COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES
Drug Medi-Cal Organized Delivery System (DMC-ODS)

SUDPOH

Substance Use Disorder Provider Operations Handbook

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Note: Given the continual evoluation of the field of Substance Use Disorder (SUD) treatment, the SUDPOH is a living document and will evolve with the availability of new information and research, or changes in policy, regulatory mandates, or contractual agreements. As a result, this document is subject to ongoing review and revision at the discretion of the County of San Diego, Behavioral Health Services.

SUDPOH

Substance Use Disorder Provider Operations Handbook

Note:

- Reminder – DHCS is the DMC Authority. Always check DHCS's website to ensure access to the most current information included in MH/SUDS Information Notices, FAQs, and other DMC-ODS related regulations and guidance.

- The Program contract, including the Service Template and Statement of Work, takes precedence over the SUDPOH. If any element of the contract is in conflict with the SUDPOH, contact the program's COR.

- All Forms and Manuals referenced in the SUDPOH can be found on the Optum website. Documents are located under the County Staff & Providers tab, and then under the Drug-Medi-Cal Organized Delivery System link.

- All internet addresses (URLs) and links in this document were current as of the publication date of this manual but are subject to change without notice.

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A. THE COUNTY OF SAN DIEGO DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

In 2015, the California Department of Health Care Services (DHCS) received approval from the Center for Medicare & Medicaid Services (CMS) for an 1115 waiver amendment which is referred to as the Drug Medi-Cal Organized Delivery System (DMC-ODS). This allowed for improvements to provision of substance use disorder services by providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services. Additionally, it enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence-based practices in substance use disorder treatment, and coordinates with other systems of care. This approach provides Drug Medi-Cal members with access to the care and system interaction needed in order to achieve sustainable recovery.

After a process of planning and collaboration with community partners and recipients of SUD services, the County of San Diego submitted their DMC-ODS Implementation Plan to DHCS in 2017. The plan was approved, and implementation began in 2018.

The DMC-ODS expands the standard Drug Medi-Cal (DMC) substance use disorder service benefits package in the following ways.

Covered DMC-ODS Services

- DMC-ODS services are provided by Drug Medi-Cal (DMC)-certified providers and are based on medical necessity.
- DMC-ODS services must be recommended by Licensed Practitioners of the Healing Arts (LPHAs), within the scope of their practice.
- DMC-ODS services include the following comprehensive continuum of outpatient, residential, and inpatient evidence-based SUD services.
    - Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)
    - Outpatient Treatment Services (ASAM Level 1)
    - Intensive Outpatient Treatment Services (ASAM Level 2.1)
    - Partial Hospitalization Services (ASAM Level 2.5)
    - Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)
    - Narcotic Treatment Program
    - Withdrawal Management Services (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, and 4-WM)
    - Medication for Addiction Treatment (also known as Medication Assisted Treatment – MAT)
    - Peer Support Specialist Services (effective July 2022)
    - Recovery Services
    - Care Coordination
    - Clinician Consultation (not a direct service to the member)

DHCS remains responsible for administering SUD treatment in California, and the County of San Diego Behavioral Health Services (COSDBHS) contracts with DHCS to fund local SUD services. As a part of the contract with DHCS, COSDBHS ensures that state SUD treatment requirements and standards are met by maintaining fiscal management systems, monitoring provider billing, conducting compliance visits, processing claims for reimbursement, and offering training and technical assistance to SUD treatment providers.

Note: To provide DMC-ODS program requirements pursuant to the California Advancing & Innovating Medi-Cal (Medi-Cal Transformation), effective January 2022 through December 2026, which replaces the Section 1115 Standard Terms and Conditions used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I § 14184.102(d), until DMC-ODS counties shall adhere to the terms in the Behavioral Health Information Notice, BHIN-24-001 or subsequent revisions, where current contracts are silent or in conflict with the terms of BHIN 24-001 or subsequent revisions. The SUDPOH has been updated to reflect policy improvements under Medi-Cal Transformation. Any county, or consortium of counties in a regional model, or Tribal or Indian managed care entity that elects to opt-in to the DMC-ODS that does not already an approved implementation plan by the Department of Health Care Services (DHCS) shall refer to BHIN 24-001 or subsequent revisions for information on requirements for the implementation plan.

Mission of the County of San Diego Drug Medi-Cal Organized Delivery System Service Programs

The County of San Diego Behavioral Health Services (COSDBHS) Division provides a continuum of Behavioral Health Services (mental health and substance use disorder services) for children, youth, families, adults, and older adults. The Division embraces *Live Well San Diego:* The County's over-arching vision to promote healthy, safe and thriving communities throughout the County of San Diego. It promotes recovery and well-being through prevention, treatment, and intervention, as well as integrated services for members experiencing co-occurring mental illness and substance use disorders. The Behavioral Health Services Division provides services under two systems of care: Adult/Older Adult Services and Children, Youth, and Family Services.

Substance use disorders are a major public health and safety problem impacting adults with diverse treatment needs, children, youth, families, and communities. Substance Use Disorder (SUD) programs provide an integrated system of community-based substance use prevention, intervention, treatment, and recovery services throughout San Diego County via contracts with local service providers. SUD program contractors should be relational and strength-based, trauma-informed, culturally competent and involve healing of the family unit in a safe and sober environment. It is the mission of the County of San Diego Behavioral Health Services to deliver these services at the highest level of quality, ensuring that members are given the necessary tools and support to become productive citizens. Services are delivered under contracts managed by a BHS Contracting Officer's Representative (COR).

The Drug Medi-Cal Organized Delivery System Substance Use Disorder Provider Operations Handbook (DMC-ODS SUDPOH) is specifically designed to be used by all administrative and direct service staff to ensure understanding of core values and principles for the SUD system of care and adherence to the clinical and business expectations meant to ensure delivery of quality and outcome-based services.

The DMC-ODS SUDPOH, along with other federal, state and local regulations, governs delivery of SUD treatment services in the County of San Diego. A partial list is as follows (see the Resources section for a more comprehensive listing):

- 42 Code of Federal Regulations (C.F.R.) Part 2 Confidentiality of Substance Use Disorder Patient Records;
- Health Insurance Portability and Accountability Act (HIPAA);
- California Code of Regulations (CCR) Title 9 Counselor Certification the California Code of Regulations;
- CCR Title 22 Drug Medi-Cal;
- Drug Medi-Cal Organized Delivery System Special Terms and Conditions; (note, in the event of conflicts between Title 22 Drug Medi-Cal provisions and the DMC-ODS Special Terms and Conditions, the provisions of Title 22 shall control if they are more stringent);
- Department of Health Care Perinatal Practice Guidelines and Adolescent SUD Best Practice Guide
- County of San Diego DMC-ODS Implementation Plan and Finance and Rates Plan;
- The DHCS & County of San Diego Intergovernmental Agreement (IA);
- State Department of Health Care Services (DHCS) Letters and Information Notices
- State mandated Performance Improvement Projects (PIP) – the State has mandated that each county undertake one administrative and one clinical improvement plan yearly.
- The Contract Template and Statement of Work for each Program including but not limited to the Specific Services to be provided.

Additionally, The Federal Managed Care Regulations, specifically part 438 of title 42 Code of Federal Regulations applies to the provision of Medicaid Managed Care (MMC) programs and managed care organizations (MCOs), Pre-Paid Inpatient Health Plans (PIHPs), and Pre-Paid Ambulatory Health Plans (PAHPs). Counties opting-in to the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver are considered PIHPs. Key goals of the final rule are:

- To support State efforts to advance delivery system reform and improve the quality of care
- To strengthen the member experience of care and key member protections
- To strengthen program integrity by improving accountability and transparency
- To align key Medicaid and CHIP managed care requirements with other health coverage programs

All providers shall adhere to the rules and regulations as stipulated in the Medicaid and CHIP Managed Care Final Rules.

Medi-Cal Transformation

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called Medi-Cal Transformation: California Advancing and Innovating Medi-Cal. Medi-Cal Transformation advances several key priorities by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

The vision of Medi-Cal Transformation is that people should have longer, healthier and happier lives by utilizing a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing. This initiative will be an integrated wellness system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

Medi-Cal Transformation has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform

For more information on Medi-Cal Transformation, please visit: https://www.dhcs.ca.gov/Medi-Cal Transformation/Pages/Medi-Cal Transformation.aspx.

System of Care Principles

Substance Use Disorders as a Chronic Disease

Substance use disorders (SUD) are often chronic, relapsing conditions of the brain that cause compulsive drug seeking and use, despite harmful consequences. They are considered a brain disease because substances change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors. (National Institute on Drug Abuse).

A chronic disease is one that cannot be easily or simply cured, but instead must be treated, managed, and monitored over time. Like heart disease, diabetes and asthma, SUD exhibits a chronic course that requires treatment and management over a longer period, and at times over the course of a lifetime. While some individuals may develop a SUD and achieve recovery after minimal intervention and over a brief period of time, the majority of individuals will exhibit a more chronic and relapsing course.

With this in mind, the County of San Diego has chosen to participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS) continuum of service model of SUD treatment. This perspective values the individualized needs of the person with a SUD, and tailors services to meet these unique needs. SUD services from this perspective are not "one size fits all," but based on an individual's needs at a specific point in time. As an individual advances along their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the member's SUD. This approach emphasizes care coordination and ensuring a full continuum of care that offers varying levels of care to best tailor service delivery to member need. As a result, a key goal of SUD treatment is to provide the right service, at the right time, for the right duration, in the right setting.

Harm Reduction:

Harm reduction is a set of strategies aimed at reducing negative consequences associated with drug use and incorporates a spectrum of tactics to meet people who use drugs "where they are" and address conditions of use along with the use itself (National Coalition for Harm Reduction). Reflective of these principles, harms related to substance use are concerns of overall health and well-being, and stigma should not be allowed to impede access to services. Harm reduction strives to respect all people who use drugs, as well

as their families and communities. It is built on a multidisciplinary evidence base and over a decade of foundational work of local and regional stakeholders.

Elements of these practices may be used in any type of service setting and must be performed by trained providers within their scope of practice. Of note, the descriptions of the evidence-based psychosocial interventions above are simply summaries and providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches. Implementation of Motivational Interviewing and Relapse Prevention is a contract requirement and is monitored through the contract compliance monitoring process.

The guiding principles of the harm reduction approach in San Diego County are as follows:

Human Rights and Dignity:
Substance Use and Harm Reduction approaches in San Diego County respect all human beings, meeting them "where they're at" without judgment and aim to reduce the stigma of people who use drugs (PWUD).

Diversity and Social Inclusivity:
The County of San Diego strives to respect all PWUD, as well as their families and communities, regardless of gender, race, age, sexual orientation, ethnicity, culture, spirituality, health, or socioeconomic status.

Health and Well-Being Promotion:
The County of San Diego aligns with the Live Well San Diego vision of healthy, safe, and thriving communities. Harm reduction efforts are oriented toward improving the health, safety, and capacity to thrive for all PWUD.

Partnerships & Collaborations:
Harm reduction approaches are informed by and carried out through partnerships and collaborations across all sectors in the community. Partnerships are built upon the foundation of shared goals and trust in the interest of serving our community.

Participation ("Nothing about us without us"):
The County of San Diego recognizes the right of PWUD to be involved in the efforts to reduce the debilitating impact of drug use in their communities.

Accountability and Improvement:
The County of San Diego is committed to continuous improvement in the quality of its harm reduction efforts and intends to use data, community feedback, and input to continually assess current and future individual and community needs.

The Countywide Comprehensive Harm Reduction Strategy was initiated in January of 2021 and aims to utilize evidence-based approaches to address substance use and overdose deaths in San Diego County. A proven strategy to prevent overdose deaths is widespread naloxone distribution within the community.

Naloxone is a medication which reverses the effects of an opioid overdose and its broad distribution in the community is aimed at providing a safety net so that its life saving capabilities are present when and where an opioid overdose occurs.

Please see the following tools and resources to aid County staff in learning how to administer naloxone, how to distribute to community members, and how to collect and record data of these efforts:

BHS - Naloxone

Harm Reduction and Naloxone Training Tools

Harm Reduction Training Link for BHS Workforce

Accessing Service: "No Wrong Door"
Consistent with the Health and Human Services Agency's "No Wrong Door" philosophy, members may access SUD services through multiple points of entry. Members who are residents of San Diego County may call the Access and Crisis Line (ACL), call or walk into a program directly, or be referred to a program by community partners.

Member-Centered Care
The County of San Diego Behavioral Health Services (COSDBHS) embraces a philosophy of member-centered care. In order to engage and retain a member in treatment, providers must work collaboratively with members, respecting an individual's preferences, needs, well-being and values. Member-centered care is not the same thing as "always doing what the member wants," as there will be times when clinical judgment does not align with a member's desires but is deemed in the best interest of the member; however, member preferences and values need to be considered as part of that decision-making process.

Customer Service
The County of San Diego Behavioral Health Services (COSDBHS) recognizes that its greatest strength lies in the talent of its providers and expects them to always treat members, families and other consumers with respect, dignity and courtesy. Members/families shall be treated equally regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, as well as source of payment or any other non-treatment or non-service-related characteristic.

Members and families deserve high-quality customer service, which includes:

- Treating customers with courtesy, respect, professionalism and a positive attitude
- Responding to customers in a timely manner whether in person, by phone, in writing or via e-mail
- Being aware of cultural diversity and focusing on understanding customer differences
- Providing complete, accurate and reliable information and feedback

SUD providers are expected to ensure that they have a customer-first attitude which is instilled throughout their operations. Systems should be in place to enable customers to voice any grievances or problems, and if needed, to do so anonymously. Review Section I: Quality Assurance for SUD program requirements regarding reporting grievances.

The following are the basic expectation that COSDBHS has for all County and contracted programs:

1. Establish Customer Service Standards. For example, the County of San Diego Customer Experience Initiative has set a standard of using a positive approach to provide customers with a positive experience. This commitment is summarized in the acronym HEART:

    - **H**elpfulness: going out of our way to find answers
    - **E**xpertise: being knowledgeable
    - **A**ttentiveness: being ready to meet customer needs
    - **R**espect: Treating customers with dignity and courtesy
    - **T**imeliness: being efficient with customer time

2. Ensure that all staff members are aware of these standards and are clear that adhering to Customer Service Standards is an expectation of the program.

3. Ensure members and families that no form of retaliation will come from any grievances or suggestions for improvement made to the program.

4. Enhance program services based on input received from customers to demonstrate receiving and accepting feedback from customers.

5. Make Customer Service Standards training available to all staff.

Ensuring a Standard Quality of Service

The DMC-ODS is a core component of the larger healthcare system and, as such, needs to maintain minimum standards and expectations to ensure high quality services for the members it serves. Similar to the management of other chronic conditions, these minimum standards for SUD ensure a reasonable degree of consistency across service providers, while also allowing sufficient flexibility to provide services that are tailored to the individual needs of members. For example, an individual with diabetes may receive slightly different services depending on the provider (e.g., one doctor may suggest a different medication or dietary/lifestyle change than another), but the treatment and management approach should be guided by certain best practice and clinical standards.

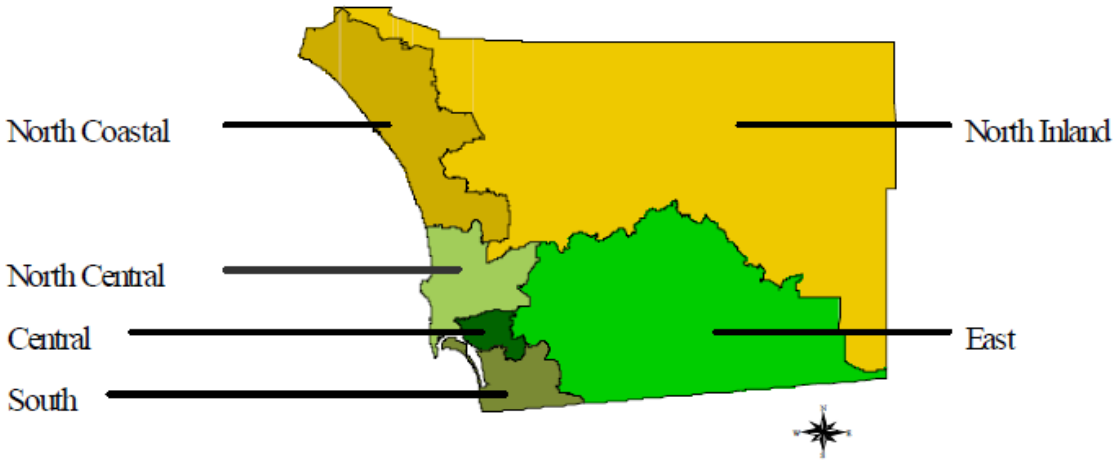
Similarly, SUD services need to be guided by best practice and clinical standards, which include the use of evidence-based practices (EBPs). Motivational Interviewing (MI) and Relapse Prevention are required EBPs in the County of San Diego DMC-ODS.

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

This provider manual describes a framework of standards that involve member services, clinical and business processes, and pertains to all providers within the County of San Diego Drug Medi-Cal Organized Delivery System. In outlining these minimum expectations, this provider manual establishes an infrastructure of qualify for SUD treatment throughout San Diego County.

County of San Diego Drug Medi-Cal Organized Delivery System Regions

The County of San Diego is divided into six Health and Human Services Agency regions by zip code. The following list presents the regions and the communities contained therein.



Service Area	Zip Codes
North Coastal	92007, 92008, 92009, 92010, 92011, 92014, 92024, 92054, 92055, 92056, 92057, 92058, 92067, 92075, 92081, 92083, 92084, 92091, 92672
North Inland	92003, 92004, 92025, 92026, 92027, 92028, 92029, 92036, 92059, 92060, 92061, 92064, 92065, 92066, 92069, 92070, 92082, 92086, 92096, 92127, 92128, 92129, 92259, 92536
North Central	92037, 92093, 92106, 92107, 92108, 92109, 92110, 92111, 92117, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92130, 92131, 92140, 92145, 92161
Central	92101, 92102, 92103, 92104, 92105, 92113, 92114, 92115, 92116, 92134, 92136, 92139, 92182
East	91901, 91905, 91906, 91916, 91917, 91931, 91934, 91935, 91941, 91942, 91945, 91948, 91962, 91963, 91977, 91978, 91980, 92019, 92020, 92021, 92040, 92071
South	91902, 91910, 91911, 91913, 91914, 91915, 91932, 91950, 92118, 92135, 92154, 92155, 92173

Clinician Consultation

Clinician Consultation replaces and expands the previous "Physician Consultation" service referred to during the years 2015-2021. Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. Clinician consultation includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific members. Consists of DMC-ODS LPHAs consulting with other LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care. Clinical consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems. Clinician consultation is *not* a direct service provided to a member.

For more information, see Clinical Consultation in Section B: Providing DMC-ODS Services.

Recovery Services
Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the member to their best possible functional level. Recovery Services emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.

For more information, see Recovery Services in Section B: Providing DMC-ODS Services.

Culturally Appropriate Services
Culturally competent care is critical in providing high quality SUD services. Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response.

Core practices that address cultural competency include:

- Attitudes, beliefs, values, and skills at the provider level.
- Policies and procedures that clearly state and outline the requirements for the quality and consistency of care.
- Readiness and availability of administrative structures and procedures to support such commitments.
- Practices that demonstrate respect for cultural differences in attitudes toward substance use, help-seeking, engagement of family (including diverse definitions of family) and significant others in the treatment process, and use of traditional healing approaches to recovery.

Providers are required to adhere to CLAS standards and are responsible for providing services that are developmentally, culturally, and linguistically appropriate, and must ensure that their policies, procedures, and practices are consistent with this requirement. Providers must also ensure that these principles are embedded in the organizational structure of their agency, as well as being upheld in day-to-day operations.

The COSD will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging members of diverse backgrounds and needs.

For more information see Section H: Cultural Competence.

Care Coordination
Care coordination are collaborative and coordinated approaches to the delivery of health and social services, linking members with appropriate services to address specific needs and achieve treatment goals. Care coordination are intended to complement and integrate with existing systems and community resources while avoiding duplication or replacement of existing services and supports. Care coordination services are available to all members who enter the County's DMC-ODS treatment system, are available throughout the treatment episode, and may be continued during recovery services as allowed by COSD.

Care coordination is meant to provide seamless transitions of care for members within the DMC-ODS, to ensure that members successfully transition between levels of SUD care (i.e., withdrawal management,

residential, outpatient, etc.) without disruption to services. This includes access to recovery services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

In the DMC-ODS, care coordination is also meant to ensure that each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member shall be provided information on how to contact their designated person or entity.

The primary role of the staff providing care coordination services is to coordinate member services:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
- With the services the member receives from any other managed care organization.
- With the services the member receives in FFS Medicaid.
- With the services the member receives from community and social support providers.

Care coordination with other member-serving entities requires recognition and communication regarding potential differences in goals and expectations for member outcomes, particularly for members who may have continued substance use while enrolled in treatment or recovery services. Staff providing care coordination services shall be knowledgeable regarding harm reduction principles and shall explain the use of a harm reduction approach to entities, such as Courts and Child Welfare Services, with whom the member is involved to ensure a clear understanding of the use of MAT as well as how member relapse, positive drug screens, or other behaviors associated with the member's SUD and/or co-occurring mental health conditions will be handled by the program.

Successful care coordination requires documentation to be maintained and shared, as appropriate. The County DMC-ODS has created the SUDURM which details the requirements for maintaining a member health record in accordance with DMC-ODS and other professional standards. Written records, and the sharing of written and other types of communications, must be done in a way that maintains member confidentiality and privacy; thus, programs are to ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

Finally, as part of care coordination, programs shall share with DHCS or other managed care organizations serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities.

<u>Care Coordination for Populations with Special Needs</u>

More intensive care coordination activities will be required for populations with special needs. These populations may include members with HIV/AIDS; members with mental illness; homeless; pregnant and parenting women; adolescents, and justice involved. Each population will require care coordination activities to help an individual effectively navigate, access, and participate in an appropriate level of care for SUD services; access health and mental health services; secure housing; and obtain other supportive services.

Field-Based Services
Care coordination activities may be appropriate for members served in field-based settings that may include, but are not limited to homeless encampments, runaway shelters, interim housing, permanent supportive housing, probation camps or other facilities. When services are provided in the field, providers must ensure confidentiality and document where in the community services were provided (as well as how confidentiality was maintained). See Section D: Service Delivery for more details on documentation.

Housing Referrals
Housing and an individual's living environment are oftentimes a critical component to the ability to achieve and maintain recovery from SUD. Before being admitted to treatment, all SUD members must be assessed on all six (6) ASAM dimensions of care, including ASAM Dimension 6 – Recovery/Living Environment. This intake assessment should reveal potential concerns regarding housing and living situations that may warrant further follow-up.

Special Populations

Prevention
San Diego County's substance use prevention strategy primarily utilizes environmental prevention, a federally approved community-change model to prevent substance use problems throughout the region. Providing a targeted focus on these issues allows the County to develop long term, strategic, cost effective and sustainable prevention plans for each initiative, provides coordination and shared resources where possible, and provides flexible prioritization in each region regarding how each initiative will be tailored to individual community needs.

Primary Prevention
Since the inception of the San Diego County Prevention Framework in 1997, the County has initiated four regional substance use disorder prevention initiatives that are aligned with the County of San Diego's Strategic Initiatives:

- Binge and Underage Drinking initiative (1996)
- Methamphetamine Strike Force (1996)
- Marijuana Initiative (2005)
- Prescription Drug Abuse Task Force (2008)
- San Diego County Substance Use and Overdose Prevention Task Force (2022)

For more information on see Primary Prevention in Section C: Prevention Services and Specialty Programs.

Adult Services
Members who are age 18 or older with substance use and/or co-occurring disorders receive services through Adult SUD programs. These services include:

- Outpatient and Residential Treatment
- Withdrawal Management
- Case Management
- Justice Programs
- Ancillary services (i.e., TB testing)

- Narcotic Treatment Programs (NTP)

Gender Responsive Treatment

Contractor's systems and services shall recognize the importance of the histories, life circumstances, and behaviors of women and men with substance use disorders and take these into account when providing SUD treatment with the goal of producing the best possible treatment outcomes. Contractor shall ensure that the program addresses gender-specific issues in determining individual treatment needs and therapeutic approaches.

As outlined in the SAMHSA TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, core principles for gender responsive treatment include:

- Acknowledging the importance as well as the role of the socioeconomic issues and differences among women.
- Promoting cultural competence specific to women.
- Recognizing the role as well as the significance of relationships in women's lives.
- Addressing women's unique health concerns.
- Endorsing a developmental perspective.
- Attending to the relevance and influence of various caregiver roles that women often assume throughout the course of their lives.
- Recognizing that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances.
- Adopting a trauma-informed perspective.
- Using a strengths-based model for women's treatment.
- Incorporating an integrated and multidisciplinary approach to women's treatment.
- Maintaining a gender responsive treatment environment across settings.
- Supporting the development of gender competency specific to women's issues.

Additionally, in SAMHSA TIP 56: Addressing the Specific Behavioral Health Needs of Men, particular factors impacting men are addressed, such as barriers to engagement and ways to engage men in SUD treatment.

Deaf and Hard of Hearing (DHH) Members

For persons who are deaf or hard of hearing, the principles of addiction are the same as they are for hearing people, yet these individuals are currently unable to fully access the resources available to hearing individuals. DHH individuals are at a severe disadvantage in receiving and realizing long-term benefits from treatment for substance use, since treatment efforts are typically not focused on culturally specific information. During treatment, the majority of the therapeutic benefit comes from being involved with the counselor on a 1:1 basis, with peers in group and the interactions that occur during non-structured periods of the day. Without the availability of communication during program hours, a deaf person does not benefit from substance use treatment in the same way and to the same extent as their hearing peers. Ideally, individuals who successfully complete an alcohol/drug treatment program should be able to return to the environment that they lived in prior to entering a treatment program. However, that environment must include a sober living option, family/friend support, professionals trained to work with members on aftercare issues and accessible support group meetings. This kind of environment is unavailable for the majority of deaf and hard of hearing individuals. Currently, there are only a handful drug and alcohol recovery programs for DHH people in the United States and less who have a full continuum of treatment

and recovery options such as residential treatment and sober living homes.

While the County of San Diego explores treatment options for this special population, the following practice guidelines are recommended:

- Member records should reflect the member's hearing status, use of personal hearing assistive technology, preferred method of communication (including language and hearing assistive technology needs), preferred language for care and for written materials, presence of interpreters/communication service providers during any service delivery, preferred method(s) of contact, and communication method used to secure informed consent;
- Intake and assessment should include gathering information about cultural identification and hearing acuity, age of onset of hearing loss, etiological components, and language proficiencies;
- Treatment plans for each DHH member shall include services necessary to meet the member's needs, including interpreters, technology support, other services to ensure full linguistic access, and culturally accessible services;
- For members whose preferred communication method is sign language, access to sign-fluent staff and/or an interpreter shall be utilized for all services.

Children, Youth, and Family Services
These services focus on a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

- *Relapse Prevention.* Relapse Prevention education and activities shall be available to help the member maintain sobriety over time. Example activities include:
    - Use relapse prevention workbooks and journals
    - Develop skills to reinforce sobriety and relapse prevention
    - Organize physical activities (individuals or teams) on site or off-site
    - Conduct meditation and relaxation activities
    - Cooking classes, food preparation, and nutrition education
    - Music appreciation sessions and/or learning to play a musical instrument
    - Organize outings to demonstrate drug free lifestyle changes
    - Communication building sessions/activities
    - Parent training on relapse prevention
    - Youth Leadership Group development/activities

For more information see Programs Serving Children, Youth & Families in Section C: Prevention Services & Specialty Populations.

Adolescent Services
As documented in the DHCS Adolescent Best Practice Guide, substance use and dependence among youth is a complex problem, resulting from multiple factors including biological predisposition, psychological factors, adolescent development, and social factors. Adolescents have added social factors such as bullying, peer pressure, and low self- esteem that have led to gang activity, sexual exploitation, and depression on

top of their substance use. Therefore, the biopsychosocial approach will aid in understanding and treating these disorders.

In San Diego County, the primary substance for adolescents upon admission into substance use disorder programs is marijuana. With recent legalization of marijuana for adults, this will further add to the appeal of marijuana use.

For more information see Adolescent Services in Section C: Prevention Services & Specialty Populations.

Perinatal Services for Women and Girls

Perinatal services (from age 15+) are gender-specific, trauma informed SUD treatment and recovery services provided to pregnant and new mothers and their dependent minor children, from birth through 17 years of age. Childcare service is provided for participants while on-site receiving services. Issues specific to perinatal members include substance use while pregnant, pre-natal care, parenting, and family violence. All Perinatal Programs, regardless of funding source, are required to comply with the Perinatal Practice Guidelines

For more information see Perinatal Services for Women & Girls in Section C: Prevention Services & Specialty Populations.

Members Involved with the Justice System

The justice system includes accused or adjudicated members who require various SUD services. Parole and probation status is not a barrier to SUD treatment services provided that the parolees and probationers meet the DMC eligibility verification and medical necessity criteria. For many people in need of alcohol and drug treatment, contact with the justice system is their first opportunity for treatment. Services can be provided through courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction. Legal incentives to enter SUD treatment at times motivate individuals to pursue recovery, whereas for other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime.

Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach for the justice population, particularly among offenders with a prolonged history of substance use and crime. However, strong empirical evidence over the past several decades has consistently shown that the justice population can be effectively treated, and that SUD treatment can reduce crime.

Best practice is that staff working with justice populations receive specific training in working with criminogenic risk, need, and responsivity (RNR), as well as SUD and CODs. Staff also must be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the member's care.

The first step in providing SUD treatment to people under justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.

In general, clinical approaches and the use of medication-assisted treatments must parallel those used with individuals who are not involved with the justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions must be based on a multidimensional assessment and individualized needs. However, working with the justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

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

Due to court mandates, classification policies and procedures, various security issues, and differences in available programming, one of the challenges of working with the justice population is determining when the ASAM Criteria can be meaningfully applied. The ideal scenario is for the level of care setting to match the severity of illness and functional impairment, similar to the general population. However, there are instances in working with offenders that necessitate close collaboration with correctional staff to provide services that are clinically appropriate and that also align with correctional and supervision case planning and/or release conditions. When skillfully applied, the ASAM Criteria can be used to access the full continuum of care in a clinically appropriate manner for the justice population.

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

DMC-ODS for members in the criminal justice system

- County should recognize and educate staff and collaborate with Parole and Probation partners.
- Parole and Probation is not a barrier to DMC-ODS treatment.
- Members may receive recovery services immediately after incarceration regardless of whether they received SUD treatment during incarceration.

Homeless Population

There is wide recognition that substance use in the homeless population cannot be treated apart from addressing the needs of the whole person in the context of his or her environment. A continuum of comprehensive services is needed to address the various safety, health, social and material needs of homeless members. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and mental health care, dental care, job training, and employment services. These services may be provided within the SUD program itself or through linkages with existing community resources. Proactive outreach, addressing needs in a non-judgmental and non-threatening environment, and addressing the various identified needs early in treatment may help to better engage this population.

On the whole, research demonstrates that effective programs for homeless members address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/TAY/older adult populations); and provide longer-term, continuous interventions. As a result of these diverse needs, effective treatment for homeless members must involve various disciplines and collaboration across agencies and organizations.

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

Psychosocial interventions and MAT for members experiencing homelessness must mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. Counselors and clinicians also must be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many individuals experiencing homelessness. Medications should be used when clinically indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that medications that require refrigeration are not prescribed when the member has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

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

For these reasons, designated programs throughout the county will provide Homeless Outreach Worker (HOW) services to assist with outreach and engagement in the community. Potential members will be screened and then provided short-term case management and referral services as needed.

Lesbian, Gay, Bisexual, Transgender, Questioning Population

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

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

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

The methods of best practice outlined in counseling competency literature apply to all populations, particularly in working with LGBTQ members. From this perspective, a counselor respects the member's frame of reference; recognizes the importance of cooperation and collaboration with the member; maintains professional objectivity; recognizes the need for flexibility; is willing to adjust strategies in accordance with member characteristics; appreciates the role and power of a counselor; appreciates the appropriate use of content and process therapeutic interventions; and is non-judgmental, respectfully accepting of the member's cultural, behavioral, and value differences.

There are also some unique aspects of treating LGBTQ members that providers must be aware of. For example, while group therapies should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ members. Staff members must ensure that LGBTQ members are treated in a therapeutic manner and group rules should make clear that homophobia is not to be tolerated. The LGBTQ member (and not the other group members) is solely responsible for deciding whether to discuss issues relating to his/her sexual orientation and/or gender identity in mixed groups. Although providing individual services decreases the likelihood that heterosexism/homophobia/transphobia will become an issue in the group setting, there is also an opportunity for powerful healing experiences in the group setting when LGBTQ members experience acceptance and support from non- LGBTQ peers.

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

Veterans

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

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

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

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

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

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

Tribal Communities
SUD services, including outpatient treatment services, withdrawal management, and medication assisted treatment, are offered through collaboration and partnership with local tribal communities via Tribal Federally Qualified Health Centers. Services are provided in rural and urban settings with the focus on providing treatment and recovery services to American Indian/Alaskan Natives residing both on and off reservation communities. For more information, refer to the Tribal Delivery System (Attachment BB) of the Special Terms and Conditions.

For more information see Indian Health Care Providers in Section C: Prevention Services & Specialty Populations.

B. PROVIDING DMC-ODS SERVICES

The County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS) provides access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria. This approach is expected to provide clients with access to the care and services they need for a sustainable and successful recovery.

The goal of the ASAM Criteria is to improve assessment and outcomes-driven treatment and recovery services. It is also used to match clients to appropriate types and levels of care.

Generally speaking, ASAM criteria are used to ensure the client receives the appropriate level of care in the correct program at the right time. The guiding principles of ASAM criteria are:

- Moving from one-dimensional to multi-dimensional assessments
- Moving from program-driven to clinical-driven and outcomes-driven treatment
- Moving from fixed length of service to variable length of service
- Moving from a limited number of discrete levels of care to a broad and flexible continuum of care
- Identifying adolescent-specific needs
- Clarifying the goals of treatment
- Not using previous "treatment failure" as an admission prerequisite
- Moving toward an interdisciplinary approach to care

For more information about DMC-ODS levels of care and services, see the following documentation guide:

- SUD Clinical Documentation Guide

Levels of Care

Early Intervention (ASAM Level 0.5)
Early intervention services are covered for members under the age of 21. Any member under age 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services.

A full assessment utilizing the ASAM Criteria© is not required for a member under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used.

- If the member under 21 meets diagnostic criteria for SUD, a full ASAM assessment shall be performed, and the member shall receive a referral to the appropriate level of care indicated by the assessment.
- Services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone. Nothing in this section limits or modifies the scope of the EPSDT mandate.

Early Intervention Model

- May be embedded in TRCs and their respective school sites and in other programs that serve clients under 21 years of age.
- 0.5 services are provided by TRC's TRC and other treatment services

- Includes school-based programs which often include education, skills training, and counseling for students and their family members
- Services include assessment, education, screening, brief intervention, and referral to treatment, other interventions aimed at reducing or preventing substance misuse, care coordination
- Service durations are individualized from one to multiple sessions
- Utilize a variety of evidence-based curricula available and approved for 0.5 level of care

Outpatient Services, OS (ASAM Level 1)

In this level of care, clients receive up to nine hours a week for adults and less than six hours a week for adolescents when determined by a Medical Director or LPHA to be medically necessary. Services may exceed the maximum based on individual medical necessity. Services may be provided in person, by telehealth, or by telephone.

These services shall include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

County is required to either offer medications for addiction treatment directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving outpatient treatment services if not provided on-site. Providing a member, the contact information for a treatment program is insufficient. County shall monitor the referral process or provision of MAT services.

Intensive Outpatient Services, IOS (ASAM Level 2.1)

In IOS, adult clients receive a minimum of nine hours up to a maximum of 19 hours per week, when determined by a Medical Director or LPHA to be medically necessary. Services may exceed the maximum based on individual medical necessity. Adolescents receive a minimum of six hours up to a maximum of nineteen hours a week when determined by a Medical Director or LPHA. Services may exceed the maximum based on individual medical necessity. Services may be provided in person, by telehealth, or by telephone. Intensive outpatient services shall include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

County is required to either offer medications for addiction treatment directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving outpatient treatment services if not provided on-site. Providing a member, the contact information for a treatment program is insufficient. County shall monitor the referral process or provision of MAT services.

Residential Services (ASAM Level 3.1, 3.5)

Level 3.1 clinically managed, low-intensity residential services are designed to prepare clients for a successful transfer to outpatient treatment services. Client's meeting criteria for Level 3.1 have an impaired ability to practice recovery skills and sustain change behaviors outside of a 24-hour structured setting. Clients are open to recovery and may have some knowledge of relapse prevention, however their ability to structure daily life in an outside environment requires additional skill building and the development of community supports to prevent relapse. Treatment goals for a client meeting criterion for 3.1 may include learning and practicing coping skills, building community connections, relapse prevention, self-efficacy, and an improved ability to structure and organize tasks of daily living. Services are driven by the member's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting; services shall address functional deficits documented in the ASAM Criteria©, aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Members shall be transitioned to appropriate levels of care as medically necessary. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

In a Level 3.1 program, clients must receive 20 hours a week of structured activities. Of those 20 hours, 5 of them must be clinical services (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

In order for residential treatment to be reimbursed on a daily basis, there needs to be one service per day.

Level 3.5 clinically managed, high-intensity residential services are designed to prepare clients for a successful transfer to lower intensity treatment services. Clients meeting criteria for Level 3.5 have severe, unstable SUD symptoms, functional impairments, demonstrate a repeated inability to control impulses, and are in imminent danger of substance use outside of a 24-hour structured setting. Level 3.5 services

sufficiently address complex needs, including significant emotional, behavioral, or cognitive conditions related to a mental health disorder. Clients receiving level 3.5 services have limited coping skills and an outside living environment that is highly conducive to substance use. Treatment services are comprehensive and address severe instability as a result of an SUD, and contributing issues which may include justice-involvement, a personality disorder, antisocial values and other maladaptive behaviors. Treatment goals include stabilization, the development of prosocial behaviors, and relapse prevention skills. Services are driven by the member's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting; services shall address functional deficits documented in the ASAM Criteria©, aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Members shall be transitioned to appropriate levels of care as medically necessary. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

Like a Level 3.1 program, clients in a Level 3.5 residential program must receive 20 hours a week of structured activities. However, of those 20 hours, 10 hours must be clinical services (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

Like a level 3.1 program, in order for residential treatment to be reimbursed on a daily basis, there needs to be a one service per day.

Residential Services (ASAM Level 3.3)

Level 3.3 clinically managed, Population Specific High-Intensity residential services are designed to meet the functional limitations of patients to support recovery from substance-related disorders. Clients meeting criteria for Level 3.3 the effects of the substance use or other addictive disorder or a co-occurring disorder resulting in cognitive impairment on the individual's life are so significant, and resulting level of impairment so great, that outpatient motivational and/ or relapse prevention strategies are not feasible or effective. The patient's cognitive limitations make it unlikely that he or she would benefit from other levels of residential care. The functional limitations seen individuals who are appropriately places at level 3.3 are primarily cognitive and can be either temporary or permanent.

24-hour case with trained and residential personnel providing clinical directed less intense program activities and professional directive treatment to stabilize and maintain SUD symptoms and to develop and apply recovery skills specific for individuals with cognitive or other functioning impairments.

Level 3.3 programs generally are considered to deliver high intensity services, which may be provided in a deliberately repetitive fashion to address the special needs of individuals for whom a Level 3.3 program is considered medically necessary. Such individuals often are elderly, cognitively impaired or developmentally delayed, or are these for whom the chronicity and intensity of the primary disease process required a program that allows sufficient time to integrate the lessons and experiences of treatment into their daily lives. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning, or because of the chronicity of their illness. Reintegration of patients in a level 3.3 program into the community requires case management activities directed toward networking patients into community-based ancillary or "wrap around" service such as housing, vocational services, or transportation assessment so that they are able to attend activities after discharge.

Services include:

- Consultation with physician, physician assistant or nurse practitioner and emergency services 24 hours a day.
- Coordination with less intensive levels of care and other services such as supportive employment, literacy training, and adult education.
- Medical, psychiatric, psychological, laboratory and toxicology services, available through consultation or referral as appropriate.
- Assessment
- Care Coordination
- Counseling (individual and group)
- Regular monitoring of resident's medication adherence
- Education on benefits of MAT
- Recovery Services

Clients in a Level 3.3 residential program must a minimum of 5 hours per week of clinical services specific for individuals with cognitive or other functioning impairments (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

Withdrawal Management

Withdrawal management services are also provided on a continuum, including ambulatory and non-ambulatory WM services, consistent with ASAM levels of care and client-specific needs. WM services focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where member can receive comprehensive treatment services.

For additional information regarding Withdrawal Management and ASAM Levels of Care, please see the ASAM Level of Care (LOC) Determination Guidelines in Appendix B.1 and the Withdrawal Management (WM) Standards posted on the Optum site under Toolbox.

The levels of Withdrawal Management are as follows:

Ambulatory Withdrawal Management (ASAM Level 1-WM)
WM services are provided as a part of a continuum of care to members experiencing withdrawal in the following outpatient, residential, and inpatient settings. Member shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis. A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where member can receive comprehensive treatment services.

Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision). Service components include:

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Observation
- Recovery Services

WM services are urgent and provided on a short-term basis. Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate. If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode. Receiving program shall adhere to initial assessment timeliness requirements.

Medication Assisted Treatment (MAT) Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving partial hospitalization services if not provided on-site (Providing a member the contact information for a treatment program is insufficient).

Ambulatory Withdrawal Management with extended on-site monitoring (ASAM Level 2-WM)
WM services are provided as a part of a continuum of care to members experiencing withdrawal in the following outpatient, residential, and inpatient settings. Member shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.

A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where member can receive comprehensive treatment services.

Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting). Service components include:

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs

- Observation
- Recovery Services

WM services are urgent and provided on a short-term basis. Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate. If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode. Receiving program shall adhere to initial assessment timeliness requirements.

Medication Assisted Treatment (MAT) Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving partial hospitalization services if not provided on-site (Providing a member the contact information for a treatment program is insufficient).

Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM)
This is an organized service delivered by an appropriately trained staff member who provides 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal. Programs providing ASAM 3.2 – WM are strongly encouraged to obtain an Incidental Medical Service (IMS) license through DHCS. This level provides services for client's whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. The clinical components of this level of care include the necessary services for assessment and medication or non-medication withdrawal management, support, services to families and significant others and referrals for ongoing support or transfer planning.

Medically Managed Intensive Inpatient Withdrawal Management (ASAM Level 4-WM)
County may voluntarily cover and receive reimbursement through DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals. Regardless of whether County covers these levels of care, the County must have a clearly defined referral mechanism and care coordination for these levels of care. DHCS All-Plan Letter 18-001 clarifies coverages of voluntary inpatient detoxification through the Medi-Cal Fee-for-Service program. A member shall live on the premises and considered a "short-term resident" of the inpatient facility where the member receives services under this DMC-ODS level of care.

Treatment services under these levels are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).

Services shall address functional deficits documented in the ASAM Criteria© and are aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services may be provided in person, by telehealth, or by telephone. Most services shall be in person. Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu. Services are driven by the member's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting. Service components include:

- Assessment

- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving partial hospitalization services if not provided on-site. Providing a member the contact information for a treatment program is insufficient). County shall monitor the referral process or provision of MAT services.

The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Members shall be transitioned to appropriate levels of care as medically necessary. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

Narcotic Treatment Program (NTP)-ASAM Level 1.0
Narcotic Treatment Program (NTP), also described in the ASAM Criteria© as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

NTPs are required to administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary including:

a. Methadone
b. Buprenorphine (transmucosal and long-acting injectable)
c. Naltrexone (oral and long-acting injectable)
d. Disulfiram
e. Naloxone
f. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the member to a provider capable of dispensing the medication.

Service components include:

- Assessment
- Care Coordination

- Counseling (individual and group)
    - Counseling services- minimum of forty-five (45) minutes per calendar month
    - Counseling services may be provided in-person, by telehealth, or by telephone
- Family Therapy
- Medical Psychotherapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Medical evaluation for methadone treatment
    - Medical history
    - Laboratory tests
    - Physical exam
    - Medical evaluation must be conducted in-person

In accordance with CCR Title 9 10270(c)(3), clients under the age of 16 years can enter detoxification treatment if they have the written consent of their parent(s) or guardian prior to the administration of the first medication dose. In accordance with CCR Title 9 10270(d)(3), the client would need to be 16 years of age to receive maintenance treatment. A licensed NTP does have the option of submitting a SMA-168 Exception Request through the SAMHSA/CSAT Opioid Treatment Program Extranet if a client under 16 years is in need of maintenance treatment. When serving a minor, the contractor shall provide a written summary, guardian consent, and SMA-168 Exception Request and results to the Children Youth and Families Supervising Psychiatrist and the COR.

NTP provides, at minimum, 45 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month. The medical director may adjust or waive at any time after admission, by medical order, the minimum number of minutes of counseling services per calendar month. The medical director shall document the rationale for the medical order to adjust or waive counseling services in the patient's care plan. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP subcontractors may bill and be reimbursed for additional counseling.

Effective 7/1/2021, prior to admission of detox or maintenance treatment, the client evaluation must include the following lab tests. See DHCS Info Notice 20-050 for more information.

- Oxycodone and fentanyl
- Hep C
- HIV testing must be offered

There are three options for NTPs to provide MAT to incarcerated members under BHIN 25-034. The purpose of this behavioral health information notice is to provide treatment options and requirements for incarcerated members diagnosed with an opioid use disorder (OUD) .

- Provision of MAT via a Medication Unit (MU) or Mobile Narcotic Treatment Program (MNTP)
- Provision of MAT via Courtesy Dosing
- Provision of MAT by Authorized correctional facility Staff

Medication Assisted Treatment (MAT)
Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) must be part of a comprehensive, whole-person approach to the treatment of a SUD that includes psychosocial interventions like counseling, behavioral therapies, case management, and care coordination. Providers shall not discourage the use of FDA approved addiction medications as part of this comprehensive, whole-person approach to the treatment of a SUD. Similarly, providers shall not deny services based solely on the fact that the clients are taking prescribed medication, regardless of the type of medication. Programs shall directly offer MAT to members with SUD diagnoses that are treatable with FDA-approved medications and biological products in oral, transmucosal, and long-acting injectable forms. For more information, see the NTP section.

Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving partial hospitalization services if not provided on-site. Providing a member the contact information for a treatment program is insufficient). County shall monitor the referral process or provision of MAT services.

Additional MAT
Additional MAT services may include the ordering, prescribing, administering, and monitoring of all medications for substance use disorders for programs contracted to provide additional MAT. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

Prevention Services & Specialty Populations
San Diego County's substance use prevention strategy primarily utilizes environmental prevention, a federally approved community-change model to prevent substance use problems throughout the region. Providing a targeted focus on these issues allows the County to develop long term, strategic, cost effective and sustainable prevention plans for each initiative, provides coordination and shared resources where possible, and provides flexible prioritization in each region regarding how each initiative will be tailored to individual community needs.

Primary Prevention
Since the inception of the San Diego County Prevention Framework in 1997, the County has initiated regional substance use disorder prevention initiatives aligned with the County of San Diego's Strategic Initiatives:

- Binge and Underage Drinking Initiative (1996)
- Marijuana Initiative (2005)
- San Diego County Substance Use and Overdose Prevention Task Force (2022)

In 2022, the Methamphetamine Strike Force and the Prescription Drug Abuse Task Force were combined to form the San Diego County Substance Use and Overdose Prevention Task Force.

Each of the County substance use prevention initiatives has a subject matter expert facilitator who provides leadership and expertise on the specific initiative's, goals and work plans, and actively engages stakeholders and community throughout the region for each effort.

The County of San Diego's prevention system is implemented through a broad array of contracted community-based prevention service providers. The providers incorporate the activities of the County Prevention Plan to ensure full coordination and continuation of efforts by working together in focused workgroups for each initiative.

The San Diego Prevention system includes a substance use prevention provider located in each of the six HHSA Regions to implement the State approved County Prevention Plan.

A key component to the San Diego Prevention system is a commitment to continuous improvement and professional development in the prevention arena by working closely with the community to mitigate issues they are concerned about. As such, each prevention contract requires a designated position for a media advocacy specialist, a community organizer and a prevention specialist to ensure capacity and expertise at service delivery.

A countywide media advocacy project provides technical expertise training and facilitates a monthly media advocate's meeting to share expertise, resources and experiences conducting media advocacy efforts.

To evaluate and measure the impact of prevention services, all prevention service providers are required to work with the evaluation provider and to provide working documents to the "Prevention Information and Resource Library" (PIRL) portal, which is accessible to County SUD prevention providers. Information includes meeting agendas, sign in sheets, media advocacy calendar, notes and other relevant information. Each County Initiative has an evaluation plan designed to measure the impact of each activity and progress is reviewed annually and over time. Access to PIRL is controlled by the evaluation contractor.

Each substance use prevention provider is required to develop an implementation manual that describes how the Statement of Work (SOW) will be implemented and updated as needed.

Service for Co-Occurring Populations

San Diego County Behavioral Health Services recognizes that members who have co-occurring mental health and substance use conditions are present in all parts of the system of care. Co-occurring conditions, while common, are associated with poor outcomes and higher costs for care. It is expected that all programs be welcoming to individuals with co-occurring needs.

The MHP has adopted a treatment and recovery philosophy that promotes the integrated treatment of members with both mental health and substance use conditions, as this approach is recognized as best clinical practice. Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for co-occurring conditions are combined within a primary treatment relationship or service setting.

Research has generally supported that the ideal approach toward treatment for co-occurring is to address all conditions simultaneously, as opposed to addressing the substance use disorder and mental health condition separately and in a silo of separate treatment approaches. When providers have staff who possess the skills and training to adequately address the needs of the co-occurring population within their scope of practice, integrated care is best provided in-house.

For additional information on Screening and Treatment of Co-Occurring Disorders: Managing Life with Co-Occurring Disorders | SAMHSA.

Programs Serving Children, Youth & Family Services

Adolescent Services

Teen Recovery Centers (TRCs) are specialty population outpatient programs for adolescents experiencing substance use disorders. They also have the capacity to meet the needs of youth with substance use experiencing complex behavioral and mental health issues. TRCs provide substance use early intervention and treatment services for adolescents aged 12-17 and their families. Outpatient early intervention and treatment services, crisis intervention, family therapy, and peer support are offered in our urban and rural communities in each region of San Diego County. Each TRC has a main clinic, and two or more school sites to increase access and coordination with school personnel. The goals of BHS TRC services are as follows:

- Provide developmentally and culturally appropriate substance use early intervention and treatment services for adolescents throughout the County
- Increase access to care by minimizing access times to entering programs
- Increase prosocial skills and eliminate illicit and harmful substance use
- Provide co-occurring disorder treatment
- Improve capability and functioning for youth and their families
- Provide family counseling and support, including peer support
- Support the youth in becoming self-sufficient through education/employment
- Decrease justice system involvement and incidence of crime

Contracted providers are required to follow the DHCS Adolescent Best Practices Guide in developing and implementing youth treatment programs/services.

Teen Recovery Centers (TRCs) have been designed to include one TRC primary site, and at least two TRC ancillary school sites within each regionally based TRC contract. It is required that all TRC sites, both TRC primary sites and TRC school sites or ancillary sites, are DMC-certified.

DMC-certified TRC school sites are required to follow all rules, regulations, and DMC-ODS Special Terms and Conditions (STCs), to include regulations which prohibit members from receiving services at more than one DMC certified facility. This guidance, as applied to TRCs, means that a member can only be seen at the location where they were admitted, and cannot receive services at other DMC- certified sites. Although it may be convenient for a TRC to serve members at multiple locations within the TRC contract, this is not allowed.

TRC programs may encounter occasions when program staff cannot access TRC school sites due to holiday closures, summer break, and/or unique situations where the students are not allowed on campus due to disciplinary action or other reasons. To assist TRC programs with navigating these situations, BHS has provided the following guidelines:

- Members admitted to a TRC school site shall utilize that site's specific facility ID and CalOMS number for SmartCare documentation.
- Members admitted to a TRC school site may receive services at the TRC primary site, on occasion,

when the TRC school site is not available due to school closures, holidays, summer breaks, or other reasons as indicated by documentation in progress note (such as school suspension or expulsion). **Group services may not be mixed with members who are admitted to the TRC primary site and the TRC school site**.

- When a service is provided to a member admitted to the TRC school site at the TRC primary site, the service location shall be documented as "in the community." As with all services that are provided in the community, documentation shall explain how program staff maintained the member's privacy in accordance with 42 CFR.
- Members admitted to TRC primary sites shall not receive services at TRC school sites, due to school/school district rules.
- If a member admitted to a TRC primary site attends a school which provides TRC school-site services and wishes to receive services at the TRC school-site, member shall be discharged from the TRC primary site as "referred" and admitted to the TRC school-site as a transfer.
- TRC ancillary sites that are not located on school campuses shall follow all guidelines listed above.

TRCs shall utilize the CRAFFT Questionnaire as a screening tool to evaluate need for treatment services or referral to early intervention services.

Additionally, it is a requirement for all DMC-ODS Teen Recovery Centers to utilize SchooLink and all required forms. SchooLink is a collaborative training program and tool kit for County-funded behavioral health providers and school staff in the County of San Diego. It provides successful strategies for linking eligible children and youth to on-campus, County-funded behavioral health services. The project launched for the 2018/2019 school year, and provides strategies and specific tools, based on best practices in the field, for a collaborative process to ensure student access to behavioral health services is used to its full capacity. Focus areas include:

- **Provider Orientation/Annual Meeting**

Setting the stage for schools and behavioral health providers to work together throughout the school year.

- **School Outreach**

Identifying and establishing school outreach strategies. Communication and connection of behavioral health staff to school staff to understand behavioral health services available on-campus.

- **Parent Outreach**

Identification of parent outreach strategies. Informing parents about on-campus behavioral health services and encourage distribution of parent brochure and educational materials.

- **Eligibility**

Informing parents/guardians of behavioral health service providers and eligibility. Describing the ways parents/guardians may access behavioral health services for their adolescent.

- **Referral and Assessment**

Creating a standardized referral process. Describing the standardized referral process and introducing the referral form and first contact procedures.

- **Treatment**

Best practices to connect adolescents with early intervention and treatment. Gain an understanding of best practices for summoning students and for sending monthly status reports via the Monthly Referral Communication Log.

- **Confidentiality**

Understanding confidentiality standards and limitations. Strategies for how behavioral health providers can respond within confidentiality limitations when school staff express caring and concern about how a student is responding to treatment.

- **Suicide/Self-Harm Procedures**

Understanding roles and responsibilities when responding to suicide risk or evidence of self-harm.
Clarifying that the Principal or designee takes responsibility for response to suicide/self-harm concerns and that the behavioral health provider follows school policy.

- **Special Education**

Understanding how to assist parents who inquire about special education services.
Best practices for behavioral health staff to respond to parent questions related to special education resources.

Perinatal Services for Women & Girls

Women and adolescents who are pregnant and/or parenting, and women seeking gender-specific services, with substance use and/or co-occurring disorders may receive SUD services through the Perinatal Services Network. Health and safety of both the mother and her child/children are key. The following are essential service elements:

- Outreach and engagement
- Screening and assessment
- Trauma Informed, gender specific, and culturally competent treatment
- Medications for Addiction Treatment (MAT)
- Withdrawal Management in outpatient and residential settings
- On-site licensed child care in accordance with child care licensing requirements, or on-site, license-exempt child care through a cooperative arrangement (aligned with DHCS Perinatal Practice Guidelines, page 20). Partnership with local licensed child care facilities for off-site provision of child care requires COR approval.
- Evidence-based parenting curriculum, such as Incredible Years
- Vocational training and job-finding assistance
- Transportation for pregnant and parenting women and their children
- Housing support for enrolled women and their children, including Community Support Services through the Managed Care Plan (MCP), such as Transitional Rent Services, and temporary housing through Recovery Residences
- Registered/certified SUD counselors and licensed/license-eligible License Practitioners of the Healing Arts (LPHA)
- Assessment and therapeutic interventions, arranged or provided to address developmental and behavioral needs of children in the custody of women in treatment
- Age- and developmentally-appropriate SUD treatment services for pregnant and/or parenting girls ages 15 and older
- Dependency Drug Court services, including screening and referral to treatment, care coordination, and supportive services

In accordance with SUBG requirements, all SUD treatment providers must treat the family as a unit and admit both women and their child(ren) into treatment services, if appropriate. Treatment providers must serve the following individuals with a SUD.

- Women who are pregnant.
- Women with dependent children.
- Women attempting to regain custody of their children.
- Postpartum women and their children.
- Women with substance exposed infants.

Additionally, SUD providers offering services funded by DMC or DMC-ODS shall address specific treatment and recovery needs of pregnant and parenting women.

The postpartum coverage period for individuals receiving postpartum care services begins after the last day of pregnancy through the last day of the month in which the 365th day occurs. Individuals will maintain coverage through their pregnancy and the 12-month postpartum coverage period regardless of income changes, citizenship, immigration status, or how the pregnancy ends. Questions concerning the postpartum coverage period should be sent to Pregnancy@dhcs.ca.gov.

It is required that SUD providers serving women shall provide preference to pregnant women with access to more urgent treatment services due to the harmful effects of substance use on the fetus. Specifically, priority must be given to pregnant women who are seeking or referred to treatment in the following order:

- Pregnant injecting drug users
- Pregnant substance users
- Injection drug users
- All others

In addition, SUD treatment and recovery services provided to women who are pregnant and/or parenting need to be cognizant of the stigma that is often directed toward this population for use of substances, which can be a barrier to seeking services and to full disclosure of substance use behavior, including relapse, due to fear of negative consequences.

Additional information regarding perinatal service delivery requirements, best practices, capacity management, and recovery support may be found in the Perinatal Practice Guidelines.

Dependency Drug Court SUD Coordination (DDCSC)

The Dependency Drug Court SUD Coordination (DDCSC) program provides screening and referral for substance use treatment, care coordination, and support to families that are involved with Child and Family Well-Being (CFWB). Substance Use Specialists (SUS) collaborate with the Juvenile Dependency Courts within the County of San Diego Superior Court. The role of the SUS is to provide support and coordination between the member, the SUD treatment program, Courts, and CFWB, and to give updates to the Court on the member's status/progress in treatment.

Services for Children of Parents Receiving SUD Services

The Perinatal Outpatient and Residential treatment programs utilize licensed/license-eligible mental health clinicians to work directly with the children of mothers receiving SUD services to:

- Screen children to determine need for mental health services, to include but not limited to, parent-child bonding
- Provide assessment and therapeutic interventions for children screened to have emotional, developmental, behavioral, attachment needs and/or trauma history
- Identify and link children with higher level needs to specialty behavioral health services

- Collaborate with County-designated contractors offering therapeutic services for children, to include but not limited to, Healthy Development Services (HDS) and Developmental Screening and Enhancement Program (DSEP)

Justice-Involved SUD Services
For many people in need of alcohol and drug services, contact with the criminal justice system is their first opportunity for treatment. Outlined below are specific requirements for providers to follow and utilize in serving the specific needs of this population. Note: Providers will not be reimbursed for report writing.

PC 1210/Prop 36
Providers who receive members referred to SUD services by the Court under PC 1210/Prop 36, shall provide reports and communication to the Court regarding member treatment status as directed by Program COR.

Community Resource Directory (CRD)
The Probation Department Community Resource Directory (CRD) is a web-based catalog of countywide services to which adults and youth can be referred. It assists in linking individuals on probation to appropriate community-based intervention services based on the individual's assessed needs. Service providers receive probation referrals through the CRD and utilize the CRD as a mechanism to report back to probation officers on an individual's progress toward meeting their program goals.

As directed by COR, Contractor shall enroll in and utilize the CRD to include referral management and weekly status updates, as one route to work closely with the case-carrying Probation Officer.

Communication with Probation
Program staff shall contact Probation within 24 hours whenever noteworthy incidents arise involving a member on probation. These noteworthy incidents include but are not limited to: Program enrollment/exit; violent behavior; positive urinalysis results; law enforcement contact; change in program location; and critical incidents, such as death or hospitalization of a member. Providers shall work closely with and be available to meet monthly or as agreed upon with case carrying Probation Officers to discuss member progress in treatment. Communication with Probation shall be documented in the member's treatment record. Contractors shall provide pertinent treatment information received from Recovery Residences, Independent Living Homes, or Board and Care Facilities to the assigned case-carrying Probation Officer to include providing information about noteworthy incidents within 24 hours of receiving the information. Providers shall be available to meet quarterly with Probation representatives to discuss systemic improvements and collaboration. Providers shall return emails and phone calls from Probation staff within two (2) business days.

Correctional Program Checklist (CPC)
As directed by COR, Contractor will fully participate in the Corrections Program Checklist (CPC) to improve treatment quality for members who are assessed to be moderate to high risk for recidivism. Additional information regarding the CPC is found in the Technical Resource Library.

