



**Drug/Medi-Cal Organized Delivery System  
(DMC-ODS) Waiver**

**County Implementation Plan**

**Submitted By:  
Ventura County Behavioral Health Department**

**June 2016**



## **Drug Medi-Cal Organized Delivery System Implementation Plan For Ventura County Behavioral Health**

The county implementation plan will be used by the Department of Health Care Services (DHCS) and the Center for Medicaid and Medicare Services (CMS) to assess the county's readiness to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The implementation plan will also demonstrate how the county will have the capacity, access and network adequacy required for DMC-ODS implementation. The questions contained in this plan draw upon the Special Terms and Conditions and the appropriate CFR 438 requirements. DHCS and CMS will review and render an approval or denial of the county's participation in the Waiver based upon the initial and follow-up information provided by the counties.

### **Table of Contents**

- Part I      Plan Questions**  
This part is a series of questions regarding the county's DMC-ODS program.
- Part II      Plan Description: Narrative Description of the County's Plan**  
In this part, the county describes its DMC-ODS program based on guidelines provided by the Department of Health Care Services.

### **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) Behavioral Health Advisory Board

2. How was community input collected?

- Community meetings
- County advisory groups
- Focus groups
- Other method(s) (explain briefly)

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: Quarterly in first year, bi-annually thereafter

Review Note: One box must be checked.

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 under this 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.

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

The county toll free 24/7 number was established on March 9, 2016. The toll free line is (844) 385-9200.

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 STCs.

Yes (required)

No

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

- Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and 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 PLAN DESCRIPTION (Narrative)**

In this part of the plan, the county must describe DMC-ODS implementation policies, procedures, and activities.

### General Review Notes:

- Number responses to each item to correspond with the outline.
- Keep an electronic copy of your implementation plan description. After DHCS and CMS review the plan description, the county may need to make revisions. When making changes to the implementation plan, use track changes mode so reviewers can see what has been added or deleted.
- Counties must submit a revised implementation plan to DHCS when the county requests to add a new level of service.

## **Narrative Description**

- 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.

The collaborative process utilized to develop this DMC-ODS Implementation Plan by Ventura County Behavioral Health included community input from Stakeholder Forums and workgroup meetings. The Stakeholder process consisted of seven meetings from October 2015 through February 2016, and bi-monthly planning committee meetings beginning July 2015. The planning committee identified a list of groups and individuals that the committee believed had a role or contribution to make in drafting the plan. Participants of the Stakeholder Forum signed up for four workgroup meetings to focus on specific sections of the plan. These consisted of the following: 1) Adult Substance Use Disorder Services Stakeholder Workgroup 2) Adolescent Substance Use Disorder Services Stakeholder Workgroup 3) Residential Substance Use Disorder Services Stakeholder Workgroup and 4) Fiscal/Technology/ Substance Use Disorder Services Workgroup. The Stakeholder committee will continue to meet on a quarterly basis during the planning process. Each meeting included a presentation overview of the DMC-ODS Waiver process and progress so far. Recommendations for future information and input was discussed, and a worksheet was used to solicit feedback on the key required components of the waiver. One-on-one in person meetings were held with key stakeholders in addition to regularly scheduled meetings, and will occur on an ongoing basis as needed throughout the planning process.

The Drug/Medi-Cal Organized Delivery System Waiver (DMC-ODS) website page was created on the VCBH Alcohol and Drug Programs website [venturacountylimits.org](http://venturacountylimits.org) to serve as an online website portal for public postings, Stakeholder Forum and Workgroup meeting flyers, agendas, presentations and links to the DMC-ODS website.

Stakeholder Forum feedback was compiled and posted on the website. The following County agencies and other entities were involved in developing the County Plan:

Ventura County Behavioral Health, Mental Health Services	Ventura County Behavioral Health Advisory Board (BHAB)
Ventura County Behavioral Health, Alcohol and Drug Programs	Law Enforcement, Ventura County Sheriff's Office
SUD Treatment Providers	Ventura County Public Health Department
Youth Treatment Services Providers	Ventura County Social Services, Human Services Agency
Medi-Cal Managed Care Plan (Gold Coast Health Plan)	County Executive Office
Physical Health Care Providers, Ventura County Health Care Agency	Ventura County Superior Court
Ventura County Probation Department	Ventura County Office of Education
Health Information Technology Stakeholders	NAMI Ventura County

Communication will continue to occur with Stakeholders throughout the planning process through this website portal, publications postings, meeting announcements, county updates and planning timelines, in order to ensure effective and timely communication during this process.

**2. Client Flow.** Describe how clients 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 clients 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.

Ventura County operates two systems of care for substance use disorder (SUD) treatment services, one for adults and one for adolescents. Services are provided through contracts with community-based State certified SUD treatment programs and the county-operated outpatient programs for men and women. (*See Client Flow Chart Attachment*)

## Referral

Ventura County will develop a centralized referral process with a “Right Care at the Right Time” philosophy for qualified persons who meet Substance Use Disorders (SUD) treatment criteria. Referrals are accepted from all sources including, but not limited to, probation, primary care clinics, mental health clinics, other county departments, criminal justice and juvenile justice agencies, Children and Family Services, and self-referrals. Regardless of the entry point, each individual is screened following the same process and screening tools. The centralized referral process receives referrals via telephone, fax, e-mails and routes referrals to geographically appropriate clinics, services or client’s preference. All individuals seeking SUD treatment can access services by contacting the centralized referral process, the 24/7 Access Line or by contacting any network provider and requesting admission. All materials for referral to services will be identical and processes will be similar regardless of location and language.

## Assessment

An individual referred for services will participate in a screening interview to determine Medi-Cal eligibility status. An initial SUD assessment is conducted using the Substance Abuse Subtle Screening Inventory (SASSI), Alcohol and Drug History, Medical History, Clinical Interview and the American Society of Addiction Medicine (ASAM) criteria, resulting in a provisional level of care (LOC) placement. Once assessed, the individual will be referred/linked to the appropriate ASAM LOC. Placement considerations include findings from the screening, assessment, geographic accessibility, threshold language needs, and the individual’s preference. Staff performing screening and assessment may refer individuals directly to any SUD network provider. The screening will be completed by Licensed Practitioners of the Healing Arts, which may include Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselor (LPCC) and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians. This also includes certified SUD counselors. Once the individual has completed the initial assessment process and it is confirmed that SUD treatment may be appropriate, the individual will be offered an intake appointment at a provider location of the individual’s choosing within the parameters of the ASAM criteria. Based on our current timeline, the average length of time from the initial assessment to an intake appointment is approximately 5 to 7 days.

## Authorization

All SUD providers will verify Medi-Cal eligibility and complete a comprehensive assessment at intake. After administering a paper SASSI, gathering medical history, administering the ASAM Worksheet Version and doing a structured clinical interview, all of these criteria will be applied to determine the appropriate level of treatment, length of stay and diagnosis. (Once the DHCS transitions to the implementation of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) we will revisit the use of a more current version of the ASAM assessment). We are currently using the Short Version ASAM Worksheet. When a county contracted provider conducts the initial eligibility determination, it will be reviewed and approved by the county prior to payment for services. Medical necessity for services must be determined as part of the intake

assessment and will be performed through a face-to-face review or via telehealth. The Medical Director, a licensed physician, or a Licensed Practitioner of the Healing Arts (LPHA), must diagnose the individual as having a least one DSM Substance-Related and Addictive Disorder. A qualifying diagnosis for an individual under the age of 21 includes an assessed risk for developing a SUD. All providers must document the diagnosis in the client chart and indicate how the client meets the ASAM Criteria definition for services. *(See Network Provider Admission Process Attachment and ASAM Worksheet Version Attachment)*.

Should it be determined that the client requires a change in the LOC during the course of treatment, the current treatment provider will assist the client in transferring to the appropriate LOC within the provider network by making a referral to another treatment program or requesting assistance from the centralized referral process/care coordination. If authorization is needed for admission to residential treatment services, the residential treatment provider accepting the client will request county authorization prior to admitting the client. *(See Network Provider Admission Process Attachment)*

#### Treatment Services Determination/Placement

As a client progresses through treatment, the treatment plan for adults will be updated at least every 90 days for outpatient services and 30 days for residential services unless there is a change in treatment LOC or a significant event that requires a new treatment plan. For adolescents, the treatment plan will be updated at least every 90 days for outpatient services and weekly for residential services, unless there is a change in treatment LOC or a significant event that requires a new treatment plan. As a client progresses through treatment, the corresponding treatment plan will be reviewed and adjusted accordingly. If a client's condition does not show improvement at a given LOC or with a particular intervention, then a progress review, abbreviated assessment, and treatment plan modification will be made in order to improve therapeutic outcomes.

