



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

BHRS Vision

Our vision is to continue to be a leader in behavioral health and to be recognized for excellence in our community, state, and nation.



BHRS Mission

In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes.

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES

August 1, 2017

For questions, contact Dawn Vercelli, Chief of Substance Use Disorder Services

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY
SERVICES

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

1115 Waiver

Table of Contents

| | |
|---|---|
| <u>PART I</u> | 2 |
| <u>PLAN QUESTIONS</u> | 2 |
| <u>PART II</u> | 5 |
| <u>PLAN DESCRIPTION (Narrative)</u> | 5 |

PART I PLAN QUESTIONS

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

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

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

Faith based organizations, BHRS' former (retired) BH Director and Associated Director, Aging and Veterans Services, AFSCME Union Representative BHRS Consultant.

2. How was community input collected?

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

Our county website: <http://www.stancounty.com/bhrs/> Under Quick Links, Medi-Cal Organized Delivery System (DMC ODS) had a survey monkey posted from 04/20/17 to 05/31/17. The survey monkey asked for input and an interest card linked to the Survey Monkey asked for content expert involvement in our Strategic Partner Workgroups.

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

- ☒ Monthly
☐ Bi-monthly
☐ Quarterly
☐ Other: _____

Review Note: One box must be checked.

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

- ☐ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.
- ☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.
- ☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.
- ☒ There were no regular meetings previously, but they will occur during implementation.
- ☐ There were no regular meetings previously, and none are anticipated.

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

REQUIRED

- ☒ Withdrawal Management (minimum one level)
☒ Residential Services (minimum one level)

- ☒ Intensive Outpatient
- ☒ Outpatient
- ☒ Opioid (Narcotic) Treatment Programs
- ☒ Recovery Services
- ☒ Case Management
- ☒ Physician Consultation

How will these required services be provided?

- ☐ All County operated
- ☒ Some County and some contracted
- ☐ All contracted

OPTIONAL

- ☐ Additional Medication Assisted Treatment
- ☐ Partial Hospitalization
- ☒ Recovery Residences
- ☒ Other (specify)

Evaluation for other two (2) optional services will be made during strategic partner workgroup planning and/or after initial implementation.

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

- ☒ Yes (required)
- ☐ No. Plan to establish by:_____.

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

BHRS has an established toll free Medi-Cal Access Line that is currently used by our Mental Health Plan. We will be using this same access line for DMC-ODS. The access line will be in operation for DMC-ODS on the day we start services.

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

- ☒ Yes (required)
- ☐ No

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

☒ Yes (required)

☐ No

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

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

☒ Yes (required)

☐ No

PART II PLAN DESCRIPTION (Narrative)

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

General Review Notes:

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

Narrative Description

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

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

Behavioral Health & Recovery Services (BHRS) participates in a number of ongoing partnerships with the goal of community based planning, collaboration, and coordination related to the provision of substance use disorders. DMC-ODS discussions began in some of these meetings as early as 10/15/15. As BHRS moves through the planning and implementation phases of the DMC-ODS, several of the meetings will be engaged ongoingly in developing a collaborative system of care that meets the needs of our clients. These meetings include, but are not limited to:

| | |
|--|------------|
| ▪ Substance Use Disorders Managers/Coordinators Meeting | Monthly |
| ▪ Substance Use Disorders Providers Meeting (begins 8/15/17) | Monthly |
| ▪ Stanislaus County Behavioral Health Board | Monthly |
| ▪ DMC-ODS Oversight Committee | Monthly |
| ▪ DMC-ODS Framework Committee | Monthly |
| ▪ Stanislaus Recovery Center Collaborative | Bi-monthly |
| ▪ Child Protective Services Collaborative | Quarterly |
| ▪ Health Plan of San Joaquin (MOU) | Quarterly |
| ▪ Health Net (MOU) | Quarterly |
| ▪ Community Corrections Partnership (CCP) | Quarterly |
| ▪ Prop 47 Meeting | As Needed |

BHRS staff met with criminal justice partners on 02/06/17 in a Prop 47 meeting. DMC-ODS information was presented and discussed; input was requested and questions were answered. Further on-going collaboration will occur as needed.

Meeting(s) with our Stanislaus County Community Service Agency (CSA) leadership partners are pending to discuss DMC-ODS information. Our goal is to develop a plan to integrate existing processes and contracts into the DMC-ODS Waiver.

BHRS leadership staff has ongoing quarterly collaborative meetings with Stanislaus County's two (2) managed care health plans. Beginning in February 2017, the meetings included discussions about DMC-ODS collaboration specific to the MOU's. These discussions will continue until the required MOU's are finalized with both Health Plans. Once the MOU's are developed, approved and implemented, BHRS will continue to meet with our health plans regularly.

Public stakeholder meetings were held on 04/21/17 and 05/04/17. The public stakeholder DMC-ODS meetings were held as informational meetings and included opportunities for stakeholder input and requests for participation in upcoming Strategic Partner Workgroups (see attachment #1 for copy of the PowerPoint).

BHRS developed a survey for all stakeholders and options for the completion of the survey included a paper and electronic format (see attachment #2 - #5 for copies of the survey). The paper version was handed out and could be completed at the meeting or taken home with a self-addressed stamped envelope to be returned to BHRS Data Management Services. The survey link to the electronic format was included in the material distributed at the meeting. After the meeting, via email, the link was sent to all stakeholder invitee's (whether they attended the stakeholder meeting or not). Additionally, a link to the electronic survey was posted and available to the general public on the Stanislaus County BHRS website from 4/20/17 to 5/31/17. Other DMC-ODS information is posted on the website as well.

One hundred three (103) individuals participated in our two (2) public stakeholder meetings. Key participants included: County and contract provider SUD programs, representatives from Stanislaus County's Chief Executive Officers (CEO) office, recovery residence providers, faith based community providers, former BHRS Director and Associate Director, BHRS Leadership Team, Public Health, staff from BHRS SUD programs and other BHRS programs.

As a result of the public stakeholder meetings and other collaborative meetings, Strategic Partner Workgroups are being formed to help develop a coordinated and seamless system of integrated care for clients.

The Strategic Partner Workgroups are:

- MAT Services
- Coordination of Care
- ASAM Comprehensive Assessment
- Youth Treatment Services (future workgroup)

Each workgroup will be facilitated by BHRS SUD system lead staff member. Participants will include BHRS and community partner service and leadership staff. Workgroup members are recruited as content experts in their specific area and are expected to make time commitments, assist in problem solving real issues, produce deliverables, and conduct focus groups with clients, if needed.

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

Review Note: A flow chart may be included.

Referral: Referrals to DMC-ODS services will come through the access line, walk-ins to provider sites, or referrals from other partners to the Case Management-Care Coordination Team (CM-CCT). Upon first contact, a brief ASAM screening or, if appropriate, a full ASAM assessment will be conducted to determine the initial level of care (LOC) placement.

The brief ASAM screening will be conducted by:

- Nonprofessional staff that have appropriate on-site orientation and training prior to hire and conducting the brief ASAM screening;
- Registered and certified alcohol and other drug counselors who must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8, who have appropriate experience and any necessary training at the time of hire; or,
- Professional staff licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Professional staff is required to have appropriate experience and any necessary training at the time of hiring.

Assessment: Assessment sites can differ depending on which access point individuals enter and the information gathered during the brief ASAM screening. Comprehensive ASAM Assessments (CAA) will be conducted at county-operated or provider DMC certified program sites or by our county-operated CM-CCT.