High Risk Services
As directed by COR, contractor shall utilize criminogenic risk and need assessment results (i.e. COMPAS) to inform individualized treatment planning and to develop specific "treatment tracks" for members who

are assessed at medium to high criminogenic risk. These treatment tracks will include evidence base practices with a target of reducing recidivism as a focus of treatment.

Criminal Offender Record Information (CORI)
Please refer to the Staffing and Training Section.

Justice Overrides
While in residential treatment, members on "justice overrides" may be allowed to hold a job and/or receive vocational activity in lieu of a structured activity. The vocational activities may replace "program structure activity hours" but minimums of 3.1 clinical hours would still be in place. County recommends members to be referred to programs directly whenever possible.

- Provider would need to utilize a DMC-billable cost center when a court-ordered members is a Medi-Cal member, meets the Program LOC, and is opened to the Program.
- Provider would need to utilize a County-billable cost center to claim the cost of screening a court-ordered member but not opened to the Program and/or the member is opened to the program but is not a Medi-Cal member.

County of San Diego Justice-Related SUD Programs

Driving Under the Influence (DUI) Programs
The Driving Under the Influence (DUI) programs are licensed by the California Department of Health Care Services and administered locally by BHS. Services are designed to meet the requirements of the Department of Motor Vehicles (DMV) and courts as stipulated for individuals who have been arrested for driving under the influence. Available services include: 3, 6, 9, 12, and 18-month programs and education only. This program is completely funded by participant fees. Spanish services are available at all locations. All facilities are wheelchair accessible.

Penal Code Section 1000 (PC 1000)
California Penal Code Section 1000 (PC 1000) establishes the authority for counties to create drug diversion programs for eligible participants who are referred from a court. A referral will be made to a County certified PC 1000 Drug Diversion program when a participant is eligible and suitable for the PC 1000 program. Persons who have a need for Substance Use Disorder (SUD) treatment, and who have private insurance, will be referred to their healthcare provider. The criminal charge is dismissed, pursuant to statute, if the participant successfully completes the program and complies with the conditions established by the court.
PC 1000 Two-Track Drug Diversion Program is intended to provide participants with either education on substance use or treatment for a diagnosed substance use disorder (SUD). The Drug Medi-Cal Organized Delivery System, and changes in state law, bring about the following changes to providers: 1) elimination of the AIDS education component, 2) maintenance of the education track, and 3) addition of a treatment track. The education track will continue at the existing sites, and on September 1, 2019, the new treatment track will be available at the six Regional Recovery Centers. All participants will be assessed SUD need through the American Society for Addiction Medicine (ASAM) criteria. If participant is assessed as having a need for treatment, they will only participate in the treatment track. Please see Appendix C.1 for service and program requirements, including communication with court requirements.

Drug Court and Re-entry Court

Drug Court Programs shall establish and maintain a program to provide non-residential substance use disorders (SUD) treatment and testing program services to serve non-violent adult male and female offenders who have been referred to Adult Drug Court. Members of the Adult Drug Court Team, which include the Adult Drug Court Judge, District Attorney, law enforcement, Public Defender, and Programs, shall participate in case conferencing and Adult Drug Court sessions.

Indian Health Care Providers

The county shall not disallow reimbursement for clinically appropriate and covered SUD prevention, screening, assessment, and treatment services due to lack of inclusion in an individual treatment plan, or lack of member signature on the treatment plan.

- Members can receive Traditional health care services while in residential or inpatient
- Regarding residential treatment, services can be provided in facilities of any size.
- The two new service types that may be provided include: Traditional Healer and Natural Helper Services. For additional detail on these service types, please see BHIN 25-036.
- Details regarding opt-in templates for participating providers, additional SUD services available, and Indian Health Care Programs and approved IHCPs can be found in BHIN 25-036.For questions related to traditional health care practices or BHIN 25-036, please email: traditionalhealing@dhcs.ca.gov.

American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted into the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). IHCPs include:

- Indian Health Service (IHS) facilities
- Tribal 638 Providers - Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the "List of Tribal Federally Qualified Health Center Providers"
- Urban Indian Organizations (UIO)

All American Indian and Alaska Native (AI/AN) Medi-Cal members whose county of responsibility is a DMC-ODS county may choose to receive DMC-ODS services at any DMC-certified IHCP, whether or not the IHCP has a current contract with the member's county of responsibility and whether or not the IHCP is located in the member's county of responsibility.

DMC-ODS counties:

- must reimburse DMC-certified IHCPs for the provision of these services to AI/AN Medi-Cal members, even if the DMC-ODS county does not have a contract with the IHCP.
- are not obligated to pay for services provided to non-AI/AN members by IHCPs that are not contracted with the DMC-ODS county.
- must adhere to all 42 CFR 438.14 requirements.
- select the DMC-certified providers with whom they contract to establish their DMC-ODS provider networks, with the exception of IHCPs.

Note: American Indian/Alaska Native (AI/AN) MC members can request DMC services from an AI/AN provider of their choice. Non-AI/AN programs shall assist members with these requests, with a warm hand-off by using the IHCP Referral Resource posted on the Optum website under the IHCP tab/IHCP resources. https://www.optumsandiego.com/content/dam/san-diego/documents/dmc-ods/toolbox/IHCP_Referral_Resource.pdf.

BHIN 25-013, Section III-f highlights that County Behavior Health Plans (BHP) and DMC-ODS shall demonstrate compliance with federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 CFR Part 438.14).

Indian Health Care Providers are not required to contract with BHP/DMC-ODS counties; however, shall document good-faith efforts to contract with all IHCPs in the BHP's County. If County BHP/DMC-ODS has a valid contract with an IHCP, the BHP/DMC-ODS County shall submit a copy of the contract with their annual submission and complete the MHP/DMC-ODS 274 data fields corresponding with IHCP. If the County BHP/DMC-ODS does not have a contract with any of the IHCPs in the County, County BHP/DMC-ODS shall submit to DHCS an attestation on county letterhead including an explanation to DHCS to justify the absence of an IHCP in the BHP/DMC-ODS' provider network, along with supporting documentation. If a BHP/DMC-ODS County is unable to contract with an IHCP, County BHP/DMC-ODS must allow eligible Members to obtain services from out-of-network IHCP in accordance with 42 CFR section 438.14. DHCS will review the BHP/DMC-ODS submission to determine compliance.

Scope of Practice

Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. For example, DHCS has clarified that although RNs are considered LPHAs, they are not permitted to determine a SUD diagnosis because it is not within their scope of practice. Therefore, programs shall not use a RN as a LPHA to identify a diagnosis. Diagnostic determination shall be made by an LPHA.

Service Descriptions

Intake/Assessment

An intake/assessment session is the process of admitting a client into substance use disorder treatment program. The intake/assessment includes the evaluation of the cause and nature of mental, emotional, psychological, behavioral, and substance use disorders. Intake occurs upon admission to the program on the first day of treatment. The assessment continues the process of the intake to further evaluate the client to determine the diagnoses and individual service needs utilizing the ASAM criteria and YAI for youth. In the treatment of persons with a SUD, assessments are an essential and ongoing process in order to help the provider focus their service delivery to best meet the individual client needs. Practitioners shall use the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service.

Consists of activities to evaluate or monitor the status of a member's behavioral health and determine the appropriate level of care and course of treatment for that member. Assessments shall be conducted in accordance with applicable State and Federal laws, regulations, and standards. Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory

testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the "Other laboratory and X-ray services" benefit of the California Medicaid State Plan).

- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the member's needs, planned interventions and to address and monitor a member's progress and restoration of a member to their best possible functional level.

For more information about assessments, see Section D: Practice Guidelines.

Group Counseling

Group counseling sessions are designed to support discussion among clients with guidance from the facilitator to support understanding and encourage participation on psychosocial issues related to substance use. Group counseling sessions need to utilize evidence-based practices.

Individual Counseling

Consists of contacts with a member. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

Family Therapy

Family therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the member's recovery as well as the holistic recovery of the family system. Family members can provide social support to the member and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the member is not present during the delivery of this service, but the service is for the direct benefit of the member.

Collateral Services

Collateral services are sessions between significant persons in the life of the client and SUD counselors or LPHA's. Significant persons are individuals that have a personal, not official or professional relationship (e.g., teachers or probation officers) with the client. These sessions are used to obtain useful information regarding the client to support their recovery. The client may be present, but it is not a requirement that the client is present. A progress note must document each session in the client's chart.

Crisis Intervention

Consists of contacts with a member in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the member an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the member's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.

Care Coordination

Care coordination was previously referred to as "case management" for the years 2015-2021. Care coordination shall be provided in conjunction with *all* levels of treatment. Service components include one of more of the following:

a. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.

b. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
c. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

Care Coordination may also be delivered and claimed as a standalone service in a DMC-ODS County. Services can be provided in clinical or non-clinical settings, including the community. Services may be provided in-person, by telehealth, or by telephone. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.

Note: There is not a separate billing code for care coordination services, so these types of activities are billed to "Case Management."

For more information, see Section D: Practice Guidelines.

Discharge Planning

Discharge planning is the process of preparing the client to transition from the current services to another level of care or out to return to the Community. Discharge planning should begin at the onset of treatment services. This ensures sufficient time to plan and prepare the client for change. It also assists in conveying the concept that recovery is an ongoing life process and not a single event or service. Discharge planning sessions are defined as face-to-face contact between one SUD counselor, or LPHA and one client at the same time. The Discharge Summary is a narrative summary that summarizes the treatment experience. Note: For details on documentation requirements for these services, please refer to the section on Documentation.

Recovery Services

Recovery Services are available for all clients and can be delivered and claimed as a standalone service, concurrently with other levels of care and immediately after incarceration with a prior diagnosis of SUD. Clients can receive recovery services immediately after leaving incarceration, whether or not they received SUD treatment during their incarceration. The last treatment provider of care will serve as the default provider of Recovery services, unless necessary services are not offered, or the client prefers a change in provider. These services can be delivered by either an SUD counselor, or LPHA and will be offered after completion of a treatment episode. Recovery Services shall not be denied to clients based on relapse or continued substance use, although assessment for appropriate level of care may be needed when client substance use patterns have changed.

Clients may receive recovery services concurrently with other DMC services and levels of care as clinically indicated. Clients receiving MAT, including NTP services, may receive recovery services.

Recovery Services include outpatient individual or group counseling (relapse prevention), peer support services, recovery monitoring/coaching, care coordination/linkages to education and job skills services, family support (i.e., childcare, parent education, etc.), support groups, and other linkages (such as to housing, transportation, etc.) Recovery services are provided either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the member. Providers may accept

Recovery Service clients from other treatment programs. If a client is accessing Recovery Services within 90 days of concluding their treatment phase, the Adult ASAM Criteria Assessment is not required but should be reviewed if within the same program. If a client is accessing Recovery Services more than 90 days after concluding their treatment phase, the Adult ASAM Criteria Assessment form shall be completed.

Recovery Services shall be utilized when the member is triggered, when the member has relapsed, or simply as a preventative measure to prevent relapse. Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the member to their best possible functional level. Recovery Services emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members. Members may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Members do not need to be diagnosed as being in remission to access Recovery Services. Additionally, recovery services are provided based on medical necessity.

For more information:

- See Care Coordination for expectations for offering Recovery Services to clients.

Clinical Consultation

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

The Center Substance Use Management team at UCSF provides free peer-to-peer consultation from physicians, clinical pharmacists, and nurses with special experts in substance use evaluation and management. Advice on all aspects of substance use management is provided, including:

- Assessment and treatment of opioid, alcohol, and other substance use disorders
- Approaches to suspected misuse, abuse, or diversion of prescribed opioids
- Methods to simplify opioid-based pain regimens to reduce risk of misuse and toxicity
- Urine toxicology testing – when to use it and what it means
- Use of buprenorphine and the role of methadone maintenance
- Withdrawal management for opioids, alcohol, and other CNS depressants
- Harm reduction strategies and overdose prevention
- Managing substance use in special populations (pregnancy, HIV, hepatitis)
- Productive ways of discussing known or suspected addiction with clients

This service does not occur in real-time, so is not appropriate for emergent and/or urgent consultation needs. Cases may be submitted for consultation via internet at the UCSF Clinical Consultation Center website http://nccc.ucsf.edu/clinician-consultation/substance-use-management/ or by calling Monday-Friday, 7a.m. – 5 p.m. PT at 844-ASK-NCCC or 844-275-6222.

Clinician services are strictly limited to routine consultation requests. Emergent and urgent consultation needs should be directed to more appropriate resources (e.g., emergency department, psychiatric emergency services, etc.).

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

Peer Services

Peer Support Services may be provided face-to-face, by telephone or by telehealth with the member or significant support person(s) and may be provided anywhere in the community.

Peer Support Services include the following service components:

- **Educational Skill Building Groups** means providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- **Engagement** means Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions between levels of care and supporting members in developing their own recovery goals and processes.
- **Therapeutic Activity** means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support persons.

Housing Needs & DMC-ODS

Recovery Residences

Recovery Residences (also known as Sober Livings) are privately-owned homes or complexes that provide transitional housing for adults actively receiving SUD Outpatient Treatment Services or Recovery Services. (On rare occasions, clients actively receiving SUD Residential Recovery Services that do not meet ASAM criteria for Residential or Outpatient Services or who decline Outpatient Services may also be referred to Recovery Residences). Recovery Residences serve residents who are in need of a recovery oriented, supportive housing environment. Recovery Residences serve as a housing option for clients who are homeless and/or in unsafe living environments.

The County has contracted with CHIP (Community Health Improvement Partners) to develop a Recovery Residence Association (RRA) to provide oversight and support for our local Recovery Residences, their proprietors, owners, and clients to ensure the highest quality of living environment and to address any issues that may arise. They will identify and implement a training curriculum and a set of quality standards and best practices for Recovery Residences that are part of RRA. BHS Providers are encouraged to use Recovery Residences that are part of the RRA.

Recovery Residence supplemental funding is an option for clients who are receiving treatment at a DMC-

ODS outpatient or residential program. Refer to Recovery Residences – Supplemental Funding Guidelines posted on the Optum site for more details on the requirements and maximum costs. County reimbursement is only available for daily utilized beds. It is important to note supplemental funding for Recovery Residences should only be utilized when other safe housing options (e.g., supportive family residence) are not readily available for the client. Recovery Residence funding can also be used on a case-by-case basis for immediate short-term/time limited housing (e.g., motel) needs when a client is at risk and there is a delay in transitioning them to a stable long-term recovery residence. Programs should contact their COR for approval in these circumstances.

Programs are responsible for having an active MOU/MOA with recovery residence providers and shall monitor compliance of the recovery residence annually to ensure treatment services are not provided in recovery residences and that the recovery residence locations are secure, safe, and alcohol/drug free. Evidence of required monitoring shall be made available to the County upon request.

Please note: For CalOMS reporting of living arrangements, clients residing in a recovery residence should be reported in the dependent living category. See CalOMS Tx Collection Guide for more information.

Outreach Services

Documentation of Outreach Services
Documentation of providers' outreach services shall be made available in the event of a County audit.

General and Injection Drug User (IDU) Alcohol and Drug Outreach Services
Providers shall conduct outreach to individuals experiencing substance use disorders problems, with special attention to reaching injection drug users and helping them to access treatment and recovery services.

Information and Education
Providers shall provide information and education to prevent and minimize the health risks of substance use disorders. Providers shall promote awareness about the relationship between substance use and the personal health risks of communicable disease such as Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) and, for pregnant women, the relationship between substance use and the risks to their children.

Homeless Shelter Outreach Services
Providers shall make available staff or volunteer participation in regional homeless shelter outreach services throughout the year. To assist members who are homeless please see link: Get Help - Regional Task Force on Homelessness.

Homeless Outreach Worker Services
The target population for the provision of Homeless Outreach Services are individuals who are homeless and may have a serious mental illness and/or substance use disorder. Homeless Outreach consists of the following services:

- Outreach and engagement
- Screening for mental health, physical health, and substance use disorders
- Linkage to services which may include:
    - Mental Health
    - Substance Use Disorder
    - Physical Health

  - Social Services
  - Housing
  - Employment Services
  - Advocacy
  - Other services as indicated
- Referral and placement in emergency homeless shelters
- Short-term care coordination and case management
- Coordination and collaboration with other providers to include psychiatric hospitals and other fee-for-service (FFS) providers.

Homeless Outreach Workers (HOWs) respond to community requests, as directed by their COR. HOWs will be notified of any known environmental safety hazards at the time of the initial referral and program shall notify COR of any safety concerns identified during outreach. Program shall develop policies and procedures for Outreach Safety in the community. Programs are required to complete a follow up report for COR requested HOW outreach services. For an overview of the HOW services model and documentation requirements, see County Technical Resource Library.

Homeless Funds

Homeless incidental funds are used for client-related needs including food, clothing, transportation, and other incidentals necessary for accessing ongoing benefits.

C. PRACTICE GUIDELINES

Programs shall ensure that Substance Use Disorder (SUD) treatment and recovery services are provided to adults and adolescents with a SUD, including those with co-occurring disorders. Programs shall provide these services to a specific subset of this population (e.g., women, probationers) based on the nature of their program. Programs are advised to refer to their contract for detailed information regarding their program's target population. To serve the target population to the standards expected by the County of San Diego Behavioral Health Services (COSDBHS), the following admission protocols shall be developed by the Programs.

Admission Policies, Procedures and Protocols

Programs shall develop and maintain written program admission policies, procedures and protocols. The policies, procedures and protocols shall be developed to ensure services to the target population and shall comply with the non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations, of the Service Template. Programs shall implement non-discriminatory admission policies, ensuring that members are admitted to treatment and recovery services regardless of anticipated treatment outcome that are in line with harm reduction principles. Policies shall also comply with the entry criteria and priority as defined by the contracts. Admission policies and procedures shall be submitted for review and approval by the COR within 60 days of Agreement execution. In the very rare occasions that providers should exclude members from their program (example: members become violent), providers are to use case managers to do a warm hand-off to appropriate services. Medi-Cal members are entitled to receive DMC services. Providers should consult with their legal entity when excluding DMC members from receiving services as this does not align with the SOW and SUDPOH requirements. Legal entities may discuss with CORs.

All programs: AB 2081 – Disclosure Requirements for SUD Programs: Beginning January 1, 2025, licensed alcoholism or drug abuse recovery facilities and certified alcohol or drug programs must disclose their licensing/certification status on their websites and admission forms. This includes a link to the DHCS webpage listing facilities on probation or with revoked/suspended.

Daily Admissions

Outpatient and Residential programs shall have capacity to conduct daily admissions and level of care determinations for the days they are open. Outpatient programs are expected to be open five (5) days a week at minimum, and to complete the Initial Level of Care Assessment upon admission. At residential programs, the LPHA initial level of care face-to-face determinations are expected to be completed within the same day of admission and no more than 24 hours after the member admission. Doing so ensures that members staying overnight receive an initial assessment. Each residential program shall have Daily Admission Policy & Procedure developed with, and approved by, Medical Director, regarding member safety.

Acclimation Periods

Programs are required to follow their policies and procedures as developed with the program's Medical Director in determining length of, and rules around, any type of acclimation (i.e. "blackout") period after members' admission to a residential program. (Please note programs are not required to have such a period). These policies and procedures shall ensure that members at residential facilities may correspond, have reasonable access to telephones, and have regularly scheduled opportunities to meet with visitors consistent with treatment needs. Program rules and restrictions must always be germane to treatment and consistent with trauma informed and DMC-ODS principles, and the policies and procedures for the acclimation period must allow for access to medically necessary and clinically indicated appointments, such as mental health appointments, medical appointments, child visitation (including phone calls with children), court and

probation meetings, etc. Additionally, member correspondence addressed to, or from, the County of San Diego, public officials, attorneys, and clergy shall be unrestricted and shall be forwarded promptly without being opened or read by provider staff. Best practice guidelines indicate that arbitrary, blanket rules tend to be disempowering and may negatively impact the treatment milieu, therefore any restrictions to access during the acclimation period should be based on individualized risk assessment factors that are clearly documented in the member's chart.

Screening Process

The screening process functions to:

- Determine an appropriate provisional level of care for an individual
- Connect with emergency services if at any point during the call or in-person screen, it is determined that emergency services are required. At such times, providers are to follow written program crisis policy and procedure
- Facilitate a "warm handoff" of the member to the identified provider capable of meeting the individualized need(s) of the individual, including programs that specialized in treatment of special populations or specific cultural groups
- Respect individual rights and choice/preference
- Offer service recommendations to include an appointment for a comprehensive assessment for possible admission into a SUD treatment program
- Obtain member personal demographic and identifying information to assist for the establishment of eligibility for SUD treatment services
- Collection required ASAM elements for DHCS reporting
- Document member contact for access time standards
- Identify priority population

Perinatal screening

- The most important domains to screen for when working with women include:
- Substance use, including the type, frequency, and impact of alcohol or drug consumption.
- Pregnancy considerations, including the stage of pregnancy, potential risks to maternal and fetal health, and the impact of any substance use or medical conditions on the pregnancy.
- Immediate risks related to serious intoxication or withdrawal.
- Immediate risks for self-harm, suicide, and violence.
- Past and present mental disorders, including Posttraumatic Stress Disorder and other anxiety disorders, mood disorders, and eating disorders.
- Past and present history of violence and trauma, including sexual victimization and interpersonal violence.
- Health screenings, including HIV/AIDS, hepatitis, tuberculosis, and sexually transmitted diseases.

Should a service/level of care recommendation not be agreed upon by the individual and/or SUD provider that matches the individual's needs and preferences as determined by the screen, or, should the individual not have a readily available appointment date, and/or the provisional recommended level of care provider not have openings, the screener will provide the individual with additional provider options and continue to work with the individual and provider to secure a "warm hand off" linkage of member to provider for a scheduled appointment. Programs have the option of using the SUDURM Brief Initial Screening tool or using another screening tool of your choice. If you choose to use a screening tool of your choice, the tool shall include required data elements needed for ASAM reporting.

Priority Population Policies & Procedures

Programs will have written policy and procedure to reflect adherence to Federal and State Health and Human Services priority and entry criteria:

- Pregnant Injection Drug Users (IDU)
- Pregnant Substance Users
- Parenting Injection Drug Users
- All other IDU
- Parenting Substance Users
- All other County Health and Human Services (HHSA) referrals

Intake/Admission Process

SUD providers within the County of San Diego system of care are required to include within their program policies, procedures, and practice, written admission and readmission criteria for determining member eligibility and medical necessity treatment per Federal, State, and County, and contractual regulations, obligations. Program admission and readmission policy and procedure will ensure services are offered to the target population to include special populations and comply with all non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations.

An Intake/Admission appointment is considered the members first treatment episode and is a billable service. The member admission to treatment date is considered the date on which any face-to-face treatment service is provided to a member. An individual becomes a member of the program once intake, assessment process, and verification of eligibility Section 51341.1(b)(13), Title 22, CCR, Federal, State, County, and program regulations, policy and procedure, is completed. Programs will ensure via policy and procedure that anticipated treatment outcome will not impact admission of an eligible member. Services for covered services are reimbursable even when:

- The Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met, as described above.
- The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan.
- Services were provided prior to determination of SUD diagnosis.
- Services provided did not meet SUD criteria for continued services.
- The DMC-ODS County shall ensure that members receiving NTP services and working in or traveling to another county (including a county that does not opt into the DMC-ODS program) do not experience a disruption of NTP services.
- In accordance with 42 CFR 438.206, if the DMC-ODS county's provider network is unable to provide necessary services to a particular member (e.g., when a member travels out of county and requires daily NTP dosing), the DMC-ODS county shall adequately and timely cover these services out-of-network for the member, for as long as the DMC-ODS county's provider network is unable to provide them. In these cases, the DMC-ODS county shall coordinate and cover the out-of-network NTP services for the member.

Initial Assessment

Initial assessment for all levels of care, except Narcotic Treatment Programs (NTP) may be conducted:

- Face-to-face
- By telephone (defined as synchronous audio-only)
- By telehealth (defined as synchronous audio and video)
- In the community
- In the home

Documentation to be completed at intake/admission may include:

- ASAM Criteria Assessment
- TB Screening Questionnaire
- Health Questionnaire
- Proof of Pregnancy and the last day of pregnancy (for Perinatal programs if applicable)
- Financial Responsibility and Information Form
- CalOMS Profile Form
- CalOMS Admission Form
- Consent for Treatment
- Notice of Privacy Practices
- Written Summary Outlining Federal Confidentiality Requirements (per 42 CFR)
- Your Personal Rights at an AOD Certified Program (required for all programs as part of compliance with the "Alcohol and/or Other Drug (AOD) Program Certification Standards" of DHCS)
- Acknowledgement of DMC-ODS Member Handbook and BHS Provider Directory Form
- Grievance and Appeal Process is explained, and brochure with envelope is offered
- Provider Directory by Provider (pdf) is explained and offered
- Language/interpretation service availability reviewed and offered, as applicable
- Voter Registration material is offered
- Consent for Release of Information, as applicable
- Release of Information to primary care physician (PCP), or to assist linkage with one if the member does not have a PCP
- Consent for Photo, TV, Video (if applicable)
- Risk Assessment and Safety Management Plan
- High Risk Assessment (optional)
- Community Resource List

Per https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-25-003.pdf (Section 7010(d)), member is to be provided an introduction and overview to describe the functions and requirements of the program within seventy-two (72) hours of admission.

Medical Necessity and SUD Diagnosis Requirements
Medical necessity refers to the applicable evidence-based standards applied to justify the level of services provided to a member for the services to be deemed reasonable, necessary and/or appropriate. It refers to those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with 42 CFR 438.201(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

It is imperative that medical necessity standards be consistently and universally applied to all members to ensure equal and appropriate access and service delivery. Medical necessity is also established to demonstrate and maintain eligibility for services delivered.

An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

Members aged 21 years of age or older, services up to 30 calendar days form first visit with LHPA or certified/registered counselors are clinically appropriate services when provided during the *initial or full* ASAM Criteria© assessment.

Members 21 years and older

- A service is considered "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- At least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

OR

- At least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

Members under age 21 years, services up to 60 calendar days from date of first visit with LHPA or certified/registered counselor and considered clinically appropriate services when provided during the *initial or full* ASAM Criteria© assessment

Members under the age of 21 may receive covered services that are appropriate, and medically necessary to correct and ameliorate health conditions (pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations). Services provided need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and substance use disorders (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

All members to receive covered and "medically necessary" services. Services are considered "medically necessary" if the service is necessary to correct or ameliorate screened health conditions (pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations).

Services for covered services are reimbursable even when:

1. Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met, as described above.
2. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or
3. Perinatal:
4. Care plans to include mother/child services, transport, education, ancillary coordination and parenting skills. Parenting skills should be integrated into the plan of care.
5.
6. The member has a co-occurring mental health condition.
    a. Clinically appropriate and covered DMC services delivered by DMC providers are covered and reimbursable whether or not the member has a co- occurring mental health disorder.
    b. Reimbursement for covered DMC services provided to a member who meets DMC criteria and has a co-occurring mental health condition shall not be denied as long as DMC criteria and requirements are met.

Diagnosis

1. Diagnostic determination shall be made by an LPHA.

2. A provisional diagnosis:
    a. may be used prior to establishing diagnosis.
    b. may be used prior to the determination of a diagnosis. It is permissible to use "Other" and "Unspecified" disorder. For Outpatient Programs, Social Determinants of Health (SDOH)/z-codes can be used.
    c. shall be updated by an LPHA to accurately reflect member needs.
3. A provisional diagnosis may be used prior to establishing diagnosis.

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4a. *For Outpatient Programs*: Per BHIN 24-001 and BHIN 22-013, Z-codes/SDOH are permitted to be used during the assessment phase of a members s treatment when a diagnosis has yet to be established. Clinically appropriate services may be delivered before a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established. An assigned z-code can be used prior to DSM 5 diagnosis to begin services.

b. For *Residential Programs*: Per DHCS, ICD-10: Social Determinants of Health (SDOH) codes/z-codes are not available for use as an available primary diagnosis. A list of Covered Diagnosis is in Appendix 5 of DMC-ODS Billing Manual (dhcs.ca.gov).

A SUD diagnosis can only be determined by a Medical Director or an LPHA. The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the member's record within timelines specified for the respective treatment modality (i.e. Within 30 calendar days of admission to outpatient services or within 10 calendar days of admission to residential services.) The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each member's assessment and intake information, including their personal, medical, and substance use history. ii. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

Level of Care Determination/Assessment

1) Outpatient providers are no longer required to complete their assessments within 30 days (60 days for those under 18 or experiencing homelessness). Assessments should now be completed "as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice." It is recommended that providers develop their own policy and procedure to ensure this standard is met and define how they will internally monitor.

2) Residential providers are no longer required to complete their assessments within ten (10) days and should follow the same standard for completion of a full assessment as outpatient providers; however, a "Multidimensional Level of Care (LOC) assessment" must be completed within 72 hours of admission. o Providers will use Optum's SUD Residential Authorization Request as the "Multidimensional LOC assessment" and will now be required to send the request to Optum within 72 hours of member admission. All other authorization timelines and requirements will remain in effect.

3) Residential Withdrawal Management (WM) providers are exempt from the 72-hour timeline to complete a "multidimensional LOC assessment" if a "pre-assessment within 72 hours" occurs and there are "contingency plans to transfer the resident to a subsequent level of care where a full assessment would be conducted

a. A "Multidimensional Level of Care (LOC) assessment" must be completed within 72 hours of admission.
b. Outpatient and Residential providers must complete assessments "as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice."
c. Residential Withdrawal Management (WM) providers are exempt from the 72-hour timeline to complete a "Multidimensional LOC assessment" if a "pre-assessment within 72 hours" occurs and there are "contingency plans to transfer the resident to a subsequent level of care where a full assessment would be conducted.
d. Placement and level of care determination shall be in the least restrictive level of care that is clinically appropriate to treat the member's condition.
e. A full ASAM assessment should be updated when a member's condition changes.

Additional Clarification

Assessments and Timely assessments:

1. To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.

2. Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, during the assessment, or prior to determination of whether SMHS, DMC, or DMC-ODS access criteria are met, even if the assessment ultimately indicates the member does not meet the access criteria for the delivery system in which they initially sought care.

3. Crisis assessments completed during the provision of SMH crisis intervention or crisis stabilization, or a SMH, DMC, or DMC-ODS Mobile Crisis Services encounter, need not meet the comprehensive assessment requirements outlined in this BHIN. However, crisis assessments are not a replacement for a comprehensive assessment. When a member who has received a crisis assessment subsequently receives other SMH, DMC, or DMC-ODS services, an assessment shall be completed in accordance with the requirements in this BHIN. For assessment and documentation requirements specific to Medi-Cal Mobile Crisis Services, please refer to BHIN 23-025.

   Timeliness - If a member withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over as noted above.
   a. Clinically necessary services are permissible prior to completion of a full ASAM assessment.
   b. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. *Please note that no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria© assessment.*
   c. A full assessment using the ASAM Criteria© shall be completed within 60 calendar days of the member's first visit with an LPHA or a registered/certified counselor (For adult members 18 years of age and over experiencing homelessness)

To establish the ASAM level of care requirement for medical necessity, the Medical Director or LPHA shall review and evaluate the member's assessment and intake information, if completed by a SUD counselor, and have a face-to-face or telehealth or telephone interaction with the counselor to verify the

member meets medical necessity criteria (MHSUDS Information Notice 16-044). The initial medical necessity determination is documented using forms as described in the SMH & DMC-ODS Health Plans (click SUDURM Tab). Initial assessment for all levels of care, except NTP may be completed by:

- A Licensed Practitioner of the Healing Arts (LPHA), OR
- A Registered/certified alcohol and other drug counselor
- An LPHA shall evaluate the assessment in consultation with the registered/certified counselor.

Consultation between LPHA and registered/certified counselor may be performed:

- In person
- Via telephone
- Via telehealth

Documentation of the initial assessment shall reflect consultation between LPHA and registered/certified counselor.

Initial medical necessity determination must clearly demonstrate use of the ASAM Criteria to determine placement into the appropriate assessed level of care for services. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the member. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, medical necessity encompasses all six ASAM dimensions for a more holistic concept of clinical necessity or clinical appropriateness for treatment.

For an individual to receive ongoing Narcotic Treatment Program (NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least annually through the reauthorization process to determine that the services are still clinically appropriate for that individual.

Clinical Documentation Guidelines

Clinical documentation refers to information within the member's health record that describes the treatment and its rationale, as provided to the member. Clinical documentation is often written in narrative form to capture treatment process and analysis of each member encounter. Clinical documentation is a critical component of quality treatment service delivery and serves multiple purposes to:

- Ensure comprehensive quality care.
- Ensure an efficient way to organize and communicate with other providers.
- Protect against risk and minimize liability.
- Comply with legal, regulatory and institutional requirements.
- Facilitate quality improvement and application of utilization management.

Member Record Documentation

County of San Diego SUD providers are required to establish, maintain, and update as needed, the individual member record for each member admitted to treatment and receiving services per Title 9, Chapter 11, and 42 CFR laws, regulations, guidelines, and professional standards. In addition, all providers must follow clinical documentation standards as outlined in BHIN-23-068. All clinical documentation must be credible and complete and is protected by HIPAA and 42 CFR Part 2. It encompasses every aspect of

clinical care to include initial assessments, progress notes, and all additional relevant encounters that occur outside of established appointments.

Upon the initial screen/intake and/or admission to treatment, the individual record shall contain member personal information to include the following:

- Information specifying member's name and/or identifier number
- Member date of birth
- Member gender
- Member race and/or ethnic background
- Member address
- Member contact number
- Member next of kin or emergency contact name and number

All clinical documentation must include the following characteristics:

- Member name and/or unique identifier
- Must be legible
- Must be completed within timelines per regulation guidelines
- Contain a "complete" signature which includes the providers
    - Legible signature
    - Appropriate credentials
    - Date

- Documentation and Co-Signature Requirements: Staff who provide direct services are required to adhere to certain documentation and co-signature requirements. In general, staff that hold the license of an M.D., D.O., N.P., R.N., Ph.D., , LCSW, LPCC, or MFT do not require a co-signature on any documentation in the medical record. This also holds true for registered associates with the Board of Behavioral Sciences (ASW, APCC or AMFT), or staff waivered according to State guidelines. These above-mentioned staff may also provide the co-signature that is required for other staff, excluding clinical trainees. For the most current information on co-signature requirements, please refer to the Substance Use Uniform Record Manual, located at the Optum Website> BHS Provider Resources> SMH & DMC-ODS Health Plans> SUDURM tab. This manual will instruct staff on form completion timeframes, licensure and co-signature requirements, and staff qualifications necessary for completion and documentation of certain forms.

<u>Treatment Episode Documentation</u>

Documentation of the treatment episode within the member record to include all activities, services, sessions, and assessment information not limited to:

- Intake and admission data/release and consent forms, and if applicable, physical examination
- Medical Necessity/Diagnosis determination
- Problem list
- Minimum Member Contact (e.g. one (1) contact per month for outpatient treatment)
- Progress Notes
- Referrals
- Lab test orders and results, clinician consultation (medical documentation that verifies member pregnancy and the last day of pregnancy)

- Discharge Plan
- Discharge Summary
- Correspondence with or regarding the member
- Authorizations for Residential Services
- Drug screening results
- Additional information relating to the treatment services rendered to the member

For more information about clinical documentation guidelines, see the following documentation guide:

- Clinical Documentation Guide

Documentation Correction Guidelines

The following Documentation Correction guidelines have been developed to help programs and the County of San Diego reduce fraud, waste, and abuse, provide clear guidelines on when and how changes can be made to documentation in member records, including paper records and electronic health records (EHR), and encourage improved member participation and collaboration in Treatment Plan/problem list development.

General guidelines:

- For paper records, corrections can only be made with a single line through the error, initials of the person making the correction and the date the correction was made. The original documentation must remain legible.
- The original author of a document should be the only person making corrections to the document. The person who signs a clinical document is attesting to the accuracy of the documentation. For documentation that is written by or countersigned by an LPHA (such as AACA assessments and treatment/peer support plans), only the LPHA can make changes to the document once the LPHA has signed.
- If that person is no longer available (i.e., medical leave, no longer with the program), a supervisory LPHA (i.e., program manager or designee, clinical supervisor, other supervisory staff member) or Medical Director may make the correction. This does not apply for instances such as the staff out sick or on vacation. The reason for the correction should be documented. This may be done in a separate informational note.
- Corrections should not change the clinical content of the documentation.
- Administrative corrections (i.e., spelling errors that do not affect the clinical content of the document) or non-clinical factual corrections can be made by direct service staff with a line through the error, initials, and date.
- Once any document is signed, it should be considered final and a should not be removed from the member's chart.

Continued Service and Discharge Criteria

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

Continued Service Criteria:

It is appropriate to retain the member at the present level of care if:

1. The member is making progress but has not yet achieved the goals articulated in the individualized treatment plan or making progress on identified problems on problem list. Continued treatment at the

present level of care is assessed as necessary to permit the member to continue to work toward treatment goals or problems;

Or

2. The member is not yet making progress but has the capacity to address his or her problems. They are actively working on the goals articulated in the individualized treatment plan or working on identified problems on problem list. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals or problems;

and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the member's new problems can be addressed effectively.

Discharge/Transfer Criteria:
It is appropriate to transfer or discharge the member from the present level of care if the following criteria are met:

1. The member has achieved the goals articulated in their individualized treatment plan or resolved problems identified on the problem list, thus resolving the need(s) that justified admission to the current level of care;

Or

2. The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan or problem list. Treatment at another level of care or type of service therefore is indicated;

Or

3. The member has demonstrated a lack of capacity to resolve their problem(s). Treatment at another level of care or type of service therefore is indicated;

Or

4. The member has experienced an intensification of their problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the member's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the member should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

Discharge Criteria for WM 1 and 2:

- Withdrawal signs and symptoms are sufficiently resolved so that the member can be safely managed at a less intensive level of care
- Signs and symptoms of withdrawal have not responded to treatment and have intensified such that a transfer to a more intensive level of withdrawal management services in indicated.
- Discharge For Perinatal
    - Recovery support post-discharge & discharge summary within 30 days

Other Service Guidelines

Self-Help and Program Structure
Support groups should always be voluntary. An individualized treatment plan related to support groups should be driven by members' preferences. Any event or support group meeting at a program should maintain the strict confidentiality requirements aligned with 42 CFR Part 2. Programs will be held to

minimum standards outlined on the Quick_Guide_-_Residential_Services 4-23-25.pdf (5 clinical (3.1)/ 10 Clinical (3.5) and minimum of 1 service per day). The 20 hours of program structure should be shaped to fit the members' individual needs and can be determined by programs. Programs can link members to existing support group programs (e.g., 12-step) in the community and/or if confidentiality is a concern and since some members may opt for not participating in support group programs, the program can choose to coordinate a support group program in a different location for members that choose to participate.

Evidence Based Practices

Research and innovations have yielded significant progress in the development, standardization, and empirical evaluation of psychosocial treatments for SUD. This has resulted in a wide range of effective programs for SUD that differ in both theoretical orientation and treatment technique. While a number of approaches and techniques are effective depending on the clinical situation, certain treatment approaches have a stronger evidence base and therefore must serve as the foundation of a high-quality system of SUD care.

Within the County of San Diego, although other psychosocial approaches may be used, SUD providers are expected to implement at least two of the following evidence-based practices (EBPs) based on the timeline of the county implementation plan. . . The two EBPs are per provider, per. service modality. The Contractor shall ensure the providers have implemented EBPs and are delivering the practices to fidelity. The State shall monitor the implementation of EBPs during reviews. The EBPs include

- Motivational interviewing (MI): A Member-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 beneficiaries' past successes

- 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 disorder treatment.
- 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.

- Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

Care Coordination

Programs should educate members about the continuum of care in the initial stage of services as part of orientation to the County of San Diego DMC-ODS. Likewise, programs should encourage the member to see any community provider engaged in the member's mental or physical healthcare as critical members of their care team. Programs should facilitate information sharing with team members such as primary care physicians and mental health practitioners whenever proper consent allows for this best clinical practice. In this way, programs establish themselves as collaborators, with the member as well as with other providers within the greater SUD system and beyond. Expectations are made clear that as a member's needs change, transitions occur either up or down within the continuum of care.

Provider-Member Communications

Adequate communication serves a key component in ensuring proper care coordination for members. Case managers have the responsibility of serving as an advocate for members in the SUD system of care and shall assist with communication between members and other service providers. Providers may have to

exchange communication through emails, letters, telephone calls, progress notes, or reports to the County, State, or other service providers on behalf of the member. Case managers shall also assist members in ensuring they are receiving adequate care from other service providers and inform members of their right to appropriate treatment.

Policies and Procedures
In order to engage members and ensure successful continuity of care, programs should create policies/procedures on care coordination focusing on seamless transitions without disruption to service for the member. Minimum considerations include the following:

- Each SUD member must be assigned a primary counselor at the initiation of services. The primary counselor will guarantee that the member is directed to appropriate resources within the program, including linkage to the program case manager. The primary counselor's contact information must be provided to the member as their designated contact for assistance with in-program needs.

- The program case manager will coordinate with any external resources as indicated by the member's needs, wishes and goals. The member must be provided with the program case manager's contact information for assistance with resources outside the program.

- Program policies, procedures, and practices must allow for members to have timely access to medically necessary and clinically indicated appointments, such as medical or mental health appointments, child visitation (including phone calls with children), and court/probation meetings. The program case manager will assist the member in scheduling and accessing appointments in the community. Routine program schedules or program rules, such as acclimation or "black-out" periods in residential programs, shall not be used as a rationale for arbitrarily delaying or restricting member access to medically necessary and clinically indicated appointments.

- In order to document coordination of care, programs shall obtain a signed authorization to release information for the member's primary care physician, mental health provider and/or other health providers and document all care coordination efforts in the progress notes.

- Programmatic, interdisciplinary team meetings are expected as a means for all staff providing member services to maintain clear communication regarding assessed needs and any indications of change to level of care recommendations.

- Programs shall follow the Missed Scheduled Appointments protocol as defined previously in this section, as a means of continued member engagement and care coordination. These standards apply to new referrals (contacting within one business day by a clinical staff when a member does not show for a scheduled first appointment) and current members (containing within one business day by clinical staff when missing a scheduled appointment without a call to reschedule). Members with recent elevated risk factors will be contacted by clinical staff on the same day as the missed scheduled appointment.

- When a member is discharging from SUD services and transition to another program is not indicated, programs must offer recovery services when determined to be medically necessary for the member. Recovery services include substance use assistance, recovery monitoring (including relapse prevention), group counseling, individual counseling, and case management/care coordination delivered by an experienced registered or certified SUD counselor who assists in meeting the goals contained in their treatment plan for recovery service. The Process for engaging

member in recovery services is as follows:

- The member should be contacted within two (2) business days of his/her last treatment service to ensure they are receiving necessary support and recovery services offered.
- At least three (3) documented attempts to engage member, when member consents to this, on three (3) separate days are required to demonstrate efforts to engage member into the recovery service benefit.
- If the counselor has neither heard from nor made contact with the member for thirty (30) calendar days after the last attempted contact, additional efforts are not required. All follow-up contacts and/or attempts should be documented.
- Members who reconnect more than three (3) months after treatment discharge requesting recovery services must be screened to determine if this level of care continues to be appropriate for the member's needs at that time.

- When a member is transitioning from one level of care to another (or to an ancillary service), care coordination will be based on warm handoff principles: carefully coordinated transfer or linkage of a member to another provider, entity, agency, or organization who will continue, add, or enhance services.

- This warm handoff process will:
  - Ensure communication between concurrent providers of service (for example, NTP and IOS providers treating a member at the same time).
  - Occur prior to the case closing at the current program.
  - Ensure the member is clear on the reason for referral or transfer to another level of care
  - Include a direct conversation between providers to ensure passing of critical information in a timely fashion.
  - Include all pertinent documents (including signed release of information when necessary and other relevant clinical information, including Level of Care Recommendation form) to ensure transfer in a timely manner.
  - Occur anytime a referral is provided to another service provider.

- The warm handoff will include:
  - Ideally, a joint session/meeting with the providers and the member via face-to-face, telephone, or telehealth.
  - Information is shared between providers about member treatment and engagement history.

- Members transitioning to another level of care, including Recovery Services, should begin services at the next indicated level of care within 10 business days of discharge. For coordination up or down the continuum of care, the handoff is considered complete after there is confirmation that the member has engaged, and initial appointment has occurred.

In all cases of care transitions (both when the transition occurs along the SUD care continuum and when the transition occurs between other health systems), the last treating SUD provider is responsible for and must coordinate transitions in care. All coordination of care activities must be documented within the member record.

Medications

Members on medications will seek services. Members shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication. Treatment services within

a harm reduction framework focus on supporting positive change, meeting individuals where they are, and working with people without judgment, coercion, discrimination, or a requirement for abstinence as a precondition for receiving care. Senate Bill No. 992 prohibits a licensee from denying admission to any individual based solely on the individual having a valid prescription from a licensed health care professional for a medication approved by the federal Food and Drug Administration for the purpose of narcotic replacement treatment or medication-assisted treatment of substance use disorders. Accordingly:

- Programs shall not deny services to a member with current, physician-prescribed medications. However, a program shall consider whether the nature and extent of the prescribed medications requires a higher level of care than offered at that program.
- With member consent, providers shall coordinate with the member's physician or health practitioner when she/he enters treatment with prescribed medications that have psychoactive characteristics. Services and support plans shall be reviewed with the prescribing physician or health practitioner.
- If while in treatment, a member exhibits behavior that is a cause for concern, the treatment provider may address this as a program issue with the member and the member's physician or health practitioner.
- Programs shall have a safety policy regarding the use of prescribed medications by a program member, including a provision for taking medications in private, if it must be taken on the premises.

Safeguarding Medications
When applicable, and to ensure appropriate access, program may store members' medication in the program facility. All medications must be in bottles with prescription labels and shall not be in envelopes. Program staff may assist with member's self-administration of medication in accordance with all relevant regulations and the Alcohol and/or Other Drug Program Certification Standards https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-25-003.pdf Medication may include over-the-counter (OTC) medicines or prescription medications for specific health conditions, inclusive of medications for substance use disorder, mental health, and physical health conditions. Programs shall maintain a central destruction log for medications, which includes two staff signatures verifying verification medications have been destroyed.

It is the responsibility of the Substance Use Disorder Program Medical Director to develop and implement medical policies and standards for the provider. At a minimum, Contractors shall ensure adherence to its own entity's policies and procedures, as developed by the Medical Director, to safeguard members' medication, and follow documentation standards for medication storage and destruction as specified in the Substance Use Disorder Uniform Record Manual (SUDURM). Policies and procedures may include but are not limited to process of observing members' self-administration of medication; security or storage/inventory system; procedure to address members' adverse reaction to medication (e.g., loss of consciousness, physical difficulties requiring hospitalization, etc.); members' and program staff's responsibility in reporting loss or theft.

Drug Testing
Providers shall develop, implement, and maintain a testing protocol to ensure against the falsification and/or contamination of any urine and/or oral fluid samples. Providers shall conduct observed, random drug testing of members when mandated by the referral source(s) and/or in adherence to the individual treatment plan. (For justice referrals expected to follow NADCP guidelines for drug testing, see Appendix C.1 for additional information). Any observed urinalysis shall be conducted by a staff member of the same gender during collection. All drug testing results shall be documented in the member record. Providers shall use the BHS designated urinalysis/oral fluid drug testing vendor unless prior written approval for another vendor is received from the COR.

Drug Testing Results Reporting
All positive drug tests shall be reported to the referring entity within two business days of testing date, if the member has provided appropriate prior consent.

Drug Testing Technologies
Drug testing may include any of the following technologies:

- Urinalysis
- Oral Fluid Testing
- Breathalyzer

Trauma Informed Services
Contractor's systems and services shall be "trauma-informed" and accommodate the vulnerabilities of trauma survivors. Services shall be delivered in a way that will avoid inadvertently re-traumatizing members and facilitate member participation in treatment. Contractor's trauma-informed systems and services shall include screening of trauma; consumer driven care and services; trauma-informed, educated and responsive workforce; provision of trauma-informed, evidence-based and emerging best practices; safe and secure environments; and ongoing performance improvement and evaluation regarding program's provision of trauma-informed services.

Information from the National Center for Trauma Informed Care & Alternatives to Seclusions and Restraint

Trauma-Informed Approach
According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in members, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

SAMHSA's Six Key Principles of a Trauma-Informed Approach
A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services

and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration. Additional information and resources: Trauma and Violence - What Is Trauma and Its Effects? | SAMHSA

Trauma Informed Care for those that have experienced Human Trafficking
Survivors of human trafficking have experienced high levels of trauma. These experiences can impact many aspects of their life, including their self-concept, behavior, and mood. Programs that work with survivors of human trafficking should be aware of the additional needs of these individuals. Below are several resources with tips and tools to assist programs in developing appropriate interventions.

- National Human Trafficking Hotline Resource Library
  - https://humantraffickinghotline.org/resources
- The National Child Traumatic Stress Network- Understanding and Addressing Trauma and Child Sex Trafficking
  - https://www.nctsn.org/resources/understanding-and-addressing-trauma-and-child-sex-trafficking-policy-brief

Residential Requirements

Required Relapse Plan for Licensed Residential SUD Treatment Facilities
Per SB992, a licensed residential treatment facility must develop and maintain a written plan to address resident relapses. A relapse plan is a written plan that addresses:

- Resident relapse including when a resident is on the licensed premises after consuming alcohol or using illicit drugs;
- How the treatment stay and treatment plan of the resident will be adjusted to address the relapse episode;
- How the resident will be treated and supervised while under the influence of alcohol or illicit drugs; and
- Resident discharge and continuing care plan, including when a residential facility determines that a resident requires services beyond the scope of their license.

Initial applicants for residential treatment facility licensure must submit a relapse plan with the Initial Treatment Provider Application (DHCS 6002). Applicants that submitted an application for licensure prior to January 1, 2019 but have not been approved for licensure will be required to submit a relapse plan prior to licensure. Existing licensees must submit a relapse plan to their assigned DHCS analyst no later than April 1, 2019. DHCS will review the submitted relapse plan to determine compliance with the statutory requirements. DHCS will notify the licensee within 30 working days whether the relapse plan is complete or incomplete. A copy of the relapse plan must be kept onsite, or at a central administrative location, provided that the plan is readily available to staff and DHCS upon request.

For more information, refer to DHCS Information Notice 19-003. If you have questions about the relapse plan or Information Notice 19-003, contact Nadalie Meadows-Martin by email at Nadalie.Meadows-Martin@dhcs.ca.gov or Pelumi Abimbola at Pelumi.Abimbola@dhcs.ca.gov.

Residential: Bed Holds and Weekend Passes
Providers may be reimbursed room and board for up to 7 days when a member is hospitalized, AWOL, incarcerated, or in crisis residential while in residential treatment. COR preapproval is required if a member is in need of a bed hold beyond 7 days (e.g., member at crisis residential). As soon as member returns to the program, the provider shall consider any revisions to the ASAM level of care determination, risk

assessments and/or medical information to incorporate into the chart and/or treatment plan. Provider would not need to discharge/readmit member.

Providers may allow a member a weekend pass when member is in 3.1 LOC with a planned discharge. Providers may be reimbursed for treatment as long as one hour of service is provided daily (e.g., 1 hour of structured daily activity on Saturday before they leave and also when they come back on Sunday evening.) Otherwise, the provider would be reimbursed for room and board only. As soon as member comes back to the program, the provider shall consider conducting a level of care assessment.

NTP Requirements

NTP Documentation Standards

NTPs shall follow all applicable federal and state laws and regulations regarding confidentiality of, procedures for, and content of patient records. For more information refer to the NTP **Behavioral Health Information Notice (BHIN) : 25-008**
https://www.dhcs.ca.gov/individuals/Documents/BHIN-25-008-NTP-Regulation-Changes-Webinar.pdf

DHCS has established the outlier threshold of nine (9) or more NTP counseling unit for a Medi-Cal member across all claims for a single date of service for services delivered within an NTP setting, inclusive of procedure codes H0004 (Individual Counseling), H0005 (Group Counseling), and T1006 (Family Counseling (DMC-ODS only) **For more information refer to NTP Behavioral Health Information Notice No: 26-022: NTP Counseling Unit Threshold and Manual Review**

D. COMPLIANCE & CONFIDENTIALITY

The County of San Diego Health and Human Services Agency (HHSA) shall adhere to all laws, rules, and regulations, especially those related to fraud, waste, abuse, and confidentiality.

Compliance

Record Retention

Per WIC 14124.1, records are required to be kept and maintained under this section and shall be retained:

- by the provider for a period of 10 years from the final date of the contract period between the plan and the provider,
- from the date of completion of any audit,
- or from the date the service was rendered, whichever is later, in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations

Documentation Requirements

To promote consistency and standardization of County of San Diego required record documentation, a Uniform Record Manual (SUDURM) was implemented July 1, 2014. The SUDURM contains all required forms to ensure documentation compliance with Federal, State, and County laws and regulations under Title 9, Chapter 11, and 42 CFR. SUD providers are required to complete County-required protocols (including documentation standards and timelines) for assessment, treatment plans/problem lists, level of care determination, progress notes, and other documentation requirements as specified within the SUDURM and SUDPOH. Within the SUDURM, documentation forms are filed in specific order starting with Section 1: Intake/Financial and ending with Section 8: Drug Test Results/Reports. Individual programs are responsible for ensuring their providers utilize the required forms within the SUDURM as appropriate. SUDURM forms are located on the Optum San Diego website. Directions regarding access to this website can be found in the Appendix F.1 - Optum Website Tip Sheet.

False Claims Act

All HHSA employees, contractors, and subcontractors, are required to report any suspected inappropriate activity. Suspected inappropriate activities include but are not limited to, acts, omissions or procedures that may be in violation of health care laws, regulations, or HHSA procedures. The following are examples of health care fraud:

- Billing for services not rendered or goods not provided
  - Falsifying certificates of medical necessity and billing for services not medically necessary
  - Billing separately for services that should be a single service
  - Falsifying treatment plans or medical records to maximize payment
  - Failing to report overpayments or credit balances
  - Duplicate billing
  - Unlawfully giving health care providers such as physicians' inducements in exchange for referral services.

If any County or Contracted program needs training on the False Claims Act, reach out to BAC at 619-237-8571 or email Compliance.HHSA@sdcounty.ca.gov.

In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit. Reporting can be done by phone, online form, email or by mail.

- 1-800-822-6222
- fraud@dhcs.ca.gov
- Medi-Cal Fraud Complaint – Intake Unit Audits and Investigations

- P.O. Box 997413; MS 2500 Sacramento, CA 95899-7413

All reporting shall include contacting your program COR immediately, as well as the BHS QA team at QIMatters.BHS@sdcounty.ca.gov to report any of these same concerns, or suspected incidents of fraud, waste, and/or abuse.

Code of Conduct

Per CCR Title 9 §13065: Within 24 hours of the time an alleged violation(s) of the code of conduct by a registrant or a certified AOD counselor becomes known to an AOD program, the program shall report it to DHCS and to the registrant or counselor's certifying organization. Such report may be made by contact DHCS and the certifying organization in person, by telephone, in writing, or by an automated or electronic means, such as e-mail or fax. The report shall include facts concerning the alleged violation.
Department of Health Care Services
Licensing and Certification Division
P.O. Box 997413, MS 2601
Sacramento, CA 95899-7413

Toll Free: (877) 685-8333
Fax: (916) 440-5094
Email: sudcomplaints@dhcs.ca.gov

To access additional information, please visit DHCS website for Licensing and Certification- Complaints.

Program Integrity/Service Verification
San Diego County Behavioral Health Services (SDCBHS) established Program Integrity (PI) procedures to prevent fraud, waste, and abuse in the delivery, claiming and reimbursement of behavioral health services. County and Contracted Programs shall develop a process of verifying that paid claims were provided to members and that services were medically necessary. County and Contracted Programs are expected to conduct regular PI activities and maintain records for audit purposes. Questions regarding PI can be directed to QI Matters email at QIMatters.BHS@sdcounty.ca.gov.

PI activities will be monitored by QA at a minimum annually during site visits and medical record review. QA tracks and monitors results of medical record reviews and may require a program to develop a Quality Improvement Plan (QIP) to address specific documentation concerns.

Mandated Reporting
All treatment providers shall adhere to mandated reporter requirements regarding child abuse and neglect, elder abuse and neglect, and homicide or homicidal ideations (California Welfare and Institutions Code section 15630 and California Penal Code section 11164). Mandated reporting as required by law is not to be considered unauthorized release of confidential information. Permissive exceptions to confidentiality may include:

- Danger to self
- Danger to others
- Another's property
- When such disclosure is necessary to prevent the threatened danger (Tarasoff Notification)

For further information regarding legal and ethical reporting mandates, contact your agency's attorney, the State licensing board, or your professional association.

Confidentiality

Member and community trust is fundamental to the provision of quality mental health services and abiding by confidentiality rules is a basic tenet of that trust. Thus, County and Contracted workforce members shall follow all applicable state and federal laws regarding the privacy and security of information.

SUD Quality Assurance (QA) Responsibilities & Confidentiality

In order to ensure compliance with confidentiality procedures and protocols, the SUD QA enforces the following procedures:

- Every member of the workforce is informed about confidentiality policies as well as applicable state and federal laws regarding anonymity and the confidentiality of clinical information.
- As a condition of employment, each member of the workforce signs a confidentiality agreement promising to comply with all confidentiality protocols. This statement must include a minimum General Use, Security and Privacy safeguards, Unacceptable Use, and Enforcement Policies.
    - The statement must be signed by the workforce member prior to access to protected health information (PHI). PHI is any health data that is individually identifiable and relates to the past, present or future physical or mental health of an individual. PHI can be in many forms, including written records, electronic records, images and information shared verbally. While not an exhaustive list, the following are considered individually identifiable data: member names, Social Security numbers, phone numbers, email addresses, dates related to health or identity, biometric identifiers, electronic health records, and images that could identify the subject.
    - The statement must be renewed annually.

Any member treatment records gathered during the course of provision of services, provider site and record reviews, or as necessary are protected through strictly limited access. Program staff have access to case data or files only as necessary to do their jobs.

Providers within the County of San Diego SUD system of care demonstrate ongoing commitment and compliance to the protection of member personal and health information as defined in 42 CFR Part 2, Health Insurance Portability and Accountability Act of 1996 (HIPAA), the State/County agreement, and other Federal, State regulations/laws through:

1. Established written policies and procedures to address workforce members' code of conduct to include protection of member confidentiality while providing services within the SUD system of care. ("Workforce members" includes, but is not limited to, all employee types, including per diem/contracted/temporary volunteers, students/interns, subcontractors, and others with access to members and/or member data).

2. Verifiable program orientation and/or trainings/staff meetings, with focus on current/updated member confidentiality/disclosure information and applicable Federal and State laws governing such.

3. All workforce members, working within the SUD system of care, are required to sign an agreement to comply with all confidentiality protocols as defined by law, regulation, and program code of conduct policy and procedure.

4. The Confidentiality Agreement must include language in which the workforce member agrees to

not divulge personal information (PI), personally identifiable information (PII), and protected health information (PHI) to any unauthorized person or organization unless authorized or required by law. PI, PII and PHI definitions are found in Article 14 of the program's contract with the County.

5. Workforce members will be given access to member PHI only after # 1 and # 2 are completed.

6. Workforce members will renew their Confidentiality Agreement annually as verified by signature and date on the statement and placement within their personnel record.

7. Programs will have written policies and procedure which identify potential sanctions should violations of unauthorized release of confidential member health information occur.

8. Providers will respect a member's right to revoke their consent/authorization to disclose information in part or whole. Should this occur, the SUD treatment providers must notify the involved entities of this update immediately.

All substance use disorder treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements. If services were provided in the community, documentation must identify the location and how the provider ensured confidentiality.

Final Rule, 42 CFR Part 2

The SUD system of care is moving into a new era that encourages information sharing with the physical and mental health systems for improvement of care coordination and member health outcomes. (See Examples of Permissible Payment and Healthcare Operations Activities below.)

It is well recognized that SUD members often have additional health conditions that complicate care and can prevent long-term achievement of recovery goals if left un/under treated.

Final Rule, 42 CFR Part 2, published February 16, 2024, effective April 16, 2024, implements new changes to the federal rules governing confidentiality and disclosures of substance use disorder member records, known as 42 CFR Part 2 or "Part 2" to afford persons with substance use disorder, receipt of integrated and coordinated care while still protecting member confidentiality. While the new Final Rule maintains Part 2's core protections, including consent requirements, it expands the ways in which members' protected substance use disorder information may be shared. It aligns several provisions with HIPAA regulations including allowing for a single consent for TPO, penalties, breach notification, member notice and Safe Harbor. For more information, please reference the Final Rule 42 CFR Part 2.