#### Transition to Levels of Care

All transitions to levels of care are managed via the care coordination and treatment staff from the levels involved, and the assigned clinician from VCBH. The County staff are trained in care coordination and engagement. The AVATAR system will be used to track the episode, containing all levels of treatment in which the client participates. Information Technology needs have been identified, and enhanced ability to seamlessly track the transition of individuals to a new level of care are being developed. A client can be assigned to a higher or lower level of care according to clinical assessment and identified needs. Clients' needs, clients' preferences, clinical team assessment, and medical necessity will determine level of care provided. Each transition will be accompanied by a justification to continue treatment and a treatment plan defining and describing the goals and timeline.

#### Re-Assessment

Re-Assessments allow the treatment team to review client progress, comparing the most recent client functioning and severity to the initial assessment and to evaluate the

client's response to treatment services. Each ASAM dimension is reviewed to determine the current level of functioning and severity. Providers are required to demonstrate that clients continue to meet current LOC criteria or determine that an alternative is most appropriate. All clients will be reassessed any time there is a significant change in their status, diagnosis, a revision to the client's individual treatment plan, and as requested by the client. Providers will reassess for medical necessity and appropriate LOC within the maximum time frames noted below:

<b>Level of Care</b>	<b>Reassessment Timeframe Maximum</b>
Residential Detoxification, Level 3.2	5 days, 3 days, 1 day, thereafter
Residential Treatment, Levels 3.1, 3.3,3.5	30 days
Intensive Outpatient, Level 2.1	90 days
Outpatient Treatment, Level 1	90 days
Narcotic Treatment Programs	1 year
Medication Assisted Treatment	1 year
Recovery Services	6 months
Case Management	Evaluate as part of above service modalities

### Continuing Care

Discharge planning is an integral component of the treatment process and begins at the time of admission. Care Coordination services will help assure clients move through the system and access other needed health and ancillary services to support their recovery. As clients complete primary treatment, they are connected to medically necessary recovery services to build connections with the recovery community and to continue to develop self-management strategies to prevent relapse. Recovery services are available to clients whether they are triggered, have relapsed, or as a preventive measure to prevent relapse. Processes to prepare the client for return or re-entry into the community includes recovery coaching and monitoring via telephone/telehealth, peer-to-peer services and relapse prevention, linkages to essential supportive services such as education, employment and training, housing, benefit enrollment, family support, community self-help and faith-based support groups and other human services as indicated at assessment and during the treatment process. Clients who no longer meet medical necessity criteria for SUD treatment services, or prematurely exit the SUD system of care, will receive recovery monitoring services and will re-engage the individual in treatment if needed. If a client does relapse, peer coaches can quickly reconnect the client to treatment for further care. The Access Line staff and SUD network providers can all redirect clients to more intensive care in the event of crisis or relapse.

The Medical Director, a licensed physician, or a Licensed Practitioner of the Healing Arts (LPHA), must diagnose the individual as having a least one DSM Substance-Related and Addictive Disorder. A client can be assigned as needed to a higher or lower level of care, bypassing the immediately subsequent level according to need and clinical

assessment. All such decisions will consider client's needs, client's preference, clinical team assessment, and medical necessity. Each transition will be accompanied by a justification to continue treatment and a treatment plan defining and describing the goals and timeline for such. Should it be determined that the client requires a change in the LOC during the course of treatment, the current treatment provider will assist the client in transferring to the appropriate LOC within the provider network by making a referral to another treatment program or requesting assistance from the Care Coordination services. If authorization is needed for admission to residential treatment services, the residential treatment provider accepting the client will request county authorization prior to admitting the client. *(See Network Provider Admission Process Attachment)*

We will ensure the successful care transitions for high-utilizers or individuals at risk of unsuccessful transitions. For example, for *Withdrawal Management Services (ASAM Levels 1-WM, 3.2-WM)*, discussed under section #4, Treatment Services, this level of care may be provided post assessment. Use of a Care Coordination tool, such as "LACE" or "FIT" will allow the Care Coordination team to calculate clients at high risk for readmission. Use of an efficient tool will allow Care Coordination staff to calculate readmission risk based on length of stay, acute readmission through emergency room visits (prior overdose, and critical drug related health consequences), and co-morbid mental health and physical health consequences related to or exacerbated by drug and alcohol use. Post-risk assessment, high scores will prompt care coordination services to ensure clients receive additional support services to address identified risk, thereby mitigating the risk of readmission.

*This is a place holder for the Client Flow Chart, Network Provider Admission Process, and ASAM Worksheet Version).*

- 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.

VCBH established a 24-hour toll free number that beneficiaries can call to access services, on March 9, 2016. The toll free line is (844) 385-9200. The toll free number is offered to provide general information about services, locations, and phone number to clinic locations. Services will be offered in English and Spanish.

The Beneficiary Access Line will have the capability to capture basic data such as number of calls received and answered, abandonment rates, etc. Reports will be

developed to track volume of calls and customer service responses. The county will determine how to enable data collection and reporting, and it is expected that there will be data collection systems in place by the end of Implementation Year 1. The following data to be collected will include, but not be limited to:

- ✓ Number of calls received, including the date, time and length of call
- ✓ Number of calls requesting/requiring non-English translation
- ✓ Number of calls that are determined to be emergency, urgent and routine
- ✓ Rate of unanswered calls
- ✓ Rate of call abandonment
- ✓ First available (first available appointment offered to the individual) and first scheduled (appointment time that the individual selects) appointment times for face-to-face assessments
- ✓ Number of individuals screened and referred to DMC-ODS services, including the ASAM Level of Care of the referral
- ✓ Number of individuals screened
- ✓ Number of referrals to treatment

The access line will be listed on all marketing materials for services within the county, including print and online sources. The access line will be on all county websites and resource listings. This line will be given out at all county provider locations. Additionally, the 24/7 number will be added to the 211 Informational and Referral Services, managed by Interface Services, as well as verbally announced at all VCBH presentations. The access line will be toll-free, functional 24/7, accessible in English and Spanish and ADA-compliant (TTY).

**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.

Recovery services and Physician Consultation will be provided on day one. See below under the Recovery Services and Physician Consultation Sections.

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.

As demonstrated in the *Adult Admissions Criteria Crosswalk*, the county collaborates with a variety of treatment providers. It should be noted that we do not consider high intensity services, for example medically managed withdrawal services, as stand-alone services, rather as a continuum of services. Integrated care with primary care and mental health services occur either with concurrent treatment, referral to the Integrated Dual Diagnosis Treatment (IDDT) program when the primary presenting problem is a serious mental illness and the secondary diagnosis is substance use, or co-occurring treatment in the county clinics. These service linkages and partnerships are possible with formal MOUs and cross collaboration agreements, staff that are trained to facilitate admission assessments, and shared tools for SUD assessments. The on-going involvement of a Care Coordinator involves clear responsibility to continually assess treatment as medically necessary regarding the level of care, length of the treatment episode, and modifications to the treatment plan that is shared with the rest of the treatment team. (*See Adult Admissions Criteria Crosswalk Attachment*)

The benefits offered to adolescents differ from the adult continuum of care regarding special requirements for informed consent, including parental involvement for an out-of-home placement. (Level 3 &4) (*See Adolescent Admissions Criteria Crosswalk Attachment*)

We understand that counties surrounding Ventura County are opting into the Drug Medi-Cal Organized Delivery System, therefore it will not be necessary to coordinate a plan to limit disruption of services for beneficiaries who reside in a neighboring opt-out county.