The comprehensive ASAM Assessment will be conducted by:

- Registered or Certified alcohol and other drug counselors who must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8, who have appropriate experience and any necessary training at the time of hire, If assessment is conducted by certified alcohol and other drug counselors, medical necessity has to be approved and signed-off on by an LPHA; or
- Professional staff licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Professional staff is required to have appropriate experience and any necessary training at the time of hiring.

Authorization: Residential services require BHRS authorization review within 24 hours of request. See #19 for details on BHRS' Authorization Process.

Placement: Once the initial brief ASAM screen or initial CAA has been completed and level of care determined, entry into treatment programs will be initiated and the client will be scheduled for an intake appointment. If needed, the CM-CCT will be available to assist in

clients with treatment engagement, communication, placement, transportation, and warm hand-offs.

Transition to another level of care: When a change in level of care is indicated through a brief ASAM screening, current discharging treatment programs and receiving treatment programs will provide case management to ensure clients timely transitions to different levels of care and/or programs. The CM-CCT can assist the treatment programs with high-utilizers and/or individuals at risk of unsuccessful transitions; and when transition issues occur.

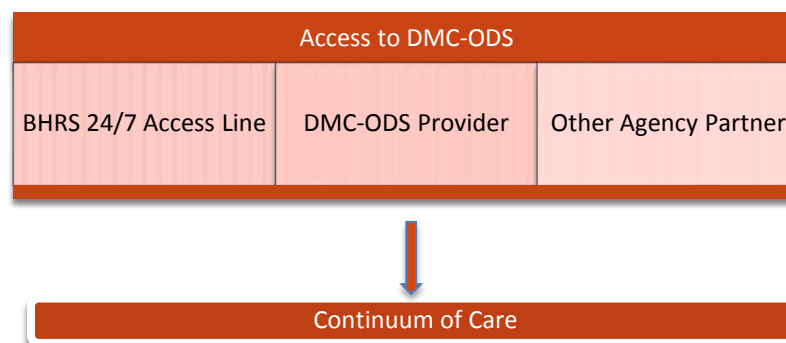
Once it is determined that a client in treatment needs a different level of care, it is *anticipated* that in most levels of care, clients will stay in their current level of treatment until they are transitioned to the next level of care and/or program.

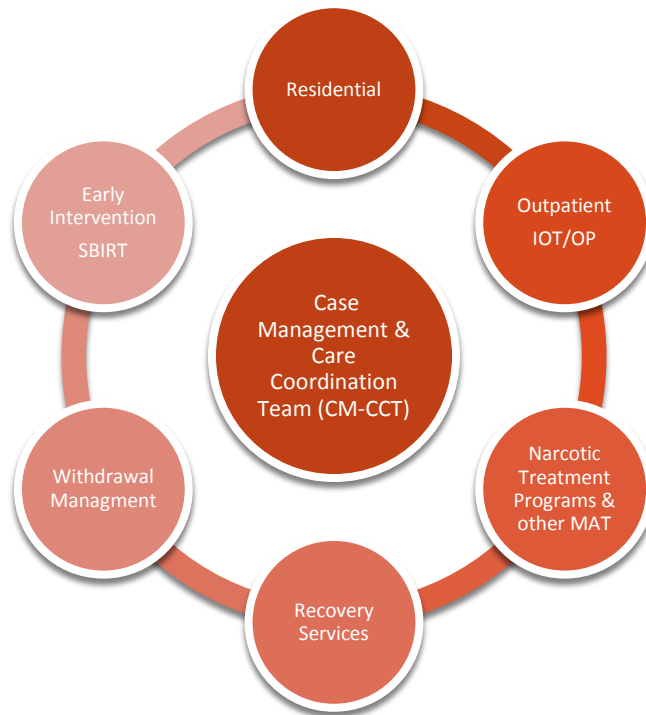
Re-Assessment: During SUD treatment, the client will need to be re-assessed for justification of continued services (per Title 22 regulations) every 6 months or every 12 months for NTP's.

The Re-Assessment will be conducted by:

- Registered or Certified alcohol and other drug counselors who must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8, who have appropriate experience and any necessary training at the time of hire, if assessment is conducted by certified alcohol and other drug counselors, medical necessity has to be approved and signed-off on by an LPHA; or
- Professional staff licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Professional staff is required to have appropriate experience and any necessary training at the time of hiring.

Flow Chart 1, DMC-ODS





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

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

The Beneficiary Access Line, which is a functional 24/7 county-operated integrated mental health and substance use toll free Access Line (888-376-6246) is ADA-compliant (TTY) and accessible in prevalent non-English languages through the AT&T Telephone Line. All written information will also be available in the prevalent non-English languages identified by the state. Individuals will be able to locate the Access Line telephone number from a variety of sources, including the Stanislaus County website, and printed outreach materials. All calls are logged per DHCS regulations.

The Access Line is answered by the Access Line staff from 8:30 AM to 4:30 PM, Monday through Friday. Access Line staff will be trained to perform a brief ASAM screening designed to initially determine the beneficiaries needed level of care placement for SUD services. After hours, the line is answered by a contracted professional exchange service that triages calls as necessary. The exchange transfers emergency calls to our Community Emergency Response Team, or when necessary, to the Stanislaus County 911 operator. Urgent requests for SUD

treatment may be forwarded to our DMC-ODS Case Management and Care Coordination Team (CM-CCT) for an assessment and/or referral to be scheduled same or next day, if appropriate. The Professional Exchange Service follows all regulations around documentation of calls, language line use, and is also TTY accessible.

During business hours, appointments will be scheduled with the selected provider while the caller is on the line whenever possible, but no later than three business days from the initial call. The calls and the subsequent appointments scheduled will be tracked through the Electronic Health Record (EHR) to ensure that all appointments are scheduled according to current timeliness standards and regulations.

The initial provider will be responsible for transitioning the beneficiary to the subsequent provider. All Access Line procedures will be conducted with the individual as a full participant in the decision-making process, including offering referral options that align with geographic areas, service hour availability, cultural and other preferences.

The following information will be collected by the Beneficiary Access Line for continuous quality improvement purposes:

- * Number of calls received each day from Access Line staff and from the professional exchange.
- * Rate of call abandonment
- * Rate of unanswered calls
- * Number of ASAM brief screenings that are conducted
- * Number of referrals to treatment by level of care
- * Number of days from initial call/contact to assessment/admission appointment

Our DMC-ODS CM-CCT will be an essential component to ensuring that individuals successfully engage in the initial treatment episode, receive necessary services, and transition through care as is clinically appropriate. These services will assist clients in accessing services, and will be provided by registered/certified SUD counselors or LPHAs.

In each case, all beneficiaries, where medical necessity for SUD services has been determined, a referral will be made to treatment. They will also have access to case-management services to assist with admission into SUD services, transitioning from one LOC to another, and navigating the mental health/physical health and behavioral health systems.