Examples of Permissible Payment and Health Care Operations Activities under 42 CFR Part 2 Section 2.33(b) SAMHSA:

- Billing, claims management, collections activities, obtaining payment under a contract for reinsurance, claims filing and related health care data processing
- Clinical professional support services (e.g., quality assessment and improvement initiatives; utilization review and management services)
- Member safety activities
- Activities pertaining to the training of student trainees and health care professionals
- Activities pertaining to the assessment of practitioner competencies
- Activities pertaining to the assessment of provider and/or health plan performance, and

- Activities pertaining to the training of non-health care professionals
- Accreditation, certification, licensing, or credentialing activities
- Underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care
- Third-party liability coverage
- Activities related to addressing fraud, waste and abuse
- Conducting or arranging for medical review, legal services, and auditing functions
- Business planning and development, such as conducting cost-management and planning related analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies
- Business management and general administrative activities, including management activities relating to implementation of and compliance with the requirements of this or other statutes or regulations
- Customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers
- Resolution of internal grievances
- The sale, transfer, merger, consolidation, or dissolution of an organization
- Determinations of eligibility or coverage (e.g., coordination of benefit services or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Review of health care services with respect to medical necessity, insurance coverage under a health plan, appropriateness of care, or justification of charges.

SUD providers are advised to contact the legal representative within their organizations for legal interpretation and direction in regard to application of Confidentiality Law/Regulations to program specific policy and procedure. Should legal entities or programs have further questions regarding interpretation of 42 CFR Part 2 Final Rule, please see more information through the County of San Diego Health & Human Services Business Assurance & Compliance Office.

Federal Delegation of Authority to OCR: The federal HHS Secretary issued a formal Delegation of Authority for enforcement of 42CFR Part 2 to the federal Office of Civil Rights (OCR).

This is the latest step in a process initiated by the CARES Act in 2020 to align the Part 2 substance-use disorder privacy rule more closely with HIPAA. As part of those changes, the CARES Act revised the enforcement scheme so that the civil and criminal penalties applicable to HIPAA are also applicable to Part 2 violations (previously, Part 2 was purely enforceable through criminal authorities). HHS finalized the rule implementing the CARES Act changes in February of 2024. That rule clarified—consistent with the CARES Act—that violations of Part 2 would be subject to the same penalties as violations of HIPAA. Now HHS has further implemented the change by delegating enforcement authority to OCR, which is the same entity that enforces HIPAA. They have also delegated Part 2 implementation and interpretation authority more broadly to OCR. The federal regulatory body enforcing Part 2 is now an agency with a specialized expertise in privacy and a broader toolkit of enforcement tools, including civil penalties in addition to criminal penalties.

It is suggested that Legal Entities review their Part 2 compliance programs and make sure they are up to date with the substantial changes that have been made by the CARES Act.

Member Confidentiality

Providers shall comply with federal member confidentiality regulations (Confidentiality of Substance Use Disorder Member Records- 42U.S.C.290dd-2; 42CFR part 2), and all applicable Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

Member Answering Program Business Phones

Providers shall have trained provider staff available to answer business phone calls during hours of operation. Program shall ensure participants in DMC-ODS programs shall not answer phones on behalf of program staff. Providers shall ensure member confidentiality is maintained at all times.

Member File Storage and Transportation

Sites must keep a record of the members/members being treated at that location. If it is required to transport records offsite, to maintain the confidentiality of all member files and medical records, the standard protocol for storing confidential material shall be maintained until transport is possible. Member files are to be stored under double lock and key (i.e., locked cabinet in a locked room) at the program location. No member files are to be taken to staff's private residences. The program supervisor shall designate staff members who will be responsible for the transportation of member files. A staff member shall inform the program director if file transport is necessary. Member files shall be transported in a portable locked file box. When transporting identifying member data or medical records such as progress notes or forms requiring signatures, no identifying information shall be put on the documents until which time said documents are secured in the member's medical record at the primary clinic where the record is being stored. Progress notes or other individual documents transported while in the field shall not contain the full name of the member. Under no circumstances are any records to be left unattended.

Off Site Record Storage

Programs shall notify their program COR when member records are moved offsite permanently (i.e., records moved to storage).

Cloud-Based Record Storage

Cloud-based storage for member records is an option for providers. Contractor must ensure that Article 14 requirements, including the DHCS SUD Agreement, are included in the contract with the vendor providing the service. Contracted providers are also expected to vet and monitor the vendor and services to ensure compliance. For additional information on the DHCS SUD agreements, see the County of San Diego Health & Human Services Business Assurance & Compliance Office.

Member Requests for Records

When a member (or the individual with authority of the record) requests access to or a copy of their record, all Programs shall abide by applicable privacy laws and reasonably confirm the identity of the requestor before releasing member information. Remember that member requests for records are not the same as a request for records from a third party; different rules apply. County Programs shall follow the relevant BAC policies and procedures related to record requests (HHSA L-01). Contracted Programs may, but are not required, to use the HHSA Member Record Request Form (HHSA 23-01). If a Contracted Program chooses to use the HHSA form, it must replace the HHSA logo and contact information with its own and should also review the contents of the HHSA form to ensure it meets all applicable privacy requirements. Contracted programs may also use their own form so long as it complies with all applicable rules and regulations. Contracted Programs shall also have a Member Request for Records policy to ensure these requirements are followed by workforce members.

State law, 45 CFR 164.524, regarding a member's access to health records requires the following:

- Member records may be requested by any adult member, member personal representative, minor member authorized by law to medical treatment, or attorney.
- Health care providers cannot require a member's request for health records to be submitted in writing.
- Requires health care providers to provide a copy of the records in a paper or electronic copy, in the form or format requested if the records are readily producible in that form or format.
- Requires health care providers to permit inspection of member records during business hours within five (5) working days after the receipt of the request.
- Requires health care providers to provide copies within fifteen (15) days after receiving the request.
- Requires health care provider fees to be based on specified costs for labor, supplies, postage, and preparing an explanation or summary of the member record instead of clerical costs. These costs are capped.
- Prohibits health care providers from withholding member records because of unpaid bills for health care services.
- Health care providers no longer can provide a summary in lieu of the actual record unless agreed upon by the member.
- Allows disclosure to a business associate for health care operations purposes.

Adult and minor child members who consent or could have consented to their own treatment have a right to access their own records. Providers cannot refuse access based on the provider's judgement that access would interfere with the therapeutic relationship or cause emotional harm. A summary of the record is not an acceptable alternative to providing access to the record. Parent access, however, can be limited if the minor child member consented or could have consented to the care.

Record Requests Past 365 Days (SmartCare)

The County of San Diego BHS manages an electronic health record (EHR) for the BHP County and contracted providers (SmartCare). Contracted providers have access to a member's chart for 365 days post-discharge to respond to record requests accordingly. Once that timeframe expires, a request will need to be made via the Optum Help Desk to access documents past one year. Optum will grant access for 72 hours, closing the record again after that time.

DAYS	HOURS	CONTACT
Monday - Friday	6:00 am to 6:00 pm	1-800-834-3792

CalMHSA has the following additional instructions on the Release of Information processes:

- How to Document a Release of Information (Authorization to Disclose Confidential Information
- How to Revoke a Standard Release of Information/Authorization to Disclose Information
- How to Determine What Disclosure Authorizations (Release of Information) the Member has Signed

Notice of Privacy Practices

County and Contracted Programs must provide a HIPAA and Part 2-compliant Notice of Privacy Practices (NPP) to all members, as well as those with authority to make treatment decisions on behalf of the member. If the covered health care provider maintains a physical service delivery site: 1) They must have the NPP available at the delivery site for individuals to request to take with them; and 2) Post the notice in a clear and prominent location where it is reasonable to expect individuals seeking service from the covered provider to be able to read the notice (45 CFR § 164.520). A covered entity that maintains a website that provides information about the covered entity's customer services or benefits must prominently post its notice on the website and make the notice available electronically through the website. Providers should ensure members (and those with authority) understand the NPP and address any member questions about member privacy rights and the Program's privacy requirements.

Contracted Programs may, but are not required, to use the HHSA NPP. If a Contracted Program chooses to use the HHSA NPP, it must replace the HHSA logo and contact information with its own and should also review the contents of the HHSA NPP to ensure it meets all applicable privacy requirements. Contracted Programs shall also have an NPP policy or procedure to ensure NPP requirements are followed by workforce members.

County TLS Email Encryption

The county has Transport Layer Security (TLS) available for sending encrypted email through a secured connection. This means when a TLS connection is established with a vetted County business partner, all email communication sent between the County and the business partner will be automatically encrypted in transit over the internet through the secured connection. Contact the County BHS COR or COR's designee for more information about TLS and how to initiate the process for your agency.

Privacy Incidents

A privacy incident is an incident that involves the following:

- Unsecured protected information in any form (including paper and electronic); or
- Any suspected incident, intrusion, or unauthorized access, use, or disclosures of protected information; or
- Any potential loss or theft of protected information.

Common Privacy Incidents may include, but are not limited to:

- Sending emails with member information to the wrong person
- Sending unencrypted email with member information outside of your legal entity
- Giving Member A's paperwork to Member B (even if you immediately get it back)
- Lost or stolen charts, paperwork, laptops, or phones
- Unlawful or unauthorized access to member information (peeking issues)

If any Program believes that a privacy incident has occurred, they must complete the online HHSA privacy incident reporting form. For Contracted Programs, this is outlined in Article 14 of your County contract. For County programs, follow BAC policies and procedure (L-24). All programs shall immediately notify BAC Privacy Officer and COR via email. Programs shall submit an initial Privacy Incident Report (PIR) online within one (1) business day. To access the landing page and link to the PIR web-form, these documents can be found at www.cosdcompliance.org.

Contracted Programs must additionally ensure compliance with HIPAA breach requirements, such as risk analysis and federal reporting and inform the BAC of any applicable requirements.

Privacy Incident Reporting (PIR) for Staff and Management

- Staff becomes aware of a suspected or actual privacy incident.
- Staff notifies Program Manager immediately.
- Program Manager notifies County COR and Privacy Officer immediately upon knowledge of incident.
- Program Manager completes the online Privacy Incident Report within one business day.
- Continue investigation and provide daily updates to the Privacy Officer.
- Updates to the online Privacy Incident Report should be made through the same online reporting portal within 7 business days.
- Complete any other actions as directed by the Privacy Officer.

San Diego County contracted providers should work directly with their agency's legal counsel to determine external reporting and regulatory notification requirements. See Appendix F.2 for more information. Additional compliance and privacy resources are available at: https://www.sandiegocounty.gov/hhsa/programs/sd/compliance_office/

E. MEMBER RIGHTS

Consumer Grievances, Appeals, and State Fair Hearings

The County of San Diego is committed to providing a fair, impartial, and effective process for resolving member grievances in compliance with all Federal and State regulations for substance use disorder services. The Grievance/Appeals and State Fair Hearing processes are available for all members, their authorized representative, or providers acting on behalf of the member and with the member's written consent ("involved parties") to utilize. All SUD treatment providers must also have policies and procedures in place for collecting/logging, reviewing, and acting upon all member grievances or appeals. The process should be clear and transparent to all members and providers and should be integrated into the provider's quality assurance processes. At all times, grievance and appeal information must be readily available for members without the need for request. (42 CFR §438.228)

The Grievance/Appeals and State Fair Hearing process is designed to:

- Provide grievance/appeals and State Fair Hearing process adhering to Federal and State regulations
- Provide straightforward member/provider access
- Support and honor the rights of every member
- Be action-oriented
- Provide resolution within State established timeframes
- Encourage effective grievance resolution at program level
- Improve the quality of SUD services for all County of San Diego residents

Providers shall have self-addressed stamped envelopes (CCHEA and JFS will provide upon request), posters, brochures, grievance/appeal forms (available on the Optum website) in all threshold languages to include interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The county can also provide auxiliary aids and services to a family member, friend, or anyone else with who is appropriate to communicate with on your behalf (available on the Integrated MHP and DMC-ODS Member Handbook, page 6 Optum website. These materials shall be displayed in a prominent public place. The member shall not be discouraged, hindered, or otherwise interfered with when seeking or attempting to file a grievance/appeal. The member is also not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested. Providers shall inform members, their authorized representative, or the provider acting on behalf of the member, about their right to file a grievance with assistance from one of the County's contracted advocacy organizations listed below (42 CFR §438.406):

Jewish Family Services, Patient Advocacy Program (JFS)
(For inpatient or residential SUD services)
1-800-479-2233 or 619-282-1134
Email:patientadvocacy@jfssd.org

Website: www.jfssd.org/patientadvocacy

Consumer Center for Health, Education, and Advocacy (CCHEA)
(For outpatient SUD services)
1-877-734-3258
TTY-1-800-855-7100

Advocacy Services and Records Requests

In accordance with the Code of Federal Regulation (CFR) Title 42, Part 438, Subpart F – Grievance System, the JFS Patient Advocacy Program and CCHEA are required to conduct grievance investigations and appeals pursuant to State and Federal law. These processes may include, but are not limited to, consulting with facility administrators, interviewing staff members, requesting copies of medical records, submitting medical records to independent clinical consultants for review of clinical issues, conducting staff member trainings, suggesting policy changes, submitting requests for Plans of Correction (POC), and preparing resolution letters.

There are mandated timelines for grievances and appeals. Providers' quick and efficient cooperation will ensure compliance with these requirements. When requested, SUD providers shall provide copies of medical records to the JFS Patient Advocacy Program and CCHEA within 3 business days from the date of the medical record request. The Advocacy Agencies will provide the program with a signed release of information from the member with the request. For more information, please review the following memo on the Optum DMC-ODS page (found in Communications Tab): Patient Advocacy Services for BHS

Process Definitions (Title 42 CFR § 438.400 (b))

- **Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination as defined below (under appeal). Grievances may include but are not limited to: the quality of care of services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, failure to respect the rights of the member regardless of whether remedial action is requested, including the member's right to dispute an extension of time proposed by the plan to make an authorization decision. A grievance can be filed at any time, orally or in writing. **(42 CFR § 438.402)**

- **Discrimination Grievance** is when a member believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance (Discrimination grievance" means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation)with the county plan (found on the Optum website, NOABD tab, Nondiscrimination Notice), the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights. San Diego County complies with all State and Federal civil rights laws. **(45 CFR §§ 92.7 and 92.8; WIC§14029.91)**

- **Grievance Exemption** is when grievances are received over the telephone or in-person by the County, or a DMC-certified provider, that is resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter. Note: Grievances received via mail are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a complaint is received pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance, and the exemption does not apply.

- **Appeal per federal guidelines, an "Appeal" is a review of an Adverse Benefit Determination** which may include:
    - Denial or limited authorization of a requested service, including determinations based on

the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
  - The reduction, suspension, or termination of a previously authorized service.
  - The denial, in whole or in part, of payment for a service.
  - The failure to act within the timeframes regarding the standard resolution of grievances and appeals.
  - The failure to provide services in a timely manner.
  - The denial of a member's request to dispute financial liability.

- **Grievance and appeal system** are the processes the county and providers implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

- **State Fair Hearing** is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal member is required to exhaust the SUD problem resolution process prior to requesting a State Fair Hearing and only a Medi-Cal member may request a state fair hearing.

- **Aid Paid Pending (APP)** Members have the right to request APP pending their determination. APP indicates that the member's benefits shall continue pending resolution of the appeal and or state fair hearing (42 CFR § 438.420)

In many cases, a responsible and reasonable resolution can be achieved through an informal and professional discussion between the member and the provider, either verbally or in writing. However, additional action in the form of a grievance or appeal may be necessary to offer the member, or if requested by the member. In accordance with 42 CFR and Title 9, the County of San Diego SUD Quality Assurance (QA) team has implemented a SUD Provider Grievance/Appeals and State Fair Hearing process for when member grievances cannot be resolved informally. Timelines for acknowledgement of receipt of grievances/appeals and resolution, are highlighted within the tables below. An opportunity for provider appeals has been added in addition to clinical review of grievances and appeals concerning clinical issues.

ASCMI Form

As of 3/31/26 the Coordinated Care Consent form will be deactivated and replaced with the Authorization to Share Confidential Member Information (ASCMI) Form to share information within SmartCare and "drop or raise" the CDAG wall. If members choose to sign, this form allows the member to provide consent to share sensitive physical health, behavioral health, housing, and social services information across providers outside of the electronic health record. The Grievance process can be facilitated via member signing of this form as it will grant permission for advocacy agencies to access needed information in the member's chart which can reduce coordination time in the event that the member files a grievance during his/her time in treatment.

Although this form is required to be offered to all members, signing the form is optional. Member denial to sign the form can be documented on the form itself within the EHR. All paper downtime forms must eventually be entered into the EHR for the form to be effective. Details on how to use the form, FAQs, and additional information can be found at ASCMI – CalAIM.

Transgender, Gender Diverse or Intersex Grievances

Per BHIN 25-019 if a member submits a grievance against a BHP, its subcontractors, or staff for failure to provide trans-inclusive health care, the BHP is required to submit quarterly reports to DHCS. BHPs are also required to submit additional information when the outcomes of the grievance reported are resolved in

a member's favor. If the grievance is resolved in the member's favor, then the individual named in that grievance must complete a refresher course by retaking the trans-inclusive health cultural competency training (outlined within BHIN 25-019) within 45 days of the resolution of the grievance and before they have direct contact with members again. BHPs are required to submit to DHCS verification of the completed refresher training quarterly as well as a reporting template to be submitted within quarterly submission timelines outlined in the BHIN.

Provider Program Grievance Process
Per DHCS requirements, the County must have a process in place to ensure all SUD program members' grievances are reported and investigated per regulations.

Program and members are encouraged to resolve grievances at a program level. (Note: Grievances received over the telephone or in-person by a program that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter.) Additionally, programs should refer the member to the appropriate advocacy program for further assistance in finding a resolution to their grievance. If resolution to the member's satisfaction has not occurred by close of the next business day following receipt of a verbal, written, or phone contact grievance, and/or the member refuses to utilize the advocacy organization, programs must notify County SUD QA within 72-hours of receipt of the grievance. Unresolved member grievances should be reported to the program's COR. They are also to be recorded on a SUD Complaint/Grievance Report Form and sent to BHS SUD QA within 72-hours (see Optum site for the SUD Complaint Form) of receipt of the grievance. Completion of this form is to be done by the program with or without the member present.

Programs are required to have policies and procedures in place to address and track all member grievances. Tracking shall include, at a minimum:

- Member initials,
- Date of the grievance,
- Who received grievance,
- How the grievance was made (verbally, in writing, etc.),
- The nature of grievance,
- How the program responded to the grievance,
- If the grievance was resolved to the member's satisfaction by the close of the next business day following receipt, and if unresolved,
- If member was provided information for the appropriate advocacy agency.

Review of Grievance policies and procedures as well as tracking logs will be part of annual site visits by BHS COR and/or BHS SUD QA.

County of San Diego SUD QA or the appropriate advocacy program shall acknowledge all member grievances, in writing, to the member, within five calendar days. BHS SUD QA will record all SUD Complaint/Grievance Report Forms received and monitor adherence to process regulations internally or through collaboration with the appropriate advocacy agency until member/program resolution occurs. Should a member initiate a grievance directly to BHS, the member will be reminded about their right to file a grievance with assistance from one of the County's contracted advocacy organizations (e.g., JFS or CCHEA). If the member refuses to utilize the advocacy organization, then the SUD QA unit will send the member acknowledgement of receipt of the grievance as described above and contact both the provider and the provider's COR to initiate an investigation and facilitate a resolution within process timeframes as described below.

Grievance Process and Timeframes

A grievance can be filed at any time. A resolution must occur within 30 days (but many will be resolved sooner) from receipt of grievance to resolution. A grievance is defined as an expression of dissatisfaction about any matter other than an "adverse benefit determination." JFS Patient Advocacy facilitates all grievance process for members within inpatient facilities and 24-hour residential facilities. CCHEA facilitates the grievance process for members seeking/receiving services within outpatient programs and all other SUD services. Advocacy services will provide the member with written acknowledgement of receipt of a grievance within five days of receipt of the grievance. Providers will be contacted within two business days of written permission from the member to represent him/her. To maintain compliance within mandated federal timelines, providers shall work closely with the advocacy organization to find a mutually agreeable solution for grievance resolution. Should a grievance or appeal focus on a clinical issue, then CCHEA and the JFS Patient Advocacy Program will utilize a clinician with the appropriate clinical credentials and treatment expertise to review and render a decision regarding the case.

Grievance tracking logs from JFS and CCHEA are sent monthly to the County SUD QA unit and include at minimum:

- Date of receipt of the grievance
- Member name/identifying number
- Nature of grievance
- Resolution
- Name of representative who received and resolved the grievance

County of San Diego SUD QA will maintain, review, and provide ongoing monitoring of all logged grievances as protocol for its continual quality assurance and management process.

Description	Receipt of Notification	Written Decision Notification
Grievance An informal/formal expression of dissatisfaction about any matter other than an "action," or adverse benefit determination, quality of care, services, and/or treatment.	Postmarked within five (5) calendar days from receipt of a grievance.	Within 30 calendar days of receipt of a grievance.

Standard Appeal Appeals are a formal process of challenging denial decisions involving, but not limited to DMC eligibility, services, or level of care decisions. *Must be filed within 60 calendar days from the date on the written decision notification/Notice of Adverse Benefits Determination (NOABD)	Postmarked within five (5) calendar days of appeal by advocacy organization.	Within 30 calendar days of receipt of an appeal. Adverse determinations must include information to member re: fair hearing, how to file, right to request and receive benefits, costs, etc. (as specified in DHCS Information Notice 18-010E).
Expedited Appeal The expedited resolution of appeals begins when it is determined (in response to a request from the patient or patient representative), or the provider indicates (in making the request on the patient's behalf), that taking the time for a standard resolution could seriously jeopardize the patient's life, health, or functional status. Appeals for initial residential authorizations and medication-assisted treatment will routinely be expedited. *If request for expedited resolution of an appeal is denied, it will be transferred to the timeframe for standard resolution. Written notification of this change to a standard appeal process will be provided within 72 hours.		Within 72 hours of receipt of an expedited appeal, it must be resolved and notice provided to the member.

<u>Appeal Process</u>
Timeline:

- Filing: Within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NOABD).
- Decision: Within 30 calendar days from receipt of appeal.

Oral and/or written appeals are reviews of actions by the county regarding provision of services through an authorization process, including:

- Reduction/limitation or delay of services
- Reduction, suspension or termination of a previously authorized service
- Denial of, in whole or part, payment for services
- Failure to provide services in a timely manner

- Grievance, appeal or expedited appeal was not resolved in time

Advocacy services will provide the member with written acknowledgement of receipt of an appeal postmarked within (5) calendar days of receipt of the appeal. The advocacy organization will contact the provider within two (2) business days of receiving written permission from the member to represent him/her. The advocacy organization shall investigate the appealed matter and make a recommendation to the county. The County will review the recommendations of the advocacy organization and make a decision on the appealed matter.

Note: A decision by a counselor to limit, reduce, or terminate a member's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

Expedited Appeal Process
Timeline: Decision: Decision: Within 72 hours.
Should a standard appeal process jeopardize a member's life, health, or functioning, an expedited appeal may be filed by the advocacy organization on behalf of the member. Notification to the provider by the advocacy organization will occur in less than (2) business days. A decision by the County with notification to affected parties will occur within (72) hours after receipt of the expedited appeal request.

Activity	Timeline		Reference/Notes
What is the timeline for submission of an Appeal?	Within 60 days of Notification of Action-Denial (date on letter). Orally or in writing.		**42 CFR §438.402(c)(2)(ii)**
Timeline for notification of receipt of appeal [Acknowledgement Letter from JFS (residential or inpatient program members) or CCHEA (outpatient program members).]	Standard	(5) business days	Can be earlier
	Expedited	If the county plan decides the appeal does not qualify as an expedited appeal, notification is (2) business days.	
Timeline for submission of State Fair Hearing Appeal	Within 120 days after Denial of Appeal		Plan must notify members of resolution within (90) days of date of the request for the hearing. For expedited State Fair Hearings, the Plan must notify members of resolution within (3) working days of the date of the request for the hearing. (**42 CFR§431.244(f)(2)**).

Note: County of San Diego SUD QA will maintain, review, and provide ongoing monitoring of all logged standard and expedited appeals as part of its continual quality review process.

State Fair Hearings (42 CFR §438.402(c))
Medi-Cal members must exhaust the County's appeal process prior to requesting a State Fair Hearing. A member has the right to request a State Fair Hearing only after receipt of notice that the County is upholding

an Adverse Benefit Determination. Members may request a State Fair Hearing within 120 calendar days from the date of the NAR (Notice of Appeal Resolution).
A request for a State Fair Hearing may occur if:

- Appeals are not wholly resolved
- If a provider/contractor fails to adhere to the notice and timing requirements per **42CFR§438.408**
- After exhausting the grievance process regardless of receipt of a Notice of Adverse Benefit Determination
- Denial of services due to not meeting medical necessity criteria
- Services are not provided in a timely manner
- County denial of provider request for member treatment

County of San Diego SUD QA will maintain, review, and provide ongoing monitoring of all logged State Fair Hearing requests as part of its continual quality review process.
Written requests for a State Fair Hearing:

State Hearing Divisions, California Dept. of Social Services
P.O. Box 944243, Mail Station 9-17-37
Sacramento, California 94244-2430
1-800-952-5253
TDD 1-800-952-8349

State Fair Hearings (42 CFR §438.420) [also known as Aid Paid Pending]
The beneficiary's right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten days from the date the letter was post-marked or delivered to the beneficiary) in accordance with Title 42, CFR, Section 438.420.

Provider Appeal Process
If a provider and advocacy organization cannot successfully resolve a member's grievance or appeal, the advocacy organization will issue a finding to be sent to the member, provider, and County, which may include the need for a Plan of Correction to be submitted by the provider to the County within 10 days. In the rare occurrence when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the County within 10 days, requesting an administrative review. The County shall have the final decision about needed action.

Monitoring the Member and Member Problem Resolution Process
The County shares concern with providers regarding areas affecting improvement in member access to services and improved quality of care in all services provided. County SUD QA staff will monitor and review program and advocacy organization grievance/appeal/state fair hearing logs/records and view feedback from the grievance and appeal process as a reflection of potential problems with service effectiveness and/or efficiency, and as an opportunity for positive change. Depending on the nature of the grievance, more targeted follow up at the provider level may be needed, including concerns inherent in-service access and delivery which may become part of the ongoing contract monitoring and/or credentialing process. The method of feedback, review, and quality review monitoring can more efficiently address needed improvements in system access, delivery, and quality of service for all members.

Member Notice of Adverse Benefit Determination (NOABD)
An Adverse Benefit Determination is defined as one which encompasses all previous elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations

involving medical necessity, appropriateness and setting of covered benefits, and financial liability. An Adverse Benefit Determination is defined to mean any of the following actions taken by a provider or the County:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The failure to act within the required timeframes for standard resolution of grievances and appeals
- The denial of a member's request to dispute financial liability.

Members must receive a written NOABD when the Program/Plan takes any of the actions described above. The Program/Plan must give members timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in **42 CFR §438.10.**
All SUD providers shall follow procedures for issuing a written NOABD and "Your Rights" Form for Medi-Cal members per **42 CFR §438.10** to include notification timeframes per **42 CFR §438.404(c).** A NOABD must explain the following:

- The adverse benefit determination made, or the Plan intends to make
- Clear and concise explanation of the reason for the decision
- A description of the criteria used; medical necessity criteria, processes, strategies, or evidentiary standards used
- The members right to be provided upon request, and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the NOABD
- The members right to request a second opinion and/or appeal of the adverse benefit determination and/or right to a State Fair Hearing once the process is exhausted, to include assistance through the process
- Procedures/methods by which the member/provider can exercise appeal rights
- Circumstances under which an appeal process can be expedited/how to request it
- Members right to have benefits continue pending resolution of the appeal
- To request such, and under what circumstances the member may be required to pay the costs of these services.

Issuing of an NOABD begins the 120-day period that a member has to file for a State Fair Hearing.

Provider Process When Issuing a NOABD
The following procedures shall be followed by providers when issuing a NOABD:

- A NOABD and "Your Rights" form shall be issued to a Medi-Cal member following a SUD assessment when it is determined by the provider that the member does not meet medical necessity criteria, resulting in a denial of services
- The appropriate NOABD shall be offered to the member with explanation per regulations with "Your Rights" form
- In accordance with Federal regulations, the NOABD shall be hand delivered on the date of the notice or deposited with the US Postal Service in time for pick-up no later than (2) business days of the decision by the provider

County of San Diego SUD programs shall have a written policy and procedure addressing the collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations. It is recommended that programs maintain all Notice of Adverse Benefit Determinations in a confidential location at the program site for no less than ten (10) years after discharge for adults. For minors, records are to be kept until they have reached the age of 18, plus seven (7) years.

- All SUD programs shall maintain a monthly NOABD Logs on program site
- Programs shall include in their NOABD Logs:
  - Date NOABD was issued
  - Member identification number
  - Member response, requests, provisions for second opinions, initiation of grievance/appeal procedure, and/or request for a State Fair Hearing if known
- NOABD Logs will be maintained at program site
- Logs to contain copies of each NOABD and "Your Rights" forms attached
- Log to reflect "NO NOABD ISSUED" if none are issued within a month
- Program's NOABD Log will be used by the program as a reference to accurately complete the Monthly or Quarterly Status Report (MSR or QSR).
- NOABD Logs must be available for review at COR or SUD QA request.

Types of Notice of Adverse Benefit Determination (NOABD) and Notice of Appeal Resolution (NAR)
NOTE: There are some cases in which a Notice of Adverse Benefit Determination may not be received; in which case, the member/provider can still file an appeal with the county plan. You can request a State Fair Hearing when this occurs.

- Notice of Adverse Benefit Determination – Denial of authorization for requested services
- Notice of Adverse Benefit Determination – Denial of payment for a service rendered by a provider
- Notice of Adverse Benefit Determination – Modification of requested services
- Notice of Adverse Benefit Determination – Termination of a previously authorized service
- Notice of Adverse Benefit Determination – Delay in processing authorization of services
- Notice of Adverse Benefit Determination – Failure to provide timely access to services
- Notice of Adverse Benefit Determination – Dispute of financial liability
- Notice of Appeal Resolution (NAR) – Formal letter informing a member that an Adverse Benefit Determination has been overturned or upheld.

NOABD Table of Notices, Forms, "Your Rights" form, and NAR forms, are available for view/use on the Optum Website under the NOABD tab. You can also access the NOABD Webinar under the NOABD tab.

Transgender, Gender Diverse or Intersex Grievance Monitoring

• Per BHIN 25-019 if a member submits a grievance against a BHP, its subcontractors, or staff for failure to provide trans-inclusive health care, the BHP is required to submit quarterly reports to DHCS.

• BHPs are also required to submit additional information when the outcomes of the grievance reported are resolved in a member's favor. If the grievance is resolved in the member's favor, then the individual named in that grievance must complete a refresher course by retaking the trans-inclusive health cultural competency training (outlined within BHIN 25-019) within 45 days of the resolution of the grievance and before they have direct contact with members again.

• BHPs are required to submit to DHCS verification of the completed refresher training quarterly as well as a reporting template to be submitted within quarterly submission timelines outlined in the BHIN.

Member Rights
Programs shall inform members of their nine (9) personal rights at an AOD certified program; this is documented in the member file as a signed acknowledgement that the member understands their rights during treatment. In addition to these rights, if the member is a Medi-Cal member, the member is entitled to additional rights. Members are to review these additional rights in the Drug Medi-Cal Organized Delivery System Member Handbook offered to the member at the time of admission to the program. They will also sign a form acknowledging they were offered the Member Handbook.

Member's Personal Rights, Complaint Information, and Advance Directive, for AOD Certified/Licensed Programs forms, are available for view on the OPTUM website see Member Rights 203b under the SUDURM tab, and all brochures can be found under the Beneficiary tab.

AB 1740 Requirements to Post Human Trafficking Notice
AB 1740 amends Section 52.6 of the Civil Code relating to human trafficking to additionally require a notice, as developed by the Department of Justice, that contains information relating to slavery and human trafficking, including information regarding specified nonprofit organizations that a person can call for services or support in the elimination of slavery and human trafficking be posted by facilities that provide pediatric care, as defined in W&I Code Section 16907.5

- "Pediatric services" means all medical services rendered by any licensed physician to persons from birth to 21 years of age.
- The notice must be posted in English, Spanish, and third language that is most widely spoken in the county (notice template is available on the California's DOJ's website Notice Template)
- Please note, facilities providing services to persons 21 years of age and up, posting this notice is optional.

Guidance for Facilities on Service and Support Animals

Service Animals

"Service animals" are animals that are trained to perform specific tasks to assist individuals with disabilities, including individuals with mental health disabilities. Service animals do not need to be professionally trained or certified. Under the Americans with Disabilities Act, service animals can only be dogs or miniature horses.

Service animals are different from support animals (see below for further information concerning support animals) and the Americans with Disabilities Act is clear that service animals are allowed in all public spaces, businesses, and are not limited to dwellings or residences. In other words, there are few limitations on where service animals would be permitted to go (even within healthcare facilities). This includes locked behavioral health facilities, where service animals are allowed.
Staff members are not permitted to preemptively deny a service animal. All health care facilities are required to make an "individualized assessment" of a service animal's behavior and its handler's ability to care for it. This means that staff should observe the behavior of the service animal over time and document

specific concerns, if any arise. Facility staff are only authorized to deny service animals in limited circumstances such as if it becomes clear that the animal poses a threat to others through aggressive behavior or if the animal is not being cared for by its handler. The reasons for denial of a service animal should be carefully documented by facility staff and clearly communicated to the handler.
Unless there is a reason to believe that an animal poses a threat to others, facility representatives can only ask two questions to determine whether an animal qualifies as a service animal:

- Is the animal required because of the handler's disability?
- What work or task the animal has been trained to perform?

The reasonable accommodation process does not apply to service animals as there is a presumption that they are allowed. In other words, facility staff have less flexibility in making determinations regarding service animals. For example, staff members are not permitted to request documentation for a service animal. Service animals are not required to be formally trained, nor must they wear a special tag or vest. If the member affirmatively answers the two questions above, the animal would be considered a service animal under the law and should be allowed in the facility unless one of the legal justifications for denial applies (see further below).

Support Animals

"Support animals" are animals that provide emotional, cognitive, or other similar support to an individual with a disability. A support animal does not need to be trained or certified.

Current fair housing act (and regulations) indicate that support animals should be allowed in any dwelling or housing accommodation, subject to limited exceptions. The law and regulations have a broad definition of dwelling to include essentially any location that is occupied by an individual person as a residence, even on a temporary or short-term basis. For example, the California Code of Regulations includes language describing that a "room used for sleeping purposes" would be considered a dwelling. However, this specific issue continues to evolve. Therefore, we recommend that facilities develop policies to address this issue. The following is provided as guidance that should be considered.
If a facility has a "no pets" policy, any member may request a "reasonable accommodation" to allow their support animal in the facility. Requests for reasonable accommodation do not have to be in writing and do not require any specific keywords. However, facilities should promptly address these requests.
Evaluating reasonable accommodation(s) should be an interactive process between the requester and the facility staff. If the facility staff members do not understand the initial request, they should continue to work with the requester until they can understand how the support animal will assist with the requester's disability-related need. Staff members can request documentation regarding the member's disability and the need for the support animal. This documentation should only be requested if the disability and/or need for the animal are not already apparent. Facility staff can also require that emotional support animals be licensed and/or vaccinated according to state and local laws that apply to all other animals.

The reasonable accommodation process allows staff members more flexibility in making determinations on support animals. However, if the connection between the disability-related need and the support animal is readily apparent, or if the requester submits appropriate documentation establishing this connection, staff members should allow the support animal, unless one of the legal justifications for denial applies (see below). If the connection is not readily apparent, and the requester does not submit appropriate documentation, then the individual's request could possibly be denied (pending submission of documentation).

Choosing to Deny a Service or Support Animal

We reiterate that denials for both a service or support animal must be based on an individualized assessment that relies on objective evidence about the specific animal's or handler's actual conduct. A service or support animal cannot be denied based solely on the animal's breed. Notably, determinations cannot be made on evidence that is so old it is not credible or reliable, or on mere speculation or fear about the types of harm or damage an animal may cause or on evidence about harm or damage that other animals have caused. The recommendation is that the animal must be allowed but if there is evidence that the owner cannot provide care, the animal is aggressive etc., then the facility should document such behavior and assess whether the animal should remain. If facility staff decide to deny reasonable accommodation for a support animal or deny access to a service animal, they must provide a specific legal justification to the member.

Examples of specific legal justifications include the following:

- Fundamental Alteration
- Permitting the animal would alter the essential nature of the program.
- Undue Burden
- Permitting the animal would cause significant difficulty or expense.
- Direct Threat
- Permitting the animal would lead to significant risk of substantial bodily harm to the health or safety of others or would cause substantial physical damage to the property of others, and that harm cannot be sufficiently mitigated or eliminated by reasonable accommodation.

In cases when facility staff are denying an animal because the requester fails to establish the connection between their disability-related need and the support animal, facility staff should explain why they believe the connection was not established but would not be required to cite one of the specific legal justifications above. Also, to the extent practical, if an animal requires removal, efforts should be made to ensure that it is retrievable by the owner.

In all cases, facilities need to make (and document) case-by-case determinations. The decision should not assume the denial of either service or support animals unless there is a legitimate reason for such a decision. The regulations do not provide specific requirements for how facility staff should communicate a denial to the requester, but our recommendation is that facilities provide the requester with a written summary of the reasons for the denial and include a copy of this summary in the requester's file. For any non-English speaking individuals, it is also recommended that if feasible, the facility should attempt to provide this information in the individual's preferred language.

Individuals who feel they have been wrongfully denied a service or support animal can file complaints with the U.S. Department of Justice, the U.S. Department of Housing and Urban Development, the California Department of Fair Employment and Housing, and the California Civil Rights Department. They may also file suit in state, federal, or small claims court or seek other legal representation. Additionally, individuals can choose to file a grievance or complaint through the appropriate patient advocacy agency. For this reason, it is important that facility documentation be comprehensive and detailed as to the reasons for any denial.

The information provided above is a summary of applicable law, regulations, and is intended as guidance. In developing policies and procedures, it is recommended that facility representatives utilize the legal guidelines that can be found in Cal. Code Regs. Title 2 § 12005, Cal. Code Regs. tit. 2 § 12176-12181, Cal. Code Regs. Title 2, § 12185, Cal. Code Regs. Title 2 § 14020, Cal. Code Regs. Title 2 § 14331, 28 C.F.R. § 36.104, 28 C.F.R. § 36.302, 28 C.F.R. § 36 app A to Part 36, 28 C.F.R. § 36 app C to Part 36. •

Requests for Materials in Alternative Formats

Members reserve the right to request written information in their preferred formats (large print, braille, audio or other accessible electronic formats). Requests for alternative formats may be made with directly to programs or through Optum's Access & Crisis Line. Programs are expected to address and assist members with these requests. Below are the steps to follow if a program or Optum ACL receives a request.

Process for Requests Made to the Program

- If materials requested are not already available on the Optum website, programs shall contact QI Matters (
- QIMatters.BHS@sdcounty.ca.gov
-) with the following information:
  - Member name and contact information (address, phone number, email address)
  - Preferred method of delivery (mail, email (if applicable), pick up at program)
- QA will coordinate directly with the program once materials are ready

Process for Requests made to Optum's ACL

- If materials requested are not already available on the Optum website, ACL staff shall contact QI Matters (
- QIMatters.BHS@sdcounty.ca.gov
-) with the following information:
  - Member name and contact information (address, phone number, email address)
  - Preferred method of delivery (mail, email (if applicable), pick up at a program)
- QA will coordinate directly with the member once materials are ready

For additional information on these rights and for items that are readily available in alternative format, programs may refer members to the Optum Beneficiary & Families page.

F. ACCESSING SERVICES

In order to receive SUD services within the County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS), clients must be a resident of San Diego County.

Access
In our commitment to providing excellent customer service, timely access is emphasized. Consistent with the County of San Diego's Health and Human Services Agency's "No Wrong Door" philosophy, Behavioral Health Services members are able to access DMC-ODS services by directly contacting DMS-ODS providers or via the Access and Crisis line. County of San Diego DMC-ODS providers will maintain hours of operation during which services are provided to members in an equal capacity to all members regardless of funding source (e.g., Medi-Cal).

County of San Diego DMC-ODS providers will post the Access and Crisis Line (ACL), 888 724-7240, to assist members with after hour's access. This line includes language translations in the member's preferred language via Language Line which has 150 languages. The ACL uses the California Relay Service (711) for TTY. The ACL maintains policies and procedures to screen for emergency medical and behavioral conditions as well as general screenings to assist with appropriate referrals to access services. Contact information for the Access and Crisis Line is also available on the County of San Diego Behavioral Health Services website and on printed materials as well as Optum San Diego's website.

County of San Diego DMC-ODS providers will ensure an appointment within ten (10) business days of the request for Outpatient, Intensive Outpatient and Residential Services. Opioid Treatment Programs will ensure an appointment within three (3) business days of the request for services. Providers shall ensure an appointment for urgent requests within 48 hours of the request. Requests for withdrawal management services are considered "urgent". Members referred to outpatient due to limited residential capacity shall also be considered "urgent". Residential program will offer intakes to be conducted 24 hours a day, 7 days a week.

***Reminder: Providers shall issue a Timely Access NOABD when there is a delay in providing timely services as required by the timely access standards.**

All programs will ensure to not have standard wait lists. SUBG funded providers shall follow the standard for priority population members requesting services which includes offering interim services. (See the Priority Population section for more information.) Programs are required to contact other appropriate level programs within the provider network if they do not have capacity, to ensure warm handoffs as needed. Providers shall have policies and procedures in place to screen for emergency medical conditions and immediately refer members to emergency medical care. Time and distance for Outpatient, Intensive Outpatient Services, and Opioid Treatment Programs shall be within thirty (30) minutes from the member's place of residence or up to fifteen (15) miles, unless an alternate access standard has been approved by the Department of Health Care Services (DHCS). There is no "wrong door" in which individuals, and/or organizations, providers, family, or law enforcement, can access specialty SUD services for themselves or on behalf of someone else within San Diego County. Main entry methods are:

- Direct-to-provider self-referrals (member walk-ins, member direct provider calls);
- Member call to the Access and Crisis Line (ACL) toll free number: 1-800-724-7240 (TTY: 711). A 24 hour/7 day a week access number for information/referral and crisis/behavioral health/SUD screening as provided by master level, licensed providers;

- Provider to Provider on behalf of member (referrals from medical partners, SUD Dependency Drug Court or CalWORKs Case Management);

In person or telephonic screenings are often considered first points of entry into the SUD system of care. To ensure the customer experience is viewed as both professional and helpful, Access and Crisis Line screeners are master level, licensed providers with advance clinical and member engagement skills. SUD programs are required by contract to provide trained staff for screening purpose should an individual call or walk in expressing interest in and/or have been referred for services.

Geographical Service Area
Programs shall establish and operate substance use disorder treatment and recovery services for individuals in San Diego County. Service area may be specified to one of six HHSA-identified regions (North Coastal, North Inland, North Central, South, East, and Central). Specific service areas are listed in the contracts, but services shall not be limited to geographic/residential criteria and shall be available to individuals seeking treatment in San Diego County.

Network Adequacy
The State requires County Behavioral Health Plans (which include Mental Health Plans and DMC-ODS Plans) to comply with BHIN 25-013 to ensure covered services are available, accessible, and in accordance with timely access requirements as well as time or distance standards per the Medicaid Managed Care Final Rule (Mega Regs).
In addition, Behavioral Health Plans are required, per BHIN 22-032, to report data on its network providers using the "274" standard which is an Electronic Data Interchange selected by DHCS to ensure provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. This information is used by DHCS to monitor whether the BHP's provider network is adequate to support the estimated need and demand for behavioral health services. Required provider information, inclusive of identifying information, is sent to DHCS on a **monthly** basis for these purposes.
The SOC Application hosted by Optum (BHS' Administrative Services Organization) is intended to streamline workflows and provider data collection related to Network Adequacy.

Required Actions on the SOC Application:

1. Registration

New hires and program transfers are required to register on the SOC Application promptly, and attest to the accuracy of their information once registration is complete.

2. Information Update
    a. Staff/Providers are expected to update their personal profiles as changes occur.
    b. Program Managers are expected to review their programs' site profiles and update the information as changes occur.
    c. Program Managers can submit an Access Request Form (ARF) to modify information as needed to maintain the provider roster. ARFs can be submitted to BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov.
3. Monthly Attestations

Staff/Providers and Program Managers are required to attest to the accuracy of all SOC information on a **monthly** basis.

For tips, FAQs, and other resources on how to complete registration and attestations on the SOC Application, visit the SOC Tips and Resources webpage. If any direct assistance is needed, contact:

Optum Support Desk
1-800-834-3792

sdhelpdesk@optum.com

Out-of-Network (OON) Access

The State Department of Health Care Services (DHCS) requires Behavioral Health Plans (BHPs) to ensure that Members receive medically necessary services within applicable time, distance, and timely access standards.

If the BHP's provider network is unable to meet those standards, the BHP shall allow Members to access out-of-network services and ensure they are adequately and timely covered.

Accordingly, when required access standards cannot be met through in-network providers, the BHP must arrange and authorize services through an Out-of-Network (OON) provider at no greater cost to the Member.

San Diego BHP contracts with Optum, as its Administrative Services Organization (ASO), to administer and execute Out-of-Network (OON) authorizations through Accommodation Agreements.

MHP and DMC-ODS providers shall refer Members to in-network providers when arranging services related to the Member's care. If medically necessary services are not available within required time, distance, or timely access standards, Members may access services from an OON provider through the process described below.

Procedure

1. **Criteria for Executing an Accommodation Agreement.** Accommodation Agreements with OON providers are executed when one or more of the following criteria are met:
    a. There are no San Diego County in-network providers within a reasonable geographic range who meet the cultural, ethnic, and clinical needs of the Member.
    b. Treatment by an OON provider is in the clinical best interest of the Member, as determined by County of San Diego Behavioral Health Services (BHS).
    c. Special requests are made by designated County BHS staff, which may include reimbursement of providers with non-Medi-Cal funds.

2. **Referring Provider Responsibilities.** When a provider determines that medically necessary SMHS or SUD services cannot be delivered within required time, distance, or timely access standards:
    a. The provider shall provide case management services.
    b. The provider shall assist the Member in contacting the ASO's Access and Crisis Line at 888-724-7240 (TTY 711) for referral to an appropriate provider.
    c. The provider shall facilitate a warm handoff to ensure continuity of care.
    d. Providers shall initiate and support the established OON process when required access standards cannot be met.

3. ASO (Optum) Responsibilities. Upon receipt of an OON service request:
    a. ASO Review and Processing
        i. Send written acknowledgment to the Member within three (3) working days.
        ii. Determine whether network adequacy or timely access standards cannot be met.
        iii. Complete review and authorization within thirty (30) calendar days of receipt of required documentation.
        iv. If standards cannot be met:

1. Identify an appropriate OON provider; or
2. Offer telehealth when clinically appropriate.

v. If telehealth is declined and no in-network provider can meet standards, coordinate transportation for an in-person visit.
vi. Notify the Member in writing within seven (7) calendar days of approval.

b. Execution of Accommodation Agreement. If OON criteria are met, the ASO shall:
i. Contact the identified OON provider.
ii. Execute an Accommodation Agreement requiring the OON provider to:
1. Follow County standard care procedures;
2. Accept standard Medi-Cal rates unless otherwise negotiated;
3. Submit required documentation (license, liability insurance, DEA if applicable).
4. Verify licensure (Primary Source Verification through the Credentialing Committee does not occur).
5. Establish the provider in the Designated Database (DDS) to enable authorization and payment.

Accommodation Agreements are time-limited and apply only to authorized service dates.

4. **Member Protections**
a. The Member may access the OON provider for as long as medically necessary, unless the OON provider agrees to provide services for a shorter timeframe.
b. If the BHP does not have an in-network provider able to meet applicable access standards, OON authorization shall be maintained as necessary to ensure uninterrupted access to medically necessary services.
c. The BHP shall ensure that the cost to the Member for authorized OON services is no greater than it would be if services were provided in-network.

Standards for Timely Access and for Time/Distance

1. BHIN 24-020 requires the following Timely Access Standards for services under DMC-ODS:

Modality Type	Standard
Outpatient Services – Outpatient Substance Use Disorder Services	Offered an appointment within 10 business days of request for services.
Residential	Offered an appointment within 10 business days of request for services.
Opioid Treatment Program*	Within three business days of request
Non-urgent Follow-up Appointments with a Non-Physician	Offered an appointment within 10 business days of the request for services.**

*For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations. (For example, with take- home medication, time in treatment requirements is not applicable to buprenorphine patients.)

*Reference: HSC §1357.03 (a)(5)(B), (D), (E) and (F)

Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function. Reference: HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21)). **NOTE:** All Withdrawal Management (WM) is considered urgent.

2. WIC § 14197 determines the standard for **Time or Distance**. For San Diego County, it is 30 minutes or 15 miles from the Medi-Cal member's (or beneficiary's) residence for the following behavioral health services:
    a. Outpatient mental health services and psychiatrist services
    b. Outpatient substance use disorder services
    c. Opioid Treatment Programs

3. Please refer to the document Transportation for Medi-Cal Members:
    a. When providing information to Medi-Cal members or beneficiaries about options for accessing covered non-emergency medical transportation to an in-network provider within time or distance and timely access standards for medically necessary services, when an in-person visit is requested by a member.
    b. When coordinating transportation with local Managed Care Plans (MCPs) for a Medi-Cal member or beneficiary to a network provider and meet timely access standards for medically necessary services when a member is offered a telehealth visit but requests an in-person visit.

DMC-ODS Transition of Care Policy

According to DHCS Information Notice Number 18-051, the County of San Diego as a DMC-ODS county, is required to allow a member to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the member would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

DMC-ODS treatment services with the existing provider shall continue for a period of no more than ninety (90) days unless medical necessity requires the services to continue for a longer period of time, not exceeding 12 months.

The County of San Diego DMC-ODS shall provide a member with transition of care with an out-of-network provider when all of the following criteria are met:

1. The County determines through assessment that moving a member to a new provider would result in a serious detriment to the health of the member, or would produce a risk of hospitalization or institutionalization;
2. The County is able to determine that the member has an existing relationship with an out-of-network provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
    a. An existing relationship means the member was receiving treatment from the out-of-network provider prior to the date of his or her transition to the DMC-ODS County.
3. The out-of-network provider is willing to accept the higher of the County of San Diego's DMC-ODS contract rates or DMC rates for the applicable DMC-ODS service(s);
4. The out-of-network provider meets the County of San Diego's DMC-ODS applicable professional standards and has no disqualifying quality of care issues (a quality-of-care issue means the County of San Diego DMC-ODS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other DMC-ODS members);
5. The provider is verified as a current DMC certified provider; and
6. The out-of-network provider supplies the County of San Diego DMC-ODS with all relevant treatment information, for the purposes of determining medical necessity and developing a current treatment plan, as long as it is consistent with federal and state privacy laws and regulations. Additionally, the provider supplies the County of San Diego DMC-ODS with all relevant outcomes data.

Transition of Care Request Process

Members, their authorized representatives, or their current provider, may submit a request to the County of San Diego DMC-ODS to retain their current provider for a period of time by calling the Access and Crisis Line (ACL) at (888-724-7240. TTY: 711). Upon receipt of the request, the County of San Diego DMC-ODS shall send the member written acknowledgement of receipt of the request and begin to process the request within three (3) working days.

Retroactive Transition of Care Request Process

The County of San Diego DMC-ODS shall retroactively approve a transition of care request and reimburse out-of-network providers for services that were provided if the request meets all transition of care requirements described above and the services that are the subject of the request meet the following requirements:

- Occurred after the member's enrollment into the County of San Diego DMC-ODS; and
- Have dates of service that are within thirty (30) calendar days of the first service for which the provider requests retroactive continuity of care reimbursement.

Retroactive Transition of Care requests can be initiated by calling the Access and Crisis Line (ACL) at (888-724-7240. TTY: 711) for more information.

Transition of Care Request Denial Process

The County of San Diego DMC-ODS may deny a member's request to retain their current provider under the following circumstance:

- The DMC-ODS county has documented quality of care issues with the DMC provider

If the County of San Diego DMC-ODS denies a member's request to retain their current provider based on the above, then the County shall notify the member of the denial in writing, offer the member at least one

in-network alternative provider that offers the same level of services as the out-of-network provider, and inform the member of their right to file a grievance if they disagree with the denial. If a DMC-ODS county offered the member multiple in-network provider alternatives and the member does not make a choice, then the DMC-ODS County shall refer or assign the member to an in-network provider and notify the member of that referral or assignment in writing.

Transition of Care Request Approval Process

On behalf of the County of San Diego DMC-ODS, Optum will manage Transition of Care request approvals. If the County of San Diego DMC-ODS and out-of-network provider are able to enter into a suitable arrangement for transitioning care for a given member, then the County shall allow a member to have access to that provider for the length of the continuity of care period, as deemed medically necessary, unless the out-of-network provider is only willing to provide services to the member for a shorter timeframe. In this case, the DMC-ODS County shall allow the member to have access to that provider for the shorter period of time, as established by the out-of-network provider.

Within seven (7) calendar days of approving a transition of care request, the County shall notify the member of the following in writing:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; and
- The member's right to choose a different provider from the DMC-ODS County's provider network.

At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the County shall work with the provider to establish a care plan for the member.

Transition of Care Request Completion Timeline

Each transition of care request shall be completed within thirty (30) calendar days from the date that Optum, on behalf of the County of San Diego DMC-ODS, received the request. Retroactive claims for services from the date of request shall be processed as described above. A transition of care request is considered completed when:

- The County of San Diego DMC-ODS notifies the member, in the manner outlined above, that the request has been approved; or
- The member has either selected or been assigned to an in-network provider after the DMC-ODS county notified the member, in the manner outlined above, that the request was denied.

Termination of Transition of Care Process

The County of San Diego DMC-ODS shall notify the member in writing thirty (30) calendar days before the end of the transition of care period about the process that will occur to transition the member's care to an in-network provider at the end of the transition of care period. This process includes engaging with the member and affected provider(s) before the end of the transition of care period to ensure continuity of services through the transition to an in-network provider.

Referrals

When appropriate, a member shall be referred via consultation with medical staff to a licensed medical professional for physical, psychiatric, labs, and/or other examinations. When a member is referred to a licensed medical professional due to medical concerns, a medical clearance or release will be obtained prior

to readmission. The referral and medical clearance shall be documented within the member's file. Refer to AOD Certification Standards Section 7020. Appointments for residential members with medical professionals in the community for examinations or due to medical concerns shall not be delayed arbitrarily based on routine program schedules or program rules, such as acclimation or "black-out" periods, and shall be based on an individualized assessment of the client's medical and clinical risk clearly documented in the client record.

Telehealth

Under the County of San Diego DMC-ODS, telehealth is an option for most services as a means of increasing accessibility to SUD services. BHS is responsible for ensuring that SUD providers who are part of the County of San Diego DMC-ODS Network follow standard telehealth protocols for protecting member confidentiality. Contracted organizational providers in the County of San Diego DMC-ODS shall:

- Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to beneficiaries:
    - The beneficiary has a right to access covered services in person.
    - Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access Medi-Cal covered services in the future.
    - Non-medical transportation benefits are available for in-person visits.
    - Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.
- Use a secure, trusted platform for videoconferencing.
- Verify devices and software use the latest security patches and updates.
- Install the latest antivirus, anti-malware, and firewall software to devices. The underlying network must provide security.
- Verify devices use security features such as passphrases and two-factor authentication. Devices preferably will not store any patient data locally, but if it must, it should be encrypted.
- Verify audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telehealth vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on the program's own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.
- Choose a software solution that is HIPAA-compliant, as many popular, free products are not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) and 42 CFR Part 2 is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so programs must be sure to check any relevant statute for California. Just because software says its HIPAA-compliant isn't enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of the program's practice, such as EHRs, so it is best to think about HIPAA and telehealth from a global, "all technologies" perspective.
- It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.

- When reviewing software options, many vendors require a "business associate agreement," or a BAA, to ensure HIPAA compliance. Contact the vendor and confirm what such an agreement entails.
- Effective no sooner than January 1, 2024, all providers furnishing applicable covered services via synchronous audio-only interaction must also offer those same services via synchronous video interaction to preserve member choice. Also, effective no sooner than January 1, 2024, to preserve a member's right to access covered services in person, a provider furnishing services through telehealth must do one of the following:
    - Offer those same services via in-person, face-to-face contact; or
    - Arrange for a referral to, and a facilitation of, in-person care that does not require a member to independently contact a different provider to arrange for that care
- Requirements for obtaining consent for telehealth services (and exception for establishing new relationships via telehealth)

Compliance these requirements will be monitored through annual BHS SUD QA site visits (see BHIN 23-018 for more information).

Referral Resource
SUD programs shall serve as a community referral resource, directing individuals in need of other services beyond the scope of the program. The program shall maintain and make available to participants a current list of resources within the community that offer services that are not provided within the program. At a minimum the list of resources shall include medical, dental, mental health, public health, social services and where to apply for the determination of eligibility for State, Federal, or County entitlement programs.

Release of Information to Referrals
In order to facilitate linkage and care coordination, providers shall report all required client information to identified referral source according to specified format and established timelines, providing there is current written consent to release information contained in the client file.

Programs shall have written policy and procedures regarding their role as a community referral resource. Program policy and procedure will identify conditions under which referrals are made, details of the referrals, and additional follow-up services as documented within the client record. Programs will offer individuals either requesting, or in need of services not otherwise offered by the program, resource options/referrals from an updated list of community service resources available within San Diego County.

Missed Scheduled Appointments
All providers shall have policies and procedures in place regarding the monitoring of missed scheduled appointments for clients (and/or caregivers, if applicable). These policies and procedures shall cover both new referrals and existing clients, and at minimum, include the following standards:

- For new referrals: When a new client (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an **elevated risk**, the client (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

- For current clients: When a client (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an **elevated risk** the client (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For clients

who are at an **elevated risk** and are unable to be reached on the same day, the program policy needs to document next steps, which may include consultation with a supervisor, contacting the client's emergency contact, or initiating a welfare check. Additionally, the policy shall outline how the program will continue to follow up with the client (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters).

All attempts to contact a new referral and/or a current client (or caregiver, if applicable) in response to a missed scheduled appointment must be documented by the program.

Note: **Elevated risk** is to be defined by the program and/or referral source.

Crisis Intervention Protocol
SUD programs are to have a protocol in place to address client crises and emergency situations. These protocols shall be available to all program staff and staffs are to be trained in crisis intervention procedures. Phone numbers for the Programs' local police, PERT team, fire department, and other emergency services shall be readily available to all staff members.

Access and Crisis Line: 1-888-724-7240 (TTY: 711)
Optum Health operates the Access and Crisis Line (ACL) on behalf of the County of San Diego Behavioral Health Services (COSDBHS). The ACL, which is staffed by licensed and master's level clinicians, provides telephone crisis intervention, suicide prevention services, and behavioral health information and referral 24 hours a day, seven days a week. The ACL may be the client or the family's initial access point into the system of care for routine, urgent or emergency situations.

All ACL clinicians are trained in crisis intervention, with client safety as the primary concern. ACL Counselors evaluate the degree of immediate danger and determine the most appropriate intervention (e.g., immediate transportation to an appropriate treatment facility for evaluation, or notification of Child or Adult Protective Services or law enforcement in a dangerous situation). In an emergency situation, ACL counselors make direct contact with an appropriate emergency services provider to request immediate evaluation and/or admission for the client at risk. The ACL counselor makes a follow-up call to that provider to ensure that the client was evaluated and that appropriate crisis services were provided.

If the client's mental health condition is serious but does not warrant immediate admission to a facility, the ACL counselor performs a telephone risk screening and contacts an SUD provider directly to ensure that the provider is available to assess the client within 72 hours.

Additionally, the ACL conducts a Brief Level of Care Screening Tool in order to determine a provisional level of care recommendation to guide linkage to an appropriate referral to SUD services. During business hours, the ACL will offer the client the opportunity for a warm handoff to a SUD program best aligned with the client's provisional level of care need.

The ACL has Spanish-speaking counselors on staff. Other language needs are met through the Language Line, which provides telephonic interpreter services for approximately 140 languages at the point of an initial ACL screening. Persons who have hearing impairment may contact the ACL via the California Relay Service 711.

Eligibility Determination
County of San Diego Substance Use Disorder services offer a comprehensive continuum of care to better meet the unique recovery needs of adults, adolescents, and specific subset populations (probation, perinatal), including those struggling with co-occurring disorders.