### Recovery Services

VCBH will have the capacity to provide recovery services on day one. Recovery services are important to the beneficiary's recovery and wellness. As part of the assessment and treatment needs of Dimension 6. Recovery Environment of the ASAM Criteria, and during the transfer/transition planning process, beneficiaries will be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse. Recovery services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community. The Recovery Services planning is part of the beneficiary's discharge planning process through the transition from treatment to recovery. In Year 1, the County will design the following support services for all providers:

- Outpatient counseling services, relapse prevention services, support groups
- Recovery monitoring, recovery coaching, support groups and relapse prevention
- Substance Abuse Assistance, peer-to-peer services
- Linkages to County services, life skills, employment services, education services, job training
- Family Support, linkages to childcare, parent education, child development resources, family/marriage education and support

- Support Groups, linkages to self-help groups, faith-based support
- Ancillary Services, linkages to County support services with housing assistance, transportation, case management and individual services coordination, health care, economic resources

A. Early Intervention (ASAM Level 0.5)

VCBH ADP will assist, as needed, in providing technical assistance training to primary care clinics and other medical providers on the SBIRT model of care, as is required by the ACA. *Barriers: Currently no barriers have been identified.*

B. Outpatient Services (ASAM Level 1.0)

VCBH ADP provides outpatient services to both adults and adolescents through a continuum of county clinics and contracted providers. This level of care consists of less than nine (9) hours per week for adults, and six (6) hours per week for adolescents. The network of care for this service level includes assessment, treatment planning, individual and group counseling, collateral sessions, discharge planning and care coordination. These services may be provided in person at an established clinic, community based setting, school setting and/or using telehealth. Note: As stated elsewhere, if clients/potential clients self-refer to this level of care, the network provider may provide their own screening and assessment, with a request for authorization and documentation establishing that treatment at the outpatient level is a) adequate and b) medically necessary. After administering a paper SASSI, gathering medical history, administering the ASAM Worksheet Version and doing a structured clinical interview, all of these criteria will be applied to determine the appropriate level of treatment, length of stay and diagnosis. This level of care, ASAM Level 1, is determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized treatment plan. As with all ASAM Levels of Care, this is an ASAM assessment, and may be done by the network provider. (*See Network Provider Admission Process Attachment*). *Barriers: In the county, we have most treatment spots in ASAM level 1.0. Growth in some of the other levels of care may require the re-allocation of staff and resources from this level of care.*

C. Intensive Outpatient Services (ASAM Level 2.1)

The IOP level of care will be provided for by county clinics as well as contracted service providers. This will be considered a step down level of care in the continuum of care at locations throughout the County of Ventura. When IOP is medically necessary using the common screening, assessment and placement tools indicated in the *Network Provider Admission Process*, treatment will consist of between 9 and 19 hours of treatment per week. These services include assessment, treatment planning, group and individual counseling sessions, physician consultation, collateral services, treatment planning, discharge planning, and care coordination. These services may be provided at established certified sites, school settings, community based settings and/or using telehealth. As with the outpatient level of care, clients/potential clients self-refer to this level of care, and the network provider may provide their own screening and assessment, with a request for authorization and documentation establishing that

treatment at the outpatient level is a) adequate and b) medically necessary. After administering a paper SASSI, gathering medical history, administering the ASAM Worksheet Version and doing a structured clinical interview, all of these criteria will be applied to determine the appropriate level of treatment, length of stay and diagnosis. This level of care, ASAM Level 2.1, is determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized treatment plan. As with all ASAM Levels of Care, this is an ASAM assessment, and may be done by the network provider. *(See Network Provider Admission Process Attachment)*. *Barriers: Need to increase staff and resources for this level of care. We will require technical assistance from DHCS in regards to the appropriate billing of IOT services.*

#### D. Withdrawal Management Services (ASAM Levels 1-WM, 3.2-WM)

This level of care may be provided post screening by the Centralized Care Coordination Team or VCBH staff. The Care Coordination Team consists of a multiple disciplinary treatment team employed by VCBH. Use of a Care Coordination tool, such as “LACE” or “FIT” will allow Coordinators to calculate clients at high risk for readmission. This tool will allow Care Coordination staff to calculate risk based on such factors as length of stay, acute readmission through emergency room visits (e.g., prior overdose, and critical drug related health consequences), and co-morbid mental health and physical health consequences related to or exacerbated by drug and alcohol use. Post risk assessment, high scores will prompt Care Coordination staff to initiate care coordination services to ensure clients receiving treatment at this level, transition through the continuum of care to prevent readmissions at the same or appropriate level of care. When treatment with withdrawal management services are deemed medically necessary, client services will include assessment, medication assisted therapy, discharge planning, and care coordination. Adolescents and adult clients that require residential withdrawal management will receive treatment in the county when available. This level of care is currently being provided by network service providers. VCBH ADP anticipates the same level of care will be provided under the ODS Waiver Plan. *Barriers: We will need technical assistance from DHCS in the area of cost containment based on medical necessity for this level of care. We will need to determine if we will be allowed to set up regulations to contain costs, including clients who may refuse referrals to the appropriate level of care.*

#### E. Residential Treatment Services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4)

What is currently available in our County? We contract with two providers for residential treatment. We offer a men’s residential treatment program and a women’s residential treatment program. The ASAM LOC is 3.1, 3.3 and 3.5 for these programs.

How will we expand services? We have reached out to an in county provider recently certified to provide ASAM Levels of Care 3.1, 3.5 and 4.0 and this provider was involved extensively with the stakeholder input process. The Requests for Proposals will be posted in February 2017.

What coordination will occur levels 3.7 and 4.0? We currently contract with a provider that offers medically monitored intensive inpatient services. This is a 24-hour nursing care with physician availability for significant problems. The County care coordination team will have the ability to refer clients directly to this program.

As in the case of withdrawal management services, clients receiving treatment at this level of care will enter the system through the Centralized Care Coordination process. Prior authorization for services will occur when Care Coordination deem this level of care necessary to stabilize the client and prevent future readmissions using the assessment tool mentioned above. If residential treatment services are determined to be medically necessary, treatment will be provided at any of our contracted residential providers located throughout the County of Ventura. Residential treatment is a 24-hour, short term service that provides stabilization for adults, perinatal, and adolescent clients. The length of stay ranges from 1-90 days, with one 30-day extension. The 30-day extension requires review by the Central Assessment and Care Coordination staff. Residential treatment includes assessment, treatment planning, individual and group counseling, client education, family therapy, collateral services, crisis intervention, treatment planning, discharge planning and care coordination. All residential network providers will accept clients who are receiving medication assisted treatment. VCBH ADP will provide care coordination services to ensure that clients receive treatment at lower levels of care post discharge from residential treatment. After administering a paper SASSI, gathering medical history, administering the ASAM Worksheet Version and doing a structured clinical interview, all of these criteria will be applied to determine the appropriate level of treatment, length of stay and diagnosis. This level of care, ASAM Level 3, is determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized treatment plan. As with all ASAM Levels of Care, this is an ASAM assessment, and may be done by the network provider. ([See Network Provider Admission Process Attachment](#)).

*Barriers: We will need technical assistance from DHCS in the area of cost containment based on medical necessity for this level of care. We will need to determine if we will be allowed to set up regulations to contain costs, including clients who may refuse referrals to the appropriate level of care. We will need technical assistance regarding how to expand capacity within adult residential programs without displacing our current treatment providers, and determine the RFI process for expansion of residential providers. Capacity for adolescent residential treatment is a barrier now as no adolescent residential treatment provider currently exists. We will be contacting all providers of such services and will be inviting them to participate. Medically necessary residential services will be coordinated for at implementation.*

We will be reaching out to out of county adolescent providers. In our County, we are negotiating with a provider for adolescent residential services if treatment is medically necessary. It is expected that the RFI process for adolescent residential treatment will

begin no later than the 3<sup>rd</sup> quarter of 2017. We project beginning 12 months after the launch of the ODS Implementation plan.

#### F. Opioid (Narcotic) Treatment Program

VCBH ADP contracts with Narcotic Treatment Programs (NTPs), conveniently located throughout the county. These services are provided in addition to other levels of care. Prescribed medications include methadone, buprenorphine, naloxone, and disulfiram, in addition to other medications covered by the DMC ODS MAT schedule.