4. Treatment Services. Describe the required types of DMC-ODS services (withdrawal

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

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

Table 1. Overview of Treatment Services with Projected Implementation Timeline

| DMC-ODS Service | ASAM Level | Implementation Timeline | | | | |
|-------------------------------|------------|-------------------------|-----------|-----------|-----------|-----------|
| | | Implementation | End of Y1 | End of Y2 | End of Y3 | End of Y4 |
| Required Services | | | | | | |
| Withdrawal Management | 1.0-WM | X | | | | |
| Outpatient Services | 1.0 | X | | | | |
| Intensive Outpatient Services | 2.1 | X | | | | |
| Residential | 3.1 | X | | | | |
| Withdrawal Management | 3.2-WM | X | | | | |
| Residential | 3.3 | | | | | X |
| Residential | 3.5 | X | | | | |
| Opioid TX Program | OTP | X | | | | |
| Recovery Services | | X | | | | |
| Case Management | | X | | | | |
| Physician Consultation | | X | | | | |
| Optional Services | | | | | | |
| Recovery Residences | | | X | | | |

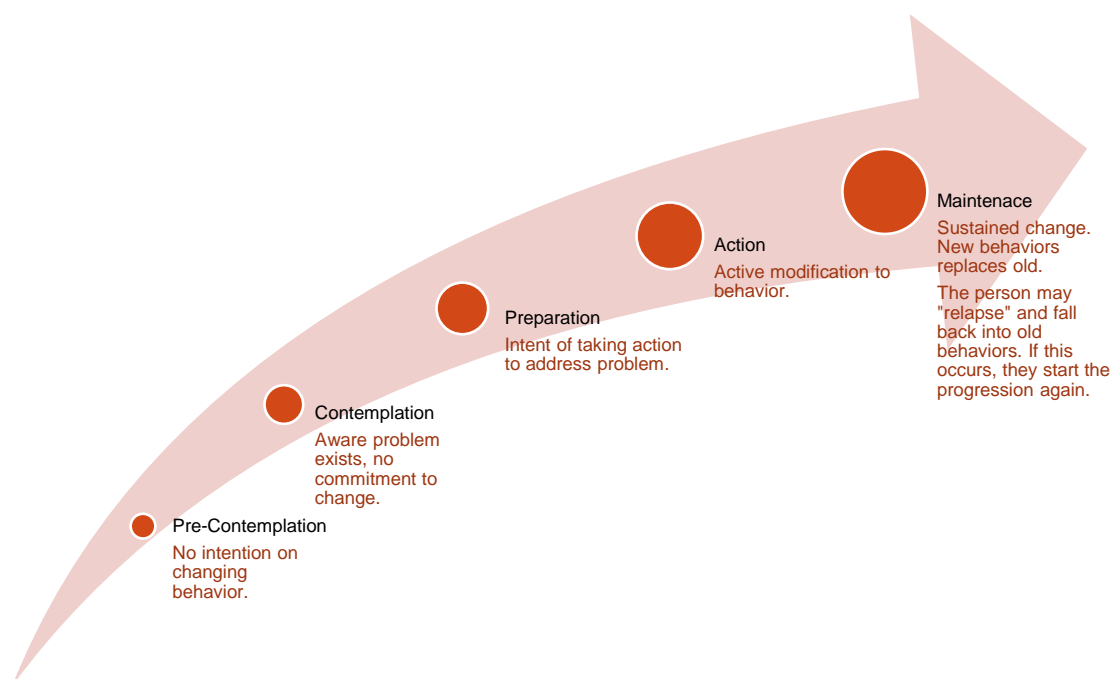
Outpatient Services (ASAM Level 1.0): Outpatient services consist of up to 9 hours per week of medically necessary services for adults and less than 6 hours per week of services for adolescents. Providers will offer ASAM Level 1 services including: assessment, treatment

planning, individual and group counseling, family therapy, patient psychoeducation, medication services, collateral services, crisis intervention services, and discharge planning and coordination. Services may be provided in person, by telephone, or by telehealth in any appropriate setting in the community.

BHRS has one (1) county operated site and three (3) provider sites that are currently DMC certified for this level of care.

BHRS' county operated site plans to pilot an innovative strategy to provide harm reduction services to beneficiaries based on this level of care. Interventions will be based on the Prochaska and DiClemente's Stages of Change Model, with the goal of overall reduction in harm and moving beneficiaries forward in the change progression. Motivational Interviewing will also be used for those in pre-contemplation and contemplation stages. If/when they are ready for the action stage, they will be transferred to outpatient or IOP services that are intended to provide beneficiaries the framework for on-going recovery.

Stages of Change Progression Chart



Intensive Outpatient Services (ASAM Level 2.1): Intensive Outpatient Services involves structured programming provided to beneficiaries as medically necessary for a minimum of nine (9) hours and a maximum of 19 hours per week for adult perinatal and non-perinatal clients. Adolescents are provided a minimum of six (6) and a maximum of 19 services per week. Services include assessment, treatment planning, individual and group counseling, family therapy, patient psychoeducation, medication

services, collateral services, crisis intervention services, and discharge planning and coordination. Services may be provided in person, by telephone, or by telehealth in any appropriate setting in the community. BHRS has one (1) county operated site and five (5) provider sites that are currently DMC certified for this level of care.

Residential Treatment (ASAM Level 3.1, 3.3 & 3.5): Residential treatment is a non-institutional 24-hour non-medical, short-term residential program that provides rehabilitation services to beneficiaries when determined medically necessary. Residential 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.

Residential services can be provided in facilities with varying capacity. The length of residential services range from 1-90 days with a 90-day maximum for adults and a 30-day maximum for adolescents, unless medical necessity authorizes a one-time extension for up to 30 days on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period.

The components of residential treatment include intake, individual and group counseling, family therapy, patient education, safeguarding medications, collateral services, crisis intervention services, treatment planning, transportation services, and discharge services. Case management will be provided to coordinate care with ancillary service providers (including physical and mental health) and facilitate transitions between levels of care.

BHRS currently has one (1) county operated, 44-bed DHCS-licensed residential facility, which has been designated as ASAM Level 3.1 and 3.5. This facility is currently pending “residential services” as an additional service to our approved DMC certified county operated site.

Withdrawal Management (ASAM 1.0-WM & 3.2-WM): Withdrawal management services are provided to beneficiaries when medically necessary. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized treatment plan, and approved and authorized according to the State of California requirements. The components of withdrawal management services are intake, observation, medication services, and discharge services.

BHRS currently has two (2) county operated withdrawal management programs:

- ASAM 1.0 WM is available at our DHCS licensed and DMC certified OTP clinic and provides ambulatory opioid withdrawal management services.
- ASAM 3.2-WM is available at our DHCS licensed residential treatment program. This program is licensed with a detox designation and is pending DMC certification.

The residential treatment program provides 24-hour clinically managed withdrawal services.

Opioid Treatment Program (ASAM OTP Level 1): Narcotic Treatment Programs (NTP's) are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of California requirements. NTP/OTP's are required to offer and prescribe medications covered under the DMC-ODS formulary, including methadone.

A patient must receive a minimum of fifty (50) minutes of counseling sessions for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

The components of OTP/NTP's are intake, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy, and discharge services.

BHRS currently has two (2) OTP/NTP clinics that provide methadone services, one (1) is county operated and one (1) is provider operated.

BHRS is establishing a medication assisted treatment strategic partner workgroup. This workgroup is tasked for developing resources and procedures for access to buprenorphine naloxone and disulfiram.

Recovery Services (ASAM Dimension 6): Recovery services are important to the beneficiary's recovery and wellness. As part of the assessment and treatment needs of dimension 6, recovery environment of the ASAM criteria and during the transition planning process, beneficiaries will be linked to applicable recovery services. The treatment community becomes a therapeutic agent through whom patients are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the patients central role in managing their health, use of effective self-management support strategies, and the organization of internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary.

Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventative measure to prevent relapse. Recovery services may be provided face-to-face, by telephone, or by telehealth and may be provided anywhere in the community.

The components of recovery services include individual and group outpatient counseling, recovery monitoring, substance abuse assistance, peer to peer services, relapse prevention,

education and job skills, family support, support groups, and linkage to ancillary services including housing assistance, transportation, case management, and service coordination.

BHRS' philosophy is that planning for successful recovery begins at admission and is intended to be a part of a beneficiary's planning through transition from treatment to aftercare (recovery services) to their own individual recovery process. BHRS currently provides two (2) aftercare groups available to any client that resides in Stanislaus County and who has completed treatment. Stanislaus Recovery Center (SRC), our largest county operated SUD treatment site is where these aftercare services are currently offered. In addition to our aftercare groups, we have a peer/volunteer run drop-in center and a volunteer program. We will be working from these aforementioned services to expand and provide recovery services to beneficiaries that meet medical necessity for dimension "6" of the ASAM criteria.

