Recovery Maintenance Services were provided to approximately 10% of the unduplicated clients in 2014-15. There is an RFP in process to expand services and, in addition, all treatment providers will be required to offer recovery services. Therefore, during

the first year it is estimated that approximately 15-20% of the beneficiaries will participate. Using these percentages for the anticipated number of DMC beneficiaries (7,556), anticipated utilization is reflected in Table 5.

Table 5. ADDITIONAL SERVICES		
Case Management	Physician Consultation	Recovery Services
5,667	76-378	1133-1,511
75%	1-5%	15-20%

Utilization estimates of all modalities for subsequent years will be determined based upon an analysis of actual utilization in the first year of implementation. It is anticipated that population growth will continue to average no more than 1% a year, based upon the *Orange County Economic Forecast*. Demographic data also indicates the youth population in Orange County is declining. Further, Medi-Cal enrollment increased dramatically in the last two years due to the ACA expansion population, but now appears to be maintaining a fairly consistent level. These factors will impact future utilization and capacity needs estimates and will be closely monitored.

- ***The numbers and types of providers required to furnish the contracted Medi-Cal services.***

Based upon historical and estimated utilization and the number of provider sites noted in Table 6, the capacity for each service modality will be sufficient to meet the expected demand for services in the first year of implementation, however, additional beds will be needed, and will be provided, for Adult Residential Services. See Attachment II for Directory of Providers.

TABLE 6. CURRENT SUD PROVIDER SITES			
Service	**Adult Only**	**Youth Only**	**Adult and Youth**
Outpatient	17	4	1
Intensive outpatient	2*		
MAT	2		
Residential Treatment	9	1	
Hard of Hearing	1**		
Withdrawal Management:			
Social Model Residential	2		
Medical Inpatient	2		
NTP	2		
Total	**37**	**5**	**1**

*IOT Certified and/or capable-not currently contracted

**Provider offers services by Letter Agreement, on a Negotiated Rate basis.

- ***A demonstration of how the current network of providers compares to the expected utilization by service type.***

The HCA BHS provider network has sufficient capacity to provide timely services, with the present exception of Adult Residential Treatment. Among the outpatient providers, over 6,000 beneficiaries can receive services. Recovery Services, Case Management and Physician Consultation will be available to all in need. As indicated in Table 7, the majority of programs can accommodate estimated needs. There would be an unmet need for Level 3.1 Adult Residential Services, under the current contracts. The current contract level is up to 295 beds and more will be required to meet increased demand. Not less than 303 beds will be needed to meet needs in the first year of implementation. Current contract providers have additional capacity to provide up to 322 beds and HCA BHS will be negotiating with them to increase capacity to meet anticipated needs. The addition of IOT will also reduce the demand for residential services, as it is anticipated that the ASAM assessments for many adults seeking residential treatment will result in appropriate IOT placements. A solicitation will also be released seeking additional providers, if necessary.

Table 7. Comparison of Beneficiaries to Provider Capacity

Modality	Year One Beneficiaries	Average Length of Stay	Contract/ Full Capacity	Unmet Need
Outpatient[1]	3083	90-280 days	6,000+	None
Medical Detox.	76	7 days	Neg.Rate/70 beds	None
Social Model Detox.	1209	5.6 days	22/30 beds	None
Adult Residential[2]	1987	55.6 days	295/322 beds	8beds/ None
Youth Residential	80	30-60 days	19/22 beds	None
NTP[3]	1138	2 years	1138/1600 slots	None

[1]Includes Outpatient, Intensive Outpatient, MA
[2]Based on current # of contracted beds and total capacity of current contract providers
[3]Includes capacity of additional NTP provider

❖ ***Hours of Operation***

All program hours of operation at all sites are available for services to all services recipients, including Medi-Cal beneficiaries. The hours of operation vary among the providers. Outpatient clinics are open Monday through Friday at least from 8:00 am to 5:00 pm or 9:00 am to 6:00 pm, with evening hours at least one night per week and contract providers also offer outpatient services at least 6 hours on Saturdays. IOT will be provided during the outpatient clinic hours. NTP services are available seven (7) days a week. Residential and residential detox program hours are 24 hrs./7 days week/365 days year.

The 24-hour Access Line accepts calls after hours and refers callers to appropriate services.

❖ ***Language capability for the county threshold languages.***

Services are made available in the non-English threshold languages for Orange County which are: Spanish, Vietnamese, Korean, Farsi and Arabic. Only eight percent (8%) of SUD treatment beneficiaries identified their primary language as other than English in a recent 12-month period and 82% of those identified Spanish as their primary language. Among the outpatient treatment programs, staff provides services in Spanish, Vietnamese, Farsi, Korean, Arabic and American Sign Language, at select sites. If an

SUD clinician is not available for a beneficiary in a specific language at County operated clinic, other qualified staff with the language capability may be assigned on a case by case basis. Residential programs are currently available that provide services in English, Spanish, Vietnamese and American Sign Language.

Interpreter services are utilized when necessary and Interpreter Training for Interpreters and Interpreter Training for Users of Interpreters are available to all staff. In addition, all written materials will be available in the threshold languages and notices about oral interpretation will be available in all threshold languages and posted in every treatment location. If no other resources are available when needed, the Language Line is used for translation purposes. The video relay service may also be used for deaf and hard of hearing beneficiaries.

- ***Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.***

Programs are able to provide same-day assessments, as well as by appointment. The HCA BHS standard for an appointment at an outpatient program is 10 business days from the initial assessment, unless there is an urgent condition. Non-medical withdrawal management services are considered urgent and are generally available within one to two days. Beneficiaries needing residential treatment may have an initial screening and if there is no available bed, due to a beneficiary's request for a specific program, may begin receiving interim, or alternative (such as outpatient treatment) services within 7 days of the initial screening. The DMC-ODS will enable HCA BHS to ameliorate any residential admission delays by increasing the number of contracted beds to provide timely access and by adding IOT services which is expected to be the appropriate ASAM level of care for many currently served in residential treatment. Follow up appointments are scheduled and provided in conformance with the treatment plan.

The 24-hour Access Line will be available to respond to after-hours calls regarding access to services and make referrals, as appropriate. In addition, all outpatient contract providers will be contractually required to establish procedures to address after hours beneficiary needs. The HCA BHS Centralized Assessment Teams are also available to respond to emergency situations, as appropriate.

Upon a beneficiary's request, HCA BHS will provide for a second opinion from a qualified health care professional within the network, or will arrange for the beneficiary to obtain one outside the network at no cost.

HCA BHS is evaluating additional methods to provide after-hour access for beneficiaries, including amending the warm-line contract to respond to beneficiary needs.

- ***The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities***

Orange County encompasses 799 square land miles comprising urban, suburban and outlying semi-rural areas. The HCA BHS standard is that beneficiaries travel no more than 20 miles to a clinic location to ensure geographic accessibility.