According to the Centers for Disease Control and Prevention, the United States is in the midst of an opioid overdose epidemic. Opioids (including prescription opioid pain relievers and heroin) killed more than 28,000 people in 2014, more than any year on record. At least half of all opioid overdose deaths involve a prescription medication. Overdoses from prescription opioid pain relievers are a driving factor in the 15-year increase in overdose deaths nationally. Since 1999, the amount of prescription opioids sold in the U.S. nearly quadrupled. *“When you look at the staggering statistics in terms of lives lost, productivity impacted, costs to communities, but most importantly, cost to families from this epidemic of opioids abuse - it has to be something that is right up there at the top of our radar screen.” - President Obama*

Services at this level of care will include assessment, treatment planning, individual and group counseling. Additionally, this level of care includes patient education, collateral services, crisis intervention services and treatment planning, medical evaluation and treatment, and discharge services. When clients are receiving MAT, they may also be receiving services A-E above.

*Possible barriers include staff and contractor biases against ‘replacing one drug with another’ and varying degrees of familiarity with state-of-the-art practice of opioid-dependence treatment. Therefore, staff and contractors will be trained on both the role and the efficacy of MAT.*

#### Case Management Services

Care Coordination (Case Management) is a service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Assessment time is costly, and one area of benefit is the use of Care Coordinators. Using a ‘managed care’ approach, clients will benefit by having their recent assessment move across the continuum of care with them, rather than requiring repeated assessments. We estimate the Care Coordinator ratio to be approximately 60-100 clients per Care Coordinator. All elements of program involvement will be overseen by a Care Coordinator who will work with the specific program and staff. The Care Coordinators are Licensed Practitioners of the Healing Arts and/or certified counselors. A Care Coordinator is a County Staff that will manage client transitions through the levels of care for a beneficiary. They will ensure that the beneficiary will access necessary services as they move through the continuum of care, ensuring responsibility for proper transitions to the next LOC. The county will be responsible for determining which entity monitors the care coordination activities. The entities who will monitor the

care coordination activities will include the VCBH Quality Management team. At the same time, efficient movement to the proper level of care helps to contain costs associated with care provided at higher or lower levels than are medically indicated. A more integrated approach, good care coordination can address the “whole person” needs of the client, expand our reach and capacity within primary care and other specialty care settings, and achieve better long-term outcomes for the client.

The components of care coordination include:

- ✓ Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of care.
- ✓ Transition to a higher or lower SUD level of care.
- ✓ Development and periodic revision of a client plan that includes service activities.
- ✓ Communication, coordination, referral and related activities.
- ✓ Monitoring service delivery to ensure beneficiary access to service and the service delivery system.
- ✓ Monitoring the beneficiary’s progress.
- ✓ Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services.
- ✓ Compliance with confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

All transitions between higher and lower levels of care will involve professional Care Coordination services as part of a Care Coordination team. This team is described in section #2. Client Flow and See #4 Treatment Services, Withdrawal Management Services (ASAM Levels 1-WM, 3.2-WM).

### Physician Consultation

VCBH has a medical director that is available for consultation. We have psychiatrists, pharmacist, and addiction medicine physician within VCBH. We will also make sure that all contract providers will have physicians available for physician consultation as part of their contracts. Therefore, starting in Year 1, the Behavioral Health Medical Director will provide physician consultation to all DMC providers and clinics in order to provide expert services to all of our DMC ODS SUD clients. The Medical Director, or the designated physician will address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. If and when necessary, providers and the county may contract with one or more physicians or pharmacists in order to provide consultation services.

### Treatment Services Process

Key features of our treatment services include:

- ✓ Each center, clinic, and service provider processes any and all referrals regardless of origin.
- ✓ An appointment for orientation and/or assessment is provided within 5 working days; there are no wait lists. Assessment appointments occur within 7 days of orientation.
- ✓ Case conference with MD to establish medical necessity.

- ✓ Placement in treatment modality is done per ASAM criteria taking into account client's needs/requests, and availability of said service. Referral to detoxification and residential services as determined by assessment and MD recommendations. Care Coordinator assigned who will oversee transition to appropriate level of care as determined by MD and clinical review of client's needs. If a level of care is not immediately available at the county of residence the Care Coordinator will provide referrals to the nearest available service provider.
- ✓ Treatment planning occurs within 5 working days post assessment. Clients will be an integral part of the process of selection of level of care and ensuing treatment plan. VCBH will facilitate the inclusion of families in this process, as permitted by proper releases. The treatment will start within 5 working days from date of Treatment Plan session(s). The first treatment per ASAM LOC will be provided within 22 working days, for outpatient services. For the NTP process, currently there is no wait list for new admissions and patients are scheduled the same week or following week. Patients are scheduled for their first face to face service on the day they are admitted to do their intake. Medical Doctor Appointments are scheduled 7 day and 14 day follow up or sooner at the patient's request.  
(See Network Provider Admission Process Attachment and Provider Network Table Attachment).
- ✓ Treatment plan review based on progress of client and current needs; to occur at a minimum every 90 days for ODF; per ASAM criteria.
- ✓ Coordination of care through the Levels of Care (LOC) is provided by a Care Coordinator, who will also address the referral and connection to ancillary services as determined by the treatment plan.
- ✓ Completion of treatment and referral to subsequent service.
- ✓ Care Coordination will refer to post-treatment recovery services and coordinate with service provider the final transition and actual completion of episode (or return to active treatment).
- ✓ All elements of program involvement will be overseen by a Care Coordinator. That team is described in section #2 Client Flow and See #4 Treatment Services, Withdrawal Management Services (ASAM Levels 1-WM, 3.2-WM)

*This is a place holder for the Adult Admissions Criteria Crosswalk Attachment and Adolescent Admissions Criteria Crosswalk Attachment.*

**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?

VCBH is an integrated department with divisions of SUD (ADP) and Mental Health (both Adults and Children's). From executive management to shared program locations, the VCBH has a long history of coordinating mental health services for beneficiaries with

co-occurring disorders. This includes co-leading Ventura County's first "dual diagnosis" program with Mental Health in the early/mid 1990s to present day. VCBH ADP has the only co-licensed Mental Health/ADP clinic, A New Start for Moms (perinatal substance abuse program). Likewise, all ADP clients enrolled at county clinics have a release of information on file and there is active coordination between SUD and MH clinicians.

For non-county based programs, it is an expectation, clearly noted in the contractual agreement, that risk factors for relapse, including the presence of psychiatric disorders, are part of the initial assessment. Similarly, if care by MH is already being provided, contracted programs will establish contact by use of a properly formatted release of information. For cases that require referral for assessment and admission, contractors will be required to identify working relationships with MH providers in their area. The above mentioned Care Coordination team will be monitoring for risk identifiers and quality assurance will be reviewing files to see that beneficiaries with co-occurring disorders are being properly identified and treatment is being properly matched. Noting national prevalence rates of co-occurring disorder, the provider CalOMS admission data will alert VCBH as to the level of attention these issues are being given.

**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?

VCBH has strong working relationships with a variety of primary care and specialty care providers, including Clinicas Del Camino Real, and information and referral services such as Interface 2-1-1 and various community resource pages. VCBH is working closely with the Ventura County Health Care Agency Ambulatory Care Clinics to identify patients who have substance use disorders and refine the process for them to be referred to SUD treatment services. VCBH implemented a SBIRT Pilot Program at the Sierra Vista Family Medical Clinic in the city of Simi Valley in 2012 and a "billable service test" in 2014. This tested the ability of the health care clinic to successfully implement SBIRT protocols to all patients, and train providers to make the appropriate referrals to SUD treatment. VCBH is working with HCA Ambulatory Care leadership as well as Gold Coast Health Plan to develop SBIRT referral protocols, including annual SBIRT screenings for all patients at all county Health Care Agency clinics. SBIRT training is available to all clinic locations within the system to enable them to meet requirements for SBIRT screening for alcohol for Medi-Cal beneficiaries. Provider referrals to SUD treatment occur if a patient's level of alcohol or drug use is determined to be "harmful" or "dependent" level of use, and deemed appropriate for a referral to treatment services. The referral process for treatment is outlined in the MOU with the Gold Coast Health Care Plan. (*See VCBH Mental Health/Gold Coast Health Care Plan MOU Attachment*)

VCBH will make an effort to connect beneficiaries who show up for SUD services to a primary care provider if they don't have one. This will be part of the treatment planning

process and assisting with linkages to County services through the Care Coordination team. We will link them up with a primary care provider within the County system or a referral will be given to link the client with the appropriate primary care services.