Case Management: Stanislaus County will coordinate case management to assist beneficiaries to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services will focus on the coordination of SUD care, integration around primary care and mental health especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.

Case management services may be provided face-to-face, by telephone, or by telehealth and may be provided anywhere in the community.

Case management services may include comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services, transitions to lower or higher level of SUD care, development and periodic revision of a client treatment plan, communication and coordination of services, referrals, monitoring of services delivery to ensure beneficiary access to service and the service delivery system, patient advocacy, linkages to physical and mental health care, and transportation .

Case management services will be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

Case management services will be provided, as needed, by county and provider DMC certified treatment programs to beneficiaries currently open to their program. Examples of case management from providers include transitions to lower or higher level of SUD care, development and periodic revision of a client treatment plan, communication and coordination of services, referrals, patient advocacy linkages to physical and mental health care and transportation.

Case management services will also be provided by our Case Management and Care Coordination Team (CM-CCT). Examples of case management services from this team include comprehensive assessment, periodic reassessment of individual needs to determine the need for continuation of case management services, engagement in and transitions to SUD care for high

risk, high utilizers and hard to engage beneficiaries, development and periodic revision of a client treatment plan, communication and coordination of services, referrals, monitoring of services delivery to ensure beneficiary access to service and the service delivery system, patient advocacy, linkages to physical and mental health care, and transportation .

This team will also play a role in access, utilization management, care coordination, authorizations etc.

Physicians Consultation Services: These services include DMC physicians’ consulting with addiction-trained physicians, psychiatrists, or clinical pharmacists. Physician consultation services are designed to assist DMC physicians with seeking expert advice on treatment planning for specific DMC-ODS beneficiaries.

Physician consultation services are to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions or level of care considerations.

BHRS will provide physician services by our Behavioral Health Medical Director, a local addiction trained physician or a clinical pharmacist.

BHRS does not anticipate a high demand for these services.

Recovery Residences: Recovery residences (RR), currently known as Sober Living Environments (SLE’s), are an optional, ancillary component of the DMC-ODS.

Recovery residences are safe, clean, sober, residential environments that promote individual recovery through positive peer group interactions among the house members and staff. Recovery residences are affordable, alcohol and drug free, and allow the house members or residents to continue to develop their individual recovery plans and to become self-supporting. Recovery residences do not provide SUD services or require licensure by DHCS. Eligibility to Recovery residences requires residents to be actively engaged, off-site, in medically necessary DMC-ODS treatment services.

BHRS currently has agreements with community-based SLE’s with the same above requirements. Through our DMC-ODS, we will transition to the term “Recovery Residence” and to a more formalized contract with our providers. BHRS via our ASAM level of care placement criteria has historically used IOT with SLE and an alternative to residential treatment when indicated.

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

In Stanislaus County, substance abuse and mental health services have been integrated under the department of Behavioral Health and Recovery Services (BHRS) since 1996. Within BHRS there are systems of care including adult services, children's services, forensics services, and substance use disorder services. Each system of care is supervised under a single executive management structure consisting of a chief and a manager. Each system of care includes both county operated and/or contract providers and both SUD and MH providers. Described below are examples of how BHRS currently coordinates and structures services for clients with co-occurring disorders.

At Stanislaus Recovery Center (SRC), our county operated main hub for SUD treatment, we provide MH OP services when individuals meet the criteria for a substance use disorder and meet the criteria of having a serious mental illness (SMI). These services are provided to clients in our detox, residential, IOT and OP SUD levels of care. These services last during the course of all SUD levels of treatment provided at this site. During their treatment, a transition plan to continued MH services upon discharge is developed. Clients may be referred during or post treatment to another MH program, to our health plans or to a PCP. Coordination of care is provided so smooth transitions and reduction of barriers occurs.

Additionally, at SRC these same services are provided when referrals are made from our county or provider operated MH programs, and the client meets medical necessity for a substance use disorder. In this case, medication services continue to be provided by the referring team's psychiatrist.

In both of these instances, there is a multi-disciplinary team with a blend of MH and SUD staff who meet regularly about their clients. Because of different funding revenues, co-occurring clients, have both a MH and an SUD treatment plan.

Most of our MH treatment sites have certified SUD staff members who work as case managers. These staff members are assets to their team and they can provide engagement and encouragement from an SUD perspective to BHRS' co-occurring clients. As noted above, when a co-occurring client is identified as needing SUD treatment, and if the client meets medical necessity for SUD services, a referral to treatment may be made.

BHRS currently has an MHSA Co-occurring Disorder Full Service Partnership (COD FSP) on the SRC campus under the SUD Services System of Care, for some of our county's hardest to engage individuals. Constant engagement and referral into SUD treatment occurs for these clients and the COD FSP has the ability to provide OP SUD services.

BHRS' Forensics System of Care (FSOC) includes similarities to SRC's process. There are both MH and SUD programs on the same site, in some cases treating the same clients. These FSOC programs have a multi-disciplinary team with a blend of MH and SUD staff who meet regularly about their clients.

Substance use disorder programs, county operated and contract providers in our system of care, that have clients who need a screening for a mental health condition, call our Medi-Cal Access Line to be screened. If appropriate an appointment is scheduled with our-county operated Medi-Cal Assessment Team (MAT). Additionally, our contract providers can consult with our staff at SRC and come through that door as long as the client meets medical necessity for an SMI.

Additionally, coordination of services between programs for individuals with co-occurring disorders for most of our providers occurs through a single electronic health record, coordinated treatment plans and as stated above, integrated or coordinated service teams that remain in regular communication with one another since most employees are co-located, share the same email, and calendaring. All HIPPA and 42 CFR Part 2 requirements are met.

DMC-ODS provides further opportunity to fully align BHRS programs and services not only for cases of co-occurring disorders, but to assure there is no wrong door when an individual makes the decision to seek treatment and begin their recovery in the following ways:

- Provider contracts will include language that promotes cross system of care referral.
- Our combined Medi-Cal Access Line initial screening will identify the potential of co-occurring disorders.
- Our comprehensive ASAM assessment will be utilized to identify the needs of the client to ensure adequate referrals to mental health, substance abuse or concurrent treatment.
- Written procedures for linking beneficiaries with mental health and substance abuse services will be developed.
- Our DMC-ODS CM-CCT will also be providing initial and on-going assessment and other services to those beneficiaries who are identified as “at risk” or high utilizers of services. This team will provide services to ensure and facilitate, as needed, coordination with mental health and other needed services.
- Most clients with co-occurring disorders who do not meet the threshold for admission to specialty mental health services, but do meet the requirements for a mild to moderate mental health diagnosis, are referred to Stanislaus County Health Plans. The implementation of screening, referral, and care coordination activities are outlined in the MOU with Medi-Cal Managed Care. These clients will be provided substance use disorder services as indicated by the ASAM.

BHRS follows these “Key Principles of Integrated Treatment”.

- Co-occurring conditions are an expectation, not an exception.
- Clients must receive treatment that emphasizes empathy, hope, integration, and a strength-based approach.
- Treatment for co-occurring disorders must be tailored to the needs of the population.
- Treatment of both mental illness and substance use disorders must be concurrent.
- Recovery involves moving through the stages of change.

- Progress occurs in an environment in which a client is adequately supported and rewarded for skill-based learning for each condition.
- Recovery plans and interventions must be individualized.