SUD programs within the County of San Diego system of care are required to develop and maintain written program eligibility, admission, and readmission policy, procedure, and protocols to include non-discriminatory eligibility and admission practices compatible with 42 CFR 438.3, Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, The Rehabilitation Act of 1973, The Americans with Disabilities Act, and Title IX of the Education Amendments of 1972 to include:

- Enrollment discrimination is prohibited (42 CFR Title 438.3)
- Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in (42 CFR § 438.50 (c)
- Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the client's health status or need for health care services (42 CFR 438.3)
- The Provider accepts individuals eligible for enrollment in the order in which they apply without restriction (42 CFR Title 438.3)
- The provider will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability (42 CFR 438.3)
- Eligible individuals may not be denied services pending establishment of Medi-Cal

Eligible Populations
Program policies will include a description of "target populations" eligible to receive SUD services within their programs as defined within their contracts. Eligibility may include one or any combination of:

- Adolescents age 12 – 17
- Adults age 18 and over
- Clients self-referred or referred by another person or organization
- Geographical Service Area: Residents of San Diego County (North Coastal, North Inland, North Central, Central, East, South)
- Persons with Medi-Cal or are Medi-Cal eligible (regardless of % FPL and regardless if they have additional insurance), including those served by local Medi-Cal managed care plans and their plan partners. Note: Clients who are at or under 138% of FPL are eligible for Medi-Cal.
- Special populations based on: disabilities, cultural, linguistic, and sexual orientation **(**DHCS AOD Certification Standards, Sec. 7000**)**
- No DMC/Low Income or no insurance:
    - Clients within 138% to 200% FPL without insurance (**and** not Medi-Cal eligible). Please refer to Section O, Provider Contracting, for more information.
    - Clients under 200% FPL with health coverage other than Medi-Cal may be invoiced to the County BHS contract.
    - Clients above the 200% FPL are outside of the BHS target population may not be invoiced to the County BHS contract.
    - Optum will require a denial or Assignment of Benefits (AOB). Check with Optum for requirements.
- Persons meeting DMC-ODS medical necessity criteria
- Justice Overrides
- Individuals under age 21 are eligible to receive Early Periodic Screening, Diagnostic and Treatment (EPSDT) services. They are eligible to receive all appropriate and medically necessary services

needed to correct and ameliorate health conditions that are coverable under section 1905(a) of the Social Security Act.

(See Section A: County of San Diego DMC-ODS for more information.) For more information on the current FPL, see the Poverty Guidelines at US Department of Health & Human Services website.

Sobriety

Request for treatment services shall not be deny based on substance use in during an established period of time (i.e., 24 hours, 72 hours, or 10 days) preceding an admission. Per DHCS, "If a client has been assessed, meets the diagnosis of a substance use disorder (SUD), and is determined to not be under the influence or in need of detoxification or withdrawal management services at the time of admission, the client may be admitted into the residential program for SUD treatment and recovery services. Record of the assessment(s), diagnosis, and determination of the client's level of care must be documented and contained in the client record for review." DHCS does not promote termination of clients from treatment for relapse. Each client should have a relapse plan on file.

Assisting Clients with Medi-Cal

Providers shall make every effort to assist clients with applying for and maintaining eligibility for Medi-Cal and attempt to maintain a minimum of 80% Medi-Cal enrollment of its total program population. Programs will assess the client's insurance status during the initial assessment and throughout treatment. Programs must check clients' Medi-Cal status monthly, including Share of Cost, to verify DMC eligibility. When programs receive information about changes in a client's circumstances that may affect a client's eligibility, programs shall assist the client with reporting changes such as a change in residence, to the MC eligibility office. Changes such as a death of a client shall be reported to the SUD QA team following the SIR procedures. QA will notify DHCS for all client deaths reported.

Medi-Cal Enrollment

For clients who are currently uninsured and eligible for Medi-Cal, programs will offer assistance to obtain Medi-Cal and/or maintain their benefits, by connecting them with a Medi-Cal enrollment entity and/or assisting with the Medi-Cal application process. Medi-Cal applications can be completed throughout the year. For additional Medi-Cal qualifying information, please visit the DHCS website.

There are several ways to assist clients in the Medi-Cal enrollment process:

- Clients may complete or SUD providers may assist clients in completing an online application at:
  - MyBenefits CalWIN
  - Covered California
- Clients may make an appointment or walk-in to a Federally Qualified Health Center (FQHC) where dedicated enrollment staff will assist them with the application process
- Clients may make an appointment or walk-in to a County of San Diego operated Family Resource Center or Live Well Center where dedicated eligibility staff will assist the client with the application process
- The SUD program may partner with local FQHC to host a Medi-Cal enrollment event at the program site
- The SUD program may partner with the County of San Diego Eligibility staff to host a Medi-Cal enrollment event at the program site
- To find a Federally Qualified Health Center or County of San Diego Family Resource Center located near your program, please visit the 2-1-1 San Diego website.

Coordination of Transitions in Care (Step-Up/Down within SUD System and between Health Systems)

Coordinating transitions in client care is foundational to clients benefiting from a full SUD continuum with various levels of care to continuously meet their needs as they progress through treatment and ultimately toward recovery.

In all cases of care transitions (both when the transition occurs along the SUD care continuum and when the transition occurs between other health systems), the last treating SUD provider is responsible for and must coordinate transitions in care. Case management is a billable service that needs to be used to support these care transition responsibilities.

Important Components of Successful Transitions in Care

- Having established policies and procedures for standardizing the care transition process
- Ensuring sufficient training for case managers and staff who are responsible for managing transition in care to ensure understanding of the various levels of care in the DMC-ODS and other service delivery systems
- Clear and thorough treatment and discharge planning so the goals of treatment are clear, such as when transitions may be necessary and the goals of transition
- Client and family preparation and education about transitions in care (i.e. Why they are necessary, what to expect, how to seek help if the need arises, etc.)
- Warm handoffs that involve interpersonal communication and ideally physically accompanying the client during the transition, rather than solely relying on written or electronic communication
- Ensuring that the receiving provider receives necessary information to all of a smooth transition in care
- Interdisciplinary team involvement with assigned accountability for transition-related tasks and outcomes
- Follow up and tracking of referrals to ensure smooth and completed transitions in care
- Positive relationships between the sending and receiving providers
- Medication reconciliation, as needed
- Establishing a quality and process improvement process to identify and ultimately address obstacles (like transportation) to care transitions, both at individual and systemic levels.
- Maintaining client engagement throughout the transition process.

Residential Service Authorization

An Administrative Services Organization (ASO) provides customized administrative services to the County's clients and providers and is responsible for residential placement authorization and coordinating intakes to SUD providers. Optum acts as the ASO for County Behavioral Health Services. While there is no "wrong door" for clients to enter the SUD treatment system, the two most frequently used portals are the Optum Access and Crisis Line (ACL) and direct referrals. Clients seeking residential SUD services in the County may go directly to a SUD residential treatment provider or contact them by telephone to initiate services. Less frequently, clients are referred to SUD services by physical and mental health providers, law enforcement, and County agencies. For assistance with SmartCare during normal business hours (7:00 am to 4:30 pm, M-F), contact the HHSA, BHS_EHRSupport BHS_EHRSupport.HHSA@sdcounty.ca.gov For assistance with SmartCare after normal business hours and on weekends, contact the Optum Support Desk at 800-834-3792.

Residential providers are expected to have established workflow processes in place to meet submission of complete information in authorization requests, and to meet the timelines as described below. The date the

authorization request is considered received is the date complete information for the request has been received. Incomplete authorization requests received by Optum that require additional follow-up for information may not meet required timelines.

County shall provide prior authorization for residential and inpatient services--excluding Withdrawal Management (WM) Services--within 24 hours of the prior authorization request being submitted by the provider.

Initial Authorization

The SUD Provider begins the authorization process by 1) Assigning the client to SmartCare Client Programs in Enrolled or Requested status, 2) checking the client's Medi-Cal eligibility, which is not a requirement for services, and communicating client's Medi-Cal eligibility to Optum when calling in initial authorization requests, and 3) completing the required intake/admission documentation (See the SUDURM for further details). If the client meets criteria for admission, the SUD Program will complete the SUD Residential Authorization Request form or the Adolescent Initial Level of Care Assessment form to establish medical necessity and submit it to Optum within 72 hours of the client's admission to the program. The Optum SUD Care Advocates are available for consultation by telephone at 800-798-2254 (select option 3, and then option 2) at any time before or during the authorization process. Residential programs are encouraged to consult should they have questions regarding a client's needs, documentation, or other questions related to authorization.

The SUD Program will notify the Optum SUD Care Advocate of the initial authorization request via telephone and will provide demographic information. The SUD Provider will then fax the Optum fax coversheet with the SUD Residential Authorization Request form or the Adolescent Initial Level of Care Assessment form to Optum at 855-244-9359. Upon receipt of the authorization request, Optum will: verify Medi-Cal eligibility, check SmartCare Client Programs review the clinical documentation, consider Provider's request for ASAM Level of Care 3.1, 3.3, or 3.5, and enter the information into the designated data system. The Optum clinician will make an authorization determination within twenty-four (24 hours) of receipt of a complete initial authorization request and will notify the SUD Provider. See Quick Guide posted on the Optum site.

Approved Request

If the initial authorization request is approved, the SUD Provider will be given an initial authorization for fifteen (15) days. Optum will notify the provider of authorization via a telephone call, and the SUD Provider will begin the continued authorization request process.

Denied Request

If the initial authorization request is denied, then the client receives a Notice of Adverse Benefit Determination (NOABD "denial" letter). The Optum clinician will verbally notify the SUD Provider of the denial and fax the Notice of Adverse Benefit Determination (NOABD) - Denial Notice along with the additional following documents: Your Rights Under Medi-Cal, Language Assistance, and the Nondiscrimination Notice. The SUD Provider will provide the client with the NOABD and Client Rights. Clients may appeal the denial through the Grievance and Appeal Process. Providers may also appeal the denial. For more information on the Grievance and Appeal Process, please see Section G: Member Rights.

Continuing Authorization

After the initial authorization request is approved, the SUD Provider will submit via fax within ten (10) days of admission a Continuing Authorization Request. The SUD Provider will fax the Optum fax coversheet with the SUD Residential Authorization form, the ASAM Criteria Assessment, or a new Adolescent Initial Level of Care Assessment form to Optum at 855-244-9359. Prior to faxing authorization

request to Optum, the SUD Provider will update SmartCare Client Programs if request is for a different level of care.

The Optum clinician will review the clinical documentation for medical necessity and enter the submitted information in the designated data system. The Optum clinician will make an authorization determination within five (5) calendar days of receipt of the continuing authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client's life, health or functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving a complete request.

Approved Continuing Authorization
If continuing authorization request is approved, the Optum clinician will provide a continuing authorization of seventy-five (75) days and will notify the SUD Provider by telephone. For adolescent programs, a continuing authorization of fifteen (15) days will be provided.

Denied Continuation Request
If an authorization request is denied, the Optum clinician will verbally notify the SUD Provider of the denial and fax to the program the Notice of Adverse Benefit Determination (NOABD) – Denial Notice along with the additional following documents: Your Rights Under Medi-Cal, Language Assistance, and the Nondiscrimination Notice. The program will provide the notice and other documents to the client. Clients may appeal the denial through the Grievance and Appeal Process (for more information on the Grievance and Appeal Process, please see Section I: Quality Assurance).

Extension Authorization Request
If the SUD Provider determines that a client needs additional residential treatment services, the SUD Provider will submit an extension request for continuing authorization for thirty (30) more days, no later than 10 days before their current authorization expires. Perinatal SUD programs may submit extension authorization requests in thirty (30) day increments,and shall also defer to any postpartum timelines outlined in their contract with the County of San Diego. Adolescent SUD Provider may request an extension request for thirty (30) more days and must be submitted to Optum by day thirty (30). Prior to faxing authorization request to Optum, the SUD Provider will update SmartCare Client Programs if request is for a different level of care.

The Extension Authorization Request may include any documentation that indicates ASAM Medical Necessity. The extension authorization request documentation will be faxed and include at a minimum:

- Optum RSUD Auth Request Fax Cover Sheet **AND**
- SUD Residential Authorization Request Form **OR**
- A new Adolescent Initial Level of Care Assessment

The Optum clinician will review all submitted clinical documentation for medical necessity and document in the designated data system. The Optum clinician will make an authorization determination within five (5) calendar days of receipt of the extension authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client's life, health or functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving a complete request.

Residential Level of Care Changes
If the client's assessed level of care changes and the client needs to be moved to another residential level of care (e.g., 3.1 to 3.5), the SUD Provider will update SmartCare Client Programs level of care and submit a request to change the level of care via fax that will include:

- Optum RSUD Auth Request Fax Cover Sheet **AND**
- SUD Residential Authorization Request Form **OR**
- A new Adolescent Initial Level of Care Assessment

The Optum clinician will review all submitted clinical documentation for medical necessity and document in the designated data system. The Optum clinician will make an authorization determination within five (5) calendar days of receipt of the continuing authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client's life, health or functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving a complete request.

Discharge
When medical necessity is no longer met for residential treatment during an authorized stay, the SUD Provider shall recommend a change in level of care and transfer or discharge the client. The SUD Provider will submit to Optum via fax the discharge summary within thirty (30) days of the last face-to-face with the client (please see "Timelines" under "Discharge Summary" further in this section for more information).
Retrospective Authorization Request Requirements
Residential providers are expected to submit all authorization requests within prescribed timelines. There are limited circumstances in which retrospective authorizations may be conducted, including:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for members with other health care coverage pending evidence of billing, including dual-eligible members;
- Circumstances beyond the program's control (such as natural disaster. This does not include negligence, misunderstanding of requirements, illness or absences of staff), and/or,
- Member's failure to identify payer/concealed Medi-Cal eligibility at the time of admission.

The residential program shall be required to send copies of the entire client chart and documentation as to why an authorization request is being sent retrospectively.

All Retrospective Authorization Requests must be submitted within four (4) months from the date of the client's retrospective eligibility or within four (4) months of Provider being notified of denial from other primary health insurance coverage. Retrospective Authorization Requests which are not submitted timely will be administratively denied.

In cases where the review is retrospective, the ASO, on behalf of the DMC-ODS, will communicate the decision to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall communicate to the provider in a manner that is consistent with state requirements.

Charitable Choice Regulations
Charitable Choice regulations require that religious organizations provide notice to all clients regarding their right to referral to another provider to which they have no religious objection. Charitable Choice referrals shall be reported to the County. This is applicable to religious organizations only. Please refer to 68 FR 56429 9/30/2003 (model notice on page 56438).

Nondiscrimination against religious organizations

- A religious organization is a nonprofit organization which is eligible on the same basis as any other

organization to participate in applicable programs consistent with the First Amendment to the U.S. Constitution. These applicable programs include those under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, 42 U.S.C. 300x to 300x-66 and the Projects for Assistance in Transition from Homelessness (PATH) Formula Grants, 42 U.S.C. 290cc-21 to 290cc-35 as these programs fund substance abuse and/or treatment services.

- Nothing in these regulations except the provisions provided herein and the SAMHSA Charitable Choices provisions which are the provisions of 42 U.S.C. 300x-65 and 42 U.S.C. 290kk, et seq. shall limit the ability of a governmental entity to have the same eligibility conditions apply to religious organizations and any other nonprofit private organization.
- No governmental entity receiving funds under these programs shall discriminate against an organization on the basis of religion or religious affiliation.

Religious activities, character, and independence

- Programs which receive funds from SAMHSA, or a governmental entity will not use these funds for religious activities. The organization's religious activities must be offered in a separate time or location and participation is voluntary for an individual who receives substance use disorders services.
- A religious organization maintains its independence from governmental entities to practice and express its religious beliefs.
- Faith-based organizations which provide services need not remove religious materials from their facilities. A SAMHSA-funded religious organization may keep its structure of governance and include religious terms in its printed material and governing documents.

Non-discrimination requirement

- A religious organization which provides substance use services will not discriminate against a program member or a participant who receives substance use services based on religious beliefs or a refusal to participate in a religious practice.

Rights to services from an alternative provider

- An individual who receives or is interested in services and disagrees with the religious nature of the program has a right to obtain a notice, a referral, and alternative services within a reasonable time period.
- A program that provides a referral to an individual or interested individual will provide the participant with a notice of a right to receive services from an alternative provider who will meet the requirements of needed services such as accessibility and timeliness of treatment.
- Programs will maintain a system that ensures that appropriate referrals are made which meets the needs of the individual such as in the geographic area. A SAMHSA treatment locator may be used.
- Referrals will maintain the laws of confidentiality and specifically confidentiality regarding alcohol and drug abuse records (42 CFR Part 2). The program will contact the State regarding the referral and make sure the individual contacts the alternative provider.

Priority Population Clients Requests for Services

SUBG funded programs must follow the priority population list for treatment admission preferences:

- Pregnant person using IV substances
- Pregnant person using other non-IV substances
- Person using IV substances
- All other eligible individuals

When priority population clients are not able to be admitted to a SUBG funded program due to capacity limitations, interim services shall be provided within 48 hours if no other facility has capacity to admit the client. Examples of interim services include referrals/education for prenatal care, HIV/TB services/education, referrals for housing, self-sufficiency services, medical care, etc.

All DHCS funded programs shall report capacity and waitlist management information to DHCS monthly via DATAR. QA monitors priority population waitlists reported to confirm accuracy of the data and confirm if interim services provided for priority population clients. Programs shall keep records of interim services for each priority population client not admitted, which includes documenting efforts for each client, and provide upon request to QA.

Persons with Disabilities (PWD) Access to Services
Any enterprise licensed or certified by the DHCS or any entity (counties and providers) receiving state or federal funding that has been allocated by DHCS must comply with statutory and regulatory requirements such as:

- Americans with Disability Act (ADA) Exhibit 1
- Section 504 and 508 of the Rehabilitation Act of 1973;
- 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance;
- Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance and;
- Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities (PWD).

These statutory and regulatory requirements assist in ensuring Persons with Disabilities (PWD) are provided access to Substance Use Disorder (SUD) prevention, treatment and recovery services. The legislation and regulations require all providers make reasonable accommodations and provide accessible services for PWD, and this also includes providers making electronic and information technology accessible to people with disabilities. These are per program standards within the Legal Entity, so each program site needs to comply with the above statutory and regulatory requirements.

Providers applying for initial licensure or certification must plan to be fully accessible at the time of application. Applicants for renewal of a licensure or certification must have conducted an assessment to identify barriers to service and develop an Access to Service Plan (i.e., corrective action plan) for removing or mitigating any identified barriers. Applicants failing to address these requirements can anticipate denial of their initial application or the withholding of renewals for existing licensed or certified programs until these requirements are adequately addressed.

The county is responsible for ensuring that SUD services and the SUD contracted providers are accessible and do not discriminate against or deny equal opportunity to a PWD to participate in and benefit from the provided service. Language Requirement
Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. Programs shall access professional certified interpreter services as needed for deaf, hard of hearing and late deafened participants to facilitate complete communication and to ensure provision of appropriate confidential treatment and

recovery services. The offer of interpreter services and the client's response must be documented, as should the use of an interpreter, and include documentation when services are provided in a language other than English.

DMC-ODS County of Responsibility
As outlined in MHSUDS 18-051, the DMC-ODS county must allow the member to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the member would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

If a member moves to a new county and initiates an inter-county transfer, the new county is immediately responsible for DMC-ODS treatment services and can claim reimbursement from DHCS through the Short Doyle Medi-Cal System, as of the date of the inter-county transfer initiation. (BHIN 21-032)

The DMC-ODS County shall ensure that members receiving NTP services and working in or traveling to another county (including a county that does not opt in to the DMC-ODS program) do not experience a disruption of NTP services.

In accordance with 42 CFR 438.206, if the DMC-ODS county's provider network is unable to provide necessary services to a particular member (e.g., when a member travels out of county and requires daily NTP dosing), the DMC-ODS county shall adequately and timely cover these services out-of-network for the member, for as long as the DMC-ODS county's provider network is unable to provide them. In these cases, the DMC-ODS county shall coordinate and cover the out-of-network NTP services for the member.

G. QUALITY ASSURANCE

Quality assurance and monitoring constitutes the processes by which the County will ensure improvement and high quality of care provided to clients. The County of San Diego's quality assurance and monitoring will adhere to the larger framework established by the County of San Diego Behavioral Health Services with DHCS DMC-ODS and EQRO oversight. The processes by which the County will perform involve ensuring compliance of regulations set forth by governmental and/or administrative entities. Essentially, the goal of quality assurance is to assess and evaluate quality of services, recognize and address issues with service delivery, construct plans of action to overcome issues and maintain quality improvement, continuing to follow-up and monitor that plans of action meet their anticipated objectives.

The County of San Diego is committed to providing high quality substance use disorder services that follow harm reduction principles, client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. In order to achieve the goal, each program in the system must have internal quality improvement controls and activities in addition to those provided by the County of San Diego. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Improvement department or position, which offers training and technical assistance to program staff. Internal monitoring and auditing are to include the provision of prompt responses to detected problems. Staff shall participate in activities that promote quality assurance and quality improvement and bring concerns regarding possible deficiencies or errors \in the quality of care, treatment or services provided to clients to the attention of those who can properly assess and resolve the concern.

Each program shall develop written policies and procedures regarding internal quality assurance and improvement controls and activities and maintain internal systems of controls and monitoring to ensure that all aspects of the program including, but not limited to, personnel files, client files, billing and fiscal, data, and programming are in compliance with the contract and maintain the highest possible standards.

Programs shall conduct an internal review and evaluation at least once every fiscal year as it relates to the statement of work. Results of the review and any plans for correction shall be available for review by the County of San Diego.

In addition, all provider programs are required to attend regular Program Manager Meetings, quarterly Leadership Plus meetings, QA In-Service, Documentation trainings and other behavioral health meetings as required. Attendance at these meetings is essential to keep abreast of system changes and requirements as part of our continuous improvement efforts. Since communication is vital to ongoing quality improvement, programs are also required to read and disseminate information that is provided by the County of San Diego, including (but not limited to) materials such as the BHS QA monthly newsletter, "Up to the Minute" (UTTM) as these communications are relied upon as mechanisms for sharing updated information from DHCS, form revisions, and other important announcements related to providing quality SUD services within the County.

The quality of the SUD system of care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

- 42 CFR, (Code of Federal Regulations)
- Title 22 of the California Code of Regulations
- State Department of Health Care Services (DHCS) Letters and Notices,

- The Intergovernmental Agreement between DHCS and the County of San Diego, and
- The Special Terms and Conditions (STCs) of the DMC-ODS Waiver

Quality Improvement Plan
The purpose of the County of San Diego's BHS Quality Improvement (QI) Program is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The QI Program delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance use services provided. The QI Program encompasses the efforts of clients, family members, clinicians, behavioral health advocates, substance use treatment programs, quality improvement personnel, and other stakeholders.

The QI Program and QI Work Plan (QIWP) are based on the following values:

- Development of QI Program and QIWP objectives is completed in collaboration with clients and stakeholders.
- Client feedback is incorporated into the QI Program and QIWP objectives.
- QI Program and QIWP are mindful of those whom data represented, therefore, integrate client feedback to improve systems and services.

The QI Unit monitors the services provided for safety, effectiveness, responsiveness to clients, timeliness, efficiency, and equity. Key variables related to practices and processes performed or delivered by service providers that affect the outcome of services to client and family members are measured and analyzed on a weekly, quarterly, or annual basis. QI staff perform client record reviews and work with contracted providers on continuous improvement activities. Access times, serious incidents, and grievances are tracked and trended. Surveys are conducted to monitor client and provider satisfaction.

Monitoring
SUD programs are monitored by DHCS for Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) and DMC compliance and by the County of San Diego for these and additional standards, such as the DMC-ODS STCs. For the audit, evaluation, or inspection purposes, all providers shall make available their premises, physical facilities, equipment, books, record, contracts, computer and other electronic systems related to their Medi-Cal clients. All programs shall comply with requirements established within the State of California and DHCS standards, and the County of San Diego shall utilize their requirements to monitor program compliance and provision of services.

DHCS, CMS, the Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related services (i.e. Drug Medi-Cal) are conducted. The right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Therefore, contracted providers are to retain medical records for no less than ten (10) years after discharge date. This includes member grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610.

<u>Cultural Competence Requirement Monitoring</u>
Providers are expected to provide services that are suitable for and sensitive to clients' cultural, developmental, and linguistic needs. Providers are required to adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and shall implement policies and procedures to

ensure that all methods utilized, and services provided are in line with this expectation. In order to provide appropriate and adequate services, it is vital that Providers ensure that these values are ingrained in the structural and daily practices of their organization. The County of San Diego's QI Unit and CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. For more information see Staff Development & Training Plans in Section M: Staff Qualificators & Requirements.

Provider Selection

Selection and monitoring of organizational agencies is governed by contracting procedures, which require a review of the organization's fiscal soundness, resumes of principal administrators and supervisors, the agency's experience with similar services, proposed program design, outcomes, staffing plan and budget. All contracted providers are expected to adhere to contractual requirements which are routinely monitored by BHS.

Contractor Orientation

Once providers are contracted with BHS, they will receive a contractor orientation to review all contract requirements. Providers will also have assigned to their program a designated Program Monitor (also known as Contracting Officer's Representative - COR) to assist with all questions related to contract compliance.

Program Monitoring

At the beginning of each Fiscal Year a risk assessment is conducted for each program and a monitoring plan is developed based on the risk level determined. The designated COR monitors compliance with outcome measures, productivity requirements and other performance indicators, analyzes reports from providers, and provides programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/CORs hold regular providers meetings to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COR.

An additional note: Contractor's Program Manager shall be available during regular business hours and respond to the Program Monitor/COR or designee within 2 business days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software

Notification in Writing of Status Changes

Providers are required to notify BHS Contract Support, (BHSCS) COR and QA in writing if any of the following changes occur:Change in office address, phone number or fax;

- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
- Additions or deletions from your roster of Medi-Cal billing personnel (BHSCS & MIS); or
- Proposed change in Program Manager, Head of Service, or Medical Director.
    - NOTE: Programs are required to provide the following evidence to the COR team for Medical Director candidates to ensure compliance with DMC requirements:
        - Enrolled with DHCS under applicable state regulations.
        - Screened as a "limited" categorical risk within a year prior to serving as Medical Director.
        - Signed a Medicaid provider agreement with DHCS.

QUALITY ASSURANCE

Site Visits

The County of San Diego will conduct, at a minimum, annual site visits to all organizational providers.Site visits include BHS Program Monitor/COR/Designee, BHS Administrative Services Unit, BHS Quality Assurance (QA) Unit, and the Health and Human Services Agency (HHSA) Contract Support Unit. All site visits are part of the contract monitoring process.

The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work;
- Review of client files for compliance with:
    - Documentation Standards
    - ASAM principles
    - Evidence Based Practice requirements
    - Substantiation of medical necessity
    - Care coordination and case management activities
- Building and safety issues;
- Staff turnover rates;
- Insurance, licensure, NPI, and certification validation;
- Fiscal and accounting policies and procedures (including Policies on preventing Fraud, Waste and Abuse and paid claims verification);
- Member informing materials requirement;
- Compliance with DHCS required processes for credentialing/re-credentialing
- Compliance with standard terms and conditions.

Also, to ensure program compliance with confidentiality procedures and protocols, SUD QA will monitor the following as part of site visits:

- Program written confidentiality policy and procedures
- Client consent/authorizations/release of information forms (content and signatures)

Additionally, BHS Program Monitor/COR/Designee and BHS Quality Assurance Unit will monitor for compliance with the Minimum Quality Drug Treatment Standards for DMC and SUBG. These standards are required in addition to CCR Title 9 and 22 regulations for all SUD treatment programs either partially or fully funded through DMC and/or SUBG. If conflict between regulations and standards occurs, the most restrictive shall apply. These standards include the following:

A. Personnel Policies

1. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
    a) Application for employment and/or resume;
    b) Signed employment confirmation statement/duty statement;
    c) Job description;
    d) Performance evaluations;
    e) Health records/status as required by program or Title 9;
    f) Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
    g) Training documentation relative to substance use disorders and treatment;
    h) Current registration, certification, intern status, or licensure;
    i) Proof of continuing education required by licensing or certifying agency and program; and
    j) Program Code of Conduct and for registered/certified SUD counselors, a copy of the

certifying/licensing body's code of conduct as well.

2. Job descriptions shall be developed, revised as needed, and approved by the Program's governing body. The job descriptions shall include:
   a) Position title and classification;
   b) Duties and responsibilities;
   c) Lines of supervision; and
   d) Education, training, work experience, and other qualifications for the position.

3. Written code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
   a) Use of drugs and/or alcohol;
   b) Prohibition of social/business relationship with members or their family members for personal gain;
   c) Prohibition of sexual contact with members';
   d) Conflict of interest;
   e) Providing services beyond scope;
   f) Discrimination against members or staff;
   g) Verbally, physically, or sexually harassing, threatening, or abusing members family members or other staff;
   h) Protection member confidentiality;
   i) The elements found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under; and
   j) Cooperate with complaint investigations.

4. If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:
   a) Recruitment;
   b) Screening;
   c) Selection;
   d) Training and orientation;
   e) Duties and assignments;
   f) Scope of practice;
   g) Supervision;
   h) Evaluation; and
   i) Protection of member confidentiality.

   Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a program representative and physician.

B. Program Management

1. Admission or Readmission
   a) Each program shall include in its policies and procedures written admission and readmission criteria for determining member's eligibility and suitability for treatment. These criteria shall include, at minimum:
      i. DSM diagnosis;
      ii. Use of alcohol/drugs of abuse;
      iii. Physical health status;
      iv. Documentation of social and psychological problems;
      v. Level of Care determination

b) If a potential member does not meet the admission criteria, the member shall be referred to an appropriate service provider.

c) If a member is admitted to treatment, a consent to treatment form shall be signed by the member.

d) The Medical Director or LPHA shall document separately from the treatment plan/problem list, the basis for the diagnosis in the member's record within timelines specified for the respective treatment modality. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each member's assessment and intake information, including their personal, medical, and substance use history. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

e) All referrals made by program staff shall be documented in the member record.

f) Copies of the following documents shall be provided to the member upon admission:
   i. Member rights share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.

g) Copies of the following shall be provided to the member or posted in a prominent place accessible to all members:
   i. A statement of nondiscrimination by sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation., and ability to pay, if the client meets the County's eligibility population requirements;
   ii. Grievance process and procedures;
   iii. Appeal process for involuntary discharge; and
   iv. Program rules, expectations and regulations.
   v. Notice of Privacy Practices

h) Where drug screening by urinalysis is deemed medically appropriate the program shall:
   i. Establish procedures which protect against the falsification and/or contamination of any urine sample; and
   ii. Document urinalysis results in the member's file.

2. Treatment
   a) Assessment for all members shall include:
      i. Drug/Alcohol use history;
      ii. Medical history;
      iii. Family history;
      iv. Psychiatric/psychological history;
      v. Social/recreational history;
      vi. Financial status/history;
      vii. Educational history;
      viii. Employment history;
      ix. Criminal history, legal status; and

x. Previous SUD treatment history.

b) Treatment plans (if required) shall be developed with the member and include:
   i. A problem statement for all problems identified through the assessment whether addressed or deferred;
   ii. Goals to address each problem statement (unless deferred);
   iii. Action steps to meet the goals that include who is responsible for the action and the target date for completion;
   iv. Typed or legibly printed name, signature, and date of signature of primary counselor, member, and medical director or LPHA;
   v. All treatment plans shall be reviewed in accordance with CCR Title 22 requirements and updated to accurately reflect the member's progress or lack of progress in treatment.

c) Progress notes shall document the member's progress toward completion of activities and achievement of goals on the treatment plan (if required), or plan of care.

d) Discharge documentation shall be in accordance with CCR Title 22 51341.
   i. A copy of the discharge plan shall be given to the member.

Monthly/Quarterly Status Reports

Programs shall be responsible for data collection and completion of the Monthly or Quarterly Status Report (MSR/QSR). Due date for submission shall be directed by the program COR. All sections of the report must be completed. In addition to outcome measures and compliance, programs that provide SUD treatment are required to report Charitable Choice referrals and specific staff licensure/certifications.

Quality Assurance Program Review (QAPR) [formerly known as Medical Record Reviews (MRR)]

DHCS requires SUD QA to complete annual reviews for every contracted program. The QAPR is the official review that meets this requirement. The focus of the QAPR is on documentation of medical necessity in the clinical record and review of appropriate billing to DMC (Drug Medi-Cal) standards. Results of each QAPR is reported to assigned contract officers. This includes overall compliance rates, disallowance rates, Quality Improvement Plans requirements, and Focus Review requirements.

QAPR Results, Billing Corrections and QIP

Results from both reviews shall be returned to each provider within 14 days. If applicable, billing corrections and a QIP are due to QA within 14 days of receiving the results. For more information on the billing correction process, see Billing Disallowances in Section O.

Focus Review

For programs who are identified as needing additional assistance due to a high disallowance and/or low compliance rate during the QAPR process, in addition to a QIP a focus review process may be implemented. This can include an intensive chart review, Technical Assistance and training provided by the assigned Quality Assurance Specialist, and other assistance as identified during the QAPR. If a program is unable to demonstrate improvement during the focus review, a Corrective Action Notice (CAN) may be implemented by the program's BHPC.

Technical Assistance (TA)

Programs who are not DMC certified and/or not approved by SUD QA to bill for services are assigned a QA Specialist to provide ongoing monitoring and technical assistance. This includes on-site discussions or

TA on documentation standards, chart reviews for documentation standard compliance, billing reviews to assure all services are billable per regulation, and clinical chart review for adherence to ASAM principles and Evidence Based Practices. QA Specialists will work with residential programs regularly to meet program specific needs.

TA Results and Billing Corrections
Results from both reviews shall be returned to each provider within 14 days. If applicable, billing corrections are due to QA within 14 days of receiving the results. For more information on the billing correction process, see Billing Disallowances in section O.

Timely Access Compliance Monitoring
Per DHCS Info Notice BHIN25 013-https://www.dhcs.ca.gov/Documents/BHIN-25-013-2025-Network-Certification-Requirements.pdf DHCS calculates compliance of timely access standards using the "Date of First Contact to Request Services" and the number of business days between that date and the date of the first offered available appointment that qualifies as a billable service. Compliance monitoring will be a joint effort between the SUDQA team and assigned program COR's. Non-compliance will result in official notification from and technical assistance from assigned COR's and a submission of a Performance Improvement Plan (PIP) within 30 days to assigned COR's for approval.

QA Consultation
In addition to the many monitoring reviews, QA specialists are available to assigned programs for regular and ongoing consultation upon request for various clinical and compliance needs. This may be limited to QAPR or TA questions, reviewing documentation standards or reviewing progress notes not associated with other reviews. QA Consultation excludes clinical input, programmatic workflows, or staffing.

Medication Monitoring
State and County regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. **Out of County Providers shall adhere to their own County's Medication Monitoring process.** Current State Department of Health Care Services (DHCS) requirements for Medication Monitoring are set forth in CCR, Title 9, Chapter 11, Section 1810.440; BHP Contract with DHCS, Exhibit A, Attachment 5, 1.H. The primary purpose of medication monitoring is to ensure the most effective treatment. Program's policies, procedures and practices will be evaluated and reviewed to ensure proper compliance with State and Federal regulations regarding prescription medication storage, handling, disposal and dispensing; maintenance of a current Drug Diversion Control Plan; and documentation of initial and on-going staff training relevant to Medication Assisted Treatment (MAT), if applicable. Any areas of concern will be reviewed and may result in issuing program corrective action and resolution.

Prescribers are required to report dispensing of Schedule II-V drugs to the CURES 2.0 database within one working day. The prescriber must consult the patient activity report obtained from the CURES 2.0 database to review a patient's controlled substance history for the past 12 months before prescribing a Schedule II, III, or IV controlled substance to the patient for the first time and at least every 4 months thereafter if the prescriber renews the prescription and the substance remains part of the treatment of the patient.

State and County regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system**.** *Out of County Providers shall adhere to their own County's Medication Monitoring process.*

NTP services and regulatory requirements shall be provided in accordance with CCR Title 9, Chapter 4.

The provider shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. The IA requires all counties to have a medication monitoring process (Reference: IA Exhibit A, Attachment I A1 Program Specifications, Quality Assurance Program and Requirement for Services).

The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs
- Consideration of physical health conditions
- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of signed informed consent
- Client adherence with prescribed medication and usage
- Client medication education and degree of client knowledge regarding management of medications.
- Adherence to state laws and guidelines

Within the County of San Diego BHS system of care, programs are required to review one percent (1 %) of their active medication caseload each quarter, with a minimum of one chart reviewed. Closed cases, cases in which the client has not returned for recent services and clients that are not receiving medication are not to be reviewed. The sample shall include representation from all physicians and/or nurse practitioners who prescribe.

The Medication Monitoring Committee may be comprised of two or more representatives from different disciplines but at least one of the members must be a physician or pharmacist. Physicians may not review their own prescribing practices. It is the program's responsibility to assure that there is another physician to review the charts. The Medication Monitoring Committee function shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.

As of FY 24-25, the Clinical Director of Behavioral Health Services has advised that Nurse Practitioners (NPs) who fully qualify for the 103 path may be permitted to review other qualified NPs in the quarterly Medication Monitoring process. 103 NP Eligibility is outlined in Assembly Bill 890 (ca.gov) . This provision does not currently extend to Physician's Assistants (PAs).

Contracted providers are required to perform the first-level screening of medication monitoring for their facility. Programs will use the Medication Monitoring Report, Medication Monitoring Screening tool and the Medication Monitoring Feedback Loop (McFloop) for their screening. If a variance is found in medication practices, a McFloop form is completed, given to the physician for action, and then returned to the Medication Monitoring Committee for approval. The QA Medication Monitoring Reports for the Systems of Care are located on the Optum Website > BHS Provider Resources > SMH & DMS-ODS Health Plans> *Monitoring.*

Medication Monitoring Reporting
Send the following forms via secure email QIMatters.BHS@sdcounty.ca.gov
or fax (619) 236-1953 to QA:

- DMC-ODS Medication Monitoring Submission Form
- DMC-ODS Medication Monitoring Tool
- DMC-ODS Medication Monitoring Feedback Loop (McFloop), if applicable

DMC-ODS Medication Monitoring Submission Form

- Address all applicable prompts on the form, for example program name, date, contract, DMC ID, quarter.
- Under the Description of Activities Section, all fields must be completed.
- Enter a number for the variances for each no answer found on the tool. Do not leave variances blank.
- Program is to ensure program attestation is completed at the bottom of the form.

Medication Monitoring Reporting Instructions

Variances are when questions on the tool are answered with a "No". Variances or "No's" are totaled by type of variance. For example, if you reviewed 10 charts, and one chart had a variance for variance #2, then a "1" would be entered in the *variance* 2 box. If three charts had a variance for variance #6, then a "3" would be entered in *variance* 6 box. Keep in mind when filling out the forms

- Email/fax the DMC-ODS Medication Monitoring Submission Form and DMC-ODS Medication Monitoring Tools to SUD QA.
- Do not submit your approved McFloop forms. Keep these forms on file at your clinic.
- If you have any unapproved McFloop forms, send in by secure email or by fax (619-236- 1953) as they contain PHI.

Results of medication monitoring activities are reported quarterly to the QA unit by the 15th of each month following the end of each quarter (First quarter due October 15, second quarter due January 15, third quarter due April 15 and fourth quarter due July 15). All programs shall have a procedure in place to ensure the following:

- Signed and updated consents are completed, reviewed and documented by the prescriber, and filed in the hybrid record in a timely manner.
- Labs are ordered and those results are returned in a timely manner. Programs shall ensure that lab results have been reviewed and filed in the hybrid record in a timely manner.
- Ensure there is enough follow up with clients/family members in keeping their appointments for labs.

QA monitors the compliance of each program's medication monitoring practices. By completing the submission Quarterly, QA can monitor compliance during quarterly desk reviews and therefore not require the documents to be reviewed during the annual Quality Assurance Program Review process. The assigned QA Specialist reviews the quarterly medication monitoring report, screening tools and McFloops for any identified variances and corrective actions taken. Programs will be monitored for trends and patterns in any areas found out of compliance or areas needing improvement and a QIP may be required.

A second level review by the QA Medication Monitoring Oversight Committee (MMOC), working in collaboration with the Medical Director(s) may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with standards or contract requirements. Determination of an additional corrective action will be determined by the MMOC and

Medical Director(s).

Note: Medication Monitoring process requires that a staff physician not review their own charts. For programs that have only 1 doctor. Contact your COR for approval to have the staff physician review their own chart. CC QI Matters to coordinate CORS approval.

Program Integrity/Service Verification

San Diego County Behavioral Health Services (SDCBHS) established Program Integrity (PI) procedures to prevent fraud, waste, and abuse in the delivery, claiming and reimbursement of behavioral health services. County and Contracted Programs shall develop a process of verifying that paid claims were provided to members and that services were medically necessary. County and Contracted Programs are expected to conduct regular PI activities and maintain records for audit purposes. Questions regarding PI can be directed to QI Matters email atQIMatters.BHS@sdcounty.ca.gov
.

PI activities will be monitored by QA at a minimum annually during site and medical record review. QA tracks and monitors results of medical record reviews and may require a program to develop a Quality Improvement Plan (QIP) to address specific documentation concerns.

Program Integrity Process and Monitoring

It is recommended that programs have an Internal Compliance Program that:

- Is commensurate with the size and scope of their agency. Further, contractors with more than $250,000 annually in agreements with the County must have a Compliance Program that meets the 42 CFR guidelines:
    - Development of a Code of Conduct and Compliance Standards.
    - Assignment of a Compliance Officer, who oversees and monitors implementation of the compliance program.
    - Design of a Communication Plan, including a Compliance Hotline, which allows workforce members to raise grievances and concerns about compliance issues without fear of retribution.
    - Creation and implementation of Training and Education for workforce members regarding compliance requirements, reporting, and procedures.
    - Development and monitoring of Auditing Systems to detect and prevent compliance issues
    - Creation of Discipline Processes to enforce the program.
    - Development of Response and Prevention mechanisms to respond to, investigate, and implement corrective action regarding compliance issues.

- All Programs, regardless of size and scope, shall have processes in place to ensure at the least the following standards:
    - Staff shall have proper credentials, experience, and expertise to provide client services.
    - Staff shall document client encounters in accordance with funding source requirements and County of San Diego Health and Human Services policies and procedures.
    - Staff shall bill client services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures.

- Also, all programs shall have processes for:
    - Staff to promptly elevate concerns regarding possible deficiencies or errors in the quality

of care, client services, or client billing.
- And for Staff to act promptly to correct problems if errors in claims or billings are discovered.

- Program Reporting of Fraud, Waste and Abuse
  - Concerns about ethical, legal, and billing issues, (or of suspected incidents of fraud, waste and/or abuse) should be reported directly to your program COR immediately, as well as the SUD QA team atQIMatters.BHS@sdcounty.ca.gov
  - .
    - If there are related complaints that wish to remain anonymous, providers may contact the BAC Hotline at 866-549-0004.
  - In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit. Reporting can be done by phone, online form, email or by mail.
    - 1-800-822-6222
    - fraud@dhcs.ca.gov
    - Online form
    - Medi-Cal Fraud Complaint – Intake Unit
      Audits and Investigations
      PO Box 997413, MS 2500
      Sacramento, CA 95899-7413
  - Paid Claims Verification - Verification of paid claims is an important means of monitoring for instances of fraud, waste and/or abuse. The County requires that each program develop a P & P on Paid Claims Verification – which is how programs will verify whether services reimbursed by Drug Medi-Cal were actually provided to clients.
  - Programs must submit their Policy and Procedure for Paid Service Verification to BHS SUD QA. These are filed to help assist with monitoring activities.

- Monitoring:
  - Programs are expected to conduct their own regular program integrity activities and to maintain records for QA audit purposes.
  - The BHS SUD QA team will run reports regularly on random samples of clients, comparing billing entered to supporting documentation in the system (such as ASAM risk ratings/levels of care determinations). This will help to identify any potential issues (such as data entry errors, any obvious discrepancies between LOC documentation and services provided, etc.) so that the SUD QA team will be able to provide ongoing technical assistance to programs.
  - The BHS QI team will provide tip sheets for programs to run regular SmartCare reports to help with their own internal monitoring processes.

Department of Health Care Services (DHCS) Reviews

There are three divisions within DHCS related to SUD services:

- SUD Compliance - responsible for licensing and certification
- SUD Performance Management - responsible for Post Service/Post Payment (PSPP) reviews, Post Service/Pre-Payment (PSPP), and annual contract monitoring of the County of San Diego.
- Audits and Investigations

QUALITY ASSURANCE

The mission of Audits and Investigations (A&I) is to ensure the fiscal integrity of the health programs administered by the Department of Health Care Services (DHCS) and ensure quality of care provided to the members of these programs. The overall goal of A&I is to improve the efficiency, economy, and the effectiveness of DHCS and the programs it administers. To carry out its mission A&I will:

- Perform special audits as needed by DHCS program managers, executive staff, California Health and Human Services Agency (CHHS), or the Governor's Office.
- Perform internal audits of DHCS organizations to ensure that various internal controls are operating and effective.
- Perform medical reviews of Medi-Cal and public health providers.
- Provide technical assistance (financial and medical) in the development and expansion of the Managed Care program.
- Identify and investigate Medi-Cal member and provider fraud and abuse, emphasizing fraud prevention.
- Participate in the development or modification of DHCS policies.

A&I is divided into three branches along with Internal Audits. In addition, the division includes the Administrative Management Services Section (AMSS) and Information Technology Unit (ITU) which provides centralized administrative functions and technology services to A&I, respectively.

- Financial Audits Branch (FAB) ensures, through financial audits, that payments made to providers of Medi-Cal or other State or federally funded health care programs are valid, reasonable, and in accordance with laws, regulations, and program intent.

- Investigations Branch (IB) is mandated by the Code of Federal Regulations and California State law as the organization responsible for investigating allegations of member fraud and abuse of the Medi-Cal program.

- Medical Review Branch (MRB) is charged with the responsibility of performing federal mandated post service, post payment utilization reviews.

- Internal Audits (IA) is an independent organization housed within A&I that is charged with department-wide program audit responsibilities.

Other units within DHCS may also conduct audits or reviews (for example, the Licensing and Certification units of DHCS). When a program is contacted by DHCS for any type of review, be it a scheduled or unannounced visit, it is expected that the program will immediately notify the program COR and the BHS SUD QA unit. The QA can be notified via email at QIMatters.BHS@sdcounty.ca.gov

If a Corrective Action Plan (CAP) is required for any type of review, programs are to submit drafts directly to the BHS SUD QA unit for review and technical assistance. Once finalized, the BHS SUD QA unit will submit the CAP to DHCS on behalf of the program and will follow-up with the program periodically for monitoring of CAP implementation and continued technical assistance until the CAP is fully implemented.

Post Service Post Payment (PSPP) Reviews
PSPP reviews involve chart reviews by DHCS staff at the program location. When documentation does not meet Title 22 requirements, and/or other relevant regulations, standards, and State-County contract requirements, recovery of funding (via recoupment) can occur.

The review process involving DHCS, the Program COR and the SUD Quality Assurance (QA) unit is as follows:

- DHCS SUD Performance Management Unit will contact the DMC certified SUD program one week prior to the scheduled PSPP review.
- Program will contact the program COR and the QA SUD unit to notify them of the review.
- DHCS will conduct an Entrance Conference the first day of the review to discuss the review purpose and process, and request charts for the review. The program COR (or designee) and QA SUD unit designee will attend, if possible.
- DHCS will conduct an exit conference with a summary of findings on the last day of the review. The COR or their designee and QA SUD designee will attend the exit conference, if possible.
- DHCS will send a final PSPP Report to the SUD provider and to the QA SUD unit. DHCS may request a Corrective Action Plan (CAP). **BHS QA SUD unit has 60 calendar days from the date of the letter to return the CAP to DHCS SUD Performance Management**.

    - QA coordinates the whole process and is responsible for initially contacting the provider via e-mail to inform them of the 30-day requirement to submit the draft of the CAP to QA. Technical assistance is available for programs from the BHS SUD QA unit in drafting the CAP.
    - The program will write an initial draft of the CAP and send it to QA for review within 30 days of the final PSPP Report. Then, QA will forward the draft of the CAP to the COR for review and feedback. QA will continue to provide technical assistance as necessary to the provider.
    - After the CAP is "final approved" by the COR and the QA unit, QA staff will write and sign the cover letter for the CAP. The cover letter and CAP is sent to DHCS via encrypted email. The email communication will include a CC to the COR, the Provider Program Manager and the QI Chief.
    - The County is responsible to ensure the CAP is completed and submitted within the 60-calendar daytime requirement. In rare instances, if additional time is needed, an extension may be requested by the County.
    - Providers shall forward all DHCS correspondence associated with the CAP to the County.
    - Upon DHCS acknowledgement letter of the CAP submitted, the provider shall continue to work the County regarding an Implementation Plan and the County may provide additional technical assistance.
    - The provider shall maintain records verifying that actions denoted in the CAP are being aptly adhered to.
    - Providers shall provide the County annually documentation exhibiting that the provider is complying with implementation of the DHCS-approved CAP.
    - Documentation of any and all evidence referred to in the DHCS-approved CAP must be submitted to the County; including but not limited to:
        - Copy of DMC Certification
        - Revised and/or New Form Templates (different than what was submitted with the CAP)
        - Revised and/or New Policy and Procedures (different than what was submitted with the CAP)
        - Documentation of compliance to policy and procedures (i.e., supervision, chart utilization reviews, monthly reports, etc.)

- List of direct services staff with credentials and hours of work per week. This request includes copies of licenses and certifications for Licensed Professionals of the Healing Arts (LPHA) and SUD Counselors - both certified and registered and the full time equivalent (FTE) spent in direct service for each staff person. The list must include all staff, and includes staff who no longer work for the organization , but who provided services during the specified time frame of the review
- Templates of all forms related to the client files (Health Questionnaire and Screening, Intake, Diagnosis Determination/Medical Necessity, Treatment Plans, Discharge Summary & Plan)
- Copy of Group sign-in sheets
- Copy of a random sample of requested charts which includes: Intake/Assessment, Medical Records & Health Questionnaire, Medical Necessity, Stay Reviews, Treatment Plan(s), Progress Notes, Discharge Plan, Discharge Summary
- Copy of staff training agendas, training material and staff training sign-in sheets, and
- Copy of internal monitoring reports that reflect monitoring activities for the specified review period

Post Service Pre-Payment (PSPP) Reviews

Post Service Pre-Payment reviews, formally known as DMC Monitoring Reviews, differ from PS Post Payment reviews in that there is no financial recovery (i.e., recoupment) associated with these types of reviews. Rather, they are conducted as part of the DHCS requirement to provide programmatic, administrative, and fiscal oversight of statewide DMC SUD services. The Post Service Pre-Payment reviews include an on-site review of certain DMC charts, employee files, policy and procedures, and the physical location of the program. These monitoring reviews are a helpful resource to programs as technical assistance for compliance and recommendations is provided directly to programs by DHCS staff.

The review process involving DHCS, the program COR and the SUD QA unit is as follows:

- DHCS DMC Monitoring Unit will contact the DMC certified SUD program approximately two weeks prior to the scheduled Post Service Pre-Payment review.
- DHCS will notify the program of the types of materials to make available for the review (i.e.
- Policies and Procedures, copies of staff certifications/licenses, internal monitoring reports, etc., and will provide forms for completion prior to the review.
- Program will contact the program COR and the QA SUD unit to notify them of the review.
- The DHCS analyst will conduct an Entrance Conference the first day of the review to discuss the review purpose and process. The program COR (or designee) and QA SUD unit designee will attend, if possible.
- The DHCS analyst will conduct an exit conference on the last day with a summary of findings.
- The COR or their designee and QA SUD unit designee will attend.
- The DHCS analyst will send a final Monitoring Report to the Provider and to the QA SUD unit. DHCS may request a Corrective Action Plan (CAP). **BHS has 60 calendar days from the date of the report to return the CAP to the DHCS DMC Monitoring Unit.**

    - QA coordinates the whole process and is responsible for initially contacting the provider via e-mail to inform them of the 30-day requirement to submit the draft of the CAP to QA. Technical assistance is available for programs from the BHS SUD QA unit.
    - The program will write an initial draft of the CAP and send it to QA for review within 30 days of the final Monitoring Report. Then, QA will forward the draft of the CAP to the

- COR for review and feedback.
- After the CAP is "final approved" by the COR and the QA unit, QA staff will write and sign the cover letter for the CAP. The cover letter and CAP is sent to DHCS via encrypted email. The email communication will include a CC to the COR, the Provider Program Manager, and the QI Chief.
- The County is responsible to ensure the CAP is completed and submitted within the 60-calendar daytime requirement. In rare instances, if additional time is needed, an extension may be requested by the County.

PSPP Appeals

The County may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims (such as those resulting from a PSPP review). Such appeals shall be handled as follows:

Requests for first-level appeals

- The County shall initiate action by submitting a letter on the official stationery of the County and it shall be signed by an authorized representative of the County.
- The letter shall identify the specific claim(s) involved and describe the disputed (in)action regarding the claim. Letter sent to:

  Division Chief DHCS SUD-PPFD
  P.O. Box 997413, MS-2621
  Sacramento, CA 95899-741

The County may initiate a second level appeal to the Office of Administrative Hearings and Appeals (OAHA).

- The second level process may be pursued only after complying with first-level procedures and only when:
  - DHCS has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or
  - The County is dissatisfied with the action taken by DHCS where the conclusion is based on DHCS' evaluation of the merits.
- The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within 30 calendar days from the date DHCS failed to acknowledge the first-level appeal or from the date of DHCS' first- level appeal decision letter.
- All second-level appeals made in accordance with this section shall be directed to:

  Office of Administrative Hearings and Appeals
  1029 J Street, Suite 200, MS 0016
  Sacramento, CA 95814

In referring an appeal to the OAHA, the County shall submit all of the following:

- A copy of the original written appeal sent to DHCS.
- A copy of the DHCS report to which the appeal applies.
  - The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of the Intergovernmental Agreement.
  - State shall monitor the provider's compliance with County utilization review requirements, as specified in the Intergovernmental Agreement (Article III.EE.) Counties are also required to monitor the subcontractor provider's compliance pursuant to Article III.AA of this Intergovernmental Agreement. The federal government may also review the

existence and effectiveness of DHCS' utilization review system.
- The County shall, at a minimum, implement and maintain compliance with the requirements described in Article III.PP of the Intergovernmental Agreement for the purpose of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.
- The County shall ensure that subcontractor provider sites keep a record of the members/patients being treated at that location.
- The County and provider shall retain member records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with DHCS. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the member records shall be maintained until completion of the audit and the final resolution of all issues.

Additional Review Considerations
Per DHCS, programs shall keep sufficient financial records and statistical data to support year-end documents filed with DHCS. Programs shall include in any contract with an audit firm a clause to permit DHCS access to the working papers of the external independent auditor.

Follow-up and Monitoring
Programs will be asked to provide a summary follow-up report to QA of their monitoring efforts and results of their corrective action plans. Once notified via email, they shall provide a summary report to QA within seven calendar days.

Critical Incidents/Non-Critical Incidents (formerly known as Serious Incident Reports)
Critical Incidents/Non-Critical Incidents are defined as incidents that have a direct or indirect impact on the community, patients, staff, and/or the SUD treatment provider agency as a whole and are required to be investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues.

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community shall be reported to the BHS Quality Assurance (QA) Unit. There are two types of reportable incidents:

- Critical Incidents will be sent securely to the *QI Matters* email or via fax to the secure QA fax at 619-236-1953. The Critical Incident report form can be found on the Optum Site under the SMH & DMC-ODS Health Plans Page under the 'Incident Report' Tab. Additionally, consultation can be requested by contacting the QI Matters email address.
- Non-Critical Incidents will be reported via an online submission form that is sent to QA and the Contracting Officer's Representative (COR)
- **All incidents will require submission of reports within 24 hours of incident knowledge.**

Critical Incident Categories
- Death/Pending (Pending CME investigation) would be chosen for instances of client death in which the actual reason for death is not yet confirmed. The subsequent 'Confirmed' reasons for client death should only be chosen when the actual reason for death is known by the Program.
- Death/Natural Causes (Confirmed)
- Death/Overdose (Confirmed)

- Death/Suicide (Confirmed)
- Death/Homicide (Confirmed)
- Death/Assault by another client (Confirmed)
- Suicide Attempt
- Non-fatal Overdose
- Medication Error in prescription or distribution resulting in severe physical damage and/or loss or consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- Alleged Abuse/inappropriate behavior by staff would be chosen for behavior such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client
- Injurious assault by a client resulting in hospitalization
- Critical Injury on site (MH/SUD related) is defined as injury to a client which may require hospitalization where the injury is directly related to the client's mental health or substance use functioning and/or symptoms. Critical bodily injury means any injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, limb, organ, or of mental faculty (i.e., fracture, loss of consciousness), or requiring medical intervention, including but not limited to hospitalization, surgery, transportation via ambulance, or physical rehabilitation. Any injury not falling in these categories or not related to client mental health would be reported under the Non-Critical Incident process.
- Adverse Media/Social Media Incident (only; no leading incident))

Non-Critical Incident Categories

- Contract/policy violations by staff (unethical behavior)
- AWOL
- Non-critical injury on-site refers to injuries that require medical treatment greater than first aid and which occur on program premises.
- Adverse Police involvement/PERT
- Property destruction
- Loss or theft of medications from facility
- Tarasoff Reporting
- Other Epidemic, other infectious disease outbreak, and poisoning will be reported under the Non-Critical Incident Reporting process utilizing the "Other" incident category.

Reporting

All providers are required to report critical incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the QA Unit who will review, investigate as necessary, and monitor trends. The QA team will communicate with the program's COR and BHS management. For any client that is connected with or receiving services from other agencies or departments, such as (i.e. CWS, Probation, APS, Law Enforcement, Public Conservator) the program submitting the Critical Incident must notify the aforementioned program/department and are required to indicate the notification occurred on the Critical Incident report form with the date the notification took place. After review of the incident, QA may request a corrective action plan. QA is responsible for working with the provider to specify and monitor the recommended corrective action plan. The QI unit will monitor critical incidents and issue reports to the Quality Review Council and other identified stakeholders.

QUALITY ASSURANCE

San Diego County contracted programs may use the Critical Incident Root Cause Analysis (RCA) Worksheet, located on the Optum site, or some other process that is approved by their Legal Entity. It is strongly recommended that programs not choosing to use the Critical Incident RCA Worksheet ensure that the process they do use incorporates best practices for their analysis of findings. Technical assistance is available through the BHS QA Unit by email atQIMatters.BHS@sdcounty.ca.gov
. RCA training is also offered on a quarterly basis.

Reporting Procedures

1. Within 24hrs upon knowledge of incident, program shall report the incident and all known details via secure email or fax. All providers are required to report critical incidents involving clients in active treatment or whose discharge from services has been 30 days or less.
2. In the event of a Critical incident, the client's medical record/s will immediately be safeguarded by the program manager or designee. Program manager shall review chart as soon as possible. The client medical record shall not be accessed by unauthorized staff not involved in the incident.
3. All program staff will maintain confidentiality about client and the critical incident. The critical incident should not be the subject of casual conversation among staff.
4. All critical incidents shall be investigated and reviewed by the program. The program shall submit a complete Report of Findings (ROF) to QA within 30 days of knowledge of the incident. (See Optum site for the ROF Form). In instances where an ROF is required for a Critical Incident and there are multiple program assignments, an ROF will be required for the primary client assignment and/or the Program where the critical incident took place. The primary assignment may be viewed in the EHR if the permissions have been granted. Any other client program assignments submitting a CIR for the same incident may require an ROF per QA or COR request. In the case of a client death, there is an exception to the ROF being due to QA within 30 days of knowledge of the incident when the program is waiting on the CME report. The provider must inform QA that the CME report is pending and may request an extension.
5. The CME report is the County Medical Examiner's Report. It provides the final cause of death determination and is required for serious incidents involving death of a client. In addition to notifying the HIMS department and the County MEDS Coordinator programs should request the CME report from the medical examiner's office. Programs will need a copy to complete the ROF / RCA (if applicable). If the CME report indicates that the manner of death was suicide, programs must complete an RCA. To request the CME report, email the County Medical Examiner's Office at: Records.MX@sdcounty.ca.gov requesting the CME report and provide the following information: Name of Program, Name of client, DOB, Date of Incident. Programs will receive a confirmation email from the CME office that the request has been received.
6. A critical incident report is never to be filed in the client's medical record. A critical incident Report shall be kept in a separate secured confidential file.
7. A critical incident that results in 1) a death by suicide or 2) an alleged client committed homicide will automatically trigger a chart review by the QA Unit and require the completion of a Root Cause Analysis (RCA) within 30 days of knowledge of the incident or at the request of QA. In instances where the RCA is required for a Critical Incident where a client has multiple program assignments, the RCA will only be required for the primary client assignment and/or the program where the critical incident requiring the RCA took place. An RCA for any other client assignments may be requested by QA or your COR as clinically indicated. The primary assignment may be viewed in the EHR if the permissions have been granted
8. The Action Items because of the RCA shall be summarized and submitted to the QA unit with 30 days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Residential Requirement to Report to DHCS
Certain Incidents must also be reported by Residential SUD Programs to DHCS; these incidents include the following:

- Death of any resident from any cause – even if death did not occur at facility
    - Per BHIN 26-007:
    - Within 30 days of a resident's death, a SUD recovery or treatment facility shall submit to DHCS any relevant information that the SUD recovery or treatment facility did not know at the time of the initial incident.
    - If, at any time, DHCS determines a SUD recovery or treatment facility failed to submit information relevant to a resident's death to DHCS within 30 days of the resident's death, DHCS shall issue the SUD recovery or treatment facility a written notice of deficiency. In the notice of deficiency, DHCS will specify instructions to address any violations, including, but not limited to, the timeframe to respond to the deficiencies.
    - SUD recovery or treatment facilities shall provide a corrective action plan or verification of correction to address any violations, including a timeframe to respond to deficiencies. (Health & Saf. Code § 11834.34; Cal. Code Regs., tit. 9, § 10545.)
- Any facility- related injury of any resident which requires medical treatment
    - client transported via ambulance for an emergency medical issue such as a non-fatal overdose
- All cases of communicable disease reportable under Section 3125 of the Health and Safety Code or Section 2500, 2502, or 2503 of Title 17, California Administrative Code shall be reported to the local health officer in addition to the Department
- Poisonings
- Natural disaster
- Fires or explosions which occur in or on the premises

Residential and outpatient programs must report the incident via phone, as well as submission of form DHCS 5079 titled "Unusual Incident/Injury/Death Report" (please refer to the form for further instructions). These incidents shall be reported to DHCS as follows:

a. Programs must make a telephonic report to DHCS Complaints and Counselor Certification Division at (916) 322-2911 within one (1) working day.
b. The telephonic report must be followed with a written report to DHCS within seven (7) days of the event.
c. Death reports must be submitted via fax to the DHCS Complaints and Counselor Certification Division at (916) 445-5084 or by email to DHCSLCBcomp@DHCS.ca.gov.