An analysis of Medi-Cal data of the past 12 months indicates that the majority of the beneficiaries (71%) reside in central and northern areas of the county which are urbanized regions. These include, but are not limited to, the large cities of Anaheim, Fullerton, Garden Grove, Santa Ana, Orange, Tustin, Fountain Valley and Costa Mesa. The majority of the treatment programs are situated in these regions which facilitates ease of access due to relatively short travel distances for beneficiaries and proximity of public transportation. The eastern area is semi-rural and the western and southern areas of the county are more suburban and each includes more recreational areas than other regions of the County. Only 11 % of the beneficiaries reside in the western region which includes Huntington Beach and Westminster and 18% reside in the southern part of the County, primarily in Mission Viejo, Lake Forest, San Clemente and San Juan Capistrano. While treatment locations are within the 20-mile distance standard in these regions, and bus vouchers are provided, travel time is sometimes longer than an hour due to inconsistent availability of, and limited proximity to, public transportation. Under the DMC ODS, services may be provided in the community and by telephone, which will reduce travel time for beneficiaries. In addition to field services, outreach teams regularly go to locations such as shelters, parks, and drop-in centers throughout the county and provide Seeking Safety groups, linkage and engagement services and transport individuals to HCA BHS clinics, if needed. Staff also is stationed at the homeless center, and transport those needing detox to contracted programs. HCA BHS is and will continue to explore options to shorten transportation time.

HCA BHS has entered into discussions with the County's Local Governmental Authority about the possibility and process to establish a County MAA claiming unit for transportation services. However, if more transportation support is added, it is currently anticipated it will be through a voucher program (such as taxi), rather than MAA. Also, HCA BHS has been working to develop a transportation program for those with MH issues and that may provide assistance to those with co-occurring SUD.

Buprenorphine will be considered for NTP when necessary due to travel time to get to clinic. HCA BHS is in discussion with the current provider for an NTP MD to prescribe based upon initial face to face screening. HCA will also evaluate setting up a satellite NTP office in South County, to be staffed at least two (2) times per week by an NTP MD.

Every provider is required to meet all laws and regulations related to serving beneficiaries with disabilities. These include:

- Americans with Disabilities Act of 1990;
- Section 540 of Rehabilitation Act of 1973;
- 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in programs or Activities Receiving Federal Financial Assistance;
- Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance; and
- Unruh Civil Rights Act California Civil Code Section 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities.

Within the provider network services are available to those with vision, hearing or other physical/mobility disabilities. Beneficiaries with disabilities are referred to the most appropriate provider able to meet their physical needs.

The Map (Attachment I) represents the locations of current SUD provider facilities located in Orange County and the distribution of Medi-Cal clients by zip code.

- ***How will the county address service gaps, including access to MAT services?***

HCA BHS monitors access to services and will continue to evaluate utilization to determine expansion needs. Currently, access to residential services is limited by the number of providers and beds. HCA BHS has increased the number of contracted beds in 2016-17 and will negotiate with the contracted DMC certified providers to increase the number of beds in 2017-18. If need continues to exceed availability, a solicitation for additional providers will be made. In addition, IOT as a new service may be somewhat limited in the first year of implementation and HCA BHS will monitor utilization to determine the need to expand services.

Access to MAT is available currently, and select adult residential providers accept beneficiaries on methadone and other FDA approved MAT medications. In addition, HCA BHS intends to expand MAT availability to beneficiaries with a minimum requirement that all providers refer/link beneficiaries to MAT providers, if medically necessary.

The SUD Provider Directory (Attachment II) identifies locations, hours of service, populations served, MAT and DMC certification for all providers.

9*. Access to Services. In accordance with 42 CFR 438.206, describe how the County will assure the following:*

- ***Meet and require providers to meet standards for timely access to care and services, taking into account the urgency of need for services.***

The standard for BHS SUD services is that each beneficiary is offered a first appointment/admission within 10 business days of a request for services, unless there is an urgent situation which requires attention within 48 hours. All providers report wait times through DATAR. The contract monitors and supervisors review DATAR monthly to assess timely access to routine services. Monthly meetings with the contract providers will address compliance with the contract requirements for timely access.

Providers will also be required to note referrals and appointment dates in a Waitlist/Access log which will be reviewed by the AQIS.

- ***Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal patients.***

HCA BHS contract providers will be contractually required to maintain consistent hours of operation for services to both Medi-Cal beneficiaries and non-Medi-Cal participants, with no disparity in services provided. Clinic hours will be monitored during monthly contract meetings and site visits to assess compliance with the requirements.

- ***Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.***

The 24-hour Access Line will be available to respond to any after-hours calls regarding access to services and to make referrals, as appropriate and medically necessary. If there is an emergency requiring medical care, beneficiaries may be directed to the 911 system. The HCA BHS Centralized Assessment Teams will also be available 24 hours a day, on an emergency basis. In addition, all contracted outpatient programs will be required to establish procedures for after-hours services.

- ***Establish mechanisms to ensure that network providers comply with the timely access requirements.***

DATAR is the statewide system used by HCA BHS to record and monitor wait times from first contact to first service. Providers are required to record the dates of first contact and admission in the chart and report in DATAR, and will be required to maintain a Waitlist/Access Log. Contract monitors review the information monthly in chart and DATAR reviews. They will also review the access log. In addition, HCA BHS conducts an annual review to evaluate compliance with all contract requirements.

- ***Monitor network providers regularly to determine compliance with timely access requirements*.**

Contract monitors review various contractual requirements during monthly site visits. Timely access may be reviewed during site visit by reviewing a sample number of charts as well as the monthly DATAR and logs. Contract monitors also monitor the number of beneficiaries served compared to the program capacity, which may affect timely access.

- ***Take corrective action if there is a failure to comply with timely access requirements.***

Timely access requirements for all programs will be monitored by the manager or contract monitors. If a provider fails to meet the requirements, additional education and training will be provided related to the expectations of access and required documentation. In addition, they may be required to submit a corrective action plan, including a time frame to implement the required changes, which will be monitored by the contract monitors. Access data will be provided to and reviewed by the Community Quality Improvement Committee.

10. Training Provided. ***What training will be offered to providers chosen to participate in the waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?***

Review Note: Include the frequency of training and whether it is required or optional.

Identification of training needs will be an ongoing process during the demonstration project. A train the trainer model may be used when thought to be appropriate.

Required training:

Clinicians:

- Annual Provider Training (annual)
- DMC Documentation Training (annual) – this training is likely to be in a train the trainer format, with contract providers designating a trainer to be trained by County and then taking that training back to the contract provider's staff.
- Law and Ethics (every two years)
- SBIRT (it is likely trainings will be frequent and will be varied, with some train the trainer options, some County provided training and some outside trainers being used)
- Motivational Interviewing (frequency offered will be driven by assessed need
- Dual MH/SUD diagnosis training (frequency and specialized topics under this heading will be determined based on need and utility)
- Non-Violent Crisis Intervention certification (requires re-certification every 2 years)
- ASAM e-training (at least the two (2) required modules): *Module 1: Multidimensional Assessment and Module 2: From Assessment to Service Planning and Level of Care*

Clinician training required for specific assignments:

- Cognitive Behavioral Therapy
- Seeking Safety
- Living in Balance

All staff:

- Cultural Competence Training (annual)
- Annual Compliance Training (or their own if approved by County Health Care Agency Office of Compliance) (annual)

Optional training:

Clinicians:

- ASAM (offered at least annually)
- ASAM e-Training Module 3 "*Introduction to The ASAM Criteria*", as requested
- Trauma Informed Treatment (frequency offered will be driven by assessed need)
- Anger Management Treatment (has a follow up supervision requirement) (frequency offered will be driven by assessed need)
- Suicide Prevention Training (frequency offered will be driven by assessed need)
- Moral Reconation Training (frequency offered will be driven by assessed need)
- Cognitive Behavioral Therapy
- Seeking Safety

All Staff:

- Interpreter training for Interpreters (offered annually)
- Interpreter training for users of interpreters (offered annually)
- Assistance from DHCS would be welcomed for additional training for ASAM, documentation, billing, and the continuum of care, as well as assistance with CalOMS training updates.