BHRS monitors delivery of services and contract compliance in many ways across systems of care. Complex cross system of care case conferences occur for individuals who are not progressing in their treatment and recovery. Planning and linking conferences (PLC's) are held to support clients in transitioning into different levels of care. Weekly Hospital Care Coordination and Planning Meetings are held to ensure access to mental health and substance abuse treatment for clients who are currently in an acute psychiatric setting. Performance Improvement Projects (PIP's) occur to ensure processes are improved on a regular basis to reduce barriers and increase access to treatment. Quality Improvement Committees (QICs) are held to ensure the best quality of services. Contract monitoring occurs, at minimum, twice annually to ensure providers are meeting regulatory compliance and scope of work conditions. PIP's, QIC, peer reviews and contract monitoring are completed across systems of care to ensure proper service delivery, provide oversight for coordination efforts and ensure providers are following requirement of contracts.

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

BHRS is in the process of amending MOU's with our two managed care health plans (Health Plan of San Joaquin and Health Net), to include the DMC ODS requirements. Currently, interdisciplinary meetings occur with each health plan on a regular basis to discuss care coordination, case reviews, and referrals for mental health and co-occurring beneficiaries. Currently, a key SUD manager attends these meetings. At the start of service implementation, these interdisciplinary meetings will include additional key SUD staff members as well.

BHRS' Stanislaus Recovery Center is a main site for an array of county and provider services. Our local FQHP (Golden Valley Health Care) and our Stanislaus Recovery Center SUD programs have been in discussion and development of a MOU. The purpose of this MOU is ease of referrals between agencies.

BHRS believes that consistent contact and timely exchange of information with a PCP is desirable to achieve safe and effective treatment of a client. Coordinating behavioral health and medical care is most effective when a partnership is formed among the behavioral health practitioner, primary care practitioner, and the client. Collaboration between mental health service providers and a client's PCP has always been a part of the National Committee for Quality Assurance (NCQA) standards for managed care organizations. In 1997, when the standards for managed behavioral health care organizations were released, collaboration with PCPs was a standard with the objective of improving appropriate use of psychopharmacological medications and of reducing the incidents of adverse drug reactions.

Given the seriousness of the possible ramifications of inadequate collaboration with PCPs, PCP contact is considered a key dimension of quality of care. In addition, it is important that clients without physicians be linked with PCPs so that medical issues can be addressed as well.

A custom database linked with the current BHRS client information system automates the process of providing and receiving information from a client's PCP to improve the rate at which providers of on-going services communicate with each client's PCPs. With this database, BHRS can assess compliance in a single program or multiple programs. Compliance measures are reported to BHRS Quality Improvement Councils, the Quality Management Team, and the Department of Health Care Services.

This process has been in effect for our mental health and co-occurring clients since 2006. Our county operated narcotic treatment program (NTP), Genesis, currently has a similar non-automated process. A small workgroup has been developed to update our policy to include our SUD language with respect to 42 CFR, Part 2. Once the policy has been updated, Stanislaus County BHRS will begin to implement this process in our SUD programs.

BHRS providers will initially need to meet the current standards under Title 22 to complete a personal, medical and substance use history, and all associated medical requirements. Ongoing monitoring will occur at our established BHRS monthly SUD Peer Review; and contract monitoring to determine if a physical health screening was conducted, if physical health care coordination was included in the treatment plan, and if there is documented progress if needed.

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

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

Stanislaus County BHRS does not need technical assistance in this area at this time.

- Beneficiary engagement and participation in an integrated care program as needed;

Stanislaus County BHRS does not need technical assistance in this area at this time.

- Shared development of care plans by the beneficiary, caregivers and all providers;

Stanislaus County BHRS may need technical assistance in this area in the future due to Part II (42 CFR).

- Collaborative treatment planning with managed care;

Stanislaus County BHRS may need technical assistance in this area in the future due to

Part II (42 CFR).

- Care coordination and effective communication among providers;

Stanislaus County BHRS does not need technical assistance in this area at this time.

- Navigation support for patients and caregivers; and

Stanislaus County BHRS does not need technical assistance in this area at this time.

- Facilitation and tracking of referrals between systems.

Stanislaus County BHRS does not need technical assistance in this area at this time.

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

- The anticipated number of Medi-Cal clients.

Table 1: Medi-Cal Population Trends and Estimated Beneficiaries Likely to Seek Services

| | FY 13/14 | FY 14/15 | FY 15/16 | FY 16/17 | FY 17/18 | FY 18/19 | FY 19/20 |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| Stanislaus County Population *1 | 525,845 | 529,994 | 535,125 | 541,466 | 548,057 | 554,634 | 561,290 |
| % Change | | 0.8% | 1.0% | 1.2% | 1.2% | 1.2% | 1.2% |
| Total Medi- Cal Beneficiaries *2 | 169,305 | 217,322 | 238,094 | 245,713 | 248,818 | 251,804 | 254,826 |
| % Change | | 28.4% | 9.6% | 3.2% | 1.3% | 1.2% | 1.2% |
| MCBs as % Total Population | 32.2% | 41.0% | 44.5% | 45.4% | 45.4% | 45.4% | 45.4% |
| Estimate % | 8.8% | 8.8% | 8.8% | 8.8% | 8.8% | 8.8% | 8.8% |

| | | | | | | | |
|--|--------|--------|--------|--------|--------|--------|--------|
| of Population in Need *3 | | | | | | | |
| Estimate # of M/CBs in Need | 14,899 | 19,124 | 20,952 | 21,623 | 21,896 | 22,159 | 22,425 |
| MCBs Likely to Seek Services (20%) *4 | 2,980 | 3,825 | 4,190 | 4,325 | 4,379 | 4,432 | 4,485 |

Data Sources:

*1: California Department of Finance using US Census Data

www.dof.ca.gov/Forecasting/Demographics

*2: EQRO - MMEF file

*3: California Mental Health & Substance Use Needs Assessment

www.dhcs.ca.gov

*4: BHRS DAS 944 Report - Program Caseload Summary and Waitlist Info from DATAR

Using the California Mental Health and Substance Use Needs Assessment, it is estimated that 8.8% of these MCBs will have need of substance abuse services. Further, using service data within the County SUD system of care, it is assumed that of those who need services, 20% will actually seek services. Using these assumptions, over the next few years, Stanislaus County should expect that about 4,400 MCBs will seek SUD services annually.

- The expected utilization of services by service type.

Table 2: Anticipated Drug Medi-Cal Beneficiary Utilization by Service Type

| Type of Service | Historic Clients Served | | | Estimated Utilization | | |
|-----------------------------|-------------------------|-------------|-------------|-----------------------|-------------|-------------|
| | FY 14/15 | FY 15/16 | FY 16/17 | FY 17/18 | FY 18/19 | FY 19/20 |
| Withdrawal Management | 46 | 392 | 448 | 526 | 532 | 538 |
| Residential | 164 | 178 | 184 | 219 | 222 | 224 |
| IOT | 1,129 | 1,112 | 1,135 | 1,358 | 1,374 | 1,390 |
| Outpatient | 156 | 237 | 307 | 350 | 355 | 359 |
| Narcotic Treatment Programs | 1,215 | 1,517 | 1,619 | 1,927 | 1,950 | 1,973 |
| Case Management | 830 | 738 | 766 | 1,007 | 1,019 | 1,032 |
| Recovery Services | NA | NA | NA | 246 | 249 | 252 |
| Physician Consultation | NA | NA | NA | 231 | 234 | 237 |

Patterns of service utilization in the DMC-ODS are expected to be similar to patterns of service utilization in the current County SUD system of care. In other words, the percentage of total treatment admissions to a particular DMC-ODS treatment modality is expected to be similar to the percentage of treatment admissions to that modality in FY 16/17), except where funding shortfalls have resulted in restrictions in the level or duration of care, and where new services available under the DMC-ODS are being implemented that are not readily available in the current SUD system of care. In FY 16/17, there were 3,337 unique SUD clients served, representing a total of 3,598 unique admissions to SUD treatment services. Of those clients, 98% are estimated to be Medi-Cal beneficiaries. Approximately 2% of the clients served in FY 16/17 were in detention, which means they temporarily lost their Medi-Cal benefits while incarcerated.