Reporting of Beneficiary Deaths
All beneficiary deaths must be reported promptly and in accordance with County requirements.

- Notify both the HIMS department and the County MEDS Coordinator when a beneficiary passes.
    - Submit a BHS 025 Form and Instructions.pdf
- Send an email to 37Crdnt.HHSA@sdcounty.ca.gov including:
    - Beneficiary Name
    - Social Security Number
    - Date of Birth
    - Date of Death
- Retain a copy of the sent email(s) as documentation of compliance.
    - Death reporting is monitored by QA as part of the Medi-Cal recertification process.

Critical Incidents (formerly Level One) The Critical Incident is the most severe type. A critical incident must include at least one of the following:

- Any event that has been reported in the media/public domain (television, newspaper, internet), current or recent past, regardless of type of incident.
- The event has resulted in a death or serious physical injury on the program's premises.
- Death/Pending (Pending CME investigation) would be chosen for instances of client death in which the actual reason for death is not yet confirmed. The subsequent "Confirmed" reason for client death should only be chosen when the actual reason for death is known by the Program.
- For Critical Incidents related to an overdose by an opioid or alcohol, the client must be provided an opportunity for a referral to Medication Assisted Treatment (MAT) if the client is not already receiving MAT services. Information on MAT programs can be accessed through the Provider Directory on the Optum website or by calling the Access and Crisis Line.

A critical incident shall be reported to QI Matters immediately upon knowledge of the incident.

Non-Critical Incident (formerly Level Two and Unusual Occurrence) A non-critical Incident is defined as an incident that may indicate potential risk/exposure for the county operated contracted provider, client or community that does not meet the criteria of a critical incident. Note: Submission should exclude PHI to avoid privacy breach. If PHI is disclosed, a Privacy Incident Report (PRA) to BAC is required. PHI stands for Protected Health Information. It's any health data that can be used to identify a person. PHI can be in many forms, including written records, electronic records, and images.
What is considered PHI?

- Patient names
- Social Security numbers
- Phone numbers
- Email addresses
- Dates related to health or identity
- Biometric identifiers
- Electronic health records
- Images that could identify the subject

A program may be asked at any time to complete a Report of Findings for a Non-Critical Incident by the program COR or Quality Assurance Unit. Critical Incident Reporting on Weekends and Holidays
Critical Incidents are required reporting for Legal Entity (LE) behavioral health programs on weekends and holidays to the QA Unit and Designated County Staff. This requirement does not apply to non-critical incidents.

Follow this procedure for reporting a Critical Incident on Weekends and Holidays:

1. For a Critical Incident, email QI Matters and report the incident as soon as possible from awareness of the incident occurrence .
2. Each LE will identify key Senior Level staff (1-3) that are designated as the main contact person(s) for their programs needing to report a Critical incident on weekends and holidays. This LE designated staff will report the Critical incident by calling or leaving a message with all required information including a call back number for the County Designated Staff. Each LE will be provided the contact phone numbers of the County Designated Staff.
3. Program staff should only be reporting the Critical Incident to their LE designated staff. Program staff should not be directly contacting the County Designated Staff.

4. Report Critical Incidents to the County Designated Staff on weekends and holidays between the hours of 8:00am – 8:00pm (reporting hours). If you have a Critical Incident that occurs outside of reporting hours, then report the Critical Incident on the next or same day during reporting hours. This requirement is only for Critical Incidents.
5. Weekend Coverage is defined as Saturday and Sunday. Holiday Coverage is defined as any designated County Holiday.

Clinical Case Reviews

Under the direction of the BHS Clinical Director, a clinical case review convenes regularly to review cases involving a death by suicide, homicide, and other complex clinical issues. The purpose of the review is to identify systemic trends in quality and/or operations that affect client care. Identified trends are utilized to provide opportunities for continuous quality improvement. Program shall comply with requests for client records that are reviewed in clinical case conference.

Stakeholders, including BHS Director, CORs, Deputy Directors, QI Chief, Program Managers, County or Contractor QI staff, or other designated staff may make a request at any time for a clinical case review. Specific requests for case reviews should be coordinated through the QA Unit by contacting QIMatters.BHS@sdcounty.ca.gov
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Safety and Security Notifications to Appropriate Agencies

When a Non-Critical Incident is identified, the appropriate agencies shall be notified within their specified timeline and format:

- Child and Elder Abuse Reporting hotlines.
- Tarasoff reporting to intended victim and law enforcement
- Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.
- Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Programs Serving Child, Youth & Families Additional Reporting

Programs Serving Child, Youth & Families providers may notify other outside agencies who serve the client upon consideration of clinical, health and safety issues. Notification should be timely and within 24 hours of knowledge of the incident. These agencies include but are not limited to:

- Children Welfare Services
- Probation Officer
- Regional Center
- School District
- Therapeutic Behavioral Services (TBS)
- Other programs that also serve the client

Reportable issues may include:

- Health and safety issues
- A school suspension
- A student is taken to a hospital due to an injury or other medical issue which occurs at the program site or when the TBS worker is present
- A referral for acute psychiatric hospital care

- An issue with direct service provider staff, which may lead to worker being suspended or no longer providing services
- A significant problem arising while TBS worker is with the child

Client Satisfaction
An annual survey conducted by UCLA as part of the DMC-ODS Waiver will be conducted for adolescent and adult SUD treatment programs. Specific instructions on the designated period for conducting the surveys, as well as data collection methods, will be specified by UCLA and communicated to programs via the Population Health Team. This will generally take place sometime during October of each year.

Quality Review Council (QRC)
The Quality Review Council (QRC), mandated by State regulation, is a collaborative group that is chaired by the SUD Clinical Director and consists of SUD stakeholders including clients and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss and make recommendations regarding quality improvement issues that affect the delivery of services through the DMC-ODS. Participation in the QRC is encouraged. If you would like to participate in the QRC, email QIMatters.BHS@sdcounty.ca.gov
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Performance Improvement Projects (PIPs)
The State mandates each county be engaged in one administrative and one clinical performance improvement project each year in which order to improve processes and outcomes of care. A PIP is a comprehensive, long-term quality improvement project includes a commitment to improving quality through problem identification, evaluating interventions and making adjustments as necessary. It may provide support/evidence for implementing protocols for "Best Practices". The External Quality Review Organization (EQRO), contracted by the State, evaluates progress on each PIP annually.

The DMC-ODS may ask for your involvement in the PIP by:
- Implementing current PIP interventions/activities/procedures at your programs
- Supporting survey administration and/or focus group coordination at your programs
- Developing your own program's PIP projects

H. CULTURAL COMPETENCY

Cultural Competence involves recognizing that culture impacts our relationships and interactions in ways that may be subconscious or outside our awareness. It is a continual growth process that involves self-awareness, knowledge, skills, advocacy, and the examination of all those factors within a larger context. Recognizing the complex nature of personal identity, how each of us manages multiple identities, and how the intersection of our experience can be a powerful tool for healing and change helps those providing services within County of San Diego provide more culturally relevant and responsive care to the people being served.

Another focus that SDCBHS has incorporated is cultural humility to further support the progress toward reducing disparities in mental health services and the Cultural Competence Plan. The term is based on the idea that we must be open to the identities and experiences of others as a primary way of being in the world through a lifelong commitment to self-evaluation, a desire to fix power imbalances, and a willingness to develop partnerships with people and groups who advocate for others.

History and Background

Cultural norms, values, beliefs, customs, and behaviors may influence the manifestation of mental health problems. The County's dynamic demographics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the Behavioral Health Plan (BHP) and its contracted mental health care providers. The latest estimates for San Diego County from 2023 show that the overall population estimate of the County increased by 0.45% compared to the 2023 estimate. According to the San Diego Association of Governments *SANDAG Demographic and Socio-Economic Estimates, 2024 Estimates, San Diego Region,* 41,7% of the population identified as White, 35.8% as Hispanic, 4.2% as Black, 0.4% as Native American, 12.5% as Asian, 0.40% as Pacific Islander, and 5.0% as "Two or more".

SDCBHS continuously monitors its progress toward reducing disparities and identifies gaps between the demand for and the availability of services. To understand the needs of the County mental health population SDCBHS and the University of California, San Diego (UCSD) Research Centers analyze service disparities on a triennial basis in a report titled *Progress Towards Reducing Disparities in Mental Health Services*.

The most recent report covers three time points spanning across 8 years (Fiscal Years 2009-10, 2012-13, and 2015-16). The report provides breakdown information by age, gender, race/ethnicity, and diagnosis, as well as service utilization and service engagement, which is used to supplement the State required information. These existing reports and planning structure will assist BHS in establishing a broader county regional planning process to support all contractual funding requirements. The report has since been reimagined as the *Community Experience Partnership*, with a set of dashboards that allow flexible queries regarding health equity information that will provide timely, accessible, and actionable data for system policy development and decision making. With the County's renewed commitment to client-centered care, these tools will provide support for initiatives that focus on the members' specific long-term needs and community level services.

Community Experience Partnership

The Community Experience Partnership (CEP) is a joint initiative between County of San Diego and UC San Diego. The vision of the CEP is the integration of data and community engagement to promote behavioral health equity in San Diego County. The mission of the CEP is to promote a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans. The goal of the CEP is the integration of data and community engagement to promote

behavioral health equity in San Diego County. The CEP allows the public to explore, monitor, and visualize behavioral health equity data through a series of interactive dashboards. Data sources include surveys, vital records, hospitalization and emergency department data, and service and outcome data for individuals served by the Behavioral Health Services system. Users can explore indicators of equity over time, across neighborhoods, and for numerous subpopulations, including by race/ethnicity, gender, sexual orientation, age, justice involvement and more. http://www.communityexperiencepartnership.com/

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the members' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

Cultural Competence Training Opportunities through the BHP: Cultural Competence Trainings are available through some of SDCBHS's larger contractors. SDCBHS contracted trainings and trainings via the Learning Management System (LMS) are available through the BHS Workforce Education and Training Website, and Cultural Competency trainings are offered through Academy of Professional Excellence (APEX). Specific training for the Cultural Competency Academy is available through the Academy for Professional Excellence for BHS and BHS Contractors at no cost.

Cultural Competence Monitoring and Evaluation: The BHP CORs are responsible for monitoring and evaluating compliance with cultural competence standards to align with the State and Federal requirements. The QA Unit and the CORs utilize both the medical record review and the annual Contract Review to monitor providers regarding cultural competence. In addition, provision of/usage of the tools listed below is now cultural competence requirement.

Cultural Competence Training Requirements

A m*inimum of 4 hours of cultural competence training annually:* Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with members or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record of the annual minimum four hours of training shall be maintained in the Monthly/Quarterly Status Report.

The following conditions also apply:

a. All new staff have one year to complete the 4 hours of cultural competence training.

b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement "a".

c. Volunteers, Temporary Expert Professionals (TEP), Retire-Rehires, Certified Temporary Appointments, and Student Workers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

d. All staff billing to Medi-Cal need to review, update, and attest monthly to Cultural Competency (CC) training completion in the SOC Application.

National Culturally and Linguistically Appropriate Services (CLAS) Standards: The National Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards. The Standards are as follows:

- Principal Standard**:** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

- Governance, Leadership, and Workforce: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

- Communication and Language Assistance: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

- Engagement, Continuous Improvement, and Accountability**:** Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Cultural Competence Plan

SDCBHS has a long-term commitment to creating and maintaining a culturally relevant and culturally responsive system of care and incorporating the recognition and value of racial, ethnic, and cultural diversity within its system since 1997 in its first Cultural Competence Plan. As of FY 2026-27, the Cultural Competence Plan is no longer required, and this requirement has been replaced with the BHSA Implementation Plan as of this fiscal year. Previously, the Cultural Competence Plan summarized SDCBHS's present activities and initiatives. It included information on the eight criteria set by the State as indicators of cultural competence.

CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may be used to assist you in developing a CC Plan. They are available in the Cultural Competence Handbook (pages 12-13) on the Technical Resource Library (TRL) website. New contractors need to submit a CC Plan, as specified in their Statement of Work, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan. Plans should be sent via email to their COR and BHS-HPA.HHSA@sdcounty.ca.gov.

The CC Plan Component Guidelines are as follows:

- Current Status of Program
    - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
    - Identify how program administration prioritizes cultural competence in the delivery of services.
    - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
    - Goals accomplished regarding reducing health care disparities.
    - Identify barriers to quality improvement.
    -

Service Assessment Update and Data Analysis

- Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
- Comparison of staff to diversity in community.
- A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to member/target population needs.
    - Use of interpreter services.
    - Service utilization by ethnicity, race, language usage, and cultural groups.
    - Member outcomes are meaningful to members' social ecological needs.
- Objectives
    - Goals for improvements.
    - Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
    - Trauma-informed principles and concepts integrated
    - Faith-based services

1) .

- https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/workforce.html

mailto:BHS-HPA.HHSA@sdcounty.ca.gov

Program Level Requirements

Culturally and Linguistically Appropriate Services (CLAS) Standards: The CLAS Standards offer a strong framework to provide culturally and linguistically appropriate services. Programs are required to adhere to the CLAS Standards and ensure annual evaluation of programs are conducted in the context of CLAS Standards. County of San Diego recommends utilizing the Implementation Checklist for the National CLAS Standards to ensure CLAS Standards are met. The Checklist has listed successful CLAS-related organizational activities that were observed across organizations. A CLAS action worksheet is provided to be used to plan CLAS activities in your setting. The checklist can be found at the following link: An Implementation Checklist for the National CLAS Standards (hhs.gov). Additionally, programs may elect to utilize any of the assessment tools available in the Cultural Competence Handbook as deemed appropriate to evaluate cultural and linguistic competence and ensure CLAS Standards are met.

https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/2023 CLCPA Report_Final.pdf

Cultural Competence Training: Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with members, or anyone who provides interpreter services, must participate in at least four (4) hours of cultural competence training per year. A record of training shall be maintained in the Monthly/Quarterly Status Report. Please reference *Section O* for more information.

Transgender, Gender Diverse, or Intersex (TGI) Training: On May 12, 2025, the Department of Healthcare Services (DHCS) released the final Behavioral Health Information Notice (BHIN) 25-019 which requires staff who are in direct contact with services recipients to complete an evidenced-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse or intersex (TGI). TGI training is offered in two training formats:

- Live virtual training titled "Culturally Responsive Behavioral Health Care with Trans and Nonbinary People"
- On-demand webinar titled "Culturally Responsive Behavioral Health Care with Trans and Non-binary People" Course Code: CRABHS-Trans_webinar4

Access to these trainings can be found on the BHS workforce training website under Professional Trainings.

System of Care (SOC) Application Attestations: All staff billing to Medi-Cal need to review, update, and attest monthly to Cultural Competency (CC) training completion in the SOC Application. This includes staff serving in either direct or indirect roles, meaning that if a staff's NPI is used for Medi-Cal billing, they are expected to attest to the accuracy of their information in the SOC Application, including cultural competency training completion. To help ensure information remains accurate, Staff and Program Managers should regularly review their SOC Application information, including CC training completion, and complete the required monthly attestation. More information on the SOC Attestation can be found at the following link: SOC Tips and Resources.

1. **Member Preference – Cultural/Ethnic Requirements.** Members must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the members, members have the right to request a change in providers. Requests for transfers are to be tracked via the *Suggestion and Transfer* section attached to the Quarterly Status Report.

***Consumer Preference – Cultural/Ethnic Requirements**:*
Plan members must be given an initial choice of the person who will provide substance use services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible

and at the request of the beneficiary, members have the right to request a change of providers. Requests for transfers are to be tracked on the Suggestion and Transfer section attached to the Quarterly Status Report.

***Member Preference – Language Requirements**:* Services should be provided in the member's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. A member may choose to use a family member or friend as an interpreter, but there shall not be the expectation that family members provide interpreter services, including the use of minor children. The offer of interpreter services and the member's response must be documented. Service notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the member, members must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers. All County and Contracted providers must at a minimum be able to link members with appropriate services that meet the member's language needs regardless of whether or not the language is a threshold language.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented. A suggested process for certification of language competence can be found on the CC Handbook on TRL.

- Conduct a survey or member focus group every couple of years and include members who are bi-lingual and monolingual to assess program and staff cultural competence, community needs and the success of efforts the program is making to meet those needs. Surveys and discussion questions are available in the CC Handbook on TRL.

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I. STAFF QUALIFICATIONS & REQUIREMENTS

Each provider is responsible for ensuring that all staff meets the requirements of Federal, State, and County regulations regarding licensure, training, clinician/member ratios and staff qualifications for providing direct member care and billing for treatment services. Documentation of staff qualifications shall be kept on file at the program site. Provider shall adhere to staff qualification standards and must obtain approval from their Program Monitor or designee for any exceptions.

Provider shall comply with the licensing requirements of the California Welfare and Institutions Code Section 5751.2. Provider shall have on file a copy of all staff licenses and relevant certificates of registration with the Board of Behavioral Sciences. For staff positions requiring licensure, all licenses and registrations must be kept current and be in active status in good standing with the Board of Behavioral Sciences.

Credentialing, Recredentialing, and Provider Enrollment
The San Diego County Behavioral Health Plan's (BHP) credentialing, recredentialing, and provider enrollment requirements are designed to comply with applicable national accrediting organization standards and local, state, and federal requirements. The requirement for credentialing is established in the California Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) 18-019 (Final Rule: Credentialing), pursuant to 42 CFR §438.214. Credentialing is a component of the BHP's quality improvement system and is a required condition for participation in the County's provider network and reimbursement for covered services.

Credentialing verifies that providers meet the qualifications required to participate in the County's provider network. Recredentialing is the periodic review conducted at least every three (3) years to confirm providers continue to meet those requirements. Provider Enrollment (PAVE) is a separate DHCS process used to screen and enroll applicable providers in Medi-Cal. Although these processes are related, each serves a different purpose, and completion of one does not satisfy the others. Depending on the Legal Entity, credentialing, recredentialing, and applicable provider enrollment activities are completed either through Optum's centralized process or by an approved Credentialing Delegate. Providers delivering direct billable Medi-Cal services who are licensed, registered, certified, or waivered, as applicable, must be credentialed before providing covered services and recredentialed at least every 3 years in accordance with BHIN 18-019.

As the BHP, the County is responsible for verifying that network providers meet all applicable credentialing requirements and for maintaining documentation demonstrating ongoing compliance. The County also submits monthly attestations to DHCS that billed services met medical necessity requirements and that providers were eligible at the time services were rendered. Legal Entities remain responsible for ensuring the timely completion of credentialing activities for all applicable staff. Credentialing activities should be initiated as part of the onboarding process. Credentialing is not a new requirement. The following sections describe provider responsibilities related to credentialing, recredentialing, provider enrollment, and delegation.

Credentialing via Optum
The following process applies to Legal Entities that utilize Optum's centralized credentialing program. Legal Entities designated as Credentialing Delegates should refer to the Credentialing Delegates and Delegation Oversight section below.
Provider Responsibilities

Legal Entities utilizing Optum's centralized credentialing program remain responsible for ensuring the successful completion of credentialing activities for applicable staff.

To support timely onboarding and SmartCare access, Legal Entities should:

- Notify their assigned Optum Credentialing Representative within two (2) business days of a candidate's acceptance of an employment offer.
- Submit all required credentialing applications, attestations, and supporting documentation in a timely manner.
- Ensure credentialing is completed before applicable providers begin delivering covered services.
- Notify their assigned Optum Credentialing Representative of changes that may affect a provider's credentialing record, including new hires, terminations, changes in licensure, registration, certification, practice location, or other information affecting credentialing eligibility.

Because credentialing materials may change over time, Legal Entities should refer to the Optum **Organizational Providers Credentialing** webpage and the Credentialing Frequently Asked Questions (FAQ) for the most current instructions, forms, required documentation, and contact information.

Credentialing Review

As part of the credentialing process, Optum reviews provider qualifications and verifies information through primary sources, as applicable, to determine eligibility for participation in the BHP provider network. This review includes provider attestations, primary source verification, and other information required under applicable federal, state, and BHP requirements. Additional information or documentation may be requested as needed.

Residential Program Credentialing Requirements

Residential Programs and Residential Sites are evaluated during both credentialing and recredentialing. Programs accredited by an Optum-recognized accrediting organization shall have their accreditation status verified. Programs without accreditation shall provide documentation from the most recent applicable review conducted by DHCS, DHS, CMS, or another applicable regulatory agency.

Questions regarding Optum credentialing may be directed to the assigned Optum Credentialing Representative or BHSCredentialing@optum.com.

Recredentialing via Optum

The following process applies to Legal Entities utilizing Optum's centralized credentialing program. Individual practitioners and Residential Program Sites shall be recredentialed at least every three (3) years. Optum will initiate the recredentialing process approximately six (6) months before expiration of the current credentialing period.

Provider Responsibilities

Legal Entities shall:

- Ensure providers submit all required recredentialing applications and supporting documentation within requested timeframes.
- Respond promptly to requests for updated credentialing information.
- Maintain accurate credentialing information throughout the credentialing cycle.

Failure to Complete Recredentialing

Failure to submit a complete and signed recredentialing application and all required supporting documentation within the requested timeframe may result in expiration or termination of credentialing status. Providers whose credentialing expires may be required to complete the initial credentialing process before participation in the BHP provider network can resume.

Questions regarding Optum recredentialing may be directed to the assigned Optum Credentialing Representative or BHSCredentialing@optum.com.

Provider Enrollment (PAVE) via Optum

The following process applies to Legal Entities utilizing Optum's centralized provider enrollment process for applicable providers. Provider Enrollment and Credentialing are separate requirements. Completion of one requirement does not satisfy the other. Applicable providers may be required to complete both processes.

Provider Responsibilities

Legal Entities and providers shall:

- Complete all required Provider Enrollment (PAVE) activities for applicable providers.
- Respond promptly to requests from DHCS or Optum related to provider enrollment.
- Complete required PAVE activities within requested timeframes to avoid delays.

For applicable providers, Optum coordinates provider enrollment activities through the DHCS Provider Application and Validation for Enrollment (PAVE) portal in accordance with DHCS BHIN 20-071.

Questions regarding Provider Enrollment (PAVE) may be directed to the assigned Optum Enrollment Coordinator.

Credentialing Delegates and Delegation Oversight

Certain Legal Entities have been approved by the BHP to perform credentialing, recredentialing, and applicable Provider Enrollment (PAVE) activities on behalf of the BHP for their own providers, rather than utilizing Optum's centralized credentialing process. These organizations are referred to as Credentialing Delegates.

The following organizations currently serve as Credentialing Delegates:

- Family Health Centers of San Diego
- Fred Finch Youth Center
- HealthRIGHT 360
- Mission Treatment Services / San Diego Health Alliance / San Diego Treatment Services
- San Diego Center for Children
- San Diego Youth Services
- Telecare

Credentialing Delegates are responsible for performing delegated credentialing, recredentialing, and applicable provider enrollment activities in accordance with applicable federal and state requirements, BHP policies and procedures, NCQA standards, and the terms of the delegation agreement. On behalf of the BHP, Optum conducts annual Delegation Oversight Audits to evaluate each Credentialing Delegate's

compliance with delegated responsibilities. Delegates must achieve a minimum audit score of eighty-five percent (85%) to maintain delegated status. Delegates receiving a score below 85% will be required to complete a Corrective Action Plan (CAP). Optum may also conduct additional oversight, monitoring, or compliance activities related to delegated credentialing, recredentialing, and provider enrollment responsibilities, as appropriate, on behalf of the BHP.

Questions regarding delegated credentialing responsibilities or delegation oversight may be directed to the assigned Optum Credentialing Representative.

SUD Staffing Descriptions and Requirements
Various members of the treatment team can function as the case manager, including registered/certified SUD counselors and LPHAs.

Medical Director
The typical pre-DMC-ODS role of the medical director was a focus on signing treatment plans. Under the DMC-ODS, the focus is broader, and physicians should be engaged and integrated as a significant role into the SUD system. Medical Directors at SUD provider agencies should ideally perform functions that others within the agency are unable to optimally perform. Some possible ways to maximize the benefit and role of the Medical Director within the program include:

- Provision of Medication Assisted Treatment (MAT) when clinically necessary
- Provision of Withdrawal Management (WM), if within program scope, when clinically necessary
- Provision of clinical supervision for staff
- Assist other professional staff with challenging cases
- Refer/treat co-occurring physical and mental health conditions
- Conduct clinical trainings on issues relevant to staff (e.g., ASAM Criteria, DSM-5, MAT, co-occurring conditions)

Note: Provision of MAT, WM or treatment of physical health conditions in a residential setting requires an Incidental Medical Services (IMS) license through DHCS with the exception of WM 3.2 (which does not require IMS). The substance use disorder medical director's responsibilities shall at a minimum include all of the following:

- Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
- Ensure that physicians do not delegate their duties to non-physician personnel.
- Develop and implement medical policies and standards for the provider.
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
- Ensure that provider's physicians and LPHA’s are adequately trained to perform diagnosis of substance use disorders for members, determine the medical necessity of treatment for members and perform other physician duties, as outlined in this section.
- Review members’ health/medical information and drug history and document their review along with any orders and/or recommendations.

The substance use disorder medical director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed. Consistent with these responsibilities, programs must have written roles and responsibilities and a code of conduct for the medical director that is clearly documented, signed and dated by a provider representative and the physician. A substance use disorder medical director shall receive a minimum of five (5) hours of continuing medical education in addiction medicine each year.

Programs shall only select Medical Directors who meet the following criteria and provide evidence to assigned COR's:

- Enrolled with DHCS under applicable state regulations.
- Screened as a "limited" categorical risk within a year prior to serving as a Medical Director.
- Signed a Medicaid provider agreement with DHCS.

Each program's assigned COR will be responsible for evaluating a medical director's credentials to determine the salary cap.

Program Manager

Program Managers (PM) shall:

- be available during regular business hours and respond to emails, telephone calls, and other correspondence from the COR or designee within two (2) business days.
- notify the COR or designee if PM is to be absent from the program for more than two (2) business days and provide an alternate contact for program coverage
- not split between multiple persons and shall be one designated person working full time at a program.
- Have at least one year of experience working in a SUD treatment program and shall be a Certified SUD Counselor or Licensed Practitioner of the Healing Arts (LPHA) or Licensed Eligible Practitioner.
- have relevant experience needed to serve in this role, including experience supervising personnel. At least 50% of their time shall be spent on management and administration (non-clinical) duties for the program.

Volunteer Staff

If a program utilizes the services of volunteers, it shall develop and implement written policies and procedures, which shall be available for, and reviewed with all volunteers. The policies and procedures shall address all the following:

1. Recruitment
2. Screening
3. Selection
4. Training and orientation
5. Duties and assignments
6. Supervision
7. Protection of member confidentiality; and
8. Code of conduct.

Professional Staff

Professional staff shall be licensed, registered, certified, or recognized under California scope of practice. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapists, and License Eligible Practitioners working under the supervision of Licensed Clinicians.

State Plan Amendment (SPA) 23-0026 added the rendering provider types listed below to the Short-Doyle claiming system, effective July 1, 2023.Non- LPHA identified provider types newly eligible to claim in the DMC and DMC-ODS delivery systems are: Medical Assistant; Occupational Therapist; Licensed Vocational Nurse; Licensed Psychiatric Technician; Nurse Practitioner Clinical Trainee; Psychologist Clinical Trainee; Clinical Social Worker (LCSW); Clinical Trainee; Marriage and Family Therapist (MFT) Clinical Trainee; Professional Clinical Counselor (LPCC) Clinical Trainee; Psychiatric Technician Clinical Trainee; Registered Nurse Clinical Trainee; Vocational Nurse Clinical Trainee; Occupational Therapist Clinical Trainee; Pharmacist Clinical Trainee; Physician Assistant Clinical Trainee; Medical Student in Clerkship (Physician Clinical Trainee). Ref: FAQ

Licensed Practitioner of the Healing Arts (LPHA) - Including Licensed Eligible

A California-licensed or license-eligible (post master's degree interns registered with the appropriate State Board of licensing who are receiving clinical supervision) LPHA shall be available to provide clinical consultation as necessary, and to conduct assessments for those members who have a co-occurring mental health diagnosis. The LPHA shall also conduct clinical supervision for staff delivering program services. A plan for provision of services to members with a co-occurring disorder must be approved by the COR within 60 days of Agreement execution. If providers do not have such consultation available, a documented plan shall be approved by the COR to ensure adequate assessment and referral of co-occurring diagnosed individuals and clinical supervision for program staff.

LPHA or licensed eligible staff shall meet all California Board of Behavioral Sciences or Board of Psychology licensure requirements, as well as having documented experience working with substance abuse services for a minimum of one year. For license verification, click here. The license shall be in good standing and clear of licensing authority disciplinary actions for a minimum of three years at the date of hire and continuously while employed by Providers as an employee or consultant.

- Post Master's degree interns registered with the appropriate State Board of licensing who are receiving clinical supervision may be used to provide direct services in the program. *Note: This does not apply to Registered Psychological Associates*

- SB 1024 sponsored by the Board of Behavioral Sciences, mandates the following for all licensees and registrants:
    - Licenses and registrants must display their license or registration in a conspicuous location at their primary place of practice when rendering professional clinical services in person.
    - SB 1024 defines who qualifies as a supervisee in group supervision and caps the number of supervisees at eight (8) individuals in group supervision

- SB 1024 specifies who is included in the limit of six (s) supervisees receiving individual or triadic supervision per supervisor in non-exempt settings
- Program and clinical supervisors are advised to review the BBS SB 1024 FAQ document available on the BBS Website
- Clarification on Number of Supervisees per Supervisor Effective January 1, 2025

SUD Counselors and Counselor Certification

SUD programs must demonstrate that their registered SUD counselors do not exceed the five (5) year registration limit (from the date of initial registration). SUD programs failing to ensure compliance with these requirements will be cited appropriately.

Counselor certification is based upon the Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice (TAP 21) published by the Center for Substance Abuse Treatment. Staff who provide counseling services such as intake, assessment of need for services, treatment planning, recovery planning, individual or group counseling to participants, patients, or residents in any substance use disorder (SUD) program licensed or certified by DHCS are required by the State of California to be certified. To obtain certification, counselors must register with one (1) of the approved certifying organizations. From the date of registry, counselors have five (5) years to become certified with any certifying organization (CCR, Section 13035(f)(1)). If a counselor fails to become certified after being registered for five (5) years, the counselor will not be permitted to provide counseling services to members. The provision which allowed an individual six months from the date of hire to become registered has been repealed. Per DHCS MHSUDS Information Notice 18-035:

> *Health and Safety Code 11833 repeals California Code of Regulations (CCR) Title 9, Section 13035(f), which allowed an individual to provide counseling services, within six months of the date of hire, prior to registering with a certifying organization. In accordance with HSC Section 11833(b)(1), any individual who provides counseling services in a licensed or certified AOD program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization.*

AOD Counselor Educational Requirements

Effective January 1, 2026, Assembly Bill (AB) 2473 amended Health and Safety Code section 11833 to establish expanded core competency education requirements for all Substance Use Disorder (SUD) registered counselors. Registered counselors must complete education requirements outlined in Behavioral Health Information Notice (BHIN) 25-029 in order to renew their registration credential.

- All registered counselors shall complete a minimum of eighty (80) hours of education that meet the core competency education topics required under BHIN 25-029 within the timelines defined by DHCS based on registration date.
- Counselors who fail to complete required education within required timelines shall be unable to renew their registration and shall not provide counseling services.
- Counselors registering for the first time on or after July 1, 2025 shall complete 80 hours of core competency education within six (6) months of initial registration.
- Counselors registering on or after January 1, 2026 must complete required core competency education before their registration renewal deadline, and may complete any remaining education deficiencies prior to the one-year registration expiration.

- Registered counselors with fewer than 315 accumulated AOD educational hours shall comply with additional requirements defined by DHCS and the counselor's respective certifying organization.
- Programs shall ensure staff have access to BHIN 25-029 and the AB 2473 SUD Counselor Education Requirements Frequently Asked Questions (FAQ) issued by DHCS

- See Timeline Tables for further information

DHCS / UC San Diego ASCEND Program

- On January 12, 2026, the Department of Health Care Services (DHCS), in partnership with UC San Diego Division of Extended Studies, launched the Advancing SUD Counselor Education and Development (ASCEND) Program. ASCEND is a free, self-paced, asynchronous 80-hour online training program that fulfills all twelve (12) core competency educational topics required under BHIN 25-029. Courses are approved by CADTP and CCAPP. Programs should inform registered counselors of the availability of the ASCEND Program as a DHCS-approved option for satisfying AB 2473 educational requirements.

Program Responsibilities Related to AB 2473 Requirements

- As a SUD licensed and/or certified program, it is best practice to ensure all registered counselors employed by the program have completed AB 2473-required education to ensure successful renewal of their registration credential and continued eligibility to provide counseling services.
- Programs shall support staff in meeting all AB 2473 education requirements, including notifying staff of education timelines, providing appropriate resources, and ensuring completion is documented.
- Counselors shall be directed to their certifying organization for confirmation that selected coursework meets AB 2473 and BHIN 25-029 requirements.
- Documentation verifying completion of AB 2473 educational requirements shall be kept in each counselor's personnel file.

Approved Certifying Organizations

Per DHCS, as of March 11, 2019, there are three (3) Certifying Organizations (CO) approved by the California Department of Health Care Services (DHCS) to register and certify individuals to provide substance use disorder (SUD) counseling. Any SUD counselor registered or certified with a CO no longer approved by DHCS will need to re-register with one of approved CO's to continue providing counseling services.

- California Association of DUI treatment Programs (CADTP)
- California Consortium of Addiction Programs and Professions (CCAPP)
- California Association for Drug/Alcohol Educators (CAADE)

Each certifying organization maintains its own approval process for evaluating education coursework to determine whether it satisfies AB 2473 core competency requirements. Registered counselors shall consult their certifying organization to ensure coursework meets AB 2473 standards.
See Appendix M.1 – SUD Credentials for a list of current SUD credentials for each credentialing body and how to verify the counselor credentials.

Additional Requirements for LPHA's and Counselors

Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, case management, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in Title 9, Division 4, Chapter 8. Regulations require licensed and certified Substance Use Disorder (SUD) programs to ensure that their counseling staff are appropriately registered and/or certified at all times by an approved certifying organization, or appropriately professionally licensed. In addition, SUD programs must continue to meet the regulatory requirement that 30% of the staff providing SUD counseling are certified or professionally licensed or license eligible, per Section 13010 - Requirement for Certification, Cal. Code Regs. tit. 9 § 13010. Registered counselors must meet all AB 2473 core competency educational requirements as part of maintaining eligibility to provide counseling services. Programs must ensure that no registered counselor who has not met these requirements and who is unable to renew their registration continues to provide counseling services.

Peer Support Specialists

A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification. See BHIN 25-010 for more information.

Peer Support Specialists must provide services under the direction of a Behavioral Health Professional. "Under the direction of" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval and signing of member plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the service provided. Services are provided under the direction of a physician; a licensed psychologist; a licensed, or registered social worker; a licensed, or registered marriage and family therapist; a licensed, or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).

- Behavioral Health Professionals must be licensed or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC-ODS or Specialty Mental Health Services.
- Peer Support Specialist may be supervised by a Medi-Cal Peer Support Specialist Supervisor who meets applicable State of California requirements; however, the services shall be under the direction of a Behavioral Health Professional. See BHIN-25-010 for more information.

Peer Support Specialists are required to adhere to the practice guidelines developed by the Substance Abuse and Mental Health Services Administration, What are Peer Recovery Support Services (Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services), which may be accessed electronically through the following Internet World Wide Web connection: www.samhsa.gov/resource/ebp/what-are-peer-recovery-support-services.

Enhanced Community Health Workers (ECHW)

Community based workers provide services aimed at preventing disease, disability, and other health conditions and promoting physical/mental health and well-being via connection to health and wellness resources and address barriers to meeting health or health-related social needs. The role of the ECHW, is

to identify member's needs and connect them back to member's behavioral health and or substance abuse issues.

Duration: Limited, short-term. Limits to maximum units of service per day per member/per year; additional units require additional authorization.

ECHW Training and Certification: *Statewide Certification Pending*: DHCS does not currently require a standardized statewide certification for this role. Certification must be obtained through various providers, supervising providers are responsible for determining if certificate of completion fulfills Medi-Cal CHW requirements. *Please note, some managed care plans or employers may have their own training requirements.*

Staffing Ratios

The following guidelines for staffing ratios reflect County standards for best practice. Prior discussion with COR is needed if higher caseload ratios are proposed for LPHA, Case Manager, or SUD Counselor based on program design.

Staff Position	Residential Caseload Ratio (Staff to Member)		Outpatient Caseload Ratio (Staff to Member)		Residential Withdrawal Management Caseload Ratio (Staff to Member)	
Title	**Programs Serving Children, Youth & Families**	**Programs Serving Adults & Older Adults**	**Programs Serving Children, Youth & Families**	**Programs Serving Adults & Older Adults**	**Programs Serving Children, Youth & Families**	**Programs Serving Adults & Older Adults**
LPHA	**1:25**	**1:25**	**1:25**	**1:50**	**1:25**	**1:25**
Case Manager	**1:25**	**1:25**	**1:25**	**1:50**	**1:25**	**1:25**
SUD Counselor	**1:25**	**1:25**	**1:25**	**1:25**	**1:25**	**1:25**

*In addition to above position titles, it is required for all programs to have a Medical Director. Contact your program COR with questions regarding withdrawal management nursing requirements and overnight staff questions.

Adult & Older Adults and Children, Youth & Families System of Care Staffing Requirements

The Department of Health Care Services (DHCS) ensures the provision of quality treatment through the enforcement of standards for professional and safe treatment. DHCS does not certify counselors; however, DHCS does ensure counselors provide quality treatment to members by enforcing the Counselor Certification Regulations found in the California Code of Regulations (CCR), Title 9, Division 4, Chapter 8.

Providers shall:

- Administer, staff, and provide management systems and procedures for programs.
- Recruit, hire, train and maintain staff qualified to provide required services.

- Ensure all staff has appropriate experience and necessary training upon hire.
- Ensure members currently in treatment are not to be used in staff positions*.
- Verify identify and determine the exclusion status of all staff prior to hire (see Federal and State Database Checks below).
- Ensure all personnel are competent, trained and qualified to provide any services necessary.
- Ensure non-professional receive appropriate onsite orientation and training prior to performing assigned duties.
- Ensure professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.
- Ensure documentation of trainings, certifications and licensure shall be contained in personnel files.
- Ensure professional and/or administrative staff supervise non-professional staff.
- Maintain records of current certification and NPI registration. Registered and certified SUD counselors shall adhere to all requirements in Title 9, Chapter 8.

* Providers shall have trained provider staff available to answer phone calls during hours of operation. Program shall ensure participants in DMC-ODS programs shall not answer phones on behalf of program staff. Providers shall ensure \member confidentiality is maintained at all times.

Federal and State Database Checks

Prior to employment, programs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System (NPPES)
- List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)

Certification on Disbarment or Exclusion

All claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment of exclusion from services. In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employees with the federal System for Award Management (SAM), the Office of the Inspector General (OIG), Government Services Agency (GSA) and the Suspended and Ineligible Provider (S&I) List.

Provider shall be responsible for checking, on a quarterly basis, the office of the Inspector General (OIG) website that none of the Providers officers, board members, employees, and agents providing services are on the OIG or Medi-Cal list of excluded individuals to provide direct services to County members. Providers shall notify, in writing within thirty (30) days if any personnel are found listed on this site and the actions taken to remedy the situation.

Verification

- Federal System for Award Management (SAM) list
- Reasons for placement on OIG

- Medi-Cal Provider Suspension
    - Reasons include:
        - Convicted of felony
        - Convicted of misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.
        - Suspended from the federal Medicare or Medicaid programs for any reasons
        - Lost or surrendered a license, certificate, or approval to provide health care
        - Breached a contractual agreement with the Department of Health Care Services that explicitly specifies inclusion on this list as a consequence of the breach.

Best Practice

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on the OIG, GSA or Suspended and Ineligible Medi-Cal lists are prohibited from working in any County funded program.
- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

Notification in Writing of Status Changes

Providers are required to notify BHS Contract Support, (BHSCS) COR and QA in writing if any of the following changes occurs:

- Any change with DMC Certification, such as surrendering certification or closing program, any event triggering a DMC recertification, such as change in ownership, change in scope of services, or change in location.
- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
- Additions or deletions from your roster of Medi-Cal billing personnel (BHSCS& MIS); or
- Proposed change in Program Manager or Head of Service.

Notification of Key Personnel Changes

Programs shall notify the COR within seventy-two (72) hours when there is a change in key personnel funded by the resulting contract.

On-Site Manager/Director

Programs shall provide a full-time on-site Program Manager or Director for each program, unless prior approval received by COR. If the program manager is also serving as the program coordinator, time may be divided between administration and direct services.

Review and Comment on the Qualifications of On-Site Managers, Directors, and Higher-Level Staff

The COR shall review and comment on the final candidates under consideration for hire at the Program Manager, Director, or higher level prior to selection. Should the COR choose to provide written comments, the comments shall be provided within five (5) days of receipt of candidates' resumes and supporting

documentation.

License Verifications

All SUD providers are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. This is in accordance with the Service Template requirements. In order to ensure the license is valid and current, the appropriate website(s) shall be checked. All providers are responsible for ensuring that all staff licenses are active and valid. Providers shall keep documentation that evidences active licensure for staff.

Personnel Files

Personnel files shall be maintained on all employees, volunteers, and interns. These records will contain: application for employment and/or resume, signed employment confirmation statement, signed annual confidentiality statements, job description (which shall include position title and classification; duties and responsibilities; lines of supervision; and education, training, work experience and other qualifications for the position), performance evaluations, health records/status as required by program or Title 9 (i.e. health screening report or health questionnaire, including annual TB results), other personnel actions (e.g. commendations, discipline, status change, employment incidents and/or injuries), training documentation relative to substance use disorders and treatment, current registration, certification, intern status or licensure; proof of continuing education required by licensing or certifying agency and program, and program code of conduct. (Note: While DHCS will not look for the certifying organization copy of their Code of Conduct during personnel file reviews, registered/certified SUD counselors are still required to have a Code of Conduct with their specific certifying organization as per those organization requirements).

The program's written code of conduct for employees and volunteers/interns shall be established which addresses at least the following: use of drugs and/or alcohol; prohibition of social/business relationship with members or their family members for personal gain; prohibition of sexual contact with the members; conflict of interest; providing services beyond scope of practice; discrimination against members or staff; verbally, physically, or sexually harassing, threatening, or abusing members, family or other staff; protecting member confidentiality; the elements found in the code(s) of conduct for the certifying organization(s) the program's counselors are certified under; and, cooperation with grievance investigations.

MD's and LPHA's will receive a minimum of five (5) hours of continuing education related to addiction medicine each year. Such documentation shall be maintained in the file and the last day of the first full month of employment and shall be available for County monitoring purposes. For more information about required training for medical directors, see DMC-ODS Medical Director Training Requirements posted on the Optum site.

Personnel files for registered counselors shall include documentation verifying completion of AB 2473 education requirements, including proof of completion of eighty (80) hours of approved core competency education. Files shall include confirmation that coursework met the standards of the counselor's certifying organization, documentation of ASCEND completion or other approved training, and verification that all educational requirements were completed before registration renewal.

Discrimination

Providers shall not unlawfully discriminate against any person as defined under the laws of the United States and the State of California. Programs may not discriminate between employees with spouses and employees with domestic partners or discriminates between employees with spouses or domestic partners of a different sex and employees with spouses or domestic partners of the same sex or discriminates between same-sex and different-sex domestic partners of employees or between same-sex and different-sex spouses of employees. (Public Contract Code section 10295.3)

Programs may not discriminate between employees on the basis of an employee's or dependent's actual or perceived gender identity, including, but not limited to, the employee's or dependent's identification as transgender. (Public Contract Code section 10295.35)

Criminal Background Check Requirement

Providers shall ensure that criminal background checks are required and completed prior to employment or placement of program staff and volunteers in compliance with any licensing, certification, or funding requirements, which may be higher than the minimum standard described herein. At a minimum, background checks shall be in compliance with Board of Supervisors policy C-28 and are required for any program staff or volunteer assigned to sensitive positions funded by this contract. Sensitive positions are those that: (1) physically supervise minors or vulnerable adults; (2) have unsupervised physical contact with minors or vulnerable adults; and/or (3) have a fiduciary responsibility to any County member, or direct access to, or control over, bank accounts or accounts with financial institutions of any member.

Providers shall have a documented process to review criminal history of candidates for employment or volunteers that will be in sensitive positions. At a minimum, providers shall check the California criminal history records, or state of residence for out of state candidates. Programs shall review the information and determine if criminal history demonstrates behavior that could create an increased risk of harm to members. Programs shall document review of criminal background findings and consideration of criminal history in the selection of a candidate. For example, document consideration of such factors as: if there is a conviction in the criminal history, how long ago did it occur, what were the changes, what was the level of conviction, and if selected, where would the individual work and is the conviction relevant to the position. Programs shall either utilize a subsequent arrest notification service during the staff or volunteer's employment or check California criminal history annually. Programs shall keep the documentation of their review and consideration of the individual's criminal history on file. As of 7/1/22, the COSD BHS Standard for staff free of probation/parole history for a minimum of one (1) year prior to employment has been updated. Staff can now begin the credentialing process and Optum will alert COR teams for awareness if any staff are identified with active parole, probation or previous criminal history within less than one year prior to starting employment.

Providers will ensure that all staff members working with members are fingerprinted (LiveScan) and pass Department of Justice and Federal Bureau of Investigations background checks.

Provider Directory

The County of San Diego Behavioral Health Plan (BHP) maintains a public Provider Directory to help clients including Medi-Cal Members locate and access covered behavioral health s The County of San Diego Behavioral Health Plan (BHP) maintains a public Provider Directory to help clients including Medi-Cal Members locate and access covered behavioral health services. The Provider Directory is maintained in accordance with applicable federal and State requirements, including but not limited to BHIN 25-026.

Link to the searchable BHP Provider Directory: https://sdcountybhs.com/ProviderDirectory.

Provider Responsibilities

Providers are responsible for ensuring that Provider Directory information remains complete, accurate, and current. SmartCare, the BHP's EHR, serves as the source of truth for Provider Directory information. The SOC Application is integrated with SmartCare and provides providers with the ability to review and attest to Provider Directory information that is publicly displayed.

Providers are expected to:

- Review and attest to Provider Directory information through the SOC Application in accordance with County-established timeframes.
- Promptly notify the County of changes affecting Provider Directory information and complete any required updates or attestations.
- Contact the Optum Help Desk at sdhelpdesk@optum.com or call 1-800-834-3792 to request corrections to staff-level information maintained in SmartCare. Requests will be reviewed, and any necessary updates will be made in the Provider Directory within 30 days of receiving requests.
- Contact the assigned Contracting Officer's Representative (COR) to request corrections to program-level information.
- Respond to County requests to verify Provider Directory information within established timeframes.

The Provider Directory is maintained in accordance with applicable federal and State requirements, including but not limited to BHIN 25-026. Link to the searchable BHP Provider Directory: https://sdcountybhs.com/ProviderDirectory.

Residential Staffing Requirements

Residential Programs and Overnight Staffing

Residential programs shall ensure adequate staffing to meet the needs of the program are onsite and on-duty 24 hours a day, 7 days a week, including but not limited to:

- Staff shall be a SUD Counselor (Certified or Registered) or LPHA
- At all times, at least 1 staff on site is CPR-certified, and First Aid trained
- Overnight staff cannot be a volunteer nor an active member of the program
- Awake overnight staff are required to conduct regular walk-throughs of the facility, to include bed checks of members within their first 2 weeks of treatment and/or deemed at risk for overdose. All walkthroughs shall be documented.
- Overnight coverage staffing schedule shall be posted.
- Programs that are monitored by other agencies, such as Community Care Licensing, shall ensure that staffing rations meet the requirements of those certifying bodies.

Minimum Qualifications

- CPR/First Aid/Safety training and certification obtained within 90 days of hire and maintained;
- Eighteen (18) years or older;
- Trained on SUD confidentiality, ethics, and cultural competence/sensitivity; and,
- Trained and able to respond to emergency situations.

Note: 24/7 residential service hours are to include intake and admissions.

It is recommended that residential programs designated as ASAM Level 3.2 obtain the Incidental Medical Services (IMS) license through DHCS. A minimum of LVN level staff is recommended 24/7 in these programs and must follow the policies and procedures as established by the program's medical director. Providers are expected to implement policies and procedures that have been developed with the Medical Director, that includes at a minimum, working collaboratively with emergency departments and primary care physicians that the member is safe to return to the WM program when in-house 24/7 nursing staff is not used.

Residential Staff Living Onsite
Residential facilities licensed or certified by DHCS are for member treatment purposes. Any part of certified or licensed facilities and beds designated for treatment may not be used for staff's personal use (i.e., as staff residence). Common areas within the facility, such as kitchen and storage, may be used by staff during their work shifts as needed. Providers are to refer to the license and/or certification blueprint approved by DHCS for verification. If staff resides outside of the certified or licensed portion of the treatment facility, personal living expenses may not be charged to the BHS contract and must be aligned with the program's Cost Allocation Plan.

Ethical and Legal Standards
Programs shall develop and implement policies, procedures and training protocol that ensure that its employees, subcontractors, subcontractor employees and volunteers adhere to the highest ethical and legal conduct standards when performing work under the terms and conditions of the contract.

Code of Conduct
A Code of Conduct is a statement signed by all employees, contractors, and agents of an organization that promotes a commitment to compliance and is reasonably capable of reducing the prospect of wrongful conduct. Codes of Conduct should be created at the agency level. Programs shall have a written code of conduct that pertains to and is known about by staff, paid employees, volunteers, and the governing body and community advisory board members. Each staff, paid employee, and volunteer shall sign a copy of the code of conduct and a copy shall be placed in their personnel file. The program shall post the written code of conduct in a public are that is available to members. The code of conduct shall include the program policies regarding at a minimum the following:

- Use of alcohol and/or other drugs on the premises and when off the premises
- Personal relationships with participants
- Prohibition of sexual contact with participants
- Sexual harassment
- Unlawful discrimination
- Conflict of interest
- Confidentiality

In addition to the minimum requirements listed above, all Programs Serving Children, Youth & Families providers are encouraged to utilize the 2019 Trauma-Informed Care Code of Conduct in the creation of their agency code of conduct. This document, created by young adults with lived experience, is intended to guide programs in developing policies and procedures related to trauma informed care, to inform trainings

for staff, and to be offered to members to outline the commitment of the program to follow trauma informed principles. See M.2 – Trauma Informed Care Code of Conduct.

Counselor/Member Relationships
Relationships between members and program staff beyond the realm of treatment are prohibited. Staff must maintain healthy boundaries between themselves and their members at all times. Staff members' failure to adhere to this standard shall be disciplined at the discretion of the program director.

Sexual Contact
Sexual contact shall be prohibited between program staff, including volunteers, and members the Board of directors, and the participants. A written statement explaining the sexual contact policy shall be included in every participant's rights statement given at admission to a program. Programs shall include a statement in every personnel file noting that the employees and volunteers have read and understood the sexual contact prohibition. The policy shall remain in effect for six months after a participant is discharged from services, or a staff member of volunteer terminates employment.

Staff Development and Training Plans
Programs shall develop and maintain a management and staff training (including volunteers and interns) and development plan. The staff training plan shall be updated annually and written reports on management and staff progress in achieving their development goals shall be maintained in the employee's personnel file. Staff training and development plans shall include at minimum: Annual QI Training (at least member of leadership is required to attend); ASAM training for staff completing screening/intake, assessment and treatment planning – and those supervising them (i.e. LPHA, Medical Director) - must be completed prior to providing these services; specific treatment standards for services provided, member confidentiality, member screening and assessment, member referral, CPR, communicable diseases, cultural diversity, data collection and reporting requirements, drug testing protocols, program admissions procedures, and Evidence Based Practices of at a minimum of Relapse Prevention and Motivational Interviewing. Relapse Prevention and Motivational Interviewing trainings will be available through the BHS Workforce Training and Technical Assistance website, but staff may receive these trainings through other means, as long as the program COR has approved the alternative. Programs shall incorporate AB 2473 educational requirements into the annual staff training and development plan for registered counselors. Programs shall ensure counseling staff are informed of AB 2473 timelines, core competency requirements, and available approved training resources.

For updated training information, please refer to the most recent DMC-ODS Training Guide at https://sandiegocounty.gov/dmc. Contractors shall utilize County-approved training sources as indicated on the DMC-ODS Training Guide. Contractors may utilize training providers other than those indicated on the DMC-ODS Training Guide if approved by the COR to ensure minimum required standards are met.

Some of the following trainings may be tracked on the MSR/QSR:

- ASAM Training: Completion of ASAM A, B & C (via CIBHS) or completion of ASAM e-training Modules 1 and 2 ("Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care" (via the Change Companies) is required prior to provision of screening/intake, assessment and treatment planning services are provided (and by those supervising staff providing these services, i.e., LPHA, Medical Director)

- Cultural Competency Trainings: Minimum of four hours annual requirement for all staff. When an in-service is conducted, program shall keep on file a training agenda and a sign-in sheet for all those in attendance with sign-in/out times. For outside trainings, certificate of completion shall be kept on file at the program
- Evidence Based Practices: Professional staff shall be trained in Motivational Interviewing and Relapse Prevention
- BHS Disaster Training is available through e-learning located on the BHS Workforce Training and Technical Assistance website. A minimum of 25% of contracted staff need to be disaster trained
- System of Care Training is available through e-learning located on the BHS Workforce Training and Technical Assistance website. All direct service staff shall complete e-learning about BHS System
- CalOMS Web-based Training: For more information regarding this section, please refer to Section 7.
- Continuing Education Units (CEUs): Contractor shall require clinical staff to meet their licensing requirement. Professional staff (LPHAs) are required to receive a minimum of five (5) hours of continuing education related to addiction medicine each year. Other paraprofessional staff shall have a minimum of sixteen (16) hours of clinical training per year
- Withdrawal Management 3.2 Training Requirements:
    - Per Exhibit A of BHIN 21-001, those providing, monitoring or supervising WM services in a 3.2 facility must complete of 6 hours minimum of orientation training for new employees or for current employees within 14 days of returning to work after a break of 180 days or more that covers the needs of residents who receive WM services.
    - 8 hours minimum annually of training that covers the needs of residents who receive WM services.

Contract Required Trainings

The increasing focus and requirements on cultural sensitivity, outcome measures, practice guidelines, electronic health record and evidence-based practice necessitates the need for ongoing training. Many providers have a contractual obligation to participate in identified trainings within 60 days of hire or when trainings become available. Some trainings are to be tracked on MSR/QSR or SSR. Contractor shall attend trainings as specified in their Contract: DMC-ODS Required Trainings (sandiegocounty.gov)

- Continuing Education Units (CEUs) – Contractor shall require clinical staff to meet their licensing requirement.

- Cultural Competency Training – Minimum of four hours annual requirement for all staff. When an in- service is conducted, program shall keep on file a training agenda and a sign-in sheet for all those in attendance with sign-in/out times. For outside trainings, certificate of completion shall be kept on file at the program.

- System of Care Training – E-learning access is available through the BHS Workforce Training and Technical Assistance website. All direct service staff shall complete e-learning about BHS System, CWS System, and Pathways to Well-being.

- Medical Director Training – See one-pager for Medical Director Training Requirements posted on the Optum site.

The Quality Assurance Unit
The Quality Assurance Unit provides trainings and technical assistance on topics related to the provision of services in the Child, Youth & Family, and the Adult/Older Adult Systems of Care. Training and information are disseminated through:

- Basic Medi-Cal/County Standards Documentation Trainings and webinars
- Root Cause Analysis Training
- SmartCare Trainings
- QA Specialized Trainings
- Regular QA Communications
- SUD Organizational Provider Operations Handbook (SUDPOH)
- Regular Provider Meetings

For information on upcoming trainings or in-services, or if you require technical assistance, please contact QA at QIMatters.BHS@sdcounty.ca.gov.

J. FACILITY REQUIREMENTS: LICENSING, CERTIFICATION, ETC.

Programs shall provide all facilities, facility management, supplies and other resources necessary to establish and operate the program. The facility shall meet the County of San Diego Behavioral Health Services (COSDBHS) Health, Safety and Appearance Standards as described in the HHSA-BHS-ADS 1077 (See Appendix N.1).

All providers are required to maintain a functioning voicemail that operates 24/7 for those times when a staff is not available to answer in person. Outgoing voicemail message should include directions for accessing emergency services, as per community healthcare standards, including directing members to the Access and Crisis Line (888-724-7240) for 24/7 access to a counselor, or if in need of referrals.

Space
The facility shall have sufficient space for services and activities specified in the statement of work, as well as staff and administrative offices. The facility shall also include:

Child Care Space: Programs providing perinatal services shall establish and maintain appropriate space for childcare if serving pregnant and parenting women and their children. The childcare may be state-licensed or parent/childcare cooperative but must be supervised by an individual with at least one year of experience in a state-licensed facility.

- Service Address and Hours of Operation: Program's business shall be accessible by public transportation in compliance with Americans with Disability Act (ADA) and California State Administrative Code Title 24. Non-residential programs shall be open no less than 40 hours per week and 5 days per week, except County of San Diego Holidays. Weeks where there is a County of San Diego Holiday shall have regular business hours on all days except the County of San Diego Holiday. When closed, programs shall provide information to members (i.e. outgoing voice mail message, signage on program door, reminders provided during services prior to the closure, etc.) concerning the availability of short-term emergency counseling or referral services, including, but not limited to, emergency telephone services. For residential programs, services shall be available to residents 7 days a week, 24 hours a day. Programs shall not change the hours of operation or location from those listed in their County contract without prior written approval from the Contracting Office Representative (COR). Prior to any change in location, the COR reserves the right to conduct a site visit(s), inspect the facility plans, and approve the location and any budget and/or service delivery impact which may result from the proposed move to a new location/facility.

NOTE: Programs licensed and/or certified by DHCS shall also notify DHCS of facility relocation, change of ownership, or change in scope of services, and copy their program COR on such correspondence. See Section L.7: Reporting Provider Changes for further details about changes to DMC Certified programs.

Licensing
The California Department of Health Care Services (DHCS) offers facility certification to both residential and nonresidential SUD programs (AOD Certification), and licensing of residential programs. Additionally, DHCS certifies all programs to bill Drug Medi-Cal (i.e., DMC Certification).

Outpatient SUD programs shall obtain and retain facility certification and DMC certification. Residential programs shall obtain and retain DMC Certification, DHCS facility certification and licensing, which includes a DHCS or ASAM Level of Care Designation (See Info Notices 21-001 and 21-075 for more information). All programs shall comply with provisions obtained in the current State of California, DHCS standards, and the County of San Diego shall utilize these standards in monitoring program's delivery.

Disclosure requirements related to licensing for all SUD programs have been established by AB 2081. Beginning January 1, 2025, licensed alcoholism or drug abuse recovery facilities and certified alcohol or drug programs must disclose their licensing/certification status on their websites and admission forms. This includes a link to the DHCS webpage listing facilities on probation or with revoked/suspended licenses.