11. Technical Assistance*. What technical assistance will the county need from DHCS?*

The DMC ODS demonstration project requires many significant changes in the service delivery system and administrative functions. The majority of the providers have not participated in DMC services and the requirements will necessitate additional and on-going training. In addition to the training BHS will provide, technical assistance from DHCS to develop effective implementation strategies would be beneficial in the following areas:

- DMC Certification
- Screening and Assessment (ASAM)
- DMC ODS required Documentation, Reporting, Claiming and Cost reports.
- 42 CFR Part 2 and HIPAA requirements in coordinated/integrated care
- Standardized treatment protocols, for all providers
- Increased QA and Compliance requirements

12. Quality Assurance*. Describe the County's Quality Management and Quality Improvement programs. This includes a description of the Quality Improvement (QI) Committee (or integration of DMC-ODS responsibilities into the existing MHP QI Committee). The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:*

- **Timeliness of first initial contact to face-to-face appointment**
- **Frequency of follow-up appointments in accordance with individualized treatment plans**
- **Timeliness of services of the first dose of NTP services**
- **Access to after-hours care**
- **Responsiveness of the beneficiary access line**
- **Strategies to reduce avoidable hospitalizations**
- **Coordination of physical and mental health services with waiver services at the provider level**
- **Assessment of the beneficiaries' experiences, including complaints, grievances and appeals**
- **Telephone access line and services in the prevalent non-English languages.**

Review Note: Plans must also include how beneficiary complaints data shall be collected, categorized and assessed for monitoring Grievances and Appeals. At a minimum, plans shall specify:

- **How to submit a grievance, appeal, and state fair hearing**
- **The timeframe for resolution of appeals (including expedited appeal)**
- **The content of an appeal resolution**
- **Record Keeping**
- **Continuation of Benefits**
- **Requirements of state fair hearings.**

Quality assurance (QA), quality management and quality improvement (QI) are terms that have significant overlap and are not generally defined consistently among organizations. County currently has a Quality Management Plan that includes sections for quality assurance and quality improvement related to mental health services. This plan will be amended to include sections related to SUD services. The quality improvement committee is called the Community Quality Improvement Committee (CQIC) and is being restructured to include SUD services.

Monitoring of service quality exists at multiple levels of HCA BHS. Contracted programs are assigned a contract monitor who meets monthly with contracted programs, reviews documentation and addresses quality of care issues. In addition, the contract monitor meets quarterly with management to address a number of quality and contractual issues. Authority and Quality Improvement Services (AQIS) conducts routine audits of billable claims. The results of these audits are provided to the contract monitor for use in the monitoring process with the contracted program. AQIS also ensures that any services found to not be eligible for billing are not billed or if already billed and paid, are recouped.

Quality Improvement Work Plan:

The Quality Management Plan is a comprehensive description of the various Quality Assurance and Quality Improvement activities conducted across HCA BHS. Each year an updated Quality Improvement Work Plan is developed and approved with extensive input from the Community Quality Improvement Committee. The QI Work Plan includes broad areas such as, but not limited to:

- Monitoring beneficiary satisfaction
- Monitoring the safety and effectiveness of medication practices
- Monitoring continuity and coordination of care with physical health providers
- Performance improvement projects
- Follow up monitoring of previously identified issues
- Monitoring of grievances and appeals
- Monitoring accessibility of services

As part of the QI Work Plan process variety of reports are routinely reviewed in the Community Quality Improvement Committee and/or in management meetings, addressing elements including, but not limited to:

- Timeliness of first initial contact to face-to-face appointment
- Timeliness of first face-to-face visit and follow up
- Timeliness of services for urgent conditions and routine conditions
- DMC service utilization
    - The number of Medi-Cal beneficiaries served
    - Demographics of beneficiaries served
    - Retention analysis
- Frequency of follow-up appointments in accordance with individualized treatment plans
- Timeliness of services of the first dose of NTP services
- Access to after-hours care
- Responsiveness of the beneficiary access line – Reports addressing:
    - Total Calls received
    - Language of caller
    - Abandonment rate
    - Average time to answer call (seconds)
- Client Satisfaction
- Strategies to reduce avoidable hospitalizations
- Coordination of physical and mental health services with waiver services at the provider level
- Assessment of the beneficiaries' experiences, including complaints, grievances and appeals
- Length of stay for individualized care and compliance with residential length of stay standards
- Utilization of interpreter services
- Level of care transitions

Community Quality Improvement Committee (CQIC):

The CQIC has been active for approximately 18 years. SUD issues and services have been addressed as part of mental health service provider activity for several years, and SUD DMC-ODS issues and services have been specifically addressed since May 2016.

- **CQIC responsibilities:**

The drafted guidelines for the CQIC outline the committee responsibilities including, but not limited to:

- Review information and data on a variety of aspects of the provision of services by HCA BHS.
- Make recommendations to the committee, including the Behavioral Health Director, on
  - The development of an annually updated Quality Improvement Work Plan with long term and annual improvement targets.
  - Recommended quality/safety-related policies and practices.
  - Approving and monitoring a dashboard of key performance indicators compared to organizational goals and industry benchmarks.
  - Monitoring summary reports of areas including
    - Service delivery capacity
    - Accessibility of services
    - Beneficiary satisfaction
    - Medication monitoring
    - Coordination of care with physical health providers
    - Provider appeals
    - Beneficiary grievances
    - Beneficiary appeals
    - Performance Outcome
    - Follow up of previously identified issues
  - Making recommendations to Behavioral Health Services administration on matters related to the quality of care, customer service and organizational culture.

- **CQIC Membership**

The CQIC is chaired by the Director of Behavioral Health Services or designee. To insure broad community participation in the quality improvement process, membership on the Committee will be selected from a broad spectrum of the diverse ethnic community and will include beneficiaries and representative beneficiary family members. Additional representatives may periodically be included such as, but not limited to, the Public Guardian's office, the Probation Department and the Social Services Agency.

HCA BHS divisional quality improvement systems will remain in place and will continue to respond to changing target population needs and assess new service populations added through Phase II consolidation. Goal-specific and time-limited committees and action groups will be assigned as needed to address systems problems as identified by the Director and/Division Managers. The CQIC will meet at

least quarterly as determined by the Director. Division and program quality improvement committees will continue to meet regularly.