In addition, VCBH ADP has an MOU with Ventura County Public Health to provide Human Immunodeficiency Virus (HIV) and Early Intervention Services (EIS) services. These programs are provided at the seven ADP sites currently. It is the policy the VCBH ADP to make available tuberculosis screening for individuals participating in Alcohol and Drug programs. During HIV positive post-test counseling, clients are provided linkage to care, partner services and referrals via brochures, phone numbers and direct access, actually arranging HIV/AIDS services and medical care on the spot. Follow-up with clients is provided by the HIV/AIDS team. Quarterly reports are submitted by Ventura County Public Health to VCBH to ensure proper monitoring of their activities.

**7. Coordination Assistance.** The following coordination elements are listed in the STCs. 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:  
Ventura County ADP does not require assistance regarding comprehensive screening, as we utilize a thorough substance abuse screening (includes urinalysis), as well as a mental health screen and physical health questionnaire (with availability of physical exam by Nurse Practitioner) for every client; adult and adolescent. The implementation of SBIRT across our Medi-Cal provider network may require technical assistance in engaging primary care providers.
- Beneficiary engagement - participation in an integrated care program as needed:  
VCBH ADP anticipates requiring technical assistance with addressing the challenges of engaging eligible beneficiaries in participating in its integrated care program, especially with how to create a demand for SUD treatment.
- Shared development of care plans by beneficiary, caregivers and all providers:  
Currently VCBH ADP has no requests for assistance in addressing this requirement. We have a collaborative process for care plans with our clients; and in regards to the sharing of such with caregivers and providers, we utilize the CFR 42.2 and HIPAA confidentiality regulations to drive the process.
- Collaborative treatment planning with managed care:  
VCBH ADP would welcome some assistance in addressing the complexities of collaborative treatment planning with managed care and the confidentiality regulations for SUD treatment.
- Care coordination and effective communication among providers:

VCBH ADP would benefit from technical assistance in addressing information technology (IT) and fiscal aspects of care coordination across multiple providers, fostering of rapid, efficient, and effective communication. Currently most agencies/providers use different platforms for data management. The ability to communicate and exchange data across platforms, as well as coordinate claims for reimbursement and associated fiscal requirements will pose some challenges.

- Navigation support for patients and caregivers:  
As previously described, we will be using a modified LACE risk stratification approach within Care Coordination services, and we do not anticipate the need for significant technical assistance in this area
- Facilitation and tracking of referrals between systems:  
Tracking of referrals between systems will be addressed by our IT team and the centralized Care Coordination team. All elements of program involvement will be overseen by a Care Coordinator from a centralized Care Coordination team. That team is described in section #2 Client Flow #4 Treatment Services, Withdrawal Management Services (ASAM Levels 1-WM, 3.2-WM). The county has already begun active discussions on cross-platform capabilities to facilitate the tracking of referrals.

**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 anticipated number of Medi-Cal beneficiaries who will seek SUD services of the 200,000 Medi-Cal eligible residents of Ventura County is approximately 7 percent (qualify for medical necessity); 14,000 beneficiaries are projected to need SUD services.
- The expected utilization of services by service type:  
Expected utilization of DMC services are approximately 6 percent (currently 3 percent getting treatment and expect an increase of 3 percent growth year over year) or an increase by 697 clients over a five-year period.
- The numbers and types of providers required to furnish the contracted Medi-Cal services:  
The numbers and types of providers required to furnish the contracted Medi-Cal services are currently 16-17 existing providers, and in 12 months no less than 3 new outpatient providers, one adolescent service site, and expansion of bed

days from current level to 15 percent annually. The county presently has Drug Medi-Cal (DMC) contracts with the following providers distributed throughout the county:

- ✓ Outpatient Services: 19 sites
  - ✓ Intensive Outpatient Treatment Providers: 5 sites
  - ✓ Narcotic Treatment Program Providers: 5 sites
- Table: A demonstration of how the current network of providers compares to the expected utilization by service type.

These numbers respond to our current population in treatment services. These numbers may be distributed differently based on ASAM Placement Criteria across providers.

### Provider Types Projections

<i>Modality</i>	<i>Prior</i>	<i>ODS Yr 1</i>	<i>ODS Yr 2</i>	<i>ODS Yr 3</i>	<i>ODS Yr 4</i>	<i>ODS Yr 5</i>
Outpatient	2040	2101	2164	2229	2296	2365
IOP	39	40	41	42	42	44
NTP/MAT	1494	1539	1585	1632	1681	1731
Residential	662	682	702	723	745	767
Detox	42	43	44	45	46	47
<b>Totals</b>	<b>4277</b>					<b>4954</b>

### Perinatal Services

Ventura County has an outpatient perinatal program, A New Start for Moms (ANSFM). The county also contracts with Prototypes Women’s Center a residential program that provides services to perinatal clients, offering women-specific treatment and recovery services. ANSFM addresses the specific needs of women by delivering trauma informed services and interventions for women with substance use disorders. With the use of evidenced based practices, women receive individual and group counseling specific to perinatal and parenting women’s needs. EBP curriculum used in the outpatient setting addresses issues of relationships, sexual and physical abuse, education on substance use disorders and their impact on pregnancy and their families, coping with feelings and the effects of substance use, co-occurring disorders and trauma issues. Women receive individualized treatment with referrals and access to mental health services. ANSFM serves both women and their children while enrolled in treatment if it is appropriate to do so. Transportation is offered to women and their children, to treatment and to ancillary services, including primary medical and pediatric care, therapeutic services for children, and occupational/ vocational training programs. Children under five years old are screened upon enrollment of the cooperative child watch using the “Ages and Stages” questionnaire and referrals are made to Public Health Nursing based on the developmental needs of the child. Public Health nurses make home visits in response to the referral. Mothers are provided with parenting education and training. Through the cooperative child watch, program staff are able to role model and reinforce learned parenting techniques.

- Hours of Operation of Providers

ADP outpatient services will be operated at least five days per week during regular business hours, which is typically on-site staffing and services from 8:00 AM to 7:00 PM, with two weekday evenings of extended service hours available, and Fridays, from 8:00 AM to 5:00 PM. Residential programs will operate 24 hours per day, seven days a week. See *Provider Services Table Attachment* for the hours of operation for the NTP and IOP providers.

- Language Capability for County Threshold Languages

Effective July 2016, services will be provided by all network providers in the County threshold languages as needed, per new contracts with providers. Services in other languages may be offered by specific programs. The County maintains a contract with Interpretation Services that provides oral translation services in Spanish and other languages as requested, and is accessible to all of its network providers. We will need technical assistance from DHCS on the recruitment and retention of Spanish speaking staff.

- Timeliness of Services

The Centralized Care Coordination Team is responsible for the Access Line and will also be used to establish appointments for initial face-to-face intake appointments with providers at the time of screening. First appointments will be scheduled no later than 72 hours from the initial request for services. Accommodations will be made for urgent conditions within 24 hours. Medical attention for emergency and crisis medical conditions will be provided immediately. Frequency to follow-up appointments are the following:

- ✓ Timeliness of first face to face initial appointment for an intake/assessment interview is within 5-7 days.
- ✓ Timeliness of services for urgent conditions: Services will be provided within 36 hours, with a one-hour authorization time.
- ✓ Access to after-hours care: Beneficiaries will have access to a 24/7 toll-free phone number with availability of on-call staff. The 24/7 toll-free number will have threshold language (Spanish) speaking capability.
- ✓ Timely access to services will be ensured through our Quality Improvement performance improvement protocols. For access to after-hours-care, beneficiaries will use the Access Line to reach the centralized care coordination team to arrange clinical assessment or timely admission to services.

*(See Provider Services Table Attachment)*

- Geographic Location of Providers

A criterion for making referrals for placement in outpatient services will be that the program should be within the same day, travel time. Travel time between the East and West County is approximately 30 minutes to 60 minutes by car, or 1 to 2 hours by public transportation. Most beneficiaries will be referred to treatment locations within a 10 to 20-mile distance from their residence, at the most. Transportation is measured by the

personal or public transportation to and from the beneficiary's residence. In some outlying, semi-rural and remote areas of the county, such as the unincorporated areas of northern Ventura County, the low population density may make this criterion extremely difficult to meet, particularly if reliant upon public transportation. In such cases, every effort will be made to accommodate the beneficiary via timely, professional and linguistically appropriate Telehealth options. Telehealth will be in place on day one. These options will also be considered for adoption after the initial twelve-month implementation period as a way to expand access to services for beneficiaries with transportation, cultural or linguistic challenges.