Withdrawal management (detoxification) admissions accounted for 12% of the total FY 16/17 treatment admissions, and the average length of stay was seven days. Detoxification length of stay is not expected to change in the DMC-ODS.

Residential treatment services accounted for 5% of total FY 16/17 treatment admissions, and the average length of stay was 11 days. Historically, funding shortfalls have resulted in restrictions on level of care placements (e.g., some clients who need residential treatment have been admitted to outpatient or intensive outpatient due to lack of funding), and restrictions on the length of stay that is authorized. It is estimated that authorization of residential treatment services that is based on ASAM criteria rather than availability of funding will increase residential treatment utilization per episode approximately 25% above current baseline utilization levels. The County anticipates that implementation of the DMC-ODS will resolve current issues related to providing an adequate level and duration of residential treatment to Medi-Cal beneficiaries. If growth in the number of clients seeking residential treatment and detoxification reaches the high end of estimates, BHRS may need to work with its providers to open additional residential treatment facilities.

Outpatient and intensive outpatient treatment services accounted for 39% of total clients served in FY 16/17, and the average length of stay for clients discharged from outpatient treatment was 78 days and 58 days for intensive outpatient treatment. These average lengths of stay are not expected to change in the DMC-ODS. It is projected that providers will be able to expand service capacity to accommodate increased demand.

Narcotic treatment programs (methadone maintenance) accounted for 44% of FY 16/17 clients served, and the average length of stay was 208 days (7 months) for clients who exited from methadone maintenance.

Case management has been severely restricted by the availability of funding. Apart from the referrals to ancillary services and referrals to step down/step up SUD treatment that are made available during a treatment episode provided by SUD contractors, most clients receive very little case management. In FY 16/17, only 23% of the 3,337 unique clients who received SUD treatment services received case management services. The projection for case management utilization is based on 23% of the MCBs likely to seek treatment services.

Recovery services are offered within the SUD system of care through two aftercare groups as described previously in Section 4 (Treatment Services), but are not tracked as billable treatment services. There is little data available from SUD systems of care outside of the County to support estimates of utilization of recovery services. Recovery services will be needed by clients who complete outpatient and intensive outpatient treatment services, as well as those who exit residential treatment without transitioning to outpatient or intensive outpatient services. During FY 16/17, 17% of the outpatient, intensive outpatient, and residential admissions completed treatment. BHRS is estimating that approximately 33% of these clients will need recovery services after completing treatment.

Physician consultation services are defined in the 1115 Waiver terms and conditions as “physician consultation services with addiction medicine physicians, addiction psychiatrists or clinical pharmacists”. In FY 16/17, approximately 12% of the NTP clients enrolled for detox services, while the other 88% received maintenance services. This is a new service and BHRS does not yet have an accurate way of estimating utilization.

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

It is anticipated that BHRS will be developing an RFQ for additional residential services and using its existing array of contracted and County-operated programs for provision of DMS-ODS services, and ensuring that each of these providers is or becomes DMC-certified to provide the following DMC-ODS services:

Table 3: Providers Required by Service Type

| Type of Service | ASAM Level | Projections | | |
|-----------------------------|------------|-------------|----------|----------|
| | | FY 17/18 | FY 18/19 | FY 19/20 |
| Withdrawal Management | 3.2 | 1 | 1 | 1 |
| | 1.0 | 2 | 2 | 2 |
| Residential | 3.1 | 1 | 2 | 2 |
| | 3.5 | | | |
| IOT | 2.1 | 5 | 5 | 5 |
| Outpatient | 1.0 | 5 | 5 | 5 |
| Narcotic Treatment Programs | 2.1 | 2 | 3 | 3 |
| Case Management | | 5 | 5 | 5 |
| Recovery Services | | 3 | 3 | 3 |
| Physician Consultation | | 2 | 2 | 2 |

Note: For any contracted provider, there could be multiple programs located in different regions. Provider count in Table 3 reflects the number of county operated programs and/or contracted providers, not program locations. Withdrawal Management ASAM level 1.0 includes the two NTP providers, Aegis and Genesis.

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

Table 4: Treatment Providers and Projected Utilization by Service Type

| Type of Service | FY 16/17 | | | | FY 18/19 | | | |
|------------------------|----------|------|-------|-----|----------|------|-------|-----|
| | BHRS | % | Other | % | BHRS | % | Other | % |
| Withdrawal Management | 448 | 100% | 0 | 0% | 532 | 100% | 0 | 0% |
| Residential | 184 | 100% | 0 | 0% | 222 | 100% | 0 | 0% |
| IOT | 727 | 57% | 548 | 43% | 824 | 60% | 550 | 40% |
| Outpatient | 246 | 79% | 64 | 21% | 280 | 80% | 70 | 20% |
| NTP | 370 | 23% | 1,249 | 77% | 488 | 25% | 1,463 | 75% |
| Case Management | 584 | 76% | 182 | 24% | 764 | 75% | 255 | 25% |
| Recovery Services | 0 | 0% | 0 | 0% | 149 | 60% | 100 | 40% |
| Physician Consultation | 0 | 0% | 0 | 0% | 58 | 25% | 176 | 75% |

Note: Due to movement between programs, a client may receive treatment services from BHRS and from a contracted provider within the same fiscal year. In FY 16/17, total clients served by BHRS and contracted providers do not necessarily equal unduplicated client served in each modality from Table 2. Projected utilization is based on the total number of individuals likely to seek SUD services in FY 18/19, the first full year of the DMC-ODS implementation plan.

- Hours of operation of providers.

Listed in the table below are the anticipated hours of operation by type of service within BHRS DMC-ODS.

Table #5 BHRS Drug Medi-Cal Hours of Operation by Service Type

| Type of Service | Days of Operation | Hours of Operation |
|----------------------|-------------------|--------------------|
| W/D Mgmt. (3.2) | 7 days a week | 24 hours a day |
| W/D Mgmt. (1.0) | 7 days a week | 5:30 AM to 7:30 PM |
| Residential Services | 7 days a week | 24 hours a day |
| IOT | 5 days a week | 9:00 AM to 9:00 PM |
| Outpatient Services | 5 days a week | 9:00 AM to 9:00 PM |
| NTP | 7 days a week | 5:30 AM to 7:30 PM |
| Recovery Services | 5 days a week | 9:00 AM to 7:00 PM |

| | | |
|-----------------|---------------|--|
| Case Management | 5 days a week | 8:00 AM to 5:00 PM with an on-call during weekends, nights, & holidays |
|-----------------|---------------|--|

| | | |
|------------------------|---------------|--------------------|
| Physician Consultation | 5 days a week | 8:00 AM to 5:00 PM |
|------------------------|---------------|--------------------|

- Language capability for the county threshold languages.

The threshold languages for Stanislaus County are English and Spanish which comprises 99% of the primary language reported by recipients of SUD services, year to date for FY 16-17. BHRS SUD services are available in the required threshold languages. Besides staff, curricula and print material already available in the identified threshold language, the county also maintains contracts with interpreters that provide oral interpretations as necessary in a number of languages. All service providers including county and contract providers have access to these interpretation services.