The Community Quality Improvement Committee will include:

Permanent Members
Chair – BHS Director of Behavioral Health Services or designee
BHS Medical Director
BHS Director, Adult and Older Adult Behavioral Health
BHS Director, Children, Youth and Prevention Behavioral Health
BHS Director, Authority & Quality Improvement Services
BHS Patients' Rights Advocacy Services Coordinator
CalOptima (Managed Care Plan) representative
Rotating Members
Mental Health Board representative
Alcohol and Drug Advisory Board representative
Cultural Competence Committee representative
SUD and MH Beneficiaries
SUD and MH Family members
SUD and MH Contracted Providers
AD Hoc Members as Decided by the Committee
Public Guardian's office
Probation Department
Social Services Agency

Grievances and Appeals

BHS has a mature and active grievance and appeal process for mental health services. This process has been expanded in 2016 to include grievances and appeals related to SUD services. The process is in compliance with 42 CFR 438 and the State requirements for the Mental Health Plan. Should the State issue any specific new or varied requirements related to SUD DMC-ODS, the process will be modified to address those as well.

Grievance and Appeal information is provided to beneficiaries in a variety of ways. The information is included in the informing materials given to beneficiaries at admission and annually. Information on the Grievance and Appeal process, including Expedited Appeals and the State Fair Hearing process, is posted in service locations. Grievance and Appeal forms along with self-addressed envelopes are available in conspicuous locations at all service locations where beneficiaries may access them without having to ask staff for them. Grievance and Appeal materials are available in all threshold languages. These materials provide the toll free line for filing Grievances and Appeals as well as a TTY line. Beneficiaries are informed of their right to access Patients' Rights Advocacy Services for assistance and representation in the Grievance and Appeals process. Each clinic designates a Provider Representative to facilitate the filing of Grievances and Appeals and to assist with the process if needed. Clinics are encouraged to attempt to resolve issues with beneficiaries locally when possible as an alternative to the formal Grievance process, but the beneficiary may access the Grievance process regardless of whether or not they participate in local efforts to resolve the issue.

Grievances and Appeals are coordinated through AQIS. Grievances and Appeals are logged and tracked. The log currently includes those elements required for mental health services and will be updated to meet any DHCS guidance for SUD services. The elements include at a minimum, Date filed, Date logged, Beneficiary Name, Nature of Grievance/Appeal, Date resolution sent to beneficiary, Resolution. Timelines are followed as outlined in 42 CFR 438 and the contract with DHCS. Grievances are resolved within 60 days. An extension of 14 days is allowed if requested by the beneficiary or if staff determines that there is a need for additional information and that the delay is in the consumer's interest. Appeals are resolved within 30 calendar days. An extension of 14 days is allowed if requested by the beneficiary or if staff determines that there is a need for additional information and that the delay is in the consumer's interest. Expedited appeals are resolved within 3 days. An extension of 14 days is allowed if requested by the beneficiary or if staff determines that there is a need for additional information and that the delay is in the consumer's interest. If not requested by the beneficiary, written notice of the extension is provided to the beneficiary explaining the reason. A Notice of Action (NOA) is provided if timelines are not met. Notices of Action include information on how to file a State Fair Hearing if desired.

Grievances and Appeals may be filed by mail or verbally by phone. An Appeal filed by phone requires written follow up from the beneficiary. Grievances and Expedited Appeals do not require written follow up. When received, a letter acknowledging receipt is sent to the beneficiary and includes information on rights such as right to be represented by person of their choice, the right to examine the medical record, the right to access Patients' Rights Advocacy Services and the right to present evidence relevant to the Grievance. For Appeals and Expedited Appeals, resolution letters are sent to the client and include the results of the appeal resolution process, the date that the appeal decision was made and if the appeal has not been resolved wholly in favor of the consumer, the notice also contains information regarding the beneficiary's right to a State Fair Hearing and the procedures for filing for a State Fair Hearing. For Appeals, treatment services will continue if the beneficiary makes a request for services to continue within 10 days of receipt of the Notice of Action.

By policy, no consumer or parent/guardian shall be subject to discrimination or any other penalty for filing a Grievance, Appeal, Expedited Appeal or State Fair Hearing. The consumer's legal representative may use the appeals process on the beneficiary's behalf.

Grievance, Appeal, Expedited Appeal and State Fair Hearing documentation will be maintained for a minimum of three years.

13. ***Evidenced Based Practices: how will counties ensure that providers are implementing at least two of the identified based practices? What action will the county take if the provider is found to be in non – compliance?***

All program staffs have been trained in and are required to incorporate, evidenced based practices (EBP) in treatment. HCA BHS RFPs require bidders to identify the EBP's used in their programs and all contract providers will be contractually required to certify the use of at least two HCA BHS approved EBP in their programs.

The EBP most widely used are: Motivational Interviewing, Cognitive Behavioral Therapy, Seeking Safety, Moral Reconation Training, Relapse Prevention, Psycho-education and Mindfulness. Living in Balance by Hazelden is the most recently added EBP. These practices may be used in both individual and group sessions for adults and youth.

All clinicians will be expected to demonstrate knowledge of at least two EBP. The use of EBP will be monitored no less than quarterly by the supervisors and/or contract monitors. The focus will be on

chart notes, treatment plans and training sign-in sheets, as well as through clinical supervision. HCA BHS contract monitors do monthly site visits to contract programs and may randomly attend group sessions to monitor the quality of services. The use of EPB will also be included as part of the quality of care monitoring.

In addition to monthly site visits, HCA BHS conducts a formal annual review of all contract providers, which will include a compliance review of all the DMC-ODS Standard Terms and Conditions.

The HCA BHS training unit currently offers trainings throughout the year on EBP, enabling HCA BHS and contract provider staff to effectively incorporate the primary EBP in treatment. Staff proof of trainings will be required in order to be in compliance. All supervisors are responsible for ensuring their clinical staff has EBP training. Providers may attend BHS trainings or employ/contract with certified trainers. Contract programs will be expected to make additional trainings available to staff experiencing difficulties using EBP, as well as provide coaching and feedback regarding employment of EBP in their practice.

If a contract provider is not compliant with the EBP requirements, HCA BHS will provide technical assistance to resolve the deficiencies, the provider will be required to submit a corrective action plan with a timeframe for completion and its implementation will be monitored by HCA BHS. Continuing deficiencies may result in progressive actions such as delaying payments and finally to contract termination.

14. ***Regional Model. If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question 7)?***

In the southern counties region, all counties have indicated they are opting into the DMC-ODS. As a result, Orange County will not be implementing a regional model. However, for those individuals who live in surrounding counties and receive services in Orange County and vice versa, Orange County will comply with all federal and state *County of Responsibility/Residence* payment requirements. This may include NTP beneficiaries living in one county but working and receiving services in another. However, the most recent DHCS report indicates that beneficiaries are receiving services in the county of responsibility/residence.