Eligibility to Request Inactive Status in Case of Emergency
As described in BHIN 26-020, and pursuant to SB 582, Health and Safety Code, Division 10.5, Part 2, Chapter 7.6, a licensed AOD recovery or treatment facility or a certified AOD program may request that DHCS places its license or certification on inactive status as a result of a proclaimed or declared emergency or disaster when both of the following conditions are met:
(1) The AOD recovery or treatment facility or AOD program is forced to close because the destruction or damage to the building and/or surrounding property renders the building uninhabitable or threatens the health and safety of the residents or members; and
(2) The AOD recovery or treatment facility or AOD program intends to become operational at the same location.

The AOD recovery or treatment facility or AOD program must submit its request for an inactive license or certification to DHCS within 90 days of the applicable proclamation or declaration. AOD recovery or treatment facilities or AOD programs intending to permanently relocate to a different location may not apply for an inactive license or certification. If an AOD recovery or treatment facility or AOD program plans to continue to operate at a new address, that facility or program shall submit a license or certification amendment application according to applicable regulations.

Requests for an inactive status must include all of the following information and be submitted to DHCS by mail or email:
(1) The name of the licensed AOD recovery or treatment facility or certified AOD program,
(2) The license or certification number,
(3) The mailing address of the AOD recovery or treatment facility or AOD program,
(4) The email address of the AOD recovery or treatment facility or AOD program, if applicable,
(5) The name of the applicable proclamation or declaration,
(6) A description of the destruction or damage to the building and/or surrounding property, including photographs or insurance claims that show the destruction or damage to the building, and
(7) A statement affirming the AOD recovery or treatment facility or AOD program intends to become operational at the same location.
Requests for an inactive status may be submitted by mail to: Department of Health Care Services Licensing and Certification Division P.O. Box 997413, MS 2600 Sacramento, CA 95899-7413 Or by email to: LCDQuestions@dhcs.ca.gov.

Within 15 working days of receiving a request, DHCS will review the submission and notify the AOD recovery or treatment facility or AOD program in writing whether the request is complete or incomplete.

Please read BHIN 26-020 under "DHCS Review and Determination" for specifics on timelines for incomplete requests or resubmission.

An AOD recovery or treatment facility or AOD program must apply for reactivation of its license or certification within two years of DHCS' written notice placing it on inactive status. Reactivation is not automatic and requires the AOD recovery or treatment facility or AOD program to complete a written application for extension pursuant to Health and Safety Code Section 11834.16 or renewal pursuant to Health and Safety Code Section 11832.6, respectively. Please review BHIN 26-020 "Reactivation of License or Certification and Fee Waver" for additional information around requirements for submission of extension or renewal requests, timelines, and potential fees.

AOD Certification and Certification Renewal

All outpatient, intensive outpatient, and residential providers are required to obtain and maintain an AOD Certification from DHCS. In July 2023, AB118 added to the Health and Safety Code (HSC) Chapter 7.1, which requires all outpatient SUD treatment programs which offer "treatment, recovery, detoxification, or medication for addiction treatment (MAT) services to obtain a certification from DHCS." AB118 also maintains an avenue for residential SUD facilities to obtain certification. School site TRC's are exempt from this requirement. Outpatient programs offering ambulatory withdrawal management shall update AOD Certification to include "non-residential detox". In accordance with HSC Chapter 7.1, certification is issued to SUD programs that meet the requirements described in BHIN 25-003 Attachment 1"DHCS Certification for Alcohol and Other Drug Programs."

All existing certified SUD treatment facilities and programs and initial applicants for certification are subject to HSC Chapter 7.1 and the requirements set forth in BHIN 25-003. Per BHIN 25-003, any program not exempt from certification (as described in HSC Section 11823.3) was required to submit an Initial Application for Certification form DHCS 6040 for certification by January 1, 2024, and obtain certification by January 1, 2025. Programs must be AOD certified prior to the provision of SUD services. SUD treatment facilities that are not exempt from certification and fail to obtain certification may be subject to an assessment of civil penalties of two thousand ($2,000) dollars per day pursuant to HSC 11832.18.

Per Health and Safety Code (HSC) 11833.02, DHCS is authorized to collect licensing and certification fees from AOD recovery or treatment facilities licensed and/or certified by DHCS. DHCS is also granted the authorization to increase the licensing and certification fees. The current fees have been in effect since July 1, 2025 for FY 2025-26 and have been identified as not sufficient to support current or planned expenses incurred by DHCS for SUD licensing and certification activities.

Effective July 1, 2026, DHCS will assess a fee increase for licensure and certification of residential and outpatient SUD recovery or treatment facilities. Please see BHIN 26-004, pages 3-4, for a description of both the FY202526 fees and the increased fees for FY 2026-27.

Licensed and/or certified SUD recovery or treatment facilities, with an expiration date on or after July 1, 2026, that have already submitted biennial extension fees will be invoiced for the additional amount owed due to the increased fees. The fee difference must be submitted to the Department within 60 days of the invoice date.

The DHCS' Licensing and Certification Portal is now live. Renewal applications are available to currently licensed and/or certified SUD providers within 150 days of their license or certification expiration. Providers with renewals beyond 150 days are encouraged to sign in and verify their profile to receive notifications when their renewal becomes available.

Fee payments may be made via online through the EFT online portal or via mail. The process for submitting payment, as well as applying for a hardship waiver, is described in BHIN 26-004, page 5.

Initial Certification
Providers seeking information on obtaining certification should read the instructions and procedures contained within the Initial Application for Certification (DHCS 6040). Applicants must complete the Initial Application for Certification form and submit all required documentation and fees specified in the application.

Amending Certification
Certified providers seeking information on adding or revising services to an existing certified outpatient program should read the instructions and procedures contained within the Application for Certification Amendment(s) (DHCS 6042). Applicants must complete the Application for Certification Amendment(s) form and submit all required documentation and fees specified in the application.

*Renewing Certification*Certified providers shall submit to DHCS the Application for Certification Renewal (DHCS 6043), biennial fees, and all required information at least ninety (90) days prior to the expiration of certification. Failure to submit the Application for Certification Renewal form and fees for certification renewal at least 90 days prior to the expiration of certification shall result in automatic termination of the certification at the end of the two-year period.

BHIN 25-003 contains a list of links to the specified forms for initializing, renewing, and amending AOD Certification under section B. This BHIN also contains information regarding settings that are exempt from certification by DHCS, although may voluntarily seek certification, also in section B.

Drug Medi-Cal Certification and Re-Certification

Initial Certification
Providers applying for initial Drug Medi-Cal (DMC) certification are required to submit a complete application and supporting documents electronically via Provider Application and Validation for Enrollment (PAVE).

Additionally, new enrolling entities must complete a Live Scan for any person with a 5% or greater ownership or control and/or the Executive Director and Officers of the Corporation. Note: satellites (e.g., high school sites) are no longer permitted by DHCS and need their own DMC certification, CalOMS number, and NPI number. When applying for DMC certification for school sites, best practice is to use only the school address and avoid using classroom numbers as this limits the DMC certification to a specific classroom; if a room change is necessary, and services are provided in a non-DMC certified classroom, DMC billing will not be accepted.

Re-certification

All DMC certified providers shall be subject to continuing certification requirements at least once every five (5) years. DHCS will notify providers in writing when they are required to submit a continued enrollment application. DHCS may allow the providers to continue delivering covered services to members at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.

Re-certification is required for program relocation, remodeling, or change of ownership of greater than 50%. Refer to the PAVE link above for information on the recertification process. Providers are required to contact the program COR regarding any event that would trigger the need for DMC re-certification. It is the responsibility of the contracted provider to provide updated certifications to the provider's assigned COR and at no time should certifications lapse. Providers shall notify the COR immediately upon notification from DHCS that its license, registration, certification or approval to operate a SUD program or a covered service is revoked, suspended, modified, or not renewed by DHCS.

Other Changes
For other changes (e.g., a change in ownership less than 50% and a change with the Medical Director, staff, and/or service modality), providers must complete and submit to DHCS form DHCS 6209: Medi-Cal Supplemental Changes electronically through the PAVE system.

Resources

- Drug Medi-Cal Continued Certification questions: DHCSDMCRecert@dhcs.ca.gov
- Webinars, regulations, etc.
- Provider Enrollment Regulations (CCR Title 22, Division 3) in effect on August 17, 2015

The above Provider Enrollment Regulations link includes the amendment to section 51341.1, which addresses abusive and fraudulent practices identified during targeted field reviews and Post Service Post Payment (PSPP) reviews conducted by DHCS. The regulation contains definitions, describes in more detail how counseling sessions are to be conducted, imposes physical examination requirements, distinguishes an initial treatment plan from an updated treatment plan, and requires treatment services to be recorded in more detail.

Incidental Medical Services
Residential programs that have received approval by DHCS may provide Incidental Medical Services (IMS). IMS are services provided at a licensed residential facility by a health care practitioner that address medical issues associated with either detoxification or the provision of alcoholism or drug abuse recovery or treatment services to assist in the enhancement of treatment services.

In order to provide IMS at an approved residential program, the licensed residential provider must adhere to the conditions outlined in sections 11834.03, 11834.36, 11834.025 and 11834.026 of the Health and Safety Code, as well as to DHCS MHSUDS Information Notice Number 18-031.

Programs providing ASAM 3.2 – WM are strongly encouraged to obtain an IMS license through DHCS.

Facility Licensing
Chapter 7.5, Part 2, Division 10.5 of the California Health and Safety Code states that "no person, firm, partnership, association, corporation, or local government entity shall operate, establish, manage, conduct,

or maintain an alcoholism or drug abuse recovery or treatment facility in this state without obtaining a current, valid license pursuant to this chapter".

The code defines an alcoholism or drug abuse recovery, treatment, or detoxification facility as any facility, place or building which provides 24-hour residential non-medical services in a group setting to adults. For the purpose of further defining whether licensure is required, alcoholism or drug abuse recovery or treatment services mean services which are defined to promote treatment and maintain recovery from alcohol or drug problems which include one or more of the following: detoxification, group sessions, individual sessions, educational sessions, and recovery or treatment planning.

DHCS has the sole authority to license any facility providing 24-hour residential non-medical services to adults who are recovering from problems related to substance use disorders and who need SUD treatment. Licensure is required when at least one of the following services is provided: detoxification, group sessions, individual sessions, educational sessions, or alcoholism or drug abuse treatment or recovery planning. Additionally, facilities may be subject to other types of permits, clearances, business taxes or local fees that may be required by the cities or counties in which the facilities are located.

There are some residential facilities that do not provide SUD services and do not require licensure by the State. These include cooperative living arrangements with a commitment or requirement to be free from substance use, sometimes referred to as a sober living environment, a sober living home, transitional housing, recovery residences, or alcohol and drug free housing. It is important to note that while sober living environments or alcohol and drug free housing are not required to be licensed by DHCS, they may be subject to other types of permits, clearances, business taxes or local fees which may be required by the cities or counties in which they are located.

Residential facilities licensed by other State departments such as adolescent group homes (licensed by the Department of Social Services) or Chemical Dependency Recovery Hospitals (licensed by the Department of Public Health) do not require a residential AOD license by DHCS.

Residential Facility Licensing Requirements

- Code of Federal Regulations (CFR): Title 45 CFR, Part 96 Subpart L: Substance Abuse Block Grant
- Code of Federal Regulations: Title 42, CFR, Part 54.3: Nondiscrimination against religious organizations
- United States Code (USC): Title 42 USC, Section 300x-21-to 300x-66: Substance Abuse and Treatment Block Grant

Fire Safety Inspection

A valid and appropriate fire clearance issued from the fire authority having jurisdiction over the area in which the facility is located is required. The fire clearance shall include a determination of the number of beds for ambulatory residents and for non-ambulatory residents in the facility and any restrictions regarding non-ambulatory clearances [Regulations Section 10517 (a) (1)]. The fire clearance shall also include the number of dependent children allowed in the total capacity and the age range of the dependent children. If no number of dependent children is indicated, then no dependent children are allowed.

Plan of Operation

Plan of Operation shall include but not be limited to the following:

- Statement of program goals and objectives- written statement to include program goals (intent or purpose of its existence) and objectives of the facility [Regulations Section 10517 (a) (2) (A)].
- Outline of activities and services – written statement listing the activities and services being provided by the facility [Regulations Section 10517 (a) (2) (B)].
- Admission policies and procedures – written statement of admission policies and procedures regarding acceptance of residents [Regulations Section 10517 (a) (2) (C)].
- Assurance of nondiscrimination in employment practices and provision of benefits and services – written assurance of nondiscrimination in employment practices, provision of benefits and services [Regulations Section 10517 (a) (2) (D)].
- Facilities residential admission agreement – [Regulations Section 10517 (a) (2) (E)]. Pursuant to Title 9, California Code of Regulations, Section 10566, and in compliance with BHIN 26-006, current admission agreement used by the facility that specifies all the following:
    - Services to be provided,
    - Payment provisions including (amount assessed and payment schedule),
    - Refund policy,
    - Those actions, circumstances or conditions which may result in resident eviction from the facility,
    - The consequences when a resident relapses and consumes alcohol and/or non-health sustaining drugs, and
    - A "Return to Use" Plan (as described in BHIN 26-006.
    - Conditions under which the agreement may be terminated.

- Table of administrative organization of the facility – a chart that shows the governing board, advisory groups, including resident councils when applicable, and both lines of authority (straight lines) and communications lines (broken lines) to all staff positions [Regulations Section 10517 (a) (2) (F)].
- Staffing plan, job descriptions, and minimum staff qualifications for each position [Regulations Section 10517 (a) (2) (G)].
- Sample menus and schedule for one calendar week – menu(s) shall include times of food service, food provided for breakfast, lunch, and dinner for one week, and type and availability of snacks [Regulations Section 10517 (a) (2) (J)].
- Consultant and community resources to be utilized by the facility as part of its program. An inventory that shall be used as a resource for assisting participants in securing additional services to meet and maintain their personal well-being while continuing to enhance personal development [Regulations Section 10517 (a) (2) (K)].

Provisions for Safeguarding Residents' Property – the process of safeguarding a resident's personal property if accepted by the licensee for safekeeping and this is in the licensee's policy to accept such valuables.

Posted Brochures and Notices
All of the following brochures and notices below must be in all available threshold languages and prominently displayed unless otherwise stated. See the Optum website > "*Beneficiary*" tab for most up to date list of threshold languages. Please use the Behavioral Health Plan Informing Materials to request hard copies of brochures and posters related to the Member Grievance and Appeal Processes as well as other Member Materials. Electronic versions of all materials are available to print on the Optum Website> *Beneficiary* tab.
All of the following brochures and notices must be clearly displayed in all available threshold languages:

- Behavioral Health Plan (BHP) Member Handbook
- Current Provider Lists with instructions for accessing in all languages
- Current Limited English Proficiency Posters
- Current Notice of Privacy Practices
- Current Problem Resolution Process brochures (locatable without requiring consumer to request from staff)
- Current Problem Resolution Process posters (with fair hearing process)
- Current grievance/appeal forms with self-addressed, stamped envelopes available (without requiring a consumer to request them from staff)
- Open Payments Database Notice- included on provider/legal entity's website (if applicable).
- Physician Notice to Patients from the Medical Board of California (with QR Code)
- California Board of Psychology Consumer Statement
- BBS Notice Display of License/Registration Notice to Consumers (SB 1024)
- BBS Notice- Updated Requirement to Provide Notice to Psychotherapy Clients (Notice to Clients- AB 630)
- Human Trafficking Model Notice (For facilities that provide pediatric care)
    - More information on this notice can be located on the Optum Website and/or the DOJ Website

Operational Procedures
Providers shall develop and maintain written Operational Procedures in accordance with current State of California Standards and the most current and appropriate HHSA requirements. The written procedures shall be submitted to the COR upon request. The written procedures and all updates shall be provided to all employees charging staff hours to a County contract. Changes to a program's functions require a written change to the Operational Procedures. Providers may prepare additional written procedures not in conflict with the contract.

Program Advisory Group (PAG)
Contractor shall conduct a PAG a minimum of two (2) times per year to advise Contractor on program design, practice, and policies. The PAG membership shall consist of at least six (6) members, at least fifty

percent (50%) of whom shall be members or families served by the program and shall reflect the ages and cultures of the member population.

- Meeting minutes and action items based on PAG input shall be reported to the Contracting Officer's Representative (COR) or designee in the program status report.

Alcohol and Drug Free Environment
Programs shall provide an alcohol and drug-free environment, and all participants shall be alcohol and drug free while participating in program activities.

Recognizing that substance use disorders for many is a chronic, relapsing disease, the program shall make every effort to retain members in treatment and shall have written policies regarding appropriate supports to the member during a relapse episode. In using a harm reduction model, providers shall incorporate strategies that are not limited to abstinence but include safer use and managed use. Addressing relapse is a necessary part of the treatment/recovery process and presents an opportunity to re-engage and re-assess levels of care and motivation to change. Policies relating to relapse shall be consistent with the alcohol and drug-free environment of the program.

Members may be discharged if they engage in illegal activities or activities listed under Title 9 that compromise their safety or the safety of others, such as possessing, selling, or sharing alcohol or other drugs on-site at a program facility.

Trauma Informed Facilities
Environments that are trauma and developmentally appropriate have been shown to be beneficial to individuals seeking services. Welcoming all members upon arrival by their first name is the best practice as it can empower the individual and honor who they are as people not just as members. Contractor shall provide facilities that are in accordance with best practices described by resources such as:

- Creating Trauma- Informed Services: Tip Sheet Series- Tips for Creating a Welcoming Environment
- Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment

Communicable Disease Information, Education, and Prevention
Providers shall provide information, education and prevention services on the following communicable diseases for each individual admitted to the program: Human Immunodeficiency Virus (HIV), Hepatitis C (HCV), Tuberculosis (TB) and Sexually Transmitted Infection (STI) also known as STD.

Cooperation with Other Agencies
Providers shall cooperate with other agencies and allow presentations to program members, especially those who are at high risk or who are positive for any of the disease referenced above. Providers shall cooperate with on-site and off-site interventions, medical evaluation, laboratory testing, care coordination, and pharmaceutical therapy programs that assist participants in preserving their immune system function.

Staff Training on Communicable Diseases
Providers shall ensure that all employees and volunteers receive training in the diseases referenced above, methods of preventing transmission, confidentiality requirements, and available communicable disease-

related resources that are appropriate referrals to supportive services. All training shall be documented in each personnel file.

Liaison
Providers shall designate a minimum of one staff person to serve as a liaison between the program site, the program's community and BHS on issues related to communicable disease services. The designated staff person shall attend regularly scheduled BHS and providers facilitated meetings and shall provide staff communicable disease training and update sessions at least once every six months. Providers with multiple programs shall designate additional staff to serve in the liaison role.

HIV/HCV Services
Providers shall provide Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) information and referral services for each individual admitted into the program. Providers can refer a member to Public Health Services for testing, if needed.

TB Control
Providers must ensure that tuberculosis (TB) screening, testing and any appropriate follow up actions are completed in accordance with the applicable facility licensing requirements, including any required timeframes. Providers shall document this information in the member file and may opt to use an internal program form or the TB Screening Questionnaire in the SUDURM.

Emergency Critical Services
The County of San Diego, Behavioral Health Services, has identified, at a minimum, residential contracts as Emergency Critical. If designated and informed by the COR, providers must identify the primary program contact for emergency/disaster communication and any succession of authority should the primary contact be unavailable. Emergency/disaster contacts must be made known to the COR within 15 days of start or annual renewal of the contract, or whenever there is a change in contact person.

If the need to evacuate the primary service site arises, residential program providers must have arrangements for either an alternate site to house program participants, or a plan to discharge members back to their own homes. The alternate site or plan to discharge to home must be made known to the COR within 15 days of start or annual renewal of contract.

DHCS requires all DMC certified providers to report emergencies to DHCSDMCRecert@dhcs.ca.gov that result in displacement of a DMC certified facility to avoid interruption of or inability to continue billing for DMC services. DHCS will request the following: nature of the emergency including when and where it happened; location of temporary location; what services were provided prior to the emergency and if services will differ at the temporary location; and projected timelines of the temporary site. See DHCS Info Notice 20-055 for additional information on disaster management at DHCS Licensed or Certified Behavioral Health Facilities.

Disaster Preparedness
Providers shall contact their COR if there is an evacuation or relocation of services during the provision of services. COR must grant approval for any discontinuation of services. Funding sources specify that funding can only be claimed for services in support of contracted activities. Redirection of staff to other non-evacuation/emergency activities during an emergency/disaster may cause their time to be non-reimbursable, depending on funding availability and regulations. Note that discontinuation of outpatient

services shall, in cost reimbursement programs, result in staffing and other service costs being ineligible for reimbursement during the period of program closure. Fixed price and pay for performance contracts may also be reduced if pay points are not achieved or deliverables are interrupted.

Local Emergencies

In the event that a local health emergency or local emergency is declared, or when the State or federal government has declared an emergency that includes areas within the County of San Diego, the prompt and effective utilization of contractor resources essential to the safety, care and welfare of the public shall occur at the direction of the County, to the extent possible. Contractors shall provide assistance in the prevention of, response to, and recovery from, any public health emergency, as applicable. Contractors' staff shall be available upon request from BHS to assist in any necessary tasks during a public health disaster or County emergency state of alert. Providers shall work with the County to initiate processes and develop and implement plans, guidelines and procedures as required. As relevant, contractors shall also refer to the disaster preparedness and disaster response language outlined in this section.

Disaster Response

In the event that a local, state or federal emergency is proclaimed within San Diego County, programs shall cooperate with the County in the implementation of a Behavioral Health Services response plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters, and/or other designated areas.

Programs shall provide BHS with a roster of key administrative personnel's after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.

Programs shall identify 25% of direct service staff to prepare for and deploy (if needed and available) to a critical incident. These staff shall participate in County provided Disaster Training (or other approved training) and provide personal contact information to be included in the Disaster Personnel Roster maintained by the County. COSDBHS Disaster Training is available through the BHS Workforce Training and Technical Assistance website. Programs shall advise COR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover. Programs shall maintain 25% staff deployment capability at all times.

Naloxone in Licensed Alcohol and Other Drug (AOD) Residential Treatment Programs and Certified AOD Outpatient Programs

Naloxone is a life-saving medication that works to reverse an opioid overdose while having little to no effects on an individual if opioids are not present in their system. Naloxone blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a member is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.

As stated in DHCS Information Notice 19-009 effective March 5, 2019, licensed residential treatment programs and certified outpatient AOD treatment programs are permitted to utilize Naloxone at their program site. All forms of Naloxone are allowed at the program. If a program chooses to provide Naloxone, all forms of the medication shall be recorded, stored, and destroyed in the same manner as prescription medications. It is the responsibility of the program to develop policies, procedures, and protocols for how the program will store the medication, and accurately document the administration and disposal of

Naloxone. The staff person who administers Naloxone must have successfully completed Naloxone administration training and the training must be documented in their individual personnel file.

In addition to the State's requirements per DHCS Information Notice 19-009, it is expected that SUD outpatient, residential, and OTP providers have the necessary minimum number of naloxone kits in their facility for emergency purposes. 100% of staff should be trained in administering naloxone and at least 1 staff person who is trained to administer naloxone be on site during business hours.

Programs Serving Children, Youth & Families Program Requirements

Smoking Prohibition Requirement
Providers shall comply, and require that subcontractors comply, with Public Law 103-227, also known as the Pro-Children Act of 1994, which requires that smoking is not permitted in any portion of any indoor facility owned, leased, or contracted for or by an entity and used to provide services to children under the age of 18.

Transportation of Minors
Minors shall always be escorted when being transported by any non-public, private, or commercial transportation service including but not limited to taxi and rideshare services.

Public Contact
Providers shall have sufficient staff with adequate knowledge, skills and ability available during operating hours specified in their contracts to ensure that all persons who contact the program in person or by phone during operating hours are quickly and appropriately served with information or a referral to appropriate services.

Linkages with Support Services Organizations
SUD programs shall initiate linkage agreements, which may include a Memoranda of Understanding (MOU), and establish procedures that will ensure strong, reliable linkages with other community service providers, and service organizations for member support. These MOUs and linkages shall be designed to integrate, coordinate, and access necessary support services within the community to ensure successful member treatment and recovery. These efforts shall help achieve Federal, State and County goals to integrate services, prevent relapse by using community support services, reduce fragmentation of care, and establish better communication and collaboration at all levels, but particularly among local providers and agencies who work with this target population.

Promotional Materials and Advertising Requirements
All promotional materials for BHS-funded programs shall include the BHS logo, defined as the circular County of San Diego logo with "Behavioral Health Services" written underneath. The BHS logo should no longer be paired alongside the Live Well San Diego logo. Promotional materials shall be provided to COR for review before distribution and are subject to COR approval. For initiatives involving multiple County groups, it is allowable to use the circular County logo without "Behavioral Health Services" written underneath. Promotional materials shall include but not be limited to electronic and printed materials such as brochures, flyers, and other materials.
As described in BHIN 22-022, limits related to advertising and marketing material for SUD services and programs have been established by SB 434 - Health and Safety Code (HSC) § 11831.9. This was further

amended by SB1165, as described in BHIN 23-007. Per Section 11831.9, licensed SUD recovery or treatment facilities and certified alcohol or other drug programs, shall not do any of the following:

1. Make a false or misleading statement or provide false or misleading information about the entity's products, goods, services, or geographical locations in its marketing, advertising materials, or media, or on its internet website or on a third-party internet website.
2. Make a false or misleading statement or provide false or misleading information about medical treatments or medical services offered in its marketing, advertising materials, or media, or on its internet website, on a third-party internet website, or in its social media presence.
3. Include on its internet website a picture, description, staff information, or the location of an entity, along with false contact information that surreptitiously directs the reader to a business that does not have a contract with the entity.
4. Include on its internet website false information or an electronic link that provides false information or surreptitiously directs the reader to another internet website.

BHIN 23-007 further clarified that these four requirements were mirrored in W&I code Division 4, Part 1, Chapter 4, Section 4097 to also address licensed psychiatric or mental health facilities, including psychiatric health facilities and mental health rehabilitation centers.

Allegations of violations of Section 11831.9 may be investigated by DHCS. Upon finding a violation of this section or related regulations, sanctions may be imposed by DHCS, as described in HSC Section 11831.7. In addition, DHCS may also investigate allegations of violations of W&I Section 4097 c, and may impose sanctions described in W&I Sections 4080 and 5675.1.

Trafficking Victims Protection Act of 2000

The purpose of this Protection Act is to combat trafficking in persons, a contemporary manifestation of slavery whose victims are predominately women and children, to ensure just and effective punishment of traffickers, and to protect their victims. Trafficking in persons is a modern form of slavery, and it is the largest manifestation of slavery today. Trafficking in persons is not limited to the sex industry, but also includes forced labor and involves significant violations of labor, public health, and human rights standards worldwide.

Providers shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). This amendment states that SUD providers and their employees may not engage in severe forms of trafficking in persons, procure a commercial sex act, or use forced labor in the performance of the contract. If any of these violations occur, then the contract and/or funding may be terminated. SUD providers are to have policies and procedures in place to ensure that all SUD provider staff are aware of these requirements and to ensure full compliance with the terms of the statutory requirement. For full text of the award term, see 42 CFR Part 175.

AB 1740 amends Section 52.6 of the Civil Code relating to human trafficking to additionally require a notice, as developed by the Department of Justice, that contains information relating to slavery and human trafficking, including information regarding specified nonprofit organizations that a person can call for services or support in the elimination of slavery and human trafficking be posted by facilities that provide pediatric care, as defined in W&I Code Section 16907.5

- "Pediatric services" means all medical services rendered by any licensed physician to persons from birth to 21 years of age.

- Post a notice that complies with the requirements of this section in a conspicuous place near the public entrance of the establishment or in another conspicuous location in clear view of the public and employees where similar notices are customarily posted.
- The notice to be posted shall be at least 81/2 inches by 11 inches in size, written in a 16-point font.
- The notice to be posted shall be posted in English, Spanish, and in one other language that is the most widely spoken language in the county (per MHPS, post in the threshold language most prevalent within program's community)

The Human Trafficking Model Notice is available for download from the Department of Justice website in English, Spanish, Dual English/Spanish and 22 additional languages from their Human Trafficking Model Notice page: https://oag.ca.gov/human-trafficking/model-notice.

National Voter Registration Act (NVRA)
Per the National Voter Registration Act of 1993, providers are required to offer voter registration materials at intake (except in a crisis situation), at renewal and anytime a change of address is reported. A NVRA Voter Preference Form shall be included in all intake/admission packets. This form is available in English and 9 other languages, including the required languages of Spanish, Chinese, Vietnamese, and Tagalog at http://www.sos.ca.gov/elections/voter-registration/nvra/training/voter-preference-forms/.

When a member requests a form in a language other than those available, staff shall provide the member with the Secretary of State's toll-free number: 1-800-345-VOTE. If a member reports a preference to register to vote, then they are to be provided with a paper voter registration form or be assisted with completing the registration form online (http://registertovote.ca.gov/)Voter registration forms are available for free from the Registrar of Voters and must be onsite at the program in English, Spanish, Chinese, Vietnamese, and Tagalog. The same level of assistance shall be provided to members registering to vote as is provided for completing other forms for SUD services. For youth programs, voter registration services shall be offered to parents/guardians of members less than 18 years of age; pre-registration is available for eligible 16- and 17-year-olds.

Training on the legal requirements and County expectations under this Act is required to be taken by provider staff annually. The NVRA training is available on the HHSA BHS webpage. Failure to implement the NVRA may subject the agency to legal liability. If you have additional questions about this requirement, please contact your Contracting Officer Representative (COR) and/or review chapter 4 from the California NVRA Manual.

K. MANAGEMENT INFORMATION SYSTEMS (MIS)

Technology Requirements

Providers shall maintain technology that facilitates the collection, maintenance, and reporting of data necessary to comply with the County of San Diego and California Department of Health Care Services data requirements. Provider's computer-based data collection, maintenance, and reporting systems shall comply with current County and State standards. For more information regarding SmartCare technology requirements, go to HardwareSoftwareRequirements_Mar2024.pdf at the Optum website.

Providers shall have at least one computer with internet access. Treatment data shall be entered electronically into SmartCare; DATAR data shall be entered into DATARWeb; other required reports and forms shall be submitted electronically to the MIS Support Desk.

All providers shall be capable of transmitting and receiving information through email. Communications to the provider regarding compliance issues, system related issues, and requirements are sent through email from the MIS unit. Providers need to maintain an email address and shall notify the COR or COR's designee and the MIS unit of any change in email addresses within two business days of the effective date of the change. The MIS unit can be notified of email updates by sending an email to **BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov**.

All electronic provider files containing DHCS PHI or PI and stored on removable media or portable devices shall be encrypted with a FIPS 140-2 certified algorithm.

Electronic Health Records

DHCS requires that programs utilizing an Electronic Health Record (EHR) have the following available to DHCS staff during an audit, licensing, or certification review:

- Physical access to the EHR system
- Adequate computer access to the EHR needed for the audit or review
- Access to printers and capability to print necessary documents
- Technical assistance as requested
- Scanned documents, if needed, that are readable and complete

Additionally, DHCS requires programs using an EHR to obtain a signed "Electronic Signature Agreement" from all users who will be signing financial, program or medical records with an electronic signature. This agreement should include, among other things, that the signer has an obligation to protect their electronic signature (id/password), to keep their sign-in information secret and to not share the information, and to notify appropriate program staff if it is stolen, lost, compromised, unaccounted for, or destroyed.

Programs should contact their County BHS COR to notify them if they are planning to implement an EHR as BHS is required to certify that the system used meets DHCS standards. For more information, see ADP Bulletin 10-01 and its exhibits. Programs shall have all SUDURM forms created for the EHR approved by SUDQA. Programs shall have internal policies and procedures in place for EHR use, to include how to handle members documentation when a system outage occurs or the EHR is unavailable.

AI-Assisted Documentation and Audio Processing in SmartCare

Artificial Intelligence (AI) tools integrated with SmartCare may be used to support clinical documentation workflows. These tools may assist with transcription, summarization, compliance guidance, or drafting of clinical documentation.

Some AI-assisted documentation tools may process audio from clinical encounters to generate transcripts or documentation summaries. Audio processing may occur through secure systems integrated with SmartCare and approved by the County.

AI-assisted documentation tools are intended to support Direct Service Provider documentation and workflow efficiency. These tools do not replace clinical judgment or the responsibility of the Direct Service Provider to ensure accuracy and compliance with Medi-Cal and County documentation requirements.

For purposes of this guidance, **Eleos** is the AI-assisted documentation tool currently approved by BHS and integrated with SmartCare.

Use of Eleos is governed by Behavioral Health Services (BHS) policies and County requirements related to artificial intelligence, privacy, and data security. Use of Eleos shall comply with County of San Diego Board Policy A-140 (Artificial Intelligence) and any applicable contractual requirements.

Eleos-generated documentation is considered draft content and must be reviewed, edited as necessary, and approved by the Direct Service Provider before it is finalized in the medical record.

Direct Service Providers remain responsible for ensuring that documentation:

- Accurately reflects services delivered
- Supports medical necessity when applicable
- Complies with Medi-Cal documentation requirements

Eleos use is intended to support documentation workflows but may not always be available. Direct Service Providers remain responsible for completing timely documentation in SmartCare in accordance with Medi-Cal and County documentation requirements when Eleos is unavailable.

Eleos may not be used to generate documentation for services that were not provided or otherwise misrepresent clinical services rendered.

1. **Direct Service Provider Responsibilities.** When Eleos is used:
    a. The Direct Service Provider shall review all Eleos documentation.
    b. The Direct Service Provider shall edit or correct documentation as necessary to ensure the content accurately reflects the service delivered.
    c. The Direct Service Provider shall approve the final documentation before submitting the note in SmartCare.
    d. The Direct Service Provider remains the author of the finalized clinical documentation.
2. **Audio Processing During Clinical Encounters.**
    a. When Eleos is used during clinical encounters:
        i. Direct Service Providers should inform the Client that AI-assisted technology is being used to support documentation during the encounter.
        ii. Consent must be obtained and documented in the clinical record prior to the use of Eleos.
        iii. Direct Service Providers should confirm consent with Clients at the beginning of each session for Eleos to be used. This verbal consent at the beginning of each session shall be documented.
        iv. If a Client withdraws consent, Eleos shall no longer be used.
        v. For group services, Eleos may only be used if all participating Clients have provided consent. If any participant declines or withdraws consent, Eleos shall not be used for that group session.

vi. The client may ask questions about the technology used during documentation.
vii. Audio processing may occur for the purpose of generating a transcript or documentation summary.
viii. Audio processed by Eleos is handled in accordance with County privacy, security, and data governance policies.
ix. Direct Service Providers must ensure that client information is processed only through County-approved systems integrated with SmartCare.
x. Audio retention and deletion practices are governed by the approved system configuration and applicable County requirements.

b. Direct Service Providers shall not use external or non-approved recording or transcription tools to document clinical encounters. This includes publicly available, consumer-facing, or non-secure Artificial Intelligence tools or platforms.

3. Use of AI Documentation Suggestions

a. Eleos may generate documentation suggestions, prompts, or compliance alerts. Direct Service Providers may:
   i. Accept suggested documentation.
   ii. Modify suggested documentation.
   iii. Override suggested documentation when the suggestion does not accurately reflect the service delivered.
b. Direct Service Providers must exercise professional judgment when determining whether Eleos-generated content should be included in the clinical record.
c. Direct Service Providers must apply clinical judgment and/or consult with a clinical supervisor before making decisions that impact the type or amount of care provided if and/or when Eleos content is used to support clinical decision-making.
d. Eleos-generated content may not replace required clinical supervision, assessment, or clinical decision making.

4. Documentation Requirements

a. Documentation created with Eleos must:
   i. Accurately reflect services delivered during the encounter.
   ii. Comply with Medi-Cal and County documentation requirements.
   iii. Support medical necessity where applicable.
b. Eleos-generated documentation must be reviewed and edited as needed before it is finalized in the medical record.

5. Privacy and Confidentiality

a. Use of Eleos must comply with all applicable privacy and confidentiality requirements, including:
   i. HIPAA
   ii. 42 CFR Part 2
b. Client information may only be processed through County-approved AI systems integrated with SmartCare, unless otherwise authorized by BHS.
c. Direct Service Providers shall not enter client information into external or non-approved AI tools without prior written approval from BHS. This includes generative AI platforms, transcription services, publicly available AI platforms, or other AI-enabled tools that are not approved by the County.
d. Direct Service Providers seeking to use AI tools that are not integrated with SmartCare must submit a request to BHS at QIMatters.BHS@sdcounty.ca.gov prior to implementation. BHS will review the request and, as applicable, coordinate with DHCS to determine whether the proposed AI tool is permissible. Direct Service Providers must not use such AI tools until approval is confirmed by BHS.

6. **Training**
    a. Direct Service Providers authorized to use Eleos must complete required training prior to using the system. Training includes:
        i. Appropriate use of Eleos.
        ii. Review and editing of Eleos-generated documentation.
        iii. Medi-Cal documentation expectations.
        iv. Privacy and confidentiality protections.
        v. Client notification and consent requirements related to Eleos.
        vi. Any County-required AI-related training.
7. **Contracted Organization (Legal Entity) AI Policy Requirement**
    a. Contracted Organizations must develop, implement, and maintain organizational policies and procedures (P&P) governing the use of Eleos that aligns with County Board Policy A-140, the BHS AI Policy, this guidance, applicable laws and regulations, and other applicable BHS requirements.
    b. Prior to receiving access to Eleos, Contracted Organizations must provide confirmation, in a form specified by BHS, that the required organizational AI policies and procedures have been developed and implemented and will be made available to BHS upon request. Confirmation may be required from Legal Entity leadership, Program Managers, or other authorized organizational representatives.
    c. At a minimum, the Organization's Eleos-related P&P should address:
        i. **Governance and Oversight** Identification of responsible roles for AI use within the organization and processes to ensure alignment with County Board Policy A-140, the OPOH/SUDPOH, and other applicable County and BHS requirements. P&P should address internal oversight, risk mitigation, staff accountability, and processes for responding to concerns related to AI use.
        ii. **Human Oversight and Accountability.** Requirements that Eleos-generated outputs are reviewed, edited as necessary, and approved by the direct service provider, and that the direct service provider remains responsible for the accuracy and completeness of all finalized documentation. Eleos may not replace clinical judgment or required supervision.
        iii. **Privacy and Data Protection.** Safeguards to ensure compliance with applicable privacy and confidentiality laws (e.g., HIPAA, 42 CFR Part 2), as well as County and BHS data protection requirements, including use of only County-approved or otherwise authorized systems.
        iv. **Client Communication and Education.** P&P should address how clients will be informed about Eleos, including use of approved educational materials, responses to common client questions, and communication regarding client rights and available alternatives.
        v. **Client Notification and Consent.** Processes for informing clients when Eleos is used in care, including how notification and consent are obtained and documented consistent with County and BHS requirements. P&P should address:
            - notification that AI-assisted technology is being used;
            - documentation of consent consistent with County requirements;
            - client right to decline participation;
            - obtaining and documenting consent prior to the use of AI-assisted documentation tools;
            - ongoing notification of AI-assisted technology prior to every use;
            - reminding clients of their right to withdraw consent at any time;

- procedures for continuing services when a client declines use of AI-assisted tools.

vi. **Appropriate and Prohibited Uses.** Clear expectations regarding permissible uses of Eleos, including the prohibition of use to generate documentation for services not provided or to otherwise misrepresent services. P&P should also prohibit the use of non-approved AI tools, unauthorized recording or transcription applications, and the entry of client information into systems not approved by the County or BHS.

vii. **Staff Training.** Requirements for staff training on appropriate AI use, including responsibilities for review, editing, and compliance with documentation, privacy, and consent-related expectations, as well as completion of all vendor-related training (e.g., Eleos-provided or CalMHSA-provided), County-required AI-related training, and any other training required for the authorized use of AI-assisted tools. Training should address:

- appropriate use of AI-assisted tools;
- review and editing of AI-generated content;
- privacy and confidentiality requirements;
- client notification and consent requirements;
- documentation standards and accountability.

viii. **Monitoring and Compliance.** Processes for monitoring AI use within the organization to support documentation quality, compliance, staff training, and adherence to County and BHS requirements. Monitoring activities should support quality improvement, compliance oversight, staff training, workflow optimization, risk mitigation, and adherence to County and BHS requirements and should not be used for routine employee surveillance.

ix. **Documentation Standards and Accountability.** Requirements that Eleos-generated content be treated as draft content until reviewed, edited as necessary, and finalized by the direct service provider. P&P should clearly state that Eleos does not replace clinical judgment and that staff remain responsible for the accuracy, completeness, and compliance of finalized documentation.

x. **Approved Technology Use.** P&P should prohibit the use of non-approved AI-assisted documentation tools, recording applications, or transcription services for County-funded services unless expressly authorized by BHS.

d. Contracted Organizations must maintain documentation of their AI policy and make it available to BHS upon request.

e. Contracted Organizations must maintain documentation of staff training and any internal monitoring practices related to use of Eleos and make such documentation available to BHS upon request.

8. Quality Oversight

a. BHS may review documentation created using Eleos as part of routine quality assurance and compliance monitoring activities.

b. Monitoring may include:

i. Documentation audits
ii. Review of documentation quality trends
iii. Analysis of system-generated compliance alerts and related documentation trends
iv. Review of findings from DHCS audits or External Quality Review (EQR).

c. Monitoring activities are intended to support quality improvement, compliance oversight, training, workflow optimization, and program evaluation and are not intended for routine employee surveillance.

d. Direct Service Providers may receive feedback or additional training based on monitoring findings.
e. The County reserves the right to review, monitor, and require modification or discontinuation of Eleos use if compliance, privacy, or documentation risks are identified.

SmartCare

A semi-statewide electronic health record (EHR) offered through California Mental Health Authority (CalMHSA) has replaced SanWITS as the EHR for SUD system of care (SOC). SmartCare was designed specifically for California's behavioral health systems and meets all state reporting and billing requirements for CalAIM payment reform. It meets 42 CFR Part 2 privacy requirements and includes a robust consent management tool. SmartCare provides more efficient and streamlined workflows that satisfy CalAIM requirements.

In SmartCare, contracted treatment providers are set up by programs within a secure treatment site Clinical Data Access Group (CDAG) to ensure users have access to only the information they need to fulfill their job functions.

While the County is working toward interoperability with other systems, providers with their own EHR will need processes to accommodate dual entry of specific client data, state reporting, and billing.

Trainings

- The CalMHSA's LMS trainings found here https://moodle.calmhsalearns.org/login/index.php are mandatory for all SmartCare users prior to receiving access to SmartCare.
- SmartCare users will also be able to schedule supplemental trainings online as applicable to their job functions.
- The SmartCare ARF can be found on regpack and should be submitted to BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov
  SmartCare Resources:
- For any system-related issues, please reach out to CalMHSA. SmartCare Helpdesk Support Information
- For trouble accessing the system, please send your email to BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov

For questions related to documentation, guidelines, or policy, please send your email to QIMatters.BHS@sdcounty.ca.gov

- .
- If you would like to request a program or system change, or for deletions, please send your email to BHS_EHRSupport.HHSA@sdcounty.ca.gov

Electronic Health Record Trainings

- All users will be required to complete SmartCare Trainings on the CalMHSA LMS Module based on staff role. Additional resources and registration for supplemental trainings can be found on the OPTUM website, along with the CalMHSA Knowledge Base to assist with workflow and documentation questions. For residential, crisis residential, and crisis stabilization unit users, live in-person training is required for access to SmartCare, also provided by Optum. See the Optum

SmartCare Training webpage for training dates and registration. For questions, contact sdu_sdtraining@optum.com.

- Please refer to the SmartCare Help Desk Support Hubspot for more information.

Member Requests for Amendment and Member Requests for Accounting of Disclosure

- When a Program receives a request to amend electronic health records and believes amendments need to be made the program should contact the SDCBHSM IS team at BHS_EHRSupport.HHSA@sdcounty.ca.gov and the Agency Compliance Office at 619-338-2808 or privacyofficer.hhsa@sdcounty.ca.gov, to provide Program assistance as needed.

When a program receives a request to amend records within their internal electronic health records, the program should work with their Compliance Officer and follow internal policies and procedures in alignment with related regulations. Member Requests for Accounting of Disclosure.

When a Program receives a request for an accounting of disclosures of electronic health records, the program should follow their internal policy and procedures established for release of information (ROI). The legacy system - SanWITS will still be used for all services and state reporting dated prior to September 1, 2024, as well as any corrections for billing or state reporting as needed.

L. DATA COLLECTION & RETENTION

Providers shall maintain daily records of services provided, including dates of service, times of service, total time of service, types of services provided, persons served, and progress of members in meeting the objectives of the case plan. Data shall be recorded in accordance with the specifications in the SmartCare and CalOMS manuals. Service entry shall be kept up to date, and the data shall be entered into the SmartCare data entry systems within a timely manner.

Data Entry Standards

Data entry standards are required in order to decrease variance in provider operations within the DMC-ODS, and to create effective monitoring and billing processes.

In Accordance with **BHIN 24-020,** Behavioral Health Plans (BHPs) are required to have a system in place for tracking and measuring timeliness of care. To align with the Department of Health Care Services (DHCS) documentation requirements **recorded inquiries** should be documented within three (3) business days of the request for services in the electronic health record, with the exception of emergent or urgent type which shall be completed within one (1) calendar day.

Please refer to embedded links for step-by-step guide on documenting timely access to NTPs, How to Complete the DMC Opioid Timeliness Record - 2023 CalMHSA, Outpatient, and Residential treatment How to Complete the DMC Outpatient and Residential Timeliness Record - 2023 CalMHSA.

Accuracy of Data

Providers are responsible for ensuring that all member information is accurate including addresses and all demographic data that is required for State reporting for CalOMS. Providers must have processes in place for checking/updating member data and making the necessary corrections.

CalOMS Tx

CalOMS Treatment (CalOMS Tx) is California's data collection and reporting system for substance use disorder (SUD) treatment services. All certified facilities are required to adhere to mandated reporting by DHCS. "Any Provider that receives any public funding for SUD treatment services and all Opioid Treatment Program (OTP) Providers must report CalOMS Treatment data for all of their consumers receiving treatment, whether those individual consumer services are funded by public funds or not. Providers will collect consumer data at admission and at discharge or administrative discharge from the same treatment program. Data will also be collected annually as an annual update for consumers in treatment for over twelve (12) months" (CalOMS Treatment Data Dictionary, 2018).

Discharge Data in CalOms

BHIN 25-001 (BHIN 25-001 Update to Protocols for Collecting and Reporting Discharge Data in California Outcomes Measurement System Treatment): updates protocols and definitions for discharging members for the following standard discharge values:

- Completed Treatment Plan & Goals – Referred/Standard (status 1)
- Completed Treatment Plan & Goals – Not Referred/Standard (status 2)
- Left Before Completion with Satisfactory Progress – Referred/Standard (status 3)

In addition, DHCS is updating the timeframe when an administrative discharge can occur for non-residential outpatient programs. These updates to discharge protocols align with current trends in SUD treatment, improve the collection of Treatment Episode Data Sets1, and are in line with the American Society of Addiction Medicine (ASAM) 4th Edition, Dimension 62 for person centered considerations. This BHIN does not update existing treatment planning3 or discharge planning4 protocols

Demographic Data in CalOMS

BHIN 24-030 - 2024 California Outcomes Measurement System Treatment (CalOMS Tx) Update to Demographic Reporting Requirements. Refer to the CalOMS Tx Data Collection Guide and Data Dictionary for a complete list of demographic reporting data values/formats and meanings.

DHCS has established data standards intended to provide direct providers with clear direction on submitting complete and accurate CalOMS Tx data in a timely manner. Compliance with these data standards is required for DHCS to more effectively achieve CalOMS treatment data collection and outcome measures and objectives:

- Timeliness of Data
- Completeness of Data
- Accuracy of Data

It is a State requirement for all facilities to submit member data monthly. Best practice is to enter member data as soon as it is obtained. See Appendix L.1 for the BHS CalOMS process.

Currently DHCS offers a comprehensive training through their website. This is only accessible via user login. Users interested in this training must contact the sudehrsupport.hhsa@sdcounty.ca.gov for assistance.

CalOMS Resources:

- The CalOMS Data Collection Guide can be accessed by authorized CalOMS users at: Behavioral Health Information Systems
- CalOMS Tx Data Collection Guide Section 8 Discharge Data Collection Excerpt
- CalOMS_Tx_Data_Collection_Guide_JAN 2014
- Data Compliance Standards V3 Jan 2025
- CalOMS Tx Data Dictionary_Oct 2024.pdfThe Data Management Services Section (DMSS) has its own CalOMS Tx web page on the ADP web site that is loaded with information and helpful resources

Member Address and Demographics. Programs are required to complete the member's address and other necessary information on the Member Information screen. If the necessary fields are not filled out properly, a charge error can occur, and the County billing team may not be able to batch, and bill claims to Medi-Cal. To avoid or fix the issue, go to the Member Information screen, and click on the General tab. Then, click the Details button to enter the address. On the Demographics tab, the member's ethnicity, gender identity, sexual orientation, and race should also be completed; otherwise, the red asterisk will appear and you will not be able to click save and move to the next step

Reporting Non-CalOMS Data

Providers shall enter various non-CalOMS data into the electronic health record to comply with County Substance Use Disorders Services data system requirements. This data includes information for special populations as well as no-show encounters.

Billing

- SUD programs should continue to review the CoSD Service Error report and clear service errors, with the top priority being on older months of service so we can meet the timely billing to Medi-Cal.
- For services with "financial information has not been completed for this member," error, it means that the member does not have an active or available plan (coverage) for the specified service date you are trying to bill. When reviewing this type of service error, it is recommended to run the CoSD Client Insurance and Date Span report. By using this report, you can determine the coverage plan and payer order that the member has available in SmartCare.
- SUD programs are required to review the CoSD Client Insurance and Date Plan Span report to assist you in determining whether the Client Plan Request form you submitted to the ADS Billing Unit has been processed or added to the member's coverage. If you have any questions or need further assistance, please reach out to **SUDBillingUnit.BHS@sdcounty.ca.gov**mailto: immediately.
- **Client Plan Request Form:** Program must submit the SmartCare Member Plan Request form to the ADS Billing Unit for members who are listed on the CoSD Service Error repot with missing financial information, for members with other plans other than Medi-Cal or plans that need to be corrected or modified by the SUD billing team in SmartCare.
- Please use this format to name and save your file when submitting the SUD Member Plan Request form: ***Program Name Initials-SmartCare Member ID-Type of Coverage*****.** Example: SDC-12345678-Medi-Cal or UPAC SAS-2000012X-County Billable.
- **Medi-Cal Retroactive Eligibility in SmartCare**

As of October 2026, a feature has been configured in SmartCare to update current and historical Medi-Cal coverage per the MMEF (Monthly MEDS Extract File). SmartCare will now update the Medi-Cal DMC (and Medi-Cal MH Coverage) Time Spans on the Client Plans screen based on a client's eligibility for the current month and the previous 12 months when a new MMEF provided by DHCS is imported into SmartCare by the BHS Billing Unit at the beginning of each month. The configuration process includes eligibility matching, Medi-Cal coverage updates in SmartCare, and a current and retroactive coverage timeline. Due to activating this feature in SmartCare, you might observe a decrease in the number of 9999 charges appearing in the CoSD Charges/Claims Report. If you are aware that the client has retroactive coverage, but it hasn't been captured in this configuration, such as beneficiaries with special aid codes only, please immediately contact the SUD billing unit for further investigation or assistance.

- **Medi-Cal Share of Cost or SOC:** The SUD programs are required to complete the Financial Responsibility and Medi-Cal SOC. If your member has a share of cost, please complete and submit this form to **SUDBillingUnit.BHS@sdcounty.ca.gov**.

- **Member Information:** Programs must enter the member address and other components on the Member Information screen. Failure to complete the required fields properly may result in a charge error and prevent the County billing team from batching and billing claims to Medi-Cal. On the General tab, please click the Details button to enter the address. On the Demographics tab, please complete the required fields such as the member's ethnicity, gender identity, sexual orientation, and race.
- **Members with dual coverage:** Non-NTP programs are required to bill OHC (Commercial Insurance or Medicare Part C). The NTPs are required to bill the Medicare Part B or Medicare Part C first if a member is Medi-Medi. SUD Billing Unit accepts any of the following documents from the primary insurance to enable us to bill the unpaid balance to Medi-Cal (secondary insurance or payer of last resort).
    1) Evidence of Coverage (EOC) indicating that the SUD service is "not covered". This document may be easier to obtain from the member than billing the insurance.
    2) Explanation of Benefits (EOB) or claim denial from the OHC/primary plan after billing the insurance. The EOB must contain denial or non-coverage of the SUD services.

Note: In case you receive partial or full payment for services on the primary plan, kindly send a copy of the EOB to the SUD Billing Unit. If partial payment is received, the unpaid balance will be billed to Medi-Cal by the SUD Billing Unit.

3) If you bill OHC/Medicare and have not received any response or proper EOB after 90 days of the billing date, please submit any acceptable documentation proving that your program has billed the OHC and received no response. Some of the acceptable forms of proof that all sources of payment have been exhausted are as follows: email confirmation from the insurance company, a copy of the claim form with the mailing stamp date, a reference number from a follow-up call, and others. If you receive payment or response from the primary insurance company after Medi-Cal is billed, please contact the **SUDBillingUnit.BHS@sdcounty.ca.gov** right away to determine if the Medi-Cal payment needs to be voided.
4) **Lockout services**. Programs should use the ODS-DMC Billing Manual and the Service Table for billing guidance to prevent any lockout or same-day billing errors or denials. The charge error 'This code creates a lockout situation' appears when the County SUD Billing Unit attempts to batch charges/claims for Medi-Cal billing. It means that SmartCare's automated charge validation has detected two procedure codes that are being billed, but they are locked out against each other. Examples: G0396 billed with another G0396 on the same day, G0396 billed with G0397, G0397 billed with another G0397, G0396 or G0397 billed with H0050 (Contingency Management) . Some lockout codes are not overridable, so the SUD Billing Unit will attempt to fix the charge error and bill the procedure with a higher rate to Medi-Cal. In the event that the lockout code can be overridden (based on the Service Table, column K), our team will manually conduct the override process in SmartCare, add the correct modifier, and bill both services to Medi-Cal.

Notes: The SUD BU cannot answer specific insurance billing questions as we are not contracted with any Commercial or Medicare Advantage Plan insurance companies. Programs should contact the insurance company directly with questions about coverage, procedure codes to use, and other OHC-specific matters. OHC billing rules or requirements may change. SUD providers will receive notification through the Information Notice, email, or UTTM.

For question specific to billing data correction assistance, contact the SUD Billing Unit at ADSBillingUnit.HHSA@sdcounty.ca.gov

DMC Billing Resources:

- Billing Unit Support Desk email ADSBillingUnit.HHSA@sdcounty.ca.gov

DMC-ODS Service Table 25-26 v. 06/2025	DMC-ODS-Service-Table-25-26 v. 06.2025.xlsx	6/2025	N/A
DMC-ODS Billing Manual SFY2025-26 version 3.0	DMC-ODS Billing Manual	7/2025	N/A
List of Changes 3.0 DMC Billing Manual	List of Changes 3.0 DMC Billing Manual (002).docx	N/A	N/A
DHCS DMC-ODS Aid Codes	SDMC Aid Code Chart_v.02.2023	5/2/2023	N/A
DHCS 100186 or Claim Submission Certification Form	DHCS_100186_Form.pdf	6/2014	DHCS_100186_Instructions.pdf

Additional Billing Guides:

Name	System Of Care	Link	Description	Revised Date	Superseded File
Guidelines on Completing the SmartCare Member Plan Request Form	MH/SUD	Guidelines on Completing the SmartCare Client Plan Request Form.pdf	N/A	9/10/2024	N/A
SmartCare Member Insurance Entry	MH/SUD	SmartCare Client Insurance Entry July2024.pdf	N/A	7/12/2024	N/A
SmartCare Member Plan Request - revised 03-25-2025	MH/SUD	SmartCare Client Plan Request - revised 03-25-2025	BHS Programs (MH and SUD) are required to complete this plan request form and submit it to the BHS Billing Unit	03-25-2025	N/A

			for members who have a primary health plan that needs to be added to their coverage plan in SmartCare.		
SmartCare Non-Billable Codes	MH/SUD	SmartCare Non Billable Codes 7.29.24.pdf	N/A	7/9/2024	N/A
Workflow Change for Perinatal Billing	SUD	Perinatal Billing Workflow Change.pdf	N/A	N/A	N/A

All items in the above table can be found on the Optum Website SMH & DMC-ODS Health Plans

Other Data Collection Requirements

DATAR

The Drug and Alcohol Treatment Access Report (DATAR) is the Department of Health Care Services (DHCS) system to collect data on treatment capacity and waitlists and is considered a supplement to the California Outcomes Measurement System (CalOMS) member reporting system. Federal regulations require that each state develop a Capacity Management Program to report alcohol and other drug programs treatment capacity, to ensure the maintenance of the reporting, and to make that information available to the programs. DATAR Web is an application developed by DHCS for that purpose. DATAR assists in identifying specific categories of individuals awaiting treatment and identifies available treatment facilities for these individuals.

DATAR has information on the program's capacity to provide different types of Substance Use Disorder (SUD) treatment to members, how much of the capacity was utilized that month, and monthly waitlists for priority populations. All SUD treatment providers that receive SUD treatment funding from DHCS are required to submit capacity information online at the DATAR Web site to DHCS each month. Per County regulations, this is due by the 7th of every month. In addition, certified Drug Medi-Cal providers and Licensed Narcotic Treatment Programs (NTP) must report whether or not they receive public funding.

- Perinatal **Capacity Management** and **Waiting List**, which states:
  - Providers must maintain a **capacity management system** to track and manage member flow.
  - When a provider cannot admit a pregnant or parenting woman due to insufficient capacity, they must provide **interim services within 48 hours** and refer to DHCS through its **DATAR capacity management program**.
  - Providers serving intravenous substance users must report to DATAR when they reach or exceed **90% of treatment capacity**, and submit monthly reports by the 10th of the following month

It is a State requirement for all facilities to submit statistics monthly. See Appendix L.2 for the monthly BHS DATAR Process.

Currently DHCS does not offer training for DATAR. See Appendix L.3 for the BHS DATAR tip sheet which defines DATAR reporting requirements.

For account creation, password reset, or general DATAR issues, contact the County's DATAR analyst at BHS_EHRSupport.HHSA@sdcounty.ca.gov

DATAR Resources:

- DATAR
- DATARWeb
- DATARWeb Manual

Additional Reporting for Capacity

A program's treatment capacity is the number of members that can be served at any point in time. Providers will no longer have to notify the COR and DHCS when programs are over 90% of their contracted capacity with 7 days via email at: DHCSPerinatal@dhcs.ca.gov

For outpatient capacity, unless otherwise approved by the COR and specified in the contractor's SOW, an outpatient program's treatment capacity uses the program's annual minimum admissions number as baseline. A 12-week average length of stay is applied to that baseline then divided by 52 weeks in a year for the program's point in time capacity.

CoSD Reports. Make sure to regularly review your program's CoSD Charges/Claims report, including any 9999 issues. When checking if the charge has been assigned to the correct payer, also check the reports on CoSD Member Insurance and Time Span to see the available coverage, effective date, and COB or payer order

Reporting Provider Changes

County Administration and DMC Certified Providers are responsible for maintaining accurate records with DHCS. As a provider, you are responsible for notifying the following County entities when provider changes occur:

- QA Support Desk
- Assigned program COR

Notify the following County entities by email when changes outlined below occur or for SmartCare:

- When the Provider applies for any new or additional services by location;
- If there is any change in status to its AOD or DMC certification status by the State;
- If there is any change in ownership or executive management;
- If there is any change in Medical Director or their DMC approved status.
- MIS is no longer monitoring BHS_EHRProject.HHSA@sdcounty.ca.gov.

- For any system-related issues, please reach out to CalMHSA.
- For trouble accessing the system, please send your email to BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov

For questions related to documentation, guidelines, or policy, please send your email to QIMatters.BHS@sdcounty.ca.gov

If you would like to request a program or system change, or for deletions, please send your email to BHS_EHRSupport.HHSA@sdcounty.ca.gov

Note: The SmartCare ARF can be found on regpack and should be submitted to BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov.

For assistance, please submit inquiries to the following:

- Program Support DATAR-CalOMS Help Desk: DATAR-CalOMSProgramSupport@dhcs.ca.gov
- CalOMS system issues: SUDCalOMSSupport@DHCS.ca.gov
- DATAR system issues: SUDDATARSupport@dhcs.ca.gov
- To designate or update CalOMS Tx or DATAR county approvers and/or vendors visit the Substance Use Disorder Services webpage and submit the CalOMS Tx 5261 form or DATAR 3300 Form to DATAR-CalOMSProgramSupport@dhcs.ca.gov
- Questions regarding Provider, CalOMS Tx, DATAR numbers, or to request the most current MPF Forms to add or update SUD provider information, please visit the Master Provider File webpage or email DHCSMPF@dhcs.ca.gov

M. BH-CONNECT

In 2025, the County of San Diego opted in to the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BHCONNECT), a statewide initiative developed by DHCS as part of California's Behavioral Health Transformation. BHCONNECT aims to strengthen and expand the behavioral health continuum of care for MediCal members with significant mental health and substance use needs by improving access, coordination, and -community-based supports.