Contract providers will be encouraged to emphasize the hiring of bilingual staff in order to provide services in our threshold languages and/or insure that utilization of the interpreter's services is undertaken.

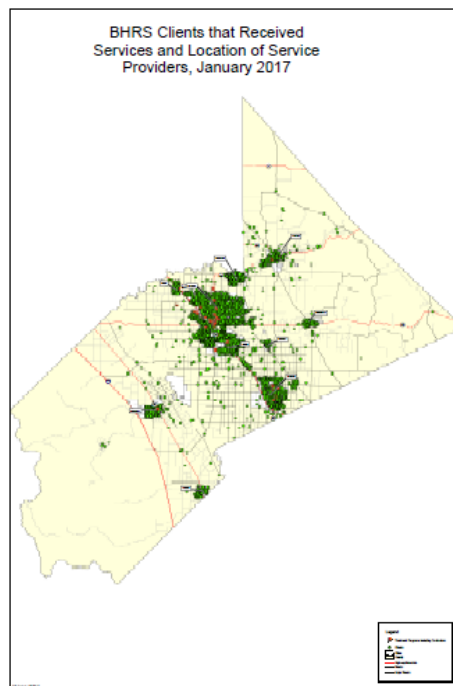
Also as a part of Stanislaus County Behavioral Health and Recovery Services ongoing training, service providers will be encouraged to attend "Principles and Practices of Interpreting" when offered.

- Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.
 - Non-Urgent: The anticipated timeline from first contact be it through the Access Line or walk-in to initial appointment will be 15 days from referral or request for service. This timeline will be for non-urgent services. Stanislaus County expects as a part of ongoing quality improvement processes to collect data for continued evaluation during the first year of plan implementation. If problems of timely access for beneficiaries are in fact identified, it is anticipated that adjustments in these timelines will occur.
 - Urgent: It is expected that at the time of first contact be it by phone or in-person, that the beneficiary will be triaged to identify the presence of an urgent condition. Urgent conditions defined as; those conditions requiring immediate attention but not requiring inpatient hospitalization. If at time of initial contact the phone screener or initial contact person become aware of an "Urgent condition," then it will be expected that the beneficiary be seen within 48 hours.
 - Emergency: Any beneficiary experiencing a medical or psychiatric emergency will be directed to the nearest hospital or psychiatric location for services.
 - Frequency of follow up appointments will occur within currently established

- timeframes and will be in accordance with individualized treatment plans.
- After hours care will be accessible through BHRS' 24 hour access call center. Caller will be screened, triaged, and risk assessed. Dependent on outcome of initial triage, referrals will be made to appropriate levels of care. It is anticipated the all network providers will be familiar with the procedures for accessing the call center and will ensure that all beneficiaries are aware of how to contact call center for crisis or referral to "on-call" staff.
- The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities

(See attachment #6 for a bigger version of the above map.)

BHRS runs an annual data report that shows counts on persons with disabilities (PWD). Along with this report programs are asked to review their accessibility of PWD.



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

BHRS will continually review the county's census tracts to determine if there are adequate treatment locations to meet the Medi-Cal population service needs. Our contracted OTP provider has applied for the CURES grant with consideration to open hub and spoke models in Newman, Patterson, Turlock and/or Oakdale.

- As an appendix document, please include a list of network providers indicating, if they provide MAT, their current patient load, their total DMC-ODS patient capacity, and the populations they treat (i.e., adolescent, adult, perinatal).

Table #6 BHRS Current Network Providers

| Network Providers | Treatment Service | Current Case Load (June 30, 2017) | Capacity | Population |
|---|--------------------------|--|-----------------|-------------------|
| BHRS-Stanislaus Recovery Center | OP | 28 | 48 | Adult |
| | IOT | 101 | 100 | Adult |
| | Detox | 10 | 10 | Adult |
| | Res | 23 | 30 | Adult |
| BHRS-Adult Drug Court | OP | 52 | 75 | Adult |
| BHRS-Genesis (MAT) | Detox-OTP | 3 | | Adult |
| | Maintenance-OTP | 220 | 230 | Adult |
| SVCFS First Step | IOT | 69 | 90 | Perinatal, Women |
| BHRS-Stanworks | IOT | 3 | 30 | Adult |
| The Last Resort | OP | 14 | 12 | Teen |
| | IOT | 0 | 12 | Teen |
| BHRS-Integrated Forensics Team DCR SUD | IOT | 25 | 48 | Adult |
| Center for Human Resources | OP | 8 | 22 | Teen |
| | IOT | 34 | 50 | Adult |
| Aegis Treatment Centers LLC (MAT) | Detox-OTP | | | Adult |
| | Maintenance-OTP | 848 | 850 | Adult |

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

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

The County will ensure that all beneficiaries have timely access to services and levels of care as required. The County standards for timeliness of services will be in compliance with 42 CFR 438.206 and will be provided in a timely manner. The BHRS official standards will be updated as needed to remain in compliance with any future defined timeliness standards for DMC ODS services.

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

The requirement to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal clients will be added into provider contracts and reviewed no less than annually by the Contract Monitor.

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

SUD outpatient and intensive outpatient services will be provided at least five days a week, including at least two days that operate during the evening hours. Residential program services will be provided 24 hours a day, seven days a week. Residential service intake appointments will be available during regular weekday administrative hours (8:00 AM – 5:00 PM).

DMC beneficiaries who need after-hours emergency medical and/or withdrawal management services will be referred directly to a hospital emergency department. Beneficiaries who need emergency psychiatric services will be referred directly to BHRS Community Emergency Response Team (CERT) for assessment and possible hospitalization.

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

BHRS' Quality Management Team (QMT) will review timely access reports on a quarterly basis.

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

BHRS will monitor SUD network providers on a regular basis to determine compliance with timely access requirements. Service agreement contracts between BHRS and SUD network providers will include language specific to these requirements.

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

Failure to comply with service agreements will result in issuance of a corrective action plan. Failure to comply with timely access requirements may result in denial of service reimbursement claims.

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

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

BHRS will minimally offer and/or support attendance in the following trainings for our DMC-ODS providers.

| DMC-ODS Provider Training | | |
|---|----------------------|--|
| Title of Training | Frequency | Required/Optional |
| ASAM E-Trainings (CIBHS) | Ongoing | <ul style="list-style-type: none"> • Required for staff conducting ASAM Assessments and Level of Care determinations • Optional for other DMC-ODS direct service staff |
| <ul style="list-style-type: none"> • Multidimensional Assessment • From Assessment to Service Planning to Level of Care | | |
| ASAM E-Trainings (CIBHS) | Ongoing | Optional but highly recommended for all staff participating in the DMC-ODS |
| <ul style="list-style-type: none"> • Introduction to the ASAM Criteria | | |
| ASAM Training | Annually | Required for staff conducting ASAM Assessments and Level of Care determinations |
| ASAM Technical Assistance | As Needed | Optional. Available to staff conducting ASAM Assessments and Level of Care determinations |
| EHR Integrated Documentation and Navigation Training | Monthly or As Needed | Required initially for all provider programs new to our electronic health record (EHR) system. (A modified training will be developed as needed for providers who do not fully use our EHR but are required to enter any data into our EHR.) |
| Cultural Competency Training | Annually | Required to participate in one topic specific training |
| Legal and Ethical Issues | Bi-annually | Required to participate in at |

| | | |
|---------------------------------|----------|---|
| Title 22 Documentation Training | Annually | minimum, one training every other year on 42 CFR Part 2 and HIPAA Required for staff providing DMC-ODS services |
|---------------------------------|----------|---|

BHRS also offers a variety of optional trainings throughout the year through its training department, all of which will be available to DMC-ODS services providers, as applicable.