15. ***Memorandum of Understanding. Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in Section 152 "Care Coordination" of the STC. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).***

Review Note: The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

- ***Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;***
- ***Beneficiary engagement and participation in an integrated care program as needed;***
- ***Shared development of care plans by the beneficiary, caregivers and all providers;***

- ***Collaborative treatment planning with managed care;***
- ***Delineation of case management responsibilities;***
- ***A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;***
- ***Availability of clinical consultation, including consultation on medications;***
- ***Care coordination and effective communication among providers including procedures for exchanges of medical information;***
- ***Navigation support for patients and caregivers; and***
- ***Facilitation and tracking of referrals.***

Cal Optima is Orange County's sole MCP. HCA BHS and Cal Optima have long standing MOU's and Agreements which contribute to coordinated, comprehensive care for Medi-Cal beneficiaries with co-occurring physical and behavioral health issues. The current MOU for Mental Health Services is being amended to include an addendum for the DMC-ODS. All the required elements as set forth in the STC have been reviewed and discussed by Cal Optima and HCA BHS and are included in the draft Behavioral Health Services MOU Amendment. The MOU is in the review process and will be provided to DCHS as an addendum to Orange County's Implementation Plan, upon final County approval.

16. ***Telehealth Services. If a county chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the county ensure confidentiality? (Please note: group counseling services cannot be conducted through telehealth).***

Telehealth services have been shown to be an effective, cost-efficient alternative to clinic visits that increases patient access to both behavioral health and physical health care. HCA BHS does not currently utilize telehealth services, but is evaluating its benefits, initially for implementation in the Children and Youth BHS county operated clinics. The objective is to determine benefits of providing telehealth clinical services to beneficiaries, using secure hardware and software, for confidential one-to-one video conferencing in a private office setting. BHS IT staff will be actively involved in selecting the appropriate equipment and software to ensure security and compliance with HIPAA and 42 CFR Part 2. Staff will be trained in their roles and responsibilities including: clinical protocols, privacy and security and regulatory requirements.

It is anticipated that a pilot project in the County operated Children and Youth BHS clinics will occur in year one of the demonstration project. It will be evaluated to determine its effectiveness and cost efficiency, increased beneficiary access and satisfaction during the pilot project and may then be considered for implementation in Adult and Older Adult County operated BHS clinics.

17. Contracting. Describe the county's selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

Selective Provider Contracting Process:

The HCA selective contracting process is consistent with requirements in the Orange County Contract Policy Manual, and 42 CFR 438.214. As defined in the County manual: "Human services contracts include all contracts for services that directly maintain or improve the social, economic, physical or mental well-being of persons for whom the County bears such a responsibility. Included in the definition of Human

Services contracts are services provided in response to or in support of federal, state and/or local service mandates to provide health and human services to a target population.

The agencies/departments responsible for providing human services will also be directly responsible for human services contracts, including the responsibility for:
a) issuing solicitations
b) accepting or rejecting proposals
c) developing and administering the proposal evaluation process
d) selecting proposal evaluation committee members, and
e) making the final selection recommendation for contract issuance or forwarding the recommendation to the Board of Supervisors for final selection."

In addition to the Request for Proposal (RFP) process, sole source selections may be made without an RFP for services that are available through only one provider, if approved by the County Procurement Office. In other instances, multiple providers may be selected using a Request for Qualifications methodology. All bidders for services under the DMC-ODS must be DHCS certified Drug Medi-Cal providers.

Contract terms range from one to not more than five years. All contracts valued at over $100,000 require Board of Supervisors approval. Biannual evaluations are conducted to determine program and administrative compliance with contract requirements.

Appeal Process:

The local solicitation protest and appeals process is clearly defined in the Contract Policy Manual, section 1.3, 105-107. The process is included in every RFP released by HCA BHS. Bidders may file a protest of the solicitation or the award of a contract. HCA must respond with a written decision within 10 business days. If not resolved at the Agency level, the bidder may request an appeal with the County Procurement Office, which will make a determination or refer the bidder to the Procurement Appeals Board and notify the bidder of the decision, in writing, within 15 business days. The entire Contract Policy Manual can be viewed at http://olb.ocgov.com. During the Demonstration Project, all current DMC providers that are not selected to contract with the County for DMC-ODS services will also be advised of the DHCS appeals process.

Beneficiary Support:

In the event a current provider does not receive a DMC-ODS contract or if a contract is terminated for any reason, a plan is in place to ensure beneficiaries can continue their treatment, without interruption. Every contract specifies a timeline for non-renewal, termination and close out of an agreement. All referrals to the provider are stopped when a termination date is identified, usually 30 to 90 days prior to contract termination. Those participating in the program, who will complete treatment prior to the contract termination, remain in the program until completion. If continued treatment is needed, the contract provider and HCA BHS collaborate with the beneficiaries to effect transitions consistent with the beneficiaries' best interests. Transition to a different provider may occur prior to the contract termination, but not later than the last date of contracted services. HCA BHS staff identifies available treatment programs and provides linkage services, in conjunction with the contract provider, to outpatient programs or a warm hand off (including transportation) to a residential provider and provide support to the beneficiary during the transition.

These procedures will also be followed in the event a provider directly contracting with DHCS is not selected to contract with the County for their current services.

18. Additional Medication Assisted Treatment (MAT). If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

HCA BHS provides Medication Assisted Treatment (MAT) services, beyond the NTP MAT requirements. Vivitrol is available at two (2) contracted, DHCS certified outpatient providers to probationers and parolees who are on Medi-Cal as well as to all AB109 beneficiaries who meet medical necessity. Beneficiaries must be dependent on opiates and/or alcohol, committed to recovery and actively participating in an outpatient or residential SUD treatment program.

Eligible beneficiaries may begin a Vivitrol course of treatment while in custody, and will receive their injection about a week before scheduled release. Vivitrol is prescribed monthly by the contract provider's physician, in accordance with the protocols established by the Food and Drug Administration, and with the drug manufacturer's instructions. Beneficiaries are required to be randomly drug and alcohol tested at least once each month. AB 109 beneficiaries are assigned an HCA BHS plan coordinator who coordinates care with the contracted providers for residential treatment of up to 90 days or outpatient services for up to six months and maintains close follow-up with beneficiaries receiving Vivitrol. Probationers and parolees on Vivitrol are referred to outpatient services for continued treatment and receive case management services from the provider. Beneficiaries may remain on Vivitrol as long as the prescribing physician determines that it is clinically necessary to maintain sobriety.

During the first two years of the demonstration project, BHS intends to expand MAT to other adult DMC beneficiaries. At a minimum, all treatment providers that do not offer MAT will be required to link beneficiaries to and coordinate care with, MAT providers as appropriate, and in compliance with 42 CFR Part 2 confidentiality regulations. MAT, in conjunction with behavioral health treatment services, will assist in withdrawal management and sustained sobriety.

Medications identified for expanded MAT are:

- Opiate dependence: Suboxone, Naltrexone (short and long acting) and methadone
- Alcohol dependence: Antabuse, Naltrexone (short and long acting), Campral

Physicians, not necessarily in the DMC ODS, will evaluate the beneficiary's needs and identify and prescribe the appropriate medications.

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19. ***Residential Authorization. Describe the county's authorization process for residential services. Prior authorization requests for residential services must be addressed within 24 hours.***

Residential Treatment Services require prior authorization by an HCA BHS Residential Placement Coordinator (RPC) within 24 hours (one business day) of the provider's request. The RPC will maintain and manage a centralized database of available beds, provide oversight of the referral/admission process. There is a two-step authorization process to expedite admission. The first is a preliminary authorization process based upon the initial screening and the second is the authorization for treatment based upon a diagnosis of medical necessity and assessment of the 6 dimensions of the ASAM criteria, completed by the provider's LPHA or MD.