We currently offer transportation services only for our A New Start for Moms ADP Treatment Program, and Prototypes Residential Treatment Program for women. We prioritize by pregnant women, mothers with children, and if there are any other available spots we transport regular ODF clients within our ADP treatment program A New Start for Moms. At Prototypes, they transport clients to medical appointments. At ADP we transport clients to and from their home to treatment and back. We do not currently offer transportation services for other clients in our treatment programs. We also have a bus token system available to clients who request assistance for public transportation.

Ventura County has developed services throughout the west and east county, including the cities of Simi Valley, Thousand Oaks, Fillmore, Oxnard and Ventura. Most current Medi-Cal beneficiaries are most located in these areas. After the implementation of our ODS Waiver Plan, we will monitor the trends in access to services to better determine whether there are adequate transportation services to meet the needs of beneficiaries. Currently, public transportation is readily available throughout the county.

#### Accessibility for Persons with Disabilities

All County-contracted SUD treatment services providers will be compliant with the Americans with Disabilities Act, as specified in Standard Contract Condition #53, which reads, in part: Contractor agrees to comply with applicable federal, state and local statutory mandates concerning culturally competent services to clients and consumers, as well as Condition #56 which requires county-contracted SUD treatment providers "shall have a completed Access to Service Plan, a completed Checklist for Accessibility and a Person with Disability Referral Service Plan. This will include, but shall not be limited to, evidence of self-review, monitoring and program needs pertaining to contractor's ability to meet the accessibility requirements of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and Title 24 of the California Building Code. Documents must be made available to the county staff upon request. The county agrees to provide consultation and training in plan development of culturally and linguistic competent services to contractors.

Contractors shall develop and submit a Cultural and Linguistic Competence Plan describing how they will provide cultural and linguistic services to clients, how competence will be assessed and evaluated, and how personnel will be trained in the delivery of such services. The contractor shall review the plan annually and submit an

updated plan within 60 days of each new fiscal year to county. (*See Provider Services Table Attachment*)

- 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.
  - 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.
  - Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
  - Establish mechanisms to ensure that network providers comply with the timely access requirements.
  - Monitor network providers regularly to determine compliance with timely access requirements.
  - Take corrective action if there is a failure to comply with timely access requirements.

The VCBH ADP Quality Assurance team will provide oversight of activities to ensure compliance with the DMC regulations including review of incident reports, oversight of site certifications, monitoring through audit charts and policy development. Standards will be included in the VCBH contract with contract providers. All network subcontracted provider's outpatient services will offer services that are no less than the hours of operation which the provider offers services to non-Medi-Cal clients.

Services will be made available to beneficiaries 24 hours a day, 7 days a week, when medically necessary. For emergency situations where a life-threatening condition is present, the Access Line or network provider will immediately contact emergency medical services for intervention. Providers will be required to establish procedures for appropriately handling urgent conditions presented by actively enrolled beneficiaries. The Access Line is available 24 hours a day, seven days a week to provide appropriate information and referral information, by type of service. The Centralized Care Coordination office will help to ensure clinical assessment and/or timely admission. Timely access to care is not anticipated to be an issue, as our current providers are anticipated to be Medi-Cal contract providers as of the implementation of the ODS Waiver plan.

Monthly program monitoring will include fidelity to ASAM criteria for Medical Necessity, Level of Care, Length of Service, and justification to extend. Contract providers shall comply with all site review, utilization review, and audit recommendations as needed. Corrective actions shall be sent to County for review and approval in writing within a timeframe that County will specify. Within 30 days to respond. Corrective action to eliminate any material noncompliance or weakness found as a result of any such audit

shall be completed prior to any extension of the contract agreement. See Monitoring Process section.

**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.

The County will offer quarterly training topics relevant to the clinical and business practices of establishing an organized delivery system (ODS). All County programs and network providers will be required to establish and operate a training plan for their employees that identifies training needs and describes steps to ensure that employees receive appropriate training aligned with the needs assessment. All providers will be monitored at least annually for compliance with this contract requirement. The County will be responsible for assessing overall network clinical training needs and coordinating training sessions in alignment with needs assessment findings. VCBH trainings, online web trainings, and outside training contract providers will serve as the primary vehicles for the provision of clinical and program capacity building training and technical assistance services for its network providers.

Current training topics identified under the DMC ODS implementation plan include the application of ASAM placement criteria and determination of medical necessity, clinical documentation, and evidence-based practices. These required trainings will be offered on a quarterly basis. These will be offered to all County and network providers, and include: Cognitive Behavioral Therapy; Medication Assisted Treatment; Motivational Interviewing; California Code of Regulations Title: 22; CalOMS Treatment; 42 CFR Part 2; ASAM Placement Criteria; and trainings on evidence-based practice curriculum for new hires and on an annual basis. Training will be continuous through the demonstration period. Training and/or technical assistance may be offered on Drug Medi-Cal Training, and Cost Report assistance on an optional basis.

**11. Technical Assistance.** What technical assistance will the county need from DHCS? Our vision is to incorporate a broad array of technical assistance possibilities to help with the implementation plan. VCBH requests technical assistance in the following areas:

- ✓ Assistance with incorporating new required services for providers, including Recovery Services and Physician Consultation.
- ✓ Telehealth training and technical assistance. Understanding the process of setting up telehealth services, required trainings for providers, and confidentiality protocols.
- ✓ Financial and administrative challenges, including rate setting, reimbursement protocols, fiscal guidelines, cost reporting and audit principles.
- ✓ ASAM training, resources and tools.
- ✓ Fidelity assessment for evidence based practices.

**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: The QIP will be provided from day one of implementation.

- 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.

The Quality Management Policies include the following:

*Grievance Form- English/Spanish*

*Action Appeal/Expedited Form- English/Spanish*

*Acknowledgement of Receipt of Grievance and Appeals Letter- English/Spanish*

*Notice of Decision- English/Spanish*

*Notice of Problem Resolution Processes- English/Spanish*

*Notice of Action – A- English/Spanish*

*Notice of Action – D- English/Spanish*

*Grievance workflow map*

*Standard Appeal workflow map*

*Expedited Appeal workflow map*

*(See Quality Management List and Attachments)*

The VCBH ADP Quality Assurance team will provide an array of oversight activities to ensure compliance with the DMC regulations including review of incident reports, oversight of site certifications, monitoring through audit charts and policy development.

### Monitoring Process

The County's process for ensuring that DMC providers are in compliance with applicable regulations and guidelines are:

- ✓ Monthly utilization reviews
- ✓ Monthly program monitoring, including fidelity to ASAM criteria for: Medical Necessity, Level of Care, Length of Service, and justification to extend.
- ✓ Quarterly provider meetings
- ✓ VCBH Policy and Procedures
- ✓ Staff training on federal, state and locally-required program policies and procedures
- ✓ Fiscal Financial Review is completed annually and provider invoices are reviewed monthly
- ✓ Monthly onsite reviews of DMC providers

County will conduct at minimum, a random utilization review in 5% of active cases. County will conduct at minimum an Annual Review of the facility, policies, and documentation of compliance, conduct a survey of clients and staff, tour the grounds and address any concerns as found. Contract providers shall comply with all site review, utilization review, and audit recommendations as needed. Corrective actions shall be sent to County for review and approval in writing within a timeframe that County will specify. Corrective action to eliminate any material noncompliance or weakness found as a result of any such audit shall be completed prior to any extension of the contract agreement.

### Disallowance Process

In the process of utilization review, should any service be found to be non-compliant, disallowable and not remediable, contract invoices will reflect the dollar amount to be disallowed. This is then communicated to both the VCBH billing officer and provider. In the submission of DMC billing to the state, should services be rejected as disallowed, Quality Management forwards that rejected service to the provider who then reviews and determines if it possible to remediate. If so, the correction is made and re-invoiced. If remediation is not allowed or possible, VCBH billing will follow the state protocol in order to properly account for and communicate final disallowed services.

### The Quality Improvement Plan

VCBH has formatted a plan with key elements that include a description of the Q.I. plan purpose, priorities and goals. Identified systems such as operations, contracts, data and I.T. along with quality assurance staff have specified roles and responsibilities. Core measurements and strategies are infused in a standardized fashion across all the provider programs.