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

In addition to the TA requested in Section 2, Question #7, BHRS anticipates needing assistance from DHCS in the following areas:

- DHCS licensing and certification, reimbursement, cost reporting, and billing practices for expanded waiver services including case management and recovery services
- Fidelity to Evidence Based Practices, including validated tools for assessing fidelity to the evidence based practices identified in the STCs
- Documentation requirements for case management, recovery services, and physician consultation
- Financial and administrative challenges, including rate setting, reimbursement protocols, fiscal guidelines, cost reporting, and audit principles
- Coordination between County of Residence and County of Responsibility
- ASAM Training: Additional access to in-person ASAM trainings for clinical staff.
- Use of ASAM for outcomes measurement
- Data collection, analysis, and reporting tools for performance and outcomes measurement

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

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

- Telephone access line and services in the prevalent non-English languages.

BHRS currently has a comprehensive and inclusive Quality Management Team (QMT) that ensures compliance and quality. QMT meets regularly one-time per month. Quality Management for DMC-ODS will be integrated into the existing structure. The current QMT structure consists of multiple Quality Improvement Committees (QICs), including a well-established SUD QIC that has been operational for approximately 9 years. Members of the QIC include BHRS staff, consumers, family members, and other interested stakeholder groups including contractors. Each QIC meets regularly to follow up on existing work, review and provide feedback to other committees, and bring new ideas to improve the work of BHRS. The QIC leads then report back to the QMT, again to ensure compliance and quality.

The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:

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

BHRS' current Problem Resolution Processes/Policies will be reviewed to ensure compliance with the DMC ODS Waiver regulations. Please see attachment #7 for our current Problem Resolution Process Policy and Procedure (#80.5.100) which includes the following:

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

13. Evidence Based Practices. How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the

county take if the provider is found to be in non-compliance?

DMC-ODS providers will be required to implement at least two (2) of the following evidence based practices (EBPs): Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education.

Technical assistance, when requested, will be provided to programs needing assistance with implementing EBPs. Implementation of two (2) EBPs will be a requirement in BHRS provider agreements and monitored through the bi-annual provider monitoring process. Issues of non-compliance will be addressed with provider staff and documented in a Corrective Action Plan (CAP). Corrective action ranging from technical assistance to disallowance will occur depending on the nature of the deficiency, frequency, and/or severity of the findings

BHRS will use the Fidelity Monitoring Committee to identify protocols to use for the DMC-ODS EBPs, and ensure that the protocol is being followed.

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

Stanislaus County BHRS is not proposing to implement a regional model at this time.

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

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

- Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Delineation of case management responsibilities;
- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;

- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures for exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals.

Stanislaus County has two health plans, Health Net and Health Plan of San Joaquin. Currently, BHRS has MOU's with both health plans related to our MHP. Preliminary positive discussions have already occurred with our current health plans regarding the required elements for the DMC ODS STC's. BHRS anticipates the amended MOU's to be executed within 90 days of the implementation of services.

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

As previously noted in Section II, #1, BHRS will be convening Strategic Partner Workgroups. "Coordination of Care" is one of the workgroups. Regarding "Telehealth", the workgroup will be tasked with, at minimum, the following:

- Consideration of need of telehealth services;
- If needed, considerations for those who may need telehealth (residents of outlying areas, those with transportation needs, and Spanish speakers, etc.);
- 42 CFR Part II and HIPAA requirements;
- Policy and procedure development;
- BHRS Medical Director, IT, Compliance Officer and Security Officer will provide input to the workgroup, as and when needed.

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

Stanislaus County BHRS utilizes competitive bid processes to allocate funds for substance use services. While the contract term varies depending on funding source and program requirements, it is typically one year, expiring on June 30 of each fiscal year. The specific policy and procedures for all competitive bid and contracting processes, including the local appeal process, are included as Attachment # 8 and on the [Stanislaus County GSA Purchasing Website](#).

In order to ensure continuity of care during the selective provider contracting process, it is the practice of Stanislaus County BHRS to not terminate services without having comparable services available for beneficiaries. It is also a contract requirement that providers give 30-day

written notice should they decide to terminate the contract, thereby giving time to ensure clients are transitioned to another provider for services.

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

As referenced in Part II, #1, Stanislaus County BHRS will be convening strategic partner workgroups. “MAT” is one of the workgroups. Regarding “Additional MAT”, the workgroup will be tasked with, at minimum, the following:

- Consideration of need for additional MAT services;
- Identification of community health providers of buprenorphine (if any) and/or other MAT;
- Identification of OP providers that may be interested in providing additional MAT services;
- BHRS Medical Director and/or both NTP’s Medical Directors will provide input to the workgroup, as and when needed.

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

For beneficiaries who seek services through our BHRS Access Line or other agency partners, receive a full comprehensive ASAM assessment from BHRS’ Case Management and Care Coordination Team (CM-CCT) and meet medical necessity for residential treatment, no further authorization for admission to residential treatment will be required.

For those clients who have not been assessed by BHRS’ Case Management and Care Coordination Team (CM-CCT), providers will submit necessary paper work to BHRS’ Utilization Management (UM) staff. UM staff will review the Comprehensive ASAM assessment, including ASAM level of care placement criteria and DSM V diagnosis ensuring that the beneficiary meets medical necessity and other requirements for the service. UM will then communicate back to the provider regarding approval for a specified number of days of treatment, denial, or request further information within 24 hours of the prior authorization request submitted by the SUD provider.

Use of the Comprehensive ASAM assessment by trained BHRS UM staff will ensure that there is consistent application of review criteria for authorization decisions.

The length of residential services can range from one (1) to ninety (90) days. Authorizations for residential may be up to ninety (90) days for adults and thirty (30) days for adolescents. One-time extensions of up to thirty (30) days on an annual basis may be authorized based on medical necessity. Only two non-continuous ninety (90) day residential treatment episodes will be

authorized in a one-year period. Extensions may be authorized per the state DMC-ODS requirements.

Residential treatment programs will monitor the beneficiaries' progress on an ongoing basis and at least monthly to determine their readiness for discharge or step-down to a lower level of care. If a client is approaching the end of their BHRS-authorized treatment episode and the provider determines (based on ASAM criteria) that the client needs additional residential treatment, the provider will request an extension of the authorization from BHRS, provided that the total residential treatment length of stay is within the limits defined in the DMC-ODS Waiver Terms and Conditions.

During after hours, county holidays or weekends, brief ASAM screenings will be available. Should the brief ASAM screening determine the individual is in need of further assessment for residential treatment; a follow-up appointment/call will be initiated on the morning of the next business day with the CM-CCT, SUD provider or Access Line.

Beneficiaries who are eligible for residential services will be prioritized for placement in a residential bed based on severity of need as follows:

1. Pregnant injecting substance users;
2. Pregnant substance users;
3. IV substance users, especially in combination with other risk factors, such as being medically compromised;
4. High risk co-occurring disorder substance users (i.e., suicidal attempt while under the influence);
5. Parent involved substance users (i.e. Reunification with parent; women and men who have or who are about to lose custody of their 0 - 5 year old children; and/or a social worker is involved with an open case or involved with Child Welfare (CW) Services or Child Protective Services (CPS));
6. Criminal justice involved substance users (i.e. Adult Drug Court, Prop 36, Parole);
7. Substance users with co-occurring disorders; and
8. Substance users who do not fall into the above categories (1 - 7) will be admitted in order of their screening date.

However, prioritization for #4 - #8, will be based on urgency of need and based on factors such as morbidity and functional impairments directly related to the substance use disorder.

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

Review Note: This question only applies to counties participating in the one-year provisional

program and only needs to be completed by these counties.

N/A for BHRS

County Authorization

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

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

County

Date