A beneficiary may be initially linked or referred to a residential provider through multiple sources, as described in ***Section 2. Participant Flow.*** These include, but are not limited to, OC Links, the HCA BHS Information and referral line, which will facilitate a "warm hand-off" to a provider; the 24 hour Access Line; and the MCP, which will link or refer beneficiaries to residential providers. Community and county providers may provide information, linkage and referral to programs. In addition, any beneficiary may self-refer to a provider for an initial screening.

Initial Screening:

Providers will screen those referred, using an HCA BHS approved brief screening tool (based on the short ASAM assessment tool developed by UCLA Integrated Substance Abuse Programs) to determine appropriateness for residential treatment. If an individual's screening indicates they are appropriate and ready for residential treatment, providers will send the Treatment Request Authorization Form (TRAF, Attachment III) and screening to the RPC for approval.

During the screening process, if the provider determines that a beneficiary's appropriate level of care is other than residential treatment, the provider shall refer the beneficiary to other treatment options or resources. Beneficiaries will be able to file a grievance, and/or request a second opinion if they disagree with the result of the initial screening. See **Section 12 Quality Improvement** for additional information.

Preliminary Authorization:

Using the centralized referral list, the RPC will identify and designate the appropriate residential treatment provider. Individuals may indicate preference for a specific provider, as long as the level of care is appropriate. Information on the BHS centralized referral list will include: name, date of birth, gender, primary drug of abuse, ingestion method of that drug, and beneficiary's preferred provider.

The RPC will review the TRAF and screening sent by the provider and send preliminary treatment authorization to the designated provider within 24 hours which is no more than one (1) business day. If the designated provider is different from the one which initiated the referral, the RPC will inform the initial provider and the designated provider of the change. The designated provider will inform the beneficiary of the change, initiate the admission process and engage the beneficiary in services.

Engagement:

All residential treatment providers will provide plan coordination services commencing at the initial screening to include motivational interviewing, and will provide and/or link the beneficiary to services that need to be addressed prior to admission, such as detox, medical or mental health services that may be required for clearance into the residential treatment.

Treatment Authorization / Outcome:

The designated treatment provider will send in the completed full ASAM assessment, approved by an LPHA or MD at time of admission or within seven (7) calendar days of admission. The RPC will review the ASAM assessment and send the treatment authorization to designated provider within one (1) business day if the individual's ASAM level of care matches the provider's ASAM designation. A beneficiary may enter program on the weekend or holidays and may have a presumptive authorization. However,

presumptive authorization does not guarantee payment and submissions of claims to Medi-Cal are subject to a client's eligibility. If the beneficiary's assessed ASAM level of care is not the appropriate level of care offered by the provider, the RPC will notify provider and link the beneficiary to an appropriate provider. That provider will contact the beneficiary and admit him/her into their program.

Reauthorization for Continuing Care:

Providers must submit a Treatment Extension Request Form (Attachment IV) prior to the completion of the authorized length of stay, for any beneficiary requiring residential treatment services beyond 90 days for adults and 30 days for youth. Reauthorization approval or denial will be made within one (1) business day of the provider's submission of a request and re-assessment completed by the provider's LPHA or MD.

20. One Year Provisional Period. For counties unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the DMC-ODS. Include in the description the phase-in plan by service or DMC- ODS requirement that the county cannot begin upon implementation of their Pilot. Also include a timeline with deliverables.

Review Note: This question only applies to counties participating in the one-year provisional program and only needs to be completed by these counties.

Orange County HCA/BHS is not requesting and does not require, a one-year provisional period.

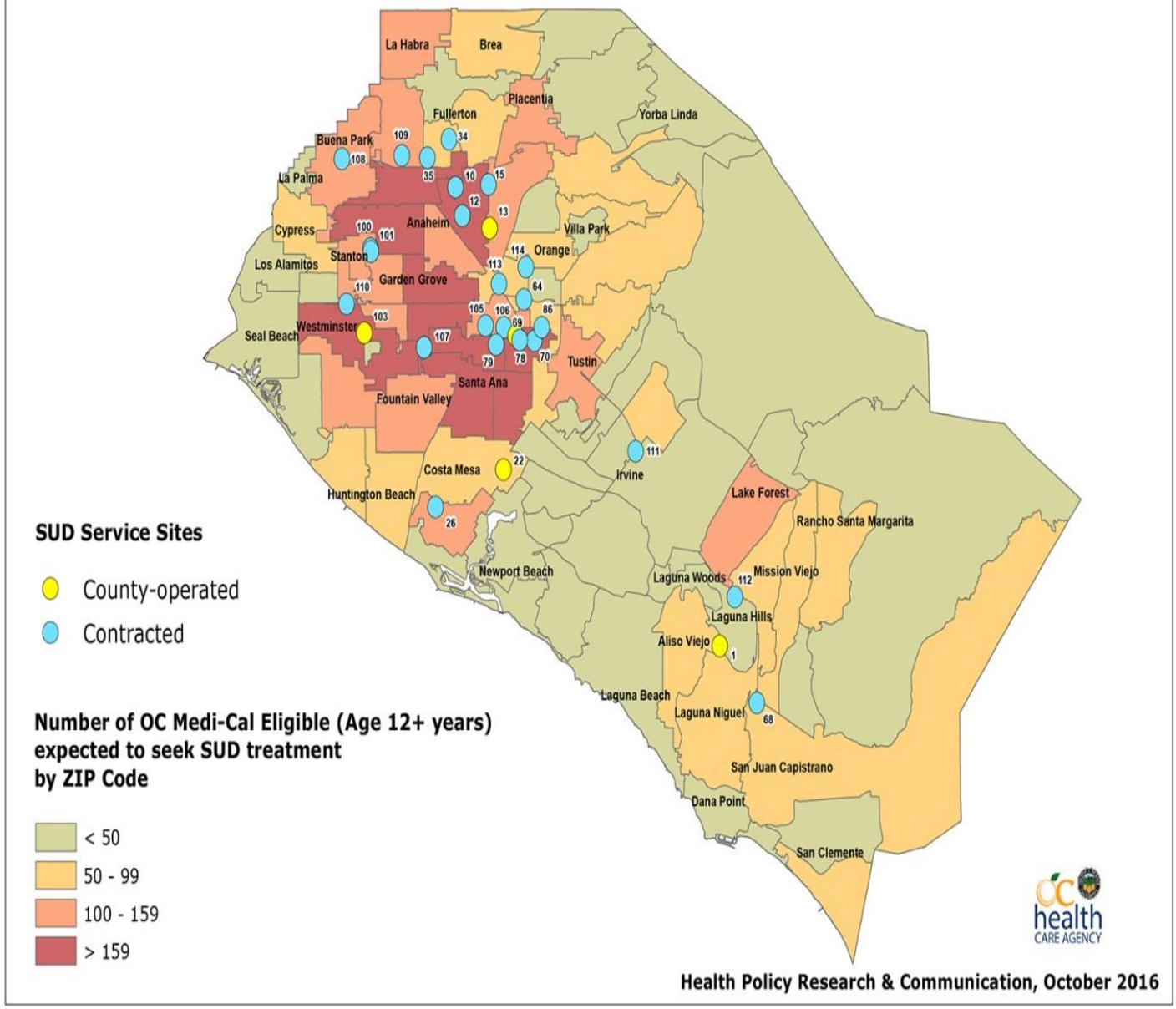
Orange County Authorization

The County Behavioral Health Director (for Los Angeles and Napa AOD Program Director) must review and approve the Implementation Plan. The signature below verifies this approval.