For example, VCBH utilizes NIATx performance improvement projects for all providers and programs to monitor and evaluate accessibility of care. NIATx is an evidence based strategy that is designed specifically for behavioral health programs. The principles of NIATx are designed to maximize patient access and retention in an effective and measurable manner. The data for these projects will be collected and reviewed on a monthly basis to ensure that the projects are effective.

Communication of Quality Improvement plans will occur in both bi-annual meetings with assigned programs and providers to present specific performance improvement projects but also at the quarterly individual contract meetings where each provider is required to present project data, successes and challenges. VCBH will maintain a written record of these meetings in order to evaluate improvements or challenges over time.

#### List members of the Quality Improvement Committee

VCBH ADP Quality Improvement Program Administrator, ADP Clinic Administrators, VCBH Quality Assurance staff, Behavioral Health Managers.

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

Providers will be obligated by contract to use evidence based practices. Providers will implement at least two of the following evidenced based treatment practices (EBPs) based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. The required EBP includes:

- Motivational Interviewing: A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes.
- Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
- Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
- Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
- Psycho-Education: Psycho-educational groups are designed to educate clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to clients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an

understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

The County will ensure that contract providers are implementing the EBPs from the National Registry of Evidence-based Program and Practices (NREPP) that are based on Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). As part of the DMC-ODS implementation process, County contracts with treatment providers will be amended to include a requirement that each contracted provider of DMC-ODS will provide at least two of the following EBPs based practices.

- Living in Balance is a comprehensive addiction treatment program that emphasizes Relapse Prevention. There are 33 psycho-educational modules covering topics designed to enhance the client's level of functioning in areas that are often neglected during prolonged drug use.
- A Woman's Workbook, by Lisa Najavits, Ph.D., is gender specific utilizing interventions designed to help women in their recovery from drugs and alcohol. The workbook is divided into two sections, explorations and healing. The exploration section helps clients look at their life in relation to gender and addiction while the healing section guides them through methods of recovery.
- The Matrix Model provides interventions in group format in relapse prevention skills and education. Programs may use the adolescent, adult, or criminal justice specific curriculum. The groups teach clients essential skills for establishing abstinence from drugs and alcohol and techniques in coping with issues of recovery and relapse avoidance.
- Triple P is a positive parenting approach designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence in the parenting experience. With the use of the Triple P tip sheets that combine advice with rehearsal and self-evaluation, this model helps to teach parents how to manage these difficult behaviors. Specialty groups are offered to clients that may be in need of more specific interventions, and are referred according to specific needs.
- Hazelden Co-Occurring Disorders Curriculum is designed to integrate therapies, using CBT, motivation enhancement and twelve step facilitation to address issues relating to people with interactive disorders. If clients are present at their assessment with a history of a mental health disorder, clients will be referred to the co-occurring track.
- Seeking Safety, by Lisa Najavits, Ph.D., is a present-focused coping skills manual for persons with trauma and substance abuse. Clients referred to the group will have demonstrated during their assessment or during course of treatment that trauma has occurred and are in need of developing coping skills and establishing safety in their lives.
- SAMHSA's Anger Management for substance abuse and mental health clients is a 12-week group curriculum. It is a cognitive behavioral approach aimed to help clients develop skills that are necessary to successfully manage their anger. If during the assessment or during the course of treatment it is determined that

anger contributes to their substance related disorder a client will be referred to this specialty class.

Implementing an EBP is about more than just a one-time training, or handing a counselor a curriculum binder, therefore the following adjustment will be made to the County annual contract monitoring:

- Annual training and reorientation to curriculums based on MI and CBT.
- Documentation supervision for staff using the above listed EBPs which includes clinical observations and feedback on the counselor's use of the curriculum.
- Contract Monitoring Tool will include review of staff training logs.
- Case chart reviews will include the necessity to demonstrate the curriculum in use at that facility.

The requirement is that they are specific to the population that the providers are serving. County Quality Assurance and monitoring processes will ensure compliance with contractual obligations. At all VCBH sites, managers shall audit groups on a regular basis. As indicated by our training policy, VCBH shall provide clinical supervision and training supportive of internal fidelity for our internal evidence based practices. Every VCBH Contract Provider will be asked to identify the EBP as found on the SAMHSA NREPP Registry. Providers will also be asked for an annual training schedule on those EBP along with evidence that there are EBP fidelity checks in place throughout their patient file (i.e. designation of topic from EBP on each group progress note). Programs found to be out of compliance will be formally notified of this deficiency and a corrective action plan will be requested to ensure compliance. Should a provider be unable to achieve compliance, progressive actions up to and including termination of a contract, will remain the purview of VCBH.

**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)?

While there are no immediate plans to implement a DMC-ODS regional model, the county currently contracts with a Los Angeles County provider to fill a gap for medical detoxification. Should that provider be eligible for DMC licensure and billing we'd expect to contract for specified services under the waiver.

**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 STCs. 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 care coordination 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.

**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 is the delivery of health-related services and information via telecommunications technologies. Unlike telemedicine (which more narrowly focuses on the curative aspect as provided by a licensed MD or LHPA) a broader application, by way of a variety of technologies Telehealth will assist our county on at least three key challenges posed by the DMC ODS waiver. First it will assist our county in the area of access, which at present is limited to physical location of clinics. Access to mono-lingual Spanish speaking staff for example will no longer be site dependent. Second, and related to the first, clinic based services are costly, whereas Telehealth will insure a level of cost efficiency. This not just because of improved access but a reduction in administrative overhead like travel and missed appointments. Finally, Telehealth can assist in efficient meeting surges in patient demand as the ODS waiver becomes more generally known in our community.

While Telehealth will eventually be available across all county clinic sites, a phased-in roll out is expected given the Department's new and limited experience with this tool. It is anticipated to be used in every billable activity which the ODS waiver will allow.

Ventura County currently uses a proprietary, encrypted, web-based vendor application to provide telehealth services which are fully compliant with CFR 42, HIPAA, and other legal and regulatory requirements. Initial usage of the telehealth service has been targeted at non-English speaking Mental Health clients in our remote clinics. Future goals include broadening the application of this technology to a wider client audience. Currently, we have over six (6) months experience using this technology. As a component of the DMC ODS implementation plan, our VCBH Alcohol and Drug Programs will be able to use this secure telehealth system following the purchase of an expanded licensing agreement and development of enhanced on-site confidentiality protocols.

**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?

Review Note: A list of all contracted providers (modality, provider, address) must be submitted to DHCS within 30 days of the waiver implementation date and as new providers are awarded contracts. DHCS will provide the format for the listing of providers.

#### Provider Selection and Monitoring

VCBH ADP will comply with all federal, state, and local regulations in the selection of contract providers. VCBH ADP will comply with regulations that relate to the provision of information about provider business transactions and provider ownership and control, prior to entering into a contract. VCBH ADP will monitor the performance of contract providers on an ongoing basis for compliance with the terms of the contract. If deficiencies or areas for improvement are identified, corrective action will be taken.

#### Request for Information

VCBH ADP plans to issue a Request for Information (RFI) on August 15, 2016 for the sole purpose of obtaining information regarding the interest/availability of Drug Medi-Cal Organized Delivery System (DMC-ODS) Service Providers. The information gathered will be used to identify the available providers for future use and evaluate procurement options. This RFI does not constitute a Request for Proposal (RFP) or a promise to issue an RFP in the future. All costs associated with responding to this RFI will be solely at the interested party's expense. All submitted documentation will remain confidential, become the property of VCBH-ADP when submitted to VCBH-ADP, and may be considered public information under the California Public Records Act, Government Code §6250.

#### Provider Eligibility

Providers must demonstrate that prior to furnishing services under this waiver, they have enrolled with or revalidated their current enrollment with DHCS as a DMC provider in their letter of interest, and that they can create an environment for clients which

- ✓ Provides welcoming support to the clients' individual recovery process.
- ✓ Utilizes DMC and American Society of Addiction Medicine (ASAM) criteria, and at least two of the evidenced based practices (EBPs).
- ✓ Creates opportunities for clients to create partnerships with family members, and other persons significant to the participant's recovery and treatment.
- ✓ Is culturally responsive and adaptive to the histories, beliefs, traditions, values, and languages of the diverse clientele. 4

#### Suspension, Debarment, Corporation Active Status Designation

In order to submit a letter of interest, agencies must not be listed as an ineligible person on the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities from federal programs or the California Department of Health Care Services Suspended and Ineligible Provider List for Medi-Cal program services. VCBH plans to use the following links to identify individuals and entities that are not eligible to contract with VCBH: <http://exclusions.oig.hhs.gov/> and <http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>. Agencies registered with the California Secretary of State as a corporation, Limited Liability Company or limited partnership must have an active status designation on the California Secretary of State Business Entities Search website. VCBH plans to use the following link to verify a business entity's status: <http://kepler.sos.ca.gov/>.