The County began phased implementation in 2025, which includes Federal Financial Participation for Specialty Mental Health Services in Institutions for Mental Diseases, Enhanced Community Health Worker Services, and expanded or clarified MediCal coverage for several Evidence Based Practices (EBPs) including:

- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)
- Coordinated Specialty Care (CSC) for First Episode Psychosis
- Clubhouse Services
- Enhanced Community Health Worker (CHW) Services*
- Individual Placement and Support (IPS) Supported Employment*
- Children's EBPs such as Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and High-Fidelity Wraparound (HFW)
-

*Available in SMHS and DMC-ODS delivery systems

Fidelity Assessments & Medi-Cal Fidelity Designation for BH-CONNECT EBPs

When implemented in alignment with evidence-based models, BH-CONNECT EBPs consistently produce positive outcomes for individuals with significant behavioral health needs. Maintaining fidelity through scheduled assessments is a core requirement for each contracted EBP to ensure services are delivered as intended and to identify areas for improvement. To support this effort, DHCS has engaged Centers of Excellence (COEs) to provide counties and behavioral health providers with no-cost training, technical assistance, and fidelity monitoring or accreditation support. COEs will conduct fidelity assessments at regular intervals for each EBP. BHS contractors are required to work within their contract scope of work and involve their COR in all conversations with the designated COE and EBP conversations.

Additional information is available on the DHCS COE website.

Claiming and Medi-Cal Payment for BH-CONNECT EBPs

Providers must adhere to DHCS guidance, including fidelity, documentation, and reporting standards, and maintain coordination with Medi-Cal claiming standards and other funding sources. BHIN 25-009 outlines guidance regarding coverage of EBPs available under Medi-Cal as part of BH-CONNECT including requirements for:

- Medi-Cal Fidelity Designation
- Claiming Requirements
- Bundled Rates
- Full and Partial Rates
- EBP Payment Requirements

- Prior Authorization
- Other Billing Limitations

For more information about BH-CONNECT, please visit:
https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

N. BEHAVIORAL HEALTH SERVICES ACT

Effective July 1, 2026

Proposition 1, approved in March 2024, modernizes California's behavioral health system by improving accountability, increasing transparency, and expanding treatment capacity. The Department of Health Care Services (DHCS) is implementing these changes through Behavioral Health Transformation (BHT), building on existing statewide initiatives. SB 326 (BHSA) replaces the 2004 Mental Health Services Act (MHSA) and expands services to include substance use disorder (SUD) treatment, housing interventions, and workforce development, with a focus on individuals with the greatest behavioral health needs. For more information, access the BHSA Policy Manual at: https://policy-manual.mes.dhcs.ca.gov/

BHSA funding may serve children, youth, adults, and older adults who meet BHSA eligibility criteria aligned with Medi-Cal Specialty Mental Health Services (SMHS), and include individuals with Substance Use Disorder. County of San Diego BHS contracts that leverage BHSA funding will also include the specific target population for the contract, inclusive of age range. These contracts may also utilize other funding sources to support the contracted services and include additional requirements.

All BHSA funded programs are categorized into one of the following components and must meet BHSA priorities and DHCS requirements.as outlined by DHCS guidance, including the BHSA Policy Manual and county-specific service needs.

- **Housing Interventions (HI)** – Housing interventions eligible for BHSA funding are broad to help support the range of needs for the target population and help provide stable housing in coordination with care to improve health outcomes. Housing Interventions services for SUD members include shared housing (e.g., recovery housing).

  As defined in W&I Code section 5830, individuals must meet the BHSA eligibility requirements, defined above, and meet the definition of:
  - At-Risk of Homelessness, or
  - Experiencing Homelessness, or
  - Chronically Homeless, with a focus on those in encampments. Of the funding distributed to counties for Housing Interventions 50 percent must be used to support the housing needs of individuals who are chronically homeless, with a focus on those in encampments.

  Pursuant to W&I Code section 5891.5, subdivision (a)(2), the provision of Housing Interventions to individuals with a substance use disorder (SUD) is optional for counties in alignment with the requirements in Section 5963.02(b)(2). However, when Housing Interventions are provided to an individual living with a SUD, all housing intervention requirements in W&I Code section 5830 must be met.

Contracted programs that are expected to support BHS and Managed Care Plan (MCP) coordination must:

- Ensure that HI funding is not used by services that are covered by MCP.
- Support seamless connections from the county to the MCP for coverage of housing services and vice versa.
- Provide whole-person care and integrated housing services for MCP-enrolled members with significant behavioral health needs who meet BHSA eligibility criteria.

- **Behavioral Health Support Services (BHSS)** – Provides an integrated delivery of early intervention services, mental health, and substance use disorder services to all ages and allows for additional components which may include workforce efforts and other critical technology.
- **Full Service Partnership (FSP) –** Programs provide individualized, team-based care to individuals living with significant behavioral health needs through a "whatever it takes" approach. SUD services within this category include Assertive Field-based Initiation for Substance Use Disorder Treatment Services and Individual Placement and Support (IPS).

BHSA funded programs must support BHS in promoting access to care through the efficient use of State and County Resources. For securing managed care and OHC payments, billing and further documentation resources, see:

- BHSA Policy Manual Section 6 BHT Fiscal Policies & Section 9 Appendix for helpful process flows and procedures

To access the BHSA Policy manual and find current information, please visit: https://policy-manual.mes.dhcs.ca.gov/

O. PROVIDER CONTRACTING

All contracted providers, including subcontractors, shall adhere to and support the Substance Use Disorder (SUD) Intergovernmental Agreement executed between San Diego County and the California State Department of Health Care Services (DHCS).

All SUD providers must contract with the County of San Diego in order to receive reimbursement for Substance Use Disorder Services. Please read your contract carefully. It contains:

- General terms applicable to all contracts;
- Special terms specific to a particular contract;
- A description of work or services to be performed;
- Payment Schedule and/or budget; and
- Statutes and/or regulations particular to the DMC-ODS SUD programs as well as programs supported by other funds.

Contracted providers shall have the policies and procedures in place for monitoring subcontractors/consultants with the following required elements:

- Frequency of monitoring
- Depth and quality of monitoring (invoice reviews, program reviews, fiscal solvency, etc.)
- Documentation of the monitoring activities
- Follow-up process for resolution of non-compliance
- Exclusion debarment Medi-Cal screening process in place
- Criminal background checks process in place

Selection and monitoring of organizational agencies is governed by contracting procedures, which require a review of the organization's fiscal soundness, resumes of principal administrators and supervisors, the agency's experience with similar services, and a proposed staffing plan. All contracted providers will be expected to adhere to these requirements. Please contact your Behavioral Health Services Contracting Officer's Representative (COR) if you have any questions regarding your contract.

Responsibilities of DMC-ODS Counties for DMC-ODS Benefits

Per BHIN 23-001 or subsequent revisions, DMC-certified providers that do not receive a DMC-ODS County contract cannot receive a direct contract with the State to provide services to residents of DMC-ODS Counties.

Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.

- Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision.
- Counties shall have a protest procedure for providers that are not awarded a contract. The protest procedure shall include requirements outlined in the State/County contract.
- Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to DHCS.
- If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS.

- A provider may appeal to DHCS as outlined in Enclosure 4 of BHIN 23-001 or subsequent revisions.

DMC-ODS Counties select the DMC-certified providers with whom they contract to establish their DMC-ODS provider networks, with the exception of IHCPs. DMC-certified providers that do not receive a DMC-ODS County contract cannot receive a direct contract with the State to provide services to residents of DMC-ODS Counties.

Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial. Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision. Counties shall have a protest procedure for providers that are not awarded a contract. The protest procedure shall include requirements outlined in the State/County contract. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to DHCS. If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS. A provider may appeal to DHCS as outlined in Enclosure 4 of BHIN 23-001 or subsequent revisions.

Disclosure Requirements
The SUD Intergovernmental Agreement (IA) providers and contractors shall disclose to the state any persons or corporations with an ownership or control interest in an organization that:

- Has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Legal Entity's equity;
- Owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Legal Entity if that interest equals at least 5% of the value of the Legal Entity's assets;
- Is an officer or director of a Legal Entity organized as a corporation; or
- Is a partner in a Legal Entity organized as a partnership.

Disclosure to the State shall be done during the following:

- When the Legal Entity submits a proposal in accordance with the County's procurement process or when the Legal Entity submits a provider application.
- When the Legal Entity executes a contract with the County or when the provider executes a provider agreement with the state.
- When the state renews or extends the County contract.
- Within 35 days after any change in ownership of the contractor/disclosing entity.
- Upon request of the state during the revalidation of the provider enrollment.
- Within 35 days after any change in ownership of the disclosing entity.
- See Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

Conflict of Interest
Contractor shall not utilize any State officer or employee in the State civil service or other appointed State official for performance of the contract unless specific criteria is met, as per Pub. Con. Code § 10410; 42

C.F.R. § 438.3(f)(2). Contractor shall inform their COR of current and former State employees who are working under a program that is funded by County BHS.

Social Security Death Master File Verification
Prior to executing a contract with a provider, the SUD Plan is required to verify that the provider (individual) is not listed within the Social Security Death Master File (DMF) upon enrollment. Should a contract provider appear on the list, the SUD Plan will notify the County to take the appropriate action regarding enrollment or disenrollment from the SUD Plan and notify the appropriate regulatory authority.

National Provider Identification Verification
All HHSA contractors are required to have an active National Provider Identification (NPI) number for the facility and verify that all clinical staff, licensed or not, have an active NPI number. For new employees, contracted programs are to provide employee with necessary paperwork needed to apply for an NPI number, should they not already have one. If the new employee has an NPI number, the contractor shall verify in the National Plan and Provider Enumeration System (NPPES) for accuracy. Contractors must update the NPPES system as needed when the employee's information changes. The SUD Plan is required to complete the same verification process for the contracted providers. When contractor submits their Access Request Form (ARF) for staff account set up in the electronic health record, the MIS unit performs validation through the NPPES database. Staff shall not have access to the electronic health record without a valid NPI number.

Provider Orientation
All new agreements require a provider orientation meeting within thirty (30) business days of the agreement's execution or start date, whichever occurs later, and as needed throughout the agreement term. Additional orientations may be required when there are changes to key provider or County staff, operational or fiscal processes, laws or regulations, funding requirements, agreement templates, or unique agreement elements. The CORs and Administrative Representatives, in conjunction with the BHS Contract Support Team, are responsible for leading the provider orientation.

The orientation ensures providers understand their contractual obligations and the County's monitoring activities, and may be conducted in person, virtually, by email, telephone, or any combination, as deemed appropriate by the COR or Administrative Representative.

The provider will designate a contact person to coordinate attendance of necessary provider staff at the orientation. For experienced providers, orientation may be limited to updates on unique agreement requirements or changes to County/BHS processes.

As a contractor in the SUD Plan, it's important for providers to be aware of the objectives of the DMC-ODS, which are:

- To increase the County SUD provider network capacity and offer new services to an expanded number of Medi-Cal members.
- To increase local oversight of the SUD provider network with the goals of improved service quality and cost efficiencies.
- To ensure efficient care coordination and linkages among physical health, mental health and SUD services.
- To increase public safety through the implementation of evidence-based treatment services.

Goals

Programs shall provide members with comprehensive, preventive, rehabilitative, and therapeutic behavioral health care delivered in the least restrictive environment and in the most effective mode based on ASAM criteria. The goal of programming should include, incorporating Harm Reduction strategies that are not limited to abstinence, but include safer use, managed use, meeting those who use drugs "where they are" and addressing conditions of substance use. Overall goals of this program include member access to timely care, retention in treatment, reduction of substance use relapse, reduction in justice involvement, and improvement in quality of life.

Measures

Providers shall refer to their contract Statement of Work for quality-of-care measures, outcome measures, and process objectives specific to their program. Measures may be adjusted during the contract term to meet changes in Federal, State, and County requirements.

Quality of Care Measures include areas such as the following:

- Assessment
- Care Coordination
- Member Satisfaction – Submission

Outcome Measures include areas such as the following:

- Reduction in Justice Involvement
- Housing Support Services
- Self-Sufficiency
- Newborn Health
- Continuum of Care
- Member Satisfaction

Process Objectives include areas such as the following:

- Minimum number of member admissions
- Minimum number of bed days

Service Eligibility

Services shall not be refused to members based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or the inability to pay, if the member meets the County's eligibility population requirements. Members who are CalWORKs eligible shall not be charged fees. Members who are DMC eligible shall not be charged fees unless there is Share of Cost (SOC).

County of Responsibility and Residency

All members receiving services through a County BHS contract shall have San Diego County residency. Regarding residency, for non Medi-Cal members, a specific period of residence in the county or state is not required to qualify for services. Intent to reside in San Diego County is a necessary condition and is established by the member's verbal declaration. This applies to foreign nationals, including individuals with immigrant or nonimmigrant status. Without intent to reside in San Diego County, any member must be

billed at full cost. County of Responsibility claims adjudication information is provided in the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual.

Financial Status Evaluation
During the treatment intake process, programs shall conduct a financial assessment of all members and collect information about participants' personal health insurance coverage, if any. If potential third-party payers are identified, programs shall develop procedures to bill the third-party payer. Programs that provide Drug Medi-Cal (DMC) services shall be responsible for verifying the Medi-Cal eligibility of each member for each month of services prior to billing for DMC services for that member. Medi-Cal eligibility verification should be performed prior to rendering service.

Monitoring Activities
The County performs various monitoring activities including desk reviews, member record reviews, and site visits conducted by the Program Monitor/COR as well as the Quality Assurance Unit. Contractor's Program Managers shall be available during regular business hours and respond to the Program Monitor/COR or designee within 2 business days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software. Providers are required to submit status reports for review, and it is important to become familiar with the status reports to document pertinent information as required. The Status Report templates offer drop-down boxes including codes to make data entry collection easier.

Corrective Action Notice
Corrective Action Notice (CAN) is a tool identifying deficiencies in compliance with contractual obligations and requires corrective actions within a specified time frame. A CAN may result from findings during site visits or information derived from reports. Contractors are required to respond to the CAN specifying course of actions initiated/implemented to comply within the specified time frame.

Contract Issue Resolution
Issues, problems or questions about your contract shall be addressed to your COR.

Claims and Billing for Contract Providers

Contractor Payments
Contractors will be paid in arrears after the month for which a service has been provided. BHS Administrative Services Unit (ASU) will process claims (invoice) in accordance with the contract terms.

Budgets, Cost Reports and Supplemental Data Sheets and Claims (Invoices)

- Budgets, cost reports, supplemental data sheets, and claims (invoices) must comply with the established procedures.
- Year-end Cost report is due by August 31.
- Drug Medi-Cal (DMC) annual cost report is generally due November 1 following the end of the previous fiscal year.
- The State reconciles after receiving the year end cost report. This is an on-going process.

Submitting Claims (Invoice) for Services
Please submit all claims (invoice) for payment to:
Behavioral Health Services Contract Support, (BHSCS) (P531K)

P O Box 85524
San Diego, CA 92186-5524
Fax to: (619) 563-2730, Attn: Lead Fiscal Analyst
Email scanned copy to: ADS_Claims.HHSA@sdcounty.ca.gov

Overpayment
In the event of overpayments, excess funds must be returned or offset against future claim payments.

Certification on Disbarment or Exclusion
All claims for reimbursement submitted must contain a certification about staff freedom from federal debarment, exclusion, suspension or ineligibility from services. For additional information on these requirements, refer to Section E: SUD Program Requirements.

Publicity, Announcements, and Materials
All public announcements and materials distributed to the community shall identify the County of San Diego as the funding source for contracted programs. Copies of publicity materials related to contracted programs shall be filed with the HHSA BHS SUD (Substance Use Disorder) unit.

Funding Restrictions
Programs shall not solicit or accept payments, contributions or donations from any business or organization primarily engaged in the manufacture, distribution or wholesale or retail sale of alcoholic beverages.

Hatch Act
Provider agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

No Unlawful Use or Unlawful Use Messages Regarding Drugs
Provider agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). Provider agrees to enforce these requirements.

Limitation on Use of Funds for Promotion of Legalization of Controlled Substances
None of the funds made available through a County may be used by any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

Restriction on Distribution of Sterile Needles
No Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) funds made available through a contract with the County shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless the State choose to implement a demonstration syringe services program for injecting drug users.

Byrd Anti-Lobbying Amendment

No Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) funds made available through a contract with the County shall be used to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, member of Congress, office or employee of Congress, or any employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 USC 1352.

Restrictions on Salaries
No part of any federal funds provided under San Diego County contracts shall be used by providers or their subcontractors to pay the salary of an individual at a rate in excess of Level II of the Executive Schedule. Salary schedules may be found at https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/.

Restrictions on the Use of Federal Block Grant Funds
Pursuant to 42 U.S.C. 300x-31, Programs shall not use SUBG Block Grant funds on the following activities:

- Provide inpatient services;
- Make cash payment to intended recipients of health services;
- Purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment;
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
- Provide financial assistance to any entity other than a public or nonprofit private entity;
- Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year:
    - See http://grants.nih.gov/grants/policy/salcap_summary.htm
- Purchase treatment services and penal or correctional institutions in the State of California; and
- Supplant state funding of programs to prevent and treat substance abuse and related activities.

Payment of Last Resort
Contracted programs shall use SUBG Block Grant funds as the "payment of last resort" and shall make every reasonable effort, including the establishment of systems for eligibility determination, billing, and collection, to:

- Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program
- Secure from patients or members payments for services in accordance with their ability to pay. [Note: Members who are DMC eligible shall not be charged fees unless there is Share of Cost (SOC)]

Gift Card Usage
Gift cards may be used to directly benefit members and program objectives (i.e., grocery store vouchers). Gift cards may not be used as an incentive for Drug Medi-Cal billed services (i.e., as prizes for opportunity drawings for group attendance).

Programs must comply with the following:

- Have adequate internal controls and procedures in place to mitigate misappropriation of Gift Cards
- Gift Cards maintained in a secured and locked environment accessible only to the designated Contractor employees
- Gift Cards are accounted for by receipts, tracking system, and follow the Contractor's internal purchase policies
- Disbursement of Gift Cards is accounted for by a tracking system that indicates at a minimum:
    - Full name of the recipient
    - Amount of the Gift Card
    - Date disbursed
    - Two full signatures (one of which must be a Contractor employee). If both signatures are those of contract employees, one must be a supervisor.
- In the event Contractor discovers misappropriation of Gift Cards, Contractor must contact assigned BHS COR within one workday of the occurrence.
- Gift card purchase receipts, tracking log and internal polices shall be available to COR or Designee for review and inspection at any time
- Records to support the use of gift cards shall be available for in-depth review visits. Gift Cards that are not used or disbursed at the end of their original approved contract year must be justified and pre-approved (again) prior to being used in the next or any future contract years.

See OPTUM website "Forms" tab for the Health and Human Services Agency – Behavioral Health Services Gift Cards Approval Form.

Cost Limitations

For each term period stated on the Signature page of the Contract:

- The parties estimate that performance of the Agreement will not cost the County more than the maximum Agreement amount specified in the Compensation clause of the Agreement Signature page.
- The Provider agrees to use their best efforts to perform the work specified and all obligations under the agreement within the maximum Agreement amount.

The Provider shall adhere to the requirements in their contract's Exhibit C, C1 and C2. Provider shall notify the Contracting Officer Representative (COR) in writing whenever there is reason to believe:

- The costs the Providers expects to incur under the agreement in the next 60 days, when added to all costs previously incurred, will exceed 75 % of the maximum Agreement term amount as specified in the Compensation clause of the Agreement Signature page, or
- The total cost for the performance of the Agreement will be either greater or substantially less than had been previously agreed to for that term.

As part of the notification, the Contractor shall provide the COR a revised estimate of the total cost of performing the Agreement for that term.

Unless otherwise stated in the agreement, the County is not obligated to reimburse the Provider for costs incurred in excess of the maximum Agreement amount specified in the Compensation clause of the Agreement Signature page.

The Provider is not obligated to continue performance under the Agreement (including actions under the Termination clause of the Agreement) or otherwise incur costs in excess of the maximum Agreement amount specified in the Compensation clause of the Agreement Signature page, until the COR notifies the Providers in writing that the maximum Agreement amount has been increased and provides a revised maximum Agreement amount of performing this Agreement.

No notice, communication, or representation in any form other than that specified in the contract, or from any person other than the COR, shall affect the contract's maximum Agreement amount to the County. In the absence of the specified notice, the County is not obligated to reimburse the Providers for any costs in excess of the maximum Agreement amount.

If the maximum Agreement amount is increased, any costs the Contractor incurs before the increase that are in excess of the previously maximum Agreement amount shall be allowable to the same extent as if they incurred afterward, unless the COR issues a termination or other notice directing that the increase is solely to cover termination or other specified expenses.

False Claims Act

All HHSA employees, contractors, and subcontractors, are required to report any suspected inappropriate activity. Suspected inappropriate activities include but are not limited to, acts, omissions or procedures that may be in violation of health care laws, regulations, or HHSA procedures. The following are examples of health care fraud:

- Billing for services not rendered or goods not provided
    - Falsifying certificates of medical necessity and billing for services not medically necessary
    - Billing separately for services that should be a single service
    - Falsifying treatment plans or medical records to maximize payment
    - Failing to report overpayments or credit balances
    - Duplicate billing
    - Unlawfully giving health care providers such as physicians' inducements in exchange for referral services.

Any indication that any one of these activities is occurring should be reported immediately to your program COR immediately, as well as the SUD QA team at QIMatters.BHS@sdcounty.ca.gov. If there are related complaints that wish to remain anonymous, providers may contact the BAC Hotline at 866-549-0004.

Drug Medi-Cal

Per Cost Reporting/Data Collection Manual the "policy of the State Agency is that reimbursement for Drug Medi-Cal services shall be limited to the lowest of published charges and actual costs".

Definitions

- ***Provider*** means the program providing the SUD services. It is part of a legal entity on file with the State's Department Health Care Services (DHCS).

- ***Published Charge or Published Rate*** is a "term used in CFR Title 42 to define provider cost reimbursement mechanisms from third party sources. This generally means that customary charges throughout the year should be as close to actual (cost) as possible to avoid a lesser of costs or charges audit exception circumstance." Published rates for services provided by organizational providers must be updated at the beginning of each fiscal year to ensure the County's MIS has the accurate information as well as ensuring no potential loss of Medi-Cal revenue. The published rate for a specific service should, at a minimum, reflect the total cost for providing that service to ensure no loss of Medi-Cal revenue. Published rates are to be submitted to BHS Contract Support Unit (CSU) NLT by August 1 of each year.
- ***Actual Cost*** is reasonable and allowable cost based on year-end cost reports and Medicare principles of reimbursement per 42 CFR Part 413 and HCFA Publication 15-1.
- ***Federal Financial Participation*** per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal members under the Medi-Cal program.

Medi-Cal Billing to the State

For the most current information on Medi-Cal billing, refer to the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual. For Same Day Billing information, see Appendix F.1 – DMC ODS Same Day Billing Matrix.

Medi-Cal Revenue

For the most current information on Medi-Cal billing, refer to the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual.

Medi-Cal Disallowance/Recoupment

BHS is obligated to disallow SUD services for Medi-Cal reimbursement per the terms of the Intergovernmental Agreement between DHCS and the County. When standards are not met in documentation of Medical Necessity, Treatment Plans, Problem Lists, Progress Notes, Group Participant Lists, and other standards as described in the current version of the SUDURM and as outlined in any reasons for recoupment established by the Department of Health Care Services (DHCS), disallowance/recoupment occurs.

Organizational providers shall be responsible for ensuring that all medical records comply with federal, state and county documentation standards when billing for reimbursement of services. The Medi-Cal claims for the above circumstances will be deducted from contractors' invoice and contract payment. In accordance with State guidelines, these disallowances may be subject to future change. Contractor shall reimburse BHS for any disallowance of DMC payments, and reimbursement shall be based on the disallowed units of service at the Contractor's actual unit rate.

Billing Disallowances

The policy of San Diego County Behavioral Health Services Administration (SDCBHS) is to recoup costs by disallowing billing which has been identified and reported to the SDCBHS by the Contracted Organizational Providers in accordance with documentation standards as set forth in the current Substance Use Disorder Uniform Record Manual (SUDURM) and as outlined in any reasons for recoupment established by the Department of Health Care Services (DHCS).

Procedures

The following are the procedures to be followed for QA-identified and Provider-Identified billing disallowances to ensure consistent procedures are used when the information is reported to Behavioral Health Services Administration by providers.

1. All programs shall conduct internal review of medical records on a regular basis (i.e., monthly) to ensure that the documentation meets all County, State and Federal standards and that billing is substantiated. Additionally, providers shall participate in additional compliance reviews by SUD QA staff as described in Section I: Quality Assurance – Monitoring.

2. If the review of a member's chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current SUDURM, the provider shall be responsible for corrective action which may include recovery of payment.
    a. If billing errors are identified, such as wrong time or procedure code, contact BHS Billing Unit via email or phone call 619-338-2385 for further instructions.

3. To void a claim identified as disallowed, providers shall complete and submit the Provider Drug Medi-Cal Payment Recovery Form, located on the Optum site under the Billing tab, and submit to the BHS Billing Unit. Refer to the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual for form instructions. Providers shall ensure that the claim item listed on the form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services must be listed on the form exactly as they were billed.
    a. Submit the encrypted recovery form to both BHS QA staff and the BHS Billing Unit
    b. SUD QA: send report via secure email to QIMatters.BHS@sdcounty.ca.gov or fax to 619-236-1953
    c. BHS Billing Unit: send report via secure email to SUDBillingUnit.BHS@sdcounty.ca.govmailto:ADSBillingUnit.HHSA@sdcounty.ca.gov
    d. or fax to 619-236-1418

4. For details on how to process disallowed services, please refer to the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual.

5. All providers are required to review the DHCS Remittance Advice (RA) list of denied claims (Excel Claim Denial Report), sent by the BHS Billing Unit, to determine if the claims or the denial reasons are valid and track internally for cost reporting or claims reconciliation purposes.

BHS Contract Support Procedures

1. At a minimum annually, SUD QA conducts a Quality Assurance Program Review. This review includes a report of findings regarding disallowances/recoupments for not meeting standards as described above. Programs are required to follow the process for disallowance/recoupment as described in the QAPR report.
2. Contractors are expected to reflect the disallowed units (including self-report) in the next invoice if findings are made within the same fiscal year.
3. If findings are made after the fiscal year ends, Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments.

- If the contractor pays by check, the check is received by ASU staff and forwarded to Financial Management staff for deposit. The payment is logged in the contract file along with a copy of the payment.
- If no check is received by ASU within 15 business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.

Billing Inquiries
Questions regarding claims (invoice) for payment should be directed in writing to:

BHS Contract Support (P531K)
PO Box 85524
San Diego, CA 92186-5524
Attn: Lead Fiscal Analyst

Note: Questions can also be addressed by calling the Contract Support Unit Fiscal Analyst

Inventory Guidelines for County Contracts
All Capital Assets/Equipment, Minor Equipment, and Consumable Supplies purchases shall be included in Cost Reimbursement contract budgets and shall be approved by the Contracting Officer's Representative (COR) upon budget submission. The equipment and supplies shall directly benefit members and program's objectives.

County retains title to all non-expendable property provided to Contractor by County, or which Contractor may acquire with contract Agreement funds if payment is on a cost reimbursement basis, including property acquired by lease purchase Agreement. Internal Controls and Procedures below provide guidelines on handling Capital Assets and Minor Equipment.

Definitions

1. **Capital Assets/Equipment**: Tangible non-expendable property that has been purchased with County funds and has a normal life expectancy of more than one year **and** a unit cost of $5,000 or more. Prior written approval from the COR is required for the acquisition of Capital Assets/Equipment. Examples of Capital Assets/Equipment include, but are not limited to building improvements, vehicles, machinery, furnaces, air conditioners, multifunction copy machines, furnishings, etc.
2. **Minor Equipment**: Any non-consumable implement, tool, or device that has a useful life of more than one year and an acquisition amount of $500 to $4,999. Examples of Minor Equipment include, but are not limited to televisions, video recorders and players, computer monitors, therapy equipment, refrigerators, hand-held electronic devices, electronic games, modular furniture, desks, chairs, conference tables, etc.
3. **Consumable Supplies**: Goods that have a useful life of one year or less **and** an acquisition value under $500. Examples of consumable supplies include, but are not limited to pens, pencils, paper, notepads, file folders, post-it notes, toner or ink cartridges, waiting room supplies, etc.

Internal Controls and Procedures
Contractors shall have the following internal controls and procedures in place for managing contract-funded Capital Assets/Equipment and Minor Equipment, whether acquired in whole or in part with County funds, until disposition takes place:

1. Prior written approval from the COR is required for the acquisition of Capital Assets/Equipment through budget development requests or Administrative Adjustment Requests.
2. Contractors shall place County of San Diego Property tags on Capital Assets/Equipment and Minor Equipment to identify items purchased with County funds. These tags can be requested through the COR.
3. Contractors shall include the expenditure of Capital Assets/Equipment and Minor Equipment on the monthly invoice/cost report that immediately follows the acquisition.
4. Contractors shall maintain inventory records that include a description of the item, a serial number or other identification number (if applicable), the acquisition date, the acquisition cost, location of the item, condition of the item, program funding for the item, and any ultimate disposition data including the date of disposal.
5. Contractors shall submit an Inventory Report of Capital Assets/Equipment and Minor Equipment purchased using County funds annually to COR no later than thirty (30) calendar days into each new contract year, and when any updates occur throughout the year (e.g., new items charged to the contract or when items are stolen, lost, damaged, missing, and upon disposal completion). The COR will review the Inventory Report to determine if the information is reasonable and complete based on their knowledge of the contract and approval of invoices containing charges for equipment.
6. The Inventory Report is to include all Capital Assets/Equipment and Minor Equipment items purchased since inception of the cost reimbursement contract.
7. Inventory records on non-expendable equipment shall be retained and shall be made available to the County upon request, for at least ten years following date of disposition.
8. Contractors may choose to utilize their own Inventory Report as long as the required information above is included. Otherwise, contractors can utilize the BHS Inventory Form.
9. Contractors shall include in the Inventory Report any items that were transferred from one County program to another and note the transfer date and program. A DPC 204 form shall be completed.
10. Contractors shall make all purchased items available to the COR (or their designee) for inspection at any time.
11. Contractors shall be responsible for accounting of all contract-funded items, whether acquired in whole or in part with County funds.
12. Contractors that are required to work with computers, laptops, portable devices or media that contain personal information relating to members, patients and residents shall have a duty to protect this data from loss, theft or misuse (refer to Article 14 Information Privacy and Security Provisions in the contract). All electronic property and information technology (IT) related items capable of storing information, regardless of acquisition price and useful life, must be included in the Inventory Report. Examples of electronic property and IT related items capable of storing information include, but are not limited to cellphones, laptops, tablets, USB memory devices, cameras, etc.
13. Contractors do not need to include in the Inventory Report consumable supplies valued under $500 except for electronic property and IT related items specified in item #1 above such as cell phones, laptops, anything that holds PII, and items subject to misuse or theft.

<u>Disposition</u>

1. Contractors should not remove the items previously listed on their Inventory Report submitted to the County, unless the COR approved the salvage or transfer of those items, or a County Behavioral Health Services policy provided such instructions.

2. Minor Equipment not meeting the requirement to be listed on the Inventory Report and Consumable Supplies does not need to be disposed of through the County process.
3. Non-expendable property that has value at the end of a contract (e.g. has not been depreciated so that its value is zero), and which the County may retain title, shall be disposed of at the end of the contract Agreement as follows:

At County's option, it may:

- Have Contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;
- Allow the Contractor to retain the non-expendable property provided that the Contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good; or
- Direct the Contractor to return to the County the non-expendable property.

Stolen, Damaged or Missing Equipment

1. Contractor shall inform the COR in writing within 48 hours of any stolen, damaged or missing equipment purchased with County funds. Exception: Any lost or missing item that contains personal information shall be reported in writing to the COR within 24 hours. Article 14 Information Privacy and Security Provisions requirements shall be followed when appropriate.
2. Contractor may be responsible for reimbursing the County for any stolen, damaged or missing equipment at the current book value of the asset.

Vehicles

1. The preferred method for Contractor(s) to acquire vehicles is through a lease arrangement. COR and County Management preapproval must be obtained for Contractor to acquire a vehicle. Vehicles shall be registered with the Contractor as the lien holder and registered owner. Whether vehicles are leased or purchased, Contractor shall maintain appropriate insurance on vehicles, follow maintenance schedule, as required by the automobile manufacturer. Vehicle(s) usage and insurance requirement language will be included/amended in the contract.
2. If vehicle will be purchased, COR must obtain written pre-approval from:
    - ACS Director, and
    - DPC Director
3. At contract termination, or when the original or replacement equipment/vehicle is no longer needed, or has become obsolete, or is inoperable and impractical to repair, a formal disposition process will be required (refer to BHS Property Transfer/Disposal Process). Contractors shall work with the COR, who will determine the final disposition of the item(s).

Inventory Disposition

1. Contact the COR before disposing of property purchased with County funds, and which the County may retain title under this paragraph, shall be disposed of at the end of the Contract Agreement as follows:

    At County's option, it may:

    - Have Contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;

- Allow the contractor to retain the non-expendable property provided that the contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good;
- Direct the Contractor to return to the County the non-expendable property.

2. BHS Property Inventory Form, (located on Optum site – Forms tab)

   - As the contractor disposes of equipment the following columns on the BHS Inventory form must be completed and a copy provided to the COR.
   - "Date of Disposition of Capital/Fixed Assets or Minor Equipment": This is the actual date the item was delivered and accepted by County Salvage.
   - "Date form AUD253 completed": This is the date the COR signs and returns AUD253 form to the contractor.

3. <u>Transfer or Disposition of Minor Equipment Form(s) and Procedures</u>

NOTE: Procedure for Property Transfer to the County of San Diego – Property Disposal or Transfer to another contractor. For purposes of this section on disposal of minor equipment, "contractor" refers to the specific numbered County contract, and that contract's County-owned property, not to the combined County-owned assets of multiple County contracts held by a parent organization/organizational provider. Both versions of form DPC 203 and the Mobile Devices SUPPLEMENTAL form can be:

- Downloaded from links in the Technical Resource Library (TRL).
- Provided to the contractor by BHS staff

BHS Contract Support administrators will keep an internal record of any County-owned property and conduct an inventory of all County-owned property during selected site visits.

There are three distinct transfer/disposition procedures in place for minor equipment. These are for disposal of Non-IT items that do not have memory, IT items containing memory, and Mobile Devices. All minor equipment salvage requests are to be completed by the contractor on the appropriate version of the BHS 203 form and forwarded to their Contracting Officer's Representative (COR) who will review, approve, sign and forward the BHS 203 form to the appropriate County staff. Once processed and approved by BHS, the COR will notify the contractor of further steps. All BHS 203 forms must include the program name, contract number, COR name, address (with Zip Code) identifying the physical location of the items, and full site contact information including name, phone number and email. Directions for transfers between contracts are included below for each procedure. A new fillable .pdf version of the basic BHS 203 (BHS 203 Fillable) is now available for use for Non-IT and IT disposal. There is also a fillable .pdf version of the IT SUPPLEMENTAL. Contractors are not to make changes to the BHS 203 forms, including changing pre-filled wording or making any entries in the forms' boxes #7 through #16. Non-IT equipment, IT equipment and Mobile Devices cannot be listed on the same 203 form. Flowcharts for the three procedures are also located in the TRL.

a. **<u>Non-IT Disposal Requests</u>** (furniture, office equipment without memory: printers, most copiers, non-memory-containing computer accessories [computer monitors, keyboards, and mice], routers, docking stations, wireless access points, DVD players, etc.)

- Requests are to be completed on the BHS 203 Fillable .pdf form, checking the Non-IT box, and sent to the COR for review, approval, electronic signature and forwarding.
- Non-IT requests require the condition of the items to be noted and must be accompanied by photos in .jpg format, preferably with like items grouped but individually identifiable in the photos.
- Once BHS approval is final, the COR will provide the program with the approved BHS 203 form and directions for delivery by the program, per pre-scheduled appointment, accompanied by the approved BHS 203 form, to the County's disposal contractor. Contractors are to retain the disposal contractor's proof of delivery and forward the documentation to the COR.
- Contractors are to retain the disposal contractor's signed proof of delivery and forward the documentation to the COR team as soon as possible.
- *[Transfers of Non-IT items between contracts/programs require the sending program to complete the BHS 204 Fillable, entering both the sending and receiving programs' names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, electronically signs the form, and secures the receiving COR's approval and electronic signature (if different). The COR then forwards the approved form to BHS staff for further processing.* Transfers of Non-IT items do not require photos or condition.*]*

b. **IT Disposal Requests** (those items with memory: computers, laptops, notebooks, servers, zip drives, higher-end copiers with memory, etc.)

- Requests are to be completed on the DPC 203 Fillable form, checking the IT box, and then sent to the COR for review, approval, electronic signature and forwarding. The DPC 203 Fillable form includes a section for Wipe Certification for use with IT disposals. (HHSA only recognizes Department of Defense (DOD) level wiping done by its approved IT Wipe Vendor). IT items must be physically located at the address provided on the DPC 203 and retained at that site for pick up.
- Use DPC 203 form as a cover sheet: no itemizing on the form.
- On the DPC 203, the "Sender Information, Equipment Location and Contract Information" section is to be completed with full contract and contact information.
- The DPC IT SUPPLEMENTAL form is to be completed, listing individual items by Description (brand and model), Serial Numbers (NOT model numbers), "N/A" under Password to Unlock (passwords must be removed on all IT devices), and indicating "N" (for No) in the "Grant Funded" column.
- Group pictures are required for IT items; they do not to be individual.
- Following receipt of the disposal form with COR approval, the contractor will be contacted by HHSA IT's Wipe Vendor to arrange for pick up for disposal. *(Include the power cords for all types of computers at point of pick-up. Note the physical location of the serial number on each unit, as the Wipe Vendor must verify serial numbers as a condition for pick up).*
- The contractor must ensure that the IT Wipe Vendor completes the first box of the Wipe Certification of the DPC 203 form at point of pick-up.

- Once the equipment is picked up, the contractor will send a copy of the DPC 203 form with the completed wipe pick-up confirmation to the COR.
- *[Transfers of IT items between contracts/programs following DOD wiping, require the sending program to complete the DPC 203 Fillable, entering both the sending and receiving programs' names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, electronically signs the form and secures the receiving COR's approval and electronic signature (if different), and forwards the BHS 204 form to BHS staff. Transfers of IT items do not require photos or condition. BHS staff then arrange for HHSA IT's Wipe Vendor to pick up the items, do the DOD wipe, and return the wiped items to the contractor at the pick-up location. The contractor secures the DOD Wipe Vendor's signature on the BHS 204 at point of pick up (first box of Wipe Certification) and again when wiped items are returned (second box of Wipe Certification). Following DOD wiping, the sending program sends the COR the DPC 203 with both sections of the Wipe Certification completed. The sending and receiving programs then coordinate transfer of wiped equipment. Contractors should discuss situations with their CORs when the wiping requirement may potentially be waived, for example certain same provider re-procured (rollover) contracts, or when a new provider will be serving the identical member base and providing identical services. In these situations, a wipe waiver, obtained by the COR from HHSA Compliance Office, is required.]*

c. **Mobile Devices Disposal Requests** (cell phones, flip phones, smart phones, hotspots, Wi-Fi cards, tablets, etc.)

- Requests are to be completed using the DPC 203 form and the DPC IT SUPPLEMENTAL, and sent to the COR team for review, approval and forwarding.
- Use DPC 203 form as a cover sheet: no itemizing on the form.
- The DPC IT SUPPLEMENTAL form is to be completed, listing individual items by brand, model and type, providing serial numbers (NOT model numbers) and "N/A" under passwords (passwords must be removed on IT devices), and indicating "N" (for No) in the "GRANT FUNDED" column. This salvage process requires a group photo, in .jpg format, of the listed Mobile Devices.
- This results in a disposal approval email which must be forwarded by the COR to the contractor along with the approved DPC 203 and IT Supplemental forms. The email includes a FedEx prepaid shipping label that must be printed only by the contractor, attaches it to the package of devices, encloses a copy of the approved Mobile Devices DPC 203 and IT Supplemental (approval with the Control No.) in the package, writes the Control No. on the outside of the package, and takes the package to the FedEx outlet for shipping to the County's Mobile Devices Salvaging Vendor.
- *[The contractor packages the devices for secure, cushioned shipping, encloses a copy of the approved Mobile Devices DPC 203 and IT Supplemental form with the Control No. in the package(s) and writes the Control No. on the outside of the package(s).]*
- **NOTE:** DPC requires that all Mobile Devices be reset to their factory default setting prior to shipping.

- *[Transfers of Mobile Devices are limited to situations where: either the provider, program and services remain the same and only the contract number changes; or where a new provider will be assuming identical services for an identical member population. For Mobile Device transfers where a provider has changed, a wipe waiver must be secured by the COR from the HHSA Compliance Office before the devices can be made available to the new provider. Transfers of Mobile Devices items do not require photos or condition.]*

Electronic Property/IT

- Contractors Inventory Minimum Guidelines on A Cost Reimbursement and Fixed PRICE Contract
- Inventory responsibility includes these minimum guidelines for the security of member information and portable electronic and data storage devices. This responsibility exists whether the information is in paper or electronic form. Additionally, all Contractor employees have the duty to protect any County assets assigned to them or in their possession, including desktop computers, portable devices and portable media.

Definitions

- Member Data: Any identifying information relating to any individual receiving services from any program.
- Portable Devices: Tools such as laptops, external hard drive, PDAs, cell phones, Tablet PCs, other USB memory devices and cameras (digital, non-digital, and video).
- Portable Media: Any tool used to transport information any distance such as CDs, DVDs, USB memory sticks, flash drives or smart cards.

Minimum Guidelines

All Contractors' executives shall be responsible for maintaining a current inventory of all portable devices and portable media in their program.

- All Contractors' electronic devices shall be password protected.
- All electronic provider files containing DHCS PHI or PI and stored on removable media or portable devices shall be encrypted with a FIPS 140-2 certified algorithm.
- Portable devices or portable media shall not be used for routine storage of member data.
- For any privacy incident (e.g., lost or stolen laptop, member files/records accessed, etc.) refer to Serious Incident Reporting procedures in Section G of this manual.

Sliding Scale Fee

The County shall conform to revenue collection requirements in HSC Sections 11841, by raising revenues in addition to the funds allocated by DHCS. These revenues include, but are not limited to, fees for services, private contributions, grants, or other governmental funds. These revenues shall be used in support of additional alcohol and other drug services or facilities. Each alcohol and drug program shall set and collect member fees based on the member's ability to pay. Sliding scale applies to low income, including those within 138% to 200% FPL without insurance (and not Medi-Cal eligible). See Appendix O.1 for the current fee schedule confirming to this requirement and will apply to future years subject to change from DHCS.

COUNTY OF SAN DIEGO DMC-ODS

P. FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS)

Budget & Fiscal Instructions for Cost Reimbursement Contract

This document includes instructions (*in italics*) to help clarify the intent of the requirements and guidelines for Cost Reimbursement payment type contracts.

Contractors prepare program budgets for County review and approval. The approved budget for each fiscal year serves to assist in defining objectives and guidelines for contract performance, and determination of allowable and appropriate expenditures. The budget guidelines allow for flexibility within specified dollar limits, and states conditions when prior written County approval must be obtained before contractors are allowed to exceed the specified limits for discretionary variance from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal year.

Budget

The annual contract amount is specified in the contract and supported by an annual detailed budget developed by the contractor. Contractor must obtain written prior approval from the County and a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year's expenditures unless authorized and supported by a Contract Amendment.

If expenses are within the allowable limits stated below, no prior approval or change to the budget is required, though all expenses must always be reasonable and appropriate for the contracted services and are subject to subsequent review and disallowance. Any expenditures requiring written approval must be requested in advance and approved by the COR. Approval is not effective, and contractor should not incur any requested expense, until notified.

Invoice

Where the term "invoice is used in the Contract Services Template Article 4, "cost report" may be substituted as appropriate.

Total Direct Labor Cost

Reimbursable direct labor cost for direct labor and program management staff incurred by Contractor in the performance of this Contract shall be limited to the total amount budgeted for such cost in Exhibit C, Contractor's Budget. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Salaries and Benefits category plus any allowable unexpended Operating Expenses without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Direct Labor costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS)

- Unexpended Salaries and Benefits (S&B), up to 10% of total annual S&B budgeted amounts with a dollar value up to $100,000, may be applied to Operating Expenses.

Budget adjustments greater than 10% to Direct Labor cost; or 10% or less than to Direct Labor but with a dollar value greater than $100,000 require prior approval from the COR. Only budget adjustments up to 10% to Direct Labor cost with a dollar value up to $100,000 do not require prior approval from the COR. Example:

Example 1: The total Salaries and Benefits amount for a program budget equals $500,000, and contractor expects to spend less than $430,000. Of the $70,000 in projected unspent funds for this category, up to $50,000 (10% of the $500,000 Total Approved Budget with the dollar value less than $100,000), may be applied to Operating Expenses without requiring prior approval or change to the budget.

Example 2: The total Salaries and Benefits amount for a program budget equals $600,000, and contractor expects to spend less than $570,000. The entire $30,000 in projected unspent funds for this category, which is less than the limit of $60,000 and with the dollar value less than $100,000, may be applied to Operating Expenses without requiring prior approval or change to the budget.

- Unexpended Salaries and Benefits that may be applied to Operating Expenses may be from temporary vacancies of budgeted staff.

Contractor shall not intentionally keep positions vacant for the purpose of accruing savings to be used for Operating Expenses. When staffing levels are reduced due to less workload, then it is expected that operating expenses would be similarly underspent. The intent is to fill all budgeted positions and to provide services to members . Unspent funds due to other reasonable circumstances may be applied to Operating Expenses.

- Unexpended Salaries and Benefits may be applied directly to any temporary replacement staff and do not require prior County approval as long as costs do not exceed amounts budgeted for these positions.

Temporary and/or replacement staff should be listed in the Salaries and Benefits category and are not subject to prior approval as long as the total of Salaries does not exceed the budgeted amount plus 10% with a dollar value less than $100,000 for this category.

- Staffing changes, including addition or deletion of budgeted staff, shall require prior COR approval. Individual salaries may be exceeded up to 5% of the highest salary range without prior COR approval.

Adequate and appropriate staffing is normally the most important factor in the successful delivery of contracted services. Any permanent change to the number (FTEs) or classification of staff requires prior written approval. Salaries for each classification may be listed as averages, with the added information of the salary ranges. An individual salary may be exceeded up to 5% of the highest salary range without prior written approval by the COR, as long as the overall 10% rule is heeded. NOTE: Bonuses, incentive pay, and other types of special employee pay require prior written approval by the COR and must comply with Office of Management and Budget (OMB) Guidelines

FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS)

Total Other Direct Cost

Reimbursable operating costs incurred by Contractor in the performance of this Contract shall be limited to the total amount budgeted for such expenses in Exhibit C. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Operating Expenses category plus any allowable unexpended Salaries and Benefits without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Other Direct costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

- Unexpended Operating Expenses (OE), up to 10% of total annual OE budgeted amounts with a dollar value up to $100,000, may be applied to Salaries and Benefits.

All budget adjustments greater than 10% to Operating Expense cost; or 10% or less than to Operating Expense Cost but with a dollar value greater than $100,000 require prior approval from the COR. Example:

Example: If the total Operating Expenses for a program budget equals $300,000, any unspent amount, up to a maximum of $30,000 (10% of the total budget for this category with the dollar value less than $100,000), may be applied to Salaries and Benefits without requiring prior COR approval.

- The budgeted amounts for Operating Expenses line items may be exceeded up to the amount stated in Behavioral Health Services Administrative Adjustment Request (AAR) Guidelines as long as the t o t a l of all items does not exceed the total budgeted Operating Expenses including any allowable unexpended Salaries and Benefits, except for asterisked line items. Overspending by more than the allowable amount per AAR Guidelines on these Operating Expense budget line items will require a one-page Administrative Adjustment Request (AAR) form. The AAR form must be submitted clearly describing the justification for overspending, the budget line items and amounts affected. AAR is applicable to Cost Reimbursement payment type contracts only.

Example: If $1,000 is budgeted for Office Supplies and AAR Guideline allowed to exceed up to $5,000, a total expense to date of $1,500, will not require prior approval or change to the budget unless the total Operating Expenses amount exceeds the approved amount in the budget. NOTE: all expenses must be reasonable and appropriate for the contracted services and are subject to subsequent review and disallowance.

- Consulting expenses shall be budgeted on Contract Budget and shall not be exceeded without prior COR approval, with the exception of temporary staffing. All other consulting services or Subcontracts not previously budgeted shall require prior written COR approval.

- Budgeted amounts for Leasehold Improvements, Consultants, Subcontracts, Interest Expense, Gift Cards and Depreciation shall not be exceed without prior written COR approval.

FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS)

- Budgeted amounts for Member's Flex Funds may exceed up to $1,000. Costs above $1,000 require prior written approval by the COR.

  No expense shall be allowed for any line item that does not have an amount currently budgeted. Expenses without a budget require prior COR approval and detailed justification. Additional expenses due to emergencies and/or unforeseen circumstances for line item(s) that have a $0 budget will be reviewed on a case-by-case basis. These expenses are not allowed to be claimed in other line items that were not intended for these types of expenses.

Fixed Assets

All fixed asset expenses shall be budgeted and itemized on the Contract Budget, and no fixed asset budget line item shall be exceeded without prior written COR approval.

The purchase of fixed assets that are not listed on the budget require prior written approval. Fixed assets include all non-expendable property with a value of $5,000 or more and a normal life expectancy of more than one year.

Purchase of fixed assets that are budgeted on the itemized Supplemental A and any assets not currently budgeted require written notification to the COR.

Total Indirect Cost

Reimbursable indirect costs incurred by Contractor in the performance of this Contract shall be limited to the total amount budgeted for such cost in Exhibit C. The sum of any and all such costs shall not exceed the total amount budgeted for the Indirect Cost category without the written approval of the COR. Reimbursable indirect costs shall be limited such that the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost.

If the total budget is underspent, it is expected that Indirect Costs would decrease proportionately.

Other Costs: Hiring Incentives and Premium Shift Differential Rates

Any HHSA contractor that can demonstrate a critical workforce need that is or will imminently negatively impact the delivery of member services and contractual capacity requirements, may consider the following strategies:

- Hiring Incentives: Contractor may choose to propose a program for hiring incentives for those positions that are in critical need. ○ Proposed hiring incentive programs must include:
  - Identification of the critical staffing needs and potential contractual impact absent any mitigation.
  - A documented policy for implementation of hiring incentives to meet the immediate needs of the program and indicates there will be no contract increases that result from the sign-on bonuses.
    - Hiring incentive program must be time-bound for immediate recruitment needs.

FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS)

- Hiring incentive programs may include moving expenses and/or sign-on incentives which must be time bound and include repayment requirements if employment terminates prior to completion of time obligation

- Proposed hiring incentive policy will require the following:
  - Adequate justification
  - COR and HHSA program management approval
  - Line-item delineation on budgets/invoices and must properly account for any staff, identification of applicable positions, amount for each position. If cost flow to the next fiscal year – claim to County will only be up to the Contract Max (covered by savings the following fiscal year), or early employment termination implications. ▪ Request at the beginning of the Fiscal Year by contractor:
    - Create a new Other line in the Operating Expense tab, label as "Other: Sign-On Bonuses: Max of "$_____". This will have a $1 budget.
    - The amount on the description will be the max amount that is approved for invoicing. If this amount is exceeded, a new AAR will need to be submitted for another approval.
  - For mid-year or end of the year request by contractor:
    - Salaries and Benefits will need to be updated to reflect the number of months the position is vacant creating an unspent amount
    - Create Other line in the Operating Expense tab "Other: Sign-On Bonuses" and reflect the budgeted amount. Reflect zero bottom net change.

- Premium Shift Differential Rates: Contractors may wish to consider premium shift differential rates for staff to support shifts that are difficult to recruit, hire, retain or fill.
  - Premium shift rates would be proposed by contractor and require approval from COR.
  - Premium shift differentials would typically be expected for consideration on overnight shifts and 24/7 facilities, but may, upon contractor proposal and approval by management and COR, be approved for certain service settings due to the acuity or high intensity of the setting.
  - Employees receiving Premium Shift Differential Rates would be eligible for hiring incentives outlined above.

Units of Service (under Cost Reimbursement type contracts only)

Units of Service are the most critical element of the program budget, and the budgeted units of service may not be changed without prior written approval by the COR. Delivery of service below budgeted levels may be considered a performance matter and subject to corrective action

FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS

Start-Up Funds (for Procurement Budget only)

Start-up or Ancillary funding as part of procurement shall be subject to funding, negotiations and shall be at the sole discretion of the County. This shall be limited to one-time costs of newly awarded contracts and shall be used for the development and implementation of a new or expanded program or service.

- The budget and timelines for expending start-up funds must be approved by the County •
  Shall not be available for option years
- Shall not exceed 10% of the annual budget of the first year of contract
- A separate cost center for start-up funds shall be included in the proposed budget for the initial contract period and expenditures shall be tracked separately from ongoing expenditures
- If multiple funding sources are identified within the contract, a plan to allocate the start-up costs amongst various funding sources shall be required and budgeted appropriately to reflect the funding
- ratios amongst the various funding sources
- Start-up costs will be reimbursed based on actual costs (cost reimbursement). Contractor shall comply with Cost Reimbursement Contract requirements. At a minimum, submit an acceptable Cost Allocation Plan and maintain an Inventory List, according to Article 2.4 of the Contract Services Template

Examples of expenditures that may be approved include:

- Costs of staff hiring
- Initial staff training and development related to a new program or operation (ongoing training and development should be included in the annual operating budget)
- Minor equipment
- Supplies and materials
- Licenses and permits
- Tenant Improvements

Start-up funds shall not be used:

- To supplant or supplement ongoing or routine operating expenses
- For ongoing or routine program activities
- To improve an existing program or service

At the end of the determined start-up period, an evaluation of the start-up expenditures shall be made, and remaining start-up funding may be rescinded at that time. Expenditures that do not meet the start-up criteria may be disallowed and subject to reimbursement.

Other Revenue Sources

Behavioral Health Services: Contractor shall determine and claim revenues from all other applicable sources other than the County as reimbursement for the cost of services rendered to members pursuant to this

FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS

Contract and in compliance with all applicable rules and regulations (the current version of which can be found online at the BHS Technical Resource Library. For further guidance, please refer to the links below.

- FORTHCOMING – BHS Billing Guide
- DMC Organizational Providers Billing Manual (pdf) (optumsandiego.com)

Multiple Programs/Cost Centers

In contracts that have multiple programs with separate budgets submitted for each program, any adjustment between individual program budgets shall have the prior written approval of the COR. Any excess funds shall remain and be utilized in the program where originally allocated or may be reallocated by the COR for other appropriate services.

Accounting System

Contractor shall use an accounting and timekeeping system for segregating, supporting, controlling, and accounting of all funds, property, expenses, salaries, wages, revenues, and assets for each County of San Diego contract distinct from other contractor activities. Contractor shall have the ability to provide assurance that the system is in accordance with generally accepted accounting principles and federal Office of Management and Budget (OMB) Circulars, located within the applicable Code of Federal Regulations. Accounting and timekeeping systems are subject to review during in-depth invoice reviews and audits conducted by the County.

Other Fiscal Instructions

Invoices are due 30 days after end of invoice month unless other due dates are required by specific funding sources unless otherwise instructed by COR.

Budget & Fiscal Instructions for Fixed Price payment type Contracts

The approved budget for each fiscal year serves to assist in defining objectives and guidelines for contract performance, and as determination of allowable and appropriate invoicing within the Fixed Price or rate structure or set by the State as listed in the Contact Exhibit. The Exhibit C provides budget guidelines that may allow flexibility within specified dollar limits, and states conditions when prior written County approval or amendment must be obtained before contractors are allowed to exceed the specified limits from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal year.

Budget

The annual contract amount is driven by the Fixed Price rate as established by the State or agreed to in the contract. If the rate is driven by the State, it is automatically adjusted to match the rate. If the rate is based on negotiated rate between the County and Contractor or a Fixed Price, a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year’s expenditures unless authorized and supported by a Contract Amendment.

FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS

Invoice

The invoice submitted to the County includes the contracted rate multiplied by the units of service or the billing milestone completed.

Units of Service

Units of Service are the most critical element of the program budget for the Fixed Price con Other Revenue Sources

Contractor shall determine and claim revenues from all other applicable sources other than the County as reimbursement for the cost of services rendered to members pursuant to this Contract and in compliance with all applicable rules and regulations. For further guidance, please refer to SUDPOH and COSD BHS Drug Medi-Cal Organizational Providers Billing Manual.

Ancillary Claims

Some contracts may allow ancillary expenses that can be claimed at cost. Please refer to your Exhibit C language for information regarding ancillary expenses added to a Fixed Price contract.

Accounting System

Contractor shall have use of an accounting system for segregating, supporting, controlling, and accounting of all funds, expenses, and revenues, for each County of San Diego contract distinct from other contractor activities. Contractor shall have the ability to provide assurance that the system is in accordance with generally accepted accounting principles and federal Office of Management and Budget (OMB) Circulars, located within the applicable Code of Federal Regulations.

Other Fiscal Instructions

Invoices are due 30 days after end of invoice month unless other due dates are required by specific funding sources unless otherwise instructed by COR.

Contractor must comply with fiscal reporting requirements upon request by County, State, or Federal.

Budget & Fiscal Instructions for Hybrid Contract

Follow the requirements and guidelines for Cost Reimbursement AND Fixed Price payment Contract.

Behavioral Health Services Funding Source Requirements – Applicable to All Contract Payment Types (Contractor Instructions)

Medi-Cal Requirements

Invoices for Payment of Medi-Cal Services. Contractor shall enter required data based on eligibility and services rendered to each Medi-Cal member into the appropriate County-designated County Data System. Contractor shall enter data on each member or group within the time required by the County.

FUNDING SOURCE REQUIREMENTS (CONTRACTOR INSTRUCTIONS

The validity of Contractor's data input is subject to State, County, Federal or other funding source review and approval. County will make payments in advance of the State, Federal or other funding source review and approval, and in advance of the reimbursement by the State, Federal or other funding to County for sums expended thereunder. In the event the State, Federal, other funding source or County disapprove any billing, whether previously paid to Contractor, Contractor shall take all necessary actions to obtain approval of the disallowed billing. If Contractor is unsuccessful, Contractor shall reimburse County in the full amount of the disallowed billing within thirty days of County's request or, at the sole discretion of County, County may withhold such amounts from any payments due under this Contract or any other contract , including successor contracts , County has entered into or will enter into with Contractor.

Penalty for Failure to Qualify Short-Doyle/Medi-Cal & Drug Medi-Cal Visits. (Rev. 9/11/08)
If County experiences a payment reduction in a Short Doyle/Medi-Cal & Drug Medi-Cal claim due to Contractor's failure to qualify the visit under Short-Doyle/Medi-Cal & Drug Medi-Cal program (failure to claim or failure to respond to inquiry) then County will reduce Contractor's reimbursement by an amount commensurate with Contractor's budgeted unit cost and the prevailing Federal Financial Participation (FFP) of Medi-Cal and EPSDT for the Contract period.