Orange County	10/28/16
_____	_____ _____
Behavioral Health Director Mary R. Hale, MS, CHC	Orange County	Date

Attachment I

BEHAVIORAL HEALTH - SUBSTANCE USE DISORDER (SUD) SERVICE SITES AND NUMBER OF OC MEDI-CAL BENEFICIERIES EXPECTED TO NEED/SEEK SUD TREATMENT



OC Health Care Agency Behavioral Health Services
SUD Treatment Providers

Attachment II

Provider Name	Location Address	Hours of Operation	Populations Treated	MAT	PT. Count	Capacity	DMC Certified*
Methadone Maintenance/NTP Withdrawal Management							
Western Pacific Rehabilitation	10751 Dale Ave, Stanton, CA 90680	M-F 5:30am-12:30pm Wkend 5:45am-9:30am	Co-ed Adults	Methadone	432	450	Y
Western Pacific Rehabilitation	218 E. Commonewealth Ave., Fullerton, CA 92832	M-F 5:00am-1:45pm Wkend 5:00am-12pm	Co-ed Adults	Methadone	501	500	Y
Withdrawal Management							
BHS / American Recovery Center	2180 West Valley Boulevard, Pomona, CA 91768	24/7	Inpatient, Co-ed Adult		n/a	50	
BHS / Tom Redgate Memorial Recovery Center	1775 Chestnut Avenue, Long Beach, CA 90813	24/7	Inpatient, Co-ed Adult		n/a	20	
Roque Center Detox	10936 Dale Ave., Stanton, CA 90680	24/7	Residential Co-ed Adult		18	24	
Woodglen Detox	771 W. Orangethorpe, Fullerton, CA 92832	24/7	Residential Co-ed Adult		4	6	
Adult Residential Treatment							
Straight Talk / Gerry House	1225 W. 6th St., Santa Ana, CA 92703	24/7	HIV+ or Opiate, Co-ed	link	10	12	
Hope House	707 N. Anaheim Blvd., Anaheim, CA 92805	24/7	Co-ed		46	56	
CHCADA / Casa Elena Recovery Home	832 S. Anaheim Blvd., Anaheim, CA 92805	24/7	Women, Latina Focused.		6	6	
Cooper Fellowship	409 N. Cooper, Santa Ana, CA 92703	24/7	Co-ed Methodone Friendly	link	15	60	
Phoenix House	1207 E. Fruit Street, Santa Ana, CA 92701	24/7	Gender segregated program. Also serve HIV+, or Opiate	link	56	86	Y
The Villa Center	910 N. French St., Santa Ana, CA 92701	24/7	Female Only		18	25	
Woodglen Recovery	771 W. Orangethorpe, Fullerton, CA 92832	24/7	Co-ed.		18	40	
SCADP / Heritage House South	2212 Placentia Ave., Costa Mesa, CA 92627	24/7	Perinatal	link	16	16	Y
SCADP / Heritage House	321 N. State College Blvd., Anaheim, CA 92806	24/7	Perinatal	link	19	21	Y
Awakenings	12322 Clearglen Ave., Whittier, CA 90604	24/7	Deaf and Hard of Hearing	as needed			
Adolescent Residential							
Social Model Recovery Systems, Touchstones	525 N. Parker St., Orange, CA 92868	24/7	Co-ed.		19	22	
Outpatient Treatment Contract Providers							
Associates in Counsling, Inc. (ACM)	960 W. 17th Street, Suite B&C, Santa Ana, CA 92701 - Main Office	M-F 9am-9pm	Co-ed Adult		35	125	
Associates in Counsling, Inc. (ACM)	25201 Paseo De Alicia, Suite 100, Laguna Hills, CA 92653	M-F 9am-9pm	Co-ed Adult		35	125	
Associates in Counsling, Inc. (ACM)	265 S. Anita Dr., Suite 117 Orange, CA 92868	M-F 9am-9pm	Co-ed Adult		35	125	
The Gary Center Vista Community Clinic	1525 E. 17th Street, Santa Ana, CA 92705	M 9am-9pm, Tues.-Sat. 9am-5:30pm	Co-ed Adolescents , Adults		76	95	Y
Mariposa Women & Family Center	812 Town & Country Rd., Orange Ca 92686	M-Thur. 9am-9pm, Fri 9am-5pm, Sat. 9am-3pm	Women		50	65	Y
Mariposa Women & Family Center	29222 Rancho Viejo Rd., San Juan Capistrano, CA 92675	M, W, Th 8:30-5:00; T 8:30-9:00pm, F 8:30-6:00	Women		3	30	
La Familia	1905 North College Ave, Santa Ana, CA 92703	M-F 8-5, M & Tues. Groups 6pm-7:30pm	Co-ed Adult, Latino focused		20	430	Y
Korean Community Services (KC Services)	1060 S. Brookhurst Rd., Fullerton, CA 92833	M-F 9am-10:00pm	Co-ed Adult				Y
KC Services	7281 Garden Grove Blvd., Suite H, Garden Grove, CA 92841	M-F 9am-10:00pm	Co-ed Adult		250	500-700	Y
KC Services	14795 Jeffrey Rd., Suite 207, Irvine, CA 92618	M-F 11:00am-10:00pm	Co-ed Adult				Y
KC Services Health Center	7212 Orangethorpe Ave., Suite 9A, Buena Park, CA 90621	M-F 9am-5:30pm	Co-ed Adult	Y	150		
Phoenix House	1207 E. Fruit Street, Santa Ana, CA 92701	M-Thur. 12pm-8pm, Fri. 9:30am-8pm, Sat. 8am-4pm	Co-ed Adult	Y	25	75	Y
County Outpatient Clinics							
Anaheim Clinic	2035 E. Ball Road, Anaheim, CA 92806	M-Thur. 8am-6pm, F 8am-5pm, 1 evening/week	Perinatal, Co-ed Adults		93	165	
Youth	2035 E. Ball Road, Anaheim, CA 92806	M-Thur. 8am-6pm, F 8am-5pm, 1 evening/week	Co-ed Youth		40	33	
North Drug and DUI Court	2035 E. Ball Road, Anaheim, CA 92806	M-Thur. 8am-6pm, F 8am-5pm, 1 evening/week	Co-ed Adult		90	150	
Aliso Viejo Clinic	5 Mareblu, Aliso Viejo, CA 92656	M-Thur. 8am-6pm, F 8am-5pm, 1 evening/week	Perinatal , Co-ed Adults		88	135	
South Drug and DUI Court	5 Mareblu, Aliso Viejo, CA 92656	M-Thur. 8am-6pm, F 8am-5pm, 1 evening/week	Co-ed Adult		30	50	
Costa Mesa Clinic Harbor Drug Court	3115 Redhill Ave., Costa Mesa, CA 92626	M-Thur. 8am-6pm, F 8am-5pm, 1 evening/week	Co-ed Adult		30	50	
Youth	3115 Redhill Ave., Costa Mesa, CA 92626	M-Thur. 8am-6pm, F 8am-5pm, 1 evening/week	Co-ed Youth		35	33	
Santa Ana Clinic	1200 N. Main St., Santa Ana, CA 92701	M-Thur. 8am-6pm, F 8am-5pm, 1 evening/week	Perinatal , Co-ed Adults		92	195	
Central Drug and DUI Court	1200 N. Main St., Santa Ana, CA 92701	M-Tues-Fri 8am-5pm Thurs. 8am-6pm, 1 evening/week	Co-ed Adult		240	350	
Youth	1200 N. Main St., Santa Ana, CA 92701	M-F 8-5, 1 evening/week	Co-ed Youth		35	33	
Westminster Clinic	14140 Beach Blvd., Westminster, CA 92683	M-Thur. 8am-6pm, Fri 8am-5pm, 1 evening/week	Perinatal , Co-ed Adults		107	135	
West Drug and DUI Court	14140 Beach Blvd., Westminster, CA 92683	M-Thur. 8am-6pm, Fri 8am-5pm, 1 evening/week	Co-ed Adult		90	90	
Youth	14140 Beach Blvd., Westminster, CA 92683	M-Thur. 8am-6pm, Fri 8am-5pm, 1 evening/week	Co-ed Youth		33	33	
Recovery Maintenance Services							
Phoenix House	1207 E. Fruit Street, Santa Ana, CA 92701	M-Thur. 12pm-8pm, Fri. 9:30am-8pm, Sat. 8am-4pm	Co-ed Adult		195	600	Y