#### Contract Failures, Sanctions, and Disciplinary Actions

VCBH requires that all agencies self-disclose any: (1) contract failures within the past two years, (2) pending charges or convictions against them or any individual with their organization for violations of criminal law, (3) any sanctions, and (4) any disciplinary actions by any federal or state law enforcement agency, regulatory agency, or licensing agency (including exclusion from Medicare and Medicaid programs).

#### Required Experience

Agencies must have a minimum of three years of experience providing services that are the same as the services specified under this RFI.

#### Option to Reject Letter of Interest

VCBH-ADP reserves the right to reject a letter of interest based upon an agency's prior history with the County or with any other party based on their prior unsatisfactory performance, criminal, adversarial or contentious behavior, significant failure(s) to meet contract milestones, or other significant contractual failures.

#### Provider Appeal Process

For a provider appeal to be considered, the appeal must be made in writing, signed by the provider's authorized representative, and delivered to the VCBH Contracts Manager at 1911 Williams Drive, Suite 200, Oxnard, CA 93036. The VCBH Contracts Manager

reserves the right to refuse to hear appeals who have not followed the procedures listed below.

The following conditions apply to provider appeals:

- a. Appeals of award must be made, no later than five (5) calendar days after the aggrieved party knows or should have known of the facts giving rise to not awarding a contract.
- b. Appeal Content. All appeals must include the following information:
  - ✓ The name, address, and telephone number of the provider.
  - ✓ The signature of the provider's authorized representative.
  - ✓ A detailed statement of the legal and/or factual grounds for the appeal.
  - ✓ The form of relief the provider is requesting.
- c. Appeal Process
  - ✓ If the VCBH Contracts Manager can resolve the issue, there is no further action required.
  - ✓ If there is no resolution, the issue will be referred to the appropriate VCBH Division Manager for review and resolution. If the issue is resolved, there is no further action required.
  - ✓ If there is no resolution, the issue will be referred to the VCBH Director who will make a determination on the issue and render a determination. This determination will be final.

The requirements described herein are considered reasonable to meet VCBH's needs. A provider who has an alternate proposal to meet these needs, may, after responding to the minimum requirements hereunder, offer alternate service levels for consideration by VCBH.

### Contract Term

The term of VCBH-ADP contract agreements is usually for one year, subject to budgetary approval by the Ventura County Board of Supervisors, and subject to mutual consent of VCBH-ADP and the contractor. Contracts may be extended by mutual agreement of the parties for additional one (1) year periods, not to be extended for more than two additional one-year periods.

### Termination

If a contract is terminated or not renewed, beneficiaries will be notified in writing, and the provider and VCBH-ADP will work together to transfer all current clients to the appropriate level of care. There will not be a disruption of services for the client. Per MOU with contractors:

- A. Either party may terminate the contract agreement at any time, with or without cause by giving thirty (30) days written notice to the other party.
- B. After giving notice of Termination the contractor shall 1) Continue to provide the same level of service as previously required under the terms of the agreement

until the date of termination, 2) If appropriate, assist County in affecting the transfer of clients in a manner consistent with the best interest of the client's welfare. (*See Termination Policy Attachment*)

**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.

The Centers for Disease Control and Prevention (CDC) has officially declared that prescription drug abuse in the United States is an epidemic. An estimated 1.9 million people in the United States suffered from substance use disorders related to prescription opioid pain medicines in 2014, and 586,000 suffered from a heroin use disorder. As of 2012, overdose deaths involving prescription opioid analgesics, that is Rx pain killers, have increased to almost 17,000 deaths a year. Similarly, a spike in Heroin dependence has made drug overdose the number one cause of accidental death. Yet, while that is in itself alarming for every fatal drug overdose there are 10 treatment admissions, 26 ER visits, 108 people who are drug dependent and 733 non-medical uses. However, even as the availability of evidence based treatment is increasing, we have a significant and ongoing treatment gap in our Nation. Among those who need treatment for an opioid use disorder, less than fifty percent are receiving Medication Assisted Treatment, despite evidence that providing such EBP offers the best alternative for securing long term stable recovery. Ventura County intends to use and expand access to science based enhancements.

In addition to NTP services, Ventura County currently has several practitioners licensed to provide Suboxone adjunct MAT. Implementation of additional MAT using Vivitrol and Naltrexone are currently being considered for clients presenting with opiate involvement. All such MAT will be determined by the direct application of ASAM criteria, specially designed for MAT. This will be done by the medical director in concert with the treatment team and if needed the designated consulted ASAM certified physician.

**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 referrals will have to be screened and authorized prior to a client being referred for treatment. The programs will do their own assessment within 24 hours of admission. Our centralized assessment team can preauthorize a referral with a 24- hour turn around. Then the structured biopsychosocial assessment will be done at the residential program site. Residential substance use disorders treatment for adults and adolescents is a level of care that requires preauthorization and assessment by the centralized intake and assessment team. Generally residential levels of care are designed for adolescents and adults with a primary presenting substance use disorder who cannot be safely managed in an outpatient setting. These programs consist of structured daily activities and are licensed at the required ASAM level of care for residential services.

Every client admitted to a residential program must have a comprehensive assessment. For admission to a residential unit, adults must have an ASAM score that indicates this level of care is necessary. As discussed elsewhere in this document, client choice may indicate a need to step down in a level of care, but would not justify a step up in a level of care. Adults preauthorized for residential treatment present with a primary substance related diagnosis and treatment in a less restrictive setting is inappropriate due to the severity of the SUD, or a recent treatment episode in a less restrictive setting resulted in a relapse during or post discharge. Additionally, there must be a reasonable expectation that the outcome will be positive after a residential treatment episode. The ASAM placement criteria must indicate a severity of their SUD across dimensions, and will consider which 'dose' or intensity of the levels of care is needed for each dimension. Residential treatment services will be offered when it is the least intensive but safest LOC. However, limitations in personal, financial, or social resources are not sufficient justification for placement in a residential treatment setting.

Adolescents may attend adolescent treatment until they are 18 years old. They also must have a valid SUD diagnosis that is likely to respond to treatment. In the case that treatment in a less restrictive setting is deemed inappropriate, or treatment in a less restrictive LOC resulted in relapse during or immediately post discharge from the lower level of care, assessment for residential treatment services will occur. VCBH ADP has providers that have participated in the Stakeholders process that likely will respond to the RFI for adolescent residential treatment providers.

It is required that all VCBH ADP residential providers have skill and program format that isn't simply "addiction only". Evidence shows that prevalence of co-occurring disorders requires a more informed approach. Using the Minkoff Quadrant scale and given the structural limitations of SUD programs that are not receiving Mental Health funding or resources, psychiatric symptoms be relatively low or well managed (Quad 3). For substance abusing clients requiring legitimate psychiatric care as a primary focus of intervention, VCBH has an IDDT model available. The IDDT program is open to all qualified MH (aka seriously mentally ill, SMI) clients. It is expected that VCBH SUD programs have proper assessment tools in place by which to make informed referrals should that be necessary to MH IDDT.

**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 DMCODS requirement that the county cannot begin upon implementation of their Pilot. Also include a timeline with deliverables.

At the writing of this plan, we currently do not have all of the mandatory required levels of service. We don't have adolescent residential treatment services, but plan to add this level of care. We will need technical assistance from DHCS on the recruitment and retention of Spanish speaking staff. Barriers to finding and recruiting Spanish speaking

counselors will be necessary as demand increases. We will need to build into the system a workplace development strategy for this issue.  
*(See Timeline of Deliverables Attachment)*

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

### **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.

\_\_\_\_\_  
County Behavioral Health Director\*  
(\*for Los Angeles and Napa AOD  
Program Director)

\_\_\_\_\_  
County

\_\_\_\_\_  
Date