Q. QUICK REFERENCE Phone Directory

• BHS	BHS website homepage
• BHS Administration Phone	(619) 563-2700
• Quality Assurance Email	QIMatters.BHS@sdcounty.ca.gov
• Quality Assurance Fax	(619) 236-1953
• Serious Incident Reporting (SIR) Phone	(619) 584-3022
• Population Health Email	BHSpophealth.hhsa@sdcounty.ca.gov
• SmartCare Related Issues	BHS_EHRSupport.HHSA@sdcounty.ca.gov
• SanWITS Support Desk Email	BHS_EHRSupport.HHSA@sdcounty.ca.gov
• SUD Billing Unit Email	SUDBillingUnit.BHS@sdcounty.ca.gov
• BHS DMC-ODS System of Care	website
• BHS DMC-ODS Email	Info-DMC-ODS.HHSA@sdcounty.ca.gov
• Health Plan Administration	BHS-HPA.HHSA@sdcounty.ca.gov

Department of Health Care Service (DHCS)

- DHCS General Website
- DMC-ODS
- Drug Medi-Cal Special Terms and Conditions
- MH/SUD Behavioral Health Information Notices
- Perinatal Practice Guidelines 2025
- Adolescent SUD Best Practice Guide
- Department of Health Care Services Certification for Alcohol and Other Drug Programs
- DMC-ODS-Billing-Manual-v-4.0
- CalOMS
- DATAR California Outcomes Measurement System Treatment | DHCS

County of San Diego Resources

- County of San Diego General website
- County of San Diego General SanDiegoCounty.gov
- Covered California website
- Medi-Cal Enrollment website

Optum- Administrative Services Organization (ASO)

- Optum San Diego

Support Desk	(800) 834-3792
Provider Line	(800) 798-2254
Access and Crisis Line (ACL)	(800) 724-7240

RESOURCES

Member Advocacy Organizations

- Consumer Center for Health Education and Advocacy (877) 734-3258
- Jewish Family Services Patient Advocacy Program (800) 479-2233

American Sign Language (ASL) Interpreter Services

Providers are encouraged to avail of resources that their organization deems appropriate. These resources could include, but are not limited to:

- Deaf Community Services (619) 398-2441
- Videophone (619) 550-3436
- Interpreter's Unlimited (858) 451-7490

Member Services Database

- 211 San Diego
- County of San Diego Behavioral Health Services Provider Directory

Other Resources

- American Society of Addiction Medicine (ASAM)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- California Institute for Behavioral Health Solutions (CIBHS)
- California Consortium of Addiction Programs and Professionals (CCAPP)
- California Association of DUI Treatment Programs (CADTP)
- National Harm Reduction Coalition

Appendix

ASAM Criteria Dimensions at a Glance

DIMENSION #	DIMENSION DESCRIPTION	ASSESSMENT & TREATMENT PLANNING FOCUS
Dimension 1	Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued SUD services.
Dimension 2	Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services.
Dimension 3	Emotional, behavioral, or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services.
Dimension 4	Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change.
Dimension 5	Relapse, Continued Use, or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or problems with motivational strategies.
Dimension 6	Recovery/Living Environment	Assess need for specific individualized, family, or significant other housing, financial, vocational, educational, legal, transportation, childcare or other needs that may help/hinder recovery.

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

Admission – When the program determines that an individual is appropriate for the program and completes and signs all required paperwork including consent to recovery/treatment form and confidentiality release.

Adolescents – Clients between the ages of twelve and under the age of twenty-one.

Adverse benefit determination - In the case of an MCO, PIHP, or PAHP, any of the following:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2) The reduction, suspension, or termination of a previously authorized service.
3) The denial, in whole or in part, of payment for a service.
4) The failure to provide services in a timely manner, as defined by the state
5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Alcohol and drug free – Free of the use of alcohol and/or the illicit use of drugs.

Alcohol and drug free environment – An environment that is free of the use of alcohol and/or the illicit use of drugs and promotes alcohol and other drug free activities.

Alcohol and/or other drug program certification standards – The most current State of California Department of Alcohol and/or other Drug Program Certification Standards, established to ensure an acceptable level of service is provided to program participants.

Ancillary Service – Additional outside services which provide resources that meet the educational, vocational, health, social, and other needs required to support the participant's recovery.

Appeal – A request for review of an adverse benefit determination.

Assembly Bill 109 (AB109) – Legislation that was passed for adult parolees, shifting supervision from the State to the County.

Assessment – An in-depth review including level of care assessment and participant strengths and needs to provide baseline information regarding life domains, i.e., substance use disorder, medical, employment, legal, social, psychological, family, environment and special needs. The diagnostic tool is based on the American Society of Addiction Medicine Patient Placement Criteria Third Revision, Revised 2014 (ASAM). The BHS-approved substance use disorder assessment tools are the Addiction Severity Index (ASI) and the Youth Assessment Index (YAI).

Associate – Per DHCS, associate is defined as license eligible staff in post graduate school obtaining hours.

Authorization - The approval process for DMC-ODS Services prior to the submission of a DMC claim.is the approval process for DMC-ODS Services prior to the submission of a DMC claim.

Available Capacity - means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.

Bed day – A day and night of a residential substance use disorder program with treatment services provided to a resident that occupies a designated general population bed. Residential programs may only claim for a bed day if a minimum one hour of activity/activities as listed in DHCS Information Notice 18-001 is provided.

Member - A person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.

Member Handbook - The state developed model enrollee handbook.

Board of Directors – The governing body that has full legal authority for governing the operations of substance use disorder programs.

Calendar Week - The seven-day period from Sunday through Saturday.

Care Coordination – Bringing together various providers and information systems to coordinate health services, client needs, and information to help better achieve the goals of treatment and care.

Case Management – A service to assist a member to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

Certified Provider - A substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

Client file – The file that contains the information required by the established standards for each client upon admission to a program.

Cognitive Behavioral Therapy – A short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Cognitive behavioral therapy (CBT) focuses on exploring relationships between a person's thoughts, feelings and behaviors. During CBT a therapist will actively work with the client to uncover unhealthy patterns of thought and how they may be causing self-destructive behaviors and beliefs. By addressing these patterns, the client and therapist can work together to develop constructive ways of thinking that will produce healthier behaviors and beliefs.

Collateral Services – Sessions with therapists or counselors and significant persons in the life of a member, focused on the treatment needs of the client, focused on the treatment needs of the client in terms of supporting the achievement of the client's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the member. Collateral services are an important means of connecting with the significant persons (as described above) as part of gathering information for assessment, as part of educating how best to support the client's recovery, etc. The client may be present, but it is not a requirement that the client is present.

COMPAS – Correctional Offender Management Profiling for Alternative Sanction, adult risk and needs assessment.

COSDBHS – County of San Diego Behavioral Health Services; COSD is used interchangeably.

Co-Occurring Disorder – A concurrent substance use and mental disorder.

Corrective Action Plan - The written plan of action document which the Contractor or its subcontracted service provider develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.

Crisis Intervention Services – A contact between a therapist or counselor and a member in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance, which presents to the member an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the member's emergency situation.

Cultural Competency – A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

Culturally and Linguistically Appropriate Services (CLAS) – Established by the federal Office of Minority Health (OMH) the Cultural and Linguistically Appropriate Services (CLAS) standards ensure equal access to quality care by diverse populations.

Days – "Days" means calendar days, unless otherwise specified.

Dedicated Capacity - The historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide DMC-ODS services to persons eligible for Contractor services.

Delivery System - DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

Discharge Services – The process to prepare the member for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

Discharge Plan – An individual plan of action to support recovery after an individual has been discharged from a treatment program.

Discharge Summary – The report that must be completed, within thirty (30) days following the discharge of any client.

Drug-Free Birth – A birth that occurs while a woman is in treatment, and the baby is free of all drugs.

Drug Medi-Cal (DMC) Program - The state system wherein members receive covered services from DMC-certified substance use disorder treatment providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS) - DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

Drug Medi-Cal (DMC) Termination of Certification - The provider is no longer certified to participate in the Drug Medi-Cal program upon the state's issuance of a Drug Medi-Cal certification termination notice.

Drug Testing – A process to collect blood, saliva, or urine to determine the presence of alcohol or illicit drugs in an individuals' system verified by a certified laboratory. Drug testing shall be conducted in conjunction with treatment.

Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) - The federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered members less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening**.**

Education and Job Skills - Linkages to life skills, employment services, job training, and education services.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2) Serious impairment to bodily functions.
3) Serious dysfunction of any bodily organ or part.

Emergency Services - Covered inpatient and outpatient services that are as follows:

1) Furnished by a provider that is qualified to furnish these services under this Title.
2) Needed to evaluate or stabilize an emergency medical condition.

Enhanced Community Health Worker (E-CHW) - Community based workers provide preventative services aimed at preventing disease, disability, and other health conditions and promoting physical / mental health and well-being via connection to health and wellness resources and address barriers to meeting health or health-related social needs. Such as:

1) Help clients access services such as counseling, primary care, housing, food or other supports.
2) Provide health education about mental health, substance use and treatment options.
3) Help clients overcome barriers to care such as scheduling appointments or assisting with transportation.

Evidence-Based Practice(s) – Practices that have been implemented and are supported by evidence. Providers will be expected to implement, at a minimum, the two EBPs of Motivational Interviewing (MI) and Relapse Prevention. Other EBPs include cognitive behavioral therapy, trauma informed treatment, family therapy and psychoeducation.

Face-to-Face –A service occurring in person.

Family Support - Linkages to childcare, parent education, child development support services, and family and marriage education. Family support is only available under Recovery services.

Family Therapy – Including a member's family members and loved ones in the treatment process, and education about factors that are important to the member's recovery as well as their own recovery can be conveyed. Family members may provide social support to members, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act

that constitutes fraud under applicable Federal or state law.

Gender Identity - One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

Grievance – An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Grievance and Appeal System - The processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

Group Counseling – Contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A member that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a member who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

Hospitalization - When a patient needs a supervised recovery period in a facility that provides hospital inpatient care.

Illicit Use of Drugs – The use of any substance defined as a drug in Section 11014, Chapter 1, Division 10 of the Health and Safety Code, except:

- Drugs or medications prescribed by a physician or other person authorized to prescribe drugs, pursuant Section 4036, Chapter 9, Division 2 of the Business and Professions Code and used in the dosage and frequency prescribed; or
- Over-the-counter drugs or medications used in the dosage and frequency described on the box, bottle, or package insert.

Imminent Danger – Imminent danger has the following three components:

- A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications)
- The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated)
- The likelihood that such adverse events will occur in the very near future
- In order to constitute "imminent danger" all three elements must be present.

Individual Counseling –Contact between a member and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service and are reimbursed without distinction.

Intake – The process of determining a member meets the medical necessity criteria and a member is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.

Intensive Outpatient (IOS) Services – (ASAM Level 2.1) Structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with

a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

Interim Services – Per SUBG guidelines, interim services referrals and education provided to priority population clients when they cannot be admitted due to capacity limitations.

Intern – Per DHCS FAQ dated 6/2019, intern staff have not received their advanced degree within their specific field and/or have not registered with appropriate state board; interns are not considered LPHA's.
Job Readiness Education – Educational sessions focused on teaching the resident how to write a resume, search for, attain, and maintain employment in the community–at–large.

Justice Override – A client is court-ordered or probation-recommended to residential treatment, but client is not assessed to meet ASAM criteria for residential LOC.

Licensed Practitioner of the Healing Arts (LPHA) – Includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Managed Care Organization - An entity that has, or is seeking to qualify for, comprehensive risk contract under this part, and that is-

1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
2) Any public Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
    a. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served by the entity.
    b. Meets the solvency standards of the §438.116.

Medical Necessity and Medically Necessary Services - SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

Medical Necessity Criteria - Adult members must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent treatment criteria. Members under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, members under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

Medical Director - Physician licensed by the Medical Board of CA or Osteopathic Medical Board of CA.

Medical Psychotherapy - A type of counseling service that has the same meaning as defined in 9 CCR § 10345.

Medication Assisted Treatment (MAT) - The use of prescription medications, in combination with

counseling and behavioral therapies, to provide a whole-person approach to the treatment of substance use disorders (SUD). Research shows that a combination of MAT and behavioral therapies is a successful method to treat SUD. There are different doors through which members in need of MAT enter the Medi-Cal system.

Medication Services – Medication Services including MAT, will be discussed and offered as a concurrent treatment option for individuals with an alcohol- and/or opioid- related SUD condition. The prescription or administration of MAT, and the assessment of side effects and/or impact of these medications, should be conducted by staff lawfully authorized to provide such services within their scope of practice and licensure.

Memoranda of Understanding (MOU) – Written agreement between entities, individuals, programs, and/or others that specifies mutual understanding of responsibility.

Methadone – An opiate agonist medication that has been approved for use in narcotic replacement therapy.

Minor – Individuals under the age of 18 years old.

Modality - Necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

Motivational Interviewing – Motivational Interviewing focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The method differs from more "coercive" or externally driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values, beliefs or wishes); but rather supports change in a manner congruent with the person's own values and concerns.

Naltrexone Treatment Services - An outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

Network - The group of entities that have contracted with the PIHP to provide services under this Agreement.

Network Provider - Any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, PAHP, or a subcontract, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

Non-participating provider - A provider that is not engaged in the continuum of services under this Agreement.

Non-Perinatal Residential Program - Services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

Notice of Adverse Benefit Determination - A formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

Observation - The process of monitoring the member's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the member and the level of care the member is receiving. This may include but is not limited to observation of the member's health status.

Opioid (Narcotic) Treatment Program (OTP) - An outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

Out-of-Network Access – A provider who is not on the County of San Diego DMC-ODS plan's list of providers.

Outpatient Services - (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

Outreach To Person Who Inject Drugs - Per 42 US Code section 300x-21, "outreach to persons who injects drugs" are activities that encourage individuals in need of such treatment to undergo treatment.

Overpayment - Any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

Participating Provider - Providing research-based education on addiction, treatment, recovery and associated health risks.

Patient Education – Providing research-based education on addiction, treatment, recovery and associated health risks. Note: Patient Education and Client Education are used interchangeably.

Payment Suspension - The Drug Medi-Cal certified provider has been issued a notice pursuant to W&I Code, Section 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

Peer Support Specialists – Peer support specialists must be self-identified as having experience with the process of recovery from mental illness and/or substance use disorder either as a consumer of these services or as the parent or family member of the consumer. They are in the recovery process and can help others experiencing similar substance use treatment and recovery life situations. Peer support specialists must possess a high school diploma or equivalent, complete the peer certification training and all trainings required on the Behavioral Health Services DMC-ODS Required Trainings website, and be 18 years or older. With certification and through shared understanding, respect, and mutual empowerment, peer support specialists help members engage in the recovery process and reduce the likelihood of relapse.

Peer Support Specialist Services (PSSS) - Peer support specialist services are culturally competent services that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Services that peer support specialists provide include but are not limited to relapse prevention services, coaching, supporting linkages to community resources, or education documented in an individualized treatment or recovery plan.

Perinatal Services – Covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

Physician - A Doctor of Medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

Clinician Consultation - Services are to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

Physician Services - Services provided by an individual licensed under state law to practice medicine.

Prepaid Inpatient Health Plan (PIHP) - An entity that: (1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates. (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.

Priority Population – Per SUBG, priority population are the highest risk populations ranked in order of priority for treatment admission preference (pregnant person using IV substances, pregnant person using other non-IV substances, person using IV substances, all other individuals).

Post-Partum – As defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.

Post Service Post Payment (PSPP) Utilization Review – The review for program compliance and medical necessity conducted by the state after service was rendered and paid. The Department may recover prior payments of Federal and state funds if such a review determines that the services did not comply with the applicable statutes, regulations, or terms as specified in Article III.PP of this Agreement.

Post Service Pre Payment (PSPP) Utilization Review - Formally known as DMC Monitoring Reviews, differ from PS Post Payment reviews in that there is no financial recovery (i.e. recoupment) associated with these types of reviews. Rather, they are conducted as part of the DHCS requirement to provide programmatic, administrative, and fiscal oversight of statewide DMC SUD services. The Post Service Pre-Payment reviews include an on-site review of certain DMC charts, employee files, policy and procedures, and the physical location of the program.

Primary Care - All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

Provider – Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

Program Fee – A fee charged to the client for program services. Fees may NOT be charged to CalWORKs or Drug Medi-Cal clients (except Medi-Cal members with a share of cost).

Quality Assessment/Utilization Review (QA/UR) – Reviews of physicians, health care practitioners and providers of health care services in the provision of health, care services and items for which payment may be made to determine whether:

1) Such services are or were reasonable and medically necessary and whether such services and items are allowable.
2) The quality of such services meets professionally recognized standards of health care.

Recertification - The process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification**.**

Recovery Monitoring - Recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

Recovery Plan – A written document, completed by the client after consultation with staff, detailing client's individual goals with specific services and activities outlined, including beginning and end dates. They shall be kept in the client file.

Recovery Services – Services and activities that support and promote a drug and alcohol-free lifestyle, develop life skills, and engage participants in recovery.

Rehabilitation Services - Includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a member to his best possible functional level.

Relapse – A single instance of a member's substance use or a member's return to a pattern of substance use.

Relapse Prevention - Learning and practicing coping skills, building community connections, relapse prevention, self-efficacy, and an improved ability to structure and organize tasks of daily living.

Relapse Trigger - An event, circumstance, place or person that puts a member at risk of relapse.

Residential Treatment Services - A non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to members. Each member shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week.

a. A member shall live on the premises and be considered a "short-term resident" of the residential facility where the member receives services under this DMC-ODS level of care.
b. Services may be provided in facilities of any size.

Safeguarding Medications - Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

Service Area - means the geographical area under Contractor's jurisdiction.

Staff – A paid individual who, by virtue of education, training and/or experience, provides services that may include listening, advice, opinion, and/or instruction to an individual or group to allow participants an opportunity to explore problems related directly or indirectly to alcohol and/or other drugs.

Structured activities – Assessment, individual and group counseling family therapy, patient education, collateral services, crisis intervention, treatment planning, transportation services to and from medically necessary treatment, and discharge services.

Substance Use Disorder Diagnoses – Set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

SUD Counselor – Provide counseling services such as intake, assessment of need for services, treatment planning, recovery planning, individual or group counseling to participants, patients, or residents in any substance use disorder (SUD) program licensed or certified by DHCS are required by the State of California to be certified**.**

Telehealth between Provider and Member - Office or outpatient visits via interactive audio and video telecommunication systems.

Telehealth between Providers - Communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

Temporary Suspension - The provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary.

Threshold Language - Language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 members or five percent of the member population, whichever is lower, in an identified geographic area. In San Diego County the threshold languages are English, Tagalog, Spanish, Arabic, Farsi, Somali, Korean, Mandarin (Chinese) and Vietnamese.

Transportation Services - Provision of or arrangement for transportation to and from medically necessary treatment.

Trauma-Informed – Awareness and understanding of the prevalence of historical and current trauma, its impact on clients and a further commitment to not re-traumatize or do further harm through interventions, policies, or procedures.

Trauma-Informed Services – All components of a given service system that have been reconsidered and evaluated in light of a basic understanding of the role that violence plays in the lives of people seeking mental health and SUD services.

Treatment Planning – The provider (SUD counselor or LPHA) shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The development and update timeframes of treatment plans will depend on the level of care in which treatment is delivered. Treatment plans are no longer required for all levels of care.

Tuberculosis (TB) Disease [Active] – Persons who have active TB usually have symptoms. TB is a disease of the lungs or larynx that can be transmitted when a person with the disease coughs, sings, laughs, speaks, or breathes.

Tuberculosis (TB) Infection – Individual may not have symptoms of the disease; the infected person generally has a positive TB skin test (TST) and a normal chest x-ray. Infection may be recent or present for a long period of time.

Unit of Service – means:

1) For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a member in 15-minute increments on a calendar day.
2) For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit or in 15-minute increments.
3) For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.
4) For Clinician services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.
5) For residential services, providing 24-hour daily service, per member, per bed rate.
6) For withdrawal management per member per visit/daily unit of service.

Urgent Care - A condition perceived by a member as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 48 hours.

Utilization - The total actual units of service used by members and participants.

Volunteer – An individual that is an unpaid staff member.

Warm Handoff – When a treatment agency, case manager, counselor, etc. refers a client for additional services related to their treatment. This is not a simple referral but entails going the extra step to ensure that the client feels supported and is not left to their own devices. An example is when a counselor calls another counselor, introduces the client to the counselor, and then sets up a meeting between the client and new counselor. The client will go into the meeting having already been introduced to the new counselor.

Withdrawal Management - Detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the level of care criteria to DMC ODS members.

ASAM Level of Care (LOC) Determination Guidelines (1 of 2)

As emergency needs come first, the highest severity problem (with specific attention to Dimensions 1, 2 and 3) should guide the client's entry point into the treatment continuum. Then, the least intensive level of care that can safely and effectively help the client meet identified needs guides the LOC determination. This brief overview is not intended to replace the use of the comprehensive admission criteria as described in "The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, 2013."

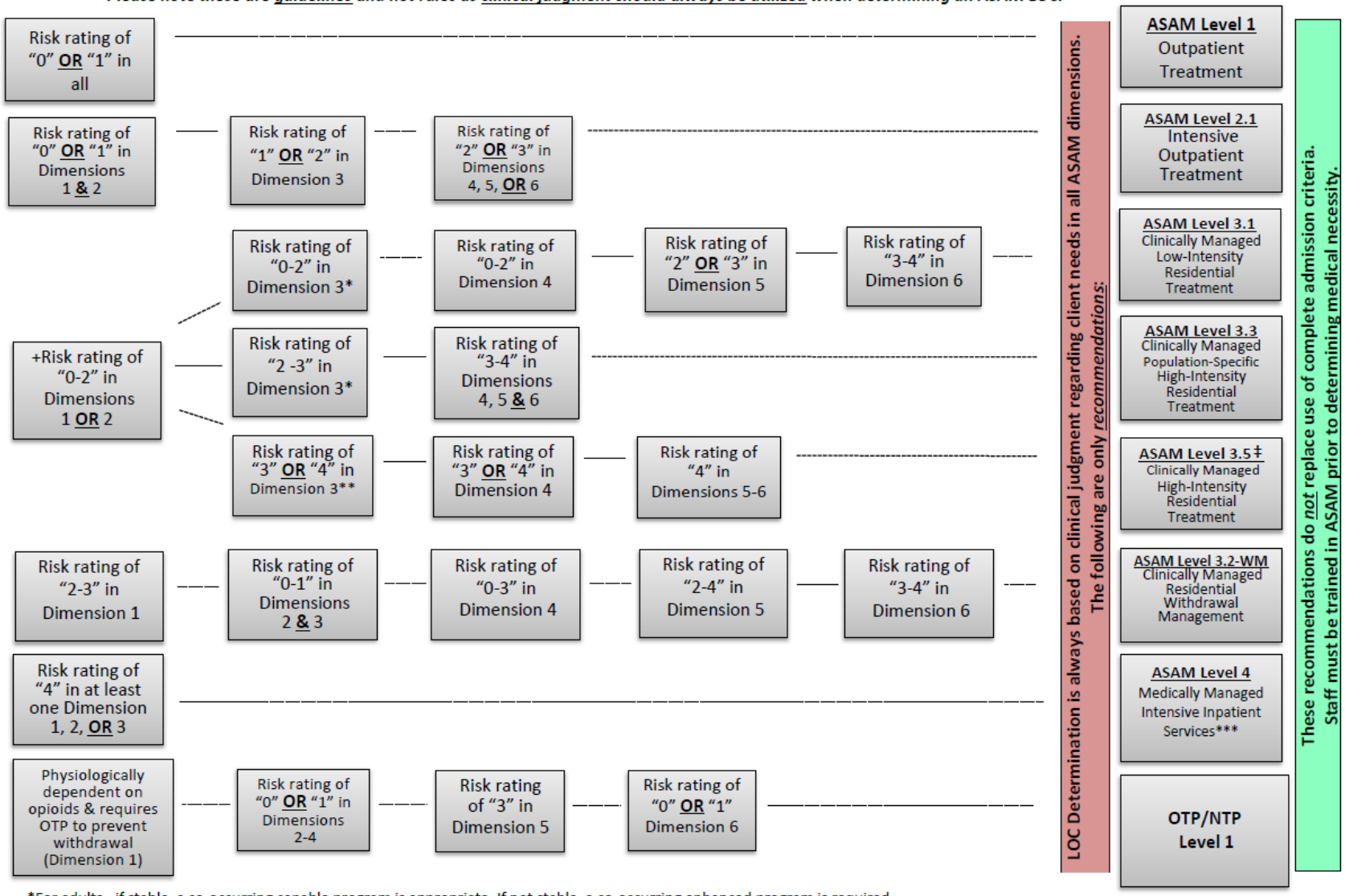
ASAM Levels of Withdrawal Management	Level	Description
Ambulatory WM without Extended Onsite Monitoring (Outpatient)	1-WM	Mild withdrawal but is at minimal risk of severe withdrawal syndrome and is assessed as likely to complete needed WM and to enter into continuing treatment or self-help recovery as evidenced by meeting one of these criteria: • Has an adequate understanding of ambulatory WM and has expressed commitment to enter such a program, or • Has adequate support services to ensure commitment to completion of WM and entry into ongoing treatment or recovery, or • Is willing to accept a recommendation for tx (i.e. MAT) or to attend outpatient sessions/self-help
Ambulatory WM with Extended Onsite Monitoring (Outpatient)	2-WM	Moderate withdrawal requiring extended WM support and supervision; at night, has supportive living situation; likely to complete WM as evidenced by meeting the first criteria and either of the three remaining criteria: • Client/supports clearly understand instructions for care and are able to follow instructions, and • Has an adequate understanding of ambulatory WM and has expressed commitment to enter such a program, or • Has adequate support services to ensure commitment to completion of WM and entry into ongoing treatment or recovery, or • Evidences willingness to accept a recommendation for treatment once withdrawal has been managed (for example, to attend outpatient sessions or self-help groups)
Clinically Managed Residential WM	3.2-WM	Moderate-severe withdrawal, but needs 24-hour support because of inadequate home supervisor or support structure, as evidenced by meeting one of these three criteria: • Recovery environment is not supportive of WM and entry into treatment, and the client does not have sufficient coping skills to safely deal with the problems in the recovery environment, or • Has a recent history of WM at less intensive levels of service that is marked by inability to complete WM or to enter into continuing addiction treatment, and the client continues to have insufficient skills to complete WM, or • Has demonstrated an inability to complete WM at a less intensive level of service, as manifested by continued use of other-than-prescribed drugs or other mind-altering substances.
Medically managed Intensive Inpatient WM	4-WM	Level 4 is the only available level of care that can provide the medical support and comfort care needed, as evidenced by one of these: • WM regimen or a client's response to that regimen requires monitoring or intervention more frequently than hourly, or • Need for WM or stabilization while pregnant, until she can be safely treated in a less intensive level of care.

Note: Clients may be in a level of Withdrawal Management and another LOC at the same time.

Revised May 2018

ASAM Level of Care (LOC) Determination Guidelines (2 of 2)

Please note these are guidelines and not rules as clinical judgment should always be utilized when determining an ASAM LOC.



*For adults - if stable, a co-occurring capable program is appropriate. If not stable, a co-occurring enhanced program is required.

+ For adolescents, withdrawal (or risk of withdrawal) is being managed concurrently at another level of care.

**For adults, a co-occurring enhanced setting is required for those with severe and chronic mental illness.

‡ For adolescents, mild to moderate withdrawal or risk, but does not need pharmacological management or frequent medical or nursing monitoring.

***If the client's only severity is in Dimensions 4-6 without high severity in Dimension 1, 2, and/or 3, then the client is not appropriate for this level of care.

Revised May 2018

Homeless Outreach Worker (HOW)
Service Model & Data Collection Flow



Outreach & Engagement

- Complete screening tool for all contacts with individuals
- Information complete to best of ability
- Turn in monthly Data Collection Log to COR and designated HOW Team



Enrolled

- Individuals who agree to ongoing services-with HOW Team
- Keep with client chart (HMIS or paper file)
- If client enrolls in program services, facilitate warm hand-off with program staff



Short Term CM Services

- Scheduled or unscheduled
- Services and referrals
- Document services in progress note



Documentation/ Outcomes

- HMIS-Clarity (All)
- Cerner Community Behavioral Health (Mental Health)
- Paper Chart
- Reminder-all contacts should have the screening tool

Rev 7.17.19 bk

Local PC 1000 Guidelines Summary

California Penal Code Section 1000 (PC 1000) establishes the authority for counties to create drug diversion programs for eligible participants who are referred from a court. A referral will be made to a County certified PC 1000 Drug Diversion program when a participant is eligible and suitable for the PC 1000 program. Persons who have a need for Substance Use Disorder (SUD) treatment, and who have private insurance, will be referred to their healthcare provider. The criminal charge is dismissed, pursuant to statute, if the participant successfully completes the program and complies with the conditions established by the court.

Two-Track Drug Diversion Process

The PC 1000 Two-Track Drug Diversion Program is intended to provide participants with either education on substance use or treatment for a diagnosed substance use disorder (SUD). The Drug Medi-Cal Organized Delivery System, and changes in state law, bring about the following changes to providers: 1) elimination of the AIDS education component, 2) maintenance of the education track, and 3) addition of a treatment track. The education track will continue at the existing sites, and on September 1, 2019, the new treatment track will be available at the six Regional Recovery Centers. All participants will be assessed SUD need through the American Society for Addiction Medicine (ASAM) criteria. If participant is assessed as having a need for treatment, they will only participate in the treatment track.

Orientation and Enrollment

Program shall enroll individuals referred to their program and site using the BHS-550 Referral Form or have been issued a referral to attend PC 1000 Drug Diversion by another California county. Participants shall be enrolled no later than 14 days past the date specified on the referral form. The orientation shall explain the PC 1000 Program Guidelines and Participant Standards document. Program shall enroll a participant by completing the PC1000 Orientation Checklist.

Leave of Absence (LOA)

Participants may request a leave of absence (LOA) whenever they are unable to attend any two consecutively scheduled program activities. To request a LOA, the participant shall submit a written request including the following information:

- The name of the participant
- The reason for requesting the LOA
- The beginning and end dates for the LOA

Program shall require the participant to request prior approval unless participant is unable to due to circumstances beyond their control. When participant requests retroactive approval**,** the written request shall document the circumstances that prevented the participant from requesting prior approval. Participants are allowed a total of 4 absences during the duration of the program and a 5th absence will result in dismissal and referral back to Court. Program shall require each participant to make up all absences. Time on LOA shall not count toward the minimum 3 months (12 weeks) required participation.

Inter-Program Transfer

A participant transferring to another PC 1000 Two-Track Drug Diversion Program in the County shall report to the receiving program within 28 days of cessation of services by the sending program. Notification of transfer shall be provided to the Court by the sending program using the County of San Diego PC 1000 Pre-Trial Diversion Program Participant Status Report (BHS-550PSR). The receiving program shall notify the sending program and the Court of the participant's enrollment or non-enrollment.

Participant Grievance Process

Program shall develop a process and procedure to address participant grievances. The plan must outline the steps for filing a grievance and the time frame required for a response.

Reporting Responsibilities

Program Reporting

- Program shall report the following participant information within 2 working days of deadline to the Court:
    - Confirmation of enrollment by required date
    - Successful completion
    - Satisfactory participation
    - Failure to complete or participate and reason

County Reporting

- Program shall submit the following reports to Behavioral Health Services (BHS):
    - Monthly Status Report
    - Monthly DATA set as specified by BHS
    - Quarterly revenue/expense report, Administration Fee Reporting Form and the Administration fee

Client Participation

Adequate participation is required for both PC 1000 Education and Treatment Tracks. For the Education Track, participants are required to complete 20 hours of classes. For the Treatment Track, participants are required to complete a minimum of 20 hours of treatment. Thresholds for unsatisfactory participation may include the following:

- Failure to comply with program rules and regulations.
- Positive drug test, failure to submit to a drug test or coming to program under the influence of alcohol or other drugs.
- Exceeding **5** unexcused absences.
- Failure to maintain contact with the program for **28** or more consecutive days.
- Failure to contact receiving program within **28** days of transfer
- Participant is physically or verbally abusive or threatening to program staff or other program participants. Program may refuse to reinstate a participant dismissed on this basis; a statement to that effect shall be included in the dismissal notice sent to the Court.

Unsatisfactory participation should be reported to the Court. The participant may be dismissed from the Education Track; however, this does not mean they are dismissed from the PC 1000 program. Clinical assessments should inform recommendation to dismiss clients, alternative referral to treatment, or change the level of care. Recommendation for dismissal or alternative referrals shall be reported on the PC 1000 Pretrial Diversion Program Participant Status Report and returned to the Court. The participant may also be dismissed from the Treatment Track. In such a case, they would not be eligible for the Education Track, and would therefore be dismissed from the PC 1000 program.

Education Track

Educational Sessions

The program shall schedule and provide ten (10) 2-hour and 10-minute educational sessions (20 hours total) scheduled once per week for (10) consecutive weeks. Each education session shall be limited to no more than 30 program participants. Each education session shall consist of:

- 90 minutes of educational activities
- 10-minute break
- 30-minute educational group discussion on the topic
- Individual completion of educational summary for each session

All programs shall utilize an approved curriculum that includes, but is not limited to the following educational topics:

- Understanding use and addiction
- Risk of legal issues and physical health

- Risk to family and employment
- Substance use disorder relapse warning signs and triggers
- Recovery skills including anger management and communication skills
- Recovery planning, relapse prevention, and abstinence
- Rewards of recovery

All programs shall develop lesson plans for each educational session that includes:

- Goals and objectives of each session
- Outline of the information to be covered
- Handouts, audiovisual aids, and/or guest speakers
- Educational sessions shall be scheduled to reasonably accommodate day/evening participant needs.

Each education session shall be limited to no more than 30 program participants. Participants shall complete a questionnaire on each education session.

Drug Testing

Baseline drug test shall be administered at program admittance. Collection shall be observed; therefore, both male and female staff shall be available. Urinalysis shall be a full panel drug screen. Program shall develop and implement a protocol for observed collection, testing, confirming, documenting, and reporting participant drug test results and shall submit the protocol to the COR for approval. Protocol shall protect against the falsification and/or contamination of any urine samples.

Baseline test may show a positive result and the participant shall not be dismissed. Subsequent drug tests shall be random. If the level remains steady or increases, this shall be considered a positive drug test and the participant shall be released from education track and re-assessed for treatment track. Notification shall be provided to the Court using the County of San Diego PC 1000 Diversion Program Participant Status Report.

Referral to Ancillary Services

Program shall refer participants to ancillary services such as withdrawal management, mental or physical health agencies, family counseling, and residential treatment/recovery services based on assessed need. Referral shall be voluntary.

Program Fees and Refunds

Program shall charge only those program fees established and approved by the COR. Standard fee/payment schedule shall be applied. See PC 1000 Education Track Program Fee document. At the time of transfer or program dismissal of a participant, program shall calculate the value of services provided, based on the cost per unit of service, and compare that total to the fees paid to date by the participant. Any fees paid more than the value of services provided shall be refunded to the participant within 60 days of the date of program dismissal or within 14 days from the date of transfer.

Participant Records

Program shall establish a participant case file to include all relevant material and documentation for each participant. Participant files shall be retained for a minimum of 48 months from the date of the last program activity. A summary of all program services, absences, fees/charges and fees paid shall be reflected in each participant file. At minimum, the participant case file shall contain:

- Supplemental documents
- Record of attendance at program services and self-help groups
- Referrals to support services
- Face-to-face contacts with staff
- Drug test results
- Fee collection status
- Exit plan

Outcomes Objectives

Completion

A minimum of 55% of clients enrolled will complete the PC 1000 Education Track, as measured by completing all required program services and paying in full all assessed program fees.

No New Arrests

A minimum of 90% of all participants who successfully complete the PC 1000 Education Track shall have no new arrests, excluding minor traffic offenses, while in the program. This is measured by participant self-report and is documented at their final service in the program.

The full program guidelines can be found at Optum.

Witnessed Collection

(from Adult Drug Court Best Practice Standards, Volume II – Text Revision. National Association of Drug Court Professionals, Alexandria, Virginia. Copyright 2018, Text Revision, National Association of Drug Court Professionals)

Drug Court participants and probationers acknowledge engaging in widespread efforts to defraud drug and alcohol tests. These efforts include, but are not limited to, consuming excessive water to dilute the sample (dilution), adulterating the sample with chemicals intended to mask a positive result (adulteration), and substituting another person's urine or a look-alike sample that is not urine, such as apple juice (substitution) (Cary, 2011; McIntire & Lessenger, 2007). Collectively, these efforts are referred to as tampering. In focus groups, Drug Court participants reported being aware of several individuals in their program who tampered with drug tests on more than one occasion without being detected by staff (Goldkamp et al., 2002).

The most effective way to avoid tampering is to ensure that sample collection is witnessed directly by a trained and experienced staff person (ASAM, 2013; Cary, 2011). If substitution or adulteration is suspected, a new sample should be collected immediately under closely monitored conditions (McIntire et al., 2007). Staff members should be trained in how to implement countermeasures to avoid tampered test specimens. Examples of such countermeasures include searching participants' clothing for chemical adulterants or fraudulent samples, requiring participants to leave outerwear outside of the test-collection room, and putting colored dye in the sink and toilet to prevent water from being used to dilute test specimens (McIntire & Lessenger, 2007).

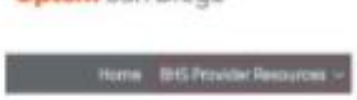
If substitution or other efforts at tampering are suspected for a urine specimen, it may be useful to obtain an oral fluid specimen immediately as a secondary measure of substance use. Generally speaking, observing the collection of oral fluid closely is easier than for the collection of urine, and oral fluid tests are less susceptible to dilution than urine tests (Heltsley et al., 2012; Sample et al., 2010). However, because oral fluid testing has a shorter detection window than urine testing, a negative oral fluid test would not necessarily rule out recent drug use or the possibility of a tampered urine test.

Because specialized training is required to minimize tampering of test specimens, under most circumstances participants should be precluded from undergoing drug and alcohol testing by independent sources. In exigent circumstances, such as when participants live a long distance from the test collection site, the Drug Court might designate independent professionals or laboratories to perform drug and alcohol testing. As a condition of approval, these professionals should be required to complete formal training on the proper collection, handling, and analyses of drug and alcohol test samples among Drug Court participants or comparable criminal justice populations. Drug Courts are also required to follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2011; Meyer, 2011). Therefore, if independent professionals or laboratories perform drug and alcohol testing, they must be trained carefully to follow proper chain-of-custody procedures.

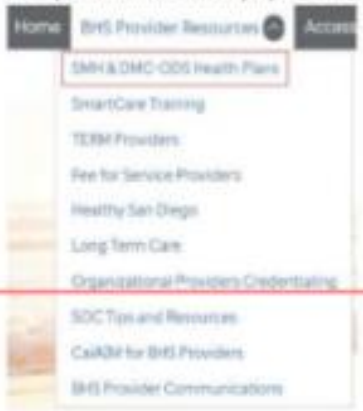
Navigating the Optum Website: A Tip Sheet for SUD Service Providers

The Optum website is an efficient way for Country Quality Assurance (QA) to post important documents and communications for providers. To access SUD program specific information, follow the steps below:

1. Go to https://www.optumsandiego.com
2. On the home screen, select the **BHS Provider Resources** button on the top of the page:



3. A drop-down menu will display. Select the option for **SMH & DMC-ODS Health Plans**:



4. This will launch a page with several tabs at the top. Please note MH and DMC-ODS items are now housed together. Wherever applicable, information within tabs will denote whether documents apply to MH only, DMC-ODS only, or MH and DMC-ODS.



   a. **SmartCare** tab is for all relevant resources related to SmartCare functionality, reporting, and billing needs
   b. **SUDPOH** tab is for the "Substance Use Disorder Provider Operations Handbook" and recent updates with the handbook
   c. **UCRM/SUDURM** tab is for the "Substance Use Disorder Uniform Record Manual," also known as the "Client File"
   d. **Communications** tab is for QA memos sent to both MH and DMC-ODS programs

5. There is also a **Search** feature at the top right of the website to help locate documents.



Revised 9-30-25

County of San Diego—HHSA

Privacy Incident Reporting Process for Programs

Staff Steps

Staff becomes aware of suspected or actual privacy incident and notifies Program Manager immediately.

Examples of reportable Privacy Incidents include:

- Giving Client A's paperwork to Client B
- Sending email with client information to wrong individual
- Sending unencrypted email with client information outside of the County
- County email hacked
- Ransomware found on County device
- Misplacing a client's chart
- Losing County-issued phone or laptop
- Looking up clients without a business purpose

Incidents at County-Operated Programs

1. For all Privacy Incidents, within 1 business day, Manager submits an initial *HHSA Privacy Incident Report* (PIR) online at https://www.sandiegocounty.gov/content/sdc/hhsa/hhsa-privdb-landing.html. The PIR is also available on the ACO website: www.cosdcompliance.org.

   If suspected or actual privacy incident involves 500 or more individuals or data from the Social Security Administration, upon discovery, Manager also immediately emails Agency Compliance Office (ACO) at: PrivacyOfficer.HHSA@sdcounty.ca.gov.

2. Within 3 business days, Manager investigates and updates PIR using the unique Access Code and PIR# provided after initial PIR submission.
3. Within 7 business days, Manager provides completed PIR.
4. ACO confers with Manager as needed before ACO makes formal breach assessment and determination as to Client Notifications.
5. If ACO determines that Notifications are needed:
   a. Manager uses ACO template to draft Notifications for ACO approval.
   b. Once approved, Manager mails signed Notifications within timeline provided by ACO
   c. Manager provides date Notifications sent to ACO.
   d. ACO may request certified mail and/or copy of Notifications
6. ACO makes any necessary breach notifications to State and/or federal oversight agencies.

Incidents at Contractor-Operated Programs

1. For all Privacy Incidents, within 1 business day, Manager submits an initial *HHSA Privacy Incident Report* (PIR) online at https://www.sandiegocounty.gov/content/sdc/hhsa/hhsa-privdb-landing.html. The PIR is also available on the ACO website: www.cosdcompliance.org.

   If suspected or actual privacy incident involves 500 or more individuals or data from the Social Security Administration, upon discovery, Manager also immediately emails Agency Compliance Office (ACO) at: PrivacyOfficer.HHSA@sdcounty.ca.gov.

2. Within 3 business days, Contractor investigates and updates the PIR using the unique Access Code and PIR# provided after initial PIR submission.
   - PIR should include Contractor's initial breach risk analysis in 'Discuss Impact of Privacy Incident' section of PIR.
3. Within 7 business days, Contractor provides completed PIR, including final breach risk analysis.
4. ACO reviews Contractor's PIR and confers with Contractor and/or State, as applicable, to determine need for Client Notifications.
5. If ACO determines that Notifications are needed:
   a. Contractor ensures Notifications comply with CA Civil Code 1798 and other legal requirements before submitting to ACO for approval.
   b. Once approved, Contractor mails signed Notifications within timeline provided by ACO
   c. Contractor provides date Notifications sent to ACO.
6. ACO completes privacy breach reporting to State to satisfy the County's contractual requirements with the State.
7. Contractor is responsible for all other notifications, such as those required by State or federal regulations.

More detail on these requirements is found in Article 14 of contract

HHSA L-24: Privacy Incident Reporting Workflow 2022.10.03

County TLS Email Encryption

The County has Transport Layer Security (TLS) available for sending encrypted email through a secured connection. This means that when a TLS connection is established with a vetted County business partner, all email communication sent between the County and the business partner will be automatically encrypted in transit over the Internet through the secured connection.

County of SD - ...@sdcounty.ca.gov **Vetted Business Partners - @xxxxxxx**



County business partners interested in establishing a TLS connection with the County must meet the following requirements:

- Must have TLS-enabled mail servers.
- Must have a server digital certificate issued by a Certificate Authority.

If both items above are met, the business partner may request the County's **TLS Boundary Encryption Form** (complete sections 2 -4) and return to HHSA Pilar.Miranda@sdcounty.ca.gov to initiate the process. It takes approximately two weeks to set up.

Note: Business partner users are to contact their IT/compliance/security officer if they have any questions regarding TLS email communication.

HHSA-ACO, Information Security (PMiranda 6/2019)

BHS CalOMS & Open Admissions Process

REQUIREMENT

- BHS MIS unit submits CalOMS data to DHCS on the 1st and 15th of each month.

CalOMS PROCESS

1. BHS MIS unit will contact providers via email with CalOMS errors generated after each data submission.

2. Providers should read the full email which will include how to resolve some of the common errors.

3. Providers are expected to have the corrections made prior to the next scheduled data submission to DHCS.

OPEN ADMISSIONS PROCESS

1. BHS MIS unit will contact providers via email with DHCS Open Admissions records that are either:
    a. Out of compliance - meaning over 11 months from CalOMS Admission or last CalOMS Annual Update
    b. At risk of becoming out of compliance – meaning between 10 - 11 months from CalOMS Admission or last CalOMS Annual Update

2. Providers should read the full email which will include instructions and due dates.

3. Providers are expected to update the records as follows:

    a. Records that are at risk of becoming out of compliance must have a CalOMS Annual Update or CalOMS Discharge record completed prior to the next scheduled CalOMS submission to DHCS.

    b. Records 11.0 months plus one day are out of compliance and must have a CalOMS Annual Update or CalOMS Discharge completed within 3 days of the email sent by the MIS unit.

BHS DATAR Process

REQUIREMENT

- Provider DATAR reporting is due to DHCS by the 7th of each month.

PROCESS

1. Monthly email reminders are sent to each provider on the 1st of each month and as needed.

2. Providers have between the 1st of each month and the 7th of each month to submit DATAR data to DHCS. DATAR must be submitted by the close of the business day on the 7th.

3. BHS MIS unit will generate a DHCS Non-Compliance DATAR Report on the 8th of each month to identify any providers not in compliance with the monthly DATAR requirement.

4. Providers identified on the Non-Compliance DATAR list will be notified via email of their non-compliance status and requested to comply immediately.

5. Assigned COR's and Analysts will be notified on the 8th of each month of providers identified on the Non-Compliance DATAR Report.

6. BHS MIS unit will continue to generate additional reports and follow-up with CORs and providers until compliance is 100%.

7. DATAR staff access, staff account deactivations, and issues submitting DATAR should be sent to the MIS SUD Support desk at SUDEHRSupport.HHSA@sdcounty.ca.gov.

8. Providers are expected to have at least two staff that have access to submit DATAR in case of staff leaves, vacation, sickness, etc.…

9. Providers are responsible for sending a pdf. file of the month's submission to the SUD Support desk at SUDEHRSupport.HHSA@sdcounty.ca.gov by the 10th of each month for auditing.

What is DATAR?

The Drug and Alcohol Treatment Access Report (DATAR) is the Department of Health Care Services (DHCS) system to collect data on treatment capacity and waiting lists and is considered a supplement to the California Outcomes Measurement System (CalOMS). DATAR assists in identifying specific categories of individuals awaiting treatment. Note: The county's Intergovernmental Agreement (IA) under Organized Delivery System (ODS) does not allow waitlist.

Who Must Report?

All Substance Use Disorder (SUD) treatment providers that receive SUD treatment funding from DHCS are required to submit the one-page DATAR form to DHCS each month. In addition, certified Medi-Cal providers, and Licensed Narcotic Treatment Programs (NTP/OTP) must report, whether they receive public funding.

DEFINITIONS

Total Treatment Capacity:
The maximum number of clients/participants who could be enrolled for SUD treatment at any one time using **ALL** sources of funds (public, DMC, 3rd party, client fees…) allocated to this treatment unit.

Public Treatment Capacity:
The maximum number of clients/participants who could be enrolled for SUD treatment at any one time, using the public funds available to this treatment provider by federal, state, and/or county government.

Public Funds:
Public funds are those that are allocated to the county SUD treatment programs as well as certain county generated funds. These funds can include (but are not necessarily limited to) state general, federal block grants, discretionary grants, county funds, federal Drug/Medi-Cal, etc.…

Slot:
Slot is the capacity to provide treatment service to one individual. Total slots reflect the maximum number of individuals a provider can serve at any one time, given its complement of staffing and other resources. "The static capacity that is being reported".

- NTP/OTP should be reported in terms of licensed slots
- Outpatient should be reported as the number of clients a provider can accommodate given available resources
- Residential should be reported in terms of available beds

Service Type(s):
Service(s) Approved by DHCS to serve clients/participants in a SUD Program. DATAR displays only the types of services the specific facility is contracted to provide.

Abbreviations for Service Types:

ABBREVIATION	DESCRIPTION
ODF	Outpatient Services (OS)
MAINT NTP/OTP	NTP/OTP Maintenance
NTP/OTP DTX	NTP/OTP Detox
NONRES DTX	Non-Residential Detox
RES DTX-NH	Residential Detox – Non-Hospital
RES	Residential
IOT/DCR	Intensive Outpatient Services (IOS)

OTHER	Hospital detoxification, Jail settings, etc.

DATAR QUESTIONNAIRE OVERVIEW

LINE 1-TOTAL TREATMENT CAPACITY- *Funding Source: (ALL) see definitions above*	Enter the total treatment capacity at this location by type of service. If a program has two or more types of service, then each entry must reflect the number of "slots" which can be provided in that service type at any given time. If the entries across the line were to be added, the result would be the total program capacity for SUD treatment service at this location. *See Definitions above*
LINE 2A-PUBLIC TREATMENT CAPACITY *Funding Source: (PUBLIC)*	Enter the public treatment capacity at this location by type of service. If a program has two or more types of service, then each entry must reflect the number of slots per service type at any given time. This number represents the maximum number of clients/participants aka "slots" who could be enrolled for SUD treatment at any one time using **PUBLIC Funds** available. *See Definitions above*
LINE 2B- AVAILABLE PUBLIC TREATMENT OPENINGS AT END OF MONTH *Funding Source: (PUBLIC)*	Enter for each service type, the unused **PUBLIC** treatment capacity at this location as of the last day of the report month (number of "slots" empty) • *NTP slot- Licensed slots* • *Outpatient services- The number of unique clients a provider can accommodate given available resources* • *Residential- Licensed beds*
LINE 3- NUMBER OF DAYS THE PROGRAMS CENSUS/ENROLLMENT EXCEEDED 90% OF PUBLIC TREATMENT CAPACITY DURING THE MONTH- *Funding Source: (PUBLIC)*	Enter for each service type the number of days during the report month that the programs enrollment exceeded 90% of its **PUBLIC** treatment capacity. *I.e. Facility A has 100 public slots per month and for 12 days they were at 92% capacity. "12" will be entered since for 12 days they were over 90%*
LINE 4- TOTAL NUMBER OF APPLICANTS ON THE WAITING LIST AT ANY TIME DURING THE ENTIRE MONTH-*Funding Source: (PUBLIC)*	Lines 4 - 7G are all related to waitlist, zero's (0) should be entered by type of service.
LINE 5-NUMBER OF APPLICANTS ON WAITING LIST ON LAST DAY OF REPORT MONTH-*Funding Source: (PUBLIC)*	
LINE 6A- NUMBER OF APPLICANTS ADMITTED TO TREATMENT FROM THE WAITING LIST-*Funding Source: (PUBLIC)*	
LINE 6B- TOTAL NUMBER OF DAYS	

THAT APPLICANTS ADMITTED TO TREATMENT SPEND ON WAITING LIST-*Funding Source: (PUBLIC)*	
LINE 7- NUMBER OF IDU ON WAITING LIST-*Funding Source: (PUBLIC)*	
LINE 7B- NUMBER OF PREGNANT WOMEN ON WAITING LIST-*Funding Source: (PUBLIC)*	
LINE 7C- NUMBER OF PREGNANT IDU ON WAITING LIST-*Funding Source: (PUBLIC)*	
LINE 7D- NUMBER OF MEDI-CAL MEMBERS-*Funding Source: (PUBLIC)*	
LINE 7E- NUMBER OF CALWORKS RECIPIENTS-*Funding Source: (PUBLIC)*	
LINE 7F- NUMBER OF SACPA COURT/PROBATION REFERRALS-*Funding Source: (PUBLIC)*	
LINE 7G- NUMBER OF SACPA PAROLE REFERRALS-*Funding Source: (PUBLIC)*	

SUBSTANCE USE DISORDER CREDENTIALS

CADTP Certification Levels
(Effective January 1, 2019)

Substance Use Disorder Registered Counselor (SUDRC)
Before becoming employed as a counselor in a DHCS licensed or certified program, an applicant must register with the California Association of DUI Treatment Programs (CADTP). Applicants will have five (5) years from the date of being registered as an AOD counselor to complete the certification process.

SUDCC- Substance Use Disorder Certified Counselor
- Passed the IC&RC Exam
- 315 hours of formal SUD related education
- 2080 hours of SUD related work experience (160 practicum)

SUDCC II- Substance Use Disorder Certified Counselor – Advanced Experience
- Passed the IC&RC Exam
- 315 hours of formal SUD related education,
- 5 years or 10,000 hours of SUD work experience

SUDCC III - Substance Use Disorder Certified Counselor – Advanced Experience and Bachelor Level Education
- Passed the IC&RC Exam
- Bachelor's degree in SUD related education
- 5 years or 10,000 hours of SUD work experience

SUDCC III-CS - Substance Use Disorder Certified Counselor Clinical Supervisor
(Effective 01/01/2019: all former CAODC-CS counselors will be grandfathered to the SUDCC III-CS)
- Passed the IC&RC Exam
- Bachelor's degree in SUD related education
- 5 years or 10,000 hours of SUD work experience which includes 2 years' experience in the direct supervision of SUD Counselors
- Completed 40 hours of Clinical Supervisor specific education

SUDCC IV: Substance Use Disorder Certified Counselor – Advanced Experience and Master Level Education
- Passed the IC&RC Exam
- Master's degree in formal SUD related education
- 5 years or 10,000 hours of SUD work experience

SUDCC IV- CS: Substance Use Disorder Certified Counselor Clinical Supervisor
- Passed the IC&RC Exam
- Master's degree in formal SUD related education
- 5 years or 10,000 hours of SUD work experience which includes 2 years experience in the direct supervision of SUD Counselors
- Completed 40 hours of Clinical Supervisor specific education

Credential Verification: http://www.cadtp.org/counselors/

Reference: www. cadtp.org

Alcohol and Other Drug Counselors Licensed, Certified, or Registered By CCAPP

In order to assist clients, employers, and state regulators in the verification and referral processes, CCAPP has developed "The Registry" for identifying qualified treatment professionals in good standing with the California Consortium of Addiction Programs and Professions Credentialing (CCAPP Credentialing). The term "pending" may identify one of the following: pending administrative review, nonpayment of renewal dues and/or declined credit card and/or a check provided that has been sent back with the status non-sufficient funds.

RADT = Registered Alcohol and Drug Technician

RADT II = Registered Alcohol and Drug Trainee II

CADC I = Certified Alcohol and Drug Counselor I

CADC II = Certified Alcohol and Drug Counselor II

CADC-CS = Certified Alcohol Drug Counselor – Clinical Supervisor

LAADC = Licensed Advanced Alcohol and Drug Counselor

LAADC-S = Licensed Advanced Alcohol and Drug Counselor - Supervisor*

*non-governmental license

IM = Membership, this is not a credential

We also offer specialty certifications:

CCJP = Certified Criminal Justice Addiction Professional

CCPS = California Certified Prevention Specialist

CCDP = Certified Co-occurring Disorder Professional

CPRS = Certified Peer Recovery Specialist

CRPM = Certified Recovery Program Manager

MATS = Medication Assisted Treatment Specialist

IS = Intervention Specialist

WTS = Women's Treatment Specialist

Credential Verification: https://ccappcredentialing.org/index.php/verify-credential

Reference: https://ccappcredentialing.org

CATC (I, II, III, IV, V, N) Certification Upgrades
The honorary CATC (I, II, III, IV, V, N) tiered system is designed to signify your higher level of education to employers and clients. The education requirements (in addition to the minimum 315 hours of AOD coursework) for each honorary CATC tier level are as follows:

(CATC-i)- Intern Registration

CATC I - Certificate of Completion from a 30-Unit minimum approved Alcohol and Other Drug (AOD)/Addiction Studies or Alcohol and Drug Studies (ADS) Community College Program (https://dev.caade.org/accreditation-of-colleges-career-track-programs/accreditedaodprograms/) and must be in Addiction Studies or Alcohol & Drug Studies
CATC II – Associate Degree – Degree must be from a regionally accredited college/university and must be in Addiction Studies or a related field.
CATC III - Bachelor's Degree - Degree must be from a regionally accredited college/university and must be in Addiction Studies or a related field.
CATC IV – Master's Degree - Degree must be from a regionally accredited college/university and must be in Addiction Studies or a related field.
CATC V – Doctoral Degree - Degree must be from a regionally accredited college/university and must be in Addiction Studies or a related field.
CATC N – Nursing Degree - Degree must be from a regionally accredited college/university and must be in Nursing

Credential Verification: http://caadeorg.azurewebsites.net/searchrecordscompoundCAADE.php

Reference: https://caade.org

Trauma-Informed Care Code of Conduct

In alignment with LiveWell San Diego, the Trauma Informed Code of Conduct, facilitated by Clinton Health Matters Initiative, was developed by young adults from Project A.W.A.R.E., Just in Time for Foster Youth, and Youth Empowerment. It is a statement of their expectation about how children, youth, and families should be treated by government agencies and communities of support who interact with them. An organization that adopts the Code of Conduct commits to ensuring that its policies and staff practices meet the standards below, and has a system of accountability to make sure that this is true.

Adopting organizations commit to apply trauma-informed care practices to ensure that their interactions, behaviors, services, and communities of support are accountable to avoid worsening the effects of trauma, to support youth in building resilience, and in being balanced, healthy, and empowered. Adopting organizations view each person as creative, resourceful, whole, and more than just a number.

ADOPTING ORGANIZATIONS WILL ADHERE TO THESE PRINCIPLES:

Safety

A safe and open-minded place where I feel welcome

a. Nurtures a reliable environment with respect for privacy and self-expression
b. Maintains nonviolent environment free of intimidation
c. Respects confidentiality unless permission is given (unless someone is harming you, you are harming yourself, or you are harming someone else)

Effective Communication

Providing me with clear and consistent information

a. Ensures needs are met with an appropriate level of urgency, prioritization, and follow-through
b. Provides accessible means of communication, with appropriate measures taken for privacy (e.g. in-person, phone, email, social media)
c. Maintains transparency about the organization's processes, and explains actions taken in any high-stress situation
d. Utilizes a process to provide constructive feedback to the organization, and ensures steps are taken for improvement when appropriate

Individualized Support

Assists me and considers the factors affecting my situation

a. Implements a welcome process to the organization and community
b. Builds mutually beneficial partnerships to promote successes and coach people to reach personal goals
c. Connects people with services and partners, or offers alternatives until needs are properly addressed
d. Views each person as creative, resourceful, whole, and more than just a number

Supportive Staff

Is kind and has a true and genuine passion for helping me

a. Integrates trauma-informed care training and awareness
b. Reflects the community served (e.g. lived experiences, ethnicity, race, gender, social status)
c. Values everyone regardless of gender, race, sexual orientation, social status, religious and personal beliefs, or culture
d. Offers a considerate, honest, and empathetic community that can be relied on

CLINTON FOUNDATION

BHS Health, Safety and Appearance Standards

Substance Use Disorder Program Facilities
Health, Safety, and Appearance Standards, HHSA: ADS 1077

For All Facilities:

1. All areas shall be kept clean.
2. All areas shall be free of health risks, i.e. vermin and their residue, contaminated water, noxious odors, and accumulated dirt. Maintenance supplies, especially toxic materials, shall be stored appropriately in secured areas.
3. Refrigerators, microwaves, coffeemakers, and any other appliances used for food preparation shall be cleaned and maintained regularly. All food items shall be stored appropriately.
4. Wastebaskets, trash cans, dumpsters, etc. shall be emptied regularly and cleaned and disinfected as necessary. Areas surrounding trashcans and dumpsters shall also be cleaned and maintained.
5. All occupied areas shall have adequate ventilation and reasonable interior temperatures (64-85 degrees).
6. All sites shall have a fully equipped first aid kit, posted emergency exit plan, up-dated fire extinguishers, and smoke and carbon monoxide detectors.
7. All electrical wiring shall be free of safety hazards and meet appropriate codes. Electrical supply cabinets must be locked/secured to prevent access by clients, children, and visitors.
8. All floors and walkways shall be intact, level, and free of all tripping hazards and other obstructions.
9. Lighting shall be adequate inside and outside the facility during all seasons of the year.
10. Boxes, records, papers, and other supplies shall be neatly kept in appropriate storage areas. None of these items shall be allowed to obstruct passage by clients, staff, or visitors.
11. Smoking, if allowed by the program, shall occur only in designated outdoor smoking areas with adequate disposal receptacles away from public entrances and exits and areas where children and youth may be present.
12. Roof, walls, ceilings, and floors shall be maintained in good condition, i.e. no peeling paint, rotting wood, etc. They shall be free of mold and mildew, water damage, and rust.
13. All furniture shall be in good repair and suitable to the program's services.
14. All decorative art shall be intact, secured, and well maintained.
15. Entrances shall be identified.
16. Window treatments shall be in good repair.
17. Emergency, fire, and safety procedures and exit maps shall be in view.

APPENDIX O.1 – Sliding Scale

UNIFORM PATIENT FEE SCHEDULE
COMMUNITY MENTAL HEALTH SERVICES
Effective October 1, 1989

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
	MEDI-CAL ELIGIBLE AREA				
0-569					
570-599					
600-649					
650-699	50				
700-749	56				
750-799	63				
800-849	71	64			
850-899	79	71			
900-949	89	80			
950-999	99	90	80		
1000-1049	111	100	90		
1050-1099	125	112	101		
1100-1149	140	126	113		
1150-1199	156	140	126	113	
1200-1249	177	159	143	129	
1250-1299	200	180	162	146	
1300-1349	226	203	183	165	149
1350-1399	255	230	207	186	167
1400-1449	288	259	233	210	189
1450-1499	326	293	264	238	214
1500-1549	368	331	298	268	241
1550-1599	416	374	337	303	273
1600-1649	470	423	381	343	309
1650-1699	531	478	430	387	348
1700-1749	600	540	486	437	393
1750-1799	678	610	549	494	445
1800-1849	752	677	609	548	493
1850-1899	835	752	677	609	548
1900-1949	927	834	751	676	608

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456
Above $4,200 Add $400 for each $100 additional income					

** Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made*

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