Orange County Health Care Agency
SUD Residential Treatment (Adult Only)
Treatment Referral and Authorization Form (TRAF)

A. Client Information

Client Last Name: _____ First Name: _____

Client Phone Number: _____ (If homeless & no phone #, pls indicate alternative contact person & phone #)

DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Transgender (pls circle: MTF / FTM)

Specific Program Request: _____ (Note: Client can enter treatment faster if not requesting specific program)

Reason requesting for specific program: _____

Previous residential treatment ☐ Yes ☐ No If yes, when _____ where _____

Current Medications (e.g. psy, benzos, opiates) _____

Client's ASAM level of care (LOC) based on screening: _____

Special Status: (*check all that apply*) **Pregnant women are a priority.**

☐ Pregnant ☐ Injection Drug User ☐ HIV+ ☐ Opiate User ☐ Perinatal

☐ MAT (Medication Assisted Treatment, e.g. Methadone, Vivitrol, Suboxone), pls specify: _____

☐ In Detox (Medical/Social, wants residential treatment, planned exit date: _____) ☐ AB109 ☐ Co-Occurring

☐ In-Custody (Planned release date: _____ Release of Info attached ☐ Yes ☐ No Minute Order attached ☐ Yes ☐ No)

☐ Non-English Speaking (pls specify primary language: _____)

B. Referring Program Information

Date of Referral: _____

Referring Program: ☐ Casa Elena ☐ Cooper ☐ Gerry House ☐ Hope House ☐ Phoenix House ☐ Villa ☐ Woodglen Recovery
☐ Heritage House ☐ Heritage House South ☐ Roque ☐ Woodglen Detox ☐ Redgate ☐ ARC ☐ Collaborative Court

Estimated wait time for this provider to admit this client: _____ days (For Residential Provider Only)

Referring Person: _____ Email Address #: _____

Phone #: _____ Fax #: _____

C. Treatment Pre-Authorization (For County use only)

☐ Pre-approved for up to 90 days at ☐ Casa Elena ☐ Cooper ☐ Gerry House ☐ Hope House ☐ Phoenix House ☐ Villa ☐ Woodglen

☐ Pre-approved for Up to 180 days at ☐ Heritage House ☐ Heritage House South

☐ County Bed ☐ Dedicated Bed (Detox) ☐ MAT ☐ HIV+ ☐ Other _____

County Authorized signature: _____Date: _____

D. Treatment Outcome (For Authorized Provider use only)

☐ Date of entry: _____ ASAM LOC: _____ ASAM Attached: ☐ Yes ☐ No

☐ Date Remove from Waitlist:_____ Reason: ☐ Unable to Locate ☐ Declined Service ☐ Receive Other Services

☐ Moved out of County ☐ Incarceration ☐ Hospitalization ☐ Private Insurance ☐ Other: _____

Counselor signature: _____ Date: _____

E. Treatment Authorization (For County use only)

☐ Treatment Authorization **Granted** ☐ Treatment Authorization **Denied**, Reason: _____

County Authorized signature: _____ Date: _____

PLEASE FAX THIS FORM TO (714) 667-3968 OR SEND IN SECURED EMAIL TO TAUTHORIZATION@OCHCA.COM

Residential Placement Coordinator Phone Number: (714) 834-3413

Orange County Health Care Agency
SUD Residential Treatment (Adult Only)
Treatment Extension Request and Authorization (TERA)

C. Treatment Extension Request

Client Last Name: _____ First Name:_____ DOB: _____

Date of Entry: _____ Planned Discharge Date: _____ # of Additional Days Requested: _____

If prior treatment extension grant: Date of Authorization: _____ # of Days Authorized: _____

Client's Progress in Treatment (Treatment Plan Attached): _____

_____

_____

Specific Reasons for Requesting Treatment Extension: _____

_____

_____

_____

_____

_____

_____

D. Program Information

Date of Extension Request: _____

Program Requesting Treatment Extension: _____

Referring Person: _____ Email Address #: _____

Requested Counselor Signature:_____ Phone #: _____

C. Treatment Extension Authorization (For County use only)

☐ Treatment Extension **Approved,** for _____ days Date from _____ Date to _____

☐ Treatment Extension **Denied**, Reasons:_____

_____

Recommendations: _____

_____

County Authorized signature: _____ Date: _____

Note:

1. Send this completed form to Residential Placement Coordinator at least 14 calendar days before planned discharge date
2. Attach client's treatment plan and any important supporting document

PLEASE FAX THIS FORM TO (714) 667-3968 OR SEND IN SECURED EMAIL TO TAUTHORIZATION@OCHCA.COM

Residential Placement Coordinator Phone Number: (714) 834-3413

Request for Extension of SUD Residential Treatment

- Provider shall submit a completed "Treatment Extension Request and Authorization" Form (TERA) to County Residential Placement Coordinator (RPC) at least 14 calendar days before client's planned discharge date
- Providers shall summarize client's treatment progress, specify the reasons for requesting treatment extension, and attach client's treatment plan and any supporting document (e.g. re-assessment) to the TERA
- Only one-time extension of up to 30 days can be authorized in a 12-month period
- RPC shall review the extension request and inform providers if the extension request is approved or denied